The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 10 January 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 10 January 2018 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.

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** 10 January 2018: 1100h – 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)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Philip 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

Mrs Evelyn O'Kane	Matron & Safeguarding Lead	(EO'K)

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies - David Gourevitch and Tim Pile	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient story – Child Safeguarding case	Presentation	EO'K
1130h	4	Minutes of Public Board Meeting held on the 1 November 2017: *for approval*	ROHTB (11/17) 010	Chair
1135h	5	Trust Board action points: *for assurance*	ROHTB (11/17) 010 (a)	SGL
1140h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (1/18) 001 ROHTB (1/18) 001 (a)	YB/PA
	6.1	Paediatric services update	Verbal	AP/GM
	6.2	Orthopaedic services in the STP	Verbal	PA
1200h	7	Proposal to establish a Staff Improvement and Experience Committee and to disestablish the Major Project & OD Committee: *for approval*	ROHTB (1/18) 002 ROHTB (1/18) 002 (a)	SGL

QUALITY & PATIENT SAFETY				
1205h	8	Patient Safety & Quality report (from November): *for assurance*	ROHTB (1/18) 003	GM
1220h	9	Learning from Deaths report: *for assurance*	ROHTB (1/18) 004 ROHTB (1/18) 004 (a)	AP
1235h	10	'Perfecting Pathways' update: *for assurance*	Presentation	JWI
FINANCE AND PERFORMANCE				
1250h	11	Finance & Performance overview including recovery: *for assurance*	ROHTB (1/18) 006	SW
COMPLIANCE AND CORPORATE GOVERNANCE				
1300h	12	Compliance with CQC fundamental standards: *for assurance*	ROHTB (1/18) 007 ROHTB (1/18) 007 (a)	SGL
1305h	13	Board Assurance Framework – Quarters 2- 3: *for assurance*	ROHTB (1/18) 008 ROHTB (1/18) 008 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1310h	14	Quality & Safety Committee: *for assurance*	ROHTB (1/18) 009	KS
	15	Finance & Performance Committee: *for assurance*	ROHTB (1/18) 010	RA
	16	Audit Committee: *for assurance*	ROHTB (1/18) 011	RA
	17	Chartitable Funds Committee minutes: *for information*	ROHTB (1/18) 012	YB
MATTERS FOR INFORMATION				
1315h	18	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 7th February 2017 at 1100h in the Boardroom, 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 November 2017: 1100h – 1300h

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 and Director of Finance & Performance	(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	(JW)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL) [Secretariat]

Guests:

Angie Martin	CQC Inspections Manager	(AM) [Item 3 only]
Sally Powell	CQC Assistant Inspector	(SP)

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Professor Phil Begg. The Board welcomed a member of the public from Symbio, a company who supported trusts with their RTT pathway management.	
2 Declarations of interest	**Verbal**
There were none declared with any item on the agenda. Tim Pile was congratulated on his recent appointment as Chair of the Greater Birmingham and	

Solihull Local Enterprise Partnership and his declaration of interest would be updated shortly.	
3 CQC regulatory framework	**Presentation**
The Board welcomed Angie Martin and Sally Powell from the CQC. They presented an update on the new CQC regulatory framework for which they thanked. In terms of both the unannounced and well led inspections, there would be informal feedback provided prior to leaving on site. The Board was advised that this would consist of a snapshot of feedback and did not fully cover all that would be incorporated into the inspection reports. It was reported that after the visits, the data request demands would not be as onerous as they had been as part of the previous process. There would be better data collection in advance. After the well led inspection, the final report would be published within approximately three months. The metrics to define the success of improvement as a result of the CQC inspection regime were discussed. It was anticipated that there would be a change in the profile of the ratings of services across all organisations, with there being more rated as 'Good' or 'Outstanding'. The new insight dashboard will inform the view about how trusts were performing. The new inspection reports will be more accessible and offer greater clarity, which was a significant improvement on the previous reports. In terms of triangulation of information and evidence seeking to verify a point of view, it was reported that the inspection team were experienced and supported by specialist advisors and they would consider comments in the light of the number of times they were made and any other substantiating information. Regarding the regulatory planning meeting, this was informed by the culmination of collecting a range of information including staff presentations and monitoring information. This was being collated at present for the ROH. The report to the regulatory planning meeting would be submitted and presented with a view to recommending the inspection of a set of services and the timing of the inspection. In terms of continuity of inspectors, the team would comprise the Trust's relationship managers and their managers, so there was a familiarity with team members.	

The algorithm to arrive at an overall rating for the Trust was discussed. This was contained in the regulatory guidance. In terms of the frequency of inspection being based on the Trust's overall score, there would be an annual inspection but a full inspection would be based on risk. The CQC would join the Board meeting as an observer as part of the yearly cycle. The Board thanked the CQC for their attendance and support. Ms Powell stayed for the remainder of the meeting.	
4 Minutes of Public Board Meeting held on 4 October 2017	**ROHTB (10/17) 012**
The minutes were accepted as a true and accurate record of discussions held on 4 October 2017.	
5 Trust Board action points	**ROHTB (10/17) 012 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern. It was agreed that the Throne project would be presented to Quality & Safety Committee rather than the Trust Board.	
ACTION: SGL to reschedule the presentation of the Throne Project update to the Quality & Safety Committee	
6 Chairman's & Chief Executive's update	**Verbal**
The Acting Chief Executive reported that there had been a de-escalation of the Trust at the recent stakeholder meeting. The Executive was thanked particularly on the work to address the 18 weeks RTT position. At the next meeting, there would be a formal update from the Guardian of Safe Working, however the Board was advised that there had been no exceptions to report at the time of the meeting. There had been a discussion with the Aston Medical School as they were looking to move into a model that could access the government funded programme. A letter of support was to be provided by the ROH. It was noted that these discussions did not involve Dame Yve, who is pro-chancellor of Aston University. The formal undergraduate clinical education visit was planned shortly. The Board was advised that there was a programme of placing the Executives in	

team meetings to provide a briefing and this was being well received by staff. There had been lots of questions and staff had been very engaged. The feedback on improved communication had been positive. It was noted that some feedback suggested that there needed to be a balance with communicating to the Paediatric area and all other areas. The Executive Director of Patient Services reported that he had had a good meeting with the housekeepers and there were some practical feedback around cleanliness that he had been able to harness, particularly around the around the impact of extending visiting times. The Chairman reported that since the Board had last met there had been a Council of Governors meeting where there continued to be debate around the Paediatric services decision and operational performance. Positively, all stakeholder governor positions were now filled. The Chairman had met with Mark Hopton, Chair of Birmingham City University and with Danielle Oum, Chair of Healthwatch & Walsall Healthcare NHS Trust. The Annual Members Meeting had been held on 5 October and was well attended. There had been a scoping session around the new Staff Experience & Improvement Committee and a proposal would come to the next meeting together with a set of terms of reference for the establishment of this new Committee. There would be a STP Board meeting shortly at which there would be an update on the Strategic Outline Case provided.	
6.1 Voting rights for interim Board members	**Verbal**
The Associate Director of Governance & Company Secretary reported that the Non Executives had met before the previous meeting of the Board as the Nominations Committee and discussed a proposal to confer voting rights on the two interim Board members, the Chief Operating Officer and the Director of Finance. It was agreed that this should be the case and had the benefit of creating more of a balance between voting Non Executive and Executive members.	
7 Patient Safety & Quality Report	**ROHTB (11/17) 002**
The Executive Director of Patient Services presented the Patient Safety & Quality report and highlighted that there had been a focus on VTEs recently; the type and number had changed including Pulmonary Embolisms. At the moment, there was no evidence and reason behind the change. The Root Cause Analyses were now concluded more rapidly and any themes would be shared. Random spot checks of the clinical areas were being undertaken. In terms of the position against NICE guidance, the level of VTEs seen at the Trust was still below the levels expected. There was no plan for an external review and the Trust was described as an	

exemplar. It was noted that the Trust collected post discharge VTE information although this was not the case in other organisations; there was regarded to be value in the learning from this. A diagnostic of where VTEs were occurring was underway. It was noted that the prevalence of VTEs was recognised to be higher in orthopaedics than other specialities. It was noted that patient compliance with practice to avoid VTEs also needed to be borne in mind. The Royal Orthopaedic Community Service (ROCS) took a role in monitoring patients when they were back at home. The classification of the VTEs in terms of 'avoidability' and 'unavoidability' was discussed. A direct report from the VTE Committee would come to the Quality & Safety Committee shortly.

There had been two patient deaths. When investigations into the deaths had been completed, there would be engagement with the vascular team at the Queen Elizabeth Hospital. Clinicians here would also be involved in the Root Cause Analysis. The reports on the deaths would be available shortly.

There had been four Serious Incidents closed around spinal deformity and this was linked with the system issues and availability of Paediatric Intensive Care Unit (PICU) beds. One child would not have surgery later in the year; the other three patients had already received their surgery.

On Ward 11, there had been deterioration in the Friends and Family Test (FFT) position and this would be investigated. The national guidance around FFT would be revisited to ensure that there was a consistency of approach. It was noted that this was still c. 96% overall for the Trust.

There was a good compliance against the WHO checklist.

It was noted that some of the data in the finance and performance report had been replicated in the quality & safety report as this was germane to the quality information considered.

In terms of the outpatient clinic waiting times, there had been a spike in waiting times. In medical records, there were new key performance indicators that were being monitored and there was a new process to pull the notes ahead of clinic. Some of the clinics which were manned by registrars would be monitored and patient times altered if needed. An incident form was completed for any waits over 60 minutes.

Mrs Sallah reported that the Quality & Safety Committee meetings were extensive but effective. On a positive note, there was proof of 100% achievement with the use of the WHO checklist. The Associate Medical Director, Mr Revell was to be thanked for this achievement. Agency nurse staffing was below 10%, although this could be a challenge to maintain in the future this in the face of Paediatric services

mitigations. Near miss incidents were to be reviewed, including the classification of these. The reporting of these was positive. There had been a good discussion on Research & Development, however clinical audit needed to be picked up; all staff could have a role in driving improvement through audit practice. It was suggested that this needed to be discussed at Audit Committee in April. In terms of the sustainability of the Pathology services, there had been a discussion with University hospital Birmingham NHS FT (UHB) around strengthening the team given that a key member of staff was leaving. A plan would be developed shortly. It was agreed that this needed to be presented to the Trust Board. This service needed to provide a robust clinical service for patients. There had been a good presentation on sepsis and the ROH was working with the national pilot and performance was significantly above expectations.	
ACTION: **SGL to schedule a discussion around Clinical Audit at the Audit Committee in April 2018** **ACTION:** **GM to present an update on Pathology services at the next meeting**	
8 Annual complaints report	**ROHTB (11/17) 003** **ROHTB (11/17) 003 (a)**
It was reported that the annual complaints report had been considered at the last two Quality & Safety Committee meetings and had also been discussed with NHS Improvement. There had been an increase in the number of complaints, which were primarily around spinal and oncology administration arrangements. The improvement plan has been described elsewhere in other plans considered by the Board. A detailed breakdown of the complaints had been considered by the Quality & Safety Committee and the detail was discussed at the divisional board meetings. The Board noted that there had been a reduction in complaints associated with waiting times to only one in the year. Attitude of staff was an key reason for complaints and to address this, customer care training would be reintroduced. This issue related to all staff groups. There was an increase in PALS contacts as a result of a directive on the bottom of the appointment letters to call PALS for any query. Letters had been amended to direct patients to call the medical secretaries instead. The use of 'You Said, We Did' methodology was to be strengthened. Key complaints Key Performance Indicators had been met. The conclusion from the Public Health Service Ombudsman (PHSO) review of two	

complaints was that they were not upheld. It was noted that there was a need to be able to deal with a complainant in the immediate rather than directing all people to PALS. It was agreed that this was critical and work would be undertaken over the next few months to better equip people to do this. It was noted that the number of compliments was very positive. The report would be shared with the Council of Governors at its next meeting.	
ACTION: **SGL to ensure that the Council of Governors received the annual complaints report**	
9 Annual Infection Control report	**ROHTB (11/17) 004** **ROHTB (11/17) 004 (a)**
The annual infection control report was considered. The delay in presentation was to enable the input from NHS Improvement to be built in and the report was now constructed in the hygiene code format. The report described the role of the Director for Infection Prevention and Control and the way that the Board was sighted on Infection Prevention and Control matters. There had been no cases of MSSA or MRSA bacteraemia. There were four *C. difficile* instances in the Bone Infection Unit. There had been a decrease in *E. coli* cases. The flu vaccination rate achieved last year was 54%. Isolation issues were not a matter of concern for the organisation. There had been six sharps incidents, however the Trust was regarded as being compliant with safe sharps requirements. The decontamination action plan developed in response to the theatre closure in June 2016 had been closed and there was good assurance from the peer review. The Mandatory Training position was above the contractual requirement. In terms of the leadership, the Executive Director of Patient Services was also the Director of Infection Prevention and Control and Mustafa Ahmed had provided the strategic oversight of the Infection Control function. An appointment had been made to the Lead Nurse for Infection Prevention and Control. The Trust was out to	

advert for the data analyst. NHS Improvement was pleased with the effectiveness of the Infection Control Committee. It was agreed that the profile of Infection Prevention and Control had improved across the Trust. The Executive Director of Patient Services provided an overview of the key challenges, which had involved the peer review feedback earlier in the year. There had been a reassessment in July and moved the Trust to a more positive rating. There had been some significant investments made. The current positon was a good improvement from earlier in the year.	
10 CQC inspection preparation	**ROHTB (11/17) 005** **ROHTB (11/17) 005 (a)**
The Executive Director of Patient Services, reported that the Interim Chief Operating Officer would lead the overview of Outpatients and he, himself, would review the High Dependency Unit (HDU); these two areas were regarded as those that required the most degree of scrutiny and focus. There was a new leadership team in Outpatients and an operational outpatient group had been set up. There was shared learning through this and progress was updated through the Finance & Performance Committee's overview. The methodology would mirror that of the Children's Board and HDU Improvement Board. The recently held focus groups had been balanced. Speciality presentations were due from a range of areas across the Trust shortly. There were some mock presentations and these were co-ordinated by a multi-disciplinary approach. It was noted that there was a good degree of enthusiasm and pride in services. The data request had been responded to in September and there were a number of shortfalls highlighted, one being around the medical locum system and absence of clinical supervision mechanisms and policy. There was an absence of audits of patients with complex needs. There was also an absence of bereavement surveys, however the ROH had a low number of deaths and another provider might be more used to provide a Service Level Agreement for this. It was reported that a letter had been received from a patient's family who had received end of life care and there was evidence of a good level of compassion. A range of action plans have been developed, showing responsiveness to issues and concerns when identified. Where actions are closed, then there is evidence of sustainability. The West Midlands Quality Review Service (WMQRS) was providing a set of tools to undertake a series of self-assessments. The incident reporting backlog would be addressed.	

There was reported to be weekly Executive oversight in preparation for the CQC inspections. A quality and safety conference was reported to be planned for 30 November. The role of the Non Executive and Governor in quality and safety as part of this was planned.	
11 'Perfecting Pathways' update	**ROHTB (11/17) 006** **ROHTB (11/17) 006 (a)**
The Interim Chief Operating Officer presented progress with engaging the organisation around the key principles set out by the Kings Fund. There was a project team set up which discussed the multiple schemes that were underway. There were a core set of individuals to assist with the development of a business case where needed for creating improvement and for logging and progressing suggested changes. There had been a good workshop on pre-operative assessment. In terms of a communication plan, progress and plans would be issued via a briefing on Monday. The team also started pulling together a set of pledges ahead of NHS Fab week (13 – 17 November 2017). It was noted that the rebrand of the programme was good, however celebrating success needed to be included in the plan. It was noted that this was a key part of the plan and effort was being directed into sharing the improvements in a more high profile way. This supported the Trust's ambition to be a learning organisation. The recent meeting had been very positive and staff were very engaged with the work within a clear structure. It was noted that the approach was 'bottom up' and reflected an empowering organisation and leadership. This could be embedded in a workforce strategy and provided evidence of the organisation being well led. In terms of improvement support, there were a number of organisations who the Trust would be approaching to secure this expertise.	
12 Finance & Performance overview	**ROHTB (11/17) 007** **ROHTB (11/17) 007 (a)**
The Interim Director of Finance reported that there had been a small improvement in the September financial position to one that was in line with the recovery plan. Activity and income was still below plan however. There was noted to be some additional analysis on the trends associated with activity and income and work was underway to understand the maximum capacity possible through theatres. Theatre utilisation was at an average of 87%, which was positive. Reducing the fluctuation	

was needed however to ensure that activity was in excess of 300 cases per week consistently. There was some learning from the management of activity from last year. There was much work to do to validate the existing Cost Improvement Programme schemes and assess where there had been slippage or replacement was needed. Trends in non-pay expenditure were being reviewed. A full stocktake in theatres was planned shortly. Performance against the 28 day reschedule guarantee target was good. Performance against the diagnostic waiting time targets was also good, as was performance against the cancer targets. In terms of non-pay spend, this did not mirroring the activity position and therefore prostheses and consumables would be reviewed. The stocktake position should give a good overview of high cost controls. It was noted that it had been reported in the Finance and Performance Committee meeting that the non-pay spend in the previous month had been far higher than planned and it would take some months for the position to be adjusted from that previously. Ordering practice also needed to change. There was also an issue concerning how stock was treated from an accountancy perspective.	
13 Quality & Safety Committee assurance report	**ROHTB (11/17) 008**
It was noted that this had been covered as part of the discussion of the Quality & Patient Safety report taken earlier on the agenda.	
14 Finance & Performance Committee assurance report	**ROHTB (11/17) 009**
The Board received and accepted the report. It was noted that there had been some discussion on the RTT position, the 'Perfecting Pathways' work and the Strategic Outline Case development. It had been a stable month financially, however not with the right drivers. Out of hours and weekend working might be needed to meet the recovery the plan. The delivery of activity to manage the 18 weeks RTT position was to be worked through as part of an annual planning process. Every week an activity plan needed to be in place to meet the RTT pathways. Unlike previously, there was a shared ownership of the activity targets by those staff needed. It was suggested that thought needed to be given to the work that needed to be developed as part of the longer term strategic development. There was a big impact of beds currently remaining closed on staff morale. This	

was across the Trust; not just nursing.	
15 Any Other Business	**Verbal**
It was suggested that there needed to balance some of the deep discussion between public and private Board sessions and the Chairman and Associate Director of Governance/Company Secretary would consider this as part of future agenda-setting.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 10 January 2018 at 1100h, Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 10 January 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

1 November 2017, Boardroom @ Trust Headquarters

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee in April 2018	SGL	30-Apr-17	ACTION NOT YET DUE	
ROHTBACT. 044	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Present an update on Pathology services at the next meeting	GM	10-Jan-18	Update presented to Quality & Safety Committee on 28 November and a further update planned for the meeting on 31 January 2018	
ROHTBACT. 045	Annual complaints report	ROHTB (11/17) 003 ROHTB (11/17) 003 (a)	01/11/2017	Ensure that the Council of Governors received the annual complaints report	SGL	17-Jan-18	To be presented to Council of Governors at the January 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	Presentation given at the November meeitng of the Quality & Safety Committee	
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	Report on nursing KPIs now considered by the Quality & Safety Committee on a routine basis	
ROHTBACT. 042	Trust Board action points	ROHTB (10/17) 012 (a)	01/11/2017	Reschedule the presentation of the Throne Project update to the Quality & Safety Committee	SGL	30-Dec-17	Presentation given at the November meeitng of the Quality & Safety Committee	

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:	**10 January 2018**

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 10th January 2018

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 public Trust Board meeting on 1st November 2017

2 REFERRAL TO TREATMENT (RTT) RECOVERY PLAN

2.1 In line with plans agreed with NHS Improvement, the ROH returned to national reporting of RTT performance in December 2017.

2.2 Performance in November showed 79% of patients on incomplete RTT pathways had been waiting for less than 18 weeks for treatment against a national standard of 92%. 80 patients had been waiting for over 52 weeks, of which 64 were spinal deformity patients.

2.3 The Trust has submitted trajectories, and has plans in place, to deliver 92% compliance by November 2018. It is expected that all 52 week patients, with the exception of spinal deformity patients, will be cleared by the end of January 2018. The Trust continues to work the health system as part of the transfer of paediatric services to ensure that there is a clear and jointly owned plan for the clearance of long waiting spinal deformity patients.

3 CQC PREPARATION

3.1 The CQC have confirmed that their announced Well-Led review will take place on Wednesday 21st February and Thursday 1st March 2018. The unannounced review of one or more core areas can take place between 2 and 8 weeks before these dates, so could therefore take place any time now.

3.2 A CQC toolkit has been circulated to all staff explaining the purpose of the CQC visit, what staff should expect and the main areas of that the CQC may focus on. It incorporates a reminder of key individuals, the Trust's vision and key priorities, a summary of key risks and includes some checklists to support preparation for the day.

3.3 Key action plans continue to be regularly reviewed at appropriate governance committees to ensure that the Trust and the CQC will have clear oversight of the improvements that have been made since the last visit and the ongoing work that continues to be delivered.

3.4 In August 2017, the CQC published their Use of Resources assessment framework, which describes how Use of Resources will be added as a sixth key question under future CQC reviews and they have recently been consulting on how this review will be reported and how it will be incorporated into the overall rating system. The Trust Board are reminded that, as a specialist hospital, the ROH will not be subject to a Use of Resources review as part of the forthcoming assessment.

4 CQC FEES – 2018/19

4.1 In November 2017, the CQC consulted on proposals to change the way in which fees are levied in 2018/19. Under the proposal, fees would be based on a percentage of overall turnover and not banded into broad turnover brackets as per the current model.

4.2 Under the proposals, small Trusts such as the ROH would pay between 0.07% and 0.11% of our turnover as an annual fee. Based on an £80m turnover, this equates to between £56,000 and £88,000. Our fee for 2017/18 was £158,902.

4.3 The outcome of this consultation has not yet been published.

5 HEALTH EDUCATION ENGLAND NHS WORKFORCE STRATEGY

5.1 On 13th December 2017, Health Education England (HEE) published a draft workforce strategy for England entitled "Facing the Facts, Shaping the Future". HEE are consulting on the strategy, with final comments due by 23rd March 2018.

5.2 Views on the strategy and the impact on the ROH will be considered by the Staff Experience and OD committee on 7th March however in summary the strategy is underpinned by six high level principles that will underpin future workforce decisions:

- Securing the supply of staff
- Enabling a flexible and adaptable workforce through investment in education and training of new and current staff
- Providing broad pathways for careers in the NHS
- Widening participation in NHS jobs
- Ensuring that the NHS and other employers in the system are inclusive modern model employers
- Ensuring that service, financial and workforce planning are intertwined.

5.3 The full strategy can be reviewed at https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-strategy

6 UKAS ACCREDITATION OF MUSCULOSKELETAL PATHOLOGY SERVICE

6.1 On 28th & 29th November, the Trust's Musculoskeletal Pathology Service was assessed by the United Kingdom Accreditation Service (UKAS) for compliance against ISO15189 standards. These set of standards are an international benchmark for quality in medical laboratories.

6.2 I am pleased to report that the Trust received very positive feedback from assessors and that we have been given full accreditation, with only a small number of minor non-conformities that the team have developed an action plan to ensure appropriate actions are taken.

7 ENVIRONMENTAL HEALTH OFFICER INSPECTION

7.1 The Trust was visited on 18th December 2017 by the Environmental Health Officer (EHO) to review our food hygiene standards. As a result of this visit, the Trust has been rated as a 5 for our standards, the highest rating that can be awarded. This provides further affirmation of the excellent service provided by our catering team.

8 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

8.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities since the last public board include:

- Midlands & East Provider CEO Event
- NHS Providers annual conference
- NHSI CEO Induction Day
- Stakeholder Oversight meetings with NHSI, NHSE, CQC & CCG
- 2 x STP Board meetings
- STP Development and Delivery Group
- STP Strategy Directors Group

9 POLICY APPROVAL

9.1 The Executive Team is focussing of ensuring that any policies beyond their review dates are reviewed as a matter of urgency and where appropriate and changes are of a minor nature, Executive Director discretionary authority is used to extend the validity of policies pending a more wholesale review.

9.2 A policy position statement is now a regular item as part of the Executive Team forward plan.

9.3 Since the Board last formally met, the following new or substantially changed policies have been approved by the CEO on the advice of the Executive Team:

- Fire policy
- Serious incidents reporting policy (subject to minor amendment)

- Mental Capacity Act and Deprivation of Liberties policy

10 RECOMMENDATION(S)

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

10.2 Note the contents of the report.

Paul Athey
Acting CEO
10th January 2017

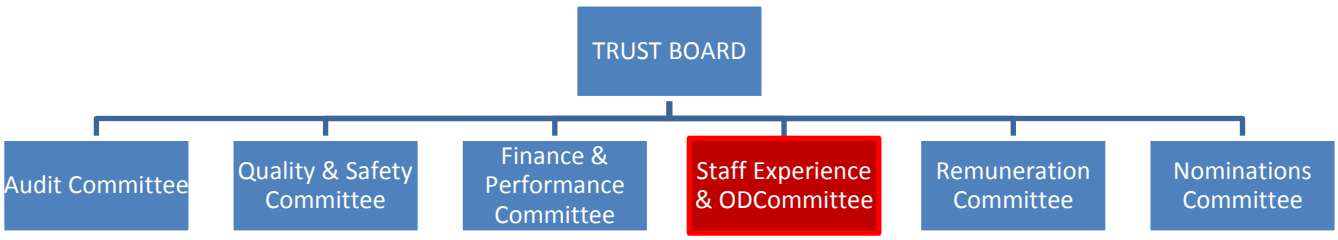
The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Staff Experience & Organisational Development Committee**
SPONSOR:	**Dame Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**10 January 2018**

EXECUTIVE SUMMARY:

The Board is asked to consider a proposal to establish a new Committee, to be known as the Staff Experience & Organisational Development (OD) Committee. The body will be one of the six formal Board committees, as below:



The establishment of the committee will strengthen the Board oversight of workforce-related matters, this currently being through consideration of different reports by the Finance & Performance Committee, the Quality & Safety Committee and the Major Projects & OD Committee.

The proposed initial Terms of Reference for the Staff Experience & OD Committee are attached for the Board's approval. A six month review is suggested to allow for a period of further refinement as the Committee embeds and to allow the new Associate Director of Workforce, HR and OD to provide input.

The current Major Projects & OD Committee splits its remit between considering progress with the implementation of initiatives into the Trust that are high cost and/or impact trustwide and the development of the organisational development framework in the Trust. It is proposed to dis-establish this formal committee and instead the Board will directly receive a quarterly update on Major Projects and the organisational development work will form part of the remit of the new Staff Experience & OD Committee.

REPORT RECOMMENDATION:

Trust Board is asked to consider the attachments and:

- APPROVE the establishment of a Board Committee, to be known as the Staff Experience &

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Organisational Development Committee and APPROVE its proposed initial terms of reference

- APPROVE the disestablishment of the Major Projects & OD Committee

ACTION REQUIRED (Indicate with 'x' the purpose that applies):

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	x	

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

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

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

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

Good governance as strengthens the Board's oversight of workforce-related matters

PREVIOUS CONSIDERATION:

The proposal has been considered and supported by relevant Non Executives and Executives.

STAFF EXPERIENCE AND ORGANISATIONAL DEVELOPMENT (OD) COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Staff Experience and OD 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 Trust's performance against a range of workforce-related metrics, indicators and targets. It shall also seek assurance as to the robustness of the Trust's organisational development framework and progress with developing a learning and improvement culture within the ROH.

4 MEMBERSHIP

4.1 The Committee will comprise of not less than three Non-Executive Directors (including the Associate Non Executive Director), the Director of Strategy & Delivery, Chief Executive and the Chief Operating Officer.

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 three 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 and organises 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 on alternate months, with additional meetings where necessary.

7 REPORTING AND ESCALATION

7.1 Following each committee meeting, the minutes shall be drawn up and presented at the next Committee meeting where they shall be considered for accuracy and approved. 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 workforce strategies, including but not limited to:

- People Strategy
- Leadership Strategy
- OD and Staff engagement strategy
- 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 workforce planning, education, training and development to meet the needs of the Trust's overall strategy

9.4 To ensure that workforce plans are adequately connected to financial and capacity/demand planning in ROH

9.5 To review plans for developing new roles, skill mix and where needed, new job plans, to meet the evolving needs of the Trust

9.6 To review data and trends against key workforce metrics, including but not limited to:

- Numbers of starters, leavers and staff turnover
- Staff in Post and vacancy rates
- Pay spend (fixed and variable) overall and by staff group
- Appraisal rates and mandatory training position
- Sickness absence and other absence
- Numbers of formal procedures
- Staff satisfaction
- Productivity and benchmarking data
- Agency and locum usage

And to seek assurances that where there are trends of concern, that plans are in place that will deliver improvement in an effective and timely way

9.7 To seek assurance on the Trust's position against the NHS Improvement and CQC Well Led Frameworks and any plans to strengthen compliance or address shortfalls against the requirements of any dimension

9.8 To review key trends and themes from staff feedback, through mechanisms including the national staff survey, internal 'pulse checks', 360 degree feedback, exit interviews, Freedom to Speak up data and whistleblowing concerns raised and seek assurance that where improvement is required that plans are sufficiently robust and timely

9.9 To review plans for developing the Trust's education and training framework, including Learning Beyond Registration, and to scrutinise income and expenditure from Health Education West Midlands

9.10 To seek assurance on the quality of wellbeing offerings to staff and on the adequacy of the health and safety framework for staff

9.11 To review and seek assurance on the robustness of the Trust's talent management and succession planning frameworks

9.12 To review the Trust's plans to develop a recognition and reward model

9.13 To have oversight of culture change across the Trust, including the development of an Improvement culture among the workforce and equipping staff with the knowledge and skills to make improvements happen at the front line

9.14 To seek assurance on behalf of the Board that the key risks to the delivery of any of the workforce strategies are adequately mitigated

Date of adoption: January 2018

Date of review: June 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

November 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.

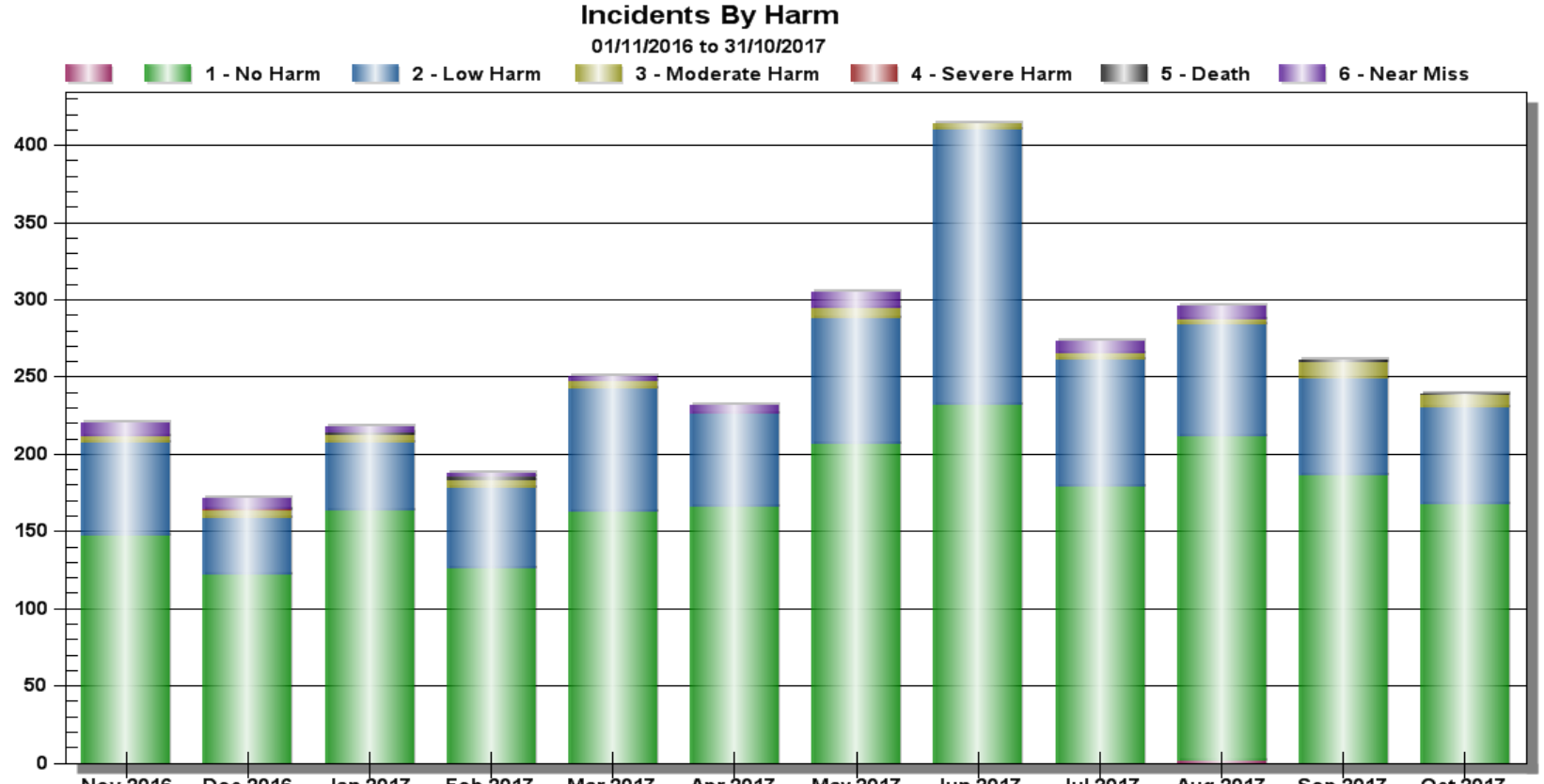
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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.

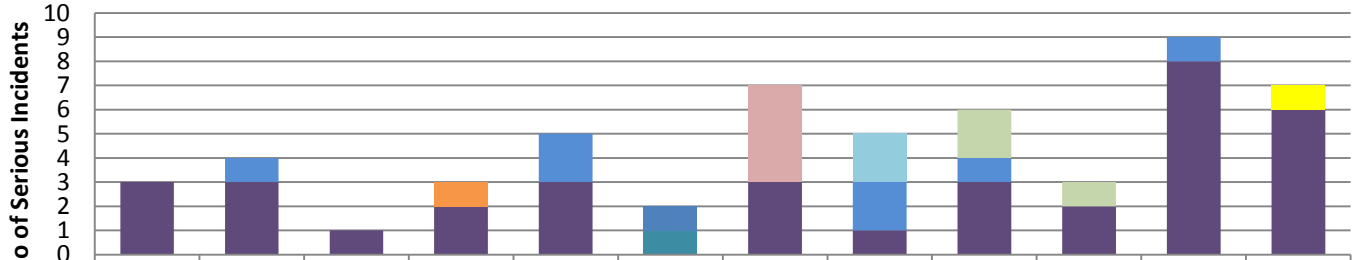


Month and Year	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017
	0	0	0	0	0	0	0	0	0	1	0	0
1 - No Harm	147	122	163	126	162	166	206	232	179	210	186	167
2 - Low Harm	60	36	44	52	80	60	82	178	82	73	63	63
3 - Moderate Harm	4	5	5	5	5	0	6	4	4	3	10	8
4 - Severe Harm	0	1	0	0	0	0	0	0	0	0	0	0
5 - Death	0	0	2	2	0	0	0	0	0	0	2	1
6 - Near Miss	9	7	4	3	3	6	11	0	8	9	0	0

INFORMATION
In October 2017 there was a total of 232 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is at follows; 167 – No Harm 63 – Low Harm 8 – Moderate Harms 0 – Near Miss 1 – Deaths
ACTIONS FOR IMPROVEMENTS / LEARNING
None
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 October 2017



	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	July	Aug-17	Sep-17	Oct-17
Unexpected Injury									2	1		
RTT Harm review							4					
Emergency transfer to HDU												
Exposure to hazardous substance				1								
Retained object												1
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	3	3	1	2	3		3	1	3	2	8	6

INFORMATION

There were **7 Serious Incidents Declared in October 2017;**

The following actions have been undertaken so far**:**

- Roundtable
- Production of a 72 hour briefing report to CCG
- Notified BBRaun and manufacturer of the instrument issue
- Request for x-ray report to see if there was a delay in reporting whether there was anything evident on the post op X- ray.
- Theatre Staff reminded of the requirement to visually check every instrument handed to the surgeon.

ACTIONS FOR IMPROVEMENTS / LEARNING

A patient attended the hospital for a right sided nerve root injection. The left side was injected in error. Once the error was identified the patient had the right side injected uneventfully.

7

This was an undeliberate mistake by the consultant who injected the wrong side, the Consultant realised the mistake straight away and apologised, then did the correct side injection. After discussions with ADCU staff, it appears that some ADCU clinicians were not compliant with the WHO checklist

Evidence of good practice:

1. Error was instantly identified and corrected
2. An immediate apology to the patient
3. A detailed incident form was written on the same day
4. An Urgent roundtable was organised by the hospital AMD
5. As the incident was identified as a serious one, the consultant involved was asked to cease clinical work until further notice
6. Consultant A was directly observed for a period of time
7. A Duty of Candour letter was sent to the patient

8. Pain Consultant met the patient for a clinic follow up

Evidence of poor practice:
1. A consent form wasn't signed in clinic when the patient was initially seen
2. The injection side wasn't appropriately marked
3. A WHO checklist wasn't filled and signed (although the incident form stated that it was done), also Team briefing wasn't documented (there is no Team brief form in ADCU)
4. An Xray request form wasn't filled by the consultant in charge

Recommendations

1. The consenting process has to be undertaken in clinic by the referring physician, with all risks discussed in details with the patient, it has to be signed by the patient and the first part signed by the clinician. We proposed to change the consent form by increasing the allocated space for RISKS, Medical Director replied that he will consider this in the near future.

2. All efforts has to be done to try and **change the 'ADCU pool system'** in the future , so that every clinician is responsible for his patient from their initial point of meeting in clinic till the patient is discharged , including undertaking the procedure in ADCU.

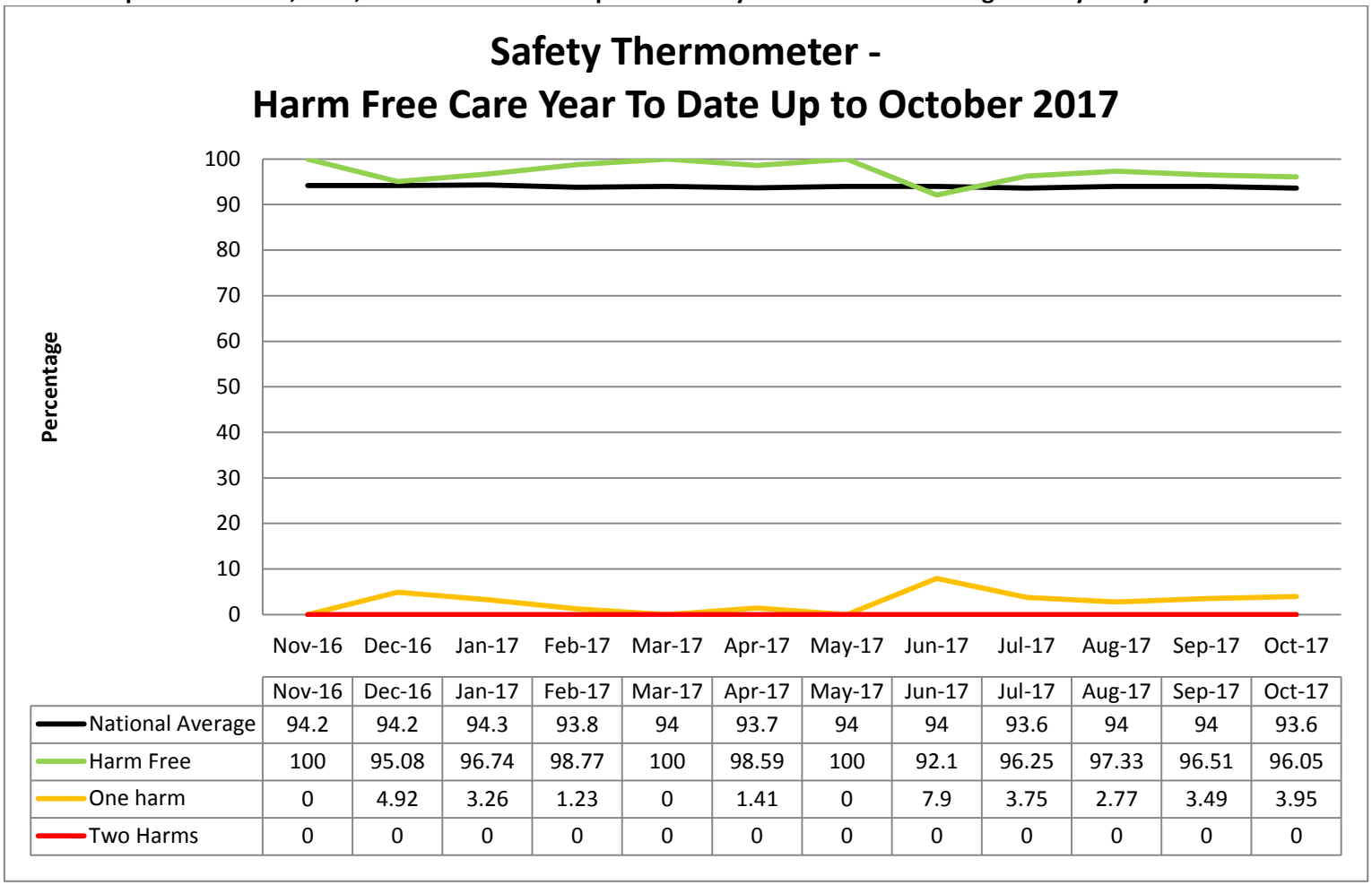
3. Team briefing and Debriefing is crucial before starting a list in ADCU (A Team Brief form designed by the pain team was submitted and awaiting approval) and should include;
a. Team introduction and delegating roles (eg. who will be responsible for the WHO)
b. Number of patients on the list
c. Discuss the order of the list and Re-print if changed
d. Discuss any personnel or equipment issues
e. Discuss any critical steps or potential difficult cases

4. WHO checklist (Sign in, Time out and Sign out) has to be read out loud and clearly signed and dated by a member of the team (however it's the consultant responsibility)

5. The injection side has to be clearly marked by a skin marker pen in close proximity to the site of the injection by the physician after confirming with the patient.

6. 'STOP BEFORE YOU BLOCK' , injection side to be confirmed out loud again with the patient and the assistant before inserting the needle **7. Xray request form** has to be signed and dated by the clinician before the procedure (Responsibility of both the Consultant and the Radiographer) **8. Procedure documentation forms** have to be updated to include all types of procedures done by Pain management consultants including radiofrequency denervation, a new form has been submitted and awaiting approval.
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.**



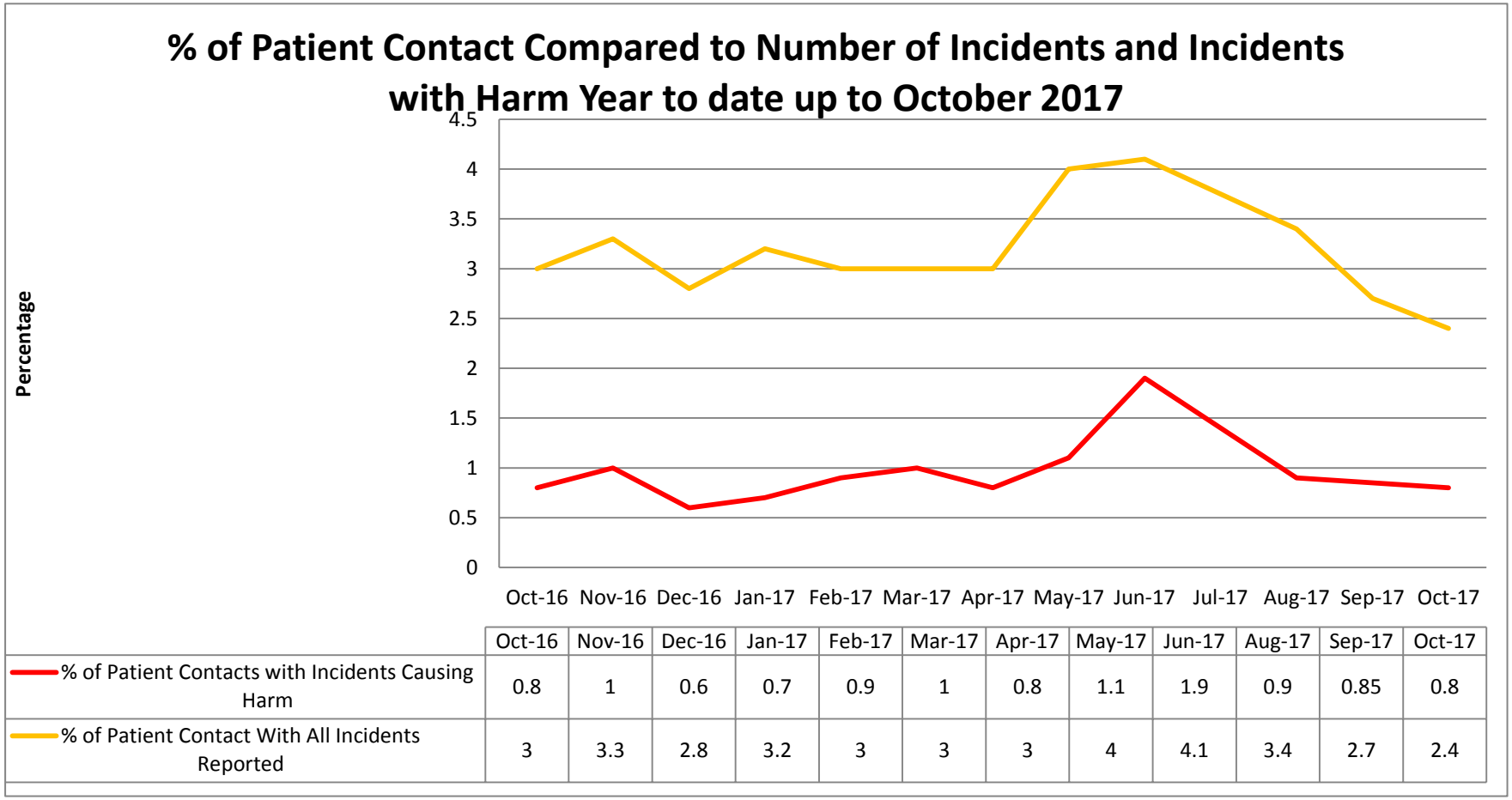
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
National Average	94.2	94.2	94.3	93.8	94	93.7	94	94	93.6	94	94	93.6
Harm Free	100	95.08	96.74	98.77	100	98.59	100	92.1	96.25	97.33	96.51	96.05
One harm	0	4.92	3.26	1.23	0	1.41	0	7.9	3.75	2.77	3.49	3.95
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The harms highlighted on the safety thermometer were;
2 x Old Pressure Ulcer, 1 New PE, 1 old PE, 1 old DVT and 1 new UTI

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 October 2017 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

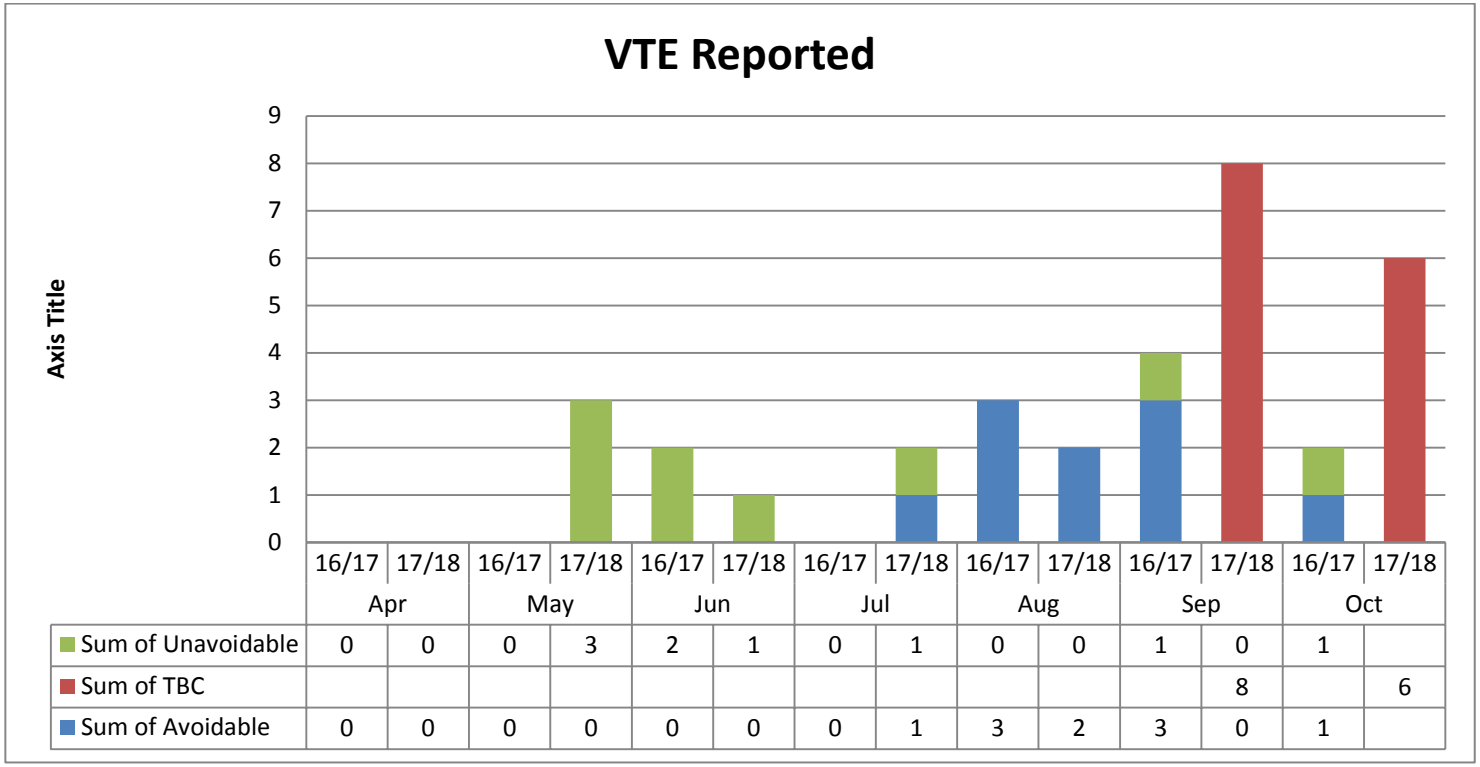
	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Aug-16	77	3	0	0	80	286	6274
Sep-16	97	5	0	0	102	268	6823
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	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
Oct-17	67	9	0	1	77	232	9571

In October 2017, there were a total of 9571 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.



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Aug-17	Sep-17	Oct-17
% of Patient Contacts with Incidents Causing Harm	0.8	1	0.6	0.7	0.9	1	0.8	1.1	1.9	0.9	0.85	0.8
% of Patient Contact With All Incidents Reported	3	3.3	2.8	3.2	3	3	3	4	4.1	3.4	2.7	2.4

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).**



	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	16/17 Sep	17/18 Sep	16/17 Oct	17/18 Oct
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0	1	0	1	
Sum of TBC												8		6
Sum of Avoidable	0	0	0	0	0	0	0	1	3	2	3	0	1	

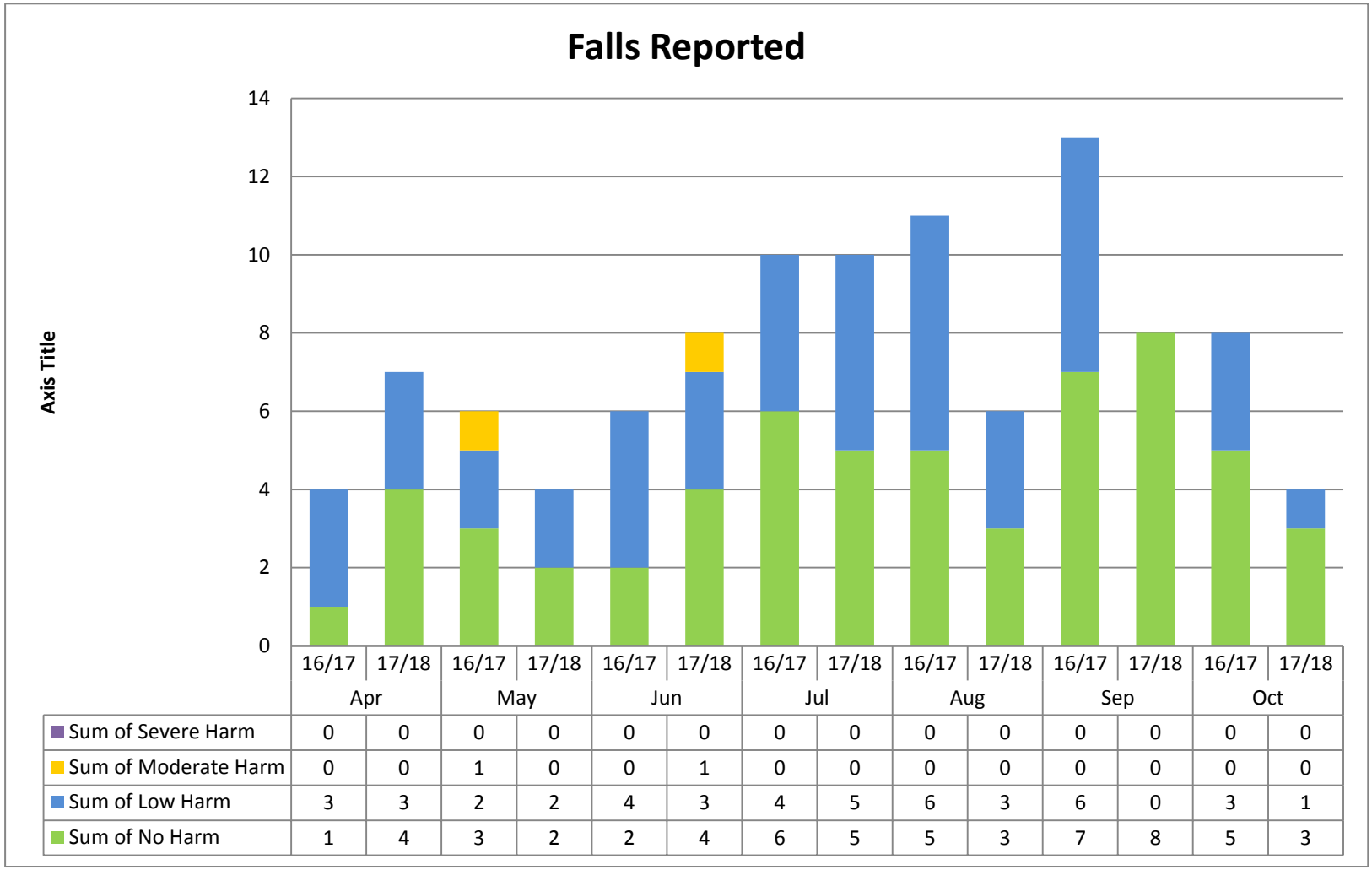
13

total		Avoidable
16/17	27	13
17/18	22	3*

***not classified**

INFORMATION
There were 6 VTEs declared in October 2017.
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 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.**



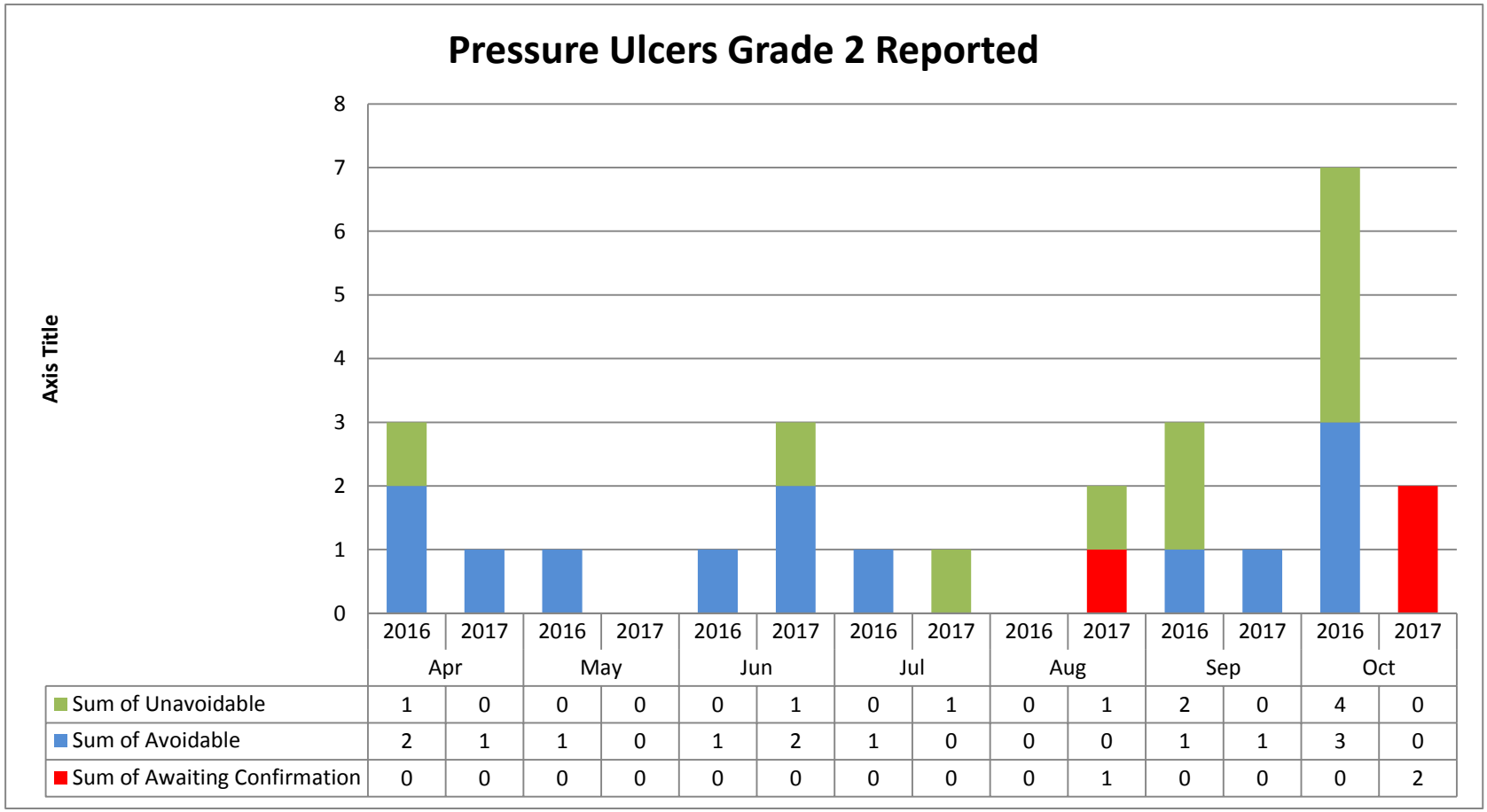
	16/17 Apr	17/18 Apr	16/17 May	17/18 May	16/17 Jun	17/18 Jun	16/17 Jul	17/18 Jul	16/17 Aug	17/18 Aug	16/17 Sep	17/18 Sep	16/17 Oct	17/18 Oct
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Moderate Harm	0	0	1	0	0	1	0	0	0	0	0	0	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3	6	0	3	1
Sum of No Harm	1	4	3	2	2	4	6	5	5	3	7	8	5	3

INFORMATION
Overall 4 fall related incidents were reported across the Trust in October 2017, all 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.

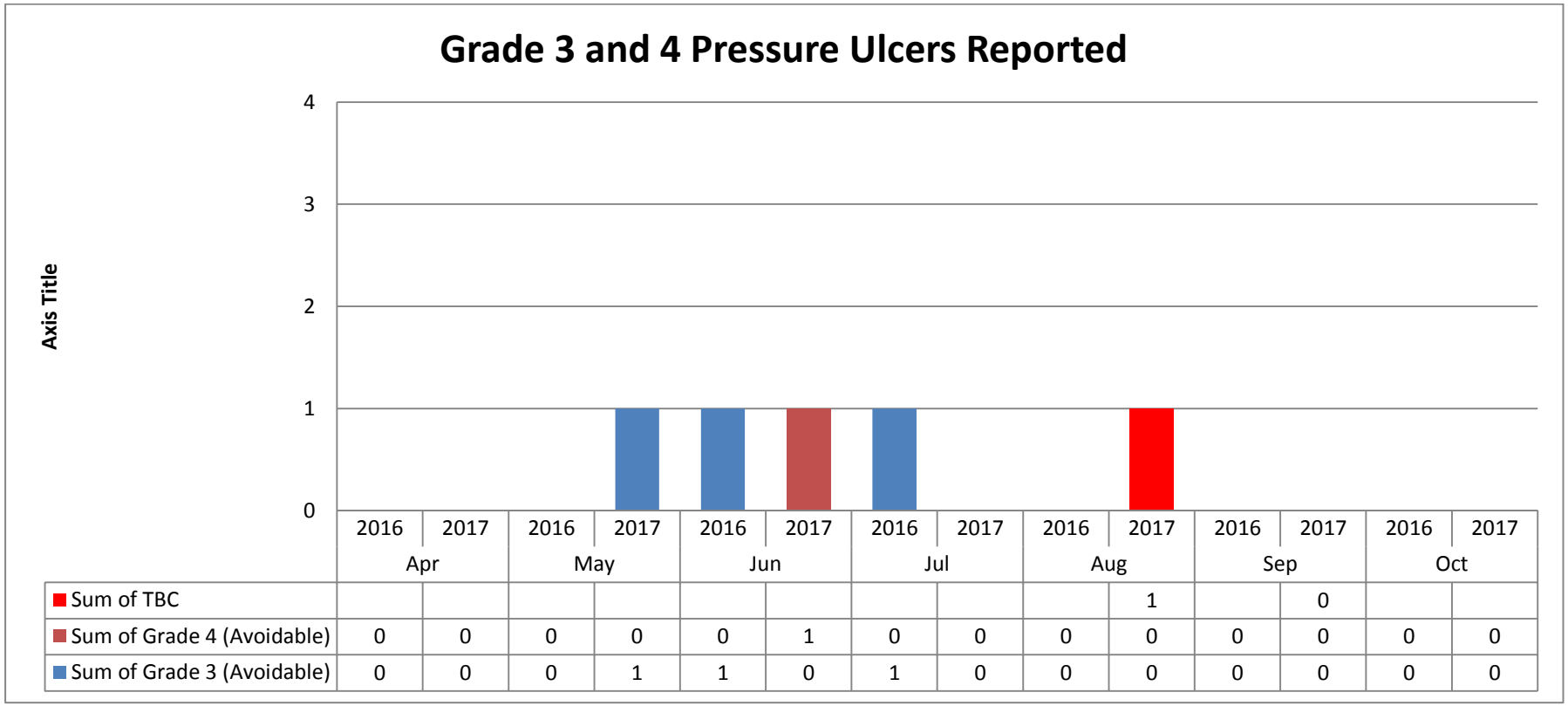
ACTIONS FOR IMPROVEMENTS / LEARNING
The Falls working group still meets bi-monthly and is multidisciplinary. The work currently being undertaken: • Reviewing and updating the bed rails policy – Karen Hughes is reviewing and circulating for comments before the next meeting in January 2018. • Throne project – this was completed earlier this year. • The SOP for patients at risk of falling and the 'fall leaves' is currently under review following the last Falls group meeting when the SOP was amended slightly. • Review of Manual Handling training across the Trust and the possibility of 'train the trainer' to ensure bespoke training to areas / wards is undertaken. Investigating the possibility of staff having 'manual handling passports' to complete with the ward trainer. Urgent training needs have been identified in Xray – Chris Aspland to contact Karen Jones to arrange training. • Chairs in main hospital corridor are to be replaced – Tracey Billingham will source appropriate chairs (ie height and design) and costings to be sent to Sue S. • Risk register specific to Falls group is to be set up and maintained by the group (risks from the outcome of the Throne Project are to be included on this register). • ROH to be bench marked against the WMQRS Quality Standards for the Falls and Fragility Fractures Pathway. • Post falls medical management and review documentation is currently under review as part of the wider documentation review.

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	2016 Oct	2017 Oct
Sum of Unavoidable	1	0	0	0	0	1	0	1	0	1	2	0	4	0
Sum of Avoidable	2	1	1	0	1	2	1	0	0	0	1	1	3	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	1	0	0	0	2


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 2016 2017
Apr May Jun Jul Aug Sep Oct
Sum of TBC 1 0
Sum of Grade 4 (Avoidable) 0 0 0 0 0 1 0 0 0 0 0 0 0 0
Sum of Grade 3 (Avoidable) 0 0 0 1 1 0 1 0 0 0 0 0 0 0

INFORMATION

For October 2017 there were;

- G4= 0
- G3 = 0
- G2= 2 - both cast (device) related – both Ward 11
  22101- POP cast-Right heel
  22213 – Cast – Lt heel/ankle

Update on Previous month incidents that were under review

- 21886- G2 thigh avoidable
- 21931- Friction traction
- 21866- None pressure

Update on Previous month August 17 incidents that were under review

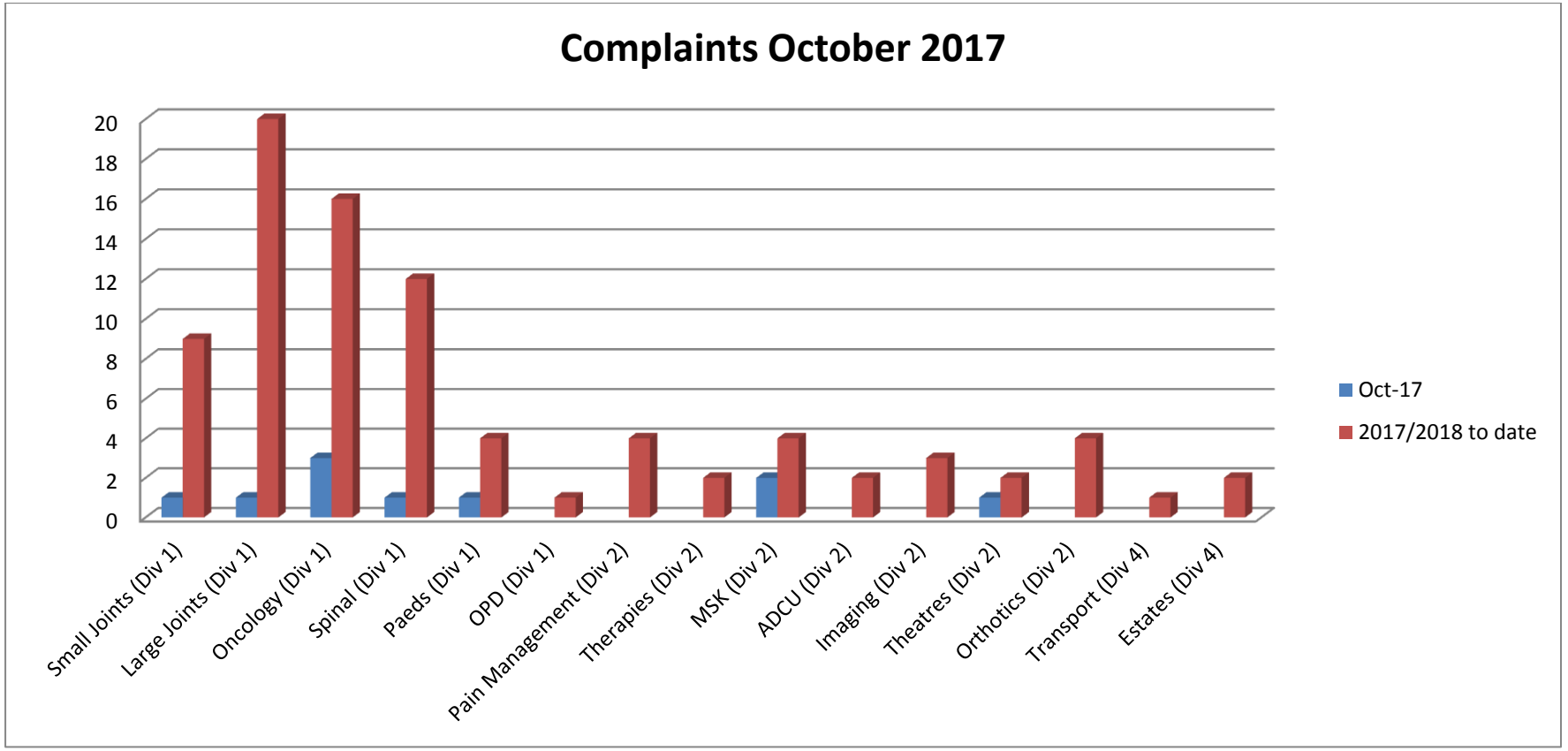
- 21722- G2-Downgraded not pressure incident it was friction to elbow
- 21732- G2-awaiting final update – preliminary outcome will be deemed avoidable due to gaps in skin documentation on admission
- 21651- G2- unavoidable-patient complex infected patient ; patient had below knee amputation – device related cast- pressure left heel
- 21695-Grade 3 –SI investigation underway
-

Summary:
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.
2 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12 (3 currently under review)
2 avoidable Grade 3 pressure Ulcers against a limit of 0. June 2017 (20769) (One Grade 3 Pressure Ulcer currently awaiting RCA's to establish avoidability and is therefore not included in this figures- August 2017(21695)

1 avoidable Grade 4 pressure ulcer against a limit of 0- June 2017 (20930).

ACTIONS FOR IMPROVEMENTS / LEARNING
• Band 7 – New Trust Tissue Viability Lead Nurse will commence into post week commencing 4.12.17 • Band 6 – Tissue Viability Nurse – interviewed on 3.11.17, candidate accepted offer, waiting clearances Commencement date to be confirmed once clearances completed –Earliest end Jan 2018. Interim cover being provided by ward managers and departmental tissue viability link/champions and Band 6 nurses from the ROCS team as required for supporting grading of pressure sores and staff support. • Matron has requested update from all ward areas on Tissue Viability Competencies completion update to be reported in Nov 2017 report.
RISKS / ISSUES
• Audit requirements have not been fulfilled due to the trust currently having 2 Tissue Viability Nurse Post vacancies. • Tissue Viability Data base has not been maintained currently– all tissue viability information being recorded in patients notes. • Training for Tissue Viability for the Trust to be reviewed to ensure best practice and this will a priority for Lead appointed • Trust Tissue Viability Policy requires updating; this will be impacted by new classification status when agreed.

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 454 contacts during October 2017 of which 113 were classified as concerns. This brings the total of PALS contact for the year to date to 3252 (780 concerns). This represents a much higher figure than at the same point last year (2347 PALS contacts)

Compliments

There were 665 compliments recorded in October 2017, with the most being recorded for Div 1. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms from this month, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues to receive a significant number of compliments. Areas have been reminded to submit their records for central recording

Complaints

There were 10 formal complaints made in October 2017, bringing the total to 86 for the year. One was withdrawn after meeting with the Consultant. All were initially risk rated amber or yellow. This is significantly lower than the same time last year (14 complaints in October 2016)

There were 13 complaints closed in October 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:

- Nursing Care (Div. 1, Spinal)
- Not seen by consultant post op. Nursing care (Div. 1,Oncologyl)
- Cancelled surgery due to no post op care arrangements (Div. 1, Small)
- Cancellation of planned surgery (Div.1, Large Joints)
- Discharged and not aware. Patient also believes has been given wrong unit number (Div. 1, Oncology)

- Attitude of secretary (Div. 2, MSK)
- injury sustained in theatres; procedure cancelled (Div. 2, Theatres)
- outcome of surgery – wound (Div. 1, Large Joints) withdrawn
- Unhappy with consultation in knee and shoulder clinic (Div. 2. MSK)
- Unhappy with consultation 9div 1, Paeds)

Initially Risk Rated Yellow:

- outcome of hip operation (Div. 1, Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

3.3 Complaints closed in October 2017

There were 13 complaints closed in October 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 October 2017 was 27 days which is within normal limits.

3.4 Learning/Actions from complaints

Of the 13 complaints closed in October 2017:

- 5 were upheld
- 6 were partially upheld
- 2 were not upheld

Learning identified and actions taken as a result of complaints closed in October 2017 include:

- Nursing staff outside of the Spinal Ward may not be familiar with spinal escalation procedures

Action: Refresher training is being provided

- Patients are still waiting longer that they or we would like in ADCU

  Action: Transformation work/Perfect Pathways underway to improve the admission process.

- Paper referral administration process does not always work effectively

  Action: Electronic referral system has been sourced and will be implemented by next summer.

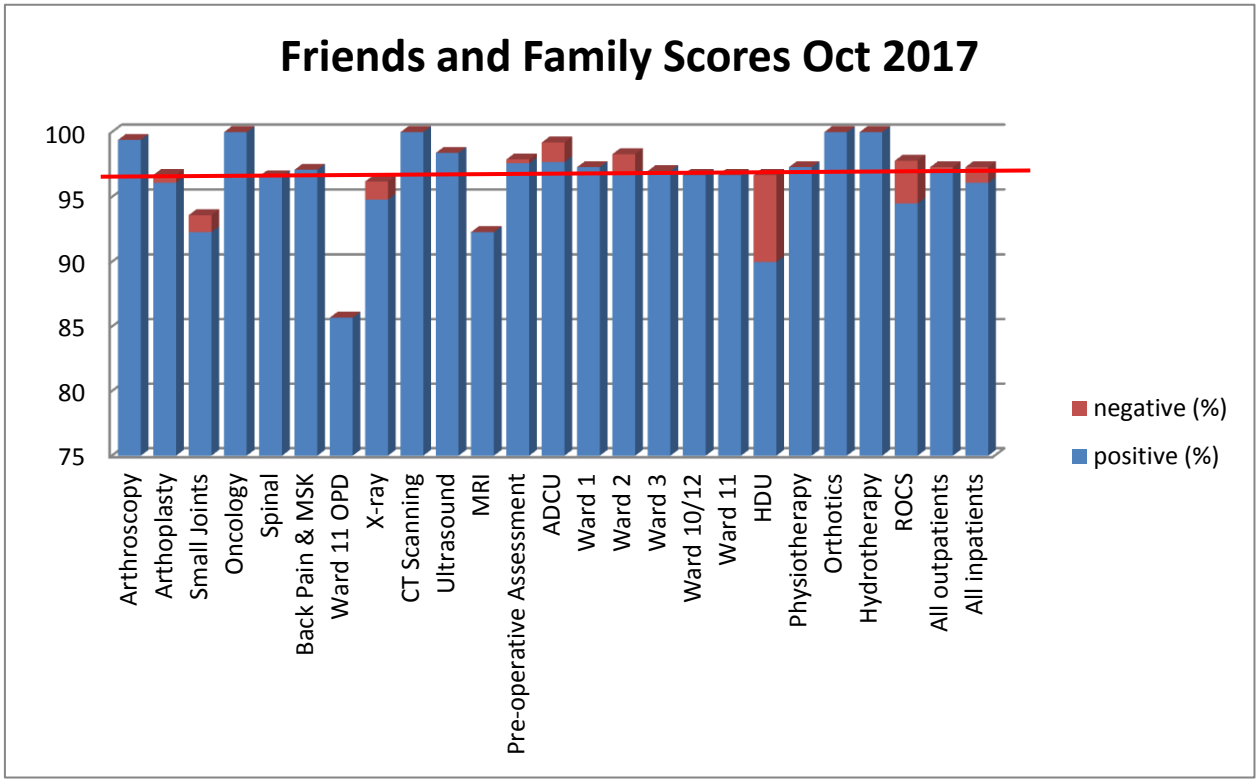
RISKS / ISSUES

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.

Area	Number of reviews	Footfall	Completion rates	Positive Rating	Negative Rating	change in response rate and achievement of target
Arthroplasty	155	1160	9.3%	99.4%	0.0%	
Arthroscopy	181	1192	15.2%	96.1%	0.6%	
Small Joints	78	1515	5.1%	92.3%	1.3%	
Oncology	8	688	1.2%	100.0%	0.0%	
Spinal	88	766	11.5%	96.6%	0.0%	
Back Pain & MSK	206	1102	18.7%	97.1%	0.0%	
Ward 11 OPD	14	451	3.1%	85.7%	0.0%	improved
X-ray	212	2559	8.3%	94.8%	1.4%	worse
CT Scanning	46	242	19.0%	100.0%	0.0%	improved
Ultrasound	64	355	18.0%	98.4%	0.0%	improved
MRI	13	840	1.5%	92.3%	0.0%	worse
Pre-operative Assessment	337	588	57.3%	97.6%	0.3%	improved
ADCU	133	697	19.1%	97.7%	1.5%	worse
Ward 1	73	139	52.5%	97.3%	0.0%	same
Ward 2	61	136	44.9%	96.7%	1.6%	improved
Ward 3	33	97	34.0%	97.0%	0.0%	improved
Ward 10/12	61	104	58.7%	96.7%	0.0%	improved
Ward 11	30	99	30.3%	96.7%	0.0%	worse
HDU	30	89	33.7%	90.0%	6.7%	worse
Physiotherapy	73	2695	2.7%	97.3%	0.0%	improved
Orthotics	3	831	0.4%	100.0%	0.0%	worse
Hydrotherapy	6	554	1.1%	100.0%	0.0%	same
ROCS	91	158	57.6%	94.5%	3.3%	worse

INFORMATION

The Scores for Friends and Family are now calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as Detractors. The Trust is require to report the %Promoter and %Detractor scores for each inpatient and outpatient area nationally.

The results remain consistently high for the Trust overall, with the red line in the graph above showing the Trust average score for Promoters overall.

The percentages are significantly affected by low response rates. Therefore in considering the Friends and Family Data, it is important to ensure the number of patients responding is known. The dataset for October is complete and this is making analysis of the data easier.

ACTIONS FOR IMPROVEMENTS / LEARNING

A more detailed analysis of the return rates for FFT nationally has been undertaken. It has been identified that the ROH already has one of the highest return rates for Outpatient Departments at 12% (latest figures published nationally are for August 2017). Therefore, the internal response rate for Outpatient Services was reviewed at the Outpatient Improvement Group and the internal target re-set for 20% as a more realistic target.

The last column in the table below shows changes to last month's collection in words and the colour relates to whether the area has met the internal targets for collection of 40% for inpatient services and 20% for outpatient services.

There were over 2000 submissions of individual data for FFT in October, representing a 60% increase in the last two months. Outpatient data is now available by speciality for the first time to continue targeted work across all areas to ensure that comparable feedback is available for all departments.

The increase in response rate and clarity of data represents real achievement in the last two months and the Trust is aiming to achieve the internal targets set by the end of Q3.

RISKS / ISSUES

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.

Duty of Candour assurance visit

An assurance visit was conducted on 30th October 2017 at the Royal Orthopaedic Hospital. The review focused on the Trusts process for managing the Duty of Candour (DOC) requirement.

For the period 1st April 2017 – 30th September 2017, there were 50 recorded incidents meeting this level of harm and 40% of these (n=20) were reviewed.

Of the 20 reviewed, we could clearly identify that DoC had been applied both verbally and in writing and that the letter confirmed that an apology had been offered to patients, with appropriate reference made to any investigation and options of how to contact the Trust.

The review was undertaken by Senior Clinical Risk and Patient Experience Manager at Birmingham CrossCity CCG who confirmed that the based upon the audit sample reviewed, the Trust has robust systems in place to manage the DoC requirement.

12. Litigation

No new litigation to report in October 2017.

13. Coroners

There was an Inquest held at Worcestershire Coroner's Court, Stourport on Severn, the Coroner recorded the cause of death as:-

1. Hypertensive heart disease

2.

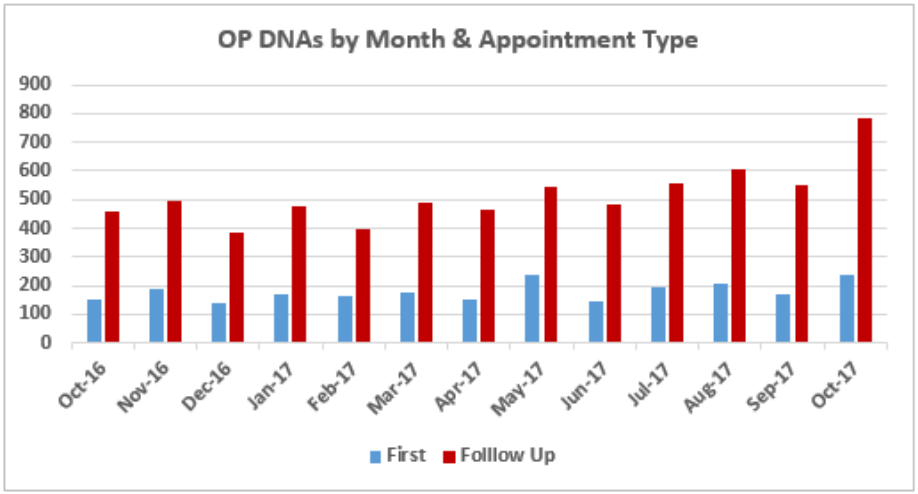
a) Revision of right hip replacement
b) chronic kidney disease
c) Hypoxia caused by Bone Cement Implantation Syndrome

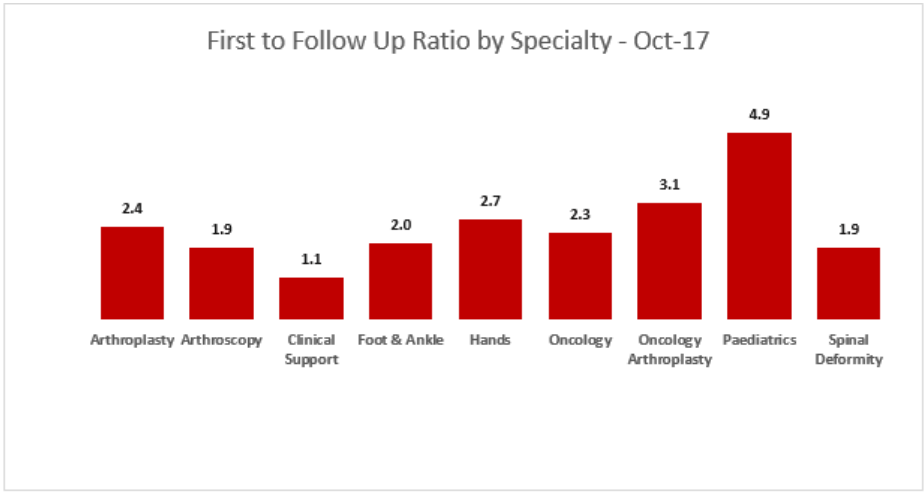
The Coroner handed down a "narrative conclusion" (used in complex deaths were the standard "short form" conclusions, such as accidental death or natural causes, are not factually applicable), stating that the patient died "from a known complication of necessary surgery".

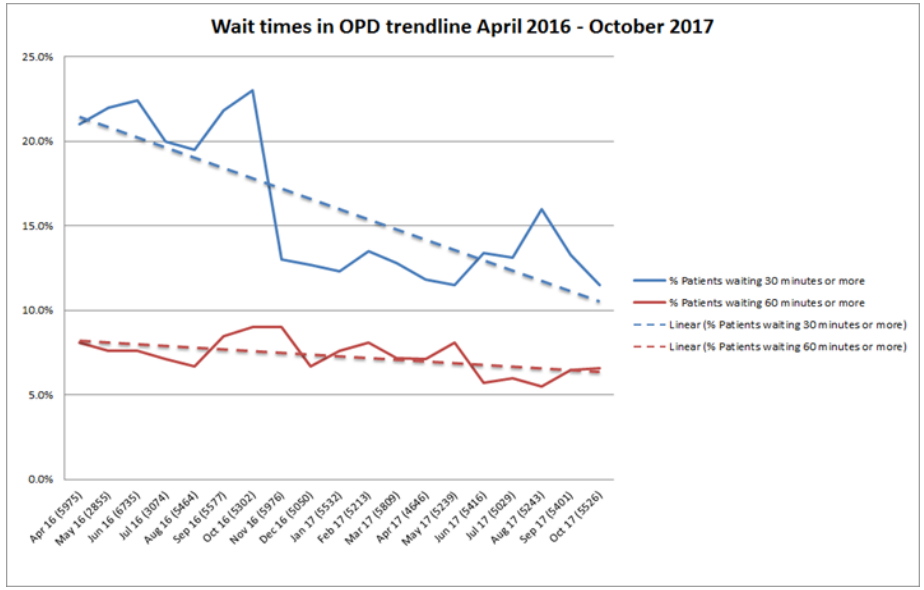
14. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

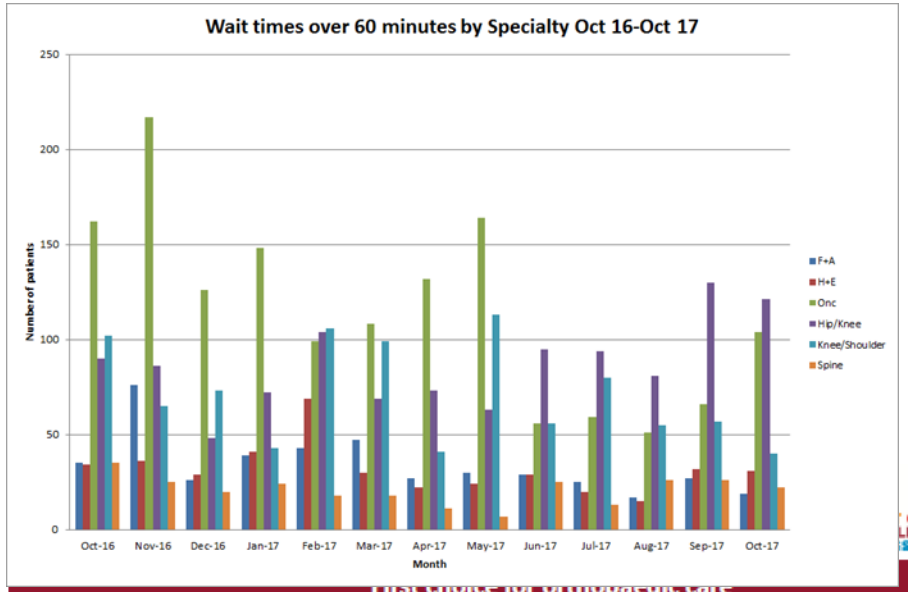
INFORMATION
The data is retrieved from the Theatre man program. The data collected is the non- completed patients on the system. **Total Cases – 901** **Incomplete patients on the system that had notes reviewed for compliance – 341** **Total WHO Compliance - 901** **October 2017 = 100% compliance**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
None

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





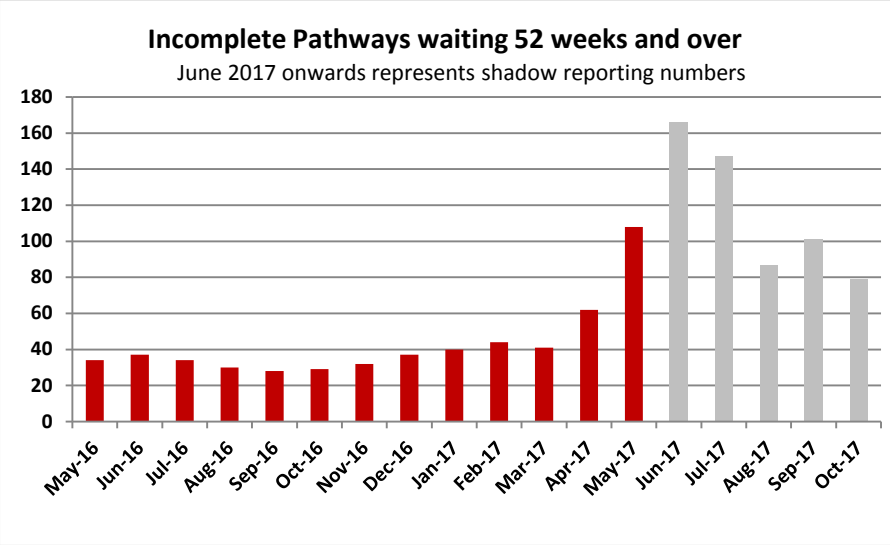


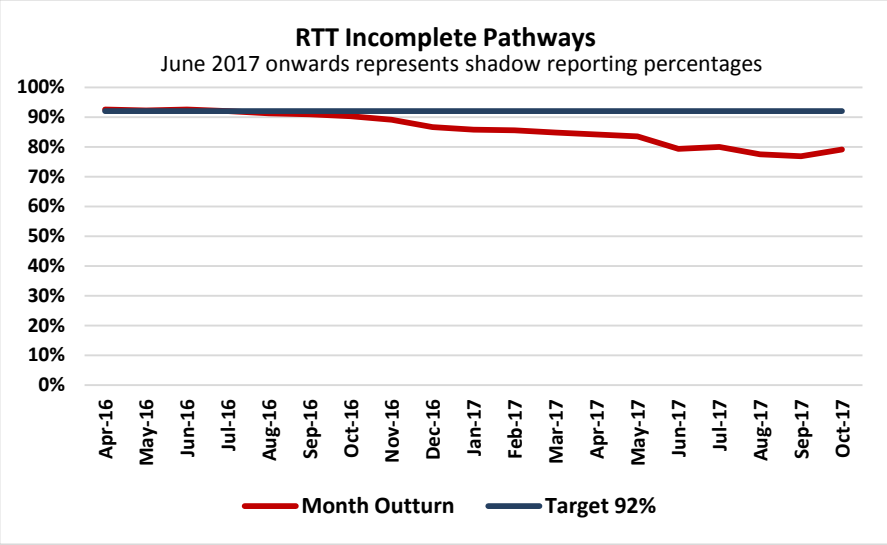


INFORMATION
The process for sharing learning in relation to clinic delays is being reviewed and future incident forms will be shared with the Clinical Service Managers alo clinic delay data. Any issues that require operational management input will be discussed and changes implemented to avoid future recurrence of issues. T reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form. A multidisciplinary operational manageme group has been set up where issues causing clinic delays are also discussed. In October 2017 there were 12 incident forms completed to highlight clinics running more than 60 minutes late. The monthly audit identified 3 main contributing factors for delays: 1) Clinic Overbooked for the Number of Staff 2) Complex Patients requiring more time t planned and 3) Unexpected Staffing Issues in Clinic. This is a change from September as there were no clinics delayed for more than an hour due to missing or late medical records.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions from October's Audit include; • Involvement of Clinical Service Managers in all incidents reported to share issues and develop action plans for improvement • 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 • Review set up of clinics on InTouch to map correctly to either Paediatric or Main Outpatients • Review of clinic cancellation and rescheduling SOP

RISKS / ISSUES
Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure and need to update process

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



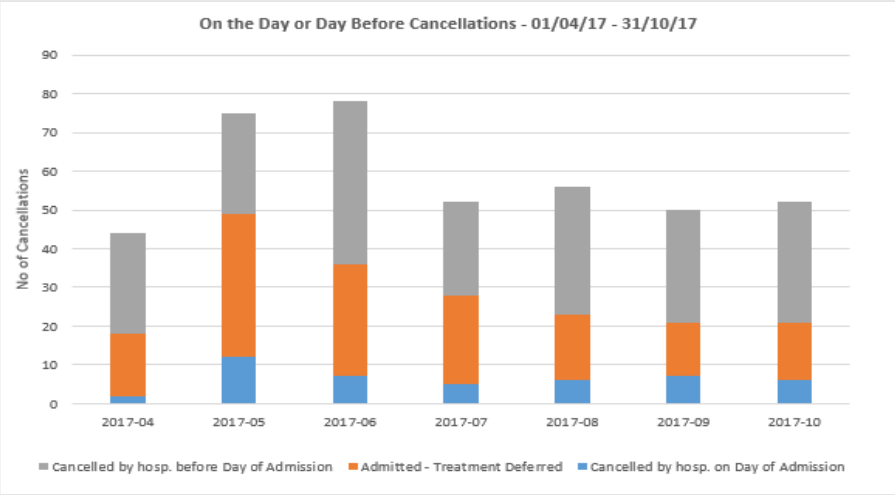


Target Name	National Standard	Indicative* Oct	Reported Month Sept	August	July	Jun	May	Apr	Reported Quarter Q2	Breach	Total	Q1	Breach	Total
2ww	93%	95%	100%	100%	100%	95.65%	100%	97.30%	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	100%	75%	100%	100%	91.67%	100%	100%	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100%	100%	100%	100%	100%	100%	100.00%	100%	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		n/a
62 day (traditional)	85%	100%	100%	100%	37.50%	71.43%	60.00%	66.67%	79%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	89%	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		n/a
No. day patients treated 104+ days		0	0	0	3	1								

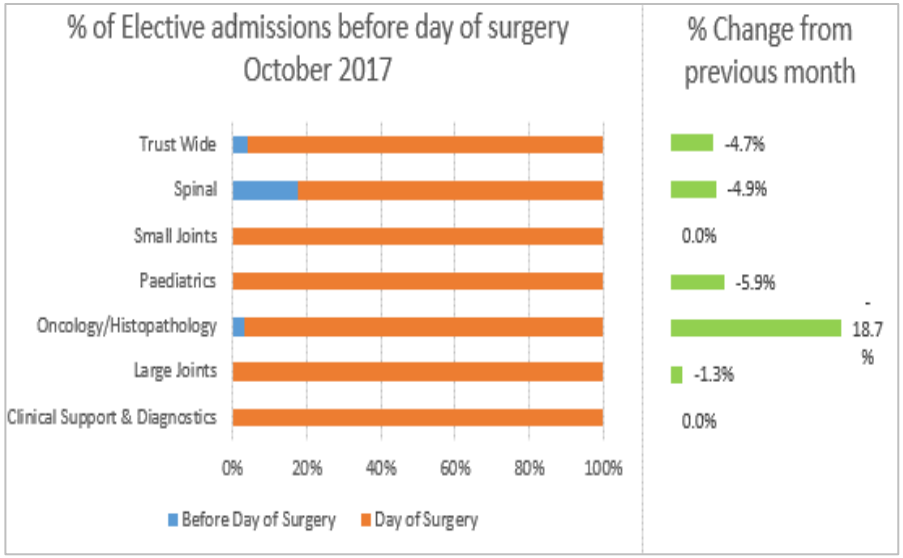
*Indicative performance – October performance reported 4th December 2017

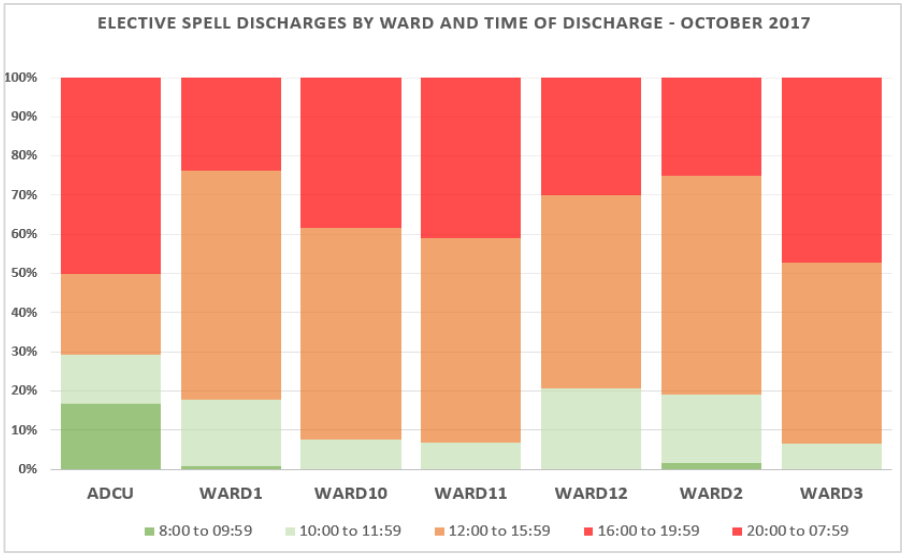
INFORMATION
The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust will recommence reportin 2017, with its first submission for November 2017. Validation has been completed reviewing clock stop data across all areas. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajecto currently being refreshed to recalculate the demand and capacity required to deliver 92% performance, this is due for completion at the end of Novem team continue to reduce the number of long waiters with the majority of admitted patients with treatment dates. The above figures have been used for the shadow reporting of the ROH RTT performance for October 2017 – 79.08%
ACTIONS FOR IMPROVEMENTS / LEARNING
The team continue to concentrate on any patient over 40weeks. The focus from November 17 has been patients on an admitted pathway between 27- non admitted over 18weeks. Good progress has been made by all the teams especially Oncology who are now achieving over 92%.
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. Dis 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 av PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (within the spinal deformity action plan) . We are currently ahead of trajectory with 12 BWCH patients treated during this period, this included 3 PICU ar beds. . Trajectory was 69pts actual 66pts. 9 further additional weekend lists have been confirmed through till April 2018.

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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	17	33	56	0
2017-09	7	14	29	50	0
2017-10	6	15	31	52	0
Grand Total	45	151	211	407	9





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 booke notice. As this is a recurring theme the look back meeting will investigate the themes and causes and as part of the rectification plan the teams will be patients to understand the reasons. A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Following on from the 12th October multi-disciplinary POAC workshop the Clinical Service Manager is reviewing the structure with the team to ensure th and patient processes are robust to meet the needs of any future changes. To further strengthen the POAC model the team now sit within Division 2, this now sits closer to the Anaesthetic service.
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 Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and ti to deliver activity and patient flow. Priorities are now being agreed as part of Perfecting Pathway which will help to deliver some of the key deliverables discussed at the POAC workshop .
RISKS / ISSUES
Continued high levels of cancellations due to medically unfit patients

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Learning from Deaths in Care – Mortality Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Andrew Pearson – Medical Director**
AUTHOR:	**Andrew Pearson – Medical Director**
DATE OF MEETING:	**10 January 2018**

EXECUTIVE SUMMARY:

In December 2016, the Care Quality Commission published its review ***Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England***. In response, the Secretary of State accepted the reports' recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die.

This paper is presented to provide assurance that the ROH has reviewed and responded to the CQC Report and to indicate the arrangements in place to meet the Trust Boards' responsibilities as set out in the subsequent National Quality Board (NQB) publication ***Guidance on Learning from Deaths March 2017***. This guidance provided a framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care.

Trust Boards' Responsibilities

The Board responsibilities are summarised below:

1. Appoint a lead Executive Director
2. Appoint a lead Non Executive Director
3. Publish the Trust policy confirming the governance arrangements in place by September 2017
4. Publically report what arrangements are in place before the end of Q2
5. Publically report via an agenda item paper and dashboard quarterly from Q2, first report by end of Q3

Executive lead is the Medical Director and the Non-Executive lead is the Chair of the Quality & Safety Committee. A previous paper presented to Public Board by the Medical Director in September 2017 included the Trust policy **'Reporting, Investigating and Learning from Deaths in Care'** and detailed the processes that the ROH follows with regard to in-hospital deaths.

The principle purpose of this process is to identify when deaths have occurred through a failure of processes and systems. From this a process for organisational, team and individual learning should be developed to reduce the likelihood of inadequate or poor care resulting in a future death. A ***Structured Judgement Review*** is undertaken by an independent and appropriately trained clinician and an assessment of the cause and avoidability of the death made. This is then presented to the Clinical Audit & Effectiveness Committee (CAEC) for review and organisation of learning as required. Learning from Deaths is a standing agenda item for the monthly CAEC meeting. CAEC upwardly reports to the Quality and Safety Committee on a quarterly basis.

Because of the nature of clinical work undertaken at the ROH, patient deaths are rare events. All in-patient deaths are classed as Serious Incidents and are investigated as such. Where the death is 'unexpected' a Root Cause Analysis is undertaken. The SI and RCA process develops an action plan which includes learning needs and processes to deliver this learning.

REPORT RECOMMENDATION:

The Board is asked to accept this report and to note the development of the Trust processes towards compliance with the National Guidance on Learning from Deaths in Care and with NHS England regulations

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		X

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

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	
Comments:					

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

High quality care and to be the first choice for orthopaedic care

PREVIOUS CONSIDERATION:

Policy for Reporting, Investigation and Learning from Deaths in Care was approved by the Board in September 2017

Learning from Deaths Dashboard 2017

	Quarter 1	Quarter 2	Quarter 3
Number of deaths	0	3	1
Cause		Case 1: 1a cardiac arrest Case 2: 1a pulmonary embolus 1b pelvic malignancy Case 3: 1a acidosis 1b spinal malignancy	Case 1: cardiac arrest
Number of deaths reviewed	0	3	1
Avoidability Number of deaths considered to be potentially avoidable (3 or 4)		0	0
Care Number of deaths considered to have significant care issues (D)		0	0

Care assessment of each death in year

	A. Care considered excellent	B. No Significant care issues	C. Some care issues	D. Care issues contributing to death
Unavoidable	2	0	2*	0
Likely avoidable				
Possibly avoidable				

* Some issues with the transfer process and end of life care – no surgery undertaken

Thematic analysis and learning

- Hospital Transfer process
- End of Life assessment and care
- Out of hours care
- MDT working

Finance and Performance Report

NOVEMBER 2017

CONTENTS

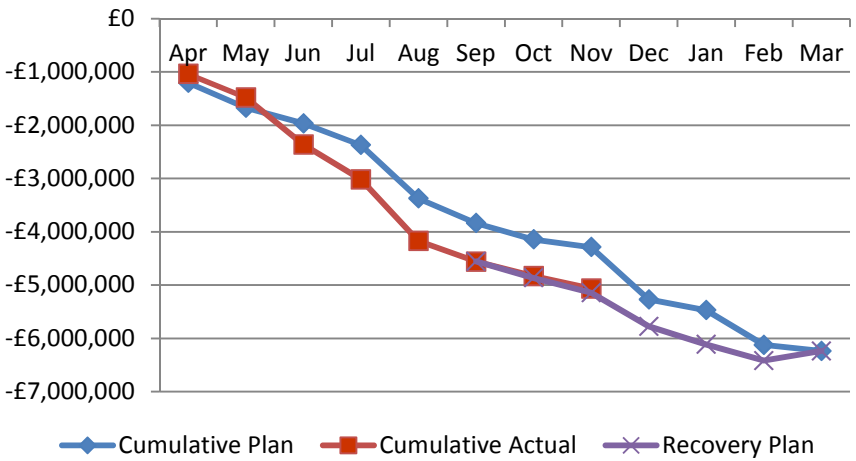
INTRODUCTION

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.

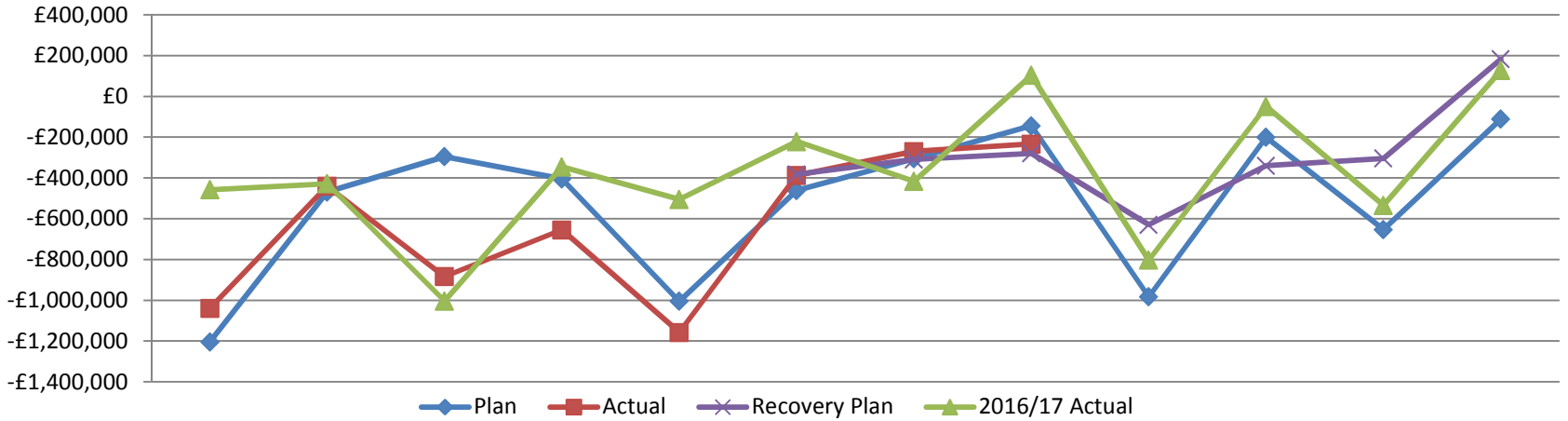
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

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	3
Agency metric	1	2
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £233,000 in November against a planned deficit of £279,000, £46,000 ahead of plan. This brings the year to date position (on a control total basis) to £5,025,000 against a plan of £4,493,000, £532,000 behind plan.

The Trust continues to action areas of efficiency improvement and activity growth outlined within the 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. November marks the third month of the recovery plan, with an over performance of £46,000 against recovery plan in month, and an over performance of £81,000 YTD.

Drivers for the year to date underperformance against plan include spend on improving RTT reporting (just over £580,000 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 time of the MRI for a period of nearly 2 weeks). 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.

As at the end of November, the Trust has recognised £1,242,000 of CIP savings, against an original plan of £2,104,000. £180,000 (14%) of savings to date are non-recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,632,000 against an original plan of £3,191,000. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

With regards to the Trust's Use of Resources Risk Rating (UOR), the overall position has remained at level 3. The other elements of the Use of Resources elements remain the same; the deficit position against plan results in the Trust reporting 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. Year to date agency spend is higher than agency cap and as a result the agency rating remains at a 2.

ACTIONS FOR IMPROVEMENTS / LEARNING

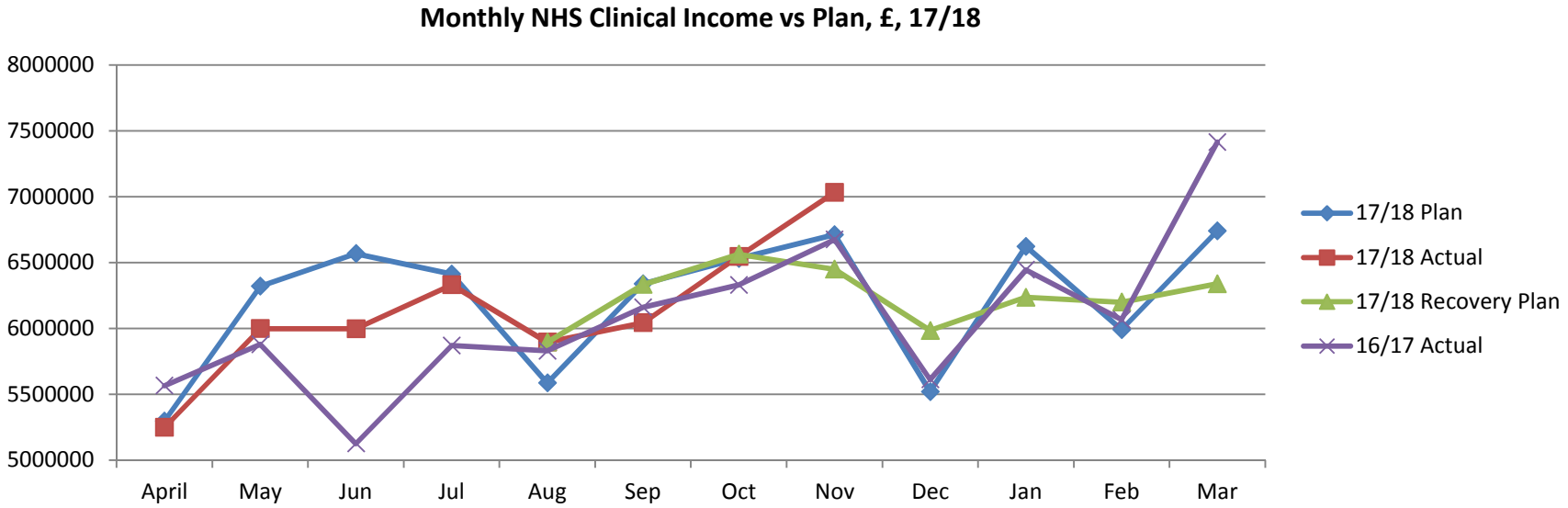
The Trust Executive are monitoring weekly progress against activity improvement and the Perfecting Pathways Project. In addition, fortnightly meetings are being held with operational, clinical and finance stakeholders to improve the theatre environment and give better visibility of stock levels and spend.

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.

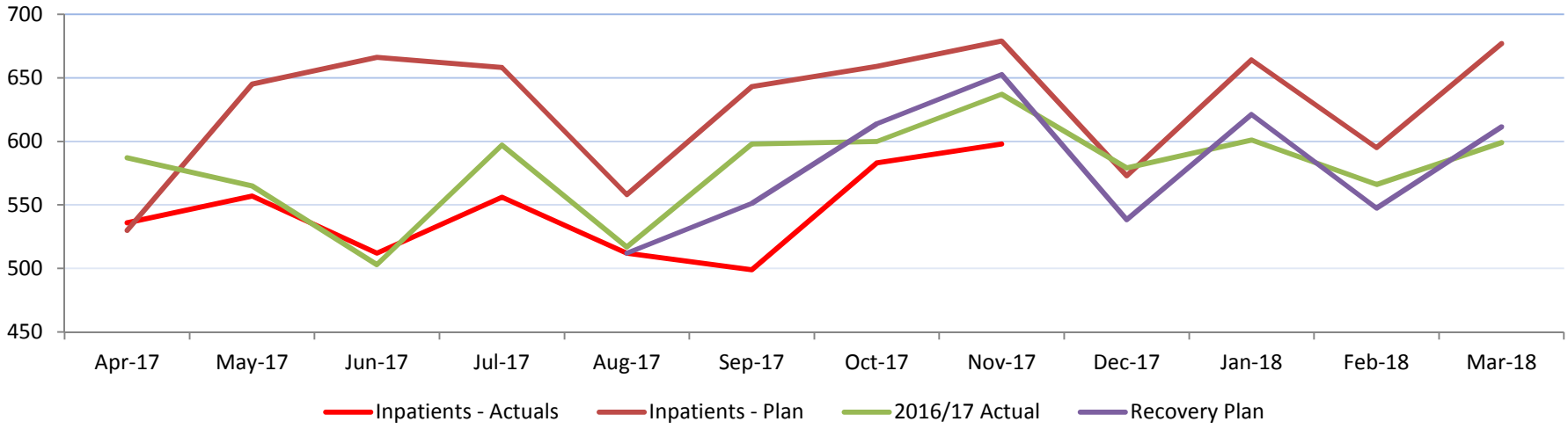
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



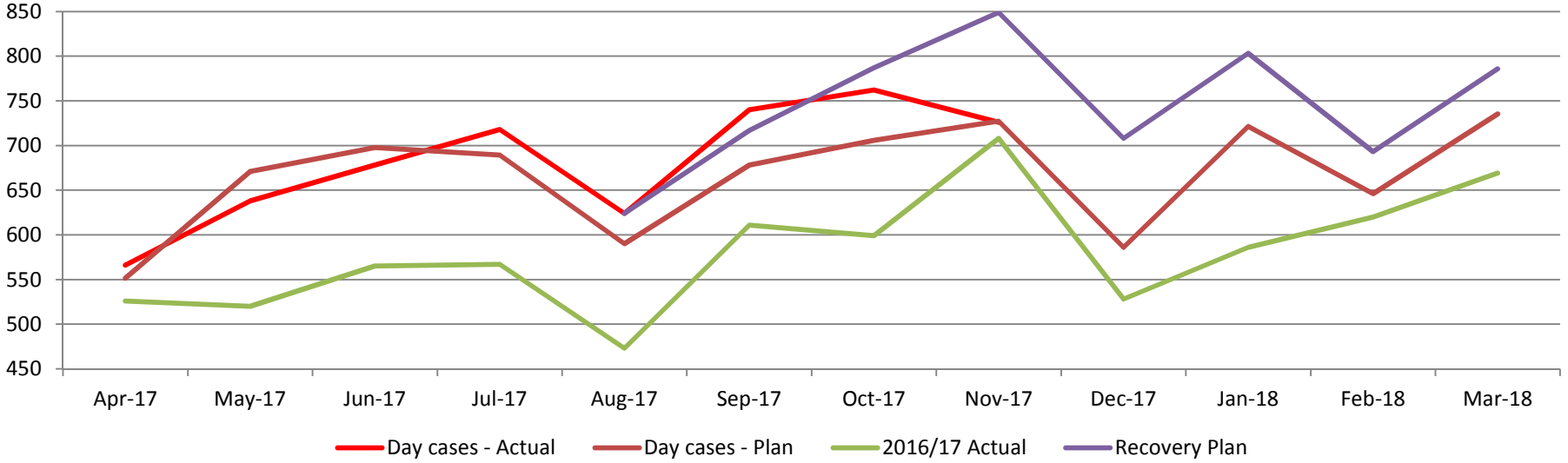
NHS Clinical Income – November 2017 £'000			
	Plan	Actual	Variance
Inpatients	3,423	3,394	-29
Excess Bed Days	107	135	28
Total Inpatients	3,530	3,529	-1
Day Cases	829	815	-14
Outpatients	663	726	63
Critical Care	266	280	14
Therapies	264	258	-6
Pass-through income	237	379	142
Other variable income	404	526	122
Block income	518	518	0
TOTAL	6,711	7,031	320

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	25,237	25,254	17
Excess Bed Days	784	384	-400
Total Inpatients	26,021	25,638	-383
Day Cases	6103	6029	-74
Outpatients	4878	4935	57
Critical Care	1956	1505	-451
Therapies	1944	1807	-137
Pass-through income	1745	2057	312
Other variable income	2970	2974	4
Block income	4144	4144	0
TOTAL	49,761	49,089	-672

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income has over-performed against plan in November by £320,000. Cumulatively, the trust is now £672,000 behind plan. The admitted patient care performance was below plan financially and on activity levels, with discharged activity 77 below target. The average tariff price for the period has decreased slightly. November has had decreased levels of activity compared with October. Case-mix in November has remained steady and elective and now makes up 42% of our income in month and year to date

	Elective/Non-Elective	Day Case
Actual Activity	602	726
Original Plan	679	727
Variance	(77)	(1)
Actual Activity	602	726
Recovery Plan	653	849
Variance	(51)	(123)

Outpatients have over-performed from an income point of due to over performance against plan in outpatient first attendances. There is still an underperformance in outpatient procedures. First and follow up outpatients are under-performing year to date and outpatient procedures are specifically underperforming as they are 16% below plan. First to follow up ratio has remained steady year to date at 2.19:1.

ACTIONS FOR IMPROVEMENTS / LEARNING

The firms have developed their recovery activity plans and are taking the actions through the Perfecting Pathway project to improve efficiency 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.

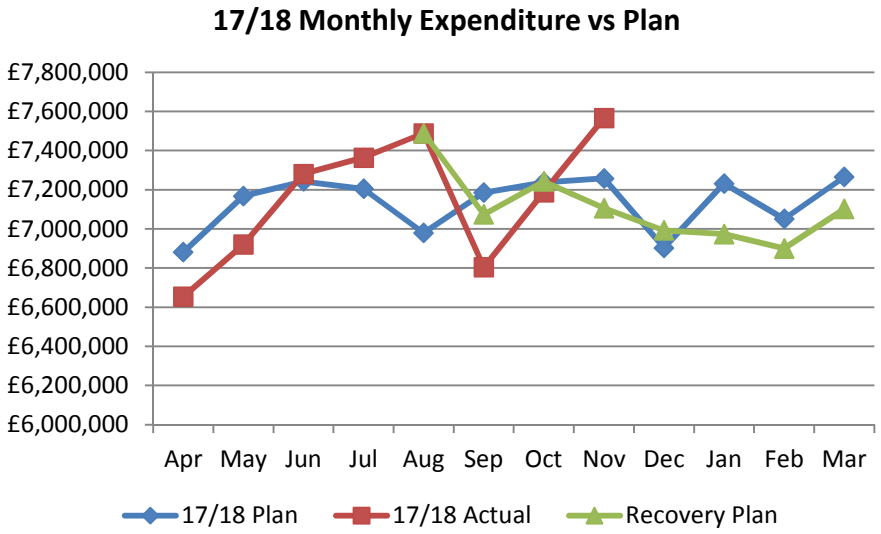
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

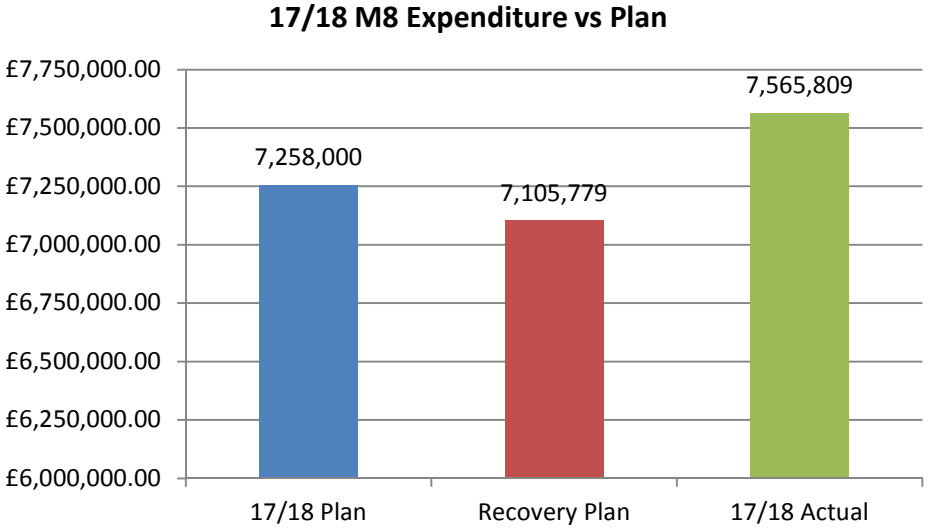
RISKS / ISSUES

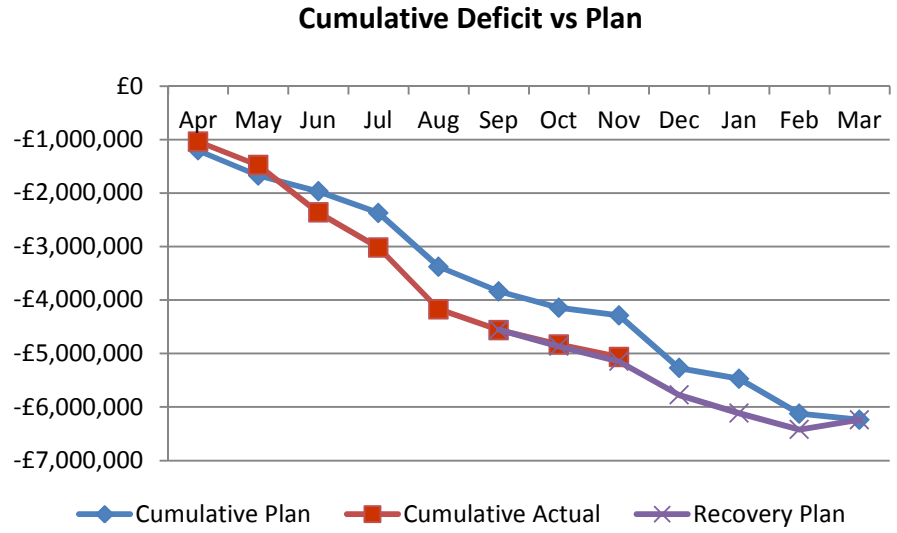
As in previous months, there remains good clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms. As noted above, a key risk 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.

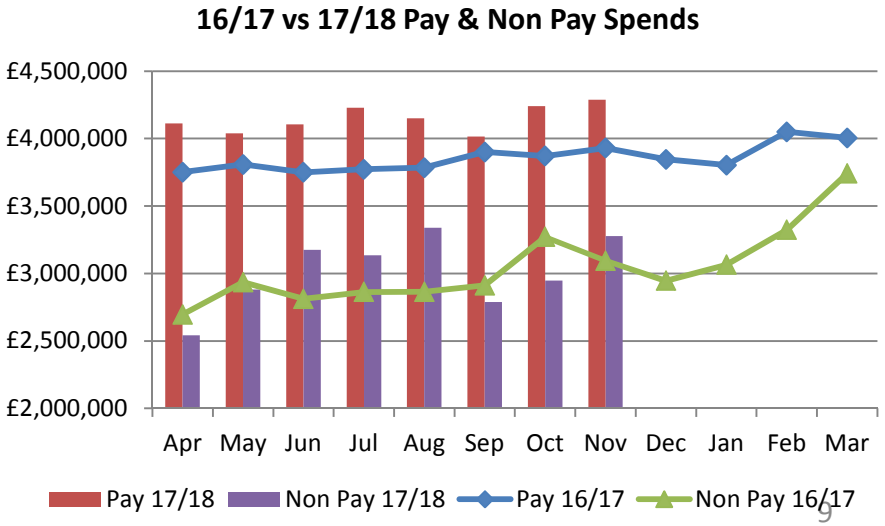
There are also key times over the next few months, where additional activity is being planned for. It will be vital to ensure that actions are taken sufficiently early to make patients aware of Christmas operating and ensure they are fit and willing to attend.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends









INFORMATION

Expenditure levels for the month were £7,565,000, which is £307,000 above the in month plan of £7,258,000 and £460,000 higher than the recovery plan of £7,105,000.

The reason for the overspend was non-pay spend being significantly above plan (£404,000), with clinical supplies being the highest area of overspend. Prosthesis and Theatres spend are the highest overspending areas with a combined overspend in month of £270,000. Non pay spend in theatres has been lower than the yearly monthly average spend for months 6 and 7 due to previously over ordering of stock, which now appears to have levelled out in month 8 seeing an increase in spend during the month. The stock count described in previous month's paper s still requires finalisation, with the results being documented and worked through to check the financial impact. This is a significant amount of manual work, which is still ongoing therefore unlikely that a result will be known at the point of the F&P Committee.

Pay spend was £260,000 higher than plan. When the pay categories are reviewed individually, agency spend was the highest spend above plan by £200,000 which has been across all staffing groups. 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 substantive spend is higher than plan. There is no single category of substantive spend which has increased significantly, with small increases month-on-month in medical, nursing and support spend.

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.

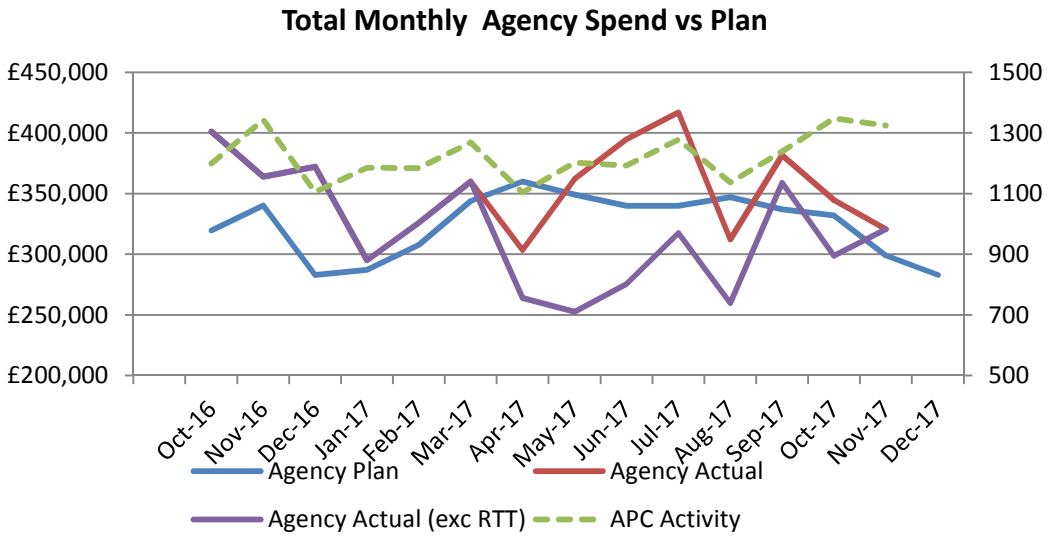
The output from the Theatres stock take will help the department to start making decisions about setting correct stock levels, which in turn will assist with forecasting spend and setting a more reflective financial plan.

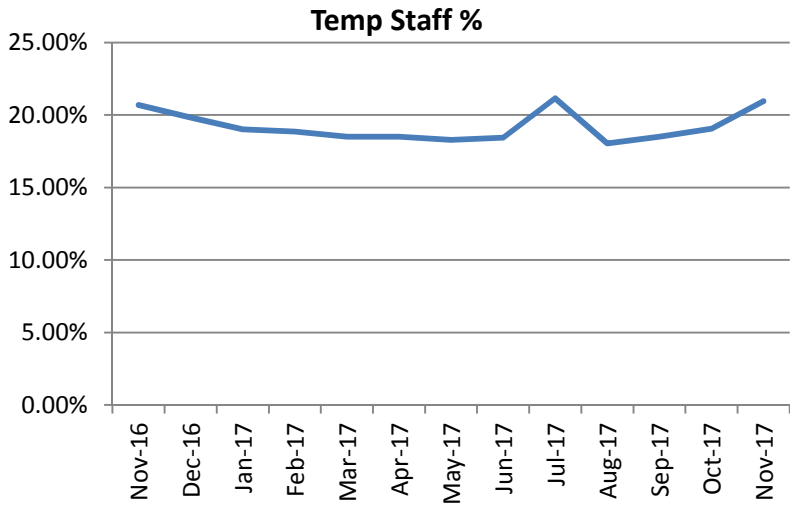
The Interim Director of Finance has been performing line by line reviews of non-pay spend with both senior finance and operational colleagues to both gain a deeper understanding of the year to date spend and ensure individuals are clear that individual budget underspends are maintained wherever possible. A similar review of pay spend is being planned over the coming month.

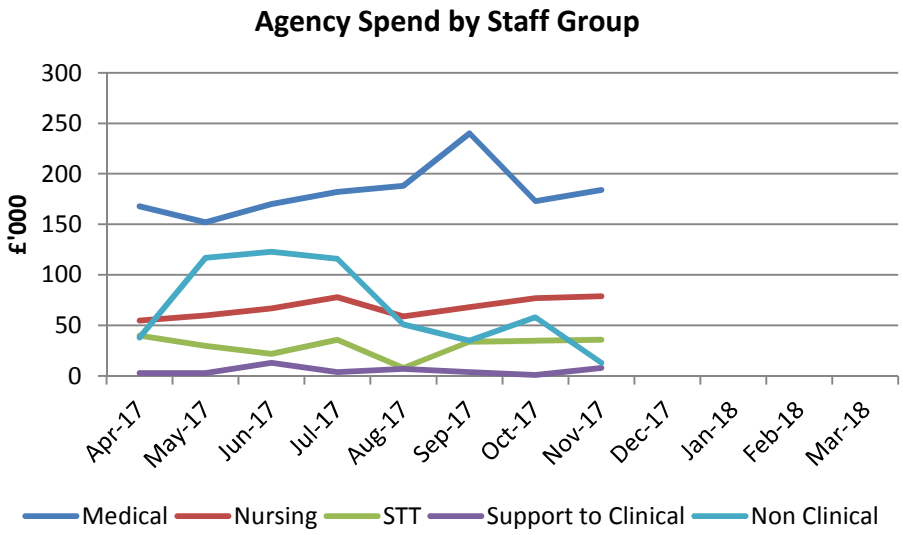
RISKS / ISSUES

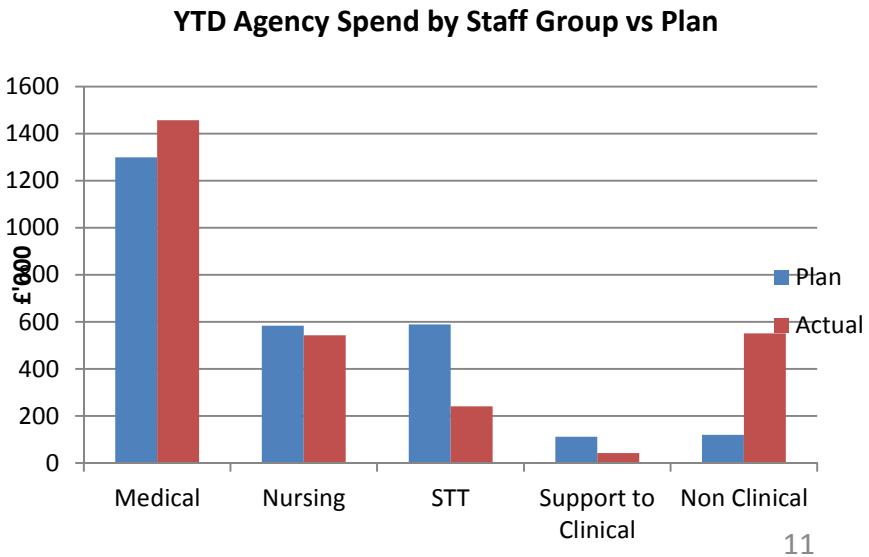
Gaining a greater understanding and control of theatre spend is essential to the recovery of the financial position, and will be mitigated via the workgroups stated above.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

The downward trend in Agency spend seen in October has continues to decrease in November (£345k to £320k) driven by a reduction in spend on non clinical staff which reduced from £58k to £13k. Presently 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. 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 Nursing in addressing use of agency continues to impact positively.

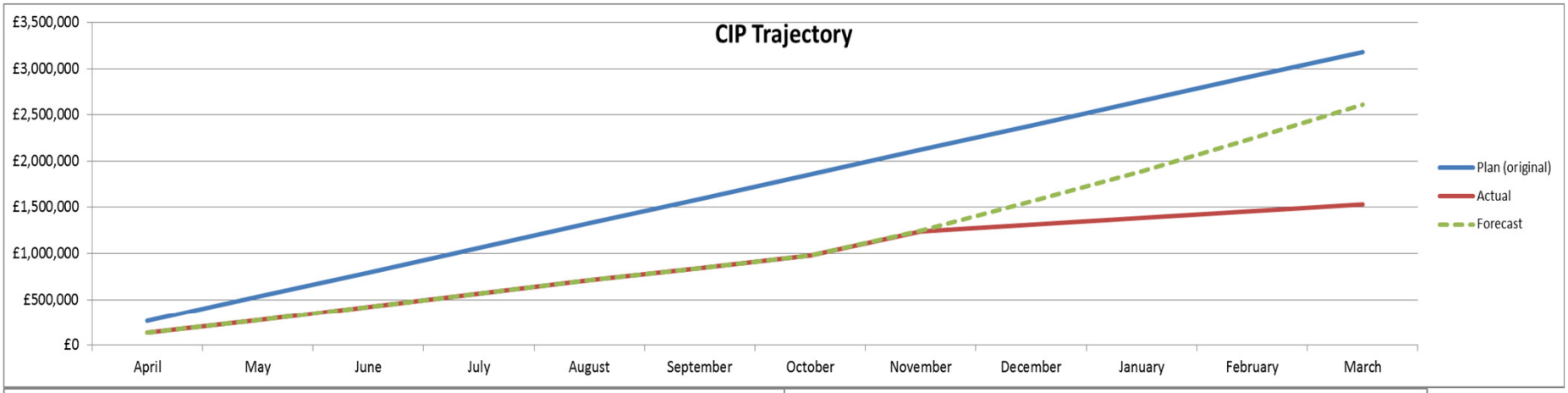
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part 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.

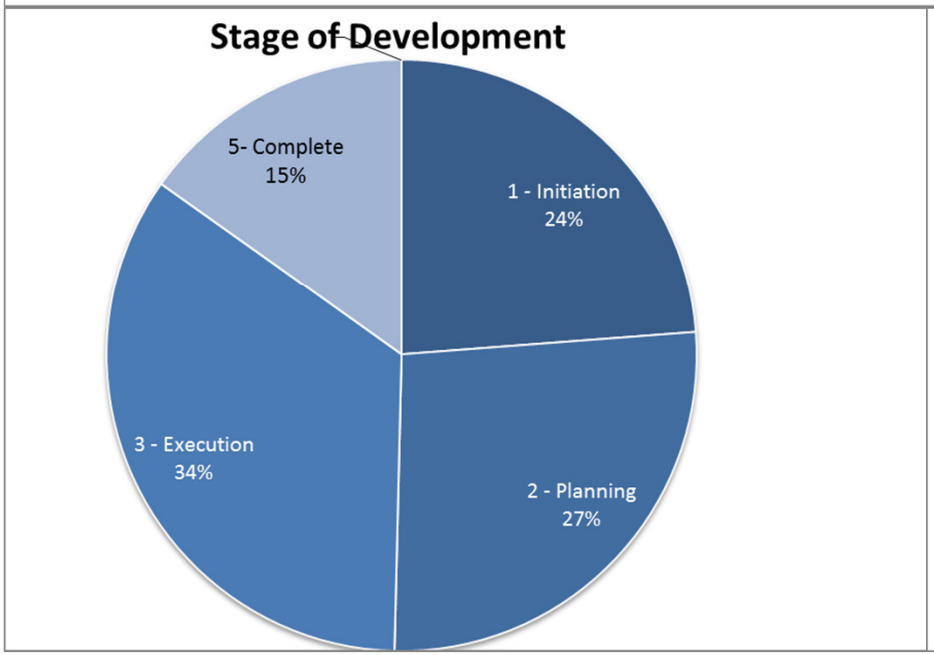
A series of meetings have been held with departmental teams in November and more scheduled during December to review staffing rotas and corresponding pay, bank and agency expenditure.

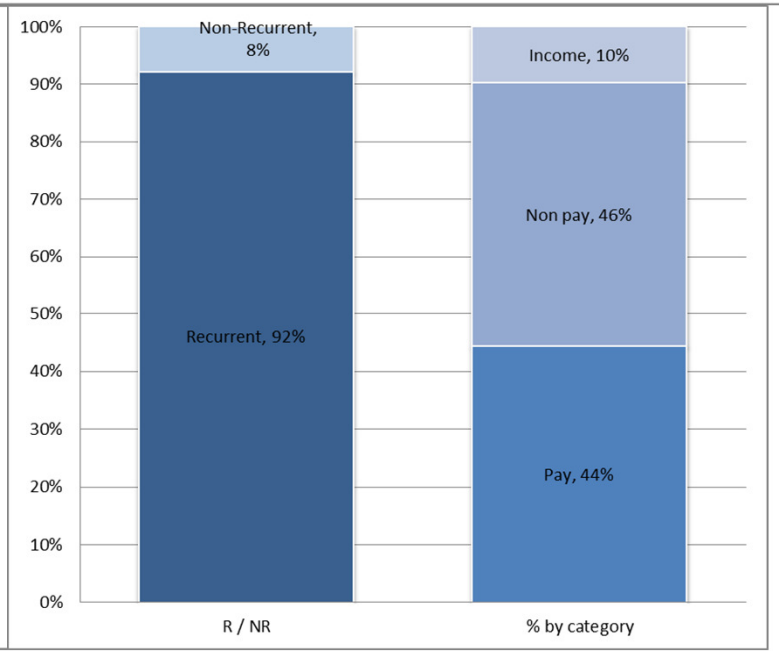
RISKS / ISSUES

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 November, the Trust has recognised £1,242,000 of CIP savings, against a plan of £2,104,000, a negative variance of £862,000.

£180,000 (12%) of savings to date are non-recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,632,000 against an original plan of £3,191,000.

The current plan contains 10% of income related schemes with the remainder of the plan split 46% non pay and 44% pay. Within the forecast position 15% of the savings have been completed, 34% are at the execution stage, 27% planning and 24% initiation stage. The detail by division is shown below;

	Original Plan	Revised Plan	Actual	Forecast	Forecast vs Revised Plan Variance	Forecast vs Original Plan Variance	YTD Plan	YTD Actual	YTD Variance
Division 1	£1,362,500	£1,422,600	£701,140	£1,200,320	-£222,280	-£162,180	£948,400	£668,017	-£280,383
Division 2	£851,270	£471,270	£138,129	£588,230	£116,960	-£263,041	£317,513	£138,129	-£179,384
Division 3	£42,875	£42,875	£42,878	£42,878	£3	£3	£28,583	£28,584	£0
Division 4	£160,000	£159,997	£138,397	£166,811	£6,814	£6,811	£106,665	£93,123	-£13,542
Corporate	£763,709	£563,709	£485,675	£553,548	-£10,162	-£210,162	£375,806	£314,706	-£61,100
Grip and Control	£0	£29,646	£0	£0	-£29,646	£0	£0	£0	£0
Productivity and Efficiency	£0	£78,300	£0	£59,400	-£18,900	£59,400	£0	£0	£0
TOTAL	£3,191,354	£2,768,398	£1,506,219	£2,611,186	-£157,212	-£580,168	£1,776,968	£1,242,559	-£534,409

ACTIONS FOR IMPROVEMENTS / LEARNING

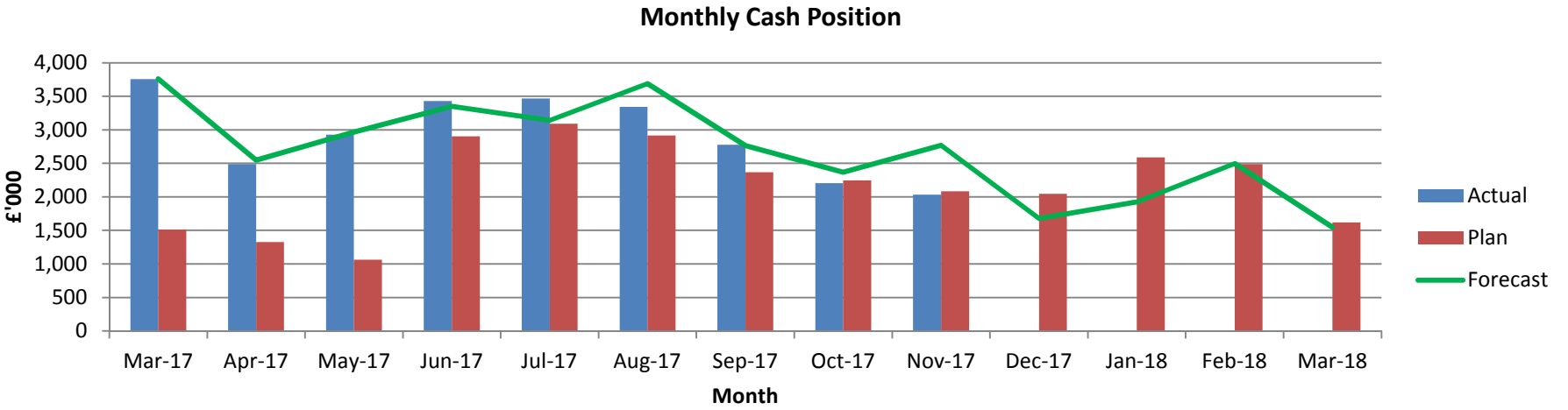
The schemes which specifically require increased focus to ensure the full CIP is delivered are;

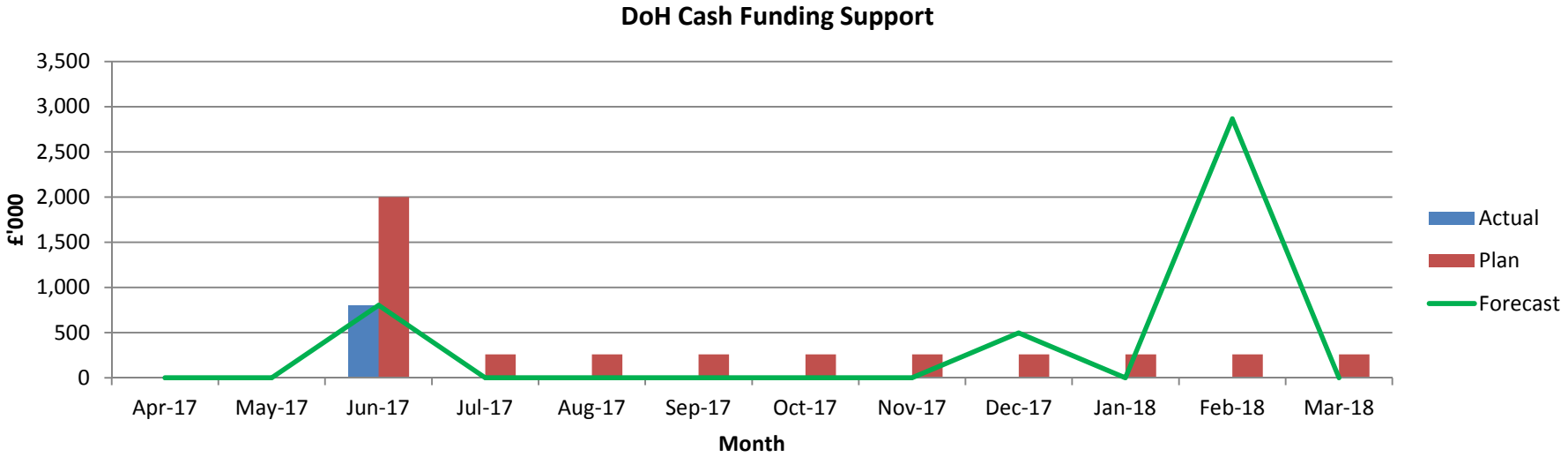
- Theatres stock management and rationalisation
- Nurse staffing review
- Implant rationalisation – ensure compliance against the agreed framework
- Other non pay consumables – rationalisation and product changes
- Coding improvements

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 was fractionally (£48k) below planned levels at the end of November, as receipts have continued to underperform against expectations . And unfortunately this tend has continued into December as well.

Due to the reduction in cash, liquidity levels within the Use of Resources Rating have dropped to 4, the lowest level. Cash support has been requested from the Department of Health - please see below for more details.

The Trust received its first cash loan of £804k from the Department of Health on 12th June 2017 as previously advised to the Committee, and for information its second loan of £498k has now been taken out in December 2017. A substantial further loan is expected to be required in February, due to the present financial position, and levels of activity.

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 2017/18. 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 for cash from the Department of Health to be actioned.

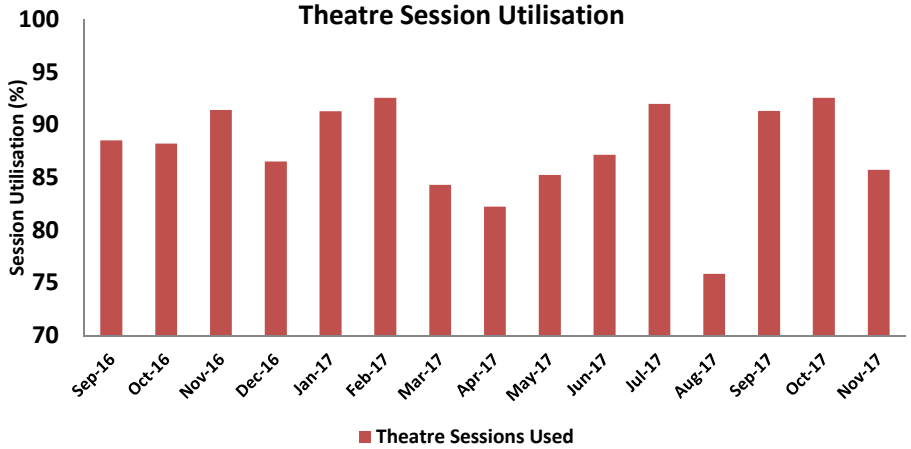
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DoH not approving a cash loan or approving a lower than requested amount.

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 weekly 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

November saw a decrease in list utilisation of 85.71% compared to the previous month.

Available lists continue to be offered out as part of the '6-4-2' weekly scheduling meeting to ensure full maximisation of funded lists. Team are required to confirm within 1 week to ensure that should they not be picked up staffing can be adjusted and the Theatre session closed.

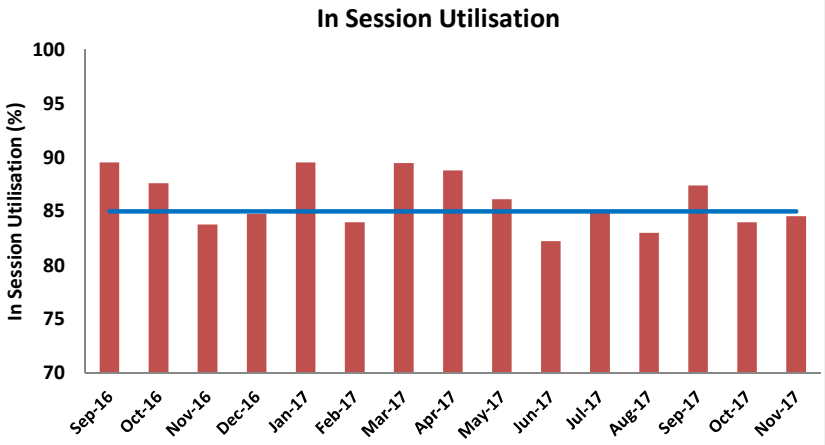
Weekend sessions have been planned throughout the remainder of the year with good uptake from consultants. Throughout November 13 additional 2 session Theatre list were delivered in comparison to October which delivered 12.

Since the start of November the team have introduced a theatre look back meeting to ensure any issues, trends or themes are addressed.

RISKS / ISSUES

Whilst the teams continue to aim to reutilise lists up to the week before they are planned , the risk remains that they may not get filled and this could have enabled a Theatre to be closed, i.e. reduce staffing costs.

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.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 84% in November, a slight improvement on the previous month.

The number of cancelled operations on the day were 3 for the month compared to 6 in October. The number of over cancellations continued to reduce however the main area of focus continues to be cancellations before the day.

A weekly pre-assessment working group will commence wk beg 8/1 and this will be the main focus.

A weekly look back meeting has been established to focus on utilisation and cancellations on the day, to better understand the themes and implement improved processes once causality has been identified.

This work is being carried out daily as part of the 9am huddle which reviews utilisation for the previous day and themes are discussed and actions logged. The team are also exploring Phase 2 of Theatreman to further enhance the reports.

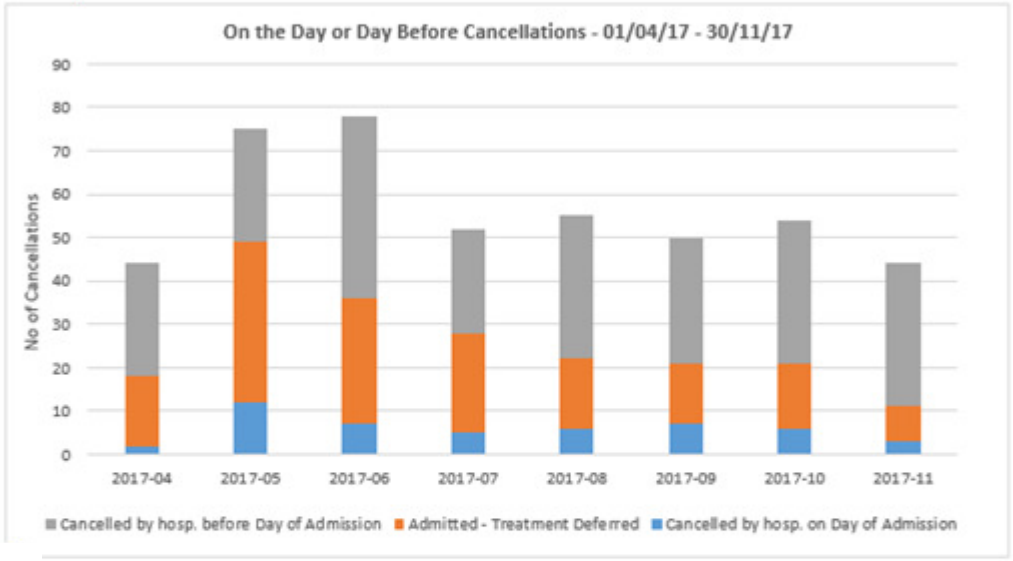
RISKS / ISSUES

Staff vacancies within theatres – on-going recruitment process is in place

Cancellations before the day of surgery still remains the highest number and therefore poses the biggest risk.

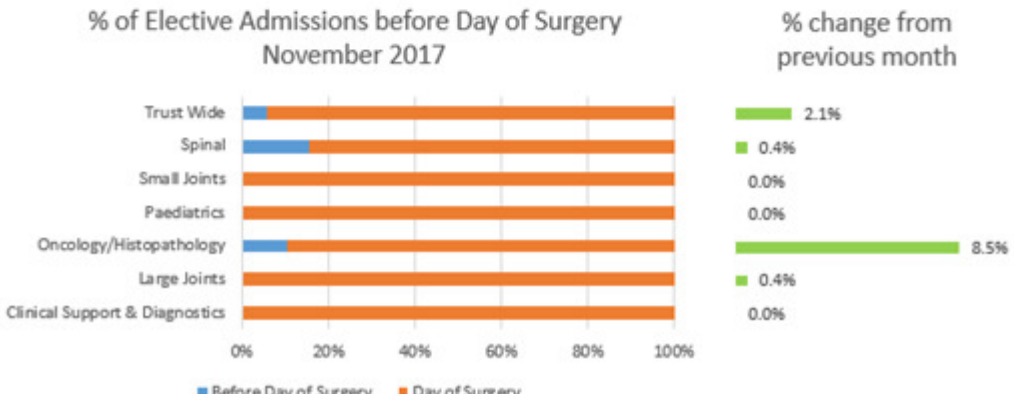
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that through the hospital in an efficient manner

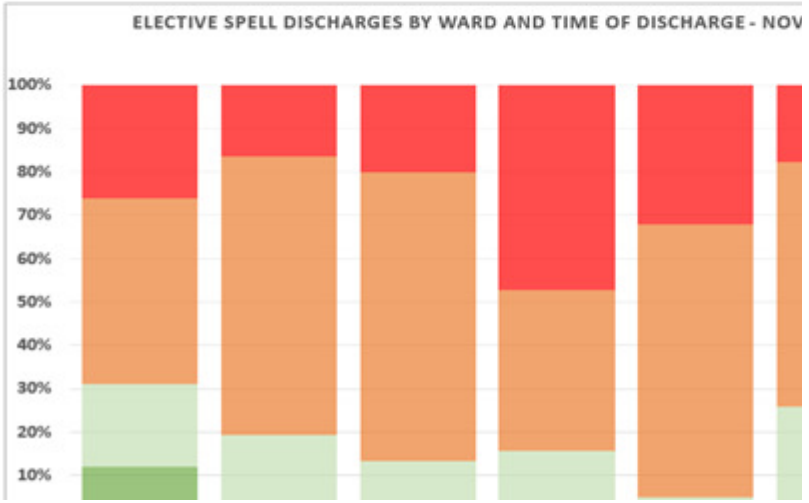
Hospital Cancellations



Sum of Total	Cancellation Categ		
Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission
2017-04	2	16	26
2017-05	12	37	26
2017-06	7	29	42
2017-07	5	23	24
2017-08	6	16	33
2017-09	7	14	29
2017-10	6	15	33
2017-11	3	8	33
Grand Total	**48**	**158**	**246**

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. As this is a recurring theme the look back meeting will investigate the themes and causes and as part of the rectification plan the teams will be contacting patients to understand the reasons.

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers.

Following on from the 12th October multi-disciplinary POAC workshop the Clinical Service Manager is reviewing the structure with the team to ensure that staffing and patient processes are robust to meet the needs of any future changes. A weekly meeting has been set up and will commence on the 8th January to help support this process.

To further strengthen the POAC model the team now sit within Division 2, this now sits closer to the Anaesthetic service.

ACTIONS FOR IMPROVEMENTS / LEARNING

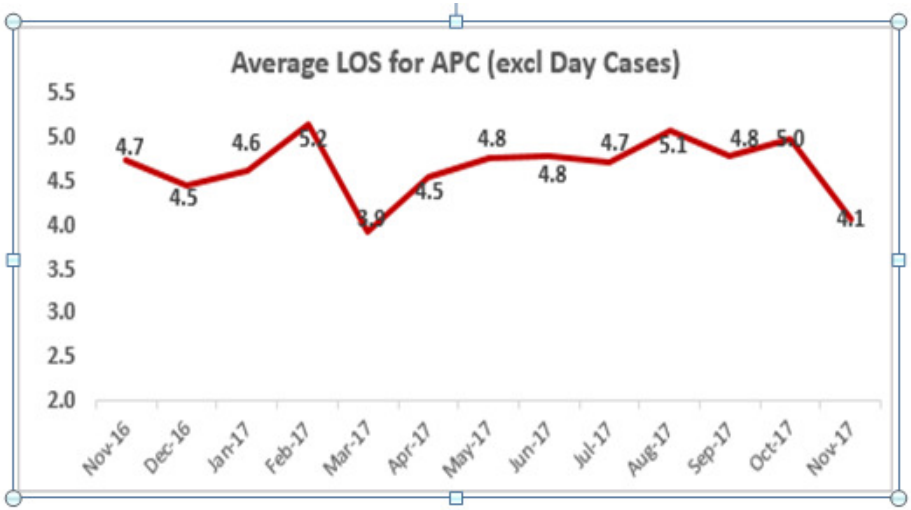
A daily update review by operational management of forward bookings has been established and the 6-4-2 and a daily 8.30am Operations huddle has continued. Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

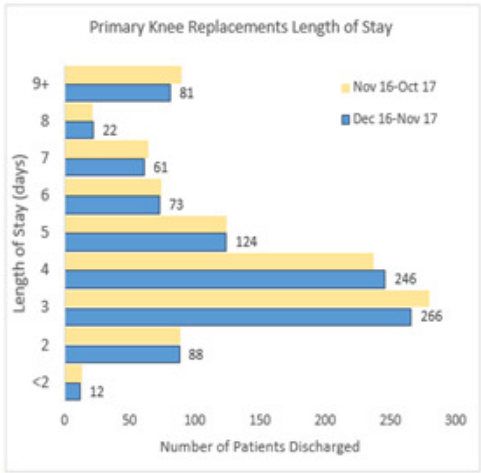
Priorities are now being agreed as part of Perfecting Pathway which will help to deliver some of the key deliverables discussed at the POAC workshop .

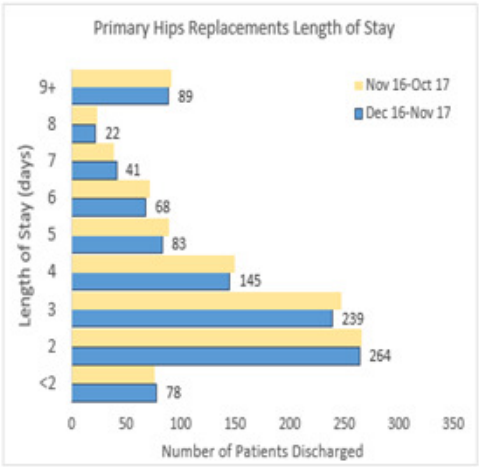
RISKS / ISSUES

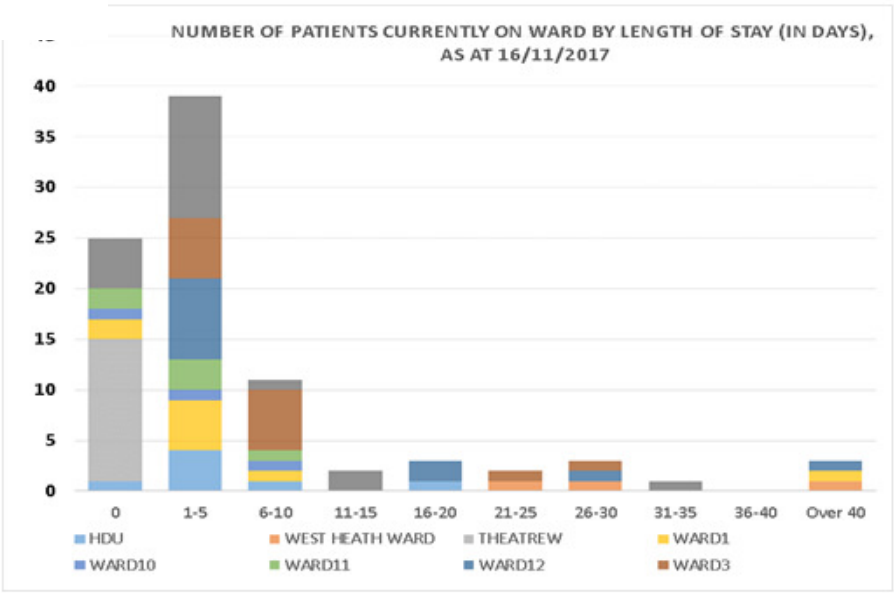
Continued high levels of cancellations due to medically unfit patients

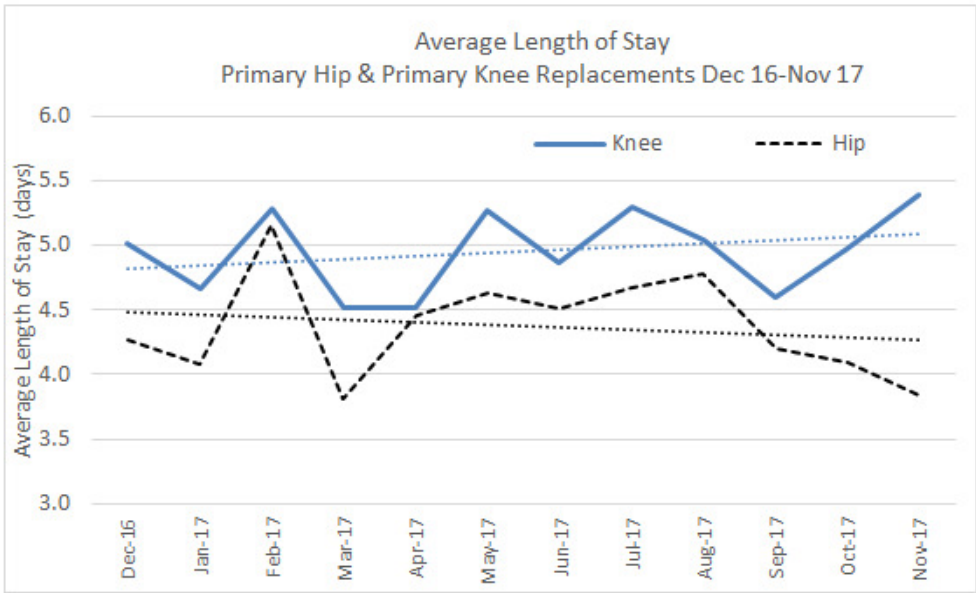
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors, Clinical Service Leads and Clinical Service Managers, work continues weekly to increase activity levels against the recovery plan.

In December 2017 as part of Perfecting Pathways a new concept Gold/Silver was implemented to support the improvement in the flow of patients and particular around increasing the use of the discharge lounge.

Red2Green with a newly formed operational discharge meeting reviewing LOS has been re-established led by the nursing team .

ACTIONS FOR IMPROVEMENTS / LEARNING

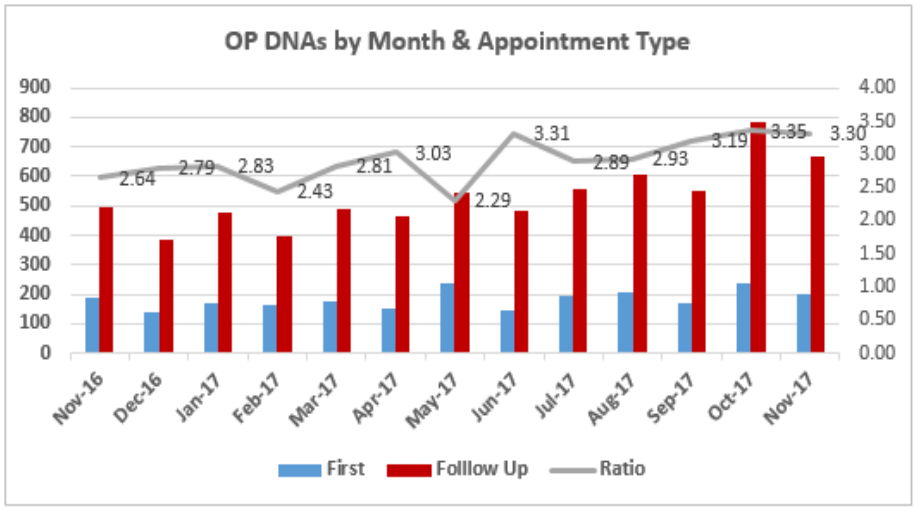
Work continues to strengthen the Arthroplasty consultant led ward rounds so that patients are seen daily. Further work continues to develop with the Arthroplasty team which includes feasibility around a dedicated Theatre environment , freeing up adjacent accommodation to house the Arthroplasty team and work around pre-assessment. A project group to support this will start in January 18.

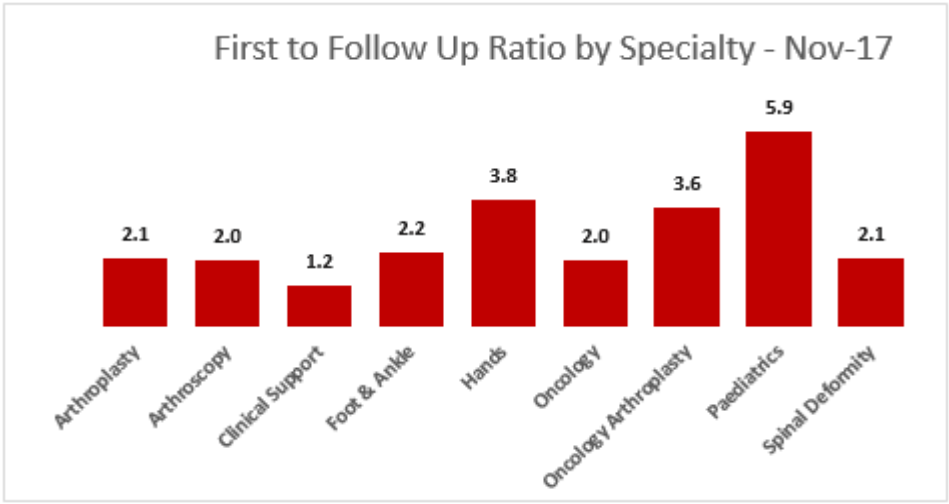
Work has also commenced to increase the number of patients who are treated on the Rapid Recovery Pathway for Knees with an improvement seen in November 17.

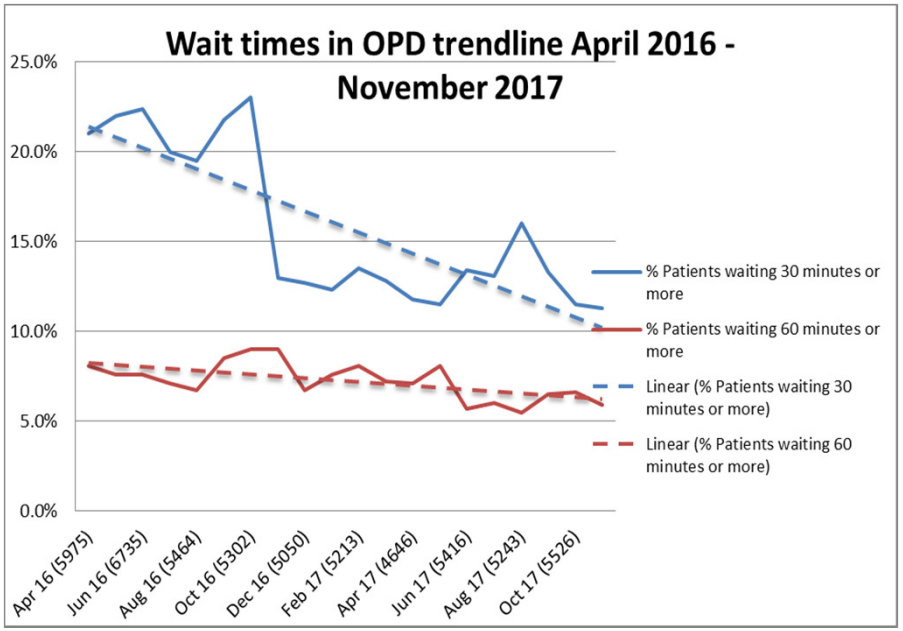
RISKS / ISSUES

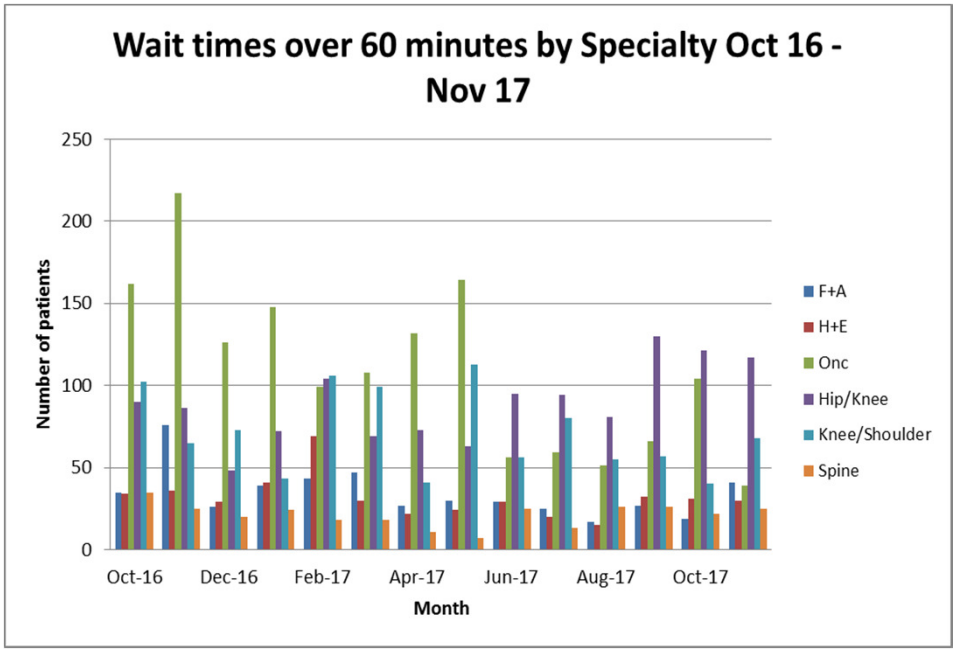
Over the next few months a more focussed approach will be in place to actively monitor and reduce LOS.

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









INFORMATION

The process for sharing learning in relation to clinic delays is reviewed and shared with the Clinical Service Managers along with the clinic delay data. In October 17 a newly formed Outpatient Operational Group was established and any issues that require operational management input are discussed at this forum.

In November 2017 there were 14 (13 main OPD, 1 Paediatric OPD) incident forms completed to highlight clinics running more than 60 minutes late. The monthly audit identified 3 main contributing factors for delays: 1) Clinic Overbooked for the Number of Staff 2) Complex Patients requiring more time than was planned and 3) consultant/clinician delay

It should be noted that there has been no incidents regarding any delays or missing medical records in November 17.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions from November's Audit include;

- All incidents to be shared with / allocated to CSM / CSSMs for investigation, feedback and action weekly at the Division 1 Operational Meeting
- Work underway to validate data quality related to clinics set up on InTouch to ensure they map to the correct locations
- Work underway with the Estates department to improve the environment on paediatric outpatients to ensure InTouch can be used effectively and in real time
- Meeting held w/c 1 January to discuss the paediatric oncology clinic template which is still problematic and incurring delays
- Rewriting and launch of new SOP in relation to clinic cancellation and reductions
- Project to implement management of clinician annual leave through Allocate has started and being managed by Division 1

RISKS / ISSUES

Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure (see above actions) to be monitored via OPD Operational Group

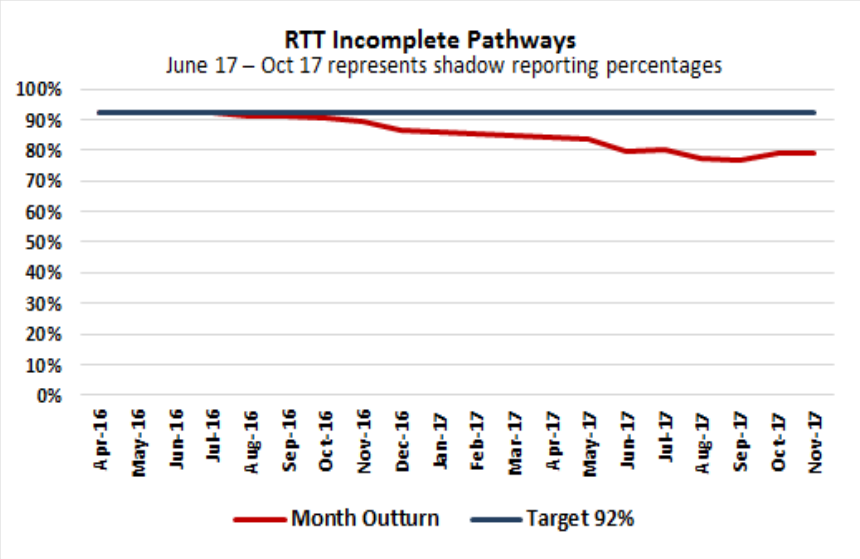
14. Treatment targets – This illustrates how the Trust is performing against national treatment target –

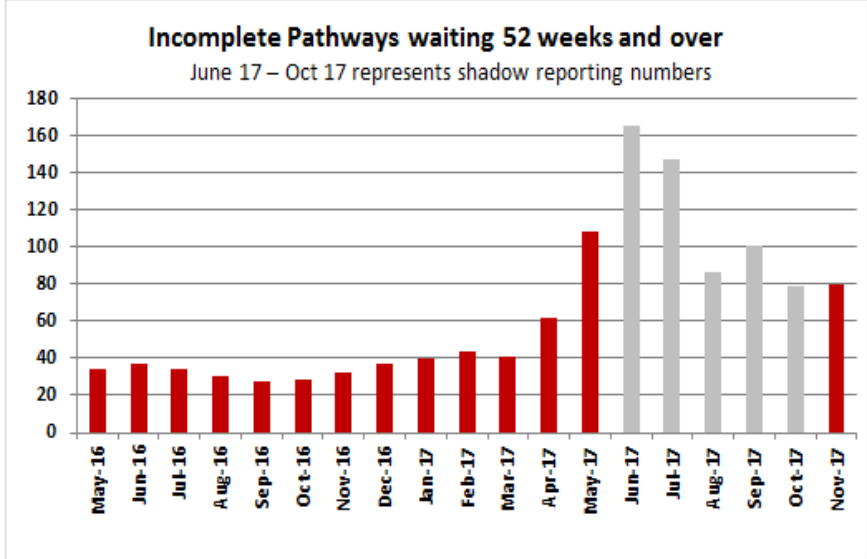
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
Month	MRI	CT	US	Total	MRI	CT	US	Total	over 6 weeks	under 6 weeks	Total	% under 6 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	99.7
May-17	784	79	296	1159	781	176	326	1283	4	1155	1159	99.7
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	99.5
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
Oct-17	912	99	416	1427	768	216	353	1337	4	1423	1427	99.7
Nov-17	789	106	469	1364	977	226	441	1644	12	1352	1364	99.1

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





			Reported Month						Reported Quarter					
Target Name	National Standard	Indicative Nov	Oct	Sept	August	July	Jun	May	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	100.00%	95%	100%	100%	100%	95.65%	100%	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	91.70%	100%	75%	100%	100%	91.67%	100%	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100.00%	100%	100%	100%	100%	100%	100%	97.40%	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		n/a
62 day (traditional)	85%	80%*	100%	100%	100%	37.50%	71.43%	60.00%	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	90.90%	81%	83%	75%	100%	100%	100%	88.9%	1	9	100%	0	4
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
No. day patients treated 104+ days		0	0	0	0	3	1							

* indicative performance- November performance reported Monday 8th Janaury 17

14. Referral to Treatment snapshot as at 30th November 2017 (Combined)

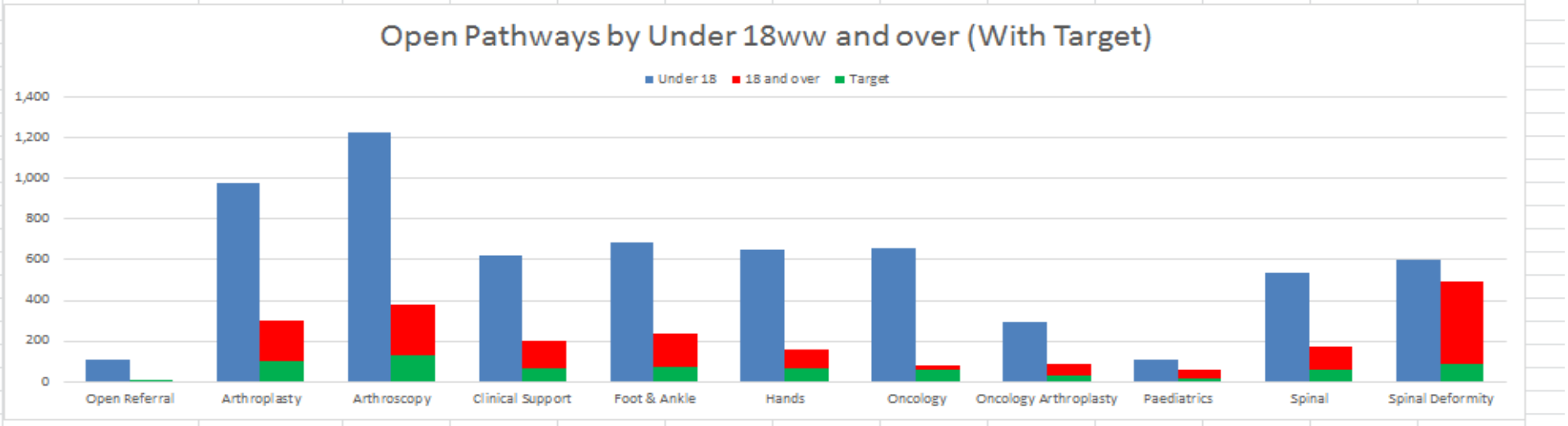
Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at: 2017-11-30

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	**3,547**	92	518	663	329	380	323	355	160	61	375	291
7-13	**2,347**	7	398	446	233	250	236	218	101	45	238	175
14-17	**959**	0	138	184	79	95	86	109	60	18	80	110
18-26	**1,044**	0	166	220	83	128	102	24	47	36	68	170
27-39	**602**	0	93	105	68	58	42	3	25	19	39	150
40-51	**163**	0	18	16	9	16	7	1	8	7	12	69
52 weeks and over	**84**	0	3	0	2	5	3	0	1	1	5	64
Total	**8,746**	99	1,334	1,634	803	932	799	710	402	187	817	1,029

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**6,853**	99	1,054	1,293	641	725	645	682	321	124	693	576
18 and over	**1,893**	0	280	341	162	207	154	28	81	63	124	453
Target	**700**	**8**	**107**	**131**	**64**	**75**	**64**	**57**	**32**	**15**	**65**	**82**

Performance against Target (92.0%)	78.4%	100.0%	79.0%	79.1%	79.8%	77.8%	80.7%	96.1%	79.9%	66.3%	84.8%	56.0%



INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

	Total Pathways	Over 18 Weeks Pathways	Over 52 Week Pathways
Admitted	949	395	12
Non Admitted	1464	338	16
Incomplete	8730	1832	80

The above figures have been submitted nationally for the ROH RTT performance for November 2017 – 79.01%

ACTIONS FOR IMPROVEMENTS / LEARNING

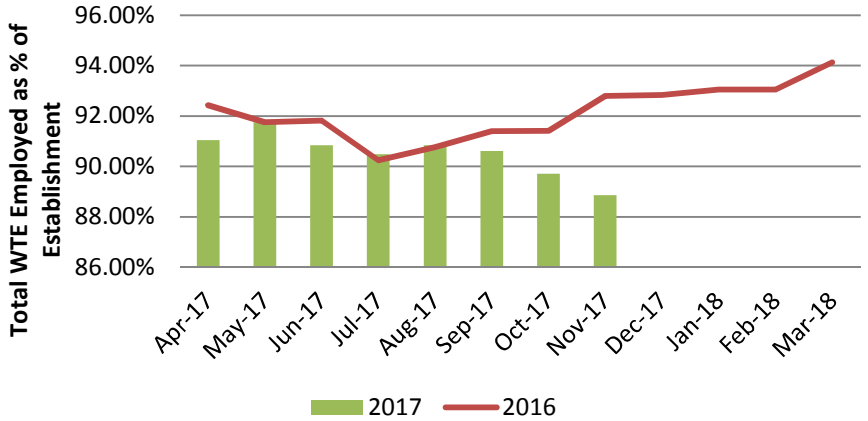
The team continue to concentrated on any patient over 40weeks. The greater focus has been on patients on a admitted pathway between 27-39 weeks and non admitted over 18weeks. Good progress has been made by all the teams especially Oncology who are now achieving over 92%.

RISKS / ISSUES

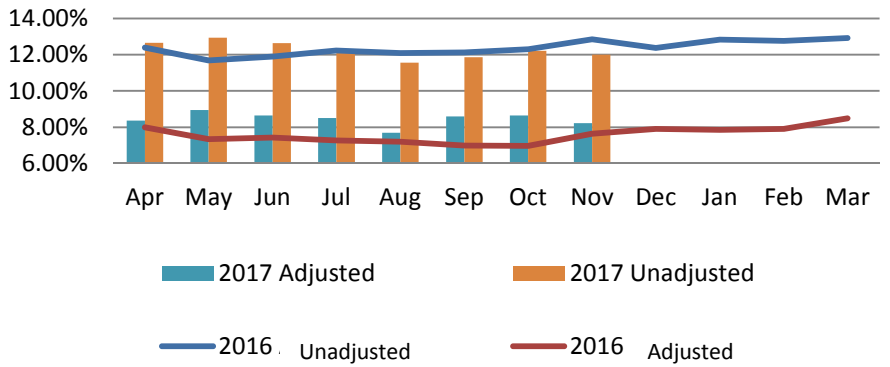
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . We are currently on track with the BWCH trajectory and the non-spinal deformity patients over 52 weeks continues to reduce.

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

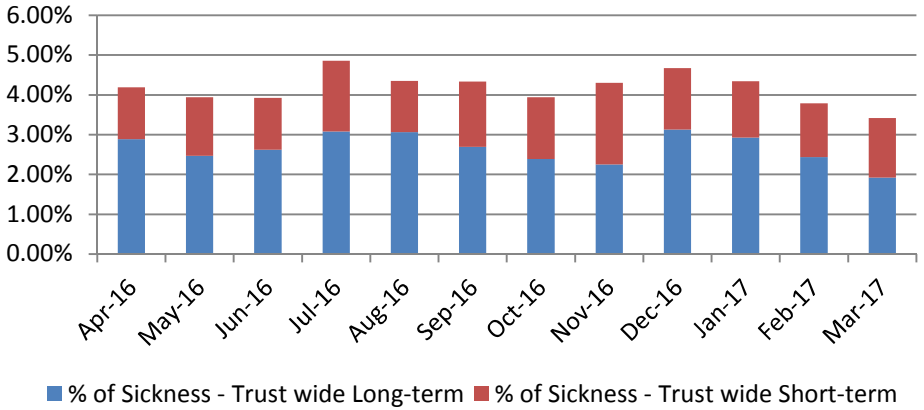
Staff in Post v Establishment



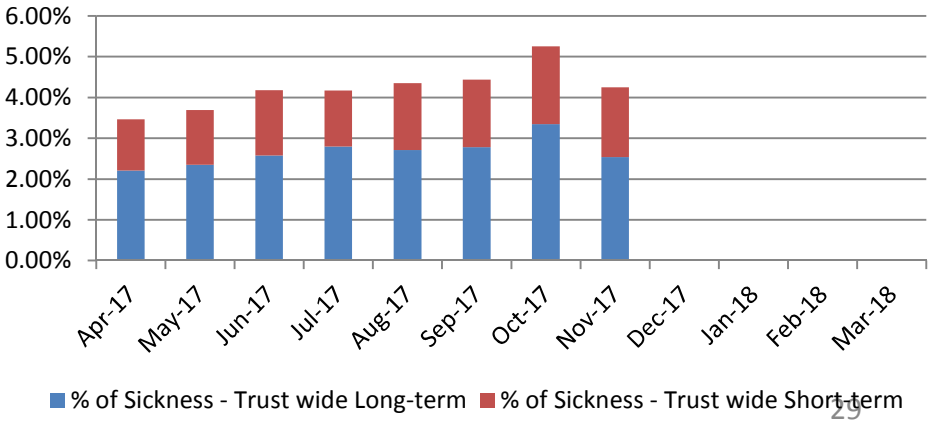
Staff Turnover



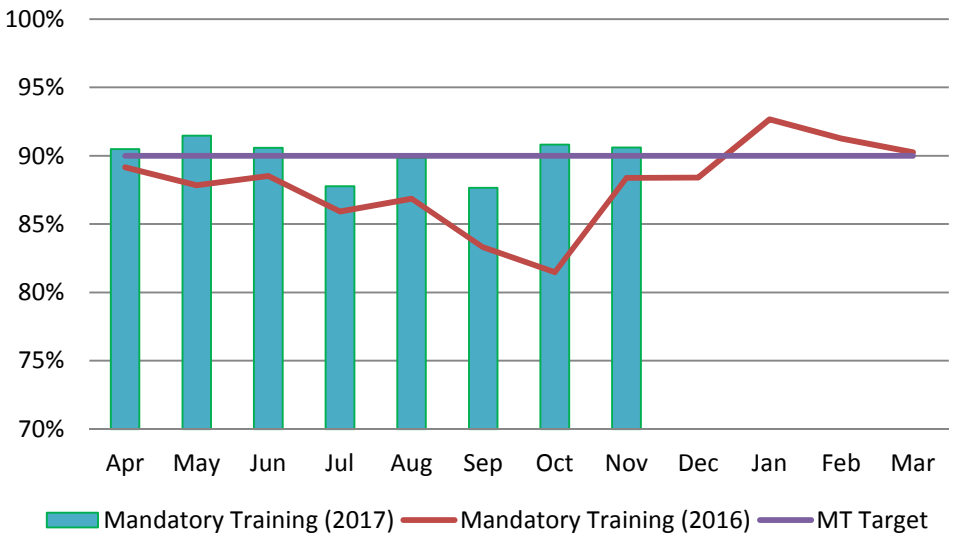
Sickness % - LT/ST (2016)



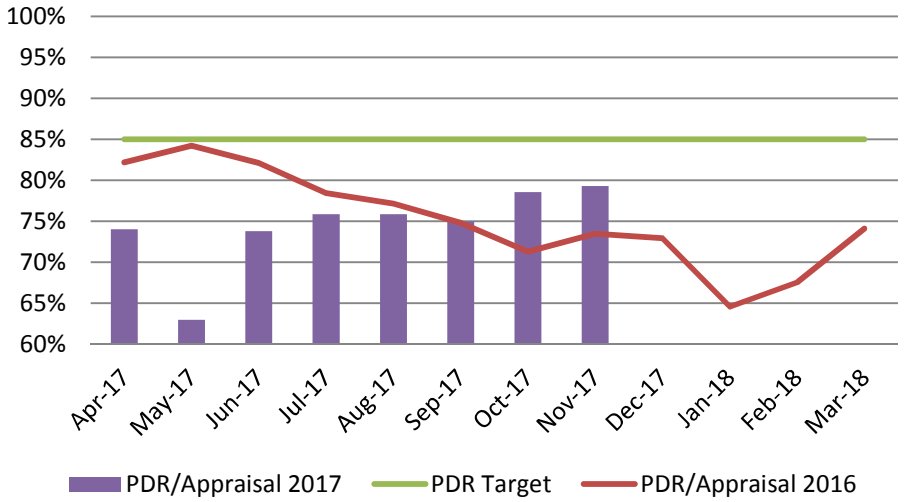
Sickness % - LT/ST (2017)



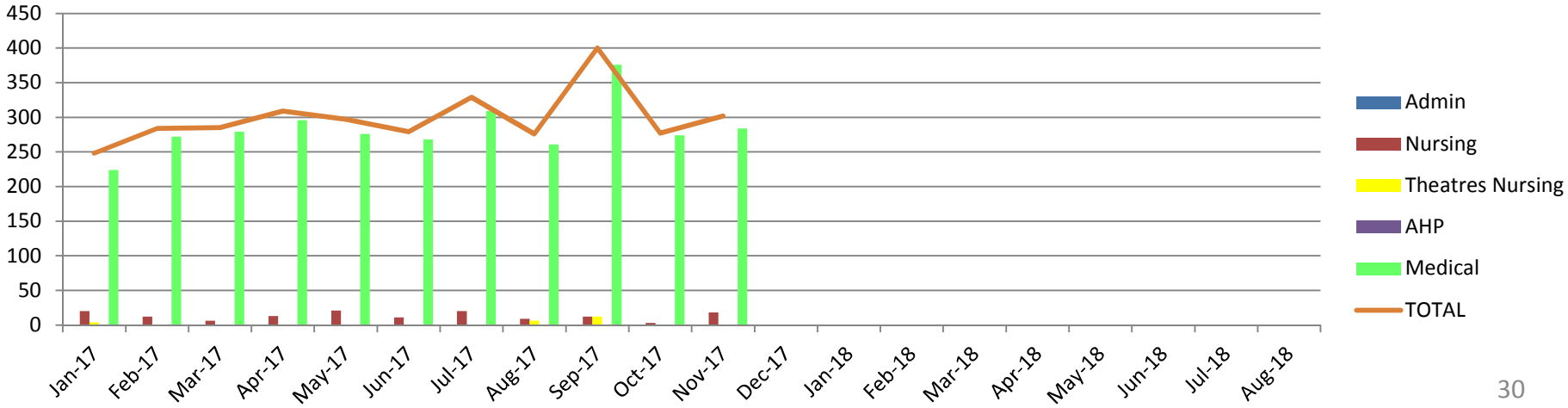
Mandatory Training



PDR/Appraisal



Agency Breaches



INFORMATION

November saw a mixed picture in terms of workforce performance across a range of indicators, with improvement in PDR, Turnover and Sickness, Mandatory Training remaining steady but the vacancy position in decline.

November saw sickness absence decrease by 1% to 4.25% in month, with decreases both in long and short term absence. The 12 month average figure again remained in amber at 4.32%. We are aware that there were a number of long term absentees returning during November.

The Trust's vacancy position dipped slightly again on last month's figure by 0.85% to 88.86%. We have remained in red for November 2017, and is typical of the vacancy position since June.

Mandatory training dipped slightly by 0.22% in November, but the Trust remains green at 90.61%. Work is continuing 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, further improvement in this position is expected going forwards.

Performance relating to appraisals in November improved again by 0.74% taking the position to 79.29%. The continued release of provisional data to Clinical Service Managers early in the month is felt to be helpful in improving both the accuracy and transparency of reporting: this system will therefore continue in order to ensure that our data are accurate. Although November's position is still red, it does reflect an improvement.

The November turnover figures both decreased, although neither is a particular cause for concern. The unadjusted turnover figure (all leavers except doctors and retire/ returners) decreased by 0.20% on last month to 12.01%., and the adjusted turnover figure ("true leavers" meaning "voluntary resignations") decreased by 0.41% to 8.23% remaining green in month.

In relation to agency breaches, the position increased slightly in relation to medical staff as forecast due to the arrival of middle grade doctors in spines and paediatrics. The 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 Nursing breaches also increased by 15 during November.

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.

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.

The return to amber for mandatory training is likely to result in the continuation of the contract performance notice by our commissioners.

ROHTB (1/18) 007

TRUST BOARD

DOCUMENT TITLE:	**Compliance against the CQC Fundamental Standards**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive and Garry Marsh, Executive Director of Patient Services**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**10 January 2018**

EXECUTIVE SUMMARY:

An assessment against the Care Quality Commission's 13 fundamental of standards of care is included in the workplan of the Quality & Safety Committee annually and was considered at the October 2017 meeting, where it was agreed that in view of the forthcoming inspection by the CQC, it would be useful for the Board to see the self-assessment and understand key areas of risk.

The fundamental standards as a whole came into force in April 2015, although the Fit and Proper and Duty of Candour Regulations were introduced earlier than this.

The Board is asked to note that there are no significant areas of concern and the position statement attached outlines the evidence of compliance against these standards AS AT OCTOBER 2017. Where there are weaknesses, these are identified, together with the actions being taken or planned to address these issues.

REPORT RECOMMENDATION:

Trust Board is asked to:

- RECEIVE and NOTE the position statement of compliance against the Fundamental Standards
- NOTE that an update will be provided to the January 2018 Quality & Safety Committee meeting on progress with addressing the weaknesses identified in compliance

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Compliance with national regulatory framework

PREVIOUS CONSIDERATION:

Quality & Safety Committee in October 2017

Compliance against the CQC Fundamental Standards – Position statement as at October 2017

Standard	What the Standard Is	Evidence
Person Centred Care **Executive Lead: Director of Patient Services**	Regulation 9 specifies that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. To meet this standard provider organisations must • Carry out an assessment of the care and treatment needs of then service user in the context of their preferences, involving the service user or their representative as appropriate; • Aim to meet the service users' preferences while ensuring that their needs are met; • Ensure that the service user understands their options for care and treatment and has the opportunity to discuss the risks and benefits of those options with a healthcare professional; • Ensure that the service user or their representative is involved in decisions relating to their care and/or treatment to the maximum extent; • Provide appropriate opportunities for people or their representatives to manage	Risk Assessments are undertaken for inpatient admissions including and not limited to : • Nutritional Risk Assessment and Fluid Balance documentation • Falls Risk Assessment • Dementia Screening • Tissue Viability Screening A document review is currently being undertaken by the Head of Nursing for Division 1. Clinical Update days support staff knowledge and development to provide high quality person centred care. Individual care planning processes are in place to document pre and post-operative care requirements. Broadly this covers all aspects of care from pain management, psychological support through to activities of daily living including social and nutritional care requirements. Pre-Operative Assessment plays a key role in meeting the individual care requirements. Examples of this include RAPID assessments, hip and knee workshops, pre-operative information on anaesthesia, the procedure, what to expect during a hospital stay, post-operative expectations and Royal Orthopaedic Community Services if applicable, expected date of discharge discussed and recorded on PAS. An opportunity at POAC is also offered to

Standard	What the Standard Is	Evidence
	their care or treatment; • Involve people using services in decisions relating about the way in which the service is delivered in so far as it relates to their care or treatment; • Provide relevant persons with the information they would reasonably need to participate in decisions on their care and treatment; • Make reasonable adjustments to enable the service user to receive their care or treatment; • Where meeting a service user's nutritional and hydration needs, have regard to the service user's well-being.	meet with medical staff to ask any further questions. Discharge planning process is holistic and inclusive involving individuals in their own right and relevant family members. Use of MDT support's active discharge planning to ensure safe discharge. Red2Green discharge initiative is currently being embedded. Translation services are available and supported by policy. Some staff within the organisation have had additional training in British Sign Language. Dementia screening in POAC enables appropriate pre-planning for patients with dementia. All emergency admissions should receive dementia screening; work is being done to ensure 100% compliance. Paediatric patients are seen in their own Pre-Operative Assessment clinic within the Paediatric ward. This is staffed by paediatric trained nurses. When things go wrong patients are now involved in the investigation process. New ward boards displaying performance against a set of KPIs are to be implemented. A set of nursing KPIs has also been developed and shared with the Quality & Safety Committee. A Learning Disability strategy has been developed by the new Learning Disability nurse. **Key Gaps in assurance and actions taken:**

Standard	What the Standard Is	Evidence
		• Dementia – it has been identified there are some gaps in consistent assessment of emergency patients. A dementia strategy has been developed and the Trust has delivered the obligations in the strategy set out for the first year. This strategy includes training in assessment and care of this specialist group of patients. There has recently been deterioration in the compliance with dementia screening, which is currently being addressed. • Carers – the Trust is yet to develop effective strategies to involve carers in the provision of care for their loved ones and relatives. • Learning disabilities – although a draft strategy is in place, the management of risk associated with treating this cohort of patients is not yet embedded. • Further work is needed to improve complex needs audits
Dignity and Respect **Executive Lead: Director of Patient Services**	Regulation 10 stipulates that patients and service users must be treated with dignity and respect. To comply with the regulation provider organisations must: • Ensuring the privacy of the patient or service user; • Support the autonomy, independence and involvement in the community of the patient or service user; • Give due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the patient or service user. The protected characteristics are age, disability, gender, gender reassignment, pregnancy and maternity	Policy in place to support the Privacy and Dignity aspect of care for our patients. Privacy and Dignity Champions are in each area, with regular meetings to share good practice and highlight any concerns. Same sex breaches reported are investigated when they happen – a change in the contract has prompted an increase in the number of breaches needing to be reported. There were four mixed sex breaches during 2016/17. **Keys Gaps in assurance and actions taken:** • Following the last CQC inspection the Trust received a legally enforceable action in relation to the lack of a Chaperone policy and staff's lack of knowledge in this area. A Chaperone policy has been

Standard	What the Standard Is	Evidence
	status, race, religion or belief and sexual orientation.	written and is embedded.
Need for consent **Executive Lead: Medical Director**	To comply with regulation 11 provider organisations must ensure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment for which they are seeking consent. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 37 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.	Updated Consent policy following nationally published standards in place. Consent Lead (Medical Director) is in place. Consent competency tested through mandatory training module for appropriate staff. Bi-yearly Medical Record Audit shows that consent is only obtained by appropriately qualified staff with appropriate knowledge of the procedure and associated risks. Internal Audit of the consent policy and process is in place.
Safe Care and Treatment **Executive Lead: Director of Patient Services**	Regulation 12 sets out what provider organisations must do to deliver safe treatment. This includes: • Assessment and control of the risks to the health and safety of patients or service users; • Ensuring staff have the qualifications, competence, skills and experience to provide safe care and treatment; • Ensuring premises are fit for purpose and safe for use; • Ensuring equipment is safe for such use and is used safely; • Ensuring equipment or medicines are available in sufficient quantities to ensure	Annual PLACE assessment undertaken which reviews multiple aspects of patient care including environment. The review team comprises of ROH staff, specialist nurses and patient representation. Recommendations follow the assessment. Mandatory training is in place with monitoring via the Corporate Performance report. Managers keep local records with local KPIs set for training figures to be maintained as greater than 85%. Additional professional training is in place for health care support workers and nursing staff, training data is maintained and reviewed by the Learning and Development department. Annual PDRs ensure that staff are maintaining mandatory competence and developing professionally. HR policy ensures that staff do not progress to

Standard	What the Standard Is	Evidence
	safe treatment; • Ensuring medicines are managed properly and safely; • Ensuring effective infection control including health care associated infections; • Ensuring that shared responsibility for care or treatment and transfer to other providers is dealt with safely and effectively.	the next pay gateway unless annual attendance at mandatory training and completed PDR undertaken. Divisional Performance reviews review training and PDR compliance together with other relevant KPI percentages. Infection Control data is considered by the Infection Control Operational Committee and Infection Prevention & Control Committee which reports up into Quality & Safety Committee. Infection rates remain low. The Trust has a Bone Infection Unit and is working collaboratively with other trusts such as Coventry and Warwickshire University Trust to share best practice. The Trust is a member of the critical care network ensuring safe transfer of level 3 patients. The new ADIOS system has been implemented for the monitoring of the use of Controlled Drugs and highlights anomalous trends is usage which can be investigated for any potential cases of misuse. Medicines management policy and controlled rugs standard operating procedure have been updated and disseminated in January 2017. Medicines management training session was delivered by Pharmacy on the Clinical Update day. There are quarterly controlled drug storage and medicines audits completed by Pharmacy. There is a monthly medicine and storage audits undertaken by medicines link nurses and area managers.

Standard	What the Standard Is	Evidence
		Key Gaps in assurance and actions taken: • There are some gaps in compliance with the hygiene code and have a NHS Improvement-agreed action plan to address these shortfalls. • There is no visible equipment replacement or maintenance plan in place beyond the capital plan. • Following CQC inspection the Trust received a legally enforceable action in relation to equipment that had been found with no visible evidence of having been properly checked and maintained in accordance with electrical safety requirements. This remains an ongoing challenge, however is overseen by a Medical Devices Group. • The existing database of electrical device safety checks will be maintained and reviewed at regular intervals to include an overview at the performance review of the Estates and Facilities service. • The Estates department will utilise the existing communication strategy across the Trust to highlight actions required to escalate out of date equipment. • During the last full inspection concerns were identified with the procedures and governance arrangements for controlled drugs. An external review was undertaken by KPMG with a number of recommendations made. This was converted into an action plan which was monitored by and closed by the Drugs & Therapeutics Committee.
Safeguarding **Executive Lead: Director of Patient Services**	The expectation set out in regulation 13 is that provider organisations have a 'zero tolerance approach' to abuse, unlawful discrimination and unlawful restraint. Abuse is defined in the regulation as: any behaviour towards a service user that is an offence	We have a policy in place to safeguard patients and service users from abuse. Safeguarding training is in place and meets contractual obligations. This has been an area of focus for the Trust this year. Training promotes 'making safeguarding personal' as a standard for safeguarding adults. The 'voice of the child' and 'professional curiosity' is emphasised to ensure that children

Standard	What the Standard Is	Evidence
	under the Sexual Offences Act 2003; ill-treatment whether of a physical or psychological nature, including degrading treatment; theft, misuse or misappropriation of money or property and neglect	are kept safe from harm and guide our safeguarding practice. We have a Safeguarding Committee in place that meet on alternate months. The Director of Patient Services attends external Safeguarding Board for both children and adult services. Each ward and department has a Safeguarding Champion who meet quarterly to undertake specialist training from outside agencies, identify good practice and share this practice with their wards and departments Themes from Serious Case Reviews, Serious Adult Reviews and Trust incident reporting/safeguarding database are shared for learning in training sessions, via Safeguarding Champions and Trust Communications. Safeguarding alerts are placed on Trust systems to ensure that all staff across the Trust are aware of safeguarding issues for individual patients The Named Nurse and Lead Nurse attend multi-partnership events to share practice and identify areas of good practice, keep up to date with local guidance that can be implemented in the Trust. Previous inspection identified that staffs implementation and documenting of Mental Capacity Assessments and request for DoLS required improvement. The Trust has commissioned an external Independent MCA and DoLS consultant to provide specialist training across the Trust to improve this. This is in the process of being audited. There is a named senior officer with responsibility in respect of allegations made against staff and volunteers. A new policy regarding Clinical Holding for Children is now in place to ensure

Standard	What the Standard Is	Evidence
		that children are kept safe and their rights are protected during clinical procedures. A review of the Safeguarding Supervision Policy is underway and steps are being taken to ensure staff have improved access to regular supervision to ensure their safeguarding practice is effective. A Learning Disability Practitioner is now in post to ensure that patients with learning disabilities, who are twice as likely to experience abuse, are safeguarded effectively. Ward and department safeguarding noticeboards are aimed at patient and carer information reflects current safeguarding themes and how to access support. Information is inclusive of male and female abuse as well as LGBT and BME groups. Trust Speak up Guardian offers staff a safe way to report concerns regarding practice that may cause harm to patients and carers. Trust has a PREVENT lead. PREVENT is included in mandatory training and the Trust has 4 PREVENT trainers. **Key Gaps in assurance and actions taken:** • A domestic abuse policy is in place but is not embedded. • The Trust has a 'Was Not Brought' policy in place but this is not embedded. Training is also arranged. • There are challenges with sustaining PREVENT training levels.
Meeting nutritional and hydration	To comply with regulation 14 provider organisations must make sure that people using their services have enough to eat to	We have an enteral feeding policy and we have policies/guidelines in place for the management and monitoring of fluid balance. A nutritional lead is in place.

Standard	What the Standard Is	Evidence
needs **Executive Lead: Director of Patient Services**	meet their nutrition needs and enough to drink to meet their hydration needs. Provider organisations must ensure that people using their services have their nutritional needs assessed and that food is provided to meet those needs. This will include prescribed nutritional supplements and/or parenteral nutrition. Provider organisations must take account of preferences and religious and cultural backgrounds when providing food and drink and must provide the support necessary to enable people to eat and drink.	Nutritional audits (to include hydration / fluid balance charts) are in place. Dietetic and Speech and Language Therapy SLA in place with UHB, providing dietician and speech and language therapy support on site. Protected mealtimes in place. Regular audits undertaken with service users to gain feedback regarding food and drink. All specialist diets, to include religious and cultural requirements, are catered for. Pre-operative fasting audits in place; noting that fasting times have reduced remarkably by the work undertaken in ADCU **Key Gaps in assurance and actions taken:** • A policy for overarching nutrition does not currently exist. • Risks associated with nutrition are escalated on to the risk register for escalation at Clinical Quality Committee.
Premises and Equipment **Executive Lead: Director of Strategy & Delivery**	To comply with regulation 15 provider organisations must ensure that premises are clean, fit purpose, well maintained and accessible. They must also ensure that equipment is clean, suitable, properly maintained, stored securely and used properly. It should be noted that legal responsibility remains with the registered provider organisation even where they delegate responsibility through contracts or legal agreements to a third party, independent suppliers, professionals, supply chains or contractors. Where the service user or patient owns the equipment needed to deliver their care and treatment, or the	Annual PLACE assessment undertaken which reviews multiple aspects of patient care including environment. The review team comprises of ROH staff, specialist nurses and patient representation. Recommendations follow the assessment. **Key Gaps in assurance and actions taken:** • The recent NHS Improvement inspection against Regulation 12, safe care and treatment and work is underway through the delivery of an action plan to address these shortfalls; this impacts on the Trust's ability to be fully compliant with the standard around Premises and Equipment. • There is no visible equipment replacement or maintenance plan in place beyond the capital plan. • Following CQC inspection the Trust received a legally enforceable action in relation to equipment that had been found with no visible

Standard	What the Standard Is	Evidence
	provider does not provide it, the provider must still make every effort to make sure that it is clean, safe and suitable for use.	evidence of having been properly checked and maintained in accordance with electrical safety requirements. This remains an ongoing challenge, however is overseen by a Medical Devices Group. • The Estates department utilise the existing communication strategy across the Trust to highlight actions required to escalate out of date equipment.
Receiving and Acting on Complaints **Executive Lead: Director of Patient Services**	To comply with regulation 16 providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints made by anyone. All complaints must be investigated thoroughly and, where failures have been identified, any necessary action must be taken. The regulation does not define what a complaint is, so it is important that provider organisations have their own robust and justifiable definition so that they can demonstrate compliance. However the guidance states that complaints may be made either orally or in writing, suggesting a broad definition of complaints along the lines of: any expression of dissatisfaction.	We have a Complaints policy in place which has been refreshed within the last year The CQC inspection undertaken in June 2014 identified no concerns with the complaints process. Friends and Family data remains extremely positive and we exceed the National average The PHSO has upheld a number of complaints in support of the ROH Good performance against the complaints KPIs **Key Gaps in assurance and actions taken:** There has been an increase in PALs contacts, although this is associated with the addition of the PALs contact number to all appointment letters; this is being rectified as part of the 'Perfecting Pathways' Programme
Good Governance	To meet regulation 17 provider organisations must ensure that the systems and processes that underpin good governance are in place and operate well. This will include systems of	The Trust has set out its internal control system within the Annual Governance Statement, the Head of Internal Audit Opinion being that there is an adequate framework of Internal Control, although there is room for further improvement.

Standard	What the Standard Is	Evidence
Executive Lead: Chief Executive and Director of Patient Services, supported by the Company Secretary	risk management, assurance and checks on assurance. One of the key he outcomes should be an enhanced ability to assess, monitor and drive improvement in the quality, safety and experience of the services provided. The regulation places a duty on provider organisations continually to evaluate and seek to improve their governance and auditing practice.	The Trust has a risk management policy in place and much work has been undertaken recently to improve the quality of local risk registers, committee risk registers, the Corporate Risk register and the Board Assurance Framework. The Board Committee structure has been revised to provide greater oversight of Finance & performance matters and is due to undergo a further refresh to provide oversight of workforce-related matters. The Board receives assurance on the Quality of Care through the Patient Safety & Quality Report, and the BAF, and through the oversight of the Quality & Safety Committee which reports upwardly through the use of assurance reports. The Quality & Safety Committee in turn receives more detailed reports from subgroups covering particular aspects of quality, for example drugs and therapeutics. This supports the process of escalation of risk related to quality throughout the Trust. There is a structured programme of quality walkabouts in which Board members gain first-hand experience regarding the quality of care and the views of patients and staff and others. These walkabouts are based on the CQC's Key Lines Of Enquiry. The Trust has embedded a robust Divisional Governance structure, with evidence of quality conversations occurring routinely. Attendance at Quality & Safety Committee has been widened to include Heads of Nursing, so it more closely aligns to the divisional structure.

Standard	What the Standard Is	Evidence
		A public governor attends the Quality & Safety Committee as an observer. The CEO holds monthly briefings (Team Brief) with Heads of Department for dissemination to teams. **Key Gaps in assurance and actions taken:** There remains a gap at Board level in the consideration of workforce-related matters, therefore a new committee is to be introduced around staff experience and OD. There remains further work to do to strengthen the linkages between risk registers and improve the functionality of the ULYSSES system to facilitate better reporting and risk management. The governance of clinical outcomes data is being reviewed; the role of clinical audit in providing assurance regarding quality and outcomes data is also being strengthened. There were regulatory concerns in 2017 around the timely escalation of issues around 18 weeks RTT performance and data quality; cancer tracking and spinal deformity waiting times. In response the Trust devised a series of action plans which are routinely monitored by the Board and the Finance & Performance Committee.
Staffing **Executive Lead: Director of**	To meet regulation 18 provider organisations must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are available to meet the	Assurance to the Quality & Safety Committee and upwards to the Board on safe nurse staffing is obtained through monthly reporting containing details of the following;

Standard	What the Standard Is	Evidence
Patient Services	needs of patients/service users at all times as well as to meet the other regulatory requirements. Provider organisations must ensure that their staff receive the support, training, professional development, supervision and appraisals necessary for them to carry out their duties effectively and so that they continue to meet the professional standards necessary to practise. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 75 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.	• The Trust's staffing position against NICE guidance • Staffing numbers including skill mix and acuity of patients. • Reported incidents pertaining to staffing including where safe minimum staffing levels have been breached and actions taken. • Bank and agency usage per clinical ward area is also documented. A recent report has been presented to the Quality & Safety Committee showing compliance against the NQB standards. A Red Flag system is in place to highlight where there are serious incidents that involve staffing issues The Board has received its 6 month nursing establishment review. This is shared with our commissioning partners and forms part of the annual contract. E-rostering and Safecare are embedded. KPIs are being developed to triangulate harm to nurse staffing. All staff should receive an annual PDR to support their development and learning needs and this is mandated by Trust policy. An overview of this criterion is provided through the Finance Overview which identifies workforce data including PDR's. Scrutiny of this data is provided by Finance & Performance Committee and Board. Department KPI's support the overarching monitoring processes The Learning and Development Department support access to development courses including LBD monies.

Standard	What the Standard Is	Evidence
		Key Gaps in assurance and actions taken: PDR Completion Rates fall below the 85% agreed Trust target consistently. Divisional and Senior managers are charged with ensuring their teams have PDRs and receive adequate access to development opportunities. Mandatory training levels are below expectations at present and work is underway through performance reviews to monitor and drive improvement. Staffing level scrutiny is mainly confined to nursing at present and there are plans to widen this to other professional groups and provide board oversight through the Staff Experience & OD Committee.
Fit and proper persons employed **Executive Lead: Director of Strategy & Delivery**	To comply with regulation 19 provider organisations must ensure that persons employed to carry on a regulated activity must: (a) be of good character; (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and (c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed.	**The Trust has in place a Fit and Proper Person's Test policy in place.** All defined in the policy requiring a fit and proper assessment have undergone the necessary checks, including three new Non Executive Directors. **Key Gaps in assurance and actions taken:** Work is underway to ensure that the new interim Board members undergo the required Fit and Proper check.
Duty of Candour	Regulation 20 makes it a statutory requirement that health service bodies to act in an open and transparent way with relevant persons in relation to care and treatment	The Trust is currently compliant with Duty of Candour requirements. As part of the Trust's contractual obligations, commissioners undertook an audit to assess compliance. The Trust was deemed to be compliant and

Standard	What the Standard Is	Evidence
Executive Lead: Director of Patient Services	provided to service users in carrying on a regulated activity.	internal systems are in place to monitor ongoing compliance. Duty of Candour is reportable as part of the national Contract arrangements with Commissioners and is reported on a monthly basis. **Key Gaps in assurance and actions taken:** A new policy has been introduced to address informal audit issues identified.
Display of CQC Ratings **Executive Lead: Director of Patient Services and Director of Strategy & Delivery**	Regulation 20A of the Fundamental Standards sets out the requirement to display ratings ('performance assessments') at their physical premises and on their website(s). This will be a legal requirement from 01 April 2015. This Annex summarises CQC's guidance but we strongly recommend you read the full guidance (13 pages) and approach CQC for clarification about how you can meet the display requirements with respect to any logistical or practical challenges for your own trusts' premises and services	The Trust displays the CQC Ratings and Report on both its internal and external internet sites. A direct link on its external site takes visitors to the summary report and findings including the overall grid ratings. Posters are displayed around the site indicating the CQC rating and their key findings during the inspection process. **Key Gaps in assurance and actions taken:** There are currently no gaps in assurance.

ROHTB (1/18) 008

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 2 - 3 2017/18 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**10th January 2018**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at the end of Quarter 3 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:

- The need to develop a plan to secure the future sustainability of the organisation
- Lack of shared ownership of the risks associated with the transition of paediatric services
- Plans for Paediatric services is not aligned with the wider STP strategy for orthopaedics
- Potential that patient care may be compromised as a result of paediatric nursing vacancies
- Potential clinical resistance to change in the way that Paediatric services are delivered
- Reputational damage if the Paediatric services transition is not delivered in a timely manner
- Transitional costs associated with the transfer of paediatric services

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 (1/18) 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:					
Audit Committee in December 2017.					

BOARD ASSURANCE FRAMEWORK Q2-3 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 deliver 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	Operations	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	3	5	15	↓	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 over 40 weeks have been reveiwed at the October 17 harm review meeting. Any patients identified as waiting over 40weeks in the Trust will go to harm review - this process is now embedded as good practice supported by a monthly meeting for any new incidents.	Ongoing	3	4	12

1089	Operations	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	4	5	20	↓	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. Nov 17- the Trust is currently refreshing the RTT trajectories now the validation has been completed- these will be completed at the end of November 17.	Q4 2017/18	4	4	16
1088	Operations	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	4	12	↓	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. 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. Nov 17- The Trust has completed a full data cleanse of all its RTT data including historical clock stops. A daily RTT dashboard and data error report is in use and supports daily RTT management. The Trust will return to national reporting in December 17.	Q2 2017/18	3	4	12

NEW	Corporate	Paul Athey	There is a risk that the ROH Trust Board carries all the clinical risk residing with the transition of Inpatient Paediatric Services whilst the system re-commission and re-provides the services elsewhere.	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	5	5	25	The Trust agreed that it could not meet the national service guidelines and as such gave notice on the provision of the inpatient service. All stakeholders have confirmed that this should be managed as a system wide risk and this is done via the monthly Stakeholder meetings and the Paediatric monthly commissioning group. The Trust and the health system all acknowledge that the Inpatient Service at the ROH is not compliant with national guidance during this transition period.		5	5	25	NEW	Continued discussion with Specialised Commissioners and other key stakeholders to agree to a risk sharing arrangement	Q4 2017/18	1	4	4
NEW	Operations	Jo Williams	Theatres - there is a risk that the department is in need of a full review supported by a organisational development programme	Delivered by highly motivated, skilled and inspiring colleagues	FPC	4	5	20	To support the Scheduled Care programme and the Trust recovery plan there is a need to conduct a full review of theatres supported by an OD programme	Scheduled Care Improvement Programme Board papers and minutes	3	3	9	↓	An initial assessment is currently ongoing to assess whether external support is required to support this. Nov 17- the operational team for Theatre has been strengthened with the appointment of a new Theatre Manager and Matron. Further work with the team is ongoing to ensure that we continue to progress development across the entire Theatre team.	Q4 17/18	2	2	4
1132	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 external (CCG) infection control expertise through a Service Level Agreement.	Infection Control Committee minutes; Infection Control upward report to Quality & Safety Committee	4	5	20	↔	Lead nurse and two IPC nurses commence later in January 2018	Q4 2017/18	1	5	5
NEW	Finance	Steve Washbourne	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	5	5	25	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	↔	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 in developing a sustainable business model for the ROH which is in line with the requirements of the STP and other commissioning bodies	Mar-18	3	5	15

293	Finance	Steve Washbourne	Financial surplus Failure to deliver planned financial surplus, impacting on financial stability, investment opportunities and regulatory rating.	With safe and efficient processes that are patient centred	FPC	4	5	20	The Trust is currently significantly off track at Month 4 and is not delivering activity or CIPs at the level required to deliver the financial plan. A finance and activity plan is in place and divisions are held to account on this through the divisional performance meetings.	FPC Reports	4	5	20	↔	Scheduled Care Improvement Programme to deliver activity and operational process improvements Additional resource provided through the STP to support improvement work New Assistant Director of Finance appointed to focus on financial delivery Continuing performance meetings for each division	Ongoing	4	3	12
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	3	4	12	↓	Delivery of the Cancer Action Plan. Onkos provides a daily tracking system. The team are developing proposal to implement a new system from April 20188 - this is supported by the Cancer Action plan	Q4 2017/18	2	2	4

544	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.The annual report for IPC was approved by the Trust Board at its November meeting - this provides some assurance of continued trajectory of compliance.	Infection Control Committee minutes; Infection Control upward report to Quality & Safety Committee	3	4	12	↓	Continued delivery of the IPC action plan and monitoring by the ICC Committee.	Q4 2017/18	1	4	4
1137	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	↔	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.	Jan-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 & QSC	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.	5	4	20	↑	All patients have been validated to provide an accurate postion of the number of patients waiting for surgery at BCH. Additonal operating list have been covered through Sept-Nov and further list are being populated until April 18. Contigency patients are in place when PICU beds are not available. Additonal Theatre capacity is being developed for Qtr 1 18/19. A trajectory is in placed to support delivery and monitor progress	Ongoing	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	3	9	↓	This will be reviewed weekly at Executive team meeting to ensure that this is not impacting on delivery of the projects Nov 17- the operational team has been strengthened within a number of areas. This will continued to be monitored monthly. Perfecting Pathway encompasses and supports the operational team to deliver service changes and redesign	Q4 17/18	2	2	4
1030	Operations	Jo Williams	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 the arthroscopy stacks have been restored and there are now 6 working units in theatres. Fridge monitoring and ambient temperature monitoring equipment is being ordered and the theatre alarm system is also being progressed urgently.	Funding requests. Outputs of the prioritisation exercise. Capital plan.	4	4	16	↔	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	Finance	Steve Washbourne	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	4	16	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	3	4	12	↓	Development of the data warehouse and ongoing development of in house intelligence	Ongoing	2	4	8
27	Operations	Jo Williams	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.	3	3	9	↔	Continued stringent controls for employing agency staffing. Nov 17 - all agency staff to support RTT have been ceased form the end of October 2017.	Ongoing	2	3	6
270	Finance	Steve Washbourne	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	Operations	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	Operations	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	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible.	Estates maintenance schedule	3	4	12	↔	Improvement Board to continue to track performance against turnaround workstreams	Ongoing	1	4	4
1031	Operations	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 now been fully implemented and is used for all products in implant stores. Final meeting of project board due to take place in early July, which will be to close the project group.	Stock internal audit report. FPC min	2	4	8	↓	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. Nov 17- a fortnightly project group is in place to support the work which is being delivered across Theatres- Chaired by the Interim COO	Q4 2017/18	2	2	4
1085	IM&T	Steve Washbourne	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	IM&T Programme Board	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	↔	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	2	4	8	↓	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. This is a Quality Priority within the 2016/17 Quality Account for the current year. Further Root Cause Analysis training is planned.	Q4 2017/18	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	A number of strategic meetings have been held with various external partners to look to develop a sustainable methodology for implementing small and larger scale change within the organisation. This includes the development of a simple continuous improvement tool. Both non-executive and executive directors have been involved in discussions with McLaren F1 Group, ABHI and their subcommittee of industry partners and finally the AHSN. All of these discussions are a various stages of maturity and the developments will be discussed at the Staff Experience and OD Sub-committee of the Board, (this is the replacement committee formerly Major Projects and OD Committee) and again at the Board. There are significant opportunities for the Trust to work in partnership in developing a strong platform for service improvement, this will be directly linked and will work with the Perfecting Pathways work that is already identifying areas for improvement.	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	Finance	Steve Washbourne	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	4	12	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	4	8	↓	Continued focus on efficiency and cost control through the recovery plan	Ongoing	2	4	8

NEW	Corporate	Paul Athey	Risk that the plan for Paediatric is not aligned with the wider STP strategy for Orthopaedics	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	3	5	15	The Trust is actively engaged with the STP and clinical reference groups across BSOL are in place to shape the orthopaedic strategy for the future .		3	5	15	NEW	STP clinical working group to agree proposed Orthopaedic strategy to the Trust Board. Agreement of the STP Board to redesign Orthopaedic pathways and ensure sustainability of the ROH site.	Ongoing	2	4	8
986	Nursing	Garry Marsh	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for	Safe and efficient processes that are patient-centred	Q&S	3	4	12	October 2017: All 4 posts recruited to have now withdrawn. 4 nurses appointed at last round of interviews, who will work across HDU and Ward 11 (3 of the 4 are not due to start until January 2018). Active recruitment continues.	Q&S Report	2	4	8	↔	4wte have been secured via agency and the induction and training programme is currently being arranged. This will be a block booking to ensure continuity. The Director of Patient Services has contacted all local NHSE providers to enquiry whether they could strengthen the rota - there is currently no additional capacity through this route.	Ongoing	1	4	4
NEW	Nursing	Garry Marsh	There is a risk that patient care/safety may be compromised as we do not have enough Paediatric staff/vacancies on the ward.	Safe and efficient processes that are patient-centred	Children's Board	3	4	12	October 2017 - On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses	Children's Board Report	3	4	12	NEW	Staffing is monitored daily and overseen by the monthly Paediatric Children's Board.	Ongoing	1	4	4

NEW	Clinical	Andrew Pearson	There is a risk that there will be some clinical resistance to the change in the way Paediatric Services are delivered	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	4	3	12	Briefing sessions have been held with all the clinical teams including clinically led reference groups established who meet to discuss the potential options and likely impact. A clinical session was also held in September chaired jointly with the ROH and BWCH Medical Directors to talk through the changes, the rational and the timeframe. This is supported by regular updates via email, team brief and 1-1 discussions with the Executives Team.		4	3	12	NEW	Continued briefing sessions to be delivered through routine and bespoke staff communication routes	Ongoing	2	2	4
NEW	Corporate	Paul Athey	There is a risk to the ROH reputation should the Paediatric service not be transferred in a timely and safe manner		Exec Team/Trust Board	4	3	12	The ROH has given 6 months contractual notice (end of December 2017) for Inpatient Paediatric Services to cease on site at the ROH . It has agreed to work with the system whilst additional capacity/provider can be sourced. A communication plan is in place to ensure patients and staff are fully briefed on the changes and how it might impact them. An monthly operational commissioning group is in place with all stakeholders.		4	3	12	NEW	As part of the system wide meeting structure all risks relating to the transfer of services will be jointly risk assessed and appropriate mitigation will be in place.	Q4 2017/18	2	2	4
NEW	Finance	Steve Washbourne	The Trust is likely to incur transitional costs with the transfer of Inpatient Paediatric Services	Safe and efficient processes that are patient-centred	FPC	4	3	12	The Trust has highlighted the risk to NHSE and requested funding support should material additional costs be incurred. The Trust continues to review how existing resources can be utilised to ensure safe services and mitigate additional cost where possible.		4	3	12	NEW	The Trust would look to gain firm agreement with NHSE for the changes in local prices where the cost base increases on recurrently during the changes	Q4 2017/18	1	4	4

801	Corporate	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. New appointments into the management team have been made to strengthen controls and ability to deliver against regulatory requirements and to provide greater resilience in delivering ad-hoc and business-as-usual actions concurrently. Clear governance lines to ensure focus on key issues for Trust and regulators.	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 continue to be used to influence the wider Health Economy as it develops and embraces a new way of working collaboratively. The Trust will not be able to mitigate against changes in national policy or new target introduced in response to areas of political interest, but must be able to adapt in these circumstances.	Ongoing	2	3	6
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	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	↔	The SOC is developing and there have been multiple direct staff engagement workshops with various groups of clinicians across the Trust. An options appraisal has been developed and scored, this will be at the centre of the SOC development and will be presented at the Board workshop on 20th December 2017. The feedback from the workshop will feed into the final cut of the SOC that will be received by the Trust Board in January 2018, where discussions will determine the development of a fuller business case designed from the agreed strategic direction for the Trust. This all has to be seen in the context of the development of the wider Birmingham and Solihull STP plan, and the impact of how services will be redesigned as a result of this work.	Ongoing	2	3	6

S800	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.	Q4 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	29 November 2017
Guests	Dr Tony Sutherland, Chair of the VTE Committee Tracey Gilbert, Physiotherapist Talitha Carding, Matron Dr Bill Rea, Chair of the Drugs & Therapeutics Committee Julie Gardner, Assistant Director of Finance (Contracting)
Presentations received	Throne project
Major agenda items discussed	• Quality & Patient Safety report • Harm review update • Nurse staffing update • West Midlands Quality Review Service action plan and summary of key issues • Quality Assurance walkabouts • Themed review of VTEs • Clinical Quality Group upward report • Drugs & Therapeutics Committee upward report • Clinical Audit & Effectiveness Committee upward report • HDU Improvement Board upward report • Medical Devices Committee upward report • CQC action plans: outpatients and HDU • Contract performance scorecard and CQUIn update
Matters presented for information, update or noting	• Children's Patient Safety & Quality report • Update on Pathology • Divisional governance updates • Quality & Patient safety risks on the Corporate Risk Register • Lampard Review action plan • RCPCH action plan
Matters of concern, gaps in assurance or key risks to escalate to the Board	• It was reported that tissue viability audit requirements had not been fulfilled due to the vacancies carried in the tissue viability team. A new tissue viability nurse is to take up post in January 2018 however. • Sickness absence was noted to have increased but a decline was expected in December. • There are a number of staff leaving the Pathology unit, however discussions are underway with other local NHS providers to assess whether this service could be supported from elsewhere

	• There remain significant challenges with paediatric nursing cover on a substantive basis and a system of escalating any shortfalls to the Trust Board • The Quality Assurance walkabout identified some estates work to do in the hydrotherapy suite. Some work would be undertaken immediately to mitigate the risks around this service and a robust maintenance schedule would be developed. • The Board received an update from the chair of the VTE Committee, given the concern over the increased in the number of VTE incidents for September 2017. It was noted that in some cases the Trust's policy in terms of not admitting patients with high BMI for surgery was not always adhered to; work was underway with commissioners to address this. • It was noted that there were a higher number of controlled drugs incidents reported in theatres and this would be investigated. • The Clinical Audit & Effectiveness Committee reported concern over the poor state of medical notes, including access to notes for research and audit projects. Some improvements to the medical records area have been implemented, however there is still further work to do. • There continues to be issues over the administrative support for the Amplitude system, however one of the Associate Medical Directors was addressing this. • It was noted that there was further work to do to share the learning from clinical audits.
Positive assurances and highlights of note for the Board	• Friends and Family Test response rates had improved, this being attributed to staff being more proactive in encouraging patients to complete the questionnaires • There had been an assurance visit by the CCG to look at the Trust's process for managing compliance with the Duty of Candour regulation. The outcome of this identified that the Trust was 100% compliant based on the sample of cases reviewed. • Compliance with the WHO checklist was reported to be 100%. • It was reported that an initiative was underway to ensure that patients were discharged earlier in the day; the 'Red to Green' approach was also being reinforced. • The Committee received a presentation on the Throne Project. Lots of positive assurance was provided around the actions that had been implemented to prevent patients falling in bathrooms and toilets. • Agency expenditure associated with nurse staffing was reported to remain at less than the 10% target. • The Committee considered the action plan to address the

	recommendations from the recent West Midlands Quality Review Service (WMQRS), which is reviewed at the Children and Young Persons' Board and the HDU Improvement Board; some long term agency staff have been recruited who would undergo rigorous induction in the same way that substantive staff do. • Good progress was reported to have been made with the improvements needed in the Outpatient Department, identified by a Quality Assurance walkabouts some months ago. • The national inpatient survey results scored the ROH within the top 20% of Trusts overall for satisfaction. • Work is underway to ensure compliance with a CAS alert around the removal or flushing of lines and cannulae after procedures. • Work has been undertaken to reinvigorate the Medical Devices Committee and to ensure that the governance around introducing new equipment into the Trust is more robust and there is better visibility of the ongoing cost of introducing devices • The Committee considered the CQC actions plans for Outpatients and HDU areas, which provided good assurance that actions raised by the CQC were being completed • A positive update report on compliance with the contract Key Performance Indicators was received, which showed that of the 64 KPIs, the Trust was rated green against 57. Work is underway to improve performance against the remaining. The Trust had achieved 100% for cancer waiting times in August, September and October. • It was reported that the ROH approach to Safeguarding had been highlighted as best practice by the Leader of Birmingham City Council.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Medical staff to be made aware that mandatory training could be accessed on line • An update on pain management is to be presented at the next meeting, including the plans to cover out of hours requirements • Investigate and progress the actions arising from the Grade 4 pressure ulcer incident which occurred in August 2017 • Further update on pathology services to be given at the next meeting • Clarification of the source of funding required for the estates work to support the Throne Project • Discussion required at the next meeting to agree the way forward for reporting nurse staffing to the Trust Board • Plan to be developed to address the key environmental risks in the hydrotherapy suite

	• A monthly report on the Quality Assurance walkabouts to be taken to the Executive Team • Ensure that a member of the Operations Team joins the Clinical Quality Group • Review the outstanding issues around room temperature monitoring • Ensure that the clinical audit plan is considered by the Clinical Audit & Effectiveness Committee • Clarify the reporting line for the Medical Devices Committee and the process for approving new equipment requests with the Executive Team • Review the future reporting requirements to the Quality & Safety committee
Decisions made	• None specifically

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

For the meeting of the Trust Board scheduled for 10 January 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	28 November 2017
Guests	Steve Allen, Programme Director, Birmingham Women's & Children's NHSFT Amanda Gaston, Assistant Director of Finance Marie Raftery, Clinical Service Manager for Theatres Will Overfield, Clinical Support Manager for Theatres
Presentations received and discussed	Strategic Outline Case development Theatreman demonstration
Major agenda items discussed	• Finance and Performance Overview and recovery • Cost Improvement plans • Ownership of activity targets • Progress with actions to address regulatory concern • Theatre improvement plan • 'Perfecting Pathways Update'
Matters presented for information, brief update or noting	• An extract of the summary Corporate Risk Register was considered
Matters of concern, gaps in assurance or key risks to escalate to the Board	• As part of the discussion around the development of the Strategic Outline Case, it was agreed that the key focus needed to be on the creation of a sustainable model for the future, which would need to be informed by a market-led analysis • The continued risks associated with operating on children was discussed, although it was noted that there was no suggestion at present that the model was unsafe; the national requirements which the Trust was required to meet had become more stringent • Pay expenditure was noted to be higher than planned; a full review of pay budgets and recruitment programmes is planned to understand the future position. Locum usage remains at a high level. • A high proportion of patients continue to cancel their appointments and surgery. Steps are being taken to effectively communicate the consequences of this, including the financial impact. Outpatient appointments are also being affected, which is thought to be due to some issues with the maps provided with appointment letters.
Positive assurances	• The financial performance of the Trust over the previous

and highlights of note for the Board	two months was noted to have been reasonable, with income being higher than plan. • The Committee noted that there were positive trends on expenditure, particularly on non-pay elements. It was noted that a full stock and inventory check had been completed. • Theatre utilisation was noted to have improved, albeit there was a dip due to the impact of half term • The Rapid Recovery pathway was noted to be working well and an 'opt out' approach was being considered to ensure as many appropriate patients benefited from this pathway • The performance of and support by the Operations Team was noted to be good and they were thanked for their hard work. • Although the Trust was behind its cost improvement plan, there was now significant additional rigour to the process and the cost savings achieved had improved. The Assistant Director of Finance was thanked for her work on this. Cost Improvement opportunities with a value of £2m had been identified for 2018/19. • The Committee was pleased to learn that Oncology had hit the 18 weeks RTT target at 94.9%. The Trust's overall RTT position would be reported in December after a period of not reporting. • The theatre improvement plan was considered and it was noted that good work had been undertaken on recruitment, implementation of The Productive Operating Theatre and consultant engagement to deliver recovery • The presentation of the Theatreman system was received positively by the Committee and demonstrated great progress with the information available in the operating theatres and overall governance of the area
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Development of further analysis ready for discussion of the Strategic Outline Case is needed for the December 2017 Board meeting • High level indicators are to be produced to show progress with the Theatre Improvement Plan
Decisions made	• None specifically

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 10 January 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	1 December 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 Andrew Pearson, Executive Medical Director & Responsible Officer also attended for part of the meeting
Major agenda items discussed	• External Audit Progress Report • NHS Protect Assessment Report of Anti-Fraud Arrangements at The Royal Orthopaedic Hospital NHS Foundation Trust • Internal audit progress report • Update on stock control • Progress on closing consent actions • Losses and compensations • Review of Audit Committee Terms of Reference • Quality & Safety Committee Feedback • Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• With regard to stock take, concern was noted that there was much preparatory work to do prior to the year-end process and an update was requested for the February Audit Committee meeting, including a comprehensive overview of the expected level of improvement including to stock counting, rationalisation of implants and filling vacancies in key positions. • It was noted that the 2018/19 cash balance would be largely determined by how the Trust performed during the final part of the year; business planning processes had commenced which would understand areas of cost pressure and areas for improvement needed • The feedback from the Quality & Safety Committee included a number of matters of concern which related to increase in the number of VTEs, two patient deaths, one Grade 3 pressure ulcer, complaints on Ward 11, 41 complaints in large joints in the course of the year, outstanding Estates work in the Radiology area, strengthening compliance against the hygiene code and exceptions report on the delivery of the CQC and RCPCH action plan. The Audit Committee recognised the above as areas for improvement.
Positive assurances and highlights of note	• Although there was further work to do, the Committee was pleased with the progress with improvement in

for the Board	theatres, including storage arrangements for stock • The Internal Audit Programme was on track and the Patient Consent Report had been finalised. • The Committee were joined by Mr Andrew Pearson, Executive Medical Director & Responsible Officer, who provided assurance and gave an update on the progress on closing consent actions. The Audit Committee was encouraged with the improvement in this area. • The NHS Protect Assessment Report of Anti-Fraud Arrangements at the Trust and the annual Self Review Tool (SRT) was a pleasing report with the 'Prevent and Deter' element rated as amber which was compliant with standards. The 'Hold to Account' section was highlighted as being red but overall, this was a positive report, especially the proactive side of 'Prevent and Deter'.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A further update from Marie Raftery and Will Overfield on Stock Management in Theatres is needed for the next meeting. • The Audit Committee was of the view that whatever support was needed for the Amplitude system that this be provided to make the system functional. • Associate Medical Director, Matt Revell to attend the next meeting to give an update on Amplitude. • Board Assurance Framework to be reviewed and the Audit Committee requested that the right controls and mitigations were in place. It was recognised that this document was under a constant review process. • The Audit Committee supported the Review of the Terms of Reference and agreed to look at strengthening these in February.
Decisions made	• The Audit Committee supported a request to ensure Clinical Audit was more robust. • The Audit Committee accepted and identified the recommendations and outstanding actions from the NHS Protect Assessment Report and these would be added to the Recommendation Tracker.

Rod Anthony

NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 10 January 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Charitable Funds Meeting held on 29th September 2017
Charitable Funds Committee, 12:00 midday in the Board Room

Present
Dame Yve Buckland (Chair)
Ms Stella Noon, Patient Representative
Mr Paul Athey, Director of Finance
Mrs Alexandra Gilder, Deputy Director of Finance
Ms Yvonne Scott, Patient Representative
Mr Tim Pile, Non-Executive Director
Mr Joshua Grundy, Assistant Financial Accountant and minute taker
Mrs Kathryn Sallah, Non-Executive Director

Apologies
Mr Garry Marsh, Director of Nursing and Governance
Mr Rod Anthony, Non-Executive Director
Ms Lin Russell, Oncology Service
Mr Andrew Pearson, Medical Director
Professor Taunton Southwood, Non-Executive Director

Minute no.	Detail	Actions
290917-01	**Minutes from September 2017** The minutes of the previous meeting were accepted by the committee as an accurate record.	
290917-02	**Action from the previous meeting** All action points from previous meetings are currently ongoing	

290917-03	**<u>Review of financial position to 31st August 2016</u>** AG presented the financial position. Highlighted that majority of the income in the period was for the Dubrowsky fund and that the bulk of the expenditure was for the specialist pressure relieving chairs. YB asked what the Windmaster 3D spend is and what fund does it relate to. PA answered it is related to an air flow system for Mr Thomas. TP explained how shocked he was at the amount of people doing a recent sponsored event for the QE and asked whether we could push to do the same Rebecca Buswell explained that Elaine Chapman, the new fundraiser, was already looking into any sponsored events we could utilise, also that we've had people from the ROH raise money for the charity this year by running the Birmingham half marathon and a Gung Ho fun run. The financial position was approved by the committee.	
290917-04	**<u>Administration Fee 2017/18</u>** AG presented the workings for the administration fee, she explained it is the same amount as the previous year but with an uplift for NI and tax. The changes were noted and the administration fee was approved.	
290917-05	**<u>5 Year Charitable Fund Plan</u>** AG presented the 5 year plan to the committee. She referred to Appendix A and highlighted that we had not received a number of plans for funds, however of the returns submitted, the largest were for the research lab (Dubrowsky Fund) and a variety of spend for the Hip research fund. AG then explained the breakdown of the general purpose fund plan (Appendix B)	

	SN stated it would be a good idea to write to the fund holders that did not return a plan regarding spending their remaining funds. JG to contact fund holders The plan was approved by the committee	
290917-06	**<u>Sign off Charitable Funds Annual Accounts and Rep Letter</u>** AG presented the annual accounts and explained we need them agreed by the committee for sign off. AG explained that net assets have increased and dividends are static. She also mentioned Cazenove and even though the market has been volatile after the Brexit vote we had a positive return of 16%, compared to a negative return at the end of the prior year. The committee reviewed the financial position, noted it was positive and wanted to thank everyone involved for their hard work The committee approved the sign off of the year end accounts	
290917-07	**<u>Cazenove market update and review of investments</u>** PA explained the Cazenove report and why we use them. TP asked if we should review using Cazenove as they are a huge company and asked whether it could be better using a smaller fund manager PA stated that Cazenove are getting results so it is probably worth staying with them. YB asked whether we could ask Cazenove to sponsor something, such as the staff awards. She also mentioned we could try this with some of our larger supplier. The members all read and agreed the Cazenove update.	

290917-08	**Bids for funding** The Committee heard the bids in Enclosure 8,9 and 10.	
a)	**Staff Awards** David Richardson presented the bid for funds. The staff awards are being hosted in February 2018, the bid is for the same amount as last years. David pointed out that he was below budget last year so will aim to do the same this year. YS asked if the staff awards was open to everyone David explained that the venue cannot host more than 120 people so it cannot be available to all members of staff KS asked if all of the nominees had been appropriately screened David said the shortlisting and winner selection processes have recently been reviewed and improved AG questioned what the entertainment cost involved David said that the room decorations make up the bulk of the entertainment cost The committee approved this bid for funds.	
b)	**Mindfulness Training** David Richardson presented the bid for funds to the committee. He explained the importance of mindfulness training and highlighted the positive responses to the previous training courses. TP asked if we can see a material improvement. David stated that from reviews taken 3 months later, staff members showed a positive outcome from the training. David highlighted that this funding is for staff members to be able to host training on site. YS asked if they will need refresher training in the	

	future. David said himself and Conny will host any refresher courses. SN queried how the people hosting the sessions will be monitored. David explained that the selection process is rigid and staff will be regularly reviewed going forward. AG stated that mindfulness is highly linked with theatres but questioned whether staff members will have the opportunity to attend with the limited time they have. David stated the importance of planning the sessions carefully so staff can attend each one and get the most out of the training. Rebecca Buswell stated she has seen mindfulness training help people identify stress and help them deal with it in a healthy manner. The committee approved this bid for funds	
c)	**Coaching Training** Rebecca Buswell presented the bid for funds in Clare Mairs absence. The bid is for funding to train some internal coaches to provide support for staff This will enable us to host more in house support/training and will reduce the need to use external suppliers. The people have been selected because of their mind set, interest and position. People are expected to pay the trust back for their training if they were to leave the organisation within 2 years. KS stated her concern about the time factor of the training and whether staff can free themselves up to host sessions. YB asked why this cannot be paid for from the training budget. David explained that the training budget is mostly used to fund mandatory training. YB noted that the committee need more convincing of the sustainability of this bid and more scope from staff that want this training.	

290917-07	**<u>Fund raiser report</u>** Rebecca Buswell presented the report for Elaine Chapman. Rebecca explained the situation with the fundraising role and that Elaine has been working as the fund raiser since July. Donation boxes have been placed around the hospital and the website for charitable funds is currently underway. Thank you letters are now being sent out from Elaine. YB asked if these can be escalated for signature before sending out. AG asked if there was any way of using compliments to promote fundraising. Rebecca stated that Elaine has already started doing this on the Friday message board. YB queried how we are advertising the changes surrounding charitable funds and how people can donate. Rebecca answered that posters have been placed around the trust as not all members of staff have access to emails.	
290917-08	**<u>Six month update reports</u>** The committee read the six month feedback forms completed by the fund holders. **<u>Overseas Nurses</u>** The approved funds have been spent and were greatly appreciated **<u>Staff Awards</u>** Committee members that attended the awards evening stated they thought it was a successful night and was good value for money.	
290917-09	**<u>Any Other Business</u>** YS stated she recently had treatment at the ROH and when she asked about the new pressure relieving chairs (bought through charitable funds), staff were unaware of them.	

	AG to feedback to comms YB asked if we could capture YS' story. YS stated she would be happy to do a Q&A regarding her experience.	AG
290917-09	**<u>Date of future meetings</u>** TBC	JG

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 10 January 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 10 January 2018 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.

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

AGENDA
COUNCIL OF GOVERNORS

Venue Board Room, Trust Headquarters **Date** 17 January 2018 : 1400h – 1615h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1#	Reappointment of Kathryn Sallah and proposal to award a cost of living payrise to Chairman and Non Executives	ROHGO (1/18) 002 ROHGO (1/18) 002 (a)	BT
1410h	2	Apologies and welcome	Verbal	Chair
1412h	3	Declarations of interest	Verbal	All
1415h	4	Minutes of previous meeting on 5 October 2017 and notes from the briefing session on 21 December 2017 (private paper)	ROHGO (10/17) 009 ROHGO (12/17) 001	Chair
1417h	5	Update on actions arising from previous meeting	Verbal	SGL
1420h	6	Chief Executive's update including five year vision (private paper)	ROHGO (1/18) 003 ROHGO (1/18) 003 (a) ROHGO (1/18) 003 (b)	PA
1430h	7	MAKO robot	Verbal	JWI
1435h	8	Establishment of the Staff Experience & OD Committee	ROHGO (1/18) 004 ROHGO (1/18) 004 (a)	SJ
1445h	9	STP update	Verbal	YB
1455h	10	Strategic Outline Case	Verbal	PA
1515h	11	Paediatrics services update	Verbal	YB/PA
1525h	12	Freedom to Speak Up update	Presentation	MJ
1545h	13	Update from the Board Committees: Quality & Safety Committee	ROHGO (1/18) 005	KS
1555h	14	Governor Matters: • Update from the Patient & Carers' Council • Council of Governors improvement plans	ROHGO (1/18) 006 ROHGO (1/18) 006 (a) Verbal	SN BT
1605h	15	For information: • Quality & Patient Safety Report • Finance & Performance Overview • Annual complaints report	ROHGO (1/18) 007 ROHGO (1/18) 008 ROHGO (1/18) 009	

1610h	16	Any other business	Verbal
	Date of next meeting: Wednesday 16 May 2018 @ 1400h – 1600h in Trust Headquarters (premeet with the Lead Governor and Chairman @ 1300h)		

1# - Governors only item.

ROHGO (1/18) 0002

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Non Executive Recruitment & Pay uplift**
SPONSOR:	**Brian Toner, Lead Governor**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**17 January 2018**

EXECUTIVE SUMMARY:

The Council of Governors is asked to consider the recommendations from the Nominations & Remuneration of the Council of Governors around the reappointment of Kathryn Sallah for a further three year term and to award the Chairman and Non Executives with a 1% uplift to their salaries in line with that of all other ROH staff.

REPORT RECOMMENDATION:

The Council of Governors is asked to approve the recommendations of its Nominations & Remuneration Committee that:

- Kathryn Sallah should be reappointed
- the Non Executives and Chairman's salaries are uplifted by 1%

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	X	Workforce	X

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

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

The retention of Kathryn Sallah aligns with the intention to further strengthen capacity and capability of the Trust Board.

PREVIOUS CONSIDERATION:

Nominations & Remuneration of the Council of Governors on 21 December 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

NON EXECUTIVE REAPPOINTMENTS & REMUNERATION

REPORT TO THE COUNCIL OF GOVERNORS – 10 JANUARY 2018

1.0 BACKGROUND

1.1 In accordance with the Trust's constitution, Non Executives and the Trust Chairman are appointed for an initial term of three years, with the possibility of reappointment for a further term once this has expired.

1.2 The appointment of Non Executives and the Trust Chairman is a matter for approval by the Council of Governors, who are generally advised by a subset of the Council of Governors acting as the joint Nominations & Remuneration Committee.

1.3 The Nominations & Remuneration Committee (Council of Governors) met on 21 December 2017 to consider a proposal around reappointment of Kathryn Sallah for a further three year term and that a 1% cost of living payrise should be awarded to the Chairman and Non Executive Directors in line with that of other ROH staff.

1.4 This paper seeks the support of the Council of Governors to approve the recommendations of the Nominations & Remuneration Committee.

2.0 KATHRYN SALLAH

2.1 Committee members may be aware that the first term of office for Kathryn Sallah, Non Executive Director is due to conclude on 31 March 2018.

2.2 The Committee is asked to consider a proposal to reappoint Kathryn for a further three years as a Non Executive Director.

2.3 In terms of skills set & experience, Kathryn brings a clinical skill set and extensive experience as a former nurse and midwife. She held three director of nursing posts in various hospital settings and undertook a regional lead nurse role for the former Birmingham Strategic Health Authority. Kathryn also has a great understanding of corporate governance and accountability from both an Executive and Non Executive Director perspective.

2.4 The Council of Governors has heard at previous meetings that Kathryn's annual

appraisals have been very positive. Of particular importance has been Kathryn's positive influence on strengthening the delivery of the quality agenda and improving the effectiveness of the Quality & Safety Committee under her chairmanship, most notably around holding key managers to account for quality and safety improvement.

2.5 Based on the feedback from her appraisal and her own personal wishes, Kathryn is keen to be reappointed.

2.6 On this basis, the Council of Governors is asked to support the recommendation from the Nominations & Remuneration Committee (Council of Governors) that Kathryn Sallah should be reappointed as Non Executive Director for a period of three years, concluding on 31 March 2021, when she will have been in post for the maximum recommended six year period.

3.0 CHAIRMAN AND NED PAY UPLIFT

3.1 The terms of reference for the Nominations & Remuneration Committee (Council of Governors) requires the Committee to consider the remuneration of the Chairman and Non Executives on an annual basis. It was agreed that the last meeting (February 2017) that formal consideration of the salaries should be revisited in early 2018, however as an interim measure, the Nominations & Remuneration Committee (Council of Governors) was asked to consider a proposal to grant a pay uplift of 1% to the salaries of the Non Executives and Chairman, this being in line with all other ROH staff, including the Executives. This was agreed by the Committee and the Council of Governors are formally asked to approve this recommendation.

4.0 SUMMARY OF RECOMMENDATIONS

4.1 The Council of Governors is asked to approve the recommendations of the Nominations & Remuneration Committee (Council of Governors) that:

- Kathryn Sallah be reappointed as Non Executive Director for a period of three years, concluding on 31 March 2021
- the salaries of the Chairman and Non Executive Directors are uplifted by 1%, with effect from 1 January 2018.

Simon Grainger-Lloyd
Associate Director of Governance & Company Secretary

11 January 2018

MINUTES

Council of Governors - Version 0.3

Venue Boardroom, Trust Headquarters **Date** 5 October 2017 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
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
Petro Nicolaides	Public Governor	PN
Carol Cullimore	Public Governor	CC
Karen Hughes	Staff Governor	KH
Mel Grainger	Staff Governor	MG
Alex Gilder	Staff Governor	AG
David Richardson	Staff Governor	DR
Paul Sabapathy	Stakeholder Governor	PS
Hannah Abbott	Stakeholder Governor	HA
Dagmar Scheel-Toellner	Stakeholder Governor	DS-T
Richard Burden	Stakeholder Governor	RB

In attendance

Tim Pile	Vice Chair and Non Executive Director	TP
Kathryn Sallah	Non Executive Director	KS
Rod Anthony	Non Executive Director	RA
Simone Jordan	Associate Non Executive Director	SJ
Paul Athey	Acting Chief Executive	PA
Jo Williams	Interim Chief Operating Officer	JWI
Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	SGL

Minutes	**Paper Ref**
1 Apologies and welcome	
Apologies were received from Rob Talboys. The Chairman welcomed David Richardson, new non-clinical staff governor, Dr	

Dagmar Scheel-Toellner, new stakeholder governor for University of Birmingham and Hannah Abbott, new stakeholder governor for Birmingham City University.	
2 Declarations of interest	
It was noted that new governors would be asked to declare their interests. Dr Scheel-Toellner reported that she was an employee of the University of Birmingham in a research position, however would make a declaration should any item to be discussed by the Council of Governors which related to research and development matters involving both the ROH and the University.	
3 Minutes of the previous meeting on 19 July 2017 and notes of the briefing session held on 12 September 2017	**ROHGO (7/17) 0XX** **ROHGO (7/17) 0XX**
The minutes of the meeting held on 19 July 2017 and notes of the briefing session held on 12 September 2017 were accepted as a true and accurate record of discussions held.	
4 Update on actions arising from previous meetings	**Verbal**
The Associate Director of Governance/Company Secretary reported that the Public and Patient Liaison Manager was finalising the annual complaints report and it would be circulated when available. Enderjit Aujla, Head of Business Intelligence is to be invited to the next meeting to present the Data Warehouse.	
5 STP update	**Verbal**
The Chairman reminded the Council that the STP was headed up by Dame Julie Moore and it had been established with the intention to share healthcare and other services across the region. It was noted that contrary to the view previously, the STP was now seen as a well functioning model. The ROH had a particular interest in the orthopaedics workstream that was currently being developed. There was focus in the STP on the merger between Heart of England NHS FT (HEFT) and University Hospital Birmingham NHS FT (UHB), alongside the improvements needed to Birmingham Women's Hospital (BWC) after the recent merger with Birmingham Children's Hospital (BCH). It was noted that the ROH benefited from the STP's first class support from UHB and BCH in the form of Jo Williams who was performing an Interim Chief Operating Officer role and Matt Boazman who was supporting the strategy development work. This was working well and was helpful. Dame Julie was thanked for her ongoing support. It was reported that there was approval from the STP to set up a region wide clinical working group on orthopaedics. This would be led by the ROH Executive Medical Director, Andrew Pearson and would be tied in with the current strategy development work. There was a long way to go before there was an agreed direction of travel however. It was suggested however, that the ROH as a	

setting should be appreciated and grown and this should be used to undertake work for which the Trust was well renowned. It was noted that the STP was looking at this to meet clinical need and requirements for patients. In terms of Paediatrics, the service had been delivered well but to keep it on site to meet Royal College standards required investment and improvement. BCH was also a centre of excellence for children's work. It was suggested that a 'hub and spoke' centre might be the future plan for the delivery of services for orthopaedics, in a way analogous to that of the South West London Elective Orthopaedic Centre. It was early days at present and the centre of excellence concept was being developed. It was agreed that Matt Boazman and team should present an update on the strategy development work at the next meeting.	
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)** **Presentation**
The Interim Chief Operating Officer gave an overview of the Scheduled Care Improvement Programme. It was noted that some of the work in the programme was not new and was already underway. In terms of text reminders to patients, these would contain the financial implications of not turning up. Work was also being undertaken to better collect mobile numbers. An app was also being developed which would allow patients to check in for appointments from their 'phones. Communicating any changes to a patient's named consultant was discussed. It was noted that some firms operated as a team and therefore naturally shared a group of patients, whereas others worked more as individuals, with their own waiting lists. There was work to reduce the number of instances that patients were waiting over 40 weeks and therefore by adopting a team-based approach, waiting lists would be shared and therefore reduce time waiting for an appointment. In terms of missing instruments from theatre trays, where there were gaps, then an incident form would be raised. It was suggested that the company decontaminating the trays needed to be alerted as soon as possible if this was the case. Regarding the expectations of the programme from the perspective of the patient, these had been developed as a starting point internally and would be tested out with patients. Patient feedback could be reviewed for any common themes that could feed into this work. Individual areas would be tasked with thinking about how this work related to them and then they would feed into the	

process; this would be launched as part of the forthcoming staff briefings.

It was noted that the questions around the 'Red2Green' discharge planning initiative would be incorporated into the quality walkabouts.

Although some of the work had been discussed previously then it was now more structured. It was noted that it was positive that Key Performance Indicators had been developed but staff ownership was key to delivery and as such, was linked to culture change. A piece of work alongside this was around staff experience and staff needed to be engaged to deliver the improvements. It was suggested that the 'centre of excellence' concept would be created through staff.

The Governors asked whether there were clear priorities and early wins in the programme. It was reported that theatres and pre-assessment & pre-admission were the areas of initial focus. It was agreed that theatres was a significant issue and cancellations needed to be understood early enough to be able to repopulate gaps in the lists. This was linked to the pre-assessment process, so only patients were included on the waiting list if they were fit, willing and able. It was suggested that patients also needed to be called to remind them of their appointment and backed up by the text messages.

In terms of the consultants, the Interim Chief Operating Officer reported that these were very engaged with improving the activity position and reducing waiting times and the Clinical Service Leads were proactively reviewing all patients waiting over 40 weeks. More scoliosis patients were also being treated now. Every effort needed to be made to ensure that theatres were used for the maximum time possible and the supporting processes for the work of the consultants were in place and working well. The Associate Medical Directors were also working well as part of the plans.

Regarding the private wards, this needed to be considered as part of an overall private practice strategy. A small clinically-led group had been set up to look at the environment and the beds were now separated out from the area where NHS patients were treated.

The positive impact of the work from the regulators point of view was questioned. It was reported that the Intensive Support Team was pleased at the amount of work that had been done and had no intention of revisiting in the near future. In terms of addressing the RTT position, they took assurance from the plan that had been developed. The 62 day cancer target had been met, which was also pleasing to regulators. The operational team was working better and in time this would translate into better patient feedback. There was also more certainty over the amount of activity being booked.

It was noted that all staff around the organisation needed to be engaged and encouraged to take part in the work. The big issues needed to be addressed firstly however, and this would galvanise staff when progress was evident. There was a good cadre of staff who were committed to delivering the work.

In terms of timing and staff morale, this was improving but there needed to be some celebration of success. In terms of an impact on the Trust's finances, this was critical. It was reported that some immediate changes that would deliver a recovered position were being undertaken. Non pay costs and savings delivery needed to taken forward, for instance. Theatres stock controls had been implemented and this would be reviewed. Sustainability of the activity position was also needed. It was anticipated that the current week's activity should deliver improvement in the immediate and an overall increase was anticipated for October. Costs savings also needed to be achieved however. It was reported that a recovery plan had been developed which had been reviewed by the Finance and Performance Committee. There were three critical elements to this plan: delivery of the Cost Improvement Plan (CIP), delivery of increased activity and control of non-pay cost. CIP was the most challenging and was a key tenant of the recovery plan. In terms of RTT, the validation work had been completed. The challenge was now improving performance against the RTT target.	
7 Paediatrics services update	**Verbal**
The Acting Chief Executive reported that the ROH was working with NHS England and BCH to transfer services to BCH, this being the preferred solution for all. These needed to be transferred in an appropriate way and timescale to ensure that this was safe. BCH was working on the requirements to accept this new work and this was through a business case which would need to be approved by their Board. It was reported that work was also underway with BCH to review staff transfers and finalise which services would transfer over. There was an expectation that there would be refurbishment of some of the theatre blocks at BCH, which would mean that the transfer of services would not be likely until autumn 2018. The implications of this were being worked through, particularly in terms of the ongoing requirement to meet the national standards. The interim arrangement needed to ensure that there was no compromise to the staffing model and safety. The national guidelines that the ROH could not meet at present were around inpatient paediatrics specifically. BCH had a preference that diagnostics and outpatient services remained on the ROH site. Sustainability of the hospital could be impacted by the decision to cease paediatric surgery should the growth of other services not be achieved to compensate for the loss and there were conversations around what might be needed to ensure that this happened. The treatment of patients in the 16-18 year old cohort needed to be given more thought as these would not be treated by BCH. Some support from external clinical bodies was needed around this model. Day case services were the areas with least certainty at present and there was a	

diverse clinical opinion at the ROH as to whether it was more appropriate to transfer them out or retain them. It was reported that the Board had recently discussed the position and it had been underlined that the patient needed to be at the centre of any decision. The Board was supportive of working within the system to agree the arrangements, even if the service was retained at the ROH for longer than originally planned. There were some meetings set up with staff to have these discussions, particularly in terms of what this meant to them. A plan across the city was being developed. The Board was clear that there should be not unnecessary drift allowed and that the risks needed to be shared. The Health Overview & Scrutiny Committee was also meeting in the next couple of weeks to discuss the transition. It was suggested by the governors that by retaining some services, staff would be presented with uncertainty. It was also suggested that BCH should be involved in developing the staffing model. The Council was advised that the ROH did have a joint approach and there were discussions with members of staff currently. A new spinal consultant was being recruited and a joint interview between BCH and ROH was to be held. A guaranteed PICU bed was available at BCH at present and from February there would be an additional list for spinal surgery. The ROH and BCH were in constant communication and a member of BCH was working with the Trust to look at the future strategy. The medical leadership team at BCH was being approached to agreed Paediatrician support at the ROH for the period until the transition was complete. There was a national shortage of Paediatric staff across the country however, which meant that BCH had their own challenges, therefore this was not an easy process to navigate. It was suggested that care needed to be taken to ensure that patients were not 'ferried' between sites to take advantage of the specialist care. It was highlighted that there were some benefits with the service being provided on the ROH site, however as a single speciality site then the ROH was not best placed in the case of post-operative difficulties. There was a challenge to upgrade BCH to ensure that the care at this facility had care provision at the same level as that at ROH. Hydrotherapy was discussed specifically and this may be one of the services that could still be provided at the ROH. It was noted that the ROH did not have any discretion in the decision around Paediatrics; it was the will of regulators. This decision needed to managed for the interests of the patients and care needed to be taken not to inconvenience the patients unnecessarily. It was noted that this was a possibility and this was a challenge in terms of patient flow. By reducing the level of Paediatric activity then there was a risk in terms of being able to maintain staff competencies to the Royal College standard as a result of low numbers and a fragmented service. There were also some queries around the anaesthetists and their skill set which were being worked through. A further update would be provided at the next information.	
8 Freedom to Speak Up update	**Presentation**

This was to be deferred.	
9 Update from Board Committees: • **Finance & Performance Committee** • **Quality & Safety Committee** • **Audit Committee**	**ROHGO (10/17) 004** **ROHGO (10/17) 005** **ROHGO (10/17) 006**
Tim Pile, Chair of the Finance and Performance Committee reported that in summary, his committee was looking at five topics: 18 weeks RTT which was now transferring into business as usual; activity; scheduled care improvement; financial performance; and strategic outline case and recovery. In terms of financial performance, he noted that there had been previously some frustrations expressed by the governors at the lack of pace of recovery. This had changed however and there was now evidence of a real drive for performance improvement. Income was roughly in line with plan in August but activity was too low. Problems were cost driven in terms of underperformance on CIP, RTT validation agency costs and the non-pay costs. There remained issues with DNAs/cancellations and poor theatre utilisation. As costs increased there was a need for more efficiency, which needed to be the focus. In terms of theatre utilisation, it was noted that the target was 85% which did not appear to be being met. In terms of non-pay costs, a breakdown of these was discussed. The stock rationalisation was discussed by Audit Committee and was associated with implants. Collective purchasing was suggested. Average length of stay needed to be reduced and therefore the discharge planning process was a key point of focus. In terms of Quality & Safety Committee, there was a new set of nursing Key Performance Indicators (KPIs) designed to show the impact of investment in quality of care. These had now been discussed and some of needed to be refined before roll out. Linked to this, there was much time spent talking about nurse staffing and other staff groups needed to be reviewed. This would be picked up through the new Staff Experience and Improvement Committee, as would workforce planning. Agency staffing had reduced although it was noted that there were fewer beds open at present. Clinical walkabouts were now more established and comprised staff from a number of disciplines. These were assessed according to the CQC criteria. There was good learning from these visits. Governors were invited to these. There was a new IT system in Pharmacy which was working well and flagged any anomalous trends. Further clarity was required on near miss incidents to clarify the gravity of these	

and the themes. Consultant participation in mandatory training was also another point of discussion. The nurses leaving HDU was discussed as a key risk on the future of the service. The WHO checklist position was discussed; compliance was good, this being validated manually, although the information could not be derived from Theatreman at present. The checklist nature of the WHO check was debated in terms of the value of this. Compliance with this was being overseen by the Associate Medical Director for Division 2. It was agreed that the target needed to be 100%. It was suggested that the more useful learning tools within the WHO checklist methodology were the pre and post debrief. The theatres teams also held a debrief from the previous day and for once a month the entire multi-disciplinary team had a lessons learned discussion. It was noted that in terms of the FFT, the score was good. Regarding the Audit Committee update, there was an ongoing good relationship with both internal and external auditors. There had been discussions around Going Concern and the Value for Money assessment. The internal auditors were being used to review areas of concern as identified by the Executive Team, which was then reflected in the internal audit plan. As a result of targeting areas of concern, the proportion of audits providing less assurance has increased. This was to be regarded as positive however, as issues were being uncovered and dealt with. The Audit Committee was much more engaged with the organisation than it had been and there had been three very productive presentations at the recent meeting on Freedom to Speak Up; Amplitude; and stock control in theatres. These had provided a good level of assurance. In terms of issues, the Committee had been concerned over the 18 weeks RTT plan. Also, stock management remained an area of focus, although there was now more grip through the new theatre management team. Patient consent had been remitted to Quality & Safety Committee. Recommendation tracking was now more improved. This had involved more ownership from the Executive Team. It was reported that the Chair of the Audit Committee had visited the Dudley Group of Hospitals NHSFT Audit Committee to gain some insight as to how another Audit Committee operated. It was suggested that there should be joint learning on stock control with other National Orthopaedic Alliance partners. It was noted that the Trust had part-funded a post to share learning and best practice which could pick this up.	
10 Governor Matters: • **Membership update** • **Governor elections** • **Lead governor nomination**	**Presentation** **Verbal** **Verbal**
The governors welcomed Elaine Chapman, Fundraising and Membership Officer. Ms Chapman delivered a presentation on the planned development of	

membership. The governors offered support in terms of volunteering to assist with recruitment particularly in universities, schools and other student groups. The use of NHS Discounts also needed to be considered. The Extra Care sheltered village in Bourneville was suggested as good source of members, as was the village in Longbridge. It was noted that the Harrison Lectures engaged students well. The Associate Director of Governance/Company Secretary reported that public governor elections were underway as the terms of office for Tony Thomas, Sue Arnott and Alan Last were coming to an end. To date four members had nominated themselves for governors. Voting packs would be issued on 23 October and the results would be declared on 13 November. It was reported that as Alan Last's term of office was drawing to a close, the governors were required to select a replacement lead governor. The Council was responsible for this decision and all governors had been asked to put themselves forward if they were interested in taking up this role. Brian Toner was the only candidate who had submitted an expression of interest and therefore the governors were asked to confirm that they were content that Mr Toner had the appropriate experience and aptitude to take on this role. Mr Toner was asked to step outside of the room while the governors debated his appointment as lead governor. All unanimously agreed that Brian Toner should be appointed as lead governor for a period of three years or until the end of his term of office, if sooner. Thanks were expressed to Alan Last, however he would be formally thanked in public at the Annual Members' Meeting which was to follow the meeting.	
11 For information: • **Quality & Patient Safety report** • **Finance & Performance overview**	**ROHGO (10/17) 007** **ROHGO (10/17) 008**
The Quality and Patient Safety report and the Finance and Performance overview were received and noted.	
12 Any other business	**Verbal**
There was none.	
13 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 17 January 2018 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):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Paul Athey, Acting Chief Executive**
DATE OF MEETING:	**17 January 2018**

EXECUTIVE SUMMARY:

This report provides an update to 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 10 January 2018

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors on 17th January 2018

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 public Trust Board meeting on 1st November 2017

2 REFERRAL TO TREATMENT (RTT) RECOVERY PLAN

2.1 In line with plans agreed with NHS Improvement, the ROH returned to national reporting of RTT performance in December 2017.

2.2 Performance in November showed 79% of patients on incomplete RTT pathways had been waiting for less than 18 weeks for treatment against a national standard of 92%. 80 patients had been waiting for over 52 weeks, of which 64 were spinal deformity patients.

2.3 The Trust has submitted trajectories, and has plans in place, to deliver 92% compliance by November 2018. It is expected that all 52 week patients, with the exception of spinal deformity patients, will be cleared by the end of January 2018. The Trust continues to work the health system as part of the transfer of paediatric services to ensure that there is a clear and jointly owned plan for the clearance of long waiting spinal deformity patients.

3 CQC PREPARATION

3.1 The CQC have confirmed that their announced Well-Led review will take place on Wednesday 21st February and Thursday 1st March 2018. The unannounced review of one or more core areas can take place between 2 and 8 weeks before these dates, so could therefore take place any time now. The CQC has asked that a focus group of the Council of Governors be arranged for Wednesday 21 February 2018 at 11:00 am.

3.2 A CQC toolkit has been circulated to all staff explaining the purpose of the CQC visit, what staff should expect and the main areas of that the CQC may focus on. It incorporates a reminder of key individuals, the Trust's vision and key priorities, a summary of key risks and includes some checklists to support preparation for the day.

3.3 Key action plans continue to be regularly reviewed at appropriate governance committees to ensure that the Trust and the CQC will have clear oversight of the improvements that have been made since the last visit and the ongoing work that continues to be delivered.

3.4 In August 2017, the CQC published their Use of Resources assessment framework, which describes how Use of Resources will be added as a sixth key question under future CQC reviews and they have recently been consulting on how this review will be reported and how it will be incorporated into the overall rating system. The Trust Board are reminded that, as a specialist hospital, the ROH will not be subject to a Use of Resources review as part of the forthcoming assessment.

4 CQC FEES – 2018/19

4.1 In November 2017, the CQC consulted on proposals to change the way in which fees are levied in 2018/19. Under the proposal, fees would be based on a percentage of overall turnover and not banded into broad turnover brackets as per the current model.

4.2 Under the proposals, small Trusts such as the ROH would pay between 0.07% and 0.11% of our turnover as an annual fee. Based on an £80m turnover, this equates to between £56,000 and £88,000. Our fee for 2017/18 was £158,902.

4.3 The outcome of this consultation has not yet been published.

5 HEALTH EDUCATION ENGLAND NHS WORKFORCE STRATEGY

5.1 On 13th December 2017, Health Education England (HEE) published a draft workforce strategy for England entitled "Facing the Facts, Shaping the Future". HEE are consulting on the strategy, with final comments due by 23rd March 2018.

5.2 Views on the strategy and the impact on the ROH will be considered by the Staff Experience and OD committee on 7th March however in summary the strategy is underpinned by six high level principles that will underpin future workforce decisions:

- Securing the supply of staff
- Enabling a flexible and adaptable workforce through investment in education and training of new and current staff
- Providing broad pathways for careers in the NHS
- Widening participation in NHS jobs
- Ensuring that the NHS and other employers in the system are inclusive modern model employers
- Ensuring that service, financial and workforce planning are intertwined.

5.3 The full strategy can be reviewed at https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-strategy

6 UKAS ACCREDITATION OF MUSCULOSKELETAL PATHOLOGY SERVICE

6.1 On 28th & 29th November, the Trust's Musculoskeletal Pathology Service was assessed by the United Kingdom Accreditation Service (UKAS) for compliance against ISO15189 standards. These set of standards are an international benchmark for quality in medical laboratories.

6.2 I am pleased to report that the Trust received very positive feedback from assessors and that we have been given full accreditation, with only a small number of minor non-conformities that the team have developed an action plan to ensure appropriate actions are taken.

7 ENVIRONMENTAL HEALTH OFFICER INSPECTION

7.1 The Trust was visited on 18th December 2017 by the Environmental Health Officer (EHO) to review our food hygiene standards. As a result of this visit, the Trust has been rated as a 5 for our standards, the highest rating that can be awarded. This provides further affirmation of the excellent service provided by our catering team.

8 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

8.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities since the last public board include:

- Midlands & East Provider CEO Event
- NHS Providers annual conference
- NHSI CEO Induction Day
- Stakeholder Oversight meetings with NHSI, NHSE, CQC & CCG
- 2 x STP Board meetings
- STP Development and Delivery Group
- STP Strategy Directors Group

9 FIVE YEAR VISION

9.1 The Board, over the last few months, has undertaken some work to clarify the ROH's major strategic principles for the next five years. The resulting Five Year Vision, is intended to lie behind the Strategic Outline Case and the document will be made available to the Care Quality Commission as part of their inspection. The key messages from this will also be issued across the Trust and discussed as part of the forthcoming staff briefings.

10 POLICY APPROVAL

10.1 The Executive Team is focussing of ensuring that any policies beyond their review dates are reviewed as a matter of urgency and where appropriate and changes are of a minor nature, Executive Director discretionary authority is used to extend the validity of policies pending a more wholesale review.

10.2 A policy position statement is now a regular item as part of the Executive Team forward plan.

10.3 Since the Board last formally met, the following new or substantially changed policies have been approved by the CEO on the advice of the Executive Team:

- Fire policy
- Serious incidents reporting policy (subject to minor amendment)
- Mental Capacity Act and Deprivation of Liberties policy

11 RECOMMENDATION(S)

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

11.2 Note the contents of the report.

Paul Athey
Acting CEO
11th January 2017

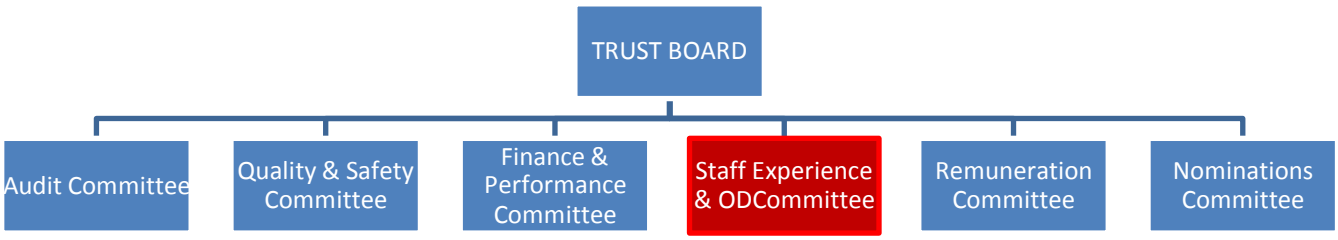
The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Staff Experience & Organisational Development Committee**
SPONSOR:	**Dame Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**17 January 2018**

EXECUTIVE SUMMARY:

The Council of Governors is asked to note the Board's agreement to establish a new Committee, to be known as the Staff Experience & Organisational Development (OD) Committee. The body will be one of the six formal Board committees, as below:



The establishment of the committee will strengthen the Board oversight of workforce-related matters, this currently being through consideration of different reports by the Finance & Performance Committee, the Quality & Safety Committee and the Major Projects & OD Committee.

The initial Terms of Reference for the Staff Experience & OD Committee are attached for the Council's reference. A six month review is planned to allow for a period of further refinement as the Committee embeds and to allow the new Associate Director of Workforce, HR and OD to provide input.

The former Major Projects & OD Committee split its remit between considering progress with the implementation of initiatives into the Trust that are high cost and/or impact trustwide and the development of the organisational development framework in the Trust. The Board has agreed to dis-establish this formal committee and instead the Board will directly receive a quarterly update on Major Projects and the organisational development work will form part of the remit of the new Staff Experience & OD Committee.

REPORT RECOMMENDATION:

Council of Governors is asked to consider the attachments and:

- NOTE the establishment of a Board Committee, to be known as the Staff Experience & Organisational Development Committee and RECEIVE its proposed initial terms of reference

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

- NOTE the disestablishment of the Major Projects & OD Committee

ACTION REQUIRED (Indicate with 'x' the purpose that applies):

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	x	

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

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

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

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

Good governance as strengthens the Board's oversight of workforce-related matters

PREVIOUS CONSIDERATION:

The proposal was agreed by the Board at its meeting on 10 January 2018

STAFF EXPERIENCE AND ORGANISATIONAL DEVELOPMENT (OD) COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Staff Experience and OD 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 Trust's performance against a range of workforce-related metrics, indicators and targets. It shall also seek assurance as to the robustness of the Trust's organisational development framework and progress with developing a learning and improvement culture within the ROH.

4 MEMBERSHIP

4.1 The Committee will comprise of not less than three Non-Executive Directors (including the Associate Non Executive Director), the Director of Strategy & Delivery, Chief Executive and the Chief Operating Officer.

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 three 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 and organises 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 on alternate months, with additional meetings where necessary.

7 REPORTING AND ESCALATION

7.1 Following each committee meeting, the minutes shall be drawn up and presented at the next Committee meeting where they shall be considered for accuracy and approved. 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 workforce strategies, including but not limited to:

- People Strategy
- Leadership Strategy
- OD and Staff engagement strategy
- 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 workforce planning, education, training and development to meet the needs of the Trust's overall strategy

9.4 To ensure that workforce plans are adequately connected to financial and capacity/demand planning in ROH

9.5 To review plans for developing new roles, skill mix and where needed, new job plans, to meet the evolving needs of the Trust

9.6 To review data and trends against key workforce metrics, including but not limited to:

- Numbers of starters, leavers and staff turnover
- Staff in Post and vacancy rates
- Pay spend (fixed and variable) overall and by staff group
- Appraisal rates and mandatory training position
- Sickness absence and other absence
- Numbers of formal procedures
- Staff satisfaction
- Productivity and benchmarking data
- Agency and locum usage

And to seek assurances that where there are trends of concern, that plans are in place that will deliver improvement in an effective and timely way

9.7 To seek assurance on the Trust's position against the NHS Improvement and CQC Well Led Frameworks and any plans to strengthen compliance or address shortfalls against the requirements of any dimension

9.8 To review key trends and themes from staff feedback, through mechanisms including the national staff survey, internal 'pulse checks', 360 degree feedback, exit interviews, Freedom to Speak up data and whistleblowing concerns raised and seek assurance that where improvement is required that plans are sufficiently robust and timely

9.9 To review plans for developing the Trust's education and training framework, including Learning Beyond Registration, and to scrutinise income and expenditure from Health Education West Midlands

9.10 To seek assurance on the quality of wellbeing offerings to staff and on the adequacy of the health and safety framework for staff

9.11 To review and seek assurance on the robustness of the Trust's talent management and succession planning frameworks

9.12 To review the Trust's plans to develop a recognition and reward model

9.13 To have oversight of culture change across the Trust, including the development of an Improvement culture among the workforce and equipping staff with the knowledge and skills to make improvements happen at the front line

9.14 To seek assurance on behalf of the Board that the key risks to the delivery of any of the workforce strategies are adequately mitigated

Date of adoption: January 2018

Date of review: June 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	29 November 2017
Guests	Dr Tony Sutherland, Chair of the VTE Committee Tracey Gilbert, Physiotherapist Talitha Carding, Matron Dr Bill Rea, Chair of the Drugs & Therapeutics Committee Julie Gardner, Assistant Director of Finance (Contracting)
Presentations received	Throne project
Major agenda items discussed	• Quality & Patient Safety report • Harm review update • Nurse staffing update • West Midlands Quality Review Service action plan and summary of key issues • Quality Assurance walkabouts • Themed review of VTEs • Clinical Quality Group upward report • Drugs & Therapeutics Committee upward report • Clinical Audit & Effectiveness Committee upward report • HDU Improvement Board upward report • Medical Devices Committee upward report • CQC action plans: outpatients and HDU • Contract performance scorecard and CQUIn update
Matters presented for information, update or noting	• Children's Patient Safety & Quality report • Update on Pathology • Divisional governance updates • Quality & Patient safety risks on the Corporate Risk Register • Lampard Review action plan • RCPCH action plan
Matters of concern, gaps in assurance or key risks to escalate to the Board	• It was reported that tissue viability audit requirements had not been fulfilled due to the vacancies carried in the tissue viability team. A new tissue viability nurse is to take up post in January 2018 however. • Sickness absence was noted to have increased but a decline was expected in December. • There are a number of staff leaving the Pathology unit, however discussions are underway with other local NHS providers to assess whether this service could be supported from elsewhere

	• There remain significant challenges with paediatric nursing cover on a substantive basis and a system of escalating any shortfalls to the Trust Board • The Quality Assurance walkabout identified some estates work to do in the hydrotherapy suite. Some work would be undertaken immediately to mitigate the risks around this service and a robust maintenance schedule would be developed. • The Board received an update from the chair of the VTE Committee, given the concern over the increased in the number of VTE incidents for September 2017. It was noted that in some cases the Trust's policy in terms of not admitting patients with high BMI for surgery was not always adhered to; work was underway with commissioners to address this. • It was noted that there were a higher number of controlled drugs incidents reported in theatres and this would be investigated. • The Clinical Audit & Effectiveness Committee reported concern over the poor state of medical notes, including access to notes for research and audit projects. Some improvements to the medical records area have been implemented, however there is still further work to do. • There continues to be issues over the administrative support for the Amplitude system, however one of the Associate Medical Directors was addressing this. • It was noted that there was further work to do to share the learning from clinical audits.
Positive assurances and highlights of note for the Board	• Friends and Family Test response rates had improved, this being attributed to staff being more proactive in encouraging patients to complete the questionnaires • There had been an assurance visit by the CCG to look at the Trust's process for managing compliance with the Duty of Candour regulation. The outcome of this identified that the Trust was 100% compliant based on the sample of cases reviewed. • Compliance with the WHO checklist was reported to be 100%. • It was reported that an initiative was underway to ensure that patients were discharged earlier in the day; the 'Red to Green' approach was also being reinforced. • The Committee received a presentation on the Throne Project. Lots of positive assurance was provided around the actions that had been implemented to prevent patients falling in bathrooms and toilets. • Agency expenditure associated with nurse staffing was reported to remain at less than the 10% target. • The Committee considered the action plan to address the

	recommendations from the recent West Midlands Quality Review Service (WMQRS), which is reviewed at the Children and Young Persons' Board and the HDU Improvement Board; some long term agency staff have been recruited who would undergo rigorous induction in the same way that substantive staff do. • Good progress was reported to have been made with the improvements needed in the Outpatient Department, identified by a Quality Assurance walkabouts some months ago. • The national inpatient survey results scored the ROH within the top 20% of Trusts overall for satisfaction. • Work is underway to ensure compliance with a CAS alert around the removal or flushing of lines and cannulae after procedures. • Work has been undertaken to reinvigorate the Medical Devices Committee and to ensure that the governance around introducing new equipment into the Trust is more robust and there is better visibility of the ongoing cost of introducing devices • The Committee considered the CQC actions plans for Outpatients and HDU areas, which provided good assurance that actions raised by the CQC were being completed • A positive update report on compliance with the contract Key Performance Indicators was received, which showed that of the 64 KPIs, the Trust was rated green against 57. Work is underway to improve performance against the remaining. The Trust had achieved 100% for cancer waiting times in August, September and October. • It was reported that the ROH approach to Safeguarding had been highlighted as best practice by the Leader of Birmingham City Council.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Medical staff to be made aware that mandatory training could be accessed on line • An update on pain management is to be presented at the next meeting, including the plans to cover out of hours requirements • Investigate and progress the actions arising from the Grade 4 pressure ulcer incident which occurred in August 2017 • Further update on pathology services to be given at the next meeting • Clarification of the source of funding required for the estates work to support the Throne Project • Discussion required at the next meeting to agree the way forward for reporting nurse staffing to the Trust Board • Plan to be developed to address the key environmental risks in the hydrotherapy suite

	• A monthly report on the Quality Assurance walkabouts to be taken to the Executive Team • Ensure that a member of the Operations Team joins the Clinical Quality Group • Review the outstanding issues around room temperature monitoring • Ensure that the clinical audit plan is considered by the Clinical Audit & Effectiveness Committee • Clarify the reporting line for the Medical Devices Committee and the process for approving new equipment requests with the Executive Team • Review the future reporting requirements to the Quality & Safety committee
Decisions made	• None specifically

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

For the meeting of the Council of Governors scheduled for 17 January 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Update from the Patient & Carers' Council**
SPONSOR:	**Stella Noon, Chair of Patient & Carers' Council**
AUTHOR:	**Claire Kettle, PA to the Chairman and Company Secretary**
DATE OF MEETING:	**17 January 2018**

EXECUTIVE SUMMARY:

This report provides an overview of discussions at the Patient & Carers' Council since the Council of Governors received its last update in May 2017.

REPORT RECOMMENDATION:

The Council of Governors is asked to note the contents of this report

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

Financial		Environmental	x	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:

Delivering exceptional patient experience and world class outcomes.

PREVIOUS CONSIDERATION:

None

ROHGO (1/18) 006 (a)

Patient & Carers Forum Upward Report to the Council of Governors - January 2018

The Patient & Carers Forum meet on a monthly basis (excluding the months of August and December).

The Terms of reference were agreed during the year and are due to be reviewed in June 2018.

Members are aware of the changes that are taking place within the Children's Programme/Paediatric Services.

The following Patient information leaflets were reviewed by the Forum:-

- Bedside Information Leaflets – these leaflets were very much supported by the Forum
- New Patient Handbook for Hip & Knee Arthroplasty Patients

Members receive regular updates on the following areas:-

- Patient Assessment Tool
- Dashboards
- National Inpatients Survey Update
- Friends & Family Update
- Patient Information: Infection Control
- Upward Reports to Clinical Quality Group

In addition to the above, members are also in receipt of monthly Patient Experience Reports to review and analyse along with verbal updates from Lisa Kealey, Public and Patient Services Manager. Lisa also provides members with a copy of the Annual Complaints Report (which is also seen by the Council of Governors).

During June 2017, the Forum received input from David Rogers, Extended Scope Physiotherapist, around Back Pain Management and Mr Kirti Moholkar, Consultant, on Patient Reported Outcome Measures (PROMS).

Other presentations included an Equality & Diversity Report, including the 'Issues and Opportunities for Improvement', delivered by Clare Mair, Head of OD & Inclusion, a talk from Lisa Kealey entitled "I Want Great Care" which concerned a new way of collecting patient feedback, an introduction from Rebecca Buswell, Head of Strategy on 'Perfecting Pathways', and a presentation entitled 'Update on Funding' from Elaine Chapman, Membership and Fundraising Manager.

Alicia Stanton, Physiotherapist, visited the Forum to present the new Patient Handbook for Hip & Knee Arthroplasty patients. With regard to this handbook, members were concerned about the departure from the usual format which has been in place for a number of years. Members' thoughts were that this document was a commercial activity but also recognised it was a good document for patients. Two members had looked at the handbook in detail and sent comments back.

During October 2017, the Forum had the pleasure of welcoming Stephanie Mawson, Practice Placement Manager at the ROH, who gave an introduction about her role. Stephanie was joined by Susan Brown, Lecturer from Birmingham City University (BCU), who gave a presentation on the BSc Nursing Programme. Susan gave an overview of her role and advised members that she was part of the team at BCU which was designing the new curriculum for nurse training due to launch in September 2019. Susan gave a brief outline of the proposed programme and it was noted that the plan is to incorporate nurse training exposure in community and voluntary areas as well as a hospital setting. There will also be the option for student nurses to undertake an international observational placement during the first two years of training. Susan commented that the University wanted feedback from service users of the programme and that meeting members would be invited to further events regarding the new training programme.

Concern was raised regarding retaining student nurses during their first year of training and nurse training becoming more clinical rather than theoretical. Susan commented that the plan is to change the programme so that students spend two days at university, two days on placement and one day on personal study during the week. New roles have also been developed to support less academic students, such as nurse apprenticeship and nurse associate roles. The new programme will be designed to equip student nurses for 2020 and will incorporate the additional skills required by the NMC with students being assessed in practice rather that at university. Susan circulated further questions and contact details to all members and it was agreed that a further presentation would be given to the forum when the programme is finalised.

In November 2017, the Forum welcomed Paul Athey, Acting Chief Executive Officer, to the meeting. Paul introduced himself and gave an update on various aspects around the Trust, including Finance.

The Forum recognised the developments in the above areas and expressed these were pleasing to hear.

The Chair of the Patients & Carers Forum, Stella Noon, represents this group at the Infection Control Committee and reports back to the group. Stella is also the IPCC Patient Representative on behalf of the Patients & Carers Forum.

The Forum always welcomes colleagues to the meeting to report on their various roles/new projects around patient care and appreciates Jo Wakeman's (Deputy Director of Nursing) input and attendance at these meetings.

The Patient & Carers Forum continue to seek new members but at present, are, not having much success. A plea for new members is to be included within the next version of 'Member News', which it is hoped will attract some interest, particularly from some members in hard to reach or under represented groups.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

November 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.

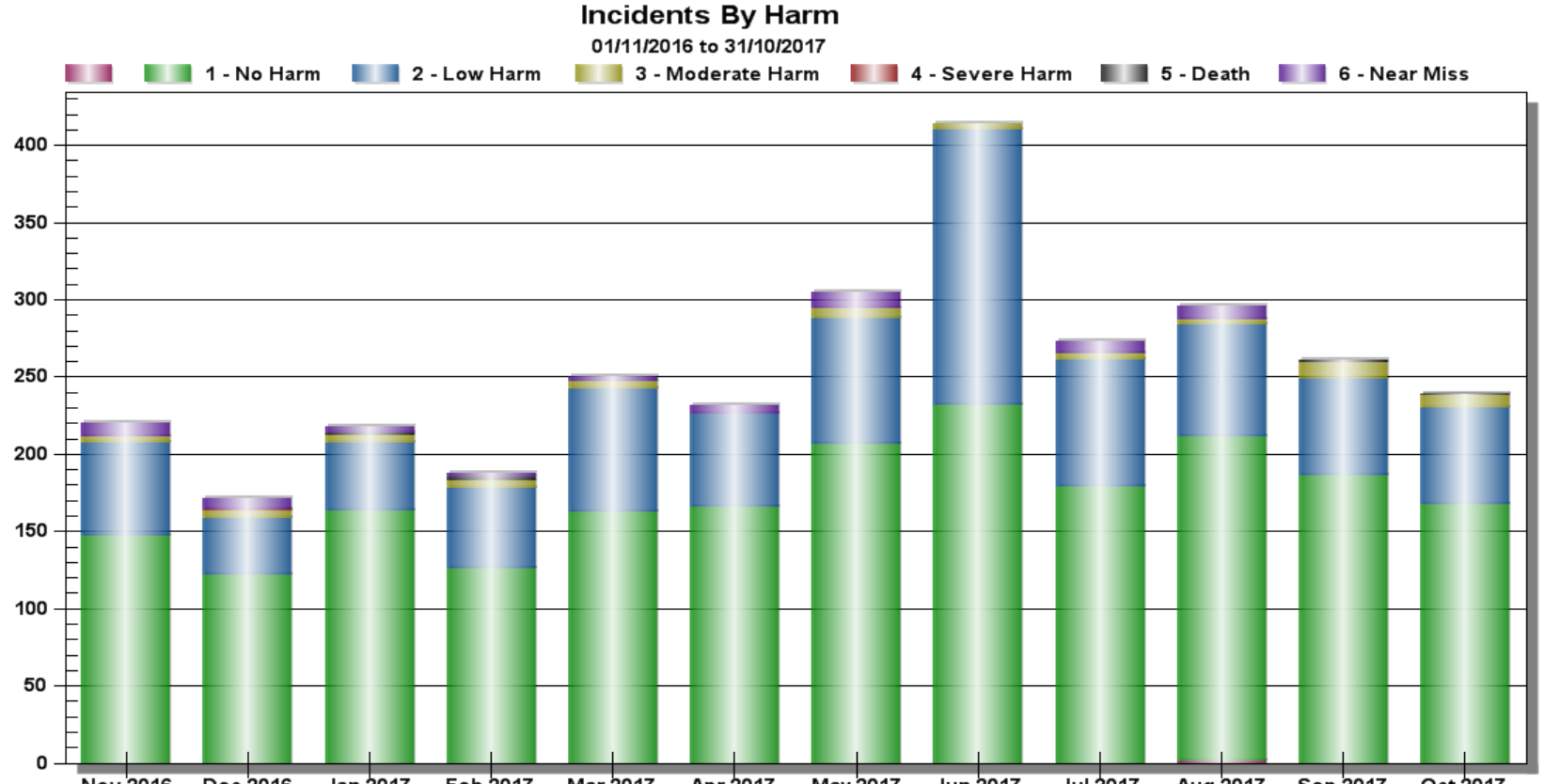
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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.

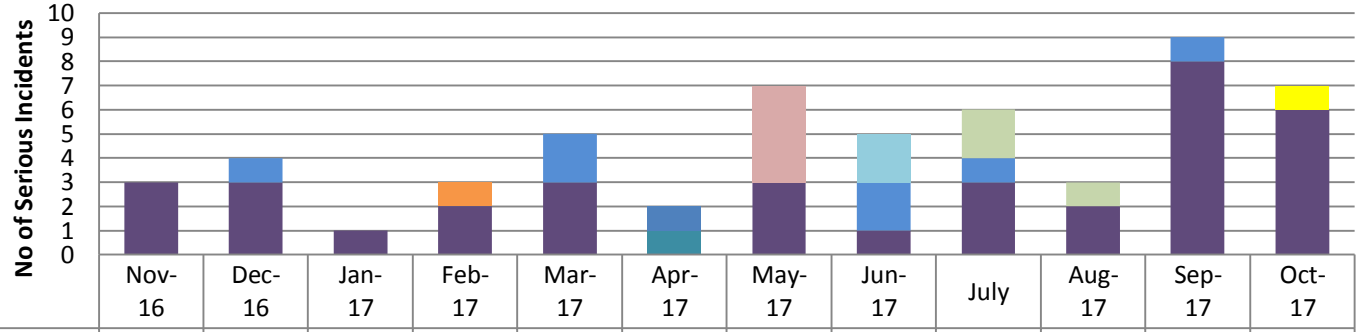


Month and Year	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017
	0	0	0	0	0	0	0	0	0	1	0	0
1 - No Harm	147	122	163	126	162	166	206	232	179	210	186	167
2 - Low Harm	60	36	44	52	80	60	82	178	82	73	63	63
3 - Moderate Harm	4	5	5	5	5	0	6	4	4	3	10	8
4 - Severe Harm	0	1	0	0	0	0	0	0	0	0	0	0
5 - Death	0	0	2	2	0	0	0	0	0	0	2	1
6 - Near Miss	9	7	4	3	3	6	11	0	8	9	0	0

INFORMATION
In October 2017 there was a total of 232 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is at follows; 167 – No Harm 63 – Low Harm 8 – Moderate Harms 0 – Near Miss 1 – Deaths
ACTIONS FOR IMPROVEMENTS / LEARNING
None
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 October 2017



	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	July	Aug-17	Sep-17	Oct-17
Unexpected Injury									2	1		
RTT Harm review							4					
Emergency transfer to HDU												
Exposure to hazardous substance				1								
Retained object												1
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	3	3	1	2	3		3	1	3	2	8	6

INFORMATION
There were **7 Serious Incidents Declared in October 2017;** The following actions have been undertaken so far**:** o Roundtable o Production of a 72 hour briefing report to CCG o Notified BBRaun and manufacturer of the instrument issue o Request for x-ray report to see if there was a delay in reporting whether there was anything evident on the post op X- ray. o Theatre Staff reminded of the requirement to visually check every instrument handed to the surgeon.

ACTIONS FOR IMPROVEMENTS / LEARNING
A female patient attended the hospital for a right sided nerve root injection. The left side was injected in error. Once the error was identified the patient had the right side injected uneventfully. This was an undeliberate mistake by the consultant who injected the wrong side, the Consultant realised the mistake straight away and apologised, then did the correct side injection. After discussions with ADCU staff, it appears that some ADCU clinicians were not compliant with the WHO checklist, I was told that some clinicians even consent patients in the treatment room (rather than the ward) immediately before having their injection. **Evidence of good practice:** 1. Error was instantly identified and corrected 2. An immediate apology to the patient 3. A detailed incident form was written on the same day 4. An Urgent roundtable was organised by the hospital AMD 5. As the incident was identified as a serious one, the consultant involved was asked to stop her clinical work until further notice 6. Consultant A was directly observed during her procedure list to ensure she's compliant with safety measures, then she was directly observed for 2 weeks 7. A Duty of Candour letter was sent to the patient on

8. Pain Consultant met the patient for a clinic follow up

Evidence of poor practice:
1. A consent form wasn't signed in clinic when the patient was initially seen
2. The injection side wasn't appropriately marked
3. A WHO checklist wasn't filled and signed (although the incident form stated that it was done), also Team briefing wasn't documented (there is no Team brief form in ADCU)
4. An Xray request form wasn't filled by the consultant in charge

Recommendations

1. The consenting process has to be undertaken in clinic by the referring physician, with all risks discussed in details with the patient, it has to be signed by the patient and the first part signed by the clinician. We proposed to change the consent form by increasing the allocated space for RISKS, Medical Director replied that he will consider this in the near future.

2. All efforts has to be done to try and **change the 'ADCU pool system'** in the future , so that every clinician is responsible for his patient from their initial point of meeting in clinic till the patient is discharged , including undertaking the procedure in ADCU.

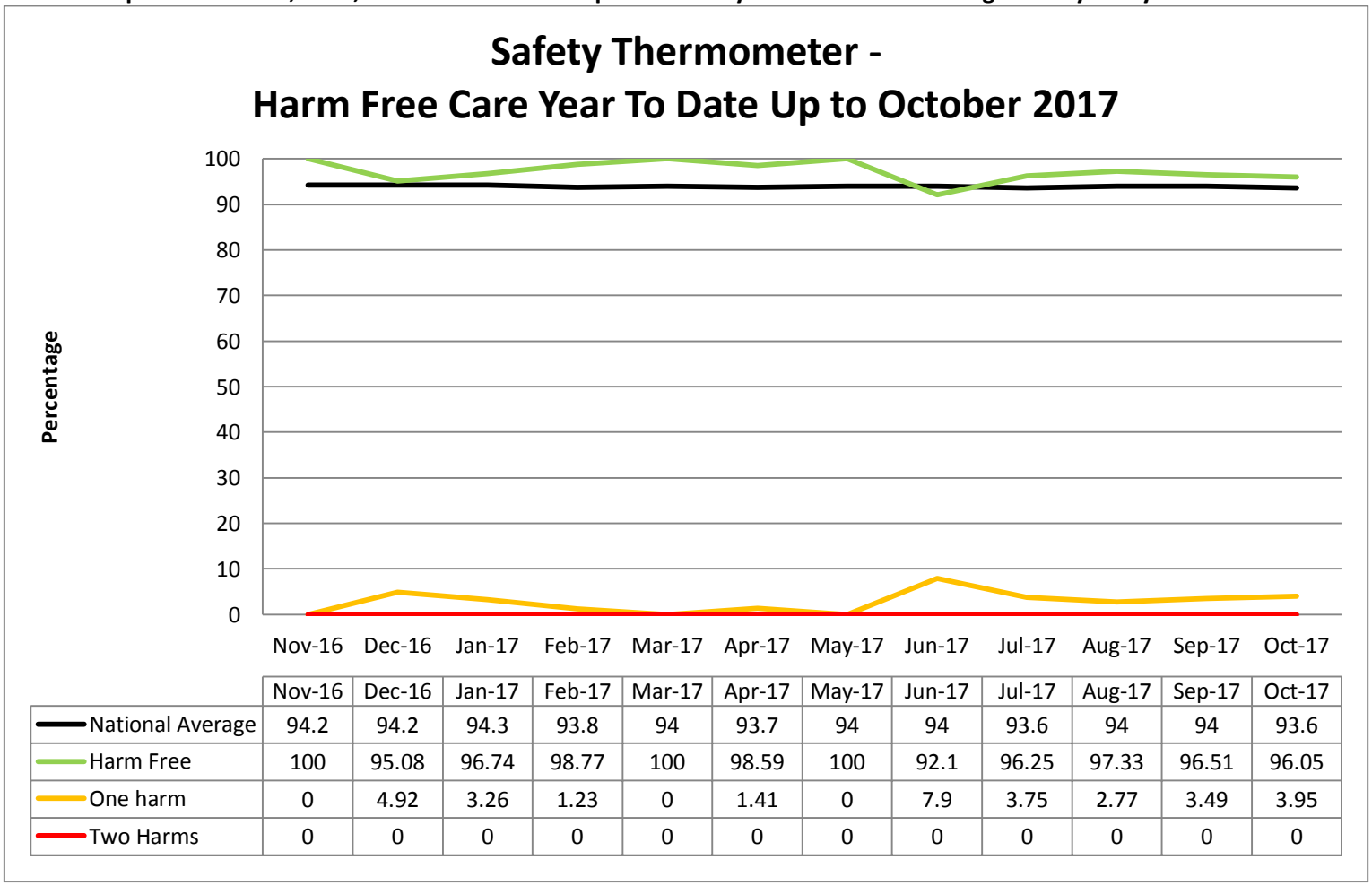
3. Team briefing and Debriefing is crucial before starting a list in ADCU (A Team Brief form designed by the pain team was submitted and awaiting approval) and should include;
a. Team introduction and delegating roles (eg. who will be responsible for the WHO)
b. Number of patients on the list
c. Discuss the order of the list and Re-print if changed
d. Discuss any personnel or equipment issues
e. Discuss any critical steps or potential difficult cases

4. WHO checklist (Sign in, Time out and Sign out) has to be read out loud and clearly signed and dated by a member of the team (however it's the consultant responsibility)

5. The injection side has to be clearly marked by a skin marker pen in close proximity to the site of the injection by the physician after confirming with the patient.

6. 'STOP BEFORE YOU BLOCK' , injection side to be confirmed out loud again with the patient and the assistant before inserting the needle **7. Xray request form** has to be signed and dated by the clinician before the procedure (Responsibility of both the Consultant and the Radiographer) **8. Procedure documentation forms** have to be updated to include all types of procedures done by Pain management consultants including radiofrequency denervation, a new form has been submitted and awaiting approval.
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.**



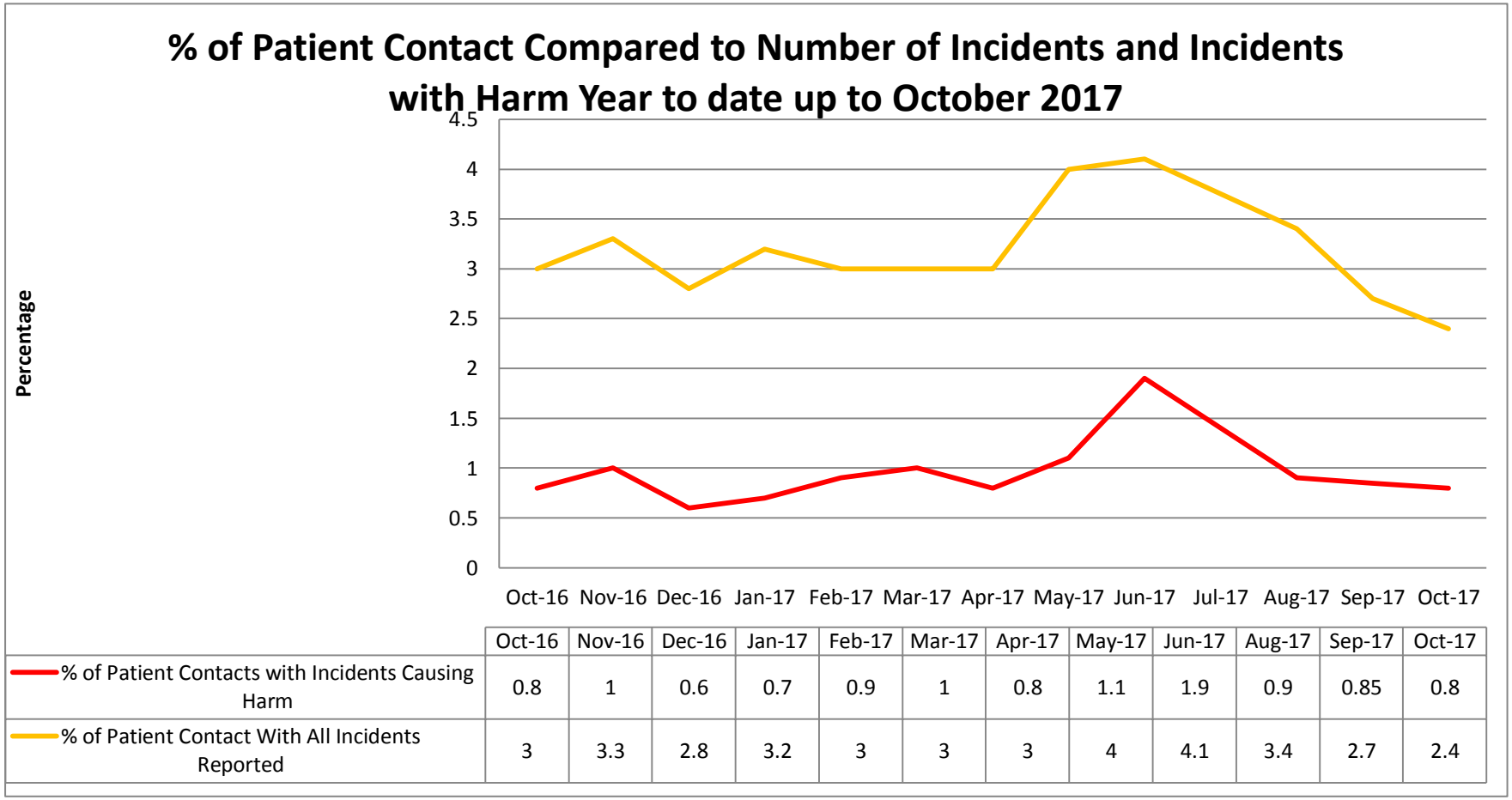
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
National Average	94.2	94.2	94.3	93.8	94	93.7	94	94	93.6	94	94	93.6
Harm Free	100	95.08	96.74	98.77	100	98.59	100	92.1	96.25	97.33	96.51	96.05
One harm	0	4.92	3.26	1.23	0	1.41	0	7.9	3.75	2.77	3.49	3.95
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The harms highlighted on the safety thermometer were;
2 x Old Pressure Ulcer, 1 New PE, 1 old PE, 1 old DVT and 1 new UTI

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 October 2017 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

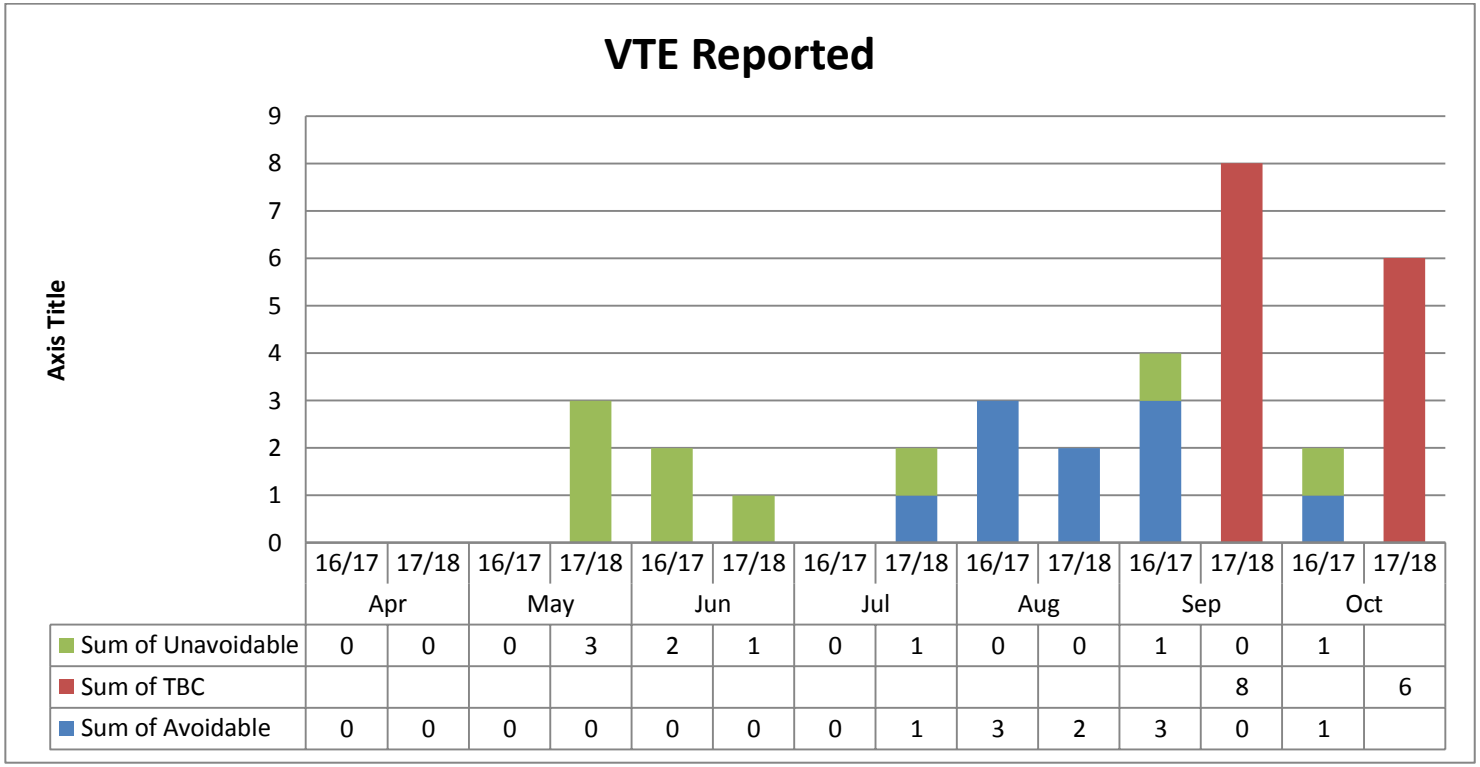
	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Aug-16	77	3	0	0	80	286	6274
Sep-16	97	5	0	0	102	268	6823
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	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
Oct-17	67	9	0	1	77	232	9571

In October 2017, there were a total of 9571 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.



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Aug-17	Sep-17	Oct-17
% of Patient Contacts with Incidents Causing Harm	0.8	1	0.6	0.7	0.9	1	0.8	1.1	1.9	0.9	0.85	0.8
% of Patient Contact With All Incidents Reported	3	3.3	2.8	3.2	3	3	3	4	4.1	3.4	2.7	2.4

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).**



	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	16/17 Sep	17/18 Sep	16/17 Oct	17/18 Oct
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0	1	0	1	
Sum of TBC												8		6
Sum of Avoidable	0	0	0	0	0	0	0	1	3	2	3	0	1	

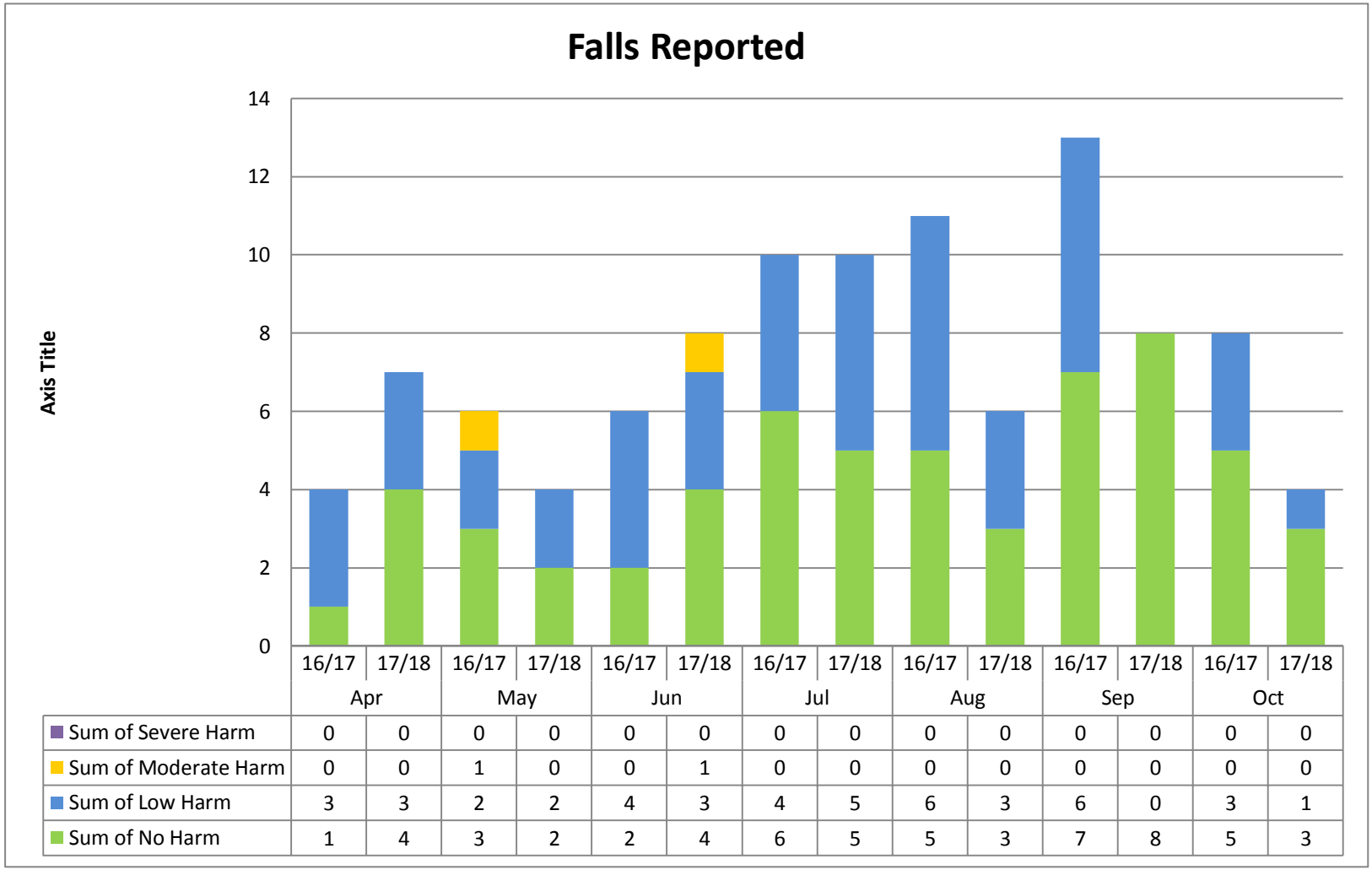
13

total		Avoidable
16/17	27	13
17/18	22	3*

***not classified**

INFORMATION
There were 6 VTEs declared in October 2017.
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 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.**



	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	16/17 Sep	17/18 Sep	16/17 Oct	17/18 Oct
Sum of Severe Harm	0	0	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	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3	6	0	3	1
Sum of No Harm	1	4	3	2	2	4	6	5	5	3	7	8	5	3

INFORMATION
Overall 4 fall related incidents were reported across the Trust in October 2017, all 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 still meets bi-monthly and is multidisciplinary.

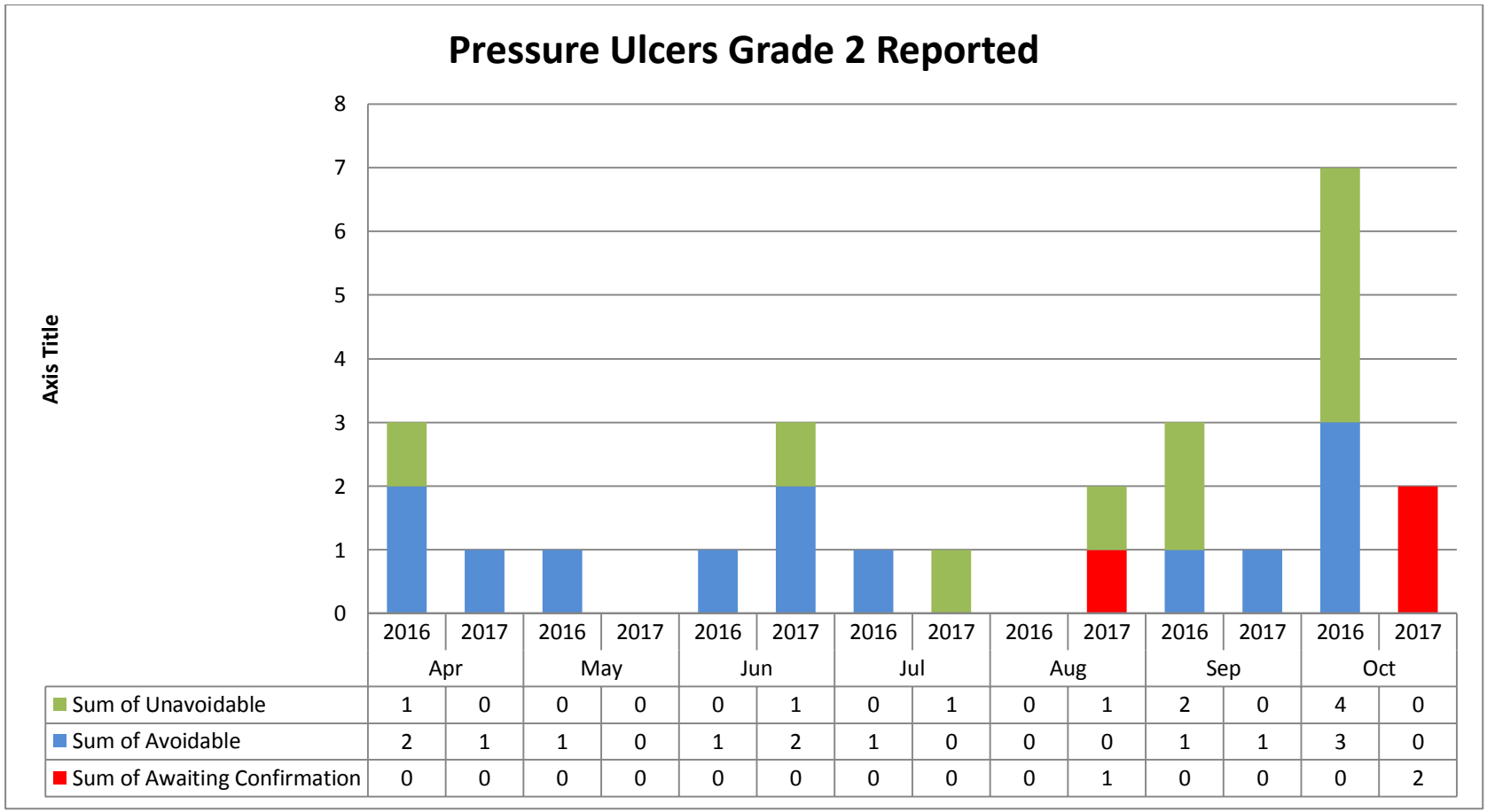
The work currently being undertaken:

- Reviewing and updating the bed rails policy – Karen Hughes is reviewing and circulating for comments before the next meeting in January 2018.
- Throne project – this was completed earlier this year.
- The SOP for patients at risk of falling and the 'fall leaves' is currently under review following the last Falls group meeting when the SOP was amended slightly.
- Review of Manual Handling training across the Trust and the possibility of 'train the trainer' to ensure bespoke training to areas / wards is undertaken. Investigating the possibility of staff having 'manual handling passports' to complete with the ward trainer. Urgent training needs have been identified in Xray – Chris Aspland to contact Karen Jones to arrange training.
- Chairs in main hospital corridor are to be replaced – Tracey Billingham will source appropriate chairs (ie height and design) and costings to be sent to Sue S.
- Risk register specific to Falls group is to be set up and maintained by the group (risks from the outcome of the Throne Project are to be included on this register).
- ROH to be bench marked against the WMQRS Quality Standards for the Falls and Fragility Fractures Pathway.
- Post falls medical management and review documentation is currently under review as part of the wider documentation review.

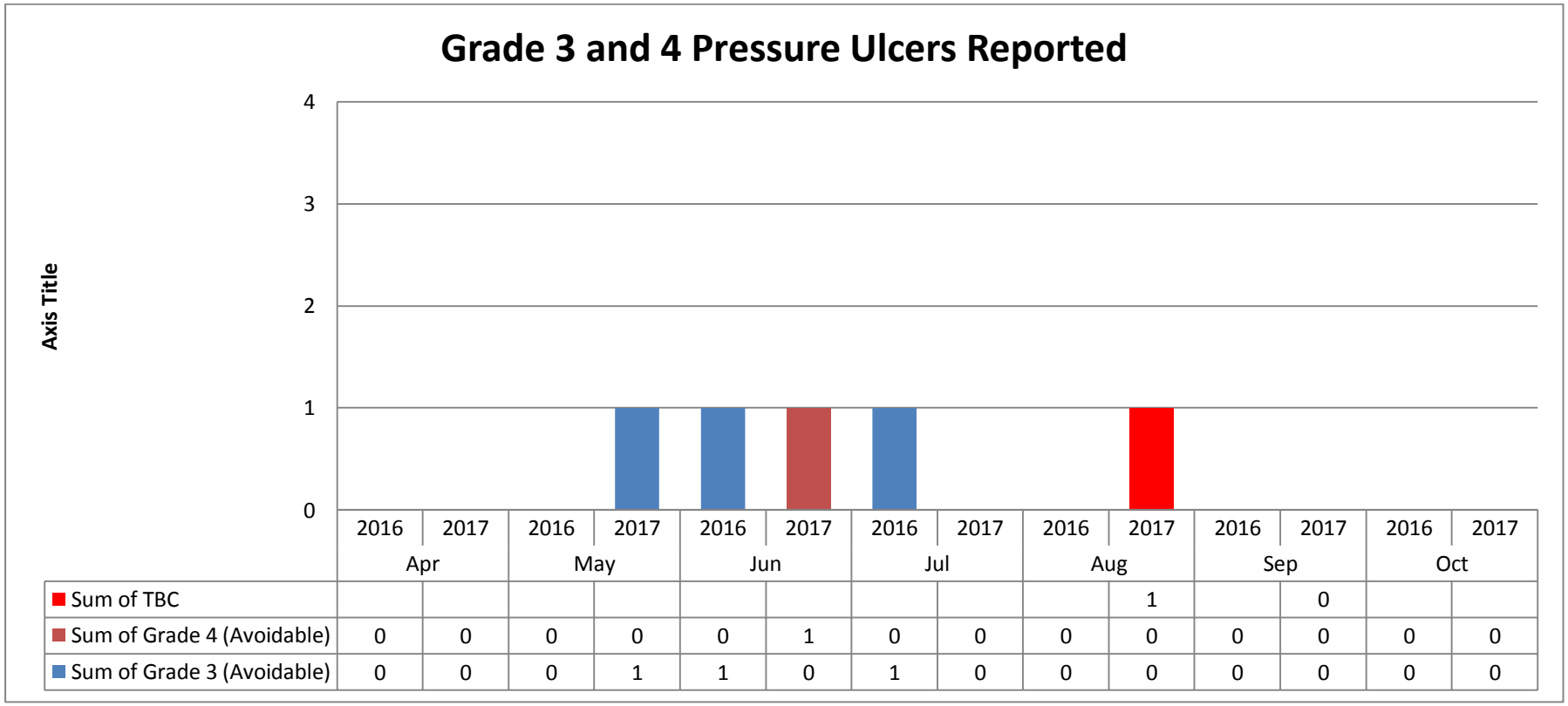
RISKS / ISSUES

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	2016 Oct	2017 Oct
Sum of Unavoidable	1	0	0	0	0	1	0	1	0	1	2	0	4	0
Sum of Avoidable	2	1	1	0	1	2	1	0	0	0	1	1	3	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	1	0	0	0	2


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 2016 2017
Apr May Jun Jul Aug Sep Oct
Sum of TBC 1 0
Sum of Grade 4 (Avoidable) 0 0 0 0 0 1 0 0 0 0 0 0 0 0
Sum of Grade 3 (Avoidable) 0 0 0 1 1 0 1 0 0 0 0 0 0 0

INFORMATION

For October 2017 there were;

- G4= 0
- G3 = 0
- G2= 2 - both cast (device) related – both Ward 11
  22101- POP cast-Right heel
  22213 – Cast – Lt heel/ankle

Update on Previous month incidents that were under review

- 21886- G2 thigh avoidable
- 21931- Friction traction
- 21866- None pressure

Update on Previous month August 17 incidents that were under review

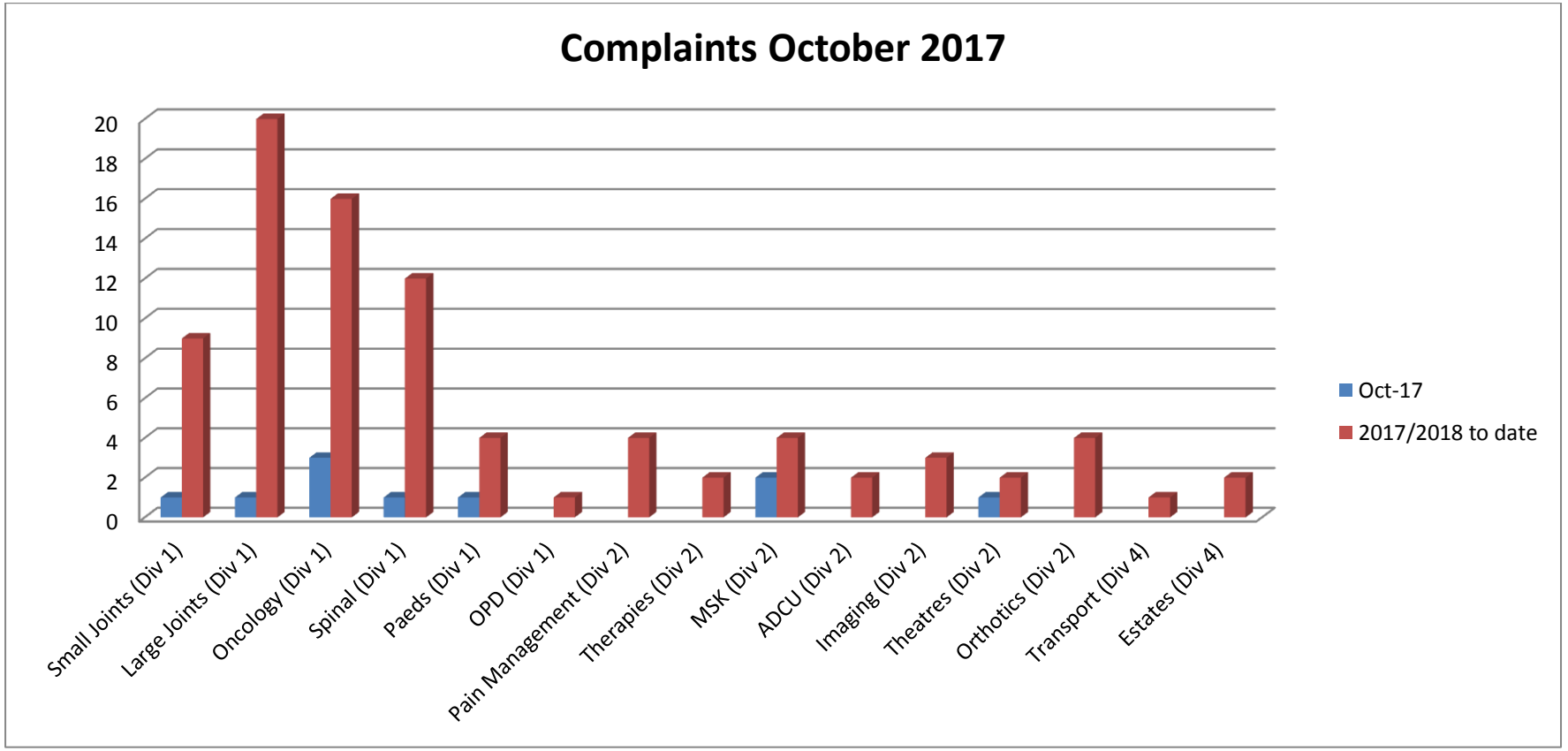
- 21722- G2-Downgraded not pressure incident it was friction to elbow
- 21732- G2-awaiting final update – preliminary outcome will be deemed avoidable due to gaps in skin documentation on admission
- 21651- G2- unavoidable-patient complex infected patient ; patient had below knee amputation – device related cast- pressure left heel
- 21695-Grade 3 –SI investigation underway
-

Summary:
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.
2 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12 (3 currently under review)
2 avoidable Grade 3 pressure Ulcers against a limit of 0. June 2017 (20769) (One Grade 3 Pressure Ulcer currently awaiting RCA's to establish avoidability and is therefore not included in this figures- August 2017(21695)

1 avoidable Grade 4 pressure ulcer against a limit of 0- June 2017 (20930).

ACTIONS FOR IMPROVEMENTS / LEARNING
• Band 7 – New Trust Tissue Viability Lead Nurse will commence into post week commencing 4.12.17 • Band 6 – Tissue Viability Nurse – interviewed on 3.11.17, candidate accepted offer, waiting clearances Commencement date to be confirmed once clearances completed –Earliest end Jan 2018. Interim cover being provided by ward managers and departmental tissue viability link/champions and Band 6 nurses from the ROCS team as required for supporting grading of pressure sores and staff support. • Matron has requested update from all ward areas on Tissue Viability Competencies completion update to be reported in Nov 2017 report.
RISKS / ISSUES
• Audit requirements have not been fulfilled due to the trust currently having 2 Tissue Viability Nurse Post vacancies. • Tissue Viability Data base has not been maintained currently– all tissue viability information being recorded in patients notes. • Training for Tissue Viability for the Trust to be reviewed to ensure best practice and this will a priority for Lead appointed • Trust Tissue Viability Policy requires updating; this will be impacted by new classification status when agreed.

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 454 contacts during October 2017 of which 113 were classified as concerns. This brings the total of PALS contact for the year to date to 3252 (780 concerns). This represents a much higher figure than at the same point last year (2347 PALS contacts)

Compliments

There were 665 compliments recorded in October 2017, with the most being recorded for Div 1. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms from this month, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues to receive a significant number of compliments. Areas have been reminded to submit their records for central recording

Complaints

There were 10 formal complaints made in October 2017, bringing the total to 86 for the year. One was withdrawn after meeting with the Consultant. All were initially risk rated amber or yellow. This is significantly lower than the same time last year (14 complaints in October 2016)

There were 13 complaints closed in October 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:

- Nursing Care (Div. 1, Spinal)
- Not seen by consultant post op. Nursing care (Div. 1,Oncologyl)
- Cancelled surgery due to no post op care arrangements (Div. 1, Small)
- Cancellation of planned surgery (Div.1, Large Joints)
- Discharged and not aware. Patient also believes has been given wrong unit number (Div. 1, Oncology)

- Attitude of secretary (Div. 2, MSK)
- injury sustained in theatres; procedure cancelled (Div. 2, Theatres)
- outcome of surgery – wound (Div. 1, Large Joints) withdrawn
- Unhappy with consultation in knee and shoulder clinic (Div. 2. MSK)
- Unhappy with consultation 9div 1, Paeds)

Initially Risk Rated Yellow:

- outcome of hip operation (Div. 1, Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

3.3 Complaints closed in October 2017

There were 13 complaints closed in October 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 October 2017 was 27 days which is within normal limits.

3.4 Learning/Actions from complaints

Of the 13 complaints closed in October 2017:

- 5 were upheld
- 6 were partially upheld
- 2 were not upheld

Learning identified and actions taken as a result of complaints closed in October 2017 include:

- Nursing staff outside of the Spinal Ward may not be familiar with spinal escalation procedures

Action: Refresher training is being provided

- Patients are still waiting longer that they or we would like in ADCU

  Action: Transformation work/Perfect Pathways underway to improve the admission process.

- Paper referral administration process does not always work effectively

  Action: Electronic referral system has been sourced and will be implemented by next summer.

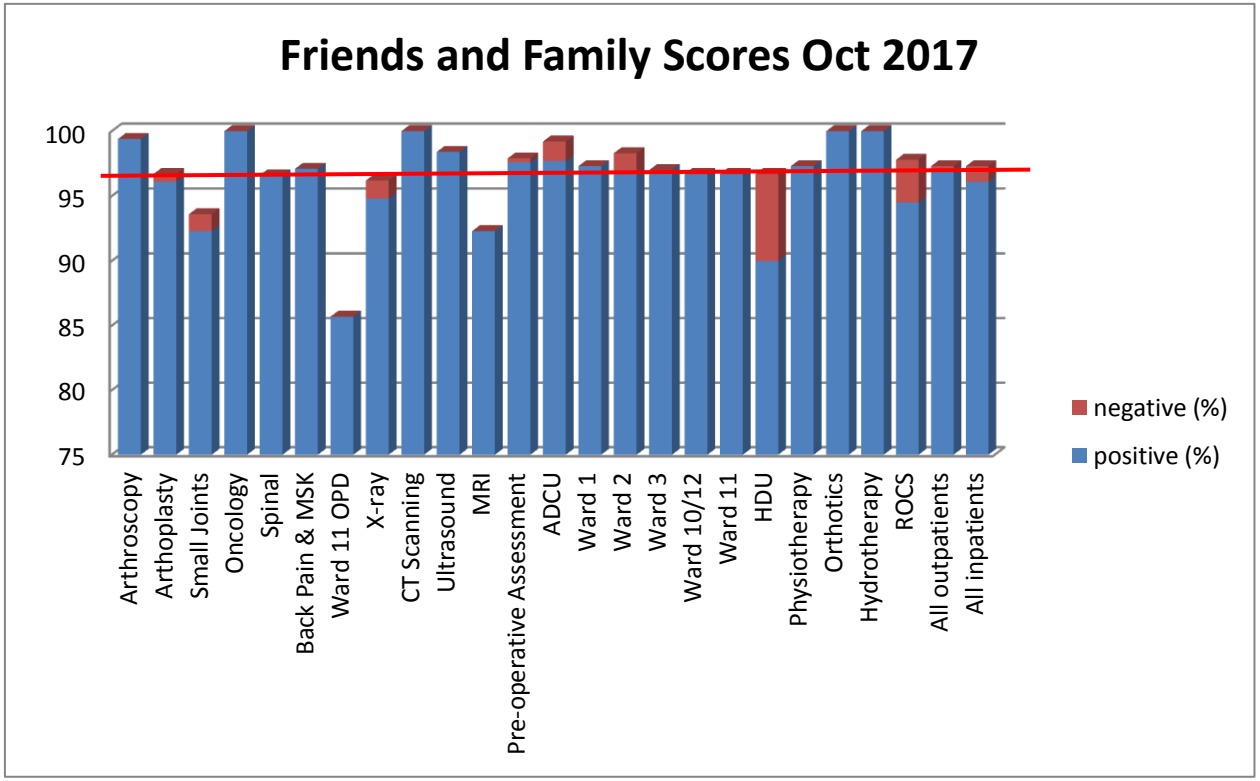
RISKS / ISSUES

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.

Area	Number of reviews	Footfall	Completion rates	Positive Rating	Negative Rating	change in response rate and achievement of target
Arthroplasty	155	1160	9.3%	99.4%	0.0%	
Arthroscopy	181	1192	15.2%	96.1%	0.6%	
Small Joints	78	1515	5.1%	92.3%	1.3%	
Oncology	8	688	1.2%	100.0%	0.0%	
Spinal	88	766	11.5%	96.6%	0.0%	
Back Pain & MSK	206	1102	18.7%	97.1%	0.0%	
Ward 11 OPD	14	451	3.1%	85.7%	0.0%	improved
X-ray	212	2559	8.3%	94.8%	1.4%	worse
CT Scanning	46	242	19.0%	100.0%	0.0%	improved
Ultrasound	64	355	18.0%	98.4%	0.0%	improved
MRI	13	840	1.5%	92.3%	0.0%	worse
Pre-operative Assessment	337	588	57.3%	97.6%	0.3%	improved
ADCU	133	697	19.1%	97.7%	1.5%	worse
Ward 1	73	139	52.5%	97.3%	0.0%	same
Ward 2	61	136	44.9%	96.7%	1.6%	improved
Ward 3	33	97	34.0%	97.0%	0.0%	improved
Ward 10/12	61	104	58.7%	96.7%	0.0%	improved
Ward 11	30	99	30.3%	96.7%	0.0%	worse
HDU	30	89	33.7%	90.0%	6.7%	worse
Physiotherapy	73	2695	2.7%	97.3%	0.0%	improved
Orthotics	3	831	0.4%	100.0%	0.0%	worse
Hydrotherapy	6	554	1.1%	100.0%	0.0%	same
ROCS	91	158	57.6%	94.5%	3.3%	worse

INFORMATION

The Scores for Friends and Family are now calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as Detractors. The Trust is require to report the %Promoter and %Detractor scores for each inpatient and outpatient area nationally.

The results remain consistently high for the Trust overall, with the red line in the graph above showing the Trust average score for Promoters overall.

The percentages are significantly affected by low response rates. Therefore in considering the Friends and Family Data, it is important to ensure the number of patients responding is known. The dataset for October is complete and this is making analysis of the data easier.

ACTIONS FOR IMPROVEMENTS / LEARNING

A more detailed analysis of the return rates for FFT nationally has been undertaken. It has been identified that the ROH already has one of the highest return rates for Outpatient Departments at 12% (latest figures published nationally are for August 2017). Therefore, the internal response rate for Outpatient Services was reviewed at the Outpatient Improvement Group and the internal target re-set for 20% as a more realistic target.

The last column in the table below shows changes to last month's collection in words and the colour relates to whether the area has met the internal targets for collection of 40% for inpatient services and 20% for outpatient services.

There were over 2000 submissions of individual data for FFT in October, representing a 60% increase in the last two months. Outpatient data is now available by speciality for the first time to continue targeted work across all areas to ensure that comparable feedback is available for all departments.

The increase in response rate and clarity of data represents real achievement in the last two months and the Trust is aiming to achieve the internal targets set by the end of Q3.

RISKS / ISSUES

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.

Duty of Candour assurance visit

An assurance visit was conducted on 30th October 2017 at the Royal Orthopaedic Hospital. The review focused on the Trusts process for managing the Duty of Candour (DOC) requirement.

For the period 1st April 2017 – 30th September 2017, there were 50 recorded incidents meeting this level of harm and 40% of these (n=20) were reviewed.

Of the 20 reviewed, we could clearly identify that DoC had been applied both verbally and in writing and that the letter confirmed that an apology had been offered to patients, with appropriate reference made to any investigation and options of how to contact the Trust.

The review was undertaken by Senior Clinical Risk and Patient Experience Manager at Birmingham CrossCity CCG who confirmed that the based upon the audit sample reviewed, the Trust has robust systems in place to manage the DoC requirement.

12. Litigation

No new litigation to report in October 2017.

13. Coroners

There was an Inquest held at Worcestershire Coroner's Court, Stourport on Severn, on the 11.10.2017 the Coroner recorded the cause of death as:-

1. Hypertensive heart disease

2.

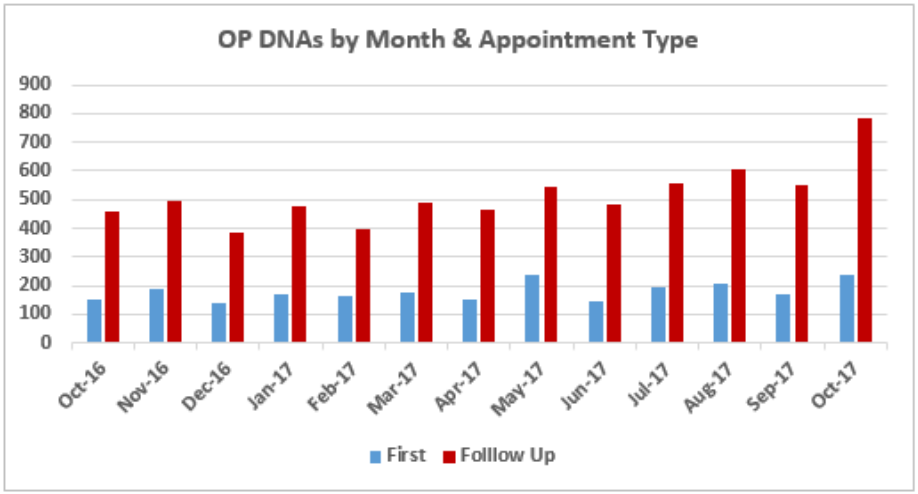
a) Revision of right hip replacement
b) chronic kidney disease
c) Hypoxia caused by Bone Cement Implantation Syndrome

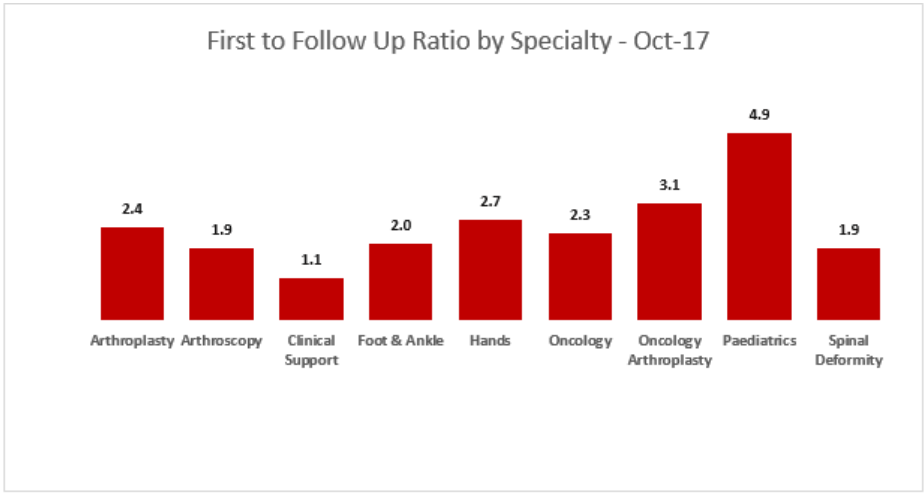
The Coroner handed down a "narrative conclusion" (used in complex deaths were the standard "short form" conclusions, such as accidental death or natural causes, are not factually applicable), stating that the patient died "from a known complication of necessary surgery".

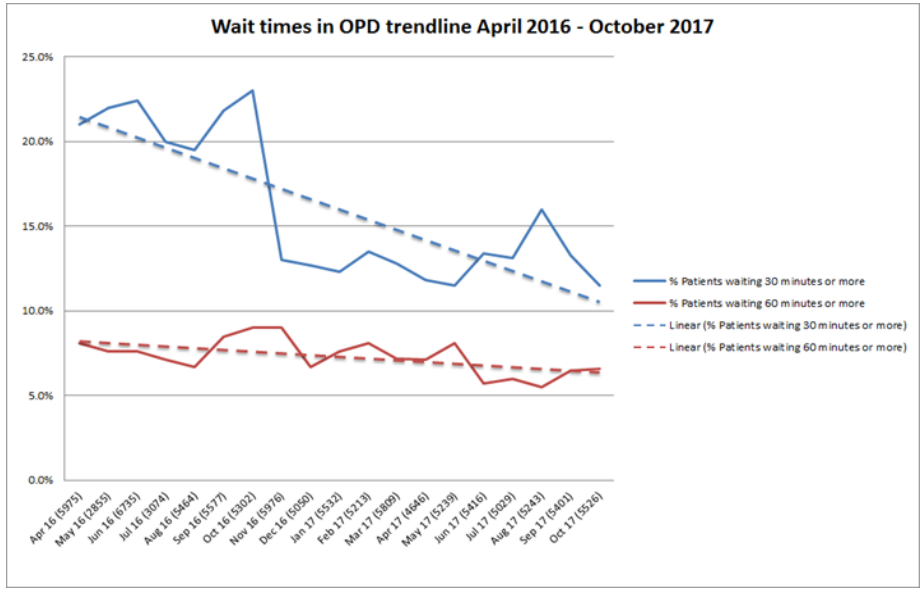
14. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

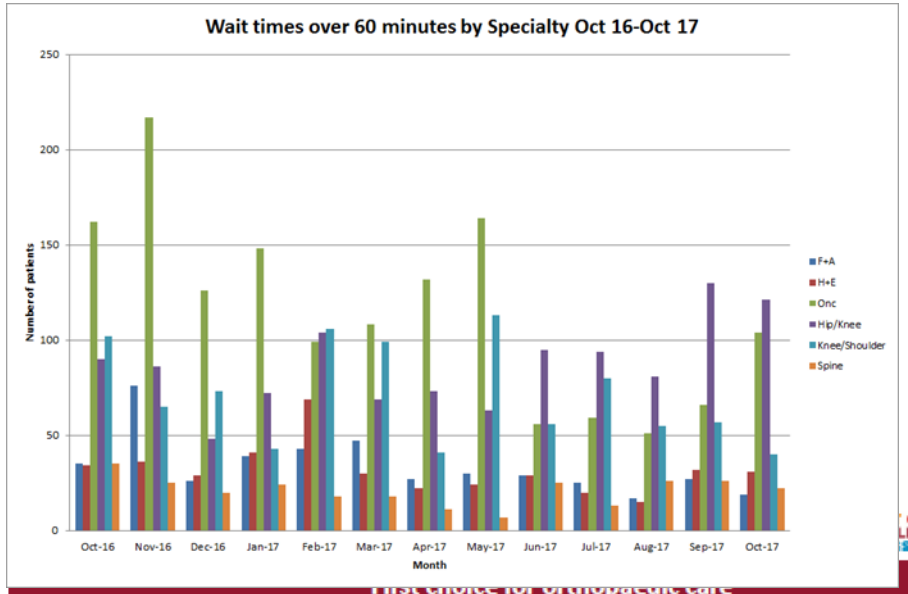
INFORMATION
The data is retrieved from the Theatre man program. The data collected is the non- completed patients on the system. **Total Cases – 901** **Incomplete patients on the system that had notes reviewed for compliance – 341** **Total WHO Compliance - 901** **October 2017 = 100% compliance**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
None

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





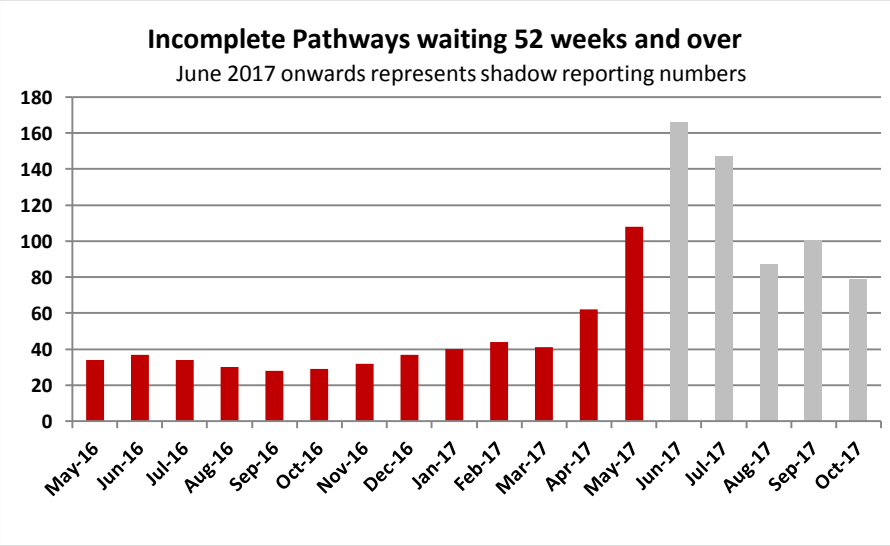


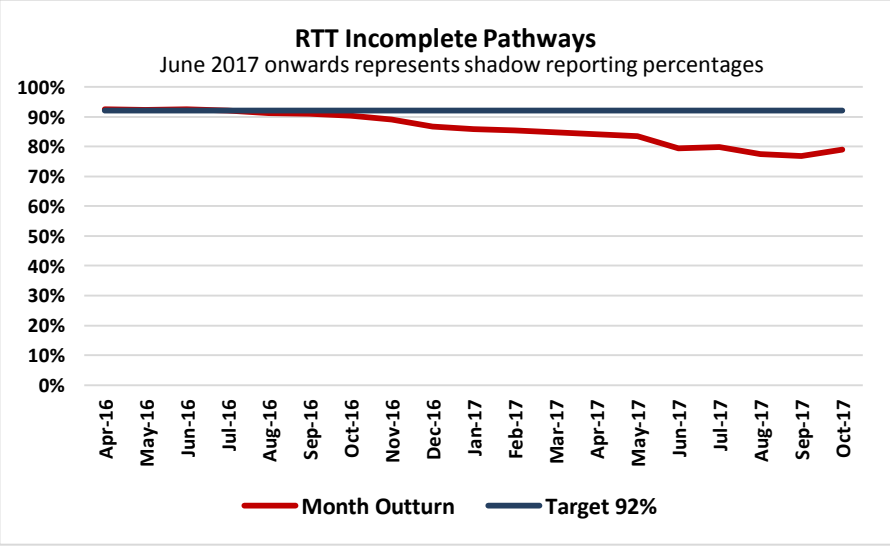


INFORMATION
The process for sharing learning in relation to clinic delays is being reviewed and future incident forms will be shared with the Clinical Service Managers alo clinic delay data. Any issues that require operational management input will be discussed and changes implemented to avoid future recurrence of issues. Th reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form. A multidisciplinary operational manageme group has been set up where issues causing clinic delays are also discussed. In October 2017 there were 12 incident forms completed to highlight clinics running more than 60 minutes late. The monthly audit identified 3 main contributing factors for delays: 1) Clinic Overbooked for the Number of Staff 2) Complex Patients requiring more time t planned and 3) Unexpected Staffing Issues in Clinic. This is a change from September as there were no clinics delayed for more than an hour due to missing or late medical records.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions from October's Audit include; • Involvement of Clinical Service Managers in all incidents reported to share issues and develop action plans for improvement • 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 • Review set up of clinics on InTouch to map correctly to either Paediatric or Main Outpatients • Review of clinic cancellation and rescheduling SOP

RISKS / ISSUES
Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure and need to update process

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





35

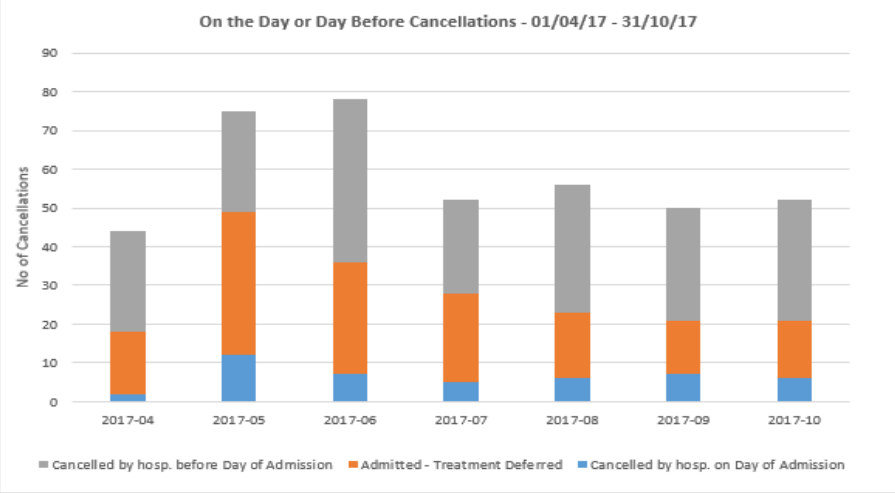
Target Name	National Standard	Indicative*	Reported Month						Reported Quarter					
		Oct	Sept	August	July	Jun	May	Apr	Q2	Breach	Total	Q1	Breach	Total
2ww	93%	95%	100%	100%	100%	95.65%	100%	97.30%	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	100%	75%	100%	100%	91.67%	100%	100%	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100%	100%	100%	100%	100%	100%	100.00%	100%	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		n/a
62 day (traditional)	85%	100%	100%	100%	37.50%	71.43%	60.00%	66.67%	79%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	89%	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		n/a
No. day patients treated 104+ days		0	0	0	3	1								

*Indicative performance – October performance reported 4th December 2017

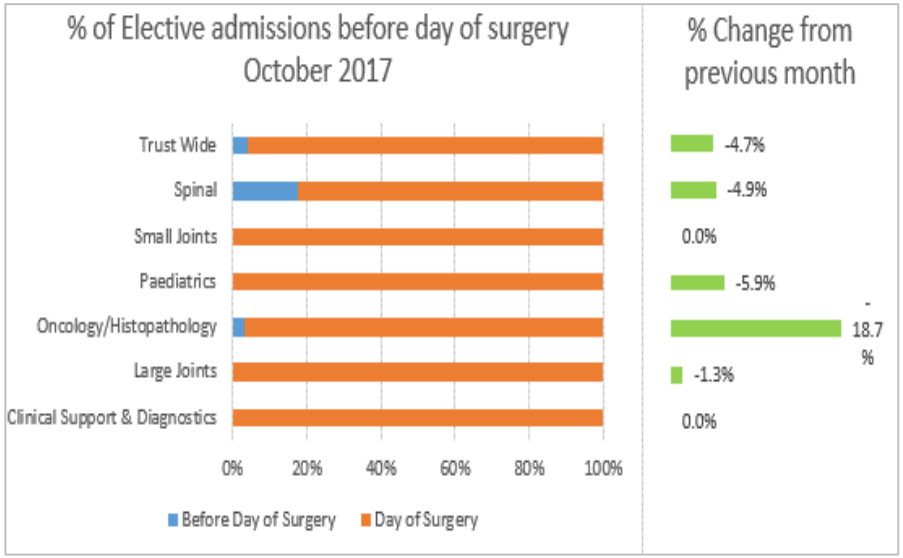
25

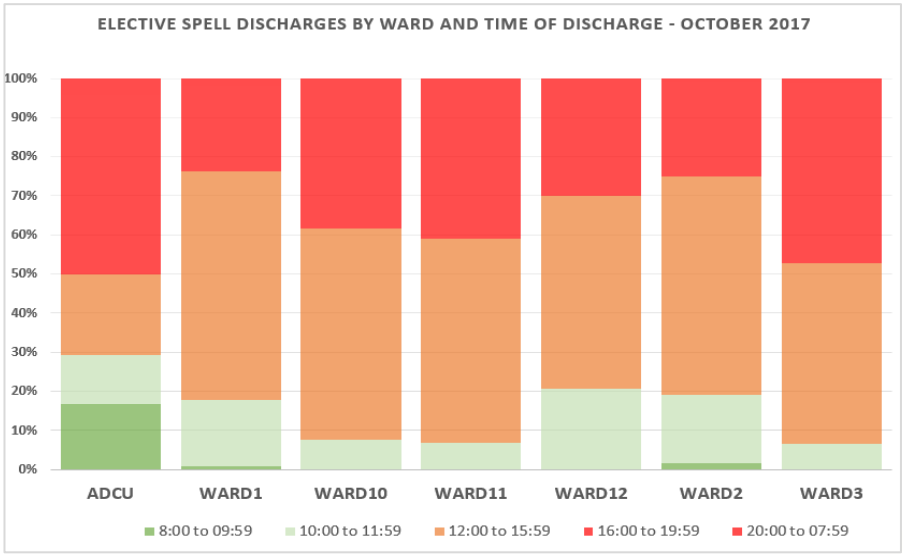
INFORMATION
The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust will recommence reportin 2017, with its first submission for November 2017. Validation has been completed reviewing clock stop data across all areas. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajecto currently being refreshed to recalculate the demand and capacity required to deliver 92% performance, this is due for completion at the end of Novem team continue to reduce the number of long waiters with the majority of admitted patients with treatment dates. The above figures have been used for the shadow reporting of the ROH RTT performance for October 2017 – 79.08%
ACTIONS FOR IMPROVEMENTS / LEARNING
The team continue to concentrate on any patient over 40weeks. The focus from November 17 has been patients on an admitted pathway between 27- non admitted over 18weeks. Good progress has been made by all the teams especially Oncology who are now achieving over 92%.
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. Dis 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 av PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (within the spinal deformity action plan) . We are currently ahead of trajectory with 12 BWCH patients treated during this period, this included 3 PICU ar beds. . Trajectory was 69pts actual 66pts. 9 further additional weekend lists have been confirmed through till April 2018.

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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	17	33	56	0
2017-09	7	14	29	50	0
2017-10	6	15	31	52	0
Grand Total	45	151	211	407	9





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 booke notice. As this is a recurring theme the look back meeting will investigate the themes and causes and as part of the rectification plan the teams will be patients to understand the reasons. A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Following on from the 12th October multi-disciplinary POAC workshop the Clinical Service Manager is reviewing the structure with the team to ensure th and patient processes are robust to meet the needs of any future changes. To further strengthen the POAC model the team now sit within Division 2, this now sits closer to the Anaesthetic service.
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 Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and ti to deliver activity and patient flow. Priorities are now being agreed as part of Perfecting Pathway which will help to deliver some of the key deliverables discussed at the POAC workshop .
RISKS / ISSUES
Continued high levels of cancellations due to medically unfit patients

Finance and Performance Report

JANUARY 2018

CONTENTS

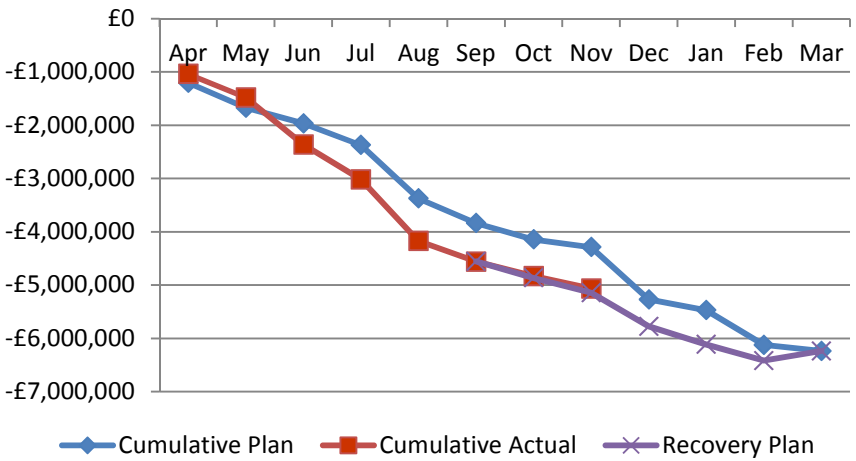
INTRODUCTION

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.

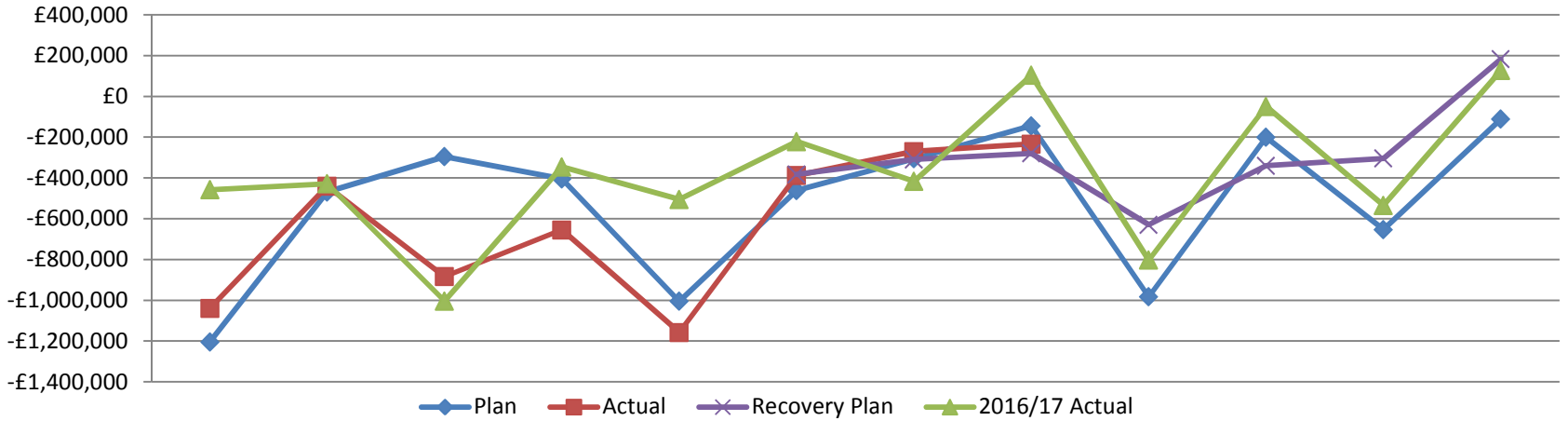
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

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	3
Agency metric	1	2
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £233,000 in November against a planned deficit of £279,000, £46,000 ahead of plan. This brings the year to date position (on a control total basis) to £5,025,000 against a plan of £4,493,000, £532,000 behind plan.

The Trust continues to action areas of efficiency improvement and activity growth outlined within the 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. November marks the third month of the recovery plan, with an over performance of £46,000 against recovery plan in month, and an over performance of £81,000 YTD.

Drivers for the year to date underperformance against plan include spend on improving RTT reporting (just over £580,000 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 time of the MRI for a period of nearly 2 weeks). 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.

As at the end of November, the Trust has recognised £1,242,000 of CIP savings, against an original plan of £2,104,000. £180,000 (14%) of savings to date are non-recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,632,000 against an original plan of £3,191,000. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

With regards to the Trust's Use of Resources Risk Rating (UOR), the overall position has remained at level 3. The other elements of the Use of Resources elements remain the same; the deficit position against plan results in the Trust reporting 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. Year to date agency spend is higher than agency cap and as a result the agency rating remains at a 2.

ACTIONS FOR IMPROVEMENTS / LEARNING

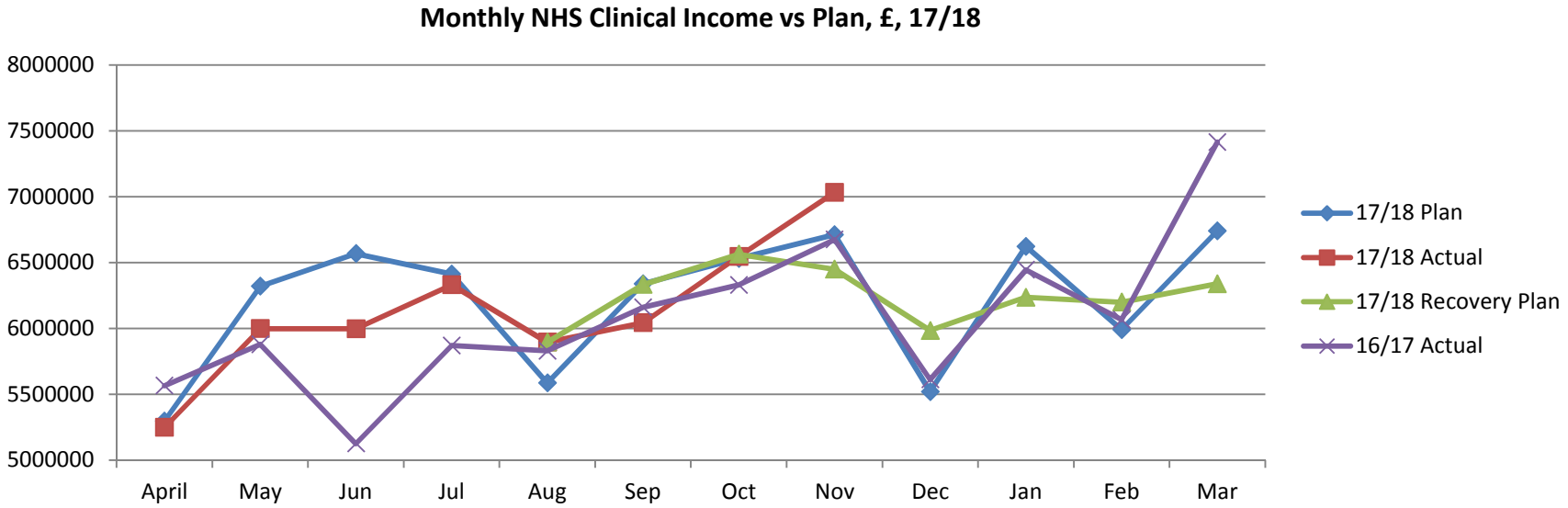
The Trust Executive are monitoring weekly progress against activity improvement and the Perfecting Pathways Project. In addition, fortnightly meetings are being held with operational, clinical and finance stakeholders to improve the theatre environment and give better visibility of stock levels and spend.

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.

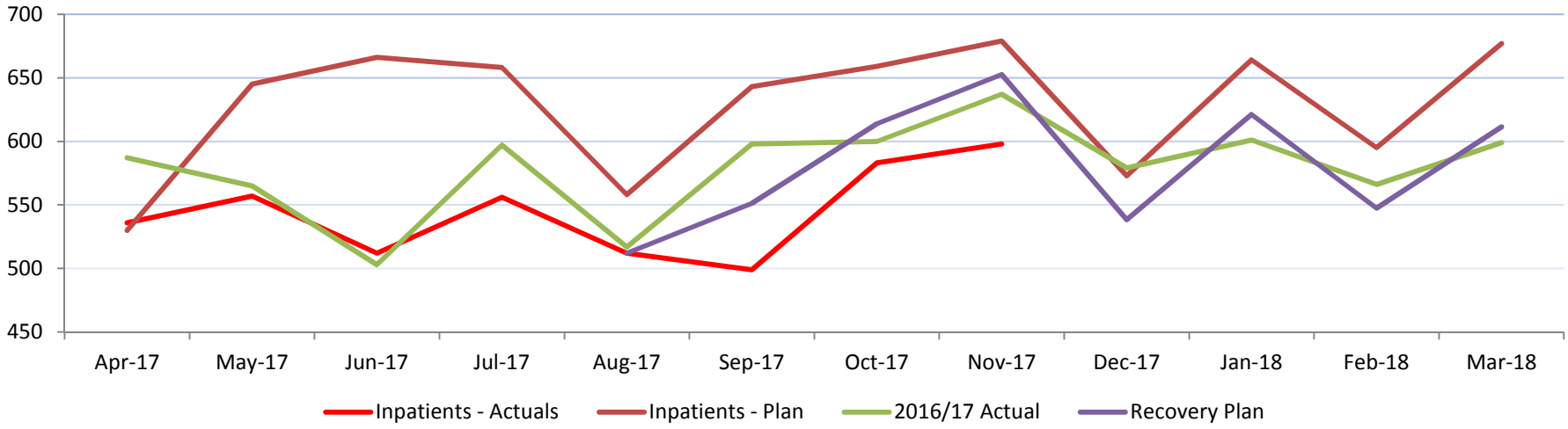
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



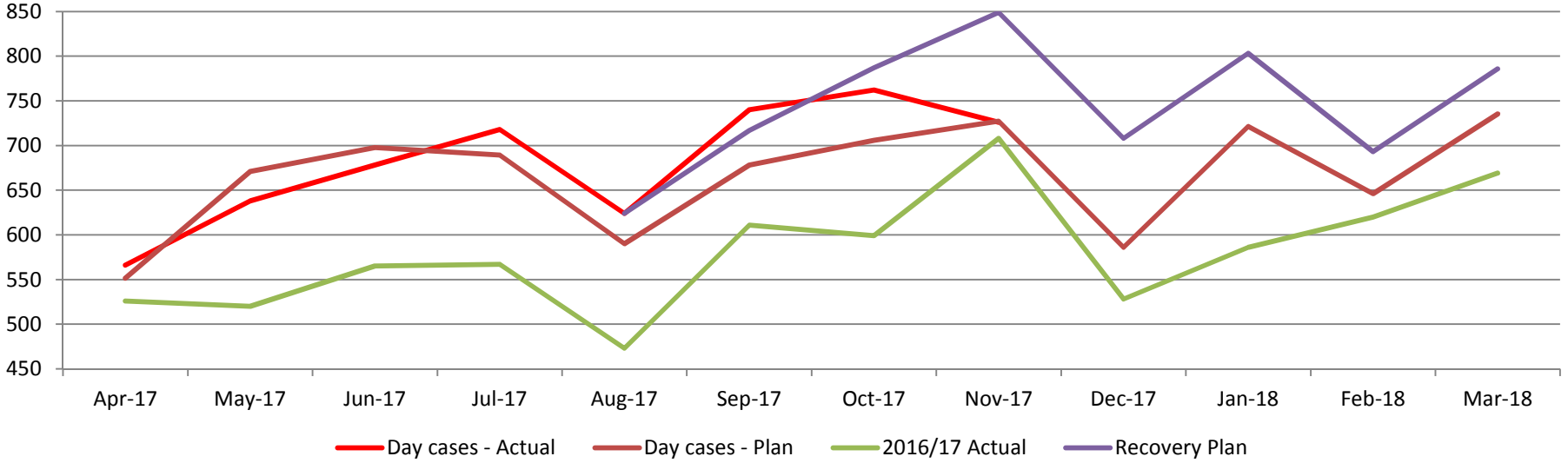
NHS Clinical Income – November 2017 £'000			
	Plan	Actual	Variance
Inpatients	3,423	3,394	-29
Excess Bed Days	107	135	28
Total Inpatients	3,530	3,529	-1
Day Cases	829	815	-14
Outpatients	663	726	63
Critical Care	266	280	14
Therapies	264	258	-6
Pass-through income	237	379	142
Other variable income	404	526	122
Block income	518	518	0
TOTAL	6,711	7,031	320

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	25,237	25,254	17
Excess Bed Days	784	384	-400
Total Inpatients	26,021	25,638	-383
Day Cases	6103	6029	-74
Outpatients	4878	4935	57
Critical Care	1956	1505	-451
Therapies	1944	1807	-137
Pass-through income	1745	2057	312
Other variable income	2970	2974	4
Block income	4144	4144	0
TOTAL	49,761	49,089	-672

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income has over-performed against plan in November by £320,000. Cumulatively, the trust is now £672,000 behind plan. The admitted patient care performance was below plan financially and on activity levels, with discharged activity 77 below target. The average tariff price for the period has decreased slightly. November has had decreased levels of activity compared with October. Case-mix in November has remained steady and elective and now makes up 42% of our income in month and year to date

	Elective/Non-Elective	Day Case
Actual Activity	602	726
Original Plan	679	727
Variance	(77)	(1)
Actual Activity	602	726
Recovery Plan	653	849
Variance	(51)	(123)

Outpatients have over-performed from an income point of due to over performance against plan in outpatient first attendances. There is still an underperformance in outpatient procedures. First and follow up outpatients are under-performing year to date and outpatient procedures are specifically underperforming as they are 16% below plan. First to follow up ratio has remained steady year to date at 2.19:1.

ACTIONS FOR IMPROVEMENTS / LEARNING

The firms have developed their recovery activity plans and are taking the actions through the Perfecting Pathway project to improve efficiency 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.

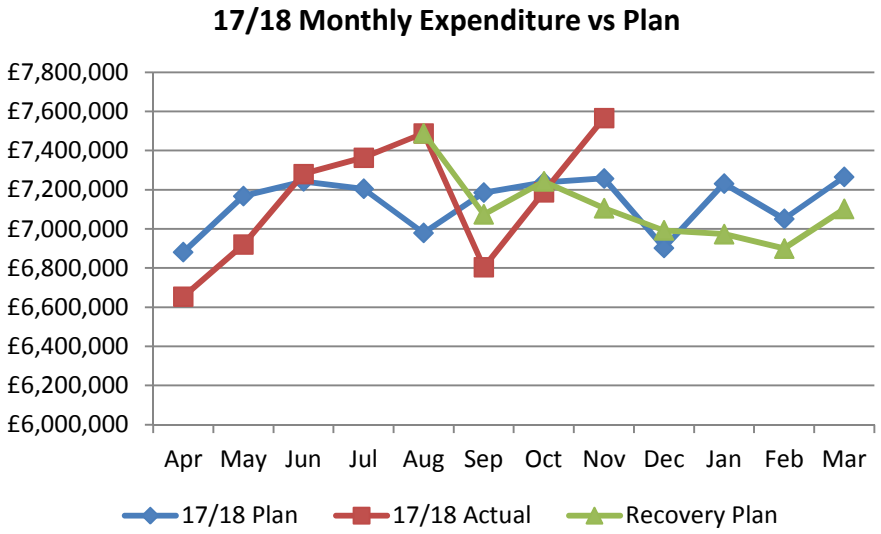
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

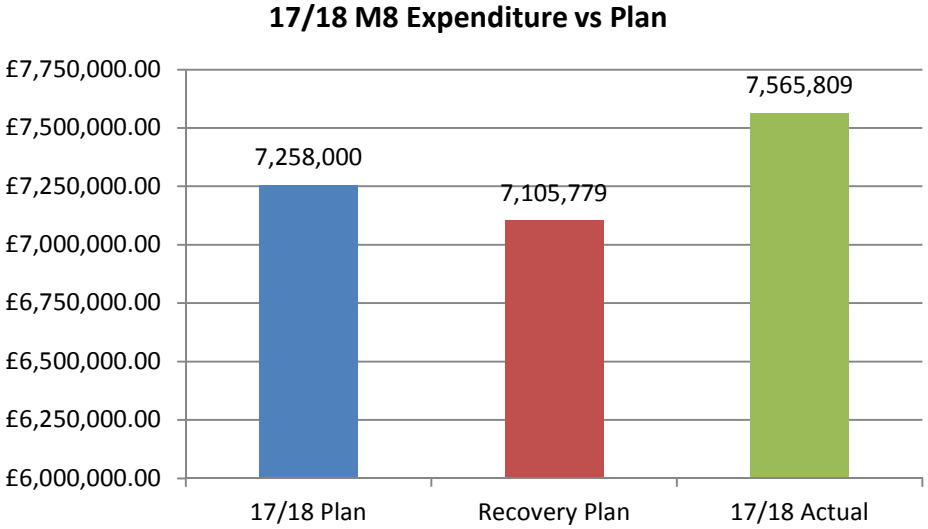
RISKS / ISSUES

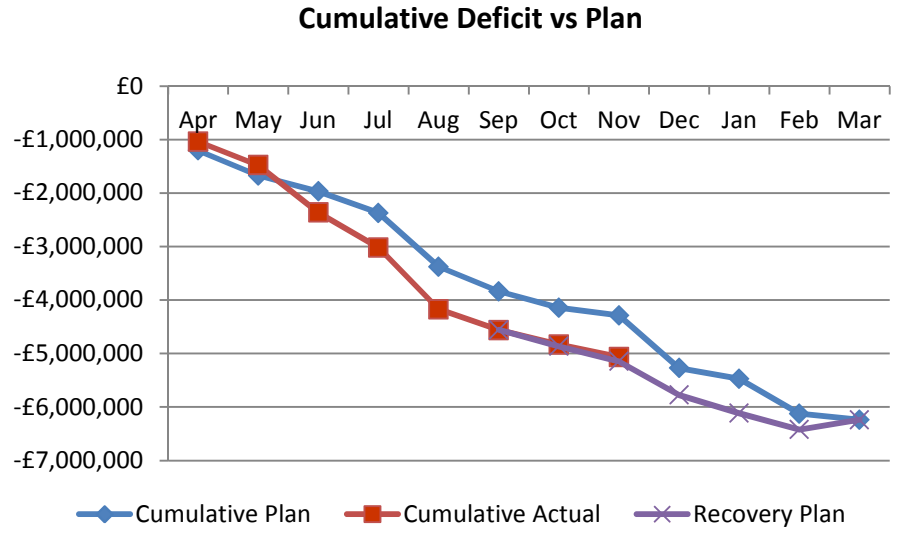
As in previous months, there remains good clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms. As noted above, a key risk 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.

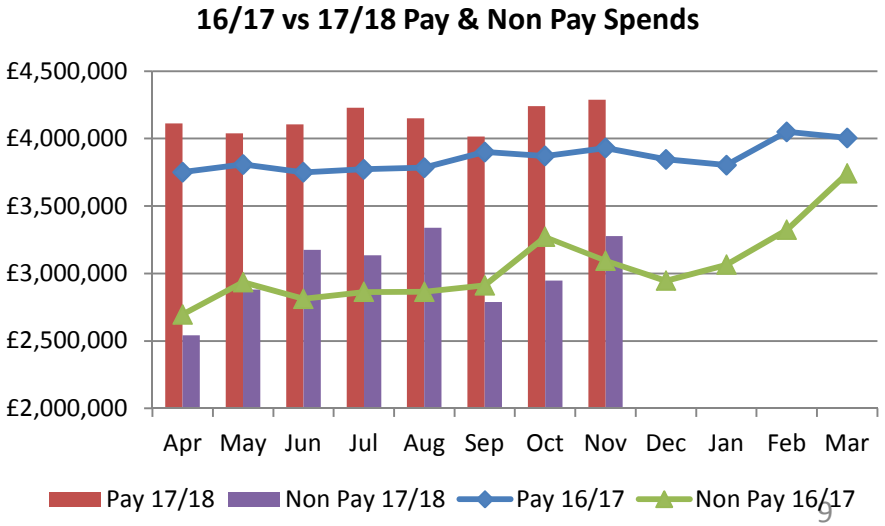
There are also key times over the next few months, where additional activity is being planned for. It will be vital to ensure that actions are taken sufficiently early to make patients aware of Christmas operating and ensure they are fit and willing to attend.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends









INFORMATION

Expenditure levels for the month were £7,565,000, which is £307,000 above the in month plan of £7,258,000 and £460,000 higher than the recovery plan of £7,105,000.

The reason for the overspend was non-pay spend being significantly above plan (£404,000), with clinical supplies being the highest area of overspend. Prosthesis and Theatres spend are the highest overspending areas with a combined overspend in month of £270,000. Non pay spend in theatres has been lower than the yearly monthly average spend for months 6 and 7 due to previously over ordering of stock, which now appears to have levelled out in month 8 seeing an increase in spend during the month. The stock count described in previous month's paper s still requires finalisation, with the results being documented and worked through to check the financial impact. This is a significant amount of manual work, which is still ongoing therefore unlikely that a result will be known at the point of the F&P Committee.

Pay spend was £260,000 higher than plan. When the pay categories are reviewed individually, agency spend was the highest spend above plan by £200,000 which has been across all staffing groups. 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 substantive spend is higher than plan. There is no single category of substantive spend which has increased significantly, with small increases month-on-month in medical, nursing and support spend.

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.

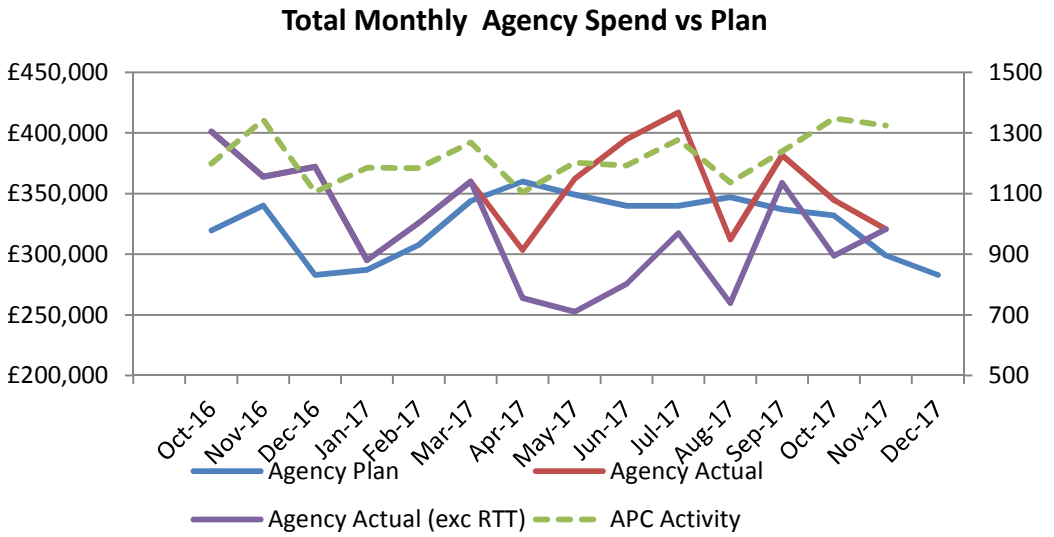
The output from the Theatres stock take will help the department to start making decisions about setting correct stock levels, which in turn will assist with forecasting spend and setting a more reflective financial plan.

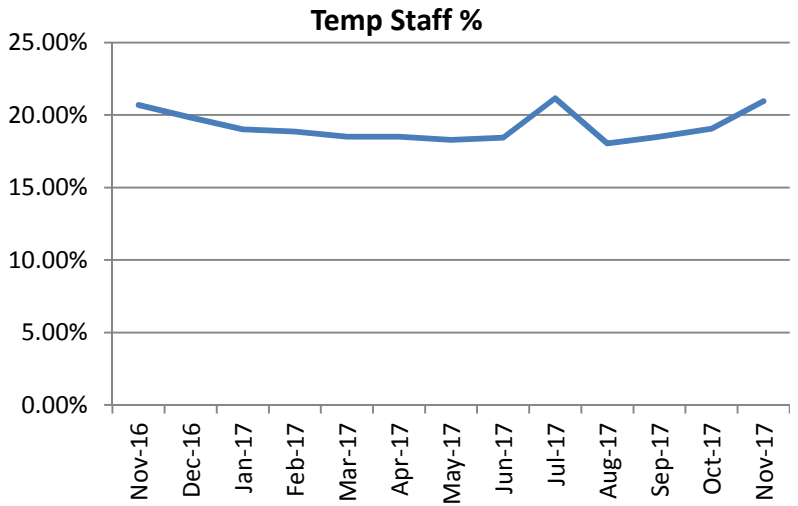
The Interim Director of Finance has been performing line by line reviews of non-pay spend with both senior finance and operational colleagues to both gain a deeper understanding of the year to date spend and ensure individuals are clear that individual budget underspends are maintained wherever possible. A similar review of pay spend is being planned over the coming month.

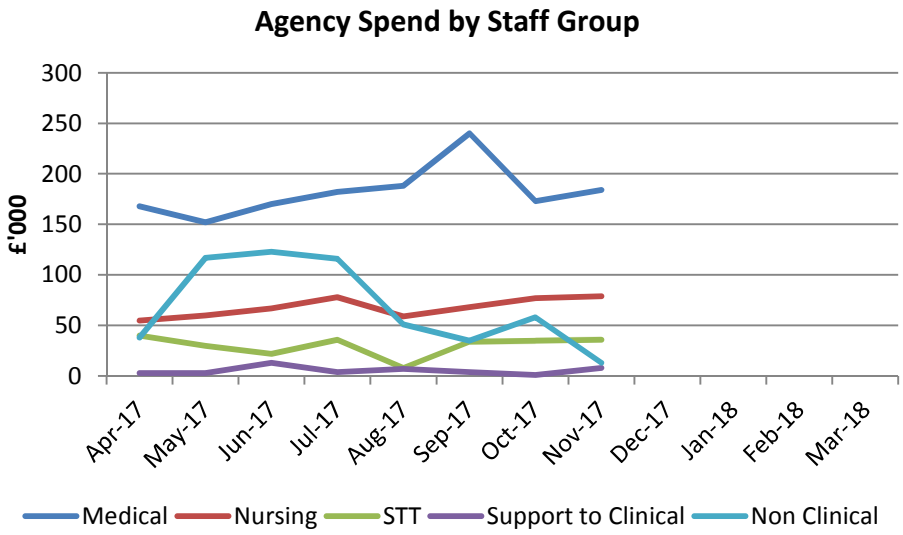
RISKS / ISSUES

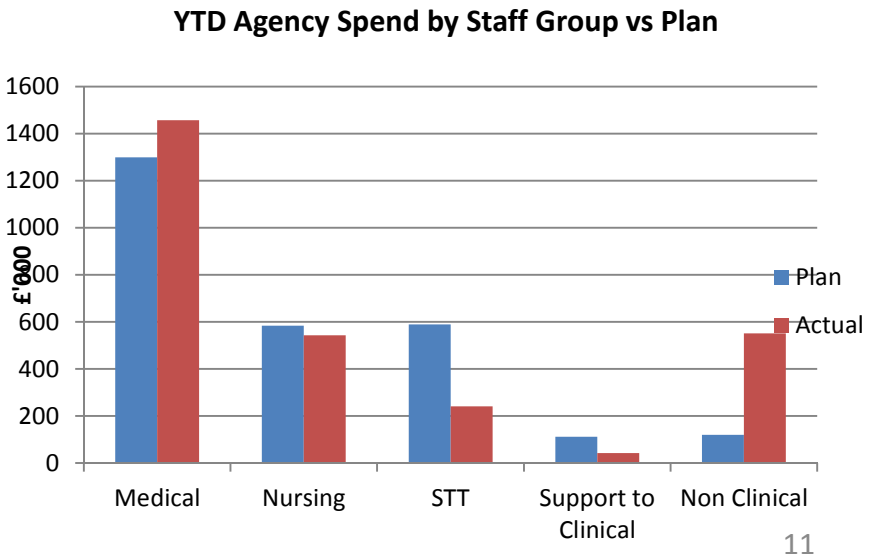
Gaining a greater understanding and control of theatre spend is essential to the recovery of the financial position, and will be mitigated via the workgroups stated above.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

The downward trend in Agency spend seen in October has continues to decrease in November (£345k to £320k) driven by a reduction in spend on non clinical staff which reduced from £58k to £13k. Presently 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. 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 Nursing in addressing use of agency continues to impact positively.

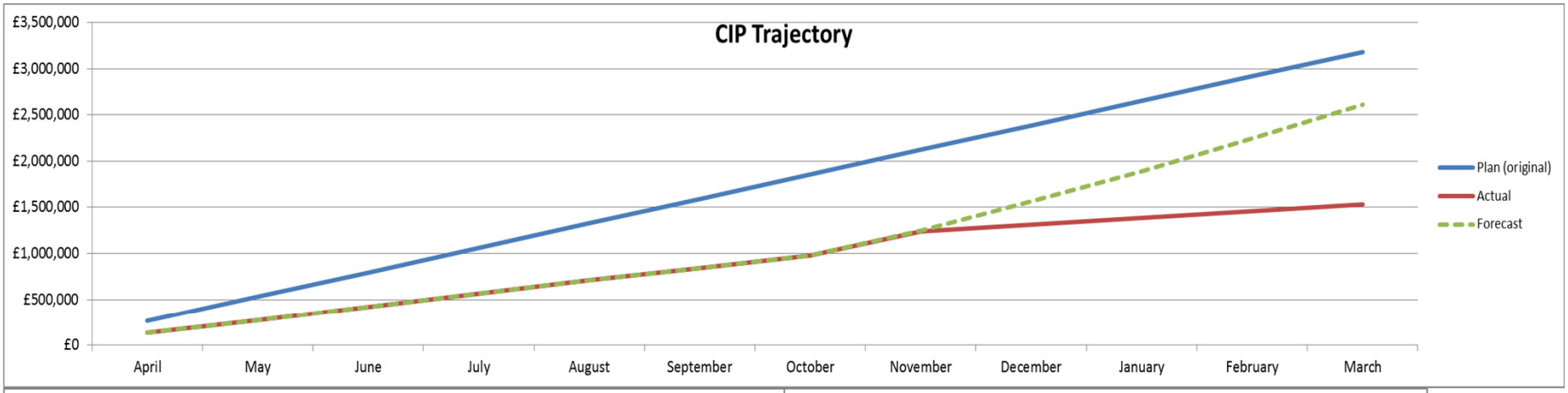
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part 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.

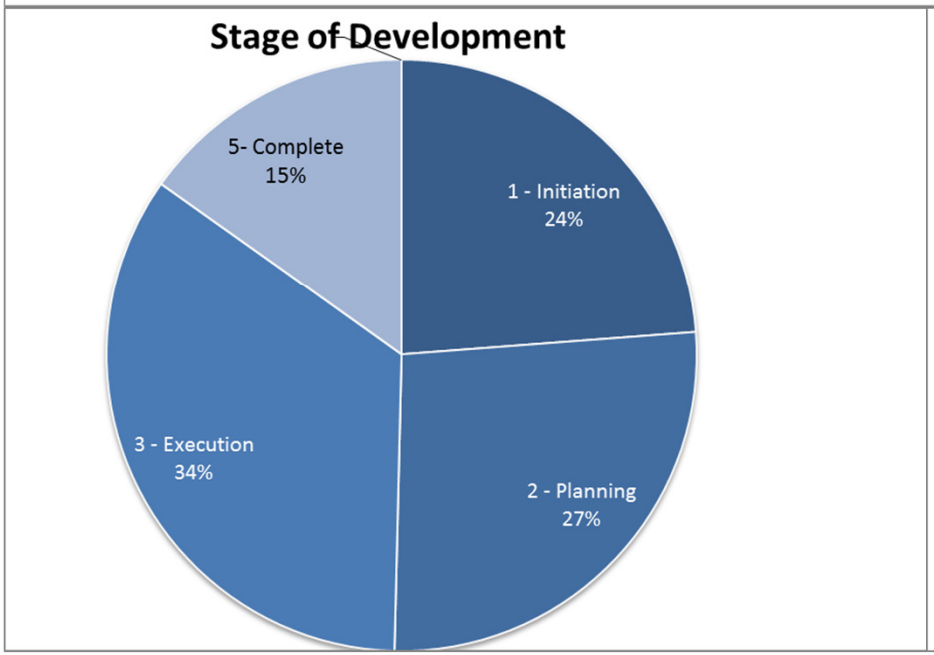
A series of meetings have been held with departmental teams in November and more scheduled during December to review staffing rotas and corresponding pay, bank and agency expenditure.

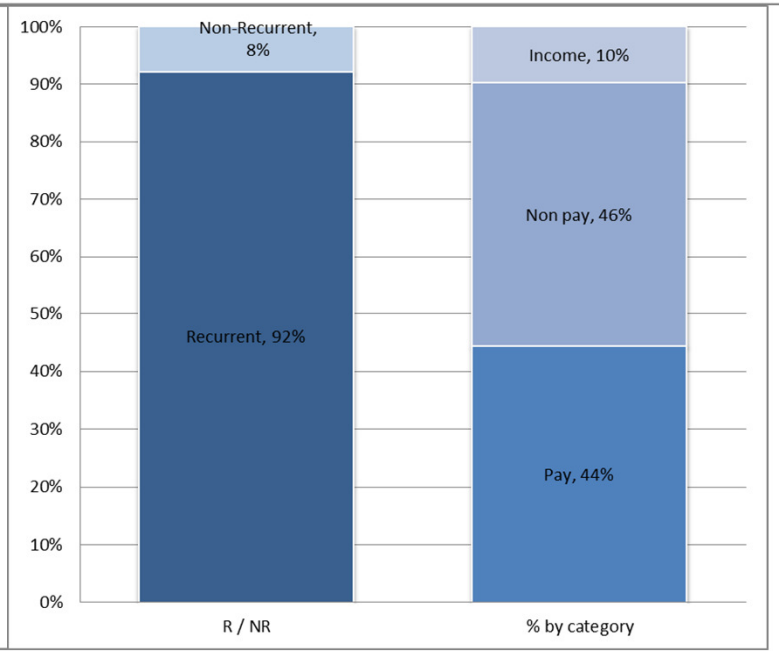
RISKS / ISSUES

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 November, the Trust has recognised £1,242,000 of CIP savings, against a plan of £2,104,000, a negative variance of £862,000.

£180,000 (12%) of savings to date are non-recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,632,000 against an original plan of £3,191,000.

The current plan contains 10% of income related schemes with the remainder of the plan split 46% non pay and 44% pay. Within the forecast position 15% of the savings have been completed, 34% are at the execution stage, 27% planning and 24% initiation stage. The detail by division is shown below;

	Original Plan	Revised Plan	Actual	Forecast	Forecast vs Revised Plan Variance	Forecast vs Original Plan Variance	YTD Plan	YTD Actual	YTD Variance
Division 1	£1,362,500	£1,422,600	£701,140	£1,200,320	-£222,280	-£162,180	£948,400	£668,017	-£280,383
Division 2	£851,270	£471,270	£138,129	£588,230	£116,960	-£263,041	£317,513	£138,129	-£179,384
Division 3	£42,875	£42,875	£42,878	£42,878	£3	£3	£28,583	£28,584	£0
Division 4	£160,000	£159,997	£138,397	£166,811	£6,814	£6,811	£106,665	£93,123	-£13,542
Corporate	£763,709	£563,709	£485,675	£553,548	-£10,162	-£210,162	£375,806	£314,706	-£61,100
Grip and Control	£0	£29,646	£0	£0	-£29,646	£0	£0	£0	£0
Productivity and Efficiency	£0	£78,300	£0	£59,400	-£18,900	£59,400	£0	£0	£0
TOTAL	£3,191,354	£2,768,398	£1,506,219	£2,611,186	-£157,212	-£580,168	£1,776,968	£1,242,559	-£534,409

ACTIONS FOR IMPROVEMENTS / LEARNING

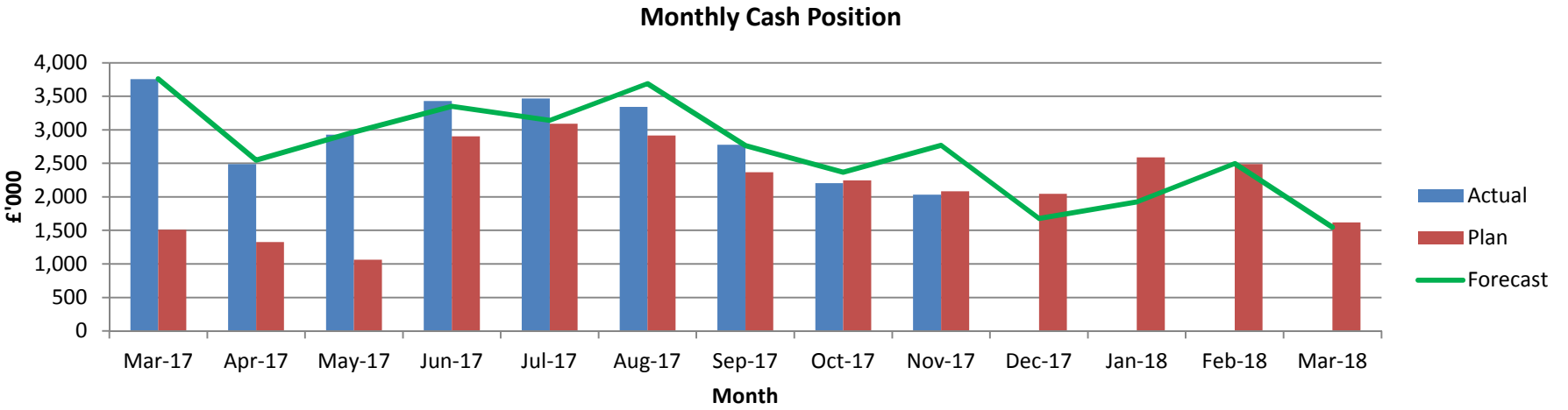
The schemes which specifically require increased focus to ensure the full CIP is delivered are;

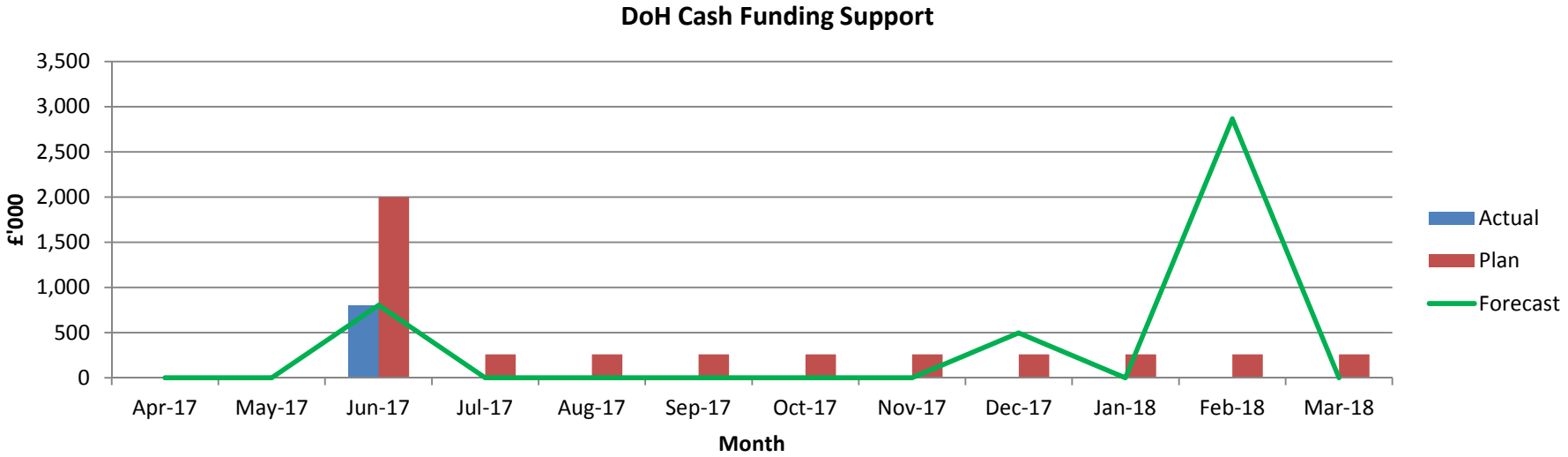
- Theatres stock management and rationalisation
- Nurse staffing review
- Implant rationalisation – ensure compliance against the agreed framework
- Other non pay consumables – rationalisation and product changes
- Coding improvements

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 was fractionally (£48k) below planned levels at the end of November, as receipts have continued to underperform against expectations . And unfortunately this tend has continued into December as well.

Due to the reduction in cash, liquidity levels within the Use of Resources Rating have dropped to 4, the lowest level. Cash support has been requested from the Department of Health - please see below for more details.

The Trust received its first cash loan of £804k from the Department of Health on 12th June 2017 as previously advised to the Committee, and for information its second loan of £498k has now been taken out in December 2017. A substantial further loan is expected to be required in February, due to the present financial position, and levels of activity.

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 2017/18. 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 for cash from the Department of Health to be actioned.

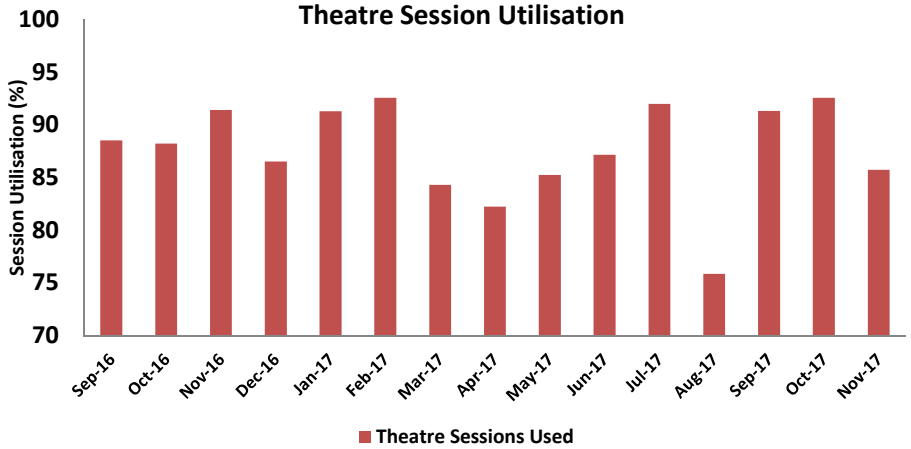
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DoH not approving a cash loan or approving a lower than requested amount.

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 weekly 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

November saw a decrease in list utilisation of 85.71% compared to the previous month.

Available lists continue to be offered out as part of the '6-4-2' weekly scheduling meeting to ensure full maximisation of funded lists. Team are required to confirm within 1 week to ensure that should they not be picked up staffing can be adjusted and the Theatre session closed.

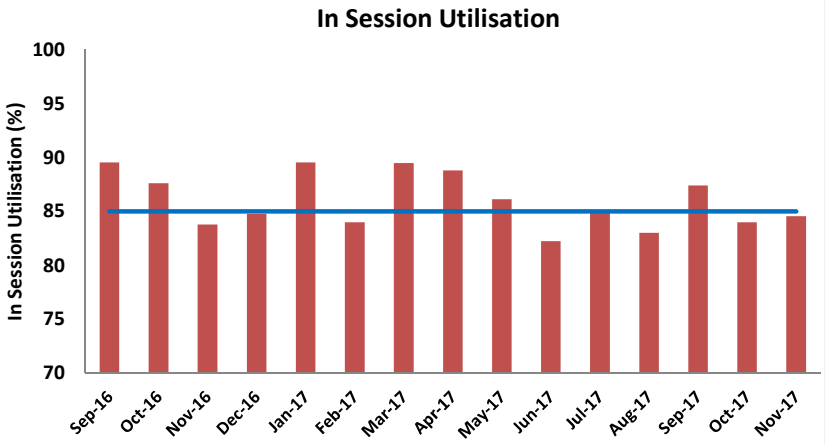
Weekend sessions have been planned throughout the remainder of the year with good uptake from consultants. Throughout November 13 additional 2 session Theatre list were delivered in comparison to October which delivered 12.

Since the start of November the team have introduced a theatre look back meeting to ensure any issues, trends or themes are addressed.

RISKS / ISSUES

Whilst the teams continue to aim to reutilise lists up to the week before they are planned , the risk remains that they may not get filled and this could have enabled a Theatre to be closed, i.e. reduce staffing costs.

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.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 84% in November, a slight improvement on the previous month.

The number of cancelled operations on the day were 3 for the month compared to 6 in October. The number of over cancellations continued to reduce however the main area of focus continues to be cancellations before the day.

A weekly pre-assessment working group will commence wk beg 8/1 and this will be the main focus.

A weekly look back meeting has been established to focus on utilisation and cancellations on the day, to better understand the themes and implement improved processes once causality has been identified.

This work is being carried out daily as part of the 9am huddle which reviews utilisation for the previous day and themes are discussed and actions logged. The team are also exploring Phase 2 of Theatreman to further enhance the reports.

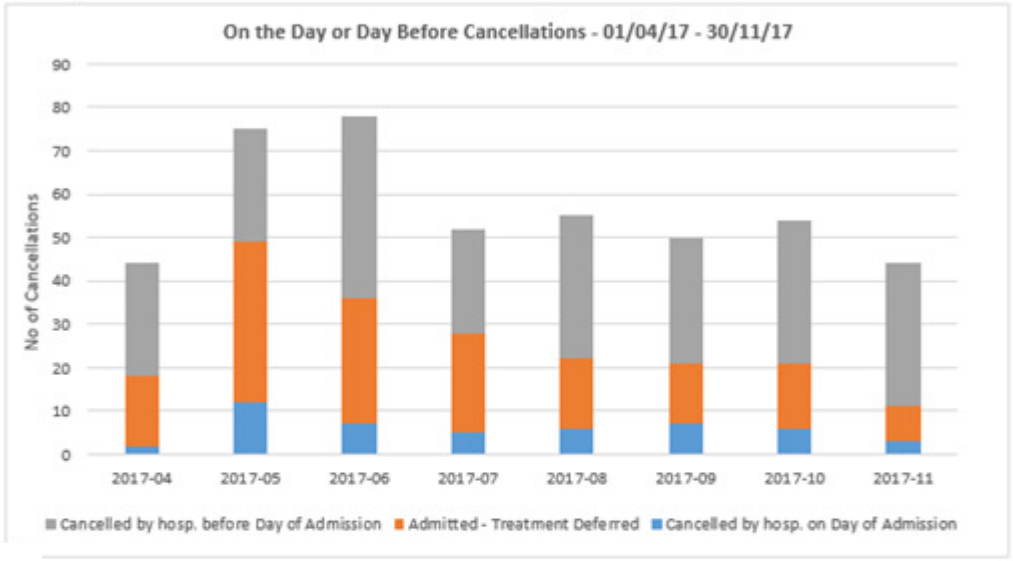
RISKS / ISSUES

Staff vacancies within theatres – on-going recruitment process is in place

Cancellations before the day of surgery still remains the highest number and therefore poses the biggest risk.

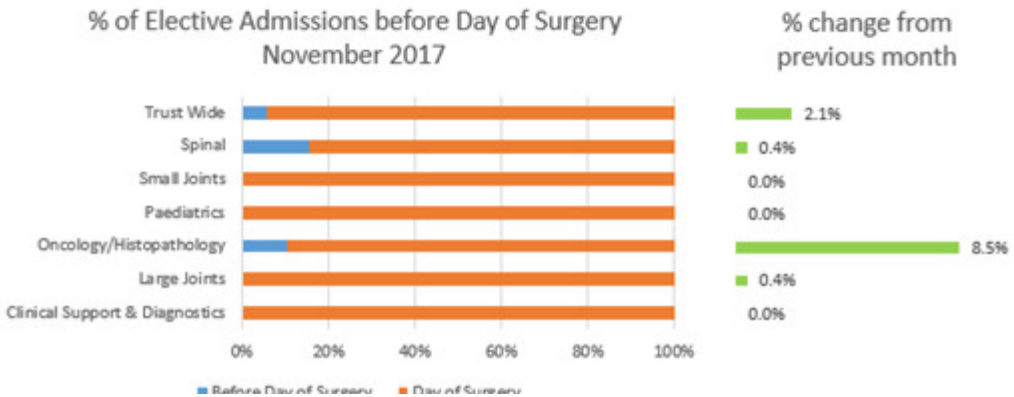
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that through the hospital in an efficient manner

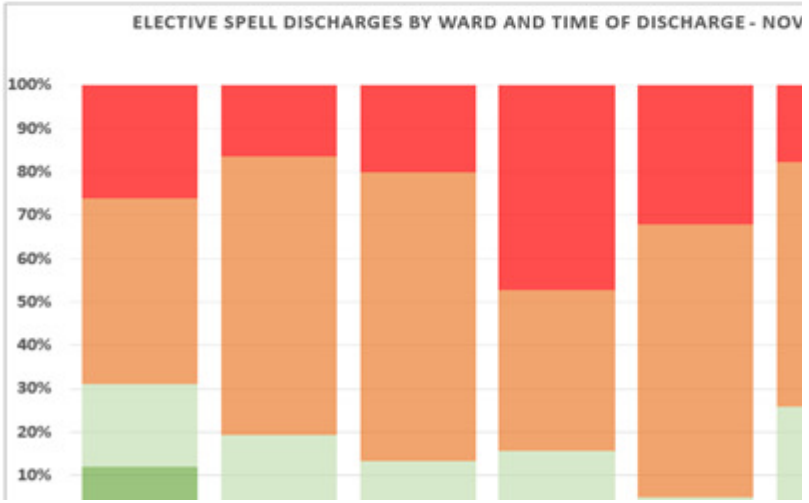
Hospital Cancellations



Sum of Total	Cancellation Categ		
Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission
2017-04	2	16	26
2017-05	12	37	26
2017-06	7	29	42
2017-07	5	23	24
2017-08	6	16	33
2017-09	7	14	29
2017-10	6	15	33
2017-11	3	8	33
Grand Total	**48**	**158**	**246**

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. As this is a recurring theme the look back meeting will investigate the themes and causes and as part of the rectification plan the teams will be contacting patients to understand the reasons.

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers.

Following on from the 12th October multi-disciplinary POAC workshop the Clinical Service Manager is reviewing the structure with the team to ensure that staffing and patient processes are robust to meet the needs of any future changes. A weekly meeting has been set up and will commence on the 8th January to help support this process.

To further strengthen the POAC model the team now sit within Division 2, this now sits closer to the Anaesthetic service.

ACTIONS FOR IMPROVEMENTS / LEARNING

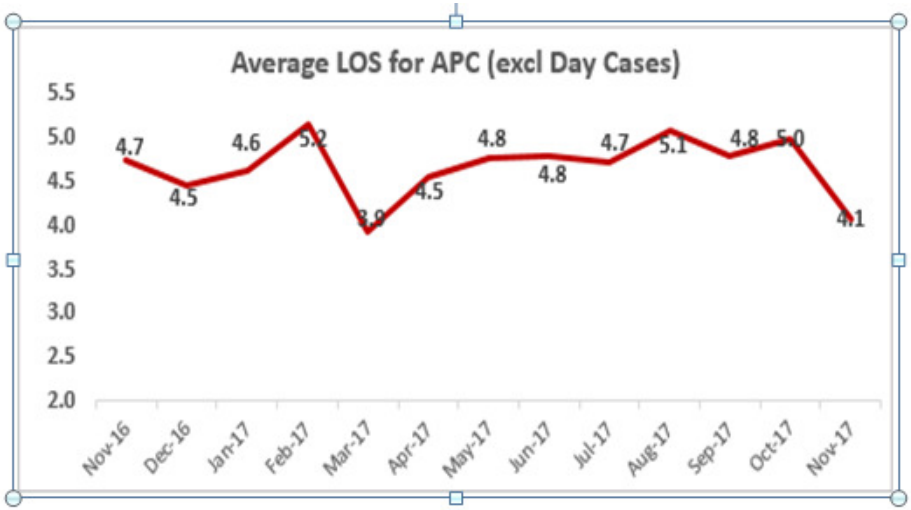
A daily update review by operational management of forward bookings has been established and the 6-4-2 and a daily 8.30am Operations huddle has continued. Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

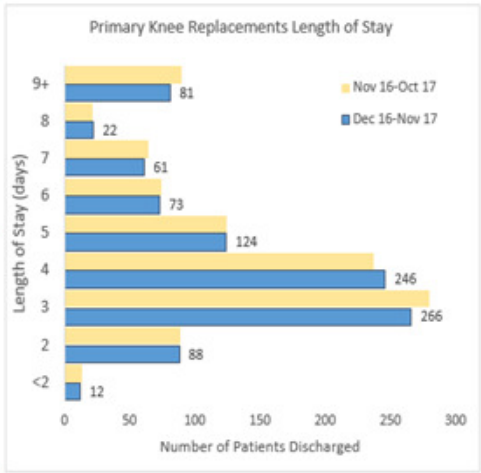
Priorities are now being agreed as part of Perfecting Pathway which will help to deliver some of the key deliverables discussed at the POAC workshop .

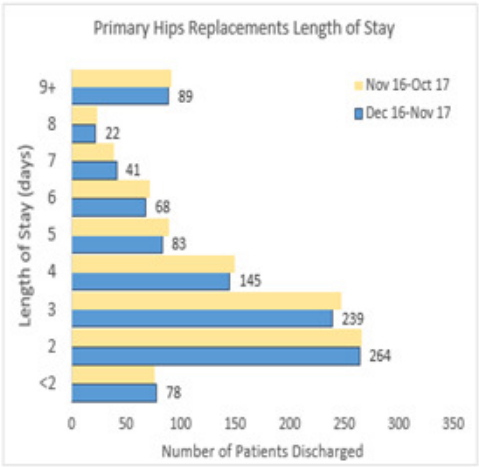
RISKS / ISSUES

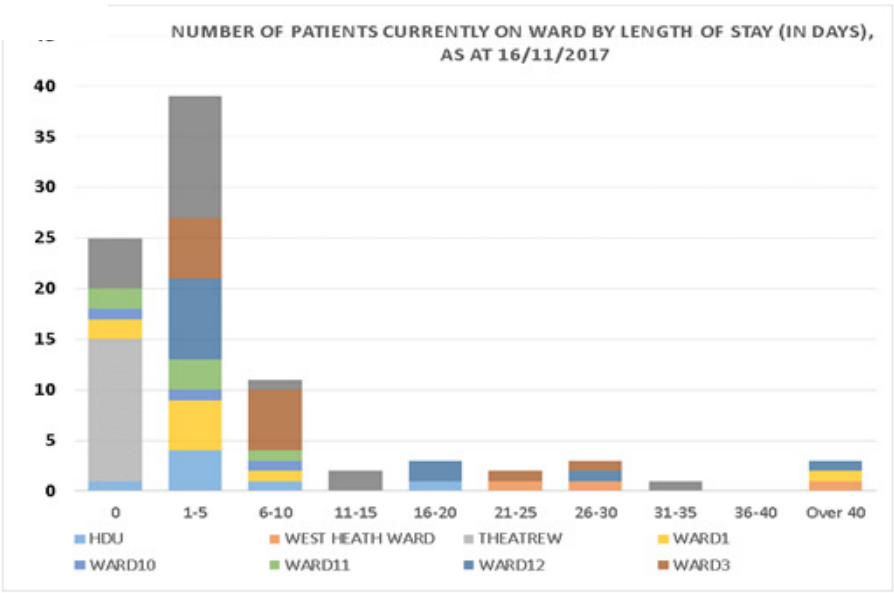
Continued high levels of cancellations due to medically unfit patients

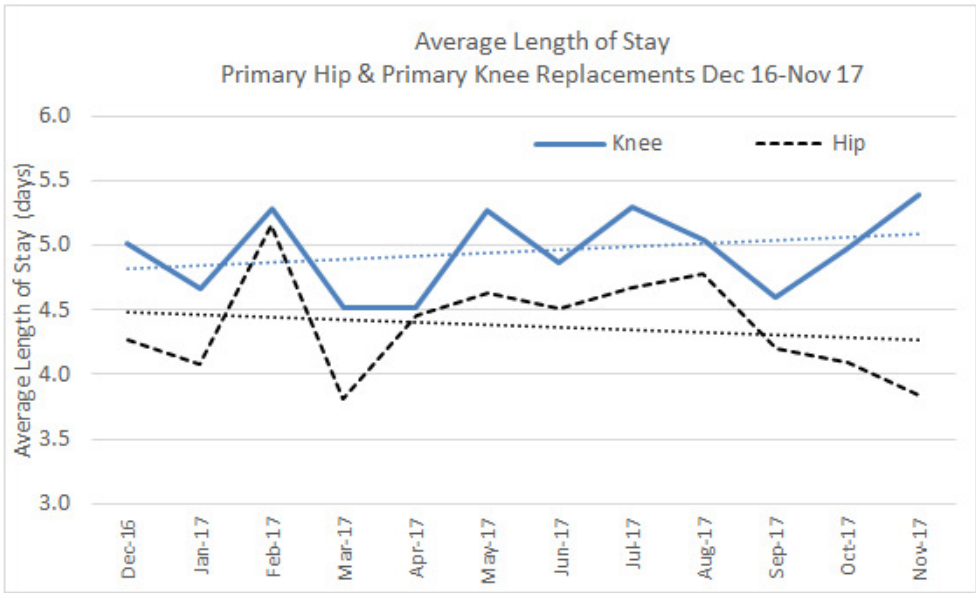
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors, Clinical Service Leads and Clinical Service Managers, work continues weekly to increase activity levels against the recovery plan.

In December 2017 as part of Perfecting Pathways a new concept Gold/Silver was implemented to support the improvement in the flow of patients and particular around increasing the use of the discharge lounge.

Red2Green with a newly formed operational discharge meeting reviewing LOS has been re-established led by the nursing team .

ACTIONS FOR IMPROVEMENTS / LEARNING

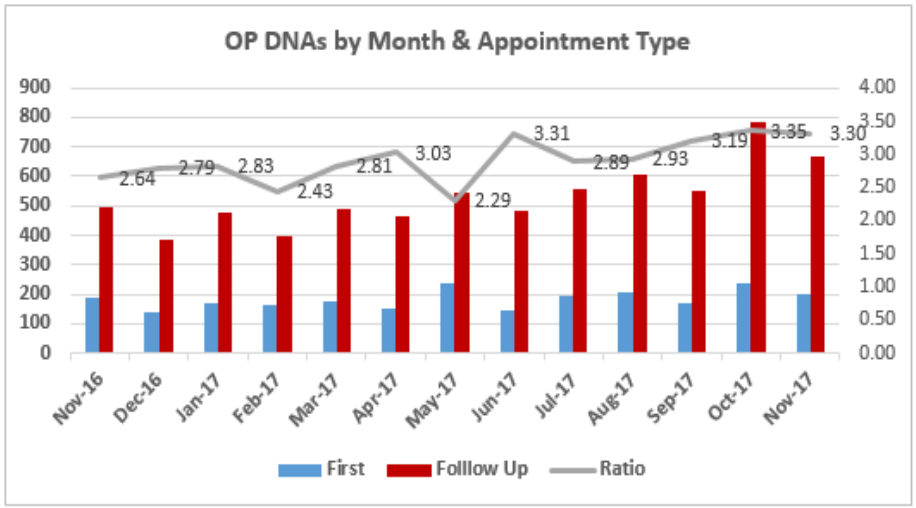
Work continues to strengthen the Arthroplasty consultant led ward rounds so that patients are seen daily. Further work continues to develop with the Arthroplasty team which includes feasibility around a dedicated Theatre environment , freeing up adjacent accommodation to house the Arthroplasty team and work around pre-assessment. A project group to support this will start in January 18.

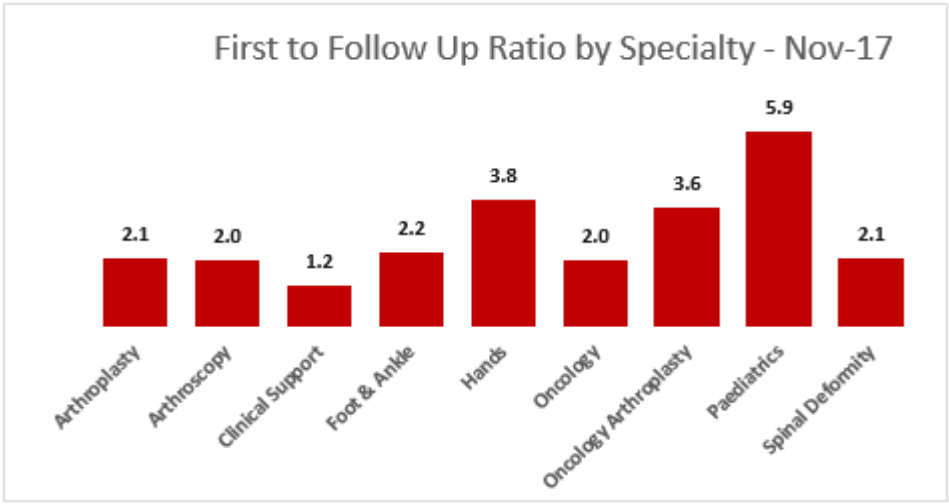
Work has also commenced to increase the number of patients who are treated on the Rapid Recovery Pathway for Knees with an improvement seen in November 17.

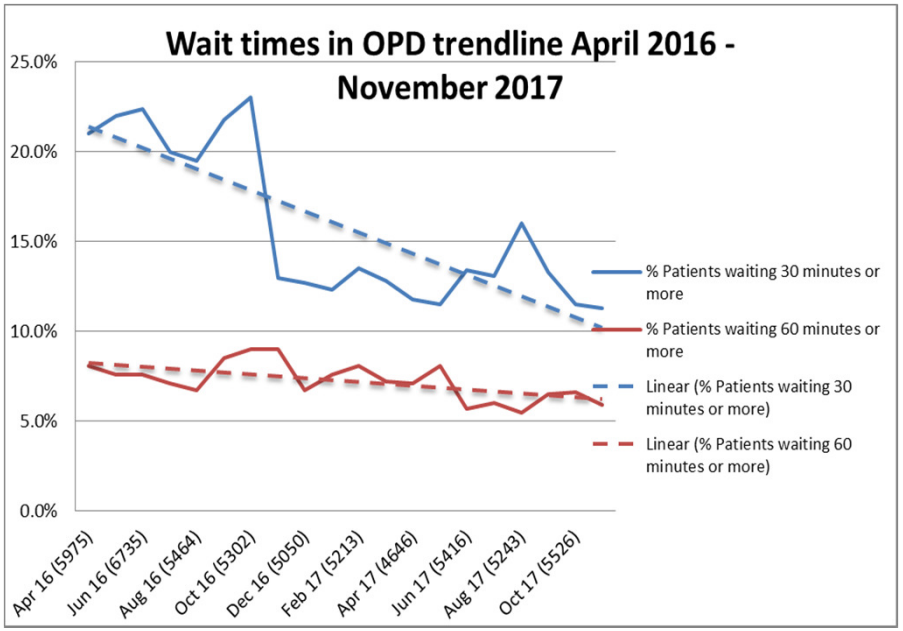
RISKS / ISSUES

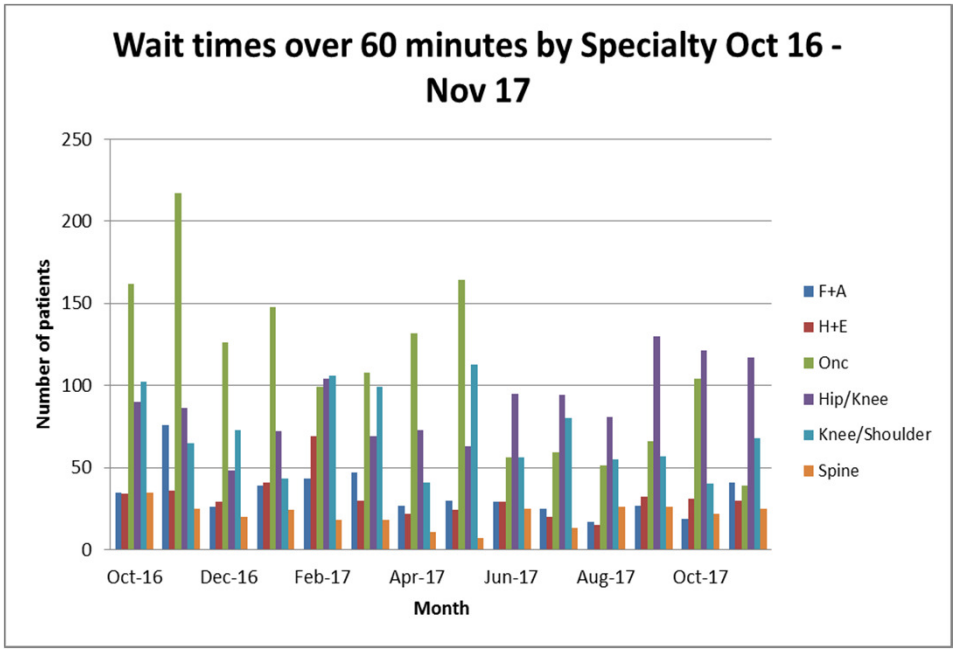
Over the next few months a more focussed approach will be in place to actively monitor and reduce LOS.

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









INFORMATION

The process for sharing learning in relation to clinic delays is reviewed and shared with the Clinical Service Managers along with the clinic delay data. In October 17 a newly formed Outpatient Operational Group was established and any issues that require operational management input are discussed at this forum.

In November 2017 there were 14 (13 main OPD, 1 Paediatric OPD) incident forms completed to highlight clinics running more than 60 minutes late. The monthly audit identified 3 main contributing factors for delays: 1) Clinic Overbooked for the Number of Staff 2) Complex Patients requiring more time than was planned and 3) consultant/clinician delay

It should be noted that there has been no incidents regarding any delays or missing medical records in November 17.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions from November's Audit include;

- All incidents to be shared with / allocated to CSM / CSSMs for investigation, feedback and action weekly at the Division 1 Operational Meeting
- Work underway to validate data quality related to clinics set up on InTouch to ensure they map to the correct locations
- Work underway with the Estates department to improve the environment on paediatric outpatients to ensure InTouch can be used effectively and in real time
- Meeting held w/c 1 January to discuss the paediatric oncology clinic template which is still problematic and incurring delays
- Rewriting and launch of new SOP in relation to clinic cancellation and reductions
- Project to implement management of clinician annual leave through Allocate has started and being managed by Division 1

RISKS / ISSUES

Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure (see above actions) to be monitored via OPD Operational Group

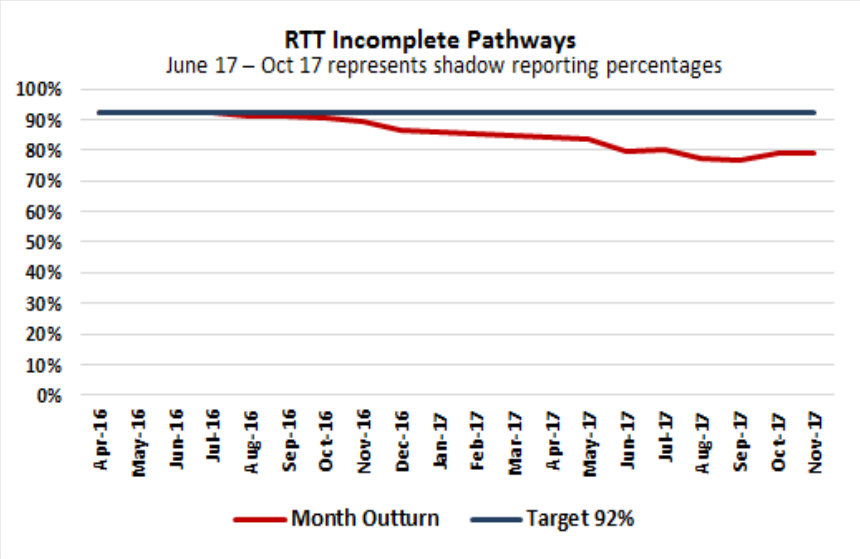
14. Treatment targets – This illustrates how the Trust is performing against national treatment target –

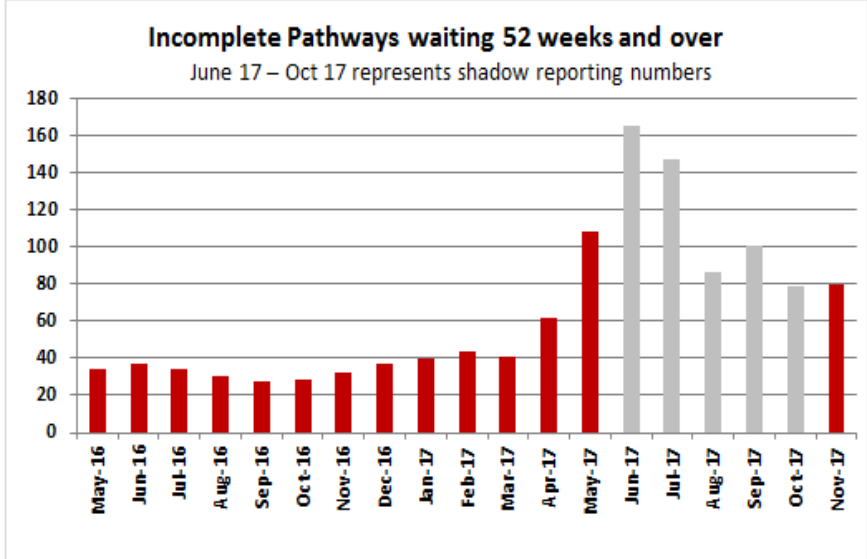
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
Month	MRI	CT	US	Total	MRI	CT	US	Total	over 6 weeks	under 6 weeks	Total	% under 6 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	99.7
May-17	784	79	296	1159	781	176	326	1283	4	1155	1159	99.7
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	99.5
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
Oct-17	912	99	416	1427	768	216	353	1337	4	1423	1427	99.7
Nov-17	789	106	469	1364	977	226	441	1644	12	1352	1364	99.1

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





			Reported Month						Reported Quarter					
Target Name	National Standard	Indicative Nov	Oct	Sept	August	July	Jun	May	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	100.00%	95%	100%	100%	100%	95.65%	100%	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	91.70%	100%	75%	100%	100%	91.67%	100%	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100.00%	100%	100%	100%	100%	100%	100%	97.40%	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		n/a
62 day (traditional)	85%	80%*	100%	100%	100%	37.50%	71.43%	60.00%	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	90.90%	81%	83%	75%	100%	100%	100%	88.9%	1	9	100%	0	4
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
No. day patients treated 104+ days		0	0	0	0	3	1							

* indicative performance- November performance reported Monday 8th Janaury 17

14. Referral to Treatment snapshot as at 30th November 2017 (Combined)

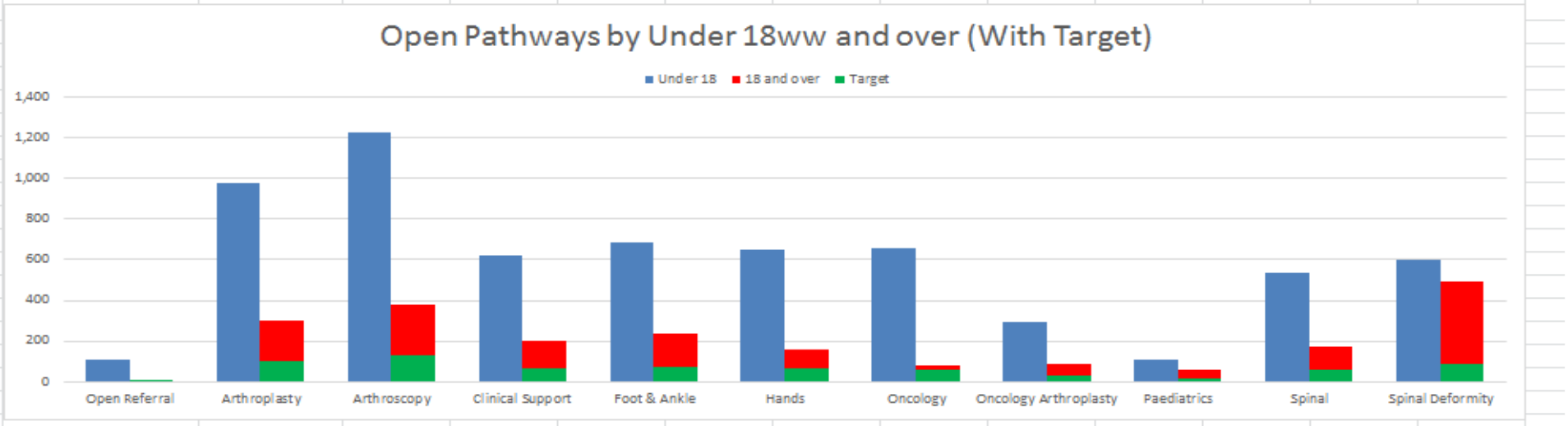
Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at: 2017-11-30

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	**3,547**	92	518	663	329	380	323	355	160	61	375	291
7-13	**2,347**	7	398	446	233	250	236	218	101	45	238	175
14-17	**959**	0	138	184	79	95	86	109	60	18	80	110
18-26	**1,044**	0	166	220	83	128	102	24	47	36	68	170
27-39	**602**	0	93	105	68	58	42	3	25	19	39	150
40-51	**163**	0	18	16	9	16	7	1	8	7	12	69
52 weeks and over	**84**	0	3	0	2	5	3	0	1	1	5	64
Total	**8,746**	99	1,334	1,634	803	932	799	710	402	187	817	1,029

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**6,853**	99	1,054	1,293	641	725	645	682	321	124	693	576
18 and over	**1,893**	0	280	341	162	207	154	28	81	63	124	453
Target	**700**	**8**	**107**	**131**	**64**	**75**	**64**	**57**	**32**	**15**	**65**	**82**

Performance against Target (92.0%)	78.4%	100.0%	79.0%	79.1%	79.8%	77.8%	80.7%	96.1%	79.9%	66.3%	84.8%	56.0%



INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

	Total Pathways	Over 18 Weeks Pathways	Over 52 Week Pathways
Admitted	949	395	12
Non Admitted	1464	338	16
Incomplete	8730	1832	80

The above figures have been submitted nationally for the ROH RTT performance for November 2017 – 79.01%

ACTIONS FOR IMPROVEMENTS / LEARNING

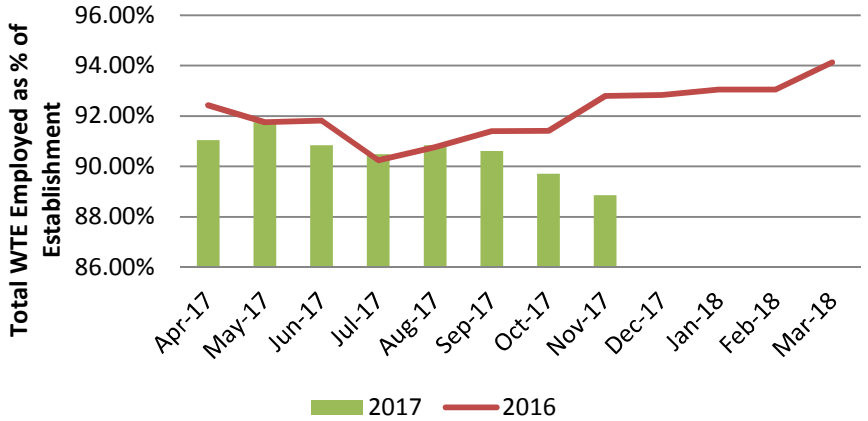
The team continue to concentrated on any patient over 40weeks. The greater focus has been on patients on a admitted pathway between 27-39 weeks and non admitted over 18weeks. Good progress has been made by all the teams especially Oncology who are now achieving over 92%.

RISKS / ISSUES

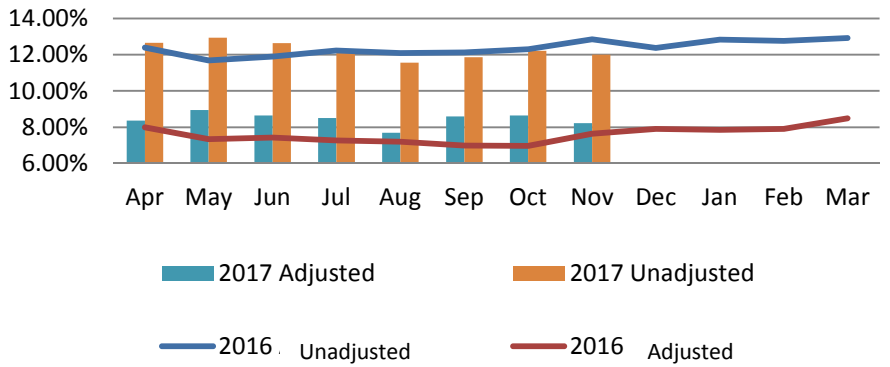
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . We are currently on track with the BWCH trajectory and the non-spinal deformity patients over 52 weeks continues to reduce.

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

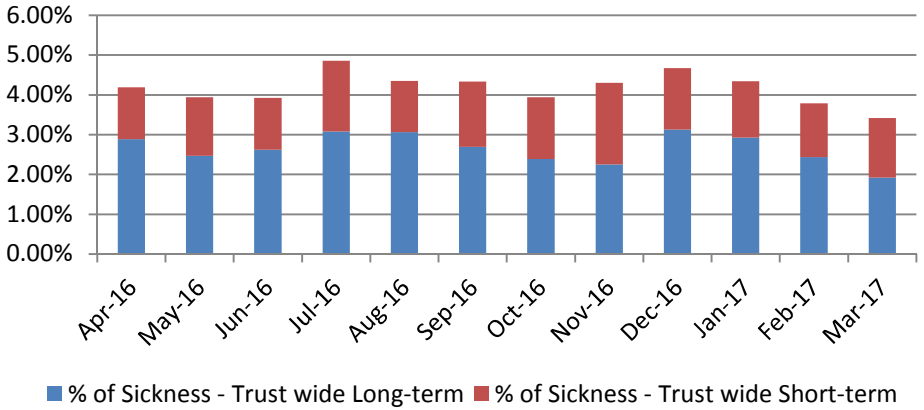
Staff in Post v Establishment



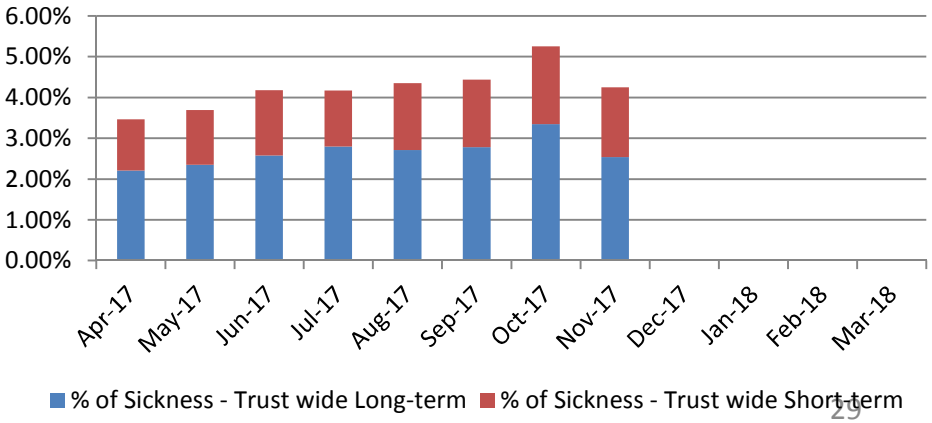
Staff Turnover



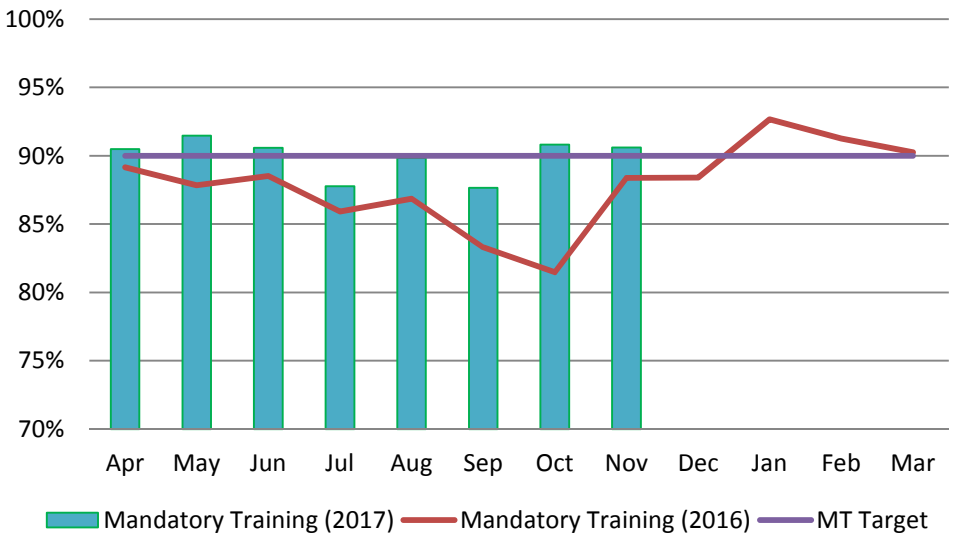
Sickness % - LT/ST (2016)



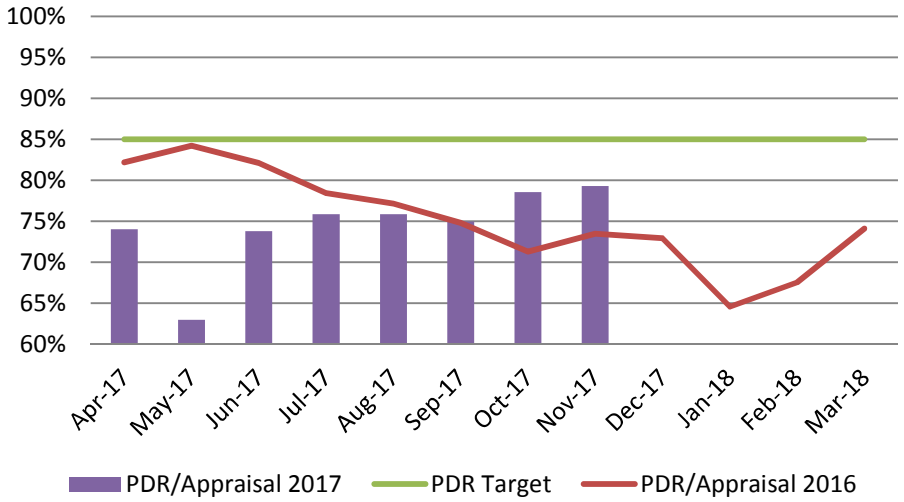
Sickness % - LT/ST (2017)



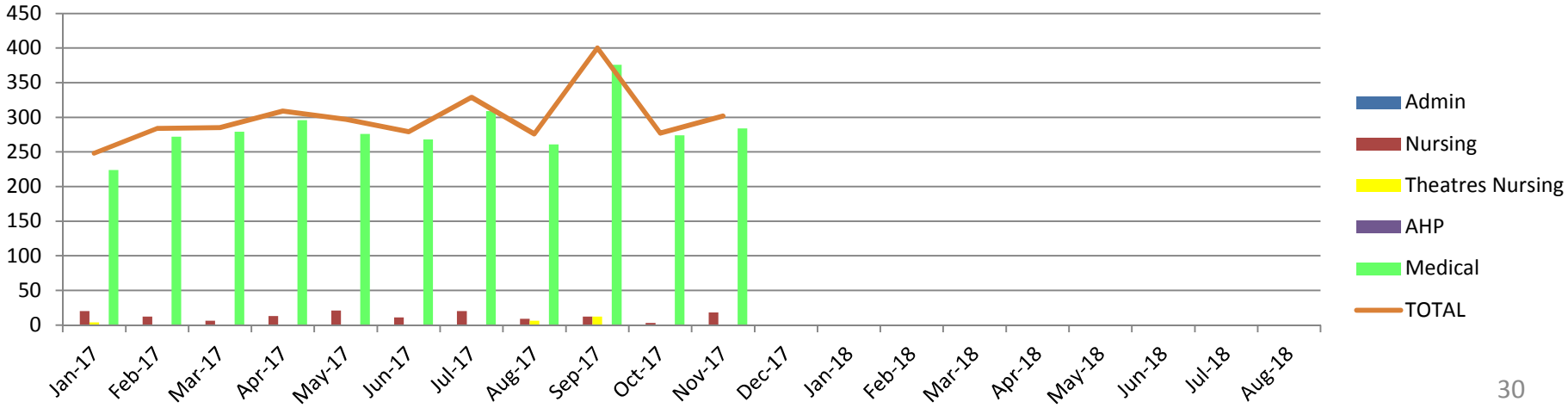
Mandatory Training



PDR/Appraisal



Agency Breaches



INFORMATION

November saw a mixed picture in terms of workforce performance across a range of indicators, with improvement in PDR, Turnover and Sickness, Mandatory Training remaining steady but the vacancy position in decline.

November saw sickness absence decrease by 1% to 4.25% in month, with decreases both in long and short term absence. The 12 month average figure again remained in amber at 4.32%. We are aware that there were a number of long term absentees returning during November.

The Trust's vacancy position dipped slightly again on last month's figure by 0.85% to 88.86%. We have remained in red for November 2017, and is typical of the vacancy position since June.

Mandatory training dipped slightly by 0.22% in November, but the Trust remains green at 90.61%. Work is continuing 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, further improvement in this position is expected going forwards.

Performance relating to appraisals in November improved again by 0.74% taking the position to 79.29%. The continued release of provisional data to Clinical Service Managers early in the month is felt to be helpful in improving both the accuracy and transparency of reporting: this system will therefore continue in order to ensure that our data are accurate. Although November's position is still red, it does reflect an improvement.

The November turnover figures both decreased, although neither is a particular cause for concern. The unadjusted turnover figure (all leavers except doctors and retire/ returners) decreased by 0.20% on last month to 12.01%., and the adjusted turnover figure ("true leavers" meaning "voluntary resignations") decreased by 0.41% to 8.23% remaining green in month.

In relation to agency breaches, the position increased slightly in relation to medical staff as forecast due to the arrival of middle grade doctors in spines and paediatrics. The 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 Nursing breaches also increased by 15 during November.

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.

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.

The return to amber for mandatory training is likely to result in the continuation of the contract performance notice by our commissioners.

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.

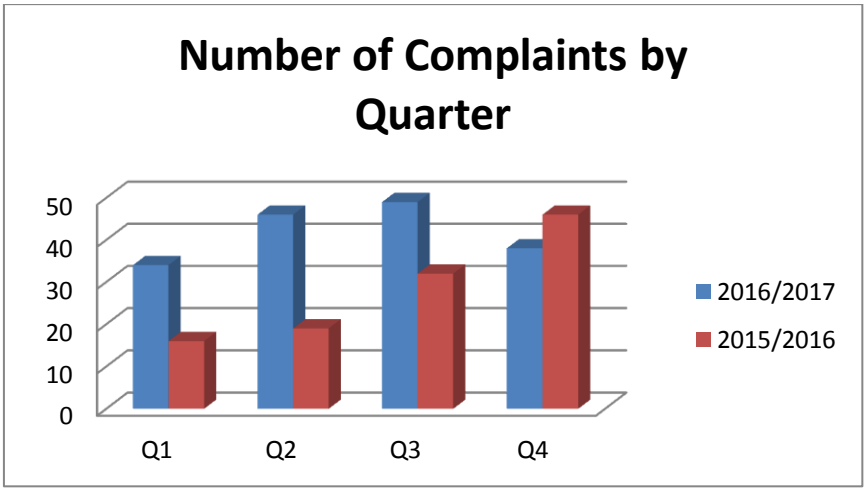
Figure 1: Numbers of complaints received 2014/2015

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

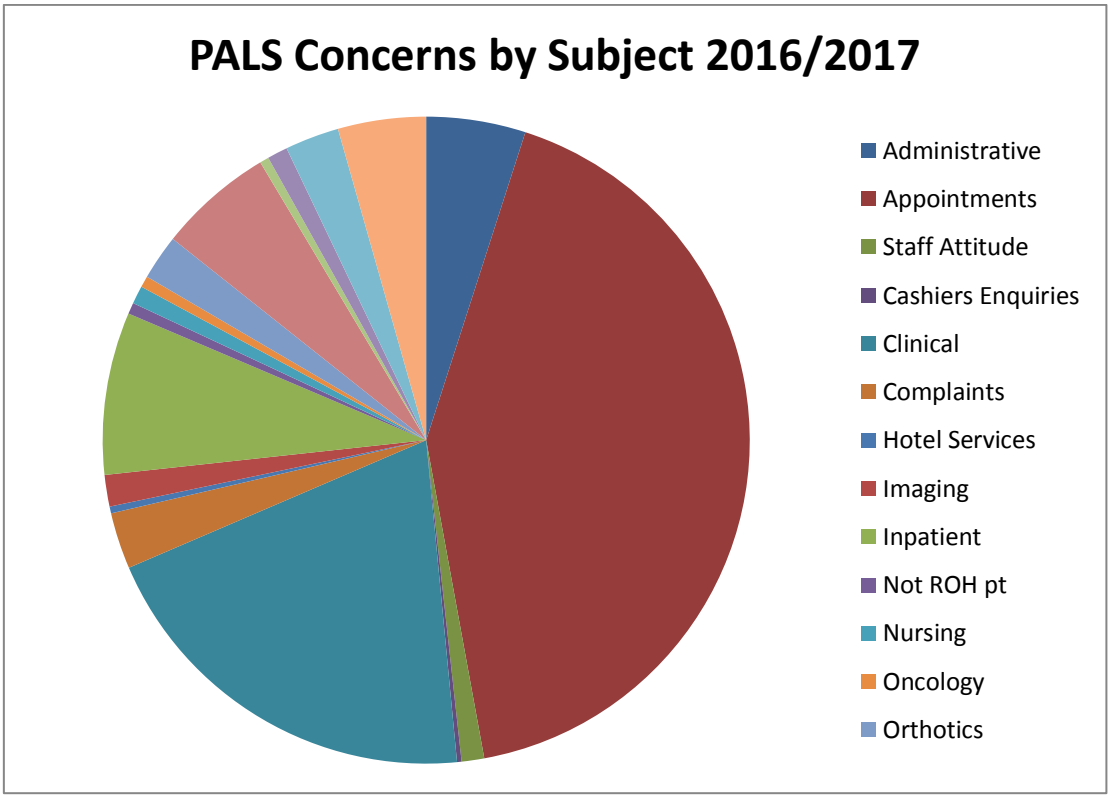


The number of complaints increased in each of the first three quarters of the year and declined in the last quarter compared with the previous year. The significant rise in complaints identifies issues that the Trust needs to improve but also offers assurance that patients and families are aware of the 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

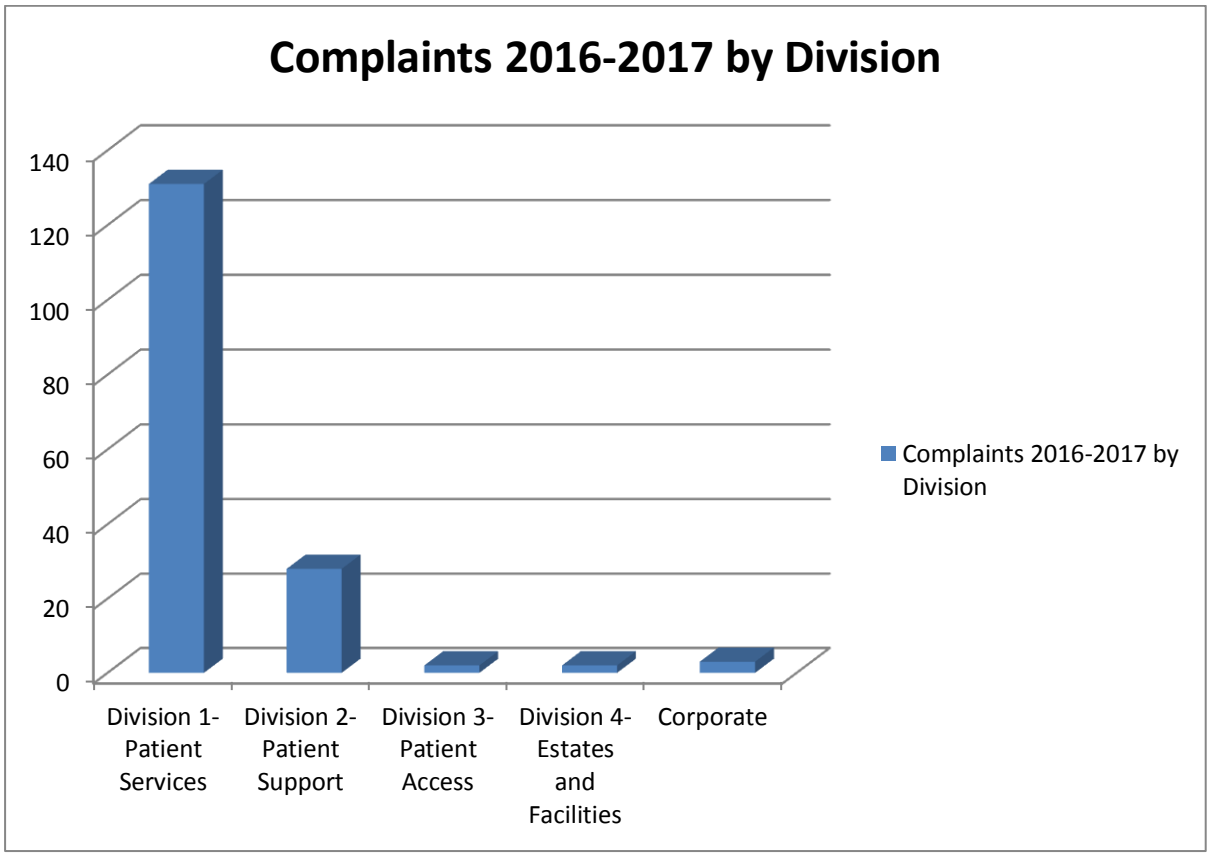
	2016/2017	2015/2016
Inpatient Attendances		
Inpatient Complaints	60	45
Inpatient Episodes	13973	14954
Complaints per 100 inpatient episodes	0.43%	0.30%
Outpatient Attendances		
Outpatient Complaints	106	68
Outpatient Episodes	67181	69253
Complaints per 1000 outpatient attendance	0.16%	0.10%

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.

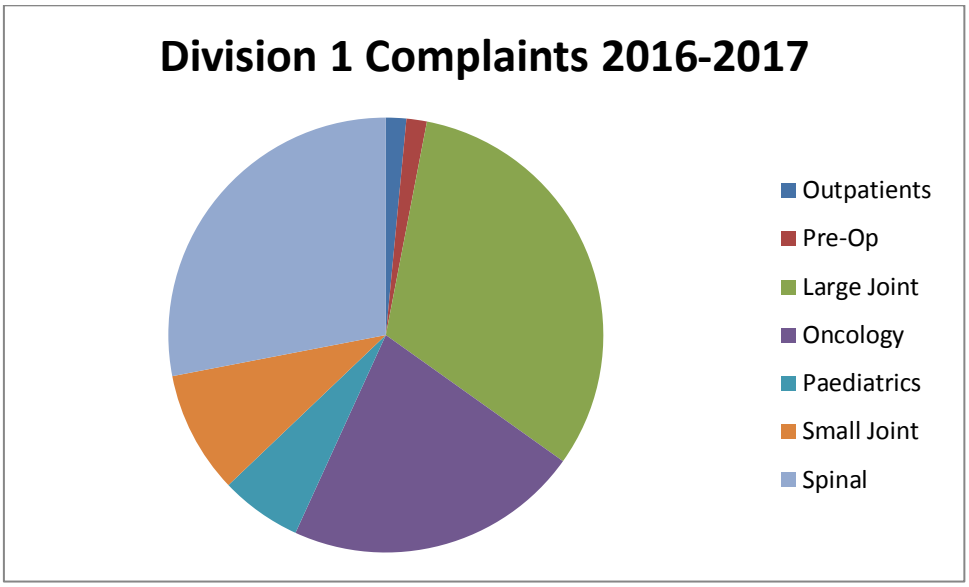
Figure 5: Number of Complaints by Division 2016/2017



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.

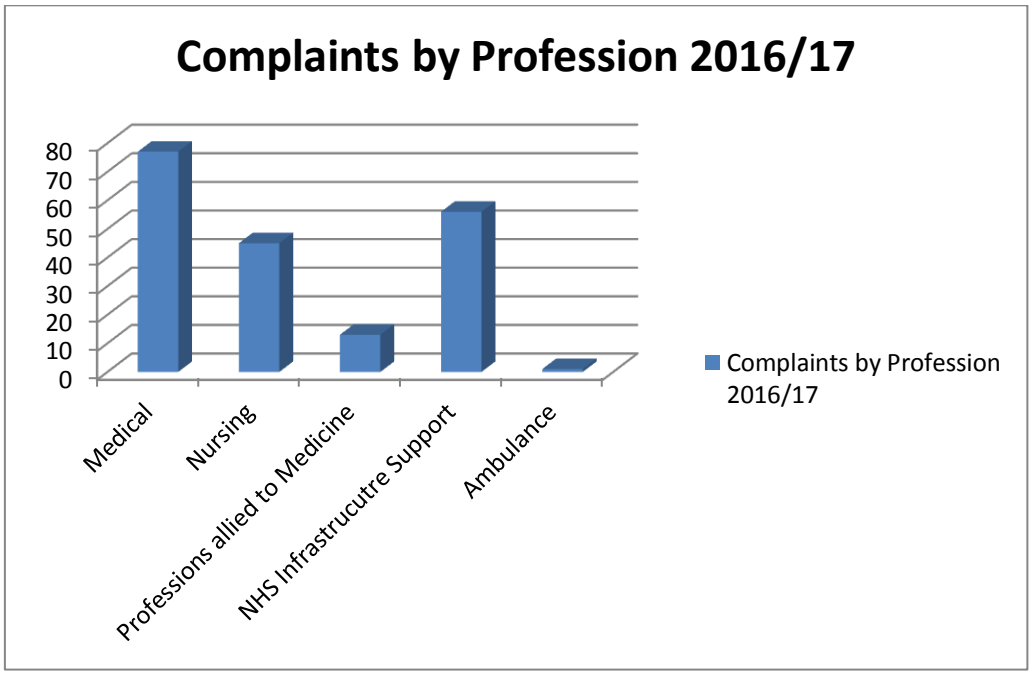
8.2 Spinal complaints

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

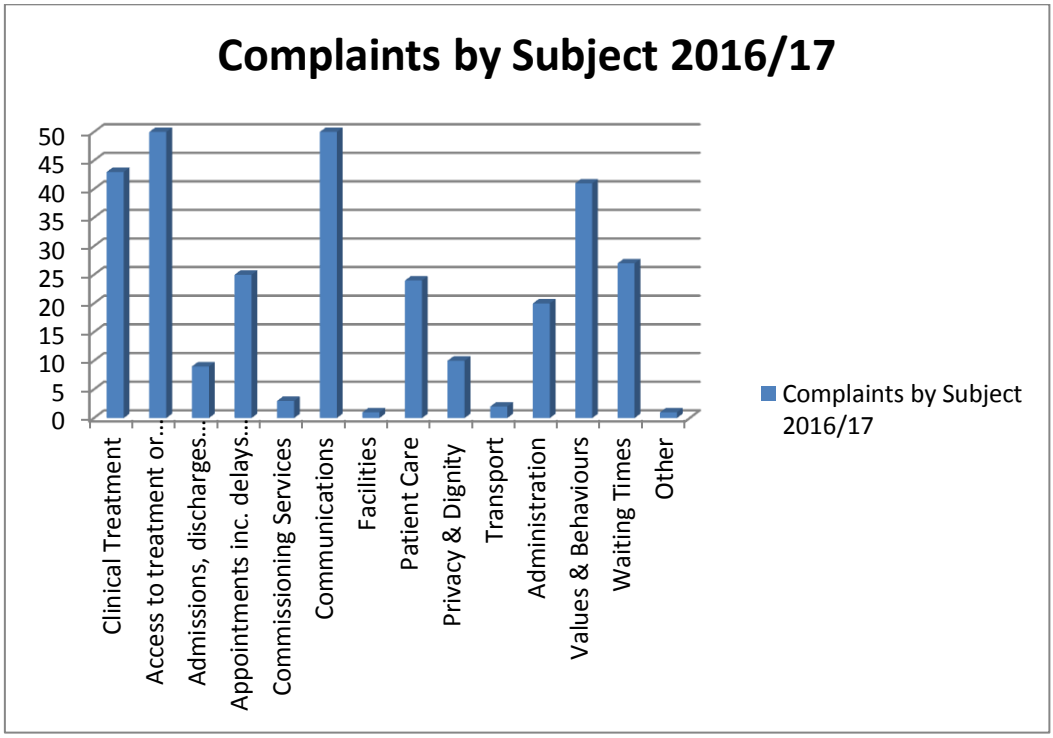
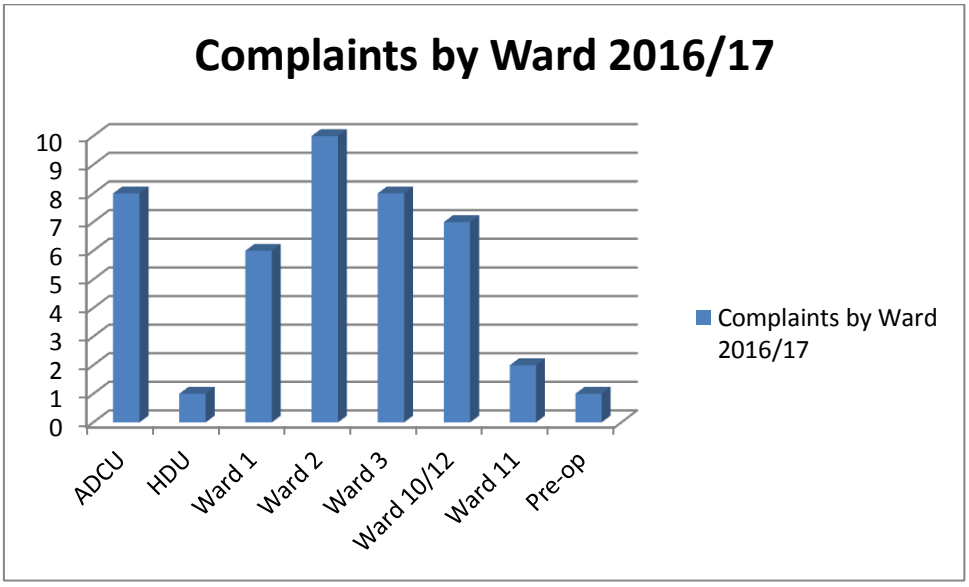


Figure 8 shows the main causes for complaints in 2016/2017, with communication with patients, access to treatment and clinical care being the highest reasons. This is a change from last year where patient care and delays in appointments together with communication were the largest concerns.

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

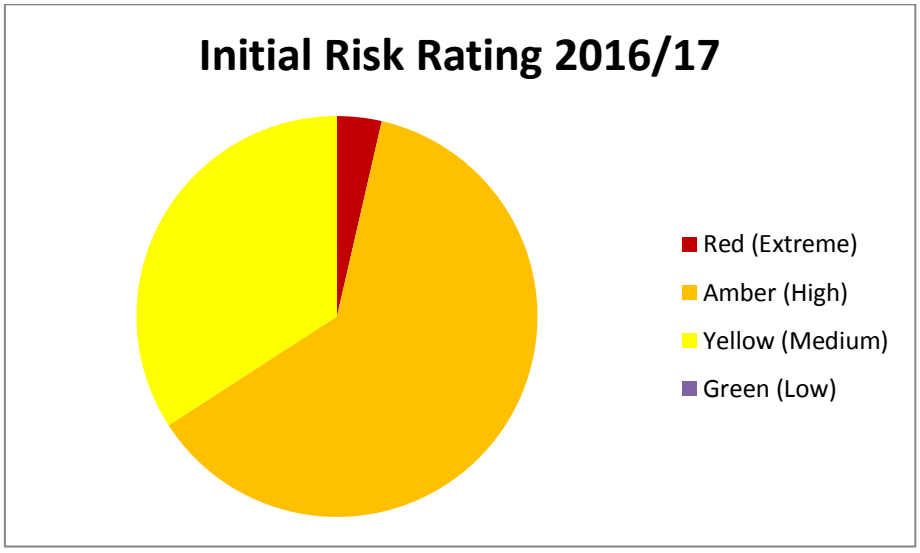
Figure 9: Complaints by Ward 2016/2017



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

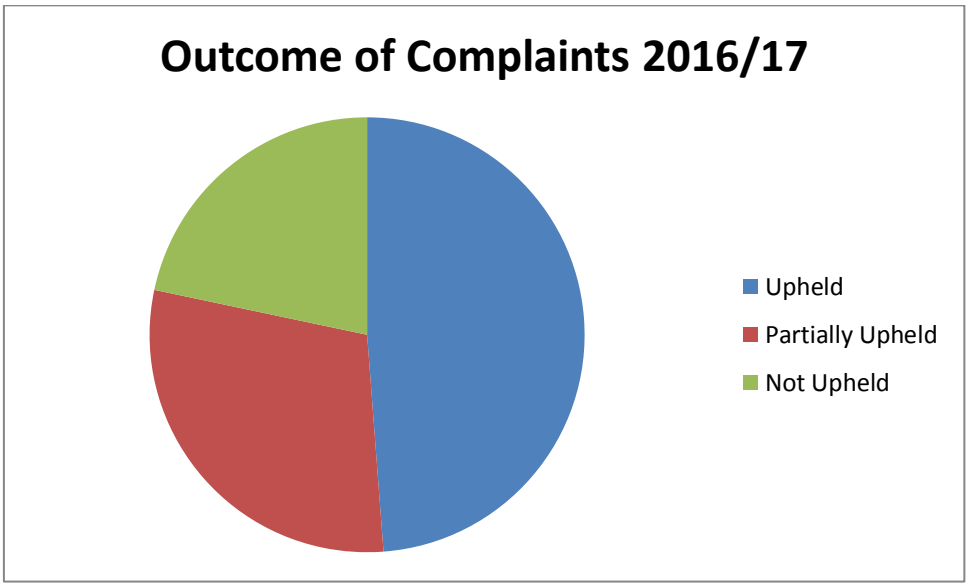
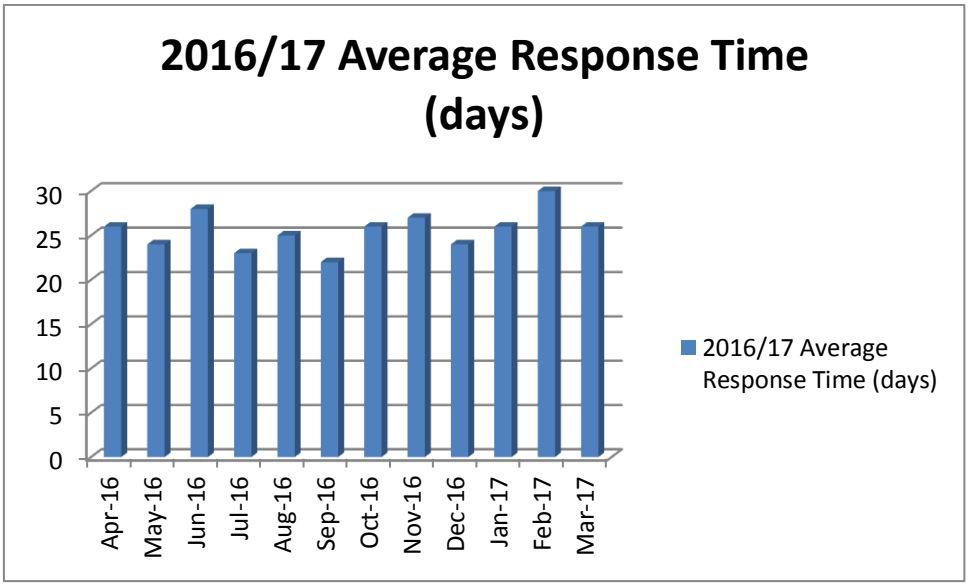


Figure 11 shows the outcome of complaints made in 2016/2017. The Trust upheld some aspects of 76% of the complaints made in this year, which is slightly lower than last year but remains significantly higher than previous years. The robust investigation and divisional involvement in quality assurance 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.

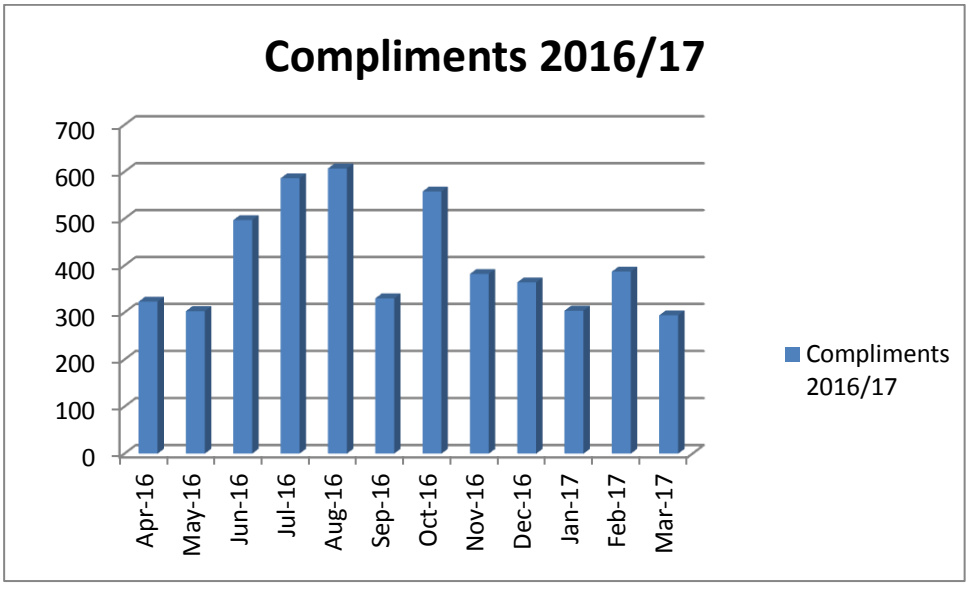
The changes to the complaints process have ensured that action plans have been created for cases that have been upheld and specific changes need to be made. These are now discussed and monitored through weekly Divisional meetings and ensure that the Trust is able to identify learning and changes that 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

Notice of Public Board Meeting on Wednesday 7 March 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 7 March 2018 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

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 7 March 2018: 1130h – 1315h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair ansd 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 Paul Athey	Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Prof Philip Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Jo Wakeman	Deputy Director of Nursing & Clinical Governance	(JWA)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NeXT scheme)	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1130h	1	Apologies – Mr Richard Phillips and Mr Garry Marsh	Verbal	Chair
1132h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1135h	3	Minutes of Public Board Meeting held on the 10 January 2018: *for approval*	ROHTB (1/18) 013	Chair
1140h	4	Trust Board action points: *for assurance*	ROHTB (1/18) 013 (a)	SGL
1145h	5	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	YB/PA
	5.1	Paediatric services update	Verbal	AP/PA
	5.2	Orthopaedic services in the STP	Verbal	PA
QUALITY & PATIENT SAFETY				
1205h	6	Patient Safety & Quality report: *for assurance*	ROHTB (3/18) 002	JWA
1215h	7	'Perfecting Pathways' update: *for assurance*	Verbal	JWI

FINANCE AND PERFORMANCE				
1225h	8	Finance & Performance overview including recovery: *for assurance*	ROHTB (3/18) 003	SW
1235h	9	Gender pay reporting: *for assurance*	ROHTB (3/18) 004 ROHTB (3/18) 004 (a)	PB
COMPLIANCE AND CORPORATE GOVERNANCE				
1245h	10	Compliance with CQC fundamental standards – update on action plan: *for assurance*	ROHTB (3/18) 005 ROHTB (3/18) 005 (a)	SGL
1250h	11	Board Assurance Framework: *for assurance*	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1255h	12	Quality & Safety Committee: *for assurance*	ROHTB (3/18) 007 ROHTB (3/18) 008	KS
	13	Finance & Performance Committee: *for assurance*	ROHTB (3/18) 009 ROHTB (3/18) 010	TP
	14	Audit Committee: *for assurance*	ROHTB (3/18) 011	RA
	15	Staff Experience & OD Committee and its revised terms of reference: *for assurance*	ROHTB (3/18) 012 ROHTB (3/18) 013 ROHTB (3/18) 014	SJ
MATTERS FOR INFORMATION				
1310h	16	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 4th April 2017 at 1100h in the Boardroom, 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

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1132h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1135h	3	Minutes of Public Board Meeting held on the 10 January 2018: *for approval*	ROHTB (1/18) 013	Chair
1140h	4	Trust Board action points: *for assurance*	ROHTB (1/18) 013 (a)	SGL
1145h	5	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	YB/PA
	5.1	Paediatric services update	Verbal	AP/PA
	5.2	Orthopaedic services in the STP	Verbal	PA
QUALITY & PATIENT SAFETY				
1205h	6	Patient Safety & Quality report: *for assurance*	ROHTB (3/18) 002	JWA
1215h	7	'Perfecting Pathways' update: *for assurance*	Verbal	JWI

FINANCE AND PERFORMANCE				
1225h	8	Finance & Performance overview including recovery: *for assurance*	ROHTB (3/18) 003	SW
1235h	9	Gender pay reporting: *for assurance*	ROHTB (3/18) 004 ROHTB (3/18) 004 (a)	PB
COMPLIANCE AND CORPORATE GOVERNANCE				
1245h	10	Compliance with CQC fundamental standards – update on action plan: *for assurance*	ROHTB (3/18) 005 ROHTB (3/18) 005 (a)	SGL
1250h	11	Board Assurance Framework: *for assurance*	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1255h	12	Quality & Safety Committee: *for assurance*	ROHTB (3/18) 007 ROHTB (3/18) 008	KS
	13	Finance & Performance Committee: *for assurance*	ROHTB (3/18) 009 ROHTB (3/18) 010	TP
	14	Audit Committee: *for assurance*	ROHTB (3/18) 011	RA
	15	Staff Experience & OD Committee and its revised terms of reference: *for assurance*	ROHTB (3/18) 012 ROHTB (3/18) 013 ROHTB (3/18) 014	SJ
MATTERS FOR INFORMATION				
1310h	16	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 4th April 2017 at 1100h in the Boardroom, 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** 10 January 2018: 1100h – 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)
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)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests:

Mrs Evelyn O'Kane	Matron & Safeguarding Lead	(EO'K)
Mrs Julie Mullis	Named Nurse for Safeguarding	(JM)
Miss Sally Powell	CQC Assistant Inspector	(SP)

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Tim Pile, Vice Chair & Non Executive Director and Prof David Gourevitch, Non Executive Director and Prof Phil Begg.	
2 Declarations of interest	**Verbal**
There were no declarations made in connection with any item on the agenda.	
3 Patient Story – Child Safeguarding Case	**Presentation**
The Board welcomed Evelyn O'Kane and Julie Mullis. It was noted that the case to be presented had been discussed at a recent Clinical Audit session to disseminate	

the points of learning. The patient story was delivered which was around some missed bruising on a child that had been treated by the ROH. The child had been identified as having an issue with the usual process of blood clotting, which created prevalence for bruising. It was noted that the school information was not available as the case occurred in the school holidays. One of the points of learning from this was that the school needed to have a Safeguarding contact available at all times. There had also been an IT failure at the ROH, which meant that the receipt of the details of the case was delayed, which prevented a speedy response to the case, including examination of the child. There was now more assurance that the notification would be made in a more timely way by both by nursing staff and medical staff. It was noted that the round table where the case had been discussed was positive and a place was given at the clinical audit day to share the case with the wider medical staff. It was noted to be encouraging that the registrar had picked up this case. It was suggested that it was the responsibility of all staff to identify children of concern based on how they were behaving in the waiting room for instance. Safeguarding was noted to be everyone's responsibility, rather than just Safeguarding nurses. There were noted to be mechanisms and contact numbers of who to contact inside and outside of the Trust in hours and out of hours set out in the Safeguarding policy. It was noted that there were periodic reviews by the CCG who were also represented at the Trust's Safeguarding meeting to scrutinise the embeddedness of learning from Safeguarding cases. The last review of Safeguarding was reported to have been positive. Body mapping, a new flow chart, team briefings and clinical supervision were now in place following this case. The patient in this instance was due to return to Outpatients and therefore if the child did not attend the 'Was Not Brought' procedures were invoked. These were robust and would ensure that the Safeguarding nurses were notified, who then would instigate lateral checks with the patient's GP and school and triggered a referral to the patient's local authority. The audit process around this had also increased and was scrutinised at Safeguarding Committee. Attendance at this meeting by ward managers was good at this forum.	
4 Minutes of Public Board Meeting held on 1 November 2017: *for approval*	**ROHTB (11/17) 010**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held on 1 November 2017.	

5 Trust Board action points	**ROHTB (11/17) 010 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern. An update on the Throne Project had been delivered to the Quality & Safety Committee.	
6 Chairman's & Chief Executive's update: *for information and assurance*	**ROHTB (1/18) 001** **ROHTB (1/18) 001 (a)**
The Acting Chief Executive noted that RTT performance was now nationally reported, this being 79% for the incomplete RTT pathway which was in line with the trajectory submitted to NHS Improvement. There was an expectation that all 52 week patients were due to be cleared by the end of February, apart from spinal deformity cases. Over the last month the patients who had been waiting between 41 – 52 weeks each had a plan for treatment. From April there would be no patient that would trip into the 52 week cohort. This was an improved position. The draft Health Education England workforce strategy had been published and was subject to a consultation which ended on 23 March 2018. Views on the strategy would be considered by the Staff Experience & OD Committee on 7 March 2018. On 28 & 29 November, the Trust's musculoskeletal pathology service was assessed by the United Kingdom Accreditation Service (UKAS) for compliance against ISO standards. This set of standards was highlighted to be an international benchmark for quality in medical laboratories. The outcome of the inspection was noted to have been very positive and reflected significant efforts that the Pathology team had made. It was reported that the Trust had been visited in December by the Environmental Health Officer to review food hygiene standards. As a result of the visit, the Trust had been awarded a '5', the highest rating possible. The Chairman gave her thanks to all around Christmas preparations, which had raised staff morale. The snow shovelling had also created a sense of camaraderie in the Trust during December. Thanks were given to Garry Marsh and Paul Athey for coming in to wish the staff and patients a happy Christmas on Christmas Day. There had been good work in the Knowledge Hub to provide Christmas buffet for the staff. It was reported that the Board would be joined by Dr Sarah Marwick as a shadow Non Executive and she would be mentored by Board members. She would also	

help the ROH with its relationships with GPs.	
ACTION: SGL to include the draft Health Education England workforce strategy on the agenda of the next Staff Experience & OD Committee	
6.1 Paediatric services update	**Verbal**
It was reported that the Operational Commissioning Group had met and a system-wide document was being pulled together to outline the plans for the transition of Paediatric services away from the ROH. Paediatrician cover was reported to be back to four days now and from early summer, this would move to five. There remained a high number of vacancies in the High Dependency Unit, however long term agency posts had been filled and induction for these nurses was as robust as if the staff members were substantive. Paediatric nurses had also been secured on a temporary basis from Royal Wolverhampton NHS Trust. Incidents involving Paediatric patients on Ward 11, HDU and Outpatients incidents were reported to be being recorded separately to spot any trends and provide additional scrutiny. E-roster software was helping with the nursing workforce around maintaining the balance of agency staff needed to cover shifts. There remained no operating at weekends while there was no Paediatrician cover. No elective work had needed to be cancelled and there had not been a need to escalate or transfer out any children. The chair of the Quality & Safety Committee confirmed that she was satisfied with the arrangements, however commented that this arrangement needed to fit into the wider plan for the transition and discussions around the cost of maintaining this service needed to be picked up. In terms of the morale and motivation, it was noted that staff recognised that the date for the transition had moved and there was open discussion around this at the Children's Board. Staff on Ward 11 remained positive. From a HDU perspective, the former Deputy Director of Nursing and NHS Improvement representative had undertaken a walkabout and there had been noticeable positive changes. The Executive Director of Patient Services highlighted that when he had visited the hospital on Christmas Day, staff echoed that they were content with the model of care at present. It was highlighted that the organisation as a whole appeared to be more comfortable with the decision around Paediatrics. Staff had been given a high level summary of TUPE requirements and how this might affect individuals where relevant. The decision of the Birmingham Women's and Children's NHS FT (BWCH) Board around the business case was also awaited, which would more definitively	

set the date for the movement of services. It was noted that there had been two consultants who had previously questioned the direction of travel, however they were now more accepting of the decision. Medical secretaries were also being engaged where possible, however they expressed reservations and were concerned around the potential movement of their consultants, particularly when they supported more than one individual. There was a request from the Board to continue to keep staff informed; this would be through the next set of CEO briefings.	
6.2 Orthopaedic Services in the STP	**Verbal**
The Acting Chief Executive noted that the STP was pushing for plans to be set around the planned care for orthopaedics. The Strategic Outline Case (SOC) had been developed which was by and large complete. A meeting had been held with the Chief Executives of University Hospital Birmingham NHSFT (UHB) and Birmingham Women and Children's Hospitals NHSFT (BWCH) to discuss how the SOC might be taken forward and agreement had been reached that this would be presented to the STP Board in February. It was noted that it was likely that the future of the ROH would be part of 'Birmingham Hospitals' within the STP and organisations would have to work more strategically and across pathways, with the ROH being one of a series of parts that was individually impacted by the joint working. The opportunity to think about the future of the ROH site was a key consideration. Turning this vision into a funded plan was a key challenge of the STP. The leadership of the STP endorsed the ROH brand. It was reported that the Council of Governors had been updated about the SOC work and the SOC key messages would be discussed with staff. The CQC, commissioners and NHS Improvement would also be appraised.	
7 Proposal to establish a Staff Improvement and Experience Committee and to disestablish the Major Project & OD Committee: *for approval*	**ROHTB (1/18) 002** **ROHTB (1/18) 002 (a)**
It was noted that it had been identified that the Board's oversight of workforce matters needed to be improved and therefore it was proposed that the Board refocused the current Major Projects & OD Committee into a Staff Experience & OD Committee. The Committee would meet first later in the afternoon where the duties of the committee would be firmed up. It was noted to be a welcome and necessary step to establish focus on workforce matters and key risks. The terms of reference for the new committee were considered. It was noted that a major part of the committee's responsibility was on culture. It was suggested that planning aligned with the workforce strategy needed to be captured within the purpose of the committee.	

It was noted that there was an absence of clinical staff on the membership which needed to be built in and it was suggested that the Deputy Director of Nursing should be added. This was agreed to be the case for the medical representation and therefore an Associate Medical Director needed to be added into the membership. It was noted that some of the detail may not need to report into the Committee but would be discussed by the People Committee instead when it was functioning well. A workforce dashboard would be developed which would largely set the agenda for the meetings. The terms of reference needed to reflect that there was a two way communication between Board and the Committee. The Board approved the establishment of the Staff Experience & OD Committee and approved the disestablishment of the Major Projects & OD Committee.	
ACTION: **SGL to amend the terms of reference for the Staff Experience & OD Committee to include workforce planning into the purpose and the add the Deputy Director of Nursing and an Associate Medical Director into the membership**	
8 Patient Safety & Quality report (from November): *for assurance*	**ROHTB (1/18) 003**
It was reported that there had been seven serious incidents, six of which were VTEs, and one being a retained screw. All of these were being investigated. In September a rise in the number of VTEs had been noted and the Chair of the VTE Committee had been invited to join the Quality & Safety committee to provide an update on the reasons for this. Since then, there had since been a reduction and the Trust was in the process of maturing the application to be an exemplar site for VTEs given that for instance, the post-discharge systems were better than elsewhere. In terms of the higher number of VTEs, a review of prophylaxis administration had been undertaken which had not identified any issues. The impact of the Rapid Recovery pathway had also been considered, which it had been identified was not a contributory factor to the rise. The Root Cause Analyses for the VTEs showed that there had been good care delivered. There had been a Grade 4 pressure ulcer, which the Root Cause Analysis had deemed to be avoidable. A new tissue viability nurse had joined recently and a second individual would start at the end of January who would undertake a review	

of the Trust's pressure ulcer position. From a complaints point of view there was a high level of PALs activity. Complaints numbers were less than previous month and had reduced further since. This was a positive trend. In terms of Friends and Family Test, this had moved back from the Communications Department into the Patient & Staff Engagement Group. Since then, a 60% increase in response rates had been seen. Ward 11 was noted to be an outlier, although this may reflect the very low numbers. It was noted that even where there were low numbers of responses received, there were high levels of satisfaction. In terms of Duty of Candour, there had been much improvement and the outcome of a recent unannounced visit by the CCG had evidenced that the Trust was exceeding the requirements of the regulation. Finally, there was a coroner's inquest from a patient that had died in 2016 and a narrative outcome was provided as the patient died from a recognised complication of necessary surgery. WHO checklist compliance was at 100%. There had been an improvement in the hospital cancellations position and time of discharge had also improved. It was noted that the report being considered had been superseded, however the Quality & Safety Committee had not sat in December 2017 at which it would usually have received additional scrutiny.	
9 Learning from Deaths report: *for assurance*	**ROHTB (1/18) 004** **ROHTB (1/18) 004 (a)**
It was suggested that the Learning from Deaths update should be scrutinised by the Quality & Safety Committee in future. A more detailed report would also be considered by the Clinical Audit & Effectiveness Committee. It was noted that Mrs Sallah, in her capacity as Chair of the Quality & Safety Committee, would attend one of the reviews. It was noted that the Trust had very few in hospital deaths and as a consequence all were treated as a serious incident and learning was derived from these. A dashboard was being adopted and this would be developed with the Informatics department. In terms of the points of learning, there were some issues around the transfer into the Trust and end of life care identified. Two patients were transferred into the	

hospital for Oncology care but did not have surgery and had to be treated for end of life. A boarding card principle was planned, which was a referral docket which detailed the previous assessment and investigations. This was being piloted by the Oncology surgeons. There had been some discussions with other providers, and although some of the cases were appropriate, accepting Oncology cases where the patients were towards the end of their lives were agreed to be inappropriate. It was noted that some patients in this situation had the potential to deteriorate rapidly and require out of hours transfer.	
10 Perfecting Pathways' update: *for assurance*	**Presentation**
The Interim Chief Operating Officer delivered a presentation summarising progress with the 'Perfecting Pathways' work. It was noted that this allowed staff to take ownership of improvements in their areas. The detail of the work was presented, together with the progress to date. It was noted that the MAKO robot was now operational. It was noted that some good publicity was planned around this when appropriate. It was suggested that for repeat patients, effort was needed to capture patients views on any improvements they noticed as a result of the robot. A lead was still to be identified for the pre-operative assessment element of the programme. It was anticipated that an internal candidate could be identified. Staff were noted not to be working with recognised methodologies and tools for improvement, however this would be considered over the next few months. It was suggested that there needed to be more structure and reporting on outcomes. It was emphasised that people should be encouraged to think on their feet and the Trust should make it easy to offer suggestions for improvement. It was noted that some of the enhanced governance arrangements were being embedded, such as the theatres huddle.	
11 Finance & Performance overview including recovery*: for assurance*	**ROHTB (1/18) 006**
The Interim Director of Finance reported that the monthly and cumulative financial deficit was on plan. In terms of income, this had been overachieved but activity was below plan. This suggested that the casemix was richer. In Month 8, the variance was due to non-pay pressure which was activity related; additional duty hour payments usage; and a technical adjustment. The impact of the snow on the activity position would be reflected in the next position to be reported, this being mainly concerned with Outpatients. It was noted that the plan forecasted a drop in activity in December 2017, with recovery between January to March 2018.	
12 Compliance with CQC fundamental standards: *for assurance*	**ROHTB (1/18) 007** **ROHTB (1/18) 007 (a)**

The latest position regarding compliance with the CQC fundamental standards was considered. It was noted that the position was described as at October 2017 and more work had been undertaken to deliver strengthened compliance since the update had been completed. The Quality & Safety Committee would consider the updated position at its meeting in February 2018.	
13 Board Assurance Framework – Quarters 2-3: *for assurance*	**ROHTB (1/18) 008** **ROHTB (1/18) 008 (a)**
The latest version of the Board Assurance Framework was considered. It was suggested that business continuity needed to be tested based on recent estates mishaps. This was partly due to the age of the estate and the latest issue was an immediate response. The capital plan and maintenance was being tested.	
14 Quality & Safety Committee assurance report: *for assurance*	**ROHTB (1/18) 009**
The Chair of the Quality & Safety Committee reported that there had been much work to improve the hydrotherapy area and it was due to open very shortly. The need to do this work had been identified as part of the quality assurance walkabouts. It had been agreed that the findings and suggested actions arising from the quality assurance walkabouts would come to Executive Team meetings in future. For non-clinical Directors, there needed to be some additional questions that they could ask. The walkabouts would also tie into the Perfecting Pathways. It was suggested that a set of questions around staff experience might be appropriate to include which could be used to evaluate culture and triangulation with the staff survey. It was agreed that the Executive Director of Patient Services would review the methodology as a whole. The Executive Medical Director was thanked for his work to ensure that medical staff mandatory training was completed.	
ACTION: GM to review the quality assurance walkabouts methodology	
15 Finance & Performance Committee assurance report – *for assurance*	**ROHTB (1/18) 010**
Rod Anthony, in place of Tim Pile, reported that performance against the Cost Improvement Plan had been discussed at the last meeting. Cancellations had reduced. Theatre utilisation was noted to be oscillating. Length of stay dipped in November and the trajectory for hips looked good but knees needed to be improved. Activity was higher than planned in January 2018, however weekend working was at risk due to the same staff being used to cover these sessions. Cash was noted to looking stable at present.	

16 Audit Committee assurance report: *for assurance*	**ROHTB (1/18) 011**
The Chair of the Audit Committee reported that he would undertake a walkabout to look at theatre stock. In terms of the theatre stock, the amount being held was significantly larger than needed. Of the £12m stock, £5.2m was consignment stock. This had been a manual stock take. The valuation would be presented to Audit Committee in February. Further environmental improvements in theatres were due to be made. 1800 lines of stock were recorded on trays. It was noted that a different model of stock control was needed and this would be presented to the Board.	
17 Charitable Funds Committee minutes: *for information*	**ROHTB (1/18) 012**
The Chairman advised that she was seeking an independent chair for the Charitable Funds Committee.	
18 Any Other Business	**Verbal**
It was noted that the updates to the Council of Governors had gone well between meetings. A new public governor was in post. There would be more linkage between the Board and Council of Governors in future.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 7 February 2018 at 1100h, Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 7 March 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee in April 2018	SGL	30-Apr-17	ACTION NOT YET DUE	
ROHTBACT. 047	Proposal to establish a Staff Improvement and Experience Committee and to disestablish the Major Project & OD Committee	ROHTB (1/18) 002 ROHTB (1/18) 002 (a)	10/01/2018	Amend the terms of reference for the Staff Experience & OD Committee to include workforce planning into the purpose and the add the Deputy Director of Nursing and an Associate Medical Director into the membership	SGL	07-Mar-18	Agreed on discussion at the February Staff Experience & OD Committee meeting to amend this to 'nominations by the Executive Director of Patient Services and the Medical Director'	
ROHTBACT. 048	Assurance report from the Quality & Safety Committee	ROHTB (1/18) 009	10/01/2018	Review the quality assurance walkabouts methodology	GM	31-Mar-18	ACTION NOT YET DUE	
ROHTBACT. 044	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Present an update on Pathology services at the next meeting	GM	10-Jan-18	Update presented to Quality & Safety Committee on 28 November and a further update planned for the meeting on 31 January 2018	
ROHTBACT. 045	Annual complaints report	ROHTB (11/17) 003 ROHTB (11/17) 003 (a)	01/11/2017	Ensure that the Council of Governors received the annual complaints report	SGL	17-Jan-18	Presented to Council of Governors at the January meeting	
ROHTBACT. 046	Chairman's & Chief Executive's update	ROHTB (1/18) 001 ROHTB (1/18) 001 (a)	10/01/2018	Include the draft Health Education England workforce strategy on the agenda of the next Staff Experience & OD Committee	SGL	07-Mar-18	Included on the agenda of the March 2018 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:	**7 March 2018**

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 7th March 2018

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 public Trust Board meeting on 10th January 2018

2 CQC INSPECTION

2.1 The CQC visited the Trust on 23rd and 24th January to undertake an unannounced inspection on the follow core areas; Medicine, Surgery and Outpatients.

2.2 The CQC commented on how welcome they had been made to feel by all the staff and patients that they spoke to and the general view from staff was that they had felt supported through the process.

2.3 Some fair and balanced initial feedback was provided on the day, and this has been followed by a letter outlining some of the initial findings.

2.4 On 21st February and 1st March, the CQC conducted the well-led section of their inspection, with interviews held with Board members and other senior managers and clinical staff. At the time of writing, no feedback has yet been provided from these interviews.

2.5 In addition to the information gathered during these visits, a total of 193 data requests have so far been made by the CQC. The information from these requests will be analysed and triangulated against other nationally available data and the findings from each of the visits and will form the basis of their full report and inspection ratings.

2.6 We anticipate receiving a draft report in mid to late April, at which point the Trust will be given the opportunity to respond to any matters of factual accuracy before final publication.

3 STP UPDATE

3.1 Following the completion of our Strategic Outline case, members of the Executive Team has been involved in a range of discussions with STP colleague around the next steps for the ROH and orthopaedic services in general.

3.2 These conversations have been very constructive and there is broad support across the STP for the inclusion of an orthopaedics workstream within the refreshed STP strategy.

3.3 Conversations have also taken place specifically with UHB-HEFT around closer collaboration around the provision of orthopaedic care, and over the next few months, more work with take place to develop this principle.

4 JOINT PATHWAYS

4.1 On 25th January, the Trust launched a full suite of Joint Pathways literature and communications material which has been produced in conjunction with Stryker.

4.2 Every patient receiving a joint replacement at the ROH will now be given a patient information book, which provides information on;

- The joint replacement surgery, including benefits and risks
- Preparing for the surgery
- What to expect in hospital
- Discharge planning
- What to expect in the future
- Exercises and Transfers

This provides an incredibly thorough set of information to support our patients through their journey with us and is part of a range of changes that will drive forward the embedding of Rapid Recovery at the ROH.

4.3 Posters are now up in outpatients, on wards and in physiotherapy to complement this information.

5 CONSULTANT APPOINTMENTS & INDUCTION

5.1 Over the two months, the Trust has been successful in recruiting a new consultant surgeon to the Orthopaedic Oncology department and two new consultant anaesthetists (1 fixed term) to the Anaesthetic department

5.2 January also saw the launch of the Trust's consultant induction programme with 15 new consultants who have joined the Trust in the last 3 years signed up to attend. The first session covered the Trust's vision and strategy, with further sessions covering;

- Finance
- Governance
- Performance and continuous improvement
- Role-modelling values
- Research

6 BACK TO THE FLOOR

6.1 Following my visit to the Pre-operative assessment unit before Christmas, I spent a day with on the Admissions and Day Case Unit (ADCU) on 15th January as part of my Back to the Floor programme.

6.2 Despite purposefully picking a Monday, which is generally regarded as the busiest day of the week in ADCU, I was very impressed with the positive attitude of all of the staff, the way that all professional groups worked together across professional boundaries and the emphasis on safety, care and patient experience that I saw from everyone.

6.3 There were some areas of challenge that need addressing, most notably the resourcing available when the department opens to process all the patients into the unit, however I saw a team committed to challenging the way in which their department works in order to deliver the best care for patients.

6.4 On 12th February, I spent the day with the MSK team and had the opportunity to attend an MDT meeting and a range of outpatient clinics along with the taking the time to speak to the Extended Scope Practitioners around the challenges they face.

6.5 It was great to see some really positive examples of multi-disciplinary working and exciting to see some of the incredible non-surgical services that we offer. I was particularly impressed with the ability of our ESPs to comfort and assure patients who did not have definitive treatment routes and received universally positive feedback from the patients around the service they received from the team.

6.6 It was interesting to hear the frustrations that the team felt, particularly in relation to some of our administration challenges and DNAs, but also positive to hear the steps that are being taken to expand our MSK services into the community.

6.7 My next back to the floor day is planned for 14th March with the Outpatients team

7 STAFF AWARDS

7.1 The Trust held a very successful staff awards evening on Friday 2nd February at Rowheath Pavilion. Feedback from those who attend has been positive and it was great to be able to recognise the incredible work that goes on at the ROH.

7.2 Many thanks to everyone who helped to organise the day and enable it to go smoothly, with particular thanks to David Richardson for compering and to Gavin Newman for opening the evening in style.

7.3 Congratulations to all the winners and nominees, with special congratulations to Uzo Ehiogu as the overall Trust Board winner.

8 HARRISON LECTURES

8.1 The latest in our excellent series of Harrison lectures took place on 13th February, with Professor Ley Jeys presenting on "Innovation in orthopaedic oncology and arthroplasty". The lecture was well attended and it was great to showcase some of the life-changing and life-saving work that we do at the ROH.

8.2 The next lecture will be delivered by Mr David Marks on 15th May as is intriguingly titled "Scoliosis and Richard III".

9 POLICY APPROVAL

9.1 The Executive Team has focussed on ensuring that any policies beyond their review dates underwent review as a matter of urgency and where appropriate any changes of a minor nature, Executive Director discretionary authority was used to extend the validity of policies pending a more wholesale review. The current position is that just over 20 of the 150 Trustwide policies are outstanding review and plans are in place to ensure that these undergo review as soon as possible.

9.2 A policy position statement is now a regular item as part of the Executive Team forward plan.

9.3 Since the Board last formally met in public, the following new or substantially changed policies have been approved by the CEO on the advice of the Executive Team:

- Electronic registries policy
- Study and Professional Leave Policy for non-training medical staff
- Physiotherapy on-call policy

10 RECOMMENDATION(S)

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

10.2 Note the contents of the report.

Paul Athey
Acting CEO
7th March 2018

QUALITY REPORT

February 2018

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 the 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 to satisfy contractual information requirements and the CQC for routine engagement visits.

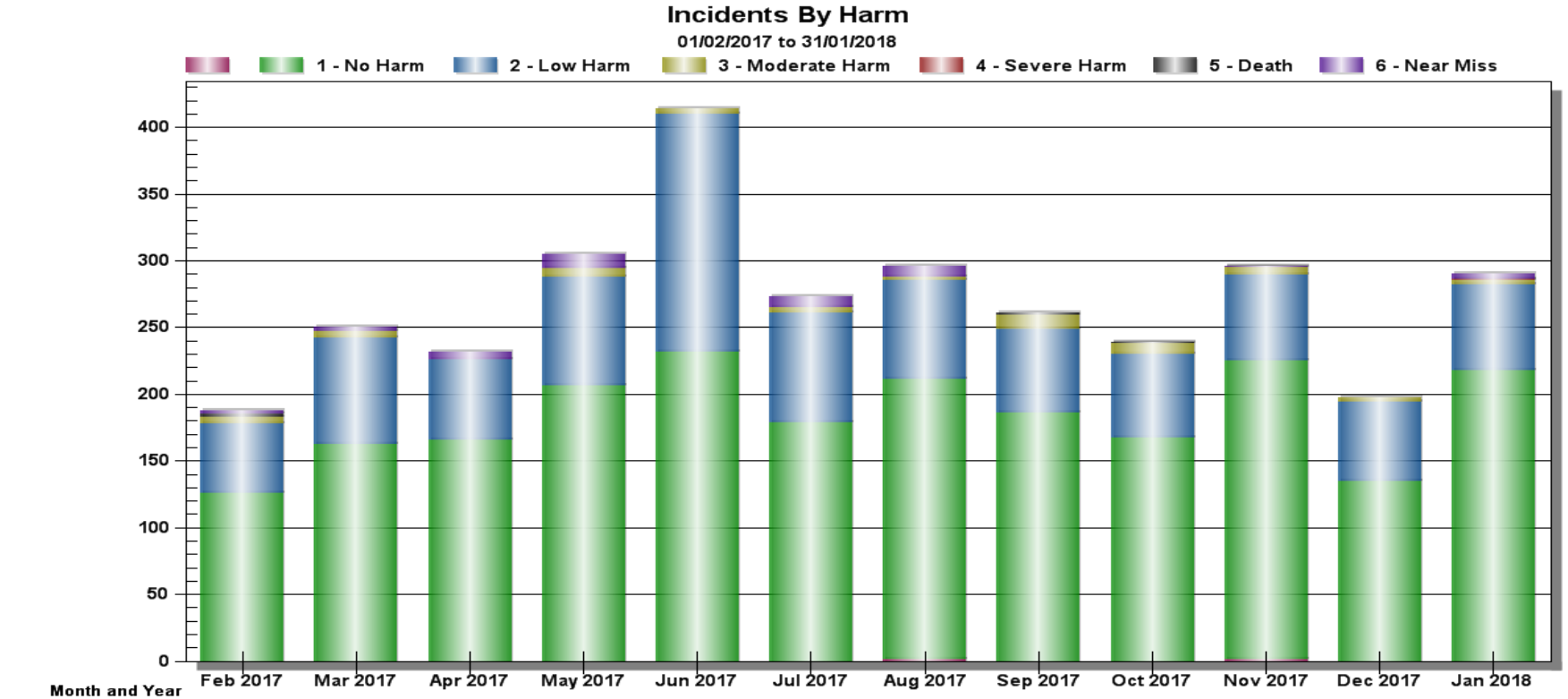
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018
	0	0	0	0	0	0	1	0	0	1	0	0
1 - No Harm	126	162	166	206	232	179	210	186	167	224	135	218
2 - Low Harm	52	80	60	82	178	82	74	63	63	64	59	64
3 - Moderate Harm	5	5	0	6	4	4	3	10	8	6	3	3
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	0	1
5 - Death	2	0	0	0	0	0	0	2	1	0	0	0
6 - Near Miss	3	3	6	11	0	8	8	0	0	1	0	4

INFORMATION

In January 2018 there was a total of 290 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;
218 – No Harm
64 – Low Harm
3 – Moderate Harms
1 – Severe Harm
4 – Near Miss

The 3 Moderate Harms and 1 Severe harm were;
22780 – Moderate Harm – 2 specimens from an outpatient ultrasound list where biopsies had been taking place were received. A staff member noticed that one of the specimens had the same patient label on the pot as the other although the patient details on the two request forms were different.

Both of these patients were re-biopsied under local anaesthesia. The previous biopsied had taken place in OPD Ultrasound suite and the samples were booked in by Theatre staff in CT. An RCA and Duty of Candour are underway.

The following recommendations have been made after a roundtable discussion;

1. Individual Reflection and learning.
2. Two stage consent process for on the same day procedures for Biopsies.
3. Full DOC to both patients and checking of their well-being.
4. Biopsies suspended in the outpatient ultrasound room to establish best practice properly.
5. Individual learning around safety measures for checking stickers and specimens with a two person check system.

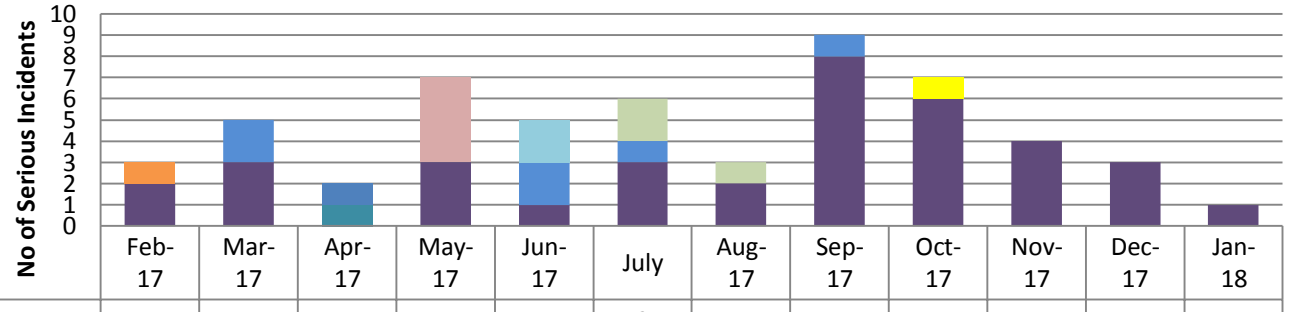
22934 - Moderate Harm – Ward 3 - Grade 3 pressure ulcer- Patient pressure areas checked and the area at the top of natal cleft approximately 3cm x 3cm was purple and non-blanching. A roundtable discussion has been completed with the following initial findings;

- There was evidence of poor documentation.
- Bank nurse did not give appropriate care on the Sunday/not escalating to Dr.
- No escalation to grade 3 when it was a grade 1 / 2.
- Clarification required why a short epidural line was used.
- More TV training + education required, especially for bank nurses.

Duty of Candour and RCA are underway. This is likely to be avoidable. 22994 - Moderate Harm – VTE – Ward 2 There was one incident recorded as Severe harm (22933) – This was discussed in the weekly executive team meeting, and it was agreed this was not a severe harm incident and needed to be reviewed and downgraded. The incident is awaiting review from the Anaesthetist Clinical Service Lead.
ACTIONS FOR IMPROVEMENTS / LEARNING
The incident backlog that was reported in the August 2017 quality report and detailed in the Ulysses action plan has now been closed. Extensive work was completed by both the Governance team and Ulysses to risk asses and close approximately 2000 incidents. Work actively continues to ensure the management and closure of incidents.
RISKS / ISSUES
An ongoing Ulysses improvement action plan is in progress. This was an agenda item in January 2018.

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.

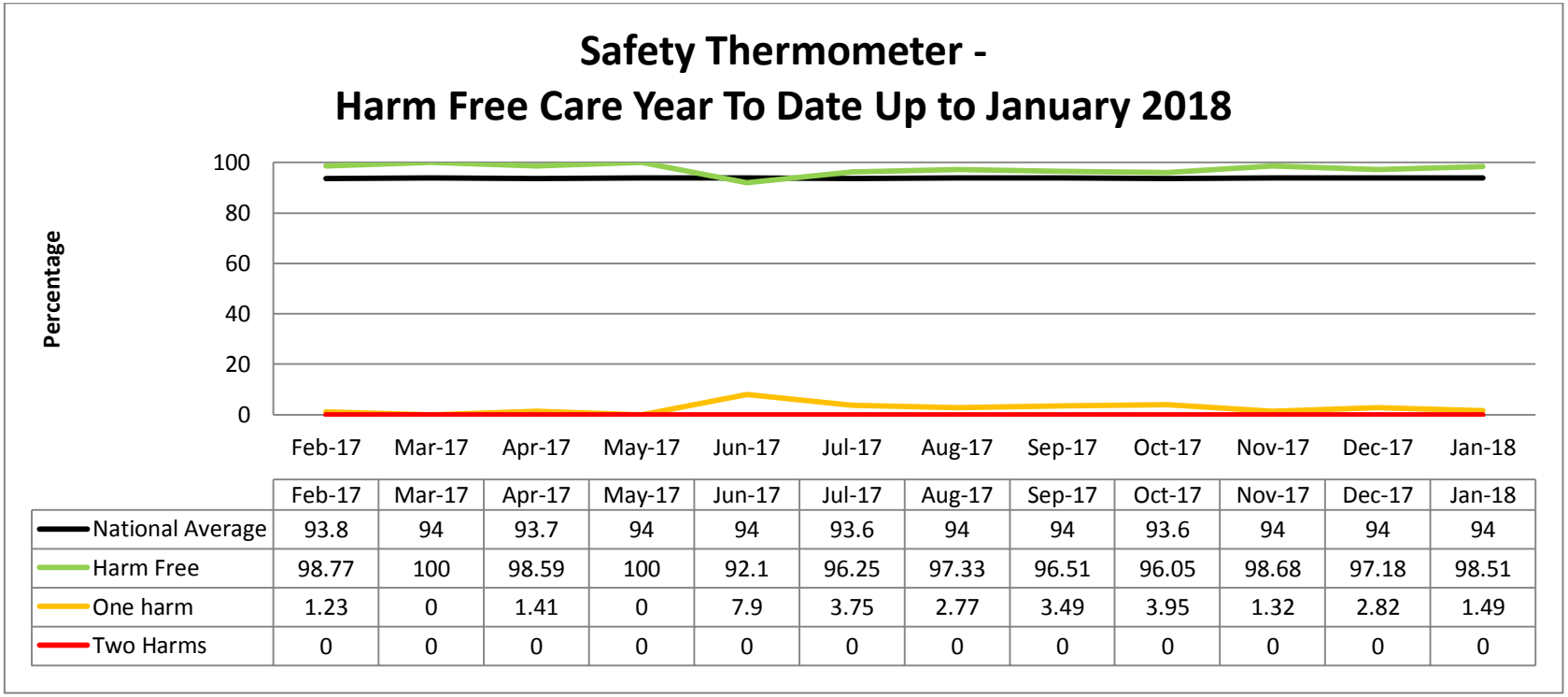
Serious Incidents Declared Year to Date to January 2018



	Feb-17	Mar-17	Apr-17	May-17	Jun-17	July	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Unexpected Injury						2	1					
RTT Harm review				4								
Emergency transfer to HDU												
Exposure to hazardous substance	1											
Retained object									1			
Wrong Implant												
Suspension to services												
RTT Data Issue			1									
Wrong side injection					2							
Suspension of Service (BCH Spinal)			1									
Slips, trips & falls												
Pressure Ulcers		2			2	1		1				
VTE meeting SI criteria	2	3		3	1	3	2	8	6	4	3	1

INFORMATION
There was **1 Serious Incident Declared in January 2018;** The graph on page 7 shows a downward trend since September 2017. 22994 – VTE – Detailed on page 5. The pressure ulcer Incident on page 5 (22934) has since been declared in February 2018 as a serious incident and will be included in the next report's figures.
ACTIONS FOR IMPROVEMENTS / LEARNING
1 avoidable VTE Serious incident was closed by the CCG in January 2018 **<u>Recommendations</u>** To ensure ROH VTE prevention guidelines are followed; To ensure VTE risk assessment is updated on admission and 24 hours post surgery. To ensure mechanical and pharmacological prophylaxis is prescribed on the risk assessment and the prescription chart. To ensure any deviations from Trust guidelines are documented and signed by the prescriber. To ensure that start dates of prescriptions are accurate and if not dated by original prescriber are signed by the second prescriber. To ensure prescription of enoxaparin is clear at what time the first postoperative dose should be given and if not to be given to be documented in the medical notes by the surgeon or the anaesthetist.
RISKS / ISSUES
None.

4. **NHS Safety Thermometer - provides a 'temperature check' on the 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.**



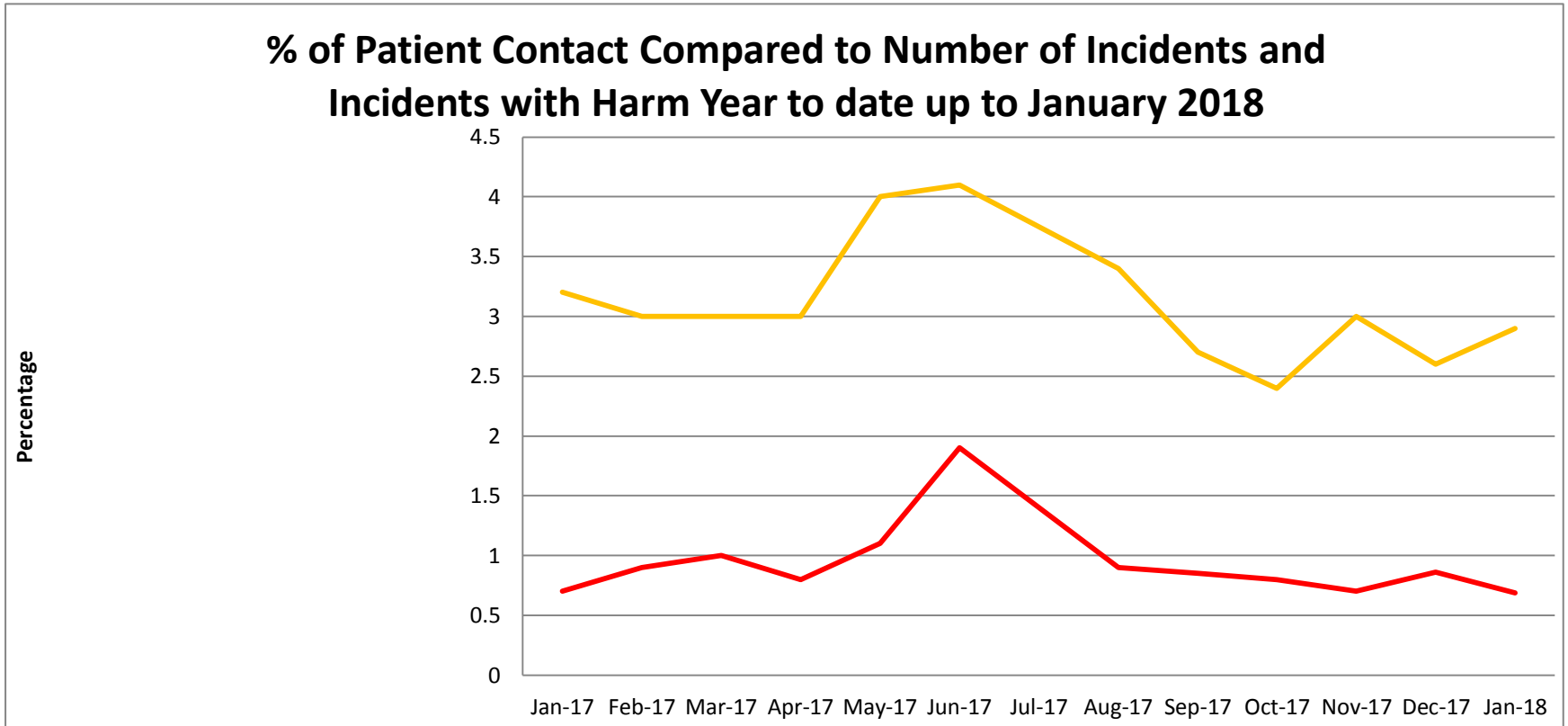
	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
National Average	93.8	94	93.7	94	94	93.6	94	94	93.6	94	94	94
Harm Free	98.77	100	98.59	100	92.1	96.25	97.33	96.51	96.05	98.68	97.18	98.51
One harm	1.23	0	1.41	0	7.9	3.75	2.77	3.49	3.95	1.32	2.82	1.49
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The harms were both recorded on Ward 3.
1 x old PE
1 x old Pressure ulcer grade 2

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 2018 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.

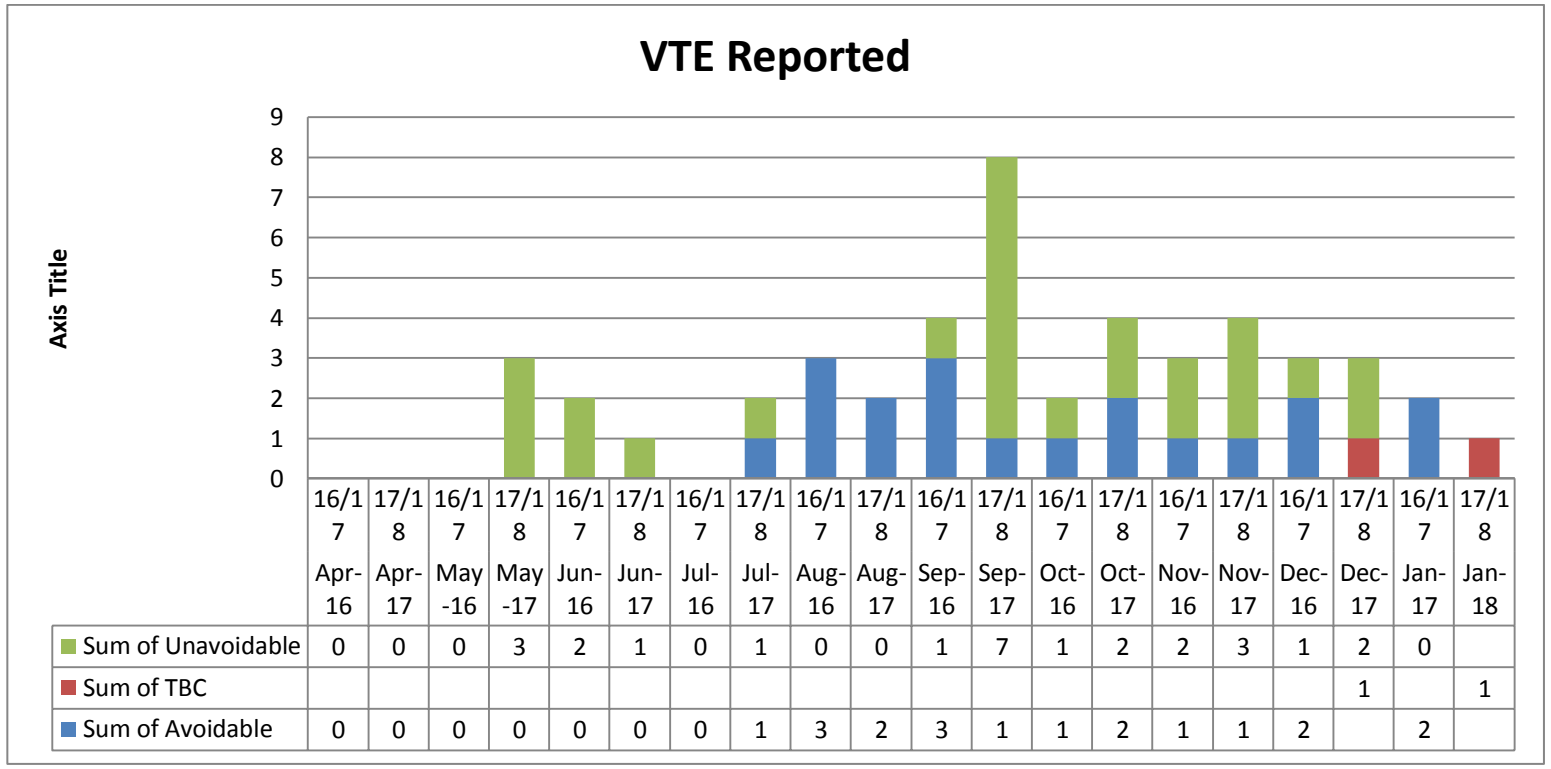
	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328
May-17	83	5	0	0	83	303	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
Oct-17	67	9	0	1	77	232	9571
Nov-17	64	7	0	0	71	295	9752
Dec-17	60	3	0	0	63	194	7285
Jan-18	64	3	1	0	68	290	9705

In January 2018, there were a total of 9705 patient contacts. There were 290 incidents reported which is 2.9 percent of the total patient contacts resulting in an incident. Of those 290 reported incidents, 68 incidents resulted in harm which is 0.69 percent of the total patient contact.



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
% of Patient Contacts with Incidents Causing Harm	0.7	0.9	1	0.8	1.1	1.9	0.9	0.85	0.8	0.7	0.86	0.69
% of Patient Contact With All Incidents Reported	3.2	3	3	3	4	4.1	3.4	2.7	2.4	3	2.6	2.9

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 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 Apr-16	17/18 Apr-17	16/17 May-16	17/18 May-17	16/17 Jun-16	17/18 Jun-17	16/17 Jul-16	17/18 Jul-17	16/17 Aug-16	17/18 Aug-17	16/17 Sep-16	17/18 Sep-17	16/17 Oct-16	17/18 Oct-17	16/17 Nov-16	17/18 Nov-17	16/17 Dec-16	17/18 Dec-17	16/17 Jan-17	17/18 Jan-18
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0	1	7	1	2	2	3	1	2	0	
Sum of TBC																		1		1
Sum of Avoidable	0	0	0	0	0	0	0	1	3	2	3	1	1	2	1	1	2		2	

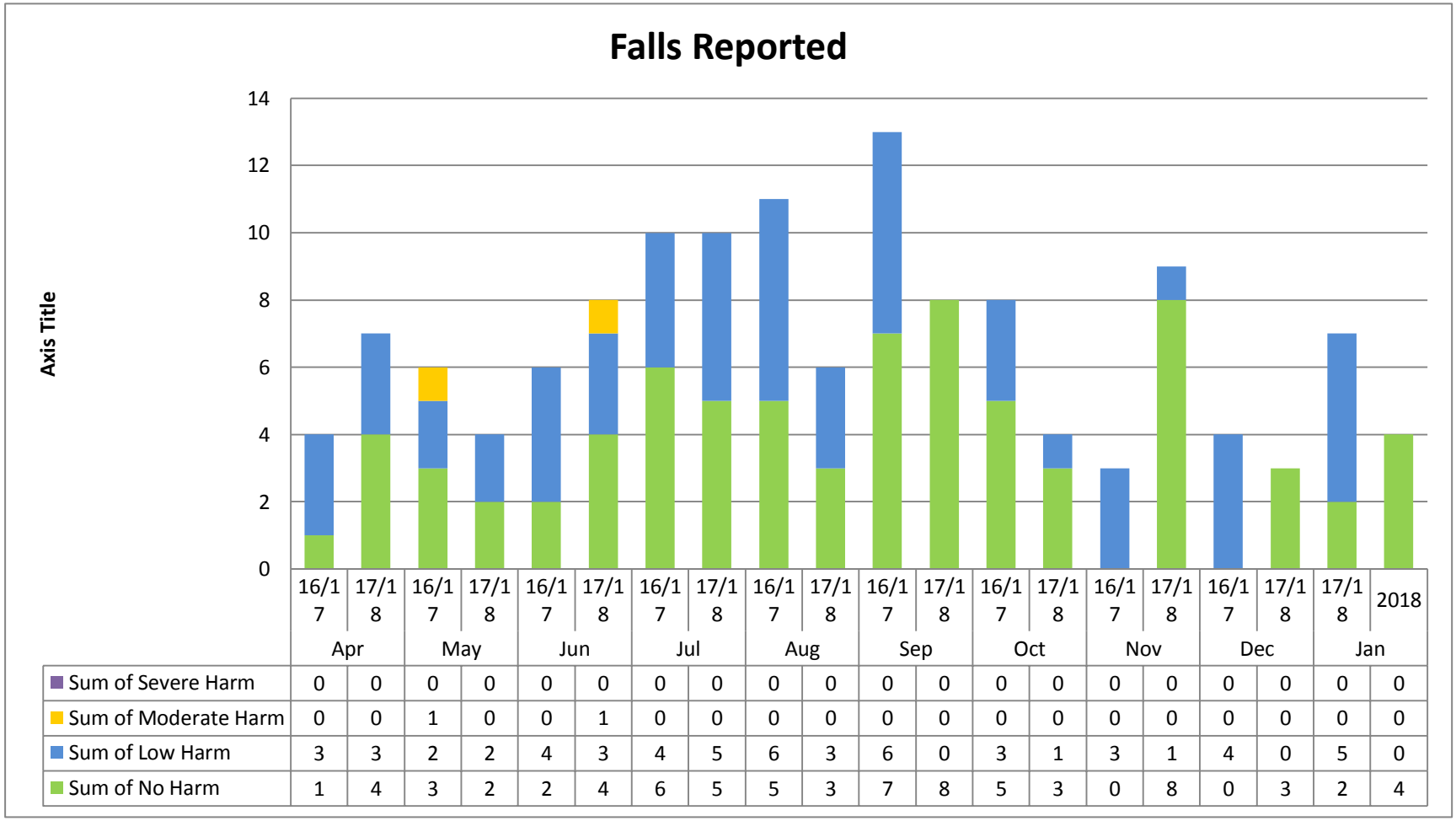
12

total		Avoidable
16/17	27	13
17/18	28	7*

***not classified**

INFORMATION
There was 1 VTE declared in January 2018.
ACTIONS FOR IMPROVEMENTS / LEARNING
September/October 2017 saw an increase in reported VTEs. Completion of RCAs was expedited, and a Multi-disciplinary review meeting took place. No overarching themes were identified which would explain the increase. BMI>30 was noted in a number, and as a result, this was added to the RCA form. A report was written and presented at CQ&SC highlighting that orthopaedic surgery alone presents a high risk of VTE and BMI>30 is an additional recognised risk factor. Subsequent completed RCA identify that BMI>30 is a common theme- even with appropriate prophylaxis. Non-completion of 24-hour re-assessment remains a theme. While improvements are seen this is not consistent, compliance continues to be monitored via Ward KPI's. PICS will resolve this when introduced as this is a mandatory field. RCA demonstrates however that most patients are on correct preventative management plans despite this not being completed. ROH continues to exceed expected targets set for VTE risk assessment on admission. ROH has a positive reporting culture about suspected or confirmed VTEs
RISKS / ISSUES
Patients undergoing Orthopaedic surgery are at high risk of VTE. Operating on patients with additional risk factors, e.g. High BMI increases the risk further. We aim to reduce risk as far as possible and reduce the number of VTE's deemed avoidable

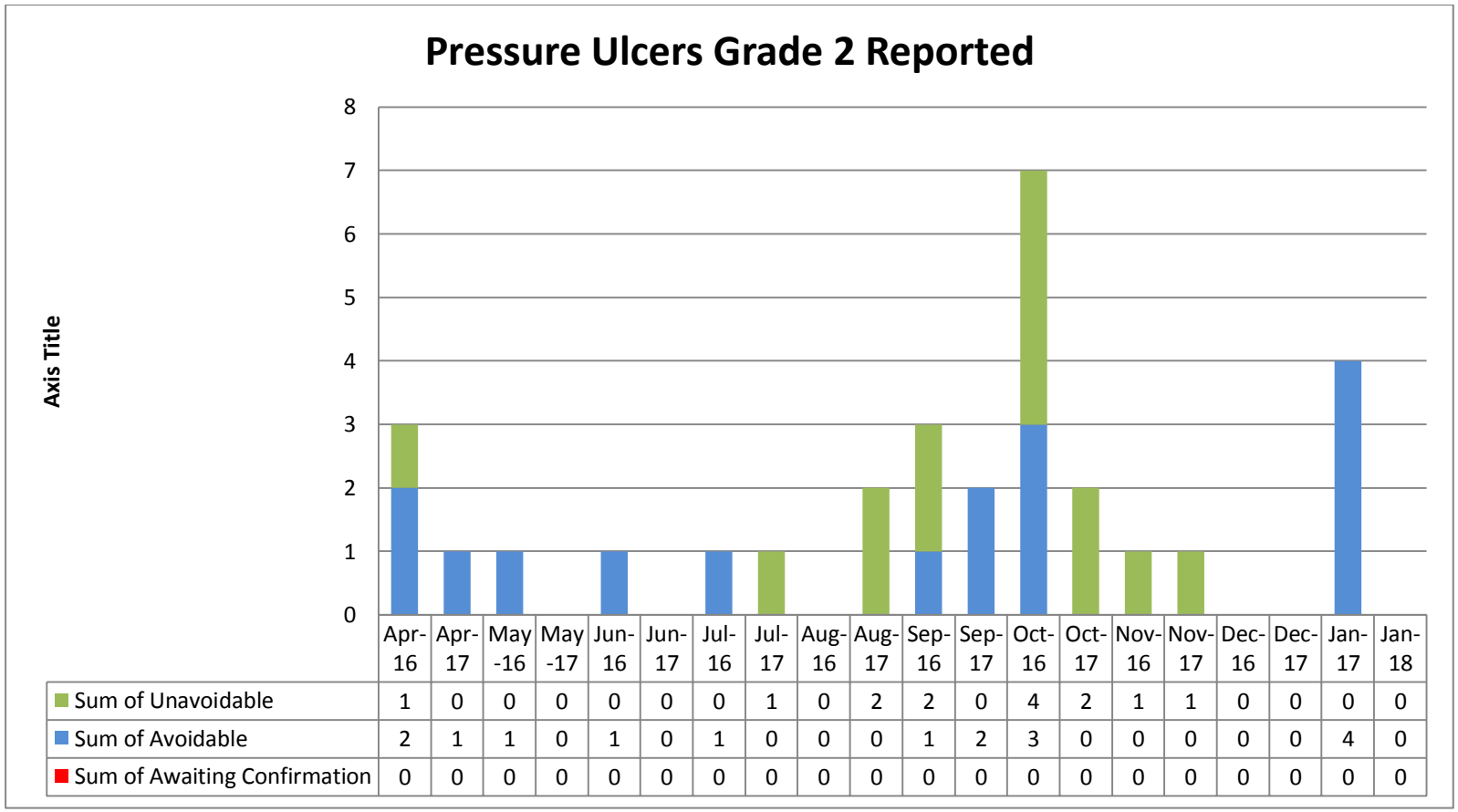
7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.



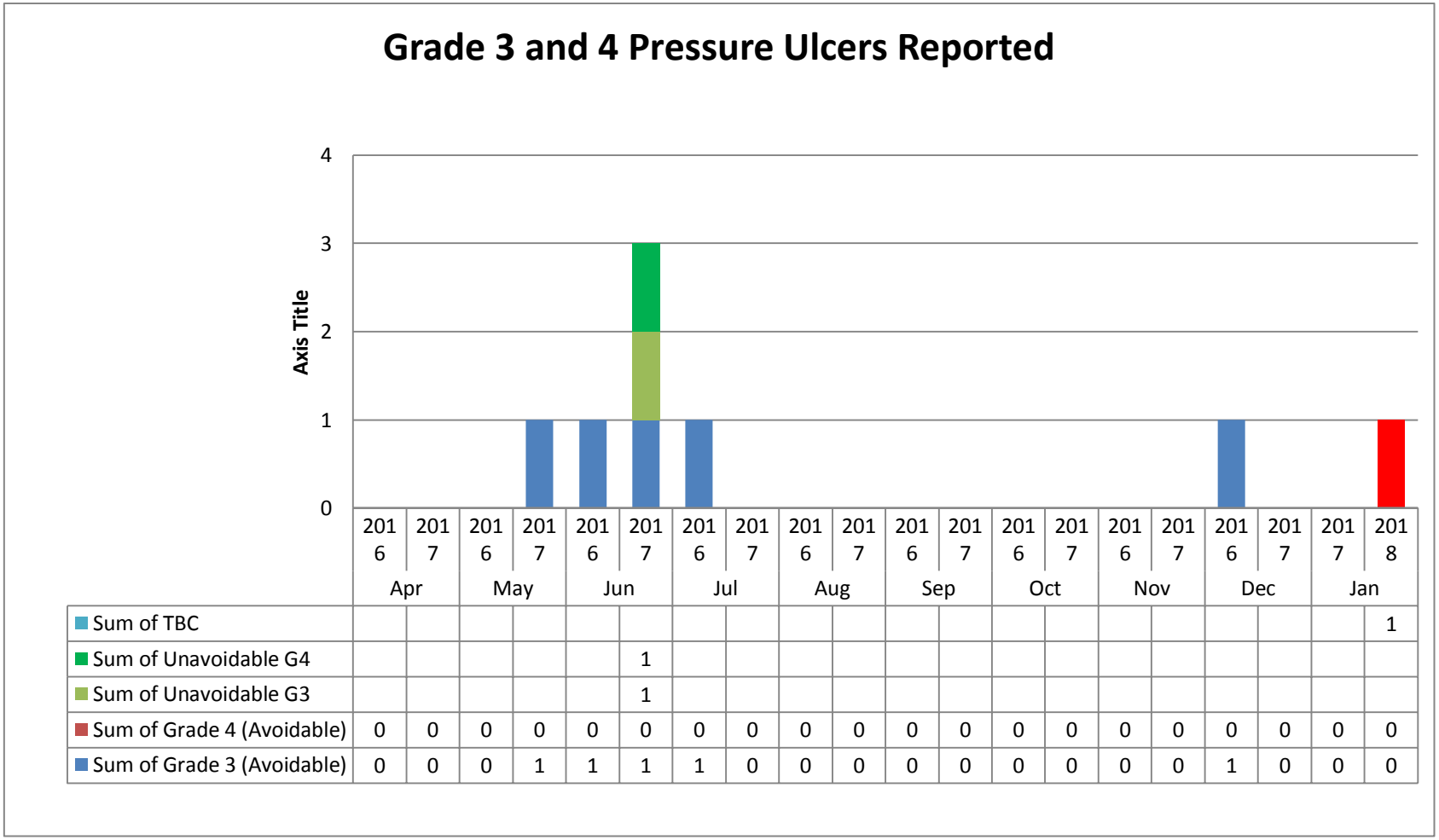
	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan	
	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	17/18	2018
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Moderate Harm	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3	6	0	3	1	3	1	4	0	5	0
Sum of No Harm	1	4	3	2	2	4	6	5	5	3	7	8	5	3	0	8	0	3	2	4

INFORMATION
Overall there were four fall-related incidents reported across the Trust in January 2018, all were related to adult inpatient falls. Two falls reported on Ward 1 and two falls reported on Ward 3. All incidents have been subject to a post-fall notes review by the ward manager or deputy, and a falls questionnaire was 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. An in-depth report on falls was presented to the Clinical Quality Group in January 2018.
ACTIONS FOR IMPROVEMENTS / LEARNING
The hoverjack that was reported in last month's quality report as out of use is now in working order and stored on Ward 1. The falls lead is in the process of arranging a task and finish group to benchmark the Trust against the WMQRS Quality standards. The Risk register specific to Falls group is to be set up and maintained by the group (risks from the outcome of the Throne Project are to be included on this register).
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	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18
Sum of Unavoidable	1	0	0	0	0	0	0	1	0	2	2	0	4	2	1	1	0	0	0	0
Sum of Avoidable	2	1	1	0	1	0	1	0	0	0	1	2	3	0	0	0	0	0	4	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



	2016 Apr	2017 Apr	2016 May	2017 May	2016 Jun	2017 Jun	2016 Jul	2017 Jul	2016 Aug	2017 Aug	2016 Sep	2017 Sep	2016 Oct	2017 Oct	2016 Nov	2017 Nov	2016 Dec	2017 Dec	2017 Jan	2018 Jan
Sum of TBC																				1
Sum of Unavoidable G4						1														
Sum of Unavoidable G3						1														
Sum of Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Grade 3 (Avoidable)	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0

INFORMATION

- There was 1 grade 3 pressure ulcer reported in January 2018. This has been reported as a serious incident and is currently under investigation to determine the avoidability.

In total, from 1st April 2017 to 31st January 2018 the Trust has reported the following avoidable pressure ulcers:

- **2 avoidable Non Device Related Grade 2 Pressure Ulcers**
- **1 avoidable Device Related Grade 2 Pressure Ulcers**
- **2 avoidable Grade 3 Pressure Ulcers** (Incident reported in January 2018 (22987) is likely to be avoidable
- **0 Avoidable Grade 4 Pressure Ulcers**

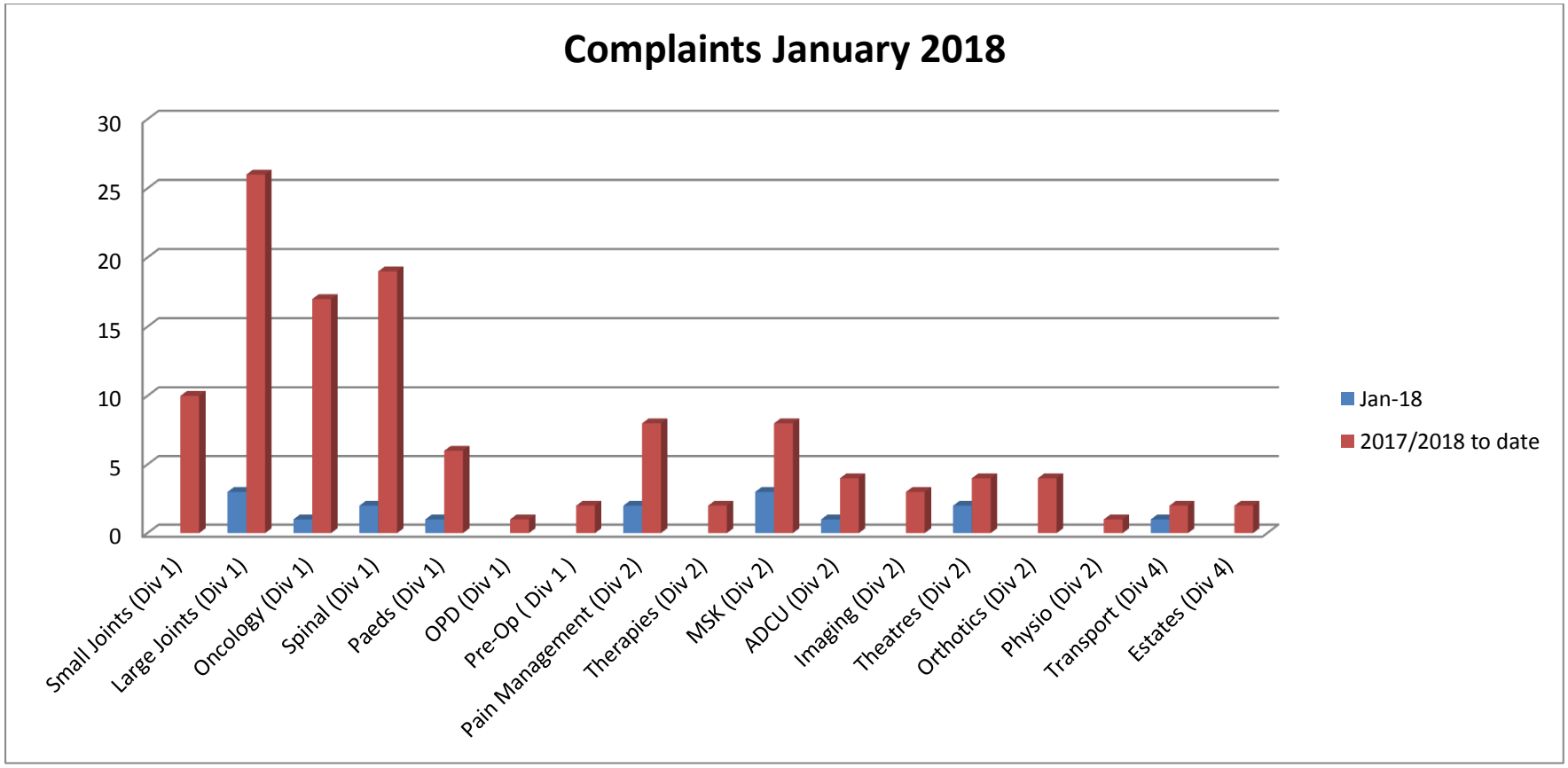
ACTIONS FOR IMPROVEMENTS / LEARNING

- TV Lead Nurse has relaunched the champion link group meetings and set a date for first meeting and workshop in the Trust
- New TV lead Nurse has drafted an action plan for the reduction in hospital-acquired pressure ulcer, which was one of the Trust quality priority targets for 17/18. (This is to be presented with Jan 18 monthly reporting).
- Ward and departmental managers have been requested to provide a timely update on reviewing of incidents and outcome questionnaires being completed.
- Theatre pre-operative checklist to have a section added about skin integrity being assessed, i.e. dry and flaky skin, a recommendation from Division 2 Head of Nursing, Trust ICP documentation is due to reviewed and updated this to be part of the changes being made.
- Incident reporting system to have suspected deep tissue injury added to the list of pressure damage for staff to report on skin incidents accurately.
- TV Lead Nurse to launch “React to Red” in the Trust, also to review the current TV documentation being used for all patients.

RISKS / ISSUES

- The tissue Viability Database has not been maintained currently– all tissue viability information being recorded in patient’s notes.
- Training for Tissue Viability for the Trust to be reviewed to ensure best practice and this will be a priority for Lead appointed
- Trust Tissue Viability Policy requires updating; this will be impacted by new classification status when agreed.

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 420 contacts during January 2018 of which 83 were classified as concerns. This brings the total of PALS contact for the year to date to 4414 (1011 concerns). This represents a much higher figure than at the same point last year (3224 PALS contacts)

Compliments

There were 547 compliments recorded in January 2018, with the most being recorded for Div. 1. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues to receive a significant amount 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 16 formal complaints made in January 2018, bringing the total to 131 for the year. All were initially risk rated rest amber or yellow. This is higher than the same time last year (13 complaints in January 2017)

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

- cancellation of surgery; approach of anaesthetist (Div.2,ADCUI)
- nursing care on Ward; development of PE (Div.1, Large Joints)
- nursing care Ward; development of complications as a result (Div. 1, Large Joints)
- changes to transport; communication of changes and now not eligible (Div.4, Transport)
- poor administration across all areas; communication with family; staff attitude (Div.1, Spinal)
- care and treatment under MSK Service (Div.2, MSK)
- medication is given on Ward (Div. 1, Large Joint)
- the approach of administrators (Div.2, MSK)
- burn after surgery in Nov 16 ?cause (Div.2, Theatres)
- burn after surgery on Jan 18 ?cause (Div.2, Theatre)
- the outcome of biopsy and care on the ward (Div.1, Spinal)

Initially Risk Rated Yellow:

- explanation of what happened at last injection and treatment plan going forward (Div. 2, pain management)
- the approach of a nurse on Ward; failure of first biopsy (Div.1, Paeds)
- Injection cancelled on the day by the manager (Div. 2, MSK)
- loss of paperwork for injection (Div. 2, Pain Management)
- the approach of fellow; incorrect clinic letter (Div.1, Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 11 complaints closed in January 2018, 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 January 2018 was 28 days which is within normal limits.

Learning identified and actions taken as a result of complaints closed in January 2018 include:

- letter inviting patients for injections is not clear
  Action: letter has been amended and new one will be evaluated

- Patient Information Leaflet for injection process not clear
  Action: Leaflet is being reviewed and placed in outpatients to be given at the point of injection being agreed

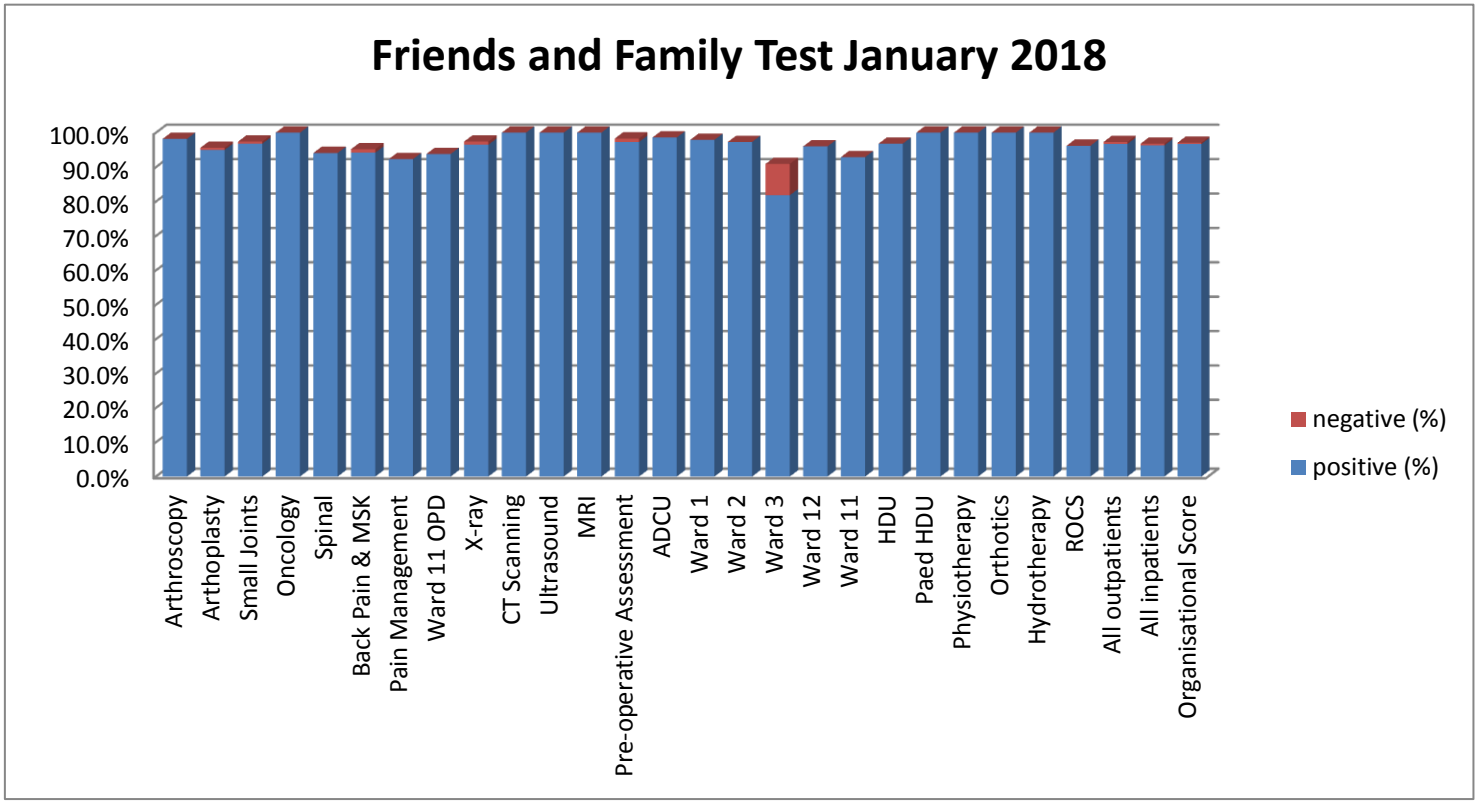
- Pathway for pain management is similar to MSK, and some GP's are confused
  Action: Perfecting Pathway work includes referral pathways

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 offered 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 friend Colour coding: Outpatient Services Community Services Inpatient Services

Area	Number of reviews	Footfall	Completion rates	Positive Rating	Negative Rating
Arthroplasty	111	1411	7.8% ↓	98.2%	0.0%
Arthroscopy	160	1136	11.7% ↓	95.0%	0.6%
Small Joints	158	1325	11.9% ↑	96.8%	0.6%
Oncology	31	713	4.3% ↑	100.0%	0.0%
Spinal	101	573	17.6% ↑	94.1%	0.0%
Back Pain & MSK	104	827	12.6% ↑	94.2%	1.0%
Pain Management	26	420	6.2% ↓	92.3%	0.0%
Ward 11 OPD	64	440	14.5% ↑	93.8%	0.0%
Pre-operative Assessment	291	580	50.2% ↓	97.4%	1.0%
ROCS	52	120	43.3% ↓	96.2%	0.0%
ADCU	213	694	30.7% ↑	98.6%	0.0%
Ward 1	48	115	41.7% ↑	97.9%	0.0%
Ward 2	74	140	52.9% ↑	97.3%	0.0%
Ward 3	11	46	23.9% ↓	81.8%	9.1%
Ward 12	25	65	38.5% ↑	96.0%	0.0%
Ward 11	14	78	17.9% ↑	87.5%	0.0%
HDU	15	64	23.4% ↓	92.9%	0.0%
Paed HDU	2	17	11.8% ↓	100.0%	0.0%

All outpatients	1259		17.00%	96.7%	0.6%
All inpatients			32.00%	96.3%	0.5%

Internal targets Outpatient & Community Services: 20% Inpatient Services: 40%

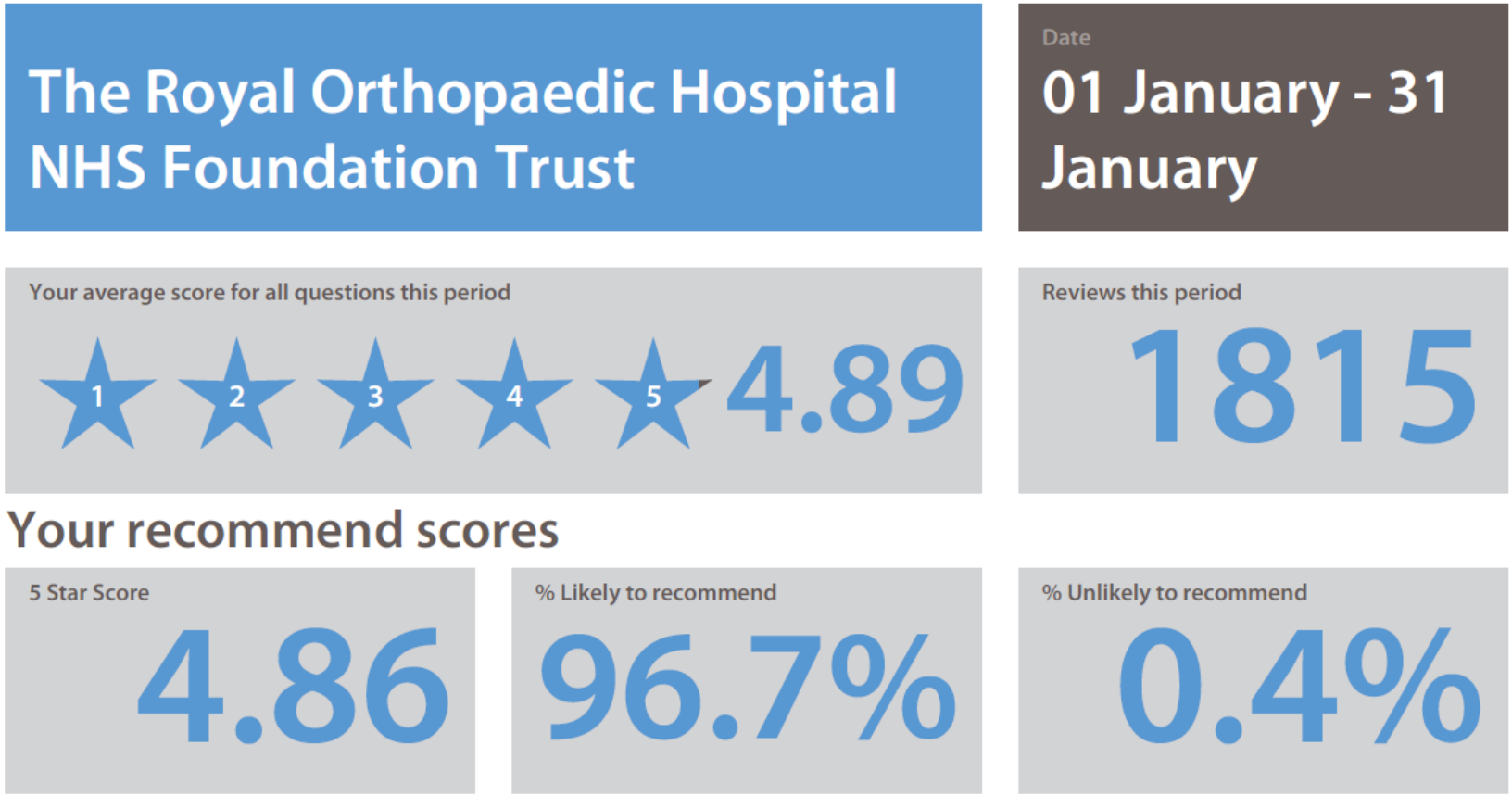
Organisational Score (External Reporting)

96.7% positive

0.4% negative

INFORMATION
There were 1815 submissions of individual data for FFT in January 2018, representing a substantial increase from last month. Areas have been working with the Public and Patient Services Manager to ensure that the opportunity to provide feedback is available to all patients at every stage of their pathway. Outpatient data is now available by speciality for the first time to continue targeted work across all areas to ensure that comparable feedback is available for all departments. The Scores for Friends and Family are now calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as Detractors. The Trust is required to report the %Promoter and %Detractor scores for each inpatient and outpatient area nationally. The results remain consistently high for the Trust overall. The percentages are significantly affected by low response rates. Therefore in considering the Friends and Family Data, it is important to ensure the number of patients responding is known, and every effort is made to increase the number of responses in each area.
ACTIONS FOR IMPROVEMENTS / LEARNING
Managers have been given individual area feedback with a reminder that FFT is a mandatory requirement and there needs to be an improvement in response rate
RISKS / ISSUES
Failure to meet the external required target for inpatient FFT response rate of 35%. Staff have been informed of this

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 monitors and compares the 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

New Claims

No new claims against the Trust were received in January 2018.

On-going claims

There are currently 28 on-going claims against the Trust.

27 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*

4 new requests for Pre-Application Disclosure of medical records were received in January.

**Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes) and governed by the Data Protection Act 1998 and the Access to Health Records Act 1990.*

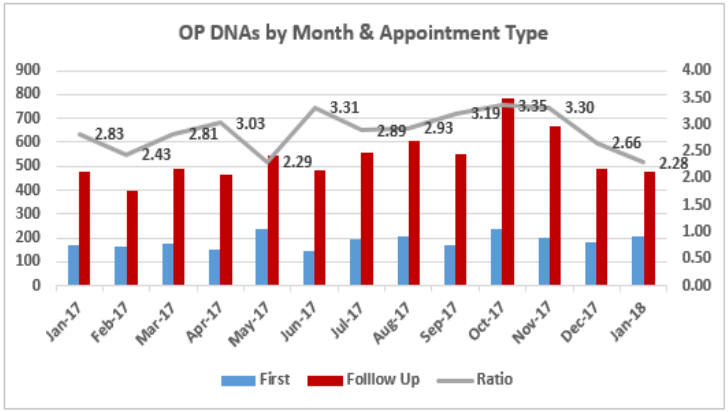
13. Coroner's

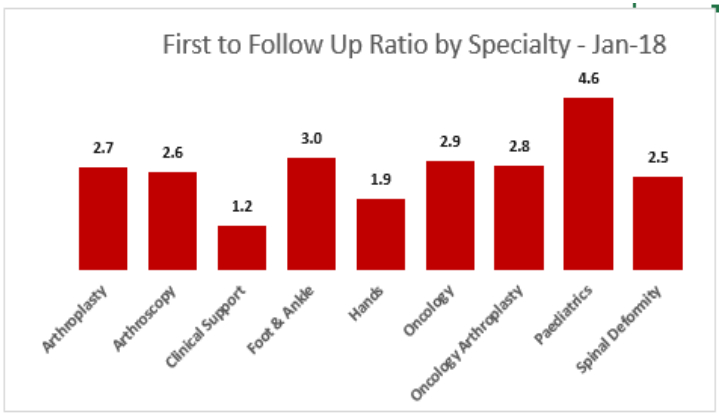
There were no coroner's inquests in January 2018.

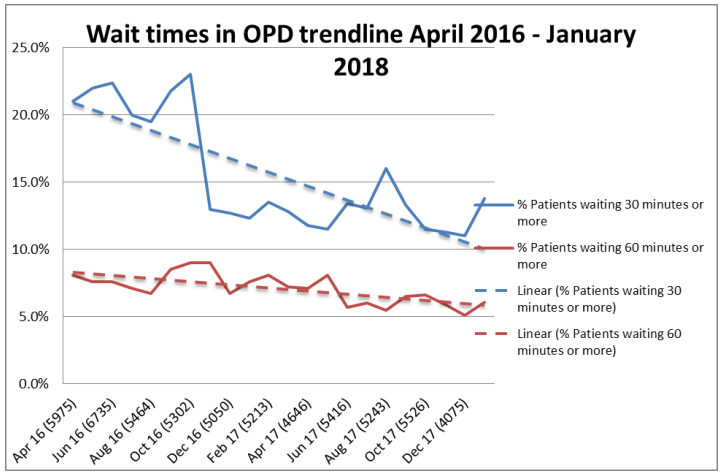
14. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

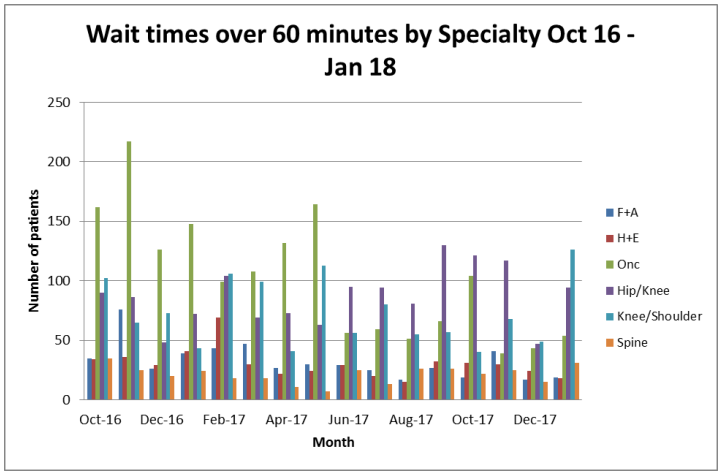
INFORMATION
The data is retrieved from the Theatre man program and the data collected is the non-completed patients. On review of the audit process, the listed patients will have their case notes retrieved and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined; • No form evident in notes • Sign in Section incomplete • Timeout section incomplete • Sign out section incomplete **Total patients for January = 811** **Incomplete Patients = 5** **WHO Non Compliance = 0** **Total WHO Compliance January 2018 = 100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
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

The process for sharing learning in relation to clinic delays is being reviewed and future incident forms will be shared with the Clinical Service Managers along with the clinic delay data. Any issues that require operational management input will be discussed and changes implemented to avoid future recurrence of issues. The incident reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form. A multidisciplinary operational management working group has been set up where issues causing clinic delays are also discussed.
In January there were 22 incident forms completed to highlight clinics running more than 60 minutes late a significant increase in previous months. 13.8% of patients waiting over 30 minutes and 6.1% waiting over 1 hour. The significant delays in the Hip / Knee and Shoulder specialities.

The monthly audit identified the following : -

- 7- Complex patients – patients taking longer to assess for their allocated time
- 4- Clinic overbooked
- 2- Consultants late
- 4- Sickness of medical staff short notice
- 2-medical students in the clinic as a reason for slow delaying
- 1 - rescheduled clinic –patient is not informed pt. was seen on the day
- 2 – medical notes unavailable

ACTIONS FOR IMPROVEMENTS / LEARNING

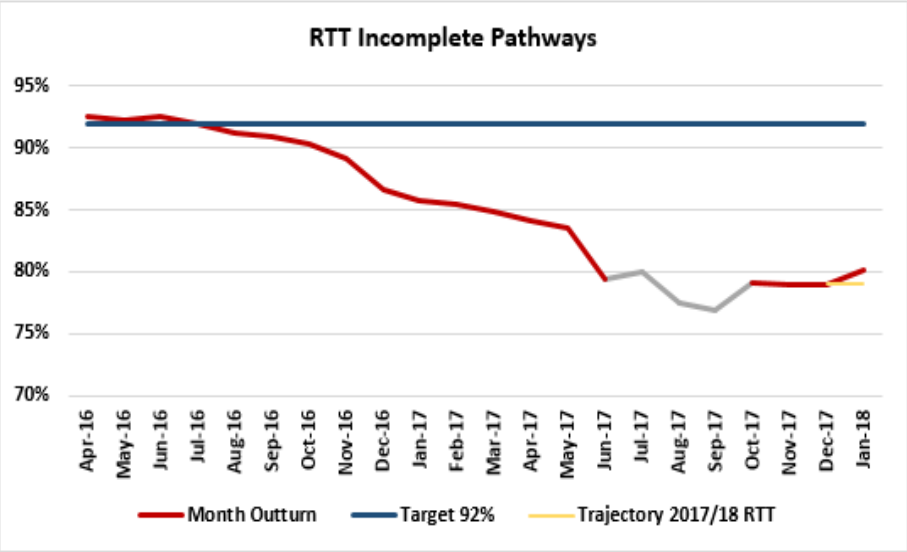
Actions from January's Audit include;
Involvement of Clinical Service Managers in all incidents reported to share issues and develop action plans for improvement

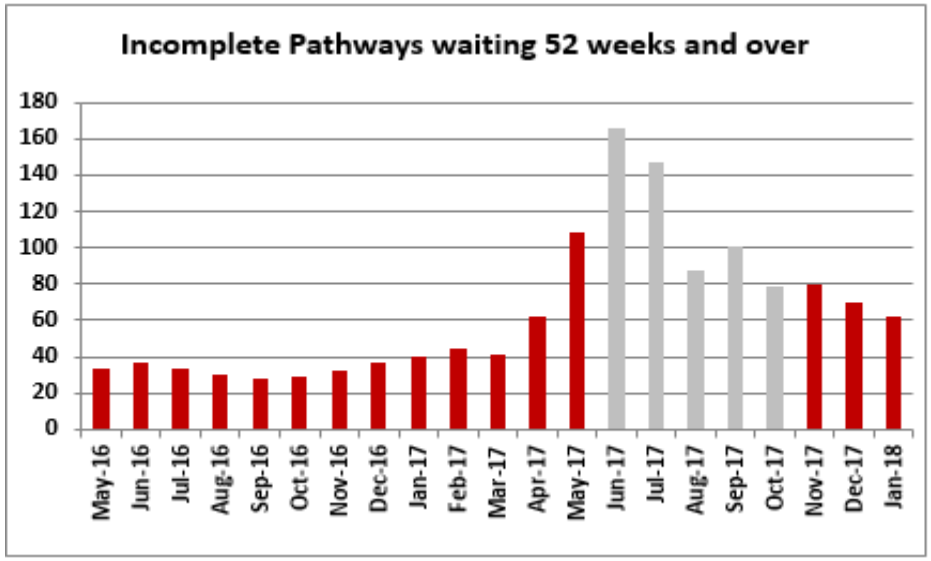
- A review of the clinics that have been overbooked
- A review of clinic cancellation and rescheduling SOP
- A review of unavailable clinic notes
- A review of the late consultants

RISKS / ISSUES

Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure and need to update process

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

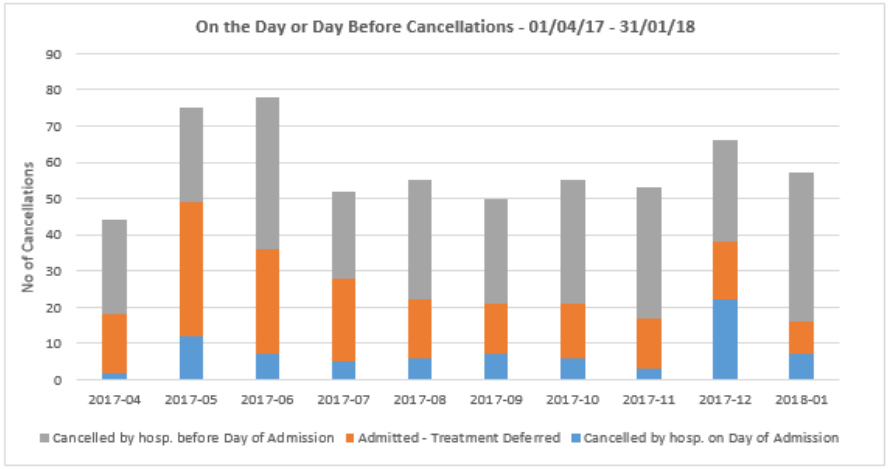




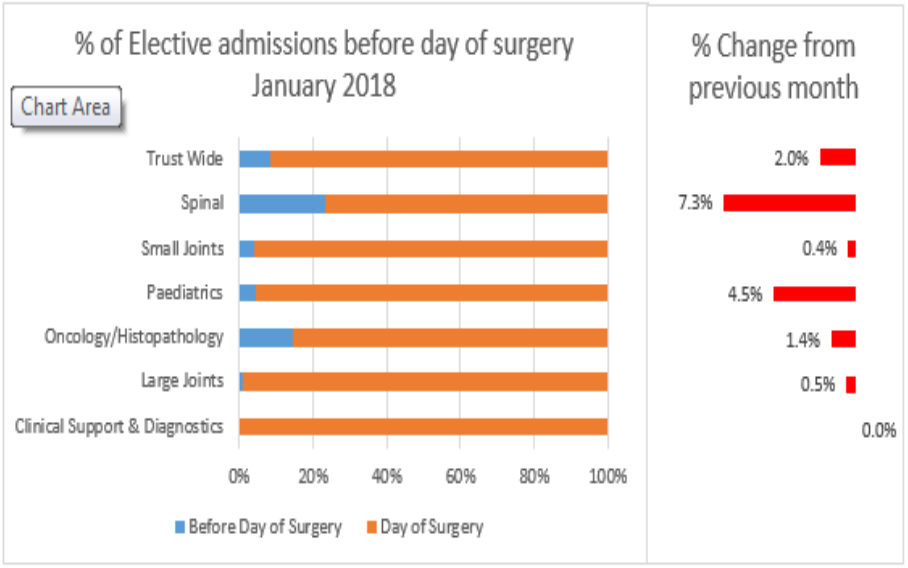
Target Name	National Standard	Jan	Dec	Nov	Oct	Sept	August	July		Q3	Breaches	Total	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	97.10%	100.00%	100%	95.10%	100%	100%	100%		98.40%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	100.00%	100.00%	91.70%	100%	75%	100%	100%		96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	93.30%	100.00%	100.00%	100%	100%	100%	100%		100.00%	0	30	97.40%	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	n/a	n/a	n/a		n/a
62 day (traditional)	85%	76.90%	83.30%	83.30%	100%	100%	100%	37.50%		87.50%	1.5	8	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	100.00%	50.00%	90.90%	81.20%	83%	75%	100%		82.80%	2.5	14	88.9%	1	9	100%	0	4
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		n/a
No. day patients treated 104+ days		2	0	0	0	0	0	3										

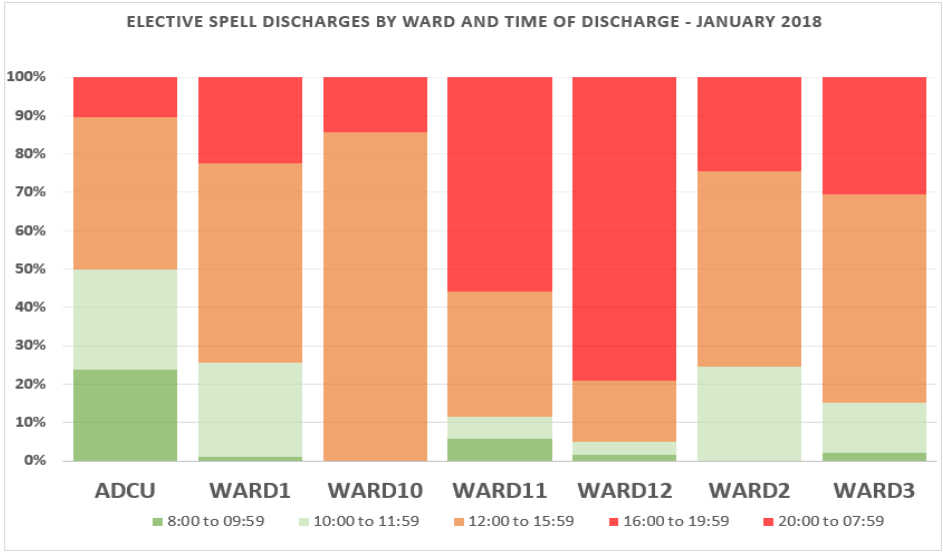
17. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	16	28	66	0
2018-01	7	9	41	57	1
Grand Total	**77**	**189**	**319**	**585**	**10**





INFORMATION
Under the leadership of the Associate Medical Directors, Clinical Service Leads and Clinical Service Managers, work continues weekly to increase activity levels against the recovery plan. In December 2017 as part of Perfecting Pathways a new concept Gold/Silver will be implemented to support the improvement in the flow of patients and particularly around increasing the use of the discharge lounge. This will be supported along with Red2Green with a newly formed operational discharge meeting reviewing LOS . The 'Red2Green' process has been relaunched and progress will be monitored through Perfecting Pathways
ACTIONS FOR IMPROVEMENTS / LEARNING
Work continues to strengthen the Arthroplasty consultant led ward rounds so that patients are seen daily. Further work continues to develop with the Arthroplasty team which includes feasibility around a dedicated Theatre environment, freeing up adjacent accommodation to house the Arthroplasty team and work around pre-assessment. There has been some dedicated focus on the Knee Replacement Pathway and this has started to show a reduction in the overall length of stay for this patient group
RISKS / ISSUES
From April 18 a more focused approach will be in place to actively monitor and reduce LOS, this will be supported by a further roll-out of the Rapid recovery pathway. This will also help to shape the review of the number of beds which the Trust needs to deliver its future capacity to support the SOC.

Finance and Performance Report

February 2018

CONTENTS

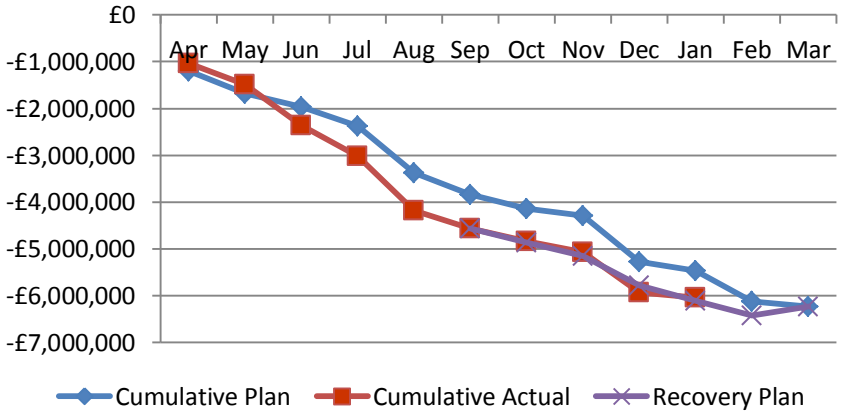
INTRODUCTION

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.

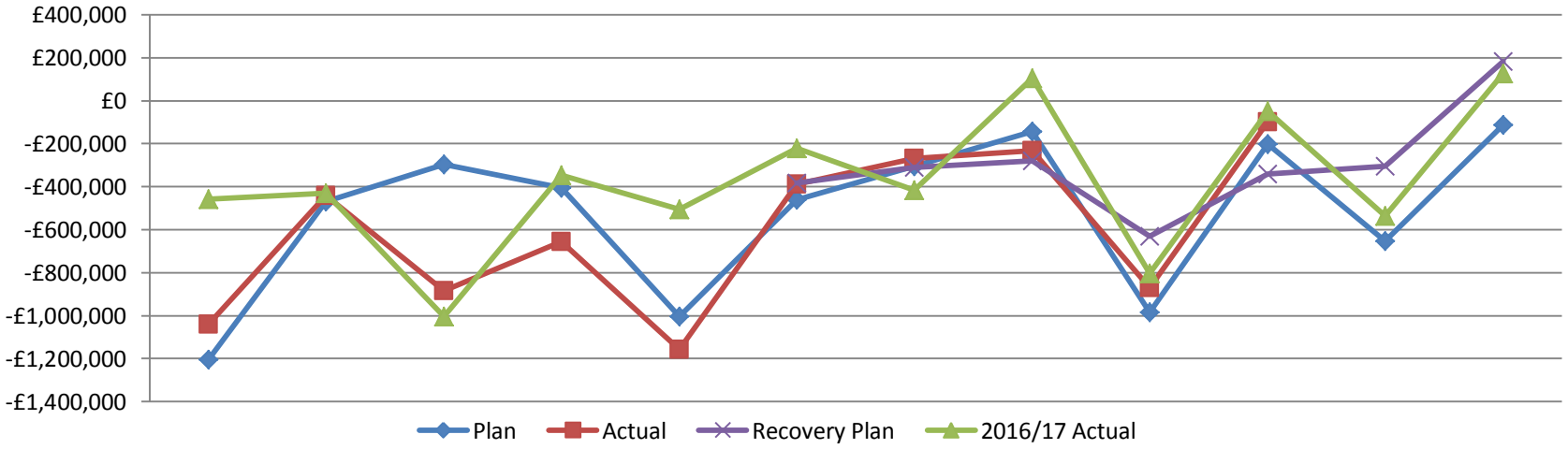
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

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	2
Agency metric	1	2
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £99,000 in January against a planned deficit of £201,000, £102,000 ahead of plan. This brings the year to date position (on a control total basis) to £5,984,000 against a plan of £5,428,000, £556,000 behind plan.

The Trust continues to action areas of efficiency improvement and activity growth outlined within the 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. January marks the fifth month of the recovery plan, with an overperformance of £205,000 against recovery plan of £304,000 deficit in month, and an over performance of 80,000 YTD.

January's performance has been driven by continued control of particularly non-pay spend, and income being largely in plan with plan. Other drivers for the year to date financial performance have included spend on improving RTT reporting (just over £610,000 year to date) and 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 time of the MRI for a period of nearly 2 weeks). 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.

As at the end of January, the Trust has recognised £2,244,000 of CIP savings, against an original plan of £2,644,000. £289,000 (13%) of savings to date are non-recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,776,000 against an original plan of £3,191,000. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

With regards to the Trust's Use of Resources Risk Rating (UOR), the overall position has remained at level 3, although there has been an improvement in the I&E variance from plan element (from a 3 to a 2). The other elements of the Use of Resources elements remain the same; the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover and I&E Margin. The Trust's requirement for cash support has resulted in a 4 for liquidity. Year to date agency spend is higher than agency cap, resulting in an agency rating of 2.

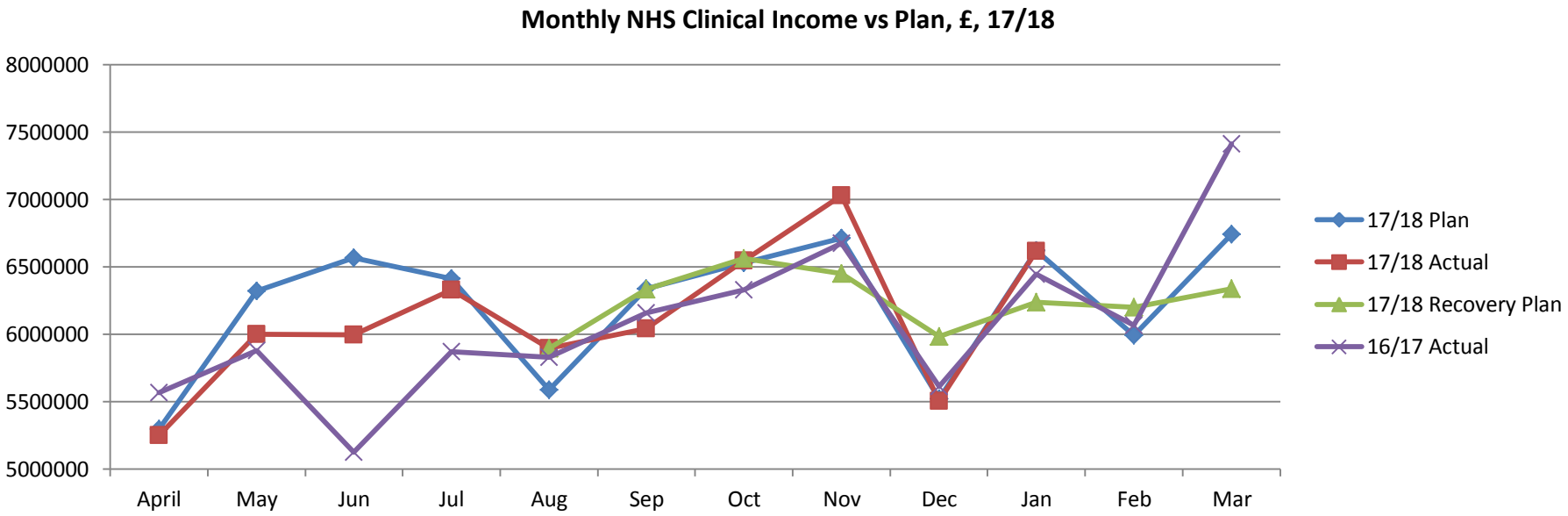
ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust Executive are monitoring weekly progress against activity improvement and the Perfecting Pathways Project.
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.
The Trust is currently in the process of business planning for next year, including defining activity plans and the resultant job plans required, cost pressures and potential areas for investment, and cost improvement plans.
Achievement of performance above the control total will result in a pound-for-pound investment from NHS Improvement.

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.

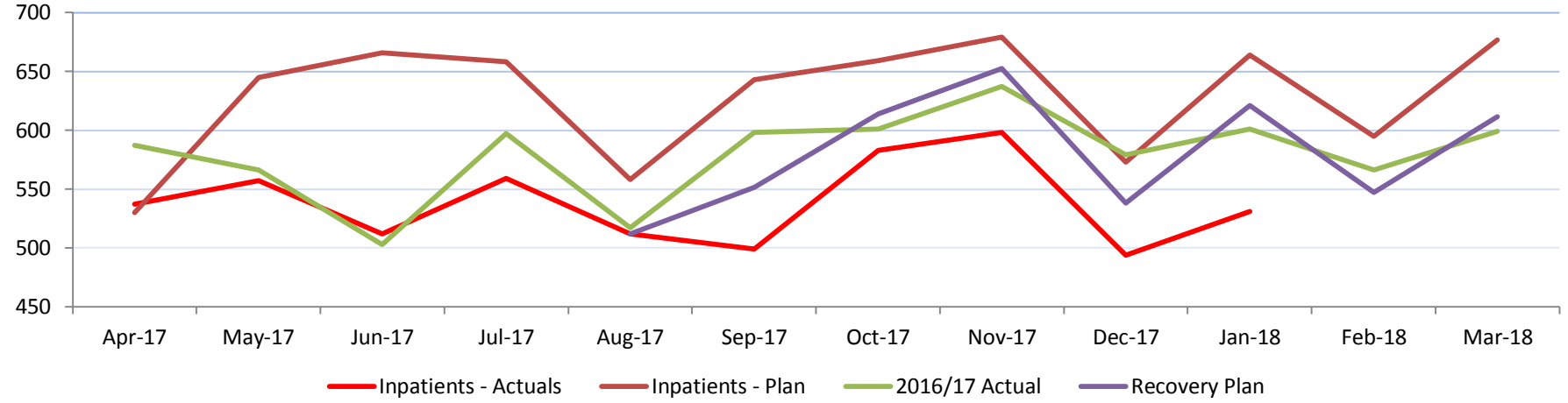
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



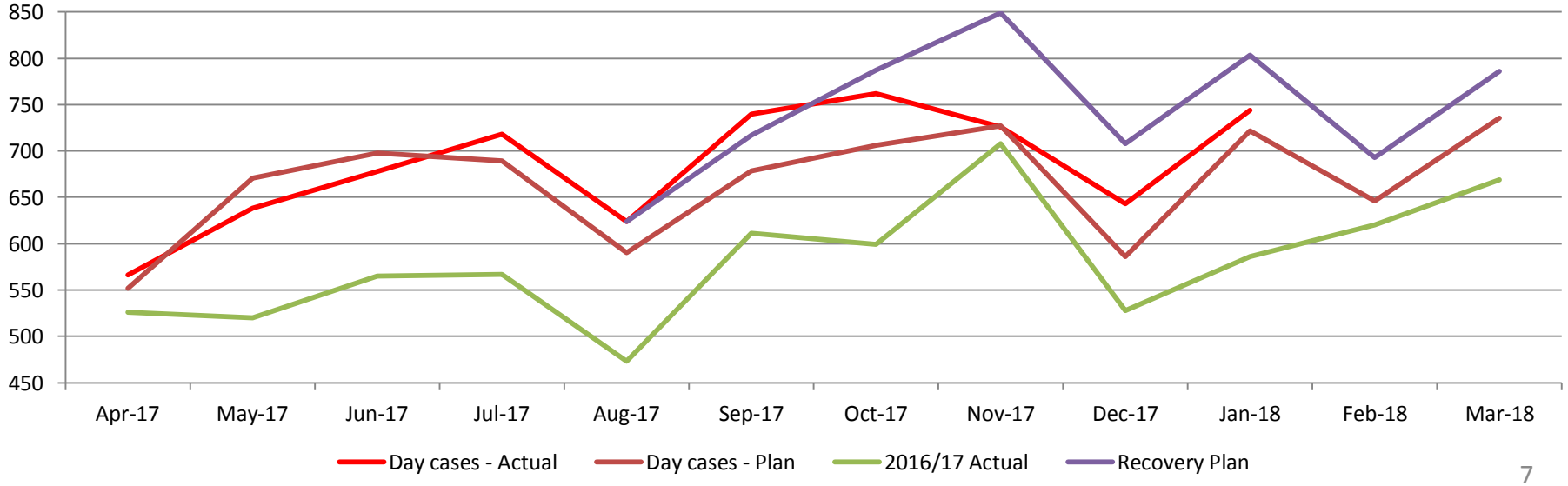
NHS Clinical Income – January 2017 £'000			
	Plan	Actual	Variance
Inpatients	3,375	3,221	-154
Excess Bed Days	105	74	-31
Total Inpatients	3,480	3,295	-185
Day Cases	817	980	163
Outpatients	653	746	93
Critical Care	262	201	-61
Therapies	260	233	-27
Pass-through income	234	336	102
Other variable income	398	299	-99
Block income	518	527	9
TOTAL	6,622	6,617	-5

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	31,382	31,060	-322
Excess Bed Days	975	490	-485
Total Inpatients	32,357	31,550	-807
Day Cases	7589	7795	206
Outpatients	6065	6157	92
Critical Care	2432	2081	-351
Therapies	2417	2195	-222
Pass-through income	2170	2780	610
Other variable income	3692	3472	-220
Block income	5180	5180	0
TOTAL	61,902	61,210	-692

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income was largely in line with January plan, although this was delivered through a greater day case mix than plan. Cumulatively, the trust is now £692,000 behind plan. Underperformance against admitted patient care activity was offset largely through an overachievement of income against plan for day case and for pass-through income.

Pass through income has increased in month 10 due to improved information from month 09 for bespoke prosthesis and we have identified more Magec Rods that can be recharged to NHSE.

	Elective/Non-Elective	Day Case
Actual Activity	531	744
Original Plan	664	721
Variance	(133)	23
Actual Activity	531	744
Recovery Plan	621	803
Variance	(90)	(59)

ACTIONS FOR IMPROVEMENTS / LEARNING

The firms have developed their recovery activity plans and are taking the actions through the Perfecting Pathway project to improve efficiency 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.

Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

As previously mentioned, the Trust is also working operationally and financially to determine what demand and capacity there is internally and how this will affect activity plans, job plans and therefore income for the coming year as part of business planning.

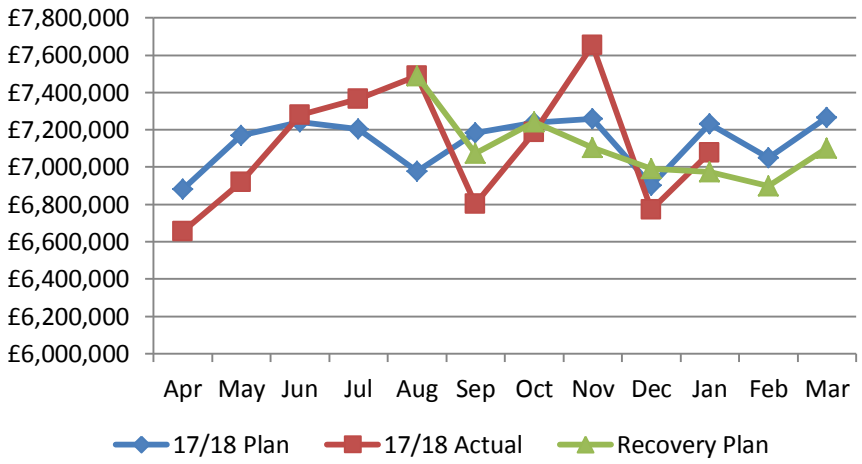
RISKS / ISSUES

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.

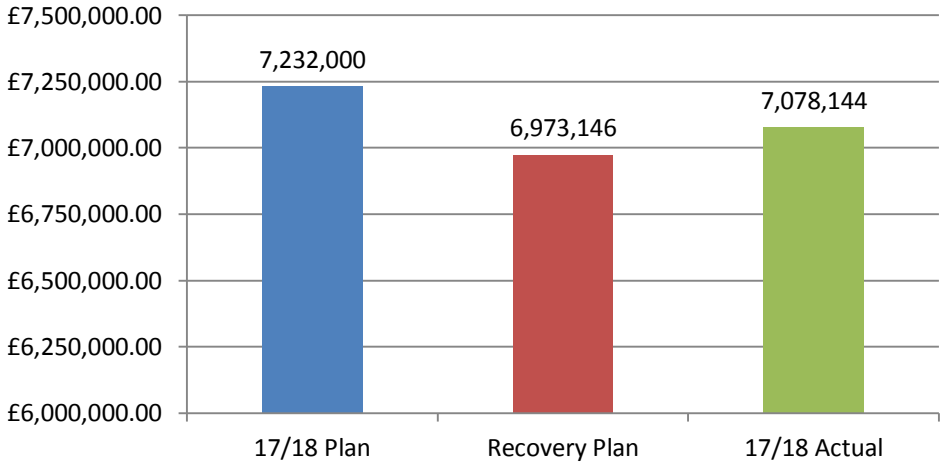
Due to the Trust's current financial position, there is a particular focus needed on achieving activity plans over the last two months of the year. March in particular is expected to be a high income month due to the number of working days. Achievement of these activity targets poses a risk for the Trust.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

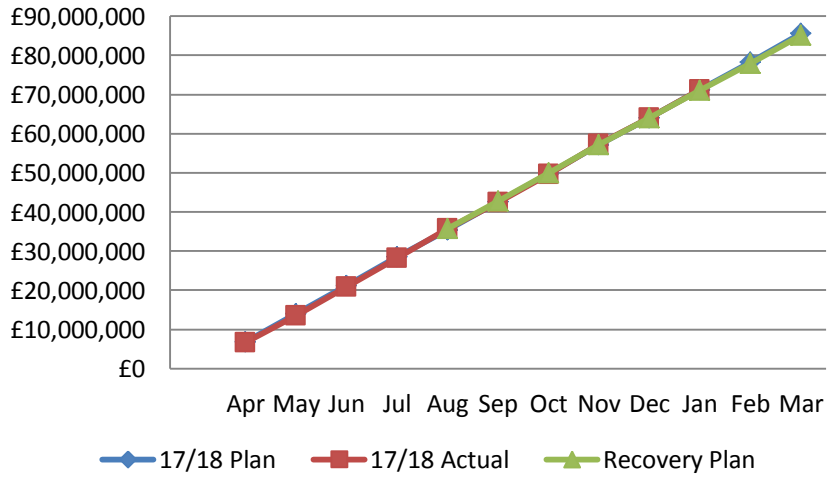
17/18 Monthly Expenditure vs Plan



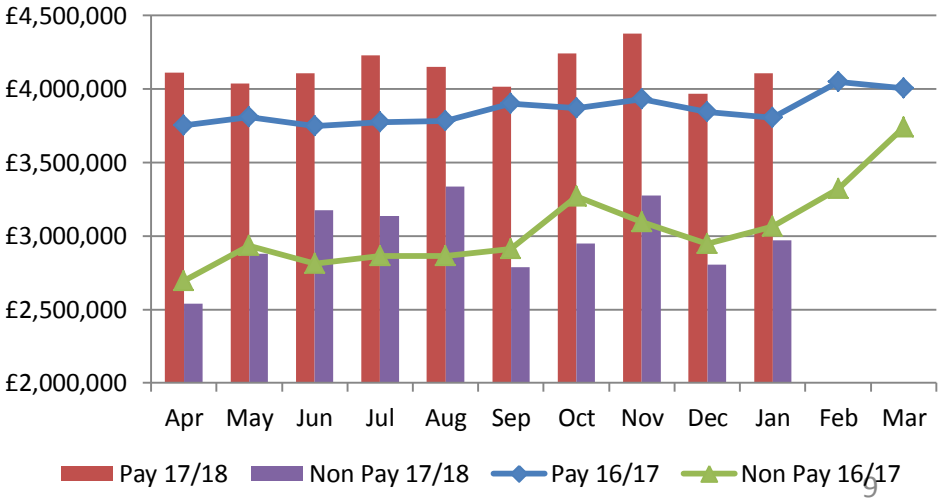
17/18 M10 Expenditure vs Plan



Cumulative Expenditure vs Plan 17/18



16/17 vs 17/18 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £7,078,000, which is £154,000 lower than the in month plan of £7,232,000, but £105,000 higher than the recovery plan of £6,973,000.

Pay spend was c.£75,000 slightly above both recovery and initial plan, partially as a result of an increased utilisation of physiotherapy, ODPs and medics.

The non-pay spend was therefore largely in line with recovery plan, with a slight overspend of £30,000. The original plan had assumed non-pay spend was going to be c.£200,000 higher than actual. The main reason for this was theatres non-pay spend being relatively low. This may correlate with discussions with theatre's management that stock will attempt to be reduced over the remaining months of the year.

ACTIONS FOR IMPROVEMENTS / LEARNING

Costs will continue to be scrutinised and minimised.

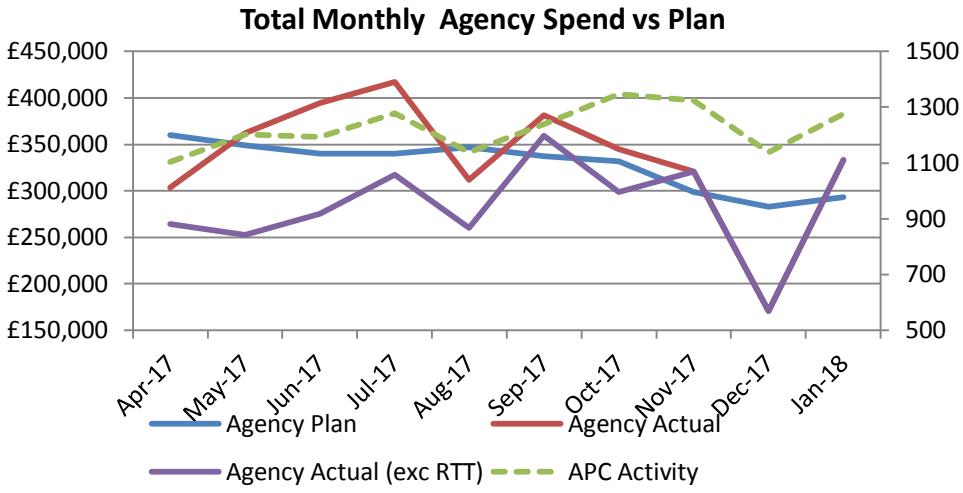
The output from the Theatres stock is now being reviewed by theatres in an effort to understand where there are areas where stock levels can be reduced. Setting correct stock levels will in turn assist with forecasting spend and setting a more reflective financial plan. Plans are underway for the year end count, but also there are frequent meetings to determine what the key areas for improvements in stock management and recording are, and how best to achieve those improvements.

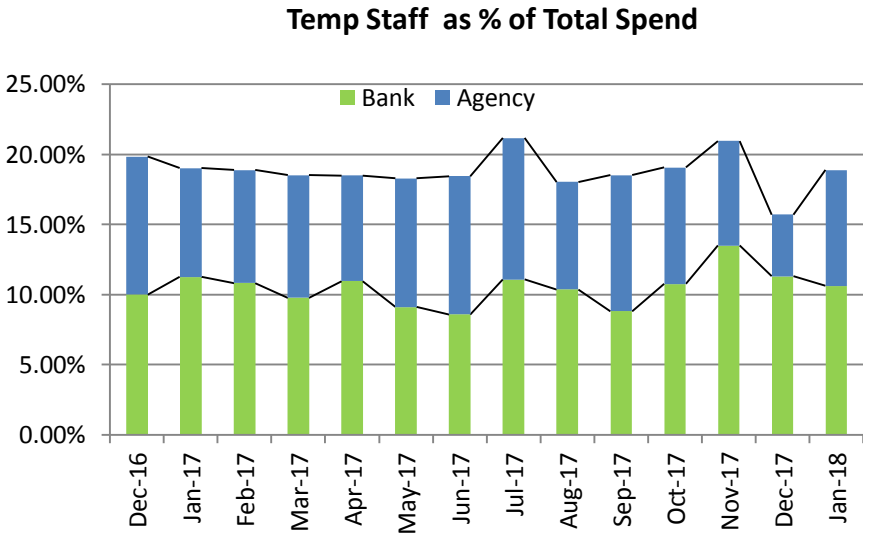
The Interim Director of Finance has been continuing to meet with key operational staff to perform line by line reviews of budgets as part of the business planning exercise. A full list of cost pressures for the 2018/19 financial year has now been completed, and will shortly be being presented on a division-by-division basis to the Interim Director of Finance and Interim Chief Operating Officer.

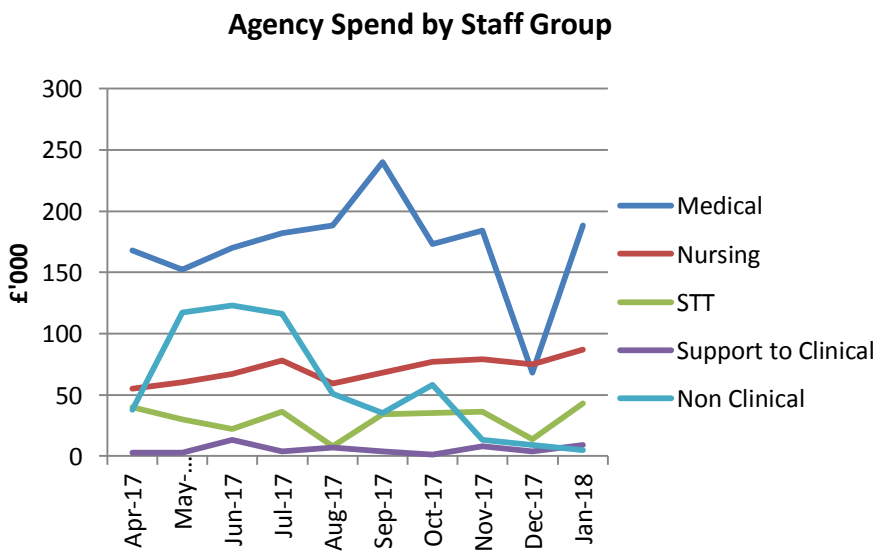
RISKS / ISSUES

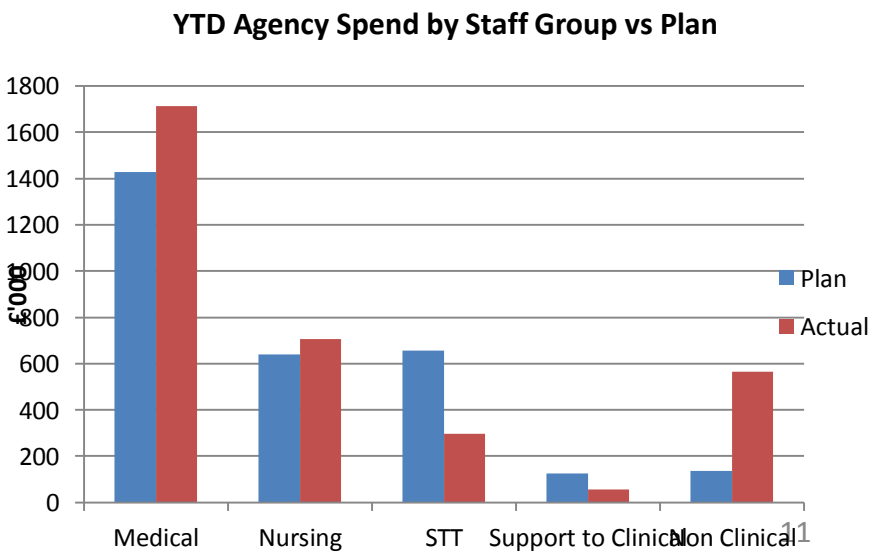
Gaining a greater understanding and control of theatre spend is essential to the recovery of the financial position, and will be mitigated via various theatre improvement workshops ongoing.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

Agency spend has seen an uplift in January, not just above the December spend, but also above that seen in the few months preceding Christmas. This is being driven by increased spend on physiotherapists, ODPs and medics. Therapy agency is largely due to vacant posts and agency is being used to help address the current waiting list. ODP support in theatres is purely to cover vacant posts and recruitment is ongoing.

Presently year to date agency spend remains above cap. Whilst it is now expected that the Trust will overspend on the cap slightly, this is being closely monitored and scrutinised to reduce it below cap if at all possible. 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 Nursing in addressing use of agency continues to impact positively and nursing agency has remained lower than prior year.

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.

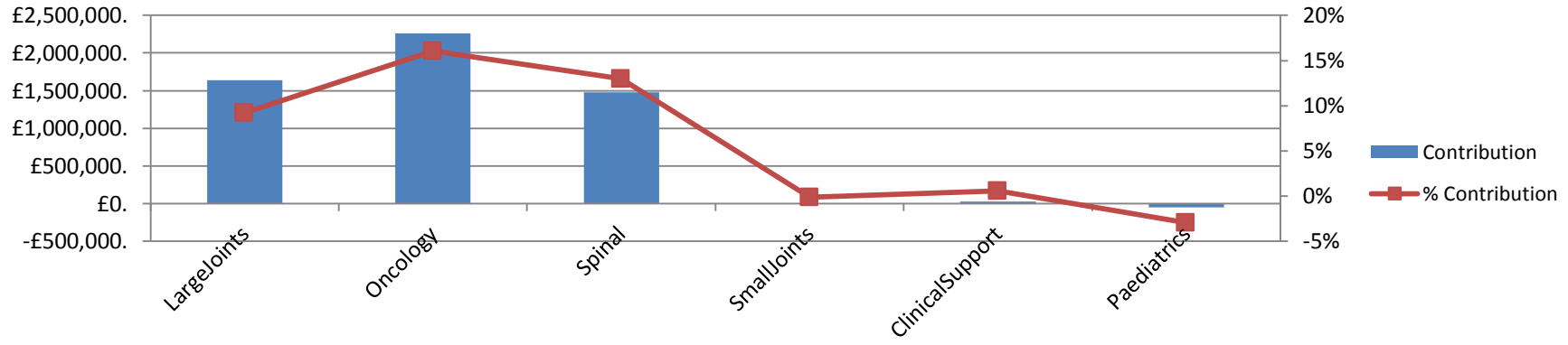
A series of meetings were held with departmental teams in December and January to review staffing rotas and corresponding pay, bank and agency expenditure.

RISKS / ISSUES

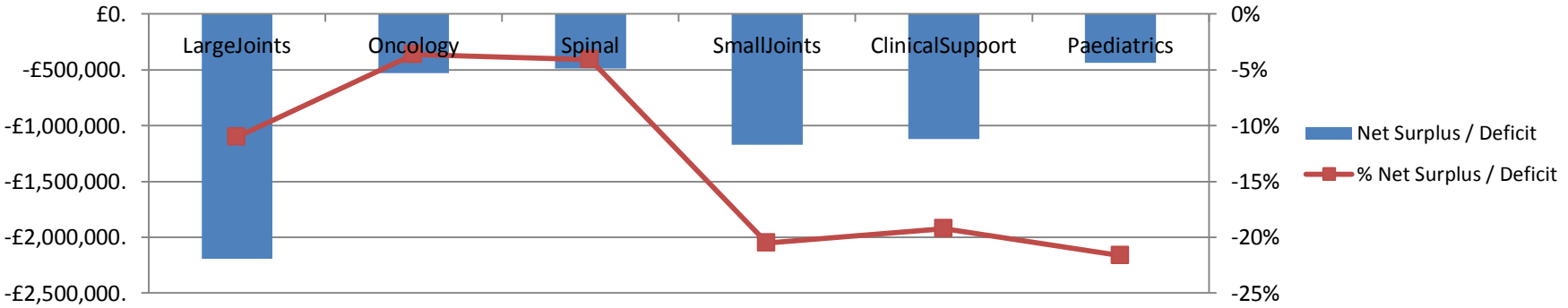
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory will have a direct impact on our regulator ratings. The Trust has remained at a 2 for agency spend, resulting in the overall UOR rating being a 4.

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

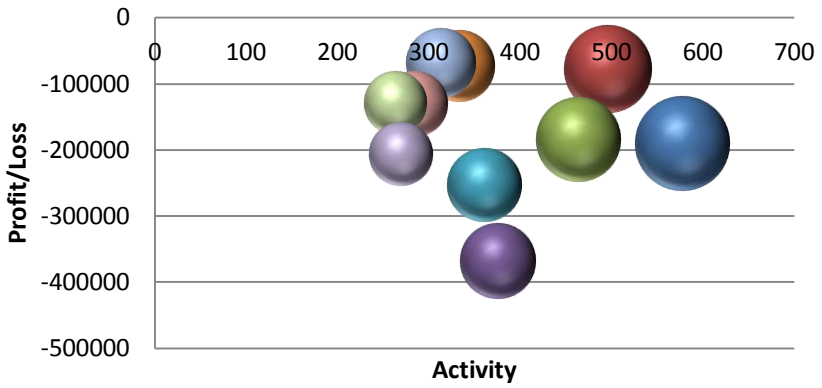
Total Contribution by Service Cumulative to Apr-Dec 2017-18



Net Surplus/Deficit by Service Cumulative to Apr-Dec 2017-18

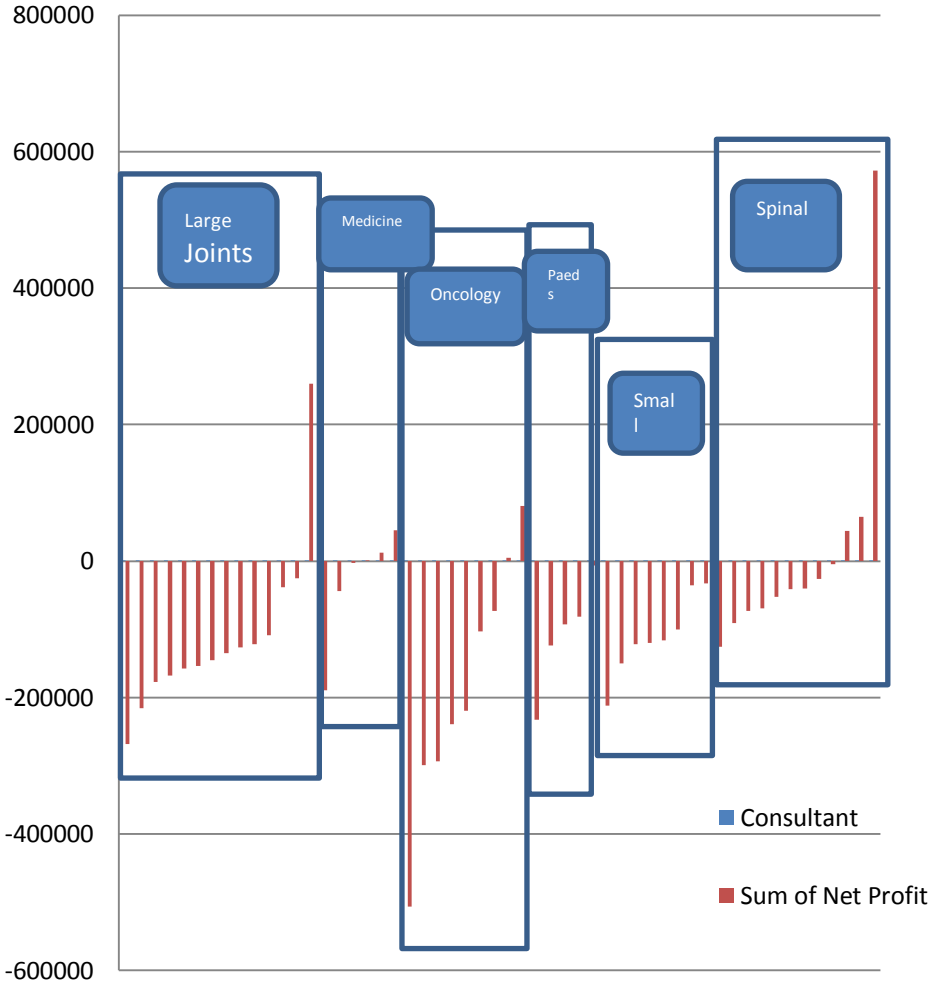


Top 10 HRG by Volume April - Dec 2017-18



- Degenerative Spinal Conditions without Interventions, with CC Score 0-2
- Minimal Hip Procedures, 19 years and over
- Very Major Hip Procedures for Non-Trauma with CC Score 0-1
- Very Major Knee Procedures for Non-Trauma with CC Score 2-3
- Very Major Knee Procedures for Non-Trauma with CC Score 0-1
- Injection of Therapeutic Substance into Joint for Pain Management
- Minor Hand Procedures for Non-Trauma, 19 years and over
- Very Major Hip Procedures for Non-Trauma with CC Score 2-3
- Image Guided Biopsy of, Lesion of Muscle or Connective Tissue
- Intermediate Knee Procedures for Non-Trauma, 19 years and over, with CC Score 0-1

Consultant Net Profit/Loss Apr-Dec 2017-18



INFORMATION

The graphs above, and the associated narrative, relate to April –December 2017.

The first graph is showing the contribution each service is generating, currently the Trust target is set at >20%. Each service line is below the set target as of December with Small Joints and Paediatrics generating a negative contribution.
It can be seen in the second graph that once the finance costs for overheads, depreciation and interest are applied; all service lines are running at a net loss.

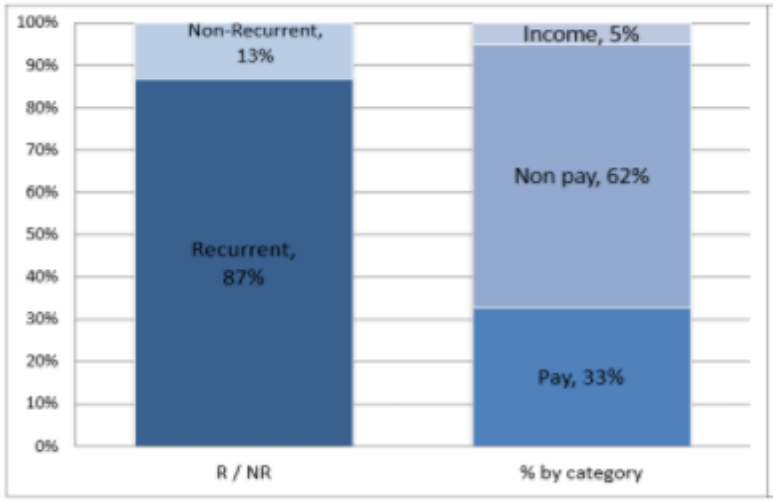
The Trust's most common HRGs being performed are all generating a loss with the majority being Degenerative Spinal Conditions, followed by Minimal Hip and Very Major Hip Procedures. The SLR data would suggest that the most profitable procedures for the Trust are largely Spinal Deformity cases and Major Shoulder procedures carried out by Arthroscopy surgeons.

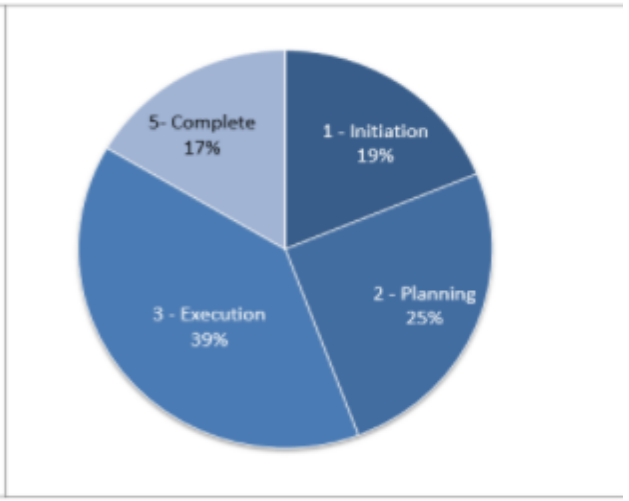
ACTIONS FOR IMPROVEMENTS / LEARNING

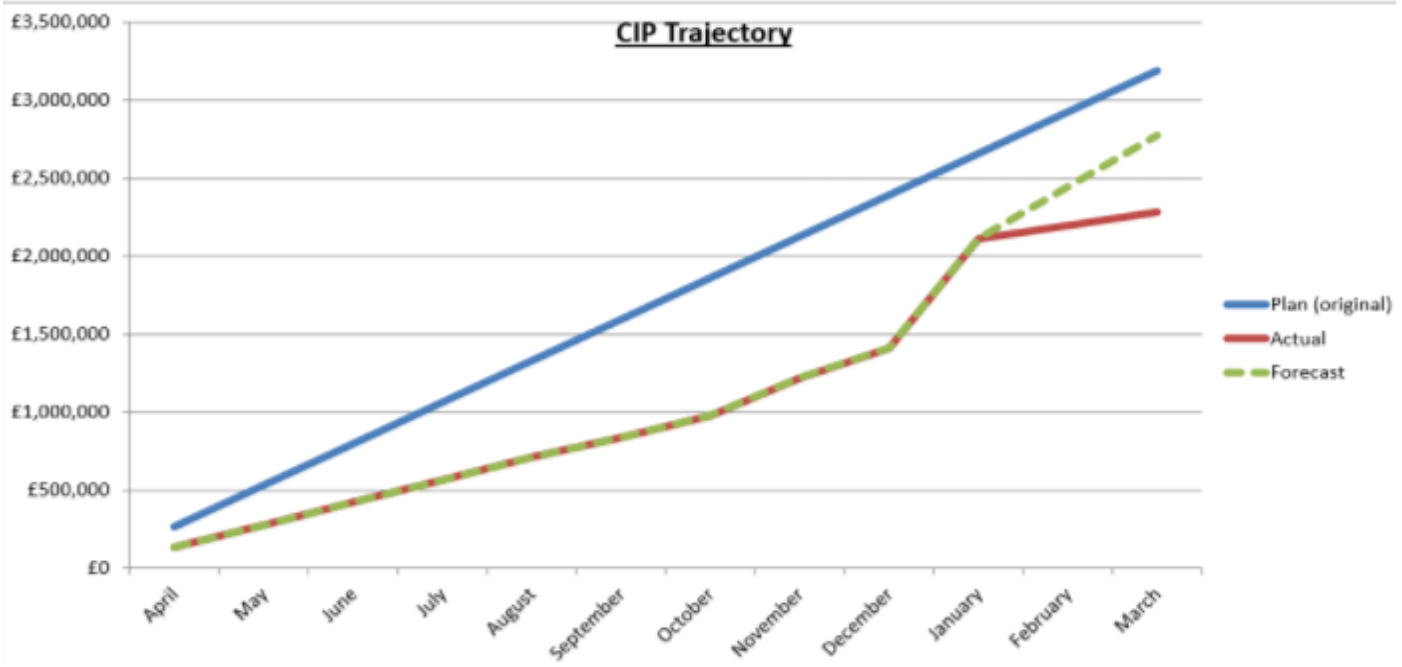
It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings. The costing team will meet with each individual firm over the next couple of months to identify areas for costing improvement and to identify any potential areas of income underrecognition.

RISKS / ISSUES

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18







INFORMATION

As at the end of January the Trust has recognised £2,244,000 of CIP savings, against a plan of £2,644,000, a negative variance of £400,000. The full year effect of the savings recognised to date is £2,283,000.

£289,000 (13%) of savings to date are non-recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,776,000 against an original plan of £3,191,000, causing a forecast variance of £415,000.

The current forecast only contains 5% of income related schemes with the remainder of the plan split 62% non pay and 33% pay. Within the forecast position 17% of the savings have been completed, 39% are at the execution stage, 25% planning and 19% initiation stage. The detail by division is shown below;

	Original Plan	YTD Original Plan	Actual Full year effect	Forecast	Forecast vs Original Plan Variance	YTD Plan	YTD Actual	YTD Variance
Division 1	£1,362,500	£1,396,420	£975,958	£1,094,145	-£268,355	£1,450,790	£1,078,249	-£372,540
Division 2	£851,270	£464,758	£345,587	£692,570	-£158,700	£464,758	£345,587	-£119,171
Division 3	£42,875	£42,614	£42,878	£42,878	£3	£42,614	£40,511	-£2,103
Division 4	£160,000	£141,670	£154,213	£149,793	-£10,208	£141,670	£131,821	-£9,849
Corporate	£774,355	£544,168	£765,020	£779,888	£5,533	£544,168	£647,786	£103,618
Grip and Control	£0	£0	£0	£0	£0	£0	£0	£0
Productivity and Efficiency	£0	£0	£0	£16,667	£16,667	£0	£0	£0
TOTAL	£3,191,000	£2,589,630	£2,283,656	£2,775,939	-£415,061	£2,644,000	£2,243,954	-£400,046
Shortfall				-£415,061				

ACTIONS FOR IMPROVEMENTS / LEARNING

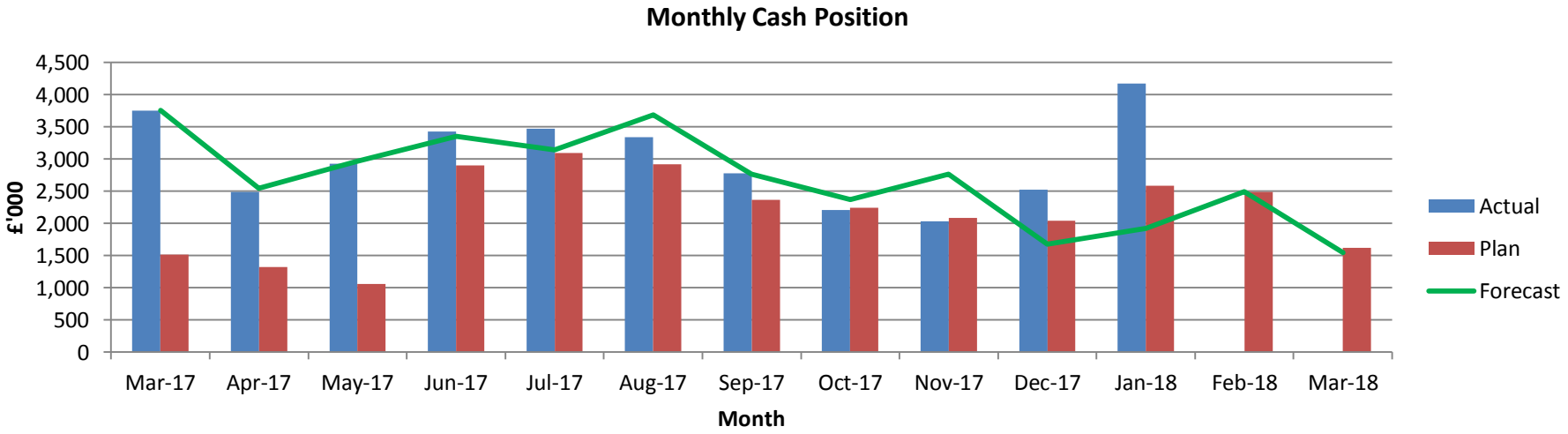
Focus has been shifted to converting non recurrent savings in year to recurrent, and to fully developing the 2018/19 CIP plan.
The schemes which have CIP to be actioned during Months 11 and 12 of this year are;

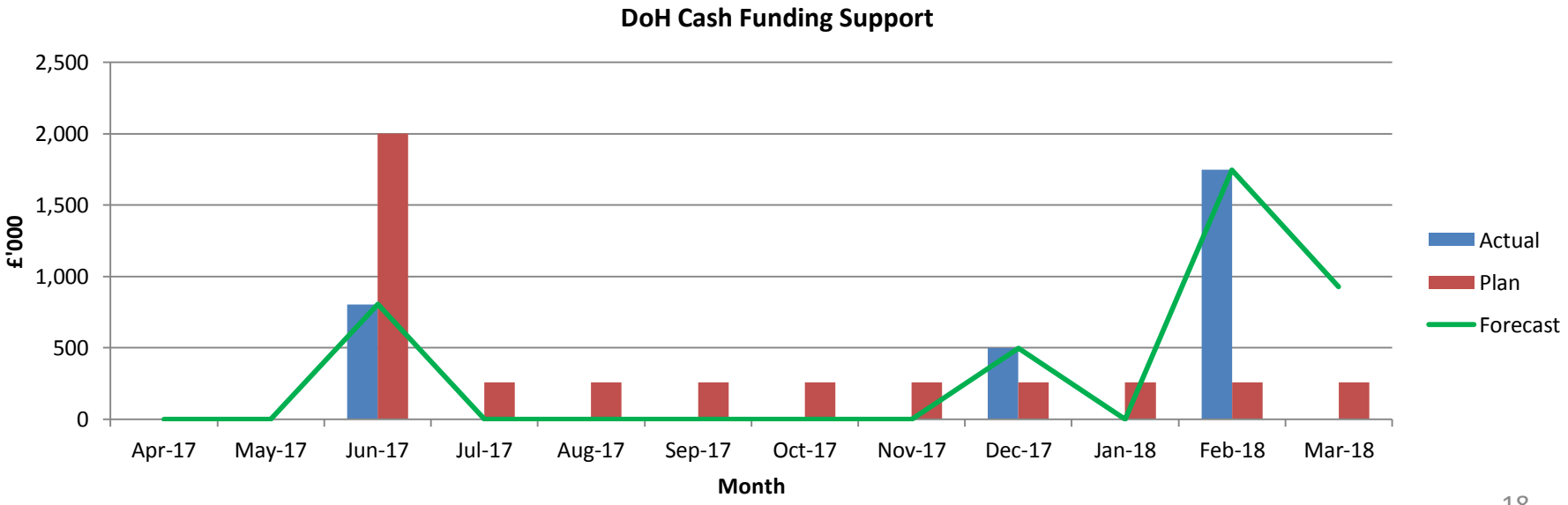
- Theatres stock management and rationalisation
- Implant rationalisation
- Other non pay consumables – rationalisation and product changes

RISKS / ISSUES

A significant amount of work remains to be completed to fully develop 2018/19 schemes to ensure they can be implemented at the required timescales so that financial benefits are maximised during 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 in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash was £1,587k above planned levels at the end of January. This is because underperformance recoveries expected in month based on discussions with commissioners were not actioned by the CCGs.

The Trust received its first cash loan of £804k from the Department of Health on 12th June 2017 and the second loan of £498k in December 2017 as previously advised to the Committee. A third loan of £1747k has now been requested in February 2018. A substantial further loan of £930k is expected to be required in March, due to the present financial position, and levels of activity. This is however in line with the planned loans required for the year.

The requirement for cash support continues to result in the trust being rated at the lowest level (level 4) for liquidity.

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 2017/18. The finance team continue to run a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team in order to scrutinise both the current and future cash position, but also to identify areas for cash control improvement. The committee continues to review cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the Department of Health to be actioned. The updated cash requirements for 2018/19 based on a refresh of the operational plan are currently being modelled.

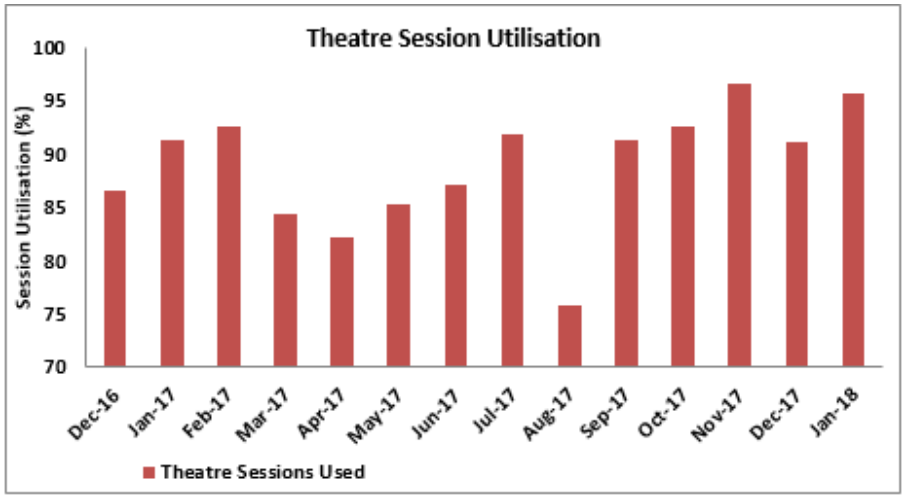
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DoH not approving a cash loan or approving a lower than requested amount.

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.

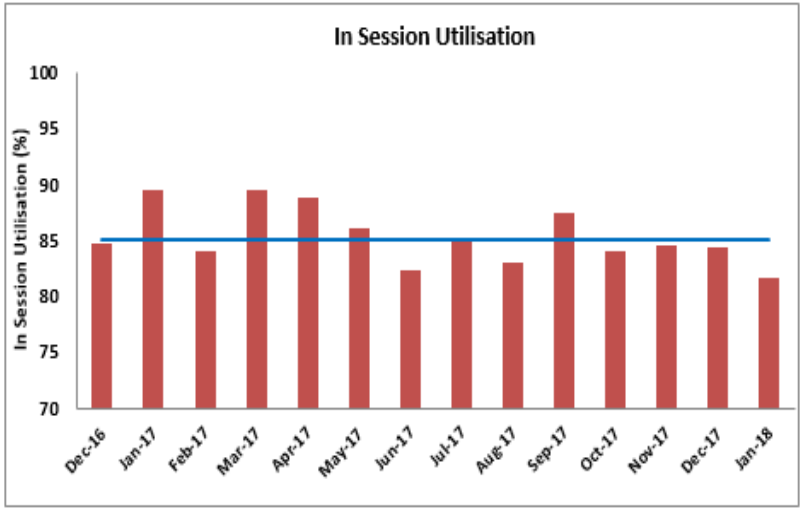
ACTIONS FOR IMPROVEMENTS / LEARNING

Theatre list utilisation for January was 95.77% up on the previous month. Theatres continue to see a consistent increase in utilisation since September, with the exception of December due to the festive period, with the weekly 6-4-2 meetings playing a vital part in this improved performance.

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc will also need to 'grow' alongside theatres to ensure maximum efficiency gains.

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



INFORMATION

Whilst list utilisation continues to improve, in-session utilisation has reduced over the last quarter.

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 was 81.61% in January, a slight decrease on the previous month. The main driver for this being patients not fit, (chest infections etc) and patients self cancelling or not attending on the day. These themes continue to be reviewed in the look back meeting held weekly.

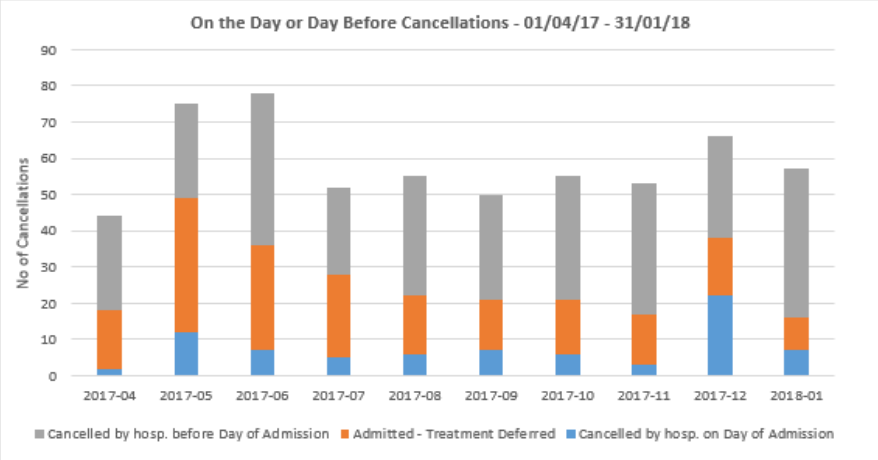
RISKS / ISSUES

Staff vacancies within theatres – on-going recruitment process is in place

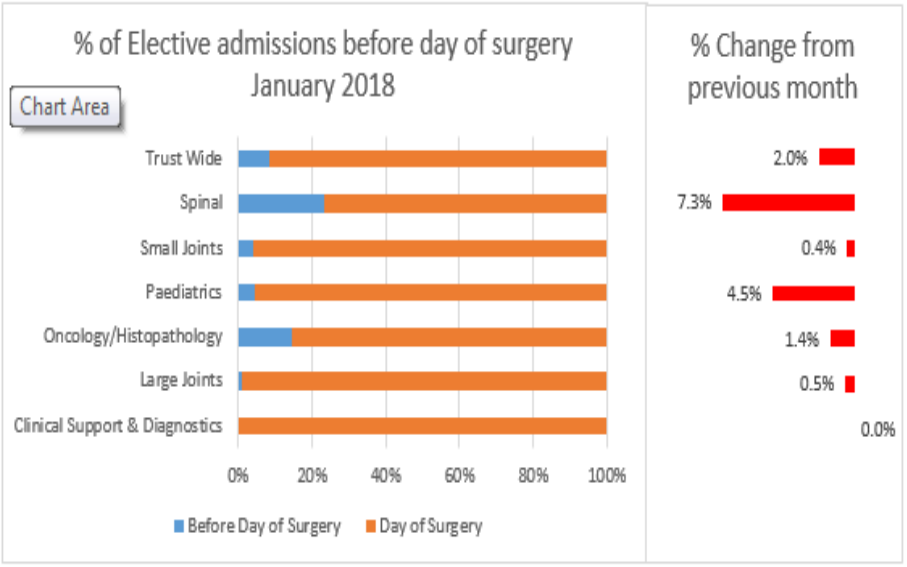
Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit.

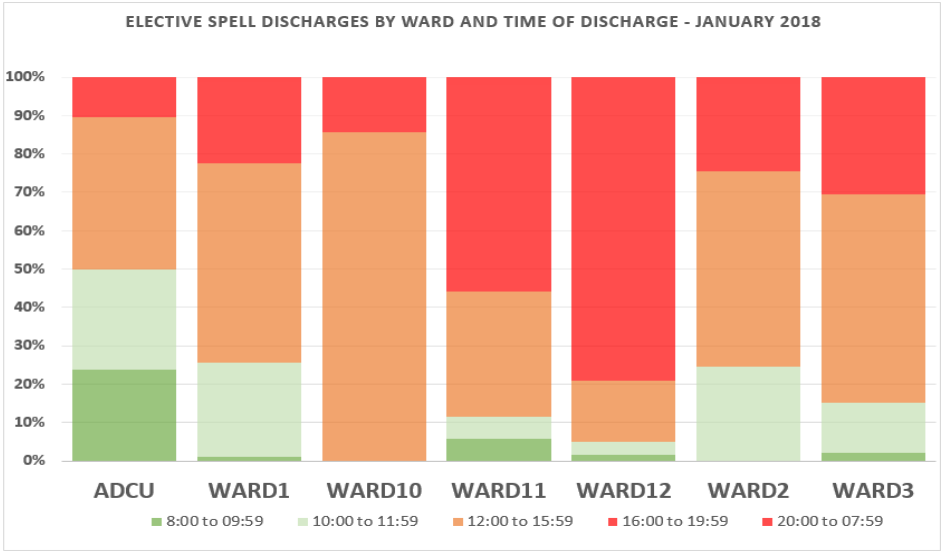
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	16	28	66	0
2018-01	7	9	41	57	1
Grand Total	77	189	319	585	10





INFORMATION

The number of cancellation on the day of surgery by the hospital continue to reduce.
There has this month been an increase in the number of patients cancelled before the day of surgery, the two main factors were the number of patients with colds / flu cancelling at short notice and consultant sickness. Patients were contacted the day before to avoid on the day cancellations

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers.

Following on from the 12th October multi-disciplinary POAC workshop the Clinical Service Manager is reviewing the structure with the team to ensure that staffing and patient processes are robust to meet the needs of any future changes.

To further strengthen the POAC model the team now sit within Division 2, this now sits closer to the Anaesthetic service.

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.

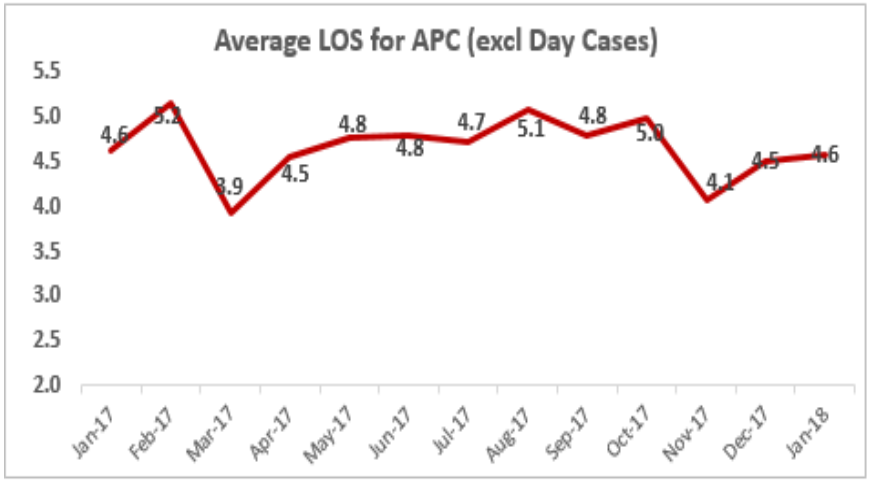
Priorities are now being agreed as part of Perfecting Pathway which will help to deliver some of the key deliverables discussed at the POAC workshop .

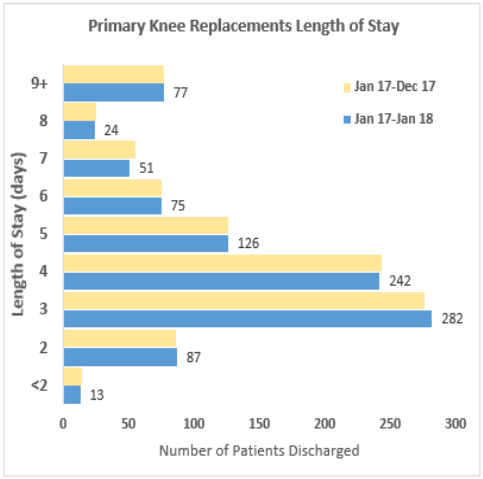
PERFECTING PATHWAYS

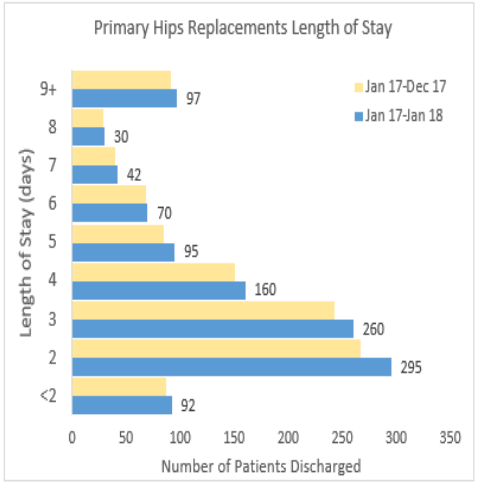
RISKS / ISSUES

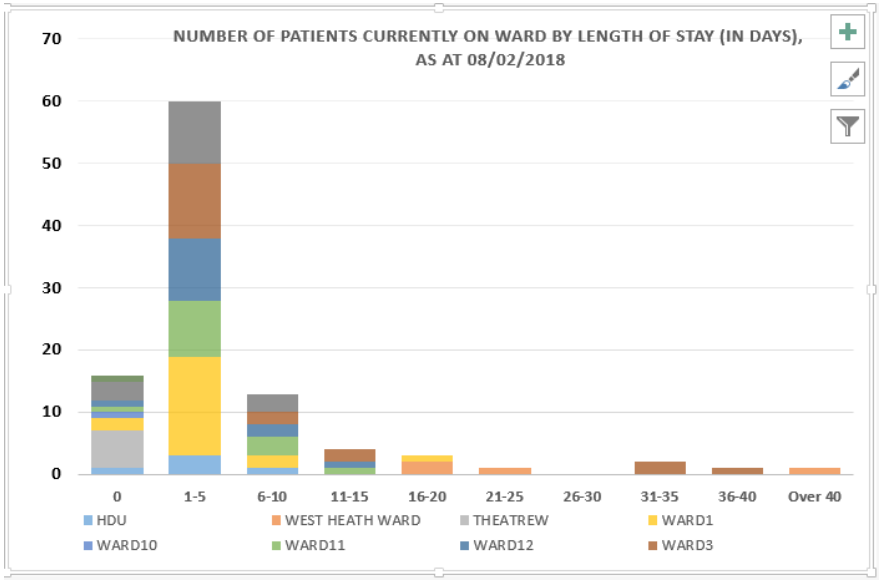
Continued high levels of cancellations due to medically unfit patients
Short turn around times to ensure patients are fit for surgery

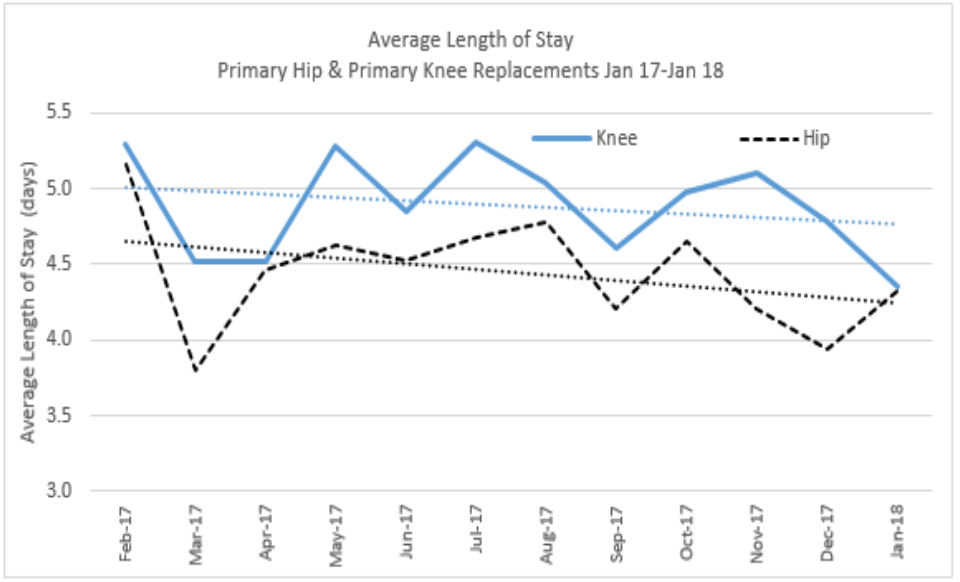
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors, Clinical Service Leads and Clinical Service Managers, work continues weekly to increase activity levels against the recovery plan.

In December 2017 as part of Perfecting Pathways a new concept Gold/Silver will be implemented to support the improvement in the flow of patients and particular around increasing the use of the discharge lounge.

This will be supported along with Red2Green with a newly formed operational discharge meeting reviewing LOS .

The 'Red2Green' process has been relaunched and progress will be monitored through Perfecting Pathways

ACTIONS FOR IMPROVEMENTS / LEARNING

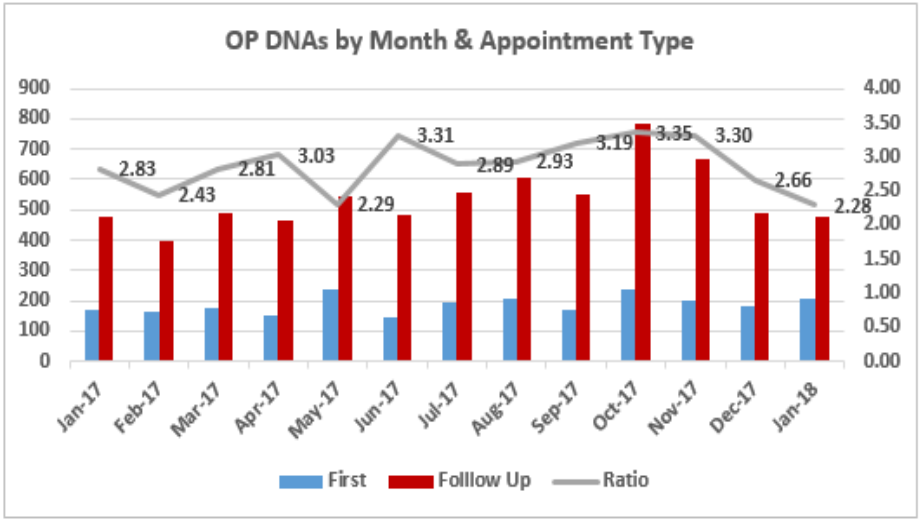
Work continues to strengthen the Arthroplasty consultant led ward rounds so that patients are seen daily. Further work continues to develop with the Arthroplasty team which includes feasibility around a dedicated Theatre environment , freeing up adjacent accommodation to house the Arthroplasty team and work around pre-assessment. There has been some dedicated focus on the Knee Replacement Pathway and this has started to show a reduction in the over all length of stay for this patient group

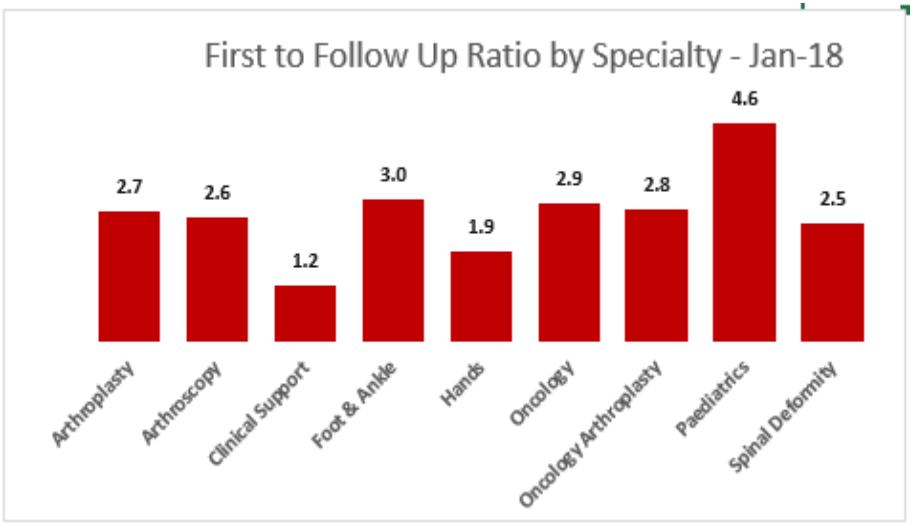
Work has also commenced to increase the number of patients who are treated on the Rapid Recovery Pathway for Knees.

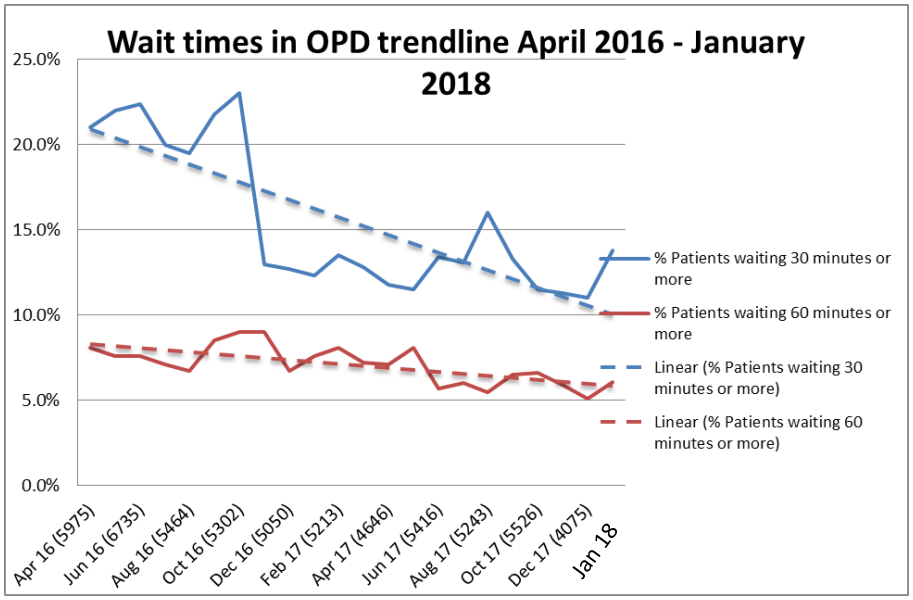
RISKS / ISSUES

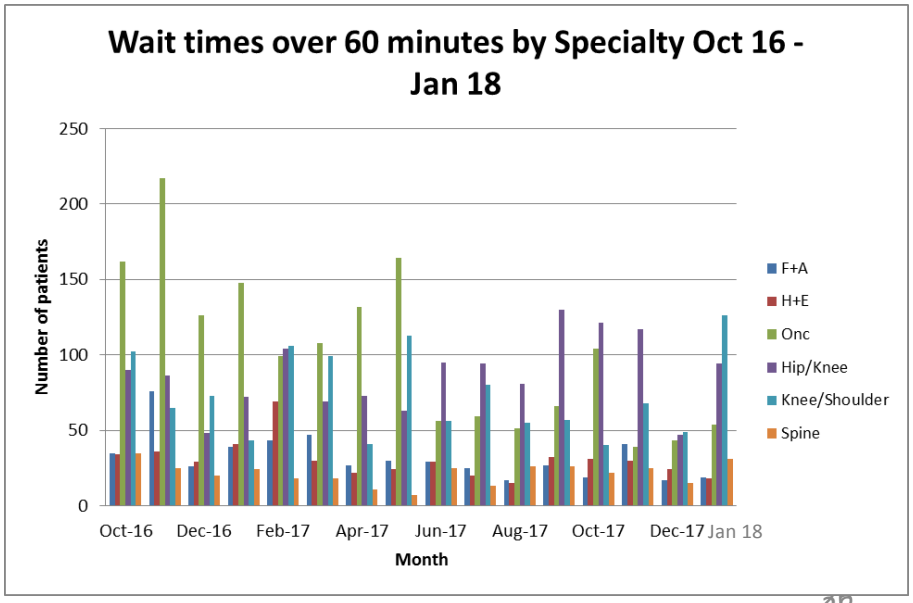
From April 18 a more focussed approach will be in place to actively monitor and reduce LOS, this will be supported by a further roll out of the Rapid recovery pathway. This will also help to shape the review of the number of beds which the Trust needs to deliver its future capacity to support the SOC.

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









INFORMATION

The process for sharing learning in relation to clinic delays is being reviewed and future incident forms will be shared with the Clinical Service Managers along with the clinic delay data. Any issues that require operational management input will be discussed and changes implemented to avoid future recurrence of issues. The incident reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form. A multidisciplinary operational management working group has been set up where issues causing clinic delays are also discussed.

In January there were 22 incident forms completed to highlight clinics running more than 60 minutes late a significant increase in previous months. 13.8% of patients waiting over 30 minutes and 6.1% waiting over 1 hour. The significant delays in the Hip / Knee and Shoulder specialties.
The monthly audit identified the following : -

- 7- Complex patients – patients taking longer to assess for their allocated time
- 4- Clinic overbooked
- 2- Consultants late
- 4- Sickness of medical staff short notice
- 2-medical students in clinic as reason for slow delaying
- 1 - rescheduled clinic –patient not informed pt. was seen on the day
- 2 – medical notes unavailable

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions from January's Audit include;

- Involvement of Clinical Service Managers in all incidents reported to share issues and develop action plans for improvement
- A review of the clinics that have been over booked
- A review of clinic cancellation and rescheduling SOP
- A review of unavailable clinic notes
- A review of the late consultants

RISKS / ISSUES

Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure and need to update process

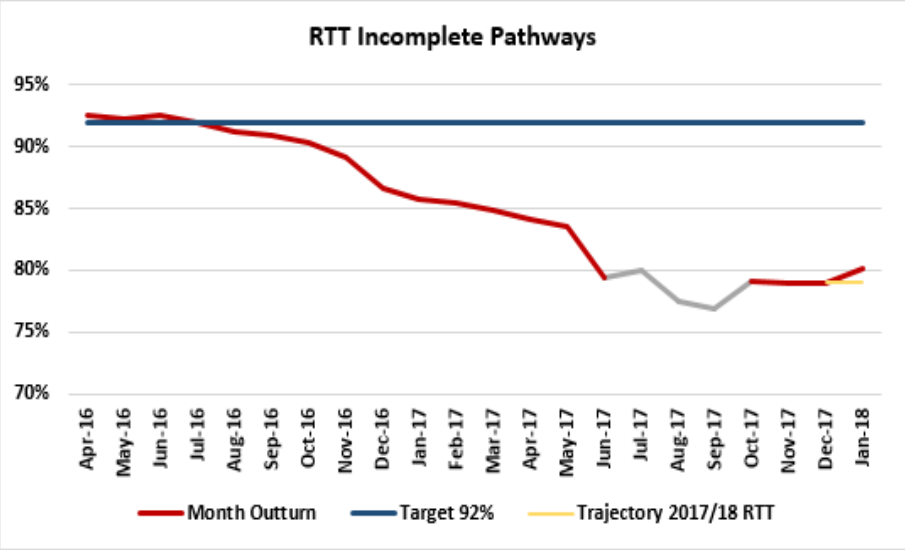
14. Treatment targets – This illustrates how the Trust is performing against national treatment target –

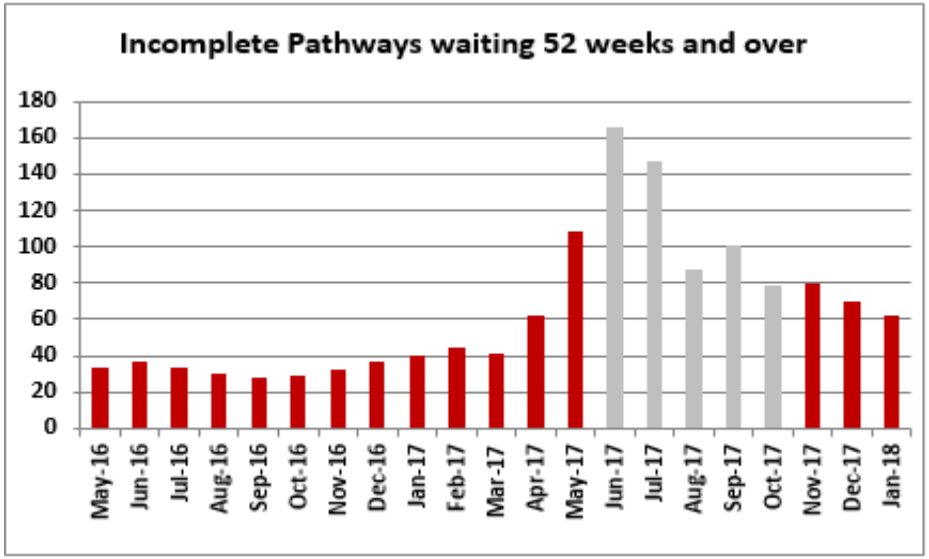
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%

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





Target Name	National Standard	Jan	Dec	Nov	Oct	Sept	August	July		Q3	Breaches	Total	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	97.10%	100.00%	100%	95.10%	100%	100%	100%		98.40%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	100.00%	100.00%	91.70%	100%	75%	100%	100%		96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	93.30%	100.00%	100.00%	100%	100%	100%	100%		100.00%	0	30	97.40%	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	n/a	n/a	n/a		n/a
62 day (traditional)	85%	76.90%	83.30%	83.30%	100%	100%	100%	37.50%		87.50%	1.5	8	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	100.00%	50.00%	90.90%	81.20%	83%	75%	100%		82.80%	2.5	14	88.9%	1	9	100%	0	4
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		n/a
No. day patients treated 104+ days		2	0	0	0	0	0	3										

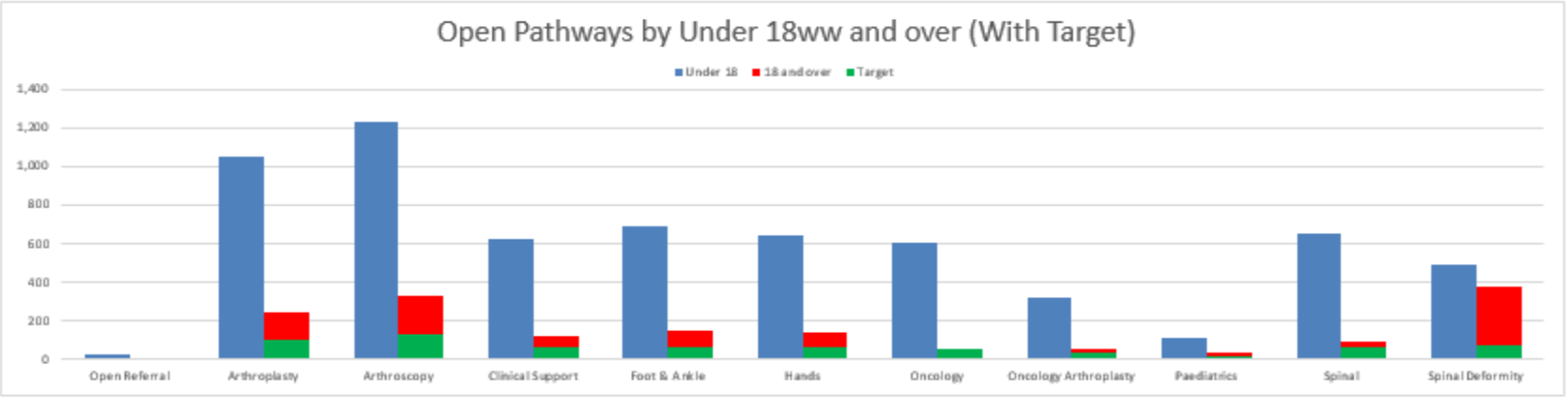
14. Referral to Treatment snapshot as at 31st December 2017 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2018

Select Pathway Type: **Both**

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,276**	20	526	621	344	307	304	324	182	67	380	198	3
7-13	**2,257**	0	357	437	208	276	241	218	95	29	196	197	3
14-17	**906**	0	167	171	72	107	97	66	40	13	79	92	2
18-26	**914**	0	159	218	71	85	95	24	31	21	50	152	8
27-39	**509**	0	74	105	35	52	33	5	18	10	37	131	9
40-47	**94**	1	9	6	8	5	6	0	3	0	7	45	4
48-51	**24**	0	0	0	2	2	1	0	1	0	1	16	1
52 weeks and over	**62**	0	0	1	1	0	0	0	0	0	0	31	29
Total	**8,042**	21	1,292	1,559	741	834	777	637	370	140	750	862	59

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**6,439**	20	1,050	1,229	624	690	642	608	317	109	655	487	8
18 and over	**1,603**	1	242	330	117	144	135	29	53	31	95	375	51
Target	**643**	**2**	**103**	**125**	**59**	**67**	**62**	**51**	**30**	**11**	**60**	**69**	**5**
	80.07%	**95.24%**	**81.27%**	**78.83%**	**84.21%**	**82.73%**	**82.63%**	**95.45%**	**85.68%**	**77.86%**	**87.33%**	**56.50%**	**13.56%**



14. Referral to Treatment snapshot as at 31st December 2017

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2018

Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,492**	20	339	456	321	279	222	240	119	39	296	161	0
7-13	**1,599**	0	187	246	190	245	195	166	41	17	147	165	0
14-17	**587**	0	73	79	69	84	70	48	20	7	58	79	0
18-26	**547**	0	76	105	53	67	55	16	13	11	33	118	0
27-39	**271**	0	32	34	30	36	24	3	3	2	21	86	0
40-47	**53**	1	4	2	6	3	1	0	0	0	5	31	0
48-51	**9**	0	0	0	1	0	0	0	0	0	0	8	0
52 weeks and over	**11**	0	0	1	1	0	0	0	0	0	0	9	0
Total	**5,569**	21	711	923	671	714	567	473	196	76	560	657	0

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**4,678**	20	599	781	580	608	487	454	180	63	501	405	0
18 and over	**891**	1	112	142	91	106	80	19	16	13	59	252	0
Target	**446**	**2**	**57**	**74**	**54**	**57**	**45**	**38**	**16**	**6**	**45**	**53**	**0**
	84.00%	**95.24%**	**84.25%**	**84.62%**	**86.44%**	**85.15%**	**85.89%**	**95.98%**	**91.84%**	**82.89%**	**89.46%**	**61.64%**	

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/01/2018

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**784**	0	187	165	23	28	82	84	63	28	84	37	3
7-13	**658**	0	170	191	18	31	46	52	54	12	49	32	3
14-17	**319**	0	94	92	3	23	27	18	20	6	21	13	2
18-26	**367**	0	83	113	18	18	40	8	18	10	17	34	8
27-39	**238**	0	42	71	5	16	9	2	15	8	16	45	9
40-47	**41**	0	5	4	2	2	5	0	3	0	2	14	4
48-51	**15**	0	0	0	1	2	1	0	1	0	1	8	1
52 weeks and over	**51**	0	0	0	0	0	0	0	0	0	0	22	29
Total	**2,473**	0	581	636	70	120	210	164	174	64	190	205	59

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**1,761**	0	451	448	44	82	155	154	137	46	154	82	8
18 and over	**712**	0	130	188	26	38	55	10	37	18	36	123	51
Target	**198**	**0**	**46**	**51**	**6**	**10**	**17**	**13**	**14**	**5**	**15**	**16**	**5**
	71.21%	**n/a**	**77.62%**	**70.44%**	**62.86%**	**68.33%**	**73.81%**	**93.90%**	**78.74%**	**71.88%**	**81.05%**	**40.00%**	**13.56%**

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For January 2018 the RTT trajectory was 79% with performance at **80.07%** , with 62 patients over 52weeks (60 spinal deformity)

The team are currently reviewing all spinal deformity patients to produce a trajectory for NHSI & NHSE for the end of February 2018, this needs to show when the Trust is likely to cease having anyone over 52weeks.

ACTIONS FOR IMPROVEMENTS / LEARNING

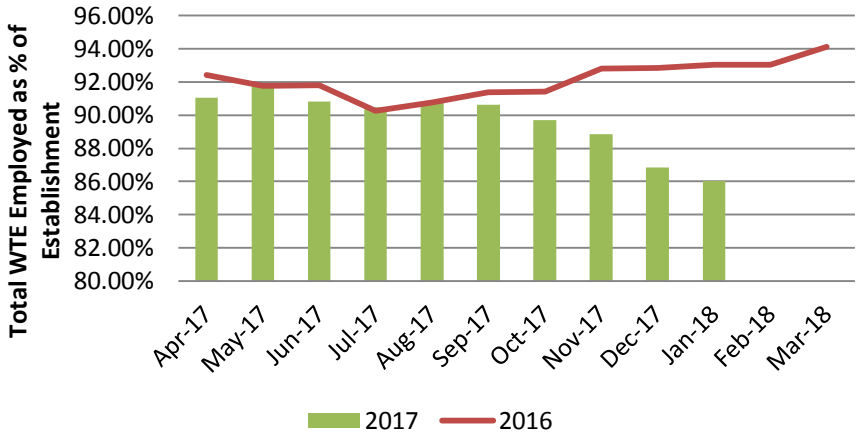
The team continue to concentrated on any patients over 40 weeks, this number continues to reduce. At the end of December 2018 we had 238 patients over 40 weeks, at the end of January 2018 this figure is now 180. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.

RISKS / ISSUES

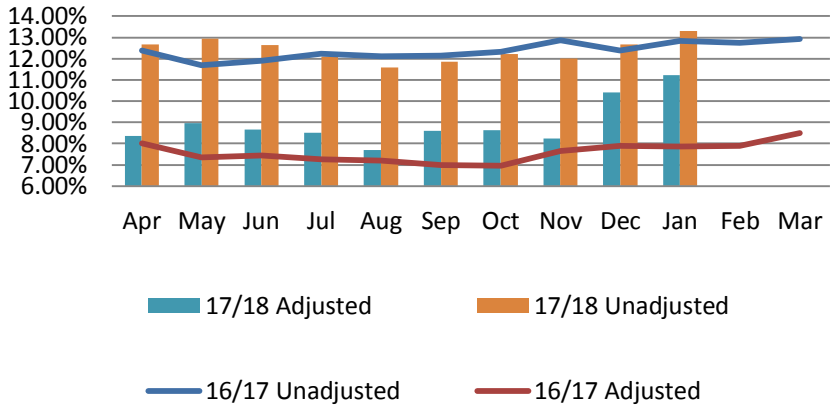
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . This had shown an additional list from BWCH in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be August 2018 before an additional weekday list will commence. Weekend activity which had been planned up till April 2018 is now being planned through the Summer to assist with the existing waiting list .

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

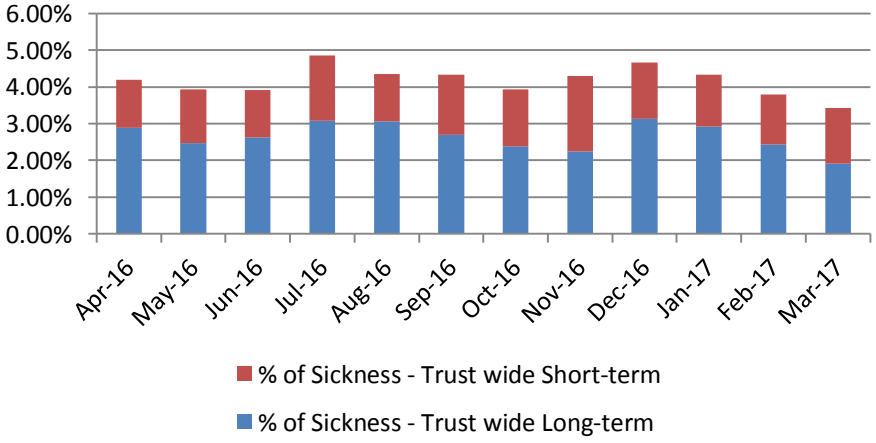
Staff in Post v Establishment



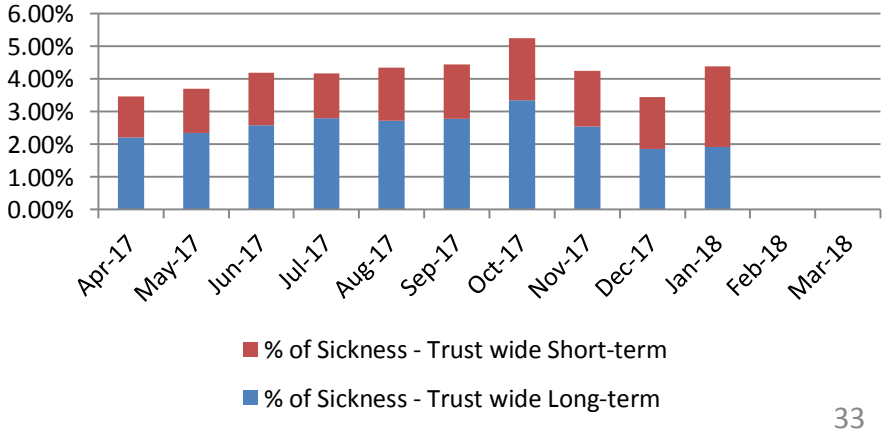
Staff Turnover



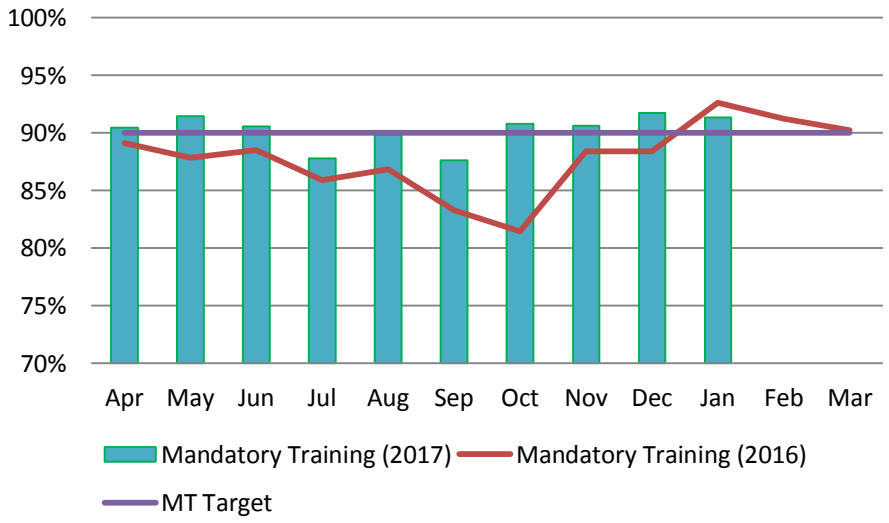
Sickness % - LT/ST (2016)



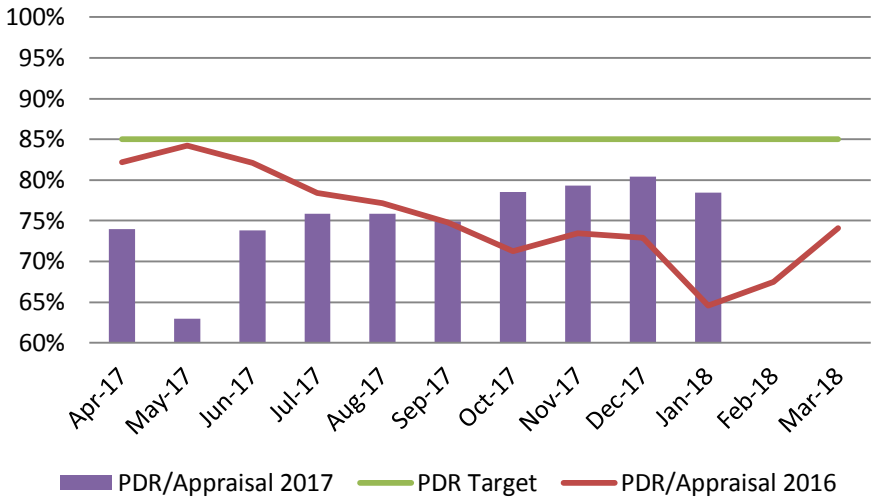
Sickness % - LT/ST (2017/18)



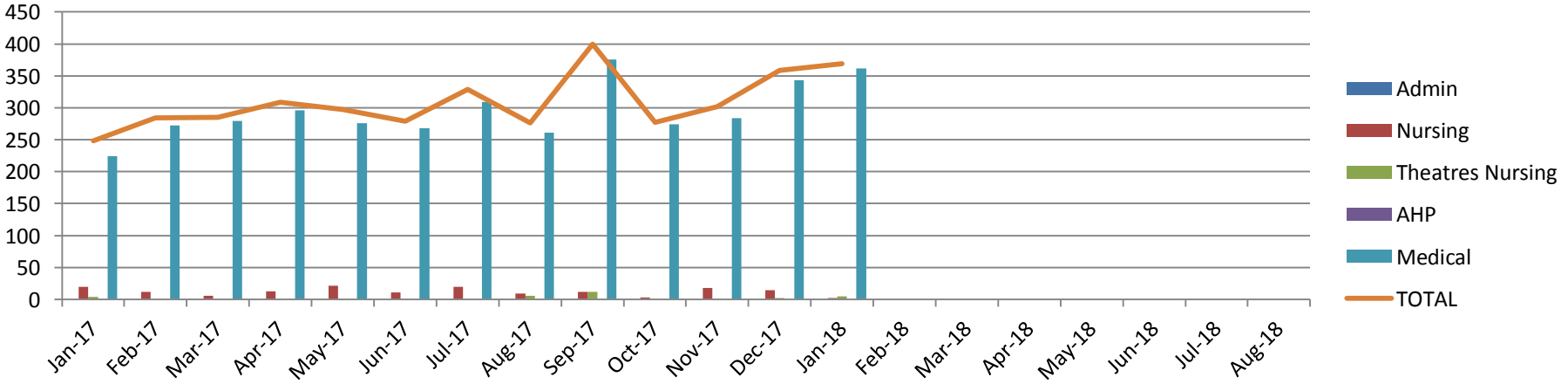
Mandatory Training



PDR/Appraisal



Agency Breaches



INFORMATION

January was a mixed month in terms of workforce performance, with flu being prevalent operationally. In January, sickness absence increased by almost a full percentage point (0.95%) to 4.38% in month, which places it in the middle of the last 5 years as a monthly January figure. Our increase was largely due to the 0.87% increase in short term absences, much of which was attributable to flu. Despite this, the underlying 12 month average figure still reduced very slightly by 0.05% and is now green. Moving forwards, the Trust's intention is to reduce its acceptable limit and to reclassify "green" to 3.7%, to seek to improve performance.

The Trust's vacancy position saw a marginal decrease by 0.85% to 86.03%. The ledger conversions of bank budgets last month is still having an impact as posts have not yet been filled. Recruitment activity over the holiday period also has an effect; the position is expected to improve over the coming months following a bulk recruitment exercise for nursing at the end of January.

Mandatory training decreased by a slight 0.39% in January but still remained green at 91.36%. The L&D Team are continuing to encourage staff to book onto courses or carry out their Mandatory Training via e-learning.

January's appraisal performance saw a decrease of 1.91% taking the position to 78.48% and the Trust from amber back to red: the Trust's increase in sickness for January may have had an impact on the decline. The HR Operations team will continue to work with divisions to remedy this issue.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) increased by another 0.65% on last month to 13.31%, although the number of leavers was lower at 14 compared to 19 last month. Half of the leavers in January resigned due to them relocating. There has been an amendment to the reporting metrics for the adjusted turnover figure, "true leavers" now includes retirements as opposed to just voluntary resignations, so the figure reported for January is 11.23%. On a like for like basis it would have been only a 0.59% increase but the gap appears much larger for this reason. New RAG ratings for this amended statistic is being discussed.

The number of Agency breaches increased in January by 10, although the number of Nursing breaches decreased from 18 to 16 in December then to only 7 in January, with Ward Nursing only having 2 in January compared to 14 last month and 18 in November. The majority of the breaches still remain with 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. There has however been far more engagement from operations and it is likely that the open advertisements will generate candidates from time to time, despite poor historical supply.

ACTIONS FOR IMPROVEMENTS / LEARNING

Compliance with return to work interviews has been included for Divisional Boards to seek assurance about the timely management of sickness absence. Whilst the data collection and system are still in early stages and may underreport performance it is now in the mainstream workforce data. It will be an important metric as we move forwards, particularly for short term absence.

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.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Gender Pay Reporting 2017/18**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Philip Begg – Executive Director of Strategy & Delivery**
AUTHOR:	**Professor Philip Begg – Executive Director of Strategy and Delivery**
DATE OF MEETING:	**7 March 2018**

EXECUTIVE SUMMARY:

From 6 April 2017 employers in Great Britain with more than 250 staff will be required by law to publish the following four types of figures annually on their own website and on a government website:

- Gender pay gap (mean and median averages)
- Gender bonus gap (mean and median averages)
- Proportion of men and women receiving bonuses
- Proportion of men and women in each quartile of the organisation's pay structure

This report sets out the Trusts actions to date and a breakdown of the current differentials based on gender analysis.

More work on this will be undertaken during 2018/19 financial year to fully understand what actions are required.

REPORT RECOMMENDATION:

The Trust Board is asked to receive the update and note the progress to date

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Recruitment and retention. Equality and diversity

PREVIOUS CONSIDERATION:

Executive Team on 6 March 2018

Gender Pay Reporting

Introduction

From 6 April 2017 employers in Great Britain with more than 250 staff will be required by law to publish the following four types of figures annually on their own website and on a government website:

- Gender pay gap (mean and median averages)
- Gender bonus gap (mean and median averages)
- Proportion of men and women receiving bonuses
- Proportion of men and women in each quartile of the organisation's pay structure

Trust Actions

Progress to date:

1. Employers had to register with the Government before 31st January 2018 – Achieved

2. We have analysed our Pay Data using the nationally developed ESR Report.

3. Organisations have to submit their data to the Reporting Service before 31st March 2018 –Achieved

    a. The Gaps reported are significant and are particularly driven by our gender bias within consultant body.
    b. Bonuses relate to clinical excellence awards given to medical staff
    c. When benchmarking across other Trusts, we are not that dissimilar although the gap is slightly higher due to extent of gender bias in orthopaedic consultants locally and nationally. (see table attached as appendix 1)

4. Organisations need to publish their data on their own website by 31st March 2018. This is outstanding as we want to include the values excluding our consultants in this narrative to evidence the impact of this.

Conclusion:

The Trust has met its responsibilities in submitting appropriate data on time. There is further analysis to be done on individual staff groups, which will be undertaken in the coming months and will drive the delivery of a set of actions to be reviewed and scrutinised through the Staff Experience and OD Committee.

Professor Phil Begg
Executive Director of Strategy and Delivery

Appendix 1.

The Royal Orthopaedic Hospital NHS FT

Gender Pay Analysis

Bonus payments	**Measurement**	**Difference**	
Difference in Mean hourly rate of pay		34.8%	
Difference in Median hourly rate of pay		25.9%	
Difference in Mean bonus pay		49.5%	
Difference in Median bonus pay		38.9%	
Pay		**Male**	**Female**
Percentage of employees who received bonus pay	%	5.8	0.2
Employees by pay quartile	%	Male	Female
Upper Quartile	%	52.4	47.6
Upper Middle Quartile	%	18.9	81.1
Lower Middle Quartile	%	18.2	81.8
Lower Quartile	%	31	69

Data analysis as at January 2018.

ROHTB (3/18) 005

TRUST BOARD

DOCUMENT TITLE:	**Compliance against the CQC Fundamental Standards**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive and Garry Marsh, Executive Director of Patient Services**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**7 March 2018**

EXECUTIVE SUMMARY:

The Care Quality Commission's 13 fundamental of standards of care as a whole came into force in April 2015, although the Fit and Proper and Duty of Candour Regulations were introduced earlier than this.

The position statement attached outlines the evidence of compliance against these standards, together with any weaknesses identified and actions taken to address these issues. The Board is asked to note that there has been significant improvement in areas of weakness identified when the assessment was undertaken in October 2017.

REPORT RECOMMENDATION:

Trust Board is asked to:

- RECEIVE and NOTE the position statement of compliance against the Fundamental Standards

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Compliance with national regulatory framework

PREVIOUS CONSIDERATION:

January 2018 by Trust Board and February 2018 by the Quality & Safety Committee

Compliance against the CQC Fundamental Standards – Position statement as at February 2018

Standard	What the Standard Is	Evidence and gaps in compliance identified
Person Centred Care **Executive Lead: Director of Patient Services**	Regulation 9 specifies that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. To meet this standard provider organisations must • Carry out an assessment of the care and treatment needs of then service user in the context of their preferences, involving the service user or their representative as appropriate; • Aim to meet the service users' preferences while ensuring that their needs are met; • Ensure that the service user understands their options for care and treatment and has the opportunity to discuss the risks and benefits of those options with a healthcare professional; • Ensure that the service user or their representative is involved in decisions relating to their care and/or treatment to the maximum extent; • Provide appropriate opportunities for people or their representatives to manage their care or treatment; • Involve people using services in decisions relating about the way in which the service is delivered in so far as it relates to their care or treatment;	Risk Assessments are undertaken for inpatient admissions including and not limited to : • Nutritional Risk Assessment and Fluid Balance documentation • Falls Risk Assessment • Dementia Screening • Tissue Viability Screening A documentation review is currently being undertaken by the senior nurses within Division 1. Clinical Update days support staff knowledge and development to provide high quality person centred care. Individual care planning processes are in place to document pre and post-operative care requirements. Broadly this covers all aspects of care from pain management, psychological support through to activities of daily living including social and nutritional care requirements. Pre-Operative Assessment plays a key role in meeting the individual care requirements. Examples of this include RAPID assessments, hip and knee workshops, pre-operative information on anaesthesia, the procedure, what to expect during a hospital stay, post-operative expectations and Royal Orthopaedic Community Services if applicable,

Standard	What the Standard Is	Evidence and gaps in compliance identified
	• Provide relevant persons with the information they would reasonably need to participate in decisions on their care and treatment; • Make reasonable adjustments to enable the service user to receive their care or treatment; • Where meeting a service user's nutritional and hydration needs, have regard to the service user's well-being.	expected date of discharge discussed and recorded on PAS. An opportunity at POAC is also offered to meet with medical staff to ask any further questions. Discharge planning process is holistic and inclusive involving individuals in their own right and relevant family members. Use of MDT supports active discharge planning to ensure safe discharge. Red2Green discharge initiative is currently being embedded. Translation services are available and supported by policy. Some staff within the organisation have had additional training in British Sign Language. The Trust has a Dementia strategy and all staff receive dementia training as part of their mandatory training. Dementia screening in POAC enables appropriate pre-planning for patients with dementia. All emergency admissions should receive dementia screening; work is being done to ensure 100% compliance. The Trust is now screening all patients now admitted for dementia this is above the national requirement but demonstrates our commitment to enhance dementia care. Paediatric patients are seen in their own Pre-Operative Assessment clinic within the Paediatric ward. This is staffed by paediatric trained nurses. When things go wrong incidents are fully investigated and more Root Cause Analysis training has recently been delivered. Patients are now involved in the investigation process. The Trust has fully implemented

Standard	What the Standard Is	Evidence and gaps in compliance identified
		the Learning from Deaths requirements and a Board report is provided to by the Medical Director to the Trust Board. New ward boards displaying performance against a set of KPIs are to be implemented. A set of nursing KPIs has also been developed and shared with the Quality & Safety Committee. Each month the Divisional Heads of Nursing review the results and submit an upward report to the Clinical Quality Group with exception reporting to the Quality & Safety Committee. A Learning Disability strategy has been developed by the new Learning Disability nurse. Learning Disability awareness training is now delivered to all staff on mandatory training from January 2018. The LD nurse supports clinical areas in developing individual care plans for patients to ensure reasonable adaptations are made. **Key Gaps in assurance and actions taken as at February 2018:** • Dementia – it had been previously identified there were some gaps in consistent assessment of emergency patients. A dementia strategy has been developed and the Trust has delivered the obligations in the strategy set out for the first year, which has largely resolved this shortfall. • Carers – the Trust is yet to develop effective strategies to involve carers in the provision of care for their loved ones and relatives. However, there have been minimal complaints and visiting hours have been extended to allow more access to patients by their relatives • Learning disabilities – although a draft strategy is in place, the management of risk associated with treating this cohort of

Standard	What the Standard Is	Evidence and gaps in compliance identified
		patients is not yet embedded. We are working with a local university to audit the care environment to identify any deficits • Further work is needed to improve complex needs audits
Dignity and Respect **Executive Lead: Director of Patient Services**	Regulation 10 stipulates that patients and service users must be treated with dignity and respect. To comply with the regulation provider organisations must: • Ensuring the privacy of the patient or service user; • Support the autonomy, independence and involvement in the community of the patient or service user; • Give due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the patient or service user. The protected characteristics are age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.	Policy in place to support the Privacy and Dignity aspect of care for our patients. Privacy and Dignity Champions are in each area, with regular meetings to share good practice and highlight any concerns. Same sex breaches reported are investigated when they happen – a change in the contract has prompted an increase in the number of breaches needing to be reported. There were four mixed sex breaches during 2016/17, these were in HDU and recovery which was a tightening of local contract as opposed to national change. The Trust appears to have resolved this challenge in 2017/18. Following the last CQC inspection the Trust received a legally enforceable action in relation to the lack of a Chaperone policy and staff's lack of knowledge in this area. Chaperone policies for adults and Paediatric patients have been written and are embedded. **Key Gaps in assurance and actions taken as at February 2018:** • None identified.
Need for consent **Executive**	To comply with regulation 11 provider organisations must ensure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment for which they are seeking consent.	Updated Consent policy following nationally published standards in place. Consent Lead (Medical Director) is in place. Consent competency tested through mandatory training module for appropriate staff.

Standard	What the Standard Is	Evidence and gaps in compliance identified
Lead: Medical Director	A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 37 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.	Bi-yearly Medical Record Audit shows that consent is only obtained by appropriately qualified staff with appropriate knowledge of the procedure and associated risks. Internal Audit of the consent policy and process is in place. With quarterly audits for compliance against Trust policy undertaken by Medical Director in 2018-19 and results of audit will be presented to clinical body with learning requirements identified. **Key Gaps in assurance and actions taken as at February 2018:** • None identified.
Safe Care and Treatment **Executive Lead: Director of Patient Services**	Regulation 12 sets out what provider organisations must do to deliver safe treatment. This includes: • Assessment and control of the risks to the health and safety of patients or service users; • Ensuring staff have the qualifications, competence, skills and experience to provide safe care and treatment; • Ensuring premises are fit for purpose and safe for use; • Ensuring equipment is safe for such use and is used safely; • Ensuring equipment or medicines are available in sufficient quantities to ensure safe treatment; • Ensuring medicines are managed properly and safely; • Ensuring effective infection control including health	Annual PLACE assessment undertaken which reviews multiple aspects of patient care including environment. The review team comprises of ROH staff, specialist nurses and patient representation. Recommendations follow the assessment. The Head of Estates and Facilities chairs a Health & Safety Group CAS alerts are monitored for closure at Clinical Quality Group Mandatory training is in place with monitoring via the Corporate Performance report. Managers keep local records with local KPIs set for training figures to be maintained as greater than 85%. Additional professional training is in place for health care support workers and nursing staff, training data is maintained and reviewed by the Learning and Development department.

Standard	What the Standard Is	Evidence and gaps in compliance identified
	care associated infections; • Ensuring that shared responsibility for care or treatment and transfer to other providers is dealt with safely and effectively.	Annual PDRs ensure that staff are maintaining mandatory competence and developing professionally. HR policy ensures that staff do not progress to the next pay gateway unless annual attendance at mandatory training and completed PDR undertaken. Divisional Performance reviews review training and PDR compliance together with other relevant KPI percentages. Infection Control data is considered by the Infection Control Operational Committee and Infection Prevention & Control Committee which reports up into Quality & Safety Committee. Infection rates remain low. The Trust has a Bone Infection Unit and is working collaboratively with other trusts such as Coventry and Warwickshire University Trust to share best practice. The Trust is a member of the critical care network ensuring safe transfer of Level 3 patients. The ADIOS system has been implemented for the monitoring of the use of Controlled Drugs and highlights anomalous trends is usage which can be investigated for any potential cases of misuse. Medicines management policy and controlled drugs standard operating procedure have been updated and disseminated in 2017. Medicines management training session was delivered by Pharmacy on the Clinical Audit day. There are quarterly controlled drug storage

Standard	What the Standard Is	Evidence and gaps in compliance identified
		and medicines audits completed by Pharmacy. There is a monthly medicine and storage audits undertaken by medicines link nurses and area managers. During the last full inspection by the CQC in 2014, concerns were identified with the procedures and governance arrangements for controlled drugs. An external review was undertaken by KPMG with a number of recommendations made. This was converted into an action plan which was monitored by and closed by the Drugs & Therapeutics Committee. Audits conducted by Pharmacy show good practice has been sustained. **Key Gaps in assurance and actions taken as February 2018:** • There are some gaps in compliance with the hygiene code and have a NHS Improvement-agreed action plan to address these shortfalls. A peer review by NHS Improvement has supported the development of a responsive action plan and the Trust is now not on any formal monitoring by NHS Improvement. • There is no visible equipment replacement or maintenance plan in place beyond the capital plan. • Following CQC inspection in 2014 the Trust received a legally enforceable action in relation to equipment that had been found with no visible evidence of having been properly checked and maintained in accordance with electrical safety requirements. This remains an ongoing challenge, however is overseen by a Medical Devices Group. This group has been taken over by the Deputy Director of Nursing as chair and the oversight and performance has improved. Methodologies to scrutinise training levels of staff are being developed to ensure

Standard	What the Standard Is	Evidence and gaps in compliance identified
		a central database is available as opposed to locally held records. • The existing database of electrical device safety checks will be maintained and reviewed at regular intervals to include an overview at the performance review of the Estates and Facilities service. • The Estates department will utilise the existing communication strategy across the Trust to highlight actions required to escalate out of date equipment.
Safeguarding **Executive Lead: Director of Patient Services**	The expectation set out in regulation 13 is that provider organisations have a 'zero tolerance approach' to abuse, unlawful discrimination and unlawful restraint. Abuse is defined in the regulation as: any behaviour towards a service user that is an offence under the Sexual Offences Act 2003; ill-treatment whether of a physical or psychological nature, including degrading treatment; theft, misuse or misappropriation of money or property and neglect	We have a policy in place to safeguard patients and service users from abuse. Safeguarding training is in place and meets contractual obligations. This has been an area of focus for the Trust this year. Training promotes 'making safeguarding personal' as a standard for safeguarding adults. The 'voice of the child' and 'professional curiosity' is emphasised to ensure that children are kept safe from harm and guide our safeguarding practice. We have a Safeguarding Committee in place that meet on alternate months. Committee upwardly reports to the Trusts Quality and Safety Committee on a min of quarterly basis. The Executive Director of Patient Services attends external Safeguarding Board for both children and adult services as Trust Safeguarding Executive Lead.

Standard	What the Standard Is	Evidence and gaps in compliance identified
		Each ward and department has a Safeguarding Champion who meet quarterly to undertake specialist training from outside agencies, identify good practice and share this practice with their wards and departments. The group of champions undertake snap shot audits on staff awareness and safeguarding documentation Themes from Serious Case Reviews, Serious Adult Reviews and Trust incident reporting/safeguarding database are shared for learning in training sessions, via Safeguarding Champions and Trust Communications. Safeguarding alerts are placed on Trust systems to ensure that all staff across the Trust are aware of safeguarding issues for individual patients. The Named Nurse and Lead Nurse attend multi-partnership events to share practice and identify areas of good practice, keep up to date with local guidance that can be implemented in the Trust. Previous inspection identified that staffs implementation and documenting of Mental Capacity Assessments and request for DoLS required improvement. The Trust has commissioned an external Independent MCA and DoLS consultant to provide specialist training across the Trust to improve this. This is in the process of being audited. There is a named senior officer with responsibility in respect of allegations made against staff and volunteers. A new policy regarding Clinical Holding for Children is now in place to

Standard	What the Standard Is	Evidence and gaps in compliance identified
		ensure that children are kept safe and their rights are protected during clinical procedures. A review of the Safeguarding Supervision Policy is underway and steps are being taken to ensure staff have improved access to regular supervision to ensure their safeguarding practice is effective. A Learning Disability Practitioner is now in post to ensure that patients with learning disabilities, who are twice as likely to experience abuse, are safeguarded effectively. Ward and department safeguarding noticeboards are aimed at patient and carer information reflects current safeguarding themes and how to access support. Information is inclusive of male and female abuse as well as LGBT and BME groups. Trust Speak up Guardian offers staff a safe way to report concerns regarding practice that may cause harm to patients and carers. Trust has a PREVENT lead. PREVENT is included in mandatory training and the Trust has 4 PREVENT trainers. Quality Assurance unannounced visit was undertaken by CCG Designated Safeguarding lead Nurse. The outcome and recommendations are reviewed and monitored at the Trust's Safeguarding Committee. **Key Gaps in assurance and actions taken as at February 2018:** • A domestic abuse policy is in place but is not embedded.

Standard	What the Standard Is	Evidence and gaps in compliance identified
		Direct questioning and DASH assessment tool training will be undertaken, audit of staff knowledge and awareness of Domestic Abuse has been undertaken. • The Trust has a 'Was Not Brought' policy in place but this is not embedded.
Meeting nutritional and hydration needs **Executive Lead: Director of Patient Services**	To comply with regulation 14 provider organisations must make sure that people using their services have enough to eat to meet their nutrition needs and enough to drink to meet their hydration needs. Provider organisations must ensure that people using their services have their nutritional needs assessed and that food is provided to meet those needs. This will include prescribed nutritional supplements and/or parenteral nutrition. Provider organisations must take account of preferences and religious and cultural backgrounds when providing food and drink and must provide the support necessary to enable people to eat and drink.	We have an enteral feeding policy and we have policies/guidelines in place for the management and monitoring of fluid balance. A nutritional lead is in place. Nutritional audits (to include hydration / fluid balance charts) are in place. Dietetic and Speech and Language Therapy SLA in place with UHB, providing dietician and speech and language therapy support on site. Protected mealtimes in place. Regular audits undertaken with service users to gain feedback regarding food and drink. All specialist diets, to include religious and cultural requirements, are catered for. Pre-operative fasting audits in place; noting that fasting times have reduced remarkably by the work undertaken in ADCU The Trust has joined a national nutrition collaborative to enhance nutritional care in line with best practice. Risks associated with nutrition are escalated on to the risk register for escalation at Clinical Quality Committee.

Standard	What the Standard Is	Evidence and gaps in compliance identified
		Key Gaps in assurance and actions taken as at February 2018: • A policy for overarching nutrition does not currently exist.
Premises and Equipment **Executive Lead: Director of Strategy & Delivery**	To comply with regulation 15 provider organisations must ensure that premises are clean, fit purpose, well maintained and accessible. They must also ensure that equipment is clean, suitable, properly maintained, stored securely and used properly. It should be noted that legal responsibility remains with the registered provider organisation even where they delegate responsibility through contracts or legal agreements to a third party, independent suppliers, professionals, supply chains or contractors. Where the service user or patient owns the equipment needed to deliver their care and treatment, or the provider does not provide it, the provider must still make every effort to make sure that it is clean, safe and suitable for use.	Annual PLACE assessment undertaken which reviews multiple aspects of patient care including environment. The review team comprises of ROH staff, specialist nurses and patient representation. Recommendations follow the assessment. The CQC inspection in 2014 identified a number of shortfalls with compliance with this Fundamental Standard. These have been addressed through the delivery of the CQC action plan which is monitored by the Quality & Safety Committee **Key Gaps in assurance and actions taken as at February 2018:** • There is no visible equipment replacement or maintenance plan in place beyond the capital plan. • A system is in place to monitor the planned preventative maintenance of medical equipment across the site. • The Estates department utilise the existing communication strategy across the Trust to highlight actions required to escalate out of date equipment.
Receiving and Acting on Complaints **Executive**	To comply with regulation 16 providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints made by anyone. All complaints must be investigated thoroughly and, where failures have been identified, any necessary action must be taken. The regulation does not define what a complaint is, so it is important	We have a Complaints policy in place which has been refreshed within the last year The CQC inspection undertaken in June 2014 identified no concerns with the complaints process. Friends and Family data remains extremely positive and we exceed the

Standard	What the Standard Is	Evidence and gaps in compliance identified
Lead: Director of Patient Services	that provider organisations have their own robust and justifiable definition so that they can demonstrate compliance. However the guidance states that complaints may be made either orally or in writing, suggesting a broad definition of complaints along the lines of: any expression of dissatisfaction.	National average The PHSO has upheld a number of complaints in support of the ROH Good performance against the complaints KPIs In the last 6 months numbers of complaints have decreased in particular from oncology and spinal deformity patients There has been noted to have been an increase in PALs contacts, although this was associated with the addition of the PALs contact number to all appointment letters; this was rectified as part of the 'Perfecting Pathways' Programme **Key Gaps in assurance and actions taken as at February 2018:** None identified
Good Governance **Executive Lead: Chief Executive and Director of Patient Services, supported by the Company**	To meet regulation 17 provider organisations must ensure that the systems and processes that underpin good governance are in place and operate well. This will include systems of risk management, assurance and checks on assurance. One of the key he outcomes should be an enhanced ability to assess, monitor and drive improvement in the quality, safety and experience of the services provided. The regulation places a duty on provider organisations continually to evaluate and seek to improve their governance and auditing practice.	The Trust has set out its internal control system within the Annual Governance Statement, the Head of Internal Audit Opinion being that there is an adequate framework of Internal Control, although there is room for further improvement. The Trust has a risk management policy in place and much work has been undertaken recently to improve the quality of local risk registers, committee risk registers, the Corporate Risk register and the Board Assurance Framework. The Board Committee structure has been revised to provide greater oversight of Finance & Performance matters and has recently undergone a further refresh with the development of a Staff Experience & OD Committee to provide oversight of workforce-related

Standard	What the Standard Is	Evidence and gaps in compliance identified
Secretary		matters. The Board receives assurance on the Quality of Care through the Patient Safety & Quality Report, and the BAF, and through the oversight of the Quality & Safety Committee which reports upwardly through the use of assurance reports. The Quality & Safety Committee in turn receives more detailed reports from subgroups covering particular aspects of quality, for example drugs and therapeutics. This supports the process of escalation of risk related to quality throughout the Trust. There is a structured programme of quality walkabouts in which Board members gain first-hand experience regarding the quality of care and the views of patients and staff and others. The Trust has embedded a robust Divisional Governance structure, with evidence of quality conversations occurring routinely. Attendance at Quality & Safety Committee has been widened to include Heads of Nursing, so it more closely aligns to the divisional structure. A public governor attends the Quality & Safety Committee as an observer. The CEO holds monthly briefings (Team Brief) with Heads of Department for dissemination to teams.

Standard	What the Standard Is	Evidence and gaps in compliance identified
		All backlog incidents have now been closed and an improvement action plan is in place. Complaints will move to this system. Action plans are now monitored at divisional level and closure monitored There were regulatory concerns in 2017 around the timely escalation of issues around 18 weeks RTT performance and data quality; cancer tracking and spinal deformity waiting times. In response the Trust devised a series of action plans which were routinely monitored by the Board and the Finance & Performance Committee to completion, with the exception of spinal deformity issues **Key Gaps in assurance and actions taken as at February 2018:** The Staff Experience & OD Committee is, at present, embryonic in its oversight, with a remit over the next six months to address some of the gaps in oversight that have been identified and from a Board perspective prioritise areas such as the equality & diversity agenda, leadership development, performance management and succession planning There remains further work to do to strengthen the linkages between risk registers and improve the functionality of the ULYSSES system to facilitate better reporting and risk management. The governance of clinical outcomes data is being reviewed; the role of clinical audit in providing assurance regarding quality and outcomes data also requires to be strengthened.
Staffing	To meet regulation 18 provider organisations must ensure that sufficient numbers of suitably qualified,	Assurance to the Quality & Safety Committee and upwards to the Board on safe nurse staffing is obtained through monthly reporting

Standard	What the Standard Is	Evidence and gaps in compliance identified
Executive Lead: Director of Patient Services	competent, skilled and experienced staff are available to meet the needs of patients/service users at all times as well as to meet the other regulatory requirements. Provider organisations must ensure that their staff receive the support, training, professional development, supervision and appraisals necessary for them to carry out their duties effectively and so that they continue to meet the professional standards necessary to practise. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 75 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.	containing details of the following; • The Trust's staffing position against NICE guidance • Staffing numbers including skill mix and acuity of patients. • Reported incidents pertaining to staffing including where safe minimum staffing levels have been breached and actions taken. • Bank and agency usage per clinical ward area is also documented. A report has been presented to the Quality & Safety Committee and Trust Board in 2017 showing compliance against the NQB standards. A Red Flag system is in place to highlight where there are serious incidents that involve staffing issues The Board receives a nursing establishment review. This is shared with our commissioning partners and forms part of the annual contract. E-rostering and Safecare are embedded. KPIs are being developed to triangulate harm to nurse staffing. All staff should receive an annual PDR to support their development and learning needs and this is mandated by Trust policy. An overview of this criterion is provided through the Finance Overview which identifies workforce data including PDRs. Scrutiny of this data is provided by Finance & Performance Committee and Board and will also move to the Staff Experience & OD Committee. Department KPIs support the overarching monitoring processes

Standard	What the Standard Is	Evidence and gaps in compliance identified
		The Learning and Development Department support access to development courses including LBD monies. **Key Gaps in assurance and actions taken as at February 2018:** PDR Completion Rates still fall below the 85% agreed Trust target and lag behind the trajectory for improvement. Divisional and Senior managers are charged with ensuring their teams have PDRs and receive adequate access to development opportunities. Mandatory training levels are below expectations at present and work is underway through performance reviews to monitor and drive improvement. Resuscitation training particularly remains a risk but a review of what training delivered to who is being undertaken to support compliance and rates have significantly increased over last few months Staffing level scrutiny is mainly confined to nursing at present and there are plans to widen this to other professional groups and provide board oversight through the Staff Experience & OD Committee.
Fit and proper persons employed **Executive Lead: Director of**	To comply with regulation 19 provider organisations must ensure that persons employed to carry on a regulated activity must: (a) be of good character; (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and (c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks	**The Trust has in place a Fit and Proper Person's Test policy in place.** All defined in the policy requiring a fit and proper assessment have undergone the necessary checks, including three new Non Executive Directors. **Key Gaps in assurance and actions taken as at February 2018:** None identified

Standard	What the Standard Is	Evidence and gaps in compliance identified
Strategy & Delivery	which are intrinsic to the work for which they are employed.	
Duty of Candour **Executive Lead: Director of Patient Services**	Regulation 20 makes it a statutory requirement that health service bodies to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.	The Trust is currently compliant with Duty of Candour requirements. As part of the Trust's contractual obligations, commissioners undertook an audit to assess compliance. The Trust was deemed to be compliant and internal systems are in place to monitor ongoing compliance. Duty of Candour is reportable as part of the national Contract arrangements with Commissioners and is reported on a monthly basis. Two CCG announced visits have shown full compliance with Regulation 20 A new policy has been introduced to address informal audit issues identified. **Key Gaps in assurance and actions taken as at February 2018:** None identified
Display of CQC Ratings **Executive Lead:**	Regulation 20A of the Fundamental Standards sets out the requirement to display ratings ('performance assessments') at their physical premises and on their website(s). This will be a legal requirement from 01 April 2015. This Annex summarises CQC's guidance but we strongly recommend you read the full	The Trust displays the CQC Ratings and Report on both its internal and external internet sites. A direct link on its external site takes visitors to the summary report and findings including the overall grid ratings. Posters are displayed around the site indicating the CQC rating and their key findings during the inspection process.

Standard	What the Standard Is	Evidence and gaps in compliance identified
Director of Patient Services and Director of Strategy & Delivery	guidance (13 pages) and approach CQC for clarification about how you can meet the display requirements with respect to any logistical or practical challenges for your own trusts' premises and services	**Key Gaps in assurance and actions taken as at February 2018:** None identified

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

ROHTB (3/18) 006

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR:	**Yve Buckland, Chairman and Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**7 March 2018**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at February 2018.

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

The BAF has been refined based on a recent refresh of the Corporate Risk Register undertaken by the Executive Team.

There have been a number of movements to the pre-mitigation scores and there are two risks proposed for closure, which the Board is asked to agree to on the advice of the Audit Committee:

- Risk 1132 – Vacancies in the Infection Control team
- Risk 796 – The Board and organisation loses its focus on patient care

REPORT RECOMMENDATION:

Trust Board is asked to:

- review the Board Assurance Framework
- confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- agree to the closure of risks 1132 and 796

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:					
Audit Committee on 23 February 2018.					

BOARD ASSURANCE FRAMEWORK - FEBRUARY 2018

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
-	Corporate	Paul Athey	There is a risk that the ROH Trust Board carries all the clinical risk residing with the transition of Inpatient Paediatric Services whilst the system re-commission and re-provides the services elsewhere.	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	5	5	25	The Trust agreed that it could not meet the national service guidelines and as such gave notice on the provision of the inpatient service. All stakeholders have confirmed that this should be managed as a system wide risk and this is done via the monthly Stakeholder meetings and the Paediatric monthly commissioning group. The Trust and the health system all acknowledge that the Inpatient Service at the ROH is not compliant with national guidance during this transition period.		5	5	25	↔	Agreement at joint stakeholder group that a system-wide risk sharing statement will be developed	Q4 2017/18	3	4	12
-	Corporate	Paul Athey	The Trust does not currently have a clear financial and operational plan in places that describes how the organisation will deliver 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. additional resources have been identified to support the Trust is developing a sustainable business model for the ROH	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	5	25	↔	The Trust will be presenting a plan to the STP Board in March 2018 to set up an STP-wide orthopaedic redesign programme in Birmingham and Solihull STP	Mar-18	2	5	10
-	Finance	Steve Washbourne	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	5	5	25	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	↔	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 in developing a sustainable business model for the ROH which is in line with the requirements of the STP and other commissioning bodies	Mar-19	3	5	15

1089	Operations	Jo Williams	There is a risk that the Trust fails to meet the trajectory to achieve the 92% 18 Week RTT national target	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	Trajectories have been 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 were held to agree how the Trust will expand capacity to meet demand. Teams have completed trajectories for all services.	Weekly report to Exec Team & Ops Board	4	5	20	↓	Work is ongoing to increase activity and treat the backlog. The Trust has in place a trajectory to deliver 92% performance by November 2018 - this is monitored monthly.	Q3 2018/19	3	4	12
1117	Operations	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	A SOP for the review of patient timelines to provide a consistent approach and level of detail for patients has been developed. 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. Daily validation process in place to ensure any RTT sequencing errors are corrected.	Weekly report to Exec Team & Ops Board	3	4	12	↓	Use of the harm process to review patients who are perceived to have had a delay in the pathway continues.	Ongoing	3	4	12
1088	Operations	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	Training of admin teams and clinical staff has been completed. The Trust has completed a full data cleanse of all its RTT data including historical clock stops. A daily RTT dashboard and data error report is in use and supports daily RTT management. The Trust returned to national reporting in December 17.	Weekly report to Exec Team & Ops Board	3	4	12	↔	Validation work continues to identify any data quality issues. A trajectory to return to 92% performance is in place.	Q2 2018/19	3	4	12

293	Finance	Steve Washbourne	Financial surplus Failure to deliver planned financial surplus, impacting on financial stability, investment opportunities and regulatory rating.	With safe and efficient processes that are patient centred	FPC	4	5	20	The Trust is currently on track at Month 10 to deliver its control total, although this is still a deficit position of £6.2m exc STF. Delivery of CIP still remains undertarget - New Assistant Director of Finance appointed to focus on financial deliver	FPC Reports	4	5	20	↔	Perfecting Pathways to continue to deliver activity and operational process improvements Continuing performance meetings for each division	Ongoing	4	3	12
1137	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 Safety Group minutes presented to IPC Group meeting.	4	5	20	↔	Future meetings scheduled for Water Safety Group who will monitor the position. Water testing undertaken at 6 monthly intervals.	Q4 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 & QSC	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. A trajectory is in place to support delivery and monitor progress.	Weekly updates to Exec Team; updates to Trust Board.	5	4	20	↑	All patients have been validated to provide an accurate position of the number of patients waiting for surgery at BWCH. Additional operating list have been covered through Sept-Nov and further list are being populated until April 18. Contingency patients are in place when PICU beds are not available. Additional Theatre capacity is being developed for Qtr 1 18/19.	Ongoing	2	4	8
-	Operations	Jo Williams	Theatres - there is a risk that the department is not operating effectively and is in need of a full review supported by a organisational development programme	Delivered by highly motivated, skilled and inspiring colleagues	FPC	4	5	20	The operational team for Theatre has been strengthened with the appointment of a new Theatre Manager and Matron. Further work with the team is ongoing to ensure that we continue to progress development across the entire Theatre team.	Perfecting Pathways Board papers and minutes	4	4	16	↑	To support the Perfecting Pathway programme and the Trust recovery plan there remains a need to conduct a full review of theatres supported by an OD programme. An initial assessment is currently ongoing to assess whether external support is required to support this. The workforce plan will be discussed at the Staff Experience and OD Committee in March 2018 as this needs to be developed to support and deliver the operational annual plan.	Q4 17/18	3	3	9

1030	Operations	Jo Williams	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 the arthroscopy stacks have been restored and there are now 6 working units in theatres. Fridge monitoring and ambient temperature monitoring equipment is being ordered and the theatre alarm system is also being progressed urgently.	Funding requests. Outputs of the prioritisation exercise. Capital plan.	4	4	16	↔	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
-	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	3	4	12	↔	Delivery of the Cancer Action Plan. Onkos provides a daily tracking system. The team are developing proposal to implement a new system from April 2018 - this is supported by the Cancer Action plan	Q1 2018/19	2	2	4

544	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	Removed from formal monitoring by NHSI in October 2017. Expected that rapid improvement will now take place due to the commencement of IPC Lead Nurse in February 2018.	Infection Control Committee minutes; Infection Control upward report to Quality & Safety Committee	3	3	9	↓	Continued delivery of the IPC action plan and monitoring by the ICC Committee.	Ongoing	1	4	4
-	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. The operational team has been strengthened within a number of areas.	Trust Board reports on operational initiatives, including validation of 18 weeks RTT, Scheduled Care Improvement Board and theatres improvement programme	3	3	9	↔	The position will be reviewed weekly at Executive team meeting to ensure that this is not impacting on delivery of the projects This will continued to be monitored monthly. Perfecting Pathway encompasses and supports the operational team to deliver service changes and redesign	Q4 17/18	2	3	6
27	Operations	Jo Williams	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.Nov 17 - all agency staff to support RTT have been ceased form the end of October 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.	3	3	9	↔	Continued stringent controls for employing agency staffing. Work is on-going to review the future junior medical workforce plan in line with the strategic outline business case. Weekly vacancies/sickness is monitored and appropriate action taken to mitigate agency staffing.	Ongoing	2	3	6

1132	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	Head of Infection Contol has commenced with the Trust and Band 7 nurses also in post. The Trust also has access to external (CCG) infection control expertise through a Service Level Agreement.	Infection Control Committee minutes; Infection Control upward report to Quality & Safety Committee	1	5	5	↔	All vacancies now filled. **PROPOSE CLOSURE.**	Q4 2017/18	1	5	5
269	Operations	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
270	Finance	Steve Washbourne	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	Ongoing	2	4	8

770	Operations	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	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible.	Estates maintenance schedule	4	4	16	↑	Improvement Board to continue to track performance against turnaround workstreams. A maintenance programme is being developed for the end of February 2018 including the cost for backlog maintenance, this will be discussed at Execs. A modular Theatre is being explored and costed to support the maintenance programme and support additional capacity for ROH and the STP	Ongoing	1	4	4
1085	IM&T	Steve Washbourne	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	IM&T Programme Board	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	↔	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. A further 3rd Party assessment is being undertaken by Dionnech in March 2018 as part of further round of national work being undertaken by NHS Digital. A capital submission has also been made.	Ongoing	2	4	8
804	Finance	Steve Washbourne	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	4	16	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	3	4	12	↓	Development of the data warehouse and ongoing development of in house intelligence	Ongoing	2	4	8

1031	Operations	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 now been fully implemented and is used for all products in implant stores.	Stock internal audit report. FPC min	2	4	8	↓	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
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	SI/RCA Action Plan closure now monitored at Divisional Level. Divisional Governance meetings are robust and include sharing lessons learnt from incidents. Incident backlog closed and the number of open incidents within clinical areas is now monitored in Ward KPI dashboard and escalated to Clinical Quality Group via the Condition Report	Patient Safety & Quality Report presented monthly to QSC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	2	3	6	↓	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. This is a Quality Priority within the Quality Account for the current year. Further Root Cause Analysis has occurred for a wide spectrum of clinical staff. Future training dates are being planned	Q4 201/18	2	2	4
-	Corporate	Paul Athey	Risk that the plan for Paediatric is not aligned with the wider STP strategy for Orthopaedics	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	3	5	15	The Trust is actively engaged with the STP and clinical reference groups across BSOL are in place to shape the orthopaedic strategy for the future	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	The Trust will be presenting a plan to the STP Board in March 2018 to set up an STP-wide orthopaedic redesign programme in Birmingham and Solihull STP	Ongoing	2	4	8

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	A number of strategic meetings have been held with various external partners to look to develop a sustainable methodology for implementing small and larger scale change within the organisation. This includes the development of a simple continuous improvement tool. Both non-executive and executive directors have been involved in discussions with McLaren F1 Group, ABHI and their subcommittee of industry partners and finally the AHSN. All of these discussions are a various stages of maturity and the developments will be discussed at the Staff Experience and OD Sub-committee of the Board, (this is the replacement committee formerly Major Projects and OD Committee) and again at the Board. There are significant opportunities for the Trust to work in partnership in developing a strong platform for service improvement, this will be directly linked and will work with the Perfecting Pathways work that is already identifying areas for improvement.	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	Finance	Steve Washbourne	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	4	12	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	4	8	↓	Continued focus on efficiency and cost control through the recovery plan	Ongoing	2	4	8
986	Nursing	Garry Marsh	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for	Safe and efficient processes that are patient-centred	Q&S	3	4	12	Nurse WTE: 30 WTE Trust Wide 18 WTE in Post 12 WTE vacant (7 HDU, 5 Ward 11) The Director of Patient Services has contacted all local NHSE providers to enquiry whether they could strengthen the rota. 10 WTE seconded from Wolverhampton Hospital. Combined rota allows better oversight of nurse staffing levels. Children's Quality Report triangulates staffing vs harm and is scrutinised at CYP Board.	Q&S Report	2	4	8	↔	4wte have been secured via agency and the induction and training programme is currently being arranged. This will be a block booking to ensure continuity.	Ongoing	1	4	4

-	Nursing	Garry Marsh	There is a risk that patient care/safety may be compromised as we do not have enough Paediatric staff/vacancies on the ward.	Safe and efficient processes that are patient-centred	Children's Board	3	4	12	10 WTE seconded from Wolverhampton Hospital. Combined rota allows better oversight of nurse staffing levels. Children's Quality Report triangulates staffing vs harm and is scrutinised at CYP Board.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses.	Ongoing	1	4	4
-	Clinical	Andrew Pearson	There is a risk that there will be some clinical resistance to the change in the way Paediatric Services are delivered	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	4	3	12	Briefing sessions have been held with all the clinical teams including clinically led reference groups established who meet to discuss the potential options and likely impact. A clinical session was also held in September chaired jointly with the ROH and BWCH Medical Directors to talk through the changes, the rational and the timeframe. This is supported by regular updates via email, team brief and 1-1 discussions with the Executives Team.		3	3	9	↓	Continued briefing sessions to be delivered through routine and bespoke staff communication routes	Ongoing	2	2	4
-	Corporate	Paul Athey	There is a risk to the ROH reputation should the Paediatric service not be transferred in a timely and safe manner		Exec Team/Trust Board	4	3	12	The ROH has given 6 months contractual notice (end of December 2017) for Inpatient Paediatric Services to cease on site at the ROH . It has agreed to work with the system whilst additional capacity/provider can be sourced, with a current planned transition date of November 2018. A communication plan is in place to ensure patients and staff are fully briefed on the changes and how it might impact them. An monthly operational commissioning group is in place with all stakeholders. There has been substantial clinical and non-clinical engagement across the Trust and externally which has been seen by specialised commissioners, CCG, NHS I and local councillors.	Team Brief; Joint stakeholder meeting minutes; E-mail correspondence from clinicians to Execs	4	3	12	↔	As part of the system wide meeting structure all risks relating to the transfer of services will be jointly risk assessed and appropriate mitigation will be in place.	Q2 2018/19	2	3	6
-	Finance	Steve Washbourne	The Trust is likely to incur transitional costs with the transfer of Inpatient Paediatric Services	Safe and efficient processes that are patient-centred	FPC	4	3	12	The Trust has highlighted the risk to NHSE and requested funding support should material additional costs be incurred. The Trust continues to review how existing resources can be utilised to ensure safe services and mitigate additional cost where possible.	Joint stakeholder meeting minutes	4	3	12	↔	The Trust would look to gain firm agreement with NHSE for the changes in local prices where the cost base increases on recurrently during the changes. The DOF met with the HoF from NHSE on 14/02/18 to discuss how a request for additional funding to support Paed services may be made during 2018.	Q4 2017/18	1	4	4

801	Corporate	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. New appointments into the management team have been made to strengthen controls and ability to deliver against regulatory requirements and to provide greater resilience in delivering ad-hoc and business-as-usual actions concurrently. Clear governance lines to ensure focus on key issues for Trust and regulators.	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 continue to be used to influence the wider Health Economy as it develops and embraces a new way of working collaboratively. The Trust will not be able to mitigate against changes in national policy or new target introduced in response to areas of political interest, but must be able to adapt in these circumstances.	Ongoing	2	3	6
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	A Strategic Outline Case has been created, the development of which included multiple direct staff engagement workshops with various groups of clinicians across the Trust. A Chief Executive briefing session was delivered in January 2018, which reinforced the key messages of the SOC, in addition to the launch of the Five Year Vision which was signed off by the Board in early 2018.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case	2	3	6	↓	Staff to continue to be engaged with the development of the Outline Business Case and later the Full Business Case for the ROH.	Q1 2019/20	2	3	6

S800	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.	Q4 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.	1	3	3	↓	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. No further actiosn to take. **PROPOSE CLOSURE.**	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	31 January 2018
Guests	Nathan Samuels, Learning Disability Nurse Evelyn O'Kane, Matron & Safeguarding Lead
Presentations received	Learning Disability Strategy
Major agenda items discussed	• Pathology update • Reporting from the Medical Devices Committee • Quality & Patient Safety report • Ulysses action plan • Pain service update • Nurse staffing updates • Resuscitation mandatory training update • Safeguarding committee upward report • Infection Prevention and Control Committee update • Divisional governance assurance • Quality Governance Framework • Policies position statement • Compliance with the CQC's fundamental standards • Streamlining plans for the Quality & Safety Committee
Matters presented for information, update or noting	• Quality & Patient safety risks on the Corporate Risk Register • HDU and Outpatient CQC action plan exceptions • Presentation on divisional governance assurance from the Quality Conference
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Compliance with the WHO checklist did not reach 100% in November; this reflected one case in which the process had not been completed correctly, which was later confirmed as an emergency • There had been three patient falls in December, one of which related to equipment failure • There remained a shortage in paediatric nurse staffing, however a long term block booking had secured some agency staff who were being inducted in a process that was as robust as that for substantive staff • The detail of red flags associated with nurse staffing was reviewed and it was agreed that the presentation of these should be revisited as currently it appeared that these suggested that these had the potential to cause harm when this was not the case

	• The issue of lower than expected training levels in resuscitation were discussed and the Committee was given assurances that a plan was in place to improve this, including undertaking a data cleanse to ensure that appropriate staff were being asked to undertake the relevant level of training. The uptake of the training sessions remained a concern however. • There remained non-compliance with the water standards, although this was anticipated by 2019 • There remained an ongoing risk concerning the absence of a data analyst in the Infection Control team; the lead nurse and two Band 7 team members would be in place shortly. • As part of the Division 2 governance report, it was noted that the estate of the Pharmacy department remained a concern • A policies position statement was received, which highlighted that there were a number of policies in existence which were beyond their review date. Good work had been undertaken to reduce the number of these however and there was a plan for those remained to be revalidated.
Positive assurances and highlights of note for the Board	• The recruitment of a Pathologist was underway and discussions were also underway with a local provider who was supporting the plans to strengthen the Pathology department. • Additional measures had been created to strengthen the governance around the medical devices committee's work • There had been a decreased number of incidents, although there was lack of clarity as to whether this dip reflected the decreased activity • A position of 96.2% had been achieved for 'I Want Great Care' • Compliance with the WHO checklist reached 100% in December • There was work underway to improve the functionality of the Ulysses system; the system had been updated to improve the use for incident reporting. The next phase was to look at improving the functionality for risk management. • There had been a number of actions to improve the efficiency of pain services, including arranging additional clinics where needed • There had been a good level of training in Prevent • The Committee received the draft Learning Disabilities strategy and heard the plans for the implementation of this in March 2018. This was noted to be a very positive development and satisfied some of the key requirements highlighted in the last CQC visit

	• As part of the IPC upward report, it was noted that the waste bins were now distributed across the site and new gel dispensers were in place. The Trust had been removed from formal monitoring against the hygiene code by NHS Improvement. • A decontamination peer review had taken place, the outcome of which was positive • The theatre maintenance schedule had been set to take place over Easter 2018 • The Committee received the quality governance framework which set out the current processes and arrangements for quality governance in the organisation and the key improvements planned • A plan to streamline the work of the Committee was presented, which included a new set templates for upward reports and cover sheets that better highlighted assurances needed
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Provide further assurances over the plans to improve the resuscitation training position at the next meeting • Amend the Quality Governance Framework to include quality assurance walkabouts and to revise the Committee map
Decisions made	• The time of the Committee meetings would start at 1030h from April 2018

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

For the meeting of the Trust Board scheduled for 7 March 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	28 February 2018
Guests	Dr Bill Rea, Chair of the Drugs & Therapeutics Committee Mr Matt Revell, Associate Medical Director Carl Measey, Head of Health & Safety
Presentations received	None
Major agenda items discussed	• Quality & Patient Safety report • Nurse staffing updates • Resuscitation mandatory training update • Clinical Quality Group upward report & minutes • Drugs & Therapeutics Committee upward report and minutes • Children's Board – upward report and minutes • HDU Improvement Board – upward report and minutes • Health & Safety Update • Divisional governance assurance • Compliance with the CQC's fundamental standards
Matters presented for information, update or noting	• Quality & Patient safety risks on the Corporate Risk Register • Resuscitation training update • HDU and Outpatients CQC action plan exceptions
Matters of concern, gaps in assurance or key risks to escalate to the Board	• In terms of VTEs, there was a common theme around obesity and work was being undertaken to ensure that the patients being treated were being appropriately referred back to GPs for weight loss prior to surgery where needed; the consenting process would also pick up the risks around operating on overweight patients • The current practice of reporting the VTEs was to be reviewed to ensure that it was consistent with other organisations • Paediatric nursing care remained a red risk that was monitored by the Children's Board • Compliance against the Accessible Information Standard needed to be addressed and this would be taken forward through the Operations team • Room temperature monitoring practice was still non-compliant, although some additional equipment had been sourced which would enable the risk to be closed when installed; the timescale for this installation was challenged to ensure it was as expeditious as possible

	• A CAS alert around flushing lines was discussed – the WHO checklist would be amended to reflect the requirements of this • It was agreed the non-compliance with medical gases would be reflected on the corporate risk register • There had been a number of 'Was Not Brought' cases, a matter thought to be reflective of rescheduling some clinics. This had now been addressed. • A case of non-compliance with set protocol in Radiology was discussed which included the appropriateness and timing of applying HR procedures • The lack of anaesthetist representation at HDU Improvement Board was challenged, but was identified to have been an exceptional circumstance • It was reported that some COSHH risk assessments were out of date and that this needed to be captured on the theatres risk register • The effectiveness of the Health & Safety Committee was questioned and it was agreed that further measures were needed to strengthen the governance and effectiveness of the committee • It was suggested that evacuation arrangements needed to be tested; this would occur as part of a forthcoming major incident exercise • It was highlighted that there was a degree of vulnerability associated with some staff, including porters, working alone out of hours which needed to be addressed
Positive assurances and highlights of note for the Board	• The number of incidents continued to decline • There was a discussion around the follow up appointments and whether in future these needed to be face to face in all instances • There was improved practice with regard to consultants undertaking ward rounds • Compliance against the WHO checklist was 100% • There was an active nurse recruitment plan, including a rolling programme to recruit Paediatric nurses • All staff that had required Paediatric Intensive Life Support training had received it and there was further work to ensure that only those staff that needed to be trained were counted within the training figures. The effect of this data cleanse would be seen from April. • More volunteers had been recruited • The new upward report template was seen as being a positive measure, although the order of the information needed to be changed • The theatre maintenance schedule was planned for Easter 2018 • There was strengthened compliance against the CQCs fundamental standards

Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Create an action plan to achieve improved compliance against the CQC fundamental standards • Revise the new upward report template • The Committee asked to receive in future the prioritised plan for the Infection Control team
Decisions made	• None specifically

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

For the meeting of the Trust Board scheduled for 7 March 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	29 January 2018
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Strategic outline case next steps • Finance and Performance overview • Progress with actions plans to address regulatory concerns • 'Perfecting Pathways' update and PIDs for POAC and Clinical Coding workstream • Theatre improvement plan and KPIs
Matters presented for information, brief update or noting	• An extract of the summary Corporate Risk Register was considered
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Performance for December had been mixed, with the deficit delivered being above plan, however against the recovery plan, the performance had been worse. The reasons behind the position largely concerned activity, where there had been less activity delivered than planned, particularly around the Christmas period. The snowfall had also impacted to some degree. • It was reported to be likely that the agency cap may be breached slightly • CIP plans were noted to be behind plan at present, although the Committee was assured that there was more focus on delivery of CIPs through the new Assistant Director of Finance and challenge was robust through the divisional performance meetings. It was suggested that thought be given to how control totals from year to year are bridged as part of the CIP development plans; some of this was likely to be through the 'Perfecting Pathways' work • RTT performance was at 79.06%, below the required 92% target.

Positive assurances and highlights of note for the Board	• Work was underway to finalise the Strategic Outline Case, following the presentation at the Trust Board in January. Staff had been briefed on the key messages and a digestible version was being prepared for dissemination to governors, staff and stakeholders. The STP Board is to be updated on the SOC work and discussions were planned around next stages of the work in the context of the STP • Early indications suggest that the stocktake may deliver a positive benefit on the year end position; this is as a result of the consignment stock that was being held in theatres • Work was planned to reduce length of stay, including refreshing some discharge initiatives and introducing more robust measures to move patients who were fit for discharge out into other settings if needed • Performance with outpatient clinic waiting times had improved and there had been no delays as a result of missing notes • There had been much work undertaken to achieve a reduction in the number of patients waiting over 52 weeks for treatment • There had been an improvement in Mandatory Training and Appraisal rates • Progress with the delivery of the action plans to address regulatory concern was good and it was agreed that these would not be considered by the Committee in future as the work was now, by and large, complete or business as usual. • The Committee received and noted the Project Initiation Documents for the Pre-Operative Assessment and Clinical Coding workstreams of the 'Perfecting Pathways' work • The use of an additional modular operating theatre was to be considered
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• For the March meeting of the Trust Board the timing and key milestones for the next phases of the strategic development work would be presented; a verbal update would be given to the Board in February • A review of the December position would be undertaken to harness any lessons to be learned around the planning during this period • The Audit Committee to verify the delivery of the actions in the RTT action plan
Decisions made	• None specifically

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

For the meeting of the Trust Board scheduled for 7 March 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	27 February 2018
Guests	None
Presentations received and discussed	2018/19 business planning
Major agenda items discussed	• Strategic outline case next steps • Finance and Performance overview • Spinal deformity performance • 'Perfecting Pathways' update
Matters presented for information, brief update or noting	• An extract of the summary Corporate Risk Register was considered
Matters of concern, gaps in assurance or key risks to escalate to the Board	• It was highlighted that of the 13 SHOs in the Trust, 11 were agency. The medical staffing model for 2018/19 needed to be revisited to explore the use of Physician Associates where possible. • There had been an increase in the number of clinics running late, some being reflective of a high number of complex patients that had needed to be seen but also as a result of staff sickness absence
Positive assurances and highlights of note for the Board	• An update on the recent discussions with UHB and HEFT had been held around the next steps regarding the collaborative arrangement for orthopaedics; these conversations had been positive and the Board would be appraised at its meeting on 7 March 2018 • The financial performance in January had been broadly positive, with the position achieved being better than the original and recovery plans. This meant that on a rolling four month basis, the Trust was running ahead of the position compared to the same time last year, this being in the face of tariff reduction, so this was a positive position • There was a possibility that the stock position at the end of the year would deliver a positive benefit • Expenditure during the month was less than planned and was well controlled • There was a discussion around the consideration of model hospital information, although at present this was of limited value due to the robustness of the information • It was agreed that there should be wider use of consultant-level contribution information within the organisation

	• Theatre utilisation was good at present and vacant lists were being recycled • The number of cancellations on the day of surgery continued to decrease • Length of stay for knee replacement cases had improved; the influence of anaesthetists on improving this further was discussed • The Trust continued to perform well against diagnostic targets and in terms of the RTT position, then this was in line with the trajectory • The progress with the 'Perfecting Pathways' work was reported to be good, particularly in the pre-operative assessment centre. The coding work also continued to proceed well. • The Committee received an update on the work to develop the financial plan for 2018/19. The adjusted control total was reported to be contingent on achievement of the 2017/18 control total. The CIP was expected to be set at £3m.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Schedule a discussion around continuity of supply in the context of Brexit • It was agreed that profit/loss information based on constant pricing levels needed to be brought to the next meeting • Consider the use of an 'At a Glance' report as a preface to the Finance Overview • Consideration to be given to identifying a 'front of house' individual in Outpatients; this had been suggested by the governors • The draft financial plan to be presented at the next meeting, which is to include the budget in the context of trends, such as the last 2-3 years of delivery • Full update on progress with 'Perfecting Pathways' at the next meeting
Decisions made	• The Board and the Finance & Performance Committee will receive further information on profit and loss and the statement of comprehensive income

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

For the meeting of the Trust Board scheduled for 7 March 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	23 February 2018
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 Matthew Revell and Ms Marie Raftery attended the meetings to provide an update on Amplitude and Theatre stock respectively
Major agenda items discussed	• External Audit progress report • Counterfraud progress report • Internal audit progress report and internal audit plan • Update on stock control • Update on Amplitude • Recommendation tracking • Timetable for the production of the annual report and accounts • Accounting policies • Going Concern status • Losses and compensations • Breaches of SFIs and single tender waivers • Review of Audit Committee workplan • Quality & Safety Committee Feedback • Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• As part of the external audit progress report, the key significant audit risks were outlined, which included recognition of NHS revenue, management of override controls, financial sustainability & Going Concern and the NHS Improvement enforcement action from 2017. It was suggested that in terms of the NHS Improvement enforcement action, NHSI should be invited to discuss whether it was appropriate for this action to be lifted, given the good progress made both at a strategic and operational level • The Committee agreed that as cyber crime remained a key risk for the Trust, there should be better visibility of this and a view of the level of risk and the mitigations to manage this would be presented to the Trust Board in May 2018 • The CIP internal audit report had provided partial assurance, in reflection that there was further work to do to improve the governance, challenge and oversight of cost improvement schemes. Although the new Assistant Director of Finance was working well to address this, the

	Committee agreed that there was still some way to go before the process was robust and challenge of the quality of the schemes, as well as their impact, was at the correct level. It was suggested that the CIP process and continuous improvement work would benefit from being more united. • The Committee received an update on stock management – the stocktake in November had highlighted a number of weaknesses with stock control, although it was likely that when consignment stock was valued, there may be some degree of positive impact on the Trust's financial position. A number of further improvements, covering adjustments in the physical environment within theatres, use of technical systems and staffing would be delivered over the next few months. Barcoding was cited as a key piece of work. • Although the use of Amplitude was improved, there remained an outstanding issue over the support from the business intelligence team for the system – this would be resolved over coming months as data analysts and business intelligence team were centralised. • The Committee considered the latest versions of the recommendation trackers and while the position had improved, there remained a number of outstanding actions that dated back some time. The plan to consider the action plans for the individual reports was accepted by the Committee although a consolidated view of the overall status of actions was still needed. It was agreed that Executive Directors should attend the Audit Committee by rotation to guide the Committee through progress with addressing the actions within their remit. This would be built into the Audit Committee workplan. • The Going Concern status of the Trust was considered and the Committee reached the view that despite the financial challenges of the ROH, given there was no suggestion that the Trust would cease to provide services and there would be access to funds to operate, it should be regarded as a Going Concern and the accounts should be made up on that basis. • The Committee considered the latest version of the Board Assurance Framework, noting the plan to ask for the Board's approval to close two risks that had been fully mitigated
Positive assurances and highlights of note for the Board	• The cash management internal audit report had provided reasonable assurance • The Committee was pleased to learn that there was improvement with the use of the Amplitude system and the position compared to peers was better. Completion rate of forms onto the system was noted to be much improved on the position previously and there was better clinical engagement. The use of apprentices to support the

	work was being considered, which the Committee agreed was a good measure.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Present a further update on cyber security at the next meeting • Provide the Trust Board on 7 March with an update on stock • Present the updated BAF to the Trust Board on 7 March 2018
Decisions made	• The Audit Committee approved the internal audit plan for 2018/19 • The Accounting policies for inclusion in the annual accounts were approved, subject to agreement over some minor discrepancies between External Audit and the Director of Finance • The Committee approved its annual workplan

Rod Anthony
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 7 March 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	10 January 2018
Guests	None
Major agenda items discussed	• Terms of Reference • Development of a workforce dashboard • Workforce Race Equality Standard 2017 and ROH benchmarking • National staff survey – headline results and next steps • Update from People Committee • Initial views on the ROH by the Associate Director of Workforce, HR & OD • Preparation for the CQC well-led assessment • Workforce-related risks
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Consideration of workforce matters, other than nurse staffing was agreed to have been poor to date and it was suggested that equivalent information to that provided around nurse staffing needed to be considered. The perspective of staffing groups beyond nursing and medics would be provided through the inclusion of the Chief Operating Officer and Chief Executive in the membership • It was noted that at present, there was not a defined workforce strategy or plan in place • The initial workforce dashboard suggested that there was a need to focus on performance management as there appeared to be few formal cases under investigation or capability proceedings underway • The response rate to the national survey was reported to have deteriorated from 2016 • The recent diagnostic of the ROH's workforce, OD and HR systems and processes suggested that the HR function may be under developed, management of performance was weak and talent management & succession planning were embryonic. Data and business intelligence were hard to find and KPIs around workforce had not been clearly defined. It was suggested that the ROH brand needed to be better sold to those it was trying to recruit. There was a good commitment by the new associate director to take the workforce agenda forward and reinvigorate it where needed. • The current risks on the Trust's corporate risk register which related to workforce matters were reviewed; these would be revised and refreshed following a review through the People Committee

Positive assurances and highlights of note for the Board	• The meeting was the inaugural meeting of the Committee, which was a welcome improvement to the oversight of workforce-related matters • The Committee noted that there were some positive indications of improvement against the Workforce Race Equality Standards; there was also evidence of good work on equality and diversity more widely which was being progressed by the Head of OD • The headlines from the 2017 national survey were considered, which suggested a slight shift in improvement against a number of the indicators; the results were under embargo until March 2018 however • The first meeting of the revitalised People Committee had been held and this body would be the primary body reporting upwards in the Staff Experience & OD Committee; it would consider some of the granular information that may not be appropriate to consider at a Board subcommittee • The preparation for the CQC well led framework was discussed, including a self assessment against the various key lines of enquiry within the CQC's framework
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Terms of Reference to be changed to add in clinical representation into the membership, workforce planning into the purpose and to reflect that meetings would be held monthly initially
Decisions made	• The Committee adopted its initial terms of reference subject to amendments to the purpose, membership and frequency of meetings

Simone Jordan on behalf of Richard Phillips
ASSOCIATE NON EXECUTIVE DIRECTOR

For the meeting of the Trust Board scheduled 7 March 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	7 February 2018
Guests	None
Major agenda items discussed	• Terms of Reference • Workforce performance report • Education and training update • Workforce risks
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Pay costs were anticipated to be higher than plan, which reflected current staffing models, both in terms of nursing and medical, in addition to the need to support some strategic developments • There continued to be agency cost pressures, however these had reduced due to the completion of the 18 weeks RTT validation work • It was highlighted that retention and recruitment strategies needed to be developed and the reasons for staff leaving were not clear at present • Staff absence was rated as 'amber' as it was slightly above the Trust's KPI • Return to work interview completion rates were low at only 52% • The Committee was advised that there were currently three suspensions and the assurances were sought that the appropriate processes were being followed for each – this was reported to be the case • The Committee was advised of the risks associated with the diversifying the medical training programme, including the potential failure to maintain the quality and level of service to the Birmingham Orthopaedic Teaching Programme (BOTP) which was currently working well • There was reported to currently be significant issues in the costs associated with junior medics and the need to operate rotations in a complaint way
Positive assurances and highlights of note for the Board	• The Committee received the updated workforce dashboard, which it was noted had developed some way since the last meeting and provided good visibility on some of the key workforce metrics • An online questionnaire was being developed to capture feedback from individuals due to leave the organisation • There was a discussion around defining the brand of the ROH, such that the perception of the organisation being a 'sleepy' and relaxed place to work was altered and the strengths of the organisation were sold to attract the right

	calibre of candidates • There was a plan to revamp the performance development review process and tailor this better to different staff groups • The new consultant induction programme was welcomed • The Trust was performing well on Mandatory Training rates and challenge was levied at divisional performance reviews where needed • Some audit days had been included in the internal audit plan for 2018/19 to consider workforce risks • The Committee received an update on education and training – this was attracting an annual income of c. £1.75m, with a contribution of over £600k. • Relationships would be developed to further the offerings to apprentices
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The workforce dashboard would be developed further over the coming months • Strong links with the other Board committees needed to be forged
Decisions made	• None specifically

Simone Jordan on behalf of Richard Phillips
ASSOCIATE NON EXECUTIVE DIRECTOR

For the meeting of the Trust Board scheduled 7 March 2018

STAFF EXPERIENCE AND ORGANISATIONAL DEVELOPMENT (OD) COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Staff Experience and OD 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 Trust's performance against a range of workforce-related metrics, indicators and targets. It shall also seek assurance as to the robustness of the Trust's strategic workforce planning arrangements, organisational development framework and progress with developing a learning and improvement culture within the ROH.

4 MEMBERSHIP

4.1 The Committee will comprise of not less than three Non-Executive Directors (including the Associate Non Executive Director), the Director of Strategy & Delivery, Chief Executive, Chief Operating Officer and representatives nominated by the Executive Director of Patient Experience and the Executive Medical Director.

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 three 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 and organises 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, with additional meetings where necessary.

7 REPORTING AND ESCALATION

7.1 Following each committee meeting, the minutes shall be drawn up and presented at the next Committee meeting where they shall be considered for accuracy and approved. 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

7.5 The Committee will receive routine upward reports from workforce-related fora, the People Committee being the principal conduit. These will report in rotation, the frequency being set out in the Committee's workplan.

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 workforce strategies, including but not limited to:

- People Strategy
- Leadership Strategy
- OD and Staff engagement strategy
- 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 workforce planning, education, training and development to meet the needs of the Trust's overall strategy

9.4 To ensure that workforce plans are adequately connected to financial and capacity/demand planning in ROH

9.5 To review plans for developing new roles, skill mix and where needed, new job plans, to meet the evolving needs of the Trust

9.6 To review data and trends against key workforce metrics, including but not limited to:

- Numbers of starters, leavers and staff turnover
- Staff in Post and vacancy rates
- Pay spend (fixed and variable) overall and by staff group
- Appraisal rates and mandatory training position
- Sickness absence and other absence
- Numbers of formal procedures
- Staff satisfaction
- Productivity and benchmarking data
- Agency and locum usage

And to seek assurances that where there are trends of concern, that plans are in place that will deliver improvement in an effective and timely way

9.7 To seek assurance on the Trust's position against the NHS Improvement and CQC Well Led Frameworks and any plans to strengthen compliance or address shortfalls against the requirements of any dimension

9.8 To review key trends and themes from staff feedback, through mechanisms including the national staff survey, internal 'pulse checks', 360 degree feedback, exit interviews, Freedom to Speak up data and whistleblowing concerns raised and seek assurance that where improvement is required that plans are sufficiently robust and timely

9.9 To review plans for developing the Trust's education and training framework, including Learning Beyond Registration, and to scrutinise income and expenditure from Health Education West Midlands

9.10 To seek assurance on the quality of wellbeing offerings to staff and on the adequacy of the health and safety framework for staff

9.11 To review and seek assurance on the robustness of the Trust's talent management and succession planning frameworks

9.12 To review the Trust's plans to develop a recognition and reward model

9.13 To have oversight of culture change across the Trust, including the development of an Improvement culture among the workforce and equipping staff with the knowledge and skills to make improvements happen at the front line

9.14 To review workforce-related internal audits and monitor progress and the impact of the delivery of any recommendations within these reports.

9.15 To seek assurance on behalf of the Board that the key risks to the delivery of any of the workforce strategies are adequately mitigated

Date of adoption: March 2018

Date of review: June 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 4 April 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 4 April 2018 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.

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 April 2018: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair ansd 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Prof Philip Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Mrs Alex Gilder	Deputy Director of Finance	(AG)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Service Improvement story: Rapid Recovery	Presentation	
1125h	2	Apologies - Steve Washbourne	Verbal	Chair
1127h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1130h	4	Minutes of Public Board Meeting held on the 7 March 2018: *for approval*	ROHTB (3/18) 015	Chair
1135h	5	Trust Board action points: *for assurance*	ROHTB (3/18) 015 (a)	SGL
1140h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (4/18) 001 ROHTB (4/18) 001 (a)	YB/PA
		STRATEGY		
1155h	7	Paediatric services update	Verbal	AP/PA
1200h	8	Orthopaedic services in the STP	Verbal	PA
1205h	9	Progress against the Five Year Vision: *for assurance*	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	PB

QUALITY & PATIENT SAFETY				
1215h	10	Patient Safety & Quality report: *for assurance*	ROHTB (4/18) 003	GM
1225h	11	Quality Priorities 2018/19: *for approval*	ROHTB (4/18) 004 ROHTB (4/18) 004 (a)	GM
FINANCE AND PERFORMANCE				
1235h	12	Finance & Performance overview: *for assurance*	ROHTB (4/18) 005	AG
COMPLIANCE AND CORPORATE GOVERNANCE				
1245h	13	Corporate Risk Register: *for assurance*	ROHTB (4/18) 006 ROHTB (4/18) 006 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1255h	14	Quality & Safety Committee: *for assurance*	ROHTB (4/18) 007	KS
	15	Finance & Performance Committee: *for assurance*	ROHTB (4/18) 008	TP
	16	Staff Experience & OD Committee: *for assurance*	ROHTB (4/18) 009	SJ/RP
MATTERS FOR INFORMATION				
1300h	17	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 2nd May 2018 at 1100h in the Boardroom, 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

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 4 April 2018: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair ansd 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Prof Philip Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)
Mrs Alex Gilder	Deputy Director of Finance	(AG)
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL) [Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Service Improvement story: Rapid Recovery	Presentation	
1125h	2	Apologies - Steve Washbourne	Verbal	Chair
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		STRATEGY		
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FINANCE AND PERFORMANCE				
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COMPLIANCE AND CORPORATE GOVERNANCE				
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UPDATES FROM THE BOARD COMMITTEES				
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	15	Finance & Performance Committee: *for assurance*	ROHTB (4/18) 008	TP
	16	Staff Experience & OD Committee: *for assurance*	ROHTB (4/18) 009	SJ/RP
MATTERS FOR INFORMATION				
1300h	17	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 2nd May 2018 at 1100h in the Boardroom, Trust Headquarters

Notes

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MINUTES

Trust Board (Public Session) - DRAFT Version 0.2

Venue Boardroom, Trust Headquarters **Date** 7 March 2018: 1130h – 1315h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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 Paul Athey	Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mrs Jo Williams	Interim Chief Operating Officer	(JW)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Prof Philip Begg	Executive Director of Strategy and Delivery	(GM)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Jo Wakeman	Deputy Director of Nursing and Clinical Governance	(JWA)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NeXT scheme)	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mr Richard Phillips, Non Executive Director and Mr Garry Marsh.	
2 Declarations of interest	**Verbal**
There were no declarations made in connection with any item on the agenda. Rod Anthony reported that he was likely to be appointed as a lay member for a Clinical Commissioning Group in the South West. This would be a temporary appointment but would be added into the register of interests when confirmed.	
3 Minutes of Public Board Meeting held on 10 January 2018: *for approval*	**ROHTB (1/18) 013**
The minutes of the meeting held on 10 January 2018 were approved as a true and	

accurate record.	
4 Trust Board action points: *for assurance*	**ROHTB (1/18) 013 (a)**
It was noted that there were three green actions, which were all in hand or covered by the agenda. The Terms of Reference for the Staff Experience & OD Committee were noted to be part of the upward report from the Staff Experience & OD Committee later on the agenda which would need to be approved.	
5 Chairman's & Chief Executive's update: *for information and assurance*	**ROHTB (3/18) 001** **ROHTB (3/18) 001 (a)**
The Chief Executive reported that the Trust was now approaching the completion of the CQC inspection process. The draft report was anticipated in the middle of April. There were some positive conversations around the STP and there may be more formal arrangements that could be applied across the system in due course. There had been some back to the floor work across the organisation and since the last meeting the Chief Executive had met with the team in the Admissions and Day Case Unit and the Musculo-Skeletal team. This had been a good opportunity to understand the pressure and work of each of these teams. A strategic session had been held with the Therapy teams, which addressed some of the issues raised by them previously. It was reported that there would be a back to the floor exercise with Domestics shortly. The staff awards ceremony had been well received and staff felt recognised. It was reported that Uzo Ehiogu had felt humbled by the Trust Board award. The Harrison lectures had been well received and the next lecture was around Scoliosis and Richard III. On 25th January, the Trust launched a full suite of Joint Pathways literature and communications material which has been produced in conjunction with Stryker. Every patient receiving a joint replacement at the ROH would now be given a patient information book, which was currently being very well received. The Chief Executive was asked to provide this new pathway information to Mrs Sallah. The Chairman reported that she had: • Participated in the new consultant programme welcome • Chaired the appointment panel for a new consultant anesthetist • Overseen the handover between Alan Last and Brian Toner for the role of	

Lead Governor • Attended the Staff Awards on 2 February which was a great evening celebrating with staff who had gone above and beyond and had delivered some inspirational work over the last year. The staff awards stories had been captured for the website. • Undertaken a walkabout in Outpatients, Imaging and Pre-Op Centre • Jointly with the Chief Executive, had met with Richard Burden MP to discuss some key strategic developments that the Trust was facing • Joined the Patient & Carer's Forum for their monthly meeting • Had been interviewed on 21 February as part of the CQC's Well Led inspection It was noted that the governors had suggested that a front of house Outpatient representative would be beneficial. The Trust had been put forward for a HSJ award for Rapid Recovery and the team would present at the Trust Board meeting on 4 April. It was suggested that a joint meeting between the Chairman and Chief Executive with the MPs across the patch was needed.	
ACTION: PA to provide KS with the details of the new pathways **ACTION: SGL to arrange for a meeting to be arranged with local MPs**	
5.1 Paediatric services update	**Verbal**
The Chief Executive reported that a decision was awaited from the Board of Birmingham Women's and Children's Hospitals NHS FT (BWCH) which was considering the Paediatrics business case. In the meantime, there remained a challenge around nursing and paediatrician cover. Everything was being done to progress matters that were within the gift of the Trust, however the pace of the work remained slow. The Deputy Director of Nursing confirmed that patients were being kept safe despite the challenges. A meeting had been arranged with NHS Improvement to discuss a shared risk arrangement while services continued to be delivered as they were. The financial implications of this were also being considered including support for any additional infrastructure. Patients and staff were being informed and the Paediatrics Ward would be visited next week to keep in touch with the staff.	
5.2 Orthopaedic Services in the STP	**Verbal**
There was a discussion underway with the STP and the orthopaedic workstream regarding the way providers worked together. The strategy refresh would go to the	

STP Board in April. There was a briefing of the Council of Governors scheduled, which would also consider this proposal and a statement from the Board would be prepared around the joint working. It was noted that a hub and spoke model had been suggested by the Council of Governors previously.	
6 Patient Safety and Quality Report: *for assurance*	**ROHTB (3/18) 002**
The Deputy Director of Nursing presented the Patient Safety & Quality Report. Three moderate harms had been reported, including one around labelling biopsies and there had been a change in process to avoid recurrence. It was reported that this mix up had not delayed the treatment of individuals however but meant that patients had needed to undergo a further biopsy which could have been avoided. Assurance was sought that the biopsies were being taken appropriately and patients were being consented. This was confirmed by the Medical Director. It had failed in outpatients due to a single point deviation from the usual process. The changes being made would be reported to the Quality & Safety Committee. There had been a Grade 3 pressure sore and a VTE on Ward 2. The serious harm incident was noted to have been downgraded as there was a failure to escalate rather than harm to a patient. 98.51% harm free care had been delivered. There had been an overall higher rate of VTEs, with there being a theme around high BMI (overweight) patients. It was suggested that if BMI was an issue that could be linked to an increase in VTEs then the admission criteria needed to be reviewed and any special equipment that might be needed should be considered. It was noted that it was difficult to correlate to the position to that elsewhere as the reporting of VTEs was different to other organisations. This was also being clarified through commissioners who were reluctant to allow patients over a certain BMI to receive treatment. At present, patients over a BMI of 35 needed to be referred back to GPs for a weight loss programme. In Rapid Recovery then there was an emphasis on mobilising patients speedily which assisted in avoiding VTEs. The higher rate of VTE and the possible link to high BMI would be kept under review. There was more work being undertaken to prevent falls. Further focus was needed on pressure ulcers and particularly cast-related issues. The new tissue viability nurse was assisting with this direction. Patients also need to be given information as to how pressure ulcers could be avoided. There had been 16 formal complaints. All complaints had been responded to in time. The Friends and Family Test results suggested that there were 96.6% positive responses. In terms of Ward 3, this was skewed by small numbers. It was suggested that the presentation needed to be considered in terms of footfall and responses as currently this was misleading in the report. It was noted that there had been an	

improvement in patients being handed the questionnaires to be completed. Additional information on the Duty of Candour cases was being included in a future version of the report. 100% compliance with the WHO checklist had been achieved. It was noted that a number of consultants had been sick which had caused clinic delays. Many of the delays were in Oncology clinics which were complex cases and the clinic templates had been reviewed. In terms of RTT, the trajectory had been exceeded at 80% vs. 79%. There had been a significant reduction in the number of patients waiting in excess of 52 weeks for treatment and of those remaining only one was not a spinal deformity case. The Trust was monitored quarterly against the cancer targets, against which the Trust performed well. There had been an improvement in hospital cancellations and there would be a particular focus on patient cancellations. More work would be done around length of stay and the roll out of Rapid Recovery to other specialities. It was highlighted that this may be a challenge over the weekend when physiotherapy was not as available however. Outpatient follow up had been a point of discussion at the recent Quality & Safety Committee and in particular the value of these in some cases as there were different ways of following up patients that did not need face to face contact. Text reminders for outpatients and physiotherapy were underway to let patients know the cost of arriving for an appointment. The time of discharge on Ward 12 had been questioned at the Quality & Safety Committee and the quality of information needed to be reviewed as may be currently recorded as the time the patient was prepared to be collected, rather than when they were clinically signed off for discharge. A member of staff in attendance at the meeting asked for a view on the current ward and bed closures. He was advised that at present there was not the right balance between theatre activity and patients needing beds. More work needed to be processed through existing theatres, through the efficiencies in theatres or by growing theatre capacity. The workforce implications to support this shift needed to be thought through and work was underway to determine how staff could be attracted. It was suggested that there was a need to ensure that the Trust was not staffing empty beds and to continue to close those not needed to manage costs. Overall, it was highlighted that the hospital was now more efficient and there were more day case patients now being seen. Furthermore, patients were not now brought in for surgery on the day before which had also freed up some beds that would otherwise have been occupied.	
7 'Perfective Pathways' update: *for assurance*	**Verbal**
It was noted that a full progress update paper on 'Perfecting Pathways' would be presented to Finance & Performance Committee at its next meeting.	

Some key highlights included: The paediatric transition group had been set up to manage the move of children's care. Staff in the Pre-Operative Assessment Centre were looking at practice elsewhere to see what other changes could be made to deliver better efficiency. Some staff had started the Flow Academy course. The plans for embedding the ePMA (electronic prescription and medicines administration) system had been firmed up. More patients would be treated as day cases in the Admissions and Day Case Unit. The use of a modular theatre was being considered. An improvement event was planned, including a series of masterclasses and Helen Bevan, Chief Transformation Officer from NHS England, would also join the team by web-ex. The Trust was to visit South West London Elective Orthopaedics Centre (SWLEOC) and a report would be presented to the Board on this. The functional restoration work would be introduced into some community settings. Six MAKO cases had been delivered so far and knees may be operated on from April 2018. Private practice work would be brought on site. Theatres were being closed around Easter to undertake maintenance work, which included a host of jobs such as flooring and maintenance of plant. The opportunity to improve training and PDRs rates would be undertaken while theatres were closed.	
ACTION: JWI to present an overview of the visit to the South West London Elective Orthopaedics Centre at the May meeting	
8 Finance & Performance overview including recovery: *for assurance*	**ROHTB (3/18) 003**
It was noted that the finance and performance overview had been considered in detail at the last meeting of the Finance & Performance Committee. This had been a positive month and in terms of the overall financial position there was confidence that the year-end control total could be met. Income was above plan, this being driven by more day case activity. Activity was slightly lower than plan which related to the number of finished	

consultant episodes, where at the end of January there were still a number of patients in progress. There had been good cost control in the month. Agency staff usage had been particularly well controlled. There remained however a pressure associated with junior doctor cover.

The Board's attention was drawn to some patient level information and service line reporting; the most useful information to review was being worked through with the Finance & Performance Committee. It was noted that the Committee was of the view that contribution needed to be considered in future.

There had been an improvement in delivery of the CIP. There was a challenge around setting the CIP for 2018/19 in terms of striking the most appropriate balance between ambition and realism.

Cash remained strong; there had been a further drawdown in January.

The control total for next year would be c.£6m providing that the control total for 2017/18 was met.

The business planning information was discussed. The Vice Chair reported that a profit and loss statement and the balance sheet would be considered at future meetings. This was in line with national guidance issued. Some of the Lord Carter productivity data would also be provided in future.

In terms of the locum positions, these individuals were recruited from a locum agency and these appointments were checked by the Medical Director prior to them joining the Trust. The dependency on medical locums was on the basis that those that the Trust received were mainly GP trainees and additional junior doctors were needed to ensure rotas were compliant. Over the coming year alternative models would be considered, including Physician Associates and other roles. It was noted that there was variability in quality of the individuals on a general basis. It was reported that this issue was being taken forward through Executive Team and Division 1 forward plan included this consideration. The Acting Chief Executive noted that the Trust was stronger than it used to be in this respect, however it was clear that the position was not sustainable. It was reported that there may be an opportunity with the developments across the region and that junior doctor cover was a national issue. Health Education England's strategy document was reported to include some objectives around this including the use of Physician Associates and nursing associate trainees. Mrs Sallah commented that that the use of a bank or agency member of staff should not be used as an explanation for incidents.

It was suggested that the impact of the changes in activity levels and higher turnover of patients on the workforce needed to be considered. The Board was advised that a capacity and demand piece of work had been undertaken and there was some focussed work to look at roles in theatres.

9 Gender pay reporting: *for assurance*	**ROHTB (3/18) 004** **ROHTB (3/18) 004 (a)**
The Executive Director of Strategy & Delivery reported that there was good progress with delivering the actions to be compliant with gender pay reporting requirements. To date the Trust had registered with the government on time and the analysis had started using the tool needed. Data had also been submitted to the reporting service. There was reported to be a gap, which reflected the gender bias in the consultant body and the information concerning bonuses was as a result of the consultant clinical excellence awards. This data needed to be published by 31 March 2018. There would be further discussion by the Staff Experience and OD Committee.	
10 Compliance with CQC fundamental standards – update on action plan: *for assurance*	**ROHTB (3/18) 005** **ROHTB (3/18) 005 (a)**
The Associate Director of Governance & Company Secretary advised that the report had been considered previously by the Quality & Safety Committee The report showed how the Trust complied with the CQC's 13 Fundamental Standards The position was as of February 2018 which showed more work has been done to strengthen compliance since the Board last reviewed the position in January. At present, there were no major areas of concern to highlight. It had been agreed at the Quality & Safety Committee that an action plan should be developed to monitor progress with delivery of the further actions.	
11 Board Assurance Framework: *for assurance*	**ROHTB (3/18) 006** **ROHTB (3/18) 006 (a)**
The Associate Director of Governance & Company Secretary advised that the Board Assurance Framework was the version that had been considered by the Audit Committee in January. There was a proposal to close two risks from the BAF, one being associated with the Infection Control Team and the other around the lack of focus on patient-centred care, which the Board approved. Mrs Sallah advised that the programme of priorities for the infection control team were due to be presented the Quality & Safety Committee in future. It was suggested that a Board workshop on the risk framework was needed, which the Associate Director of Governance & Company Secretary was asked to arrange.	
ACTION: SGL to arrange a risk workshop	
12 Quality & Safety Committee: *for assurance*	**ROHTB (3/18) 007**

	ROHTB (3/18) 008
The assurance report from the Quality & Safety Committee was received and noted.	
13 Finance & Performance Committee: *for assurance*	**ROHTB (3/18) 009** **ROHTB (3/18) 010**
The assurance report from the Finance & Performance Committee was received and noted.	
14 Audit Committee: *for assurance*	**ROHTB (3/18) 011**
Rod Anthony reported that there had been good progress with addressing the outstanding audit recommendations but there would be additional focus on this to instil further rigour in future. The internal audit would be on site to close some of the actions around the 18 weeks RTT audit audit shortly.	
15 Staff Experience & OD Committee and its revised terms of reference: *for assurance*	**ROHTB (3/18) 012** **ROHTB (3/18) 013** **ROHTB (3/18) 014**
Simone Jordan advised that there had been further good progress with the development of the workforce dashboard. It was highlighted that the terms of reference needed to be amended to change the title of the Director of Patient Services from Director of Patient Experience. The Chairman advised that a report into the governance of the Committees and the reporting up into the Board had been commissioned. This would be led by a Non Executive Director and the outcome would be reported at a future Board meeting.	
16 Any Other Business	**Verbal**
Thanks were given to everyone who had worked above and beyond in the recent snowfall to keep the hospital running.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 4 April 2018 at 1100h, Boardroom, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 7 March 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 29.03.2018

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee in April 2018	SGL	30-Apr-17	Added to the agenda for the meeting planned for 23 April 2018	
ROHTBACT. 048	Assurance report from the Quality & Safety Committee	ROHTB (1/18) 009	10/01/2018	Review the quality assurance walkabouts methodology	GM	31-Mar-18	Quality assurance walkabouts teams have been widened to include members of the Council of Governors. They reatin the focus on the five domains of the CQC framework. The outputs are considered by the Quality & Safety Committee and by the Executive Team.	
ROHTBACT. 050	Chairman's & Chief Executive's update	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	07/03/2018	Arrange for a meeting to be arranged with local MPs, the Chairman and Chief Executive	SGL	31-May-18	To be arranged after the purdah period which end in early May 2018	
ROHTBACT. 051	'Perfective Pathways' update	Verbal	07/03/2018	Present an overview of the visit to the South West London Elective Orthopaedics Centre at the May meeting	JWI	02-May-18	ACTION NOT YET DUE	
ROHTBACT. 052	Board Assurance Framework	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	07/03/2018	Arrange a risk workshop	SGL	31-Jul-18	ACTION NOT YET DUE	
ROHTBACT. 047	establish a Staff Improvement and Experience Committee and to disestablish the Major Project &	ROHTB (1/18) 002 ROHTB (1/18) 002 (a)	10/01/2018	Amend the terms of reference for the Staff Experience & OD Committee to include workforce planning into the purpose and the add the Deputy Director of Nursing and an Associate Medical Director into the membership	SGL	07-Mar-18	Agreed on discussion at the February Staff Experience & OD Committee meeting to amend this to 'nominations by the Executive Director of Patient Services and the Medical Director'	
ROHTBACT. 049	Chairman's & Chief Executive's update	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	07/03/2018	Provide KS with the details of the new pathways	PA	ASAP	Mrs Sallah now in receipt of a copy of the new information developed in conjunction with Stryker	

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 April 2018**

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 4th April 2018

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 public Trust Board meeting on 7th March 2018

2 STAKEHOLDER OVERSIGHT

2.1 The latest stakeholder oversight meeting was chaired by NHS Improvement on 15th March 2018, during which agreement was reached on an amendment to the Terms of reference that formally acknowledged that "all stakeholders within the group agree that the provision of a safe service during the transition period [for paediatric services] is their joint responsibility."

2.2 The oversight meeting received a update from all parties with regards to progress towards transition, and it was reported that the Birmingham Women's and Children's Trust Board would be considering the business case for service transfer at their meeting on 29th March 2018.

2.3 The oversight meeting also received an update on RTT performance, where it was noted continued improvement towards delivery on the 92% target and a further reduction in the number of patients waiting more than 52 weeks for treatment.

3 STP UPDATE

3.1 Lawrence Tallon, Director of Corporate Strategy, Planning & Performance at UHBFT and Rachel O'Connor, Director of Planning and Delivery at NHS Birmingham & Solihull CCG attended our Executive Business Meeting on 20th March to present the updates to the STP's draft strategy and to give the Trust the opportunity to feed into the final version before it is presented to the STP Board for approval

3.2 There was no STP Board held in March, with the next Board due on 9th April.

4 BACK TO THE FLOOR

4.1 On 14th March, I spent the day with the outpatients team and, in addition to speaking to a number of staff and patients, I had the opportunity to shadow an outpatient clinic with one of our Advanced Nurse Practitioners, an outpatient procedure performed by one of our Hand consultants and to spend time with the reception and booking teams.

4.2 The staff I spoke to were clearly committed to delivering a positive patient experience to everyone who attended the department and showed clear passion for the Trust. In particular, the reception staff were especially diligent in ensure that patients were supported and any concerns or questions were addressed quickly and courteously.

4.3 A number of challenges and frustrations were discussed and I took away a number of actions to progress. These included:

- Reviewing opportunities to support delivery of "virtual" outpatient attendances.
- Addressing challenges around recruitment
- Signage for patients entering outpatients to be directed to other areas of the hospital
- Potential improvements to the functionality and usability of the InTouch system
- Opportunities to progress the rollout of the Amplitude outcomes system

These issues have been raised with colleagues and a number will be picked up through the outpatient management board.

5 AWARDS RECOGNITION

5.1 Over the past few weeks, the Trust has been shortlisted for two national awards.

5.2 The Rapid Recovery team have been shortlisted for "Improving the value of surgical services" at the HSJ Value Awards 2018. This nomination reflects the incredible work undertaken in implementing the rapid recovery pathway and protocols for primary hips and knees, which as well as receiving exceptional patient feedback, have also supported significant reductions in length of stay for patients who have been through the programme.

5.3 Three of the multi-disciplinary team are presenting to the final judging panel on 6th April before finding out if we are successful at the awards evening on 7th June.

5.4 In addition to this, our Oncology team have been shortlisted for our work on implementing a daily MDT meeting in the "Cancer Care" category of the HSJ Patient Safety Awards 2018. This MDT brings together input for surgical, nursing, radiology and pathology professions on a daily basis to ensure that patients receive access to

high quality and timely care and treatment. Their final presentation will take place to the judging panel on 1st May, with the award winner being announced on 9th July.

6 CONTINUOUS IMPROVEMENT FOCUS

6.1 On 5th & 6th April 2018, the Trust is holding a Continuous Improvement Focus across the Trust, incorporating a combination of interactive presentations, taster sessions and workshops.

6.2 In addition to this, the Continuous Improvement Roadshow will be visiting a range of areas across the Trust to chat about improvements, capture ideas and share opportunities and we will also be hosting patient feedback sessions across the two days.

6.3 Programmes will be available at the Trust Board meeting to view and all Board members are encouraged to attend.

7 POLICY APPROVAL

7.1 Since the Board last formally met in public, the following new or substantially changed policies have been approved by the CEO on the advice of the Executive Team:

- Blood transfusion policy
- Mandatory training policy

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
Acting CEO
29 March 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Progress against the Trust's 5 Year Strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Philip Begg – Executive Director of Strategy & Delivery**
AUTHOR:	**Rebecca Lloyd – Head of Strategy**
DATE OF MEETING:	**4 April 2018**

EXECUTIVE SUMMARY:

Following the review of the Trust's 5 Year Vision & Strategy, it was agreed that a set of metrics and KPIs be developed and that the Board would receive an update throughout the year.

The attached paper shows the initial development of a dashboard that marks progress against the 9 Strategic Goals set out in the strategy. Future reporting will include quarterly targets and a clear demonstration of progress against each goal, and the KPIs within it.

There are clear areas of good progress, and areas for further development. However, the dashboard does provide the Board with some assurance that there is a forward movement within the organisation against the 9 Key Goals.

REPORT RECOMMENDATION:

The Trust Board is asked to receive the update and note the progress to date.

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		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:

Aligned to Trust's five year vision & strategy, with key performance metrics included.

PREVIOUS CONSIDERATION:

None

	Performing well & on track
	Progress made with more to do
	Behind plan

ROH Five Year Vision

Tracking progress against our nine strategic goals

Measuring our strategic goals	How we demonstrate success/by when	2017-18 – year end update	Progress rating	2018-19 priorities
Exceptional patient outcomes	We will continue to be in the top 10% for positive PROMS **ANNUAL TARGET**	• Provisional PROMS data for 2016-17 demonstrates ROH is 'not an outlier' for any Hip scores (Total Hip Replacement / Primary / Revision), and is scoring in the top 5% for Total Knee Replacements ('not an outlier' for Primary & Revision Knees)		• Expansion of Rapid Recovery (reduced length of stay, zero readmissions, positive patient experience)
Increased activity	We will treat enough patients each year to reach our 50% growth target by 2022 **10% GROWTH EACH YR**	• 2017-18 elective activity has been consistently below plan month on month • Day case activity has exceeded plan • Activity growth is dependent on additional theatre capacity		• Theatres modular build • Improved primary joint pathway (Stryker) • Improved access to Pre-Assessment
Improved Referral To Treatment compliance	92% target achieved in all sub-specialties **ANNUAL TARGET**	• February 2018 position: 81.05% compliance (Trust), with 92% compliance achieved in Oncology • On track to achieve 92% compliance by November 2018 (excluding Spinal Deformity)		• Prioritise patients waiting 52weeks+
Increased theatre productivity	A 20% increase in cases per theatre session (case mix adjusted) **4% GROWTH EACH YR**	• Theatre list utilisation is on upward trajectory (target is 95%) • In-session utilisation below target of 85% for past 6 months		• More robust clinically led 72 hour call process • Theatre recruitment • Annual planning
Reduced length of stay	A 30% reduction in overall average length of stay (case mix adjusted) **6% REDUCTION EACH YR**	• The Trust's average length of stay for 2017-18 was 4.63 days (5% reduction from 2016-17) • Average length of stay for Rapid Recovery hip patients reduced by 54% as part of the 16-17 CQUIN • Average length of stay for Rapid Recovery knee patients is 3.41 days (reduction of 37.55% from 2016-17)		• Rapid Recovery rollout • Passport to Home embedded
Highly	Positive 'Friends &	• ROH in top 10 Foundation Trusts in the country for		• Increase completion

	Performing well & on track
	Progress made with more to do
	Behind plan

Measuring our strategic goals	How we demonstrate success/by when	2017-18 – year end update	Progress rating	2018-19 priorities
recommended	Family Test' scores in the top 10% **ANNUAL TARGET**	positive patient experience (CQC survey June 2017) • February '18 FFT results – 96.6% positive and only 0.4% negative		rates
Engaged workforce	Improvement in staff survey responses **ANNUAL TARGET**	• 2017 survey shows that staff feel more engaged than in 2016 (against national trend) • 14 of 30 key findings improved, 9 remained constant and 7 decreased • Fewer staff completed the survey in 2017 than 2016		• Deliver against staff survey action plan • Speak Up & Join In campaign • Increase completion
Financial stability	Breakeven by **2019/20.** Surplus by **2021/22**	• The Trust is expecting to reach its control total of £6.2m deficit in 2017-18 and has planned to meet the £6.0m control total deficit in 2018-19. This is clearly a significant distance away from financial balance, and has been driven by a combination of decreased tariff, increased costs (particularly regarding CNST) and activity growth below expectation. • There is a clear drive to exceed next year's control total to continue a path to financial sustainability.		• Private patient activity growth through MAKO • Options for increasing access to theatres (e.g. Modular build) • Investigating options for reducing & controlling spend
Positive regulatory position	Rated 'Outstanding' by the CQC. NHSI will class us as 'Segment 1' in Single Oversight Framework **RATED 'GOOD'/ SEGMENT 2 BY 2019 AND 'OUTSTANDING' / SEGMENT 1 BY 2022**	• Currently rated as 'Requires Improvement' and awaiting CQC inspection report for unannounced visit January 2018 (including Well Led Inspection • ROH is currently classed as Segment 3 in the Single Oversight Framework. The main driver behind the position was our RTT performance and NHS Improvement enforcement action. • Significant improvements have been made to RTT performance and our future plan for sustainability has been worked through		• CQC Improvement Plan • Achieving RTT trajectory • Working within system to develop future model of sustainability

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

March 2018

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 the 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 to satisfy contractual information requirements and the CQC for routine engagement visits.

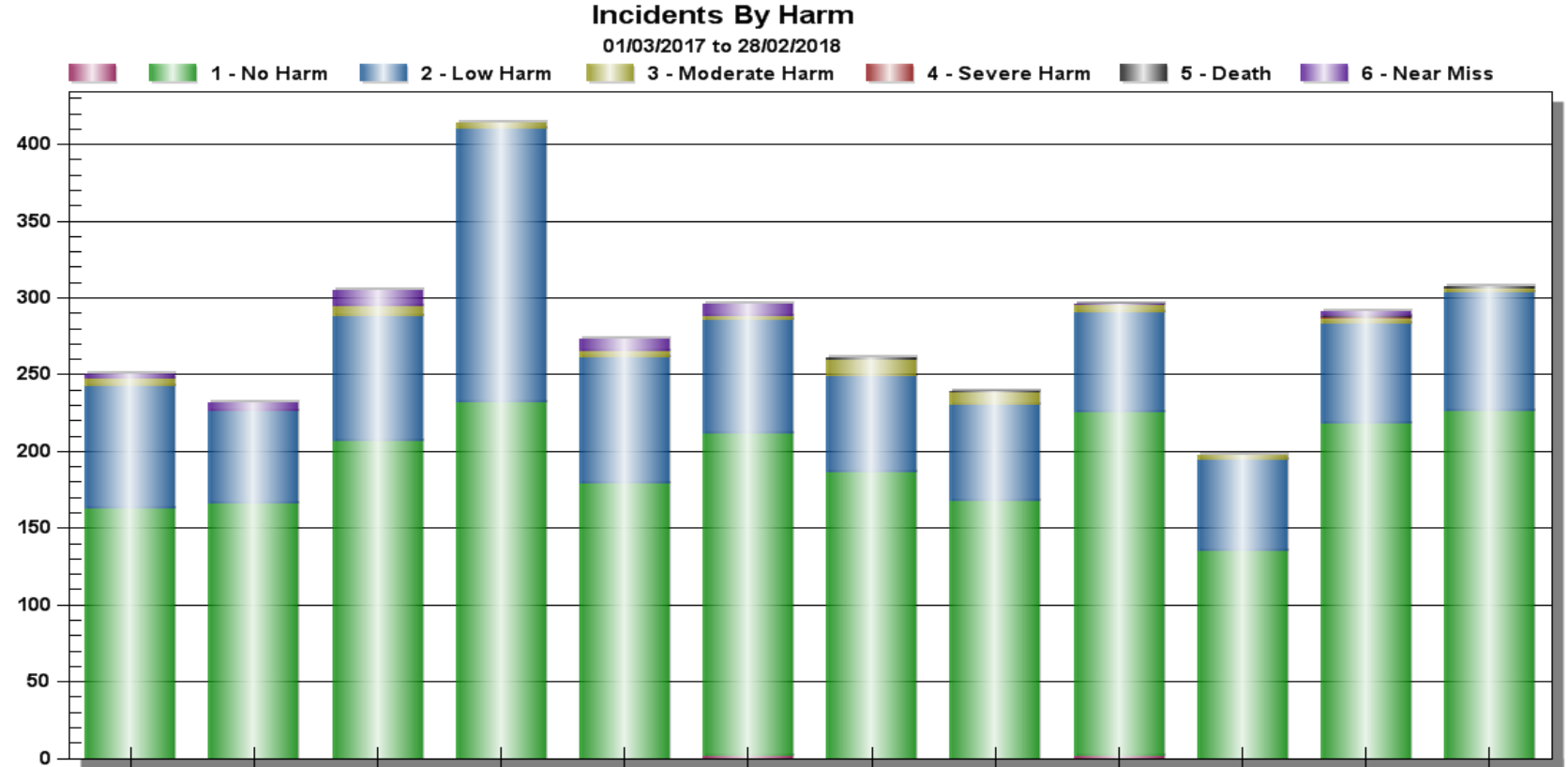
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
	0	0	0	0	0	1	0	0	1	0	0	0
1 - No Harm	162	166	206	232	179	210	186	167	224	135	218	226
2 - Low Harm	80	60	82	178	82	74	63	63	65	59	65	77
3 - Moderate Harm	5	0	6	4	4	3	10	8	5	3	3	3
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	1	0
5 - Death	0	0	0	0	0	0	2	1	0	0	1	1
6 - Near Miss	3	6	11	0	8	8	0	0	1	0	3	0

INFORMATION
In February 2018 there were a total of 307 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows; 226 – No Harm 77 – Low Harm 3 – Moderate Harms (duplicate with death incident) 0 – Severe Harm 0 – Near Miss 1 – Death **The 3 Moderate Harms and 1 death incidents were;** 23183 – VTE - Ward 2 23092 – VTE – Ward 12 23197/23279 – Patient fall – Ward 12 (patient died post discharge at another local provider trust)
ACTIONS FOR IMPROVEMENTS / LEARNING
The new Never Event framework becomes active 1st February 2018. The Serious Incident policy is to be amended to reflect these changes; ***Key Points of the new Never Event framework:*** Two new Never Events related to: • Unintentional connection of a patient requiring oxygen to an air flowmeter

- Unintended oesophageal intubation

Removal of financial sanctions from framework

Increased clarification of exclusions for existing categories

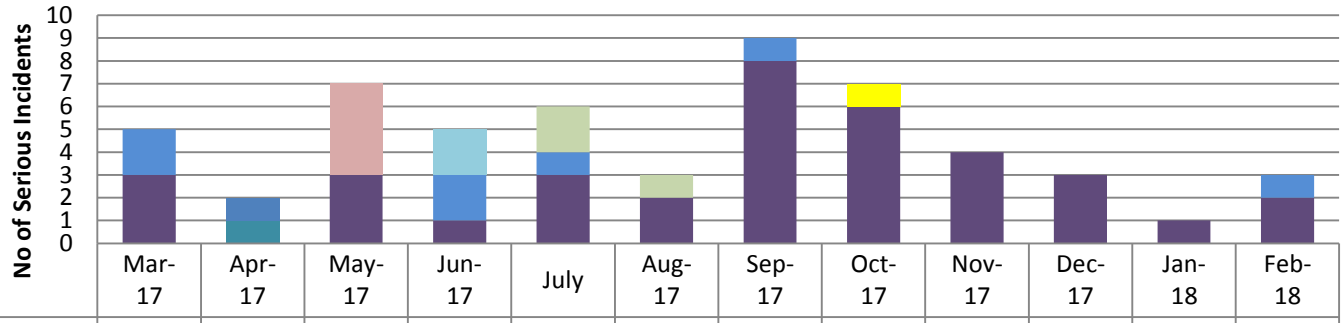
Increased focus on systematic learning

RISKS / ISSUES

An ongoing Ulysses improvement action plan is in progress. This was an agenda item in January 2018 at Quality and Safety.

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 February 2018



	Mar-17	Apr-17	May-17	Jun-17	July	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Unexpected Injury					2	1						
RTT Harm review			4									
Emergency transfer to HDU												
Exposure to hazardous substance												
Retained object								1				
Wrong Implant												
Suspension to services												
RTT Data Issue		1										
Wrong side injection				2								
Suspension of Service (BCH Spinal)		1										
Slips, trips & falls												
Pressure Ulcers	2			2	1		1					1
VTE meeting SI criteria	3		3	1	3	2	8	6	4	3	1	2

INFORMATION

There were 3 **Serious Incidents Declared in February 2018;**

23183 – VTE
23092 – VTE

The following incident was reported in last month's quality report and declared as a Serious incident in February 2018

22934 – Ward 3 - Grade 3 pressure ulcer

- There was evidence of poor documentation.
- Bank nurse did not give appropriate care on the Sunday/not escalating to Dr.
- Clarification required why a short epidural line was used.
- More TV training + education required, especially for bank nurses.

Duty of Candour and RCA are underway. This is likely to be avoidable.

ACTIONS FOR IMPROVEMENTS / LEARNING

1 avoidable VTE Serious incident was closed by the CCG in February 2018.

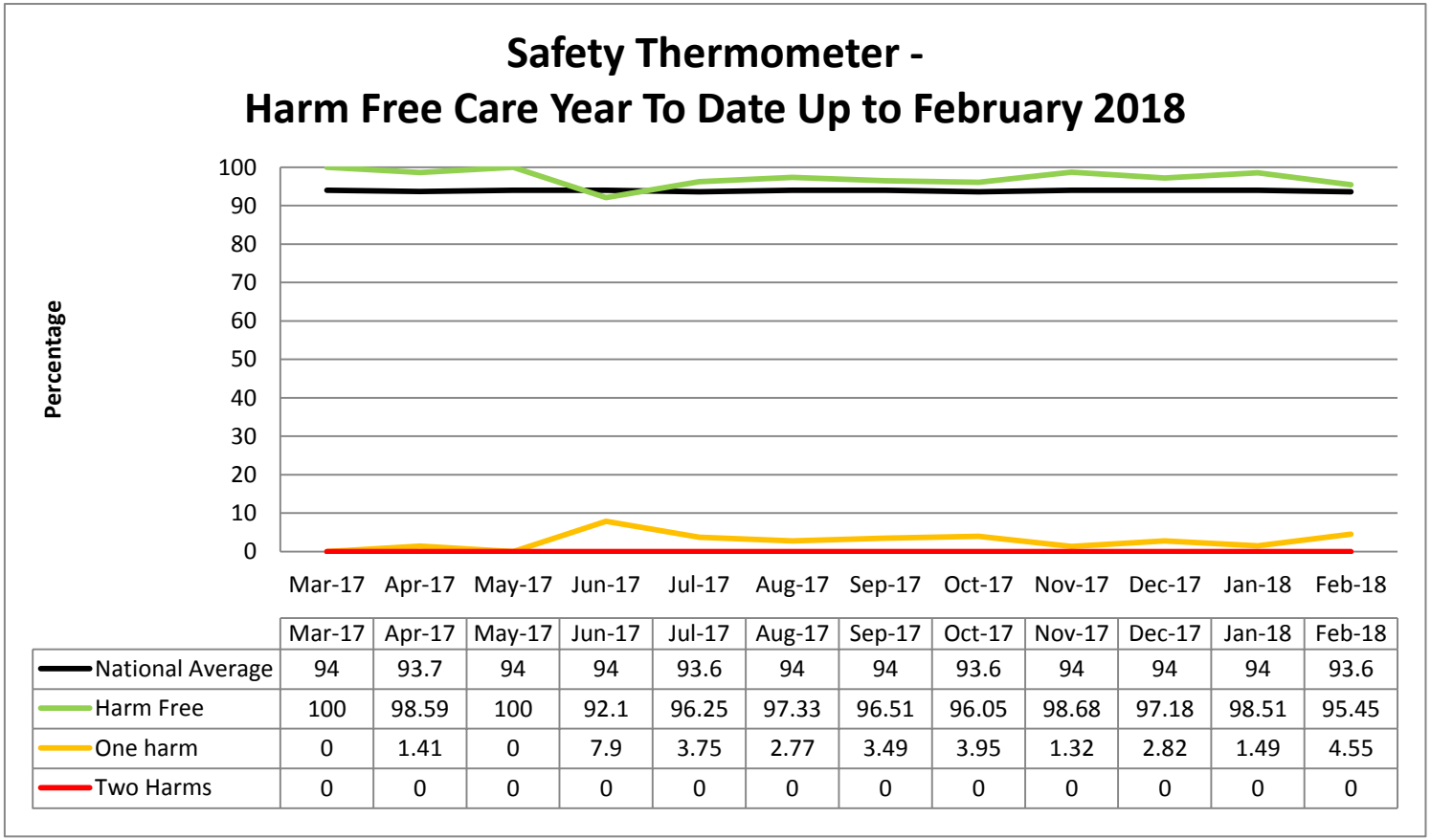
Outcome
Patient has risk factors associated with post operative DVT. Due to the fact the patient was fasted of fluid for over the recommended 2 hours and a dose of Clexane 40 mg crossed off & not given with no documented reason this has been deemed as potentially avoidable.

Recommendations
Accurate documentation of reasons for omitting Clexane by both medical & nursing staff
The morning theatre water audit needs to ensure patients are no starved of water for more than 2 hours

RISKS / ISSUES

None.

4. **NHS Safety Thermometer - provides a 'temperature check' on the 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.**



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
National Average	94	93.7	94	94	93.6	94	94	93.6	94	94	94	93.6
Harm Free	100	98.59	100	92.1	96.25	97.33	96.51	96.05	98.68	97.18	98.51	95.45
One harm	0	1.41	0	7.9	3.75	2.77	3.49	3.95	1.32	2.82	1.49	4.55
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

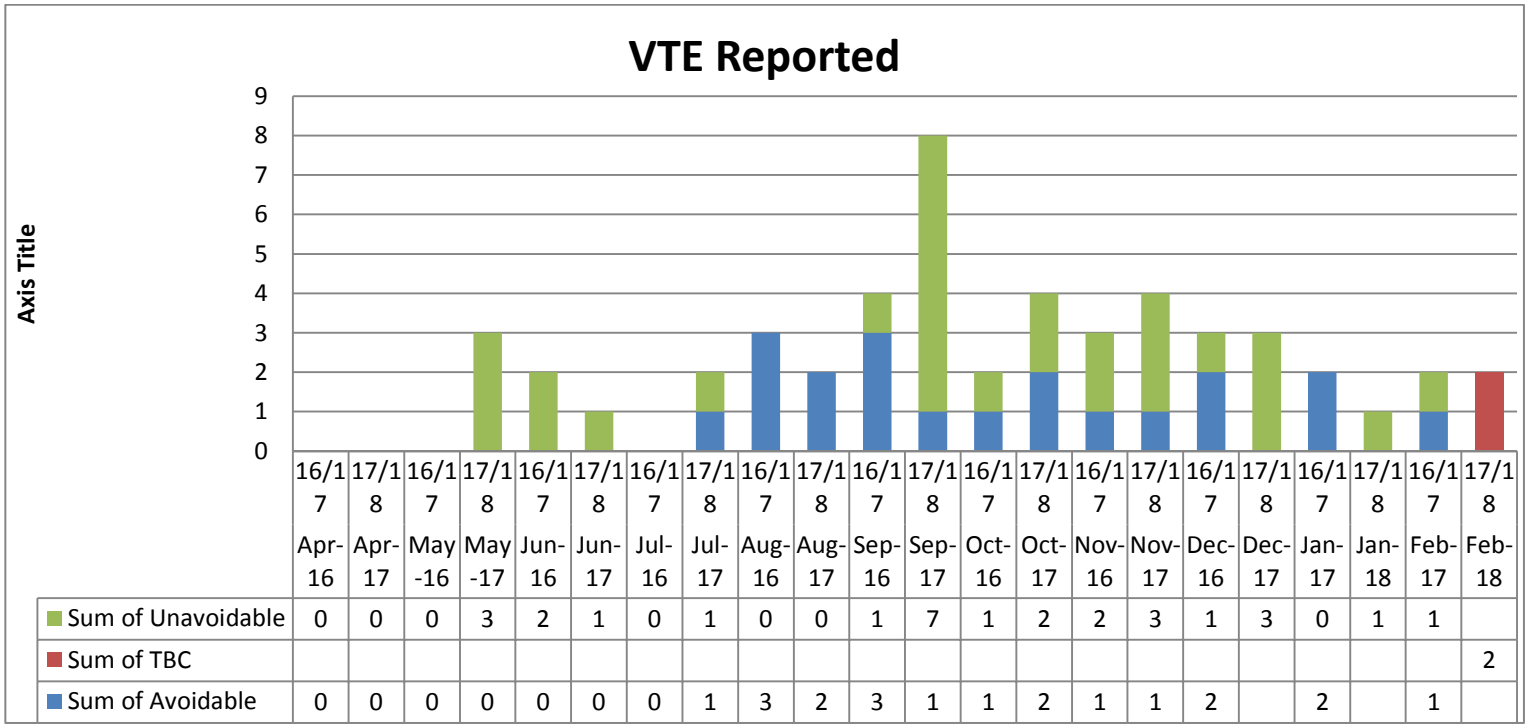
The harms were both recorded on Ward 3.
2 x old Pressure ulcer grade 2

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 February 2018 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- 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
Oct-17	67	9	0	1	77	232	9571
Nov-17	64	7	0	0	71	295	9752
Dec-17	60	3	0	0	63	194	7285
Jan-18	64	3	1	0	68	290	9705
Feb-18	77	3	0	1	81	307	8479

In February 2018, there were a total of 8479 patient contacts. There were 307 incidents reported which is 3.6 percent of the total patient contacts resulting in an incident. Of those 307 reported incidents, 81 incidents resulted in harm which is 0.95 percent of the total patient contact.

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 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 Apr-16	17/18 Apr-17	16/17 May-16	17/18 May-17	16/17 Jun-16	17/18 Jun-17	16/17 Jul-16	17/18 Jul-17	16/17 Aug-16	17/18 Aug-17	16/17 Sep-16	17/18 Sep-17	16/17 Oct-16	17/18 Oct-17	16/17 Nov-16	17/18 Nov-17	16/17 Dec-16	17/18 Dec-17	16/17 Jan-17	17/18 Jan-18	16/17 Feb-17	17/18 Feb-18
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0	1	7	1	2	2	3	1	3	0	1	1	
Sum of TBC																						2
Sum of Avoidable	0	0	0	0	0	0	0	1	3	2	3	1	1	2	1	1	2		2		1	

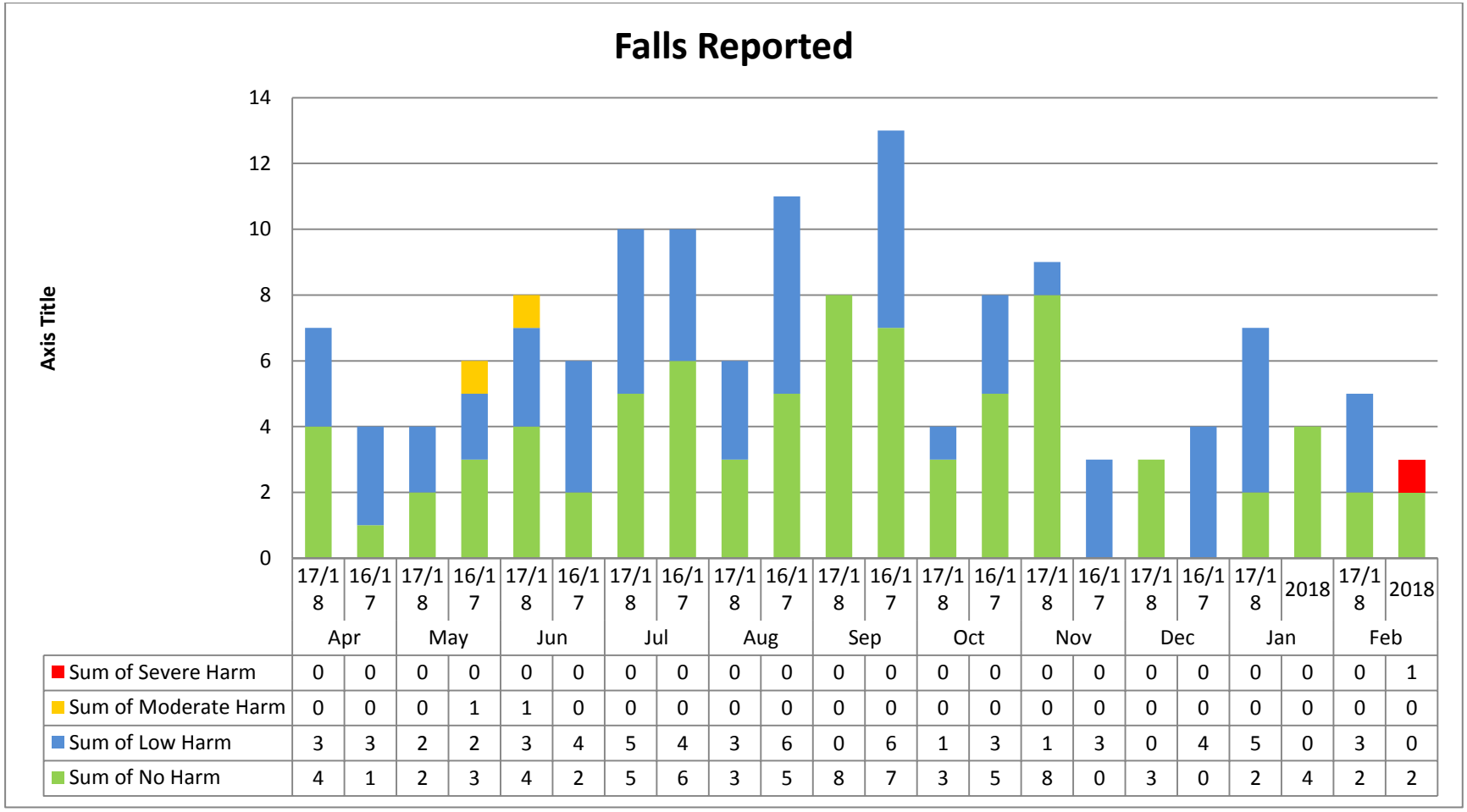
11

total		Avoidable
16/17	27	13
17/18	30	7*

***not classified**

INFORMATION
There were 2 VTEs declared in February 2018
ACTIONS FOR IMPROVEMENTS / LEARNING
It was agreed at the March 2018 Contracts meeting with the CCG that from the 1st April 2018 VTEs will no longer be declared as Serious Incidents unless they meet the criteria of the Serious Incident Framework. The Trust will continue to Perform Root Cause Analysis of all confirmed cases of pulmonary embolism and deep vein thrombosis acquired by service users and will continue to report the results of those Root Cause Analyses to the co-ordinating Commissioner on a monthly basis via the Trusts Quality report. The VTE Exemplar Site application visit will be taking place on the 23rd May 2018.
RISKS / ISSUES
Of 6 RCAs closed by commissioners, 4 were found to be unavoidable. Both of the 2 deemed avoidable were due to the 1st dose of post-operative enoxaparin not being prescribed as per Trust protocol, without rational for the decision being evident or documented. Learning has been shared with POAC prescribers via the POAC pharmacist and is being shared with anaesthetists via the Medical VTE Lead.

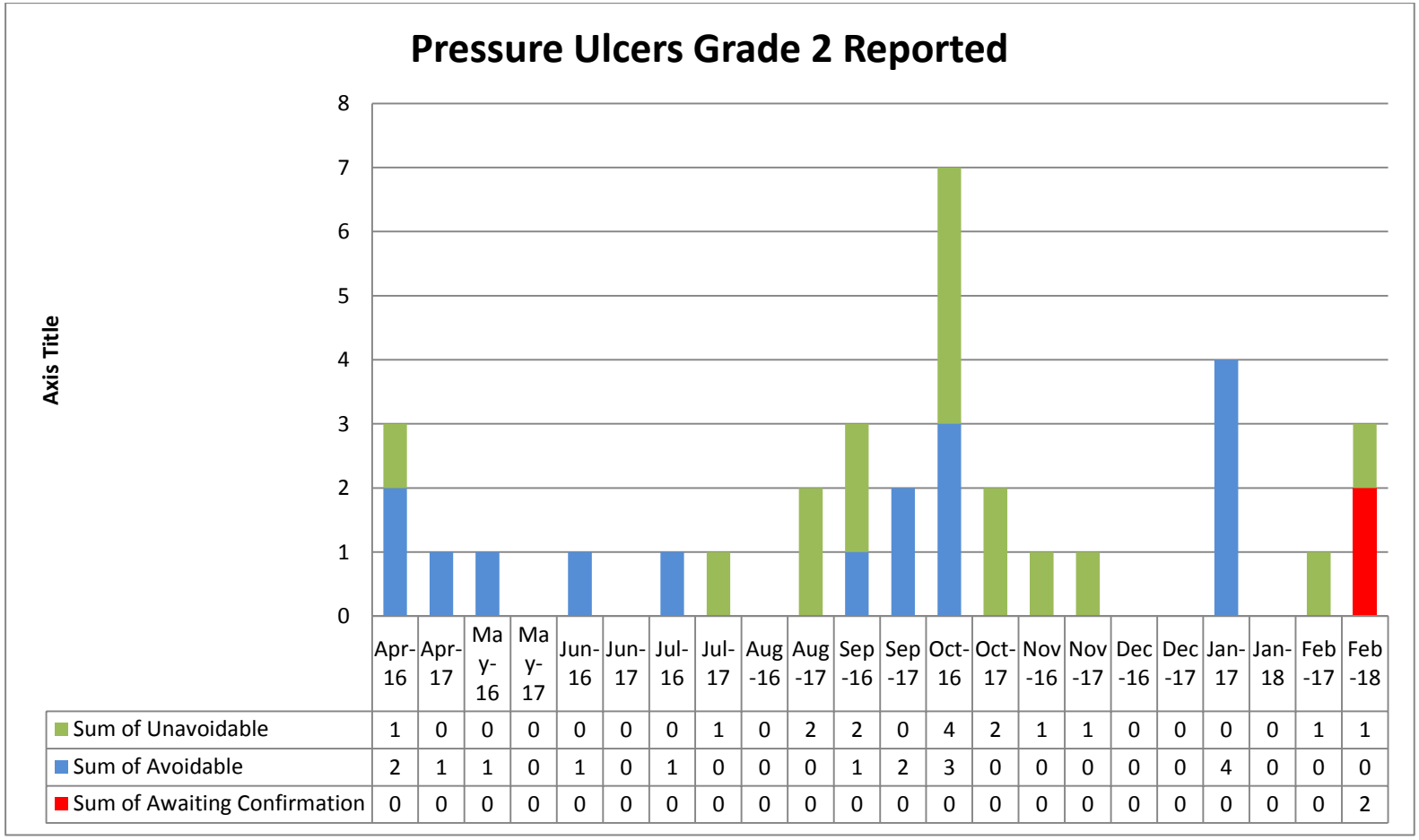
7. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.**



	17/18 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 Oct	16/17 Oct	17/18 Nov	16/17 Nov	17/18 Dec	16/17 Dec	17/18 Jan	2018 Jan	17/18 Feb	2018 Feb
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sum of Moderate Harm	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Low Harm	3	3	2	2	3	4	5	4	3	6	0	6	1	3	1	3	0	4	5	0	3	0
Sum of No Harm	4	1	2	3	4	2	5	6	3	5	8	7	3	5	8	0	3	0	2	4	2	2

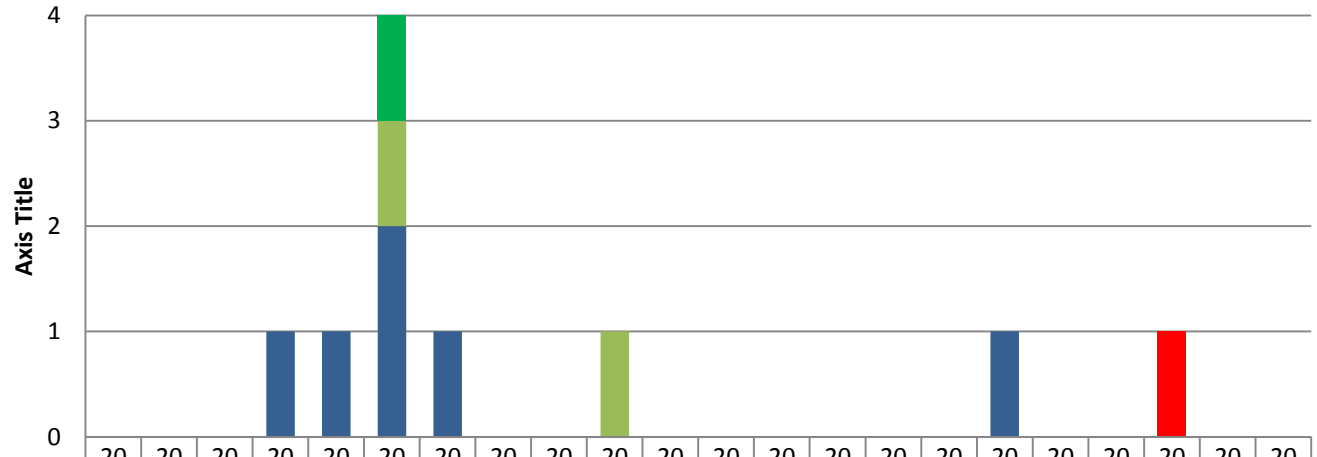
INFORMATION
Overall there were three fall-related incidents reported across the Trust in February 2018, all were related to adult inpatient falls. 1 x Ward 3 1 x Ward 12 - Patient fall – Ward 12 1 x OPD All incidents have been subject to a post-fall notes review by the ward manager or deputy, and a falls questionnaire was 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. An in-depth report on falls was presented to the Clinical Quality Group in January 2018.
ACTIONS FOR IMPROVEMENTS / LEARNING
• Falls policy is currently under review by the Falls lead; • The falls lead has set up a weekly task and finish group to bench mark our falls policy against the WMQRS falls and fragility fractures pathway. • Risk Register has been set up • There were issues with the practical aspect of manual handling training not being compulsory for all staff; this has been addressed with the training provider. Assurance has been given that this will be compulsory from now onwards and the falls group will be monitoring this.
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	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18
Sum of Unavoidable	1	0	0	0	0	0	0	1	0	2	2	0	4	2	1	1	0	0	0	0	1	1
Sum of Avoidable	2	1	1	0	1	0	1	0	0	0	1	2	3	0	0	0	0	0	4	0	0	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2

Grade 3 and 4 Pressure Ulcers Reported



	2016 Apr	2017 Apr	2016 May	2017 May	2016 Jun	2017 Jun	2016 Jul	2017 Jul	2016 Aug	2017 Aug	2016 Sep	2017 Sep	2016 Oct	2017 Oct	2016 Nov	2017 Nov	2016 Dec	2017 Dec	2017 Jan	2018 Jan	2017 Feb	2018 Feb
Sum of TBC																				1		
Sum of Unavoidable G4						1																
Sum of Unavoidable G3						1				1												
Sum of Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Grade 3 (Avoidable)	0	0	0	1	1	2	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0

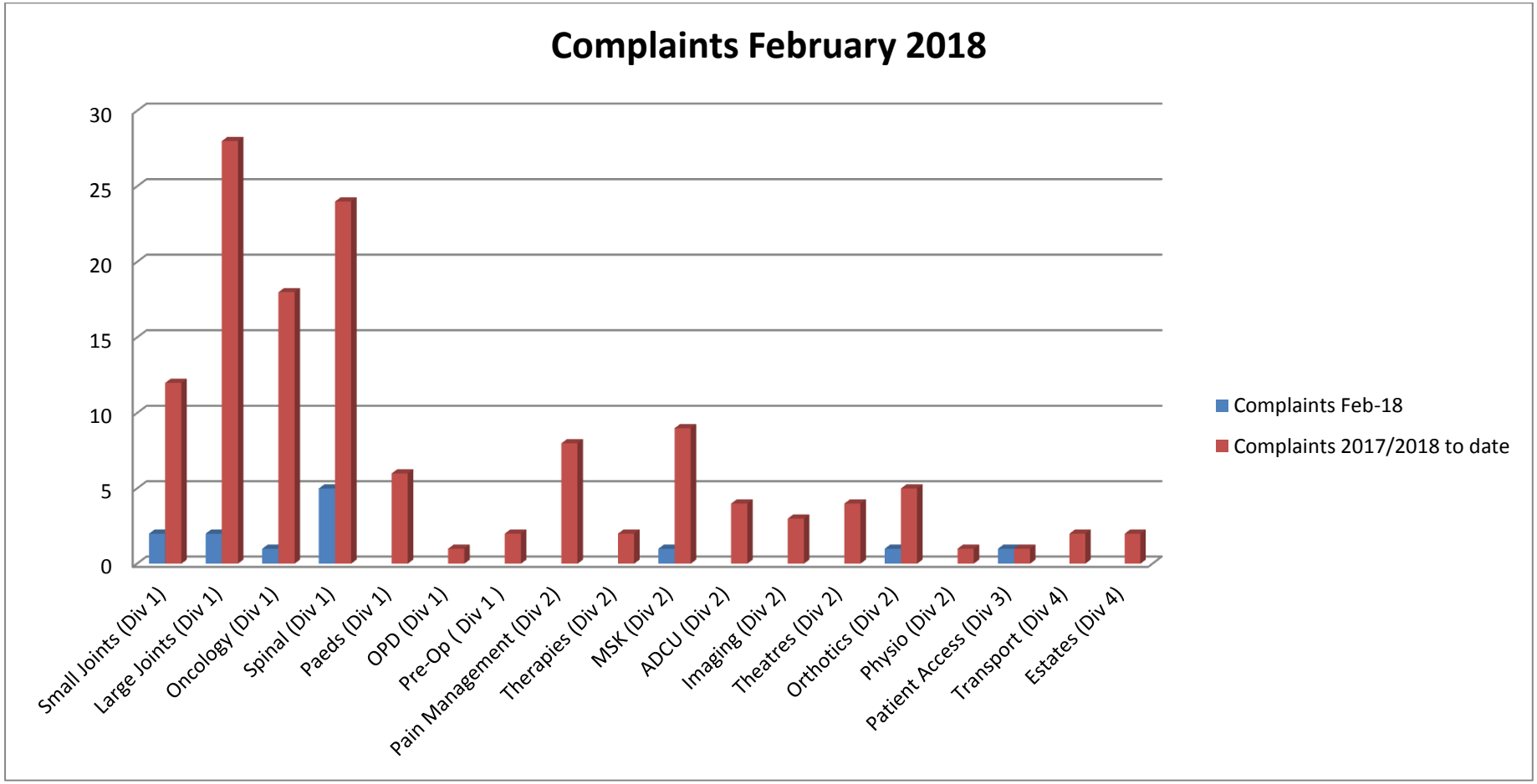
INFORMATION
3 x grade 2 pressure ulcers and 0 x grade 3/4 pressure ulcers were reported in February 2018. The grade 3 pressure ulcer reported in January 2018 is under investigation and likely to be avoidable. 23219 and 23247 (Duplicate incident) – Ward 12 - outcome unavoidable 23273 - Ward 3 - Awaiting confirmation 23345 - Ward 2 – Awaiting confirmation In total, from 1st April 2017 the Trust has reported the following avoidable pressure ulcers: • **2 avoidable Non Device Related Grade 2 Pressure Ulcers** • **1 avoidable Device Related Grade 2 Pressure Ulcers** • **2 avoidable Grade 3 Pressure Ulcers** (Incident reported in January 2018 (22987) is likely to be avoidable • **0 Avoidable Grade 4 Pressure Ulcers**
ACTIONS FOR IMPROVEMENTS / LEARNING
• TV Lead Nurse has relaunched the champion link group meetings and the first meeting and workshop in the Trust was held. Plans for this day included learning from previous PU and TV incidents, launch of new TV competencies for the link nurses, new documentation, React to Red Skin Strategy, Dressings update and the plan for the TV service and link nurses. The study day evaluated really well and there are several actions for all going forward. • One action; iF any patient going on a long ambulance journey can obtain a Kerrapro gel pad from the TV team to place under the patient's sacrum in order to reduce the risk of pressure damage. Gel pads for heels to be obtained. The TV Lead Nurse aims to work with the ambulance service to see what they can provide for patients at high risk of PUs or those with existing PU's • All ward managers have ensured that their staff have completed their TV competencies – majority are completed • New TV lead Nurse has updated the TV action plan for the reduction in hospital acquired pressure ulcer, which was one of the Trust quality priority targets for 17/18.

- Ward and departmental managers have been requested to provide timely update on reviewing of incidents and outcome questionnaires being completed.
- Theatre pre-operative checklist to have a section added about skin integrity being assessed i.e. dry and flaky skin, recommendation from Division 2 Head of Nursing, Trust ICP documentation is due to reviewed and updated this to be part of the changes being made.
- TV Lead Nurse to launch "React to Red" in the trust also is involved in the Documentation Task and Finish group to review the current TV documentation being used for all patients.

RISKS / ISSUES

- Tissue Viability Data base has not been maintained currently– all tissue viability information being recorded in patients notes and on a separate "spreadsheet" to aid reporting
- Training for Tissue Viability for the Trust is being reviewed to ensure best practice and this is a priority for Lead appointed and the new lead and TVN will undertake.
- Trust Tissue Viability Policy requires updating; this will be impacted by new classification status when agreed. Also awaiting consensus form the consensus groups tasked by NHSI – TV Lead Nurse is part of the collaborative task group looking at PU reporting.

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 337 contacts during February 2018 of which 54 were classified as concerns. This brings the total of PALS contact for the year to date to 4751 (1065 concerns). This represents a much higher figure than at the same point last year (3577 PALS contacts). The total number of enquiry contacts has reduced this month as some of the letters have been altered to remove the PALS number and replace this with the department concerned. It is anticipated that this will continue to reduce as the letters continue to be reviewed.

Compliments

There were 756 compliments recorded in February 2018, with the most being recorded for Div. 1. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues 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 13 formal complaints made in February 2018, bringing the total to 139 for the year. All risk was rated amber or yellow. This is comparable with the same time last year (13 complaints in February 2017)

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- incorrect treatment of scoliosis (Div.1, Spinal)
- wait to see Clinician; admin mix-up and delay to treatment as a result (Div.1, Large Joints)
- manufacture of orthotic boots (Div. 2, Orthotics)
- cancellation of surgery on day - due to conflicting medication information (Div.1, Spinal)

Initially Risk Rated Yellow:

- clinical opinion and treatment from 2 consultants (Div. 1, Large Joints)
- unhappy with RCA explanations - alleging 'downplayed' injury (Div.1, Onc)
- approach of clinician (Div. 2, MSK)
- Wait for first OPD appointment (Div. 1, Spinal)
- delays and communication of treatment (Div.1, Spinal)
- care and treatment; given decommissioned treatment (shock wave) (Div 1, Small Joints)
- came for appt- had been cancelled. Wants reimbursement (Div.3, Patient Access)
- management of back pain (Div.1, Spinal)
- treatment under foot & ankle team (Div.1, Small Joints)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 8 complaints closed in February 2018, 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 February 2018 was 27 days which is within normal limits.
Learning identified and actions taken as a result of complaints closed in February 2018 include:

- process of hand off for internal referrals not robust
  Action: system has been reviewed and electronic referral system in process of being implemented

- patient found approach of clinician unhelpful
  Action: Clinician has reflected on approach and made changes to practice

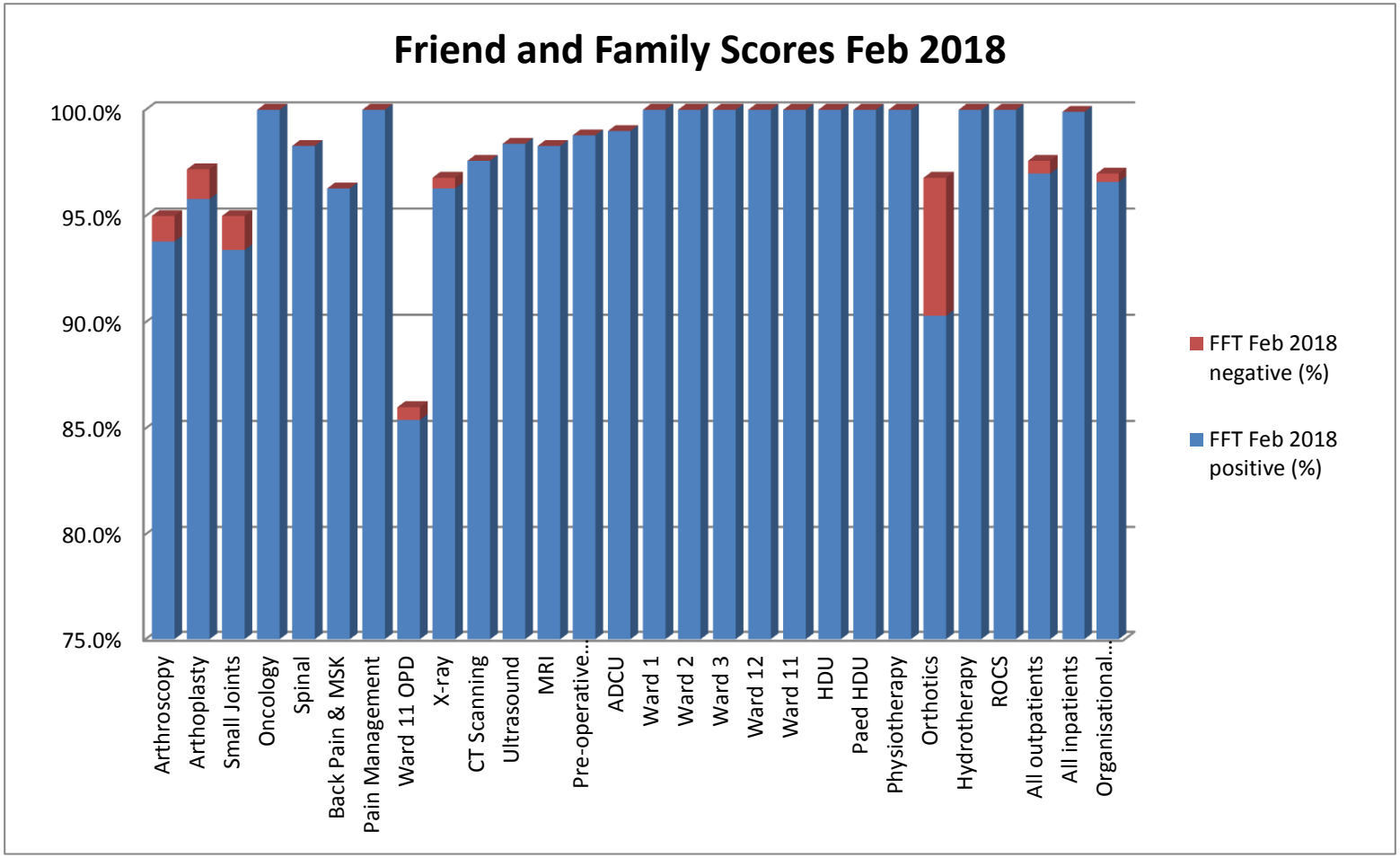
- method of informing patients of referral to local physiotherapy not clear
  Action: Information included in clinic letter

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 friend Colour coding: Outpatient Services Community Services Inpatient Services

Area	Number of reviews	Footfall	Completion rates	Positive Rating	Negative Rating
Arthroplasty	71	962	7.4% ↓	95.8%	1.4%
Arthroscopy	80	1001	8.0% ↓	93.8%	1.2%
Small Joints	61	1095	5.6% ↓	93.4%	1.6%
Oncology	3	516	0.6% ↓	100.0%	0.0%
Spinal	60	517	11.6% ↓	98.3%	0.0%
Back Pain & MSK	81	844	9.6% ↓	96.3%	1.0%
Pain Management	5	276	1.8% ↓	100%	0.0%
Ward 11 OPD	157	485	32.4% ↑	85.4%	0.6%
Pre-operative Assessment	260	536	48.5% ↓	98.8%	0.0%
ROCS	60	121	49.6% ↑	100.0%	0.0%
ADCU	202	611	33.1% ↑	99.%	0.0%
Ward 1	50	131	38.2% ↓	100.0%	0.0%
Ward 2	33	120	27.5% ↓	100.0%	0.0%
Ward 3	12	91	13.2% ↓	100%	0.0%
Ward 12	24	64	37.5% ↓	100.0%	0.0%
Ward 11	23	89	25.8% ↑	100.0%	0.0%
HDU	34	78	43.6% ↑	100.0%	0.0%
Paed HDU	3	10	30.0% ↑	100.0%	0.0%

All outpatients	1654		15.9%	97.0%	0.6%
All inpatients			31.00%	99.9%	0.0%

Organisational Score (External Reporting)

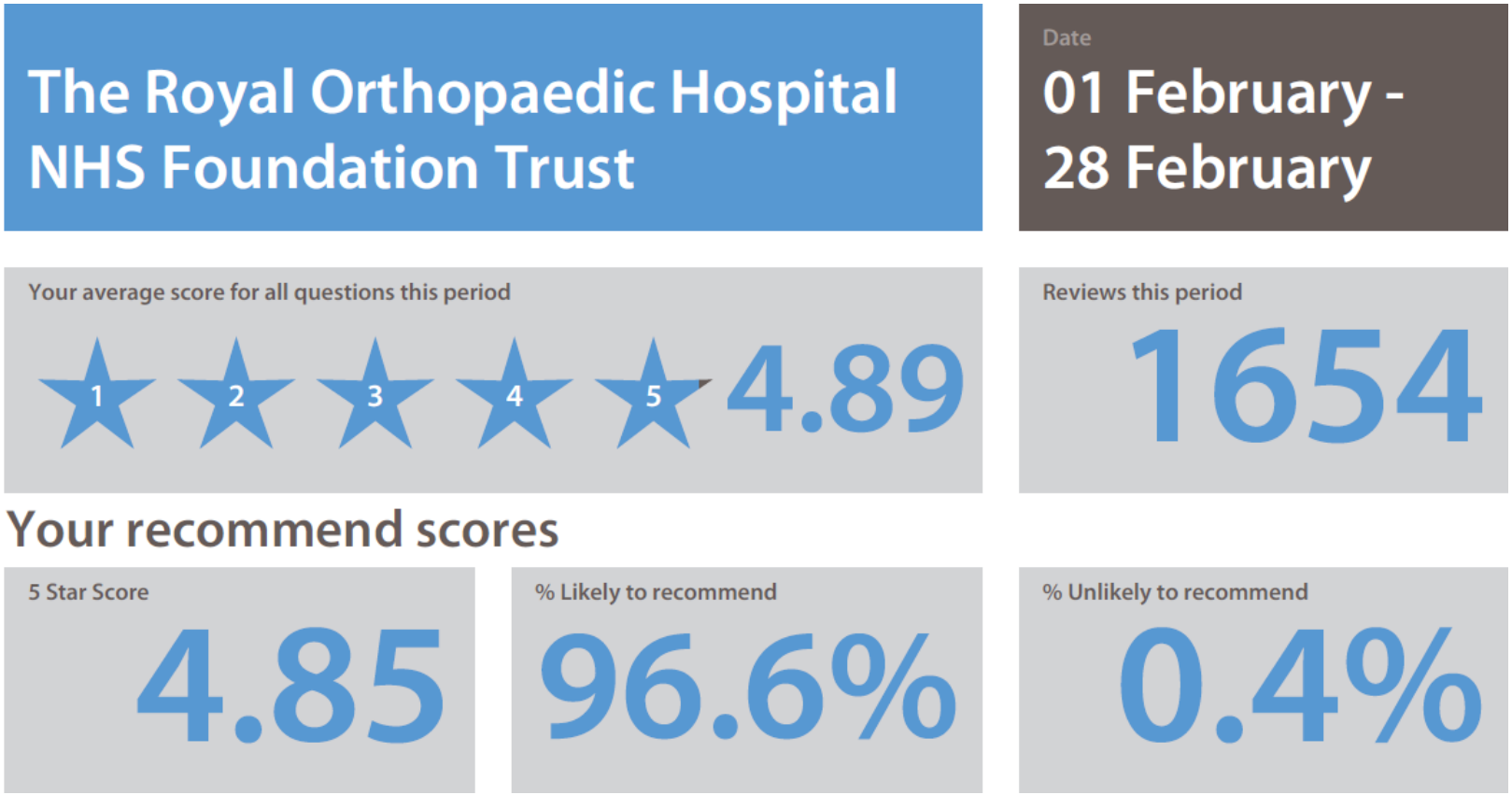
96.6% positive

0.4% negative

Internal targets Outpatient & Community Services: 20% Inpatient Services: 40%

INFORMATION
There were 1654 submissions of individual data for FFT in February 2018, representing a slight decrease from last month. Areas have been working with the Public and Patient Services Manager to ensure that the opportunity to provide feedback is available to all patients at every stage of their pathway. Outpatient data is now available by speciality for the first time to continue targeted work across all areas to ensure that comparable feedback is available for all departments. Ward 3 is receiving additional support to ensure that the system in place for collection is being followed. The Scores for Friends and Family are now calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as Detractors. The Trust is require to report the %Promoter and %Detractor scores for each inpatient and outpatient area nationally. The results remain consistently high for the Trust overall. The percentages are significantly affected by low response rates. Therefore in considering the Friends and Family Data, it is important to ensure the number of patients responding is known and every effort is made to increase the number of responses in each area.
ACTIONS FOR IMPROVEMENTS / LEARNING
Managers have been given individual area feedback with a reminder that FFT is a mandatory requirement and there needs to be an improvement in response rate
RISKS / ISSUES
Failure to meet external required target for inpatient FFT response rate of 35%. Staff have been informed of this

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 monitors and compares the 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 16 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

New Claims

No new claims against the Trust were received in February 2018.

On-going claims

There are currently 28 on-going claims against the Trust.

27 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*

6 new requests for Pre-Application Disclosure of medical records were received in February 2018.

**Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes, the Data Protection Act 1998 and the Access to Health Records Act 1990).*

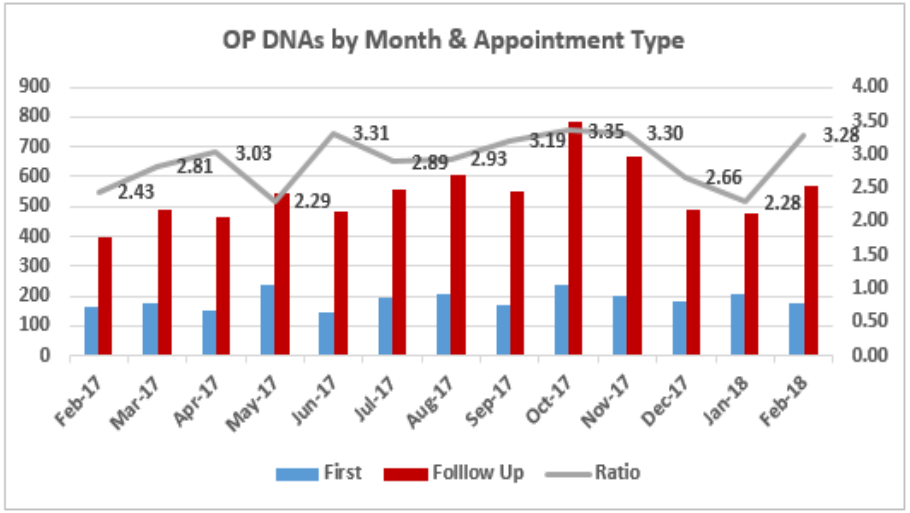
13. Coroner's

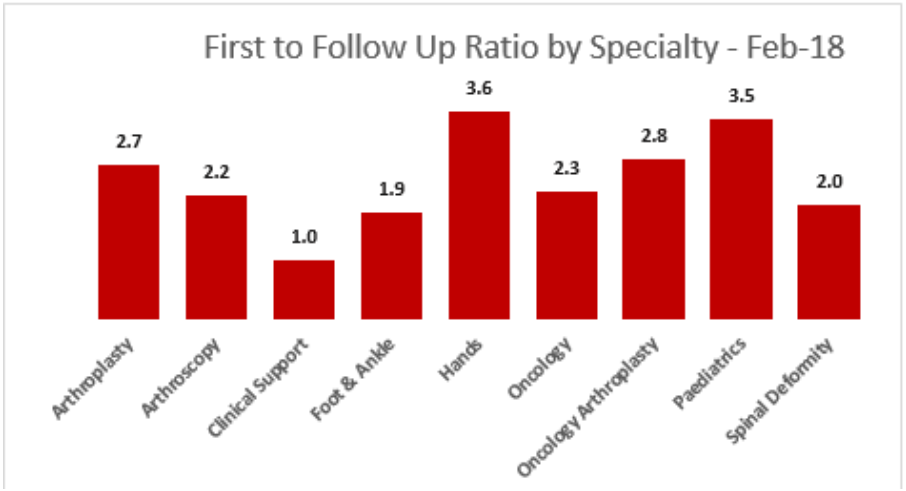
There were no coroner's inquests in February 2018.

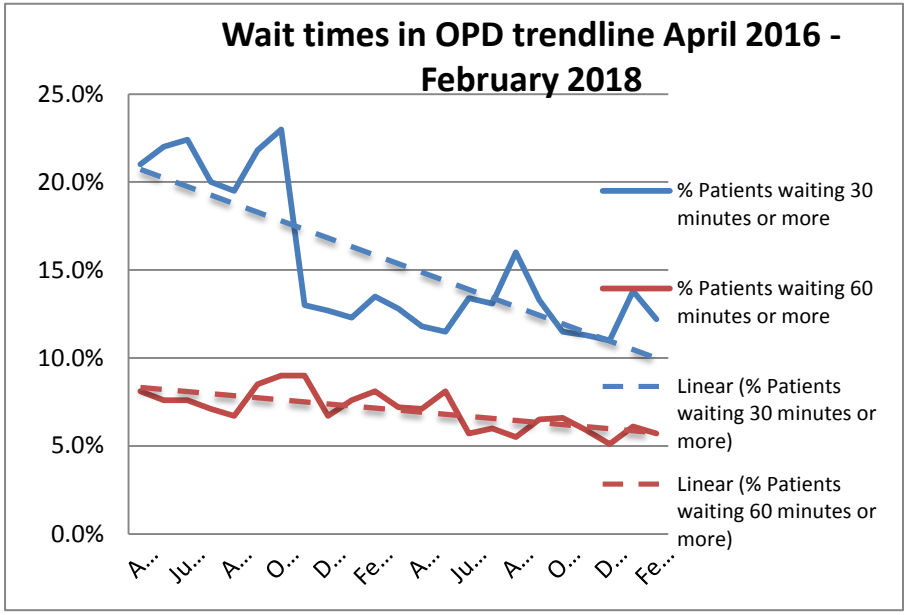
14. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.

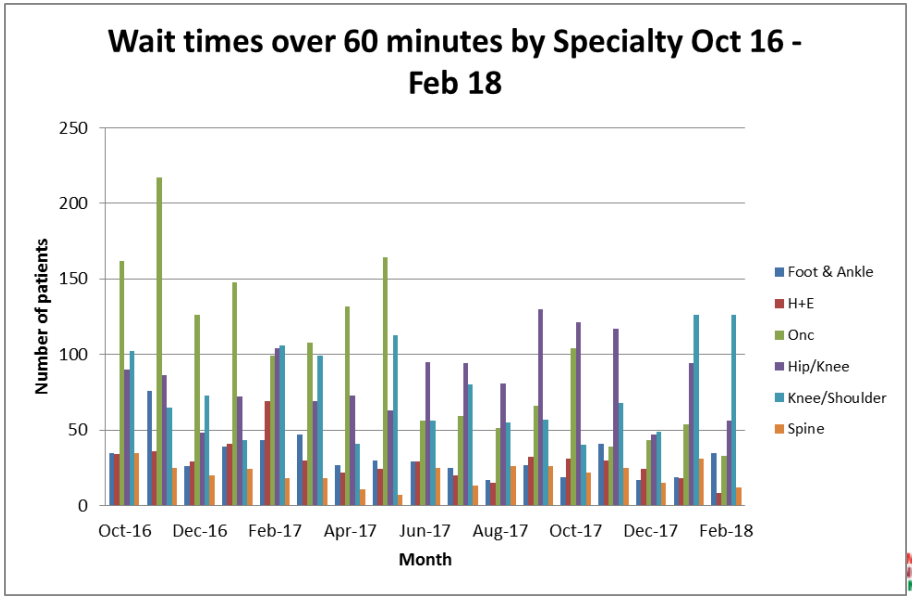
INFORMATION
The data is retrieved from the Theatre man program and the data collected is the non-completed patients. On review of the audit process, the listed patients will have their case notes retrieved and the WHO Safety Checklist is then examined for any omission incompletion. The following areas examined; • No form evident in notes • Sign in Section incomplete • Timeout section incomplete • Sign out section incomplete Total patients = 765 Incomplete patients – 4 Non compliant – 0 The total WHO compliance for February, 2018 was **100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
None

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





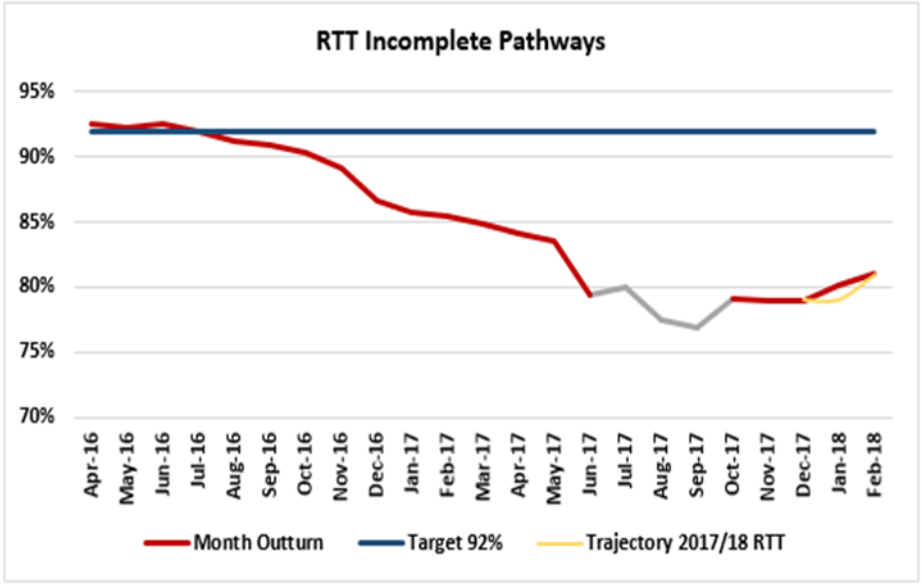


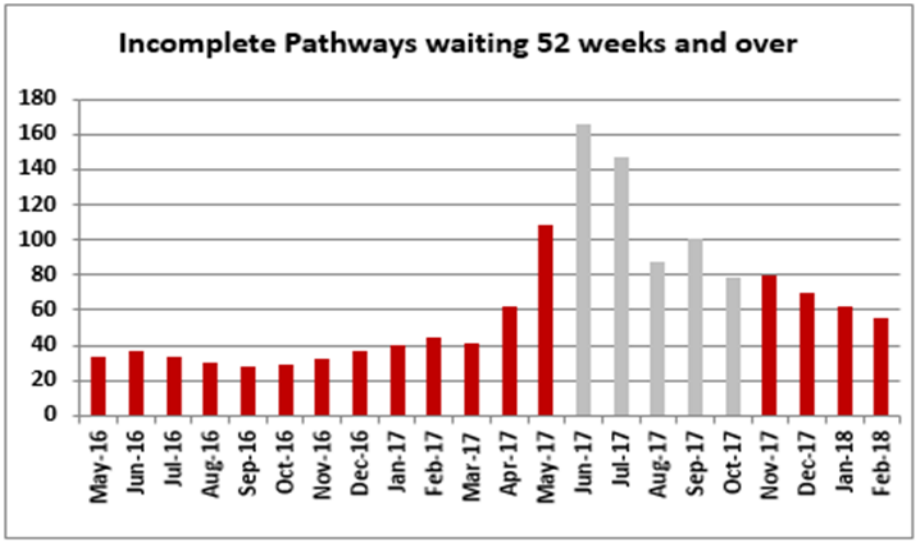


INFORMATION
The process for sharing learning in relation to clinic delays is being reviewed and future incident forms will be shared with the Clinical Service Managers along with the clinic delay data. Any issues that require operational management input will be discussed and changes implemented to avoid future recurrence of issues. The incident reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form. In February 2018 there were 23 incident forms completed to highlight clinics running more than 60 minutes. 20 in the Main OPD and 3 in Paediatric OPD. 12.2% of patients waiting over 30 minutes and 5.7% waiting over 1 hour. The monthly audit identified the following : - 7 x complex patients 4 x clinician delays 1 x X-ray delay 8 x overbooked clinic 3 x not specified
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions from February's Audit include; •Work underway with the Estates department to improve the environment on paediatric outpatients to ensure InTouch can be used effectively and in real time •The paediatric Oncology template has been reviewed and a new template will be implemented once Health Informatics team have confirmed the charging structure for these clinics is correct •An electronic clinic rescheduling form is being developed on TopDesk to help manage this workload and provide an audit trail for clinic changes •The SOP in relation to clinic cancellation and reductions will be re written and launched after the electronic clinic rescheduling form has been completed •Project to implement management of clinician annual leave through Allocate has started and being managed by Division 1 •An upgrade of the InTouch system is due to take place in the next few months which will provide improved functionality in the management of clinics and clinic utilisation

RISKS / ISSUES
Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure and need to update process

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

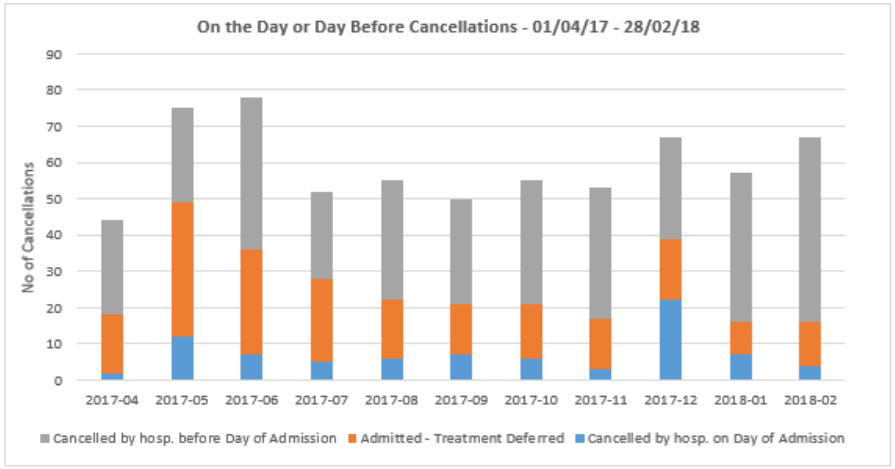




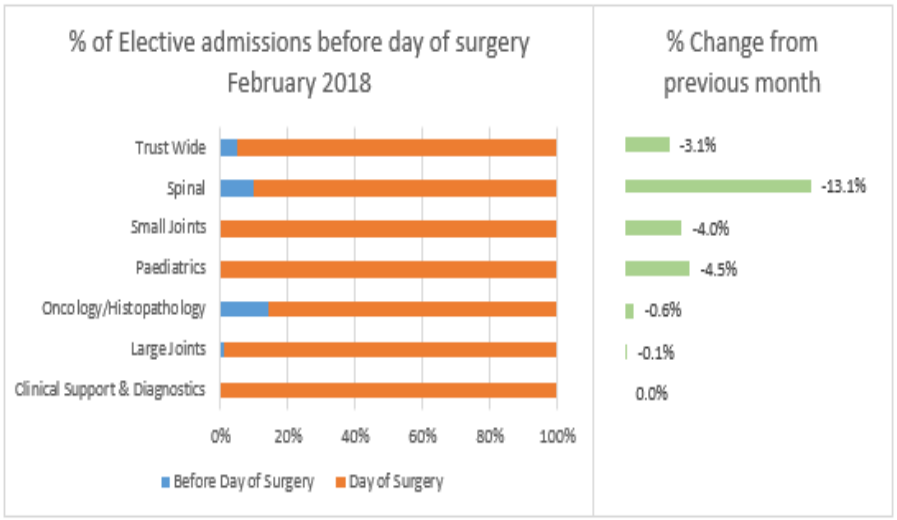
		Reported Month				Reported Quarter 2017/18								
Target Name	National Standard	Jan-18	Dec-17	Nov-17	Oct-17	Q3 (Oct, Nov, Dec)	Breach	Total	Q2 (July, August, Sept)	Breach	Total	Q1 (April, May, June 17)	Breach	Total
2ww	93%	97.10%	100%	100%	95%	98.30%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	91.67%	100%	91.70%	100%	96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	94.10%	100%	100%	100%	100.00%		30	97.40%	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		n/a
62 day (traditional)	85%	86.67%	83.30%	83.30%	100%	88.6%	1.5	7	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	100%	90.90%	90.90%	81%	82.10%	2.5	14	88.90%	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		n/a
No. day patients treated 104+ days		0	0	0	0									

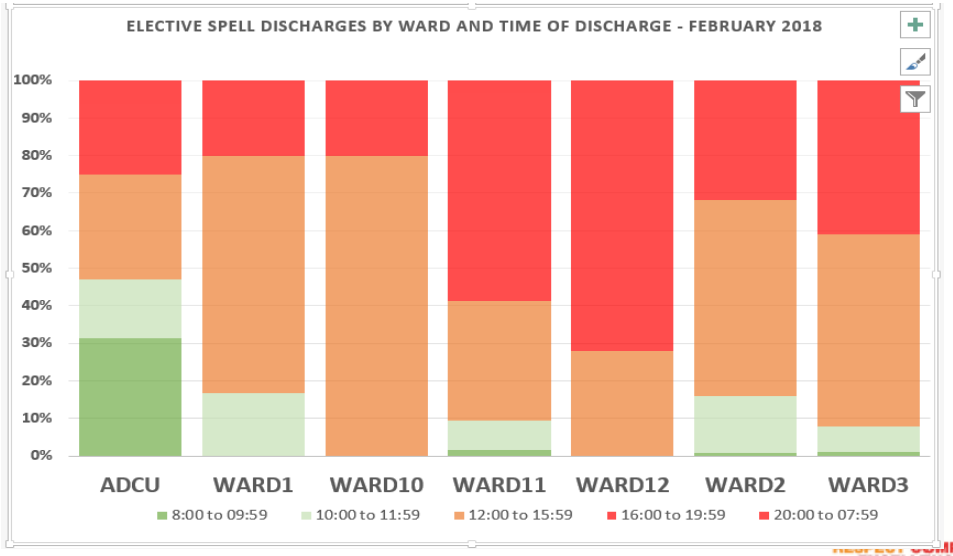
INFORMATION
The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the delivery of this target which is monitored weekly. For February 2018 the RTT trajectory was 81% with performance at **81.05%** , with 56 patients over 52weeks (54 spinal deformity) (62pts January 2018) The team have reviewed all spinal deformity patients and produce a trajectory for NHSI & NHSE submitted at the end of February 2018 for all patients at or likely to breach 52weeks.
ACTIONS FOR IMPROVEMENTS / LEARNING
The team continue to concentrate on any patients over 40 weeks, this number continues to reduce. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.
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 monitored monthly (detailed within the spinal deformity action plan) . This had shown an additional list from BWCH in February 2018 through the refurbishment of Waterfall House on site at BWCH. This has now been moved to September 2018. The date for the completion of this work will be confirmed at the end of March 2018 and the trajectory will be updated to reflect this. Weekend activity which had been planned up till April 2018 is now being planned through the Summer to assist with the existing waiting list.

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



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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	28	67	0
2018-01	7	9	41	57	1
2018-02	4	12	51	67	
Grand Total	81	202	370	653	10





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

INFORMATION
The number of cancellations on the day of surgery by the hospital continue to reduce. There has this month been an increase in the number of patients cancelled before the day of surgery, the two main factors were patients cancelling due to medical issues and patients given earlier date for procedure due to additional weekend capacity. A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Key themes identified enable pro-active interventions to resolve any future challenges. To further strengthen the POAC model a visit to SWLEOC (South West London Elective Orthopaedic Centre) took place on the 14th March to review their nurse led model , with a view to implement a best practice Pre – Operative Model. The team have also visited the team at Dudley and following both site visits they are now producing the future model for POAC, this model will be presented to the weekly operational group in April 2018.
ACTIONS FOR IMPROVEMENTS / LEARNING
A daily update review by operational management of forward bookings and the 6-4-2 and a daily 8.30am Operations huddle is now embedded in practice to maximise theatre utilisation. Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to monitor activity and patient flow. POAC improvement team finalising clinical model and resource requirements to deliver flexible pre- operative pathway to meet surgical demand.
RISKS / ISSUES
High levels of cancellations prior to day of surgery Ability to flex POAC capacity to meet demands of additional activity.

ROHTB (4/18) 004

TRUST BOARD

DOCUMENT TITLE:	**Quality Priorities 2018/19**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Patient Services**
AUTHOR:	**Garry Marsh, Executive Director of Patient Services**
DATE OF MEETING:	**4 April 2018**

EXECUTIVE SUMMARY:

The attached provides a summary of discussions at a recent meeting of the Clinical Quality Group around progress with the 2017/18 quality priorities and those for 2018/19.

REPORT RECOMMENDATION:

Trust Board is asked to:

- RECEIVE and NOTE the update on progress with the Quality Priorities for 2017/18
- APPROVED the proposed Quality Priorities for 2018/19

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X	X	

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

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical	X	Equality 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:

Clinical Quality Group on 9 March 2018
Council of Governors on 13 March 2018
Executive Team on 27 March 2018
Quality & Safety Committee on 28 March 2018
Patient & Carer's Forum on 29 March 2018

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY ACCOUNT 2018/19 – QUALITY PRIORITIES

Report to the Trust Board – 4 April 2018

The Quality Priorities from the Quality account were individually scrutinised in the Clinical Quality Group chaired by the Executive Director of Patients services on 9 March 2018.

The Clinical Quality Group took the decision based on evidence of delivery and ongoing scrutiny within a governance forum within the Trust to close the following priorities:

- Reduce the number of avoidable pressure ulcers;
- Learning from deaths – implement, embed a culture of learning from deaths;
- Reduction in PALS complaints by 20% by introducing 'time to talk' across all clinical areas.

The Clinical Quality Group took the decision to roll over the following priorities into the new Quality Account:

- Reduce the number of incidences of consent on day;
- Medical wards rounds to be supported by the wider MDT;
- Ensuring that learning identified from serious incidents and complaints are embedded in practice;
- Ensure that all clinical and corporate policies are in date and have an appropriate audit plan;
- Reduction in waiting times in OPD clinic;

It was also agreed to recommend to the Council of Governors at their meeting on 13 March that their sponsored indicator be rolled over to the forthcoming year, which they accepted:

- Reducing cancellations on the day of surgery

All of the priorities above demonstrated partial delivery, therefore they were rated as Amber.

The Clinical Quality Group rated no priority as Red for this year.

The Clinical Quality Group took a decision to only introduce one new Quality Priority to the Quality Account in the coming year to allow final closure of the rolled over priorities.

The new priority to be added is

- Reduced the number of times patients Outpatient Clinic appointments are rescheduled.

The Trust Board is asked to:

- NOTE this status update on progress with the 2017/18 Quality priorities
- APPROVE the proposed Quality Priorities as described for 2018/19

Garry Marsh
Executive Director of Patients Services
29th March 2018

SUMMARY OF QUALITY PRIORITIES 2017/18

Reduce the number of incidences of consent on day	To be carried forward to 2018/19 as a Quality Priority. Relevant staff have received consent training via eLearning which is now at 100%. There are a range of outstanding actions relating to an internal audit that has been undertaken that are overseen by the Audit Committee. Whilst there has been a reduction in the number of patients consented on the day further operational work is required to ensure full compliance.
Medical wards rounds to be supported by the wider MDT	To be carried forward to 2018/19 as a Quality Priority. Multidisciplinary ward rounds have been embedded within the High Dependency Unit. Multidisciplinary Ward round methodology continues to be developed with in patient wards.
Reduce the number of avoidable pressure ulcers	This priority has been achieved. There has been a reduction in avoidable pressure ulcers. An analysis will be undertaken to determine any themes in the reported avoidable pressure ulcers at the Trust and in association with the responsive action plan which has been developed. This analysis and action plan will be overseen by the Clinical Quality Group.
Learning from deaths – implement, embed a culture of learning from deaths	This priority has been achieved. The learning from deaths policy and processes have been implemented and embedded within in the Trust. Reports on deaths are overseen by the Quality & Safety Committee and Trust Board.
Ensuring that learning identified from serious incidents and complaints are embedded in practice	To be carried forward to 2018/19 as a Quality Priority. The Governance Structure and processes are strongly embedded within the Trust around Serious Incidents and complaints with evidence of learning from incidents within the investigation reports. The Trust has had a reduction in Serious Incidents and has met all of the Clinical Commissioning Group key performance indicators and the quality of

	investigations undertaken by the Trust has significantly improved. The quality priority will be changed to focus on the 'embedding' of learning and also address the staff survey results in relation to the poor quality feedback our staff receive feedback from the incidents they report.
Ensure that all clinical and corporate policies are in date and have an appropriate audit plan	To be carried forward to 2018/19 as a Quality Priority. There has been a significant reduction in policies that are beyond their review date within the Trust from 78 to 22 policies. Oversight of the policies is now delivered at Executive Team meeting and the Quality & Safety Committee. This priority will be carried forward with a focus on the embedding mechanisms for policies into the Trust and associated audit plans for policies.
Reduction in waiting times in OPD clinic	To be carried forward to 2018/19 as a Quality Priority. There has been a reduction in wait times in OPD. The targets of 10% for 30-minute waits and 5% for 60-minute waits have not been met. However there has been a downward trend in waiting times within clinics from April 2017 and any exception being clearly understood through robust incident reporting. Software is actively being utilised to deliver this standard using the InTouch system with an upgrade to the system planned which will allow greater oversight.
Reducing cancellations on the day of surgery (Governors Priority)	Recommendation to Governors to carry forward as a Quality for 2018/19. The causation for on the day cancellation has changed over the last year from equipment and theatre overrun in previous years as the main causation. The cause of cancellation is now unfit patients due to short term illness and patients failing to attend on the day of surgery. The key improvement work required is a consistent methodology of the 72 hour call to patients before their surgery with a stronger model of clinical oversight. It is clear there is stronger oversight and feedback of cancellations and the Chief Operating Officer is

	leading a service review of all pre-operative processes at the Trust.
Reduction in PALS complaints by 20% by introducing 'time to talk' across all clinical areas	This priority has been achieved. Work has been started on the patient's letters to remove the PALS as the primary contact point for patients. This will result in a reduction of PALS contacts. The Trust has seen a reduction in complaints over the last year with particular decrease in complaints associated with spinal and oncology patients which is associated with the Trusts improvement in Referral to Treatment times in both specialities and the associated administrative process improvements. The Trust has introduced supervisory time for the Ward & Department Managers which has allowed greater contact and time to talk with patients and their relatives which has enhanced the resolution of concerns in a more timely manner.

Finance and Performance Report

March 2018

CONTENTS

INTRODUCTION

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

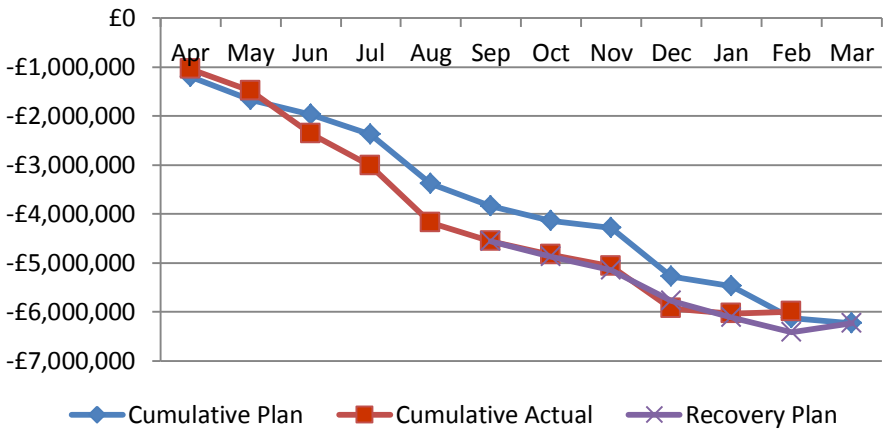
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M11 Original Plan £'000	YTD M11 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	67,890	67,881	(9)
Other Operating Income	4,328	4,292	(36)
Total Income	**72,218**	**72,173**	**(45)**
Employee Expenses (inc. Agency)	(44,453)	(45,461)	(1,008)
Other operating expenses	(32,572)	(31,452)	1,120
Operating deficit	**(4,807)**	**(4,741)**	**66**
Net Finance Costs	(1,319)	(1,251)	68
Net deficit	**(6,126)**	**(5,992)**	**134**
Remove donated asset I&E impact	50	56	6
Adjusted financial performance	**(6,076) (YTD Control Total)**	**(5,935)**	**140**

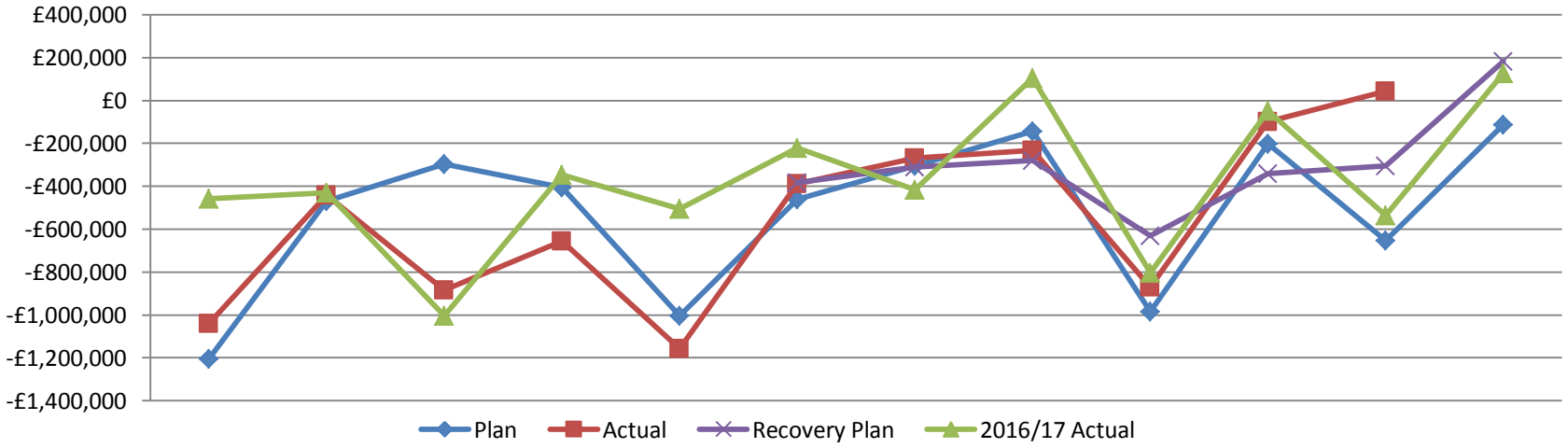
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

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	2
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a surplus of £44,000 in February against a planned deficit of £653,000, £697,000 ahead of plan. Whilst subject to a number of in-month adjustment, this is the first month in year where a surplus has been delivered. This brings the year to date position (on a control total basis) to £5,935,000 against a plan of £6,076,000, £140,000 ahead of plan.

The Trust continues to action areas of efficiency improvement and activity growth outlined within the 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. February marks the sixth month of the recovery plan, with an over performance of £349,000 against recovery plan of £305,000 deficit in month, and an over performance of 429,000 YTD.

There have been a number of unexpected influencing factors on the February position, including achievement of CQUINs which had previously been provided against, and a reversal of an element of non-clinical spend in light of the outcomes of the in-year stock count. These factors will be discussed further in the relevant sections, but without these the position would be much closer to plan. Other drivers for the year to date financial performance have included spend on improving RTT reporting (just over £610,000 year to date) and 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 time of the MRI for a period of nearly 2 weeks). 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.

As at the end of February, the Trust has recognised £2,327,000 of CIP savings, against an original plan of £2,919,000. £1,921,000 (83%) of savings to date are recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,698,000 against an original plan of £3,191,000. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

With regards to the Trust's Use of Resources Risk Rating (UOR), the overall position has remained at level 3, although there has been an improvement in the I&E variance from plan element (from a 2 to a 1). The other elements of the Use of Resources elements remain the same; the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover and I&E Margin. The Trust's requirement for cash support has resulted in a 4 for liquidity. Year to date agency spend is higher than agency cap, resulting in an agency rating of 2.

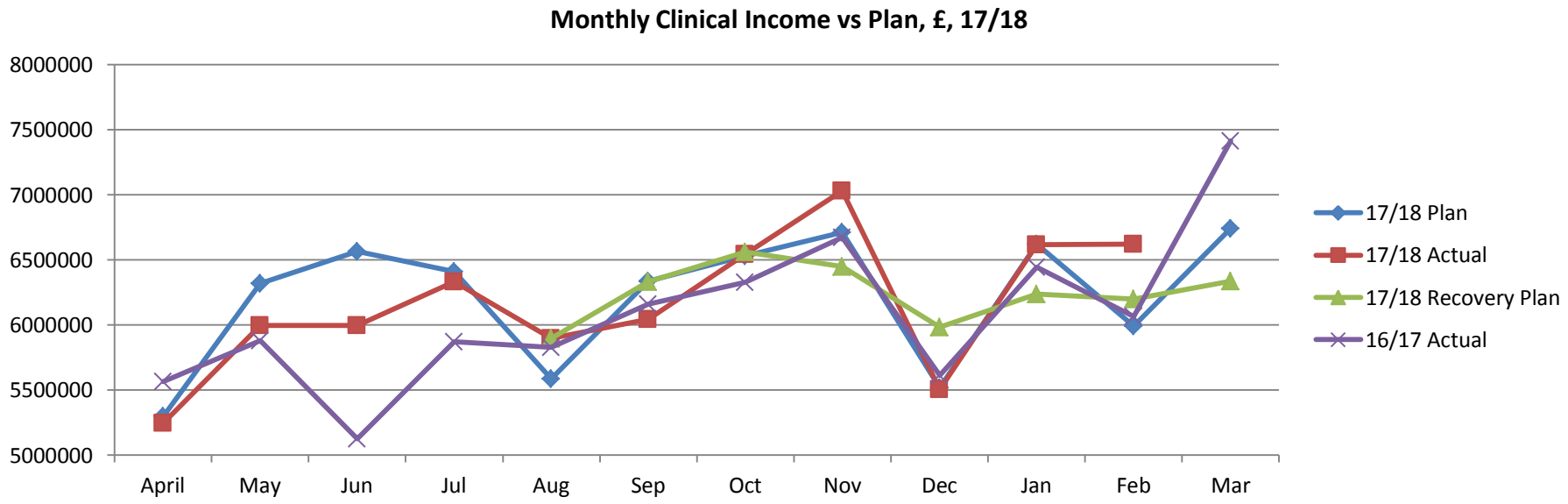
ACTIONS FOR IMPROVEMENTS / LEARNING

A draft of the annual plan has been submitted to NHS Improvement, with further work ongoing to ensure there are sufficiently robust plans in place to deliver the trust's control total. This includes defining activity plans and the resultant job plans required, reviewing and minimising cost pressures and ensuring cost improvement plans are sufficiently robust and quality impact assessed.

RISKS / ISSUES

The Trust needs to continue to deliver consistent activity and deliver the expected stock count position to deliver its Control Total. Achievement of performance above the control total will result in a pound-for-pound investment from NHS Improvement in addition to an adjustment to Control Total for 2018-19 and an increased Provider Sustainability Fund.

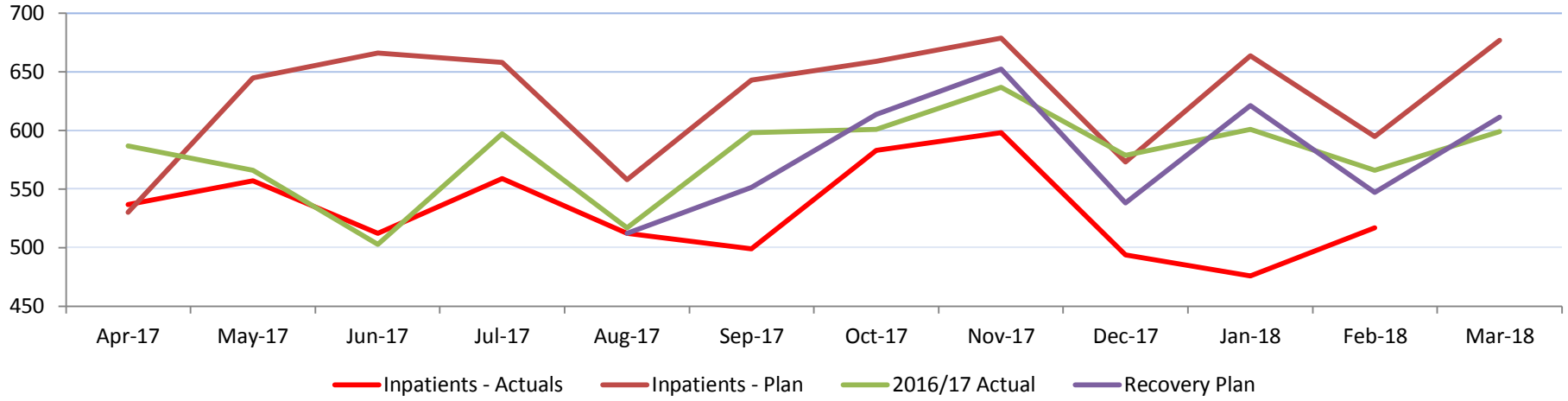
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



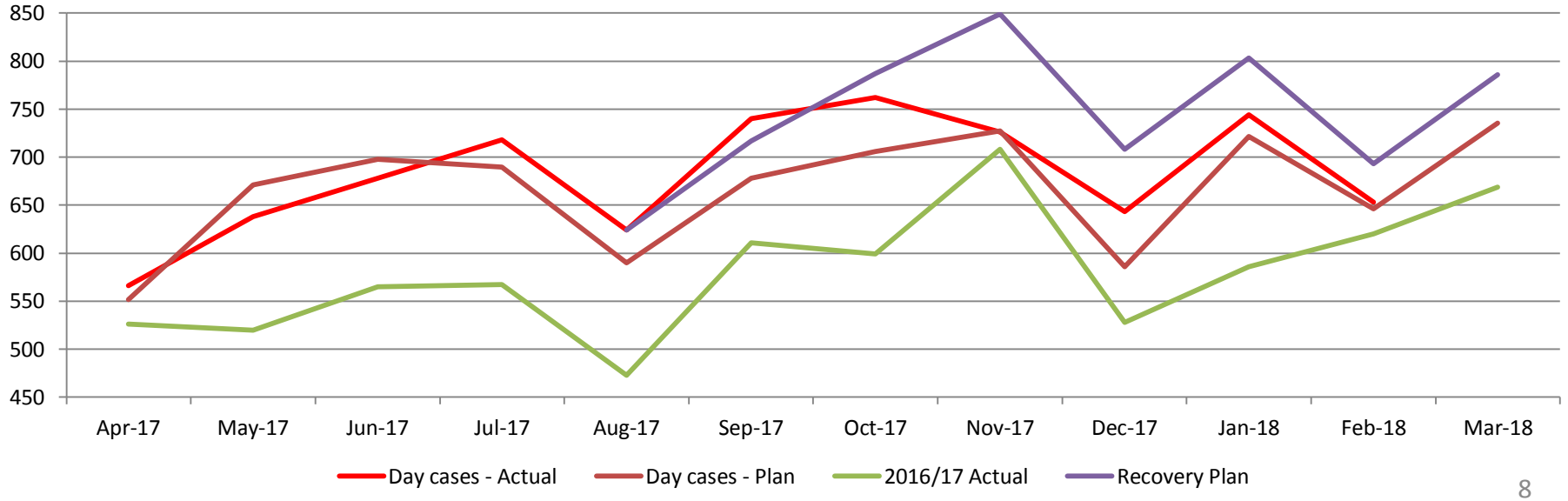
Clinical Income – February 2018 £'000			
	Plan	Actual	Variance
Inpatients	3,029	3,249	220
Excess Bed Days	94	53	-41
Total Inpatients	3,123	3,302	179
Day Cases	732	778	46
Outpatients	585	616	31
Critical Care	235	225	-10
Therapies	233	230	-3
Pass-through income	209	21	-188
Other variable income	355	930	575
Block income	518	518	0
TOTAL	5,990	6,620	630

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	34,410	34,308	-102
Excess Bed Days	1,069	543	-526
Total Inpatients	35,479	34,851	-628
Day Cases	8321	8573	252
Outpatients	6650	6773	123
Critical Care	2666	2307	-359
Therapies	2650	2425	-225
Pass-through income	2379	2802	423
Other variable income	4049	4403	354
Block income	5698	5698	0
TOTAL	67,892	67,832	-60

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income was significantly ahead of February's plan, with the trust now £60,000 behind plan year to date. Other variable income has increased in month largely due to clarification of the likely CQUIN position, particularly with regards to likely achievement of the NHS England CQUINs. This has allowed released of a provision against them. In addition, an agreement was reached on the 2016/17 income position with a commissioner, which resulted in an increased in elective income (apportioned over the relevant POD). Excluding these adjustments, the income position would have been in line with the expected position.

	Elective/Non-Elective	Day Case
Actual Activity	517	653
Original Plan	595	646
Variance	(78)	7

	Elective/Non-Elective	Day Case
Actual Activity	517	653
Recovery Plan	547	693
Variance	(40)	(40)

Inpatient activity and day case activity were below recovery plan in February, although elective activity improved on the January position which is surprising given the shorter number of working days. The average tariff price for the period has decreased slightly in elective and in day cases. Case-mix in February has reverted back to the year yearly average after a sharp rise towards day cases in January as a result of RTT clearance activities. Elective makes up 42% of the trust's income in month and also year to date.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust is working operationally and financially to determine what demand and capacity there is internally and how this will affect activity plans, job plans and therefore income for the coming year as part of business planning as previously discussed. This work is ongoing to enhance the final annual plan submission in comparison to draft.

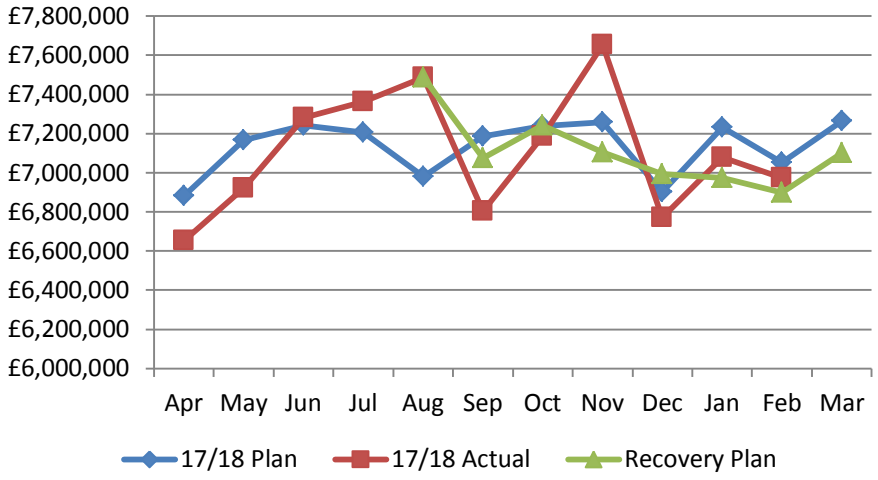
Further work still needs to be performed to ensure that clinicians are recording the appropriate co-morbidities of the patient's they treat, resulting in the trust being funded for the work actually performed.

RISKS / ISSUES

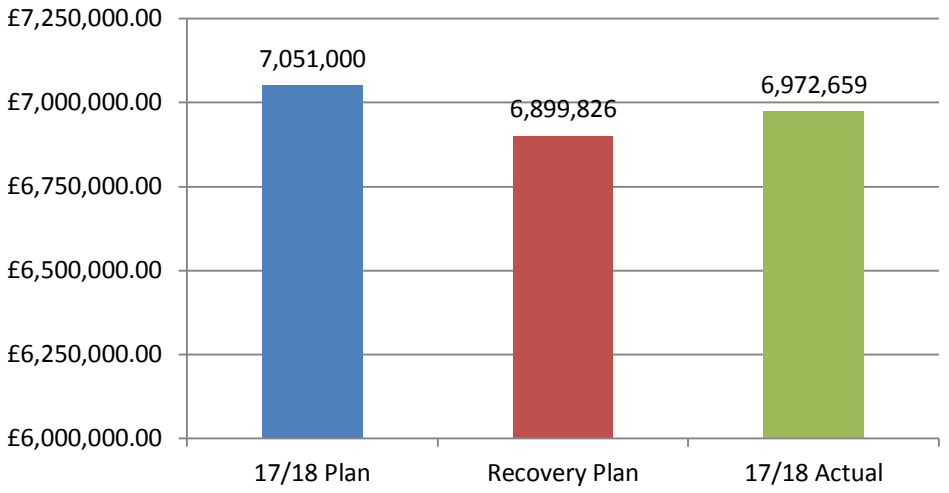
There is a particular focus needed on achieving activity plans over the last month of the year, with March expected to be a high income month due to the number of working days. Achievement of the activity targets poses a risk for the Trust.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

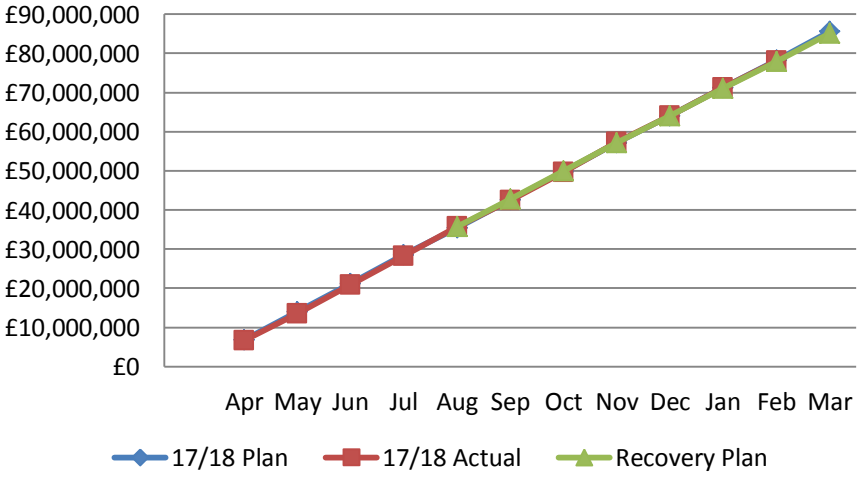
17/18 Monthly Expenditure vs Plan



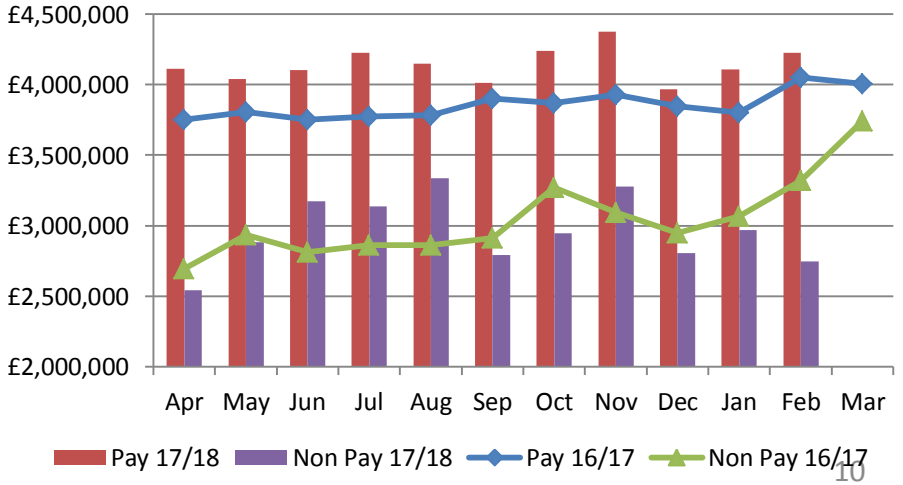
17/18 M11 Expenditure vs Plan



Cumulative Expenditure vs Plan 17/18



16/17 vs 17/18 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £6,973,000, which is £78,000 lower than the in month plan of £7,051,000, but £73,000 higher than the recovery plan of £6,900,000.

Pay spend was c.200,000 above plan, driven by increased use of bank and agency staff. Agency staff will be discussed in the next page, but bank staff has increased through higher nursing and ADH spend in month.

Non-pay spend was c.£300k behind plan. This was driven largely by control of underlying spend, with a backdated adjustment to take into account some of the over-recognition of clinical spend in relation to stock that was identified by the in-year stock count. It was considered prudent to wait until the final stock count before making a final stock adjustment at the year end.

ACTIONS FOR IMPROVEMENTS / LEARNING

Costs will continue to be scrutinised and minimised.

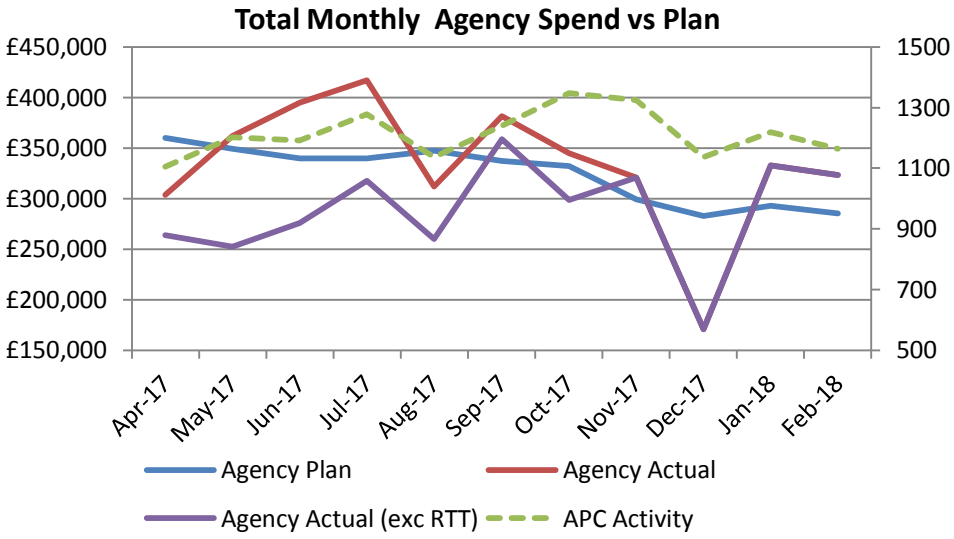
The output from the Theatres stock is now being reviewed by theatres in an effort to understand where there are areas where stock levels can be reduced. Setting correct stock levels will in turn assist with forecasting spend and setting a more reflective financial plan. Plans are underway for the year end count, but also there are frequent meetings to determine what the key areas for improvements in stock management and recording are, and how best to achieve those improvements.

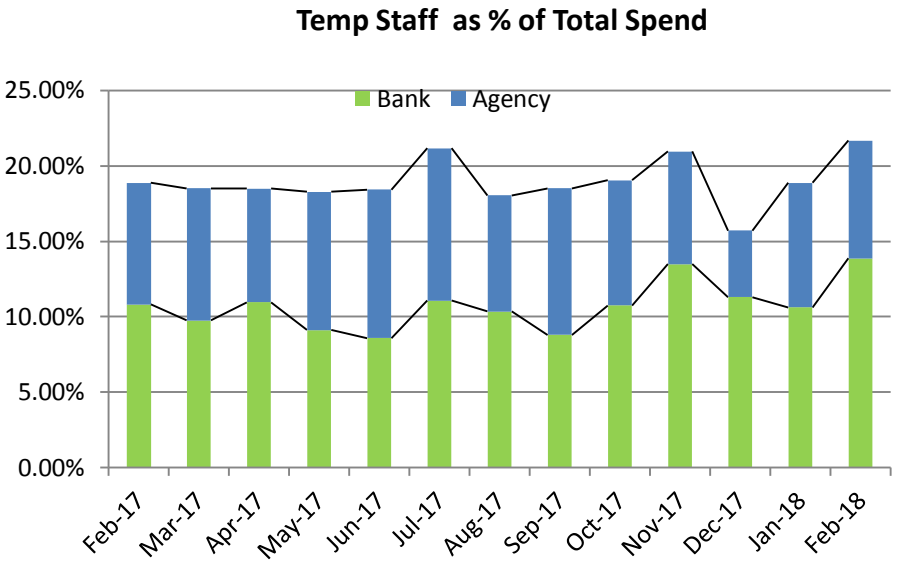
A full list of cost pressures for the 2018/19 financial year has now been reviewed by the Interim Chief Operating Officer and Interim Director of Finance, and built accordingly into business planning and the budget setting exercises.

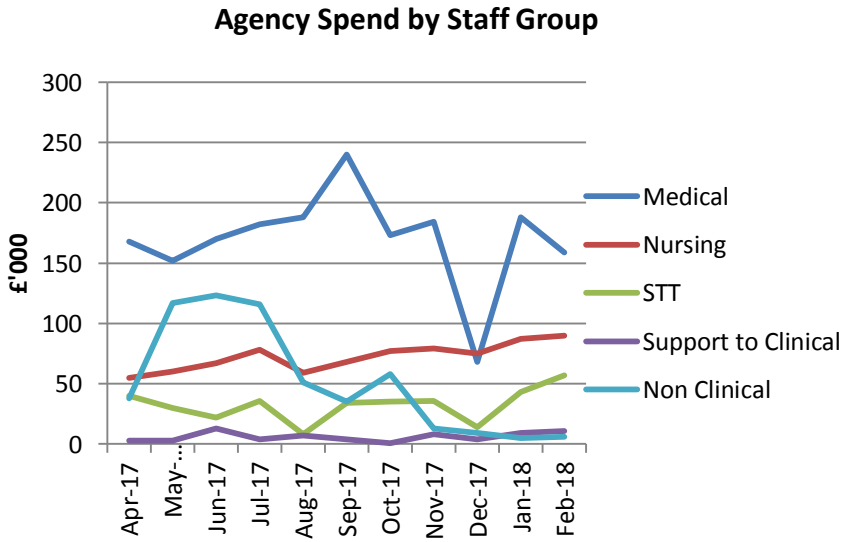
RISKS / ISSUES

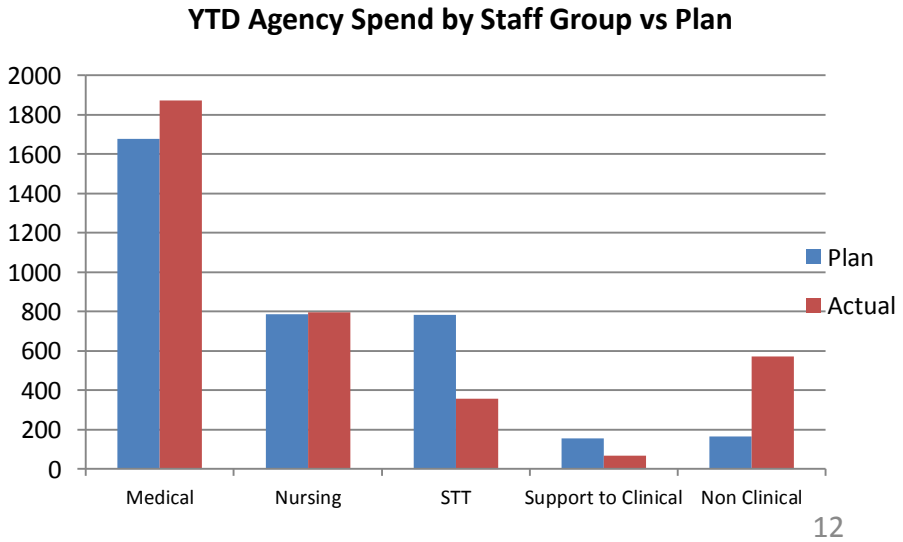
Gaining a greater understanding and control of theatre spend is essential to the recovery of the financial position, and will be mitigated via various theatre improvement workshops ongoing.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

Agency spend has seen a slight reduction in February as would be expected for a shorter month. The in-month spend was however slightly above plan (by £37,000). This is being driven by a decreased spend on medics, being offset by an increase in physiotherapy and nursing staff usage. Therapy agency is largely due to vacant posts and agency is being used to help address the current waiting list. Nursing agency spend is within the theatre environment as a result of vacancies.

Presently year to date agency spend remains above cap. Whilst it is now expected that the Trust will overspend on the cap slightly, this is being closely monitored and scrutinised to reduce it below cap if at all possible. 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

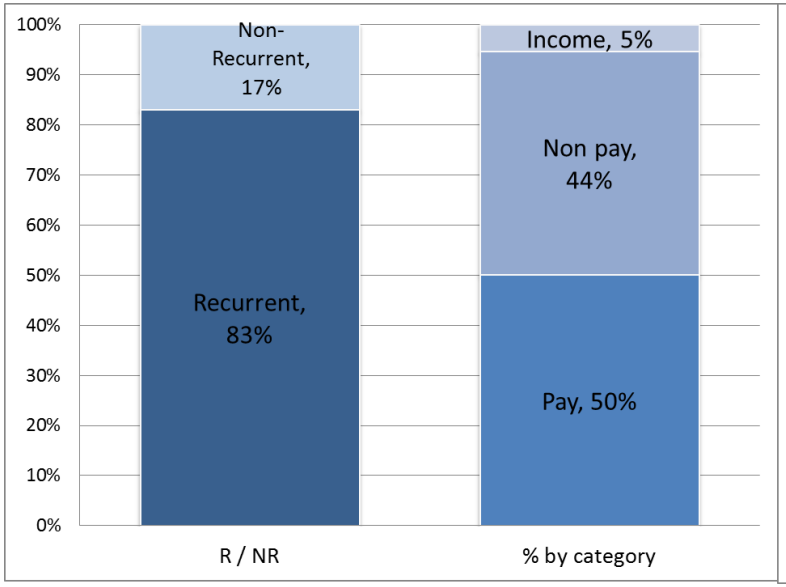
The trust needs to continue ensuring that it is monitoring Health Roster to ensure agency spend on nursing is kept at a minimum.

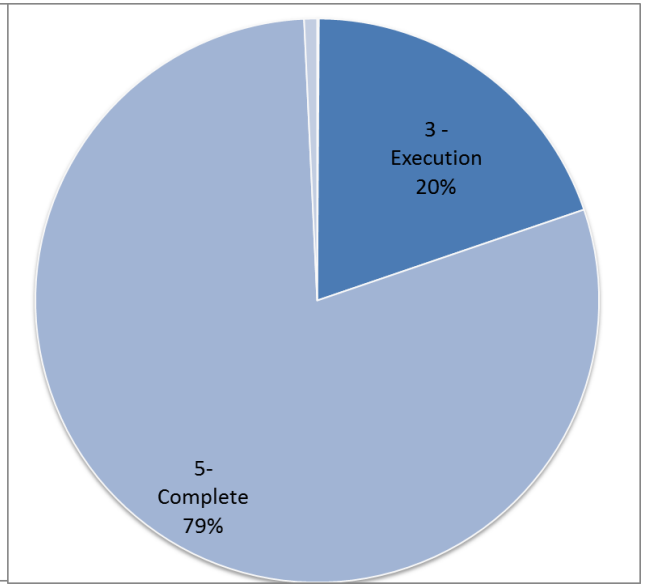
RISKS / ISSUES

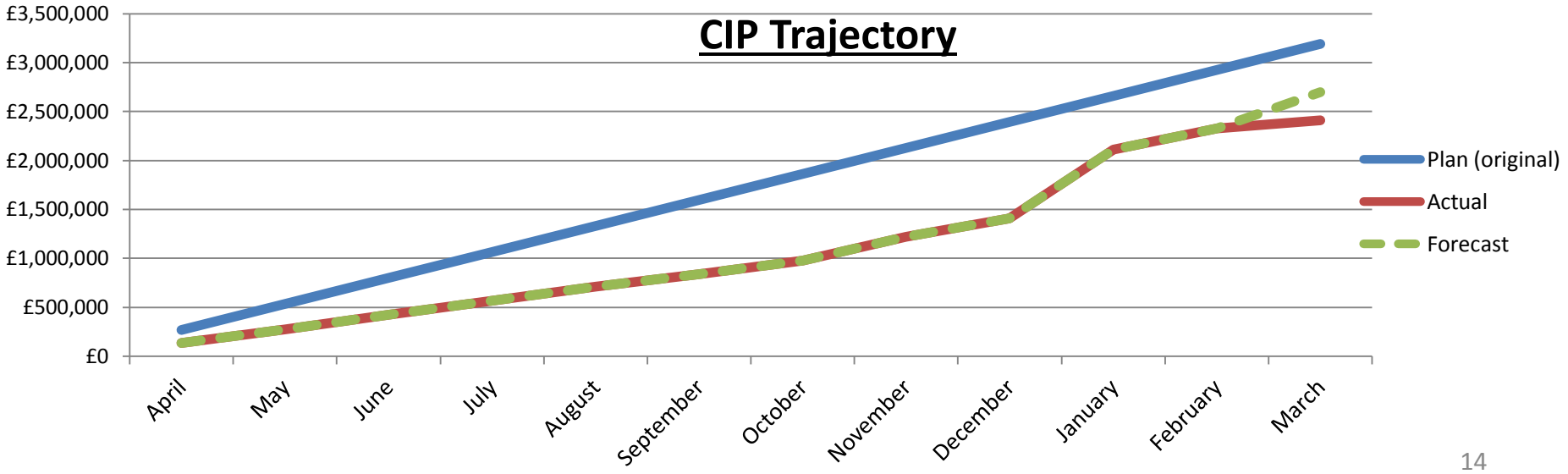
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory will have a direct impact on our regulator ratings. The Trust has remained at a 2 for agency spend, resulting in the overall UOR rating being a 4.

Within the draft annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

5. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18







INFORMATION

As at the end of February the Trust has recognised £2,327,000 of CIP savings, against a plan of £2,919,000, a negative variance of £592,000. The full year effect of the savings recognised to date is £2,413,000.

£406,000 (17%) of savings to date are non-recurrent. A revised CIP plan has been developed and incorporated within the financial recovery plan, this includes a forecast for CIP of £2,698,000 against an original plan of £3,191,000, causing a forecast variance of £494,000.

The current forecast contains 6% of income related schemes with the remainder of the plan split 44% non pay and 50% pay. Within the forecast position 78% of the schemes have been completed, 20% are at the execution stage, 1% planning and 1% initiation stage. The detail by division is shown below;

	Original Plan	YTD Original Plan	Actual Full year effect	Forecast	Forecast vs Original Plan Variance	YTD Plan	YTD Actual	YTD Variance
Division 1	£1,362,500	£1,248,958	£1,035,719	£1,111,310	-£251,190	£1,508,262	£1,020,865	-£487,397
Division 2	£851,270	£780,331	£403,591	£610,705	-£240,565	£465,811	£403,591	-£62,220
Division 3	£42,875	£41,692	£42,878	£42,878	£3	£129,535	£41,694	-£87,841
Division 4	£160,000	£155,558	£157,355	£159,356	-£645	£263,654	£146,159	-£117,495
Corporate	£774,355	£807,378	£773,705	£780,900	£6,545	£502,411	£715,088	£212,677
Grip and Control	£0	£0	£0	£0	£0	£23,775	£0	-£23,775
Productivity and Efficiency	£0	£0	£0	-£2,500	-£2,500	£25,552	£0	-£25,552
TOTAL	£3,191,000	£3,033,917	£2,413,248	£2,702,647	-£488,353	£2,919,000	£2,327,397	-£591,603
Shortfall				-£488,353				

ACTIONS FOR IMPROVEMENTS / LEARNING

Focus has been shifted to converting non recurrent savings in year to recurrent, and to fully developing the 2018/19 CIP plan.

The schemes which have CIP to be actioned during Months 11 and 12 of this year are;

- Theatres stock management and rationalisation
- Implant rationalisation
- Other non pay consumables – rationalisation and product changes

RISKS / ISSUES

A significant amount of work remains to be completed to fully develop 2018/19 schemes to ensure they can be implemented at the required timescales so that financial benefits are maximised during the year.

6. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M11 Plan £'000	M11 Actual £'000	Var £'000	What does this include?
Intangible Assets	2,044	891	(1,153)	The Trust's intangible assets, e.g. software that meets the criteria for capitalisation.
Tangible Assets	41,885	43,450	1,565	The Trust's tangible assets, e.g. property, plant and equipment that meets the criteria for capitalisation.
Total Non-Current Assets	**43,929**	**44,341**	**412**	
Inventories	3,931	4,078	147	Theatres and pharmacy drug stock
Trade and other receivables	2,932	1,298	(1,634)	NHS and non-NHS debtors outstanding net of bad debt provisions
Other Current Assets	1,048	492	(556)	For example prepayments and accrued income
Cash	3,138	6,366	3,228	Cash in hand and in bank inclusive of loaned cash
Total Current Assets	**11,049**	**12,234**	**1,185**	
Trade and other payables	(10,812)	(13,071)	(2,259)	Payments outstanding to NHS and other suppliers
Borrowings	(4,157)	(418)	3,739	Loans borrowed from the Department of Health and finance leases
Provisions	(116)	(78)	38	The current element of provisions for e.g. potential legal disputes or injury claims.
Other liabilities	(391)	(443)	(52)	Other liabilities, e.g. deferred income
Total Current Liabilities	**(15,476)**	**(14,010)**	**1,466**	
Borrowings	(1,661)	(4,302)	(2,641)	Non-current element of loans borrowed and finance leases
Provisions	(332)	(348)	(16)	The element of provisions which are expected to reverse over a period longer than a year.
Total Non-Current Liabilities	**(1,993)**	**(4,650)**	**(2,657)**	
Total Net Assets Employed	**37,509**	**37,915**	**406**	
Total Taxpayers' and Others' Equity	**37,509**	**37,915**	**406**	The reserves of the Trust, which includes public dividend capital, the income and expenditure reserve and the revaluation reserve.

INFORMATION

The inclusion of a full Statement of Financial Position is new within this pack, and has been included in order to give an oversight of other asset and liability balances, particularly to give a more informed overview of the cash position by having visibility of debtor and creditor balances.

Cash is significantly higher than plan, and this is discussed in further detail in the cash section overleaf.

Debtors are lower than plan, and have been decreasing throughout the year. This is positive, and has been driven through more focus on debt collection through the restructure of the Transaction Team to include a debt collector role. The trust is finding that there is an increasing move towards aged debt however, which is concerning, but to be expected, particularly where other trusts are also reliant on cash support. On the whole these balances are expected to be slow but recoverable, with provisions having been made for some of the balances considered more at risk.

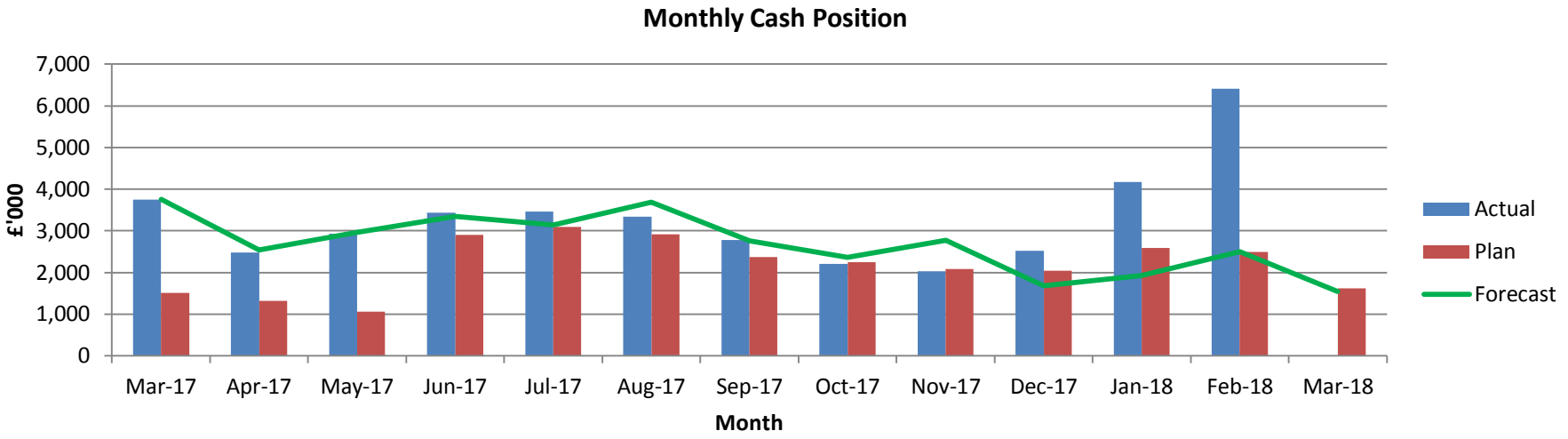
Creditors balances have conversely risen throughout the year, with the peak being in November, but since reduced. This is due to two main reasons; firstly, there have been staff shortages through vacancy and sickness within the theatre environment which has slowed down approval of invoices to allow payment. This is being managed through use of an agency member of staff who is starting to work through the backlog. Secondly, with the trust now reliant on cash funding, the team need to be more careful regarding payment of invoices to ensure the minimum cash balance of £1m is not breached, and this therefore results in higher creditor balances.

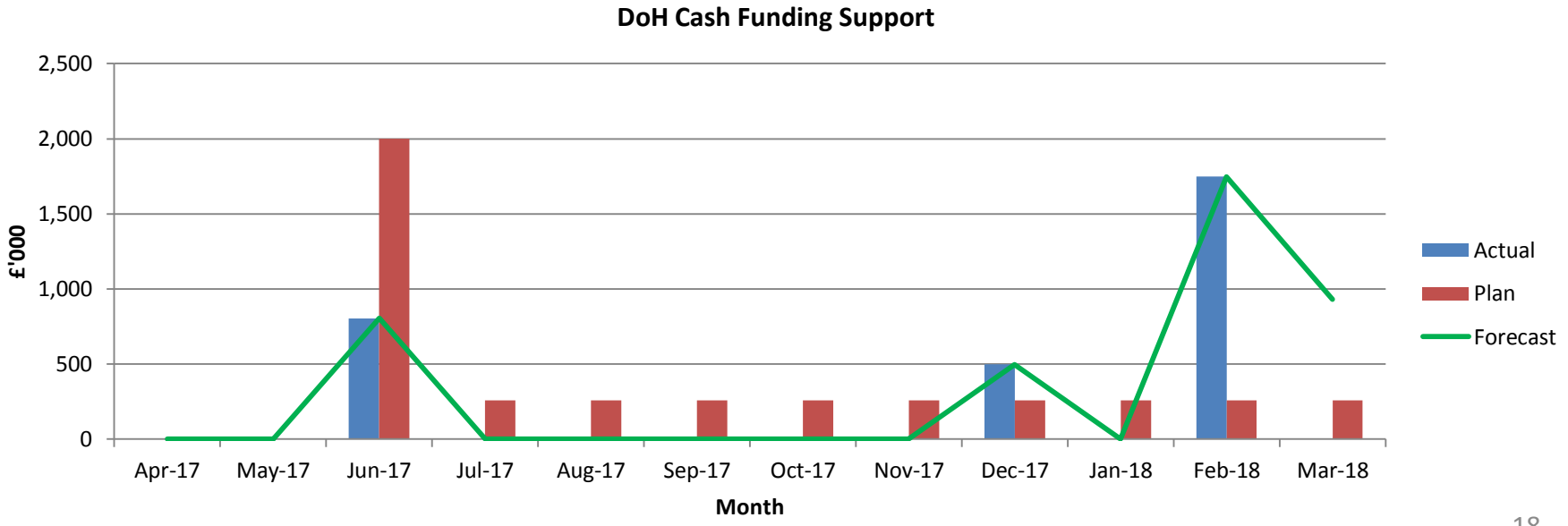
ACTIONS FOR IMPROVEMENTS / LEARNING

In the coming months, further balance sheet metrics regarding better payment practice code and debtor ageing will be included within the report.

RISKS / ISSUES

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 was £3,914k above planned levels at the end of February, as credit notes for underperformance have not recovered by the CCGs. Cash receipts in March will be lower as a result of underperformance repayment.

The Trust received its first cash loan of £804k from the Department of Health in June 2017, a second of £498k in December 2017 and a third of £1,747k in February 2018. The final loan for the year of £930k was received after month end, taking full year borrowing to £3,979k. This is within the level of loans which were predicted for the year in the Annual Plan

Post month end the Trust has also received £280k cash from the Department of Health to fund cybersecurity improvements. The order for the relevant items has been placed, as the cash was required to be spent in advance of the year end. This has been funded through public dividend capital rather than an additional loan.

The requirement for cash support continues to result in the trust being rated at the lowest level (level 4) for liquidity.

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 2017/18. The finance team continue to run a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team in order to scrutinise both the current and future cash position, but also to identify areas for cash control improvement. The committee continues to review cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the Department of Health to be actioned. The updated cash requirements for 2018/19 based on a refresh of the operational plan continue to be modelled.

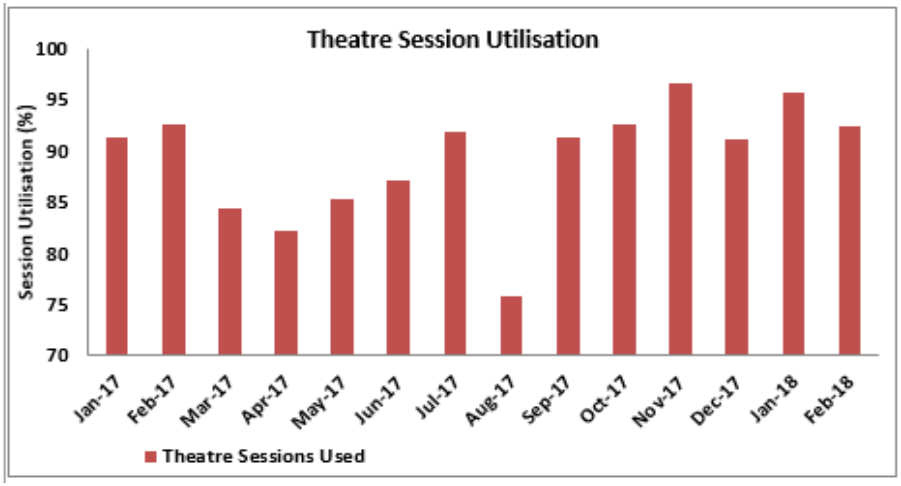
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DoH not approving a cash loan or approving a lower than requested amount.

8. 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

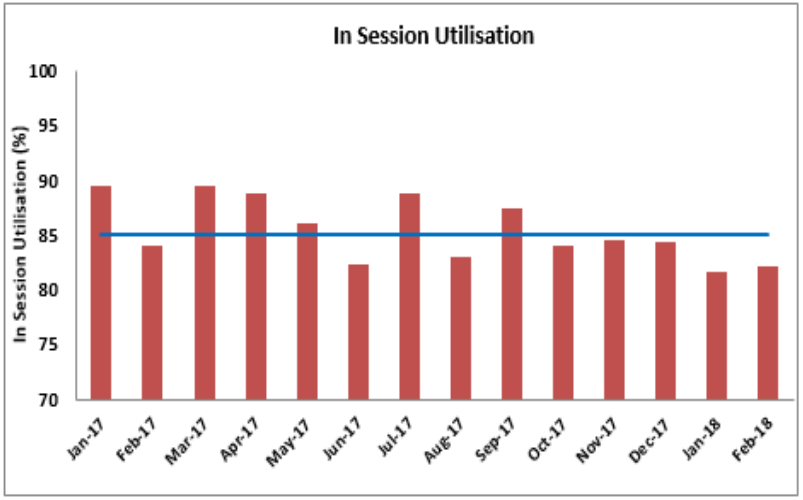
Theatre list utilisation for February was 92.43% down on the previous month. This was mostly due to half term week.

The trend remains on an upwards trajectory, with the average utilisation figures for the last 3 months (Dec-Feb) running at 93% with work continuing on a weekly basis to recycle lists where possible to ensure full maximisation of theatre lists.

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc will also need to 'grow' alongside theatres to ensure maximum efficiency gains.

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



INFORMATION

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 was 82.23% in February an increase on the previous month.

The recurring themes continue to be patients not fit, patients self cancelling or not attending on the day. A more robust clinically led 72 hour call process is being scoped to ensure patients are contacted ahead of their planned admission to hospital to check that the patient still plans on coming to hospital and that there has not been any change in the patients condition, such as feeling unwell, or change in symptoms etc.

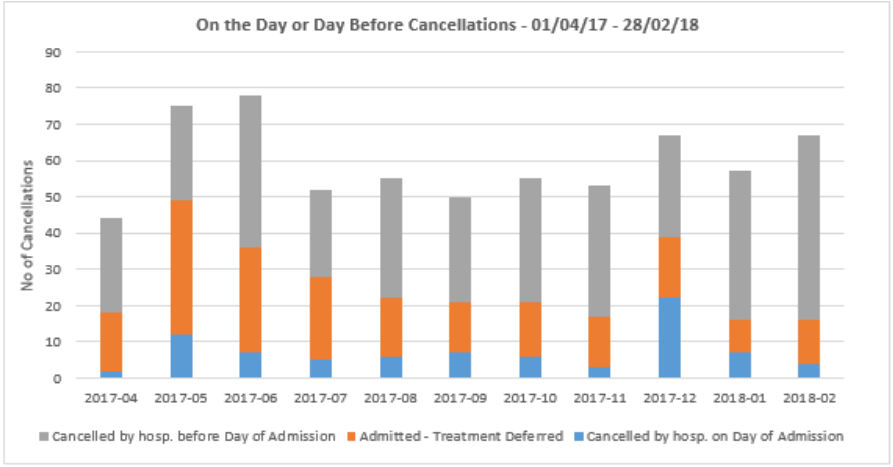
RISKS / ISSUES

Staff vacancies within theatres – on-going recruitment process is in place

Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit.

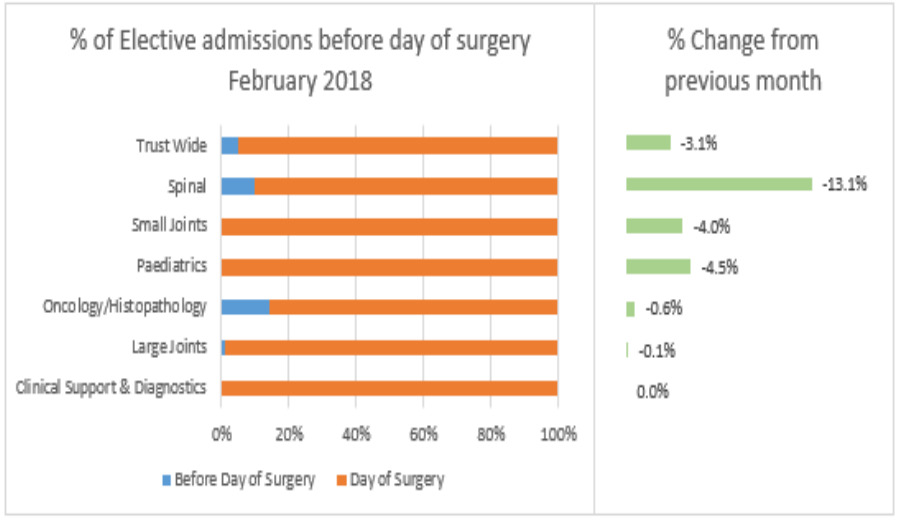
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

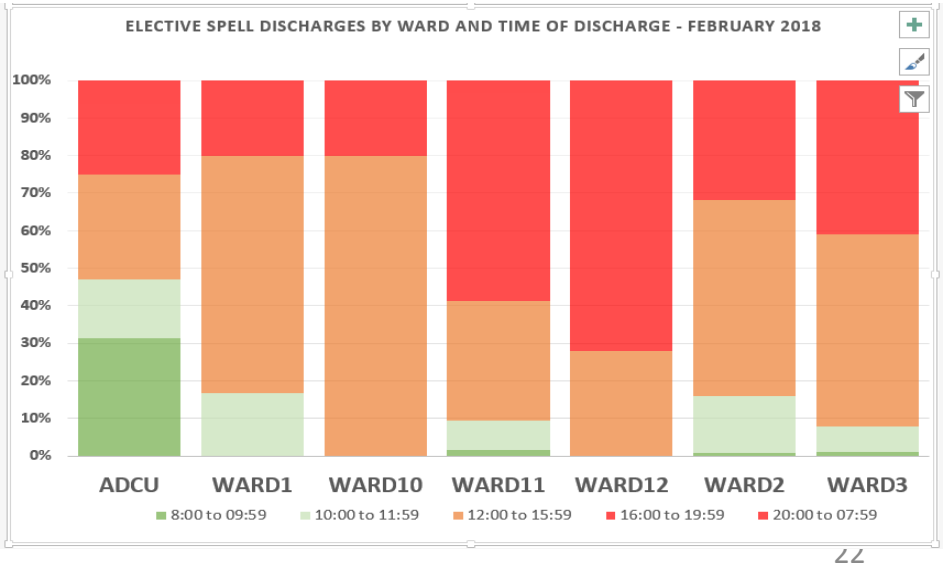
Hospital Cancellations



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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	28	67	0
2018-01	7	9	41	57	1
2018-02	4	12	51	67	
Grand Total	**81**	**202**	**370**	**653**	**10**

Admission the day before surgery





INFORMATION

The number of cancellations on the day of surgery by the hospital continue to reduce.
There has this month been an increase in the number of patients cancelled before the day of surgery, the two main factors were patients cancelling due to medical issues and patients given earlier date for procedure due to additional weekend capacity.

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Key themes identified enable pro-active interventions to resolve any future challenges.

To further strengthen the POAC model a visit to SWLEOC (South West London Elective Orthopaedic Centre) took place on the 14th March to review their nurse led model , with a view to implement a best practice Pre – Operative Model. The team have also visited the team at Dudley and following both site visits they are now producing the future model for POAC, this model will be presented to the weekly operational group in April 2018.

ACTIONS FOR IMPROVEMENTS / LEARNING

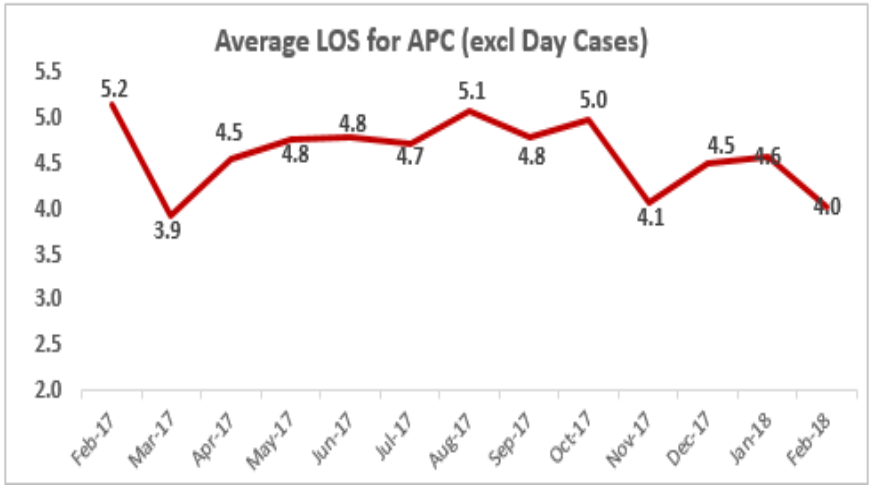
A daily update review by operational management of forward bookings and the 6-4-2 and a daily 8.30am Operations huddle is now embedded in practice to maximise theatre utilisation.
Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to monitor activity and patient flow.
POAC improvement team finalising clinical model and resource requirements to deliver flexible pre- operative pathway to meet surgical demand.

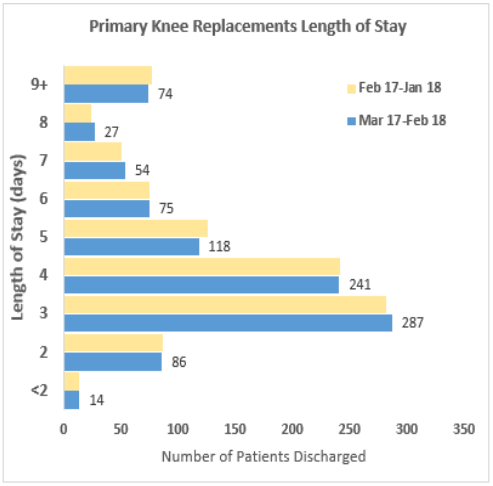
PERFECTING PATHWAYS

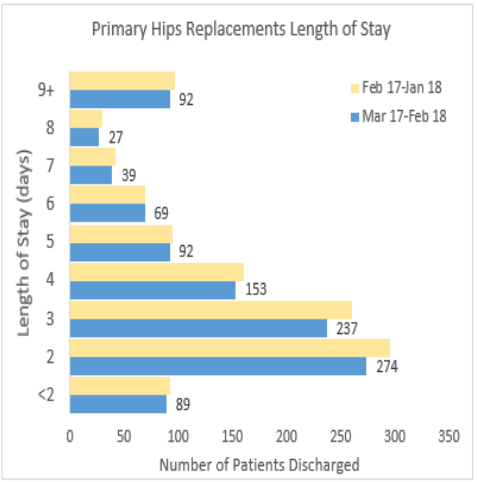
RISKS / ISSUES

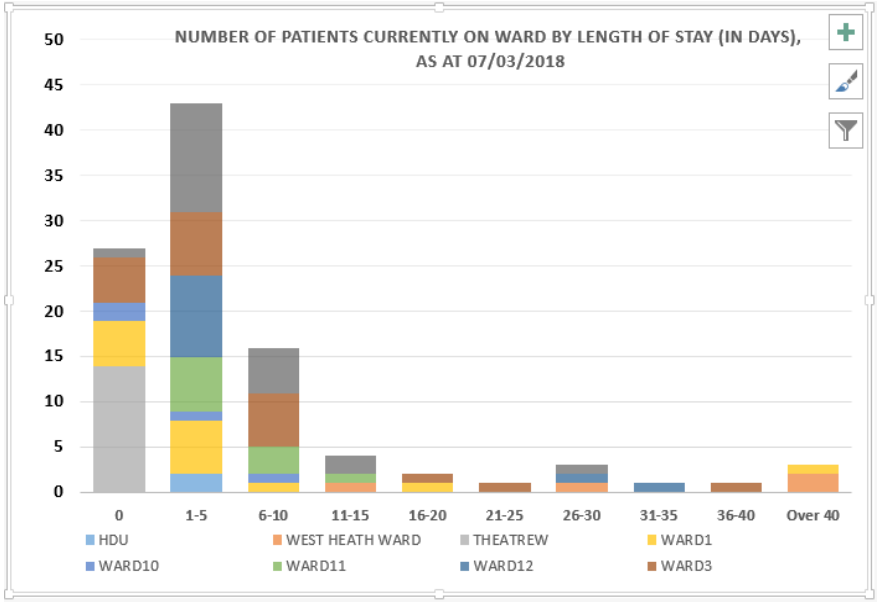
High levels of cancellations prior to day of surgery
Ability to flex POAC capacity to meet demands of additional activity.

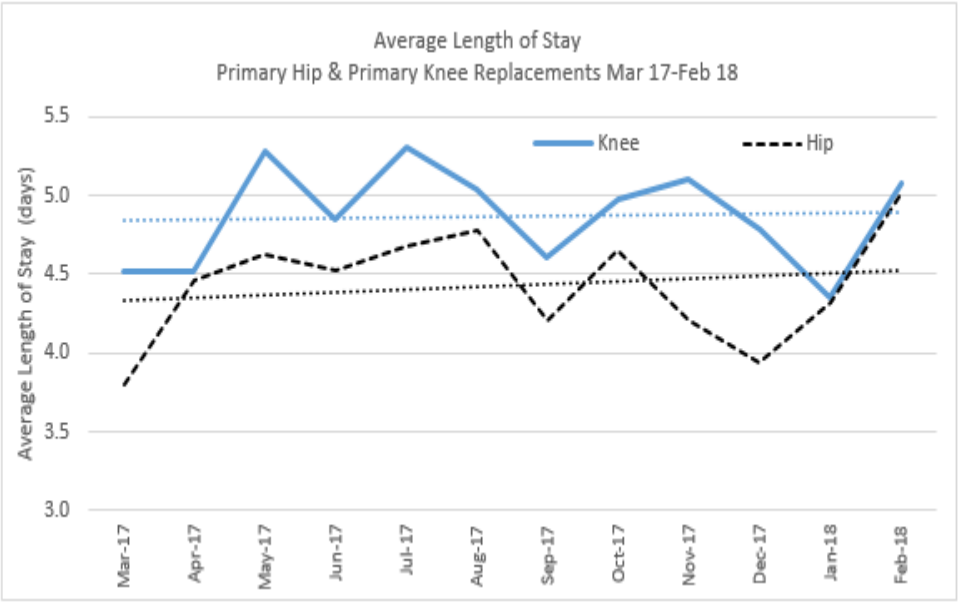
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors, Clinical Service Leads and Clinical Service Managers, work continues weekly to increase activity levels against the recovery plan and improve LOS.

This will be supported by a renewed focus on implementation of Red to Green , rapid recovery roll out and the implementation of the passport to home initiative from April 2018. (The head nurse for Division 1 commences beginning of April 2018 and will prioritise leadership of these initiatives)

ACTIONS FOR IMPROVEMENTS / LEARNING

Work continues to strengthen the Arthroplasty consultant led ward rounds so that patients are seen daily.

Job plan changes to support this will be in place from April 2018 .
Further work continues to develop with the Arthroplasty team which includes feasibility around a dedicated Theatre environment , freeing up adjacent accommodation to house the Arthroplasty team and work around pre-assessment. T
here has been some dedicated focus on the Knee Replacement Pathway which is anticipated to demonstrate a reduction in the over all length of stay for this patient group

Work has also commenced to increase the number of patients who are treated on the Rapid Recovery Pathway for Knees.

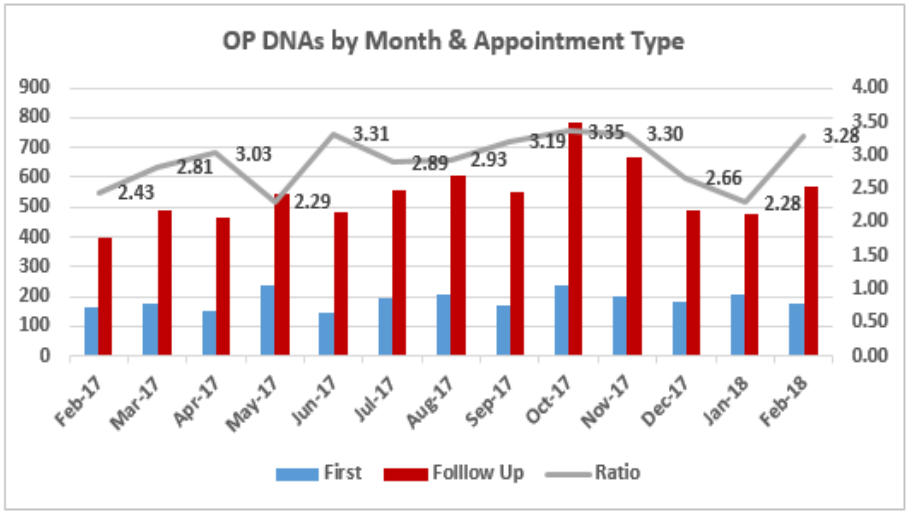
The Trust will also be actively supporting the #end PJ paralysis initiative (70 day Challenge) commencing on the 17th of April led by the Director of Patient Services .

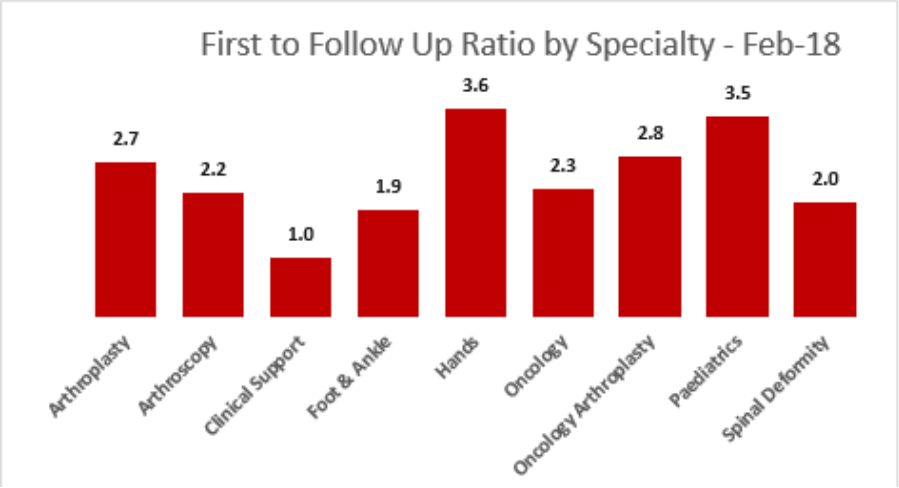
RISKS / ISSUES

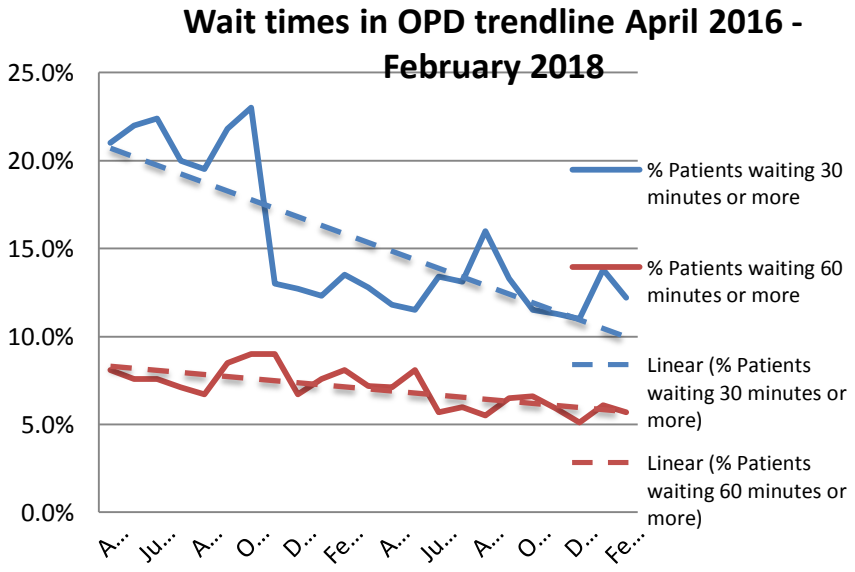
From April 18 a more focussed approach will be in place to actively monitor and reduce LOS, this will be supported by a further roll out of the Rapid recovery pathway.

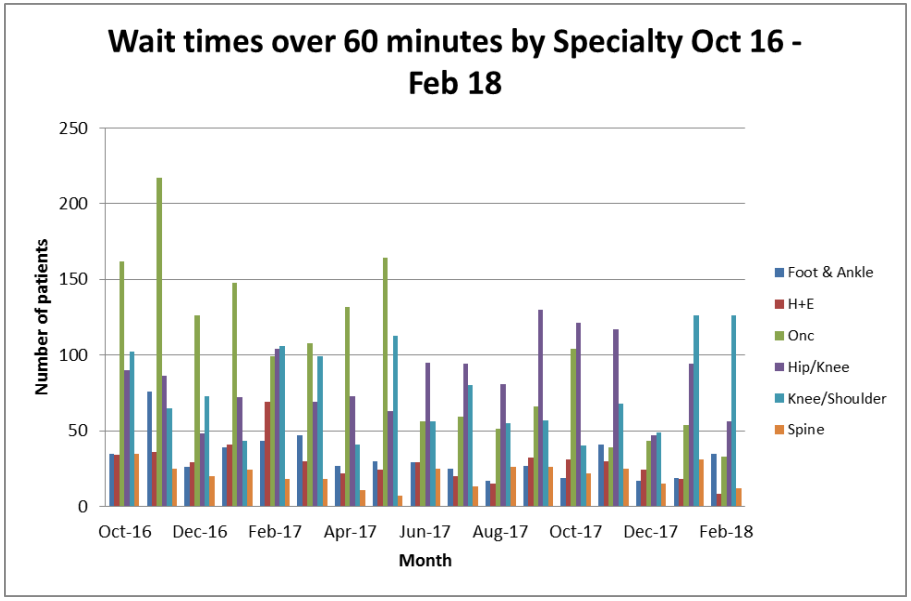
This will also help to inform the bed modelling to review of the number of beds which the Trust needs to deliver its future capacity to support the SOC.

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









INFORMATION

The process for sharing learning in relation to clinic delays is being reviewed and future incident forms will be shared with the Clinical Service Managers along with the clinic delay data. Any issues that require operational management input will be discussed and changes implemented to avoid future recurrence of issues. The incident reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form.
In February 2018 there were 23 incident forms completed to highlight clinics running more than 60 minutes. 20 in the Main OPD and 3 in Paediatric OPD.

12.2% of patients waiting over 30 minutes and 5.7% waiting over 1 hour.

The monthly audit identified the following : -
7 x complex patients
4 x clinician delays
1 x X-ray delay
8 x overbooked clinic
3 x not specified

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions from February's Audit include;
•Work underway with the Estates department to improve the environment on paediatric outpatients to ensure InTouch can be used effectively and in real time
•The paediatric Oncology template has been reviewed and a new template will be implemented once Health Informatics team have confirmed the charging structure for these clinics is correct
•An electronic clinic rescheduling form is being developed on TopDesk to help manage this workload and provide an audit trail for clinic changes
•The SOP in relation to clinic cancellation and reductions will be re written and launched after the electronic clinic rescheduling form has been completed
•Project to implement management of clinician annual leave through Allocate has started and being managed by Division 1
•An upgrade of the InTouch system is due to take place in the next few months which will provide improved functionality in the management of clinics and clinic utilisation

RISKS / ISSUES

Clinic Cancellation and Rescheduling – Adherence to Standard Operating Procedure and need to update process

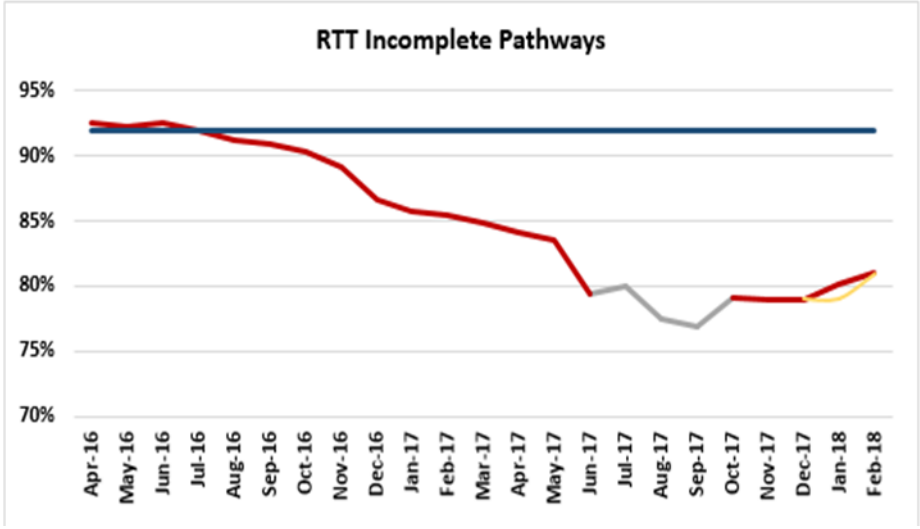
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

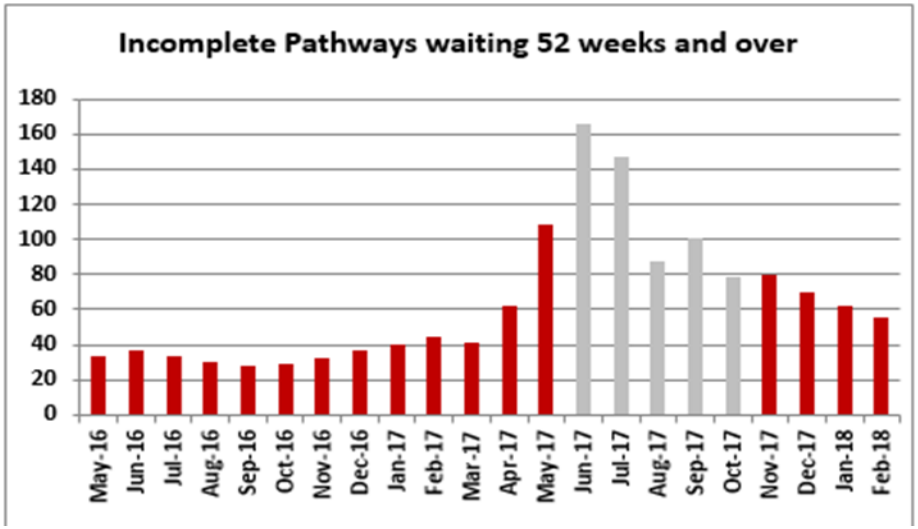
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%

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





		Reported Month				Reported Quarter 2017/18								
Target Name	National Standard	Jan-18	Dec-17	Nov-17	Oct-17	Q3 (Oct, Nov, Dec)	Breach	Total	Q2 (July, August, Sept)	Breach	Total	Q1 (April, May, June 17)	Breach	Total
2ww	93%	97.10%	100%	100%	95%	98.30%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	91.67%	100%	91.70%	100%	96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	94.10%	100%	100%	100%	100.00%		30	97.40%	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		n/a
62 day (traditional)	85%	86.67%	83.30%	83.30%	100%	88.6%	1.5	7	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	100%	90.90%	90.90%	81%	82.10%	2.5	14	88.90%	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		n/a
No. day patients treated 104+ days		0	0	0	0									

13. Referral to Treatment snapshot (Combined) 28th February 2018

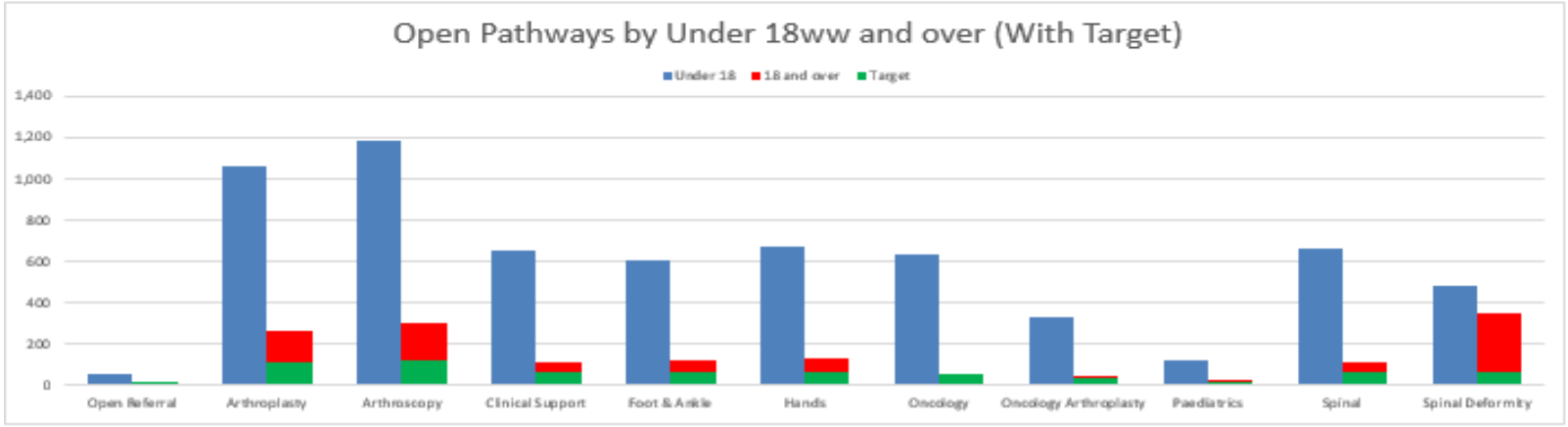
Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways

Select Pathway T **Both**

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,600**	50	576	641	408	319	361	337	213	77	397	217	4
7-13	**1,958**	6	339	355	163	203	216	199	90	34	200	150	3
14-17	**894**	0	141	185	79	85	89	97	28	11	67	109	3
18-26	**912**	0	184	204	66	88	91	23	20	16	70	145	5
27-39	**431**	0	65	88	39	28	30	4	15	7	29	114	12
40-47	**86**	0	9	7	6	5	4	0	3	0	10	41	1
48-51	**24**	0	0	1	1	0	1	0	0	0	1	19	1
52 weeks and over	**56**	0	0	0	1	1	0	0	0	0	0	29	25
Total	**7,961**	56	1,314	1,481	763	729	792	660	369	145	774	824	54

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**6,452**	56	1,056	1,181	650	607	666	633	331	122	664	476	10
18 and over	**1,509**	0	258	300	113	122	126	27	38	23	110	348	44
Target	**637**	**4**	**105**	**118**	**61**	**58**	**63**	**53**	**30**	**12**	**62**	**66**	**4**

	81.05%	**100.00%**	**80.37%**	**79.74%**	**85.19%**	**83.26%**	**84.09%**	**95.91%**	**89.70%**	**84.14%**	**85.79%**	**57.77%**	**18.52%**



13. Referral to Treatment snapshot

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways

Select Pathway Ty Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,781**	50	384	457	362	282	295	249	137	53	324	187	1
7-13	**1,419**	6	184	222	145	178	169	160	52	17	160	126	0
14-17	**620**	0	76	96	68	68	65	82	11	9	50	95	0
18-26	**548**	0	82	85	57	69	55	13	9	7	51	120	0
27-39	**243**	0	34	34	36	22	20	0	2	2	14	79	0
40-47	**47**	0	5	3	4	3	3	0	0	0	5	24	0
48-51	**12**	0	0	1	0	0	0	0	0	0	0	11	0
52 weeks and over	**5**	0	0	0	0	1	0	0	0	0	0	4	0
Total	**5,675**	56	765	898	672	623	607	504	211	88	604	646	1

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**4,820**	56	644	775	575	528	529	491	200	79	534	408	1
18 and over	**855**	0	121	123	97	95	78	13	11	9	70	238	0
Target	**454**	**4**	**61**	**72**	**54**	**50**	**49**	**40**	**17**	**7**	**48**	**52**	**0**

	84.93%	100.00%	84.18%	86.30%	85.57%	84.75%	87.15%	97.42%	94.79%	89.77%	88.41%	63.16%	100.00%

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways

Select Pathway Ty Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**819**	0	192	184	46	37	66	88	76	24	73	30	3
7-13	**539**	0	155	133	18	25	47	39	38	17	40	24	3
14-17	**274**	0	65	89	11	17	24	15	17	2	17	14	3
18-26	**364**	0	102	119	9	19	36	10	11	9	19	25	5
27-39	**188**	0	31	54	3	6	10	4	13	5	15	35	12
40-47	**39**	0	4	4	2	2	1	0	3	0	5	17	1
48-51	**12**	0	0	0	1	0	1	0	0	0	1	8	1
52 weeks and over	**51**	0	0	0	1	0	0	0	0	0	0	25	25
Total	**2,286**	0	549	583	91	106	185	156	158	57	170	178	53

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**1,632**	0	412	406	75	79	137	142	131	43	130	68	9
18 and over	**654**	0	137	177	16	27	48	14	27	14	40	110	44
Target	**183**	**0**	**44**	**47**	**7**	**8**	**15**	**12**	**13**	**5**	**14**	**14**	**4**

	71.39%	n/a	75.05%	69.64%	82.42%	74.53%	74.05%	91.03%	82.91%	75.44%	76.47%	38.20%	16.98%

INFORMATION

The Trust re-commenced reporting of RTT in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For February 2018 the RTT trajectory was 81% with performance at **81.05%** , with 56 patients over 52weeks (54 spinal deformity)
(62pts January 2018)

The team have reviewed all spinal deformity patients and produce a trajectory for NHSI & NHSE submitted at the end of February 2018 for all patients at or likely to breach 52weeks.

ACTIONS FOR IMPROVEMENTS / LEARNING

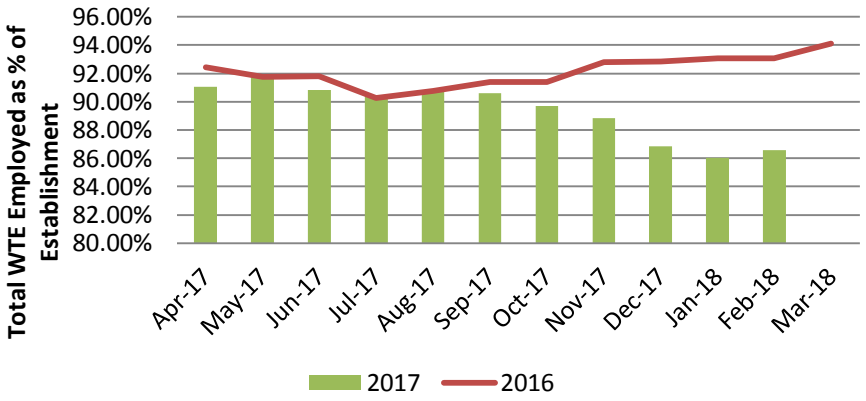
The team continue to concentrated on any patients over 40 weeks, this number continues to reduce. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.

RISKS / ISSUES

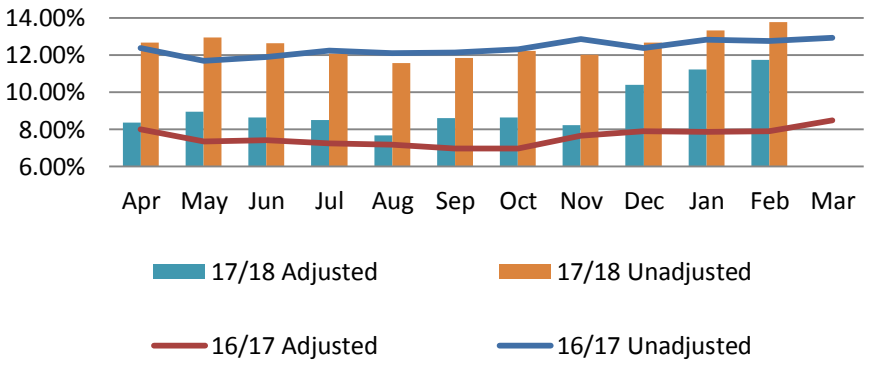
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . This had shown an additional list from BWCH in February 2018 through the refurbishment of Waterfall House on site at BWCH. This has now been moved to September 2018. The date for the completion of this work will be confirmed at the end of March 2018 and the trajectory will be updated to reflect this. Weekend activity which had been planned up till April 2018 is now being planned through the Summer to assist with the existing waiting list .

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

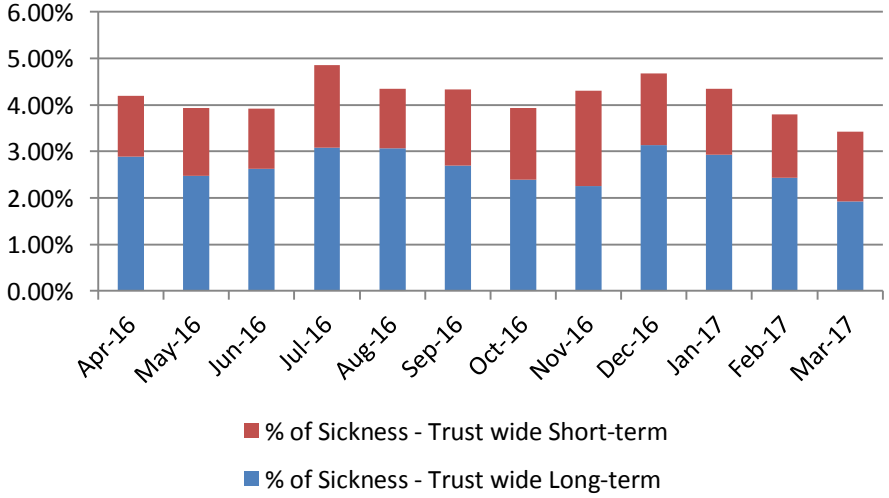
Staff in Post v Establishment



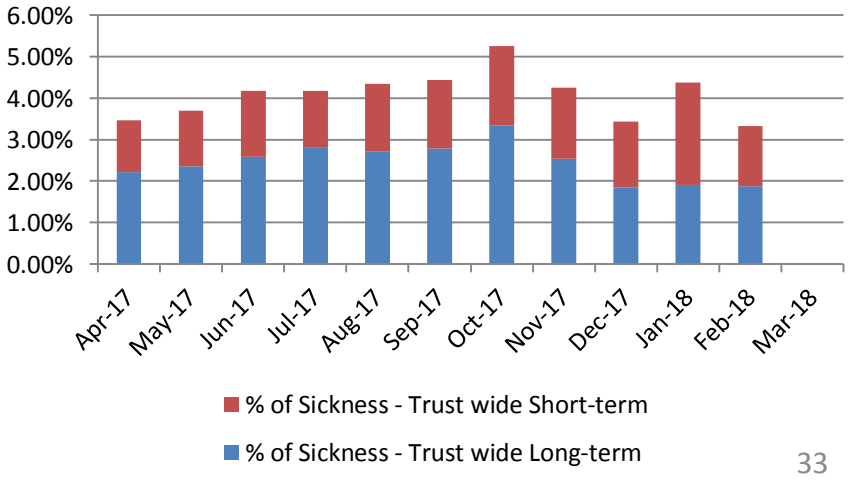
Staff Turnover



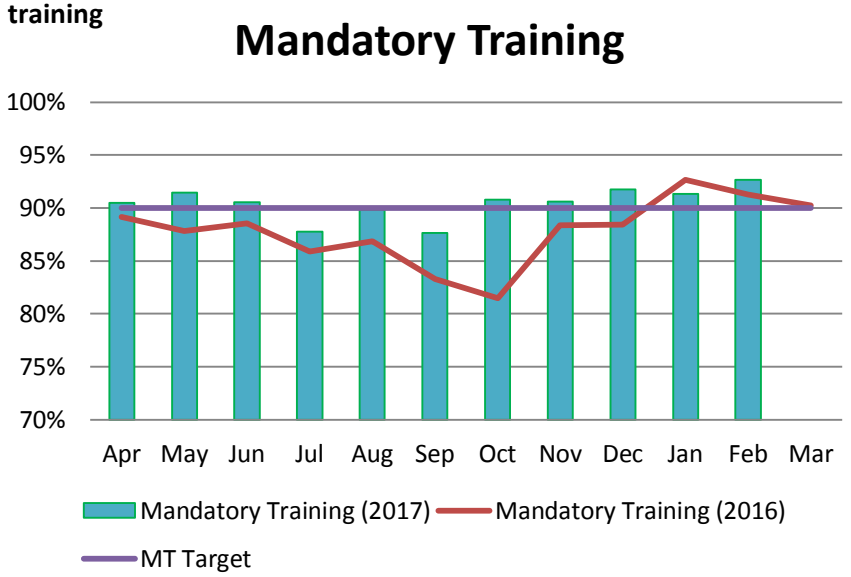
Sickness % - LT/ST (2016)

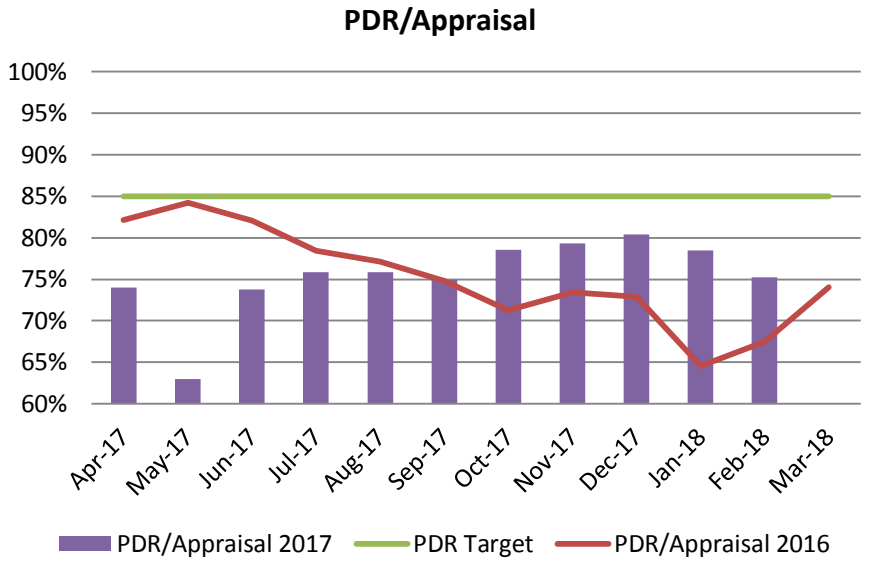


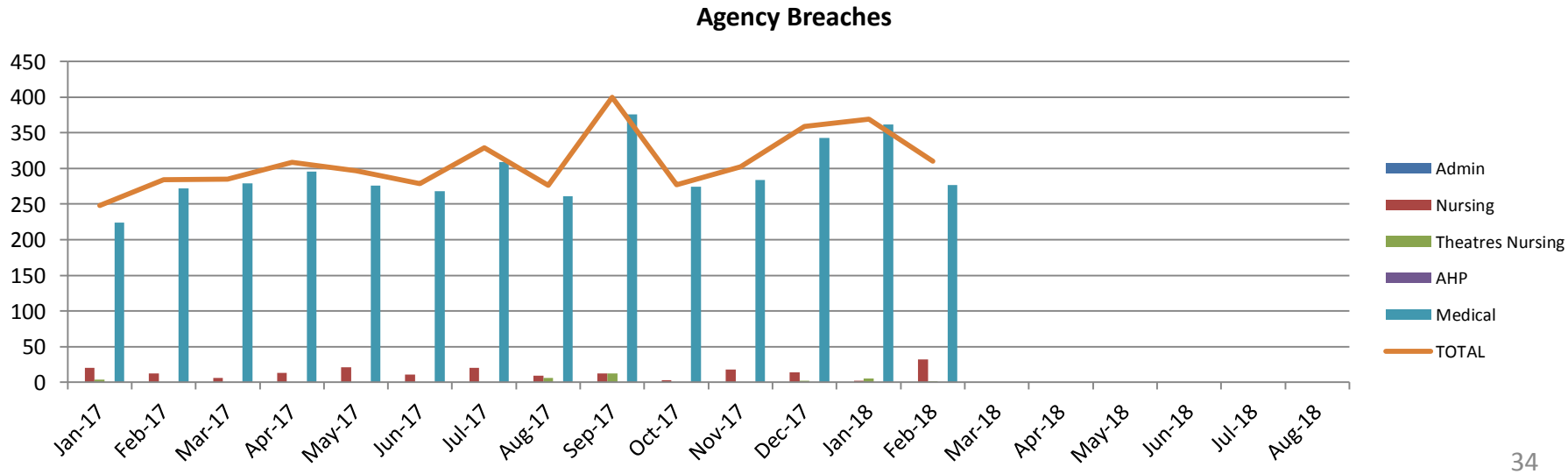
Sickness % - LT/ST (2017/18)



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







INFORMATION

In February, sickness absence decreased by (1.06%) to 3.32% in month. This is the lowest single month figure since August 2013 and the lowest February figure since 2008. Notwithstanding this, our underlying 12 month average figure increased very slightly by 0.02%: the cause is most likely due to late retrospective input of sickness absence. It is, however, still green as an underlying figure.

The Trust's vacancy position saw an improvement of 0.56% to 86.59%. Our staff in post has increased by 8 this month to 1007, which accounts for the increase in the total staff employed vs the funded establishment.

Mandatory training increased in February by 1.3% and remains green at 92.66%, which equals January 2017 and is the best performance in the last 2 calendar years. The L&D Team are continuing to encourage staff to book onto courses or carry out their Mandatory Training via e-learning.

January's appraisal performance saw a further decline of 3.24% to 75.24%, so the Trust remains red. This will be addressed in Divisional Boards and divisional performance reviews in March. It is also interesting to note that the proposed revisions to the national Agenda for Change pay arrangements focus on improvements in both statutory and mandatory training and appraisal performance.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) increased by a slight 0.38% on last month to 13.69%. This is the highest we have recorded since April 2013. It is mainly due to having an unusually high number of leavers in December and January, including 9 retirements in December and 7 relocations in January. In context, our average number of leavers per month for the year compared to last year has only increased by 2. Corporate services continue to drive the turnover position with a turnover rate of over 18%. When coupled with the unusual theatre retirements, the position appears high. Turnover is however expected to reduce in the coming months.

The number of Agency breaches decreased by 59 in February, although the number of Nursing breaches increased from 7 in January to 33 in February, Ward Nursing used the majority of the breaches, with Theatres only reporting 1. The majority of the breaches still remain with medical staff (and of these, most are junior medical staff in non-deanery posts, where long term locums are in post). It is also interesting to note that the number of staff on maternity leave in February (24) is at its highest point for 2 years, which will have an impact on staff available for shifts.

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ACTIONS FOR IMPROVEMENTS / LEARNING

Appraisal continues to be an area where focus is needed. There is work ongoing in HR&OD to review the process to ensure that high quality appraisals are easy for managers to undertake.

RISKS/ISSUES

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

ROHTB (4/18) 006

TRUST BOARD

DOCUMENT TITLE:	**Corporate Risk Register**
SPONSOR:	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**4 April 2018**

EXECUTIVE SUMMARY:

Attached is the summary of the current entries on the Corporate Risk Register.

The report shows the movement in scoring as mitigating treatment plans have been applied over the past year.

The Corporate Risk Register contains those risks from divisional and committee risk registers which remain amber or red post mitigation, in addition to a number of risks that have been added at the specific request of the Executive Team. Those that remain at red post mitigation automatically get transferred onto the Board Assurance Framework which the board sees on a quarterly basis.

It is proposed that this summary report is presented to the Trust Board on a quarterly basis, with the Board Committees retaining responsibility for reviewing the detail behind the relevant sections of the risk register on a monthly basis.

REPORT RECOMMENDATION:

Trust Board is asked to:

- review the summary of the Corporate Risk Register
- agree to receive the summary on a quarterly basis, with the Committees retaining responsibility for reviewing entries in detail for those that naturally fall within the remit of their terms of reference

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X	**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:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Covers risks to the delivery of the Trust's strategic objectives and high level risks from around the Trust.
PREVIOUS CONSIDERATION:
Executive Team on 3 April 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Corporate Risk Register – Risk Assurance/Risk Progress Summary – Q4 2017/18

Key
CEO Chief Executive Officer
COO Interim Chief Operating Officer
EMD Executive Medical Director
EDF&P Interim Director of Finance & Performance
EDPS Executive Director for Patient Services
EDS&D Executive Director for Strategy & Delivery

Risk Lead	Risk No	Risk Description	Initial Risk Score	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Target Risk Score
COO	1088	There is a risk that the organisation's reported position against the 92% target is inaccurate due to data quality issues	25	25	15	12	12	12
COO	1089	There is a risk that the Trust will fail to meet the trajectory set for the improved performance against the national 18 Week RTT target of 92%	25	25	25	20	20	16
COO	1117	There is a risk that patients may experience a delay in their clinical pathway due to data quality issues, which may result in harm.	25	25	25	15	12	12

CEO	CE1	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	25	N/A	25	25	25	10
EDF&P	FP1	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	25	N/A	20	20	20	10
CEO	CE2	The Trust Board carries all the clinical risk residing with the transition of Inpatient Paediatric Services whilst the system re-commission and re-provides the services elsewhere.	25	N/A	N/A	25	25	12
COO	7	Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays.	20	16	16	20	20	8
COO	27	There is a risk of financial loss due to high expenditure on temporary (locum agency) staff. There is an associated increased clinical risk that could result in financial and reputational loss from possible shortcomings in continuity of care and less certainty over the competency of temporary staff than permanent appointments.	20	9	9	9	9	6
EDF&P	293	Failure to deliver planned financial surplus, impacting on financial stability, investment opportunities and regulatory rating.	20	20	20	20	20	15
EDF&P	804	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	20	12	12	12	12	4
EDPS	544	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).	20	12	12	12	12	4
EDS&D	1137	Non-compliance with Healthcare Technical Memorandum 04-01: 'Safe Water in Healthcare Premises'.	20	20	20	20	20	5
COO	CO1	Lack of a Cancer operational tracking system to support day to day management and national reporting	20	N/A	20	12	12	4

COO	CO2	Operational capacity - there is a risk that the number of recovery programmes, redesign initiatives and services changes may be impacted due to the breadth of operational resources including informatics	20	N/A	15	9	9	5
COO	CO3	Theatres - there is a risk that the department is in need of a full review supported by a organisational development programme	20	N/A	20	9	16	5
COO	1002	There is a risk that the current status of all live patients under the Spinal Deformity service is not known in all cases, which has the potential to create a delay with treating patients resulting in the possibility of further clinical deterioration of patients waiting excessively long for treatment and lost financial recompense for cases needing to be treated.	20	12	12	12	12	4
EDPS	639	There is a risk that the Trust is unable to meet the standard for consultant paediatric cover for CYP Services.	20	12	12	15	15	6
EDPS	275	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.	16	12	12	8	6	4
COO	671	There is a risk to the department of minimal numbers of trained spinal scrub practitioners, impacting on capacity in theatres and overreliance on agency members of staff in the face of national guidelines to adhere to an agency spend cap.	16	12	12	12	8	4
EDPS	770	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant operational impact on clinical services	16	12	12	12	15	4
EDS&D	1047	Risk of staff or patient harm and or / non-compliance with regulatory and commissioner requirements due to failure by line managers to effectively plan the release of staff for attendance on training.	16	12	12	8	8	4
EDF&P	270	National tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist.	16	12	16	16	16	8
EDS&D	582	There is a risk that strategic objectives will not be achieved, caused by shortfalls in leadership/management capability, which may result in sub-optimal management of the changes required in the organisation.	16	12	12	12	12	8

EDF&P	1028	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	16	16	16	8	8	6
EDF&P	971	There is a risk that the IT network infrastructure, including wireless connectivity (wi-fi) will prove unreliable and breakdown.	16	9	9	9	9	6
COO	1032	There is a risk that there will be no future facility to store medical records on site due to the fact that the health records library to full to capacity.	16	16	16	9	9	6
EDF&P	1055	There is a risk that EPMA implementation will be delayed from its scheduled start date of October 2017 as a result of the need for improvements to the IT Network Infrastructure.	15	6	6	6	6	3
EDF&P	1074	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	15	15	10	10	8	10
EDPS	1050	There is a risk that the services on Ward 11 are not up to required standards due to a short fall in staffing establishment of registered children's nurses	15	12	12	12	12	6
EDPS	1129	There is a risk that CYP patients could be seen as receiving Level 3 care when the Trust is not able to deliver sustained long term level 3 care.The WMQRS reviewing team have raised a concern that some of our complex CYP patients admitted to our Level II HDU would be admitted to Level III area in other organisations.	15	15	15	10	10	5
EDPS	1130	The WMQRS raised the concern that the Trust did not meet the standard for consultant paediatrician cover for a Level 2 unit.	15	15	15	15	15	5
CEO	CE3	Risk that the plan for Paediatric is not aligned with the wider STP strategy for Orthopaedics	15	N/A	N/A	15	15	8
CEO	791	There is a risk that safe practices and patient care are compromised by the large number of organisational policies which are overdue for renewal	12	9	9	9	9	6
COO	656	Due to reliance on paper-based systems, there is a risk that paper request forms for Imaging investigations are lost or delayed, resulting in the investigation not happening or delays to the requested investigation taking place	12	8	8	8	8	4
EDPS	986	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	12	8	8	8	8	4

EDPS	549	There is a risk that the Trust is non compliant with hand hygiene and bare below the elbow as described in policy.	12	9	9	9	9	4
EDS&D	972	There is a risk due to its age that the current telephone system will breakdown, have limited function and not be repairable due to parts availability. T	12	12	12	12	12	6
EMD	MD1	There is a risk that there will be some clinical resistance to the change in the way Paediatric Services are delivered	12	N/A	N/A	9	9	4
CEO	CE4	There is a risk to the ROH reputation should the Paediatric service not be transferred in a timely and safe manner	12	N/A	N/A	12	12	4
EDF&P	FP2	The Trust is likely to incur transitional costs with the transfer of Inpatient Paediatric Services	12	N/A	N/A	12	12	4
EDPS	PS1	There is a risk that patient care/safety may be compromised as we do not have enough Paediatric staff/vacancies on the ward.	12	N/A	N/A	12	12	4
EDF&P	973	There is a risk that the PAS will come to the end of the current contract before the process of implementing a new PAS is completed.	8	8	8	8	8	4

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	28 March 2018
Guests	Mrs Angie Howling
Presentations received	None
Major agenda items discussed	• Quality & Patient Safety report • Nurse staffing update • Quality Priorities 2018/19 • Safeguarding Committee – upward report and minutes • Infection Control Committee – upward report and minutes • HDU and Outpatients CQC action plan exceptions • Divisional governance assurance
Matters presented for information, update or noting	• Quality & Safety risks on the Corporate Risk Register
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Committee discussed the details of a recent patient death. The individual had not died at the Trust however had been an inpatient shortly before. The matter had been referred to the Coroner. • Work was reported to be underway to establish what equipment was needed improve the treatment of bariatric patients • It was noted that the robustness of the harm review process was being reviewed and it was noted that there had been a gap in upwards reporting to the Committee which needed to be addressed • There remained 26 vacancies in theatres, although a number of offers of employment had been made which would address this • There had been a higher level of agency staffing used during the month, although this remained below the 10% limit set • In terms of safeguarding, there had been a need for more one to one nursing, which was challenging from a resource perspective. Administration resource for the Safeguarding team was also highlighted as an issue. • There continued to be a risk around accessing some infection control information, although a data analyst was being recruited • There remained a high risk around compliance with water management regulations

	• There was a discussion around antimicrobial stewardship. The ROH could not meet national guidelines due to the nature of the surgery undertaken at the hospital. This was recognised by the national professional bodies and regional stakeholders. • The paediatric matron had raised a risk concerning the nurse staffing arrangements for the care of children, however the specifics of this risk were being reviewed as there was no apparent risk based on incidents and trends against the quality indicators
Positive assurances and highlights of note for the Board	• Assurances were given that the level of resuscitation training was improving and a further report would be presented at the April meeting • There was a higher level of incidents reported during the month, which was seen to be reflective of an improved reporting culture • Assurances were given that the CAS alert concerning the risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders had been mitigated • From April 2018, VTEs would not be declared as serious incidents unless they fulfilled the criteria of causing severe harm; this was in line with practice in other organisations • There was more work underway to strengthen the 72 hour call to patients prior to admission in an attempt to reduce instances when patients did not attend or coming in when they were not fit for surgery • The number of hospital cancellations on the day of surgery had reduced • A nursing workforce operational group had been set up and there a possibility that this would be widened to encompass other workforce modelling programmes as a subcommittee of the Staff Experience & OD Committee • The Committee supported the set of proposed Quality Priorities for 2018/19 • It was noted that the Safeguarding Committee was functioning effectively. • There had been positive progress with the estates works that had been needed to reduce risks around infections • There had been a reduction in sharps injuries • Significant work had been undertaken to strengthen the Division 2's risk register
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Arrange for the PALS details to be removed from all appointment letters as soon as possible • Additional narrative was needed around the Friends and Family Test information to provide some context to numbers and the nature of the feedback • Harm review update to be presented at the next meeting • An update on cancellations is to be considered at a future meeting

	• Widen the quality report to include additional non-nursing metrics and information • Arrange for the Bone Infection Unit to present to the Quality & Safety Committee • The infection control team's workplan is to be presented at the next meeting • Ensure that all patient information is directed through the Patient & Carers' forum • Arrange for an upward report from Division 1 to be presented at the next meeting
Decisions made	• None beyond those above

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

For the meeting of the Trust Board scheduled for 4 April 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	27 March 2018
Guests	Marie Peplow attended for Jo Williams Rebecca Lloyd, Head of Strategy
Presentations received and discussed	Perfecting Pathways
Major agenda items discussed	• Strategic planning update • Finance and performance overview including consultant performance by contribution • Spinal deformity performance – progress against the 52 week trajectory • Draft 2018/19 financial plan • Managed Service Contract for theatres
Matters presented for information, brief update or noting	• Finance & Performance entries on the Corporate Risk Register
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Expenditure had deteriorated which reflected some ongoing cost pressures associated with the reliance on medical locums. There was also some reliance on agency nurse staffing associated with the vacancies currently being carried by the Trust. • There was a degree of risk associated with recovering some of the aged debt • Length of stay associated with hip and knee procedures had increased and needed to be understood • During the month, 23 incidents had been raised around clinic delays over 60 minutes • It was highlighted that the biggest risks to the achievement of the RTT trajectory was access to capacity at Birmingham Children's Hospital; theatres staffing and surgeon capacity were also key risks • There remained outstanding agreement of a contract with one of the local Clinical Commissioning Groups
Positive assurances and highlights of note for the Board	• The development of the Outline Business Case for the Trust had been paused, pending the outcome of the work with local partners to agree the formation of new model of delivery. The Head of Strategy had been identified to lead the work on behalf of the ROH. • Income performance was reported to be close to plan and a small surplus had been achieved during February. This

	was noted to be particularly encouraging as this was the first time a surplus had been generated for several months. • The delivery of the CIP continued to accelerate, albeit not to the level in the original plan; nonetheless it was noted that 83% of the programme was delivering recurrent savings. • There continued to be a strong performance on day case activity. • The Committee found the additional information concerning service line and service costs by cost pool useful. The latter highlighted areas which incurred a higher proportion of costs associated with theatres which may impact on profitability. • The cash position was reported to be strong and was above plan. • In session theatre utilisation had increased as a result of more active recycling of theatre lists. • Overall length of stay had reduced and The Trust was more rigorously implementing initiatives to ensure a more speedy discharge, such as 'End Pyjama Paralysis' and 'Red to Green' • The performance against the 18 weeks RTT was at 81.05%, ahead of the trajectory submitted the NHS Improvement and there was an expectation that the target of 82% would be met for March • There had been a further reduction in the number of patients waiting over 52 weeks to 54 • The Committee received a positive update on the progress with 'Perfecting Pathways' • An Improvement event had been scheduled for 5-6 April 2018
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Present information about patient instigated cancellations at the next meeting • Develop a better understanding of the influences and trends associated with of theatre utilisation • Develop a means of displaying progress with the 'Perfecting Pathways' workstreams • The final capital plan to be presented to the Trust Board in May 2018
Decisions made	• Delegated authority to approve the final financial plan and budget for 2018/19 was to be sought for the Committee • The Committee supported a proposal to develop a full business case for a managed theatres contract

Tim Pile

VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 4 April 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	7 March 2018
Guests	None
Major agenda items discussed	• Workforce performance report • Draft Health Education England workforce strategy • Apprenticeship strategy • Gender pay gap • Workforce risks
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• There had been an increase in the use of agency staff associated with the continued reliance on medical locum staff • The Trust was reported to lose a high number of staff within the first two years of employment, although the reasons for this were not clear at present. • It was noted that short term persistent absence needed to be tackled. • The quality of appraisals at the ROH was suggested to need improvement and the system would need to be overhauled. This was a key theme from the recent staff survey results. • Mandatory training in VTE and insulin management was poor • The Committee was advised that there was a gender pay gap, which reflected the gender bias of the consultant body; it was also impacted by the clinical excellence awards received by the consultants. As a point of clarity, it was highlighted that there was no inequality in payments made between different sexes in the same profession.
Positive assurances and highlights of note for the Board	• Work was planned to review and revise the medical and nurse staffing models, including the possibility of using a rotational arrangement with local organisations. This work may prompt the introduction of new roles. • A new online exit interview tool had been introduced. It was suggested that the use of a manager other than the individual's line manager could be offered to conduct the exit interview, including the Freedom to Speak Up Guardian • There had been a small improvement in the rolling 12 month average for sickness absence • The Occupational Health arrangements were being reviewed and immediate support to staff taking sickness absence was being investigated. • Succession planning work would start shortly.

	• There had been an improvement in the Mandatory Training rates for resuscitation training • The Committee was advised that Health Education England has released a workforce strategy for consultation and members were asked for their views
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Present a report on staff engagement at a future meeting • Present the people metrics at the next meeting • Undertake benchmarking as part of the development of the people metrics • Present the updated Workforce Race Equality Standards information at the next meeting • Include medical workforce model as a separate item on the agenda of a future meeting • Arrange for the Freedom to Speak Up Guardian to present to the Committee quarterly • Arrange for an apprentice to present their experience to the Trust Board • Present a revised gender pay gap report which excluded consultants at the next meeting • The terms of reference for the People Committee is to be presented at the next meeting
Decisions made	• The Committee received an apprenticeship strategy which it supported

Simone Jordan on behalf of Richard Phillips
ASSOCIATE NON EXECUTIVE DIRECTOR

For the meeting of the Trust Board scheduled 4 April 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 2 May 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 2 May 2018 commencing at **1030h** 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** 2 May 2018: 1030h – 1215h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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 Paul Athey	Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Prof Philip Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1030h	1	Service Improvement story: ePMA	Presentation	
1050h	2	Apologies - Richard Phillips	Verbal	Chair
1052h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1055h	4	Minutes of Public Board Meeting held on the 4 April 2018: *for approval*	ROHTB (4/18) 010	Chair
1100h	5	Trust Board action points: *for assurance*	ROHTB (4/18) 010 (a)	SGL
1105h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (5/18) 001 ROHTB (5/18) 001 (a)	YB/PA
		STRATEGY		
1115h	7	Paediatric services update	Verbal	AP/PA
1120h	8	Orthopaedic services in the STP	Verbal	PA

QUALITY & PATIENT SAFETY				
1125h	9	Patient Safety & Quality report: *for assurance*	ROHTB (5/18) 002	GM
FINANCE AND PERFORMANCE				
1135h	10	Finance & Performance overview: *for assurance*	ROHTB (5/18) 003	SW
1145h	11	Perfecting Pathways update: *for assurance*	Presentation	JW
COMPLIANCE AND CORPORATE GOVERNANCE				
1155h	12	Board Assurance Framework: *for assurance*	ROHTB (5/18) 005 ROHTB (5/18) 005 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1205h	13	Quality & Safety Committee and revised terms of reference: *for assurance*	ROHTB (5/18) 006 ROHTB (5/18) 006 (a)	KS
	14	Finance & Performance Committee: *for assurance*	ROHTB (5/18) 007	TP
	15	Staff Experience & OD Committee and summary of the NHS Contract refresh: *for assurance*	ROHTB (5/18) 008	SJ
	16	Audit Committee: *for assurance*	ROHTB (5/18) 009	RA
MATTERS FOR INFORMATION				
1215h	17	Any Other Business	Verbal	ALL
Date of next meeting: Friday 25th May 2018 at 1200h in the Boardroom, Trust Headquarters				

Notes

Quorum

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

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

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

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 4 April 2018: 1100h – 1315h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mrs Jo Williams	Interim Chief Operating Officer	(JW)
Prof Philip Begg	Executive Director of Strategy and Delivery	(GM)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Alex Gilder	Deputy Director of Finance	(AG)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Service Improvement story: Rapid Recovery	**Presentation**
Alicia Stanton, Senior Physiotherapist, Mr Matthew Revell, Associate Medical Director and Patrick Thies, Physician Associate, were welcomed to the Trust Board meeting. They delivered a presentation about Rapid Recovery which would be delivered to the Health Service Journal panel on 6 April 2018 as part of an award shortlisting process. The team was asked how vulnerable patients were treated as part of this pathway. They advised that although it was the intention for Rapid Recovery to become the norm, there remained a robust assessment process, so any vulnerable patients, such as the elderly who did not have support at home, would not be discharged with such rapidity. It was reported that there was a range of patients from simple to more complex where the length of their stay was reduced as a result of the new pathway by	

approximately a day. The surgery was noted to be the same but the pre-operative processes and post-operative care was different to those undergoing the traditional joint replacement pathway. For instance, there was improved patient education and a therapy workshop was undertaken prior to surgery. Expectations were better clarified prior to surgery and then post operatively, physiotherapy would begin on the day of surgery. Patient flow through diagnostics and post operative processes was also more efficient. There was more consistency to the support for the approach from the surgeons across the Trust.

The impact of the pathway on staff was discussed. It was noted that this had been driven from the top previously but the Rapid Recovery model was more reliant on staff engagement from all disciplines involved in the care and treatment.

The team was asked if there was any comparable patient feedback from patients that had not gone through the Rapid Recovery process. They advised that there was no comparable patient feedback on the same cohort of patients but overall the satisfaction levels were above those arising from the Trust's Friends and Family Test. There was also a sense that the patient was now a central part of the process; this was a change from the previous process which was hospital driven. Anaesthetist 'buy in' was improving.

A number of suggestions were made that in the Board's view could be made to improve the presentation, which included:

- Include a single slide which comprehensively to highlight the issue needing solving, the solution delivered, the benefits and the impact.
- The differences between Rapid Recovery and Enhanced Recovery needed to be outlined.
- The financial impact, particularly as a result of bed days saved needed to be included.
- How patients had been engaged in the redesign of the pathway should be mentioned, particularly associated with the development of the patient information which was agreed to be impressive.
- Include a mention of the ability to upscale Rapid Recovery outside of the ROH by offering opportunities to other regional centres.
- The fact that there was a cohort of people turned round in 24 hours should be included in the presentation.
- The numbers of patients included in the pilot should be reflected.
- The pivot between the pilot and the mainstream offering needed to be

clarified. The team were congratulated for their work and wished well for the presentation.	
2 Apologies	**Verbal**
Apologies were received from Mr Steve Washbourne and Dr Sarah Marwick.	
3 Declarations of interest	**Verbal**
There were no declarations made in connection with any item on the agenda.	
4 Minutes of Public Board Meeting held on 4 April 2018: *for approval*	**ROHTB (3/18) 015**
The minutes of the last public Board meeting were agreed as a true and accurate reflection of discussions held.	
5 Trust Board action points: *for assurance*	**ROHTB (3/18) 015 (a)**
The Associate Director of Governance/Company Secretary advised that there were no matters that required escalation.	
6 Chairman's & Chief Executive's update: *for information and assurance*	**ROHTB (4/18) 001** **ROHTB (4/18) 001 (a)**
The Board considered the Acting Chief Executive's written report. He highlighted that the Trust had been shortlisted for a Health Service Journal (HSJ) award for the Trust's daily MDT in Oncology and also for Rapid Recovery. The Board's attention was drawn to the Continuous Improvement event that was planned for 5 and 6 April. This was deliberately timed to coincide with the theatre shut down so clinical staff could attend. It was hoped that many of the junior doctors would attend the sessions. This was the first time that an event on this scale had been arranged, although it was noted that the quality conference held in November 2017 had been a test bed. The communications and branding of the event was particularly praised. The Chairman advised that it had been a fairly quiet time with the Easter holidays and the departure of the CQC. She had held a Council of Governors briefing session on 13 March, where the governors were updated with the strategic developments across the region and the latest finance & performance position. There had been a meeting with Dame Julie Moore on 14 March for further discussion on the way in which the ROH played into the STP and the Birmingham Hospitals plans. It was noted that the governors would come together in a forum across the areas and a similar arrangement would be organised for Non Executives. The Chairman had visited Ward 11 paediatric outpatients on 21 March.	

It was noted that all data requests for the CQC had been satisfied. Given the burden of servicing the data requests, it was suggested that the experience needed to be communicated back to NHS Improvement. It was noted however that the request were clearly designed to triangulate the findings of the inspectors. Thanks were expressed for the work undertaken and it was noted that the pace of the response was better than in previous years.	
7 Paediatric services update	**Verbal**
The Acting Chief executive reported the ROH continued to work with the system to arrange a smooth transition of Paediatric services. Birmingham Women's and Children's NHS FT (BWCH) had been considering the business case recently. Some enhanced medical cover had been arranged. A discussion had been held with the Clinical Director for Paediatrics from Heart of England NHSFT (HEFT) and it had been agreed that a combined rota for four hour cover would be developed. It was noted that the Children's Board would keep the issue under review and debate the cover when agreed. In terms of Paediatric nursing, Ward 11 continued to operate to adequate staffing levels. The staffing on the High Dependency Unit (HDU) continued to be a concern however. Some long standing temporary nurses had been booked who had been rigorously inducted. A suite of mitigations were in place in case the staffing numbers dropped below the level required and patients were cancelled if safety was compromised. Meetings with Specialised Commissioners were underway. There was an expectation that a plan needed to be put into place and this would be circulated to the stakeholder group. Overall, it was highlighted that there were at present no safety issues and any incidents were considered at Children's Board. Staff were noted to be retaining a good standard of care and compassion despite the uncertainty. Another formal round of communications for staff and patients would be arranged.	
8 Orthopaedic Services in the STP: *for information*	**Verbal**
The Executive Medical Director reported that there had not been significant progress on developing the plans for orthopaedics within the STP, but work continued on orthopaedic redesign and a productive discussion had been held with HEFT and University Hospital Birmingham NHS FT (UHB) around formalising an alliance. Terms of reference for this arrangement were being developed. A functional restoration programme was being run from within the community and	

a further roll out was planned. A therapy strategy would be developed in due course which would reach out into the STP. It was noted that there was a national skills shortage and for physiotherapists this was a challenge. One of the advantages that the ROH had was that the specialist nature of the Trust proved attractive. The training and education was being considered for this group of staff. The rotation at Band 6 level was noted to be a particular attractive role. There was also significant pull for Extended Scope Practitioner (ESP) support from medical staff; this was a new and welcomed approach. This would help with recruitment issues. On discussion with Dame Julie Moore, it was understood that there was a development opportunity to use and train staff between hospitals in the region. It was suggested that this would link into a talent management plan for the region. This may be facilitated through a staff passport. It was noted that the Directors of Nursing posts were vacant in some organisations in the region which had prevented some degree of inter hospital discussion.	
9 Progress against the Five Year Vision: *for assurance*	**ROHTB (4/18) 002** **ROHTB (4/18) 002 (a)**
The first cut of the progress against the strategic goals in the Five Year Vision was presented by the Executive Director of Strategy & Delivery. Progress was against the priorities for 2018/19 and those for future years would be considered in a next version. It was agreed to be a helpful snapshot and appeared to be a realistic assessment of progress. In terms of theatres capacity, there was a piece of work underway to maintain current theatre stock and to add on an additional two modular theatres. The plans for this would come to Board in June. Rapid recovery would assist with driving up activity. It was suggested that exceptional staff experience would be useful to build into the report. After some debate, it was agreed that the ambition for the CQC rating should remain as being 'Outstanding' as even at this level there was room for further improvement in some areas. In terms of how the clinical staff stretched themselves towards excellence, it was suggested that there needed to be enhanced visibility of this. Learning from areas where there was good practice was also needed. The clinical teams were presenting at divisional performance reviews but the Executive Medical Director was asked to consider how the Board could be made aware of this work. It was reported that GP events were being organised to build relationships and promote services that were of benefit. It was agreed that the marketing plan	

needed to be considered in future, which identified which patients should be targeted. It was noted that the improved RTT position was helpful in this respect. It was agreed that the progress summary should be presented quarterly.	
ACTION: **JWI to present the plans for modular theatre in June 2018** **ACTION:** **PB to build exceptional staff experience into the strategic goals progress report** **ACTION:** **AP to consider how the Board could be made aware of how clinical staff stretched themselves towards excellence** **ACTION:** **PB to present the marketing plan to the Board**	
10 Patient Safety and Quality Report: *for assurance*	**ROHTB (4/18) 003**
It was reported that there had been an increase in incidents reported, this being positive as it linked to a better reporting culture. There were a higher level of incidents associated with transport and discussions were underway with West Midlands Ambulance Service to resolve the issue. The Board was made aware that this was a CCG commissioned service; not an internal service provision. The patient fall on Ward 12 and the subsequent death was undergoing the mortality process. There had been two changes to the Never Event Framework and internal work was underway to ensure that the new Never Events could not occur at the ROH. There had been three Serious Incidents, including a pressure ulcer. From a VTE point of view, there had been two. There was now a change to the reporting, where not all VTEs would be reported as a Serious Incident; only those that fulfilled the Serious Incident criteria (moderate harm or above) would be reported centrally in future. In terms of learning from Serious Incidents, this detail was provided in the report. In the area of the Trust which had experienced incidents, the lessons learned were communicated better. The Freedom to Speak Up Guardian was also used to test the understanding of learning in the areas where incidents had occurred. The improved position was agreed to be a big difference to previous years. It was suggested that the recommendation associated with the hydration of patients prior to surgery needed to be realistic and pragmatic. There were three Grade 2 pressure ulcers and work was being undertaken to triangulate these with staffing vacancies. The Quality & Safety Committee had asked for the assessment as to whether these were avoidable and unavoidable be undertaken in a more timely way.	

In terms of Friends and Family Test, there needed to be additional and new information to provide context to ensure that the information was discussed appropriately. The statutory areas of reporting also needed to be clarified in the report. The high number of compliments was noted. It was highlighted that there was variation in what constituted a compliment and the practice for capturing these. In the operational performance data, there had been discussions around the discharge times of patients and the new Head of Nursing would refresh and relaunch the 'Red to Green' and 'End Pyjama Paralysis' projects. The 'Did Not Attend' rate for follows up appointments had been discussed and the value in these in all cases was being considered. It was noted that the quality report would be expanded to include additional indicators in future.	
11 Quality Priorities 2018/19: *for approval*	**ROHTB (4/18) 004** **ROHTB (4/18) 004 (a)**
The progress with the achievement of the quality indicators for 2017/18 was reviewed which had been taken to a number of fora for discussion. Three of the existing ones would be closed and the remaining would be rolled over. The only new priority was the rescheduling of patient clinics. It was noted that there would be an upper limit to the number of times an indicator was rolled over in future. Key Performance Indicators would be defined for each to allow better scrutiny at the Quality & Safety Committee. In terms of consent on the day of surgery, there remained a suite of audit actions that needed to be closed down. It was noted that although there was improvement there was further work to do informed by clinical staff in the Trust. It was suggested that a different way of seeing progress was needed in the Quality Report. The messaging to the organisation needed to be considered.	
ACTION: GM to include progress with the Quality indicators in the Trust's Quality Report	
12 Finance & Performance overview: *for assurance*	**ROHTB (4/18) 005**
The Deputy Director of Finance reported that a small surplus had been generated in the month. From a Cost Improvement perspective, the gap was being closed. 83% of the schemes were noted to be recurrent, which was agreed to be a positive position. The Board noted that there were new slides including the balance sheet and the	

Income and Expenditure position were highlighted. The performance against the 18 weeks RTT target stood at 81.05%. In terms of patients waiting over 52 weeks, there were now 56, none of which related to specialities other than spinal deformity. Three patients had been transferred over to Stoke. The cancer target had been met and the diagnostic target was at 99%. It was noted that the Chair of Finance & Performance Committee was keen to understand why patients were cancelling their appointments and this would be considered at a future meeting. The Board agreed that the financial and operational performance was excellent progress overall. There was no complacency but there was a sense of optimism. The in-session utilisation position was questioned. It was reported that as theatre utilisation was improved and activity was flat then this impacted on in-session theatre utilisation. The existing theatres were old and this also impacted the decision to secure two new theatres. To expand the service it was highlighted that the Trust would need to move into other theatres. All beds had been used recently. It was suggested that the extension of the session time might allow an additional operation to be completed. It was suggested that this was a good opportunity in the new financial year to manage the activity and change processes. The workforce model to support the theatres was to be developed through the Executive Director of Patient Services and Interim Chief Operating Officer. This was the single biggest risk to the achievement of the Trust's overarching strategy. Thanks were given from the Board for all who had contributed to the improvements.	
13 Corporate Risk Register: *for assurance*	**ROHTB (4/18) 006** **ROHTB (4/18) 006 (a)**
The Associate Director of Governance/Company Secretary presented an overview of the Corporate Risk Register and suggested that the Board should see this on a quarterly basis. It was agreed that the risk register was unwieldy as it stood and the Executive needed to overhaul it to remove duplicate risks and capture new ones. It was agreed that there should be a Board discussion around this over the summer.	
ACTION: SGL to arrange a risk session for the Board	
14 Quality & Safety Committee assurance report: *for assurance*	**ROHTB (4/18) 007**
The Board received and noted the Quality & Safety assurance update.	
15 Finance & Performance Committee assurance report: *for assurance*	**ROHTB (4/18) 008**
The Board received and noted the Finance & Performance assurance update.	

16 Staff Experience & OD Committee: *for assurance*	**ROHTB (4/18) 009**
Ms Jordan reported that good progress had been made with the development of the workforce dashboard and there was greater visibility of the data. There was good triangulation. Talent management and succession plans needed to be worked through. The retention and recruitment agenda was noted to be important.	
17 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 2 May 2018 at 1100h, Boardroom, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 2 May 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 27.04.2018

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee	SGL	18-Jul-18	To be scheduled in for when the clinical audit internal audit has been completed	
ROHTBACT. 050	Chairman's & Chief Executive's update	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	07/03/2018	Arrange for a meeting to be arranged with local MPs, the Chairman and Chief Executive	SGL	31-May-18	To be arranged after the purdah period which end in early May 2018	
ROHTBACT. 051	'Perfective Pathways' update	Verbal	07/03/2018	Present an overview of the visit to the South West London Elective Orthopaedics Centre at the May meeting	JWI	02-May-18	Included on the private agenda of the May 2018 meeting	
ROHTBACT. 052	Board Assurance Framework	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	07/03/2018	Arrange a risk workshop	SGL	31-Jul-18	ACTION NOT YET DUE	
ROHTBACT. 053	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Present the plans for modular theatre in June 2018	JWI	06-Jun-18	ACTION NOT YET DUE	
ROHTBACT. 054	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Build exceptional staff experience into the strategic goals progress report	PB	04-Jul-18	ACTION NOT YET DUE	
ROHTBACT. 055	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Consider how the Board could be made aware of how clinical staff stretched themselves towards excellence	AP	06-Jun-18	ACTION NOT YET DUE	
ROHTBACT. 056	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Present the marketing plan to the Board	PB	04-Jul-18	ACTION NOT YET DUE	
ROHTBACT. 057	Quality Priorities 2018/19	ROHTB (4/18) 004 ROHTB (4/18) 004 (a)	04/04/2018	Include progress with the Quality indicators in the Trust's Quality Report	GM	04-Jul-18	Reported on quarterly, so Q1 update in July. ACTION NOT YET DUE	
ROHTBACT. 048	Assurance report from the Quality & Safety Committee	ROHTB (1/18) 009	10/01/2018	Review the quality assurance walkabouts methodology	GM	31-Mar-18	Quality assurance walkabouts teams have been widened to include members of the Council of Governors. They retain the focus on the five domains of the CQC framework. The outputs are considered by the Quality & Safety Committee and by the Executive Team.	

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:	**2 May 2018**

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 2nd May 2018

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 public Trust Board meeting on 4th April 2018

2 STAKEHOLDER OVERSIGHT & NHSI LICENSE

2.1 We have received confirmation that the monthly stakeholder oversight meeting, originally introduced by NHSI/NHSE to oversee the delivery of our RTT improvement work and more latterly used to ensure the appropriate management of risk during the transition of paediatric services, will be stood down from May 2018.

2.2 Oversight from regulators and commissioners will now be managed through the usual performance routes. The current system-wide commissioning board for paediatrics will be developed into a transitional oversight board, which will be provider-led but will enable some continued oversight from other stakeholders.

2.3 The executive team have started conversations with NHSI around the process of removing our current breach of licence with regards to RTT delivery and governance. Assuming continued delivery of our RTT trajectory, we will be working jointly with NHSI over the next couple of months to provide the evidence required to remove this breach.

2.4 It is likely that the element of our breach of licence relating to financial sustainability will remain whilst work continues to look at wider plans for orthopaedic provision across Birmingham and Solihull and, as such, will be reviewed later in the financial year.

3 STP UPDATE

3.1 The STP Board met on 9th April and considered the draft strategy that had previously been shared with ROH Board members. All parties were given the opportunity to

provide feedback which enabled us to highlight points raised by ROH Board members around STP-wide workforce opportunities and the importance of NED and Governor input into the delivery of the strategy.

3.2 There was agreed support from all parties for the overarching principles within the strategy which was approved in principle subject to some work from the strategy directors to build in the feedback given at the STP Board.

4 BACK TO THE FLOOR

4.1 I will be spending the day in Imaging on Monday 30th April and will report back verbally to the Board.

5 CONTINUOUS IMPROVEMENT FOCUS

5.1 On 5th & 6th April 2018, the Trust held a Continuous Improvement Focus across the Trust, incorporating a combination of interactive presentations, taster sessions and workshops.

5.2 We received positive feedback from a number of staff who attended the event, who felt that the range and quality of subjects and speakers was excellent. Sessions run by Suzanne Cleary, Director of Transformation at BWCH, and Helen Bevan, Chief Transformation Officer at NHS Horizons, were particularly well received.

5.3 A significant number of improvement ideas were recorded by staff over the two days and the transformation team are currently working through these to review how these can be built in to our improvement plans.

5.4 In order to retain the focus on improvement and the recognition of improvement success, we are planning to set up an improvement area by Café Royale to showcase the work that is ongoing across the Trust. More information on this will be provided at a future meeting. Consideration is also being given to a follow-up event in September 2018.

6 MEDIA INTEREST

6.1 A number of media outlets ran a story last week about an amazing girl called Amelia Eldred who was diagnosed with bone cancer in her left leg and was operated on at the ROH.

6.2 Professor Lee Jeys performed a rare procedure called rotationplasty to reattach the lower part of the leg backwards to allow the ankle joint to work as a knee joint.

6.3 In addition to the traditional media interest, the Trust received a significant amount of positive social media exposure around the story and it was heart-warming to see the incredible way that Amelia responded to the challenges in front of her. It provided a great reminder of the impact that our amazing staff can have on improving the lives of our patients.

7 POLICY APPROVAL

No new trustwide policies have been approved since the last Board meeting.

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
Acting CEO

27 April 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (5/18) 002

QUALITY REPORT

April 2018

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 the 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 to satisfy contractual information requirements and the CQC for routine engagement visits.

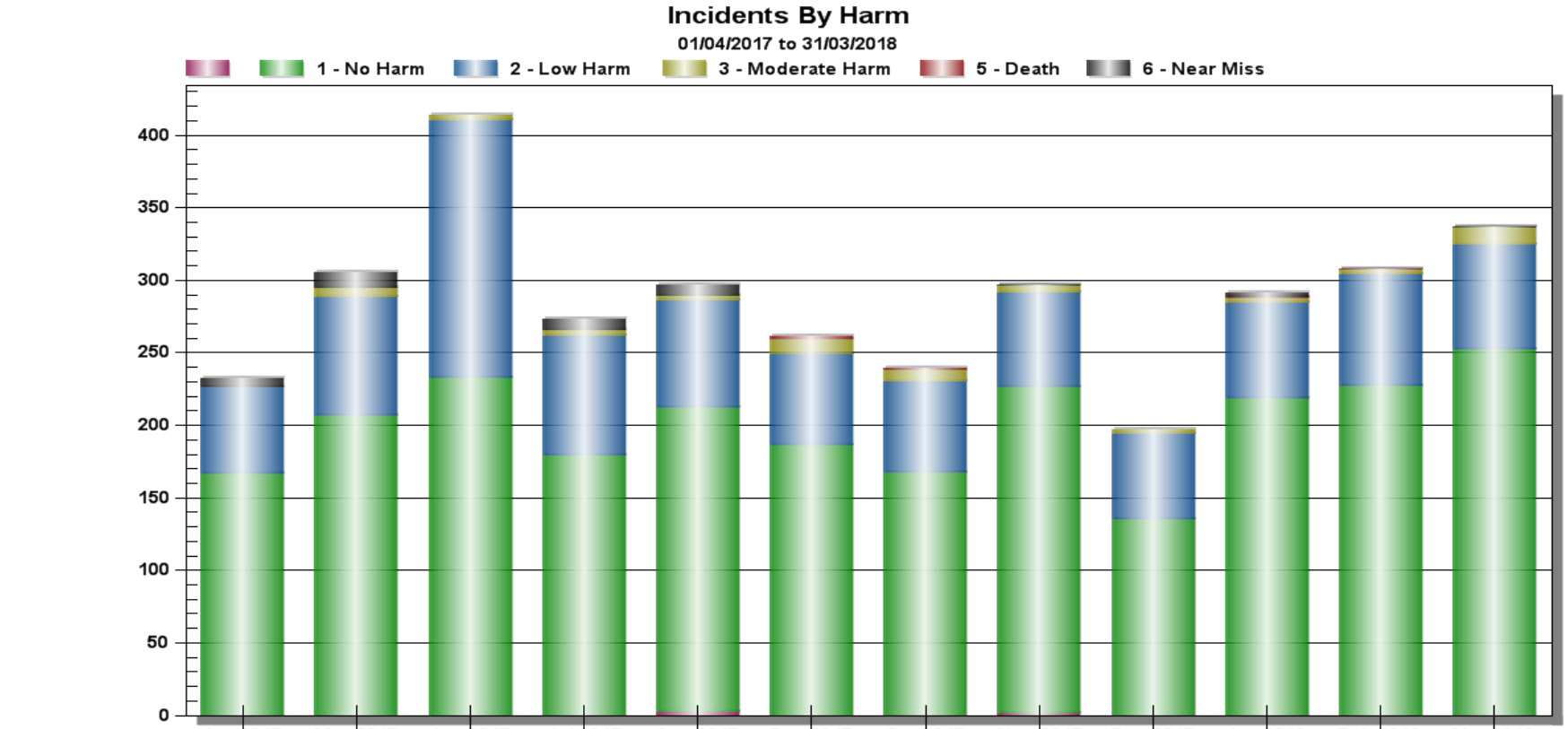
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
	0	0	0	0	2	0	0	1	0	0	0	0
1 - No Harm	166	206	232	179	210	186	167	225	135	218	227	252
2 - Low Harm	60	82	178	82	74	63	63	65	59	66	77	72
3 - Moderate Harm	0	6	4	4	3	10	8	5	3	3	3	12
5 - Death	0	0	0	0	0	2	1	0	0	1	1	0
6 - Near Miss	6	11	0	8	8	0	0	1	0	3	0	1

INFORMATION

In March 2018 there were a total of 337 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

252 – No Harm
72 – Low Harm
11 Moderate Harms (1 duplicate incident)
0 – Severe Harm
1 – Near Miss
0 – Death

The 11 Moderate Harms + Near Miss were;

Site	Incident Number	Cause Group
ROCS	23477	VTE
Patients Home	23408	VTE – Ward 12
Ward 3	23450	VTE – Ward 3
Theatres	23465	Medical Device, Equipment – Near Miss
HDU	23624	Emergency Transfers

Outpatients	23631	Information Governance
Trust Wide	23647	VTE – Ward 3
Wards	23663	Infection Control
Wards	23677	Infection Control
Theatres	23678	Pressure Ulcers
Wards	23704	Infection Control
Wards	23712	Infection Control

ACTIONS FOR IMPROVEMENTS / LEARNING

The Governance team have a number of improvements highlighted planned;

- The review process for allocation of RCAs to ensure this supports timely completion of RCAs to establish if any further changes are required in response to the findings of this report
- Review training needs of investigators and establish a rolling training programme Governance to review sign off process for completed RCA's to establish if any further changes are required in response to this report.
- Review Current RCA template and measure against the national standard
- The Creation of an RCA guide to support the RCA process
- New Duty of candour process map added to policy form recommendations of the audit committee
- New Serious Incident Policy to include 'Just culture.'

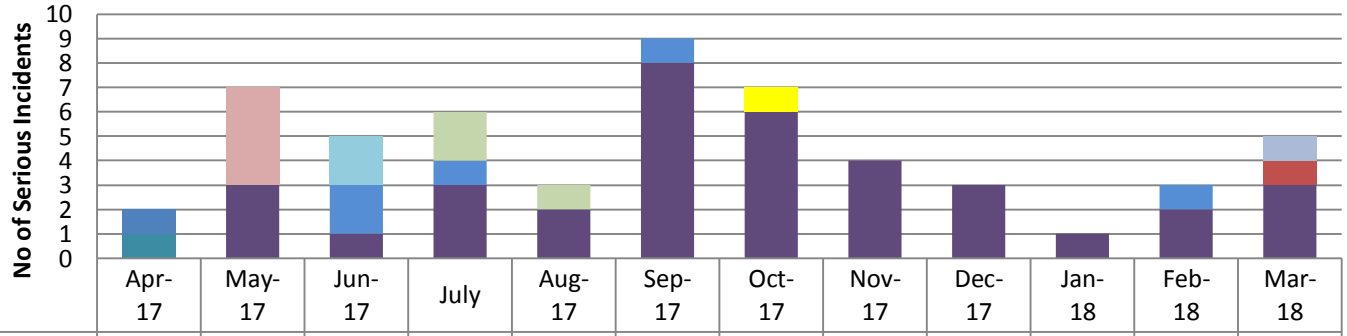
The NRLS have released the latest data for patient safety incidents. The data show the total number of incidents occurring during a six month period. These are broken down by the degree of harm, incident type and care setting of occurrence.

The ROH uploaded 614 Patient safety incidents to the NRLS in the dates of March 2017 – September 2017 at a rate of 45.38 per 1000 bed days. This is Compared to Robert Jones and Agnes Hunt at 32.23 per 1000 bed days and The Royal National Orthopaedic Trust at 31.76 per 1000 bed days.

RISKS / ISSUES
An ongoing Ulysses improvement action plan is in progress. This was an agenda item in January 2018 on Quality and Safety.

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 2018



	Apr-17	May-17	Jun-17	July	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Unexpected Injury				2	1							
RTT Harm review		4										
Information Governance Missing Laptop												1
Exposure to hazardous substance												
Retained object							1					
Wrong Implant												
Suspension to services												
RTT Data Issue	1											
Wrong side injection			2									
Suspension of Service (BCH Spinal)	1											
Slips, trips & falls												1
Pressure Ulcers			2	1		1					1	
VTE meeting SI criteria		3	1	3	2	8	6	4	3	1	2	3

INFORMATION

There were 5 **Serious Incidents Declared in March 2018;**

23408 – VTE
23450 – VTE
23647 - VTE
23631 – Information Governance Missing laptop

The following incident was reported in last month's quality report and declared as a Serious incident in March 2018

23197/23279 – Patient fall – Ward 12

ACTIONS FOR IMPROVEMENTS / LEARNING

1 avoidable VTE Serious incident was closed by the CCG in March 2018.

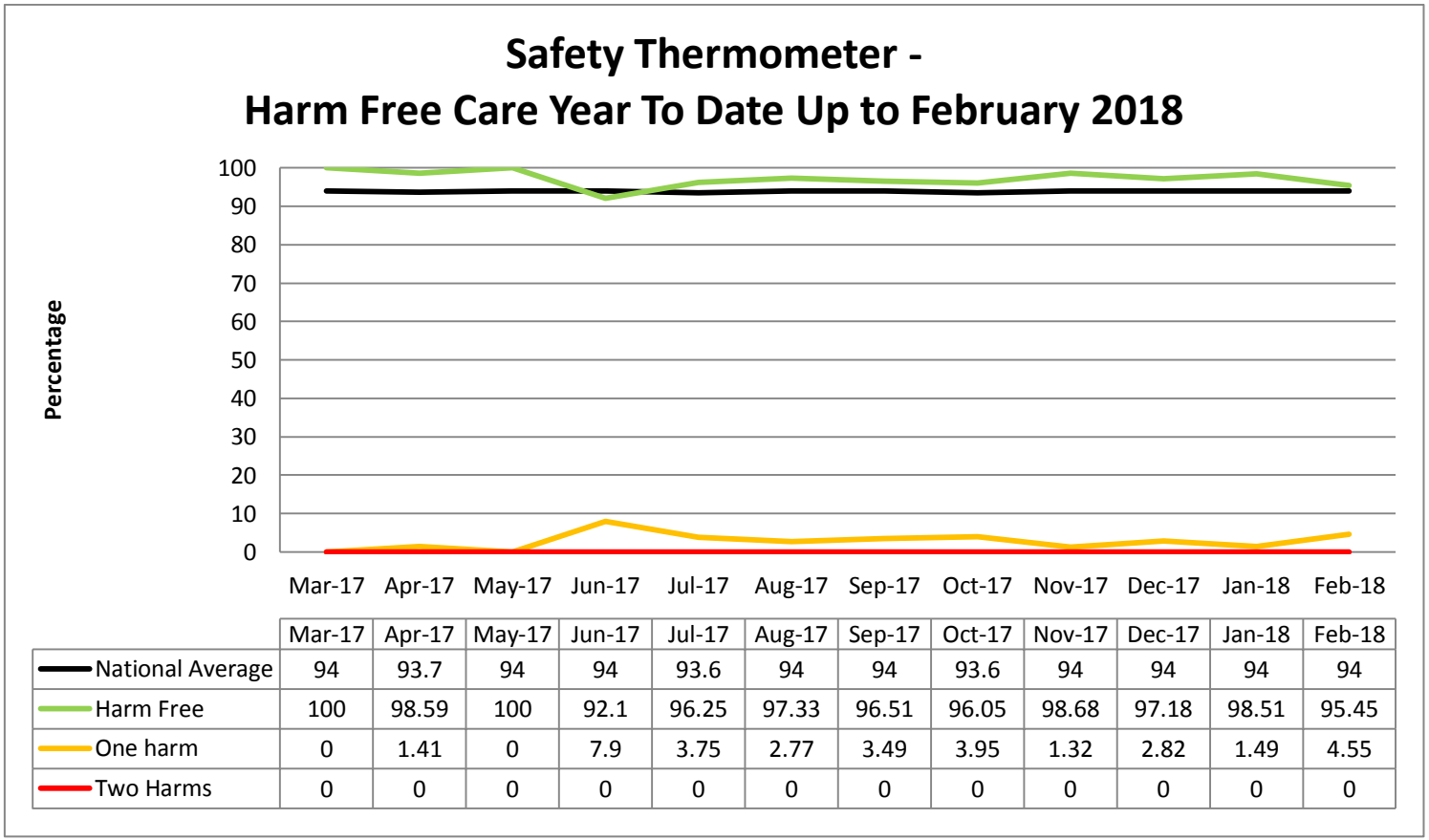
22324 – Avoidable VTE

Learning

To ensure ROH VTE prevention guidelines are followed; To ensure VTE risk assessment is updated on admission and 24 hours post surgery. To ensure mechanical and pharmacological prophylaxis is prescribed on the risk assessment and on the prescription chart. To ensure any deviations from Trust guidelines are clearly documented and signed by the prescriber. To ensure that start dates of prescriptions are accurate and if not dated by original prescriber are signed by the second prescriber. To ensure prescription of enoxaparin is clear at what time the first postoperative dose should be given and if not to be given to be documented in the medical notes by the surgeon or the anaesthetist.

RISKS / ISSUES
None.

4. **NHS Safety Thermometer - provides a 'temperature check' on the 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.**



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
National Average	94	93.7	94	94	93.6	94	94	93.6	94	94	94	94
Harm Free	100	98.59	100	92.1	96.25	97.33	96.51	96.05	98.68	97.18	98.51	95.45
One harm	0	1.41	0	7.9	3.75	2.77	3.49	3.95	1.32	2.82	1.49	4.55
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

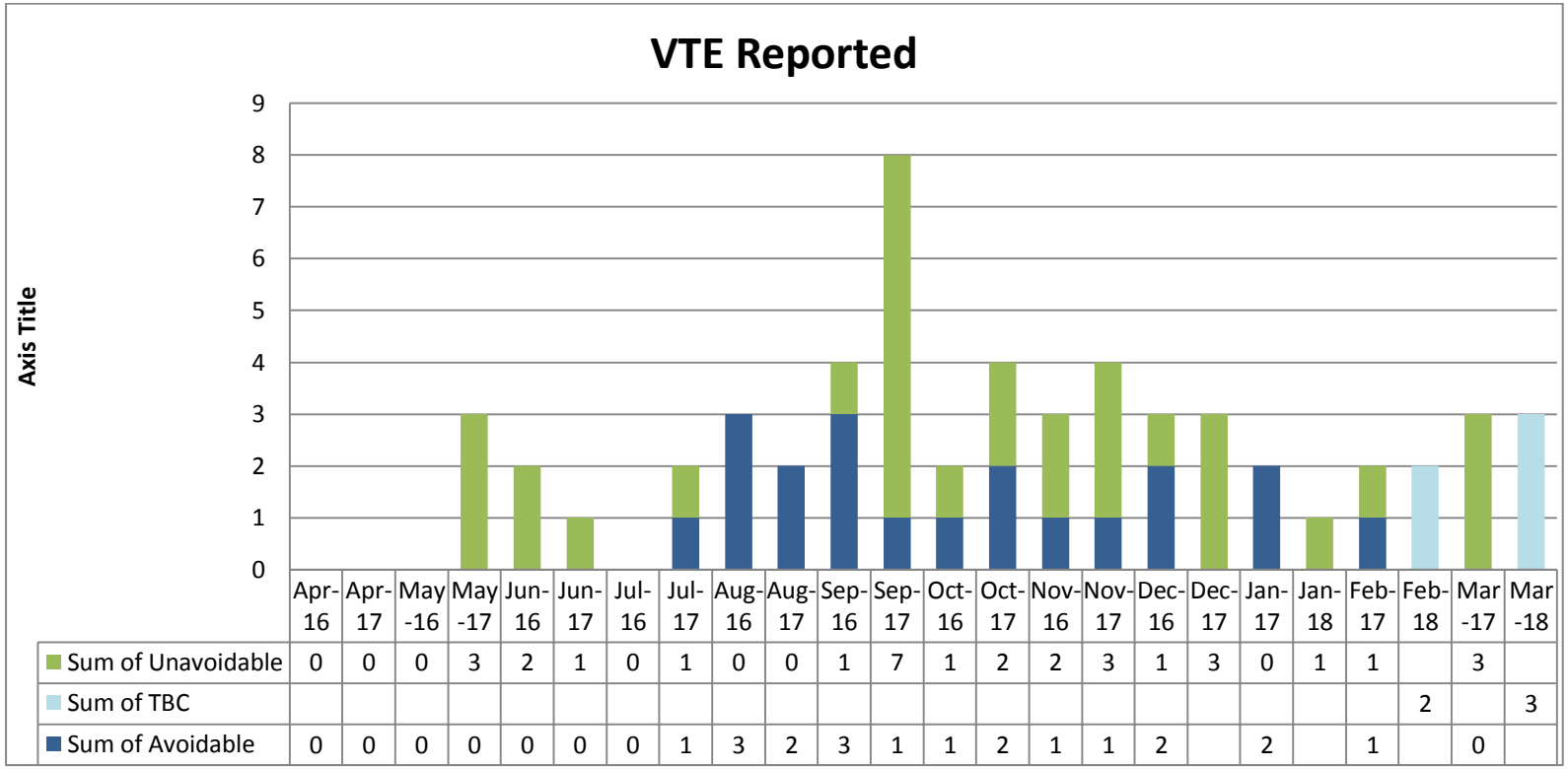
Due to a national issue, March 2018 data is not yet available.

5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in March 2018 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
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
Oct-17	67	9	0	1	77	232	9571
Nov-17	64	7	0	0	71	295	9752
Dec-17	60	3	0	0	63	194	7285
Jan-18	64	3	1	0	68	290	9705
Feb-18	77	3	0	1	81	307	8479
Mar-18	72	12	0	0	84	337	9064

In March 2018, there were a total of 9064 patient contacts. There were 337 incidents reported which is 3.7 percent of the total patient contacts resulting in an incident. Of those 337 reported incidents, 84 incidents resulted in harm which is 0.92 percent of the total patient contact.

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 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	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0	1	7	1	2	2	3	1	3	0	1	1		3	
Sum of TBC																						2		3
Sum of Avoidable	0	0	0	0	0	0	0	1	3	2	3	1	1	2	1	1	2		2		1		0	

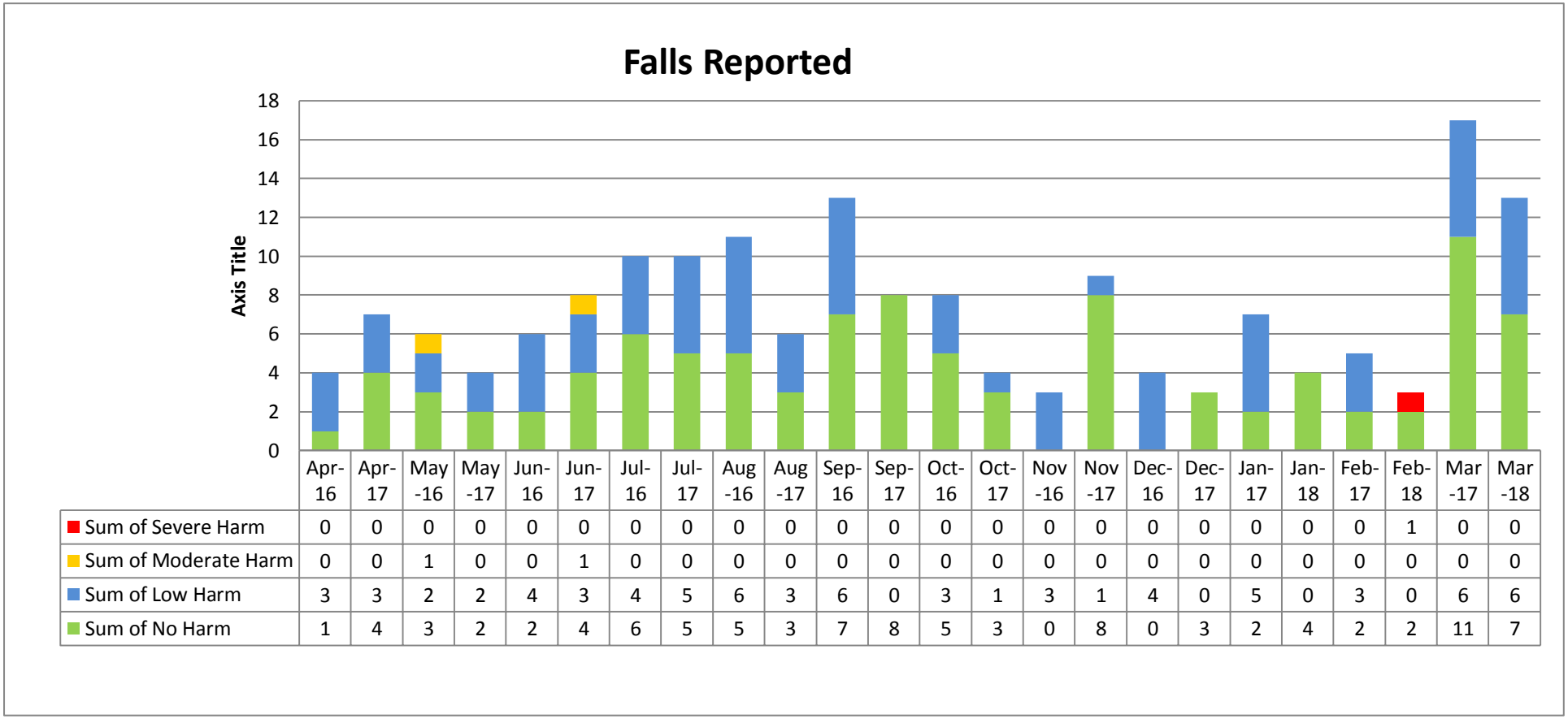
13

total		Avoidable
16/17	27	13
17/18	33	7*

***not classified**

INFORMATION
There were 3 VTEs declared in March 2018 - Detailed on page 5. 1 Incident reported in awaiting confirmation.
ACTIONS FOR IMPROVEMENTS / LEARNING
VTE incidents no longer have to be reported to CCG as Serious Incidents (unless they meet the specific criteria for such), however, internal RCAs will continue to enable identification of any learning and monitoring of avoidable VTE's. ROH will be assessed for compliance with the VTE exemplar site criteria on 23rd May 2018. Award of VTE Exemplar Site status would demonstrate that it is recognised the Trust have policies, processes and training in place to reduce the risk of VTE for or patients. Updated NICE guidance on Venous Thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism was produced in March 2018. There have been a number of changes within it which are currently under review by the VTE Leads and will be discussed at the next VTE Advisory Group meeting on 2nd May 2018.
RISKS / ISSUES
None

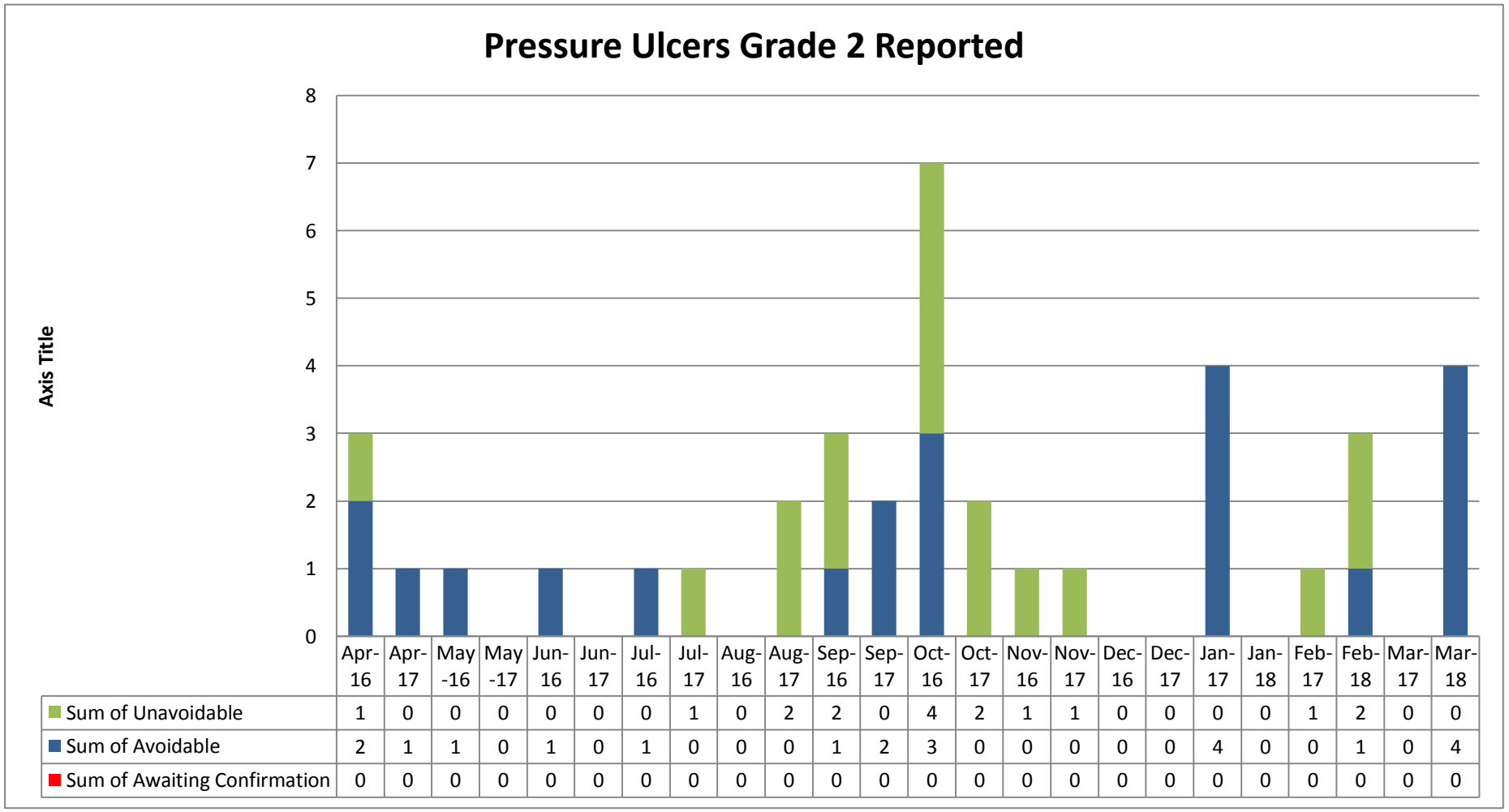
7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.



	Apr-16	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Sum of Moderate Harm	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3	6	0	3	1	3	1	4	0	5	0	3	0	6	6
Sum of No Harm	1	4	3	2	2	4	6	5	5	3	7	8	5	3	0	8	0	3	2	4	2	2	11	7

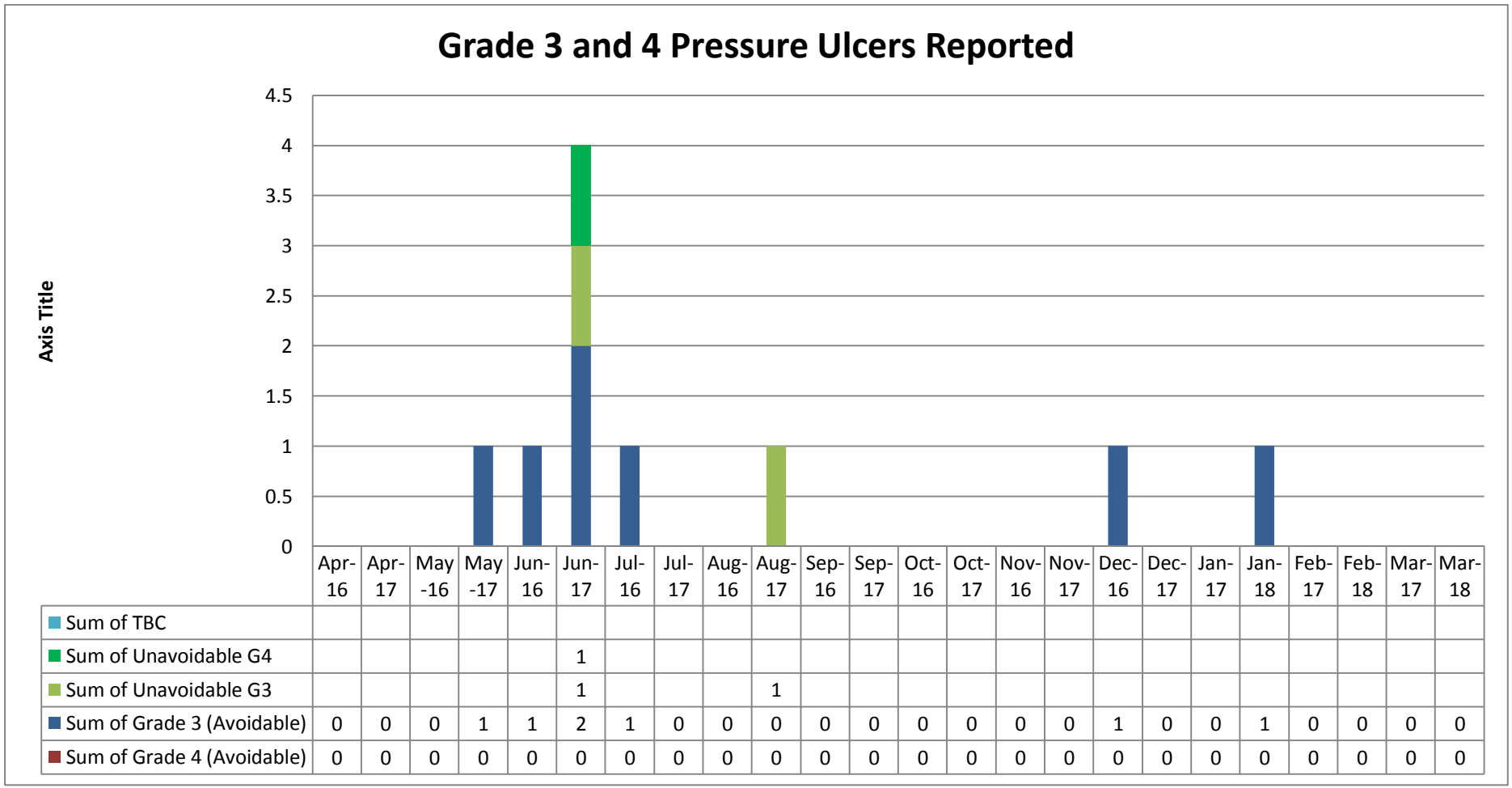
INFORMATION
Overall there were 13 fall-related incidents reported across the Trust in March 2018, all were related to adult inpatient falls. All falls were graded either no or low harm and are reviewed in the Trust Falls group with an upward report to Clinical Quality group. All incidents have been subject to a post-fall notes review by the ward manager or deputy, and a falls questionnaire was 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. An in-depth report on falls was presented to the Clinical Quality Group in January 2018.
ACTIONS FOR IMPROVEMENTS / LEARNING
• Falls policy is currently under review by the Falls lead; • The falls lead has set up a weekly task and finish group to benchmark our falls policy against the WMQRS falls and fragility fractures pathway. • Risk Register has been set up • There were issues with the practical aspect of manual handling training not being compulsory for all staff; this has been addressed with the training provider. Assurance has been given that this will be compulsory from now onwards and the falls group will be monitoring this.
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**



	Apr-16	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of Unavoidable	1	0	0	0	0	0	0	1	0	2	2	0	4	2	1	1	0	0	0	0	1	2	0	0
Sum of Avoidable	2	1	1	0	1	0	1	0	0	0	1	2	3	0	0	0	0	0	4	0	0	1	0	4
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

they were avoidable or unavoidable.



	Apr-16	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of TBC																								
Sum of Unavoidable G4						1																		
Sum of Unavoidable G3						1				1														
Sum of Grade 3 (Avoidable)	0	0	0	1	1	2	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0
Sum of Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

INFORMATION

In March 2018, the following pressure ulcers were reported;

Grade 4 =0
Grade 3= 0
Grade 2 Non device related= 1

- 23412 and 23455–Gaps in turning HDU – 13 hours post op with epidural between turns, no documentation of heel offloading. outcome avoidable

Grade 2 Device-related = 3

- 23411 – HDU- due to the wedge pillow – to be confirmed;
- 23521 – HDU - Likely due to flowtron boots - to be confirmed;
- 23525 – Ward 3- Small intact blister to the back of knee – to be confirmed.

ACTIONS FOR IMPROVEMENTS / LEARNING

Action – TV Link Nurse – provided a teaching and training session to a large number of HDU staff on 5/4/18 and highlighted the importance of skin inspection, moving patients regularly in a timely manner – especially those who have had an epidural with subsequent loss of sensation and movement and taking off as able and observing skin under medical devices.

A documentation task and finish group have developed more specific user-friendly documentation, which will act as prompts to care and highlight any gaps in order that action can be taken.

2016/2017:

13 - avoidable Grade 2 pressure Ulcers against a limit of 15

3 - avoidable Grade 3 pressure Ulcers against a limit of 0
0 - avoidable Grade 4 pressure Ulcers against a limit of 0

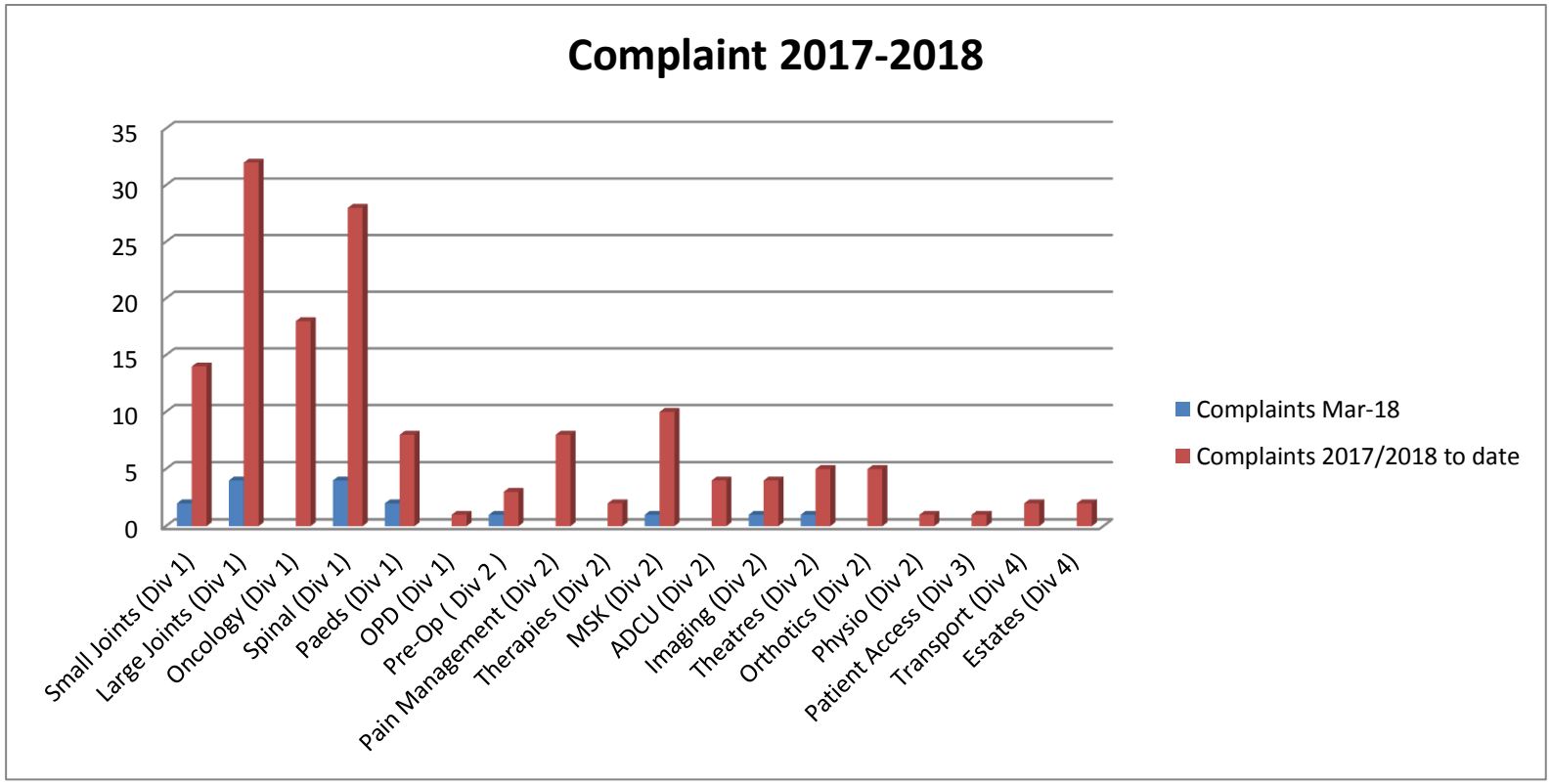
2017/2018:

6 - avoidable Grade 2 pressure Ulcers against a limit of 12
3 - avoidable Grade 3 pressure Ulcers against a limit of 0
0 - avoidable Grade 4 pressure Ulcers against a limit of 0

RISKS / ISSUES

- Tissue Viability Database has not been maintained currently– all tissue viability information being recorded in patients notes and on a separate "spreadsheet" to aid reporting
- Training for Tissue Viability for the Trust is being reviewed to ensure best practice, and this is a priority for Lead appointed, and the new lead and TVN will undertake.
- Trust Tissue Viability Policy requires updating; this will be impacted by new classification status when agreed. Also awaiting consensus form the consensus groups tasked by NHSI – TV Lead Nurse is part of the collaborative task group looking at PU reporting.

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 343 contacts during March 2018 of which 70 were classified as concerns. This brings the total of PALS contact for the year to 5094 (1135 concerns). This represents a much higher figure than at the same point last year (4136 PALS contacts). The total number of enquiry contacts has reduced for the second month in a row as the letters sent to patients have been altered to remove the PALS number and replaced with the department concerned. However, there were still 273 enquires made to the department this month, so the removal of the number has clearly not affected patients being able to access the service.

Compliments

There were 510 compliments recorded in March 2018, with the most being recorded for Div. 1. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues 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 16 formal complaints made in March 2018, bringing the total to 155 for the year. All were initially risk rated rest amber or yellow. This is higher than the same time last year (12 complaints in March 2017). Although 155 complaints were made in 2017/2018, 7 were either withdrawn or closed due to no consent being received. Therefore the official number of complaints for the Trust in this year is 148, and this is a significant reduction from the previous year's total of 167

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- care and treatment under Consultant (Div.1, Large Joints)
- care and treatment on Ward 2; including pain management (Div.1, Paeds)

- care and treatment on Ward 2; including pain management (Div.1, Large Joints)
- delay being seen by foot & ankle and orthotics (Div. 1, Small Joints)

Initially Risk Rated Yellow:

- provision of information to father (separated from mother) (Div. 1, Spinal)
- care and treatment under Consultant (Div.1, Paediatrics)
- the approach of secretary; delay in reviewing referral (Div.1, large Joints)
- the approach of Registrar (Div. 2, MSK)
- the approach of x-ray staff (Div.2, Imaging)
- discharged with no support at home (Div. 1, Small Joints)
- the approach of Clinician in OPD appt (Div.1, Spinal)
- miscommunication over operation date; pre-op repeatedly confirming the wrong date (Div.2, POAC)
- the patient believes that she had no anaesthetic during her procedure; the outcome of surgery (Div.2, Theatres)
- delay to surgery date (Div.1, Large Joints)
- Nursing Care on Ward 1 (Div. 1, Spinal)
- delay in receiving injection date (Div.1, Spinal)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 12 complaints closed in March 2018, 11 of which were closed within the agreed timescales. This gives a 92% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in March 2018 was 26 days which is within normal limits.

Learning identified and actions taken as a result of complaints closed in March 2018 include:

- procedure for referrals to pain management service has not always been followed
  Action: procedure has been reiterated, and staff have refreshed their understanding of this

- incorrect information included in clinic letter

Action: Letter changed. Clinician undertook reflection and discussed with Clinical Supervisor

- Patients may be receiving conflicting information about decommissioned treatment in one CCG (not our lead CCG)
  Action: Information provided to the patient and their GP

RISKS / ISSUES

None Identified.

10. Friends and Family Test Results and iwantgreatcare

INFORMATION

The Friends and Family Test in its current format was implemented on 1st April 2014. The Department of Health changed the methodology of the Net Promoter Score to a more straightforward % of patients likely to recommend a service and % not likely to recommend a service. This was because evaluation showed that patients and most NHS employees did not understand the Net Promoter Score and the information provided was frequently misinterpreted.

The Friends and Family Test (FFT) is the mandated patient 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

Following a review was undertaken by NHS England, the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics. Since 8 October 2015, all FFT data has been published in a single release The data for Inpatient Services, Outpatient Services and Community Services is required to be submitted to the NHS Digital Data Collection System monthly and the results for every facility are published on the NHS England website.

NHS England has set a mandatory response rate of 35% for all inpatient services. There are no minimum response requirements for outpatient and community services. The Trust sets internal targets for all areas as it is agreed that the data will then be more meaningful.

The guidance for outpatient services is less stringent than for inpatient services. Trusts have the discretion to vary how the test is applied in outpatient settings. For example, at ROH, every patient having an appointment in the outpatient clinic is offered the opportunity to complete a form. However, physiotherapy patients are offered the form at the end of their set of sessions (usually 4 or 5 sessions). As long as there are forms on display in a department that allow an individual to provide feedback after each session should they wish to, this is compliant.

The Trust breaks down its outpatient data into specialities which is more useful to departmental managers. However, the return for Outpatient Services is submitted as a single service.

There are no official requirements to undertake the FFT survey in imaging or theatre departments. However, the Trust takes the view that if feedback is provided in the same format across all departments, then the data is comparable and of use. In addition, there is an expectation that patient feedback

is gathered in all areas, even if not mandated.

RISKS / ISSUES

The Trust is not currently meeting the mandated 35% response rate for inpatient services. There has been a considerable improvement at approximately 30%, but this is being actively monitored and managed to ensure that we first exceed the mandated response rate and then achieve the internal target of 40% for Inpatient Services.

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would recommend the department in March 2018**	**% of people who would NOT recommend the department in March 2018**	**Number of Reviews submitted in March 2018**	**Number of Individuals who used the Department in March 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	100.0%	0.0%	44	135	32.6%
Ward 2	98.1%	0.0%	53	120	44.2%
Ward 3	100.0%	0.0%	21	89	23.6%
Ward 12	97.7%	0.0%	43	92	46.7%
Ward 11 (CYP)	100.0%	0.0%	3	88	3.4%
ADCU	97.9%	0.0%	146	644	22.7%
HDU	100.0%	0.0%	17	71	23.9%
CYP HDU	100.0%	0.0%	5	14	35.7%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2018**	**% of people who would NOT recommend the department in March 2018**	**Number of Reviews submitted in March 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.1%	0.3%	858	15%
COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2018**	**% of people who would NOT recommend the department in March 2018**	**Number of Reviews submitted in March 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	92.8%	1.4%	69	58%

In addition to the Friends and Family Test question, there are an additional 5 questions on the survey which relate to the following key elements of patient experience:

- Privacy & Dignity
- Cleanliness
- Kindness and Compassion
- Timely Information
- Being involved in the decision-making process

These give an overall star rating out of 5 stars on the system, with 5 out of 5 being the highest available score.

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 monitors and compares the 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.

The Royal Orthopaedic Hospital NHS Foundation Trust

Date
01 March - 31 March

Your average score for all questions this period

4.88

Reviews this period

1259

Your recommend scores

5 Star Score

4.86

% Likely to recommend

97.2%

% Unlikely to recommend

0.3%

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 14 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

New Claims
No new claims against the Trust were received in March 2018.

On-going claims
There are currently 28 on-going claims against the Trust.

27 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*
3 new requests for Pre-Application Disclosure of medical records were received in March 2018.

**Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes, the Data Protection Act 1998 and the Access to Health Records Act 1990).*

13. Coroner's

There were no coroner's inquests in March 2018

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 and 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 incompletion. The following areas examined;

- No form evident in notes
- Sign in Section incomplete
- Timeout section incomplete
- Sign out section incomplete
-

Total cases = 837

Total incomplete patients = 5

non compliance = 1 - 23rd March – anaesthetic care plan completed but no other perioperative data.

The total WHO compliance for March 2018 was **99.88%**

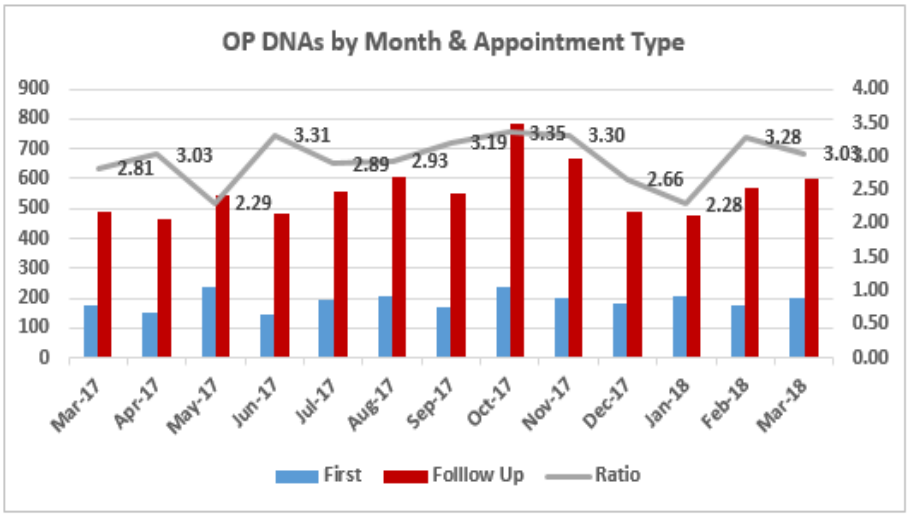
ACTIONS FOR IMPROVEMENTS / LEARNING

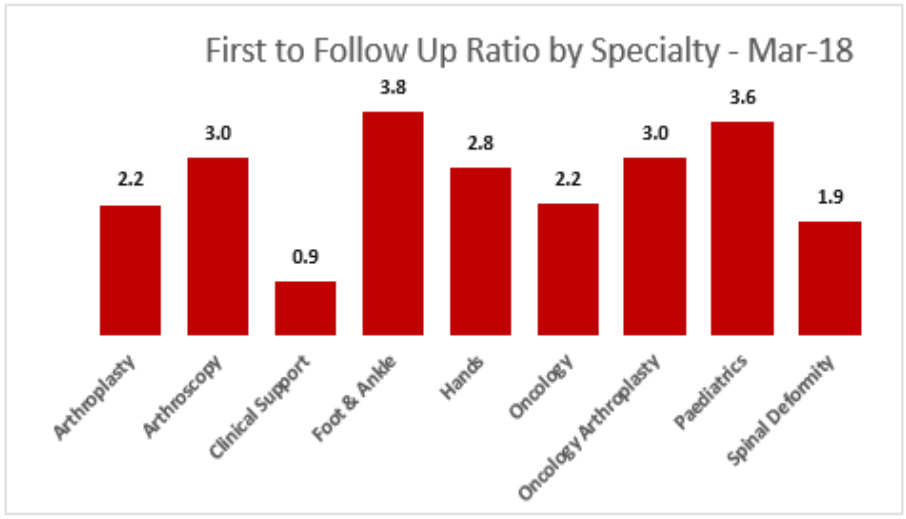
Any non- compliance will be reported back to the relevant clinical area.

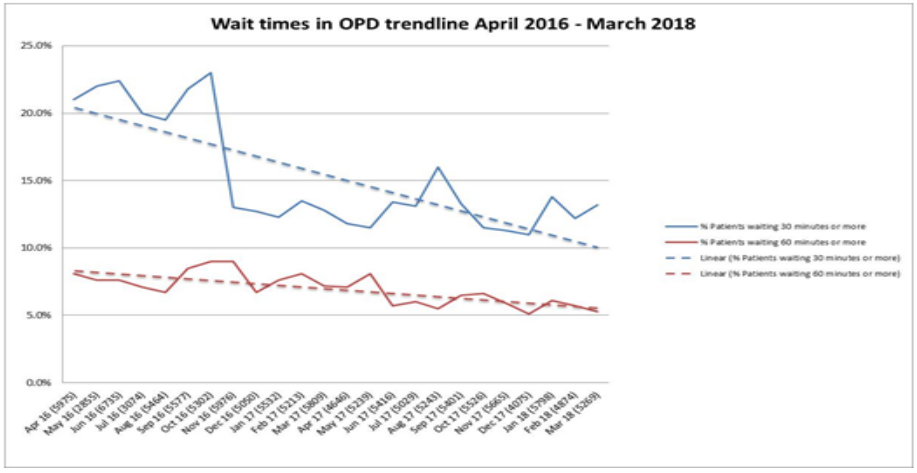
RISKS / ISSUES

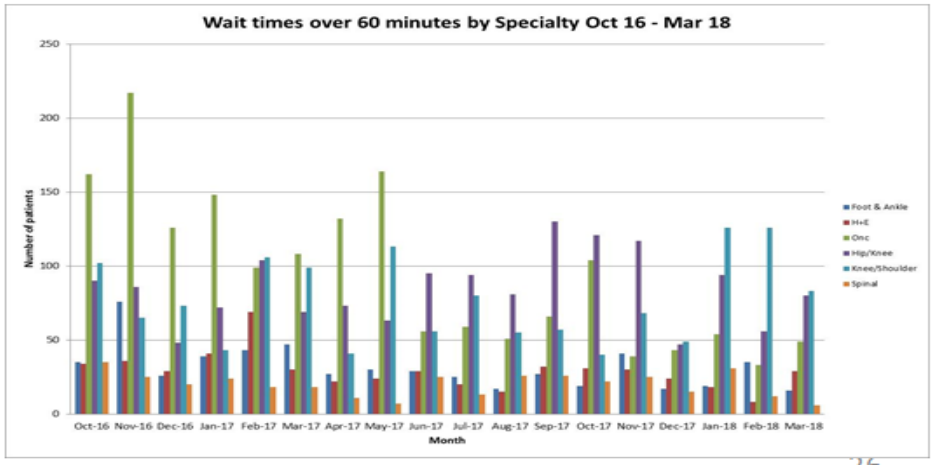
None

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



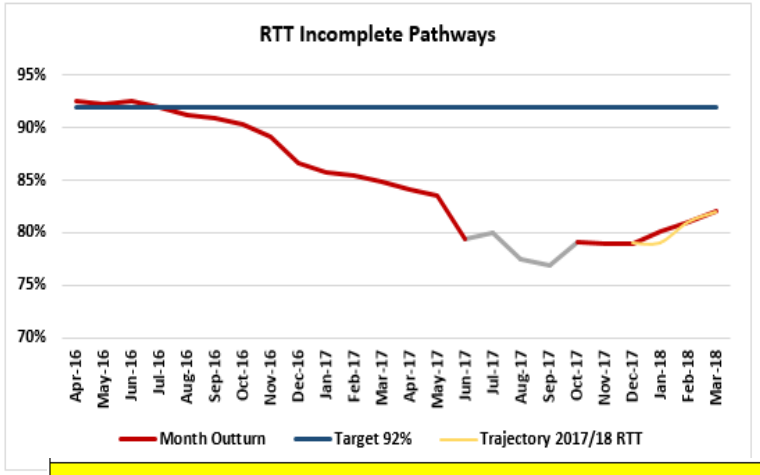


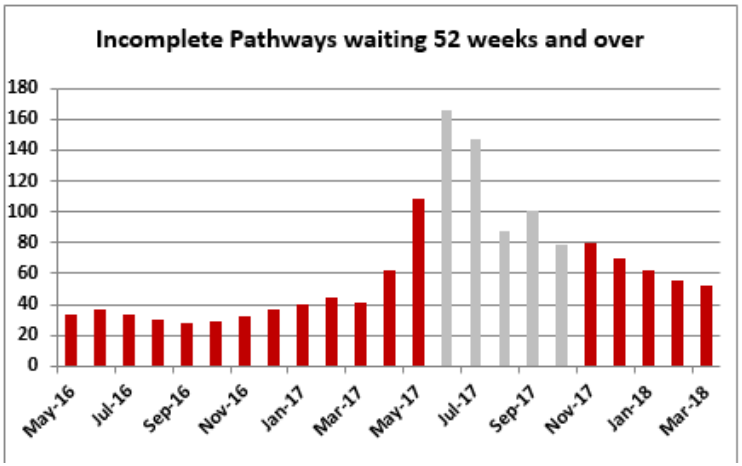




INFORMATION
The involvement of the operational management team in the investigation of incident forms relating to clinic delays continues and has triggered at least one new review of a consultant's outpatient clinic template. Issues of clinic capacity continue to contribute to delays in the clinic, and the ops team are reviewing reporting and processes in order to regularly review this information. In addition, there are plans to carry out capacity modelling for outpatient clinics across all specialties as well as reports to monitor and improve clinic utilisation. In March there were 32 incident forms completed to highlight clinics running more than 60 minutes late; a significant increase on previous months. 13.2% of patients waiting over 30 minutes and 5.3% waiting over 1 hour and this (over 1 hour) is an improvement on the previous month's position. The largest number of incidents was reported in Hip / Knee and Shoulder specialties. The monthly audit identified the following : - 12- Clinic overbooked 9- Complex patients 8- Consultant/Clinician Delay 2- Xray delay 1- Other
ACTIONS FOR IMPROVEMENTS / LEARNING
March; Continue to drive incident investigations and action through the relevant operational manager A review of the clinics that have been overbooked Development and Launch of new electronic clinic rescheduling system through Top Desk Review of SOP in relation to clinic rescheduling Development of clinic utilisation tools through InTouch and Health Informatics Review of individual clinics which are overbooked
RISKS / ISSUES
Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place

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

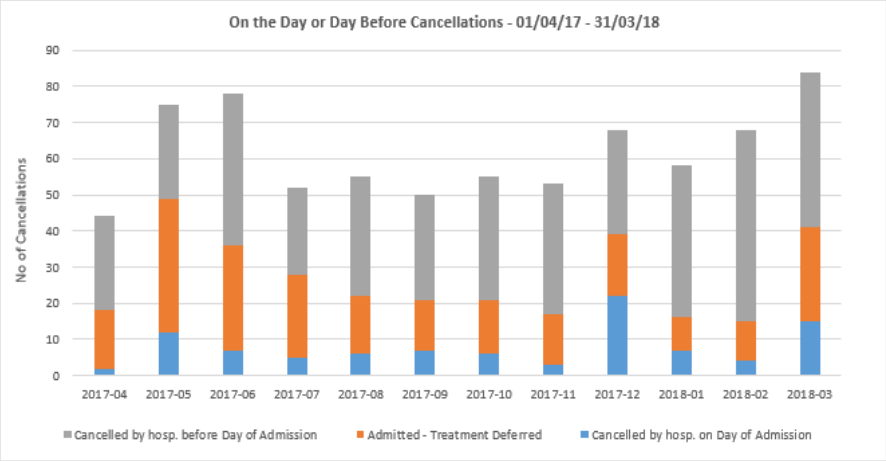




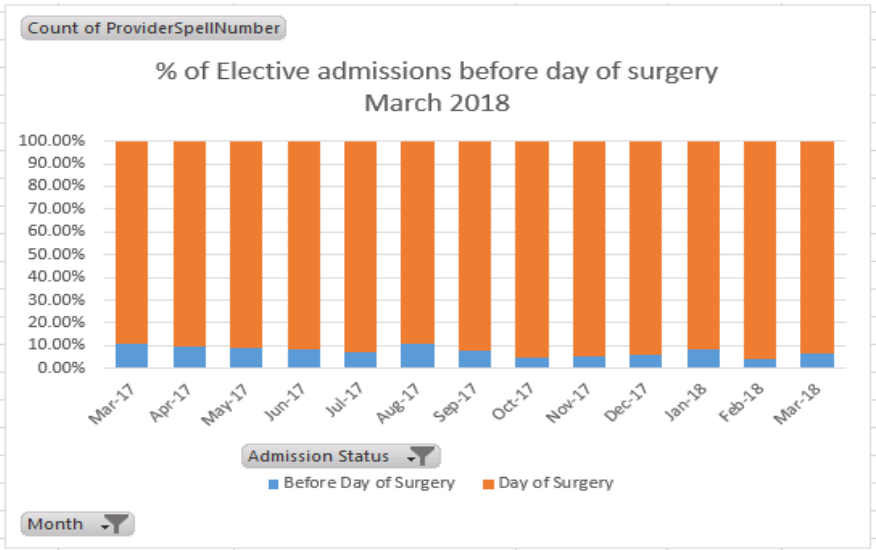
Target Name	National Standard	Feb	Jan	Dec	Nov	Oct	Q3	Breaches	Total	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	100.00%	97.10%	100.00%	100%	95.10%	98.40%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	88.90%	91.67%	100.00%	91.70%	100%	96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100.00%	94.10%	100.00%	100.00%	100%	100.00%	0	30	97.40%	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	n/a		n/a
62 day (traditional)	85%	87.50%	86.67%	83.30%	83.30%	100%	87.50%	1.5	8	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	77.80%	100.00%	50.00%	90.90%	81.20%	82.80%	2.5	14	88.9%	1	9	100%	0	4
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
No. day patients treated 104+ days		0	1	0	0	0									
Accountable Treated 62 Standard		4	7.5	3	5										
Actual Treated 62 Standard		6	10	6	3										
Accountable Breaches 62 Standard		0.5	1.0	0.5	1										

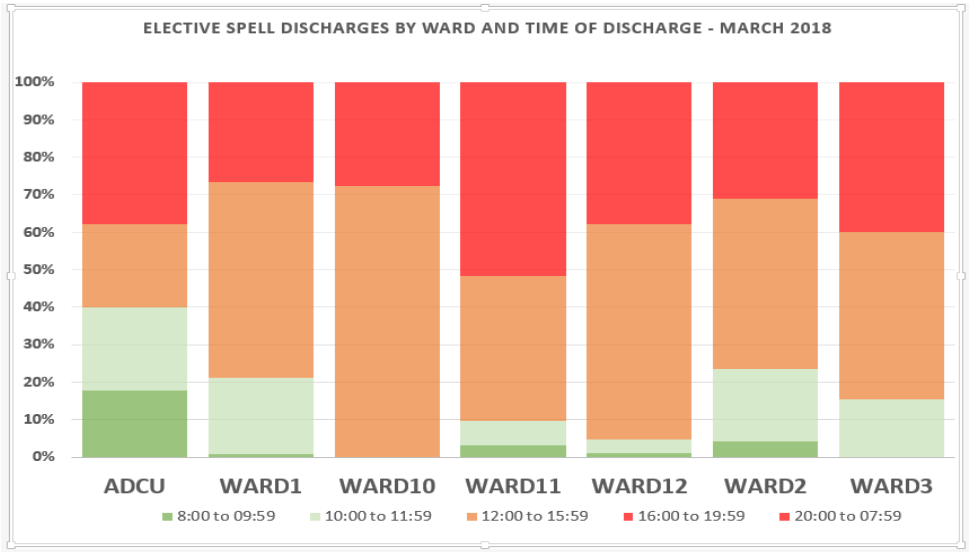
INFORMATION
The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%; the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the delivery of this target which is monitored weekly. For March 2018 the RTT trajectory was 82% with a performance at 82.07% , with 52 patients over 52weeks. As confirmed in the trajectory all specialties other than spinal deformity would treat all patients at or over 52 weeks – this was achieved in March 2018. The team have reviewed all spinal deformity patients and produced a trajectory submitted to NHSI & NHSE. This has been reviewed by the NHSI Intensive Support Team (IST).
ACTIONS FOR IMPROVEMENTS / LEARNING
The team continue to concentrate on any patients over 40 weeks, this number continues to reduce. At the end of December 2018, we had 238 patients over 40 weeks, at the end of February 2018 this figure is now 123. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.
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 the availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan). An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay in the completion of the building, it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity which had been planned up till April 2018 is now being planned through the Summer to assist with the existing waiting list . 5 patients have been transferred to Stoke for treatment following discussion with patients and their families.

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



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	42	58	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
Grand Total	96	227	417	740	10





INFORMATION

The number of cancellations on the day of surgery by the hospital has increased in a month. An analysis of this shows that the reasons for cancellation varied across a broad range of issues, key themes identified were: ran out of theatre time , Consultant sickness, theatre staffing and emergency patients taking priority. In addition, reasons for patient-led cancellations included clinical changes in patient condition and patient choice. Cancellations before the day of surgery have reduced in a month. The two main factors for cancellations prior to surgery were patients being offered earlier dates for surgery and patient choice to move / defer surgery.

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Trends are analysed and I interventions delivered to reduce cancellations. Further work has been delivered to develop the new POAC model, following focus groups working with staff to develop new ways of working developing an efficient patient focussed service which supports the needs of the expanding operative activity in a timely efficient manner. The pathway model and clinical protocols are currently being finalised and will be presented with the associated workforce plan by 2nd May 2018.

ACTIONS FOR IMPROVEMENTS / LEARNING

A daily update review by the Operational management team of forward bookings has been established, as well as the and the 6-4-2 weekly meeting. The operations 'Huddle 'is now embedded in practice, with learning shared at weekly Operational meetings across divisions .

Additional focus is being delivered:

- To reinforce accuracy and importance of ADT information (Admission, Discharge and Transfer)
- Increased Consultant led clinical review with full support from support services
- Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation discussed at the POAC workshop .

PERFECTING PATHWAYS

RISKS / ISSUES
Continued high levels of cancellations in Month. Shorter turnaround times for preoperative assessment are required to respond flexibly to increased levels of activity.

Finance and Performance Report

March 2018

CONTENTS

INTRODUCTION

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

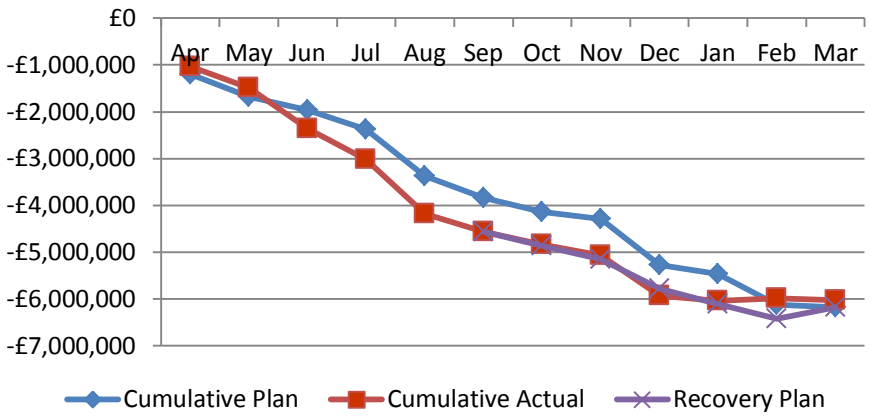
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M12 Original Plan £'000	YTD M12 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	74,633	75,360	727
Other Operating Income	4,738	5,198	460
Total Income	**79,371**	**80,558**	**1,187**
Employee Expenses (inc. Agency)	(48,479)	(50,116)	(1,637)
Other operating expenses	(35,681)	(32,764)	2,917
Operating deficit	**(4,789)**	**(2,323)**	**2,466**
Net Finance Costs	(1,448)	(1,413)	36
Net deficit	**(6,237)**	**(3,736)**	**2,501**
Remove revaluation I&E impact	-	(2,114)	(2,114)
Remove donated asset I&E impact	55	61	6
Remove CQUIN 0.5% risk reserve impact	-	(232)	(232)
Adjusted financial performance	**(6,183) (Control Total)**	**(6,021)**	**161**

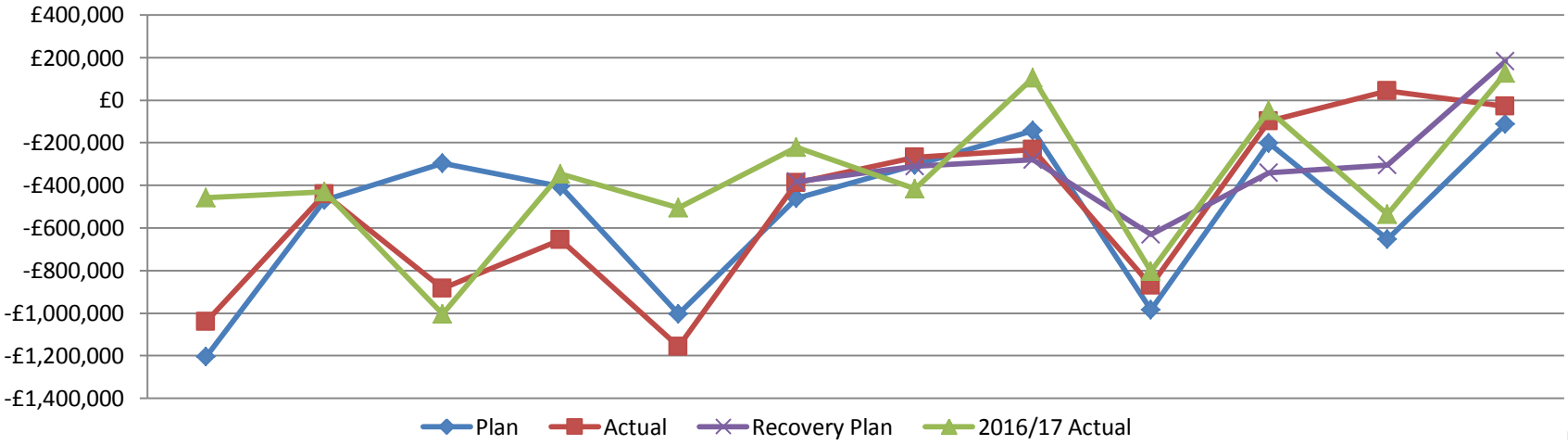
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan (excluding reval gains)



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	2
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan (excluding revaluation gains)



INFORMATION

The Trust has delivered a deficit of £30,000 in March against a planned deficit of £112,000. This brings the full year position (on a control total basis) to £6,021,000 against a plan of £6,183,000, £162,000 ahead of plan and recovery plan. Overachievement against the control total will result in a incentive STF payment of £162,000 (£ for £ investment for achievement over the control total) in addition to the 'standard' STF of £436,000. The trust may also be eligible for bonus STF, to be advised by NHS Improvement dependent on other trust's achievement of their control totals.

There have been a number of adjustments made to the year position as would be expected within a normal year as the Trust takes a slightly longer period to ensure all significant income and costs are accurately reflected ready for the financial accounts submission. These adjustments have been described in more detail on the expenditure slides. Other drivers for the in year performance have included spend on improving RTT reporting (just over £610,000 for the year), 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 time of the MRI for a period of nearly 2 weeks), in addition to an unexpected insurance payment for the historic on-site fire.

As at the end of March the Trust has recognised £2,685,000 of CIP savings, against a plan of £3,191,000, a negative variance of £506,000. £455,000 (17%) of savings to date are non-recurrent. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

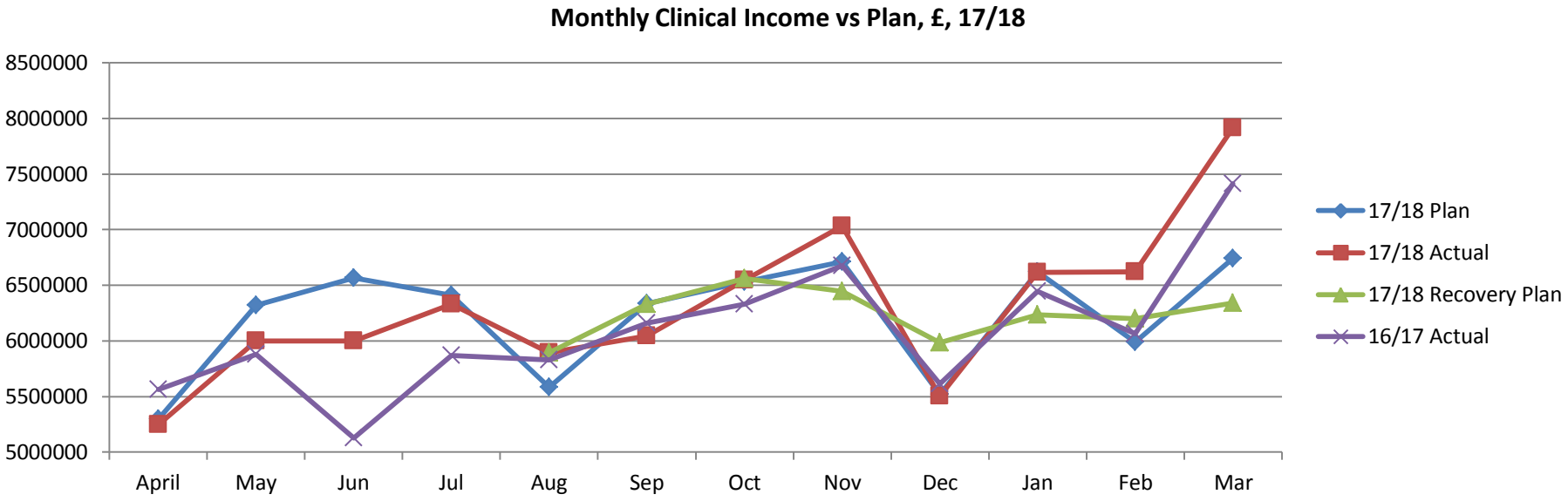
With regards to the Trust's Use of Resources Risk Rating (UOR), the overall position has remained at level 3, with the over performance against control total resulting in a '1' for I&E performance against plan. The other elements of the Use of Resources elements remain the same; the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover and I&E Margin. The Trust's requirement for cash support has resulted in a 4 for liquidity. Full year agency spend is higher than agency cap, resulting in an agency rating of 2.

ACTIONS FOR IMPROVEMENTS / LEARNING

A draft of the annual plan has been submitted to NHS Improvement, with further work ongoing to ensure there are sufficiently robust plans in place to deliver the trust's control total. This includes defining activity plans and the resultant job plans required, reviewing and minimising cost pressures and ensuring cost improvement plans are sufficiently robust and quality impact assessed. These discussions are significantly progressed in time for the final plan submission on 30th April.

RISKS / ISSUES

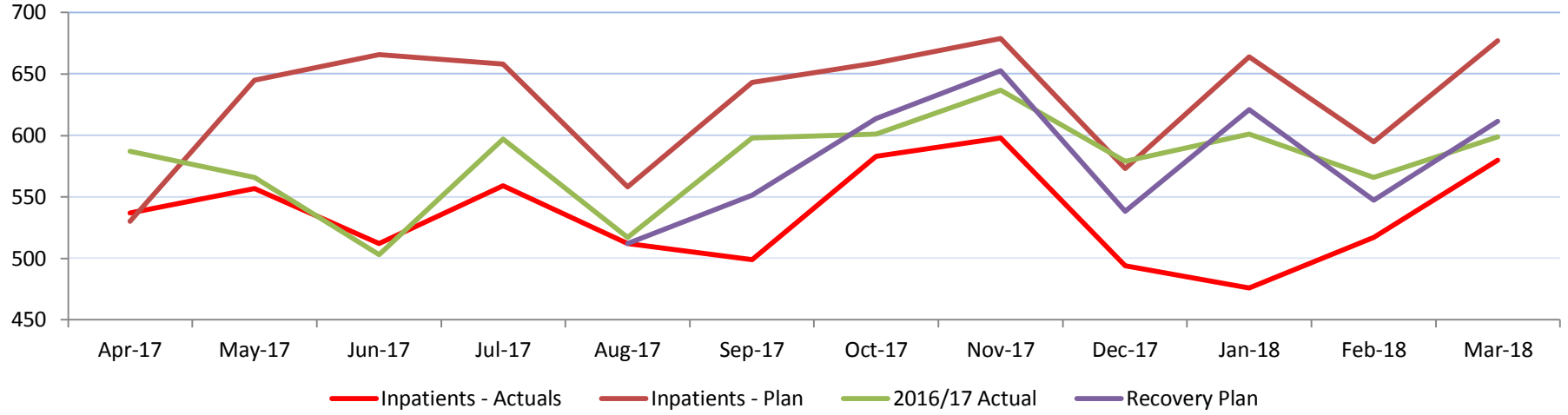
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



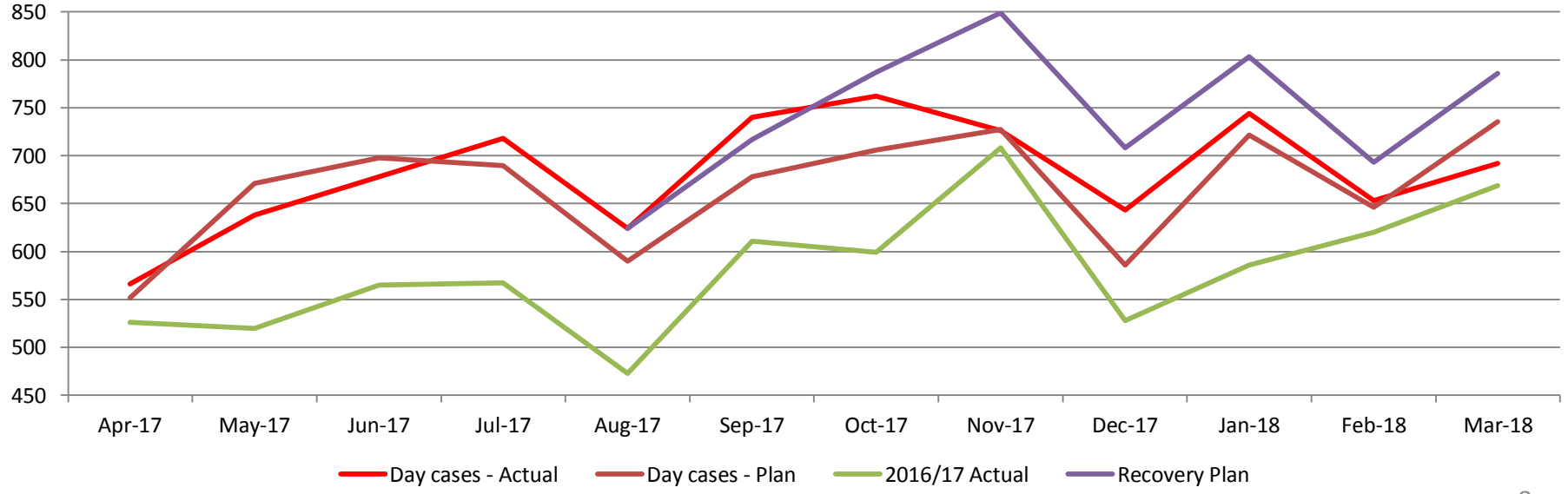
Clinical Income – March 2018 £'000			
	Plan	Actual	Variance
Inpatients	3,440	3,365	-75
Excess Bed Days	107	165	58
Total Inpatients	3,547	3,530	-17
Day Cases	833	1028	195
Outpatients	666	764	98
Critical Care	267	178	-89
Therapies	233	223	-10
Pass-through income	239	376	137
Other variable income	874	1298	424
Block income	518	518	0
TOTAL	7,177	7,915	738

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	37,851	37,673	-178
Excess Bed Days	1,176	708	-468
Total Inpatients	39,027	38,381	-646
Day Cases	9154	9601	447
Outpatients	7315	7537	222
Critical Care	2933	2485	-448
Therapies	2916	2648	-268
Pass-through income	2617	3177	560
Other variable income	4891	5702	811
Block income	6216	6216	0
TOTAL	75,069	75,747	678

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income was significantly ahead of March's plan, with the trust now overachieving against its original income plan. Inpatient activity was strong, and in line with November, and just slightly behind November. Day case activity was behind plan, but this is considered reflective of the case mix required to be delivered to achieve the RTT trajectory over the next few months. In addition the trust's activity was again impacted by snow in March.

The main in-month income performance however was with regard to pass through costs and other variable income. Pass through costs were high largely as a result of better information being received from theatres regarding the use of bespoke prostheses, although orthotic appliances were also high in month.

Other variable income has increased for a number of reasons. The trust was informed it should recognise £232k of CQUIN income (0.5% risk reserve CQUIN) in month where it had been previously required to provide for this amount. In addition, the trust received confirmation that it would receive additional funding in relation to the Welsh block contract that it was not expecting to receive (£161k – this is spread across various income categories including other variance income). In addition, the Trust has recognised £85k of income offered by Solihull CCG to manage its RTT challenge with physiotherapy.

The Trust is working operationally and financially to determine what demand and capacity there is internally and how this will affect activity plans, job plans and therefore income for the coming year as part of business planning as previously discussed. This work is ongoing to enhance the final annual plan submission in comparison to draft. Activity plans at a specialism level have now been agreed with operations, but these are being further split down to consultant level before the submission of the final annual plan.

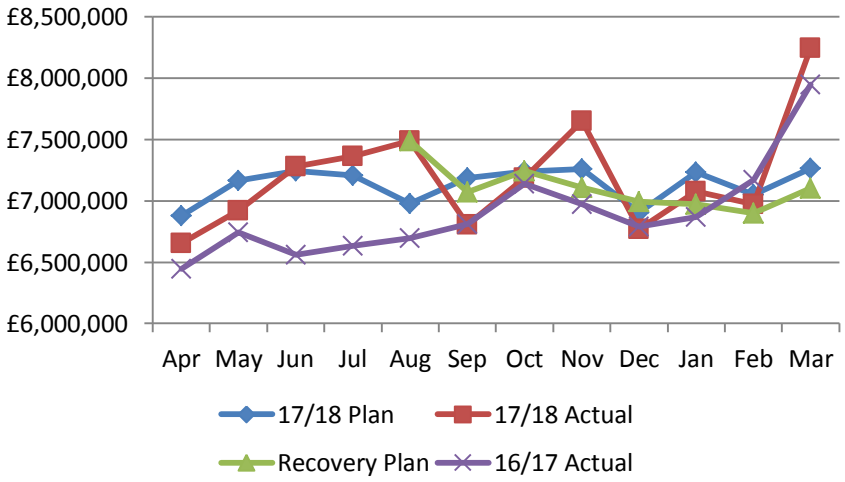
Further work still needs to be performed to ensure that clinicians are recording the appropriate co-morbidities of the patient's they treat, resulting in the trust being funded for the work actually performed.

RISKS / ISSUES

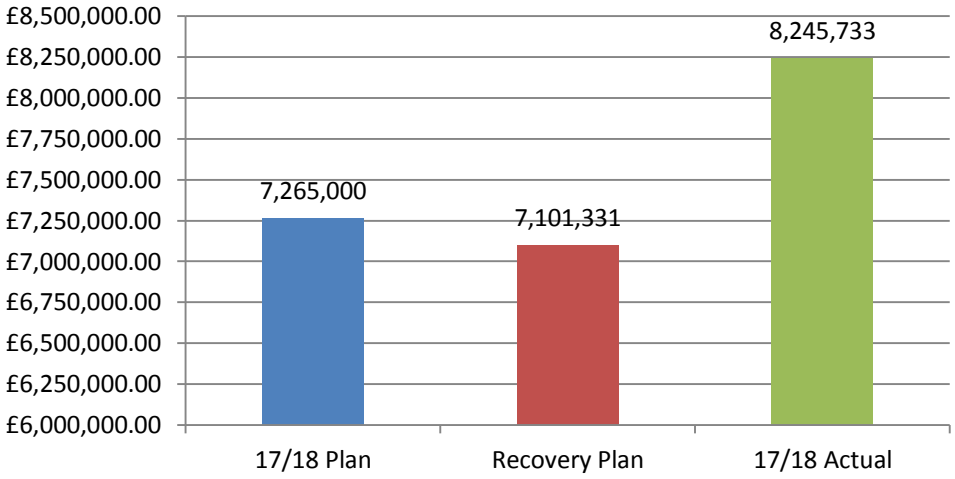
The first week of April 2018 was utilised to maintain theatres and as such no elective activity was undertaken. This puts increased pressure on the trust to deliver its activity targets for the remainder of the coming year.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

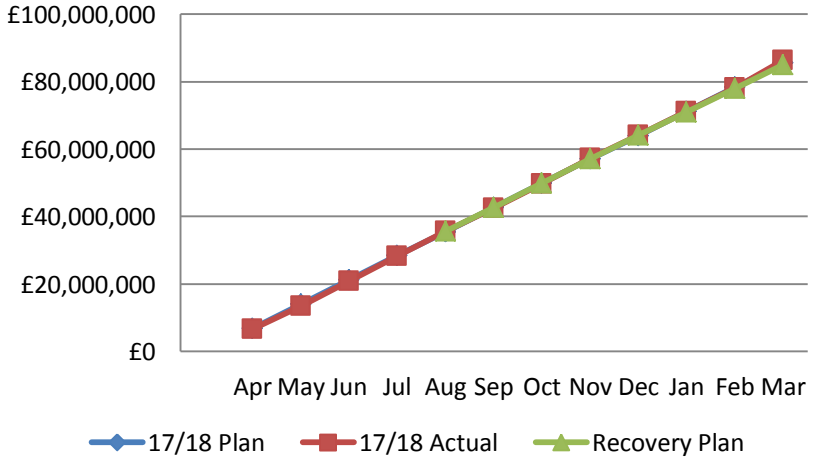
17/18 Monthly Expenditure vs Plan (excl reval gain)



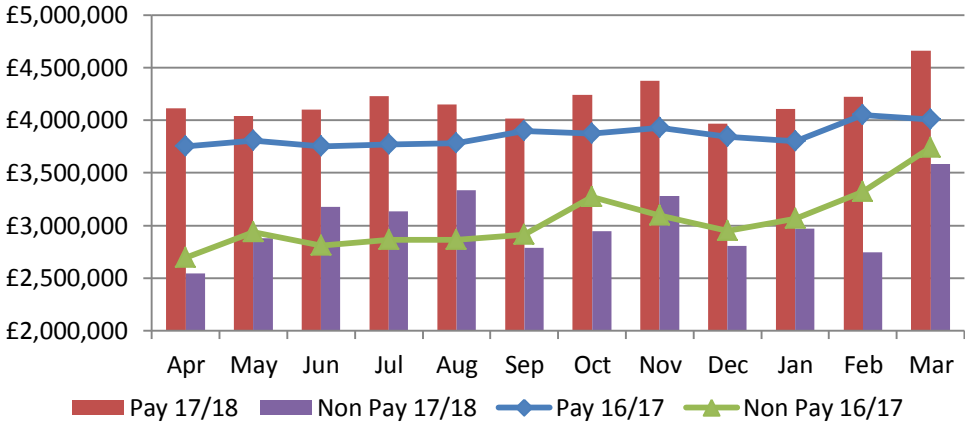
17/18 M12 Expenditure vs Plan (excl reval gain)



Cumulative Expenditure vs Plan 17/18 (excl reval)



16/17 vs 17/18 Pay & Non Pay Spends (exc. reval gain)



INFORMATION

Expenditure levels for the month were £8,245,000, which is significantly above the level expected within the original and recovery plan. The expenditure (and income) position in month 12 will always contain a number of non-recurrent adjustments that are made to more accurately reflect annual expenditure, but even accounting for these expenditure was high in month.

Such adjustments have included the outcome of the stock count, and provision/accruals for adhoc costs such as two redundancy payments, a stock valuation provision (unrelated to the stock count itself), and the potential for a fine. In addition, underlying pay spend was high, particularly with regard to agency, as has been described in further detail in the next slides. Bank and ADH spend was also high in order to deliver additional elective activity in the month. Whilst some of this spend on agency was planned to provide additional support into POAC, vacancy levels and sickness was also high in month. We believe that this is non-recurrent expenditure and nor reflective of recurrent trends but this will be monitored and reviewed closely in April

The expenditure shown excludes a revaluation gain of £2m, which has been excluded to allow visibility of the underlying position. This is excluded for control total purposes and therefore does not translate to addition STF bonus above and beyond the £161k overachievement.

ACTIONS FOR IMPROVEMENTS / LEARNING

Costs will continue to be scrutinised and minimised, particularly relating to workforce in April.

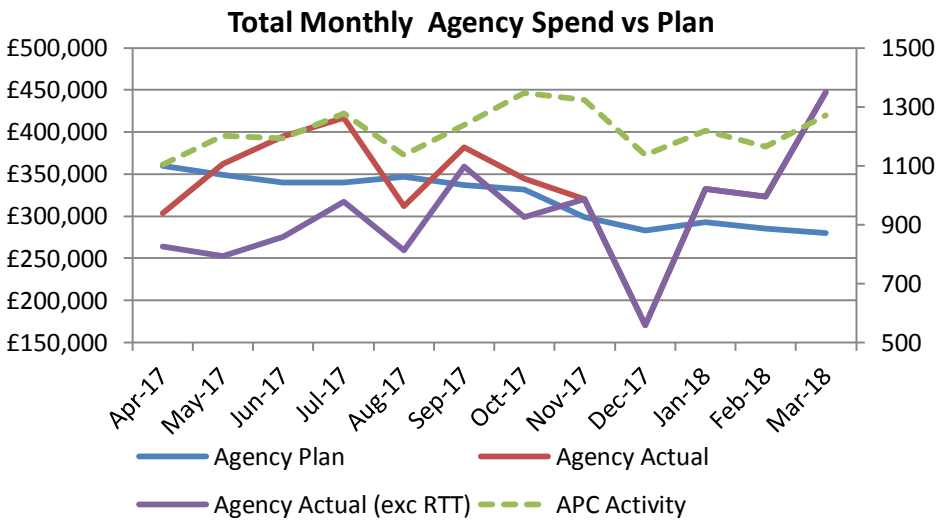
There is further learning from the year end stock count which will be taken forward and acted upon within 2018-19.

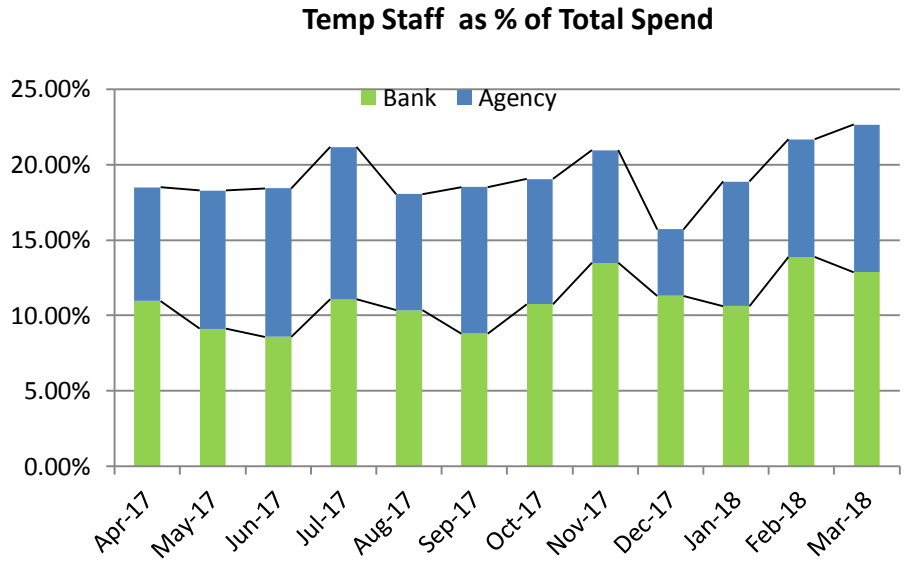
A full list of cost pressures for the 2018/19 financial year has now been reviewed by the Interim Chief Operating Officer and Interim Director of Finance, and built accordingly into business planning and the budget setting exercises.

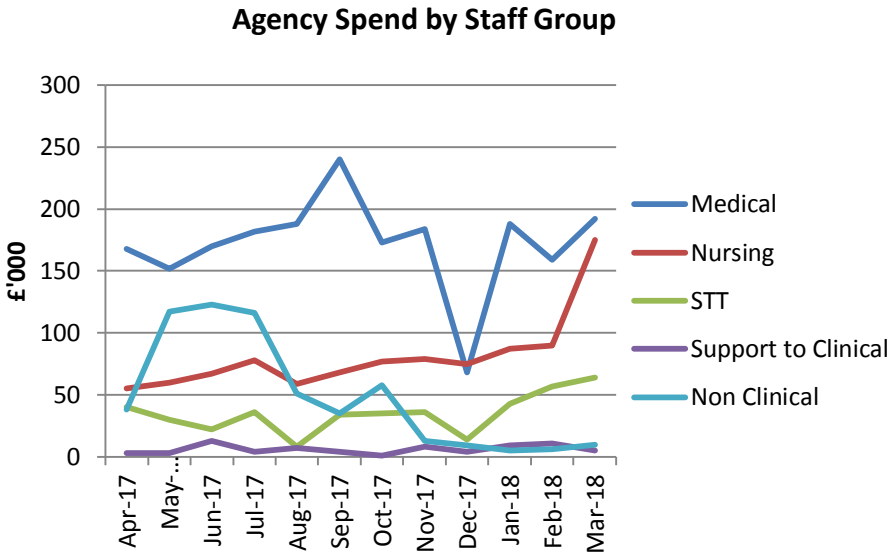
RISKS / ISSUES

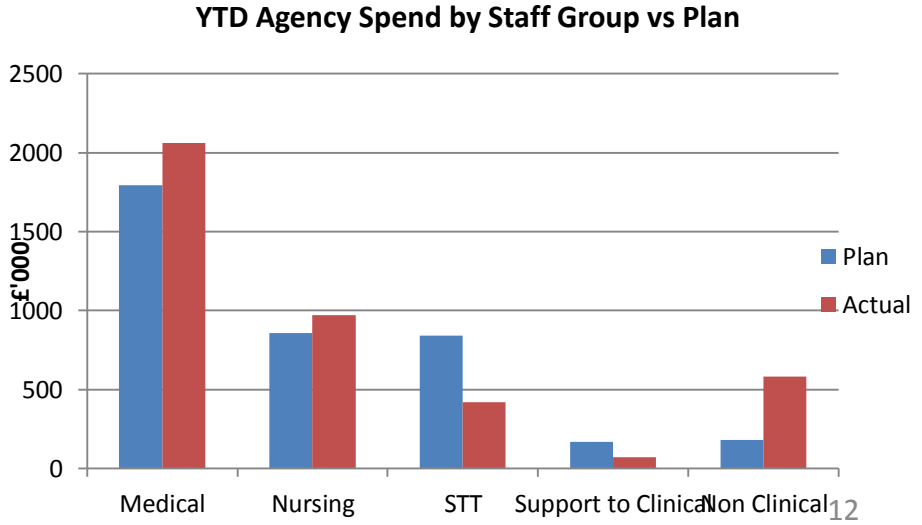
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops ongoing.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

Agency spend has seen a significant increase of over £100k in March. Whilst higher agency spend would be expected in March due to the number of working days, this increase is above and beyond what would be expected for the increased working days. Analysis of the spend shows a general increase across the wards, which would be expected given the increased elective activity in March. In addition, there was significant 'specialling' cover required for particular patients in March. Finally, agency POAC nurses are being used within the Trust, but they are outside of usual nursing agency cap spends due to their particular specialist skills.

Other categories of agency spend are much more in line with previous patterns. Medical agency has increased, but is in line with the level of spend seen across the year ,and STT agency spend continues to remain high due to use of agency physiotherapists being used to reduce waiting lists.

ACTIONS FOR IMPROVEMENTS / LEARNING

The trust needs to continue ensuring that it is monitoring Health Roster to ensure agency spend on nursing is kept at a minimum. The new Head of Nursing for Division 1 is scrutinising nursing agency spend in particular over the coming months to ensure it is reasonable and appropriate.

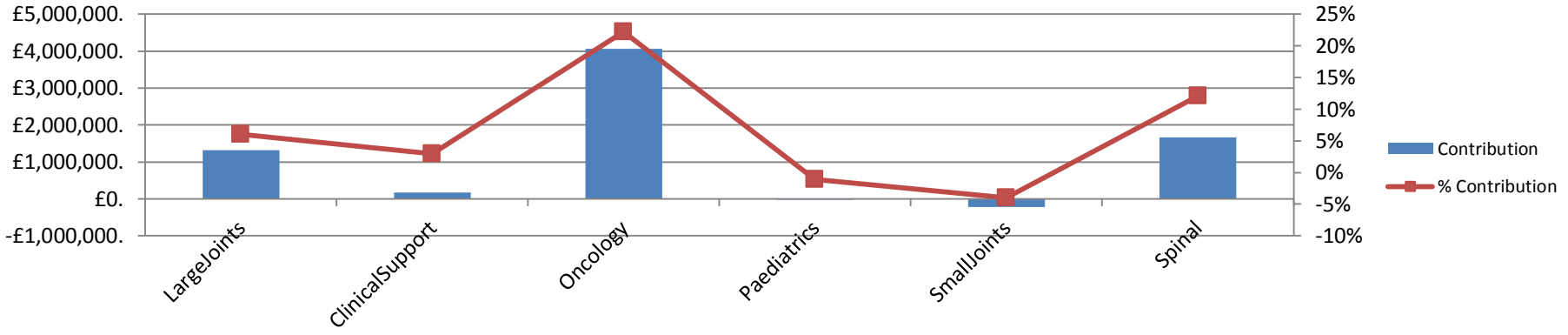
RISKS / ISSUES

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.

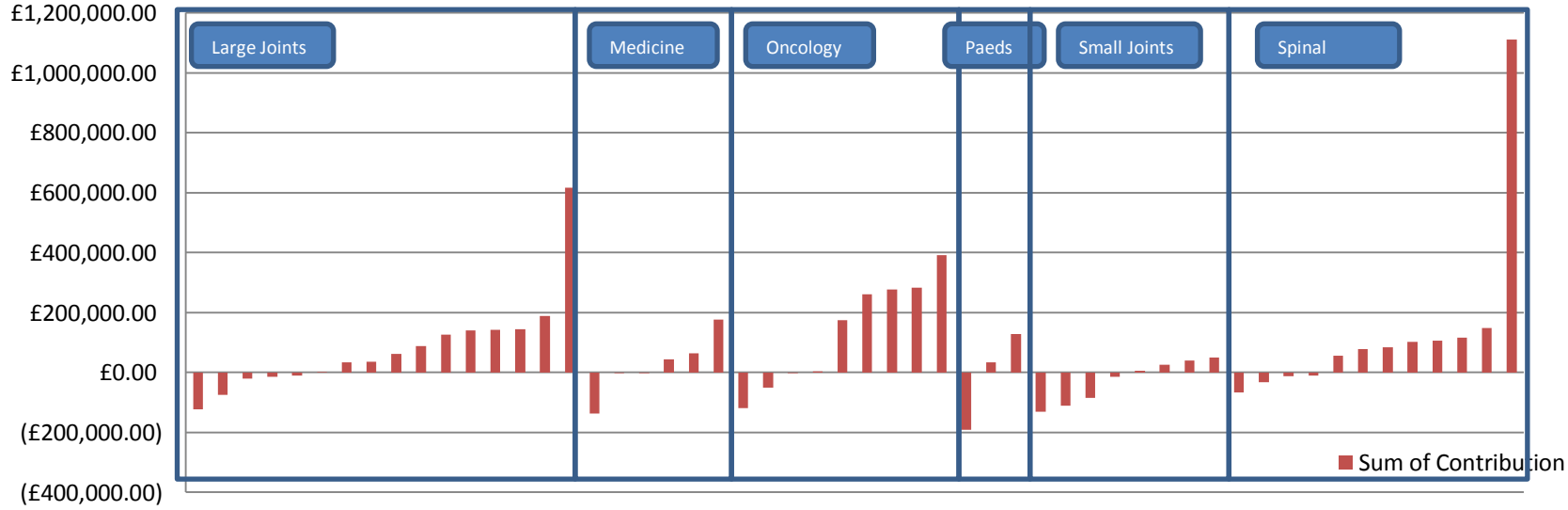
Within the draft annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

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

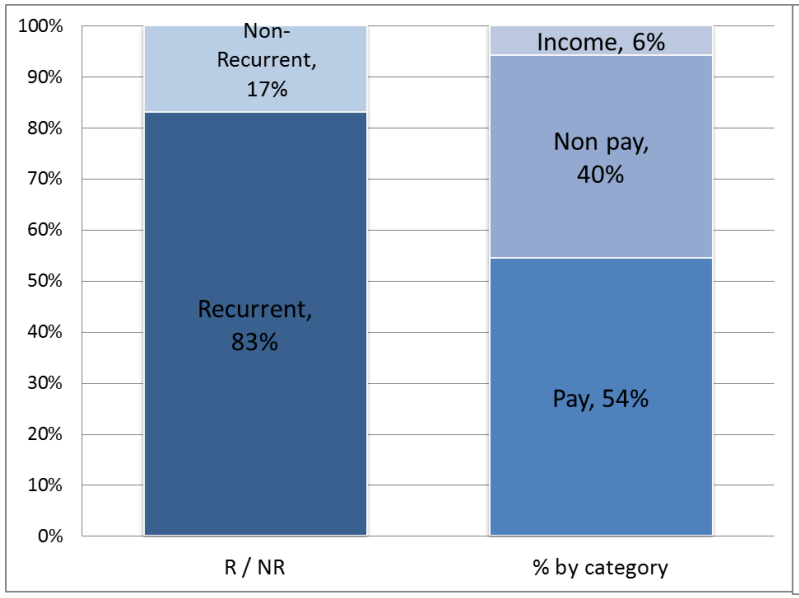
Total Contribution by Service
Cumulative to Apr-Feb 2017-18

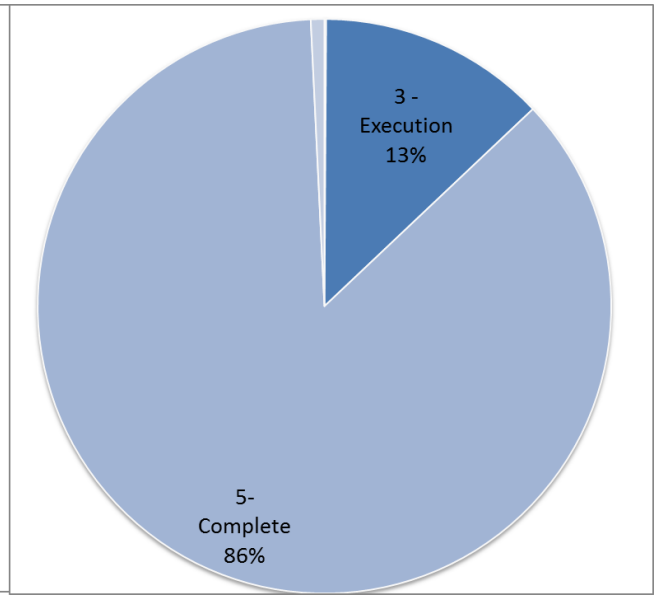


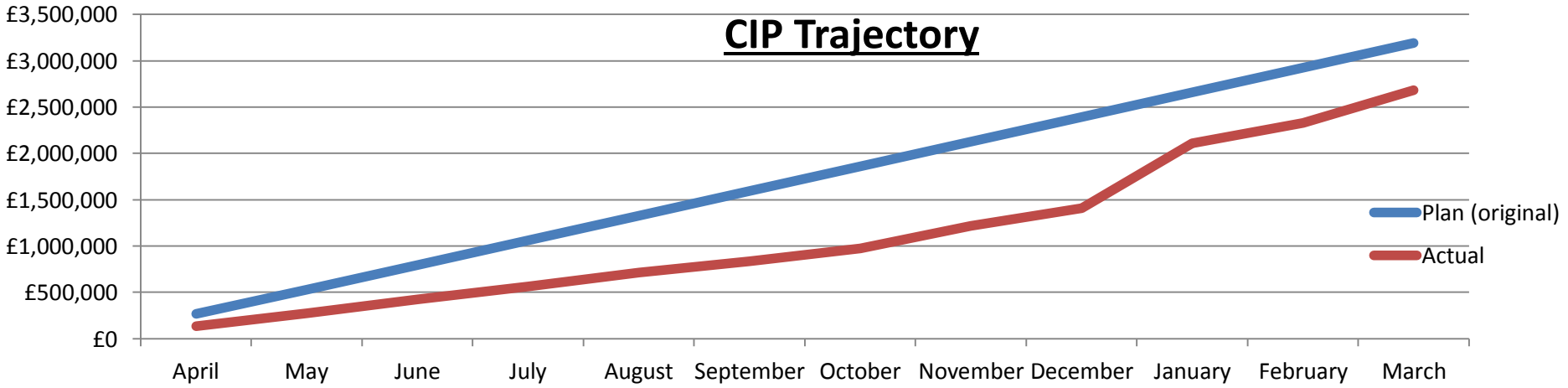
Consultant Contribution Apr-Feb 2017-18



6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18







INFORMATION

As at the end of March the Trust has recognised £2,685,000 of CIP savings, against a plan of £3,191,000, a negative variance of £506,000. £2,230,000 (83%) of savings are recurrent.

	Original Plan	Actual	Forecast vs Original Plan Variance
Division 1	£1,362,500	£1,086,801	-£275,699
Division 2	£851,270	£568,442	-£282,828
Division 3	£42,875	£42,878	£3
Division 4	£160,000	£160,000	£0
Corporate	£774,355	£826,724	£52,369
Grip and Control	£0	£0	£0
Productivity and Efficiency	£0	£0	£0
TOTAL	£3,191,000	£2,684,845	-£506,155
Shortfall		-£506,155	

ACTIONS FOR IMPROVEMENTS / LEARNING

Focus has been shifted to fully developing the 2018/19 CIP plan.
During 2017/18 CIP planning process the CIP unidentified throughout the year failed to be identified as a result of the resources focussing on delivering the schemes that had been identified. Learning has been taken from this and the current unidentified CIP in the 2018/19 is to be addressed during Q1 of 2018/19.
A CIP Programme Board chaired by the Interim Director of Finance will commence on 19th April and initially be held monthly during Q1 with the frequency to be reviewed after this.

RISKS / ISSUES

A significant amount of work remains to be completed to fully develop 2018/19 schemes to ensure they can be implemented at the required timescales so that financial benefits are maximised during the year.

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M12 Plan £'000	M12 Actual £'000	Var £'000
Intangible Assets	2,030	856	(1,174)
Tangible Assets	41,890	47,995	6,105
Total Non-Current Assets	**43,920**	**48,851**	**4,931**
Inventories	3,931	4,857	926
Trade and other receivables	2,714	3,507	793
Other Current Assets	1,048	-	1,048
Cash	3,142	3,751	609
Total Current Assets	**10,835**	**12,115**	**1,280**
Trade and other payables	(10,423)	(12,272)	(1,849)
Borrowings	(4,395)	(1,640)	2,755
Provisions	(116)	(173)	(57)
Other liabilities	(249)	(207)	42
Total Current Liabilities	**(15,183)**	**(14,292)**	**891**
Borrowings	(1,842)	(3,979)	(2,137)
Provisions	(332)	(354)	(22)
Total Non-Current Liabilities	**(2,174)**	**(4,333)**	**(2,159)**
Total Net Assets Employed	**37,398**	**42,341**	**4,943**
Total Taxpayers' and Others' Equity	**37,398**	**42,341**	**4,943**

INFORMATION

Tangible assets are significantly above plan due to a revaluation gain of £3.9m (split between the I&E and revaluation reserve).

As previously mentioned, the inventory balance is that which has been counted and valued at the year end. As had been expected from the November interim stock count, stock levels are significantly higher than last year. This is to be expected given the stock rationalisation - stock is held with both the old and new supplier whilst the rationalisation is embedded, with stock levels then being reduced over time.

Cash is largely in line with plan at year end, although borrowing is lower than expected from the Department of Health due to the timing of underperformance payments and a number of other unexpected cash inflows (e.g. the £101k insurance receipt).

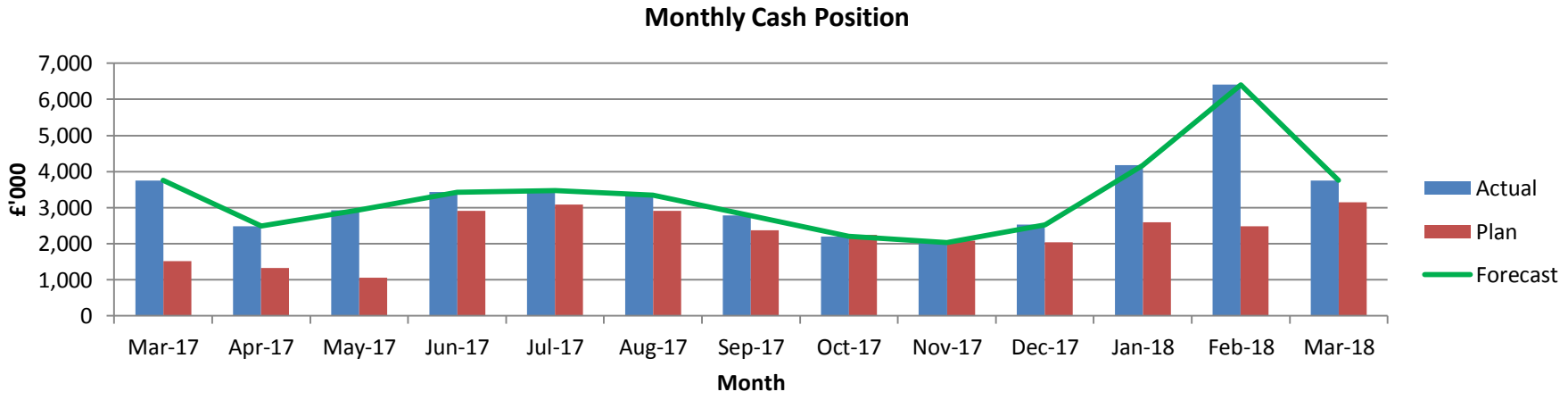
Creditors balances have risen throughout the year. This is due to two main reasons; firstly, there have been staff shortages through vacancy and sickness within the theatre environment which has slowed down approval of invoices to allow payment. This is being managed through use of an agency member of staff who is working through the backlog. Secondly, with the trust now reliant on cash funding, the team need to be more careful regarding payment of invoices to ensure the minimum cash balance of £1m is not breached, and this therefore results in higher creditor balances.

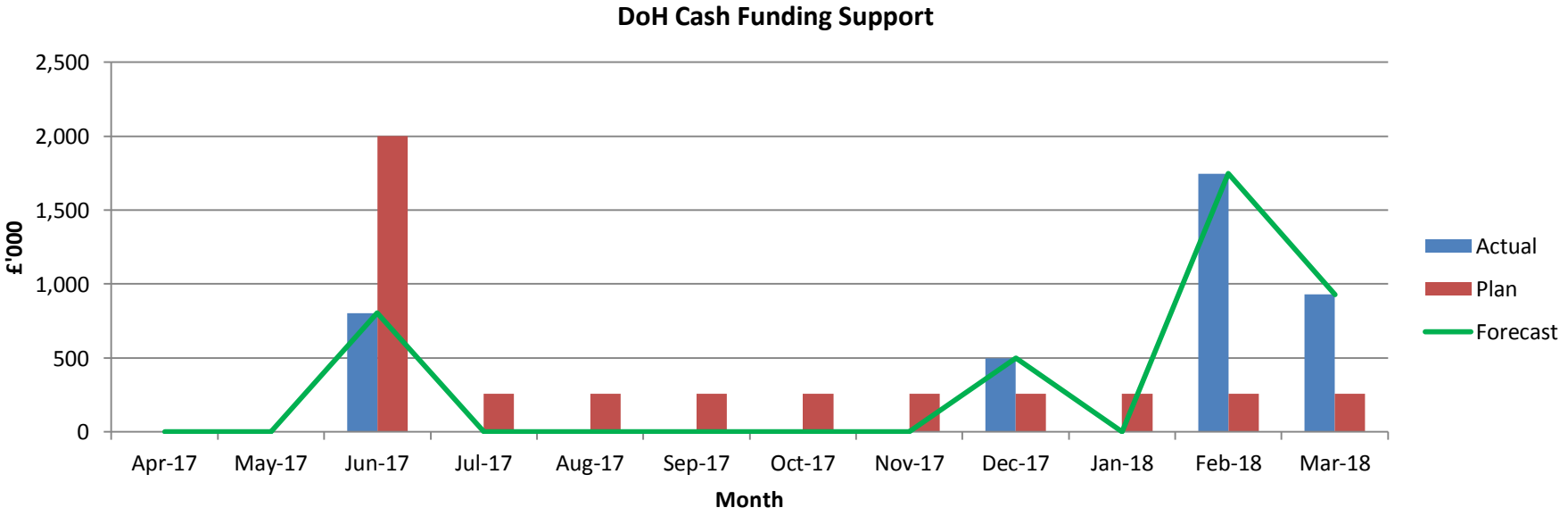
ACTIONS FOR IMPROVEMENTS / LEARNING

In the coming months, further balance sheet metrics regarding better payment practice code and debtor ageing will be included within the report.

RISKS / ISSUES

8. 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 was £609k above planned levels at the end of March, as some credit notes for underperformance have not recovered by the CCGs.

The Trust received its first cash loan of £804k from the Department of Health in June 2017, a second of £498k in December 2017 and a third of £1,747k in February 2018. The final loan for the year of £930k was received in March, taking full year borrowing to £3,979k. This is within the level of loans which were predicted for the year in the Annual Plan.

In March the Trust also received £280k cash from the Department of Health to fund cybersecurity improvements. This has been funded through public dividend capital rather than an additional loan.

The requirement for cash support continues to result in the trust being rated at the lowest level (level 4) for liquidity.

ACTIONS FOR IMPROVEMENTS / LEARNING

The finance team continue to run a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team in order to scrutinise both the current and future cash position, but also to identify areas for cash control improvement. The committee continues to review cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the Department of Health to be actioned. The updated cash requirements for 2018/19 based on a refresh of the operational plan continue to be modelled.

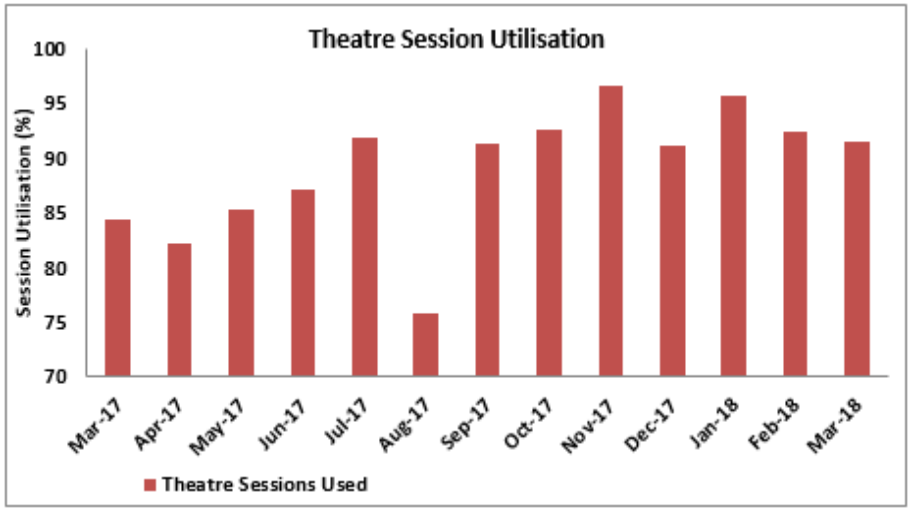
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DoH not approving a cash loan or approving a lower than requested amount.

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

Theatre list utilisation for March was 91.47% slightly down on the previous month. Contributing factors were the impact of Consultant surgeon annual leave which reduces the opportunities for other colleagues to cover the additional available lists and Consultant surgeon sickness. Also the annual Hip Society Conference took place during this month, which some Consultants attended.

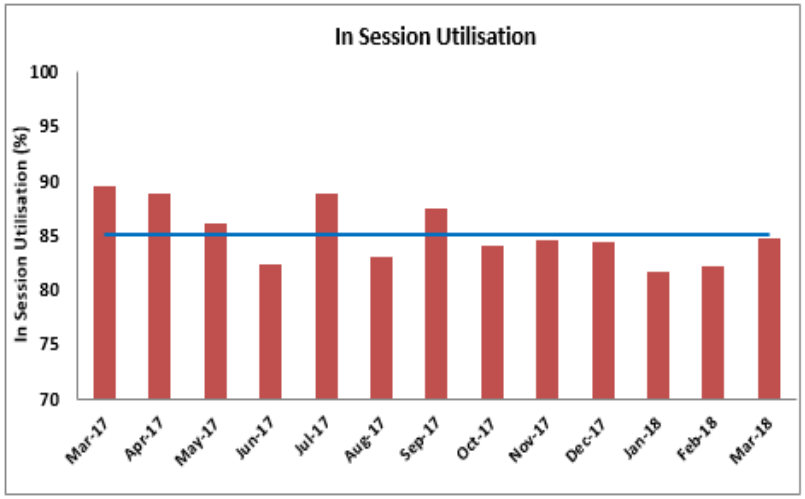
Overall utilisation from July 2017* averaged 91.04% with improved performance from October, averaging 93.35% .

*April to Jun data has been excluded due to the implementation of a new Theatre System (ORMIS to Theatre Man)

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc. will also need to 'grow' alongside theatres to ensure maximum efficiency gains.

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



INFORMATION

Whilst sessional utilisation has remained strong, the average in session utilisation has struggled to reach the target of 85% over the last 6 months, although the average for the year is 84.8%. We are reviewing the correlation between the two measures.

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.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 84.65% in March up on the previous month (82.23%)

The development of a Theatre Dashboard to provide a more detailed analysis of speciality performance within theatres, focussing on start / end times, turn around times, early finishes, over runs etc. This will allow for trends to be more easily identified, for example the ability to look at specific theatres on specific days.

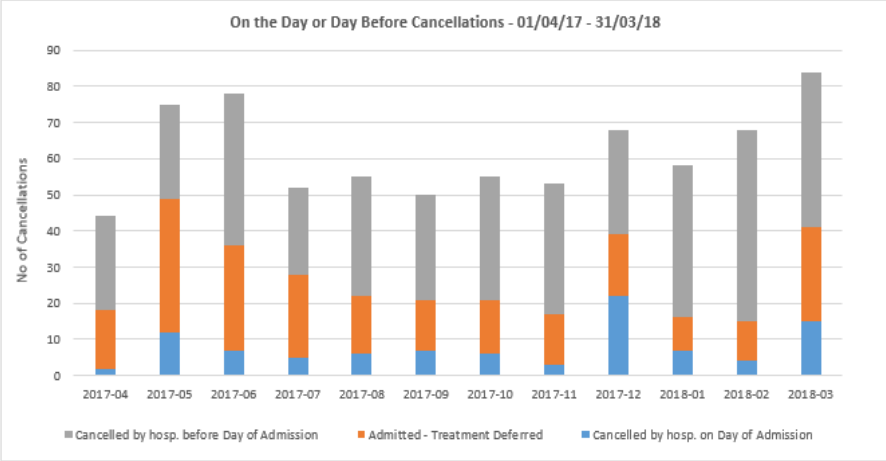
This data analysis will then form the basis to hold speciality specific meetings where speciality theatre usage and utilisation can be discussed, and recurring themes or areas of concern can be highlighted and rectification plans put into place to improve performance generally.

RISKS / ISSUES

- Development of the dashboard will require Informatics support and potentially IT support which may delay development and implementation due to other project priorities for those services.

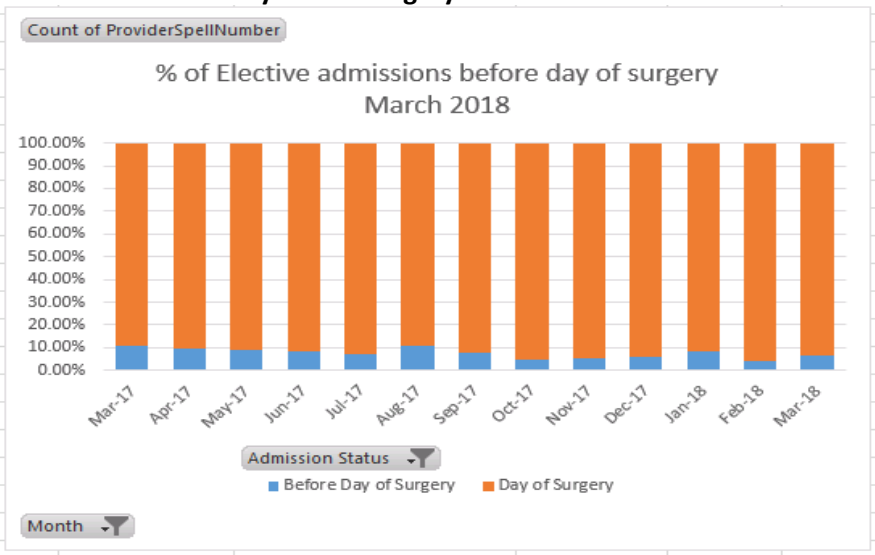
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

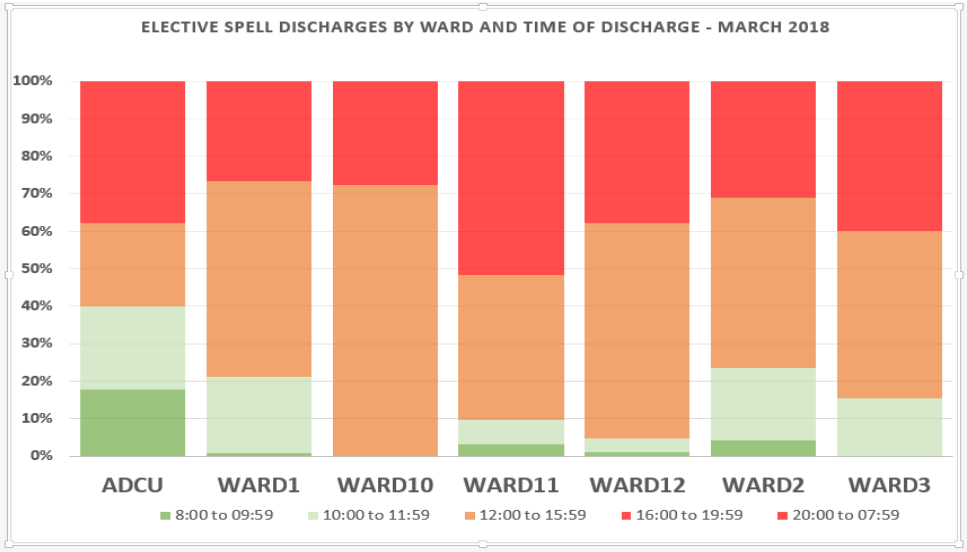
Hospital Cancellations



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	42	58	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
Grand Total	96	227	417	740	10

Admission the day before surgery





INFORMATION

The number of cancellations on the day of surgery by the hospital has increased in month. An analysis of this shows that the reasons for cancellation varied across a broad range of issues , key themes identified were : ran out of theatre time , Consultant sickness, theatre staffing and emergency patients taking priority . In addition reasons for patient led cancellations included clinical changes in patient condition and patient choice .

Cancellations before the day of surgery have reduced in month. The two main factors for cancellations prior to surgery were patients being offered earlier dates for surgery and patient choice to move / defer surgery .

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Trends are analysed and interventions delivered to reduce cancellations. Further work has been delivered to develop the new POAC model, following focus groups working with staff to develop new ways of working developing an efficient patient focussed service which supports the needs of the expanding operative activity in a timely efficient manner .
The pathway model and clinical protocols are currently being finalised and will be presented with the associated workforce plan by 2nd May 2018 .

ACTIONS FOR IMPROVEMENTS / LEARNING

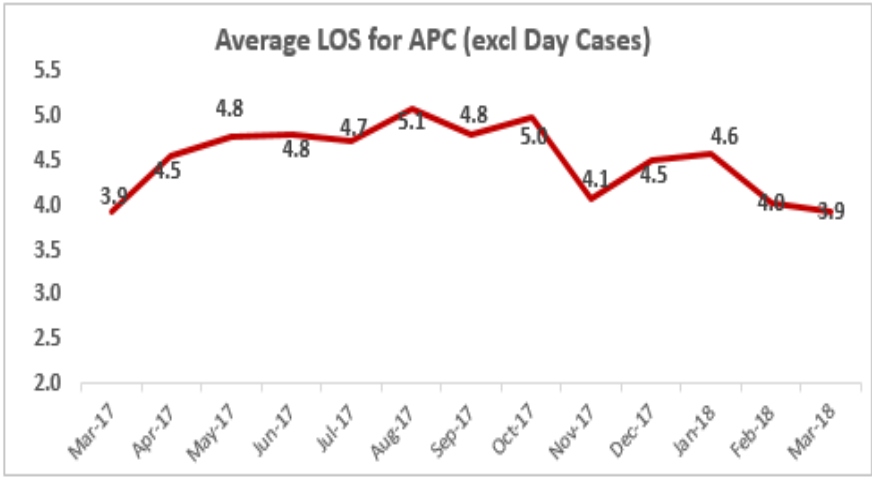
A daily update review by the Operational management team of forward bookings has been established, as well as the and the 6-4-2 weekly meeting. The operations 'Huddle ' is now embedded in practice, with learning shared at weekly Operational meetings across divisions .
Additional focus is being delivered:
- to reinforce accuracy and importance of of ADT information (Admission, Discharge and Transfer)
- Increased Consultant led clinical review with full support from support services
- Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation discussed at the POAC workshop .

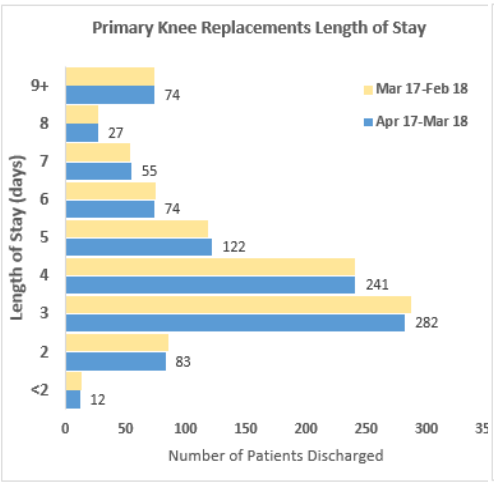
PERFECTING PATHWAYS

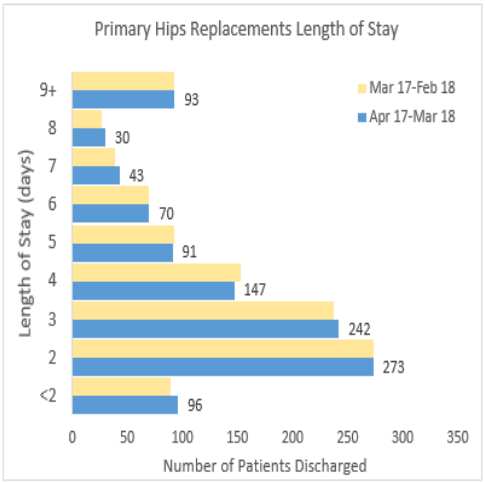
RISKS / ISSUES

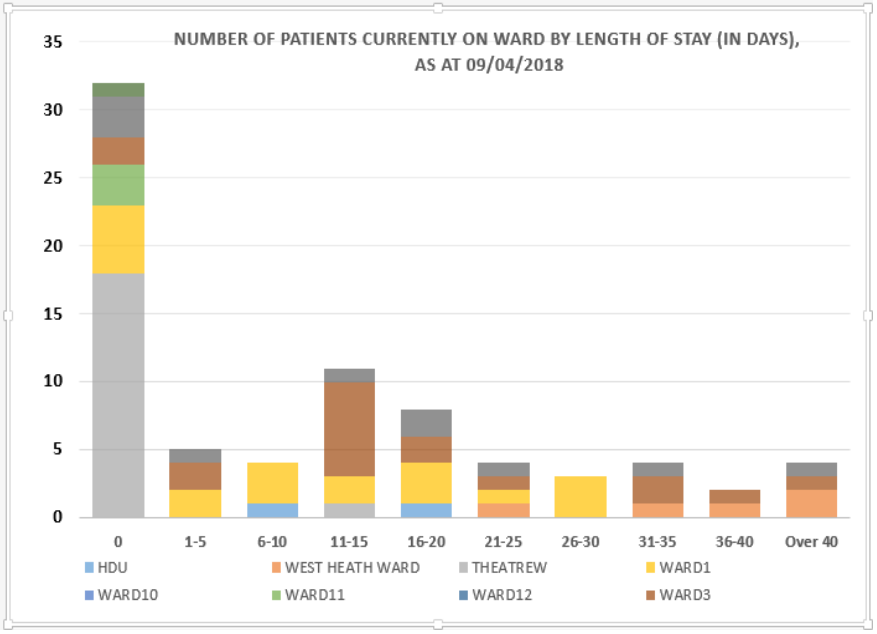
Continued high levels of cancellations in Month .
Shorter turn around times for pre –operative assessment are required to respond flexibly to increased levels of activity.

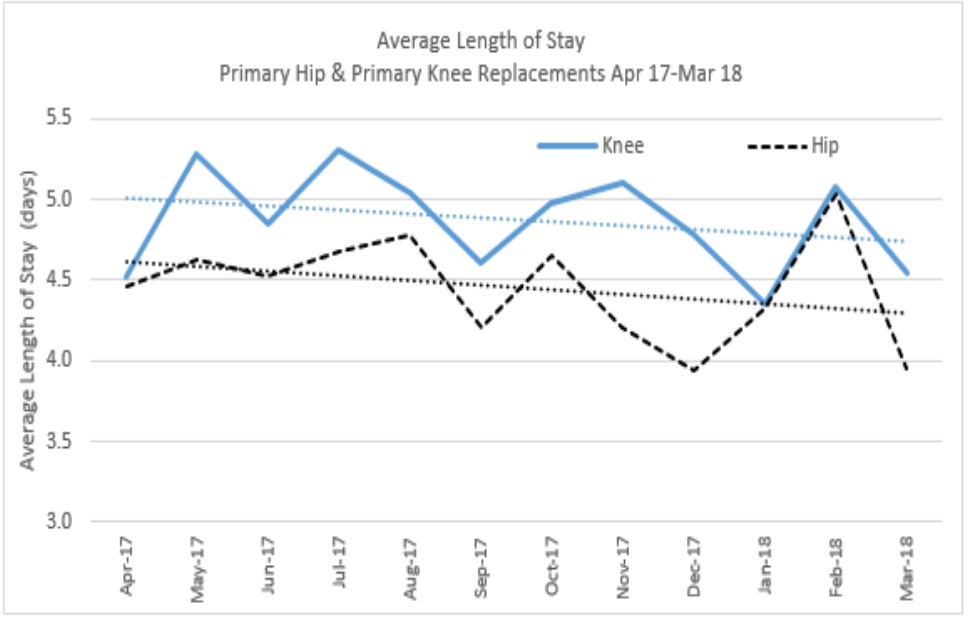
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Activity levels continue to increase against the recovery plan and a reduced LOS is demonstrated in month .
Initiatives to continue to improve LOS are as follows:

- Red2Green is now launched on all wards, supported by a daily 'huddle' which is currently being piloted on ward 2 at 12.00 hrs Monday to Friday. Multi disciplinary Teams are attending these meetings to ensure a pro active collaboration to support timely discharge .
- 'PJ paralysis challenge' is underway (launched April 17th) by Christian Ward (Head of Nursing for Div 1). All wards are fully engaged with this challenge, signing up to the on line app in order to enter the number of patients who are in their own clothes each day actively participating in this national initiative .
- 'Passport to Home 'patient information has now been agreed . PCF have provided input on the correspondence to be provided to patients and it is anticipated that the roll out of the new patient information will commence in May 18.
- Gold/Silver concept now reinforced on all wards to support the improvement in the flow of patients and maximise utilisation of the discharge lounge. Gold/ Silver patients also now being identified on Saturday / Sunday by the sight co-ordinator to highlight patients ready for discharge, to ensure patient flow is maintained over weekends .
- Daily Operational bed meetings commenced 9/4/18 at 9.30am 12pm and 2.30pm to escalate any delays for social care , inter-hospital transfer and expedite appropriate discharges .

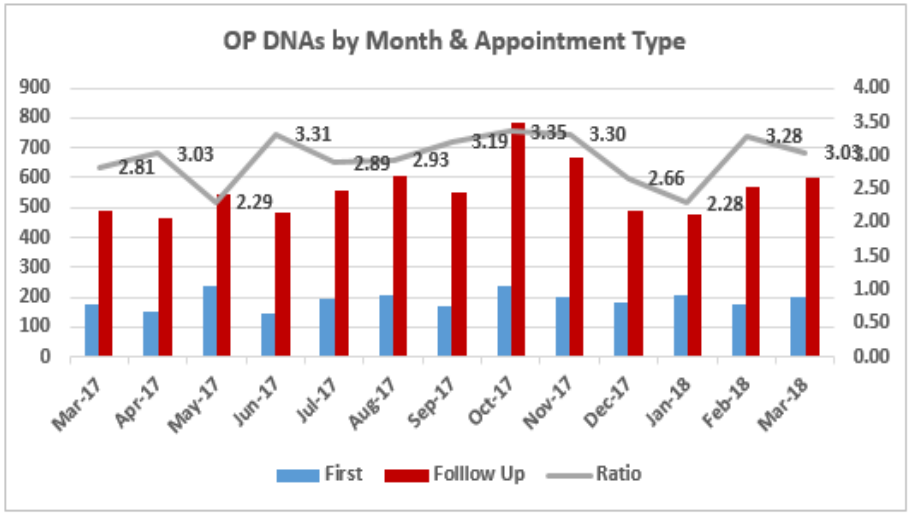
ACTIONS FOR IMPROVEMENTS / LEARNING

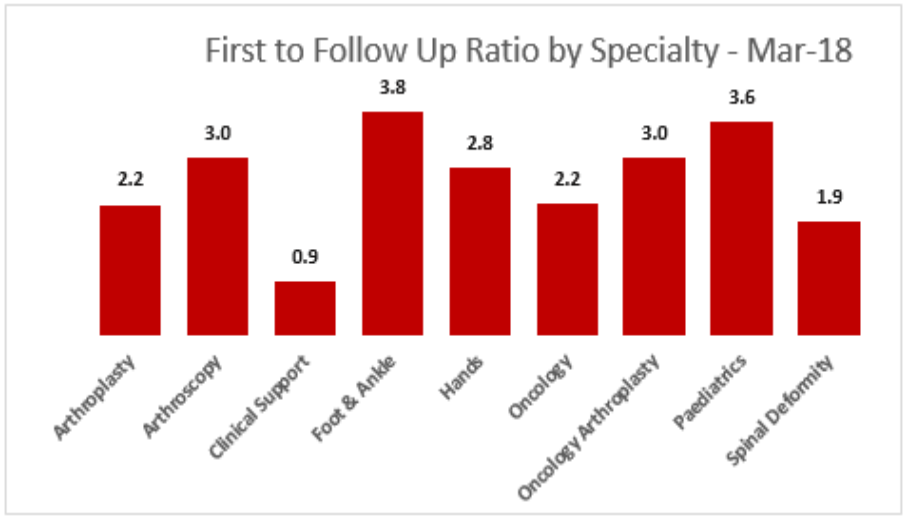
- The Red2Green dashboard development has now been signed off by the pilot wards and is being launched across all wards effective 1 May 2018. (This will provide average length of stay data for each ward, together with the top 10 reasons for any discharge delays. The dash board also records how many Green or Red days were recorded on the wards. This should provide intelligence to support a continued emphasis on reducing LOS across all wards .
- Consultant led ward rounds are now being rolled out across all wards so that all patients are reviewed to support timely discharge . Further work continues to develop with the Arthroplasty team which includes feasibility around a dedicated Theatre environment , freeing up adjacent accommodation to house the Arthroplasty team and work around pre-assessment. There has been some dedicated focus on the Knee Replacement Pathway and this has started to show a reduction in the over all length of stay for this patient group, which will be rolled out to all patients as ' the ROH way ' going forward.

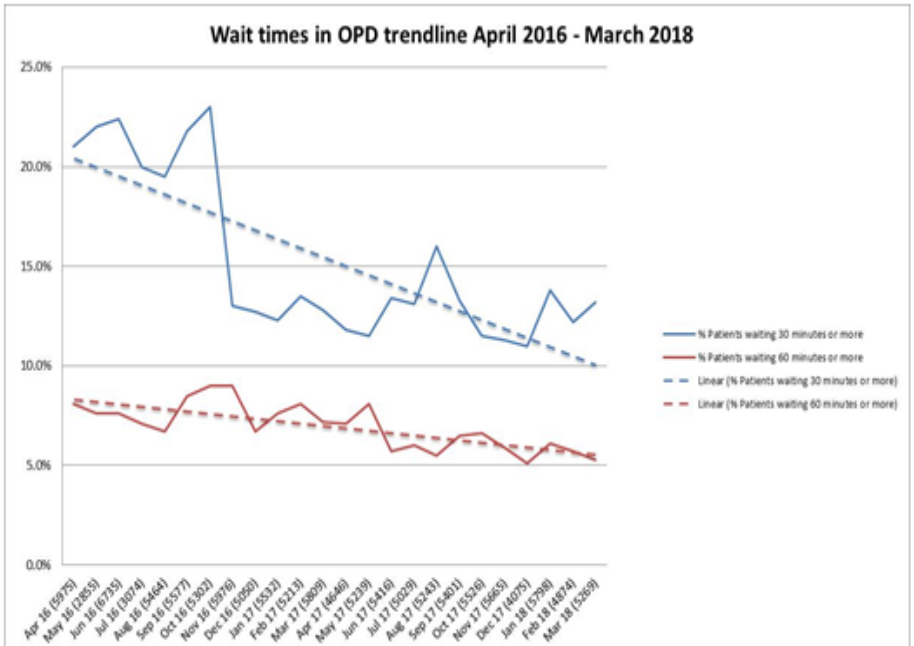
RISKS / ISSUES

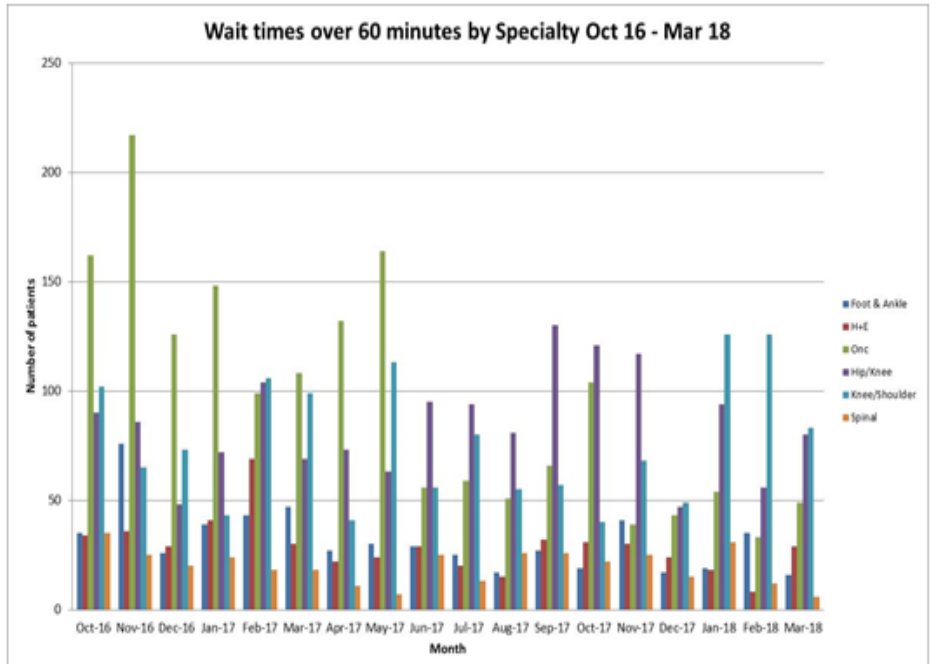
A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity . A bed modelling exercise is now underway to inform future capacity the Trust requires to deliver its activity to support the SOC.

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









INFORMATION

The involvement of the operational management team in the investigation of incident forms relating to clinic delays continues and has triggered at least one new review of a consultant's outpatient clinic template. Issues of clinic capacity continue to contribute to delays in clinic and the ops team are reviewing reporting and processes in order to regularly review this information. In addition there are plans to carryout capacity modelling for outpatient clinics across all specialties as well as reports to monitor and improve clinic utilisation.

In March there were 32 incident forms completed to highlight clinics running more than 60 minutes late; a significant increase on previous months. 13.2% of patients waiting over 30 minutes and 5.3% waiting over 1 hour and this (over 1 hour) is an improvement on the previous month's position. The largest number of incidents were reported in Hip / Knee and Shoulder specialties.
The monthly audit identified the following : -

- 12- Clinic overbooked
- 9- Complex patients
- 8- Consultant/Clinician Delay
- 2- Xray delay
- 1- Other

ACTIONS FOR IMPROVEMENTS / LEARNING

March;
- Continue to drive incident investigations and action through relevant operational manager
- A review of the clinics that have been over booked
- Development and Launch of new electronic clinic rescheduling system through Top Desk
- Review of SOP in relation to clinic rescheduling
- Development of clinic utilisation tools through InTouch and Health Informatics
- Review of individual clinics which are overbooked

RISKS / ISSUES

Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place

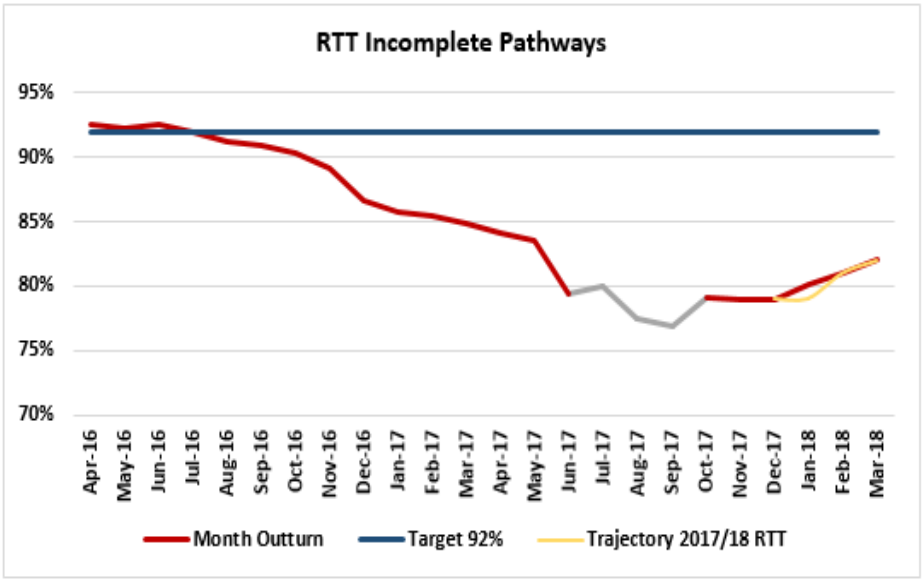
14. Treatment targets – This illustrates how the Trust is performing against national treatment target –

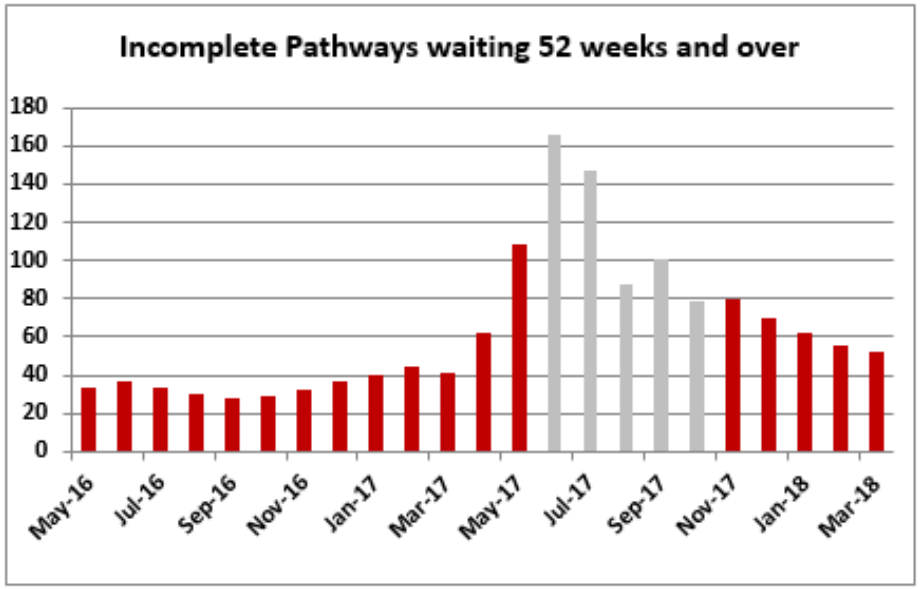
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%

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



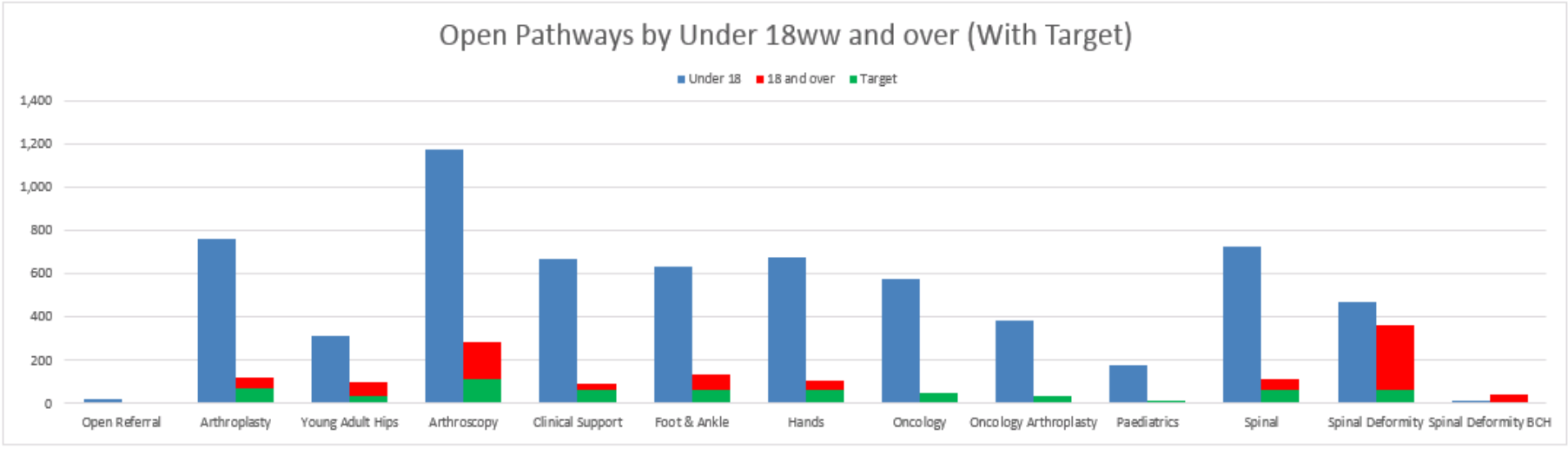


Target Name	National Standard	Feb	Jan	Dec	Nov	Oct	Q3	Breaches	Total	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	100.00%	97.10%	100.00%	100%	95.10%	98.40%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	88.90%	91.67%	100.00%	91.70%	100%	96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100.00%	94.10%	100.00%	100.00%	100%	100.00%	0	30	97.40%	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	n/a		n/a
62 day (traditional)	85%	87.50%	86.67%	83.30%	83.30%	100%	87.50%	1.5	8	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	77.80%	100.00%	50.00%	90.90%	81.20%	82.80%	2.5	14	88.9%	1	9	100%	0	4
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
No. day patients treated 104+ days		0	1	0	0	0									
Accountable Treated 62 Standard		4	7.5	3	5										
Actual Treated 62 Standard		6	10	6	3										
Accountable Breaches 62 Standard		0.5	1.0	0.5	1										

14. Referral to Treatment snapshot as at 31st March 2018 (Combined)

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,530**	14	379	128	625	397	336	368	320	230	115	376	237	5
7-13	**2,166**	6	287	114	386	195	205	226	171	120	41	262	149	4
14-17	**913**	0	96	74	167	76	93	86	89	37	20	90	82	3
18-26	**872**	0	78	64	196	55	100	80	28	20	7	74	166	4
27-39	**397**	0	39	27	83	33	26	24	2	7	9	30	105	12
40-47	**113**	0	5	9	8	6	7	4	0	3	0	10	58	3
48-51	**10**	0	1	0	0	0	0	0	0	0	0	1	7	1
52 weeks and over	**52**	0	0	0	0	0	0	0	0	0	0	0	30	22
Total	**8,053**	20	885	416	1,465	762	767	788	610	417	192	843	834	54

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**6,609**	20	762	316	1,178	668	634	680	580	387	176	728	468	12
18 and over	**1,444**	0	123	100	287	94	133	108	30	30	16	115	366	42
Target	**644**	**2**	**71**	**33**	**117**	**61**	**61**	**63**	**49**	**33**	**15**	**67**	**67**	**4**
	82.07%	100.00%	86.10%	75.96%	80.41%	87.66%	82.66%	86.29%	95.08%	92.81%	91.67%	86.36%	56.12%	22.22%



14. Referral to Treatment snapshot as at 31st March 2018

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**929**	0	123	53	175	43	40	112	111	91	44	94	39	4
7-13	**653**	0	155	37	170	26	10	41	45	67	17	57	25	3
14-17	**252**	0	54	13	66	11	11	18	17	14	10	21	14	3
18-26	**358**	0	51	23	130	8	20	30	22	14	2	28	26	4
27-39	**159**	0	17	18	43	7	6	7	1	7	6	11	24	12
40-47	**53**	0	3	4	5	0	4	2	0	2	0	3	27	3
48-51	**8**	0	1	0	0	0	0	0	0	0	0	1	5	1
52 weeks and over	**44**	0	0	0	0	0	0	0	0	0	0	0	23	21
Total	**2,456**	0	404	148	589	95	91	210	196	195	79	215	183	51

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**1,834**	0	332	103	411	80	61	171	173	172	71	172	78	10
18 and over	**622**	0	72	45	178	15	30	39	23	23	8	43	105	41
Target	**196**	**0**	**32**	**12**	**47**	**8**	**7**	**17**	**16**	**16**	**6**	**17**	**15**	**4**

	74.67%	n/a	82.18%	69.59%	69.78%	84.21%	67.03%	81.43%	88.27%	88.21%	89.87%	80.00%	42.62%	19.61%

Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,601**	14	256	75	450	354	296	256	209	139	71	282	198	1
7-13	**1,513**	6	132	77	216	169	195	185	126	53	24	205	124	1
14-17	**661**	0	42	61	101	65	82	68	72	23	10	69	68	0
18-26	**514**	0	27	41	66	47	80	50	6	6	5	46	140	0
27-39	**238**	0	22	9	40	26	20	17	1	0	3	19	81	0
40-47	**60**	0	2	5	3	6	3	2	0	1	0	7	31	0
48-51	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
52 weeks and over	**8**	0	0	0	0	0	0	0	0	0	0	0	7	1
Total	**5,597**	20	481	268	876	667	676	578	414	222	113	628	651	3

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**4,775**	20	430	213	767	588	573	509	407	215	105	556	390	2
18 and over	**822**	0	51	55	109	79	103	69	7	7	8	72	261	1
Target	**448**	**2**	**38**	**21**	**70**	**53**	**54**	**46**	**33**	**18**	**9**	**50**	**52**	**0**

	85.31%	100.00%	89.40%	79.48%	87.56%	88.16%	84.76%	88.06%	98.31%	96.85%	92.92%	88.54%	59.91%	66.67%

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For March 2018 the RTT trajectory was 82% with performance at **82.07%** , with 52 patients over 52weeks. As confirmed in the trajectory all specialties other than spinal deformity would treat all patients at or over 52 weeks – this was achieved in March 2018.

The team have reviewed all spinal deformity patients and produced a trajectory submitted to NHSI & NHSE. This has been reviewed by the NHSI Intensive Support Team (IST).

ACTIONS FOR IMPROVEMENTS / LEARNING

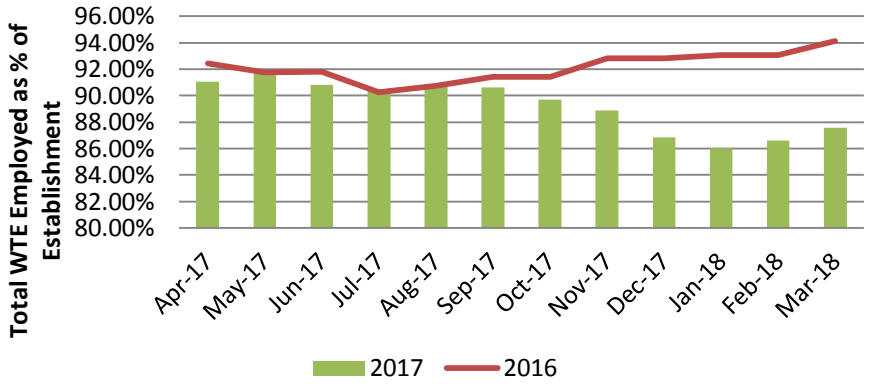
The team continue to concentrated on any patients over 40 weeks, this number continues to reduce. At the end of December 2018 we had 238 patients over 40 weeks, at the end of February 2018 this figure is now 123. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.

RISKS / ISSUES

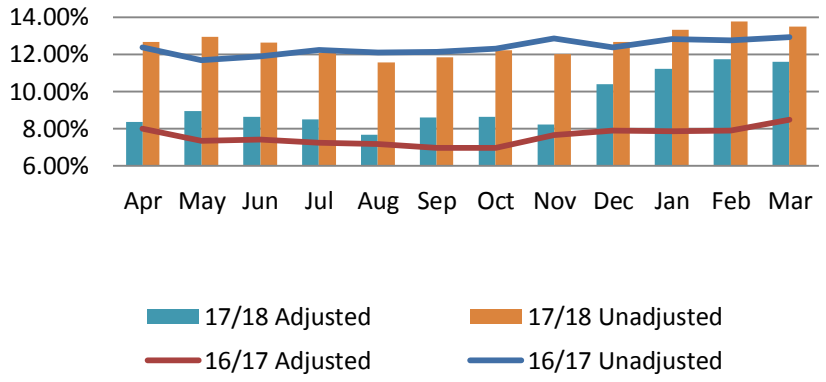
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity which had been planned up till April 2018 is now being planned through the Summer to assist with the existing waiting list . 5 patients have been transferred to Stoke for treatment following discussion with patients and their families.

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

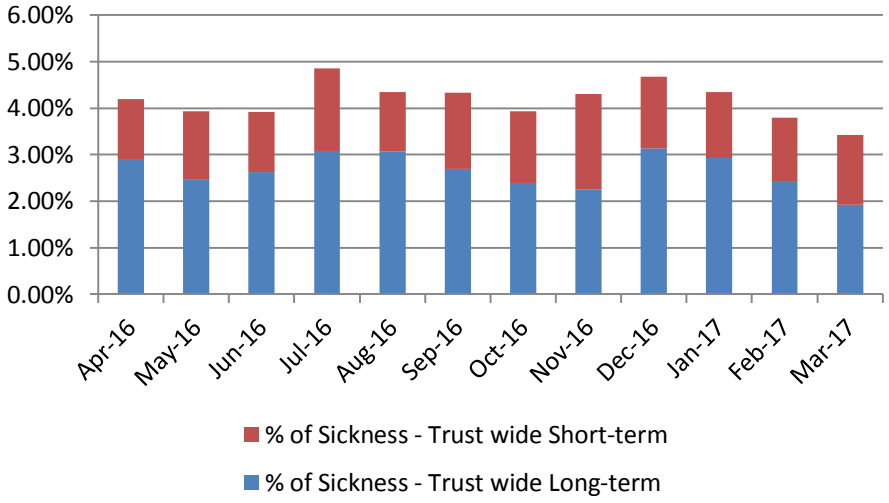
Staff in Post v Establishment



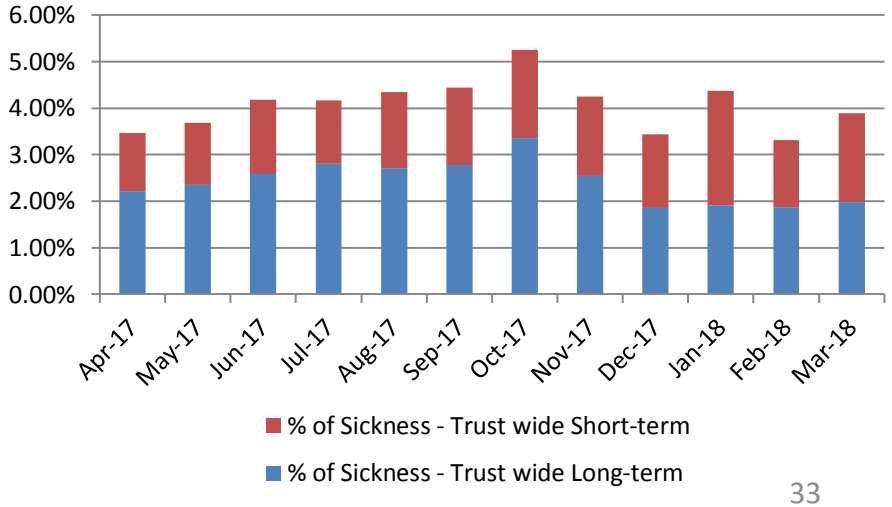
Staff Turnover



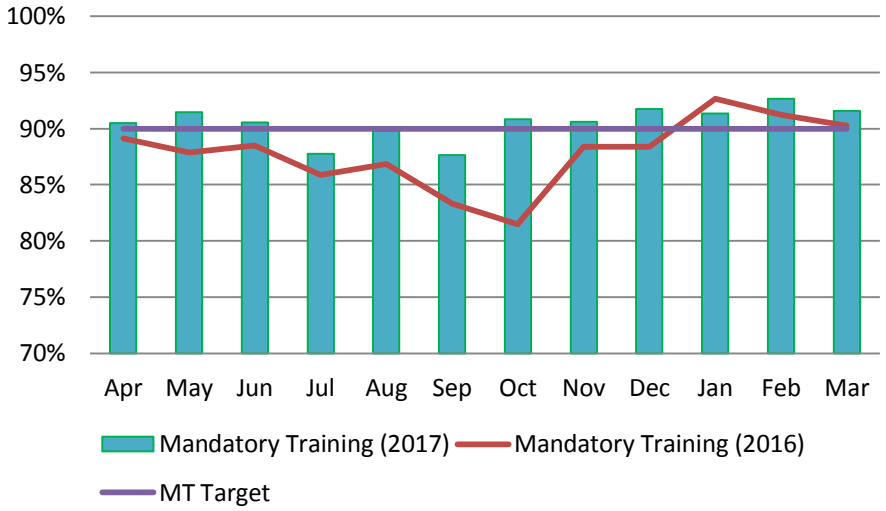
Sickness % - LT/ST (2016/17)



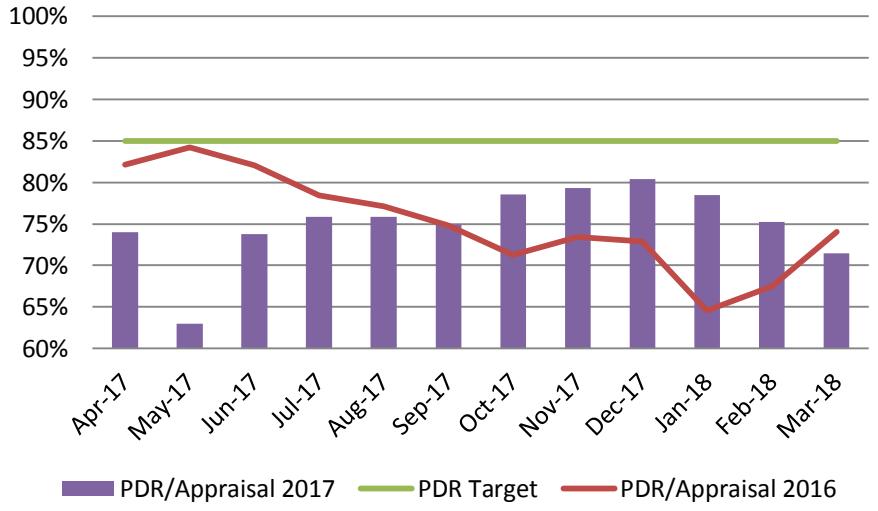
Sickness % - LT/ST (2017/18)



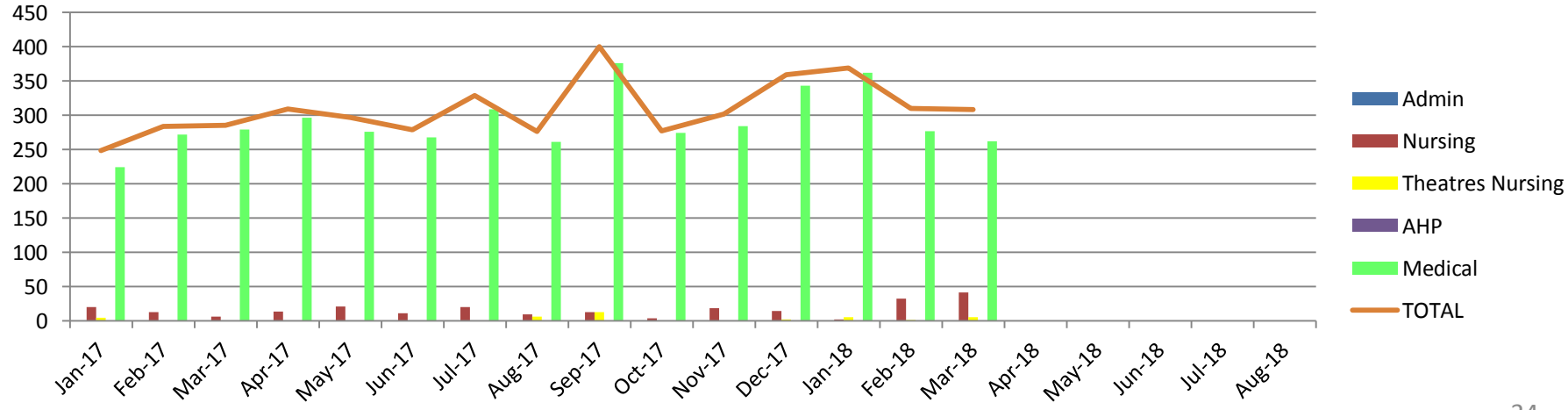
Mandatory Training



PDR/Appraisal



Agency Breaches



INFORMATION

In general terms, March was a month of encouraging performance. Staff in post increased, turnover fell, agency breaches fell very slightly, and mandatory training and sickness absence both remained green. Appraisal was the indicator which remains in need of focus.

In March, sickness absence increased by 0.58% to 3.90% in month - but remains green - and is lower than the average for the month of March (4.25% over the last 10 years). On the other hand, our underlying 12 month average figure decreased very slightly by 0.01% to 4.16% and is also still green. From next month, sickness absence metrics will change to represent an attendance figure as opposed to an absence figure; the green key performance indicator rating has also been adjusted from 4.1%/95.9% to 3.9%/96.1%. The Trust is changing its thinking to considering attendance at work as the metric at the same time as setting higher expectations.

This month the Trust's vacancy position saw improvement of 0.98% to 87.57%. Our staff in post headcount continues to rise as our recruitment activity to unfilled posts continues. This financial year will see a slight variation to the vacancy position; the green Key Performance Indicator (KPI) rating will be divided into a Trust wide figure (which will be reduced to 90% compared to the current 93%) and also a Non-Clinical filled posts target of 94%. It is recognised that this will be a stretch target but reflects the Trust's ambition to improve its recruitment performance.

Mandatory Training decreased in March by 1.1% but continues the last 6 month trend by remaining green at 91.56%. It is still higher than the 17/18 average of 90.55%. The L&D Team are continuing to encourage staff to book onto courses or carry out their mandatory training via e-learning. The target for mandatory training will also increase to 92% from next month.

March's appraisal performance saw a decrease of 3.78% to 71.46%, the lowest it has been since May 2017, so the Trust remains red. This will be addressed in Divisional Boards and divisional performance reviews in April. The implementation of the proposed revisions to the national Agenda for Change pay arrangements (on the assumption that the proposed arrangements are agreed) should produce an increase in appraisal performance and enable more of a performance management framework and culture; consequently the PDR Key Performance Indicator will increase from 85% to 92.5% from April 2018.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) as expected decreased by 0.20% to 13.49%. There will be no changes to the KPI for unadjusted turnover, although from next month the adjusted turnover figure (substantive staff leavers including retirements) will be 11.5%, this is a revised rating as previous adjusted turnover figures omitted retirements.

ACTIONS FOR IMPROVEMENTS / LEARNING

The number of Agency breaches decreased by 2 in March, due to the number of Medical breaches decreasing from 362 in January to 277 in February and then to 262 in March. Oppositely, Nursing breaches increased from 32 in February to 41 in March, with Ward Nursing using the majority but Theatres also increased from 1 to 5 this month.

RISKS/ISSUES

Appraisal continues to be an area where focus is needed. There is work ongoing in HR&OD to review the process to ensure that high quality appraisals are easy for managers to undertake.

ROHTB (5/18) 005

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**2 May 2018**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at April 2018

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

<u>Summary of Key Updates</u>

The following risks have seen a reduction in their 'controlled risk score':-

- Risk No CE2 – 25 down to 20
- Risk No 1089 – 16 down to 12
- Risk No 1088 – 12 down to 8
- Risk No 7 – 20 down to 16
- Risk No CO3 – 16 down to 9
- Risk No CO1 – 12 down to 9
- Risk No 269 – 16 down to 12
- Risk No 770 – 16 down to 12

1 risk is proposed for closure:-

- Risk No 801 – Risk has reached its target score and will be proposed for closure at the next Board meeting

ROHTB (5/18) 005

REPORT RECOMMENDATION:					
Audit Committee 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:					
Audit Committee on 23 April 2018					

BOARD ASSURANCE FRAMEWORK Q4 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
CE2	Corporate	Paul Athey	There is a risk that the ROH Trust Board carries all the clinical risk residing with the transition of Inpatient Paediatric Services whilst the system re-commission and re-provides the services elsewhere.	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	5	5	25	The Trust agreed that it could not meet the national service guidelines and as such gave notice on the provision of the inpatient service. All stakeholders have confirmed that this should be managed as a system wide risk and this is done via the monthly Stakeholder meetings and the Paediatric monthly commissioning group. The Trust and the health system all acknowledge that the Inpatient Service at the ROH is not compliant with national guidance during this transition period. All stakeholders have agreed an amendment to the oversight group terms of reference stating "Whilst it is acknowledged that the ROH maintains accountability for each patient that is treated during the period during which the paediatric service remains with the ROH, all stakeholders within the group agree that the provision of a safe service during the transition period is their joint responsibility".	Minutes of stakeholder oversight meeting	4	5	20	↓	Agreement at joint stakeholder group that a system-wide risk sharing statement will be developed	Q4 2017/18	3	4	12
CE1	Corporate	Paul Athey	The Trust does not currently have a clear financial and operational plan in places that describes how the organisation will deliver 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. This strategy has been updated by the Board in Q4 2017/18. A Strategic Outline Case has been accepted by the Board outlining options for future growth. Discussions are taking place with partners in the STP to work through options for providing closer clinical integration between the ROH and other partners, which will built resilience and support the move towards financial sustainability	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	5	25	↔	Agreement of system wide clinical and operational model for orthopaedics and subsequent ROH business and financial plan for sustainability	Mar-19	2	5	10
FP1	Finance	Steve Washbourne	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	5	5	25	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	↔	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 in developing a sustainable business model for the ROH which is in line with the requirements of the STP and other commissioning bodies	Mar-19	3	5	15
1089	Operations	Jo Williams	There is a risk that the Trust fails to meet the improvement trajectory for the national 18 weeks RTT target	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	Trajectories have been 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 were held to agree how the Trust will expand capacity to meet demand. Teams have completed trajectories for all services. A recovery trajectory is in place to achieve 92% by November 2018	Weekly report to Exec Team & Ops Board	3	4	12	↓	Work is ongoing to increase activity and treat the backlog. The Trust has in place a trajectory to deliver 92% performance by November 2018 - this is monitored monthly.	Q3 2018/19	3	4	12

1117	Operations	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	A SOP for the review of patient timelines to provide a consistent approach and level of detail for patients has been developed. 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. Daily validation process in place to ensure any RTT sequencing errors are corrected.	Weekly report to Exec Team & Ops Board	3	4	12	↔	Use of the harm process to review patients who are perceived to have had a delay in the pathway continues.	Ongoing	3	4	12
1088	Operations	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	Training of admin teams and clinical staff has been completed. The Trust has completed a full data cleanse of all its RTT data including historical clock stops. A daily RTT dashboard and data error report is in use and supports daily RTT management. The Trust returned to national reporting in December 17.	Weekly report to Exec Team & Ops Board	2	4	8	↓	Validation work continues to identify any data quality issues. A trajectory to return to 92% performance is in place.	Q2 2018/19	2	4	8
293	Finance	Steve Washbourne	Financial surplus Failure to deliver planned financial surplus, impacting on financial stability, investment opportunities and regulatory rating.	With safe and efficient processes that are patient centred	FPC	4	5	20	Draft figures for month 12 suggest that the Control Total for 2017/18 (£6.2m deficit) has been met. A final financial plan will be discussed at Finance and Performance Committee in April before submission to NHSI which shows the Trust meeting an improved control total of circa £6m deficit in 2018/19.	FPC Reports	4	5	20	↔	Perfecting Pathways to continue to deliver activity and operational process improvements Continuing performance meetings for each division	Ongoing	4	3	12
1137	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 Safety Group minutes presented to IPC Group meeting.	4	5	20	↔	Future meetings scheduled for Water Safety Group who will monitor the position. Water testing undertaken at 6 monthly intervals.	Q4 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 & QSC	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. A trajectory is in place to support delivery and monitor progress.	Weekly updates to Exec Team; updates to Trust Board.	4	4	16	↓	All patients have been validated to provide an accurate position of the number of patients waiting for surgery at BWCH. Additional operating list have been covered through Sept-Nov and further list are being populated until April 18. Contingency patients are in place when PICU beds are not available. Additional Theatre capacity is being developed for Qtr 1 18/19. Additional weekend operating is in place until July 2018 and a small cohort of patients have been transferred to Stoke for treatment	Ongoing	2	4	8
CO3	Operations	Jo Williams	Theatres - there is a risk that the department is not operating effectively and is in need of a full review supported by a organisational development programme	Delivered by highly motivated, skilled and inspiring colleagues	FPC	4	5	20	The operational team for Theatre has been strengthened with the appointment of a new Theatre Manager and Matron. Further work with the team is ongoing to ensure that we continue to progress development across the entire Theatre team.	Perfecting Pathways Board papers and minutes	3	3	9	↓	To support the Perfecting Pathway programme and the Trust recovery plan there remains a need to conduct a full review of theatres supported by an OD programme. An initial assessment is currently ongoing to assess whether external support is required to support this. The workforce plan will be discussed at the Staff Experience and OD Committee in March 2018 as this needs to be developed to support and deliver the operational annual plan. The Theatre Manager post will be advertised & recruited substantively in April 2018.	Q2 2018/19	3	3	9

1030	Operations	Jo Williams	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 the arthroscopy stacks have been restored and there are now 6 working units in theatres. Fridge monitoring and ambient temperature monitoring equipment is being ordered and the theatre alarm system is also being progressed urgently.	Funding requests. Outputs of the prioritisation exercise. Capital plan.	4	4	16	↔	Current exercise reviewing risks and re- prioritisation of equipment replacement/repair is ongoing to direct the spending of the existing 2017/18 equipment budget. 2017/2018 allocated equipment has been delivered, 2018/2019 capital has been agreed and will go to F&P Committee at the end of April 2018.	Ongoing	2	2	4
CO1	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	3	3	9	↓	Delivery of the Cancer Action Plan. Onkos provides a daily tracking system. The team are developing proposal to implement a new system from April 2018 - this is supported by the Cancer Action plan. A new system has been approved for implementation in 2018. A project group will be established in April 2018 to manage the implementation	Q1 2018/19	2	2	4
544	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	Removed from formal monitoring by NHSI in October 2017. Expected that rapid improvement will now take place due to the commencement of IPC Lead Nurse in February 2018.	Infection Control Committee minutes; Infection Control upward report to Quality & Safety Committee	3	3	9	↔	Continued delivery of the IPC action plan and monitoring by the ICC Committee.	Ongoing	1	4	4

CO2	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 needs 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. The operational team has been strengthened within a number of areas.	Trust Board reports on operational initiatives, including validation of 18 weeks RTT, Scheduled Care Improvement Board and theatres improvement programme	3	3	9	↔	The position will be reviewed weekly at Executive team meeting to ensure that this is not impacting on delivery of the projects This will continued to be monitored monthly. Perfecting Pathway encompasses and supports the operational team to deliver service changes and redesign. A substantive Deputy COO joined the Trust in February 2018	Q4 17/18	2	3	6
27	Operations	Jo Williams	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.Nov 17 - all agency staff to support RTT have been ceased form the end of October 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.	3	3	9	↔	Continued stringent controls for employing agency staffing. Work is on-going to review the future junior medical workforce plan in line with the strategic outline business case. Weekly vacancies/sickness is monitored and appropriate action taken to mitigate agency staffing. A medical workforce officer will be recruited to the Trust during April and May 18 to further strengthen this function working closer with the operational and clinical teams	Ongoing	2	3	6
269	Operations	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.	3	4	12	↓	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
270	Finance	Steve Washbourne	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	Ongoing	2	4	8

770	Operations	Jo Willams	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	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible.	Estates maintenance schedule	3	4	12	↓	Improvement Board to continue to track performance against turnaround work streams. A maintenance programme is being developed for the end of February 2018 including the cost for backlog maintenance, this will be discussed at Execs. A modular Theatre is being explored and costed to support the maintenance programme and support additional capacity for ROH and the STP. A full week of maintenance was carried out in theatre with a full shutdown 30th March 2018-9th April 2018.	Ongoing	1	4	4
1085	IM&T	Steve Washbourne	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	IM&T Programme Board	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	↔	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. A further 3rd Party assessment is being undertaken by Dionnech in March 2018 as part of further round of national work being undertaken by NHS Digital. A capital submission has also been made.	Ongoing	2	4	8
804	Finance	Steve Washbourne	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	4	16	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	3	4	12	↔	Development of the data warehouse and ongoing development of in house intelligence	Ongoing	2	4	8

1031	Operations	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 now been fully implemented and is used for all products in implant stores.	Stock internal audit report. FPC min	2	4	8	↔	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. A full stock take took place at the end of March 2018.	Q4 2017/18	2	2	4
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	Production of the monthly Quality Report that contains a clear focus on lessons learned from incidents, Litigation, Coroners cases, Serious Incidents, Patient Advice and Liaison Service (PALS), Friends and Family Test FFT, Complaints and Training Compliance. The Trust has in place an effective process to report, investigate, monitor and learn from Serious Incidents and complaints. There is the timely and appropriate dissemination of learning following an incident or/and complaint. This includes dissemination to Consultants at the Clinical Audit day. All Trust Operational Divisions have both monthly and weekly meeting of their Divisional Governance Team as part of their local governance arrangements. Meetings are attended by the senior management team of the Division which includes as a minimum the Associate Medical Director, Head of Nursing, Divisional manager and Head of Professional Service (e.g. Pharmacy, Pathology Services Manager etc.). The Divisional Governance Team will receive local intelligence relevant to their areas of responsibility so that they can assess performance against an extensive range of quality indicators. The Divisional Governance Teams report to the Clinical quality group Committee on a monthly basis via the Quality Dashboards and Condition reports that were introduced in March 2017 as a framework to assure quality, safety. The divisional weekly meeting focus on examining the evidence that actions have been taken to help the Trust learn from serious incidents, complaints, risks and claims. The action plans are active documents which identify the context of the recommendations, clear goals and implementation plans, for example, timescales and the names and positions of staff delegated to lead the changes. The Trust Quality committee structure and subcommittees are established to facilitate Trust wide level representation and sharing of minutes. The Complaints/Governance team ensuring all incidents, complaints and claims are monitored and have Executive oversight at the weekly Executives Meeting. Monthly analyses of incidents/Complaints are included in the monthly Divisional management board Governance report and show Trust and Divisional trends.	Patient Safety & Quality Report presented monthly to QSC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	2	3	6	↔	The Trust has some key recommendations and actions to improve the sharing of learning further:- Ensuring that the electronic reporting system (Ulysses) is used to its full potential to enable a thorough analysis of the incidents, causes and outcomes of incidents, complaints and claims. Action plans will be programmed to remind staff of actions automatically; The annual staff and patient surveys will be reviewed for information relating to patient safety; with a focus on feedback from incidents; The development of local ward and department level quality reports that contains a clear focus on lessons learned from incidents, Litigation, Coroners Court, Serious Incidents, PALS, FFT, Complaints, Clinical Audits, Training Compliance. This will allow lessons to be disseminated to frontline staff more efficiently; To implement and embed the three intentions of the Quality Governance Framework; and Further Human Factors training as the Trust looks to embed the human factors principles to develop solutions that reduce the risk of the same incidents happening again.	Q4 201/18	2	2	4
CE3	Corporate	Paul Athey	Risk that the plan for Paediatric is not aligned with the wider STP strategy for Orthopaedics	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	3	5	15	The Trust is actively engaged with the STP and clinical reference groups across BSOL are in place to shape the orthopaedic strategy for the future	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Agreement of transition plan following formal approval of transfer of paediatric surgery by BWCH	Q1 18/19	2	4	8

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	A number of strategic meetings have been held with various external partners to look to develop a sustainable methodology for implementing small and larger scale change within the organisation. This includes the development of a simple continuous improvement tool. Both non-executive and executive directors have been involved in discussions with McLaren F1 Group, ABHI and their subcommittee of industry partners and finally the AHSN. All of these discussions are a various stages of maturity and the developments will be discussed at the Staff Experience and OD Sub-committee of the Board, (this is the replacement committee formerly Major Projects and OD Committee) and again at the Board. There are significant opportunities for the Trust to work in partnership in developing a strong platform for service improvement, this will be directly linked and will work with the Perfecting Pathways work that is already identifying areas for improvement.	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	Finance	Steve Washbourne	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	4	12	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 cash flow 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	4	8	↔	Continued focus on efficiency and cost control through the recovery plan	Ongoing	2	4	8
986	Nursing	Garry Marsh	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for	Safe and efficient processes that are patient-centred	Q&S	3	4	12	Nurse WTE: 30 WTE Trust Wide 18 WTE in Post 12 WTE vacant (7 HDU, 5 Ward 11) The Director of Patient Services has contacted all local NHSE providers to enquiry whether they could strengthen the rota. 10 WTE seconded from Wolverhampton Hospital. Combined rota allows better oversight of nurse staffing levels. Children's Quality Report triangulates staffing vs harm and is scrutinised at CYP Board.	Q&S Report	2	4	8	↔	4wte have been secured via agency and the induction and training programme is currently being arranged. This will be a block booking to ensure continuity. Interviews held in January 2018, WTE band 5 appointed awaiting start date from HR.	Ongoing	1	4	4
PS1	Nursing	Garry Marsh	There is a risk that patient care/safety may be compromised as we do not have enough Paediatric staff/vacancies on the ward.	Safe and efficient processes that are patient-centred	Children's Board	3	4	12	10 WTE seconded from Wolverhampton Hospital. Combined rota allows better oversight of nurse staffing levels. Children's Quality Report triangulates staffing vs harm and is scrutinised at CYP Board.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses.	Ongoing	1	4	4

MD1	Clinical	Andrew Pearson	There is a risk that there will be some clinical resistance to the change in the way Paediatric Services are delivered	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	4	3	12	Briefing sessions have been held with all the clinical teams including clinically led reference groups established who meet to discuss the potential options and likely impact. A clinical session was also held in September chaired jointly with the ROH and BWCH Medical Directors to talk through the changes, the rational and the timeframe. This is supported by regular updates via email, team brief and 1-1 discussions with the Executives Team.		3	3	9	↔	Continued briefing sessions to be delivered through routine and bespoke staff communication routes	Ongoing	2	2	4
CE4	Corporate	Paul Athey	There is a risk to the ROH reputation should the Paediatric service not be transferred in a timely and safe manner		Exec Team/Trust Board	4	3	12	The Transition of services is due to take place from November 2018, however formal sign off is still outstanding. There is a risk that this timeframe could be extended. The Executive team continue to play an active part in system conversations to drive agreement of a transition plan. An internal governance structure for the transfer of services has been agreed by the Trust Board in April 2018. A communication plan is in place to ensure staff and patients are updated as and when circumstances develop	Team Brief; Joint stakeholder meeting minutes; Other system wide meeting minutes; Local transition group minutes, Children's Board minutes; E-mail correspondence from clinicians to Execs	4	3	12	↔	As part of the system wide meeting structure all risks relating to the transfer of services will be jointly risk assessed and appropriate mitigation will be in place.	Q2 2018/19	2	3	6
FP2	Finance	Steve Washbourne	The Trust is likely to incur transitional costs with the transfer of Inpatient Paediatric Services	Safe and efficient processes that are patient-centred	FPC	4	3	12	The Trust has highlighted the risk to NHSE and requested funding support should material additional costs be incurred. The Trust continues to review how existing resources can be utilised to ensure safe services and mitigate additional cost where possible.	Joint stakeholder meeting minutes	4	3	12	↔	The Trust would look to gain firm agreement with NHSE for the changes in local prices where the cost base increases on recurrently during the changes. The DOF met with the HoF from NHSE on 14/02/18 to discuss how a request for additional funding to support Paed services may be made during 2018.	Q4 2017/18	1	4	4

801	Corporate	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. New appointments into the management team have been made to strengthen controls and ability to deliver against regulatory requirements and to provide greater resilience in delivering ad-hoc and business-as-usual actions concurrently. Clear governance lines to ensure focus on key issues for Trust and regulators. Recent evidence with regards to the actions of regulators suggest that their emphasis is supportive of the Trust's strategic direction and creating incentives to pursue this rather than diverting attention from it	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.	2	3	6	↓		Ongoing	2	3	6
5799	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	A Strategic Outline Case has been created, the development of which included multiple direct staff engagement workshops with various groups of clinicians across the Trust. A Chief Executive briefing session was delivered in January 2018, which reinforced the key messages of the SOC, in addition to the launch of the Five Year Vision which was signed off by the Board in early 2018.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case	2	3	6	↓	Staff to continue to be engaged with the development of the Outline Business Case and later the Full Business Case for the ROH.	Q1 2019/20	2	3	6

S800	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	New structure for the Clinical Governance Team developed. Processes for reporting up into the Quality & Safety Committee continue to work well and form a key part of the Committee's agenda at each meeting. Assurance reports from Committee chairs up to the Trust Board continue. Assurance review into effectiveness of Board & Committee operating commissioned.	Divisional Management Board agendas, papers and minutes. Clinical Governance structure chart; TOR and work plan 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. New Governance Team structure to be implemented in May 2018. Report from Board & Committee review to be concluded and make recommendations.	Q1 2018/19	1	3	3

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 April 2018
Guests	Ms Karen Hughes, Patient safety & Clinical Training Lead Dr Graham Caine, Head of Pathology Mrs Ange Howling, Lead Nurse for Infection Prevention & Control Ms Carolyn Langford, Head of Research, Audit and Development Mrs Julie Gardner, Assistant Director of Finance (Contracting)
Presentations received	None
Major agenda items discussed	• Quality & Patient Safety report • Nurse staffing update • Draft Quality Account 2017/18 • HTA licence compliance assurance report • CIP quality impact assessments • Quality assurance walkabouts updates • Research & Development Committee – upward report • Infection Control Committee – upward report, terms of reference and workplan • HDU and Outpatients CQC action plan exceptions • Divisional governance assurance • Contract scorecard and CQUIN update • Terms of Reference
Matters presented for information, update or noting	• Minutes of the Clinical Quality Group • Quality & Safety risks on the Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Committee discussed a case where a patient had, post-surgery, deteriorated due to sepsis and had needed to be transferred out to another acute provider, but had subsequently died. Some shortfall in the management of the patient and a failure to escalate early enough had been identified and would be investigated • There were a greater number of infection control incidents reported, although it was suggested that this related to the renewed focus by the new Infection Control team and the widened scope of surveillance beyond the previous set of specialities • There had been a near miss incident in theatres which the Associate Medical Director was investigating and a report will be brought to the next meeting • There had been an increase in the number of falls and the inpatient matron was reviewing the position

	• There had been an increase in the number of pressure ulcers, with three out of the four reported this month being in the HDU. Work was underway to understand the reasons behind these and the Tissue Viability Lead was engaged with this; an early view is that not all would be classed as avoidable • The Trust's use of agency staffing had increased – this reflected the increase in core activity and vacancy coverage • The Committee was advised that there was a risk in terms of central funding for the Research & Development work. It was also highlighted that there was a lack of space for Research & Development to interview patients in clinical areas which needed to be addressed. The attendance at the R&D Committee from areas across the Trust was noted to be poor and therefore some suggestions were given as to how this might be addressed. • The Trust had not met the Quarter 4 CQUIN target against timely treatment of sepsis.
Positive assurances and highlights of note for the Board	• The Committee was advised that the level of resuscitation training had improved and further work was underway to ensure that staff were undertaking training appropriate to their level and role • The Trust's position on the National Reporting and learning System was good compared with other trusts and this suggested a positive incident reporting culture • Work was underway to widen the scope of information included in the Quality Report and discussions were being held with senior medical staff, therapies and diagnostics to understand what would constitute useful metrics to include. The procurement of an electronic system to assist with this was being considered. • The Committee received an encouraging update on work to strengthen the Trust's nutrition arrangements. A multi-disciplinary task and finish group had been established, whose work included optimising patient's nutritional state prior to surgery. The individuals in this group who were provided by a Service Level Agreement were noted to be particularly effective. A nutrition strategy was under development. • The Committee reviewed the draft Quality Account, noting the significant work that had been needed to develop this document • An update on the Trust's compliance with the Human Tissue Act (HTA) licence was provided, which did not highlight any issues of significance; the Trust would be assessed again shortly • The improved process for developing and approving Cost Improvement schemes' Quality Impact Assessments was

	discussed • The outcome of the Quality Assurance walkabouts to Radiology & MRI and Ward 12 was presented. In both cases, the areas had been rated 'Good'. The cleanliness standards in Radiology were noted to have been maintained. • A positive update on Infection Prevention and Control was provided, which highlighted that standards were good across the Trust in general. The delivery plan for the IPC team was received and noted. • It was noted that the Clinical Quality Group was now operating more effectively. • An update from the Research & Development Committee was considered, which highlighted that it had been a strong year in terms of recruitment into clinical trials • An update on the performance against the contract and CQUINs was discussed. Overall this was a positive picture, with improvements in the performance against the 18 weeks RTT target, the declining number of 52 week waits and improved training position. CQUINs associated with healthy foods and 'flu vaccinations had been met.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Alison Warren to be invited to the next meeting to provide an update on resuscitation training • An update on water management and compliance with the associated regulations to be presented at the next meeting • Discussion to occur at Staff Experience & OD Committee to understand the work being undertaken to address the nursing vacancies • An update on compliance with the HTA licence to be provided to the Clinical Quality Group • Report into burns in theatres to be presented at the next meeting • The Executive Team to review the R&D Committee terms of reference
Decisions made	• The Committee approved the revised terms of reference for the Infection Prevention & Control Committee • The Committee supported the proposed revisions to its terms of reference and agreed that they should be presented at the next Trust Board meeting

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

For the meeting of the Trust Board scheduled for 2 May 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Quality & Safety Committee
Terms of Reference
Revised April 2018

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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) Staff Experience & OD Committee
(iv) Finance & Performance Committee

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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** – 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.

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, Health & Safety Committee, Research & Development Committee, Clinical Audit & Effectiveness Committee 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
Chief Operating Officer

9 Quorum

At least two NEDs (including the Associate Non Executive Director) and one from Executive Medical Director or Executive Director of Patient Services. In the event that either the Executive Medical Director or Executive Director of Patient Services is unable to attend, a deputy will be provided, although they will not contribute to

the quorum.

10 Secretariat
Associate Director of Governance & Company Secretary

11 In attendance, by standing invitation

Deputy Director of Nursing & Clinical Governance
Clinical Governance Manager
Heads of Nursing
A representative from the Council of Governors may attend in a non-participative, observatory capacity

Others relevant to the agenda of the meeting such as chairs of advisory groups and Clinical Service Leads and successor roles may attend by invitation

Deleted: Directors

12 Internal Executive Lead
Executive Director of Patient Services

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 May 2018
Date of next review April 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	24 April 2018
Guests	None
Presentations received and discussed	Perfecting Pathways
Major agenda items discussed	• Finance and performance overview including year-end position • Spinal deformity performance – progress against the 52 week trajectory • Final 2018/19 financial plan • Managed Service Contract for theatres
Matters presented for information, brief update or noting	• Strategic planning update • Finance & Performance entries on the Board Assurance Framework • 18 weeks RTT internal audit and action plan • Cancer waits internal audit and action plan
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Temporary staff pay costs had increased across all wards. There were suggested to be a couple of drivers for this: a higher level of vacancies and the need to support the higher number of beds being used. The impact of staff taking annual leave in March may also be a factor. • It had been identified that there was a negative impact on consultant productivity if surgeons were not able to access the same theatre team, therefore work was underway to develop a workforce model in theatres that settled this position • There remained more work to do to review outpatient clinics template, particularly those in Oncology, where there were the most significant delays • More challenging workforce metrics would be introduced and work was underway with managers to help achieve these ambitious targets around sickness absence, appraisal and mandatory training. Appraisal rates were currently below the planned position.
Positive assurances and highlights of note for the Board	• The overall financial position both in Month 12 and as a year end performance, was noted to be positive overall. Activity performance and associated income delivery was good in particular. The underlying operational performance was in line with plan. • Expenditure had been less than plan, some of which

	related to non-recurrent adjustment. • The Trust had benefited from Sustainability and Transformation Funding which was beyond the level anticipated, which improved the overall year end position and would mean that there would be less of a requirement to borrow in the coming year • The Trust had received £232k of CQUIN funding • Progress with the Cost improvement Programme was strong, with over 80% of schemes delivering a recurrent benefit. The Quality Impact Assessment process for these schemes was reported to be more effective than previous years and good progress had been made for those schemes going into 2018/19 • Performance against the prompt payment target was adequate and above that of many other NHS organisations • There had been good work to improve patient flow and a number of national initiatives, such as 'Red to Green' and 'End Pyjama Paralysis' has been implemented • Performance was good against the diagnostic and cancer waiting times targets • Performance was good against the 18 weeks RTT trajectory • Positive feedback had been received from the recent review of the Trust's 52 weeks position by the Intensive Support Team; the situation had been noted to be 'fragile' however, based on the limited support from partner organisations • There was good progress with the 'Perfecting Pathways' work. In terms of the STP elective work, new patients had been secured from Heartlands, Good Hope and Solihull Hospitals (HGS), with 34 having been referred to date. • A meeting with commissioners had been held to agree a date for the transition of Paediatric care • A new model of care for the Pre Operative Assessment Centre had been identified
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Amend the finance overview with comments made by the Committee prior to discussion by the Board on 2 May 2018 • Provide an update on patient cancellations at the next meeting • Provide an update on 'Perfecting Pathways' to the Trust Board on 2 May 2018 • Circulate the final budget and financial plan, together with a commentary highlighting any amendments since the Committee had last seen it, for final approval
Decisions made	• None specifically

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

For the meeting of the Trust Board scheduled for 2 May 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	4 April 2018
Guests	None
Major agenda items discussed	• Review of people metrics • National staff survey • Refreshed gender pay gap analysis • NHS staff contract refresh
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• It was highlighted that the response rate to the national staff survey had been poor, therefore the statistical significance of some of the results needed to be treated with caution • The Committee was concerned with the increase in staff reporting that they had experienced harassment, bullying or abuse. This needed to be better understood. • The Committee discussed in general terms a staff Safeguarding case; assurances were given that the prescribed process for handling this was being followed
Positive assurances and highlights of note for the Board	• The Committee debated a set of revised people metrics and targets, which created more ambition around matters such as engagement, reducing sickness absence and appraisal • It was reported that work was underway to overhaul the appraisal system, so that staff felt as though their appraisals were worthwhile and high quality • There was a discussion around the results of the national staff survey; there had been a slight improvement in terms of engagement and based on some benchmarked information, it was clear that the Trust was on a positive trajectory. This was against the national trend. • The Committee was given an outline of the 'Speak Up and Join' in campaign, which aimed to encourage staff to highlight opportunities for improvement in which they could get involved • Incident reporting was highlighted as key area of strength from the national staff survey, although there was further work to do to ensure that staff felt as though the feedback received was of value • The outline of the People & OD strategy was provided, which was based on four stands: maximising employee engagement; collective responsibility for high performance & outstanding patient care; a culture of continuous improvement; and a sustainable workforce for the future • The importance of the Freedom to Speak Up Guardian was

	underlined as part of the staff engagement plans • An updated position against the gender pay gap was reviewed, which removed the medical workforce which was noted to skew the results. The overall position showed that there was not an underlying issue regarding pay between sexes. • The Committee was provided with an outline summary of the key points of the staff contract refresh, which overall was positive for staff in the NHS. Implementation was likely from 1 July 2018.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Circulate the Health Education England NHS Providers summary of the consultation response • The approach to appraisal to be discussed at the June meeting • An update on workforce planning would be considered at the next meeting • An update on the NHS contract refresh would be provided to the Trust Board at its May meeting
Decisions made	• The Committee supported the revised people metrics

Simone Jordan for Richard Phillips
NON EXECUTIVE DIRECTOR AND CHAIR OF THE STAFF EXPERIENCE & OD COMMITTEE

For the meeting of the Trust Board scheduled 2 May 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	23 April 2018
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. Mrs Jo Williams, Interim Chief Operating Officer Paul Athey, Acting Chief Executive
Major agenda items discussed	• External Audit progress report • Internal Audit progress report • Internal Audit annual report and Head of Internal Audit Opinion • Internal Audit workplan • 18 weeks RTT target audit • Cancer waits audit • Counterfraud workplan • Counterfraud self-assessment review toolkit • Draft DoF commentary on the annual accounts • Review of the draft accounts • Review of the draft Annual Governance Statement • Review of the draft Quality Account • Losses and special payments • Review of the hospitality register • Review of the declarations of Interest register • Board Assurance Framework • Quality & Safety Committee Feedback
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The timetable for the preparation for the annual accounts was highlighted to be tight, although auditors and ROH staff involved anticipated that there would not be an issue in meeting the statutory requirements. • The internal audit review of cancer waits identified that there was a pressing need to move away from using the OnKos database; assurances were provided that there was an intention to move to the more nationally-recognised Somerset system • There were still a number of outstanding confirmation of declarations of interest to be received
Positive assurances and highlights of note for the Board	• The Committee was provided with a summary of the arrangements it had made to ensure it was protected from cybercrime. Meeting the requirements set out in the Information Governance toolkit was noted to be useful in helping the Trust's cybersecurity framework. The

	Committee was also assured that the Trust was preparing well for the forthcoming General Data Protection Regulations (GDPR). • The Committee received updates from Internal Audit and the Interim Chief Operating Officer around the progress with addressing the recommendations from the 18 weeks RTT and cancer waiting times audits. The Committee agreed that there was good progress and overall a far sounder system of delivery against national requirements than there had been previously. • There were no issues identified as part of the internal audit review of compliance with the IG toolkit • The internal audit review of the Board Assurance Framework was noted to be positive and did not highlight any issues or recommendations • The Head of Internal Audit Opinion was noted to be positive, suggesting that although there could be enhancements, the overall system of internal control was sound • The self-assessment against the counterfraud toolkit was noted to be an improved position • The draft commentary by the Director of Finance on the accounts was considered which revealed a positive year end position, this being better than anticipated now that the Sustainability and Transformation Funding had been confirmed, which included a bonus element and an allocation from general distributions. The effect of this, in addition to the better year end position, was the need to borrow less in 2018/19, thereby saving interest payments. <u>The Board however is asked to delegate approval to the Finance & performance Committee to approve signing up to the working capital loan that would be needed</u>. • The Committee noted the overall positive Annual Governance Statement which illustrated good progress with addressing the performance and data quality issues identified last year • The good progress with developing the Quality Account was noted • Some of the controlled scores associated with some of the operational risks in the Board Assurance Framework had reduced
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Circulate the draft accounts for the Committee's review before the Board meeting • Include the risk around Paediatrics more clearly in the Annual Governance Statement • Create a summary of the key points of the annual report and Quality Account • Clarify in future the 'unknown' amounts in the hospitality register

Decisions made	• None specifically

Rod Anthony
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 2 May 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 11 May 2018

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 16 May 2018 at 1400h to transact the business detailed on the attached agenda.

Members of the press and public are welcome to attend.

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** 16 May 2018 : 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 January 2018 and note of briefing on 13 March 2018 (PRIVATE ITEM)	ROHGO (1/18) 010 ROHGO (3/18) 001	Chair
1410h	4	Update on actions arising from previous meeting	Verbal	SGL
	4.1	Governors role and responsibilities	ROHGO (5/18) 001 ROHGO (5/18) 001 (a)	SGL
1420h	5	Chief Executive's and Chair's update including paediatric transition and STP system working	ROHGO (5/18) 002 ROHGO (5/18) 002 (a)	PA/YB
1440h	6	CQC inpection update	Verbal	YB
1500h	7	DRAFT Annual Report (including Quality Account) & Accounts 2017 (PRIVATE ITEM)	ROHGO (5/18) 004 ROHGO (5/18) 004 (a) ROHGO (5/18) 004 (b) ROHGO (5/18) 004 (c)	SGL SW
1515h	8	Staff survey results	ROHGO (5/18) 005 ROHGO (5/18) 005 (a)	YB/CM
1530h	9	Membership update	Presentation	EC
1545h	10	Update from the Board Committees: • Audit Committee • Quality & Safety Committee • Finance & Performance Committee and Staff Experience & OD Committee	ROHGO (5/18) 006 ROHGO (5/18) 007 ROHGO (5/18) 008 & 9	RA KS RA/KS
1555h	11	Governor Matters: • Feedback	Verbal	All
1600h	12	For information: • Finance & Performance Overview • Quality & Patient Safety Report	ROHGO (5/18) 010 ROHGO (5/18) 011	

13	Any other business	Verbal
Date of next meeting: Thursday 4 October 2018 @ 1400h – 1600h in Trust Headquarters		

MINUTES

Council of Governors - Version 0.4

Venue Boardroom, Trust Headquarters **Date** 17 January 2018 @ 1400h

Members present

Yve Buckland	Chairman	YB
Brian Toner	Lead Governor	BT
Marion Betteridge	Public Governor	MB
Lindsey Hughes	Public Governor	LH
Sue Arnott	Public Governor	SA
Carol Cullimore	Public Governor	CC
Petro Nicolaides	Public Governor	PN
Karen Hughes	Staff Governor	KH
Mel Grainger	Staff Governor	MG
Alex Gilder	Staff Governor	AG
David Richardson	Staff Governor	DR
Paul Sabapathy	Stakeholder Governor	PS
Hannah Abbott	Stakeholder Governor	HA

In attendance

Kathryn Sallah	Non Executive Director	KS	
Simone Jordan	Associate Non Executive Director	SJ	
Paul Athey	Acting Chief Executive	PA	
Jo Williams	Interim Chief Operating Officer	JWI	
Andrew Pearson	Executive Medical Director	AP	[Item 7 only]
Mandy Johal	Freedom to Speak Up Guardian	MJ	[Item 12 only]

Minutes	**Paper Ref**
1 Reappointment of Kathryn Sallah and proposal to award a cost of living pay increase to Chairman and Non Executives	**ROHGO (1/18) 002** **ROHGO (1/18) 002 (a)**
PRIVATE DISCUSSION FOR GOVERNORS ONLY	
2 Apologies and welcome	
Apologies were received from Dagmar Scheel – Toellner, Rob Talboys, Richard Burden and Kennedy Iroanusi. It was noted that there was a separate meeting with Richard Burden planned which would be attended by the Chairman and Acting Chief Executive.	

3 Declarations of interest	
The Associate Director of Governance/Company Secretary was asked to make a note of Hannah Abbott's interest as an Associate Professor and Acting Head of School for the School of Health Sciences at Birmingham City University.	
ACTION: SGL to record Hannah Abbott's declaration of interest in the minutes of the last meeting	
4 Minutes of the previous meeting on 5 October 2017 and notes of the briefing session held on 21 December 2017	**ROHGO (10/17) 009** **ROHGO (12/17) 001**
The minutes of the meeting held on 5 October 2017 and notes of the briefing session held on 21 December 2017 were accepted as a true and accurate record of discussions held.	
5 Update on actions arising from previous meetings	**Verbal**
There were no matters that required escalation or were outstanding.	
6 Chief Executive's update including five year vision	**ROHGO (1/18) 003** **ROHGO (1/18) 003 (a)** **ROHGO (1/18) 003 (b)**
It was reported that there had been much work to address the 18 weeks RTT performance issues that the Council of Governors had been briefed about previously. In line with plans agreed with NHS Improvement, the Trust had returned to national reporting of RTT performance in December 2017. In terms of the number of patients waiting in excess of 52 weeks, there were 80 waiting at the end of November of which 64 were spinal deformity patient. It was reported that as part of the CQC's Well Led assessment, a focus group had been arranged for the Council of Governors on 21 Fedbruary. The Health Education England workforce strategy had been issued and consultation was underway. The Trust's Pathology services had received ISO accreditation. The kitchens and catering services had also been inspected by the Environmental Health and received a rating of '5', this being the highest possible. The five year vision was discussed. The ambition to be 'first choice for orthopaedic care' remained the headline. The goals and success factors which would illustrate delivery were being developed. It was suggested that the vision needed to reflect the need to support the future workforce in terms of training as a teaching trust; this was agreed. It was noted that some of the elective cases had been cancelled and there was	

active conversations with Heartlands Hospital to identify whether there was additional support that the Trust could access. Discussions would start around winter 2018 soon.	
7 MAKO robot	**Verbal**
The Medical Director joined the meeting to support the discussions for this item. The Interim Chief Operating Officer presented an overview of the plans to revitalise the private ward, which would be branded as the Woodland Suite. A new private offering was planned, this being the MAKO robot. It was reported that the Trust was the first NHS organisation that was using the robot. The plans to publicise the work were discussed, particularly around the launch which would be done in conjunction with Stryker who was providing the robot. The sensitivity of publicising this when it was not open to NHS patients was noted, as the offering was only available for self-pay patients at present. It was noted that there was an expectation that revision rates would be improved as a result of the technology, however at present the tariff covering this did not sufficiently reimburse the cost of providing this to NHS patients. A question was asked in terms of whether there was a will from the consultants to bring in cases in to be handled and whether this could be an opportunity to attract new staff. The governors were advised that the business case had been supported by a commitment by the consultants and work had been undertaken to make it as attractive possible, with a view to attracting good quality applications when needed. Mrs Sallah highlighted that appropriate nurse staffing was needed to support the private area. It was suggested that the workforce model needed to be considered and Saturday & Sunday needed to be key working hours. It was highlighted that by investing in this work, this clearly demonstrated that the Trust embraced innovation. There had been several different iterations around what the private ward would be used for and now there was a clear plan which was pleasing. There was no period of exclusivity for the use of the robot, so some other organisations may soon start using similar technology. Health economics research was underway with commissioners to see whether this may be good to roll out the technology into the NHS and this would be informed by the work at the ROH. Patient feedback on private treatment was questioned. It was noted that Wards 10 & 12 were now separated to create a specific environment for private treatment. The feedback on the care was positive.	
8 Establishment of the Staff Experience & OD Committee	**ROHGO (1/18) 004** **ROHGO (1/18) 004 (a)**
Simone Jordan, Associate Non Executive Director, reported that the first meeting of the Staff Experience & OD Committee had been held and the agenda included workforce, training and staff experience. It was suggested that there	

was good evidence to indicate that staff having a good experience at work would translate into good patient care. A workforce dashboard was being developed to gather together workforce metrics on cost and governance. More work was planned on how staff thought and felt and to build on the organisational culture work and preparation for the CQC's well led inspection. The work also considered how people felt about speaking up and whether there was a sense of fairness and a focus on continuous improvement focus. It was reported that the the meeting had been energised. It was noted that clinical representation would be needed at the meetings, both from a nurse and a medical perspective. The People Committee and the Education and Learning Development meetings would report up into the Staff Experience & OD Committee. It was noted that some of the challenges around cultural change and the reporting would need to be discussed with the governors in future. There were indicators available to measure the culture such as staff survey, sickness absence and turnover rates. Qualitative data would be considered as well as quantitive data. Outcomes and patient satisfaction could also be reviewed. The staff survey results would be brought to the next meeting. Different roles may be required in future as a result of the financial and strategic challenges. It was suggested that the headings in the dashboard should be meaningful; this was under development at present.	
ACTION: **SGL to arrange for the results of the national staff survey to be presented at the next meeting**	
9 STP update	**Verbal**
It was noted that the decision around Paediatrics services had been discussed previously with the Council of Governors. Overall, it remained the intention to work collaboratively across the region, including delivery of more complex work jointly with other organisations. A meeting had been held with the Chief Executives of both Birmingham Women's and Children's Hospital (BWCH) and University Hospital Birmingham (UHB) and there had been an agreement that the outcome of the Strategic Outline Case (SOC) and the plans for orthopaedics would be presented to the STP Board in February 2018. A more joined up approach across all three organisations was the intention, with the creation of low organisational boundary walls. It was noted that the ROH was a good brand within the STP. The SOC was currently being launched with staff. The SOC was a document which was generally used in the public sector and was the first part of setting a change in strategy and options for the future. There had been support from the STP to develop this work, including Public Health support around demographic influences. A set of information around the market was also integral to the SOC. It was reported that the ROH only delivered around 30-40 % of orthopaedics in the region, with a significant amount being handled in the private sector at present. A number of workshops with the clinical teams had been undertaken, which produced a longlist of options for each service considering potential	

growth, impact of complexity, ability to support more medically complex work, whether partnerships to deliver this were needed or whether there was a need to move the service elsewhere. The way of scoring to develop a short list of options was described. The summary was support for growing work on the existing site, both for simple and surgically complex work; medically complex work needed to be supported by partnerships. Oncology may also need closer working relationships. A joint group for orthopaedics across Birmingham and Solihull had been arranged to facilitate discussions. In terms of the plans for sustainability, it was noted that that there needed to be a significant growth in work and it was clear that this needed to be a step change and delivered using a different, more efficient, operational model. The benefits of this model, both to the ROH and the STP needed to be considered and the structure of the hospital to deliver more work needed additional thought. Coversations had been held with the system leaders, however a STP-wide support was needed. Even if, within the orthopaedic community, the model was agreed then capacity was still limited and a demand and capacity exercise was needed. The different elements would progress at different speeds. Paediatrics movement was the first of the many steps needed. As an organisation, there needed to be thought as to how additional work could be delivered using exisiting resources and estate. This would also include different workforce models such as seven day or extended day working. Additional investment would be needed into modular type buildings to create capacity. Models elsewhere were being examined to see if they were suitable or adaptable. More data and a better emerging picture of what was needed on site was available. It was noted that session utuilisation was now much more improved and the '6-4-2' process was looking at recycling lists that were not filled. Oncology lists were given focus in particular. Workforce needed to be considered as the same people covering the same lists was also difficult and needed to be more flexible. There needed to be a wholesale review of the theatre model as there was not a significant amount more that could be achieved given the current model. It was noted that estates considerations were a big deal, although what more that could be done in the exisiting estate needed thought. The more that we could demonstrate the efficiency of the current model then this would be accepted by the STP. Additional theatre sessions and weekend working were being considered.	
10 Strategic Outline Case	**Verbal**
It was noted that this item had been covered during the previous discussions.	
11 Paediatrics services update	**Verbal**
It was noted that the Board of Birmingham Women's and Children's Hospital NHS FT would consider the paediatric transition business case at a forthcoming meeting.	
12 Freedom to Speak Up update	**Presentation**

Mandy Johal, Freedom to Speak Up Guardian (FTSUG), joined the Council of Governors and presented an update of her work over the past year. The benefits of her dual role, being both a physiotherapist and the FTSUG was discussed. It was reported that if there was a trend of concerns linked to training in a particular area then there would be a discussions with Clare Mair, the Head of OD & Inclusion. It was suggested that if the majority of the concerns were raised anonymously then this would suggest that there was work needed to change the culture. Mrs Sallah suggested that people could come to Board or Committee meetings to understand the corporate discussions and decisions which may make them feel more informed.	
13 Update from Board Committees: • **Quality & Safety Committee**	**ROHGO (1/18) 005**
Mrs Sallah reported that there had been a themed review of VTEs, which was a key consideration at the November meeting of the Quality & Safety Committee, although it had been identified that there were no trends of concern to highlight. This would be kept under review however and there had been a reduction since the meeting. Sickness absence had reduced. There was further work to do to develop the clinical audit programme and audits that were not part of the formal process but were underway needed to be captured. The Trust's Friends and Family Test results had improved overall, although Ward 11 Outpatients rates were low. It was reported that this was a known issue with the environment and some changes had already been made. With the move of Paediatrics the Ward 11 Outpatient area would be used for something different. Treatment or care in the area was not an issue. It was noted that as only 14 people had completed the feedback, this was of limited significance statistically. The audit against the Duty of Candour regulation was noted to show compliance and the WHO checklist compliance was now 100%. Medical staff were reported to have been encouraged to undertake their consent training and this was now at 100%. The Grade 4 pressure ulcer was reported to be unavoidable. The hydrotherapy area was being given a refresh and had now opened and was much improved. An MP enquiry had been received around hydrotherapy. It was noted that the information was being considered at Quality & Safety Committee and some of the Executive fora.	
14 Governor Matters: • **Update from the Patient & Carers' Council**	**ROHGO (1/18) 006**

• **Council of Governor improvement plans**	**ROHGO (1/18) 006 (a)**
The Council received and noted an update on the work of the Council of Governors. It was noted that the pre-meet of the Council of Governors had included a discussion around a number of suggestions to improve the effectiveness of the Council. These had all been endorsed by the Council and would be taken forward by the Associate Diretcor of Governance/Company Secretary and the Lead Governor.	
15 For information: • **Quality & Patient Safety report** • **Finance & Performance overview** • **Annual Complaints report**	**ROHGO (1/18) 007** **ROHGO (1/18) 008** **ROHGO (1/18) 009**
These were agreed to be for information.	
16 Any other business	**Verbal**
A staff governor had submitted some questions in advance of the meeting. The contents of the email were outlined, which were: I have just attended the strategy update, and there were a couple of comments made that I wondered if it would be possible to follow up for tomorrow's Council of Governor's meeting (apologies for the short notice). The questions are related really. 1. There was mention of an instance where a child had not been safeguarded in the manner that would have been expected by the Trust (I believe the story has been discussed at Board). I wondered if we could hear a bit more about that and the learning that has been taken from this incident. 2. The related discussion was regarding mandatory training. Resus training was the particular area mentioned as being an issue, but I would also be interested to hear about safeguarding training given point 1. Could the COG see the levels of staff who have not received key clinical or patient related mandatory training such as resus and safeguarding, preferably at a level of detail which shows with details regarding; - how mandatory training splits into particular teams, e.g. if resus training levels are lax in HDU I would be more concerned than if they were in Imaging for example. - Absolute numbers of staff in addition to percentages if possible - Where MT rates are failing in areas, what the trajectory is for	

meeting the standard. - Is there ever the possibility that there would be no-one appropriately trained on duty in each clinical area that was available if someone needed resus? - How are the NEDs assured that enough urgency is being placed on meeting those targets and that patients are not being put at risk? (I would assume that the new Staff experience and oversight committee will help the Board become more assured regarding these areas). - Are the NEDs assured that a lack of safeguarded training did not contribute to Point 1? It was reported that in terms of the safeguarding query, then there had been a presentation to the Trust Board. Escalation out of hours was the key issue and staff had been reminded how the escalation process worked. There had been much learning since which has tested the Safeguarding processes and confirmed that they are robust. This had been discussed at Clinical Audit meetings. It was reported that compliance with resuscitation training was monitored through Resuscitation Committee and there had been an escalation and a key risk highlighted around the lack of visibility. The trajectory was now on an upward path. It was agreed that further monitoring was needed to Quality & Safety Committee. The current methodology of delivering training was noted to impact activity and needed to be different, including consideration of e-learning.	
ACTION: **KS to present an update on resuscitation training at the next meeting**	
17 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 16 May 2018 at 1400h – 1600h in the Boardroom, Trust HQ.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Governors' role and responsibilities**
SPONSOR:	**Dame Yve Buckland, Chairman of the Council of Governors**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance and Company Secretary**
DATE OF MEETING:	**16 May 2018**

EXECUTIVE SUMMARY:

It was suggested at the previous meeting that a refreshed sight of the key responsibilities of governors needed to be provided.

The attached document was produced by Monitor (now NHS Improvement) in March 2014 and contains guidance for governors that remains current.

It is proposed that over the summer, in line with the suggestions for improving the Council discussed at the January 2018 meeting, that an exercise be carried out using a survey technique to establish how effective the Council currently is, which will include how effectively the governors discharge their duties.

One of the disclosures in the annual report concerns the mechanisms in place to advise the public how the governors have discharged their duties. At present, we outline the governor's section in Members News and that the public are welcome to attend the meetings of the Council of Governors, however there is further work that could be done to strengthen this which could be picked up as part of this work.

REPORT RECOMMENDATION:

The Council of Governors is asked to:

- NOTE the contents of this report and refresh themselves with the statutory duties that are attached to this role
- SUPPORT the plans to assess the effectiveness of the Council of Governors, including how effectively the governors discharge their duties

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Legal requirements for the governors to execute a set of duties
PREVIOUS CONSIDERATION:
The guide to the duties of being a governor are included in the induction booklets provided to all governors on induction

Monitor

Making the health sector work for patients

In association with:
Care Quality Commission
Department of Health
Foundation Trust Governors' Association
Foundation Trust Network

Your duties: a brief guide for NHS foundation trust governors

www.monitor.gov.uk

Contents

What is this guide and who is it for?

This document is a brief guide to introduce your core duties as the governor of a National Health Service (NHS) foundation trust. It is provided as a more accessible summary of 'Your statutory duties: A reference guide for NHS foundation trust governors', which you can refer to for further detail on any point.

It describes governors' "statutory" duties, meaning those you are required to carry out by law. It also outlines what governors can expect from the regulatory framework.

The guide is intended as an easy reference point on core parts of the governor role for:

- current governors (both those with experience and those new to the role)
- those who are thinking about standing for election
- other interested audiences such as patients and the public, NHS foundation trust leadership teams and staff, other NHS bodies, MPs and the media.

Some important organisations for governors

Following the Health and Social Care Act 2012, the NHS changed its structures and processes to more clearly put patients first, by focusing on improved quality and outcomes. NHS foundation trusts – and their governors – now interact with a range of organisations with new or changed roles.

Monitor

Monitor is the sector regulator for health services in England. Its job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, Monitor makes sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, it works particularly closely with the Care Quality Commission (CQC), the quality and safety regulator. When the CQC establishes that an NHS foundation trust is failing to provide good quality care, Monitor takes remedial action to ensure the problem is fixed.

Monitor also sets prices for NHS-funded services, tackles anti-competitive practices that are against the interests of patients, helps commissioners ensure essential local services continue if providers get into serious difficulty and enables better integration of care so services are less fragmented and easier to access.

Care Quality Commission

The CQC is the independent regulator of health and adult social care in England. Its purpose is to make sure health and social care services provide people with safe, effective, compassionate, high quality care and to encourage care services to improve. The CQC's role is to monitor, inspect and regulate services to make sure

they meet fundamental standards of quality and safety and to publish what it finds, including performance ratings to help people choose care.

The CQC will ask the following questions when it inspects services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

The CQC's principles are to:

- put people who use services at the centre of our work
- be independent, rigorous, fair and consistent
- have an open and accessible culture
- work in partnership across the health and social care system
- be committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others and
- promote equality, diversity and human rights.

The CQC regulates:

- treatment, care and support provided by hospitals, GPs, dentists, ambulances, community and mental health services
- treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care)
- services for people whose rights are restricted under the Mental Health Act.

A changed healthcare landscape

The way the NHS plans and buys services has changed following the Health and Social Care Act 2012, with 211 clinical commissioning groups (CCGs) taking on the role of primary care trusts locally.

Health and wellbeing boards (HWB) are where CCGs and local authorities come together to strategically plan and integrate health and social care in an area. Each HWB has a representative of the local HealthWatch (a consumer champion) as a member.

There are a large number of organisations seeking to maintain and improve the performance of the healthcare sector, each with discrete roles. These include the boards of the healthcare providers (eg hospitals, mental health, community and ambulance services), Monitor, the CQC, NHS England and CCGs, as well as Royal Colleges, the National Institute for Health and Care Excellence (NICE) and the General Medical Council (GMC). They all share the same goal: to make sure people get the best possible care and service from the NHS, in line with the principles and values of the NHS Constitution.[1]

What is an NHS foundation trust?

NHS foundation trusts are different from NHS trusts; they have a unique legal form known as "public benefit corporations". NHS foundation trusts provide healthcare services for patients and service users in England. Unlike NHS trusts, they are free from central government control and can manage their own affairs and make their own decisions, including whether to make and invest surpluses. However, they remain subject to legal requirements and have a duty to exercise their functions "effectively, efficiently and economically".[2]

Each NHS foundation trust sets out its governance structure in its constitution. There are legislative requirements concerning the governance of all NHS foundation trusts. For example, all NHS foundation trusts have:

- members
- a council of governors
- a board of directors.

We explain these further below.

Please note, in this document where we use the word "board", it refers to the board of directors; where we use "council" it refers to the council of governors.

Members

Members of the public and staff who work at an NHS foundation trust can be "members" of the trust. In addition, NHS foundation trusts may opt to have a category of members who are either patients/service users and/or their carers. Members vote to elect governors and can also stand for election themselves.

Council of governors

The council of governors is made up of elected and appointed governors. Governors are volunteers and are not paid.

Elected governors are elected by distinct constituencies:

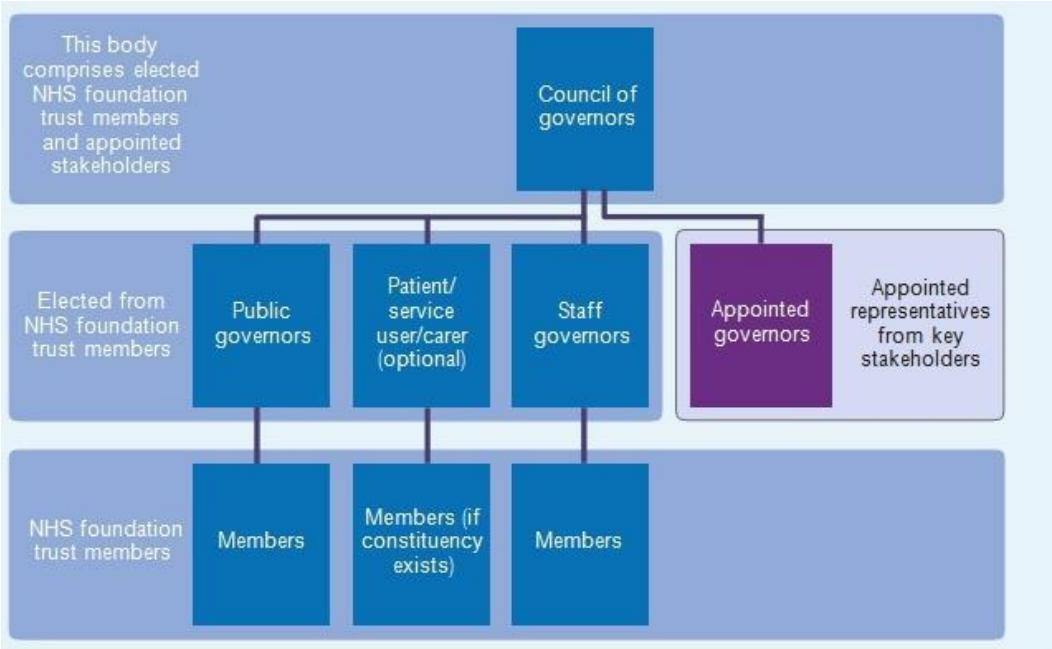
- public governors are elected by members of the public constituency

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[2] National Health Service Act 2006, Chapter 5, s.63.

- staff governors are elected from the staff body and
- patient, carer or service user governors are elected by members who are patients/service users and/or their carers.

Appointed governors represent stakeholder organisations such as the local council or local charities. If the foundation trust wants governors appointed by an external organisation, this must be specified in the constitution. The structure of the council of governors is shown in the diagram below.

Figure 1: The structure of the council of governors



Governors are not directors. The governors' duty to "hold the non-executive directors, individually and collectively, to account for the performance of the board of directors" does **not** mean that governors are responsible for decisions taken by the board of directors on behalf of the NHS foundation trust. Responsibility for those decisions remains with the board of directors, acting on behalf of the trust. This is covered more fully in the full guide to your statutory duties.

Board of directors

The board of directors is made up of executive directors and non-executive directors. The executive directors are employees, are led by the chief executive and are responsible for the day to day management of the foundation trust. Foundation trust boards must also include the following executive directors: a finance director, a director who is a registered doctor, a director who is a registered nurse or a registered midwife.

The non-executive directors are not employees. They bring an independent perspective to the board meeting and have a particular duty to challenge decisions and proposals made by executive directors. The board is led by the chair who is also a non-executive director. The board will also have a deputy chair and a senior independent director (SID).

The board's overall duty is to ensure the provision of safe and effective services for members and for the public. The board does this through the governance of the foundation trust. Governance is the process by which boards lead and direct their organisation. This process includes setting the corporate strategy, setting organisational values and culture, and supervising the work of the executive directors. The board will reserve certain key decisions to itself but will delegate many decisions either to executive directors or to committees of the board. The board also has a duty to be accountable to governors, to regulators and to key stakeholders such as commissioners.

(The role and responsibilities of the board are covered in more detail on page 12 of the full guide to your statutory duties.)

The dual role of the chair

The chair of the board of directors is also the chair of the council of governors. They are responsible for ensuring that the board and council work effectively together and that they receive the information they need to undertake their respective duties.

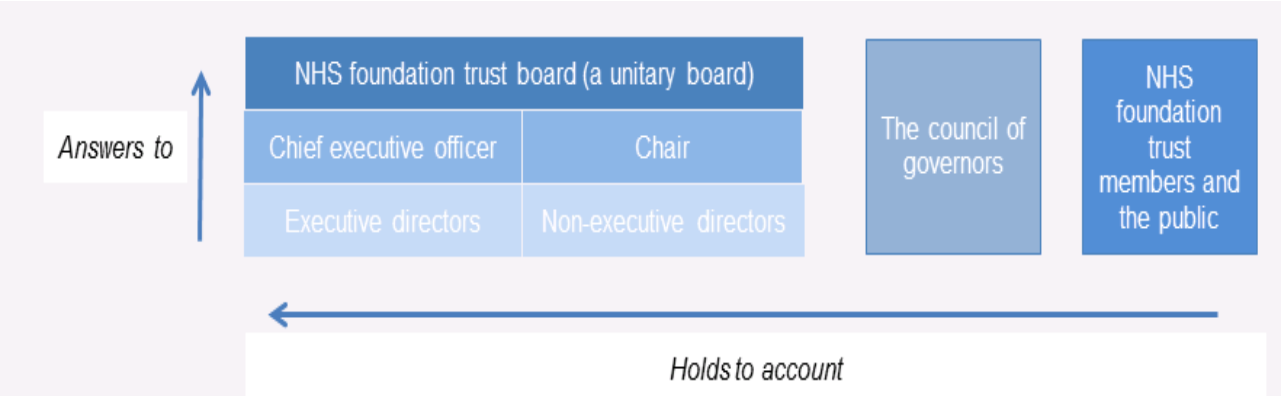
> It is important that the board of directors and council of governors see their interaction as being one of constructive partnership and seeking to work effectively together.

Committees

NHS foundation trusts use board committees to make decisions in key business areas that might be delegated and to help the board obtain the assurances it needs. The trust is required by law to have board committees in place to make decisions on appointments, remuneration and matters relating to audits. The trust may also decide to have other committees and working groups, including governor committees and groups, but these are not compulsory.

A trust's "chain of accountability" – including the position of the council of governors – is shown below.

Figure 2: NHS foundation trust "chain of accountability"



What does a governor do?

Governors have an important role in making an NHS foundation trust publicly accountable for the services it provides. They bring valuable perspectives and contributions to its activities. Importantly, as a governor you will hold non-executive directors to account for the performance of the board and represent the interests of NHS foundation trust members and the public. These duties are explained further below.

> The over-riding role of the council of governors is to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public.

Holding non-executive directors to account for performance of the board

There is no one "right way" to hold non-executive directors to account and local approaches are emerging. It could be done by exercising the other required duties outlined in more detail below. For example:

- appointing or removing the chair, non-executive directors or auditors
- questioning non-executive directors on how the board is delivering on the goals identified in the forward plan
- inviting members of the board to meetings of the council of governors to answer questions.

The full guide to your statutory duties (see Table 2 on page 27) outlines the governors' role in holding non-executives to account in more detail.

Representing the interests of members and the public

Governors are required by law to represent the interests of both members of the NHS foundation trust and of the public. They may choose a range of different ways to engage with these groups. We are aware of a number of methods that some councils of governors have chosen to adopt – and which you may wish to consider – such as governor "drop-in days" where members and the public can come and meet governors, or surveys.

Other specific governor duties

Here we list all the specific duties in which governors have a role; for further explanation see the full guide to your statutory duties.

Amending the constitution

NHS foundation trusts working with governors have the power to amend their constitutions. Any changes made to the constitution of a NHS foundation trust must be:

- consistent with schedule 7[3] of the National Health Service Act 2006 (which outlines the minimum requirements for the constitution of an NHS foundation trust)[4]
- approved by both more than half the council of governors and more than half the directors who are present at the vote.

Approving the appointment of the chief executive

The non-executive directors, including the chair, are responsible for appointing or removing the NHS foundation trust's chief executive. The council of governors can decide whether or not to approve the appointment of the chief executive.

Appointing and removing the chair and other non-executive directors

It is for the council of governors at a general meeting of the council to appoint or remove the chair and the other non-executive directors. As well as appointment and removal powers, governors also decide the remuneration, allowances and other terms and conditions for the chair and non-executive directors, working with the appointments[5] and remuneration committees. However, if there is a breach of the conditions of the trust's licence, Monitor may need to exercise its statutory powers to suspend or remove a chair or other non-executive director. Under such circumstances, Monitor's statutory powers take precedence over the powers that may be exercised by the council of governors.

Appointing and removing the NHS foundation trust's external auditor

This duty will be carried out at a general meeting of the council of governors, after they have received a report from the Audit Committee on the matter. When appointing or removing the NHS foundation trust's external auditor, governors must consider the criteria for auditors set out in 'Audit Code for NHS Foundation Trusts'. The process is covered in more detail in the statutory guide.

Receiving the NHS foundation trust's annual accounts and annual report

Governors must be presented with the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report at a general meeting of the council. The presentation of the annual report and accounts to the council of governors is a good opportunity for the board of directors to brief the council of governors on the overall performance of the trust in the previous year. The council of governors should provide feedback to the board of directors based on its view of the

[3] www.legislation.gov.uk/ukpga/2006/41/schedule/7
[4] For support in understanding the relevant Acts of Parliament, please ask your trust's board secretary in the first instance.
[5] Appointments committees can also be known as nomination committees.

overall performance of the board. Governors cannot change the content of the reports. To aid the feedback process, Monitor's NHS Foundation Trust Annual Reporting Manual (updated annually) sets out requirements for the content of these documents and includes both quality and financial aspects.

Preparing the forward plan

Preparation of the trust's forward plan is led by the board, but the law requires the board of directors to have regard to the view of the council of governors. To present an informed and representative view, governors should canvass the views of members and the public and feed back their views to the board of directors.

Taking decisions on significant transactions

Governors have a range of decision-making responsibilities on "significant transactions", mergers, acquisitions, separations and dissolutions. These are all explained further in the full guide to your statutory duties.

In brief, **more than half of the council of governors present and voting at a meeting** can approve significant transactions locally (the definition of "significant" is set out in the constitution or the constitution will state that there is no local definition, but could include financial thresholds or changes to the nature of the business, such as taking on community services). For mergers, acquisitions, separations and dissolutions, **more than half of all governors, not just half the number that attends the meeting at which the decision is taken,** must approve the decision.

Following a merger with another NHS foundation trust (whose council of governors must also approve the transaction), both the respective councils of governors would be dissolved, and one new council of governors would be established.

Following an acquisition of an NHS foundation trust by another NHS foundation trust, the council of governors of the acquiring trust may remain in place. The acquiring NHS foundation trust is likely to extend its public constituency areas to cover the areas served by the acquired NHS foundation trust and new governors will need to be elected to represent these additional public constituency areas.

Taking decisions on non-NHS income

The principal purpose of an NHS foundation trust is to provide goods and services for the health service in England; income from these goods and services must always exceed the income from non-NHS sources. Governors have to approve any change to the proportion of income derived from non-NHS sources by deciding whether they believe the change would interfere, to any significant extent, with fulfilling the trust's principal purpose or its other functions.

If the board of an NHS foundation trust proposes to increase its non-NHS income by 5% or more in any one year (for example from 2% of income to 7%) then **more than half the governors voting at the meeting** must approve the proposal before it can take effect. This change would normally be signalled in the forward plan. It is possible that a change in non-NHS activities (such as an investment) could be subject to the provisions on significant transactions, outlined above.

What is a lead governor?

The lead governor is the main point of contact in a few specific circumstances in which Monitor may need to contact the council of governors or the other way round (see 'How governors will normally work with Monitor', below). Trust secretaries will usually disseminate communications from Monitor to governors. Some trusts choose to broaden the role of the lead governor (although this is not compulsory); some also choose deputy lead governors too. Where the role is broadened, the directors and governors should seek to agree a description of the role. Directors should not be involved in the choice of lead governor however – that is for the governors to decide.

What does the senior independent director do?

In consultation with the council of governors, the board appoints one of the non-executive directors as the senior independent director. They are an alternative point of contact for governors (and directors) when:

- they have concerns that have not been resolved through normal channels
- contact with the chair, finance director or chief executive is inappropriate
- discussing the chair's performance appraisal, remuneration or allowances.

What is the Panel for Advising Governors?

"The Panel" is both independent and national. Its role is to answer questions raised by the governors of an NHS foundation trust about whether the trust has failed or is failing to act in accordance with either:

- its own constitution or
- Chapter 5 of the NHS Act 2006 (which sets out how NHS foundation trusts operate and therefore the Panel also answers questions around healthcare standards).

A governor may refer a question to the Panel only if **more than half the members of the council of governors voting** approve the referral. Evidence of the vote will need to be provided to the Panel before it can consider a question from governors. The Panel's remit is to support governors in fulfilling their role in representing the interests of their members and the public. Best interests are served by governors seeking to resolve any questions or issues with their trust chair and other non-executive directors before posing a question to the Panel. However, the Panel is available as a free resource in the event of continued uncertainty.

How governors will normally work with Monitor

When appropriate, Monitor will interact with the council of governors through the lead governor. There are three main points where this would normally happen:

1. On appointment of the lead governor

   Monitor staff, typically senior regional managers, will introduce themselves to the lead governor (usually in a telephone call), in the same way as they might with a new chair or chief executive.

2. During business as usual

   In "business as usual" circumstances, the board and council of governors of an NHS foundation trust will manage their own relationship, though Monitor representatives might meet a small number of governors or the lead governor during the annual visit if it was felt appropriate – for example, to maintain communication.

3. If there is planned or actual regulatory action

   Monitor will contact the lead governor if any action is planned. For example, Monitor may telephone the lead governor or write on the launch of an investigation, inviting comments, and again on conclusion of the investigation with likely recommendations. If a trust is found to be in breach of its licence to provide healthcare services, governors may wish to arrange to meet Monitor to hear its concerns and its expectations of the trust. Certainly, lead governors should feel able to contact Monitor where concerns arise while the trust is in breach.

Full detail of how Monitor manages interventions is described in its 'Risk Assessment Framework' and the 'Enforcement Guidance'.

A diagram outlining the full range of actions that Monitor may take to fulfil its core responsibilities appears on page 7 of the full guide to your statutory duties.

Further information and useful contacts

The full guide provides sources of further information but some important sources of support are:

Care Quality Commission	www.cqc.org.uk
Foundation Trust Governors' Association	www.ftga.org.uk
Foundation Trust Network	www.foundationtrustnetwork.org
Monitor	www.monitor.gov.uk
Panel for Advising Governors	www.monitor.gov.uk/governorpanel

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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Paul Athey, Acting Chief Executive**
DATE OF MEETING:	**16 May 2018**

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 2 May 2018

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors on 16th May 2018

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 recently.

2 STAKEHOLDER OVERSIGHT & NHSI LICENSE

2.1 We have received confirmation that the monthly stakeholder oversight meeting, originally introduced by NHSI/NHSE to oversee the delivery of our RTT improvement work and more latterly used to ensure the appropriate management of risk during the transition of paediatric services, will be stood down from May 2018.

2.2 Oversight from regulators and commissioners will now be managed through the usual performance routes. The current system-wide commissioning board for paediatrics will be developed into a transitional oversight board, which will be provider-led but will enable some continued oversight from other stakeholders.

2.3 The executive team have started conversations with NHSI around the process of removing our current breach of licence with regards to RTT delivery and governance. Assuming continued delivery of our RTT trajectory, we will be working jointly with NHSI over the next couple of months to provide the evidence required to remove this breach.

2.4 It is likely that the element of our breach of licence relating to financial sustainability will remain whilst work continues to look at wider plans for orthopaedic provision across Birmingham and Solihull and, as such, will be reviewed later in the financial year.

3 STP UPDATE

3.1 The STP Board met on 9th April and considered the draft strategy that had previously been shared with ROH Board members. All parties were given the opportunity to provide feedback which enabled us to highlight points raised by ROH Board

members around STP-wide workforce opportunities and the importance of NED and Governor input into the delivery of the strategy.

3.2 There was agreed support from all parties for the overarching principles within the strategy which was approved in principle subject to some work from the strategy directors to build in the feedback given at the STP Board.

4 BACK TO THE FLOOR

4.1 I have spent a number of sessions undertaking back to the floor exercises across the Trust and will report back verbally to the Council.

5 CONTINUOUS IMPROVEMENT FOCUS

5.1 On 5th & 6th April 2018, the Trust held a Continuous Improvement Focus across the Trust, incorporating a combination of interactive presentations, taster sessions and workshops.

5.2 We received positive feedback from a number of staff who attended the event, who felt that the range and quality of subjects and speakers was excellent. Sessions run by Suzanne Cleary, Director of Transformation at BWCH, and Helen Bevan, Chief Transformation Officer at NHS Horizons, were particularly well received.

5.3 A significant number of improvement ideas were recorded by staff over the two days and the transformation team are currently working through these to review how these can be built in to our improvement plans.

5.4 In order to retain the focus on improvement and the recognition of improvement success, we are planning to set up an improvement area by Café Royale to showcase the work that is ongoing across the Trust. More information on this will be provided at a future meeting. Consideration is also being given to a follow-up event in September 2018.

6 MEDIA INTEREST

6.1 A number of media outlets ran a story recently about an amazing girl called Amelia Eldred who was diagnosed with bone cancer in her left leg and was operated on at the ROH.

6.2 Professor Lee Jeys performed a rare procedure called rotationplasty to reattach the lower part of the leg backwards to allow the ankle joint to work as a knee joint.

6.3 In addition to the traditional media interest, the Trust received a significant amount of positive social media exposure around the story and it was heart-warming to see

the incredible way that Amelia responded to the challenges in front of her. It provided a great reminder of the impact that our amazing staff can have on improving the lives of our patients.

7 RECOMMENDATION(S)

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

7.2 Note the contents of the report.

Paul Athey
Acting CEO

11 May 2018

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS	
DOCUMENT TITLE:	**2017 National Staff Survey (NSS)**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Darren Tidmarsh, Associate Director of Workforce**
DATE OF MEETING:	**16 May 2018**

EXECUTIVE SUMMARY:

This paper provides analysis of the 2017 National Staff Survey (NSS) at Key Finding Level (KF). KFs are calculated from the combination of responses to several individual questions and are presented thematically. The Paper provides details of the key staff messaging, including the establishment of the new brand for employee engagement, Speak Up and Join In, specific targeted actions along with the quarter one and quarter two Speak Up and join in Pulse Survey Schedule.

The paper then describes the link with the key strategic aims of a refreshed People and OD Strategy and introduces a five-dimension engagement framework which is being used to shape the refreshed strategy.

REPORT RECOMMENDATION:

The Council of Governors is asked to consider the report and endorse the suggested forward approach.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider 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	x	Workforce	x

Comments:

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

People and OD Strategy , Equality and Diversity Standard (EDS)2 , WRES and CQC well-led framework

PREVIOUS CONSIDERATION:

Staff Experience & OD Committee on 4 April 2018

2017 National Staff Survey (NSS) and Link to People and OD Strategy

Report to the Council of Governors on 16 May 2018

1.0 Executive Summary

This paper provides analysis of the 2107 National Staff Survey (NSS) at Key Finding Level (KF). KFs are calculated from the combination of responses to several individual questions and are presented thematically. The Paper provides details of the key staff messaging, including the establishment of the new brand for employee engagement, Speak Up and Join In, specific targeted actions along with the quarter one and quarter two Speak Up and join in Pulse Survey Schedule.

The paper then describes the link with the key strategic aims of a refreshed People and OD Strategy and introduces a five-dimension engagement framework which is being used to shape the refreshed strategy.

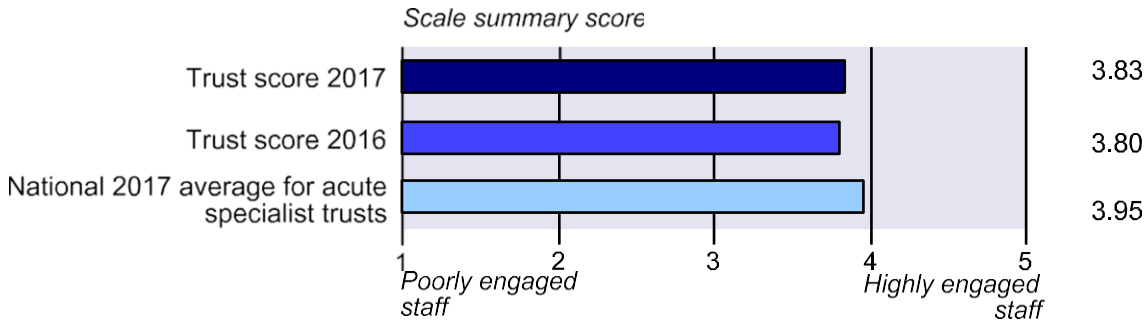
Headlines:

- ROH response rate (38%) was lower than 2017 (46%) well below the AST average (53%);
- There are 32 Key Findings (KF). ROH performs better than average in two, average in fifteen and worse than average in fifteen when compared to ASTs;
- Acute Specialist Trusts (AST) as a group perform better than other segments of the NHS;
- Overall Engagement has marginally increased up 0.03 to 3.83 against a decline nationally across the NHS. However, ROH is bottom quartile for Overall Engagement amongst Acute Specialist Trusts;
- Overall Engagement is significantly driven by recommend as place to work responses, which whilst improved in 2017 remains well below the average for ASTs;
- Two KFs have improved (statistically significantly) since 2016, 30 KFs show no statistically significant change and none have deteriorated (statistically significantly) since 2016;
- Areas of strength (most positive and above average benchmark): Flexible Working Patterns and Incident Reporting and
- Area for improvement (least positive and / or below average benchmark): Appraisals & support for development, Job satisfaction, Equality & diversity, Violence, harassment & bullying, Health and wellbeing, Relationship with Managers and Patient care & experience.

2.0 Detailed Analysis

2.1 Overall indicator of staff engagement for The Royal Orthopaedic Hospital NHS Foundation Trust

Diagram 1 Overall Staff Engagement at the ROH



Overall Engagement (as calculated) rose slightly in 2017 from 3.80 to 3.83 against an acute Specialist Trust mean of 3.95, a normal range of 3.88 – 4.00 and a high of 4.07.

It is to be noted that throughout the analysis and benchmarking, ROH performance is benchmarked against Acute Specialist Trusts, which broadly perform better than other parts of the NHS (see table below).

Table 1 Overall 2017 Staff Engagement by NHS Segment

	Lowest score attained	Threshold for lowest 20%	Threshold for worse than average	Average (median) score	Threshold for better than average	Threshold for highest 20%	Highest score attained
Acute trusts	3.54	3.72	3.77	3.79	3.82	3.88	3.96
Combined acute and community trusts	3.60		3.75	3.78	3.82		3.99
Acute specialist trusts	3.80		3.88	3.95	4.00		4.07
Mental health / learning disability trusts	3.54		3.76	3.79	3.82		4.01
Combined mental health / learning disability trusts	3.56		3.74	3.79	3.82		3.93
Community trusts	3.67		3.77	3.78	3.85		3.97
Ambulance trusts	3.22		3.38	3.45	3.49		3.58
CCGs	3.31		3.79	3.86	3.92		4.39

This overall indicator of staff engagement is calculated using the questions that make up Key Findings (KF) 1, 4 and 7. These Key Findings relate to staff members' perceived ability to contribute to improvements at work (KF 7); their willingness to recommend the trust as a place to work or receive treatment (KF 1); and the extent to which they feel motivated and engaged with their work (KF 4).

KF1 is the main driver for below median AST performance in the Overall Engagement measure in 2017 despite significant improvement in this measure 2017. As can be seen from the table below, KF1 for the ROH Trust is significant influenced by responses to question 21c *"I would recommend my organisation as a place to work".* This is despite staff indicating they feel more valued for the contribution they make, enjoy opportunities for flexible working patterns and feel able to contribute to improvements. Further exploration to determine why responses to this question remain lower than the norm is required.

Table 2 Detail of KF1- Staff recommendation of the organisation as a place to work or receive treatment

		Your Trust in 2017	Average (median) for acute specialist trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	79%	86%	69%
Q21b	"My organisation acts on concerns raised by patients / service users"	79%	81%	73%
Q21c	"I would recommend my organisation as a place to work"	62%	72%	56%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	83%	89%	77%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.85	4.16	3.73

2.1.1. ROH Overall Engagement by Division and Occupational Group

ROH Overall Staff Engagement scores range from 3.30 – 4.15 (Specialist Acute Trust Normal range 3.88-4.00)

Table 3 ROH Directorate Overall Engagement Scores and KF 1,4 & 7 by Division

Department	No. of responses	OE (3.88-4.00)	KF1 (3.95-4.19)	KF4 (3.91-3.95)	KF7 (70-75%)
Division 4 - Facilities	40	3.91	4.12	3.86	68%
Corporate	84	3.86	3.85	3.80	81%
Division 2 – Patient Support	143	3.85	3.92	3.85	76%
Division 1 – Patient Services	94	3.80	3.72	3.90	78%
Division 3 – Patient Access	14	3.50	3.33	3.90	43%

Overall engagement by Occupational Group

There are four groups that vary materially from ROH score:

1. Admin and Clerical (the largest OG with 69 responses) with Overall Engagement Score of 3.56;
2. AHPs (29 responses) Overall engagement score of 3.68;
3. Physiotherapy (25 responses) Overall engagement score 4.09 and
4. General Management (26 responses) overall engagement score 4.12.

Table 4 ROH departments outside Specialist Acute Trust Normal Range for Overall Engagement with KF 1, 4 and 7 scores (Normal AST ranges in brackets).

Department	OE (3.88-4.00)	KF1 (3.95-4.19)	KF4 (3.91-3.95)	KF7 (70-75%)
Knowledge Management & Research	4.15	4.23	4.08	85%
Therapies	4.06	4.07	3.99	98%
Patient Services	3.72	3.56	3.89	69%
Theatres	3.70	3.79	3.71	65%
Small Joints/Spinal	3.67	3.51	3.77	82%
Outpatients	3.66	3.64	3.69	75%
IM&T	3.64	3.85	3.52	61%
Oncology	3.30	3.03	3.42	64%

Shaded departments will provide an initial focus for further exploration though staff focus groups and even better if work listening sessions.

2.1.2 Overall Engagement by Protected Characteristic

With the exception of disabled workers, there is minimal difference across the three protected characteristics which are reported upon.

Department	No. of Responses	OE (3.88-4.00)	KF1 (3.95-4.19)	KF4 (3.91-3.95)	KF7 (70-75%)
Male	95	3.94	3.99	4.00	72%
Female	269	3.81	3.83	3.82	78%
BME	64	3.85	3.85	4.03	70%
White	307	3.82	3.84	3.81	77%
Disabled	75	3.64	3.68	3.58	71%
Not disabled	272	3.88	3.88	3.93	76%

2.2 Statistical Significance of Movements in KF Measures

The research methodology provides for calculating the statistical significance of movements since 2016.

The following two tables show the Key Findings where the variance 2016-2017 or 2015-2017 is considered to be of statistical significance compared to change in the National Median for that Key Finding.

Table 6 Statistically Significant movements 2016-2017

Key Finding [KF]	2017 Score	2016 Score	Variance	2017 Acute Specialist Trust Median	Variance to AST Median
KF1 Staff recommendation of the organisation as a place to work or receive treatment	3.86	3.74	0.12	4.16	-0.32 (-6.4%)
KF5. Recognition and value of staff by managers and the organisation	3.54	3.38	0.16	3.53	0.01

Table 7 Statistically Significant Movements 2015-2017

Key Finding [KF]	2017 Score	2015 Score	Variance	2017 Acute Specialist Trust Median	Variance to AST Median
KF 11 % appraised in last 12 months	86	93	-7	88%	-2%
KF 17 % feeling unwell due to work related stress in last 12 months	36%	29%	7%	35%	1%
KF14. Staff satisfaction with resourcing and support	3.38	3.49	-0.11	3.41	0.03

2.3 Areas of strength and Area for Improvement

Areas of strength (most positive and above average benchmark):

- Flexible Working Patterns and
- Incident Reporting

Area for improvement (least positive and / or below average benchmark):

- Appraisals & support for development;
- Job satisfaction;
- Equality & diversity;
- Violence, harassment & bullying;
- Health and wellbeing;
- Relationship with Managers and
- Patient care & experience.

Appendix 1 provides a detail analysis of each KF RAG rated with trend and benchmarking with Acute Specialist Trusts.

Appendix 2 provides wider benchmarking data of top and bottom five for three key Findings published in HSJ, pleasingly ROH is none of the bottom five lists but disappointingly it is not in any of the top five lists either.

2.4 Staff Communications and Speak Up and Join In Pulse Survey Schedule

A new brand has been developed for employee engagement; Speak Up and Join In. This will be used consistently in the communication of survey and wider engagement activity.

Appendix 3 provides details of staff communication objectives and key messages. It all provides associated target actions and which elements will form part of the Speak Up and Join In Pulse Survey to seek further and more timely feedback.

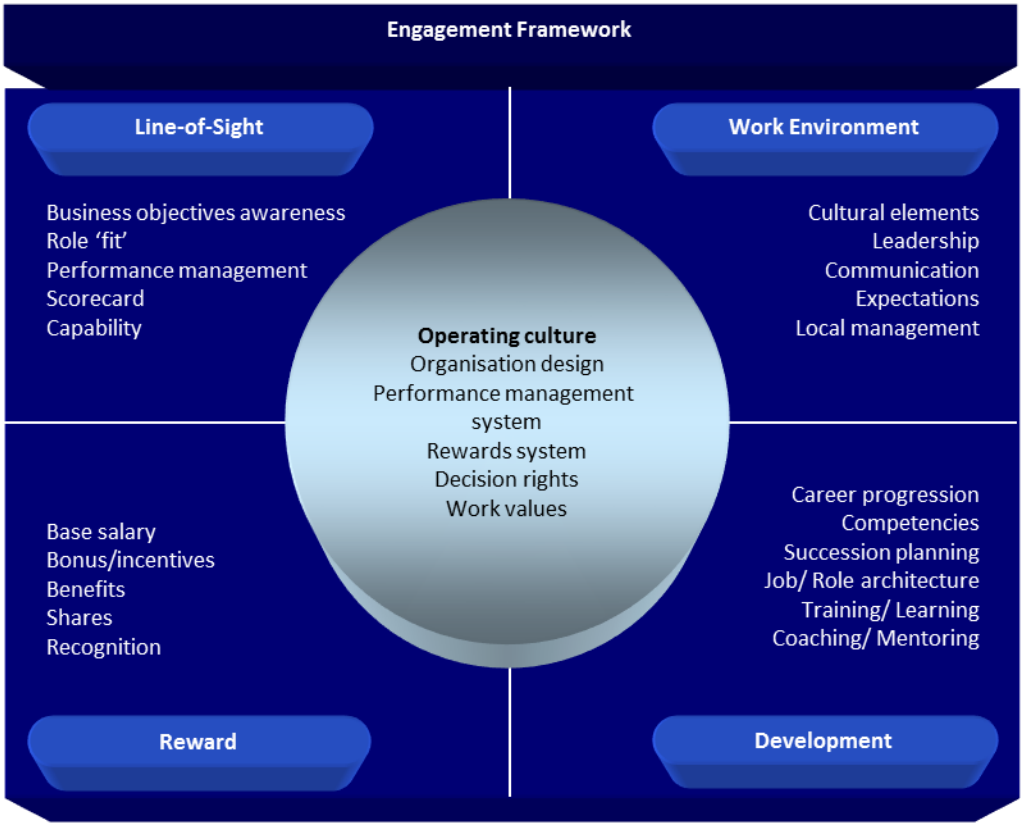
3.0 Link with People and OD Strategy

The Trusts refreshed People and OD Strategy will have four strategic aims:

1. Maximising employee engagement;
2. Collective responsibility for high performance and outstanding patient care;
3. A culture of continuous improvement and
4. A sustainable workforce for the future.

Whilst there are a number of specific targeted actions associated with a number of KFs as identified in Appendix 3, the following five dimension engagement framework is being used to shape the work of HR and OD and ensure it is coherent. Clearly what and how interventions are implemented from each of the outer segments will determine the culture and a desired operating culture will need to inform the design of each of intervention.

Work is underway on mapping current culture and identifying a desired culture for the future.



4.0 Recommendation

The Council of Governors is asked to receive and note the report.

Darren Tidmarsh, Associate Director of HR, Workforce and OD

April 2018

Appendix 1 Detailed Analysis of each Key Finding

The Following Table provides analysis and benchmarking for all 32 Key Findings.

Column 1 – Key Finding (contributing NSS questions numbers in brackets), KFs in bold red are used to determine the overall engagement measure.

Column 2 – ROH 2015 Survey Performance

Column 3 – Trend in ROH Performance 2015-2016

Column 4 – ROH 2016 Survey Performance

Column 5 – Trend in ROH performance 2016 – 2017 and if the change is statistically significant against changes in the national median.

Column 6 -2017 ROH Performance, first bracketed nos. is 95% confidence level and second set is departmental range.

Column 7 – Acute Specialist Trust Benchmark Performance for 2016

Column 8 - Acute Specialist Trust Benchmark Performance for 2017

Column 9 – Acute Specialist Trust Benchmark Trend 2016-2017

Column 10 – Acute Specialist Trust Benchmark Normal Range 2016-2017

Column 11 – Acute Specialist Trust Benchmark High 2016-2017

Column 12 – Notes and Commentary

Column 13 – RAG Rating

Green shaded row - Top 5 ROH scores which rank the highest against Acute Trust Performance

Red Shaded - Bottom 5 ROH scores which rank the lowest against Acute Trust Performance

Key Finding	ROH 2015	15-16 Trend	ROH 2016	16-17 Trend and if statistically significant?	ROH 2017	AST 2016 Median	AST 2017 Median	National Trend	AST 2017 Normal Range	AST 2017 High	Notes	RAG Rating
Appraisal and Support for Development												
KF 11 % appraised in last 12 months (q20a)	93%	▼	84%	▲ [Statically Significant 2015-2017]	86% [83-90] [67-100]	87%	88%	=	87-90%	96%	Whilst an improvement on 2016, performance remains outside of normal range and well below 2015 performance. Significant differences in performance at Directorate Level. Need to review and revise ROH KPI.	
KF12. Quality of appraisals (Q20b-d)	3.20	=	3.21	▼	3.15 [3.08 - 3.21] [2.74-3.11]	3.21	3.16	▼	3.07-3.30	3.45	Second quartile of normal range but declining in line with national performance. One of largest national ranges, likely key metric for Trust performance (good correlation). Not perceived as value adding and leaves appraisee feeling not valued – introduce coaching approach	
KF13. Quality of non-mandatory training, learning or development (q18-b-d)	3.94	=	3.97	▲	4.04 [3.96-4.12] [3.96-4.21]	4.07	4.08	=	4.05-4.10	4.15	Improving position but remains lower end of national range. Driven by larger number of neutral responses to perceived impact on individual performance (indicates weakness in PDR).	
Equality and Diversity												

KF20. % experiencing discrimination at work in last 12 months (q17a-b)	**11%**	▲	**8%**	=	**8% [6-11%]**	**9%**	**9%**	**=**	**10-8%**	**6%**	**Stable higher performance than most AS trusts. Celebrate with caution around BME difference [+7% c/f white].**	🟢
KF21. % believing the organisation provides equal opportunities for career progression / promotion (q16)	86%	=	86%	▼	84% [79-88%] [77-92]	86%	88%	▲	84-88%	91%	Declined to lower end of normal range with improving national performance. Big difference between BME and White (66%/87%). No empirical evidence from internal progression data but a clear perception from BME staff. Score significantly affected by the high proportion of don't know answers (which are excluded for scoring) making no answers a more significant proportion.	🟡
Errors and Incidents												
[KF28] % of respondents witnessing potentially harmful errors, near misses or incidents in last month (survey q11a and/or q11b)	29%	▲	33%	▼	26%	28%	27%	=	25%-31%	21%	Improved performance from 2016 high to below median [115 incidents in last month at survey point]. However higher levels of occurrence in clinical areas offset by low levels in non-clinical areas. Need to check correlation with incident reporting. Opportunity to learn from incidents messaging remains important here.	🟡
[KF29] % reporting errors, near misses or incidents	90%	▲	95%	▲	97% [93-100]	92%	92%	=	92-93%	97%	Good evidence of impact on messaging around importance of reporting to learn from incidents.	🟢

witnessed in last month (survey q11c)											Good Practice! Celebrate this.	
[KF30] Fairness and effectiveness of procedures for reporting errors, near misses and incidents (survey q12a-q12d)	3.61	▲	3.65	=	3.68 [3.60-3.75]	3.79	3.80	=	3.77-3.88	4.04	Low ranking performance and of significant interest when compared to KF29. Largely driven by neutral responses to effective action taken and less positive responses to getting feedback following reporting of incidents.	
[KF31] Staff confidence and security in reporting unsafe clinical practice (Survey q13b-c)	3.57	▲	3.61	▲	3.65	3.73	3.71	=	3.68-3.80	3.94	Steady improvement towards normal AST range. Driven by larger number of neutral responses to confidence in trust to take action following incident reporting. Links with KF30	
Health and Wellbeing												
KF17. % feeling unwell due to work related stress in last 12 months (q9c)	**29%**	▲	**33%**	▲	**36%** [31-41]	**33%**	**35%**	▲	**33-36%**	**28%**	Despite increase in national levels of staff reporting stress, steady year on year increase to upper end of normal range. Strong Correlation with Longer-term absence data. Needs robust intervention OH / EAP review.	
KF18. % attending work in last 3 months despite feeling unwell because they felt pressure to	54%		49%	▲	50%	50%	50%	=	48-51%	45-56%	Needs more exploration. Is this a positive or negative indicator???? We don't want people to be ill but is this an indicator of purpose and	

do so (q9d-g)											discretionary effort or fear??	
KF19. Organisation and management interest in and action on health and wellbeing (q7f,q9a)	3.65	▼	3.55	▲	3.60	3.71	3.73	=	3.68-3.80	3.98	Improvement on 2016 low. Largely driven by to some extent: definitely ratio responses to q9a. Messaging needed. If we definitely did show interest what would this look like?	
Working Patterns												
KF15. % satisfied with the opportunities for flexible working patterns	56%	▲	57%	▲	61%	53%	54%	=	51-56%	61%	Highest performer. Significant improvement against steady national mean, why???	
KF16. % working extra hours	74%	=	75%	=	74%	74%	75%	=	71-75%	76%	Remains stable at upper end of normal range [c/f KF14]	
Job Satisfaction [KF coloured red indicates used to calculate overall engagement score]												
KF1 Staff recommendation of the organisation as a place to work or receive treatment (q21a, c, d)	3.83	▼	3.74	▲ YES	3.86 [3.01-3.28]	4.12	4.16	=	3.95-4.19	4.26	Broad indicator. Significantly improving position against marginally improving national norm but remains outside the normal range. Driven by recommended place to work responses [scored 2.64]. Need to ask why not a recommend place of work. Check 4th quarter FFT.	
KF4 Staff motivation at work	3.87	=	3.90	= NO	3.86 [3.78-3.94]	3.98	3.94	=	3.91-3.95	4.08	Broad indicator, stable position against marginally declining national position.	

(q2a -c)												
KF7 Staff able to contribute towards improvements at work (q4a –q4d)	73%	▲	76%	= NO	75% [70-80]	73%	73%	=	70-75	78%	Maintained upper quartile position. Reflects focused activity around wide involvement in continuous improvement. This could be a real strength if involvement and effecting change at a local could be further improved.	
KF8 Staff satisfaction with level of responsibility and involvement (q3a-b,q4c,q5d-e)	3.90	=	3.91	= NO	3.89 [70-80]	3.97	3.93	▼	3.91-3.97	4.04	Sits just outside normal range and stable in declining national position. Biggest influencing factor is involvement in local change	
KF14. Staff satisfaction with resourcing and support (q4e-g,q5c)	3.49	▼	3.37	= NO	3.38 [3.31-3.45]	3.43	3.41	=	3.38-3.50	3.62	No change and remains lower end of normal range. Biggest influencing factor is perception of staffing levels.	
Managers												
KF5. Recognition and value of staff by managers and the organisation (q5a,5f,7g)	3.49	▼	3.38	▲ YES	3.54	3.60	3.53	▼	3.50-3.61	3.69	Significant improvement from 2016. Now Around national median due to national decline. Evidence of impact.	
KF6. % reporting good communication between senior	30%	▼	24%	▲	29%%	40%	35%	▼	32-42%	48%	Well below normal range despite significant progress from 2016. National challenge. Need to pulse	

management and staff (q8a-d)											this quickly to see if changing since survey if not needs early focus.	
KF10. Support from immediate managers (q5b,q7a-e)	3.79	=	3.79	=	3.80	3.80	3.81	=	3.76-3.88	3.95	Broadly in line with national norms	
Patient Care & Experience												
KF2 Staff satisfaction with the quality of work and care they are able to deliver (q3c,6a,6c)	4.14	▼	3.99	▲ NO	4.03 [3.94-4.12]	3.43	4.02	=	3.95-4.07	4.23	In line with median and normal range	
KF3 % agreeing that their role makes a difference to patients / service users (q3c,6a,6c)	91%	=	90%	= NO	91% [88-94%]	92%	91%	=	89-93%	4.23	In line with median and normal range	
KF32. Effective use of patient / service user feedback (q21b,q22b-c)	3.67	▼	3.57	▲	3.72[3.61-3.83]	3.81	3.83	=	3.75-3.86	4.00	Outside normal range. Lower score driven by high number of neutral responses.	
Violence , Harrassment & Bullying												

* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 months (q14a)*	7%	▼	5%	▲•	6%	7%	7%	=	4%-9%	2%	In normal range.	
KF23. % experiencing physical violence from staff in last 12 months (q14b-c)	2%	=	2%	▼	1%	2%	1%		1-1%	1%	5 reports of physical violence in last 12 months 1 from manager 4 from other colleagues	
KF24. % reporting most recent experience of violence (Q14d)	57%	▼	52%	▲	66%[45-88%]	67%	70%		69-72%	81%	Reporting below normal range but with relatively low numbers [43 cases in total]	
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (q15a)	22%	▲	24%	▲	21%	20%	21%		17-23%	12%		
KF26. % experiencing harassment, bullying or abuse from staff in last 12 months (q15b-c)	24%	▲	25%	▲	27%	25%	23%		22-26%	18%		
KF27. % reporting most recent experience of	44%	▲	49%	▼	40%	47%	47%		45-49%	54%		

harassment, bullying or abuse (q15d)												

Appendix two – Wider Benchmarking data

Overall Employee Engagement

ROH FT score 3.83

Top Five	2016 score	2017 score
West Suffolk NHS Foundation Trust	4.10	4.12
Derby Teaching Hospitals NHS Foundation Trust	4.02	4.02
South Warwickshire NHS Foundation Trust	4.06	4.00
University Hospitals Birmingham NHS Foundation Trust	3.97	3.98
Sherwood Forest Hospitals NHS Foundation Trust	3.86	3.92

Bottom Five	2016 score	2017 score
Walsall Healthcare NHS Trust	3.45	3.38
United Lincolnshire Hospitals NHS Trust	3.62	3.43
Kettering General Hospital NHS Foundation Trust	3.67	3.50
Sandwell And West Birmingham Hospitals NHS Trust	3.60	3.52
Worcestershire Acute Hospitals NHS Trust	3.49	3.53

Bullying and Harassment

ROH score 27%

Lowest percentage of staff experiencing bullying	2016 score	2017 score		Highest percentage of staff experiencing bullying	2016 score	2017 score
West Suffolk FT	25%	20%		Northampton General Hospital Trust	26%	29%
Chesterfield Royal Hospital FT	21%	21%		East and North Hertfordshire Trust	29%	29%
The Ipswich Hospital Trust	27%	23%		Colchester Hospital University FT	28%	29%
Burton Hospitals FT	26%	23%		Mid Essex Hospital Services Trust	23%	29%
Derby Teaching Hospitals FT	23%	23%		The Queen Elizabeth Hospital King's Lynn FT	28%	29%

Incidents

ROH score 26%

Highest percentage of staff witnessing errors	2016 score	2017 score		Lowest percentage of staff witnessing errors	2016 score	2017 score
The Princess Alexandra Hospital Trust	36%	37%		Burton Hospitals FT	26%	24%
Mid Essex Hospital Services Trust	30%	35%		University Hospitals Birmingham FT	26%	27%
Worcestershire Acute Hospitals Trust	35%	33%		Heart of England FT	26%	27%
Milton Keynes University Hospital FT	30%	33%		University Hospitals of Leicester Trust	29%	28%
Southend University Hospital FT	31%	33%		West Suffolk FT	29%	28%

Appendix 3 2017 National Staff Survey Messaging and Initial Action

1.0 What do we want to achieve from Key Messaging and Staff Communication?

The following are the key messaging objectives:

- Say thank you to those completing the survey
- Convey message that feedback is invaluable, start process of improving response rate
- Share key findings – JAM (just affirm more) approach whilst remaining authentic
- Keep personal – use of you etc.
- Show genuine listening and responding to feedback
- Support culture of continuous improvement
- Encourage collective responsibility and involvement
- Establish common brand - **Speak up and Join in**
- Convey a call to action
- Communicate how everyone can get involved , local approach

2.0 Overall Message

Thank you to all those staff that completed the National Staff Survey at the back end of last year. Bucking the national trend, you have told us you feel more engaged than in 2016. Scores in 14 of the 30 key findings improved in 2017 and nine remained constant. This is great news but like the many pieces of continuous improvement work, we want to get even better. You have also told us about things we need to improve; we are listening carefully and will be taking action on these things. Your feedback is invaluable so we will be checking how you think we are doing throughout the year. We can all contribute to making this a great place to work so please **Speak up and Join in.**

3.0 Key Messaging, initial action and pulse schedule

Message	Action	Q1 Pulse	Q2Pulse
Fewer staff than in other similar Trusts would recommend ROH as a place to work. This is despite you telling us that we provide good opportunities for flexible working; indeed we perform better than any other comparable trust on this measure. You tell us you feel more valued for the work you do and generally you feel able to contribute to improvements in what you do. So we will be arranging 'even better if' worktime listening sessions to hear your ideas on how we can make this an even better place to work.	Work time listening sessions with continuous improvement. Review Friends and Family Survey Results. Need to understand if the current ambiguity around ROH future is shaping this. Use Pulse survey for this.		
Our mission is to be first choice for orthopaedic care and many more of you told us you were satisfied with the quality of care you can provide and that your contribution makes a difference. You also told us we are making better use of patient feedback, although we can still do better at this.	Comms on patient feedback and how we are making things better. Department Contribution case studies – 'this is how we contribute to the best patient care' (these need to be developed by the departments as its as much about the process as the output)		
We have been working hard to recognise everyone's contribution. You told us that you have felt more valued in the last 12 months. We want everyone to fell valued for the work they do so we will continue to make this a priority.	• Further development instant recognition scheme, possibly named 'spotlight' designed to shine a light on good practice or continuous improvement effected. • Continue with and develop staff awards. • Continue with long service awards. • Department Contribution case studies – this is how we contribute to the best patient care. • Continue with high level recognition messaging –n team brief and Friday message.		
At the time of the survey, you told us that communication between senior management and staff had improved in the last 12 months but requires more work. We have been working hard to address this over the last six	• Further development of Team Brief. • Deliver Communications Strategy. • Pulse survey to check progress		

Message	Action	Q1 Pulse	Q2Pulse
months, so we would like to ask you if this has now improved.			
You told us that the quality of Performance & Development Reviews needs further development and that the quality varies depending on where you work. Many of you who responded were not sure that any non-mandatory training and development undertaken had a positive impact on your individual performance. We will be making changes to the PDR process over the coming year.	Complete overhaul of the PDR process. Include in Q2 pulse for staff having a refreshed PDR		
Compared to other specialist trusts we are generally less good at undertaking timely staff appraisals (PDRs). However, some departments are good and we need everyone to perform at this level. We know high quality appraisals are important to you so we will be keeping a close watch on this.	Our current ROH KPI (85%) lacks ambition and does not help support robust monitoring of this so move to change this. Need to understand reasons why not completed e.g. time available, value attributed to process, non-completion from manager or individual (include this in pulse survey).		
Pleasingly staff responding to the survey report less experience of discrimination in the last 12 months and lower than the majority of similar NHS Trusts.	However significant difference amongst BME staff – Pick up in WRES/EDS2 action planning but to include establishing staff interest group.		
Too many of you told us you have experienced bullying in the last twelve month from a colleague. There is no place for bullying at the ROH. If you experience bullying talk to your trade union, a contact officer or a member of HR.	Evaluate contact officer work Need to build upon no bullying campaign.		
You tell us that you witness fewer dangerous incidents than in other comparable specialist trusts and when you do you these are well reported, in fact better than any other comparable trust. However, you told us that you are not sure that action is always taken and feedback is not always received. We are going to work on improving this and check back with staff in the	Feedback built in to Quality Standard for 18/19.		

Message	Action	Q1 Pulse	Q2Pulse
summer to see if things are improving.			
Many staff told us that they did not know if they believed the organisation provides equal Opportunities for career progression or promotion.	No empirical evidence for this, need to strengthen messaging to shift high proportion of staff are not sighted on this. Use of Cases studies? Need to think carefully about this as we move forward with talent management.		
We are concerned about the number of staff who reported feeling unwell due to work related stress in the last 12 months. Whist improving in 2017 too few staff believe the Trust is interested and enough action is taken in the health and wellbeing of all staff. The wellbeing of all staff is paramount. We are setting up a task and finish group to identify further action to support staff in reducing levels of work related stress.	Task and Finish Group - Full review of stress management. OH service review. Establish EAP from saving from new OH service. Mindfulness and individual resilience training and development. Bullying and harassment actions. Note National CtA – On CGQ well led radar. Need to think about how we package Wellbeing.		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	23 April 2018
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. Mrs Jo Williams, Interim Chief Operating Officer Paul Athey, Acting Chief Executive
Major agenda items discussed	• External Audit progress report • Internal Audit progress report • Internal Audit annual report and Head of Internal Audit Opinion • Internal Audit workplan • 18 weeks RTT target audit • Cancer waits audit • Counterfraud workplan • Counterfraud self-assessment review toolkit • Draft DoF commentary on the annual accounts • Review of the draft accounts • Review of the draft Annual Governance Statement • Review of the draft Quality Account • Losses and special payments • Review of the hospitality register • Review of the declarations of Interest register • Board Assurance Framework • Quality & Safety Committee Feedback
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The timetable for the preparation for the annual accounts was highlighted to be tight, although auditors and ROH staff involved anticipated that there would not be an issue in meeting the statutory requirements. • The internal audit review of cancer waits identified that there was a pressing need to move away from using the OnKos database; assurances were provided that there was an intention to move to the more nationally-recognised Somerset system • There were still a number of outstanding confirmation of declarations of interest to be received
Positive assurances and highlights of note for the Board	• The Committee was provided with a summary of the arrangements it had made to ensure it was protected from cybercrime. Meeting the requirements set out in the Information Governance toolkit was noted to be useful in helping the Trust's cybersecurity framework. The

	Committee was also assured that the Trust was preparing well for the forthcoming General Data Protection Regulations (GDPR). • The Committee received updates from Internal Audit and the Interim Chief Operating Officer around the progress with addressing the recommendations from the 18 weeks RTT and cancer waiting times audits. The Committee agreed that there was good progress and overall a far sounder system of delivery against national requirements than there had been previously. • There were no issues identified as part of the internal audit review of compliance with the IG toolkit • The internal audit review of the Board Assurance Framework was noted to be positive and did not highlight any issues or recommendations • The Head of Internal Audit Opinion was noted to be positive, suggesting that although there could be enhancements, the overall system of internal control was sound • The self-assessment against the counterfraud toolkit was noted to be an improved position • The draft commentary by the Director of Finance on the accounts was considered which revealed a positive year end position, this being better than anticipated now that the Sustainability and Transformation Funding had been confirmed, which included a bonus element and an allocation from general distributions. The effect of this, in addition to the better year end position, was the need to borrow less in 2018/19, thereby saving interest payments. <u>The Board however is asked to delegate approval to the Finance & performance Committee to approve signing up to the working capital loan that would be needed</u>. • The Committee noted the overall positive Annual Governance Statement which illustrated good progress with addressing the performance and data quality issues identified last year • The good progress with developing the Quality Account was noted • Some of the controlled scores associated with some of the operational risks in the Board Assurance Framework had reduced
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Circulate the draft accounts for the Committee's review before the Board meeting • Include the risk around Paediatrics more clearly in the Annual Governance Statement • Create a summary of the key points of the annual report and Quality Account • Clarify in future the 'unknown' amounts in the hospitality register

Decisions made	• None specifically

Rod Anthony
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Council of Governors scheduled for 16 May 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 April 2018
Guests	Ms Karen Hughes, Patient safety & Clinical Training Lead Dr Graham Caine, Head of Pathology Mrs Ange Howling, Lead Nurse for Infection Prevention & Control Ms Carolyn Langford, Head of Research, Audit and Development Mrs Julie Gardner, Assistant Director of Finance (Contracting)
Presentations received	None
Major agenda items discussed	• Quality & Patient Safety report • Nurse staffing update • Draft Quality Account 2017/18 • HTA licence compliance assurance report • CIP quality impact assessments • Quality assurance walkabouts updates • Research & Development Committee – upward report • Infection Control Committee – upward report, terms of reference and workplan • HDU and Outpatients CQC action plan exceptions • Divisional governance assurance • Contract scorecard and CQUIN update • Terms of Reference
Matters presented for information, update or noting	• Minutes of the Clinical Quality Group • Quality & Safety risks on the Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Committee discussed a case where a patient had, post-surgery, deteriorated due to sepsis and had needed to be transferred out to another acute provider, but had subsequently died. Some shortfall in the management of the patient and a failure to escalate early enough had been identified and would be investigated • There were a greater number of infection control incidents reported, although it was suggested that this related to the renewed focus by the new Infection Control team and the widened scope of surveillance beyond the previous set of specialities • There had been a near miss incident in theatres which the Associate Medical Director was investigating and a report will be brought to the next meeting • There had been an increase in the number of falls and the inpatient matron was reviewing the position

	• There had been an increase in the number of pressure ulcers, with three out of the four reported this month being in the HDU. Work was underway to understand the reasons behind these and the Tissue Viability Lead was engaged with this; an early view is that not all would be classed as avoidable • The Trust's use of agency staffing had increased – this reflected the increase in core activity and vacancy coverage • The Committee was advised that there was a risk in terms of central funding for the Research & Development work. It was also highlighted that there was a lack of space for Research & Development to interview patients in clinical areas which needed to be addressed. The attendance at the R&D Committee from areas across the Trust was noted to be poor and therefore some suggestions were given as to how this might be addressed. • The Trust had not met the Quarter 4 CQUIN target against timely treatment of sepsis.
Positive assurances and highlights of note for the Board	• The Committee was advised that the level of resuscitation training had improved and further work was underway to ensure that staff were undertaking training appropriate to their level and role • The Trust's position on the National Reporting and learning System was good compared with other trusts and this suggested a positive incident reporting culture • Work was underway to widen the scope of information included in the Quality Report and discussions were being held with senior medical staff, therapies and diagnostics to understand what would constitute useful metrics to include. The procurement of an electronic system to assist with this was being considered. • The Committee received an encouraging update on work to strengthen the Trust's nutrition arrangements. A multi-disciplinary task and finish group had been established, whose work included optimising patient's nutritional state prior to surgery. The individuals in this group who were provided by a Service Level Agreement were noted to be particularly effective. A nutrition strategy was under development. • The Committee reviewed the draft Quality Account, noting the significant work that had been needed to develop this document • An update on the Trust's compliance with the Human Tissue Act (HTA) licence was provided, which did not highlight any issues of significance; the Trust would be assessed again shortly • The improved process for developing and approving Cost Improvement schemes' Quality Impact Assessments was

	discussed • The outcome of the Quality Assurance walkabouts to Radiology & MRI and Ward 12 was presented. In both cases, the areas had been rated 'Good'. The cleanliness standards in Radiology were noted to have been maintained. • A positive update on Infection Prevention and Control was provided, which highlighted that standards were good across the Trust in general. The delivery plan for the IPC team was received and noted. • It was noted that the Clinical Quality Group was now operating more effectively. • An update from the Research & Development Committee was considered, which highlighted that it had been a strong year in terms of recruitment into clinical trials • An update on the performance against the contract and CQUINs was discussed. Overall this was a positive picture, with improvements in the performance against the 18 weeks RTT target, the declining number of 52 week waits and improved training position. CQUINs associated with healthy foods and 'flu vaccinations had been met.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Alison Warren to be invited to the next meeting to provide an update on resuscitation training • An update on water management and compliance with the associated regulations to be presented at the next meeting • Discussion to occur at Staff Experience & OD Committee to understand the work being undertaken to address the nursing vacancies • An update on compliance with the HTA licence to be provided to the Clinical Quality Group • Report into burns in theatres to be presented at the next meeting • The Executive Team to review the R&D Committee terms of reference
Decisions made	• The Committee approved the revised terms of reference for the Infection Prevention & Control Committee • The Committee supported the proposed revisions to its terms of reference and agreed that they should be presented at the next Trust Board meeting

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

For the meeting of the Council of Governors scheduled for 16 May 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	24 April 2018
Guests	None
Presentations received and discussed	Perfecting Pathways
Major agenda items discussed	• Finance and performance overview including year-end position • Spinal deformity performance – progress against the 52 week trajectory • Final 2018/19 financial plan • Managed Service Contract for theatres
Matters presented for information, brief update or noting	• Strategic planning update • Finance & Performance entries on the Board Assurance Framework • 18 weeks RTT internal audit and action plan • Cancer waits internal audit and action plan
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Temporary staff pay costs had increased across all wards. There were suggested to be a couple of drivers for this: a higher level of vacancies and the need to support the higher number of beds being used. The impact of staff taking annual leave in March may also be a factor. • It had been identified that there was a negative impact on consultant productivity if surgeons were not able to access the same theatre team, therefore work was underway to develop a workforce model in theatres that settled this position • There remained more work to do to review outpatient clinics template, particularly those in Oncology, where there were the most significant delays • More challenging workforce metrics would be introduced and work was underway with managers to help achieve these ambitious targets around sickness absence, appraisal and mandatory training. Appraisal rates were currently below the planned position.
Positive assurances and highlights of note for the Board	• The overall financial position both in Month 12 and as a year end performance, was noted to be positive overall. Activity performance and associated income delivery was good in particular. The underlying operational performance was in line with plan. • Expenditure had been less than plan, some of which

	related to non-recurrent adjustment. • The Trust had benefited from Sustainability and Transformation Funding which was beyond the level anticipated, which improved the overall year end position and would mean that there would be less of a requirement to borrow in the coming year • The Trust had received £232k of CQUIN funding • Progress with the Cost improvement Programme was strong, with over 80% of schemes delivering a recurrent benefit. The Quality Impact Assessment process for these schemes was reported to be more effective than previous years and good progress had been made for those schemes going into 2018/19 • Performance against the prompt payment target was adequate and above that of many other NHS organisations • There had been good work to improve patient flow and a number of national initiatives, such as 'Red to Green' and 'End Pyjama Paralysis' has been implemented • Performance was good against the diagnostic and cancer waiting times targets • Performance was good against the 18 weeks RTT trajectory • Positive feedback had been received from the recent review of the Trust's 52 weeks position by the Intensive Support Team; the situation had been noted to be 'fragile' however, based on the limited support from partner organisations • There was good progress with the 'Perfecting Pathways' work. In terms of the STP elective work, new patients had been secured from Heartlands, Good Hope and Solihull Hospitals (HGS), with 34 having been referred to date. • A meeting with commissioners had been held to agree a date for the transition of Paediatric care • A new model of care for the Pre Operative Assessment Centre had been identified
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Amend the finance overview with comments made by the Committee prior to discussion by the Board on 2 May 2018 • Provide an update on patient cancellations at the next meeting • Provide an update on 'Perfecting Pathways' to the Trust Board on 2 May 2018 • Circulate the final budget and financial plan, together with a commentary highlighting any amendments since the Committee had last seen it, for final approval
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 16 May 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	4 April 2018
Guests	None
Major agenda items discussed	• Review of people metrics • National staff survey • Refreshed gender pay gap analysis • NHS staff contract refresh
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• It was highlighted that the response rate to the national staff survey had been poor, therefore the statistical significance of some of the results needed to be treated with caution • The Committee was concerned with the increase in staff reporting that they had experienced harassment, bullying or abuse. This needed to be better understood. • The Committee discussed in general terms a staff Safeguarding case; assurances were given that the prescribed process for handling this was being followed
Positive assurances and highlights of note for the Board	• The Committee debated a set of revised people metrics and targets, which created more ambition around matters such as engagement, reducing sickness absence and appraisal • It was reported that work was underway to overhaul the appraisal system, so that staff felt as though their appraisals were worthwhile and high quality • There was a discussion around the results of the national staff survey; there had been a slight improvement in terms of engagement and based on some benchmarked information, it was clear that the Trust was on a positive trajectory. This was against the national trend. • The Committee was given an outline of the 'Speak Up and Join' in campaign, which aimed to encourage staff to highlight opportunities for improvement in which they could get involved • Incident reporting was highlighted as key area of strength from the national staff survey, although there was further work to do to ensure that staff felt as though the feedback received was of value • The outline of the People & OD strategy was provided, which was based on four stands: maximising employee engagement; collective responsibility for high performance & outstanding patient care; a culture of continuous improvement; and a sustainable workforce for the future • The importance of the Freedom to Speak Up Guardian was

	underlined as part of the staff engagement plans • An updated position against the gender pay gap was reviewed, which removed the medical workforce which was noted to skew the results. The overall position showed that there was not an underlying issue regarding pay between sexes. • The Committee was provided with an outline summary of the key points of the staff contract refresh, which overall was positive for staff in the NHS. Implementation was likely from 1 July 2018.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Circulate the Health Education England NHS Providers summary of the consultation response • The approach to appraisal to be discussed at the June meeting • An update on workforce planning would be considered at the next meeting • An update on the NHS contract refresh would be provided to the Trust Board at its May meeting
Decisions made	• The Committee supported the revised people metrics

Richard Phillips
NON EXECUTIVE DIRECTOR AND CHAIR OF THE STAFF EXPERIENCE & OD COMMITTEE

For the meeting of the Council of Governors scheduled 16 May 2018

Finance and Performance Report

March 2018

CONTENTS

INTRODUCTION

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

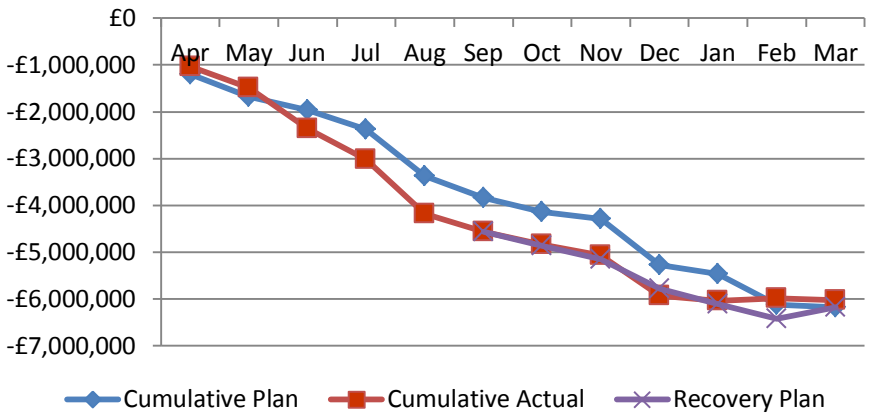
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M12 Original Plan £'000	YTD M12 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	74,633	75,360	727
Other Operating Income	4,738	5,198	460
Total Income	**79,371**	**80,558**	**1,187**
Employee Expenses (inc. Agency)	(48,479)	(50,116)	(1,637)
Other operating expenses	(35,681)	(32,764)	2,917
Operating deficit	**(4,789)**	**(2,323)**	**2,466**
Net Finance Costs	(1,448)	(1,413)	36
Net deficit	**(6,237)**	**(3,736)**	**2,501**
Remove revaluation I&E impact	-	(2,114)	(2,114)
Remove donated asset I&E impact	55	61	6
Remove CQUIN 0.5% risk reserve impact	-	(232)	(232)
Adjusted financial performance	**(6,183) (Control Total)**	**(6,021)**	**161**

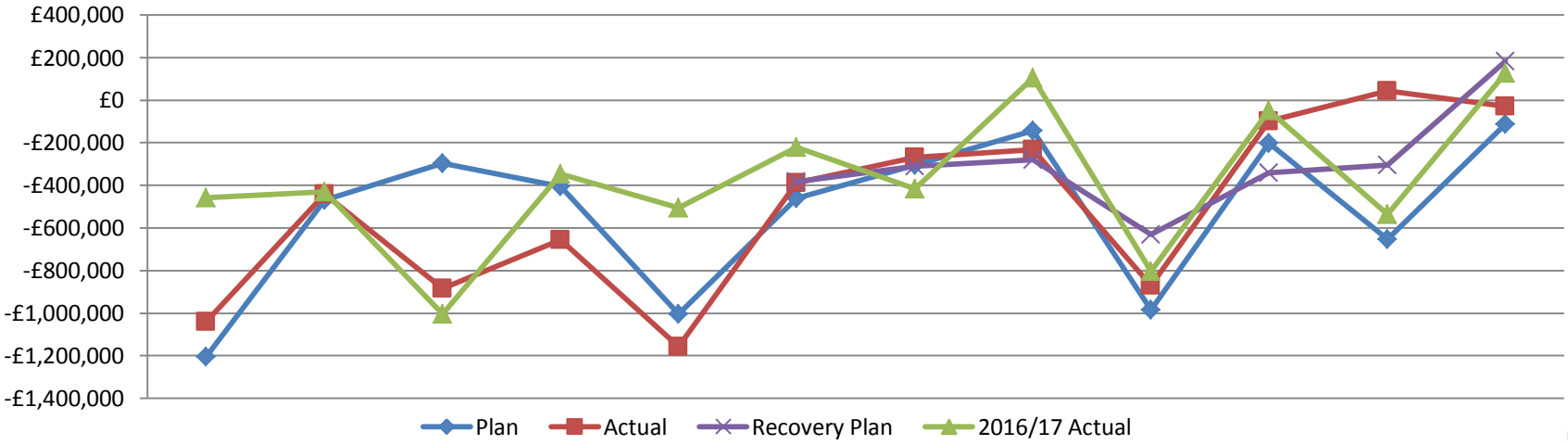
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan (excluding reval gains)



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	2
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan (excluding revaluation gains)



INFORMATION

The Trust has delivered a deficit of £30,000 in March against a planned deficit of £112,000. This brings the full year position (on a control total basis) to £6,021,000 against a plan of £6,183,000, £162,000 ahead of plan and recovery plan. Overachievement against the control total will result in a incentive STF payment of £162,000 (£ for £ investment for achievement over the control total) in addition to the 'standard' STF of £436,000. The trust may also be eligible for bonus STF, to be advised by NHS Improvement dependent on other trust's achievement of their control totals.

There have been a number of adjustments made to the year position as would be expected within a normal year as the Trust takes a slightly longer period to ensure all significant income and costs are accurately reflected ready for the financial accounts submission. These adjustments have been described in more detail on the expenditure slides. Other drivers for the in year performance have included spend on improving RTT reporting (just over £610,000 for the year), 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 time of the MRI for a period of nearly 2 weeks), in addition to an unexpected insurance payment for the historic on-site fire.

As at the end of March the Trust has recognised £2,685,000 of CIP savings, against a plan of £3,191,000, a negative variance of £506,000. £455,000 (17%) of savings to date are non-recurrent. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

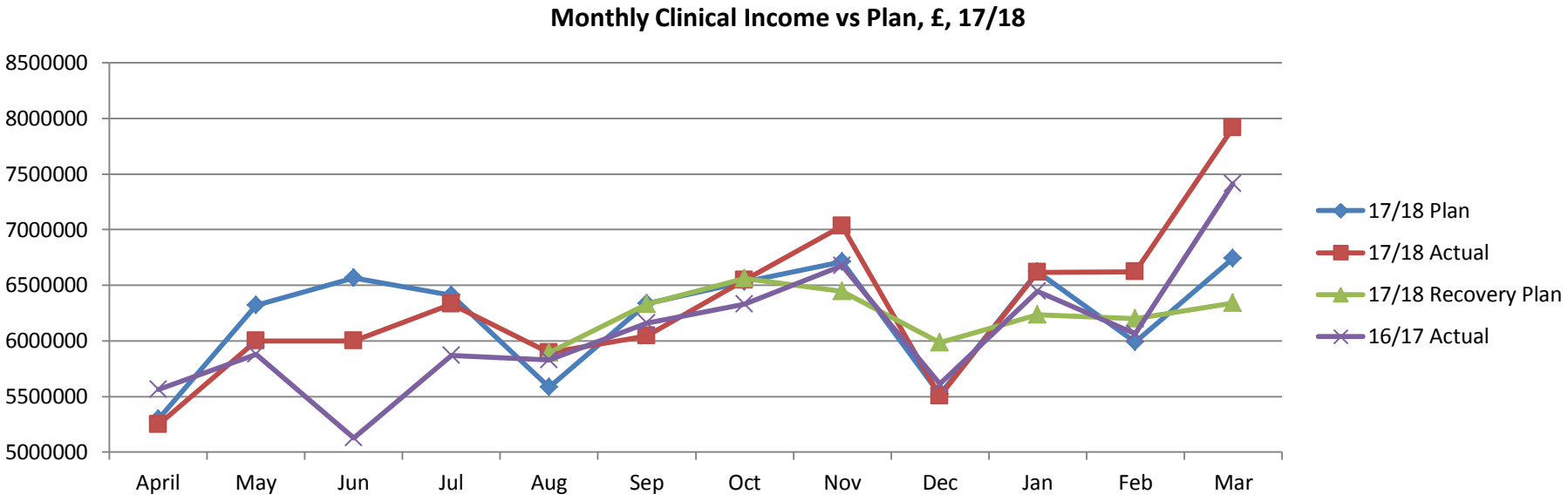
With regards to the Trust's Use of Resources Risk Rating (UOR), the overall position has remained at level 3, with the over performance against control total resulting in a '1' for I&E performance against plan. The other elements of the Use of Resources elements remain the same; the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover and I&E Margin. The Trust's requirement for cash support has resulted in a 4 for liquidity. Full year agency spend is higher than agency cap, resulting in an agency rating of 2.

ACTIONS FOR IMPROVEMENTS / LEARNING

A draft of the annual plan has been submitted to NHS Improvement, with further work ongoing to ensure there are sufficiently robust plans in place to deliver the trust's control total. This includes defining activity plans and the resultant job plans required, reviewing and minimising cost pressures and ensuring cost improvement plans are sufficiently robust and quality impact assessed. These discussions are significantly progressed in time for the final plan submission on 30th April.

RISKS / ISSUES

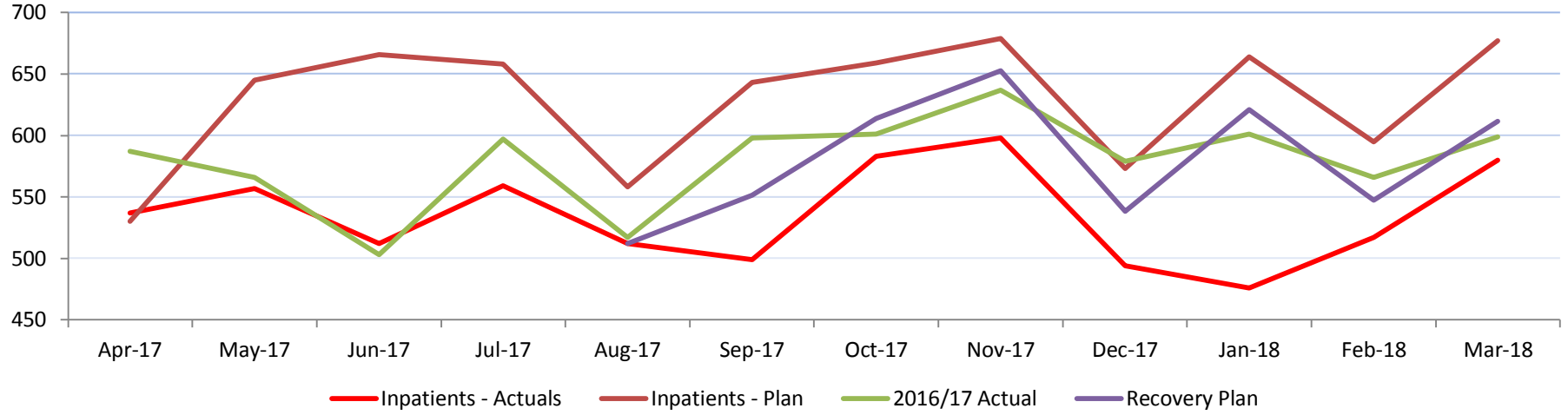
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



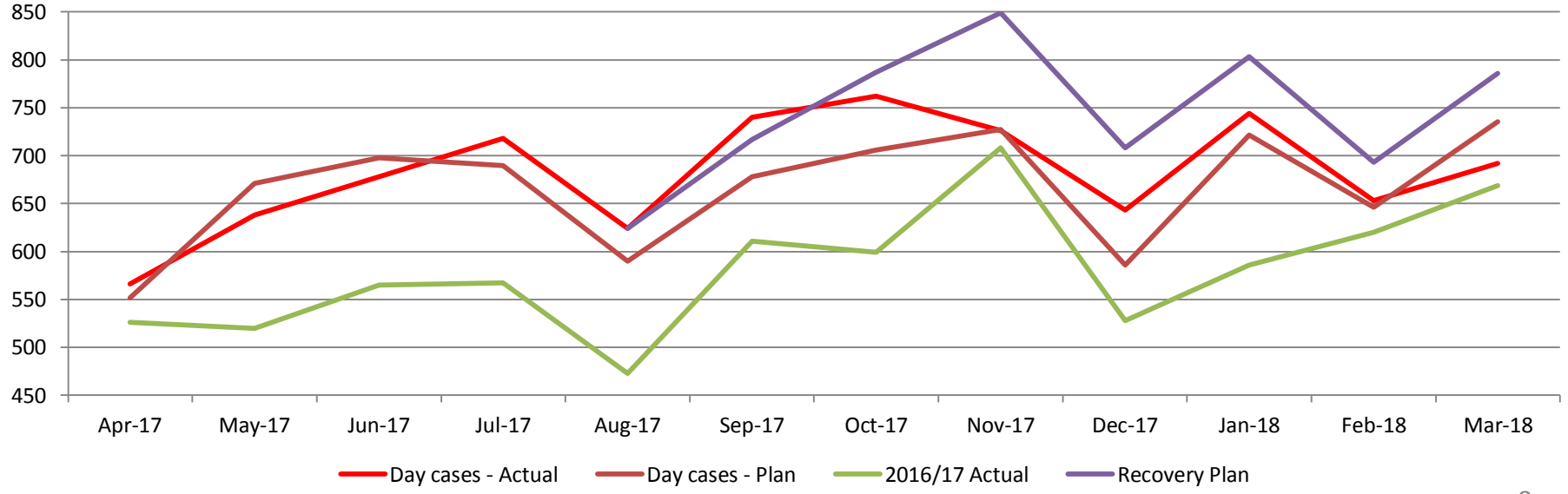
Clinical Income – March 2018 £'000			
	Plan	Actual	Variance
Inpatients	3,440	3,365	-75
Excess Bed Days	107	165	58
Total Inpatients	3,547	3,530	-17
Day Cases	833	1028	195
Outpatients	666	764	98
Critical Care	267	178	-89
Therapies	233	223	-10
Pass-through income	239	376	137
Other variable income	874	1298	424
Block income	518	518	0
TOTAL	7,177	7,915	738

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	37,851	37,673	-178
Excess Bed Days	1,176	708	-468
Total Inpatients	39,027	38,381	-646
Day Cases	9154	9601	447
Outpatients	7315	7537	222
Critical Care	2933	2485	-448
Therapies	2916	2648	-268
Pass-through income	2617	3177	560
Other variable income	4891	5702	811
Block income	6216	6216	0
TOTAL	75,069	75,747	678

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income was significantly ahead of March's plan, with the trust now overachieving against its original income plan. Inpatient activity was strong, and in line with November, and just slightly behind November. Day case activity was behind plan, but this is considered reflective of the case mix required to be delivered to achieve the RTT trajectory over the next few months. In addition the trust's activity was again impacted by snow in March.

The main in-month income performance however was with regard to pass through costs and other variable income. Pass through costs were high largely as a result of better information being received from theatres regarding the use of bespoke prostheses, although orthotic appliances were also high in month.

Other variable income has increased for a number of reasons. The trust was informed it should recognise £232k of CQUIN income (0.5% risk reserve CQUIN) in month where it had been previously required to provide for this amount. In addition, the trust received confirmation that it would receive additional funding in relation to the Welsh block contract that it was not expecting to receive (£161k – this is spread across various income categories including other variance income). In addition, the Trust has recognised £85k of income offered by Solihull CCG to manage its RTT challenge with physiotherapy.

The Trust is working operationally and financially to determine what demand and capacity there is internally and how this will affect activity plans, job plans and therefore income for the coming year as part of business planning as previously discussed. This work is ongoing to enhance the final annual plan submission in comparison to draft. Activity plans at a specialism level have now been agreed with operations, but these are being further split down to consultant level before the submission of the final annual plan.

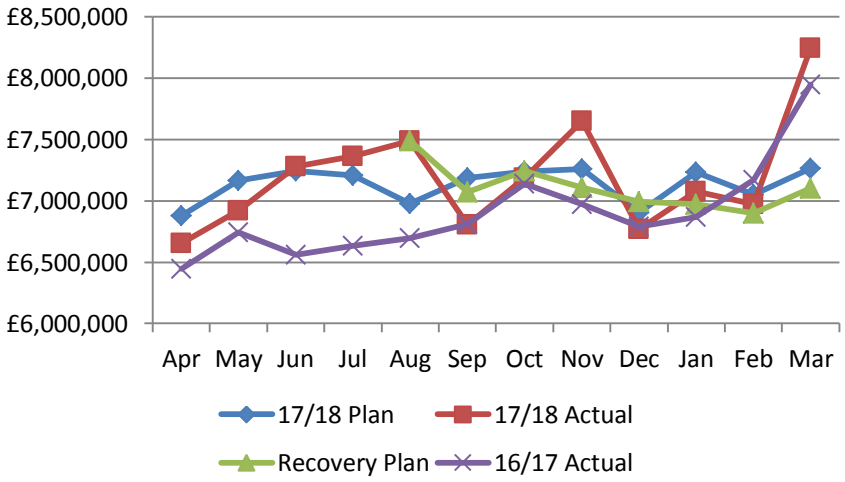
Further work still needs to be performed to ensure that clinicians are recording the appropriate co-morbidities of the patient's they treat, resulting in the trust being funded for the work actually performed.

RISKS / ISSUES

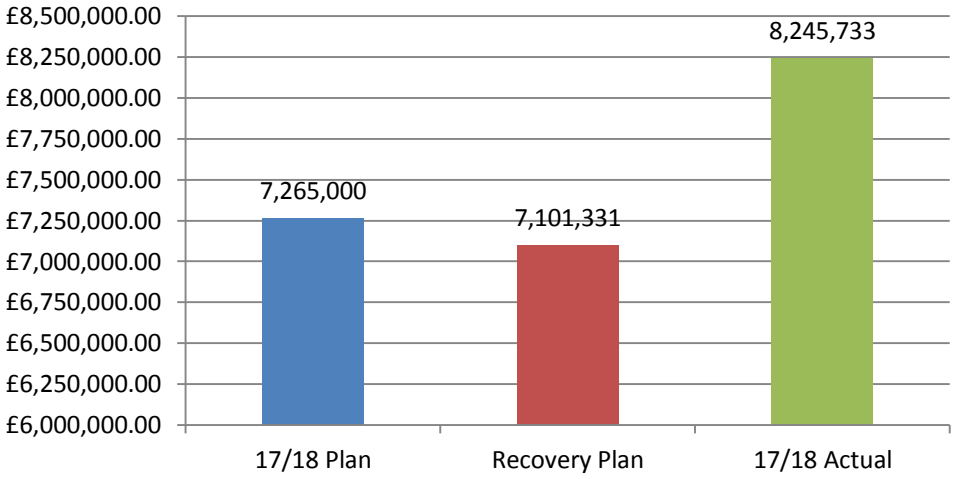
The first week of April 2018 was utilised to maintain theatres and as such no elective activity was undertaken. This puts increased pressure on the trust to deliver its activity targets for the remainder of the coming year.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

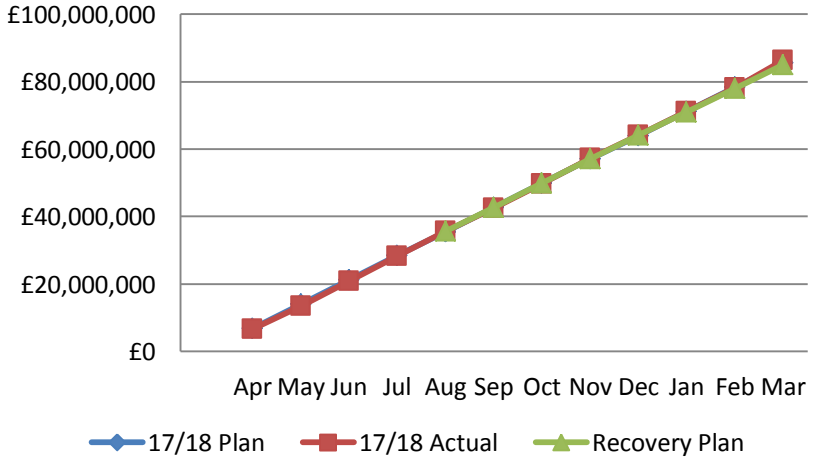
17/18 Monthly Expenditure vs Plan (excl reval gain)



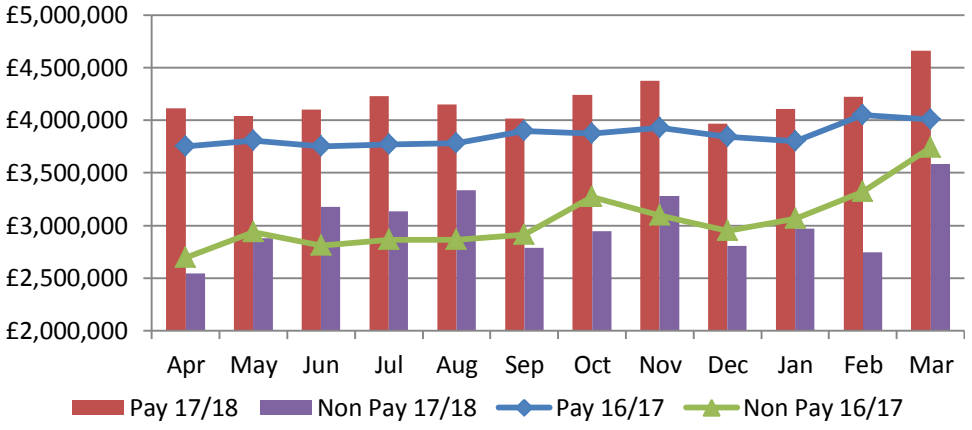
17/18 M12 Expenditure vs Plan (excl reval gain)



Cumulative Expenditure vs Plan 17/18 (excl reval)



16/17 vs 17/18 Pay & Non Pay Spends (exc. reval gain)



INFORMATION

Expenditure levels for the month were £8,245,000, which is significantly above the level expected within the original and recovery plan. The expenditure (and income) position in month 12 will always contain a number of non-recurrent adjustments that are made to more accurately reflect annual expenditure, but even accounting for these expenditure was high in month.

Such adjustments have included the outcome of the stock count, and provision/accruals for adhoc costs such as two redundancy payments, a stock valuation provision (unrelated to the stock count itself), and the potential for a fine. In addition, underlying pay spend was high, particularly with regard to agency, as has been described in further detail in the next slides. Bank and ADH spend was also high in order to deliver additional elective activity in the month. Whilst some of this spend on agency was planned to provide additional support into POAC, vacancy levels and sickness was also high in month. We believe that this is non-recurrent expenditure and nor reflective of recurrent trends but this will be monitored and reviewed closely in April

The expenditure shown excludes a revaluation gain of £2m, which has been excluded to allow visibility of the underlying position. This is excluded for control total purposes and therefore does not translate to addition STF bonus above and beyond the £161k overachievement.

ACTIONS FOR IMPROVEMENTS / LEARNING

Costs will continue to be scrutinised and minimised, particularly relating to workforce in April.

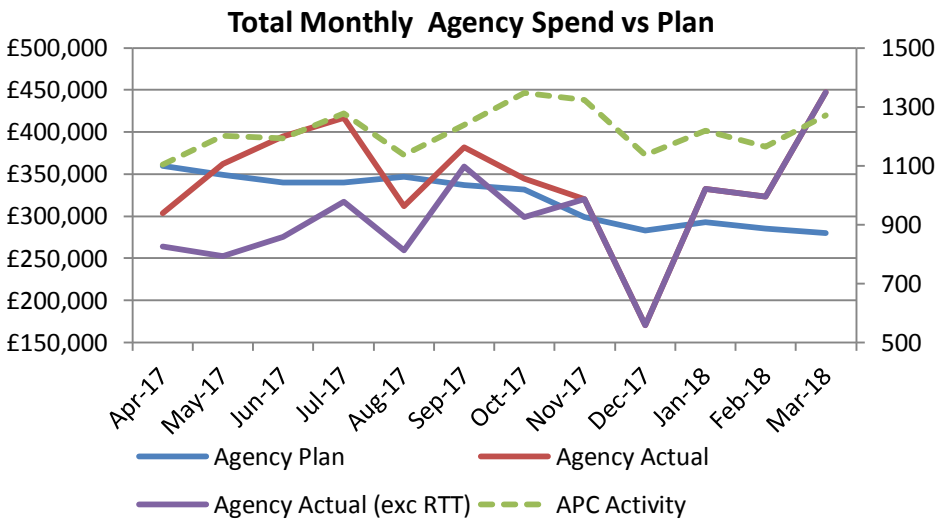
There is further learning from the year end stock count which will be taken forward and acted upon within 2018-19.

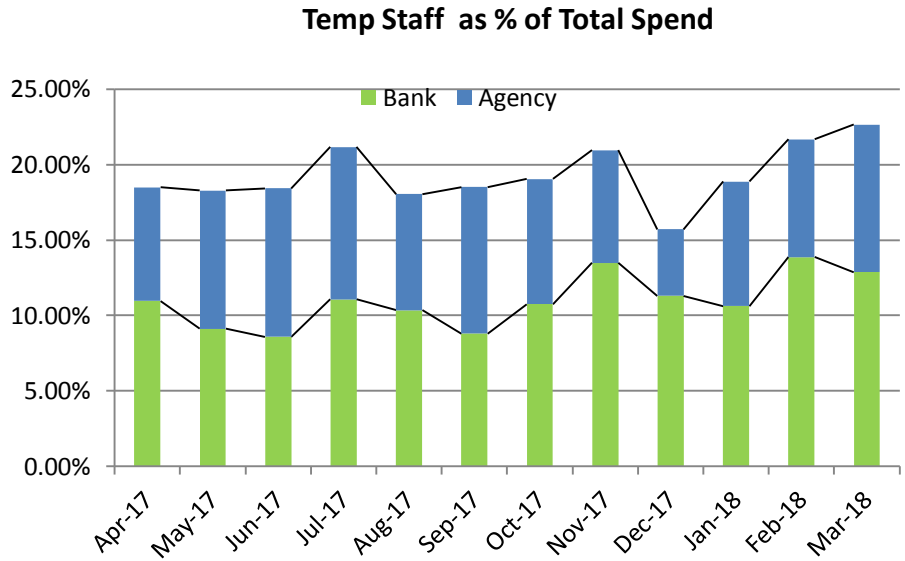
A full list of cost pressures for the 2018/19 financial year has now been reviewed by the Interim Chief Operating Officer and Interim Director of Finance, and built accordingly into business planning and the budget setting exercises.

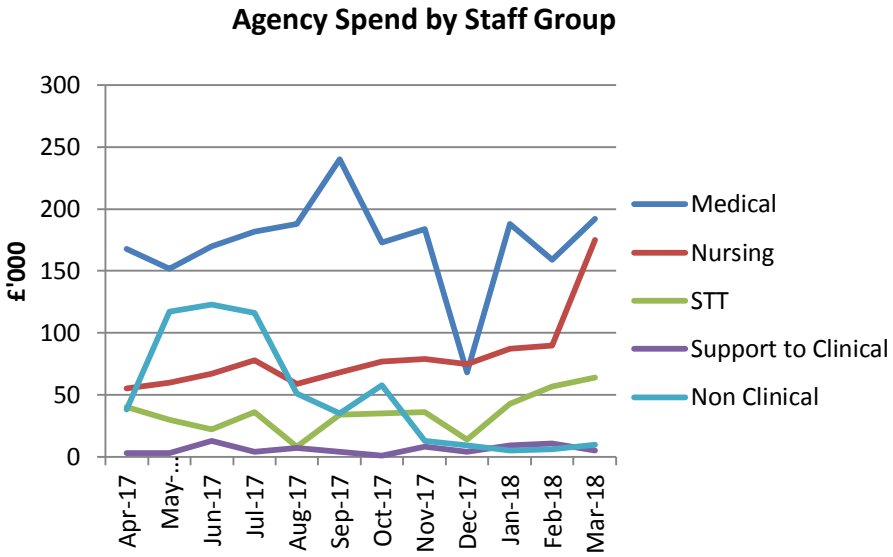
RISKS / ISSUES

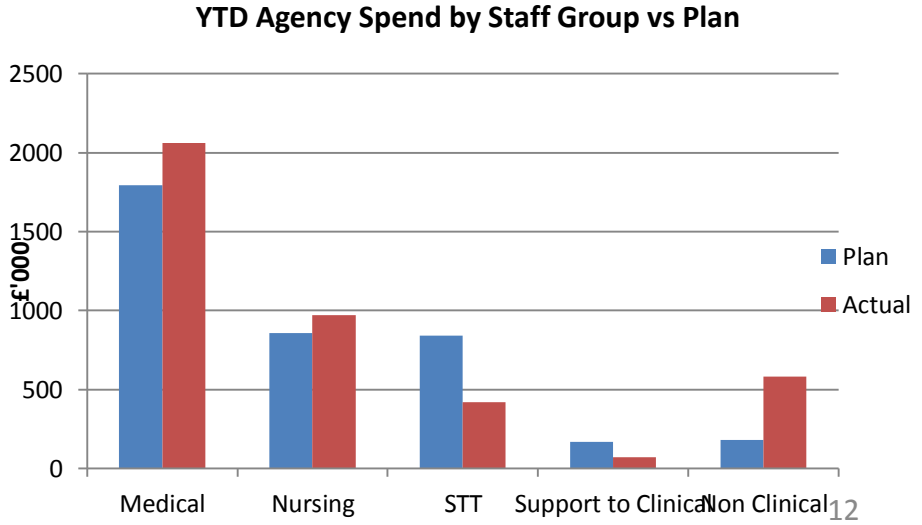
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops ongoing.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

Agency spend has seen a significant increase of over £100k in March. Whilst higher agency spend would be expected in March due to the number of working days, this increase is above and beyond what would be expected for the increased working days. Analysis of the spend shows a general increase across the wards, which would be expected given the increased elective activity in March. In addition, there was significant 'specialling' cover required for particular patients in March. Finally, agency POAC nurses are being used within the Trust, but they are outside of usual nursing agency cap spends due to their particular specialist skills.

Other categories of agency spend are much more in line with previous patterns. Medical agency has increased, but is in line with the level of spend seen across the year ,and STT agency spend continues to remain high due to use of agency physiotherapists being used to reduce waiting lists.

ACTIONS FOR IMPROVEMENTS / LEARNING

The trust needs to continue ensuring that it is monitoring Health Roster to ensure agency spend on nursing is kept at a minimum. The new Head of Nursing for Division 1 is scrutinising nursing agency spend in particular over the coming months to ensure it is reasonable and appropriate.

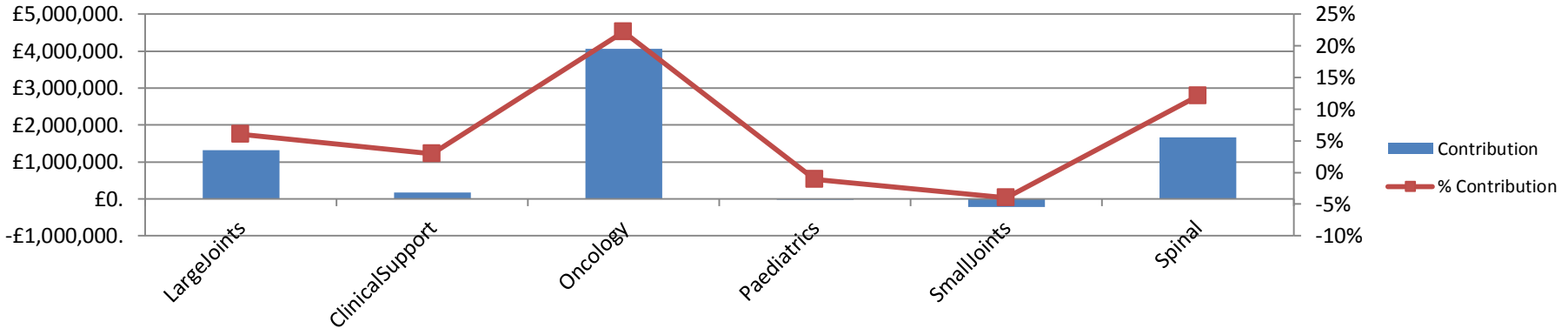
RISKS / ISSUES

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.

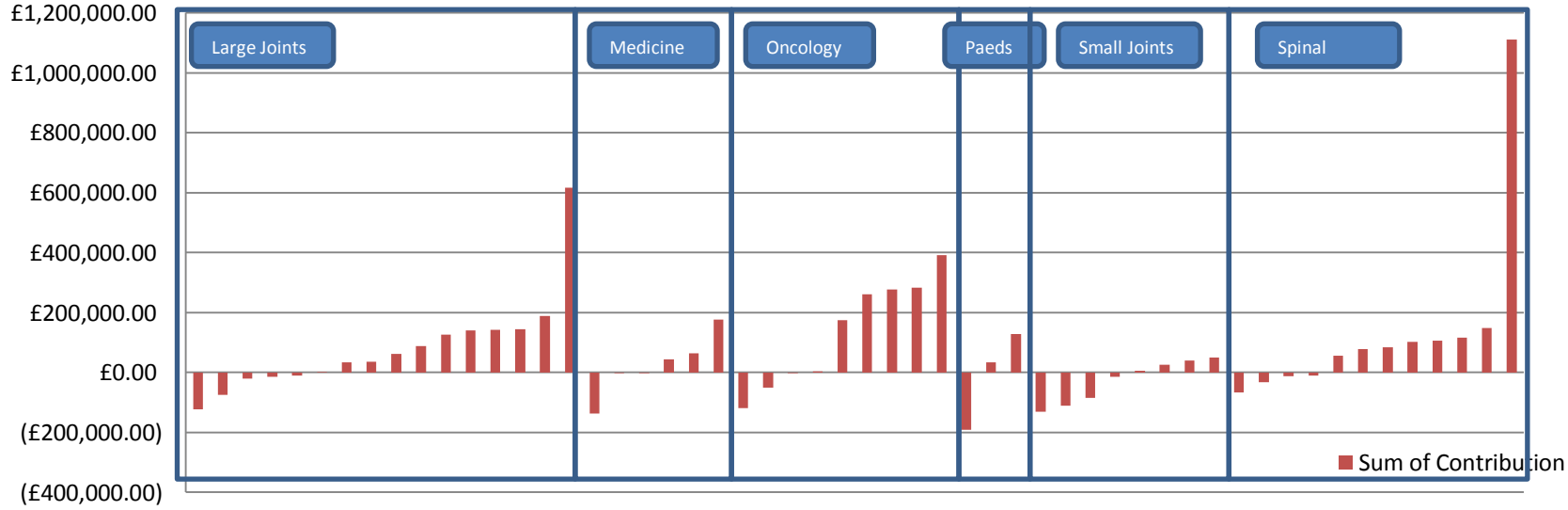
Within the draft annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

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

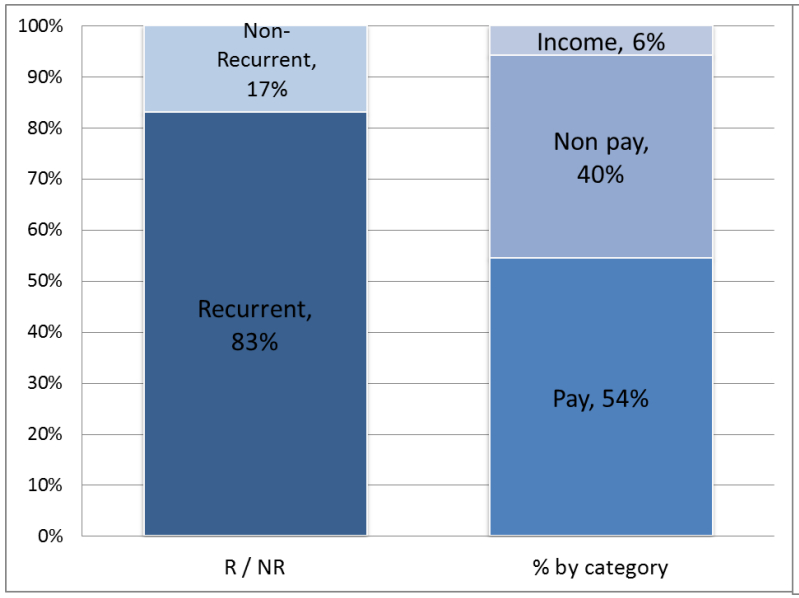
Total Contribution by Service
Cumulative to Apr-Feb 2017-18

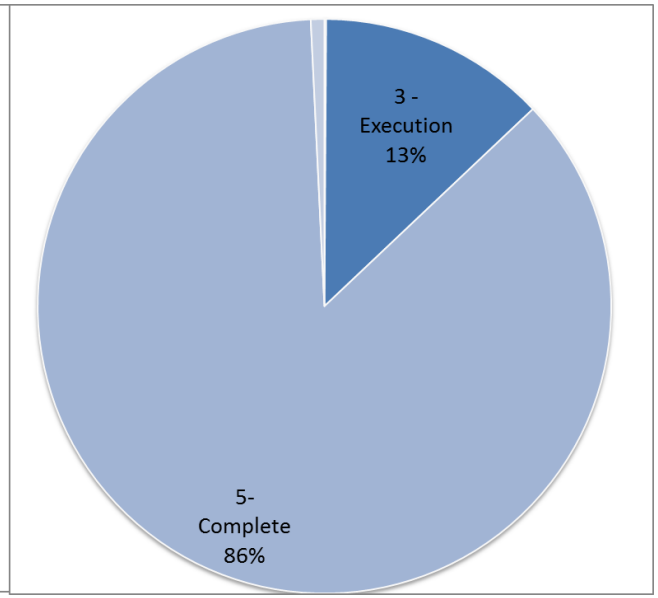


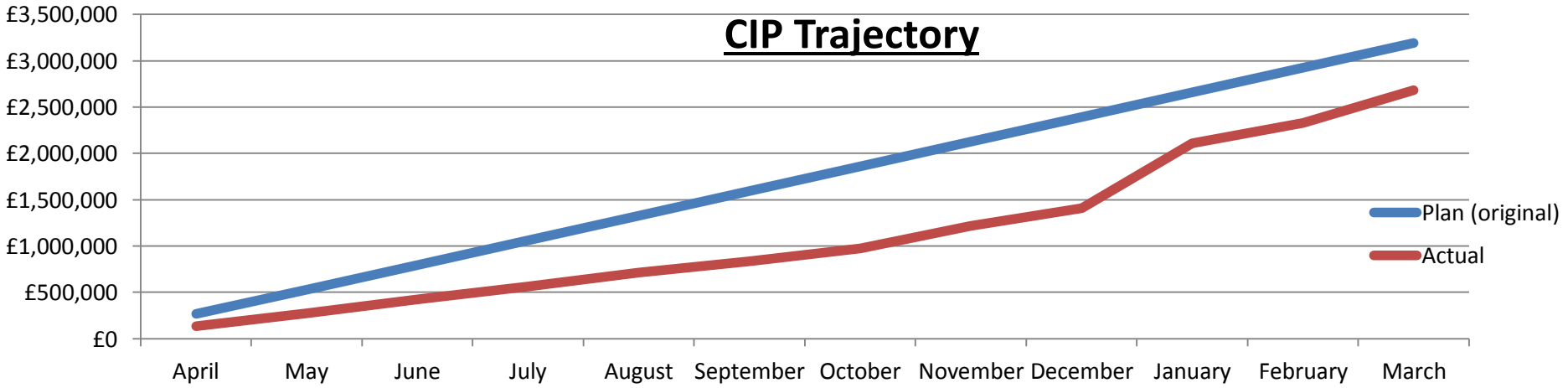
Consultant Contribution Apr-Feb 2017-18



6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18







INFORMATION

As at the end of March the Trust has recognised £2,685,000 of CIP savings, against a plan of £3,191,000, a negative variance of £506,000. £2,230,000 (83%) of savings are recurrent.

	Original Plan	Actual	Forecast vs Original Plan Variance
Division 1	£1,362,500	£1,086,801	-£275,699
Division 2	£851,270	£568,442	-£282,828
Division 3	£42,875	£42,878	£3
Division 4	£160,000	£160,000	£0
Corporate	£774,355	£826,724	£52,369
Grip and Control	£0	£0	£0
Productivity and Efficiency	£0	£0	£0
TOTAL	£3,191,000	£2,684,845	-£506,155
Shortfall		-£506,155	

ACTIONS FOR IMPROVEMENTS / LEARNING

Focus has been shifted to fully developing the 2018/19 CIP plan.
During 2017/18 CIP planning process the CIP unidentified throughout the year failed to be identified as a result of the resources focussing on delivering the schemes that had been identified. Learning has been taken from this and the current unidentified CIP in the 2018/19 is to be addressed during Q1 of 2018/19.
A CIP Programme Board chaired by the Interim Director of Finance will commence on 19th April and initially be held monthly during Q1 with the frequency to be reviewed after this.

RISKS / ISSUES

A significant amount of work remains to be completed to fully develop 2018/19 schemes to ensure they can be implemented at the required timescales so that financial benefits are maximised during the year.

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M12 Plan £'000	M12 Actual £'000	Var £'000
Intangible Assets	2,030	856	(1,174)
Tangible Assets	41,890	47,995	6,105
Total Non-Current Assets	**43,920**	**48,851**	**4,931**
Inventories	3,931	4,857	926
Trade and other receivables	2,714	3,507	793
Other Current Assets	1,048	-	1,048
Cash	3,142	3,751	609
Total Current Assets	**10,835**	**12,115**	**1,280**
Trade and other payables	(10,423)	(12,272)	(1,849)
Borrowings	(4,395)	(1,640)	2,755
Provisions	(116)	(173)	(57)
Other liabilities	(249)	(207)	42
Total Current Liabilities	**(15,183)**	**(14,292)**	**891**
Borrowings	(1,842)	(3,979)	(2,137)
Provisions	(332)	(354)	(22)
Total Non-Current Liabilities	**(2,174)**	**(4,333)**	**(2,159)**
Total Net Assets Employed	**37,398**	**42,341**	**4,943**
Total Taxpayers' and Others' Equity	**37,398**	**42,341**	**4,943**

INFORMATION

Tangible assets are significantly above plan due to a revaluation gain of £3.9m (split between the I&E and revaluation reserve).

As previously mentioned, the inventory balance is that which has been counted and valued at the year end. As had been expected from the November interim stock count, stock levels are significantly higher than last year. This is to be expected given the stock rationalisation - stock is held with both the old and new supplier whilst the rationalisation is embedded, with stock levels then being reduced over time.

Cash is largely in line with plan at year end, although borrowing is lower than expected from the Department of Health due to the timing of underperformance payments and a number of other unexpected cash inflows (e.g. the £101k insurance receipt).

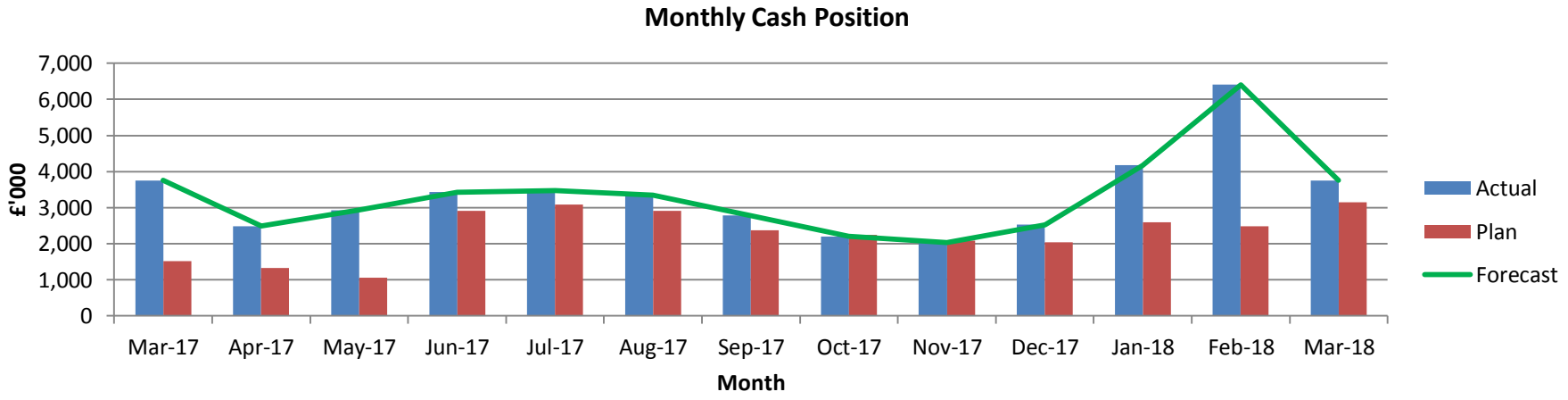
Creditors balances have risen throughout the year. This is due to two main reasons; firstly, there have been staff shortages through vacancy and sickness within the theatre environment which has slowed down approval of invoices to allow payment. This is being managed through use of an agency member of staff who is working through the backlog. Secondly, with the trust now reliant on cash funding, the team need to be more careful regarding payment of invoices to ensure the minimum cash balance of £1m is not breached, and this therefore results in higher creditor balances.

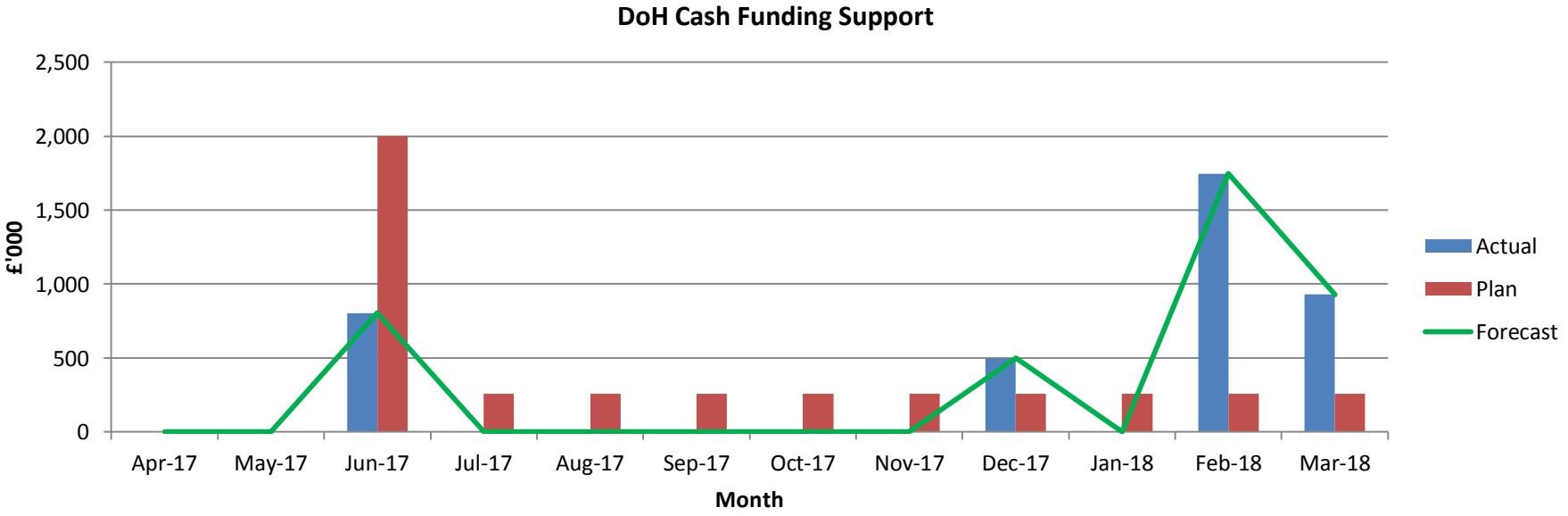
ACTIONS FOR IMPROVEMENTS / LEARNING

In the coming months, further balance sheet metrics regarding better payment practice code and debtor ageing will be included within the report.

RISKS / ISSUES

8. 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 was £609k above planned levels at the end of March, as some credit notes for underperformance have not recovered by the CCGs.

The Trust received its first cash loan of £804k from the Department of Health in June 2017, a second of £498k in December 2017 and a third of £1,747k in February 2018. The final loan for the year of £930k was received in March, taking full year borrowing to £3,979k. This is within the level of loans which were predicted for the year in the Annual Plan.

In March the Trust also received £280k cash from the Department of Health to fund cybersecurity improvements. This has been funded through public dividend capital rather than an additional loan.

The requirement for cash support continues to result in the trust being rated at the lowest level (level 4) for liquidity.

ACTIONS FOR IMPROVEMENTS / LEARNING

The finance team continue to run a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team in order to scrutinise both the current and future cash position, but also to identify areas for cash control improvement. The committee continues to review cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the Department of Health to be actioned. The updated cash requirements for 2018/19 based on a refresh of the operational plan continue to be modelled.

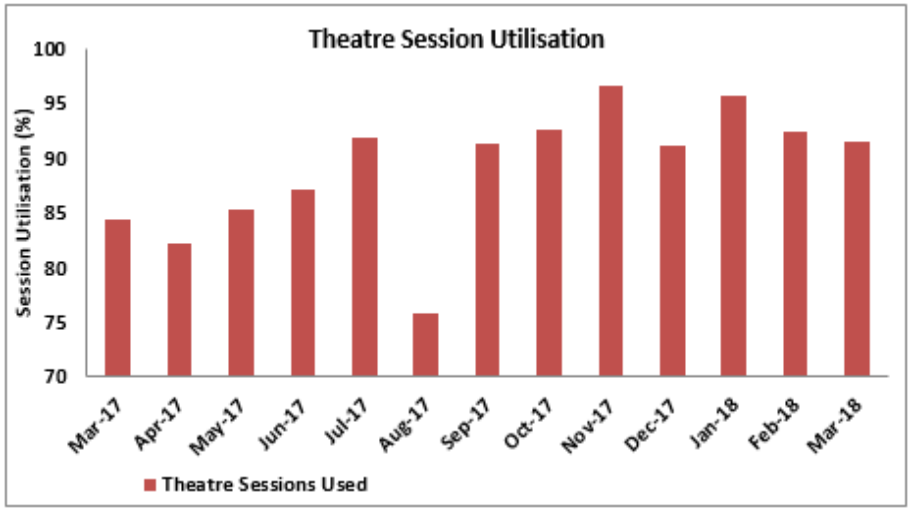
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DoH not approving a cash loan or approving a lower than requested amount.

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

Theatre list utilisation for March was 91.47% slightly down on the previous month. Contributing factors were the impact of Consultant surgeon annual leave which reduces the opportunities for other colleagues to cover the additional available lists and Consultant surgeon sickness. Also the annual Hip Society Conference took place during this month, which some Consultants attended.

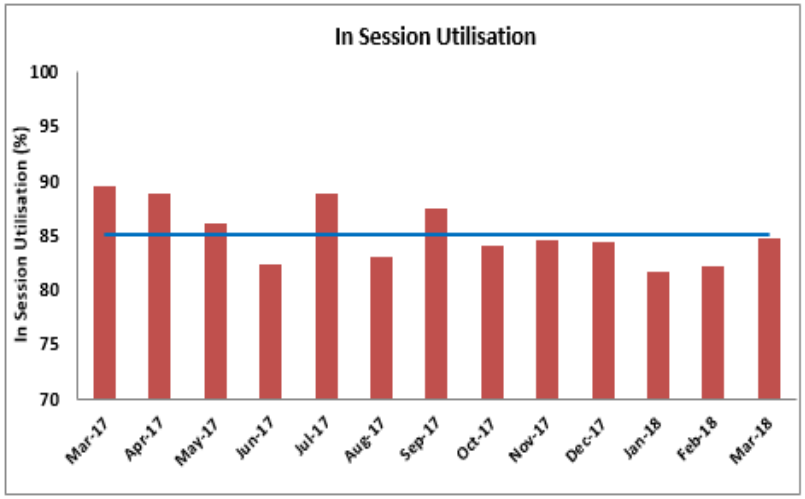
Overall utilisation from July 2017* averaged 91.04% with improved performance from October, averaging 93.35% .

*April to Jun data has been excluded due to the implementation of a new Theatre System (ORMIS to Theatre Man)

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc. will also need to 'grow' alongside theatres to ensure maximum efficiency gains.

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



INFORMATION

Whilst sessional utilisation has remained strong, the average in session utilisation has struggled to reach the target of 85% over the last 6 months, although the average for the year is 84.8%. We are reviewing the correlation between the two measures.

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.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 84.65% in March up on the previous month (82.23%)

The development of a Theatre Dashboard to provide a more detailed analysis of speciality performance within theatres, focussing on start / end times, turn around times, early finishes, over runs etc. This will allow for trends to be more easily identified, for example the ability to look at specific theatres on specific days.

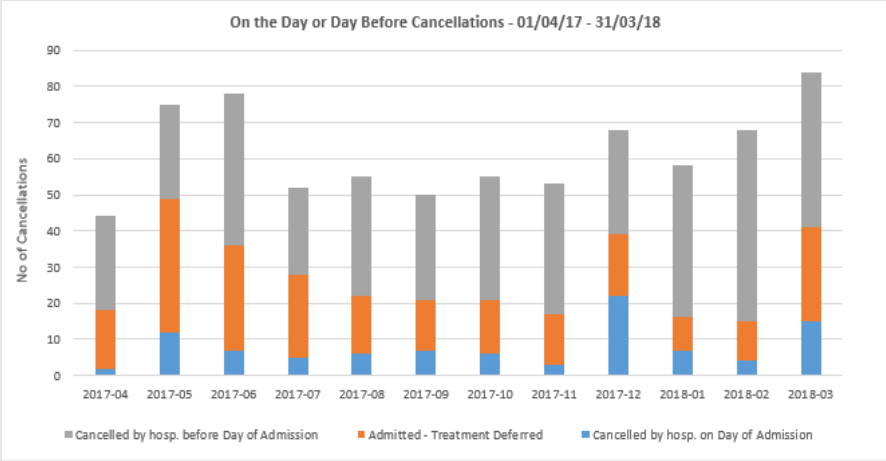
This data analysis will then form the basis to hold speciality specific meetings where speciality theatre usage and utilisation can be discussed, and recurring themes or areas of concern can be highlighted and rectification plans put into place to improve performance generally.

RISKS / ISSUES

- Development of the dashboard will require Informatics support and potentially IT support which may delay development and implementation due to other project priorities for those services.

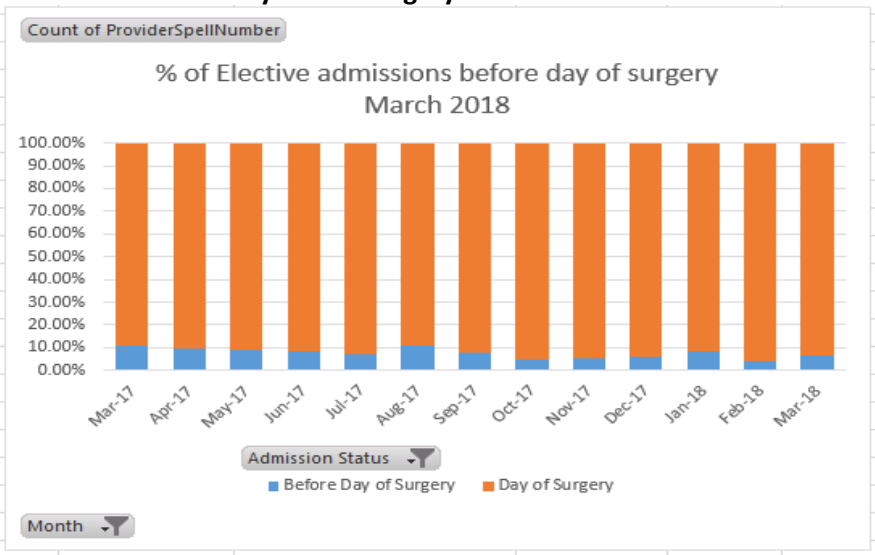
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

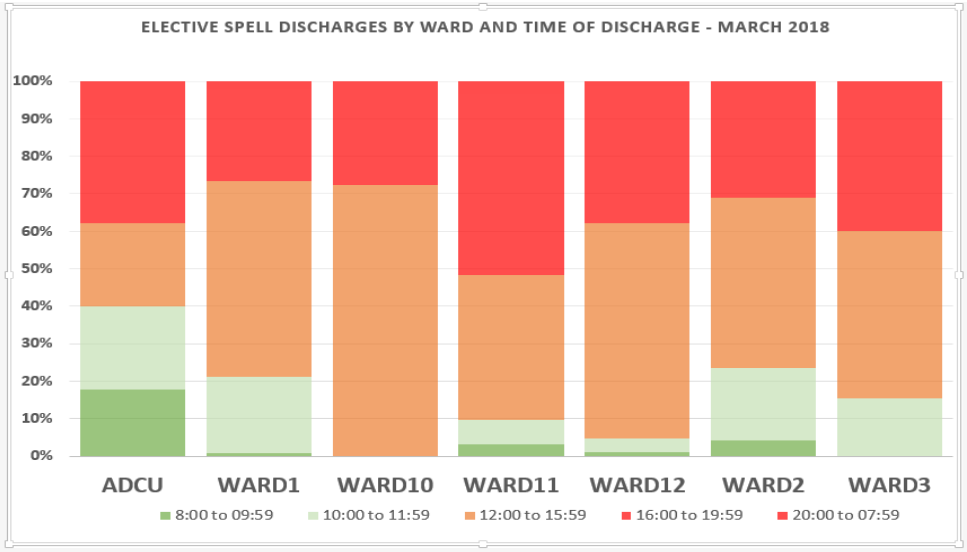
Hospital Cancellations



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	42	58	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
Grand Total	96	227	417	740	10

Admission the day before surgery





INFORMATION

The number of cancellations on the day of surgery by the hospital has increased in month. An analysis of this shows that the reasons for cancellation varied across a broad range of issues , key themes identified were : ran out of theatre time , Consultant sickness, theatre staffing and emergency patients taking priority . In addition reasons for patient led cancellations included clinical changes in patient condition and patient choice .

Cancellations before the day of surgery have reduced in month. The two main factors for cancellations prior to surgery were patients being offered earlier dates for surgery and patient choice to move / defer surgery .

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Trends are analysed and interventions delivered to reduce cancellations. Further work has been delivered to develop the new POAC model, following focus groups working with staff to develop new ways of working developing an efficient patient focussed service which supports the needs of the expanding operative activity in a timely efficient manner .
The pathway model and clinical protocols are currently being finalised and will be presented with the associated workforce plan by 2nd May 2018 .

ACTIONS FOR IMPROVEMENTS / LEARNING

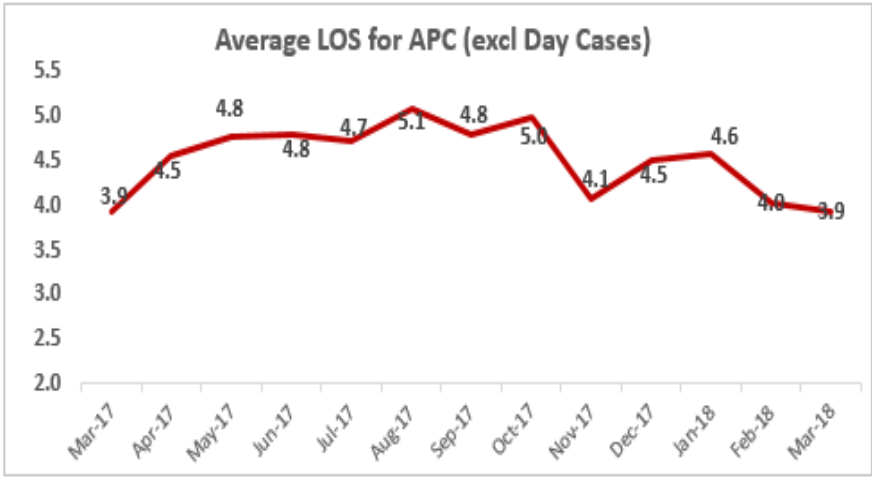
A daily update review by the Operational management team of forward bookings has been established, as well as the and the 6-4-2 weekly meeting. The operations 'Huddle ' is now embedded in practice, with learning shared at weekly Operational meetings across divisions .
Additional focus is being delivered:
- to reinforce accuracy and importance of of ADT information (Admission, Discharge and Transfer)
- Increased Consultant led clinical review with full support from support services
- Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation discussed at the POAC workshop .

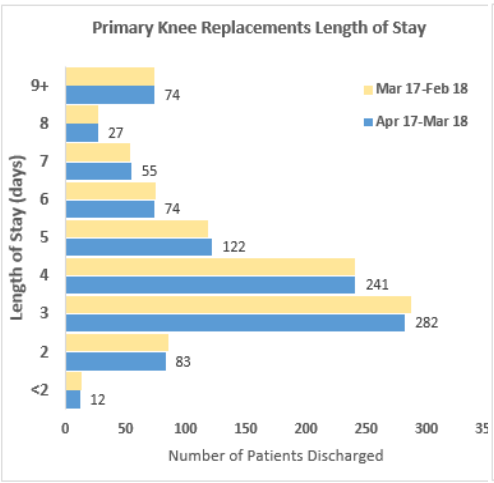
PERFECTING PATHWAYS

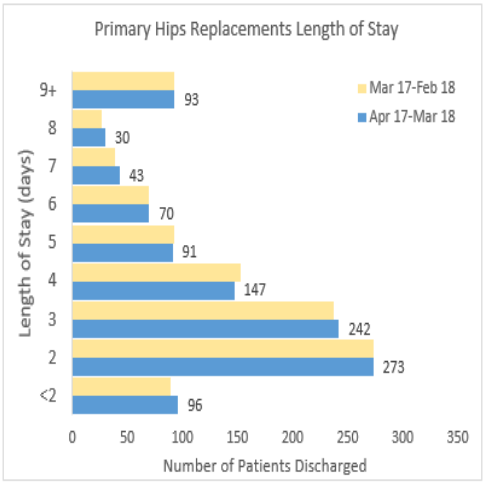
RISKS / ISSUES

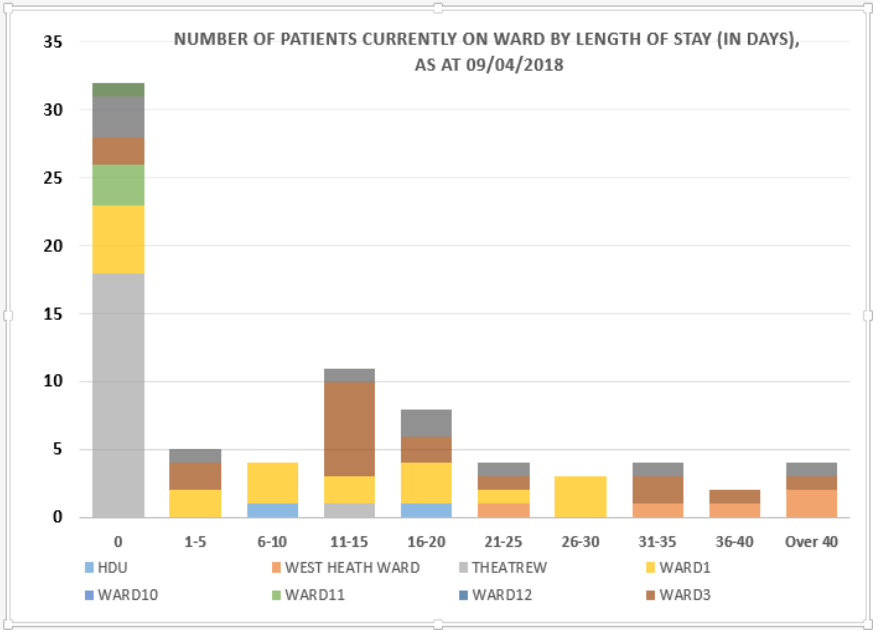
Continued high levels of cancellations in Month .
Shorter turn around times for pre –operative assessment are required to respond flexibly to increased levels of activity.

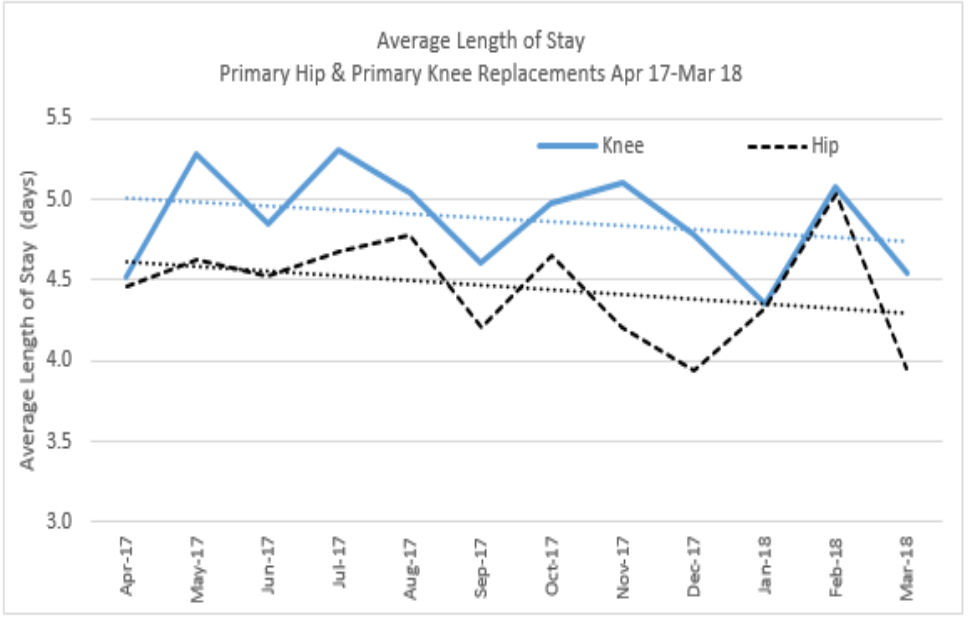
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Activity levels continue to increase against the recovery plan and a reduced LOS is demonstrated in month .
Initiatives to continue to improve LOS are as follows:

- Red2Green is now launched on all wards, supported by a daily 'huddle' which is currently being piloted on ward 2 at 12.00 hrs Monday to Friday. Multi disciplinary Teams are attending these meetings to ensure a pro active collaboration to support timely discharge .
- 'PJ paralysis challenge' is underway (launched April 17th) by Christian Ward (Head of Nursing for Div 1). All wards are fully engaged with this challenge, signing up to the on line app in order to enter the number of patients who are in their own clothes each day actively participating in this national initiative .
- 'Passport to Home 'patient information has now been agreed . PCF have provided input on the correspondence to be provided to patients and it is anticipated that the roll out of the new patient information will commence in May 18.
- Gold/Silver concept now reinforced on all wards to support the improvement in the flow of patients and maximise utilisation of the discharge lounge. Gold/ Silver patients also now being identified on Saturday / Sunday by the sight co-ordinator to highlight patients ready for discharge, to ensure patient flow is maintained over weekends .
- Daily Operational bed meetings commenced 9/4/18 at 9.30am 12pm and 2.30pm to escalate any delays for social care , inter-hospital transfer and expedite appropriate discharges .

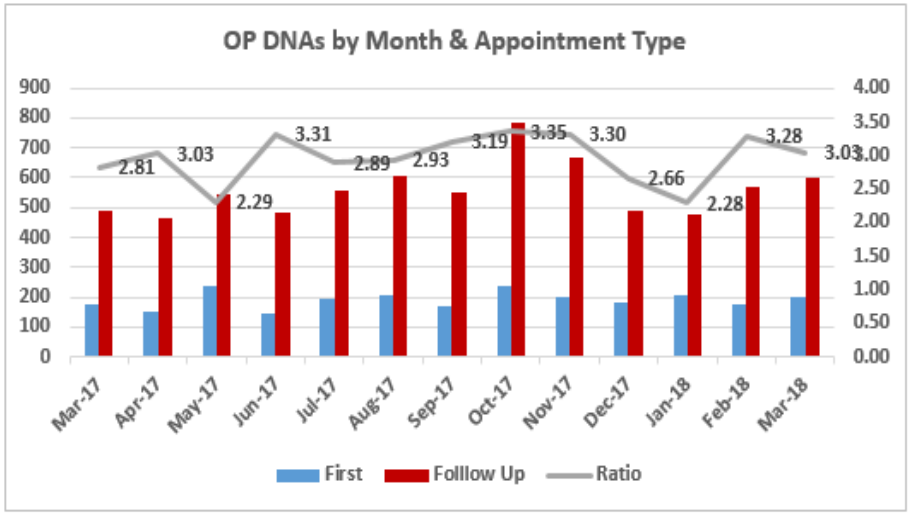
ACTIONS FOR IMPROVEMENTS / LEARNING

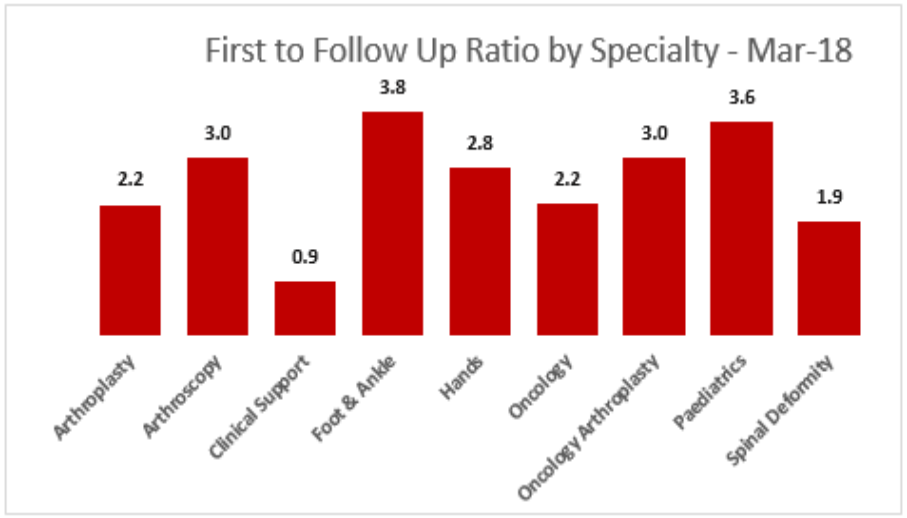
- The Red2Green dashboard development has now been signed off by the pilot wards and is being launched across all wards effective 1 May 2018. (This will provide average length of stay data for each ward, together with the top 10 reasons for any discharge delays. The dash board also records how many Green or Red days were recorded on the wards. This should provide intelligence to support a continued emphasis on reducing LOS across all wards .
- Consultant led ward rounds are now being rolled out across all wards so that all patients are reviewed to support timely discharge . Further work continues to develop with the Arthroplasty team which includes feasibility around a dedicated Theatre environment , freeing up adjacent accommodation to house the Arthroplasty team and work around pre-assessment. There has been some dedicated focus on the Knee Replacement Pathway and this has started to show a reduction in the over all length of stay for this patient group, which will be rolled out to all patients as ' the ROH way ' going forward.

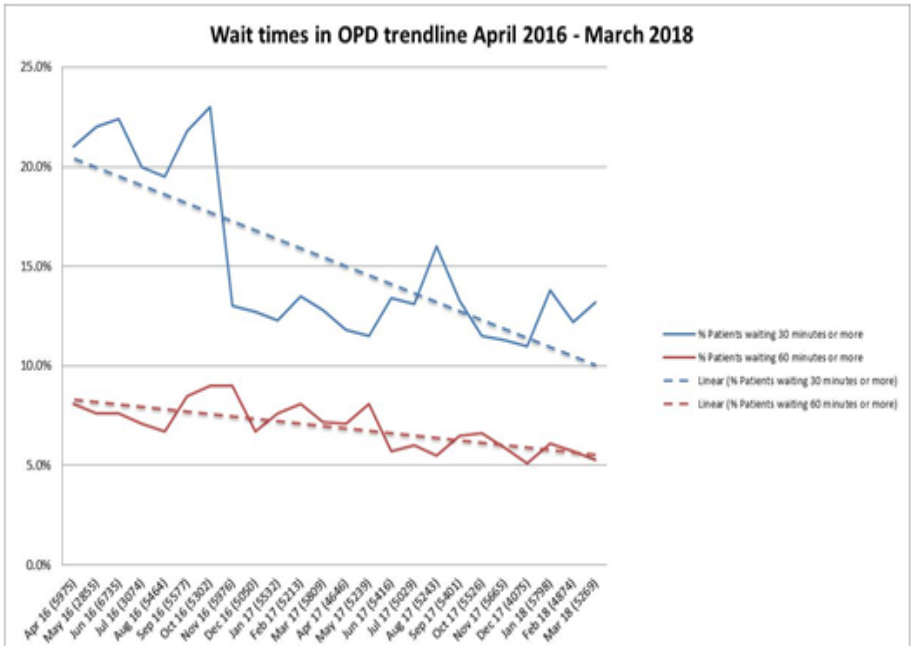
RISKS / ISSUES

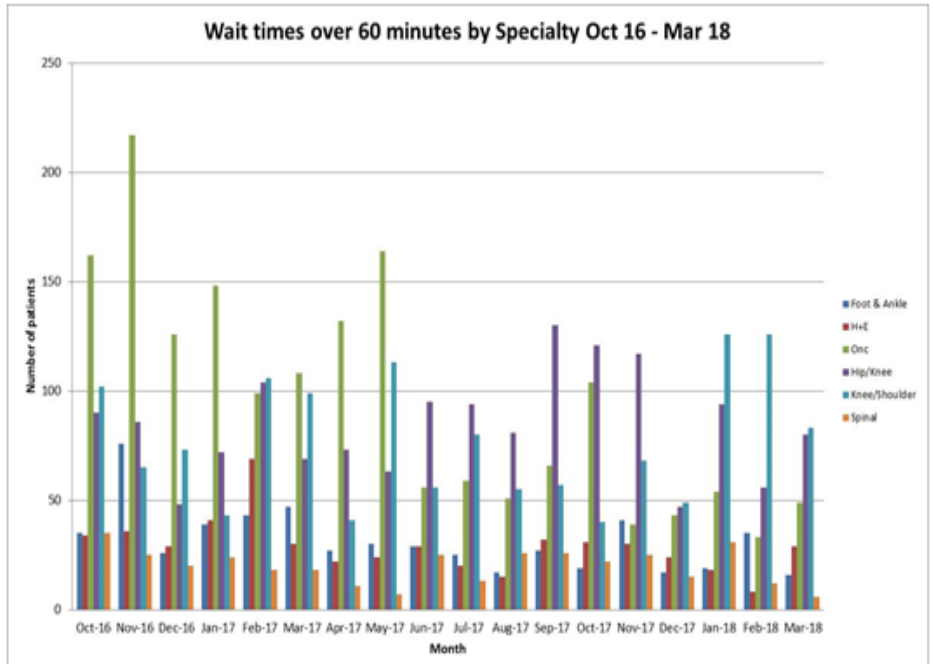
A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity . A bed modelling exercise is now underway to inform future capacity the Trust requires to deliver its activity to support the SOC.

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









INFORMATION

The involvement of the operational management team in the investigation of incident forms relating to clinic delays continues and has triggered at least one new review of a consultant's outpatient clinic template. Issues of clinic capacity continue to contribute to delays in clinic and the ops team are reviewing reporting and processes in order to regularly review this information. In addition there are plans to carryout capacity modelling for outpatient clinics across all specialties as well as reports to monitor and improve clinic utilisation.

In March there were 32 incident forms completed to highlight clinics running more than 60 minutes late; a significant increase on previous months. 13.2% of patients waiting over 30 minutes and 5.3% waiting over 1 hour and this (over 1 hour) is an improvement on the previous month's position. The largest number of incidents were reported in Hip / Knee and Shoulder specialties.
The monthly audit identified the following : -

- 12- Clinic overbooked
- 9- Complex patients
- 8- Consultant/Clinician Delay
- 2- Xray delay
- 1- Other

ACTIONS FOR IMPROVEMENTS / LEARNING

March;
- Continue to drive incident investigations and action through relevant operational manager
- A review of the clinics that have been over booked
- Development and Launch of new electronic clinic rescheduling system through Top Desk
- Review of SOP in relation to clinic rescheduling
- Development of clinic utilisation tools through InTouch and Health Informatics
- Review of individual clinics which are overbooked

RISKS / ISSUES

Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place

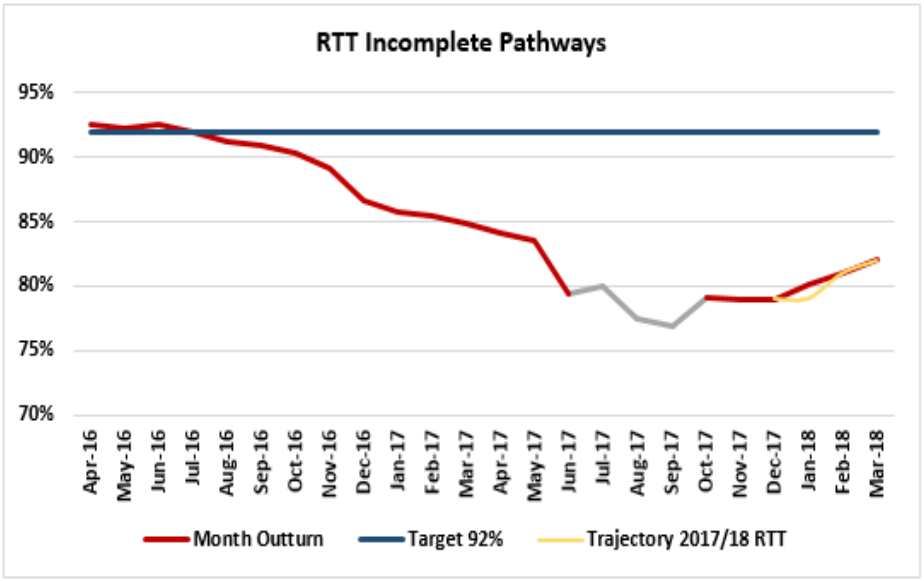
14. Treatment targets – This illustrates how the Trust is performing against national treatment target –

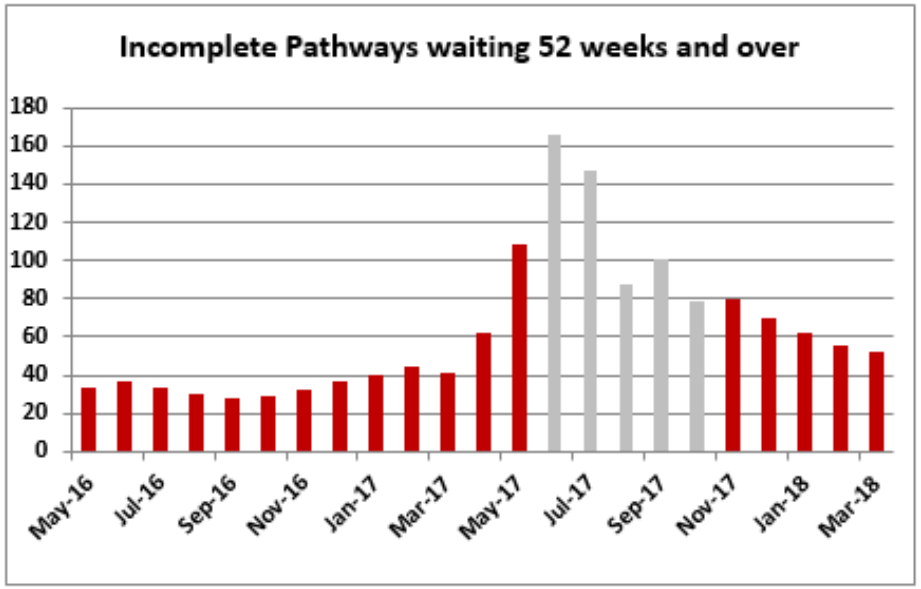
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%

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



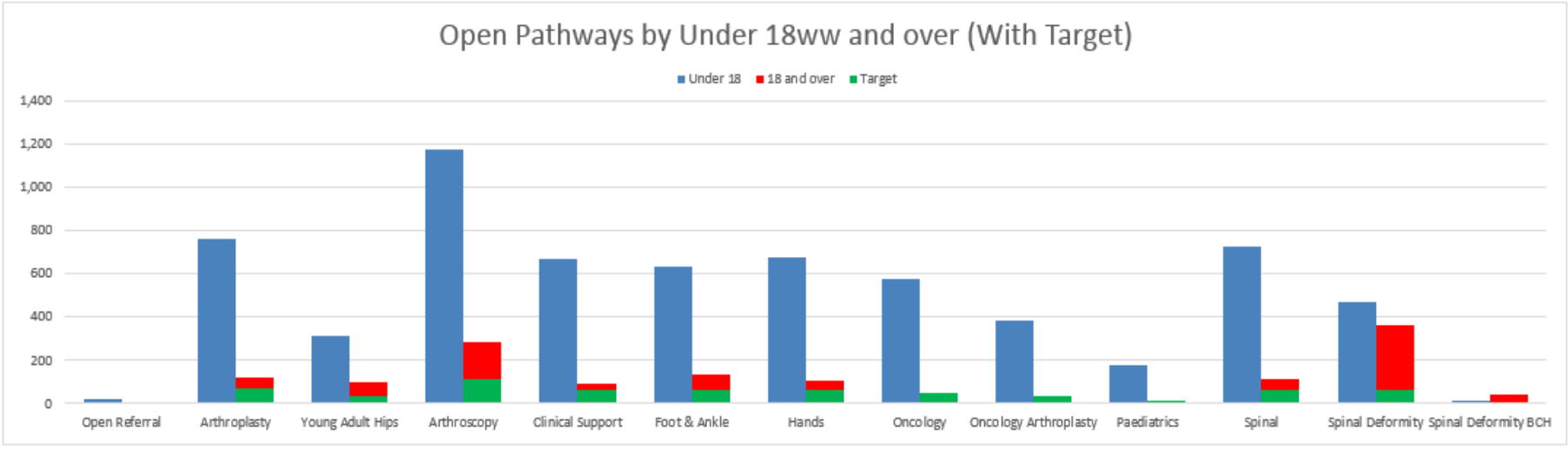


Target Name	National Standard	Feb	Jan	Dec	Nov	Oct	Q3	Breaches	Total	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	100.00%	97.10%	100.00%	100%	95.10%	98.40%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	88.90%	91.67%	100.00%	91.70%	100%	96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100.00%	94.10%	100.00%	100.00%	100%	100.00%	0	30	97.40%	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	n/a		n/a
62 day (traditional)	85%	87.50%	86.67%	83.30%	83.30%	100%	87.50%	1.5	8	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	77.80%	100.00%	50.00%	90.90%	81.20%	82.80%	2.5	14	88.9%	1	9	100%	0	4
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
No. day patients treated 104+ days		0	1	0	0	0									
Accountable Treated 62 Standard		4	7.5	3	5										
Actual Treated 62 Standard		6	10	6	3										
Accountable Breaches 62 Standard		0.5	1.0	0.5	1										

14. Referral to Treatment snapshot as at 31st March 2018 (Combined)

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,530**	14	379	128	625	397	336	368	320	230	115	376	237	5
7-13	**2,166**	6	287	114	386	195	205	226	171	120	41	262	149	4
14-17	**913**	0	96	74	167	76	93	86	89	37	20	90	82	3
18-26	**872**	0	78	64	196	55	100	80	28	20	7	74	166	4
27-39	**397**	0	39	27	83	33	26	24	2	7	9	30	105	12
40-47	**113**	0	5	9	8	6	7	4	0	3	0	10	58	3
48-51	**10**	0	1	0	0	0	0	0	0	0	0	1	7	1
52 weeks and over	**52**	0	0	0	0	0	0	0	0	0	0	0	30	22
Total	**8,053**	20	885	416	1,465	762	767	788	610	417	192	843	834	54

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**6,609**	20	762	316	1,178	668	634	680	580	387	176	728	468	12
18 and over	**1,444**	0	123	100	287	94	133	108	30	30	16	115	366	42
Target	**644**	**2**	**71**	**33**	**117**	**61**	**61**	**63**	**49**	**33**	**15**	**67**	**67**	**4**
	82.07%	100.00%	86.10%	75.96%	80.41%	87.66%	82.66%	86.29%	95.08%	92.81%	91.67%	86.36%	56.12%	22.22%



14. Referral to Treatment snapshot as at 31st March 2018

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**929**	0	123	53	175	43	40	112	111	91	44	94	39	4
7-13	**653**	0	155	37	170	26	10	41	45	67	17	57	25	3
14-17	**252**	0	54	13	66	11	11	18	17	14	10	21	14	3
18-26	**358**	0	51	23	130	8	20	30	22	14	2	28	26	4
27-39	**159**	0	17	18	43	7	6	7	1	7	6	11	24	12
40-47	**53**	0	3	4	5	0	4	2	0	2	0	3	27	3
48-51	**8**	0	1	0	0	0	0	0	0	0	0	1	5	1
52 weeks and over	**44**	0	0	0	0	0	0	0	0	0	0	0	23	21
Total	**2,456**	0	404	148	589	95	91	210	196	195	79	215	183	51

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**1,834**	0	332	103	411	80	61	171	173	172	71	172	78	10
18 and over	**622**	0	72	45	178	15	30	39	23	23	8	43	105	41
Target	**196**	**0**	**32**	**12**	**47**	**8**	**7**	**17**	**16**	**16**	**6**	**17**	**15**	**4**

	74.67%	n/a	82.18%	69.59%	69.78%	84.21%	67.03%	81.43%	88.27%	88.21%	89.87%	80.00%	42.62%	19.61%

Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,601**	14	256	75	450	354	296	256	209	139	71	282	198	1
7-13	**1,513**	6	132	77	216	169	195	185	126	53	24	205	124	1
14-17	**661**	0	42	61	101	65	82	68	72	23	10	69	68	0
18-26	**514**	0	27	41	66	47	80	50	6	6	5	46	140	0
27-39	**238**	0	22	9	40	26	20	17	1	0	3	19	81	0
40-47	**60**	0	2	5	3	6	3	2	0	1	0	7	31	0
48-51	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
52 weeks and over	**8**	0	0	0	0	0	0	0	0	0	0	0	7	1
Total	**5,597**	20	481	268	876	667	676	578	414	222	113	628	651	3

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**4,775**	20	430	213	767	588	573	509	407	215	105	556	390	2
18 and over	**822**	0	51	55	109	79	103	69	7	7	8	72	261	1
Target	**448**	**2**	**38**	**21**	**70**	**53**	**54**	**46**	**33**	**18**	**9**	**50**	**52**	**0**

	85.31%	100.00%	89.40%	79.48%	87.56%	88.16%	84.76%	88.06%	98.31%	96.85%	92.92%	88.54%	59.91%	66.67%

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For March 2018 the RTT trajectory was 82% with performance at **82.07%** , with 52 patients over 52weeks. As confirmed in the trajectory all specialties other than spinal deformity would treat all patients at or over 52 weeks – this was achieved in March 2018.

The team have reviewed all spinal deformity patients and produced a trajectory submitted to NHSI & NHSE. This has been reviewed by the NHSI Intensive Support Team (IST).

ACTIONS FOR IMPROVEMENTS / LEARNING

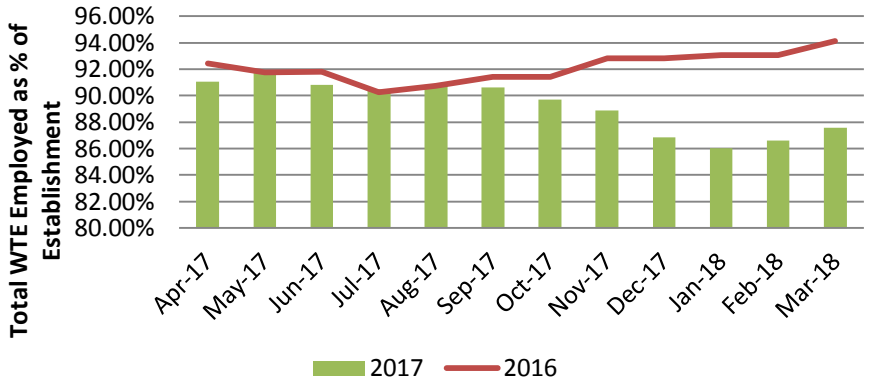
The team continue to concentrated on any patients over 40 weeks, this number continues to reduce. At the end of December 2018 we had 238 patients over 40 weeks, at the end of February 2018 this figure is now 123. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.

RISKS / ISSUES

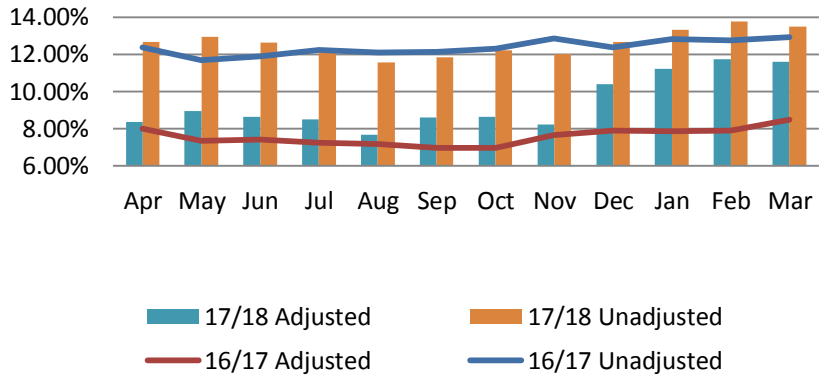
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity which had been planned up till April 2018 is now being planned through the Summer to assist with the existing waiting list . 5 patients have been transferred to Stoke for treatment following discussion with patients and their families.

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

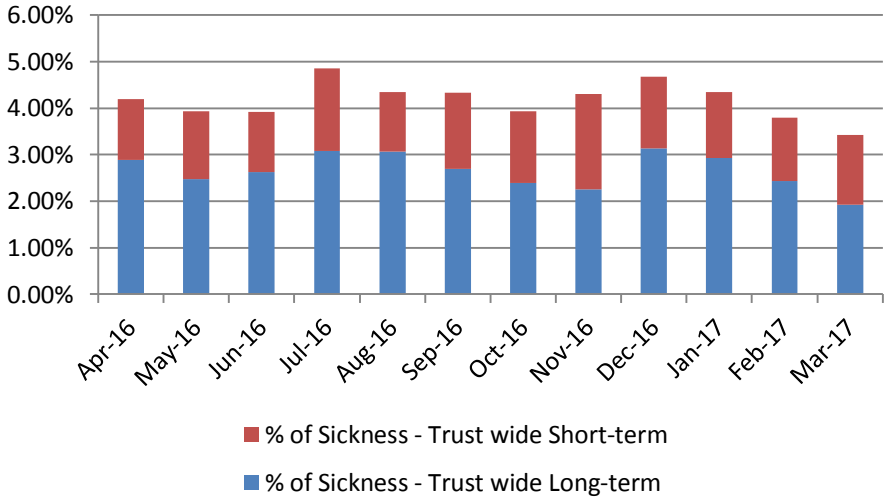
Staff in Post v Establishment



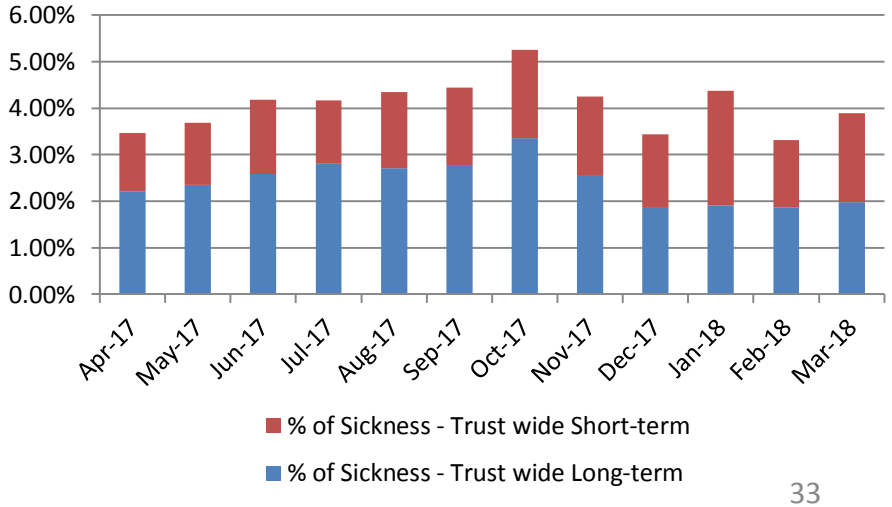
Staff Turnover



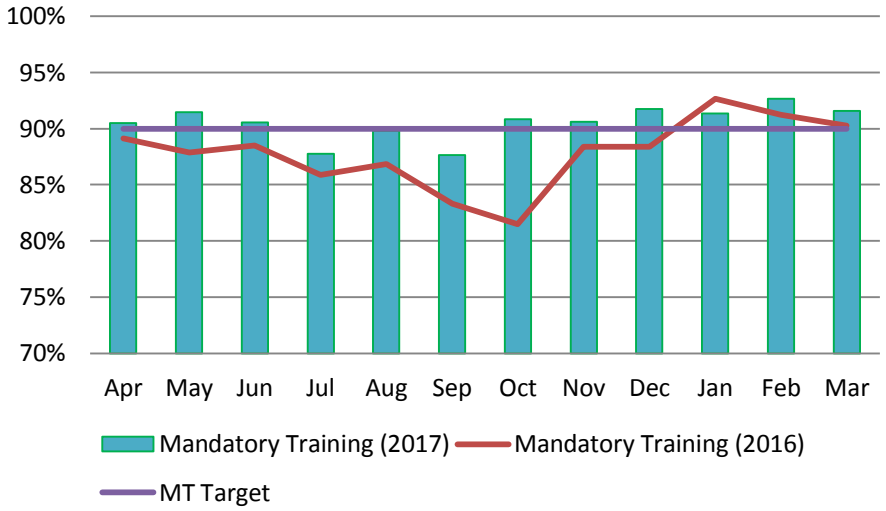
Sickness % - LT/ST (2016/17)



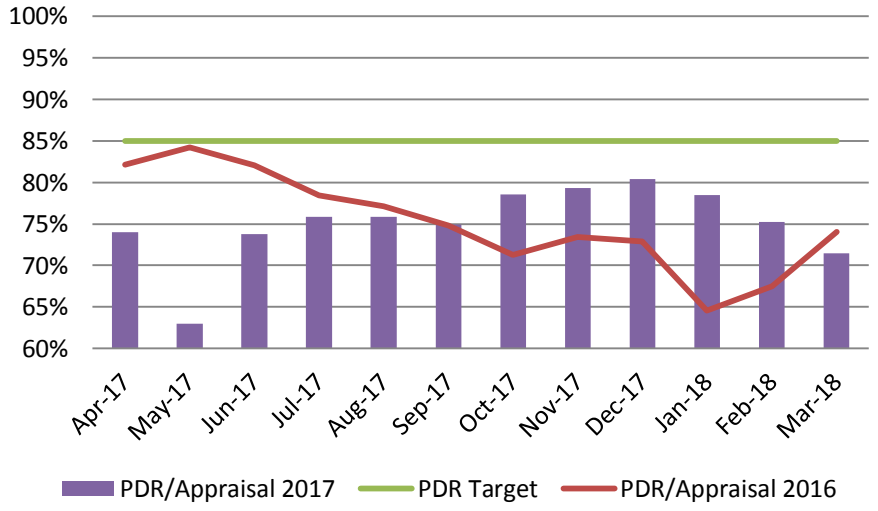
Sickness % - LT/ST (2017/18)



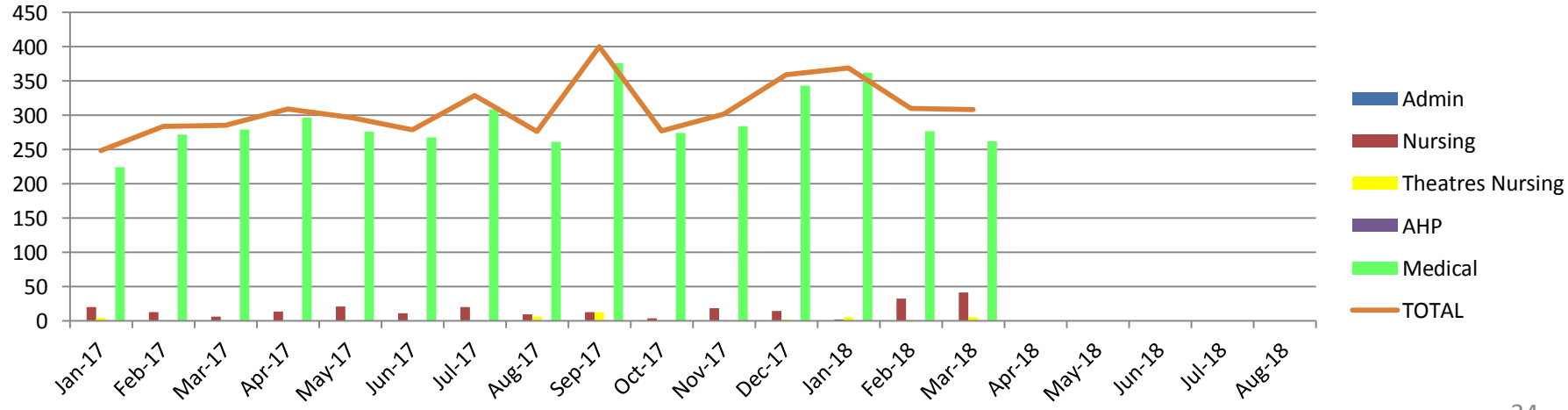
Mandatory Training



PDR/Appraisal



Agency Breaches



INFORMATION

In general terms, March was a month of encouraging performance. Staff in post increased, turnover fell, agency breaches fell very slightly, and mandatory training and sickness absence both remained green. Appraisal was the indicator which remains in need of focus.

In March, sickness absence increased by 0.58% to 3.90% in month - but remains green - and is lower than the average for the month of March (4.25% over the last 10 years). On the other hand, our underlying 12 month average figure decreased very slightly by 0.01% to 4.16% and is also still green. From next month, sickness absence metrics will change to represent an attendance figure as opposed to an absence figure; the green key performance indicator rating has also been adjusted from 4.1%/95.9% to 3.9%/96.1%. The Trust is changing its thinking to considering attendance at work as the metric at the same time as setting higher expectations.

This month the Trust's vacancy position saw improvement of 0.98% to 87.57%. Our staff in post headcount continues to rise as our recruitment activity to unfilled posts continues. This financial year will see a slight variation to the vacancy position; the green Key Performance Indicator (KPI) rating will be divided into a Trust wide figure (which will be reduced to 90% compared to the current 93%) and also a Non-Clinical filled posts target of 94%. It is recognised that this will be a stretch target but reflects the Trust's ambition to improve its recruitment performance.

Mandatory Training decreased in March by 1.1% but continues the last 6 month trend by remaining green at 91.56%. It is still higher than the 17/18 average of 90.55%. The L&D Team are continuing to encourage staff to book onto courses or carry out their mandatory training via e-learning. The target for mandatory training will also increase to 92% from next month.

March's appraisal performance saw a decrease of 3.78% to 71.46%, the lowest it has been since May 2017, so the Trust remains red. This will be addressed in Divisional Boards and divisional performance reviews in April. The implementation of the proposed revisions to the national Agenda for Change pay arrangements (on the assumption that the proposed arrangements are agreed) should produce an increase in appraisal performance and enable more of a performance management framework and culture; consequently the PDR Key Performance Indicator will increase from 85% to 92.5% from April 2018.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) as expected decreased by 0.20% to 13.49%. There will be no changes to the KPI for unadjusted turnover, although from next month the adjusted turnover figure (substantive staff leavers including retirements) will be 11.5%, this is a revised rating as previous adjusted turnover figures omitted retirements.

ACTIONS FOR IMPROVEMENTS / LEARNING

The number of Agency breaches decreased by 2 in March, due to the number of Medical breaches decreasing from 362 in January to 277 in February and then to 262 in March. Oppositely, Nursing breaches increased from 32 in February to 41 in March, with Ward Nursing using the majority but Theatres also increased from 1 to 5 this month.

RISKS/ISSUES

Appraisal continues to be an area where focus is needed. There is work ongoing in HR&OD to review the process to ensure that high quality appraisals are easy for managers to undertake.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHGO (5/18) 011

QUALITY REPORT

April 2018

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 the 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 to satisfy contractual information requirements and the CQC for routine engagement visits.

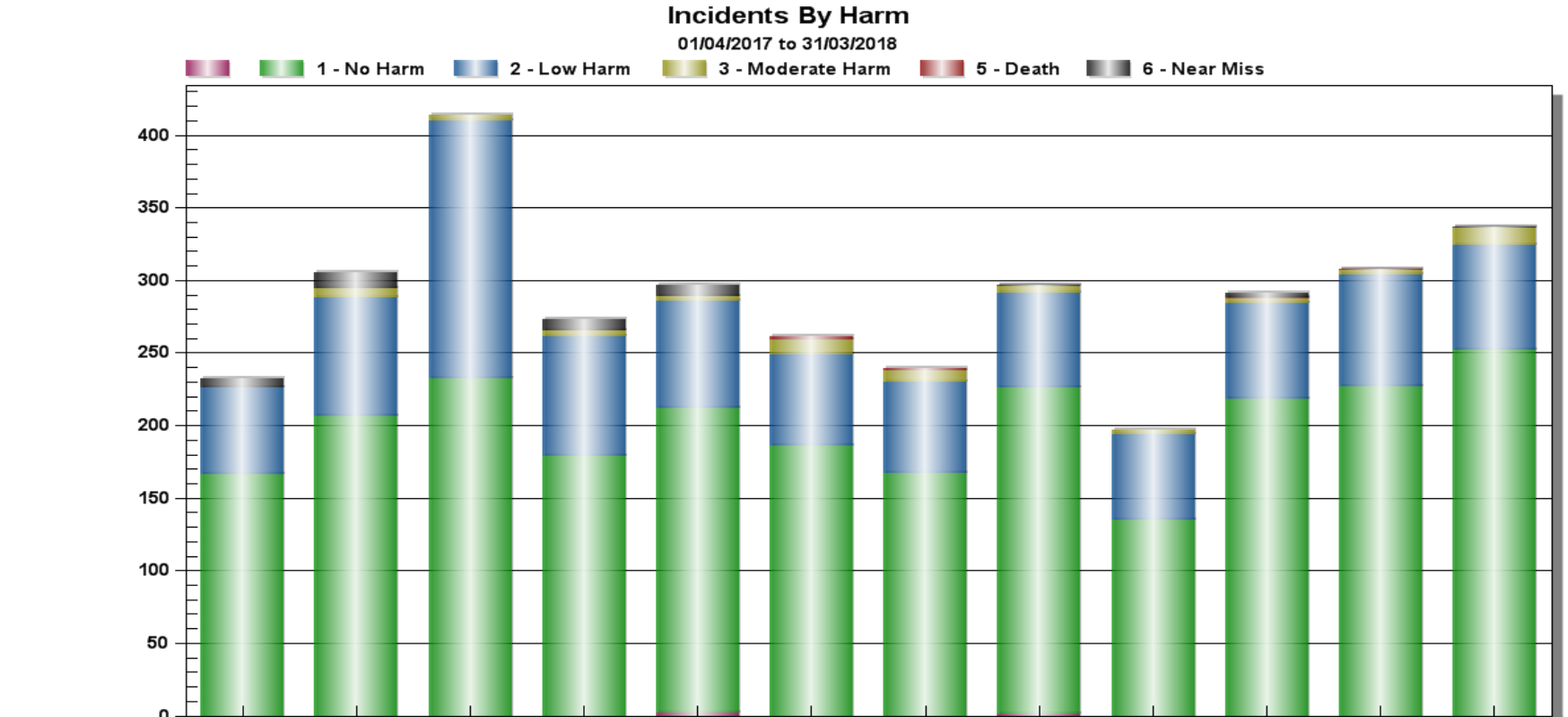
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
	0	0	0	0	2	0	0	1	0	0	0	0
1 - No Harm	166	206	232	179	210	186	167	225	135	218	227	252
2 - Low Harm	60	82	178	82	74	63	63	65	59	66	77	72
3 - Moderate Harm	0	6	4	4	3	10	8	5	3	3	3	12
5 - Death	0	0	0	0	0	2	1	0	0	1	1	0
6 - Near Miss	6	11	0	8	8	0	0	1	0	3	0	1

INFORMATION

In March 2018 there were a total of 337 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

252 – No Harm
72 – Low Harm
11 Moderate Harms (1 duplicate incident)
0 – Severe Harm
1 – Near Miss
0 – Death

The 11 Moderate Harms + Near Miss were;

Site	Incident Number	Cause Group
ROCS	23477	VTE
Patients Home	23408	VTE – Ward 12
Ward 3	23450	VTE – Ward 3
Theatres	23465	Medical Device, Equipment – Near Miss
HDU	23624	Emergency Transfers

Outpatients	23631	Information Governance
Trust Wide	23647	VTE – Ward 3
Wards	23663	Infection Control
Wards	23677	Infection Control
Theatres	23678	Pressure Ulcers
Wards	23704	Infection Control
Wards	23712	Infection Control

ACTIONS FOR IMPROVEMENTS / LEARNING

The Governance team have a number of improvements highlighted planned;

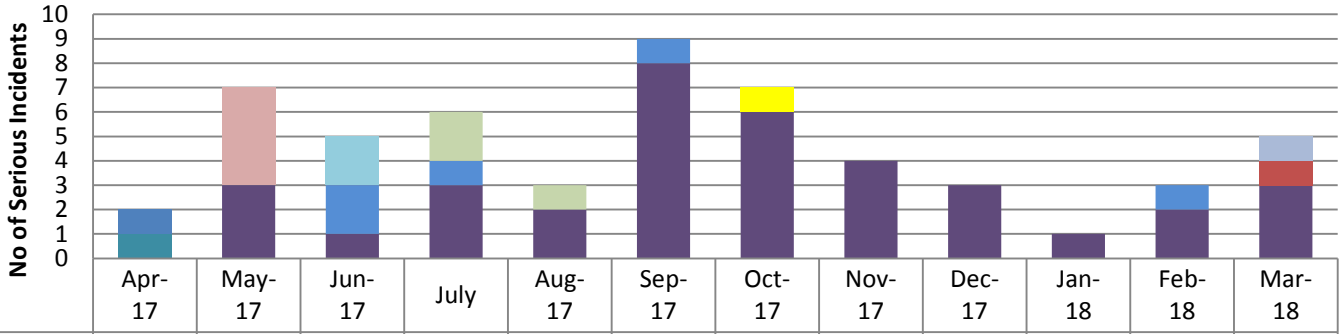
- The review process for allocation of RCAs to ensure this supports timely completion of RCAs to establish if any further changes are required in response to the findings of this report
- Review training needs of investigators and establish a rolling training programme Governance to review sign off process for completed RCA's to establish if any further changes are required in response to this report.
- Review Current RCA template and measure against the national standard
- The Creation of an RCA guide to support the RCA process
- New Duty of candour process map added to policy form recommendations of the audit committee
- New Serious Incident Policy to include 'Just culture.'

The NRLS have released the latest data for patient safety incidents. The data show the total number of incidents occurring during a six month period. These are broken down by the degree of harm, incident type and care setting of occurrence.
The ROH uploaded 614 Patient safety incidents to the NRLS in the dates of March 2017 – September 2017 at a rate of 45.38 per 1000 bed days. This is Compared to Robert Jones and Agnes Hunt at 32.23 per 1000 bed days and The Royal National Orthopaedic Trust at 31.76 per 1000 bed days.

RISKS / ISSUES
An ongoing Ulysses improvement action plan is in progress. This was an agenda item in January 2018 on Quality and Safety.

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 2018



	Apr-17	May-17	Jun-17	July	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Unexpected Injury				2	1							
RTT Harm review		4										
Information Governance Missing Laptop												1
Exposure to hazardous substance												
Retained object							1					
Wrong Implant												
Suspension to services												
RTT Data Issue	1											
Wrong side injection			2									
Suspension of Service (BCH Spinal)	1											
Slips, trips & falls												1
Pressure Ulcers			2	1		1					1	
VTE meeting SI criteria		3	1	3	2	8	6	4	3	1	2	3

INFORMATION

There were 5 **Serious Incidents Declared in March 2018;**

23408 – VTE
23450 – VTE
23647 - VTE
23631 – Information Governance Missing laptop

The following incident was reported in last month's quality report and declared as a Serious incident in March 2018

23197/23279 – Patient fall – Ward 12

ACTIONS FOR IMPROVEMENTS / LEARNING

1 avoidable VTE Serious incident was closed by the CCG in March 2018.

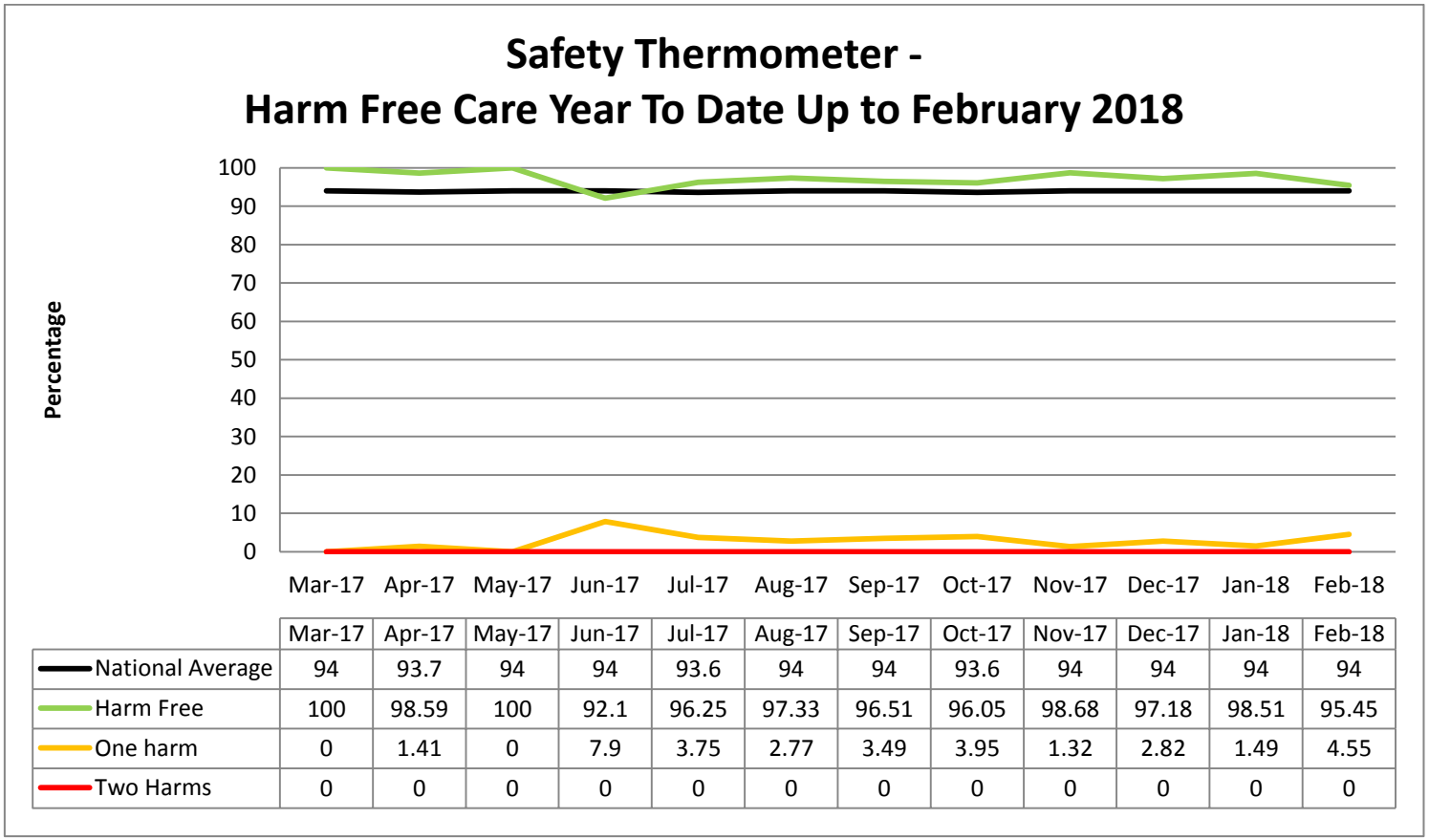
22324 – Avoidable VTE

Learning

To ensure ROH VTE prevention guidelines are followed; To ensure VTE risk assessment is updated on admission and 24 hours post surgery. To ensure mechanical and pharmacological prophylaxis is prescribed on the risk assessment and on the prescription chart. To ensure any deviations from Trust guidelines are clearly documented and signed by the prescriber. To ensure that start dates of prescriptions are accurate and if not dated by original prescriber are signed by the second prescriber. To ensure prescription of enoxaparin is clear at what time the first postoperative dose should be given and if not to be given to be documented in the medical notes by the surgeon or the anaesthetist.

RISKS / ISSUES
None.

4. **NHS Safety Thermometer - provides a 'temperature check' on the 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.**



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
National Average	94	93.7	94	94	93.6	94	94	93.6	94	94	94	94
Harm Free	100	98.59	100	92.1	96.25	97.33	96.51	96.05	98.68	97.18	98.51	95.45
One harm	0	1.41	0	7.9	3.75	2.77	3.49	3.95	1.32	2.82	1.49	4.55
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

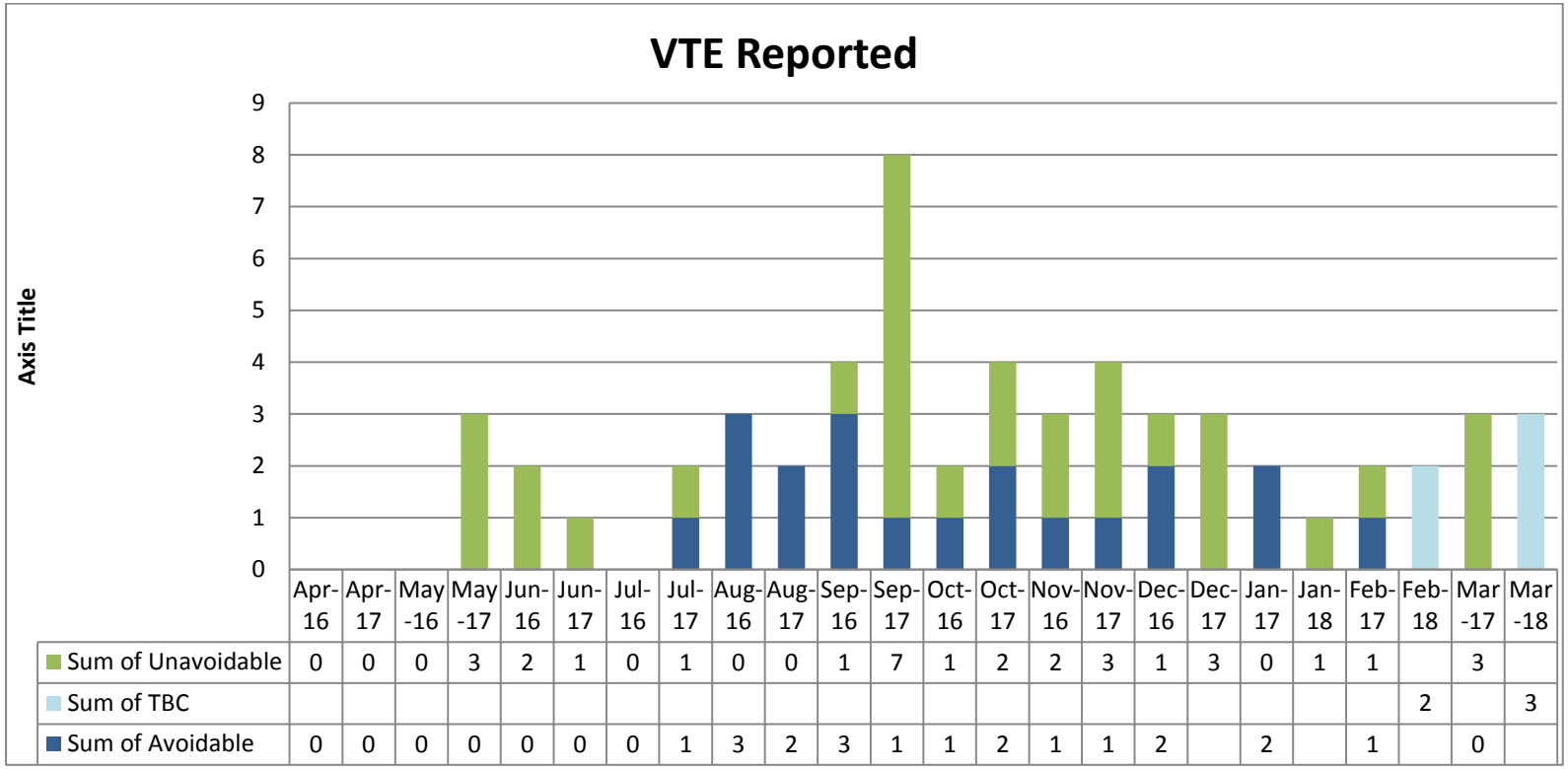
Due to a national issue, March 2018 data is not yet available.

5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in March 2018 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
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
Oct-17	67	9	0	1	77	232	9571
Nov-17	64	7	0	0	71	295	9752
Dec-17	60	3	0	0	63	194	7285
Jan-18	64	3	1	0	68	290	9705
Feb-18	77	3	0	1	81	307	8479
Mar-18	72	12	0	0	84	337	9064

In March 2018, there were a total of 9064 patient contacts. There were 337 incidents reported which is 3.7 percent of the total patient contacts resulting in an incident. Of those 337 reported incidents, 84 incidents resulted in harm which is 0.92 percent of the total patient contact.

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 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	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0	1	7	1	2	2	3	1	3	0	1	1		3	
Sum of TBC																						2		3
Sum of Avoidable	0	0	0	0	0	0	0	1	3	2	3	1	1	2	1	1	2		2		1		0	

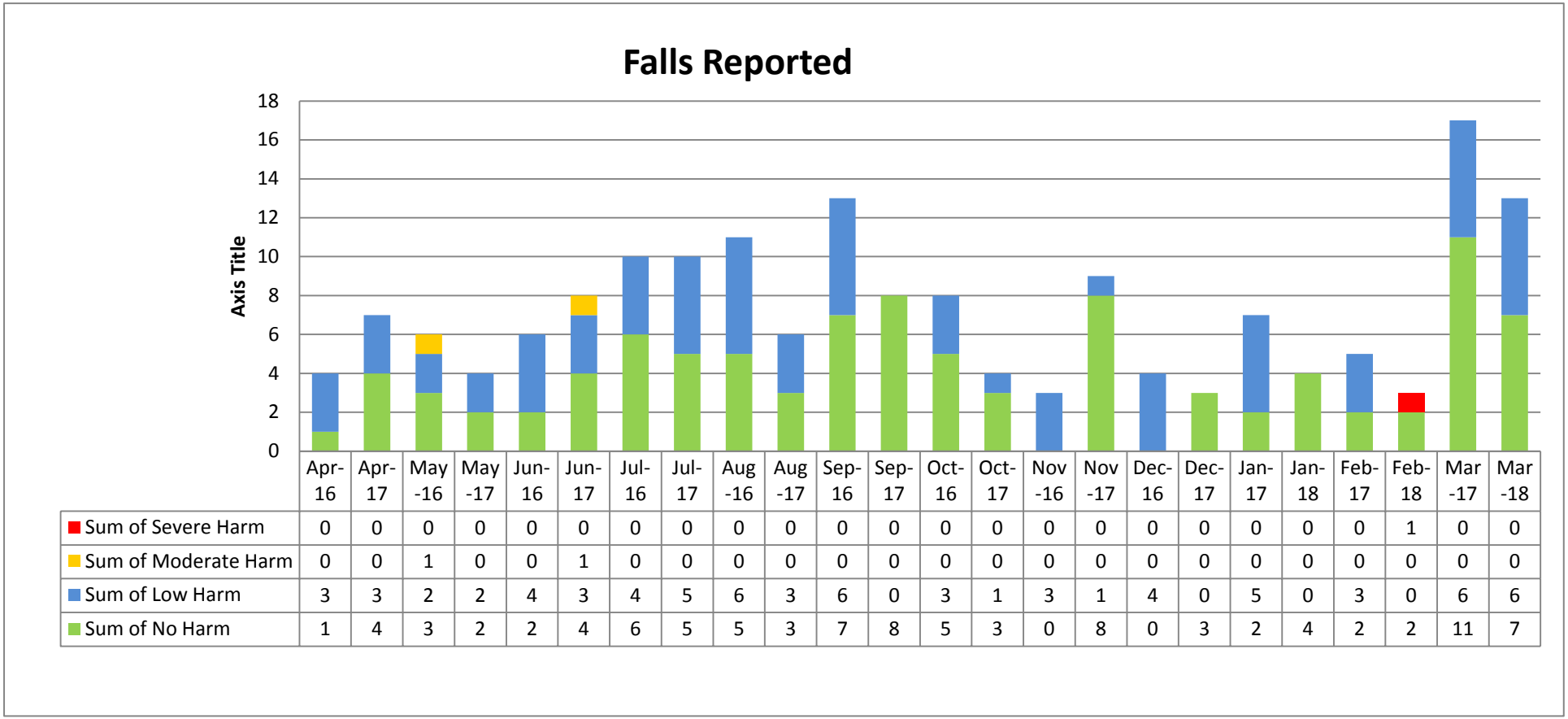
13

total		Avoidable
16/17	27	13
17/18	33	7*

***not classified**

INFORMATION
There were 3 VTEs declared in March 2018 - Detailed on page 5. 1 Incident reported in awaiting confirmation.
ACTIONS FOR IMPROVEMENTS / LEARNING
VTE incidents no longer have to be reported to CCG as Serious Incidents (unless they meet the specific criteria for such), however, internal RCAs will continue to enable identification of any learning and monitoring of avoidable VTE's. ROH will be assessed for compliance with the VTE exemplar site criteria on 23rd May 2018. Award of VTE Exemplar Site status would demonstrate that it is recognised the Trust have policies, processes and training in place to reduce the risk of VTE for or patients. Updated NICE guidance on Venous Thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism was produced in March 2018. There have been a number of changes within it which are currently under review by the VTE Leads and will be discussed at the next VTE Advisory Group meeting on 2nd May 2018.
RISKS / ISSUES
None

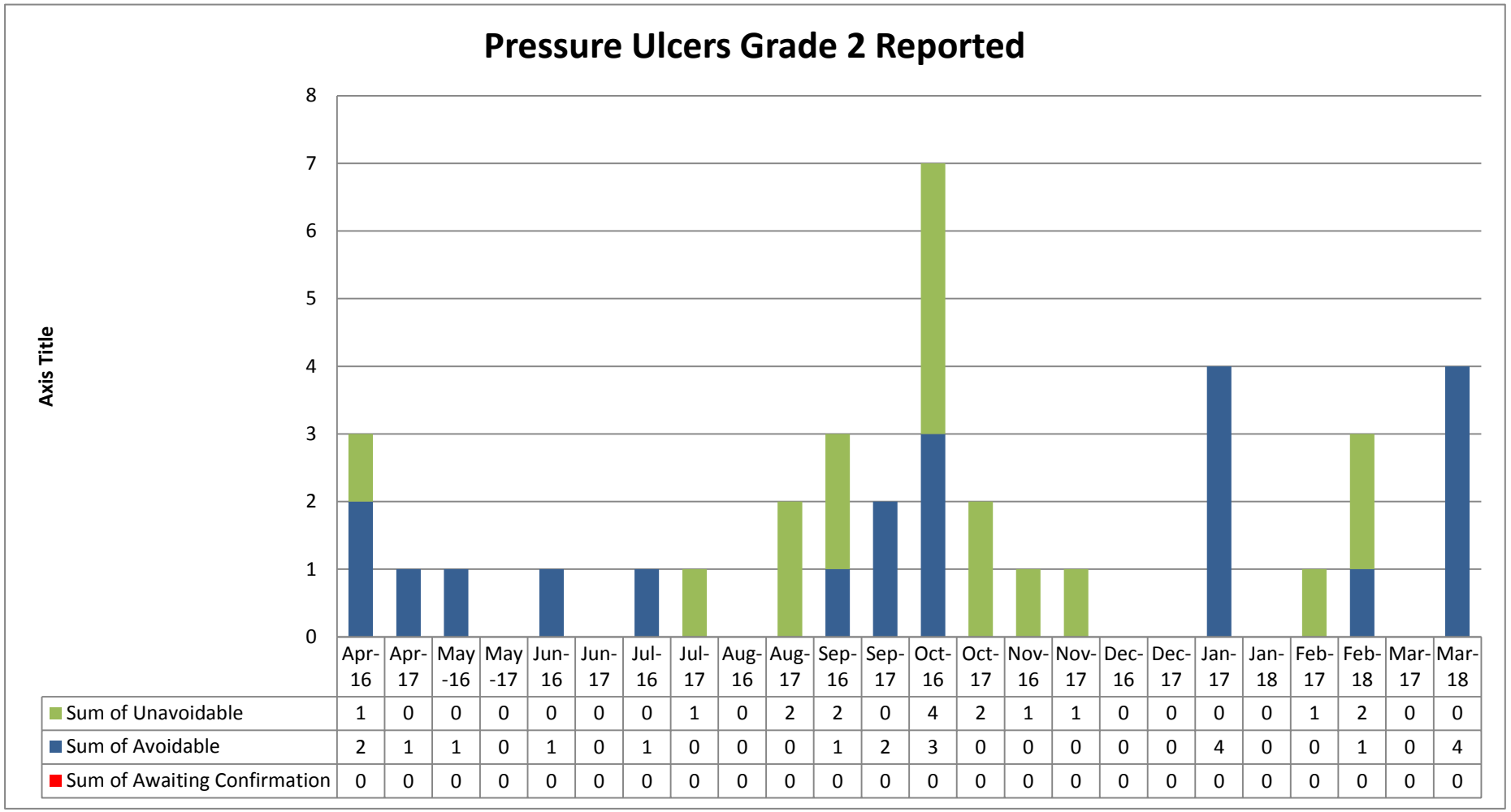
7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.



	Apr-16	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Sum of Moderate Harm	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3	6	0	3	1	3	1	4	0	5	0	3	0	6	6
Sum of No Harm	1	4	3	2	2	4	6	5	5	3	7	8	5	3	0	8	0	3	2	4	2	2	11	7

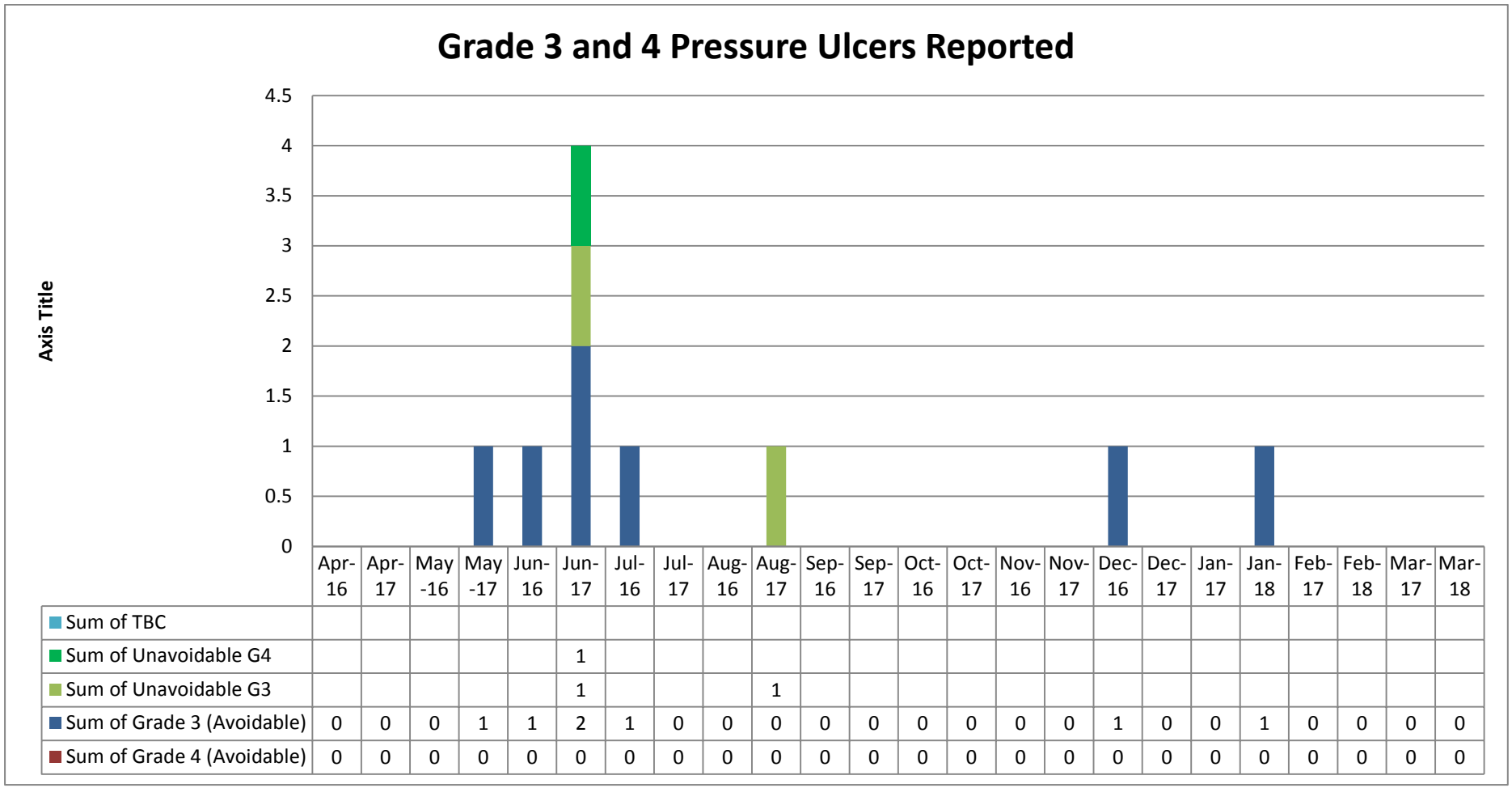
INFORMATION
Overall there were 13 fall-related incidents reported across the Trust in March 2018, all were related to adult inpatient falls. All falls were graded either no or low harm and are reviewed in the Trust Falls group with an upward report to Clinical Quality group. All incidents have been subject to a post-fall notes review by the ward manager or deputy, and a falls questionnaire was 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. An in-depth report on falls was presented to the Clinical Quality Group in January 2018.
ACTIONS FOR IMPROVEMENTS / LEARNING
• Falls policy is currently under review by the Falls lead; • The falls lead has set up a weekly task and finish group to benchmark our falls policy against the WMQRS falls and fragility fractures pathway. • Risk Register has been set up • There were issues with the practical aspect of manual handling training not being compulsory for all staff; this has been addressed with the training provider. Assurance has been given that this will be compulsory from now onwards and the falls group will be monitoring this.
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**



	Apr-16	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of Unavoidable	1	0	0	0	0	0	0	1	0	2	2	0	4	2	1	1	0	0	0	0	1	2	0	0
Sum of Avoidable	2	1	1	0	1	0	1	0	0	0	1	2	3	0	0	0	0	0	4	0	0	1	0	4
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

they were avoidable or unavoidable.



	Apr-16	Apr-17	May-16	May-17	Jun-16	Jun-17	Jul-16	Jul-17	Aug-16	Aug-17	Sep-16	Sep-17	Oct-16	Oct-17	Nov-16	Nov-17	Dec-16	Dec-17	Jan-17	Jan-18	Feb-17	Feb-18	Mar-17	Mar-18
Sum of TBC																								
Sum of Unavoidable G4						1																		
Sum of Unavoidable G3						1				1														
Sum of Grade 3 (Avoidable)	0	0	0	1	1	2	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0
Sum of Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

INFORMATION
In March 2018, the following pressure ulcers were reported; Grade 4 =0 Grade 3= 0 Grade 2 Non device related= 1 • 23412 and 23455–Gaps in turning HDU – 13 hours post op with epidural between turns, no documentation of heel offloading. outcome avoidable Grade 2 Device-related = 3 • 23411 – HDU- due to the wedge pillow – to be confirmed; • 23521 – HDU - Likely due to flowtron boots - to be confirmed; • 23525 – Ward 3- Small intact blister to the back of knee – to be confirmed.
ACTIONS FOR IMPROVEMENTS / LEARNING
Action – TV Link Nurse – provided a teaching and training session to a large number of HDU staff on 5/4/18 and highlighted the importance of skin inspection, moving patients regularly in a timely manner – especially those who have had an epidural with subsequent loss of sensation and movement and taking off as able and observing skin under medical devices. A documentation task and finish group have developed more specific user-friendly documentation, which will act as prompts to care and highlight any gaps in order that action can be taken. **2016/2017:** 13 - avoidable Grade 2 pressure Ulcers against a limit of 15

3 - avoidable Grade 3 pressure Ulcers against a limit of 0
0 - avoidable Grade 4 pressure Ulcers against a limit of 0

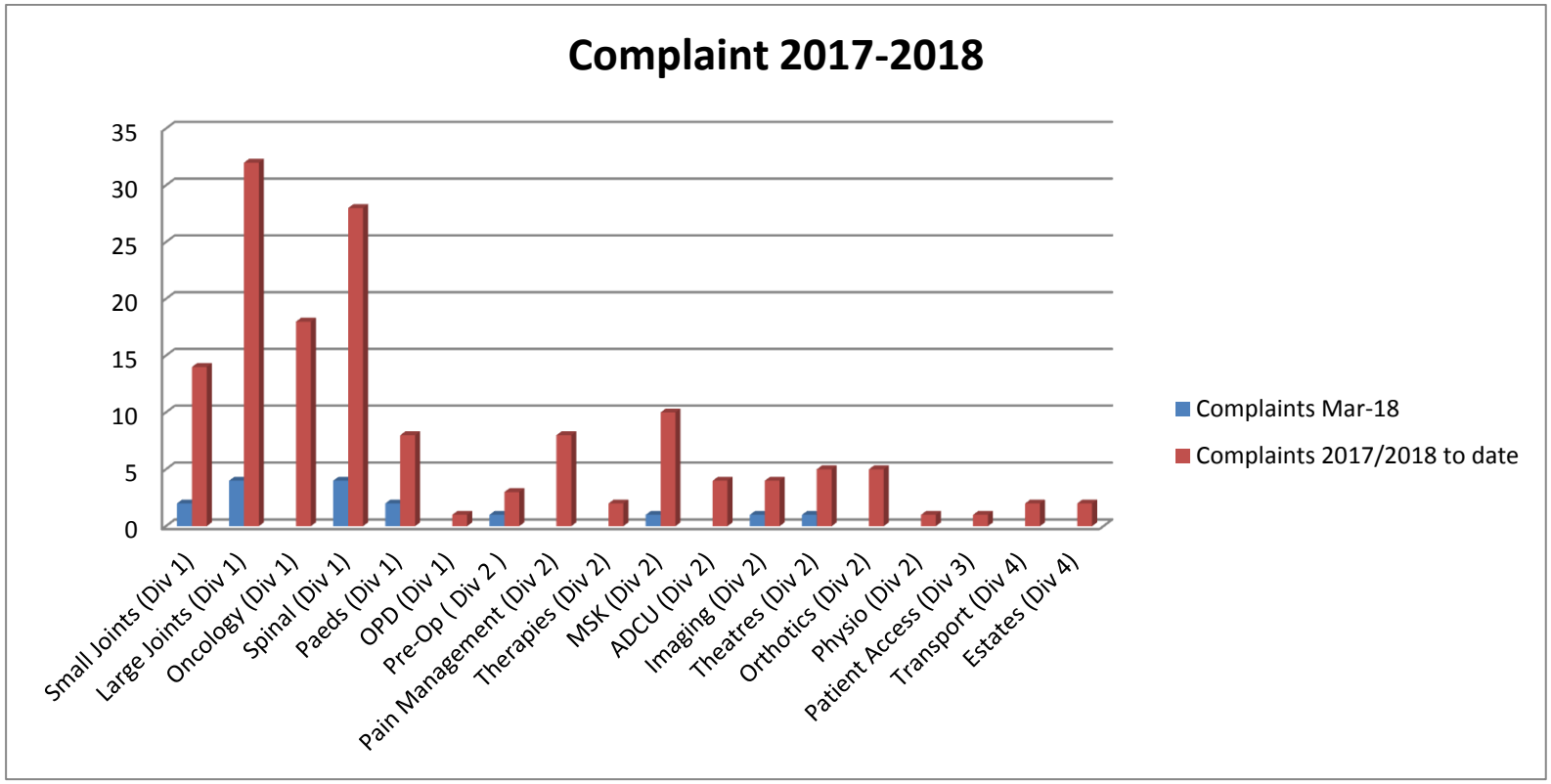
2017/2018:

6 - avoidable Grade 2 pressure Ulcers against a limit of 12
3 - avoidable Grade 3 pressure Ulcers against a limit of 0
0 - avoidable Grade 4 pressure Ulcers against a limit of 0

RISKS / ISSUES

- Tissue Viability Database has not been maintained currently– all tissue viability information being recorded in patients notes and on a separate "spreadsheet" to aid reporting
- Training for Tissue Viability for the Trust is being reviewed to ensure best practice, and this is a priority for Lead appointed, and the new lead and TVN will undertake.
- Trust Tissue Viability Policy requires updating; this will be impacted by new classification status when agreed. Also awaiting consensus form the consensus groups tasked by NHSI – TV Lead Nurse is part of the collaborative task group looking at PU reporting.

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 343 contacts during March 2018 of which 70 were classified as concerns. This brings the total of PALS contact for the year to 5094 (1135 concerns). This represents a much higher figure than at the same point last year (4136 PALS contacts). The total number of enquiry contacts has reduced for the second month in a row as the letters sent to patients have been altered to remove the PALS number and replaced with the department concerned. However, there were still 273 enquires made to the department this month, so the removal of the number has clearly not affected patients being able to access the service.

Compliments

There were 510 compliments recorded in March 2018, with the most being recorded for Div. 1. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues 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 16 formal complaints made in March 2018, bringing the total to 155 for the year. All were initially risk rated rest amber or yellow. This is higher than the same time last year (12 complaints in March 2017). Although 155 complaints were made in 2017/2018, 7 were either withdrawn or closed due to no consent being received. Therefore the official number of complaints for the Trust in this year is 148, and this is a significant reduction from the previous year's total of 167

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- care and treatment under Consultant (Div.1, Large Joints)
- care and treatment on Ward 2; including pain management (Div.1, Paeds)

- care and treatment on Ward 2; including pain management (Div.1, Large Joints)
- delay being seen by foot & ankle and orthotics (Div. 1, Small Joints)

Initially Risk Rated Yellow:

- provision of information to father (separated from mother) (Div. 1, Spinal)
- care and treatment under Consultant (Div.1, Paediatrics)
- the approach of secretary; delay in reviewing referral (Div.1, large Joints)
- the approach of Registrar (Div. 2, MSK)
- the approach of x-ray staff (Div.2, Imaging)
- discharged with no support at home (Div. 1, Small Joints)
- the approach of Clinician in OPD appt (Div.1, Spinal)
- miscommunication over operation date; pre-op repeatedly confirming the wrong date (Div.2, POAC)
- the patient believes that she had no anaesthetic during her procedure; the outcome of surgery (Div.2, Theatres)
- delay to surgery date (Div.1, Large Joints)
- Nursing Care on Ward 1 (Div. 1, Spinal)
- delay in receiving injection date (Div.1, Spinal)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 12 complaints closed in March 2018, 11 of which were closed within the agreed timescales. This gives a 92% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in March 2018 was 26 days which is within normal limits.

Learning identified and actions taken as a result of complaints closed in March 2018 include:

- procedure for referrals to pain management service has not always been followed
  Action: procedure has been reiterated, and staff have refreshed their understanding of this

- incorrect information included in clinic letter

Action: Letter changed. Clinician undertook reflection and discussed with Clinical Supervisor

- Patients may be receiving conflicting information about decommissioned treatment in one CCG (not our lead CCG)
  Action: Information provided to the patient and their GP

RISKS / ISSUES

None Identified.

10. Friends and Family Test Results and iwantgreatcare

INFORMATION

The Friends and Family Test in its current format was implemented on 1st April 2014. The Department of Health changed the methodology of the Net Promoter Score to a more straightforward % of patients likely to recommend a service and % not likely to recommend a service. This was because evaluation showed that patients and most NHS employees did not understand the Net Promoter Score and the information provided was frequently misinterpreted.

The Friends and Family Test (FFT) is the mandated patient 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

Following a review was undertaken by NHS England, the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics. Since 8 October 2015, all FFT data has been published in a single release The data for Inpatient Services, Outpatient Services and Community Services is required to be submitted to the NHS Digital Data Collection System monthly and the results for every facility are published on the NHS England website.

NHS England has set a mandatory response rate of 35% for all inpatient services. There are no minimum response requirements for outpatient and community services. The Trust sets internal targets for all areas as it is agreed that the data will then be more meaningful.

The guidance for outpatient services is less stringent than for inpatient services. Trusts have the discretion to vary how the test is applied in outpatient settings. For example, at ROH, every patient having an appointment in the outpatient clinic is offered the opportunity to complete a form. However, physiotherapy patients are offered the form at the end of their set of sessions (usually 4 or 5 sessions). As long as there are forms on display in a department that allow an individual to provide feedback after each session should they wish to, this is compliant.

The Trust breaks down its outpatient data into specialities which is more useful to departmental managers. However, the return for Outpatient Services is submitted as a single service.

There are no official requirements to undertake the FFT survey in imaging or theatre departments. However, the Trust takes the view that if feedback is provided in the same format across all departments, then the data is comparable and of use. In addition, there is an expectation that patient feedback

is gathered in all areas, even if not mandated.

RISKS / ISSUES

The Trust is not currently meeting the mandated 35% response rate for inpatient services. There has been a considerable improvement at approximately 30%, but this is being actively monitored and managed to ensure that we first exceed the mandated response rate and then achieve the internal target of 40% for Inpatient Services.

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would recommend the department in March 2018**	**% of people who would NOT recommend the department in March 2018**	**Number of Reviews submitted in March 2018**	**Number of Individuals who used the Department in March 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	100.0%	0.0%	44	135	32.6%
Ward 2	98.1%	0.0%	53	120	44.2%
Ward 3	100.0%	0.0%	21	89	23.6%
Ward 12	97.7%	0.0%	43	92	46.7%
Ward 11 (CYP)	100.0%	0.0%	3	88	3.4%
ADCU	97.9%	0.0%	146	644	22.7%
HDU	100.0%	0.0%	17	71	23.9%
CYP HDU	100.0%	0.0%	5	14	35.7%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2018**	**% of people who would NOT recommend the department in March 2018**	**Number of Reviews submitted in March 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.1%	0.3%	858	15%
COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2018**	**% of people who would NOT recommend the department in March 2018**	**Number of Reviews submitted in March 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	92.8%	1.4%	69	58%

In addition to the Friends and Family Test question, there are an additional 5 questions on the survey which relate to the following key elements of patient experience:

- Privacy & Dignity
- Cleanliness
- Kindness and Compassion
- Timely Information
- Being involved in the decision-making process

These give an overall star rating out of 5 stars on the system, with 5 out of 5 being the highest available score.

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 monitors and compares the 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.

The Royal Orthopaedic Hospital NHS Foundation Trust

Date
01 March - 31 March

Your average score for all questions this period

4.88

Reviews this period

1259

Your recommend scores

5 Star Score

4.86

% Likely to recommend

97.2%

% Unlikely to recommend

0.3%

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 14 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

New Claims

No new claims against the Trust were received in March 2018.

On-going claims

There are currently 28 on-going claims against the Trust.

27 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*

3 new requests for Pre-Application Disclosure of medical records were received in March 2018.

**Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes, the Data Protection Act 1998 and the Access to Health Records Act 1990).*

13. Coroner's

There were no coroner's inquests in March 2018

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 and 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 incompletion. The following areas examined;

- No form evident in notes
- Sign in Section incomplete
- Timeout section incomplete
- Sign out section incomplete
-

Total cases = 837

Total incomplete patients = 5

non compliance = 1 - 23rd March – anaesthetic care plan completed but no other perioperative data.

The total WHO compliance for March 2018 was **99.88%**

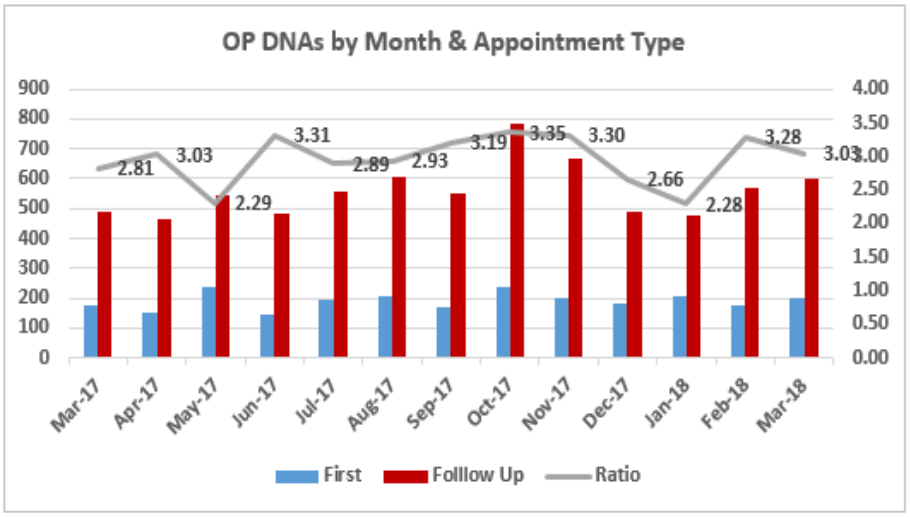
ACTIONS FOR IMPROVEMENTS / LEARNING

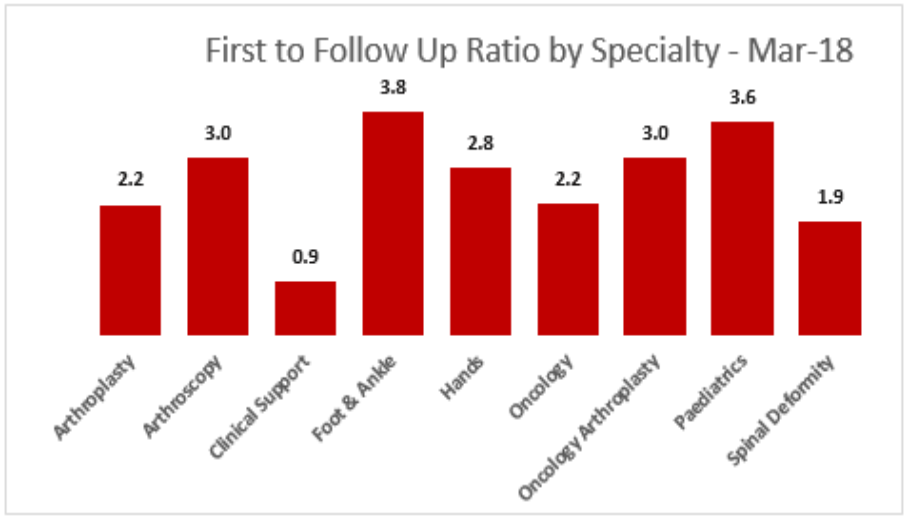
Any non- compliance will be reported back to the relevant clinical area.

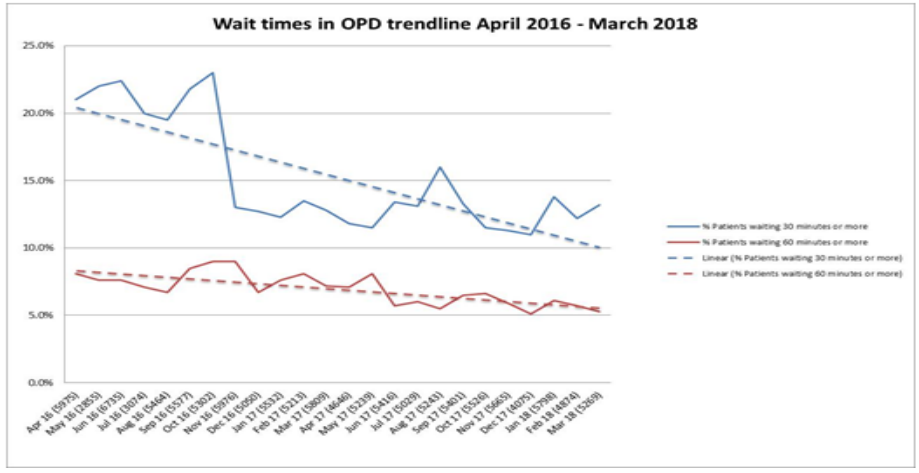
RISKS / ISSUES

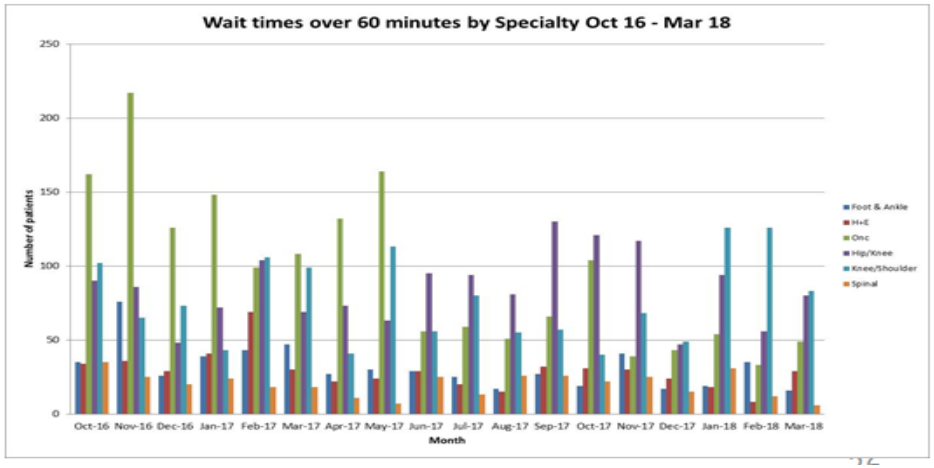
None

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



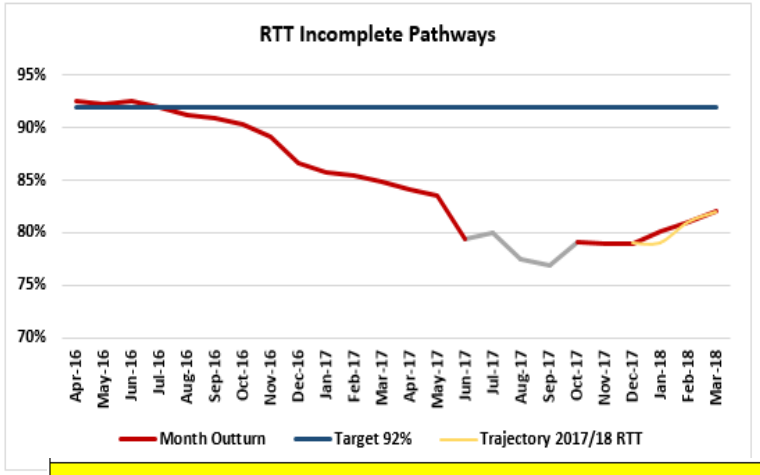


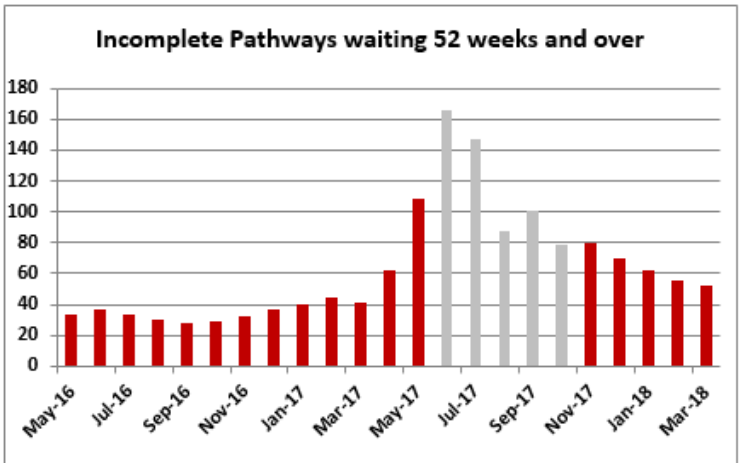




INFORMATION
The involvement of the operational management team in the investigation of incident forms relating to clinic delays continues and has triggered at least one new review of a consultant's outpatient clinic template. Issues of clinic capacity continue to contribute to delays in the clinic, and the ops team are reviewing reporting and processes in order to regularly review this information. In addition, there are plans to carry out capacity modelling for outpatient clinics across all specialties as well as reports to monitor and improve clinic utilisation. In March there were 32 incident forms completed to highlight clinics running more than 60 minutes late; a significant increase on previous months. 13.2% of patients waiting over 30 minutes and 5.3% waiting over 1 hour and this (over 1 hour) is an improvement on the previous month's position. The largest number of incidents was reported in Hip / Knee and Shoulder specialties. The monthly audit identified the following : - 12- Clinic overbooked 9- Complex patients 8- Consultant/Clinician Delay 2- Xray delay 1- Other
ACTIONS FOR IMPROVEMENTS / LEARNING
March; Continue to drive incident investigations and action through the relevant operational manager A review of the clinics that have been overbooked Development and Launch of new electronic clinic rescheduling system through Top Desk Review of SOP in relation to clinic rescheduling Development of clinic utilisation tools through InTouch and Health Informatics Review of individual clinics which are overbooked
RISKS / ISSUES
Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place

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

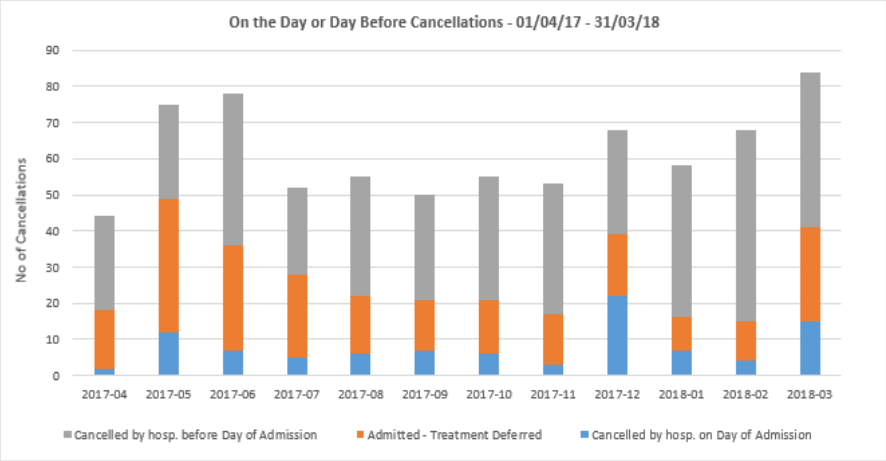




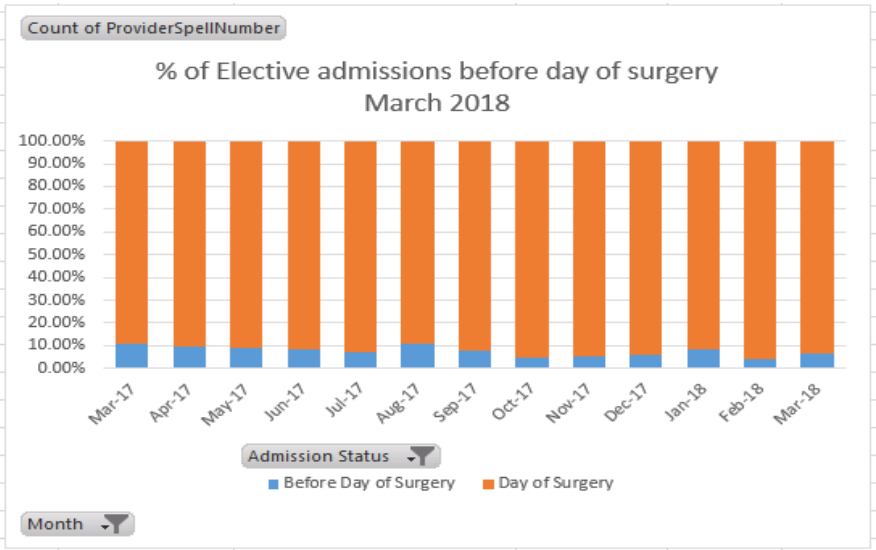
Target Name	National Standard	Feb	Jan	Dec	Nov	Oct	Q3	Breaches	Total	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	100.00%	97.10%	100.00%	100%	95.10%	98.40%	2	119	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	88.90%	91.67%	100.00%	91.70%	100%	96.30%	1	27	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100.00%	94.10%	100.00%	100.00%	100%	100.00%	0	30	97.40%	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	n/a		n/a
62 day (traditional)	85%	87.50%	86.67%	83.30%	83.30%	100%	87.50%	1.5	8	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	77.80%	100.00%	50.00%	90.90%	81.20%	82.80%	2.5	14	88.9%	1	9	100%	0	4
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
No. day patients treated 104+ days		0	1	0	0	0									
Accountable Treated 62 Standard		4	7.5	3	5										
Actual Treated 62 Standard		6	10	6	3										
Accountable Breaches 62 Standard		0.5	1.0	0.5	1										

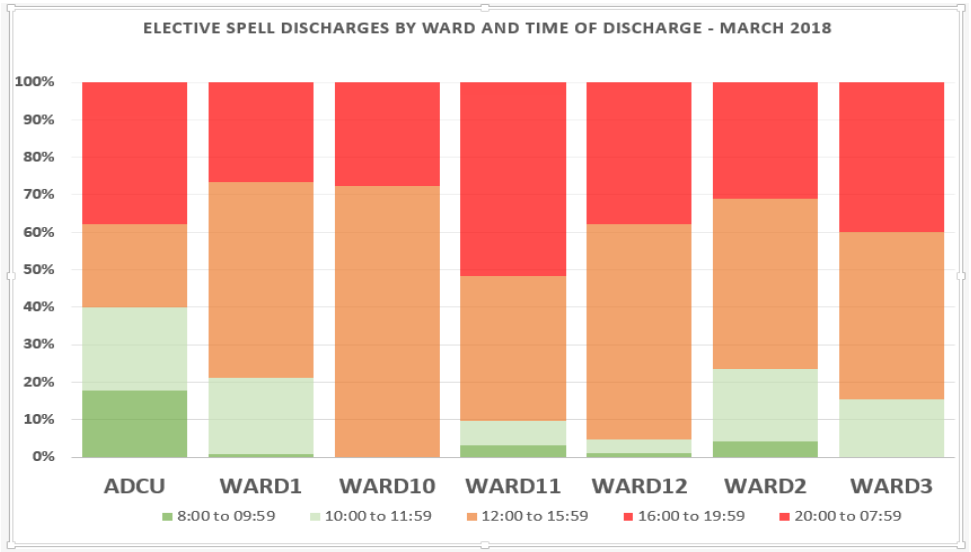
INFORMATION
The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%; the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the delivery of this target which is monitored weekly. For March 2018 the RTT trajectory was 82% with a performance at 82.07% , with 52 patients over 52weeks. As confirmed in the trajectory all specialties other than spinal deformity would treat all patients at or over 52 weeks – this was achieved in March 2018. The team have reviewed all spinal deformity patients and produced a trajectory submitted to NHSI & NHSE. This has been reviewed by the NHSI Intensive Support Team (IST).
ACTIONS FOR IMPROVEMENTS / LEARNING
The team continue to concentrate on any patients over 40 weeks, this number continues to reduce. At the end of December 2018, we had 238 patients over 40 weeks, at the end of February 2018 this figure is now 123. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.
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 the availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan). An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay in the completion of the building, it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity which had been planned up till April 2018 is now being planned through the Summer to assist with the existing waiting list . 5 patients have been transferred to Stoke for treatment following discussion with patients and their families.

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



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	29	42	78	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	42	58	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
Grand Total	96	227	417	740	10





INFORMATION

The number of cancellations on the day of surgery by the hospital has increased in a month. An analysis of this shows that the reasons for cancellation varied across a broad range of issues, key themes identified were: ran out of theatre time , Consultant sickness, theatre staffing and emergency patients taking priority. In addition, reasons for patient-led cancellations included clinical changes in patient condition and patient choice. Cancellations before the day of surgery have reduced in a month. The two main factors for cancellations prior to surgery were patients being offered earlier dates for surgery and patient choice to move / defer surgery.

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Trends are analysed and I interventions delivered to reduce cancellations. Further work has been delivered to develop the new POAC model, following focus groups working with staff to develop new ways of working developing an efficient patient focussed service which supports the needs of the expanding operative activity in a timely efficient manner. The pathway model and clinical protocols are currently being finalised and will be presented with the associated workforce plan by 2nd May 2018.

ACTIONS FOR IMPROVEMENTS / LEARNING

A daily update review by the Operational management team of forward bookings has been established, as well as the and the 6-4-2 weekly meeting. The operations 'Huddle 'is now embedded in practice, with learning shared at weekly Operational meetings across divisions .

Additional focus is being delivered:

- To reinforce accuracy and importance of ADT information (Admission, Discharge and Transfer)
- Increased Consultant led clinical review with full support from support services
- Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation discussed at the POAC workshop .

RISKS / ISSUES
Continued high levels of cancellations in Month. Shorter turnaround times for preoperative assessment are required to respond flexibly to increased levels of activity.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 6 June 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 6 June 2018 commencing at **1145h** 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 Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 6 June 2018: 1145h – 1315h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Prof Philip Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1145h	1	Patient story: Division 2	Presentation	
1205h	2	Apologies	Verbal	Chair
1207h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1210h	4	Minutes of Public Board Meeting held on the 2 May 2018: *for approval*	ROHTB (5/18) 010	Chair
1215h	5	Trust Board action points: *for assurance*	ROHTB (5/18) 010 (a)	SGL
1220h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (6/18) 001 ROHTB (6/18) 001 (a) ROHTB (6/18) 001 (b)	YB/PA
		STRATEGY		
1230h	7	Paediatric services update	Verbal	AP/PA
1235h	8	Orthopaedic services in the STP	Verbal	PA

QUALITY & PATIENT SAFETY				
1240h	9	Patient Safety & Quality report: *for assurance*	ROHTB (5/18) 002	GM
FINANCE AND PERFORMANCE				
1250h	10	Finance & Performance overview: *for assurance*	ROHTB (5/18) 003	SW
COMPLIANCE AND CORPORATE GOVERNANCE				
1300h	11	Annual declarations: Corporate Governance Licence Condition and Governor training: *for assurance*	ROHTB (6/18) 004 ROHTB (6/18) 004 (a) ROHTB (6/18) 004 (b) ROHTB (6/18) 004 (c)	SGL
1305h	12	Proposal to establish a new Board committee: *for approval*	ROHTB (6/18) 005 ROHTB (6/18) 005 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1310h	13	Quality & Safety Committee: *for assurance*	ROHTB (6/18) 006	KS
	14	Finance & Performance Committee: *for assurance*	ROHTB (6/18) 007	TP
	15	Staff Experience & OD Committee: *for assurance*	ROHTB (6/18) 008	SJ
	16	Audit Committee: *for assurance*	ROHTB (6/18) 009	RA
MATTERS FOR INFORMATION				
1315h	17	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 4th July 2018 at 1100h in the Boardroom, Trust Headquarters

Notes

Quorum

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

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

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

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 2 May 2018: 0900h – 1030h

Members attending:

Dame Yve Buckland	Chairman	(YB)	
Mr Tim Pile	Vice Chair and 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 Paul Athey	Acting Chief Executive	(PA)	
Mr Andrew Pearson	Executive Medical Director	(AP)	
Mr Garry Marsh	Executive Director of Patient Services	(GM)	
Mr Steve Washbourne	Interim Director of Finance	(SW)	
Mrs Jo Williams	Interim Chief Operating Officer	(JW)	
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)	

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive Director	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests:

Mr Jonathan Bamford	Project Manager	(JB)	[Item 1]

Minutes	**Paper Reference**
1 Service Improvement story - ePMA	**Presentation**
Mr Jonathan Bamford joined the Trust Board to present an update on the plans to implement an electronic prescribing and medicines administration system (ePMA). It was highlighted that ePMA was one of the major elements of the 'Perfecting Pathways' programme. In terms of benefits of the system, it was reported that there would be a reduction in medication errors, including those that could cause harm; improved VTE compliance; strengthened antibiotic stewardship; improved clinical confidence;	

compliance with MSSA and MRSA treatment regimes; medicines audit link compliance; reduction in the checking of pathology lab results; reduction in printing costs; and an anticipation that this could have a positive impact on some parts of the staff survey results. There were also a range of strategic benefits associated with the system. It was suggested that some of the targets for the system were not as ambitious as they could be and it would be useful to see some form of financial quantification for the reduction in harm anticipated. It was noted that the initial contract was for seven years which would provide some stability for the new platform. Training in the new system would start from 4 June. 'Go live' in the Pre-Operative Assessment Centre was planned for 18 June, with the full 'go live' being on 24 July. 450 staff would be trained across a range of clinical disciplines. The support to staff after the training was discussed. 70-80 of the staff had used the system elsewhere and their experience would be useful as part of the roll out. Link users would be in place who essentially would be acting as superusers to support colleagues. 'Wash up' training sessions would be offered after the 24 July. Surgeons would not use the system for operating lists in the first few phases. The plan for agency and ad hoc staffing using the system was discussed. It was noted that an active directory account and an ePMA account needed to be set up for each user, so ad hoc individuals, such as junior doctors, could not prescribe which could create a delay. It was noted that this was an issue that needed to be resolved through the Clinical Quality Group. This system could not link with GP systems at present. Conversations and plans were underway which included the local Clinical Commissioning Group to arrange a clinical portal where GPs could access the trust's system. This was a positive development going forward. This work had been supported by the network infrastructure improvement work that had been undertaken over recent months. The implementation plans were outlined and every care would be taken to ensure that the flow of work was not hindered through a very detailed operational plan. It was noted that the Patient Administration System (PAS) had always been the main data source, although it was acknowledged that this was not always kept up to date so work was being done to ensure that these are harmonised. The hard work from Mr Bamford was acknowledged and it was noted that there had been good communication across all areas and stakeholders.	
2 Apologies	**Verbal**
Apologies were received from Richard Phillips.	

3 Declarations of interest	**Verbal**
It was noted that the register of interests was available on request from Company Secretary. Rod Anthony had been appointed as an interim finance director in a subsidiary business of Gloucester Hospitals.	
4 Minutes of Public Board Meeting held on the 4 April 2018: *for approval*	**ROHTB (4/18) 010**
The minutes of the last meeting were approved, subject to some minor amendments.	
5 Trust Board action points: *for assurance*	**ROHTB (4/18) 010 (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: *for information and assurance*	**ROHTB (5/18) 001** **ROHTB (5/18) 001 (a)**
The Acting Chief Executive reported that he had spent a day in Imaging recently and there was a positive feeling in the team. The team had requested that the Trust moved to electronic ordering of scans as this would resolve some of their current challenges. They were also keen to have a second MRI scanner. It was reported that the monthly stakeholder meeting to review progress against the RTT trajectory and the plans for Paediatrics was to be stood down on the basis that there was greater confidence around the work to improve performance. This was positive and thanks were expressed to all involved. A template had been provided which would need to be completed by 22 May which would then be used by NHS Improvement to seek a view from their Board as to whether the enforcement undertakings on the Trust could be lifted. It was suggested that the element which related to long term sustainability and strategy would be likely to remain. There was positive feedback on the Improvement focus event that had occurred at the end of April. The challenge around how to broaden this out needed to be considered. There was a maximum of 50-60 per session and a total of over 100 staff were involved at some point. It was suggested that if quality and safety were improved then there were efficiencies in terms of productivity and reduction in waste as a by product. The reward system was being considered. There were plans to create an improvement area within the Trust. The Chairman reported that a STP chairs group has been formed. A meeting had been held with Birmingham Women's and Children's NHSFT (BWCH)	

to discuss the future plans for the two organisations to work together and manage the paediatric transition. The Chairman had met with Jenny Richardson from the ROHBTS charity. The charity would be folding as a result of the Paediatric transition, however Ms Richardson would join the Charitable Funds Committee.	
7 Paediatric services update	**Verbal**
It was reported that following negotiations with Heartlands, Good Hope and Solihull Hospitals (HGS), eleven paediatricians would join the Trust which would cover the weekend rotas until the end of December 2018. This was in line with the plan for paediatrics transition. One to one conversations would occur with the staff involved with the transition to clarify their future working arrangements. Kathryn Sallah would join a joint group with BWCH to oversee the transition. In the meantime, good and safe paediatric care continued to be provided at the ROH. An operational transition group was now in place and this would provide a valuable link with BWCH.	
8 Orthopaedic services in the STP	**Verbal**
The first meeting of the orthopaedic alliance executive oversight group had been held and clinicians from the two major providers were being identified as part of the work. There was good work to support musculo-skeletal services in the community and the expansion of this service had been discussed with the Executive Team recently. The therapies strategy would be presented to the Trust Board in September.	
ACTION: JW to arrange for the therapies strategy to be presented in September	
9 Patient Safety & Quality report: *for assurance*	**ROHTB (5/18) 002**
In terms of incidents, the Executive Director of Patient Services reported there was an increase in numbers, although with no obvious trends. A higher number of incidents causing moderate harm had been reported. A patient had been transferred as an emergency to Royal Shrewsbury Hospital who had subsequently died. A Root Cause Analysis for the event was currently being undertaken. There had been a near miss reported associated with an anaesthetic machine, however there was no harm to the patient. There were four incidents related to infection control and these had been discussed at the recent meeting of the Quality & Safety Committee. A round table involving representatives from a number of teams had been held to review the incidents and it had been determined that they related to the reinvigorated practice introduced by the new infection control team and there was no link between surgeons, theatre or organism.	

The Trust was reported to be compliant with its uploading of information onto National Reporting and Learning System (NRLS) and was reporting better than peer organisations. There had been five serious incidents reported, one being the patient who had fallen which had been discussed previously. The serious incidents included three VTEs and an Information Governance incident relating to a missing laptop. An investigation was occurring about this. There had been an increase in falls in March and this was being reviewed by Clinical Quality Group and the matron for inpatients was reviewing the position. In March, there had been three Grade 2 pressure ulcers. There was some work to triangulate with staffing levels and it had been identified that there was no correlation. The pressure ulcers reported in HDU were being reviewed particularly , given the high ratio of nurses to patients in this area. It was reported that the presentation of the Friends and Family Test information was being reviewed and the methodology in inpatient areas was discussed. Return rates were noted to be low on Ward 11; this reflected the variance in methodology and the appetite of staff to gather the information. There was good preparation for the upcoming coroner's inquest. It was noted that the report would be broadened out into non-nursing metrics.	
10 Finance & Performance overview: *for assurance*	**ROHTB (5/18) 003**
The Interim Director of Finance reported that the year end performance against the control total including the core Sustainability and Transformation Fund (STF) was £6.0m. By over achieving the control total, this had attracted an incentive STF. There had been a notification that the £436k core STF would be received, alongside £162k incentive and a bonus STF of £771k plus a further general distribution STF to the value of £475k. This provided £1.4m that would not have to be borrowed in 2018/19. This would be provided as a cash bottom line adjustment and could only support the revenue position and as it was understood, could not be used for capital. This would be discussed with NHS Improvement to understand if there was to be any flexibility. In terms of the Month 12 position, there had been a small deficit. There was a good income position but higher than planned expenditure. In terms of expenditure, this reflected the additional activity that was being handled and there was some non-recurrent pressures in non-pay which was believed to reflect the year end adjustment processes. Bank expenditure was high and there had been a peak in agency spend, including in the Pre-Operative Assessment Centre (POAC). The Head of Nursing for Division 1 was reviewing pay and staffing at present.	

In terms of RTT, the trajectory of 82% had been met. For any patients that were waiting over 52 weeks, there were none outside the spinal deformity cohort. The diagnostic target had been met and the 62 day cancer target this had also been achieved. The number of patient cancellations would be considered at the next Finance & Performance Committee meeting and the outpatient waiting time improvements would also be worked through. In terms of theatres there had been an improvement in month regarding utilisation. It was noted that there had been some bed pressures recently and all ward staff had pulled together to arrange discharges and implement flow initiatives. The Chair of the Finance & Performance Committee commented that it was encouraging to see income being in line with plan. There remained further improvements which could drive improved productivity and efficiency however. In terms of workforce, the number of staff being recruited had increased and there had been a reduction in agency breaches. Mandatory training rates had improved which was partly addressed by the theatre close down. Appraisal rates remained a concern and the divisional performance meetings were picking this up. The contract refresh was noted to create a link between pay progression and appraisal.	
11 Perfecting pathways update: *for assurance*	**Presentation**
The Interim Chief Operating Officer presented an overview of performance against the 'Perfecting Pathways' programme. The modular build was a significant addition to the programme. An option appraisal would be considered at the June meeting of the Trust Board. A multi-disciplinary team had reviewed the Royal Berkshire Hospital to see how these worked and were enthused. A further addition to the programme was the Stryker Performance Solutions plans. This was a two-year programme commencing on 24 May 2018. There would be some good learning opportunities and joint working. The clinical lead would be the Medical Director. The reduction in the length of stay was a key performance metric which would indicate the success or otherwise of the work and there would be agreement as to any others that were appropriate. It was noted that there was a key link to the theatres workstream. Income from private patient work had increased on the position last year. There was good work to redefine the pre-operative assessment processes, with	

more work being undertaken at the initial point of assessment. The orthopaedic alliance was part of the 'Perfecting Pathway' programme. There was work with HGS to discuss how the ROH could work with them to reduce their waiting list. There were some referrals that had already been received. Other spinal referrals had also been received. There was a plan to meet the spinal and neurosurgery teams to discuss future service provision between the organisations. A new element to the programme was around the therapies collaboration in primary care including a functional restoration programme. The lead therapist had developed a strategy for therapies which would be presented to the Trust Board in due course. It was suggested that a model of service provision needed to be developed to prevent drift. The musculo-skeletal service pilot would be used to define the look of this model. The plans for future-proofing were also being developed. The plans also outlined the opportunities for staff to develop and broaden their skills and experience. The status of the Trust as a specialist trust was useful in attracting some good candidates. Progress with the smaller schemes was reviewed.	
12 Board Assurance Framework	**ROHTB (5/18) 005** **ROHTB (5/18) 005 (a)**
This Associate Director of Governance & Company Secretary presented the Board Assurance Framework, which it was noted was the version that the Audit Committee had considered on 23 April There had been some positive movement in some controlled risk scores, which reflect the better operational position One risk was proposed for closure, this being the potential divergence of energy and attention away from strategy as a result of regulatory intervention. The Board was asked to agree this, which was supported.	
13 Quality & Safety Committee and revised terms of reference: *for assurance*	**ROHTB (5/18) 006** **ROHTB (5/18) 006 (a)**
The Chair of the Quality & Safety Committee advised that at the recent meeting, there had been a report received from the Research and Development Committee, which highlighted that there was a concern over the lack of space in clinical areas for patients to be interviewed as part of research trials. To resolve this would assist with developing the services. It was noted that this was part of the wider outpatient plans.	
14 Finance & Performance Committee: *for assurance*	**ROHTB (5/18) 007**

The update from the Finance & Performance Committee was received and noted.	
15 Staff Experience & OD Committee and summary of the NHS Contract refresh: *for assurance*	**ROHTB (5/18) 008**
The update from the Staff Experience & OD Committee was received and noted.	
16 Audit Committee: *for assurance*	**ROHTB (5/18) 009**
The update from the Audit Committee was received and noted. The plans for the development of the annual report were underway. Annual declarations of interest continued to be requested from those outstanding.	
17 Any Other Business	**Verbal**
It was reported that a Board tasting of the menu was scheduled for a future meeting. The Board was advised that a substantive Clinical Service Manager for theatres would be recruited. The Bone Infection service had been joined by a senior clinical director, Dr Neil Jenkins, who had experience in infectious diseases. The Interim Chief Operating Officer was thanked for progressing the matter.	
Details of next meeting	
The next meeting is planned for Friday 25 May 2018 at 1200h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 6 June 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 1.06.2018

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 050	Chairman's & Chief Executive's update	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	07/03/2018	Arrange for a meeting to be arranged with local MPs, the Chairman and Chief Executive	SGL	~~31/05/2018~~ 31/07/2018	To be arranged after the purdah period which end in early May 2018. To be arranged late July.	
ROHTBACT. 055	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Consider how the Board could be made aware of how clinical staff stretched themselves towards excellence	AP	~~06/06/2018~~ 31/07/2018	Part of the discussion around medical staffing models being considered by the Staff Experience & OD Committee	
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee	SGL	18-Jul-18	To be scheduled in for when the clinical audit internal audit has been completed	
ROHTBACT. 052	Board Assurance Framework	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	07/03/2018	Arrange a risk workshop	SGL	31-Jul-18	ACTION NOT YET DUE	
ROHTBACT. 053	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Present the plans for modular theatre in June 2018	JWI	06-Jun-18	Included on the agenda of the June private session	
ROHTBACT. 054	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Build exceptional staff experience into the strategic goals progress report	PB	04-Jul-18	ACTION NOT YET DUE	
ROHTBACT. 056	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Present the marketing plan to the Board	PB	04-Jul-18	ACTION NOT YET DUE	
ROHTBACT. 057	Quality Priorities 2018/19	ROHTB (4/18) 004 ROHTB (4/18) 004 (a)	04/04/2018	Include progress with the Quality indicators in the Trust's Quality Report	GM	04-Jul-18	Reported on quarterly, so Q1 update in July. ACTION NOT YET DUE	
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	05-Sep-18	ACTION NOT YET DUE	
ROHTBACT. 051	'Perfective Pathways' update	Verbal	07/03/2018	Present an overview of the visit to the South West London Elective Orthopaedics Centre at the May meeting	JWI	02-May-18	Included on the private agenda of the May 2018 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:	**6 June 2018**

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 6th June 2018

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 public Trust Board meeting on 2nd May 2018

2 UPDATE ON NHS IMPROVEMENT BREACH OF LICENSE

2.1 The Trust have submitted evidence to NHS Improvement to support the removal of the current undertakings relating to RTT performance and governance. NHS Improvement will be considering the evidence provided at a meeting on 22nd June.

2.2 Further progress with regards to financial performance and system working, linked to the development of more robust forward-looking financial plans, will be required before any consideration can be given to removing the undertakings relating to financial sustainability.

3 STP UPDATE

3.1 The STP Board met on 14th May, the main agenda item being consideration of proposed changes to the governance structures of the STP, specifically the boards and working groups reporting up into the main STP Board. A proposal was received to structure four portfolio boards aligning with the three priority areas for the STP, namely; Children & Adolescents, Adulthood & Work, Ageing and Later Life, plus a fourth focusing on enabling priorities. Alongside these boards, an operating model portfolio board would be set up to operationalise the outputs from the portfolio boards and a finance board would continue to oversee the system finances and capital and estate plans.

3.2 Members of the STP Board felt that the proposals could be streamlined to provide clearer lines of delivery, and also requested that further consideration be given to the interaction between the portfolio boards and the enabling priorities. Further

development of the proposals will now be taken forward before being reconsidered by the STP Board.

3.3 The Chair of the STP Board reported that, with Dame Julie Moore retiring, a formal process would be undertaken to appoint a new STP lead. Expressions of interest are currently being sought from local chairs to form the recruitment panel.

4 NHSE / NHSI RESTRUCTURING

4.1 On 24th May, the first joint NHSE/NHSI Board meeting was held at which a paper was presenting outlining how the two organisations will work more closely together to provide more joined-up, effective leadership to the NHS.

4.2 The key points from this paper were as follows:

- NHSE and NHSI will establish a new Executive Group, co-chaired by the CEOs of the two organisations and comprising the membership of all national and regional directors of each organisation.
- A new NHS Assembly will be established to create better engagement with the wider NHS and to co-design the forthcoming NHS 10 year plan.
- 7 joint regional teams will be established, led by a single Regional Director reporting into both NHSE and NHSI. The ROH will be part of the Midlands region, comprising the areas commonly referred to as the West Midlands and East Midlands.
- Regional Directors will have full responsibility for the performance of all NHS organisations within their region, making decisions on how best to assure and support performance. They will also drive strategic visions for the patterns of services and provider configurations.
- A number of national director roles will be established reporting to both CEOs:
    - A single NHS Medical Director
    - A single NHS Chief Nurse
    - A single NHS Chief Finance Officer
    - A single national director for transformation and corporate development

4.3 The paper also focuses on the aim to change the culture of these two organisation, with a greater emphasis on the devolution of powers to localities and regions and the intention to provide a more supportive and engaging form of oversight.

4.4 Further detail is provided in the attached appendix.

5 VTE EXEMPLAR SITE STATUS

5.1 On 23rd May, the Trust was inspected by the NHS England National VTE Prevention programme. The inspection team were very impressed by the processes in place at the ROH with regards to VTE care.

5.2 As a result, the ROH has been awarded VTE exemplar site status, becoming the first specialist orthopaedic hospital in the country to receive this accolade.

5.3 Congratulations are offered to the whole clinical team, involving a combination of nurses, physicians, anaesthetists and pharmacists for this success.

6 LONG SERVICE AWARDS

6.1 On 11th May, I had the pleasure of presenting long service awards to ten members of ROH staff who had completed 20 years of service within the NHS, and one member of staff who had worked for 40 years for the ROH.

6.2 Carol Reeves started at the Royal Orthopaedic Hospital 1977 as a Nursing Auxillary and spent much of her early career working in the Trust's dental department. In 2004 Carol became the Manual Handling Training officer, a role she continued throughout her career at the trust, attending to the training needs of all of the theatre staff. I was very proud to have had the opportunity to present an award to Carol for her incredible service to the hospital.

7 POLICY APPROVAL

7.1 Since the Board last formally met in public, the following new or substantially changed policies have been approved by the CEO on the advice of the Executive Team:

- PREVENT policy

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
Acting CEO
31 May 2018

Next steps on aligning the work of NHS England and NHS Improvement

NHS Improvement (NHSI) and NHS England (NHSE) have published a board paper which sets out the detail of how NHSI intends to shift its primary focus from regulating the trust sector to supporting improvement and how the two organisations will work together to provide more joined-up, effective, leadership to the NHS. This briefing provides a brief overview and our view on the proposals which are a combination of changes to how NHSI will operate and how NHSI and NHSE work together.

Background

Local health and care systems are responding to the challenges of a growing and ageing population by collaborating across organisational boundaries and developing more integrated models of care. NHSI and NHSE recognise that they need to adapt and transform the way they work to create an operating model that best supports local health systems and the people they serve and provide more joined up national system leadership. NHSI is also seeking to change its primary focus from regulation to supporting improvement.

NHSI and NHSE acknowledge that primary legislation sets out the need for separate board governance, chairs and CEOs for the two organisations and that the statutory frameworks assign NHSI (Monitor) and NHSE distinctive functions. In addition, under the statutory framework, clinical commissioning groups (CCGs) and NHS trusts and foundation trusts have different, distinct, functions which are reflected in the functions of NHSI and NHSE, including those Secretary of State functions delegated to the NHS Trust Development Authority (TDA). However, the board paper sets out ways that the two bodies can enhance joint working within the current legislative framework.

Proposals

Joint governance, systems and processes

NHSI and NHSE will establish a new NHS Executive Group, co-chaired by the two CEOs and comprising membership of all national directors and Regional Directors from the two organisations (see below for more details of these posts). A new NHS Assembly (provisional title) will be created to ensure better engagement with the wider NHS and its users, and its membership will include a wide range of statutory and non-statutory organisations. It will become the forum that oversees progress on the NHS Five Year Forward View and will help co-design the proposed upcoming NHS 10 Year Plan.

NHSI and NHSE will align their core processes so that all interactions with the frontline NHS are conducted once. This includes establishing a single financial and operating planning process for the NHS, a single

performance management process and the alignment of regulatory interventions, a single internal management process and a single process for establishing and reviewing national strategic programmes such as cancer, mental health and digital. The two bodies will establish a joined up and aligned approach to reporting and sharing information about the system.

The NHSI and NHSE boards will also be considering, over the next several months, the extent to which some of NHSE's and NHSI's non-executive led board committees might be reshaped and aligned.

Regional level changes

The proposed structure involves a potentially very significant change at regional level through the creation of seven integrated (i.e. spanning both NHSI/NHSE) Regional Directors with much wider responsibilities and greater power compared to the current structure. The new regional teams will have a major leadership role driving improvement and transformation for local health systems and providing joined-up oversight across the NHS in their region. They will act as 'translators' between the national level and local health and care systems, helping to ensure that national work is responsive to local system needs.

The Regional Directors will have full responsibility for the performance of all NHS organisations in their region. They will make decisions about how best to support and assure performance within their region as well as support the development and identity of local STPs and ICSs. The regional teams will decide when and how to intervene in systems, providers or CCGs in their region, or - where required - make the relevant recommendations to the national NHS Executive Group. They will also be responsible for creating clear strategic visions for how the pattern of services and the pattern of provider configuration (e.g. mergers etc.) should develop within their regions.

The Regional Directors will report to the two NHSE and NHSI CEOs and be full members of the national NHS Executive Group, with responsibility for working with the national directors to develop the overarching strategy and architecture for the NHS as well as translating that into operational plans.

The integrated regional teams will deliver a number of core functions, including: performance, improvement and intervention; strategy and system transformation; commissioning; operational management; finance; specific quality responsibilities; workforce and leadership; information, digital and technology; estates and procurement; analysis and insight; communications and engagement; and corporate functions (including HR). There will be a particular emphasis on developing a much more proactive approach to senior leadership talent management within each region. The plan is for Regional Directors to oversee a more planned approach to Chair, CEO and executive board appointments and development, though the details of this are still being worked through.

In this structure, the current functions of NHSI's central Regulation Directorate are devolved to the Regional Directors as, for example, are the NHSI Medical Director's current responsibilities for special measures trusts. These changes are emblematic of the proposed scale of devolution from "central NHSI" to the integrated new Regional Directors.

It is important to note that the shift to seven regions, rather than four, is designed to enable Regional Directors to exercise these functions effectively. There are concerns that the existing four region structure gives regional directors an impossibly large number of providers within their region. 230 trusts divided by four regions equates to 58 trusts per region. 230 trusts across seven regions equates to 33 trusts per region. The intention is to enable the seven Regional Directors to have a much closer and deeper relationship with every trust in their region as opposed to only being able to concentrate on those that most require attention.

National level changes

As part of the devolution of power and responsibility to the more powerful Regional Directors, the role of the national level arms-length bodies' functions changes to being one of supporting the regional directors and working with them to create the national level strategic framework. Within NHSI the new national level structure, combined with the new approach to the regional directors, is designed to enable the change of primary focus from regulation to improvement support.

There will be a number of national director roles, which will report to both CEOs:

- A single NHS Medical Director
- A single NHS Nursing Director/Chief Nursing Officer for England
- A single Chief Financial Officer, who will have responsibility for a single NHS financial and operational planning framework and performance oversight process
- A single National Director for Transformation and Corporate Development – who will lead most corporate operations across both organisations including people and organisational development functions, both internally and with respect to system transformation.

A number of 'do-once' functions will be led by individual national directors in NHSE and NHSI, including:

- NHS England Deputy CEO – national service programmes such as cancer and mental health, implementation of the Five Year Forward View, and leadership of NHSE's distinct responsibilities including commissioning specialized services and primary care
- National Director for Strategy and Innovation (NHSE) – strategic programmes such as life sciences, commissioning development, patient choice and personalization, innovation and research
- Chief Provider Strategy Officer (NHSI) – a new strategic approach to configuration of the provider landscape
- Chief People Officer (NHSI) – a new post based in NHSI which is designed to develop a more systematic approach to leadership and development and people management issues+
- Chief Improvement Officer (NHSI) – a senior level post designed to support improvements in quality, access and efficiency with particular emphasis on supporting trusts to deliver improvements in these areas
- Chief Commercial Officer (NHSI) – supporting improvements to estates, procurement, back office services and clinical support services

- National Director for Emergency and Elective Care (NHSI) – shared approach to urgent and emergency care and elective care.

Taken together, the last five of these posts are designed to enable the shift in primary NHSI focus from regulation to supporting improvement. These post holders, working with the regional directors, will be seeking to support improvement at a trust level as well as at a sector wide level.

The effect of these changes is that the two organisations will be increasingly be working in a combined way on a single set of system priorities, covering most key functions, including:

- System strategy
- Planning and performance
- Supporting STPs and ICSs
- Service transformation
- Improvement
- NHS leadership and workforce
- NHS information and digital technology
- NHS estates, procurement, back office services and clinical support services.

There will however be some functions that remain distinct to each organisation. NHSI's regulatory functions in relation to pricing, competition and patient choice, and its hosting of the Healthcare Safety and Investigation Branch, and NHSE's responsibility for tariff currency development, commissioning of specialised services and primary care, and Emergency Preparedness, Resilience and Response (EPRR), will remain separate and distinct.

STPs and ICSs

Under the new integration regional model, STPs and ICSs will relate to a single Regional Director. As they develop and mature, the national bodies envisage ICSs holding more responsibility, including:

- Developing a system vision, strategy and plans to meet operational, financial and quality requirements
- Developing and maintaining relationships with local people, staff, local government, voluntary and independent sectors
- Leading on provider transformation including integrated providers and primary care networks
- Providing first line support to organisations within their system, drawing down national and regional expertise where needed
- Some commissioning (including current direct commissioning) not performed at national level.

Implementing the proposals

Changes to the most senior roles will be made by September and to the roles at the next level during the autumn. The aim is for all changes to be made by the end of this financial year. NHSI and NHSE recognise that this work requires a reshaping of the culture, mind-sets and ways of working for the two organisations so that they collectively see their role and purpose as providing system leadership to the NHS, and are not

defined by traditional boundaries. The implementation of this change programme has been titled 'Project 70'.

It is worth noting that there are major structural, cultural and behavioural shifts required to make this proposed approach work, including:

- Genuine commitment to devolve power from the centre to the regions
- Much greater alignment between NHSI and NHSE to work as a single system leader than at present
- Finding ways to overcome the natural split between commissioning and provision inherent in the 2012 Act, the ongoing need for separate boards and CEOs and the way the Act requires the NHS to work e.g. the NHS budget formally being allocated to NHSE.

NHS Providers' view

These proposals represent a significant change for NHSE, NHSI and the wider NHS. Over time they could herald a profound shift in the way the NHS is led at national and regional level and how trusts experience that leadership on the ground.

Trusts have consistently told us, for example via our latest regulation survey and informal feedback, that:

- They want the two organisations to work more closely together and provide single, integrated, system leadership of the NHS
- They want NHSI to provide more support and focus less on regulation, recognising there are inherent tensions between the two roles
- They want access to a more empowered and integrated regional structure that can give them clear, rapid and trusted guidance on issues such as whether it is worth them pursuing a merger, reconfiguration or capital project, confident in the knowledge that, if positive, the appropriate support will quickly follow
- They want more help, where needed, to create the right strategic framework for the larger regional and sub regional geographic footprints in which they work, helping resolve issues that affect multiple trusts or local systems where there may be competing interests.

NHSI has told us that these proposals are designed to address these concerns. We think they offer significant potential benefits, but there are also significant risks, and a lot depends on successful implementation and some major cultural/behavioural changes that are far from assured. We set out the potential benefits, the risks and the critical success factors, as we see them, in three short sections below.

Potential benefits

Reduce duplication and eliminate contradictory messaging / activity

The "do it once" new structure offers potential to eliminate the duplicative interactions trusts currently report in their dealings with NHSI and NHSE as different national and regional teams, both within and across the two organisations, act in an uncoordinated way on the same issue – for example asking for the same information or promoting contradictory approaches. A single approach to finances and contracting,

for example, offers the chance to solve financial challenges collaboratively rather than pit providers and commissioners unhelpfully against each other.

Single system framework

As the NHS moves to local system working, with the distinctions between CCGs and providers starting to blur, the new structure offers the opportunity to create a single, aligned, local system focussed, NHS performance, financial and operational framework.

An effective empowered regional level offering support

This structure offers the opportunity to create empowered integrated regional teams that really understand the problems and challenges facing local providers and can then provide appropriate advice and support on a systematic and trusted basis. That could include:

- Providing advice and guidance and then acting as a champion on issues that require arms length body or national system level input, approval or support such as capital projects, reconfigurations and transactions.
- Acting as solution facilitator for regional or sub regional issues where competing provider/local system interests or competing provider / commissioner issues occur;
- Regional Directors providing CEOs and boards with high quality, effective, advice and personal support and helping develop a more systematic approach to senior NHS talent.

Greater value for money

Greater joint working between NHSI and NHSE has the potential to deliver better value for money and increase efficiency. Given current NHS financial pressures, it is more important than ever that the national bodies are realising potential efficiencies and that any cost savings are diverted to frontline care.

Risks

Importance of provider sector understanding and influence

The NHS national strategic framework over the last few years has been the product of an explicit, often hard fought, private, negotiation between a provider-focussed NHSI and a commissioner-focussed NHSE. Whilst this is potentially wasteful, the duality inherent in this structure has ensured that the provider sector has had a robust and effective champion in NHSI arguing the provider cause in these negotiations. Trusts tell us that they don't always feel that NHSE understands the provider perspective or scale of challenge. For example there is a strong perception that excessive financial and performance risk has been loaded on to providers and this would have been even greater had there not been strong provider sector/NHSI pushback. It is important that this proposed joint venture is therefore a genuine joint venture of equal partners. For example, the single NHS finance and planning framework needs to be led by a single Finance Director who understands provider needs, will ensure an appropriate level of provider risk and will be committed to creating a provider task that is genuinely achievable.

The need for the right behaviours from regional leaders

This structure devolves power to the new Regional Directors that needs to be used in the right way. Trusts tell us that the behaviours exhibited in these or similar roles have sometimes been inappropriate and short of supportive. The desire for a support-led, rather than regulation-led, approach to the national arms length body/local trust relationship must be consistently expressed in the right behaviours, particularly in a context where the NHS will continue to experience considerable financial and operational pressures.

Potential loss of provider autonomy

Trusts tell us that the burden of regulation is significant and growing. Integrated regional teams with greater powers and a smaller number of trusts within each region creates risk as well as opportunity. Trusts will welcome appropriate, effective, extra support, particularly if it is provided in areas where the support is requested. Trusts will be less comfortable with unwanted activity that adds burden and complexity, intervenes unnecessarily or unreasonably curtails provider freedom and autonomy.

The creation of an unmanageable monolith

NHSI and NHSE together create a very large organisation that is likely to be significantly more difficult to manage and lead.

Critical success factors

In our view, successful implementation of this new structure will therefore require the following:

Much greater alignment between NHSI and NHSE than is currently the case. Dual reporting lines are difficult to manage and the existence of two boards and two CEOs will bring difficult tensions (though we would argue they also bring the potential advantage of a guaranteed strong, equal, voice for providers/frontline delivery organisations).

Genuine commitment to devolving power to Regional Directors and their teams. Trusts tell us they feel that executive power is currently strongly concentrated at the top of both organisations. There has to be a genuine and equal commitment across both organisations to devolve power to the new integrated regional structure.

The right appointments, skills, behaviours and appointment process. Effective, powerful, Regional Directors require senior level appointments who can carry the required credibility and authority with provider CEOs, Chairs and boards. We will struggle to make this system work effectively without them. It is also important NHSI/E are seen to go through due process in making these and the national director level appointments – setting out proper job descriptions and person specifications which frontline leaders can help shape, and then running open competitions. Understanding of the frontline delivery challenge and what is needed to support leaders to meet that challenge will be crucial in whoever is appointed.

The right single planning, finance and performance framework and process that is also based on a proper understanding of what provider leaders need to deliver effectively and is not an over ambitious, impossible to deliver, commissioner-led framework. The approach of the new joint Finance Director will be crucial here.

Effective management of a difficult change process, without adversely impacting other major priorities like the new, post PM funding commitment, NHS plan and the financial/planning reset required in 2019/20.

Genuine commitment to involve frontline leaders in the details of these changes as they develop. This new structure and approach will only work if local leaders feel they own and support it too.

Greater clarity on the relationship between the new regional structures and the STPs/ICSs that sit within their region and assurance that we are not creating new layers of bureaucracy for local leaders to navigate.

Next steps for NHS Providers

We have, as you would expect, been inputting the provider sector perspective as this work has developed. This included a successful member roundtable ten days ago as today's Board paper was being drafted, where members shared the concerns and welcomed the opportunities we set out above.

We would welcome your feedback on our views above and will continue to try to influence this process. NHSI have told us that they are strongly committed to involving providers in the detail of this work as it progresses.

ROHTB (5/18) 002

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

May 2018

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 the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

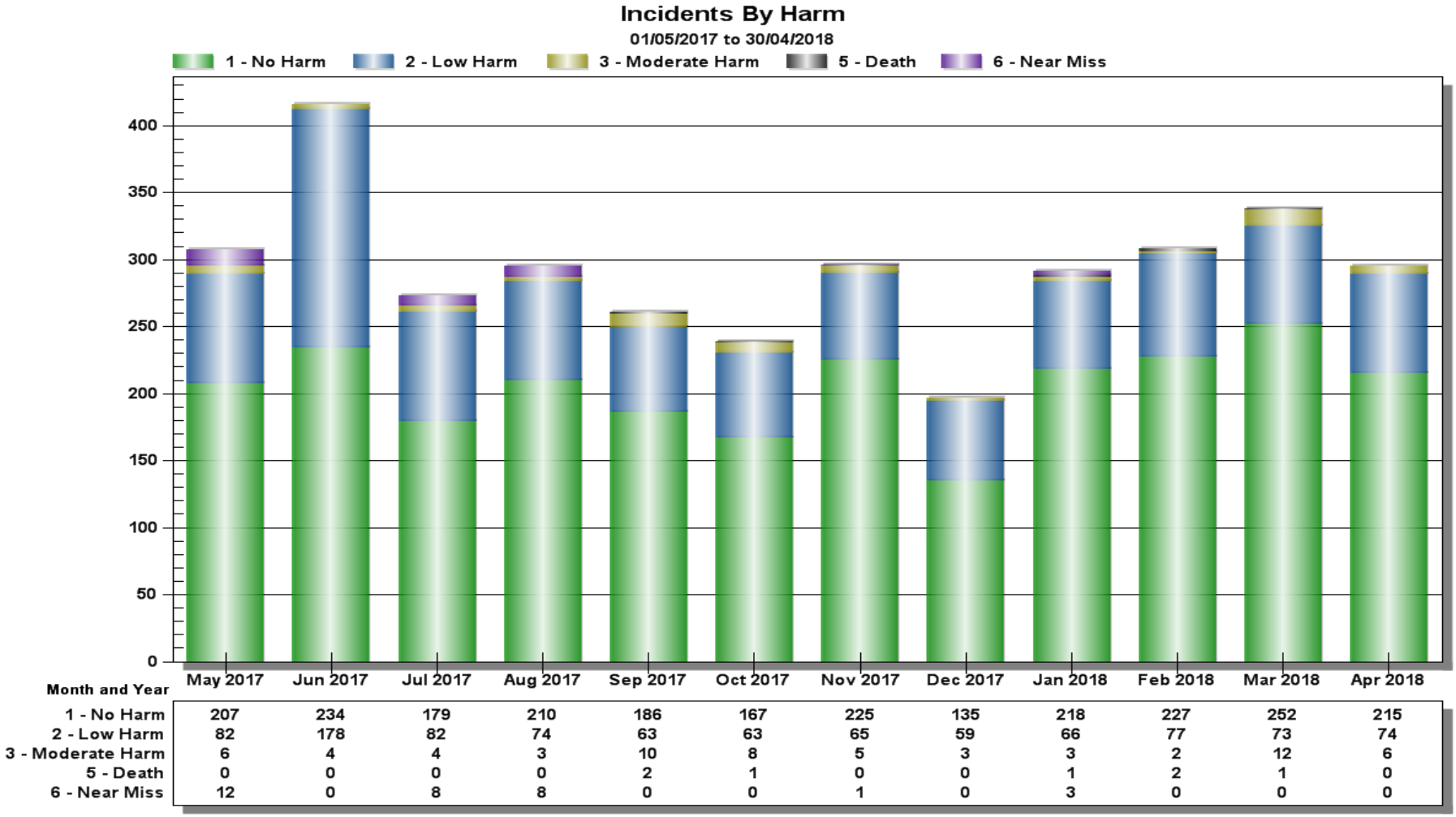
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
1 - No Harm	207	234	179	210	186	167	225	135	218	227	252	215
2 - Low Harm	82	178	82	74	63	63	65	59	66	77	73	74
3 - Moderate Harm	6	4	4	3	10	8	5	3	3	2	12	6
5 - Death	0	0	0	0	2	1	0	0	1	2	1	0
6 - Near Miss	12	0	8	8	0	0	1	0	3	0	0	0

INFORMATION

In April 2018 there were a total of 295 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

215 – No Harm
74 – Low Harm
6 - Moderate Harms
0 – Severe Harm
0 – Near Miss
0 – Death

In April 2018, there were a total of 8907 patient contacts. There were 295 incidents reported which is 3.3 percent of the total patient contacts resulting in an incident. Of those 295 reported incidents, 80 incidents resulted in harm which is 0.8 percent of the total patient contact.

The 6 Moderate Harms were;

Site	Cause Group
Ward 2	Pathological Fracture
Ward 3	Thromboembolic (Known/Suspected)
Ward 3	Fall

Ward 12 - Short Stay	Thromboembolic (Known/Suspected)	
Ward 12	Thromboembolic (Known/Suspected) PE	
Ward 1	Thromboembolic (Known/Suspected)	

ACTIONS FOR IMPROVEMENTS / LEARNING

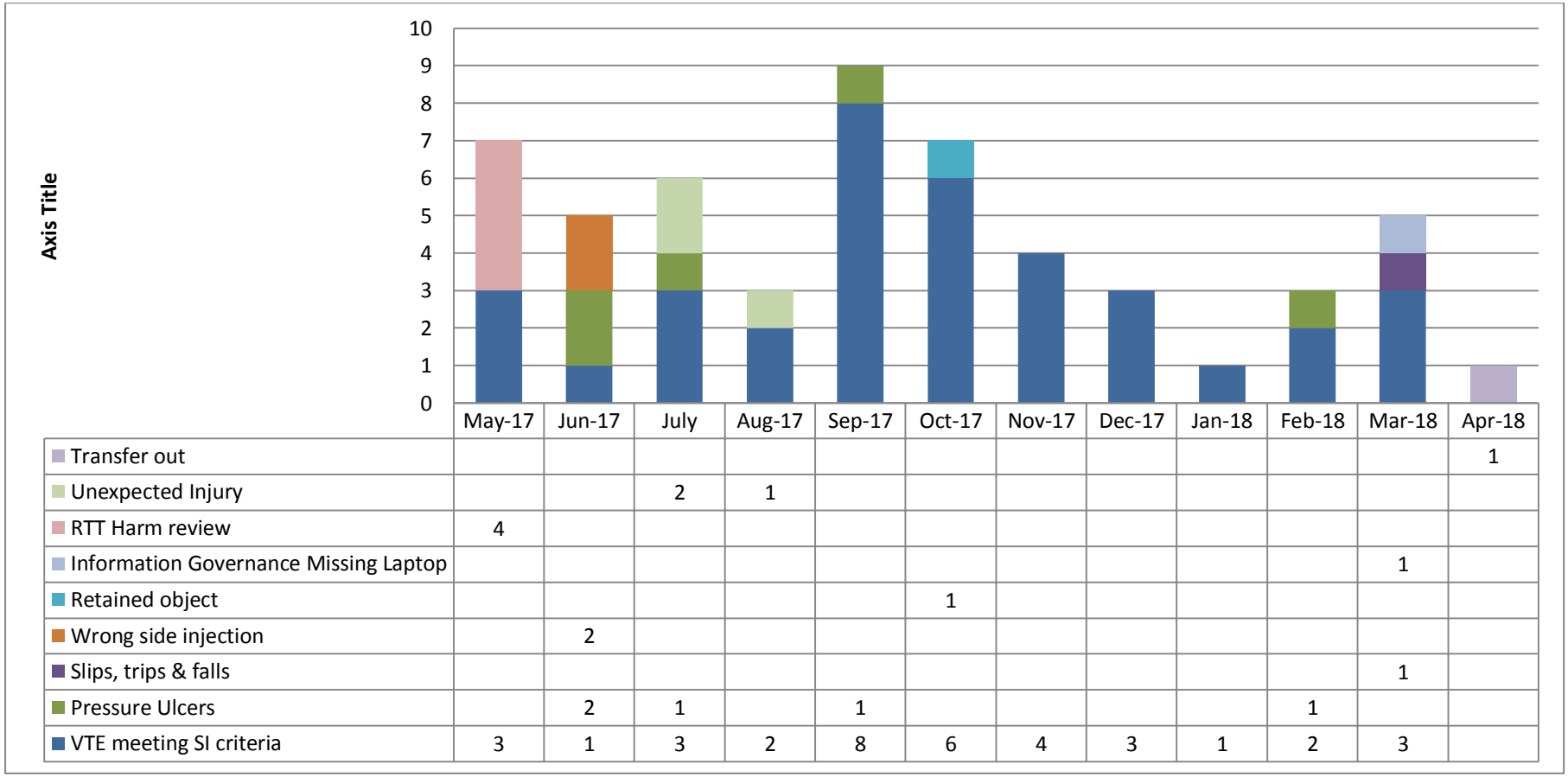
The Governance team have a number of improvements planned;

- Review the current RCA template and measure against the national standard
- The Creation of an RCA guide to support the RCA process

RISKS / ISSUES

A Risk has been added to the risk register due to the staffing levels within the Governance team. The Governance team currently have 2 X WTE vacancies. Interviews are scheduled for Monday 21st May 2018.

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.



	May-17	Jun-17	July	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Transfer out												1
Unexpected Injury			2	1								
RTT Harm review	4											
Information Governance Missing Laptop											1	
Retained object						1						
Wrong side injection		2										
Slips, trips & falls											1	
Pressure Ulcers		2	1		1					1		
VTE meeting SI criteria	3	1	3	2	8	6	4	3	1	2	3	

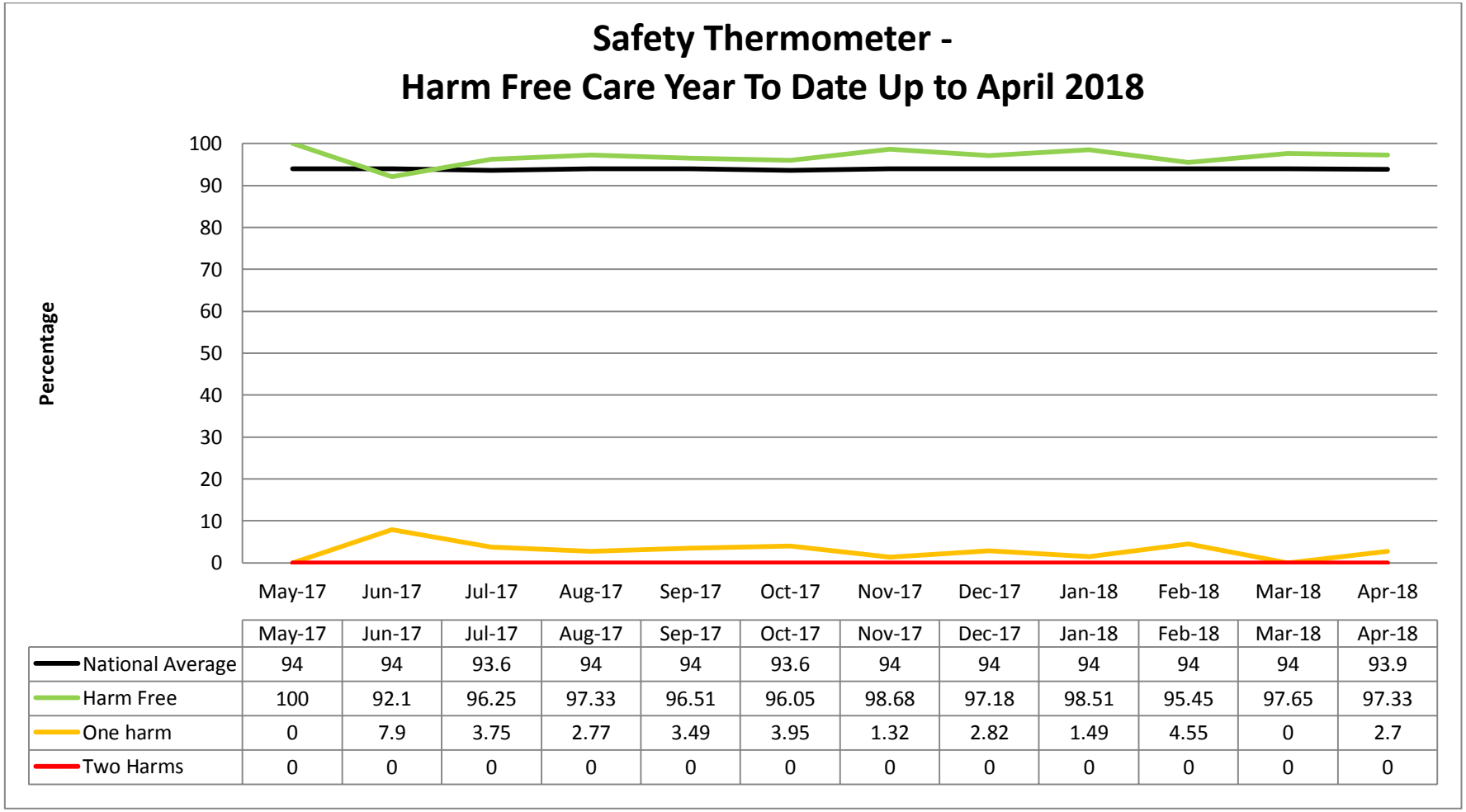
INFORMATION
1 Serious Incidents were Declared in April 2018; The Serious incident was reported in last month's quality report and has been discussed in April 2018 Quality and Safety Committee.

HDU	Emergency Transfers

ACTIONS FOR IMPROVEMENTS / LEARNING
1 unavoidable VTE Serious incident was closed by the CCG in April 2018.

RISKS / ISSUES
None.

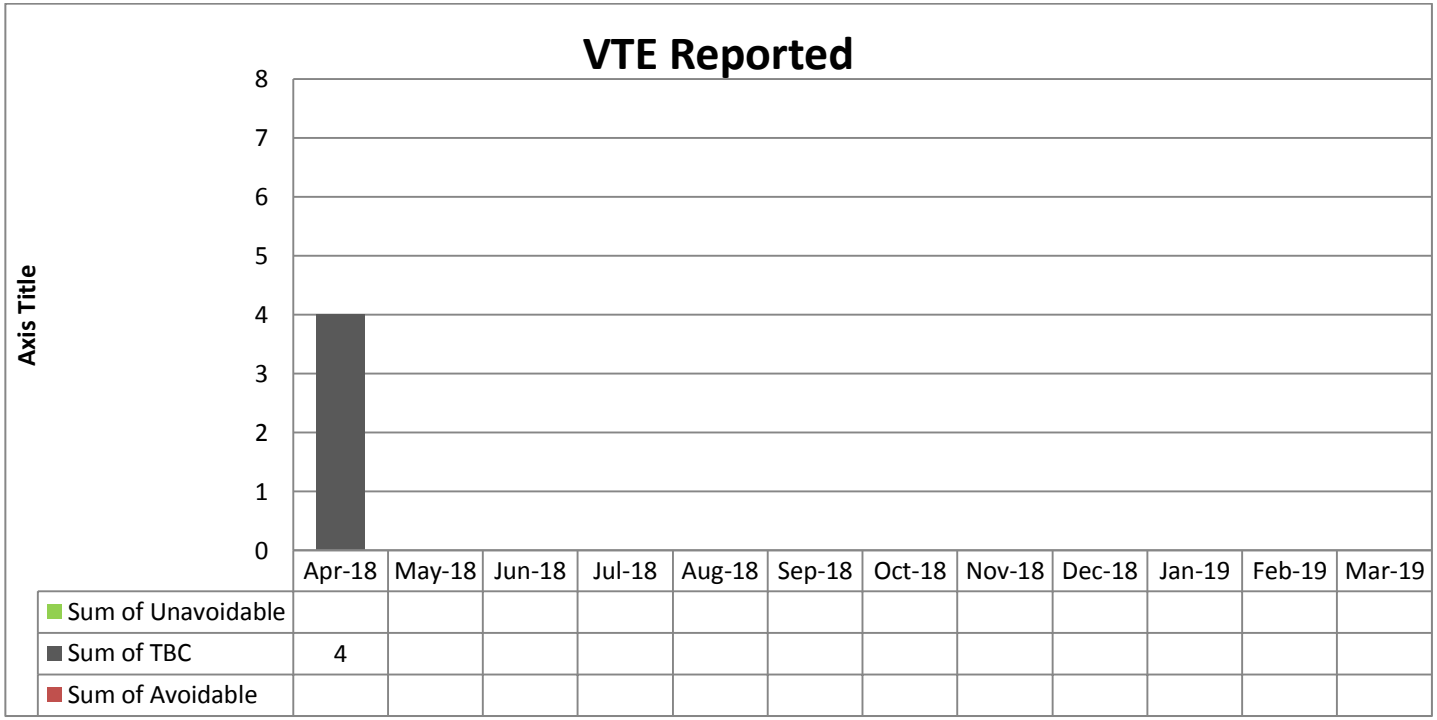
4. **NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
National Average	94	94	93.6	94	94	93.6	94	94	94	94	94	93.9
Harm Free	100	92.1	96.25	97.33	96.51	96.05	98.68	97.18	98.51	95.45	97.65	97.33
One harm	0	7.9	3.75	2.77	3.49	3.95	1.32	2.82	1.49	4.55	0	2.7
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The Harms recorded in April 2018 are; 1 x old pressure ulcer (ward 2), and 2 x patient falls (Ward 2 and Ward 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 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).**



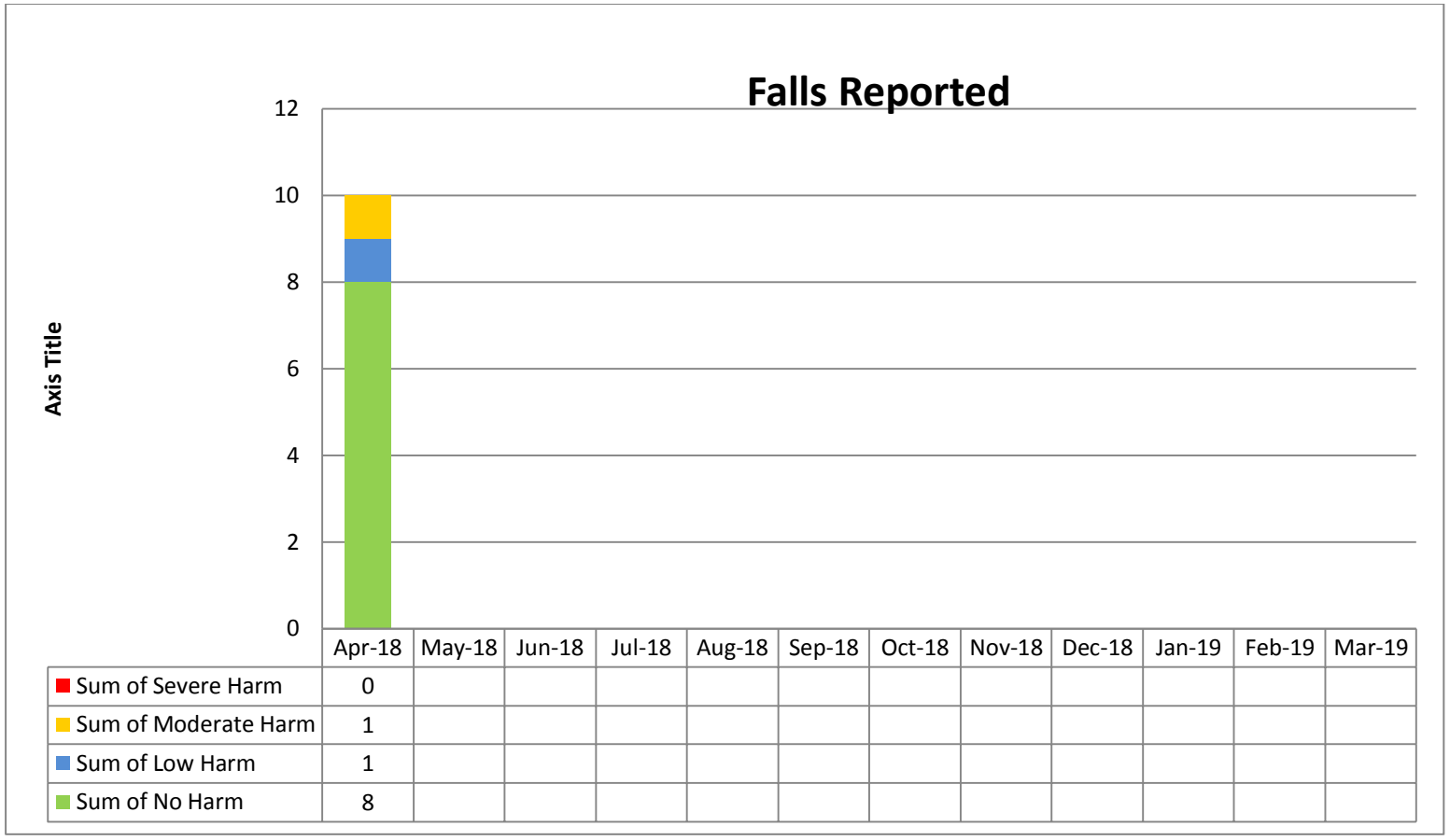
10

total		Avoidable
17/18	33	10
18/19	4	0*

***not classified**

INFORMATION
There were 4 VTEs reported in April 2018; this compares to 0 reported in April 2017 The incidents are detailed on Page 5 of this report and are currently under investigation
ACTIONS FOR IMPROVEMENTS / LEARNING
On the 23rd May 2018, the ROH achieved VTE Exemplar membership with the Exemplar Centre network. In March 2018 NICE updated their guidance on Venous Thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. This has been reviewed in detail by the VTE Advisory Group. There have been changes with regards to prevention options which allows for variation. It is felt that wherever possible there should be a standard approach. CSLs/AMDs have been asked to review speciality specific sections and provide team decision. This information will be collated by the VTE Advisory Group alongside benchmark information from RJAH and RNOH. Our current Trust VTE prevention guidance is safe, and any variations go above the new recommendations. Staff have been advised current policy should continue to be followed until review/update of new recommendations is complete
RISKS / ISSUES
None

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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Severe Harm	0											
Sum of Moderate Harm	1											
Sum of Low Harm	1											
Sum of No Harm	8											

total	
17/18	115
18/19	10

12

INFORMATION

Overall there were 10 fall-related incidents reported across the Trust in April 2018, all were related to adult inpatient falls. All falls were graded either no or low harm and are reviewed in the Trusts Falls group with an upward report to Clinical Quality group. One incident was graded as moderate harm and is included in the narrative on page 5.

A falls annual report was an agenda item at the May 2018 Clinical Quality Group.

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 and are also reported in the Monthly Quality Report. Across in-patient areas, we continue to utilise a collaborative, multi-disciplinary approach to falls risk assessment, care planning and falls prevention strategies.

ACTIONS FOR IMPROVEMENTS / LEARNING

In 2017/2018 there was a reduction in the reported number of falls (115) in comparison to the 144 falls incidents that occurred in 2016/2017.

Improvement work completed

- Falls documentation review.
- Bed rails policy updated.
- Sara Stedy; manual handling equipment training underway.
- Falls information boards implemented in all clinical areas.

Future improvements planned

- Falls policy under review, amendments being done to be in line with the WMQRS and updated nursing documentation. Aiming to complete this by the end of May 2018.
- West Midlands quality review service (WMQRS) benchmarking in progress. 7 standards in total, which we currently have, just need assurance that it's embedded. Aim to complete by the end of May 2018
- Throne projects; assessments are done to identify changes required in each bathroom to reduce patient falls in the bathroom and make it

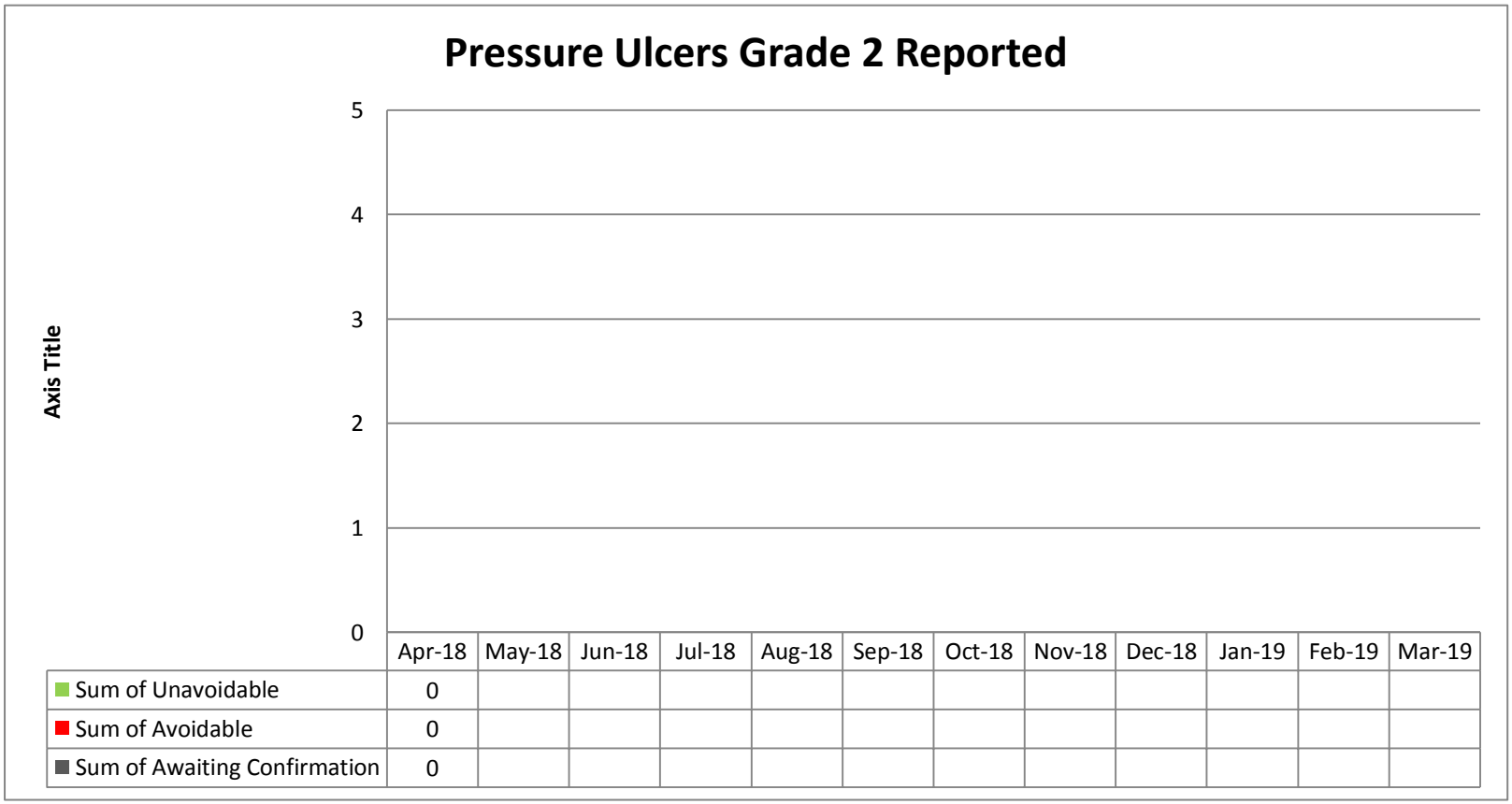
dementia friendly.

- Staff training of Sara Stedy and hoist, commenced on ward 3 by physiotherapist team.
- Falls E-learning training- plan for link nurses and ward managers to do the national e-Learning module available via ESR.
- Yearly clinical skills update training.
- Review of the Falls RCA process and questionnaire.
- A retrospective audit of the reported 71 falls from inpatient area.
- Peer review of the falls prevention and management.
- Mandatory fields to be added on to Ulysses indicating whether falls was avoidable or unavoidable.

RISKS / ISSUES

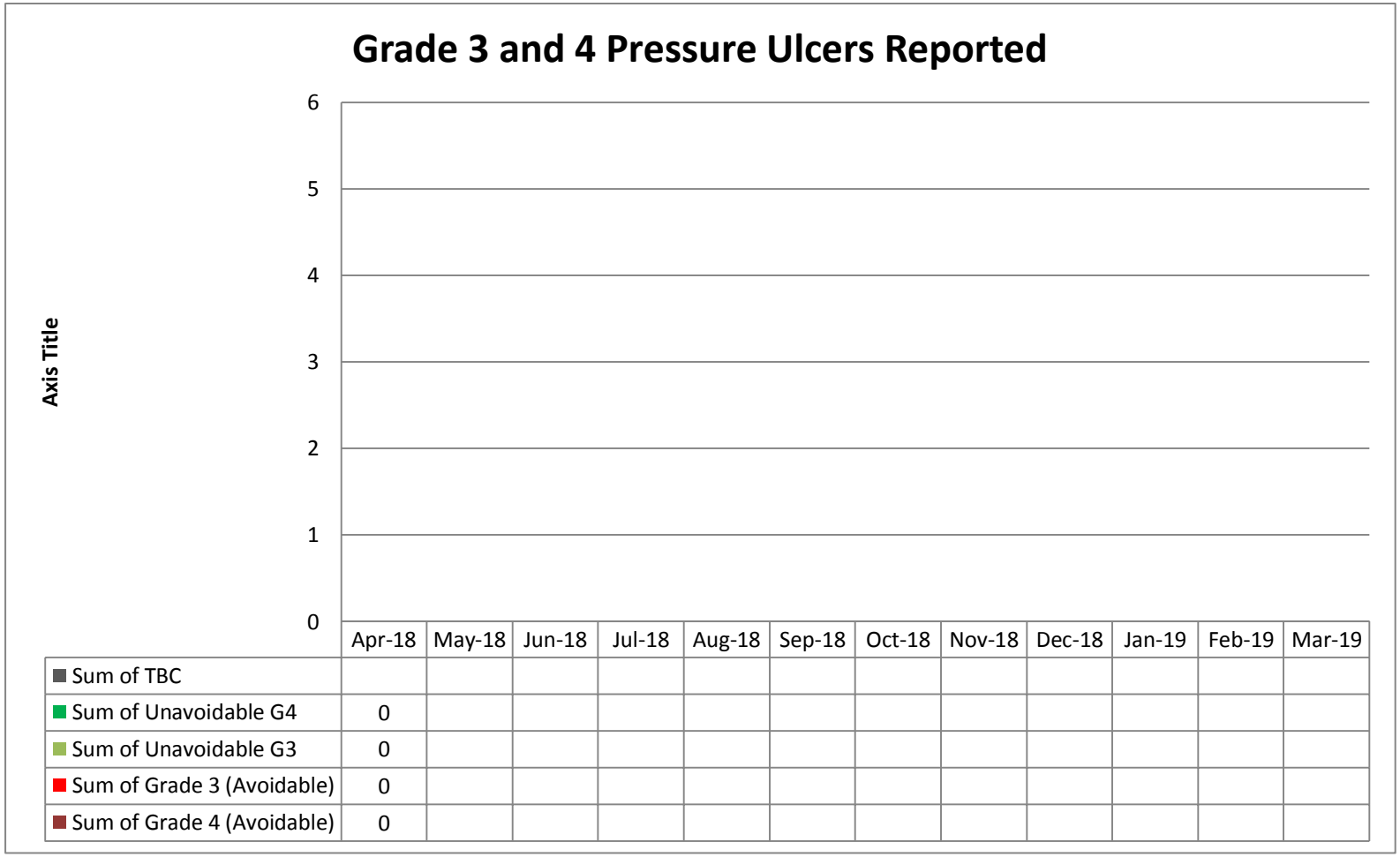
- A high number of inpatient falls especially in wards 1 and 3. This was challenged in the May 2018 Clinical Quality Group and a fall reduction plan has been requested by the Chair.
- Increase in a number of falls resulting in patient harm. Total of 3 between February 2018 and April 2018
- Staff training on the use of manual handling equipment such as Sara Stedy.
- Falls training awareness due to changes in the clinical skills update; (once only for staff rather than yearly update).

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.**



total	Avoidable
17/18	6
18/19	0

15



total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

INFORMATION

In April 2018, there were no recorded pressure ulcers. This compares to the one Grade 2 pressure ulcer reported in April 2017.

There were 3 reported Grade 2s reported in last month's Quality report. These have now been investigated and downgraded. The end of year total is below;

Avoidable Pressure Ulcer Targets

2018/2019:

0 - Avoidable Grade 2 pressure Ulcers limit of 12
0 - Avoidable Grade 3 pressure Ulcers limit of 0
0 - Avoidable Grade 4 pressure Ulcers limit of 0

2017/2018:

6 - Avoidable Grade 2 pressure Ulcers against a limit of 12
3 - Avoidable Grade 3 pressure Ulcers against a limit of 0
0 - Avoidable Grade 4 pressure Ulcers against a limit of 0

ACTIONS FOR IMPROVEMENTS / LEARNING

Future Actions Planned

- A documentation task and finish group have developed more specific user-friendly documentation, which will act as prompts to care and highlight any gaps in order that action can be taken. TV documentation will enable a clear outcome of a skin assessment carried out in ACDU, Theatre Recovery, Admission to HDU or Ward and include a SKIN bundle encompassing a care and comfort type of repositioning chart
- React to Red Skin Strategy will be shown at the next TV Link Nurse Study Day on 23/5/18 and formal launch will take place when the new documentation is launched. It is proposed to "test" the documentation on 2 ward areas – Ward 2 and Ward 12 – w/c 14/5/18 for 2 weeks
- This will include the use of Repositioning Clocks and Red – React to Red badges to be placed by or above the bed of patients at very high risk of PUs.

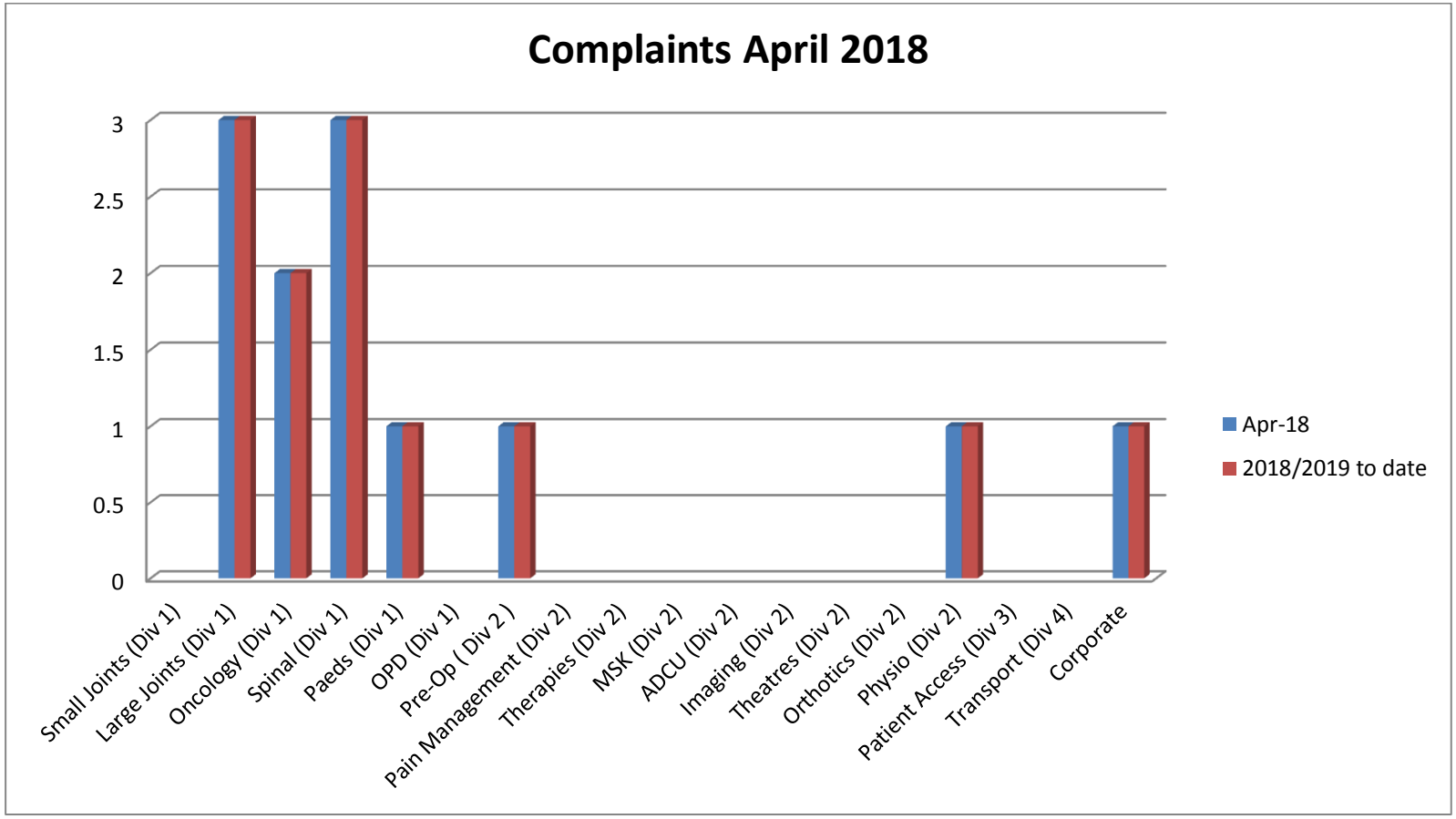
- Training and education will be given and the importance of checking skin regularly if a patient at risk of PUs – reminder Waterlow is a guide and if patients are immobile despite a "low" score – they need repositioning and skin checking more frequently
- TV Resource folders to be made available on all ward/clinical areas
- A new patient leaflet has been developed to demonstrate what a pressure ulcer is for patients who want more information or have the capacity and refusing to move

RISKS / ISSUES

Band 6 TVN leaves the Trust on 25th May 2018; this will leave the TV Service understaffed. Interviews are taking place on 16/05/18 to fill this vacancy.

Trust Tissue Viability Policy requires updating; this will be impacted by new classification status when agreed. Also awaiting consensus form the consensus groups tasked by NHSI – TV Lead Nurse is part of the collaborative task group looking at PU reporting.

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 278 contacts during April 2018 of which 52 were classified as concerns. At the start of the New Financial Year, this is a similar amount to the same time last year (327 contacts in April 2017) but significantly fewer concerns (72 in April 2017). The total number of enquiry contacts has remained reduced for the third month in a row as the letters sent to patients have been altered to remove the PALS number and replaced with the department concerned. However, there were still 226 enquires made to the department this month so the removal of the number has not affected patients being able to access the service.

Compliments

There were 583 compliments recorded in April 2018, with the most being recorded for Div. 1, although Div.2 are increasingly recording their compliments. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues 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 12 formal complaints made in April 2018. All were initially risk rated rest amber or yellow. This is comparable to the same time last year (11 complaints in April 2017).

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Cancelled surgery (not on the day) (Div.1, Paeds)
- Care on Ward 2. Fall with injury (Div.1, Oncology)
- Care on Ward 1; complications following surgery (Div.1, Spinal)
- Complications following surgery (Div. 1, Spinal)
- care and treatment under Oncology Service (Div.1, Oncology)
- care on Ward 2; discharge communication (Div.1, Large Joint)

Initially Risk Rated Yellow:

- treatment provided in orthotics, physiotherapy and OPD clinic (Div. 1, Large Joints)
- Unhappy with treatment received (Div.1, Spinal)
- denied reimbursement for taxi fares; not eligible for transport; PALS couldn't change this (Corporate)
- the approach of a member of staff (Div. 1, Large Joints)
- POAC undertook despite no surgery date for 6 months (Div.2, Pre-Op)
- delay in GP receiving referral letter; delay in receiving an appointment (Div. 2, Physio)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 11 complaints closed in April 2018, 10 of which were closed within the agreed timescales. This gives a 91% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in April 2018 was 26 days which is within normal limits.

Learning identified and actions taken as a result of complaints closed in April 2018 include:

- RCA had not been completed as thoroughly as expected (historical)
  Action: RCA reviewed, redone and shared with complainant with apologies

- Protocol for short notice cancellation of appointments not always being followed
  Action: Staff have been reminded of the protocol

- Changes to the pre-operative protocol for aspirin in spinal patients has not been communicated to pre-op
  Action: Teams are meeting to address this

RISKS / ISSUES

None Identified.

9. Friends and Family Test Results (collected in the iwantgreatcare system)

INFORMATION

The Friends and Family Test in its current format was implemented on 1st April 2014. The Department of Health changed the methodology of the Net Promoter Score to a more straightforward % of patients likely to recommend a service and % not likely to recommend a service. This was because evaluation showed that patients and most NHS employees did not understand the Net Promoter Score and the information provided was frequently misinterpreted.

The Friends and Family Test (FFT) is the mandated patient 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 offered 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

Following a review was undertaken by NHS England the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics. Since 8 October 2015 all FFT data has been published in a single release The data for Inpatient Services, Outpatient Services and Community Services is required to be submitted to the NHS Digital Data Collection System monthly and the results for every facility are published on the NHS England website.

NHS England has set a mandatory response rate of 35% for all inpatient services. There are no minimum response requirements for outpatient and community services. The Trust sets internal targets for all areas as it is agreed that the data will then be more meaningful.

The guidance for outpatient services is less stringent than for inpatient services. Trusts have the discretion to vary how the test is applied in outpatient settings. For example, at ROH, every patient having an appointment in the outpatient clinic is offered the opportunity to complete a form. However, physiotherapy patients are offered the form at the end of their set of sessions (usually 4 or 5 sessions). As long as there are forms on display in a department that allow an individual to provide feedback after each session should they wish to, this is compliant.

The Trust breaks down its outpatient data into specialities which is more useful to departmental managers. However, the return for Outpatient Services is submitted as a single service.

There are no official requirements to undertake the FFT survey in imaging or theatre departments. However, the Trust takes the view that if feedback is

provided in the same format across all departments, then the data is comparable and of use. In addition, there is an expectation that patient feedback is gathered in all areas, even if not mandated.

RISKS / ISSUES

The Trust is not currently meeting the mandated 35% response rate for inpatient services. There has been an improvement from last month to 31% but this is being actively monitored and managed to ensure that we first exceed the mandated response rate and then achieve the internal target of 40% for Inpatient Services.

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would recommend the department in April 2018**	**% of people who would NOT recommend the department in April 2018**	**Number of Reviews submitted in April 2018 (previous month in brackets)**	**Number of Individuals who used the Department in April 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	92.2%	3.9%	51 (44)	102	50%
Ward 2	97.9%	0.0%	47 (53)	110	42.7%
Ward 3	100.0%	0.0%	6 (21)	60	10.0%
Ward 12	94.1%	2.9%	34 (43)	85	40.0%
Ward 11 (CYP)	100.0%	0.0%	5 (3)	62	8.1%
ADCU	97.9%	0.0%	145 (146)	507	28.6%
HDU	100.0%	0.0%	17 (17)	70	24.3%
CYP HDU	100.0%	0.0%	3 (5)	4	75.0%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in April 2018**	**% of people who would NOT recommend the department in April 2018**	**Number of Reviews submitted in April 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	98.2%	0.2%	868 (858)	12%
COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in April 2018**	**% of people who would NOT recommend the department in April 2018**	**Number of Reviews submitted in April 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	98.6%	0%	72 (69)	80%

In addition to the Friends and Family Test question, there are an additional 5 questions on the survey which relate to the following key elements of patient experience:

- Privacy & Dignity
- Cleanliness
- Kindness and Compassion
- Timely Information
- Being involved in the decision-making process

These give an overall star rating out of 5 stars on the system, with 5 out of 5 being the highest available score.

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 monitors and compares the 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.

The Royal Orthopaedic Hospital NHS Foundation Trust

Date
01 April - 30 April

Your average score for all questions this period

4.90

Reviews this period

1320

25

Your recommend scores

5 Star Score

4.88

% Likely to recommend

97.5%

% Unlikely to recommend

0.4%

10. 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 14 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.

11. Litigation

New Claims

No new claims against the Trust were received in April 2018.

On-going claims

There are currently 28 on-going claims against the Trust.
27 of the claims are clinical negligence claims.
1 claim is a staff claim

Pre-Application Disclosure Requests*

8 new requests for Pre-Application Disclosure of medical records were received in April 2018.

*Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes, the Data Protection Act 1998 and the Access to Health Records Act 1990).

12. Coroner's

There were no Coroner's inquests held in April 2018

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 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 and 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 incompletion. The following areas examined; • form evident in notes • Sign in Section • Timeout section • Sign out section Total cases = 644 Total incomplete patients = 5 The total WHO compliance for April 2018 **= 100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
None

14. Infection Prevention Control

INFORMATION

Infections Recorded in April 2018 and Year to Date (YTD)	Total	YTD
Methicillin Resistant Staphylococcus Aureus blood stream infection (MRSA BSI)	0	0
Post 72 hour Clostridium difficile infection (CDI)	0	0
Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

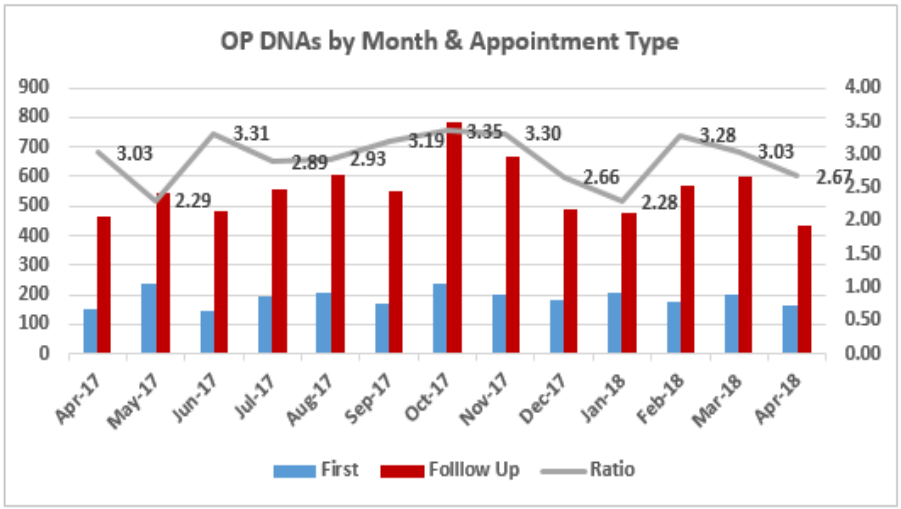
Mandatory Training rate for the Trust in IPC is currently 91.56%.

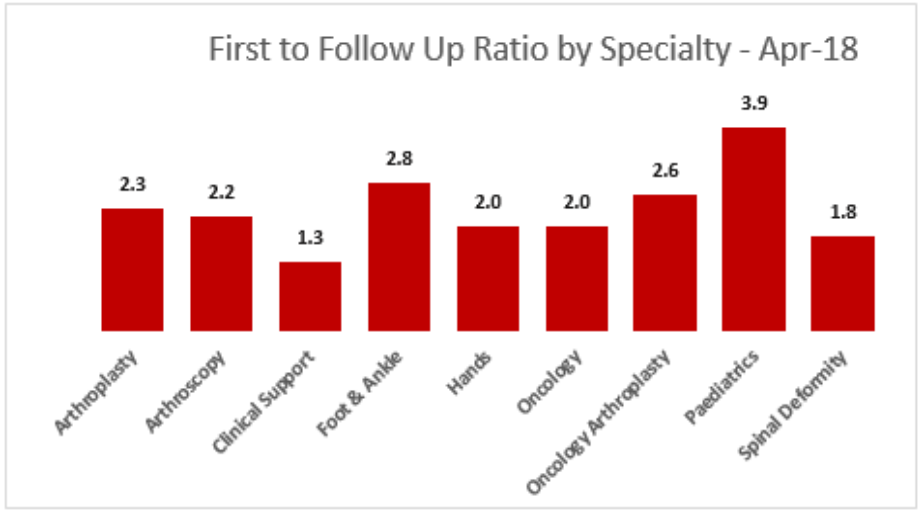
RISKS / ISSUES

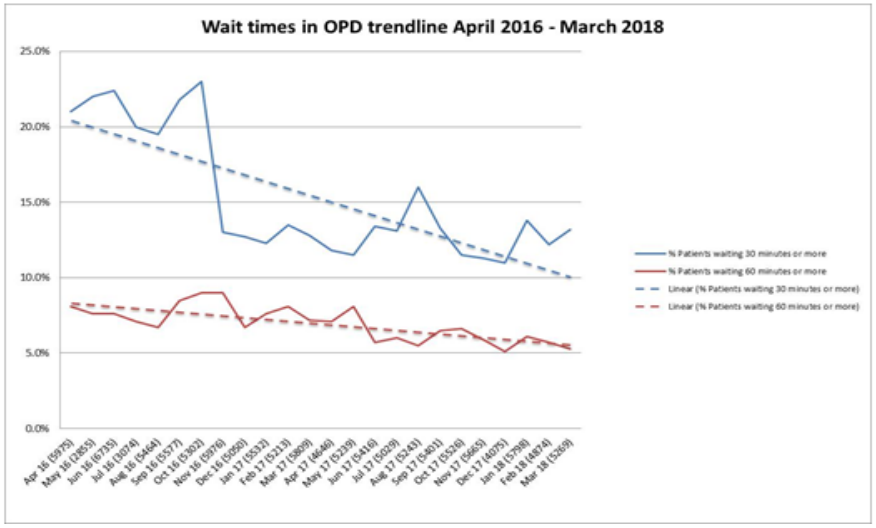
There are currently 10 IPC risks on the Risk Register, recorded from July 2017 (3 corporate, 2 divisional and 5 local). These are presently under review by the Head of IPC.

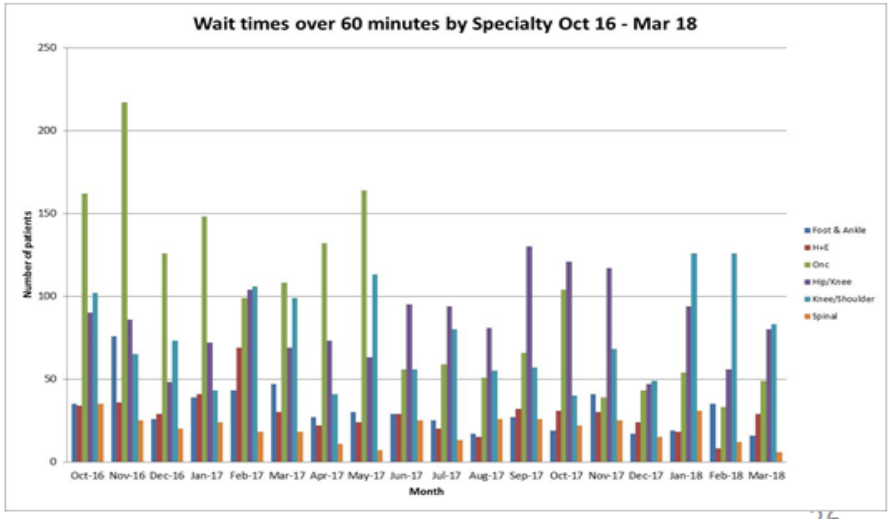
1 recorded incident from April 9th recorded as moderate risk – suspected wound infection presently under review by the IPC Team

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









INFORMATION

In April there were 14 incident forms completed to highlight clinics running more than 60 minutes late.
There were 13.0% of patients waiting over 30 minutes and 6.8% waiting over 1 hour. The over 30 minute waits have improved slightly from the previous month but the over 60 minute wait position has deteriorated. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month.
The monthly audit identified the following : -

- 6 - Complex patients
- 3 - Clinic overbooked
- 2 - Consultant/Clinician Delay
- 3 – Other

All incidents continue to be sent to the relevant operational managers to investigate each one. A record of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause, is being shared with the Ops team at the weekly Operational Management Team meeting. Work is underway to develop a report that will help analyse how clinics ran and where delays were experienced. This is a manual process now, but when the InTouch system is upgraded there will be an opportunity to develop better reporting functionality. Capacity issues continue to negatively impact clinic waiting times – full capacity modelling for outpatient clinics and inpatients across all specialties is to be undertaken. Additional funding is to be requested via a business case to increase the qualified and unqualified nursing establishment within both main and paediatric outpatients to support any required increase in capacity.

ACTIONS FOR IMPROVEMENTS / LEARNING

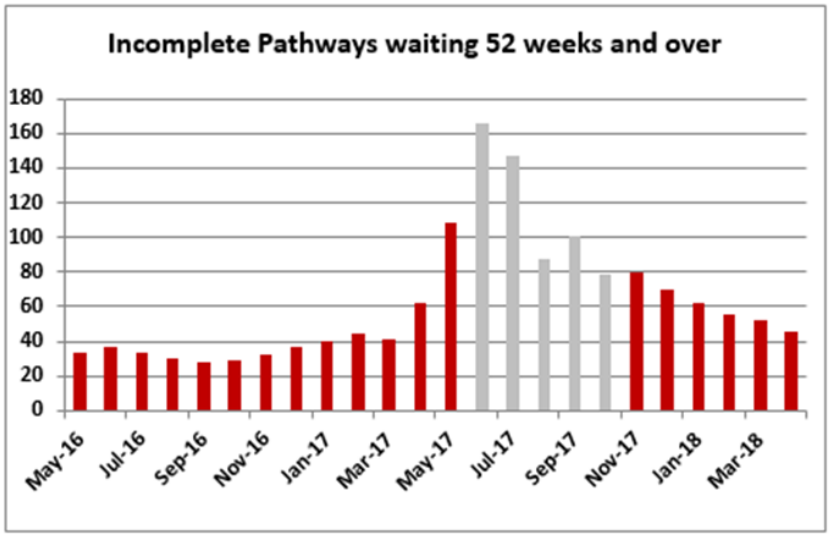
- Continue to drive incident investigations and action through relevant operational manager
- Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays
- Electronic clinic rescheduling form has been completed and is being trialled in Hands. Next steps to roll this out to the rest of the Trust
- Review of SOP in relation to clinic rescheduling following learning from aforementioned pilot of clinic rescheduling form
- Development of clinic utilisation tools through InTouch and Health Informatics
- Full capacity and demand analysis for all specialties

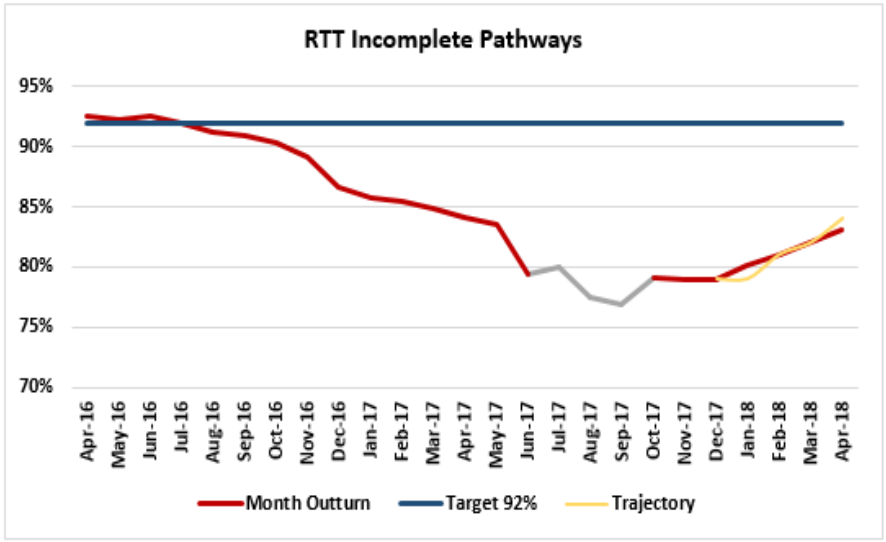
RISKS / ISSUES

Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. This will be addressed as part of the electronic clinic rescheduling form project
InTouch upgrade has not yet begun due to limited IT and project management resources. These are currently being reviewed and will be discussed at

the IM&T project board

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





		Indicative	Reported Month						Reported Quarter 2017/18					
Target Name	National Standard	Apr 18	Mar 18	Feb 18	Jan-18	Dec-17	Nov-17	Oct-17	Q3 (Oct, Nov, Dec)	Breach	Total	Q2 (July, August, Sept)	Breach	Total
2ww	93%	98%	94.4%	100%	97.10%	100%	100%	95%	98.30%	2	119	99.20%	1	120
31 day first treatment	96%	100%	90%	88.9%	91.67%	100%	91.70%	100%	96.30%	1	27	96.60%	1	29
31 day subsequent (surgery)	94%	90%	100%	100%	94.10%	100%	100%	100%	100.00%		30	97.40%	1	38
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
62 day (traditional)	85%	87.5%	71.4%	87.5%	86.67%	83.30%	83.30%	100%	82.40%	1.5	7	72.20%	2.5	9
62 day (Cons Upgrade)	n/a	100%	72.7%	80%	100%	90.90%	90.90%	81%	82.10%	2.5	14	88.90%	1	9
31 day rare (test, ac leuk, child)	n/a		0%		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	0	0						

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For April 2018 the RTT trajectory was 84% with performance at **83.14%** , with 46 patients over 52weeks (trajectory 75). The performance reflects the lack of activity through Theatres as part of the 1 week planned closure for maintenance. In month, Clinical Support met the 92% target ahead of its September 2018 trajectory

A benign Oncology Arthroplasty patient is showing over 52 in this month's position- the patient has surgery booked for 24th May 2018. This was picked up as part of the weekly RTT tracking meeting as an incorrect clock start. The tertiary referral date was not recorded correctly- the date received not original referral date was entered into PAS). They will be discussed at the next harm review meeting as part of the embedded process in place.

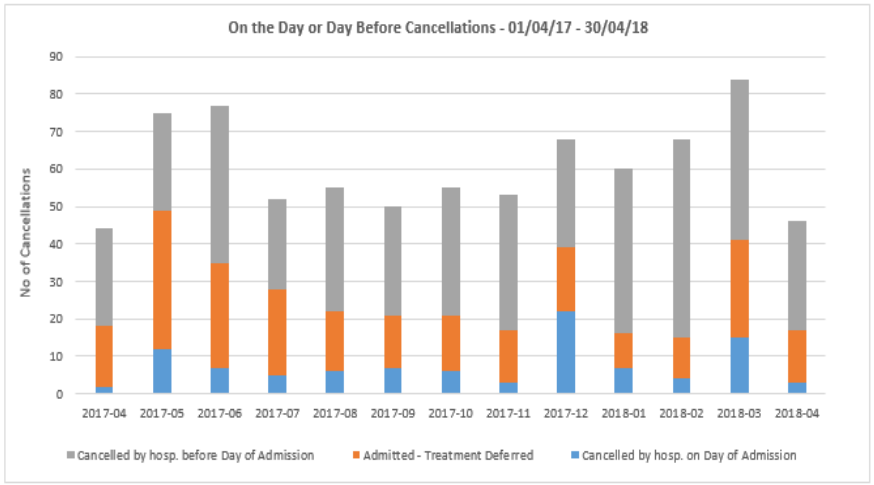
ACTIONS FOR IMPROVEMENTS / LEARNING

The team continue to concentrated on any patients over 40 weeks, this number continues to reduce. At the end of December 2018 we had 238 patients over 40 weeks; at the end of April 2018 this figure is now 157, 119 of which are Spinal Deformity. The focus continues with patients on an admitted pathway between 27-39 weeks and non-admitted over 18 weeks. Good progress continues to be made by all the teams.

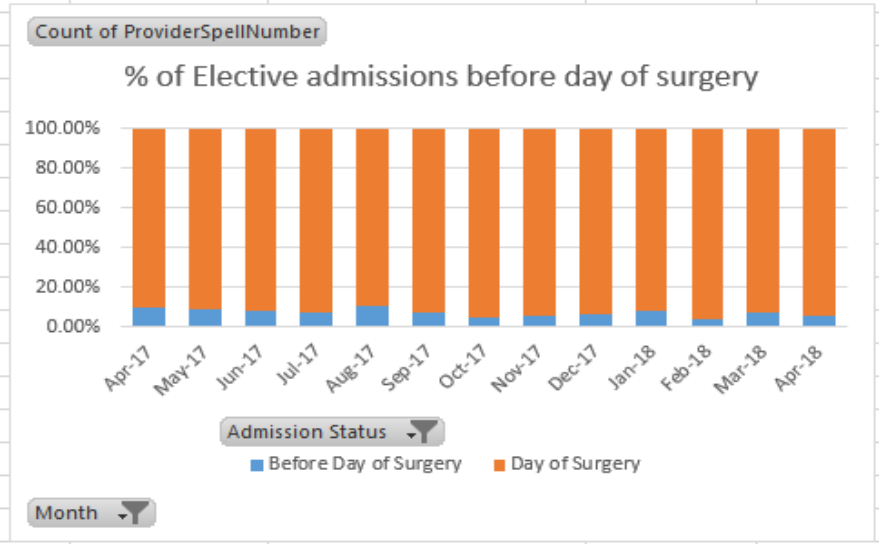
RISKS / ISSUES

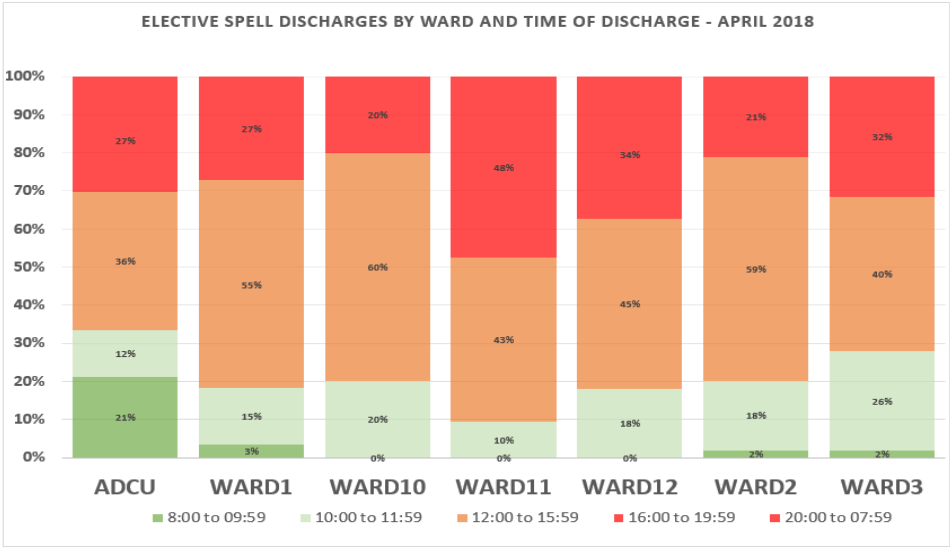
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance.
Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity continues through the Summer. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families.

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



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	28	42	77	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
2018-04	3	14	29	46	0
Grand Total	99	240	448	787	10





INFORMATION
The number of cancellations on the day of surgery by the hospital has decreased in month. An analysis of the 17 patients cancelled on the day of admission highlighted the reasons for cancellation varied across a range of issues, key themes identified were: ran out of theatre time, emergency patients taking priority and availability of equipment. In addition, patients cancelled due to medication issues were also identified as a contributing factor to cancellations on the day. Cancellations before the day of surgery have also reduced in month. An analysis of the 29 patients cancelled by the hospital before admission highlighted two main factors for cancellations prior to surgery: patients being offered earlier dates for surgery and patients being deferred to accommodate emergencies. A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Trends are analysed and interventions delivered to reduce cancellations. Work continues to strengthen the POAC process. The pathway model and clinical protocols are currently being finalised with the associated workforce model and will be presented at the Audit Meeting on 31st May for wider Clinical engagement and sign off .
ACTIONS FOR IMPROVEMENTS / LEARNING
A daily update review by the Operational management team of forward bookings has been established, as well as the 6-4-2 weekly meeting. The operations 'Huddle 'is now embedded in practice, with learning shared at weekly Operational meetings across divisions. Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data : - Refresher training to support improved accuracy of data inputting on the PAS system to inform actions and allow robust audit of cancellation reasons. - Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation. The launch of the Stryker project commences on 24th May 2018. - 72 hour Patient call proforma has been redesigned following clinical input to improve the information discussed with the patient at 72 hours , to further reduce cancellations on the day. - Roll out of replacement theatre equipment has commenced to reduce issues relating to equipment availability.
RISKS / ISSUES
Shorter turnaround times for pre –operative assessment are required to respond flexibly to increased levels of activity.

Finance and Performance Report

April 2018

CONTENTS

INTRODUCTION

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

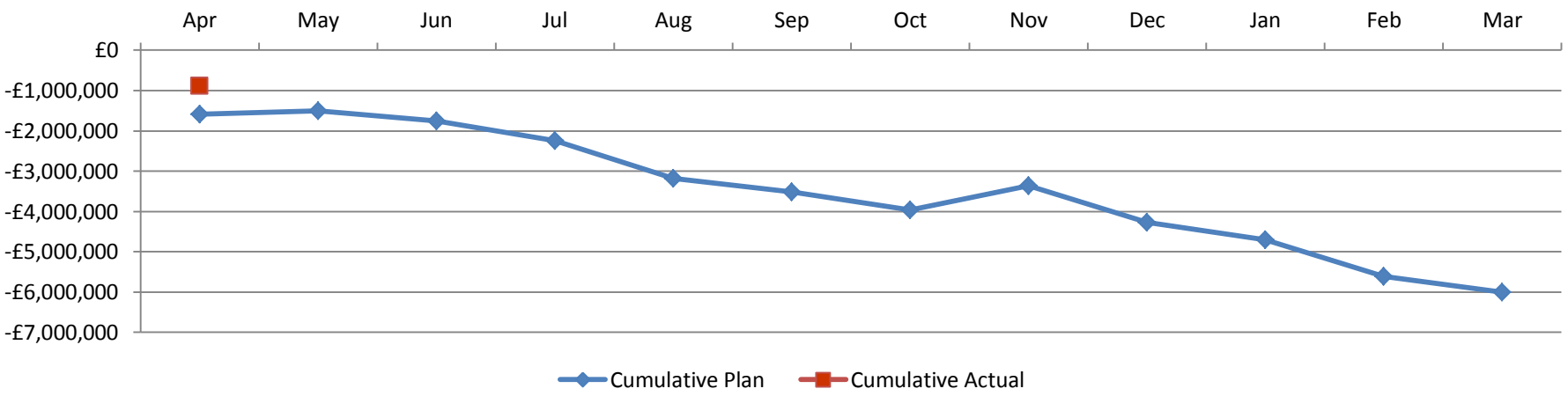
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

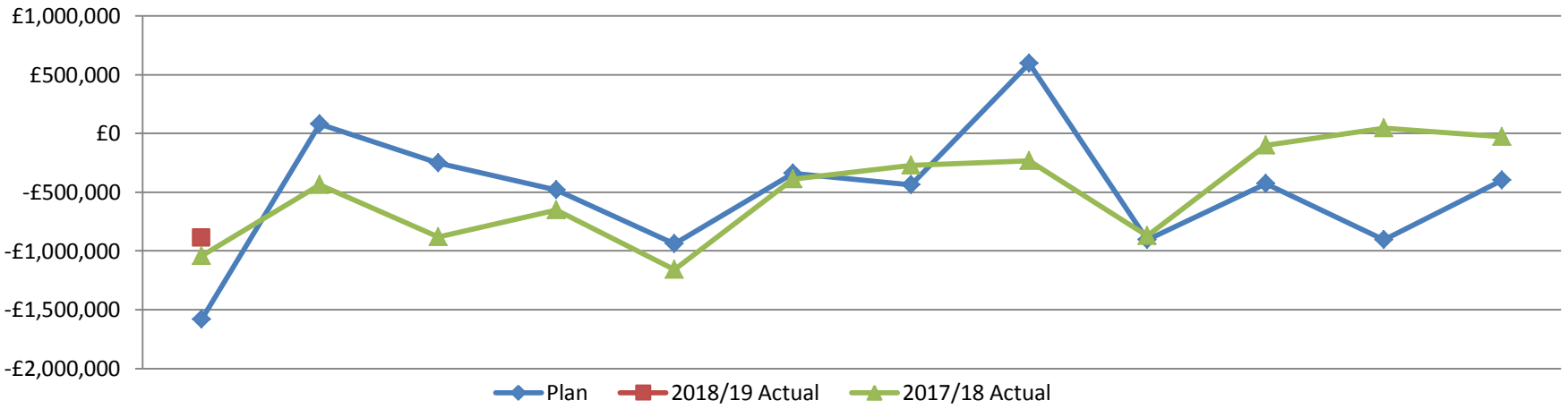
	YTD M1 Original Plan £'000	YTD M1 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	4,941	5,772	831
Other Operating Income	409	359	(50)
Total Income	**5,350**	**6,130**	**780**
Employee Expenses (inc. Agency)	(4,222)	(4,172)	50
Other operating expenses	(2,600)	(2,734)	(134)
Operating deficit	**(1,472)**	**(776)**	**696**
Net Finance Costs	(117)	(116)	1
Net deficit	**(1,589)**	**(893)**	**696**
Remove donated asset I&E impact	5	5	-
Adjusted financial performance	**(1,584)**	**(888)**	**696**

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 (excluding revaluation gains)



Monthly Surplus/Deficit Actual vs Plan (excluding revaluation gains)



INFORMATION

The Trust has delivered a deficit of £892,000 in April against a planned deficit of £1,584,000, £691,000 ahead of plan.

The main driver for this overperformance is the activity delivered in month. As can be seen in the income page there has been overperformance in not only elective and day case income, but also outpatients and therapies. Non pay spend was up on plan as would be expected given the increased activity. Pay costs were in line with plan although agency spend was slightly up against the cap for the month.

The CIP target for 2018/19 is £3,000,000 of which £2,984,000 has been identified. During month 1 £106,000 of saving was recognised against a plan of £167,000 and a forecast of £2,986,000. The current plan is based on 21% delivered through non pay savings, 41% through income schemes and 18% with pay schemes. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

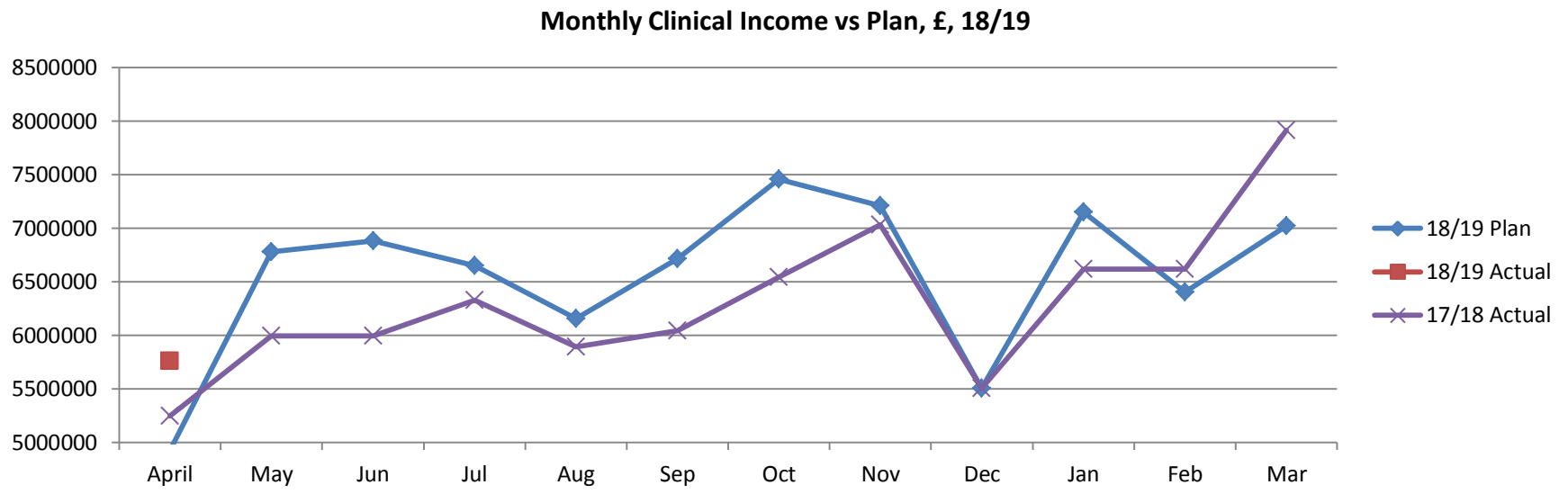
ACTIONS FOR IMPROVEMENTS / LEARNING

There needs to be focussed attention on bridging the gap on CIP schemes and if possible building in a slippage contingency to ensure the full year target is achieved.

RISKS / ISSUES

Month 2 has a challenging financial target off a surplus of c.£70k. Activity is looking relatively strong thus far in May, but this remains a challenging target.

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



Clinical Income – April 2018 £'000			
	Plan	Actual	Variance
Inpatients	2,525	2,880	355
Excess Bed Days	40	58	18
Total Inpatients	2,565	2,938	373
Day Cases	599	680	81
Outpatients	467	669	202
Critical Care	164	179	15
Therapies	161	233	72
Pass-through income	152	249	97
Other variable income	297	291	-6
Block income	521	521	0
TOTAL	4,926	5,760	834

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	2,525	2,880	355
Excess Bed Days	40	58	18
Total Inpatients	2,565	2,938	373
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Therapies	161	233	72
Pass-through income	152	249	97
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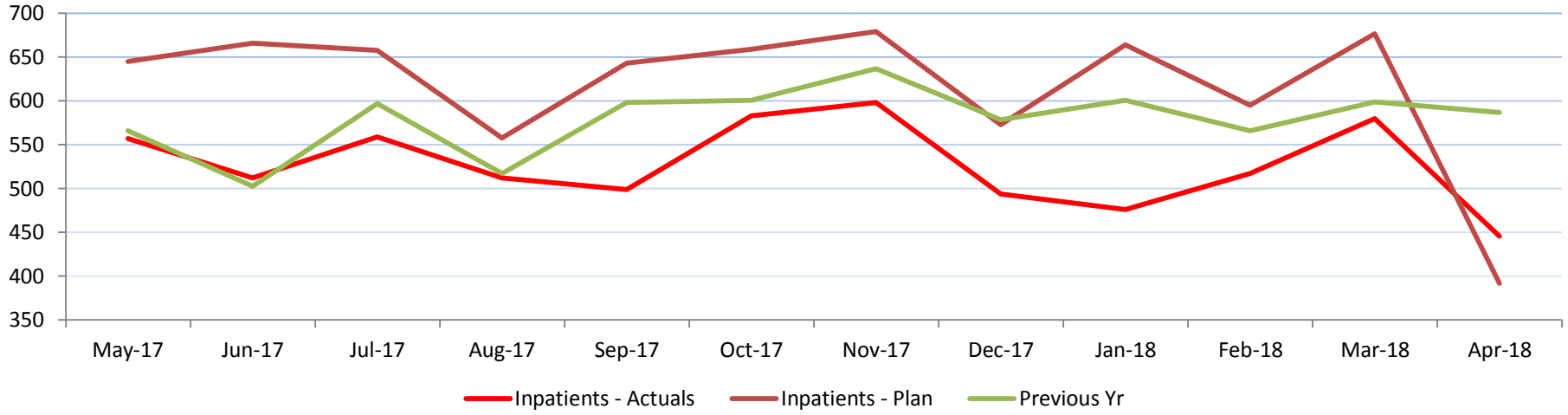
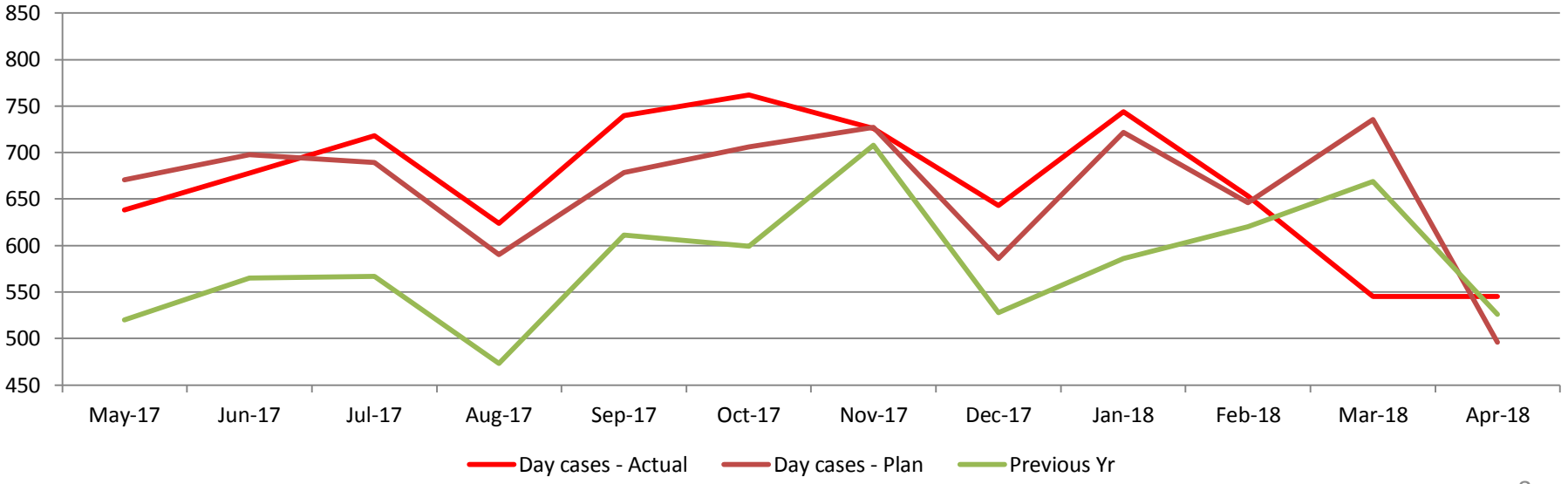
Block income	521	521	0
TOTAL	4,926	5,760	834

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income was significantly ahead of April's plan, ending the month at £834k ahead. Most income performance was stronger than expectation, with elective, day case, outpatient and therapies all showing significant over performance. The plan for the month expected clinical income to be low due particularly to the theatre closure for the first week of the month. Whilst income was low compared to a normal month, the impact of that week's shut down was lower than expectation.

In terms of activity, Elective activity delivered was 446 against a plan of 392 and day case activity was 545 against a plan of 496. Day case activity was in line with that delivered in March.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust is working operationally and financially to plan for the impact of various consultant changes within the Trust and ensure that the activity plans are delivered.

The IP activity plans have been developed in conjunction with operations, and have been split down to agreed levels by week, service, individual consultant and activity type. OP activity plans by week have also been developed with operations.

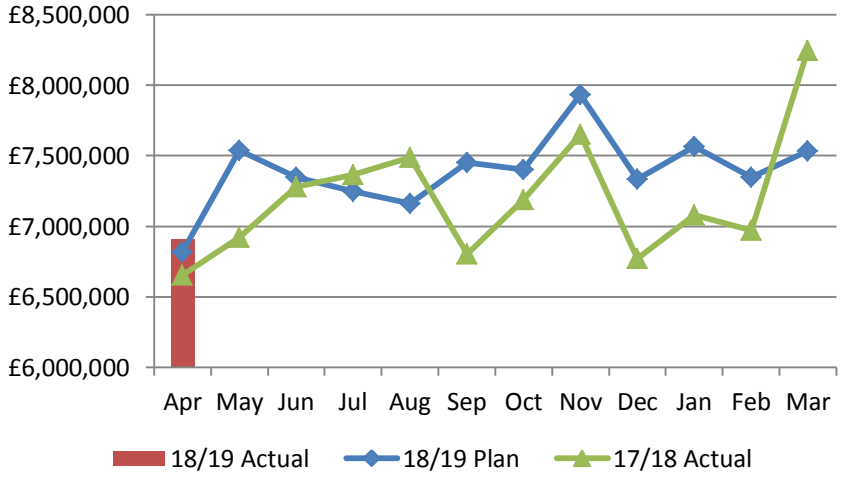
Work remains ongoing as part off Perfecting Pathways to ensure that clinicians are recording the appropriate co-morbidities of the patient's they treat, resulting in the trust being funded for the work actually performed.

RISKS / ISSUES

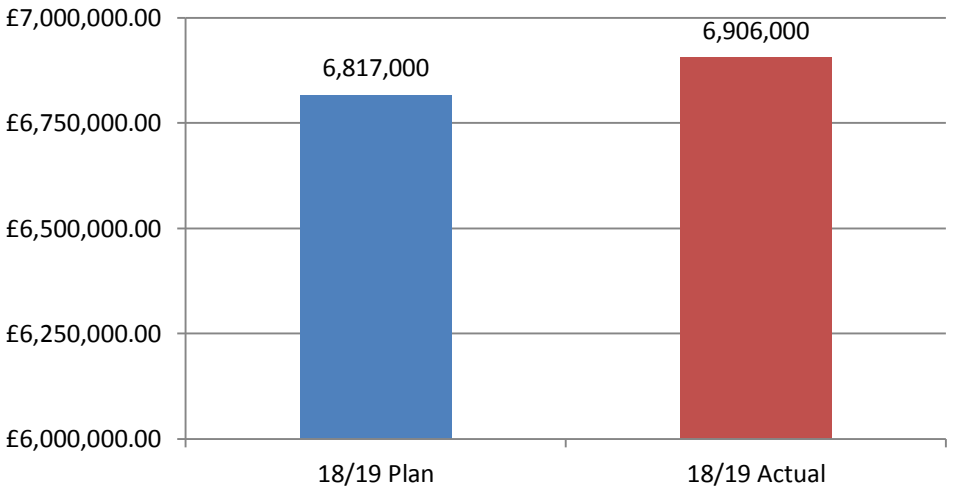
Whilst Month 1's income targets were overachieved, the trust is not being complacent. The May plan builds in some challenging targets, and it will be important to continue to aim ahead of plan throughout the year to avoid the need to deliver a recovery plan as in the previous year.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

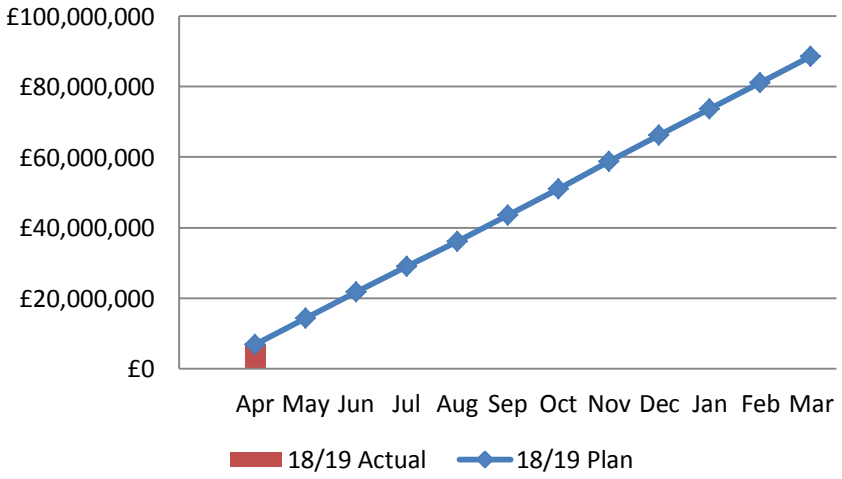
18/19 Monthly Expenditure vs Plan



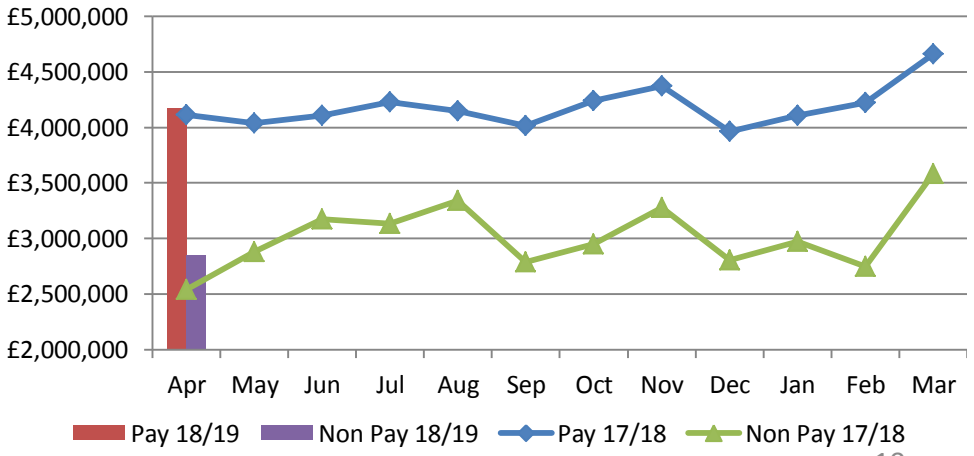
18/19 M1 Expenditure vs Plan



Cumulative Expenditure vs Plan 18/19



17/18 vs 18/19 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £6,906,000, which was slightly above plan for the month (by £84,000).

Pay spend was almost in line with plan, being £50,000 underspent, although agency spend was slightly higher than plan, as will be discussed in the following page.

Non-pay spend was greater than plan by £134,000. This is to be expected given the increase activity performed compared to plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

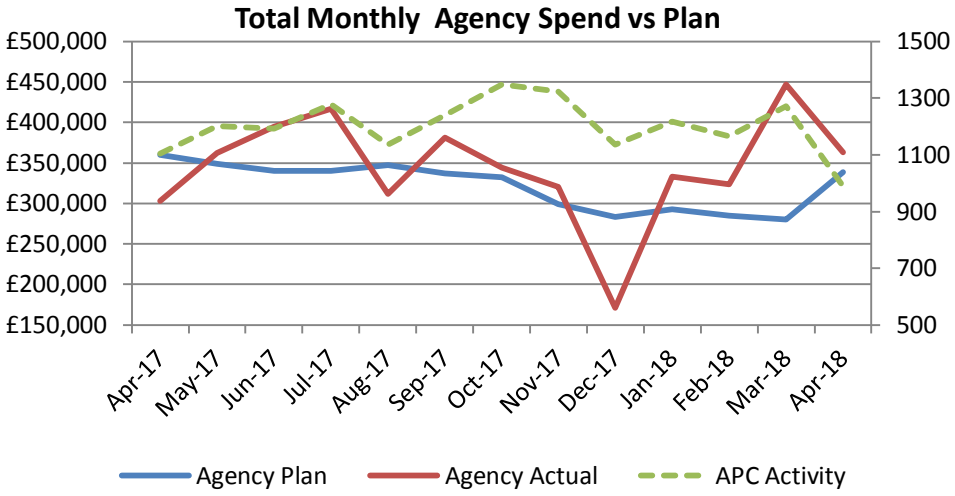
Costs will continue to be scrutinised and minimised.

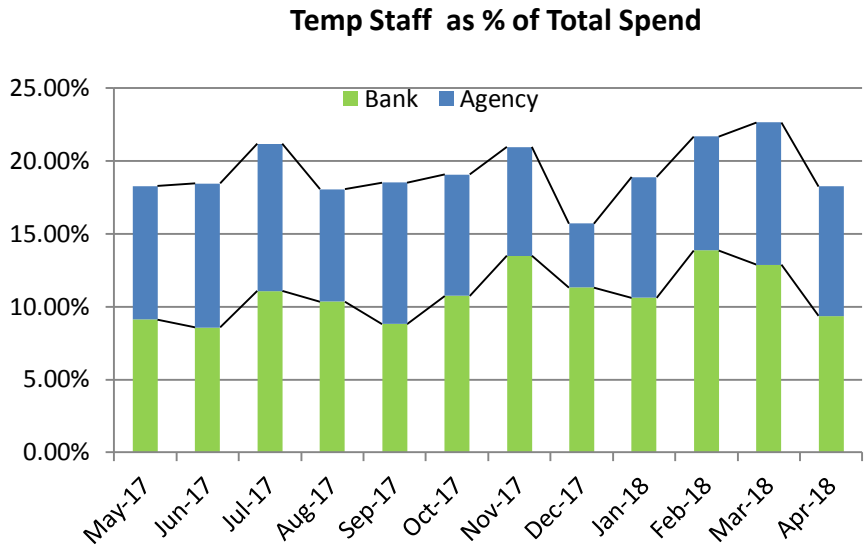
There is further learning from the year end stock count and subsequent audit which will be taken forward and acted upon within 2018-19 to give greater control over stock costs throughout the year.

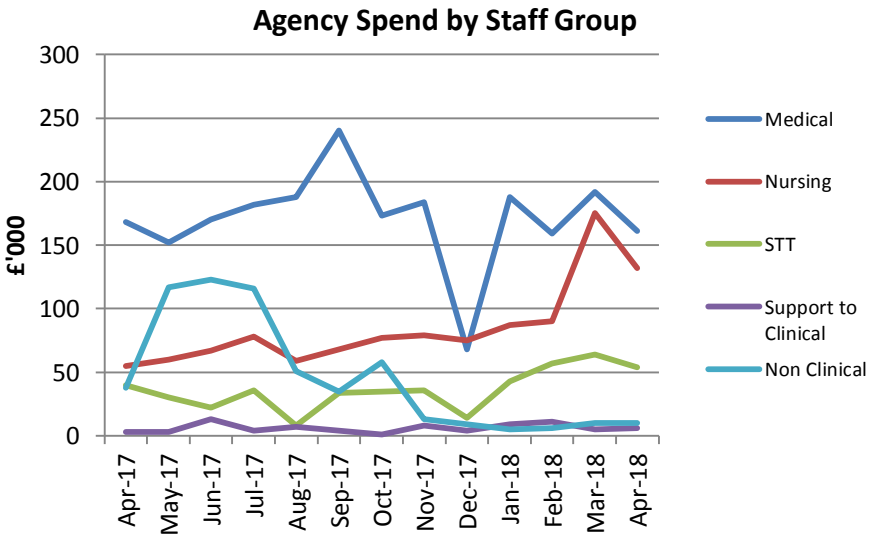
RISKS / ISSUES

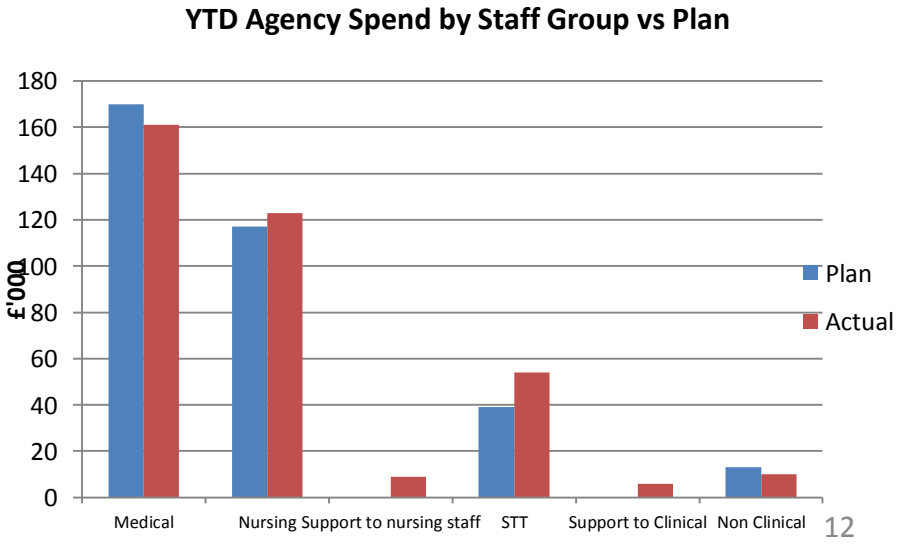
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

Agency spend has seen a reduction on March's figure of £83,0000 down to £363,000. This figure does however remain high in comparison to the average in previous months, and the agency cap was slightly overspent against in month. An analysis of the spend against plan shows that the main reasons for the overspend are agency spend in therapies, nursing and nursing support. In particular, it is relevant to note that the Trust reopened 6 beds on Ward 12 to support activity which has required additional registered nurse staffing and Ward 10 (Private Suite) has on occasions been full and required 2 Registered Nurses rather the 1 Registered Nurse allocated within the establishment.

Ward 2 saw a large proportion of HCA agency spend on 2 particular patients under a Deprivation of Liberty Safeguarding (DOLS) assessment for much of the month (this equated to in excess of 1000hrs).

Therapies are still utilising agency in order to reduce waiting times. Analysis of nursing agency suggests that in comparison to the previous 12 months, bookings to cover vacancies, specialling and acuity are all significantly higher. Absence and sickness are also drivers, but to a much lesser extent.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

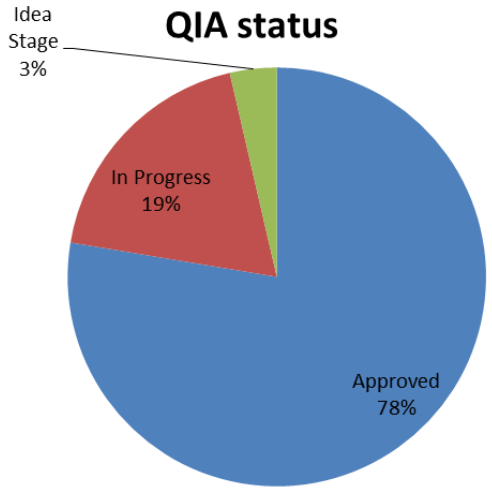
With regards to nursing agency, the Head of Nursing for Division 1 will continue to scrutinise nursing agency bookings and spend to ensure it is reasonable and appropriate. There are ongoing recruitment drives in order to lower the vacancy rate and reduce reliance on agency nursing.

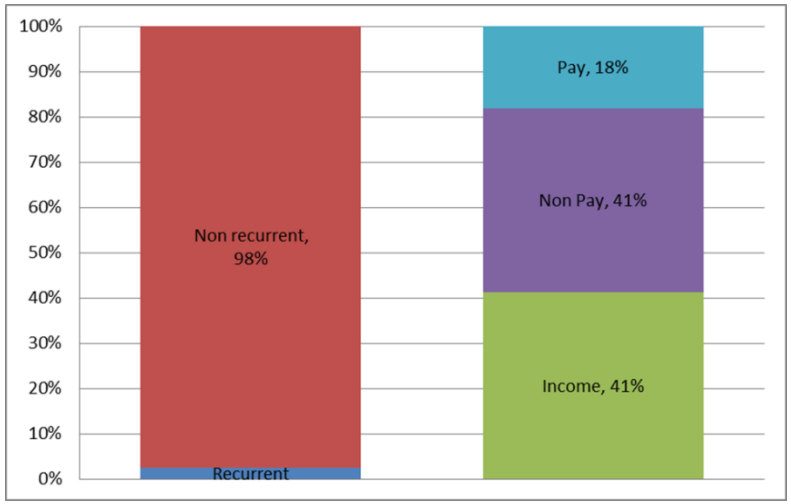
RISKS / ISSUES

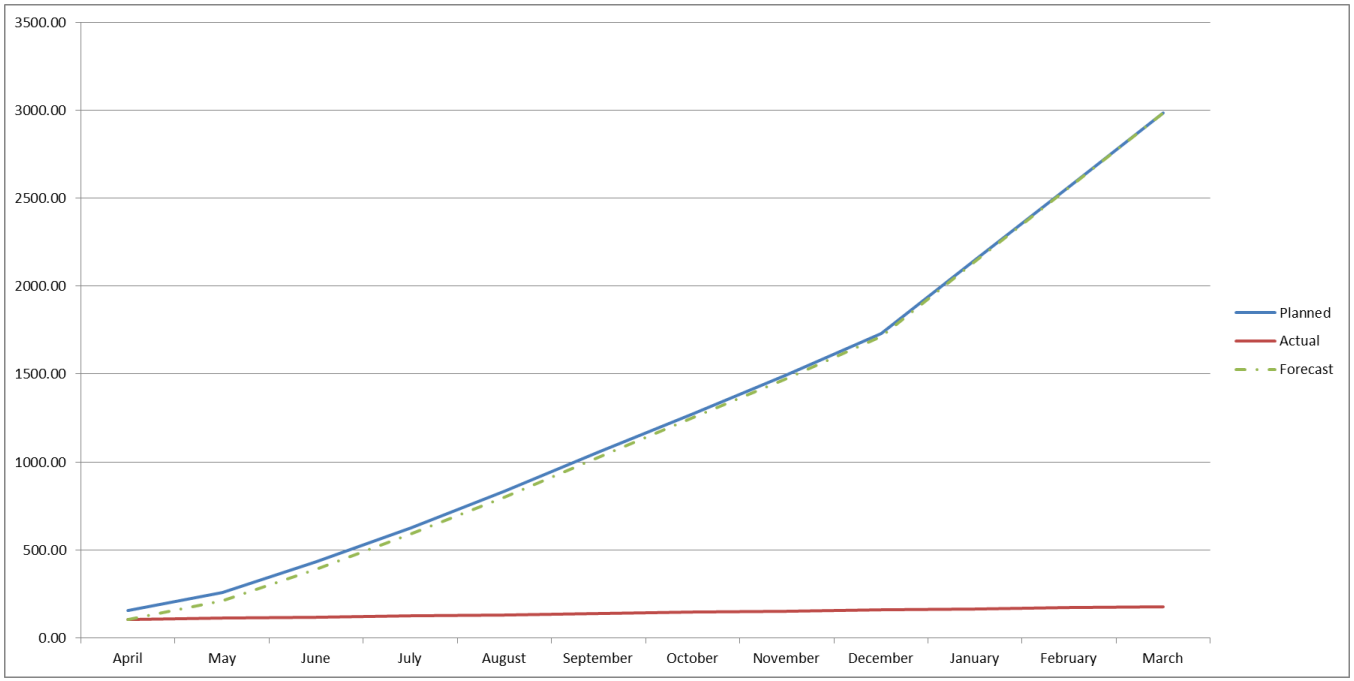
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory will have a direct impact on our regulator ratings.

Within the draft annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

5. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2018/19







INFORMATION

As at the end of April the Trust has recognised £106,000 of CIP savings, against a plan of £167,000, a negative variance of £61,000. The full year impact of these savings are £212,000 against a full year plan of £2,984,000. There is an unidentified gap of £16,000.

	Plan	Actual Full year effect	Forecast	Forecast vs Plan Variance	YTD Plan	YTD Actual	YTD Variance
Division 1	£705	£13	£705	-£1	£26	£13	-£13
Division 2	£1,125	£2	£1,126	£0	£26	£2	-£24
Division 4	£33	£33	£33	£0	£0	£0	£0
Corporate	£1,121	£164	£1,123	£2	£114	£91	-£24
TOTAL	£2,984	£212	£2,986	£2	£167	£106	-£61
Unidentified			-£16				
Shortfall			-£14				

ACTIONS FOR IMPROVEMENTS / LEARNING

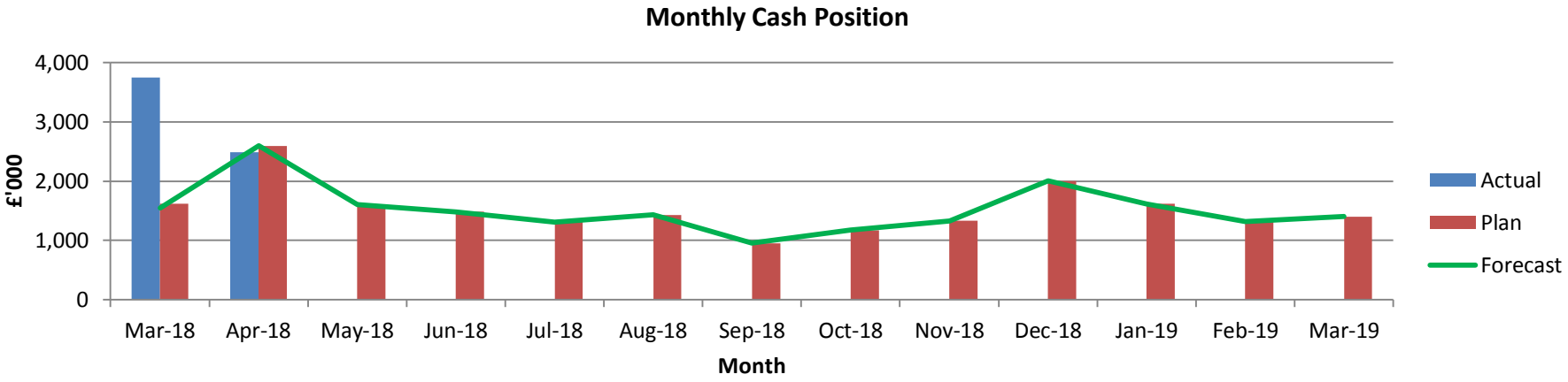
A CIP Programme Board chaired by the Interim Director of Finance commenced on 19th April and will be held monthly during Q1 with the frequency to be reviewed after this. The purpose of this group will be to monitor performance and escalate any risks/issues.

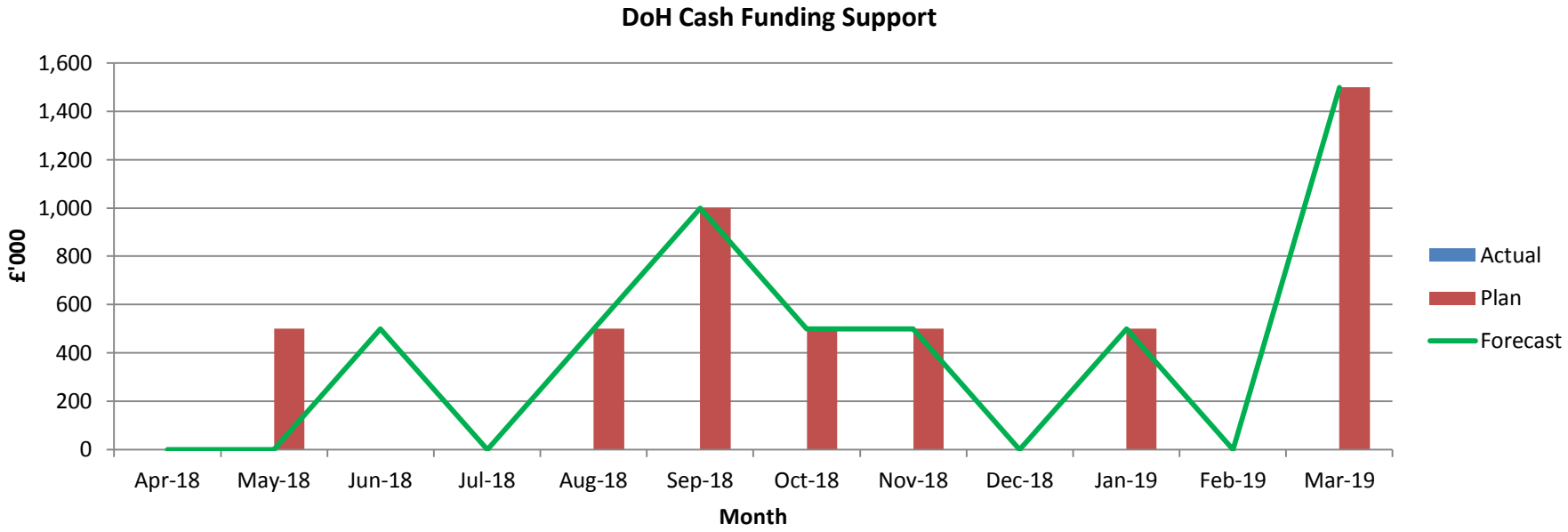
During 2017/18 the in year unidentified gap was not recovered, and as such significant work has been done to ensure full plans have been developed for 2018/19.

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the Managed Service Contract for Theatres scheme which is expected to deliver £550,000 from January 2019. A project group has been established and project specific resources are currently being identified to ensure that timescales can be met.

6. 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

At the end of March 18 the Trust had DHSC borrowings of £3,979k, and plans to receive another c.£5,000k within the financial year to support its deficit plan. The current expected timing for the next loan element is forecast as June, but this is because the trust have been instructed by the DHSC to exclude expected STF payments from its forecasting. If that funding is received in a timely manner, the need to borrow further will be delayed.

ACTIONS FOR IMPROVEMENTS / LEARNING

The finance team continue to run a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team in order to scrutinise both the current and future cash position, but also to identify areas for cash control improvement. The committee continues to review cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the DHSC to be actioned.

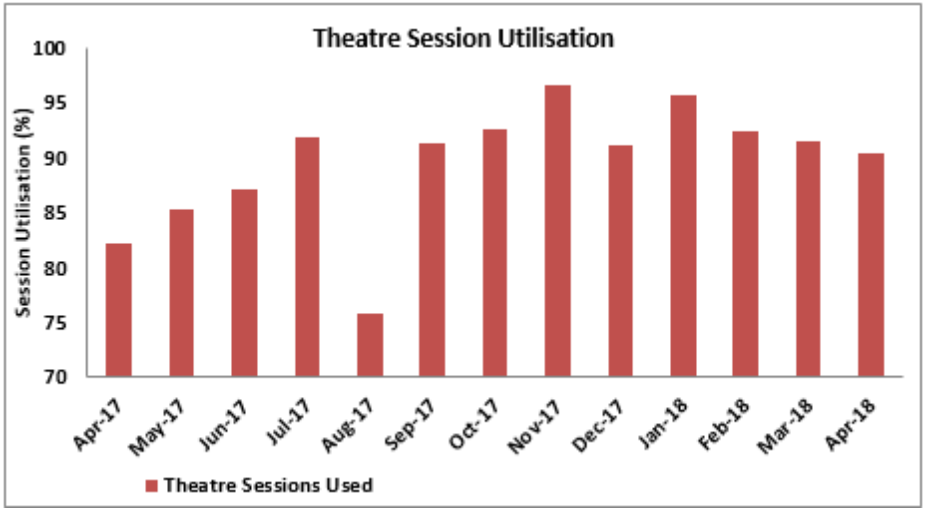
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DHSC not approving a cash loan or approving a lower than requested amount.

7. 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

Theatre list utilisation for April 2018 was 90.43%.

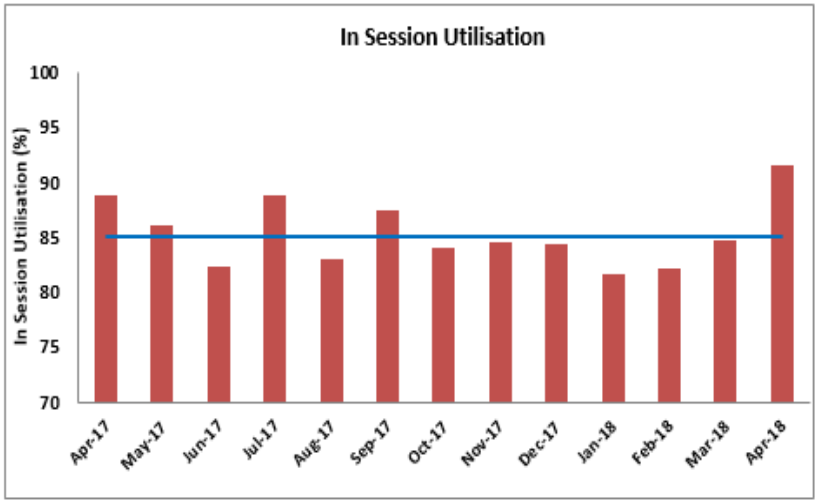
The last 12 months have seen significant improvements in theatre utilisation when compared to April 2017. This has been as a result of improved usage of fallow lists and the introduction of the weekly 6-4-2 meeting.

Input and support from Stryker Business Solutions, in better improving flows both outside and inside theatres will give us the potential to achieve higher list utilisation rates for the coming year.

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc. will also need to 'grow' alongside theatres to ensure maximum efficiency gains.
- Equipment – not enough power tools etc to keep up with increased activity/demand.

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



INFORMATION

Whilst sessional utilisation has remained strong, the average in session utilisation has struggled to reach the 85% over the last 6 months, although the average for the year is 84.8%. We are reviewing the correlation between the two measures.

Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 91.61% in April up on the previous month (84.65%)

April saw the highest level of session utilisation in recent months, despite the theatre maintenance shutdown. This was due to an increase in activity over the 3 weeks where theatres were fully operational, especially in day cases which allowed for a quicker turnover of lists.

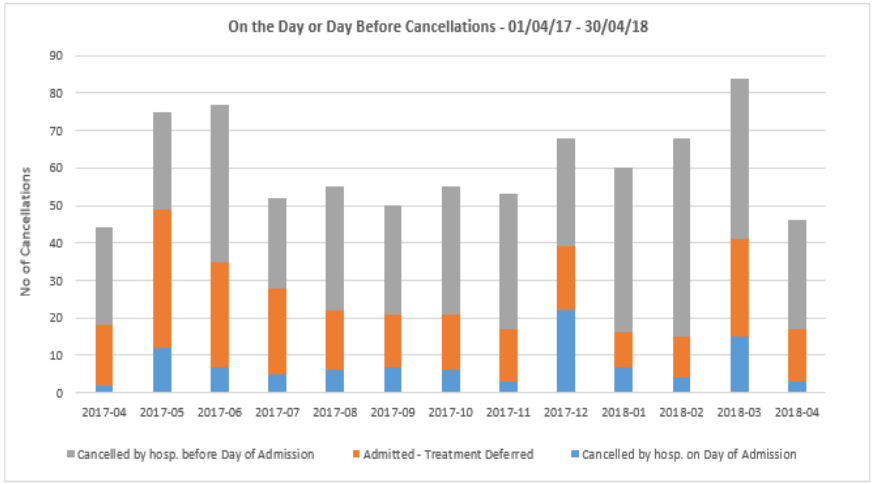
Locking down of lists a week before to ensure robust planning for the week ahead, will allow the ability to 'trouble shoot' logistical issues to ensure better efficiency and reduce 'down time' during the day.

RISKS / ISSUES

- Last minute changes to lists impact on the efficient running and planning of theatre lists which inevitability cause delays.

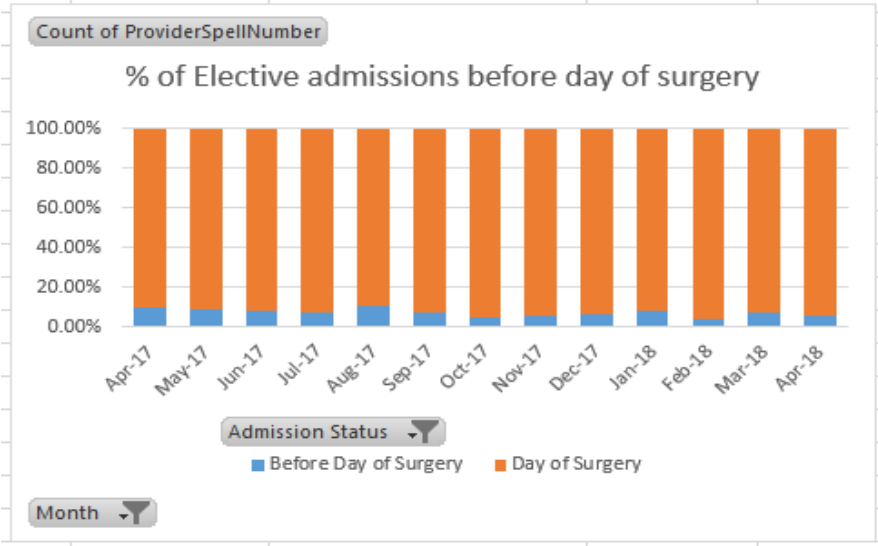
9. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

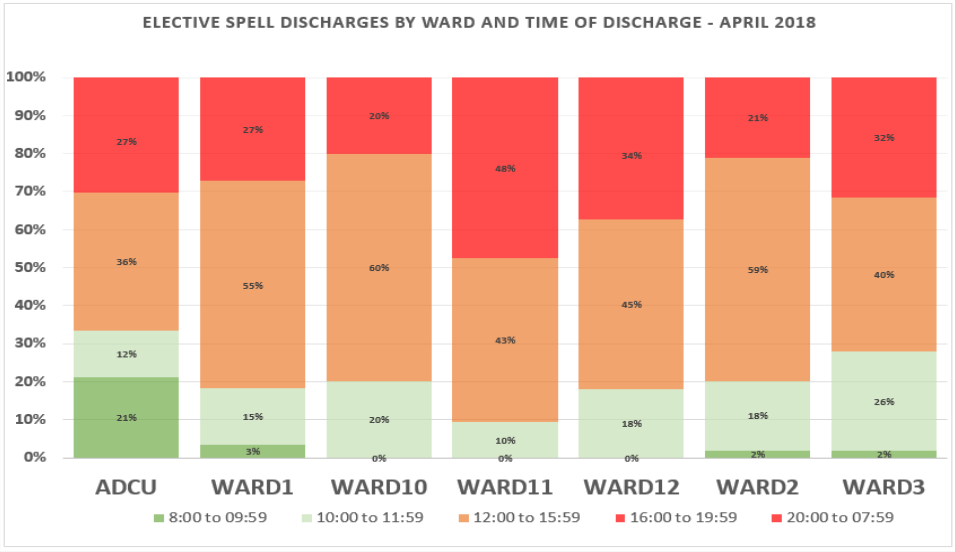
Hospital Cancellations



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	28	42	77	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
2018-04	3	14	29	46	0
Grand Total	99	240	448	787	10

Admission the day before surgery





INFORMATION

The number of cancellations on the day of surgery by the hospital has decreased in month. An analysis of the 17 patients cancelled on the day of admission highlighted the reasons for cancellation varied across a range of issues , key themes identified were : ran out of theatre time , emergency patients taking priority and availability of equipment . In addition, patients cancelled due to medication issues was also identified as a contributing factor to cancellations on the day.

Cancellations before the day of surgery have also reduced in month. An analysis of the 29 patients cancelled by the hospital before admission highlighted two main factors for cancellations prior to surgery : patients being offered earlier dates for surgery and patients being deferred to accommodate emergencies.

A weekly analysis of cancellations continues with representation from the Clinicians, Theatres and Clinical Service managers. Trends are analysed and interventions delivered to reduce cancellations. Work continues to strengthen the POAC process . The pathway model and clinical protocols are currently being finalised with the associated workforce model and will be presented at the Audit Meeting on 31st of May for wider Clinical engagement and sign off .

ACTIONS FOR IMPROVEMENTS / LEARNING

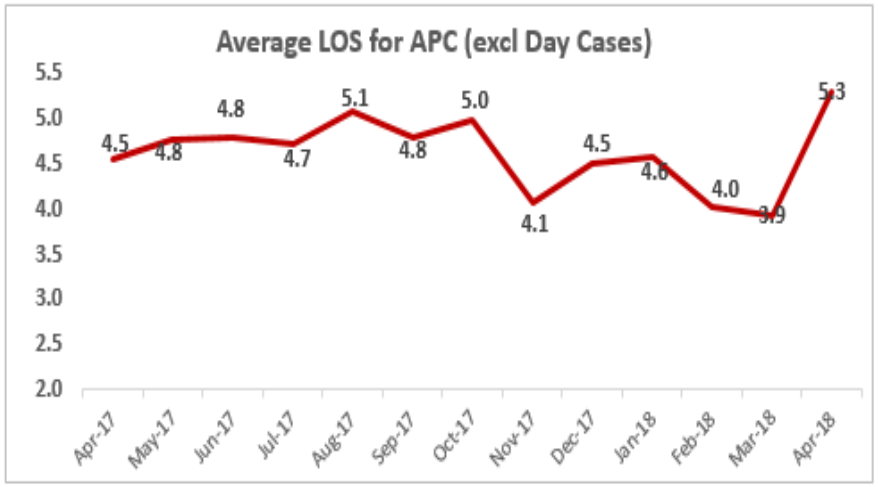
A daily update review by the Operational management team of forward bookings has been established, as well as the 6-4-2 weekly meeting. The operations 'Huddle ' is now embedded in practice, with learning shared at weekly Operational meetings across divisions .
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

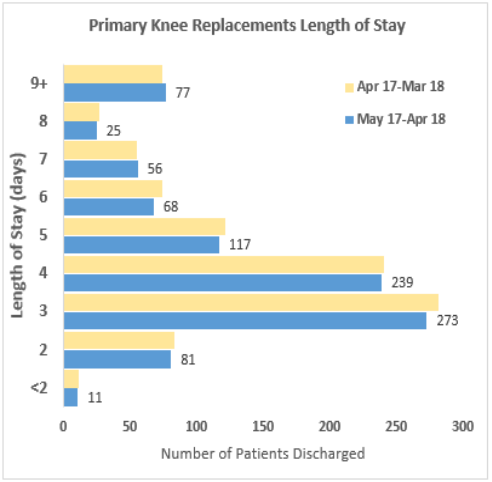
- Refresher training to support improved accuracy of data inputting on the PAS system to inform actions and allow robust audit of cancellation reasons.
- Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation . The launch of the Stryker project commences on 24th May 2018.
- 72 hour Patient call proforma has been redesigned following clinical input to improve the information discussed with the patient at 72 hours , to further reduce cancellations on the day.
- Roll out of replacement theatre equipment has commenced to reduce issues relating to equipment availability.

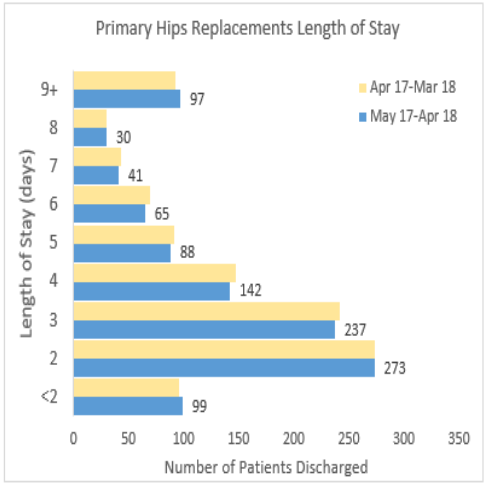
RISKS / ISSUES

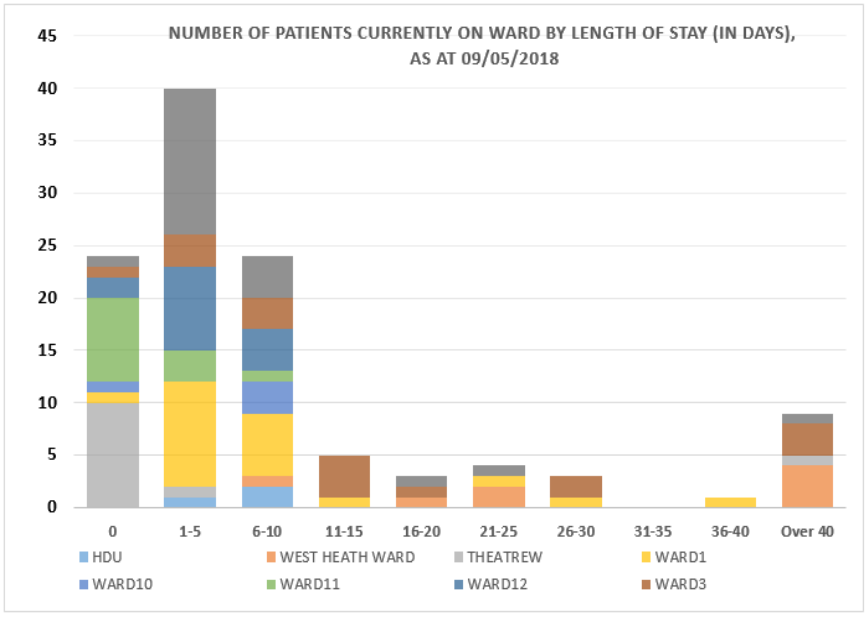
Shorter turn around times for pre –operative assessment are required to respond flexibly to increased levels of activity.

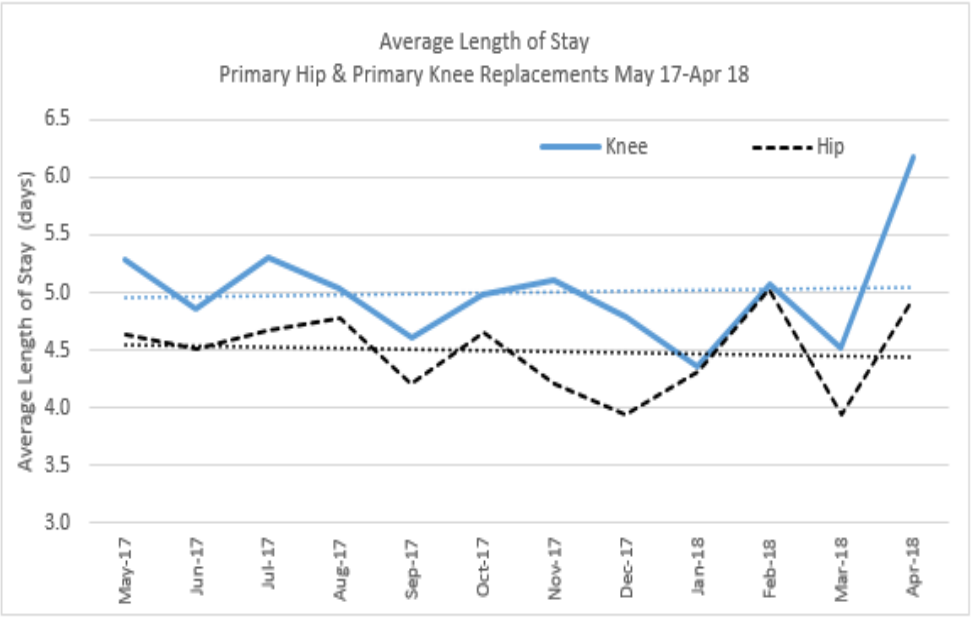
10. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Activity levels continue to increase in line with the local delivery plan . In April there has been an increase on LOS in month .
On analysis of this data the median length of stay is 3 days however this month increases in LOS were seen in Spinal and Oncology services with a number of complex patients.
Initiatives to continue to improve LOS are as follows:

- Red2Green is now launched on all wards Monday to Friday. Discharges are now identified the day before discharge and on day of discharge the ward staff work closely with the discharge team to ensure timely discharge . A weekly ward meeting is now in place with ward managers and the discharge team to raise and resolve issues relating to discharge and deliver continuous improvements in the process.
- 'PJ paralysis challenge' is underway led by Christian Ward (Head of Nursing for Div 1). All wards are fully engaged with this challenge. Early indications suggest that particular benefit has been gained on ward 12 and ward 2, where patients now have very clear mutually agreed LOS expectations . However all wards are actively participating in the challenge and collating data to support this national initiative .
- 'Passport to Home 'patient information has now been agreed and is currently being rolled out on all wards . This includes a patient/ROH agreement regarding Estimated Date of Discharge (EDD), provision of patients own clothes and transport arrangements..
- Gold/Silver concept is now reinforced on all wards to support the improvement in the flow of patients and maximise utilisation of the discharge lounge. Gold/ Silver patients are also now being identified on Saturday / Sunday by the sight co-ordinator to highlight patients ready for discharge, ensuring patient flow is maintained over weekends .
- Daily Operational bed meetings are now embedded to escalate any delays for social care , inter-hospital transfer and expedite appropriate discharges .

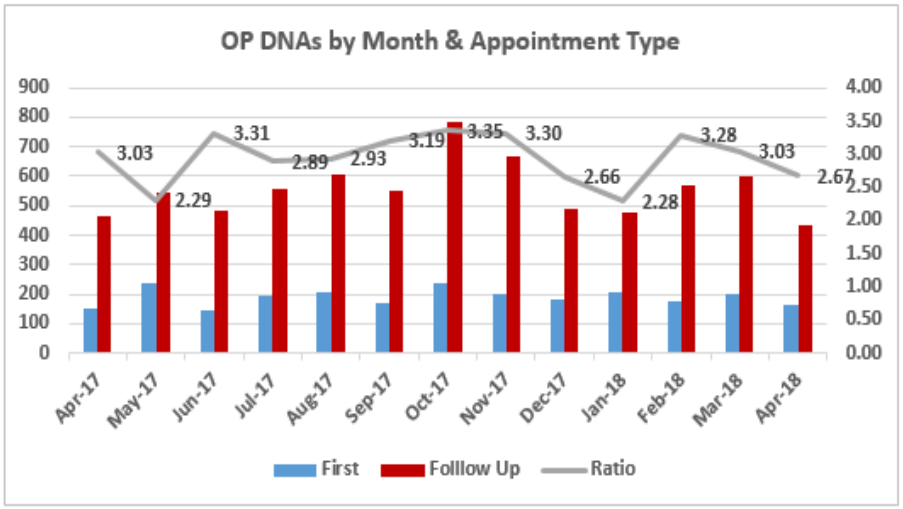
ACTIONS FOR IMPROVEMENTS / LEARNING

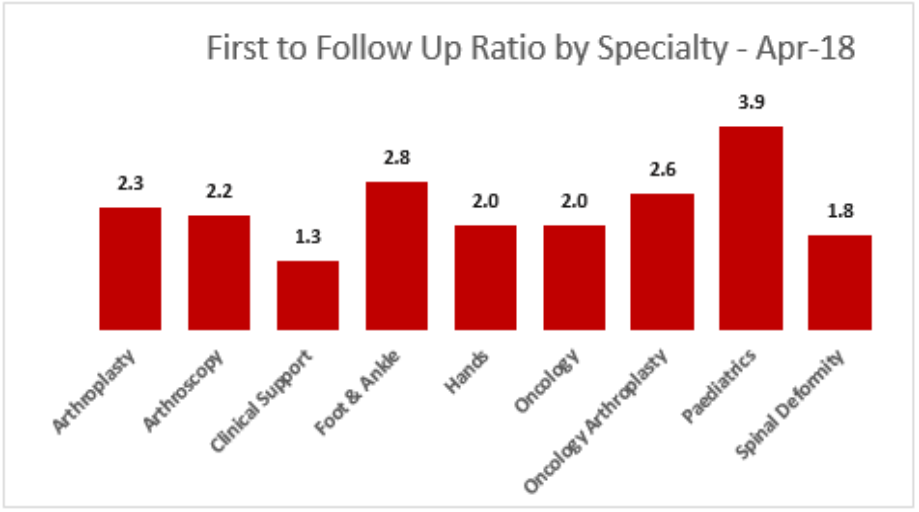
- The Red2Green dashboard development is now launched across all wards . (This will provide average length of stay data for each ward, together with the top 10 reasons for any discharge delays.) The dash board also records how many Green or Red days were recorded on the wards. This provides a continual focus on reducing LOS.
- Consultant led ward rounds are now being rolled out across all wards so that all patients are reviewed to support timely discharge . Further work continues to develop with the Arthroplasty team which includes scoping to include anaesthetic support for ward rounds and the feasibility around a dedicated Theatre environment . This work has been progressed in the clinical pathway group as part of the theatre expansion and redesign project to inform improved flow in theatres .

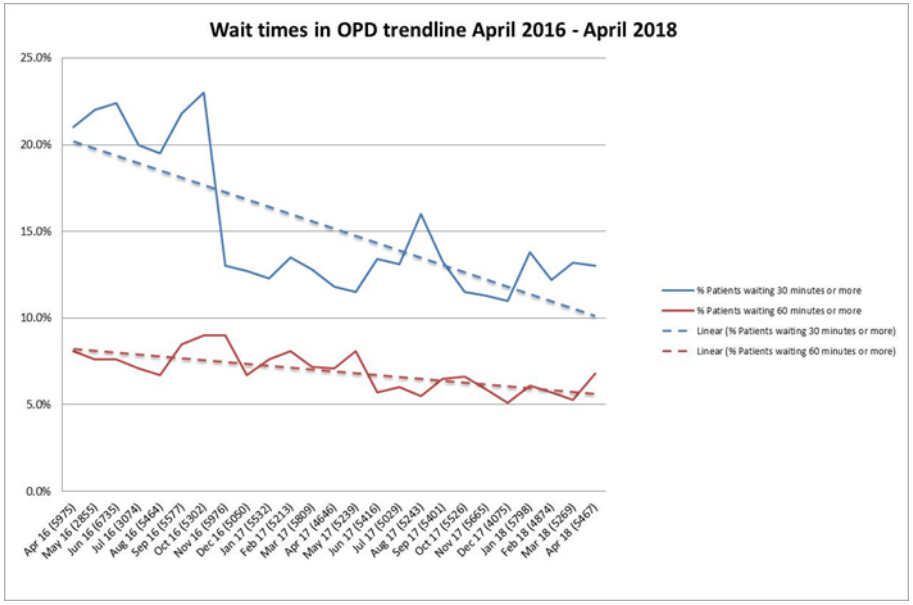
RISKS / ISSUES

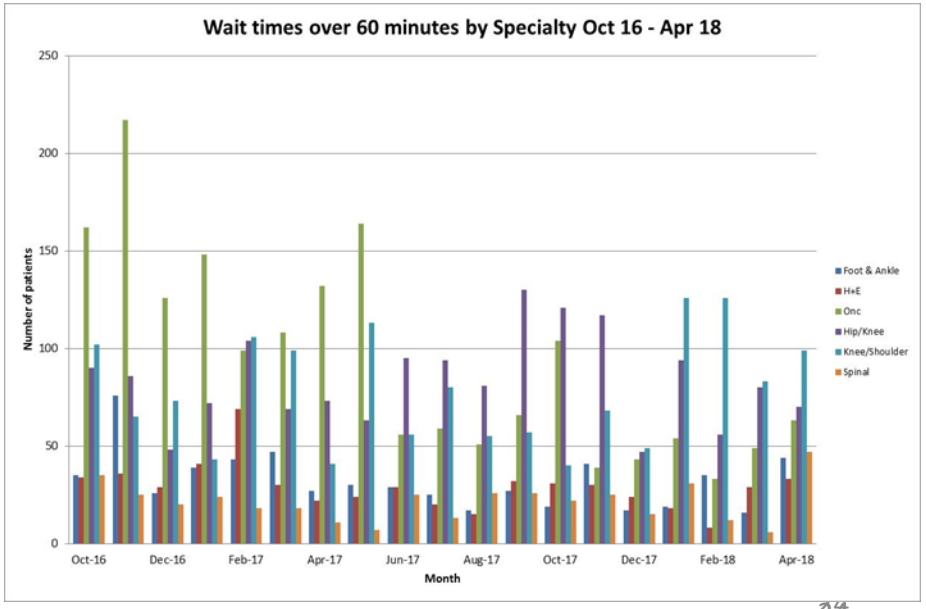
A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity . A full bed modelling exercise will therefore inform the future capacity required to deliver activity to support the wider STP orthopaedic alliance .

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









INFORMATION

In April there were 14 incident forms completed to highlight clinics running more than 60 minutes late.
There were 13.0% of patients waiting over 30 minutes and 6.8% waiting over 1 hour. The over 30 minute waits have improved slightly from the previous month but the over 60 minute wait position has deteriorated. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month.

The monthly audit identified the following : -

- 6 - Complex patients
- 3 - Clinic overbooked
- 2 - Consultant/Clinician Delay
- 3 – Other

All incidents continue to be sent to the relevant operational managers to investigate each one. A record of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause, is being shared with the Ops team at the weekly Operational Management Team meeting. Work is underway to develop a report that will help analyse how clinics ran and where delays were experienced. This is a manual process now, but when the InTouch system is upgraded there will be an opportunity to develop better reporting functionality. Capacity issues continue to negatively impact clinic waiting times – full capacity modelling for outpatient clinics and inpatients across all specialties is to be undertaken. Additional funding is to be requested via a business case to increase the qualified and unqualified nursing establishment within both main and paediatric outpatients to support any required increase in capacity.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Continue to drive incident investigations and action through relevant operational manager
- Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays
- Electronic clinic rescheduling form has been completed and is being trialled in Hands. Next steps to roll this out to the rest of the Trust
- Review of SOP in relation to clinic rescheduling following learning from aforementioned pilot of clinic rescheduling form
- Development of clinic utilisation tools through InTouch and Health Informatics
- Full capacity and demand analysis for all specialties

RISKS / ISSUES

Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. This will be addressed as part of the electronic clinic rescheduling form project

InTouch upgrade has not yet begun due to limited IT and project management resources. These are currently being reviewed and will be discussed at the IM&T project board

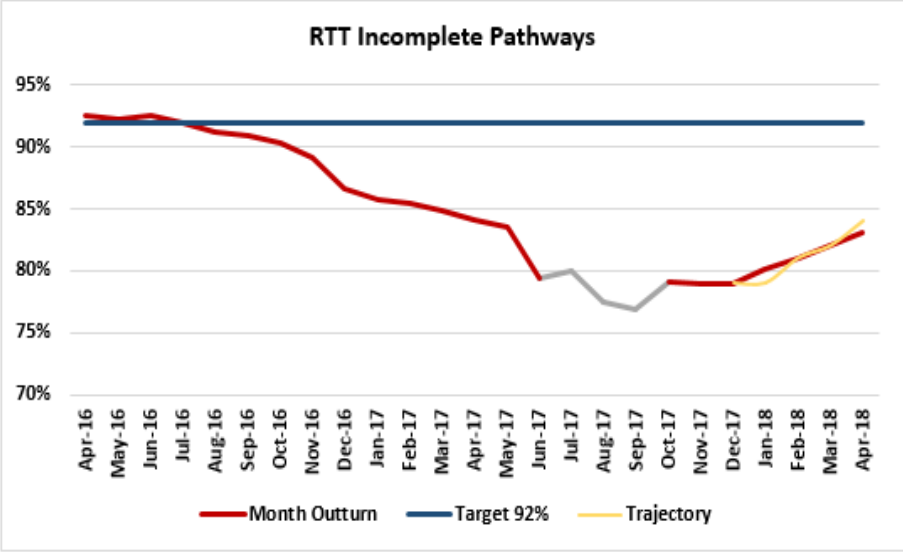
12. Treatment targets – This illustrates how the Trust is performing against national treatment target –

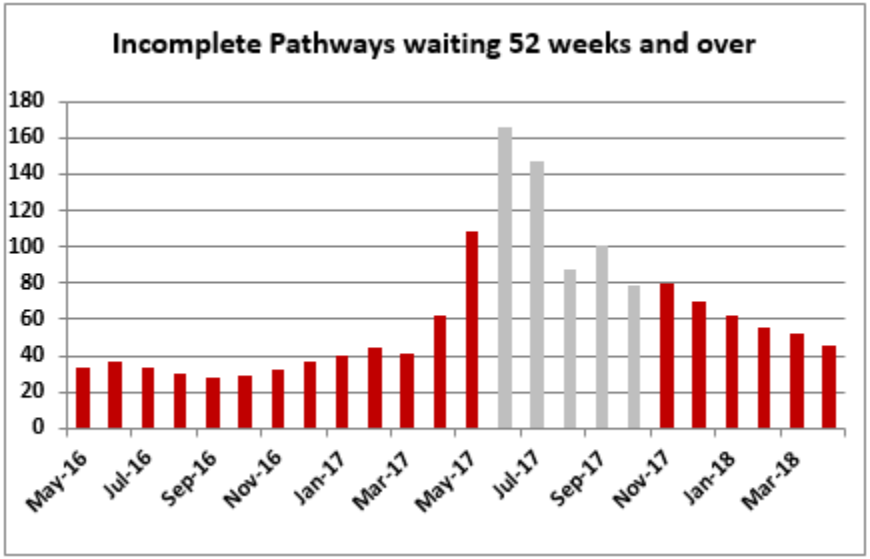
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%
Apr-18	1,022	148	409	1,579	850	253	387	1,490	8	1,571	1,579	99.5%

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



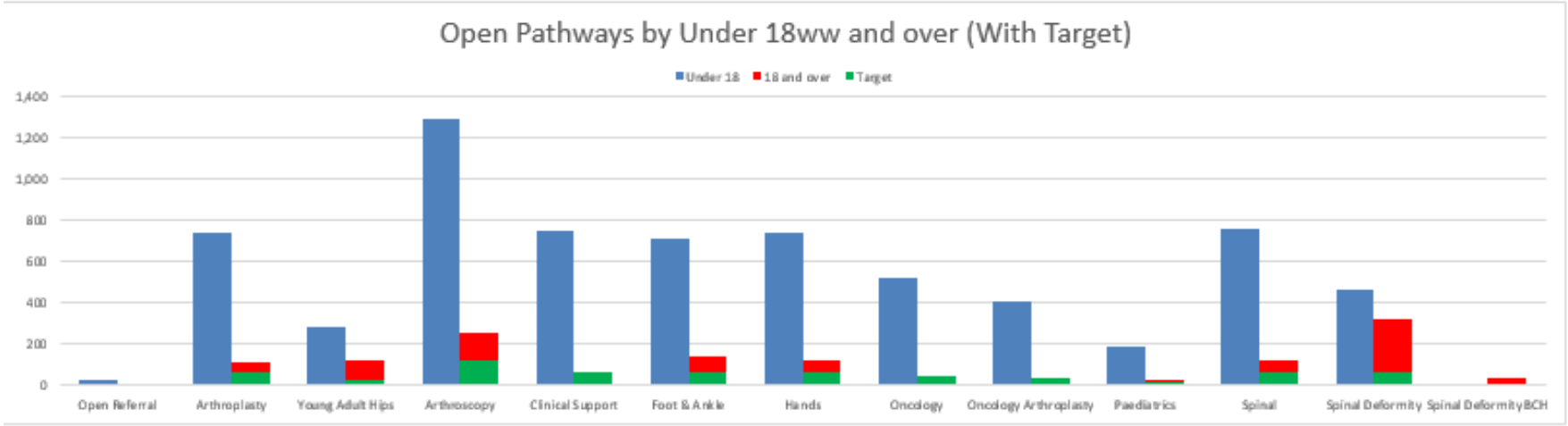


		Indicative	Reported Month						Reported Quarter 2017/18					
Target Name	National Standard	Apr 18	Mar 18	Feb 18	Jan-18	Dec-17	Nov-17	Oct-17	Q3 (Oct, Nov, Dec)	Breach	Total	Q2 (July, August, Sept)	Breach	Total
2ww	93%	98%	94.4%	100%	97.10%	100%	100%	95%	98.30%	2	119	99.20%	1	120
31 day first treatment	96%	100%	90%	88.9%	91.67%	100%	91.70%	100%	96.30%	1	27	96.60%	1	29
31 day subsequent (surgery)	94%	90%	100%	100%	94.10%	100%	100%	100%	100.00%		30	97.40%	1	38
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
62 day (traditional)	85%	87.5%	71.4%	87.5%	86.67%	83.30%	83.30%	100%	82.40%	1.5	7	72.20%	2.5	9
62 day (Cons Upgrade)	n/a	100%	72.7%	80%	100%	90.90%	90.90%	81%	82.10%	2.5	14	88.90%	1	9
31 day rare (test, ac leuk, child)	n/a		0%		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	0	0						

14. Referral to Treatment snapshot as at 30th of April 2018 (Combined)

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,630**	15	345	110	742	455	368	390	293	222	105	365	217	3
7-13	**2,504**	8	300	123	400	248	274	270	179	154	65	292	184	7
14-17	**762**	2	101	49	147	47	73	78	49	35	18	100	61	2
18-26	**864**	0	73	81	185	38	107	90	22	25	18	86	132	7
27-39	**377**	1	36	34	64	23	30	27	5	8	8	34	103	4
40-47	**82**	0	5	9	6	3	3	4	0	1	1	0	44	6
48-51	**29**	0	0	1	1	0	1	1	1	0	0	0	23	1
52 weeks and over	**46**	0	0	0	0	0	0	0	0	1	0	2	22	21
Total	**8,294**	26	860	407	1,545	814	856	860	549	446	215	879	786	51

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**6,896**	25	746	282	1,289	750	715	738	521	411	188	757	462	12
18 and over	**1,398**	1	114	125	256	64	141	122	28	35	27	122	324	39
Target	**664**	**2**	**69**	**33**	**124**	**65**	**68**	**69**	**44**	**36**	**17**	**70**	**63**	**4**
	83.14%	**96.15%**	**86.74%**	**69.29%**	**83.43%**	**92.14%**	**83.53%**	**85.81%**	**94.90%**	**92.15%**	**87.44%**	**86.12%**	**58.78%**	**23.53%**



*2 patients showing over 52week in Spinal Surgery are Spinal Deformity

15. Referral to Treatment snapshot as at 30th of April 2018

Select Pathway T Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**1,040**	0	138	35	226	55	57	138	84	75	40	130	60	2
7-13	**776**	0	146	41	165	31	17	81	65	77	28	87	33	5
14-17	**268**	1	63	15	69	8	4	26	14	15	8	31	12	2
18-26	**360**	0	43	24	124	8	28	31	15	17	8	35	20	7
27-39	**163**	0	20	17	45	6	8	12	5	5	5	11	25	4
40-47	**45**	0	4	8	2	0	2	2	0	1	1	0	19	6
48-51	**19**	0	0	0	1	0	0	1	0	0	0	0	16	1
52 weeks and over	**41**	0	0	0	0	0	0	0	0	1	0	2	17	21
Total	**2,712**	1	414	140	632	108	116	291	183	191	90	296	202	48

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**2,084**	1	347	91	460	94	78	245	163	167	76	248	105	9
18 and over	**628**	0	67	49	172	14	38	46	20	24	14	48	97	39
Target	**217**	**0**	**33**	**11**	**51**	**9**	**9**	**23**	**15**	**15**	**7**	**24**	**16**	**4**
	76.84%	**100.00%**	**83.82%**	**65.00%**	**72.78%**	**87.04%**	**67.24%**	**84.19%**	**89.07%**	**87.43%**	**84.44%**	**83.78%**	**51.98%**	**18.75%**

Select Pathway T Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,590**	15	207	75	516	400	311	252	209	147	65	235	157	1
7-13	**1,728**	8	154	82	235	217	257	189	114	77	37	205	151	2
14-17	**494**	1	38	34	78	39	69	52	35	20	10	69	49	0
18-26	**504**	0	30	57	61	30	79	59	7	8	10	51	112	0
27-39	**214**	1	16	17	19	17	22	15	0	3	3	23	78	0
40-47	**37**	0	1	1	4	3	1	2	0	0	0	0	25	0
48-51	**10**	0	0	1	0	0	1	0	1	0	0	0	7	0
52 weeks and over	**5**	0	0	0	0	0	0	0	0	0	0	0	5	0
Total	**5,582**	25	446	267	913	706	740	569	366	255	125	583	584	3

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**4,812**	24	399	191	829	656	637	493	358	244	112	509	357	3
18 and over	**770**	1	47	76	84	50	103	76	8	11	13	74	227	0
Target	**447**	**2**	**36**	**21**	**73**	**56**	**59**	**46**	**29**	**20**	**10**	**47**	**47**	**0**
	86.21%	**96.00%**	**89.46%**	**71.54%**	**90.80%**	**92.92%**	**86.08%**	**86.64%**	**97.81%**	**95.69%**	**89.60%**	**87.31%**	**61.13%**	**100.00%**

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For April 2018 the RTT trajectory was 84% with performance at **83.14%** , with 46 patients over 52weeks (trajectory 75). The performance reflects the lack of activity through Theatres as part of the 1 week planned closure for maintenance. In month, Clinical Support met the 92% target ahead of its September 2018 trajectory

A benign Oncology Arthroplasty patient is showing over 52 in this month's position- the patient has surgery booked for 24th May 2018. This was picked up as part of the weekly RTT tracking meeting as an incorrect clock start. The tertiary referral date was not recorded correctly- the date received not original referral date was entered into PAS). They will be discussed at the next harm review meeting as part of the embedded process in place.

ACTIONS FOR IMPROVEMENTS / LEARNING

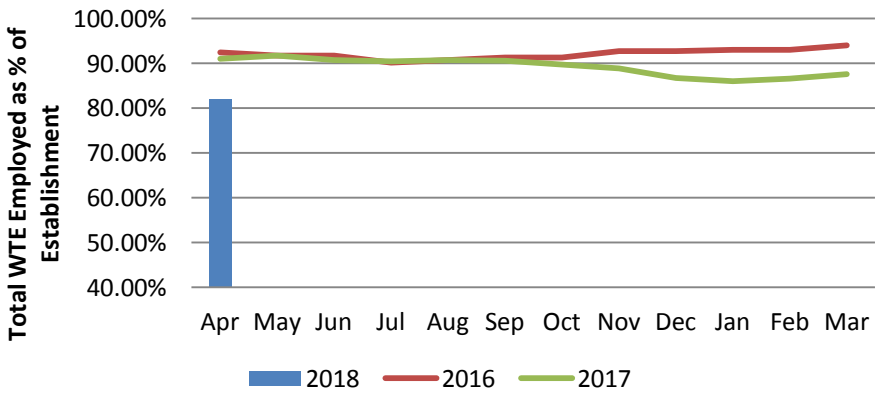
The team continue to concentrated on any patients over 40 weeks, this number continues to reduce. At the end of December 2018 we had 238 patients over 40 weeks, at the end of April 2018 this figure is now 157, 119 of which are Spinal Deformity. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.

RISKS / ISSUES

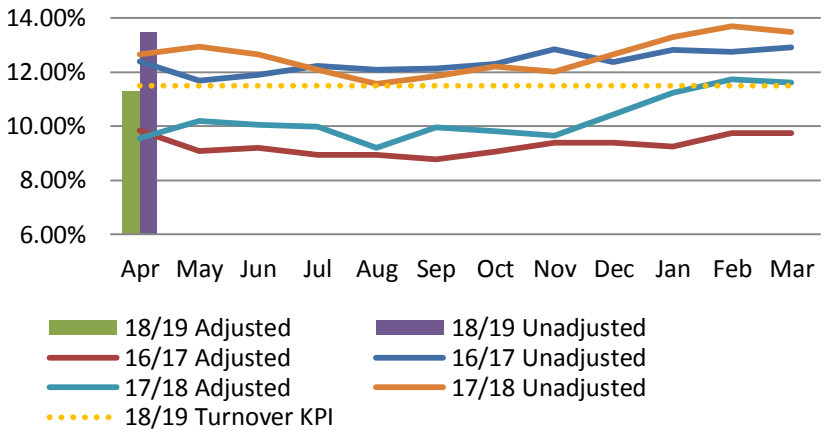
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance.
Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity continues through the Summer. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families.

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

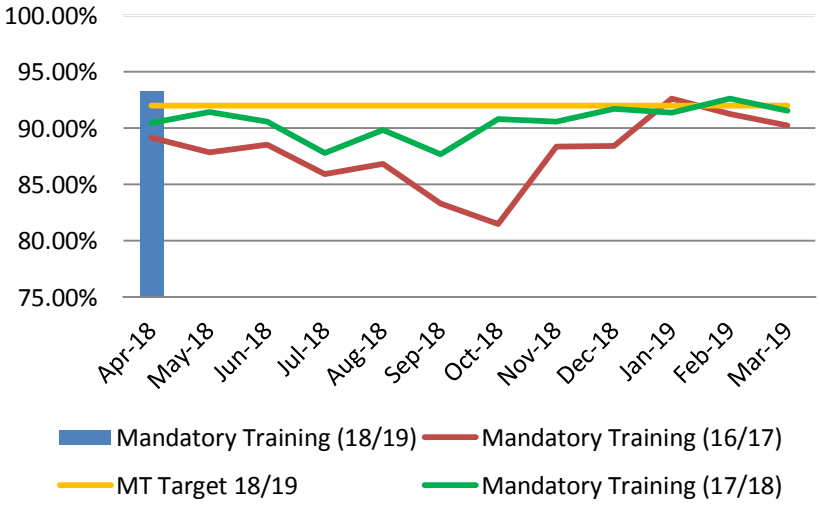
Staff in Post v Establishment



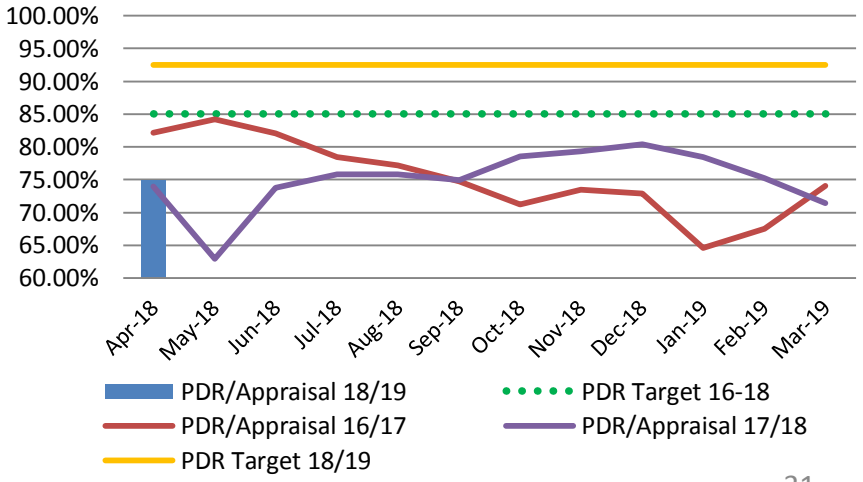
Staff Turnover



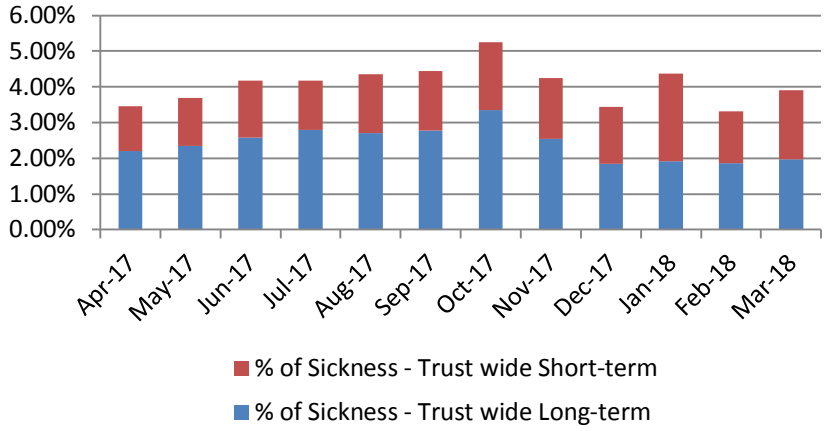
Mandatory Training



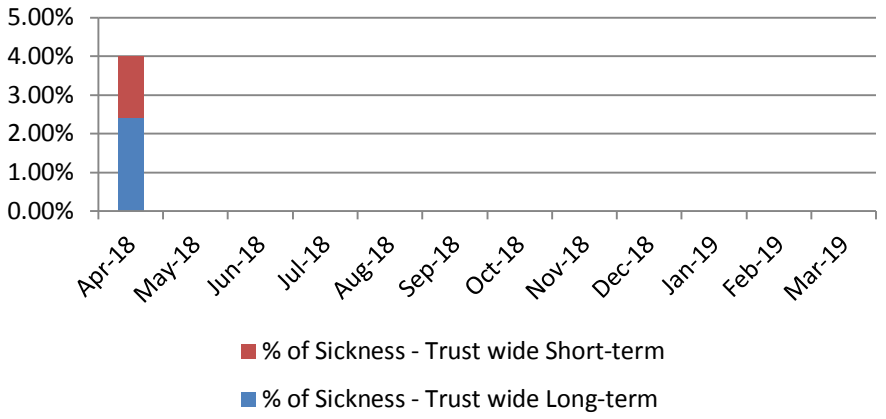
PDR/Appraisal



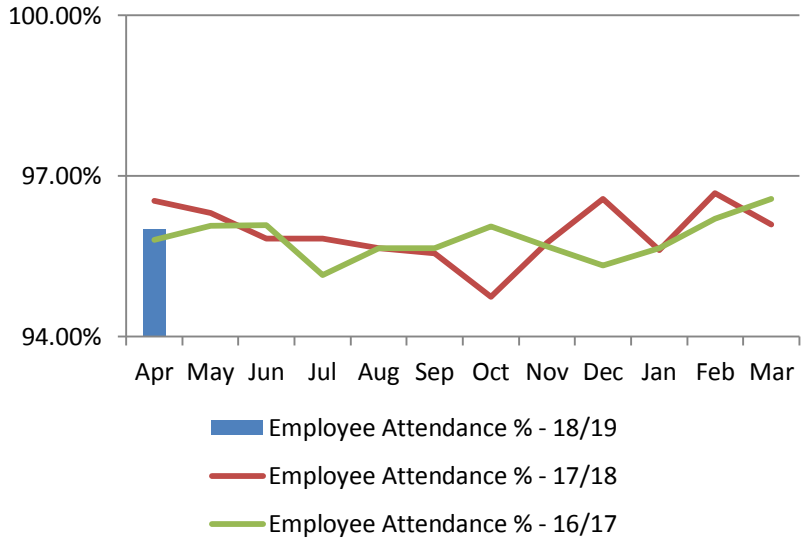
Sickness % - LT/ST (2017/18)



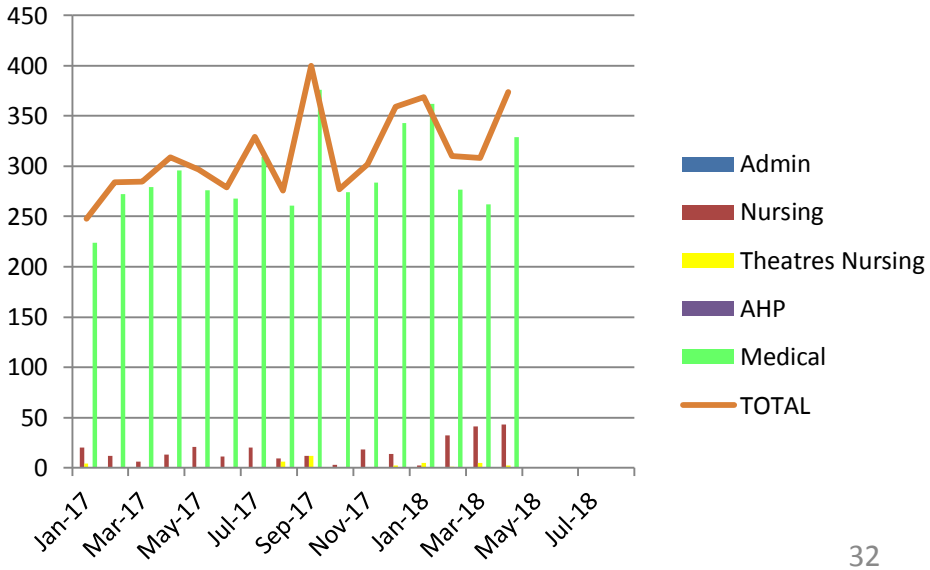
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

April was an encouraging month for workforce performance on the whole. Statutory and mandatory and appraisal figures both showed improvement, turnover decreased slightly and sickness absence held at around 4%. Some of the Trust's people metrics have been refreshed as part of the drive to provide clearer, more transparent and challenging targets and workforce data. As a result, sickness absence is now reported as a percentage of staff who attended work: the new graph has been introduced with previous sickness data recalculated as attendance figures to enable comparison.

Monthly attendance worsened marginally versus March by 0.09% from 96.10% to 96.01%. The new Key Performance Indicator (KPI) stretch target is 96.10%, so this is amber, although this very similar to the monthly average for April for the past 10 years. Our underlying 12 month average figure also decreased slightly by 0.05% from 95.84% to 95.79% and also moves to amber with the new KPI.

This month the Trust's vacancy position saw a gap of 18.03% with WTE employed percentage as 81.97% against a Trust target of 90%. However, there is an increase in the funded establishment as a result of some posts being converted from bank and agency to substantive, so the vacancy position will appear markedly higher in April than in March. This shows the size of the recruitment challenge as the Trust moves forwards. In practice, there was actually an increase of 0.03WTE on the payroll from March to April, so this figure is not necessarily a cause for concern but will need careful tracking for the next 6 months as posts are filled. Work is underway to align the Electronic Staff Record system with the Trust's Financial Ledger data to enable reporting on clinical and non-clinical vacancy positions to be more refined.

Mandatory Training numbers continue to grow with an increase of 1.73% in April to 93.29%. This is the largest increase in the last 6 months and remains green despite the new Trust KPI rising from 90% to 92%. The L&D Team are continuing to encourage staff to book onto courses or carry out their mandatory training via e-learning, for which speedier refresher training is also available.

April's appraisal performance saw a welcome increase of 3.46% to 74.92%. This is the first increase since the start of the year, but the Trust remains red, with the increased stretch target of 92.5%. This will continue to be addressed in Divisional Boards and divisional performance reviews in May but will take time to achieve. Additional resource has been provided to managers to identify any underlying issues. The implementation of the proposed revisions to the national Agenda for Change pay arrangements should also produce an increase in appraisal performance for staff who wish to progress through a pay band.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) declined very slightly to 13.47%. The adjusted turnover figure (substantive staff leavers including retirements) decreased by 0.32% to 11.29% and is now green with the new rating of less than 11.5%.

The number of agency breaches in April was proportionately higher than March due to a 5 week reporting period (March was 4 weeks). The number of overall agency breaches increased by 66 in April, the number of medical breaches rose from 262 in March, which had been the lowest since August 2017, to 329 in April. Nursing breaches increased slightly, with POAC using the majority as Theatres decreased from 5 to 2 this month.

ACTIONS FOR IMPROVEMENTS / LEARNING

Appraisal continues to be an area where focus is needed. There is work ongoing in HR&OD to review the process to ensure that high quality appraisals are easy for managers to undertake.

RISKS/ISSUES

The biggest challenge will be to ensure effective recruitment is undertaken to close the gap on revised funded establishments in the months ahead. A second area of challenge is to maintain effective communication with staff as the paediatric transition of services draws nearer.

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):	**Paul Athey, Acting Chief Executive & Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6 June 2018**

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 letter from NHS Improvement received in May 2017.

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 C 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 25 May 2018
- 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 issued in March 2018 and specifically compliance with the Trust's licence to operate.

PREVIOUS CONSIDERATION:

The licence condition declaration was discussed at the May private session on 25 May 2018

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

The Royal Orthopaedic Hospital NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

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 "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	There are no risks identified to complaince with this statement	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	There are no risks identified to complaince with this statement	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Not confirmed	A letter form NHS Improvement in May 2017, the Board was required to sign up to a series of undertakings to address shortfalls in its management and oversight of its waiting lists and to set out more clearly its future model of sustainability. Much work has been done during the year to address the shortcomings, however until the undertakings are lifted, the Trust is unable to declare compliance with this statement.	Please complete both Risks and Migitating actions & Explanatory Information
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and 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 (h) To ensure compliance with all applicable legal requirements.	Not confirmed	A letter form NHS Improvement in May 2017, the Board was required to sign up to a series of undertakings to address shortfalls in its management and oversight of its waiting lists and to set out more clearly its future model of sustainability. Much work has been done during the year to address the shortcomings, however until the undertakings are lifted, the Trust is unable to declare compliance with this statement.	Please complete both Risks and Migitating actions & Explanatory Information
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Not confirmed	A letter form NHS Improvement in May 2017, the Board was required to sign up to a series of undertakings to address shortfalls in its management and oversight of its waiting lists and to set out more clearly its future model of sustainability. Much work has been done during the year to address the shortcomings, however until the undertakings are lifted, the Trust is unable to declare compliance with this statement.	Please complete both Risks and Migitating actions & Explanatory Information
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	There remain some risks associated with vacancies in some key posts across the Trust, particualrly in theatres, however these are not believed to be sufficiently serious to impact on NHS Improvement's licence requirements as arrangements are in place to ensure that there is sufficient safe staffing.	Please complete Risks and Mitigating actions

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 _____ **Name** _____

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: The reasons are captured in the risks and mitigations boxes above.

OK

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

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		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

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.** • **Quarterly judgements under the Single Oversight Framework by NHS Improvement.** Currently Segment 3 • **Head of Internal Audit Opinion 2017/18** 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.**	ADG&CS
The Board has regard to such guidance on good corporate governance as may		• **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**	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
be issued by NHS Improvement from time to time		**Governance/Company Secretary and NHS Improvement** • **New national guidance issued on conflicts of interest; conflicts of interest policy** • Routine bulletins from NHS Improvement are received and reviewed by the Executive Team – **bulletins**	
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 Staff Experience & OD Committee for oversight of workforce, staff engagement, leadership and development. **Paper proposing the establishment of a Staff Experience & OD Committee considered at the January 2018 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** 2017/18 outlines the Board & Committee structure. • The Board and most Committees have **annual workplans**. • The **meetings structure chart** has been revised during the year • Notwithstanding the evidence above, in a 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, it is felt necessary to declare non-compliance with this element of the corporate governance statement.	ADG&CS
	(b) Clear	• The Trust has a **Scheme of Delegation** in place which sets out the matters reserved to	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;	the Board. This has been refreshed during the year. • The **terms of reference for the Committees** have been reviewed and amended during the year and the Staff Experience & OD Committee was established during 2017/18. **Paper proposing the establishment of a Staff Experience & OD Committee considered at the January 2018 Board meeting.** • **Governance review** commissioned by the Chairman and to be reported back by a Non Executive at the June 2018 Board meeting • **CQC report** highlights that the governance arrangements in respect of the Board and its Committees is sound • The **Quality & Safety Committee workplan** includes reports from the clinical governance committees that present by rotation. • Executive Team weekly meeting is the main advisory group to the Chief Executive. **Agendas of Executive Team business meetings**	

	(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 Patient Services has been revised to remove oversight of operational matters, this now being within the remit of the Interim Chief Operating Officer, sourced from the STP. An Interim Director of Finance has been sourced during the year to backfill the role vacated by the Acting Chief Executive. **Job descriptions for Executive Directors. Objectives of the Executive Directors. Minutes of the Remuneration Committee in December 2017.** • 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. Objectives of the Associate Director of Governance & Company Secretary.** • **An Associate Director of Workforce, HR & OD has been recruited during the year to strengthen expertise in this area. Job description for the Associate Director of Workforce, HR & OD. Objectives of the Associate Director of Workforce, HR & OD.** • 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.** • Divisional performance reviews have been held during the year on a monthly basis. **Papers from divisional reviews.** • Notwithstanding the evidence above, in a 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	CEO

		breached. On this basis, it is felt necessary to declare non-compliance with this element of the corporate governance statement.	
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.** • **Action plans developed in response to NHS Improvement's letter of undertakings**	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 2017/18 by the additional of a Staff Experience & OD Committee. **Paper proposing the establishment of a Staff Experience & OD Committee considered at the January 2018 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 was reviewed by the Trust Board in private at a number of formal meetings of the Board during the year. The Trust was inspected again in Quarter 4 2017/18 against the new CQC framework, with the outcome moving the trust from 'Requires Improvement' to 'Good'. Although this was outside of the financial year covered by this statement, it is felt important to include this significant development as ongoing context for this element. • **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	CEO/DPS/ COO

		their registration therein. Failure to comply with their expected professional standards would lead to disciplinary action via the Trust's disciplinary policy and in some cases removal from their professional register. Assurance is obtained routinely on compliance with professional member registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect to members of staff working within their specific areas and more generally in maintaining internal control systems such as annual PDR, and re-validation processes. **Appraisal and revalidation reports to Trust Board and Staff Experience & OD Committee.** • Notwithstanding the evidence above, in a 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, it is felt necessary 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 the estates & facilities division. The scope of these reviews is being extended to corporate areas in 2018/19. **Agendas and minutes for these meetings may be used to evidence this.**	DOF

		• 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, which have been reviewed during the year. **Paper to Audit Committee in September 2017.** • Governors are required to approve 'significant transactions' although have not been required to do so during the year. **Governor induction handbook.** • 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 two board workshops 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 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, it is felt necessary 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) material risks to compliance with the Conditions of its Licence;	• **Declaration approved by the Board on 25 May 2018, 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 a number of times during the year. • The Corporate Risk Register is considered monthly by the Executive Team and the elements of this relevant to each Board committee are also considered monthly, the most serious of which are included on the Board Assurance Framework. **Corporate Risk Register.** • Notwithstanding the evidence above, in a 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, it is felt necessary to declare non-compliance with this element of the corporate governance statement.	Ch/ ADG&CS
	(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	• 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 Chief Executive, Interim Director of Finance, Interim Chief Operating Officer, Director of Patient Services and Divisional representatives. **Agendas for these meetings may be used to evidence this.**	ALL

	and	• 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, therefore a new process has been introduced where executives attend the Audit Committee by rotation to present progress with actions in their respective areas.	
	(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** reflects the legal requirements governing the operation of the foundation trust. • The Board is not aware of any other material issues that would place it in contravention of any legal requirements. • The Trust has undertaken sound preparation for the introduction of the new GDPR. **Paper to Trust Board outlining the preparations for GDPR.**	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 an Associate Non-Executive Director, with a skill set in workforce and improvement to strengthen the Board's expertise in this area. **Board member profiles in annual report.** • During the year in order to response to the operational challenges outlined in the letter of undertakings from NHS Improvement, the Board was joined by an Interim Chief Operating Officer, whose initial remit was to address the data quality issues in respect of the 18 weeks open pathways. This was subsequently widened to include all operational responsibility. **Board structure in annual report. Paper to Remuneration Committee in December 2017.**	Ch

		• 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.** • Notwithstanding the evidence above, in a 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, it is felt necessary 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;	• Many public Board meetings include 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** has been considered by the Board and the Quality & Safety Committee during the year. • CIP schemes are quality impact assessed, and the process has been strengthened during the year under the remit of the new Assistant Director of Finance for Financial Delivery. **CIP QIA register.** • The **Quality Account** includes a set of quality priorities, delivery of which will be monitored by the Clinical Quality Group on a quarterly basis. • Notwithstanding the evidence above, in a 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, it is felt necessary to declare non-compliance	DPS

		with this element of the corporate governance statement.	
	(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. • A new **Workforce Overview** has been developed which provides a suite of information which is scrutinised by the Staff Experience & OD Committee. • Notwithstanding the evidence above, in a 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, it is felt necessary 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

		• A number of external reports have been reviewed by the Board during the year, including an assessment of the Trust's position against the hygiene code. **Report to Trust Board in August 2017.** • The Board has received an update from the Freedom to Speak Up Guardian during the year which has outlined some key areas of concern over patient care and the actions planned to address them. **Presentation to Trust Board.** • Notwithstanding the evidence above, in a 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, it is felt necessary 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 a senior nurse, which involves patient representatives, governors and Non-Executive Directors • A governor attends meetings of the Quality & Safety Committee as an observer **Minutes of Quality & Safety Committee**	DPS

		• Notwithstanding the evidence above, in a 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, it is felt necessary to declare non-compliance with this element of the corporate governance statement.	
	(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, the Interim Chief Operating Officer and the Chief Executive. **Terms of Reference for Quality & Safety Committee.** • The Trust has in place a Clinical Quality Committee, chaired by the Director of Patient Services 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 & therapeutics and safeguarding and health & safety. 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**	DPS

		the Knowledge Hub and update to the Quality & Safety Committee on the development of the Knowledge Hub (April 2017). • Notwithstanding the evidence above, in a 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, it is felt necessary 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. • The Board has been joined by an Associate Non Executive Director during the year with specific skills in workforce and improvement. This addresses a gap identified by the Board during the year and has also led to the development of a Staff Experience & OD Committee. An Associate Director of Workforce, HR & OD has also been recruited during the year. **Board structure in annual report.** • The Quality & Safety Committee has considered at most meetings a **nurse staffing update** which shows where there have been gaps in nurse staffing, the mitigations that have been applied to address these. Any incidents associated with nurse staffing are also reviewed in the same 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. The Trust benefits from paediatrician cover sourced from local partner organisations to be able to currently maintain the paediatric medical rota until December 2018.	Ch/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 Freedom to Speak Up and Data Quality. Further work is planned during 2018/19 to strengthen the partnerships with governors of other peer organisations. **Minutes from Council of Governors meetings. Training material on Freedom to Speak Up and Data Quality.**	ADG&CS

KEY:

Abbreviation	Job Title
CEO	Chief Executive Officer
COO	Interim Chief Operating Officer
DOF	Interim Director of Finance
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	25 May 2018	**Date**	25 May 2018

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, primarily on the basis of the breaches that NHS Improvement has identified within its 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 term sustainability of the Trust. Although improvements have been made, NHS improvement is yet to release the undertaking obligations formally.

ROHTB (6/18) 005

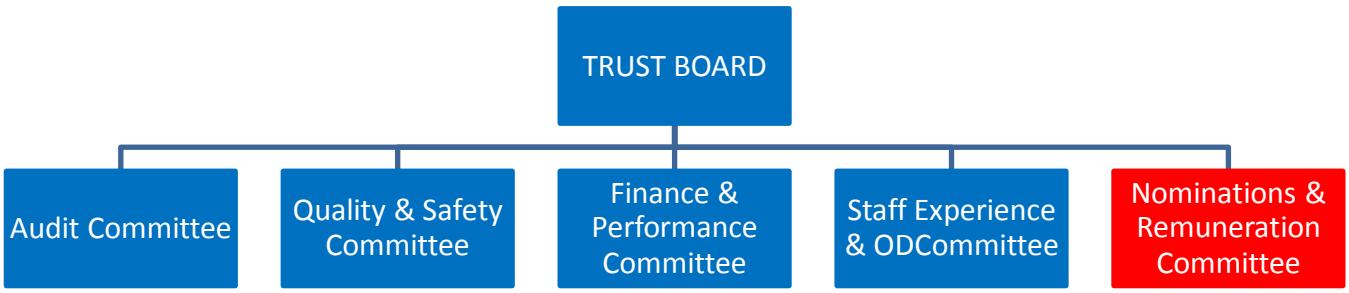
The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Nominations and Remuneration Committee (Executive Directors)**
SPONSOR:	**Dame Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6 June 2018**

EXECUTIVE SUMMARY:

The Board is asked to consider a proposal to establish a new Committee, to be known as the Nominations & Remuneration Committee (Executive Directors). The body will be one of the formal Board committees, as below:



The establishment of the committee will streamline the Board oversight of Executive Director appointment, succession planning, performance and arrangements for setting terms & conditions. This currently being through consideration of separate reports by the Nominations Committee (Executive Directors) and Remuneration Committee (Executive Directors).

The proposed initial Terms of Reference for the Nominations & Remuneration Committee (Executive Directors) are attached for the Board's approval.

The Board is additionally asked to formally approve the dis-establishment of the Nominations Committee (Executive Directors) and Remuneration Committee (Executive Directors).

The changes will be reflected in the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions, as well as the Trust's constitution, which will need to be presented to the Council of Governors for approval at its next meeting.

REPORT RECOMMENDATION:

Trust Board is asked to consider the attachment and:

- APPROVE the establishment of a Board Committee, to be known as the Nominations & Remuneration Committee (Executive Directors) and APPROVE its proposed initial terms of reference
- APPROVE the disestablishment of the Nominations Committee (Executive Directors) and

Remuneration Committee (Executive Directors)

ACTION REQUIRED (Indicate with 'x' the purpose that applies):

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	x	

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

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

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

A small piece of legal advice was taken which confirmed that there were no risks to non-compliance with any legislation governing the operation of the Trust

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

Good governance as streamlines the Board's oversight Executive Director appointments, performance and terms & conditions

PREVIOUS CONSIDERATION:

The shadow meeting of the Nominations & Remuneration Committee (Executive Directors)

NOMINATIONS AND REMUNERATION COMMITTEE (EXECUTIVE DIRECTORS)

Terms of Reference – DRAFT 0.1

1. Purpose

The Nomination and Remuneration Committee (Executive Directors) is constituted as a standing Committee of the Trust Board.

The Committee is authorised by the Trust Board to act within its terms of reference, as set out below, subject to amendments at future meetings of the Trust Board.

The Committee is authorised by the Trust Board to obtain such internal information as it considers necessary for or expedient to the exercise and fulfilment of its functions. All members of staff of the Trust are directed to cooperate with any request made by the Committee.

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

2. Duties/Responsibilities

2.1 Nominations

- To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust Board and make recommendations to the Board with regard to any changes.
- To give consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed in future.
- Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.
- Before an appointment is made, to evaluate the balance of skills, knowledge and experience on the Trust Board and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisors to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

- To consider any matter relating to the continuation in office of any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the Committee's responsibilities.
- Receive the annual declaration of the Chief Executive in respect of the Trust's compliance with the Fit and Proper Persons regulation and receive evidence-based assurance that all newly appointed executive Directors, including the Chief Executive are deemed Fit and Proper
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons Regulation

2.2 Remuneration

- To decide upon and review the terms and conditions of office of the Trust's Executive Directors in accordance with all relevant Trust policies, including:
  - salary
  - provision for other benefits
  - allowances
- To monitor and evaluate the performance of individual Executive Directors.
- To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective.
- To advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.
- To determine arrangements for annual salary review for all staff on Trust contracts.

3. Accountable to

The Committee is accountable to the Trust Board

4. Reports to and Method (including minutes circulation)

The minutes of all meetings of the Committee shall be formally recorded and shall be retained by the Company Secretary, on behalf of the Chairman, and shall not be shared with the Executive Directors.

The Committee shall report to the Trust Board after each meeting of the Committee via an assurance report.

The Company Secretary, on behalf of the Chairman, shall ensure that the work of the Committee is accurately reported in the Annual Report and Accounts in accordance with any direction from NHS Improvement

5. Membership

Members
All Non Executive Directors (including the Associate Non Executives) shall be members.

In attendance by invitation

- Chief Executive
- Executive Director of Strategy & Delivery
- Associate Director of HR, Workforce and Organisational Development

Serviced by
Associate Director of Governance and Company Secretary

6. Quorum

A quorum shall be three members.

7. Meeting Frequency and Procedures (minimum if applicable)

Meetings shall be held as and when required, but at least once per year.

8. Process for Reviewing Effectiveness

The effectiveness of the Committee will be monitored on an annual basis via the following:

- Annual review of the Terms of Reference by the Trust Board
- Report of Committee's work in Annual Report and Accounts in accordance with direction.

10. Reporting Structure (list of Groups/Committees which report to this Committee)

None.

11. Review Terms of Reference

Undertaken at least annually or as required.

12. Date of adoption

6 June 2018

13. Date of Review

June 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	30 May 2018
Guests	Mrs Mandy Johal, Freedom to Speak Up Guardian
Presentations received	Freedom to Speak Up update
Major agenda items discussed	• Quality & Patient Safety report • CIP quality impact assessment register • Clinical Quality Group – upward report and minutes • Cancer Board – upward report • Clinical Audit & Effectiveness Committee – upward report and minutes • Children's Board – upward report and minutes • Divisional governance assurance reports
Matters presented for information, update or noting	• Quality & Safety risks on the Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Committee was appraised of a fall on Ward 3 which was noted to be associated with the poor use of equipment to manage patient mobility; work was underway to understand the reasons why the usual mobility aids had not been used • There was a higher number of complaints associated with the spinal service and these were being reviewed for any trends • It was reported that there was inconsistency with the collection of feedback as part of the Friends and Family Test and work was underway to devise a standard methodology • The Freedom to Speak Up Guardian highlighted that it appeared that staff from a Black & Ethnic Minority background were more reluctant to speak up than staff from other backgrounds. • It was highlighted that the risk associated with the vacancies in the Clinical Governance team had been discussed by the Clinical Quality Group at its last meeting • The ongoing use of the ONKOS system to manage cancer pathways was noted to present a risk. Secretarial and administration support for the Oncology team was also an issue that was being addressed • The Committee was concerned at the lack of assurance around the effectiveness and work of the Drugs and

	Therapeutics Committee • A replacement named doctor for children was yet to be identified, although the previous incumbent was covering the role as needed at present • The Committee chair highlighted that she had attended the recent meeting of the Patients' and Carers' Forum and highlighted some inefficiencies around how this operated. This would be reviewed fully by the Executive Director of Patient Services
Positive assurances and highlights of note for the Board	• The Trust had recently been awarded exemplar status for its VTE practice by NHS England • The Committee noted the new information on mandatory reportable infections; there were none to date • Cancellations on the day of surgery had reduced • The detail of the four patient deaths that had occurred over recent months was considered. The review process of these was noted to be sound and the detail would be provided in the quarterly report to the Board • There were plans being developed to widen the suite of quality information that could be considered by the Committee. This included some of the work with Stryker, the proposed electronic governance solution that was being investigated and suggestions from medical, operations and therapy staff • 85% of Cost improvement schemes had quality impact assessments • The Committee was joined by the Freedom to Speak Up Guardian. It was noted that since November 2017 there had been no concerns raised anonymously, which suggested that staff were willing to speak out without fear of reprisal. The Committee was guided through the different concerns that had been raised by staff on a recent night shift. There were more concerns raised at the ROH than some other larger acute trusts, which suggested a positive reporting culture. • There were a significant number of offers made to newly qualified nurses. Support processes while these individuals gained confidence and familiarity with the organisation, were being worked through. • The Oncology MDT had been reconfigured and had been nominated for a Health Service Journal award • There had been good improvement in the way that the Paediatric Outpatients area operated and there were now good links with the Operations team • From May 2018, there were additional paediatric consultants who would support the medical rota on a seven day week basis, sourced from Heartlands Hospital
Significant follow up action commissioned	• Further information was requested on the process of the quality impact assessment and to see the template that

including discussions needed with any other Executive Boards/Committees	was used to score the impact of the schemes • The Committee wished to understand the progress with developing the Board walkabouts under the remit of the Executive Director of Strategy & Delivery • A written update on the harm review process to be presented at the next meeting • A further update on the planned improvement for the Drugs & Therapeutics Committee is to be presented at the next meeting
Decisions made	• The Committee agreed that all areas using the WHO checklist in whatever form, should be captured in future versions of the Quality Report

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

For the meeting of the Trust Board scheduled for 6 June 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	1 June 2018 (May meeting)
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Finance and performance overview • Spinal deformity performance – progress against the 52 week trajectory • Modular build plans • Upward report from the Operational Management Board • Perfecting Pathways progress report
Matters presented for information, brief update or noting	• Finance & Performance entries on the Corporate Risk Register
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Agency staffing was slightly higher than planned, although this was associated with the higher levels of activity that the Trust had been handled. Medical agency staffing in particular remained high. • Length of stay was noted to have increased. Given the significant rise, the Interim Chief Operating Officer was asked to challenge the position to understand the reasons for this. • There had been a dip in performance against the 18 week RTT trajectory, with the April theatre closure impacting on this. Far more patients were now however being treated in under 18 weeks. • The appraisal position remained poor, although this was being picked up as part of divisional performance meetings. • The paediatric transition programme was rated 'Red' within the 'Perfecting Pathways' progress report, this being reflective of the ongoing discussions of the operating model and uncertainty over the date of the transfer • One of the key concerns from the Operational Management Board was also the paediatric transition plans
Positive assurances and highlights of note for the Board	• The financial position was reported to be ahead of plan, despite theatres having been closed during the first week of April. This position was driven by high levels of activity. • There had been a strong start to CIP delivery. The target of

	£3m was noted to be ambitious. • Theatre utilisation was much improved from previous months and in particular in-session utilisation. • The number of hospital cancellations had reduced. A new proforma had been introduced to help manage the 72 hour pre-admission conversations. • There were some encouraging improvements in terms of staff training levels. • Activity through the private patient suite had increased and the position would be reported quarterly • The plans for the development of a modular theatre facility were presented; an update will be provided at the private Trust Board session. It was suggested that there should be clarity within the business case as to whether sufficient activity could be sourced to make the new set up viable. There were good benefits to the plans in terms of business continuity and future sustainability of the organisation. • There was good progress with the 'Perfecting Pathways' programme, particularly around the performance solutions work and the implementation of ePMA
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The plan for the private patient suite to be considered at the August meeting • Investigate the reasons behind the length of stay deterioration • Consider producing a summary of press and media attention for future Board meetings • Present the full business case for modular theatres at the June Finance & Performance Committee and July Trust Board • Reframe the risk around future sustainability to reflect the risk around returning the financial balance and profitability
Decisions made	• None specifically

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

For the meeting of the Trust Board scheduled for 6 June 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	2 May 2018
Guests	None
Major agenda items discussed	• Workforce dashboard • Staff engagement update • Workforce planning update • General workforce update • People Committee upward report and terms of reference • People risks
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• It was reported that there were 100 staff in the 'clearing' process (waiting to join the Trust), including 20 qualified nurses – it was agreed that a method of keeping in touch with those who had been given offers of employment was needed to prevent attrition between offer acceptance and joining • Long term sickness absence was noted to relate to stress, depression and musculoskeletal issues as majority causes • The current appraisal system was noted to not be fit for purpose and therefore a new system was to be developed • Although the quarterly staff Friends and Family Test results were good for recommending the ROH as a place for treatment, recommending the ROH as a place to work less positive
Positive assurances and highlights of note for the Board	• Annual staff turnover was noted to be stable, although there was a slight upturn in staff in post vs. establishment • There were plans to develop the use of e-roster to assist with managing vacancies and other workforce performance issues • Improvement targets were being set to reduce the time between conditional to unconditional offer letters • Succession plans down to Band 7 level were being developed • There was an improvement seen in terms of core mandatory training compliance • The 'Speak Up and Join In' brand was being used widely and Team Brief had been changed to seek feedback from staff • The Committee considered an alternative way of plotting staff engagement, based on a quadrant format • Workforce planning was underway and the proposals would be considered by the Executive Team shortly • The ROH is to participate in the recruitment of

	international fellows • The inaugural meeting of the People Committee was reported to have been positive and productive
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Development of a workplan for the Staff Experience & OD Committee • Present detail of training for VTE and insulin at a future meeting • Consideration was to be given to the oversight of the clinical excellence awards mechanism • It was agreed that the Workforce overview be presented to the Board in future
Decisions made	• The Committee approved the People Committee's terms of reference • The Committee agreed that the workforce overview be presented on alternative months in future • Consideration of the nurse staffing report would be by the Staff Experience & OD Committee in future

Simone Jordan for Richard Phillips
NON EXECUTIVE DIRECTOR AND CHAIR OF THE STAFF EXPERIENCE & OD COMMITTEE

For the meeting of the Trust Board scheduled 6 June 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 May 2018
Guests	External Audit (Deloitte)
Major agenda items discussed	• Annual report (including Quality Report) and accounts • Auditors opinion on annual report and accounts • Auditors opinion on quality account
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The audit had identified some weakness with valuing stock, particularly consignment stock, and there was some stock with no assigned value. A number of audit recommendations had been raised around this • Some errors with waiting lists management had been identified as part of the testing of core indicators for the Quality Account
Positive assurances and highlights of note for the Board	• The assurance statements on the Quality Account were noted to be positive • It was expected that the auditors would provide unmodified opinion on the annual accounts and on the quality account, although there was an emphasis on the Trust's Going Concern status and sustainability from a value for money point of view
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A number of drafting amendments to the annual report were suggested, which would be made prior to final submission on 29 May
Decisions made	• To recommend to the Board the approval of the annual report and adoption of the annual accounts

Rod Anthony
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 6 June 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 4 July 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 4 July 2018 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.

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 Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 4 July 2018: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Patient/service improvement story: Quality Service Improvement and Redesign	Presentation	
1120h	2	Apologies - Prof Phil Begg	Verbal	Chair
1122h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1125h	4	Minutes of Public Board Meeting held on the 6 June 2018: *for approval*	ROHTB (6/18) 010	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (6/18) 010 (a)	SGL
1135h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (7/18) 001 ROHTB (7/18) 001 (a)	YB/PA
	6.1	Estates review	Verbal	PA
STRATEGY				
1145h	7	Paediatric services update	Verbal	AP/PA
1155h	8	Orthopaedic services in the STP	Verbal	PA

QUALITY & PATIENT SAFETY				
1205h	9	Patient Safety & Quality report: *for assurance*	ROHTB (7/18) 002	GM
FINANCE AND PERFORMANCE				
1220h	10	Finance & Performance overview: *for assurance*	ROHTB (7/18) 003	SW
COMPLIANCE AND CORPORATE GOVERNANCE				
1235h	11	CQC action plan: *for assurance*	ROHTB (7/18) 004 ROHTB (7/18) 004 (a)	GM
UPDATES FROM THE BOARD COMMITTEES				
1245h	12	Quality & Safety Committee: *for assurance*	ROHTB (7/18) 005	KS
	13	Finance & Performance Committee: *for assurance*	ROHTB (7/18) 006	TP
	14	Staff Experience & OD Committee: *for assurance*	ROHTB (7/18) 007	RP
MATTERS FOR INFORMATION				
	15	Press and media report	ROHTB (7/18) 008	
1255h	16	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 5th September 2018 at 1100h in the Boardroom, Trust Headquarters

Notes

Quorum

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

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

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

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 6 June 2018: 1145h – 1315h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JW)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive Director	(SM)	
Ms Stacey Keegan	Head of Nursing for Division 2	(SK)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	Paper Reference
1 Patient Story: Division 2	**Presentation**
A patient story was presented by the Head of Nursing for Division 2, Stacey Keegan. The story reflected the improvements in the Trust's safeguarding procedures that had also been noted by the Care Quality Commission when they inspected in January 2018. A patient being treated had disclosed that they suffered domestic abuse. The case was dealt with compassionately and staff handled the case well. A risk assessment had been undertaken and the patient was kept in the hospital rather than being discharged, a position agreed between joint agencies. The Board	

agreed that it was positive that the recovery nurse had picked up the signs initially. In terms of the impact on the team, there was a debrief but this was to celebrate the handling of the case. An incident had been logged. There were no children involved in this case. There had been no threat that the patient's partner would arrive on site on this occasion. It was reiterated that the story was backed up the findings of the Clinical Commissioning Group and the CQC. It was noted that there were more cases identified by the Trust as a result of increased awareness. The safeguarding policy and the training was much improved. This was noted to also support the nursing strategy, so this was very positive. The nurses involved in the work were to be congratulated. The legal requirements around the situation were discussed; if the adult had mental capacity and did not consent to intervention then there was little that the Trust could action. The Board congratulated Ms Keegan on her appointment as Deputy Director of Nursing & Clinical Governance.	
2 Apologies	**Verbal**
There were no apologies.	
3 Declarations of interest	**Verbal**
There were no declarations of interest notified. The register of interests was available on request from the Company Secretary.	
4 Minutes of Public Board Meeting held on the 2 May 2018: *for approval*	**ROHTB (5/18) 010**
The minutes of the public Board meeting held on 2 May 2018 were accepted as a true and accurate record of discussions held.	
5 Trust Board action points: *for assurance*	**ROHTB (5/18) 010 (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: *for information and assurance*	**ROHTB (6/18) 001** **ROHTB (6/18) 001 (a)** **ROHTB (6/18) 001 (b)**
It was reported that there was an expectation that the RTT breach of licence imposed on the Trust in 2017 by NHS Improvement would be removed. The 'On the Day' briefing produced by NHS Providers was considered which	

discussed the planned closer relationship between NHS Improvement and NHS England, including harmonising the reporting structures into these bodies and streamlining the support to providers from these. It was reported that the Trust had become the first specialist orthopaedic trust to be awarded an exemplar status for VTE management. This showed a journey on the management of VTEs. Karen Hughes, Patient Safety and Clinical Training Lead had been charged with this improvement and therefore should be congratulated on this achievement. The compliance of clinicians with VTE policy was pleasing. The Chairman reported that she had undertaken a walkabout with the Interim Chief Operating Officer on 9 May and had attended a private patient working group, a bed meeting and a 6-4-2 meeting. She had had a telephone catch up with Jacqui Smith, Chair of University Hospitals Birmingham NHSFT (UHB) on 10 May, which included a discussion about how the two trusts might work together in future. There had been a Harrison lecture delivered by Mr Marks, consultant surgeon, on Richard III and scoliosis, which had been held on 15 May. The Council of Governors meeting on 16 May had considered the draft annual report and accounts and the governors had been briefed on the contents of the CQC report. There were plans to go out to election for a number of public governors and staff governor posts, as the terms of office of some of the governors had come to an end. The Chairman had attended a ROHBTS function on 23 May to give her best wishes to Jenny Richardson who retired but would join the Charitable Funds Committee. An independent chair for the committee was still to be identified. The celebration of the NHS 70th anniversary was planned for 5 July.	
7 Paediatric services update	**Verbal**
It was reported that safe Paediatric care continued to be provided on the site. There were ongoing conversations at an operational and clinical level. A meeting with the medical and nurse directors of Birmingham Women's and Children's NHSFT (BWCH) was planned to discuss next steps. The Paediatric Transition Group's meeting was also planned on 13 June, which would be co-chaired by Mrs Sallah with BWCH partners. It was agreed that named deputies for each attendee at this meeting would be useful. The workforce considerations would be within the remit of the operational body which would report up to the Paediatric Transition Group. It was noted that consultants from Heartlands, Good Hope and Solihull Hospitals (HGS) were enjoying their cover at the ROH. Meetings would be held to gain any	

tips on continuous improvement.	
8 Orthopaedic services in the STP	**Verbal**
It was reported that there was a monthly meeting with UHB to identify opportunities for close working. Work was underway on the development of an opportunities paper for July. There were Board-level discussions which were productive and aligned although there was more work to do on external clinical engagement. 77 patients had been received from HGS, 15 of which had been treated and 40 were dated for surgery. 13 spinal patients had been accepted from UHB and there would be more patients which would be triaged. There was a meeting with Lordswood GP Practice, to agree the plans to recruit a joint fellow post for the musculoskeletal service. Opportunities with Birmingham Community Healthcare NHSFT would be explored.	
9 Patient Safety & Quality report: *for assurance*	**ROHTB (5/18) 002**
The Executive Director of Patient Services advised that out of the six moderate harms, one fall would become classified as a serious incident which related to the lack of training on equipment. A robust training process was now in place and staff had been reminded not to use equipment on which they had not been trained. A serious incident was reported which related to a patient which had been transferred out as a result of sepsis. The details of the potential inquest was awaited. There had been 33 VTEs in the last year, of which 10 were avoidable which was an improvement of the previous position. In terms of falls, the matron for inpatients was undertaking a review of falls and there had been a reduction from 144 falls in 2016/17 to 115 in 2017/18. Pressure ulcers had decreased and any which had occurred were reviewed by the new tissue viability nurse. Regarding the Friends and Family Test results, the mandatory collection had not been achieved in some areas and there was a very variable process for collection of this information. A standard approach would be introduced. It was noted that in some cases patients had been asked multiple times to provide feedback at different parts of their pathway. There had been a conversation around the WHO checklist to ensure that the position regarding the WHO checklist completion included areas where it was	

undertaken in addition to theatres. The addition of infection information was noted to be new into the report and was good practice. There had been no infections to report during the period, however. Mrs Sallah reported that there had been a presentation from the Freedom to Speak Up Guardian at the last Quality & Safety Committee meeting who had worked a night shift. She had noted that there was reluctance for BME patients to raise their concerns; this was being considered by the Executive. It was noted that the momentum of the Drugs & Therapeutics Committee needed to be regained. It was suggested that the membership and chairmanship of the Committee needed to be refreshed. The Executive Director of Patient Services advised that the agenda and the upward reporting into the Committee was good, however there needed to be a difference in the membership to provide challenge to those reporting up into the Committee. A Controlled Drugs group was chaired which provided assurance on this at present. Work would be undertaken to reinvigorate the work of the Patient & Carer's Forum, as at present there was little assurance on the effectiveness of the body. This would include some link into the Stryker work. It was reported that the Patient Experience strategy would be developed by Ange Howling, the current Head of Infection Control so that the work from Morecombe Bay NHSFT, where she had previously worked, could be harnessed.	
10 Finance & Performance overview: *for assurance*	**ROHTB (5/18) 003**
The Interim Director of Finance reported that in month a deficit of £892,000 had been delivered against a planned deficit of £1,584,000. This was driven by strong performance against activity. Expenditure was in line with plan, although agency staff expenditure was higher than expected. This was associated with agency staffing in theatres and the need to cover junior medical staff rotas. The Trust was considering accessing an international fellows programme which would assist with the position. Cash was ahead of plan, although further cash may need to be accessed before the next Board meeting dependent on whether the Sustainability and Transformation funding was received. The Board was asked to and agreed that this should be delegated to a Chair's action if needed. It was agreed that the previous practice of allowing the Director of Finance to drawn down cash should be reinstated, with this being reported to the Finance & Performance Committee. In terms of the May position, a small surplus was forecast.	

Regarding activity, there had been a slight reduction on day cases. For electives the plan had been met. There was a slight underperformance on outpatients. Work would be undertaken to change pathways and reduce follow up appointments. Outpatient with procedures was also above plan. It was suggested that the Board should recognise that this was the first time that the Trust had started ahead of plan at the beginning of the year for a significant time. Congratulations were expressed to the team for this achievement. The in session utilisation was reported to be at 91.6% and the on day cancellations had reduced. In terms of length of stay, there was some further work to understand this position around primary joints and this would be fed back to Finance & Performance Committee at its next meeting. In terms of performance against the 18 weeks RTT target, this had been impacted by the theatre closure and was therefore slightly below trajectory. There were currently 45 patients who had waited for treatment for 52 weeks or more, which was a reduction on the plan. The latest 52-week breach was discussed, which was an individual who had been referred to the ROH late as a tertiary referral. Indicative performance for cancer had been over the 85% target, however it was reported that there had been a further breach which had reduced the performance to 66%. This would be corrected in the summary of performance and would be reviewed by the cancer steering group. In terms of workforce, there had been a mixed month. Statutory and mandatory training rates had improved and there had been an improvement in appraisals, although there was still much work to do to improve this further through the divisional boards.	
11 Annual declarations: Corporate Governance licence Condition and Governor training *for assurance*	**ROHTB (6/18) 004** **ROHTB (6/18) 004 (a)** **ROHTB (6/18) 004 (b)** **ROHTB (6/18) 004 (c)**
The Associate Director of Governance and Company Secretary reported that this was the second set of annual declarations, this time to confirm the Trust's compliance with the corporate governance licence condition and also to confirm that the obligations with respect to the training of the governors had been discharged. It was proposed that given that the Trust remained bound by the notice of enforcement action by NHS Improvement that the declaration with regard to the corporate governance licence condition should be recorded as non-compliant. The declaration in respect of governor training should be one of compliance however. There was some discussion around the necessity to declare non-compliance with the corporate governance licence condition, given the significant improvements to	

the overall performance of the Trust and the strengthened governance arrangements which had also been noted by the Care Quality Commission. As the the Trust was still technically in breach of licence then it was agreed that the recommendation should stand, however a caveat should be added to the declaration to capture the noted improvement.	
ACTION: **The Associate Director of Governance and Company Secretary to publish the annual declarations with the necessary caveat around the improvements in performance and governance**	
12 Proposal to establish a new Board committee: *for approval*	**ROHTB (6/18) 005** **ROHTB (6/18) 005 (a)**
The Associate Director of Governance and Company Secretary presented a proposal to establish a new Board subcommittee which dealt with Nominations and Remuneration matters jointly. This had the benefit of streamlining discussions around pay, performance and appointments. This was agreed. It was agreed that the Chief Executive should receive a standing invite for matters that did not relate to themselves. The Board was also asked to agree to disestablish the separate Remuneration and Nominations Committee, which it did.	
13 Quality & Safety Committee: *for assurance*	**ROHTB (6/18) 006**
The assurance report was received and noted.	
14 Finance & Performance Committee: *for assurance*	**ROHTB (6/18) 007**
The assurance report was received and noted.	
15 Staff Experience & OD Committee: *for assurance*	**ROHTB (6/18) 008**
It was reported that the workforce dashboard was providing some useful insights, however there was a need to develop an action plan for the Committee.	
16 Audit Committee: *for assurance*	**ROHTB (6/18) 009**
The team was congratulated on the successful production of the year's annual report and accounts.	
17 Any Other Business	**Verbal**
It was reported that a Cyber security workshop would be arranged for the Board. Dr Marwick reported that a musculoskeletal workshop for GPs was being arranged	

and over 100 people would be attending in the Knowledge Hub to discuss the means of referral.	
Details of next meeting	
The next meeting is planned for Wednesday 4 July 2018 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 4 July 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 29.06.2018

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 050	Chairman's & Chief Executive's update	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	07/03/2018	Arrange for a meeting to be arranged with local MPs, the Chairman and Chief Executive	SGL	~~31/05/2018~~ 31/07/2018	To be arranged after the purdah period which end in early May 2018. To be arranged late July.	
ROHTBACT. 055	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Consider how the Board could be made aware of how clinical staff stretched themselves towards excellence	AP	~~06/06/2018~~ 30/09/2018	Outcome of the Clinical Excellence awards to be outlined to Staff Experience & OD Committee in September	
ROHTBACT. 052	Board Assurance Framework	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	07/03/2018	Arrange a risk workshop	SGL	~~31/07/2018~~ 31/08/2018	To be arranged during August to allow sufficient time for discussion outside preset meeting schedule	
ROHTBACT. 054	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Build exceptional staff experience into the strategic goals progress report	PB	~~04/07/2018~~ 05/09/2018	Deferred to the September meeting to allow for annual leave commitments	
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee	SGL	18-Jul-18	To be scheduled in for when the clinical audit internal audit has been completed	
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	05-Sep-18	ACTION NOT YET DUE	
ROHTBACT. 053	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Present the plans for modular theatre in June 2018	JWI	06-Jun-18	Included on the agenda of the June and July private session	
ROHTBACT. 059	Annual declarations: Corporate Governance licence Condition and Governor training	ROHTB (6/18) 004 ROHTB (6/18) 004 (a) ROHTB (6/18) 004 (b) ROHTB (6/18) 004 (c)	06/06/2018	Publish the annual declarations with the necessary caveat around the improvements in performance and governance	SGL	30-Jun-18	Published with requested caveat	

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 July 2018**

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 Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 4th July 2018

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 public Trust Board meeting on 6th June 2018

2 UPDATE ON NHS IMPROVEMENT UNDERTAKINGS FOR BREACH OF LICENSE

2.1 NHSI have verbally confirmed that the Midlands & East regional management team have agreed that all undertakings relating to the delivery, governance and data quality of our RTT performance and reporting should be removed from our breach of licence conditions. At the time of writing, the Trust is still awaiting formal written confirmation of this.

2.2 Undertakings relating to financial sustainability will remain whilst conversations continue with the STP and local providers around the potential review of orthopaedic pathways in Birmingham & Solihull however NHSI confirmed that that are happy with the progress that the Trust is making with regards to these undertakings.

3 STP UPDATE

3.1 The ROH continues to support the local health economy around the treatment of patients waiting long periods of time for orthopaedic surgery as an knock-on impact to the urgent care pressures over winter 2017/18. Some discussions are ongoing around whether a more formal agreement with prospective activity volumes could be agreed for the remainder of 2018/19 whilst discussions continue at STP level around future plans for orthopaedic services across Birmingham & Solihull.

3.2 The latest Birmingham & Solihull STP Board meeting was held on Monday 2nd July. A verbal update will be provided to Trust Board.

4 NHS FUNDING SETTLEMENT

4.1 On 18th June 2018, the Prime Minister announced a major new funding settlement for the NHS to cover the five years from 2019/20 to 2023/24.

4.2 The funding settlement equated to a 3.4% annual uplift above inflation (as the OBR projections), with some front-loading of funds into the first 2 years (uplifts per year of 3.6%, 3.6%, 3.1%, 3.1% & 3.4%)

4.3 Some commentators have been quick to highlight that this settlement remains below the average annual increase in the NHS over its 70 year life, and is largely in line with figures quoted as needed to maintain services levels in the face of ongoing health and demographic projections. That said, the settlement is at the higher end of the expected range and has generally been seen as a positive outcome from the longstanding negotiations.

4.4 Focus now moves to the outcomes expected from the additional funding and the 10 year plan required for how these outcomes will be delivered.

4.5 The Prime Minister has emphasised the important of engagement in the development of this plan, particularly from the clinical workforce, and has set out her five key priorities, namely:

- Putting the patient at the heart of how care is organised
- A workforce empowered to deliver the NHS of the future
- Harnessing the power of innovation
- A focus on prevention
- True parity of care between mental and physical health

4.6 It is expected that the 10 year plan, alongside further details on how the settlement will be funded, will be released as part of the autumn budget.

5 NHS70 CELEBRATIONS

5.1 As part of the celebrations for the 70th anniversary of the NHS, the ROH is holding a Tea Party on Thursday 5th July from 12pm to 3pm on the courtyard balcony.

5.2 All staff and patients are encouraged to attend and take advantage of the stalls, food outlets and free gifts both as a thank you for their support of the NHS in general but also as a celebration of the successes at the ROH over the last 12 months.

6 BOURNVILLE VILLAGE TRUST

6.1 On 12th June, along with the Chair and Chief Operating Officer, I met with Board colleagues from Bournville Village Trust (BVT). The purpose of the meeting was partly to introduce Pete Richmond as the new CEO of BVT, but also to reignite

discussions that started several years ago around the potential for the ROH to have a presence in the health centre that BVT are developing on the Bournville Gardens campus approximately 1 mile north of the ROH site.

6.2 A range of options were discussed, particularly in relation to our expanding MSK and therapies service and the work currently underway to redesign our joint replacement pathway. Further discussions are planned to explore these options in more detail.

7 EQUALITY & DIVERSITY FORUM

7.1 On 27th June, the Trust held its first Equality & Diversity forum. It was open to anyone in the Trust to attend, and around 20 members of staff from a range of professions, departments and bands attended.

7.2 The group considered a range of Equality & Diversity priorities and were asked to discuss what was important to them and how they could support the hospital to make improvements.

7.3 Overall, there was a positive feel to the session with participants appreciating the opportunity to share ideas and gain support as well as starting to work on quick wins.

7.4 We will be looking to build upon this at our next forum on 9th August.

8 POLICY APPROVAL

8.1 Since the Board last formally met in public, the following new or substantially changed policies have been approved by the CEO on the advice of the Executive Team:

- Safeguarding supervision policy

9 RECOMMENDATION(S)

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

9.2 Note the contents of the report.

Paul Athey
Acting CEO
29th June 2018

ROHTB (7/18) 002

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

June 2018

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 the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

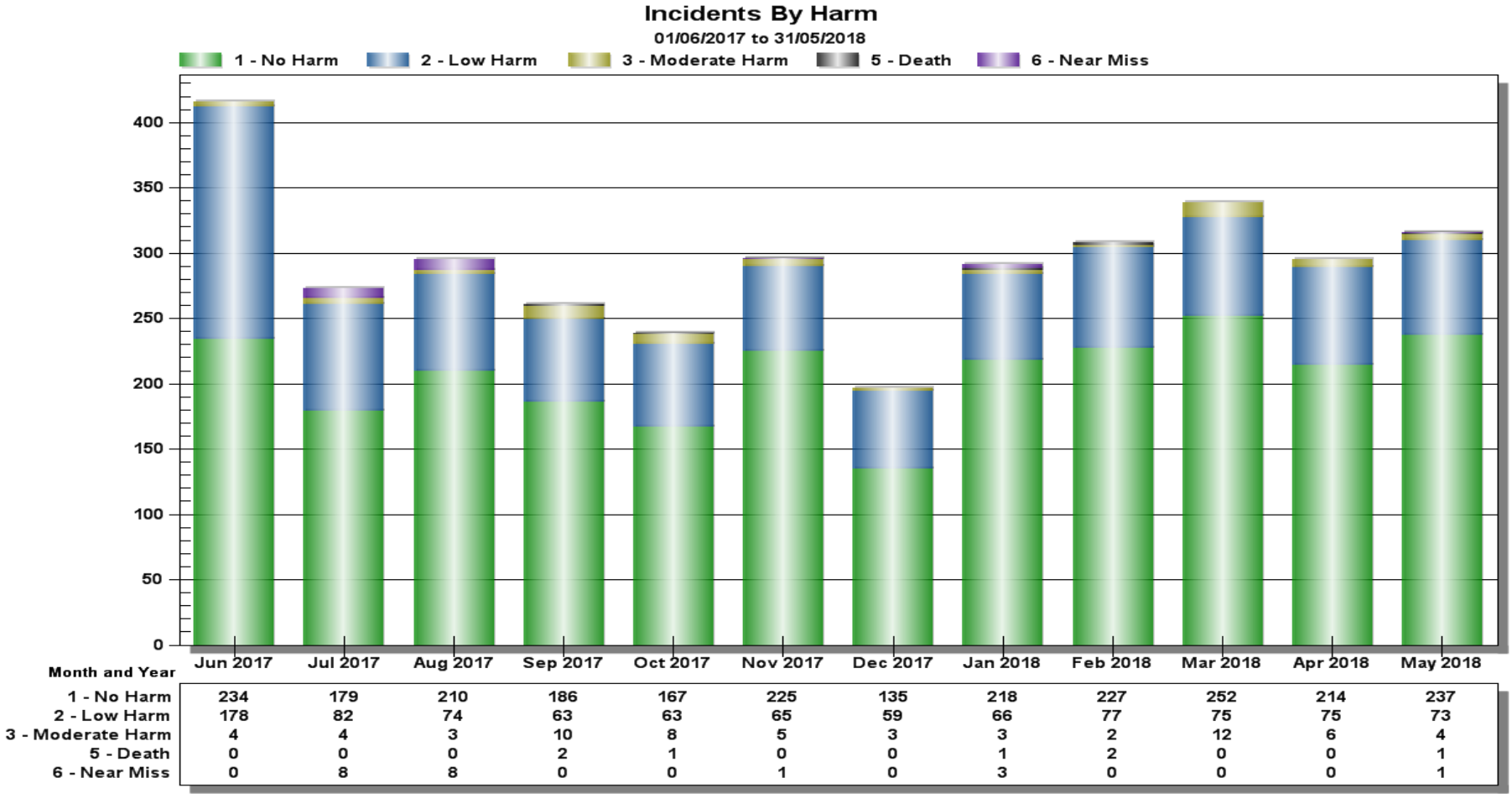
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018
1 - No Harm	234	179	210	186	167	225	135	218	227	252	214	237
2 - Low Harm	178	82	74	63	63	65	59	66	77	75	75	73
3 - Moderate Harm	4	4	3	10	8	5	3	3	2	12	6	4
5 - Death	0	0	0	2	1	0	0	1	2	0	0	1
6 - Near Miss	0	8	8	0	0	1	0	3	0	0	0	1

INFORMATION

In May 2018, there were a total of 316 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;
237 – No Harm
73 – Low Harm
4 - Moderate Harms
0 – Severe Harm
1 – Near Miss
1 – Death

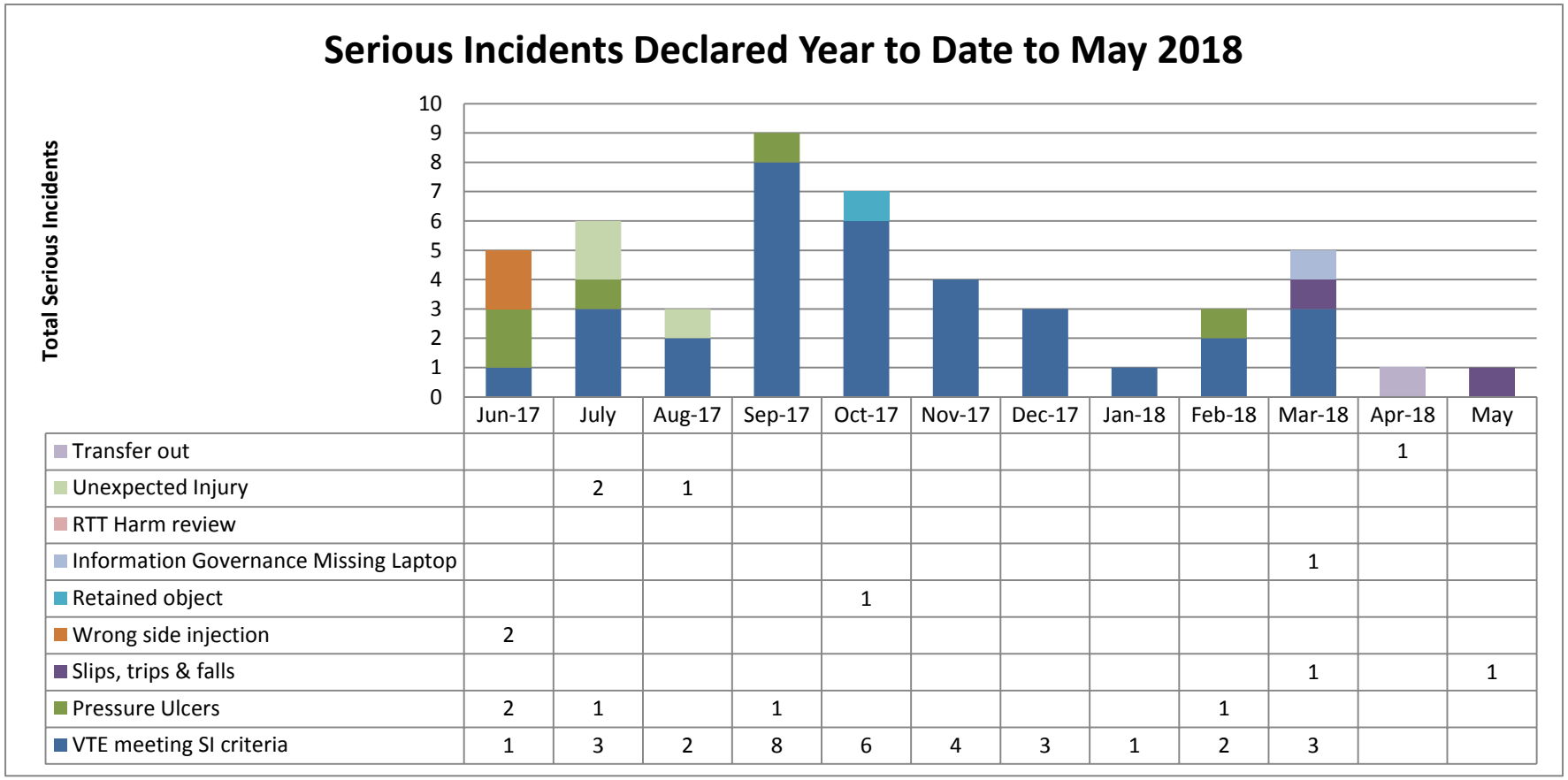
In May 2018, there were a total of 9548 patient contacts. There were 316 incidents reported which is 3.3 percent of the total patient contacts resulting in an incident. Of those 316 reported incidents, 77 incidents resulted in harm which is 0.8 percent of the total patient contact.

The 4 Moderate Harms and 1 death incident were;

Site	Incident Date	Incident Number	Cause 1
HDU	04/05/2018	24072	Thromboembolic Events (Known/Suspected) /Death
HDU	04/05/2018	24117	Controlled Drug Issue
Wards	08/05/2018	24122	Other Injuries
Wards	18/05/2018	24219	Fall - Inpatient
ADCU	10/05/2018	24147	VTE

ACTIONS FOR IMPROVEMENTS / LEARNING
The Governance team have a number of improvements planned; • New RCA template approved at Clinical Quality Group that includes a new guide. • The Governance team are currently scoping RCA training.
RISKS / ISSUES
A Risk has been added to the risk register due to the staffing levels within the Governance team. The Governance team currently have 2 X WTE vacancies. As a result of the vacancy position, the Ulysses improvement plan is making slow progress.

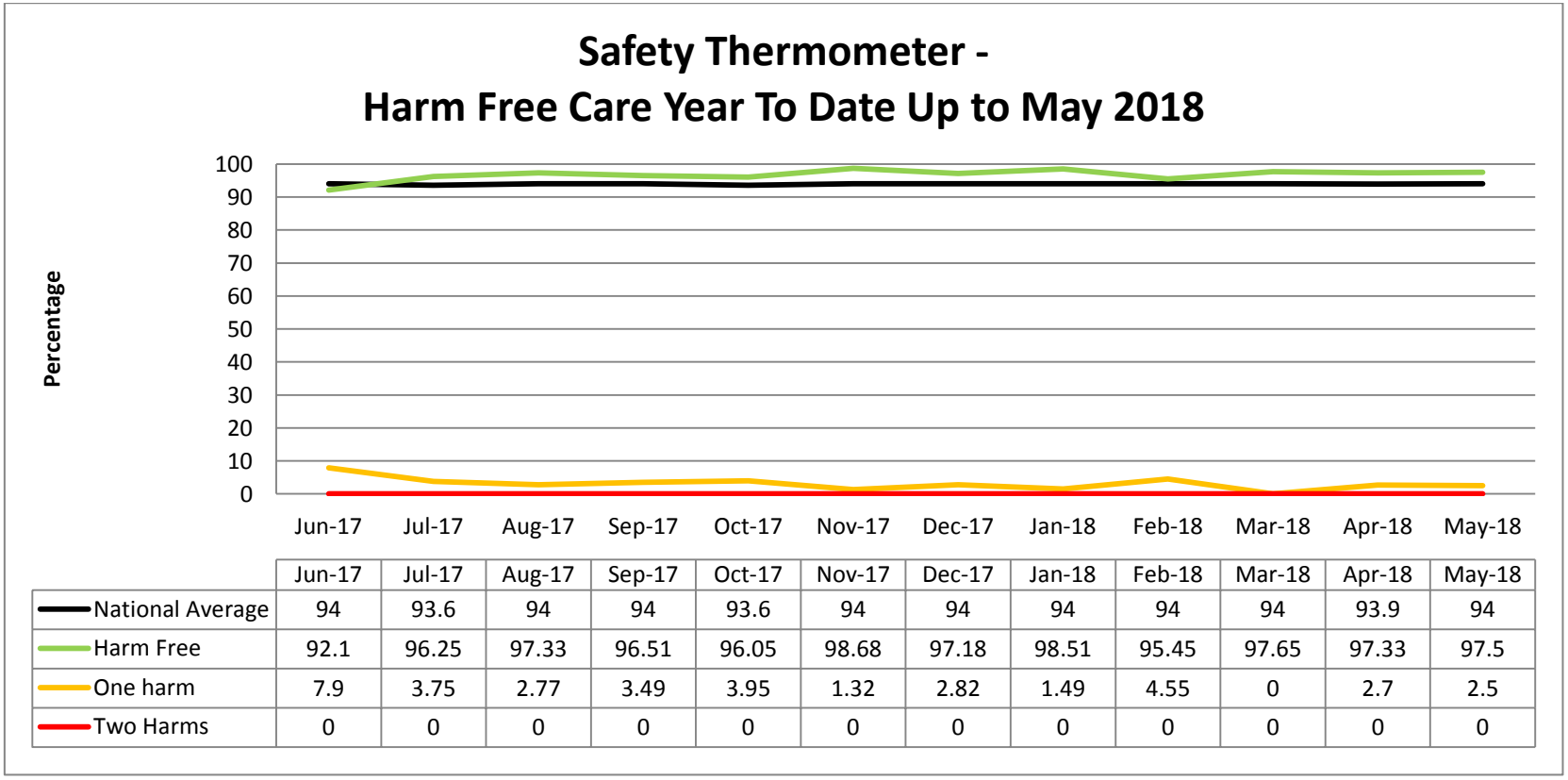
3. Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.



	Jun-17	July	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May
Transfer out											1	
Unexpected Injury		2	1									
RTT Harm review												
Information Governance Missing Laptop										1		
Retained object					1							
Wrong side injection	2											
Slips, trips & falls										1		1
Pressure Ulcers	2	1		1					1			
VTE meeting SI criteria	1	3	2	8	6	4	3	1	2	3		

INFORMATION
1 Serious Incidents were Declared in May 2018; The Serious incident was reported in last month's quality report and has been discussed in April 2018 Quality and Safety Committee.
ACTIONS FOR IMPROVEMENTS / LEARNING
No Serious Incidents were closed in May 2018
RISKS / ISSUES
The Trust currently has 4 open Serious incidents with the CCG. The Governance Team has chased for these to be closed to ensure we do not delay the findings with the patients and relatives.

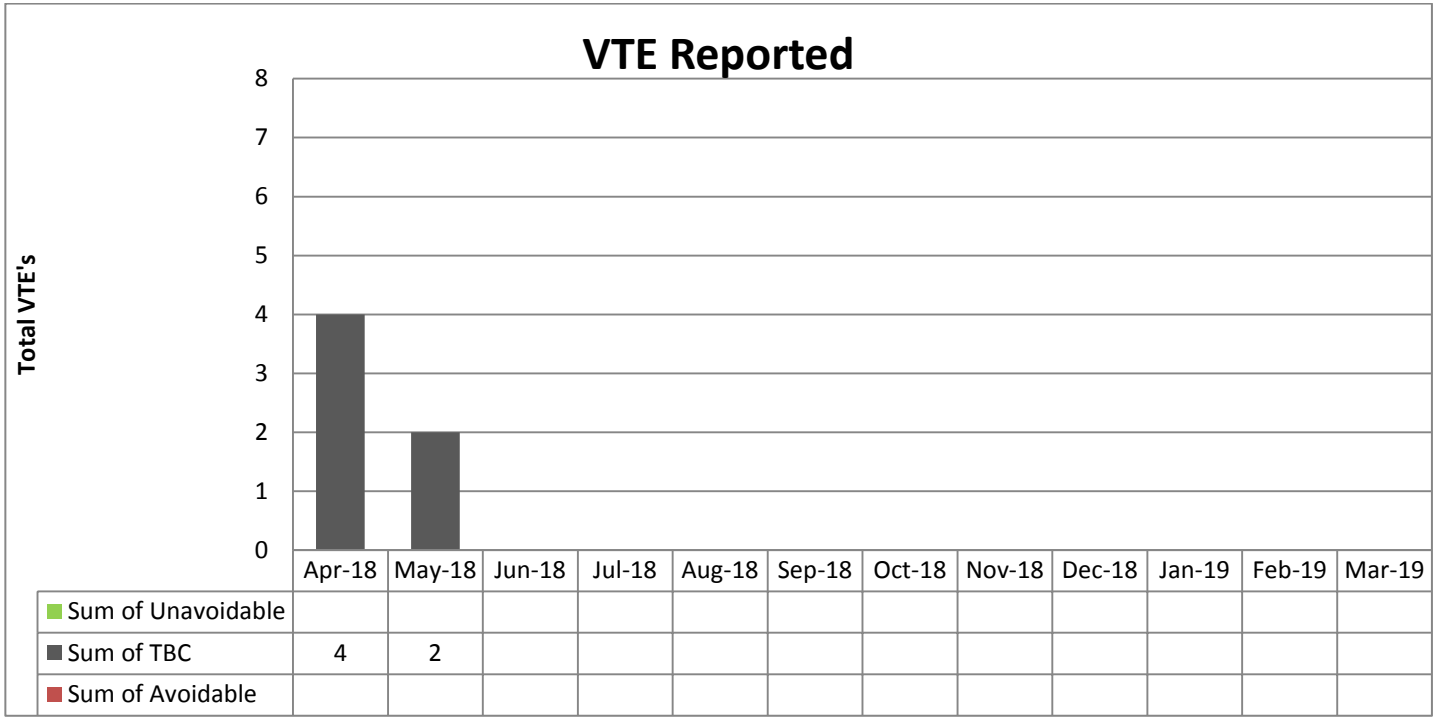
4. **NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
National Average	94	93.6	94	94	93.6	94	94	94	94	94	93.9	94
Harm Free	92.1	96.25	97.33	96.51	96.05	98.68	97.18	98.51	95.45	97.65	97.33	97.5
One harm	7.9	3.75	2.77	3.49	3.95	1.32	2.82	1.49	4.55	0	2.7	2.5
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The Harms recorded in May 2018 are; 2 New UTI (Ward 3). The Head of Nursing is looking into the catheter management on Ward 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 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).**



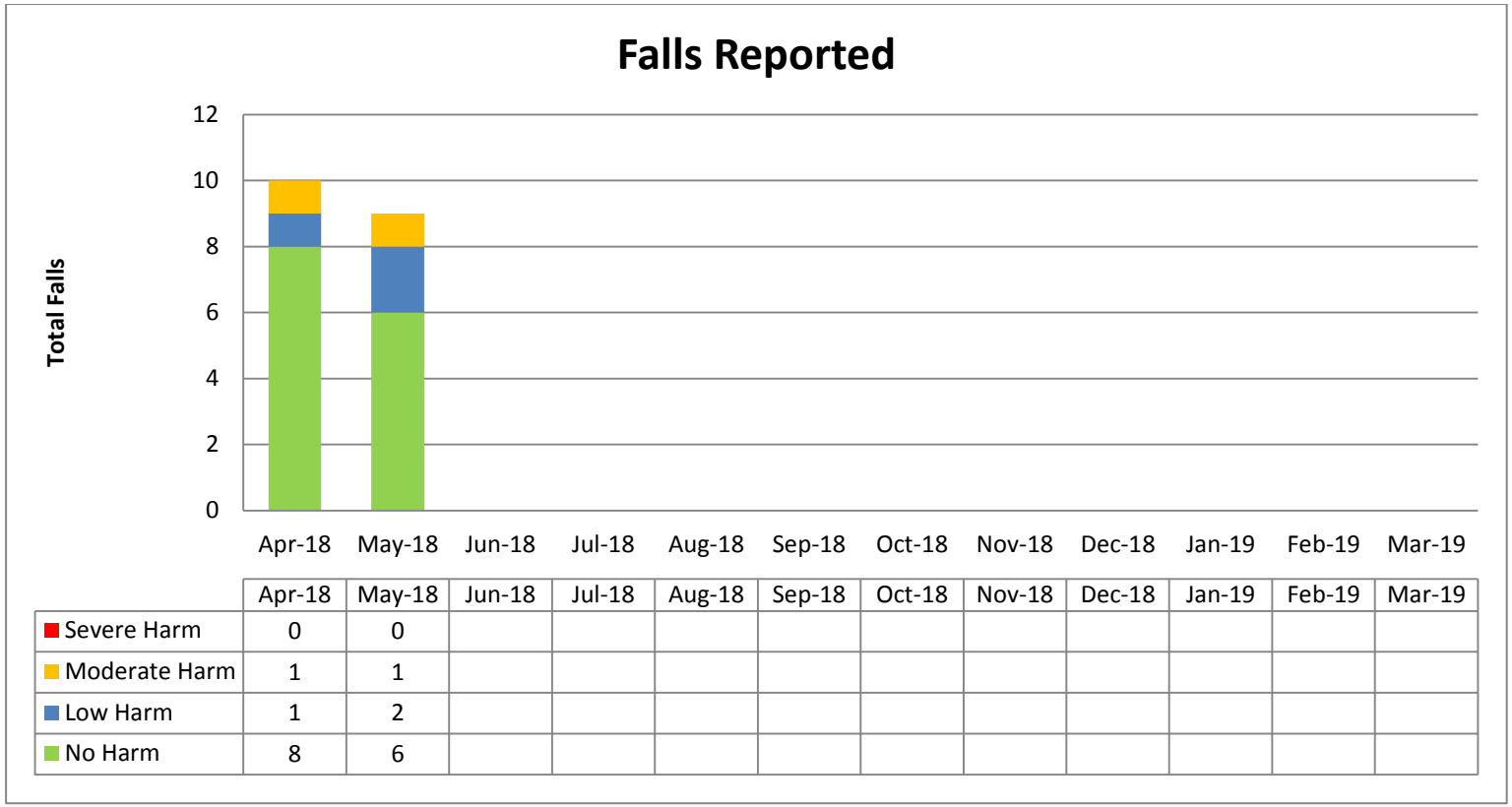
10

total		Avoidable
17/18	33	10
18/19	6	0*

***not classified**

INFORMATION
There were 2 VTEs reported in May 2018; this compares to 3 reported in May 2017. 1 resulted in patient death. The incidents are detailed on Page 5 of this report and are currently under investigation
ACTIONS FOR IMPROVEMENTS / LEARNING
On the 23rd May 2018, the ROH achieved VTE Exemplar membership with the Exemplar Centre network. We are the first Orthopaedic Hospital to be part of this network. The Exemplar network is challenging some of the guidance within the updated NICE guidance on Venous Thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism and have advised not rushing to make changes. The guidance has been reviewed in detail by the VTE Advisory Group. ROH CSLs/AMDs are currently reviewing speciality specific sections. This information will be collated by the VTE Advisory Group alongside benchmark information from RJAH and RNOH before any changes are agreed. Our current Trust VTE prevention guidance is safe. Staff have been advised current policy should continue to be followed until review/update of new recommendations is complete.
RISKS / ISSUES
None

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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Severe Harm	0	0										
Moderate Harm	1	1										
Low Harm	1	2										
No Harm	8	6										

total	
17/18	115
18/19	19

12

INFORMATION

Overall there were 9 fall-related incidents reported across the Trust in May 2018, all were related to adult inpatient falls. 8 Falls were graded either no or low harm are reviewed in the Trusts Falls group with an upward report to Clinical Quality group. One incident was graded as moderate harm and is included in the narrative on page 5.

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 and are also reported in the Monthly Quality Report. Across in-patient areas, we continue to utilise a collaborative, multi-disciplinary approach to falls risk assessment, care planning and falls prevention strategies.

ACTIONS FOR IMPROVEMENTS / LEARNING

In 2017/2018 there was a reduction in the reported number of falls (115) in comparison to the 144 falls incidents that occurred in 2016/2017.

Improvement work completed

- Falls documentation review.
- Bed rails policy updated.
- Falls information boards implemented in all clinical areas.
- West Midlands quality review service (WMQRS) benchmarking is complete and has currently been circulated around the falls group for comments.
- Training on Sara Stedy has been purchased, now incorporated in manual handling training

Future improvements planned

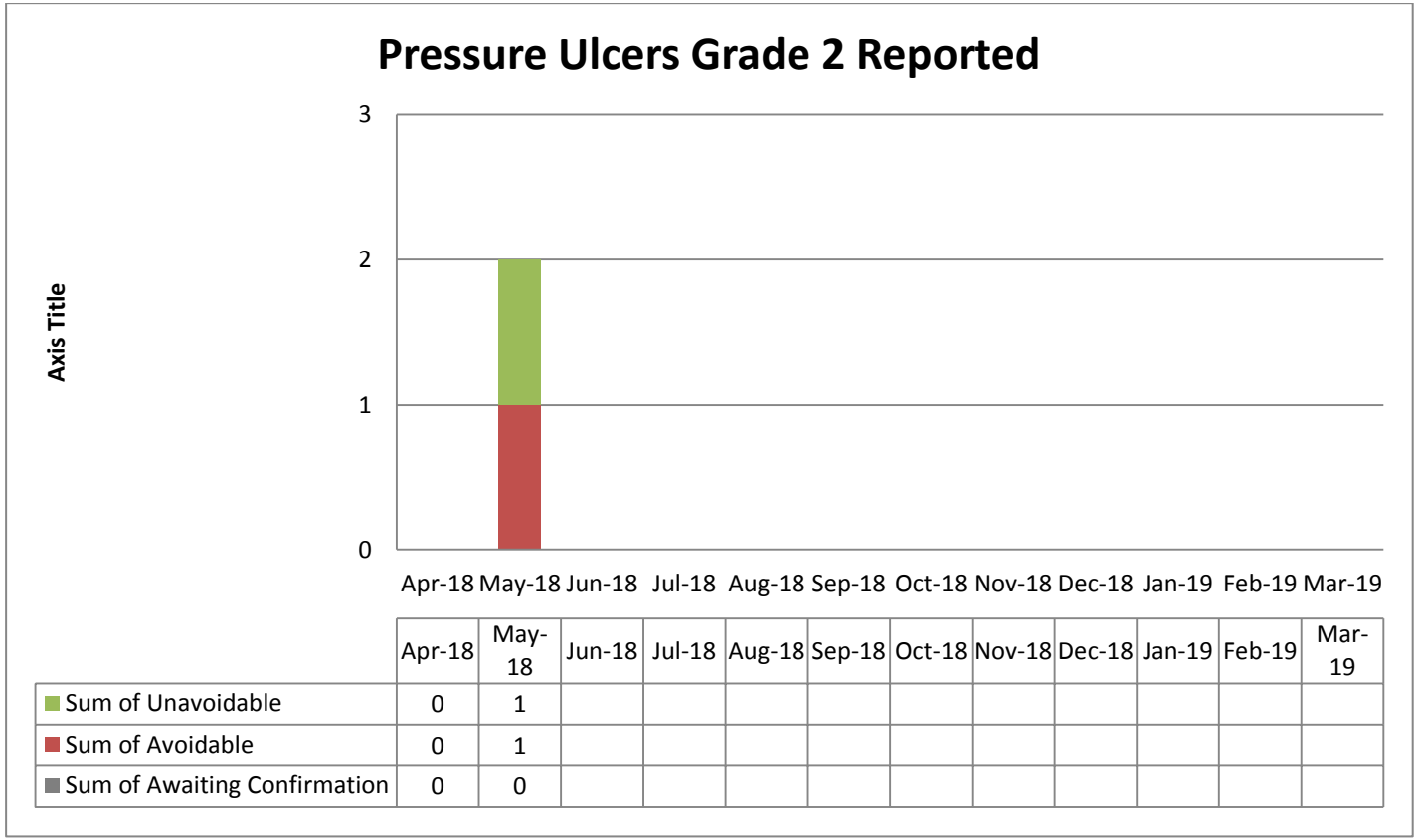
- Falls lead is visiting the UHB falls lead on the 18th of June 2018 to see how they work and see if there is anything we can learn from them.
- Falls policy under review, amendments being done to be in line with the WMQRS and updated nursing documentation.
- Throne project; assessments are done to identify changes required in each bathroom to reduce patient falls in the bathroom and make it dementia friendly.
- Falls E-learning training- plan for link nurses and ward managers to do the national e-Learning module available via ESR.
- Yearly clinical skills update training.
- Review of the Falls RCA process and questionnaire.

- A retrospective audit of the reported 71 falls from inpatient area.
- Peer review of the falls prevention and management.
- Mandatory fields to be added on to Ulysses indicating whether falls was avoidable or unavoidable.

RISKS / ISSUES

None

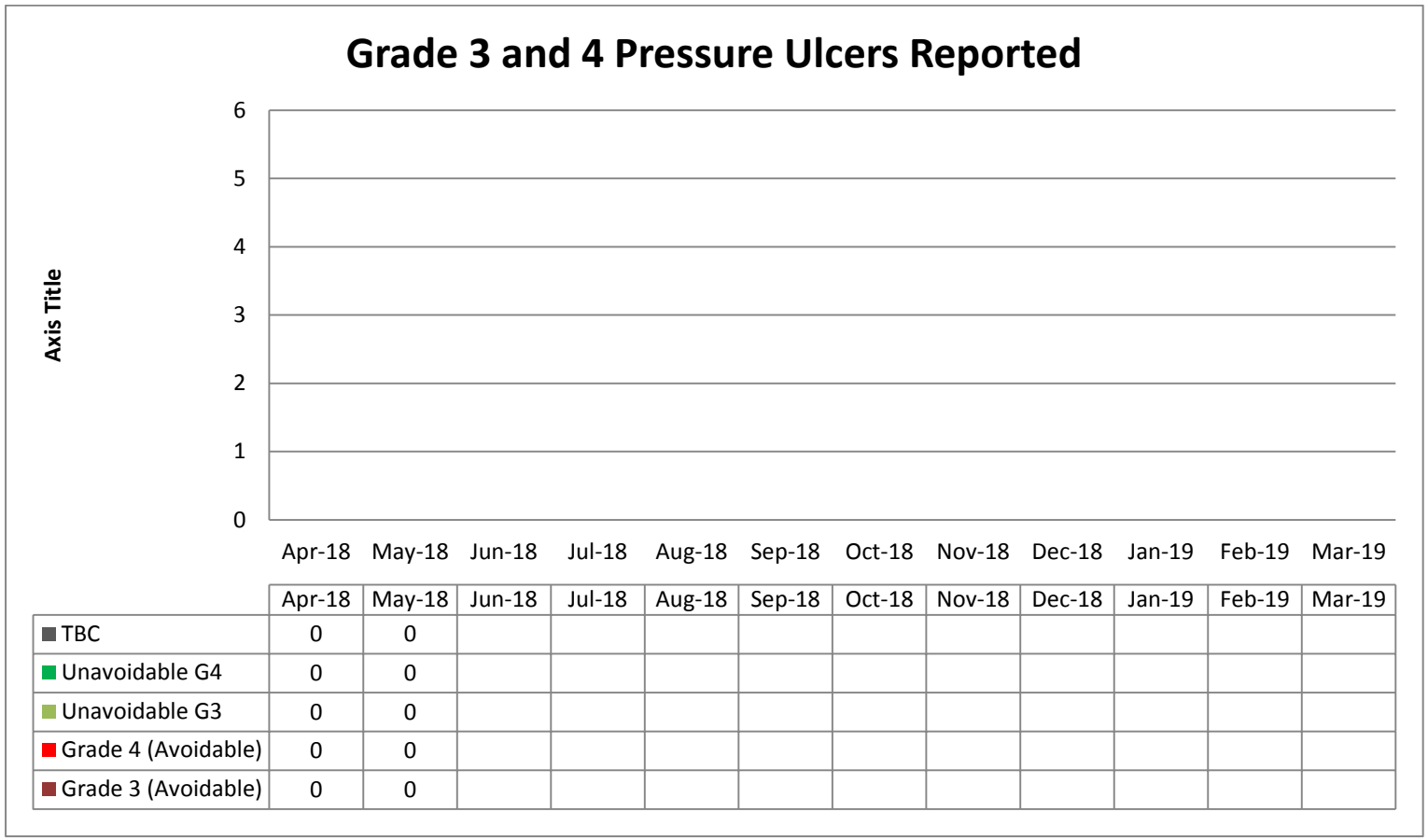
7. **Pressure Ulcers - are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	0	1										
Sum of Avoidable	0	1										
Sum of Awaiting Confirmation	0	0										

total	Avoidable
17/18	6
18/19	1

15



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
TBC	0	0										
Unavoidable G4	0	0										
Unavoidable G3	0	0										
Grade 4 (Avoidable)	0	0										
Grade 3 (Avoidable)	0	0										

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

INFORMATION

In May 2018, there was 2 recorded Grade 2 pressure ulcers (1 Unavoidable and 1 Avoidable). This compares to the zero pressure ulcer reported in May 2017.

Grade 2

1 **Avoidable** – due to poor documentation. It is highly likely that this patient was admitted with this PU but there is limited evidence of skin inspection, and there is a note that the patient said his skin was "good". ACDU and theatre recovery staff have been spoken to, and the new MDT documentation will act as a prompt to ensure skin is checked.

Avoidable Pressure Ulcer Targets

2018/2019:

1 - Avoidable Grade 2 pressure Ulcers limit of 12
0 - Avoidable Grade 3 pressure Ulcers limit of 0
0 - Avoidable Grade 4 pressure Ulcers limit of 0

2017/2018:

6 - Avoidable Grade 2 pressure Ulcers against a limit of 12
3 - Avoidable Grade 3 pressure Ulcers against a limit of 0
0 - Avoidable Grade 4 pressure Ulcers against a limit of 0

ACTIONS FOR IMPROVEMENTS / LEARNING

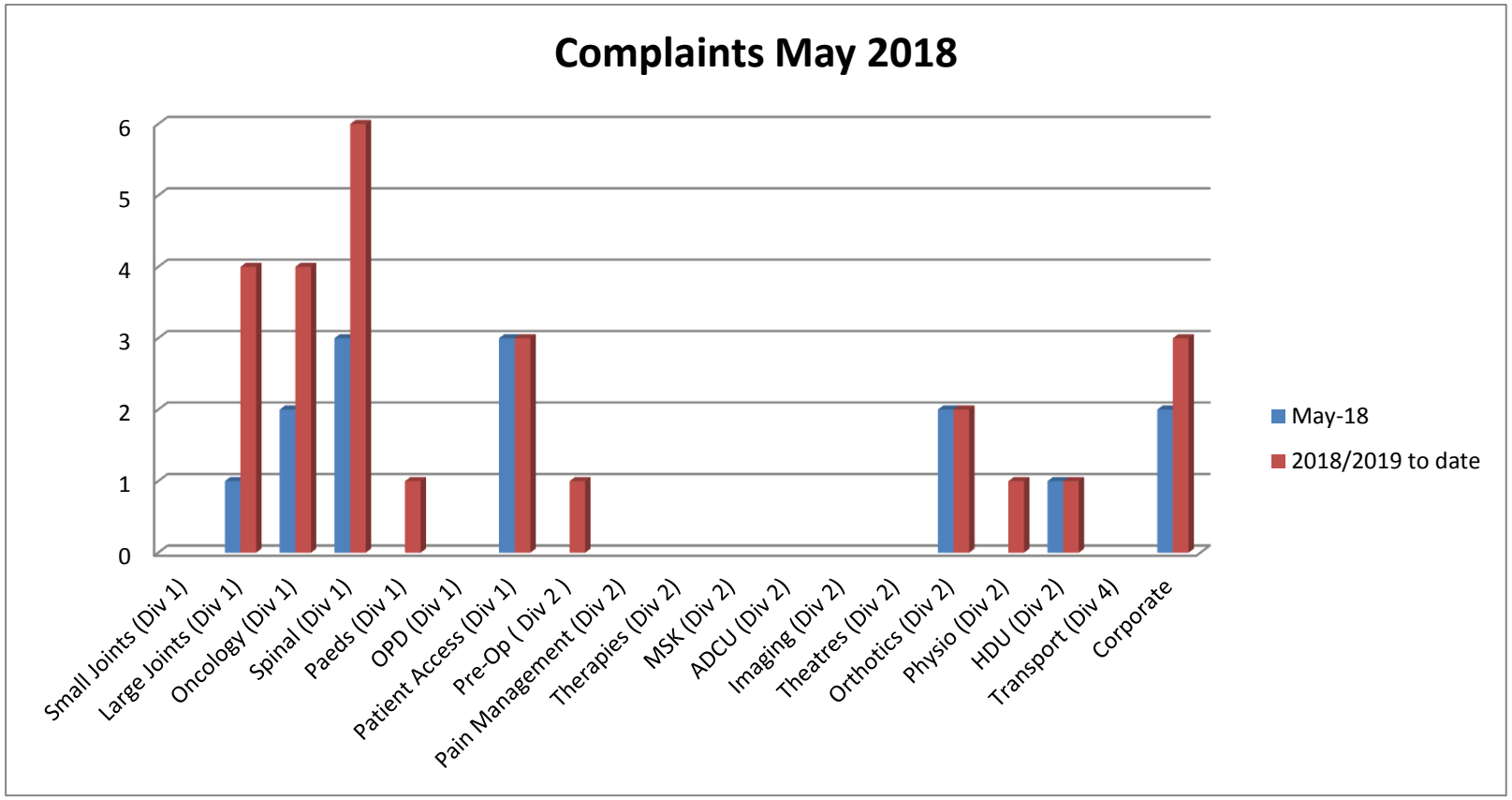
Future Actions Planned

- A documentation task and finish group has developed more specific user-friendly documentation, which will act as prompts to care and highlight any gaps in order that action can be taken. TV documentation will enable a clear outcome of a skin assessment carried out in ACDU, Theatre Recovery, Admission to HDU or Ward and include a SKIN bundle encompassing a care and comfort type of repositioning chart
- Training has been given to all Trust staff and this new documentation has gone "live" for a trial period of 4 weeks. The Task and Finish group will meet in 2 weeks' time to review any issues with the documentation and identify any further training needed.
- React to Red Skin Strategy will be an integral stratagem and formal launch will take place with the new documentation
- Training and education given emphasised the importance of checking skin regularly if patient at risk of PUs – reminder Waterlow is a guide and if patients are immobile despite a "low" score – they need repositioning and skin checking more frequently
- TV Resource folders have been made available on all ward/clinical areas
- A new patient leaflet has been developed to demonstrate what a pressure sore is for patients who want more information or have capacity and refusing to move
- An investigation into the cause of the patient who developed extensive grade 1 PUs following extensive spinal surgery demonstrated that all appropriate pressure redistributing (PR) equipment – PR theatre table surfaces and gel pads had been utilised and the unforeseen complications during the surgery which prolonged the time the patient spent on the operating table meant that the patient could not be moved. However, use of the gel pads mitigated the risk of further damage that could have occurred.

RISKS / ISSUES

The 1.0 wte Band 6 for TV left in early May. The TV Lead Nurse wte 0.8 is currently maintaining the service and prioritising clinical workload. A new band 6 has just been appointed and when commences the TV team can continue to develop the service.

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 202 contacts during May 2018 of which 83 were classified as concerns. This is a significant reduction in calls compared to the same time last year (497 contacts in May 2017) and significantly fewer concerns (141 concerns in May 2017). The total number of enquiry contacts has remained reduced for the fourth month in a row as the letters sent to patients have been altered to remove the PALS number and replaced with the department concerned. However, there were still 119 enquires made to the department this month, so the removal of the number has clearly not affected patients being able to access the service.

Compliments

There were 633 compliments recorded in May 2018, with the most being recorded for Div. 1, although Div.2 are increasingly recording their compliments. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues 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 14 formal complaints made in May 2018. All were initially risk rated rest amber or yellow. This is a reduction to the same time last year (17 complaints in May 2017). The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Cancelled surgery on the day (Div.1, Oncology)
- refusal of Trust to pay for Orthotic shoes from patients choice of provider; poor quality orthotic provision (Div.2, Orthotics)
- Infection following biopsy (Div.1, Oncology)
- Overprescribed opiates; dislocated prosthesis (Div.2, HDU)
- Potential missed diagnosis (Div.1, Spinal)
- Administration of orthotics; poor quality of alterations (Div.2, Orthotics)

Initially Risk Rated Yellow:

- Loss of personal data on a laptop (Corporate)
- Appt cancelled on the day - wants the loss of earnings refunded (Div.1, Patient Access)
- Development of a pressure ulcer in 2015 - continuing treatment still needed (Div.1, Large Joint)
- Administration of C&B appointments (Div.1, Patient Access)
- Arrived for an appointment but cancelled and not informed (Div.1, Patient Access)
- Safeguarding concerns following actions are taken (no consent from patient so generic response) (Corporate)
- Communication regarding the procedure. Admission time altered and the patient was not informed (Div.1, Spinal)
- Unhappy with treatment received and outcome of surgery; communication from secretary and Orthotics (Div.1, Spinal)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 22 complaints closed in May 2018, 20 of which were closed within the agreed timescales. This gives a 91% completion on time rate and meets the KPI for the month.
The average length of time to close complaints in May 2018 was 29 days which is within normal limits.
Learning identified and actions taken as a result of complaints closed in May 2018 include:

- Some miscommunication has occurred as a result of the changes to Non-Emergency Patient Transport and eligibility for reimbursement
  Action: Position has been clarified, and all relevant departments notified

- Process for booking pre-operative assessment is not robust
  Action: Work is ongoing in the Perfecting Pathways programme

- Pathway for transitioning from epidural pain management is not always followed
  Action: Additional training is being provided

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

No comebacks were received in May 2018. There has been 1 to date in the current financial year

9. Friends and Family Test Results (collected in the iwantgreatcare system)

INFORMATION

The Friends and Family Test in its current format was implemented on 1st April 2014. The Department of Health changed the methodology of the Net Promoter Score to a more straightforward % of patients likely to recommend a service and % not likely to recommend a service. This was because evaluation showed that patients and most NHS employees did not understand the Net Promoter Score and the information provided was frequently misinterpreted.

The Friends and Family Test (FFT) is the mandated patient 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 offered 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

Following a review was undertaken by NHS England, the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics. Since 8 October 2015, all FFT data has been published in a single release The data for Inpatient Services, Outpatient Services and Community Services is required to be submitted to the NHS Digital Data Collection System monthly and the results for every facility are published on the NHS England website.

NHS England has set a mandatory response rate of 35% for all inpatient services. There are no minimum response requirements for outpatient and community services. The Trust sets internal targets for all areas as it is agreed that the data will then be more meaningful.

The guidance for outpatient services is less stringent than for inpatient services. Trusts have the discretion to vary how the test is applied in outpatient settings. For example, at ROH, every patient having an appointment in the outpatient clinic is offered the opportunity to complete a form. However, physiotherapy patients are offered the form at the end of their set of sessions (usually 4 or 5 sessions). As long as there are forms on display in a department that allow an individual to provide feedback after each session should they wish to, this is compliant.

The Trust breaks down its outpatient data into specialities which is more useful to departmental managers. However, the return for Outpatient Services is submitted as a single service.

There are no official requirements to undertake the FFT survey in imaging or theatre departments. However, the Trust takes the view that if feedback is provided in the same format across all departments, then the data is comparable and of use. In addition, there is an expectation that patient feedback is gathered in all areas, even if not mandated.

FFT CONCERNS

The team are now recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In May 2018, 7 concerns were identified from the 1280 individual pieces of feedback we received. As these are anonymous, it is not always possible to track these back to individual patients, but they are shared with the relevant teams and managers as additional feedback. The top three areas of concern in May 2018 were communication with the patient, the information that they had received and arrangements for admission. It should be stressed that this information has been taken from just 7 responses, so it is anticipated that this trend monitoring will be much more significant over a quarter or annually.

RISKS / ISSUES

The Trust is not currently meeting the mandated 35% response rate for inpatient services. There has been an improvement from last month to 31%, but this is being actively monitored and managed to ensure that we first exceed the mandated response rate and then achieve the internal target of 40% for Inpatient Services.

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would recommend the department in May 2018**	**% of people who would NOT recommend the department in May 2018**	**Number of Reviews submitted in May 2018 (previous month in brackets)**	**Number of Individuals who used the Department in May 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	100.0%	0.0%	45 (51)	126	35.7%
Ward 2	95.1%	1.6%	61 (47)	145	42.1%
Ward 3	100.0%	0.0%	19 (6)	60	31.7%
Ward 12	100.0%	2.9%	40 (34)	125	32.0%
Ward 11 (CYP)	50.0%	0.0%	25 (3)	81	2.5%
ADCU	98.4%	0.0%	184 (145)	657	28.0%
HDU	100.0%	0.0%	16 (17)	69	23.2%
CYP HDU	100.0%	0.0%	2 (3)	6	33.3%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in May 2018**	**% of people who would NOT recommend the department in May 2018**	**Number of Reviews submitted in May 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.3%	0.8%	770 (868)	10.8%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in May 2018**	**% of people who would NOT recommend the department in May 2018**	**Number of Reviews submitted in May 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	100%	0%	57 (72)	36.3%

In addition to the Friends and Family Test question, there are an additional 5 questions on the survey which relate to the following key elements of patient experience:

- Privacy & Dignity
- Cleanliness
- Kindness and Compassion
- Timely Information
- Being involved in the decision-making process

These give an overall star rating out of 5 stars on the system, with 5 out of 5 being the highest available score

I **Want Great Care** -

The Royal Orthopaedic Hospital NHS Foundation Trust

Date
01 May - 31 May

Your average score for all questions this period

4.90

Reviews this period

1280

Your recommend scores

5 Star Score

4.87

% Likely to recommend

97.3%

% Unlikely to recommend

0.5%

10. Duty of Candour – *The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.*

There are currently 12 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. Litigation

New Claims

3 new claims against the Trust were received in May 2018. The detail of these was reviewed by the Quality & Safety Committee and a summary report into all ongoing claims will be considered at the July meeting of the Committee.

On-going claims

There are currently 31 on-going claims against the Trust.
30 of the claims are clinical negligence claims.
1 claim is a staff claim

Pre-Application Disclosure Requests*

0 new requests for Pre-Application Disclosure of medical records were received in May 2018.

*Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes, the Data Protection Act 1998 and the Access to Health Records Act 1990).

12. Coroner's

There was 1 Coroner's inquest held in May 2018. This is detailed on page 5.

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 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 and 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 incompletion. The following areas examined; • form evident in notes • Sign in Section • Timeout section • Sign out section Total cases = 844 The total WHO compliance for May 2018**= 100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
The WHO checklist for ADCU had is scheduled into Phase 2 on the Theatre man rollout. Contractually the Trust requested that the WHO checklist is created on Theatre man for Theatres and CT initially within phase 1. This was due to the paper version of the WHO in use being deemed satisfactory for ADCU's use during this period by the individuals on the project team.

14. Infection Prevention Control

INFORMATION

Infections Recorded in May 2018 and Year to Date (YTD)	Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72 hour Clostridium difficile infection (CDI)	0	0
Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

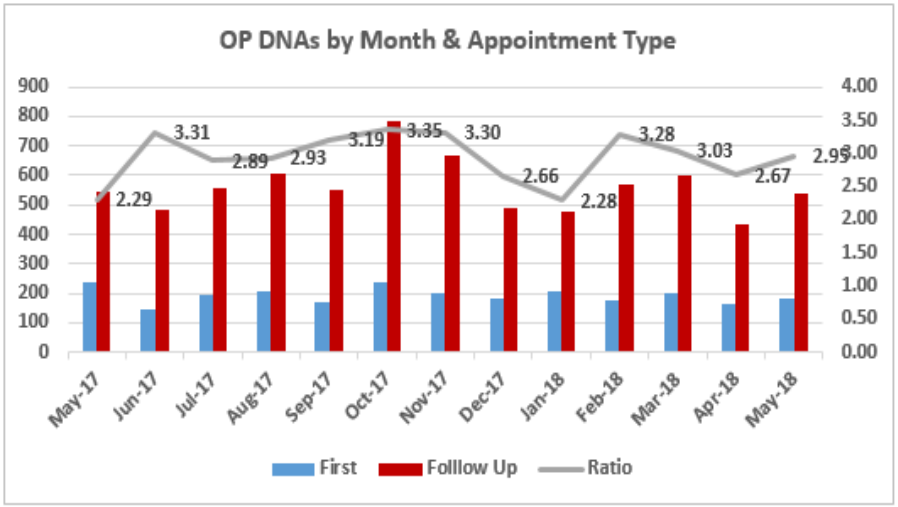
Mandatory Training rate for the Trust in IPC is currently 93.29% compliance

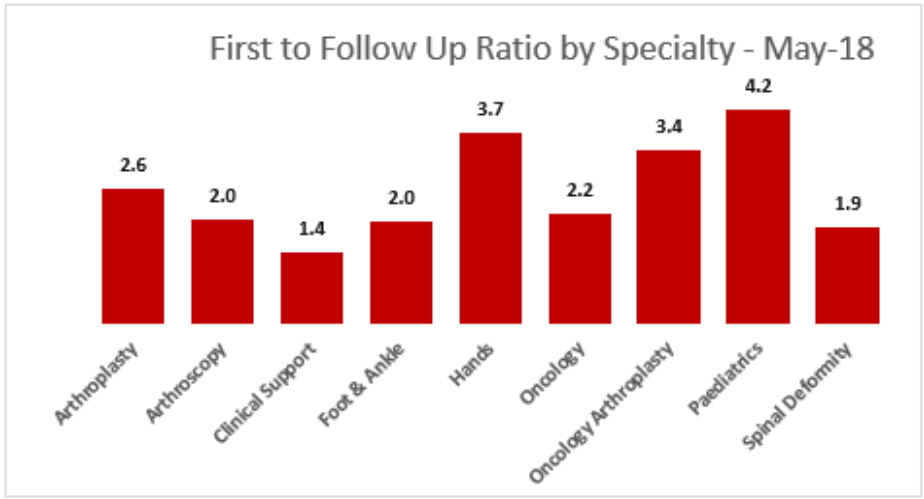
RISKS / ISSUES

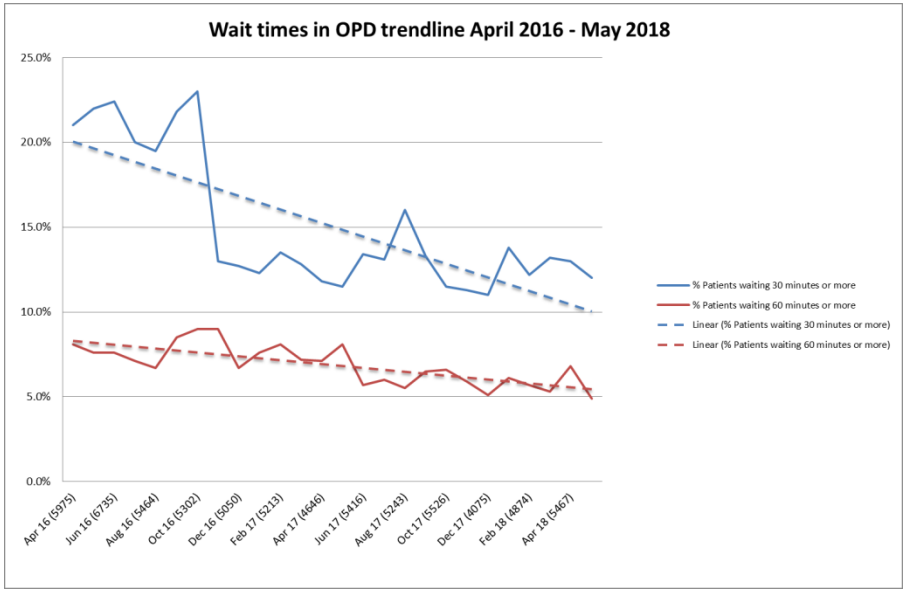
There are currently 10 IPC risks on the Risk Register, recorded from July 2017 (3 corporate, 2 divisional and 5 local). 1 risk (542) is to be removed, as agreed at the recent IPCC and the remaining 9 continue to be monitored by the Head of Infection Prevention.

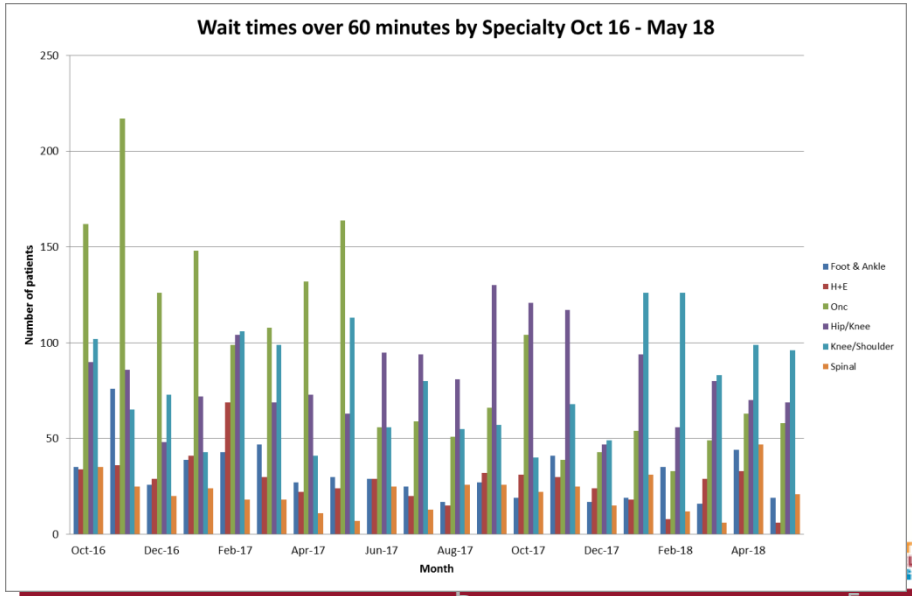
8 incidents in May recorded. 5 recorded as no harm, 2 as low harm and 1 as moderate harm. 3 cases have been completed (poor management of sharps bins within theatres) and 5 cases remain under review (3 suspected SSIs, 1 unclean patient sling and 1 malfunctioning Bioquell machine).

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





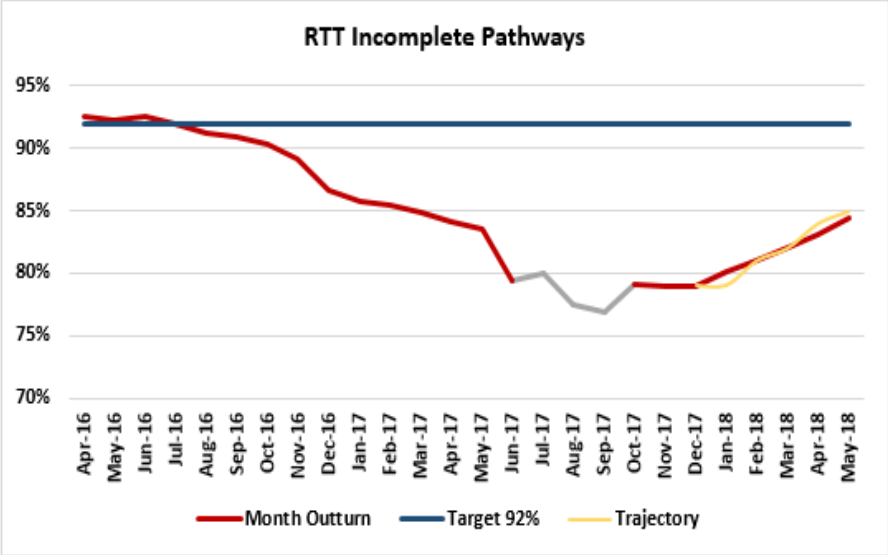


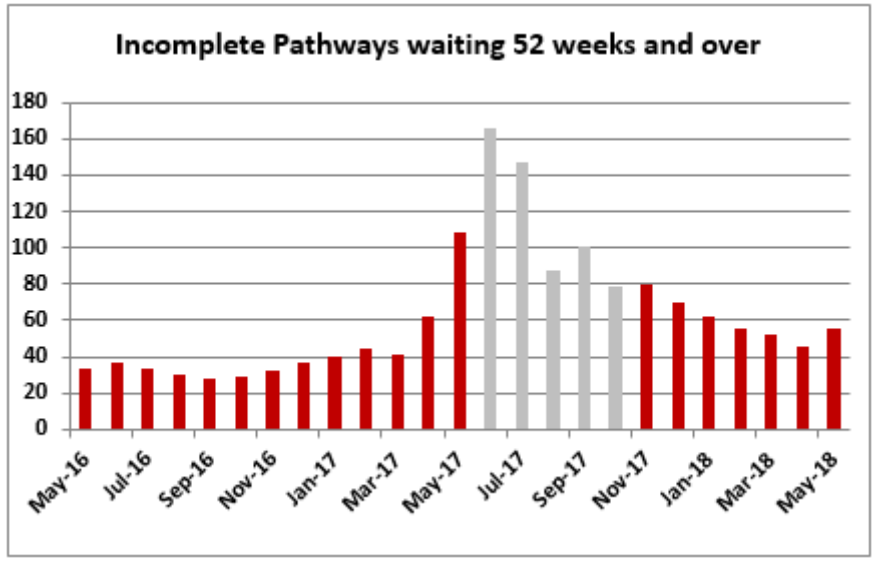


INFORMATION
In May there were 11 incident forms completed to highlight clinics running more than 60 minutes late. There were 12.0% of patients waiting over 30 minutes and 4.9% waiting over 1 hour which is below the target of 5% and this is the first time this has be The over 30 minute waits have improved slightly from the previous month from 13%. The largest number of incidents were reported in Hip / Knee and S specialties which is consistent with the previous month. The monthly audit identified the following : - • 6 - Complex patients 3 - Clinic overbooked 1 - Consultant/Clinician Delay 1 – Other All incidents continue to be investigated by the relevant operational managers. An audit of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause. This data is shared with the Ops team at the weekly Operational Management Team meeting to review trends and effect appropriate improvement interventions . A more detailed analysis of data has been carried out for May and this has highlighted 2 outliers who have particularly high number of patients waiting more than 30 and 60 minutes. Focussed review of the clinic templates will be undertaken with the Clinicians to share these results. Full capacity modelling for outpatient clinics and inpatients across all specialties has been completed for the majority of specialties. Additional funding is to be requested via a business case to increase the qualified and unqualified nursing establishment within both main and paediatric outpatients to support any required increase in capacity, although there continue to be challenges in recruitment for qualified and unqualified staff.

ACTIONS FOR IMPROVEMENTS / LEARNING
• Continue to drive incident investigations and action through relevant Operational Manager • Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays • Electronic clinic rescheduling form has been trialled in hands and is due to be rolled out across the Trust by 2ND July 2018 • Development of clinic utilisation tools through InTouch and Health Informatics • Work is being planned in CYPOPD to improve the reception environment which will allow InTouch to be used in real time and therefore provide waits as currently this is not available
RISKS / ISSUES
Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. This will be addressed as part of the electronic clinic rescheduling form project InTouch upgrade has not yet begun due to limited IT and project management resources. These are currently being reviewed and will be discussed and prioritised at the IM&T project board.

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



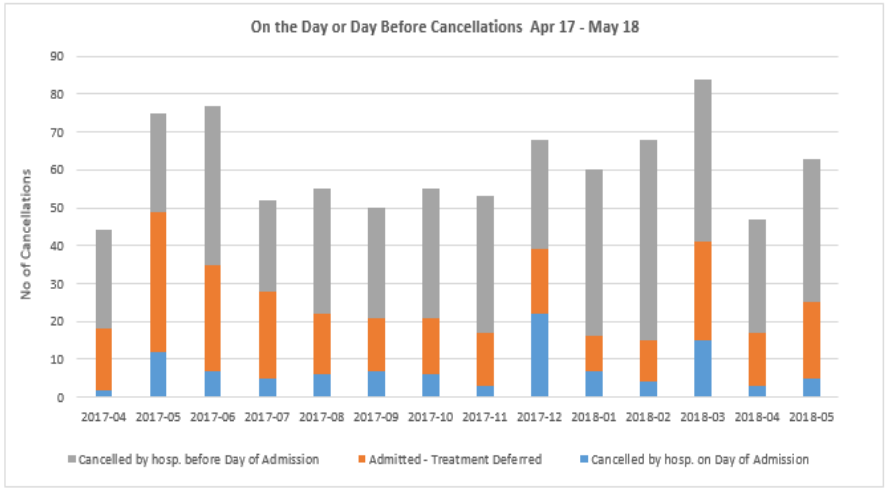


		Indicative	Reported Month						Reported Quarter 2017/18					
Target Name	National Standard	Apr 18	Mar 18	Feb 18	Jan-18	Dec-17	Nov-17	Oct-17	Q3 (Oct, Nov, Dec)	Breach	Total	Q2 (July, August, Sept)	Breach	Total
2ww	93%	98%	94.4%	100%	97.10%	100%	100%	95%	98.30%	2	119	99.20%	1	120
31 day first treatment	96%	100%	90%	88.9%	91.67%	100%	91.70%	100%	96.30%	1	27	96.60%	1	29
31 day subsequent (surgery)	94%	90%	100%	100%	94.10%	100%	100%	100%	100.00%		30	97.40%	1	38
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
62 day (traditional)	85%	87.5%	71.4%	87.5%	86.67%	83.30%	83.30%	100%	82.40%	1.5	7	72.20%	2.5	9
62 day (Cons Upgrade)	n/a	100%	72.7%	80%	100%	90.90%	90.90%	81%	82.10%	2.5	14	88.90%	1	9
31 day rare (test, ac leuk, child)	n/a		0%		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	0	0						

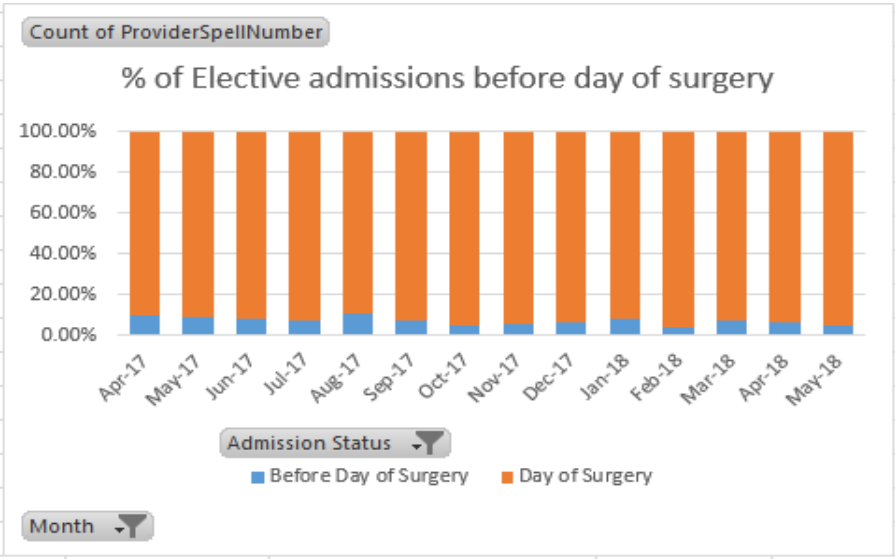
INFORMATION
The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly. For May 2018 the RTT trajectory was 85% with performance at **84.38 %** , with 55 patients over 52weeks (trajectory 67) No patients were recorded as over 52 weeks in specialties other than Spinal Deformity.
ACTIONS FOR IMPROVEMENTS / LEARNING
The team continue to concentrate on any patients over 40 weeks, this number continues to reduce. At the end of December 2018 we had 238 patients over 40 weeks; at the end of May 2018 this figure is now 149, 117 of which are Spinal Deformity. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.
RISKS / ISSUES
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance. 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 monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity continues through the Summer with discussion underway to continue the lists until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families, one patient has a date for surgery at the end of June.

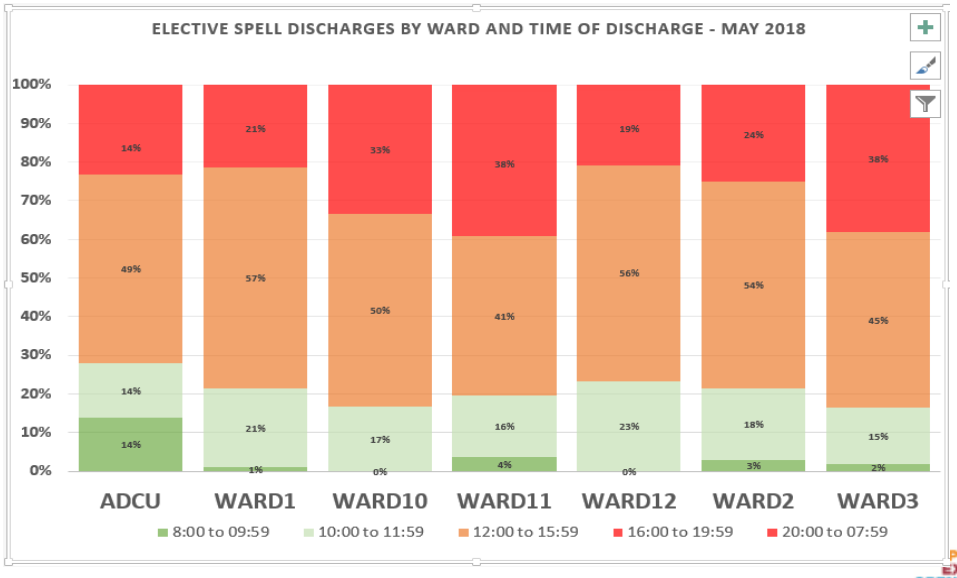
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

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	12	37	26	75	3
2017-06	7	28	42	77	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
2018-04	3	14	30	47	0
2018-05	5	20	38	63	
Grand Total	**104**	**260**	**487**	**851**	**10**





INFORMATION
The number of cancellations on the day of surgery by the hospital has increased in May from 17 to 25 . An analysis of the 25 patients cancelled on the day of admission highlighted the reasons for cancellation varied across a range of issues; however the main contribution to the increase was the CT scanner breakdown – where 10 patients required reconvening of their appointments. Other reasons included ran out of theatre time, emergency patients taking priority, availability of equipment and bereavement. In addition, patients cancelled due to medication issues was also identified as a contributing factor to cancellations on the day. Cancellations before the day of surgery have increased in month from 30 to 38 patients. An analysis of the 38 patients cancelled by the hospital before admission highlighted two main factors for cancellations prior to surgery: patients being offered earlier dates for surgery and patients being deferred to accommodate emergencies. A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The Terms of reference of this meeting have recently been revisited and now includes correlation with incident reporting prior to the meeting and analysis of issues identified at the theatre' huddle' meetings to ensure interventions are delivered to reduce avoidable cancellations, wherever possible. Work continues to strengthen the POAC process . The Clinical Model was presented at the Audit Meeting on 31st of May for wider Clinical engagement and sign off , which was received well and generated useful clinical feedback which will be included in the work stream going forward .

ACTIONS FOR IMPROVEMENTS / LEARNING
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data : - Refresher training continues to support improved accuracy of data inputting on the PAS system to inform actions and allow robust audit of cancellation reasons. - Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation . - The launch of the Stryker project commenced on 24th May 2018. - An audit of patients who DNA on the day of surgery is currently being undertaken to drive improvements in this area following patient feedback. - Roll out of replacement theatre equipment continues to reduce issues relating to equipment availability and additional power tools are currently being scoped.
RISKS / ISSUES
Shorter turnaround times for pre –operative assessment are required to respond flexibly to increased levels of activity. Existing aging equipment asset base .

Finance and Performance Report

May 2018

CONTENTS

INTRODUCTION

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

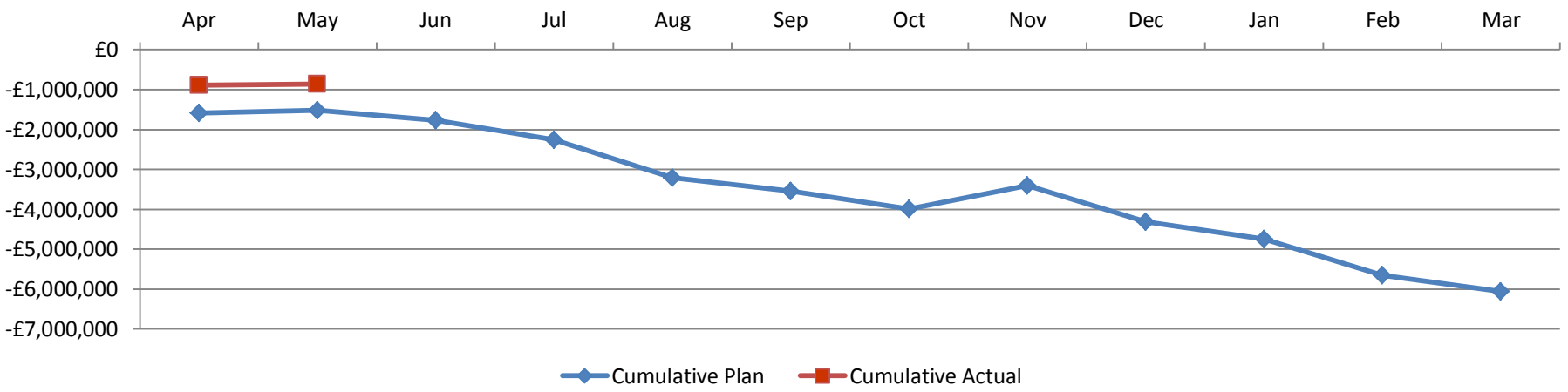
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

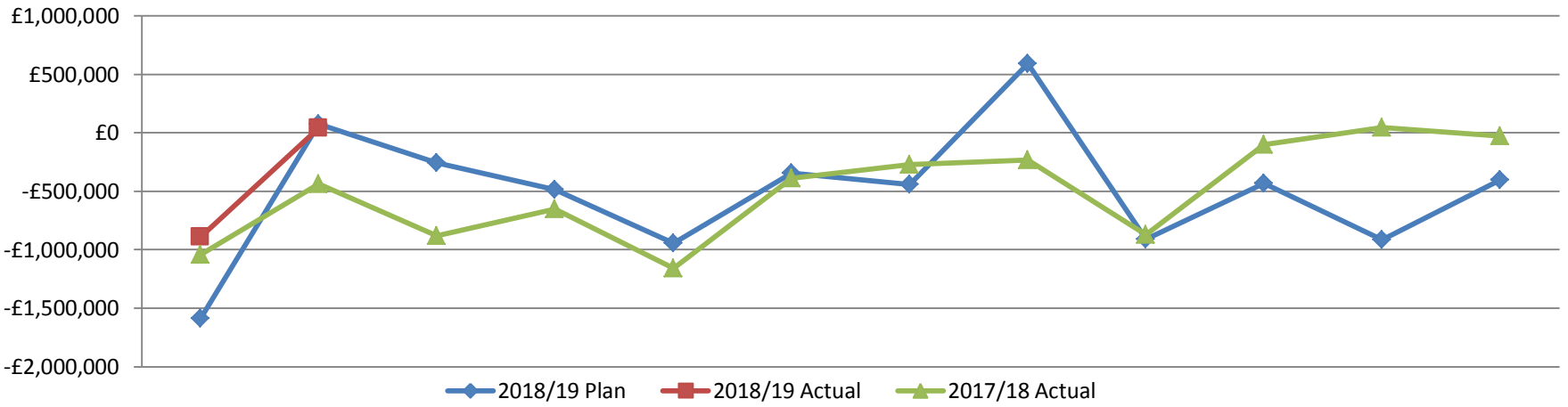
	YTD M2 Original Plan £'000	YTD M2 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	12,273	12,928	655
Other Operating Income	809	809	-
Total Income	**13,082**	**13,737**	**655**
Employee Expenses (inc. Agency)	(8,448)	(8,461)	(13)
Other operating expenses	(5,917)	(5,898)	20
Operating deficit	**(1,283)**	**(621)**	**662**
Net Finance Costs	(234)	(233)	1
Net deficit	**(1,517)**	**(854)**	**663**
Remove donated asset I&E impact	10	11	1
Adjusted financial performance	**(1,507)**	**(843)**	**664**

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 (excluding revaluation gains)



Monthly Surplus/Deficit Actual vs Plan (excluding revaluation gains)



INFORMATION

The Trust has delivered a deficit of £892,000 in April against a planned deficit of £1,584,000, £691,000 ahead of plan.

Activity in month remained strong although slightly underperformed against plan whilst YTD activity and income are still ahead of plan, representing a strong start to the year.

Total Expenditure was also down on plan in month 2, and on plan on a cumulative basis. Both Pay and Non Pay are showing increases when compared to 17/18 spend but this is generally reflective of additional activity being delivered.

The main concern is still agency spend which remained up against the cap for the month. This is discussed in more detail later.

The CIP target for 2018/19 is £3,000,000 of which £2,976,000 has been identified. During month 2 £106,000 of saving was recognised against a plan of £167,000 and a forecast of £2,986,000. The current plan is based on 21% delivered through non pay savings, 41% through income schemes and 18% with pay schemes. A CIP supplementary slide has been included in these papers to give a more detailed update on the schemes.

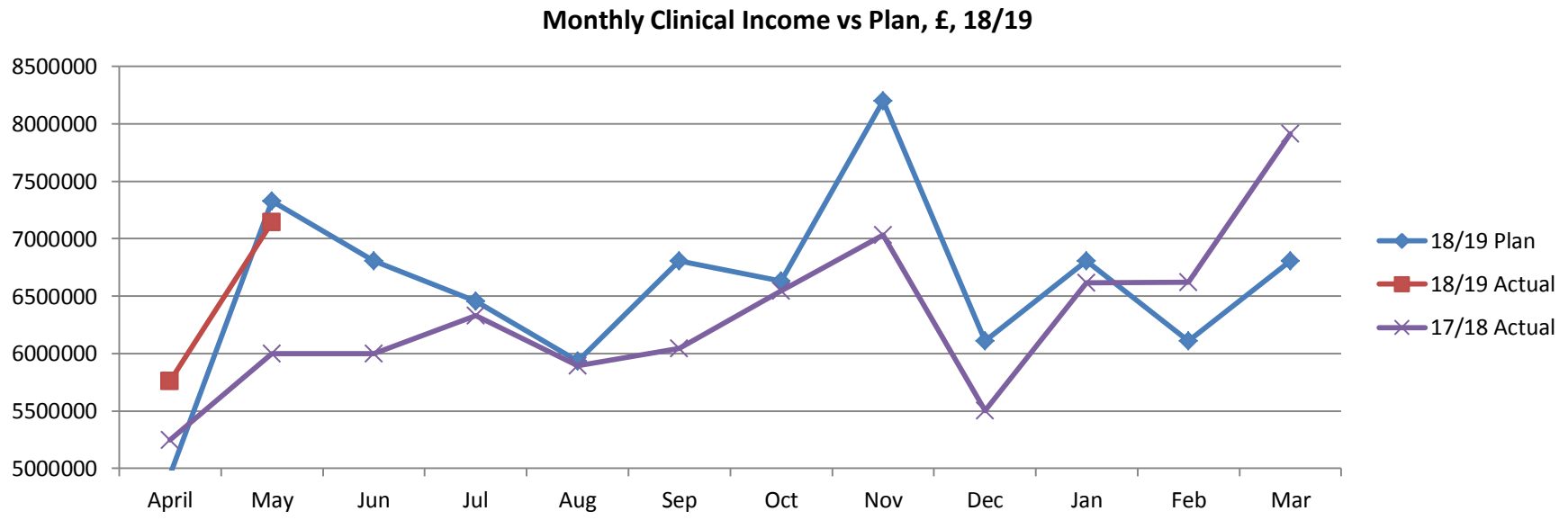
ACTIONS FOR IMPROVEMENTS / LEARNING

There needs to be focussed attention on bridging the gap on CIP schemes and if possible building in a slippage contingency to ensure the full year target is achieved.

RISKS / ISSUES

Month 2 has a challenging financial target off a surplus of c.£70k. Activity is looking relatively strong thus far in May, but this remains a challenging target.

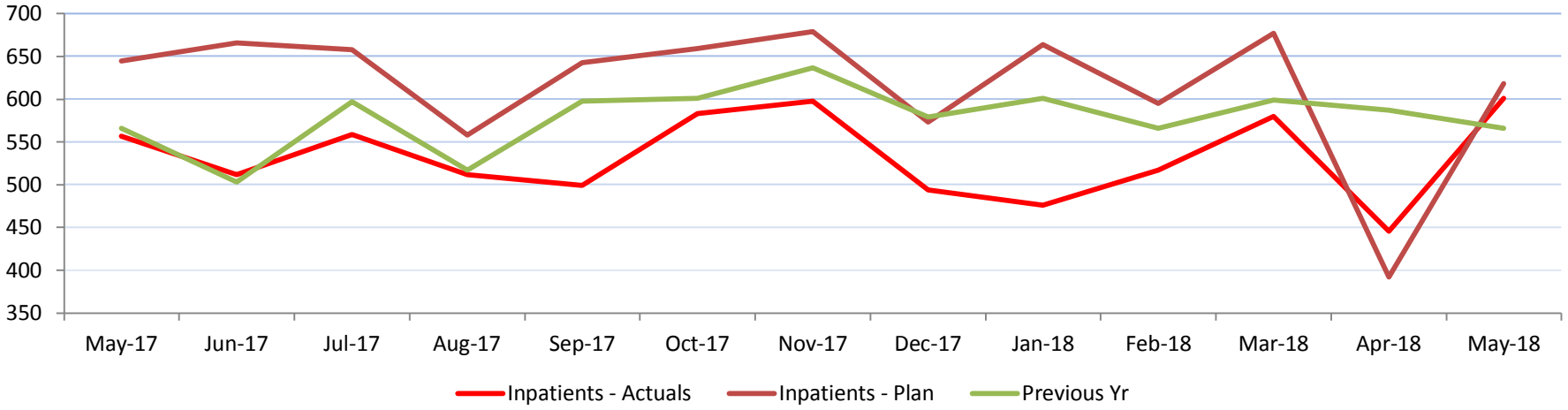
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



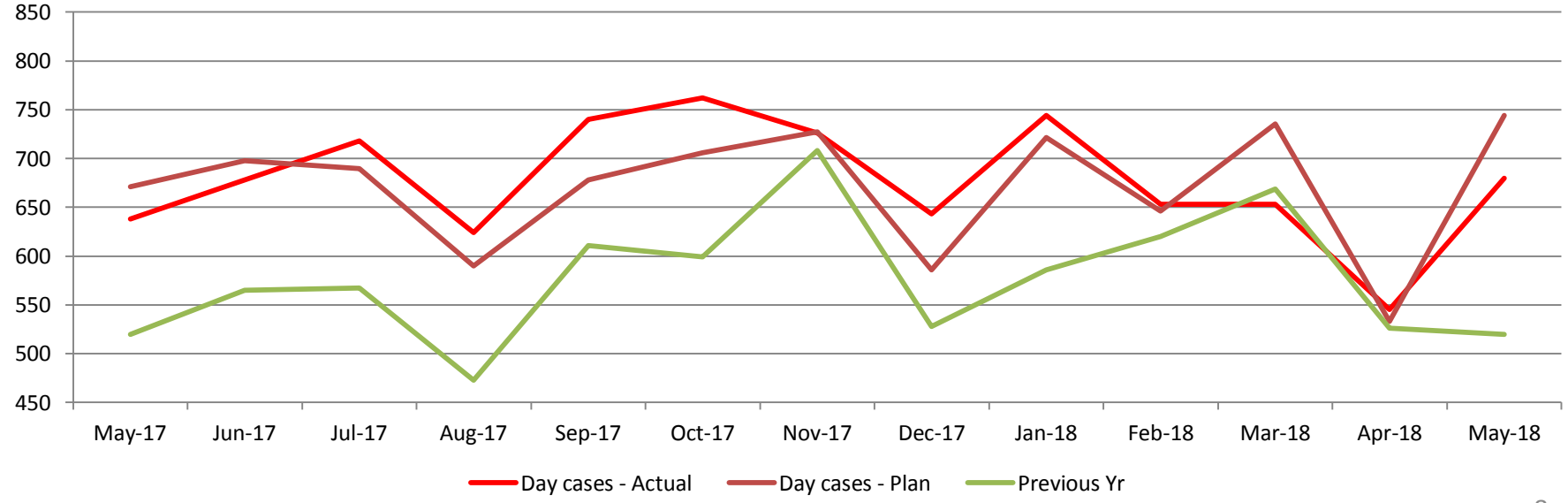
Clinical Income – May 2018 £'000			
	Plan	Actual	Variance
Inpatients	3,871	3,702	-169
Excess Bed Days	45	58	13
Total Inpatients	3,916	3,760	-156
Day Cases	922	887	-35
Outpatients	717	667	-50
Critical Care	253	219	-34
Therapies	248	108	-140
Pass-through income	233	304	71
Other variable income	460	618	158
Block income	580	580	0
TOTAL	7,329	7,143	-186

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	6,483	6,641	158
Excess Bed Days	75	58	-17
Total Inpatients	6,558	6,699	141
Day Cases	1543	1568	25
Outpatients	1202	1336	134
Critical Care	423	397	-26
Therapies	415	341	-74
Pass-through income	390	552	162
Other variable income	770	1039	269
Block income	972	972	0
TOTAL	12,273	12,904	631

Inpatient Activity



Day Case Activity



NHS Clinical income has under-performed against plan by 2.56% in May having over-performed by 16.94% in April. Cumulatively, the trust is now 5.13% above plan. The admitted patient care performance was below plan financially and below on activity levels, with discharged activity 17 below the target. Day case activity also underperformed and was below the target by 64 cases. The average tariff price for the period has decreased slightly in elective and in day cases. Case-mix in May has moved slightly towards elective at 45% compared to 42% in April.

Outpatients have over-performed year to date with although there has been a decrease in attendances against plan in May for first and follow up attendances . First to follow up ratio has increases year to date at 2.12:1.

Other variable income over performed in month. This is due to a number of reasons including a data clean-up exercise within informatics which identified an additional £60k of Diagnostic Imaging income. Pre operative attendances also improved with an increase of £35k compared to month 1, whilst private patient activity performance remains strong.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust is working operationally and financially to plan for the impact of various consultant changes within the Trust and ensure that the activity plans are delivered.

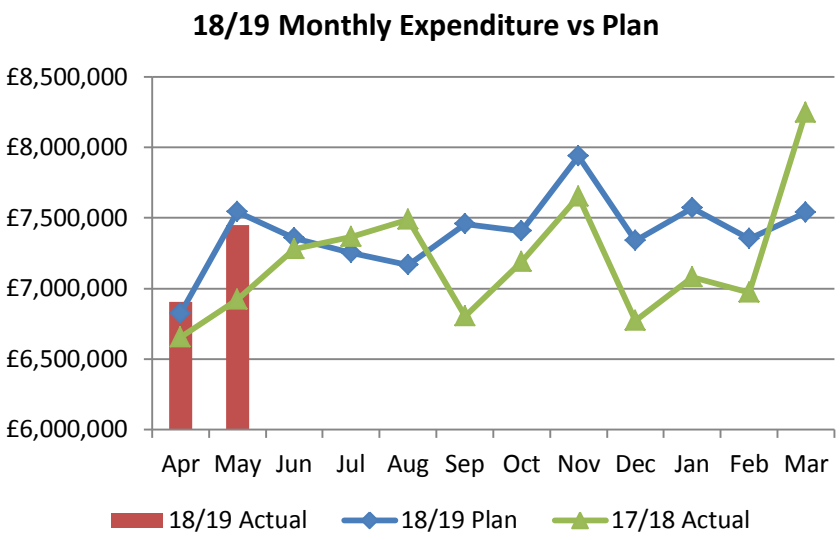
The IP activity plans have been developed in conjunction with operations, and have been split down to agreed levels by week, service, individual consultant and activity type. OP activity plans by week have also been developed with operations.

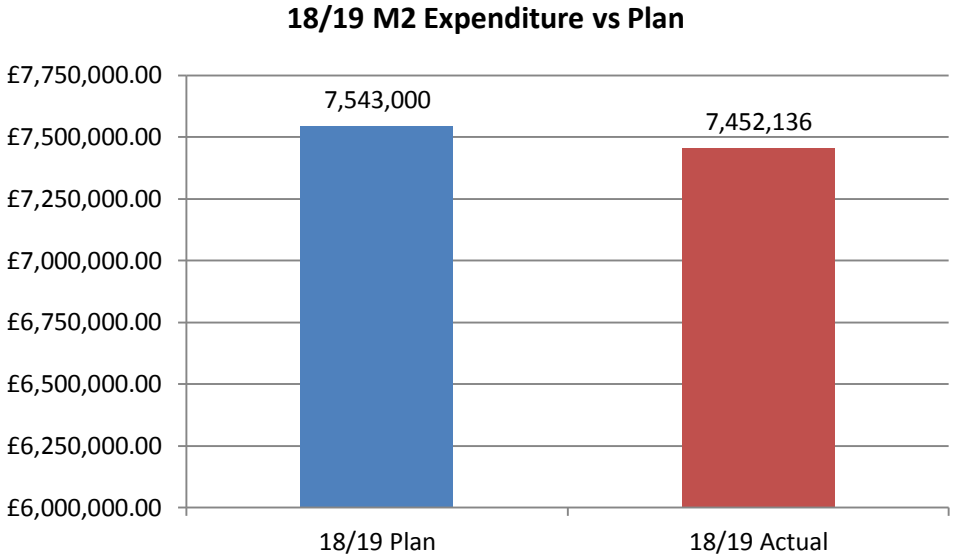
Work remains ongoing as part of Perfecting Pathways to ensure that clinicians are recording the appropriate co-morbidities of the patient's they treat, resulting in the trust being funded for the work actually performed.

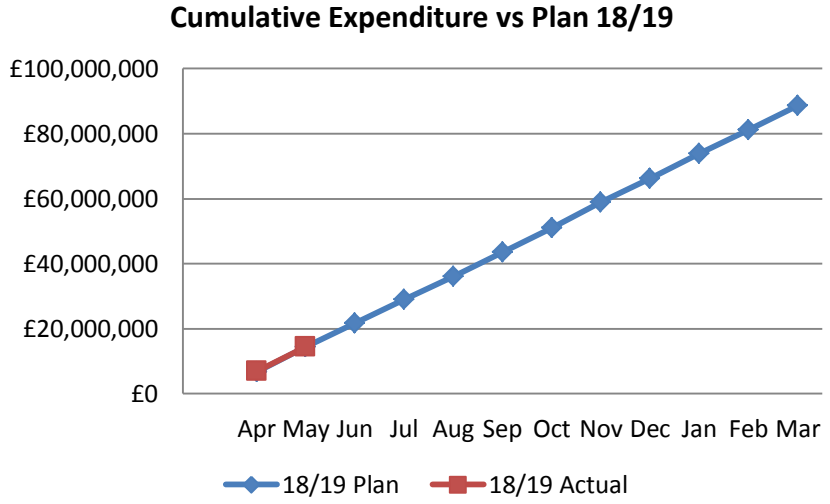
RISKS / ISSUES

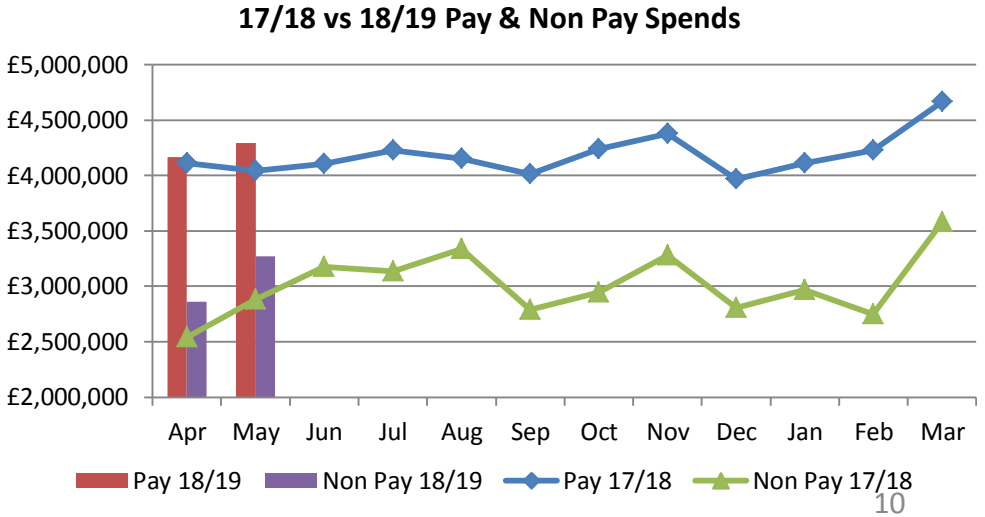
The June activity targets remain challenging, and therefore it will be key to continue to track performance against those targets to ensure they are being met, or that underperformance is mitigated against.

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 £7,452,000, which was a £91,000 underspend against the plan of £7,543,000.

Pay spend is in line with plan year to date with a £63,000 overspend in month. This has been driven largely by agency spend, as will be discussed on the following page.

Non-pay spend was £154,000 lower than plan, with particularly strong performance in theatres.

ACTIONS FOR IMPROVEMENTS / LEARNING

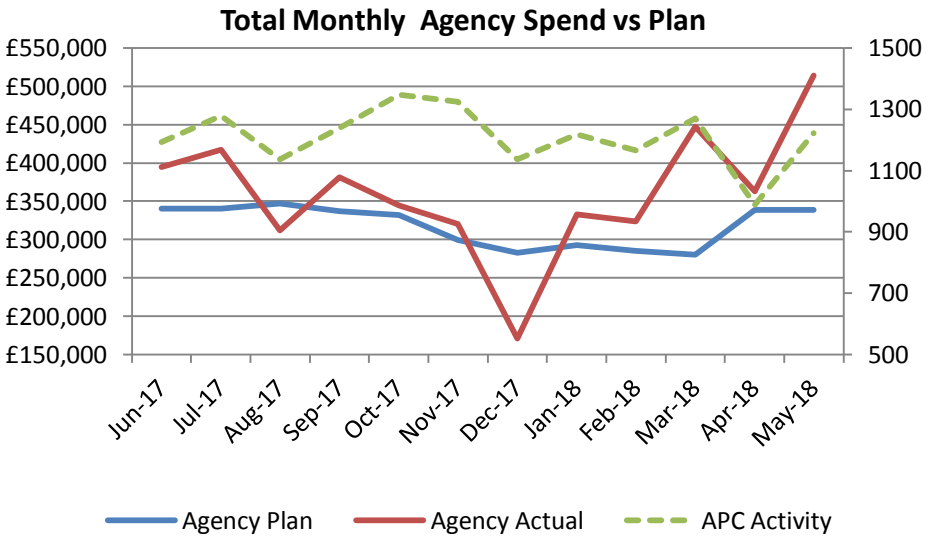
Costs will continue to be scrutinised and minimised.

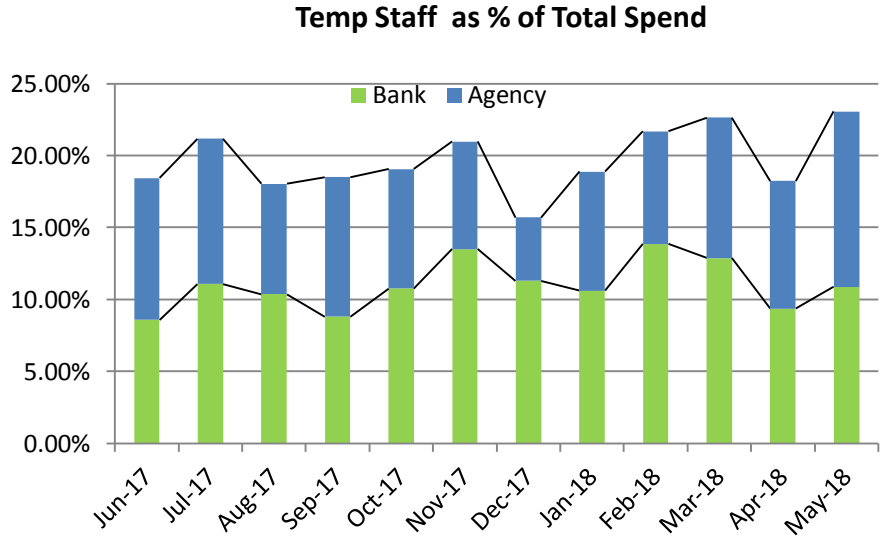
There is further learning from the year end stock count and subsequent audit which will be taken forward and acted upon within 2018-19 to give greater control over stock costs throughout the year.

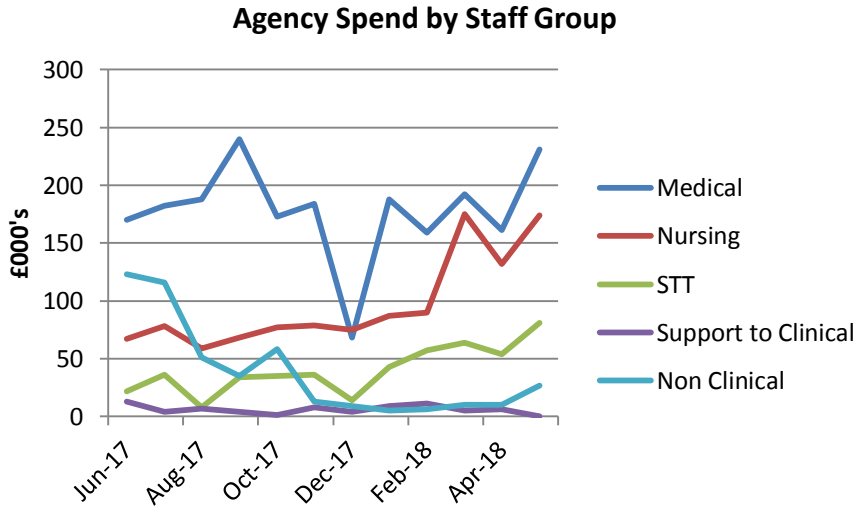
RISKS / ISSUES

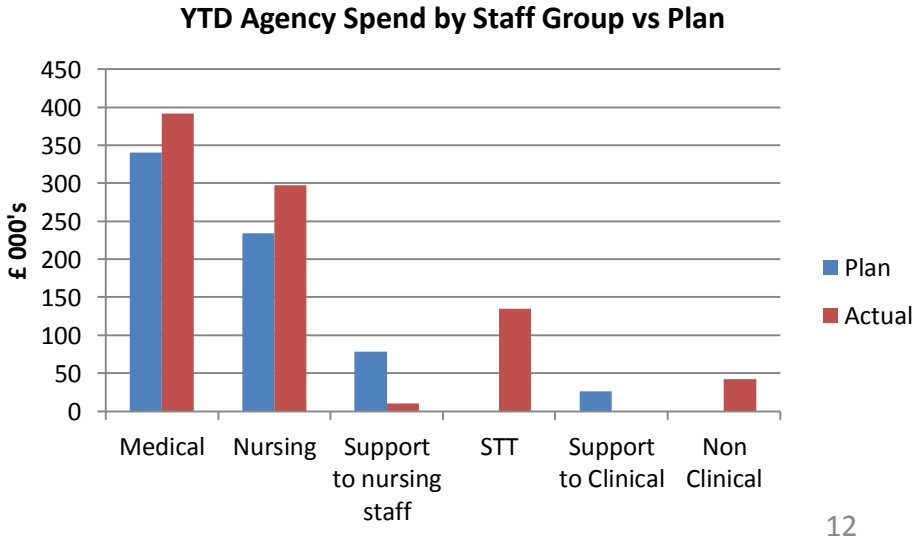
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements









INFORMATION

Agency spend has seen a further increase and reached £514,000. In addition this figure remains high in comparison to the average in previous months, and the agency cap was overspent against in month.

An analysis of the spend against plan shows that the main reasons for the overspend are agency spend in therapies (both clinical and admin), nursing (particularly Wards 12 and 3) and medical.

Analysis of nursing spend using the rostering system suggests that there was an increase in agency spend due to acuity, vacancies and sickness.

Therapies are still utilising agency in order to reduce waiting times.

Medical agency continues to be challenging due to the placement of deanery funded doctors, although new contracting arrangements for agency medics should militate further increases.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

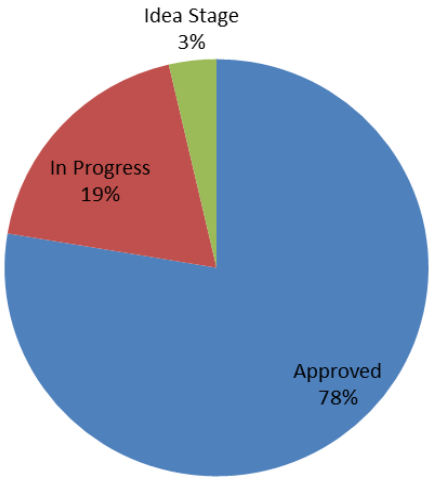
With regards to nursing agency, finance are working with the operational team to review the accuracy of agency spend categorisation on e-roster to allow targeted review and action on agency spend actions.

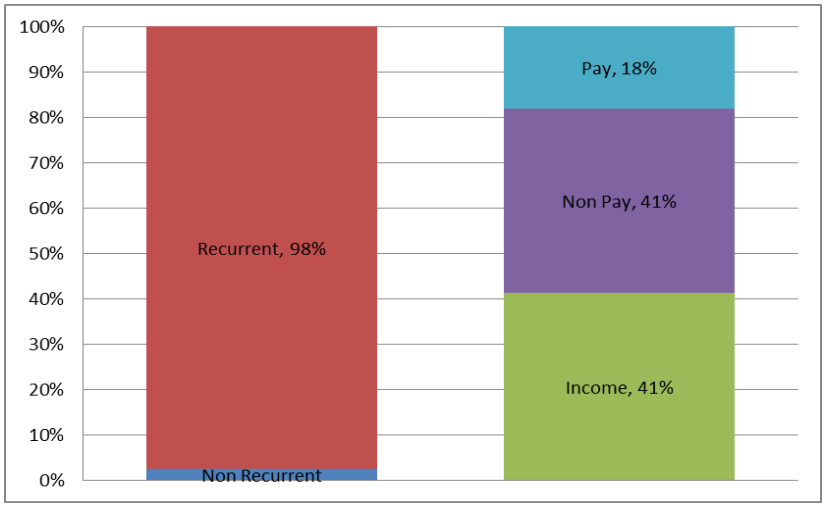
RISKS / ISSUES

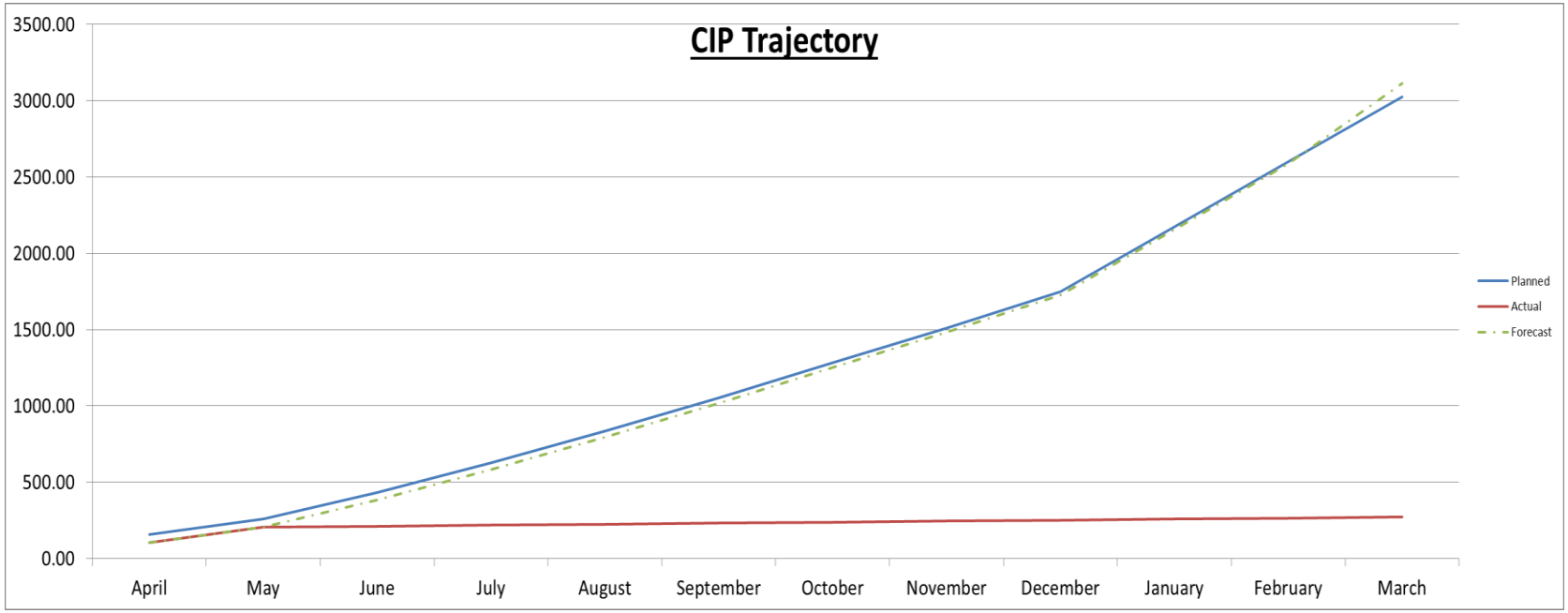
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory will have a direct impact on our regulator ratings.

Within the draft annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

5. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2018/19







INFORMATION

The CIP target for 2018/19 is £3,000,000 of which £2,976,000 has been identified. During month 2 £106,000 of saving was recognised against a plan of £167,000 and a forecast of £2,986,000. The current plan is based on 21% delivered through non pay savings, 41% through income schemes and 18% with pay schemes. The full year impact of these savings are £304,000 against a full year plan of £3,024,000. There is an unidentified gap of £24,000.

	Plan	Actual Full year effect	Forecast	Forecast vs Plan Variance	YTD Plan	YTD Actual	YTD Variance
Division 1	£705	£13	£702	-£3	£58	£13	-£45
Division 2	£1,165	£13	£1,150	-£15	£58	£13	-£46
Division 4	£33	£33	£33	£0	£0	£0	£0
Corporate	£1,121	£246	£1,227	£106	£182	£179	-£3
TOTAL	£3,024	£304	£3,112	£88	£299	£205	-£94
Unidentified			£24				
Shortfall			£112				

ACTIONS FOR IMPROVEMENTS / LEARNING

A CIP Programme Board chaired by the Interim Director of Finance commenced on 19th April, with the second meeting now having been held. These will be held monthly during Q1 with the frequency to be reviewed after this. The purpose of this group will be to monitor performance and escalate any risks/issues.

During 2017/18 the in year unidentified gap was not recovered, and as such significant work has been done to ensure full plans have been developed for 2018/19.

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the Managed Service Contract for Theatres scheme which is expected to deliver £550,000 from January 2019. A project group has been established and project specific resources are currently being identified to ensure that timescales can be met.

6. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M2 Plan £'000	M2 Actual £'000	Var £'000
Intangible Assets	690	645	(45)
Tangible Assets	48,158	47,569	(589)
Total Non-Current Assets	**48,848**	**48,214**	**(634)**
Inventories	4,858	4,890	32
Trade and other current assets	6,643	5,378	(1,265)
Cash	1,607	2,048	441
Total Current Assets	**13,108**	**12,316**	**(792)**
Trade and other payables	(12,942)	(12,118)	824
Borrowings	(1,557)	(435)	1,122
Provisions	(173)	(173)	-
Other liabilities	(207)	-	207
Total Current Liabilities	**(14,879)**	**(12,726)**	**2,153**
Borrowings	(4,479)	(5,167)	(688)
Provisions	(354)	(354)	-
Total Non-Current Liabilities	**(4,833)**	**(5,521)**	**(688)**
Total Net Assets Employed	**42,244**	**42,283**	**39**
Total Taxpayers' and Others' Equity	**42,244**	**42,283**	**39**

INFORMATION

Tangible assets are significantly below plan due to slippage on various schemes throughout the trust. The Deputy Financial Accountant is performing a full review in a timely manner for next month end to ensure the trust will be on track to deliver its capital target by the year end.

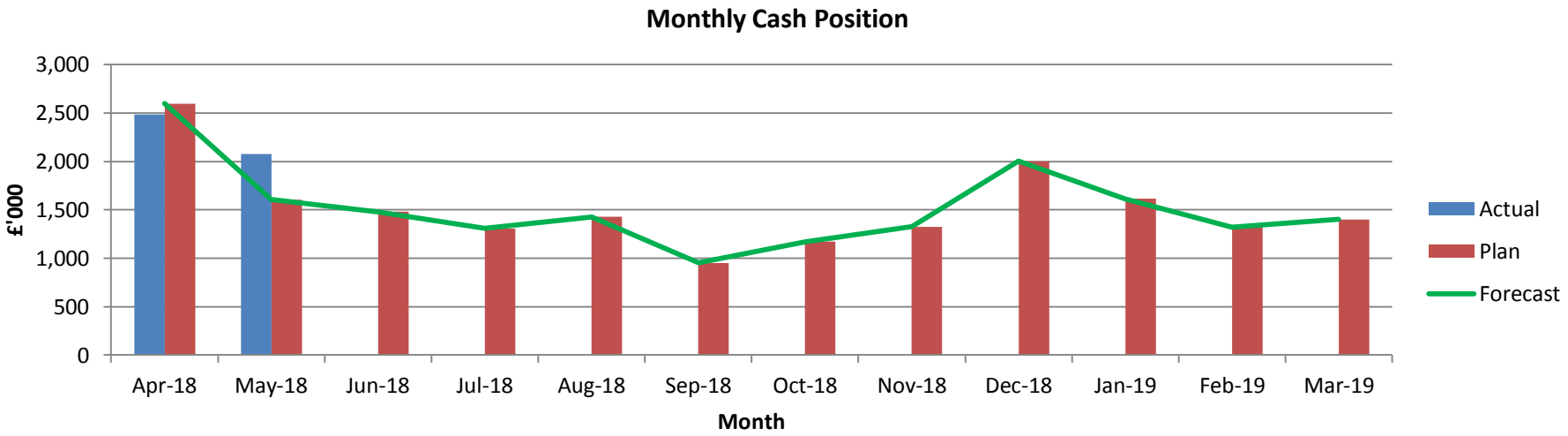
The variances on borrowings are as a result of the ageing of the loans being incorrectly calculated at the time of the annual plan submission. The actuals therefore represent an accurate split. Borrowing is lower than expected at this time of the year overall due to the cash balances being higher than plan as described on the next page.

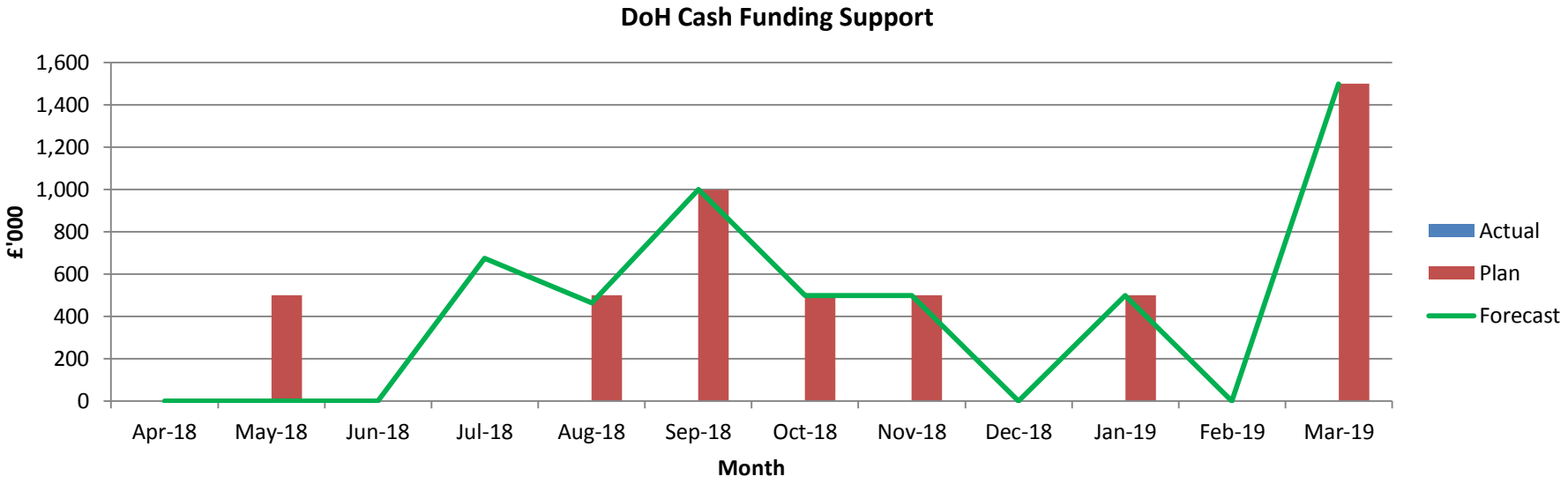
ACTIONS FOR IMPROVEMENTS / LEARNING

In the coming months, further balance sheet metrics regarding better payment practice code and debtor ageing will be included within the report.

RISKS / ISSUES

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 was £441,000 above planned levels at the end of May, due to the higher than expected levels of cash at the year end.

However, overall liquidity remains challenging and cash support has been requested from the Department of Health for July of £676,000. This is due to the Trust being requested to exclude the expected STF payment from its cash flow forecasting. If this is received in a timely manner then the trust will not be required to draw this loan down.

ACTIONS FOR IMPROVEMENTS / LEARNING

The finance team continue to run a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team in order to scrutinise both the current and future cash position, but also to identify areas for cash control improvement. The committee continues to review cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the DHSC to be actioned.

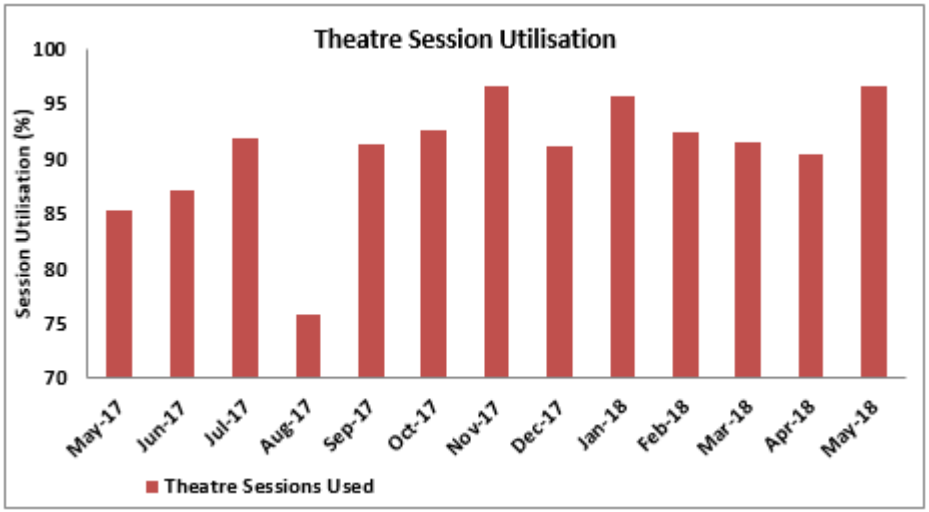
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DHSC not approving a cash loan or approving a lower than requested amount.

8. 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

Theatre list utilisation for May was 96.58% compared to April (90.43%).

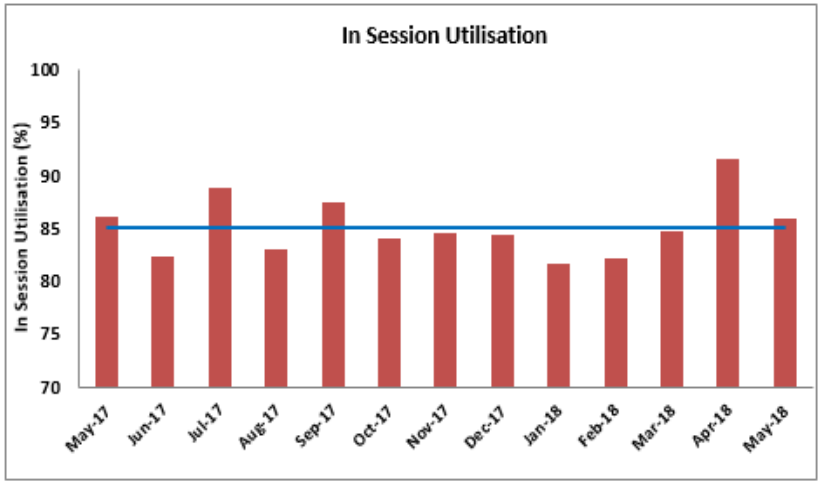
Activity was also one the highest recorded, with 576 cases being completed during the month, despite there being two bank holidays.

Input and support from Stryker Business Solutions has begun with an early focus on surgeons preference cards, tray rationalisation, patient flow covering ADCU through to theatre recovery and current processes for the introduction of new equipment and/or implants.

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc. will also need to 'grow' alongside theatres to ensure maximum efficiency gains.
- Equipment – not enough power tools etc. to keep up with increased activity/demand.

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



INFORMATION

Whilst sessional utilisation has remained strong, the average in session utilisation has struggled to reach the 85% over the last 6 months, although the average for the year is 84.8%. We are reviewing the correlation between the two measures.

Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 85.91% in May compared to the previous month (91.61%).

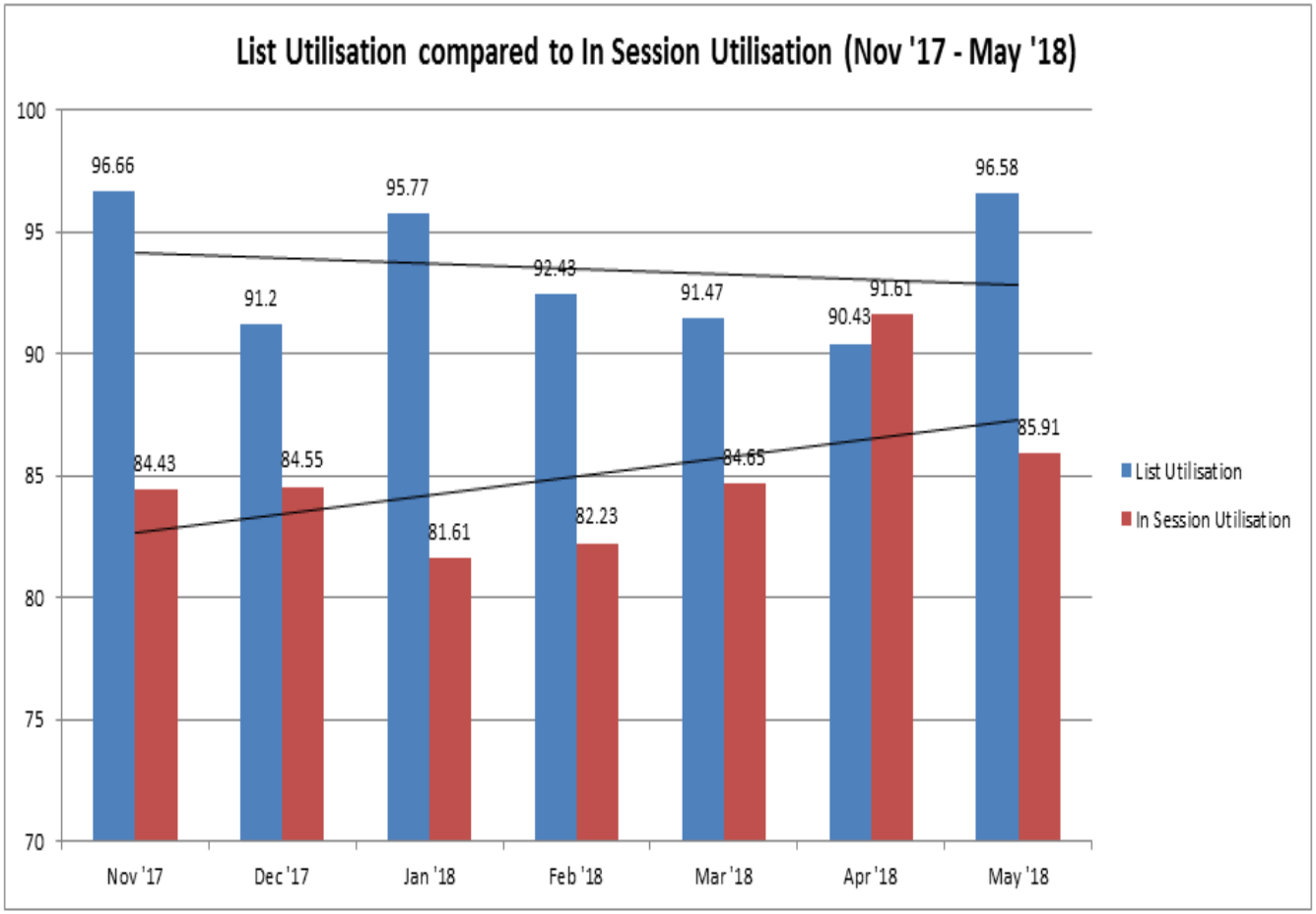
May saw a slighter higher level of cancellations either on the day of admission or before the day of admission which would have impacted on the in session utilisation.

Themes continue to remain DNA's and medically not fit.

RISKS / ISSUES

- Last minute changes to lists impact on the efficient running and planning of theatre lists .

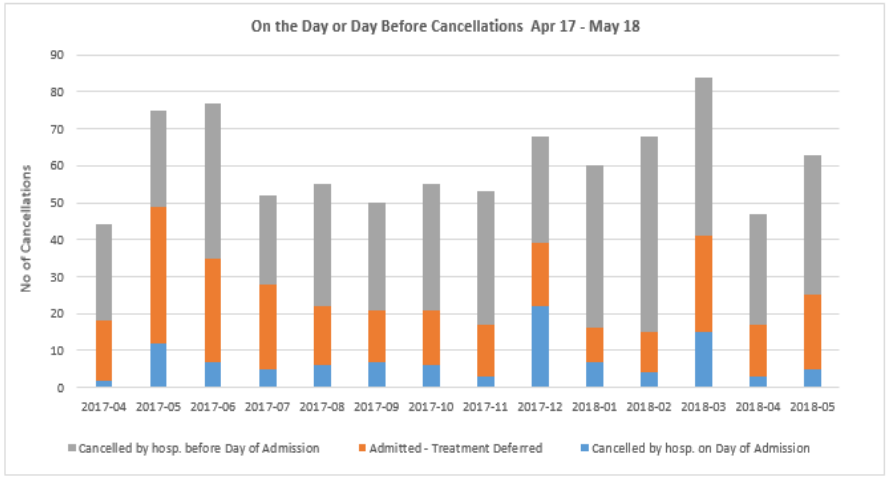
9a. Theatre List utilisation compared to In session utilisation – November 2017-May 2018



Mth	List Utilisation	In Session Utilisation
Nov '17	96.66	84.43
Dec '17	91.2	84.55
Jan '18	95.77	81.61
Feb '18	92.43	82.23
Mar '18	91.47	84.65
Apr '18	90.43	91.61
May '18	96.58	85.91
Average	93.51	85.00

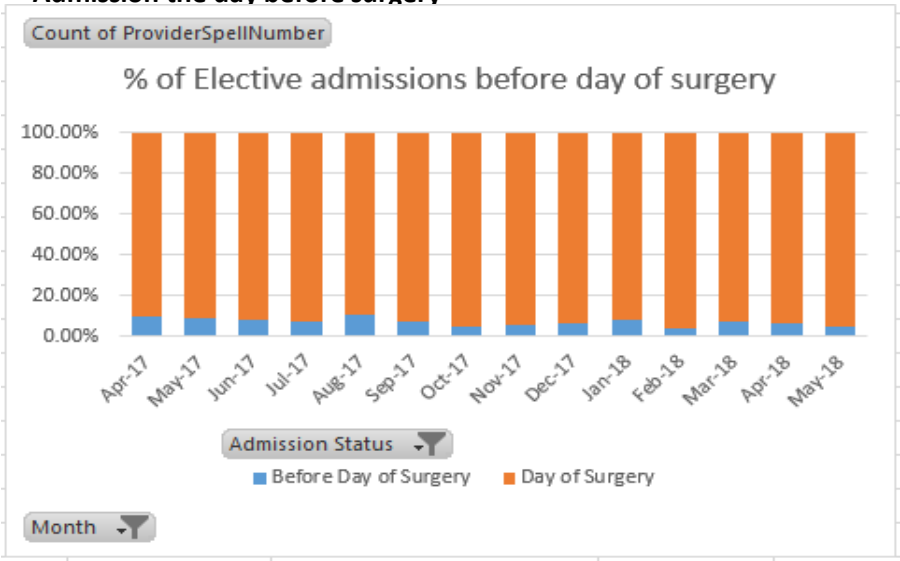
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

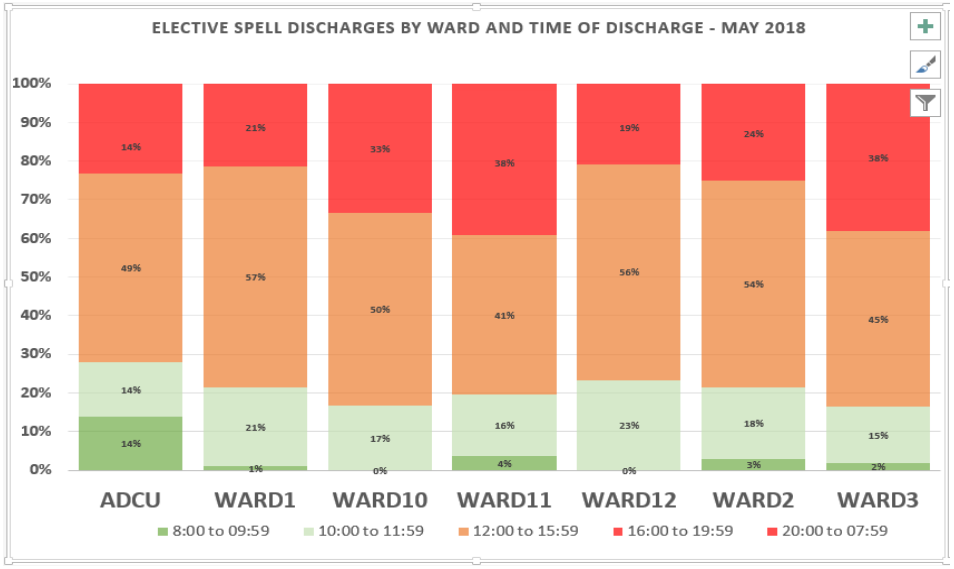
Hospital Cancellations



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	12	37	26	75	3
2017-06	7	28	42	77	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	15	26	43	84	0
2018-04	3	14	30	47	0
2018-05	5	20	38	63	
Grand Total	104	260	487	851	10

Admission the day before surgery





The number of cancellations on the day of surgery by the hospital has increased in May from 17 to 25 .
An analysis of the 25 patients cancelled on the day of admission highlighted the reasons for cancellation varied across a range of issues, however the main contribution to the increase was the CT scanner breakdown – where 10 patients required reconvening of their appointments. Other reasons included ran out of theatre time, emergency patients taking priority, availability of equipment and bereavement. In addition, patients cancelled due to medication issues was also identified as a contributing factor to cancellations on the day.

Cancellations before the day of surgery have increased in month from 30 to 38 patients . An analysis of the 38 patients cancelled by the hospital before admission highlighted two main factors for cancellations prior to surgery : patients being offered earlier dates for surgery and patients being deferred to accommodate emergencies.
A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The Terms of reference of this meeting have recently been revisited and now includes correlation with incident reporting prior to the meeting and analysis of issues identified at the theatre' huddle' meetings to ensure interventions are delivered to reduce avoidable cancellations, wherever possible.
Work continues to strengthen the POAC process . The Clinical Model was presented at the Audit Meeting on 31st of May for wider Clinical engagement and sign off , which was received well and generated useful clinical feedback which will be included in the work stream going forward .

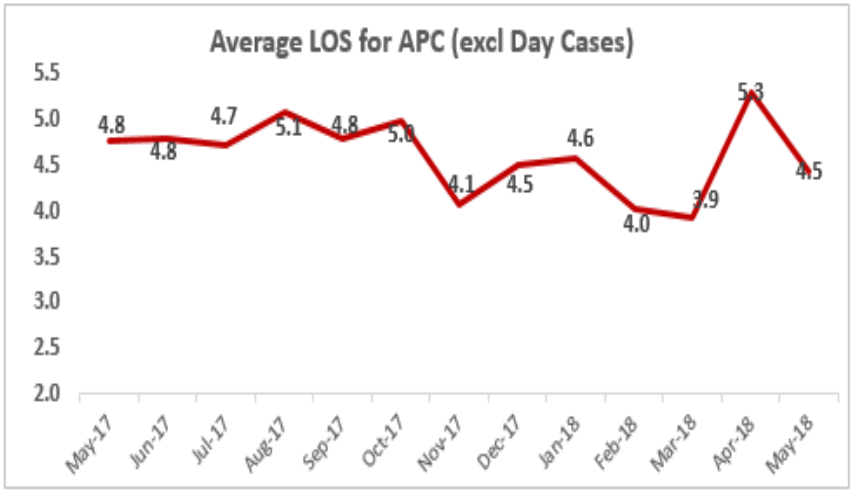
ACTIONS FOR IMPROVEMENTS / LEARNING

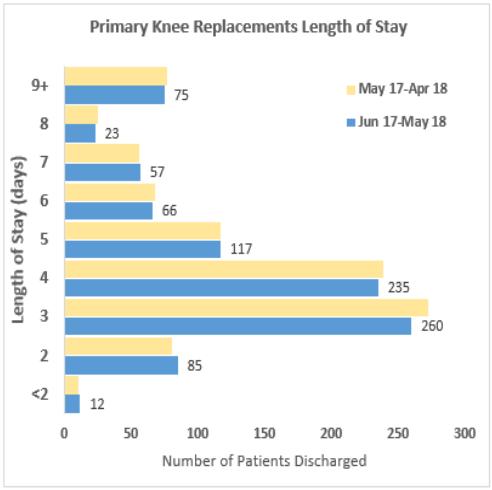
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :
- Refresher training continues to support improved accuracy of data inputting on the PAS system to inform actions and allow robust audit of cancellation reasons.
- Priorities are now being agreed as part of Perfecting Pathways which will help to support some of the key deliverables to ensure improved theatre utilisation .
- The launch of the Stryker project commenced on 24th May 2018.
- An audit of patients who DNA on the day of surgery is currently being undertaken to drive improvements in this area following patient feedback.
- Roll out of replacement theatre equipment continues to reduce issues relating to equipment availability and additional power tools are currently being scoped .

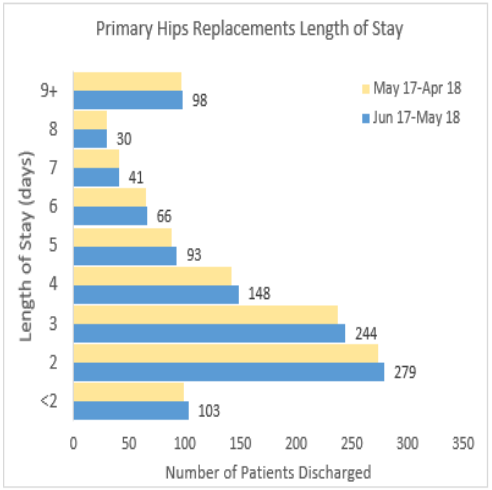
RISKS / ISSUES

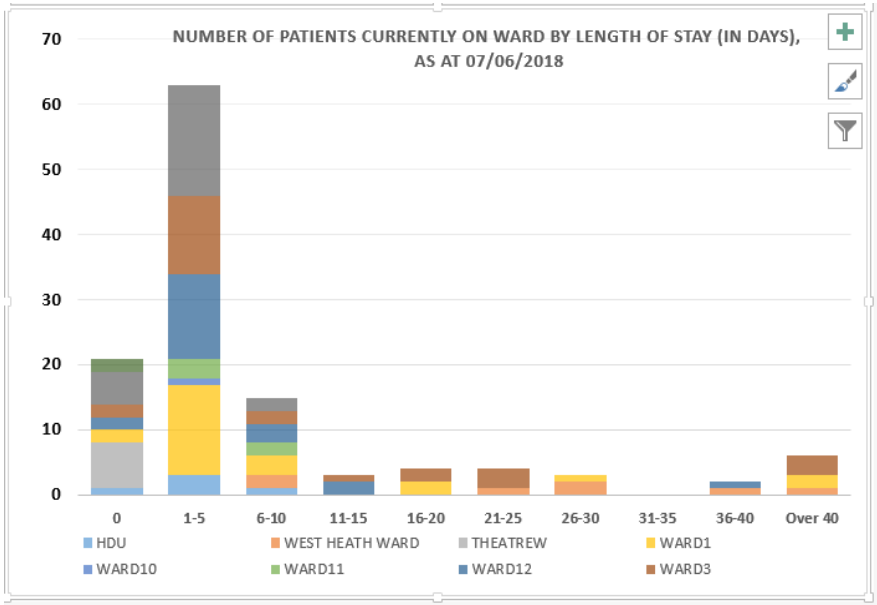
Shorter turn around times for pre –operative assessment are required to respond flexibly to increased levels of activity.
Existing aging equipment asset base .

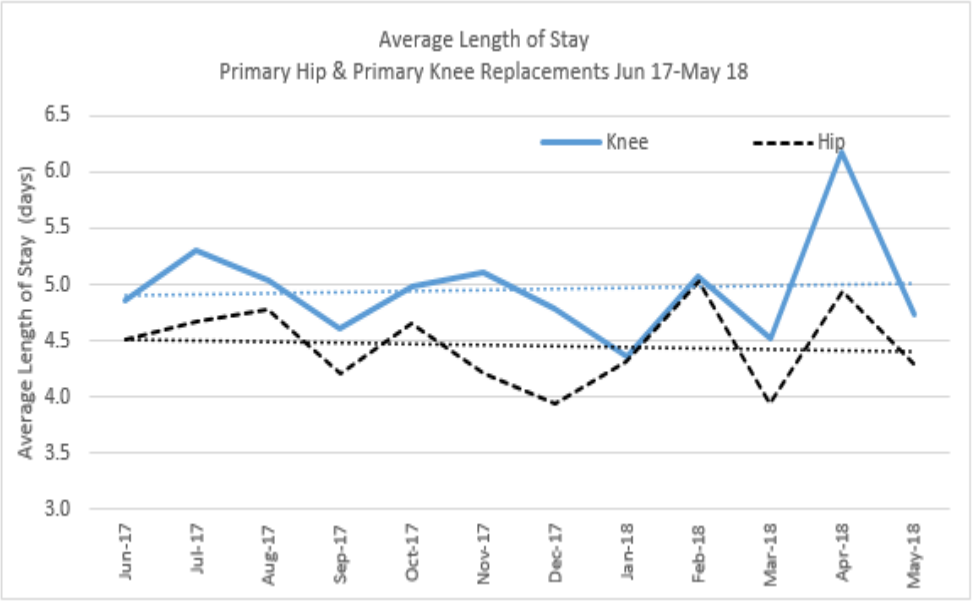
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS has decreased in May following an increase in April due to multiple admissions of extremely complex patients with high trim points (up to 180 days) . Overall LOS is noted to be reducing and initiatives are in place to continue this reduction further:

- Red2Green is now launched on all wards. Discharges are now identified the day before discharge and on day of discharge the ward staff work closely with the discharge team to ensure timely discharge . A weekly ward meeting is now in place with ward managers and the discharge team to raise and resolve issues relating to discharge and deliver continuous improvements in the process. Further work is now ongoing on introducing a weekday daily meeting to escalate issues which are not resolvable at ward level.
- 'PJ paralysis challenge' is underway led by Christian Ward (Head of Nursing for Div 1). All wards are fully engaged with this challenge. Thus far this has resulted in over 400 additional days where patients are dressed and over 250 contacts with patients for additional mobilising.
- 'Passport to Home' patient information has now been agreed and is currently being rolled out on all wards . This includes a patient/ROH agreement regarding Estimated Date of Discharge (EDD), provision of patients own clothes and transport arrangements.
- Gold/Silver concept is now reinforced on all wards to support the improvement in the flow of patients and maximise utilisation of the discharge lounge. The discharge team have evidenced the use of Gold/Silver in the increasingly early movement of patients to the discharge lounge.
- Daily Operational bed meetings are now embedded to escalate any delays for social care , inter-hospital transfer and expedite appropriate discharges .

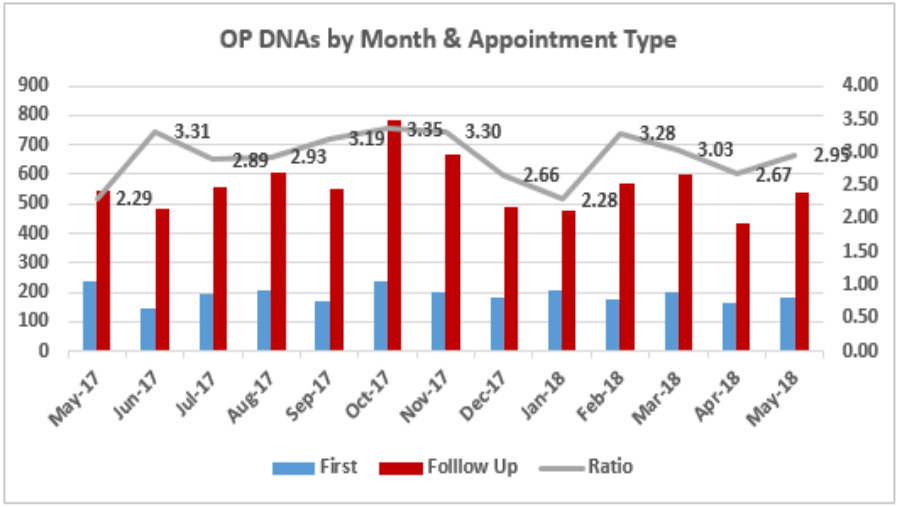
ACTIONS FOR IMPROVEMENTS / LEARNING

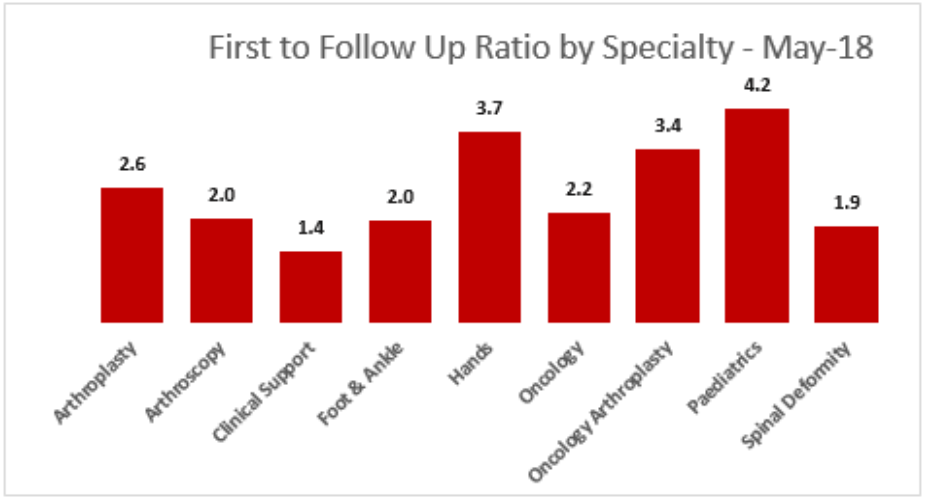
- The Red2Green dashboard development is now launched across all wards .The dash board also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds are now being rolled out across all wards so that all patients are reviewed to support timely discharge . Further work continues to develop with the Arthroplasty team which includes scoping to include anaesthetic support for ward rounds and the feasibility around a dedicated Theatre environment . This work will be progressed as part of the theatre expansion and redesign project to inform improved flow in theatres .

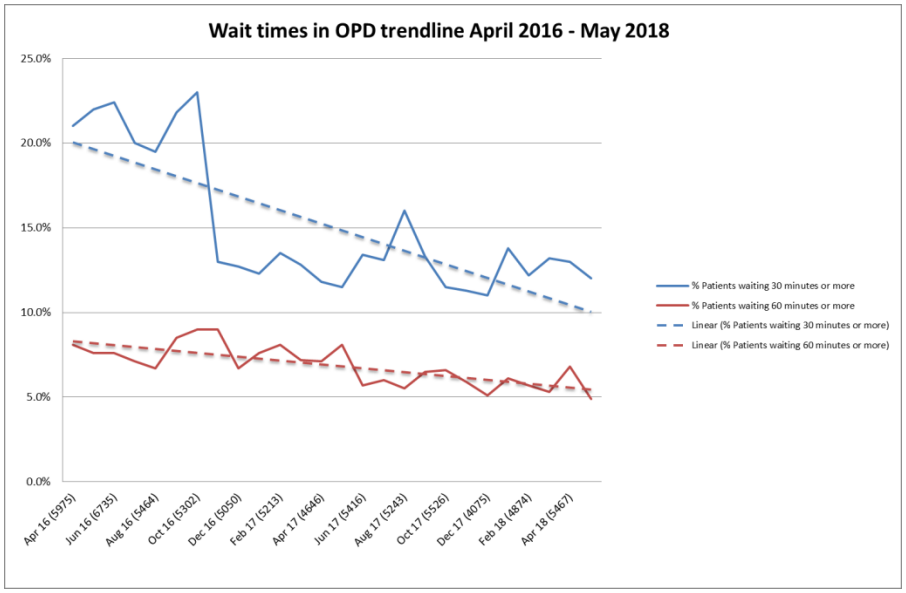
RISKS / ISSUES

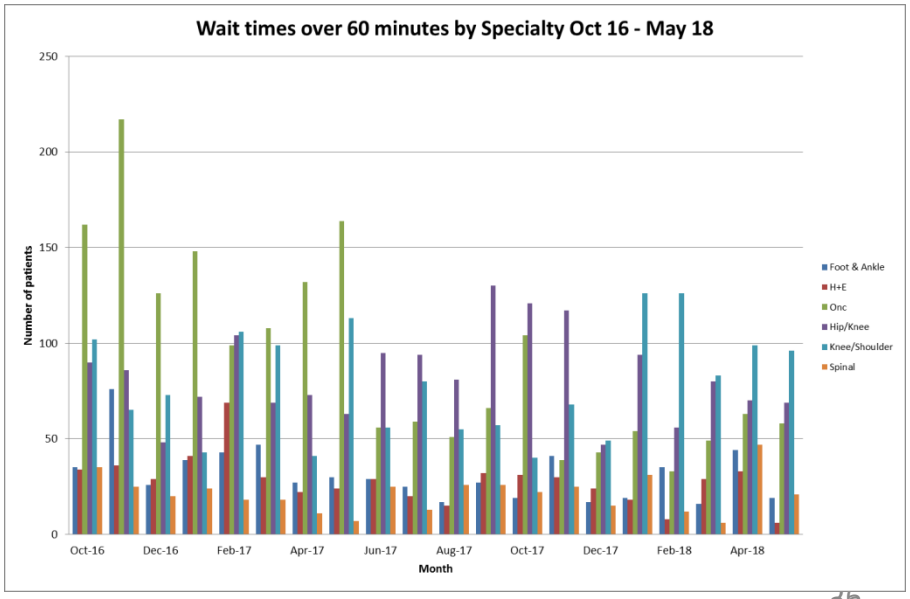
A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity . A full bed modelling exercise will therefore inform the future capacity required to deliver activity to support the wider STP orthopaedic alliance .

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









INFORMATION

In May there were 11 incident forms completed to highlight clinics running more than 60 minutes late.
There were 12.0% of patients waiting over 30 minutes and 4.9% waiting over 1 hour which is below the target of 5% and this is the first time this has been achieved. The over 30 minute waits have improved slightly from the previous month from 13%. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month.

The monthly audit identified the following : -

- 6 - Complex patients
- 3 - Clinic overbooked
- 1 - Consultant/Clinician Delay
- 1 – Other

All incidents continue to be investigated by the relevant operational managers. An audit of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause. This data is shared with the Ops team at the weekly Operational Management Team meeting to review trends and effect appropriate improvement interventions .
A more detailed analysis of data has been carried out for May and this has highlighted 2 outliers who have particularly high number of patients waiting more than 30 and 60 minutes. Focussed review of the clinic templates will be undertaken with the Clinicians to share these results.
Full capacity modelling for outpatient clinics and inpatients across all specialties has been completed for the majority of specialties.
Additional funding is to be requested via a business case to increase the qualified and unqualified nursing establishment within both main and paediatric outpatients to support any required increase in capacity, although there continue to be challenges in recruitment for qualified and unqualified staff.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Continue to drive incident investigations and action through relevant Operational Manager
- Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays
- Electronic clinic rescheduling form has been trialled in hands and is due to be rolled out across the Trust by 2ND July 2018
- Development of clinic utilisation tools through InTouch and Health Informatics
- Work is being planned in CYPOPD to improve the reception environment which will allow InTouch to be used in real time and therefore provide data of clinic waits as currently this is not available

RISKS / ISSUES

Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. This will be addressed as part of the electronic clinic rescheduling form project
InTouch upgrade has not yet begun due to limited IT and project management resources. These are currently being reviewed and will be discussed and prioritised at the IM&T project board.

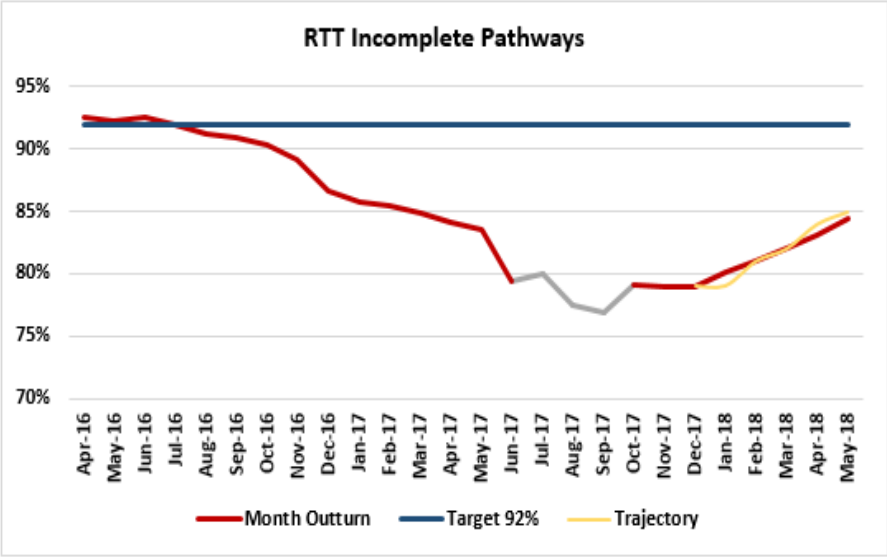
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

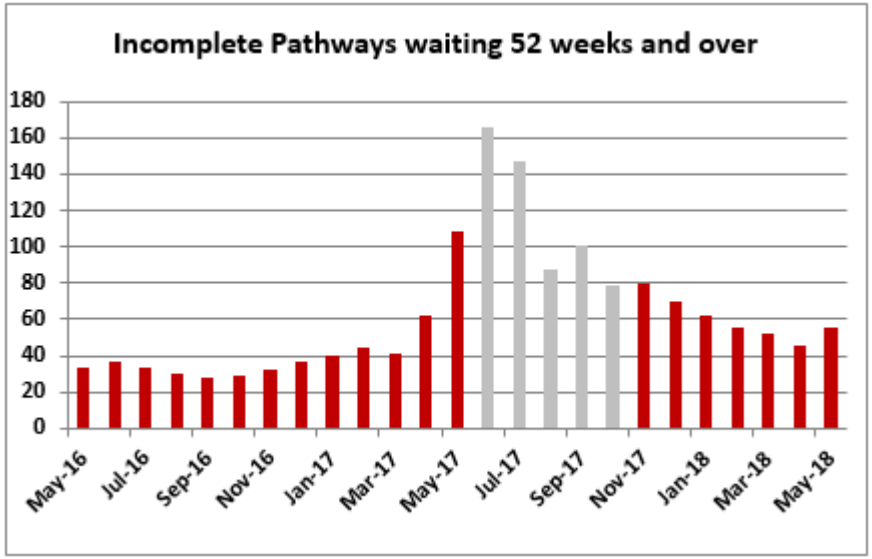
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%
Apr-18	1,022	148	409	1,579	850	253	387	1,490	8	1,571	1,579	99.5%
May-18	1,002	136	353	1,491	725	236	373	1,334	1	1,490	1,491	99.9%

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





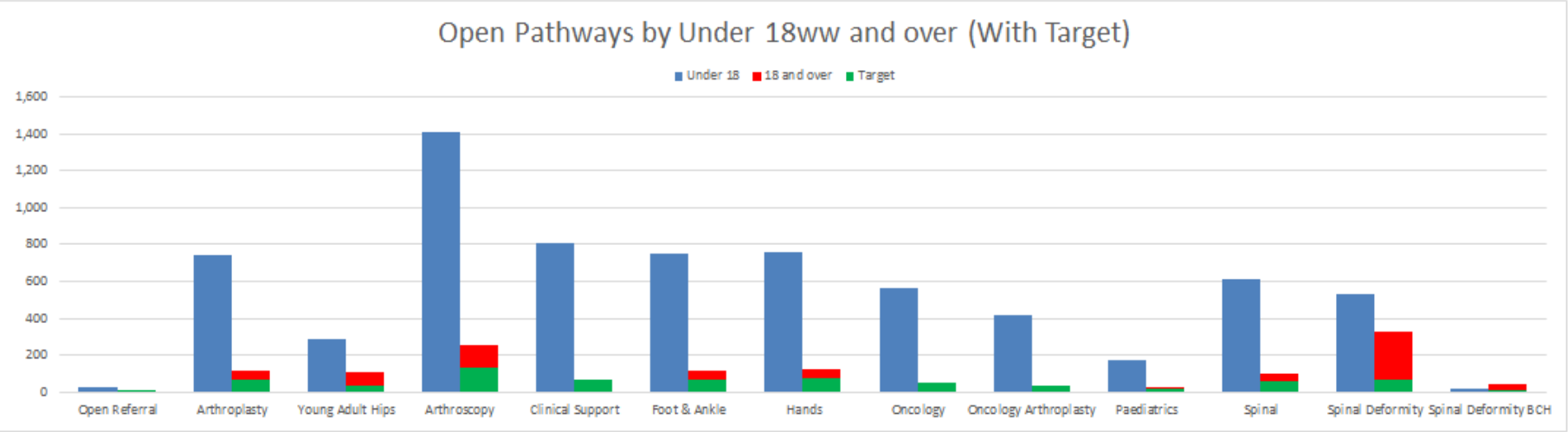
		Indicative		Reported Month		Reported Quarter 2017/18			
Target Name	National Standard	Jun-18	May-18	Apr-18		Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	*	*98.10%*	98%		97.10%	98.30%	99.20%	97.60%
31 day first treatment	96%	*	*100%*	100%		90.00%	96.30%	96.60%	96.60%
31 day subsequent (surgery)	94%	*	*100%*	90%		98.00%	100.00%	97.40%	100.00%
31 day subsequent (drugs)	98%	*	*n/a*	n/a		n/a	n/a	n/a	n/a
62 day (traditional)	85%	70.00%	*90%*	66.70%		81.86%	82.40%	72.20%	66.70%
62 day (Cons Upgrade)	n/a	*	*100%*	100%		84.00%	82.10%	88.90%	100.00%
31 day rare (test, ac leuk, child)	n/a	n/a	*n/a*	n/a		n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1		1					

*June position will be confirmed on 2nd August 2018

13. Referral to Treatment snapshot as at 31st of May 2018 (Combined)

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,692**	18	375	150	776	486	392	365	322	198	82	307	213	8
7-13	**2,403**	4	262	90	456	258	247	277	168	154	64	198	218	7
14-17	**1,001**	3	106	49	181	66	116	116	73	63	23	107	96	2
18-26	**770**	0	82	77	162	34	90	90	15	27	18	66	104	5
27-39	**395**	0	24	30	84	14	24	33	7	8	4	29	130	8
40-47	**69**	0	5	4	8	2	2	2	0	1	1	4	33	7
48-51	**25**	0	1	0	0	0	0	0	0	0	0	2	21	1
52 weeks and over	**55**	0	0	0	0	0	0	0	0	0	0	0	36	19
Total	**8,410**	25	855	400	1,667	860	871	883	585	451	192	713	851	57

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**7,096**	25	743	289	1,413	810	755	758	563	415	169	612	527	17
18 and over	**1,314**	0	112	111	254	50	116	125	22	36	23	101	324	40
Target	**673**	**2**	**68**	**32**	**133**	**69**	**70**	**71**	**47**	**36**	**15**	**57**	**68**	**5**
	84.38%	**100.00%**	**86.90%**	**72.25%**	**84.76%**	**94.19%**	**86.68%**	**85.84%**	**96.24%**	**92.02%**	**88.02%**	**85.83%**	**61.93%**	**29.82%**



13. Referral to Treatment snapshot as at 31st of May 2018

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**900**	0	102	57	204	60	48	109	87	65	24	99	38	7
7-13	**771**	0	127	26	192	42	17	104	51	75	25	62	44	6
14-17	**309**	0	59	12	80	5	11	35	19	32	7	34	14	1
18-26	**310**	0	55	27	94	7	15	34	9	12	6	26	20	5
27-39	**187**	0	17	17	66	2	9	17	3	4	2	14	28	8
40-47	**36**	0	2	4	6	1	2	0	0	1	1	2	10	7
48-51	**15**	0	1	0	0	0	0	0	0	0	0	1	12	1
52 weeks and over	**47**	0	0	0	0	0	0	0	0	0	0	0	28	19
Total	**2,575**	0	363	143	642	117	102	299	169	189	65	238	194	54

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**1,980**	0	288	95	476	107	76	248	157	172	56	195	96	14
18 and over	**595**	0	75	48	166	10	26	51	12	17	9	43	98	40
Target	**206**	**0**	**29**	**11**	**51**	**9**	**8**	**24**	**14**	**15**	**5**	**19**	**16**	**4**

	76.89%		79.34%	66.43%	74.14%	91.45%	74.51%	82.94%	92.90%	91.01%	86.15%	81.93%	49.48%	25.93%

Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,792**	18	273	93	572	426	344	256	235	133	58	208	175	1
7-13	**1,632**	4	135	64	264	216	230	173	117	79	39	136	174	1
14-17	**692**	3	47	37	101	61	105	81	54	31	16	73	82	1
18-26	**460**	0	27	50	68	27	75	56	6	15	12	40	84	0
27-39	**208**	0	7	13	18	12	15	16	4	4	2	15	102	0
40-47	**33**	0	3	0	2	1	0	2	0	0	0	2	23	0
48-51	**10**	0	0	0	0	0	0	0	0	0	0	1	9	0
52 weeks and over	**8**	0	0	0	0	0	0	0	0	0	0	0	8	0
Total	**5,835**	25	492	257	1,025	743	769	584	416	262	127	475	657	3

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,116**	25	455	194	937	703	679	510	406	243	113	417	431	3
18 and over	**719**	0	37	63	88	40	90	74	10	19	14	58	226	0
Target	**467**	**2**	**39**	**21**	**82**	**59**	**62**	**47**	**33**	**21**	**10**	**38**	**53**	**0**

	87.68%	100.00%	92.48%	75.49%	91.41%	94.62%	88.30%	87.33%	97.60%	92.75%	88.98%	87.79%	65.60%	100.00%

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For May 2018 the RTT trajectory was 85% with performance at **84.3%** with 55 patients over 52weeks (trajectory 67)

No patients were recorded as over 52 weeks in specialties other than Spinal Deformity.

ACTIONS FOR IMPROVEMENTS / LEARNING

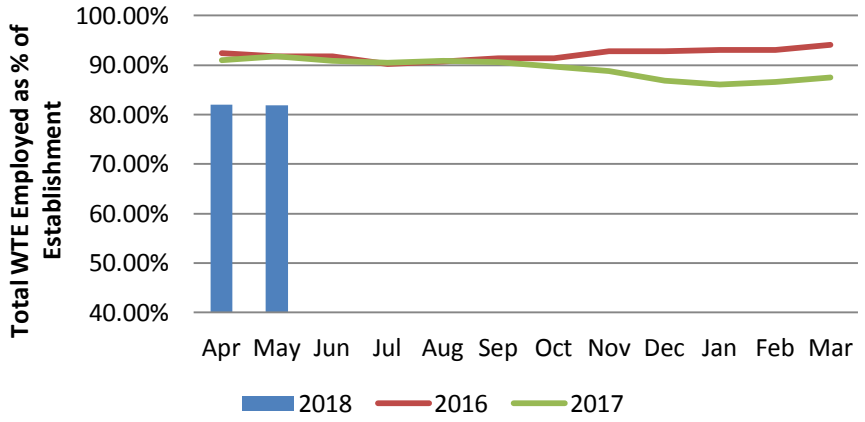
The team continue to concentrated on any patients over 40 weeks, this number continues to reduce. At the end of December 2018 we had 238 patients over 40 weeks, at the end of May 2018 this figure is now 149, 117 of which are Spinal Deformity. The focus continues with patients on an admitted pathway between 27-39 weeks and non admitted over 18 weeks. Good progress continues to be made by all the teams.

RISKS / ISSUES

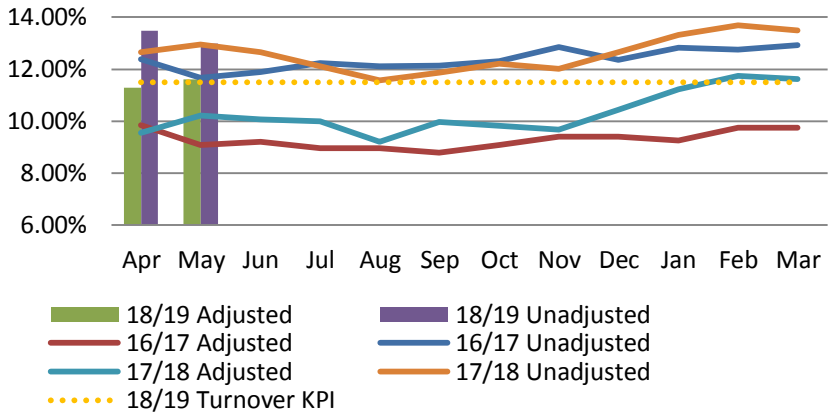
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance.
Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity continues through the Summer with discussion underway to continue the lists until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families , one patient has a date for surgery at the end of June 2018 .

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

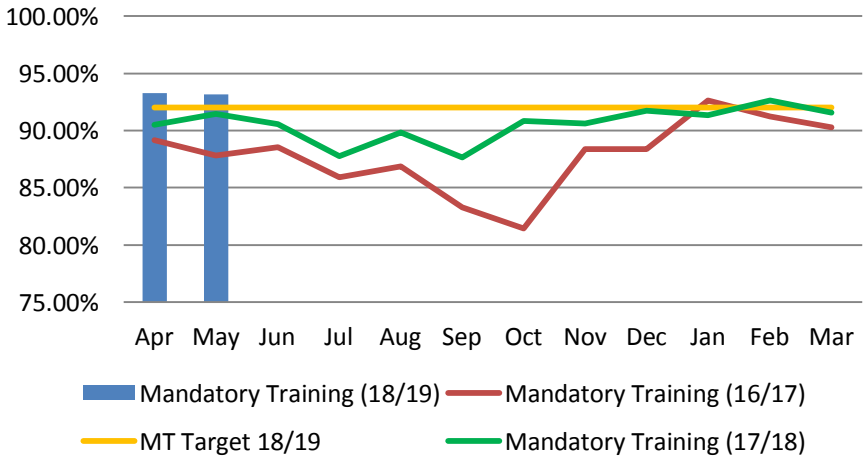
Staff in Post v Establishment



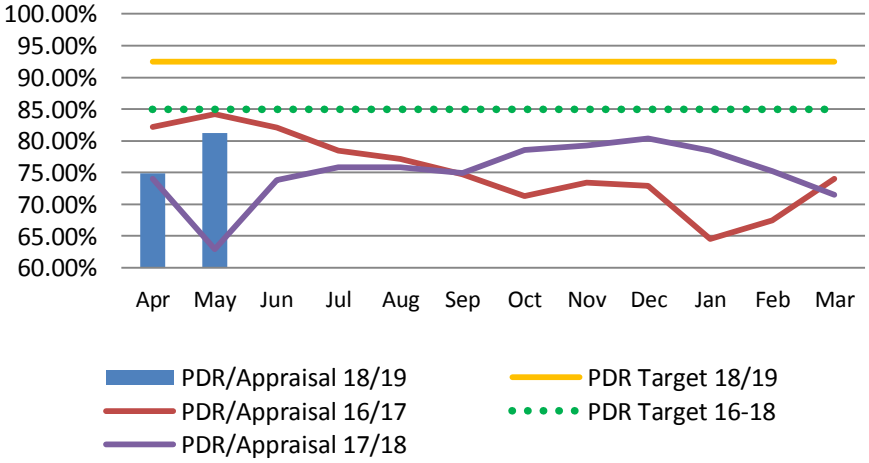
Staff Turnover



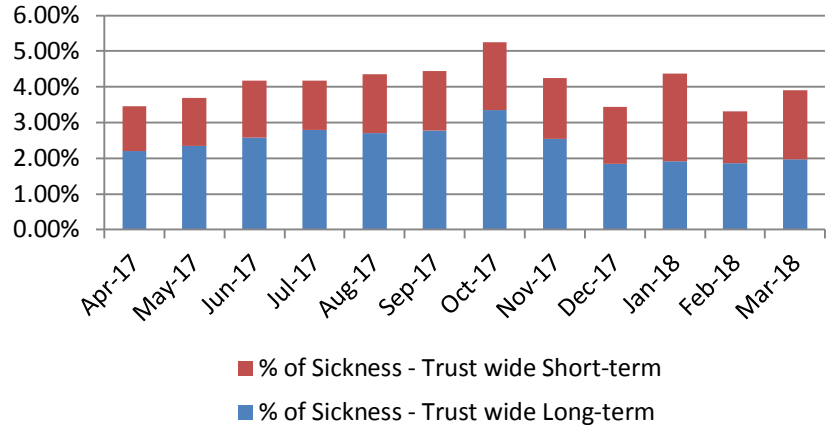
Mandatory Training



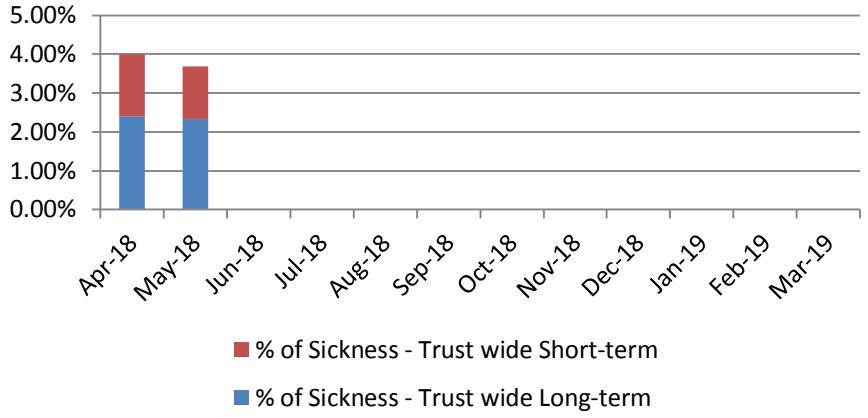
PDR/Appraisal



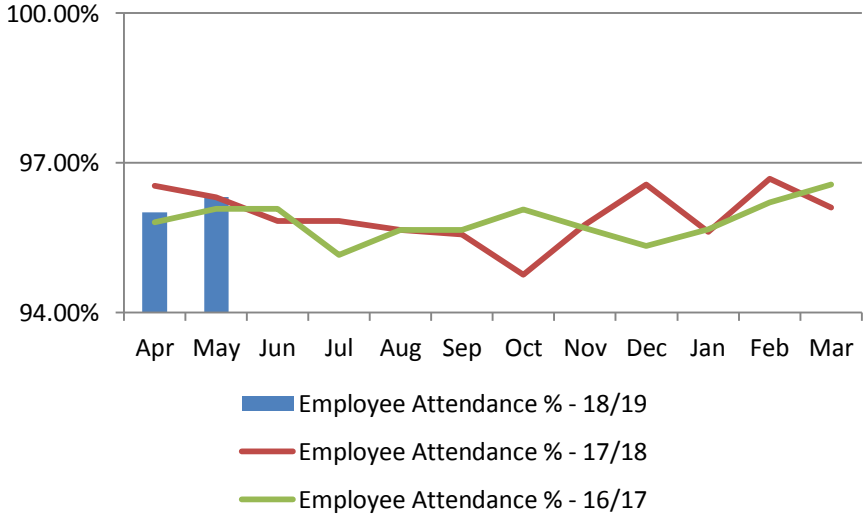
Sickness % - LT/ST (2017/18)



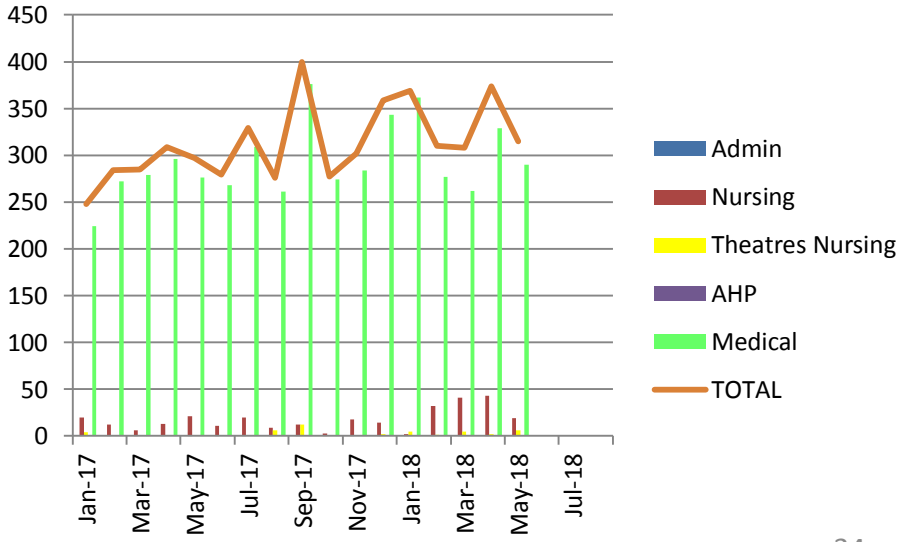
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

Overview: May was a relatively good month for workforce performance, with decreases in sickness absence and headline turnover versus April, plus a marked improvement in appraisal figures and continuing "green" status for mandatory training.

Monthly attendance improved versus April 2018 by 0.31% from 96.01% to 96.32%. The new Key Performance Indicator (KPI) target is 96.10%, so this reflects a "green" in month position. Our underlying 12 month average figure did not change from 95.79%, however, due to an almost identical performance in May 2017.

This month the Trust's vacancy position saw a gap of 18.14% with WTE employed percentage as 81.86% against a Trust target of 90%. However, this is inclusive of a further small increase in the funded establishment since April. In practice, there was actually an increase of 2.77 WTE on the payroll from April to May.

Following a significant amount of effort between HR and finance colleagues, work is almost complete in aligning ESR to the ledger to enable transparent reporting and analysis of vacancies, and shape plans to fill relevant posts.

Mandatory Training numbers maintained their "green" status with a May performance figure of 93.17% versus a revised Trust target of 92%. The L&D Team are continuing to encourage staff to book onto courses or carry out their mandatory training via e-learning, for which speedier refresher training is also available.

May's appraisal performance saw a significant increase of over 6% to 81.22%, with increases reported in all operational divisions. This figure is higher than at any point in the previous 12 months and is progress towards the Trust's stretch target of 92.5%, which will take continued focus.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) declined to under 13% for the first time since January 2018. The adjusted turnover figure (substantive staff leavers including retirements) however, increased marginally to 11.60%, which is at the low end of amber against a target of 11.5%. The SE&OD Committee sees details of leavers and will be monitoring performance against this bi-monthly; for this single month, however, there is no particular cause for concern.

May returned to a more typical month in terms of agency breaches with 315 shift breaches in total of which 290 were medical. Nursing agency breaches increased slightly, with POAC using the majority (19) and Theatres (6) to maintain activity.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS/ISSUES

Further announcements forecast about paediatric services may make the proposed service transfer seem more "real" for staff in the short term and may cause a deterioration in performance/increase in turnover: careful communications and as much transparency as possible will help to mitigate this, however.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Care Quality Commission Responsive Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Patient Services**
AUTHOR:	**Ashleigh Tullett, Clinical Governance Manager**
DATE OF MEETING:	**4 July 2018**

EXECUTIVE SUMMARY:

In January 2018 the Care Quality Commission (CQC) carried out an inspection of the Trust.

During this inspection the domains of Medical Care, Surgery and Outpatients were inspected in addition to a planned Well Led assessment being carried out subsequently.

This resulted in the Trusts' overall rating improving from REQUIRES IMPROVEMENT to GOOD.

The report was formally released into the public domain on 17th May 2018.

Within the report are areas that require action by the Trust to enhance the delivery of services to our patients.

The report has been reviewed and a responsive action plan formulated. The attached action plan has continued with the previously used methodology of CQC responsive action plans. The owner of the action plan will be the Executive Director of Patient Services.

The action plan states the areas for improvement, the accountable Executive Director, operational owner and predicted date of delivery with associated narrative updates.

The action plan will have regular scrutiny at Executive management meetings on a monthly basis with oversight by the accountable directors for delivery of their actions.

REPORT RECOMMENDATION:

Trust Board is asked to:

- Note & accept version one of the responsive action plan
- Note & accept the oversight arrangements by the executive management team
- Approve devolvement of monthly monitoring of the action plan to the Quality & Safety Committee for delivery
- Approve the recommendation that exceptions to non-delivery will be reported monthly to Trust Board from Quality & Safety Committee
- Approve Trust Board receiving quarterly a full update and oversight of the responsive 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	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	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:

Safe and efficient processes

Delivery of the action plan will mitigate any risk to non-compliance with the CQC's regulatory framework

PREVIOUS CONSIDERATION:

None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROH ACTION PLAN

NO	QUALITY IMPROVEMENT PROJECT	EXPECTED OUTCOME	KPI / MEASURE	EXECUTIVE LEAD	CLINICAL / PROJECT LEAD	ROH ACTION NO	ACTION	FINAL DEADLINE	UPDATES	ONGOING ASSURANCE
									Unsatisfactory Progress / Slow Progress / Satisfactory Progress / Completed	
Executive Director of Patient Service										
1	The Trust should ensure when learning is identified a process is in place to ensure it is embedded in all the core services.	Learning from serious incidents and never events will be shared across the hospital. This included areas outside of where the incident happened	100% compliance with Stop before you block audit	Executive Director of Patient Service	Head of Clinical Governance	1a	Stop before you block Audit to be completed	Sep-18	Snap shot audits are completed to provide an overview of the daily running of anaesthetic rooms and to identify underlying factors that may impede safe patient care. Audits completed to confirm that an adequate escort had been provided and to highlight any interruptions occurring during the induction of anaesthetic and / or administrating of blocks. The audit was initiated on the 5th January, 2017 in response to incident 17866 and showed 23.2% compliance There were a total of 32 interruptions in the anaesthetic rooms out of an audit of 82 patients which equates to 39.02%. Interruptions have increased from 23.2% to 32% - it was agreed at the Clinical Quality group that audits will be undertaken monthly and will report to the Clinical Quality Group.	
			100% compliance with Serious Incident Learning Audit			1b	Audit of serious incident learning to be undertaken	Sep-18	The Clinical Governance Team are to audit the action plans resulting from RCA investigations to ensure the actions are taken and embedded in the Trust.	
						1c	Trusts Quality Report to be presented at all relevant meetings to strengthen Ward to Board communication.	Aug-18	The Clinical Governance Team are to audit the action plans resulting from RCA investigations to ensure the actions are taken and embedded in the Trust.	
						1d	Closure of the Ulysses action plan to assure fit for purpose reporting and feedback system.	Jan-19	Ulysses action plan is 70% complete.	
						1e	Routine Communication of key incidents and learning methodology across the Trust to be reviewed	Sep-18		
2	The Trust should review their policies and procedures for caring for patients with mental ill- health including those patients detained under the Mental Health Act.	Updated Mental Health (MH) policies and procedure to ensure staff have the confidence to support and care for patients with Mental Health	100% of patients and staff with a Mental health illness will be supported to have full access to all Trust Services.			2a	Ensure the SLA in place is responsive to Trust need.	Jun-18	SLA has been updated and it available to all staff. This will be communicated to all bleep holders and relevant staff.	

				Executive Director of Patient Service	MH lead Nurses	2b	Launch of a Mental Health Service in the Trust available to patients.	Jul-18	The intranet page has been reviewed and refreshed with up-to-date contact details and information. The Trust is meeting with Birmingham and Solihull Mental Health Trust on the 27/07/18 to review the Trust's referral pathways and flowcharts. Staff resource folders have been reviewed and updated. A new icon on the intranet to be added to the homepage once actions are completed for ease of access for staff.	
						2c	Ensure all relevant staff are trained in mental health	Aug-18	2 x Lead nurses have been identified and received training on the Mental Health first aid course. Mental Health lead nurse to meet with other providers to scope and benchmark training for staff. This will be reported as an options appraisal to Quality and Safety in August 2018	
						2d	Engage staff and patient in Mental Health services	Sep-18	Matron for Mental Health is due to meet with the CCG Mental Health lead. Mental Health lead is currently seeking local mental health groups in the community. Mental Health lead to meet with Head of OD and Inclusion to support the engagement of patients with mental health.	
						2e	Undertake audit of compliance with principles of strategy and present to Safeguarding Committee.	Dec-18	Methodology to be designed when actions 2a to 2d achieved .	
3	Staff should have sufficient understanding of terms such as 'never event' and 'duty of candour'.	All staff to have a knowledge of the Trust's process for Duty of Candour and Never Events	100% percent compliance on the Safety walk rounds audits	Executive Director of Patient Service	Head of Clinical Governance	3a	Focussed educational engagement events with departments and wards	Aug-18	The Governance team have developed leaflets that are to be launched into the Trust. The team are currently planning local engagement events with departments to ensure compliance. The Trust has shown 100% compliance with the Duty of Candour Audit for the external CCG for the last 3 times.	
			Fit for purpose Mandatory training slides			3b	Review of Mandatory Training Slides	Aug-18	The Governance team are reviewing the Mandatory training slides and also seeking the possibility of an electronic learning for Governance and Risk Management. The Learning and Development team are developing the mandatory training process for the Trust and Clinical Governance will be included in the improvement work.	
4	The Trust should review the Bone Infection Unit (BIU) strategy and performance outcomes.	BIU to have a clear strategy, outcome monitoring and service evaluation		Executive Director of Patient Service	Head of Infection Prevention Control	4a	Review and strengthening of organisational structure around Bone Infection Unit (BIU)	Jun-18	Clinical Lead has been agreed. A new Operations manager has been appointed. MDT coordinator and Data Analysis is in recruitment process.	
						4b	Bone Infection MDT to be launched	Jul-18	Terms Of Reference drafted. To be approved.	
						4c	SLA to be agreed with UHB for support services	Sep-18	Service Level Agreement in place with UHB to provide Consultant Microbiologist support to both infection control and bone infection service but will be reviewed.	
						4d	Development of surgical and blood monitoring SOPS	Sep-18	Mr Va Faye Consultant Orthopaedic Surgeon, Mr Hughes Consultant Spinal and Mr Parry Consultants Oncology have agreed to obtain standards operating procedure from other specialist orthopaedic centres for review/editing/adoption by ROH.	
						4e	Outpatient and Parenteral Antimicrobial Therapy policies to be updated	Dec-18	Clinical Lead assigned to lead this work.	
						4f	Develop and launch a BIU business model	Dec-18	Options appraisal to be completed to show a range of business models and funding options to be presented to Commissioners Established weekly meeting to oversee. Assistant Director of Finance to lead on development of business model	

5	The Trust should ensure staff have access to relevant specialist training to carry out their roles effectively	All staff will have the relevant specialist training including oncology, mentorships and leadership courses		Executive Director of Patient Service	Clinical Nurse Tutor	5a	Develop and deliver a Band 6 development programme	Aug-18	The Clinical Nurse Tutor is currently designing a Band 6 Development day to train staff on key leadership and management subjects such as Finance, Governance, and Management. This will be mandatory training for all band 6 staff, This will include staff from other disciplines.	
						5b	Specialist Training to be offered to staff	Jan-19	The Clinical Nurse Tutor has met with Staffordshire University to scope the possibility of 10 members of staff undertaking an orthopaedic/spinal degree module. The Trust is also scoping the possibility of Wolverhampton university offering a course in September 2018. The Trust is also working with the Royal National Orthopaedic in the possibility of apprenticeships schemes for other healthcare professionals and ANP roles.	
6	Public engagement required re-energising; for instance, we noted the Trust charity needed further overview to improve its performance.	Patients and stakeholders are involved in decisions regarding the Trust and their care	Patient feedback	Executive Director of Patient Service	Head of Infection Prevention Control	6a	Patient and Carers Forum to be reviewed	Aug-18	Lead is currently scoping out the current practice in the Trust. The lead is attending the next patient and Carers Forum to review the functionality. Terms of reference are to be reviewed and work plan for the group created.	
						6b	Develop and launch of a Patient Experience and Engagement strategy	Nov-18	Initial scoping phase of other providers strategies. Contact with other NHS providers formed.	
						6c	Undertake audit of compliance with principles of the strategy and report to Quality and Safety Committee	Jan-19	Methodology to be devised when action 6a to 6b designed.	
Executive Director of Finance										
7	The Trust should ensure all staff have appropriate access to all relevant electronic patient care systems to carry out their role effectively	Staff will be accessing patient identifiable information in a timely manner and IT software systems will communicate effectively to allow staff to carry out their role.	New control process to ensure interoperability of new and existing systems. Successful implementation of EPMA and clinical portal	Executive Director of Finance	IMT Board	7a	Implementation of EPMA (electronic prescribing and decision support system) system Development of Clinical Portal to provide single point of access across multiple clinical systems. Implementation of gateway process to control new requests for clinical and non-clinical applications.	Jan-19	EPMA went live in POAC in June 2018. Draft Gateway process has been discussed at IM&T Board in June 2018. There are ongoing discussions with UHB regarding clinical portal.	
8	The Trust should review and improve the security of patient notes and data within the outpatient department.	Patient data is secure to national standards	Compliance with new Data Security and Protection Toolkit and 10 data security requirements to ensure all staff ensure that all personal confidential data is handled, stored and transmitted securely. Personal confidential data is only shared for lawful and appropriate purposes	Executive Director of Finance	Information Governance Manager	8a	Improve the security of patient notes	Dec-18	GCHQ Board Certified Training delivered to Exec and Non Exec Directors. Learning and further training to be rolled out to all staff groups.	
						8b	Improve the security of computers in the Trust	Dec-18	Annual review of processes.	

Executive Medical Director									
9	The Trust should ensure there is robust audit process for the WHO checklist to ensure all parts of the checklist are followed as per best practice.	WHO checklist to be completed as per best practice	100% compliance with WHO checklist Audit on end debrief	**Executive Medical Director**	**Associate Medical Directors**	**9a**	Team Brief and Team Brief process to be reviewed on the WHO checklist	Oct-19	Ongoing work with Stryker team. The Trust have highlighted that work is needed on the Team Brief and Debrief and are awaiting the automatic reports still from Trisoft. The Trust have also asked Stryker if they have any best practice on how the Trust ensure it keeps the briefing fresh and meaningful rather than just a drill. Monthly audits confirm 100% WHO checklist compliance.	
			100% compliance with WHO checklist Audit	**Executive Medical Director**	**Associate Medical Directors**	**9b**	ADCU and CT to be included on the Theatreman system for the WHO	Oct-19	The WHO checklist for ADCU is scheduled into Phase 2 on the Theatreman rollout. Contractually the Trust requested that the WHO checklist is created on Theatreman for Theatres and CT initially within phase 1. This was due to the paper version of the WHO checklist in use being deemed satisfactory for ADCU's use during this period by the individuals on the project team.	
10	The Trust should review medical cover at weekends to ensure adequate cover.	Medical Cover to meet the national guidance	Meet the National standard	**Executive Medical Director**	**Associate Medical Director**	**10a**			Ensure the Trust meeting national standards for medical cover. Escalation process to be devised for ward level staff.	
11	Processes should be put in place to ensure that patient records, in particular consent forms, are properly updated at all times including when the department is busy and that delays in sending letters are reduced	Clear process in place to ensure records are updated at all times		**Executive Medical Director**	**Associate Medical Directors**	**11a**	Staff to adhere to the Consent policy		All Staff have been trained on the consent process. The Trust undertook an audit of compliance against the Trust policy and found improvement to be made. Further Audits are planned for 2018/19 and this overseen by the Medical Director and Clinical Audit Committee. Consent is a quality priority for 2018/2019 Quality accounts. Audits show improving compliance.	
Executive Director of Strategy and Delivery									
12	The Trust should ensure they comply with the fit and proper person regulations, in particular ensuring they have all parts of the assurance documents available in the personnel files, including for those staff on secondment.	The Fit and Proper regulation will be in line with the Trust and national policy	All relevant staff will have undergone the fit and proper person process and this will be recorded in their personal files	**Executive Director of Strategy**	**Associate Director of HR**	**12a**	All Staff meet the Fit and Proper person regulations	Jul-18	Confirmation that there is a process in place and that all relevant staff will comply.	
						12b	Review fit and proper persons act Trust process	Sep-18	All executives have signed fit and proper persons self declaration as per Trust policy.	
13	The Trust should ensure that all staff are able to access mandatory training so that targets for completion are achieved	All staff to be trained to the 90% Trust target	The Trust will meet the 90% target	**Executive Director of Strategy**	**Head of Learning and Development**	**13a**	Mandatory training process to be reviewed	Jan-19	Strong trend of maintaining compliance for the core mandatory training day for permanent staff– maintaining above 93% for May. Slow increase in people completing the core mandatory training modules online – with around 10% of completions being online to date. core mandatory training for Bank / Temp staff has achieved over 90% this month. Core mandatory training – Mandatory training streamlining / CIP project continues. Positive engagement with subject leads so far. Benefits to be identified by Q3, and implemented by Q4.	

14	The Trust should ensure that the Workforce Race Equality Standard (WRES) report is maintained	Trust to meet the WRES standard	Up to date WRES report	Executive Director of Strategy	Associate Director of HR	14a	April - Trust Board reviewed completed WRES report.	Aug-18	The WRES report was received by Trust Board in April 2018 and will be submitted to NHSE in late August 2018.	
15	Ensure staff meet their training needs as agreed in their annual PDR	Staff meet their training needs	Staff Survey	Executive Director of Strategy	Associate Director of HR	15a	Refreshing the PDR method to performace model	Mar-19	Refreshing performance manager approach. Qualifying of a career framework. Monitoring PDR compliance.	
Executive Chief Operating Officer										
16	The Trust should ensure that the Accessible information standards is met	To meet the Accessible Information standard	Closure of the responsive action plan	Chief Operating Officer	Operational Service manager	16a	Closure of the Trust responsive action plan		A future meeting of the accessible information standard group has been set up for July 2018 and work continues on the action plan. The Trust is in talks with a company called Drdoctor who will be taking on the Trust's communication with patients around appointment and admission dates. This company is able to send information to patients in a number of different formats, including brail, and patients will be able to flag their own communication needs via the patient portal available on the internet. The Trust currently have an accessible information improvement group with a responsive action plan that reports the Clinical Quality Group. Progress of this action plan is monitored via this group and upward reports to the Quality and Safety Committee.	
		Translation service to be available in all relevant areas				16b	The Trust should ensure all patients with communication needs have access to translation services at all times.		The Trust uses word360 as its supplier of translation services and patients are flagged on the patient administration system if they have translation needs. The Trust has recently been benchmarked against other outpatient departments at Trusts nationally and the ROH came out as a high user of translation services which demonstrates that patients are able to access these services easily. Translation service is included in the accessible information standard.	
17	The Trust should continue improve the flow through the outpatients so patients are not kept waiting for appointments.	Improved access and flow to OPD.	To meet the target on clinic wait times	Chief Operating Officer	Clinical Service Manager	17a		Sep-18	The Trust continues to work and improve clinic waiting times and the data from May 2018 has demonstrated that the delays over an hour have dropped below the target of 5% for the first time. Work continues with the operational management team to identify clinics that are consistently overrunning, to amend the templates going forward. There is an update of the InTouch system due in the next few months which will give better functionality from the reports. Estates work is planned to take place in CYP outpatients to assist in the effective use of InTouch in real time which will provide additional data which is currently unavailable. A quote has been received and the work plan agreed by infection prevention control. The completion of this work will depend on the workload of the estates department but is expected to be completed by the summer 2018.	
Associate Director of Governance & Company Secretary										
18	The Trust Should ensure Policies and procedures which staff would refer to for best practice guidance are reviewed and updated	All Trust policies to be up to date and reviewed	Audit of compliance against policies	Associate Director of Governance & Company Secretary	Corporate Governance Lead	18a	All polices to be up to date and reviewed	Sep-18	The Trust has now agreed to invest in a system by Allocate software. The system is designed to enable the ward, service, divisions, and Trust leads to evidence their CQC/other assessments with live staffing data and quality measures. The system will allow electronic tracking of policies and NICE guidance to ensure they are both up to date and compliant	
						18b	Process for reviewing policies to be launched	Sep-18	Current process for monitoring policies is manual. The new process will be designed in line with the electronic system Allocate.	

19	The Trust should ensure that the corporate risk register is reviewed by the full board	The Trust Board is sighted on the entirety of the corporate risk register, in addition to taking assurances from its committees on the effectiveness of the management of the risks associated with their respective remits	The Board is able to describe the key risks to the organisation beyond those it sees on the Board Assurance Framework	**Associate Director of Governance & Company Secretary**	**Corporate Governance Lead**	**19a**	The Trust should ensure that the corporate risk register is reviewed by the full board	Jun-18	The Board receives a twice yearly update on the corporate risk register at its public board meetings. The first of these was presented at the April meeting. Next due October 2018	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board last met: 27 June 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There remained a risk around the staffing in the governance team as there were two vacancies for a governance facilitator; one offer of employment had been made to date. • The detail of a paediatric patient who had reacted adversely to medication was discussed; although there was no suggestion that the treatment of the patient had been suboptimal, any lessons learned as a result of the review were being captured. • It was noted that the issuing of appointments letter process needed to be improved and the appointments process as a whole was being reviewed against best practice standards. • The Committee was made aware of an issue with a piece of equipment which had been sent for decontamination. Further information was awaited to determine whether the issue was a key risk or a one-off situation. • It was noted that there had been a dip in overall compliance with basic adult and paediatric life support training due to additional staff being identified to need this training. • There remains non-compliance with the Accessible Information Standards; an action plan will ensure compliance by December 2018. • There was a detailed discussion around the non-compliance with water safety regulations and on the basis of an out of date action plan provided to the Committee it was agreed that there was little assurance that could be gleaned on the progress with the measures to ensure that compliance was achieved. • Paediatric nurse vacancies remained a key risk for the divisions, although the position was currently being mitigated using a temporary staffing solution. • Non compliance with Controlled Drugs cupboard requirements was	• An update on reasons for patients not arriving for appointments is to be provided for the next meeting. • Further information was needed on time of discharge, including any trends. • It was agreed that a trajectory for achievement of 100% compliance with resuscitation training was needed for the next meeting. • It was agreed that an overview of the reports into the Drugs and Therapeutics Committee was needed for a future meeting. • A breakdown of health and safety incidents by visitor, staff member and contractor was requested. • The Associate Director of Estates and Facilities is to join the next meeting to present the updated position on the actions to achieve compliance with water safety standards. This needed to articulate the key priorities of the work.

discussed and it was highlighted that the storage was secure, however there was non-compliance with the type of wall to which the cupboards were attached.	
POSITIVE ASSURANCES TO PROVIDE • Assurances were provided that the concerns raised by the Freedom to Speak Up Guardian around the management of poorly performing agency staff did not appear to be systemic issues and performance management and communication with the agencies was robust. • Response rates to the Friends and Family Test had improved and more focussed attention was planned on the Paediatrics areas and to standardising the approach across the Trust. • There is a plan to purchase an electronic governance solution to assist with providing ongoing assurance on compliance with the CQC's key lines of enquiry, management of NICE guidance and policy management. • An update from the harm review panel was received which showed that the Trust was ahead of its trajectory to treat the spinal deformity patients. This was a result of additional capacity being provided by and better joint working with Birmingham Children's Hospital. • It was reported that the Clinical Quality Group was working effectively and there was good attendance. • The governance of the Drugs and Therapeutics Committee had been strengthened. • Fridge monitoring, a long standing risk, was now in place. • A stress management policy had been developed, however this had been stalled for the present until the interventions to support staff had been identified.	**DECISIONS MADE** • None specifically above those above.
Chair's comments on the effectiveness of the meeting: It was agreed that although there had been a good opportunity to check and challenge, in some cases those responsible for the area under scrutiny had not been able to join the meeting. It was also suggested that the cover sheets to the reports in some cases needed to be more thoughtfully completed to point out to the Committee more clearly what the paper intended to achieve or provide.	

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UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board last met: 26 June 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Agency spend remained high with the main areas of spend being medical locums and ward nurse staffing. The position would be alleviated when those offered posts recently joined the Trust over the summer when vacancies would be filled. • Performance against the 18 weeks RTT national target continued to improve, however was behind trajectory at present.	• Further work was needed to reduce the number of patient 'Did Not Attend' cases and cancellations; this would be picked up through the performance solutions work. • Further work to contextualise the need for a modular theatre build needed to be set out in the paper to the Board, including the demographic changes, impact on productivity and patient experience and flow.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• A small surplus had been generated in month and the financial position was just over £600k ahead of plan year to date. The main driver for income was strong performance on activity. • Performance against the cost improvement plan remained steady; replacement schemes for those that may not deliver would be identified over coming weeks. • The cash positon was ahead of plan, although the Sustainability & Transformation Funding was yet to be received and the funding model for the national pay award still needed to be fully understood. • Theatre utilisation has increased and a contingency list of patients to fill unexpected gaps in theatre lists was to be developed. • Length of stay continued to improve. • There has been a significant reduction in month on delays in outpatient clinics. The two outlier clinics would be reviewed. • The number of patients waiting above 52 weeks was better than the trajectory for treatment and additional capacity in the form of a new consultant due to commence would assist further. • There were further plans to improve the use of the private patient wing • The Committee considered a strategic outline case for the	• The Committee agreed to recommend to the Trust Board, Option 5 for the modular theatre build, which included a managed service provision for the building and equipment. It was likely that the facilities would be commissioned in Spring 2019. • The Committee agreed to recommend to the Trust Board that the Outpatient hub strategic outline case be submitted to the STP for consideration.

development of an Outpatients hub, in addition to some redevelopment of Ward 11 outpatients, Orthotics, Therapies, Pharmacy, provision of car parking and additional MRI capacity.	

Chair's comments on the effectiveness of the meeting: The Committee agreed that it had been useful to consider the business cases that would be presented to the Trust Board on 4 July.

ROHTB (7/18) 007

NHS
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UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board last met: 6 June 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was some challenge over the level of vacancies reported, particularly those which it was suggested related to healthcare assistants; more work was to be done to clarify and understand the position. • There were challenges around recruitment of Band 5 staff nurses, particularly for Ward 2. • The level of staffing in the HR recruitment team was cited as a risk, given the high level of new starters that were planned; additional staffing into the team was being arranged. • It was noted that the Freedom to Speak Up Guardian had highlighted that she felt staff from a BME background were more reluctant to speak up than some other groups; this was being investigated.	• As the meeting had been running for six months, it was emphasised that the Committee would be looking for evidence of action and delivery to provide the required assurance to the Board that there was sufficient grip on workforce matters. • The timeline for the 'root and branch' review of recruitment was requested. • The plan to address staff vacancies was to be developed, showing when staff would join the Trust and the consequential impact of these joiners. • The reporting structure into the People Committee to be reviewed at the next meeting. • Consideration to be given to reviewing workforce in other disciplines in the same level as currently undertaken for nurse staffing. • Present the action plan for EDS2 in October. • The therapies strategy to be presented to the trust Board in September.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Head of HR operations provided some good assurance that he felt the Committee was working well and driving the need to develop more and better workforce information. • The level of turnover had reduced slightly. • Appraisal rates had improved from those last reported. • There had been a positive recruitment event and more work was being undertaken to make the roles at the ROH as attractive as possible. • The Committee received the updated assessment against the Equality & Delivery System 2 (EDS2).	• None specifically above any beyond the above.

Chair's comments on the effectiveness of the meeting: The Committee agreed that the attendance of the Head of HR Operations and the Head of OD & In was useful and had helped the debate

Press and media report

June 2018

Prepared by the Communications Team | roh.comms@nhs.net

Current state

- Since the beginning of 2018 we have put more emphasis on proactive press and media coverage.

- Our aims:
  - bolster the reputation of the Trust
  - share good news stories
  - Build brand awareness with the public (joint replacement = ROH)
  - Drive additional activity
  - Support staff engagement

- We have made progress but there remains a lot of opportunity

- Capacity and resource have prevented us from fully exploiting this opportunity. A plan is being considered to address these issues

Progress

- We have received one or more significant pieces of press coverage in every month of 2018 including print, online and radio, both regionally and nationally

- These include stories about pioneering treatment, inspiring patient stories an clinical developments. Our most notable stories include Mako robotics with Prof Davis, ACI surgery with Prof Snow and rotationplasty with Prof Jeys

- We are building stronger relationships with journalists which helps sustain our PR

April and May in numbers

3	331m	317k	1.4k
pieces of coverage	Online readership	Estimated coverage views	Social shares on coverage

Progress in social media

Twitter annual comparison: 2017 - 2018

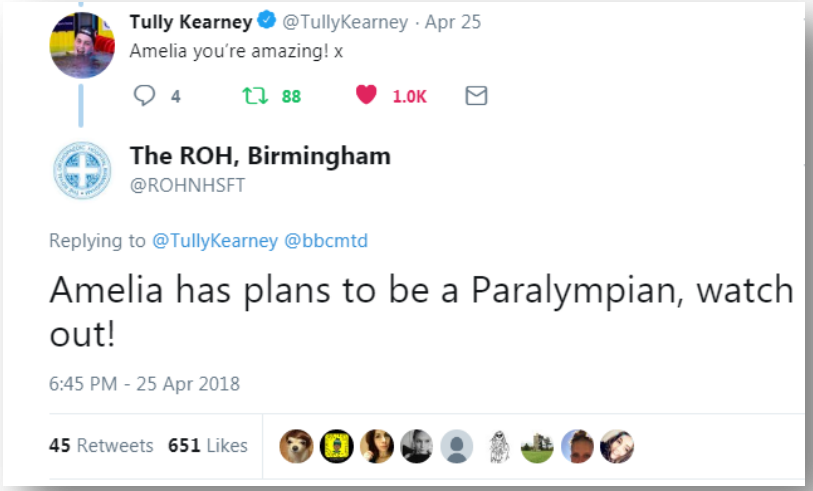
Month	Tweets	Impressions	Profile Visits	Mentions	New Followers
April 17	4	10.5K	931	51	20
May 17	3	5,938K	1,204	102	195

Month	Tweets	Impressions	Profile Visits	Mentions	New Followers
April 18	35 ▲	409K ▲	3,612 ▲	224 ▲	34 ▲
May 18	30 ▲	30.5K ▲	3,275 ▲	315 ▲	29 ▼

Social media in April and May

Top tweet in April 2018

A conversation with a Paralympian regarding our rotationplasty patient



Top tweet in May 2018

The news of our new 'good' rating from the CQC

Facebook

April unique views: **502**
May unique views: **723**

Plans to grow

We are working with Doctify to build consultant profiles on their site. This is a paid service which will maximise SEO (get on to the top of google) www.doctify.co.uk

We will be using boost services on social media (<£50) to maximise our reach and exposure

We are planning significant marketing campaigns around our Private Suite (tailored radio advertising) and the Stryker hip and knee pathway project (full campaign). We will be working with agencies on these campaigns which is partly resourced by Stryker.

We want to add capacity through the use of a day-rate consultant to maximise press and coverage while we consider longer term capacity solutions

Upcoming media

As part of the NHS 70th birthday celebrations we have planned:

- A broadcast piece with BBC Midlands Today which will air on Thursday 5 July
- A radio interview on BBC Five Live with an ROH patient which will air on Thursday 5 July

Future reports

- We are currently looking for an affordable automated system to compile coverage and give you *at-a-glance* metrics in a digestible format
- This will include the temperature of coverage, unique views and shares, readership – all the metrics you would expect to show progress or deterioration
- Reports will look different going forward but will still include upcoming activity and plans
- If there's anything you would like to see, please let us know and we can build it in

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 5 September 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 5 September 2018 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.

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 5 September 2018: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Patient/service improvement story: Theatre improvements	Presentation	
1120h	2	Apologies	Verbal	Chair
1122h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1125h	4	Minutes of Public Board Meeting held on the 4 July 2018: *for approval*	ROHTB (7/18) 008	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (7/18) 008 (a)	SGL
1135h	6	Board Assurance Framework: *for assurance*	ROHTB (9/18) 001 ROHTB (9/18) 001 (a)	SGL
1140h	7	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (9/18) 002 ROHTB (9/18) 002 (a)	YB/PA
	7.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	PA
		STRATEGY		
1155h	8	Paediatric services update: *for information* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (9/18) 003 ROHTB (9/18) 003 (a)	JW

TIME	ITEM	TITLE	PAPER	LEAD
1210h	9	Progress against the five year vision: *for assurance* BAF REF: All risks	ROHTB (9/18) 004 ROHTB (9/18) 004 (a)	PB
		QUALITY & PATIENT SAFETY		
1220h	10	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (9/18) 005	GM
1230h	11	Radiology Review – A national review of radiology reporting within the NHS in England (CQC July 2018): *for assurance* BAF REF: None	ROHTB (9/18) 006 ROHTB (9/18) 006 (a) ROHTB (9/18) 006 (b)	JW
		FINANCE AND PERFORMANCE		
1240h	12	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2,	ROHTB (9/18) 007 ROHTB (9/18) 008	SW
		COMPLIANCE AND CORPORATE GOVERNANCE		
1250h	13	Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2018 NHS Core Standards: *for approval* BAF REF: None	ROHTB (9/18) 009 ROHTB (9/18) 009 (a)	PB
1255h	14	Board Code of Practice: *for approval* BAF REF: S800	ROHTB (9/18) 010 ROHTB (9/18) 010 (a)	RA
		UPDATES FROM THE BOARD COMMITTEES		
1305h	15	Quality & Safety Committee: *for assurance*	ROHTB (9/18) 011	KS
	16	Finance & Performance Committee: *for assurance*	ROHTB (9/18) 012	TP
	17	Staff Experience & OD Committee: *for assurance*	ROHTB (9/18) 013	RP
	18	Audit Committee and annual report: *for assurance*	ROHTB (9/18) 014 ROHTB (9/18) 015	RA
		MATTERS FOR INFORMATION		
	19	Meeting effectiveness	Verbal	ALL
1310h	20	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 7th November 2018 at 1100h in the Boardroom, Trust Headquarters

Notes

Quorum

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

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

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

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 4 July 2018: 1145h – 1315h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JW)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive Director	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient/service improvement story: Quality Service Improvement and Redesign	**Presentation**
Amanda Gaston, Assistant Director of Finance and Rachel Matthews, Clinical Service Support Manager, joined the meeting to present an update on their recent course on Quality Service Improvement and Redesign (QSIR). The team's examples of applying learning into practice were outlined, including for pooling patients to improve clinic capacity and pathway redesign for injections in the Admissions and Day Case Unit (ADCU) which the Board agreed were very positive steps. The Board congratulated the team on their success with their training. It was noted that this was a good example of involving people in the solutions to their problems. The benefits of the approach were noted to include better engagement with those tasked with delivering improvement, part of this being attributed to the language	

used. The tools and techniques were noted to be directly relevant to the NHS and the feedback from the clinical leaders who had been involved had been positive. It was suggested that it would be beneficial for clinical staff to undertake the training as the early interest was encouraging. It was noted that the connections with others having the same skill set across the region were important and helped resolve some cross organisational initiatives. There were reported to be initiatives in other provider trusts and external private industry into which the Trust could link. It was noted that NHS Improvement also had a range of tools that could be accessed which supported this work. To roll out this methodology, it was agreed that other staff needed to be encouraged to participate in improvement work and that staff should be freed up when needed. There were noted to be a number of initiatives where the technique could be applied. It was suggested that the work needed to be reported up into Staff Experience & OD Committee routinely. The publication of the work was being considered and participation in the work of the People Committee was being encouraged. The team was thanked for the attendance and the update. Mrs Gaston was thanked for her work ahead of her maternity leave, including the development of the Cost Improvement Plan. Ms Matthews was also thanked for her work to implement e-referrals, with the ROH being only one of three trusts that had achieved this to date.	
ACTION: **SGL to schedule in an update on the progress with embedding the QSIR process into the workplan for the Staff Experience & OD Committee**	
2 Apologies	**Verbal**
Prof Phil Begg tendered his apologies. The Board was joined by Simon Pitts, the Trust's relationship manager for the Care Quality Commission.	
3 Declarations of interest	**Verbal**
The register was reported to be available on request from Company Secretary. There were no additional declarations that needed to be made.	
4 Minutes of Public Board meeting held on the 6 June 2018: *for approval*	**ROHTB (6/18) 010**
The minutes of the Public Board meeting held on the 6 June 2018 were accepted as a true and accurate record of discussions held.	
5 Trust Board action points: *for assurance*	**ROHTB (6/18) 010 (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: ***for information and assurance***	**ROHTB (7/18) 001** **ROHTB (7/18) 001 (a)**
It was noted that NHS Improvement had written to the Trust to say that the enforcement undertakings around performance and governance would be lifted. This was very positive news for the organisation. The undertakings linked to financial sustainability would remain, however NHS Improvement was pleased at the work underway to address this which included the assistance from the STP. Applications had been issued for expressions of interest for the Chair of the STP. These were to be received by the end of July and a nominations committee would be convened to make a recommendation to the STP Board. The governance structure of the STP was being revised. The work would be managed through three portfolio boards and this also formalised the creation of a Chief Executive group. A number of enabling boards had been set up and these had been placed under the oversight of the delivery group which simplified the structure. The proposals for a capital funding were discussed, including the submission for the ROH around Outpatient, diagnostics, therapies and the Knowledge Hub. It was noted that the Trust's scheme did not feature within the top ten in terms of priority however. The total public estate in the region would be reviewed within Birmingham and Solihull. In terms of STP engagement, the plan was within the public, yet the formal engagement would occur after the NHS 70th anniversary with events planned for October. It was reported that the NHS 70th tea party was planned for Thursday 5 July. It was reported that the Chairs of the STP were meeting regularly as a group. A meeting had been held with Sarah-Jane Marsh around her role as the lead Chief Executive for the provider trusts and there had been a discussion as to how low organisational boundary walls would be established. Maternity and orthopaedics would be treated as priorities by the STP. Talent management across the patch was also planned. The Chairman advised that with the Chief Executive and the Chief Operating Officer, she had met with representatives from Bournville Village Trust (BVT) to discuss the possibility of a presence by ROH in their Bournville Gardens campus and to meet their new Chief Executive. It was noted that by October there needed to be a decision as to how the BVT site would be used.	

It was reported that Prof Surinder Sharma had joined the Board as a consultant. A volunteers' event had been held and a lunch had been provided to celebrate their work. The Charitable Funds Committee was being reinvigorated.	
6.1 Estates review	**Verbal**
It was noted that there had been a discussion of the estates review in detail in the private meeting of the Trust Board. Thanks were given to Professor Begg for the stocktake he had undertaken of all the buildings and the risks and opportunities around the estate. There had also been some thinking around how services might be delivered in the future across the estate and there was consideration around bidding for funds from the STP. It was noted that the estates work would report into the Finance & Performance Committee in future.	
7 Paediatric services update	**Verbal**
It was reported that there had been significant engagement with Birmingham Women's and Children's Hospitals (BWCH) over the recent months. BWCH was still in the process of signing off its business case but the date to which all were working for the transfer of the paediatric service was by 31 January 2019. The joint governance structure was now well embedded and an operational delivery group was set up, alongside an oversight group. Mrs Sallah reported that the joint oversight meeting had been effective and that chairing was by a Non Executive from BWCH and herself by rotation. The challenges were around the capacity and capability to meet the timeline for transition. Assurance was given that this was in place from the ROH perspective. The level of engagement with the Senior Responsible Owner (SRO) at BWCH was reported to be good. A monthly commissioning group would hold the Chief Operating Officers to account for the progress with transition. The project plan that had been developed was to be strengthened to highlight dependencies and the key points within the timeline. There had been a staff briefing which had been well attended by those impacted by the transfer. There were some good and mature questions around impact, particularly associated with the implications of TUPE. Staff had welcomed the opportunity to have a briefing and for being given some clear dates for the transfer. In terms of the ongoing service at the ROH, it was reported that there had been no escalations or transfers out and a daily review by a Paediatrician was in place. The number of nurses to support the paediatric service had increased, with there	

being a focus on the requirement for two qualified nurses on the High Dependency unit. There had been no nurse staffing incidents which had resulted in harm. In terms of the challenge from a consultant around the oncology service that the Board had discussed previously, the Clinical Service Lead was to visit the accommodation at BWCH and there would be a proposal developed as to how the service would look. A proposal for outpatients and diagnostics was also being worked through. It was noted that around six paediatric patients were in the hospital per day. The split site working model arrangements were being addressed. This would include job planning and practical arrangements for patients and staff. It was agreed that a written update needed to be in public in future.	
ACTION: **JW to arrange for a written update on the paediatric plans to be presented to the Board in public in future**	
8 Orthopaedic services in the STP	**Verbal**
It was reported that there had been limited progress on this work, other than agreement that orthopaedics would report up into the STP as as part of one of the key worksteams. There had been some positive discussions with partner organisations and movement of work onto the ROH site. The financial implications were being worked through, alongside the capacity available on each of the sites and the profile of this incorporating the impact of winter pressures. A piece of independent work would quantify the value of the work. The Trust was supporting Heartlands, Good Hope and Solihull Hospitals (HGS) with the management of their backlog and 67 patients were to be treated from HGS. The financial arrangement for this had been finalised. In terms of health partnerships, work was underway to look at what services may be offered and the Trust was also offering clinic space to run extended GP hours. Outpatient staff had embraced this for a range of services and accommodation. A GP fellow would be funded, which was positive. The therapies strategy would be presented to the Board in September. It was noted that Mr Grainger, former spinal consultant, had left the Trust to join University Hospitals Birmingham NHSFT (UHB), although he was working for the ROH one day per week. Some spinal patients would be received from UHB. The referral arrangements were also being reviewed.	
9 Patient Safety & Quality report: *for assurance*	**ROHTB (7/18) 002**

The Executive Director of Patient Services reported that the four moderate harm incidents included a patient who had fallen and the CT scan had been undertaken at UHB. A patient had also experienced a VTE. A paediatric patient suffered an adverse reaction to a controlled drug. The provisional finding to this was reported to be an unknown sensitivity to this medication. There had been an unexpected death. The coroner held an inquest on 11 May that concluded that the patient had died of known complications. There was a serious incident reported during the month that related to how a patient was mobilised, however there was now assurance that training in the relevant equipment was now complete and practice was more robust. Regarding the Medical Devices Advisory Group, the process for the introduction of a new piece of medical equipment would be strengthened through this body. The membership of the Group had also been extended. It was suggested that there needed to be a cross check to the internal audit programme for any recommendations that concerned medical device training. There had been a peak of complaints in the spinal service but there were no themes that were of concern. Work was underway to improve the response rates for the Friends and Family Test across the Trust and there was evidence of improvement on a month on month increase. There was 100% compliance with the WHO checklist which included paper-based processes in areas other than theatres. There had not been any notifiable infections during the month. It was reported that several months ago a fall had occurred, after which the patient had died. The learning from this and the action would be considered by the Quality & Safety Committee at the next meeting. The clinicians had met the family. The matter would be included in the learning from deaths process.	
10 Finance & Performance overview: *for assurance*	**ROHTB (7/18) 003**
It was reported that a small surplus had been generated in the month, resulting in a £843k deficit year to date, this being better than planned. Elective activity had been strong and year to date the Trust was ahead of plan. Expenditure was also in line with plan. There had been a further increase in agency staff usage which was as a result of covering vacancies and covering the medical rota. There had been a meeting with NHS Improvement and new financial plans were	

being requested from a number of trusts, but not that of the ROH. Overall it had been a strong start to the new financial year. The Sustainability and Transformation Funding had not yet been received. This meant that the first installment of cash from the Department of Health needed to be drawn down shortly. It was reported that Mr Green, consultant surgeon, was working five three session days. As a result, his waiting times would be below 18 weeks for knee cases by the end of month. Quality and patient outcomes were being monitored, although it was noted that he already undertaken three session days as part of his regular job plan therefore there was no reason for any concern. There had been a reduction in outpatient clinic waiting times. Performance against the diagnostics was strong. A performance of 90% had been achieved for the 62-day cancer target. Performance against the 18 weeks Referral to Treatment Time target was slightly below trajectory, however this was an improvement on the previous months. The number of patients waiting in excess of 52 weeks had reduced below the level anticipated. It was noted that there was some good energy across the Trust. An improvement project behind the scenes was underway. The MAKO robot was working well and knee surgery was now being undertaken using this technology.	
11 CQC action plan: *for assurance*	**ROHTB (7/18) 004** **ROHTB (7/18) 004 (a)**
The Executive Director of Patient Services presented the CQC action plan which it was noted was a first version. Actions were divided into the accountable executives' portfolio. There would be monthly oversight by the Executive Team and the plan would be considered by the Quality & Safety Committee, with a report to the Trust Board quarterly. The methodology for preparing the organisation for the next inspection would be considered. The intranet site had been amended to clarify the contact points for mental health expertise. There was also work with the Mental Health trust. The action around sharing lessons learned was noted to be at amber status as this remained a challenge. Root Cause Analysis training was planned and the methods of messaging points of learning were also being considered.	

12 Quality & Safety Committee: *for assurance*	**ROHTB (7/18) 005**
Mrs Sallah suggested that the effectiveness of the Drugs and Therapeutics Committee needed to be strengthened, including a review of the leadership of this body. There had been a dip in compliance with paediatric life support training and the right training at the right level for individuals was being worked through. The compliance with requirements for the controlled drugs cupboards was discussed and further risk assessments were needed given that there were no concrete permanent structures to which the cupboards should be attached. The Board was advised that there was currently no risk to the security of the drugs under the current arrangements however. There was reported to be a plan to purchase an electronic governance solution which would enhance reporting and help with the management of trustwide policies. Compliance with water safety standards needed to be reviewed and an update was planned for the next meeting.	
13 Finance & Performance Committee: *for assurance*	**ROHTB (7/18) 006**
Mr Pile drew the Board's attention to the excellent performance for the start of the year was highlighted which was different to previous years. Good operational performance and team work were noted to be drivers for this position. Theatre utilisation was highlighted to be particularly impressive. The Committee had also discussed the business cases considered on the private agenda earlier in the day.	
14 Staff Experience & OD Committee: *for assurance*	**ROHTB (7/18) 007**
It was reported that the Committee was keen to see some action plans behind the work and this would be discussed later in the day at the next meeting.	
15 Press and media report	**ROHTB (7/18) 008**
It was agreed that the Communications Manager should be invited to the Board in future. There had been three positive stories in the local media recently which was pleasing. There would be a broadcast piece on Midlands Today.	
ACTION: SGL to invite the Communications Manager to present an update on the work of his team at a future meeting	
16 Any Other Business	**Verbal**
It was agreed it had been a good meeting. More written reports needed to be on	

the public agenda. The service improvement story was well received. It was suggested that service improvement and patient stories should be alternated.	
Details of next meeting	
The next meeting is planned for Wednesday 5 September 2018 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 5 September 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 31.08.2018

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 055	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Consider how the Board could be made aware of how clinical staff stretched themselves towards excellence	AP	~~06/06/2018~~ ~~30/09/2018~~ 3/10/2018	Outcome of the Clinical Excellence awards to be outlined to Staff Experience & OD Committee in ~~September~~ October 2018	
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee	SGL	18-Jul-18	To be scheduled in for when the clinical audit internal audit has been completed. Due to be discussed at the Audit Committee on 25 January 2019	
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	05-Sep-18	Update on therapy services planned for the private Board meeting in September, with the strategy due for presentation in November 2018	
ROHTBACT. 052	Board Assurance Framework	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	07/03/2018	Arrange a risk workshop	SGL	~~31/07/2018~~ 31/08/2018	Arranged for 3 October 2018 as part of the Board workshop	
ROHTBACT. 054	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Build exceptional staff experience into the strategic goals progress report	PB	~~04/07/2018~~ 05/09/2018	Added into the Board report considered at the September 2018 meeting	
ROHTBACT. 060	Patient/service improvement story: Quality Service Improvement and Redesign	Presentation	04/07/2018	Schedule in an update on the progress with embedding the QSIR process into the workplan for the Staff Experience & OD Committee	SGL	07-Nov-18	Scheduled in for the November meeting of the Staff Experience & OD Committee	
ROHTBACT. 061	Paediatric services update	Verbal	04/07/2018	Arrange for a written update on the paediatric plans to be presented to the Board in public in future	JWI	05-Sep-18	Included on the agenda of the September Trust Board meeting	
ROHTBACT. 062	Press and media report	ROHTB (7/18) 008	04/07/2018	Invite the Communications Manager to present an update on the work of his team at a future meeting	SGL	07-Nov-18	Scehduled for the November meeting	
ROHTBACT. 050	Chairman's & Chief Executive's update	ROHTB (3/18) 001 ROHTB (3/18) 001 (a)	07/03/2018	Arrange for a meeting to be arranged with local MPs, the Chairman and Chief Executive	SGL	~~31/05/2018~~ 31/07/2018	Meeting arranged with Olly Amstrong, Councillor for Northfield for 19 September. Separately, a meeting has been held with local MPs to discuss security and other topical issues.	

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 (9/18) 001

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**5 September 2018**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at August 2018

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

Summary of Key Updates

It is proposed that the following risks be added:

- HRD1 - There is a risk that the current gap between staff in post and staffing required (total establishment) creates operational difficulties (with a potential impact on patient safety and experience), premium cost of temporary staffing or has a negative impact on staff engagement
- HRD2 - There is a risk that the future gap between staff in post and staffing required (total establishment) creates operational difficulties (with a potential impact on patient safety and experience), premium cost of temporary staffing or has a negative impact on staff engagement

Three risks are proposed for de-escalation to local risk registers:-

- 1117 – There is a risk that patients may experience a delay in their clinical pathway due to data quality issues, which may result in harm
- 1088 – There is a risk that the organisation's reported position against the 92% target is inaccurate due to data quality issues
- 1074 – 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
- 799 - The Board is unable to create the common beliefs, sense of purpose and ambition across the organisation among clinicians and other staff to deliver the strategy and avoid the diversion

of energy into individual agendas

REPORT RECOMMENDATION:

Trust Board is asked to:

- review the Board Assurance Framework
- confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- APPROVE the addition of risks HRD1 & 2
- APPROVE the de-escalation of risks 1117, 1088, 1074 & 799

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:

A version of the BAF was considered by the Audit Committee on 18 July 2018

BOARD ASSURANCE FRAMEWORK Q2 2018/19

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
CE1	Corporate	Paul Athey	The Trust does not currently have a clear financial and operational plan in places that describes how the organisation will deliver 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. This strategy has been updated by the Board in Q4 2017/18. A Strategic Outline Case has been accepted by the Board outlining options for future growth. Discussions are taking place with partners in the STP to work through options for providing closer clinical integration between the ROH and other partners, which will built resilience and support the move towards financial sustainability	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	5	25	↔	Agreement of system wide clinical and operational model for orthopaedics and subsequent ROH business and financial plan for sustainability	Mar-19	2	5	10
FP1	Finance	Steve Washbourne	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	5	5	25	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. The Trust Board at its meeting in July 2018, agreed to a proposal to invest in additional modular theatres, which provide additional capacity to support the plans to secure future sustainability.	FPC reports; Board approval for cash borrowing; Finance & Performance overview	4	5	20	↔	The Trust is supporting an STP review of orthopaedic provision in Birmingham and Solihull. There is anticipation that the new modular theatre set up will be operational during Spring 2019.	May-19	3	4	12
CE2	Corporate	Paul Athey	There is a risk that the ROH Trust Board carries all the clinical risk residing with the transition of Inpatient Paediatric Services whilst the system re-commission and re-provides the services elsewhere.	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	5	5	25	The Trust agreed that it could not meet the national service guidelines and as such gave notice on the provision of the inpatient service. All stakeholders have confirmed that this should be managed as a system wide risk and this is done via the monthly Stakeholder meetings and the Paediatric monthly commissioning group. The Trust and the health system all acknowledge that the Inpatient Service at the ROH is not compliant with national guidance during this transition period. All stakeholders have agreed an amendment to the oversight group terms of reference stating "Whilst it is acknowledged that the ROH maintains accountability for each patient that is treated during the period during which the paediatric service remains with the ROH, all stakeholders within the group agree that the provision of a safe service during the transition period is their joint responsibility". Joint strategic and operational delivery groups have been set up creating a closer ownership of the transition from both organisations. A letter has been received from BWCH outlining the Trust's commitment to supporting safe staffing arrangements during the transition.	Minutes of stakeholder oversight meeting	4	4	16	↔	Agreement at joint stakeholder group that a system-wide risk sharing statement will be developed	Mar-19	3	4	12

1089	Operations	Jo Williams	There is a risk that the Trust fails to meet the trajectory to achieve a performance of 92% against the 18 Week RTT target as agreed with regulators	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	Trajectories have been 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 were held to agree how the Trust will expand capacity to meet demand. Teams have completed trajectories for all services. A recovery trajectory is in place to achieve 92% by November 2018	Weekly report to Exec Team & Ops Board	3	4	12	↔	The Trust has in place a trajectory to deliver 92% performance by November 2018 - this is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current position for June is circa 1% below agreed trajectory, however plans are in place to meet trust forecasted position for delivery in November 2018. Work is underway with the operational management team to review demand and capacity models for each service and provide additional capacity to meet the demand. Differential waiting times within specialties has been shared with CSLS as part of a plan to meet RTT. One consultant has already completed a week of 3 session per day operating to improve their 18 week position and further capacity is being sourced, following this successful trial. In additional extra outpatient clinics are being delivered in specialities where waits are extended, such as spinal deformity. Pathway work is planned in key areas to support compliance further by understanding the current barriers to 18 week delivery .	Q3 2018/19	3	4	12
1117	Operations	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	A SOP for the review of patient timelines to provide a consistent approach and level of detail for patients has been developed. 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. Daily validation process in place to ensure any RTT sequencing errors are corrected.	Weekly report to Exec Team & Ops Board	3	4	12	↔	Use of the harm process to review patients who have had a delay in the pathway continues. A new clinic outcome form has been implemented for the Spinal consultant team which is working very well . Clinic outcomes are being checked monthly as part of validating the 18 week position. Work is underway to redesign the appointments process and centralise the completion of clinic outcomes on PAS . This work will continue to support improved data quality. PROPOSE CLOSURE/DE-ESCALATION	Ongoing	3	4	12
1088	Operations	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	Training of admin teams and clinical staff has been completed. The Trust has completed a full data cleanse of all its RTT data including historical clock stops. A daily RTT dashboard and data error report is in use and supports daily RTT management. The Trust returned to national reporting in December 17.	Weekly report to Exec Team & Ops Board	2	4	8	↔	Validation work continues to identify any data quality issues and inform ongoing training and development of the team. Further lists of required validation have been identified by the Health Informatics team which are being sampled / risk assessed and addressed as part of robuust data integrity monitoring . Recruitment plans are in place to support delivery of this plan for an additional 3 validation posts to carry out this work. Daily data quality issues continue to be rectified to ensure data quality continually improves. PROPOSE CLOSURE/DE-ESCALATION	Q2 2018/19	2	4	8
293	Finance	Steve Washbourne	Financial surplus Failure to deliver planned financial surplus, impacting on financial stability, investment opportunities and regulatory rating.	With safe and efficient processes that are patient centred	FPC	4	5	20	The Trust met its control total in 2017/18 and has submitted a plan to NHS Improvement to deliver its £6m Control Total in 2018/19. It is important for the trust's long term sustainability however to return to surplus to enable it to generate cash and not continue to rely on loans from the Department of Health. A business case for the development of additional theatres and wards has been approved at July's Trust Board, which will drive additional contribution through the organisation over the coming years. The transition of paediatrics remains a risk with regards to the Trust's overall deficit position. Discussions are also ongoing with the STP in order to develop a Orthopaedic Provider Alliance.	FPC Reports	4	5	20	↔	Perfecting Pathways to continue to deliver activity and operational process improvements Continuing performance meetings for each division Delivery of the theatre/ward business case development and subsequent uplift in activity. Ongoing discussions with the STP to develop a revised model for orthopaedics across the Birmingham and Solihull region.	Ongoing	4	3	12

1137	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	Updated Safe Operation and Maintenance of Water Systems Policy. Expanded Terms of Reference for Water Safety Group. Future meetings scheduled for Water Safety Group . Water Safety Group minutes presented to IPC Group meeting. 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	↔	Water safety plan is in development. Pseudomonas Aeruginosa Risk Assesment under review by Water Safety Group	Aug-19	1	5	5
HRD2	WFOD	Paul Athey	There is a risk that the future gap between staff in post and staffing required (total establishment) creates operational difficulties (with a potential impact on patient safety and experience), premium cost of temporary staffing or has a negative impact on staff engagement	Highly motivated, skilled and inspiring colleagues	People Committee/SE & OD Committee	5	4	20	Whilst work has been undertaken to more fully understand the short-term resourcing needs and recruitment plan, the known additional staffing required for the theatre expansion has led to an increased level of likelihood for this risk beyond April 2019.	SE&ODC papers. Nurse staffing reports. People Committee reports.	5	4	20	NEW	Plans for longer term (5 year) workforce transformation being developed including review of middle medial provision, specialist nursing programme, evaluation of use of Nursing Associate, new early engagement model for qualifying nurses, collaboration with STP partners, ACPs. Significant initial investment is required.	Jan-21	3	3	9
HRD1	WFOD	Paul Athey	There is a risk that the current gap between staff in post and staffing required (total establishment) creates operational difficulties (with a potential impact on patient safety and experience), premium cost of temporary staffing or has a negative impact on staff engagement	Highly motivated, skilled and inspiring colleagues	People Committee/SE & OD Committee	5	4	20	No current evidence of adverse effect on patient safety due to safe staffing levels maintained through bank and in some cases agency staff. Increased activity through the Autumn months may provide some challenge. A better understanding of development and employment routes. Routine Workforce Performance Data scrutinised at various levels within the Trust. Clinical staff now excluded from UKBA Tier 2 applications. New clinical workforce governance structure with increased focus on attraction, recruitment and retention of clinical staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Overseas recruitment group meets monthly to consider opportunities for oversees recruitment. Additional countries being explored to increase opportunity. Healthy Staff Bank to which staff are recruited regularly	SE&ODC papers. Nurse staffing reports. People Committee reports.	4	4	16	NEW	Potential for recruitment to six fellow posts significantly reducing agency spend on locums (September 18) Significant initial investment is required. Actions taken to maximise employee engagement to aid retention [ongoing]. Launch recruitment microsites and increase use of social media (September 2018)	Jan-21	3	3	9
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 & QSC	5	4	20	All patients continue to be validated, the 52 week RTT position for the end of July is at 54 patients, this is in line with the trajectory of 55. Additional lists have been provided throughout the year. We have employed an additional spinal deformity consultant from 1st August 2018. Hei s booked to deliver an additional clinic per week for new patients (6 pts) for the next 3 months	Weekly updates to Exec Team; updates to Trust Board.	4	4	16	↔	All patients have been validated to provide an accurate position of the number of patients waiting for surgery at BWCH. Additional adhoc operating lists are being sourced as part of the paediatric transition project from Aug - December 18. Contingency patients are in place when PICU beds are not available. Additional established Theatre capacity is being developed at BCH for Qtr 4 18/19. A small cohort of patients have been transferred to Stoke for treatment.	Ongoing	2	4	8

27	Operations	Jo Williams	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	Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. Work is on-going to review the future junior medical workforce plan in line with the strategic outline business case led by Phil Begg . Initial meeting of stakeholder group planned for July 18. Weekly vacancies/sickness is monitored and appropriate action taken to mitigate agency staffing. A medical workforce officer will be recruited to the Trust to further strengthen this function working closer with the operational and clinical teams.	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.	5	3	15	↑	At present there is little evidence of tight control of agency staff expenditure. Agency usage has been necessary to cover vacancies in key areas. Recruitment plans suggest that a number of substantive staff will come into post during September 2018, which should alleviate the position.	Q3 2018/19	2	3	6
770	Operations	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	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible.	Estates maintenance schedule	3	5	15	↔	Theatre User Group to continue to track performance against turnaround work streams. Exploring possibility of using pre-fabricated theatres.	Ongoing	1	4	4
CO3	Operations	Jo Williams	Theatres - there is a risk that the department is not operating effectively and is in need of a full review supported by a organisational development programme	Delivered by highly motivated, skilled and inspiring colleagues	FPC	4	5	20	The operational team for Theatre has been strengthened with the appointment of a new Theatre Manager and Matron. Further work with the team is ongoing to ensure that we continue to progress development across the entire Theatre team.	Perfecting Pathways Board papers and minutes	3	3	9	↔	To support the Perfecting Pathway programme and the Trust recovery plan there remains a need to conduct a full review of theatres supported by an OD programme. An initial assessment is currently ongoing to assess whether external support is required to support this. The workforce plan will be discussed at the Staff Experience and OD Committee in March 2018 as this needs to be developed to support and deliver the operational annual plan. The Theatre Manager post will be advertised & recruited substantively in April 2018. July 18 -A substantive Matron and Theatre Manger have been appointed. A full workforce plan is being developed by the Director of Patient Services and the Head of Nursing to further support the team Stryker Business Solutions have commenced in Theatres working alongside the team on the new hip and knee pathway which will review the processes across all Theatres. Tray rationilisation and preference cards and currently being reviewed. Proposals for further development of the theatre workforce to be considered by the Staff Experience & OD Committee in September, which includes the plans for the introduction of the Theatre Advanced Practitioner.	Q3 2018/19	3	3	9

CO1	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	3	3	9	↔	Delivery of the Cancer Action Plan. Onkos provides a daily tracking system. The team are developing proposal to implement a new system from April 2018 - this is supported by the Cancer Action plan. A new system has been approved for implementation in 2018. A project group will be established in April 2018 to manage the implementation. July 18- Someset Oncology tracking system will be implemented with a go live date of October 2018	Q3 2018/19	2	2	4
CO2	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 needs 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. The operational team has been strengthened within a number of areas. Further work undertaken by the Executive Team during August 2018 to review the full range and projects and resources required. This will be reviewed on an ongoing basis and reprioritised where needed.	Trust Board reports on operational initiatives, including validation of 18 weeks RTT, Scheduled Care Improvement Board and theatres improvement programme	3	3	9	↔	The position will be reviewed weekly at Executive team meeting to ensure that this is not impacting on delivery of the projects This will continued to be monitored monthly. Perfecting Pathway encompasses and supports the operational team to deliver service changes and redesign. A substantive Deputy COO joined the Trust in February 2018 July 2018 - A dedicated post has been established to support Paediatric transition from 16.7.18. The post has been backfilled to support daily operational management. Further review of the list of organisation-wide projects planned by the Executive Team.	Q3 2018/19	2	3	6
269	Operations	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. Perfecting Pathways papers. Modular theatre business case	3	4	12	↔	Embedding and delivery of Perfecting Pathways. Delivery of the integrated action plan round 18 weeks RTT, cancer services and spinal deformity. Development and delivery of recovery plan. Modular theatre set up anticipated to become functional in Spring 2019, which creates additional capacity for activity. Continued suppprt provided to Heartlands, Good Hope and Solihull Hospitals.	Q1 2019/20	2	4	8
270	Finance	Steve Washbourne	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 Trust are currently operating within a 2 year 2-17/18-2018/19 tariff, which results in ongoing financial pressure for the trust as on a net basis it does not adequately reimburse the trust for the costs of delivery. The risks associated with operating with this tariff have been made clear in discussions with regulators & commissioners, and the trust continues to work with the regulators to develop a tariff which more adequately reflects the costs of treatment.	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	3	12	↔	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. A specific review of BIU activity is ongoing.	Ongoing	2	4	8

804	Finance	Steve Washbourne	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	4	16	The Business Intelligence team continue to increase the number of self service reports available to users via the BI Reporting Portal. In addition to the self-service aspect of the BI reporting portal. The BI team now mailshot out activity reports and consultant statements each month to consultants. Confidence in the Business Intelligence team is growing, the role of Bone Infection Data Analyst that traditionally sat outside the department has now being centralised into the BI Team. Dialogue has started between BI and the Oncology team to improve the level of support the BI team currently offer the service. The turnaround times of dealing with ad-hoc information requests has improved considerably over the last few months. Over 90% of requests being completed within 2 days. The BI structure has been changed to better cope better with increasing demands of reporting, with two posts due to go to advert this week (Business Intelligence Systems Manager & Information Analyst). These posts will help drive forward the team's ability to build interactive online reports and cope with new demands for reporting from new clinical systems such as around ePMA.	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	3	4	12	↔	Recruit to Business Intelligence Systems Manager & Information Analyst posts	Q3 2018/19	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	Production of the monthly Quality Report that contains a clear focus on lessons learned from incidents, Litigation, Coroners cases, Serious Incidents, Patient Advice and Liaison Service (PALS), Friends and Family Test FFT, Complaints and Training Compliance. The Trust has in place an effective process to report, investigate, monitor and learn from Serious Incidents and complaints. All Trust Operational Divisions have both monthly and weekly meeting of their Divisional Governance Team as part of their local governance arrangements. The Divisional Governance Team will receive local intelligence relevant to their areas of responsibility so that they can assess performance against an extensive range of quality indicators. The Divisional Governance Teams report to the Clinical quality group Committee on a monthly basis via the Quality Dashboards and Condition reports that were introduced in March 2017 as a framework to assure quality, safety. The Trust Quality committee structure and subcommittees are established to facilitate Trust wide level representation and sharing of minutes. The Complaints/Governance team ensuring all incidents, complaints and claims are monitored and have Executive oversight at the weekly Executives Meeting. Monthly analyses of incidents/Complaints are included in the monthly Divisional management board Governance report and show Trust and Divisional trends .Further improvements have been made in terms of; The development of a Quality Governance Framework;The electronic reporting system (Ulysses) has seen improvements around incident reporting and action plan monitoring. This enables a thorough analysis of the incidents, causes and outcomes of incidents. Action plans are programmed to remind staff of actions automatically; Root Cause Analysis (RCA) training was provided for relevant staff undertaking investigations to help move the focus of the investigation from the acts or omissions of staff, to identify the underlying causes of the incident and to create a better standard of RCA. Futher training is to be provided;	Patient Safety & Quality Report presented monthly to QSC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	2	3	6	↔	Ensuring that the electronic reporting system (Ulysses) is used to its full potential to enable a thorough analysis of the incidents, causes and outcomes of incidents, complaints and claims. Action plans will be programmed to remind staff of actions automatically; The annual staff and patient surveys will be reviewed for information relating to patient safety; with a focus on feedback from incidents; The development of local ward and department level quality reports that contains a clear focus on lessons learned from incidents, Litigation, Coroners Court, Serious Incidents, PALS, FFT, Complaints, Clinical Audits, Training Compliance. This will allow lessons to be disseminated to frontline staff more efficiently; and Further Human Factors training as the Trust looks to embed the human factors principles to develop solutions that reduce the risk of the same incidents happening again. A new Serious incident policy has been approved with a key focus on Prioritising serious incidents that require a full investigation. Routinely look to involve patients and families in investigations. Engaging and supporting the staff involved in the incident and investigation process. A clear SOP for the process of investigating Serious Incidents included roundtable discussions. Learning from Incidents will remain as one of the Trusts quality priority and progress will be monitored by Clinical Quality Group. Governance sessions at Clinical Audit reinstated.	Q4 2018/19	2	2	4

CE3	Corporate	Paul Athey	Risk that the plan for Paediatric is not aligned with the wider STP strategy for Orthopaedics	Developing services to meet changing needs, through partnership where appropriate	Exec Team/Trust Board	3	5	15	The Trust is actively engaged with the STP and clinical reference groups across BSOL are in place to shape the orthopaedic strategy for the future	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Agreement of transition plan following formal approval of transfer of paediatric surgery by BWCH	Q3 2018/19	2	3	6
1074	Finance	Steve Washbourne	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 drawn down loans in the previous financial year from the DOH and expects to borrow further loans this financial year. Receipt of the STF funds has delayed the need for those loans, but further funding is expected to be needed in the Autumn. Feedback on the cash flow modelling provided to the DOH and NHS Improvement each month has been 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	4	8	↔	Continued focus on efficiency and cost control through the recovery plan. PROPOSE CLOSURE/DE-ESCALATION	Ongoing	2	4	8
986	Nursing	Garry Marsh	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for	Safe and efficient processes that are patient-centred	Q&S	3	4	12	Joint work continues between Ward 11 and CYPHDU to review activity in line with staffing requirements. Active recruitment continues with a rolling advert. HDU: 2 Band 6 nurses currently going through HR process awaiting start date. Ward 11: 4 Band 5 nurses due to commence in September 2018. Agency (regular) continue. No children cancelled or no harms occurred due to paediatric staffing.	Q&S Report	3	4	12	↔	Ongoing recruitment programme	Ongoing	1	4	4
PS1	Nursing	Garry Marsh	There is a risk that patient care/safety may be compromised as we do not have enough Paediatric staff/vacancies on the ward.	Safe and efficient processes that are patient-centred	Children's Board	3	4	12	10 WTE seconded from Wolverhampton Hospital. Combined rota allows better oversight of nurse staffing levels. Children's Quality Report triangulates staffing vs harm and is scrutinised at CYP Board.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses.	Ongoing	1	4	4

CE4	Corporate	Paul Athey	There is a risk to the ROH reputation should the Paediatric service not be transferred in a timely and safe manner	Safe and efficient processes that are patient-centred	Exec Team/Trust Board	4	3	12	The Transition of services is due to take place from November 2018, however formal sign off is still outstanding. There is a risk that this timeframe could be extended. The Executive team continue to play an active part in system conversations to drive agreement of a transition plan. An internal governance structure for the transfer of services has been agreed by the Trust Board in April 2018. A communication plan is in place to ensure staff and patients are updated as and when circumstances develop	Team Brief; Joint stakeholder meeting minutes; Other system wide meeting minutes; Local transition group minutes, Children's Board minutes; E-mail correspondence from clinicians to Execs	4	3	12	↔	As part of the system wide meeting structure all risks relating to the transfer of services will be jointly risk assessed and appropriate mitigation will be in place.	Q4 2018/19	2	3	6
FP2	Finance	Steve Washbourne	The Trust is likely to incur transitional costs with the transfer of Inpatient Paediatric Services	Safe and efficient processes that are patient-centred	FPC	4	3	12	The Trust has highlighted the risk to NHSE and requested funding support should material additional costs be incurred. The Trust continues to review how existing resources can be utilised to ensure safe services and mitigate additional cost where possible.	Joint stakeholder meeting minutes	4	3	12	↔	The Trust would look to gain firm agreement with NHSE for the changes in local prices where the cost base increases on recurrently during the changes. The DOF met with the HoF from NHSE on 14/02/18 to discuss how a request for additional funding to support Paed services may be made during 2018.	Q4 2018/19	1	4	4
MD1	Clinical	Andrew Pearson	There is a risk that there will be some clinical resistance to the change in the way Paediatric Services are delivered	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	4	3	12	Briefing sessions have been held with all the clinical teams including clinically led reference groups established who meet to discuss the potential options and likely impact. A clinical session was also held in September chaired jointly with the ROH and BWCH Medical Directors to talk through the changes, the rational and the timeframe. This is supported by regular updates via email, team brief and 1-1 discussions with the Executives Team.	Trust Board meeting minutes of updated on staff enagagement sessions; record of discussions around concern about delivery of Oncology service	3	3	9	↔	Continued briefing sessions to be delivered through routine and bespoke staff communication routes	Jan-19	2	2	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	A Strategic Outline Case has been created, the development of which included multiple direct staff engagement workshops with various groups of clinicians across the Trust. A Chief Executive briefing session was delivered in January 2018, which reinforced the key messages of the SOC, in addition to the launch of the Five Year Vision which was signed off by the Board in early 2018.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case	2	3	6	↔	Staff to continue to be engaged with the development of the Outline Business Case and later the Full Business Case for the ROH. PROPOSE CLOSURE/DE-ESCALATION	Q1 2019/20	2	3	6

S800	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	New structure for the Clinical Governance Team developed. Processes for reporting up into the Quality & Safety Committee continue to work well and form a key part of the Committee's agenda at each meeting. Assurance reports from Committee chairs up to the Trust Board continue. Assurance review into effectiveness of Board & Committee operating commissioned.	Divisional Management Board agendas, papers and minutes. Clinical Governance structure chart; TOR and work plan 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. Report from Board & Committee review to be concluded and make recommendations. Purchase of new eletronic governance solution for better management of Trustwide policies and creation of additonal dashboards of performance against key quality metrics.	Q3 2018/19	1	3	3

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:	**5 September 2018**

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 5th September 2018

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 public Trust Board meeting on 4th July 2018.

2 STP UPDATE

2.1 Following the retirement of Dame Julie Moore, the STP Board unanimously accepted the recommendation of the nominations committee to appoint Paul Jennings, CEO of Birmingham & Solihull CCG, as the new STP system leader. The appointment is subject to the approval of NHSI and NHSE.

2.2 A stakeholder engagement event, focused on NEDs, governors and councillors is planned for November 2018. Further details are to be developed, however it is intended to help to build awareness and to shape the key Year 1 priorities required to deliver the STP strategy.

3 STP PARTNERSHIPS

3.1 On 18th July 2018, myself and the Chair met with David Rosser, the new CEO of University Hospitals Birmingham as part of his induction into the role. The meeting was very positive and David was keen to stress to importance of building strong relationships with the ROH and the respect that he had for the clinical expertise provided by the Trust. He also emphasised his support for the work currently ongoing to standardise orthopaedic pathways across the city.

3.2 The ROH has been confirmed as one of 7 GP out-of-hours hubs covering the Our Health Partnership practices across Birmingham and, from October 2018 onwards, will be hosting GP out-of-hours clinics 7 days a week. Work is currently ongoing to finalise operational arrangements, however this has been positively received by both GPs and ROH outpatient staff and is a real step forward in emphasising the important role that the ROH can provide in healthcare across the city.

4 CQC REVIEW OF COMPLIANCE WITH IR(ME)R GUIDELINES

4.1 On Friday 10th August, the Imaging Department received notification that they would be inspected by the CQ**C** specialist team on Wednesday 15th August. The IR(ME)R team (Ionising Radiation (Medical Exposure) Regulation) inspect healthcare providers to ensure the protection of patients undergoing medical exposure to ionising radiation e.g. X-ray's & CT scans. Their initial feedback was extremely positive and they witnessed great working relationships, meeting staff who knew what was expected of them and understood the protocols in place to help keep themselves and patients safe. They were able to see first-hand how a Centre of Excellence delivers its care to patients with an ongoing passion to continue to improve.

4.2 The formal letter from the CQC, summarising the outcome of the inspection, was received on 29 August, which is attached at Appendix A. This confirmed that the CQC team found that the Trust was overall compliant with the requirements of the new IR(ME)R. The CQC also commented on the good understanding of the regulation by those staff delivering care and also noted the good leadership of Radiology.

4.3 There were two areas which the CQC identified for improvement, these being concerned with the development of referral guidelines for its referrers, and with respect of training records which the CQC could not fully access on the day. Both of these actions are already in hand and form part of the overall plan to strengthen the operation of the Imaging area.

4.4 Overall, the outcome of the inspection is very positive and thanks are to be given to the Radiology Team for their hard work in preparing for the inspection and for the sound practice in the area.

5 NATIONAL ORTHOPAEDIC ALLIANCE

5.1 Along with Trust colleagues, I attended the most recent National Orthopaedic Alliance Board meeting on 1st October. The meetings have been revamped in recent months to provide greater focus on the sharing of best practice across orthopaedic providers and this quarter's meeting provided some interesting learning on the following topics:

- Orthopaedic Provision in Northern Ireland
- Day case Uni-compartmental knee surgery at NOC
- Using PROMS to inform and improve practice at Northumbria Healthcare
- The BOA over the next 5 years

5.2 There were also updates on the NOA workstreams on coding, tariff and procurement.

5.3 Paediatric orthopaedics proved to be a hot topic for discussion at the meeting and the Trust have been invited to share our experiences at a future date.

6 BACK TO THE FLOOR

6.1 On 7th July, I spent the morning with the Oncology team, observing both the daily diagnostic and full MDT meetings. As a reasonably new concept, the daily diagnostic MDT meeting was particularly impressive, running very efficiently with highly effective multi-professional input.

6.2 Garry Marsh, Executive Director of Nursing & Clinical Governance has also spent a number of sessions during July and August working with the clinical teams. He spent time working across the Oncology pathway from MDT, Ward rounds and Nurse Led clinics. As I was, Garry was impressed with the professionalism of the teams and both the MDT working and autonomy of the Advanced Nurse Practitioner.

On 6th July Garry spent time with a physiotherapist within the ward areas. The physiotherapist spoke of how engaged he currently was with the Trust around the range of service improvements. During this time it was identified that unfortunately some patients' pain assessment and control was not optimised and so Garry and one of the Associate Medical Directors beginning a review of the very varied pain control pathways we have, with a view to standardising the pathway.

On 10th July, Garry spent time in the Pre-Operative Assessment Centre (POAC) and whilst the journey to deliver the service we would all like for our patients has some way to go, it was clear that staff were energised about the future of POAC and morale certainly felt far higher than it had been during previous visits.

Garry has also spent time with our Critical Care outreach service, which provided a timely reminder of the increasing frailty and comorbidities of the patients we now serve and the acutely unwell episodes our staff now regularly face.

Garry joined the MDT with the discharge nurse and again he witnessed the teams working together to deliver safe and timely discharge plans. It is evident that the complexity of our patient discharges grows.

Finally on 1st August, Garry spent time with one of the Advanced Nurse Practitioners and he was again was impressed with her autonomous practice and the level of care given to our patients as a standard.

7 POLICY APPROVAL

The Chief Executive, on the advice of the Executive Team has approved the following policies since the Trust Board last sat:

- External Transfer Policy
- Management of Medical Devices Policy
- Radiation Safety Policy

Work is currently underway to implement a software solution for the management of the Trust's key policies. This will issue automatic reminder notices for policies due to need review and escalate situations where policies are not reviewed in a timely manner. It is anticipated that this solution will be in place by November 2018.

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
Acting CEO
30 August 2018

Care Quality Commission
151 Buckingham Palace Road
London
SW1W 9SZ
Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Paul Athey,
Chief Executive
Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
B31 2AP

Date: 29th August 2018

Dear Mr Athey,

Re: IR(ME)R inspection of The Royal Orthopaedic Hospital

You will know that CQC inspectors conducted a short-notice announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 [IR(ME)R17] of the radiology department at The Royal Orthopaedic Hospital NHSFT on 15th August 2018. Compliance was assessed against all aspects of IR(ME)R.

We carried out this inspection as part of a proactive IR(ME)R inspection programme of hospitals. We made it clear from the outset that we had concerns that the commission had received no notifications from the trust for over 4 years relating to exposures 'much greater than intended'. The inspection was carried out under the new IR(ME)R regulations which came into force in February 2018. We were clear from the beginning of the inspection that we would be making enquiries about compliance with the new requirements under IR(ME)R17. We understand that whilst there is an absence of up to date professional guidance surrounding some of the new requirements, we would expect any gaps to be identified and addressed as best as possible until such time further information is published.

How we inspected

Prior to the inspection we requested and received a copy of the trust IR(ME)R employer's procedures. During the inspection, we spent our time in discussion with the Head of Imaging, the Deputy COO, the trust's Medical Physics Expert (MPE) from UHB, and a Consultant Radiologist. We visited the department and collected both verbal and written evidence. We set out the programme for the day with yourself and many of your senior management team and we gave provisional feedback to you at the end of our inspection. We also requested and received further information later the same day.

An overview of our findings

During the inspection, we found the trust to be compliant with the main requirements of the new IR(ME)R regulations. We found there to be a clear understanding of the requirements of IR(ME)R with respect of justification and optimisation of individual patient exposures, good understanding of procedures and examination protocols by staff delivering care. Local radiology leadership was knowledgeable and responsive to our questioning. There was a clear vision of how it wanted to provide improved radiology services and had already involved senior managers to enlist their support for these plans. We heard too how it was amending governance structures to allow a broader discussion of radiation protection issues, not just 'by exception'. We also examined the arrangements

for reviewing those exposures which require notification to us and were largely satisfied that arrangements were in place to identify them and to report them to us if the criteria were met. We could not fully examine records of training activity for those within the department because of a long-term absence of a key member of staff. We felt that the trust should review how these could be more universally accessible. Examination protocols were in place as required. We also observed records demonstrating that plain radiology equipment was being tested by radiographers to standards set down by the trust's MPE. The employer's procedures were satisfactory, though we did point out some areas where they might be clarified to better reflect established clinical practice and to emphasise personal responsibilities of duty-holders under the regulations. This included a discussion on how feasible it might be to entitle radiographers to justify requests for 'plain film' imaging themselves using their own expertise and skills.

Good practice

We saw that the department had a governance structure in place which it was strengthening to ensure that radiation protection raised its profile and provided an opportunity to discuss issues more than simply by exception as well as to improve the involvement of the MPE. We observed good working relationships across all professions.

We heard how the trust had established, with its MPEs, an audit programme of patient dose estimation which had led to the establishment of local diagnostic reference levels for CT general x-ray, theatre and fluoroscopy examinations.

We heard how the trust provided training for its non-medical referrers to enable their patients to safely access radiology services. We heard that this included a visit to the radiology department to better understand what was required of them first-hand, a review of their practice, an allocated buddy and prior approval from their line manager.

Areas for improvements

Inspectors were of the view that in 2 areas could compliance be improved concerning the development of referral guidelines for its referrers, and with respect of training records which we could not fully access on the day.

Regulation	Actions Required
6(5)(a) Referral Guidelines	The trust will review its 'protocols' document with a view to considering it for amendment into a format consistent with referral guidelines and subsequent sharing with its referring clinicians and non-medical referrers within and GPs and others from outside the trust
17(4) Training	The trust should, at the next available opportunity, provide us with evidence and assurance that it maintains records of training to its IR(ME)R practitioners and operators consistent with IR(ME)R schedule 3, table 2, and consider developing an overarching matrix of training and entitlement to carry out specific tasks.

What happens next?

As we explained during our visit, individual IR(ME)R inspection reports are, at the present time, not published by the Commission on our website. However, the findings above may be included in an overall 'themed' summary report, aimed at the radiology community with a view to improving compliance with IR(ME)R, where it is not our intention to name specific providers.

Please note that it is likely that the contents of this letter would have to be disclosed in the event of relevant enquiries made under the Freedom of Information Act. It is important, therefore, that you review the accuracy of the contents of this letter, and contact us should you feel that a correction is required.

I would be grateful if you could acknowledge receipt of this letter by email (to the address below) and provide an action plan in relation to the 2 recommendations made above within 6 weeks of the date on this letter.

If you have any questions about this letter, please contact using the details below:

Telephone: 0207 448 9025
Email: IRMER@cqc.org.uk

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

Yours sincerely,

Cliff Double
IR(ME)R Inspector

cc.

Joanne Williams, Chief Operating Officer
Sandra Milward, Head of Imaging
Alan Davies, Consultant Radiologist
Simon Pitts, Inspector, Hospital Inspectorate, Birmingham, CQC

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Paediatric Transition update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Interim Chief Operating Officer**
AUTHOR:	**Rebecca Lloyd, Head of Strategy**
DATE OF MEETING:	**5 September 2018**

EXECUTIVE SUMMARY:

This paper provides an update on the transition of paediatric inpatient & day case surgery from The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) to Birmingham Women's & Children's NHS Foundation Trust (BWC), and includes:

- The background to the decision to cease provision of inpatient & day case paediatric surgery on the ROH site
- Details of the transition of the service
- The timeline for the transition
- The governance infrastructure supporting a safe & timely transition
- Key workstreams
- Risk

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	x	Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services

PREVIOUS CONSIDERATION:

The Trust Board has considered the plans as they developed as part of its private agenda over previous months.

ROHTB (09/18) 003 (a)

Paediatric Service Update – September 2018

1 Executive Summary

This paper provides an update on the transition of paediatric inpatient & day case surgery from The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) to Birmingham Women's & Children's NHS Foundation Trust (BWC), and includes:

- The background to the decision to cease provision of inpatient & day case paediatric surgery on the ROH site
- Details of the transition of the service
- The timeline for the transition
- The governance infrastructure supporting a safe & timely transition
- Key workstreams
- Risk

2 Background to decision to cease provision of service

2.1 External reviews

The Care Quality Commission (CQC) carried out an inspection of ROH in July 2015, and again in July 2016. The final reports for each inspection stipulated a number of areas of improvement, including requirement notices to improve paediatric nurse staffing levels and improved facilities for the care of paediatric patients on HDU.

The Royal College of Paediatrics and Child Health (RCPCH) undertook a review of the ROH paediatric service provision in April 2016, and a number of actions were taken to address concerns following this review, and the previous CQC reports:

- Paediatric expertise strengthened by appointing a Paediatric Matron and Associate Medical Director (2PAs) to oversee risk and governance
- Established a Service Level Agreement (SLA) between the ROH and Birmingham Women's and Children's Hospital (BWC). This SLA provided for:
- Increased paediatrician presence over five days per week, this being an increase from two days previously;
- Associate Medical Director cover (2PAs) from a paediatrician employed by the BWC;
- Access to training courses for staff groups to maintain paediatric clinical skills;
- Clinical supervision for our Paediatric Matron;

- 24/7 access to clinical advice from the Birmingham Women's & Children's (BWC) site management teams and on-call manager infrastructure;
- Access to the BWC nurse staffing bank.

During 2017, there was increased scrutiny of the Trust from external regulatory bodies. NHS England Specialised Commissioners commenced a review of paediatric orthopaedics, with particular focus upon the increasing number of patients waiting over 52 weeks for treatment. A Stakeholder Oversight Meeting was established with representation from NHS England, NHS Improvement, CQC, and local CCGs.

In June 2017, the Trust was inspected by the West Midlands Quality Review Service (WMQRS) to review the ROH's arrangements for the care of the critically ill and critically injured children. WMQRS outlined a set of risks to clinical safety or clinical outcomes identified by the inspection. Of major concern was the risk that related to paediatric medical cover, which calls into question the adequacy of the Trust's arrangements for caring for children on the High Dependency Unit (HDU), particularly out of hours. The narrative reports that the 'unit did not meet the expected standard for consultant cover for a Level 2 paediatric critical care unit and reviewers considered that it was not feasible for this standard to be achieved at the Royal Orthopaedic Hospital'.

The report also highlights that although not technically Level 3 care cases, some children treated by the Trust, should they have been treated elsewhere, may have been admitted to Level 3 facilities given the complexity of the care needed.

2.2 Trust Board decision

The decision taken by the Trust Board was to cease the provision of all paediatric surgery on the ROH site by December 2017. The Trust Board felt that, given the safety concerns raised, it could not endorse the medium-term continuation of a service which had no reasonable prospect of meeting the nationally expected guidelines. The key rationale for this decision was:

- Long term sustainability of paediatric service in standalone elective orthopaedic hospital. While services are safe, the Royal College guidelines outline that the most appropriate way to provide paediatric care in a large centralised care setting.
- As a relatively small, elective organisation, the Trust does not have the infrastructure in place to provide services to the same standard & levels as set out by the Royal College and in the advice provided by paediatric experts (i.e. 24-7 on site paediatrician medical cover).
- WMQRS raised a number of concerns about provision of paediatric care that could not be addressed on a long term and sustainable basis
- Ongoing challenges with paediatric nurse recruitment

Formal notice was provided to NHS England Specialised Commissioners on 14 July 2017.

3 Transition of service

3.1 Birmingham Women's & Children's

Following on from the Trust Board's decision to formally cease provision of paediatric surgery, BWC was identified by commissioners as the 'preferred provider' for activity transferring from ROH. The priority for all partners was to establish a 'Birmingham solution' for this service, maintaining the provision of high quality paediatric orthopaedic care for patients.

BWC have received support from commissioners to refurbish an existing theatre to allow for the transfer of operating lists from ROH to BWC, having recently transferred some operating activity to the new Waterfall House on the BCH site.

3.2 Scope

3.2.1 Patients

The transition of 'paediatric services' relates to children aged between 0-15 years old.

The decision has been made to retain patients aged 16+ at the ROH. It has been agreed in discussions with senior medical and nursing teams that patients aged 16 and above would be treated as adults, and that any patients with learning disabilities would be treated on a case by case basis in the same manner as any patient with specialist additional needs.

3.2.2 Services

At present, NHS England Specialised Commissioning transition arrangements do not include the immediate transfer of outpatient activity. An options appraisal is being developed to determine the future delivery of outpatient & diagnostic services for this patient cohort, and this will be completed by the end of December 2018.

No inpatient or day case surgery for under 16s will take place on the ROH site from 1st February 2019.

The Oncology service for under 16s is intended to be delivered in its entirety on the BCH site, however there will be a transition period whilst the diagnostic pathway is developed & agreed.

3.3.3 Staff

There will be 24 staff who are impacted by the service move to BWC, and they will transfer under TUPE on 1st February 2019.

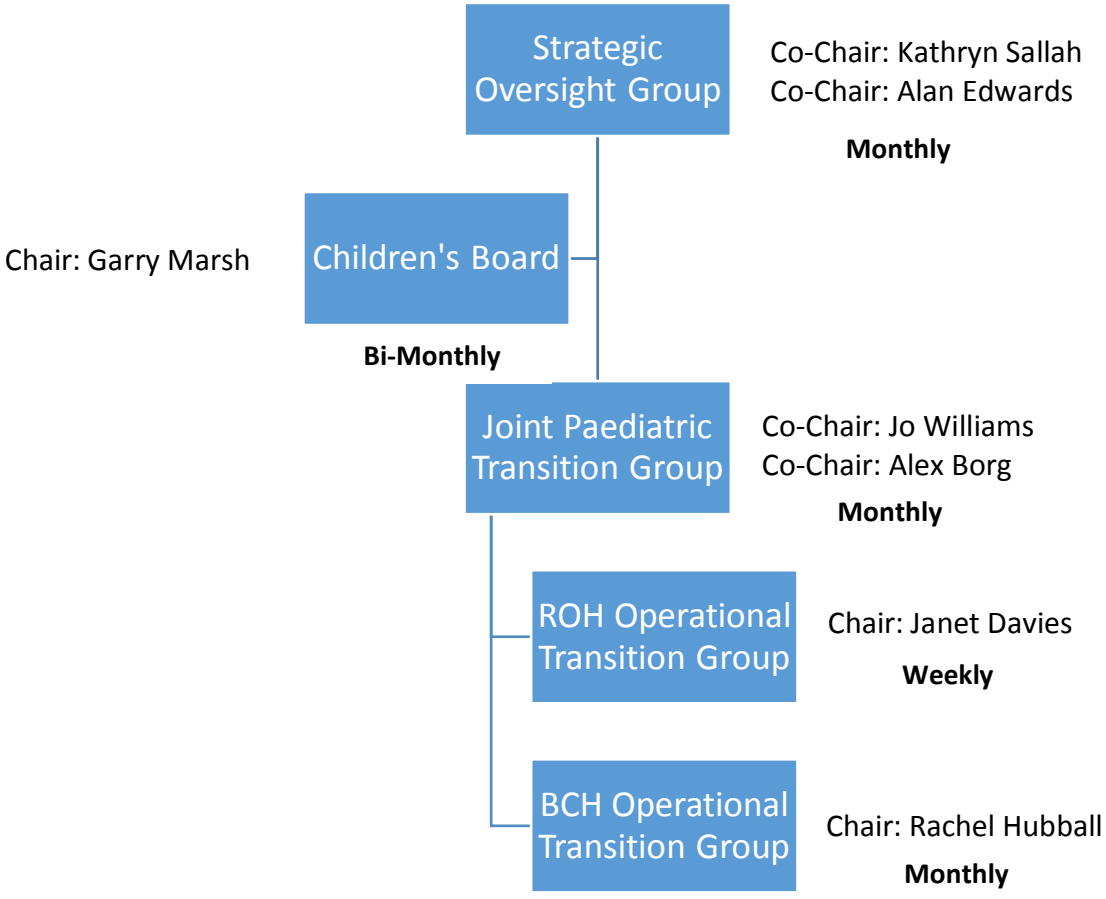
4 Timeline for service transfer to BWC

The service will transfer by 31 January 2019. The critical path to ensure that this date is met is summarised below:

- Waterfall House opening - August 2018 **(COMPLETE)**
- Post-transition clinical pathways signed off – September 2018
- HR Information transfer – September 2018
- Job plans signed off – October 2018
- Contract model agreed in principle – November 2018
- Contract model sign off – December 2018
- Additional nursing / theatre / admin staff recruited – December 2018
- Outpatient model options developed – December 2018
- Theatre 8 work complete – January 2019
- Ward 15 work complete – January 2019
- Ward 5 work complete – January 2019
- Service & staff transfer – 1 February 2019

5 Governance

There is a strong governance structure to oversee the process of transferring the paediatric inpatient & day case surgery service:



6 Workstreams

There are six key workstreams:

6.1 Clinical

Lead: Bruce Morland (Associate Medical Director – Paediatrics)	
Priority	**Timeframe**
Confirm current clinical pathways by sub-specialty	June – August 2018
Confirm future clinical pathways by sub-speciality	August – September 2018
Sign off by relevant ROH/BWC group/Board	October 2018

6.2 Operational

Lead: Janet Davies (Clinical Service Manager ROH) & Liz Meredith (Associate Director of Operations)	
Priority	**Timeframe**
Theatre scheduling	September – October 2018
Administrative & pre-assessment pathways	August – October 2018
Job planning	September – October 2018

6.3 HR & Workforce

Lead: Surinder Kaur (Deputy Director of Workforce BWC)	
Priority	**Timeframe**
Support staff visits to BWC	August – December 2018
Workforce model agreed	August – September 2018
HR information transfer	September 2018

6.4 Communications & Engagement

Lead: Amos Mallard (Communications Manager ROH) & Sam Kendall (Interim Head of Communications)	
Priority	**Timeframe**
Plan, communicate and deliver patient and families engagement event	September 2018
Briefing to key stakeholders	September 2018
Co-develop engagement materials with patients	September – December 2018
Weekly communications to all staff	Ongoing

We are working with one of our long-standing patients, Kieran Mills, who is leading a campaign ('Children's Orthopaedics Services Transfer (COST) Campaign'), to improve the patient & family engagement in the transition, and information available to all stakeholders. There has been media coverage of the COST campaign with ITV Central which included a recording of an interview with Paul Athey Acting CEO with Kieran and his mother.

6.5 Governance & Risk

Lead: Janette Carveth (Information Governance Manager) & Brian Healy (Head of Risk)	
Priority	**Timeframe**
Scope IT/image sharing requirements for split site working	August – November 2018
Agree process for transfer of information	December 2018

6.6 Finance & Contracting

Lead: Alexandra Gilder (Deputy Director of Finance ROH) & Mishaal Gohil (Deputy Commercial Finance Manager)	
Priority	**Timeframe**
Contracting model agreed in principle	September – November 2018
Agree ROH/BWC Service Level agreements	December 2018
Agree contract with commissioners	December 2018

7 Risks

ROH & BWC have developed a joint risk register to record, assess & monitor the risks associated with this complex service transition. Those risks deemed more significant are reflected in the ROH Board Assurance Framework, and are being actively managed through the oversight/operational groups outlined in section 5.

8 Priorities for September 2018

Throughout September there will be a key focus on:

- continuing to provide support to those staff impacted by the transition of services
- signing off clinical pathways
- agreeing theatre schedules at BCH
- reviewing consultant job plans
- engaging with patients, families & stakeholders and improving communications about the service transition

9 Recommendations

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

Author:

Rebecca Lloyd, Head of Strategy
30 August 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Progress against the Trust's 5 Year Strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Philip Begg – Executive Director of Strategy & Delivery**
AUTHOR:	**Rebecca Lloyd – Head of Strategy**
DATE OF MEETING:	**5 September 2018**

EXECUTIVE SUMMARY:

Following the review of the Trust's 5 Year Vision & Strategy, it was agreed that a set of metrics and KPIs be developed and that the Board would receive an update throughout the year.

The attached paper shows progress as at Quarter 2 of 2018-19 against the 9 Strategic Goals set out in the strategy.

There are clear areas of good progress, and areas for further development. However, the dashboard does provide the Board with some assurance that there is a forward movement within the organisation against the 9 Key Goals.

REPORT RECOMMENDATION:

The Trust Board is asked to receive the update and note the progress to date.

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		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:

Aligned to Trust's five year vision & strategy, with key performance metrics included.

PREVIOUS CONSIDERATION:

Update to Trust Board in April 2018

	Performing well & on track
	Progress made with more to do
	Behind plan

ROH Five Year Vision 2018/19 – 2022/23

Tracking progress against our nine strategic goals

The table below provides detail on the Trust's progress against the set of metrics that were developed in line with our nine strategic goals:

1. **Deliver world leading outcomes**
2. **Develop & enhance specialist skills & services**
3. **Become an Orthopaedic Centre of Excellence**
4. **Grow for the future**
5. **Embed productive & effective processes**
6. **Modernise our technology**
7. **Leaders in innovation, teaching, research & development**
8. **Create a continuous improvement culture**
9. **Proactively support our workforce**

The metrics set out from page 3 onwards are focused upon predominantly performance-related, quantitative measures that will evidence improvement from 2018-2023.

There are 3 strategic goals that do not have a dedicated metric assigned to them. A narrative update for each of these is provided below:

Modernising Our Technology – Q2 update

- Launched new electronic prescribing system 'PICS' (July 2018)
- Processing all of our referrals through the new Electronic Referral System (ERS)
- New RISP system is giving access to historic images across local Trusts
- Better patient care through the analysis of Outcome measures
- Better analysis of the quality and effectiveness of care through Data Warehouse development
- Greater use of mobile devices to support real time patient care
- Much improved network infrastructure supporting mobility

	Performing well & on track
	Progress made with more to do
	Behind plan

Leaders in Innovation, Teaching, Research & Development – Q2 update

- Proposal for becoming 'Aston Ready' developed and actions underway
- Regenerative Medicine Laboratory build underway and Project Team established with clinical engagement
- STP bid submitted for capital funds to support a refurbishment of the Knowledge Hub
- Apprenticeships strategy signed off and 60% of the current levy has been allocated to staff
- Working with Robert Jones & Agnes Hunt & Staffordshire University to develop a new Orthopaedic Nursing module
- Six Birmingham Orthopaedic Trainee Programme Registrars qualified in July 2018
- R&D launched a new Physio trial to track patients against normal treatments & research physio to improve quality of research physio provision
- New research database embedded in the team
- R&D team attended Bone Cancer Research Trust (BCRT) conference with Professor Jeys and received incredibly positive feedback on their work carried out to date

Continuous Improvement Culture – Q2 update

- Perfecting Pathways Steering Group meets monthly to receive updates from Large Scale Change projects, with project leads attending the meeting to share progress & future ideas
- Two members of staff have completed the NHS Improvement Quality Service Improvement Redesign Practitioner Course and will be delivering a programme of training to staff later this year
- Two members of staff are half way through the Flow Academy course and will be delivering a programme of training on completion (in conjunction with UHB)
- The first cohort of Solution Based Coaching is underway, with twelve members of staff undertaking six tailored sessions of training
- Continuous Improvement branding has been developed and a Communications & Engagement strategy will be launched in September 2018, with a regular update in Team Brief. The key focus of this strategy is sharing success through regular bulletins & updates to staff about individual and team achievements
- Poster competition planned for October 2018 to link with NHS Change Day, celebrating team improvements & sharing success
- Speak Up & Join In campaign encouraging staff to identify where change needs to happen & feel empowered to take action

	Performing well & on track
	Progress made with more to do
	Behind plan

Performance against five year strategic goals (Quarter 2, 2018-19)

Measuring our strategic goals	How we demonstrate success/by when	2018-19 Quarter 2 update	Progress rating (2017-18)	Progress rating (Q2)	Future priorities
World Leading Outcomes	We will continue to be in the top 10% for positive PROMS **ANNUAL TARGET**	• Provisional PROMS data for 2016-17 demonstrates ROH is 'not an outlier' for any Hip scores (Total Hip Replacement / Primary / Revision), and is scoring in the top 5% for Total Knee Replacements ('not an outlier' for Primary & Revision Knees) • Pilot to take place for Spinal patients undergoing a discectomy as a day case using Rapid Recovery methodology • JointCare project established to deliver improved outcomes & patient experience • Orthopaedic Provider Alliance model is being developed to streamline elective orthopaedic activity on to the ROH & Solihull sites, and for pathways to be standardised and patient outcomes improved			<u>2018-19</u> • Expansion of Rapid Recovery (reduced length of stay, zero readmissions, positive patient experience) • Develop full proposal for Orthopaedic Provider Alliance including finance & contracting model • Analyse & publish outcomes from JointCare programme implementation • Further focus on use of clinical outcomes data to inform individual practice • Work towards publishing clinical outcomes data online
Growing for the Future **Becoming an Orthopaedic**	We will treat enough patients each year to reach our 50% growth target by 2022 **10% GROWTH EACH YR**	• YTD activity is as follows: ○ Inpatient activity is 286 behind plan ○ Day case activity is 9 ahead of plan ○ Outpatients is 72 ahead of plan • 4 x additional modular theatres have			<u>2018-19</u> • Robust project management of theatres modular build • Launch of JointCare in November 2018 • Treating additional patients from elective backlog at HGS

	Performing well & on track
	Progress made with more to do
	Behind plan

Measuring our strategic goals	How we demonstrate success/by when	2018-19 Quarter 2 update	Progress rating (2017-18)	Progress rating (Q2)	Future priorities
Centre of Excellence		been approved by the Trust Board – 2 will be in place by May 2019, and the remaining 2 by May 2020			• Supporting STP partners through Winter 2018 • Improved access to Pre-Assessment
	92% target achieved in all sub-specialties **ANNUAL TARGET**	• July 2018 position: 85.25% compliance (Trust), with 92% compliance achieved in Oncology & Clinical Support • Number of 52 week waiters has reduced to 37 (against a trajectory of 50 for August 2018) • Paediatrics are 13 patients short of the 92% compliance target • Arthroplasty are 18 patients short of the 92% compliance target • Foot & Ankle are 22 patients short of the 92% compliance target • On track to achieve 92% compliance by November 2018 (excluding Spinal Deformity)			<u>2018-19</u> • Prioritise patients waiting 52weeks+ • Additional 2-3 specialties consistently meeting 92% target
Increased productivity & efficiency	A 20% increase in cases per theatre session (case mix adjusted) **4% GROWTH EACH YR**	• Theatre list utilisation is on upward trajectory (target is 95%) May 2018 saw an exceptionally high utilisation of 96%. June 2018 was 90.42%. • In-session utilisation has seen improvement over past 3 months, meeting target of 85% or above			<u>2018-19</u> • More robust clinically led 72 hour call process • Theatre recruitment • Annual planning
	A 30% reduction in overall average	• The Trust's average length of stay for June 2018 was 4.3 days (against 4.95			<u>2018-19</u> • JointCare launch (soft launch

	Performing well & on track
	Progress made with more to do
	Behind plan

Measuring our strategic goals	How we demonstrate success/by when	2018-19 Quarter 2 update	Progress rating (2017-18)	Progress rating (Q2)	Future priorities
	length of stay (case mix adjusted) **6% REDUCTION EACH YR**	day average for last 12 months) • JointCare launch in November 2018. Business case predicated on reducing length of stay by 0.5 days for hip & knee patients in first 12 months • Internal stretch target set by JointCare Project Team is to reduce further than this, with expectation of 1 night stay for majority of hip & knee patients			November, hard launch December) • Rapid Recovery rollout (pilot in Spinal) • Passport to Home embedded
Specialist Skills & Services	Positive 'Friends & Family Test' scores in the top 10% **ANNUAL TARGET**	• ROH in top 20 Foundation Trusts in the country for positive patient experience (CQC survey June 2018) • ROH met national target of 35% response rate for June & July 2018 • July'18 FFT results – 96.3% positive and only 1% unlikely to recommend			2018-19 • Continue to increase completion rates • Develop Patient Experience Strategy
Proactively supporting our workforce	Improvement in staff survey responses **ANNUAL TARGET**	• 2017 survey shows that staff feel more engaged than in 2016 (against national trend) • 14 of 30 key findings improved, 9 remained constant and 7 decreased • Fewer staff completed the survey in 2017 than 2016			2018-19 • Deliver against staff survey action plan • Speak Up & Join In campaign • Increase completion
	Exceptional staff experience	• Q1 Friends & Family Test – increase from 57% TO 81% of staff feel ROH is a great place to work • Staff Wellbeing Task & Finish Group			2018-19 • February 2019 Annual Staff Awards • Implement 'instant

	Performing well & on track
	Progress made with more to do
	Behind plan

Measuring our strategic goals	How we demonstrate success/by when	2018-19 Quarter 2 update	Progress rating (2017-18)	Progress rating (Q2)	Future priorities
		established in Q1 in response to Staff Survey results to reduce work pressure on staff • Briefings held with teams across the Trust to support workforce models adapting to integrate apprenticeship opportunities • Schwartz Rounds embedded for 12 months • 'Speak up & Join In' campaign launched, and 'even better if…' sessions started • Equality & Diversity Forum established			recognition scheme' • Career pathways developed for staff
Growing for the future	Breakeven by **2019/20.** Surplus by **2021/22**	• YTD – Trust is currently £1.9m in deficit (£300k ahead of plan) • Private Patient income YTD = £537,000 (Month 4) against 2018-19 target of £845,000 • Additional income streams identified through GP out of hours clinics, additional theatre capacity & MSK growth			2018-19 • Private patient activity growth through MAKO • Options for increasing access to theatres (e.g. Modular build) • Investigating options for reducing & controlling spend
Orthopaedic Centre of Excellence	Rated 'Outstanding' by the CQC. NHSI will class us as 'Segment 1' in Single Oversight Framework	• CQC inspection took place in January 2018 and Well-Led inspection in February/March 2018. Final report published in April 2018 and ROH rated as 'Good' by the CQC • CQC IR(ME)R inspection took place in			2018-19 • Deliver actions in our CQC Improvement Plan • Achieving RTT trajectory by November 2018 • Working within system to

	Performing well & on track
	Progress made with more to do
	Behind plan

Measuring our strategic goals	How we demonstrate success/by when	2018-19 Quarter 2 update	Progress rating (2017-18)	Progress rating (Q2)	Future priorities
	RATED 'GOOD'/ SEGMENT 2 BY 2019 AND 'OUTSTANDING' / SEGMENT 1 BY 2022	Imaging department in August 2018 with initial positive feedback • Currently classed as Segment 3 in Single Oversight Framework due to financial sustainability • NHS Improvement have removed the Trust's breach of licence conditions relating to delivery, governance & data quality (RTT performance)			develop future model of sustainability

ROHTB (9/18) 005

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

August 2018

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 the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

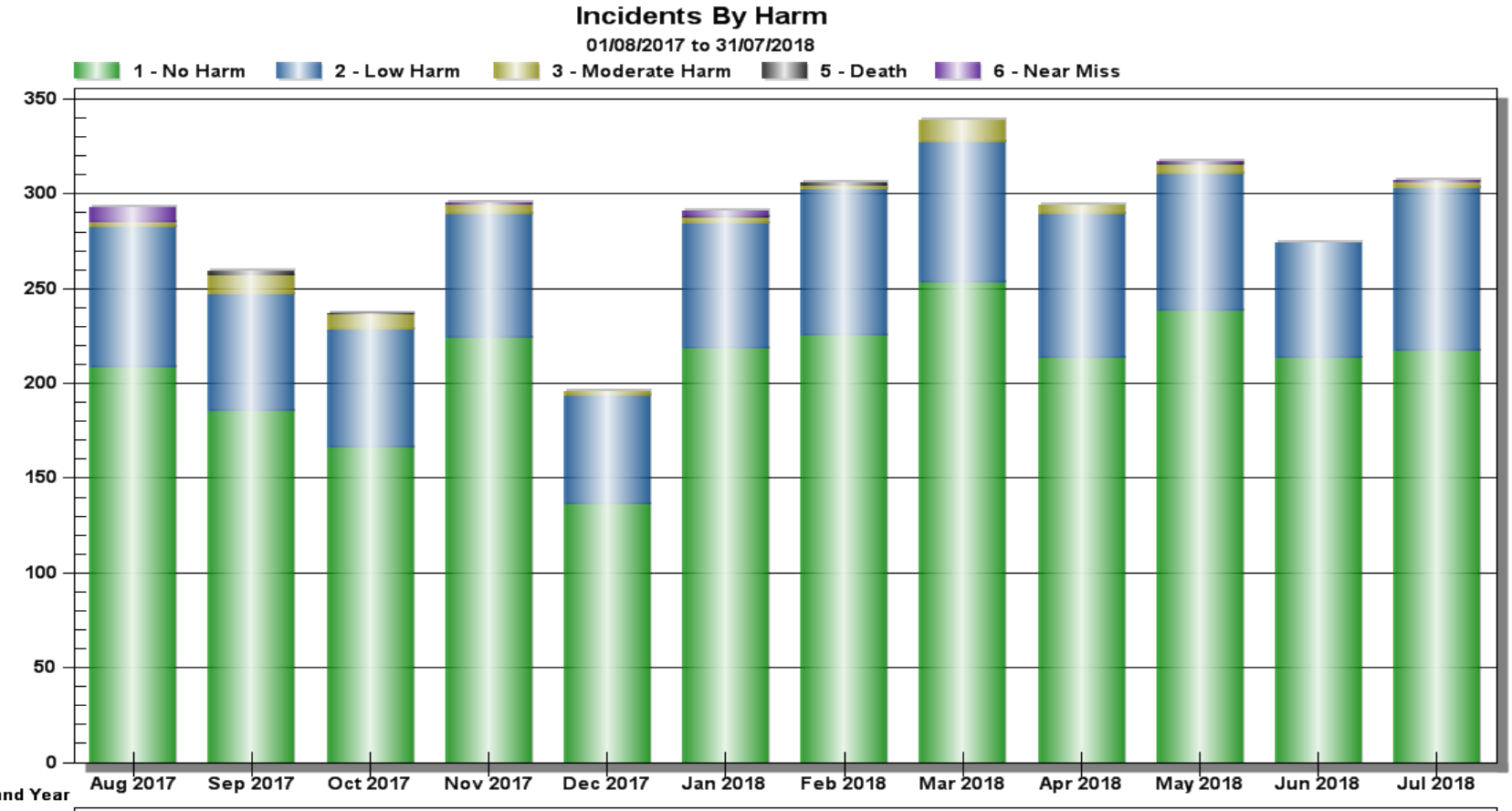
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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)

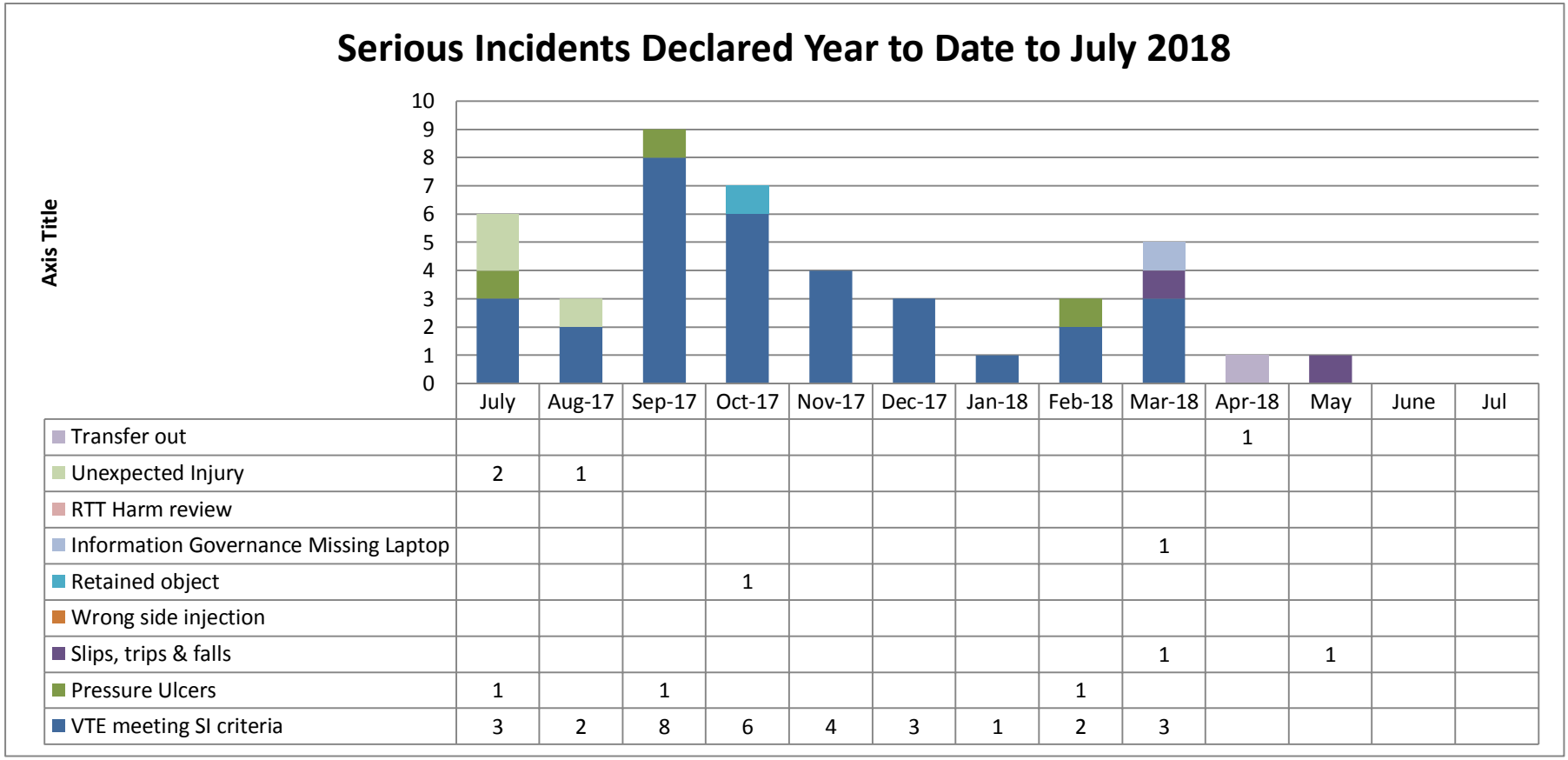
2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



Month and Year	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018
1 - No Harm	208	185	166	224	136	218	225	253	213	238	213	217
2 - Low Harm	74	62	62	65	57	66	77	74	76	72	61	86
3 - Moderate Harm	3	10	8	5	3	3	2	12	5	5	0	3
5 - Death	0	2	1	0	0	1	2	0	0	1	0	0
6 - Near Miss	8	0	0	1	0	3	0	0	0	1	0	1

INFORMATION
In July 2018, there were a total of 307 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows; 217 – No Harm 86 – Low Harm 3 - Moderate Harm 0 – Severe Harm 1 – Near Miss 0 – Death In July 2018, there were a total of 9229 patient contacts. There were 307 incidents reported which is 3.3 percent of the total patient contacts resulting in an incident. Of those 307 reported incidents, 89 incidents resulted in harm which is 0.96 percent of the total patient contact.
ACTIONS FOR IMPROVEMENTS / LEARNING
The Governance team have a number of improvements planned; • New incident management policy and a new process for round tables on the agenda for Clinical Quality Group The CCG have now closed Incident 23631 (An unencrypted laptop containing patient identifiable went missing or was stolen) – The Information Commissioners Office (ICO) deemed it unnecessary to take further action, as they were assured by the actions taken by the Trust. The outcome of the RCA will be included in next month's quality report.
RISKS / ISSUES
A Risk has been added to the risk register due to the staffing levels within the Governance team. The Governance team currently have 2 X WTE vacancies. As a result of the vacancy position, the Ulysses improvement plan is making slow progress. The potential Governance Facilitator has withdrawn from the recruiting process. The advert will be on NHS jobs week commencing 16th July 2018

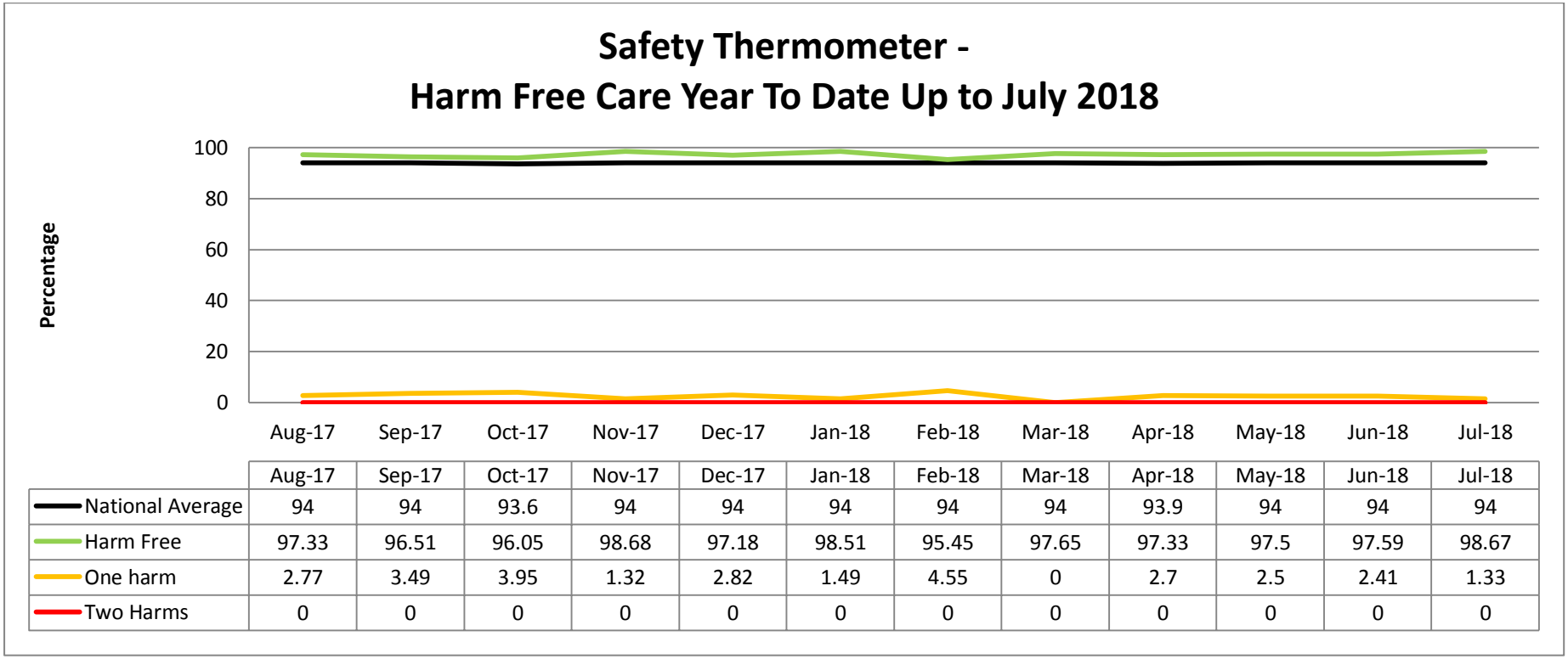
3. Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a Serious Incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.



	July	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May	June	Jul
Transfer out										1			
Unexpected Injury	2	1											
RTT Harm review													
Information Governance Missing Laptop									1				
Retained object				1									
Wrong side injection													
Slips, trips & falls									1		1		
Pressure Ulcers	1		1					1					
VTE meeting SI criteria	3	2	8	6	4	3	1	2	3				

INFORMATION
No Serious Incidents were Declared in July 2018; The Trust currently has a total of 1 open Serious incident. The Trust now only report avoidable VTEs on STIES, this is the reason for the reduction of Serious Incidents reported. There remains confidence that should a Serious Incident require reporting then the systems and processes in place within the organisation would ensure that this would happen.
ACTIONS FOR IMPROVEMENTS / LEARNING
1 Serious Incident was closed in July 2018 – This was an inpatient fall
RISKS / ISSUES
None

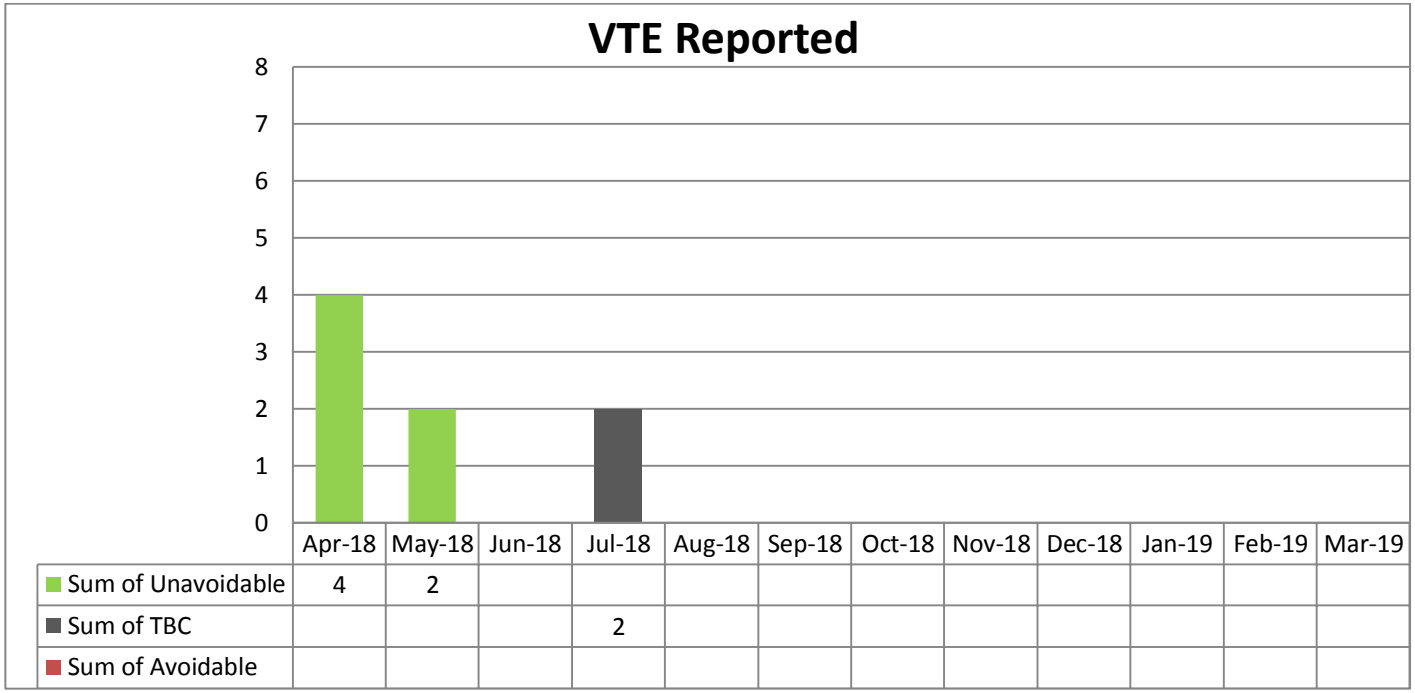
4. **NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
National Average	94	94	93.6	94	94	94	94	94	93.9	94	94	94
Harm Free	97.33	96.51	96.05	98.68	97.18	98.51	95.45	97.65	97.33	97.5	97.59	98.67
One harm	2.77	3.49	3.95	1.32	2.82	1.49	4.55	0	2.7	2.5	2.41	1.33
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The harms recorded in July 2018 was on Ward 1 - Old Pressure Ulcer.

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 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).**



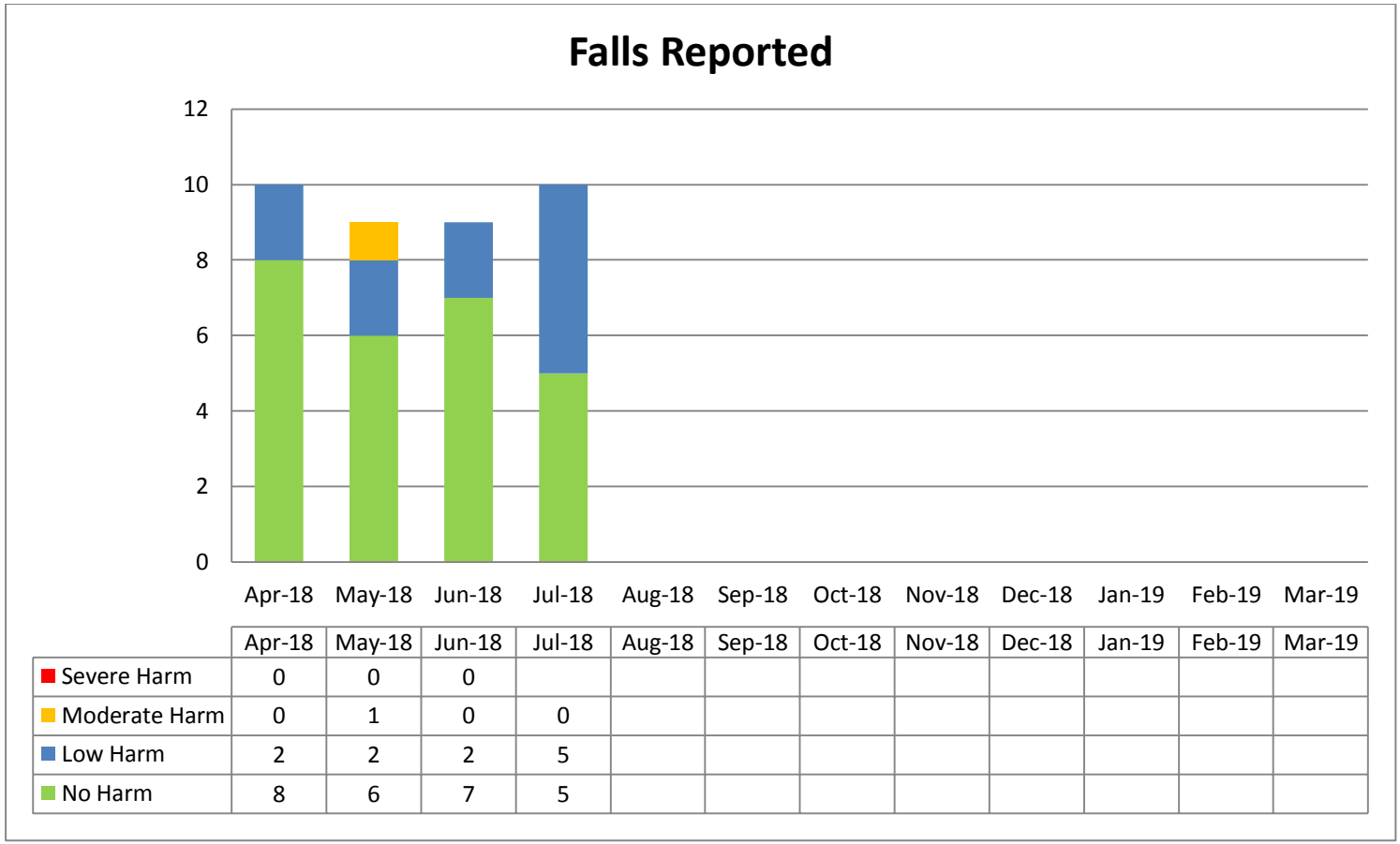
9

total		Avoidable
17/18	33	10
18/19	8	0*

***not classified**

INFORMATION
There were x 2 VTE's reported in July 2018; this compares to x 2 reported in July 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement 95%): This has been consistently exceeded since August 2013. Since 2015/16 this data is collected monthly by the Trust but only requires quarterly reporting. **Training.** VTE training continues for Student nurses, registered and non-registered staff (clinical update days) It is mandatory for clinical staff that has direct patient contact to complete a VTE e-learning module. Compliance with VTE e-learning completion has increased from 51% to 77% in month. Lead is working with L&D to continue increase compliance. Annual Rolling training programme on mechanical prophylaxis provided by company trainers has been agreed. **NICE Guidance** –Updated March 2018 Clinical Service Leads are currently reviewing relevant sections with their teams to enable a consensus agreement to be provided to the VTE Advisory group prior to any changes in local policy. It is noted that no member of the VTE Exemplar Site Network has implemented this new guidance as yet and there are some challenges to it. PICS has been launched trust wide for adults. VTE on admission and 24 hour risk assessment are mandatory fields which will lead to increased compliance with 24 hour re-assessment.
RISKS / ISSUES
Potential perceived risk regarding delay in introducing changes relating to updated NICE guidance- review and current actions by VTE Advisory Group are in line with all other Trusts with the VTE Exemplar Network.

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.**

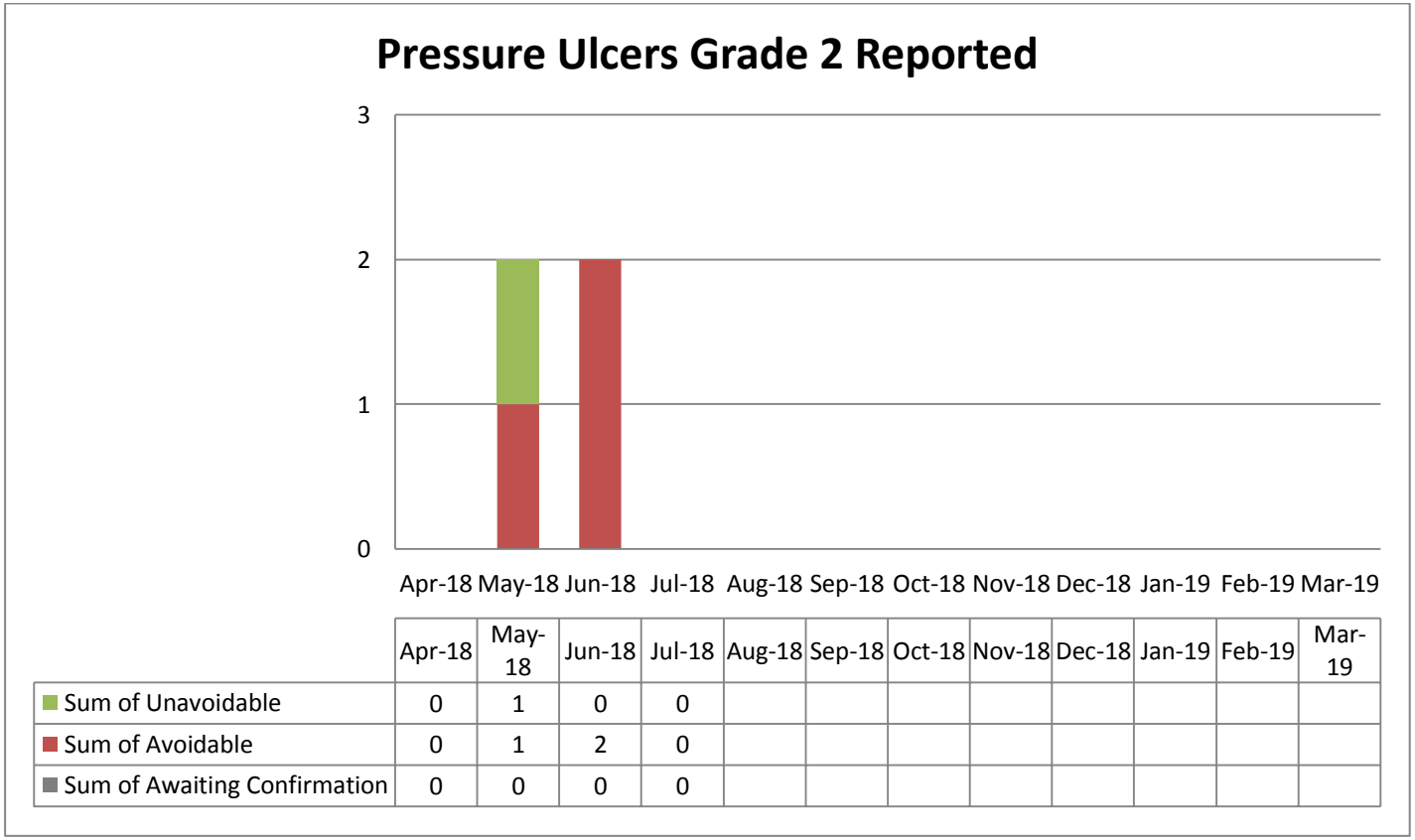


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Severe Harm	0	0	0									
Moderate Harm	0	1	0	0								
Low Harm	2	2	2	5								
No Harm	8	6	7	5								

total	
17/18	115
18/19	38

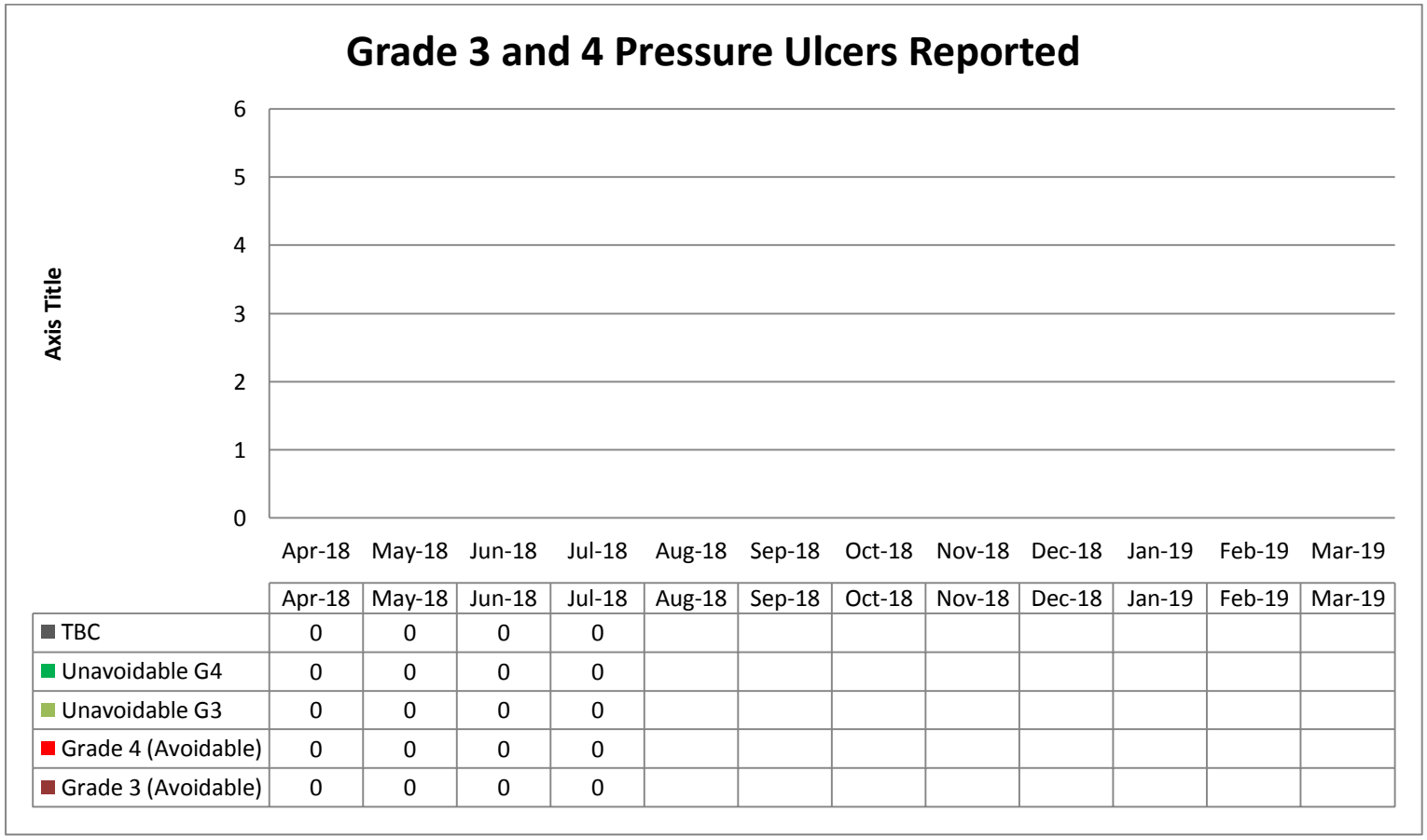
INFORMATION
Overall there were 10 fall-related incidents reported across the Trust in July 2018, all were related to adult inpatient falls. 10 Falls were graded either no or low harm. All falls are reviewed in the Trust's Falls group with an upward report to Clinical Quality group. All incidents have 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 and are also reported in the Monthly Quality Report. Across in-patient areas, we continue to utilise a collaborative, multi-disciplinary approach to falls risk assessment, care planning and falls prevention strategies.
ACTIONS FOR IMPROVEMENTS / LEARNING
In 2017/2018 there was a reduction in the reported number of falls (115) in comparison to the 144 falls incidents that occurred in 2016/2017. • Review against the WMQRS and shared with falls group members, feedback discussed at the fall's group meeting on 25/07/18 and is on the agenda for Clinical Quality Group in September 2018. The new policy and nursing documentation address the gaps found in the review. • Demonstration/ training for the use of Sara steady done by Arjo rep for inpatient areas, now also in the manual handling training • Falls lead looking into developing a falls intranet site • Revamp the falls training to include simulation, video scenarios and case studies. • The Trust is looking to organise a patient engagement event to gain further understanding of how patients fall and how the Trust can make further improvements to prevent falls.
RISKS / ISSUES
None

7. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" 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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	0	1	0	0								
Sum of Avoidable	0	1	2	0								
Sum of Awaiting Confirmation	0	0	0	0								

total	Avoidable
17/18	6
18/19	3



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
TBC	0	0	0	0								
Unavoidable G4	0	0	0	0								
Unavoidable G3	0	0	0	0								
Grade 4 (Avoidable)	0	0	0	0								
Grade 3 (Avoidable)	0	0	0	0								

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

14

INFORMATION
In July 2018, there were no pressure ulcers recorded. This compares to the one Grade 2 reported in July 2017. **July 2018- Incidents – Hospital acquired** Grade 4 =0 Grade 3= 0 Grade 2 Device related = 0 Grade 2 Non device related = 0 Grade 1 – 0 **Number of Patients admitted with PU's –July 2018** PU From Other Hospital - Grade 2 = 4 PU from Home – Grade 2 =3 Total = 7 grade 2 PU's **Avoidable Pressure Ulcer Targets** **2018/2019:** 3 - Avoidable Grade 2 pressure Ulcers limit of 12 0 - Avoidable Grade 3 pressure Ulcers limit of 0 0 - Avoidable Grade 4 pressure Ulcers limit of 0 **2017/2018:** 6 - Avoidable Grade 2 pressure Ulcers against a limit of 12

3 - Avoidable Grade 3 pressure Ulcers against a limit of 0

0 - Avoidable Grade 4 pressure Ulcers against a limit of 0

ACTIONS FOR IMPROVEMENTS / LEARNING

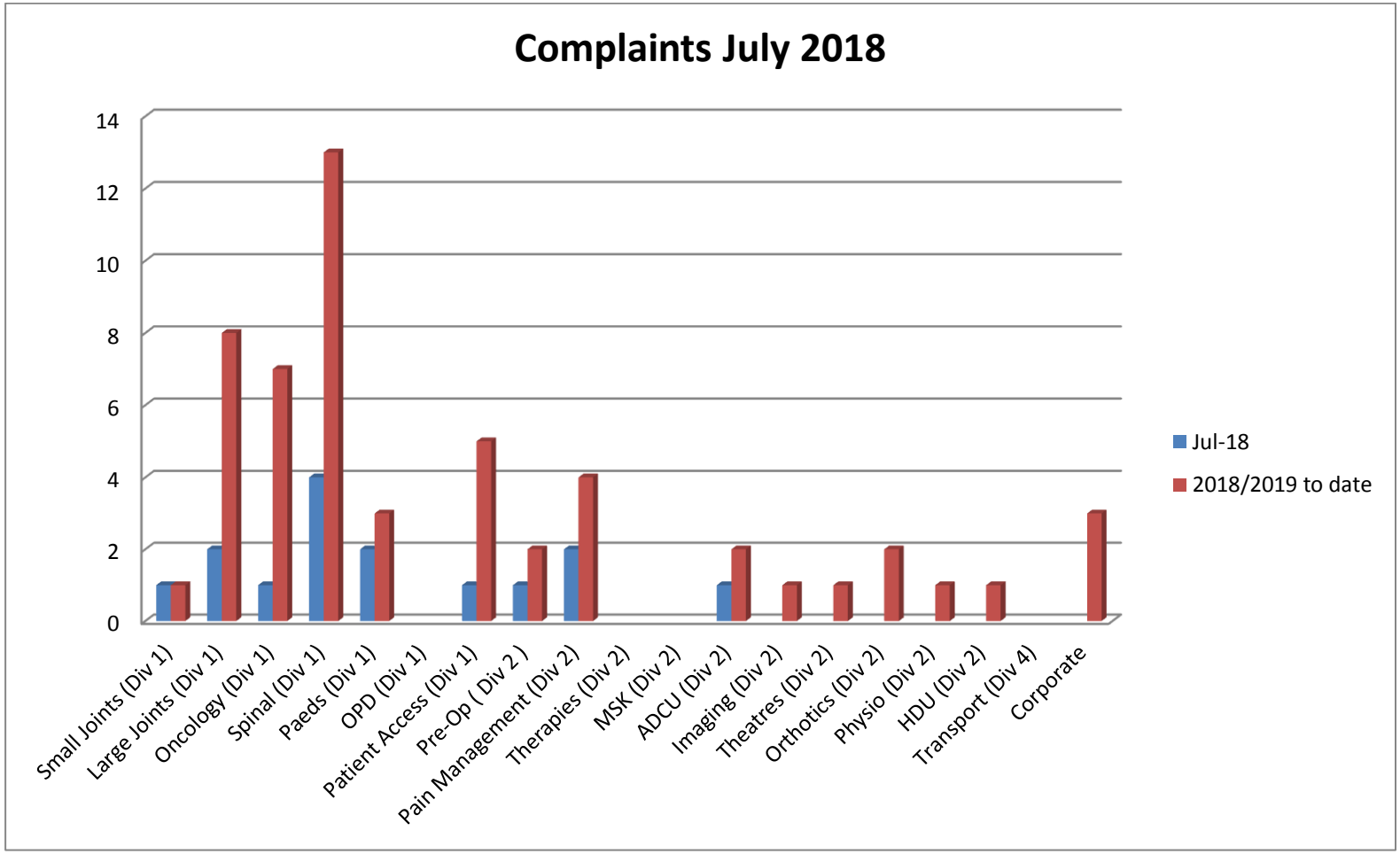
Current Actions

- A documentation task and finish group has developed more specific user-friendly documentation, which will act as prompts to care and highlight any gaps in order that action can be taken. TV documentation will enable a clear outcome of a skin assessment carried out in ACDU, Theatre Recovery, Admission to HDU or Ward and include a SKIN bundle encompassing a care and comfort type of repositioning chart
- The new MDT documentation went "live" for a trial period of 4 weeks. The Task and Finish group then made amendments due to feedback
- Training and education given emphasised the importance of checking skin regularly if patient at risk of PUs – reminder Waterlow is a guide and if patients are immobile despite a "low" score – they need repositioning and skin checking more frequently
- TV Resource folders have been made available on all ward/clinical areas
- A new patient leaflet has been developed to demonstrate what a pressure sore is for patients who want more information or have capacity and refusing to move
- TV Lead Nurse has carried out a Gap analysis related to the new NHSI recommendations: Pressure Ulcers Revised Definition and Measurement 2018. Deadlines are December 2018.
  - ROH is mainly compliant – Ulysses will need some definitions changing and some new ones added
  - The PU guidelines/Policy that is been amended at present will incorporate these changes
  - The CCG contract will be affected and may need to be renegotiated as other Trusts are doing
  - The changes will be introduced into all training and wider circulation to all staff when all changes are made

RISKS / ISSUES

The 1.0 wte Band 6 for TV left in early May. The TV Lead Nurse wte 0.8 is currently maintaining the service and prioritising clinical workload. A new band 6 has just been appointed and commences on 1/10/18, the TV team can then continue to develop the service.

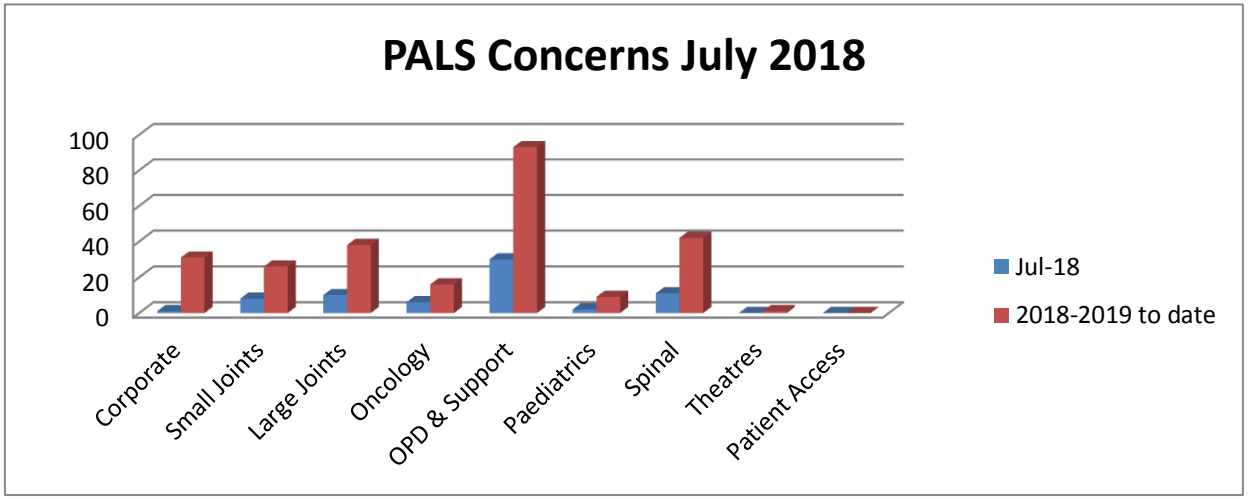
8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



INFORMATION

PALS

The PALS department handled 214 contacts during July 2018 of which 68 were classified as concerns. This is a significant reduction in calls compared to the same time last year (374 contacts in July 2017) and significantly fewer concerns (123 concerns in July 2017). The main themes in the PALS data relate to communication issues and appointment queries



Compliments

There were 544 compliments recorded in July 2018, with the most being recorded for Div. 1, although Div.2 are increasingly recording their compliments. The Public and Patient Services Team have started to log and record compliments expressed on the Friends and Family forms, which is the reason for the increase in numbers. The Pre-Operative Assessment Clinic continues 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 15 formal complaints made in July 2018. All were initially risk rated amber or yellow. This is an increase on the same time last year (12 complaints in July 2017).

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Canx of op due to no stryker bed (Div.1, Spinal)
- Regular medication not prescribed. Pt was suicidal (Div.1, Spinal)
- Potential missed diagnosis 5 years ago (Div.1, Spinal)
- Attended for appointment that had been cancelled (Div.1, Patient Access)
- Complications following surgery (Div.1, Spinal)
- Communication with patient and support for partner on ADCU (Div.2, ADCU)
- Management and diagnosis of chondrosarcoma (Div.1, Oncology)

Initially Risk Rated Yellow:

- Refusal of Trust to undertaken TKR yet due to BMI (Div.1, Large Joint)
- Complications following surgery in 2011 (Div.1, Paeds)
- Referral for pain management rejected op cancelled on the day (Div.2, Pain Management)
- Approach of pre-operative assessment nurse (Div.2, pre-op)
- Cancelled appts; outcome of surgery (Div.1, Small)
- Approach of nurse & OT on Ward (Div.1, Paeds)
- Approach of Consultant (Div.2, Pain Management)

- Outcome of surgery & given general anaesthetic against wishes (Div.1, Large Joint)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 16 complaints closed in July 2018, 14 of which were closed within the agreed timescales. This gives an 87.5% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in July 2018 was 29 days which is within normal limits.

Learning identified and actions taken as a result of complaints closed in July 2018 include:

- Patients arriving for biopsy are not aware that they may be waiting for a prolonged period of time
  Action: Biopsy Leaflets are being reviewed and amended.

- Storage for patient property in Theatre is not always adequate
  Action: Wider review of handling of patient property is being undertaken; process for property taken to theatre is being reviewed.

- Process for requesting copies of medical records is handled in two departments, with potential for confusion
  Action: Process is being reviewed.

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

1 comeback was received in July 2018. There have been 4 to date in the current financial year. Complainant disagrees with the response and has provided further information.

9. Friends and Family Test Results (collected in the iwantgreatcare system)

INFORMATION

The Friends and Family Test in its current format was implemented on 1st April 2014. The Department of Health changed the methodology of the Net Promoter Score to a more straightforward % of patients likely to recommend a service and % not likely to recommend a service. This was because evaluation showed that patients and most NHS employees did not understand the Net Promoter Score and the information provided was frequently misinterpreted.

The Friends and Family Test (FFT) is the mandated patient 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

NHS England have set a mandatory response rate of 35% for all inpatient services. There are no minimum response requirements for outpatient and community services. The Trust sets internal targets for all areas as it is agreed that the data will then be more meaningful.

There are no official requirements to undertake the FFT survey in imaging or theatre departments. However, the Trust takes the view that if feedback is provided in the same format across all departments, then the data is comparable and of use. In addition, there is an expectation that patient feedback is gathered in all areas, even if not mandated.

The Trust is continuing to perform well in comparison to other organisations in this survey and has developed a system to track themes and trends in the anonymous data collected alongside the FFT question. Departments are now beginning to take responsibility for providing feedback directly onto the iwantgreatcare system which is in the public domain. This will enable the Trust to further evidence its commitment to openness and exceptional Patient Experience at every step of the journey.

FFT CONCERNS

The team are now recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In July 2018, 14 concerns were identified from the 1969 individual pieces of feedback we received. As these are anonymous, it is not always possible to track these back to individual patients but they are shared with the relevant teams and managers as additional feedback. The top three areas of concern in July 2018 were values & behaviours (staff), communication and information provided. Information has been shared with departmental managers and the department is using the data collected from the beginning of the year in conjunction with other patient experience data to identify wider trends across departments and the Trust as a whole.

RISKS / ISSUES

The Trust met the mandated 35% response rate for inpatient services this month, but fell just short of the internal target. However, there was significant improvement in the areas of concern (Ward 11 and ADCU) and the actions being taken by the Ward Managers and Head of Nursing will continue. Ward 3, who originally had a very low return rate have now been invited to share their obviously successful changes with other areas.

Ward 11 have increased their response rates from 2% to 17.7% in the last two months, The Patient Experience team continue to work closely with Ward 11 to increase this further.

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would recommend the department in July 2018**	**% of people who would NOT recommend the department in July 2018**	**Number of Reviews submitted in July 2018 (previous month in brackets)**	**Number of Individuals who used the Department in July 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	93.8%	3.1%	65 (84)	122	53.3%
Ward 2	98.0%	0.0%	51 (58)	134	38.1%
Ward 3	95.7%	0.0%	47 (70)	67	70.1%
Ward 12	100.0%	2.9%	34 (30)	100	34.0%
Ward 11 (CYP)	76.5%	0.0%	17 (11)	96	17.7%
ADCU	98.0%	1.3%	151(92)	599	25.2%
HDU	96.6%	3.4%	29 (30)	85	34.1%
CYP HDU	100%	0.0%	3 (7)	12	25.0%
Overall Trust Inpatient Response Rate for July 2018					37.9%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in July 2018**	**% of people who would NOT recommend the department in July 2018**	**Number of Reviews submitted in July 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	96.9%	0.9%	1458 (942)	15.6%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in July 2018**	**% of people who would NOT recommend the department in July 2018**	**Number of Reviews submitted in July 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	96.5%	0.0%	57(73)	100.0%

In addition to the Friends and Family Test question, there are an additional 5 questions on the survey which relate to the following key elements of patient experience:

- Privacy & Dignity
- Cleanliness
- Kindness and Compassion
- Timely Information
- Being involved in the decision making process

These given an overall star rating out of 5 stars on the system, with 5 out of 5 being the highest available score.

I **Want Great Care –**

The Royal Orthopaedic Hospital NHS Foundation Trust

Date
01 July - 31 July

Your average score for all questions this period

★1 ★2 ★3 ★4 ★5 **4.86**

Reviews this period
1969

Your recommend scores

5 Star Score
4.81

% Likely to recommend
96.3%

% Unlikely to recommend
1.0%

10. Duty of Candour – *The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.*

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. Litigation

New Claims
1 new claim against the Trust was received in July 2018.

On-going claims
There are currently 30 on-going claims against the Trust.

29 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*
2 new requests for Pre-Application Disclosure of medical records were received in July 2018.

*Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes, the Data Protection Act 1998 and the Access to Health Records Act 1990).

12. Coroner's

There was 1 Coroner's Inquest held in July 2018

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 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 and 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 incompletion. The following areas examined; • form evident in notes • Sign in Section • Timeout section • Sign out section Total cases = 818 The total WHO compliance for July 2018 **= 100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
The WHO checklist for ADCU had is scheduled into Phase 2 on the Theatre man rollout. Contractually the Trust requested that the WHO checklist is created on Theatre man for Theatres and CT initially within phase 1. This was due to the paper version of the WHO in use being deemed satisfactory for ADCU's use during this period by the individuals on the project team.

14. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in July 2018 and Year to Date (YTD)	July Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72 hour Clostridium difficile infection (CDI)	0	1
Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

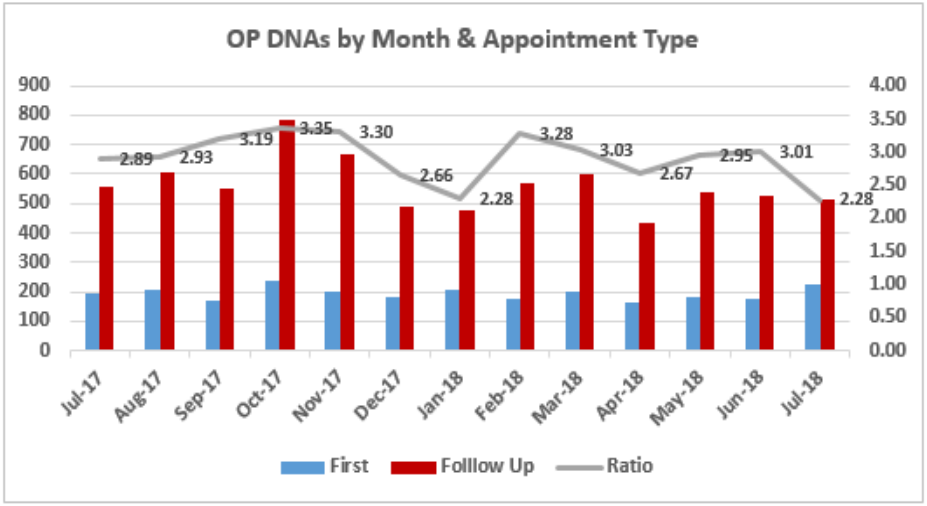
CDI case, identified 23rd July 2018 is presently under investigation. The affected patient is a 14year old with an oncology history – to date, no lapses in care have been identified.

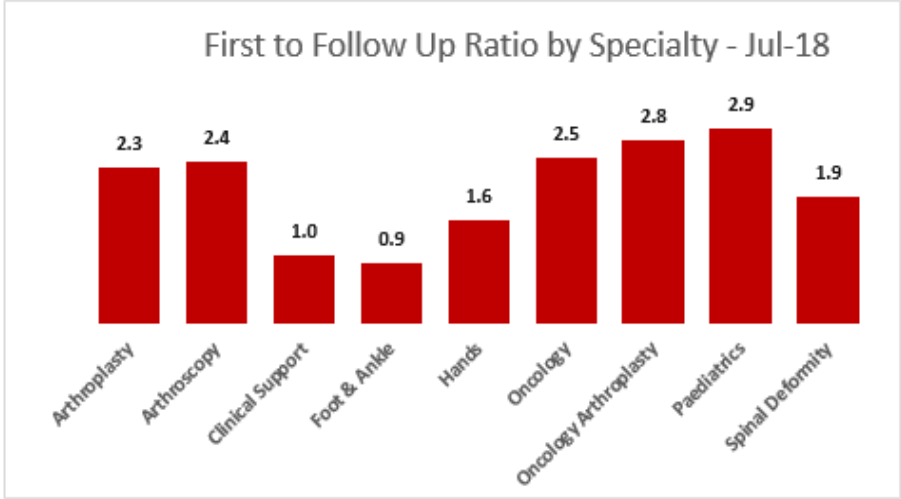
RISKS / ISSUES

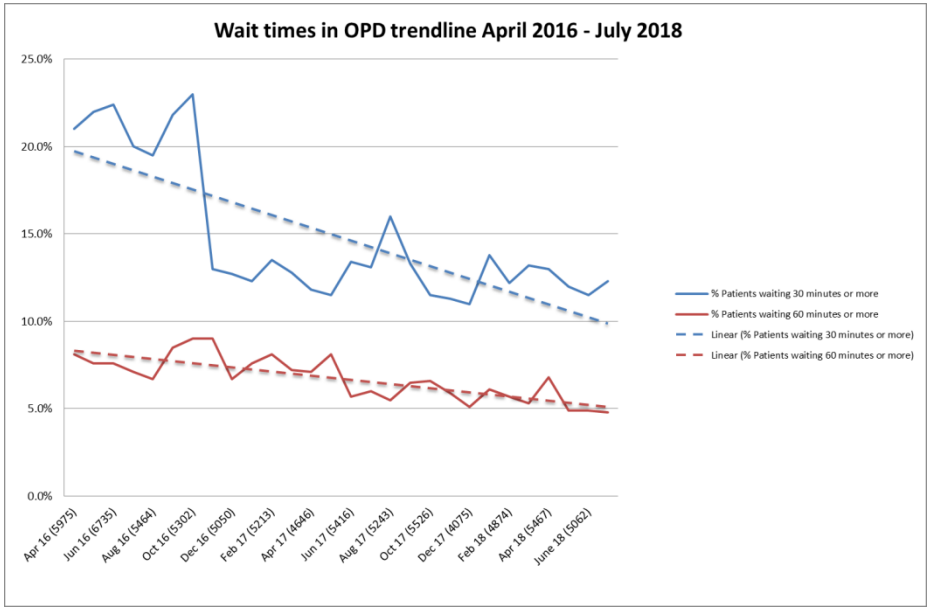
There are currently 9 IPC risks on the Risk Register, recorded from July 2017 (1 corporate, 4 divisional and 4 local). All risks continue to be monitored by the Head of Infection Prevention).

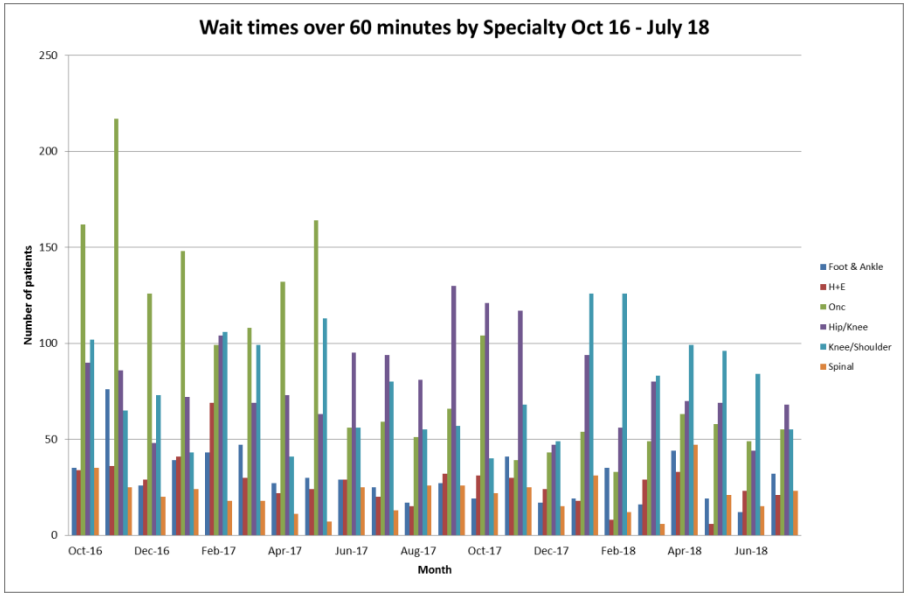
4 IP recorded incidents in July. 2 recorded as no harm (both SSI's) and 2 recorded as low harm (1-CPE affected patient admitted to ROH for surgery, 2- IV capped off without any documentation as to who or why) All cases remain under review

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









INFORMATION

In July 18 there were 10 incident forms completed to highlight clinics running more than 60 minutes late.

There were 12.3% of patients waiting over 30 minutes and 4.8% waiting over 1 hour which is below the target of 5%. This is now the second month that the target of 5% has been achieved. The over 30 minute waits has deteriorated slightly from the previous month from 11.5%. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month.

The monthly audit identified the following : -

- 5 - Clinic overbooked
- 4 - Complex patients
- 1 - Consultant/Clinician Delay

All incidents continue to be investigated by the relevant operational managers. An audit of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause. This data is shared with the Ops team at the weekly Operational Management Team meeting to review trends and effect appropriate improvement interventions .

There are 2 consultants who are outliers in relation to the clinic delays and the Outpatient manager is working with the Clinical Service Manager for large joints to review and amend the clinic templates of these consultants to reduce the delays in these clinics.

Full capacity modelling for outpatient clinics and inpatients across all specialties has been completed for the majority of specialties.

Additional funding is to be requested via a business case to increase the qualified and unqualified nursing establishment within both main and paediatric outpatients to support any required increase in capacity, although there continue to be challenges in recruitment for qualified and unqualified staff.

ACTIONS FOR IMPROVEMENTS / LEARNING
• Continue to drive incident investigations and action through relevant Operational Manager • Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays • Electronic clinic rescheduling form has rolled out and is in use in the majority of specialties which ensures there is an operational authorisation to any changes • Development of clinic utilisation tools through InTouch and Health Informatics • Work is being planned in CYPOPD (Children & Young People) to improve the reception environment which will allow InTouch to be used in real time and therefore provide data of clinic waits as currently this is not available
RISKS / ISSUES
Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. This will be addressed as part of the electronic clinic rescheduling form project InTouch upgrade has not yet begun due to limited IT and project management resources.

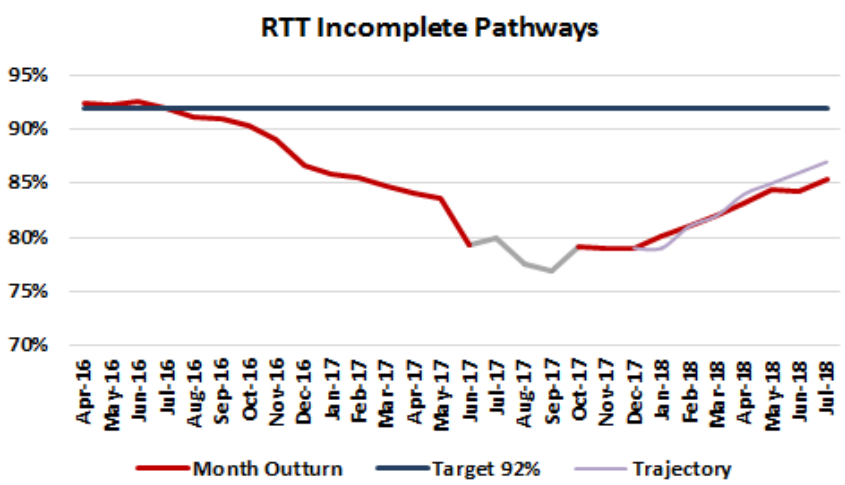
16. Treatment targets – This illustrates how the Trust is performing against national treatment target

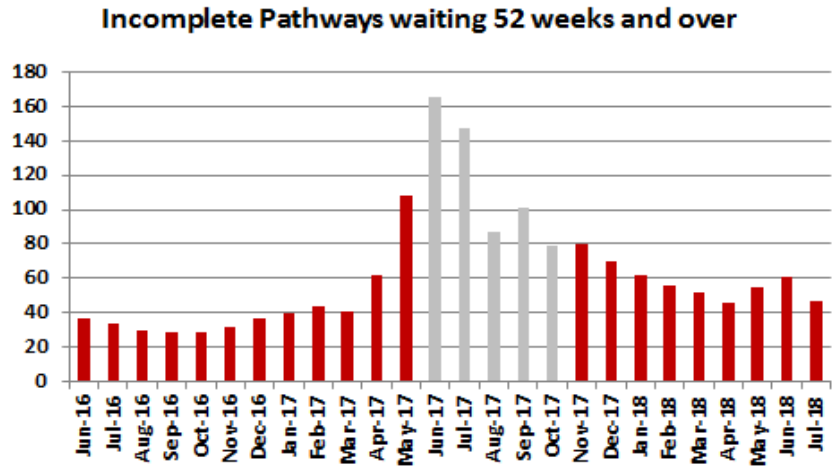
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%
Apr-18	1,022	148	409	1,579	850	253	387	1,490	8	1,571	1,579	99.5%
May-18	1,002	136	353	1,491	725	236	373	1,334	1	1,490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1,256	1,261	99.6%
Jul-18	732	112	336	1,180	961	211	290	1,462	8	1,172	1,180	99.3%

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





Target Name	National Standard	Indicative	Reported Month			Reported Quarter 2017/18			
		Jul-18	Jun-18	May-18	Apr-18	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 18 (Apr, May, June)
2ww	93%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	100%	100%	100%	90%	98%	100%	97%	100%
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%	81.8%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)		*	*	100%	100%	84%	82%	89%	100%
31 day rare (test, ac leuk, child)		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1	1	0	0				

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For July 2018 the RTT trajectory was 87% with performance at **85.44%** with 47patients over 52weeks (trajectory 55)

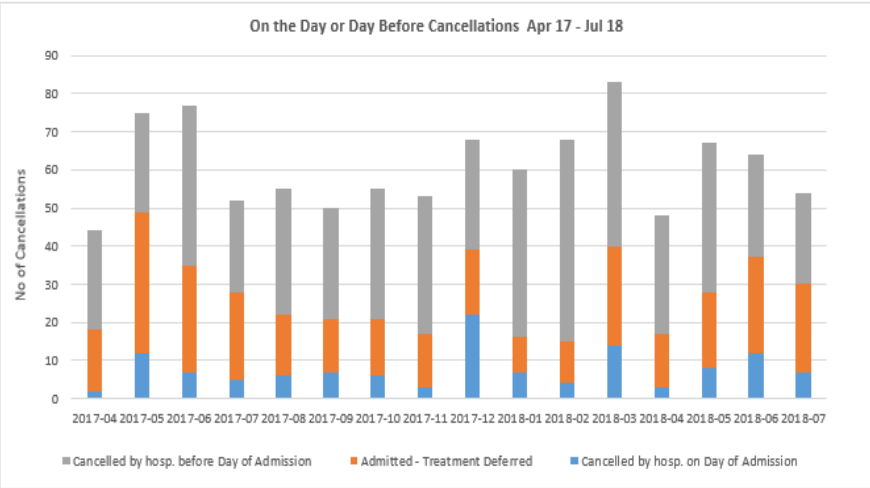
The Hands patient delay was patient choice and could have been treated under 52 weeks, they have been treated at the beginning of August 2018.

ACTIONS FOR IMPROVEMENTS / LEARNING

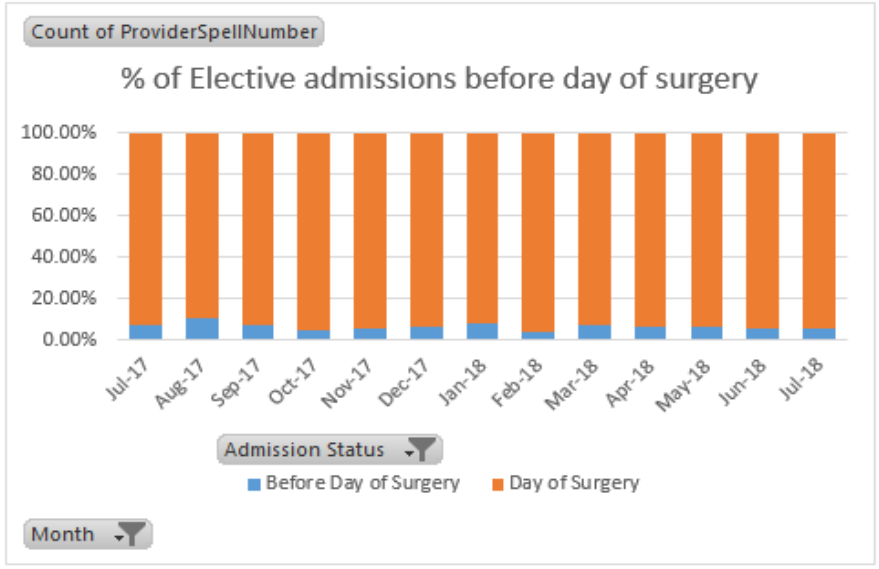
The team continue to concentrate on any patients over 40 weeks, with the exception of Spinal Deformity this figure is now 16. Whilst the trajectory was missed for July 18 performance has improved and we continue to see an improvement in the number of patients waiting over 26 weeks. At the end of December 2017 we had 926 patients over 26 weeks, this figure has now reduce to 522 in June to 390 in July. Throughout August 18 the team continue to work through a targeted list of patients who are listed with consultants with the longest waits. Good progress continues to be made by all the teams.

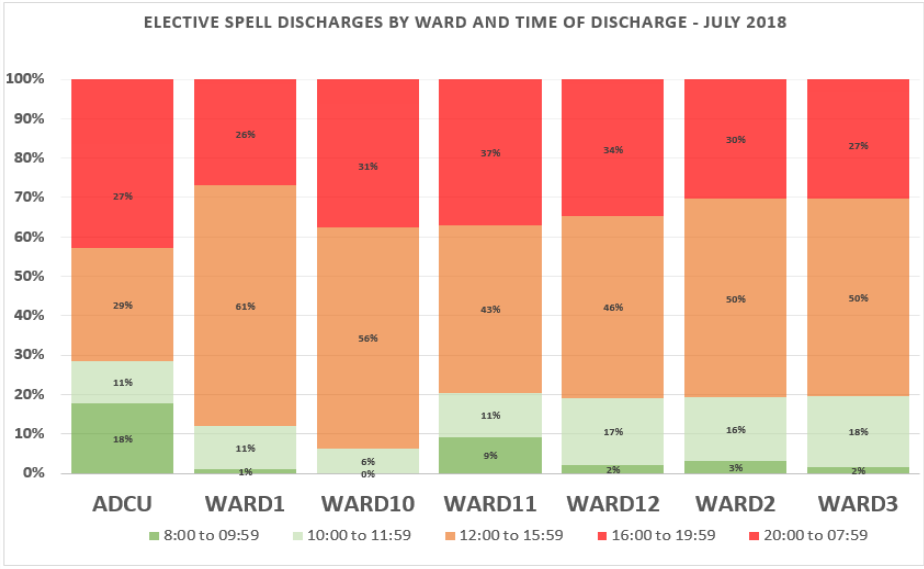
RISKS / ISSUES
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan). An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be February 2019 before an additional weekday list will commence. Weekend activity continues through the Summer with discussion underway to continue the lists until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families , one patient had a date for surgery at the end of June 2018 .

18. 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



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	28	42	77	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	14	26	43	83	0
2018-04	3	14	31	48	0
2018-05	8	20	39	67	0
2018-06	12	25	27	64	0
2018-07	7	23	24	54	0
Grand Total	125	308	540	973	10





INFORMATION
The number of cancellations on the day of surgery (by the hospital) has decreased in July to 7 patients Cancellations before the day of surgery have decreased in month from 27 to 24 patients . A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The Terms of reference of this meeting have been revisited and now includes correlation with incident reporting prior to the meeting and analysis of issues identified at the theatre' huddle' meetings to ensure interventions are delivered to reduce avoidable cancellations, wherever possible. Work continues to strengthen the POAC process supported with a full workforce plan which supports the move to over recruitment of staff in preparation to commence training on the new Advance Practice Workforce Model. Funding has been confirmed by HEE for 5 wte ACPs who will commence the course in September2018
ACTIONS FOR IMPROVEMENTS / LEARNING
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data : - Refresher training continues to support improved accuracy of data inputting on the PAS system to inform actions and allow robust audit of cancellation reasons. - Jointcare project is ongoing with weekly stakeholder meetings in place. - All cancellations by patients on the day of surgery are followed up with a telephone call from ADCU to understand the reasons
RISKS / ISSUES
Existing aging equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools are currently being scoped Managed Service Contract is being developed to support delivery of a rolling replacement programme for theatre equipment.

TRUST BOARD	
DOCUMENT TITLE:	**Radiology Review – A national review of radiology reporting within the NHS in England (CQC July 2018)**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Interim Chief Operating Officer**
AUTHOR:	**Jo Williams, Interim Chief Operating Officer**
DATE OF MEETING:	**5 September 2018**

EXECUTIVE SUMMARY:

The attached paper details the recent report which the Care Quality Commission (CQC) published in July 2018 following a review of all hospitals Radiology reporting services across England.

The paper gives a summary of the findings and recommendations which Trust Boards are required to review.

The Board is asked to:

- DISCUSS the findings
- RECEIVE and NOTE the context

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

Safe, efficient processes. CQC regulations and inspection

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

RADIOLOGY REVIEW
A NATIONAL REVIEW OF RADIOLOGY REPORTING WITHIN THE NHS IN ENGLAND
(CQC JULY 2018)
REPORT TO THE BOARD ON 5TH SEPTEMBER 2018

1 EXECUTIVE SUMMARY

1.1 This paper provides a summary of the CQC report published in July 2018 following a review of Radiology reporting services across all hospitals in England. (*Appendix 1- A national review of radiology reporting within the NHS in England CQC July 2018)*

1.2 Between July 2016 and July 2017, the CQC uncovered serious concerns around the reporting of radiology examinations in the Radiology Departments at Worcester Royal Hospital, Kettering General Hospital and the Queen Alexandra Hospital. At these trusts, they found serious problems with delays in reporting on radiology examinations, leading to a backlog in reporting, and images that had only been reported on by non-radiology clinicians who were not adequately trained to do so.

1.3 Following the problems uncovered on these inspections, the CQC then wanted to look in more depth at radiology reporting to understand the extent of the problem across NHS trusts in England.

1.4 In November 2017, an information request was sent out to all Chief Executives of NHS Acute (151) and Community (19) trusts and asked for information regarding timeliness and governance of Radiology reporting in their trusts between August 2017 and October 2017 and the ROH responded to this request.

1.5 The CQC found that there are few national standards for trusts to benchmark themselves against so trusts can be unclear about what good looks like. In particular, they found huge variation in reporting times and how trusts monitored these. The CQC confirmed that having a defined set of key performance indicators (KPIs) would allow trusts to monitor reporting times effectively, to know when to escalate backlogs to senior management, and would help to drive improvements in the service. However, variation was found in whether trusts had KPIs in place, what these measured and how frequently, as well as how concerns were escalated.

1.6 Issues with staffing were also found to be affecting reporting times as there are not enough Radiologists to meet current demand. They found the average vacancy rate across all responding trusts was 14%. This supports evidence from the Royal College of Radiologists and NHS Benchmarking, which have shown ongoing issues with the recruitment and retention of Radiologists.

2 THE ROYAL ORTHOPAEDIC RADIOLOGY DEPARTMENT (November 2017 submission)

2.1 The Trust responded to the CQC data request in November 2017, they asked:-

(a)Local key performance indicators (KPIs) for report turnaround times set out by modality.
Response- The Trust has set a local KPI which is 5 working days

(b)The proportion of patients that have breached trust reporting turnaround time KPIs expressed as a percentage, broken down by modality and urgency, over the last 3 months up to and including 31 October 2017.

Modality	Average time (Days)	Total	Breaches	% Breaches
CT	1.4	634	22	3.4
MR	1.5	2561	168	6.5
NM	0.9	88	0	0
XR	2.1	7796	399	5.1
US	2.1	1124	56	4.9

(c)The number of unreported examinations as of the date of this letter (17/11/17), broken down by those that are within and outside of local KPIs.
Response-We are currently typing dictations that were dictated on 20th November. These were performed on 20th November onwards. There are 522 un-typed dictations. 522 Unreported examinations of which the the oldest examination date is 20th November. Therefore 0 examinations fell outside of the local KPI

(d)Details for local monitoring of report turnaround times
Response-A monthly validation report is produced which has unreported files this allows the Department to check and audit any backlogs

(e)What are your internal triggers/KPIs to alert you that any reporting backlog requires action and how is this achieved?
Response-Radiologists report off CRIS worklists which ensures that the work is reported in a timely manner

(f)What examinations are not routinely reported by radiology?
Response-Fluoroscopic examinations, imported images unless requested

(g)Do you outsource any reporting and if so what percentage of the total examinations are outsourced (please specify if this is in-hours or out of hours)?
Response-For MRI and CT head we ensure that they are reported by a specialist by arrangement with a neighbouring acute trust. MRIs performed using the mobile service are reported as part of a managed service which is all on hours.

3 PERFORMANCE REPORTING STRUCTURE

3.1 The Department internally track and monitor performance against the local KPI's which they had set. It is intended that they will commence formal reporting of performance through the Divisional Management Board which will report into Finance & Performance and Quality & Committee monthly from October 2018. This will then form part of the performance pack which will be presented at Trust Board and this will ensure that we comply with the recommendations which the CQC have stated and detailed below.

The directorate are currently fully established within the Radiologist team, therefore all local reporting turnaround KPIS are being met and in a recent CQC inspection the reporting turnaround was commended. Reporting demand is currently being scoped in order to ensure appropriate reporting capacity is in place for current and future growth plans within the organisation.

4 RECOMMENDATIONS

4.1 The CQC have made the following recommendations and states that NHS trust boards should ensure that:

- they have effective oversight of any backlog of radiology reports
- risks to patients are fully assessed and managed
- Staffing and other resources are used effectively to ensure examinations are reported in an appropriate timeframe.

5.2 The National Imaging Optimisation Delivery Board should advise on national standards for report turnaround times, so that trusts can monitor and benchmark their performance.

5.3 The Royal College of Radiologists and the Society and College of Radiographers should make sure that clear frameworks are developed to support trusts in managing turnaround times safely

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

5.5 Note the contents of the report and agree the proposed performance reporting structure detailed in the paper.

Jo Williams
Interim Chief Operating Officer (COO)
21 August 2018

Care Quality Commission

Radiology review

A national review of radiology reporting within the NHS in England

July 2018

Contents

Foreword

It is widely recognised that the demand on health and social care services is increasing year-on-year. This is putting pressure on all areas of the system including radiology services, which play a key role in the diagnosis and management of many different of conditions.

In 2017, we uncovered serious concerns around the length of time it was taking for Worcester Royal Hospital, Kettering General Hospital and Queen Alexandra Hospital to report on radiology examinations, and the potential risk to patients that this posed. The issues found at these trusts warranted immediate action, but it flagged wider concerns about delays in reporting across NHS trusts.

Following these inspections, we have strengthened our approach to assessing radiology services. This includes introducing new key lines of enquiry to help inspectors monitor the reporting of imaging examinations to make sure that radiology services are providing a safe, effective, caring, responsive and well-led service for patients.

However, the issues flagged in our report highlight that there has been a lack of recognition and management of the risk these present. There is a need for wider local and national action to address current delays and to keep people safe from harm. In particular, the lack of clear national standards for trusts to benchmark themselves against is a key barrier to ensuring that radiology examinations are both reported on in a timely manner, and making sure that trusts are effectively monitoring the performance of radiology services.

Ongoing issues with the recruitment and retention of radiologists is another area of concern that has had a negative effect on the timeliness of reporting. While this is a national issue, trusts need to make sure that they are using the staff they have as effectively as possible to address any gaps, including recognising the skills of reporting radiographers. Trusts should also be able to assure themselves that any reporting that is outsourced or delegated to non-radiology clinical staff is being reviewed by clinicians who are appropriately trained and competent to perform the task. The safety of any such approach must be closely assessed and monitored.

Our report calls for action to address these issues, which have gone under the radar for far too long. Action needs to be taken now to help minimise the risks to patients and make sure that patient examinations are reported on in a timely way by an appropriately trained healthcare professional.

Professor Ted Baker
Chief Inspector of Hospitals

Summary

Radiology* is a key service that plays an essential role in diagnosing and monitoring a range of diseases and conditions from broken bones, to blood clots and gastrointestinal conditions. Over the last five years, the use of radiology has grown more than 16%, with more than 42 million examinations carried out on NHS patients in England in 2016/17. With technological advances and an aging population, this demand is likely to continue to increase year-on-year.

Between July 2016 and July 2017, we uncovered serious concerns around the reporting of radiology examinations in the radiology departments at Worcester Royal Hospital, Kettering General Hospital and the Queen Alexandra Hospital. At these trusts, we found serious problems with delays in reporting on radiology examinations, leading to a backlog in reporting, and images that had only been reported on by non-radiology clinicians who were not adequately trained to do so.

Following the problems uncovered on these inspections, we wanted to look in more depth at radiology reporting to understand the extent of the problem across NHS trusts in England. In November 2017, we sent an information request to the chief executives of all NHS acute (151) and community (19) trusts and asked them to tell us about the timeliness and governance of radiology reporting in their trusts between August 2017 and October 2017.

We found that there are few national standards for trusts to benchmark themselves against so trusts can be unclear about what good looks like. In particular, we found huge variation in reporting times and how trusts monitored these. Having a defined set of key performance indicators (KPIs) allows trusts to monitor reporting times effectively, to know when to escalate backlogs to senior management, and helps to drive improvements in the service. However, whether trusts had KPIs in place, what these measured and how frequently, as well as how concerns were escalated, varied across trusts.

Even trusts that we found were routinely monitoring turnaround times and performance against KPIs, as well as monitoring and managing unreported images, were sometimes struggling to provide timely reports. This suggests that the problems we are seeing in reporting delays for radiology examinations cannot solely be addressed through improving governance and escalation processes in local trusts.

Issues with staffing were also found to be affecting reporting times as there are not enough radiologists to meet current demand. We found the average vacancy rate across all responding trusts was 14%. This supports evidence from the Royal College of Radiologists and NHS Benchmarking, which have shown ongoing issues with the recruitment and retention of radiologists. Radiographers who are trained to report on radiology examinations play a valuable role in reporting on radiology examinations in a timely manner and reducing reporting delays, but it is clear that the skills of reporting radiographers are not always recognised or they are not being given protected time to report on radiology exams.

* In this report we use the term radiology, which includes all imaging techniques, including those that do not use ionising radiation, for example ultrasound and magnetic resonance imaging (MRI).

The issues being faced by radiology do not have a single solution and involve both local and national action now. As part of our review, we have made a number of recommendations that are aimed at reducing the potential risks to patients caused by delays in reporting on radiology examinations and having inappropriately trained staff outside of radiology reporting some studies. CQC, NHS Improvement, NHS England, the Royal College of Radiologists and the Society and College of Radiographers all need to work together to action these recommendations.

Recommendations

1. NHS trust boards should ensure that:
    - they have effective oversight of any backlog of radiology reports
    - risks to patients are fully assessed and managed
    - staffing and other resources are used effectively to ensure examinations are reported in an appropriate timeframe.
2. The National Imaging Optimisation Delivery Board should advise on national standards for report turnaround times, so that trusts can monitor and benchmark their performance.
3. The Royal College of Radiologists and the Society and College of Radiographers should make sure that clear frameworks are developed to support trusts in managing turnaround times safely.

Introduction

Radiology is a key service that plays an essential role in diagnosing and monitoring a range of diseases and conditions from broken bones, to blood clots, and gastrointestinal conditions. Types of radiology examination include plain film X-rays, computed tomography (CT), ultrasound and magnetic resonance imaging (MRI).* Over the last five years, the use of radiology has grown more than 16%, with more than 42 million examinations carried out on NHS patients in England in 2016/17.[1]

Plain film X-rays make up the majority of activity carried out in radiology departments, with 22.9 million examinations carried out in 2016/17, an increase of 8% over the previous five years. More complex types of radiology examination, such as CT and MRI, have seen a larger increase with 44% and 43% respectively over the previous five years. However, these examinations are performed less frequently than plain film X-rays. For example, approximately 3.4 million MRI scans were performed in 2016/17, compared with 9.4 million ultrasound scans and 4.8 million CT scans. With technological advances and an aging population, this demand is likely to continue to increase year-on-year.

A radiologist is a doctor who is specially trained to interpret diagnostic images, while radiographers are registered healthcare professionals trained to perform a wide range of imaging. When a patient has a radiology examination, a radiologist or a radiographer who has undertaken training to report on radiology examinations, will usually report on the images. Some images may be reported on by a specialist doctor in other fields in medicine. The report will summarise their findings and make recommendations for treatment. This report is sent to the doctor who referred the patient for the examination, for them to discuss the results with the patient and act on any findings.

Depending on where the patient has been referred from and the type of examination, for example X-ray requests from outpatient clinics or the emergency department, images may be reviewed by the referring clinician before a formal report is written by radiology staff. However, the doctor who referred the patient will not usually have expert training in reviewing such images and will rely on an expert opinion, which the radiology report provides.

Between July 2016 and July 2017, we uncovered serious concerns around the reporting of radiology examinations in the radiology departments at Worcester Royal Hospital, Kettering General Hospital and the Queen Alexandra Hospital.[2,3,4,5] At these trusts, we found serious problems with delays in reporting on radiology examinations, leading to a backlog in reporting, and images that had only been reported on by non-radiology clinicians who were not adequately trained to do so. We took enforcement action at these trusts as patients were being put at risk, with diagnoses having been missed and trusts not following expert guidance produced by the Royal College of Radiologists (RCR).[6] Inspectors at one trust found there had been three serious incidents where patients with lung cancer had suffered significant harm because their chest X-rays had not been seen by radiologists.

Issues around delays in reporting and backlogs of unreported images have previously been highlighted in national reports, for example from the RCR and NHS Benchmarking. In particular, these organisations have highlighted issues with workforce capacity and increasing delays to images being reported. For example, the 2016 RCR annual workforce census showed that 97% of radiology departments in the UK said they were unable to meet reporting requirements

* See appendix A for further information on the types of radiology exam.

within contracted hours.[7] This was supported by findings of the 2017 NHS Benchmarking radiology service report, which found that report turnaround times had deteriorated and reporting backlogs were evident across responding sites, with the majority of delays for plain film X-rays.[8]

In light of all of this evidence, we carried out a review of radiology reporting to understand if this was a more widespread problem across NHS trusts in England. In November 2017, we sent an information request to the chief executives of all NHS acute (151) and community trusts (19) and asked them to tell us about the timeliness and governance of radiology reporting in their trusts between August 2017 and October 2017. As part of our analysis of responses, we selected a group of 30 trusts to look in detail at their numbers of unreported images.[*] This report sets out the key findings from our information request and makes recommendations about improving radiology services for patients.

[*] See appendix B for full methodology.

1. Performance monitoring and governance processes

As part of our information request, we looked at the governance and operational frameworks around radiology reporting, to identify whether there were any common themes that would indicate poor local monitoring of report turnaround times. In this section, we look in more detail at trusts' monitoring and escalation arrangements.

1.1 Key performance indicators

We looked at the key performance indicators (KPIs) organisations had in place to monitor report turnaround times. Of the 151 acute trusts that we contacted, 14 told us that they had no formal KPIs in place to monitor report turnaround times. Three trusts told us that they monitored the turnaround time for the entire patient's pathway through radiology, for example from the date the request was received to the date the report was completed.

Of the trusts that had KPIs for turnaround times in place, just under a quarter had general KPIs that applied to all types of diagnostic imaging. For example, a seven-day KPI across all imaging activity or, at another trust, 90% of images to be reported within 24 hours.

However, over two thirds of trusts told us that they had more specific KPIs in place, which again varied by length and structure. KPIs were often structured around the urgency or referral source rather than the examination type, with shorter turnaround times for urgent patients, and turnaround times being the shortest for emergency department patients. The KPIs that tended to be longest were for routine, outpatients and GP requests. Example of the ranges of KPIs within the sample group by referral group include[*]:

- Urgent or fast track – from two days to five working days.
- Routine – from seven days to three weeks.
- Emergency department – from one hour to two working days.
- Inpatient – from 24 hours to 60% of reports within 72 hours.
- Outpatient – from five days to an informal KPI of 90% within 21 days.
- GP/direct access – from 95% of reports within 24 hours to an informal KPI of 90% within 21 days.

The longest KPIs within the dataset as a whole, were six weeks for any routine examination (three trusts) and a KPI of eight weeks for outpatient plain film X-rays at another trust.

Where KPIs were broken down by imaging technique, they were often also structured by referral source. For example:

- Plain film X-ray – at one trust, KPIs varied from one hour for critical pathways up to three weeks for all routine plain film reports. At another trust, an informal KPI of 48 hours applied to all plain film reports and two trusts reported an eight-day KPI.
- MRI – reports within one hour to 48 hours for emergency department examinations. The longest KPI for MRIs within the sample group was three weeks for routine examinations.
- CT – from being reported immediately for urgent examinations up to three weeks for routine examinations.

[*] See appendix B for details

A small number of trust responses only covered particular examinations or patient pathways. For example, one trust had a set of KPIs for urgent inpatients and another set of KPIs for cancer pathways, but it was not clear from the response whether KPIs were in place for all other patients.

There are little in the way of national standards for trusts to be able to benchmark themselves against, so trusts can be unclear about what good looks like. National standards relating to report turnaround times are limited to the national Seven Day Services Clinical Standards, which provide standards for all inpatient examinations, and specific recommendations from the National Institute for Clinical Excellence (NICE), for a limited range of emergency department pathways such as head injury, major trauma and non-complex fractures.[9,10,11,12]

This huge variation poses a number of issues for both patients and local trusts. The time taken for reports to be finalised differs on a trust-by-trust basis. As a result, patients may wait different length of times to receive their results depending on which trust they use. For example, from the information we received, a chest X-ray for a GP patient would probably be reported within two days at one trust, but at a neighbouring trust 15 miles away it could take up to 10 days.

1.2 Governance and monitoring of KPIs

Our inspections at Portsmouth, Kettering and Worcester showed that the trusts were monitoring report turnaround times, but we found that this monitoring was not always effective and, where leaders knew about reporting backlogs, escalation processes were either ineffective (as they had not improved the situation) or non-existent. This meant that the trusts only took limited action to address or mitigate the risks caused by the backlog.

Responses to our information request showed that the frequency and level at which monitoring was carried out varied. Where trusts were monitoring turnaround times well, there were dashboards in place that were updated regularly.[*] These dashboards included information such as:

- The percentage of scans performed and reported within KPIs.
- Average time (in days) from request to examination and examination to report.
- Specific NICE pathways, for example the percentage of suspected stroke patients receiving a head CT within an hour of admission.

[*] Dashboards allow an organisation to monitor performance against various KPIs.

Chelsea and Westminster Hospital NHS Foundation Trust

Chelsea and Westminster had a backlog of just over 15,000 unreported images at one site, and just over 6,800 unreported images at the other site. The trust told us that they had reviewed the backlog and had found 55 cases where the unreported images had had a positive finding. However, they had reviewed the patient notes and these findings had been actioned by the requesting staff at the time of the examination and none had resulted in harm to the patient.

The trust told us that they had sought advice from Portsmouth about the action they had taken to address their reporting backlog. In much the same way as Portsmouth, the trust had decided to auto-report all studies older than two years as the likelihood was that any positive findings either would have been detected subsequently or would have resolved. We asked the trust to provide us with monthly progress reports and as at May 2018 the trust had cleared the backlog at both sites. See section on auto-reporting for further information.

The trust told us that they have put in place standard operating procedures to make sure that referrers know when they are responsible for reporting the images. The trust is also monitoring the reporting situation at an executive level on a monthly basis.

A small number of trusts told us that IT challenges and technical issues with their Radiology Information System (RIS)[*] and Picture Archiving and Communication System (PACS)[†] limited their ability to monitor turnaround times. Examples of the effect this had in practice included:

> "We are unable to report the number of unreported examinations… due to the technical issues currently being experienced."

> "We have recently moved to a new RIS/PACS… However, we have experienced very significant operational difficulties during this transition and only now, some six months after go-live are we able to address this aspect of the service."

Through inspections and other intelligence, we are also aware of how IT challenges have impacted on reporting itself. We heard how technical issues with the reporting platforms (RIS or PACS) had reduced reporting productivity in a number of trusts, leading to backlogs and delays in report turnaround times.

[*] RIS is a system used for managing radiology records, imaging examination requests and appointments.
[†] PACS is a system used for short and long-term storage, retrieval, management and display of radiology images.

IT issues and report turnaround times

Five NHS hospitals in the East Midlands formed a radiology consortium (EMRAD) from December 2015 (with three further trusts finalising details to go live). This consortium, which has vanguard status and national funding, was to replace existing RIS and PACS and to enable images and reports to be shared across the consortium hospitals.

During the installation and for several months following the changeover to the new system, we became aware that multiple trusts had been experiencing severe issues with the stability of the IT systems and poor NHS IT infrastructures. This had meant that images, at times, were unavailable to various members of staff across the hospital to review or report, and reduced functionality had meant that reporting productivity had massively reduced. Trusts told us about a significant drop in productivity (50% in some cases). For example, during an inspection we saw the system take 45 minutes to log on, which staff claimed was not unusual. Problems had affected all trusts within the consortium to varying degrees, but we found that not all trusts had managed the risk appropriately.

We saw a comprehensive error log during an inspection showing the problems experienced at one trust with their IT systems. We were told that this error log was discussed regularly with the suppliers. However, we observed multiple entries where the suppliers did not give timescales for resolution and consistent upgrades that did not solve the problems.

We are assured that the stability of the IT systems have now significantly improved, but because of how long the system has been unreliable, some trusts are still recovering from the drop in productivity. The teamwork among the consortium has meant that many of the expected benefits from the collaboration are now being seen and images can be shared within the region, where expert radiologists and multidisciplinary teams can view them in their fields and insourcing between sites is possible.

How frequently performance was monitored and at which management level this was carried out varied between trusts. Reviews and monitoring by radiology teams took place daily, weekly or monthly, and some trusts carried out a combination of these. For example:

- Daily monitoring of patient tracker lists by the head of each radiology area, for example, CT, MRI and ultrasound.
- Weekly review of waiting and reporting turnaround times at radiology management team meetings, at which actions needed were discussed.
- Daily system checks by operational managers, with weekly statistics reported from the RIS, and monthly senior management meetings to review trends and action needed.

Examples of good practice in governance

- Daily data from RIS produced by radiology, showing the length of time each examination had been waiting to be reported, and the radiologist that it had been allocated to.
- Daily performance data sent to the divisional manager, with monitoring at monthly divisional performance and governance meetings, and escalation to a board sub-committee as needed.
- Weekly radiology meetings to look at turnaround times alongside capacity and demand, with data available through a dashboard updated twice a day. A weekly divisional meeting was also held at which radiology performance was discussed, considering the wider impact on other trust targets, such as the 18-week referral to treatment time and 31-day cancer targets.

1.3 Triggers, escalations and actions

Where trusts were monitoring their reporting performance, most had triggers in place to alert them to the fact that a backlog was starting to develop. While most trusts had specific actions in place to address turnaround times, the triggers used varied. Some trusts had one trigger to identify backlogs across all types of radiology examination, while others used types examination and/or patient pathway.

Examples of triggers alerting trusts to backlogs:

- A trigger when a KPI is breached.
- A trigger based on number of days. For example:
    - Reports waiting more than 21 days for GP and outpatient examinations. This reflected the KPI in place at the trust for GP patients, but meant that the outpatients KPI of 72 hours would be breached by 18 days before the trigger was reached.
    - Any examinations waiting over 28 days, regardless of imaging technique. At this trust, the KPIs were based on a percentage being completed within a certain number of days, the longest being 10 days for outpatients.
- A trigger based on the volume of unreported examinations. For example, backlogs of:
    - Over 350 unreported examinations, with over 500 unreported examinations triggering urgent action.
    - Two weeks' worth of activity per type of radiology exam that was unreported.

When backlogs were identified or trigger points had been reached, trusts described a variety of actions used to address risks to patients. These included:

- Re-prioritisation – triaging unreported examinations in terms of risk and urgency, or moving staff time to enable timely reporting.
- Insourcing – this included sharing the backlog of outstanding examinations between the radiologists own staff; employing locums or agency staff specifically to deal with the backlog or paying in-house staff for additional reporting sessions outside of their normal working hours.
- Outsourcing – this was the main action taken in some trusts, while for others outsourcing was only used when other actions, for example being able to manage the backlog internally, were not possible (see section 2.1).
- NHS support – one trust reported that it was part of a consortium, through which it could request local NHS reporting support.

Example of good practice in monitoring, escalation and action

The RIS/PACS team at one trust carried out daily checks on unreported examinations. Any examination unreported on by day six (with a KPI of eight days for all examinations) was either outsourced or allocated to a named consultant who had 48 hours to report. This was seen to be effective and from the data they provided, we saw their mean reporting time for all types of radiology examination and priorities was 1.43 days and the percentage of breaches of their KPI was 1.88% (Aug), 0.86% (Sept) and 0.71% (Oct).

1.4 National performance against KPIs

The aim of our review was to look at the national picture around radiology reporting and understand if the problems we found were unique to the three trusts we inspected or if it was a wider problem. However, from the data it was not possible to directly compare the performance of trusts because of the huge variation in the way local trusts had set KPIs. For example, a high percentage of breaches of a one-hour KPI may not indicate worse performance than a low percentage of breaches of a six-week KPI.

We received information on breaches of KPIs that could be broadly transcribed into a single dataset (although still with some important caveats) from 72 acute non-specialist trusts. Across the 72 responses, the data was supplied in a range of formats, including by imaging technique, degree of urgency (for which the definitions were often inconsistent), and different time periods.

Even for urgent examinations, it was clear that there was no agreement among trusts about how quickly an examination should be reported. For example, for urgent MRI examinations one trust showed breaches of 34.5% against a 48-hour KPI, but another trust had an 11% breach of seven-day KPI. Some trusts had KPIs for routine examinations that were shorter than those set by other trusts for their urgent examinations, for example one trust showed a 3.9% breach of 72-hour KPI for routine CT examinations.

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals had just under 8,300 examinations outside of their KPI. We chose to meet with this trust due to the size of the backlog, the fact that the trust KPIs were at the longer end of the reporting spectrum, and because radiology were not reporting most inpatient plain films and emergency department chest and abdomen X-rays. The trust told us that the maximum waiting time for an examination to be reported was approximately 35 days. We were told that the reporting challenges were due to a number of reasons, including locum radiologists that had left at short notice and shortages of radiographers meaning the reporting radiographers were needed to work clinically. The trust also told us that their RIS was unstable and had frequent outages, one of which had resulted in 8,500 examinations waiting to be reported.

To address these challenges, the trust told us they were increasing the number of reporting radiographers and consultant radiologists. They were also increasing the amount of cross-site working as one site in their trust was particularly hard to recruit to. We asked the trust to provide us with monthly progress reports and to carry out an audit of the presence and accuracy of the reports performed by non-radiology staff. As at 16 April 2018, there were 256 CT and MRI examinations waiting longer than 14 days for a report. However, the trust did not provide us with any information for the other types of radiology exam. We are still waiting for the results of the audit at the time of publication.

2. Managing reporting workloads

2.1 Outsourcing

Outsourcing is a common method used by trusts to reduce reporting backlogs. This is where images are sent electronically to an external provider (normally independent) to report. Radiologists, or occasionally reporting radiographers, will report these images either from home or from other offices in the UK and sometimes internationally. Outsourcing is commonly used overnight, especially at smaller trusts, as this means the trust radiologists are not required to work on night shifts (or work on-call) and will therefore be available in the department during the day. However, there is also demand to outsource normal working day activities to reduce backlogs. The two main types of outsourcing services used by trusts are:

- Hot reporting/out-of-hours – for example, urgent emergency department CT scans that are performed out-of-hours. These would be reported on and returned to the trust within an hour by radiologists working for independent providers.
- Cold reporting/in hours – for example, where a trust is experiencing reporting backlogs, trusts may use independent radiology reporting companies to take specified numbers of scans to report. That company will then send reports back to the trust to action within an agreed timeframe.

Responses we received from the acute NHS trusts (excluding the specialist centres) indicated that 102 trusts (76%) were outsourcing at least some of their radiology reporting work to external companies in an effort to keep up with demand. A number of responses indicated that individual trusts had contracts in place with several outsourcing providers. Our figures are similar to those from the RCR 2016 census where 78% of respondents said that they outsourced images.[13] The census also put the amount spent on outsourcing into perspective. In the UK as a whole, £88 million was spent on outsourcing/insourcing, which the RCR calculated as the equivalent of the combined salaries of 1,028 consultant radiologists.

The mean percentage of total examinations outsourced by individual trusts was 8% (median 5%) from the responses received. The maximum (before disaggregating to in hours and out-of-hours) was 41% at one trust.

Some trust responses suggested that their ability to reduce reporting backlogs through outsourcing was limited. For example, one trust commented on issues with turnaround times by outsourcing companies, and that at certain periods outsourcing capacity has been unable to meet demand. Another trust told us that the outsourcing company they used had capacity issues with reporting chest and abdominal plain film X-rays.

At another trust we again found issues with RIS and PACS had prevented them from using outsourcing as a way of reducing their reporting backlogs. These issues were also raised by several trusts during engagement meetings we held with them to discuss their reporting backlogs.

Trusts need to assure themselves that the radiologists employed by the outsourcing companies are appropriately trained (and registered with the General Medical Council if they are to also undertake the justification of imaging request), that clinical audits of the quality of the reports are performed and that systems are in place to flag up urgent and unexpected findings. Justification is the process of weighing up the expected benefits of the examination against the possible risk.

Following a review of our inspection methodology, we will be inspecting and, for the first time, rating outsourcing companies based in England this financial year (2018/19).

2.2 Auto-reporting

All radiology examinations should have a documented report, especially those involving ionising radiation such as plain film X-rays, CT and nuclear medicine, where it is a legal requirement.[14] One way that trusts can manage the radiology reporting workload is to identify which examinations could be reported by non-radiology staff. This process is known as auto-reporting as it involves sending a standard response automatically to referrers, informing them that the examination will not receive a formal radiology report and that it is their responsibility to provide one. (This process is different to situations where non-radiology staff review images shortly after they are taken to direct treatment, such as when checking to see if a patient in emergency department has broken their wrist and needs a cast applying, as these images will also receive a formal radiology report at a later time.)

Auto-reporting may be an appropriate tool for managing workloads in some circumstances, for example for follow-up images for patients attending fracture clinics where the initial X-ray has been reported by a radiologist or a reporting radiographer, and subsequent images are to assess healing.

However, as seen from the Portsmouth hospital inspection findings, there is a potential risk of harm to patients associated with non-radiology staff reporting images that do not receive a separate formal radiology report. This is especially a risk for chest and abdomen X-rays, where general medical training does not constitute adequate training. Non-radiology staff may be able to spot large cancerous masses and other obvious pathologies, but may miss smaller, more subtle cancers that are more likely to respond positively to treatment and lead to a better outcome for the patient when they are caught early.

Responses to our information request showed considerable variation in the governance, type and amount of reporting by non-radiology specialists. For example:

- 16 trusts (11.9% of respondents, excluding specialist trusts) stated that all imaging examinations carried out within the radiology department were reported by either radiologists or reporting radiographers, including all plain film X-rays.
- Plain film X-rays was the most common imaging technique to be auto-reported.
- Eight trusts delegated cardiac MRI, CT and/or Nuclear Medicine imaging to cardiologists.
- 117 trusts (87.3%) delegated the reporting of plain film X-rays of the limbs from orthopaedic referral sources to the orthopaedic doctors. This was for fracture clinics, outpatient clinics and/or post-operative orthopaedic plain film X-rays.
- Other areas we found where plain film X-rays were auto-reported were:
    - Intensive care and high dependency unit chest X-rays (18)
    - Chest X-rays from chest outpatient clinics (14)
    - Rheumatology extremity X-rays (10)
    - Abdomen X-rays from urology outpatients looking for kidney stones (8).

We followed up our original request for information with additional questions to 18 trusts that said radiology did not routinely provide a report for inpatient, outpatient and/or emergency department images, to ask about local governance processes and monitoring of report accuracy. We also asked what assurances these 18 trusts had that non-radiology staff were appropriately trained for this task.

A number of trusts stated that they felt their medical staff were adequately trained to report images, for example, "We work on the basis that all medical staff have undergone image interpretation as part of their studies, and are working under the guidance of a clinical specialist in their field." They also stressed that if the medical staff felt that the image was outside of their area of expertise they could request a radiology report.

In response to the letter and media attention around the release of the Portsmouth inspection report, some trusts had reviewed the risk and had since started producing a radiology report for all chest X-rays, while other trusts told us that they had reviewed the training they provide for non-radiology staff who report X-rays. However, all trusts confirmed they had supporting measures in place to make sure that a radiology opinion was available if requested.

The range of responses we received to our follow-up questions show that there is no agreement on what constitutes adequate training for non-radiology staff that are responsible for reporting on images that do not receive a formal radiology report.

3. Staffing

3.1 Radiologist vacancies

Demand for radiology services is increasing year-on-year, especially for CT and MRI examinations, which take longer to report than plain film X-rays – it may take 10 times longer to report a CT or MRI than a plain film X-ray.[15] Delays in reporting radiology examinations, and backlogs in reporting, are made worse by issues with staffing as there are not enough radiologists to meet current demand.

Responses from our information request show that the majority of trusts had vacancies for radiologists, with the highest vacancy rate at 65.2%. The average (mean) vacancy rate across all responding trusts was 14%. In total, the trusts who provided information on radiologist staffing (118 out of 134 non-specialist trusts) reported 391.4 whole-time equivalent (WTE) vacancies. This supports findings from the RCR and NHS Benchmarking that have shown ongoing issues around the recruitment and retention of radiologists. A lack of staff is a key contributing factor to the delays and backlog in reporting on radiology examinations.

In light of this, trusts need to make sure that they are using the staff they have as effectively as possible. For example, at one trust they had completed a directorate-wide team job planning review. This was performed across nine subspecialty teams and 74 consultants. Since the introduction of this exercise, the number of examinations waiting longer than 14 days had "fallen dramatically", and they no longer needed to outsource any plain film X-rays. Another trust told us they were using radiologists' time better by providing secretarial support for planning multidisciplinary team meetings.

King's College Hospital NHS Foundation Trust

King's College Hospital NHS Foundation Trust had a backlog of 33,400 unreported images (the oldest images had been waiting to be reported for eight months). This backlog had been caused by a sudden decrease in the number of radiologists. The trust had identified the problem early on but had struggled to recruit radiologists and find an outsourcing company who could help with reducing the reporting backlog, despite the trust making funds available to address the situation.

We discussed the measures they had put in place, including the recruitment of additional consultant radiologists, a contract with an outsourcing company, the introduction of protected reporting time for reporting radiographers and the use of locum radiologists. The trust told us that they had reviewed the situation and had not discovered any patients that had come to harm because of the delay in reporting their examinations. We asked the trust to provide us with monthly progress reports and, as of July 2018, the backlog had been reduced by 62% to 13,708 compared with the situation in December 2017. They told us that they had also successfully recruited 10 consultant radiologists and were continuing to outsource examinations.

Lewisham and Greenwich NHS Trust

Lewisham and Greenwich NHS Trust has two similar sized hospitals both with emergency departments; the Lewisham site had almost no unreported images outside of KPI (365 studies), while the Queen Elizabeth site had a backlog of 8,700 examinations outside of their KPI. We discussed what the trust had done to address this imbalance in reporting performance across the two sites. The trust told us that the radiologists at the site with no backlog were able to manage the reporting of plain film X-rays by providing an insourcing service to the trust. However, this service was at capacity and IT issues meant those radiologists were not able to view examinations performed at the other site on suitable PACS monitors, so even if they had capacity this would not be an appropriate solution. The trust also told us that the reporting of plain film X-rays had not been included in the radiologists' job plan but that a recent review had managed to increase the time for plain film reporting by two hours (split between four radiologists).

The trust had arranged outsourcing contracts with multiple companies to address the backlog and they were monitoring the situation on a weekly basis. The trust was also in the process of recruiting some new consultant radiologists and reporting radiographers. We asked the trust to provide us with monthly progress reports and, as of May 2018, the backlog had been reduced to 291 examinations waiting longer than seven days to be reported

3.2 Reporting radiographers

Radiographers are trained primarily to carry out a wide range of imaging techniques. With additional training, some radiographers are also able to report on images. Reporting radiographers have been present in radiology departments for many years and the range of examinations they report has expanded from plain film X-rays to more complex examinations such as CT and MRI. There is evidence to show that, when trained appropriately, their reports are comparable to those produced by consultant radiologists.[16,17,18] Reporting radiographers play a valuable role in reporting radiology examinations in a timely manner and reducing reporting delays.

During inspections at Worcester, Kettering and Portsmouth we looked at how the departments had used reporting radiographers. These three trusts all had radiographers reporting plain film X-rays, but there was no robust management of these roles. For example:

- In 2016, at Worcester Royal Hospital, we found that although there was a dedicated rota for radiographer reporting sessions, radiographers were not always being released from their other clinical duties because they had to cover radiographer vacancies. This meant trained reporting radiographers were required to work in the general department, for example taking X-rays, rather than undertaking their scheduled reporting sessions.
- At Kettering General Hospital in 2016, we found radiographer reporting sessions were not rostered or part of established job plans. This meant that reporting sessions were only carried out when reporting radiographers could be released from normal clinical duties. As a result, reporting sessions were sporadic and depended on staffing levels and out-of-hours shift working.

- At the Queen Alexandra Hospital in 2017, we found that some radiographers had been trained to carry out a wider scope of practice in relation to reporting, for example, CT head scans. However, due to a mixture of demand for other clinical duties (such as taking X-rays) and limited amount of support and time from radiologists, these radiographers were not able to continue with the reporting and were quickly de-skilled.

From the responses we received, all but one non-specialist acute trusts employed reporting radiographers in some capacity. Our findings showed that the number of reporting radiographers and the types of radiology examination that they covered varied.[*]

Although we would expect to see some variation based on the size of the trusts and the level of reporting that is outsourced, responses suggested that the number of reporting radiographers varied even for trusts of a similar size. Across all responses, reporting radiographers were most likely to report plain film X-rays. Other examinations commonly reported by radiographers included CT and MRI head, breast imaging and fluoroscopy studies. Several trusts told us that reporting radiographers could only report examinations when they were not needed to carry out clinical duties in the department.

Reporting radiographers were in training at a number of trusts and some indicated that they were hoping to increase the number of reporting radiographers through recruitment and training, or increase the range of reporting to include more imaging techniques.

Some responses mentioned collaborative working between trusts to support reporting radiographers. For example, two trusts told us about a joint initiative to train radiographers for reporting in collaboration with other trusts in their region and they were extremely encouraged by the potential this offered. This collaboration will increase the number of reporting radiographers across the three trusts by six in total (two at each trust).

Some trusts provided examples of how using reporting radiographers had helped to reduce reporting backlogs. For example, one trust provided details of how the employment of two WTE reporting radiographers has resulted in a drop in the level of outsourced reporting and compliance with the reporting turnaround times for that imaging technique.

Technological advances in reporting

We recognise the potential that artificial intelligence (AI) and machine learning developments have to shape the way radiology departments work, especially in the reviewing and reporting of images. According to evidence presented at a parliamentary select committee on artificial intelligence, in the next five to 10 years, diagnostic imaging will be "revolutionised" by machine learning.[19]

The RCR believes that these techniques should be seen as a diagnostic tool rather than a workforce replacement, and AI has the potential, by "weeding out" all normal X-rays, freeing up capacity to allow radiologists to work on the more complex studies.

It is clear that AI and machine learning, will have a place in radiology departments and it will be important in addressing some of the challenges radiology departments face in the medium to long term. However, this technology is not yet developed enough to be an immediate solution.

[*] A sonographer is someone who has been trained to perform and report ultrasound examinations. Sonographers have been excluded from the findings relating to reporting radiographers as reporting is usually done at the time of the examination and is included as part of the training to become a sonographer.

Conclusions and next steps

Our review aimed to look at the national picture around radiology reporting and understand if the problems we found at Worcester Royal Hospital, Kettering General Hospital and the Queen Alexandra Hospital were unique to these three trusts or if it was a wider problem. Broadly we found that radiology departments across England are facing a number of challenges when making sure that patients' examinations are reported in a timely manner. However, it was difficult to make direct comparisons between trusts because of the huge variation in practice.

Having a defined set of key performance indicators (KPIs) is the foundation for a good radiology service as they allow for effective performance monitoring, appropriate escalation of backlogs to senior management and help drive improvements in the service. However, there are few national standards for trusts to benchmark themselves against, provide guidance on what is acceptable practice in terms of report turnaround times, and in turn help them to set KPIs.

Once KPIs are set, it is important to have strong governance processes in place, with regular monitoring and clear processes in place for escalation when they are regularly missed or defined trigger points are reached. However, we found that the frequency and level at which monitoring took place varied. Similarly, how trusts addressed backlogs when they were identified also varied.

Outsourcing is a common method used by trusts to reduce reporting backlogs. However, this has its own challenges and trusts need to assure themselves that the radiologists employed by the outsourcing companies are appropriately trained (and registered with the General Medical Council if they are to also undertake the justification of imaging request), that clinical audits of the quality of the reports are performed, and that systems are in place to flag up urgent and unexpected findings.

We also found issues with auto-reporting, where examinations are reported on by non-radiology staff. As highlighted by the issues found at Portsmouth, there is a potential risk of harm to patients associated with this, particularly for chest and abdomen X-rays. While all trusts confirmed that they had supporting measures in place to make sure a radiology opinion was available if requested, trusts need to assure themselves that non-radiology staff who are responsible for reporting images are aware of this and that they are competent to perform the task. Trusts also need to make sure that audits are performed to make sure that reports are documented and accurate.

Even in trusts that are routinely monitoring turnaround times and performance against local KPIs, as well as putting measures in place to deal with unreported images, some are still are not able to provide timely reports. This suggests that the problems we are seeing in reporting delays for radiology examinations cannot solely be addressed through improving governance and escalation processes in local trusts.

Staffing was another area of concern, with trusts reporting high vacancy rates and struggling to fill posts. From the range of responses we received it is clear that there is no agreement on what constitutes adequate training for non-radiology staff responsible for reporting images that do not receive a formal radiology report. It is also clear that the issues found at Portsmouth, Kettering and Worcester about reporting radiographers are not unique, and the skills of reporting radiographers are not always recognised or they are not being given protected time to report on radiology exams.

The issues being faced by radiology do not have a single solution and involve both local and national action. As part of the latest comprehensive inspection methodology, we have updated our inspection key lines of enquiry and provider information requests to make sure that we can inspect radiology services in more depth. We have also improved the resources we provide our hospital inspectors to make sure that they feel confident when inspecting diagnostic imaging departments. These changes will mean that we can monitor the reporting of imaging examinations as part of our inspections to make sure that radiology services are providing a safe, responsive, effective, caring and well-led service for patients.

However, the changes we have made will not in themselves address the challenges faced by radiology departments around making sure that patient examinations receive a timely report by an appropriately trained healthcare professional. Action needs to be taken now to agree what good looks like in terms of radiology reporting. This will allow departments to benchmark their performance and will improve the quality of care for patients.

CQC, NHS Improvement, NHS England, the Royal College of Radiologists and the Society and College of Radiographers all need to work together to action the following recommendations, which aim to improve radiology reporting and reducing the potential risks to patients caused by delays.

Recommendations

1. NHS trust boards should ensure that:
    - they have effective oversight of any backlog of radiology reports
    - risks to patients are fully assessed and managed
    - staffing and other resources are used effectively to ensure examinations are reported in an appropriate timeframe.
2. The National Imaging Optimisation Delivery Board should advise on national standards for report turnaround times, so that trusts can monitor and benchmark their performance.
3. The Royal College of Radiologists and the Society and College of Radiographers should make sure that clear frameworks are developed to support trusts in managing turnaround times safely.

Appendices

Appendix A: Glossary – types of radiology examination

Computed Tomography (CT) is a scan that combines a series of X-ray images taken from different angles around the body to create detailed cross-sectional images (slices) of the inside of the body.

Fluoroscopy is similar to an X-ray 'movie'. The images are transmitted to a TV-like monitor in real time so that the body part and its motion can be seen in detail. Fluoroscopy is used to look at many body systems, including the digestive, urinary and reproductive systems and provides information on their function as well as anatomy.

Magnetic Resonance Imaging (MRI) is similar to CT in that it produces cross-sectional images of the body, but it uses strong magnetic fields and radio waves instead of X-rays. MRI is particularly good at looking at soft tissues such as the brain, ligaments, tendons and the spinal cord.

Nuclear medicine (NM) uses small amounts of radioactive material to diagnose, determine the severity of or treat a variety of diseases, including many types of cancer and heart disease. PET-CT and SPECT are similar but they combine the NM examination with a CT scan.

Plain film X-rays are two-dimensional pictures of the inside of the body. They are good at looking for problems in bones, teeth, the chest and some soft tissue areas, such as the abdomen, and are usually the first (and sometimes only) diagnostic imaging used to diagnose a disease or condition.

Ultrasound uses high-frequency sound waves to create an image of part of the inside of the body. A common example is using ultrasound to assess the growth and development of a baby during pregnancy. Ultrasound is also very useful for looking at abdominal organs and the heart.

Appendix B: Methodology – how did we carry out this review?

In November 2017, we sent an information request to the chief executives of all NHS acute (151) and community trusts (19) and asked them to tell us about the timeliness and governance of radiology reporting in their trusts between August 2017 and October 2017. We asked trusts to tell us about:

- Local key performance indicators (KPIs) for report turnaround times*
- The proportion of patients that had breached the KPIs
- The number of unreported examinations
- The process for monitoring reporting KPIs
- The triggers used to flag developing reporting backlogs
- The examinations not routinely reported by radiology
- Whether the trust outsources any radiology reporting
- Radiologist staffing
- The number of reporting radiographers and the examinations they are trained to report.

We received responses from all trusts (151 acute and 19 community trusts). Most community trusts did not provide diagnostic imaging services directly (excluding community dental services), but had contracts with local acute trusts. This being the case, we excluded community trusts from the data analysis. Unless specified otherwise, we have also excluded specialist trusts (17 trusts in total), for example those providing only orthopaedic services, from the data analysis due to the different operational models they use.

Trust responses to the questions included in our letter were collated in a spreadsheet and responses for a sample of 30 trusts were selected ensuring coverage across regions, all rating categories and a range of trust sizes. We used a sample of responses because the wide variation in information provided by trusts made statistical analysis of the complete dataset impossible.

We also developed and tested a coding framework for the responses we received relating to the setting, monitoring and triggers related to KPIs as well as the number of reporting radiographers. Responses for the 30 trusts were then coded in software designed for qualitative analysis, MaxQDA 11, and the data analysed using the framework we had developed. Responses were coded from the collated spreadsheet, not directly from the responses received.

We sent a follow-up information request to any trust who told us they did not routinely report inpatient, outpatient and/or emergency department plain film X-rays. We asked them to send us additional information around their processes for ensuring that staff reporting plain film X-rays outside of their clinical expertise were competent to report and detect potential incidental findings, especially with regards to chest X-rays. This was an area of concern that had been raised during some of the previous inspections.

We also held meetings with trusts where data indicated that they had significant reporting backlogs. These meetings included discussions around how the reporting backlog had arisen, whether any patients had come to harm, plans to reduce the backlog and whether these plans were sustainable.

* A key performance indicator is a measure used to evaluate whether an organisation or department is meeting specific performance objectives.

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CQC-418-072018

Finance and Performance Report

June 2018

CONTENTS

INTRODUCTION

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

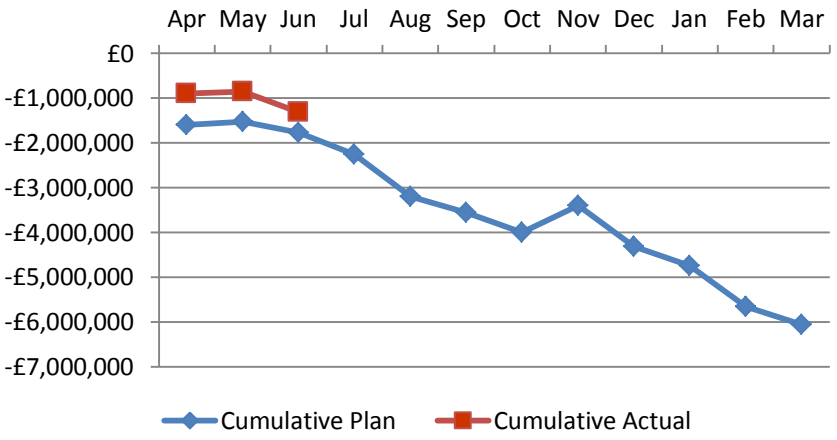
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M3 Original Plan £'000	YTD M3 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	19,080	19,485	405
Other Operating Income	1,218	1,213	(5)
Total Income	**20,298**	**20,698**	**400**
Employee Expenses (inc. Agency)	(12,642)	(12,808)	(166)
Other operating expenses	(9,078)	(8,849)	229
Operating deficit	**(1,422)**	**(959)**	**463**
Net Finance Costs	(351)	(345)	6
Net deficit	**(1,773)**	**(1,303)**	**470**
Remove donated asset I&E impact	15	16	1
Remove STF Funding	(92)	(92)	-
Adjusted financial performance	**(1,850)**	**(1,380)**	**470**

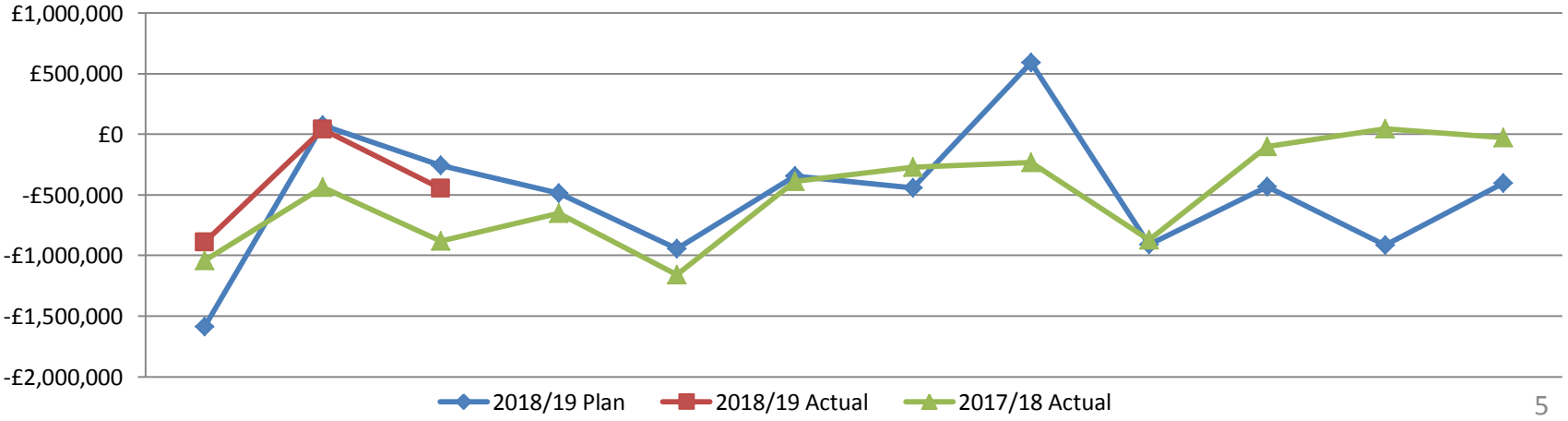
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan (excluding revaluation gains)



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	3	4
Overall UOR	3	3

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered an in-month deficit of £450,000 in June against a planned deficit of £256,000, £194,000 behind plan. Year to date the Trust is £470,000 ahead at a deficit of £1,380,000. This position includes full achievement of the £92,000 Q1 element of the Prover Sustainability Fund (PSF – the replacement for STF).

The main driver for this underperformance is an in-month income under delivery in addition to higher than expected agency spend. The year to date performance is reflective of strong activity performance, particularly elective inpatient activity.

The CIP target for 2018/19 is £3,000,000 of which £2,984,000 has been identified. During month 3 £34,000 of savings were recognised against a plan of £172,000. The current plan is based on 41% delivered through non pay savings, 41% through income schemes and 18% with pay schemes.

The Use of Resources Rating is in line with plan with the exception of the overspend in agency. All sub-ratings are currently at a 4 (the lowest level) with the exception of performance against plan, which is a 1. This 1 rating is what is keeping the Trust at an overall rating of 3, but any deterioration would result in an overall Use of Resources Rating of 4.

ACTIONS FOR IMPROVEMENTS / LEARNING

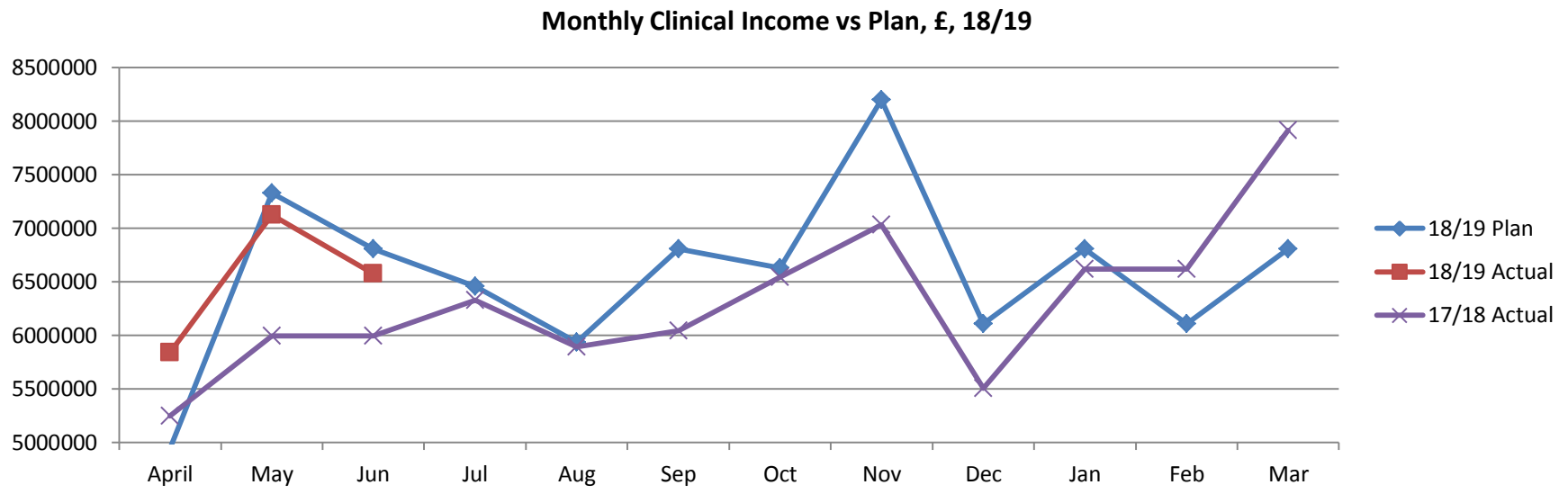
There needs to be focussed attention on bridging the gap on CIP schemes and if possible building in a slippage contingency to ensure the full year target is achieved.

In addition, the trust needs to ensure that it is building on the early activity headroom from months 1 and 2 to ensure that the trust continues to remain ahead of plan. This will help the trust remain on track during the latter months of the year when the transition of paediatric services is expected to occur.

RISKS / ISSUES

The Trust Board approved a business case this month for the intention to build a 4 theatre, 6 recovery bed, 23 bedded ward development over the coming 2 years. This creates fantastic opportunities to further support the STP and to grow income at the trust, but there will need to be careful management of the risks regarding staffing in particular.

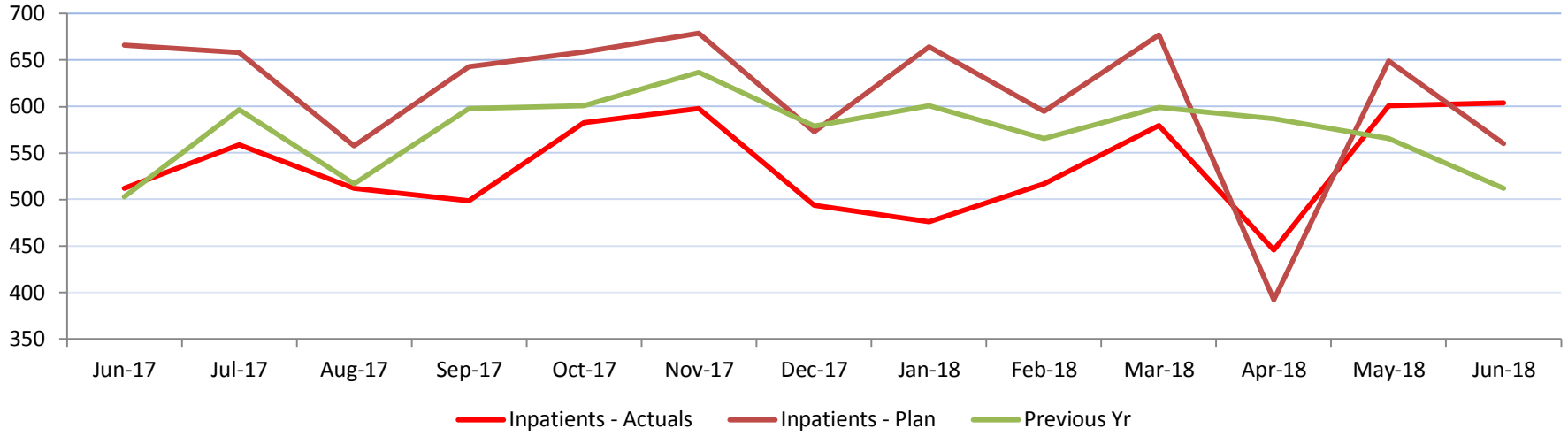
2. Income and Activity– This illustrates the total income generated by the Trust in 2018/19, including the split of income by category, in addition to the month's activity



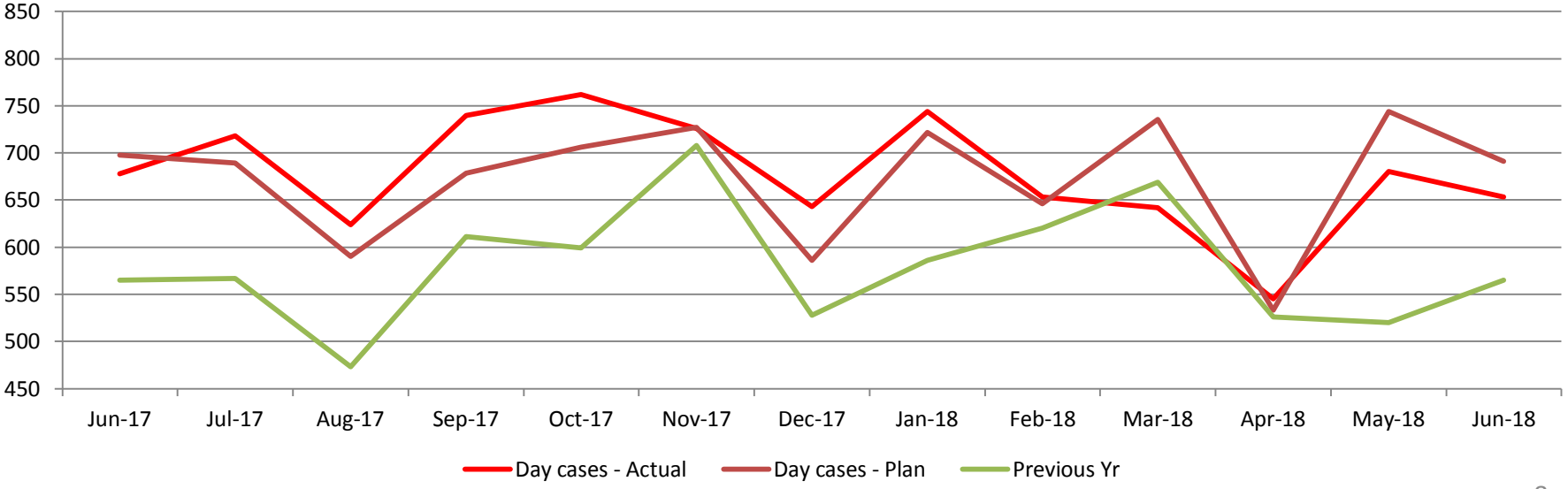
Clinical Income – July 2018 £'000			
	Plan	Actual	Variance
Inpatients	3,595	3,207	-388
Excess Bed Days	42	117	75
Total Inpatients	3,637	3,324	-313
Day Cases	856	840	-16
Outpatients	666	604	-62
Critical Care	235	176	-59
Therapies	230	257	27
Pass-through income	216	215	-1
Other variable income	427	604	177
Block income	539	558	19
TOTAL	6,806	6,578	-228

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	10,078	9,792	-286
Excess Bed Days	117	230	113
Total Inpatients	10,195	10,022	-173
Day Cases	2399	2408	9
Outpatients	1868	1940	72
Critical Care	658	573	-85
Therapies	645	734	89
Pass-through income	606	768	162
Other variable income	1197	1423	226
Block income	1511	1675	164
TOTAL	19,079	19,543	464

Inpatient Activity



Day Case Activity



Loss on Tariff 16/17-18/19

HRG Chapter	Gain/(Loss) 1617	Gain/(Loss) 1718	Gain/(Loss) 1819
CARDIAC DISORDERS	(736)	(309)	2
CARDIAC PROCEDURES	(2,417)	0	0
DIGESTIVE SYSTEM PROCEDURES AND DISORDERS	326	(1,385)	148
HAEMATOLOGICAL PROCEDURES AND DISORDERS	357	(841)	224
IMMUNOLOGY, INFECTIOUS DISEASES, POISONING, SHOCK, SPECIAL EXAMINATIONS, SCREENING AND OTHER HEALTHCARE CONTACTS	(1,571)	8,336	1,015
MOUTH, HEAD, NECK AND EARS PROCEDURES AND DISORDERS	96	5,669	141
MULTIPLE TRAUMA	166	362	110
MUSCULOSKELETAL DISORDERS	18,495	30,920	764
NERVOUS SYSTEM PROCEDURES AND DISORDERS	973	(145,199)	1,180
ORTHOPAEDIC NON-TRAUMA PROCEDURES	(515,375)	1,471,706	281,500
ORTHOPAEDIC RECONSTRUCTION PROCEDURES	(1,392,269)	(2,807,578)	121,522
ORTHOPAEDIC TRAUMA PROCEDURES	(63,802)	45,700	4,092
PAEDIATRIC MEDICINE	(24,804)	(57,054)	3,943
PAIN MANAGEMENT	21,889	(132,038)	13,046
RENAL PROCEDURES AND DISORDERS	47	(361)	9
SKIN DISORDERS	188	7,457	117
SKIN SURGERY	(11,054)	(644)	1,973
SPINAL SURGERY AND DISORDERS	(26,610)	(140,865)	43,236
THORACIC PROCEDURES AND DISORDERS	(406)	9,726	46
UNDEFINED GROUPS	(4,251)	25	26
UROLOGICAL AND MALE REPRODUCTIVE SYSTEM	36	294	16
VASCULAR PROCEDURES AND DISORDERS	(20,316)	2,757	1,037
Soft Tissue Sarcoma	(298,194)	181,810	926
Grand Total	**(2,319,233)**	**(1,521,513)**	**475,070**
Inflation Uplift	3.10%	3.00%	3.00%
Efficiency saving	-2.00%	-2.00%	-2.00%
Overall uplift	1.10%	1.00%	1.00%
Avg RPI	2.10%	3.80%	3.40%
Clinlcal Income Base relates to increase income year on year	1.28%	1.61%	4.59%
The table reflects the 2015-16 activity extrapolated using future year's tariff, this does not take into account change in case mix			
Gain in 1819 mainly relates to increase in tariff price for inflation			

Although inpatient activity has remained strong in month and is higher than plan, NHS Clinical Income has under-performed. This is due to a number of factors:-

- A reduction in WO52 (Implantation Massive Endoprosthetic Replacement of Bone) activity of 13 spells. These have a spell value of £28k.
- A reduction in high value spinal activity
- Day Case activity and outpatient activity that is slightly behind plan in month.

However, a cumulative analysis for the first quarter shows that elective activity is over-performing by 4.68%, and first outpatient activity is up by 7.17% which is significantly better than the same period in 17/18. Day case activity is slightly down at 4.08%.

Other variable income over performed in month and YTD. This includes £92k YTD PSF and circa £140k that relates to HGS patients that have had their treatment at ROH.

Private patient income is now at £317k for the first quarter.

Also shown is an analysis of tariff loss over the last three year. Due to a change form HRG4 to HRG4+ in 2017/18 this is shown at the Chapter level, and identifies the income change based on 2015/16 activity levels and tariff. This shows a reduction of £2.3m and £1.5m in 2017/18. The 2017/18 and 2018/19 Tariff was set for two years, so the gain shown in 2018/19 is simply the impact of a 1% overall uplift on the core PbR activity circa £48m. Excluding inflation would give a total tariff loss of circa £4.8m based on 2015/16 activity.

ACTIONS FOR IMPROVEMENTS / LEARNING

Whilst inpatient activity remains strong it is important to remain focused on delivery. Whilst the IP activity plans have been developed in conjunction with operations, the plan for July does look stretched when compared with known leave, although the plan for August is modest.

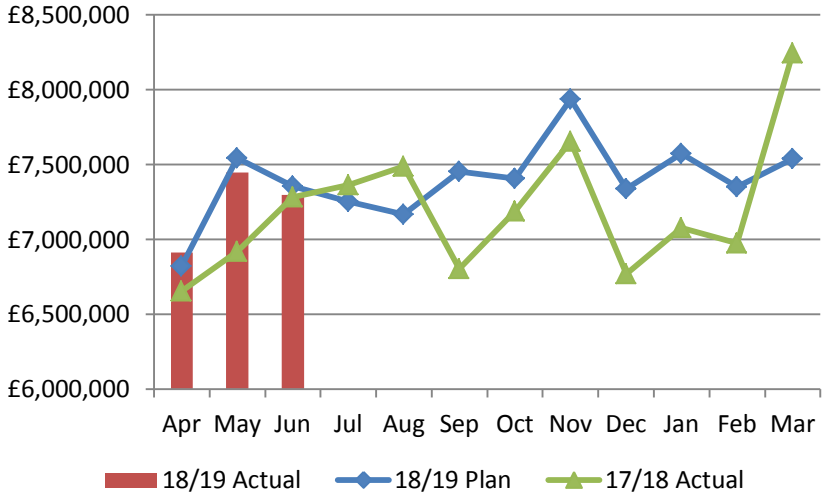
Work remains ongoing as part of Perfecting Pathways to ensure that clinicians are recording the appropriate co-morbidities of the patient's they treat, resulting in the trust being funded for the work actually performed. Moreover, the Trust have been working with the NOA and NHSI and are hopeful a pilot may be introduced for 2018/19 to address identified tariff deficiencies for complex procedures.

RISKS / ISSUES

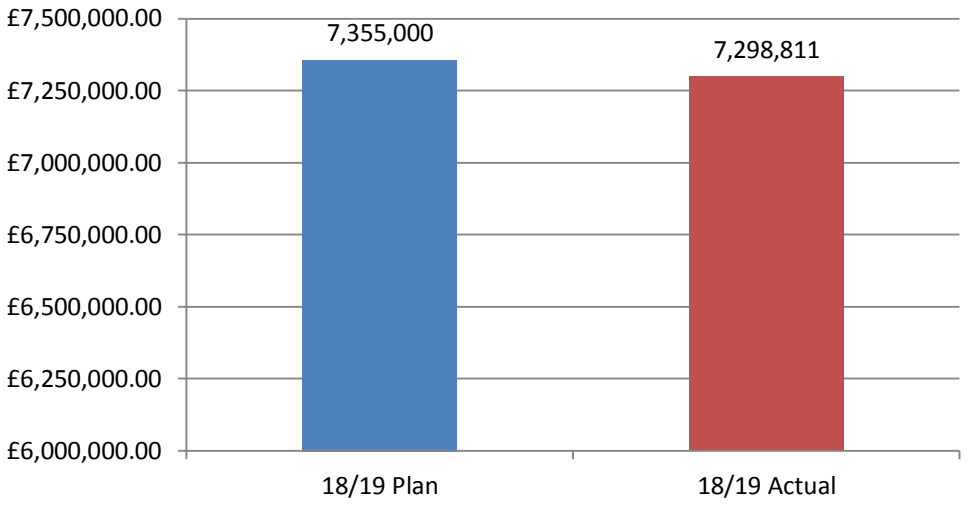
The transition of paediatric services in Q4 will create a pressure from an income perspective which will need to be closely managed to ensure that the control total is met.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2018/19, compared to historic trends

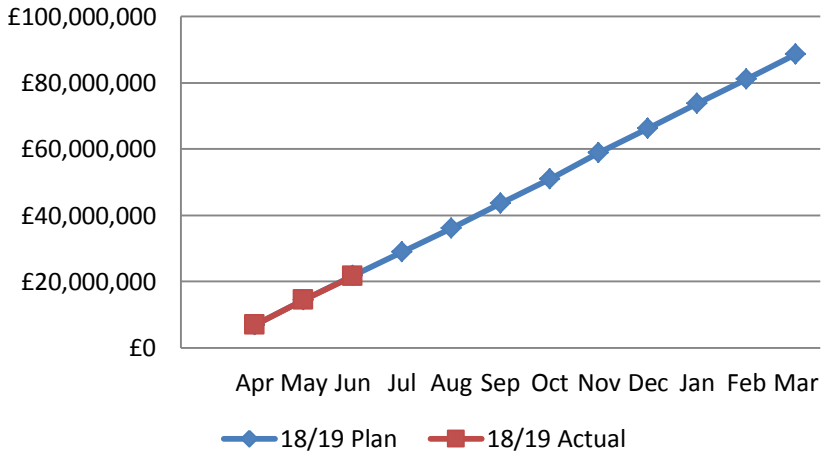
18/19 Monthly Expenditure vs Plan



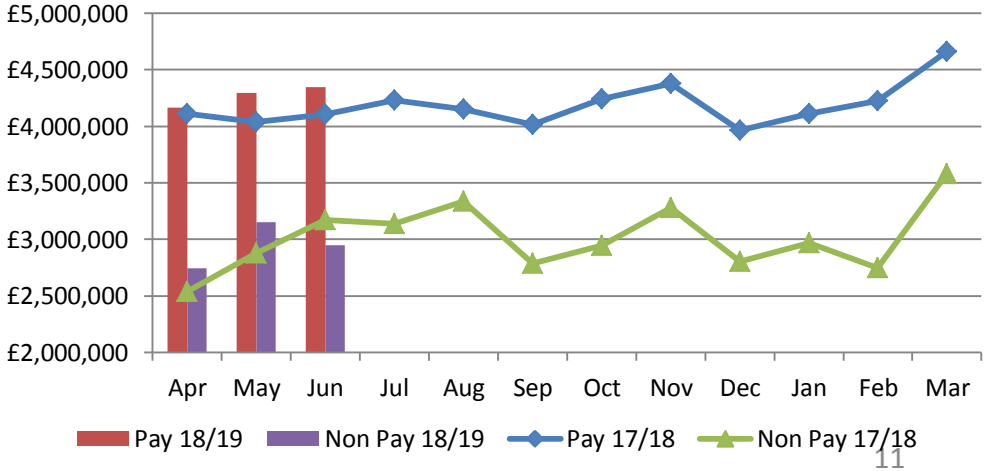
18/19 M3 Expenditure vs Plan



Cumulative Expenditure vs Plan 18/19



17/18 vs 18/19 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £7,299,000, which was a £56,000 underspend against the plan of £7,355,000.

Pay has overspend in month and increased on prior month, with a year to date overspend of £166,000. Agency spend is a factor in the overspend, as it remains high (further detail on the next slide) but it has decreased in month. Substantive spend has increased as the trust has had some success in recruiting to its vacancies. Early indications suggest that the improved CQC rating may be helping the trust attract substantive staff.

Non-pay spend was £229,000 lower than plan year to date, with particularly strong performance in theatres.

ACTIONS FOR IMPROVEMENTS / LEARNING

Costs will continue to be scrutinised and minimised.

There is further learning from the year end stock count and subsequent audit which will be taken forward and acted upon within 2018-19 to give greater control over stock costs throughout the year. These discussions will need to be factored into the considerations regarding the potential for a theatres managed service contract.

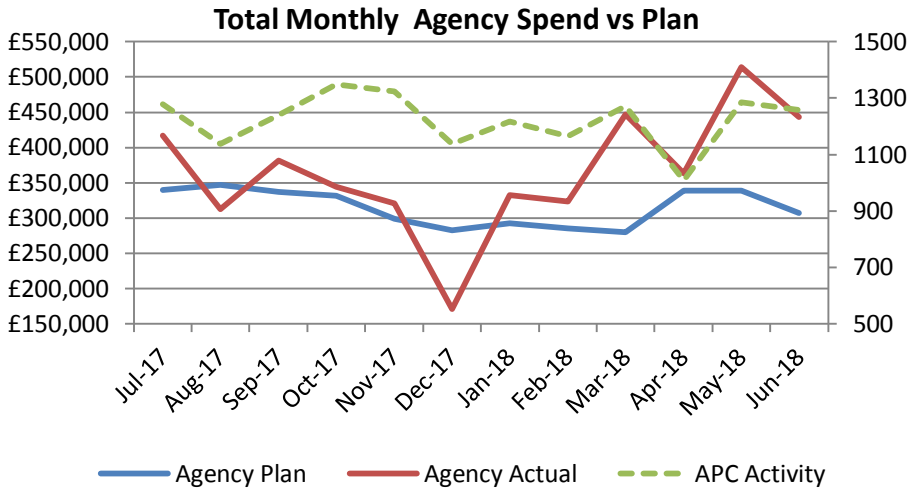
RISKS / ISSUES

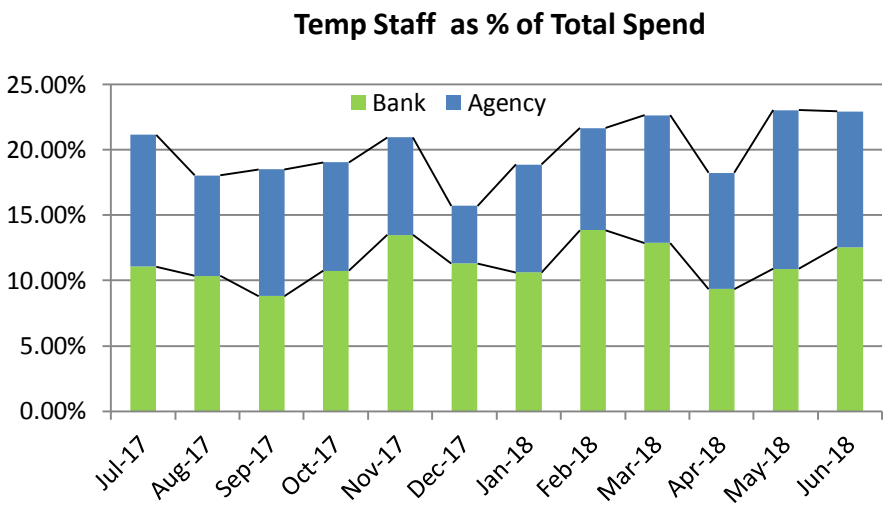
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops.

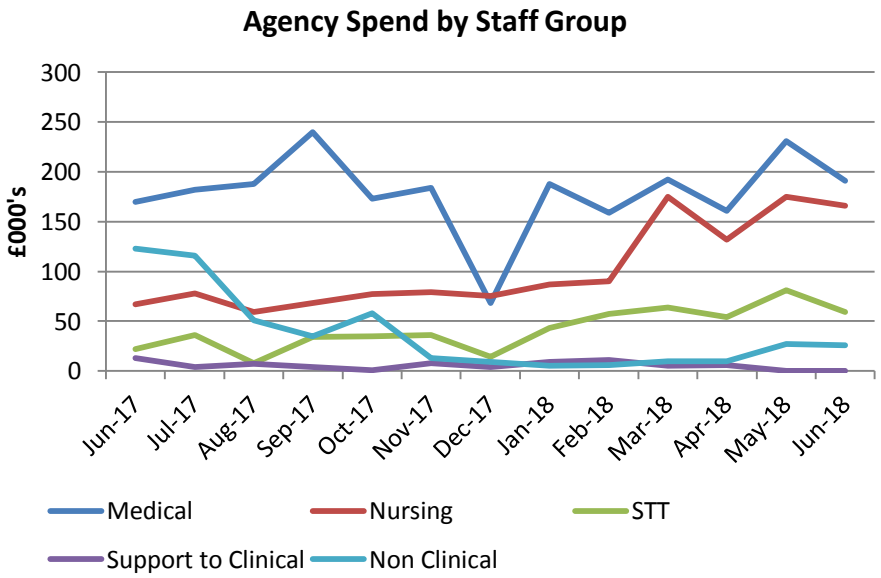
In addition, in month the final Agenda for Change pay rates have been finalised, and trust allocations provided. This have been based on planned levels of spend for AFC posts and bank, with a top-slice deduction for Workforce Reform and a DHSC scaling factor. This means that vacancies (and Agency costs) haven't been explicitly funded.

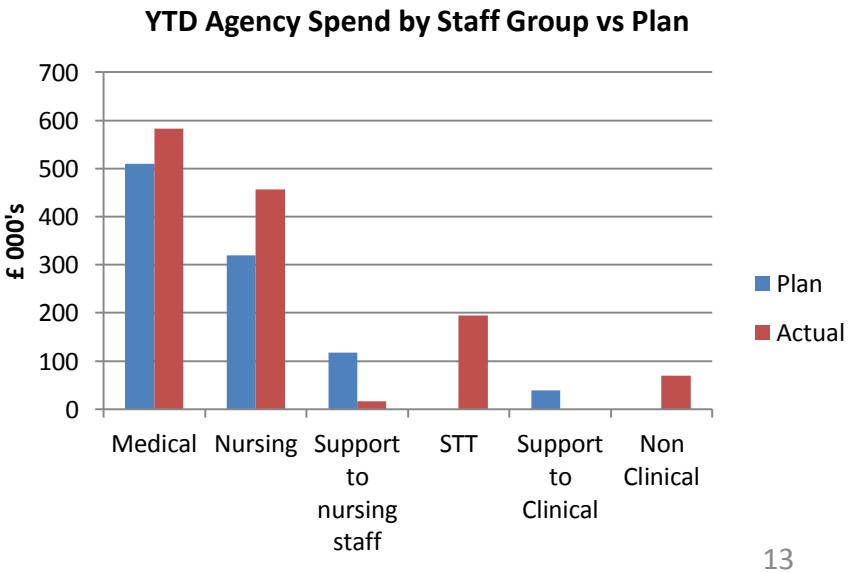
A revised analysis of the impact for the ROH will be presented at the meeting.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2018/19, and performance against the NHSI agency requirements









INFORMATION

Agency spend has seen a reduction on May's figure of £514,0000 to £443,000, but this still remains high in comparison to a rolling average of last year. As a result the agency cap remains overspent, which is impacting on the agency spend element of the Use of Resources Rating.

An analysis of the spend against plan shows that the main reasons for the overspend year to date are agency spend in nursing, medical and therapies.

Analysis of nursing spend using the rostering system suggests that there has been continued use of agency due to acuity, vacancies and sickness. Encouragingly however there are currently 38 nurses in the recruitment process, which should help to significantly reduce this level. Medical agency continues to be challenging due to the placement of deanery funded doctors, although the trust have had confirmation that the visa application for a medic has been approved which will result in one fewer locum from the Autumn.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

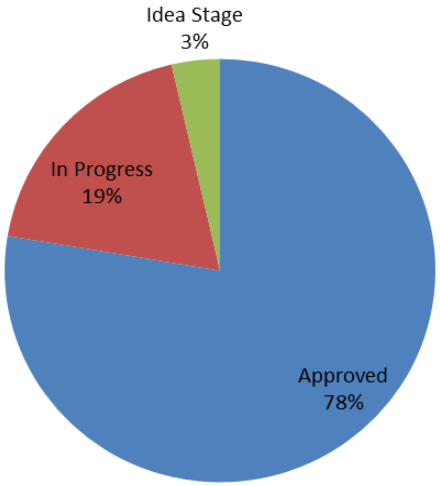
With regards to nursing agency, finance are working with the operational team to review the accuracy of agency spend categorisation on e-roster to allow targeted review and action on agency spend actions, particularly in response to activity variation and bed requirements.

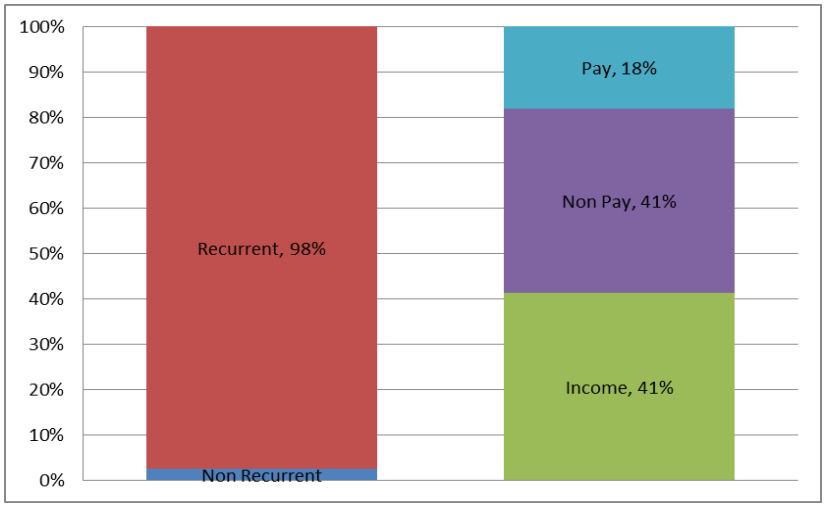
RISKS / ISSUES

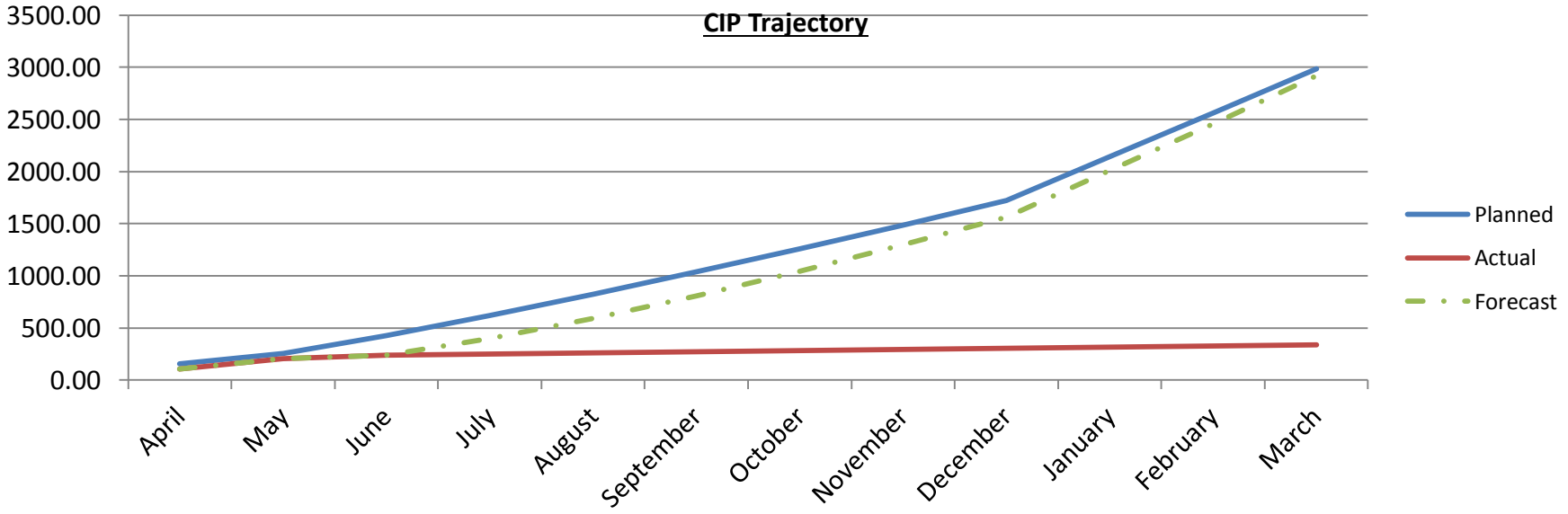
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

Within the annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

5. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2018/19







INFORMATION

The CIP target for 2018/19 is £3,000,000 of which £2,984,000 has been identified. During month 3 £34,000 of savings were recognised against a plan of £172,000. The current plan is based on 41% delivered through non pay savings, 41% through income schemes and 18% with pay schemes.

	Annual (£'000s)				Year to date (£'000s)		
	Plan	Actual Full year effect	Forecast	Forecast vs Plan Variance	Plan	Actual	Variance
Division 1	£705	£62	£806	£100	£73	£23	-£50
Division 2	£1,157	£25	£1,147	-£10	£103	£25	-£78
Division 4	£33	£0	£33	£0	£0	£0	£0
Corporate	£1,090	£250	£934	-£156	£251	£190	-£61
TOTAL	£2,984	£337	£2,918	-£66	£427	£239	-£189
Target			£3,000				
Unidentified plan against target	-£16						
Forecast against target			-£82				

ACTIONS FOR IMPROVEMENTS / LEARNING

A CIP Programme Board chaired by the Interim Director of Finance commenced on 19th April, with the second meeting now having been held. These will continue to be held monthly during Q2 with the frequency to be reviewed after this. The purpose of this group will be to monitor performance and escalate any risks/issues.

During 2017/18 the in year unidentified gap was not recovered, and as such significant work has been done to ensure full plans have been developed for 2018/19.

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the Managed Service Contract for Theatres scheme which is expected to deliver £550,000 from January 2019. A project group has been established and project specific resources are currently being identified to ensure that timescales can be met.

6. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M3 Plan £'000	M3 Actual £'000	Var £'000
Intangible Assets	685	633	(52)
Tangible Assets	48,489	47,567	(922)
Total Non-Current Assets	**49,174**	**48,200**	**(974)**
Inventories	4,858	4,955	97
Trade and other current assets	6,127	6,205	78
Cash	1,481	1,257	(224)
Total Current Assets	**12,466**	**12,417**	**(49)**
Trade and other payables	(12,891)	(12,051)	840
Borrowings	(1,543)	(1,591)	(48)
Provisions	(173)	(127)	46
Other liabilities	(207)	(639)	(432)
Total Current Liabilities	**(14,814)**	**(14,408)**	**405**
Borrowings	(4,479)	(3,979)	500
Provisions	(3544)	(335)	19
Total Non-Current Liabilities	**(4,833)**	**(4,314)**	**519**
Total Net Assets Employed	**41,973**	**41,895**	**(98)**
Total Taxpayers' and Others' Equity	**(41,973)**	**(41,895)**	**98**

INFORMATION

Tangible assets are significantly below plan due to slippage on various schemes throughout the trust. The Deputy Financial Accountant is in the process of reviewing each scheme in more detail with the respective scheme leads, and there has been focus placed in the divisional meetings on ensuring schemes will progress in a timely manner.

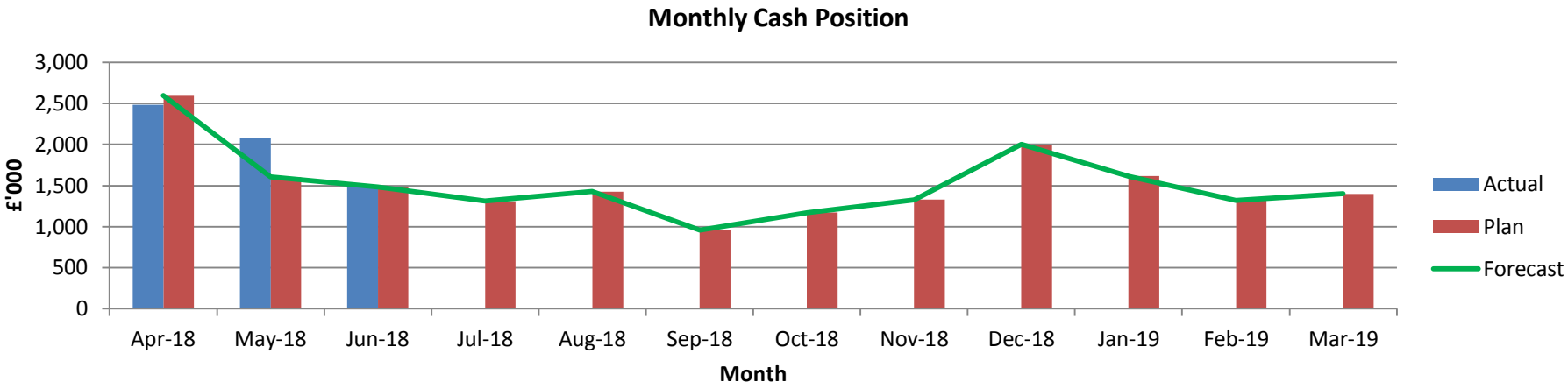
The variance on borrowings is as a result of the trust managing its cash in a manner to reduce the borrowing needed in addition to a higher than expected opening cash balance for the year. Subsequent to month end, the STF funding from last financial year of £1.8m was received into the bank, which has removed the need to borrow in July.

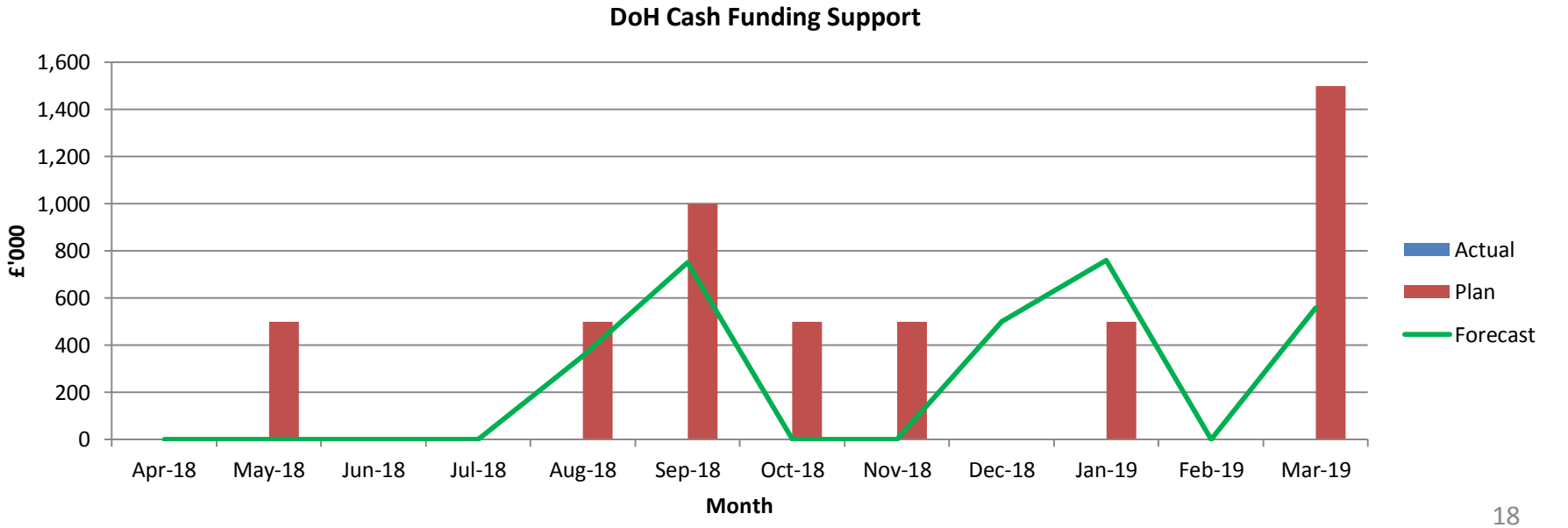
ACTIONS FOR IMPROVEMENTS / LEARNING

In the coming months, further balance sheet metrics regarding better payment practice code and debtor ageing will be included within the report.

RISKS / ISSUES

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 was £1,480k as per planned levels at the end of June.

Due to the reduction in cash, liquidity levels within the Use of Resources Rating have dropped to 4, the lowest level. Cash support was initially requested in July for £676,000, although this did not need to be drawn down due to the receipt of the STF funding of £1.8m after June month end. The next draw down is therefore expected to be in August and is in the order of £355,000.

ACTIONS FOR IMPROVEMENTS / LEARNING

The finance team continue to run a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team in order to scrutinise both the current and future cash position, but also to identify areas for cash control improvement. The committee continues to review cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the DHSC to be actioned.

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.

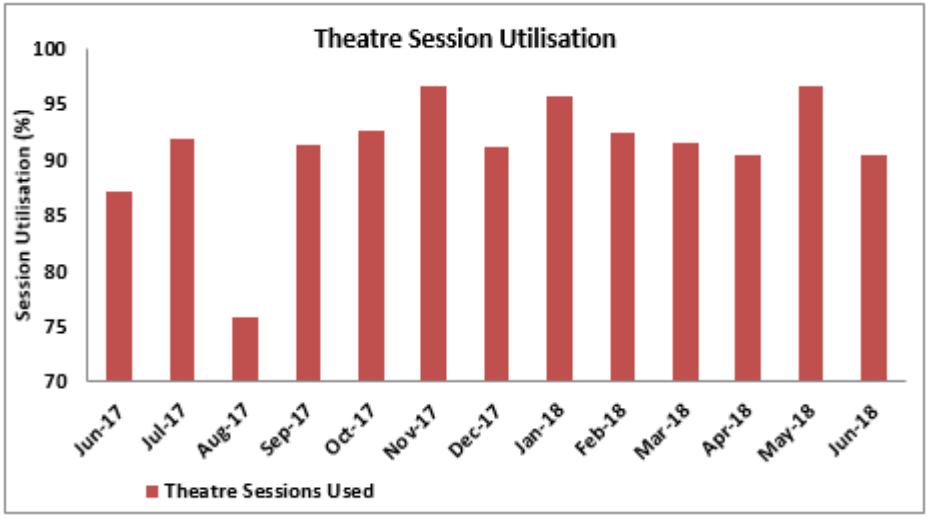
Based on the feedback from NHS Improvement the information provided to request funding was robust. The Finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

RISKS / ISSUES

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

The risk is in relation to DHSC not approving a cash loan or approving a lower than requested amount.

8. 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

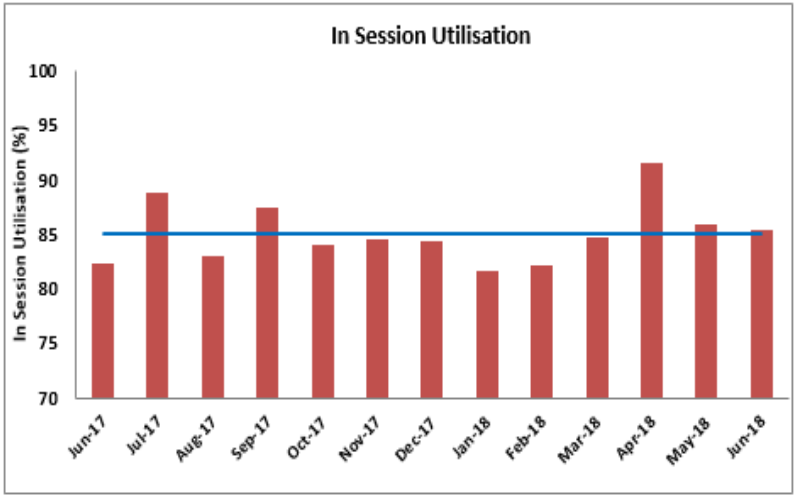
Theatre list utilisation for June was 90.42% compared to an exceptionally high level of utilisation in May (96%). The average utilisation is 93.51% for the period Nov '17 – May '18.

Issues remain around the ability to back fill fallow lists, with this trend likely to become more apparent during the summer holiday period. Re-profiling the utilisation target to take into the account the seasonal variation during July and August is being scoped out to ensure we are measuring utilisation against realistic parameters.

RISKS / ISSUES

- Equipment – not enough power tools etc. to keep up with increased activity/demand.

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



INFORMATION

Whilst sessional utilisation has remained strong, the average in session utilisation has struggled to reach the 85% over the last 6 months, although the average for the year is 84.8%. We are reviewing the correlation between the two measures.

Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 85.43% in June compared to the previous month (85.91%).

In session utilisation remains consistent, running at an average of 85% for the period Nov '17 – May '18.

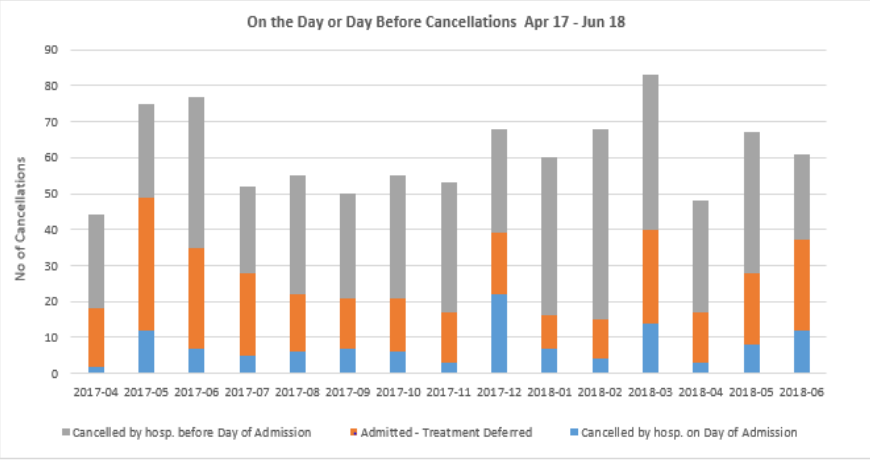
Areas to focus on remain reducing cancelations on the day but also on ensuring that lists are 'locked down' as much as possible to allow for better planning logistically, but also to trouble shoot any issues ahead of time that may impact on the day of surgery resulting in the possible cancellation of a patient on the day.

RISKS / ISSUES

- Last minute changes to lists impact on the efficient running and planning of theatre lists .

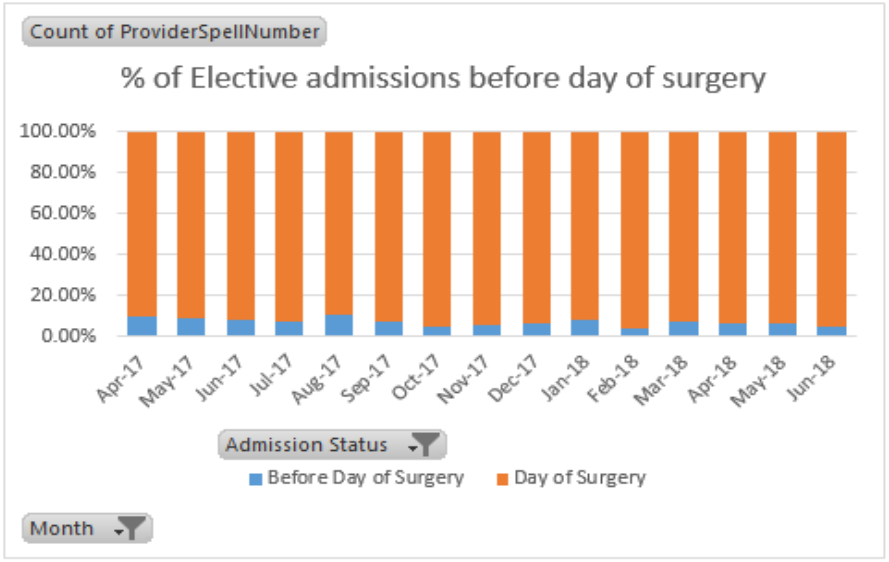
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

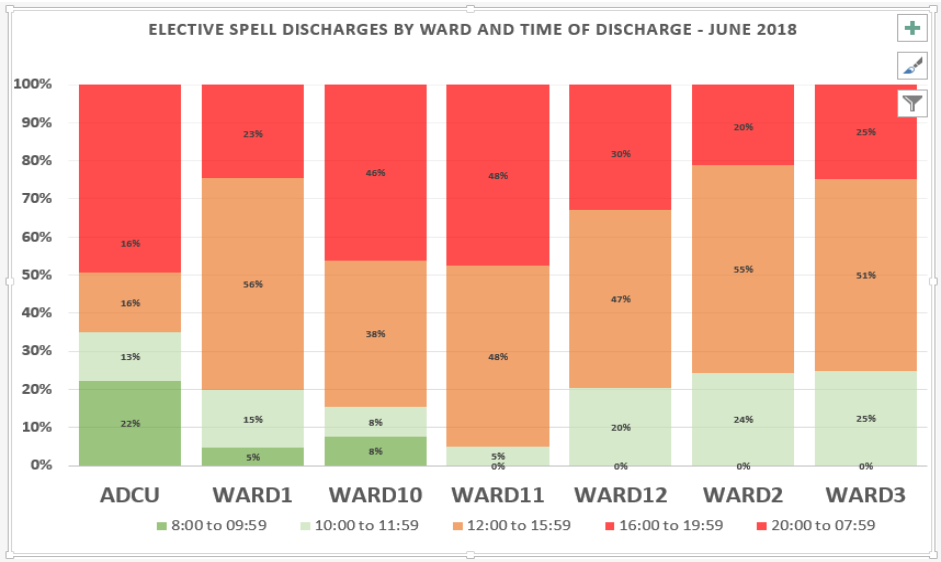
Hospital Cancellations



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	12	37	26	75	3
2017-06	7	28	42	77	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	14	26	43	83	0
2018-04	3	14	31	48	0
2018-05	8	20	39	67	0
2018-06	12	25	24	61	0
Grand Total	**118**	**285**	**513**	**916**	**10**

Admission the day before surgery





The number of cancellations on the day of surgery by the hospital has increased in June from 28 to 37.

An analysis of the 37 patients cancelled on the day of admission highlighted the reasons for cancellation varied across a range of issues, however the main contribution to the increase was due to unexpected Consultant sickness and Consultant date of session error. Other reasons included are ran out of theatre time and availability of equipment.

Cancellations before the day of surgery have decreased from 39 to 24 patients . An analysis of the 24 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery : patients being offered earlier dates for surgery, patients being deferred to accommodate emergencies and Pre-op cancellations due to patients not being fit for surgery.
A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The meeting now includes robust correlation with incident reporting prior to the meeting and analysis of issues identified at the theatre' huddle' meetings to ensure interventions are delivered to reduce avoidable cancellations, wherever possible. Senior Nursing staff from ADCU have also started to attend these meetings which is proving extremely useful to delivery of actions to reduce cancellations going forward and strengthen the process through the whole system.

Work continues to strengthen the POAC process A full workforce plan will be presented at Executive meeting in July to support a move to over recruitment of staff in preparation to commence training on the new Advance Practice Workforce Model.

ACTIONS FOR IMPROVEMENTS / LEARNING

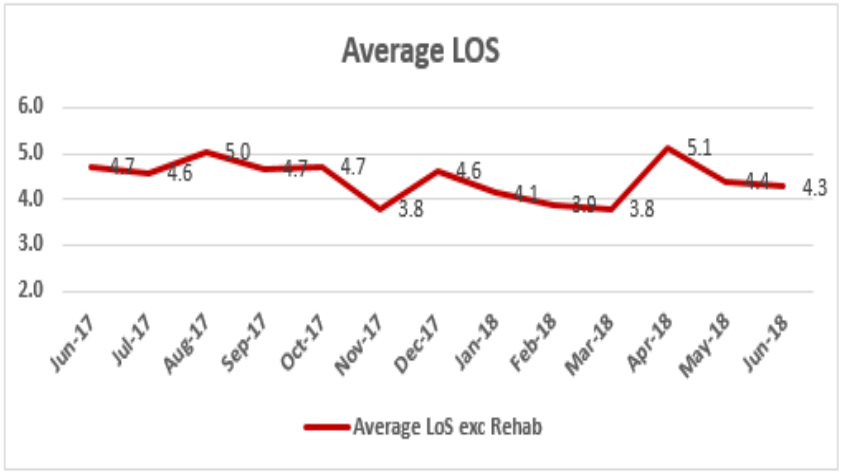
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

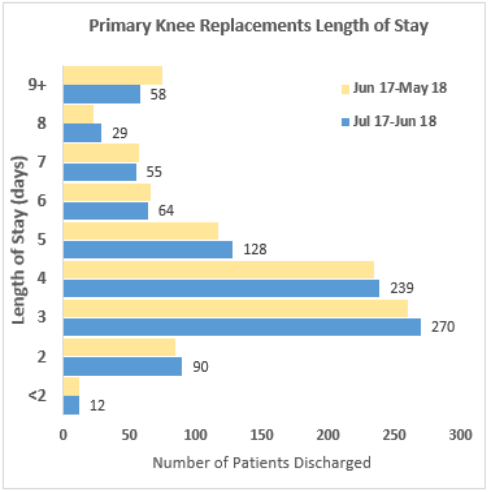
- Refresher training continues to support improved accuracy of data inputting on the PAS system to inform actions and allow robust audit of cancellation reasons.
- Stryker project is ongoing / weekly stakeholder meetings are in place .
- An audit of patients who DNA on the day of surgery is currently being undertaken and will be presented at Sept F&P meeting for wider discussion and sharing of an agreed action plan .
- Roll out of replacement theatre equipment continues.
- Additional power tools are currently being scoped and the Managed Service Contract is being developed to support delivery of a rolling replacement programme for theatre equipment.

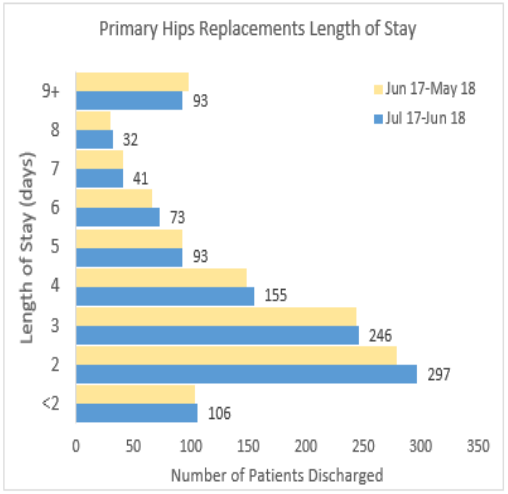
RISKS / ISSUES

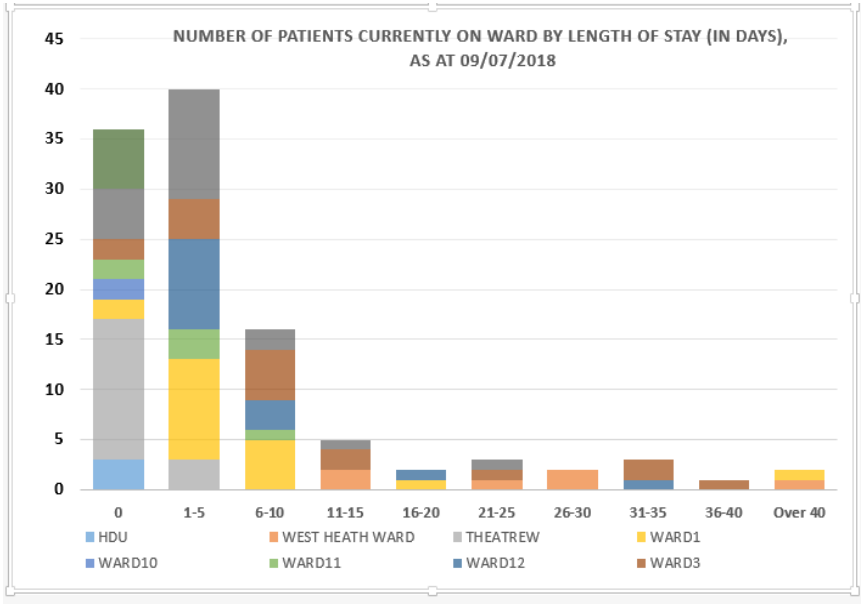
Shorter turnaround times for pre –operative assessment are required to respond flexibly to increased levels of activity.
Existing aging equipment asset base .

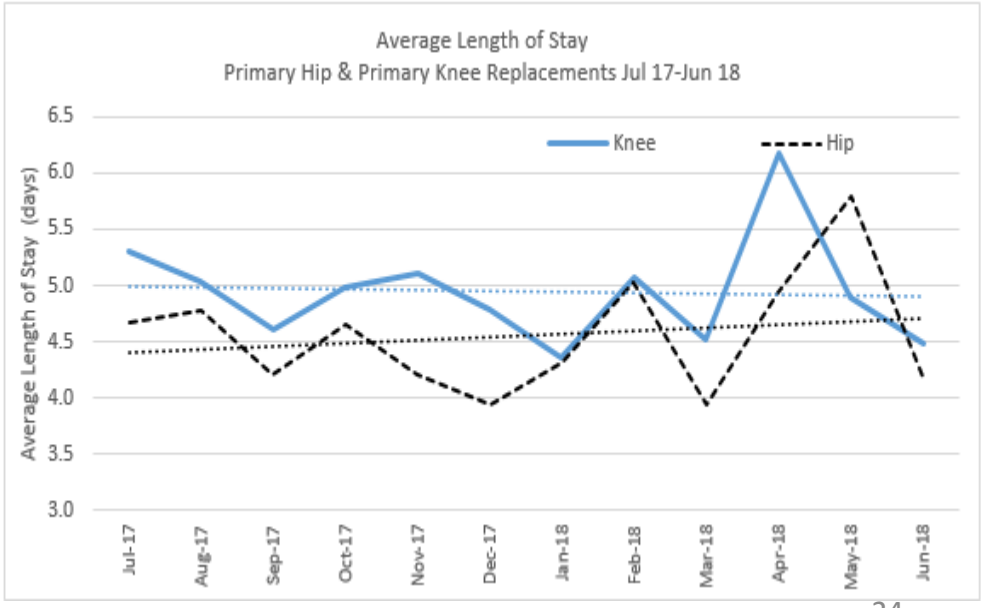
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS continues to decrease in June. Hip and Knee specific LOS has also reduced in June and is now ahead of trajectory , due to continued focus in this area .

- Red2Green is now embedded on all wards. Daily ward meetings continue to monitor LOS. A review of the guide to Reducing Long Hospital Stay has been presented to the senior nurses by the Head Nurse for Division 1 to generate discussion for further innovation in this area . One of the projects currently being scoped led by Head Nurse for div. 1 and Deputy COO is to introduce a multidisciplinary review of all patients with a protracted LOS (> 21 DAYS) as part of a regular LOS review involving the Duty Manager/ Lead Nurse/ Clinician .
- 'PJ paralysis challenge' is now completed and is embedded within ward practice. All wards participated in this challenge and a review of data supplied by / patients/ carers and staff to this national initiative will be shared at the LOS Meeting on 17th July chaired by Chris Ward to analyse the impact and share best practice to incorporate as ' business as usual.'
- 'Passport to Home' patient information has now been agreed and Passports have arrived and are currently being fitted behind each bed on all wards . The use of these passports will be monitored at the Los Meetings to review and refine going forward.
- Gold/Silver concept is now reinforced on all wards to support the improvement in the flow of patients and maximise utilisation of the discharge lounge. The discharge team have evidenced the use of Gold/Silver in the increasingly early movement of patients to the discharge lounge.

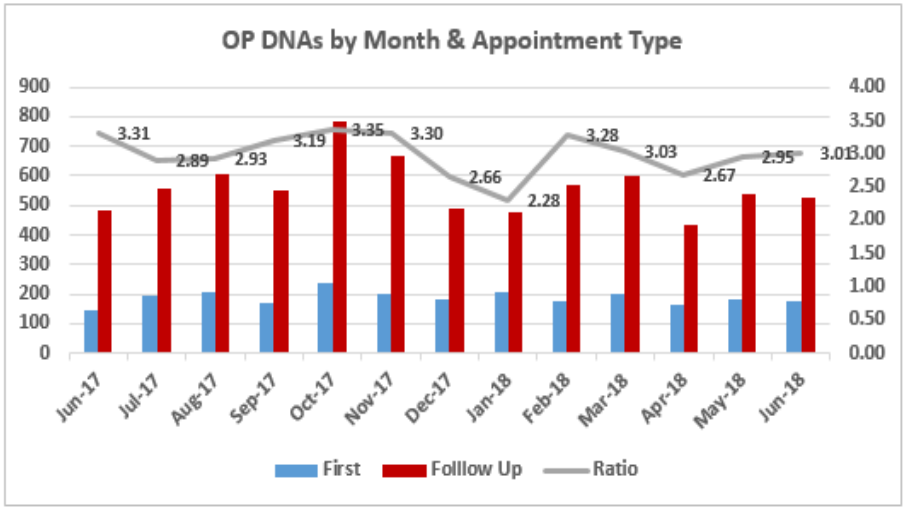
ACTIONS FOR IMPROVEMENTS / LEARNING

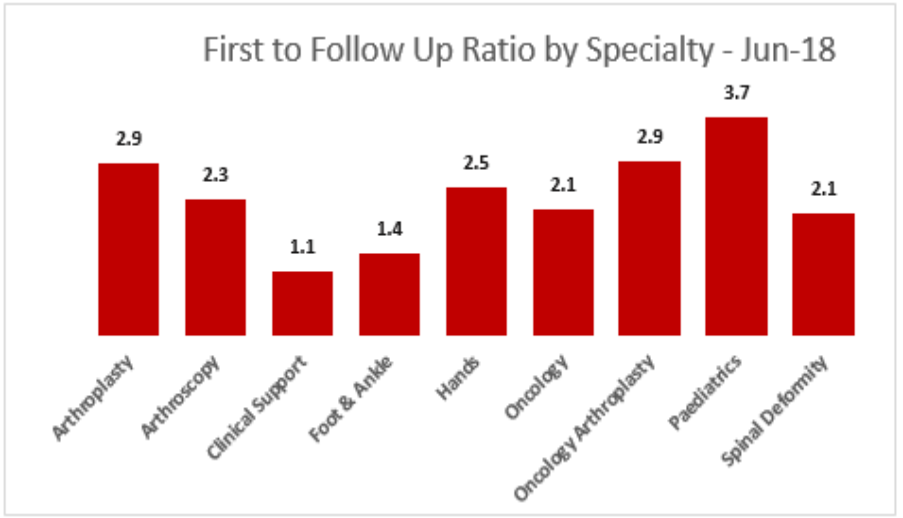
- The Red2Green dashboard development is now launched across all wards .The dash board records Green or Red days . This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds are now being rolled out across all wards so that all patients are reviewed to support timely discharge . Further work continues to develop with the Arthroplasty team which includes scoping to include anaesthetic support for ward rounds and the feasibility around a dedicated Theatre environment . This work will be progressed as part of the theatre expansion and redesign project to inform improved flow in theatres .
- To support the new national initiative of reducing long stays in hospitals by 25% , the Trust is currently reviewing actions which apply specifically to us e.g. for example, a technical solution for a real-time bed management system and criteria led discharge.
- It is envisage that there will be technical guidance published to support the measures with a Board level reporting tool. Further information will follow in the next few weeks

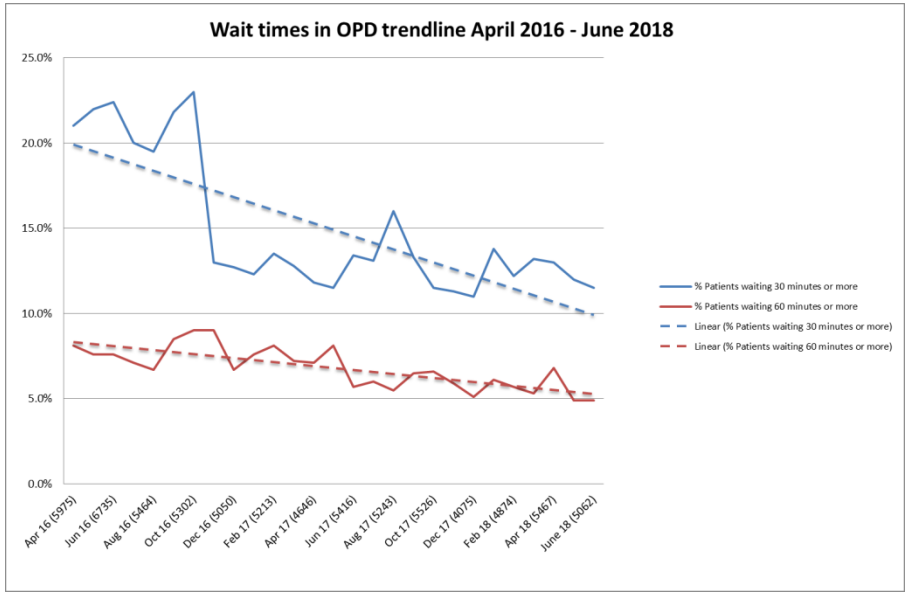
RISKS / ISSUES

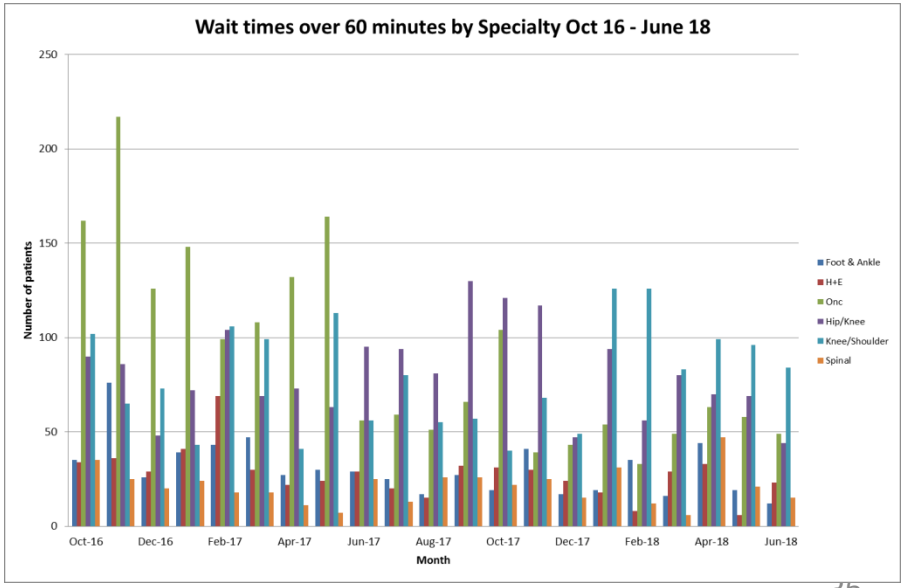
. A resilient focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity . A full bed modelling exercise will inform the future capacity required to deliver activity to support the wider STP orthopaedic alliance in line with the theatre expansion project .

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









INFORMATION

In June there were 6 incident forms completed to highlight clinics running more than 60 minutes late.
There were 11.5% of patients waiting over 30 minutes and 4.9% waiting over 1 hour which is below the target of 5% a level which has been maintained since the previous month. The over 30 minute waits have improved slightly from the previous month from 12%. The largest number of incidents were reported in Knee and Shoulder specialties which is consistent with the previous month.

The monthly audit identified the following : -

- 4 - Complex patients
- 2 - Clinic overbooked

All incidents continue to be investigated by the relevant operational managers. An audit of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause. This data is shared with the Ops team at the weekly Operational Management Team meeting to review trends and effect appropriate improvement interventions .

Data from a more detailed analysis of data done previously has identified 2 consultants whose clinics have the highest number of delays. The clinic templates for one of these consultants have already been reviewed and a review of the second consultant's clinics is planned soon. There is also going to be a review of appointment triage to ensure that consultants are identifying patients who need to have an x-ray on arrival rather than this decision being made on the day. A decision on the day of a patient's appointment to x-ray them could cause unexpected delay for the patient.

Recruitment within the main outpatient department for the qualified and unqualified nursing staff continues in order to provide sufficient cover for additional clinics as the need for additional capacity continues to be a major factor in clinic delays.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Observe how some of the clinics run for the consultants identified as having the largest number of clinic delays
- Review the triage of clinics and appointments by consultant in relation to x-ray or other imaging request forms
- Continue to monitor clinic delay data and share incident forms with operational managers
- Review clinic template of second consultant identified as having long delays
- Continue work to implement an upgrade of the InTouch system which should help with data reporting

RISKS / ISSUES

InTouch upgrade may be delayed due to a lack of IT resource due to competing priorities
Estates work to improve the environment within CYP OPD has not yet started and therefore InTouch is not being used in real time

13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

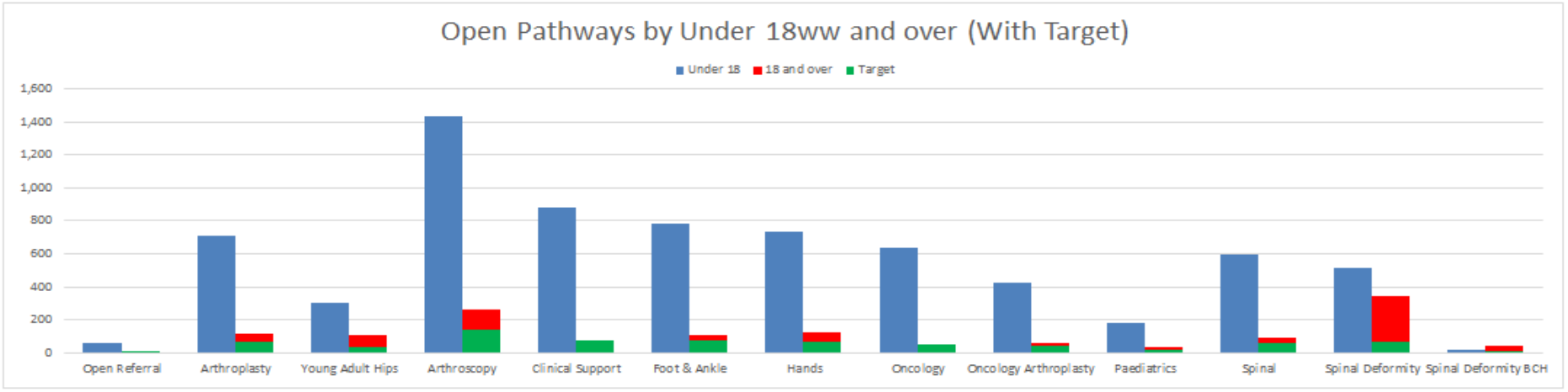
	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%
Apr-18	1,022	148	409	1,579	850	253	387	1,490	8	1,571	1,579	99.5%
May-18	1,002	136	353	1,491	725	236	373	1,334	1	1,490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1,256	1,261	99.6%

13. Referral to Treatment snapshot as at 30th of June 2018 (Combined)

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,735**	53	369	165	735	494	414	320	377	231	93	289	193	2
7-13	**2,487**	2	236	102	500	293	266	296	181	136	60	212	194	9
14-17	**1,050**	0	106	36	203	97	103	119	77	62	25	94	124	4
18-26	**840**	0	89	67	172	50	84	96	29	46	25	53	124	5
27-39	**367**	0	20	39	80	9	20	28	2	8	3	29	123	6
40-47	**75**	0	3	4	6	1	2	1	0	1	2	9	42	4
48-51	**19**	0	1	0	0	0	0	1	0	0	0	1	11	5
52 weeks and over	**61**	0	0	0	0	0	0	0	0	0	0	0	42	19
Total	**8,634**	55	824	413	1,696	944	889	861	666	484	208	687	853	54

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**7,272**	55	711	303	1,438	884	783	735	635	429	178	595	511	15
18 and over	**1,362**	0	113	110	258	60	106	126	31	55	30	92	342	39
Target	**691**	**4**	**66**	**33**	**136**	**76**	**71**	**69**	**53**	**39**	**17**	**55**	**68**	**4**
	84.23%	**100.00%**	**86.29%**	**73.37%**	**84.79%**	**93.64%**	**88.08%**	**85.37%**	**95.35%**	**88.64%**	**85.58%**	**86.61%**	**59.91%**	**27.78%**



13. Referral to Treatment snapshot as at 30th of June 2018

Select Pathway T Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**746**	0	102	55	167	56	26	76	87	65	18	71	21	2
7-13	**808**	0	137	30	214	43	27	103	35	59	25	89	38	8
14-17	**303**	0	38	6	96	14	4	42	26	23	11	22	18	3
18-26	**325**	0	47	23	107	6	8	38	11	22	10	29	20	4
27-39	**167**	0	12	21	63	2	7	9	0	3	1	14	29	6
40-47	**25**	0	3	3	1	0	0	1	0	0	1	4	8	4
48-51	**13**	0	1	0	0	0	0	1	0	0	0	1	5	5
52 weeks and over	**53**	0	0	0	0	0	0	0	0	0	0	1	33	19
Total	**2,440**	0	340	138	648	121	72	270	159	172	66	231	172	51

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**1,857**	0	277	91	477	113	57	221	148	147	54	182	77	13
18 and over	**583**	0	63	47	171	8	15	49	11	25	12	49	95	38
Target	**195**	**0**	**27**	**11**	**52**	**10**	**6**	**22**	**13**	**14**	**5**	**18**	**14**	**4**

	76.11%		**81.47%**	**65.94%**	**73.61%**	**93.39%**	**79.17%**	**81.85%**	**93.08%**	**85.47%**	**81.82%**	**78.79%**	**44.77%**	**25.49%**

Select Pathway T Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,989**	53	267	110	568	438	388	244	290	166	75	218	172	0
7-13	**1,679**	2	99	72	286	250	239	193	146	77	35	123	156	1
14-17	**747**	0	68	30	107	83	99	77	51	39	14	72	106	1
18-26	**515**	0	42	44	65	44	76	58	18	24	15	24	104	1
27-39	**200**	0	8	18	17	7	13	19	2	5	2	15	94	0
40-47	**50**	0	0	1	5	1	2	0	0	1	1	5	34	0
48-51	**6**	0	0	0	0	0	0	0	0	0	0	0	6	0
52 weeks and over	**8**	0	0	0	0	0	0	0	0	0	0	0	8	0
Total	**6,194**	55	484	275	1,048	823	817	591	507	312	142	457	680	3

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,415**	55	434	212	961	771	726	514	487	282	124	413	434	2
18 and over	**779**	0	50	63	87	52	91	77	20	30	18	44	246	1
Target	**496**	**4**	**39**	**22**	**84**	**66**	**65**	**47**	**41**	**25**	**11**	**37**	**54**	**0**

	87.42%	**100.00%**	**89.67%**	**77.09%**	**91.70%**	**93.68%**	**88.86%**	**86.97%**	**96.06%**	**90.38%**	**87.32%**	**90.37%**	**63.82%**	**66.67%**

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For June 2018 the RTT performance was **84.23%** with 61 patients over 52weeks (trajectory 68)

No patients were recorded as over 52 weeks in specialities other than Spinal Deformity.

ACTIONS FOR IMPROVEMENTS / LEARNING

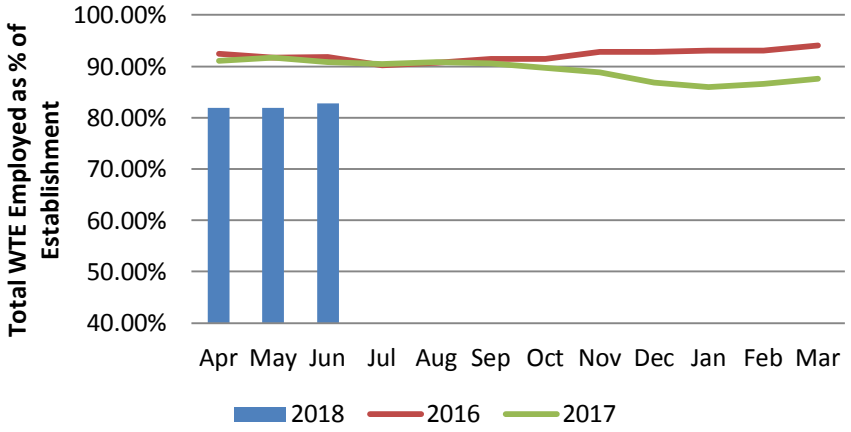
The team continue to concentrated on any patients over 40 weeks, albeit with the exception of Spinal Deformity this figure is now 31 patients. Whilst the trajectory was missed for June we continue to see an improvement in the number of patients waiting over 26 weeks. At the end of December 2017 we had 926 patients over 26 weeks, this figure has now reduce to 522 patients . Throughout July the team are working through a targeted list of patients who are listed with consultants with the longest waits. Good progress continues to be made by all the teams.

RISKS / ISSUES

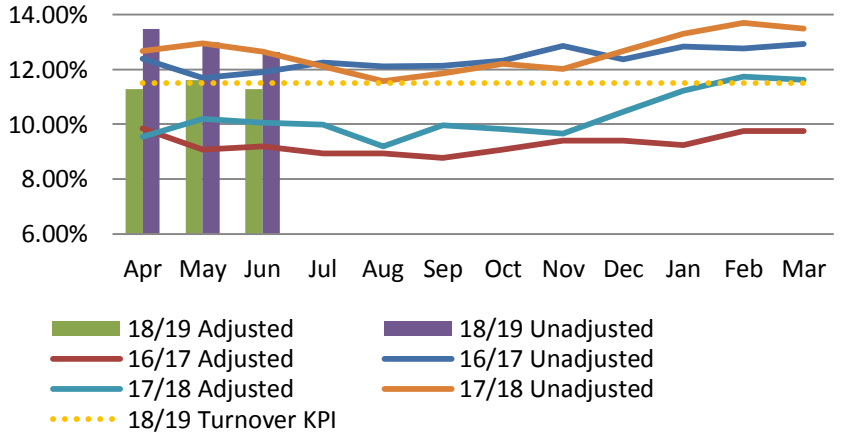
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance.
Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be January 2019 before an additional weekday list will commence. Weekend activity continues through the Summer with discussion underway to continue the lists until December 2018. Additional clinics are planned in OPD throughout August 2018 to help address the current wait. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families , one patient has been treated at the end of June 2018 .

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

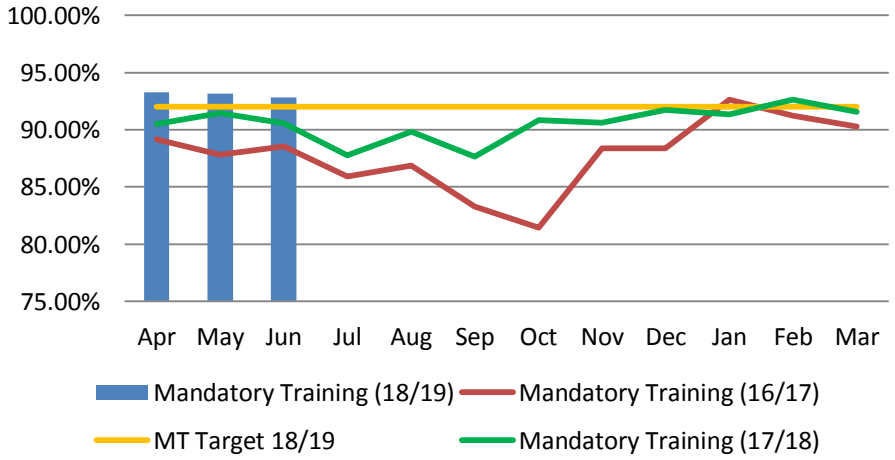
Staff in Post v Establishment



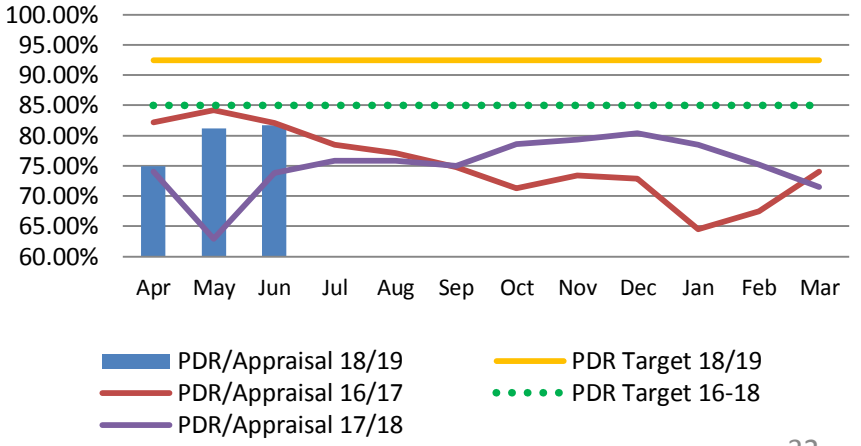
Staff Turnover



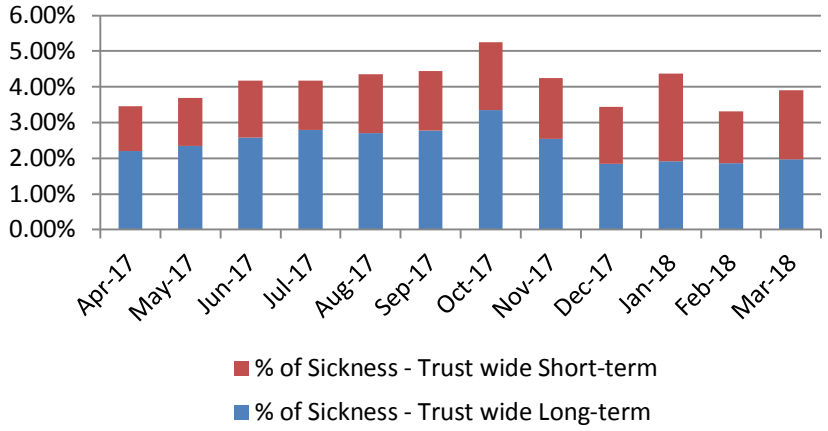
Mandatory Training



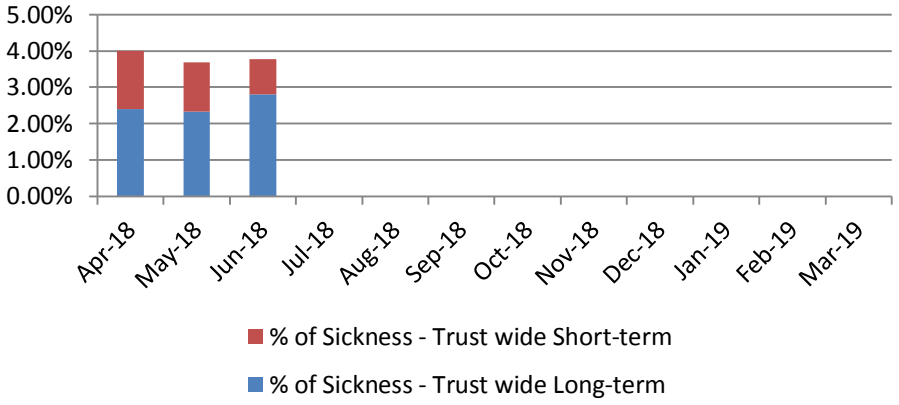
PDR/Appraisal



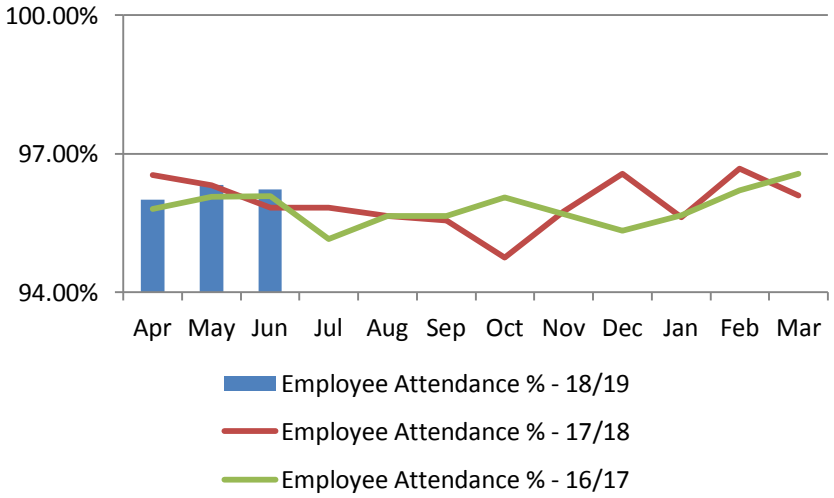
Sickness % - LT/ST (2017/18)



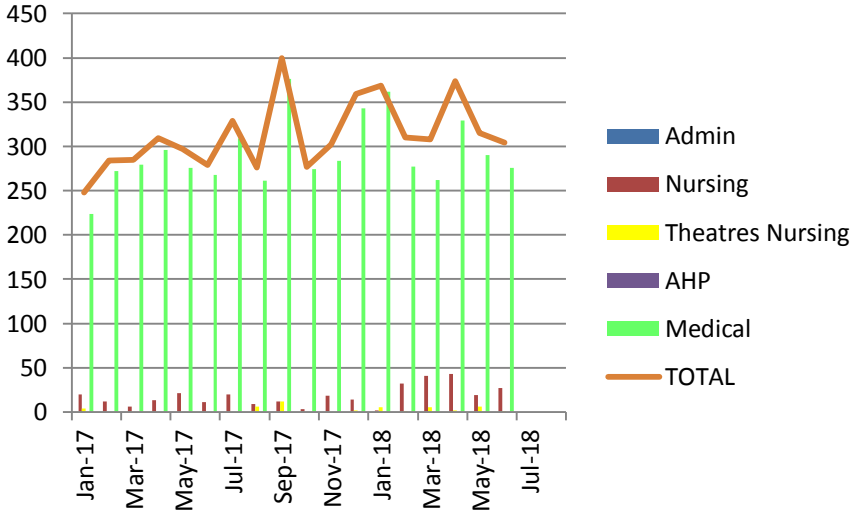
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

Overview: June was another relatively good month for workforce performance, with decreases in turnover and short term sickness absence, the vacancy position improved and a continuing "green" status for mandatory training.

This month the Trust's vacancy position saw a decrease from 18.14% to 17.21% with WTE employed percentage as 82.79% against a Trust target of 90%. Although, this is inclusive of a further small increase in the funded establishment since May.

Work has now been completed to align ESR to the ledger, the next steps to analyse vacancies and generate plans to fill vacant posts will be undertaken in the coming weeks.

Monthly attendance decreased slightly by 0.09% from a position of 96.32% in May 2018 to 96.23% in June 2018. Nonetheless remains green with our attendance performing above 96% for 5 out of the first 6 months of 2018, producing an average of 96.16%. Oppositely, our underlying 12 month average figure increased marginally to 95.80%.

Mandatory Training numbers sustained its "green" status with a June performance figure of 92.83%. The L&D Team are continuing to encourage staff to book onto courses or carry out their mandatory training via e-learning, for which speedier refresher training is also available.

June's appraisal performance increased by 0.53% to 81.75%, which is the highest it has been since June 2016, teams are making small growths towards the Trust's stretch target of 92.5%, which will take continued focus. HR are liaising with services to identify ways to make improvements.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) declined once again this month to 12.63%. The adjusted turnover figure (substantive staff leavers including retirements) also decreased to 11.29%, and turned green against a KPI of 11.5%

In June, Agency breaches decreased from 315 to 304 shift breaches in total, of which 276 were medical compared to 290 last month. Nursing agency breaches increased slightly, with POAC increasing from 19 to 27, whilst Theatres decreased from 6 to 1.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS/ISSUES

Further communications with paediatric services regarding the service transfer may produce deterioration in performance/increase in turnover: continued transparent and careful communications will continue to help to mitigate this.

Finance and Performance Report

July 2018

CONTENTS

INTRODUCTION

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

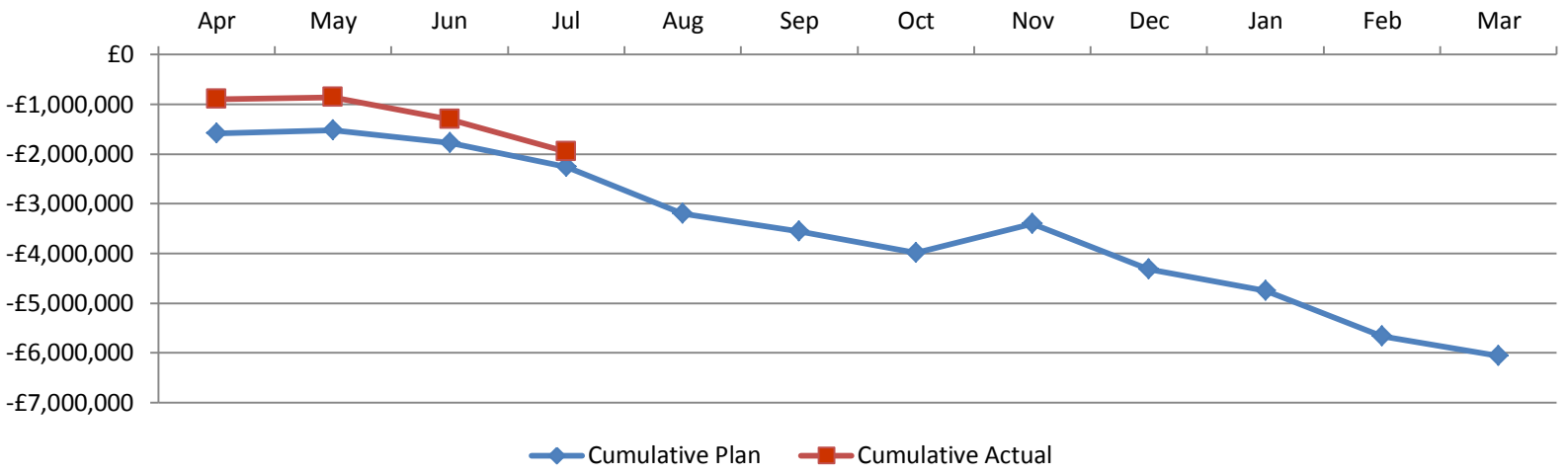
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

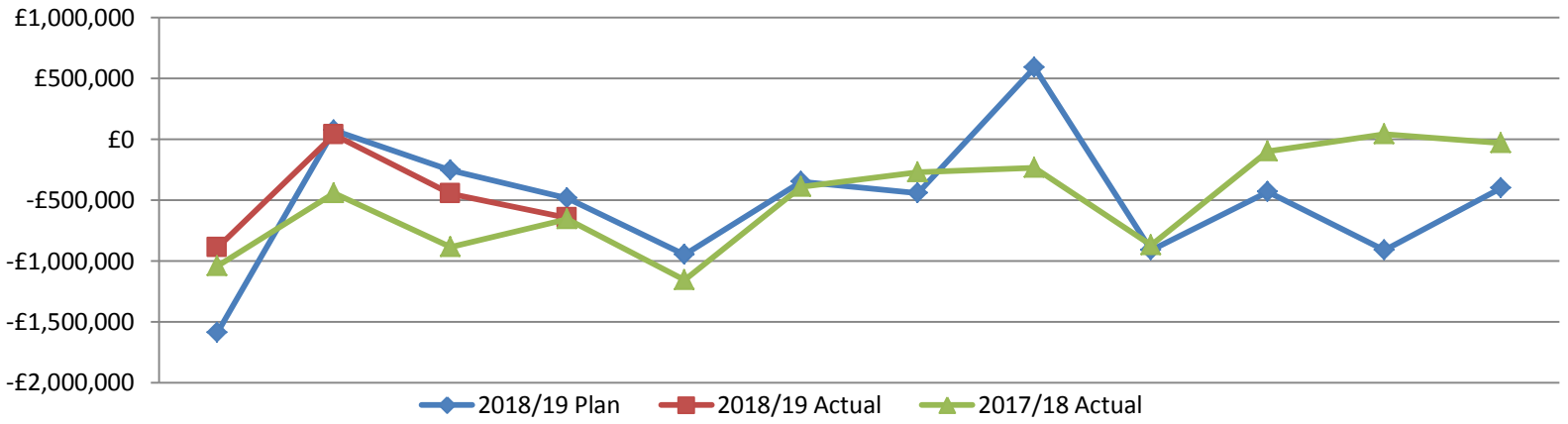
	YTD M4 Original Plan £'000	YTD M4 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	25,537	26,454	917
Other Operating Income	1,647	1,647	-
Total Income	**27,184**	**28,101**	**917**
Employee Expenses (inc. Agency)	(16,840)	(17,332)	(492)
Other operating expenses	(12,134)	(12,254)	(120)
Operating deficit	**(1,790)**	**(1,485)**	**305**
Net Finance Costs	**(468)**	**(464)**	**4**
Net deficit	**(2,258)**	**(1,948)**	**310**
Remove donated asset I&E impact	20	20	-
Adjusted financial performance	**(2,238)**	**(1,928)**	**310**

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 (excluding revaluation gains)



Monthly Surplus/Deficit Actual vs Plan (excluding revaluation gains)



INFORMATION

The Trust has delivered an in-month deficit of £548k in July against a a planned deficit of £388k, £160k behind plan. Year to date the Trust now has a a deficit of £1,948k in July against a planned deficit of £2,258k; £310k ahead of plan.

Inpatient activity reduced from July although still ahead of planned levels, however case mix has resulted in a slight underperformance in income. Day case activity has remained consistent and generated an over-peforrmance against plan.

More concerning is that expenditure has been high in month, £674k above plan. Pay is overspent in month due to increased agency expenditure (whilst the pay award has been accounted for in-month), whilst there has also been increased expenditure on prosthetics and drugs.

ACTIONS FOR IMPROVEMENTS / LEARNING

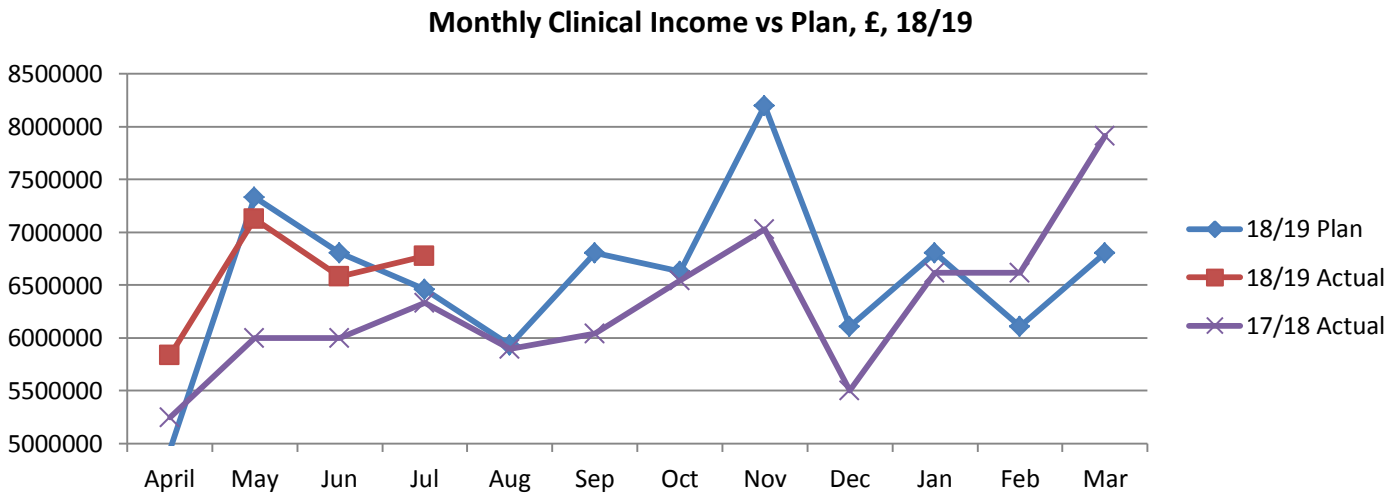
There needs to be focussed attention on bridging the gap on CIP schemes and if possible building in a slippage contingency to ensure the full year target is achieved.

In addition, the trust needs to ensure that it is building on the early activity headroom from months 1 and 2 to ensure that the trust continues to remain ahead of plan. This will help the trust remain on track during the latter months of the year when the transition of paediatric services is expected to occur.

RISKS / ISSUES

The Trust Board approved a business case this month for the intention to build a 4 theatre, 6 recovery bed, 23 bedded ward development over the coming 2 years. This creates fantastic opportunities to further support the STP and to grow income at the trust, but there will need to be careful management of the risks regarding staffing in particular.

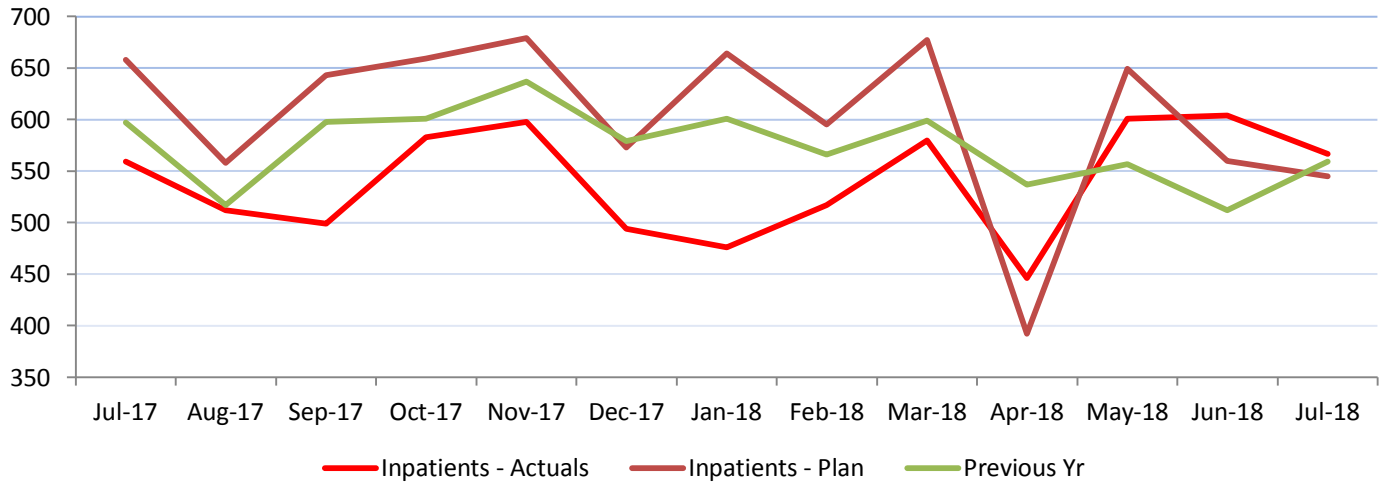
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



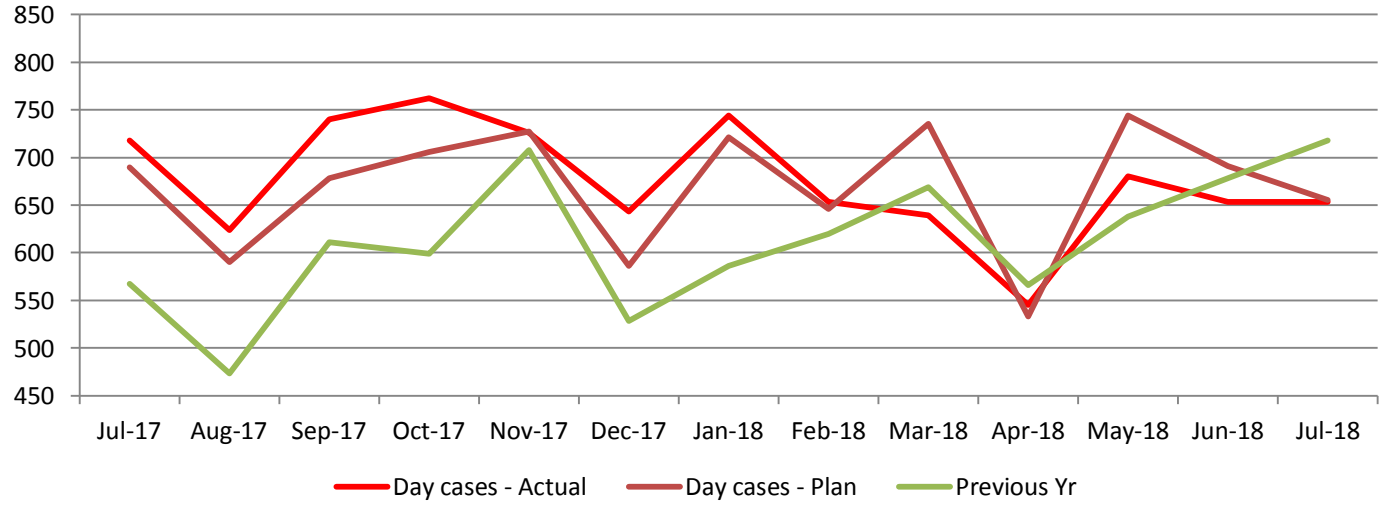
Clinical Income – July 2018 £'000			
	Plan	Actual	Variance
Inpatients	3,409	3,311	-98
Excess Bed Days	42	61	19
Total Inpatients	3,451	3,372	-79
Day Cases	811	989	178
Outpatients	632	651	19
Critical Care	223	221	-2
Therapies	230	258	28
Pass-through income	206	268	62
Other variable income	393	458	65
Block income	511	559	48
TOTAL	6,457	6,776	319

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	13,529	13,103	-426
Excess Bed Days	117	291	174
Total Inpatients	13,646	13,394	-252
Day Cases	3210	3397	187
Outpatients	2500	2590	90
Critical Care	880	793	-87
Therapies	645	992	347
Pass-through income	812	1036	224
Other variable income	1820	1882	62
Block income	2022	2234	212
TOTAL	25,535	26,318	783

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income has over-performed against plan by 4.94% in July having under-performed by 3.47% in June. Cumulatively, the trust is now 3.07% above plan. The admitted patient care performance was below plan financially but above on activity levels, with discharged activity 22 above the target. Average inpatient tariff for the period has increased by £81 per case but the case mix is still lower than April and May. Day case activity over performed financially but was below the target by 3 cases, the average tariff price for day case has increased by £239. July has had decreased levels of activity compared with June as expected. Case-mix in July has moved slightly as elective at 44% compared to 45% in June. For the year the elective makes up 44% year to date and day case 53%. Non Elective make up the other 3%.

Outpatients have over-performed year to date with a increase in attendances against plan in July for first and follow up attendances . First to follow up ratio has decreases year to date at 1.85:1.

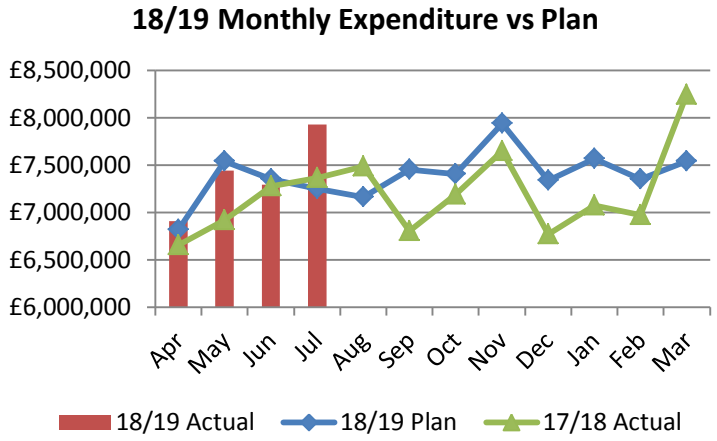
ACTIONS FOR IMPROVEMENT/LEARNING

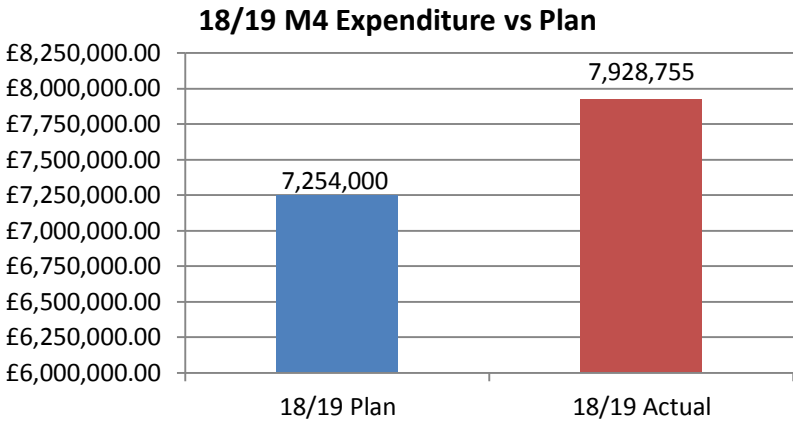
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

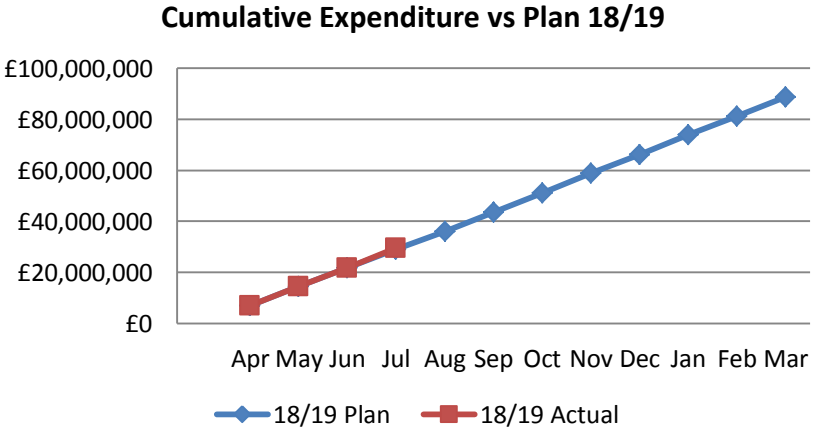
RISKS / ISSUES

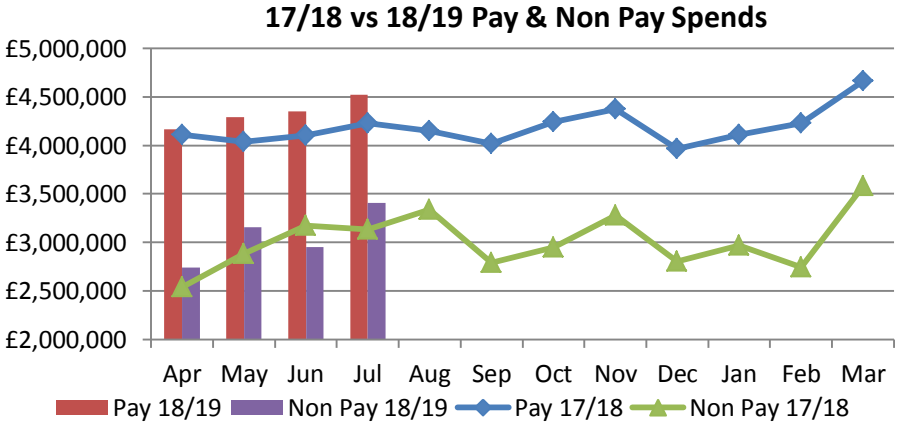
The month 4 position includes an initial in-month correction of previously overstated income. A further correction relating to the Q1 position will be made in month 5. The plan to achieve the control total will not be impacted by this.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends









INFORMATION

Current Month Expenditure is running at £7928k which is £674k above Plan of £7254k

Pay overspend in month of £326k has increased the ytd overspend to £492k. This relates mainly to Agency and bank spend being used to cover existing vacancies, further detail on the next slide.

AfC pay increases have been paid this month and arrears accounted for which contributes to the variance against plan.

Non Pay is £349k over plan resulting in a ytd position of £120k above plan, this relates to an increase in theatre costs and in particular prosthetic spending with a further additional increase in drug purchases in month.

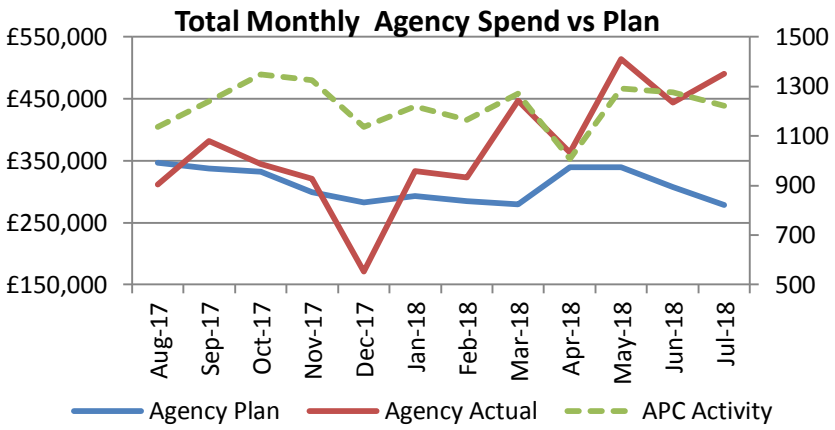
ACTIONS FOR IMPROVEMENTS / LEARNING

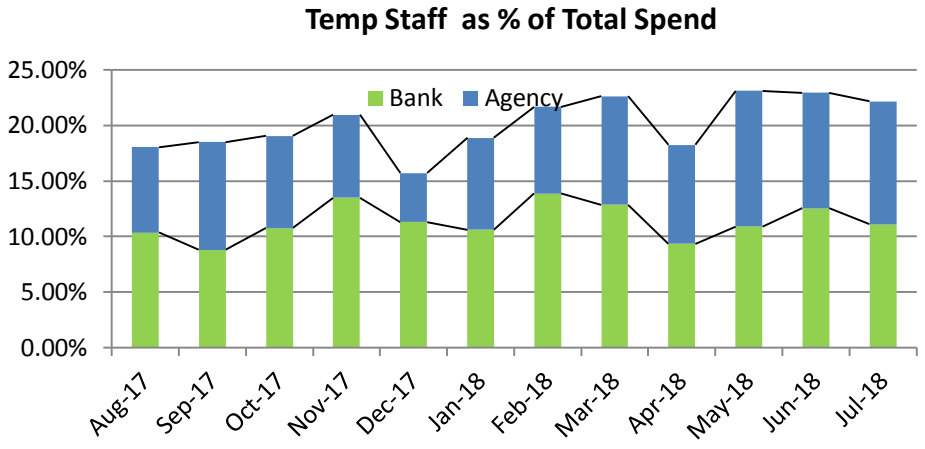
There is further learning from the year end stock count and subsequent audit which will be taken forward and acted upon within 2018-19 to give greater control over stock costs throughout the year. Monthly meetings are now taking place to review theatre spending between the Theatre manager, logistics and finance.

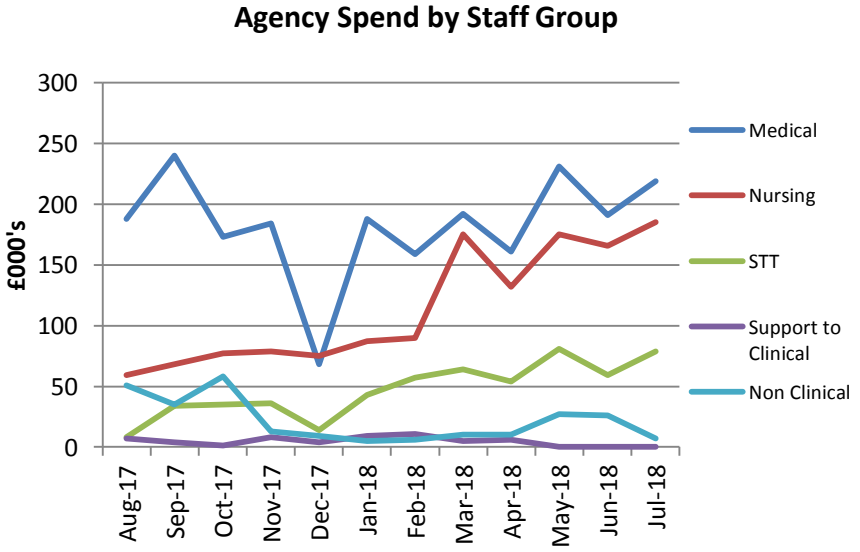
RISKS / ISSUES

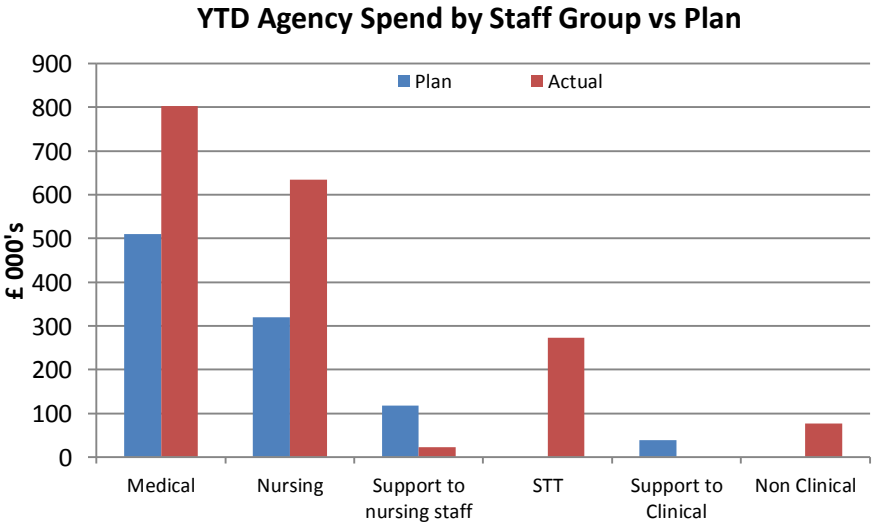
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Agency spend has increased by £49k to £490k in month which is £212k above the monthly plan and £548k above ytd plan.

An analysis of the spend against plan continues to show that the main reasons for the overspend year to date are agency spend in nursing (£246k), medical (£121k) and therapeutic (£128k).

Recruitment remains the main driver behind agency , although vacancies of 28.00 wte have been recruited to and 47.00 wte conditional offers made, this should help to improve the position in the next quarter. Medical agency continues to be challenging due to the placement of deanery funded doctors, although the trust have had confirmation that the visa application for a medic has been approved which will result in one fewer locum from the Autumn.

AfC change pay rate increase will impact on agency costs as and when levied by the prospective agencies in the coming months.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

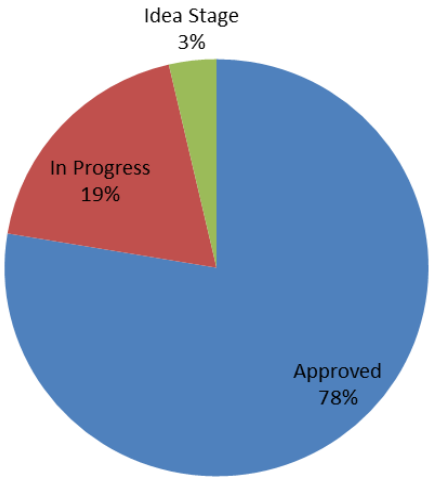
Review of e-Roster continues and shifts approved by the relevant Matron and head of Nursing.

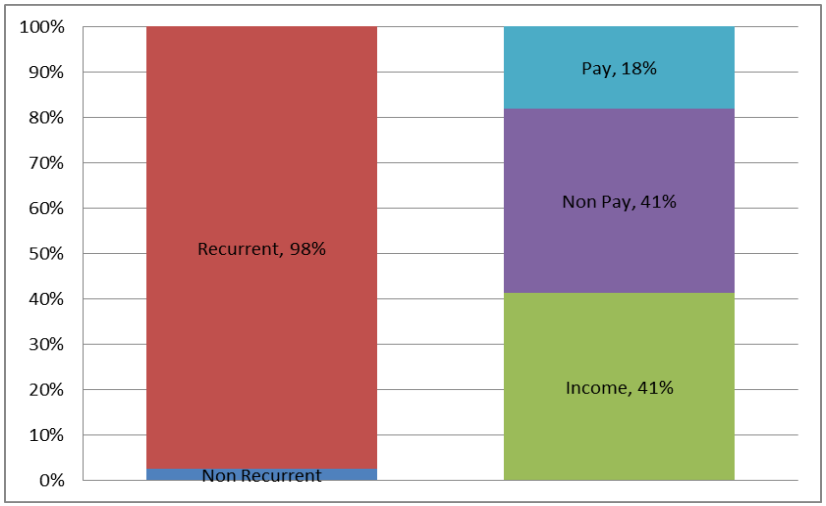
RISKS / ISSUES

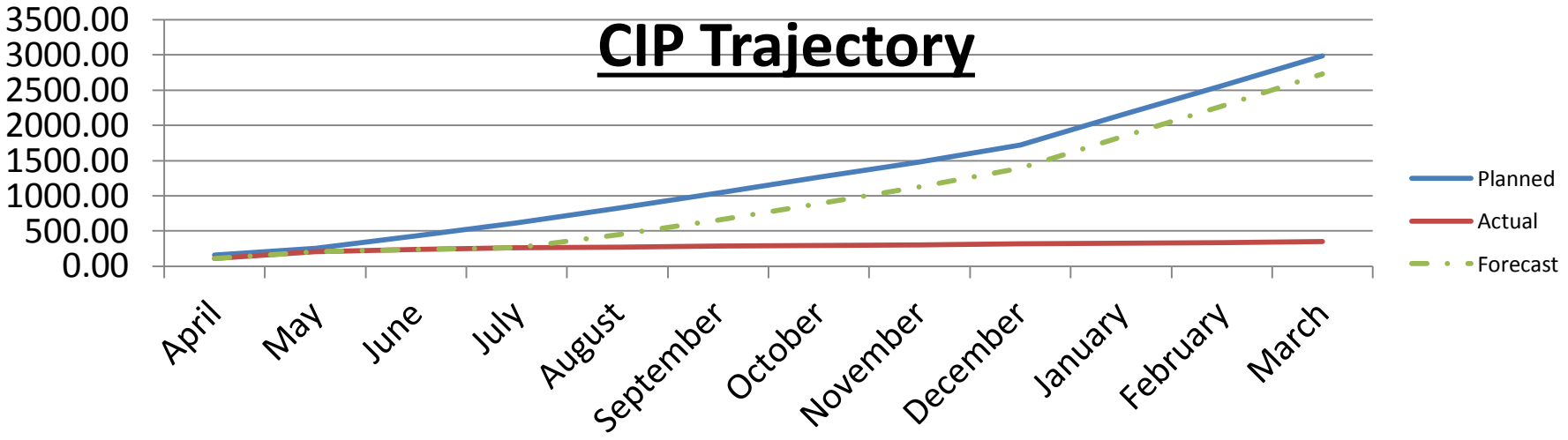
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

Within the annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

5. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2018/19







INFORMATION

The CIP target for 2018/19 is £3,000,000 of which £2,984,000 has been identified. At month 4 £261k of savings have now been identified against a plan of £427k

	Annual (£'000s)				Year to date (£'000s)		
	Plan	Actual Full year effect	Forecast	Forecast vs Plan Variance	Plan	Actual	Variance
Division 1	£705	£62	£719	£13	£73	£28	-£45
Division 2	£1,157	£34	£1,115	-£41	£103	£34	-£69
Division 4	£33	£0	£33	£0	£0	£0	£0
Corporate	£1,090	£252	£862	-£228	£251	£199	-£53
TOTAL	£2,984	£348	£2,728	-£256	£427	£261	-£167
Target			£3,000				
Unidentified plan against target	-£16						
Forecast against target			-£272				

ACTIONS FOR IMPROVEMENTS / LEARNING

There has been further slippage on schemes over the first part of the summer which now requires a renewed focus on delivery and mitigation.

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the Managed Service Contract for Theatres scheme which is expected to deliver £550,000 from January 2019. A project group has been established and project specific resources are currently being identified to ensure that timescales can be met.

6. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M4 Plan £'000	M4 Actual £'000	Var £'000
Intangible Assets	681	638	(43)
Tangible Assets	48,431	47,542	(889)
Total Non-Current Assets	49,112	48,180	(932)
Inventories	4,858	4,644	(214)
Trade and other current assets	5,797	4,740	1,057
Cash	1,310	2,476	1,166
Total Current Assets	11,965	11,860	(105)
Trade and other payables	(12,891)	(12,271)	620
Borrowings	(1,460)	(1,591)	(131)
Provisions	(173)	(108)	65
Other liabilities	(207)	(485)	(278)
Total Current Liabilities	(14,731)	(14,455)	276
Borrowings	(4,479)	(3,979)	500
Provisions	(354)	(354)	0
Total Non-Current Liabilities	(4,833)	(4,333)	500
Total Net Assets Employed	41,513	41,252	(261)
Total Taxpayers' and Others' Equity	41,513	41,252	(261)

INFORMATION

Tangible assets are significantly below plan due to slippage on various schemes throughout the trust. The Deputy Financial Accountant is performing a full review in a timely manner for next month end to ensure the trust will be on track to deliver its capital target by the year end.

The variances on borrowings are as a result of the ageing of the loans being incorrectly calculated at the time of the annual plan submission. The actuals therefore represent an accurate split. Borrowing is lower than expected at this time of the year overall due to the cash balances being higher than plan due to the receipt of the 2017/18 STF.

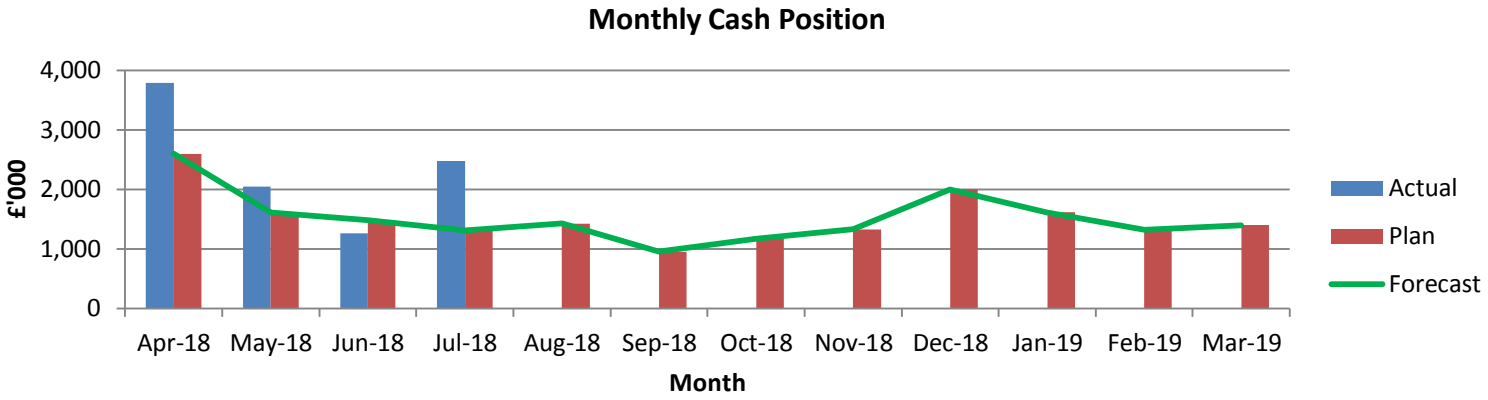
ACTIONS FOR IMPROVEMENTS / LEARNING

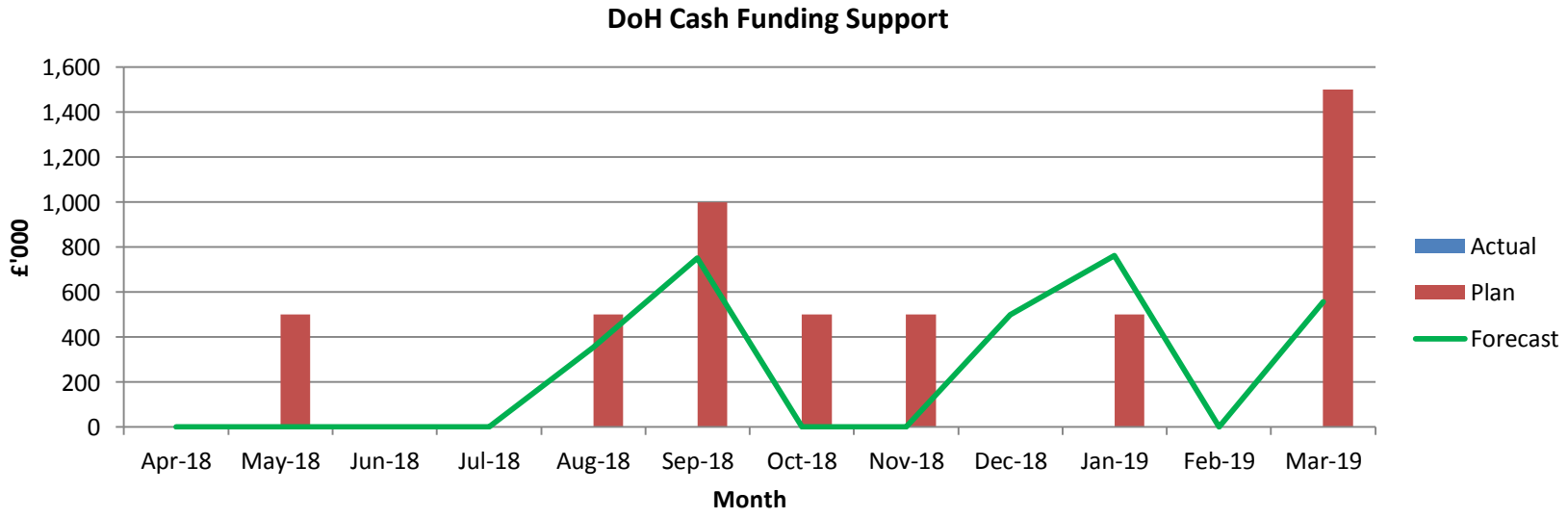
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances. NHSI have also asked all trusts for this analysis with a view to resolve balances held between NHS bodies.

RISKS / ISSUES

Despite receipt of STF, cash remains tight for the remainder 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 in addition to expected borrowing requirements from the Department of Health





INFORMATION

Cash was £2,476k following receipt of STF funds £1,844k during July.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level. Cash support has not been requested from the Department of Health (DoH).

ACTIONS FOR IMPROVEMENTS / LEARNING

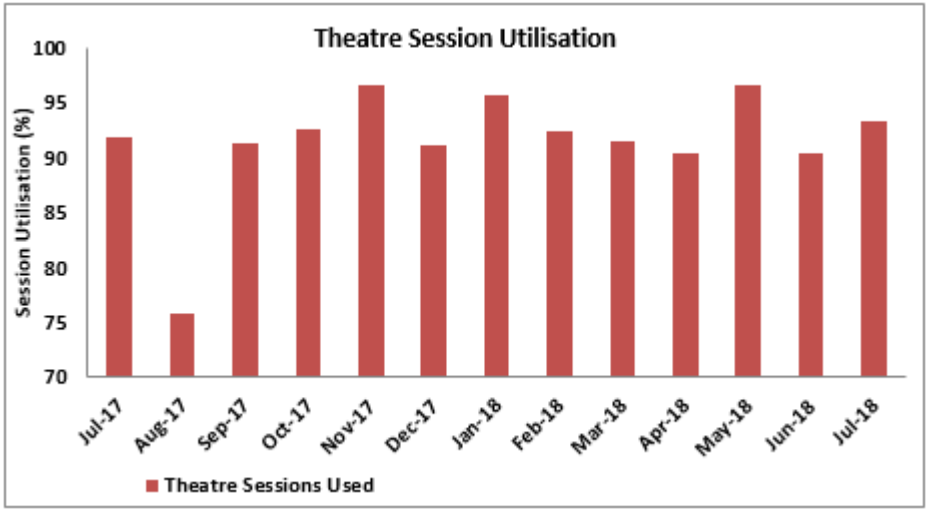
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2018/19. The Head of Financial Accounting has set up a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the Department of Health to be actioned.

DoH cash support - 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 SLA mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. 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

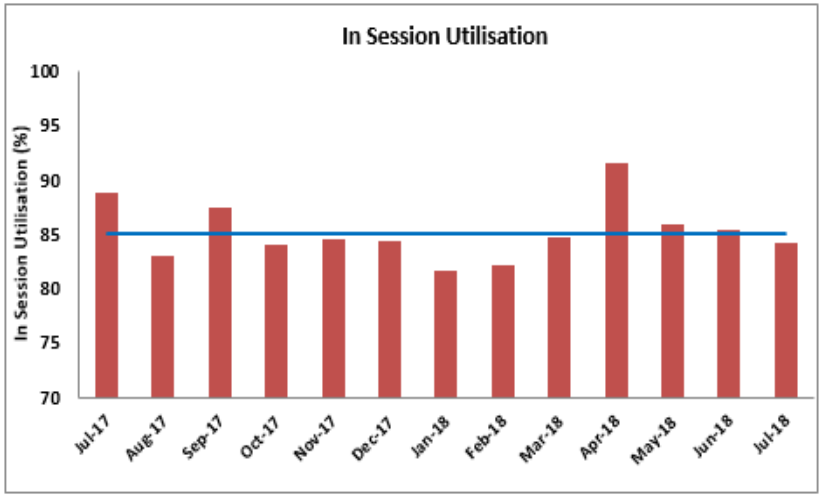
Theatre list utilisation for July was 93.65% compared to 90.42% in June. The average utilisation is 93.18% for the period Nov '17 – July '18.

Impact of the summer holidays will become more evident in August where it is expected that utilisation figures will dip below average.

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc. will also need to 'grow' alongside theatres to ensure maximum efficiency gains.
- Equipment – not enough power tools etc. to keep up with increased activity/demand.

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



INFORMATION

Whilst sessional utilisation has remained strong, the average in session utilisation has struggled to reach the 85% over the last 6 months, although the average for the year is 84.8%. We are reviewing the correlation between the two measures.

Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 84.28% in July compared to 85.43% in June.

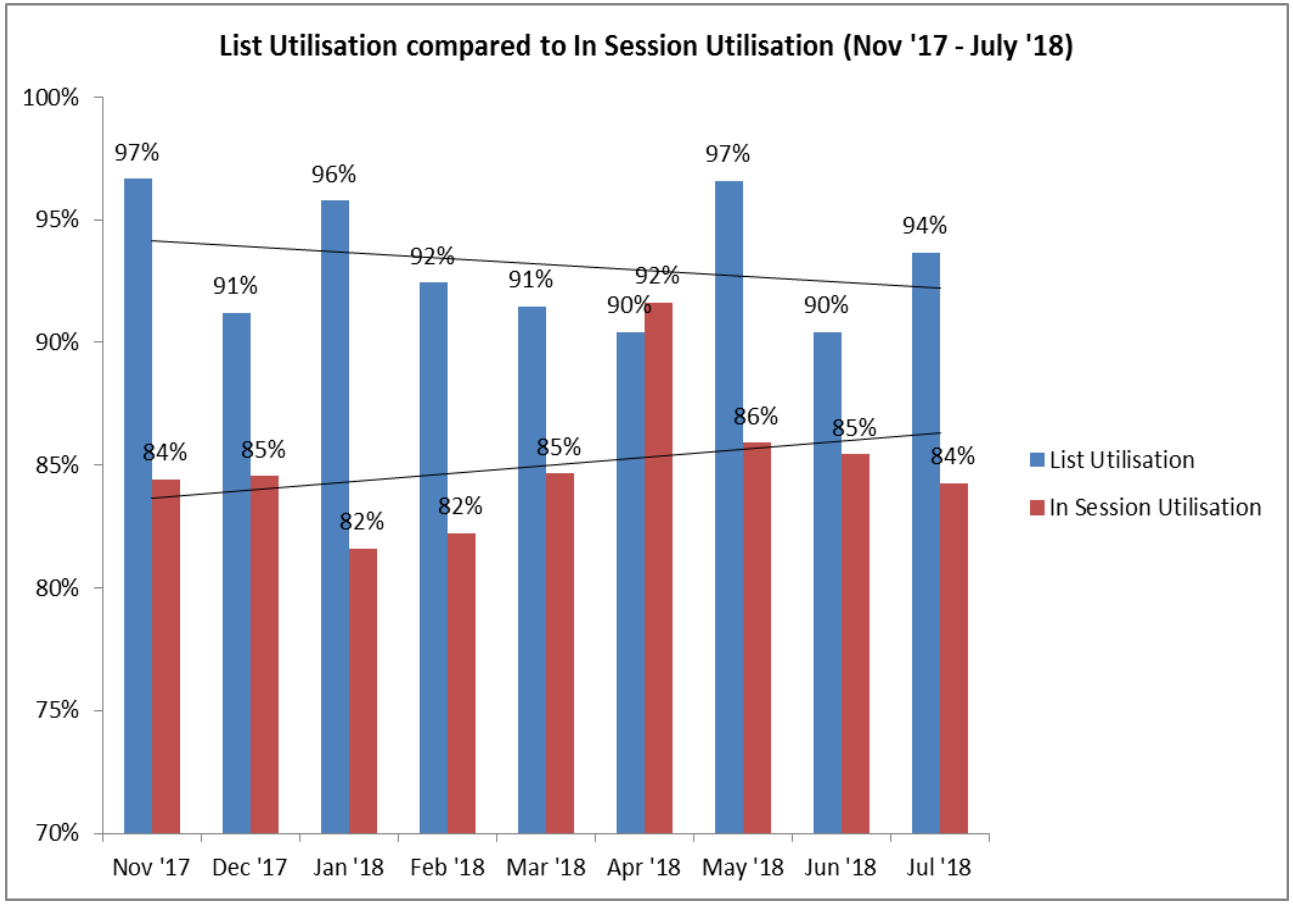
In session utilisation remains consistent, running at an average of 85% for the period Nov '17 – July '18.

At the weekly 6-4-2 meetings, more emphasis will be placed on the following week's theatre lists to ensure that lists are populated as much as possible, that all equipment requirements are clearly noted and that any specific requests identified. At the following week's 6-4-2 meeting, a look back will then be carried out to better understand what changes took place and the reasons why. This is to allow teams to start to work towards better management of lists and essentially begin the process of locking down theatre lists as much as possible.

RISKS / ISSUES

- Last minute changes to lists impact on the efficient running and planning of theatre lists .

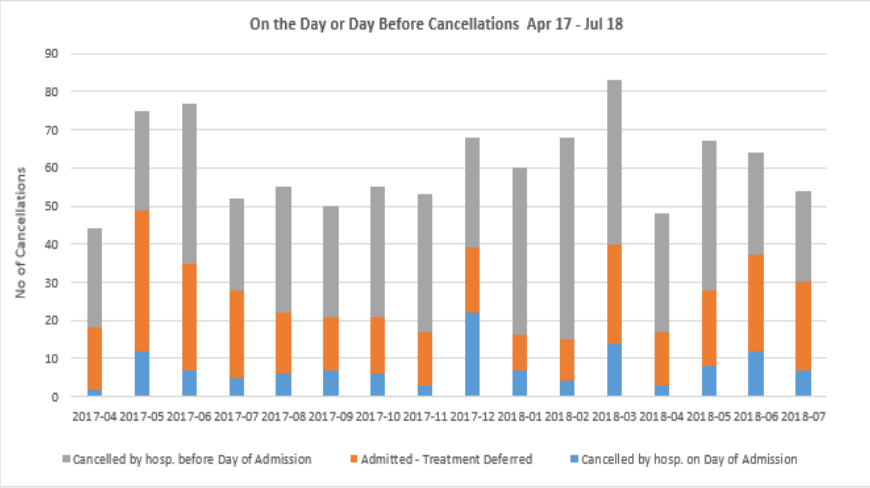
9a. Theatre List utilisation compared to In session utilisation – November 2017-July 2018



Mth	List Utilisation	In Session Utilisation
Nov '17	96.66%	84.43%
Dec '17	91.20%	84.55%
Jan '18	95.77%	81.61%
Feb '18	92.43%	82.23%
Mar '18	91.47%	84.65%
Apr '18	90.43%	91.61%
May '18	96.58%	85.91%
Jun '18	90.42%	85.43%
Jul '18	93.65%	84.28%
Average	**93.18%**	**84.97%**

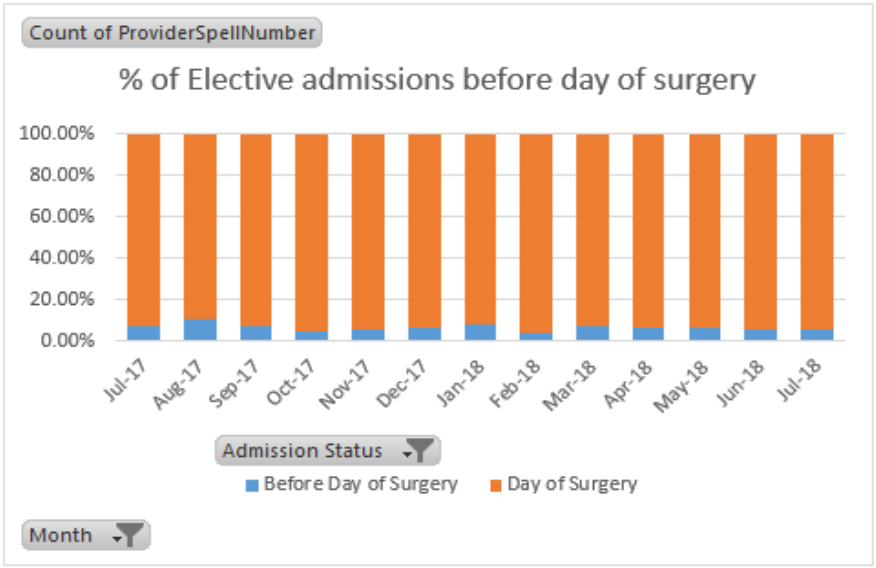
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

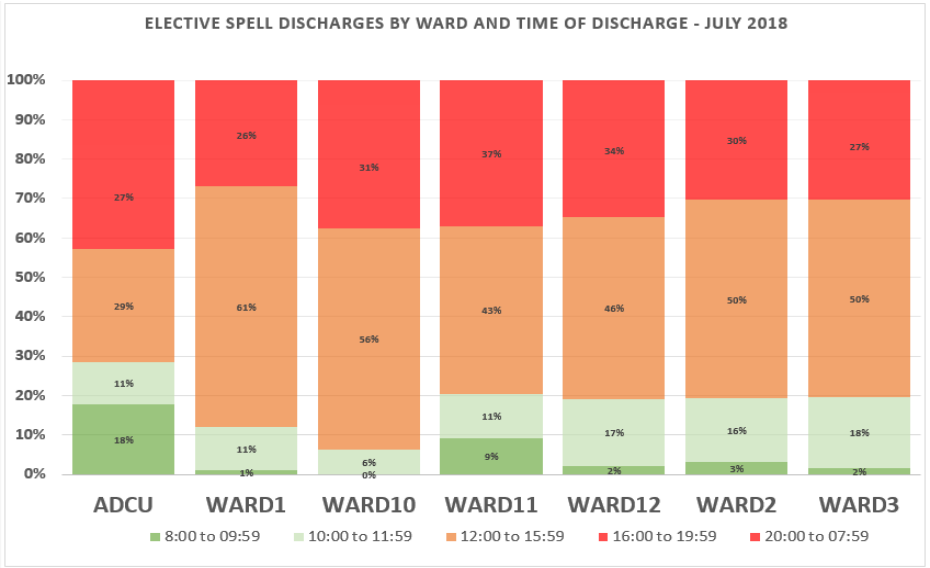
Hospital Cancellations



Sum of Total	Cancellation Categ				
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	12	37	26	75	3
2017-06	7	28	42	77	3
2017-07	5	23	24	52	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	14	26	43	83	0
2018-04	3	14	31	48	0
2018-05	8	20	39	67	0
2018-06	12	25	27	64	0
2018-07	7	23	24	54	0
Grand Total	**125**	**308**	**540**	**973**	**10**

Admission the day before surgery





The number of cancellations on the day of surgery (by the hospital) has decreased in July to 7 patients

Cancellations before the day of surgery have decreased in month from 27 to 24 patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The Terms of reference of this meeting have been revisited and now includes correlation with incident reporting prior to the meeting and analysis of issues identified at the theatre' huddle' meetings to ensure interventions are delivered to reduce avoidable cancellations, wherever possible.

Work continues to strengthen the POAC process supported with a full workforce plan which supports the move to over recruitment of staff in preparation to commence training on the new Advance Practice Workforce Model. Funding has been confirmed by HEE for 5 wte ACPs who will commence the course in September2018

ACTIONS FOR IMPROVEMENTS / LEARNING

Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

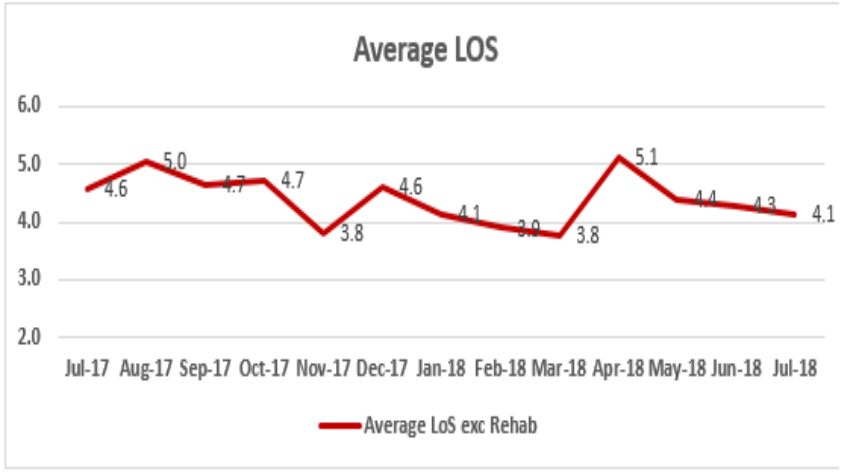
- Refresher training continues to support improved accuracy of data inputting on the PAS system to inform actions and allow robust audit of cancellation reasons.
- Jointcare project is ongoing with weekly stakeholder meetings in place.
- All cancellations by patients on the day of surgery are followed up with a telephone call from ADCU to understand the reasons

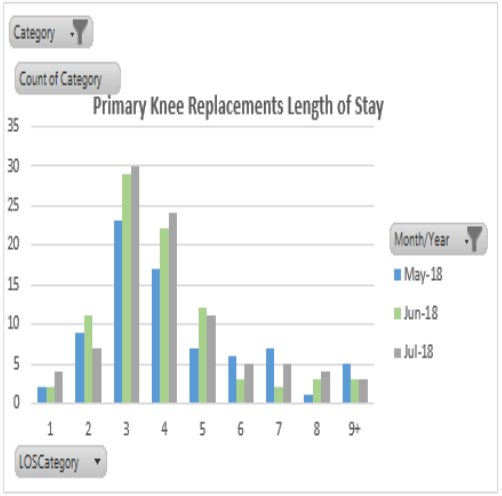
PERFECTING PATHWAYS

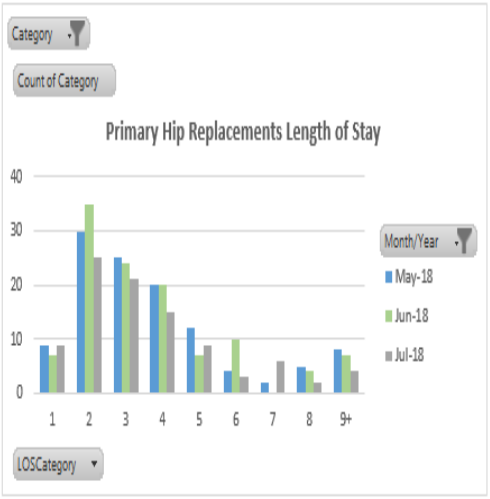
RISKS / ISSUES

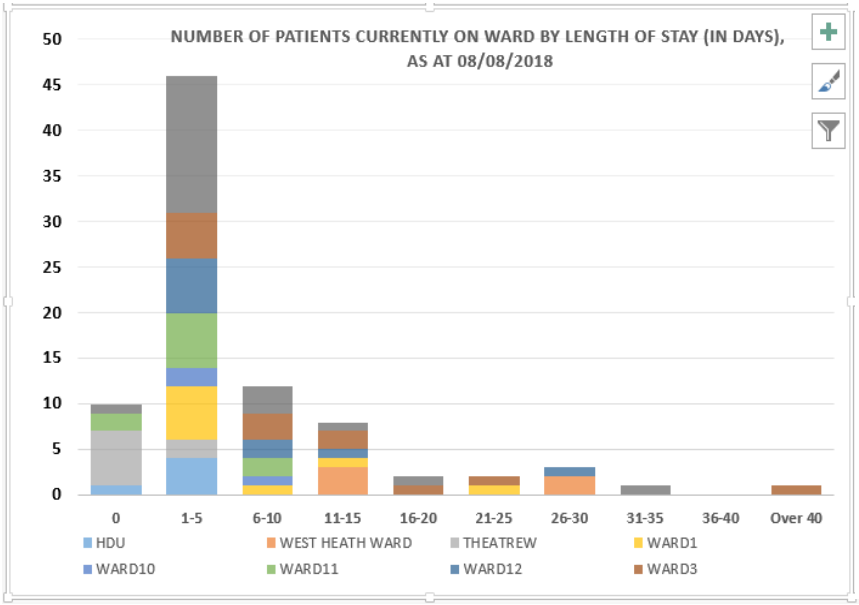
Existing aging equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools are currently being scoped as the Managed Service Contract is being developed to support delivery of a rolling replacement programme for theatre equipment.

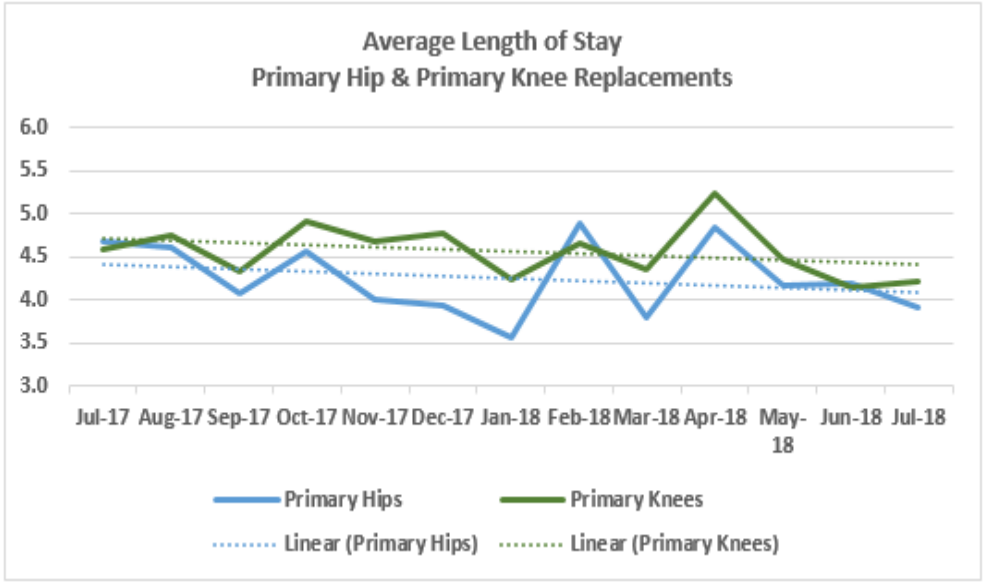
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS has decreased in July 18 supported by a number of initiatives which are in place :

- Red2Green is now launched on all wards. Discharges are now identified the day before discharge and on day of discharge the ward staff work closely with the discharge team to ensure timely discharge . A weekly ward meeting is now in place with ward managers and the discharge team to raise and resolve issues relating to discharge and deliver continuous improvements in the process. Further work is now ongoing on introducing a weekday daily meeting to escalate issues which are not resolvable at ward level.
- 'Passport to Home' patient information has now been agreed and rolled out on all wards . This includes a patient/ROH agreement regarding Estimated Date of Discharge (EDD), provision of patients own clothes and transport arrangements.
- Gold/Silver concept is now reinforced on all wards to support the improvement in the flow of patients and maximise utilisation of the discharge lounge. The discharge team have evidenced the use of Gold/Silver in the increasingly early movement of patients to the discharge lounge.
- Daily Operational bed meetings are now embedded to escalate any delays for social care , inter-hospital transfer and expedite appropriate discharges .
- A Daily Consultant led MDT ward round on Ward 2 (Arthroplasty)

A full programme of work is ongoing with the Jointcare project to reduce length of stay for Hips & Knees which is planned to go live on 5th November

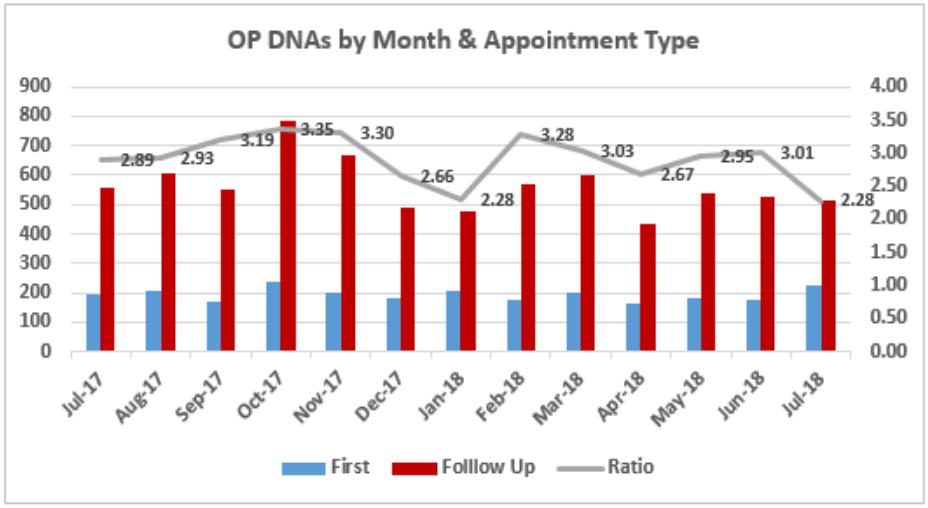
ACTIONS FOR IMPROVEMENTS / LEARNING

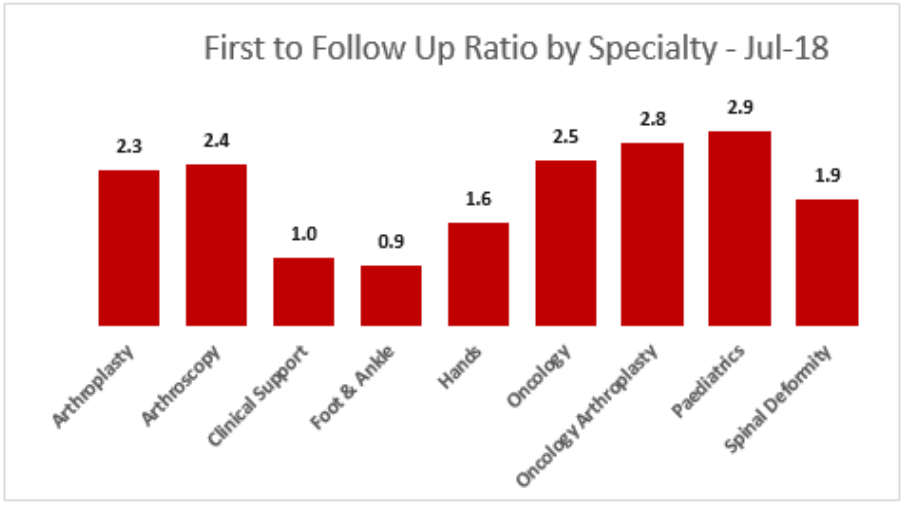
- The Red2Green dashboard development is now launched across all wards .The dash board also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds are now being rolled out across all wards so that all patients are reviewed to support timely discharge

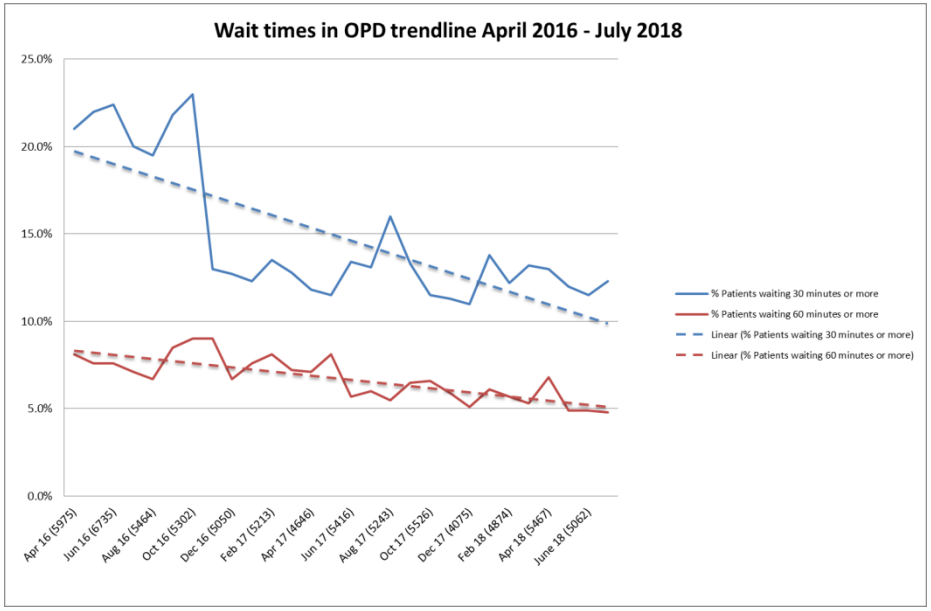
RISKS / ISSUES

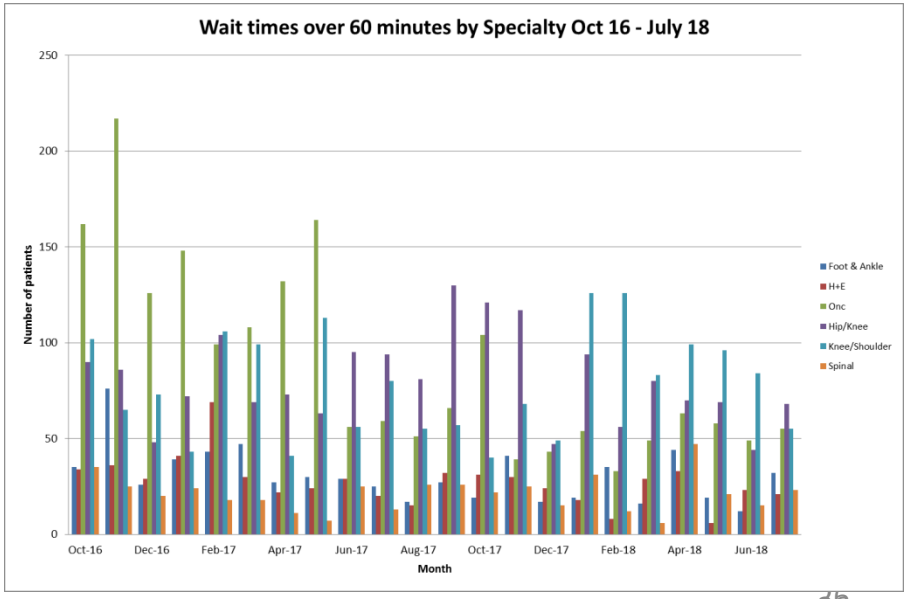
A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity .

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









INFORMATION

In July 18 there were 10 incident forms completed to highlight clinics running more than 60 minutes late.
There were 12.3% of patients waiting over 30 minutes and 4.8% waiting over 1 hour which is below the target of 5%. This is now the second month that the target of 5% has been achieved. The over 30 minute waits has deteriorated slightly from the previous month from 11.5%. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month.

The monthly audit identified the following : -

- 5 - Clinic overbooked
- 4 - Complex patients
- 1 - Consultant/Clinician Delay

All incidents continue to be investigated by the relevant operational managers. An audit of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause. This data is shared with the Ops team at the weekly Operational Management Team meeting to review trends and effect appropriate improvement interventions .
There are 2 consultants who are outliers in relation to the clinic delays and the Outpatient manager is working with he Clinical Service Manager for large joints to review and amend the clinic templates of these consultants to reduce the delays in these clinics.
Full capacity modelling for outpatient clinics and inpatients across all specialties has been completed for the majority of specialties.
Additional funding is to be requested via a business case to increase the qualified and unqualified nursing establishment within both main and paediatric outpatients to support any required increase in capacity, although there continue to be challenges in recruitment for qualified and unqualified staff.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Continue to drive incident investigations and action through relevant Operational Manager
- Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays
- Electronic clinic rescheduling form has rolled out and is in use in the majority of specialties which ensures there is an operational authorisation to any changes
- Development of clinic utilisation tools through InTouch and Health Informatics
- Work is being planned in CYPOPD (Children & Young People) to improve the reception environment which will allow InTouch to be used in real time and therefore provide data of clinic waits as currently this is not available

RISKS / ISSUES

Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. This will be addressed as part of the electronic clinic rescheduling form project
InTouch upgrade has not yet begun due to limited IT and project management resources.

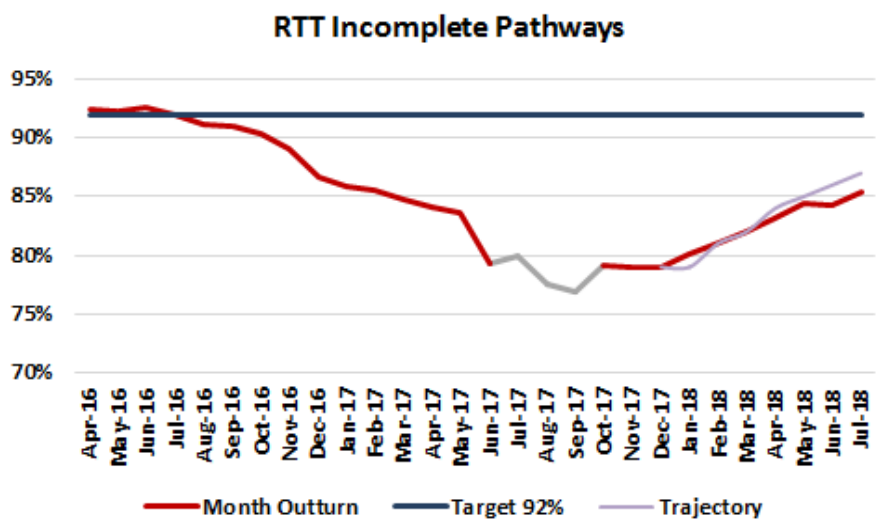
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

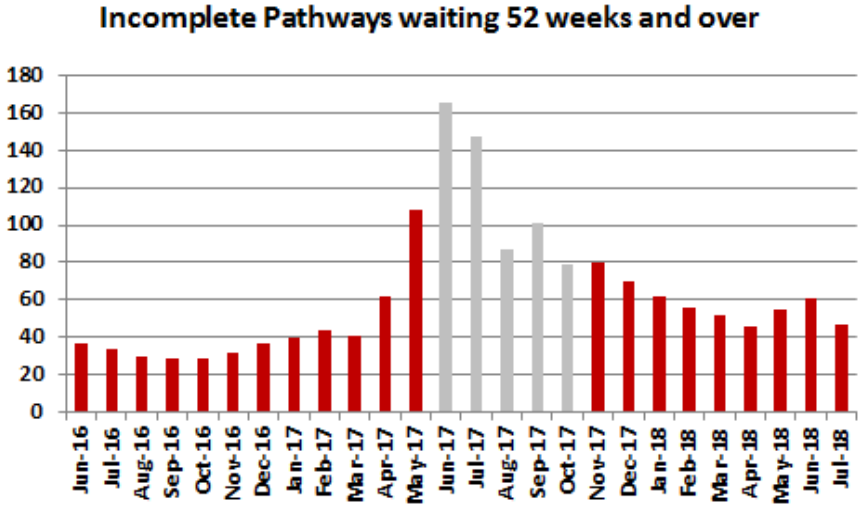
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%
Apr-18	1,022	148	409	1,579	850	253	387	1,490	8	1,571	1,579	99.5%
May-18	1,002	136	353	1,491	725	236	373	1,334	1	1,490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1,256	1,261	99.6%
Jul-18	732	112	336	1,180	961	211	290	1,462	8	1,172	1,180	99.3%

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



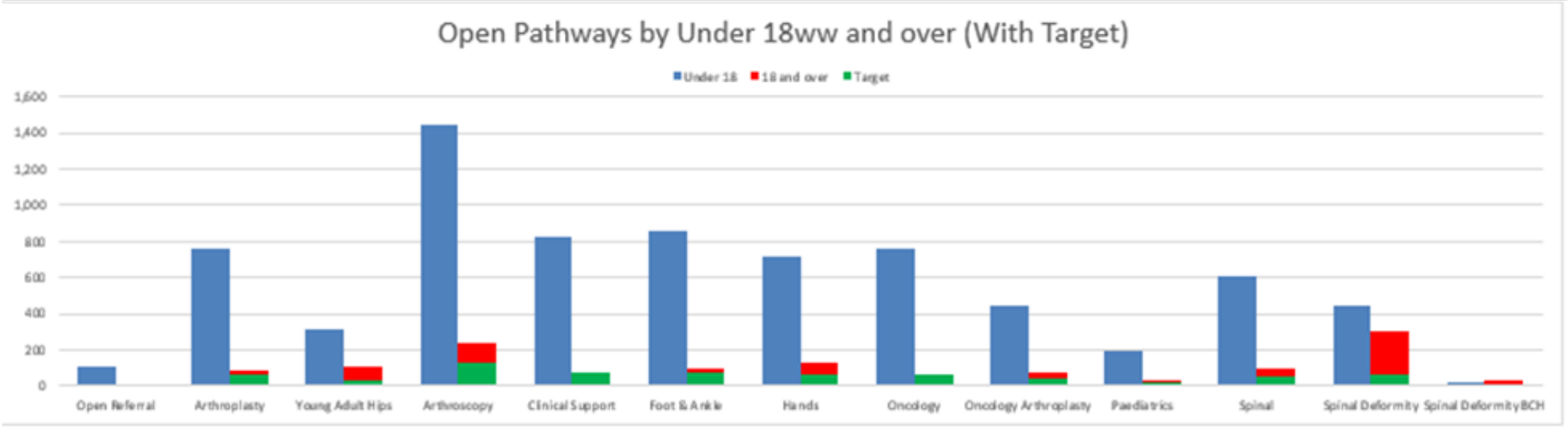


		Indicative	Reported Month			Reported Quarter 2017/18			
Target Name	National Standard	Jul-18	Jun-18	May-18	Apr-18	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 18 (Apr, May, June)
2ww	93%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	100%	100%	100%	90%	98%	100%	97%	100%
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%	81.8%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)		*	*	100%	100%	84%	82%	89%	100%
31 day rare (test, ac leuk, child)		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1	1	0	0				

13. Referral to Treatment snapshot as at 31st July 2018 (Combined)

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,875**	94	408	156	750	401	446	354	431	249	105	299	178	4
7-13	**2,652**	11	261	122	504	334	287	253	254	151	61	220	189	5
14-17	**964**	2	87	41	195	95	123	109	72	45	25	85	78	7
18-26	**887**	0	74	66	188	49	80	101	26	58	26	67	144	8
27-39	**291**	0	10	35	50	10	17	23	3	14	5	20	96	8
40-47	**46**	0	1	3	1	1	1	1	1	1	0	5	28	3
48-51	**6**	0	0	0	1	0	0	0	0	0	0	0	4	1
52 weeks and over	**47**	0	0	0	0	0	0	1	0	0	0	0	29	17
Total	**8,768**	107	841	423	1,689	890	954	842	787	518	222	696	746	53

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**7,491**	107	756	319	1,449	830	856	716	757	445	191	604	445	16
18 and over	**1,277**	0	85	104	240	60	98	126	30	73	31	92	301	37
Target	**701**	**9**	**67**	**34**	**135**	**71**	**76**	**67**	**63**	**41**	**18**	**56**	**60**	**4**
	85.44%	**100.00%**	**89.89%**	**75.41%**	**85.79%**	**93.26%**	**89.73%**	**85.04%**	**96.19%**	**85.91%**	**86.04%**	**86.78%**	**59.65%**	**30.19%**



13. Referral to Treatment snapshot as at 31st of July2018

Select Pathway T Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**830**	1	111	49	177	50	47	103	74	76	39	76	23	4
7-13	**749**	0	132	38	175	48	21	75	51	76	17	85	26	5
14-17	**326**	0	51	14	95	13	16	34	20	24	7	33	13	6
18-26	**357**	0	43	22	115	1	7	49	10	26	16	30	32	6
27-39	**126**	0	3	16	29	4	9	16	1	8	0	9	24	7
40-47	**29**	0	1	3	1	0	0	0	1	1	0	5	14	3
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	0	1
52 weeks and over	**42**	0	0	0	0	0	0	1	0	0	0	0	25	16
Total	**2,460**	1	341	142	592	116	100	278	157	211	79	238	157	48

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**1,905**	1	294	101	447	111	84	212	145	176	63	194	62	15
18 and over	**555**	0	47	41	145	5	16	66	12	35	16	44	95	33
Target	**197**	**0**	**27**	**11**	**47**	**9**	**8**	**22**	**13**	**17**	**6**	**19**	**13**	**4**
	77.44%	**100.00%**	**86.22%**	**71.13%**	**75.51%**	**95.69%**	**84.00%**	**76.26%**	**92.36%**	**83.41%**	**79.75%**	**81.51%**	**39.49%**	**31.25%**

Select Pathway T Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,045**	93	297	107	573	351	399	251	357	173	66	223	155	0
7-13	**1,903**	11	129	84	329	286	266	178	203	75	44	135	163	0
14-17	**638**	2	36	27	100	82	107	75	52	21	18	52	65	1
18-26	**530**	0	31	44	73	48	73	52	16	32	10	37	112	2
27-39	**165**	0	7	19	21	6	8	7	2	6	5	11	72	1
40-47	**17**	0	0	0	0	1	1	1	0	0	0	0	14	0
48-51	**5**	0	0	0	1	0	0	0	0	0	0	0	4	0
52 weeks and over	**5**	0	0	0	0	0	0	0	0	0	0	0	4	1
Total	**6,308**	106	500	281	1,097	774	854	564	630	307	143	458	589	5

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,586**	106	462	218	1,002	719	772	504	612	269	128	410	383	1
18 and over	**722**	0	38	63	95	55	82	60	18	38	15	48	206	4
Target	**505**	**8**	**40**	**22**	**88**	**62**	**68**	**45**	**50**	**25**	**11**	**37**	**47**	**0**
	88.55%	**100.00%**	**92.40%**	**77.58%**	**91.34%**	**92.89%**	**90.40%**	**89.36%**	**97.14%**	**87.62%**	**89.51%**	**89.52%**	**65.03%**	**20.00%**

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017 and re-commenced reporting in December 2017, with its first submission for November 2017. The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For July 2018 the RTT trajectory was 87% with performance at **85.44%** with 47patients over 52weeks (trajectory 55)

The Hands patient delay was patient choice and could have been treated under 52 weeks, they have been treated at the beginning of August 2018.

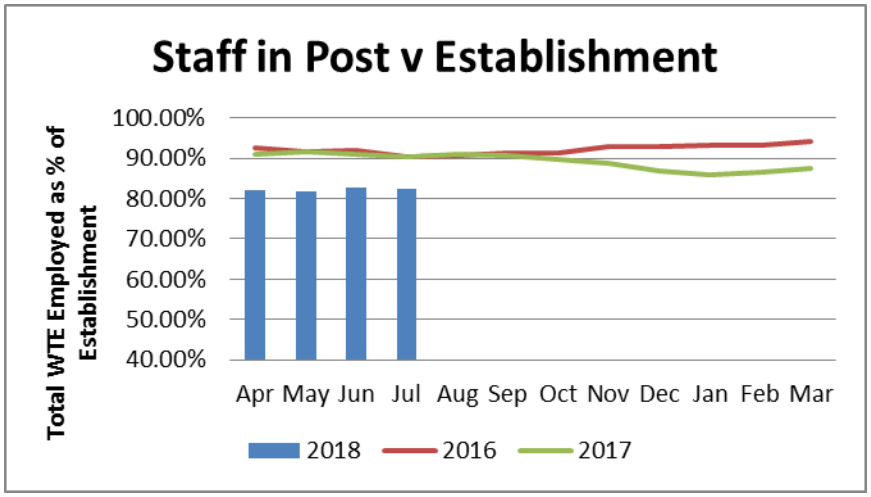
ACTIONS FOR IMPROVEMENTS / LEARNING

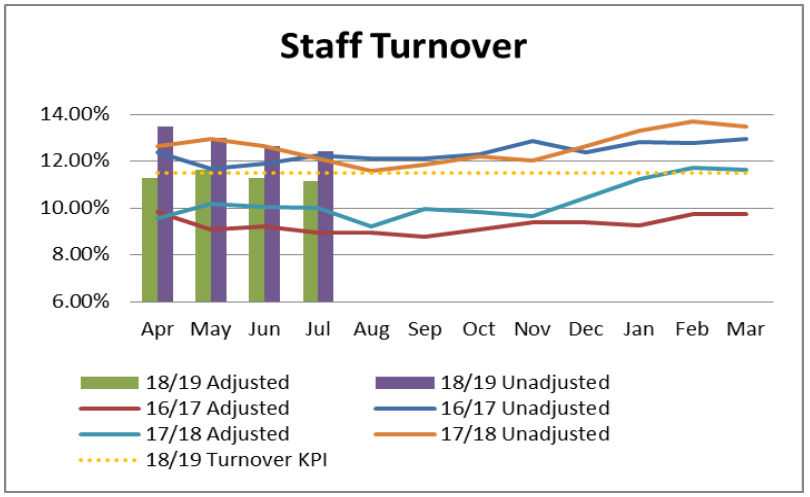
The team continue to concentrated on any patients over 40 weeks, with the exception of Spinal Deformity this figure is now 16. Whilst the trajectory was missed for July 18 performance has improved and we continue to see an improvement in the number of patients waiting over 26 weeks. At the end of December 2017 we had 926 patients over 26 weeks, this figure has now reduce to 522 in June to 390 in July. Throughout August 18 the team continue to work through a targeted list of patients who are listed with consultants with the longest waits. Good progress continues to be made by all the teams.

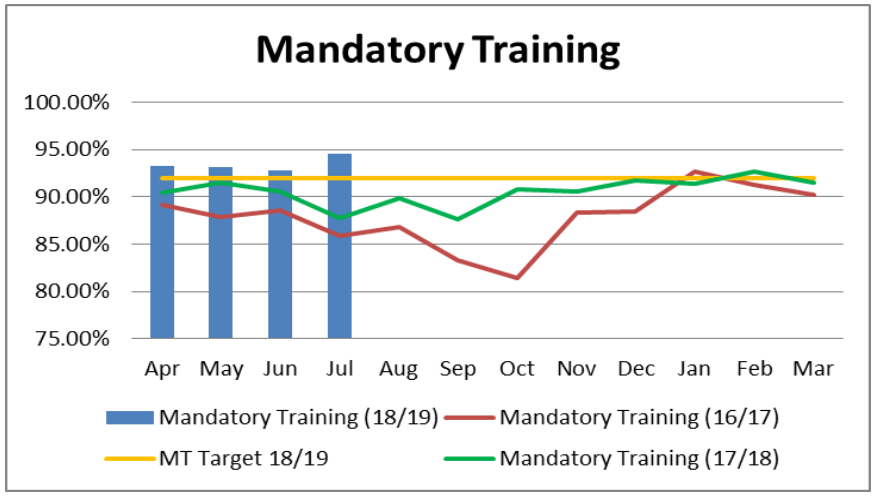
RISKS / ISSUES

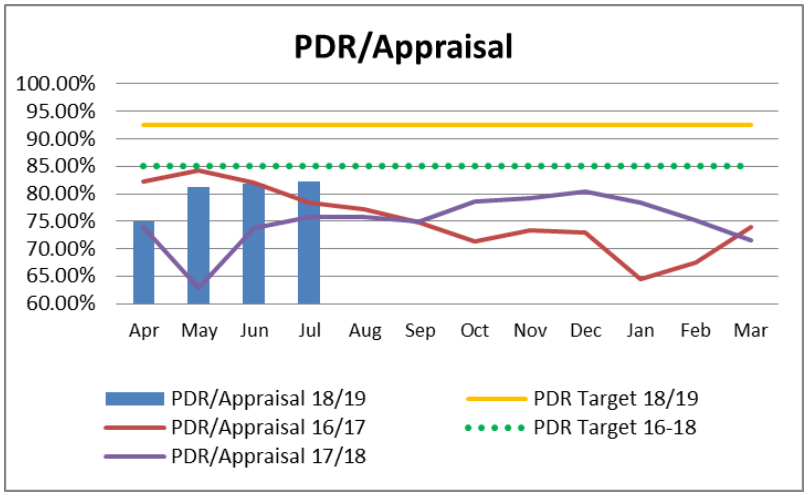
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance.
Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be February 2019 before an additional weekday list will commence. Weekend activity continues through the Summer with discussion underway to continue the lists until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families , one patient had a date for surgery at the end of June 2018 .

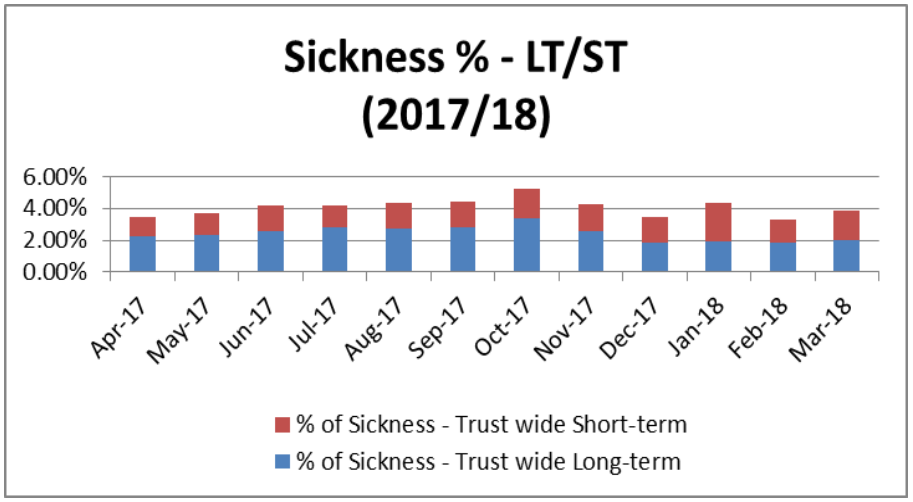
14. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

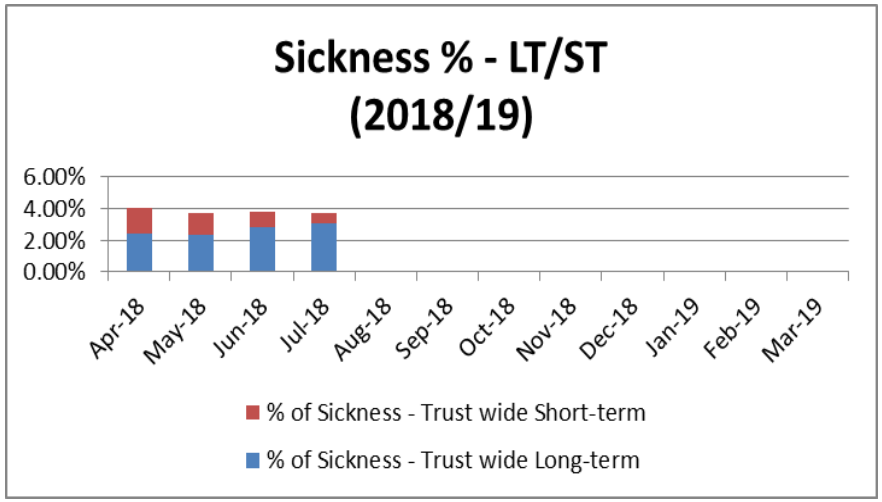


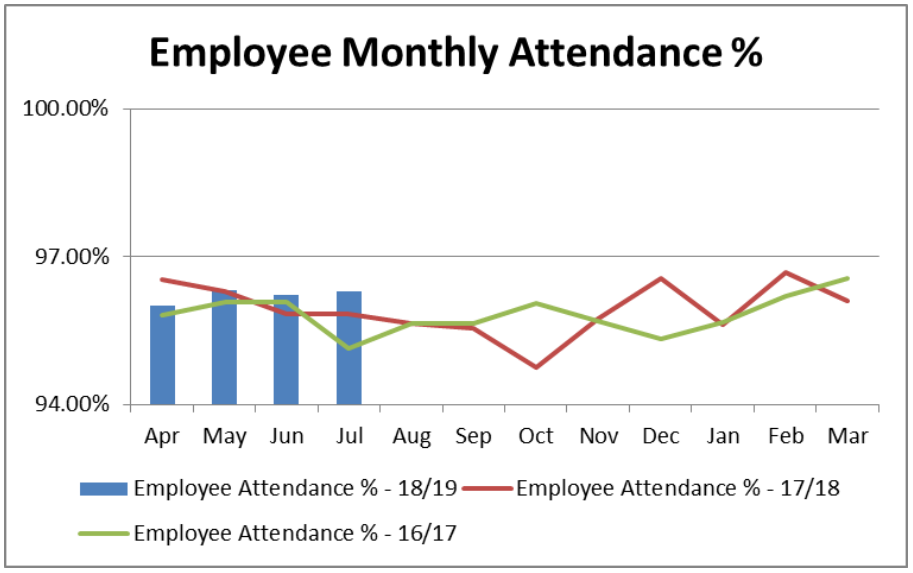


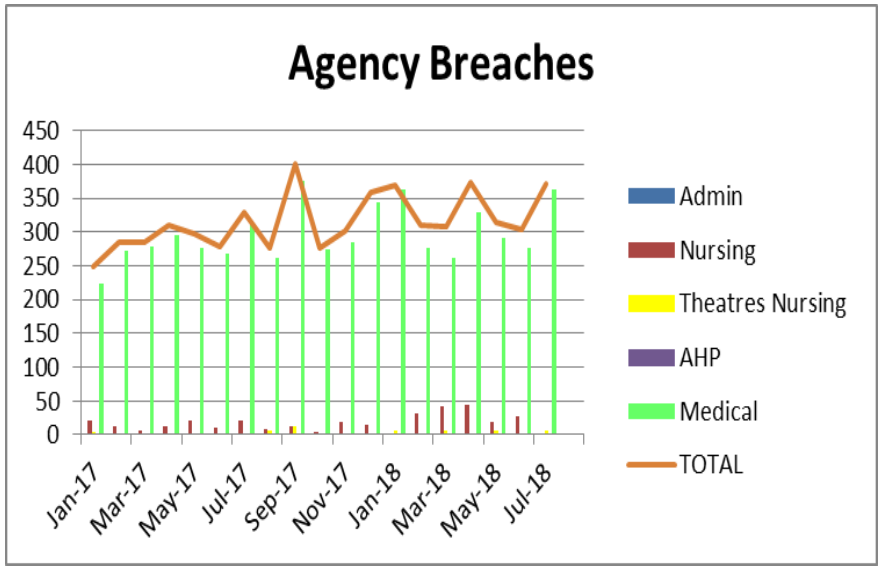





Sickness % - LT/ST (2017/18)
6.00%
4.00%
2.00%
0.00%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
% of Sickness - Trust wide Short-term
% of Sickness - Trust wide Long-term


Sickness % - LT/ST (2018/19)
6.00%
4.00%
2.00%
0.00%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
% of Sickness - Trust wide Short-term
% of Sickness - Trust wide Long-term


Employee Monthly Attendance %
100.00%
97.00%
94.00%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Employee Attendance % - 18/19
Employee Attendance % - 17/18
Employee Attendance % - 16/17


Agency Breaches
450
400
350
300
250
200
150
100
50
0
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Admin
Nursing
Theatres Nursing
AHP
Medical
TOTAL

INFORMATION

** Please note: there is a caveat around sickness absence, appraisal and mandatory training data this month: the reason is that the Healthroster feed to payroll has failed, with the effect that some sickness absence data is incomplete. This means that sickness absence may be worse than reported - and mandatory training and appraisal may be better than reported (because long term sick staff are excluded from these figures). We are working with Healthroster colleagues to remedy the issues and expect to rectify the position in August's data next month, when we will also update the July position.

This month the Trust's vacancy position saw a slight decrease of 0.37% as a percentage of WTE employed, with the figure 82.42% against a Trust target of 90%. This has arisen from an increase in the funded establishment of just under 3WTE and just under 2WTE fewer staff on the payroll in July.

Work has now been completed to align ESR to the ledger, with an ongoing monthly process in place to update changes. This has enabled greater analysis of specific vacancies. Some early work has been undertaken to identify possible overestablishments, together with some corporate level analysis of which posts are in the process of being filled. More detailed work will need to be undertaken face to face with senior operational managers in the weeks ahead to understand those posts for which there is no plan to fill currently.

Monthly attendance increased slightly by 0.06% from a position of 96.23% in June to 96.29% in July. This is green in month (target is 96.1%). The rolling 12 month average position remains amber at 95.79%, with little change: although this position is expected to improve over the next 4 months if attendance remains above 96%.

Mandatory Training numbers saw a very strong July performance figure of 94.54%. This is the highest reported figure since December 2015 and represents an increase of almost 2% since June. The Trust has now consistently performed above its revised higher target of 92% since April 2018.

July's appraisal performance increased for the fifth consecutive month, this time by 0.55% to 82.30%, which is the highest it has been since May 2016. Whilst this is still considerably adrift from our stretch target of 92.5%, teams continue to make improvement in this area.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) declined once again this month to 12.44%. The adjusted turnover figure (substantive staff leavers including retirements) also decreased to 11.16%, and remained green against a KPI of 11.5%.

In July, agency breaches increased from 304 to 373 shift breaches in total, of which 363 were medical (compared to 276 last month). It should however be noted that the reporting period was 5 weeks, so this is a proportionate increase. Nursing agency breaches decreased to 8 in month, with 6 of these in theatres.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS/ISSUES

Data quality of sickness, mandatory training and appraisal is the risk of note this month..

ROHTB (9/18) 009

The Royal Orthopaedic Hospital 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, Associate Director - Estates & Facilities**
DATE OF MEETING:	**5th September 2018**

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 2018 NHS Core Standards profile.

The review process has identified 53 areas of full compliance (Green) and 2 areas of partial compliance (Amber).

The two areas of partial compliance are:

- Strategic Responder Training
- Data Protection and Security Toolkit

The Trust through the self-assessment process has been graded as 'Substantially Complaint'.

An 'action plan' forms part of the EPRR Core Standards spreadsheet for the areas identified as partially compliant.

The timescale identified for completion of these two areas is six months; a project lead has been nominated.

REPORT RECOMMENDATION:

The Trust Board is asked to note the content of this report which has been assessed against the 2018 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:					
September 2017					

Please select type of organisation: **Specialist Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	2	1	0
Response	5	5	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	8	1	0
CBRN	7	7	0	0
Total	55	53	2	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Director Commissioning Operations Team	NHS England Regional Team	NHS England National Team	NHS Improvement	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Evidence - examples listed below
1	Governance	Appointed AEO	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Accountable Emergency Officer - Professor Philip Begg. Emergency Planning Lead - Stuart Lovack. Non-Executive Director appointed.
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	The Trust has an EPRR Strategy, Memorandum of Understanding for mutual aid agreed with neighbouring local Trusts. Trust is part of the LHRF. Work plans and 'Best Practice Assessments' in place, current procedures and documentation have been received. Emergency Planning budget establsihed for the organisation. Emergency Planning support identified and available for EPRR. Organsiation committed to support EPRR process.
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	The Trust Board on Wednesday 6th September 2017 received and noted the latest position against the National Emergency Preparedness and Resilience Response Core Standards. The 2018 Core Standards spreadsheet will be presented to the Trust Board on 5th September 2018.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning aspects embedded in the Trust. Annual work plan developed and monitored, work plan covers annual exercising, communication cascade, Business Continuity inclduing Heatwave Planning and Risk Management. Regular attendance at the LHRF and LHRP.
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	MI Plan updated and emergency response pack developed. Business Continuity Plan developed and tested. Site assessed for climate change, directives received from DH on heatwave and cold weather planning. SLA in place with QEHB for Infection Control Doctor for advice and support. Hospital Evacuation and Shelter Plan developed incorporating Mass Casualties scenario. Road Fuel Shortage/Disruption Plan developed. Lockdown procedure currently under review. Business Continuity and local hospital arrangements in place to deal with system failures.
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Continuous improvement forms part of our EP policies/philosophies. Training is cascaded to all staff in the form of Decision Logging. The Context & Personal Awareness of EPRR, The Role of the ICR & BCT Staff, Tabletop Exercise walk through, Strategic Briefing & Refresher Update.
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning Risk Register developed, risks are reviewed on a regular basis, any significant risks are escalated to the Corporate Risk Register.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR risks are considered in the organisation's risk management policy. Reference to EPRR risk management is in the organisation's EPRR policy document.
Domain 3 - Duty to maintain plans																			
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust is fully engaged with and part of the Local Health Resilience Partnership and Forum.
	Duty to maintain plans	Planning arrangements	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the following risks / capabilities:																
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The Trust has processes and procedures in place to manage 'Critical Incidents'. MI Plan up-to-date.
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	The Trust has processes and procedures in place to manage 'Major Incidents'. MI Plan up-to-date.
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Trust Heatwave Plan and Heatwave Plan for England is available on the emergency planning portal on the Trust's Intranet page. Heatwave Checklist available and guidance on Medications likely to provoke or increase the severity of heatstroke. Met Office reports received during hot weather periods.
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Cold weather plan for England available on the Emergency Planning Portal on the Trust's Intranet site. Met Office reports received during cold weather period.
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Pandemic Flu documentation available both nationally and locally. Trust does not have an A&E / Emergency Department however engages in the promotion and adminstering of Flu vaccines to all staff in line with the CCG's CQUIN vaccination target. Patients are screened before being scheduled for 'Elective Surgery'.
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Infection Control Doctor commissioned under an SLA Agreement with QE Hospital. Meeting structure establsihed through Infection Prevention & Control Group. Water Quality/Safety Group establsihed. FFP3 masks are stocked on site in the ICC.
17	Duty to maintain plans	Mass Countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Communication structure in place, resource planning functions in place to deal with a mass vacinnation programme. Staff trained to adminster vaccines. Trust part of LHRF and LHRP.
18	Duty to maintain plans	Mass Casualty - surge	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Trust is part of the LHRF and LHRP, the Trust has fostered good relationships with other local Trusts and EPRR Locality Leads. Specialist Elective Orthopaedic Trust has the ability to flex clinical services to meet the demands of 'Mass Casualty' for the treatment of Orthopaedic patients.
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Y														The Royal Orthopaedic Hospital is not a receiving hospital, in-bound pateints will have been transferred from another hospital, likely the Queen Elizabeth. The Trust's patient systems and processes are being aligned to ensure a safe transfer of patients to the ROH. Patients entering the Trust will be recorded on the current patient tracking system.
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Hospital Evacuation and Shelter Plan in place. Part of resilience network for West Midlands.

21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Y	Y	Y			Y							Y	Y	Hospital has an establsihed Lockdown procedure in place, portering staff are available 24/7.
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Y	Y	Y			Y							Y	Y	Plans are in place to cater for high profile individuals, clinical areas have been identified on site for the treatment of high profile individuals/VIP's.
23	Duty to maintain plans	Excess death planning	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Y	Y	Y			Y							Y		Hospital understands its role in the event of 'Excess deaths', contributed to the collation of mortuary facilities availability throughout the region.
Domain 4 - Command and control																				
24	Command and control	On call mechanism	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Processes described in the Trust's Emergency Preparedness Resilience and Recovery Strategy document. Escalation process detailed in 'Bleep Holder Pack'.
25	Command and control	Trained on call staff	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Trust staff are in a position of delegated authority. Trust staff can determine between a critical or major incident or a business continuity issue. Training packages are available to all staff involved in EPRR. Training records are maintained.
Domain 5 - Training and exercising																				
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Bleep Holder training delivered to all on-call staff. Training records maintained. Incident Co-ordination Centre training delivered to all on-call staff.
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Communication Exercise undertaken on a six monthly basis - 17th November 2017 and 6th March 2018. Tabletop 'Exercise Pheonix' undertaken on 14th August 2017 and Tabletop 'Exercise Hysteria' undertaken on 19th March 2018. Exercise reports produced and lessons learnt logs developed. Command and control live incident/exercise occured in June 2016.
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning Lead has undertaken JESIP Training. Additional strategic and tactical training required for On-call Executive Directors.
29	Training and exercising	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems have been tested annually			Y														Not applicable.
Domain 6 - Response																				
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Primary and Secondary 'Incident Co-ordination Centres' available at the Trust. Functions and rooms reviewed/tested on a regular basis. Training delivered on the role of the ICC and BC team.
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Electronic and hard copies of information available to all staff. Trust Intranet page has 'Emergency Planning' icon with documentation posted. ICC's are supported by hard copy information.
32	Response	Management of business continuity incidents	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Documentation covers 'business Continuity' arrangements. Business Continuity Plan is up-to-date and available to staff.
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Loggists available within Trust, on-call arrangements in place. In-house loggist training packages delivered.
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust has systems and processes in place to undertake and provide 'Sit Rep' reports. The Trust has the ability to communicate/brief the relevant people/organisations.
35	Response	Access to 'Clinical Guidance for Major Incidents'	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y																Not applicable.
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y																Not applicable.
Domain 7 - Warning and informing																				
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		The Trust has an active Media Policy which covers aspects of communication. The Trust has three social media accounts. (Twitter, YouTube and Facebook) The Communication Strategy is linked to the Trust's Major Incident Plan'. The Trust maintains active channels of communication with local groups/organisations.
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The 'Media Policy' deals with wider communication. The Trust has a number of communication modes to ensure staff, patients, visitors and the wider public are warned and informed.
39	Warning and informing	Media strategy	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust's 'Media Policy' covers its communication strategy and intervention with the general public/media.
Domain 8 - Cooperation																				
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	Y	Y	Y			Y	Y	Y			Y				Y	Delegated authority has been given to the Associate Director - Estates & Facilities (Emergency Planning Lead) to attend the LHRP. The Associate Director has attended more than 75% of meetings of the LHRP.
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	Y	Y	Y			Y	Y	Y			Y				Y	The Emergency Planning Lead participates and attends the LHRF.
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y			Y	Y	A regional Mutual Aid Handbook has been developed amonst partner organisations and recently updated.
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process 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						Y	Not applicable.
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.										Y							Not applicable.
45	Cooperation	LHRP	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) meets at least once every 6 months.								Y	Y								Not applicable.
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Memorandum of Understanding document has been signed by the Trust. Open protocol arrangements with emergency planning organsiations in place.
Domain 9 - Business Continuity																				
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Buisness Continuity Management Policy active and in place. Policy statement included.
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Buisness Continuity Management Policy incorporates scope and objectives, details a risk management approach. The information is disseminated throughout the organisation.

49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Trust has undertaken a Business Impact Assessment, this information is based on the information received/collated from departmental BC plans.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The IT Department are working towards achieving full compliance.
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The deaprtments within the Trust have business continuity plans in place, these plans are being actively reviewed. A central repository has been establsihed for all the business continuity plans.
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The organisation's BCMS is monitored and evaluated, corrective action is taken to ensure the plans and systems are adequate.
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Business Continuity process is audited and outcomes are recorded.
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	BC systems are reveiwed bi-annually, lessons learned are incorporated to foster a continuous improvement process.
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Assurance is provided via the Procurement Department for key suppliers to have Business Continuity systems in place. Specifications/documentation include for Business Continuity Plans to be in place via framework agreements.

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Director Commissioning Operations Team	NHS England Regional Team	NHS England National Team	NHS Improvement	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to acheve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control																							
Domain: Incident Coordination Centres																							
1	Incident Coordination Centres	Communication and IT equipment	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Fully compliant				The Trust has invested in it's ICC, the room is fully equiped for incident management.
2	Incident Coordination Centres	Resilience	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Up to date training records of staff able to resource an ICC	Fully compliant				The Primary ICC is available 24/7.
3	Incident Coordination Centres	Equipment testing	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Post test reports Lessons identified EPRR programme	Fully compliant				The Trust has an MI Plan and EPRR Strategy Document which sets out the requirements, the ICC is tested through incident management and exercising play.
4	Incident Coordination Centres	Functions	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant				The Trust's emergency planning documents such as MI Plan, EPRR Strategy, Hospital Evacuation and Shelter Plan, etc. all provide details on arrangements, function and form.
Domain: Command structures																							
5	Command structures	Resilience	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant				The Trust has an EPRR Strategy detailing command structures, roles and responsibilities, etc. Exercise reports are produced including lessons learnt logs.
6	Command structures	Stakeholder interaction	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR policy statement and response structure	Fully compliant				The Trust has an EPRR Strategy which details its approach to Emergency Planning and its links to the wider network.
7	Command structures	Decision making processes	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant				JDM model is embedded in documentation available including the Incident Response Plan. Training records are available for all staff who have received Emergency Planning training.
8	Command structures	Recovery planning	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant				Recovery planning incorporated into the Trust's 'Business Continuity and Recovery Plan'. Trust part of LHRP and LHRF network.

Overall assessment:			Substantially compliant																				
Ref	Domain	Standard	Detail	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments														
28	Training and exe	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Emergency Planning Lead has	tially comp	Executive Director On-call	Emergency Planning Lead	Six months	
50	Business Contin	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The IT Dep	tially comp	Working towards	Head of IT	Six months	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board & Committee Code of Practice**
SPONSOR:	**Dame Yve Buckland, Chairman**
AUTHOR:	**Rod Anthony, Non Executive Director & Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**5 September 2018**

EXECUTIVE SUMMARY:

Following the governance review undertaken earlier in the year by Rod Anthony, Non Executive Director, a series of recommendations were made as to how the effectiveness of the Board & its subcommittees could improve. The Board supported these recommendations and agreed that they should form the basis of a Code of Practice.

Attached is the proposed Code of Practice that has been devised.

It is proposed that that an annual assessment is undertaken against the Code of Practice, a process that will be led by the Associate Director of Governance & Company Secretary.

Most of the requirements of the code of practice can be achieved by simple action and as the Board & subcommittees develop over the coming year, the Code of Practice will be used to guide any changes needed.

REPORT RECOMMENDATION:

The Board is asked to:

- APPROVE the Board & subcommittee Code of Practice
- SUPPORT the proposal to undertake an annual self-assessment against the Code of Practice

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:

The Code of Practice will build on improvements to the Trust's governance arrangements that have been implemented over previous months and support the Annual Governance Statement when due in Spring 2019.

The Code of Practice further mitigates Risk S800 on the Board Assurance Framework.

PREVIOUS CONSIDERATION:
The Trust Board considered the governance review at its meeting in June 2018.

CODE OF PRACTICE FOR THE TRUST BOARD AND BOARD COMMITTEES

Board and Committee Structure

1. The Board will regularly review the Board and Committee structure, and in doing so will ensure that Directors, and more importantly senior managers across the ROH, understand this structure and the nature of the assurance processes that underpin the subcommittee approach.

Director Responsibilities

2. Directors, and particularly those new Directors undertaking an induction, will be briefed on the nature of their role- both the collective accountability of a unitary Board and the individual accountability within their area of expertise and knowledge.

3. Directors understand that although they may bring specific knowledge and expertise to the Board they are jointly accountable with all other Board members for the performance of the business and so will actively participate in all proceedings.

Executive and Non-Executive Directors

4. It is the duty of all directors to scrutinise and challenge assurances in order to discharge individual and collective accountability. The Board will look to avoid any sense of an "us and them" culture between the Executive and Non-Executive Directors.

5. Both Executive and Non-executive directors will ensure that they engage more widely on issues and avoid remaining with the comfort zone of their area of expertise.

6. Where Executive Directors discussion on matters have taken place outside of Board and Subcommittee meetings, this will be made clear to the Board or Subcommittee and the essence of the discussion and its outcome communicated through a formal report.

7. In order to ensure that the roles of Executive and Non-Executive Directors are well understood amongst the senior team, senior managers will be briefed accordingly by Directors, for example, before attending Board or sub committees for the first time.

Board and Sub Committees Terms of Reference

8. Board and subcommittee terms of reference will be formally reviewed by the Board and subcommittee at least annually. Terms of Reference will be reviewed more regularly if there is a perceived need to do so-for example where there are emerging business issues that need to be dealt with, or potential for overlap in committee business.

9. Terms of reference will acknowledge that as a default only Board members can be identified as formal subcommittee members. This does not preclude the attendance at Board and subcommittees of other senior managers where it is considered appropriate or necessary for the proper conduct of the committee business.

10. Should it be regarded as necessary and appropriate to include an Associate Director within the membership of a Board subcommittee, this will be need to be formally recognised and specifically approved by the Board.

Board and Sub Committees Operation

11. Where a deputy attends a Board or subcommittee on behalf of a Director in their absence:

- This will be considered the exception, rather than the norm
- It will be for the Chair of the Board or Subcommittee to accept the deputy as an appropriate delegate prior to the meeting
- The deputy will be properly briefed and it will be expected that the deputy will contribute fully to the committee meeting and to the subject matter discussed.

12. Each Director will make the time to attend all Committee meetings of which they are a member during the year and attend on an annual basis at least one meeting of those of which they are not a member.

13. The Board and its subcommittees will positively encourage a wide range of managers from across the Trust to attend the Board and Sub Committee meetings.

14. The Board will ensure that it pays regular attention to both developmental training for Directors and succession planning for the Board. The Board will consider more investment in developing both directors and near board managers, particularly those who are acting up or on secondment.

15. The Board will ensure that it has made sufficient time available to “stand back” to consider more strategic or higher level matters.

16. To ensure possible issues are identified and resolved earlier, the Board and its committees will regularly reflect on its effectiveness (for example at each meeting) and should “self-assess” more often. This extends to making proactive suggestions for improving the effectiveness outside of the meeting to the Chair of the Board or subcommittee

Risk Management

17. In order to ensure a clear link between the identified corporate risks and issues and Board business, the Board will ensure that the BAF drives the Board and subcommittee agendas.

18. With the Corporate Risk Register now more regularly discussed in detail at the weekly executive meetings, the Board will ensure that risk documents presented at meetings are relevant and up to date.

19. The Board will ensure that there is a strong connection made between the BAF and the high level risks, with the operational level risks. In doing this the escalation processes will be clearer and demonstrable.

20. The Board will ensure that the management of the risks facing the business are shared and that there is a reasonable balance of responsibility for risk management and mitigation across the executive and senior management team.

21. Where ownership of a risk changes there will be an effective handover between executives.

Values and Culture

22. The Board will ensure that it regularly reviews the desired culture and values that are necessary to support the development of the organisation.

23. The Board will regularly reflect on its own values and culture to ensure that it demonstrates the corporate values and achieves the appropriate balance between high support and high challenge when conducting its business.

24. Board and Committee members and attendees will reflect on how their behaviours and conduct at meetings can impact both the conduct of business and the feelings of others.

25. Where necessary Board and Committee chairs, perhaps at the request of members and attendees, will consider a break in meetings to allow the defusing of issues that may interfere with the proper execution of business.

26. Directors will reflect regularly on their own personal behaviours, and seek feedback from others.

Diversity

27. The Board will continue to pay attention to its diversity in terms ethnic background and will ensure that a broader range of culture and values can be brought to Board and subcommittee business.

Date of adoption:	September 2018
Date of review& self-assessment:	September 2019

ROHTB (9/18) 011

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UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board last met: 29 August 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The WHO checklist position was reported to be at 100%, however there remained work to do to ensure that the overall position captured areas in addition to theatres • The upward report from the Research & Development Committee highlighted that space to support clinical research was limited and created a potential barrier to opening new studies; the Director of Strategy & Delivery would assist with resolving the matter • Attendance at the Research & Development Committee was noted to remain poor at present; there was further work underway to improve the position • The named doctor for Paediatrics had stepped down and work was underway to identify a replacement. In the meantime, oversight was given by another local provider. • Compliance with water safety regulations remained a challenge and the actions planned needed to be strengthened	• It was agreed that a summary of the Trust's claims position should be presented to the Trust Board later in the year • The medico-legal forum is to be resurrected to assist with providing a view as to whether to defend a claim or admit liability • A standalone report on Mental Health is to be presented in September • The water safety action plan is to be revised to better clarify actions that had been completed against those that still needed to be undertaken • A report on the Bone Infection service is to be presented in January 2019 • The patient experience and engagement strategy is to be presented in January 2019 • An update on the pain management service is to be presented in November 2018
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• It was reported that the Information Commissioner's Office had written to the Trust to say they were assured by the actions taken in response to the stolen laptop and would not be investigating the matter further • There had been a reduction in the number of serious incidents reported. This was likely to reflect that VTEs no longer needed to be declared as a Serious Incident. There remained confidence that the systems and processes in place remained sufficiently robust to enable staff to report incidents. • There had been no Grade 3 or 4 pressure ulcers reported year to date. • The number of patients waiting in excess of 52 weeks had reduced to 47	• The Committee approved the revised terms of reference for the Infection Prevention and Control Committee • The Committee approved its revised workplan, which it was noted included an upward report from the Radiation Safety Advisory Group on a six monthly basis • The terms of reference for the Radiation Safety Advisory Group were approved

• A new electronic solution has been purchased which would assist with capturing performance against an additional set of KPIs that could feed into the Quality Report • The Committee received a detailed report into the open claims that the Trust was handling. It was assured that there were robust processes in place to manage the litigation activity. • The positive inspection by the CQC which tested compliance with the new Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) was outlined.	

Chair's comments on the effectiveness of the meeting: The meeting was noted to have included some productive debate and has highlighted a number of areas where further assurance was needed, which would be built into the forward schedule for the Committee

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UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board last met: 24 July 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was noted to remain a high level of agency spend being used, with a continued trend upwards. 37 nurses would join before the end of September which is likely to alleviate the position. • The Committee was advised that the new Agenda for Change payscales had been released which suggested that some individuals would receive a less favourable pay uplift than expected based on previously released information. • There remained a risk to the delivery of the Cost Improvement Plan; some additional projects were being identified which would deliver further savings. • Cash levels were reported to be low, however the Sustainability & Transformation Funds had been received and the cash support from the Department of Health would shortly be accessed. • An analysis of the budget in the context of tariff changes over the past few years was reviewed, which highlighted that the Trust was being funded far less favourably for its work now than it had been previously based on similar levels of activity; a pilot funding model for 2019/20 was currently being undertaken to take into account case mix, which may improve the position for the Trust in future.	• Further update on agency expenditure and plans to address this are to be discussed at the next meeting. • Edge Health analysis to be shared with the Committee at its next meeting. • Present an update on the theatre expansion work at the September meeting. • A further update on the development of the estates strategy to be presented in September. • Include an additional risk around the impact of Brexit on the Corporate Risk Register. • Create a task and finish group to oversee the planning for Brexit, with an update to be presented at the September meeting. • The workforce implications of Brexit are to be considered by the Staff Experience & OD Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Income performance for June was strong, driven by the high level of inpatient activity. • Overall, the financial performance during the first three months of the year was above that of the same period of previous years. • First outpatient appointment levels had increased creating a positive 'order book' of patients to be treated. • Theatre utilisation remained high and there were sound processes to cover fallow lists created by consultants' annual leave. • Length of stay had reduced and some of the initiatives to expedite	• The Committee agreed that appropriate processes were in place to produce accurate reference costs. • It was agreed that the Committee would not meet in August, however the financial pack would still be circulated for oversight.

discharges were working well. • The number of clinics over running had reduced, with further improvement expected. • Work to reduce the time that patients were waiting for treatment was yielding good results, with an improvement against the 18 weeks Referral to Treatment Time target and a reduction in the number of patients waiting above 52 weeks. • There was noted to be a slight improvement against some of the workforce targets, such as turnover, short term sickness absence and mandatory training compliance. • Good progress across all workstreams in the 'Perfecting Pathways' programme was noted.	

Chair's comments on the effectiveness of the meeting: The inclusion of the estates work within the remit of the Finance & Performance Committee was agreed to be useful oversight.

ROHTB (9/18) 013

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board last met: 4 July 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There were reported to be a high level of vacancies at present, which it was agreed needed further analysis to understand the risks to the Trust. Particular attention was focussed on ensuring the gaps in the agency nursing workforce were addressed. • The success of the new performance and development approach was noted to hinge on upskilling managers across the Trust in the new framework; there was a possibility that this could be time consuming and received with mixed reaction. • As part of the nurse staffing report, it was highlighted that there were some Healthcare Assistant vacancies, although agency staffing was being used at present to mitigate these gaps. There were also some gaps in the Band 6 cohort in theatres but active recruitment was planned to secure substantive individuals into these posts.	• The draft People & OD strategy to be circulated in August, ahead of the discussions at the September meeting • Suggestion made to apply the Quality Service Improvement and Redesign concept to some of the workforce initiatives • Present the timelines for the various workforce initiatives at the next meeting • Committee to receive an update on the new performance and development approach when the pilot is complete. • An overview of the Clinical Excellence Awards process is to be presented at a future meeting. • The Paediatric matron to attend the October meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Good work was underway to improve the recruitment processes, including streamlining the pre-employment checking requirements • Further work had been undertaken to improve engagement across the Trust, including embedding the 'Speak Up and Join In' brand and including an escalation element to the Team Brief presentations • A stress management task and finish group had been created to provide support for the health and wellbeing agenda • The Committee noted that the Trust's annual library quality assurance framework score had improved from the previous year • A revised performance and development approach was outlined to the Committee, which created a more tailored approach to the different staff groups. • Work was reported to be underway to make the offering to candidates applying for jobs at the ROH more appealing.	• It was agreed that the annual library quality assurance framework assessment should be submitted

• The key elements of the new agenda for change contract refresh were outlined, which had been well received by most staff groups at the ROH and nationally.	
Chair's comments on the effectiveness of the meeting: The richness of the data available was welcomed. It was agreed that having the operational leads join the meeting was effective.	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board last met: 18 July 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that there had been a review against the cyber essentials standards, which had identified some areas for improvement, including file management. A capital grant had been received which would be used to purchase and implement some cyber security software. • The internal audit review of catering highlighted some control weaknesses in terms of stock. • The Committee expressed some concern at the lack of assurance provided by the review of clinical audit, especially given that previous testing of this area had also highlighted weaknesses. • The use of a company which provided medical locum staff was being reviewed in the light of potential concerns over compliance with the IR35 regulations. • The Committee was concerned that there remained significant work to do to address the current open recommendations from internal audits.	• Work is underway to evaluate the effectiveness of the internal and external audit providers. The external audit contract is due for renewal and the award of the contract will need to be approved by the Council of Governors. • The Chair of the Quality & Safety Committee to be provided with a copy of the Clinical Audit review when finalised. • The Medical Director be invited to the December meeting to update on progress with closing actions within his remit. • An update on Additional Duty Hours payments to be presented at the next meeting. • An update on plans to address the job planning recommendations to be presented at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Both internal audit and external audit plans were progressing as expected.	• Support was given for the annual audit committee report to be presented to the Trust Board at the next opportunity.

Chair's comments on the effectiveness of the meeting: It was agreed that the Board Assurance Framework needed to be placed at the top of the Board agendas to signpost which items related to the individual elements.

The Royal Orthopaedic Hospital NHS
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AUDIT COMMITTEE ANNUAL REPORT 2017/18

1.0 Introduction

1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Audit Committee during 2017/18 and indicate its work plan for the financial year 2018/19.

1.2 The report ensures that that Trust conforms to best practice as recommended in the NHS Audit Committee Handbook (DH, 2005) and the Audit Committee Handbook (HM Treasury, 2007).

1.3 The Audit Committee reviewed its Terms of Reference in December 2017 and no changes were proposed.

1.4 During the year, the Chair of the Audit Committee was Rod Anthony.

2.0 Meetings

2.1 During 2017/18 the Audit Committee met on five formal occasions.

2.2 The attendance at these meetings is as below:

MEMBER	MEETING DATE					TOTAL
	25/04/17	30/05/17	29/09/17	01/12/17	23/02/18	
Rod Anthony (Ch)	✓	✓	✓	✓	✓	**5/5**
Tim Pile	✓	A	✓	✓	✓	**4/5**
Kathryn Sallah	✓	✓	✓	A	✓	**4/5**
Executive Directors in attendance						
Paul Athey	✓	✓	✓			**3/3**
Steve Washbourne				✓	✓	**2/2**
Garry Marsh			✓	A	✓	**2/3**

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		

2.3 During the year, it was agreed that the Non Executive representation from the Quality & Safety Committee should change from Kathryn Sallah to David Gourevitch.

2.4 Meetings are also attended routinely by representatives from the Trust's provider of External Audit and Internal Audit (to include Counterfraud) services. During the year the Audit Committee invited a number of guests to present progress on actions arising from some Internal Audit reviews that had provided limited or no assurance.

2.5 Prior to each meeting, the auditors meet in private with the members of the Audit Committee to discuss any matters or raise concerns where required, without any members of the Executive Team or guests present.

2.6 The Audit Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2017/18

The Committee dealt with the following key matters:

Routine Work

The Committee

- Reviewed and approved the Annual Report and Accounts for 2016/17, together with the Quality Account, Commentary, Head of Internal Audits report and Annual Governance Statement (and other disclosures) contained within.
- Received the 2016/17 Audit report from the External Auditors.
- Received and noted the timetable and proposed content for the Annual Report for 2017/18.
- Increased the focus on clearing outstanding audit recommendations, resulting in a review of all outstanding recommendations and an improvement in the performance of the Trust. This dipped towards the end on the year however, prompting renewed scrutiny and a different approach to be suggested, whereby the Executive Directors attend the meetings by rotation to present progress with addressing the review recommendations.
- Considered further and developed the relationship between Audit Committee and Quality & Safety Committee, strengthening in particular the upward assurance from the Quality & Safety Committee and the division in focus between the two committees
- Received the Deloitte audit planning report highlighting the key risks they had considered in planning their audit work.
- Received from Counter Fraud (RSM) updates on the counter fraud programme for 2017/18.
- Received the NHS Protect assessment report of anti-fraud, which presented a positive picture of the robust control environment in respect of fraud in the Trust.

- Received regular update reports from Internal Audit (RSM) and reviewed all significant internal audit reports. The internal audit plan remained on schedule during the year.
- Received regular updates on the tracking of implementation of all internal and external audit recommendations.
- Reviewed the proposed internal audit plan for 2018/19. This plan had been aligned to the Board Assurance Framework (BAF) and other risk mechanisms within the organisation and was therefore fairly robust.
- Received regular updates on the BAF process. The Committee noted that significant progress has been made during the year and the Committee offered its continued support to the use of the BAF, particularly in embedding it deeper into the organisation and using it to drive the focus of the Trust Board.
- Received routine updates on payments made for loss or compensation and waivers & breaches of Standing Financial Instructions. The Committee challenged when needed, the use of single tenders, given that the use of these had the potential to compromise best Value for Money.
- Received and supported proposed amendments to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation, mainly updating to the naming of the regulatory bodies and reflecting the changes in the Trust's committee structure.
- Received updates on the statutory registers, concerning hospitality and declarations of interest and urged that clinical staff be encouraged to make comprehensive and timely declarations when needed.
- Undertook a summary of its effectiveness, which did not highlight any major issues of note and agreement to repeat the exercise during 2018/19.
- Received an update on the Trust's accounting policies and approved some minor amendments to them to ensure that they remained consistent with the NHS Group Accounting Manual.
- Received an update from the Freedom to Speak Up Guardian on her work since taking up post. The Committee was encouraged to see the role had been embedded and a good level of concerns were being raised and addressed through the post.

Briefings

- The Committee received regular reports and briefings from Deloitte and RSM regarding the risks facing the Trust, together with relevant issues and topics:
    - The Apprentice Levy which came into force on 5 April 2017
    - The updated Group Accounting Manual
    - The changes to the Well Led Framework
    - The GDPR legislation which came into effect from May 2018
- Following a concern raised to the Council of Governors, the Committee received two updates from the Associate Medical Director on the Amplitude system, the main benefits of this being the ability to make more visible clinical outcomes data. The issues with the lack of administrative support for the system and lack of engagement with its use by some clinicians were the key risks to the successful implementation of the system. The Committee took assurance at the February meeting however, that the situation was being addressed and there was better support for and training in

the system. Apprentices were also to be used as 'floor walkers' to encourage patients to provide updates on the system.

- Given concerns raised in audits during previous years, the Committee received an update from the Clinical Services Manager for theatres on the actions taken to strengthen stock control in the area. The use of a new computerised solution, EDC Gold was noted to have been pivotal to the work. There had also been some estates work to alter the configuration of the area. The Committee agreed to keep the position under review, given the material impact of poor stock management seen previously.

Ad hoc matters

- The Committee received a report from the Associate Director of Governance & Company Secretary on the basis used to calculate compensation payments made to individuals under the terms of the NHS Litigation Authority requirements.
- The Committee received a detailed report on the Trust's status as a Going Concern. Taking all matters into account, it was agreed that as there were not material issues at present, the Trust could be declared as a Going Concern for 2018/19.

4.0 2018/19 Work Plan

4.1 For 2018/19, the Audit Committee will continue with its routine work as well as to deal with ad hoc requirements that will emerge from time to time.

4.2 The Committee has set clear expectations that the process for addressing recommendations arising from internal audit reviews be strengthened and is keen to see a more timely closure of actions.

4.3 Given the financial pressures on the organisation, close scrutiny on the Trust's Going Concern status will remain also an area of prime focus during the year.

5.0 Audit Committee Effectiveness

5.1 A full review of the effectiveness of the Audit Committee is next planned for October 2018, which will again be informed by a survey around the key areas of effectiveness as detailed in the Audit Committee Handbook and assess progress on the actions from the last effectiveness review.

6.0 Conclusion

6.1 The Audit Committee continues to play an important role in the governance and continued success of the Trust.

Rod Anthony
Chair of Audit Committee

July 2018

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 7 November 2018

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 7 November 2018 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 Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 7 November 2018: 1130h – 1330h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1130h	1	Apologies - Professor Gourevitch	Verbal	Chair
1132h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1135h	3	Minutes of Public Board Meeting held on the 5 September 2018: *for approval*	ROHTB (9/18) 008	Chair
1140h	4	Trust Board action points: *for assurance*	ROHTB (9/18) 008 (a)	SGL
1145h	5	Board Assurance Framework: *for assurance*	ROHTB (11/18) 001 ROHTB (11/18) 001 (a)	SGL
1150h	6	Chairman's and Chief Executive's update: *for information and assurance*	To follow	YB/PA
	6.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	PA
	6.2	Briefing on plans for Brexit 'no deal' scenario. BAF REF: FP3	Verbal	SW

TIME	ITEM	TITLE	PAPER	LEAD
QUALITY & PATIENT SAFETY				
1200h	7	Update from the Quality & Safety Committee and revised terms of reference: *for assurance and approval*	ROHTB (11/18) 003 (i) ROHTB (11/18) 003 (ii) ROHTB (11/18) 003 (a)	KS
1205h	8	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (11/18) 004	GM
1215h	9	Complaints annual report: *for assurance* BAF REF: None	ROHTB (11/18) 005 ROHTB (11/18) 005 (a)	GM
1220h	10	National patient survey: *for assurance and approval* BAF REF: CE4	ROHTB (11/18) 006 ROHTB (11/18) 006 (a) ROHTB (11/18) 006 (b) ROHTB (11/18) 006 (c)	GM
1230h	11	'Flu vaccine best practice self-assessment : *for assurance* BAF REF: None	ROHTB (11/18) 007 ROHTB (11/18) 007 (a) ROHTB (11/18) 007 (b) ROHTB (11/18) 007 (c)	GM
1240h	12	Learning from Deaths update: *for assurance* BAF REF: 275	ROHTB (11/18) 008 ROHTB (11/18) 008 (a)	AP
FINANCE AND PERFORMANCE				
1250h	13	Update from the Finance & Performance Committee: *for assurance*	ROHTB (11/18) 009 ROHTB (11/18) 010	TP
1255h	14	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (11/18) 011	SW
UPDATES FROM THE BOARD COMMITTEES & COUNCIL OF GOVERNORS				
1305h	15	Staff Experience & OD Committee: *for assurance*	ROHTB (11/18) 012 ROHTB (11/18) 013	RP
1310h	16	Audit Committee and revised terms of reference: *for assurance and approval*	ROHTB (11/18) 014 ROHTB (11/18) 014 (a)	RA
1315h	17	Charitable Funds Committee – minutes: *for information*	ROHTB (11/18) 015	YB
1320h	18	Update from Council of Governors meeting on 4 October 2018: *for information*	Verbal	YB
MATTERS FOR INFORMATION				
1325h	19	Meeting effectiveness	Verbal	ALL
	20	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 9th December 2018 at 1100h in the Boardroom, Trust Headquarters

Notes

Quorum

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

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

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

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 5 September 2018: 1100h – 1300h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and 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	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JW)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive Director	(SM)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient/service improvement story: Theatre improvements	**Presentation**
The Board received an update from Tracey Rutter, theatres matron on the improvements in theatres including the WHO checklist compliance, the 'Stop Before You Block' process, reducing the level of interruptions and improving privacy and dignity. Hydration audits were also now routinely undertaken as part of the work done to encourage patients to drink fluids prior to surgery. The Trust had submitted an application to the Nursing Times for one of its awards on the back of this work. Ms Rutter was thanked for her presentation. It was noted that the systems and processes in theatres were greatly improved and sustainability of the changes was evidenced by results of repeat audits. Staff engagement was noted to be key to the success of this work and so a routine morning staff meeting was now in place.	

These were positive meetings. The work undertaken to achieve a reduction in the level of interruption in theatres was also noted to be very positive and there was learning from other industries and could be applied elsewhere. This was highlighted to be practice already in place in nursing for drugs rounds as it was recognised to be safer if staff were not interrupted. It was suggested that an element of a staff member's uniform could be used to signify that the individual should not be interrupted. The findings of the interruption audit had been shared with the Clinical Quality Group. It was suggested that the inpatient division also needed to be challenged around reducing the interruptions. In terms of the overall improvement achieved in theatres, it was suggested that the same rigour for learning from when things went wrong needed to be applied to where things went right and therefore this improvement should be celebrated and openly shared. Morale was noted to have improved and representation at the correct forums had been secured.	
2 Apologies	**Verbal**
There were no apologies.	
3 Declarations of interest	**Verbal**
The register was reported to be available on request from Company Secretary. There were no additional declarations that needed to be made.	
4 Minutes of Public Board Meeting held on the 4 July 2018: *for approval*	**ROHTB (7/18) 008**
The minutes of the last meeting were accepted as a true and accurate record of discussions held on 4 July 2018.	
5 Trust Board action points: *for assurance*	**ROHTB (7/18) 008 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
6 Board Assurance Framework	**ROHTB (9/18) 001** **ROHTB (9/18) 001 (a)**
The Associate Director of Governance & Company Secretary presented the updated Board Assurance Framework. He proposed the de-escalation of four risks, two relating to the previous data quality issues associated with the Trust's waiting list, a further risk around access to cash management and another risk concerning staff engagement with the delivery of the Trust's strategy. It was suggested that the rationale around de-escalating this risk was around the recognised improvements in the engagement with staff around the strategy and vision, based on feedback from the staff survey, the staff Friends & Family Test outcome and the	

Well Led inspection report. The Board suggested that rather than de-escalate the risk, it needed to be reframed to reflect the need to engage correctly and the importance of the workforce agenda. Simone Jordan offered to consider how the risk might be rewritten to reflect this. The de-escalation of the other risks proposed was agreed. Two risks were proposed for addition, these being about the current and future impact of the vacancy position in the Trust. The Board agreed that these should be added. It was noted that the risks needed to be categorised in future to make it clearer at a glance what the key impact might be.	
ACTION: **SGL to amend the Board Assurance Framework in line with suggestions made by the Trust Board**	
7 Chairman's & Chief Executive's update: ***for information and assurance***	**ROHTB (9/18) 002** **ROHTB (9/18) 002 (a)**
The Acting Chief Executive invited the Director of Nursing & Clinical Governance to share his experience from recent 'back to the floor exercises'. He reported that reported that instead of ad-hoc walkabouts, he had undertaken a structured walkabout in a clinical uniform. It was apparent that the organisation felt more positive, particularly in the Pre Operative Assessment Centre (POAC) and staff were impressed by the commitment to improving the environment. The Multi Disciplinary Team (MDT) process for discharge was now daily and was safe and streamlined. It was highlighted that patients being treated by the ROH now were frailer and were living with more co-morbidities. Pain control and consistency in handling needed to be improved and a standard pathway was to be developed. The Chairman advised that her key activities since the Board had last met had included: • 5 July she had helped to celebrate the NHS's 70th birthday in the sunshine on the balcony of the Courtyard Garden. • 10 July she had joined the new consultant induction programme and was impressed with how engaged the new consultants had been. • 18 July she had undertaken an induction meeting with Professor Surinder Sharma who was engaged as an advisor on equality and diversity and was attending the Staff Experience & OD Committee later that afternoon. • 25 July, together with the Associate Director of Governance & Company Secretary, she had met with David Robinson, the Trust's new stakeholder governor for Bournville Village Trust. There had also been a round of public governor elections over the summer.	

• She had been undertaking NED appraisals, the outcome of which would be reported to the Council of Governors at the beginning of October. • She had attended a Schwartz Round around the importance of mental health support and advised that more counselling support was to be considered. A closer linkage with local mental health services was also needed. It was reported that Dame Julie Moore had now formally retired as Chief Executive of University Hospitals Birmingham NHSFT (UHB).	
7.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was reported that the Trust continued to work closely with UHB and Heartlands, Good Hope and Solihull Hospitals (HGS) to reduce waiting times and help with winter planning. There was confidence that a more consistent, standardised offering can be delivered in terms of orthopaedic care through this model.	
8 Paediatric services update: for information BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	**ROHTB (9/18) 003** **ROHTB (9/18) 003 (a)**
The Interim Chief Operating Officer advised that her update summarised the discussions that had been held in the private section of the Trust Board meetings over the past twelve months. A robust governance structure was reported to be in place around the discussions and decision-making around paediatric services, including through a joint oversight forum chaired by Non Executives from ROH and Birmingham Women's and Children's NHSFT (BWC). A meeting with the spinal deformity consultants had been held recently, where assurances had been sought as to whether there was approval from BWC for the paediatric transition business case. It was noted that readiness of Birmingham Children's Hospital (BCH) remained a key risk to the plans. It was agreed that the Acting Chief Executive would seek evidence of the formal agreement with BWC on the plans. Much work had been undertaken with the staff and the 24 staff affected had been given notice and they had been provided with the opportunity to visit BCH. Closer communications were needed between BWC and ROH to ensure there was a smooth transition, particularly for the staff. The Medical Director advised that there had been no incidents or transfers out, so in his professional view the service at the ROH remained safe. It was noted that one of the original CQC concerns had been that there should be two paediatric nurses in the Paediatric High Dependency Unit and at present in only 56% of cases this was the case, however this staffing was supported by adult staff who had appropriate paediatric care competencies. It was suggested that the impact of ROH surgeons undertaking work at BCH may	

affect the sustainability of adult services, particularly for ad hoc work undertaken on children by adult surgeons. This would need to be taken up with those making referrals. The Board noted that the Children's Orthopaedic Surgery Transfer (COST) campaign had been established, this being led by a patient of the Trust. A number of questions from the campaigner had been presented to members of the Council of Governors recently. The answers to the questions raised were tabled which would now be provided to campaigners and to the Lead Governor. An evening engagement session was planned for patients and their relatives. This would be held jointly with BWC. Flyers and posters were planned.	
ACTION: **JW to provide a further update on the paediatric transition plans at the next meeting**	
9 Progress against the five year vision: *for assurance* BAF REF: all risks	**ROHTB (9/18) 004** **ROHTB (9/18) 004 (a)**
A report tracking progress with delivery of the nine key goals within the five year vision was presented by the Director of Strategy and Delivery. The key highlights included: • The electronic prescribing and medicines administration system (ePMA) had been implemented. • Patient referrals were being made through a new electronic referrals mechanism. • Preparation for the students from the new medical school at Aston University was underway • The regenerative medicine laboratory development was well underway • The apprenticeship strategy was signed off and there was better spend against the apprentice levy. • The 'Perfecting Pathways' steering group provided oversight to large scale projects and the smaller projects had been reviewed by the Executive Team. • In terms of the growth for the future, the Trust was 129 ahead of plan for inpatients, but was 73 cases behind for day cases. • Theatre utilisation had improved significantly due to improvements as described in the earlier Board presentation.	

• 81% of staff recommended the ROH as a place to work in the recent staff Friends and Family Test, a big improvement from the previous position. The engagement score had also improved. It was suggested that there needed to be an easier read across from the original vision statement in future iterations of the report and the metrics needed to be redeveloped to more accurately reflect the vision. It was suggested that there needed to be greater clarity on the work within the wider system which needed to be added into the progress report.	
10 Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	**ROHTB (9/18) 005**
The Director of Nursing & Clinical Governance reported that there had been 217 incidents, three of which were moderate harms, these being two VTEs and a transfer out of the Trust. There had been no Serious Incidents or reportable infections during the month. There had also been no Grade 2 pressure ulcers during the month and year to date there were no Grade 3 or 4 pressure ulcers reported. There was a discussion around falls and it was reported that the numbers were static and the patients would be engaged with plans to reduce the number in future. There had been a coroner's inquest in July and the coroner was satisfied with the Trust's internal investigation. It was identified however that the process for reviewing patients who needed one to one care needed to be strengthened. A standalone report on this case was considered by the Quality & Safety Committee. A further inquest was scheduled for 12 September and some escalation issues for sepsis needed to be identified. It was suggested that some basic standards of care needed to be picked up and the leadership's responsibilities were to be reviewed.	
11 Radiology Review – A national review of radiology reporting within the NHS in England (CQC July 2018): *for assurance* BAF REF: None	**ROHTB (9/18) 006 ROHTB (9/18) 006 (a) ROHTB (9/18) 006 (b)**
It was reported that the CQC had recently undertaken an inspection of the Trust's compliance with the Ionising Radiation (Medical Exposure) Regulation and the key findings were outlined. The response to the report from the ROH was positive, however it was noted that performance was not reported formally to the Board at present. To address this, in future performance would be included in the routine performance reports which would be considered by the Quality & Safety Committee and Finance & Performance Committee. The team was thanked for the collaborative work ready for the IR(ME)R regulation assessment by the CQC, noting that the outcome of the review had been positive.	

The detailed report from the CQC following a national review of radiology was received and noted.	
12 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	**ROHTB (9/18) 007** **ROHTB (9/18) 008**
It was noted that there were two finance & performance reports, covering the two prior months. It was noted that the financial position was £1.948m in deficit against a planned deficit of £2.258m. A significant deficit was planned for August due to annual leave, although it was reported that the position was expected to be better than forecast. Inpatient activity was ahead of plan, whilst day cases were below plan at present. Income was strong however. It was reported that NHS Improvement had written out to all providers regarding elective performance and a response had been made to this to say that the operational plan that had been submitted was robust and the Trust was on plan to meet this. There had been an increase in expenditure on pay and non-pay during July. Agency staff cover was currently very high due to the number of vacancies in nursing at present. September/October would however see more nurses take up post. Some fellows would also be secured to address the medical agency position. There was reported to be greater scrutiny through e-rostering which would also assist. Mr Pile echoed this concern around the agency cost position given the upward trend. There was reported to be a clear focus on delivery of the Cost Improvement Programme (CIP) and the managed service contract in theatres was a significant scheme. Slippage was being challenged on CIP delivery where this was identified. Cash was reported to be ahead of target but this would remain tight for the remainder of the year. An analysis of the budget in the context of tariff changes over the past few years highlighted that the Trust was being funded far less favourably for its work now than it had been previously based on similar levels of activity; a pilot funding model for 2019/20 was currently being undertaken to take into account case mix, which may improve the position for the Trust in future. There had been an improvement on in-session utilisation and length of stay had also dropped. Performance against the cancer target was 90%. Performance was 85.44% against the 18 weeks RTT target; this improvement was	

due to efficiencies rather than validation. The number of patients currently over 52-weeks was 32. Performance against the diagnostic target continued to be met. In terms of workforce, the level of vacancies was a concern. Mandatory training rates were improving. Reliance on off framework agency staff had reduced.	
13 Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2018 NHS Core Standards: *for approval* BAF REF: None	**ROHTB (9/18) 009** **ROHTB (9/18) 009 (a)**
The Director of Strategy & Delivery reported that there had been an assessment against the core standards for Emergency Preparedness, Resilience and Response, which identified that there was partial compliance with two elements, including strategic training, although this was planned for 21 November. Compliance with the data protection security toolkit would be achieved by the time that the next submission was due. In terms of the oversight, there was no key forum to monitor compliance and this was being considered. The statement of compliance was approved.	
14 Board Code of Practice: *for approval* BAF REF: S800	**ROHTB (9/18) 010** **ROHTB (9/18) 010 (a)**
The Associate Director of Governance and Company Secretary advised that in response to the Governance review undertaken by Rod Anthony, a Board Code of Practice had been developed. It was proposed that that an annual assessment be undertaken against the Code of Practice, a process that would be led by the Associate Director of Governance & Company Secretary. It was noted that most of the requirements of the Code of Practice could be achieved by simple action and as the Board & subcommittees developed over the coming year, the Code of Practice would be used to guide any changes needed. It was suggested that equality and diversity should be an ongoing process and should not be confined to an annual assessment. Other than this observation, the Board approved the Code of Practice.	
15 Quality & Safety Committee: *for assurance*	**ROHTB (9/18) 011**
Kathryn Sallah, Chair of the Quality & Safety Committee reported that as part of the upward report from the Research & Development Committee, space was reported to be an issue for conducting clinical trials. The Director of Strategy &	

Delivery reported that space had been identified on Ward 3 for this purpose, which had not been reported to the Committee at the time. It was noted that compliance with water safety regulations needed to be strengthened and the action plan to achieve this needed to be revised. A summary of the claims position would be presented to the Board in future. There was positive assurance that the processes were in place to manage the Trust's litigation however. The terms of reference for the radiation safety advisory group had been approved.	
16 Finance & Performance Committee: *for assurance*	**ROHTB (9/18) 012**
The update was received and accepted.	
17 Staff Experience & OD Committee: *for assurance*	**ROHTB (9/18) 013**
The update was received and accepted.	
18 Audit Committee and annual report: *for assurance*	**ROHTB (9/18) 014** **ROHTB (9/18) 015**
The update was received and accepted and the Audit Committee's annual report was noted.	
19 Meeting effectiveness	**Verbal**
It was suggested that the agenda was broader and more balanced and discussions had been productive.	
20 Any Other Business	**Verbal**
The detail of the Board workshop on 3 October was discussed. It was noted that there had been a number of incidents of crime, including the theft of laptops and a television. It was anticipated that the crimes were all conducted by the same perpetrators. Additional security presence had been secured and as the CCTV system was out of date a review of this was underway. There had been some walkabouts out of hours and where there were weaknesses, these were being addressed including bringing forward the lock down of the site after visitors had left. A meeting of councillors, a local MP and the Police had been convened. This had been a positive meeting and there was challenge around the Police response who had agreed to support the Trust in an enhanced way. Security presence for escorting staff to off-site car parks was in place.	

It was noted that there had been similar issues identified as part of the quality assurance walkabouts and there had been much communication to staff around preventing 'tailgating' particularly. The Estates Board would provide oversight of this.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 7 November 2018 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 7 November 2018, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 2.11.2018

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 043	Patient Safety & Quality Report	ROHTB (11/17) 002	01/11/2017	Schedule a discussion around Clinical Audit at the Audit Committee	SGL	18-Jul-18	To be scheduled in for when the clinical audit internal audit has been completed. Due to be discussed at the Audit Committee on 25 January 2019	
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	05-Sep-18	Update on therapy services planned for the private Board meeting in September, with the strategy due for presentation in November 2018	
ROHTBACT. 060	Patient/service improvement story: Quality Service Improvement and	Presentation	04/07/2018	Schedule in an update on the progress with embedding the QSIR process into the workplan for the Staff Experience & OD Committee	SGL	~~07/11/2018~~ 09/01/2019	Scheduled for the ~~November~~ January meeting	
ROHTBACT. 062	Press and media report	ROHTB (7/18) 008	04/07/2018	Invite the Communications Manager to present an update on the work of his team at a future meeting	SGL	~~07/11/2018~~ 09/01/2019	Scheduled for the ~~November~~ January meeting	
ROHTBACT. 064	Board Assurance Framework	ROHTB (9/18) 001 ROHTB (9/18) 001 (a)	05/09/2018	Amend the Board Assurance Framework in line with suggestions made by the Trust Board	SGL	07-Nov-18	Amended version to be presented at the November 2018 meeting	
ROHTBACT. 065	Paediatric services update	ROHTB (9/18) 003 ROHTB (9/18) 003 (a)	05/09/2018	Provide a further update on the paediatric transition plans at the next meeting	JWI	07-Nov-18	Included in the private session of the November 2018 meeting	
ROHTBACT. 055	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Consider how the Board could be made aware of how clinical staff stretched themselves towards excellence	AP	~~06/06/2018~~ ~~30/09/2018~~ 3/10/2018	Outcome of the Clinical Excellence awards to be outlined to Staff Experience & OD Committee in ~~September~~ October 2018	
ROHTBACT. 052	Board Assurance Framework	ROHTB (3/18) 006 ROHTB (3/18) 006 (a)	07/03/2018	Arrange a risk workshop	SGL	~~31/07/2018~~ 31/08/2018	Arranged for 3 October 2018 as part of the Board workshop	
ROHTBACT. 054	Progress against the Five Year Vision	ROHTB (4/18) 002 ROHTB (4/18) 002 (a)	04/04/2018	Build exceptional staff experience into the strategic goals progress report	PB	~~04/07/2018~~ 05/09/2018	Added into the Board report considered at the September 2018 meeting	
ROHTBACT. 061	Paediatric services update	Verbal	04/07/2018	Arrange for a written update on the paediatric plans to be presented to the Board in public in future	JWI	05-Sep-18	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

TRUTS BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**7 November 2018**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at October 2018

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

<u>Summary of Key Updates</u>

It is proposed that the following risks be added:

- 1162 - Lack of dedicated resources to carry out all activities to minimise risk of cyber attacks to an acceptable level
- 1163 - There is a risk that weaknesses or vulnerabilities in software will be exploited maliciously.
- FP3 - The Trust may experience supply chain disruption in the event of a "no-deal" Brexit, resulting in operations being cancelled.

There are no risks proposed for de-escalation.

Risk 799 has been reframed in line with discussions at the Trust Board meeting on 5 September, so it now reads: There is a risk that the strategy is not embedded into the day to day operations of the organisation and fails to become part of business as usual for everyone.

Also as suggested at the Board meeting on 5 September, an attempt has been made to categorise the risks, so it is clearer what the key impacts and nature of the risk are.

The following coding system for the risk category has been developed:

- Financial health and sustainability
- Clinical excellence
- Patient safety
- Patient experience
- Workforce capacity, capability and engagement
- Systems, information and processes
- Regulatory compliance and national targets
- Equipment & estates
- Strategy and system alignment
- Reputation and brand

Finally, it is proposed in the next iteration of the BAF to refashion the document into two separate pages to better identify risks to the Trust's strategy and achievement of its vision, including those discussed in the recent Board workshop , against those risks that are included on the BAF as they have been escalated from local, divisional and committee risk registers. The Board's view on this proposal is sought.

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
- DISCUSS the proposal to stratify the BAF into high level strategic risks and those that have been elevated from local and committee risk registers through the risk escalation processes

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	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: 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 and elevated risks from local, divisional

and committee risk registers.
PREVIOUS CONSIDERATION:
Audit Committee on 18 October 2018

BOARD ASSURANCE FRAMEWORK - QUARTER 3

Risk Ref	Department	Executive Lead	Risk Statement	Risk category	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
CE1	Corporate	Paul Athey	The Trust does not currently have a clear financial and operational plan in places that describes how the organisation will deliver 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. This strategy has been updated by the Board in Q4 2017/18. A Strategic Outline Case has been accepted by the Board outlining options for future growth. Discussions are taking place with partners in the STP to work through options for providing closer clinical integration between the ROH and other partners, which will built resilience and support the move towards financial sustainability	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	5	25	↔	Agreement of system wide clinical and operational model for orthopaedics and subsequent ROH business and financial plan for sustainability	Mar-19	2	5	10
FP1	Finance	Steve Washbourne	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	5	5	25	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	↔	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 in developing a sustainable business model for the ROH which is in line with the requirements of the STP and other commissioning bodies	May-19	3	4	12
CE2	Corporate	Paul Athey	There is a risk that the ROH Trust Board carries all the clinical risk residing with the transition of Inpatient Paediatric Services whilst the system re-commission and re-provides the services elsewhere.		Developing services to meet changing needs, through partnership where appropriate	Trust Board/Quality & Safety Committee	5	5	25	The Trust agreed that it could not meet the national service guidelines and as such gave notice on the provision of the inpatient service. All stakeholders have confirmed that this should be managed as a system wide risk and this is done via the monthly Stakeholder meetings and the Paediatric monthly commissioning group. The Trust and the health system all acknowledge that the Inpatient Service at the ROH is not compliant with national guidance during this transition period. All stakeholders have agreed an amendment to the oversight group terms of reference stating "Whilst it is acknowledged that the ROH maintains accountability for each patient that is treated during the period during which the paediatric service remains with the ROH, all stakeholders within the group agree that the provision of a safe service during the transition period is their joint responsibility". Joint strategic and operational delivery groups have been set up creating a closer ownership of the transition from both organisations. A letter has been received from BWCH outlining the Trust's commitment to supporting safe staffing arrangements during the transition.	Minutes of stakeholder oversight meeting	4	4	16	↔	Agreement at joint stakeholder group that a system-wide risk sharing statement will be developed	Mar-19	3	4	12

1089	Operations	Jo Williams	There is a risk that the Trust fails to meet the trajectory to achieve a performance of 92% against the 18 Week RTT target as agreed with regulators		Delivering exceptional patient experience and world class outcomes	Finance & Performance Committee	5	5	25	Trajectories have been 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 were held to agree how the Trust will expand capacity to meet demand. Teams have completed trajectories for all services. A recovery trajectory is in place to achieve 92% by November 2018	Weekly report to Exec Team & Ops Board	3	4	12	↔	The Trust has in place a trajectory to deliver 92% performance by November 2018 - this is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for August is 85.26% against a trajectory of 88%, however plans are in place to meet trust forecasted position for delivery in November 2018. This is strengthened by each service ensuring they have a robust understanding of their Demand and Capacity issues and working with the Clinical teams to put plans in place to support the Trust objective of delivering 92% by November 2018.Differential waiting times within specialties continue to be shared with CSLS as part of a plan to meet RTT .Additional Theatre and Out patients capacity is being delivered following analysis of current waiting lists to focus on the key areas to deliver improvements in line with Trajectories. Pathway work is also ongoing in all specialities and additional therapy resources are being delivered in some areas to reduce the waiting times for pathways where these services are critical to patients progression through the pathway.	Q3 2018/19	3	4	12
293	Finance	Steve Washbourne	Financial surplus Failure to deliver planned financial surplus, impacting on financial stability, investment opportunities and regulatory rating.		With safe and efficient processes that are patient centred	Finance & Performance Committee	4	5	20	The Trust met its control total in 2017/18 and is currently on track to deliver its annual plan for 2018/19, which will meet its £6m deficit Control Total. It is important for the trust's long term sustainability however to return to surplus to enable it to generate cash and not continue to rely on loans from the Department of Health. A business case for the development of additional theatres and wards has been approved at July's Trust Board, which will drive additional contribution through the organisation over the coming years. This is currently being project managed with an expected go live of May 2019. The transition of paediatrics remains a risk with regards to the Trust's overall deficit position, although the Trust are working closely with BWCH to ensure the transition occurs smoothly and the relevant gap managed as appropriate. Discussions continue within the orthopaedic providers of the STP in order to work together in a manner most beneficial to the local population.	FPC Reports	4	5	20	↔	Perfecting Pathways to continue to deliver activity and operational process improvements Continuing performance meetings for each division Delivery of the theatre/ward business case development and subsequent uplift in activity. Ongoing working transition of the paediatric services and modelling of the impact once the patient pathways have been finalised in order to establish the activity/contribution 'gap'. Ongoing discussions with the STP to develop a revised model for orthopaedics across the Birmingham and Solihull region.	Ongoing	4	3	12
1137	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	Quality & Safety Committee	4	5	20	Updated Safe Operation and Maintenance of Water Systems Policy. Expanded Terms of Reference for Water Safety Group. Future meetings scheduled for Water Safety Group . Water Safety Group minutes presented to IPC Group meeting. Procedure for recording infrequently used outlets implemented. Water testing undertaken at 6 monthly intervals. Compliance delivery plan is also monitored at Quality & Safety Committee.	Water Safety Group minutes presented to IPC Group meeting.	4	5	20	↔	Water safety plan is in development. Pseudomonas Aeruginosa Risk Assessment completed, areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Ongoing	1	5	5

WF2	WFOD	Paul Athey	There is a risk that the future gap between staff in post and staffing required (total establishment) creates operational difficulties (with a potential impact on patient safety and experience), premium cost of temporary staffing or has a negative impact on staff engagement		Highly motivated, skilled and inspiring colleagues	SE & OD Committee	5	4	20	Whilst work has been undertaken to more fully understand the short-term resourcing needs and recruitment plan, the known additional staffing required for the theatre expansion has led to an increased level of likelihood for this risk beyond April 2019. A better understanding of development and employment routes. Routine Workforce Performance Data scrutinised at various levels within the Trust. Clinical staff now excluded from UKBA Tier 2 applications. New governance structure with increased focus on attraction, recruitment and retention of clinical staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Overseas recruitment group meets monthly to consider opportunities for oversees recruitment. Additional countries being explored to increase opportunity. Healthy Staff Bank to which staff are recruited regularly.	SE&ODC papers. Nurse staffing reports. People Committee reports.	5	4	20	↔	Plans for longer term (5 year) workforce transformation being developed including review of middle medial provision, specialist nursing programme, evaluation of use of Nursing Associate, new early engagement model for qualifying nurses, collaboration with STP partners, ACPs. Significant initial investment is required. Actions taken to maximise employee engagement to aid retention [ongoing].	Jan-21	3	3	9
WF1	WFOD	Paul Athey	There is a risk that the current gap between staff in post and staffing required (total establishment) creates operational difficulties (with a potential impact on patient safety and experience), premium cost of temporary staffing or has a negative impact on staff engagement		Highly motivated, skilled and inspiring colleagues	SE & OD Committee	5	4	20	No current evidence of adverse effect on patient safety due to safe staffing levels maintained through bank and in some cases agency staff. Increased activity through the Autumn months may provide some challenge. A better understanding of development and employment routes. Routine Workforce Performance Data scrutinised at various levels within the Trust. Clinical staff now excluded from UKBA Tier 2 applications. New clinical workforce governance structure with increased focus on attraction, recruitment and retention of clinical staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Overseas recruitment group meets monthly to consider opportunities for oversees recruitment. Additional countries being explored to increase opportunity. Healthy Staff Bank to which staff are recruited regularly.	SE&ODC papers. Nurse staffing reports. People Committee reports.	4	4	16	↔	Actions taken to maximise employee engagement to aid retention [ongoing]. Launch recruitment microsites and increase use of social media	Jan-21	3	3	9
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 & QSC	5	4	20	PTL validated, trajectory updated and currently 54 patients at 52 weeks RTT. New consultant started on 1st August and he is currently booked to undertake 1 extra new patient clinic (6pts per clinic) per week. These clinics are booked for the next 3 months	Weekly updates to Exec Team; updates to Trust Board.	4	4	16	↔	All patients have been validated to provide an accurate position of the number of patients waiting for surgery at BWCH, currently there are 42 patients awaiting surgery at BCH 5 of which 5 are waiting over 52 weeks , all listed patients have proposed operative dates. Additional adhoc operating lists are being sourced as part of the paediatric transition project from Sep - December 18. Contingency patients are in place when PICU beds are not available. Additional established Theatre capacity is being developed at BCH for Qtr 4 18/19. Following a review of the current waiting list 3 clinically appropriate patients have been transferred to Stoke for treatment.No plan at present for any further patients to transfer to Stoke.	Ongoing	2	4	8

27	Operations	Jo Williams	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	Finance & Performance Committee	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.Nov 17 - all agency staff to support RTT have been ceased form the end of October 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.	3	3	9	↔	Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. Interviews for Junior Fellow posts took place in September 2018 - 6 candidates were shortlisted -no candidates were appointed. Plan to re advertise posts in October 18 with a reviewed Job description to enhance recruitment potential. Work is also ongoing with UHB to support international recruitment. The future junior medical workforce plan is currently being reviewed in line with the strategic outline business case led by Phil Begg . 2nd meeting of stakeholder group took place in September 18- Draft Job descriptions for Alternative workforce model currently being developed. Weekly vacancies/sickness is monitored and appropriate action taken to mitigate agency staffing. A medical workforce co-ordinator has been appointed in September 18 and will commence Dec 18 to support the Operational Team and HR with the effective recruitment and co-ordination of the Medical Workforce.	Q3 2018/19	2	3	6
770	Operations	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	Quality & Safety Committee	4	5	20	This remains a very significant risk, and the likelihood of problems will increase as time goes on. Continued undertaking of maintenance where possible.	Estates maintenance schedule	3	5	15	↔	Theatre User Group to continue to track performance against turnaround work streams. Exploring possibility of using pre-fabricated theatres. Trust is working in partnership with ModuleCo on developing four new theatres.	Ongoing	1	5	5
CO3	Operations	Jo Williams	Theatres - there is a risk that the department is not operating effectively and is in need of a full review supported by a organisational development programme		Delivered by highly motivated, skilled and inspiring colleagues	FPC	4	5	20	The operational team for Theatre has been strengthened with the appointment of a new Theatre Manager and Matron. Further work with the team is ongoing to ensure that we continue to progress development across the entire Theatre team.	Perfecting Pathways Board papers and minutes	3	3	9	↔	To support the Perfecting Pathway programme and the Trust recovery plan there remains a need to conduct a full review of theatres supported by an OD programme. An initial assessment is currently ongoing to assess whether external support is required to support this. The workforce plan will be discussed at the Staff Experience and OD Committee in March 2018 as this needs to be developed to support and deliver the operational annual plan. The Theatre Manager post will be advertised & recruited substantively in April 2018.July 18 -A substantive Matron and Theatre Manger have been appointed. A full workforce plan is being developed by the Director of Nursing & Clinical Governance and the Head of Nursing to further support the team. A workforce plan is being developed to support the theatre expansion programme - led by the Deputy Director of Nursing.	Q3 2018/19	3	3	9

CO1	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	Finance & Performance Committee	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	3	3	9	↔	Delivery of the Cancer Action Plan. Onkos provides a daily tracking system. The team are developing proposal to implement a new system from April 2018 - this is supported by the Cancer Action plan. A new system has been approved for implementation in 2018. A project group will be established in April 2018 to manage the implementation. July 18- Somerset Oncology tracking system will be implemented with a go live date of October 2018. Project group in place to support the implementation of the Somerset system which is planned to go live by the end of October 18.	Q3 2018/19	2	2	4
CO2	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 needs 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. The operational team has been strengthened within a number of areas.	Trust Board reports on operational initiatives, including validation of 18 weeks RTT, Scheduled Care Improvement Board and theatres improvement programme	3	3	9	↔	The position will be reviewed weekly at Executive team meeting to ensure that this is not impacting on delivery of the projects This will continued to be monitored monthly. Perfecting Pathway encompasses and supports the operational team to deliver service changes and redesign. A substantive Deputy COO joined the Trust in February 2018. July 2018 - A dedicated post has been established to support Paediatric transition from 16.7.18. The post has been backfilled to support daily operational management. Reviewed weekly. Interim structure to support the team is in place whilst Inpatient Paediatric services are transferred	Q3 2018/19	2	3	6
269	Operations	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	Finance & Performance Committee	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. Perfecting Pathways papers. Modular theatre business case	3	4	12	↔	Embedding and delivery of Perfecting Pathways. Delivery of the integrated action plan round 18 weeks RTT, cancer services and spinal deformity. Development and delivery of recovery plan. Modular theatre set up anticipated to become functional in Spring 2019, which creates additional capacity for activity. Continued supprt provided to Heartlands, Good Hope and Solihull Hospitals.	Q1 2019/20	2	4	8
270	Finance	Steve Washbourne	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	Finance & Performance Committee	4	4	16	The Trust are currently operating within a 2 year 2-17/18-2018/19 tariff, which results in ongoing financial pressure for the trust as on a net basis it does not adequately reimburse the trust for the costs of delivery. The risks associated with operating with this tariff have been made clear in discussions with regulators & commissioners, and the trust continues to work with the regulators to develop a tariff which more adequately reflects the costs of treatment. There is a current lack of clarity regarding the likely timing of the new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. Updates are expected on the timing shortly, which should help with setting out the plan for planning activities and budget setting.	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. A specific review of BIU activity is ongoing.	Ongoing	2	4	8

804	Finance	Steve Washbourne	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	Finance & Performance Committee	4	4	16	The Business Intelligence team continue to increase the number of self service reports available to users via the BI Reporting Portal. In addition to the self-service aspect of the BI reporting portal. The BI team now mailshot out activity reports and consultant statements each month to consultants. Confidence in the Business Intelligence team is growing, the role of Bone Infection Data Analyst that traditionally sat outside the department has now being centralised into the BI Team. Dialogue has started between BI and the Oncology team to improve the level of support the BI team currently offer the service. The turnaround times of dealing with ad-hoc information requests has improved considerably over the last few months. Over 90% of requests being completed within 2 days. The BI structure has been changed to better cope better with increasing demands of reporting, with two posts due to go to advert this week (Business Intelligence Systems Manager & Information Analyst). These posts will help drive forward the team's ability to build interactive online reports and cope with new demands for reporting from new clinical systems such as around ePMA.	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	3	4	12	↔	Recruit to Business Intelligence Systems Manager & Information Analyst posts	Q3 2018/19	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	Quality & Safety Committee	4	4	16	Production of the monthly Quality Report that contains a clear focus on lessons learned from incidents, Litigation, Coroners cases, Serious Incidents, Patient Advice and Liaison Service (PALS), Friends and Family Test FFT, Complaints and Training Compliance. The Trust has in place an effective process to report, investigate, monitor and learn from Serious Incidents and complaints. All Trust Operational Divisions have both monthly and weekly meeting of their Divisional Governance Team as part of their local governance arrangements. The Divisional Governance Team will receive local intelligence relevant to their areas of responsibility so that they can assess performance against an extensive range of quality indicators. The Divisional Governance Teams report to the Clinical quality group Committee on a monthly basis via the Quality Dashboards and Condition reports that were introduced in March 2017 as a framework to assure quality, safety. The Trust Quality committee structure and subcommittees are established to facilitate Trust wide level representation and sharing of minutes. The Complaints/Governance team ensuring all incidents, complaints and claims are monitored and have Executive oversight at the weekly Executives Meeting. Monthly analyses of incidents/Complaints are included in the monthly Divisional management board Governance report and show Trust and Divisional trends .Further improvements have been made in terms of; The development of a Quality Governance Framework; The electronic reporting system (Ulysses) has seen improvements around incident reporting and action plan monitoring. This enables a thorough analysis of the incidents, causes and outcomes of incidents. Action plans are programmed to remind staff of actions automatically; Root Cause Analysis (RCA) training was provided for relevant staff undertaking investigations to help move the focus of the investigation from the acts or omissions of staff, to identify the underlying causes of the incident and to create a better standard of RCA. Further training is to be provided;	Patient Safety & Quality Report presented monthly to QSC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	2	3	6	↔	The CQC gave us specific feedback learning 'from incidents' is an area of improvement for the Trust. Learning from Incidents will remain as one of the Trusts quality priority and progress will be monitored by Clinical Quality Group. The Governance team are in the process of developing a learning strategy action plan to include; -Ensuring that the electronic reporting system (Ulysses) is used to its full potential. Action plan is on track for improvement and is monitored via the Clinical Quality Group. -Communication strategy in development with the Comms team to create online and physical resources to help highlight real incidents at ROH and the learning we can take from them. -The incident management policy has been updated and due to be ratified at execs in October 2018 -Core mandatory training has been updated to emphasise the importance of feedback for incidents reported and learning. -RCA training to be scoped -Implementation of the Allocate assure system The current production of the monthly Quality Report and local Quality Reports remain in place, and both weekly and monthly division Governance meetings are held to discuss learning and analysis from incidents and complaints. Learning is currently shared via the Governance structure and Clinical Audit days.	Q4 2018/19	2	2	4
FP3	Finance	Steve Washbourne	The Trust may experience supply chain disruption in the event of a "no-deal" Brexit, resulting in operations being cancelled.		With safe and efficient processes that are patient centred	Finance & Performance Committee	4	4	16	DH has written to all Trusts setting out a scheme to ensure a sufficient and seamless of medicines in the UK . Initial meeting with CEO of NHS Supply Chain who stated that that they are also implementing contingency plans to ensure that procurement and logistics will be sustained over the short term. Further formal communication of these plans will be published shortly.		3	4	12	NEW RISK	ROH will seek to discuss supply needs with commercial partners and new NHS Supply Chain Category Towers to ensure supplies will be available. Internal Business continuity Plan to be updated to reflect additional risk and proposed actions.	Feb-19	2	3	6

CE3	Corporate	Paul Athey	Risk that the plan for Paediatric is not aligned with the wider STP strategy for Orthopaedics		Developing services to meet changing needs, through partnership where appropriate	Trust Board	3	5	15	The Trust is actively engaged with the STP and clinical reference groups across BSOL are in place to shape the orthopaedic strategy for the future	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Agreement of transition plan following formal approval of transfer of paediatric surgery by BWCH	Q3 2018/19	2	3	6
1074	Finance	Steve Washbourne	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	Finance & Performance Committee	3	5	15	Scrutiny of cash through the cash committee is ongoing. Despite this the Trust has drawn down loans in the previous financial year from the DOH and expects to borrow further loans this financial year. Receipt of the STF funds has delayed the need for those loans, but the trust has requested a recent draw down and expects further draw downs over the coming months. Feedback on the cash flow modelling provided to the DOH and NHS Improvement each month has been 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	4	8	↔	Continued focus on efficiency and cost control through the recovery plan	Ongoing	2	4	8
986	Nursing	Garry Marsh	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for		Safe and efficient processes that are patient-centred	Quality & Safety Committee	3	4	12	1) Clinical Matron and SWS to be rostered onto clinical shifts when gaps in Ward 11 and CYP staffing occur. 2) CYP staffing roster to be reviewed and non-essential training and education to be removed and hours then used to cover the CYP roster. 3) Management time associated with B6 management responsibilities to be cancelled if necessary to maintain staffing.	Q&S Report	3	4	12	↔	Ongoing recruitment programme	Ongoing	1	4	4
PS1	Nursing	Garry Marsh	There is a risk that patient care/safety may be compromised as we do not have enough Paediatric staff/vacancies on the ward.		Safe and efficient processes that are patient-centred	Quality & Safety Committee	3	4	12	Combined rota and management of services (CYPDHDU and Ward 11) allows better oversight and utilisation of nurse staffing and staffing levels. Twice weekly meeting held to review staffing, activity and acuity and identify/escalate gaps in staffing. Children's Quality Report triangulates staffing vs harm and is scrutinised at CYP Board.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses.	Ongoing	1	4	4
CE4	Corporate	Paul Athey	There is a risk to the ROH reputation should the Paediatric service not be transferred in a timely and safe manner		Safe and efficient processes that are patient-centred	Trust Board	4	3	12	The Transition of services is due to take place from November 2018, however formal sign off is still outstanding. There is a risk that this timeframe could be extended. The Executive team continue to play an active part in system conversations to drive agreement of a transition plan. An internal governance structure for the transfer of services has been agreed by the Trust Board in April 2018. A communication plan is in place to ensure staff and patients are updated as and when circumstances develop	Team Brief; Joint stakeholder meeting minutes; Other system wide meeting minutes; Local transition group minutes, Children's Board minutes; E-mail correspondence from clinicians to Execs	4	3	12	↔	As part of the system wide meeting structure all risks relating to the transfer of services will be jointly risk assessed and appropriate mitigation will be in place.	Q4 2018/19	2	3	6

FP2	Finance	Steve Washbourne	The Trust is likely to incur transitional costs with the transfer of Inpatient Paediatric Services		Safe and efficient processes that are patient-centred	Finance & Performance Committee	4	3	12	The Trust has highlighted the risk to NHSE and requested funding support should material additional costs be incurred. The Trust continues to review how existing resources can be utilised to ensure safe services and mitigate additional cost where possible.	Joint stakeholder meeting minutes	4	3	12	↔	The Trust would look to gain firm agreement with NHSE for the changes in local prices where the cost base increases on recurrently during the changes. The DOF met with the HoF from NHSE on 14/02/18 to discuss how a request for additional funding to support Paed services may be made during 2018.	Q4 2018/19	1	4	4
MD1	Clinical	Andrew Pearson	There is a risk that there will be some clinical resistance to the change in the way Paediatric Services are delivered		Delivering exceptional patient experience and world class outcomes	Trust Board	4	3	12	Briefing sessions have been held with all the clinical teams including clinically led reference groups established who meet to discuss the potential options and likely impact. A clinical session was also held in September chaired jointly with the ROH and BWCH Medical Directors to talk through the changes, the rational and the timeframe. This is supported by regular updates via email, team brief and 1-1 discussions with the Executives Team.	Trust Board meeting minutes of updated on staff enagagement sessions; record of discussions around concern about delivery of Oncology service	3	3	9	↔	Continued briefing sessions to be delivered through routine and bespoke staff communication routes as part of the Paediatric transition plan. The issue concerning the Oncology pathway is being worked through to develop the most effective solution ahead of the service transition.	Jan-19	2	2	4
S799	Strat	PhilBegg	There is a risk that the strategy is not embedded into the day to day operations of the organisation and fails to become part of business as usual for everyone		Highly motivated, skilled and inspiring colleagues	Trust Board	4	3	12	A Strategic Outline Case has been created, the development of which included multiple direct staff engagement workshops with various groups of clinicians across the Trust. A Chief Executive briefing session was delivered in January 2018, which reinforced the key messages of the SOC, in addition to the launch of the Five Year Vision which was signed off by the Board in early 2018.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case	2	3	6	There is	Staff to continue to be engaged with the development of the Outline Business Case and later the Full Business Case for the ROH.	Q1 2019/20	2	3	6
1162	Finance & Performance	Steve Washbourne	Lack of dedicated resources to carry out all activities to minimise risk of cyber attacks to an acceptable level		Safe, efficient processes that are patient-centred	Finance & Performance Committee	3	4	12	The number of risks notified by CareCert each week means that significant effort is required across servers, networking and project teams. Many of these activities are not being actioned due to other priorities. Only High risk items from CareCert will be actioned from now on. Contractor Cyber Security Officer just been appointed at Band 6 for 3 months, so some progress to be made shortly with outstanding tasks.		3	4	12	NEW RISK	Progress made with approval of a Band 6 Cyber security officer. Recruitment is just underway so not expected to start until at least October 2018. Since resource was agreed the amount of Cyber activities have increased to beyond 1 person's capacity, so a recommendation is to be made for a 2nd resource	Ongoing	1	4	4

1163	Finance & Performance	Steve Washbourne	There is a risk that weaknesses or vulnerabilities in software will be exploited maliciously.		Safe, efficient processes that are patient-centred	Finance & Performance Committee	3	4	12	Process implemented to patch corporate windows servers monthly. Further work planned to extend the type of patches installed and the range of operating systems patched (IOS, Cisco, Intel, Linux etc.). Currently talking with 3rd party suppliers (GE, Philips, Siemens, Omnicell) to agree a process for patching their servers and/or isolating them from the corporate network		3	4	12	NEW RISK	Target dates awaited from BI to decommission old windows 2003 servers; discussions ongoing re Theatres and Finance. Options and costs awaited from BI to determine best mitigation for Apple databases and clients. Awaiting information from Pharmacy regarding XP machines for Ascribe and Omnicell. Conversations ongoing with GE to remove windows 2003 devices. Discussions ongoing with Knowledge hub staff to replace /isolate MACs in the library	Ongoing	1	4	4
S800	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	Quality & Safety Committee & Trust Board	3	3	9	New structure for the Clinical Governance Team developed. Processes for reporting up into the Quality & Safety Committee continue to work well and form a key part of the Committee's agenda at each meeting. Assurance reports from Committee chairs up to the Trust Board continue. Assurance review into effectiveness of Board & Committee operating commissioned.	Divisional Management Board agendas, papers and minutes. Clinical Governance structure chart; TOR and work plan 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. Report from Board & Committee review to be concluded and make recommendations. Purchase of new eletronic governance solution for better management of Trustwide policies and creation of additonal dashboards of performance against key quality metrics.	Q3 2018/19	1	3	3

RISK CATEGORIES

- Financial health and sustainability
- Clinical excellence
- Patient safety
- Patient experience
- Workforce capacity, capability and engagement
- Systems, information and processes
- Regulatory compliance and national targets
- Equipment & estates
- Strategy and system alignment
- Reputation and brand

ROHTB (11/18) 003

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board last met: 26 September 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee received an update on resuscitation. There was concern over the lack of clear ownership of the resuscitation agenda and attendance at the resuscitation committee meetings was reported to be poor. To address this, the Director of Nursing & Clinical Governance would take on the chairmanship of this committee in future and it would report into the Clinical Quality Group. • There remained ongoing issues with training in Basic Life Support, although the use of resuscitation carts would assist with training staff to suit their availability. • There had been three moderate harm incidents reported: two VTEs and a fall. • 78% of complaints investigated were upheld to some degree. • There were a large number of service level agreements contractually out of date, however the Executive was planning to review these shortly. • There remained a vacancy in terms of the Named Doctor for Children; there were mitigations in place to cover this until a substantive individual was identified.	• An update on the Bone Infection Unit is to be presented in January 2019 • Progress with the implementation of the Allocate system to be presented in October. • Presentation of the complaints report to the Trust Board in November. • Presentation of the patient survey results to the Trust Board in November • The CQC action plan to be refined to better reflect progress and areas off track.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• A resuscitation 'Superhero' week was being arranged to revitalise the resuscitation agenda. • A new operational manager for the Bone Infection Unit was reported to be in post and there was good engagement with clinicians to develop the future strategy for the unit. • New light leads had been purchased, in response to some incidents reported around patient burns. • Response rates to the Friends and Family Test had improved, including in Outpatients.	• It was agreed that the revised terms of reference, which streamline the regular attendee list in line with the recommendations from the recent governance review, should be presented to the Trust Board for approval.

• There was good progress with strengthening the Trust's expertise in Mental Health, including ensuring that the Trust had in place two mental health first aid facilitators. It was suggested that mental health training needed to consider staff as well as patients, so that colleagues could be supported; this was part of the health and wellbeing action plan. It was suggested that restraint be built into the plans. • There were plans to improve the patient engagement framework in the Trust and a patient experience group was to be created. The way that this interacted with the current Patient & Carers' Forum was being worked through. A stronger link with Healthwatch was being formed. • There had been a decrease in the number of formal complaints reported over the year, particularly associated with spinal services and oncology. • The Trust remained within the top 10 trusts for patient satisfaction. • The Committee received some good assurance regarding the robustness of the radiation safety arrangements. A Radiation Safety Advisory Group had been set up which would report into the Quality & Safety committee. • It was reported that there was evidence of good adherence to the national learning disability standards. • Performance against the Trust's contract with commissioners was reported to have been positive for the first quarter and in terms of CQUINS all targets had been met for Quarter 1. A 'flu target of 75% had been set.	

Chair's comments on the effectiveness of the meeting: The meeting was noted to have included some productive debate. Every effort should be made to avoid issuing key papers late however.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board last met: 31 October 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Trust was not compliant with 6 of the 30 changes to NHSI tissue viability recommendations as at 1 October. Changes have now been added to Ulysees. • Adherence to sepsis pathway continues to be a challenge. • Non-compliant with Accessible Information Standards. Compliance expected by January 2019. • Paediatric staffing continues to be a challenge. • Shortage of Hep B vaccine since June 2017 but not escalated through the Trust. Assurance is sought form OH provider that all frontline staff have been vaccinated. • Potential health hazard caused by diathermy smoke plume in theatres. Extraction system not legal requirement, advice is to refer to COSHH. Under investigation but there is a cost pressure. • Inefficient lighting around the Trust. Concerns about installing LED lighting due to proximity of private housing. • Radiation Advisory Group identified concerns that theatre staff are exposed to radiation from Mobile C arm. Radiation badges being given to staff and monitoring to take place for six months. • Concerns continue regarding the lack of a functioning Research Committee. To be escalated to appropriate director. • Long term sick leave of spinal registry clerk. • Possible failure to meet COSD V8 data requirements.	• Technology solution company being brought in to improve the current CCTV system at a cost c£8k. • CCTV control panel to be removed from porters' lodge. • Quarry tiles in the lobby near the kitchen to be covered with non-slip flooring following a significant slip incident. To be installed in the mid-term. • Deputy Director of Nursing to chair future Clinical Quality Group meetings. • Paediatric cancer pathway development at BCH. • Mental health training, education and policy development.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• There were no SIs in September and none are currently open. • The Safety Thermometer showed 98.69% harm free care in September. • There was an issue around the Trust not meeting the VTE minimum requirement of 95%. September achieved target at 95.43% and this is expected to continue. • Ahead of trajectory with paediatric spinal deformity waiting list. • Successful harm review process is with Comms with a view to submitting to HSJ for award. • PROMS scores remain at or above the national average. • A full time resource has now been allocated to the transfer of paediatrics. • Grace period offered by PHE for COSD V8 until Somerset Cancer Registry implemented.	• Children's Board meetings have reduced to bi-monthly. • New risk added to CAEC risk register to reflect PROMS provision by Quality Health. • Learning from deaths process agreed. • Inform BWCH that some sarcoma cases treated there are not being discussed at Sarcoma MDT. • Trust risks aligned to the CQC responsive action plan. • The updated terms of reference for Quality & Safety Committee were approved.

Chair's comments on the effectiveness of the meeting: It was agreed to have been an effective meeting

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Quality & Safety Committee
Terms of Reference
Revised October 2018

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) Staff Experience & 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** – 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.

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, Health & Safety Committee, Research & Development Committee, Cancer Board, Clinical Audit & Effectiveness Committee, Radiation Safety Advisory Group and Clinical Quality Group
6.8 The Committee will receive annual reports from the Infection Prevention and Control Committee and an annual complaints report for review prior to Trust Board approval
6.9 The committee will consider feedback from the Trust's patient groups and from peer reviews.
6.10 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 Nursing & Clinical Governance
Medical Director
Chief Executive
Chief Operating Officer

9 Quorum

At least two NEDs (including the Associate Non Executive Director) and one from Executive Medical Director or Executive Director of Nursing & Clinical Governance.

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, Heads of Nursing, the Head of Clinical Governance 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 Nursing & 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 **November 2018**
Date of next review **October 2019**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

October 2018

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Clinical Commissioning Group to satisfy contractual information requirements and the CQC for routine engagement visits.

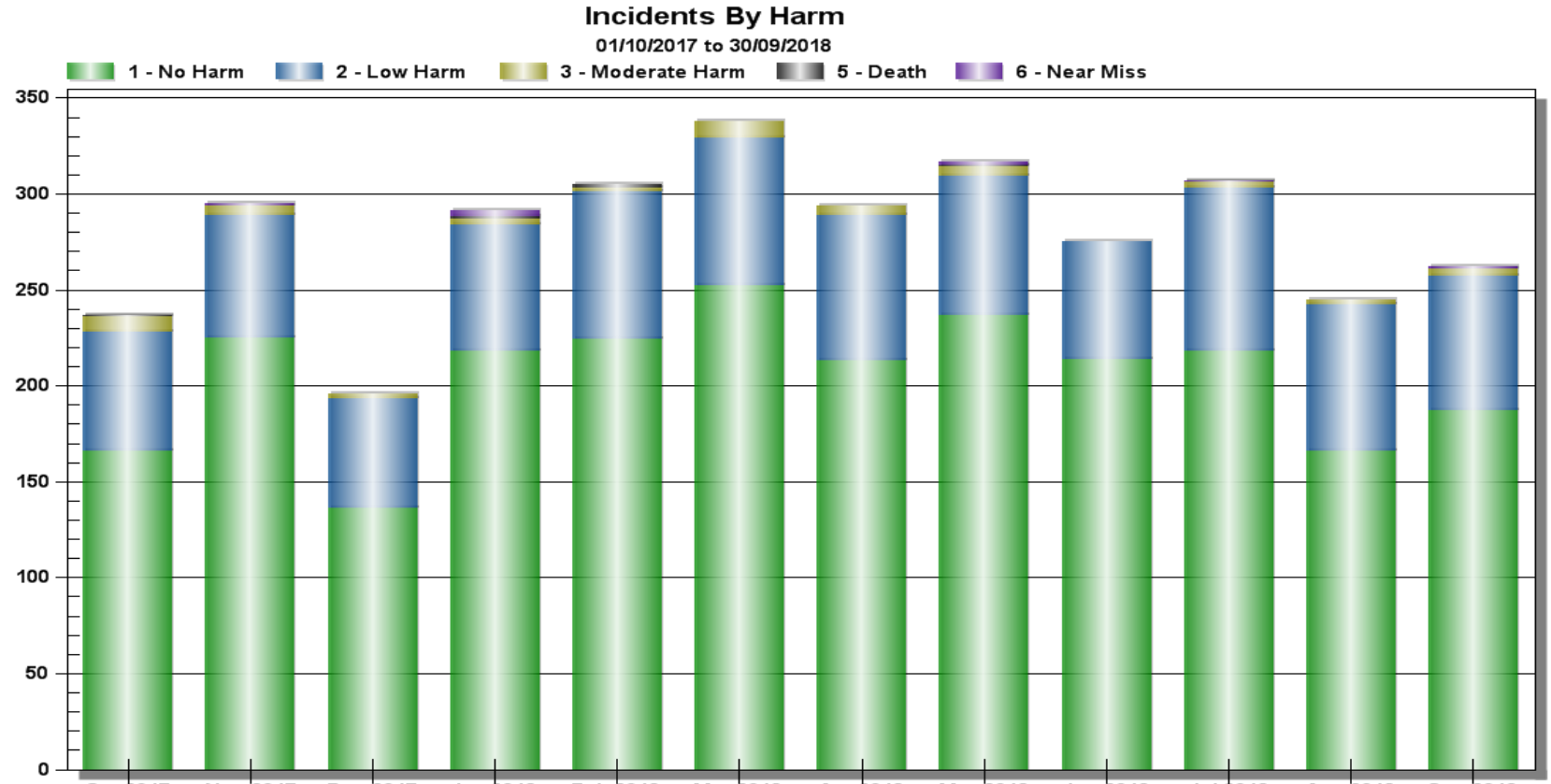
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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.

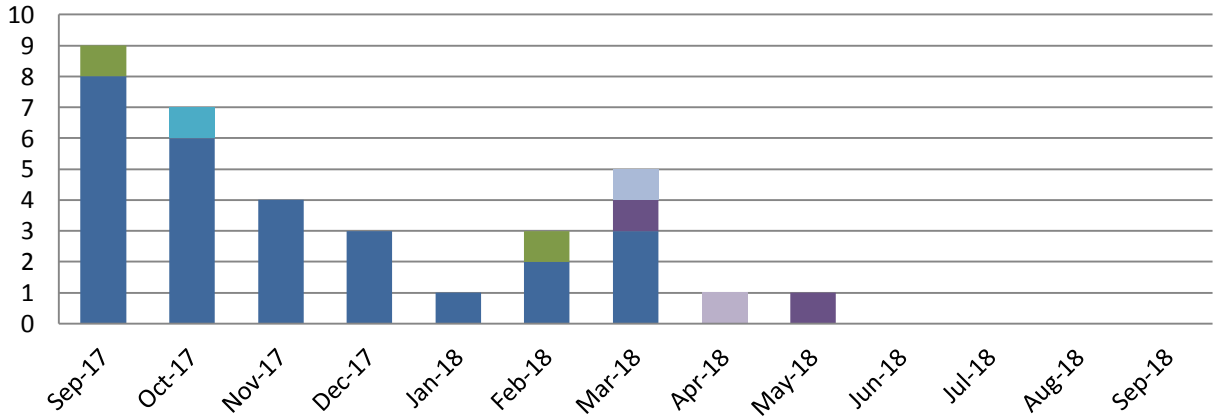


Month and Year	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018
1 - No Harm	166	225	136	218	224	252	213	237	214	218	166	187
2 - Low Harm	62	64	57	66	77	77	76	72	61	85	76	70
3 - Moderate Harm	8	5	3	3	2	9	5	5	0	3	3	4
5 - Death	1	0	0	1	2	0	0	1	0	0	0	0
6 - Near Miss	0	1	0	3	0	0	0	2	0	1	0	1

INFORMATION
In September 2018, there were a total of 265 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows; 187 – No Harm 70 – Low Harm 4 – Moderate Harms 0 – Severe Harm 1 – Near Miss 0 – Death In September 2018, there were a total of 8775 patient contacts. There were 265 incidents reported which amounts to 3.01 per cent of the total patient contacts resulting in an incident. Of those 265 reported incidents, 74 incidents resulted in harm which is 0.84 per cent of the total patient contact.
ACTIONS FOR IMPROVEMENTS / LEARNING
The Governance team have a number of improvements planned; • The incident management policy has been updated and is due to be ratified in October 2018. • System improvements are taking place to Ulysses to enable better tracking management. The action plan for improvement is on the agenda for Clinical Quality Group in October 2018. • Serious Incident Audit underway to review outstanding open action of RCAs to ensure closure.
RISKS / ISSUES
A risk has been added to the risk register due to the staffing levels within the Governance team. The Governance team currently have 1 WTE vacancy and 1 member of staff on maternity leave. As a result of the vacancy position, the Ulysses improvement plan is making slow progress. The Trust has made an offer to one potential candidate.

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.

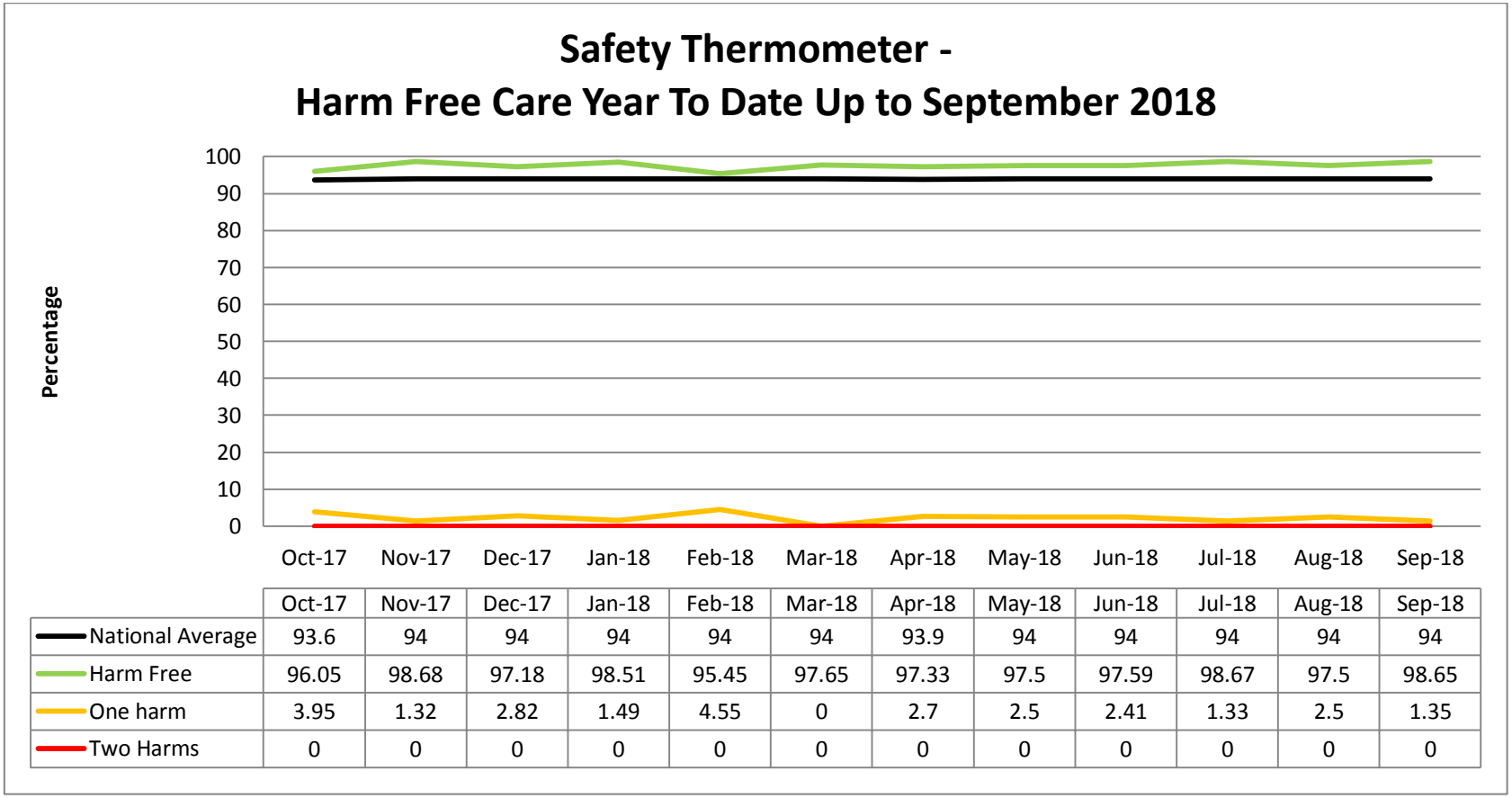
Serious Incidents Declared Year to Date to September 2018



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Transfer out								1					
Unexpected Injury													
RTT Harm review													
Information Governance Missing Laptop							1						
Retained object		1											
Wrong side injection													
Slips, trips & falls							1		1				
Pressure Ulcers	1					1							
VTE meeting SI criteria	8	6	4	3	1	2	3						

INFORMATION
No Serious Incidents were Declared in September 2018; The Trust currently has no open Serious incidents.
ACTIONS FOR IMPROVEMENTS / LEARNING
No Serious Incidents were closed in September 2018. The Governance team are currently undertaking an audit of the Open actions from Serious Incidents. Any open actions will be reported and managed through the divisions with an upward report to Clinical Quality Group. The Governance team have developed a 'Learning from Incidents action plan' with plans to; • Closure of the Ulysses action plan; • Audit the open actions of Si's; • Create online and physical resources to highlight key incidents and learning; • Launch the Quality Strategy for the Trust; • RCA training; • Human factors training; • Review the Trust against the WMQRS for Clinical Governance.
RISKS / ISSUES
None

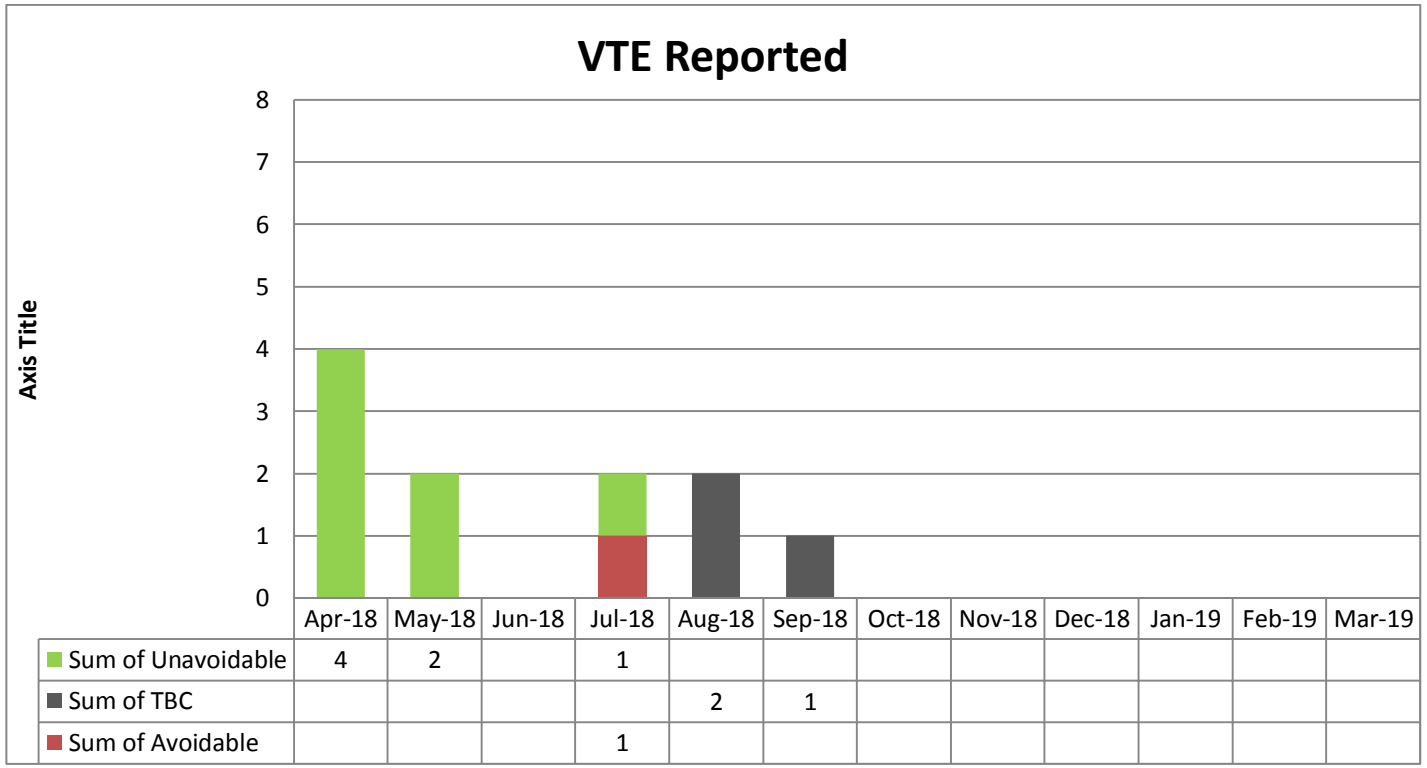
4. **NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
National Average	93.6	94	94	94	94	94	93.9	94	94	94	94	94
Harm Free	96.05	98.68	97.18	98.51	95.45	97.65	97.33	97.5	97.59	98.67	97.5	98.65
One harm	3.95	1.32	2.82	1.49	4.55	0	2.7	2.5	2.41	1.33	2.5	1.35
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

In September 2018 - There was one reported harm on the Safety Thermometer; this was the new VTE reported on page 5.

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 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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	4	2		1								
Sum of TBC					2	1						
Sum of Avoidable				1								

9

total		Avoidable
17/18	33	10
18/19	11	1

INFORMATION

There was one VTE reported in September 2018. This is compared to 8 reported in September 2018. The avoidable VTE in July 2018 is currently under review by the Division to determine if it meets the Serious Incident Framework.

ACTIONS FOR IMPROVEMENTS / LEARNING

VTE commissioner reporting requirements for 2018/19:

VTE risk assessment (minimum requirement of 95%): As highlighted in last month's Quality Report PICS was launched in September 2018 . This includes mandatory completion of on admission VTE risk assessment in PICS. Despite interventions, due to new process Q2's VTE assessment compliance was affected resulting in the minimum quarterly requirement of 95% not being met:

July 92.02%

Aug 89.33%

Sept 95.43%

Total for quarter 2=92.28%

This will continue to be closely monitored but it is anticipated target will be reached again in quarter 4.

VTE information in PICS :

Above and a recent incident has identified that ROH IMT is unable to access auditable information within PICS. This has been escalated to Servelec and relevant ROH Executives.

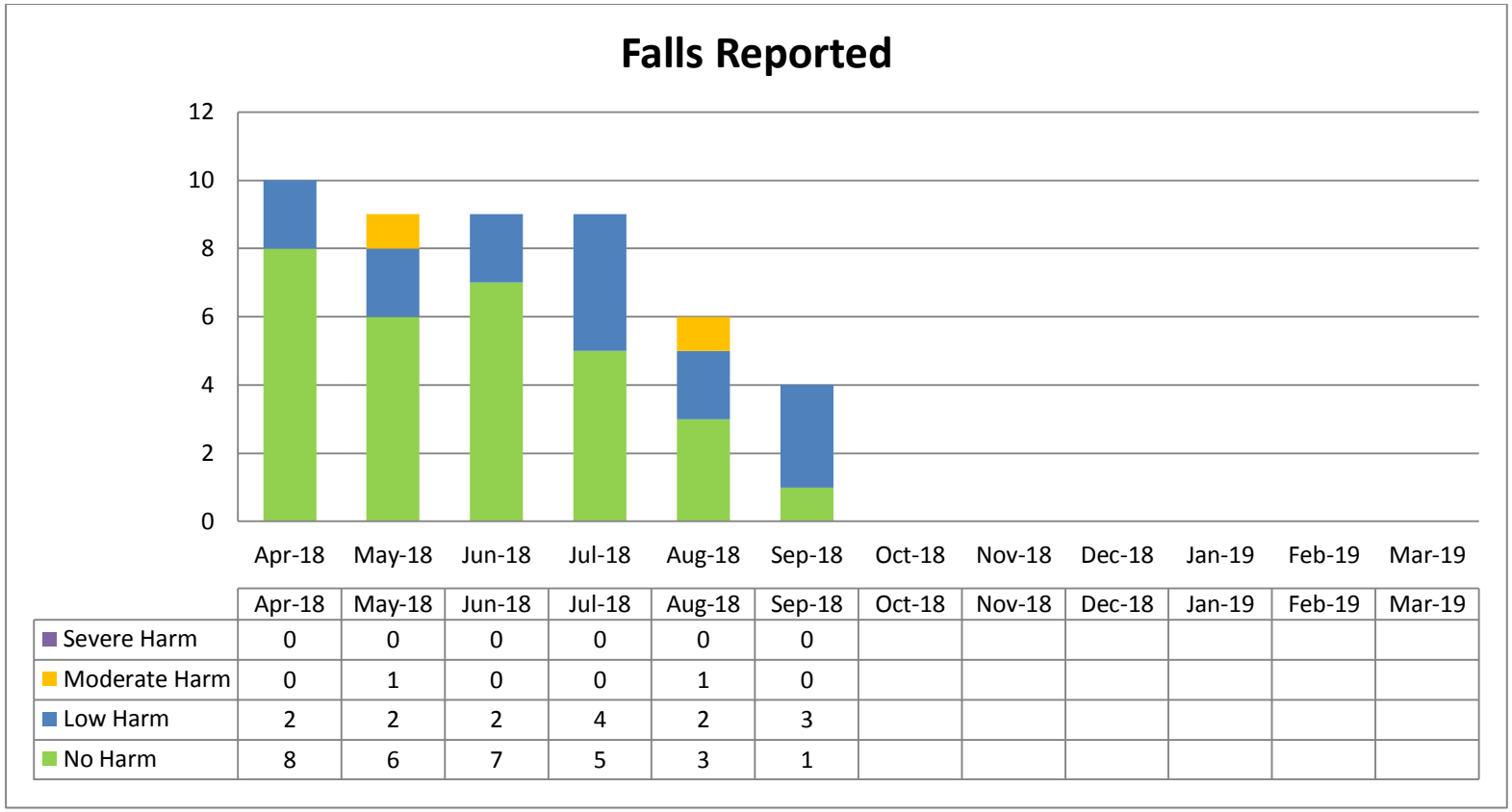
NICE VTE Prevention Guidance –Updated March 2018

VTE leads are still working internally with CSLs to reach a consensus agreement on this guidance. The VTE Exemplar network is surveying member leads, which includes us, to establish how and if guidance has been implemented. There is no risk to patients as a result of continuing to follow 2010 guidance until a consensus is reached.

RISKS / ISSUES

None

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.**

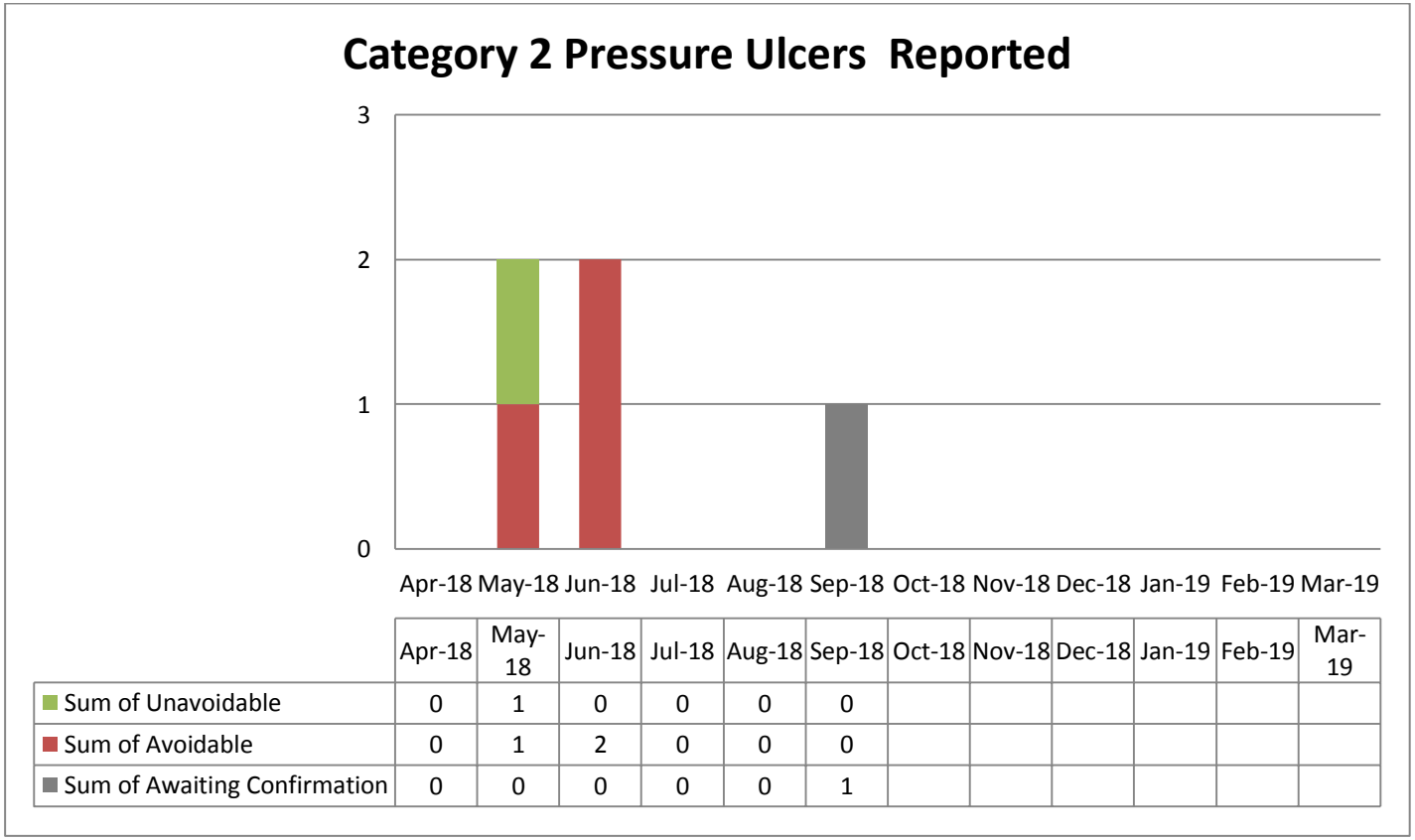


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Severe Harm	0	0	0	0	0	0						
Moderate Harm	0	1	0	0	1	0						
Low Harm	2	2	2	4	2	3						
No Harm	8	6	7	5	3	1						

total	
17/18	115
18/19	48

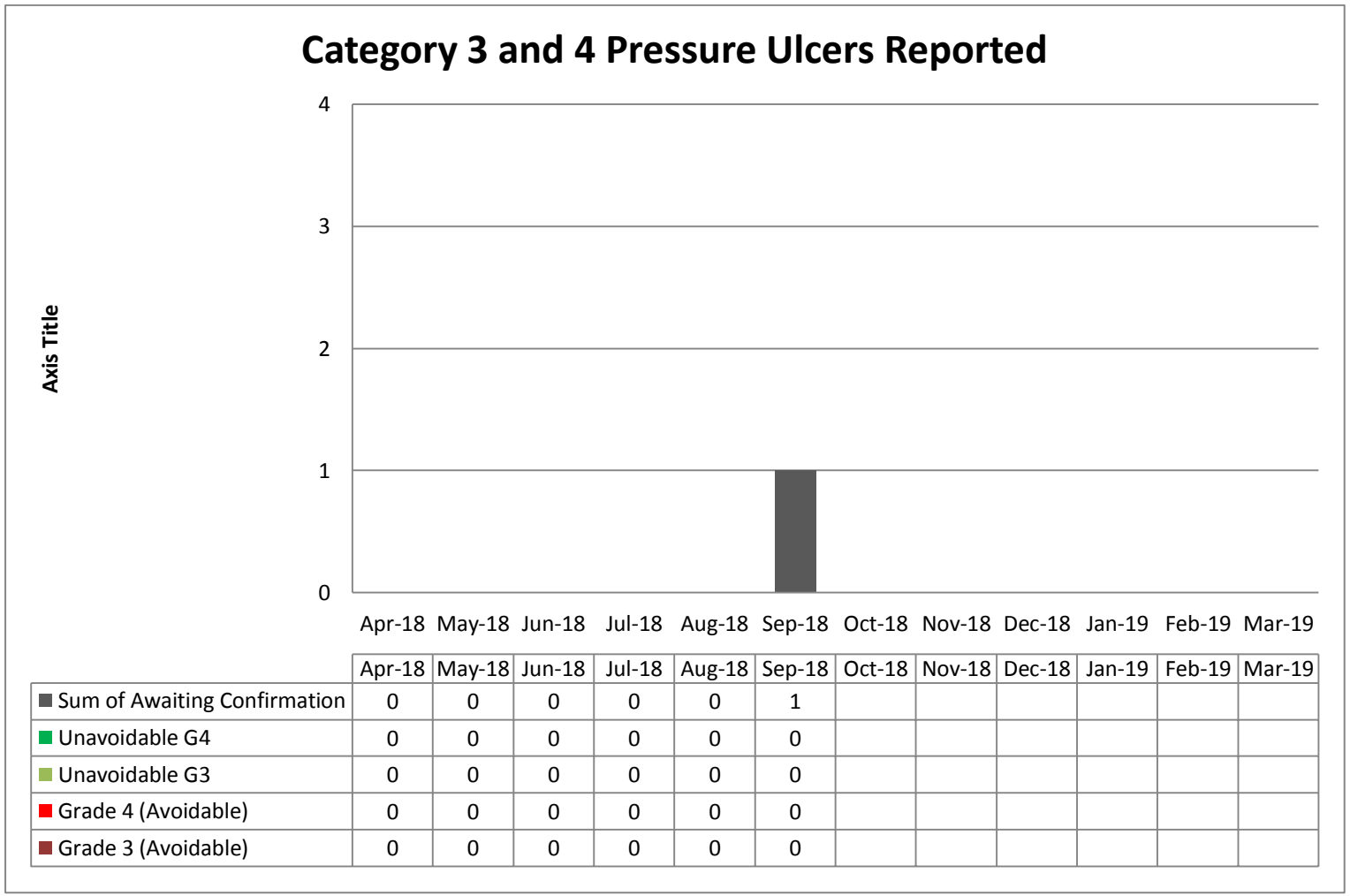
INFORMATION
Overall there were 4 patient fall-related incidents reported across the Trust in September 2018, all were related to adult patients. 4 Falls were graded either no or low harm. All falls are reviewed in the Trust's Falls group with an upward report to Clinical Quality group. All incidents 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 and are also reported in the Monthly Quality Report. Across in-patient areas, we continue to utilise a collaborative, multi-disciplinary approach to falls risk assessment, care planning and falls prevention strategies.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions Underway • Review of falls training on clinical skills updates to make it more interactive, e.g. Use of scenarios, feedback of actual incidents resulting in harm from within the trust. Use of simulation/videos for falls training. • Peer review of the falls prevention and management. • Purchase another Hover Jack, to be considered next year. • Develop Falls intranet page • Quote and demonstration for replacement hoists from Arjo, and Oxford hoists **Positive Assurances** • Falls policy review/ update. • Use of bed rails audit. • Staff training on the use of manual handling equipment such as Sara steady. • Clinical skills update reinstated to yearly. • Template for Medical review post fall • Benchmarking of the WMQRS
RISKS / ISSUES
Only one Hover Jack available for the trust, this is also used for training. Liaised with the Director of Nursing regarding raising a capital bid for another one, this will be considered next year.

7. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful" 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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	0	1	0	0	0	0						
Sum of Avoidable	0	1	2	0	0	0						
Sum of Awaiting Confirmation	0	0	0	0	0	1						

total	Avoidable
17/18	6
18/19	3



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Awaiting Confirmation	0	0	0	0	0	1						
Unavoidable G4	0	0	0	0	0	0						
Unavoidable G3	0	0	0	0	0	0						
Grade 4 (Avoidable)	0	0	0	0	0	0						
Grade 3 (Avoidable)	0	0	0	0	0	0						

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

INFORMATION

In September 2018, there were 1 Category 2 and 1 Category 3 pressure ulcers recorded. This compares to the two Grade 2 reported in September 2017.

Category – 4	0
Category – 3	1 - Unstageable at least a Category 3 – device related
Category – 2 (Non-Device)	0
Category – 2 (Device)	1
Category – 1	0

As part of the new NHSi standard '*Pressure ulcers: revised definition and measurement*' from October 2018 The Trust will now report on the below;

Number of Patients admitted with PUs

PU From Other Hospital - Grade 3 x 3

Number of Moisture lesions

There were no recorded incidents of Moisture lesions recorded

Avoidable Pressure Ulcer CCG Contracts KPI

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	**3**
Avoidable Grade 3 pressure Ulcers limit of 0	**0**
Avoidable Grade 4 pressure Ulcers limit of 0	**0**

2017/2018:

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	**6**
Avoidable Grade 3 pressure Ulcers limit of 0	**3**
Avoidable Grade 4 pressure Ulcers limit of 0	**0**

ACTIONS FOR IMPROVEMENTS / LEARNING

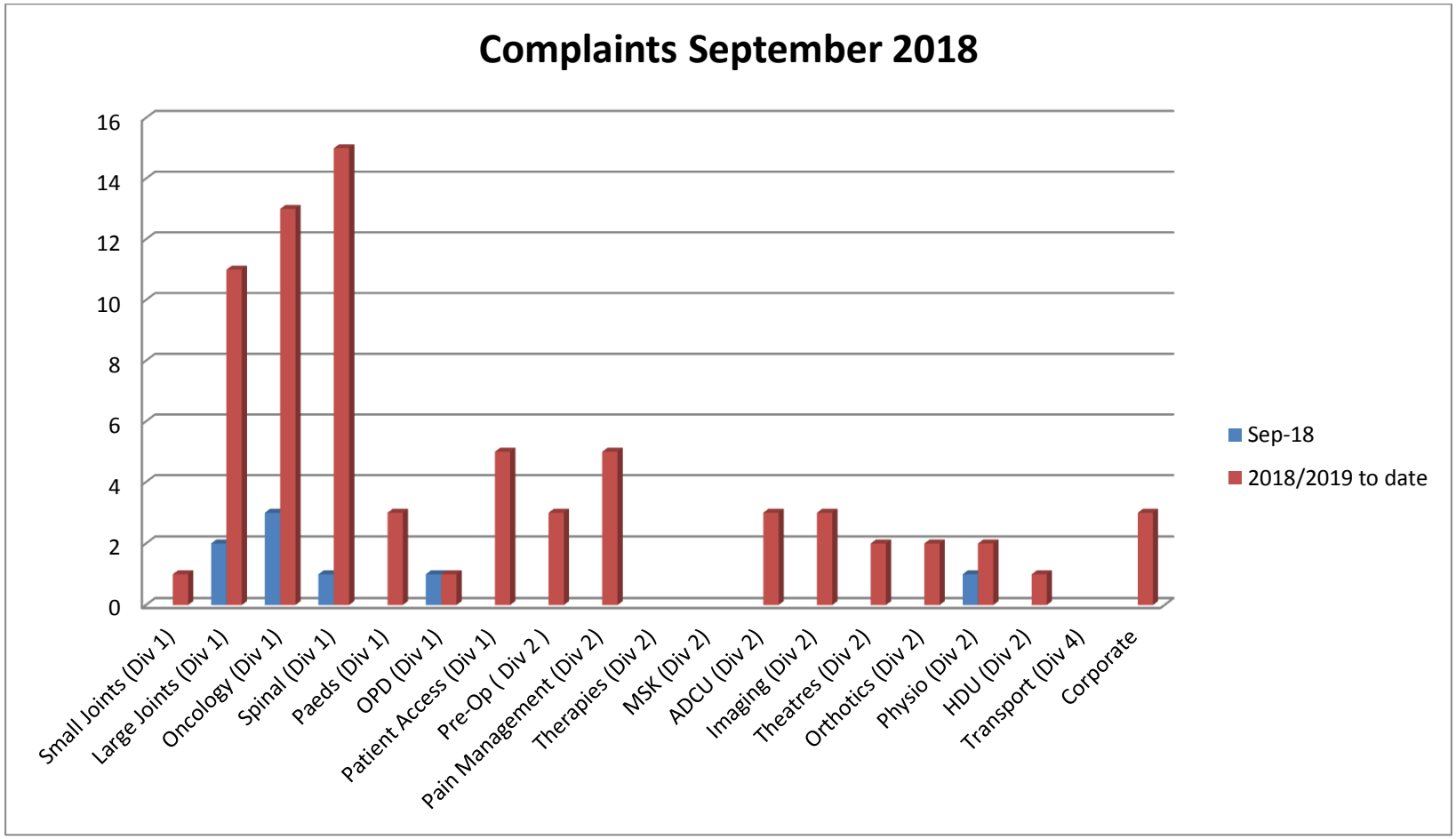
Current Actions

- The documentation task and finish group have developed more specific user-friendly documentation, which will act as prompts to care and highlight any gaps in care in order that action can be taken. TV documentation enables a clear outcome of a skin assessment carried out in ACDU, Theatre Recovery, Admission to HDU or Ward and include a SKIN bundle encompassing a care and comfort type of repositioning chart. This is due for review on 18th October. The NHSI advised that an ASSKING bundle (A = assessment and G= giving information) will be implemented and incorporated into new documentation, policies and guidelines
- The PU guidelines/Policy are currently being amended to incorporate changes
- The changes are being introduced into all training and wider circulation to all staff when all changes are made
- The CCG contract will not be affected for this financial year regarding avoidable and unavoidable PU's – all will continue to be investigated

RISKS / ISSUES

Risk Ulysses No 1247- TV risk register. The 1.0 wte Band 6 for TV has commenced on October 1st 2018. The TV team are developing a strategy for the continuation of service development.

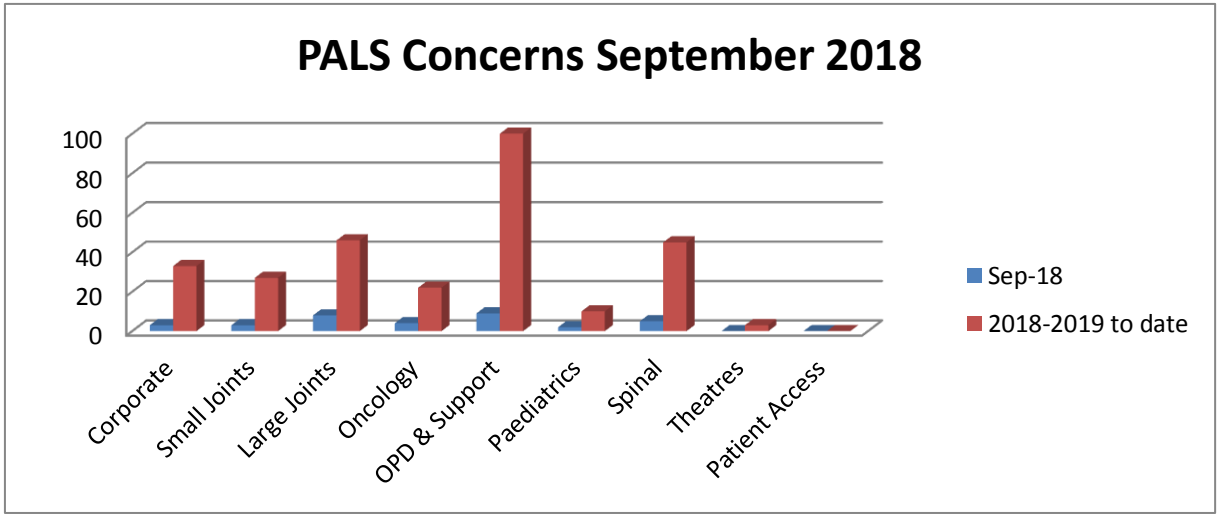
8. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



INFORMATION

PALS

The PALS department handled 80 contacts during September 2018 of which 34 were classified as concerns. This is a significant reduction in calls compared to the same time last year (430 contacts in September 2017) and significantly fewer concerns (131 concerns in September 2017). The main themes in the PALS data relate to communication issues and appointment queries. There were also a noticeable number of calls requesting complaints advice and this may be reflected in next month's formal complaints numbers. The Trust has set an internal target of 2 working days to respond to enquiries and 5 working days to respond to concerns in 80% of cases. 100% of enquires and 91% of concerns were handled within the agreed timescales, meeting this internal KPI



Compliments

There were 525 compliments recorded in September 2018, with the most being recorded for Div. 1, although Div.2 are increasingly recording their compliments. The Patient Services Team now log and record compliments expressed on the Friends and Family forms. All 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 8 formal complaints made in September 2018. All were initially risk rated amber or yellow. This is lower than last year (11 complaints in September 2017).

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Admission procedure - waited all day. Wants refund of travel and accommodation (Div.1, Oncology)
- The approach of a nurse; administrative process BMI (Div.1, Oncology)
- Care and treatment prior to death (Div.1, Spinal)

Initially Risk Rated Yellow:

- Unhappy with treatment and surgery outcome (Div.1, Large Joint)
- Delay in OPD; Patient not notified (Div.1, Pain Management)
- The approach of administrators (Div.2, Physio)
- The approach of a nurse; discharge process (Div.1, Large Joint
- Anaesthetic issues; approach of physios and 1 HCA (Div.1, Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 15 complaints closed in September 2018, 14 of which were closed within the agreed timescales. This gives a 93% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in August 2018 was 35 days which is higher than normal. This is because there were three complaints closed in September that involved either RCA or SIRI investigations and these were only closed when the patients and families involved were happy to do so. As these were agreed and actioned in conjunction with the individuals involved, this does not represent any additional risk to the Trust.

Learning identified and actions taken as a result of complaints closed in August 2018 include:

- There is a possibility that Privacy & Dignity could be compromised with the current curtains on some wards
  Action: New curtains are currently being trialled and the old ones will be replaced

- Unplanned absence can cause administrative problems
  Action: Process for picking up and reallocating tasks is being reviewed

- Communication about complications is not always as effective as it could be
  Action: Team members involved have undertaken personal reflection and discussed best practice

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

0 comebacks were received in September 2018.

9. Friends and Family Test Results (collected in the iwantgreatcare system)

INFORMATION

The Friends and Family Test in its current format was implemented on 1st April 2014. The Department of Health changed the methodology of the Net Promoter Score to a more straightforward % of patients likely to recommend a service and % not likely to recommend a service. This was because the evaluation showed that patients and most NHS employees did not understand the Net Promoter Score and the information provided was frequently misinterpreted.

The Friends and Family Test (FFT) is the mandated patient 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

NHS England has set a mandatory response rate of 35% for all inpatient services. There are no minimum response requirements for outpatient and community services. The Trust sets internal targets for all areas as it is agreed that the data will then be more meaningful.

There are no official requirements to undertake the FFT survey in imaging or theatre departments. However, the Trust takes the view that if feedback is provided in the same format across all departments, then the data is comparable and of use. In addition, there is an expectation that patient feedback is gathered in all areas, even if not mandated.

The Trust is continuing to perform well in comparison to other organisations in this survey and has developed a system to track themes and trends in the anonymous data collected alongside the FFT question. Departments are now beginning to take responsibility for providing feedback directly onto the iwantgreatcare system which is in the public domain. This will enable the Trust to further evidence its commitment to openness and exceptional Patient Experience at every step of the journey.

FFT CONCERNS

The team are now recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In September 2018, 4 concerns were identified from the 2069 individual pieces of feedback we received. As these are anonymous, it is not always possible to track these back to individual patients, but they are shared with the relevant teams and managers as additional feedback. The top three areas of concern in September 2018 were Values & Behaviours (staff), Communication and Facilities. Information has been shared with departmental managers and the department is using the data collected from the beginning of the year in conjunction with other patient experience data to identify wider trends across departments and the Trust as a whole.

RISKS / ISSUES

The Trust met the mandated 35% response rate for Inpatient Services this month, but not the internal 40% target. The internally set target for Outpatient services was also met for the second month in a row. This information has been shared with Departmental and Directorate Leads

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would recommend the department in Sept 2018**	**% of people who would NOT recommend the department in Sept 2018**	**Number of Reviews submitted in Sept 2018 (previous month in brackets)**	**Number of Individuals who used the Department in Sept 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	98.6%	0.0%	70 (61)	129	54.3%
Ward 2	95.7%	0.0%	47 (43)	134	35.1%
Ward 3	92.3%	3.8%	26 (35)	129	20.2%
Ward 12	92.3%	7.7%	26(38)	45	57.8%
Ward 11 (CYP)	92.9%	0.0%	28 (48)	76	36.8%
ADCU	95.7%	0.5%	185(203)	563	32.9%
HDU	100.0%	0.0%	20(35)	70	28.6%
CYP HDU	66.7%	33.3%	3 (4)	12	25.0%
Overall Trust Inpatient Response Rate for September 2018					38.2%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Sept 2018**	**% of people who would NOT recommend the department in Sept 2018**	**Number of Reviews submitted in Sept 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.0%	0.6%	1379 (1980)	21.8%
COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Sept 2018**	**% of people who would NOT recommend the department in Sept**	**Number of Reviews submitted in Sept 2018**	**Department Completion Rate (no mandatory return but internal target set of**

		2018		20%)
Royal Orthopaedic Community Services	100%	0.0%	47(58)	66.2%

In addition to the Friends and Family Test question, there are an additional 5 questions on the survey which relate to the following key elements of patient experience:

- Privacy & Dignity
- Cleanliness
- Kindness and Compassion
- Timely Information
- Being involved in the decision-making process

These give an overall star rating out of 5 stars on the system, with 5 out of 5 being the highest available score.

I **Want Great Care –**

The Royal Orthopaedic Hospital NHS Foundation Trust

Date
01 September - 30 September

Your average score for all questions this period

★1 ★2 ★3 ★4 ★5 **4.85**

Reviews this period

2069

Your recommend scores

5 Star Score

4.80

% Likely to recommend

96.0%

% Unlikely to recommend

0.8%

10. 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 13 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.

11. Litigation

New Claims

1 new claim against the Trust was received in September 2018.

The claim relates to an unexplainable light lead burn during surgery. This is one of the incidents reported previously in the Trust. RCA was undertaken and report to Quality and Safety Committee.

On-going claims

There are currently 31 on-going claims against the Trust.

30 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*

4 new requests for Pre-Application Disclosure of medical records were received in September 2018.

*Pre-Application Disclosure Requests are requests for release of medical records. The requests are made by solicitors acting on behalf of potential claimants. The records are requested with the view to investigating whether or not the claimant has a possible claim or not. Such requests are made in compliance with the relevant legal rules and procedures (the Pre-Action Protocol for the Resolution of Clinical Disputes, the Data Protection Act 1998 and the Access to Health Records Act 1990).

12. Coroner's Inquests

There was 1 Inquest held in September 2018

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 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 and 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 incompletion. The following areas examined; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases =727 The total WHO compliance for Theatres September 2018 **= 100%** **CT area** Total cases = 60 The total WHO compliance for CT area September 2018 **= 100%** **ADCU** The total WHO compliance for ADCU area for September = **100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
WHO checklist for ADCU had is scheduled into Phase 2 on the Theatre man rollout. A paper version of the WHO is in use and deemed satisfactory for ADCU's use during this period. ADCU WHO audit currently shows 100% compliance.

14. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in September 2018 and Year to Date (YTD)	Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72 hour Clostridium difficile infection (CDI)	0	1
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	1	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

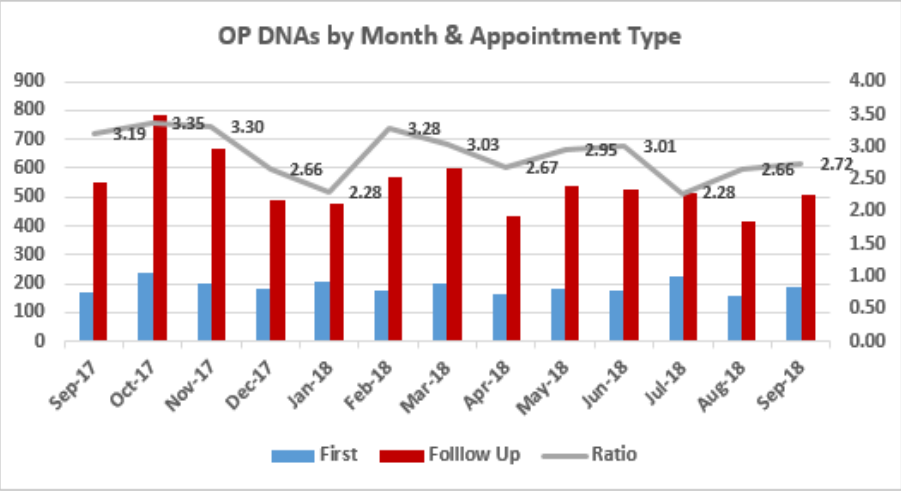
MSSA bloodstream infection – pre 48-hour infection and presently under post infection review. This is not, presently, deemed as an ROH acquired infection.

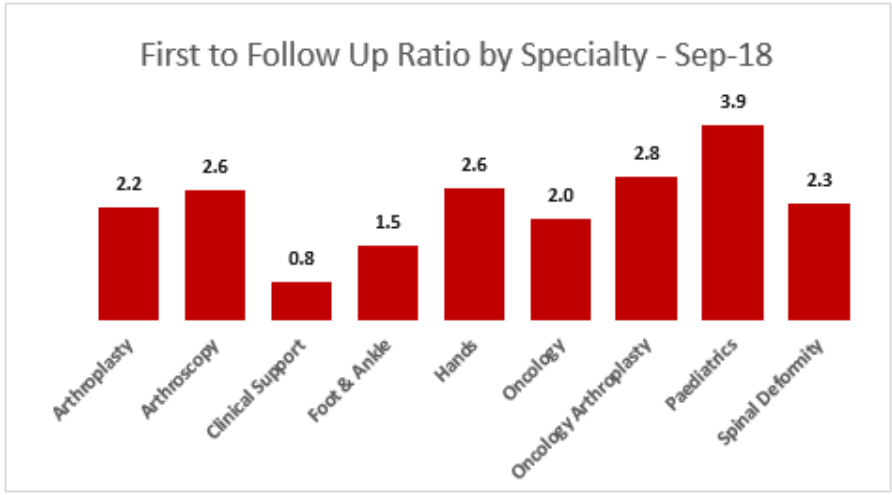
7 IP recorded incidents in August. 5 recorded as no harm (unclean equipment, fly within the theatre, non-compliance to PICC Line management and non-compliance to MRSA screening) and 2 recorded as low harm (non-compliance to MRSA screening and MRSA SSI) 1 case is closed (unclean equipment) and 6 remain under review.

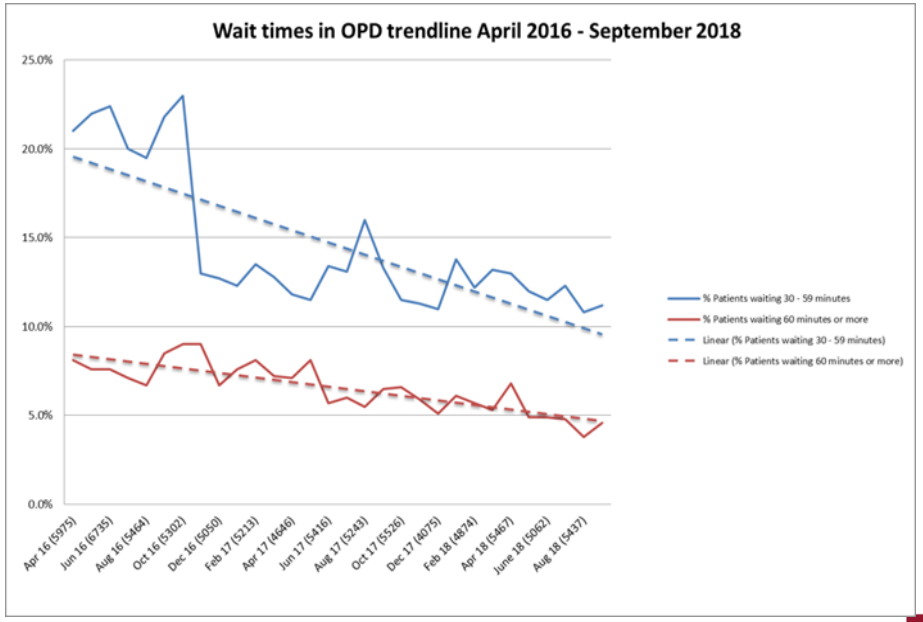
RISKS / ISSUES

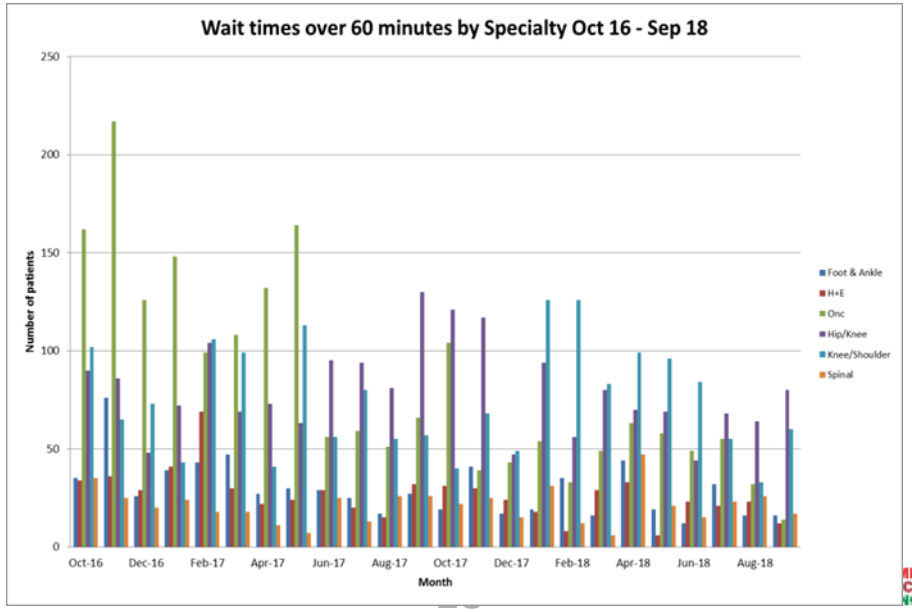
None

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









INFORMATION
In September there were 6 incident forms completed to highlight clinics running more than 60 minutes late. There were 11.2% of patients waiting over 30 minutes and 4.6% waiting over 1 hour which is below the target of 5%. This is now the fifth month that the target of 5% has been achieved. The over 30 minute wait deteriorated slightly since last month and as yet has not achieved the target or 10% or below. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month. The monthly audit identified the following categories of incident: - 3 – Clinic Overbooked 3 – Complex Patient 1 – Staffing over – running clinics All incidents continue to be forwarded to the Operational Managers within the relevant areas for investigation. An record of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause. Staffing issues within the outpatient department which have caused challenges have been significantly improved recently by the commencement of 5wte new HCAs and 2wte qualified nursing have just been employed and will start after clearances and checks.
ACTIONS FOR IMPROVEMENTS / LEARNING
Continue to drive incident investigations and action through relevant Operational Manager Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays Alter the process for managing room bookings in outpatients by moving this to the appointments team Establish a weekly meeting between the outpatient nursing and operational management team to discuss booking of future clinics and look at when clinics overran in the previous week
RISKS / ISSUES
Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. There will be engagement with other Trusts to consider the implementation of partial booking processes

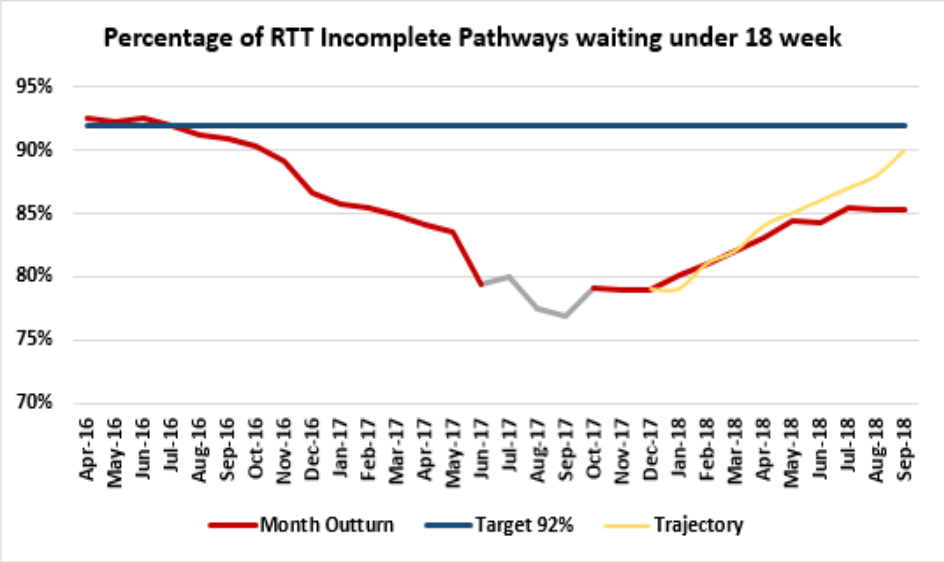
15. Treatment targets – This illustrates how the Trust is performing against national treatment target –

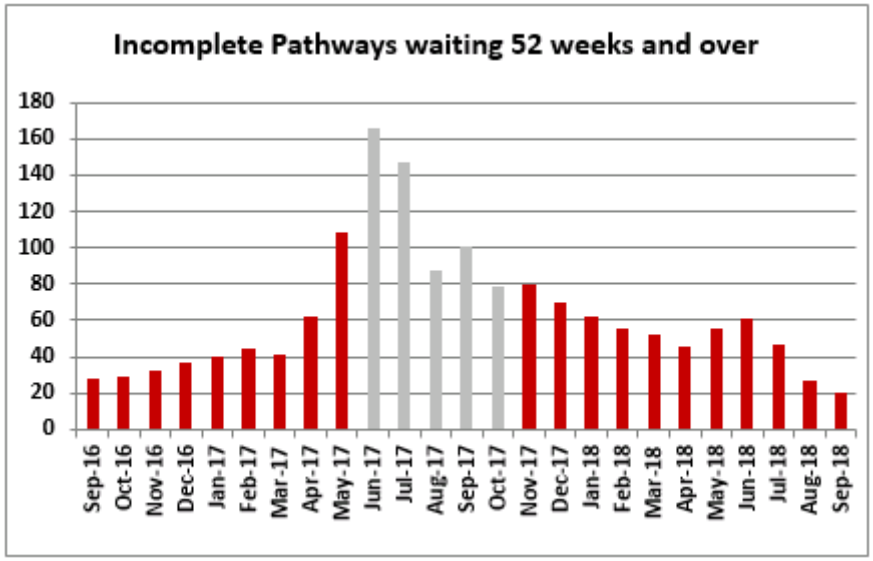
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%
Apr-18	1,022	148	409	1,579	850	253	387	1,490	8	1,571	1,579	99.5%
May-18	1,002	136	353	1,491	725	236	373	1,334	1	1,490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1,256	1,261	99.6%
Jul-18	732	112	336	1,180	961	211	290	1,462	8	1,172	1,180	99.3%
Aug-18	568	107	301	976	682	165	290	1,137	9	967	976	99.1%
Sep-18	696	110	311	1,117	778	208	394	1,380	4	1,113	1,117	99.6%

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





		Indicative	Reported Month					Reported Quarter 2017/18			
Target Name	National Standard	*Sep-18*	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	100%	100%	100%	100%	100%	90%	98%	100%	97%	100%
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
62 day (traditional)	85%	40.0%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	100%	100%	100%	83.30%	100%	100%	84%	82%	89%	100%
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
No. day patients treated 104+ days			0	0	1	0	0				

16. Referral to Treatment snapshot as at 30th September 2018

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**831**	0	116	45	167	53	39	111	92	59	30	97	22	0
7-13	**837**	0	167	33	192	65	47	101	53	59	25	79	14	2
14-17	**354**	0	66	23	84	24	19	24	26	33	8	39	4	4
18-26	**410**	0	40	25	148	10	22	45	11	43	11	25	21	9
27-39	**178**	0	8	20	63	4	2	18	3	7	2	12	32	7
40-47	**25**	0	0	4	2	0	0	0	1	0	0	0	12	6
48-51	**5**	0	0	0	0	0	0	0	0	0	0	0	4	1
52 weeks and over	**17**	0	0	0	0	0	0	0	0	0	0	0	11	6
Total	**2,657**	0	397	150	656	156	129	299	186	201	76	252	120	35

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**2,022**	0	349	101	443	142	105	236	171	151	63	215	40	6
18 and over	**635**	0	48	49	213	14	24	63	15	50	13	37	80	29
Target	**213**	**0**	**32**	**12**	**52**	**12**	**10**	**24**	**15**	**16**	**6**	**20**	**10**	**3**
	76.10%		**87.91%**	**67.33%**	**67.53%**	**91.03%**	**81.40%**	**78.93%**	**91.94%**	**75.12%**	**82.89%**	**85.32%**	**33.33%**	**17.14%**

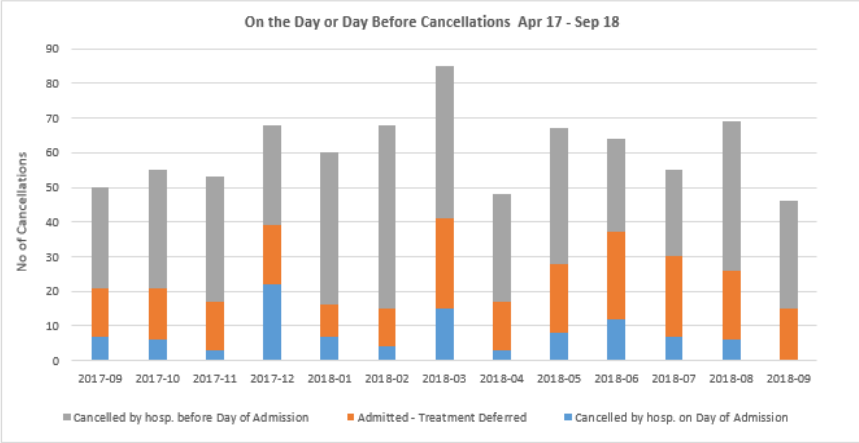
Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,849**	18	299	104	544	355	442	229	270	129	51	292	113	3
7-13	**2,059**	18	160	97	411	234	291	164	226	109	42	206	100	1
14-17	**797**	5	38	44	130	100	108	51	117	34	15	82	73	0
18-26	**520**	1	24	50	107	52	73	48	7	13	13	32	99	1
27-39	**158**	1	3	20	21	11	19	12	1	5	4	13	47	1
40-47	**14**	0	0	3	1	1	0	0	0	0	0	2	7	0
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
Total	**6,401**	43	524	318	1,214	753	933	504	621	290	125	627	443	6

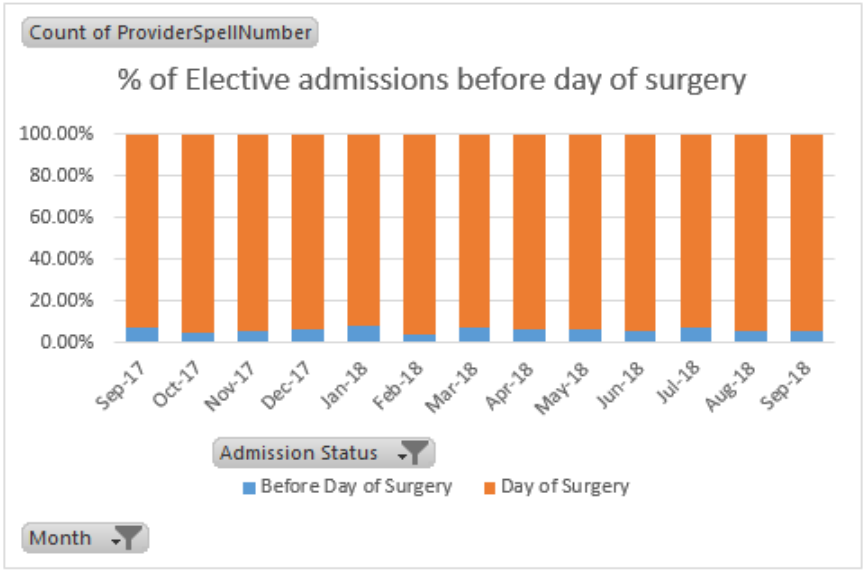
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,705**	41	497	245	1,085	689	841	444	613	272	108	580	286	4
18 and over	**696**	2	27	73	129	64	92	60	8	18	17	47	157	2
Target	**512**	**3**	**42**	**25**	**97**	**60**	**75**	**40**	**50**	**23**	**10**	**50**	**35**	**0**
	89.13%	**95.35%**	**94.85%**	**77.04%**	**89.37%**	**91.50%**	**90.14%**	**88.10%**	**98.71%**	**93.79%**	**86.40%**	**92.50%**	**64.56%**	**66.67%**

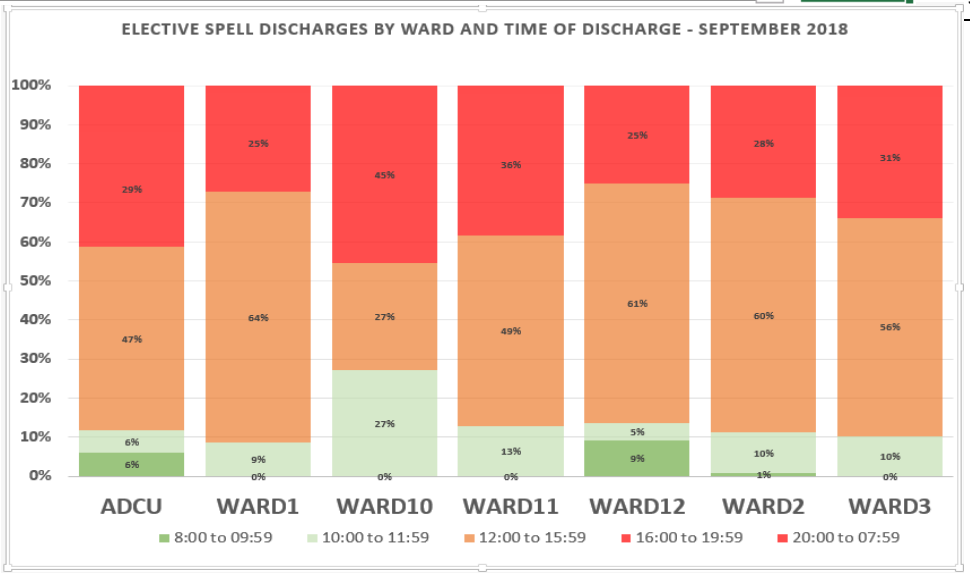
INFORMATION
The PTL is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly. For September 2018 the RTT trajectory was 90% with performance at 85.31% with 20 patients over 52weeks (trajectory 36) Excluding Spinal Deformity the Trust now has only 14 patients over 40 weeks All teams are working through a targeted list of patients to ensure that patients are dated in chronological order over 18weeks. Arthroplasty, Spinal, Clinical Support and Oncology have plans to achieve 92% for October 2018 with all remaining specialties reviewing capacity until the end of November 2018. Non-admitted performance improved in month – 89.13%
ACTIONS FOR IMPROVEMENTS / LEARNING
The team now are concentrating on any patients over 26weeks as the number over 40 weeks has continued to reduce. Throughout October and November the team continue to work through a targeted list of patients who are listed with consultants with the longest waits (6 consultants excluding spinal deformity). Good progress continues to be made by all the teams as we continue to progress to 92% in November 2018.
RISKS / ISSUES
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance. 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 monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be February 2019 before an additional weekday list will commence. Weekend activity continues through the Summer with discussion underway to continue the lists until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families. Given the limited opportunities to increase Spinal Deformity additional capacity is being sought for Adult young Hips and Arthroscopy to improve the overall Trust performance

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



Sum of Total	Cancellation Categ				
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
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	15	26	44	85	0
2018-04	3	14	31	48	0
2018-05	8	20	39	67	0
2018-06	12	25	27	64	0
2018-07	7	23	25	55	0
2018-08	6	20	43	69	1
2018-09		15	31	46	0
Grand Total	100	223	465	78	2





INFORMATION

The number of cancellations on the day of admission for surgery continues to decrease with no patients cancelled on day of surgery prior to admission in September. Patients admitted for surgery where treatment was deferred has also decreased in month from 20 to 15. Analysis of these 15 patients highlights reasons for cancellation on the day relate to lack of theatre time, equipment issues and to accommodate emergency patients.

Cancellations before the day of surgery have decreased in month from 43 to 31 patients. An analysis of the 31 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients being offered earlier dates for surgery, patients being deferred to accommodate emergencies and patient led cancellations due to patients declaring fitness issues on the 72 hour call contact.

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The key theme identified is the correlation between cancellation on the day and the resilience of ensuring the patient is contacted 72 hours prior to surgery. This process moves to the pre-operative assessment team on 29th of October to ensure a more robust service can be offered with easy access to clinical support if required, ensuring an improved patient experience.

Work continues to strengthen the POAC process and a business case is progressing to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity.
The service will commence the roll out of the new triage model on the 22nd of October to enable more patients to be seen on the day of listing for surgery in pre- operative assessment where clinically appropriate, avoiding multiple attendances at POAC clinic and improved service efficiency.

ACTIONS FOR IMPROVEMENTS / LEARNING

Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

- Joint care project is ongoing with weekly stakeholder meetings in place Soft Launch -5TH November .
- All cancellations by patients on the day of surgery are followed up with a telephone call from ADCU to understand the reasons and the audit will be presented as part of the October 2018 F &P report.

RISKS / ISSUES
Existing aging equipment asset base and the need to increase the number of power tools in Theatre. Some additional power tools are currently being scope the capital programme slippage and the Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatr

ROHTB (11/18) 005

TRUST BOARD

DOCUMENT TITLE:	**Annual Complaints Report 2017/2018**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Lisa Kealey, Patient Services Manager**
DATE OF MEETING:	**7 November 2018**

EXECUTIVE SUMMARY:

The report provides a summary of the complaints data for 2017/2018 and satisfies the requirements of the Health Service (England) Regulations 2009

Of note, there has been an 11% decrease in complaints during the year to 148, compared with 167 the previous year

The level of satisfaction with the way we have handled complaints has remained high. The recent CQC report highlighted that complainants are well supported at this hospital.

23% increase in PALS activity – due to telephone number being on all letters. Has been counter-productive so this has been changed and activity will reduce and become more meaningful.

Decrease in Spinal and Oncology complaints ; better communication and process changes have impacted on Patient Expectations and Satisfaction

All Patient Experience data (PALS, Complaints, FFT Concerns, Compliments, Surveys) is now being collected comparatively to allow for trend analysis. This is enabling early detection of potential issues and allowing a proactive management approach. Examples include identification of issues on a ward - Round table was convened and actions taken to resolve issues.

5 out of 6 agreed actions were fully completed. 1 was partially completed

3 new actions identified to further improve the service

REPORT RECOMMENDATION:

Board is asked to:

- Accept the report
- Agree the actions for 2018/2019

ROHTB (11/18) 005

ACTION REQUIRED (Indicate with 'x' the purpose that applies): The receiving body is asked to receive, consider and:		
Note and accept	**Approve the recommendation**	**Discuss**
X	**x**	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical		Equality and Diversity		Workforce	
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Report aligned to Strand 2 of Trust Objectives and required for Commissioners and Regulations

PREVIOUS CONSIDERATION:
Quality & Safety Committee on 26 September 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Annual Complaints Report 2017/18

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 01/04/2017 and 31/03/2018. 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 2017/2018 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 – Patient Services Manager (1.0 WTE) and PALS Manager (1.0 WTE).

The Patient Services Manager is responsible for the day to day operational management and performance of both services.

The team reports directly to the Head of Clinical Governance and the Executive Director of Patient Services is the Executive Officer with overall responsibility.

4.0 Data Collection and analysis

All complaints data is now entered into the Customer Service Module within the Ulysses Safeguard system mostly in real time, which was an agreed action from the previous year. 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. However, the system is still not completely effective and able to produce the necessary reports, which will form part of the improvement work in 2018/2019

5.0 Number of complaints

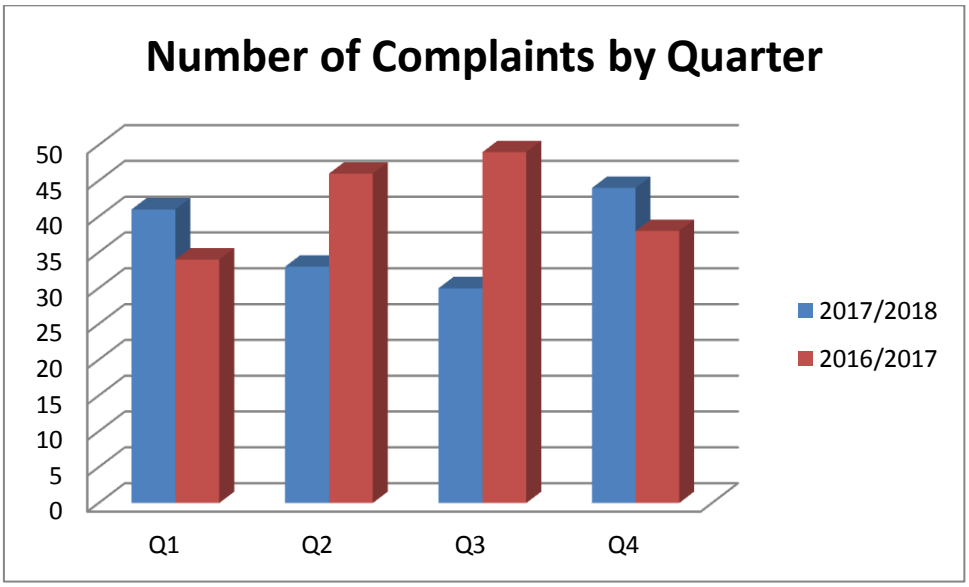
In 2017/2018, ROH received 155 formal complaints. 7 were withdrawn leaving a total of 148 to be investigated and formally responded to. Figure 1 below shows the total number of formal complaints received over a three year period. Figure 2 details the number of complaints by quarter in 2017/18 with the previous year's data for comparison.

Figure 1: Numbers of complaints received 2014/2015

Formal Complaints	2015/2016	2016/2017	2017/2018
	113	167	148

Formal complaints experienced an 11% decrease compared to the previous year

Figure 2: Number of complaints by quarter

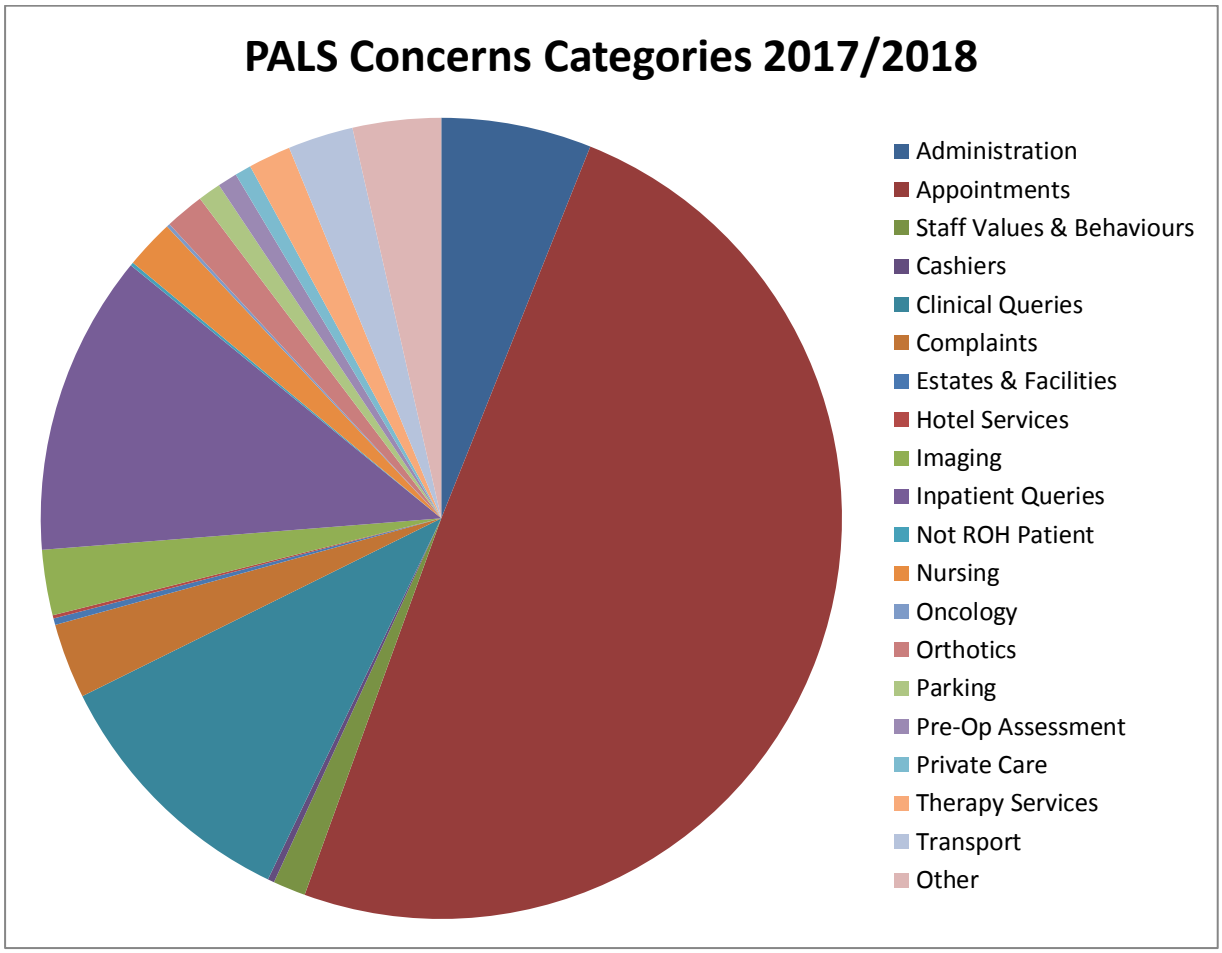


The number of complaints decreased over the first three quarters of the year and increased in the last quarter. This coincides with an increase in activity level over the same time period.

6.0 PALS Contacts during 2017/2018

There were 5094 contacts with the Patient Advice and Liaison Service this year of which 1135 were concerns. This represents a 23% increase in the work of the PALS service and is mostly likely to be the result of the increased visibility of the service. The number for the service is routinely included on all patient correspondence and this has now been reviewed as it has been recognised that this may not be the most effective use of the PALS resource. The number of general enquiries began to reduce towards the end of the year, so it is anticipated that this number will be much lower in next year's report. The PALS Manager has been able to invest more time in managing concerns and assisting patients as a result.

Figure 3: Number of PALS Concerns by Subject



The most common concerns expressed via PALS in 2017/2018 were:

- Patients and relatives requesting a sooner appointment than currently offered
- Repeated cancellations of appointments
- Queries about obtaining a surgery date or injection date

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 Learning Disabilities and Safeguarding Teams in the coming year.

7.0 Formal Complaints numbers measured against Trust activity

Figure 4: Complaints against Trust Activity 2017/2018

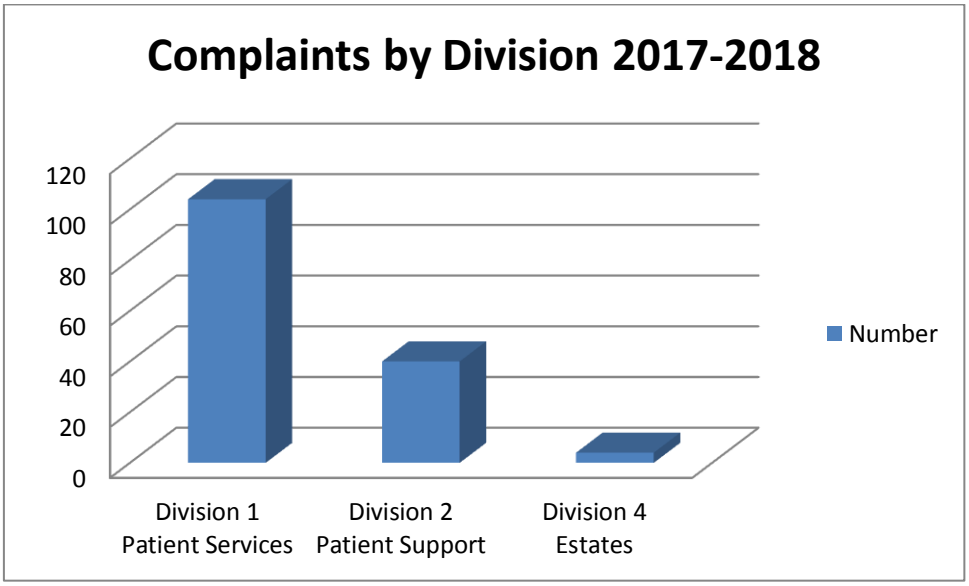
	2017/2018	2016/2017
Inpatient Attendances		
Inpatient Complaints	74	60
Inpatient Episodes	14,646	13973
Complaints per 100 inpatient episodes	0.51%	0.43%
Outpatient Attendances		
Outpatient Complaints	74	106
Outpatient Episodes	66,642	67181
Complaints per 1000 outpatient attendance	0.11%	0.16%

The Trust has seen a decrease in Outpatient Complaints and an increase in Inpatient Complaints over the year.

8.0 Number of Complaints by Division

Figure 5 below illustrates the number of formal complaints by Division in 2017/2018.

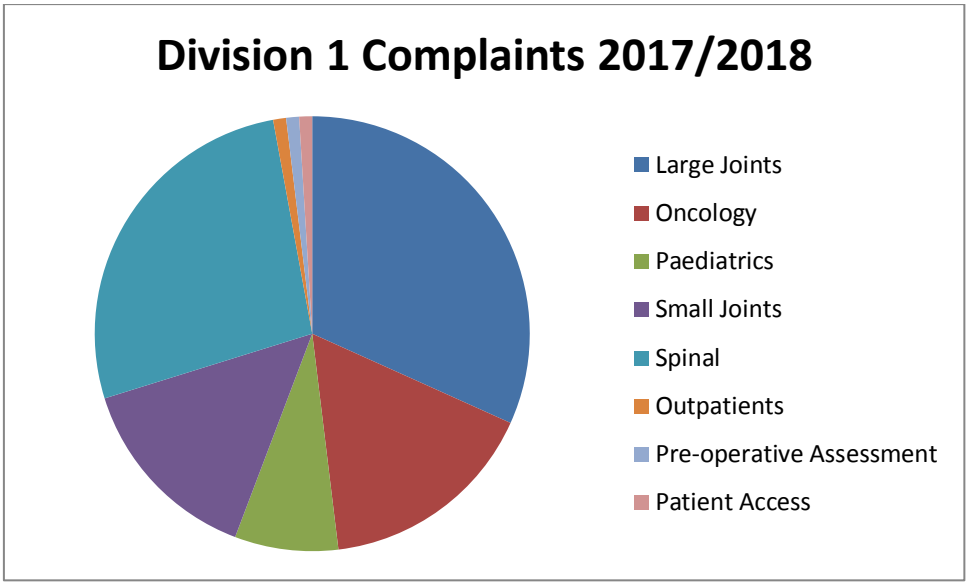
Figure 5: Number of Complaints by Division 2017/2018



The majority of complaints (70%) relate to the Patient Services Division which is to be expected since this Division oversees all inpatient and outpatient activity. This is a decrease from 79% last year. The two areas with the highest number of complaints in 2017/18 were the Large Joint (22%) and Spinal Services (19%).

Figures 6 below provides an in-depth breakdown of complaints within Division 1

Figure 6: Number of Complaints by area in Division 1 2017/2018



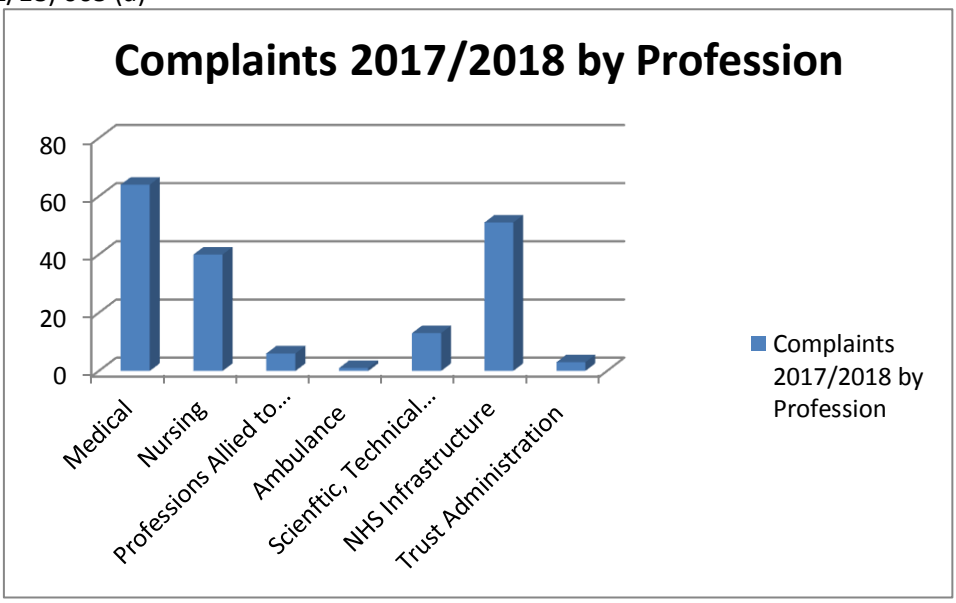
8.1 Spinal Service complaints

The largest numbers of complaints in Division 1 related to concerns about the Large Joints Service (32% of Div.1 complaints this year). These related to all aspects of the service, including clinical treatment, care provided and administration processes.

The spinal service has received a lower number of complaints about paediatric spinal patients this year. (46% of complaints about the spinal service this year relate to children and young people) It is believed that the ongoing work to transfer all Paediatric Inpatient work to Birmingham Children's Hospital and the increased communication of the issues within the service has helped to manage expectations better.

9.0 Complaints by Profession

Figure 7: Number of Complaints by Profession 2017/2018



It can be seen that most complaints received relate to aspects of medical care which is reflective of the type and nature of activity carried out in a specialist orthopaedic Trust. The complaints received during this year raised concerns about surgical outcome, complications and clinical opinions and treatment options. This is similar to the last two years, although the number of complaints relating to infrastructure support within the hospital has continued to increase. It is believed that this is related to more accurate logging and investigation of complaints, rather than a significant increase.

10.0 Complaints by Subject

Figure 8: Complaints by Subject 2017/2018

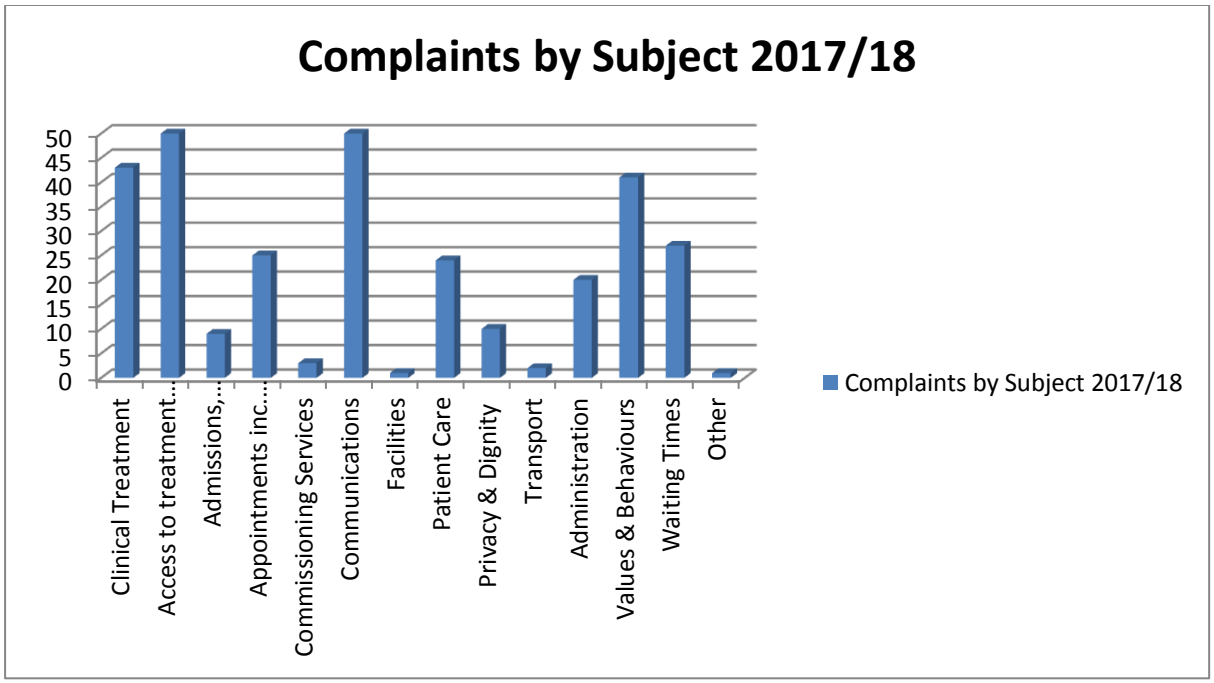


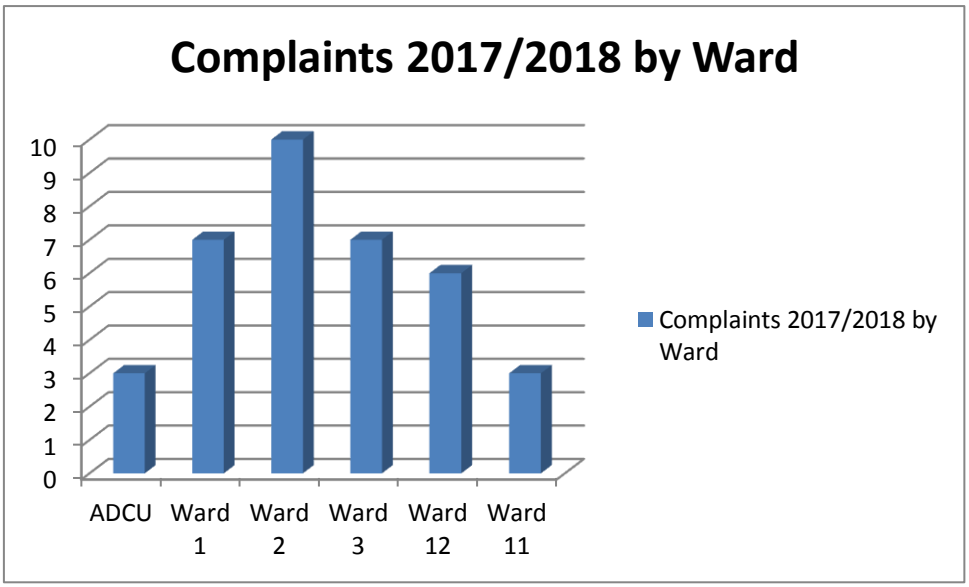
Figure 8 shows the main causes for complaints in 2017/2018, with communication with patients, delays or cancellation of appointments and dissatisfaction with clinical

treatment being the highest reasons. This shows changes from last year and as such provides some assurance that actions are being taken to address identified issues

Trends and individual issues identified from complaints are monitored more effectively and evidence of actions to drive improvements has started to be more widespread within the Divisions. There is improved recorded evidence of Trust wide learning from trends identified across the organisation. The governance and complaints teams will continue to work with operational colleagues to ensure that learning from complaints is embedded within organisational changes to enhance patient experience overall.

11. Complaints by Ward during 2017/2018

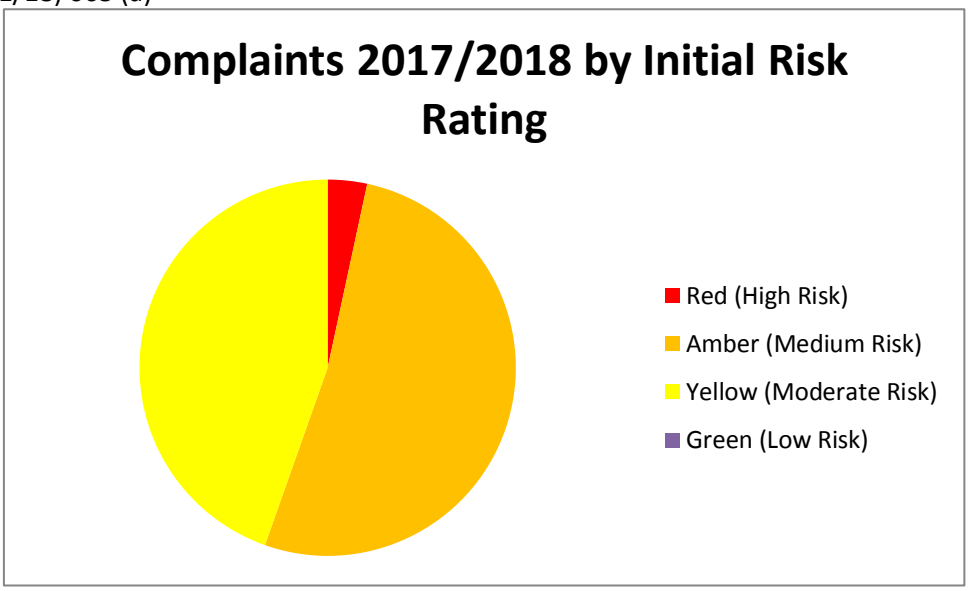
Figure 9: Complaints by Ward 2017/2018



Concerns about aspects of ward care or treatment has been mentioned in 24% of complaints this year, which is slightly lower than last year (25%). This indicator was implemented in 2015/2016 as there was a marked increase in the number of complaints about ward care in the final quarter of that year (45%).The data is scrutinised, together with other ward performance data in Clinical Quality Group meetings and forms part of the Quality Dashboard completed each month. These are also discussed with Senior Nurses and Ward Managers at their respective meetings. The Trust believes that the greater scrutiny has enabled any necessary changes to be made earlier thereby allowing the significant improvement last year to become embedded and continue.

12. Risk Ratings of Complaints during 2017/2018

Figure 10: Initial Risk Rating of Complaints 2017/2018



The Trust implemented a more robust system of tracking and monitoring complaints three years ago. Part of this tracking involves the logging of an initial risk rating. The Patient Services Manager monitors these risk ratings and the Head of Clinical Governance reviews all complaints that are initially rated Red or High Amber, to ensure Duty of Candour requirements have been discussed and met where required. The Trust Risk Scoring Matrix can be found in Appendix B.

The results of this monitoring clearly shows that most of the complaints that represent a lower risk to the Trust are handled via different processes within the Trust, such as PALS or informally, as the number of complaints assessed as green or low risk are few (none this year). A review of the formal complaints assessed in the lower risk categories 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 2017/18 the Trust had 2 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 (80% KPI – contractual requirement)
- Response within timescales agreed with Commissioner for complaints that come via this route (100% KPI – contractual obligation)

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.

98% of complaint letters received during the 2017/2018 were acknowledged verbally or by e-mail within the correct timescale, thereby meeting the KPI.

98% of complaint letters were formally acknowledged by letter within the agreed timescale. 2 complaints were overlooked in error for a short period so the acknowledgment letter was not sent until after the agreed a date. This KPI was met.

13.2 Responding to complaints within the agreed timescale

The PALS and Complaints Policy 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 Head of Clinical Governance, the Designated Complaint Investigator and the complainant as to the complexity of work required).

In line with ROH Policy, it is permissible to discuss an extension with the complainant. If they are in agreement with the extension, the complaint will be deemed to have been completed within agreed timescales. Any complaint can only be extended once.

Annual Compliance with the contractual reporting requirement of 80% for the year has been met

14.0 Outcome of complaints made in 2017/2018

Figure 11: outcome of complaints 2017/2018

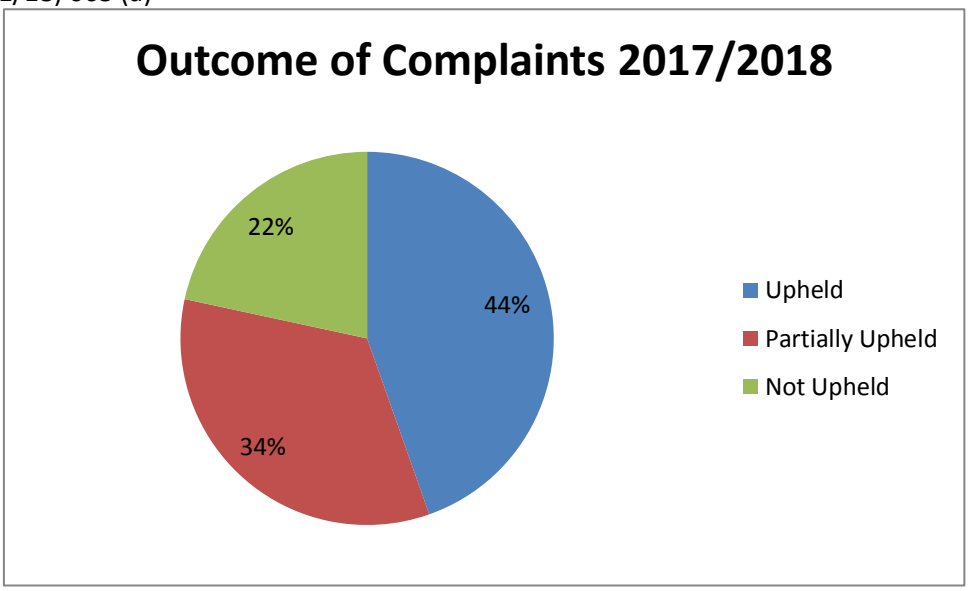


Figure 11 shows the outcome of complaints made in 2017/2018. The Trust upheld some aspects of 78% of the complaints made in this year, which is similar to last year (81%). Complaints are coded in line with the guidance from NHS Digital and there may be more than one aspect in each complaint. The decisions about whether to uphold or not are taken from the results of the investigation and discussion with the Investigation Lead if this is not explicitly clear in the report. The Trust believes that these figures show robust investigation and clearer expectations of good service provision across the Trust, which is being defined by the changes to the operational structure, the Transformation Agenda and the Quality Agenda priorities

15.0 Satisfaction with the Complaints Service

During 2017/2018, a total of 41 satisfaction surveys were returned by complainants representing 28% 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 was 68%, which was a slight reduction from last year. However, 95% of respondents indicated that they felt that the complaints staff were helpful, sympathetic and professional. 87% were happy with the time taken to answer their concerns which is the highest satisfaction recorded for this question.

The information from the full satisfaction survey will continue to be reviewed and used to inform further improvement work in 2018/2019.

16.0 Complaints referred to the Parliamentary Health Service Ombudsman (PHSO)

We aim to resolve complaints by undertaking a thorough investigation, providing a comprehensive response and offering all complainants the opportunity to discuss further concerns with us. Generally the Trust is successful with this, but sometimes it is not always possible to achieve a resolution which satisfies the complainant.

Under the NHS Complaint Regulations, any complainant who remains dissatisfied with the response has the right to request an independent review of their case with the PHSO. Every response contains this information together with the contact details for the PHSO.

During 2017/2018, the PHSO requested information about 5 complaints made to the Trust. 4 of these were not upheld. One is still under investigation currently and the outcome is not yet know

17.0 Listening and Learning from Complaints

Patient Story

Mr X made a formal complaint about the outcome of his knee replacement operation. He had developed some complications and believed that someone other than his Consultant must have undertaken the operation to cause the difficulties. Investigation revealed that his Consultant had undertaken the procedure and spoken to him about the operation afterwards, but Mr X had no recollection of this.

Mr X was offered a meeting with his Consultant and accepted this. He was accompanied and given support by the Patient Services Manager to ensure that he asked all of the questions that were concerning him. The Consultant explained what had happened and agreed a plan for further treatment with Mr X. They agreed that there had clearly been some misunderstanding in the information that Mr X had received and the Consultant apologised for this. He indicated that he would try to ensure that patients had understood and recalled what had been discussed more carefully in the future.

Mr X felt supported and happy that he had the opportunity to discuss his concerns directly and considered the matter closed.

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 Divisional Governance meetings are now well established and provide an opportunity to discuss any complaints and matters of concern in more detail. Action Plans arising from complaints are also monitored and signed off in this group.

Individual Action plans are created for any actions that are specific to an individual complaint. Where actions form part of a larger work plan, patients are informed of this in their response. This ensures that complaint action plans remain targeted and

relevant. Once actions have been completed, they are signed off at the meeting and a letter is sent to the complainant confirming that they have been completed.

In 2017/2018, 22 individual action plans were created. A further 62 complaints had actions that were completed prior to the response being sent. 8 responses had actions that were part of a larger work stream such as Perfecting Pathways and 2 had the actions incorporated into a more in-depth Governance investigation.

Learning and actions taken as a result of Complaints in 2017/2018 include:

Learning	Action
Process for ensuring that patient identification is correctly performed was not always followed	Staff have been re-trained in the correct identification procedures
Waiting times in Outpatients was still an issue for patients	Work to improve patient flow in outpatient areas continues. New clinic templates have been implemented
No system in place for recording received calls and action in ADCU reception	Message book has been implemented.
Communication about needs of inpatients with Learning Disability was not robust	Learning Disability Strategy Launched
Communication to patient about discharge arrangement and what needs to happen before being allowed to go home is not always clear.	New patient information leaflet on the steps to discharge has been created for the bedside
Information for patients about what to expect in a hydrotherapy appointment did not exist	New Patient Information leaflet has been produced
Nursing staff outside of the Spinal Ward may not be familiar with spinal escalation procedures	Refresher training is being provided
Post-operative care for patients who don't meet social services criteria is inadequate	Round Table undertaken to identify possible solutions

Pre-Operative Assessment process for fitness assessment is not always being followed	Pre-Operative Process is being reviewed under the Perfecting Pathways Programme
Parents of children being cared for were not always asked if they were comfortable to help with their care.	New process for agreeing and recording involvement of parents has been developed
letter inviting patients for injections was not clear that it was an injection appointment	Letter was amended

17.0 Looking ahead to 2018/2019

The Department continues to work with nursing and operational colleagues to identify more effective ways of working that benefit all and improve patient experience.

Improvements planned for 2018/2019:

- The Ulysses system will be further modified to allow all complaints reports to be pulled directly from this system.
- Complaint investigation and report writing training will continue to be provided for staff that require it.
- The KPI of 80% of complaints completed within the agreed timescale will be achieved.
- The coding of PALS Concerns will be altered to the same system for complaints to allow for direct comparison of the data.

18.0 Conclusion

At the ROH, we remain committed to investigating, learning from and taking action from complaints where it is confirmed that mistakes have been made or services can be improved. We recognise that the process of improvement is continual and that transparency and honesty are vital when things go wrong.

Lisa Kealey
Patient and Public Services Manager

November 2018

Appendix A

Progress against 2016/2017 priorities for the Complaints Department

Priority	Status	Detail
A centralised system for monitoring and completing action plans for complaints will be developed.	Achieved	Directorate shared files are now on the Public Drive and are only available to the relevant people in the Division
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.	Achieved	Process is now part of standard procedure
Complaint investigation and report writing training will be undertaken for all staff involved in investigating and responding to complaints where the need is identified.	Achieved	Complaints investigation and response training has been undertaken as required
In conjunction with the Governance department, an agreed process for sharing of Trust wide learning from complaints will be created and evaluated	Partially Achieved	Learning is now shared through Clinical Quality Group and the Quality Report. Process for ensuring Clinicians share learning still needs to be completed
Achieve the KPI of 80% of complaints completed within the agreed timescale	Achieved	Data is provided monthly
A review of current staffing provision for PALS and Complaints will be undertaken	Achieved	Additional Administrative Support has been provided

Appendix B

Trust Risk Rating Matrix

	SEVERITY				
LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM riskRed = HIGH risk**

ROHTB (11/18) 006

TRUST BOARD

DOCUMENT TITLE:	**National Inpatient Survey 2017 Results and Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Lisa Kealey, Patient Services Manager**
DATE OF MEETING:	**7 November 2018**

EXECUTIVE SUMMARY:

This paper presents a summary report of the results of the National Inpatient Survey 2017.

- The Trust is better significantly in 7 of the 10 overall sections that are monitored. (The 11th section relates to Emergency/A&E cover where the hospital is not scored). This is the third significant year of improvement.
- This is overall a very positive report. The Trust is also mentioned in the CQC outlier report where we are one of eight Trusts that performed 'much better than expected'.
- The Trust is in the top 20% of Trust for 7 of the 10 domains that it is scored in and at the top of the middle 60% band for the other 3.
- The Trust achieved a better ranking in 34 questions compared to 2016 and got worse in no questions.
- With 776 surveys returned completed, the Trust had a response rate of 63%, maintaining its high response rate. The national average return was 41%.
- The survey has delivered highly positive results, both in individual question scores and analysis of written patient comments.

REPORT RECOMMENDATION:

The Board is asked to:

- Approve the updated rolling action plan (to be monitored through Clinical Quality Group)
- Accept the report

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X	**x**	

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

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

ROHTB (11/18) 006

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Forms part of the evidence for Strand 2 of Strategy and is a mandatory requirement. Forms part of the information for the Quality Report
PREVIOUS CONSIDERATION:
Quality & Safety Committee on 26 September 2018

July 2018

National Inpatient Survey Results 2017

1.0 Introduction

The National Inpatient Survey results were published on the CQC and NHS Choices websites on 13th June 2018. The Care Quality Commission uses the results from the survey in the regulation, monitoring and inspection of NHS acute and NHS foundation trusts in England. Survey data is used in CQC Insight system, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs that are produced to inform inspections. Results will also form a key source of evidence to support the judgements and ratings published for trusts.

The Trust commissioned Patient Perspective to undertake the survey on behalf of the Royal Orthopaedic Hospital NHS Trust in 2017. This organisation provides a more detailed report of Patient's views of the care that they receive from us. This is helpful in planning actions from the results of the survey.

This brief paper presents an overview of the key findings from the National Inpatient survey 2017 together with an update on the rolling action plan completed each year. It also gives areas for improvement identified by the Patient Perspective Report.

2.0 Summary of Key Findings:

This report summarises the results of the National Inpatient Survey of patients seen in July 2017.

In the CQC report, the results are presented using a ranking system, rather than a percentage response rate which means that we are assessed as better as or worse than other providers. This paper provides a summary of the key findings of the 2017 CQC national inpatient survey report for ROH which is attached as Appendix 1.

.

- The Trust is better significantly in 7 of the 10 overall sections that are monitored. (The 11th section relates to Emergency/A&E cover where the hospital is not scored). This is the third significant year of improvement.
- This was overall a very positive report. The Trust is also mentioned in the CQC outlier report where we are one of eight Trusts that performed 'much better than expected'.
- The Trust is in the top 20% of Trust for 7 of the 10 domains that it is scored in and at the top of the middle 60% band for the other 3.
- The Trust achieved a better ranking in 34 questions compared to 2016 and got worse in no questions.
- With 776 surveys returned completed, the Trust had a response rate of 63%, maintaining its high response rate. The national average return was 41%.
- The survey has delivered highly positive results, both in individual question scores and analysis of written patient comments.

Key Areas of Strength for ROH

The Trust scores in the top 20% of all Trusts nationally on 50 questions – these cover core areas which include:

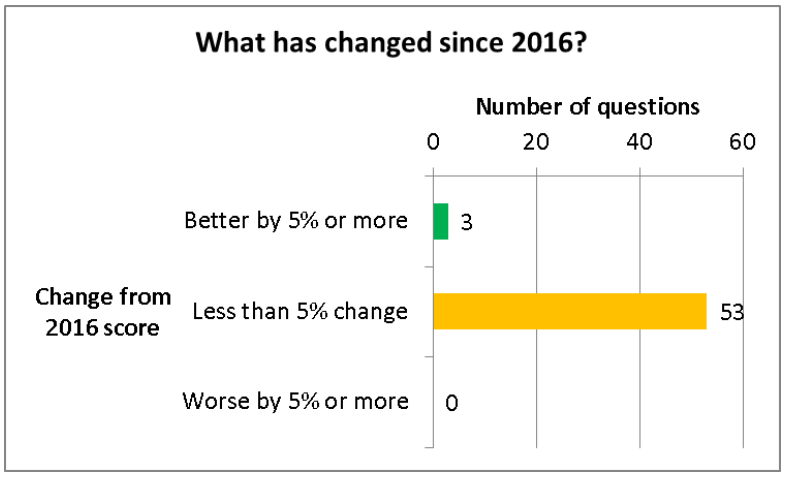
- Confidence and Trust in doctors and nurses and their decisions about care
- Staff - including communications and information giving, care, emotional and practical support, explanations, information about medicines, support around and after discharge, treating people with respect and dignity
- How patients are involved in decisions about their care and discharge
- Hospital environment and facilities including food, noise, cleanliness, privacy

Key areas for Improvement for ROH

- Waiting times for admission.
- Changing admission dates.
- Non-clinical staff interactions
- Knowing the name of the nurse who is looking after the patient

3.0 Patient Perspective detailed report

The data from Patient Perspective is not ranked and therefore provides additional value as it is presented in straightforward percentage terms. This means it is easier to see changes to the ROH data over time.



The ROH has seen a statistically significant improvement in 2 questions:

- Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?
- Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

There are no statistically significant worse questions.

4.0 Patient Experience Research undertaken by the Picker Institute

Research undertaken by Picker specifically to support the National Survey Programme has identified 8 dimensions of quality important to patients:

- fast access to reliable health advice
- effective treatment delivered by trusted professionals
- participation in decisions and respect for preferences
- clear, comprehensible information and support for self-care
- attention to physical and environmental needs
- emotional support, empathy and respect

- involvement of, and support for family and carers
- continuity of care and smooth transitions

The Trust performs well against all of these dimensions and will be using these and the results the survey to assist in the production of a new Patient Experience Strategy.

5.0 Patient Comments

The Trust received over 1200 comments from the 2017 survey, of which the significant majority were positive. Comments about care and treatment tended to be general in nature and positive. Negative comments generally were made where communication was not effective for an individual or where physical, emotional or support needs were different to the majority and these were not met.

Examples of Positive Comments

- I was very pleased with the care I received in all departments.
- All staff, whether administrative or medical, were very helpful and friendly.
- Yes the nursing staff were wonderful thanks.
- The HCA's were brilliant. As soon as I pressed my buzzer, they were there. Very helpful.
- Yes re. physiotherapy/girls in the pool 10/10 great help.
- They were very kind/sensitive to me during my stay. Staff doctors all.
- Friendly, relaxed atmosphere at hospital and with staff, including nurses, HCAs and theatre staff.
- Exceptional skill of the plastic surgeon (and his team) who managed excision and reconstruction rather than amputation. Dedicated and compassionate staff in HDU.
- I only had to wait a month for my operation.
- The good part was having the operation. I was very respected for my age.
- I cannot fault my care at all while I was in hospital, nothing was too much trouble.

- Overall my stay was comfortable. All staff made me feel at ease and dealt with complications quickly and with care.
- Local hospital, excellent surgeon, very caring staff.
- All the staff I came into contact with were so lovely. Put me at ease before I went into surgery.
- The kindness of all members of staff who work so hard for the benefit of patients. Their selfless dedication is much appreciated.
- All staff were kind and considerate, helpful and encouraging.

Examples of Negative Comments

- Food - not a great choice of gluten free. While every meal had gluten free options they were sometimes just sides or the same option was repeated for tea as it was for lunch.
- The discharge letter sent to my GP was very poor. It didn't state what they had done in surgery. Some of the information was wrong. I also feel my post-operative physiotherapy has been very inconsistent.
- Basic stuff needs attention - food - beds - nurse's morale/attitude. Overall the service I received was good - but could be even better.
- The discharge procedure and discharge lounge.
- Help with cleaning my teeth when bed bound.
- More nurses are needed, desperately.
- The waiting time from being admitted. I arrived at 10.30 and waited in the admissions lounge until 4.45pm. I had no water and was hungry, I felt faint.
- BSL sign language. There is very little support to help communication for deaf people. They shouldn't rely on family or friends to translate information. No hand wipes or toilet rolls.
- The discharge lounge very slow.
- I was left in pain for 3 hours the day after hip bone pelvis and thigh surgery. I was given no pain relief at all! I was crying in agony - bone pain - the nurses did nothing to help me, they did not care!
- The major improvement needed is in food provision. The quality of food was poor at best, not well presented and appetising. The number of nursing staff

could do with improvement, although they coped well, it was possible to realise that there was a lot of pressure.

- I would like to see more privacy when being examined and discussing my conditions with doctors etc. when on the ward. It is very embarrassing when the whole of the ward, plus visitors, can hear clearly the whole conversation.

6.0 Progress on rolling action plan

The action plan with updates following the 2017 survey publication is attached in Appendix 2. Good progress has been made against all of the agreed actions; however, the brief period of time between publication of an annual survey and the taking of the next (3 months) does not allow for the more complex change management work to be completed in time for impact on the scoring. The Trust therefore develops a longer view of actions until the impact can be seen on the ranking.

7.0 Next Steps

The results of the 2017 survey have already been disseminated and a new updated action plan will be developed and agreed. This will be monitored quarterly at Clinical Quality Group.

Appendix 1

National Inpatient Survey Report 2017

Appendix 2

National Inpatient Survey Rolling Action Plan

	Major Delay
	Some Delay
	Action is not yet due for completion and there is no foreseen issues that may prevent deliver
	Action Completed
	No Action Required / Not Applicable

ACTION LOG: National Inpatient Survey rolling Action Plan - updated July 2018

Ref/Date	Action	Owner	Actions being taken	Update	Status
2015/02 & 2017/01	To improve patient satisfaction with relation to changes to admission dates made by ROH – kept on action plan as no change to response in 2016	CSM for Patient Access	Baseline assessment for trends undertaken identified annual leave booking and processing in pre-op as causative factors. Procedures reviewed and new booking systems evaluated	2017 survey: still an issue for patients Intention: remain on action plan	
2015/03	To improve patient satisfaction with regards to being involved in discharge planning – kept on action plan as some improvement to response in 2016	Head of Nursing (Div. 1)	Discharge planning now started in pre-op. SS referrals now sent at the point of admission. Weekly MDT for discharge planning in place on each ward	2017 survey: significantly better in 9 of 15 questions. In the top 20% of Trusts for Discharge domain Intention: remove from action plan	
2015/04	To reduce delays in discharge due to waiting for medicine or ambulance services - kept on action plan as some improvement to response in 2016	Head of Nursing (Div. 1)	Red2Green project initiated and monitoring being undertaken. Pharmacist in pre-op to identify medication issues earlier.	2017 survey: about the same as previous surveys Intention: remain on action plan	
2016/01 & 2017/02	To improve patient satisfaction with length of time spent on the waiting list for surgery	Operational Team	Perfecting Pathways Process	2017 survey: about the same as previous surveys Intention: remain on action plan	

2016/02 & 2017/03	To improve patient satisfaction with knowing the name of the nurse looking after you for each shift	Head of Nursing (Div.1)	Patient information Boards to be reviewed. Initiate handovers at the bedside. Review wearing of Name Badges	2017 survey: about the same as previous surveys Intention: remain on action plan	
2016/03	To improve patient satisfaction with the explanations about what is going to be done during the procedure	Associate Medical Director	Letter to be sent to all clinical staff. Ongoing monitoring of question on FFT survey	2017 survey: significantly better and top 20% in all questions relating to clinical communication Intention: remove from action plan	
2016/04	To improve patient satisfaction with being allowed to provide feedback on the quality of care that they received	Patient Services Manager	Increase use of FFT Survey to all clinical areas Provision of information to departmental managers to ensure feedback is requested from all patients	2017 survey: about the same as previous surveys Intention: remain on action plan	
2017/04	To improve patient satisfaction with non-clinical staff interactions	All CSM's	Review all patient experience feedback to date and identify any issues Take corrective action where necessary		
2017/05	To ensure that quality of food remains a focus and improvements made are maintained	Patient Services Manager	To reinstate the real-time patient survey including food questions and monitor monthly		

Care Quality Commission

Survey Coordination Centre

Patient survey report 2017

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

NHS Patient Survey Programme
Survey of adult inpatients 2017

The Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

Survey of adult inpatients 2017

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The fifteenth survey of adult inpatients involved 148 acute and specialist NHS trusts across England. Responses were received from 72,778 people, a response rate of 41%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2017[1]. Trusts counted back from the last day of July 2017, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2017). Fieldwork took place between September 2017 and January 2018.

Surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2016. They are part of a wider programme of NHS patient surveys, which cover a range of topics including emergency departments, children's inpatient and day-cases, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be use to support CQC inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold them to account for the outcomes they achieve. NHS Improvement will use the results to guide its work to improve the quality of care provided by NHS Trusts and Foundation Trusts.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S11 in the 'section scores'. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward', 'doctors', 'nurses' and so forth.

This report shows the same data as published on the CQC website (http://www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

[1] 37 trusts sampled additional months because of small patient throughputs.

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we standardise the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q44 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the grey section of the graph, its result is 'about the same' as most other trusts in the survey
- If your trust's score lies in the orange section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'. These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no orange and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed. The column called 'change from 2016' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2016. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2016 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2016 survey, or if a trust committed a sampling error in 2016. Please note that comparative data are not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q36: Two new response options, “I was not given any information about my treatment or condition” and “Don’t know/ can’t remember”, were added to question 36 (“How much information about your condition or treatment was given to you?”). As a result data is no longer comparable to the same question in 2016.

Q50 and Q51: The information collected by Q50 “On the day you left hospital, was your discharge delayed for any reason?” and Q51 “What was the main reason for the delay?” are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q51 and is worded as: “Discharge delayed due to wait for medicines/to see doctor/for ambulance.”

Q52: Information from Q50 and Q51 has been used to score Q52 “How long was the delay?” This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q53 and Q56: Respondents who answered Q53 “Where did you go after leaving hospital?” as “I was transferred to another hospital” were not scored for question Q56 (“Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?”). This decision was taken as there is not a requirement for hospital transfers.

Trusts with female patients only

Q11: If your trust offers services to women only, a trust score for Q11 “While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?” is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E department.

Questions added and removed for 2017

The following questions are new for 2017 and will therefore have no comparative results:

Q11: “While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?"

Q13: “Did the hospital staff explain the reasons for being moved in a way you could understand?”

Q22: “During your time in hospital, did you get enough to drink?

Q31: “Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?

Q43: “If you needed attention, were you able to get a member of staff to help you within a reasonable time?”

Q63: “Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?”

Q71: “Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?”

The following questions were removed from the 2017 questionnaire (2016 numbering):

Q13: “After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?”

Q14: “While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?”

Q18: “How clean were the toilets and bathrooms that you used in hospital?”

Q19: “Did you feel threatened during your stay in hospital by other patients or visitors?”

Q44: “How many minutes after you used the call button did it usually take before you got the help you needed?”

Q46: “Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?”

Q47: “Beforehand, did a member of staff explain what would be done during the operation or procedure?”

Q50: “Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?”

Q51: “Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?”

Q73: “During your time in hospital did you feel well looked after by hospital staff?”

For more information on questionnaire redevelopment and the rationale behind adding or removing individual questions please refer to the Survey Development Report, available here: http://www.nhssurveys.org/survey/2008

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2016 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/1084

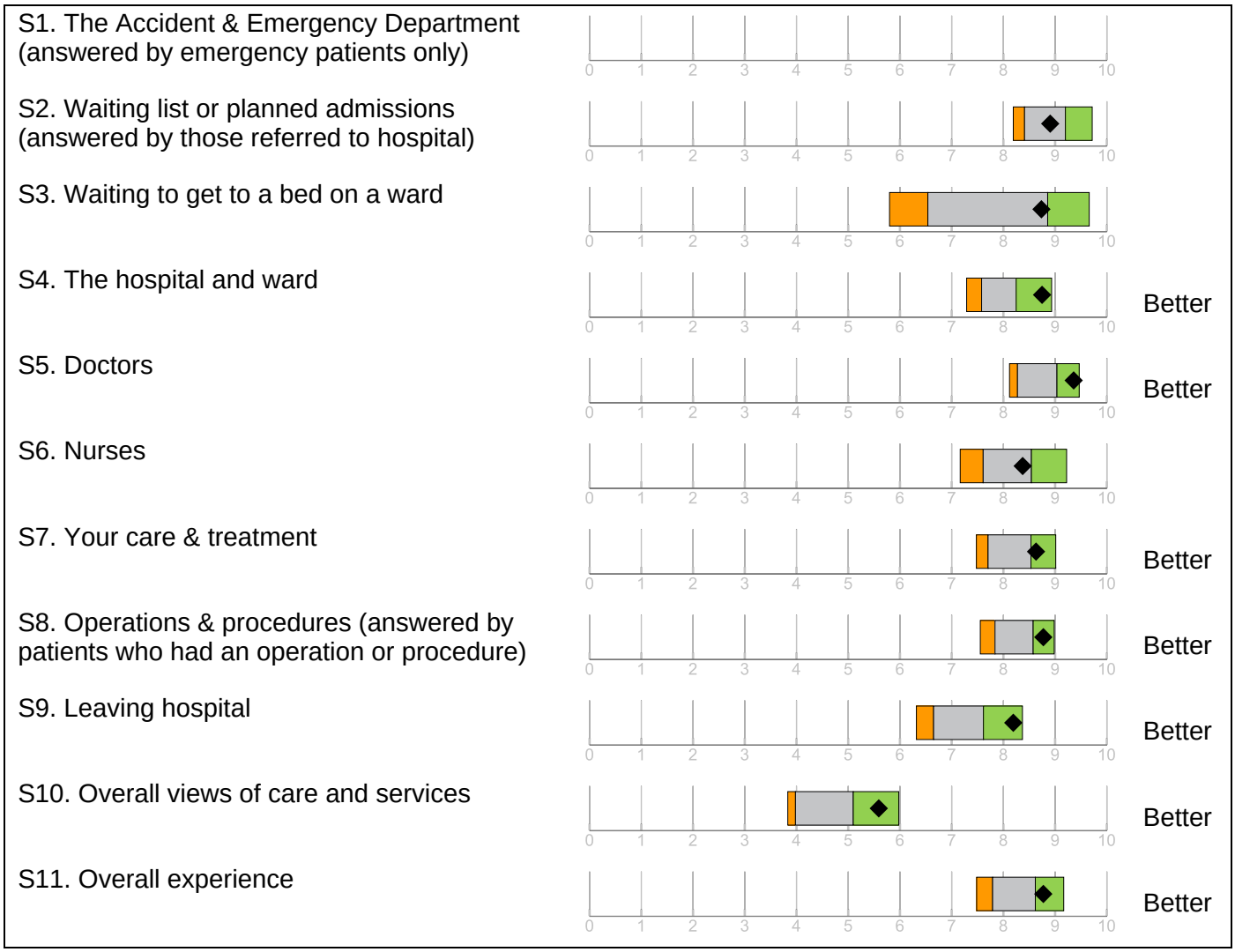
More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

Section scores



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

The Accident & Emergency Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Waiting list or planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?

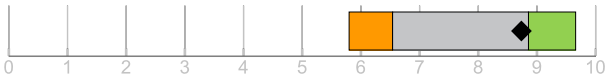
Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Better

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

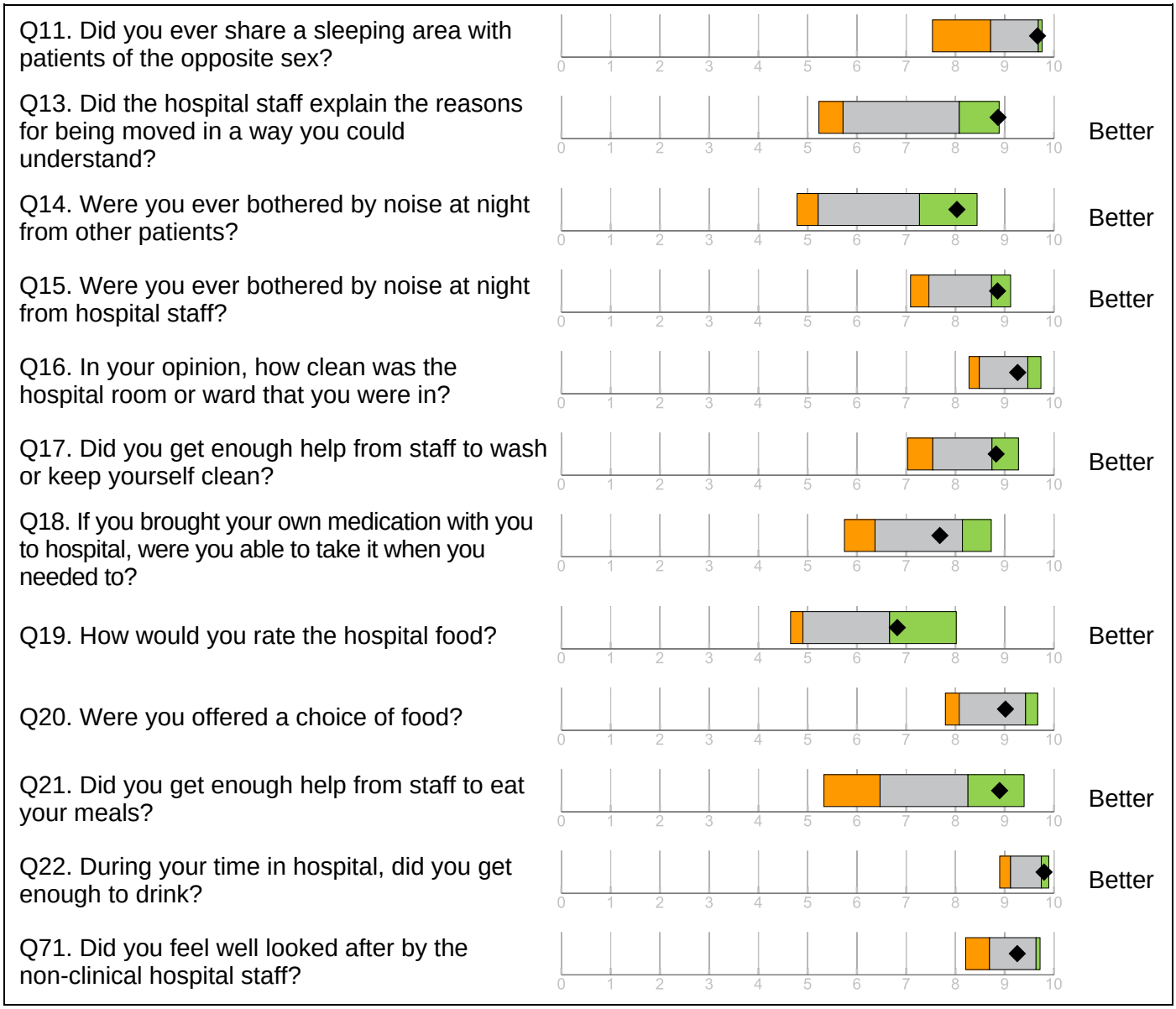


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

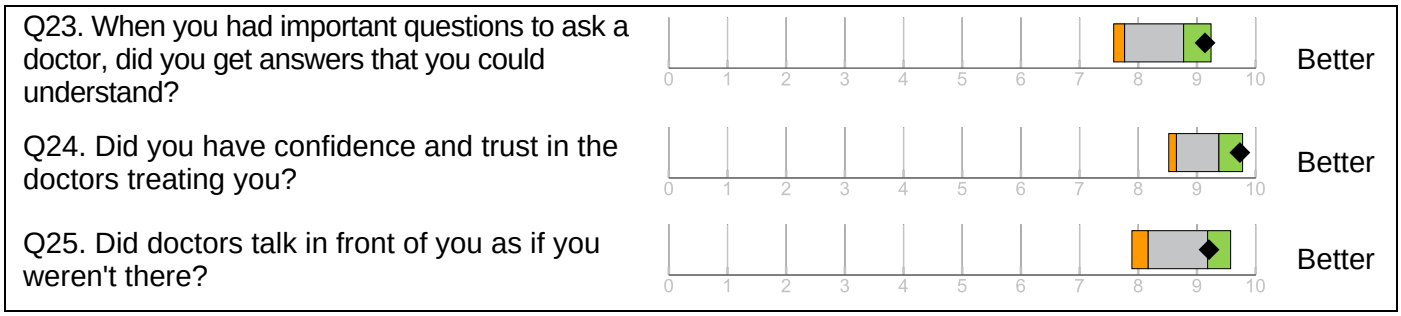
Survey of adult inpatients 2017

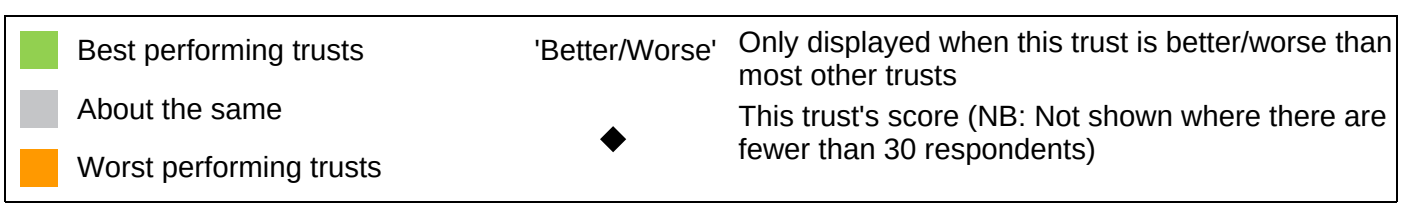
The Royal Orthopaedic Hospital NHS Foundation Trust

The hospital and ward



Doctors



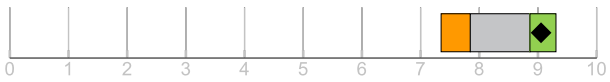


Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

Nurses

Q26. When you had important questions to ask a nurse, did you get answers that you could understand?



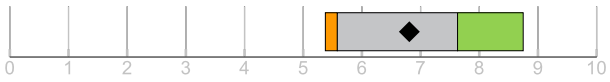
Better

Q27. Did you have confidence and trust in the nurses treating you?

Q28. Did nurses talk in front of you as if you weren't there?

Q29. In your opinion, were there enough nurses on duty to care for you in hospital?

Q30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)

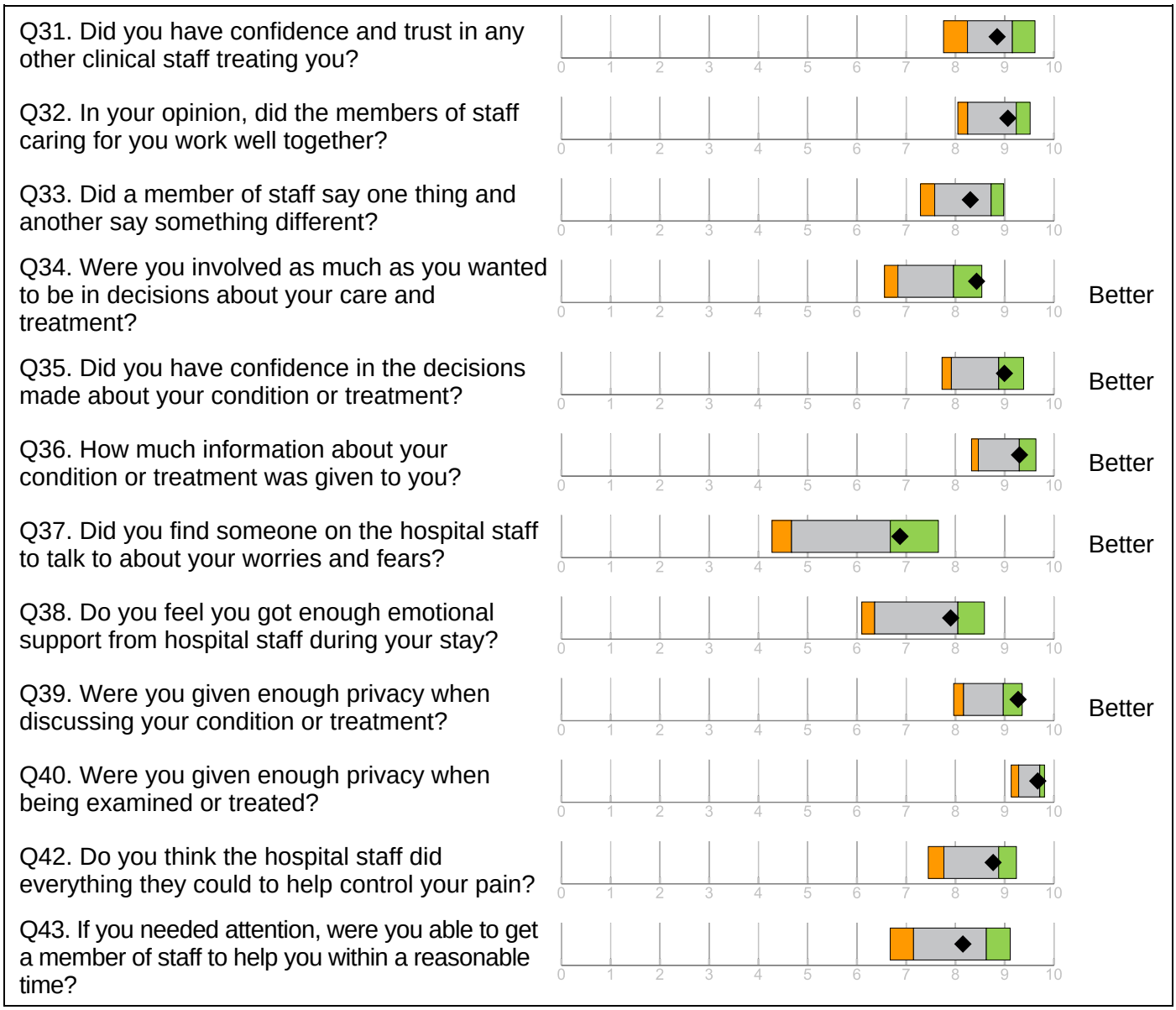


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

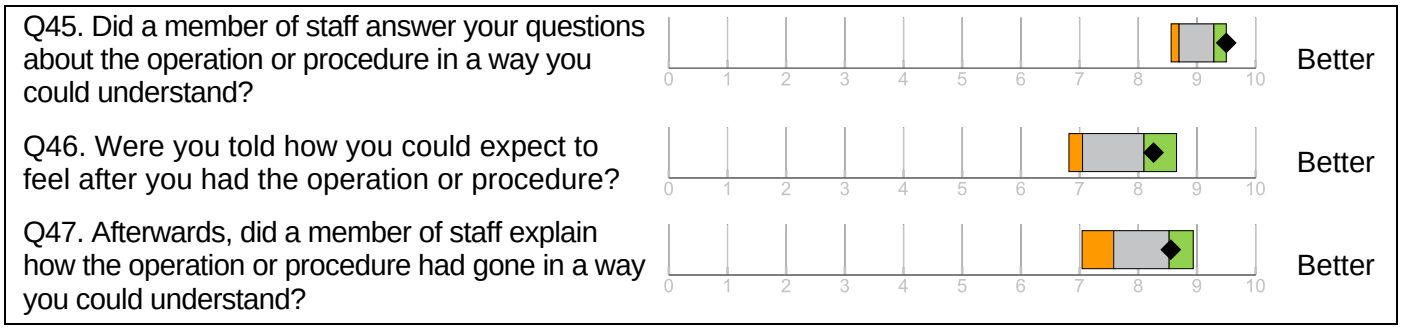
Survey of adult inpatients 2017

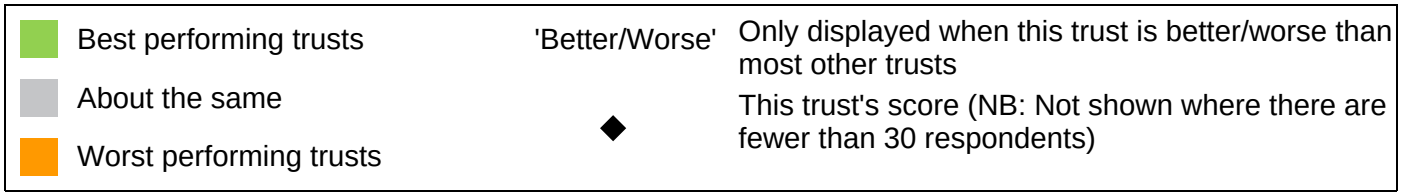
The Royal Orthopaedic Hospital NHS Foundation Trust

Your care & treatment



Operations & procedures (answered by patients who had an operation or procedure)

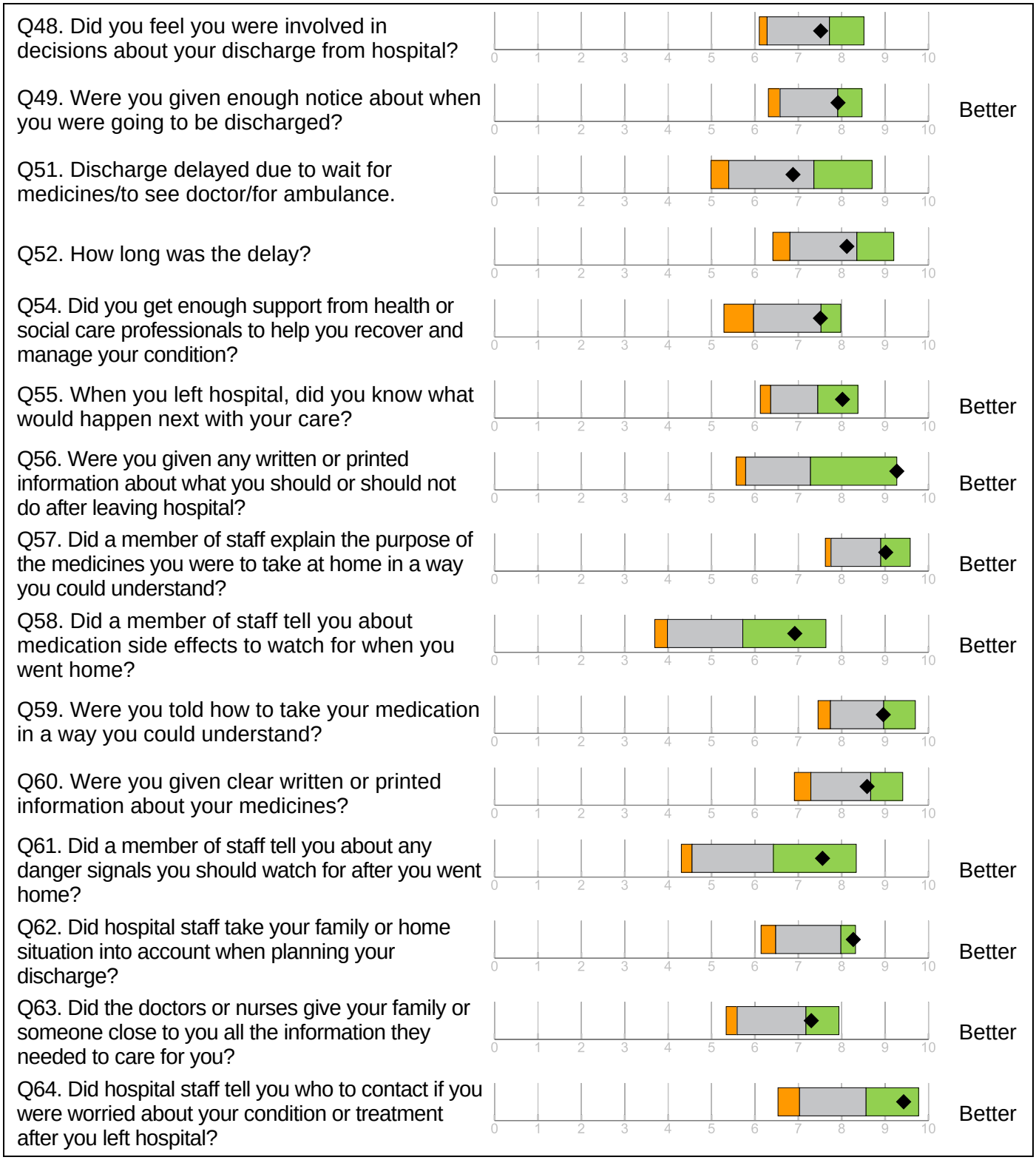


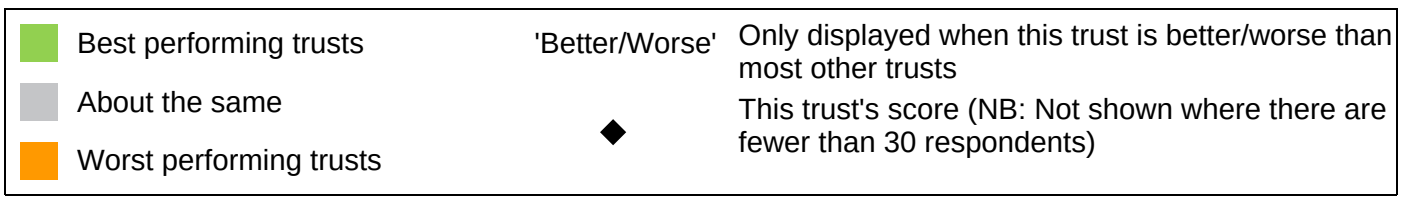


Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

Leaving hospital

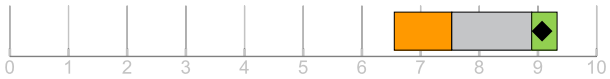




Survey of adult inpatients 2017

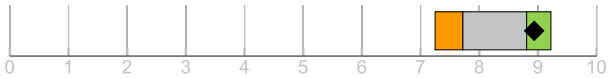
The Royal Orthopaedic Hospital NHS Foundation Trust

Q65. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?



Better

Q66. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



Better

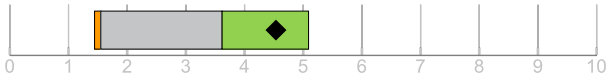
Overall views of care and services

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Better

Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?

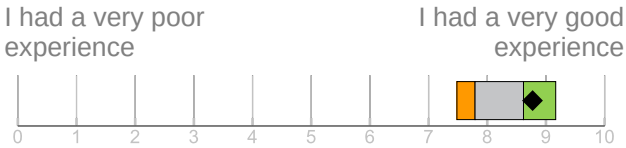
Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Better

Overall experience

Q68. Overall...



Better

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
The Accident & Emergency Department (answered by emergency patients only)							
S1	Section score	-	7.5	9.2			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	-	7.4	9.1			
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	-	7.5	9.5			
Waiting list or planned admissions (answered by those referred to hospital)							
S2	Section score	8.9	8.2	9.7			
Q6	How do you feel about the length of time you were on the waiting list?	8.2	6.3	9.7	739	8.0	
Q7	Was your admission date changed by the hospital?	9.1	8.1	9.9	743	9.1	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.4	8.3	9.6	733	9.1	
Waiting to get to a bed on a ward							
S3	Section score	8.7	5.8	9.7			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.7	5.8	9.7	768	8.7	

↑ or ↓	Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
The hospital and ward							
S4	Section score	8.7	7.3	8.9			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.7	7.5	9.8	774		
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	8.9	5.2	8.9	30		
Q14	Were you ever bothered by noise at night from other patients?	8.0	4.8	8.4	768	7.7	
Q15	Were you ever bothered by noise at night from hospital staff?	8.9	7.1	9.1	767	8.9	
Q16	In your opinion, how clean was the hospital room or ward that you were in?	9.3	8.3	9.7	775	9.5	
Q17	Did you get enough help from staff to wash or keep yourself clean?	8.8	7.0	9.3	611	8.8	
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.7	5.7	8.7	540	7.7	
Q19	How would you rate the hospital food?	6.8	4.7	8.0	753	7.1	
Q20	Were you offered a choice of food?	9.0	7.8	9.7	768	9.4	
Q21	Did you get enough help from staff to eat your meals?	8.9	5.3	9.4	191	9.0	
Q22	During your time in hospital, did you get enough to drink?	9.8	8.9	9.9	766		
Q71	Did you feel well looked after by the non-clinical hospital staff?	9.3	8.2	9.7	727		
Doctors							
S5	Section score	9.4	8.1	9.5			
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	9.1	7.6	9.2	690	9.0	
Q24	Did you have confidence and trust in the doctors treating you?	9.7	8.5	9.8	773	9.7	
Q25	Did doctors talk in front of you as if you weren't there?	9.2	7.9	9.6	767	9.5	

↑ or ↓	Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Nurses							
S6	Section score	8.4	7.2	9.2			
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	9.1	7.3	9.3	668	8.7	
Q27	Did you have confidence and trust in the nurses treating you?	9.2	8.0	9.6	774	9.3	
Q28	Did nurses talk in front of you as if you weren't there?	9.1	8.0	9.6	773	9.5	
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	7.7	6.5	9.1	774	8.6	↓
Q30	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.8	5.4	8.7	774	6.2	

↑ or ↓	Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Your care & treatment							
S7	Section score	8.6	7.5	9.0			
Q31	Did you have confidence and trust in any other clinical staff treating you?	8.8	7.8	9.6	710		
Q32	In your opinion, did the members of staff caring for you work well together?	9.1	8.0	9.5	752	9.1	
Q33	Did a member of staff say one thing and another say something different?	8.3	7.3	9.0	773	8.9	↓
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.4	6.6	8.5	764	8.0	
Q35	Did you have confidence in the decisions made about your condition or treatment?	9.0	7.7	9.4	768	9.2	
Q36	How much information about your condition or treatment was given to you?	9.3	8.3	9.6	760		
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	6.9	4.3	7.7	385	6.7	
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	7.9	6.1	8.6	442	8.0	
Q39	Were you given enough privacy when discussing your condition or treatment?	9.3	8.0	9.4	765	9.1	
Q40	Were you given enough privacy when being examined or treated?	9.7	9.1	9.8	770	9.9	↓
Q42	Do you think the hospital staff did everything they could to help control your pain?	8.8	7.4	9.2	612	8.7	
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	8.2	6.7	9.1	741		
Operations & procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.8	7.6	9.0			
Q45	Did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.5	8.6	9.5	725	8.9	
Q46	Were you told how you could expect to feel after you had the operation or procedure?	8.3	6.8	8.7	755	7.9	
Q47	Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	8.6	7.0	8.9	754	8.1	

↑ or ↓	Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Leaving hospital							
S9	Section score	8.2	6.3	8.4			
Q48	Did you feel you were involved in decisions about your discharge from hospital?	7.5	6.1	8.5	755	7.7	
Q49	Were you given enough notice about when you were going to be discharged?	7.9	6.3	8.5	771	7.6	
Q51	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.9	5.0	8.7	705	7.1	
Q52	How long was the delay?	8.1	6.4	9.2	702	8.5	
Q54	Did you get enough support from health or social care professionals to help you recover and manage your condition?	7.5	5.3	8.0	560	7.2	
Q55	When you left hospital, did you know what would happen next with your care?	8.0	6.1	8.4	725	7.8	
Q56	Were you given any written or printed information about what you should or should not do after leaving hospital?	9.3	5.6	9.3	752		
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	9.0	7.6	9.6	670	9.3	
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	6.9	3.7	7.6	576	6.9	
Q59	Were you told how to take your medication in a way you could understand?	9.0	7.5	9.7	621	9.4	
Q60	Were you given clear written or printed information about your medicines?	8.6	6.9	9.4	603	9.1	
Q61	Did a member of staff tell you about any danger signals you should watch for after you went home?	7.6	4.3	8.3	678	7.4	
Q62	Did hospital staff take your family or home situation into account when planning your discharge?	8.3	6.1	8.3	629	8.4	
Q63	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	7.3	5.3	7.9	586		
Q64	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	9.4	6.5	9.8	744	9.4	
Q65	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	9.1	6.6	9.3	493	9.5	
Q66	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.9	7.2	9.2	595	8.9	

↑ or ↓	Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Overall views of care and services							
S10	Section score	5.6	3.8	6.0			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.5	8.5	9.7	771	9.6	
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	2.8	0.7	3.6	644	2.8	
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	4.5	1.4	5.1	569	4.1	
Overall experience							
S11	Section score	8.8	7.5	9.2			
Q68	Overall...	8.8	7.5	9.2	754	8.9	

↑ or ↓	Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017
The Royal Orthopaedic Hospital NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	776	72778
Response Rate (percentage)	63	41

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	44	47
Female	56	53
Age group (percentage)	(%)	(%)
Aged 16-35	7	5
Aged 36-50	8	8
Aged 51-65	29	23
Aged 66 and older	56	64
Ethnic group (percentage)	(%)	(%)
White	87	90
Multiple ethnic group	1	1
Asian or Asian British	7	3
Black or Black British	2	1
Arab or other ethnic group	0	0
Not known	3	5
Religion (percentage)	(%)	(%)
No religion	18	16
Buddhist	0	0
Christian	72	77
Hindu	2	1
Jewish	0	0
Muslim	3	2
Sikh	2	0
Other religion	1	1
Prefer not to say	1	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	96	94
Gay/lesbian	1	1
Bisexual	0	0
Other	0	1
Prefer not to say	3	4

ROHTB (11/18) 007

TRUST BOARD

DOCUMENT TITLE:	**Health Care Worker Flu Vaccination**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Director of Nursing & Clinical Governance**
AUTHOR:	**Angela Howling, Head of Infection Prevention**
DATE OF MEETING:	**7th November 2018**

EXECUTIVE SUMMARY:

In order to ensure that the Trust is doing everything possible as an employer to protect patients and staff from seasonal flu the Trust is asked to complete the best practice management checklist for healthcare worker vaccination and publish a self-assessment against these measures in board papers before the end of 2018.

The Trust is expected to ensure greatest protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. The evidence suggests that in these 'higher-risk' clinical environments more robust steps should be taken to limit the exposure of patients to unvaccinated staff and move as quickly as possible to 100% staff vaccination uptake.

In these higher-risk areas, staff should confirm to their clinical director / head of nursing / head of therapy whether or not they have been vaccinated. This information should be held locally so that trusts can take appropriate steps to maintain the overall safety of the service, including considering changing the deployment of staffing within clinical environments if that is compatible with maintaining the safe operation of the service.

It is strongly recommend that the Trust work with recognised professional organisations and trade unions to maximise uptake of the vaccine within the workforce; to identify and minimise any barriers; to discuss and agree which clinical environments and staff should be defined as 'higher-risk'; and to ensure that the anonymous information about reasons for declining the vaccine is managed with full regard for the dignity of the individuals concerned.

Medical and nurse director colleagues will need to undertake an appropriate risk assessment and discuss with their staff and trade union representatives how best to respond to situations where clinical staff in designated high risk areas decline vaccination.

The Trusts' overall progress towards the 100% ambition will be tracked monthly during the vaccination season via 'ImmForm' and in addition this year there is a requirement to report how many healthcare workers, with direct patient contact, have been offered the vaccine and opted-out. This information will be published monthly by Public Health England on its website.

By February 2019 the Trust is expected to use its public board papers to locally report performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, to include details of rates within each of the areas you designate as 'higher-risk'. This report should also give details of the actions undertaken to deliver the 100% ambition for coverage this winter.

REPORT RECOMMENDATION:

In order to support the ambition of 100% of healthcare workers, with direct patient contact, to be vaccinated the Board is asked to :

- Consider and discuss, following conversations with staff and trade union representatives, how best to respond to situations where clinical staff, in high risk areas, decline the vaccination

ACTION REQUIRED
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
		X

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

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

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

Covers all risks to the delivery of the Trust's strategic objectives.

PREVIOUS CONSIDERATION:

This is the first consideration for the 2018/19 'Flu campaign

A	Committed Leadership	Trust Self-Assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker w h o decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so. **This was commenced alongside 2018/19 Flu vaccination campaign.**	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1). **400 vaccines ordered in and received for commencement of Flu vaccination campaign. A further 300 received Friday 26th October, 218.**	
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6) **Responsibility of the Assistant Director of Finance.**	
A4	Agree on a board champion for flu campaign (3,6) **Director of Nursing and Clinical Governance**	
A5	Agree how data on uptake and opt-out will be collected and reported **Vaccinators responsible for collecting data, Assistant Director of Finance will report on this data.**	
A6	All board members receive flu vaccination and publicise this (4,6) **Members of The Board received vaccinations and the publicity used to commence the Flu vaccination campaign for 2018/19.**	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6) **Flu campaign team formed prior to Flu vaccination campaign.**	
A8	Flu team to meet regularly from August 2018 (4) **Team meet twice monthly.**	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6) **Supported by required staff and regular publishing cascaded that is also supported by a dedicated Trust communication link.**	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4) **Drop in clinics, roving trolley vaccination rounds and**	

	peer to peer vaccination in place.	
B3	Board and senior managers having their vaccinations to be publicised (4) **See point A6.**	
B4	Flu vaccination programme and access to vaccination on induction programmes (4) **Infection Prevention Team providing vaccinations on induction days.**	
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6) **Undertaken as point B1.**	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6) **Responsibility of the Assistant Director of Finance.**	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6) **Peer vaccinators identified, trained and supported with bank payments to meet the needs of the campaign.**	
C2	Schedule for easy access drop in clinics agreed (3) **Drop in clinics agreed, scheduled and advertised.**	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6) **Trained vaccinators available to cover the 24hour shift patterns.**	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this (3,6) **Agreed – no incentives.**	
D2	Success to be celebrated weekly (3,6) **Shared responsibility with Assistant Director of Finance, Communication Team Infection Prevention Team.**	

Wellington House
133-155 Waterloo Road
London SE1 8UG
martin.wilson1@nhs.net

Friday 7 September 2018

To: Chief Executives of NHS Trusts and Foundation Trusts

Dear Colleague

Health care worker flu vaccination

We know you appreciate the importance of all healthcare workers protecting themselves, their patients, their colleagues and their families by being vaccinated against seasonal flu, because the disease can have serious and even fatal consequences, especially for vulnerable patients. Your leadership, supported by the Flu Fighter campaign and the CQUIN has increased take-up of the flu vaccine, with some organisations now vaccinating over 90% of staff. Our ambition is for 100% of healthcare workers with direct patient contact to be vaccinated.

In February, the medical directors of NHS England and NHS Improvement wrote to all Trusts to request that the quadrivalent (QIV) vaccine is made available to all healthcare workers for winter 2018-19 because it offers the broadest protection. This is one of a suite of interventions that can and should be taken to reduce the impact of flu on the NHS.

Today we are writing to ask you to tell us how you plan to ensure that every one of your staff is offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Healthcare workers with direct patient contact need to be vaccinated because:

a) Recent National Institute for Health and Care Excellence (NICE) guidelines[1] highlight a correlation between lower rates of staff vaccination and increased patient deaths;

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues;

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence;

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated.

[1] https://www.nice.org.uk/guidance/ng103

In order to ensure your organisation is doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018.

Where staff are offered the vaccine and decide on the balance of evidence and personal circumstance against having the vaccine, they should be asked to anonymously mark their reason for doing so by completing a form, and you should collate this information to contribute to the development of future vaccination programmes. We have provided an example form [appendix 2] which you may wish to tailor and use locally, though we suggest you use these opt out reasons to support national comparisons.

We specifically want to ensure greatest protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. The evidence suggests that in these 'higher-risk' clinical environments more robust steps should be taken to limit the exposure of patients to unvaccinated staff and you should move as quickly as possible to 100% staff vaccination uptake. At a minimum these higher-risk departments include haematology, oncology, bone marrow transplant, neonatal intensive care and special care baby units. Additional areas may be identified locally where there are a high proportion of patients who may be vulnerable, and are receiving close one-to-one to clinical care.

In these higher-risk areas, staff should confirm to their clinical director / head of nursing / head of therapy whether or not they have been vaccinated. This information should be held locally so that trusts can take appropriate steps to maintain the overall safety of the service, including considering changing the deployment of staffing within clinical environments if that is compatible with maintaining the safe operation of the service.

We would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce; to identify and minimise any barriers; to discuss and agree which clinical environments and staff should be defined as 'higher-risk'; and to ensure that the anonymous information about reasons for declining the vaccine is managed with full regard for the dignity of the individuals concerned. Medical and nurse director colleagues will need to undertake an appropriate risk assessment and discuss with their staff and trade union representatives how best to respond to situations where clinical staff in designated high risk areas decline vaccination.

It is important that we can track trusts' overall progress towards the 100% ambition. Each trust shall continue to report uptake monthly during the vaccination season via 'ImmForm'. However from this year you are also required to report how many healthcare workers with direct patient contact have been offered the vaccine and opted-out. This information will be published monthly by Public Health England on its website.

By February 2019 we expect each trust to use its public board papers to locally report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, to include details of rates within each of the areas you designate as 'higher-risk'. This report should also give details of the actions that you have undertaken to deliver the 100% ambition for coverage this winter. We shall collate this information nationally by

asking trusts to give a breakdown of the number of staff opting out against each of the reasons listed in appendix 2.

You can find advice, guidance and campaign materials to support you to run a successful local flu campaign on the NHS Employers Flu Fighter website www.nhsemployers/flufighter

Finally we are pleased to confirm that NHS England is once again offering the vaccine to social care workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely

- signed jointly by the following national clinical and staff side professional leaders -

Prof Stephen Powis .....National Medical Director, NHS England and on behalf of National Escalation Pressures Panel

Prof Paul Cosford .. Medical Director & Director of Health Protection, Public Health England

Prof Jane Cummings..... Chief Nursing Officer, NHS England

Sara Gorton (Unison)..... Co-chair, National Social Partnership Forum

Prof Dame Sue Hill..... Chief Scientific Officer, NHS England

Dame Donna Kinnair. Acting Chief Executive & General Secretary, Royal College of Nursing

Prof Carrie MacEwen ..... Chair of the Academy of Medical Royal Colleges

Ruth May..... Executive Director of Nursing, NHS Improvement

Dr Kathy Mclean..... Executive Medical Director NHS Improvement

Danny Mortimer (NHS Employers)..... Co-chair, National Social Partnership Forum

Pauline Philip .....National Director of Urgent and Emergency Care

Suzanne Rastrick..... Chief Allied Health Professions Officer, NHS England

Keith Ridge.....Chief Pharmaceutical Officer, NHS England

John Stevens .....Chairman, Academy for Healthcare Science

Gill Walton..... Chief Executive, Royal College of Midwives

Appendix 1 - Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2018

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	
A4	Agree on a board champion for flu campaign (3,6)	
A5	Agree how data on uptake and opt-out will be collected and reported	
A6	All board members receive flu vaccination and publicise this (4,6)	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	
A8	Flu team to meet regularly from August 2018 (4)	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	
B3	Board and senior managers having their vaccinations to be publicised (4)	
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	
C2	Schedule for easy access drop in clinics agreed (3)	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this (3,6)	
D2	Success to be celebrated weekly (3,6)	

Reference links

1. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Vaccine-ordering-for-2018-19-influenza-season-06022018.pdf?la=en&hash=74BF83187805F71E9439332132C021EFA3E6F24C
2. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/Reviewing-your-campaign-a-flu-fighter-guide.pdf
3. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Flu-fighter-infographic-final-web-3-Nov.pdf
4. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-acute-trusts-TH-formatted-10-June.pdf
5. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-ambulance-trusts-TH-formatted-10-June.pdf
6. https://www.nice.org.uk/guidance/ng103/chapter/Recommendations

Appendix 2 – Example opt out forms for local adaptation and use

Form to be potentially co-branded by NHS organisation and key trade unions

Dear colleague,

Did you know that 7 out of 10 front line NHS staff had the flu vaccine last year, and in some departments more than 9 out of 10 staff were vaccinated?

The flu jab gives our body the information it needs to fight the flu, which stops us from contracting and spreading the virus. For those of us who work in care settings, getting the flu jab is an essential part of our work. In vaccinating ourselves we are protecting the people we care for, and helping to ensure that we are able to provide the safest environment and effective care for patients.

We want everyone to have the jab. The sooner you get it, the more people you can protect. We hope that you will agree to having the vaccine – this really helps to protect patients, you and your family. But, if you choose not to have the flu vaccine, we want to understand your reasons for that by filling in this anonymous form.

Signed

Chief Executive, Medical Director, Director of Nursing, and Trade Union representative

Please tick to confirm that you have chosen not to have the vaccine this year:

☐ I know that I could get flu and have only mild symptoms or none at all; and that because of this I could give flu to a patient. I know that vaccination is likely to reduce the chances of me getting flu and of me passing it to my patients. But I still don't want the vaccine.

Please tick each of the boxes below that apply to your decision not to have the jab.

I DON'T WANT TO BE FLU VACCINATED BECAUSE:

☐ I don't like needles

☐ I don't think I'll get flu

☐ I don't believe the evidence that being vaccinated is beneficial

☐ I'm concerned about possible side effects

☐ I don't know how or where to get vaccinated

☐ It was too inconvenient to get to a place where I could get the vaccination

☐ The times when the vaccination is available are not convenient

☐ Other reason – please tell us here ▸

Thank you for completing this form.

ROHTB (11/18) 007 (c)

2017-18 Flu Campaign

CQUIN	**1c – Improving the uptake of flu vaccinations for frontline clinical staff within Providers**
Quarter	**Year 1**
ROH Achievement	**ACHIEVED – 70.21%**
Author	**Julie Gardner – Assistant Director of Finance - Contracting**

Description of Indicator

Year 1 – Achieving an uptake of flu vaccination by frontline clinical staff of 70%.

ROH Flu Campaign

Our Executive Team started off our flu vaccinations.

ROH had an ongoing campaign throughout the flu season with 'flu fighters' outside the onsite restaurant one day a week every week. We issued a flu vaccination email address that people could request a vaccination on and the ROH flu fighters walked around the Trust targeting areas that had a low uptake. We deployed bank staff all day to visit clinical areas and we ensured we had our 'flu fighters' available at all training events and clinical audit mornings.

ROHTB (11/18) 007 (c)

ROH frequently prepared updates for Managers to help staff understand areas which were particularly slow; an example of this is in appendix A

In November 2018 staff who had not had the vaccine were emailed directly to see if they wanted the flu vaccination.

During January 2018 Birmingham had a flu outbreak and this encouraged a number of staff to have the vaccination and this gained enough momentum to reach the 70% threshold.

ROH Flu Vaccination Summary

ROH reported the flu vaccine figures on a weekly basis.

Seasonal Flu Vaccine Uptake (Frontline Healthcare Workers - Midlands & East Trusts) 2017/18				
Trust Name - select from drop down below	Trust Type	2017/18		
		Number of HCWs involved with direct patient care	Cumulative Seasonal Flu doses given since 1st September 2017	Vaccine uptake (%)
Royal Orthopaedic Hospital NHS Foundation Trust	Acute			
Week Ending	15/10/2017			
	22/10/2017	821	292	35.57%
	29/10/2017	866	409	47.11%
	05/11/2017	849	427	50.00%
	12/11/2017	879	464	53.00%
	19/11/2017	853	469	55.00%
	26/11/2017	857	481	56.00%
	03/12/2017	871	504	57.86%
	10/12/2017	871	504	57.86%
	17/12/2017	877	510	58.15%
	24/12/2017	877	510	58.15%
	31/12/2017	877	510	58.15%
	07/01/2018	835	501	60.00%
	14/01/2018	874	544	62.24%
	21/01/2018	839	545	64.96%
	28/01/2018	865	567	65.55%
	04/02/2018	874	586	67.05%
	11/02/2018	876	615	70.21%
	18/02/2018	876	615	70.21%
	25/02/2018	876	615	70.21%
	04/03/2018	876	615	70.21%

Notes
Trust Name *- Please use the drop down box to select your Trust*
Trust Type *- Automated*
No. of HCWs involved with direct patient care *- enter the total number for your Trust at the time of completing the template*
Cumulative Seasonal Flu doses given since 1 September 2017 *- enter the number of HCWs that have received the Flu dose in 17/18 as at 1 September 2017*
Vaccine uptake *(%) - Automated*
Return *: Please return your submissions to* ***NHSI.MidlandsEast@nhs.net*** *by mid-day each Wednesday for the relevant week*

ROHTB (11/18) 007 (c)

Challenges

- A significant number of senior clinical staff did not have the vaccination because they did not believe it worked – this had an impact on a number of staff across the wards
- ROH frequently advertised an email address that no member of staff had access to; this was identified in month 3 of the campaign
- ROH ran out of vaccinations and had to order additional to hit the target
- Some staff who did not want the vaccination were very rude to the 'flu fighters'
- ROH staff do not experience patients with flu like a hospital with an A&E and therefore were less likely to want the vaccination
- During December a significant amount of the 'flu fighters' were unwell and ROH did not have staff available to give the vaccine.

Learning for 2018-19

- Need to ensure we have enough staff trained to give the vaccination.
- Need to ensure ROH have enough vaccinations on site.
- ROH need to produce a communications plan for the next flu season
- ROH should establish a 'flu group' to ensure the target is met
- ROH should use 2017-18 data to baseline a trajectory for 2018-19

Author: Julie Gardner

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Learning From Deaths Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Andrew Pearson, Medical Director**
AUTHOR:	**Mr Andrew Pearson, Medical Director**
DATE OF MEETING:	**7 November 2018**

EXECUTIVE SUMMARY:

The Trust has historically collected data on deaths that occur as in-patients and within 30 days of discharge. These deaths are discussed at the Clinical Audit and Effectiveness Committee chaired by the Medical Director.

The responsibility for delivery of action plans where individual, service, divisional or organisational learning is identified to be required from investigations sits with the Divisional Board Leadership. CAEC will oversee that this delivery is happening.

All deaths are reported through the serious incident reporting process and undergo investigation where the death is unexpected. As you would imagine, the ROH has very few in-patient deaths. It is challenging to find out about and investigate deaths that occur within 30 days of discharge from hospital or where death has occurred in a patient who has been transferred from the hospital for level 3 care.

The Trust *Reporting, Investigation and Learning from Deaths in Care Policy* has been updated to more appropriately reflect the case mix of the ROH and to make the process of identification, investigation and learning easier for all staff to follow. This updated policy is currently going through the good governance processes in order to be ratified.

The process of collecting information regarding patient deaths is coordinated by Clinical Governance which has had difficulties in collating this information due to low staff numbers.

From January 2018 to date five deaths have occurred in patients who are either or have been in-patients at the ROH. Of these known deaths 2 occurred at the ROH and 3 at level 3 units following 'transfer-out'. One of these deaths was an expected death in a terminal oncology patient who was transferred to the ROH for specialist care, but was not suitable for treatment.

Due to difficulties with Clinical Governance support of the process of oversight, it is not possible at this stage to provide assurance that there is satisfactory CAEC board review of the delivery of action plans. This is being addressed and will be in place by the time of the next upward report in Q4.

A spreadsheet is attached which details the anonymised cases.

REPORT RECOMMENDATION:

Accept and Discuss

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider 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	**x**	Legal & Policy		Patient Experience	**x**
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					

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

1st choice for orthopaedic care. Exceptional patient experience.

PREVIOUS CONSIDERATION:

Board Report 06.08.17

arning from Deaths ROH 2018

All in-patient and 30 day post discharge deaths are fully investigated and undergo a Structured Judgement Review

No	Incident No	Date of Death	Place of Death	Service	Procedure	Complications	Cause of Death	Pre-existing Risks	Coroner's Inquest	RCA Author	SJR Findings	Organisational Learning	Action Plan	Completed
1	23197	18.04.18	QEH	Arthroscopy	Elective TKR	Internal Haemorrhage	1(a) Hypovolaemia 1(b) Retroperitoneal haematoma 1(c) Pelvic fracture 2 Anticoagulation	Falls risk Recent TKR Confusion warfarin for AF	02.07.18 **Verdict: Accidental Death** underlying cause was fall inadequate assessment of falls risk lack of 1 to 1 observation	Sandra Phillpott		1. Falls Policy to be reviewed and updated 2. Proforma for medical review of patient after a fall 3. Falls booklet for all patients	\\gamma\users$\root\chugtaia\Desktop\05.MC	Yes Yes Yes
2	23624	11.04.17	Royal Shrewsbury	Oncology	Elective TKR	AKI Sepsis	1(a) Multi organ failure 1(b) Bronchopneumonia 1(c) Elective TKR	Chronic Obstructive Pulmonary Disease Lower Respiratory Tract Infections Breast Cancer Tourette's Syndrome	14.09.18 **Verdict: Narrative** "Patient died as a result of complications of surgery"	Peter Gibbons	Good care	1. Training & awareness of sepsis for all staff 2. Review of MEWS application 3. Full utilisation of 'Fluid Balance Charts' 4. Timely collection of bloods on 1st post-op day	\\gamma\users$\root\chugtaia\Desktop\STEPS	Yes Yes Yes Yes
3	24072	05.05.18	ROH	Spinal	Scoliosis Surgery	Collapse	1(a) Pulmonary Embolism 1(b) DVT 2 Acute Kidney Injury		No inquest	Jackie Dobson	Good care	1. Review of 24 hour re-assessment for VTE risk	\\gamma\users$\root\chugtaia\Desktop\24072	
4	24901	31.05.18	ROH	Oncology	palliative	expected death	1(a) Metastatic Breast Cancer		No inquest	n/a	Good care	1. Review of End of Life Policy 2. Oncology service to review transfer in criteria	n/a	
5	25520	09.10.18	Sandwell	Spinal	Metastic cord compression	Sepsis/Bowel Perforation	TBC	Barrett's Oesophagus Episodes of confusion	TBC	Sandra Phillpott	In Progress			

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board last met: 25 September 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee received an analysis that highlighted that for some complex procedures, at a national level, the tariff did not fully reimburse the costs of providing them. This issue was being considered at a by NHS England's pricing committee. • Expenditure was high during the month, although this was associated with the high level of inpatient activity handled. • A key risk to the achievement of an acceptable financial positon concerned the progress with the delivery of the Trust's Cost Improvement Programme. The Committee was concerned at the poor progress year to date although much hinged on a managed service contract that would be implemented later in the financial year. • There had been a breach to the 28 day guarantee following a cancelled operation. • There remained a high number of vacancies, although the position would be improved to some degree shortly with new staff taking up post. • The Committee was appraised of some of the key risks associated with the estates work for modular theatre build, including potential delay due to the timescales regarding the planning application and the various surveys of the site needed.	• Continued focus on the potential impact of Brexit from a supplies and workforce perspective. • A review of the local procurements arrangements was reported to be underway.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• An update on the work in the STP was provided and a clinical engagement meeting had been held which would drive forward some of the workstreams and assigned a clinical lead to each. • The financial performance of the Trust for Month 5 was better than expected, with the Trust being £300k ahead of plan year to date. • The inpatient activity position remains strong. • The controls to reduce bank and agency staffing costs were noted	• None specifically

to be taking effect, although the overall costs remained high. • Clinic waiting times were noted to be improving. • Performance against the diagnostic target was good. • There had been a further reduction in the number of patients waiting in excess of 52 weeks for treatment; these were all spinal deformity patients. • The performance of the private patient unit was reported to be strong, with further plans to improve the position further over the coming months by the recruitment of a GP liaison/private practice manager. • There was good progress across all aspects of the 'Perfecting Pathways' programme. • There was work at a national level to channel more purchasing through NHS Supply chain which could deliver an efficiency gain for the Trust as a result of rationalisation.	

Chair's comments on the effectiveness of the meeting: The meeting was noted to be productive and the key risks to the financial position of the Trust had been debated fully.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board last met: 26 October 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Income below budget. • Activity behind plan. • Both were looking more positive for October. • CIP Plans – still behind and a revised forecast to be given to next Board. • Costs were better than plan but more than they should be given the activity levels. • Sickness. • Review of Service Risks in relation to Brexit. •	• IM&T case to come to the next F&PC. • New dashboard for JointCare to come to next FPC. • Update on Estates Strategy. • Agree the need to review the marketing across all key aspects of the hospital (employee, activity, internal etc).
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Performance in October is anticipated to be good. • Positive progress on key performance metrics such as length of stay and treatment targets though we will need to see the 18 week figure improving over the next couple of months. • Overall financial performance is exactly in line with plan year to date. • Overall Perfecting Pathways making good progress. • The Committee noted a number of major initiatives were coming together at the same time.	• Agreed to bring the Supply Chain Self Assessment to this Committee to understand what supply mitigations are to ensure continuity of supply and also look at the lead time.
Chair's comments on the effectiveness of the meeting: This was an effective meeting, concentrating on core issues.	

Finance and Performance Report

September 2018

CONTENTS

INTRODUCTION

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

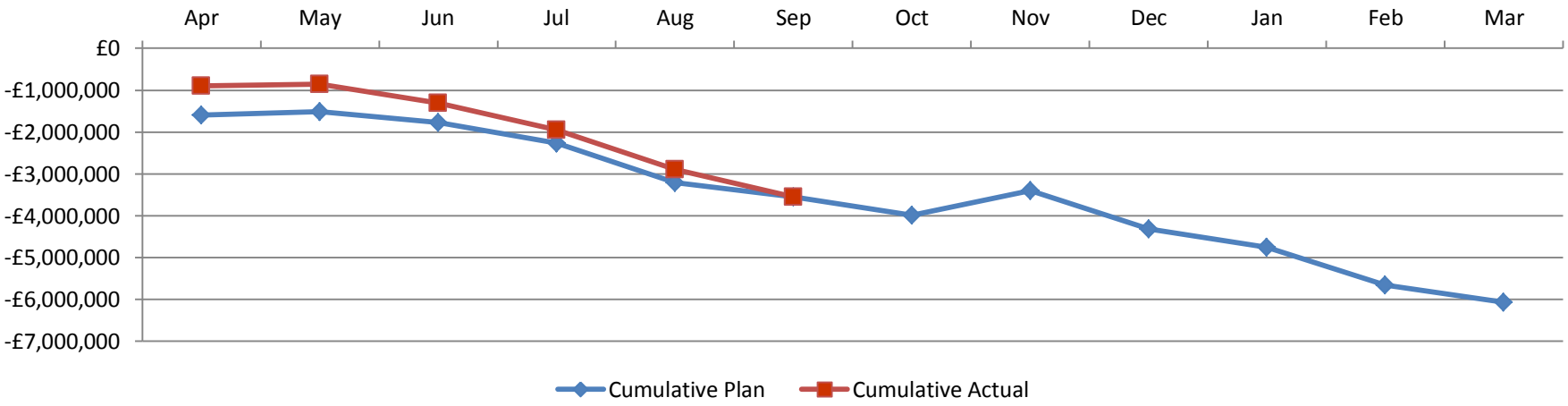
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

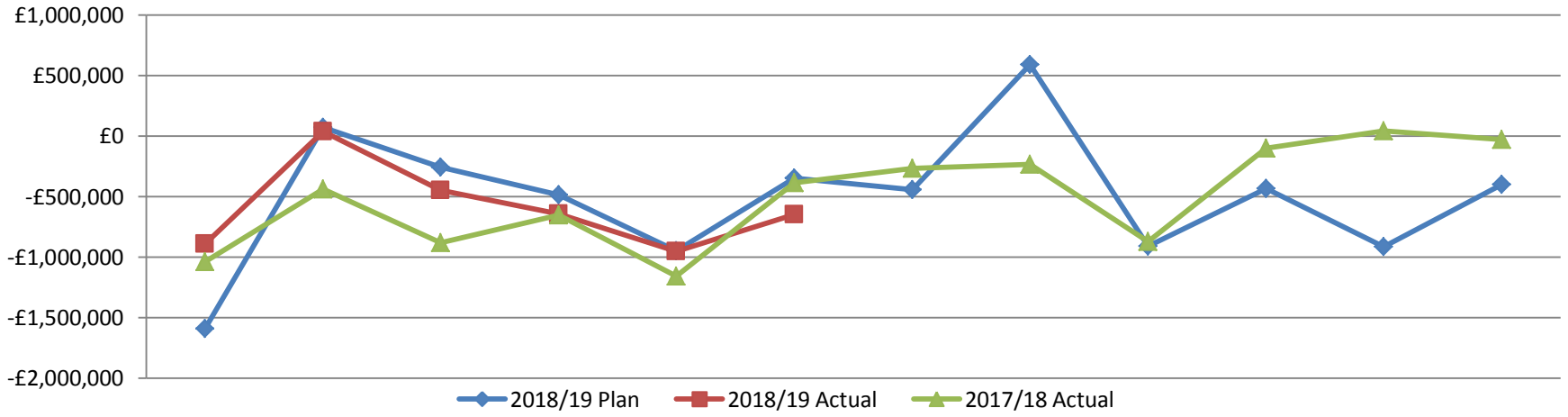
	YTD M6 Original Plan £'000	YTD M6 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	38,278	39,077	799
Other Operating Income	2,469	2,558	89
Total Income	**40,747**	**41,636**	**889**
Employee Expenses (inc. Agency)	(25,402)	(25,955)	(553)
Other operating expenses	(18,193)	(18,534)	(341)
Operating deficit	**(2,848)**	**(28,854)**	**(6)**
Net Finance Costs	**(702)**	**(692)**	**10**
Net deficit	**(3,550)**	**(3,546)**	**4**
Remove donated asset I&E impact	30	31	1
Adjusted financial performance	**(3,520)**	**(3,515)**	**5**

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 (excluding revaluation gains)



Monthly Surplus/Deficit Actual vs Plan (excluding revaluation gains)



INFORMATION

The Trust has delivered an in-month deficit of £646k in September against a a planned deficit of £346k, £300k behind plan. Year to date the Trust now has a deficit of £3,546k against a planned deficit of £3,550k; £5k ahead of plan.

Both elective and day case activity were behind plan in September. Day case activity increased from prior month, but elective activity reduced. Activity was partially impacted by the BOA conference which had strong consultant attendance. Overall income was £449k behind plan for the month.

Expenditure has lower than plan in month by £80k, although this was clearly not at the level sufficient to offset the activity underperformance. Pay was £80k overspent, and non-pay was £170k underspent. Whilst agency and bank spend remain high, agency expenditure has reduced for the second month.

Cost Improvement performance remains of concern, with year to date performance £254k behind plan, and a forecasted 18/19 £813k shortfall vs the plan. 66% of forecasted 18/19 CIP delivery is via non-recurrent schemes. The 18/19 Full-Year Effect (FYE) is £246k favourable vs. the 18/19 £3m Trust target, however this includes £1.8m of forecasted FYE CIP from the Theatres Managed service contract, with expected commencement from Jan 2019. A greater emphasis on delivery of the Trust CIP plan has commenced from M6, with regular operational CIP meetings to be enhanced from October.

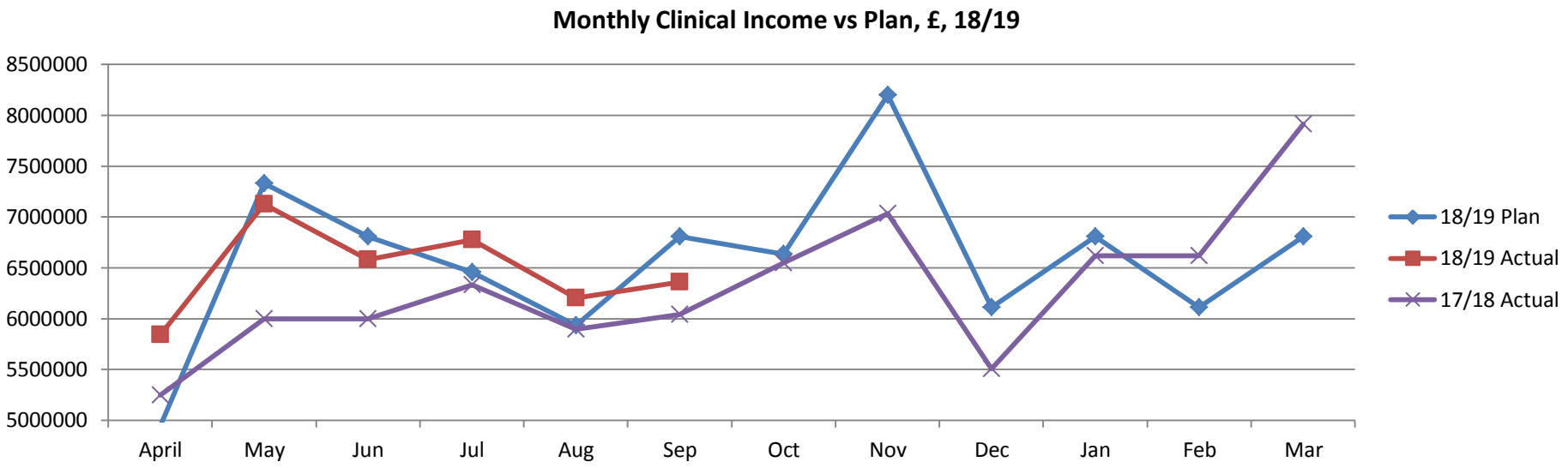
ACTIONS FOR IMPROVEMENTS / LEARNING

There needs to be focussed attention on bridging the gap on CIP schemes, exploring conversion of non-recurrent to recurrent CIP schemes, recovery of slippage and identification of new CIP schemes to ensure delivery of the Trust-wide CIP plan.

RISKS / ISSUES

The Trust Board approved a business case for the intention to build a 4 theatre, 6 recovery bed, 23 bedded ward development over the coming 2 years. This creates fantastic opportunities to further support the STP and to grow income at the trust, but there will need to be careful management of the risks regarding staffing in particular. There will also need to be careful management of the budget, particularly with regards to the infrastructure costs given the number of unknowns regarding the site preparation.

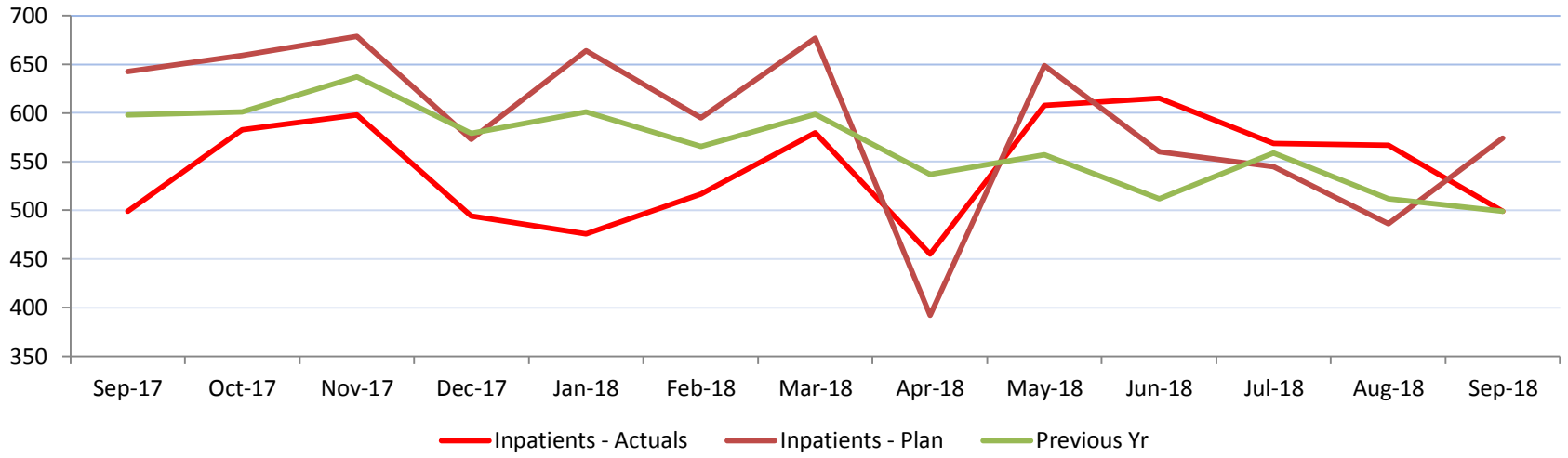
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



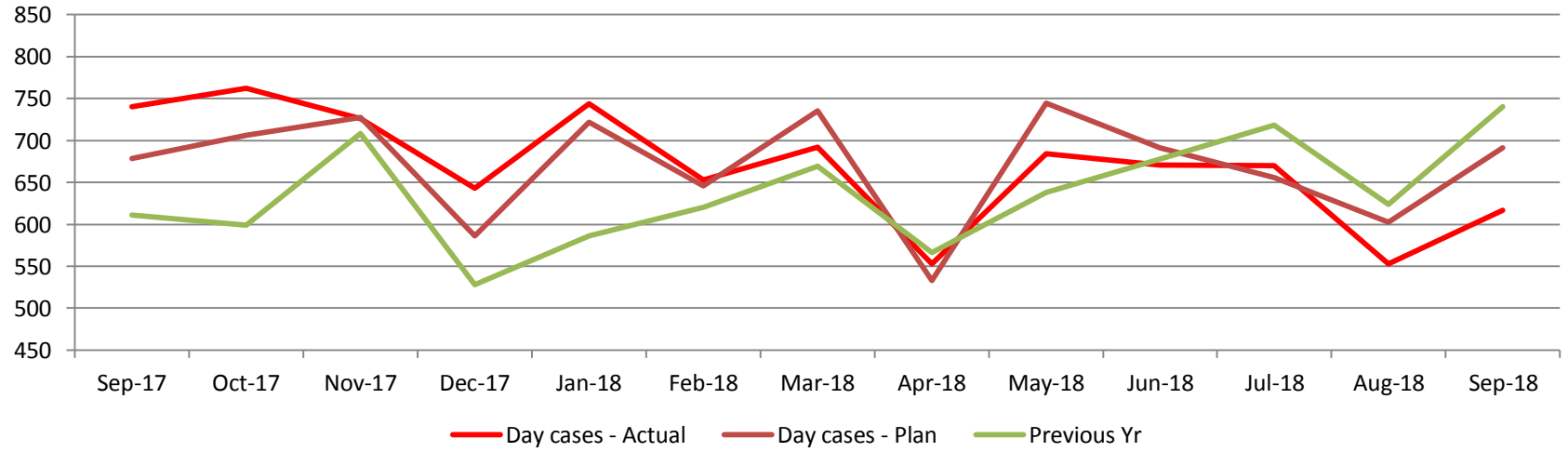
Clinical Income – September 2018 £'000			
	Plan	Actual	Variance
Inpatients	3,595	2,994	-601
Excess Bed Days	42	18	-24
Total Inpatients	3,637	3,012	-625
Day Cases	856	752	-104
Outpatients	666	659	-7
Critical Care	235	165	-70
Therapies	201	234	33
Pass-through income	216	313	97
Other variable income	456	663	207
Block income	539	559	20
TOTAL	6,806	6,357	-449

Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	20,219	19,000	-1,219
Excess Bed Days	235	357	122
Total Inpatients	20,454	19,357	-1,097
Day Cases	4812	4921	109
Outpatients	3747	3888	141
Critical Care	1319	1135	-184
Therapies	1294	1471	177
Pass-through income	1216	1647	431
Other variable income	2403	3109	706
Block income	3031	3350	319
TOTAL	38,276	38,878	602

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income has under-performed against plan by 6.60% in September having over-performed by 4.5% in August. Cumulatively, the trust is now 1.57% above plan. The admitted patient care performance was below plan financially and below on activity levels, with discharged activity 76 below the target. Day case activity also underperformed financially and was below the target by 74 cases. Case-mix in September has moved significantly as day cases have increased to 55% compared to 49% in August. For the year the elective makes up 44% year to date and day case 53%. Non Elective make up the other 3%.

Outpatients have over-performed year to date with and there has been a decrease in attendances against plan in September for first and follow up attendances . First to follow up ratio has decreased year to date at 1.96:1.

Some of the main non IP income variances against plan include;

- Critical care income being £70k down against plan. This is due to a general underperformance in elective activity, which has an impact on the number of individuals therefore needing HDU care.
- Pass through income was ahead of plan by £97k. Improved data from BCH has identified additional chargeable Magec rods in addition to further orthotic appliance and prosthesis income.
- Other variable income is up £207k due to additional BIU activity, and a catch up on ROCS activity.

Private patient income (included within inpatient income) continues to remain strong, with a year to date performance of £810k, which is above the full year income for last year. This increase represents a combination of improved activity and case mix in addition to enhanced procedures for income billing and recognition.

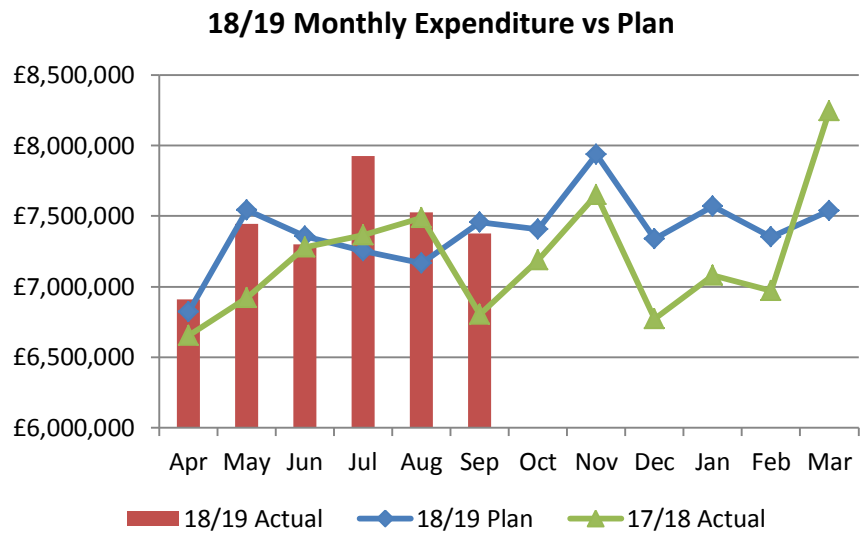
ACTIONS FOR IMPROVEMENT/LEARNING

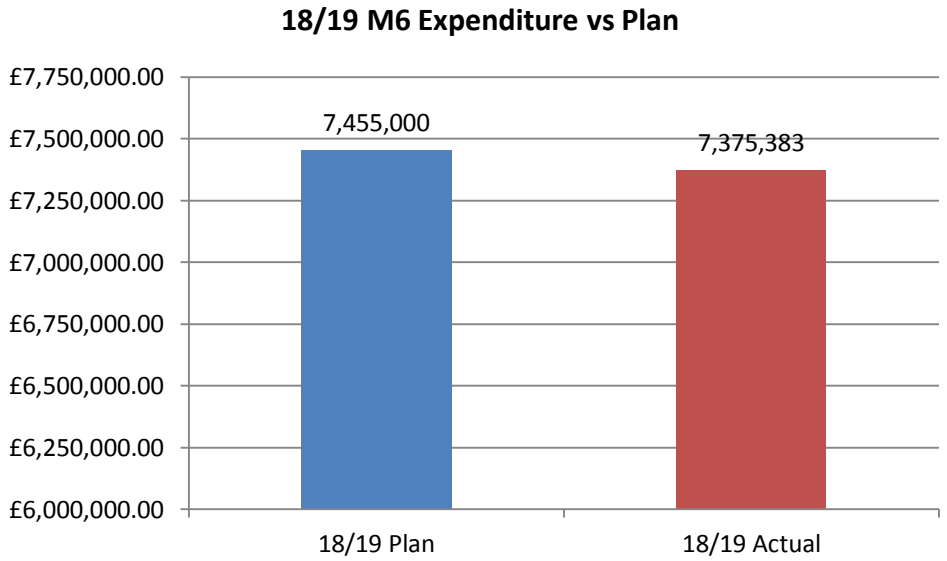
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

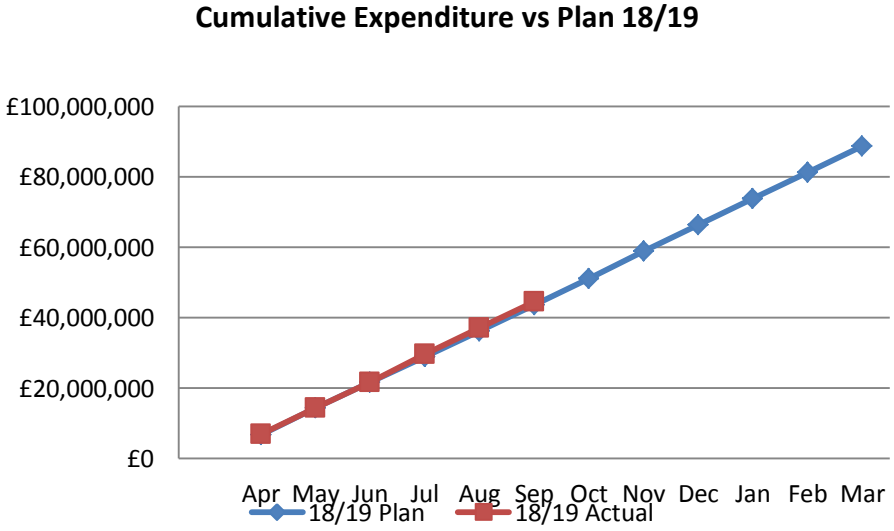
RISKS / ISSUES

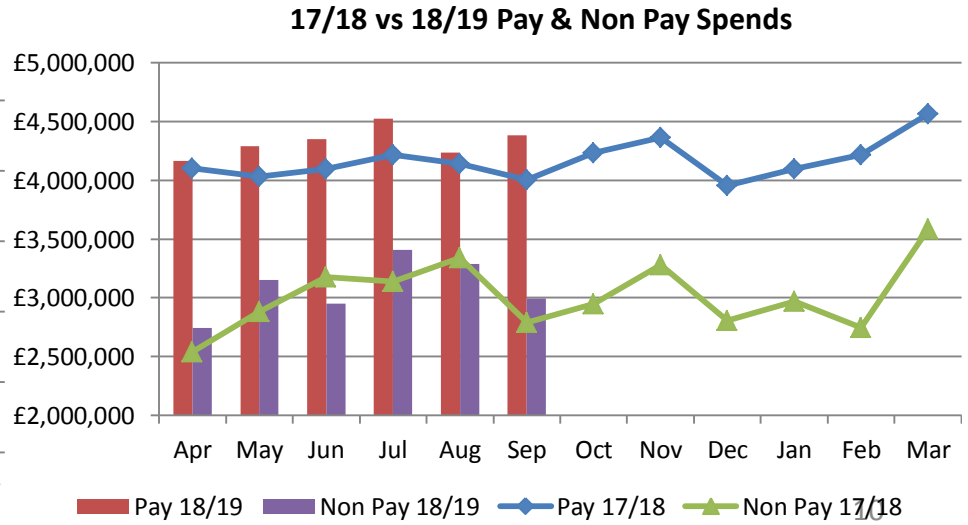
The month 6 position includes an correction of previously overstated income, as referenced in last month's paper. The plan to achieve the control total will not be impacted by this.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends









INFORMATION

September's expenditure was £7,375k, £80k lower than the plan of £7,455k.

Pay was £90k overspent in month, although within this bank and agency spend remain high, offset partially by underspends on substantive staffing. Whilst agency spend was high, it has reduced for a second month – further detail on agency spend has been given on the next slide.

Non pay spend is £170k below plan resulting in a year to date position of £341k above plan. The in-month underspend is within various categories of spend, but particularly clinical supplies. This correlates with the reduced activity compared to plan.

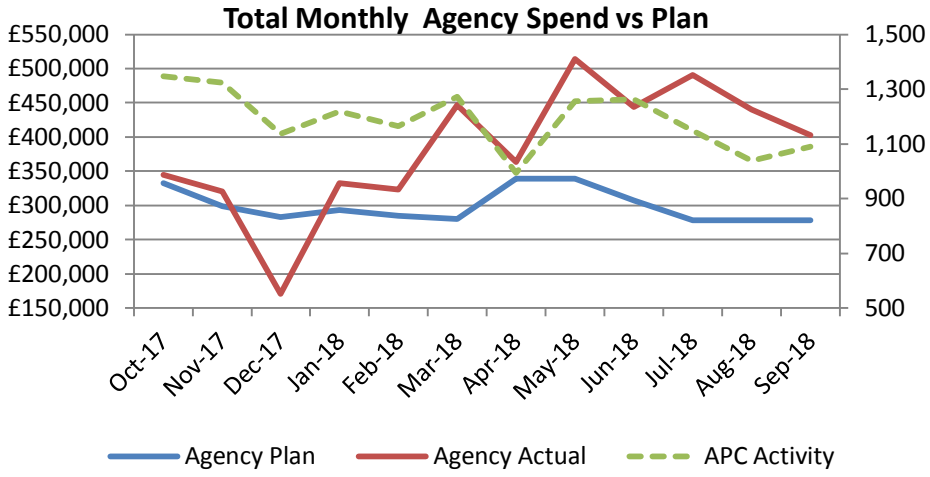
ACTIONS FOR IMPROVEMENTS / LEARNING

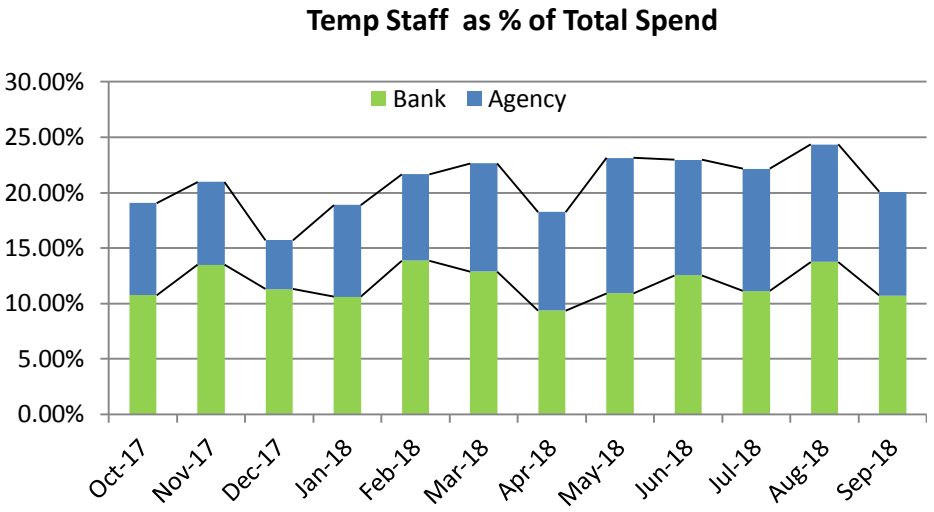
There is further learning from the year end stock count and subsequent audit which will be taken forward and acted upon within 2018-19 to give greater control over stock costs throughout the year. Monthly meetings are now taking place to review theatre spending between the Theatre manager, logistics and finance.

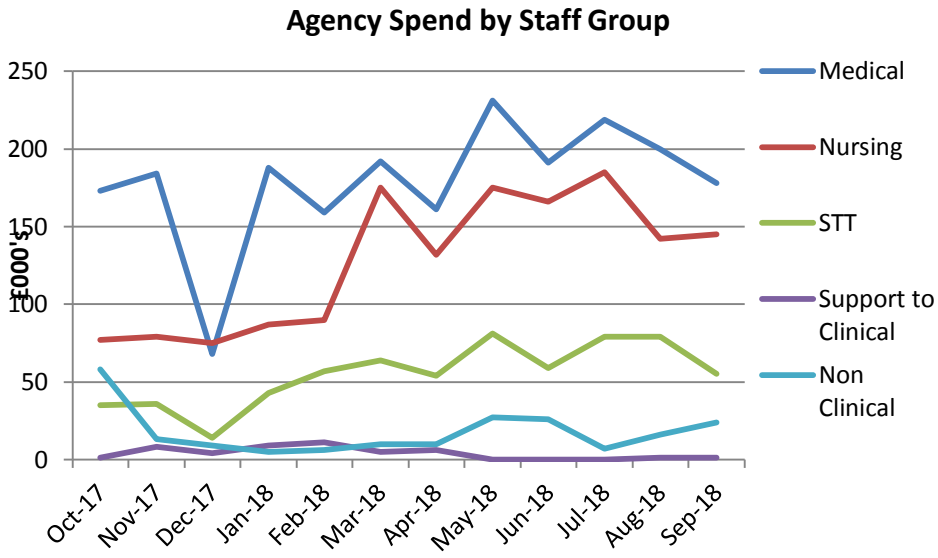
RISKS / ISSUES

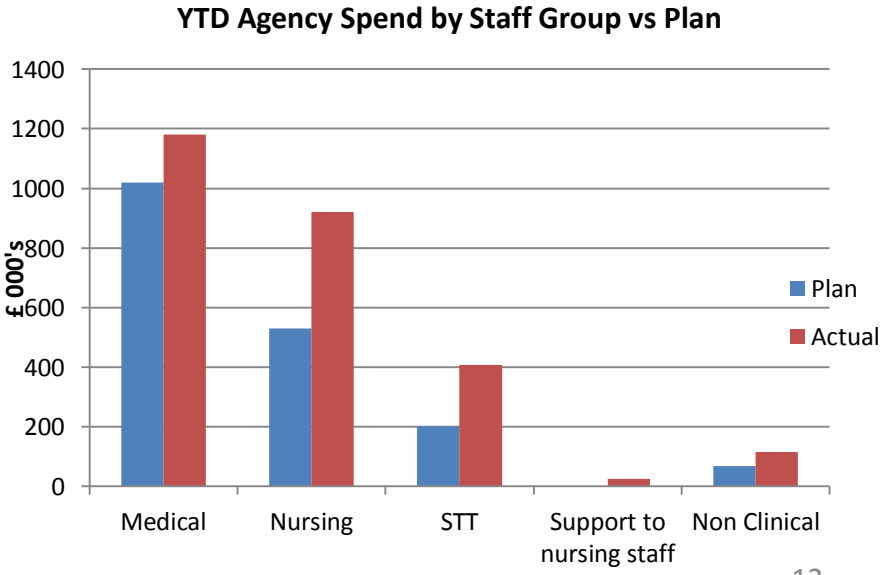
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Agency spend has reduced by £38k to £402k in month which is £124k above the monthly plan and £834k above year to date plan.

An analysis of the spend against plan continues to show that the main reasons for the overspend year to date are agency spend in nursing (£391k), medical (£159k) and therapeutic (£207k).

Recruitment remains the main driver behind agency, although there has been substantial recruitment, which should help to improve the position in the next quarter. Medical agency continues to be challenging due to the placement of deanery funded doctors.

The AfC change pay rate increase will also impact on agency costs as and when levied by the prospective agencies in the coming months.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

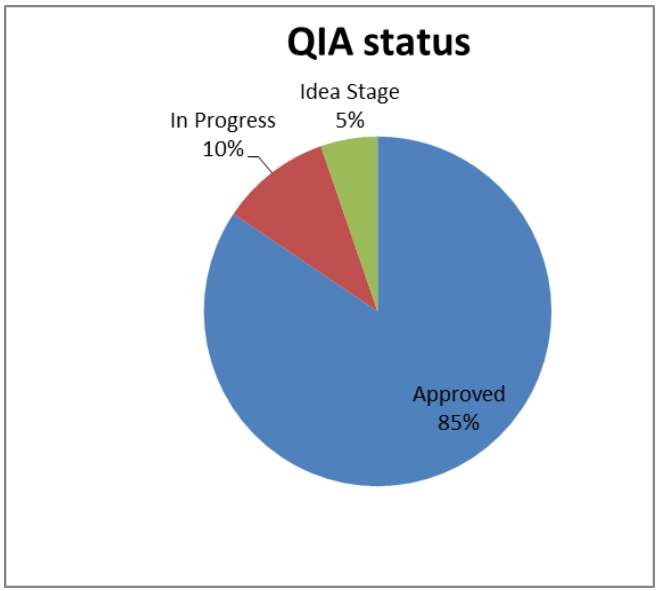
Review of e-Roster continues and shifts approved by the relevant Matron and head of Nursing.

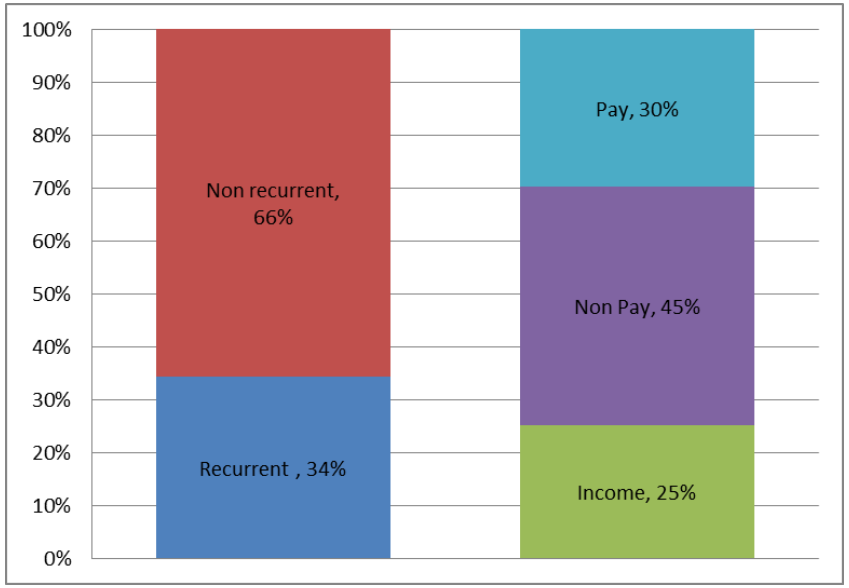
RISKS / ISSUES

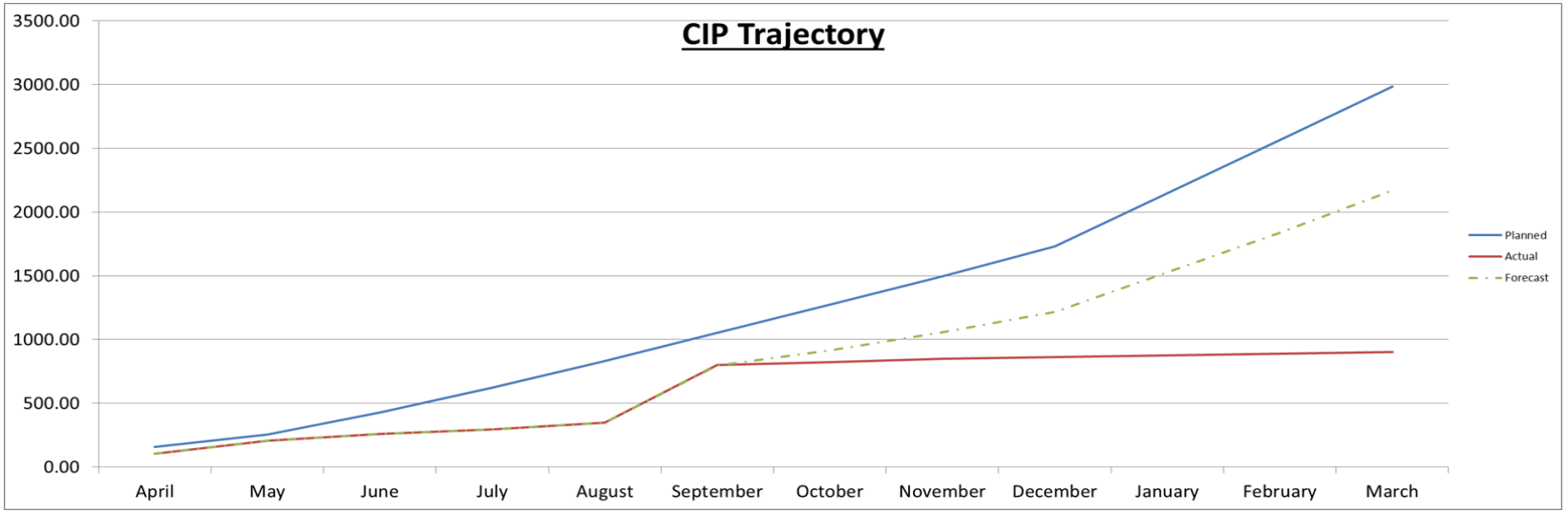
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

Within the annual plan it has been assumed that the agency cap for 2018/19 will be breached. This is due to the continued pressure on medical locum spend, coupled with a need to ensure that paediatric cover remains safe during the period of transition.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2018/19 (£000's)







ON

The CIP target for 2018/19 is £3,000k of which £2,985k (99% of target) has been identified/planned. As at month 6 £2,171k is forecasted for delivery in 18/19 (73% of identified/planned). At month 6 £798k of savings have been delivered against a plan of £1,052k year to date. (YTD) The main reason for the over-performance in-month and YTD is accounting for non-recurrent savings from vacancy management and reduced non-pay expenditure YTD.

Division	In-Month Plan	In-Month Actual	In-Month Variance	YTD Plan	YTD Actual	YTD Variance	18/19 Plan	18/19 FOT	18/19 Variance	Sum of Forecast vs Plan %	18/19 FYE	18/19 FYE Variance
Corporate	92	117	25	528	327	(201)	1,090	679	(412)	62%	541	(549)
Division 1	71	138	67	266	217	(49)	705	533	(172)	76%	646	(59)
Division 2	53	161	109	254	222	(32)	1,157	906	(251)	78%	2,017	860
Division 4	5	33	28	5	33	28	33	54	21	166%	43	10
Grand Total	**220**	**449**	**229**	**1,052**	**798**	**(254)**	**2,985**	**2,171**	**(813)**	**73%**	**3,246**	**262**

Despite the improved identification of CIP's there is still a mixture of small slippages on various schemes in addition to a couple of larger underperformances on coding improvement and direct engagement of medics.

18/19 FYE CIP identification has improved and is expected to over-perform against the 18/19 £3m target, (£246k) however £1.8m of the FYE schemes relate to the Theatres MSC.

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved forecasted performance, 66% of schemes identified in-year are non-recurrent, thus the following has been planned:

- targeted focus on CIP's, explore conversion of non-recurrent to recurrent CIP schemes, recovery of slippage and identification of new CIP schemes
- Larger focus on transformation (Outpatients, Theatres) and coding schemes, with focus also on demand and capacity management to deliver cost improvements

Plans for regular divisional CIP meetings are being addressed with focus on existing schemes and identification of mitigation/new schemes.

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the following schemes:

- Managed Service Contract for Theatres scheme which is forecasted to deliver £450k from January 2019. Whilst a project group is driving this forward, it remains a challenging scheme
- The counting & coding scheme is forecasted to deliver £153k from November 2018, despite a plan of £484k in 18/19, a project group is working on methods of improving coding and activity capture, and will feedback improvements to the Nov F&P committee
- Delivery against the direct engagement CIP has improved, withthe Medical Rota co-ordinator recruitment ongoing and further reviews taking place

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M6 Plan £'000	M6 Actual £'000	Var £'000
Intangible Assets	688	619	(69)
Tangible Assets	48,323	47,726	(597)
Total Non-Current Assets	**49,011**	**48,345**	**(666)**
Inventories	4,858	4,885	27
Trade and other current assets	6,137	4,583	(1,527)
Cash	954	1,882	928
Total Current Assets	**11,949**	**11,350**	**(599)**
Trade and other payables	(12,570)	(12,118)	452
Borrowings	(1,446)	(1,591)	(145)
Provisions	(173)	(108)	65
Other liabilities	(207)	(587)	(380)
Total Current Liabilities	**(14,396)**	**(14,404)**	**(8)**
Borrowings	(5,979)	(5,284)	695
Provisions	(354)	(354)	0
Total Non-Current Liabilities	**(6,333)**	**(5,638)**	**695**
Total Net Assets Employed	**40,231**	**39,653**	**(578)**
Total Taxpayers' and Others' Equity	**40,231**	**39,653**	**(578)**

INFORMATION

Tangible assets are significantly below plan due to slippage on various schemes throughout the trust. The Deputy Financial Accountant is performing a full review to ensure the trust will be on track to deliver its capital target by the year end.

The variances on borrowings are as a result of the ageing of the loans being incorrectly calculated at the time of the annual plan submission. The actuals therefore represent an accurate split. Borrowing is lower than expected at this time of the year overall due to the cash balances being higher than plan due to the receipt of the 2017/18 STF and NHS Supplies moving to 30 day payment terms.

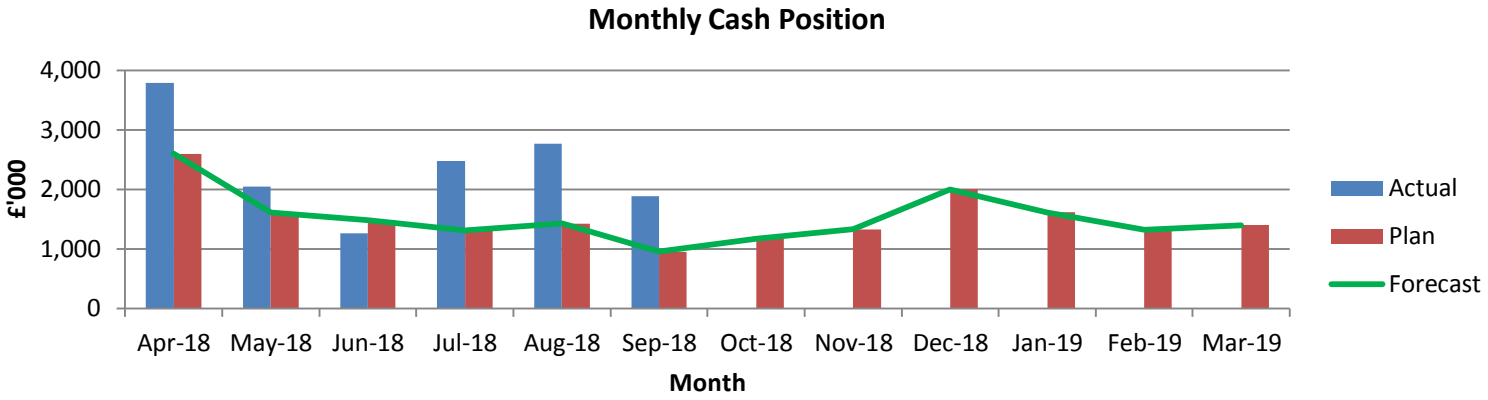
ACTIONS FOR IMPROVEMENTS / LEARNING

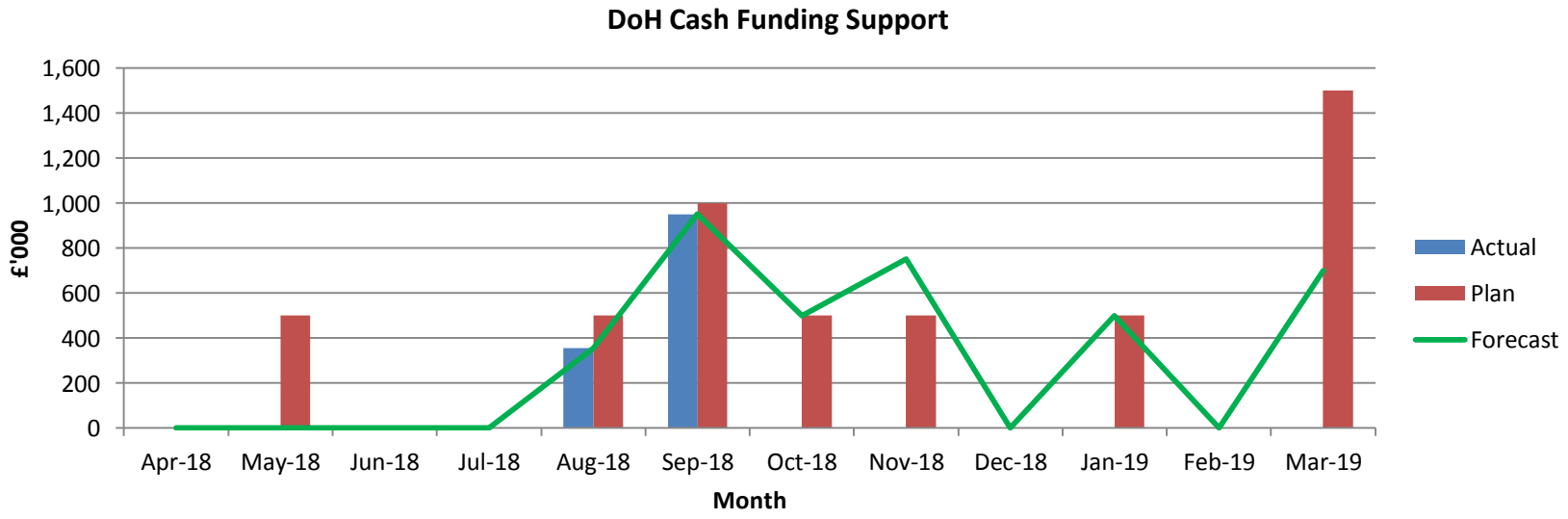
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances. Month 6 is the start of the agreement of balances due and owing between NHS organisations.

RISKS / ISSUES

Despite the receipt of STF, cash remains tight for the remainder 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 in addition to expected borrowing requirements from the Department of Health





INFORMATION

Cash was £1,882k which is higher than forecast following receipt of the 2017/18 STF cash and NHS Supplies moving to 30 day payment terms in August following the withdrawal of the discount for prompt payment.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £950k has been requested from the Department of Health (DoH) which is lower than forecast.

ACTIONS FOR IMPROVEMENTS / LEARNING

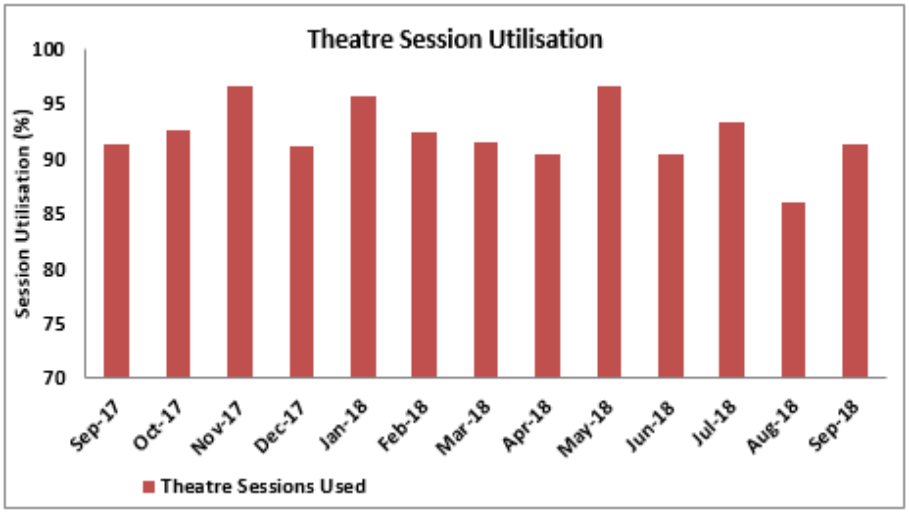
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2018/19. The Head of Financial Accounting has set up a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications for cash from the Department of Health to be actioned.

DoH cash support - 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 SLA mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. 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

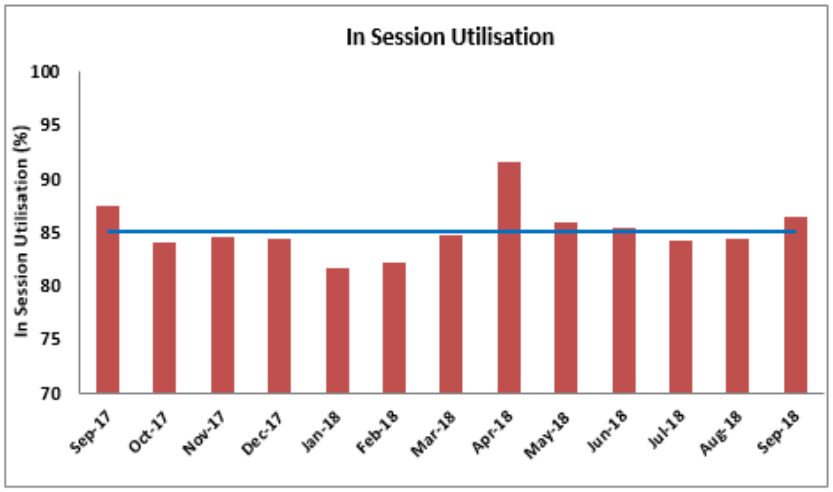
September saw a predicted improvement in list utilisation of 91.38% compared to 86.07% the previous month. This was due to the impact of the summer holidays in August

Average utilisation is 91.42% for the period April '18 – September '18, and remains consistent month on month.

RISKS / ISSUES

- Theatre recruitment to support future growth
- Other departments such as pharmacy, radiology etc. will also need to 'grow' alongside theatres to ensure maximum efficiency gains.
- Equipment – not enough power tools etc. to keep up with increased activity/demand.

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



INFORMATION

Whilst sessional utilisation has remained strong, the average in session utilisation has struggled to reach the 85% over the last 6 months, although the average for the year is 84.8%. We are reviewing the correlation between the two measures.

Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation was 86.37% in September compared to 84.42% in August.

In session utilisation remains consistent, running at an average of 86% for the period April '18 – September '18.

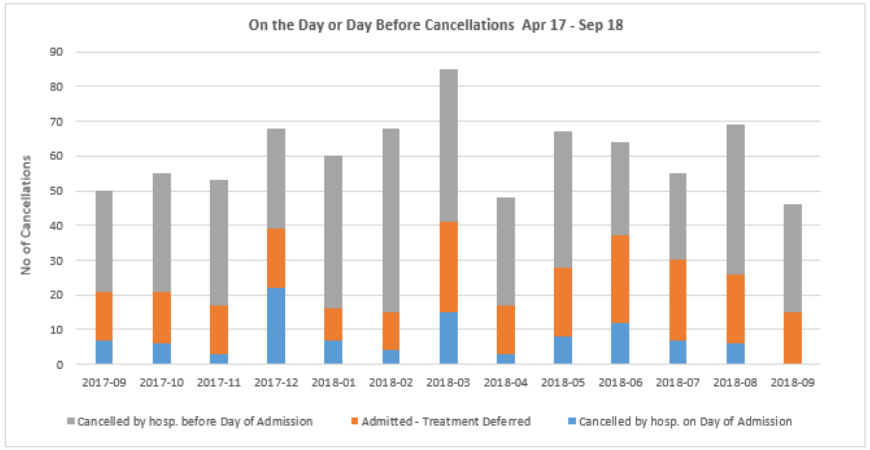
The trial of locking down theatre lists at 24hrs has proved successful and has been rolled out across all specialties, with positive feedback being received from the various stakeholders involved. November will see the lock down being expanded to 3 days. Urgent/emergent cases will be exempt and will be booked as per usual protocols.

RISKS / ISSUES

- Last minute changes to lists impact on the efficient running and planning of theatre lists - *risk being better managed due to introduction of lock down process*

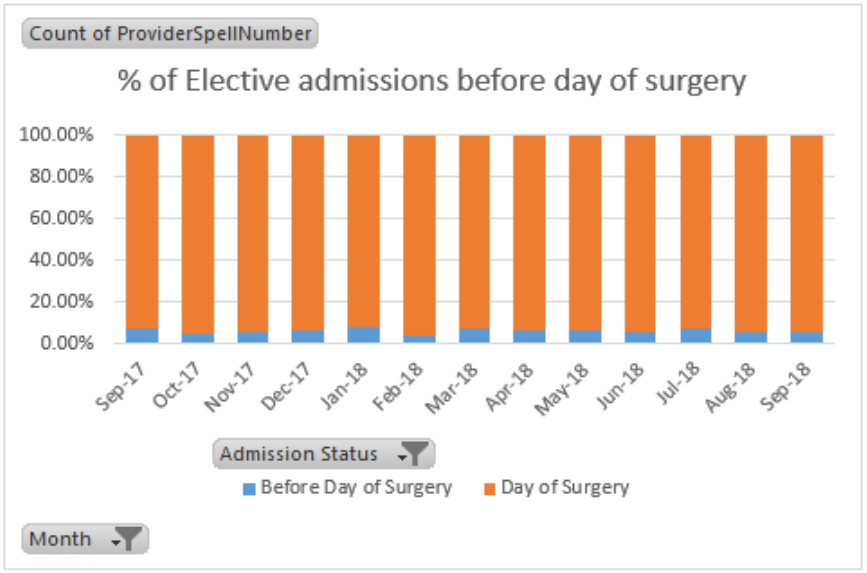
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

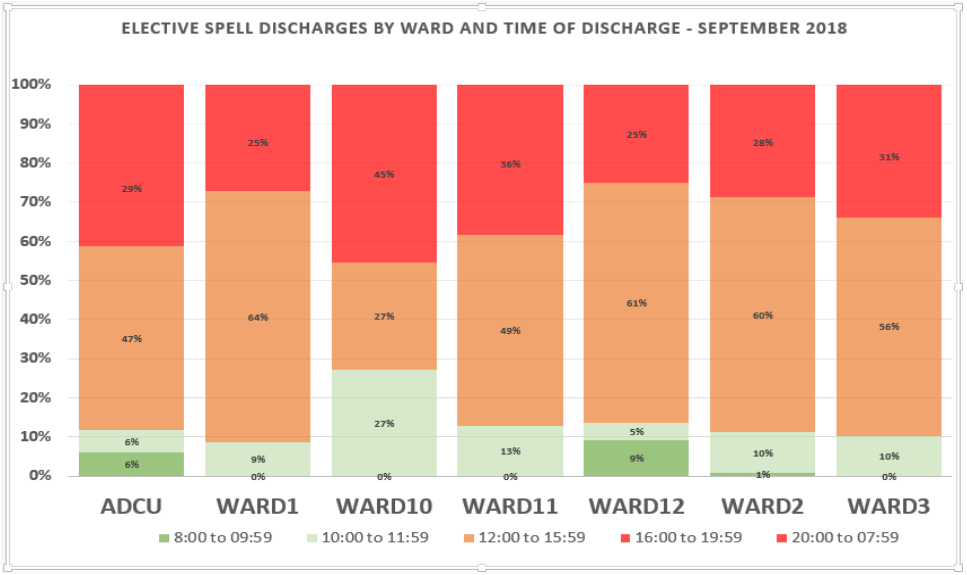
Hospital Cancellations



Sum of Total	Cancellation Categ				
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
2017-09	7	14	29	50	0
2017-10	6	15	34	55	0
2017-11	3	14	36	53	0
2017-12	22	17	29	68	0
2018-01	7	9	44	60	1
2018-02	4	11	53	68	0
2018-03	15	26	44	85	0
2018-04	3	14	31	48	0
2018-05	8	20	39	67	0
2018-06	12	25	27	64	0
2018-07	7	23	25	55	0
2018-08	6	20	43	69	1
2018-09		15	31	46	0
Grand Total	100	223	465	78	2

Admission the day before surgery





The number of cancellations on the day of admission for surgery continues to decrease with no patients cancelled on day of surgery prior to admission in September . Patients admitted for surgery where treatment was deferred has also decreased in month from 20 to 15. Analysis of these 15 patients highlights reasons for cancellation on the day relate to lack of theatre time, equipment issues and to accommodate emergency patients .

Cancellations before the day of surgery have decreased in month from 43 to 31 patients. An analysis of the 31 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients being offered earlier dates for surgery, patients being deferred to accommodate emergencies and patient led cancellations due to patients declaring fitness issues on the 72 hour call contact.

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The key theme identified is the correlation between cancellation on the day and the resilience of ensuring the patient is contacted 72 hours prior to surgery . This process moves to the pre-operative assessment team on 29th of October to ensure a more robust service can be offered with easy access to clinical support if required, ensuring an improved patient experience.

Work continues to strengthen the POAC process and a business case is progressing to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity.

The service will commence the roll out of the new triage model on the 22nd of October to enable more patients to be seen on the day of listing for surgery in pre- operative assessment where clinically appropriate, avoiding multiple attendances at POAC clinic and improved service efficiency.

ACTIONS FOR IMPROVEMENTS / LEARNING

Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

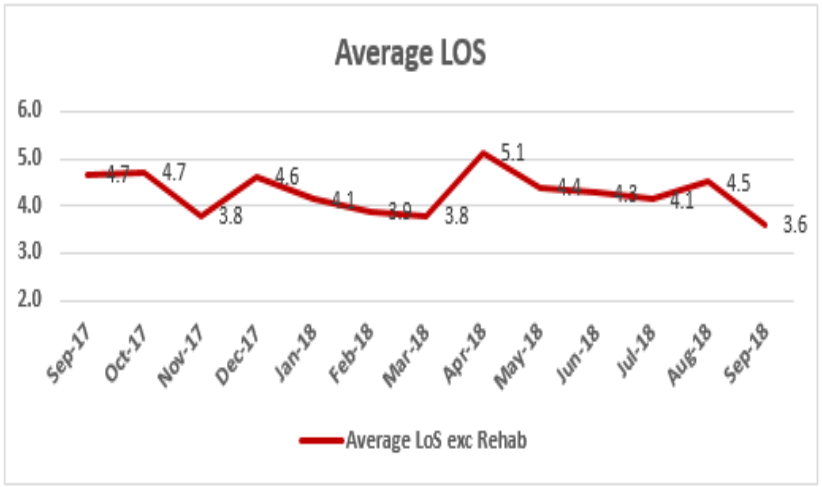
- Joint care project is ongoing with weekly stakeholder meetings in place Soft Launch -5TH November .
- All cancellations by patients on the day of surgery are followed up with a telephone call from ADCU to understand the reasons and the audit will be presented as part of the October 2018 F &P report.

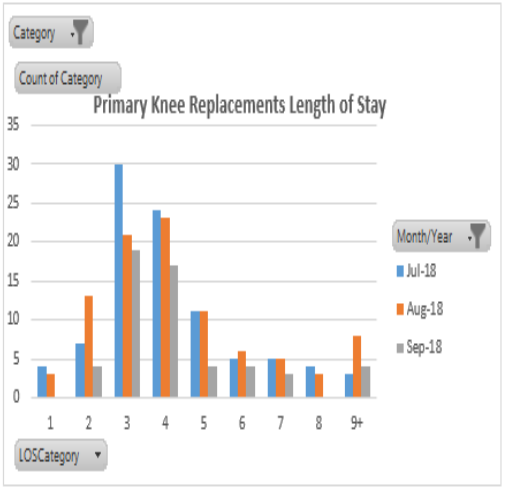
PERFECTING PATHWAYS

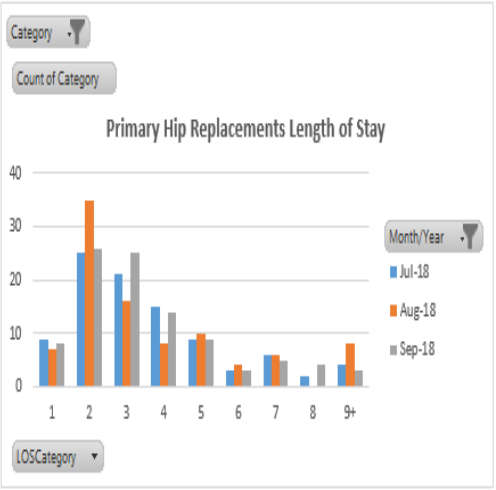
RISKS / ISSUES

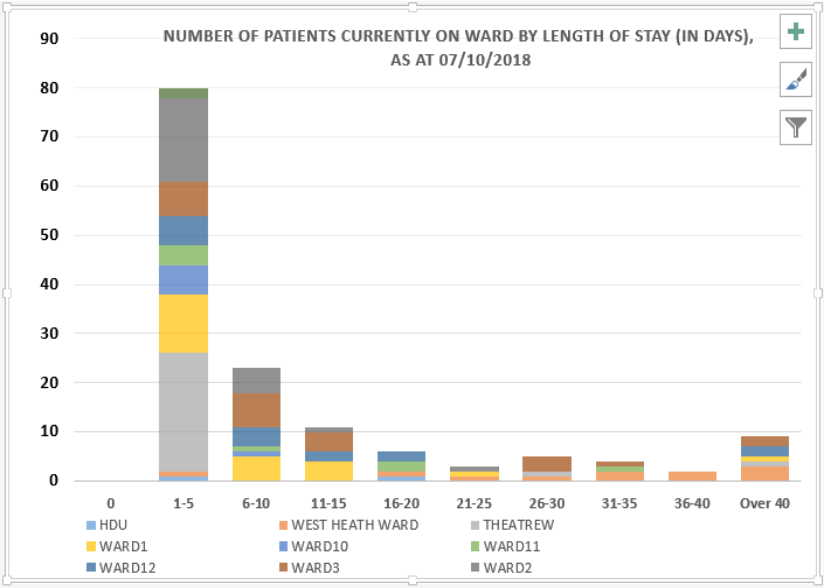
Existing aging equipment asset base and the need to increase the number of power tools in Theatre. Some additional power tools are currently being scoped as part of the capital programme slippage and the Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

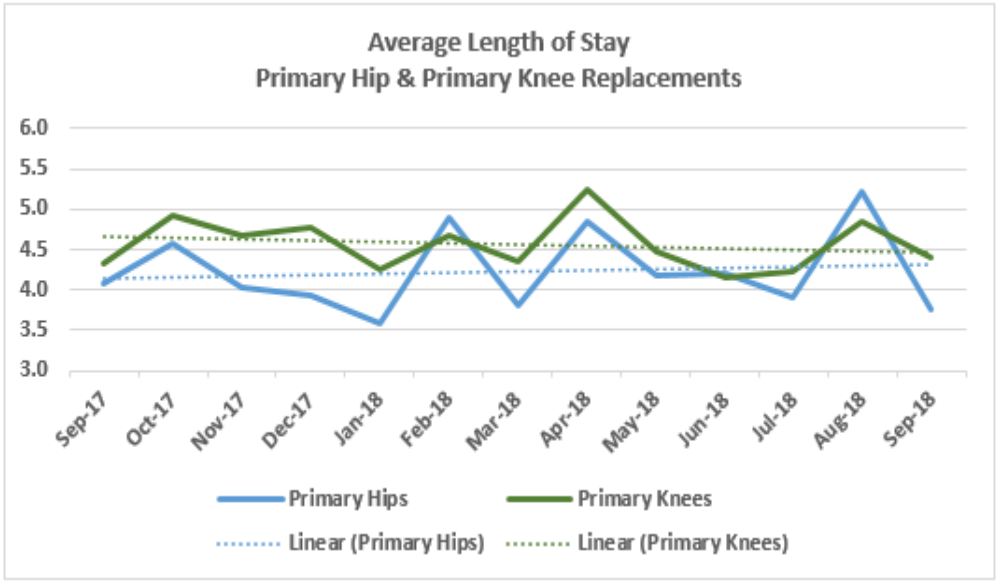
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS has reduced in September and a number of initiatives are in place to continue to drive down length of stay.

- Red2Green is now launched on all wards. Discharges are now identified the day before discharge and on day of discharge the ward staff work closely with the discharge team to ensure timely discharge . Current data suggests that we have reduction in Red Days on Ward 2 for example the number of red days make up less than 5% of patient days.
- A weekday matron led daily adult ward meeting under the auspices of R2G is now in place with ward managers and the discharge team to raise and resolve issues relating to discharge and deliver improvements in the process. including escalating any delays for social care , inter-hospital transfer and expedite appropriate discharges .
- 'Passport to Home' - This includes a patient/ROH agreement regarding Estimated Date of Discharge (EDD), provision of patients own clothes (#PJParalysis) and transport arrangements.
- Gold/Silver concept is now reinforced on all wards to support the improvement in the flow of patients and maximise utilisation of the discharge lounge. The discharge team have evidenced the use of Gold/Silver in the increasingly early movement of patients to the discharge lounge.
- A Daily Consultant led MDT ward round on Ward 2 (Arthroplasty) and a Twice weekly review Ward 3 (oncology). The Trust strategic intentions includes daily MDT ward rounds in all wards and this is being monitored as part of Trust strategy.
- Jointcare project to reduce length of stay for Hips & Knees which is planned to go live on 5th November.
- Launch of the new Jointcare performance dashboard to monitor a range of KPI's supporting reducing length of stay
- A new discharge lounge open on 5th November with increased capacity to support all ward areas

ACTIONS FOR IMPROVEMENTS / LEARNING

- The Red2Green dashboard development is now launched across all wards .

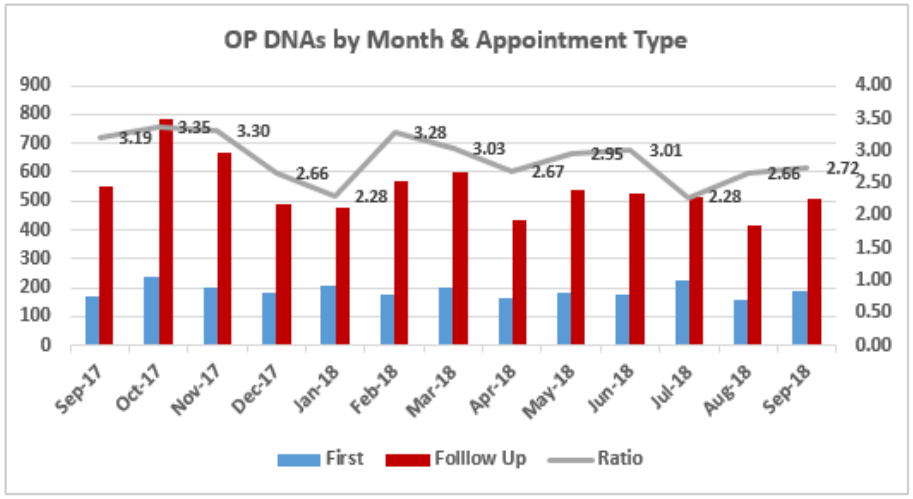
The dashboard also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .

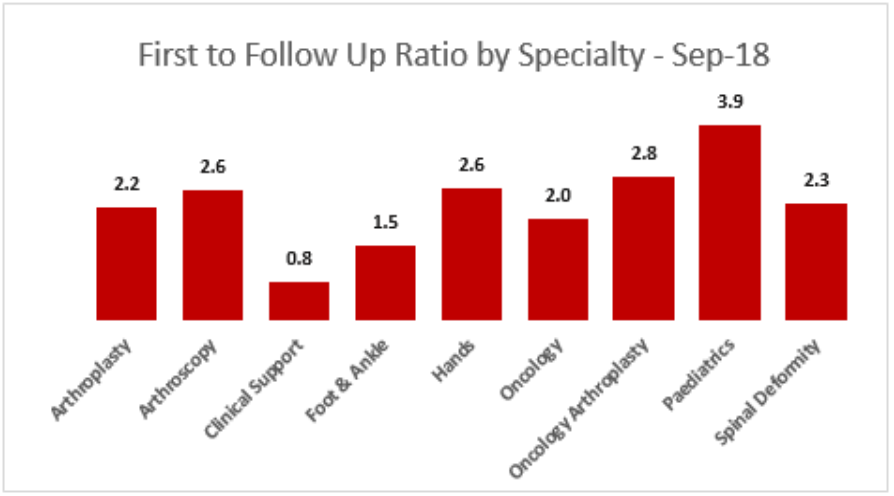
- Consultant led ward rounds are now being rolled out across all wards so that all patients are reviewed to support timely discharge

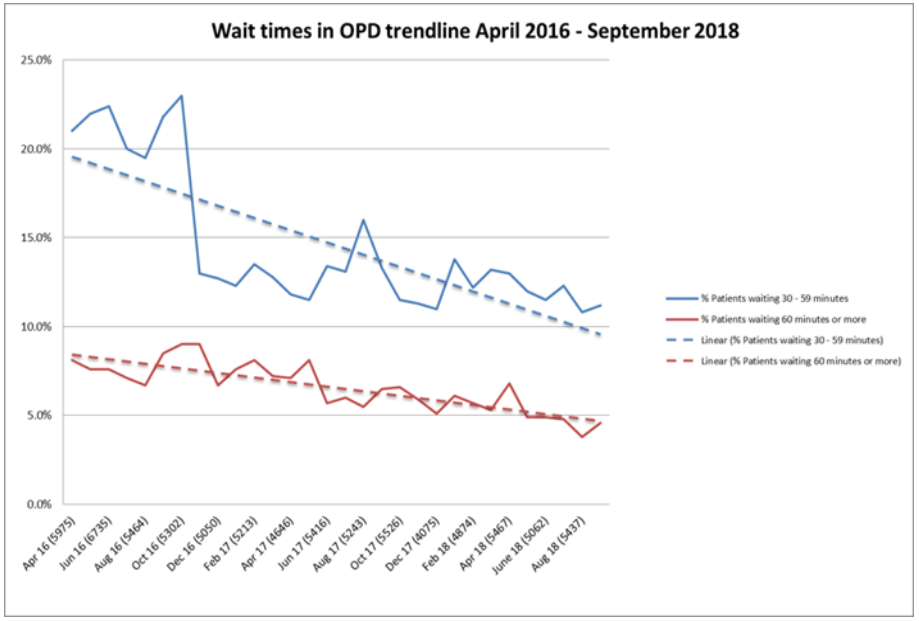
RISKS / ISSUES

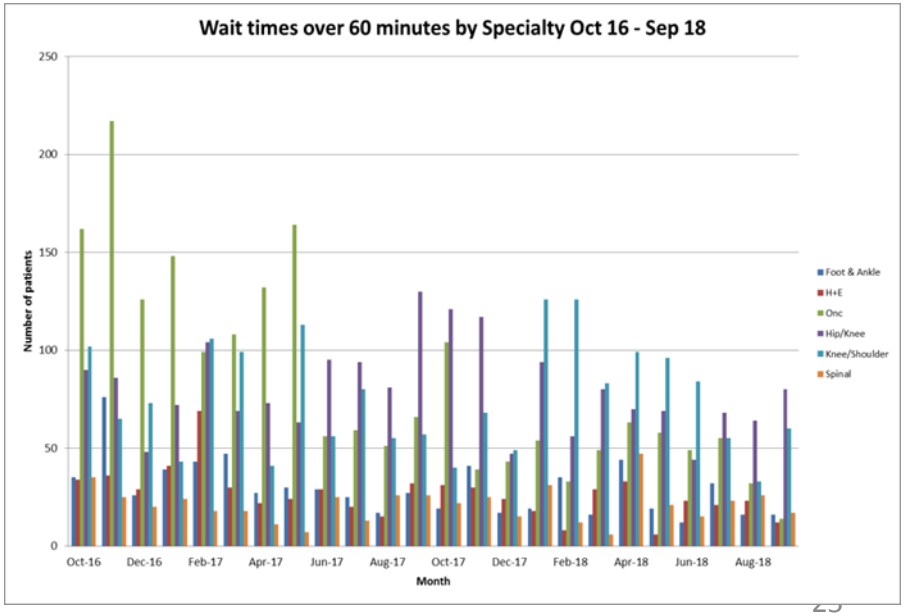
A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity .

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









INFORMATION

In September there were 6 incident forms completed to highlight clinics running more than 60 minutes late.

There were 11.2% of patients waiting over 30 minutes and 4.6% waiting over 1 hour which is below the target of 5%. This is now the fifth month that the target of 5% has been achieved. The over 30 minute wait deteriorated slightly since last month and as yet has not achieved the target or 10% or below. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month.

The monthly audit identified the following categories of incident: -

- 3 – Clinic Overbooked
- 3 – Complex Patient
- 1 – Staffing over – running clinics

All incidents continue to be forwarded to the Operational Managers within the relevant areas for investigation. An record of these incidents is being kept and summary data in relation to the specialties and consultants they relate to, as well as the category of cause.

Staffing issues within the outpatient department which have caused challenges have been significantly improved recently by the commencement of 5wte new HCAs and 2wte qualified nursing have just been employed and will start after clearances and checks.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Continue to drive incident investigations and action through relevant Operational Manager
- Begin to use new report to analyse clinics within specialties and consultants who have high numbers of clinic delays
- Alter the process for managing room bookings in outpatients by moving this to the appointments team
- Establish a weekly meeting between the outpatient nursing and operational management team to discuss booking of future clinics and look at when clinics overran in the previous week

RISKS / ISSUES

Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. There will be engagement with other Trusts to consider the implementation of partial booking processes

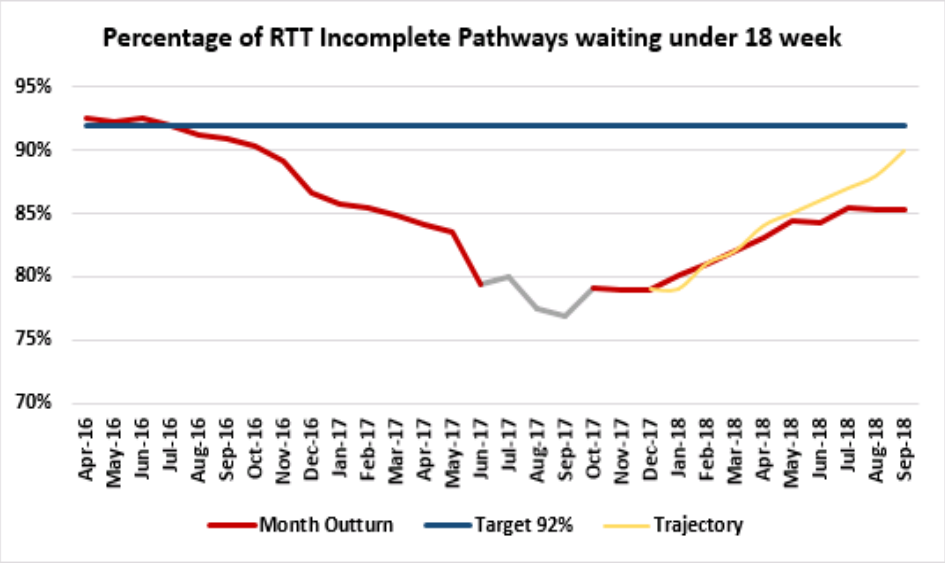
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

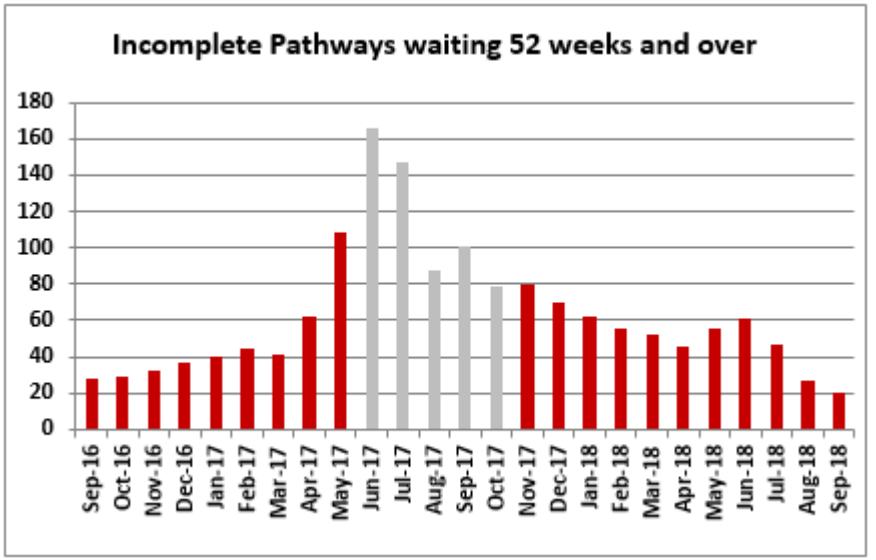
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	Total	MRI	CT	US	Total	Over 6 Weeks	Under 6 Weeks	Total	%Under 6 Weeks
Apr-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1,155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1,328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1,276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1,338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1,407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1,423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1,352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1,425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1,200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1,242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1,183	1,186	99.7%
Apr-18	1,022	148	409	1,579	850	253	387	1,490	8	1,571	1,579	99.5%
May-18	1,002	136	353	1,491	725	236	373	1,334	1	1,490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1,256	1,261	99.6%
Jul-18	732	112	336	1,180	961	211	290	1,462	8	1,172	1,180	99.3%
Aug-18	568	107	301	976	682	165	290	1,137	9	967	976	99.1%
Sep-18	696	110	311	1,117	778	208	394	1,380	4	1,113	1,117	99.6%

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



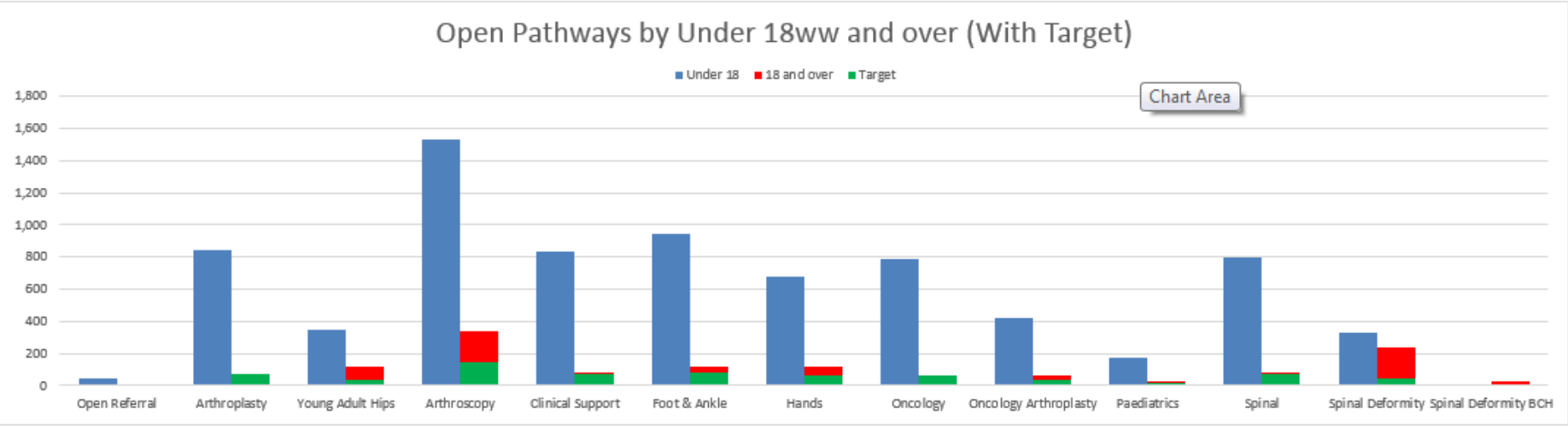


		Indicative	Reported Month					Reported Quarter 2017/18			
Target Name	**National Standard**	***Sep-18***	**Aug-18**	**Jul-18**	**Jun-18**	**May-18**	**Apr-18**	**Q4 (Jan, Feb, March)**	**Q3 (Oct, Nov, Dec)**	**Q2 (July, August, Sept)**	**Q1 (Apr, May, June)**
2ww	**93%**	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	**96%**	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	**94%**	100%	100%	100%	100%	100%	90%	98%	100%	97%	100%
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
62 day (traditional)	**85%**	40.0%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	**n/a**	100%	100%	100%	83.30%	100%	100%	84%	82%	89%	100%
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
No. day patients treated 104+ days			0	0	1	0	0				

13. Referral to Treatment snapshot as at 30th September 2018 (Combined)

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,680**	18	415	149	711	408	481	340	362	188	81	389	135	3
7-13	**2,896**	18	327	130	603	299	338	265	279	168	67	285	114	3
14-17	**1,151**	5	104	67	214	124	127	75	143	67	23	121	77	4
18-26	**930**	1	64	75	255	62	95	93	18	56	24	57	120	10
27-39	**336**	1	11	40	84	15	21	30	4	12	6	25	79	8
40-47	**39**	0	0	7	3	1	0	0	1	0	0	2	19	6
48-51	**6**	0	0	0	0	0	0	0	0	0	0	0	5	1
52 weeks and over	**20**	0	0	0	0	0	0	0	0	0	0	0	14	6
Total	**9,058**	43	921	468	1,870	909	1,062	803	807	491	201	879	563	41

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**7,727**	41	846	346	1,528	831	946	680	784	423	171	795	326	10
18 and over	**1,331**	2	75	122	342	78	116	123	23	68	30	84	237	31
Target	**725**	**3**	**74**	**37**	**150**	**73**	**85**	**64**	**65**	**39**	**16**	**70**	**45**	**3**
	85.31%	**95.35%**	**91.86%**	**73.93%**	**81.71%**	**91.42%**	**89.08%**	**84.68%**	**97.15%**	**86.15%**	**85.07%**	**90.44%**	**57.90%**	**24.39%**



13. Referral to Treatment snapshot as at 30th September 2018

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**831**	0	116	45	167	53	39	111	92	59	30	97	22	0
7-13	**837**	0	167	33	192	65	47	101	53	59	25	79	14	2
14-17	**354**	0	66	23	84	24	19	24	26	33	8	39	4	4
18-26	**410**	0	40	25	148	10	22	45	11	43	11	25	21	9
27-39	**178**	0	8	20	63	4	2	18	3	7	2	12	32	7
40-47	**25**	0	0	4	2	0	0	0	1	0	0	0	12	6
48-51	**5**	0	0	0	0	0	0	0	0	0	0	0	4	1
52 weeks and over	**17**	0	0	0	0	0	0	0	0	0	0	0	11	6
Total	**2,657**	0	397	150	656	156	129	299	186	201	76	252	120	35

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**2,022**	0	349	101	443	142	105	236	171	151	63	215	40	6
18 and over	**635**	0	48	49	213	14	24	63	15	50	13	37	80	29
Target	**213**	**0**	**32**	**12**	**52**	**12**	**10**	**24**	**15**	**16**	**6**	**20**	**10**	**3**

	76.10%		**87.91%**	**67.33%**	**67.53%**	**91.03%**	**81.40%**	**78.93%**	**91.94%**	**75.12%**	**82.89%**	**85.32%**	**33.33%**	**17.14%**

Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,849**	18	299	104	544	355	442	229	270	129	51	292	113	3
7-13	**2,059**	18	160	97	411	234	291	164	226	109	42	206	100	1
14-17	**797**	5	38	44	130	100	108	51	117	34	15	82	73	0
18-26	**520**	1	24	50	107	52	73	48	7	13	13	32	99	1
27-39	**158**	1	3	20	21	11	19	12	1	5	4	13	47	1
40-47	**14**	0	0	3	1	1	0	0	0	0	0	2	7	0
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
Total	**6,401**	43	524	318	1,214	753	933	504	621	290	125	627	443	6

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,705**	41	497	245	1,085	689	841	444	613	272	108	580	286	4
18 and over	**696**	2	27	73	129	64	92	60	8	18	17	47	157	2
Target	**512**	**3**	**42**	**25**	**97**	**60**	**75**	**40**	**50**	**23**	**10**	**50**	**35**	**0**

	89.13%	**95.35%**	**94.85%**	**77.04%**	**89.37%**	**91.50%**	**90.14%**	**88.10%**	**98.71%**	**93.79%**	**86.40%**	**92.50%**	**64.56%**	**66.67%**

INFORMATION

The PTL is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. Trajectories have been developed for all specialties to deliver 92%, the Trust trajectory is detailed below. This has been submitted to NHSI with a return to RTT compliance by November 2018. An internal trajectory is in place to support the deliver of this target which is monitored weekly.

Trust combined trajectory :-

Royal Orthopaedic Hospital Referral to Treatment Trajectory												
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
%	79%	79%	81%	82%	84%	85%	86%	87%	88%	90%	91%	92%

For September 2018 the RTT trajectory was 90% with performance at **85.31%** with 20 patients over 52weeks (trajectory 36)

Excluding Spinal Deformity the Trust now has only 14 patients over 40 weeks

All teams are working through a targeted list of patients to ensure that patients are dated in chronological order over 18weeks.

Arthroplasty, Spinal, Clinical Support and Oncology have plans to achieve 92% for October 2018 with all remaining specialties reviewing capacity until the end of November 2018. Non-admitted performance improved in month – 89.13%

ACTIONS FOR IMPROVEMENTS / LEARNING

The team now are concentrating on any patients over 26weeks as the number over 40 weeks has continued to reduce. Throughout October and November the team continue to work through a targeted list of patients who are listed with consultants with the longest waits (6 consultants excluding spinal deformity) . Good progress continues to be made by all the teams as we continue to progress to 92% in November 2018.

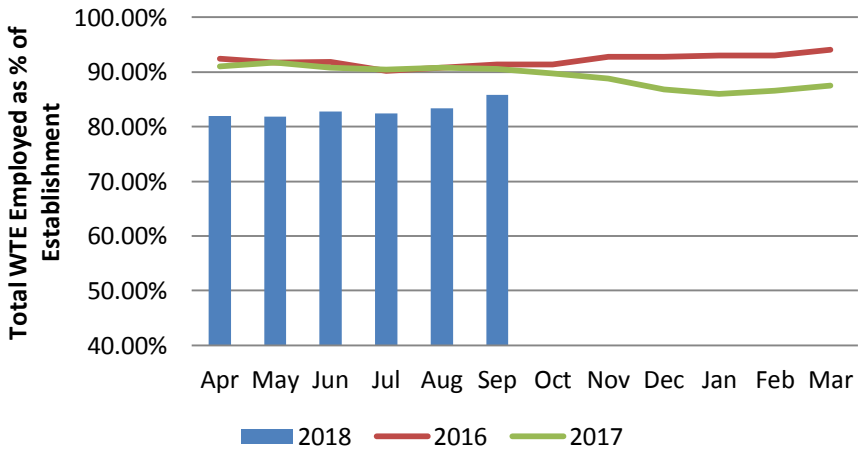
RISKS / ISSUES

52 weeks: Spinal deformity remains a risk with regard to overall Trust performance.
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 monitored monthly (detailed within the spinal deformity action plan) . An additional theatre list had been planned in February 2018 through the refurbishment of Waterfall House on site at BWCH. Due to a delay with the completion of the building it is now likely to be February 2019 before an additional weekday list will commence. Weekend activity continues through the Summer with discussion underway to continue the lists until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families.

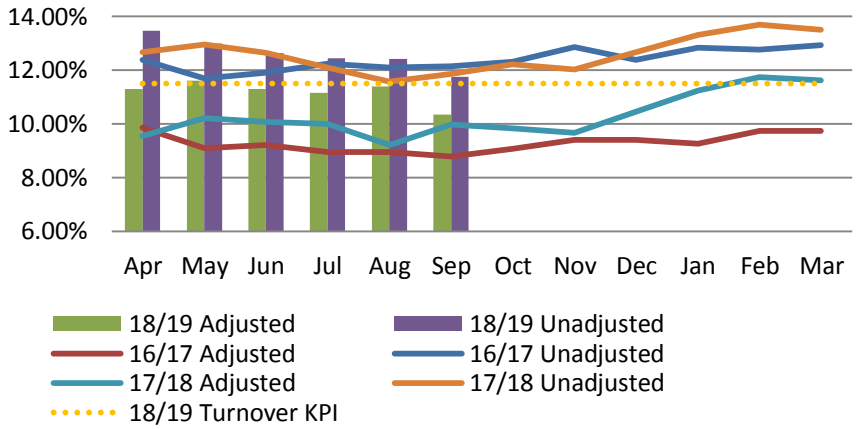
Given the limited opportunities to increase Spinal Deformity additional capacity is being sought for Adult young Hips and Arthroscopy to improve the overall Trust performance

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

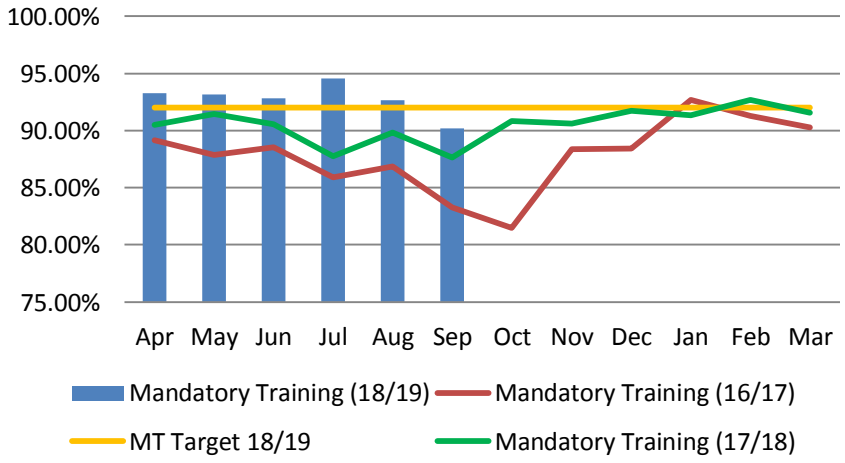
Staff in Post v Establishment



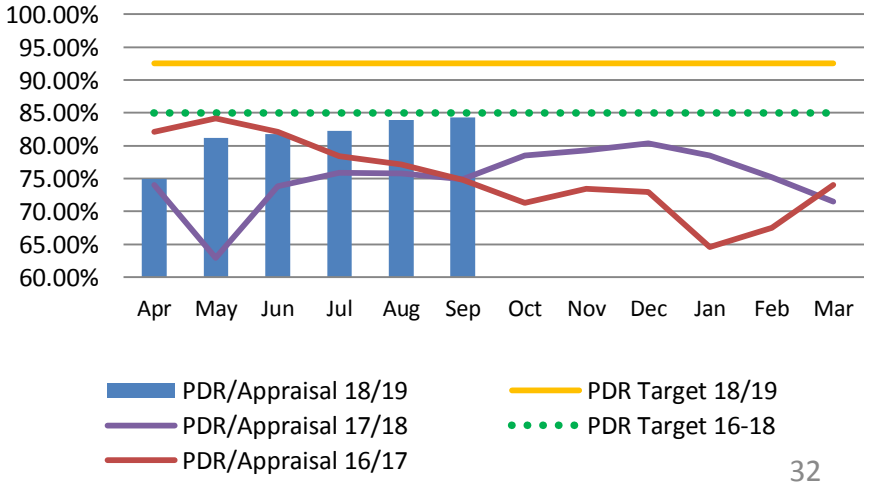
Staff Turnover



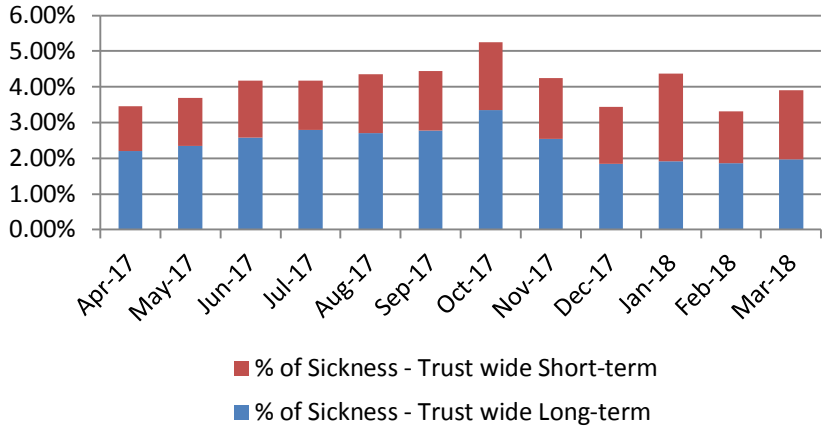
Mandatory Training



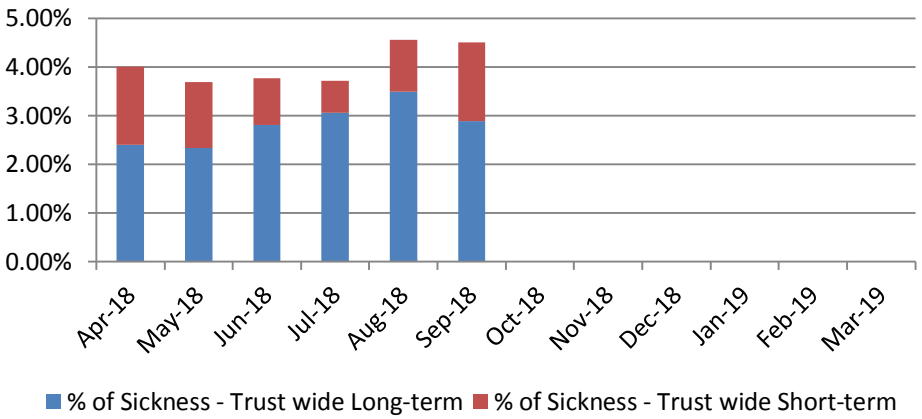
PDR/Appraisal



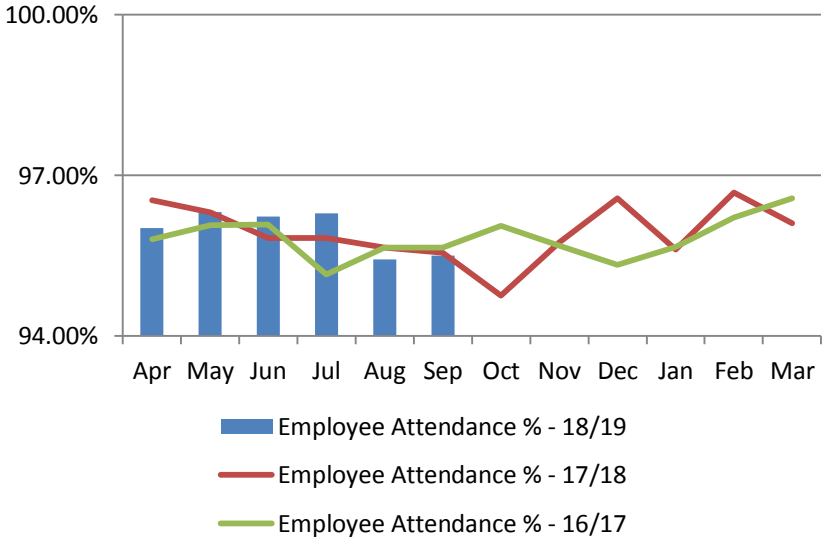
Sickness % - LT/ST (2017/18)



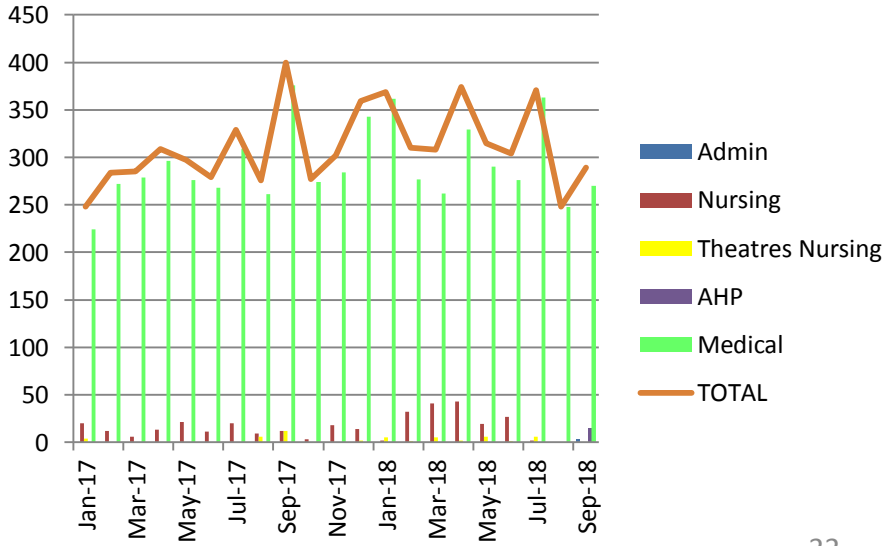
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

September was largely an encouraging month in terms of workforce performance. The vacancy position improved, as did the appraisal position; sickness absence decreased slightly; and turnover fell. This was set against a reduction in the mandatory training position, however, which fell below the Trust's internal target.

This month the Trust's vacancy position saw a significant increase of over 2.5% of WTE employed, with a headline figure of 85.83% against a Trust target of 90%. In other words, the vacancy "gap" has fallen below 15% for the first time since the start of the financial year. This position has arisen from a decrease in the funded establishment of almost 20 WTE due to the removal of some vacant posts due to cost improvement programmes – but also that comparatively, there were additional staff on the payroll totalling almost a further 16 WTE in September.

Monthly attendance in September improved slightly on August's position to 95.50% - but this was still red. In September, a decrease in long term sickness absence was largely offset by a corresponding increase in short term absence. The rolling 12 month average position remains amber at 95.71%, with little change.

Mandatory Training numbers saw a decrease in September and whilst above 90%, fell into amber at 90.22%. This is the first time the figure has dropped below our increased target of 92% since April 2018. The position was driven by a decline in all divisions except Division 4, which remained above 95%.

September's appraisal performance increased for the seventh consecutive month, this time by just under 0.4% to 84.27%, which remains the highest it has been since May 2016. Whilst this is still adrift from our stretch target of 92.5%, teams continue to make improvement in this area.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) decreased to 11.74%, which is an amber rating. The adjusted turnover figure (substantive staff leavers including retirements) increased slightly to 10.34% and remained green against a KPI of 11.5%.

In September, agency breaches declined increased from 248 to 289 shift breaches in total, 270 of which were medical. Other breaches in month came predominantly from Allied Health Professionals (15).

Statutory and mandatory training needs some operational focus to ensure that the position does not worsen.

RISKS/ISSUES

ROHTB (11/18) 012

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board last met: 5 September 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The current vacancy position was presented, which highlighted a number of cases where there was not an identified plan to fill the posts. This was being followed up with teams to understand whether there was a continuing need for the post. • The Workforce Race Equality Standards performance was discussed which showed that although the range of individuals invited for interview was broadly even across all ethnic groups, there was a higher proportion of white individuals who had been appointed. This was understood to be in line with the national picture, however the situation would be reviewed further. • The Committee received the outcome of a workforce process review that had been commissioned by the Trust's chairman, which highlighted some weaknesses in terms of workforce processes. An action plan would be developed to address these. • The impact of Brexit on workforce was discussed; work was underway at a national level to mitigate the risks around this.	• A paper from the Executives accounting for the vacancy position in each area was requested. This was to include the medical workforce. • The Committee agreed to receive a presentation of the Trust's maturity from a health and wellbeing perspective at the next meeting • The action plan to address the workforce process issues is to be presented to the Committee in December.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There were reported to be plans to purchase an electronic system that would assist with collecting quality information and assist with triangulating between staffing level, harm and deterioration in quality of care • The Committee received a positive presentation from one of the Trust's apprentices. The apprentice would encourage others to join in similar roles on the basis that in her view the Trust provided a great service and that staff were 'amazing'! • There was noted to be an encouraging positive trend downwards of short term sickness absence. • The staff Friends and Family Test results were noted to have improved markedly	• None specifically.

• The draft People & OD strategy was reviewed, which was based on two elements: Employer of Choice and Sustainability. • The Committee received reports from the Deputy Director of Nursing & Clinical Governance that proposed the development of a theatre assistant practitioner role and the introduction of a nursing associate role. • The Trust was meeting its statutory requirements in terms of nurse staffing care hours per patient day	

Chair's comments on the effectiveness of the meeting: The staff story was received well. It was noted that there needed to be clarity that papers coming to the Committee should not seek approval for spend, as the Committee did not have the delegated powers to agree this.

ROHTB (11/18) 013

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board last met: 3 October 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Capacity to oversee and implement an all encompassing health & wellbeing framework was noted to be limited • The people risk relating to vacancies had been separated out into current and future impact • The pay progression arrangements under the new Agenda for Change contract would take effect only for new starters, creating concerns over equity on process for different staff groups in the Trust; this has been escalated to a national level • There remain a high number of vacancies at a Band 6 level in theatres, therefore work was underway to understand what skill set might address this gap.	• Systematising equality and diversity at a divisional level would be undertaken, with some joint work between the Associate Medical Director and the Head of OD & Inclusion • Papers to the Committee in future needed to define how they aligned to the People & OD strategy • Apprenticeship data publication is to be presented in November • A summary of workforce STP activity is to be presented in November • A workforce model needed to be created to link into the plans for financial sustainability; this will include new roles
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee considered the performance against the Workforce Race Equality Standard (WRES), which showed a positive movement in compliance against some of the key indicators • There was reported to be much work underway to understand some of the key concerns and experiences of staff from a BME background as reported as part of the WRES assessment • An assessment of the organisation's maturity concerning the health and wellbeing agenda was presented, which showed that there was a good range of offerings available to staff, however the work needed to be branded so staff identified the services as part of the overall health and wellbeing framework • The Committee was pleased to hear that a stress and wellbeing action group had been established • The Chairmanship of the People Committee would rotate between the Heads of OD & Inclusion, Education & Training and HR Operations • The Trust was on course to have recruited 24 apprentices	• The Committee agreed that the WRES assessment could be published on the Trust's website, along with detail of the actions underway to address any shortfalls identified

• A summary of the Clinical Excellence awards process and outcomes was provided; there are plans to revise the process for the coming year • The questions and feedback from staff as part of the Team Brief were reviewed, which showed that there was a useful two way dialogue on key issues • The Trust was noted to be achieving its statutory requirements in terms of care hours per patient day • A nurse staffing board was being convened to oversee issues such as the number of times a member of staff does not work on the same ward consecutively	

Chair's comments on the effectiveness of the meeting: The meeting was productive, however it was felt that in the absence of an Associate Director of Workforce, HR & OD that the Heads of OD & Inclusion, Education & Training and HR Operations should attend the full meeting in future if at all possible

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board last met: 17 October 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Board need to be assured at year end that the Trust can operate as going concern.
- Report on patient consent to be reported to the Quality and Safety Committee with an action plan being reported to the Trust Board.
- Any operational risks with ADH Payments or Job Planning be raised with the Trust Board.
- BAF to be reported to the Trust Board once the high level risks have been stratified and the required internal work has been undertaken.
- Significant risks have been identified in respect of the Trust's recognition of NHS clinical revenue, financial sustainability and going concern, valuation and existence of stock and management override controls. There is also expected to be challenge from CCGs around activity and over performance. The risk around the evaluation of existing stock will be followed up. Further information will be sought around management estimates, bad debts, etc, to assess the risk around the control total. Accounting systems will also be reviewed.
- Assurance is required that there are no system problems with the valuation of stock.
- Council of Governors should endorse the external audit fees on the advice of the Audit Committee.
- Report to be taken to the Quality and Safety around patient consent with the recommendation that an action plan be reported to the Trust Board.
- For ADH payments, this will be actioned by the staff experience committee. Any operational risks will be raised with the Trust Board.
- It was agreed that the high level risks around cyber security would be stratified. Subject to the required internal work being undertaken the BAF would be reported to the Trust Board.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The ordering Catalogue on INTEGRA to be continually updated and rationalised. Work to continue around developing a shared catalogue across Birmingham. Procurement savings will be one of the main efficiency challenge schemes.
- Debate continues around NHS supply chain and the risks associated with the supply of specialist supplies once the UK leaves the EU. NHSI have issued a self assessment pack to enable all trusts to identify the risks and effects. There are national plans for supplies via NHS Supply Chain. Plans will need to be put in place for goods and services procured outside NHS Supply Chain. Work will continue in the Trust, including a Brexit meeting which will be chaired by Prof Phil Begg. The non-supply chain elements to be risk assessed to ensure plans are in place, including an action plan to address short falls.
- As part of IFRS 9 and IFRS 15, use of assets to be included on the balance sheet, including depreciation. This is expected to have a small financial impact and is expected to impact on capital funding and capital expenditure limits. The operating lease with ModularCo will be reported on the balance sheet. The cost pressure associated with this will be reviewed, together with concerns around the capital element.
- The risk of fraud in revenue recognition is a presumed risk under International Standard on Auditing. There are also issues around SFS targets and achieving the activity targets agreed with commissioners. External audit will continue to review this.
- The Trust to review the impact of IFRS 9 and 15 before the final accounts are submitted once the information for the Group accounting Manual is issued.
- Areas of concern around improving the working environment for junior doctors to be addressed.
- The risk of a cyber attack to be escalated so plans are developed. Detailed planning will be undertaken to scope the work.
- The report on the Catering review to be presented to the next Audit

	Committee which will also pick up concerns around stock control. • An improvement plan has been put into place to address issues picked up during the review of clinical waste management. • SLA with SWBH for procurement support to be reviewed with the intention that the Trust transfers to the cross-Birmingham arrangement. • Professional advice has been requested around direct engagement models used and compliance with IR35 (for medical locums). • A fraud risk assessment will be undertaken in December to assess areas of risk, linking this with the work of internal audit. • Fraud awareness training will continue throughout the year to raise awareness of fraud and bribery risks. • Responses from the survey in the effectiveness of counter fraud and levels of understand will be collated and reported to the next meeting. • Management actions from the counter fraud report to be progressed and outstanding issues reported to the next Audit Committee. • Work to continue around staff engagement and reporting for counter fraud. Counter fraud will engage with staff and circulate information for fraud awareness month in November. Learning from fraud awareness month to be included in the next counter fraud report to the Audit Committee. • Counter fraud authority to continue engagement with the Audit Committee. Counter fraud training (which is part of mandatory training) to be explicit. • Information to be sent to Steve Washbourne around risks around cyber crime and scam e.mails being sent to private e.mail addresses of staff. • The process for sending out and completing questionnaires for the Auditors effectiveness review will be clarified to endeavour to get a better response rate next time. The exercise will be repeated next year to get a broader response. • Outstanding actions in the recommendation tracker to be progressed. Executive Team members to attend the Audit Committee to address specific areas of detail to give a more focussed approach to outstanding actions. • Internal audit action log to be updated. • Outstanding job plans to be progressed to achieve a high level of compliance, including bringing the compliance point forward. • Work to continue with the theatre team to identify CIP and procurement

	savings, whilst bringing about improvements in stock control. Work will also continue around the theatre Provider Contract and picking up outstanding actions. • A regular report on breaches of SFIs will be given to the Audit Committee and approach action taken if the number of breaches increases. • A report will be given to the next meeting on the database of SLAs and agreements with other providers. • All staff to be reminded of the Trust policy around the hospitality register and the declarations of interest register, including the requirement to submit nil returns. • In future, Garry Marsh will chair the Resuscitation Committee which will give assurance to the Quality and Safety Committee. • Appropriate governance discussions will take place at Divisional level with any concerns being escalated to the Clinical Quality Group.
POSITIVE ASSURANCES TO PROVIDE • 80% of the CIP target for 2018/19 will be achieved, with the remaining 20% being non-recurrent. • Current Finance and Use of Resources Score is 3 and is encouraged to maintain the current scoring. • The relationship with NHSI remains positive. The Enforcement action around reporting of RTT was lifted earlier this year with the enforcement action remaining around financial sustainability. The Trust need to monitor the cash position, currently supported by loans from DH, and ensure there is more formalised documentation around this. • Good progress has been made in delivering the internal audit plan for the 6 audit assignments. Four of them have partial assurance with no negative opinion being received. The stores and stock review reviews have been completed. Two remaining reviews are also planned and programmed in. The Trust is in a good position around the delivery of the plan. • Review on Internal Performance reporting is positive with some improvements being made around audit trails and meetings. Matrons and ward managers have given positive signs of resilience and an awareness of the Trust's challenging position. • The review of the management of controlled drugs has identified that improvements have been made. All incidents are reported to the	**DECISIONS MADE** • Council of Governors should endorse the external audit fees on the advice of the Audit Committee. • The action plan for NHS counter fraud will evidence how issues have been progressed and discussed at the Audit Committee. • Audit Committee noted and accepted the findings from the assessment of the auditors' effectiveness based on the positive feedback received. • Audit Committee supported the actions proposed to address areas where a shortfall in effectiveness is evident. • Audit Committee noted the approval of the re-appointment of Deloitte LLP for a further two year period by the Council of Governors and the plan to test the market following the conclusion of this period. • The terms of reference were amended to include the Director of Nursing and Governance as a regular attendee.

Medicines Safety Group with most actions now resolved. • The key activities for 2017/18 were in line with counter fraud expectations to address concerns in line with the action plan. • A number of issues in the annual report have been addressed. The self assessment tool has been completed and submitted to the counter fraud authority. Feedback is awaited on future assessments. • An exercise has been undertaken around invoicing and no major concerns have been identified.	

Chair's comments on the effectiveness of the meeting:

The agenda for the Audit Committee needs to be appropriate and only relevant items being on the agenda.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust

Audit Committee

1 Constitution

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

2 Delegated Authority

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

3 Accountability

The Trust Board

4 Reporting Line

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

5 Objective

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

6 Duties

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

6.1 Internal control and risk management

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

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

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

6.2 Internal audit & counter fraud

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

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

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

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

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

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

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

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

6.3 External audit

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

- Appointment
- Reappointment
- Removal

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

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

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

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

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

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

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

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

- The meaning and significance of the figures, notes and significant changes
- Areas where judgment has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
- 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
Associate Director of Governance & Company Secretary

11 In attendance, by invitation
Regular attendance
Director of Finance
Director of Nursing and Clinical Governance
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 18 October 2018

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MINUTES

Charitable Funds Committee - APPROVED

Venue CEO Office, Trust Headquarters **Date** 15 June 2018

Members present

Dame Yve Buckland	Chairman	(YB) [Chair]
Mrs Kathryn Sallah	Non-Executive Director	(KS)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JW)
Mrs Stella Noon	Patient Representative	(SN)
Mrs Yvonne Scott	Patient Representative	(YS)

In attendance

Mr David Richardson	Head of Education & Learning	(DR) [Item 6 – 003 & 004]
Miss Elaine Chapman	Membership & Fundraising Officer	(EC) [Item 6 – 005 & 006]
Mr Daxon Powell	Financial Accounting Officer	(DP)
Mrs Sue Arnott	Public Governor	(SA)
Mrs Claire Kettle	Personal Assistant	(CK) [Secretariat]

Minutes	Reference
1 Welcome and Apologies YB welcomed all to the meeting and informed members that Jenny Richardson would be joining future meetings as a new member, given her invaluable experience with the ROHBTS Charity. YB explained that Simon Grainger-Lloyd and Claire Kettle would be involved in these meetings to provide secretariat support and assurance around Board. Members were in agreement with this. Apologies were received from Mr Paul Athey, Acting CEO, Mr Tim Pile, Non-Executive Director, Mr Andrew Pearson - Executive Medical Director, Rod Anthony – Non-Executive Director, Simone Jordan, Associate Non-Executive Director, Richard Phillips- Non-Executive Director, Phil Begg - Executive Director of Strategy & Delivery Josh Grundy - Deputy Financial Accountant, Mr Garry Marsh - Executive Director of Patient Services & Jenny Richardson, Member.	**Verbal**
2 Minutes of the Charitable Funds Meeting Held on 20 December 2017	**ROHCF(12/19) 001**

The above minutes were agreed as a true record of the meeting. YB commented that the Committee were still looking for a new Chair and asked members if they were aware of anyone that would like to join the Committee. DR commented that he would have a conversation with Kirk Bent.	
3 Charitable Funds Action Points from Meeting held on 20 December 2017	**ROHCF (12/17) 002**
Please see paper reference ROHCF (6/18) 002 for updated actions.	
4 Bids for Funding	
• Investment in Learning – Training for Housekeeping DR presented the above and commented that the Charitable Fund supports the Investment in Learning initiative. DR explained that £80,000 has been allocated for staff training to support the development of staff in Bands 1-4 roles and higher banded non-clinical staff. DR explained that this bid is to request £13,365 of funding for specialist training for 25 housekeeping staff as discussed with Steve Harnett and Sandra Crook. DR explained that Environmental Excellence Training Limited will provide the housekeeping team with enhanced learning and a qualification. YS commented on what happens if staff leave the next day and also suggested staff could report back on what the training consisted of and what it has given the. KS suggested this should be linked to driving outcome measures. Members of the Committee agreed to this bid and to the funds being taken from the existing pot of money. DR to report back to members with an update.	**ROHCF (6/18) 003**
• Birmingham Orthopaedic Teaching Programme (BOTP) Anatomy Module DR explained the above bid is for orthopaedic registrars to fund an anatomy teaching module based at Keele University Anatomy Department. DR commented that Keele University offers great opportunities. DR explained the recurrent costs will be funded by the annual FRCS Revision Course which students pay for and the money is reinvested back into registrars. Committee members were in agreement with this bid.	**ROHCF (6/18) 004**
• Motorised Wheelchairs EC presented this bid on behalf of Roger Bishton to request motorised wheelchairs. EC explained the request has come in as the current wheelchairs are difficult for the	**ROHCF (6/18) 005**

porters to navigate when on a slope, especially on the slope from Café Royale to Outpatients and from Outpatients to the Physio Gym. It was noted that the company we are liaising with provide bariatric wheelchairs and the wheelchair that has been looked at has a seatbelt which improves patient safety and a motor which will help manoeuvring on slopes. KS suggested that the Trust looks at the bariatric equipment in general and if the Trust accept this on Health & Safety grounds. It was requested that clarification and details be sought of the wheelchairs and bed movers that are currently used. EC commented that the supplier will provide training for the motorised wheelchairs. YB asked if the company will be prepared to loan us the equipment to pilot and trial to gage a sense on how much it is used. Following discussion, if we were able to pilot the equipment, it was discussed that a health and safety assessment could be carried out as part of the pilot. Other things to look at would be the implications of only having one chair and advice to patients and relatives on the use of it. In conclusion, members of the Committee understood the implications but following consideration, it was felt this application seemed to be more problematic that originally appeared at face value and members would like a loan prior to making a decision and authorising this bid. SA also mentioned consideration needs to be around the security of the chair.	
• London Marathon Charity Spot 2019 – For Information EC presented the above and explained that an oncology patient approached the Trust stating he would like to run the London Marathon next year to give something back to the Trust having been a patient for many years. EC commented a provisional space has been applied for. EC explained the Virgin Money Giving sign up form which is a one-off fee of £180.00 including VAT and commented the 2019 London Marathon was sponsored by Virgin Money Giving. It was discussed to set a fundraising target for individuals to ensure one-off costs are covered if he does not get through the general ballot. SA offered her help and support. It was noted that we would need to find someone every year to run for us. Members were in agreement with this arrangement and thought it would be sensible to set a minimum sponsorship to cover the cost.	**ROHCF (6/18) 006**
5 Review of Financial Position to 31 March 2018 (subject to change due to	**ROHCF (6/18) 007**

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Audit)	
SW explained that the Trust's annual accounts are required to be submitted for year-end which included the charity accounts and that the charity accounts were subject to change during Audit in July 2018. SW went through the financial position and overview of the charitable funds for 2017/18 and explained the financial position in relation to the accounts as at 31 March 2018. SW explained the closing balance on the Trust's accounts for March 2018 was £2.2 million; £1.5 million in cash, £756,000 was investment and £93,000 was short term investment. The Charity has incurred material expenditure of £133,000 during 2017/18, which included £27k for pressure relieving chairs, and £18k on initial expenditure relating to the regenerative medicine laboratory.	
SW explained that the income received equates to £88,000; £57,000 of donations and legacies, £31,000 interest.	
6 Cazenove Market Update & Review of Investments	**ROHCF (6/18) 008**
SW referred to the Cazenove report as at 31 May 2018. SW explained that Cazenove manage the Trust's investments.	
Members reviewed these papers and SN asked if there were plans to unlock the League of Friends money in the sum of circa £63,000. It was thought that some of this money would go towards developing physiotherapy facilities. SW agreed to investigate this. SW commented that work had commenced on the Regenerative Medicine Lab and funds have started to be spent on design fees. It was noted the Dubrowsky legacy in the sum of £1.5 million had been left to research differentiated chondrosarcoma. YB asked what would happen to funds allocated to the Children's ward and will the monies have to transfer. SW commented that the ROH will still provide a children's outpatient service, therefore, funds will remain in this pot. It was recognised that on a more general point, the more that individual funds could be consolidated into a single fund, the easier it would be to manage.	
SN asked if there was any feedback on the specialist chairs in the hospital that were purchased for relieving pressures. It was suggested that feedback be sought from Elaine Bethell, the new Tissue Viability Nurse. JW agreed to pick this up with Garry	

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Marsh. SA referred to the Cazenove report and asked if an exercise has been carried out to check they are performing above benchmarking for charitable investments. SW agreed to look into this. YB explained Cazenove were on the benchmark for the small amount of charitable funds the Trust hold and the Trust was receiving a good deal on balance but suggested it would be worth checking. YB commented that the charitable funds are independently audited. SW explained that the funds are reviewed by Deloitte's and are consolidated charitable expenditure and ensures that what the Trust is doing is in order and above board.	
7 Fundraiser Report	**ROHCF (6/18) 009**
Elaine Chapman (EC) joined the meeting to give an update on fundraising. EC explained that she had been in post for a year and went through the fundraising events that were being focussed on and commented that more donation boxes had been placed in various areas around the Trust. EC went through the work that had taken place to date and commented that she was working closely with Finance to streamline various routes involved in the charitable funds processes. EC explained the new GDPR rules state we are no longer able to keep donor information without their explicit consent. Therefore in May 2018, all previous donors were written to asking for their permission to keep their information on record. Out of the 22 donors contacted, we only received consent from 4. EC commented going forward, we will be asking for this consent on receipt of any donations coming through the hospital via our thank you letter and donation form. EC stated that we have received confirmation from Justgiving that they are GDPR ready and have taken the necessary measures to ensure we have our fundraisers consent to hold their information. EC explained since December 2017, work has been carried out around exploring new ways of raising money for the charity to make it more transparent for donors to see the impact of their donation. EC went through the 4 main fundraising appeals for 2018 which all fundraising will align to: <u>Learning Disability Appeal</u> EC commented that £1,335.00 has been raised so far for this appeal. EC explained this appeal has been created to ensure our learning disability patients have the best possible experience of being in hospital. EC commented the funds raised for this will go towards specialist training for all frontline staff and also to build sensory areas around the hospital to create a more relaxed environment.	

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The Throne Project

EC stated that this is a new appeal for 2018 and £203.00 has been raised so far for this project. EH commented that the 10K Run and Gung-ho events are taking place to raise money for this appeal.

The money raised will go towards making patient bathrooms dementia friendly. EC commented that the Estates Department are working on costing for this. JW agreed to help with the costing for new toilets etc.

KS suggested contacting DIY companies for example, B&Q, for sponsorship.

It was noted that the toilets in M&S, Longbridge were very dementia friendly so maybe worth touching base with them for ideas and supplier details.

Research & Development Appeal

EC explained this is an ongoing appeal in which the charity has supported for many years.

EC commented that AMRC are in the process of signing up to hospital sites to provide extra funding through referred channels.

It was agreed that EC and Carolyn Langford would be invited to the next meeting to provide an update. It was agreed to ask Carolyn if any specialist training was required for staff.

Staff Appeal

EC explained this is an ongoing appeal whereby we actively ensure staff are recognised and thanked for their work across the year. It is evidenced that having happy engaged staff, mean we have more happy patients , and high patient feedback rates. Many donations have been received from patients wishing to thank staff for the care and treatment received. EC commented that we needed to ensure these donations are used for this purpose.

EC gave examples of how the appeal money is used and gave examples of funding staff celebratory awards and training which would not otherwise be funded by the NHS.

SA commented that research was a most important piece of work particularly around longitudinal studies and robotics. SA commented that this work can be used across other studies, for example cartilage regeneration. YB requested an update from Phil Begg with regard to underfunded research.

SN spoke about the teaching topography for scoliosis. JW commented that the Trust were in process of putting in a pathway for all patients and this would be a category

in the HSJ Awards for 2019. KS asked if staff carried out their own research and if outcomes changed via this, maybe give colleagues an award to reflect this. KS commented this could be clinical or non-clinical staff who have made a difference for patients. YB congratulated EC on the hard work carried out to date in respect of fundraising and asked members to put forward names for staff appeals. YB suggested renaming the "Staff Appeal Fund" to the "Thank You Fund" instead.	
EC went through the future fundraising events as detailed below: • **The Big7Tea – 5 July 2018, 12:00 Noon to 3:00 pm, ROH Balcony** ROH Party – raising money for the general fund and predicted to make £500.00 through a raffle, merchandise sales and games. • **ASDA 7Tea Party** ASDA are teaming up with all NHS charities to celebrate the 70th anniversary. Asda Barnes Hill agreed to hold a tea party in their store to raise money for the ROH and QE charity funds. • **Half Marathon 2018 –Raising money for the Throne Project** Planned to raise at least £1,000. Currently we have 5 runners signed up and 4 more interested. Plans to meet with a running team to discuss the possibility in recruiting the team to run for us this year. • **London Marathon 2018** Predicted to raise at least £1,000.00. Currently have one fundraiser signed up who is a patient who got in touch. • **ROH Charity Christmas Ball 2018 – Friday 30 November 2018**, **Tally-Ho , Lord Night Suite** Predicted to raise at least £2000 if all tickets sold. Following discussion around the above, JW suggested we produce a document that shows how the Trust is spending the money raised. YS requested that Christmas cards go on sale earlier in the year. A suggestion was made to sell photographs of the hospital for the NHS 70th Birthday celebrations. YB asked if we can get a sense of how much the Trust makes from the Traders that pitch up outside Café Royale. A suggestion was made to have market stalls outside the Trust, near Outpatients, similar to the UHB fruit and veg stall. JW agreed to look into this.	

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It was suggested to have a fundraising page on website, giving guidance of what happens when a bid comes in and how people are thanked, the process for submitting and processing a bid and also a tab under this showing comments from staff stating this is how simple the process is and these are the things that have been purchased from the Charitable Funds.	
8 Proposed New Terms of Reference	**ROHCF (6/18) 010**
YB confirmed via SW the Trust Board was in agreement to the proposed new Terms of Reference.	
9 Any Other Business	
No items were raised under any other business. YB thanked members for joining the meeting and for their support and contributions.	
10 Details of Next Meeting	
To be agreed.	