The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 9 January 2019

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 9 January 2019 commencing at **1100h** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust Headquarters.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 9 January 2019: 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)
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 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 Roger Bishton	Acting Freedom to Speak Up Guardian	(RB)	[Item 8]
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Minutes of Public Board Meeting held on the 7 November 2018: *for approval*	ROHTB (11/18) 0XX	Chair
1110h	4	Trust Board action points: *for assurance*	ROHTB (11/18) 0XX (a)	SGL
1115h	5	Board Assurance Framework: *for assurance*	ROHTB (1/19) 001 ROHTB (1/19) 001 (a)	SGL
1120h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (1/19) 002 ROHTB (1/19) 002 (a)	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				
1135h	7	Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (1/19) 003 ROHTB (1/19) 003 (a)	JW
1155h	8	Update from the Freedom to Speak Up Guardian: *for assurance*	Presentation	RB
1215h	9	Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (1/19) 004	DG
1220h	10	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (1/19) 005	GM
FINANCE AND PERFORMANCE				
1230h	11	Update from the Finance & Performance Committee: *for assurance*	ROHTB (1/19) 007	TP
1235h	12	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (1/19) 008	SW
WORKFORCE				
1245h	13	Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (1/19) 009	RP
1250h	14	Workforce overview: *for assurance*	ROHTB (1/19) 009	PA
MATTERS FOR INFORMATION				
1300h	15	Meeting effectiveness	Verbal	ALL
	16	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 6th March 2019 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** 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 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)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Professor Gourevitch and Sarah Marwick tendered their apologies.	
2 Declarations of interests	**Verbal**
It was noted that the register of interests was available from the Company Secretary.	
3 Minutes of Public Board Meeting held on the 5 September 2018: *for approval*	**ROHTB (9/18) 008**
It was noted that Professor Begg's attendance needed to be reflected in the minutes of the last meeting. Subject to this, the minutes were approved.	

4 Trust Board action points: *for assurance*	**ROHTB (9/18) 008 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
5 Board Assurance Framework	**ROHTB (11/18) 001** **ROHTB (11/18) 001 (a)**
The Associate Director of Governance and Company Secretary presented the updated Board Assurance Framework, which he advised had been considered previously by the Audit Committee. He drew the Board's attention to some proposed changes, these being the addition of the following risks: • 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 were no risks proposed for de-escalation. It was noted that risk 799 had been reframed in line with discussions at the Trust Board meeting on 5 September, so it now read: '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 had been made to categorise the risks, so it was clearer what the key impacts and nature of the risk were and a colour coding system applied. The Board received the Board Assurance Framework and agreed with the proposed changes.	
6 Chairman's & Chief Executive's update: *for information and assurance*	
An update from the recent meeting of the STP Board was provided. It was highlighted that Birmingham Children's Hospital had been rated as 'Inadequate' for children's services and therefore the STP was bringing together partners across the city to redesign the system. This was part of the plans for integration.	

A further update would be provided at the December 2018 Board meeting. The Chairman reported that since the Board had last met formally, she had: • Undertaken Non Executive Director appraisals which was the main item for discussion at the Council of Governors meeting that had been held on 4 October • Met with new governors: Cllr Liz Clements, and staff governors Gavin Newman and Adrian Gardner • Hosted the Annual General Meeting on 4 October • Met with Cllr Olly Armstrong on 9 October to discuss local issues, including security and the plans for the new modular theatres • Helped with some Non Executive Director interviews at Birmingham & Solihull Mental Health NHSFT • Had an introductory meeting with Roger Bishton, the Acting Freedom to Speak Up Guardian	
6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was noted that the musculoskeletal services redesign work was the main development that was occupying the STP at present in terms of orthopaedic services.	
6.2 Briefing on plans for Brexit 'no deal' scenario BAF REF: FP3	**Verbal**
It was reported that a 'Brexit' subcommittee had been established which included operational and financial managers across the Trust. The messages from the centre were discussed in this forum, including any relating to supply chain matters. Whilst there was a national conversation underway, the regional activity and mitigations still needed to be understood. Oncology products and provisions were suggested as an area of sensitivity. Human Tissue handling also needed to be considered. A readiness self-assessment was being worked through and any risks would be considered by the Finance & Performance Committee and the Committee would also consider the minutes of the Brexit subgroup. A detailed national piece of work would look at workforce implications of a 'no deal' outcome. There was no STP co-ordinated work underway to prepare for Brexit.	

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)**
The revised terms of reference for the Quality & Safety Committee were presented which streamlined the attendance at the meetings. These were approved by the Trust Board. Mrs Sallah reported that the concerns around resuscitation training had been discussed and there was had been a resuscitation superhero week organised, which had worked well and engaged staff. The training aid for this was seen to be useful. The light leads incidents had been discussed and assurances had been given that the light leads had now been changed which would avoid any recurrence. There had been a review of tissue viability and there was a high degree of compliance with the required standards. A number of issues on health and safety had been raised, however the Committee had been advised that the Health and Safety Group would be chaired by the Director of Strategy & Delivery in future which would address these. The harm review model was noted to be excellent and the submission of this framework for possible national awards would be considered. The communication of the Patient Reported Outcome Measures (PROMs) was being considered and this would be picked up through JointCare. These were also discussed internally through the annual appraisal. It was noted that the Board supported posters on the walls to highlight the good outcomes at the ROH.	
8 Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	**ROHTB (11/18) 004**
The Executive Director of Nursing & Clinical Governance reported that there had been four moderate harm reported: a VTE, a pressure ulcer, a delay in starting the sepsis pathway and a transfer out of the organisation. There had been no Serious Incidents. Falls had decreased and from a pressure ulcer point of view, two device-related occurrences had been reported. These had been reviewed. It was noted that the assurance offered by the Quality report was now sounder which was pleasing. The recent Coroner's inquest reported that there had been complications of surgery that were known risks and there was no follow up action mandated.	

It was noted that on Ward 12, there appeared to have been an issue with pain management. This was noted to be a matter reported on the risk register. There had been a discussion with Mr Matt Revell, Associate Medical Director and a report would be brought to Quality & Safety Committee to update on the plans to improve this.	
9 Complaints annual report: *for assurance*	**ROHTB (11/18) 005** **ROHTB (11/18) 005 (a)**
It was noted that the annual complaints report had been received at Quality & Safety Committee. There was reported to be an overall decrease in the number of complaints received. The complaints associated with patient bookings and spinal deformity had decreased particularly. The numbers of PALS enquiries had increased as a result of the contact number for PALS being included on appointment letters, however this had now been rectified. There were no clear complaints trends to highlight to the Board.	
10 National patient survey: *for assurance and approval*	**ROHTB (11/18) 006** **ROHTB (11/18) 006 (a)** **ROHTB (11/18) 006 (b)** **ROHTB (11/18) 006 (c)**
It was noted that the national patient survey report had been received at Quality & Safety Committee. Overall, the report was positive. It was agreed that issues regarding specialist diets needed to be addressed as this was a recurring theme, including gluten free meals. The Board was advised that the entire catering provision was being considered. The timeliness of discharge and attitude of staff were key themes of negativity. However, 'customer care' training had commenced which it was hoped would address this.	
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)**
The 'flu vaccine self-assessment was noted to present a positive position. 36% of front line staff had been vaccinated to date. Intelligence was provided as to the reasons for not being vaccinated and this was being reviewed. Every effort was being made to improve the position. It was agreed that the 'flu stand outside Café Royale needed to manned more comprehensively.	

12 Learning from Deaths update: *for assurance* BAF REF: 275	**ROHTB (11/18) 008** **ROHTB (11/18) 008 (a)**
The Executive Medical Director reported that there was a requirement to review hospital deaths considered to be avoidable, however it was noted that all deaths were reviewed at ROH regardless. There was noted to have been a challenge over the last few months with the oversight of deaths due to lack of individuals to support the process. This was currently included on the corporate risk register. The Board was concerned at this position and offered its support to address this where it could. It was noted that the Learning from Deaths policy had been rewritten. There was good discussion at Quality & Safety Committee around the deaths and the Root Cause Analyses that had been completed. Coroner cases were also discussed in detail. It was noted that the CQC needed to be satisfied that the process was proper. The list of deaths provided was received and noted and the action plans were considered which addressed any points of learning.	
13 Update from the Finance & Performance Committee: *for assurance*	**ROHTB (11/18) 009** **ROHTB (11/18) 010**
Tim Pile reported that the Trust was £5k ahead of the budget year to date, a position which was a deterioration on that reported at the last meeting. The issue related to the Trust being behind in terms of activity and income for the month. A number of consultants were absent in September which had impacted and the challenges with covering the fallow lists was a concern. The October position had improved considerably however. Activity had increased for inpatients and day cases at present and the highest week for some time had been achieved. The delivery of the Cost Improvement Programme remained a concern and the projections showed an end of year shortfall and therefore mitigations were being considered. Some additional benefits had been identified. Private patient income was far higher than last year and the team overseeing the area was congratulated. Length of stay was reported to be improving. In October, arthroscopy, spinal services, clinical support and Oncology had all achieved the 92% 18 weeks Referral to Treatment Time target, however some of the other specialities were driving down the performance.	
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**

It was reported that in terms of IT infrastructure, £200k investment in IT was included in the capital plan. Since then the vision for IT across the NHS had been released by the new Secretary of State for Health and Social Services. The use of Cloud solutions presented some challenges to the NHS, including the expenditure model. Some of the applications currently used were reported to be application based and needed to be installed on machines which created a further issue. A roadmap would be developed to consider how the Trust evolved to where it needed to be. Given that the Board was not due to meet formally again until January 2019, it was suggested that delegated approval be given to the Finance and Performance Committee to approve the infrastructure business case at its next meeting. This was agreed. In terms of the number of patients waiting 52 weeks or more, the number had reduced to 20 which was less than the 36 projected. This has a positive impact in the confidence of regulators in terms of management of activity.	
15 Staff Experience & OD Committee: *for assurance*	**ROHTB (11/18) 012** **ROHTB (11/18) 013**
Richard Phillips reported that steps were being taken to improve the voice of the staff. A staff experience walkabouts would be organised. Mr Phillips advised that he had attended the People Committee which was a positive forum. A new appointment had been made to the Associate Director of Workforce, HR & OD who would start in the new year. Thanks were extended to Surinder Khan for her continued support in the meantime.	
16 Audit Committee and revised terms of reference: *for assurance and approval*	**ROHTB (11/18) 014** **ROHTB (11/18) 014 (a)**
The issue around Going Concern was a key consideration for the Audit Committee. The revised terms of reference, the changes being minor in nature, were approved.	
17 Charitable Funds Committee – minutes: *for information*	**ROHTB (11/18) 015**
The minutes of the Charitable Funds Committee were accepted.	
18 Update from Council of Governors meeting on 4 October 2018: *for information*	**Verbal**
The Chairman advised that the key topics covered in the meeting of the Council of Governors on 4 October were:	

• Chair and NED appraisal • STP update • Annual complaints report • Paediatric transition update • Council of Governors effectiveness review • Feedback from the Patient & Carers' forum In terms of the Patient & Carers' forum, the body would be refreshed and refocussed to make it more strategic. It was agreed that an update on patient engagement should be given to the Board in future. It was noted that attendance at the meeting needed to be considered. It was noted that there had been some good challenge around the paediatric transition.	
ACTION: **SGL to schedule a presentation on patient engagement into a future Board meeting**	
19 Meeting effectiveness	**Verbal**
The Board agreed that there had been good debate and focussed discussion on the key issues.	
20 Any Other Business	**Verbal**
Jo Williams reported that the Board had made a commitment to be part of the STP Pathology Hub. There was an issue for bone tissue given the fragility of the service however. As such, conversations had been held with Royal National Orthopaedic Hospital NHS Trust (RNOH) who had agreed to assist with this service provision, pending the transfer to University Hospital NHS FT (UHB) by April for handling soft tissue and bone becoming handled through a national approach. The staff affected at the ROH had been briefed given the TUPE implications. It was noted that a public narrative was needed for paediatrics, given the ongoing delay and an update should be provided at the next public Trust Board meeting. The announcement had been issued that Andrew Pearson would be stepping down as Executive Medical Director from March 2019. Although there would be another chance to do so in the New Year, thanks were expressed to Mr Pearson for all his support to the Board during his tenure.	
ACTION: **JW to present an update on the paediatric transition work at the**	

next public Trust Board meeting	
Details of next meeting	
The next meeting is planned for Wednesday 9 January 2018 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 9 January 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 4.01.2019

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. Ongoing discussions around therapies with commisisoners, thereby not in a position to be able to present updated strategy until Spring 2019.	
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~~ 06/03/2019	Scheduled for the ~~November~~ March meeting	
ROHTBACT. 066	Update from Council of Governors meeting	Verbal	07/11/2018	Schedule a presentation on patient engagement into a future Board meeting	SGL	31-Mar-19	ACTION NOT YET DUE	
ROHTBACT. 060	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	Added into the Staff Exeperience forward plan for autumn 2019 to allow for individual to return from maternity leave	
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 presented at the November 2018 meeting	
ROHTBACT. 067	AOB	Verbal	07/11/2018	Present an update on the paediatric transition work at the next public Trust Board meeting	JWI	09-Jan-19	Added to the agenda for the January 2019 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:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**9 January 2019**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at December 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 closed:

- **Risk CO3** – Risk relating to the operational management of theatres. This risk was closed and removed from Corporate Risk Register in December as considered that the management structure in place is working well and is effective. The ongoing risk remains staffing, which is managed as a separate risk

It is proposed that the following risks be added:

- **Risk No 1298** – Risk relates to cyber security and is proposed to replace the previous cyber security risks (Nos 1162 & 1163). Risk No 1298 is an amalgamated and re-worded risk that better reflects the current risk to the Trust and the full range of factors/causes of the risk.

The post treatment score for Risk WF1 has been elevated to reflect that whilst work has been undertaken to more fully understand the short-term resourcing needs and recruitment plan, the perceived likelihood of the risk materialising is higher.

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

REPORT RECOMMENDATION:

Trust Board is asked to:

- Review the Board Assurance Framework
- Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- APPROVE the proposed changes to the Board Assurance Framework

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

Note and accept	Approve the recommendation	Discuss
X	X	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:

Trust Board on 7 November 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 Request for planning permission to build new theatres to increase potential for income generation	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 Commitee	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. NHSI/E continued oversight of system response Regular briefings to CQC and oversight of actions being taken	Minutes of stakeholder oversight meeting	4	4	16	↔	Ongoing work with BWCH to agree joint approach to staffing which will increase numbers and skills and therefore mitigate clinical risk.	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 trajectory to deliver 92% performance is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for October is 86.13% with only 13 patients (Excluding spinal deformity)over 40 weeks , however plans are in place to meet trust forecasted position for delivery of 92% in November 2018 for Arthroplasty , Spinal, Paediatrics , Foot and ankle , Hands and CSS . Given the challenges in some specialties it is unlikely that the trust will deliver 92% overall in November 2018. A revised trajectory will be submitted by the 31st December to NHSI, confirming when the trust will deliver 92% overall. Additional capacity is planned for the YAH service in December 2018 with a refreshed demand and capacity plan for spinal deformity incorporating the impact of any delay in transition of Paediatric inpatient services . Pathway work is ongoing in all specialities and additional therapy resources are being delivered in focussed areas to reduce the waiting times for patient 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. The Trust are currently awaiting the outcome of a planning application for the development at which point the likely go live date will be able to be more clearly defined. 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. The potential redesign of MSK services by the local CCGs poses a threat to the Trust's financial position.	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 with particular focus on MSK services.	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Water Safety Group minutes presented to IPC Group meeting.	4	5	20	↔	Water safety plan is in development.	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	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	3	4	12	↔	Workforce design to become an integral part of HR Business Partner discussions.	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	**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.** 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 governace structure with increased focus on attraction, recruitment and retention of clinical staff.nursing 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, collaboartion with STP partners, ACPs. Launch recruitment microsites and increase use of social media Work to review staffing models and consider options for integration of new roles	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	Currently 15 patients over 52 weeks 9, adult 6, paediatric patients . All patients monitored at weekly PTL - plans in place for all patients over 40 weeks Full RCA and harm review for all patients over 52 weeks presented monthly at harm review board.	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. Junior Fellow posts have been re advertised in November 2018 with a revised 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 . The draft Job Description for the alternative medical workforce has been presented at the stakeholder meeting in November 2018 . A presentation on implementation of the ACP role was also present and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator will commence on December 10th and will focus on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve 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. Risk closed and removed from CRR as management structure in place is working well and effective. The ongoing risk remains staffing which is managed as a separate risk	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. "Soft Go Live" for Somerset went live as planned in November 2018 full roll out of the system planned for January 2019	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 .All project are managed via Perfecting Pathway framework and all project current on track.	Q3 2018/19	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	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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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 continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. A specific review of BIU activity is ongoing.	Ongoing	2	4	8

1298	Finance & Performance	Steve Washbourne	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:		Safe, efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	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. 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.		4	4	16	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. 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	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	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 support provided to Heartlands, Good Hope and Solihull Hospitals.	Q1 2019/20	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 function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	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	↔	An information analyst has been recruited and is due to start at the trust early Jan-19 . The recruitment of the Business Intelligence Systems Manager had been delayed due to budget issues, but the post will now go to advert early Jan-19.	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 ratified -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	↔	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
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	Risk remains unchanged. CYP HDU is staffed 24/7 with a minimum standard of 1 RNC and 1 RN from adult HDU with paediatric competencies. The roster is reviewed on a daily basis by the HDU Senior Sister and there is a weekly meeting between HDU senior nursing team and CYP services senior nursing team. In addition a weekly meeting has been scheduled with the Executive Director of Nursing & Clinical Governance to monitor staffing for both CYPHDU and adult HDU. Operational management of CYP HDU returned to Division 2 on 16/10/18 after transfer to Division 1 on 13/08/18. Clinical Matron and SWS to be rostered onto clinical shifts when gaps in Ward 11 and CYP staffing occur. CYP staffing roster to be reviewed and non-essential training and education to be removed and hours then used to cover the CYP roster. 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. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	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 Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	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	↔	Continued oversight by NHSI/E & CQC	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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	Phil Begg	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	↔	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	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 electronic governance solution for better management of Trustwide policies and creation of additional dashboards of performance against key quality metrics.	Q4 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

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:	**9 January 2019**

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 9th January 2019

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 November 2018.

2 STP UPDATE

2.1 At the STP Board on 3rd December, the Board reviewed the 1 year priorities recommended by the four portfolio boards, along with progress against the system's CQC action plan.

2.2 The STP CEOs meeting on 13TH December discussed in detail proposals to introduce a social value policy across STP organisations, aimed at including consideration of economic, social and environmental wellbeing of the local area in any procurement processes. The principle of this was supported by the CEOs but further detailed work was requested in conjunction with the proposed Birmingham Procurement Hub to consider how this aligned with NHS requirements around the Carter Review and Model Hospital.

2.3 The STP CEOs meeting also received a presentation reviewing emerging models across the NHS of system governance and integration in advance of further focus on integrated care expected in the NHS 10 year plan.

3 BIRMINGHAM HOSPITALS ALLIANCE UPDATE

3.1 On 3rd December, the Chair and I attended the working group to the Birmingham Hospitals Alliance along with Executive and Non-Executive colleagues from University Hospitals Birmingham and Birmingham Women's and Children's Hospital.

3.2 In addition to an open discussion on strategic opportunities and risks, the working group also received proposals relating to an integrated approach to clinical

governance for the local maternity system and plans for a shared procurement function across the 3 Trusts.

4 GIRFT VISIT

4.1 On 4th December, the Trust was visited by Professor Tim Briggs CBE, the National Director for Clinical Quality and Efficiency.

4.2 Professor Briggs and his team were invited to experience the new JointCare programme and to speak with some of the clinicians driving the initiative forward with a view to identifying opportunities and learning as part of the Getting It Right First Time (GIRFT) programme. The Trust also discussed with Professor Briggs the work that we are undertaking with partners across the STP to standardise and improve clinical pathways and protocols in orthopaedic surgery.

5 2019/20 PLANNING

5.1 Initial planning and contracting guidance, along with draft tariffs, was released to Trusts just before Christmas to support the development of financial, operational and workforce plans for 2019/20. More detailed guidance is expected to be released alongside the NHS 10 year plan in January 2019.

5.2 Key headlines from the guidance are as follows:

- Trust and CCG plans will need to be combined to form a coherent system-level operating plan. This will provide the start point for every STP and ICS to develop 5 year plans up to 2024.
- Each STP will be given a system control total, which will be the sum of each individual control total.
- Subject to consultation the gross uplift in national tariff will be set at 3.8%. This includes a range of cost pressures, including the Agenda for Change pay awards in 18/19 and 19/20.
- The minimum efficiency ask of the NHS in the next 5 years is 1.1% per year, which will be top-sliced from national tariffs. Efficiency plans should be appropriately phased and not back-loaded.
- CQUIN funding and Provider Sustainability funding has been reduced, with the balance transferred into national tariffs. The majority of this funding has been targeted into urgent and emergency care.
- There will be an increased focus on workforce planning and, in particular, on ensuring that every Trust has a 'bank first' temporary staffing model in place.

5.3 Initial, activity-focused plans are to be submitted by 14th January with full draft organisational plans submitted by 12th February. It is expected that all contracts will

be signed by 21st March, in advance of a final organisational plan submission on 4th April.

6 MEDICAL RECRUITMENT

6.1 Andrew Pearson, the Trust's Medical Director will be standing down from the role after six years in March 2019. The post has been advertised and 3 candidates have been shortlisted for interview on 18th January.

6.2 The Executive Team have approved a business case to recruit up to 2 additional oncology consultants over a two year period. The first post is required to ensure capacity is maintained once services are split between the ROH and BWCH following the transition of paediatric surgery. The second post will provide succession planning within the team and support opportunities for service growth as a result of STP discussions linked to bone infection and metastatic cancers.

7 STAFF AWARDS

7.1 290 nominations were received for the 2019 ROH Staff Awards, nearly three times as many as in 2018.

7.2 The shortlisting panel met on 4th December 2018 and agreed the winners of the 15 awards. Letters have gone out to those staff who have been shortlisted for awards, plus the people who nominated them, to invite them to attend the Leading Lights ceremony on 8th February 2019.

8 POLICY APPROVAL

8.1 The Chief Executive, on the advice of the Executive Team has approved the following policies since the Trust Board last sat:

- Incident reporting and management
- Smoke Free
- Learning from Deaths

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
4th January 2019

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:	**Janet Davies, Clinical Service Manager / Project Lead for the paediatric transition**
DATE OF MEETING:	**9 January 2019**

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:

- Update regarding the delay to the transition of the Paediatric service from 31st January 2019
- Revised timeline for the service transfer to BWC
- Addition to the governance infrastructure supporting transition
- Additional risks
- Communication with stakeholders

REPORT RECOMMENDATION:

The Board is asked to accept 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		Communications & Media	x
Business and market share	x	Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services.

PREVIOUS CONSIDERATION:

Last considered as part of the public agenda as a standalone item in September 2018.

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Paediatric Service Update – January 2019

UPDATE TO THE TRUST BOARD ON 9 JANUARY 2019

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:

- Update regarding the delay to the transition of the Paediatric service from 31st January 2019
- Revised timeline for the service transfer to BWC
- Addition to the governance infrastructure supporting transition
- Additional risks
- Communication with stakeholders

2 Transition of Service

At the Joint Transitional Meeting in October 2018 both ROH and BWC raised concerns regarding the planned transitional date of 31st January 2019 being safely achievable. Following an options appraisal the below points were highlighted to be crucial in the decision to delay the transition from the 31st January 2019

- BWC recruiting sufficient numbers of theatre staff to support the additional activity
- BWC undertaking an External Oncology Quality Assurance Evaluation (as this is not a service they currently provide)
- BWC completing the renovation of Theatre 8 and Ward 15 (which is currently on track for delivery by February 2019).

Both Trusts remain committed to securing the safe and timely transition of services to the BWC site and are working closely with NHS Improvement (NHSI) and NHS England (NHSE).

BWC will submit a staffing recruitment timeline to NHSI and NHSE and the February 19 oversight meeting will review their progress with recruitment of theatre staff. The planned Oncology Quality Assurance Evaluation is due to be concluded by Mid-February 2019. The BWC Trust Board will formally review this in February 2019.

The main risks to the ROH as a result of the delay are the paediatric nursing staff levels on ward 11 and HDU and CQC regulatory inspection of these areas. Currently both nursing teams at ROH and BWC are working together to propose deliverable nursing models which mitigates the concerns around sustainability and continuation of the retained services on the ROH site. The CQC together with NHSI and NHSE have been kept fully informed with the delay.

All other paediatric support has been extended included the paediatrician support from both BWC and UHB (Heartlands Hospital) which was originally in place to the end of January 2019 and the ongoing Associate Medical Director cover from BWC.

3 Revised timeline for service transfer to BWC

There has been no new date agreed for the transition of paediatric services however early summer 2019 has been suggested as a possible date. The critical path has presumed this new date for all services to be transitioned (including Oncology):

- BWC to submit staffing recruitment timeline NHSI and NHSE – Mid Jan 2019 / Feb oversight meeting to review the progress made with recruitment.
- Update Stakeholders of delay, including ROH website – Jan 2019
- BWC - Additional nursing / theatre / admin staff recruited – ongoing
- Theatre and Ward refurbishment Jan 2019 (on track)
- IT Pathways to be agreed – Jan 2019
- Post-transition clinical pathways signed off – January 2019 (excluding Oncology)
- Job plans signed off – February 2019
- Oncology Quality Assurance Quality Assurance Evaluation completion – Mid Feb 2019
- Update from BWC Board to review finding of above - Feb 2019
- HR TUPE Transfer – waiting on a new date for transfer (everything in place but require 1 month for completion)
- The revised project plan is working to a new revised time line for all services to transfer to BWC as June 2019 (this date has not been agreed and excluding oncology timelines for other specialties could be brought forward depending on BWC recruitment)

4 Governance

There remains a strong governance structure to oversee the process of transferring the paediatric inpatient & day case surgery service:

The Strategic Oversight Group Meeting currently co-chaired by Kathryn Sallah (ROH) and Alan Edwards (BWC) will now be chaired jointly by NHS improvement and NHS England to ensure the milestones for the transition are delivered. This will also ensure system wide support and ownership for the transition of the service.

5 Risks

ROH & BWC have developed a joint risk register to record, assess & monitor the risks associated with this complex service transition.

The risks can be summarised as follows:

- Risk of insufficient theatre staff numbers recruited to at BWC
- Risk of insufficient Ward 11 and HDU staff numbers at ROH
- Unknown recommendations following the Oncology assurance evaluation
- Unknown CQC inspection at ROH

All of the above may result in further delays or cessation of services in the region.
As discussed in the paper there is a focus on managing & mitigating against these risks through the governance structure outlined in section 4.

6. Communications

Key to the process continues to be our communication with stakeholders, therefore we will ensure that we remain focused on providing support to those staff impacted by the transition of service and ensure we engage with patients, families and stakeholders with key information about the service transition**.**

Authors: Janet Davies Clinical Service Manager / Project Lead for the paediatric transition

4 January 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Freedom to Speak Up – NHS Improvement self-assessment**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**9 January 2019**

EXECUTIVE SUMMARY:

The introduction of a Freedom to Speak Up Guardian and associated processes to enable staff to raise concerns were recommended in February 2015, following the Freedom to Speak Up review commissioned by the Secretary of State for Health.

The ROH Trust Board in July 2015, agreed to support the appointment of a Freedom to Speak Up Guardian, who commenced in post in autumn 2016 following the establishment of a National Guardian's Office.

Although there were clear expectations set around the role and its aim from the National Guardian's Office, the local operation of the FTSU Guardians remained fairly fluid as the role became embedded and the effectiveness of the FTSU arrangements was tested.

In May 2018, NHS Improvement set out some guidance and further expectations around how the FTSU role should perform, in addition to the implications for and understanding of staff and stakeholders. The guidance was based on the eight key lines of enquiry set out in the NHS Improvement well-led framework, which are:

- Leaders are knowledgeable about FTSU
- Leaders have a structured approach to FTSU
- Leaders actively shape the speaking up culture
- Leaders are clear about their role and responsibilities
- Leaders are confident that wider concerns are identified and managed
- Leaders receive assurance in a variety of forms
- Leaders engage with all relevant stakeholders
- Leaders are focused on learning and continual improvement

To assist trusts with making a judgment as to how they stood against these key lines of enquiry, NHS Improvement developed a self-assessment tool for Boards to complete.

Attached to this summary sheet is an initial view against the various questions in the self-assessment.

In summary, although the ROH performs well against the NHS Improvement guidance, there remains work to do, particularly in the following areas:

- Development of a formal strategy and vision for the FTSUG
- Linking in to the wider piece of work around lessons learned and disseminating these
- Systematising the reporting to the Board and widening the content to include detail cases handled when it is appropriate to do so
- Sharpening the relationship with the Non Executive Director lead for Freedom to Speak Up

REPORT RECOMMENDATION:

The Board is asked to:

- Note and comment where needed on the self-assessment
- Agree to receive an action plan to address any shortfalls against the requirements in April 2019

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		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:

The work aligns with a number of the Trust's values, most notable 'Openness'

PREVIOUS CONSIDERATION:

None

National Guardian
Freedom to Speak Up

NHS Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

	Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	Our expectations			
1	**Leaders are knowledgeable about FTSU**			
1a	Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	**MET** The FTSU guardian regularly meets with Executive Team lead for FTSU and reports latest guidance from NGO bi weekly. Also, any other important updates are provided by email/telephone if the matter is urgent and an update is required prior to 1:1 meeting with Executive Team lead.	FTSUG to continue to feedback to Executive Team lead in bi-weekly 1:1 Forward the weekly bulletin sent by NGO to the Executive Team lead.	Feedback from Executive Team lead on an ad-hoc basis Monthly update to all board members from FTSU Guardian by email.
1b	Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	**MET** The FTSUG attends and reports to various Trust committees' as well as reporting to board once a year. The FTSUG has the added option of attending the weekly executive meetings if there is an urgent matter that needs to be discussed.	FTSUG to ensure there is feedback from board on concerns that have been raised and start to publish a 'you said we did' on the intranet so staff are aware of any changes that have taken place as a result of speaking up/raising patient safety concerns.	Board report from FTSUG Regular 1:1 with Executive Team lead Continuation of reporting to Q&S committee, Staff Experience & OD Committee, Audit Committee and attending weekly executive

		The Board regularly communicate the importance of 'speaking up' when visiting departments and during staff briefings.		meetings if necessary FTSUG to also continue to attend Trust Consultative Committee, Patient and Carers' forum and public board meetings.
1c	They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	**NOT MET** Leadership development strategy currently under construction, which will be led by the new Associate Director of HR	The current People & OD strategy references leadership development, however a leadership development plan is yet to be constructed	A leadership development strategy will be developed and presented to the Board-level committee responsible for oversight of Staff Experience & OD
1d	Senior leaders can describe the part they played in creating and launching the Trust's FTSU vision and strategy.	**PARTIALLY MET** The Trust Board supported the plans to implement a Freedom to Speak Up Guardian at its concept in July 2015 The Executive Team was involved in the evaluation and selection of the current FTSUG for the Patient Safety staff award in February 2018, which	A written work plan for the FTSUG role is to be developed.	The FTSUG will report to the Board and the other Board Committees, thereby proving the opportunity for the future vision for the role can be tested.

		is an endorsement of the activities and vision of the FTSUG		
2	**Leaders have a structured approach to FTSU**			
2a	There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	**PARTIALLY MET** The 'freedom to speak up' policy provides information on the role and purpose of a FTSUG 'Speak up and join in' is an initiative led by the HR department which links patient safety, staff experience and continuous improvement together. There has been a lot of comms work done around this and many 'drop in sessions' for staff to attend. There is a 'raising concerns flow chart' that has been used in briefings by CEO/board and also available on the intranet as well as in poster format in departments to guide staff on how to raise all types of concerns and routes available internally.	Formulate a clear strategy and vision for FTSU FTSUG to have regular 1:1 with HR department to ensure better 'sharing of information' of patient safety cases raised through the 'speak up and join in' initiative. Regular advertisement of the 'raising concerns' flow chart on the intranet.	Quarterly report on patient safety cases raised through 'speak up and join in' Feedback to Executive Team lead A documented concise and clear strategy

2b	There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	**MET** The current policy is up to date and is due for review in July 2019.	FTSUG and Executive Team lead to review policy before expiry and work with HR to ensure it has all the relevant up to date details in terms of raising patient safety concerns.	Comparison between the ROH policy and the NHS Improvement model policy Use of quantitative measures to rate the policy
2c	The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	**PARTIALLY MET** There is no definitive strategy that has been documented and approved by the Board and stakeholders, yet, but the current FSTU framework for the ROH is structured in which the FTSUG reports to Executive Team lead on alternate weeks and CEO every 4 months. The FTSUG works with many stakeholders, including departmental managers and senior leaders to help improve staff engagement. The FTSUG meets regularly with Head of OD & Inclusion to share information on types of cases and themes, and updates on activity from a contact officer	Develop a strategy and vision, involving stakeholders and board for approval. FTSUG to keep up to date with guidance from NGO and feedback any changes to the relevant stakeholders and executive team lead for FTSU New FTSUG job description	FTSU board report to include information on the strategy and vision and the stakeholders involved in its development.

		perspective. The new Job description provided by the NGO has also been reviewed to see if any further changes need to be made and will be used to formulate a the strategy		
2d	Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	**PARTIALLY MET** The FTSUG reviews the number of cases quarterly to see if there is a reduction or increase in cases. Data is submitted to the NGO quarterly. An increase in the number of cases suggests the policy is clear in how to raise concerns.	Develop an audit programme to review compliance with policy	Report from FTSUG quarterly on number of cases and themes by email to board Establish what measures are used to review compliance with the policy
3	**Leaders actively shape the speaking up culture**			
3a	All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	**MET** All senior leaders have fully supported the Trust's vision for speaking up and have shared their ideas at Board meetings.	Continue as present	Continue to work with FTSUG in the promotion of raising concerns

		They also attend staff forums and briefings around cultural changes at ROH and have recently held an 'continuous improvement ideas' event for staff. The Executive team and CEO have recently spent considerable time visiting various departments and have expressed the importance of raising concerns.		
3b	They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	**PARTIALLY MET** The Trust has a 'Perfecting Pathways' programme which creates a vehicle for continuous improvement across the full patient pathway. This includes various patient safety initiatives. The Trust has been praised for its approach to discharging Duty of Candour responsibilities.	The 'Perfecting Pathways' approach will continue to improve patient experience & safety and new initiatives are underway through JointCare to create a shift in the effectiveness of the basic orthopaedic pathway Quality Report to include information on Freedom to Speak Up information from a patient safety perspective	Quality Report
3c	Senior leaders are visible, approachable and use a variety of methods to seek and act on	**PARTIALLY MET** Many of the Executive Team have undertaken back to the Floor visits. Quality Assurance	A structured approach to Back to the Floor is to be developed as part of the leadership development	Back to the Floor exercises are reported as part of the CEO report to the Board and the Quality

	feedback from workers.	walkabout and a Staff Experience walkabout schedule is in place.	programme	& Safety Committee hears the feedback from the Quality Assurance walkabouts by exception; the Staff Experience & OD Committee hears about the Staff Experience walkabout
3d	Senior leaders prioritise speaking up and work in partnership with their FTSUG.	**MET** Support from board when matters are raised has been evident with action taken on several cases FTSUG given the opportunity to attend weekly executive meetings if necessary CEO, exec directors and executive team lead for FTSUG readily available if there is an urgent concern that has been raised. Very good access to board FTSUG has direct and 'open door policy' with executive team lead	Continue to have regular 1:1 sessions with executive team lead for FTSUG	Quarterly report from FTSUG to board on concerns raised and actions taken.

3e	Senior leaders model speaking up by acknowledging mistakes and making improvements.	**MET** There have been issues over the past year concerning reporting on some key targets. The matter was raised to the Board and regulators and corrected	Senior leaders continue to be encouraged to speak up about mistakes identified when needed	The Board takes responsibility for overseeing recovery plans through the work of its committees
3f	The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	**PARTIALLY MET** Number of anonymous cases has declined over the last 12 months, with none reported since November 2017 and there has been an increase in number of cases raised with the FTSUG, highlighting that staff feel they have the confidence and are treated fairly There have been a few cases where individuals have expressed they have suffered detriment as a result of speaking up, but the CEO has asked for further information on this and so feedback forms have since been distributed to individuals with a section of explaining 'why they felt they suffered detriment'	Better triangulation of data from raised concerns across the Trust i.e. contact officers and HR FTSU survey every 6 months	Qualitative feedback from feedback forms to be provided to board every 6 months via email/executive team lead (anonymity maintained) FTSU survey results to be reported to Executive Team lead and board report

4	**Leaders are clear about their role and responsibilities**			
4a	The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	**MET** Named Executive team lead – Simon Grainger- Lloyd Named Non Executive lead – Tim Pile	Continue as present but with more formality around the meetings with the non-executive lead	Continuation of bi-weekly 1:1 with executive team lead and discussions by NED at board meetings
4b	They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	**MET** FTSUG meets with the CEO every 4 months. FTSUG meets with Chair, CEO and all other leaders at Board meetings/committees approximately once every 4 months.	Continue as present	Inform Executive Team lead of all 1:1 meetings and any updates
4c	Other senior leaders support the FTSU Guardian as required.	**MET** Full support from all other senior leaders as and when necessary.	Continue as present	Inform Executive team lead when FTSUG has met with senior leaders
	Leaders are confident that wider concerns are identified and managed			
4d	Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues	**PARTIALLY MET** No systematic ready access provided by senior leaders however information can be	Sharing of data with governance dept (incident reporting) and cases that go directly to HR, with reference to patient safety only.	Annual board report by the FTSUG to include this data also.

	to proactively identify potential concerns.	provided upon request.	Share Quality Report with FTSUG	
4e	The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	**MET** The FTSUG reports directly to the executive team lead for FTSU issues and has alternate weekly 1:1 sessions with an 'open door policy' and direct mobile phone contact in between. The executive team lead will also arrange meetings with the relevant senior leader promptly if a concern raised is of an urgent nature.	Continue as present	Feedback from FTSUG to CEO and board on ease or difficulty of access to board in annual board report
5	**Leaders receive assurance in a variety of forms**			
5a	Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	**PARTIALLY MET** Departmental managers and staff are now vastly aware of the FTSU vision and are aware of the Trusts speaking up process. Core Mandatory training, Junior doctor inductions and team briefs all include information on how to raise concerns internally.	FTSUG to ensure they attend departmental team briefs regularly Survey to ask staff about their awareness of FTSUG role	FTSUG Board report to include information on which departmental team briefs have been attended. Board report to include results from FTSU survey

		There is a clear and concise raising concerns policy and information available on the staff intranet on how to raise concerns. FTSUG has also attended team briefs to explain role of FTSUG.		
5b	Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	**PARTIALLY MET** FTSUG has met with several BAME workers to listen to their concerns if any, around how they feel about the raising concerns process. This information was then cascaded to the Associate Director of HR.	Formal BAME 'feedback sessions' with FTSUG and HR's Head of OD & Inclusion. Presence of senior leader at session	Feedback from FTSUG to Executive Team lead for FTSU Written report FTSUG to Associate Director of HR
5c	Speak up issues that raise immediate patient safety concerns are quickly escalated	**MET** Concerns that require immediate action are escalated without delay with immediate action	Continue as present	Reported in annual Board report
5d	Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	**PARTIALLY MET** Some staff members, shortly after the introduction of the Freedom to Speak Up Guardian's work reported they felt victimised as a result of speaking up and are advised to	Ensure all staff whom feel they have been victimised because of speaking up, can meet with a senior leader to discuss their concerns	Written feedback to be provided to the FTSUG and executive lead for FTSUG regarding action taken from those feeling they have suffered detriment.

		speak with HR or referred to the 'freedom to speak up policy' which provides clarity as to what action to take		
5e	Lessons learnt are shared widely both within relevant service areas and across the trust	**MET** The Trust has set a quality priority for 2018/19 to ensure that lessons learned from incidents, claims and complaints are shared widely Quality Week in December 2018 provided a good focus sharing lessons learned	Better use of the Clinical Audit sessions and other tools to share lessons learned are being considered	Within the monthly Quality Report to the Quality & Safety Committee and the Board lessons learned are detailed.
5f	The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	**NOT MET**	FTSUG to work with HR and West Midlands Guardian network on an appropriate 'audit template'	Audit to be completed every 12 months by FTSUG on patient safety concerns raised and included in the FTSU board report.
5g	FTSU policies and procedures are reviewed and improved using feedback from workers	**PARTIALLY MET** Feedback from staff has been used to further improve the raising concerns process and the FTSU survey has also highlighted that 'lack of feedback' was a cause for	Review and develop policy and procedures in line with minimum standards and FTSU vision and strategy	FTSU Policy and Procedures

		concern. This has since improved but still requires improvement		
5h	The board receives a report, at least every six months, from the FTSU Guardian.	**MET** Board currently receives a report from the FTSUG once a year which is deemed adequate for the size of the Trust. Board is however updated on themes and raised concerns in other committees throughout the year and there are multiple opportunities for the FTSUG to attend Board subcommittees.	Continue as present	Board and committee reports throughout the year
6	**Leaders engage with all relevant stakeholders**			
6a	A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	**PARTIALLY MET** The FTSUG visits all clinical areas and other departments on a rotational basis to ensure all workers have the chance to express their concerns – these concerns are then fed back to the board and any action required, is taken by involving and escalating to the relevant stakeholders. Leaders have also attended 'back to the floor'	Develop a FTSUG vison and plan	Regular updates from the FTSUG to the executive team lead for FTSU

		visits enabling staff the chance to raise concerns directly with themselves.		
6b	Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	**NOT MET** FTSU concerns are reported quarterly to the NGO. The CQC as part of their well-led visit asked for a suite of information about FTSU concerns.	Include FTSU concerns within the Quality Report in future which is then shared with commissioners and is a source of information for NHSI and CQC.	The Board and the Quality & Safety Committee receives the Quality report which will include FTSU concerns
6c	Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	**MET**	FTSUG to report to public board once a year (next time due is January 2019)	Evidenced in public board by a paper and minutes of the Board meeting
6d	The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	**NOT MET**	The Trust's annual report for 2018/19 will contain more detail on FTSU concerns.	The Trust Board receives the Annual Report for approval prior to laying before parliament.
6e	Reviews and audits are shared externally to support improvement elsewhere.	**MET** Met. The detail of FTSU concerns is shared across the region as part of the FTSUG network. The success of the role has been recently shared with one of the local large acute	Systematise the reporting of reviews and audits.	As part of the annual update from the FTSUG the sharing of information region-wide is discussed.

		trusts which has helped embed the role in that organisation.		
6f	Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	**PARTIALLY MET** Not directly – but FTSUG provides feedback from regional meetings and NGO conferences to board and executive lead for FTSU.	Include opportunity for review of NGO Case Studies at committee/ board meetings and include outcomes in quarterly reporting and shared learning systems	Regular written updates from FTSUG to executive lead and board
6g	Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	**MET** FTSUG has 'protected time' to carry out the role and duties required of a FTSUG. The FTSUG is supported to attend all regional and national meetings and has had the opportunity to meet with CQC inspector informally.	Need to arrange for next engagement session with CQC	FTSUG to inform executive team lead if there is little or no encouragement to continue to meet with other guardians and regulators
6h	Senior leaders request external improvement support when required.	**MET** Met. Third party organisations have been regularly asked to assist with improving the operation of the Trust. The STP has also provide expertise in the form of an Interim COO and Interim Director of Finance	Continue as present	Progress with work involving external organisations is shared with the Board as part of its routine agendas. The Interims from the STP are part of the Trust Board and have voting rights.

7	**Leaders are focused on learning and continual improvement**			
7a	Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	**MET** The feedback from the FTSUG is regarded as a valuable source of improvement and has generated changes in various areas as a result.	Continue as present	The Quality & Safety Committee reports upwardly to the Trust Board to share instances where speaking up has generated improvements.
7b	Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	**MET** FTSUG is supported to work with other guardians from other Trusts to identify best practice	Continue to network with other guardians both nationally and regionally and attend all regional and national conferences to ensure the Trust is up to date with 'best practice'	Share/feedback guidance from other guardians to executive team lead.
7c	Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	**PARTIALLY MET** FTSUG has used some of the case reviews to help identify areas for learning and Improving. Issues discussed and explored at regional group	Include opportunity for review at regular meetings and include outcomes in quarterly reporting and shared learning systems	Committee and Board meeting
7d	Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	**MET** The feedback from the FTSUG is embraced as a valuable source of improvement and has generated changes in various areas as a result. The culture of the organisation has changed	Continue as present	The Quality & Safety Committee reports upwardly to the Trust Board to share instances where speaking up has generated improvements.

		over recent months to better embrace a continuous improvement model. Some staff have been trained in QSIR.		
7e	The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	**PARTIALLY MET** A written strategy is not yet in place, however the FTSUG has been set objectives as part of the annual appraisal process which are then monitored and reviewed to establish progress and achievement.	A written strategy is to be developed	The written FTSUG strategy to be developed will be shared with the Trust Board.
7f	The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	**PARTIALLY MET** The Freedom to Speak Up policy is reviewed every three years to ensure it remains current.	Implement an annual review of the Freedom to Speak Up policy.	The Executive Team will be appraised of the policy review as part of the routine monitoring of policies.
7g	A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being	**MET** HR investigations are overseen by a senior individual and overall by the Associate Director of HR to ensure their robustness.	Continue as present Distribution of formal feedback forms	Example cases to be included in the annual FTSUG report. FTSU annual report to Board to include

	measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	Workers are individually thanked by the FTSUG for speaking up when a concern is raised and verbal feedback is provided by the FTSUG throughout the process.		evidence of number of individuals that have expressed they are happy with level of feedback and provided with an outcome
7h	Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	**PARTIALLY MET** Positive cases have been promoted when the FTSUG has been present in team briefs, with true examples given	FTSUG to work with comms team to have a dedicated page on positive outcomes from raised concerns in the Trusts staff magazine and information on this to be shared on staff intranet	Board report
	Individual responsibilities			
8	**Chief executive and chair**			
8a	The chief executive is responsible for appointing the FTSU Guardian.	**NOT MET** The executive lead for FTSU and other stakeholders have	Any future recruitment of FTSUG to involve CEO	Guardian currently in post

		been responsible in appointing the FTSUG to date and the guardian was appointed to a permanent position in Aug 2018.		
8b	The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	**MET** The CEO holds to account the Associate Director of Governance/Company Secretary for the effectiveness of the FTSUG and includes this as a regular part of routine 121s.	Continue as present	The Board will be made aware where there are shortfalls in the delivery of the FTSUG role.
8c	The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	**MET** The CEO and Chairman holds to account the Associate Director of Governance/Company Secretary for ensuring that the FTSUG attend regional and national events	2018/19 annual report will include information about the FTSUG role.	The Board reviews and approves the annual report prior to it being laid before parliament.
8d	The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	**MET** The CEO and Chairman holds to account the Associate Director of Governance/Company Secretary for ensuring that the FTSUG attend regional and national events	Continue as present	Included as part of the annual report to the Board on the activities of the FTSUG

8e	Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	**PARTIALLY MET** FTSUG meets with CEO every 4 months and meets with Chair at board and committee reporting.	FTSUG To meet with Chair every 4 months on a 1:1 basis	Information on how often FTSUG meets with CEO and chair to be reported at public and private board.

9	**Executive lead for FTSU**			
9a	Ensuring they are aware of latest guidance from National Guardian's Office.	**MET** Executive team lead and FTSUG meet every 2 weeks for a formal 1:1 and the FTSUG feeds back any important information and updates from NGO on a regular occurrence.	FTSUG to continue regular 1:1 sessions with executive lead for FTSU	Completion of Self review tool and development plan
9b	Overseeing the creation of the FTSU vision and strategy.	**PARTIALLY MET** Executive team lead for FTSU regularly monitors the work completed by the FTSUG and suggests ideas on how to improve the service and also offers guidance on how to ensure the role is being implemented effectively. FTSU vision and strategy currently under development and to be overseen by Exec Team Lead for FTSU	Executive Team lead to continue to work closely with FTSUG and support the FTSUG as necessary with development of vision and strategy	FTSU Vision and strategy Board and committee reporting.
9c	Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the	**MET** Executive lead for FTSUG is responsible for the recruitment of the FTSUG and has used the current JD and guidance from	Continue as present	FTSUG in post

	National Guardian.	the NGO to recruit a suitable candidate. The process for recruitment was fair, allowing all staff members (clinical and non - clinical) the chance to apply for the permanent position.		
9d	Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	**MET** The FTSUG Has 15 hours protected time to carry out FTSU duties. There is a guardian in place to cover maternity leave for the current FTSUG and this temporary guardian will then act in any other unplanned absence. Staff can also raise concerns in the absence of the guardian through other routes available in the Trust, and details of these can be found in the 'raising concerns policy'	Continue as present	Executive lead to inform Board of any changes
9e	Ensuring that a sample of speaking up cases have been quality assured.	**MET** The Associate Director of Governance/Company Secretary tests the robustness of case handling as part of routine 121s with the FTSUG	Continue as present	The Board will be made aware of the process as part of the annual report to the Board.

9f	Conducting an annual review of the strategy, policy and process.	**NOT MET**	The Associate Director of Governance/Company Secretary has responsibility for policy governance and will ensure that the Speaking Up policy is reviewed annually. The process and strategy will be tested annually as part of the appraisal of the FTSUG.	To be included as part of the annual report to the Board.
9g	Operationalising the learning derived from speaking up issues.	**MET** The learning from the FTSU concerns raised to date has generated investigations and improvement were needed. This is generally within the responsibility of the DoN, the Medical Director or the COO.	Continue as present	The learning will be shared with the Board as part of the routine reports from the FTSUG to the Board and its committees
9h	Ensuring allegations of detriment are promptly and fairly investigated and acted on.	**MET** Some of those reporting concerns have been fearful of reprisal, however no member of staff has reported suffering detriment. Should this be the case then the Associate Director of Governance/Company Secretary would ensure that there is prompt investigation.	Continue as present	The Board would be appraised of any detrimental consequences of speaking up in the private part of its Board agenda.

9i	Providing the board with a variety of assurance about the effectiveness of the trust's strategy, policy and process.	**MET** The Board has been satisfied with the conduct and effectiveness of the current FTSUG policy and processes. This has been minotored closely as the Acting FTSUG took up post in September 2018.	Continue as present	The Board receives a routine update from the FTSUG which assesses performance against the policy and process
10	**Non-executive lead for FTSU**			
10a	Ensuring they are aware of latest guidance from National Guardian's Office.	**NOT MET**	The NED lead for the FTSUG will need to be linked into the national requirements for the FTSUG role and responsibilities.	Commentary from the NED lead will be invited as part of the routine reports to the Board.
10b	Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	**PARTIALLY MET** The NED lead has had meetings with the FTSUG as has the Audit Committee chair, although these need to be systematised.	Create a schedule of meetings with the NED lead	The NED lead will report to the Board on when he has met with the FTSUG.
10c	Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	**MET** The NED lead also chairs the Finance & Performance Committee and regularly challenges the Executive to focus on continuous improvement and	Continue as present	Upward assurance reports to the Trust Board which detail the challenges made.

		implementation of learning		
10d	Role-modelling high standards of conduct around FTSU.	**PARTIALLY MET** Non executives are required to abide by the values of the Trust including openness	Engage the NED FTSU lead on the launch of the strategy.	The NED lead will report to the Board on his engagement with launching the FTSU strategy.
10e	Acting as an alternative source of advice and support for the FTSU Guardian.	**PARTIALLY MET** The NED lead has had meetings with the FTSUG as has the Audit Committee chair, although these need to be systematised..	Create a schedule of meetings with the NED lead	The NED lead will report to the Board on when he has met with the FTSUG.
10f	Overseeing speaking up concerns regarding board members.	**MET** The NED lead has had occasion during his tenure to oversee a concern raised against a senior officer	Continue as present	The Board was kept in the loop about the progress with the investigation and key findings.
11	**Human resource and organisational development directors**			
11a	Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as	**MET** The FTSUG has routine access to the Trust's Head of OD & Inclusion, who oversees the Trust's FFT quarterly return and National Staff Survey.	Continue as present	The FTSUG will report on key relationships and triangulation of information as part of the annual report to the Trust Board.

	measures of FTSU culture or indicators of barriers to speaking up.			
11b	Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	**MET** The HR team has launched a 'Speak Up and Join In' brand which aims to encourage staff to raise ideas and drive continuous improvement	Continue as present	The Trust Board's Staff Experience & OD Committee is routinely appraised of the effectiveness of the 'Speak Up and Join In' campaign
11c	Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	**PARTIALLY MET** The Trust's culture regarding speaking up is improving.	Further embedding of the 'Speak Up and Join In' concept and the 'Even Better If…' notion	The Trust Board's Staff Experience & OD Committee is routinely appraised of the effectiveness of the 'Speak Up and Join In' campaign.
12	**Medical director and director of nursing**			
12a	Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	**PARTIALLY MET** The FTSUG has open access to the Director of Nursing & Clinical Governance and the Medical Director.	Formalise the relationship between the FTSUG and the Trust's Safeguarding Lead'	The Director of Nursing & Clinical Governance and the Medical Director will contribute to the discussions around the effectiveness of the FTSUG at Board

				meetings, highlighting their relationship and action taken as a result of the concerns raised.
12b	Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	**MET** During recent concerns raised, there has been a rapid meeting with the Director of Nursing & Clinical Governance and an Associate Medical Director who have investigated the concerns without delay.	Continue as present	The Director of Nursing & Clinical Governance and the Medical Director will highlight the action they took when concerns were raised at either the Board or committee meetings.
12c	Ensuring learning is operationalised within the teams and departments that they oversee.	**MET** The Trust makes use of the Clinical Audit sessions to share lessons learned and the Trust has set a quality indicator for 2018/19 to ensure that lessons are learned from incidents, claims and complaints	Continued systematising the sharing of learning	The Board reviews the quality account and progress with the quality indicators.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board last met: 28 November 2018 (formal meeting) and 28 December 2018 (assurance call)

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was highlighted that there had been a national shortfall in the availability of the Hepatitis B vaccination for two years, however the situation had now been resolved. Work was underway to ensure that all frontline staff at the ROH that needed to be vaccinated would be recalled to receive their immunisation.
- There was an increased risk around staffing in the clinical governance team due to delays in recruitment processes, which impacted on the delivery of the usual suite of work, including 'Learning from Deaths' reviews.
- The Committee received an update on the outcome of the recent inspection by the Human Tissue Authority (HTA); although the Trust retained its licence, a number of shortfalls against the standards had been identified which needed to be addressed. An action plan to address these was received.
- The quality & safety assurance walkabout to Outpatients had generated an 'Inadequate' rating; the remedial action plan would be monitored by the Clinical Quality Group.
- It was reported that there had not been adequate attendance by the Estates and Facilities representatives at the Infection Control meeting, which had meant that the water safety update had not been presented.
- There had been a patient death, which was recorded within 48 hours of discharge. The matter had been referred to the Coroner who did not plan to organise an inquest. *

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Provide the detail of the new claims at future meetings, including whether they could be triangulated to a complaint received.
- Present the plan to reduce outpatient DNAs at the next meeting.
- Add an entry to the Corporate Risk Register to reflect the risk around non-conformity with the HTA licence.
- Present the plans for Pathology services at the next meeting.
- Revise the risk scoring of the water safety entry on the Corporate Risk Register.
- An update on consent was reported to be required for the Committee in February 2019.
- Present the 'bible' of policies to govern water safety at the May 2019 meeting
- Update on Health Assure would be considered at the next meeting.*

POSITIVE ASSURANCES TO PROVIDE

- It was reported that work was underway to benchmark the ROH against the NHS Improvement patient experience standards and the outcome of this would be presented in January 2019.
- A new incident management policy had been developed had been

DECISIONS MADE

- Remit the discussion around 'time to recruit' to the Staff Experience & OD Committee.

launched.

- A Quality Week was scheduled for December, which focussed on shared learning in particular.
- There had been no Serious Incidents reported in October.
- The Committee received an update on the plans to strengthen the arrangements around acute pain management.
- The level of interruptions during the 'Stop Before You Block' process was noted to reduced considerably.
- The annual report from the Director of Infection Prevention and Control was received.
- An update from the Water Safety Group was received which described the work being done to gain full compliance with water safety regulations. This included the creation of a water safety 'bible'. The Committee was assured that the Trust was operating safely despite the outstanding work to achieve full compliance.
- Good progress was reported on the delivery of the CQC action plan.
- The number of falls had reduced. Three were noted to be on Ward 3, therefore this incidence would be reviewed. *
- A new patient experience group would be set up shortly and consider complaints that were received. *

Chair's comments on the effectiveness of the meeting: The meeting had overrun however this reflected the detailed level of discussion needed around some of the key items.

Items marked with * were discussed at the assurance briefing call on 28 December 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

December 2018

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
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.

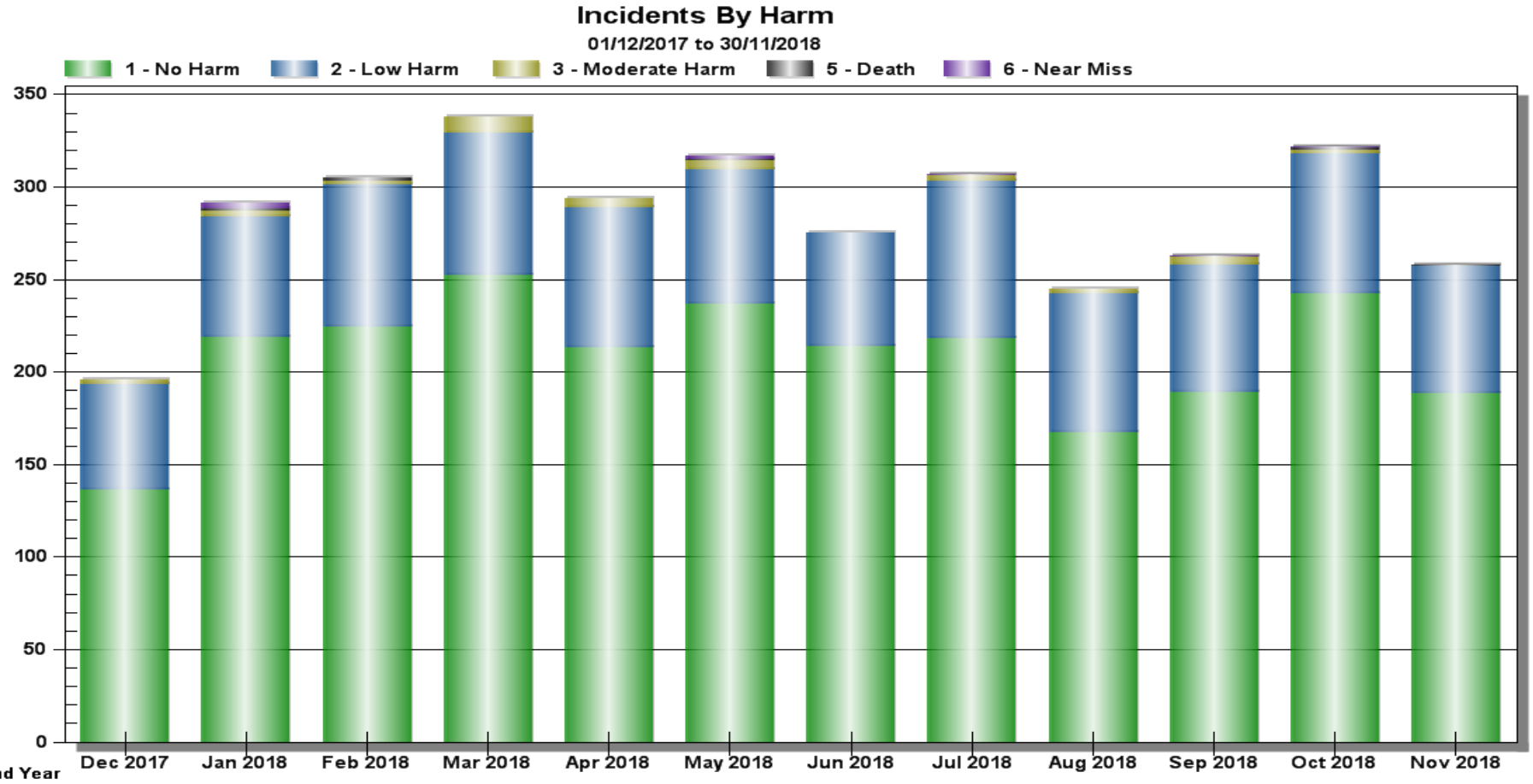
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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.

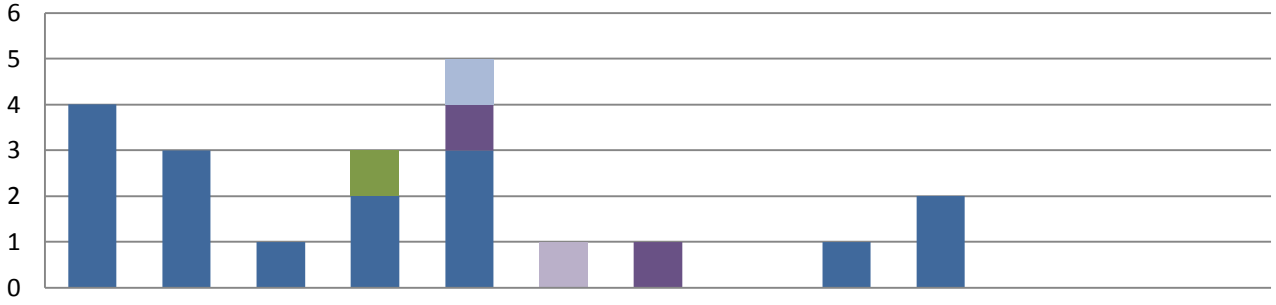


Month and Year	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018
1 - No Harm	136	219	224	252	213	237	214	218	167	189	242	188
2 - Low Harm	57	65	77	77	76	72	61	85	75	69	76	69
3 - Moderate Harm	3	3	2	9	5	5	0	3	3	4	2	0
5 - Death	0	1	2	0	0	1	0	0	0	0	1	1
6 - Near Miss	0	3	0	0	0	2	0	1	0	1	1	0

INFORMATION
In November 2018, there were a total of 258 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows; 188 – No Harm 69 – Low Harm 0 – Moderate Harms 0 – Severe Harm 0 – Near Miss 1 – Death In November 2018, there were a total of 9831 patient contacts. There were 258 incidents reported, which amounts to 2.62 per cent of the total patient contacts resulting in an incident. Of those 258 reported incidents, 80 incidents resulted in harm which is 0.71 per cent of the total patient contact.
ACTIONS FOR IMPROVEMENTS / LEARNING
Quality week was undertaken in the week commencing 4th December with a focus of learning from incidents.
RISKS / ISSUES
The risk added to the risk register regarding the staffing levels within the Governance team has been increased from a 8 risk score to a 12 risk score. The Governance team currently have 1 WTE vacancy, 1 WTE member of staff on maternity leave and 1 WTE member of staff on sick.

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.

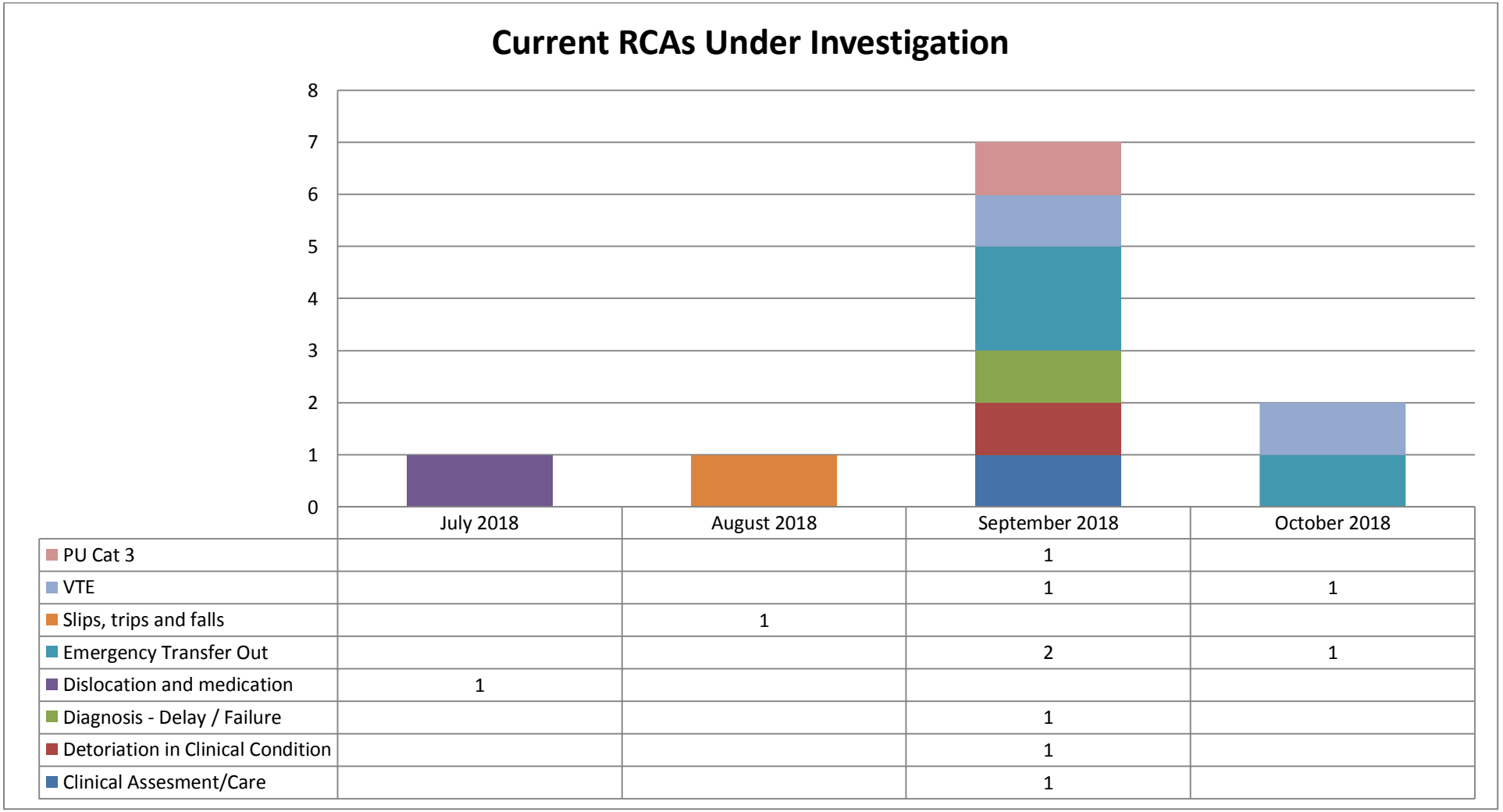
Serious Incidents Declared Year to Date to November 2018



	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Transfer out						1							
Unexpected Injury													
RTT Harm review													
Information Governance Missing Laptop					1								
Retained object													
Wrong side injection													
Slips, trips & falls					1		1						
Pressure Ulcers				1									
VTE meeting SI criteria	4	3	1	2	3				1	2			

INFORMATION
Three Serious Incidents were declared in November 2018; It has been agreed with the CCG that all avoidable VTEs will be declared as Serious Incidents. After investigation three VTEs previously declared were deemed as avoidable. These have now been declared with the commissioners as serious incidents.
ACTIONS FOR IMPROVEMENTS / LEARNING
No Serious Incidents were closed in November 2018.
RISKS / ISSUES
None

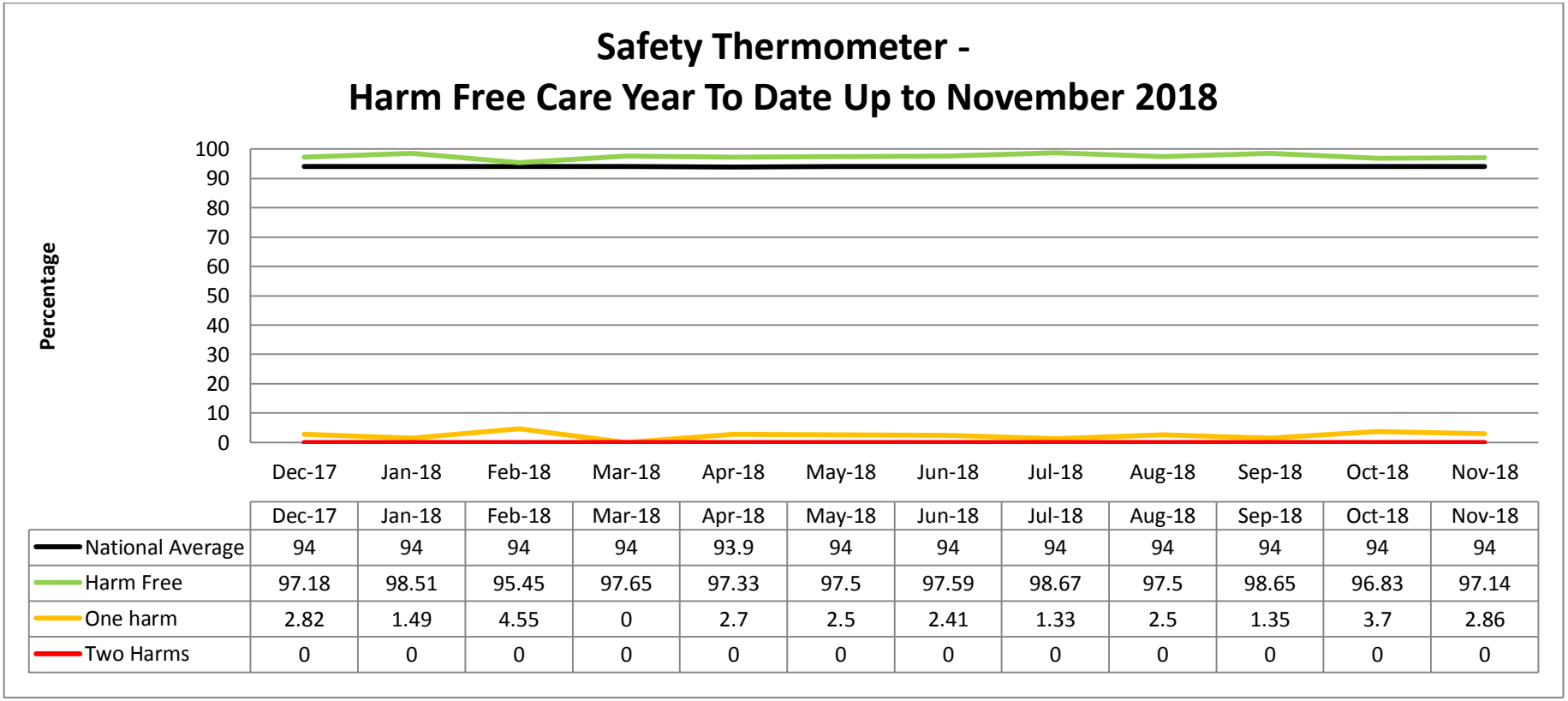
4. Internal RCA's - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision that a heightened level of response is needed for these incidents.



	July 2018	August 2018	September 2018	October 2018
PU Cat 3			1	
VTE			1	1
Slips, trips and falls		1		
Emergency Transfer Out			2	1
Dislocation and medication	1			
Diagnosis - Delay / Failure			1	
Detoriation in Clinical Condition			1	
Clinical Assesment/Care			1	

INFORMATION
One incident reported in November 2018 will be undertaken as an internal RCA; This was reported in November 2018 Quality Report. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.
ACTIONS FOR IMPROVEMENTS / LEARNING
One RCA was closed in November 2018 – the detail has been provided to the Quality & safety Committee**.**
RISKS / ISSUES
None

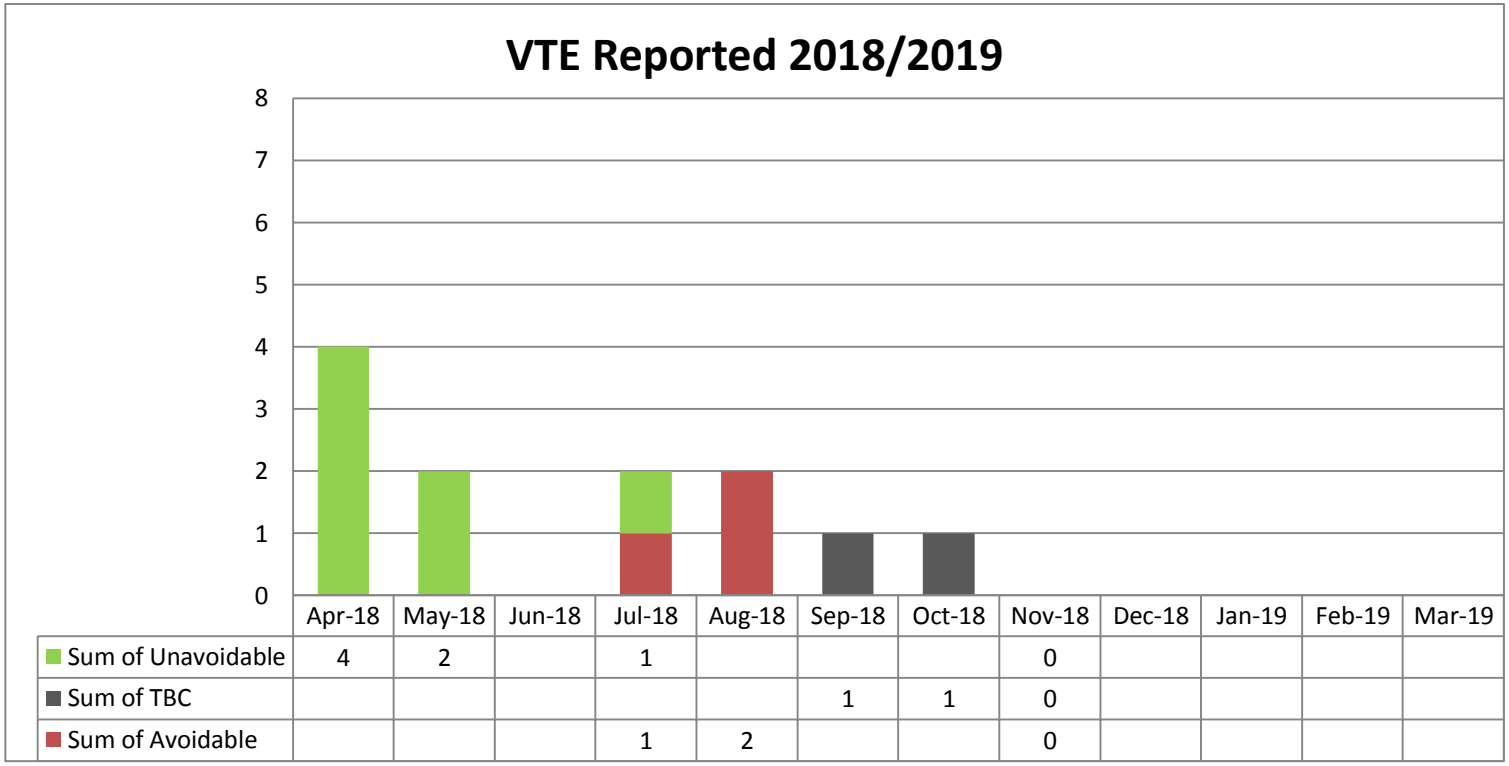
5. **NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
National Average	94	94	94	94	93.9	94	94	94	94	94	94	94
Harm Free	97.18	98.51	95.45	97.65	97.33	97.5	97.59	98.67	97.5	98.65	96.83	97.14
One harm	2.82	1.49	4.55	0	2.7	2.5	2.41	1.33	2.5	1.35	3.7	2.86
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The 3 harms recorded on the Safety Thermometer audit were;
1 x old Pressure Ulcer on Ward 3
1 x old DVT on Ward 3

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called 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).**



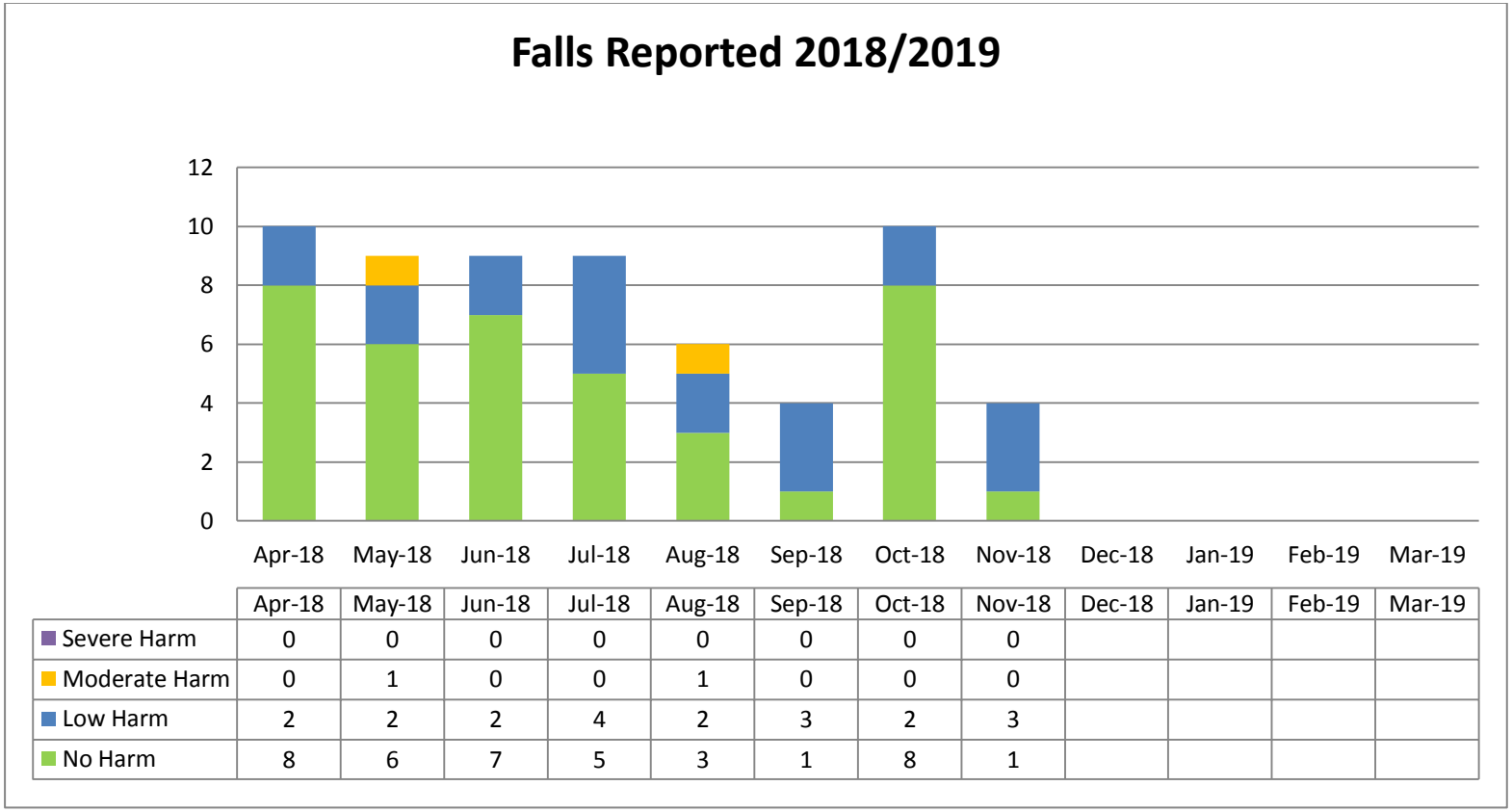
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	4	2		1				0				
Sum of TBC						1	1	0				
Sum of Avoidable				1	2			0				

11

total		Avoidable
17/18	33	10
18/19	12	3

INFORMATION
There was no VTE incidents reported in November 2018. This is compared to the 4 reported in November 2018. All avoidable VTE's are now reportable again to CCG. Themes in those deemed avoidable to date are BMI >30, omitted enoxaparin dose post-operative, lack of documented 24 hour re-assessment. Action plans are in place for all.
ACTIONS FOR IMPROVEMENTS / LEARNING
VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement of 95%): Compliance for November: 97.4%. IMT are now able to provide data on which patients did not have a VTE risk assessment completed. This information is being followed up with teams in order to progress to 100% compliance. It has been identified that those being missed are patients who do not need any medications prescribed, e.g. day case patients, as this results in the mandatory VTE completion field not being triggered. This will continue to be closely monitored. **NICE VTE Prevention Guidance –Updated March 2018** Medical VTE lead is going to attend December CSL meeting to discuss the updated standards and attempt to gain consensus regarding any changes. The VTE Exemplar network has surveyed members, which includes us, to establish how and if guidance has been implemented. Very few Trusts have made any changes; the majority are not planning to change from the previous guidance or are in the same position as us at present. There is no risk to patients as a result of continuing to follow 2010 guidance until a consensus is reached.
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-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	0	0				
Moderate Harm	0	1	0	0	1	0	0	0				
Low Harm	2	2	2	4	2	3	2	3				
No Harm	8	6	7	5	3	1	8	1				

total	
17/18	125
18/19	61

INFORMATION

There were 4 patient fall-related incidents reported across the Trust in November all were related to adult patients. This is a significant decrease in the number in October which saw 10 falls in month. October's figures were abnormally high and it is reassuring that this month the figures have returned to an expected number. 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 October falls incidents were reviewed at the Falls Working group meeting on 5th December 2018 and were scrutinised for appropriateness of prevention and actions following the fall. 1 incident was agreed 9 have been returned to the ward managers for further review.

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.

4 falls were reported in November.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions Underway

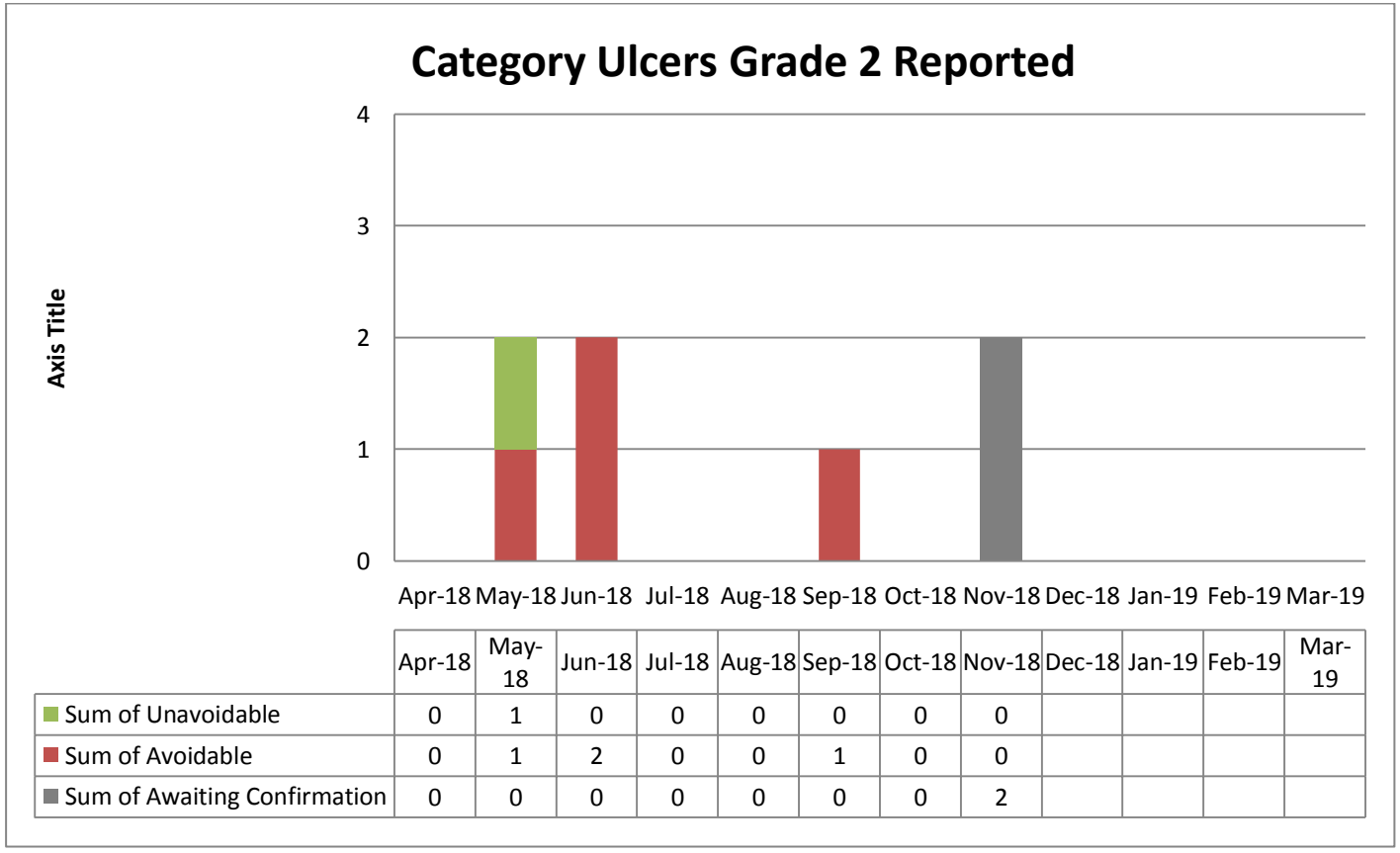
- Falls lead has left Trust, and a new lead has been identified by the Deputy Director of Nursing and will commence on 31.12.18
- Purchase of another Hover Jack, to be considered next year- plan to submit a capital bid
- Trust wide replacement of hoists delayed as funding is not in place. Additionally due to the size of the capital bid this will need to go out to tender rather that proceed with current supplier which was the original plan.

Positive Assurance

- Falls policy revised and updated
- Staff training on the use of manual handling equipment such as Sara steady.
- Clinical skills update day reinstated to be delivered annually.
- Template for Medical review post fall
- Benchmarking of the WMQRS

Risk register reviewed by falls working group 5.12.18 and updated. All October incident reviewed and discussed at falls working group 5.12.18
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 financial year.

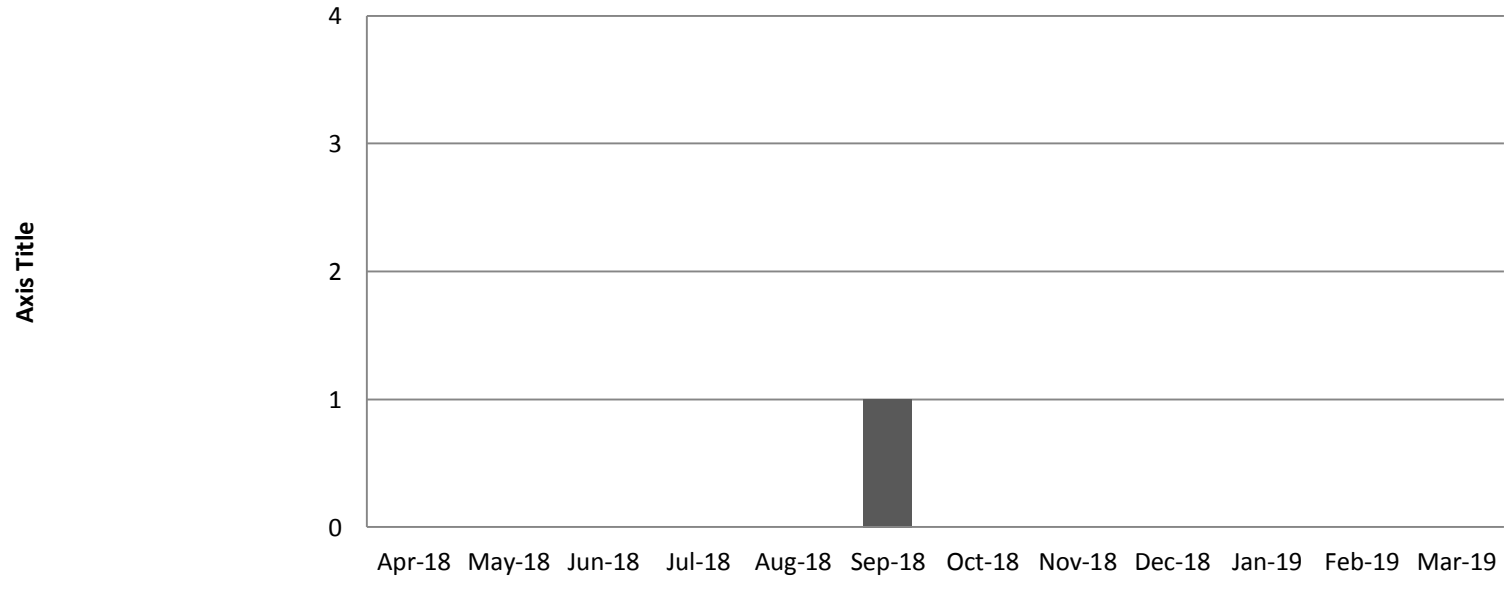
8. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open 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	0	0				
Sum of Avoidable	0	1	2	0	0	1	0	0				
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	2				

total	Avoidable
17/18	6
18/19	4

Category 3 and 4 Pressure Ulcers Reported



	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	0	0				
Unavoidable G4	0	0	0	0	0	0	0	0				
Unavoidable G3	0	0	0	0	0	0	0	0				
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0				
Grade 3 (Avoidable)	0	0	0	0	0	0	0	0				

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

INFORMATION

In November 2018, there were no pressure ulcers recorded. This compares to the two Category 3's reported in November 2017.

November 2018- Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	1
Category – 2 (Device)	Medical Device Related PU's (MDPRU) = 1 – not yet determined if avoidable or unavoidable (26026).
Category – 1	1 MDRPU
Suspected Deep Tissue Injury	2 - both resolved
Moisture Associated Skin Damage (MASD)	1 natal cleft
Patients admitted with PU's	Category 3 MDRPU = 1

Avoidable Pressure Ulcer CCG Contracts KPI

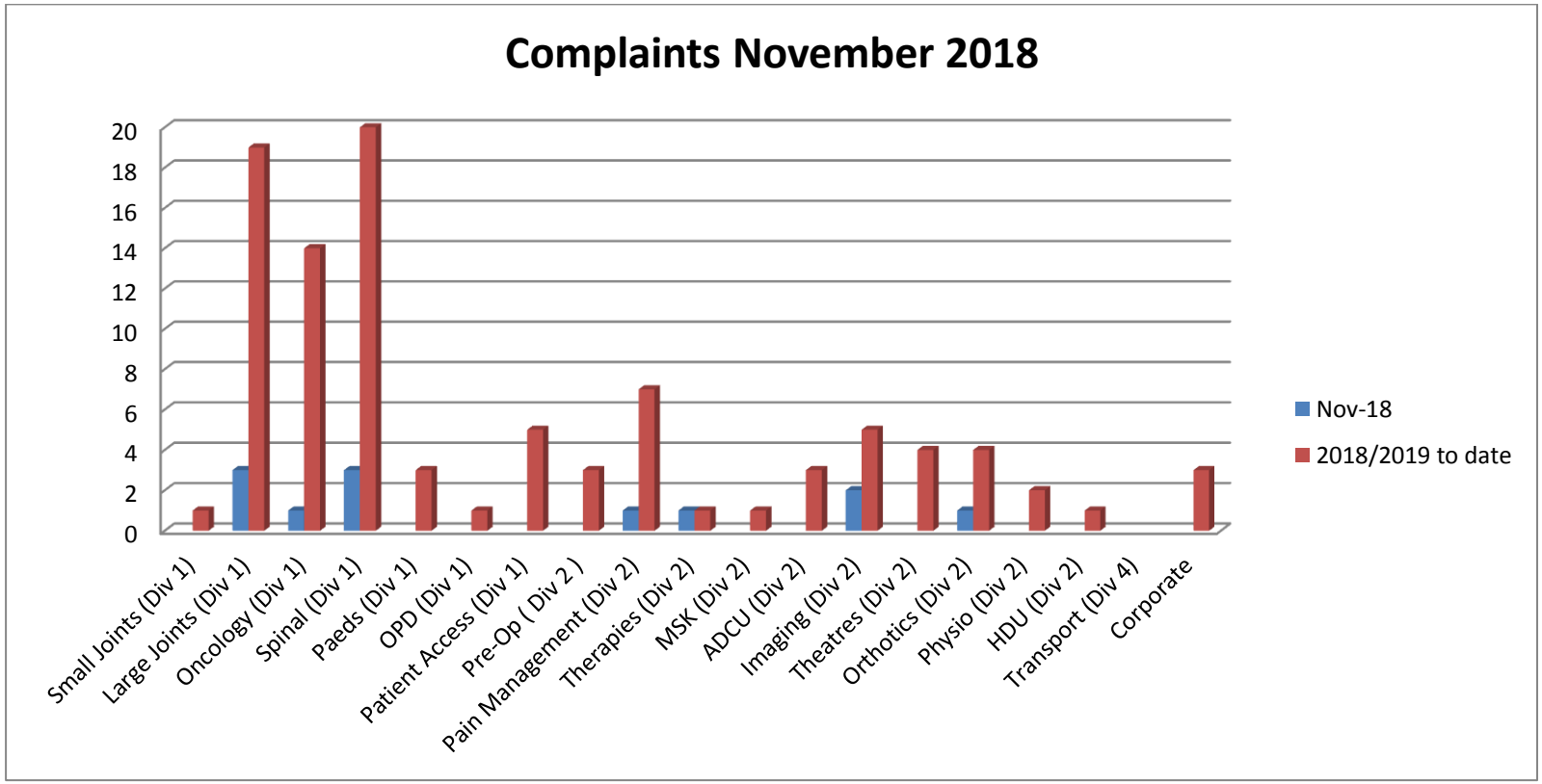
2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	4
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2017/2018:

2017/2018	
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, and Admission to HDU or Ward and include a SKIN bundle encompassing a care and comfort type of repositioning chart.. 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
None

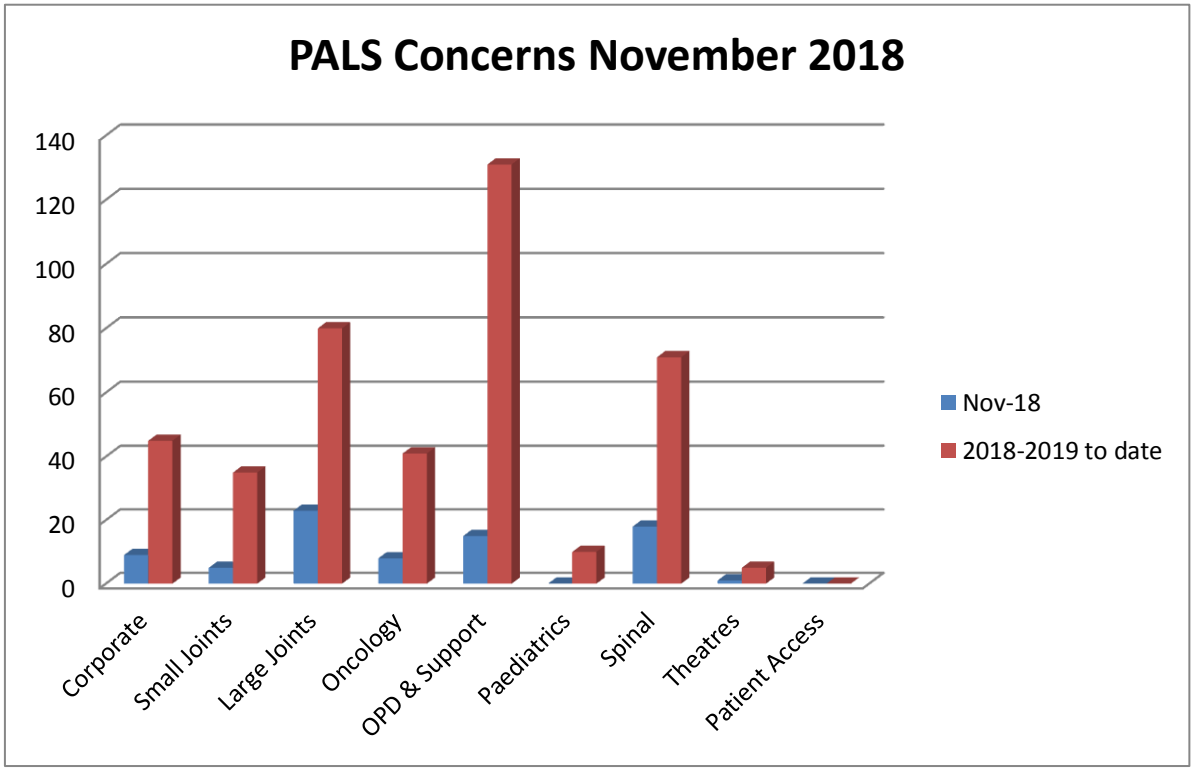
9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



INFORMATION

PALS

The PALS department handled 116 contacts during November 2018 of which 79 were classified as concerns. This is a significant reduction in calls compared to the same time last year (442 contacts in November 2017) and significantly fewer concerns (102 concerns in November 2017). The main themes in the PALS data relate to queries about appointments; length of wait or repeated cancellations. 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 87% of concerns were handled within the agreed timescales, meeting this internal KPI



Compliments

There were 546 compliments recorded in November 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 12 formal complaints made in November 2018, bringing the total number of complaint to 97 for the year to date. All were initially risk rated rest amber or yellow. This is higher than last year (9 complaints in November 2017)

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Approach of x-ray staff (Div.2, Imaging)
- Outcome of surgery (Div.1, Large Joints)

Initially Risk Rated Yellow:

- clinical opinion and treatment plan (Div.1, Spinal)
- clinical opinion and approach of clinician (Div.1, Large Joints)
- different opinions and treatments in physio (Div.2, Physio)
- wait for pain management appt (Div.2, Pain Management)
- progression of treatment (Div.1, Large Joint)
- wait for surgery (Div.1, Spinal)
- awaiting letter for 2nd opinion - not done (Div.1, Oncology)
- approach of clinician (Div.2, Orthotics)

- treatment during biopsy (Div.1, Oncology)

approach of clinician (Div.1, Spinal)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 10 complaints closed in November 2018, 9 of which were closed within the agreed timescales. This gives a 90% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in November 2018 was 29 days which is within normal limits.

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

- Escalation process for concerns about biopsy patients to their Consultant was not robust
  Action: All biopsy patients now see the on call Doctor before discharge

- Agency nurse attempted a potentially unsafe drug route on a patient
  Action: Agency nurse suspended immediately and investigated. PICS access withdrawn until outcome known

- Policy for discharging DNA patients is being applied differently in different departments
  Action: Teams have been reminded of current policy and Clinical Service Manager for Patient Access informed

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

0 comebacks were received in November 2018.

10. 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 November 2018, 10 concerns were identified from the 2383 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 November 2018 were Values & Behaviours, Patient Care and Communication. 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 and the internal 40% target. The internally set target of 20% for Outpatient services was also met this month. 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 Nov 2018**	**% of people who would NOT recommend the department in Nov 2018**	**Number of Reviews submitted in Nov 2018 (previous month in brackets)**	**Number of Individuals who used the Department in Nov 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	97.1%	0.0%	68 (75)	121	56.2%
Ward 2	88.7%	4.8%	62 (82)	145	42.8%
Ward 3	89.7%	0.0%	39 (16)	90	43.3%
Ward 12	98.1%	0.0%	53(47)	85	62.4%
Ward 11 (CYP)	89.8%	0.5%	60(115)	77	78%
ADCU	97.4%	0.7%	268(196)	601	44.6%
HDU	95.1%	0.0%	41(24)	72	56.9%
CYP HDU	100.0%	0.0%	7 (2)	14	50.0%
Overall Trust Inpatient Response Rate for November 2018					51.0%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Nov 2018**	**% of people who would NOT recommend the department in Nov 2018**	**Number of Reviews submitted in Nov 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	98.3%	0.3%	1445 (1212)	21.1%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Nov 2018**	**% of people who would NOT recommend the department in Nov 2018**	**Number of Reviews submitted in Nov 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	98.2%	0.0%	57 (49)	67.1%

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 November - 30 November

Your average score for all questions this period

1 2 3 4 5 **4.86**

Reviews this period

2383

Your recommend scores

5 Star Score

4.84

% Likely to recommend

96.4%

% Unlikely to recommend

0.5%

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 11 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

1 new claim against the Trust was received in November 2018.

Claim relates to death of patient following a fall on the ward.

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*

3 new requests for Pre-Application Disclosure of medical records were received in November 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 Inquests

There were no Inquests held in November 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; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases =839 The total WHO compliance for Theatres October 2018 = **100%** **CT area** Total cases = 90 The total WHO compliance for CT area October 2018 **= 100%** **ADCU** The total WHO compliance for ADCU area for October = **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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in November 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)	0	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

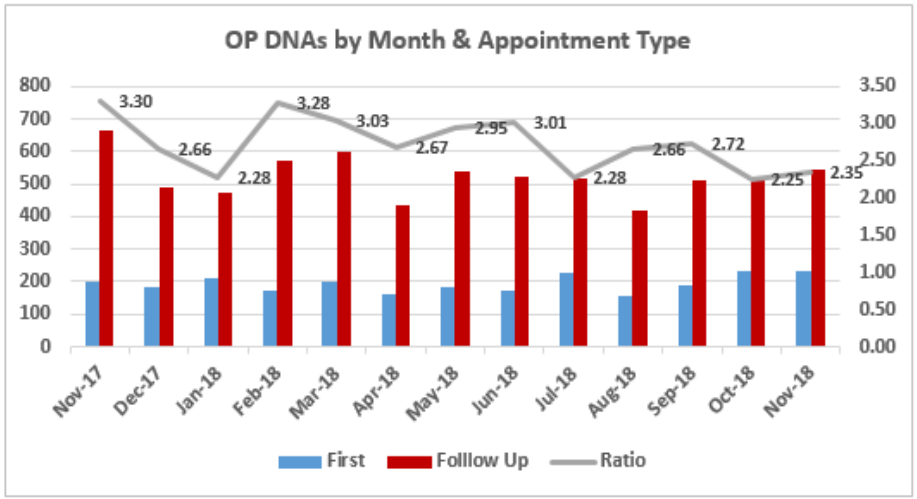
ACTIONS FOR IMPROVEMENTS / LEARNING

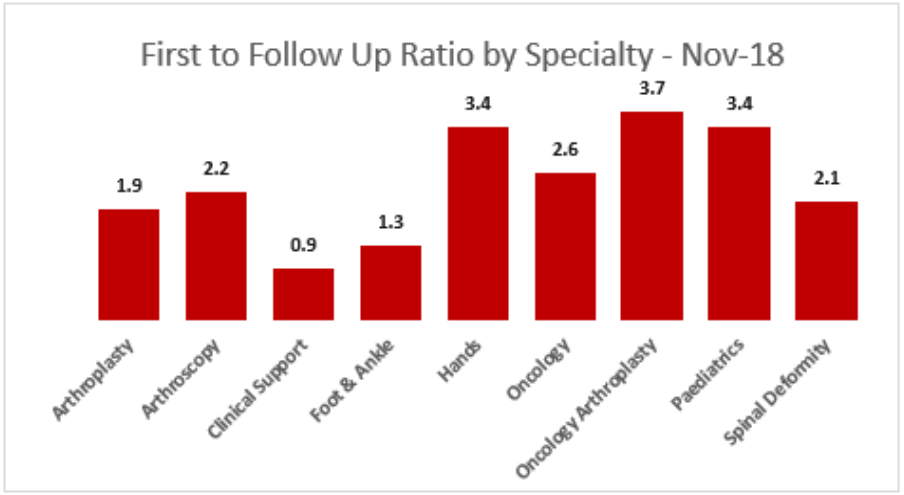
7 IP recorded incidents in November

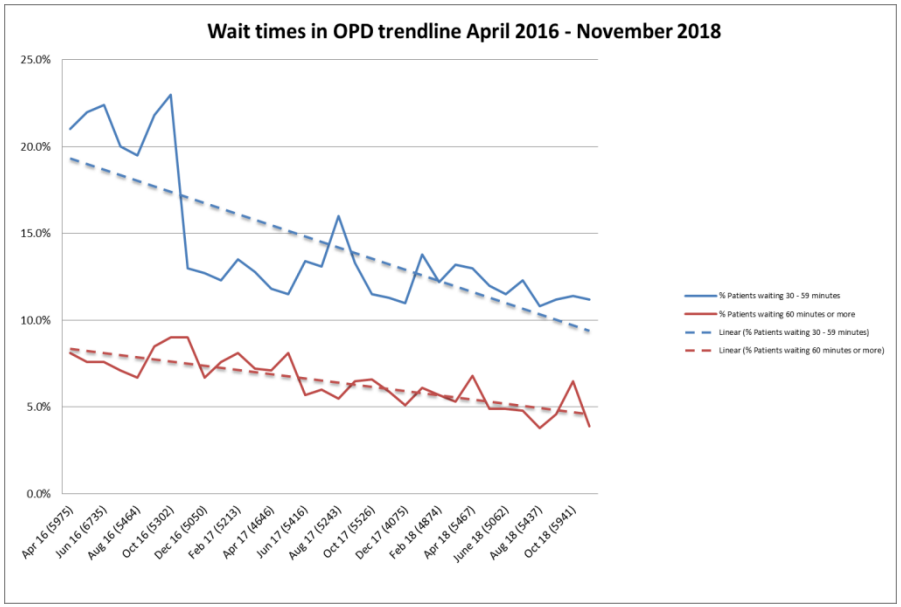
RISKS / ISSUES

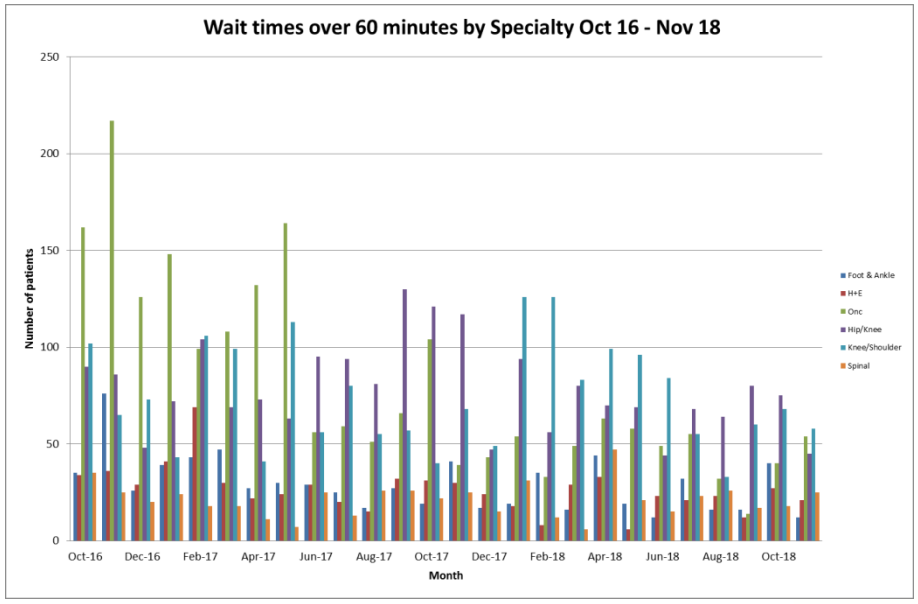
ROH is presently awaiting a position statement from Occupational Health regarding the re-calling of staff for Hepatitis B vaccinations. This is being led by HR who manage the agreed service for ROH.

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









INFORMATION

In November there were only 3 incident forms completed to highlight clinics running more than 60 minutes late. This is a very low number and investigations should take place and reaffirm the importance of reporting these incidents.

There were 11.2% of patients waiting over 30 minutes and 3.9% waiting over 1 hour which is below the target of 5%. Both of these metrics have improved since last month however the target for 30 minute delays has still not been achieved. Positively this is the 7th month out of the last 8 that the over 60 minute target has been achieved. The largest number of incidents were reported in Knee / Shoulder and Oncology specialties whereas last month this was Hip and Knee rather than Oncology.

The monthly audit identified the following categories of incident: -

2 – Clinic Overbooked
1 – X-ray delays

Work is underway to begin to collect information about daily room allocations within outpatients. With this information and activity data it will be possible to review clinic utilisation.

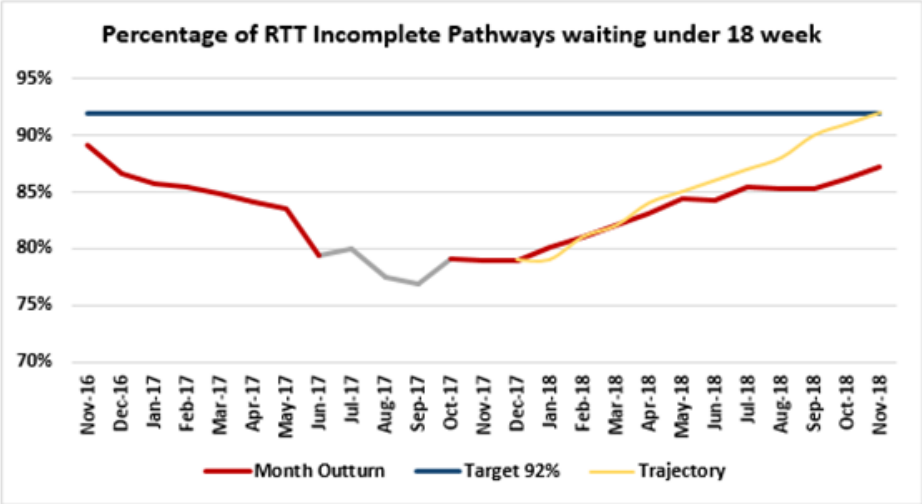
New nursing staff have commenced in recent weeks and there may have been a reduction in reporting because of this. The Matron for outpatients will reiterate the importance of reporting all incidents relating to clinic delays

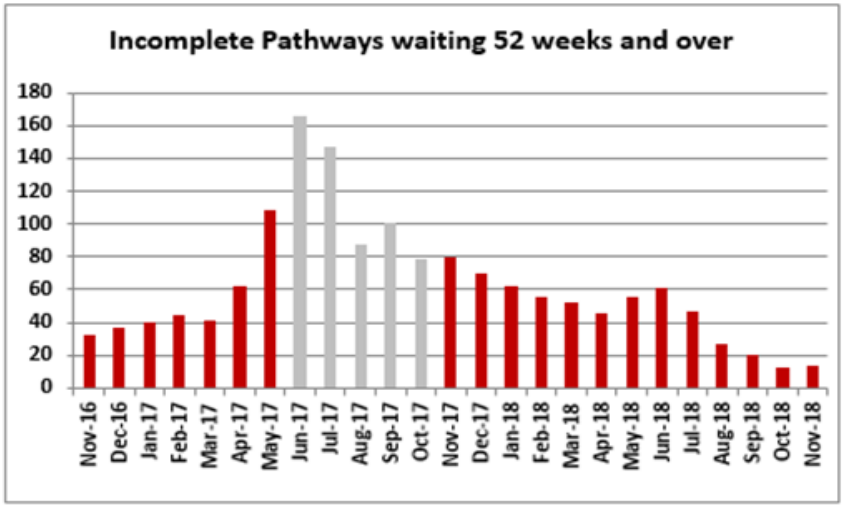
ACTIONS FOR IMPROVEMENTS / LEARNING

- Reiterate the importance of submitting incident forms with the staff
- Commence a weekly 6-3-2 meeting to discuss activity for future weeks, avoiding overbookings and identifying additional clinic rooms available
- Begin to collect room occupancy data
- Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available
- Investigation of partial booking processes to reduce clinic rescheduling and overbooking

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. The engagement with other Trusts to consider the implementation of partial booking processes

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



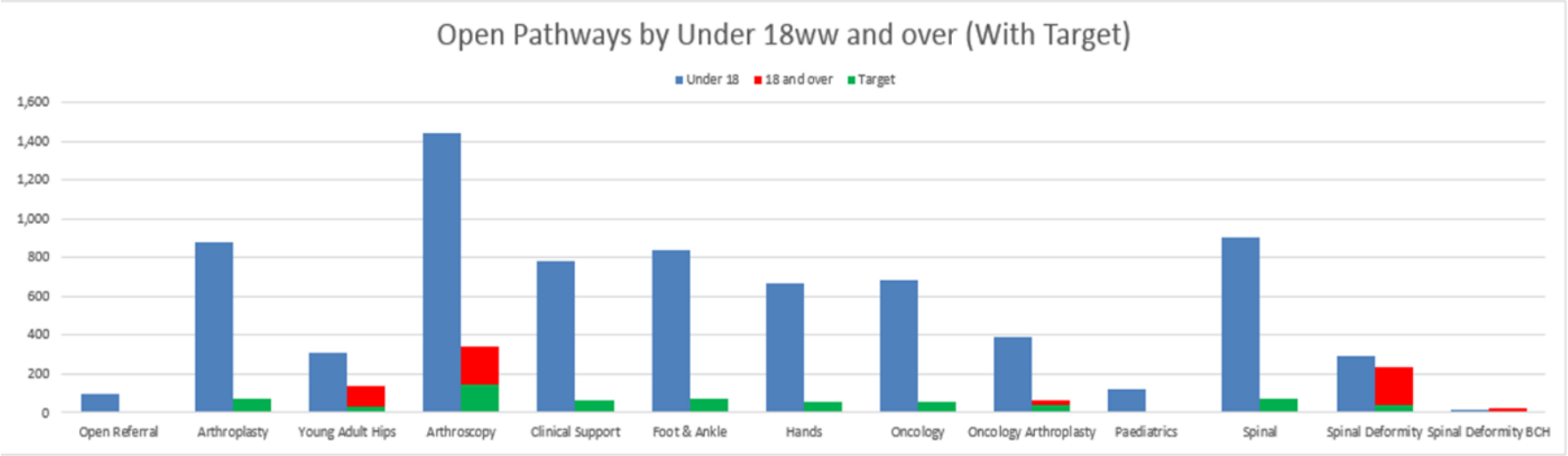


		Indicative	Reported Month							Reported Quarter		Reported Quarter 2017/18			
Target Name	National Standard	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q2 (July, August, Sept)	Q1 (Apr, May, June)	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	*98.2%*	100%	100%	100%	100%	100%	98%	98%	100%	99%	97%	98%	99%	98%
31 day first treatment	96%	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*100%*	100%	100%	100%	100%	100%	100%	90%	100%	97%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	*54.5%*	100.0%	62.5%	57.1%	90%	89%	90%	67%	70%	82%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	*90%*	88.9%	77.8%	100%	100%	83.30%	100%	100%	93%	94%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1		1			1		100%						

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	**3,828**	77	470	152	673	431	393	362	361	207	72	480	140	10
7-13	**2,612**	10	300	116	532	271	345	202	215	135	40	336	106	4
14-17	**984**	7	107	43	238	79	100	101	105	53	12	92	45	2
18-26	**771**	10	49	93	244	36	44	39	26	50	2	38	135	5
27-39	**262**	0	7	36	90	9	8	5	4	15	0	4	73	11
40-47	**33**	0	0	7	4	0	0	0	0	0	0	0	19	3
48-51	**6**	0	0	0	0	0	0	0	0	0	0	0	3	3
52 weeks and over	**14**	0	0	0	0	0	0	0	0	0	0	1	7	6
Total	**8,510**	104	933	447	1,781	826	890	709	711	460	126	951	528	44

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	**7,424**	94	877	311	1,443	781	838	665	681	395	124	908	291	16
18 and over	**1,086**	10	56	136	338	45	52	44	30	65	2	43	237	28
Target	**681**	**8**	**75**	**36**	**142**	**66**	**71**	**57**	**57**	**37**	**10**	**76**	**42**	**4**

	87.24%	90.38%	94.00%	69.57%	81.02%	94.55%	94.16%	93.79%	95.78%	85.87%	98.41%	95.48%	55.11%	36.36%



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	**926**	0	153	52	190	54	44	113	96	60	32	98	25	9
7-13	**824**	0	163	49	195	41	49	84	37	61	18	104	22	1
14-17	**378**	0	60	20	122	12	22	44	19	28	6	39	4	2
18-26	**348**	1	34	28	147	8	16	21	15	29	2	14	28	5
27-39	**159**	0	7	17	66	2	3	4	2	10	0	4	34	10
40-47	**24**	0	0	5	1	0	0	0	0	0	0	0	16	2
48-51	**5**	0	0	0	0	0	0	0	0	0	0	0	2	3
52 weeks and over	**12**	0	0	0	0	0	0	0	0	0	0	0	6	6
Total	**2,676**	1	417	171	721	117	134	266	169	188	58	259	137	38

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	**2,128**	0	376	121	507	107	115	241	152	149	56	241	51	12
18 and over	**548**	1	41	50	214	10	19	25	17	39	2	18	86	26
Target	**214**	**0**	**33**	**14**	**58**	**9**	**11**	**21**	**14**	**15**	**5**	**21**	**11**	**3**
	79.52%	**0.00%**	**90.17%**	**70.76%**	**70.32%**	**91.45%**	**85.82%**	**90.60%**	**89.94%**	**79.26%**	**96.55%**	**93.05%**	**37.23%**	**31.58%**

Select Pathway Type: Non-Admit

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	**2,902**	77	317	100	483	377	349	249	265	147	40	382	115	1
7-13	**1,788**	10	137	67	337	230	296	118	178	74	22	232	84	3
14-17	**606**	7	47	23	116	67	78	57	86	25	6	53	41	0
18-26	**423**	9	15	65	97	28	28	18	11	21	0	24	107	0
27-39	**103**	0	0	19	24	7	5	1	2	5	0	0	39	1
40-47	**9**	0	0	2	3	0	0	0	0	0	0	0	3	1
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	1	1	0
Total	**5,834**	103	516	276	1,060	709	756	443	542	272	68	692	391	6

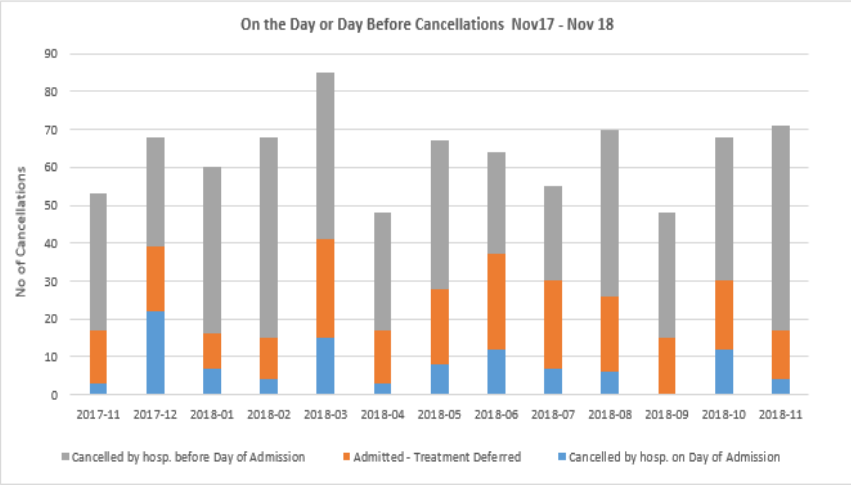
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,296**	94	501	190	936	674	723	424	529	246	68	667	240	4
18 and over	**538**	9	15	86	124	35	33	19	13	26	0	25	151	2
Target	**467**	**8**	**41**	**22**	**85**	**57**	**60**	**35**	**43**	**22**	**5**	**55**	**31**	**0**
	90.78%	**91.26%**	**97.09%**	**68.84%**	**88.30%**	**95.06%**	**95.63%**	**95.71%**	**97.60%**	**90.44%**	**100.00%**	**96.39%**	**61.38%**	**66.67%**

INFORMATION
The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. Trajectories had been developed for all specialties and were submitted to NHSI with a return to overall RTT compliance (92%) by November 2018. Given the challenges still remaining in some specialties the Trust will not meet 92% in November 2018. A revised trajectory will be submitted by the end of December 2018 to NHSI confirming when the Trust will return to 92%. The November RTT performance is 87.24% As expected Paediatrics and Foot & Ankle have achieved 92% in November 2018. Additional capacity has been planned for Young Adult Hip and Arthroscopy in December 2018 with a refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been planned to move from the ROH site at the end of February 2019. Excluding Spinal Deformity the Trust now has only 12 patients waiting over 40 weeks. In November 2018 the Trust had 14 patients waiting over 52weeks the trajectory was 43. All patients are dated and the trajectory is being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All teams continue to work through a targeted list of patients to ensure that patients are dated in chronological order over 18weeks. Non-admitted performance improved again in month – 90.78%.

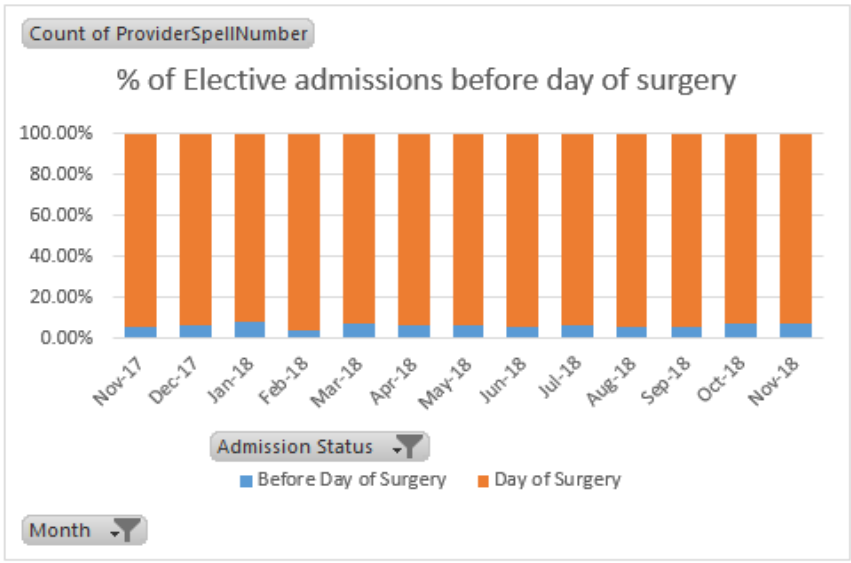
ACTIONS FOR IMPROVEMENTS / LEARNING
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019

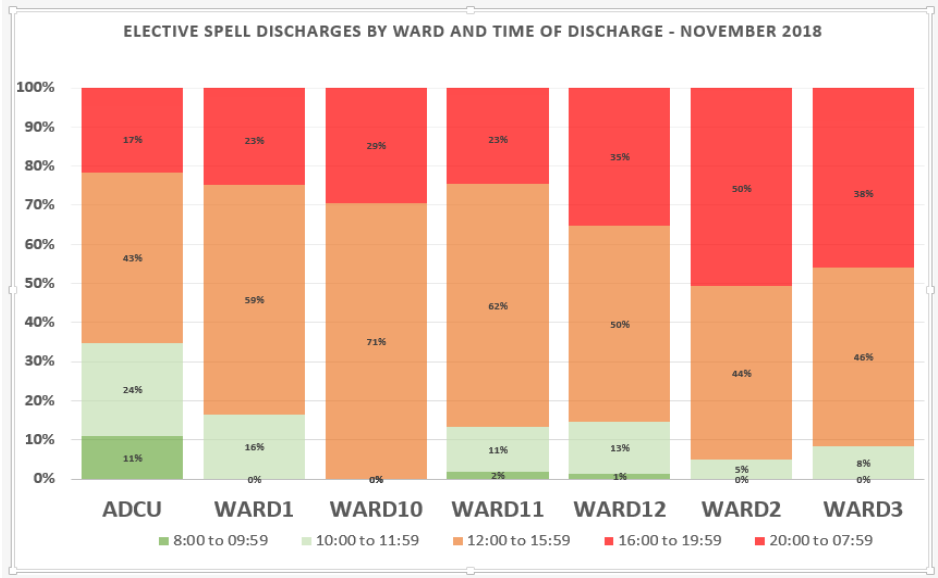
RISKS / ISSUES
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over 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 delayed from February 2019 to June 2019. Weekend activity continues until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families .

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
2017-11	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	44	70	1
2018-09		15	33	48	0
2018-10	12	18	38	68	0
2018-11	4	13	54	71	?
Grand Total	103	225	497	825	2





INFORMATION
The number of cancellations on the day of admission for surgery continues to decrease with 4 patients cancelled on day of surgery prior to admission in November . Patients admitted for surgery where treatment was deferred has also decreased in month from 18 to 13. Analysis of these 13 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 increased in month from 38 to 54 patients. An analysis of the 54 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 a higher number of 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 moved 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. The current service is being strengthened and an extended hour's contact service is being developed so patient can be contacted at evenings and weekends to improve compliance. 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 triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to expand the triage model and ensure more patients are 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
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.

ROHTB (1/19) 007

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board last met: 27 November 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was reported to have been an increase in pay costs, associated with agency staff and medical locums to fill rotas. This also reflected the significant numbers of vacancies in nursing and pressures in paediatrics. High levels of sickness absence and the need to support the higher levels of activity were also factors. • The delivery of the Cost Improvement Plan was a concern, with only £1m having been delivered to date against the overall target of £3m. • The levels of cancelled operations prior to surgery had increased, although this was described as being as a result of better pre-operative assessment processes. Work was needed to collect better patient contact details, which would improve the 72 hour pre-operative call assessment. • Length of stay remained higher than desired, although initiatives such as JointCare would improve this position. • The performance against the overall 18 weeks Referral to Treatment Time target was below trajectory at 87%, however this would be reworked shortly. • There was some delay reported to be against the following elements of the 'Perfecting Pathways' programme: clinical coding, paediatric transition and theatre expansion. • Work was reported to be continuing to evaluate the Trust's readiness for Brexit in the event of a 'no deal' scenario	• Present the plan for private patient work at the January 2019 meeting. • A further update on the JointCare dashboard to be presented in February 2019. • An update on procurement to be provided to the Board at the next available opportunity.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The activity and income positon was reported to be positive for October, with inpatient elective activity being at the highest level for 18 months. • Physiotherapy was noted to be over performing against its activity plan and there was a plan to secure additional staff in this discipline	• Remit the discussion of sickness absence to the Staff Experience & OD Committee at its next meeting. • Given the delegated authority provided at the November Trust Board meeting, the Committee approved the recommended option for an upgrade of the Trust's IT infrastructure, this being a hybrid model

to support an even higher level of activity. • Business planning had commenced, which would inform the activity plan to be submitted to NHS Improvement. • Spinal services and arthroscopy specialities had achieved the required 92% Referral to Treatment Time target. • There had been a drop in the number of patients waiting in excess of 52 weeks to 13 against a plan of 35. • There was good progress against some elements of the 'Perfecting Pathways' programme, including JointCare, electronic prescribing and medicines administration (ePMA) and pre-operative assessment. • The Committee received a presentation of the JointCare dashboard, which presented information such as operating times and length of stay, which could be displayed by surgeon. • The Committee received an update on the plans and implications of creating a shared procurement function across Birmingham and Solihull acute hospital trusts.	which was to replace the storage hardware via an operating lease, while Cloud-based solutions were investigated in line with the national steer. • The terms of reference for the Estates Strategy & Delivery Group were approved.
Chair's comments on the effectiveness of the meeting: The meeting had run to time and included a good balance of discussions. The decision to approve the IT infrastructure solution needed to be highlighted to the Board in particular.	

ROHTB (1/19) 008

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board last met: 18 December 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that there had been an underperformance against the financial plan in November, although it was noted that the performance for the month remained the second best year to date. • The drop in financial performance was reported to be associated with a decline in activity, particularly in day cases. • Delivery of the Cost Improvement Plan remained concerning, although there was a plan to implement a managed service in theatres and to reduce the costs associated with agency medical staff, following a recent review. Despite the expected shortfall in delivery by year end, it was agreed that staff needed to be recognised for delivering what had been achieved so far. • The sickness absence trend continued to be a concern and would be reviewed by the Staff Experience & OD Committee in January 2019. • There were further delays with the paediatric transition and theatre expansion aspects of the 'Perfecting Pathways' programme. • There continued to be much work to prepare for the eventuality of a 'no deal' Brexit. Discussions with suppliers of drugs to the ROH had been held, which highlighted that at present there was not a significant risk for the ROH, however the situation would continue to be monitored.	• It was agreed that the Corporate Risk Register needed to reflect risks around delivery of the Cost Improvement Programme and the current delay with the theatres expansion project • It was agreed that a cost/income ratio should be included in future reports as one of the performance measures. • Present the activity plan at the next meeting. • Present the impact assessment for Brexit readiness to the Quality & Safety Committee at its next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• It was noted that there had been only one month year to date that the income position had fallen below that of 2017/18. • There had been good performance in terms of private patient income. • Pay was in line with plan, despite there being a high level of bank and agency spend. Agency nursing expenditure had dropped considerably. • In session theatre utilisation had seen a slight improvement.	• None specifically.

• There had been a reduction in the length of stay and daily ward rounds were supporting this. • Diagnostic targets had been met. • There continued to be an improvement in the performance against the Referral to Treatment Time target, both overall and at a speciality level. • A new lead had been sourced to support the clinical coding project within the 'Perfecting pathways' programme and income had been recognised from the work • The Committee was advised that there had been a positive visit by the 'Getting it Right first Time' team who had reviewed the JointCare pathway • An update on the estates work was received which highlighted that over 20 projects had been run and completed over the past year.	

Chair's comments on the effectiveness of the meeting: The meeting had run to time and included some focussed discussion on key issues.

Finance and Performance Report

November 2018

CONTENTS

INTRODUCTION

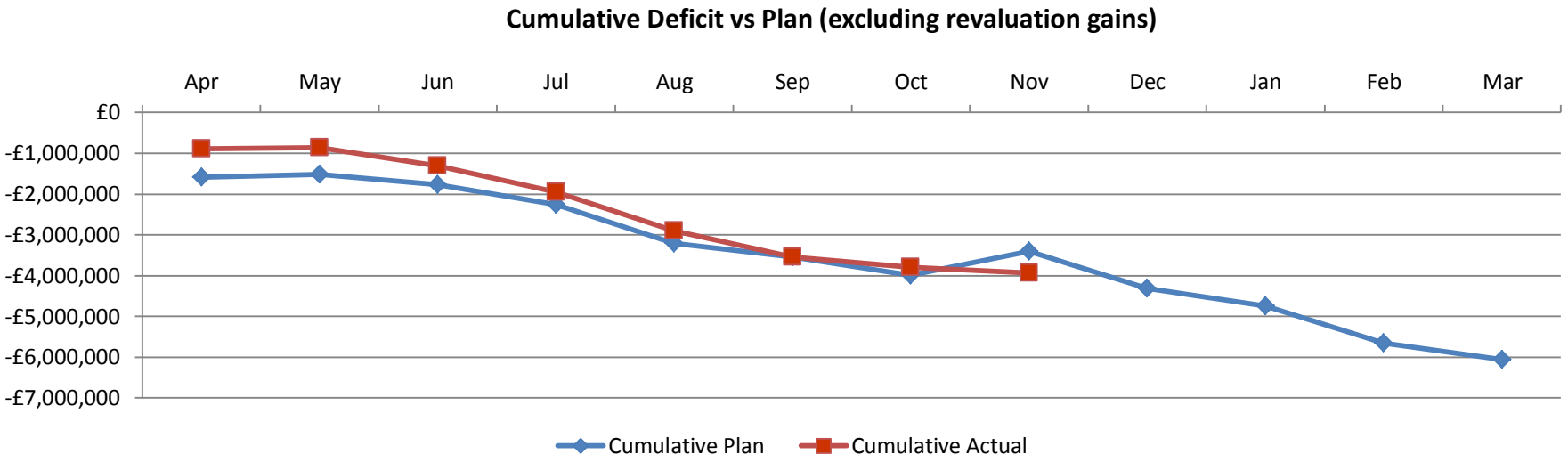
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

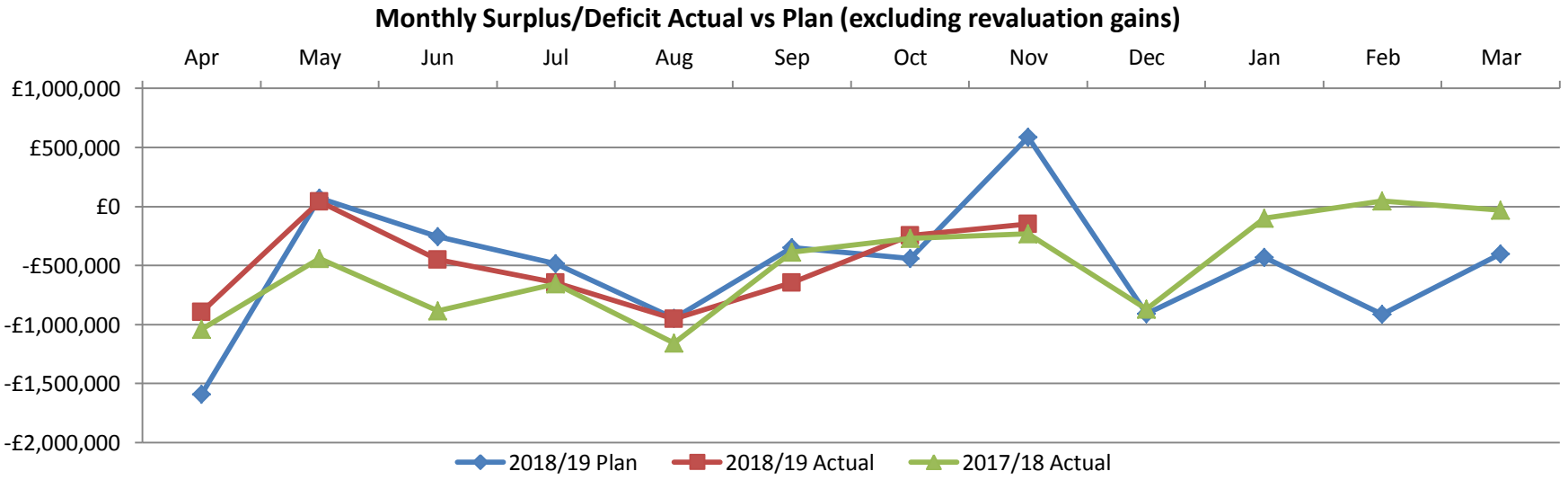
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M8 Original Plan £'000	YTD M8 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	53,113	53,375	262
Other Operating Income	3,358	3,323	(35)
Total Income	**56,471**	**56,698**	**227**
Employee Expenses (inc. Agency)	(34,060)	(34,917)	(857)
Other operating expenses	(24,879)	(24,795)	84
Operating deficit	**(2,468)**	**(3,014)**	**(546)**
Net Finance Costs	(936)	(927)	**9**
Net deficit	**(3,404)**	**(3,941)**	**(537)**
Remove donated asset I&E impact	40	42	2
Adjusted financial performance	**(3,364)**	**(3,899)**	**(535)**

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)





INFORMATION

The Trust has delivered an in-month deficit of £147k in November against a a planned surplus of £589k, £736k behind plan. It should be noted that this was a significant in-month plan to be achieved, and in hindsight was too ambitious. The current year deficit is an improvement on last year's November deficit of £233k. Year to date the Trust now has a deficit of £3,899k against a planned deficit of £3,364k; £535k behind plan.

Whilst this is a significant deterioration against plan, actual performance still represents an improvement over previous months. Planning for the rest of the year is prudent, therefore continued focus on activity delivery and cost control over the remaining 4 months should still result in achievement of the control total.

The position was very much driven by actual activity performance against plan. Both elective and day case activity were behind plan, although elective activity was in line with last November. Overall income was £1.2m behind plan for the month.

Expenditure has lower than plan in month by £472k, although this was clearly not at the level sufficient to offset the activity underperformance. Pay was in line with plan, and non-pay was £441k underspent. Whilst agency and bank spend remain high, both have reduced substantially in comparison to last month.

Cost Improvement performance remains of concern, with year to date performance £411k behind plan, and a forecasted 18/19 £830k shortfall vs the plan. 33% of forecasted 18/19 CIP delivery is via non-recurrent schemes. The 18/19 Full-Year Effect (FYE) is £19k 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, however this is at significant risk. Focus on 19/20 business planning has led to a reduced focus on 18/19 CIP identification and mitigation, however a renewed focus will commence in Q4 and the exploration of bringing 19/20 schemes into 18/19 is in progress.

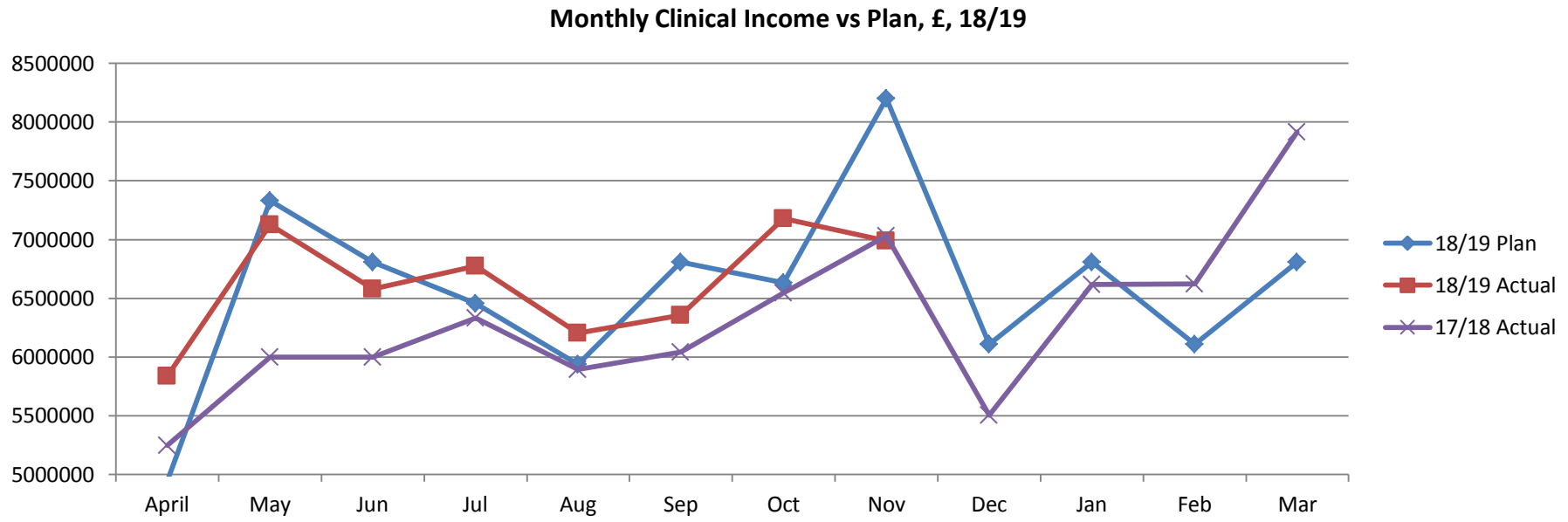
ACTIONS FOR IMPROVEMENTS / LEARNING

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 an 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. The Trust awaits a planning decision for this development.

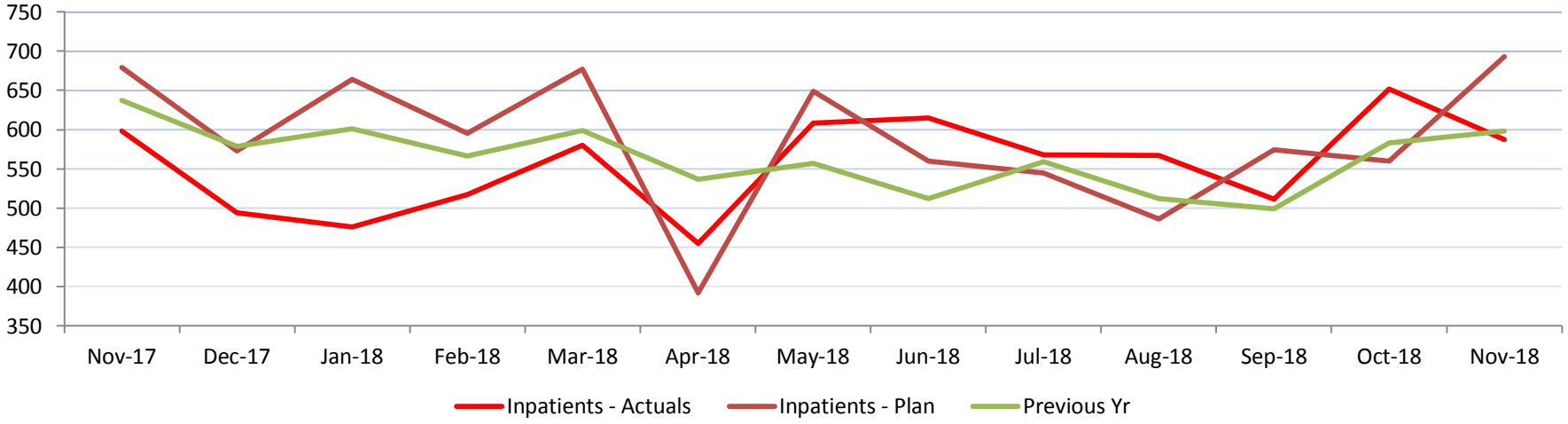
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



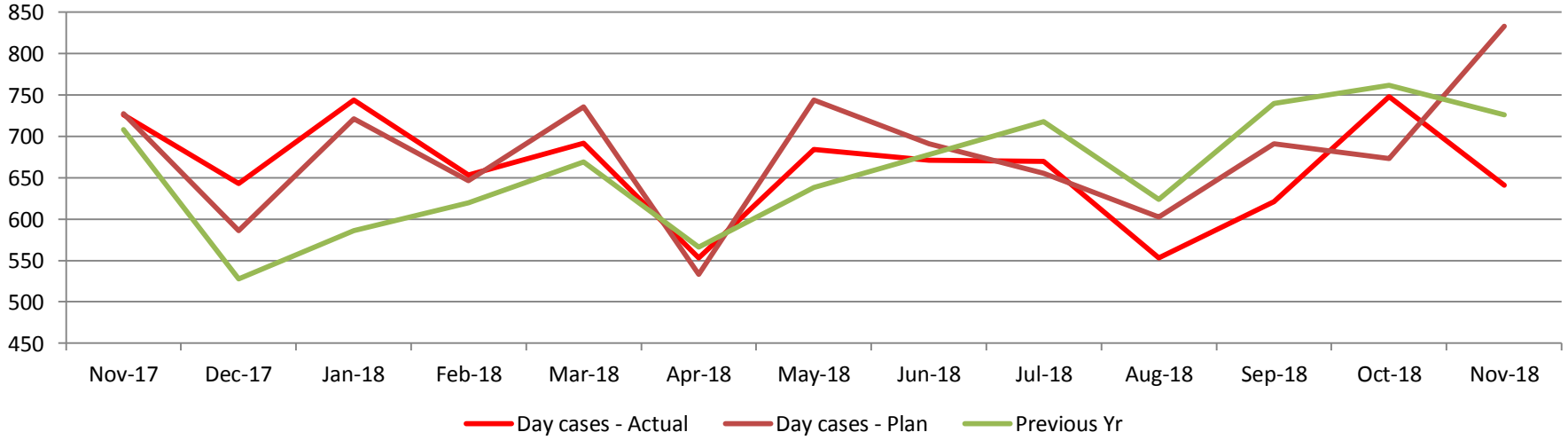
Clinical Income – November 2018 £'000			
	Plan	Actual	Variance
Inpatients	4,330	3,528	-802
Excess Bed Days	50	77	27
Total Inpatients	4,380	3,605	-775
Day Cases	1031	905	-126
Outpatients	803	752	-51
Critical Care	283	146	-137
Therapies	277	260	-17
Pass-through income	261	-18	-279
Other variable income	515	778	263
Block income	650	559	-91
TOTAL	8,200	6,983	-1,217

Clinical Income – Year To Date 2018/19 £'000			
	Plan	Actual	Variance
Inpatients	28,053	26,255	-1,798
Excess Bed Days	326	599	273
Total Inpatients	28,379	26,854	-1,525
Day Cases	6677	6700	23
Outpatients	5199	5433	234
Critical Care	1831	1498	-333
Therapies	1796	2001	205
Pass-through income	1688	1843	155
Other variable income	3332	4246	914
Block income	4206	4467	261
TOTAL	53,108	53,042	-66

Inpatient Activity



Day Case Activity



NHS Clinical income has under-performed against plan by 14.84% in November having over-performed by 8.22% in October. Cumulatively, the trust is now 0.12% below plan. The admitted patient care performance was below plan financially and on activity levels, with discharged activity 107 below the target. Average tariff for the period has decreased by £39 per case. Day case activity also underperformed financially and was below the target by 192 cases. The average tariff price for the period has increased by £292 per case. November has had decreased levels of activity compared with October. Case-mix in November has moved as day cases has decreased to 52% compared to 53% in October. 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 but there has been a decrease in attendances against plan in November for first and follow up attendances . First to follow up ratio has increased year to date at 1.94:1.

Other variable income has increased this month due to NHSE funding the Paediatric project management.

Given that the overall position at M8 is now behind plan, PSF has been removed for M7 and not included for M8 as a prudent measure. (circa £130k in total). This can still be claimed at the end of the quarter, or at year end if the control total is hit.

ACTIONS FOR IMPROVEMENT/LEARNING

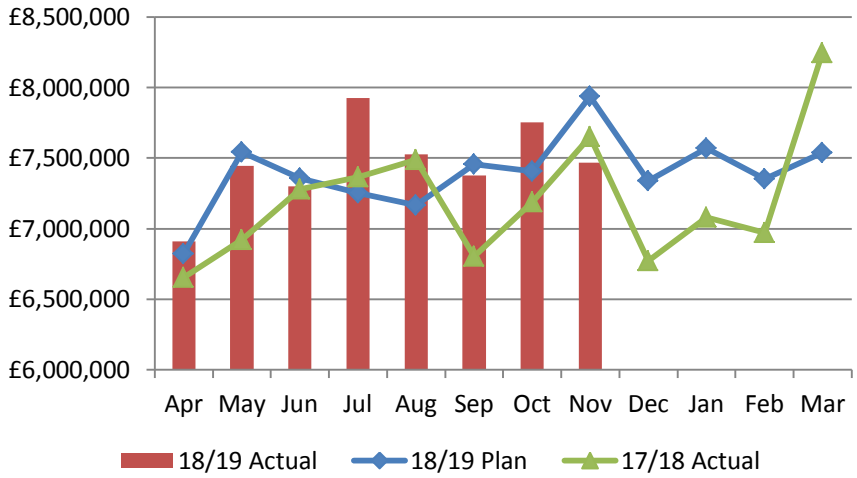
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

RISKS / ISSUES

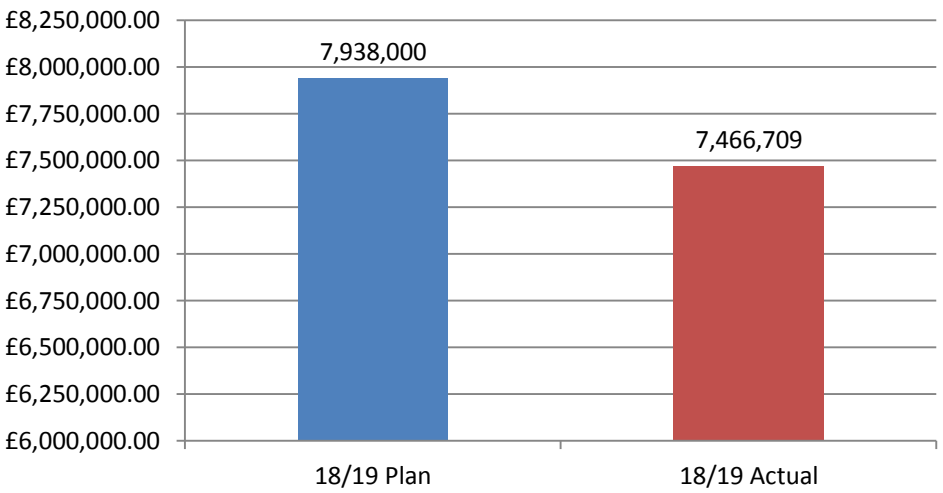
The month 8 position includes an correction of previously overstated income, as referenced in last month's paper. The plan to achieve the control total will not be impacted by this.

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

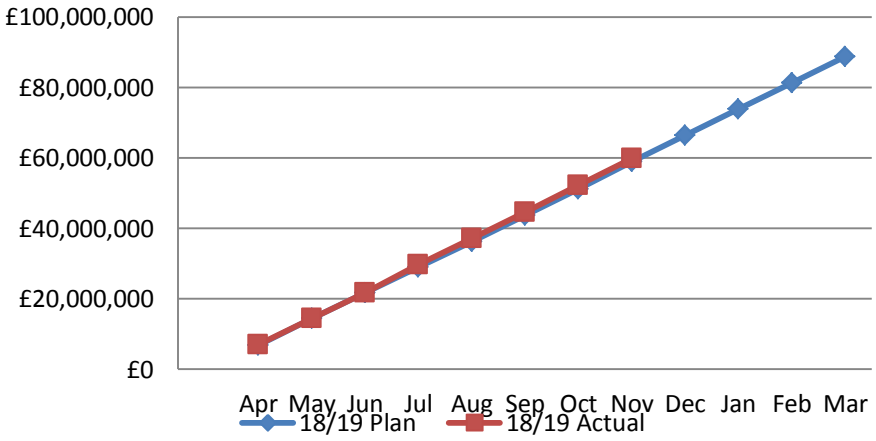
18/19 Monthly Expenditure vs Plan



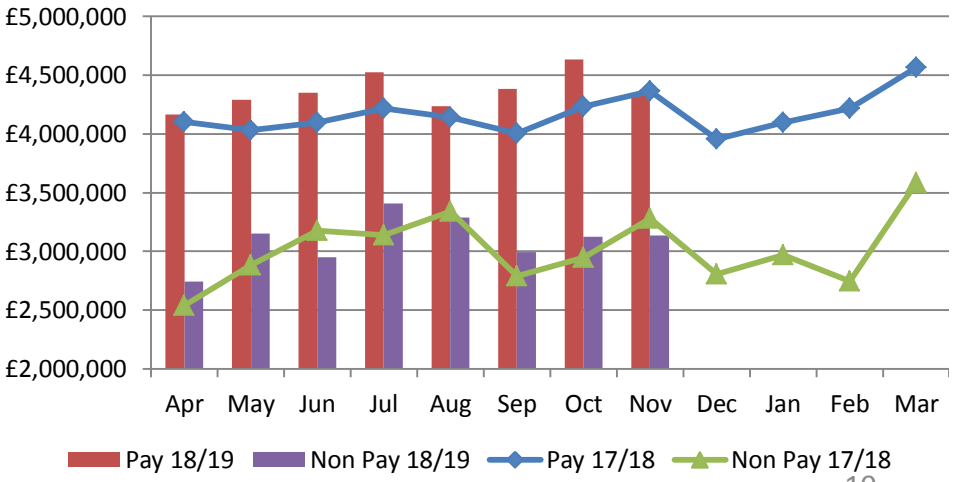
18/19 M8 Expenditure vs Plan



Cumulative Expenditure vs Plan 18/19



17/18 vs 18/19 Pay & Non Pay Spends



INFORMATION

November's expenditure was £7,466k, £472k lower than the plan of £7,938k.

Pay was in line with plan in month, although within this bank and agency spend remain higher than plan, offset by underspends on substantive staffing. Whilst agency spend was high, it has reduced substantially, along with bank spend. This is in line with the activity reduction. Further detail on agency spend has been given on the next slide.

Non pay spend is £441k below plan. The in-month underspend is within various categories of spend, but particularly clinical supplies. This again correlates with the reduced activity compared to plan.

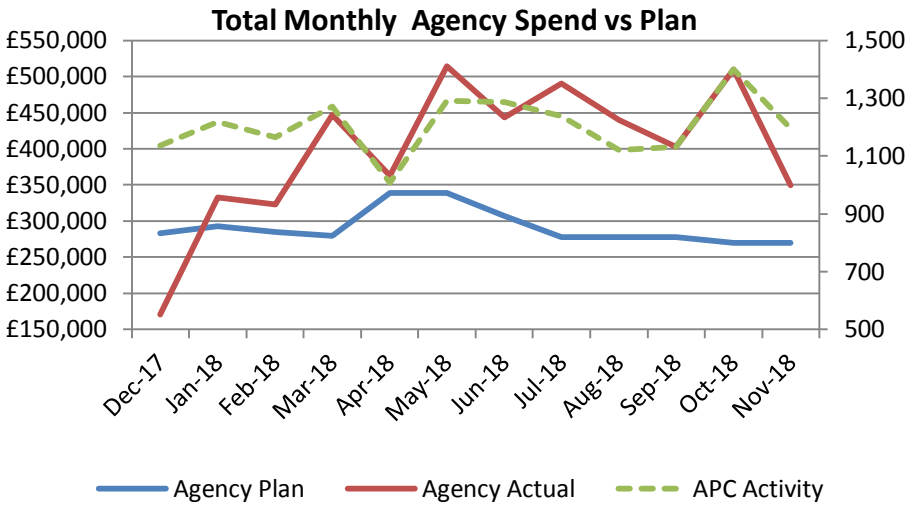
ACTIONS FOR IMPROVEMENTS / LEARNING

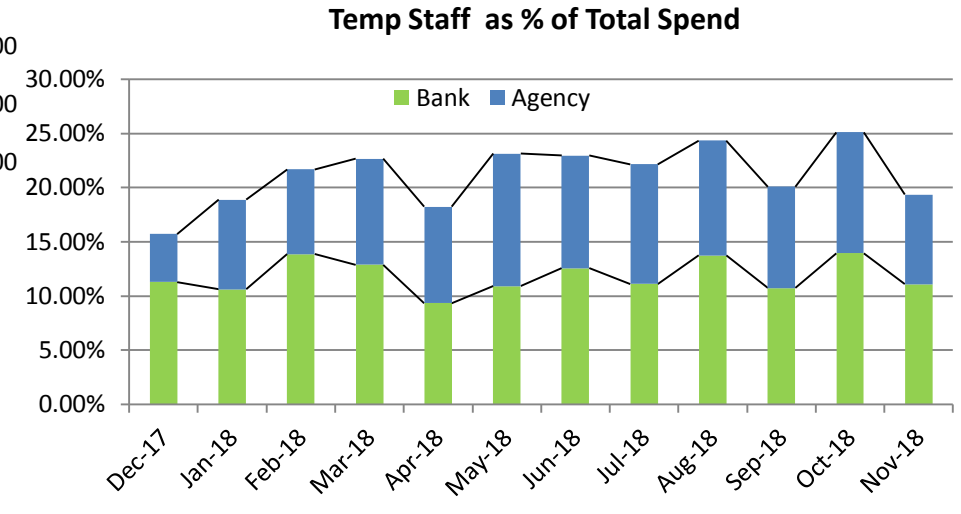
There is further learning from the year end stock count and subsequent audit which will be taken forward and acted upon within 2018-19 to give greater control over stock costs throughout the year. Monthly meetings are now taking place to review theatre spending between the Theatre manager, logistics and finance.

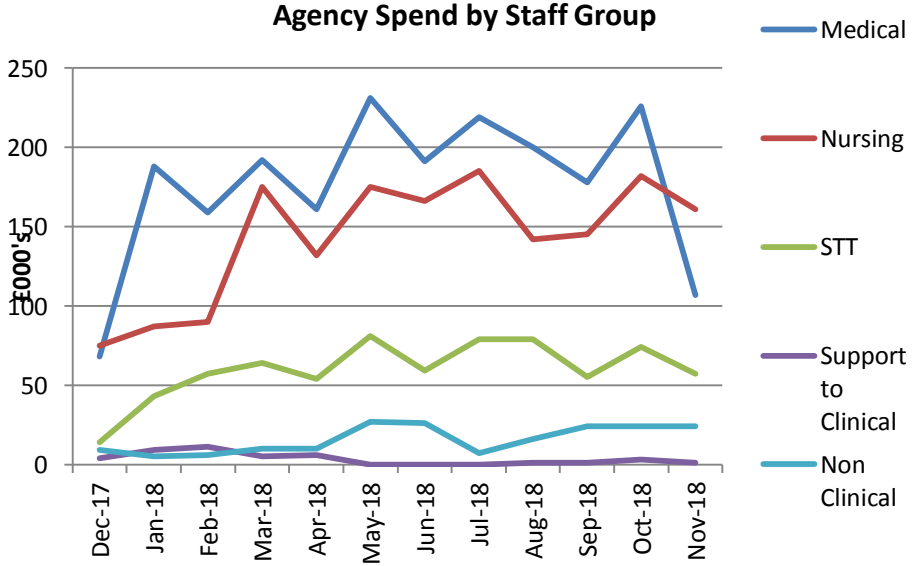
RISKS / ISSUES

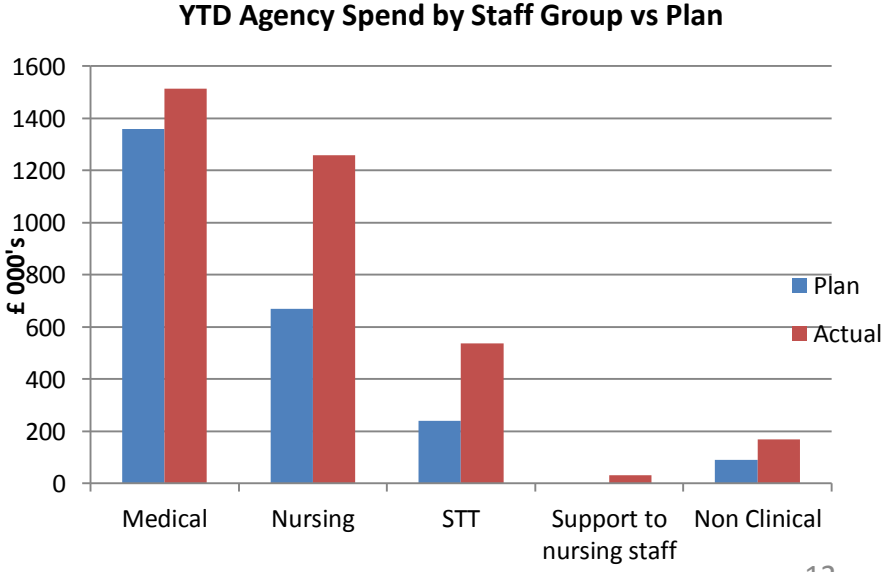
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops.

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 £159k to £350k in month which is £80k above the monthly plan and £1.2m 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 (£590k), medical (£153k) and therapeutic (£297k).

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. Whilst there has not been a material reduction in wte employed in month, there has been a significant reduction in out of hours working, whilst there had also been an overly prudent accrual of usage in the previous month which has now also been corrected.

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.

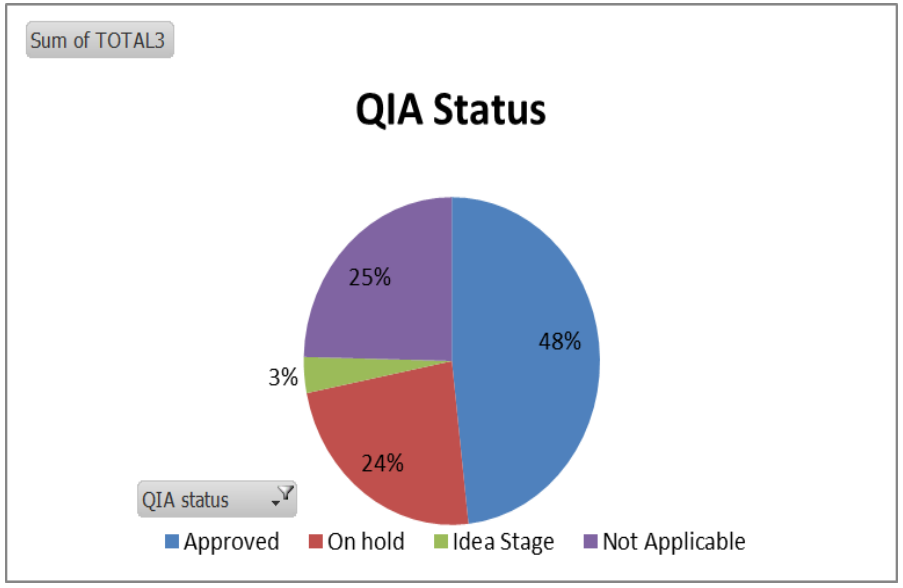
Review of e-Roster continues and shifts approved by the relevant Matron and head of Nursing.

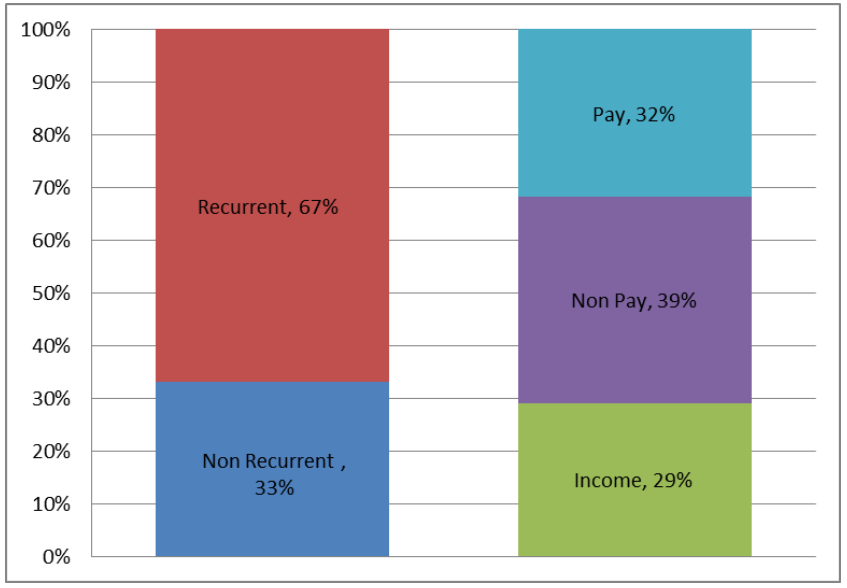
RISKS / ISSUES

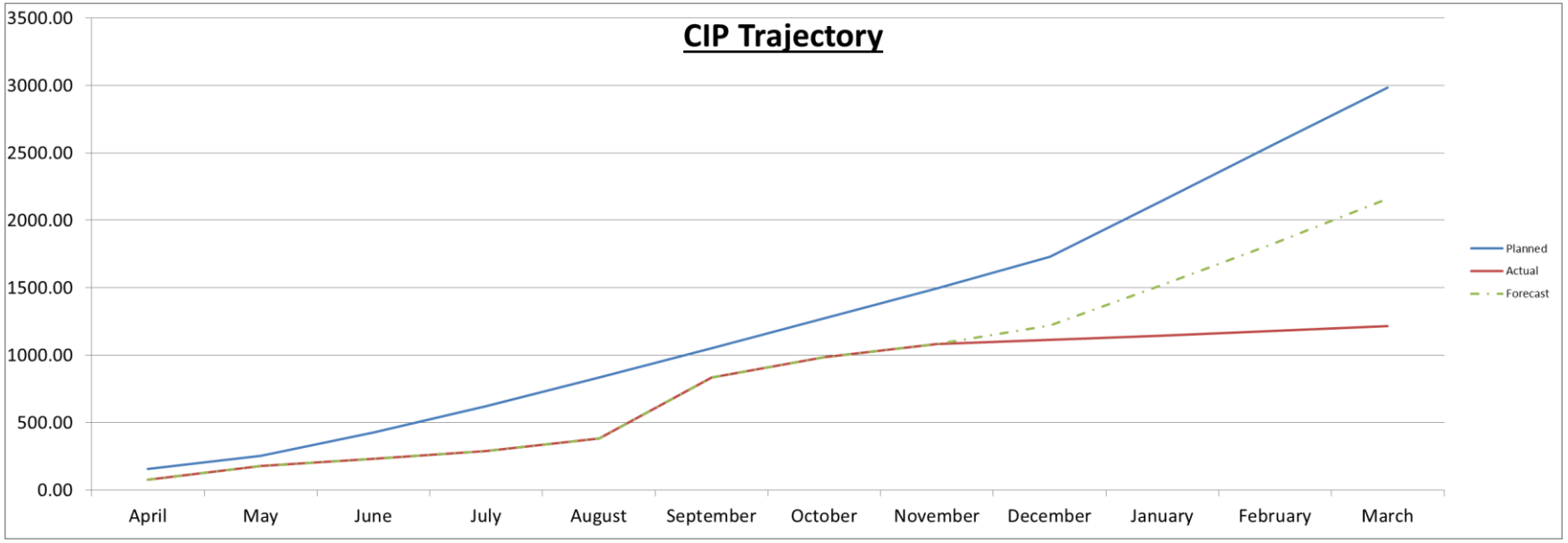
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

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.

5. 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 8 £2,155k is forecasted for delivery in 18/19 (72% of identified/planned). At month 8 £1,083k of savings have been delivered against a plan of £1,494k year to date. (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	93	29	(64)	714	451	(263)	1,090	749	(341)	69%	649	(441)
Division 1	71	35	(35)	407	311	(96)	705	472	(233)	67%	611	(94)
Division 2	53	32	(21)	359	306	(53)	1,157	901	(256)	78%	1,747	591
Division 4	5	5	0	14	15	1	33	33	1	103%	12	(21)
Grand Total	**221**	**100**	**(121)**	**1,494**	**1,083**	**(411)**	**2,985**	**2,155**	**(830)**	**72%**	**3,019**	**35**

The summary reasons for under-performance are below:

- Non-delivery and slippage against some clinical and operational saving schemes such as Implant rationalisation, GIRFT recommendations, LOS reduction and clinical pathway/process redesign savings
- Slippage and under-delivery against large scale savings schemes such as Direct Engagement, Theatres Stock control and Managed Service Contract and Counting & Coding improvement schemes
- *See CIP Pack for performance against schemes*

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved forecasted performance, 33% 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 Directorate Finance & CIP meetings are being addressed for Q4; 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 £252k in 2018/19, 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
- Focus on 19/20 Business Planning including 19/20 CIP scheme identification, however this has led to a reduced focus on (2018/19) in-year identification, renewed focus in Q4 is required

6. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M8 Plan £'000	M8 Actual £'000	Var £'000
Intangible Assets	726	588	(138)
Tangible Assets	48,194	48,005	(189)
Total Non-Current Assets	**48,920**	**48,593**	(327)
Inventories	4,858	5,108	250
Trade and other current assets	7,555	5,939	(1,616)
Cash	1,327	1,042	(285)
Total Current Assets	**13,740**	**12,089**	(1,651)
Trade and other payables	(13,197)	(12,459)	738
Borrowings	(1,363)	(1,591)	(228)
Provisions	(173)	(108)	65
Other liabilities	(207)	(379)	(172)
Total Current Liabilities	**(14,940)**	**(14,594)**	403
Borrowings	(6,979)	(6,534)	445
Provisions	(354)	(354)	0
Total Non-Current Liabilities	**(7,333)**	**(6,831)**	445
Total Net Assets Employed	**40,387**	**39,257**	(1,130)
Total Taxpayers' and Others' Equity	**40,387**	**39,257**	(1,130)

INFORMATION

Tangible assets are 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.

Whilst the variance against the planned position looks significant , the actual move from Month 7 is minor. Cash has been above planned levels since Month 1 due to receipt of 2017/18 STF but the impact of this has now been utilised with a number of significant payments made in Month 8, and an earlier in month drawdown of DH support . The next expected drawdown of £1m is planned for the 9th of January.

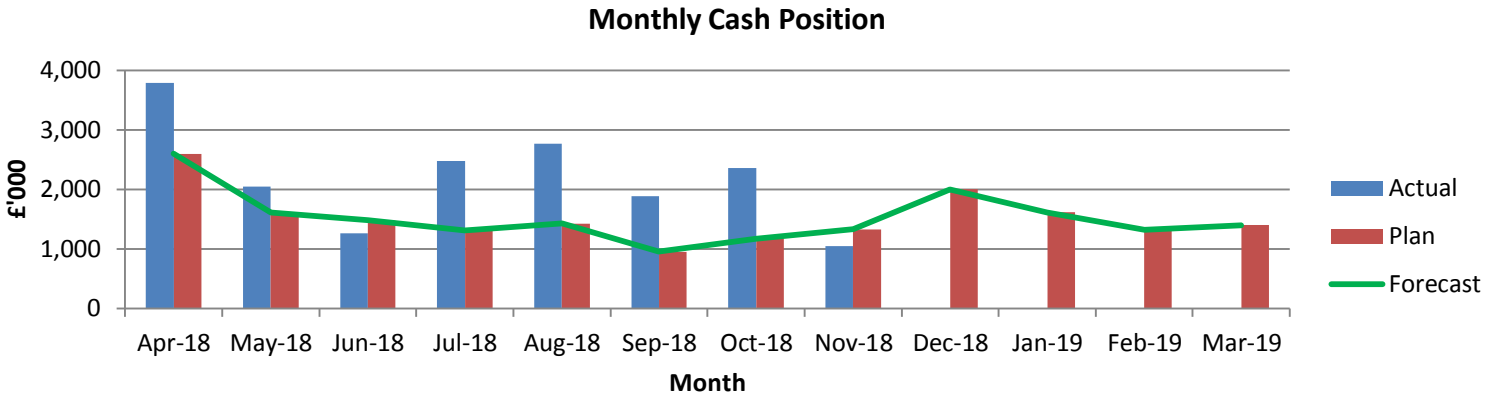
ACTIONS FOR IMPROVEMENTS / LEARNING

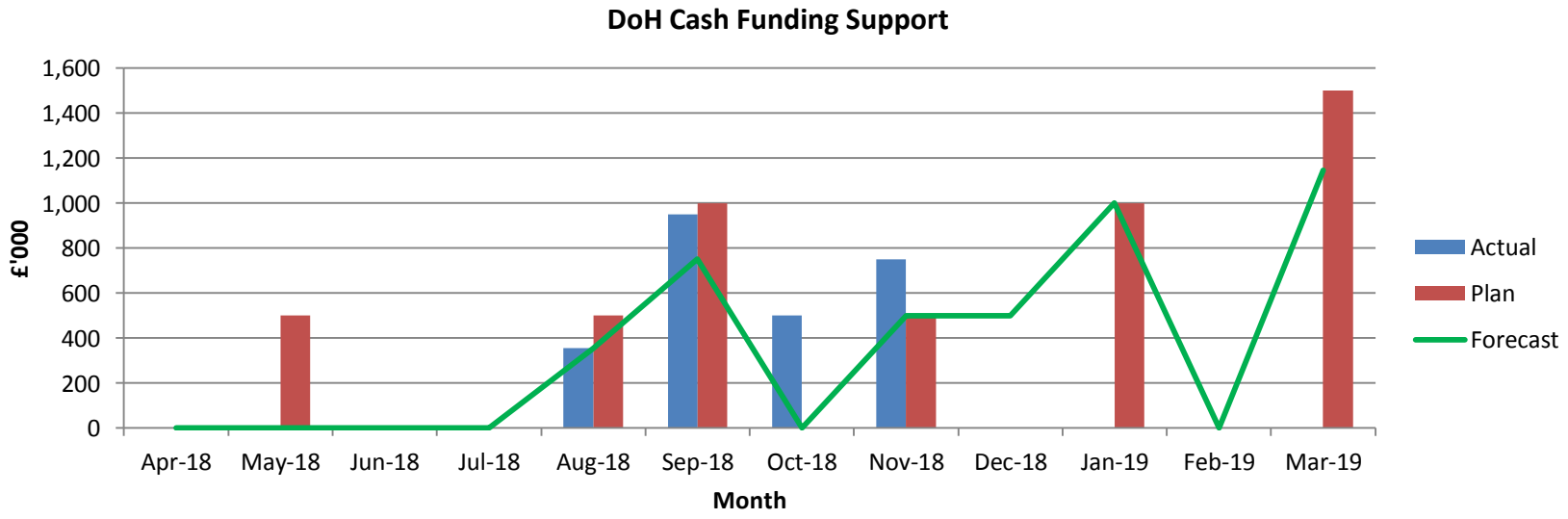
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

RISKS / ISSUES

Despite the receipt of STF, cash remains tight for the remainder of the year with a projected cash balance at year end of £1.4m as per plan after a lower uptake of the borrowing facility during the year than planned.

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 £1,042k which is lower than forecast following the return of NHS Supplies to the standard payment terms of 30 days.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £1,000k has been requested from the Department of Health (DoH) for January which is within the forecast for 2018/19.

ACTIONS FOR IMPROVEMENTS / LEARNING

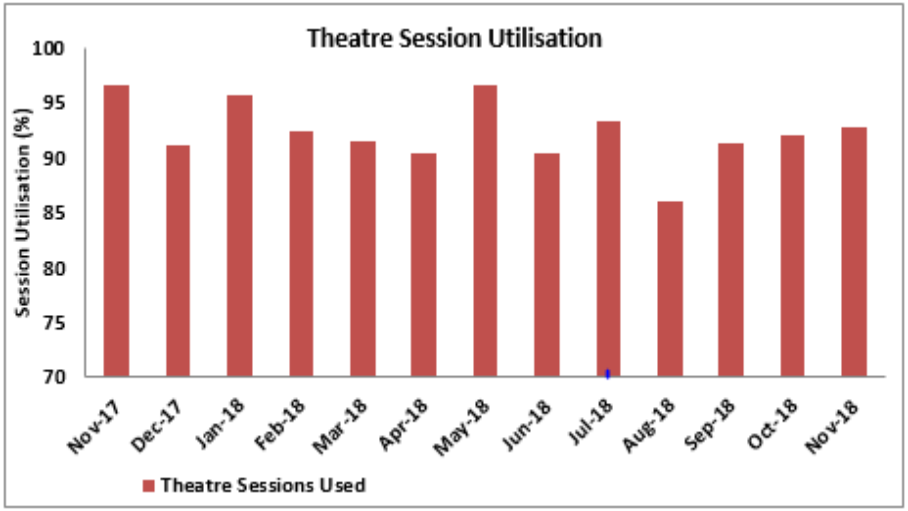
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2018/19. The Head of Financial Accounting has set up a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team. The 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

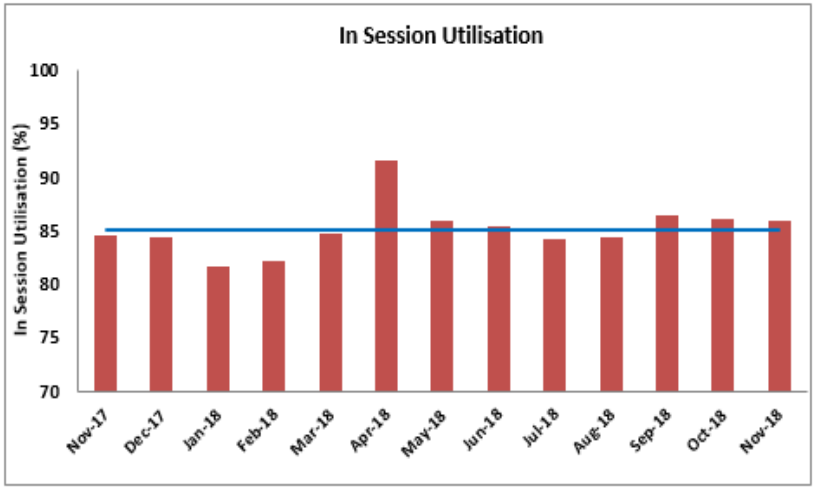
Session utilisation for November was 92.86% a slight increase on October which was 92.11%

Average utilisation is 92.39% for the period April '18 – November '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 dropped slightly from 86.16% in October to 85.97% in November.

In session utilisation remains consistent, running at an average of 86% for the period April '18 – November '18.

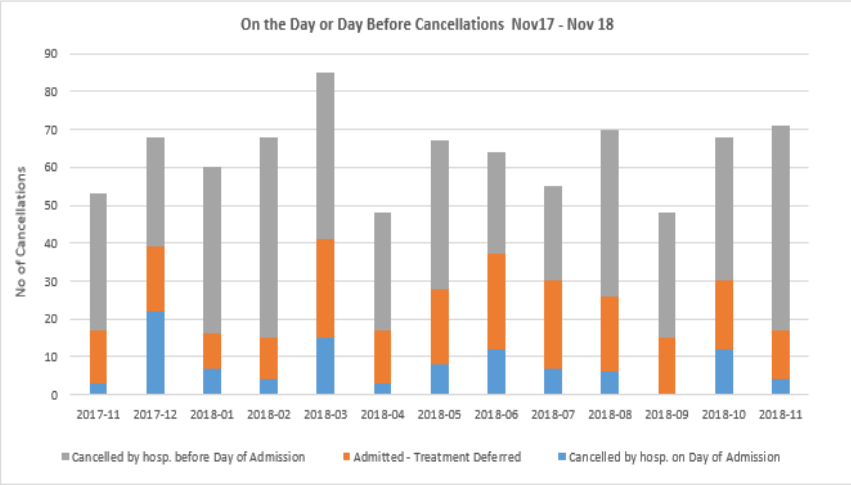
The 72hr call service has now been transferred from Outpatients to POAC. A service review is being undertaken which will look at resource requirements based on the volume of calls, and the times of the day patients are being contacted and the number of 'non contacts'. The aim is to change the operational hours so that patients can be contacted into the early evening

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*

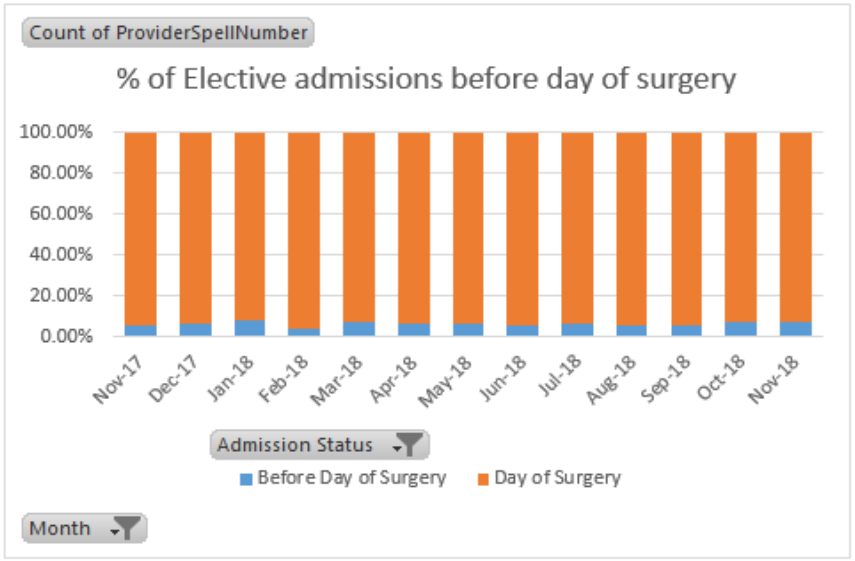
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

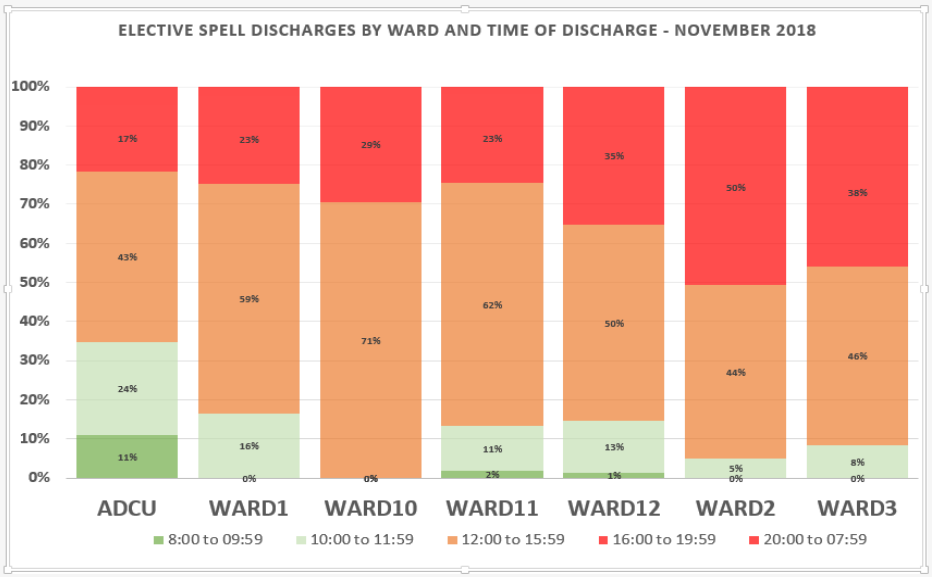
Hospital Cancellations



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
2017-11	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	44	70	1
2018-09		15	33	48	0
2018-10	12	18	38	68	0
2018-11	4	13	54	71	?
Grand Total	103	225	497	825	2

Admission the day before surgery





The number of cancellations on the day of admission for surgery continues to decrease with 4 patients cancelled on day of surgery prior to admission in November . Patients admitted for surgery where treatment was deferred has also decreased in month from 18 to 13. Analysis of these 13 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 increased in month from 38 to 54 patients. An analysis of the 54 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 a higher number of 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 moved 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. The current service is being strengthened and an extended hours contact service is being developed so patient can be contacted at evenings and weekends to improve compliance .

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 triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to expand the triage model and ensure more patients are 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

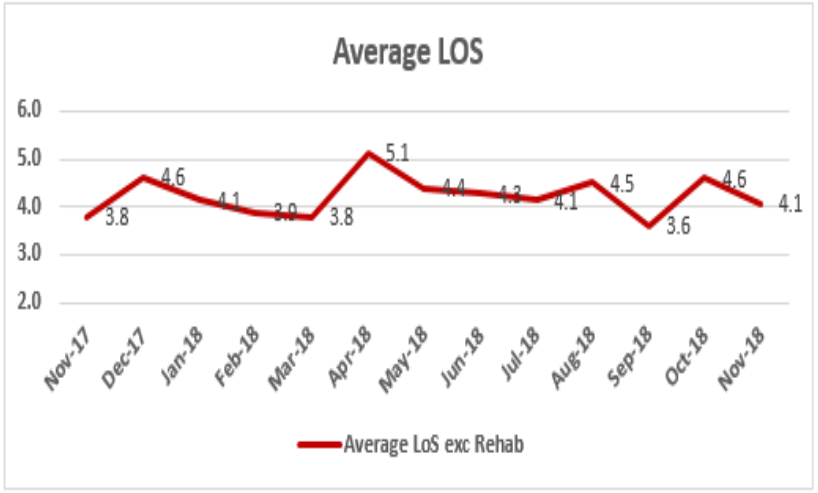
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

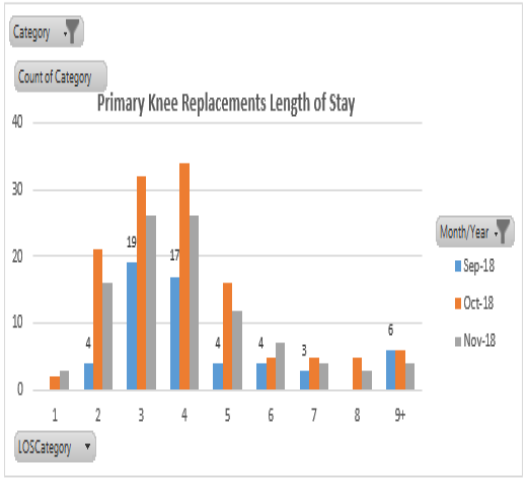
- Joint care project is ongoing

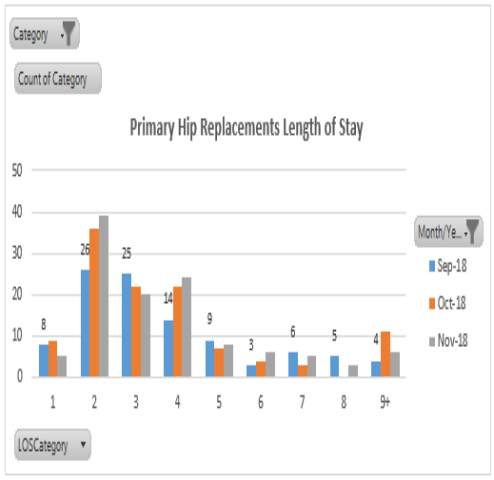
RISKS / ISSUES

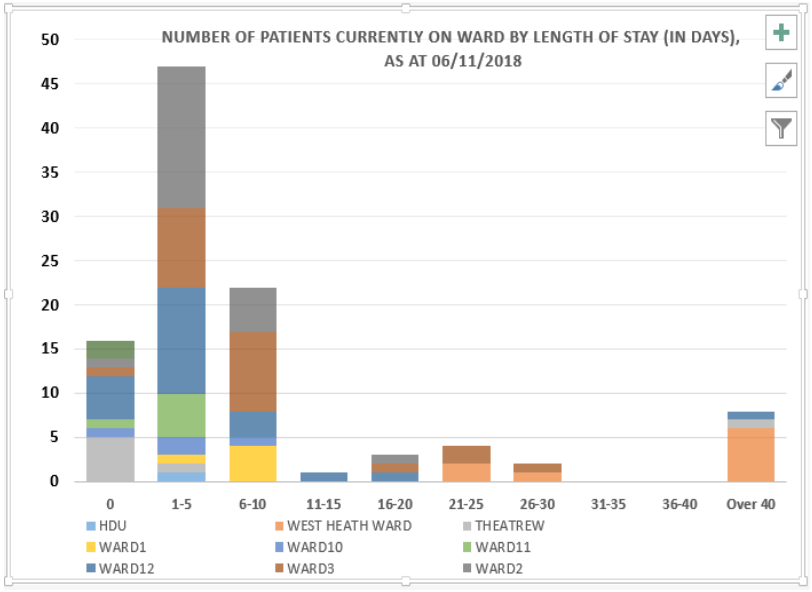
Existing aging equipment asset base and the need to increase the number of power tools in Theatre. Some additional power tools are currently being scoped as part of the capital programme slippage and the Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

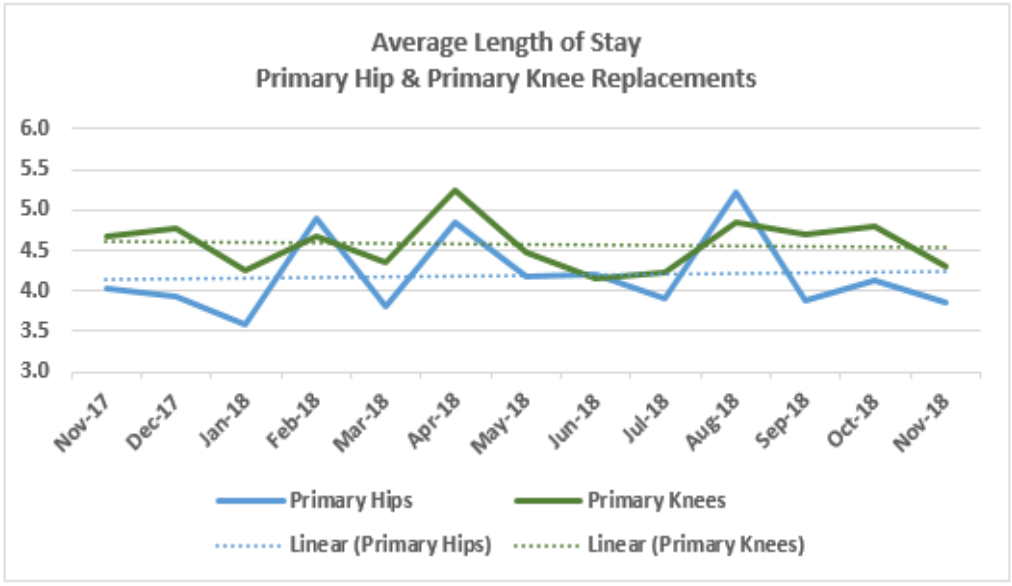
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS has reduced in November 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 went 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 opened on 5th November with increased capacity to support all ward areas

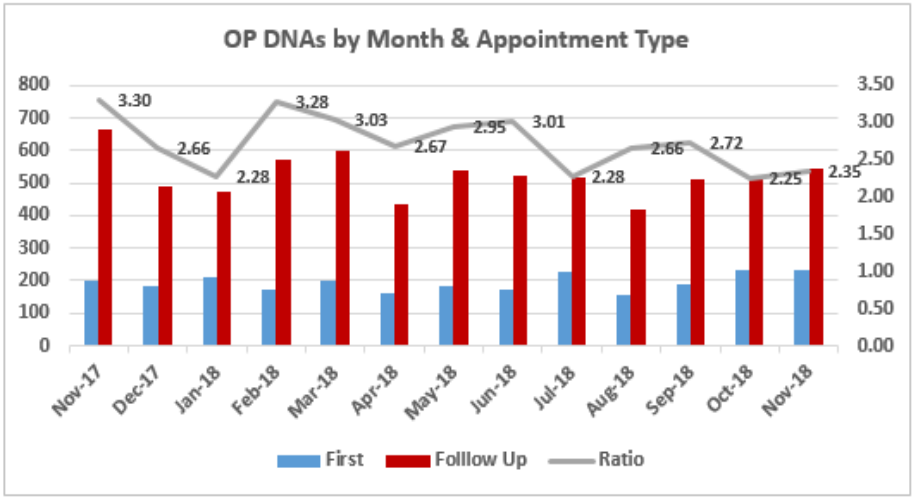
ACTIONS FOR IMPROVEMENTS / LEARNING

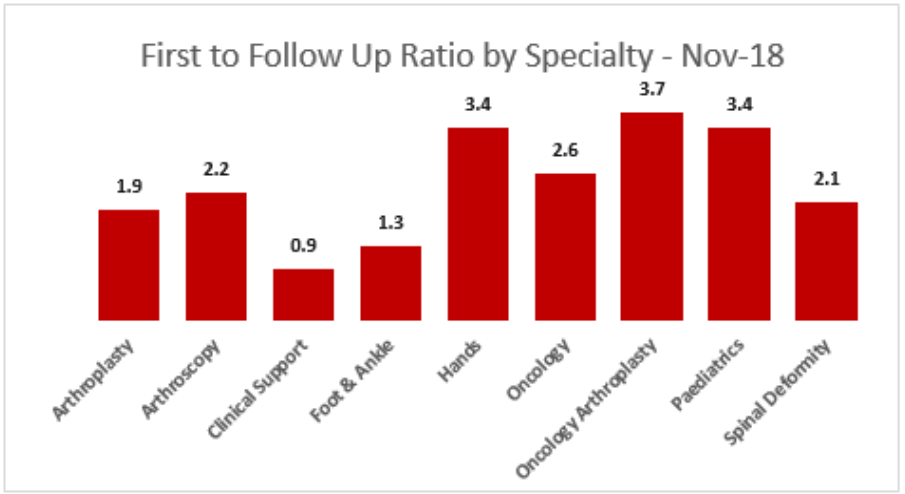
- The Red2Green dashboard development is now launched across all wards .
- The dashboard also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds on Ward 12 still needs to be put in place and conversations with arthroscopy surgeons are ongoing led by AMD and CSM.

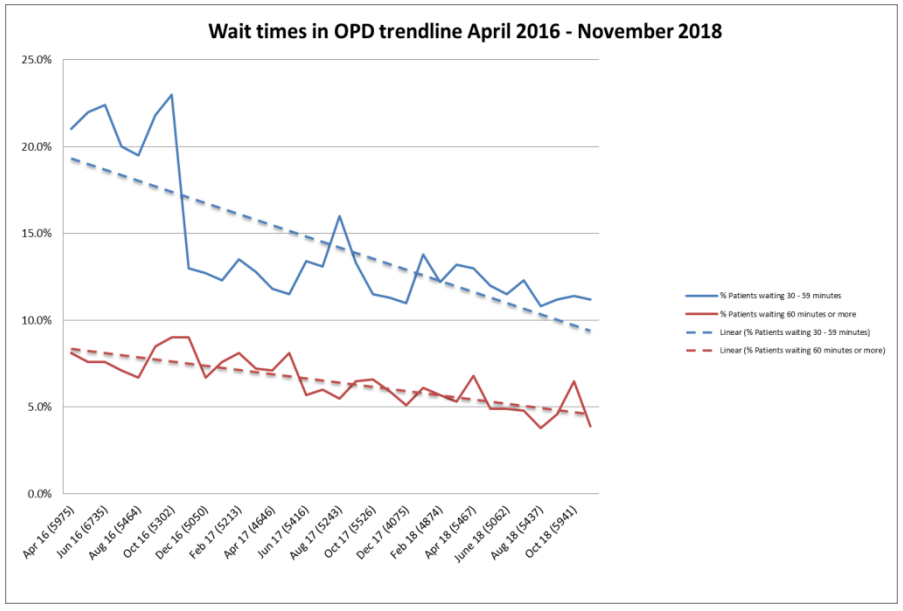
RISKS / ISSUES

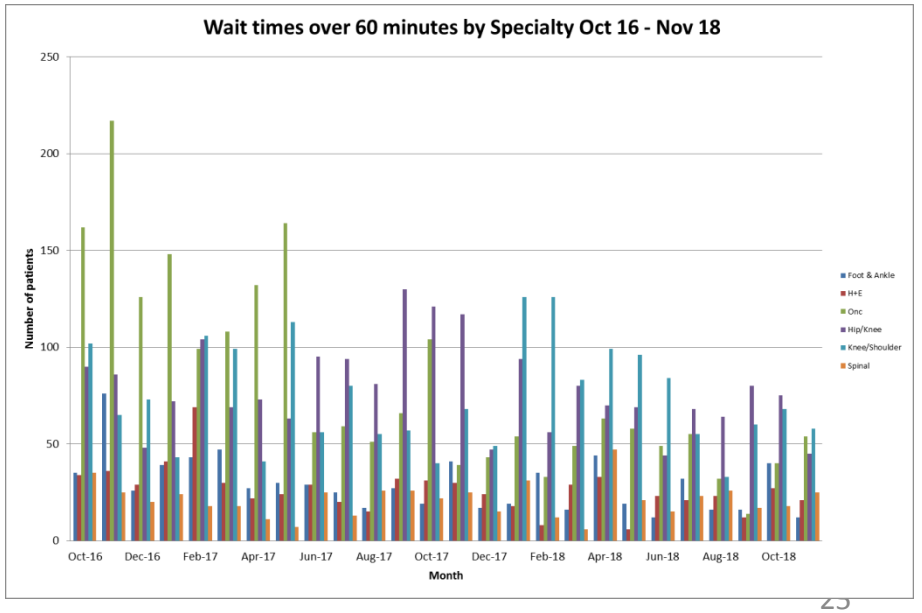
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases have a significantly higher LOS and this is reflected in the LOS data monthly variation. The underlying Hip and Knee LOS excluding oncology varies between 3.3 and 3.7 in data analysed.

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









INFORMATION

In November there were only 3 incident forms completed to highlight clinics running more than 60 minutes late. This is a very low number and investigations should take place and reaffirm the importance of reporting these incidents.

There were 11.2% of patients waiting over 30 minutes and 3.9% waiting over 1 hour which is below the target of 5%. Both of these metrics have improved since last month however the target for 30 minute delays has still not been achieved. Positively this is the 7th month out of the last 8 that the over 60 minute target has been achieved. The largest number of incidents were reported in Knee / Shoulder and Oncology specialties whereas last month this was Hip and Knee rather than Oncology.

The monthly audit identified the following categories of incident: -

- 2 – Clinic Overbooked
- 1 – X-ray delays

Work is underway to begin to collect information about daily room allocations within outpatients. With this information and activity data it will be possible to review clinic utilisation.

New nursing staff have commenced in recent weeks and there may have been a reduction in reporting because of this. The Matron for outpatients will reiterate the importance of reporting all incidents relating to clinic delays.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Reiterate the importance of submitting incident forms with the staff
- Commence a weekly 6-3-2 meeting to discuss activity for future weeks, avoiding overbookings and identifying additional clinic rooms available
- Begin to collect room occupancy data
- Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available
- Investigation of partial booking processes to reduce clinic rescheduling and overbooking

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

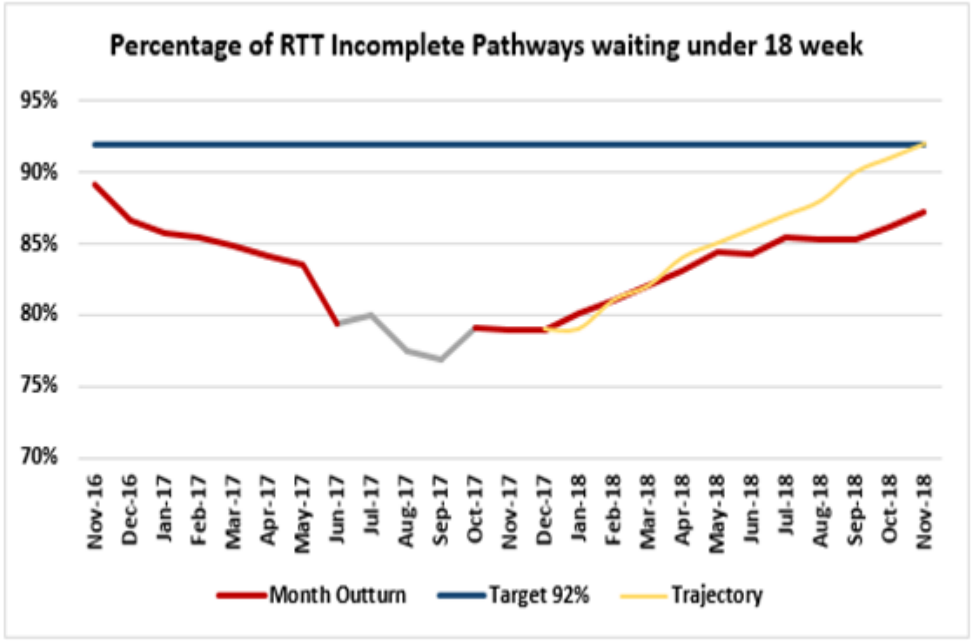
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

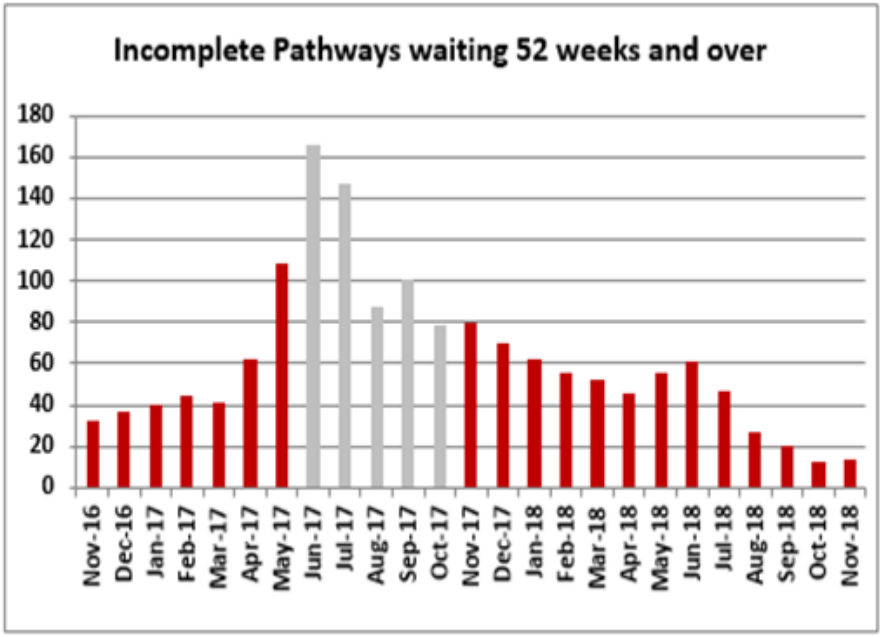
% of patients waiting <6weeks for Diagnostic test.

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%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1,254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1,245	1,252	99.4%

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





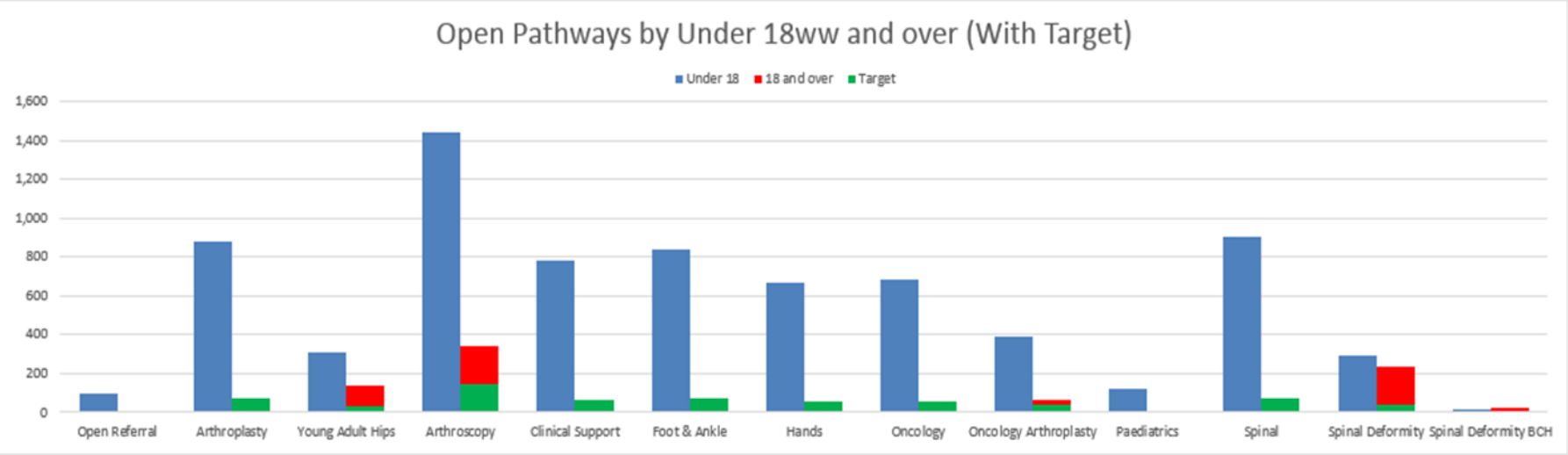
		Indicative	Reported Month							Reported Quarter		Reported Quarter 2017/18			
Target Name	National Standard	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q2 (July, August, Sept)	Q1 (Apr, May, June)	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	*98.2%*	100%	100%	100%	100%	100%	98%	98%	100%	99%	97%	98%	99%	98%
31 day first treatment	96%	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*100%*	100%	100%	100%	100%	100%	100%	90%	100%	97%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	*54.5%*	100.0%	62.5%	57.1%	90%	89%	90%	67%	70%	82%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	*90%*	88.9%	77.8%	100%	100%	83.30%	100%	100%	93%	94%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1		1			1		100%						

13. Referral to Treatment snapshot as at 30 November 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	**3,828**	77	470	152	673	431	393	362	361	207	72	480	140	10
7-13	**2,612**	10	300	116	532	271	345	202	215	135	40	336	106	4
14-17	**984**	7	107	43	238	79	100	101	105	53	12	92	45	2
18-26	**771**	10	49	93	244	36	44	39	26	50	2	38	135	5
27-39	**262**	0	7	36	90	9	8	5	4	15	0	4	73	11
40-47	**33**	0	0	7	4	0	0	0	0	0	0	0	19	3
48-51	**6**	0	0	0	0	0	0	0	0	0	0	0	3	3
52 weeks and over	**14**	0	0	0	0	0	0	0	0	0	0	1	7	6
Total	**8,510**	104	933	447	1,781	826	890	709	711	460	126	951	528	44

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	**7,424**	94	877	311	1,443	781	838	665	681	395	124	908	291	16
18 and over	**1,086**	10	56	136	338	45	52	44	30	65	2	43	237	28
Target	**681**	**8**	**75**	**36**	**142**	**66**	**71**	**57**	**57**	**37**	**10**	**76**	**42**	**4**

	87.24%	90.38%	94.00%	69.57%	81.02%	94.55%	94.16%	93.79%	95.78%	85.87%	98.41%	95.48%	55.11%	36.36%



13. Referral to Treatment snapshot as at 30th November 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	**926**	0	153	52	190	54	44	113	96	60	32	98	25	9
7-13	**824**	0	163	49	195	41	49	84	37	61	18	104	22	1
14-17	**378**	0	60	20	122	12	22	44	19	28	6	39	4	2
18-26	**348**	1	34	28	147	8	16	21	15	29	2	14	28	5
27-39	**159**	0	7	17	66	2	3	4	2	10	0	4	34	10
40-47	**24**	0	0	5	1	0	0	0	0	0	0	0	16	2
48-51	**5**	0	0	0	0	0	0	0	0	0	0	0	2	3
52 weeks and over	**12**	0	0	0	0	0	0	0	0	0	0	0	6	6
Total	**2,676**	1	417	171	721	117	134	266	169	188	58	259	137	38

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	**2,128**	0	376	121	507	107	115	241	152	149	56	241	51	12
18 and over	**548**	1	41	50	214	10	19	25	17	39	2	18	86	26
Target	**214**	**0**	**33**	**14**	**58**	**9**	**11**	**21**	**14**	**15**	**5**	**21**	**11**	**3**
	79.52%	**0.00%**	**90.17%**	**70.76%**	**70.32%**	**91.45%**	**85.82%**	**90.60%**	**89.94%**	**79.26%**	**96.55%**	**93.05%**	**37.23%**	**31.58%**

Select Pathway Type: Non-Admi

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	**2,902**	77	317	100	483	377	349	249	265	147	40	382	115	1
7-13	**1,788**	10	137	67	337	230	296	118	178	74	22	232	84	3
14-17	**606**	7	47	23	116	67	78	57	86	25	6	53	41	0
18-26	**423**	9	15	65	97	28	28	18	11	21	0	24	107	0
27-39	**103**	0	0	19	24	7	5	1	2	5	0	0	39	1
40-47	**9**	0	0	2	3	0	0	0	0	0	0	0	3	1
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	1	1	0
Total	**5,834**	103	516	276	1,060	709	756	443	542	272	68	692	391	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	**5,296**	94	501	190	936	674	723	424	529	246	68	667	240	4
18 and over	**538**	9	15	86	124	35	33	19	13	26	0	25	151	2
Target	**467**	**8**	**41**	**22**	**85**	**57**	**60**	**35**	**43**	**22**	**5**	**55**	**31**	**0**
	90.78%	**91.26%**	**97.09%**	**68.84%**	**88.30%**	**95.06%**	**95.63%**	**95.71%**	**97.60%**	**90.44%**	**100.00%**	**96.39%**	**61.38%**	**66.67%**

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. Trajectories had been developed for all specialties and was submitted to NHSI with a return to overall RTT compliance (92%) by November 2018.

Given the challenges still remaining in some specialties the Trust will not meet 92% in November 2018. A revised trajectory will be submitted by the end of December 2018 to NHSI confirming when the Trust will return to 92%.

The November RTT performance is **87.24%**

As expected Paediatrics and Foot & Ankle have achieved 92% in November 2018.

Additional capacity has been planned for Young Adult Hip and Arthroscopy in December 2018 with a refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been planned to move from the ROH site at the end of February 2019.

Excluding Spinal Deformity the Trust now has only 12 patients waiting over 40 weeks.

In November 2018 the Trust had **14** patients waiting over 52weeks the trajectory was 43. All patients are dated and the trajectory is being reviewed in light of the delay in the service now not being transferred to BCH in February 2019.

All teams continue to work through a targeted list of patients to ensure that patients are dated in chronological order over 18weeks.

Non-admitted performance improved again in month – 90.78%.

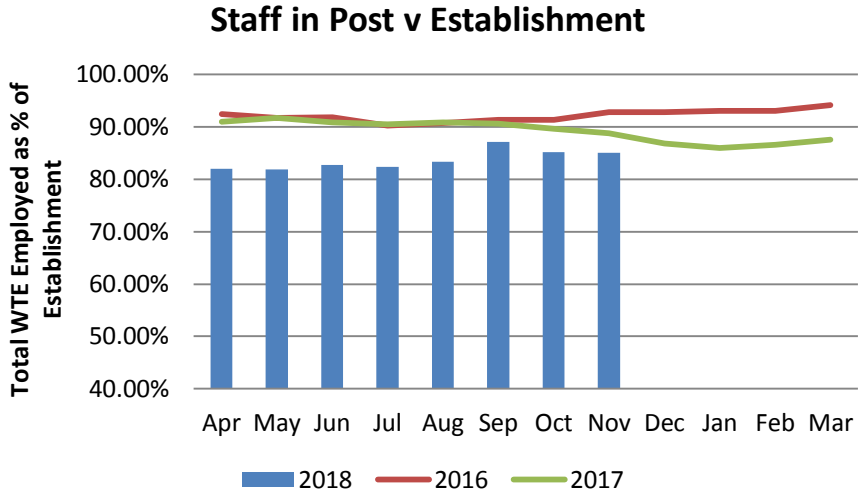
ACTIONS FOR IMPROVEMENTS / LEARNING

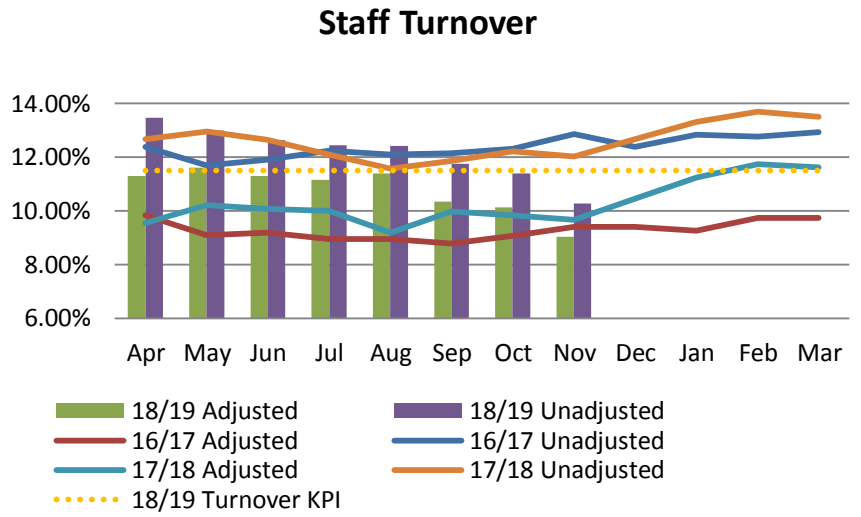
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019

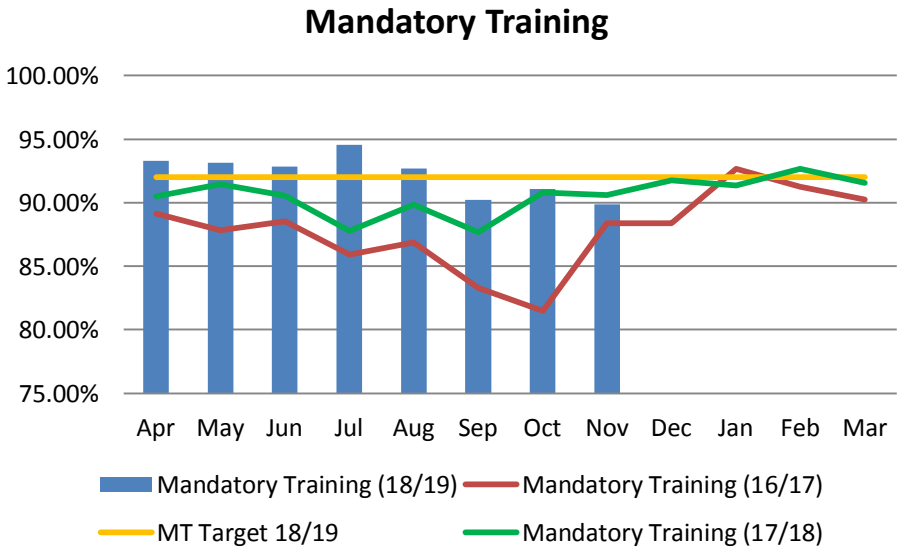
RISKS / ISSUES

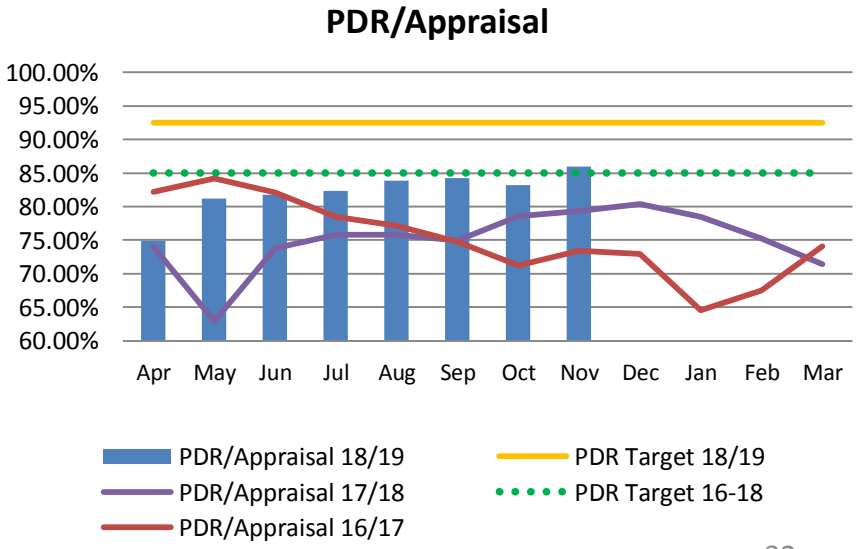
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter 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 delayed from February 2019 to June 2019. Weekend activity continues until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families

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

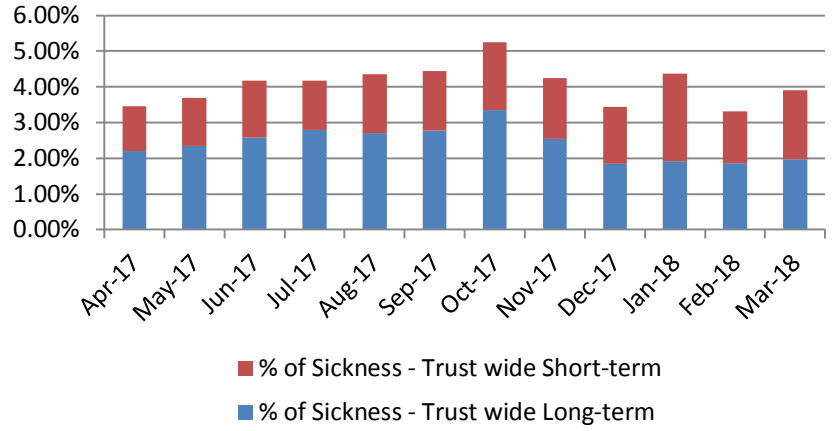




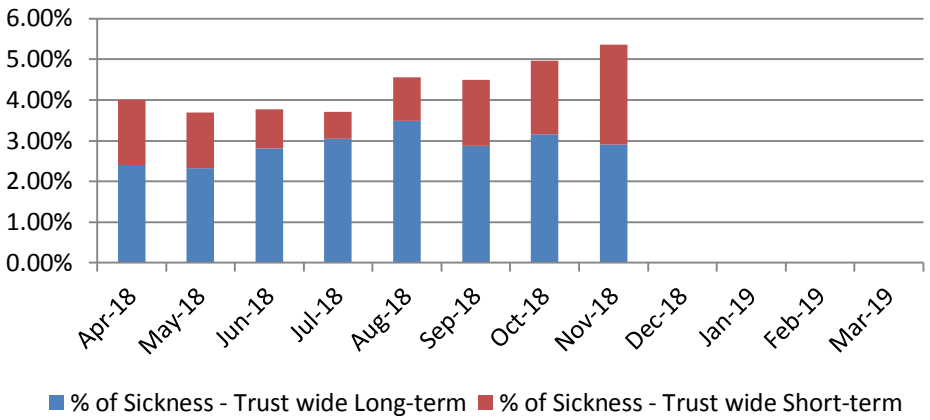




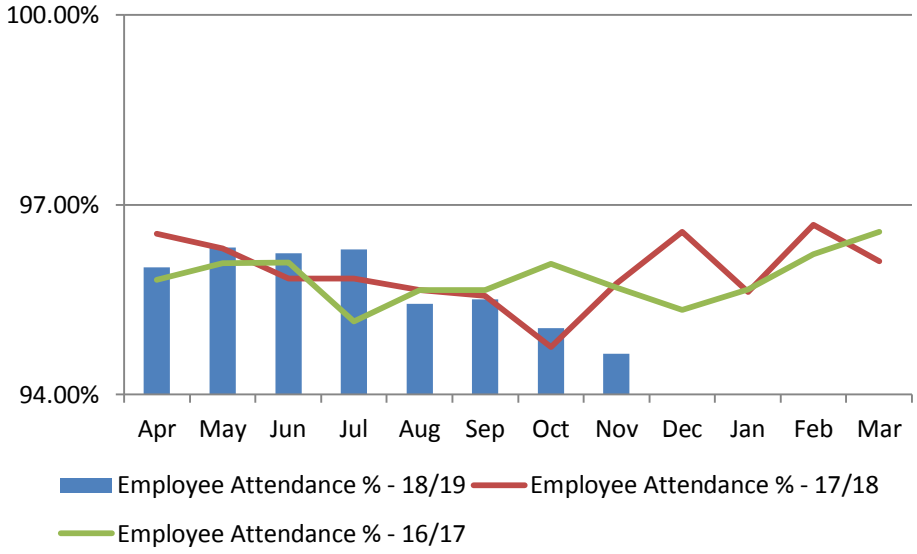
Sickness % - LT/ST (2017/18)



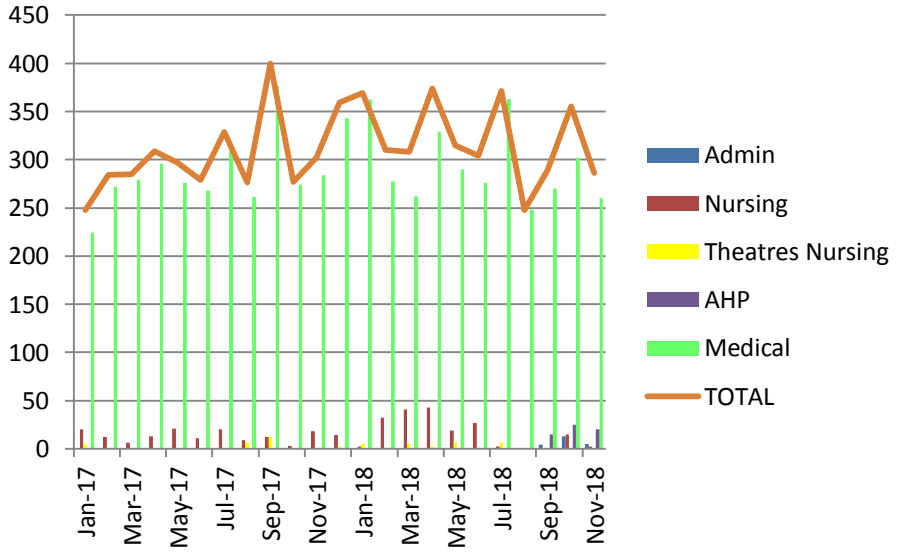
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

November saw a decrease in the vacancy position (despite an increase of staff in post), an improvement in appraisal and a further reduction in turnover; this is set against a decline in our core mandatory training position and a further increase in sickness absence.

This month the Trust's vacancy position saw a decrease of 0.16% as a percentage of WTE employed, with the figure 85.05% against a Trust target of 90%. In context, however, the WTE number of staff on the payroll stood at 924.51, an increase on the October position of just under 2 WTE. The variance is explained by changes in the funded establishment for the Trust, which increased in month by more than the increase in staff in post.

Monthly attendance is now a cause for concern. In November, the position stood at 94.64% (the lowest figure since January 2015), with the stubborn 3% of long term absence (since July 2018) being compounded by almost 2.5% of short term absence. A separate report into this will be provided to the SE&OD Committee in January.

Mandatory Training numbers saw a decrease in November to a position below 90% (89.85%). This is amber for the third consecutive month and will be raised with the operational divisions via their Boards. It is quite possible in month that operational pressures created by short term sickness absence in particular have impacted upon the release of staff for mandatory training.

In contrast, November's appraisal performance increased to the highest level since August 2015, to 85.95%. Whilst this is still adrift from our stretch target of 92.5%, teams continue to make improvement in this area, which is encouraging. There is an increased focus on appraisal corporately.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) reduced for the eighth consecutive month to 10.27%. The adjusted turnover figure (substantive staff leavers including retirements) decreased to 9.02%. Both are green against a KPI of 11.5%. The repeated reduction in turnover since April is particularly being driven by numbers in A&C and ancillary staff groups.

In November, agency breaches showed no great movement from October's weekly average. There were 287 shift breaches in total, 260 of which (c 90.5%) were medical, 20 (c 7%) were AHP, 5 (c 1.74%) were A&C and 2 (c 0.7%) were nursing.

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

Sickness absence is a cause for concern: whilst an element of it is undoubtedly seasonal, it is worthy of further analysis and assurance/ action.

ROHTB (1/19) 010

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

The Royal Orthopaedic Hospital NHS Foundation Trust

Date Group or Board last met: 7 November 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that as at 30 September, there were 53 vacant posts (some being part time) which did not have a plan to recruit into them. This had dropped from a level of 115 in June 2018 however. • It was noted that there was more work to do to improve the Trust's rating against the Workforce Race & Equality Standards (WRES). • There were reported to be 3% of staff on long term sickness absence. There was confidence in the process and policies in place to manage these individuals however. • There remain difficulties with recruiting into nursing posts in theatres in particular. • It was reported that Ward 2 was staffed by only 28% permanent nurses, although temporary staff are block booked to secure some stability in the workforce.	• It was suggested that further work was needed to obtain value from the information that staff provided on their exit questionnaires or to declare why they are moving on. • Produce a document for the Executive Team to detail current conduct cases. • The equality and diversity action plan to show more clearly when key actions are to be delivered on a month by month basis. • A further update on plans to address vacancy gaps was requested for the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee heard a staff story from Peter Gibbons, Charge Nurse for Ward 3, which presented a positive experience from the perspective of the level of development opportunity available at the ROH and the engaging tone of the Friday messages from the Chief Executive. • The equality and diversity action plan was noted to show good progress, particularly on actions associated with mental health. • The Committee was advised of some positive work underway to address the nurse staffing vacancies, including engagement with educational establishments and recruitment fairs. • The staff friends and family test results remained positive and suggested that staff believe the ROH is a great place for patients to receive treatment.	• The workforce overview will be presented to Trust Board from January 2019 onwards, in the same way that the equivalent reports for Finance & Performance and Quality & Safety are.

Chair's comments on the effectiveness of the meeting: The Chair requested that the correct cover sheet for reports be used in future to highlight how the paper aligned with the People & OD strategy. It was agreed that the input of the departmental heads of workforce, HR & OD had been useful at the meeting.

Workforce Performance Report

November 2018

CONTENTS

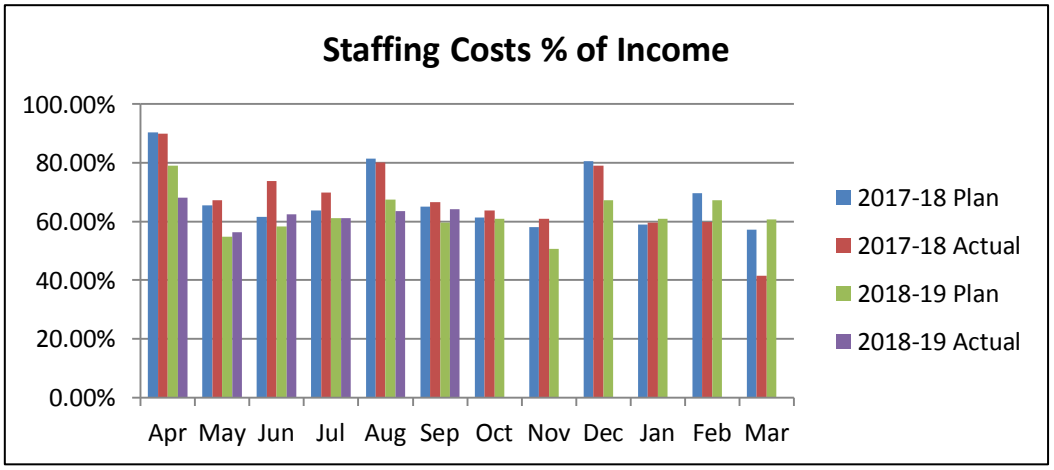
Staffing costs

1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	40747	
Actual Income YTD	41636	102%
Planned Pay Costs (YTD)	25462	
Actual Pay Costs (YTD)	25974	102%
Planned Substantive Pay Costs (YTD)	21225	
Actual Substantive Pay Costs (YTD)	20375	96%
Planned Bank Pay Costs (YTD)	2332	
Actual Bank Pay Costs (YTD)	2924	125%
Planned Agency Pay Costs (YTD)	1819	
Actual Pay Costs (YTD) Agency Staff	2653	146%
Planned Agency Pay Costs as % of total Pay costs (YTD)		7.1%
Actual Agency Pay Costs as % of total Pay costs (YTD)		10.2%

Total ADH Payments (Apr - Sep) £000s	1044

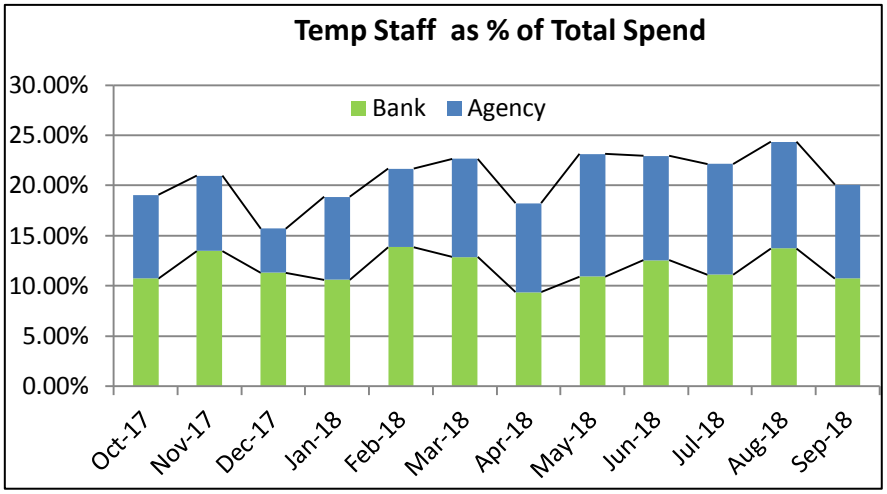


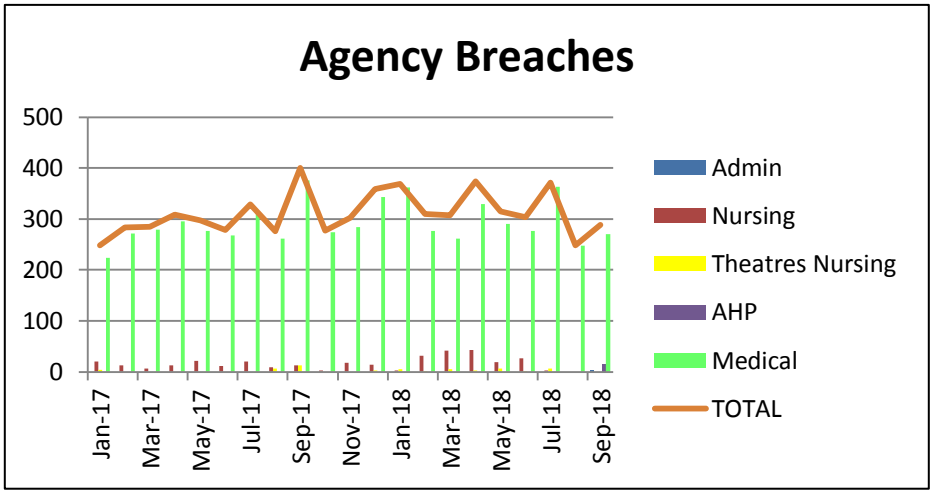
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	242	363
May	242	514
Jun	242	443
Jul	242	490
Aug	242	440
Sep	242	402

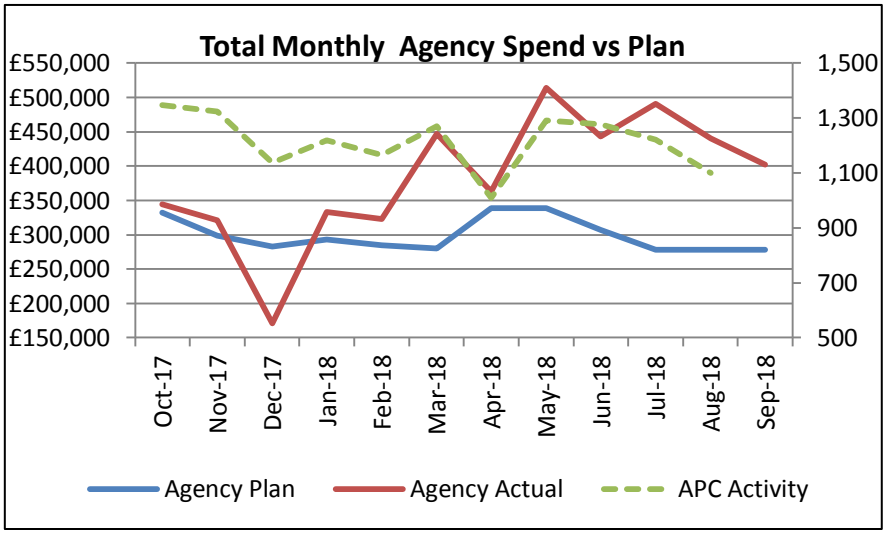
Data based upon September Management Accounts

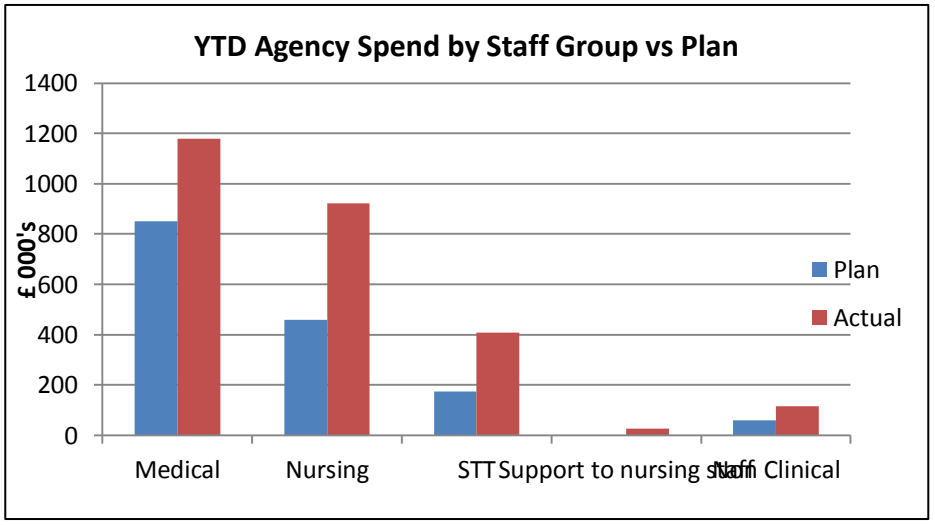
1 Workforce Composition and Cost

1a Temporary Staffing Analysis



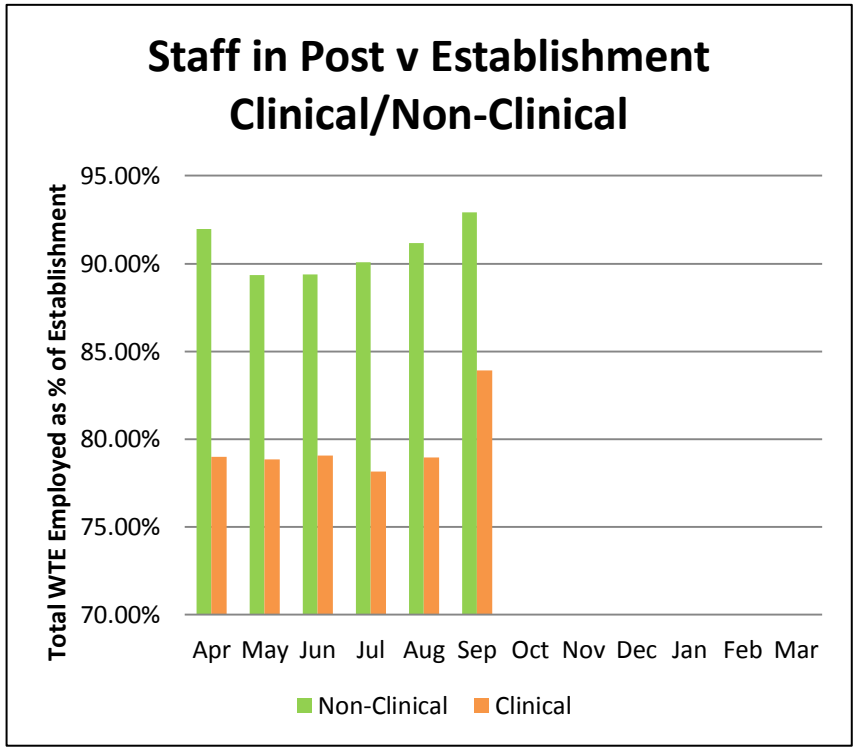


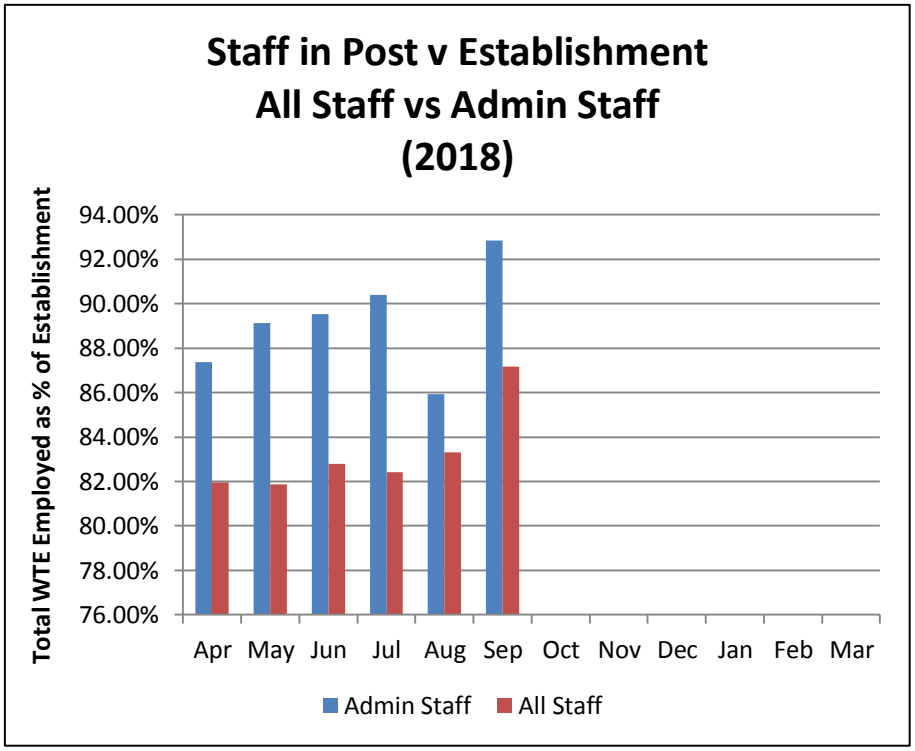




1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

Establishment





1 Workforce Composition , Resourcing and Cost

1c Recruitment and Selection

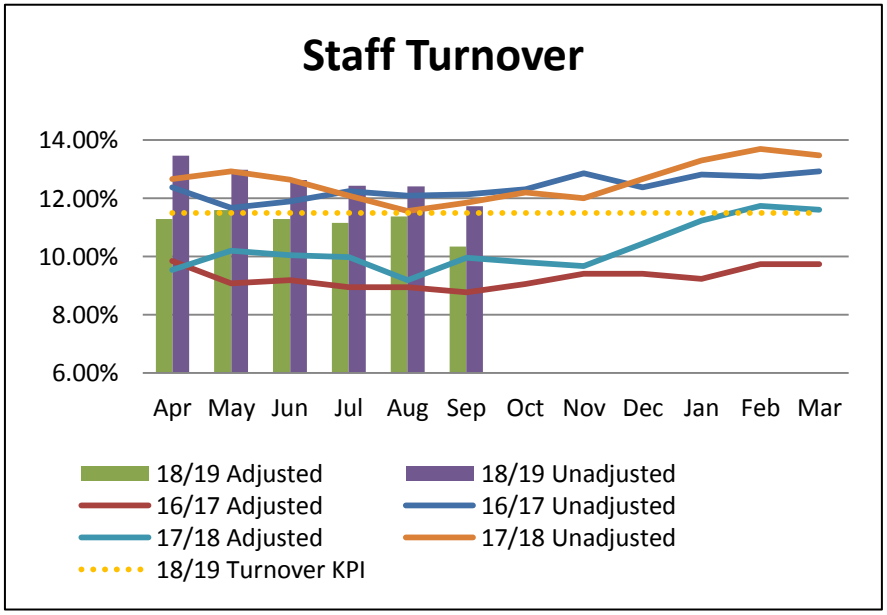
R&S

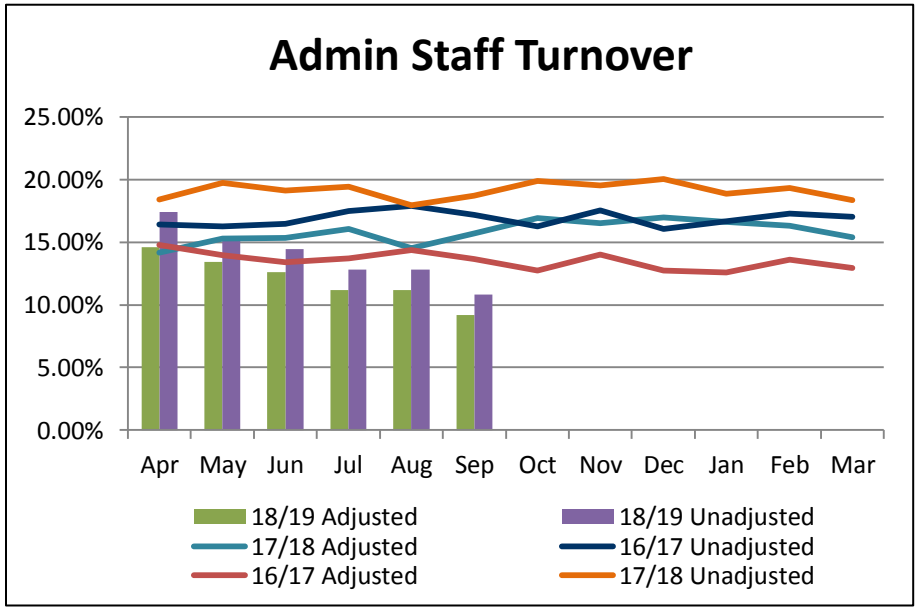
	FTE Variance	Vacancies FTE Variances	Over-establishment	Awaiting ATR /ATR in progress	Advertised	Shortlisting	Interview	Conditional Offer	Complete awaiting Start Date	Alternative Recruitment	Bulk Recruitment	No recruitment plan
Add Prof Scientific & Technical	-16.06	-23.06	7.00	4.29	5.50			7.00	2.00	3.00		1.27
Additional Clinical Services	-24.72	-30.46	5.74	1.89		7.45		10.50	6.00	1.00		6.30
Administrative and Clerical	-20.85	-49.49	28.64	5.25	1.00	3.00	1.00	3.40	2.53	13.02		21.18
Allied Health Professionals	-4.49	-9.89	5.40					2.68	2.00	2.15		3.05
Estates and Ancillary	-5.85	-6.85	1.00							4.20		2.65
Healthcare Scientists	2.00	-1.00	3.00									1.00
Medical and Dental	-15.29	-25.62	10.33	1.75	2.00	1.00	2.00	3.00	2.00	3.50		10.87
Nursing and Midwifery Registered	-48.96	-64.99	16.03	1.00	28.60			5.96	13.11	2.46	8.76	7.01
Grand Total	**-134.22**	**-211.36**	**77.14**	**14.18**	**37.10**	**11.45**	**3.00**	**32.54**	**27.64**	**29.33**	**8.76**	**53.33**

As at 30th September 2018

1	Workforce Composition , Resourcing and Cost
1d	Staff Turnover

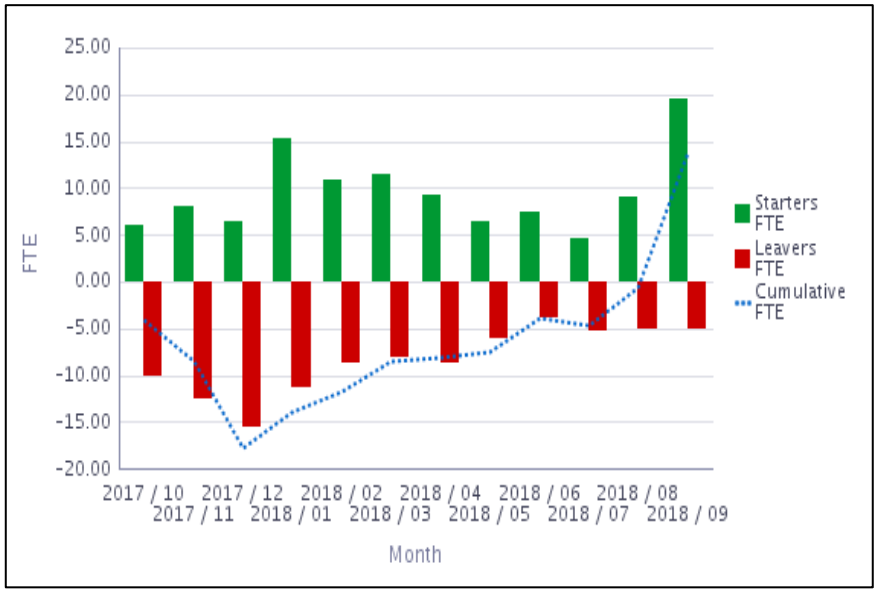
Turnover



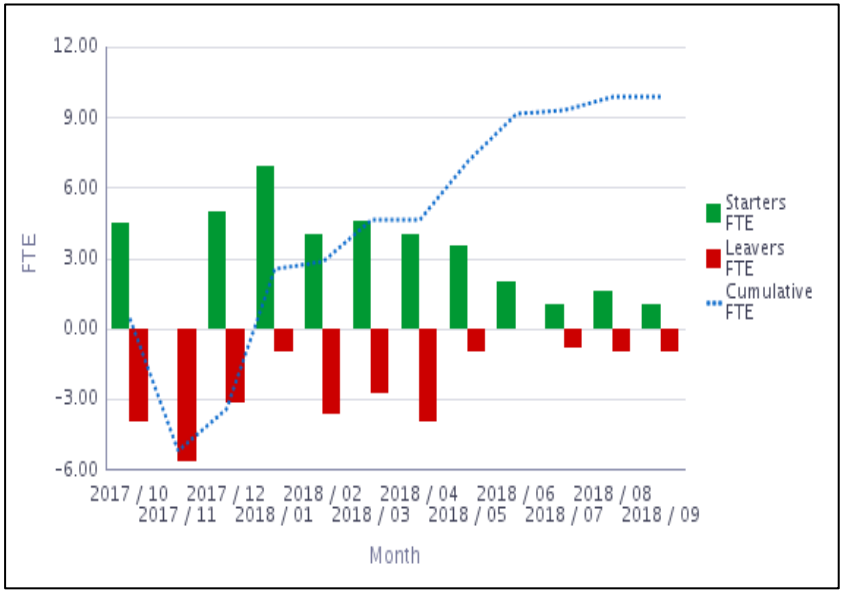


1	Workforce Composition , Resourcing and Cost
1d	Staff Turnover

Starters / Leavers by Month - All Staff

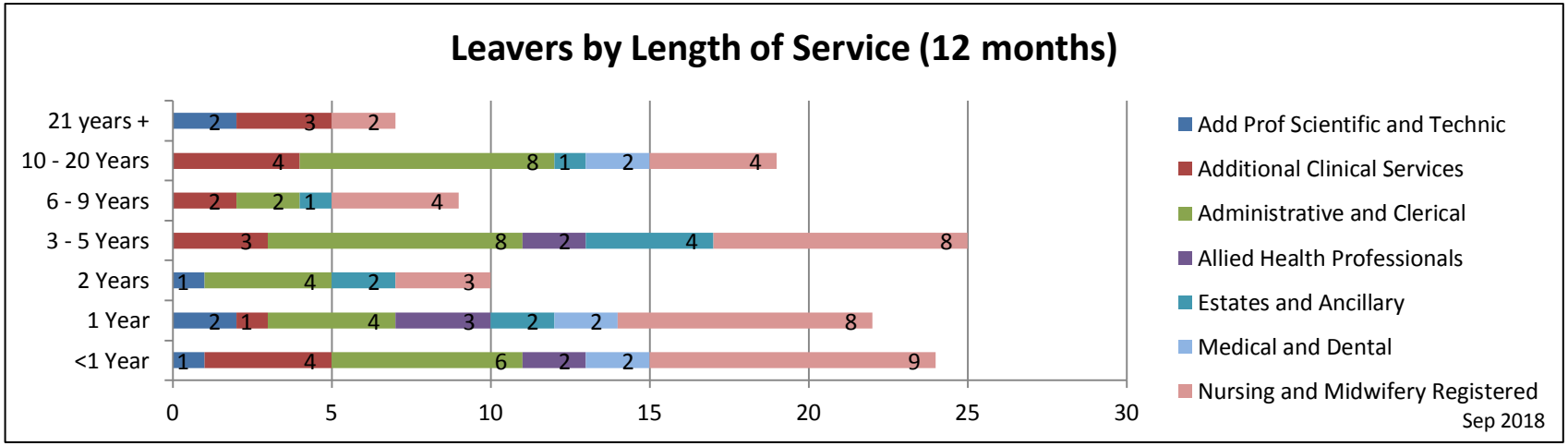


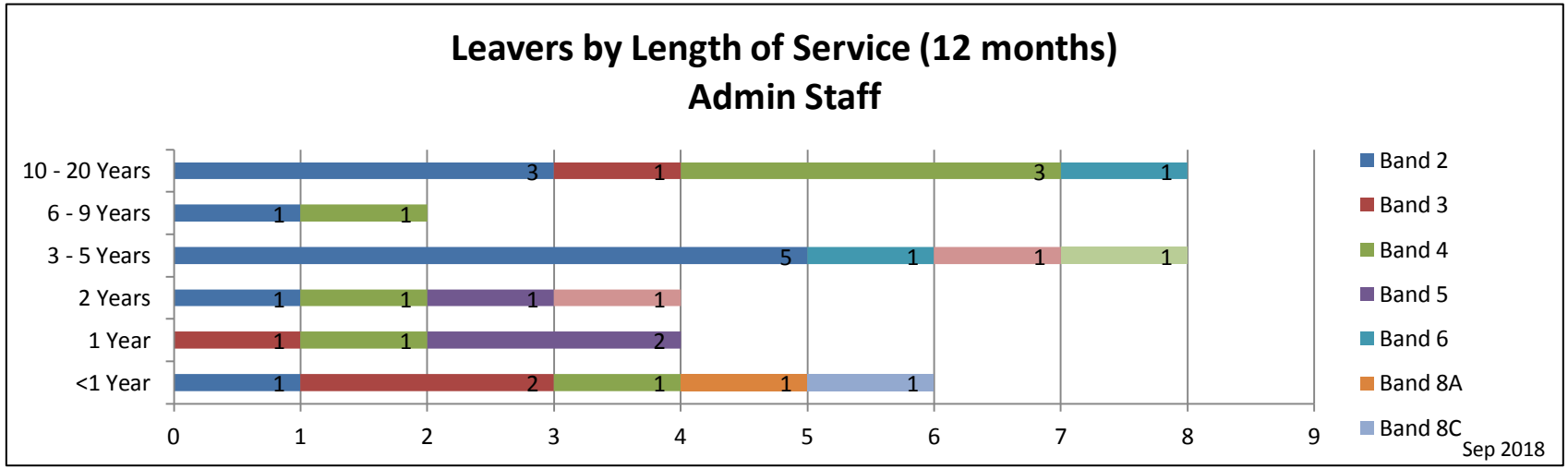
Starters / Leavers by Month – Admin Staff



1 Workforce Composition , Resourcing and Cost

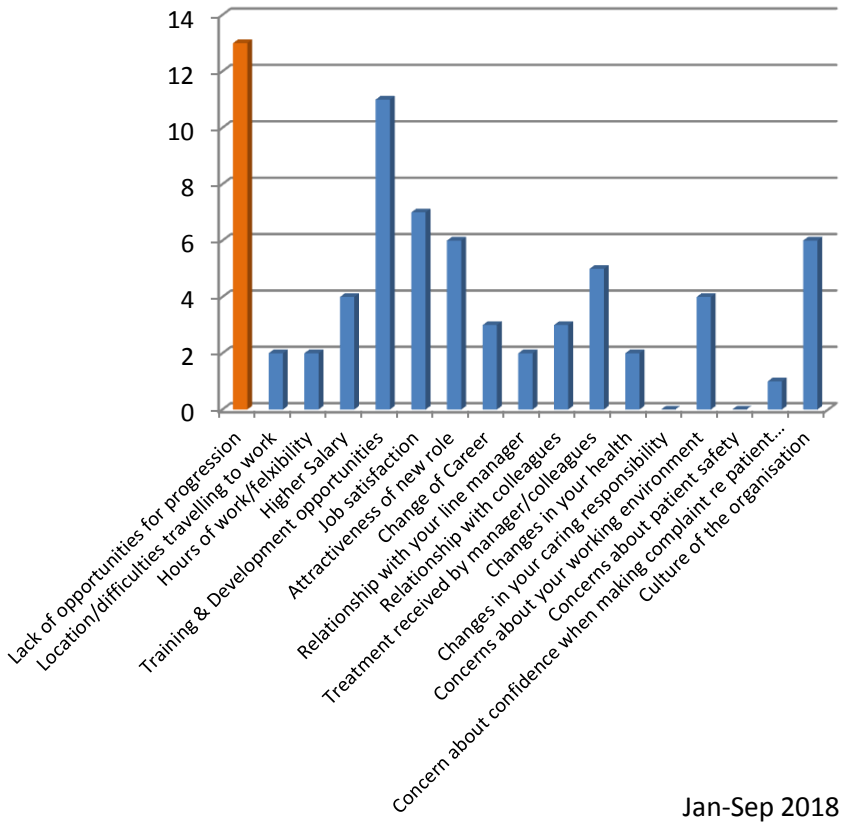
1d Staff Turnover





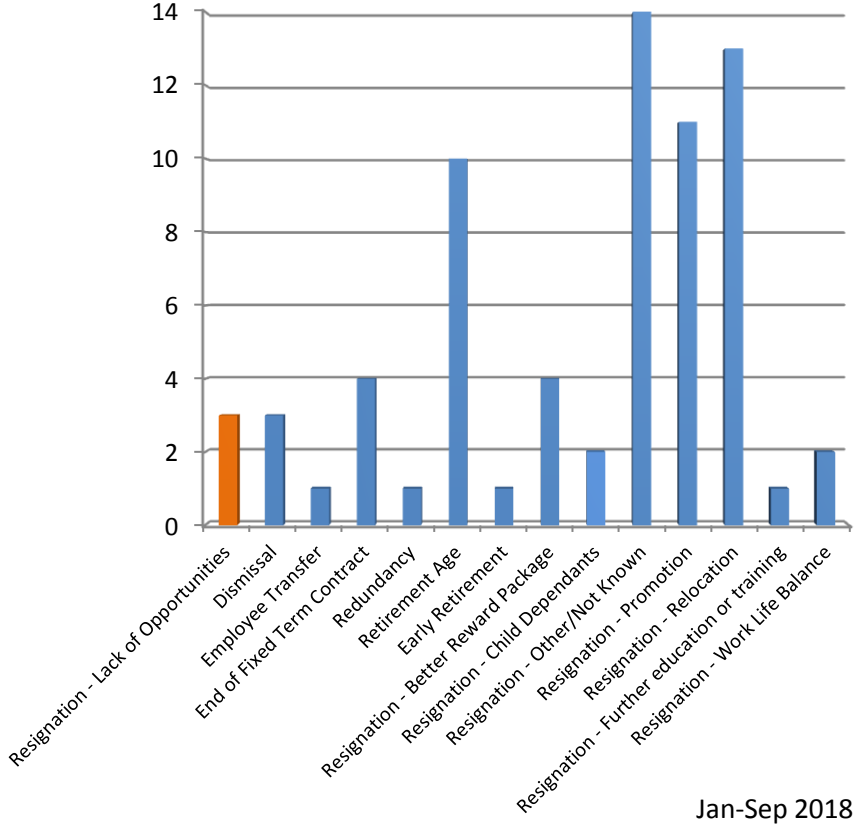
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire

Reason for Leaving (Exit Questionnaire data)



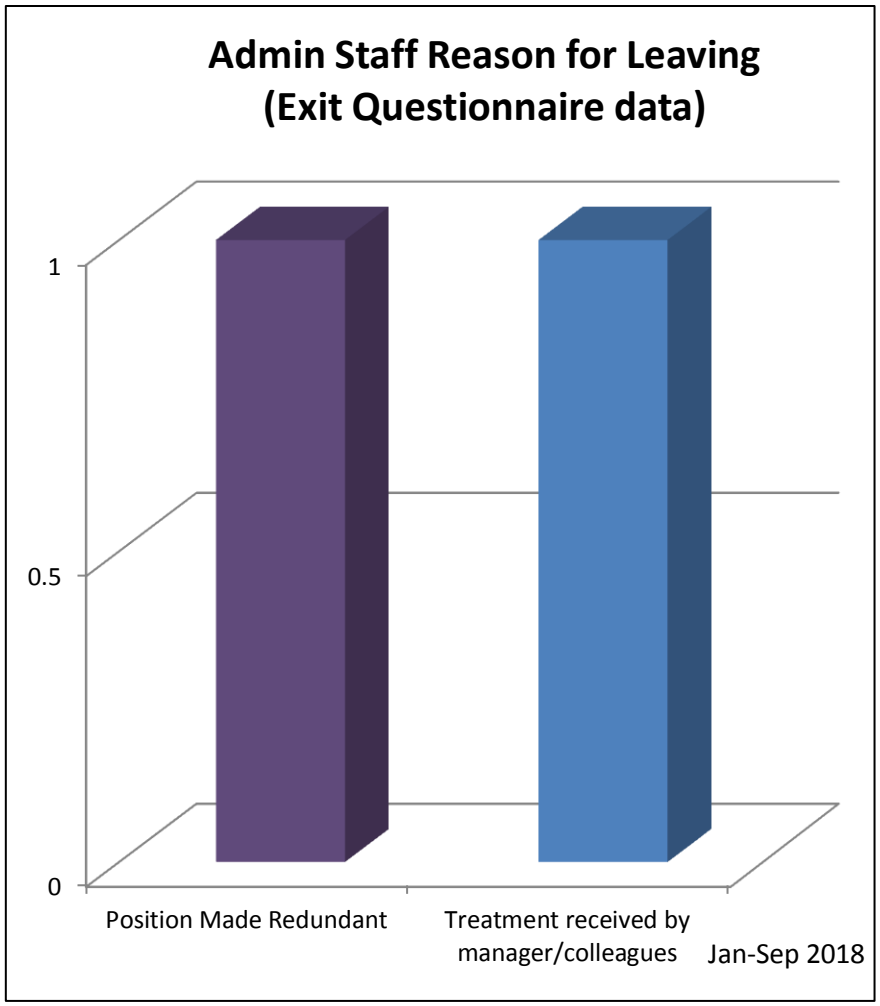
Jan-Sep 2018

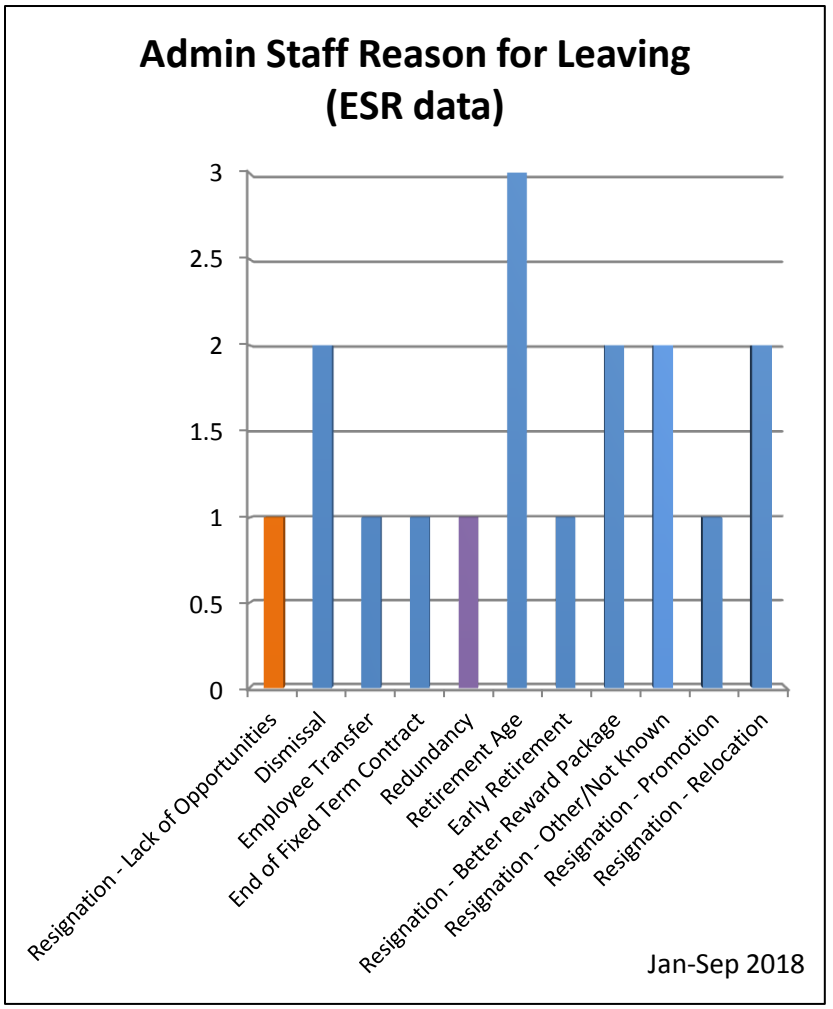
Reason for Leaving (ESR data)



Jan-Sep 2018

1	Workforce Composition , Resourcing and Cost
1f	Exit Questionnaire

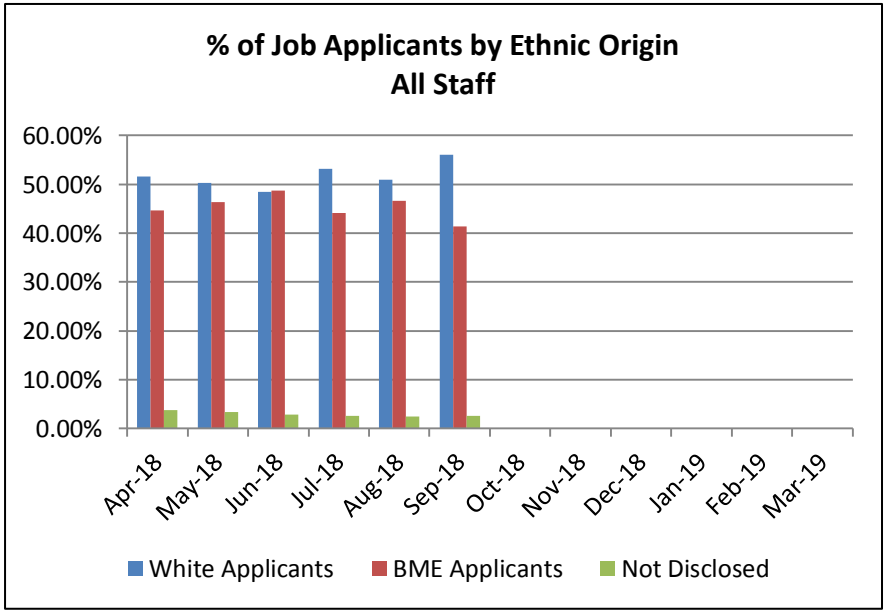


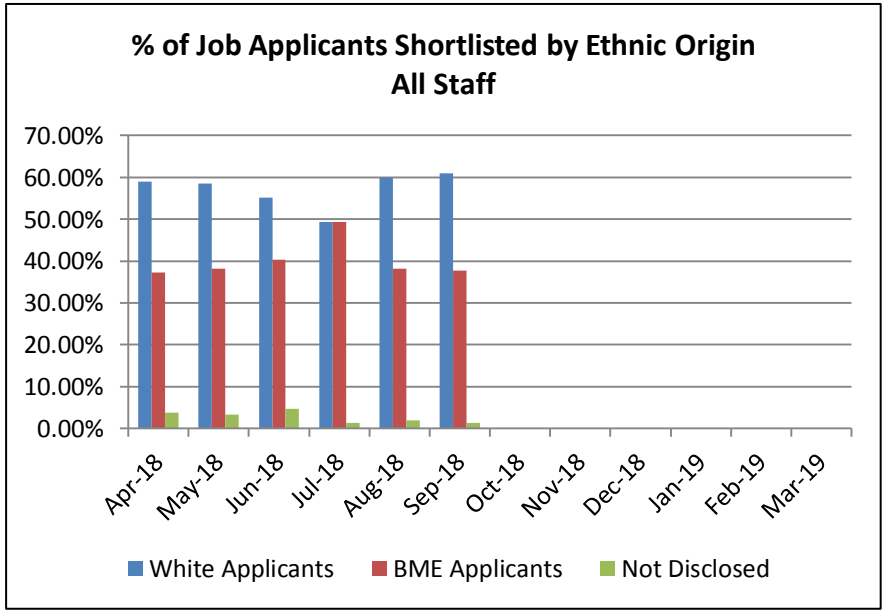


1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



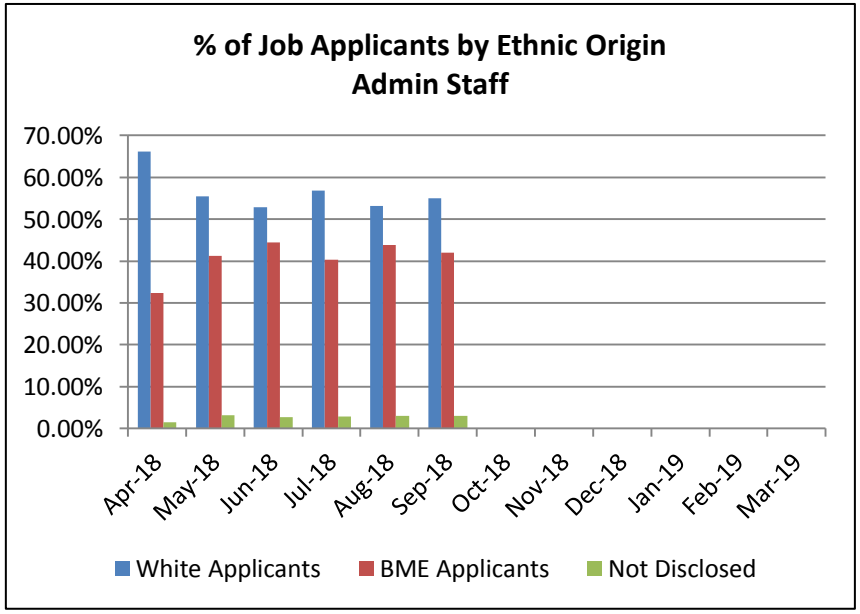


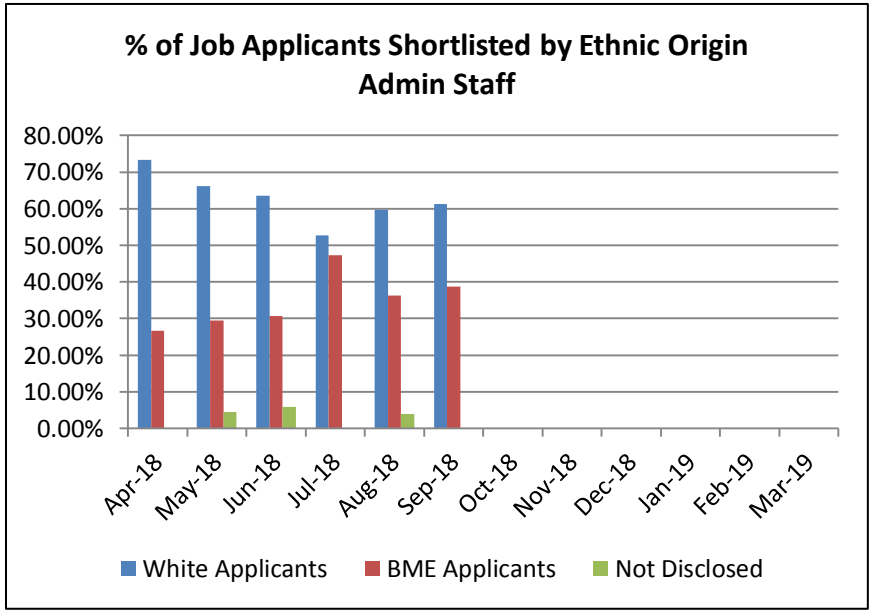
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.82	↓	0.22	+ 0.18	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1g	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month	Trend	Variance to National benchmark	National Benchmark
1.51	N/A	TBC	TBC

Workforce Composition, Resourcing and Cost

Staffing Costs – The actual spend on staffing was slightly above that planned for the year to date as at the end of September (102% of plan). This position is driven by higher than planned expenditure on bank and agency staff (agency staff in medical, nursing and therapy staff groups). Encouragingly, however, agency spend has reduced for each of the last 3 months - and in addition, income stands at 102% of plan. There is inevitably a cost to delivering increased activity and the challenge remains to close the current vacancy gap as outlined below – but there is some cause for cautious optimism.

Turnover – Adjusted turnover is reported at 10.34% as a rolling 12 month figure against a refreshed trust KPI of 11.5%. This is at its lowest level since January 2018, when the report calculations were rebased to include retirements. Together with the recruitment and selection data below, this paints an encouraging picture.

Slightly deeper analysis of attrition by length of service is provided at page 7. This data is being used by the Nursing and ODP Working Group to explore and develop solutions. Almost 45% of nursing staff who have left in the last 12 months had under 2 years' service, which remains a cause for concern, although separate ESR analysis yields no further insights (7 promotions, 5 relocations and 5 resignations out of 21 nursing staff). Work has begun by senior nursing colleagues to keep in touch with new joiners in particular, to help them into the Trust.

In terms of reasons for leaving, the more prescriptive ESR options yield the usual 4 categories in order: voluntary resignation other/ not known, relocation, promotion and retirement. The exit questionnaire reasons offer more scope, however: lack of opportunities for progression, and training and development opportunities are the top 2 reasons, with lack of job satisfaction a less frequent reason in third place. This can be seen to correlate with ESR to the extent that some staff are resigning for promotion or training and development opportunities elsewhere (ESR) and may offer an insight into the often used "other/ not known" ESR category.

There is always going to be a progression challenge given the size of the Trust, but there is longer term work ongoing to map competences to articulate available career progression opportunities, and 15 nursing staff are being supported to undertake an orthopaedic module as further specialist training, so there is some progress to report in this area.

Recruitment and selection - There were 15.64 WTE more staff on the payroll in September than in August (total now is 905.67WTE), meaning that the Trust has its highest ever number of WTE staff employed.

The size of the outstanding vacancy gap and recruitment plans to fill is contained on page 6: there has been a marked increase in the percentage of filled clinical posts, which now stands at 84%. This is in part due to new starters, and also removal of some establishment posts which were (safely) never going to be filled. From a detailed analysis of posts in the recruitment process, there remain 134.22 FTE ledger vacancies but of these, just 53.33 FTE now have no recruitment plan identified. This is marked progress compared with the 116.89 WTE without a plan as reported to SE&OD Committee in July 2018.

Workforce Composition, Resourcing and Cost

- Rolling adverts are now in use for a number of roles and attraction materials are being refreshed. This will be important for theatre expansion in particular in the months ahead.

- **WRES Indicator 2** monitoring is now provided. The diversity of applications remains strong and the shortlisting rations appear consistent. However, there has been a slight worsening in the last month which would suggest that there is a disproportionate likelihood of being appointed if you are from a white background. Further work will be undertaken on this in Q3, with a sample of jobs from NHS Jobs being analysed in more depth to understand this better. There will also be benchmark data available early in Q4, so this will enable some assessment of the extent to which the Trust is typical or unusual in its performance in this regard.

- **Deep dive – A&C staff workforce information**

The deeper dive into the A&C staff group yields the following observations;

They are generally easier to recruit than their clinical counterparts (93% of the establishment is filled) and there are more FTE in post than ever before

In contrast, they are the staff group with the most vacancies for which there is no recruitment plan (this is not altogether surprising, as managers will most often not fill A&C posts as opposed to clinical posts)

Turnover has dropped as with the rest of the Trust since April 2018

Retirement seems to have been the most common reason for leaving, as opposed to promotion/ relocation

They are proportionately more likely to be off with SAD than with musculoskeletal problems: this will be fed into the well being group and considered as part of branding

They are more likely to receive a return to work interview, which suggests that clerical staff who are their managers are struggling less with input than their clinical colleagues.

2 Workforce Performance

2a Staff Attendance

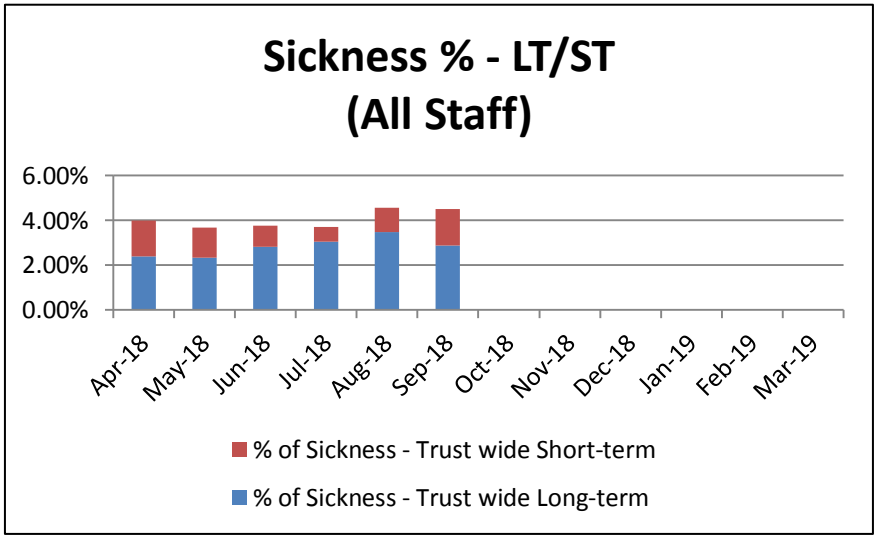
Staff Attendance

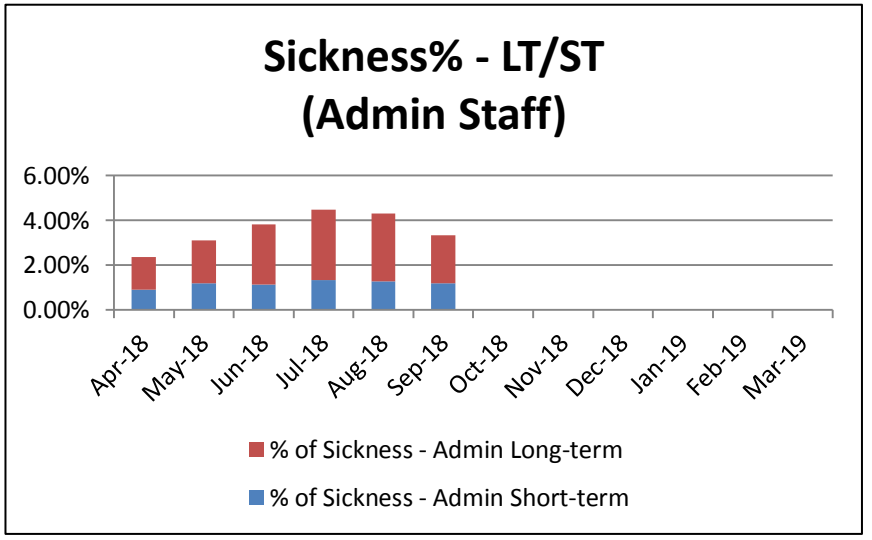
Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
95.71%	95.79%	↓	0.39%	96.10%

ALL STAFF * 12 months to End of September 2018

Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
96.67%	95.70%	↑	-0.57%	96.10%

ADMIN STAFF * 12 months to End of September 2018





2 Workforce Performance

2b Staff attendance – short-term absence management

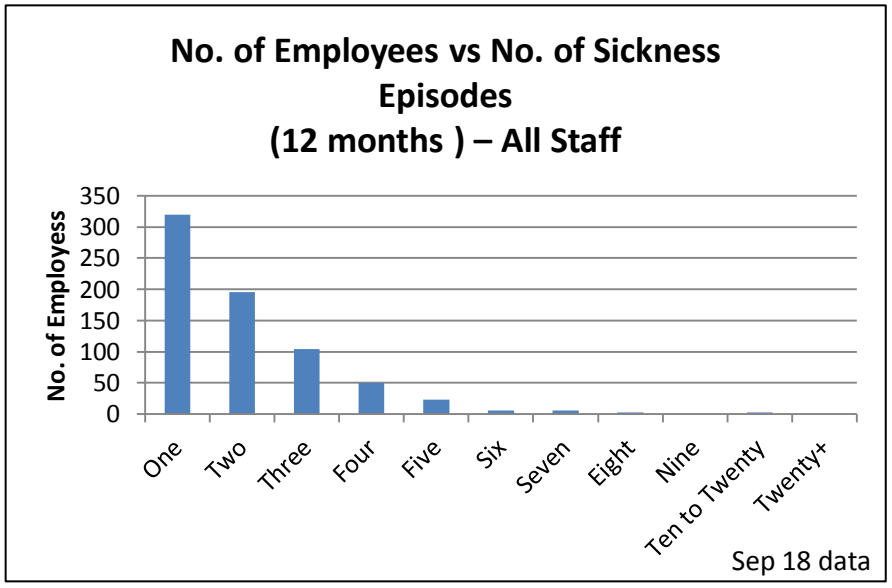
Staff Absence

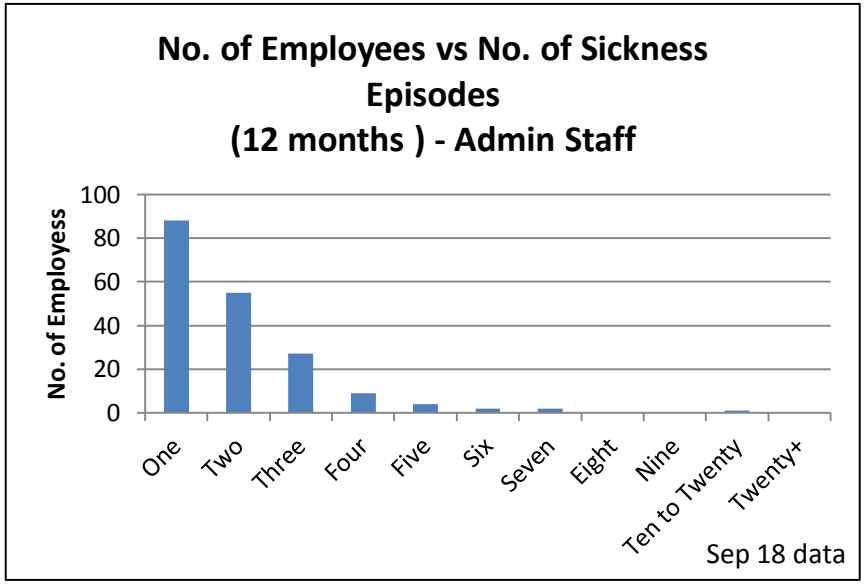
Return to Work Process Completion Rate (12 months) *Sept18

ALL STAFF

Return to Work Process Completion Rate (12 months) *Sept18

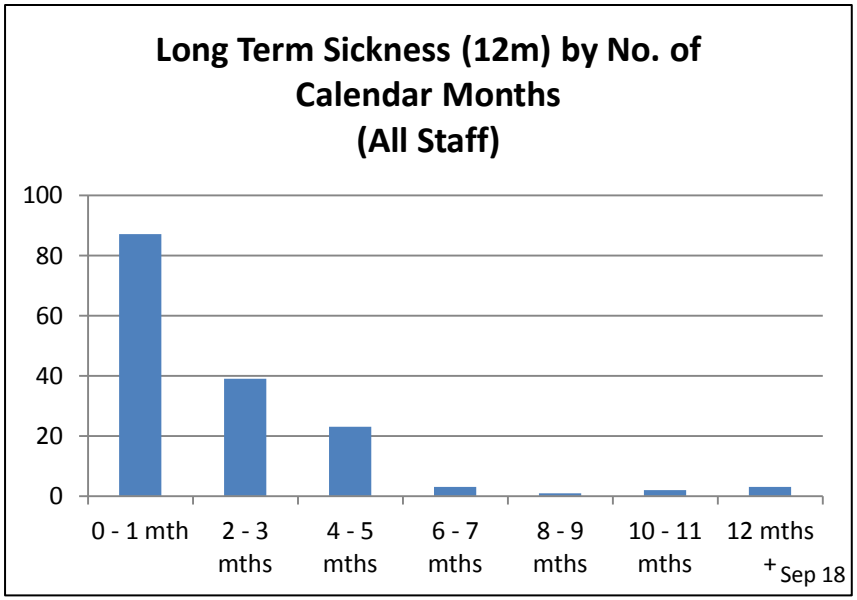
ADMIN STAFF

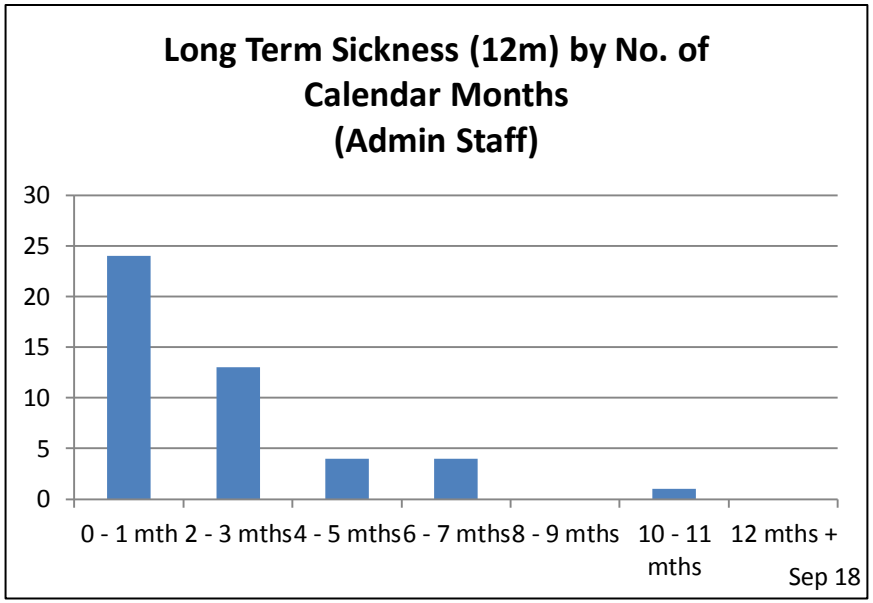




2	Workforce Performance
2c	Longer-term Staff Absence

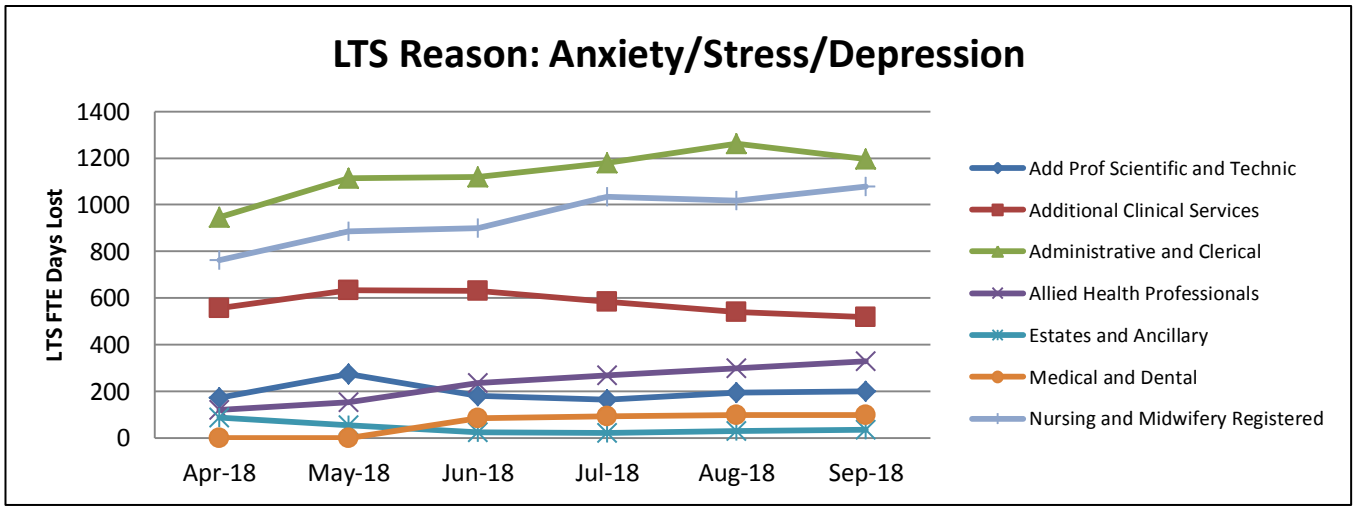
Long-term Staff Absence

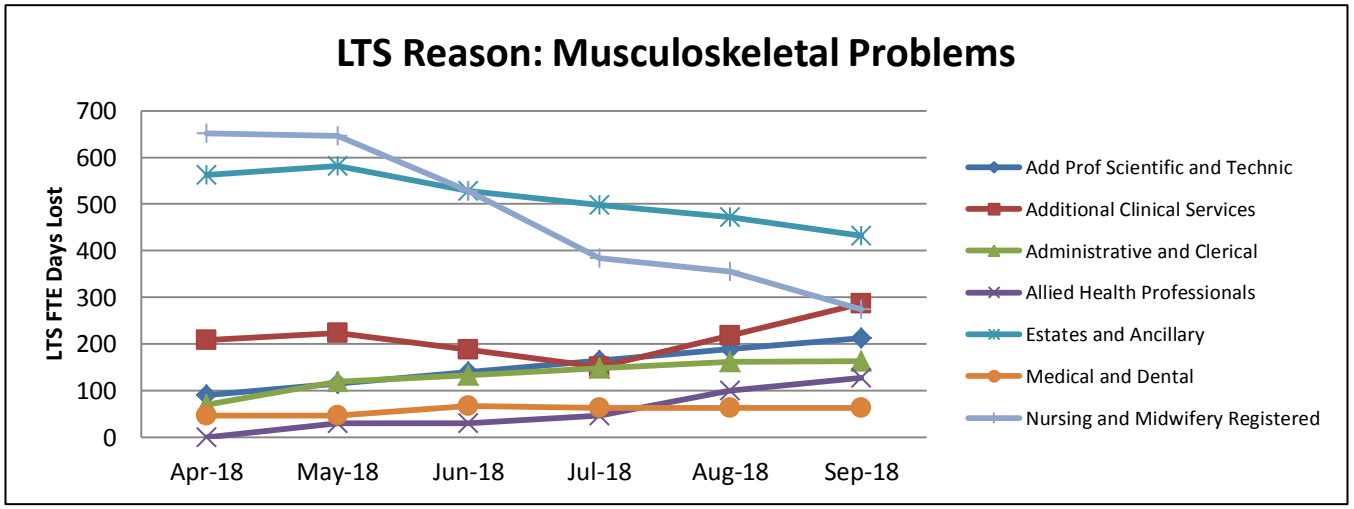




2 Workforce Performance

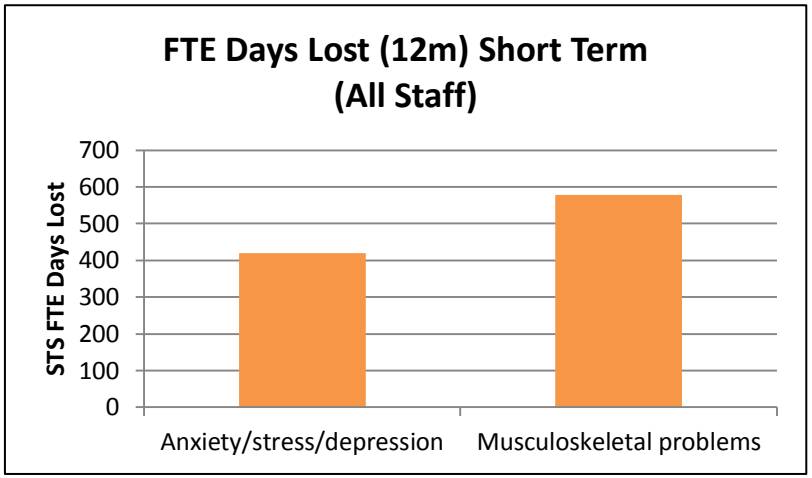
2c Longer-term Staff Absence

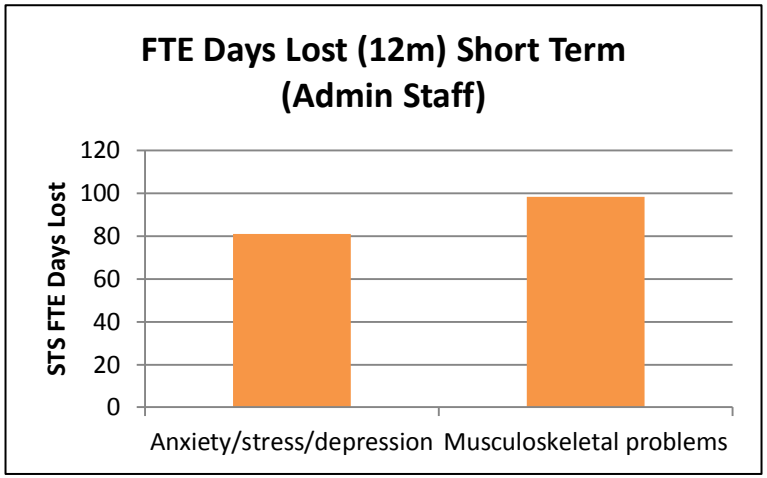


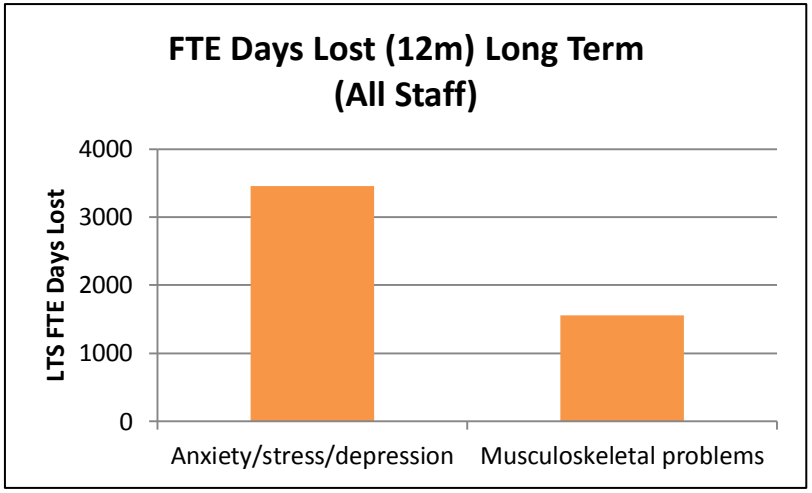


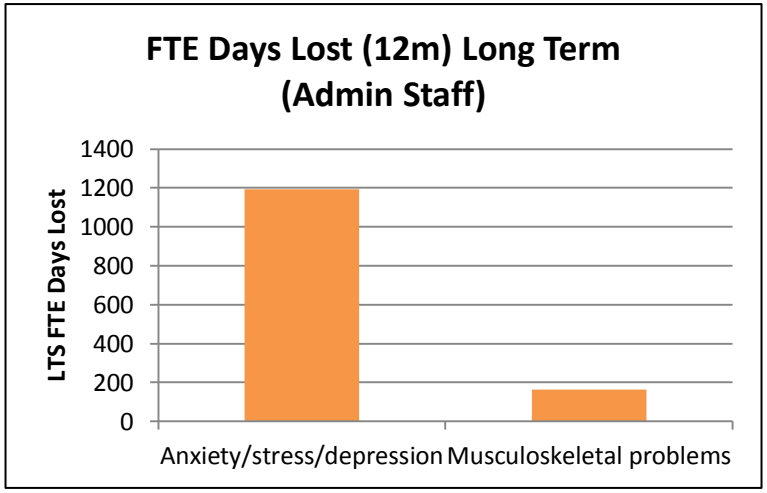
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary

Management of Performance

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	0	0	1	1	7	5

September 2018 – 12 month reference period

INFORMATION

Staff Attendance – Monthly attendance in September improved slightly on August's position to 95.50% - but this was still red, following a sickness absence long term "spike" in July.

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% (against a Trust target of 96.1%), with little change on previous months. The long and short term cases are known to HR Managers via separate reports and are pursued with individual line managers as necessary – and are also referenced at Divisional Boards on an ongoing basis.

The 12 month completion rate for return to work (rtw) meetings is stable at over 50%, but improvement is still required in this area. At divisional performance reviews, assurance is sought and given that rtw meetings are being held but computer input is cited as a main reason why this is perceived as an under-report.

Work continues on staff well being, with an assessment having been completed by the Trust's Health and Safety Adviser into areas of relative strength and weakness using the NHS Employers Toolkit. A key recommendation of that analysis is the absence of branding for staff wellbeing, which will be a focus for the October SWAG meeting. It is proposed that the group's terms of reference be widened following the rebranding because of the natural links with wider physical and mental wellbeing.

In terms of EAP/ Occupational Health provision, there is work underway at STP level to scope collaboration with other local Trusts to develop options for an effective long term solution, with resource being provided from HEE until March 2019 to support this work. The EAP/OH solution which was previously being explored is unlikely to bear fruit, as BWCH would like to disassociate from the same provider.

ACTIONS FOR IMPROVEMENTS / LEARNING

Procure new OH and EAP provision via STP partners
Succession and key competency resilience maps to be completed.

RISKS/ISSUES

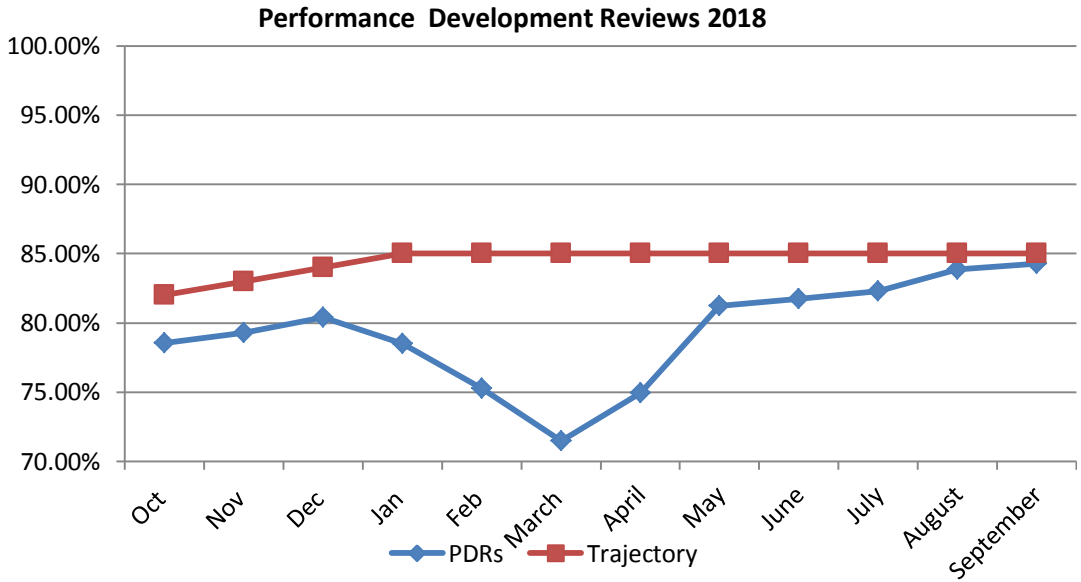
Long term absence through mental health including stress and anxiety and MSK
Ineffective performance management.

3	Workforce Learning and Development
3a	Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NNS Engagement Question	2017	2016	2015
20a	In the 12 months have you had an appraisal or annual review?	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	64%	74%	79%
20f	Were any training, learning or development needs identified?	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date



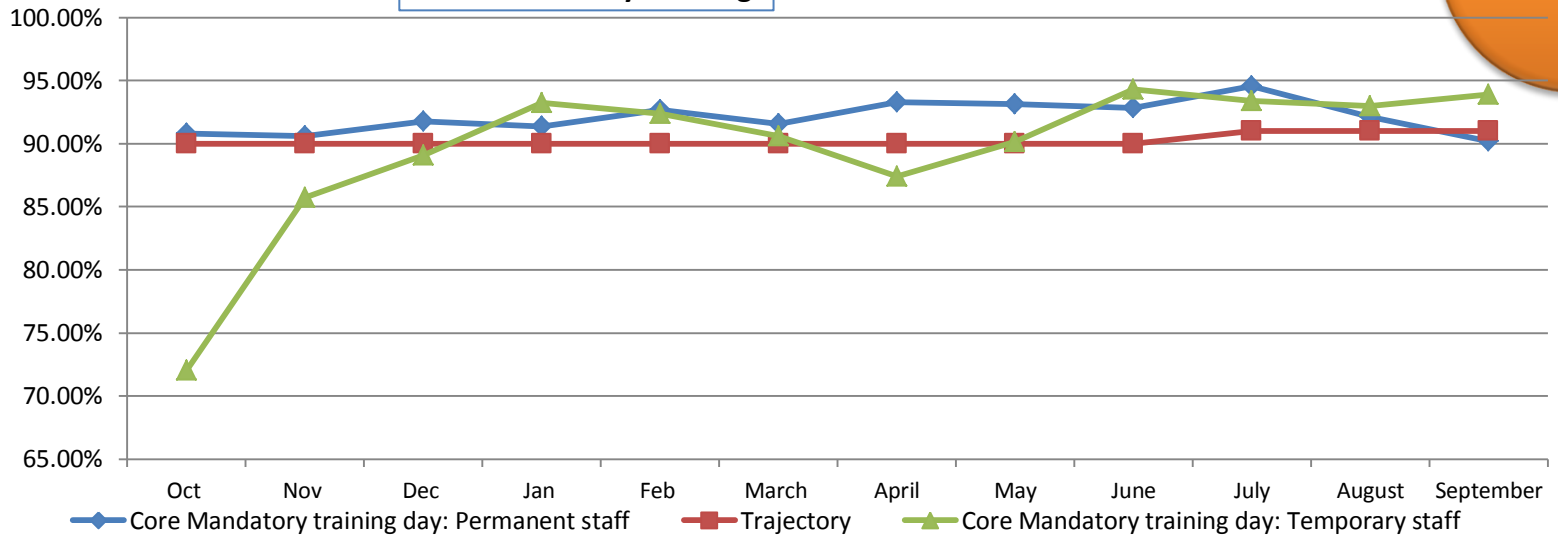
Outcomes from the National Staff Survey suggest that the Trust appraisal process occurs with staff at rates comparable with similar trusts, however the effectiveness of the process, the identification of behavioural and skills development needs and the management of these requires improvement. This links to the overall requirement to improve performance management processes within the Trust.

3 Workforce Learning and Development

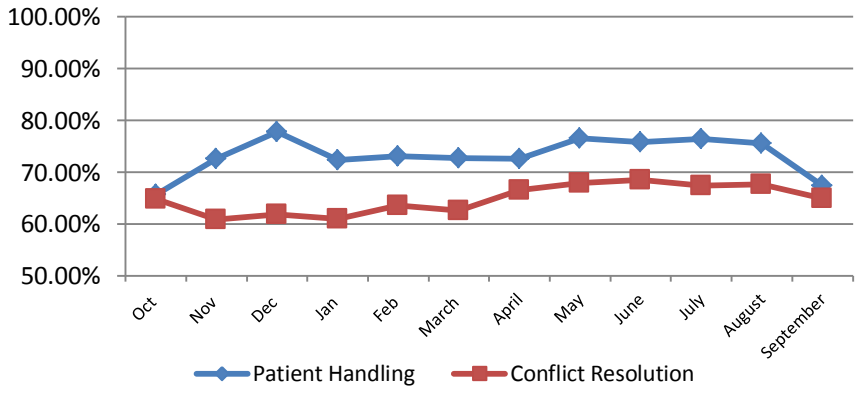
3c Core Mandatory Training, Specialist Training and Corporate Induction

Mandatory Training

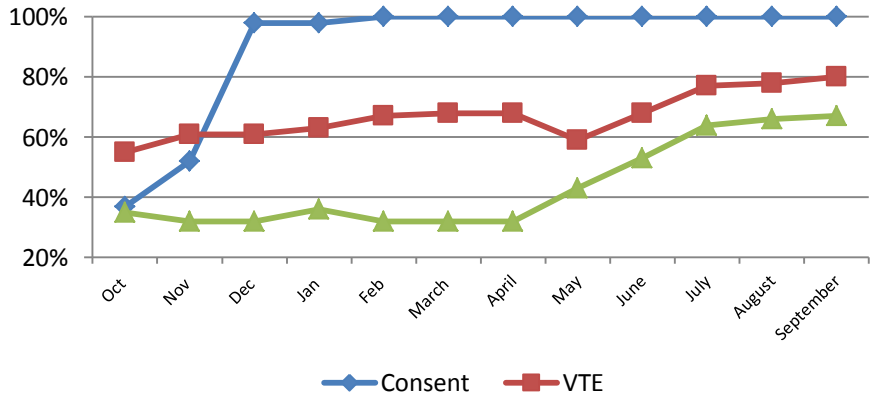
Core Mandatory Training



Patient Handling and Conflict Resolution Compliance



e-learning Modules Compliance

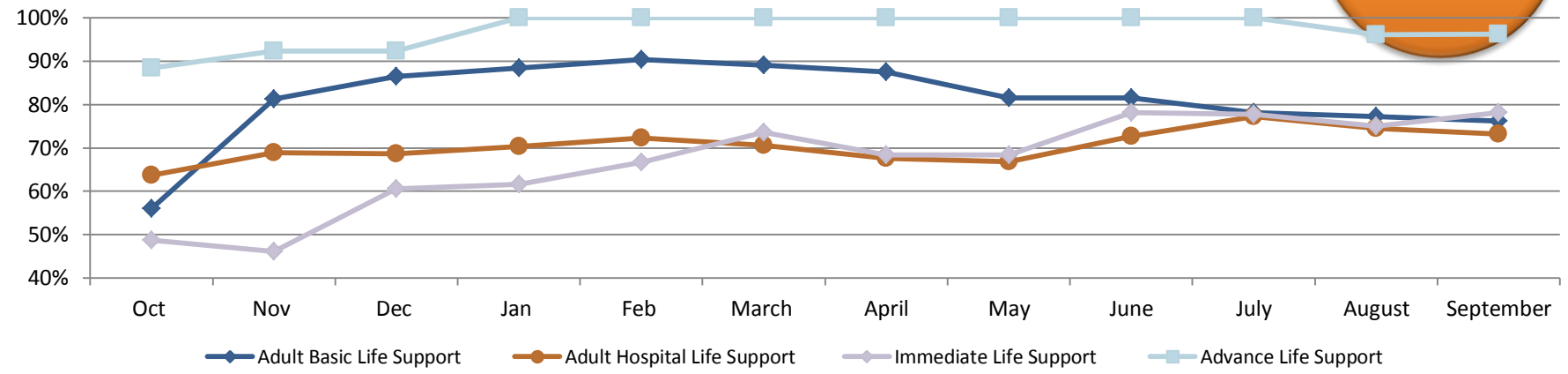


3 Workforce Learning and Development

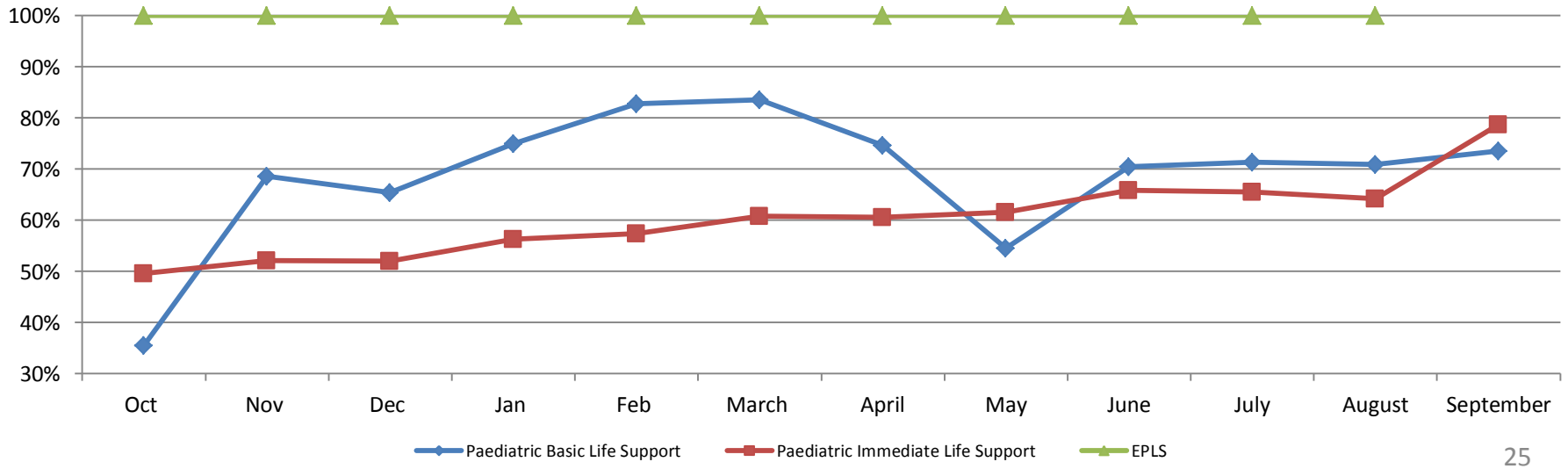
3c.1 Resuscitation Training

Mandatory Training

Adult Resuscitation Training



Paediatric Resuscitation Training



INFORMATION

Core Mandatory Training – the Trust remained above 90% for the month of September, but slipped below its performance target of 92% for the first time this year. 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%.

There has been a slow increase in people completing the core mandatory training modules online – with around 10% of completions being online to date.

CMT for Bank / Temp staff has been maintained at a level of over 90% for 4 months.

Role Specific Mandatory training –

The Trust Resuscitation training compliance level for adults still hovers just under 80%. Encouragingly, paediatric resuscitation has seen a steady increase to 80% over the last few months. Resuscitation standards and governance processes have recently been reviewed and updated . The risk for resuscitation training compliance figures is monitored through the quality and safety group.

There have been slight deteriorations in September both in conflict resolution and patient handling compliance, and both are still non-compliant. This has been raised with the clinical quality group, and a small focus group is to be created to explore solutions.

VTE / Insulin – There have been good improvements in compliance following the IT issues being resolved during May. Improvements have been seen in staff completing insulin, and VTE has been noted following the review of requirements.

ACTIONS FOR IMPROVEMENTS / LEARNING

Core mandatory training :– Mandatory training streamlining / CIP project continues. There has been positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information.

Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place

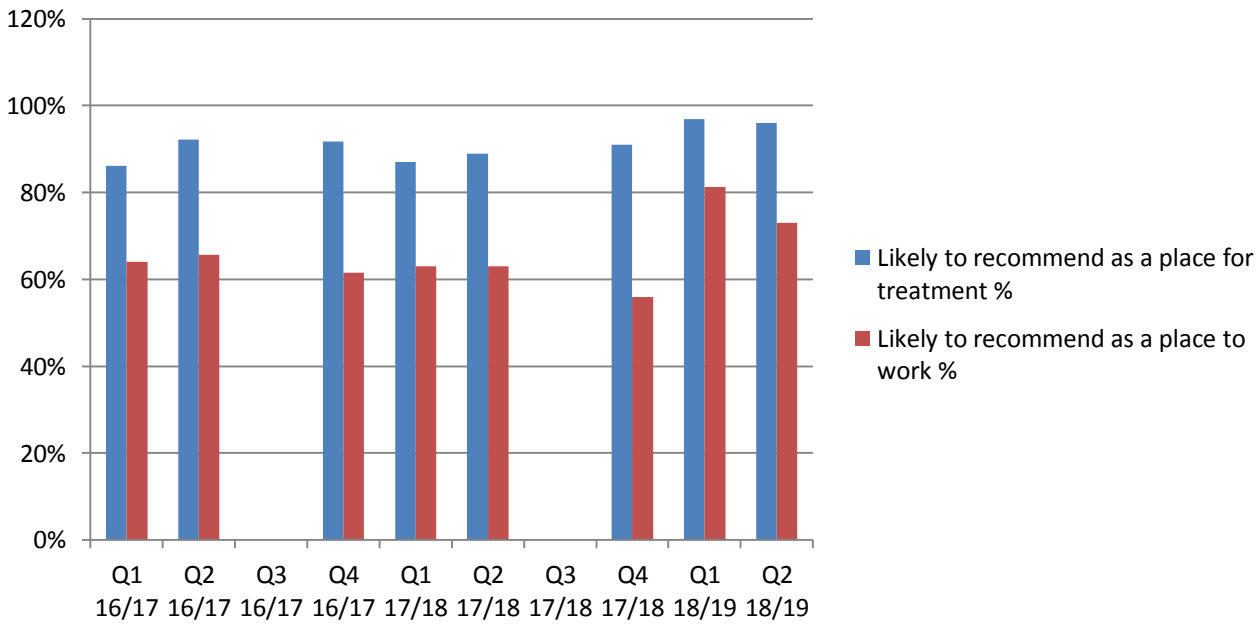
VTE/Insulin online modules: the e-learning facilitator is working closely with subject matter lead to increase compliance, creating learning paths in ESR, and spending time in theatres to support key staff. It has been agreed that medical staff do not need to complete the insulin modules as they do not administer.

RISKS/ISSUES

Staff booking onto and completing their role specific mandatory training modules is low.
Resuscitation levels still too low
In house trainers for resus and patient handling are needed – their absence is reducing availability to support training .

FFT

4	Workforce – Experience and Engagement
4a	Friends and Family Test Survey

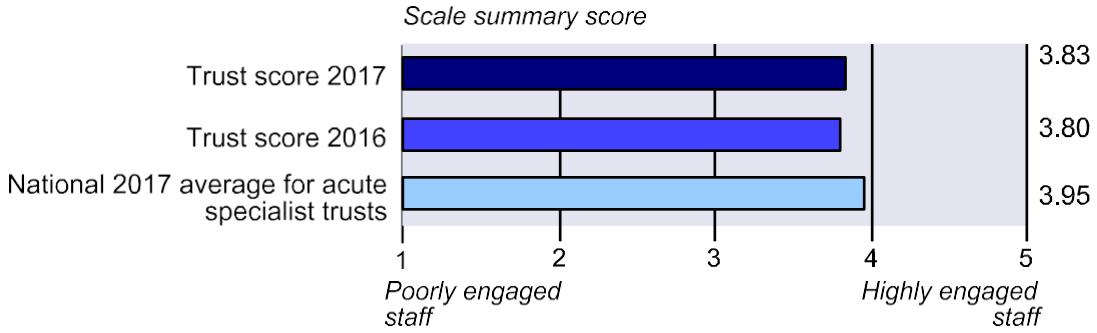


The overall Staff Engagement Score in Quarter Two 2018/2019 is **4.09** which compares favourably to the 2018 Score of 3.88.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

Employee Engagement

OVERALL STAFF ENGAGEMENT

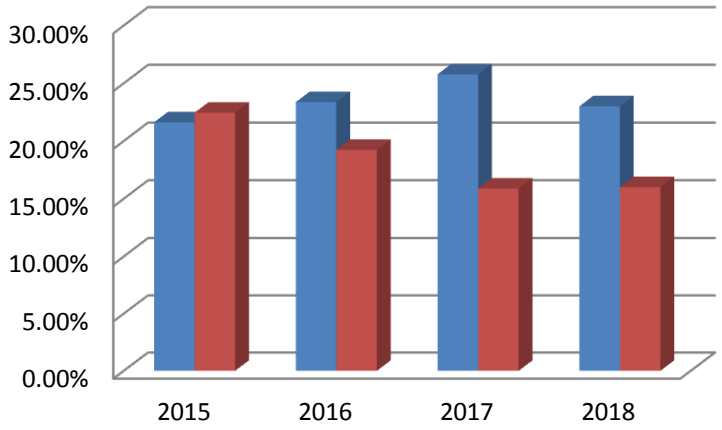


		Your Trust in 2017	Average (median) for acute specialist trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	79%	86%	69%
Q21b	"My organisation acts on concerns raised by patients / service users"	79%	81%	73%
Q21c	"I would recommend my organisation as a 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

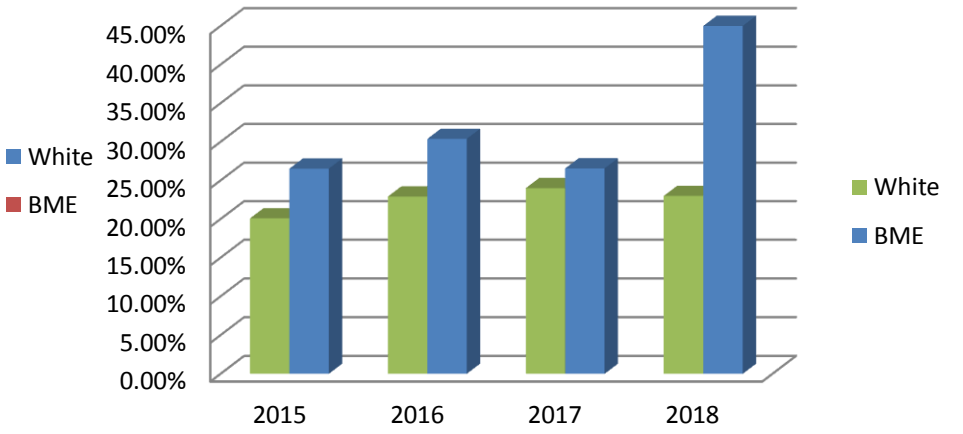
4	Workforce – Experience and Engagement
4c	WRES Indicators

WRES Indicators

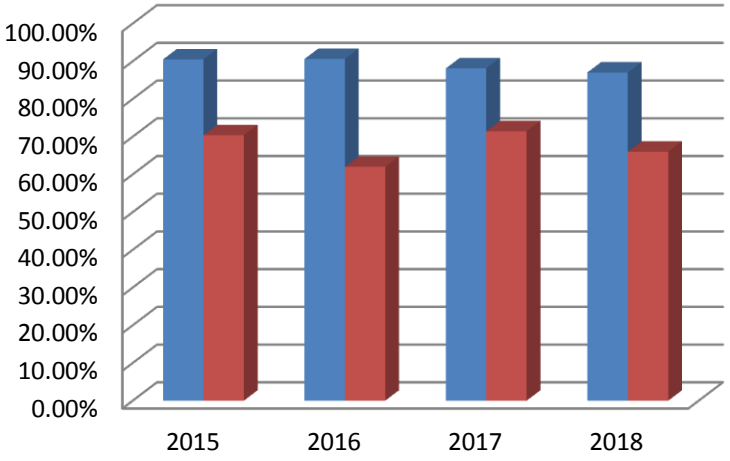
Indicator 5: Experiencing bullying from patients



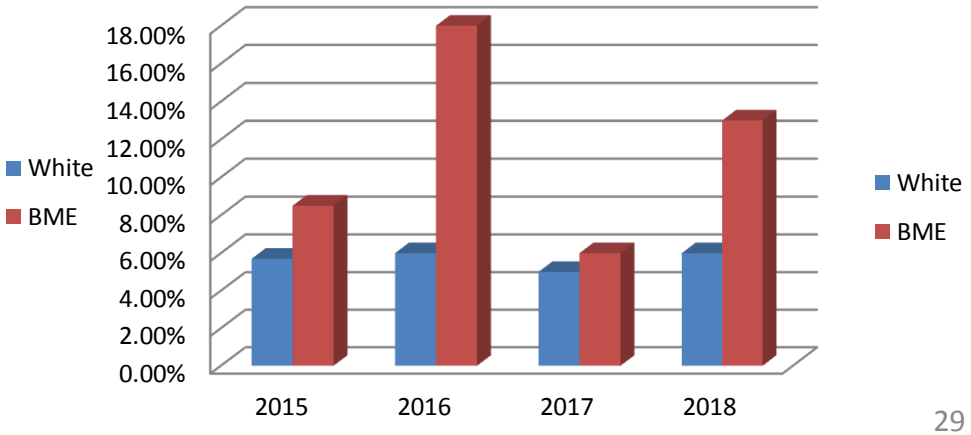
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION
National survey and Friends and Family Test FFT - Q2 survey results shows stable data. October report in SE&OD information pack shows key observations. National survey launched in October 4th and will run for two months. Current completion rate is 21%. **Engagement and Job Satisfaction** – Speak Up and Join in brand is still being established. Even better if… sessions being rolled out across teams. **Equality and Diversity–** The latest data for WRES has now been compiled with an action plan to address different areas. These actions are included in the Equality and Diversity action plan. Progress is being made with forming the new Equality and Diversity network group.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions to encourage survey completion to improve data reliability Ensure feedback from staff from E&D forums and network meetings is used to inform E&D action plan for 2019 Look at ways to engage BME staff members to shape E&D agenda e.g. through the E&D network
RISKS/ISSUES
Completion rate for National Staff survey (NSS) affects the reliability of the data as a representation of staff views

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 11 January 2019

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 January 2019 at 1400h to transact the business detailed on the attached agenda.

Members of the press and public are welcome to attend the public part of the agenda which commences at 1410h.

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 January 2019 : 1400h – 1615h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1#	Proposal to award a cost of living payrise to Chairman and Non Executives (PRIVATE ITEM)	ROHGO (1/19) 002 ROHGO (1/19) 002 (a)	BT
1410h	2	Apologies and welcome	Verbal	Chair
1412h	3	Declarations of interest	Verbal	All
1415h	4	Minutes of previous meeting on 4 October 2018	ROHGO (10/17) 012	Chair
1417h	5	Update on actions arising from previous meeting	Verbal	SGL
1420h	6	Chief Executive's update	ROHGO (1/19) 003 ROHGO (1/19) 003 (a)	PA
1430h	7	Birmingham Hospitals update and STP key messages	Verbal	YB/PA
1500h	8	Modular theatres plans	Presentation	JWI
1520h	9	Paediatrics services update	Verbal	YB/PA
1535h	10	Membership update	Presentation	EC
1550h	11	Update from the Board Committees: • Staff Experience & OD Committee • Audit Committee	ROHGO (1/19) 004 ROHGO (1/19) 005	RA SJ
1600h	12	Governor Matters: • Representation on the Estates Strategy & Delivery Group • Governor drop in sessions	Verbal	BT
1605h	13	For information: • Quality & Patient Safety Report • Finance & Performance Overview • Workforce Overview	ROHGO (1/19) 006 ROHGO (1/19) 007 ROHGO (1/19) 008	
1610h	14	Any other business	Verbal	
	Date of next meeting: Wednesday 22 May 2019 @ 1400h – 1600h in Trust Headquarters (premeet with the Lead Governor and Chairman @ 1300h)			

1# - Governors only item

MINUTES

Council of Governors - Version 0.3

Venue Boardroom, Trust Headquarters **Date** 4 October 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
Robert Talboys	Public Governor	RT
Arthur Hughes	Public Governor	AH
Gavin Newman	Staff Governor	GN
Adrian Gardner	Staff Governor	AG
David Richardson	Staff Governor	DRi
David Robinson	Stakeholder Governor	DRo
Hannah Abbott	Stakeholder Governor	HA
Liz Clements	Stakeholder Govenor	LC

In attendance

Kathryn Sallah	Non Executive Director	KS	
Tim Pile	Vice Chair and Non Executive Director	TP	
Richard Phillips	Non Executive Director	RP	
Simone Jordan	Associate Non Executive Director	SJ	
Rod Anthony	Non Executive Director	RA	
Simon Grainger-Lloyd	Company Secretary	SGL	[Secretariat]
Paul Athey	Acting Chief Executive	PA	

Minutes		Paper Ref
1	Exclusion of the press and public	Verbal
The Council resolved that representatives of the press and other members of the public be excluded from items 2 and 3 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.		
2	Trust Chairman's appraisal	Verbal

[redacted]

3	Non Executive appraisals	Verbal

[redacted]

ACTION:	Lead governor to seek views from the Council as to whether Tim Pile should be retained as a Non Executive for a further year from 31 December 2018
ACTION:	Chair to consider means by which the Non Executives are given greater visibility across the Trust

4	Apologies and welcome	ROHGO (10/17) 009 ROHGO (12/17) 001

The Non Executives and Acting Chief Executive joined this public part of the meeting.

Apologies were received from Karen Hughes, Dr Dagmar Scheel-Toellner and Richard Burden.

5	Declarations of interest	Verbal

There were none.

6	Minutes of previous meeting on 16 May 2018	ROHGO (5/18) 012

The minutes of the previous meeting were accepted as a true and accurate record.

7	Update on actions arising from previous meetings	Verbal

There were no specific actions on which to update the Council.

8	Chief Executive's update	ROHGO (10/18) 001 ROHGO (10/18) 001 (a) ROHGO (10/18) 001 (b)

The Acting Chief Executive reported that the Trust had been confirmed as one of the out of hours hubs for GPs. The launch week of this service was imminent and there was an opportunity to grow this service.

The CQC review of Radiology was discussed. Thanks were expressed to all of the team and the outcome was positive, with little criticism. The diagniostics function would be reviewed more fully as part of the general CQC review.

It was noted that Executive Director of Nursing & Clinical Governance had spent much time out in the organisation working 'back to the floor' recently. The latest 'back to the floor' that the Acting Chief Executive had undertaken was in theatres, which was a positive experience and had shown a change in the culture and evidenced good multi-professional working. Adrian Gardner agreed that the theatres environment was more positive and the number of cases being handled through theatres had improved. There was good enagement across the teams. There had been much work with the team leaders to create a shift in culture within the area.

9	STP update	Verbal

It was noted that relationships within the STP were much better and the strategy had been approved, although this needed to be translated down to the local population. An event for governors and NEDs was planned for 5 December in which the lead for the STP would present his vision, proposed outcomes and priorities. A Birmingham Hospitals Board had been set up to bring all hospitals together across the patch. The outcome of this would be reported back at future meeting.

ACTION: Chair to provide an overview of the Birmingham Hospitals work at the next meeting

10	Paediatric transition update	ROHGO (10/18) 002 ROHGO (10/18) 002 (a) ROHGO (10/18) 002 (b)

The key highlights of the paediatrics paper were outlined by Kathryn Sallah. The proposal covered patients

0-16 years of age and the plan to move the paediatric service to Birmingham Children's Hospital (BCH) was to be concluded by 31 January 2019. The plans for Oncology were separate to this and were being worked up at present. There were reported to be 24 staff impacted by the change and there had been good engagement with them over the months.

The governance arrangements were outlined, which provided challenge over a number of levels. There were critical points in the programme: ward and theatres estates works, theatre timetabling, diagnostics, theatre staffing and ward and HDU staffing. These were supported by a number of enabling workstreams. Adrian Gardner asked if BCH was not ready to take the services, whether there would be a need to review the position and contingency plans be developed that were around sending children to a setting other than BCH. It was reported that if this was the case, the issue would need to be referred to commissioners, especially as there may be issues with TUPE transfer arrangements.

In terms of the Children's Orthoapedic Services Transfer (COST) campaign, there had been good engagement and the answers to the questions were being developed. Some questions were being asked of BCH which were also being worked up.

There was reported to be a joint risk register and work directed into consideration of emerging risks.

Mrs Sallah advised that she had attended a spinal consultants meeting. She was also attending a patient and carers' engagement event. Her equivalent counterpart at BCH would test the engagement there.

Contrary to rumour, it was noted that there was no edict issued that required staff to choose between supporting adults and paediatric work. It was also noted that patients could not be told about the transfer plans until the business case had been approved by BCH.

11 Annual complaints report	ROHGO (10/18) 003 ROHGO (10/18) 003 (a)

Kathryn Sallah presented the latest verison of the annual complaints report. She advised that the annual report was received in a number of forums but complaints information was reviewed on a regular basis through the monthly Quality Report.

The key highlights were:

- There had been a decrease in complaints compared to 2017/2018 (148 this year; 167 previous year)
- The increase in number of complaints in Quarter 4 coincided with increased activity and therefore this was not to be treated as a concerning trend
- There had been 5094 PALS contacts, a 23% increase on last year. The PALS telephone number had now been removed from appointment letters and therefore the number of PALS contacts was expected to reduce this year
- The main themes of PALS contacts were around appointment queries and surgery date queries
- There had been a reduction in the number of Oncology complaints due to better processes
- A reduction in the number of Spinal complaints had been seen, this being associated with better communication with families of paediatric spinal patients
- All complaints key performance indicators had been achieved
- Some or all aspects of 78% of complaints were upheld
- 28% of all complainants had completed a satisfaction survey; 95% were happy with the complaints services, even if they did not agree with the outcome of the investigation
- Learning and resolutions needed to be captured

- Gaps in training and education would be reviewed

It was noted that communication was a 'golden thread' through the issues.

The ROH was noted to be the top organisation in the country for patients complimenting the trust on the quality of information provided.

12	Council of Governors effectiveness review	ROHGO (10/18) 004 ROHGO (10/18) 004 (a)

The Associate Director of Governance and Company Secrtary reported that as agreed at the last meeting, he had issued a questionnaire to governors over the summer canvassing opinion on the effectiveness of the Council across a range of areas.

Nine responses had been received back, which, in summary, provided a positive view of the effectiveness of the Council, particularly around:

- Skill mix of the governors
- Quality of discussion and debate
- The Council being able to identify performance issues

There were a number of areas where there was an opportunity to strengthen processes and understanding, particularly in relation to induction of new governors. Some of the areas had however, already been addressed.

Some of the feedback had identified some training needs and this would be picked up in the workplan for the governors over the next year.

Mr Grainger-Lloyd was thanked for his work to pull this together. He advised that this exercise would be undertaken on an annual basis.

13	Feedback from the Patient & Carer's Fourm	Verbal

Stella Noon, Chair of the Patient & Carers' forum (PCF) present at the meeting presented a summary of the work and discussions of the PCF.

The terms of reference for the PCF would be revised to fit more closely to the strategic remit of patient experience.

It was noted that there had been a focus on reducing the number of DNAs.

There had been a report from Clare Mair, the Head of OD and Inclusion on equality and diversity. There had also been an update on the qualifications of newly registered staff.

It was suggested that there had been a valuable input to the Throne Project. It was agreed that Mrs Arnott would be connected with the project lead to provide the benefit of her experience. Patient comments from the patient experience leaflets also needed to be factored into this project.

Mrs Kettle was thanked for her support on the administration of the PCF.

It was noted that Mr Hughes and Mrs Betteridge would be the governor representatives on this forum.

14 Approval of the appointment of the Trust's external auditors	ROHGO (10/18) 005

Rod Anthony, Chair of the Audit Committee reported that the four year contract for Deloitte, as the Trust's auditors, had been completed in March 2018 and the governors were asked for their support to reappoint for a further two years. This was a matter reserved to the Council of Governors.

It was acknowleged that reappointment was not best practice without a market assessment, however this would be undertaken at the end of the contract.

Mr Anthony advised that the auditors provided reasonable value for money and costs were benchmarked as being lower than those of some other providers where prices had increased considerably.

The Council of Governors agreed that the contract could be extended to March 2020.

15 Updates from the Board Committees	ROHGO (10/18) 006 ROHGO (10/18) 007 ROHGO (10/18) 008 ROHGO (10/18) 009

The Committee updates were discussed.

In terms of the Quality & Safety Committee update, Mrs Sallah reported that the last meeting had been held in September. The WHO checklist compliance was now recorded more robustly across all areas using it. More assurance was needed on the compliance with water safety regulations. In terms of major actions, the litigation update would be presented in November. Significant progress was being made on mental health. Policies were being developed around mental health which were to include restraint. IT systems were to be put in place to assist with broadening the scope of the Quality Report and there were plans to include a wider set of indicators beyond the nursing indicators. There had been a review of the membership of the Committee to make it more streamlined. The effectiveness of the Research and Development Committee was to be strengthened and this had been escalated to the Board.

From the Finance and Performance Committee, it was reported that the overall financial position was ahead of budget and August had been a better month than expected. Income was stronger than planned and this was the first time for many years that the Trust was ahead of plan. Significantly, an analysis of the budget in the context of tariff changes over the past few years had been 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. There was room for improvement in terms of financial recovery, but the position was more positive than planned. Day case activity was reprted to be behind plan to some degree. Agency expenditure remained very high and was a continuing challenge. Cancellations were noted to remain high and an analysis was planned on this. It was noted that cancellations were a mixture of hospital and patient-instigated. More preparations were needed to engage patients prior to their appointment. There were also reasons concerning overrunning operations or patients not being fit for surgery. JointCare and Perfecting Pathways were making a difference to the operation of the Trust. It was noted that there remained a high number of agency staff needed to cover vacancies. In terms of the concerns, there was a risk to delivery of the Cost Improvement Plan (CIP). The CIP total was over £3m and this was backloaded, including a managed service contract service in theatres. Another key scheme was the reduction in the use of medical locums. There was work underway to confirm that all schemes had been fully recognised.

In terms of the Staff Experience & OD Committee, this was a new body which assisted with meeting the CQC's well led requirements. There was good triangulation with the other committees. The level of staff vacancies was being addressed, including the improved recruitment plans. There was also some

innovative work to develop new roles. The Committee also looked at the Workforce Race Equality Standards. A People & OD strategy had been developed and this aligned to the work of the Committee. Each meeting started with a staff story and an apprentice had most recently given an account of her work. The staff survery had been launched and the response to this over the last year was considered. Health and Wellbeing efforts were being considered as part of the journey from 'Good' to 'Outstanding' from a CQC perspective. Much of the work had been led by the Associate Director of Workforce, HR and OD who it was noted had recently left the Trust. Simone Jordan noted that there had been a focus on metrics and information to drive improvement. There has been a good change as a result of this. To maintain the focus created previously, there were senior staff and executives who were championing the work and it had been mandated that there should not be a loss of focus. The Acting Chief Executive agreed that the focus by the Executive Team had not been lost. It was agreed that the forward thinking on the plans to achieve an 'Outstanding' CQC rating was good, however staff needed to be on board with the journey and own the strategy. It was suggested that affordable housing needing to be a consideration as part of the recruitment process.

In terms of Audit Committee, the audit work was progressing well. It was noted that the report from the external audit would be received at the Annual General Meeting (AGM) later that day. They were challenging but supportive. There were a couple of areas needing to be fully resolved around addressing the audit recommendations against the 18 weeks Referral to Treatment Time performance. Stock control remained an area of focus for the coming year. It was reported that managers joined the meeting to talk through audit reports. In terms of Amplitude there had been two briefings and the Committee was aware of the implementation issues. The audit plan was in place and an area of focus was cyber security going forward. In terms of backlog of recommendations, there was a continued focus on addressing these.

16	Governor updates	Verbal
There were no specific updated raised.		
17	For information: • Finance and performance update • Quality & Patient Safety update	ROHGO (10/18) 010 ROHGO (10/18) 011
The performance reports were received and accepted. In terms of theatres workforce, this was challenging, however there was a new theatres facility planned which would attract the right calibre of individuals. A new theatre assistant practitioner roles would be introduced.		
18	Details of next meeting	Verbal
The next meeting is planned for Wednesday 16 January 2019 at 1400h – 1600h in the Boardroom, Trust HQ.		
19	Any Other Business	Verbal
The governors questioned the plans for the recruitment of a substantive Chief Executive. The Chair advised that there were currently discussions with local stakeholders at present that needed to conclude.		

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 January 2019**

EXECUTIVE SUMMARY:

This report provides an update to the 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 9 January 2019

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors on 16th January 2019

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 November 2018.

2 STP UPDATE

2.1 At the STP Board on 3rd December, the Board reviewed the 1 year priorities recommended by the four portfolio boards, along with progress against the system's CQC action plan.

2.2 The STP CEOs meeting on 13TH December discussed in detail proposals to introduce a social value policy across STP organisations, aimed at including consideration of economic, social and environmental wellbeing of the local area in any procurement processes. The principle of this was supported by the CEOs but further detailed work was requested in conjunction with the proposed Birmingham Procurement Hub to consider how this aligned with NHS requirements around the Carter Review and Model Hospital.

2.3 The STP CEOs meeting also received a presentation reviewing emerging models across the NHS of system governance and integration in advance of further focus on integrated care expected in the NHS 10 year plan.

3 BIRMINGHAM HOSPITALS ALLIANCE UPDATE

3.1 On 3rd December, the Chair and I attended the working group to the Birmingham Hospitals Alliance along with Executive and Non-Executive colleagues from University Hospitals Birmingham and Birmingham Women's and Children's Hospital.

3.2 In addition to an open discussion on strategic opportunities and risks, the working group also received proposals relating to an integrated approach to clinical

governance for the local maternity system and plans for a shared procurement function across the 3 Trusts.

4 GIRFT VISIT

4.1 On 4th December, the Trust was visited by Professor Tim Briggs CBE, the National Director for Clinical Quality and Efficiency.

4.2 Professor Briggs and his team were invited to experience the new JointCare programme and to speak with some of the clinicians driving the initiative forward with a view to identifying opportunities and learning as part of the Getting It Right First Time (GIRFT) programme. The Trust also discussed with Professor Briggs the work that we are undertaking with partners across the STP to standardise and improve clinical pathways and protocols in orthopaedic surgery.

5 2019/20 PLANNING

5.1 Initial planning and contracting guidance, along with draft tariffs, was released to Trusts just before Christmas to support the development of financial, operational and workforce plans for 2019/20. More detailed guidance is expected to be released alongside the NHS 10 year plan in January 2019.

5.2 Key headlines from the guidance are as follows:

- Trust and CCG plans will need to be combined to form a coherent system-level operating plan. This will provide the start point for every STP and ICS to develop 5 year plans up to 2024.
- Each STP will be given a system control total, which will be the sum of each individual control total.
- Subject to consultation the gross uplift in national tariff will be set at 3.8%. This includes a range of cost pressures, including the Agenda for Change pay awards in 18/19 and 19/20.
- The minimum efficiency ask of the NHS in the next 5 years is 1.1% per year, which will be top-sliced from national tariffs. Efficiency plans should be appropriately phased and not back-loaded.
- CQUIN funding and Provider Sustainability funding has been reduced, with the balance transferred into national tariffs. The majority of this funding has been targeted into urgent and emergency care.
- There will be an increased focus on workforce planning and, in particular, on ensuring that every Trust has a 'bank first' temporary staffing model in place.

5.3 Initial, activity-focused plans are to be submitted by 14th January with full draft organisational plans submitted by 12th February. It is expected that all contracts will

be signed by 21st March, in advance of a final organisational plan submission on 4th April.

6 MEDICAL RECRUITMENT

6.1 Andrew Pearson, the Trust's Medical Director will be standing down from the role after six years in March 2019. The post has been advertised and 3 candidates have been shortlisted for interview on 18th January.

6.2 The Executive Team have approved a business case to recruit up to 2 additional oncology consultants over a two year period. The first post is required to ensure capacity is maintained once services are split between the ROH and BWCH following the transition of paediatric surgery. The second post will provide succession planning within the team and support opportunities for service growth as a result of STP discussions linked to bone infection and metastatic cancers.

7 STAFF AWARDS

7.1 290 nominations were received for the 2019 ROH Staff Awards, nearly three times as many as in 2018.

7.2 The shortlisting panel met on 4th December 2018 and agreed the winners of the 15 awards. Letters have gone out to those staff who have been shortlisted for awards, plus the people who nominated them, to invite them to attend the Leading Lights ceremony on 8th February 2019.

8 POLICY APPROVAL

8.1 The Chief Executive, on the advice of the Executive Team has approved the following policies during November and December 2019:

- Incident reporting and management
- Smoke Free
- Learning from Deaths

9 RECOMMENDATION(S)

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

9.2 Note the contents of the report.

Paul Athey
Acting CEO
4th January 2019

ROHGO (1/19) 004

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board last met: 7 November 2018

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that as at 30 September, there were 53 vacant posts (some being part time) which did not have a plan to recruit into them. This had dropped from a level of 115 in June 2018 however. • It was noted that there was more work to do to improve the Trust's rating against the Workforce Race & Equality Standards (WRES). • There were reported to be 3% of staff on long term sickness absence. There was confidence in the process and policies in place to manage these individuals however. • There remain difficulties with recruiting into nursing posts in theatres in particular. • It was reported that Ward 2 was staffed by only 28% permanent nurses, although temporary staff are block booked to secure some stability in the workforce.	• It was suggested that further work was needed to obtain value from the information that staff provided on their exit questionnaires or to declare why they are moving on. • Produce a document for the Executive Team to detail current conduct cases. • The equality and diversity action plan to show more clearly when key actions are to be delivered on a month by month basis. • A further update on plans to address vacancy gaps was requested for the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee heard a staff story from Peter Gibbons, Charge Nurse for Ward 3, which presented a positive experience from the perspective of the level of development opportunity available at the ROH and the engaging tone of the Friday messages from the Chief Executive. • The equality and diversity action plan was noted to show good progress, particularly on actions associated with mental health. • The Committee was advised of some positive work underway to address the nurse staffing vacancies, including engagement with educational establishments and recruitment fairs. • The staff friends and family test results remained positive and suggested that staff believe the ROH is a great place for patients to receive treatment.	• The workforce overview will be presented to Trust Board from January 2019 onwards, in the same way that the equivalent reports for Finance & Performance and Quality & Safety are.

Chair's comments on the effectiveness of the meeting: The Chair requested that the correct cover sheet for reports be used in future to highlight how the paper aligned with the People & OD strategy. It was agreed that the input of the departmental heads of workforce, HR & OD had been useful at the meeting.

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

QUALITY REPORT

December 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.

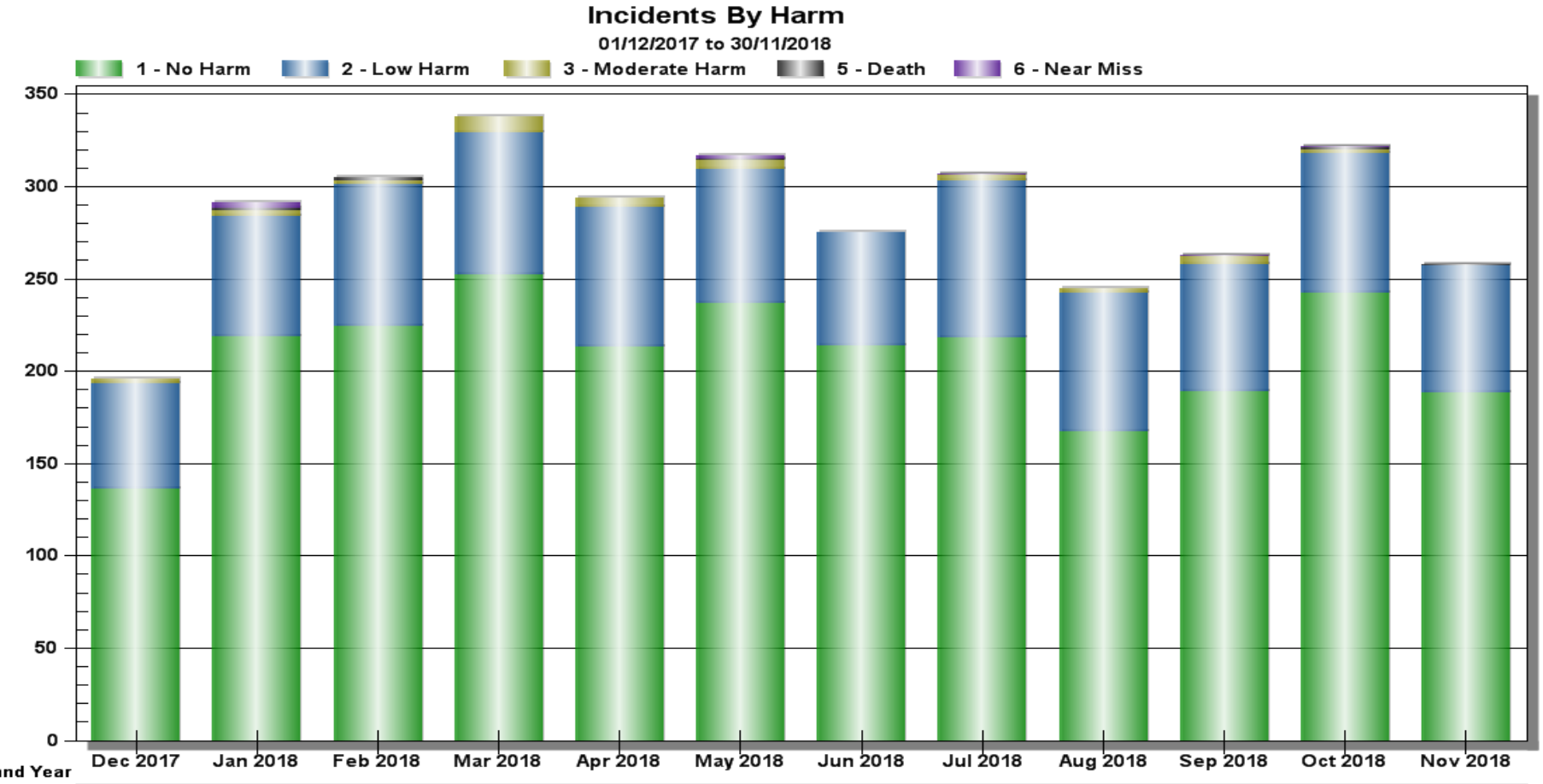
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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.

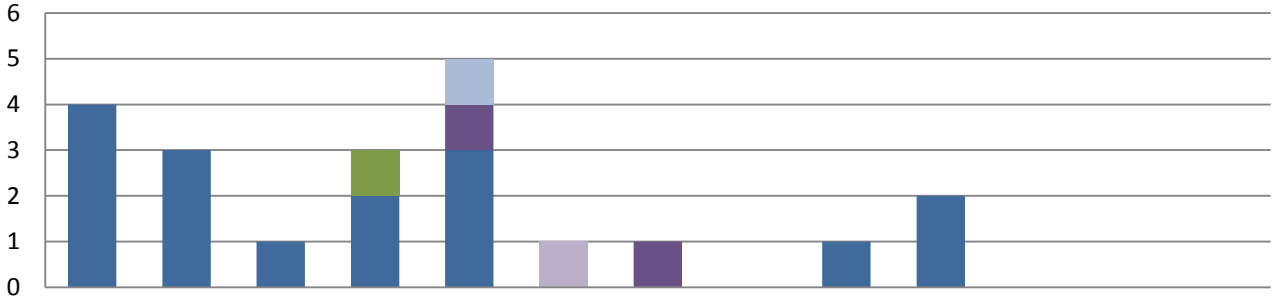


Month and Year	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018
1 - No Harm	136	219	224	252	213	237	214	218	167	189	242	188
2 - Low Harm	57	65	77	77	76	72	61	85	75	69	76	69
3 - Moderate Harm	3	3	2	9	5	5	0	3	3	4	2	0
5 - Death	0	1	2	0	0	1	0	0	0	0	1	1
6 - Near Miss	0	3	0	0	0	2	0	1	0	1	1	0

INFORMATION
In November 2018, there were a total of 258 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows; 188 – No Harm 69 – Low Harm 0 – Moderate Harms 0 – Severe Harm 0 – Near Miss 1 – Death In November 2018, there were a total of 9831 patient contacts. There were 258 incidents reported, which amounts to 2.62 per cent of the total patient contacts resulting in an incident. Of those 258 reported incidents, 80 incidents resulted in harm which is 0.71 per cent of the total patient contact.
ACTIONS FOR IMPROVEMENTS / LEARNING
Quality week was undertaken in the week commencing 4th December with a focus of learning from incidents.
RISKS / ISSUES
The risk added to the risk register regarding the staffing levels within the Governance team has been increased from a 8 risk score to a 12 risk score. The Governance team currently have 1 WTE vacancy, 1 WTE member of staff on maternity leave and 1 WTE member of staff on sick.

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.

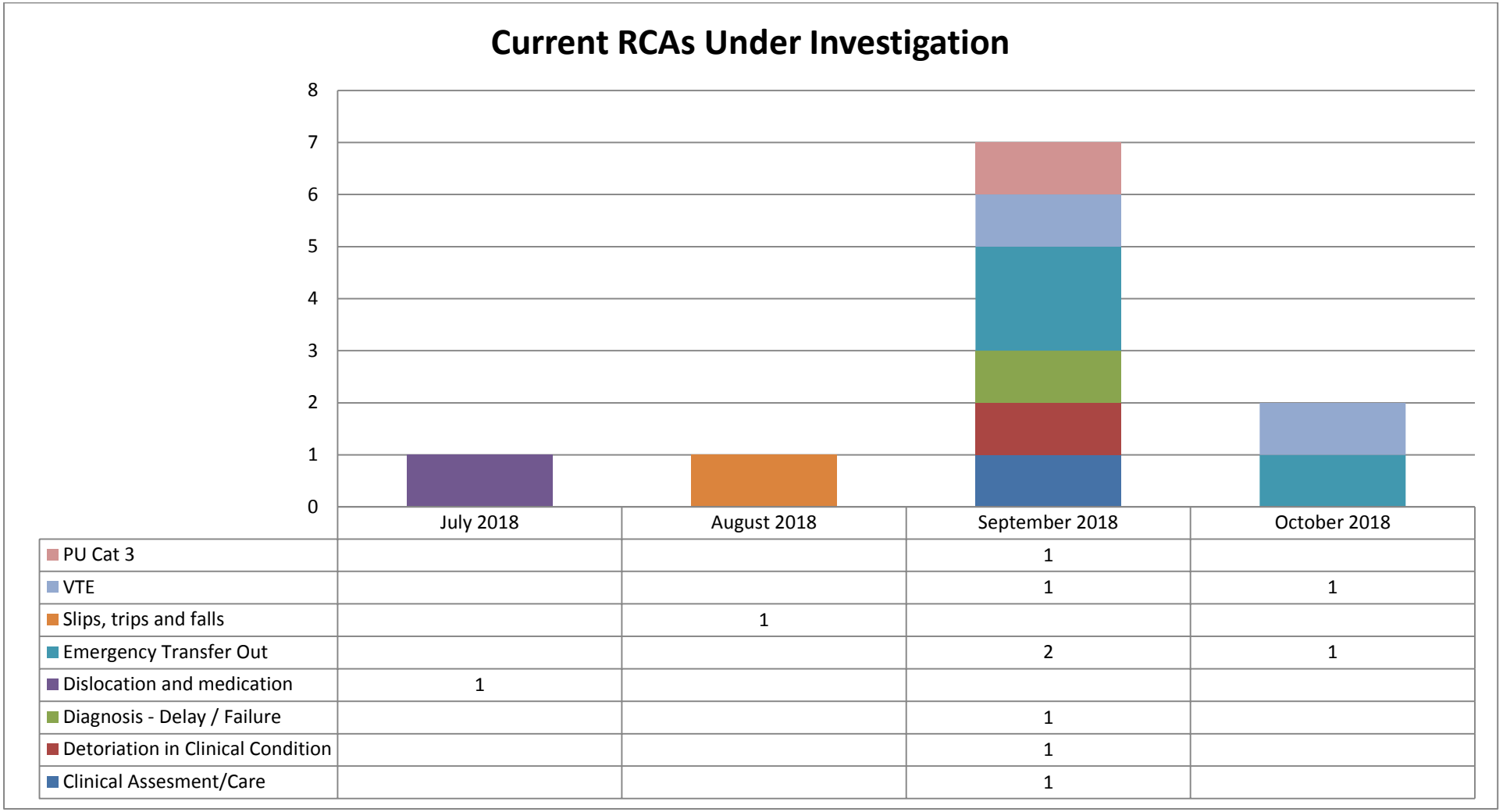
Serious Incidents Declared Year to Date to November 2018



	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Transfer out						1							
Unexpected Injury													
RTT Harm review													
Information Governance Missing Laptop					1								
Retained object													
Wrong side injection													
Slips, trips & falls					1		1						
Pressure Ulcers				1									
VTE meeting SI criteria	4	3	1	2	3				1	2			

INFORMATION
Three Serious Incidents were declared in November 2018; It has been agreed with the CCG that all avoidable VTEs will be declared as Serious Incidents. After investigation three VTEs previously declared were deemed as avoidable. These have now been declared with the commissioners as serious incidents.
ACTIONS FOR IMPROVEMENTS / LEARNING
No Serious Incidents were closed in November 2018.
RISKS / ISSUES
None

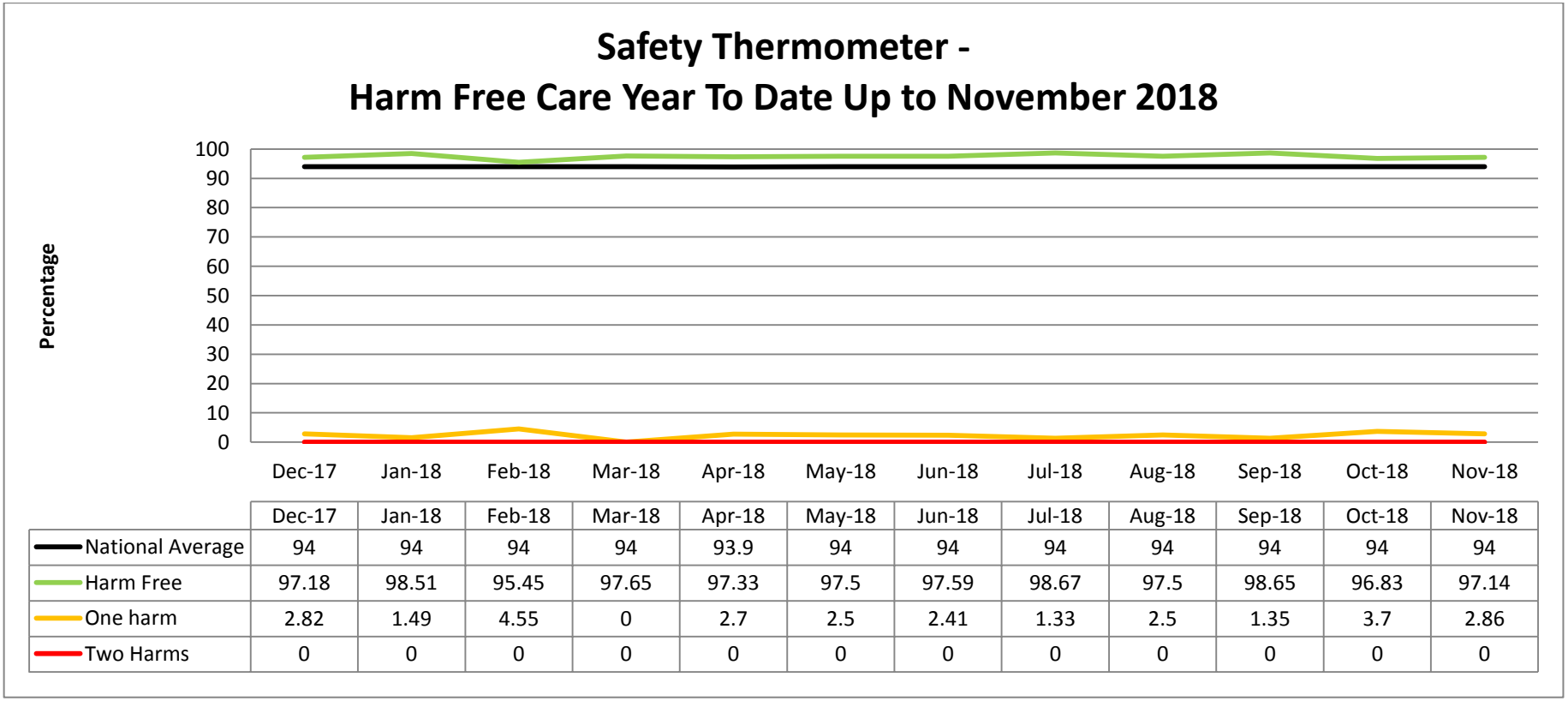
4. Internal RCA's - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision that a heightened level of response is needed for these incidents.



	July 2018	August 2018	September 2018	October 2018
PU Cat 3			1	
VTE			1	1
Slips, trips and falls		1		
Emergency Transfer Out			2	1
Dislocation and medication	1			
Diagnosis - Delay / Failure			1	
Detoriation in Clinical Condition			1	
Clinical Assesment/Care			1	

INFORMATION
One incident reported in November 2018 will be undertaken as an internal RCA; This was reported in November 2018 Quality Report. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.
ACTIONS FOR IMPROVEMENTS / LEARNING
One RCA was closed in November 2018 – the detail has been provided to the Quality & safety Committee**.**
RISKS / ISSUES
None

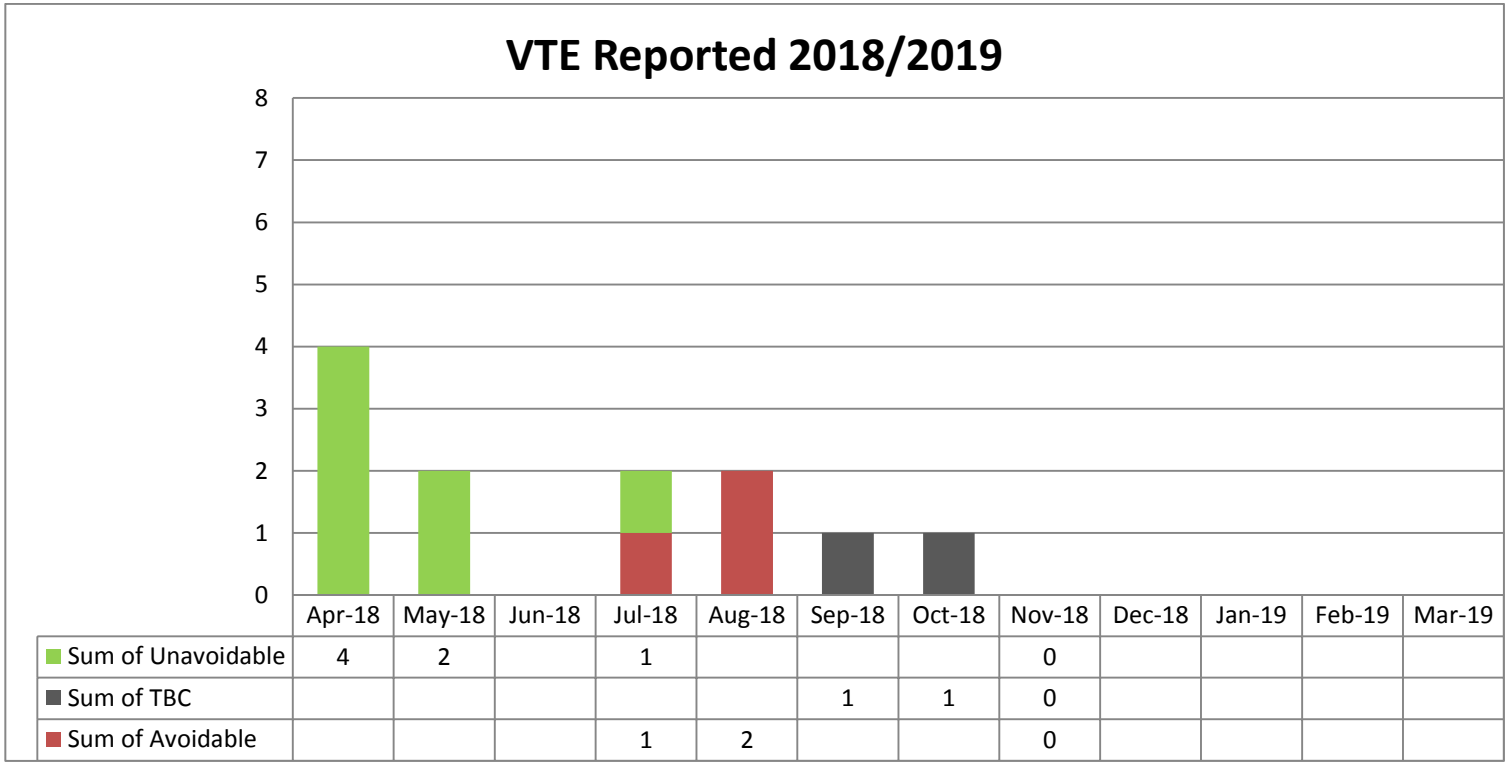
5. **NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
National Average	94	94	94	94	93.9	94	94	94	94	94	94	94
Harm Free	97.18	98.51	95.45	97.65	97.33	97.5	97.59	98.67	97.5	98.65	96.83	97.14
One harm	2.82	1.49	4.55	0	2.7	2.5	2.41	1.33	2.5	1.35	3.7	2.86
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The 3 harms recorded on the Safety Thermometer audit were;
1 x old Pressure Ulcer on Ward 3
1 x old DVT on Ward 3

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called 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).**

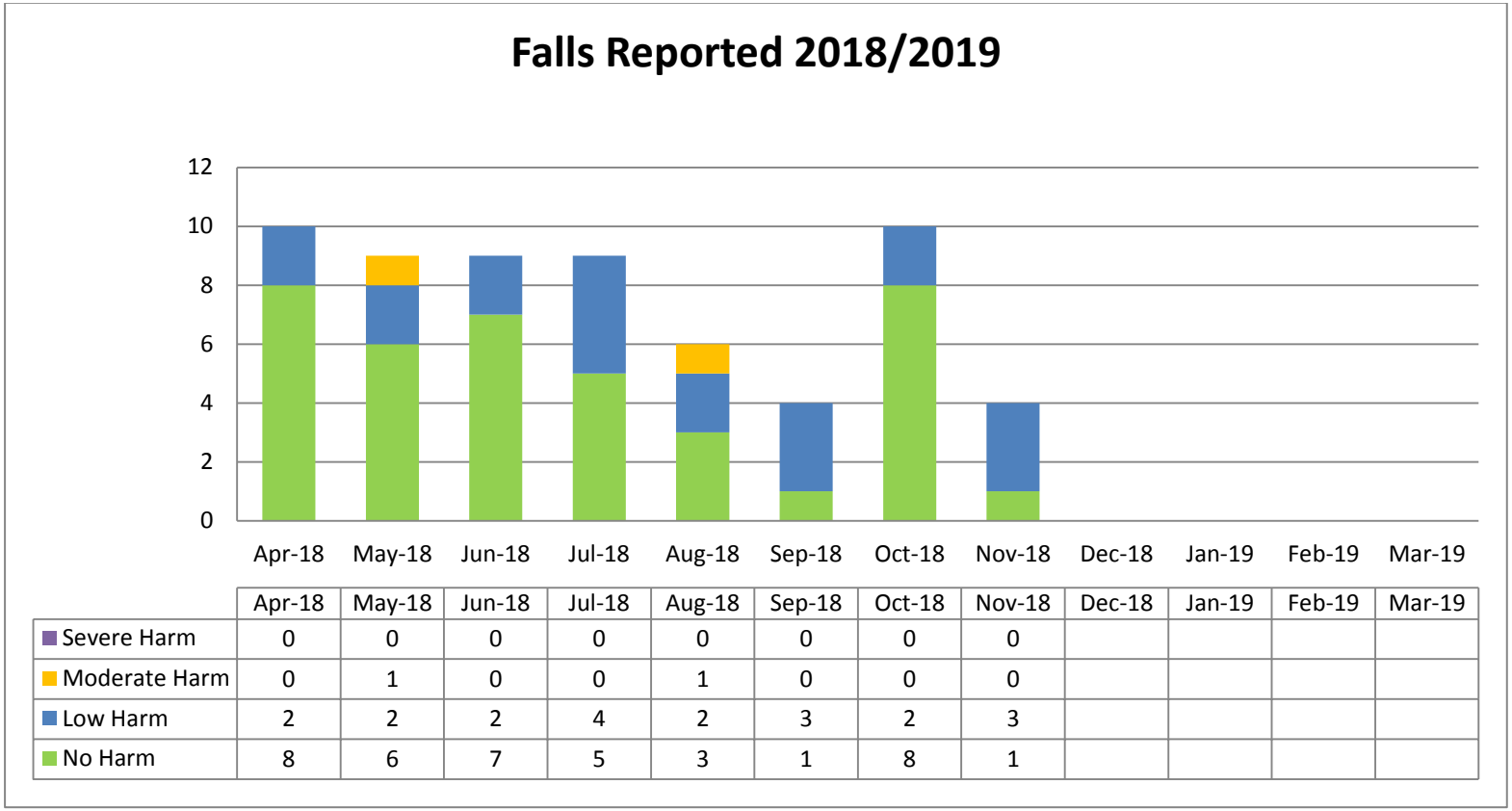


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	4	2		1				0				
Sum of TBC						1	1	0				
Sum of Avoidable				1	2			0				

total		Avoidable
17/18	33	10
18/19	12	3

INFORMATION
There was no VTE incidents reported in November 2018. This is compared to the 4 reported in November 2018. All avoidable VTE's are now reportable again to CCG. Themes in those deemed avoidable to date are BMI >30, omitted enoxaparin dose post-operative, lack of documented 24 hour re-assessment. Action plans are in place for all.
ACTIONS FOR IMPROVEMENTS / LEARNING
VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement of 95%): Compliance for November: 97.4%. IMT are now able to provide data on which patients did not have a VTE risk assessment completed. This information is being followed up with teams in order to progress to 100% compliance. It has been identified that those being missed are patients who do not need any medications prescribed, e.g. day case patients, as this results in the mandatory VTE completion field not being triggered. This will continue to be closely monitored. **NICE VTE Prevention Guidance –Updated March 2018** Medical VTE lead is going to attend December CSL meeting to discuss the updated standards and attempt to gain consensus regarding any changes. The VTE Exemplar network has surveyed members, which includes us, to establish how and if guidance has been implemented. Very few Trusts have made any changes; the majority are not planning to change from the previous guidance or are in the same position as us at present. There is no risk to patients as a result of continuing to follow 2010 guidance until a consensus is reached.
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-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	0	0				
Moderate Harm	0	1	0	0	1	0	0	0				
Low Harm	2	2	2	4	2	3	2	3				
No Harm	8	6	7	5	3	1	8	1				

total	
17/18	125
18/19	61

INFORMATION

There were 4 patient fall-related incidents reported across the Trust in November all were related to adult patients. This is a significant decrease in the number in October which saw 10 falls in month. October's figures were abnormally high and it is reassuring that this month the figures have returned to an expected number. 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 October falls incidents were reviewed at the Falls Working group meeting on 5th December 2018 and were scrutinised for appropriateness of prevention and actions following the fall. 1 incident was agreed 9 have been returned to the ward managers for further review.

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.

4 falls were reported in November.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions Underway

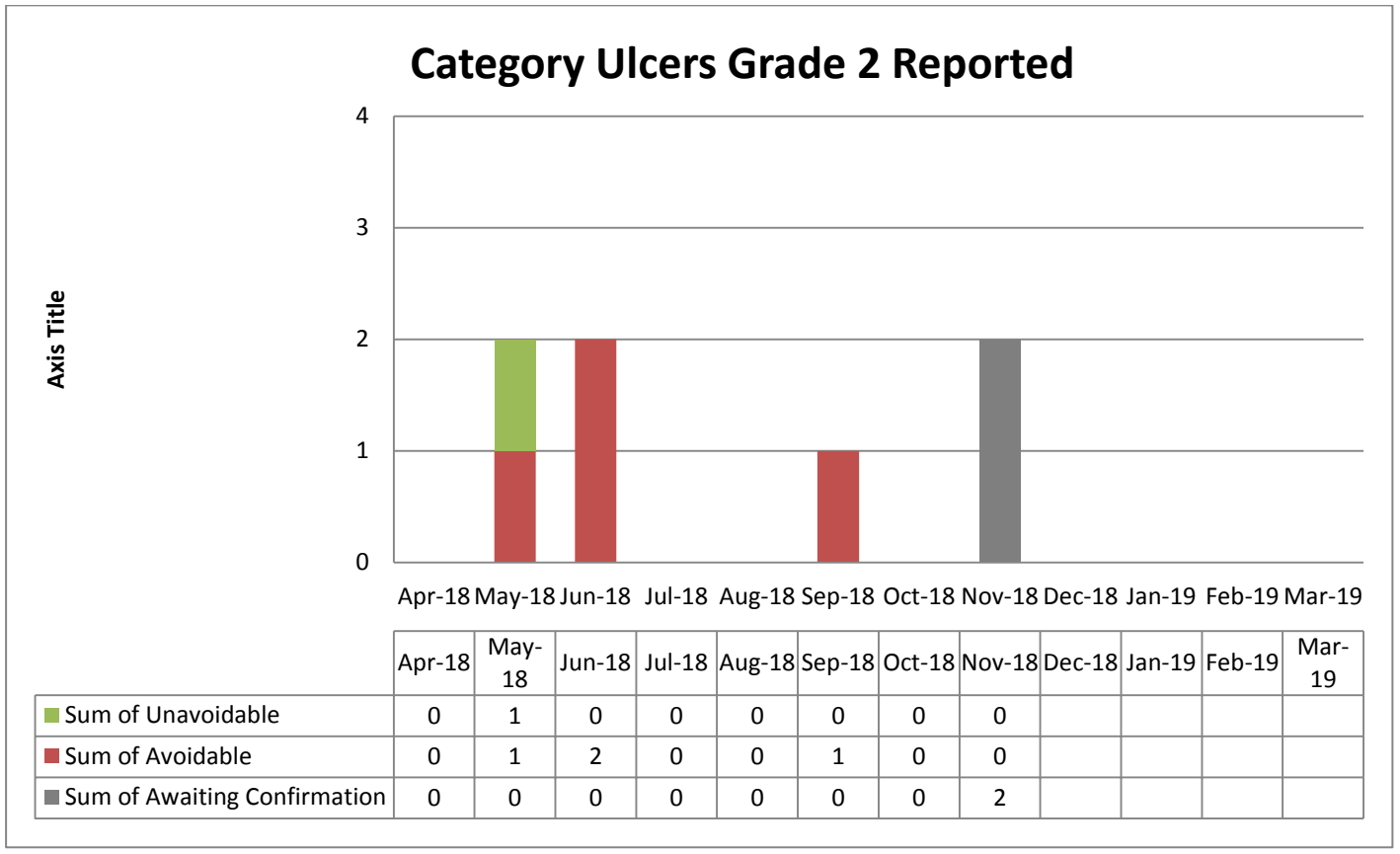
- Falls lead has left Trust, and a new lead has been identified by the Deputy Director of Nursing and will commence on 31.12.18
- Purchase of another Hover Jack, to be considered next year- plan to submit a capital bid
- Trust wide replacement of hoists delayed as funding is not in place. Additionally due to the size of the capital bid this will need to go out to tender rather that proceed with current supplier which was the original plan.

Positive Assurance

- Falls policy revised and updated
- Staff training on the use of manual handling equipment such as Sara steady.
- Clinical skills update day reinstated to be delivered annually.
- Template for Medical review post fall
- Benchmarking of the WMQRS

Risk register reviewed by falls working group 5.12.18 and updated. All October incident reviewed and discussed at falls working group 5.12.18
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 financial year.

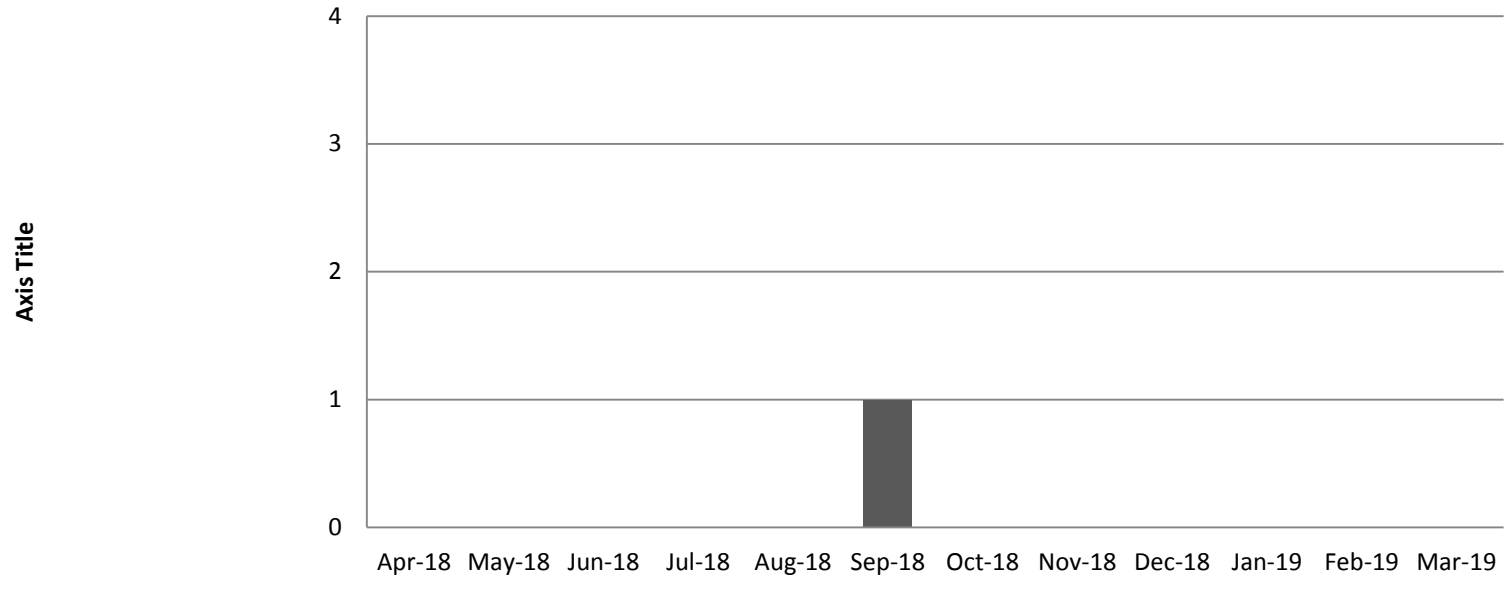
8. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open 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	0	0				
Sum of Avoidable	0	1	2	0	0	1	0	0				
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	2				

total	Avoidable
17/18	6
18/19	4

Category 3 and 4 Pressure Ulcers Reported



	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	0	0				
Unavoidable G4	0	0	0	0	0	0	0	0				
Unavoidable G3	0	0	0	0	0	0	0	0				
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0				
Grade 3 (Avoidable)	0	0	0	0	0	0	0	0				

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

INFORMATION

In November 2018, there were no pressure ulcers recorded. This compares to the two Category 3's reported in November 2017.

November 2018- Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	1
Category – 2 (Device)	Medical Device Related PU's (MDPRU) = 1 – not yet determined if avoidable or unavoidable (26026).
Category – 1	1 MDRPU
Suspected Deep Tissue Injury	2 - both resolved
Moisture Associated Skin Damage (MASD)	1 natal cleft
Patients admitted with PU's	Category 3 MDRPU = 1

Avoidable Pressure Ulcer CCG Contracts KPI

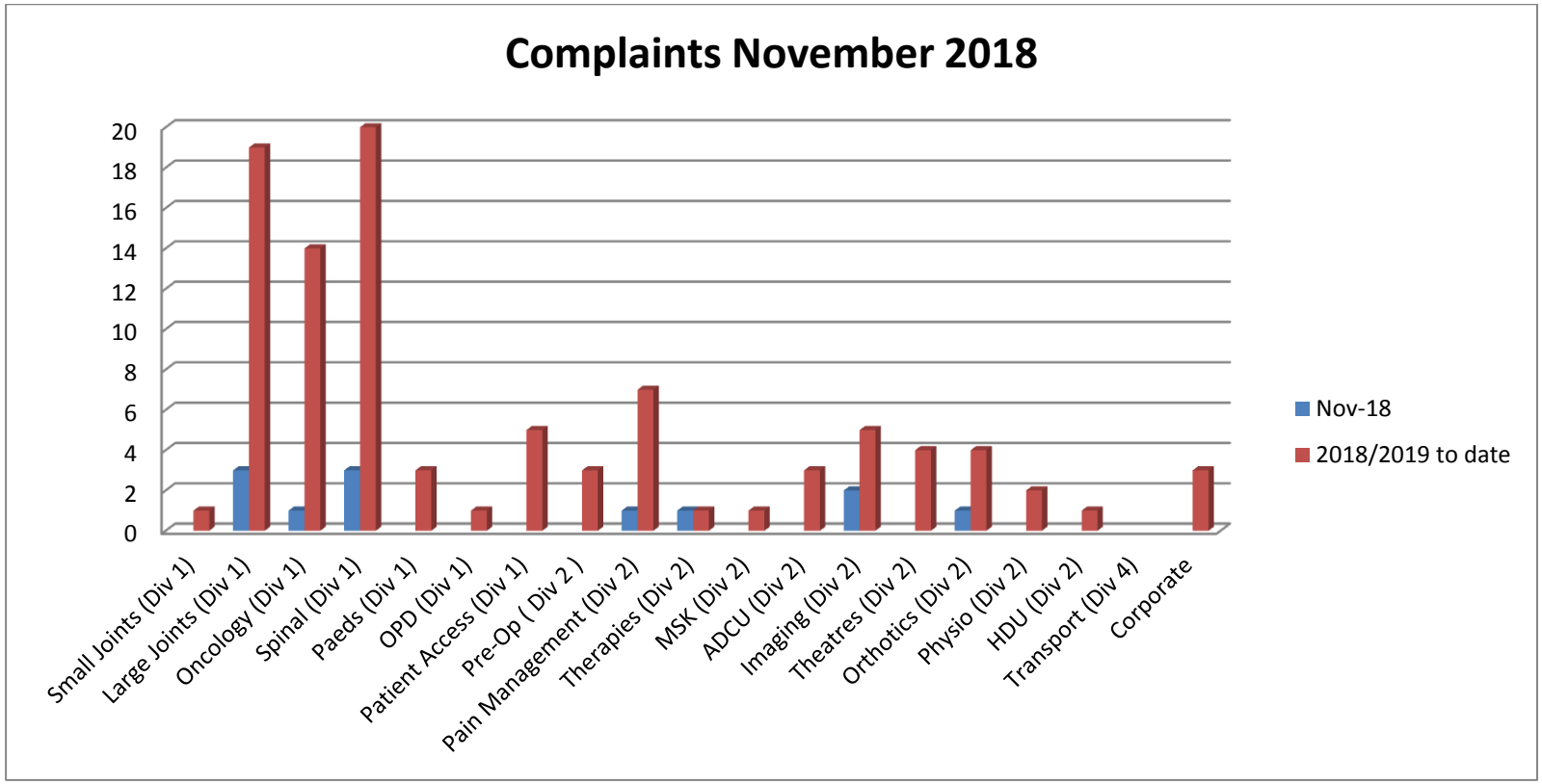
2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	4
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2017/2018:

2017/2018	
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, and Admission to HDU or Ward and include a SKIN bundle encompassing a care and comfort type of repositioning chart.. 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
None

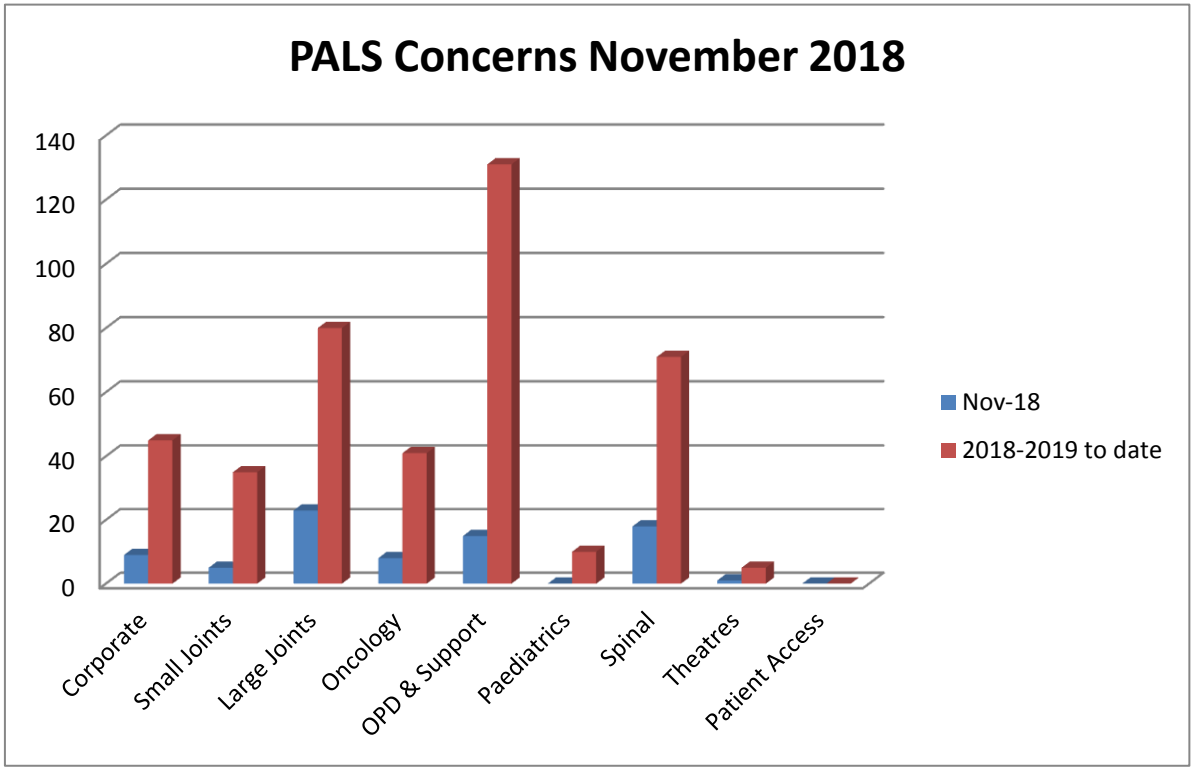
9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



INFORMATION

PALS

The PALS department handled 116 contacts during November 2018 of which 79 were classified as concerns. This is a significant reduction in calls compared to the same time last year (442 contacts in November 2017) and significantly fewer concerns (102 concerns in November 2017). The main themes in the PALS data relate to queries about appointments; length of wait or repeated cancellations. 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 87% of concerns were handled within the agreed timescales, meeting this internal KPI



Compliments

There were 546 compliments recorded in November 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 12 formal complaints made in November 2018, bringing the total number of complaint to 97 for the year to date. All were initially risk rated rest amber or yellow. This is higher than last year (9 complaints in November 2017)

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Approach of x-ray staff (Div.2, Imaging)
- Outcome of surgery (Div.1, Large Joints)

Initially Risk Rated Yellow:

- clinical opinion and treatment plan (Div.1, Spinal)
- clinical opinion and approach of clinician (Div.1, Large Joints)
- different opinions and treatments in physio (Div.2, Physio)
- wait for pain management appt (Div.2, Pain Management)
- progression of treatment (Div.1, Large Joint)
- wait for surgery (Div.1, Spinal)
- awaiting letter for 2nd opinion - not done (Div.1, Oncology)
- approach of clinician (Div.2, Orthotics)

- treatment during biopsy (Div.1, Oncology)

approach of clinician (Div.1, Spinal)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 10 complaints closed in November 2018, 9 of which were closed within the agreed timescales. This gives a 90% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in November 2018 was 29 days which is within normal limits.

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

- Escalation process for concerns about biopsy patients to their Consultant was not robust
  Action: All biopsy patients now see the on call Doctor before discharge

- Agency nurse attempted a potentially unsafe drug route on a patient
  Action: Agency nurse suspended immediately and investigated. PICS access withdrawn until outcome known

- Policy for discharging DNA patients is being applied differently in different departments
  Action: Teams have been reminded of current policy and Clinical Service Manager for Patient Access informed

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

0 comebacks were received in November 2018.

10. 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 November 2018, 10 concerns were identified from the 2383 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 November 2018 were Values & Behaviours, Patient Care and Communication. 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 and the internal 40% target. The internally set target of 20% for Outpatient services was also met this month. 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 Nov 2018**	**% of people who would NOT recommend the department in Nov 2018**	**Number of Reviews submitted in Nov 2018 (previous month in brackets)**	**Number of Individuals who used the Department in Nov 2018**	**Department Completion Rate (Mandated at 35%)**
Ward 1	97.1%	0.0%	68 (75)	121	56.2%
Ward 2	88.7%	4.8%	62 (82)	145	42.8%
Ward 3	89.7%	0.0%	39 (16)	90	43.3%
Ward 12	98.1%	0.0%	53(47)	85	62.4%
Ward 11 (CYP)	89.8%	0.5%	60(115)	77	78%
ADCU	97.4%	0.7%	268(196)	601	44.6%
HDU	95.1%	0.0%	41(24)	72	56.9%
CYP HDU	100.0%	0.0%	7 (2)	14	50.0%
Overall Trust Inpatient Response Rate for November 2018					51.0%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Nov 2018**	**% of people who would NOT recommend the department in Nov 2018**	**Number of Reviews submitted in Nov 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	98.3%	0.3%	1445 (1212)	21.1%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Nov 2018**	**% of people who would NOT recommend the department in Nov 2018**	**Number of Reviews submitted in Nov 2018**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	98.2%	0.0%	57 (49)	67.1%

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 November - 30 November

Your average score for all questions this period

1 2 3 4 5 **4.86**

Reviews this period

2383

Your recommend scores

5 Star Score

4.84

% Likely to recommend

96.4%

% Unlikely to recommend

0.5%

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 11 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

1 new claim against the Trust was received in November 2018.

Claim relates to death of patient following a fall on the ward.

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*

3 new requests for Pre-Application Disclosure of medical records were received in November 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 Inquests

There were no Inquests held in November 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; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases =839 The total WHO compliance for Theatres October 2018 = **100%** **CT area** Total cases = 90 The total WHO compliance for CT area October 2018 **= 100%** **ADCU** The total WHO compliance for ADCU area for October = **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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in November 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)	0	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

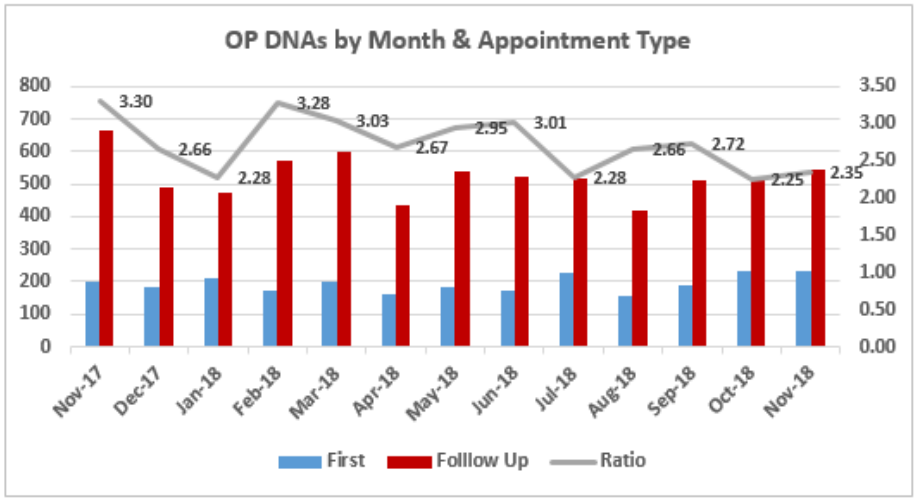
ACTIONS FOR IMPROVEMENTS / LEARNING

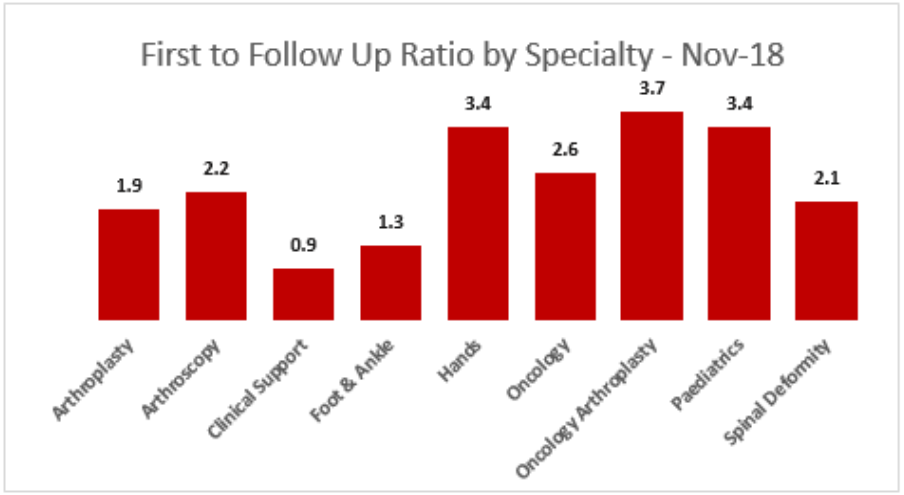
7 IP recorded incidents in November

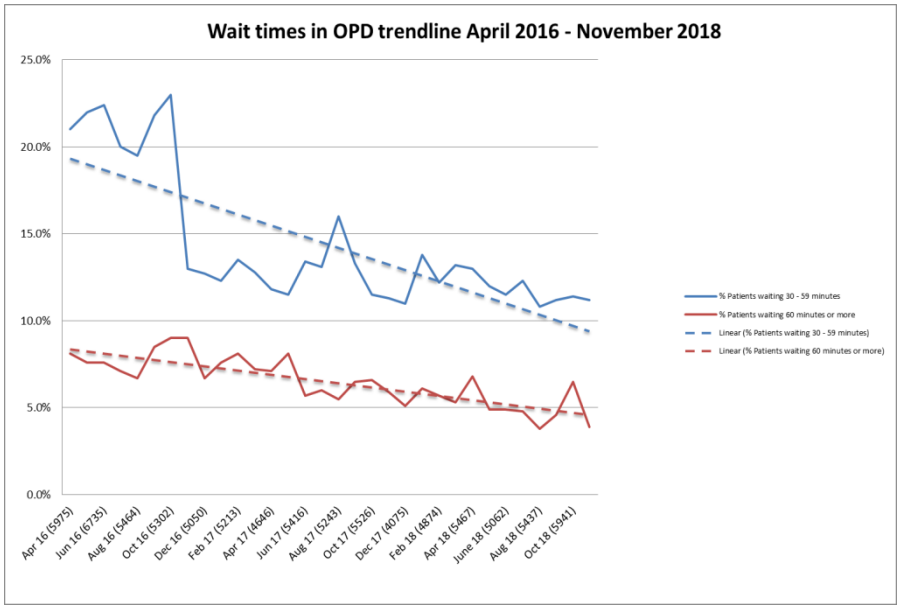
RISKS / ISSUES

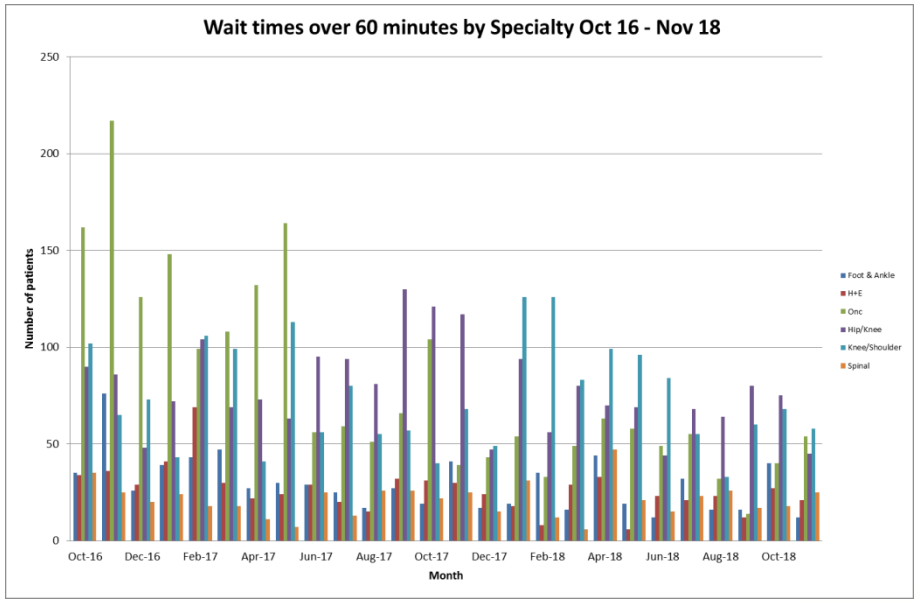
ROH is presently awaiting a position statement from Occupational Health regarding the re-calling of staff for Hepatitis B vaccinations. This is being led by HR who manage the agreed service for ROH.

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





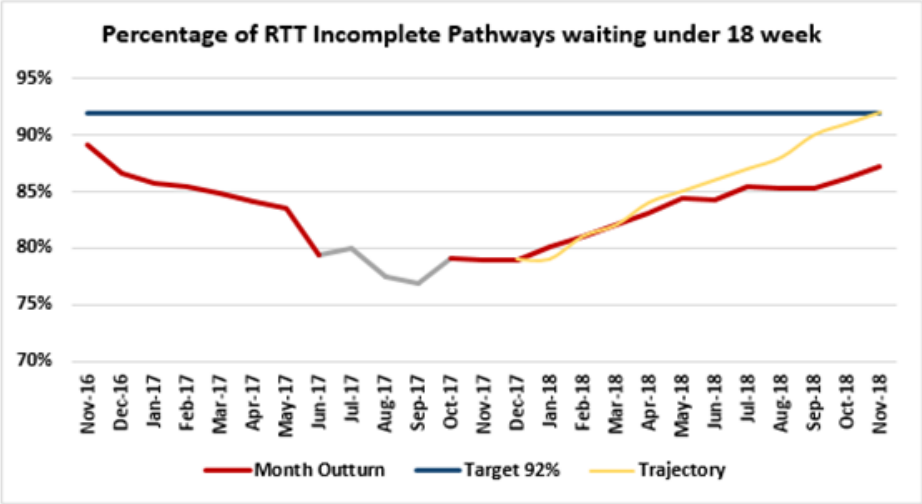


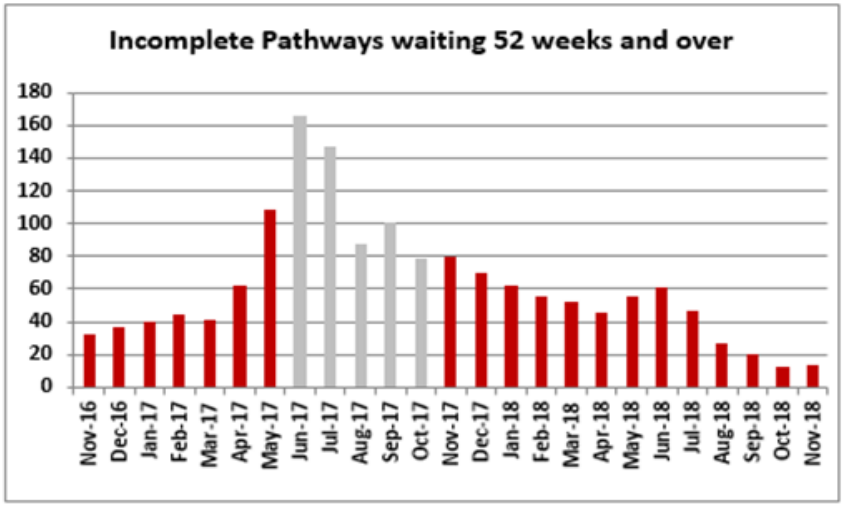


INFORMATION
In November there were only 3 incident forms completed to highlight clinics running more than 60 minutes late. This is a very low number and investigations should take place and reaffirm the importance of reporting these incidents. There were 11.2% of patients waiting over 30 minutes and 3.9% waiting over 1 hour which is below the target of 5%. Both of these metrics have improved since last month however the target for 30 minute delays has still not been achieved. Positively this is the 7th month out of the last 8 that the over 60 minute target has been achieved. The largest number of incidents were reported in Knee / Shoulder and Oncology specialties whereas last month this was Hip and Knee rather than Oncology. The monthly audit identified the following categories of incident: - 2 – Clinic Overbooked 1 – X-ray delays Work is underway to begin to collect information about daily room allocations within outpatients. With this information and activity data it will be possible to review clinic utilisation. New nursing staff have commenced in recent weeks and there may have been a reduction in reporting because of this. The Matron for outpatients will reiterate the importance of reporting all incidents relating to clinic delays
ACTIONS FOR IMPROVEMENTS / LEARNING
• Reiterate the importance of submitting incident forms with the staff • Commence a weekly 6-3-2 meeting to discuss activity for future weeks, avoiding overbookings and identifying additional clinic rooms available • Begin to collect room occupancy data • Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available • Investigation of partial booking processes to reduce clinic rescheduling and overbooking

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. The engagement with other Trusts to consider the implementation of partial booking processes

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



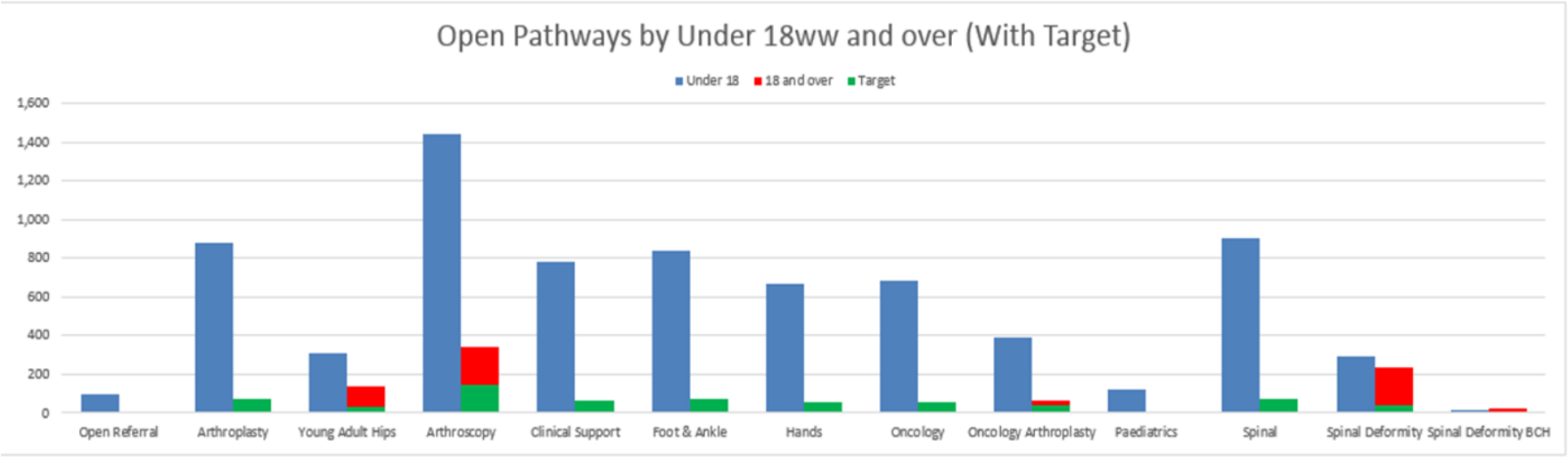


		Indicative	Reported Month							Reported Quarter		Reported Quarter 2017/18			
Target Name	National Standard	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q2 (July, August, Sept)	Q1 (Apr, May, June)	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	*98.2%*	100%	100%	100%	100%	100%	98%	98%	100%	99%	97%	98%	99%	98%
31 day first treatment	96%	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*100%*	100%	100%	100%	100%	100%	100%	90%	100%	97%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	*54.5%*	100.0%	62.5%	57.1%	90%	89%	90%	67%	70%	82%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	*90%*	88.9%	77.8%	100%	100%	83.30%	100%	100%	93%	94%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1		1			1		100%						

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	**3,828**	77	470	152	673	431	393	362	361	207	72	480	140	10
7-13	**2,612**	10	300	116	532	271	345	202	215	135	40	336	106	4
14-17	**984**	7	107	43	238	79	100	101	105	53	12	92	45	2
18-26	**771**	10	49	93	244	36	44	39	26	50	2	38	135	5
27-39	**262**	0	7	36	90	9	8	5	4	15	0	4	73	11
40-47	**33**	0	0	7	4	0	0	0	0	0	0	0	19	3
48-51	**6**	0	0	0	0	0	0	0	0	0	0	0	3	3
52 weeks and over	**14**	0	0	0	0	0	0	0	0	0	0	1	7	6
Total	**8,510**	104	933	447	1,781	826	890	709	711	460	126	951	528	44

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	**7,424**	94	877	311	1,443	781	838	665	681	395	124	908	291	16
18 and over	**1,086**	10	56	136	338	45	52	44	30	65	2	43	237	28
Target	**681**	**8**	**75**	**36**	**142**	**66**	**71**	**57**	**57**	**37**	**10**	**76**	**42**	**4**

	87.24%	90.38%	94.00%	69.57%	81.02%	94.55%	94.16%	93.79%	95.78%	85.87%	98.41%	95.48%	55.11%	36.36%



RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

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	**926**	0	153	52	190	54	44	113	96	60	32	98	25	9
7-13	**824**	0	163	49	195	41	49	84	37	61	18	104	22	1
14-17	**378**	0	60	20	122	12	22	44	19	28	6	39	4	2
18-26	**348**	1	34	28	147	8	16	21	15	29	2	14	28	5
27-39	**159**	0	7	17	66	2	3	4	2	10	0	4	34	10
40-47	**24**	0	0	5	1	0	0	0	0	0	0	0	16	2
48-51	**5**	0	0	0	0	0	0	0	0	0	0	0	2	3
52 weeks and over	**12**	0	0	0	0	0	0	0	0	0	0	0	6	6
Total	**2,676**	1	417	171	721	117	134	266	169	188	58	259	137	38

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	**2,128**	0	376	121	507	107	115	241	152	149	56	241	51	12
18 and over	**548**	1	41	50	214	10	19	25	17	39	2	18	86	26
Target	**214**	**0**	**33**	**14**	**58**	**9**	**11**	**21**	**14**	**15**	**5**	**21**	**11**	**3**
	79.52%	**0.00%**	**90.17%**	**70.76%**	**70.32%**	**91.45%**	**85.82%**	**90.60%**	**89.94%**	**79.26%**	**96.55%**	**93.05%**	**37.23%**	**31.58%**

Select Pathway Type: Non-Admit

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	**2,902**	77	317	100	483	377	349	249	265	147	40	382	115	1
7-13	**1,788**	10	137	67	337	230	296	118	178	74	22	232	84	3
14-17	**606**	7	47	23	116	67	78	57	86	25	6	53	41	0
18-26	**423**	9	15	65	97	28	28	18	11	21	0	24	107	0
27-39	**103**	0	0	19	24	7	5	1	2	5	0	0	39	1
40-47	**9**	0	0	2	3	0	0	0	0	0	0	0	3	1
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	1	1	0
Total	**5,834**	103	516	276	1,060	709	756	443	542	272	68	692	391	6

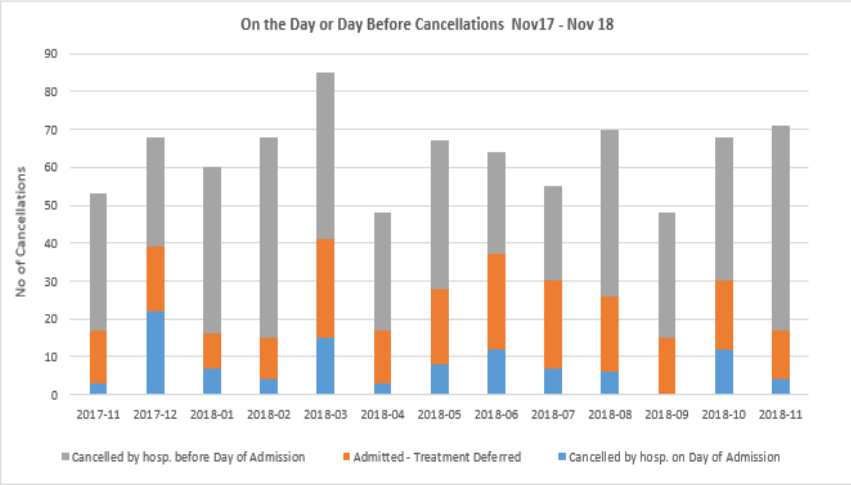
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,296**	94	501	190	936	674	723	424	529	246	68	667	240	4
18 and over	**538**	9	15	86	124	35	33	19	13	26	0	25	151	2
Target	**467**	**8**	**41**	**22**	**85**	**57**	**60**	**35**	**43**	**22**	**5**	**55**	**31**	**0**
	90.78%	**91.26%**	**97.09%**	**68.84%**	**88.30%**	**95.06%**	**95.63%**	**95.71%**	**97.60%**	**90.44%**	**100.00%**	**96.39%**	**61.38%**	**66.67%**

INFORMATION
The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. Trajectories had been developed for all specialties and were submitted to NHSI with a return to overall RTT compliance (92%) by November 2018. Given the challenges still remaining in some specialties the Trust will not meet 92% in November 2018. A revised trajectory will be submitted by the end of December 2018 to NHSI confirming when the Trust will return to 92%. The November RTT performance is 87.24% As expected Paediatrics and Foot & Ankle have achieved 92% in November 2018. Additional capacity has been planned for Young Adult Hip and Arthroscopy in December 2018 with a refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been planned to move from the ROH site at the end of February 2019. Excluding Spinal Deformity the Trust now has only 12 patients waiting over 40 weeks. In November 2018 the Trust had 14 patients waiting over 52weeks the trajectory was 43. All patients are dated and the trajectory is being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All teams continue to work through a targeted list of patients to ensure that patients are dated in chronological order over 18weeks. Non-admitted performance improved again in month – 90.78%.

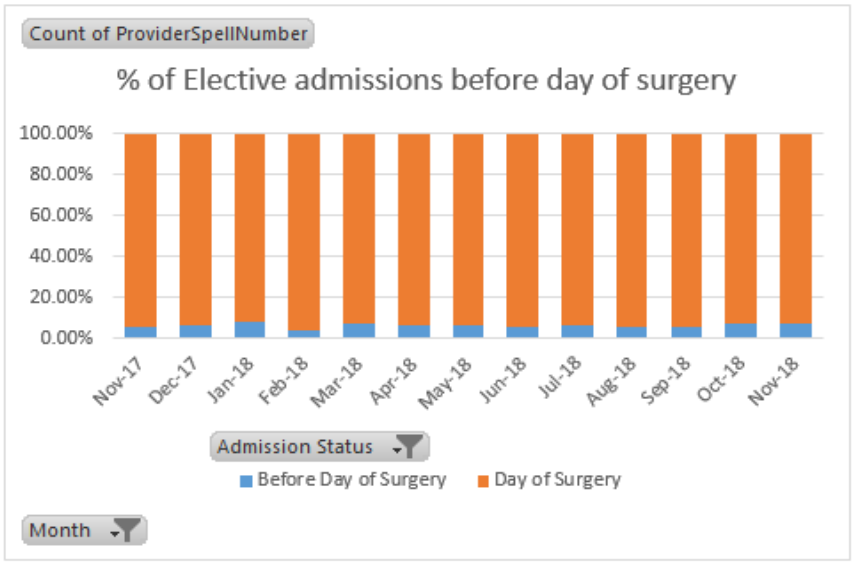
ACTIONS FOR IMPROVEMENTS / LEARNING
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019

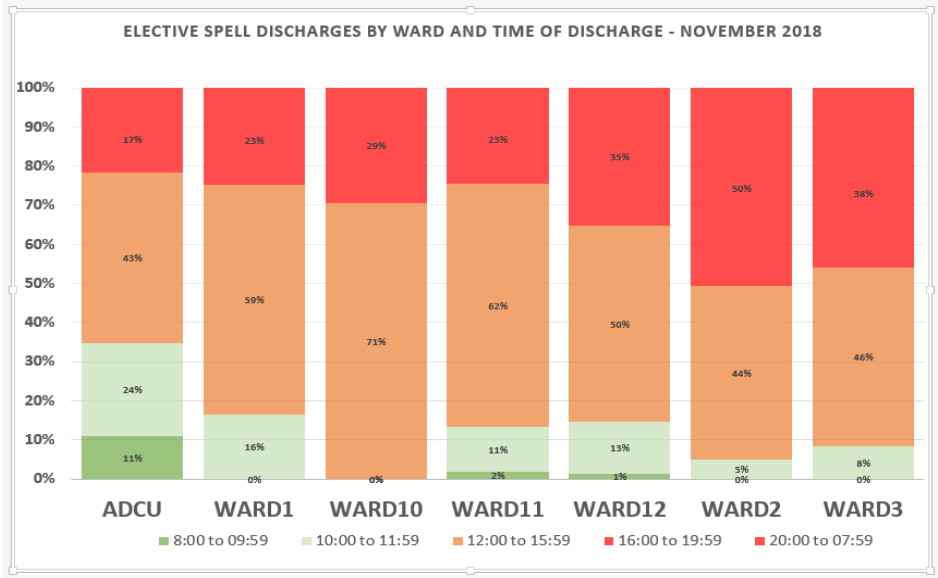
RISKS / ISSUES
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over 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 delayed from February 2019 to June 2019. Weekend activity continues until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families .

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
2017-11	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	44	70	1
2018-09		15	33	48	0
2018-10	12	18	38	68	0
2018-11	4	13	54	71	?
Grand Total	103	225	497	825	2





INFORMATION
The number of cancellations on the day of admission for surgery continues to decrease with 4 patients cancelled on day of surgery prior to admission in November . Patients admitted for surgery where treatment was deferred has also decreased in month from 18 to 13. Analysis of these 13 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 increased in month from 38 to 54 patients. An analysis of the 54 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 a higher number of 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 moved 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. The current service is being strengthened and an extended hour's contact service is being developed so patient can be contacted at evenings and weekends to improve compliance. 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 triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to expand the triage model and ensure more patients are 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
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.

Finance and Performance Report

November 2018

CONTENTS

INTRODUCTION

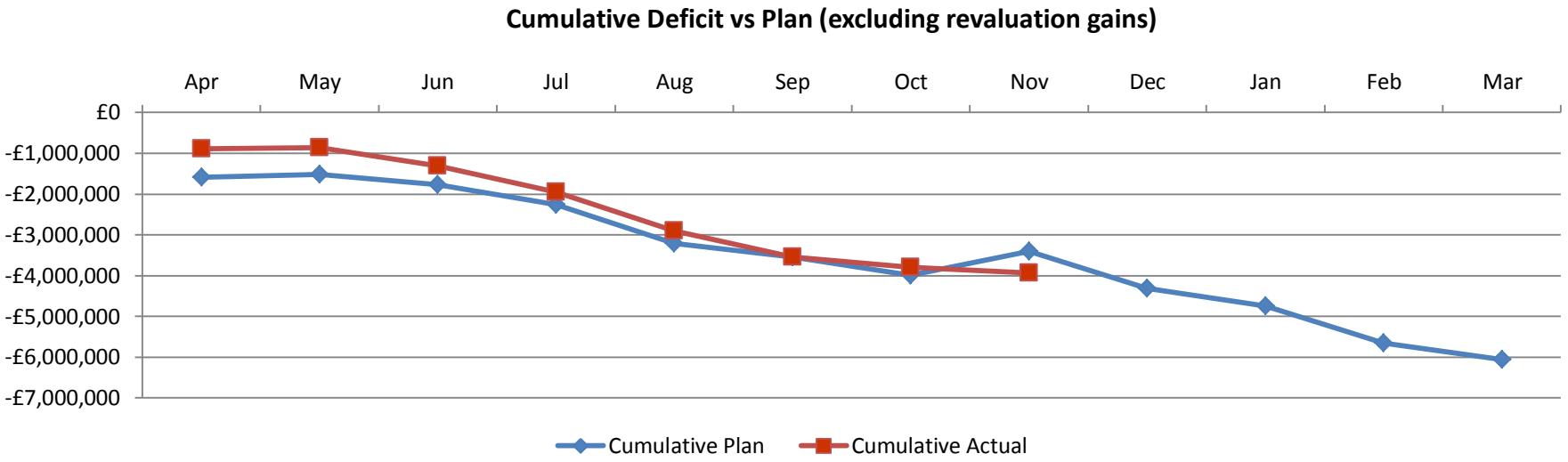
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

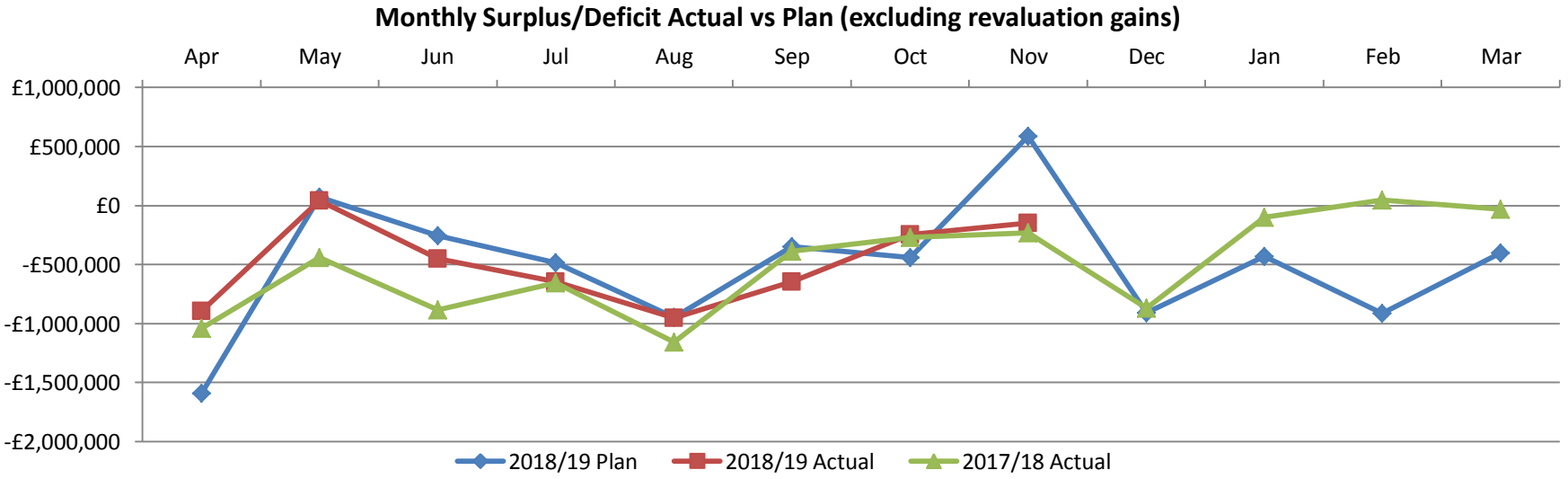
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M8 Original Plan £'000	YTD M8 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	53,113	53,375	262
Other Operating Income	3,358	3,323	(35)
Total Income	**56,471**	**56,698**	**227**
Employee Expenses (inc. Agency)	(34,060)	(34,917)	(857)
Other operating expenses	(24,879)	(24,795)	84
Operating deficit	**(2,468)**	**(3,014)**	**(546)**
Net Finance Costs	(936)	(927)	**9**
Net deficit	**(3,404)**	**(3,941)**	**(537)**
Remove donated asset I&E impact	40	42	2
Adjusted financial performance	**(3,364)**	**(3,899)**	**(535)**

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)





INFORMATION

The Trust has delivered an in-month deficit of £147k in November against a a planned surplus of £589k, £736k behind plan. It should be noted that this was a significant in-month plan to be achieved, and in hindsight was too ambitious. The current year deficit is an improvement on last year's November deficit of £233k. Year to date the Trust now has a deficit of £3,899k against a planned deficit of £3,364k; £535k behind plan.

Whilst this is a significant deterioration against plan, actual performance still represents an improvement over previous months. Planning for the rest of the year is prudent, therefore continued focus on activity delivery and cost control over the remaining 4 months should still result in achievement of the control total.

The position was very much driven by actual activity performance against plan. Both elective and day case activity were behind plan, although elective activity was in line with last November. Overall income was £1.2m behind plan for the month.

Expenditure has lower than plan in month by £472k, although this was clearly not at the level sufficient to offset the activity underperformance. Pay was in line with plan, and non-pay was £441k underspent. Whilst agency and bank spend remain high, both have reduced substantially in comparison to last month.

Cost Improvement performance remains of concern, with year to date performance £411k behind plan, and a forecasted 18/19 £830k shortfall vs the plan. 33% of forecasted 18/19 CIP delivery is via non-recurrent schemes. The 18/19 Full-Year Effect (FYE) is £19k 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, however this is at significant risk. Focus on 19/20 business planning has led to a reduced focus on 18/19 CIP identification and mitigation, however a renewed focus will commence in Q4 and the exploration of bringing 19/20 schemes into 18/19 is in progress.

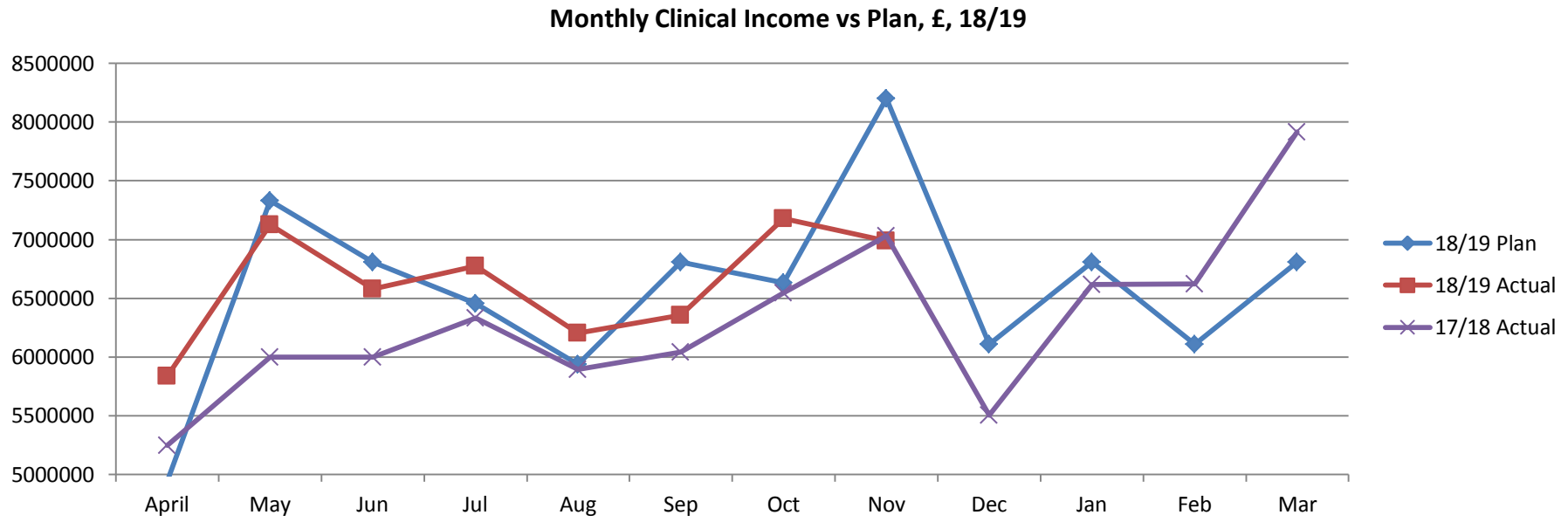
ACTIONS FOR IMPROVEMENTS / LEARNING

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 an 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. The Trust awaits a planning decision for this development.

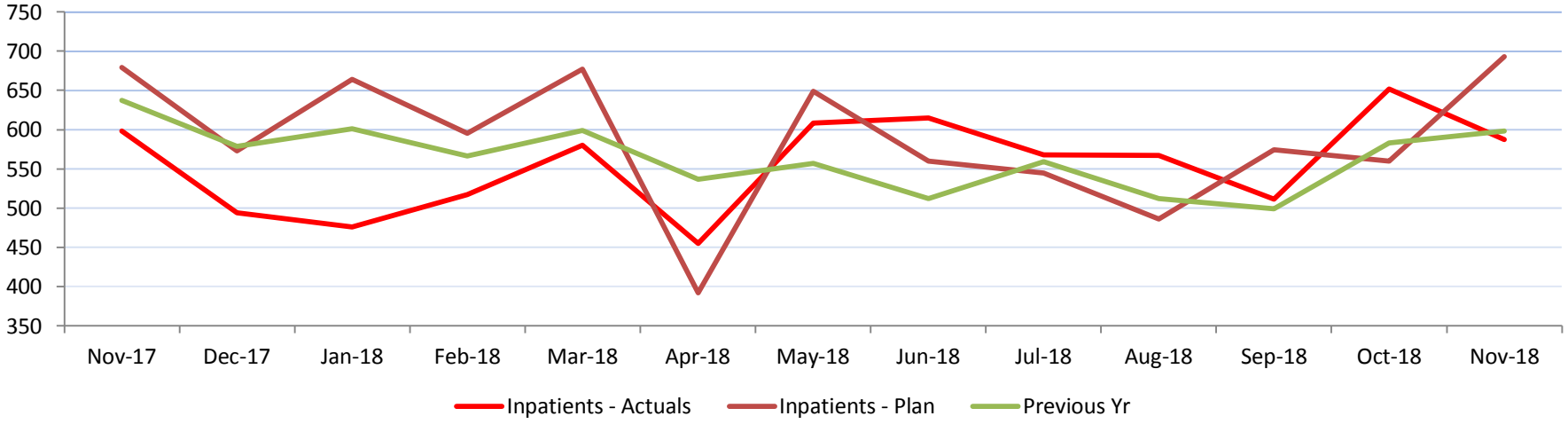
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



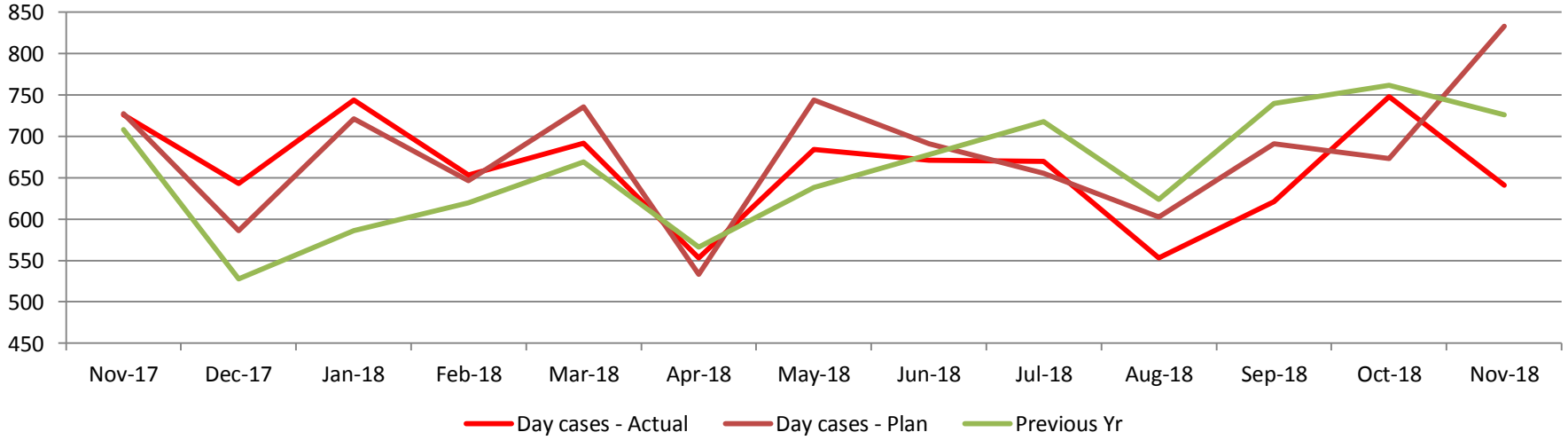
Clinical Income – November 2018 £'000			
	Plan	Actual	Variance
Inpatients	4,330	3,528	-802
Excess Bed Days	50	77	27
Total Inpatients	4,380	3,605	-775
Day Cases	1031	905	-126
Outpatients	803	752	-51
Critical Care	283	146	-137
Therapies	277	260	-17
Pass-through income	261	-18	-279
Other variable income	515	778	263
Block income	650	559	-91
TOTAL	8,200	6,983	-1,217

Clinical Income – Year To Date 2018/19 £'000			
	Plan	Actual	Variance
Inpatients	28,053	26,255	-1,798
Excess Bed Days	326	599	273
Total Inpatients	28,379	26,854	-1,525
Day Cases	6677	6700	23
Outpatients	5199	5433	234
Critical Care	1831	1498	-333
Therapies	1796	2001	205
Pass-through income	1688	1843	155
Other variable income	3332	4246	914
Block income	4206	4467	261
TOTAL	53,108	53,042	-66

Inpatient Activity



Day Case Activity



NHS Clinical income has under-performed against plan by 14.84% in November having over-performed by 8.22% in October. Cumulatively, the trust is now 0.12% below plan. The admitted patient care performance was below plan financially and on activity levels, with discharged activity 107 below the target. Average tariff for the period has decreased by £39 per case. Day case activity also underperformed financially and was below the target by 192 cases. The average tariff price for the period has increased by £292 per case. November has had decreased levels of activity compared with October. Case-mix in November has moved as day cases has decreased to 52% compared to 53% in October. 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 but there has been a decrease in attendances against plan in November for first and follow up attendances . First to follow up ratio has increased year to date at 1.94:1.

Other variable income has increased this month due to NHSE funding the Paediatric project management.

Given that the overall position at M8 is now behind plan, PSF has been removed for M7 and not included for M8 as a prudent measure. (circa £130k in total). This can still be claimed at the end of the quarter, or at year end if the control total is hit.

ACTIONS FOR IMPROVEMENT/LEARNING

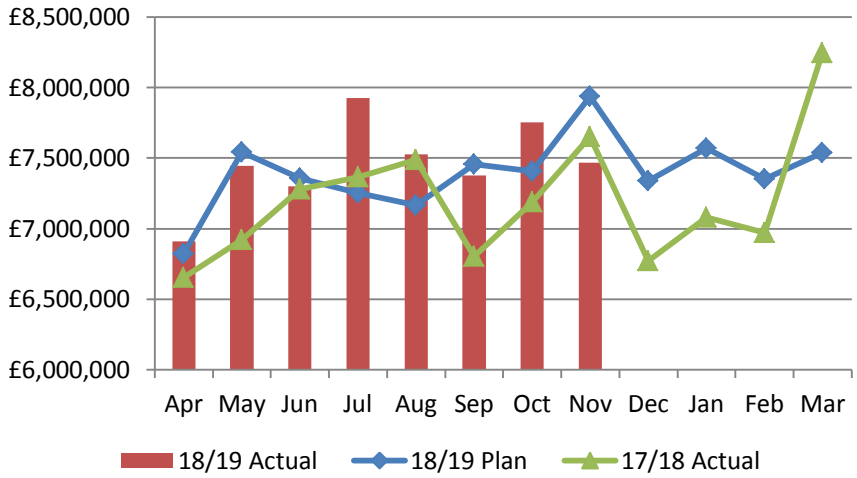
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

RISKS / ISSUES

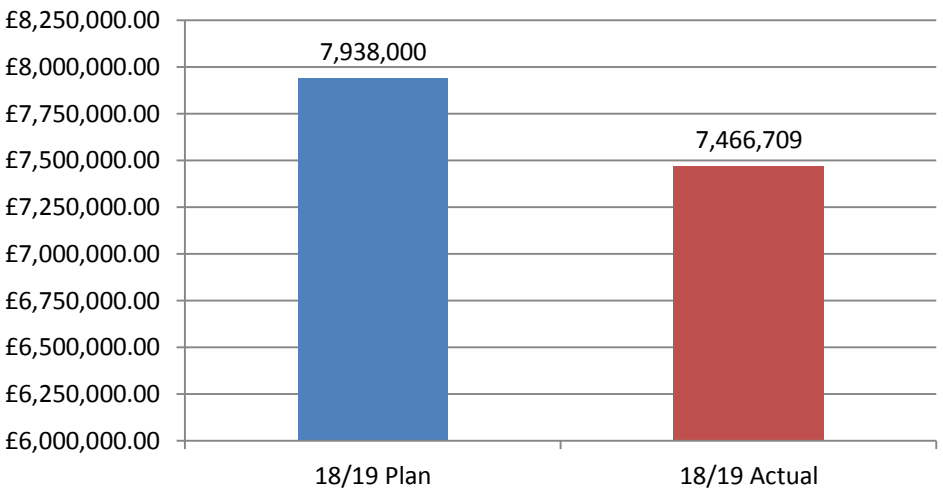
The month 8 position includes an correction of previously overstated income, as referenced in last month's paper. The plan to achieve the control total will not be impacted by this.

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

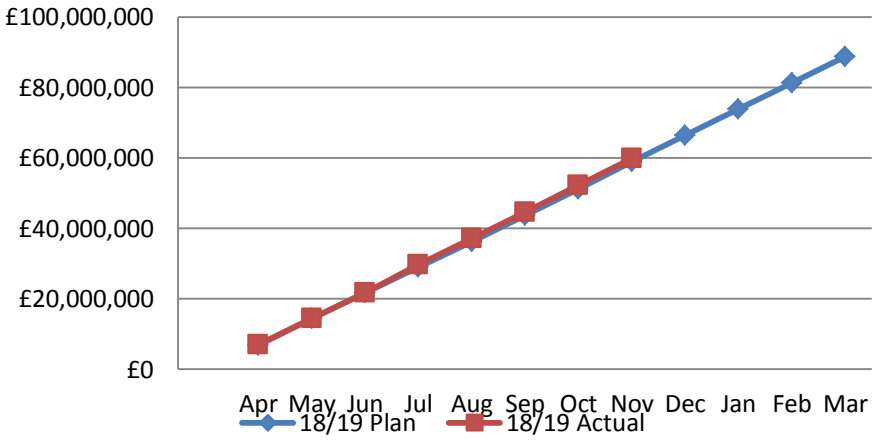
18/19 Monthly Expenditure vs Plan



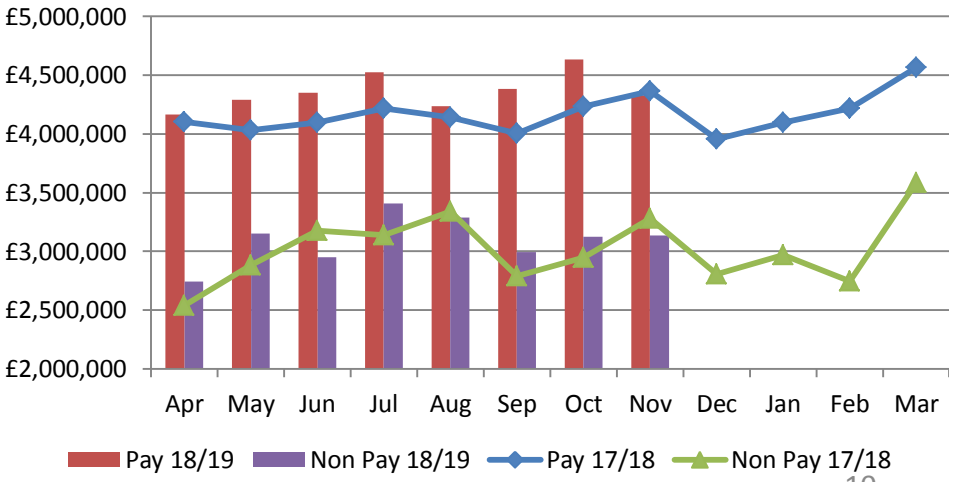
18/19 M8 Expenditure vs Plan



Cumulative Expenditure vs Plan 18/19



17/18 vs 18/19 Pay & Non Pay Spends



INFORMATION

November's expenditure was £7,466k, £472k lower than the plan of £7,938k.

Pay was in line with plan in month, although within this bank and agency spend remain higher than plan, offset by underspends on substantive staffing. Whilst agency spend was high, it has reduced substantially, along with bank spend. This is in line with the activity reduction. Further detail on agency spend has been given on the next slide.

Non pay spend is £441k below plan. The in-month underspend is within various categories of spend, but particularly clinical supplies. This again correlates with the reduced activity compared to plan.

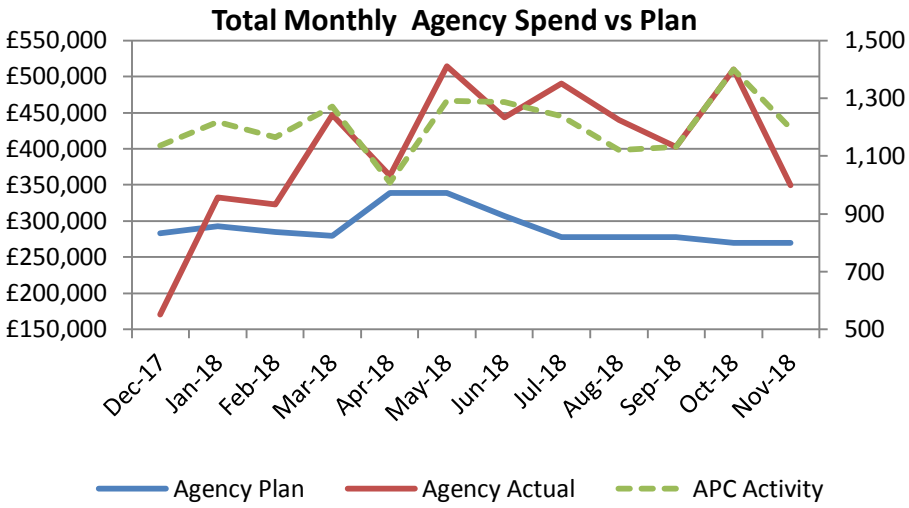
ACTIONS FOR IMPROVEMENTS / LEARNING

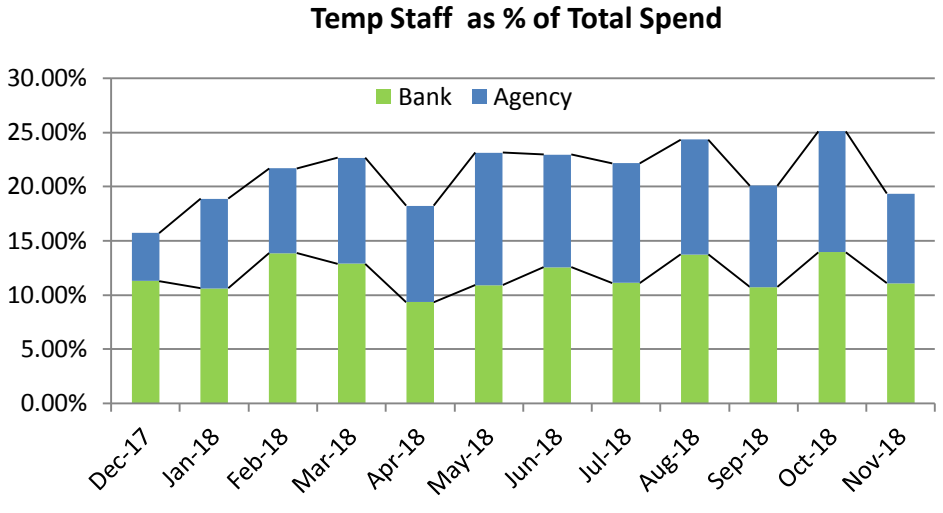
There is further learning from the year end stock count and subsequent audit which will be taken forward and acted upon within 2018-19 to give greater control over stock costs throughout the year. Monthly meetings are now taking place to review theatre spending between the Theatre manager, logistics and finance.

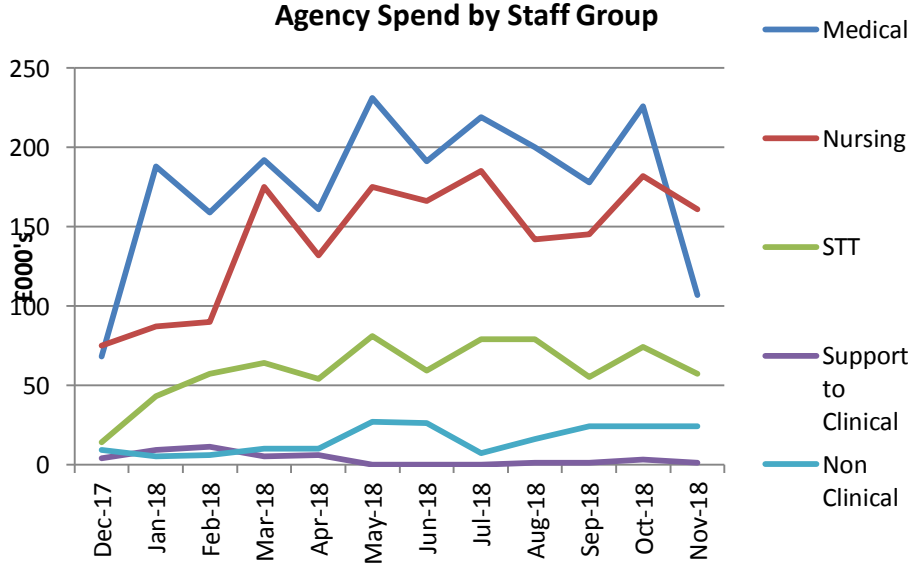
RISKS / ISSUES

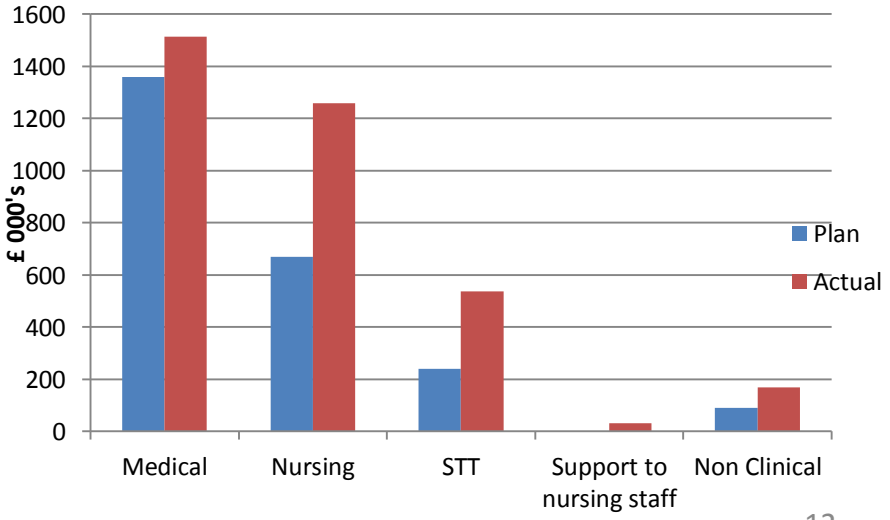
Gaining a greater understanding and control of theatre spend is essential to the trust's ongoing ability to predict theatre costs, and will be mitigated via various theatre improvement workshops.

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 £159k to £350k in month which is £80k above the monthly plan and £1.2m 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 (£590k), medical (£153k) and therapeutic (£297k).

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. Whilst there has not been a material reduction in wte employed in month, there has been a significant reduction in out of hours working, whilst there had also been an overly prudent accrual of usage in the previous month which has now also been corrected.

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.

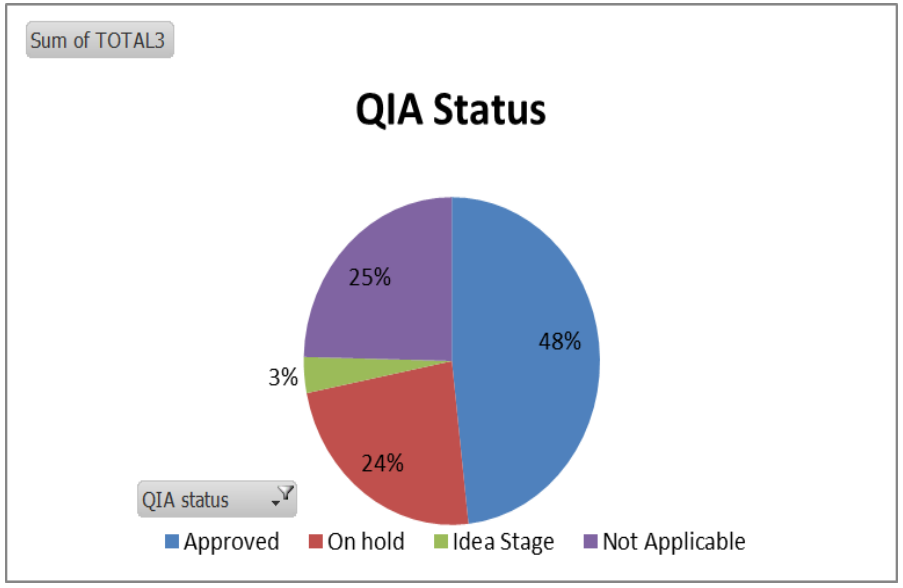
Review of e-Roster continues and shifts approved by the relevant Matron and head of Nursing.

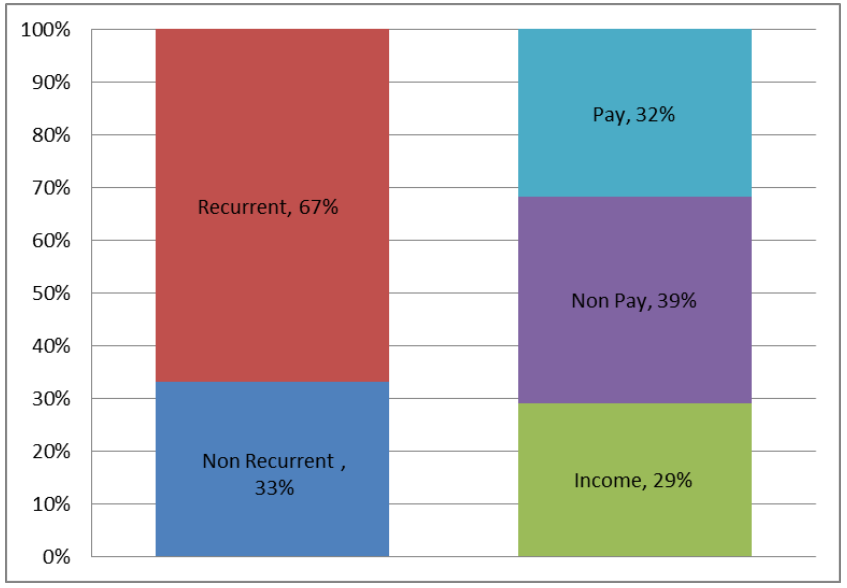
RISKS / ISSUES

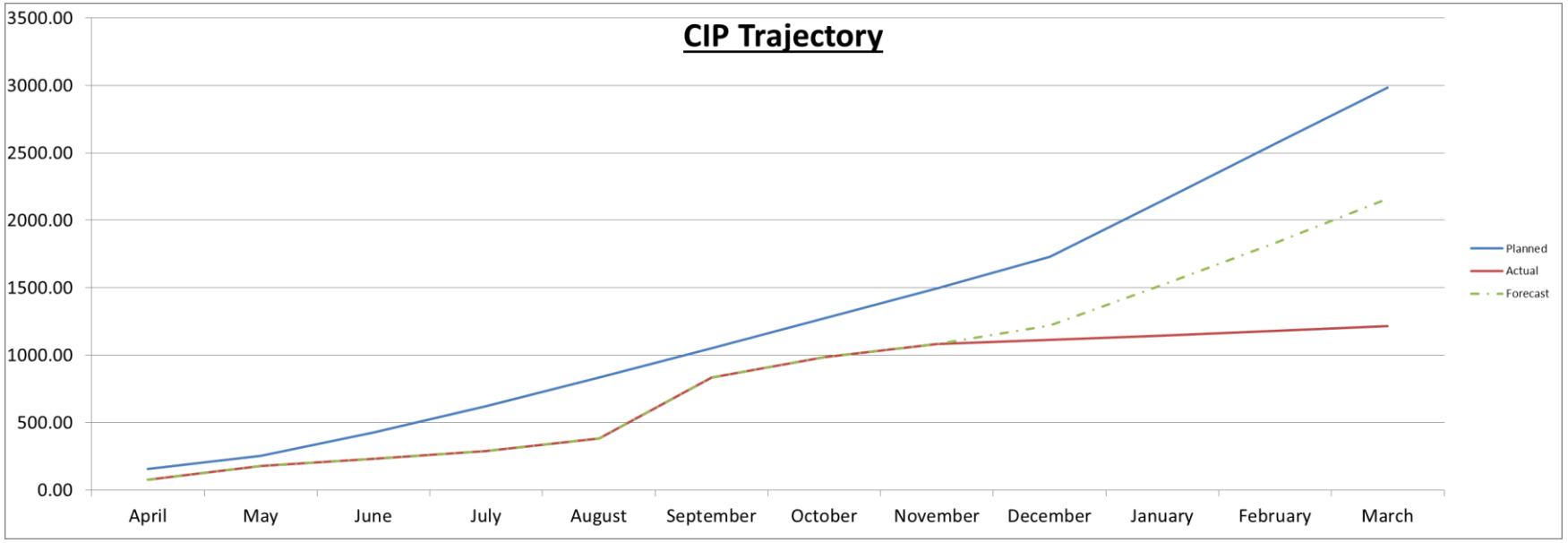
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

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.

5. 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 8 £2,155k is forecasted for delivery in 18/19 (72% of identified/planned). At month 8 £1,083k of savings have been delivered against a plan of £1,494k year to date. (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	93	29	(64)	714	451	(263)	1,090	749	(341)	69%	649	(441)
Division 1	71	35	(35)	407	311	(96)	705	472	(233)	67%	611	(94)
Division 2	53	32	(21)	359	306	(53)	1,157	901	(256)	78%	1,747	591
Division 4	5	5	0	14	15	1	33	33	1	103%	12	(21)
Grand Total	**221**	**100**	**(121)**	**1,494**	**1,083**	**(411)**	**2,985**	**2,155**	**(830)**	**72%**	**3,019**	**35**

The summary reasons for under-performance are below:

- Non-delivery and slippage against some clinical and operational saving schemes such as Implant rationalisation, GIRFT recommendations, LOS reduction and clinical pathway/process redesign savings
- Slippage and under-delivery against large scale savings schemes such as Direct Engagement, Theatres Stock control and Managed Service Contract and Counting & Coding improvement schemes
- *See CIP Pack for performance against schemes*

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved forecasted performance, 33% 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 Directorate Finance & CIP meetings are being addressed for Q4; 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 £252k in 2018/19, 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
- Focus on 19/20 Business Planning including 19/20 CIP scheme identification, however this has led to a reduced focus on (2018/19) in-year identification, renewed focus in Q4 is required

6. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M8 Plan £'000	M8 Actual £'000	Var £'000
Intangible Assets	726	588	(138)
Tangible Assets	48,194	48,005	(189)
Total Non-Current Assets	**48,920**	**48,593**	(327)
Inventories	4,858	5,108	250
Trade and other current assets	7,555	5,939	(1,616)
Cash	1,327	1,042	(285)
Total Current Assets	**13,740**	**12,089**	(1,651)
Trade and other payables	(13,197)	(12,459)	738
Borrowings	(1,363)	(1,591)	(228)
Provisions	(173)	(108)	65
Other liabilities	(207)	(379)	(172)
Total Current Liabilities	**(14,940)**	**(14,594)**	403
Borrowings	(6,979)	(6,534)	445
Provisions	(354)	(354)	0
Total Non-Current Liabilities	**(7,333)**	**(6,831)**	445
Total Net Assets Employed	**40,387**	**39,257**	(1,130)
Total Taxpayers' and Others' Equity	**40,387**	**39,257**	(1,130)

INFORMATION

Tangible assets are 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.

Whilst the variance against the planned position looks significant , the actual move from Month 7 is minor. Cash has been above planned levels since Month 1 due to receipt of 2017/18 STF but the impact of this has now been utilised with a number of significant payments made in Month 8, and an earlier in month drawdown of DH support . The next expected drawdown of £1m is planned for the 9th of January.

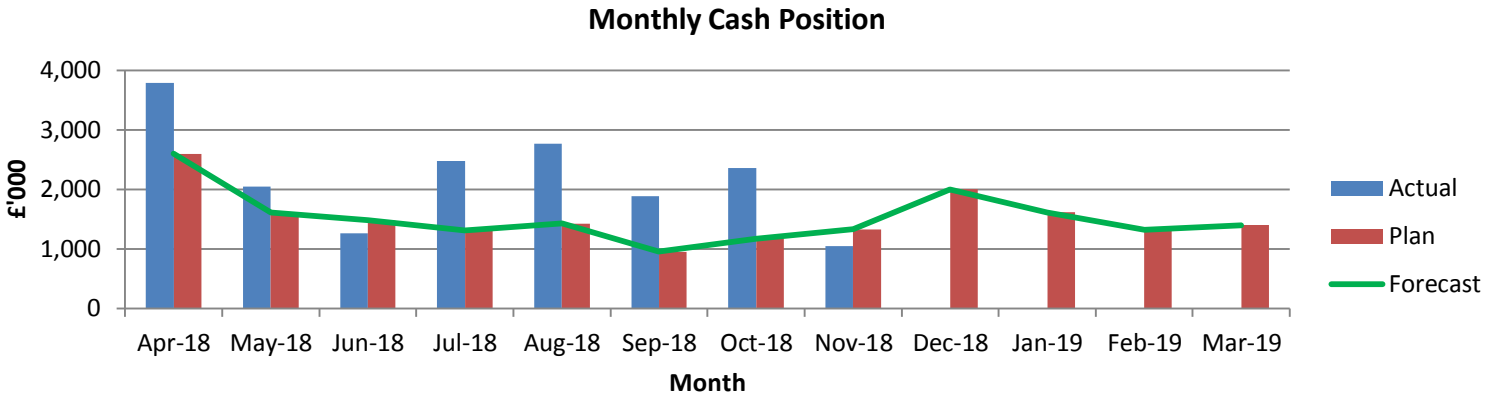
ACTIONS FOR IMPROVEMENTS / LEARNING

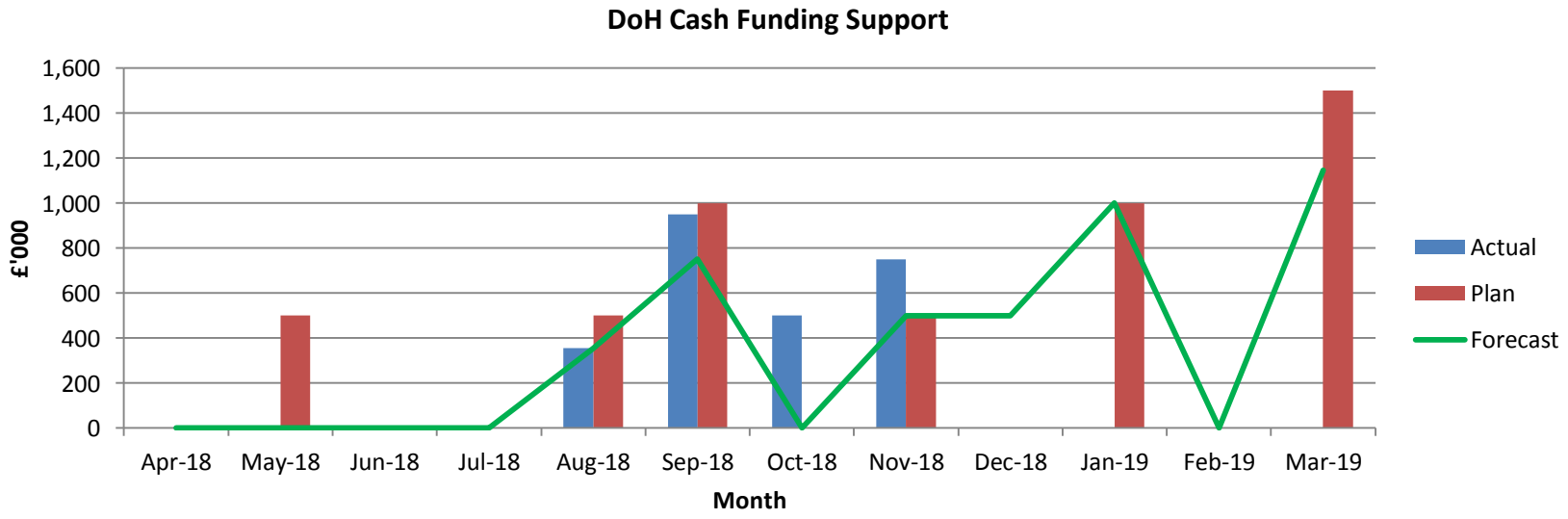
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

RISKS / ISSUES

Despite the receipt of STF, cash remains tight for the remainder of the year with a projected cash balance at year end of £1.4m as per plan after a lower uptake of the borrowing facility during the year than planned.

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 £1,042k which is lower than forecast following the return of NHS Supplies to the standard payment terms of 30 days.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £1,000k has been requested from the Department of Health (DoH) for January which is within the forecast for 2018/19.

ACTIONS FOR IMPROVEMENTS / LEARNING

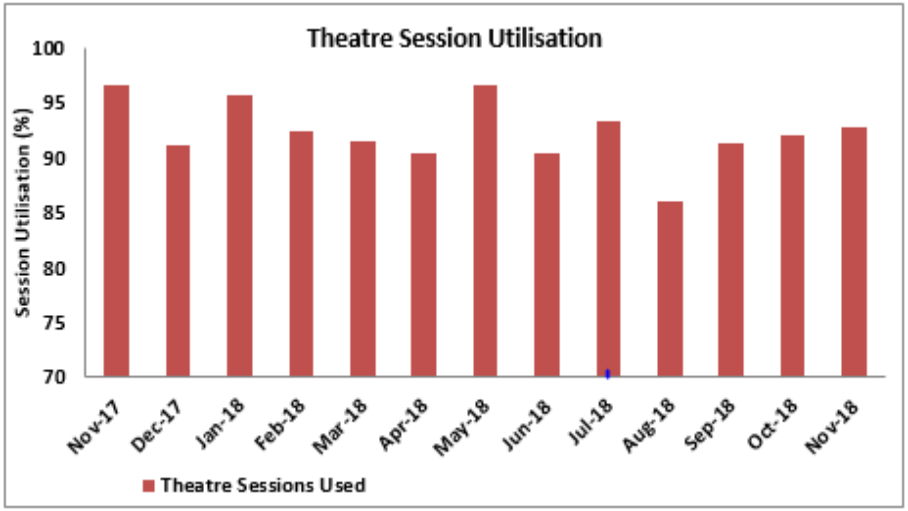
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2018/19. The Head of Financial Accounting has set up a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team. The 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

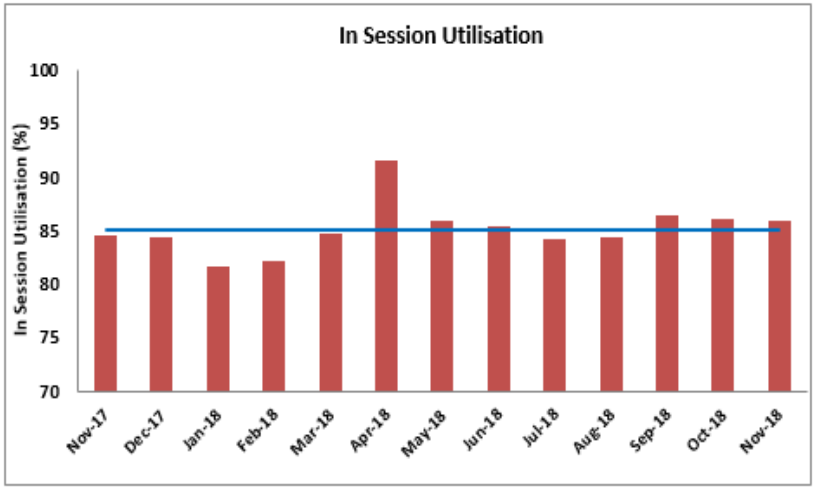
Session utilisation for November was 92.86% a slight increase on October which was 92.11%

Average utilisation is 92.39% for the period April '18 – November '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 dropped slightly from 86.16% in October to 85.97% in November.

In session utilisation remains consistent, running at an average of 86% for the period April '18 – November '18.

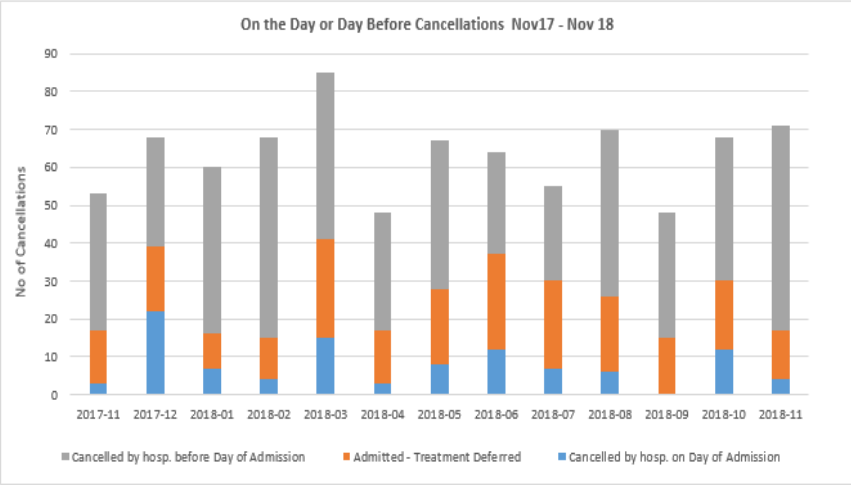
The 72hr call service has now been transferred from Outpatients to POAC. A service review is being undertaken which will look at resource requirements based on the volume of calls, and the times of the day patients are being contacted and the number of 'non contacts'. The aim is to change the operational hours so that patients can be contacted into the early evening

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*

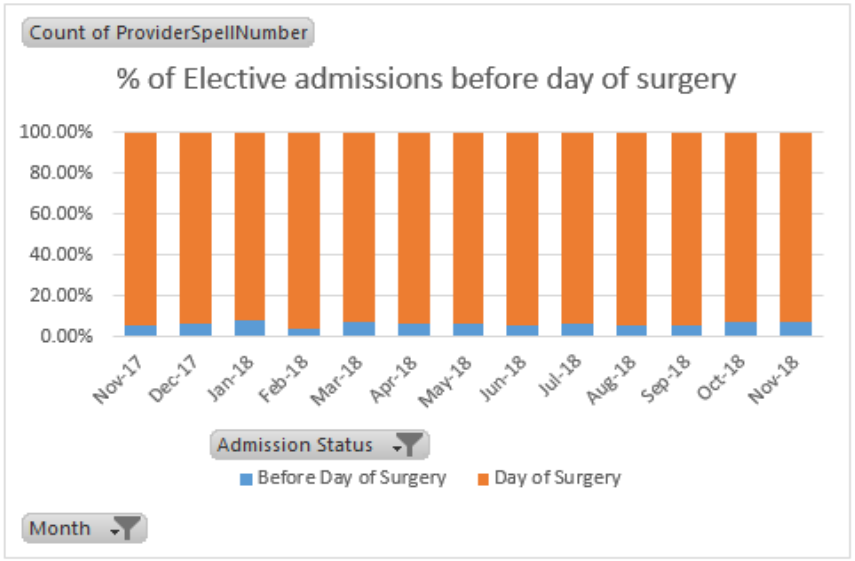
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

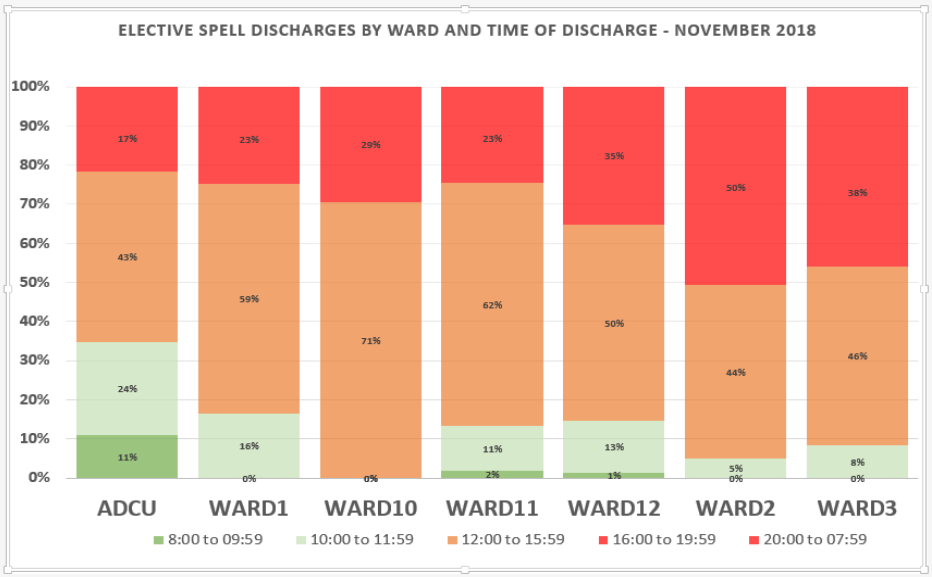
Hospital Cancellations



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
2017-11	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	44	70	1
2018-09		15	33	48	0
2018-10	12	18	38	68	0
2018-11	4	13	54	71	?
Grand Total	103	225	497	825	2

Admission the day before surgery





The number of cancellations on the day of admission for surgery continues to decrease with 4 patients cancelled on day of surgery prior to admission in November . Patients admitted for surgery where treatment was deferred has also decreased in month from 18 to 13. Analysis of these 13 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 increased in month from 38 to 54 patients. An analysis of the 54 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 a higher number of 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 moved 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. The current service is being strengthened and an extended hours contact service is being developed so patient can be contacted at evenings and weekends to improve compliance .

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 triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to expand the triage model and ensure more patients are 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

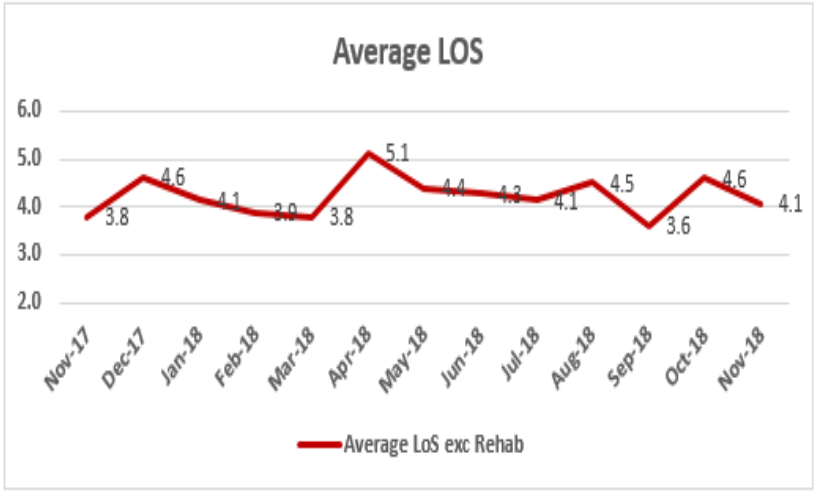
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

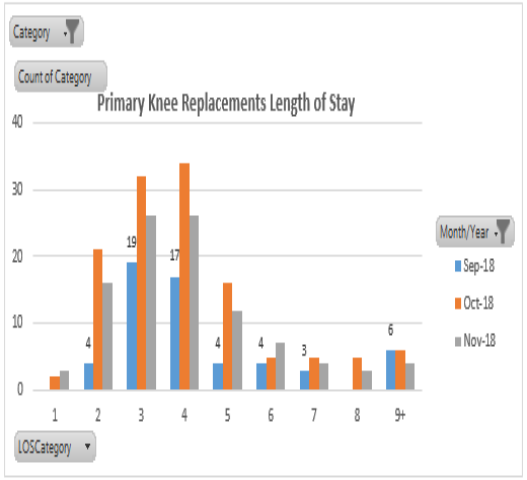
- Joint care project is ongoing

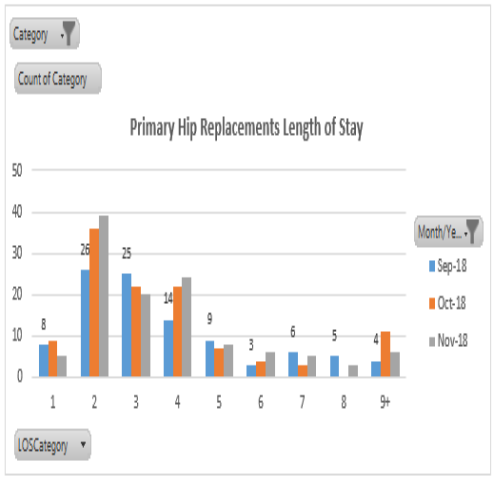
RISKS / ISSUES

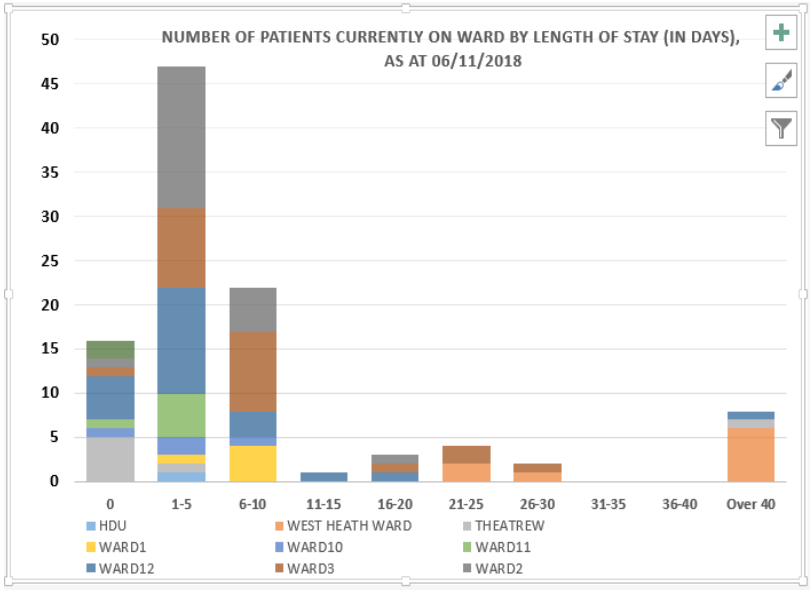
Existing aging equipment asset base and the need to increase the number of power tools in Theatre. Some additional power tools are currently being scoped as part of the capital programme slippage and the Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

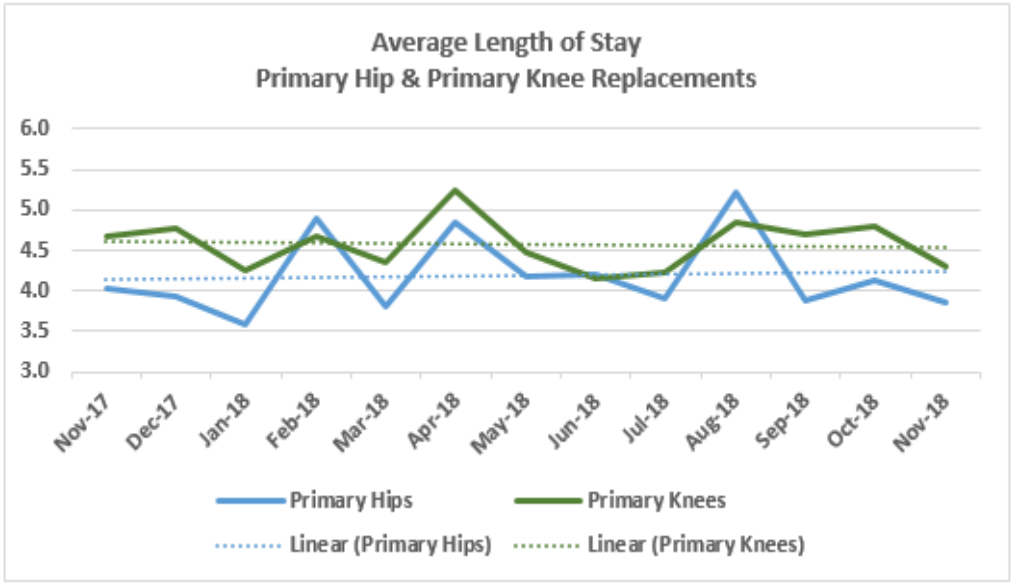
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS has reduced in November 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 went 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 opened on 5th November with increased capacity to support all ward areas

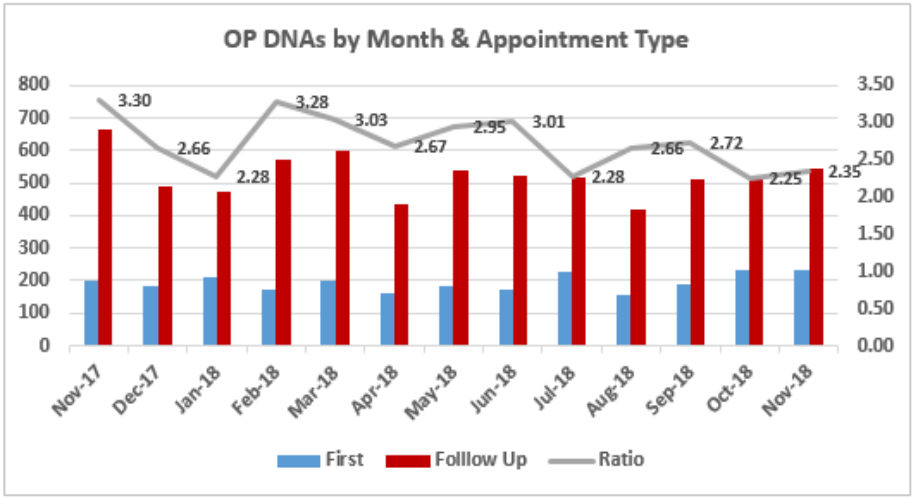
ACTIONS FOR IMPROVEMENTS / LEARNING

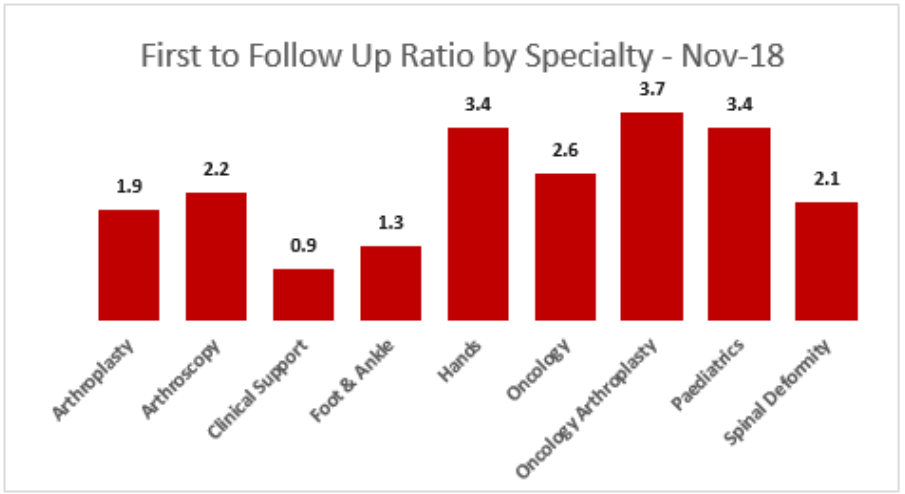
- The Red2Green dashboard development is now launched across all wards .
- The dashboard also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds on Ward 12 still needs to be put in place and conversations with arthroscopy surgeons are ongoing led by AMD and CSM.

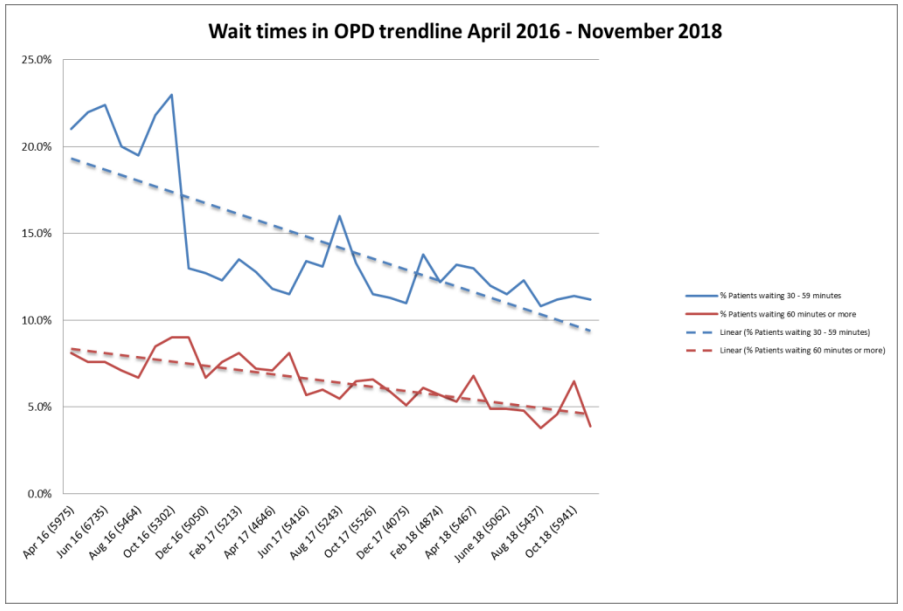
RISKS / ISSUES

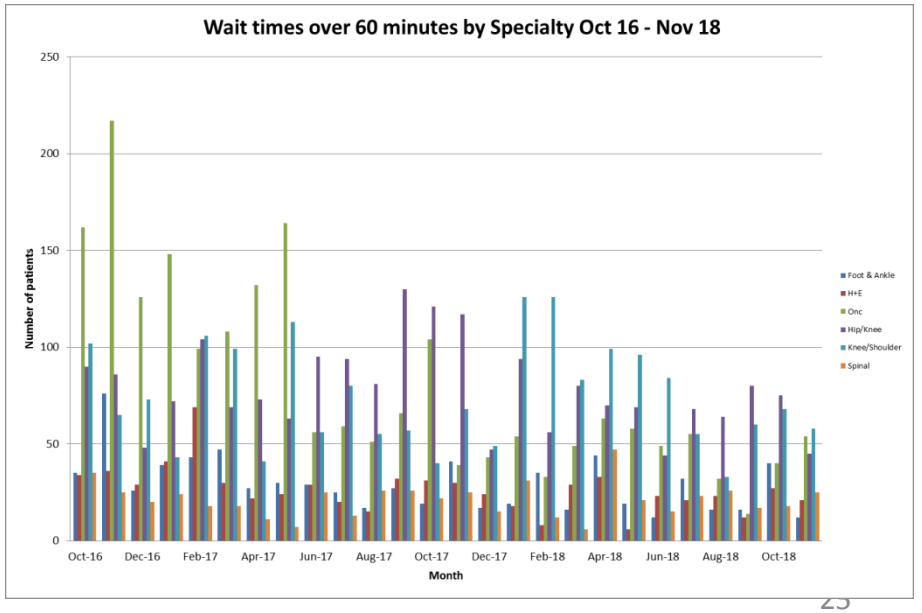
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions supporting maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases have a significantly higher LOS and this is reflected in the LOS data monthly variation. The underlying Hip and Knee LOS excluding oncology varies between 3.3 and 3.7 in data analysed.

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









INFORMATION

In November there were only 3 incident forms completed to highlight clinics running more than 60 minutes late. This is a very low number and investigations should take place and reaffirm the importance of reporting these incidents.

There were 11.2% of patients waiting over 30 minutes and 3.9% waiting over 1 hour which is below the target of 5%. Both of these metrics have improved since last month however the target for 30 minute delays has still not been achieved. Positively this is the 7th month out of the last 8 that the over 60 minute target has been achieved. The largest number of incidents were reported in Knee / Shoulder and Oncology specialties whereas last month this was Hip and Knee rather than Oncology.

The monthly audit identified the following categories of incident: -

- 2 – Clinic Overbooked
- 1 – X-ray delays

Work is underway to begin to collect information about daily room allocations within outpatients. With this information and activity data it will be possible to review clinic utilisation.

New nursing staff have commenced in recent weeks and there may have been a reduction in reporting because of this. The Matron for outpatients will reiterate the importance of reporting all incidents relating to clinic delays.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Reiterate the importance of submitting incident forms with the staff
- Commence a weekly 6-3-2 meeting to discuss activity for future weeks, avoiding overbookings and identifying additional clinic rooms available
- Begin to collect room occupancy data
- Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available
- Investigation of partial booking processes to reduce clinic rescheduling and overbooking

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

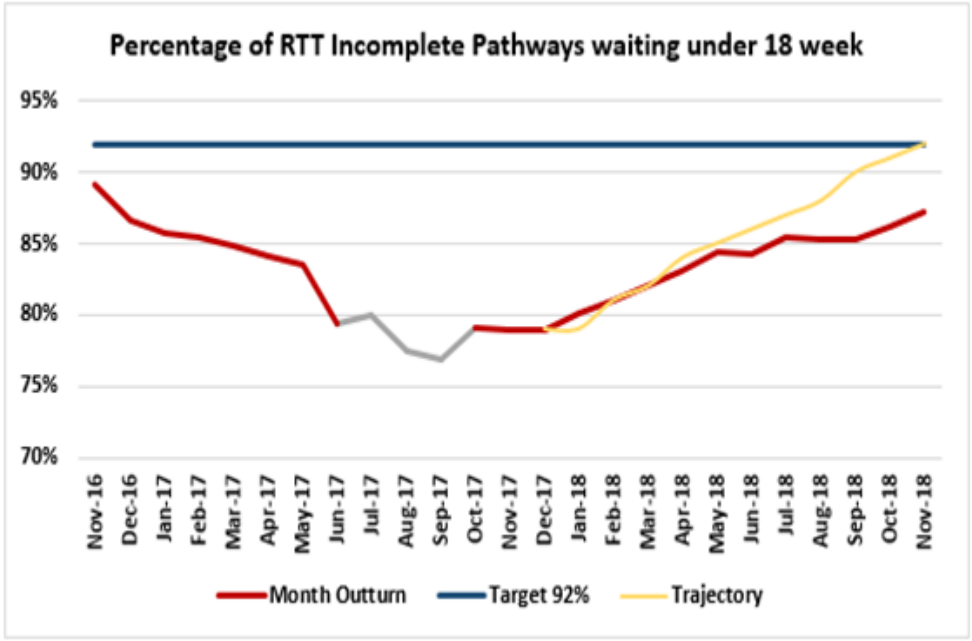
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

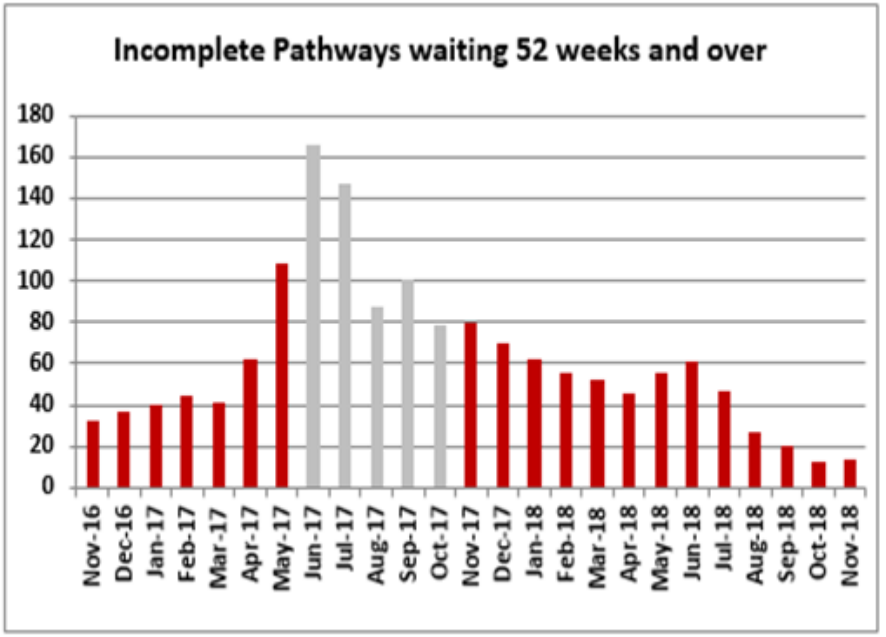
% of patients waiting <6weeks for Diagnostic test.

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%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1,254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1,245	1,252	99.4%

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





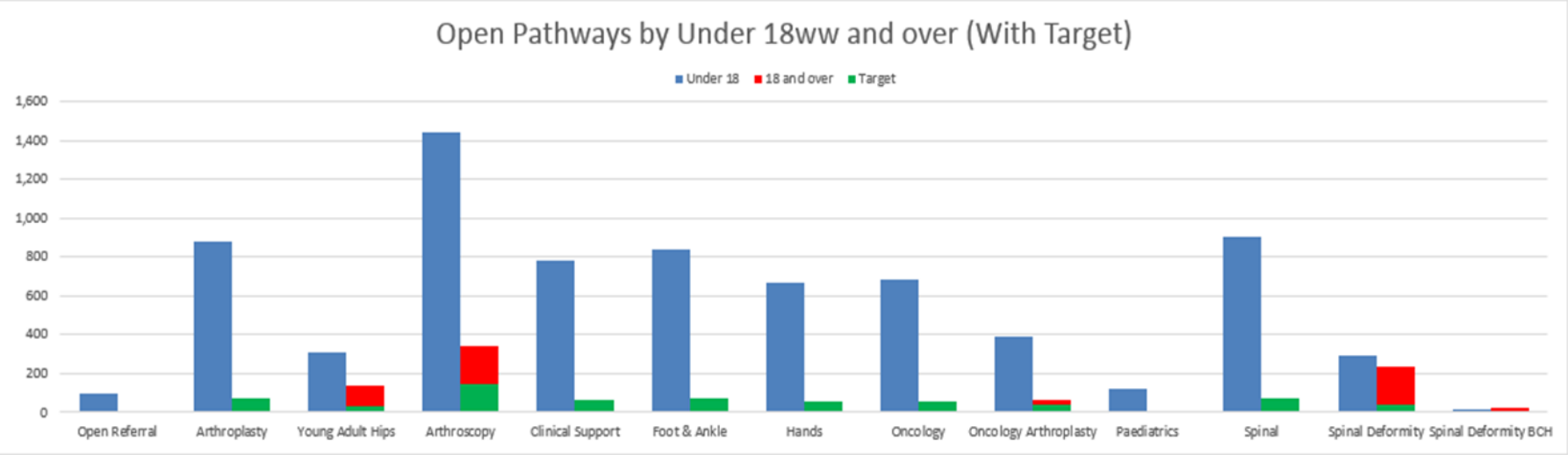
		Indicative	Reported Month							Reported Quarter		Reported Quarter 2017/18			
Target Name	National Standard	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q2 (July, August, Sept)	Q1 (Apr, May, June)	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	*98.2%*	100%	100%	100%	100%	100%	98%	98%	100%	99%	97%	98%	99%	98%
31 day first treatment	96%	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*100%*	100%	100%	100%	100%	100%	100%	90%	100%	97%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	*54.5%*	100.0%	62.5%	57.1%	90%	89%	90%	67%	70%	82%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	*90%*	88.9%	77.8%	100%	100%	83.30%	100%	100%	93%	94%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days		1		1			1		100%						

13. Referral to Treatment snapshot as at 30 November 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	**3,828**	77	470	152	673	431	393	362	361	207	72	480	140	10
7-13	**2,612**	10	300	116	532	271	345	202	215	135	40	336	106	4
14-17	**984**	7	107	43	238	79	100	101	105	53	12	92	45	2
18-26	**771**	10	49	93	244	36	44	39	26	50	2	38	135	5
27-39	**262**	0	7	36	90	9	8	5	4	15	0	4	73	11
40-47	**33**	0	0	7	4	0	0	0	0	0	0	0	19	3
48-51	**6**	0	0	0	0	0	0	0	0	0	0	0	3	3
52 weeks and over	**14**	0	0	0	0	0	0	0	0	0	0	1	7	6
Total	**8,510**	104	933	447	1,781	826	890	709	711	460	126	951	528	44

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	**7,424**	94	877	311	1,443	781	838	665	681	395	124	908	291	16
18 and over	**1,086**	10	56	136	338	45	52	44	30	65	2	43	237	28
Target	**681**	**8**	**75**	**36**	**142**	**66**	**71**	**57**	**57**	**37**	**10**	**76**	**42**	**4**

	87.24%	90.38%	94.00%	69.57%	81.02%	94.55%	94.16%	93.79%	95.78%	85.87%	98.41%	95.48%	55.11%	36.36%



13. Referral to Treatment snapshot as at 30th November 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	**926**	0	153	52	190	54	44	113	96	60	32	98	25	9
7-13	**824**	0	163	49	195	41	49	84	37	61	18	104	22	1
14-17	**378**	0	60	20	122	12	22	44	19	28	6	39	4	2
18-26	**348**	1	34	28	147	8	16	21	15	29	2	14	28	5
27-39	**159**	0	7	17	66	2	3	4	2	10	0	4	34	10
40-47	**24**	0	0	5	1	0	0	0	0	0	0	0	16	2
48-51	**5**	0	0	0	0	0	0	0	0	0	0	0	2	3
52 weeks and over	**12**	0	0	0	0	0	0	0	0	0	0	0	6	6
Total	**2,676**	1	417	171	721	117	134	266	169	188	58	259	137	38

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	**2,128**	0	376	121	507	107	115	241	152	149	56	241	51	12
18 and over	**548**	1	41	50	214	10	19	25	17	39	2	18	86	26
Target	**214**	**0**	**33**	**14**	**58**	**9**	**11**	**21**	**14**	**15**	**5**	**21**	**11**	**3**
	79.52%	**0.00%**	**90.17%**	**70.76%**	**70.32%**	**91.45%**	**85.82%**	**90.60%**	**89.94%**	**79.26%**	**96.55%**	**93.05%**	**37.23%**	**31.58%**

Select Pathway Type: Non-Admi

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	**2,902**	77	317	100	483	377	349	249	265	147	40	382	115	1
7-13	**1,788**	10	137	67	337	230	296	118	178	74	22	232	84	3
14-17	**606**	7	47	23	116	67	78	57	86	25	6	53	41	0
18-26	**423**	9	15	65	97	28	28	18	11	21	0	24	107	0
27-39	**103**	0	0	19	24	7	5	1	2	5	0	0	39	1
40-47	**9**	0	0	2	3	0	0	0	0	0	0	0	3	1
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	1	1	0
Total	**5,834**	103	516	276	1,060	709	756	443	542	272	68	692	391	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	**5,296**	94	501	190	936	674	723	424	529	246	68	667	240	4
18 and over	**538**	9	15	86	124	35	33	19	13	26	0	25	151	2
Target	**467**	**8**	**41**	**22**	**85**	**57**	**60**	**35**	**43**	**22**	**5**	**55**	**31**	**0**
	90.78%	**91.26%**	**97.09%**	**68.84%**	**88.30%**	**95.06%**	**95.63%**	**95.71%**	**97.60%**	**90.44%**	**100.00%**	**96.39%**	**61.38%**	**66.67%**

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. Trajectories had been developed for all specialties and was submitted to NHSI with a return to overall RTT compliance (92%) by November 2018.

Given the challenges still remaining in some specialties the Trust will not meet 92% in November 2018. A revised trajectory will be submitted by the end of December 2018 to NHSI confirming when the Trust will return to 92%.

The November RTT performance is **87.24%**

As expected Paediatrics and Foot & Ankle have achieved 92% in November 2018.

Additional capacity has been planned for Young Adult Hip and Arthroscopy in December 2018 with a refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been planned to move from the ROH site at the end of February 2019.

Excluding Spinal Deformity the Trust now has only 12 patients waiting over 40 weeks.

In November 2018 the Trust had **14** patients waiting over 52weeks the trajectory was 43. All patients are dated and the trajectory is being reviewed in light of the delay in the service now not being transferred to BCH in February 2019.

All teams continue to work through a targeted list of patients to ensure that patients are dated in chronological order over 18weeks.

Non-admitted performance improved again in month – 90.78%.

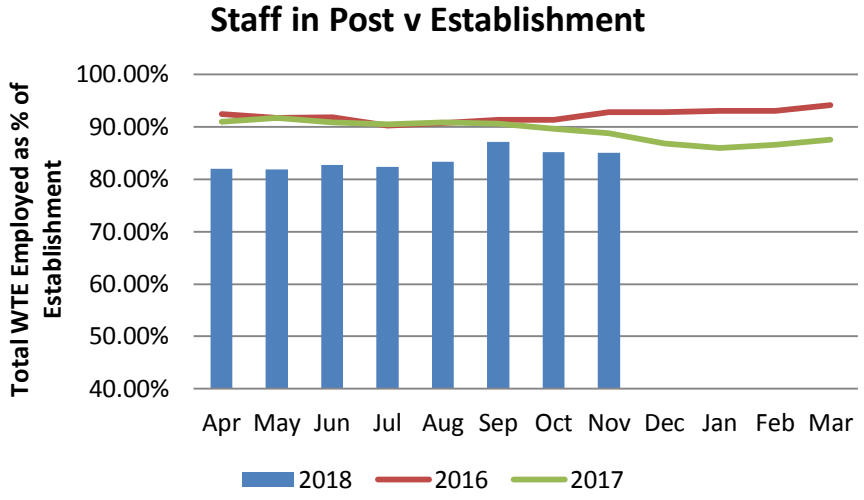
ACTIONS FOR IMPROVEMENTS / LEARNING

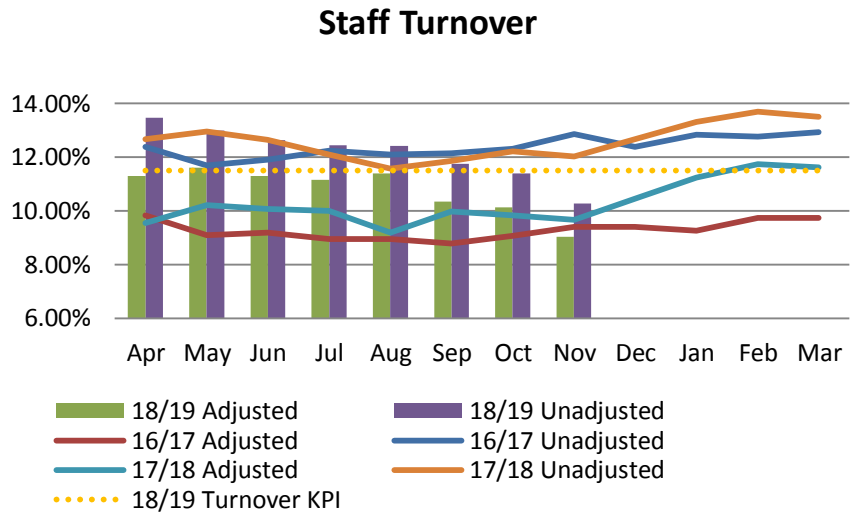
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019

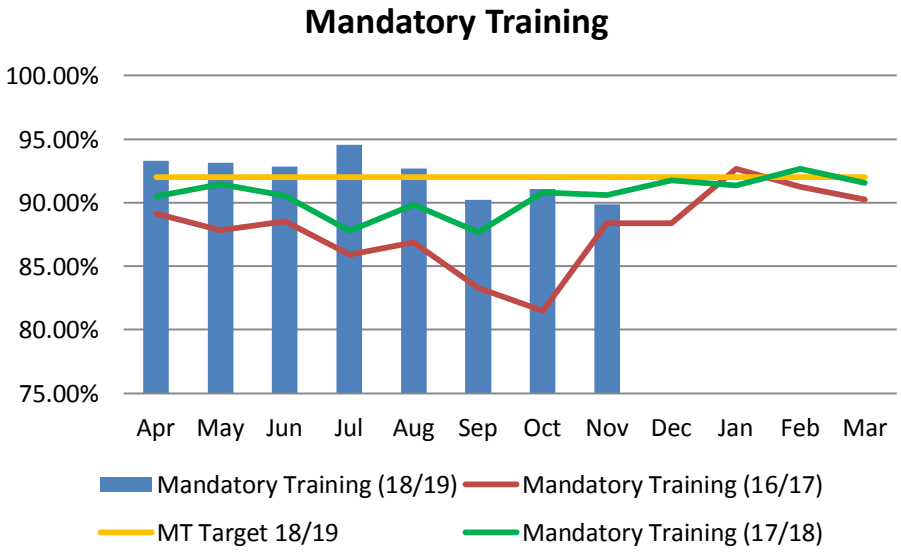
RISKS / ISSUES

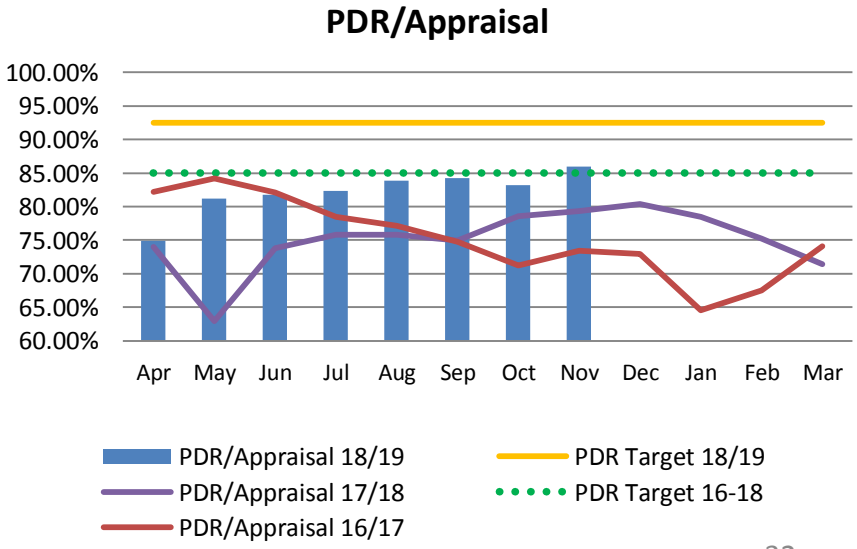
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter 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 delayed from February 2019 to June 2019. Weekend activity continues until December 2018. A small number of patients have been transferred to Stoke for treatment following discussion with patients and their families

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

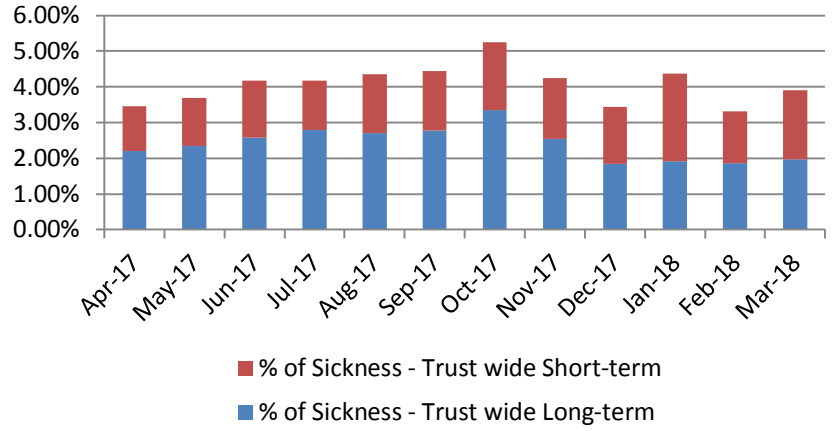




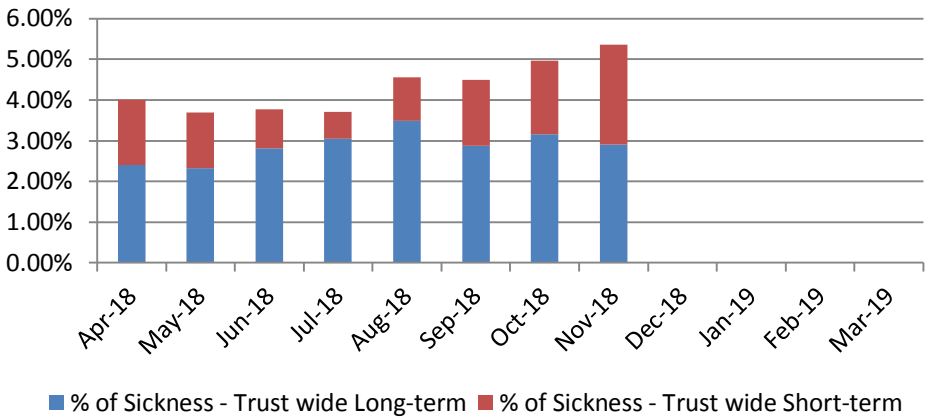




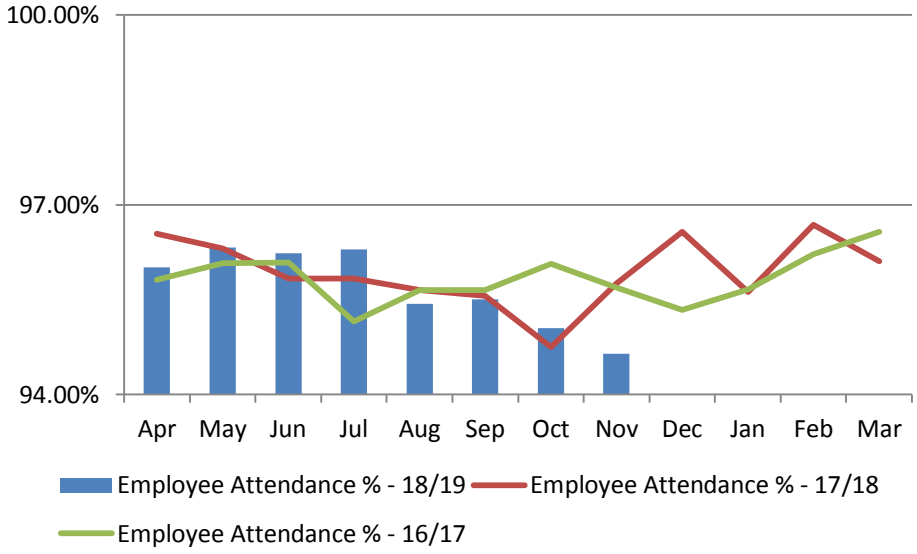
Sickness % - LT/ST (2017/18)



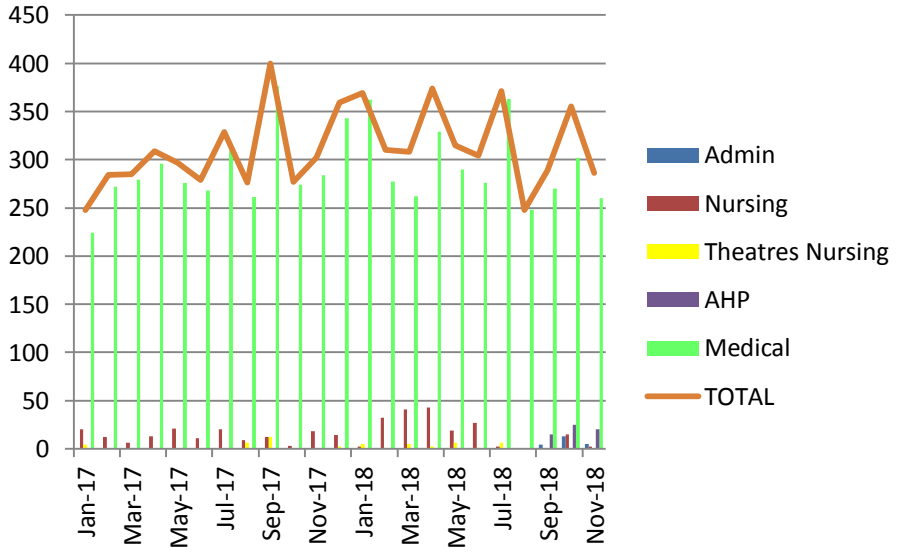
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

November saw a decrease in the vacancy position (despite an increase of staff in post), an improvement in appraisal and a further reduction in turnover; this is set against a decline in our core mandatory training position and a further increase in sickness absence.

This month the Trust's vacancy position saw a decrease of 0.16% as a percentage of WTE employed, with the figure 85.05% against a Trust target of 90%. In context, however, the WTE number of staff on the payroll stood at 924.51, an increase on the October position of just under 2 WTE. The variance is explained by changes in the funded establishment for the Trust, which increased in month by more than the increase in staff in post.

Monthly attendance is now a cause for concern. In November, the position stood at 94.64% (the lowest figure since January 2015), with the stubborn 3% of long term absence (since July 2018) being compounded by almost 2.5% of short term absence. A separate report into this will be provided to the SE&OD Committee in January.

Mandatory Training numbers saw a decrease in November to a position below 90% (89.85%). This is amber for the third consecutive month and will be raised with the operational divisions via their Boards. It is quite possible in month that operational pressures created by short term sickness absence in particular have impacted upon the release of staff for mandatory training.

In contrast, November's appraisal performance increased to the highest level since August 2015, to 85.95%. Whilst this is still adrift from our stretch target of 92.5%, teams continue to make improvement in this area, which is encouraging. There is an increased focus on appraisal corporately.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) reduced for the eighth consecutive month to 10.27%. The adjusted turnover figure (substantive staff leavers including retirements) decreased to 9.02%. Both are green against a KPI of 11.5%. The repeated reduction in turnover since April is particularly being driven by numbers in A&C and ancillary staff groups.

In November, agency breaches showed no great movement from October's weekly average. There were 287 shift breaches in total, 260 of which (c 90.5%) were medical, 20 (c 7%) were AHP, 5 (c 1.74%) were A&C and 2 (c 0.7%) were nursing.

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

Sickness absence is a cause for concern: whilst an element of it is undoubtedly seasonal, it is worthy of further analysis and assurance/ action.

Workforce Performance Report

November 2018

CONTENTS

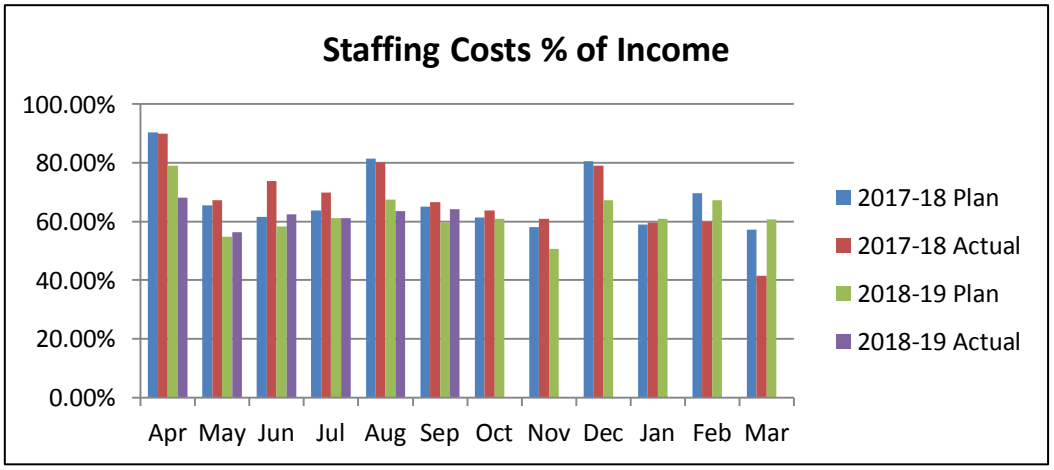
Staffing costs

1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	40747	
Actual Income YTD	41636	102%
Planned Pay Costs (YTD)	25462	
Actual Pay Costs (YTD)	25974	102%
Planned Substantive Pay Costs (YTD)	21225	
Actual Substantive Pay Costs (YTD)	20375	96%
Planned Bank Pay Costs (YTD)	2332	
Actual Bank Pay Costs (YTD)	2924	125%
Planned Agency Pay Costs (YTD)	1819	
Actual Pay Costs (YTD) Agency Staff	2653	146%
Planned Agency Pay Costs as % of total Pay costs (YTD)		7.1%
Actual Agency Pay Costs as % of total Pay costs (YTD)		10.2%

Total ADH Payments (Apr - Sep) £000s	1044

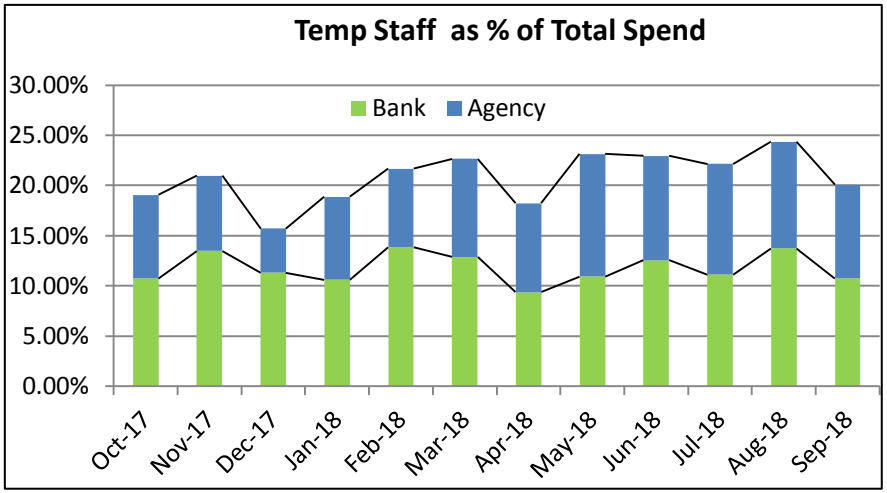


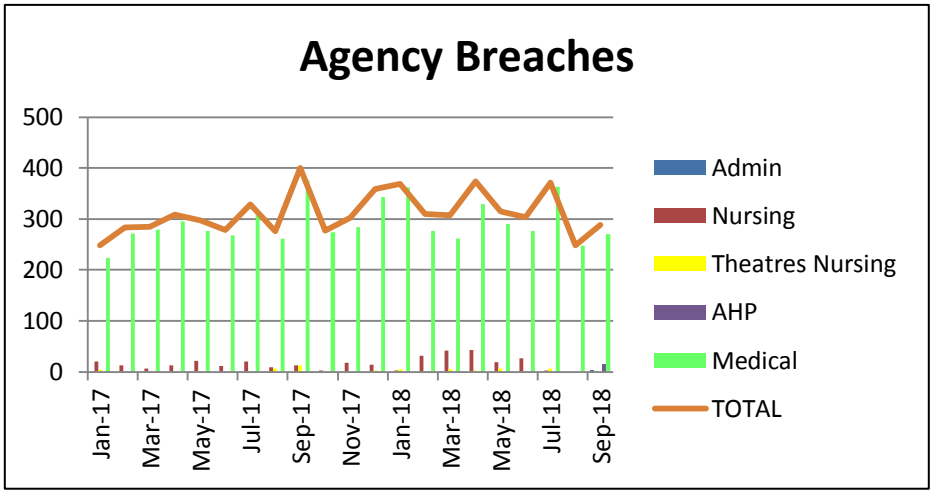
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	242	363
May	242	514
Jun	242	443
Jul	242	490
Aug	242	440
Sep	242	402

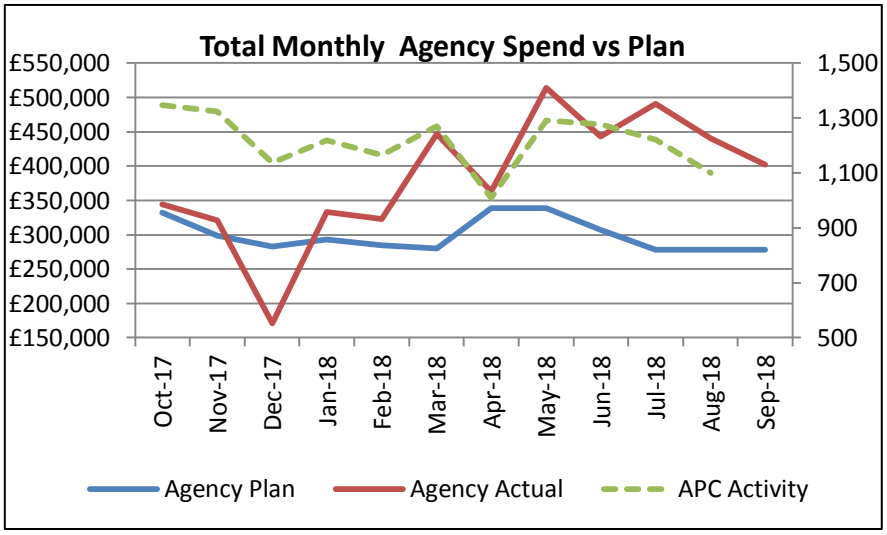
Data based upon September Management Accounts

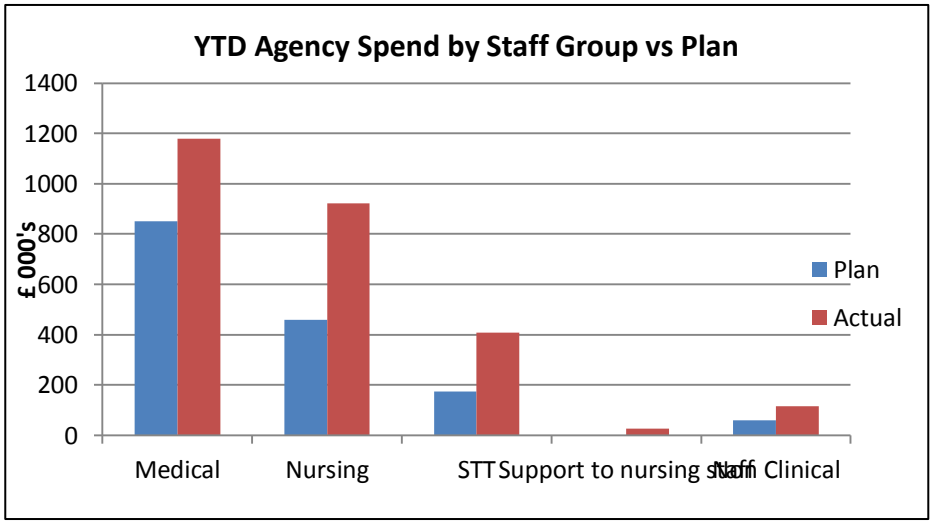
1 Workforce Composition and Cost

1a Temporary Staffing Analysis



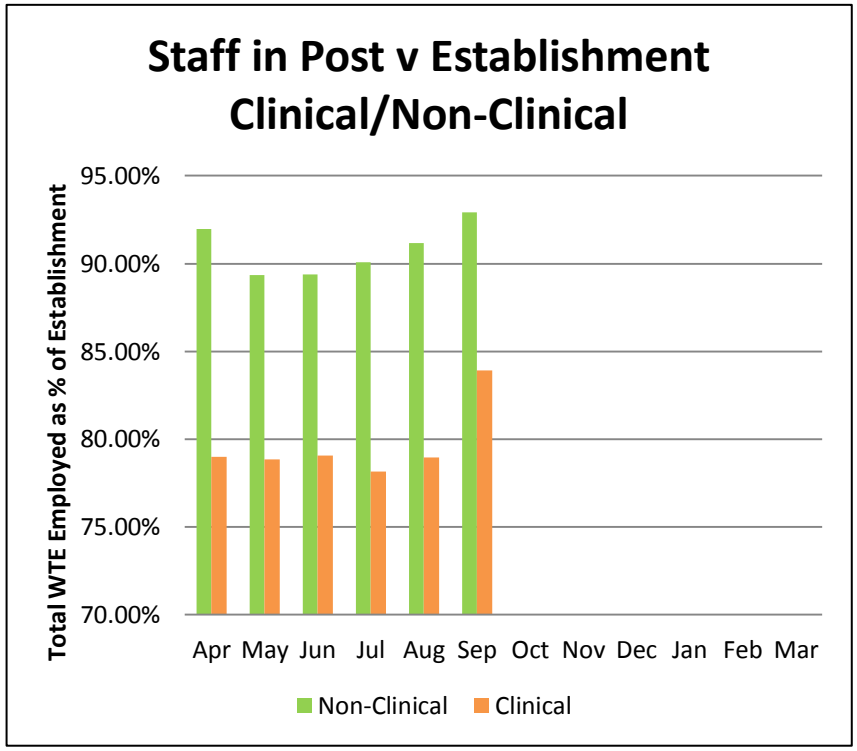


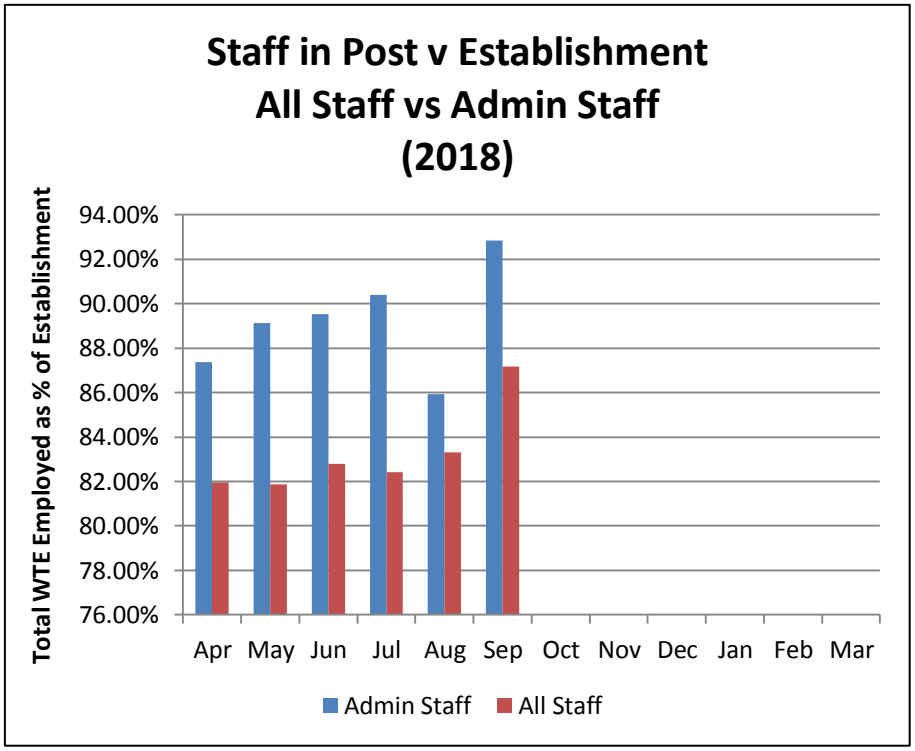




1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

Establishment





1 Workforce Composition , Resourcing and Cost

1c Recruitment and Selection

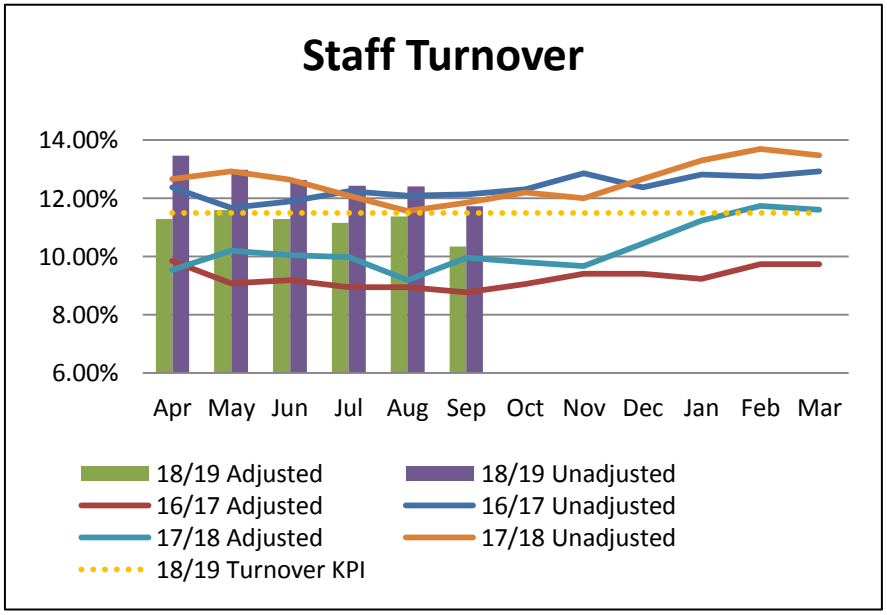
R&S

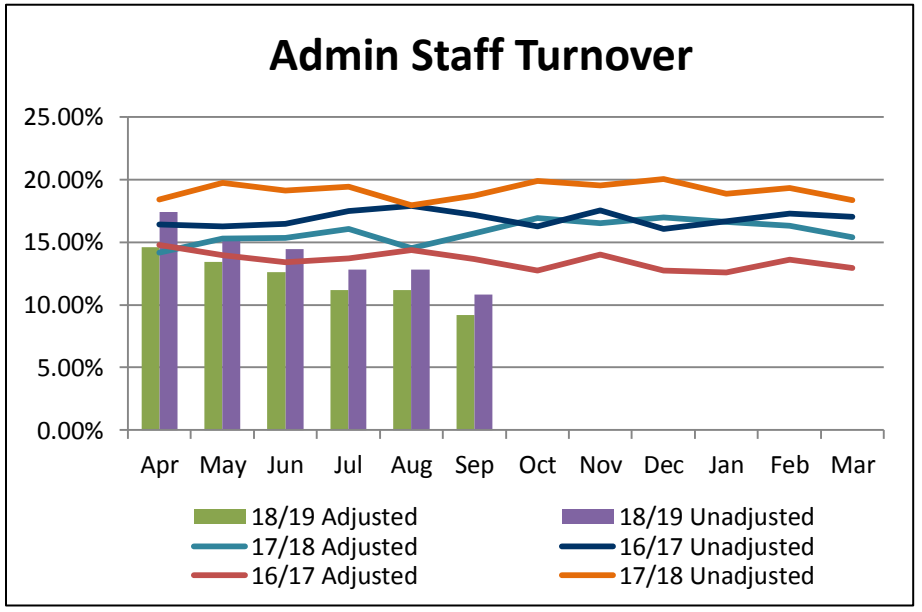
	FTE Variance	Vacancies FTE Variances	Over-establishment	Awaiting ATR /ATR in progress	Advertised	Shortlisting	Interview	Conditional Offer	Complete awaiting Start Date	Alternative Recruitment	Bulk Recruitment	No recruitment plan
Add Prof Scientific & Technical	-16.06	-23.06	7.00	4.29	5.50			7.00	2.00	3.00		1.27
Additional Clinical Services	-24.72	-30.46	5.74	1.89		7.45		10.50	6.00	1.00		6.30
Administrative and Clerical	-20.85	-49.49	28.64	5.25	1.00	3.00	1.00	3.40	2.53	13.02		21.18
Allied Health Professionals	-4.49	-9.89	5.40					2.68	2.00	2.15		3.05
Estates and Ancillary	-5.85	-6.85	1.00							4.20		2.65
Healthcare Scientists	2.00	-1.00	3.00									1.00
Medical and Dental	-15.29	-25.62	10.33	1.75	2.00	1.00	2.00	3.00	2.00	3.50		10.87
Nursing and Midwifery Registered	-48.96	-64.99	16.03	1.00	28.60			5.96	13.11	2.46	8.76	7.01
Grand Total	**-134.22**	**-211.36**	**77.14**	**14.18**	**37.10**	**11.45**	**3.00**	**32.54**	**27.64**	**29.33**	**8.76**	**53.33**

As at 30th September 2018

1	Workforce Composition , Resourcing and Cost
1d	Staff Turnover

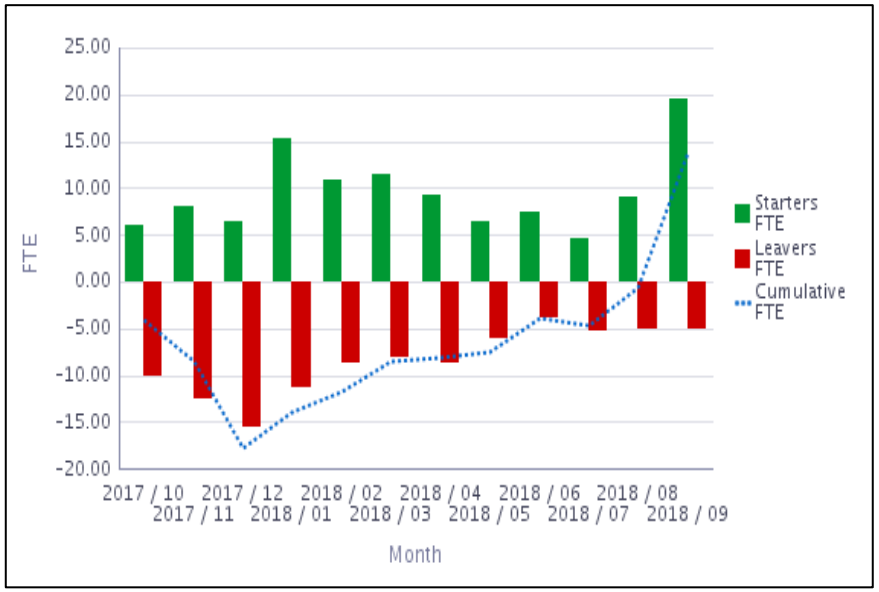
Turnover



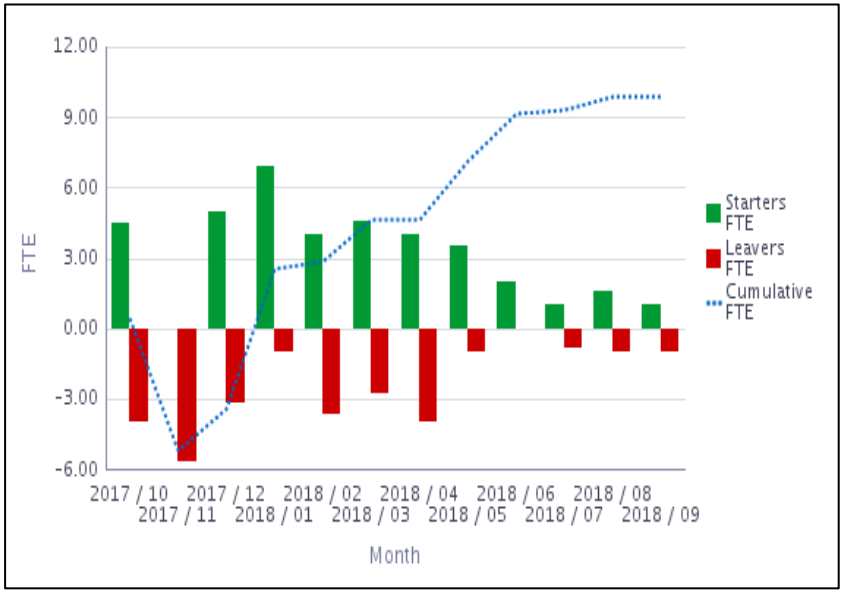


1	Workforce Composition , Resourcing and Cost
1d	Staff Turnover

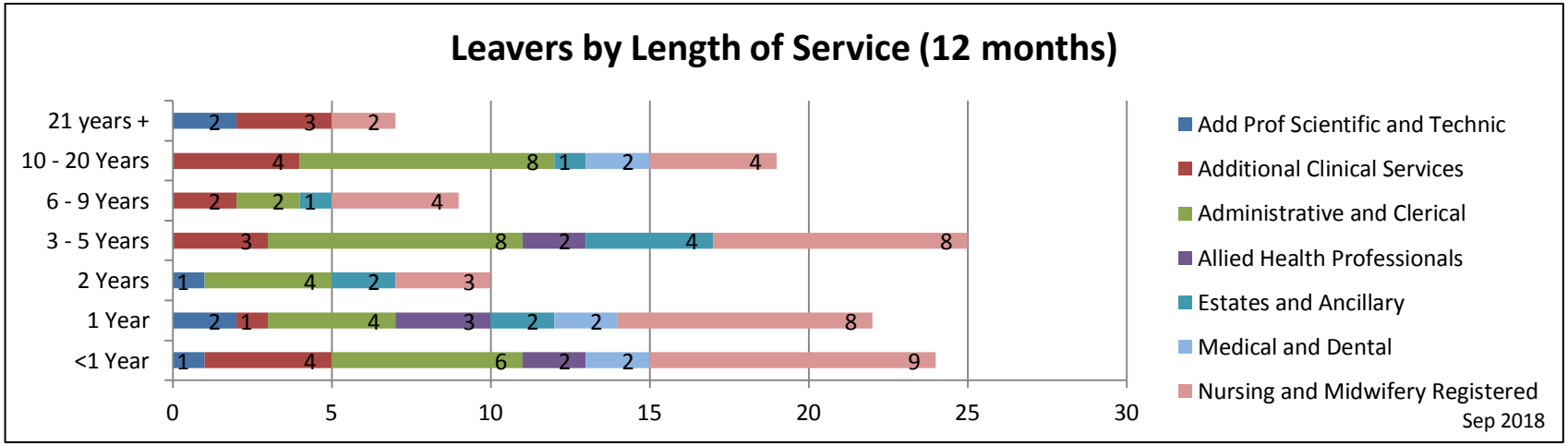
Starters / Leavers by Month - All Staff

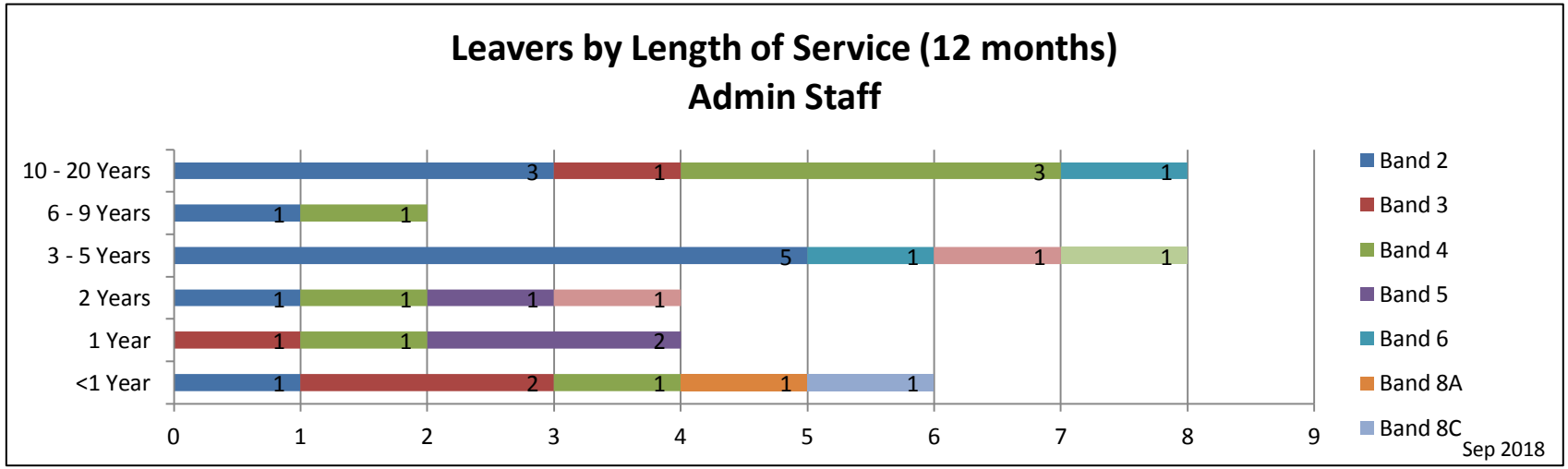


Starters / Leavers by Month – Admin Staff



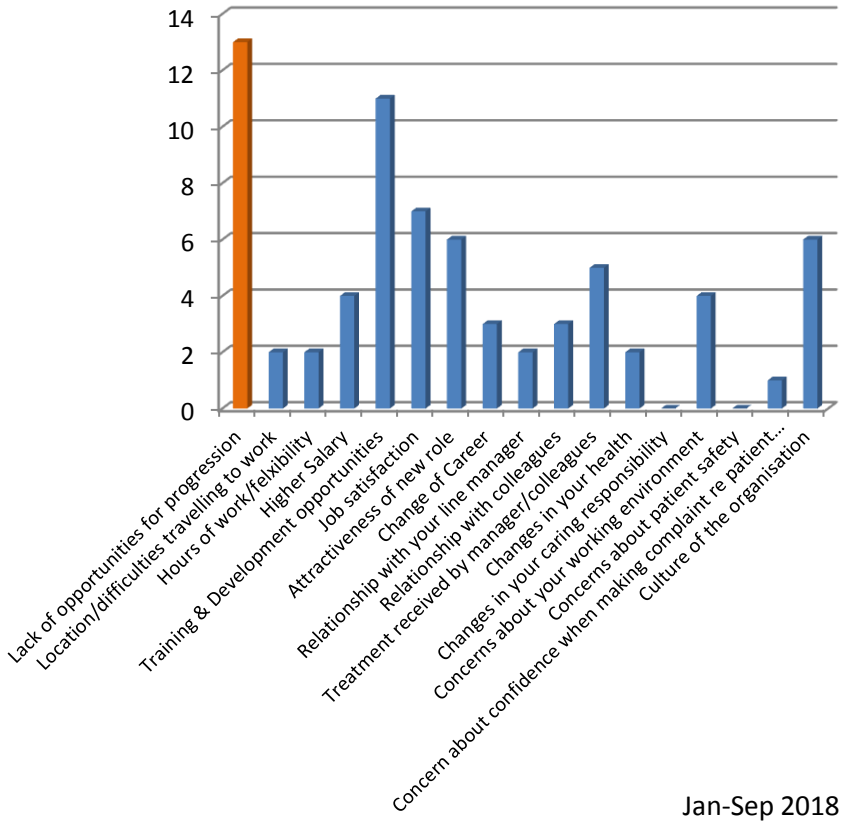
1	Workforce Composition , Resourcing and Cost
1d	Staff Turnover





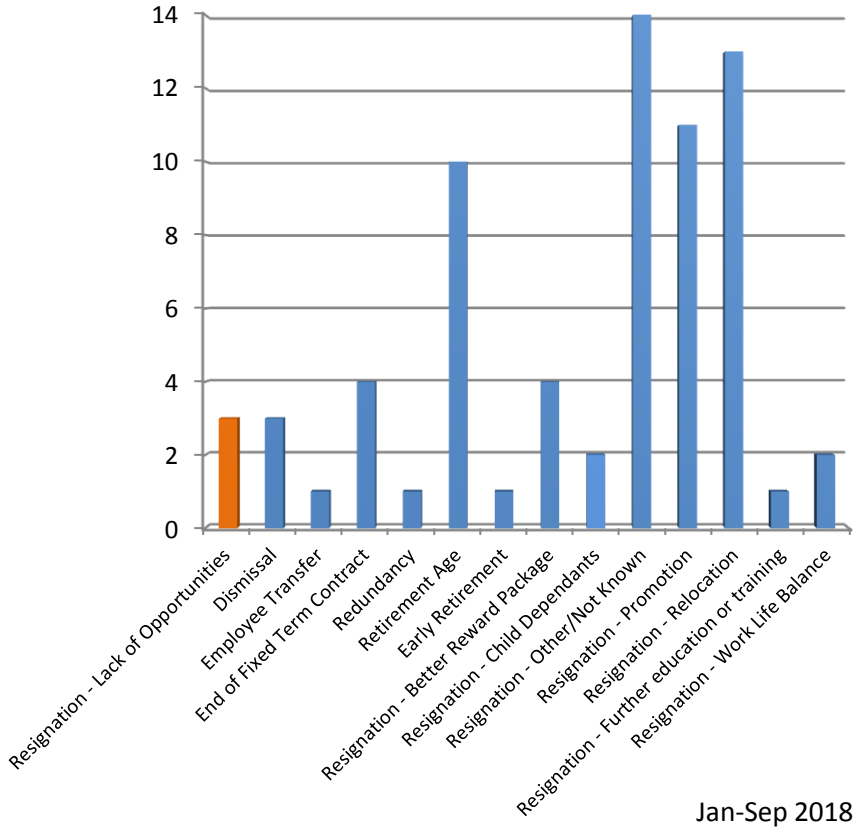
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire

Reason for Leaving (Exit Questionnaire data)



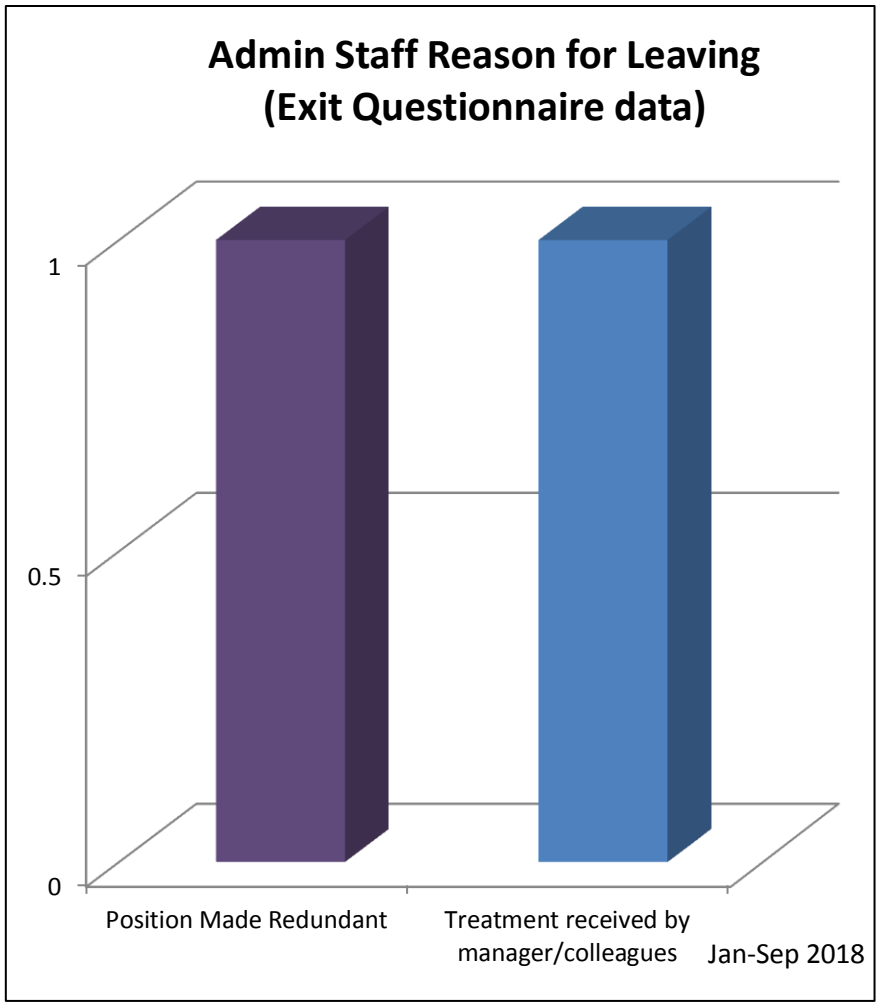
Jan-Sep 2018

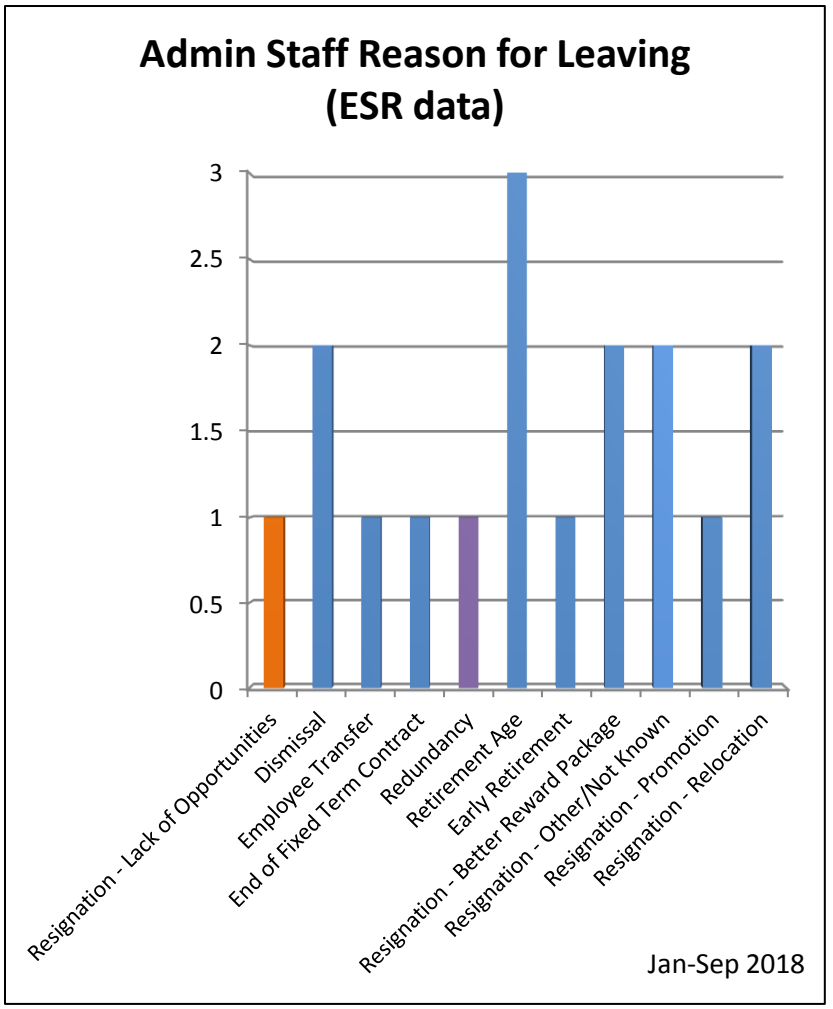
Reason for Leaving (ESR data)



Jan-Sep 2018

1	Workforce Composition , Resourcing and Cost
1f	Exit Questionnaire

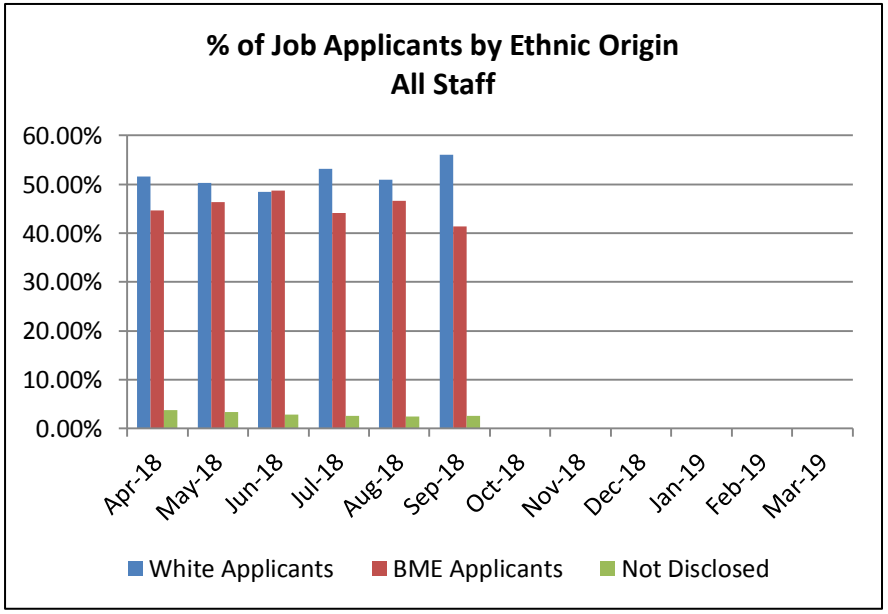


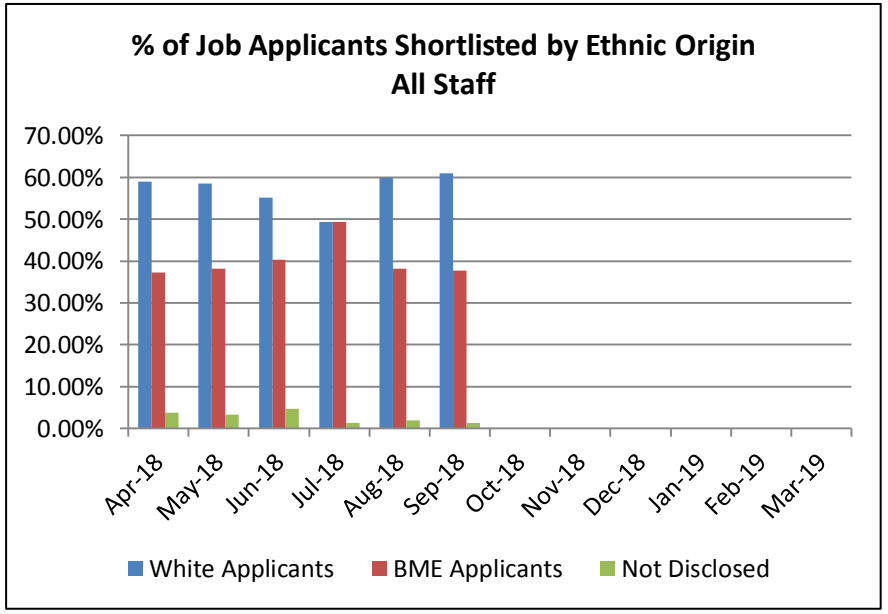


1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



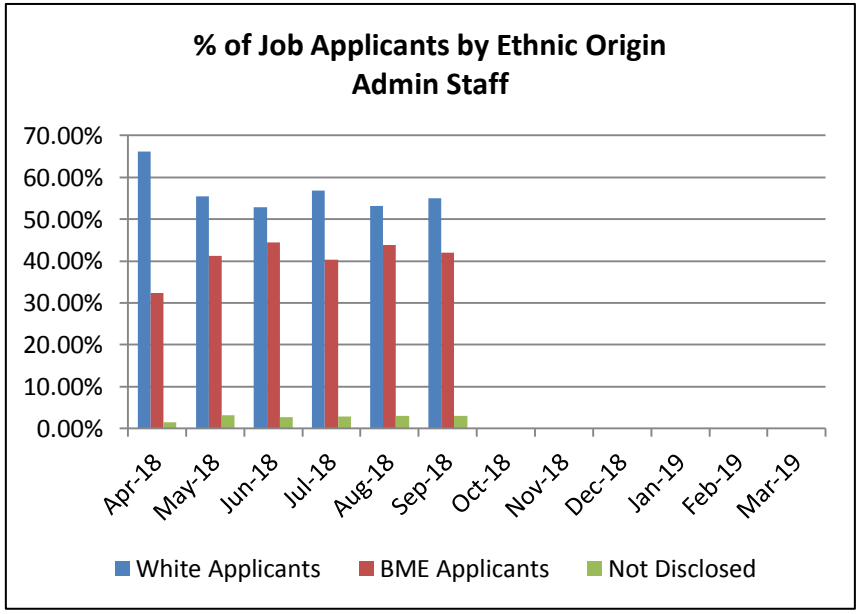


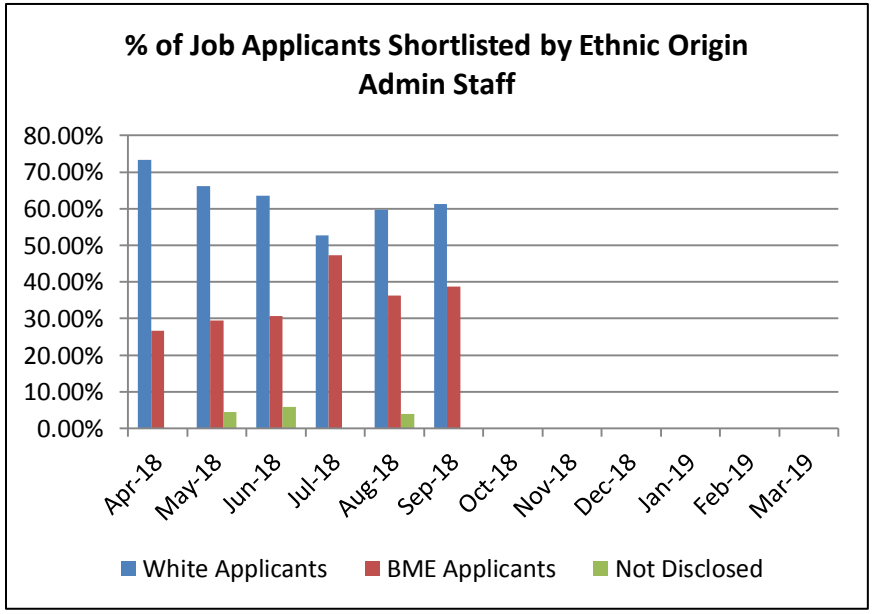
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.82	↓	0.22	+ 0.18	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1g	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month	Trend	Variance to National benchmark	National Benchmark
1.51	N/A	TBC	TBC

Workforce Composition, Resourcing and Cost

Staffing Costs – The actual spend on staffing was slightly above that planned for the year to date as at the end of September (102% of plan). This position is driven by higher than planned expenditure on bank and agency staff (agency staff in medical, nursing and therapy staff groups). Encouragingly, however, agency spend has reduced for each of the last 3 months - and in addition, income stands at 102% of plan. There is inevitably a cost to delivering increased activity and the challenge remains to close the current vacancy gap as outlined below – but there is some cause for cautious optimism.

Turnover – Adjusted turnover is reported at 10.34% as a rolling 12 month figure against a refreshed trust KPI of 11.5%. This is at its lowest level since January 2018, when the report calculations were rebased to include retirements. Together with the recruitment and selection data below, this paints an encouraging picture.

Slightly deeper analysis of attrition by length of service is provided at page 7. This data is being used by the Nursing and ODP Working Group to explore and develop solutions. Almost 45% of nursing staff who have left in the last 12 months had under 2 years' service, which remains a cause for concern, although separate ESR analysis yields no further insights (7 promotions, 5 relocations and 5 resignations out of 21 nursing staff). Work has begun by senior nursing colleagues to keep in touch with new joiners in particular, to help them into the Trust.

In terms of reasons for leaving, the more prescriptive ESR options yield the usual 4 categories in order: voluntary resignation other/ not known, relocation, promotion and retirement. The exit questionnaire reasons offer more scope, however: lack of opportunities for progression, and training and development opportunities are the top 2 reasons, with lack of job satisfaction a less frequent reason in third place. This can be seen to correlate with ESR to the extent that some staff are resigning for promotion or training and development opportunities elsewhere (ESR) and may offer an insight into the often used "other/ not known" ESR category.

There is always going to be a progression challenge given the size of the Trust, but there is longer term work ongoing to map competences to articulate available career progression opportunities, and 15 nursing staff are being supported to undertake an orthopaedic module as further specialist training, so there is some progress to report in this area.

Recruitment and selection - There were 15.64 WTE more staff on the payroll in September than in August (total now is 905.67WTE), meaning that the Trust has its highest ever number of WTE staff employed.

The size of the outstanding vacancy gap and recruitment plans to fill is contained on page 6: there has been a marked increase in the percentage of filled clinical posts, which now stands at 84%. This is in part due to new starters, and also removal of some establishment posts which were (safely) never going to be filled. From a detailed analysis of posts in the recruitment process, there remain 134.22 FTE ledger vacancies but of these, just 53.33 FTE now have no recruitment plan identified. This is marked progress compared with the 116.89 WTE without a plan as reported to SE&OD Committee in July 2018.

Workforce Composition, Resourcing and Cost

- Rolling adverts are now in use for a number of roles and attraction materials are being refreshed. This will be important for theatre expansion in particular in the months ahead.

- **WRES Indicator 2** monitoring is now provided. The diversity of applications remains strong and the shortlisting rations appear consistent. However, there has been a slight worsening in the last month which would suggest that there is a disproportionate likelihood of being appointed if you are from a white background. Further work will be undertaken on this in Q3, with a sample of jobs from NHS Jobs being analysed in more depth to understand this better. There will also be benchmark data available early in Q4, so this will enable some assessment of the extent to which the Trust is typical or unusual in its performance in this regard.

- **Deep dive – A&C staff workforce information**

The deeper dive into the A&C staff group yields the following observations;

They are generally easier to recruit than their clinical counterparts (93% of the establishment is filled) and there are more FTE in post than ever before

In contrast, they are the staff group with the most vacancies for which there is no recruitment plan (this is not altogether surprising, as managers will most often not fill A&C posts as opposed to clinical posts)

Turnover has dropped as with the rest of the Trust since April 2018

Retirement seems to have been the most common reason for leaving, as opposed to promotion/ relocation

They are proportionately more likely to be off with SAD than with musculoskeletal problems: this will be fed into the well being group and considered as part of branding

They are more likely to receive a return to work interview, which suggests that clerical staff who are their managers are struggling less with input than their clinical colleagues.

2 Workforce Performance

2a Staff Attendance

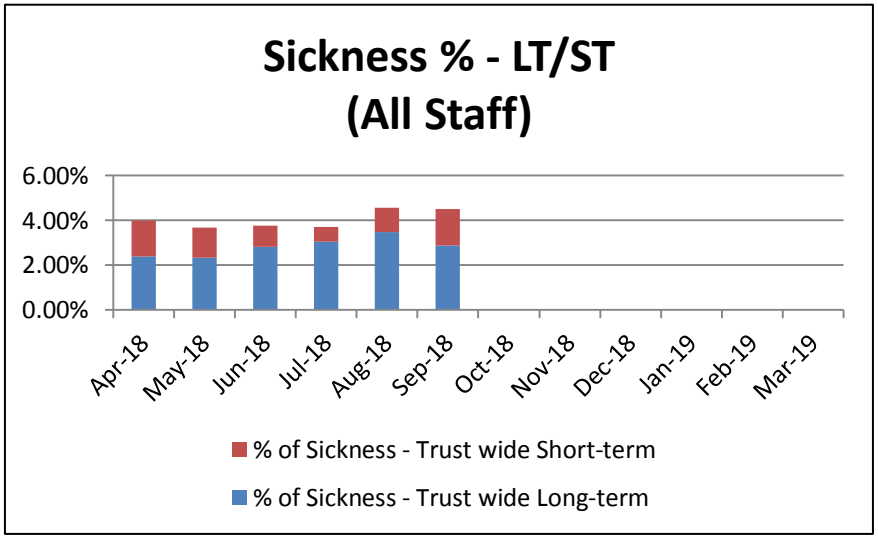
Staff Attendance

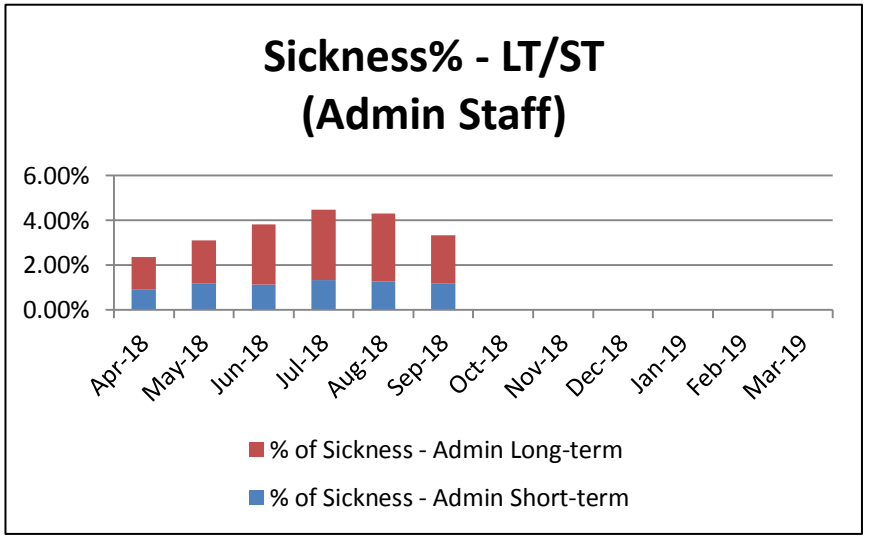
Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
95.71%	95.79%	↓	0.39%	96.10%

ALL STAFF * 12 months to End of September 2018

Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
96.67%	95.70%	↑	-0.57%	96.10%

ADMIN STAFF * 12 months to End of September 2018





2 Workforce Performance

2b Staff attendance – short-term absence management

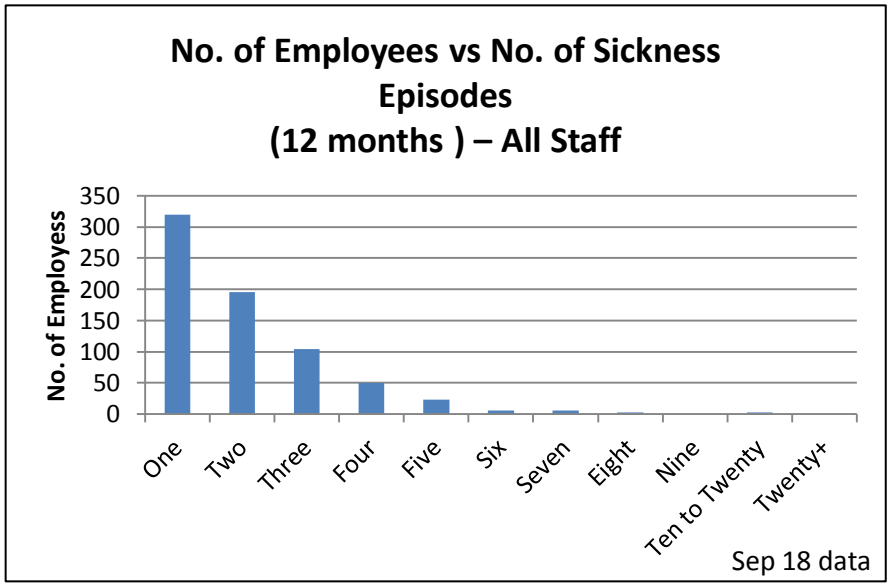
Staff Absence

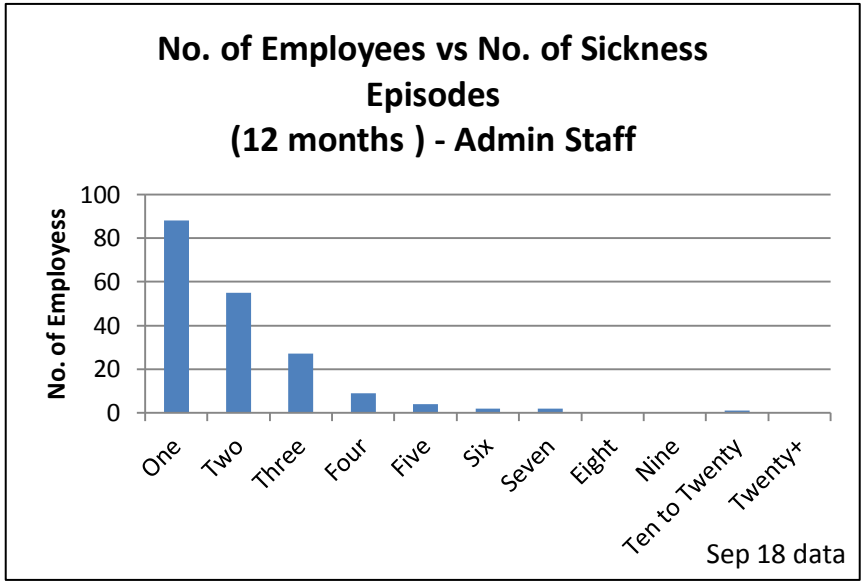
Return to Work Process Completion Rate (12 months) *Sept18

ALL STAFF

Return to Work Process Completion Rate (12 months) *Sept18

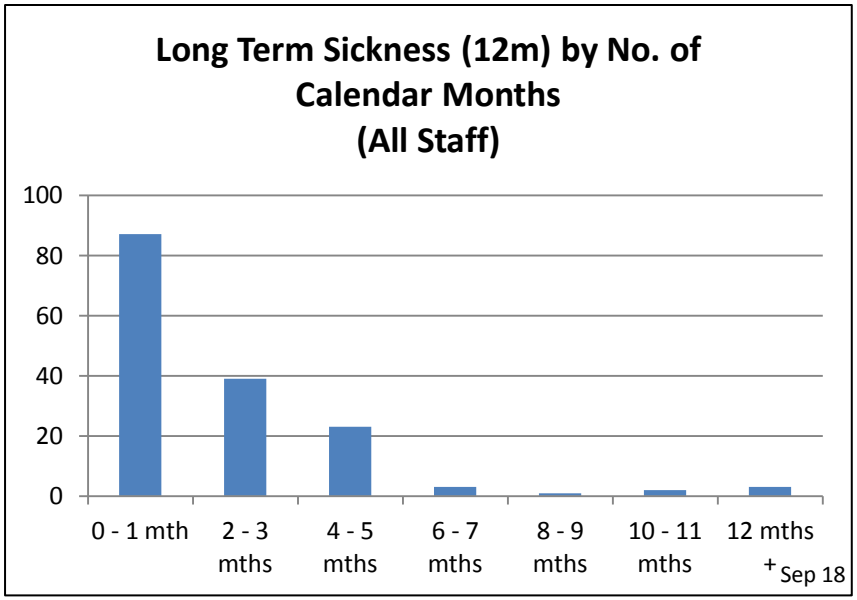
ADMIN STAFF

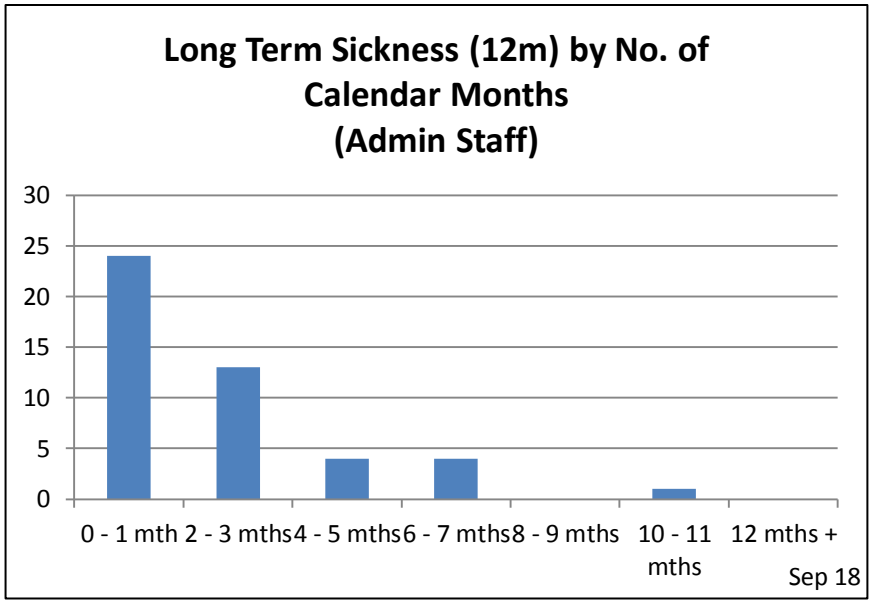




2	Workforce Performance
2c	Longer-term Staff Absence

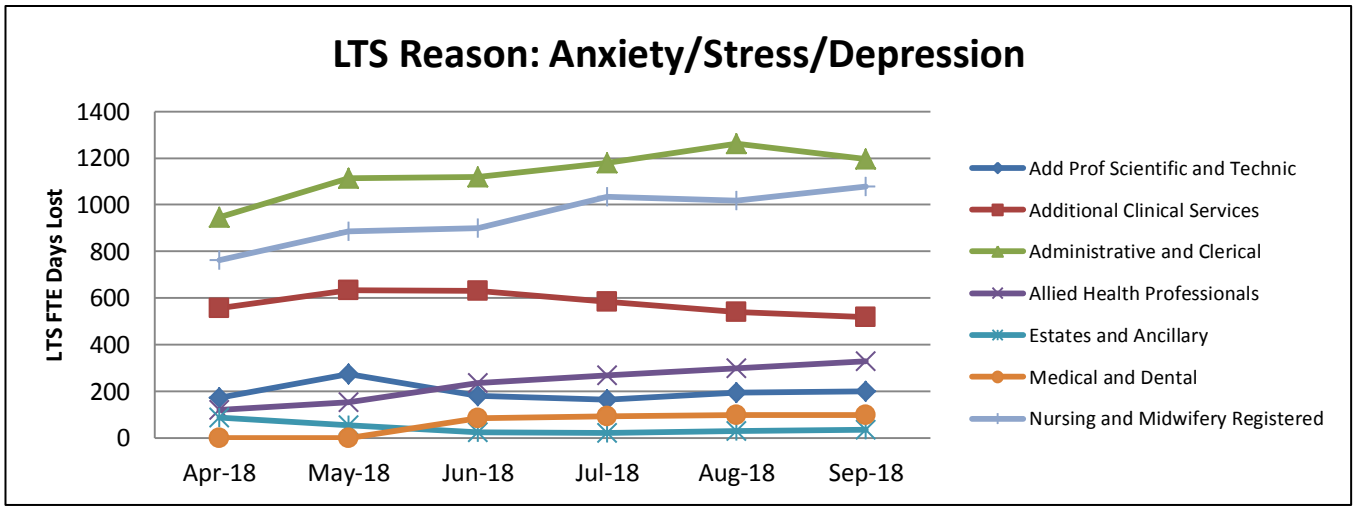
Long-term Staff Absence

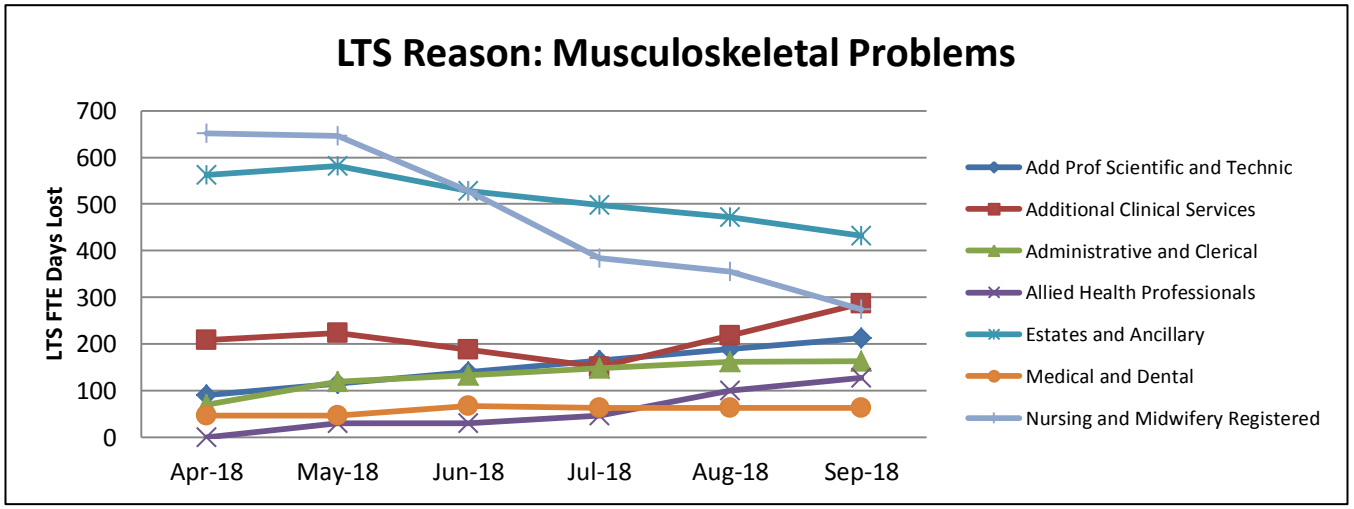




2 Workforce Performance

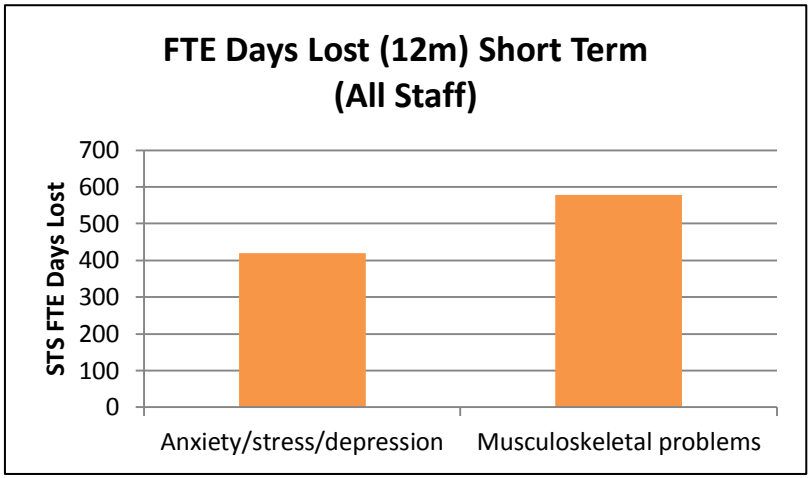
2c Longer-term Staff Absence

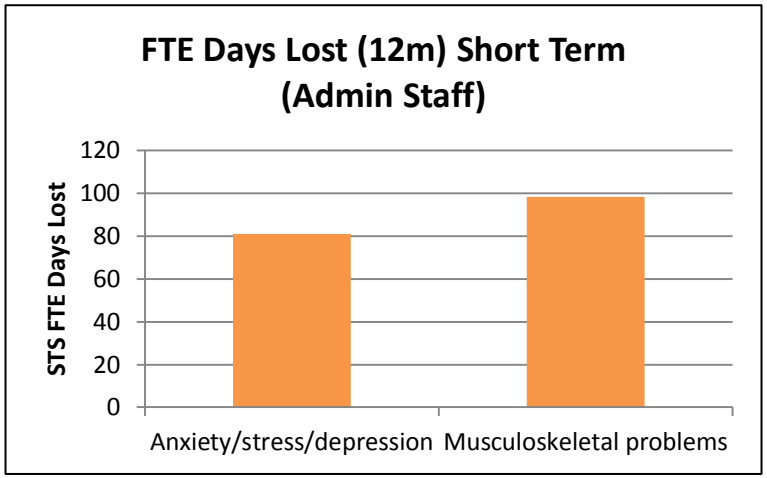


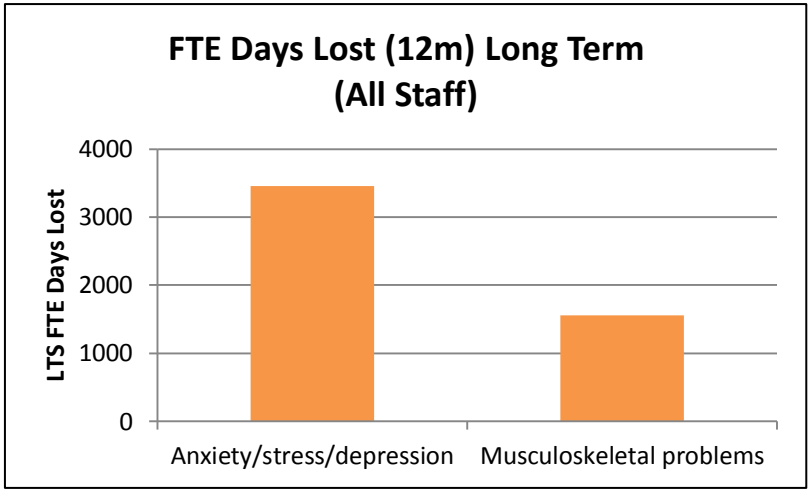


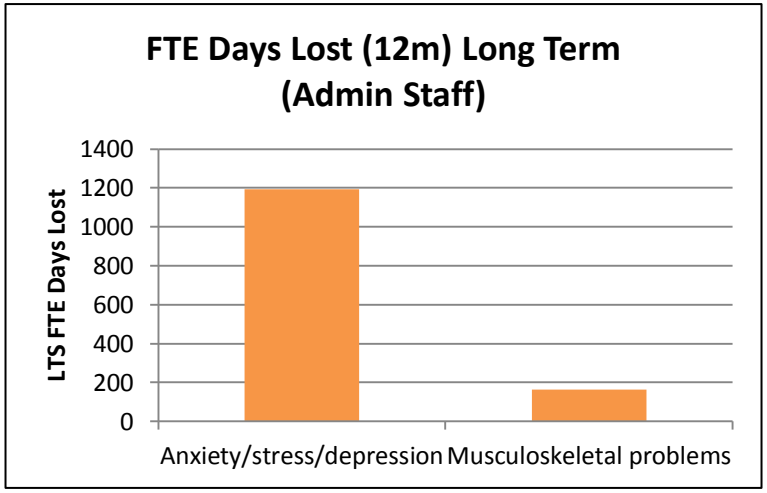
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary

Management of Performance

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	0	0	1	1	7	5

September 2018 – 12 month reference period

INFORMATION

Staff Attendance – Monthly attendance in September improved slightly on August's position to 95.50% - but this was still red, following a sickness absence long term "spike" in July.

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% (against a Trust target of 96.1%), with little change on previous months. The long and short term cases are known to HR Managers via separate reports and are pursued with individual line managers as necessary – and are also referenced at Divisional Boards on an ongoing basis.

The 12 month completion rate for return to work (rtw) meetings is stable at over 50%, but improvement is still required in this area. At divisional performance reviews, assurance is sought and given that rtw meetings are being held but computer input is cited as a main reason why this is perceived as an under-report.

Work continues on staff well being, with an assessment having been completed by the Trust's Health and Safety Adviser into areas of relative strength and weakness using the NHS Employers Toolkit. A key recommendation of that analysis is the absence of branding for staff wellbeing, which will be a focus for the October SWAG meeting. It is proposed that the group's terms of reference be widened following the rebranding because of the natural links with wider physical and mental wellbeing.

In terms of EAP/ Occupational Health provision, there is work underway at STP level to scope collaboration with other local Trusts to develop options for an effective long term solution, with resource being provided from HEE until March 2019 to support this work. The EAP/OH solution which was previously being explored is unlikely to bear fruit, as BWCH would like to disassociate from the same provider.

ACTIONS FOR IMPROVEMENTS / LEARNING

Procure new OH and EAP provision via STP partners
Succession and key competency resilience maps to be completed.

RISKS/ISSUES

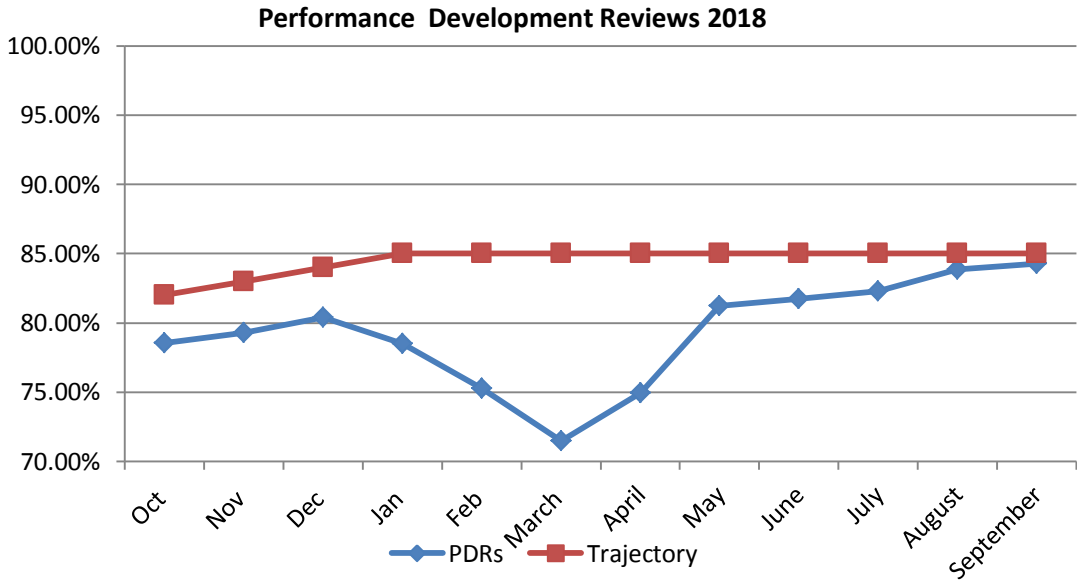
Long term absence through mental health including stress and anxiety and MSK
Ineffective performance management.

3	Workforce Learning and Development
3a	Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NNS Engagement Question	2017	2016	2015
20a	In the 12 months have you had an appraisal or annual review?	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	64%	74%	79%
20f	Were any training, learning or development needs identified?	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date



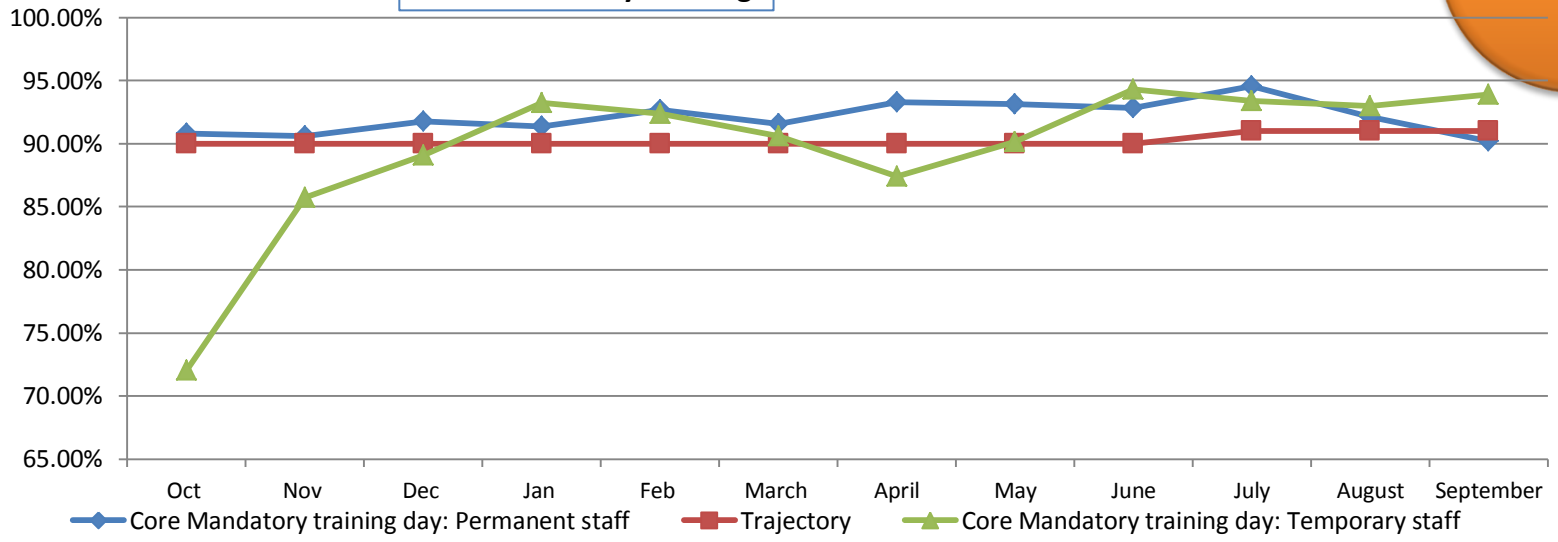
Outcomes from the National Staff Survey suggest that the Trust appraisal process occurs with staff at rates comparable with similar trusts, however the effectiveness of the process, the identification of behavioural and skills development needs and the management of these requires improvement. This links to the overall requirement to improve performance management processes within the Trust.

3 Workforce Learning and Development

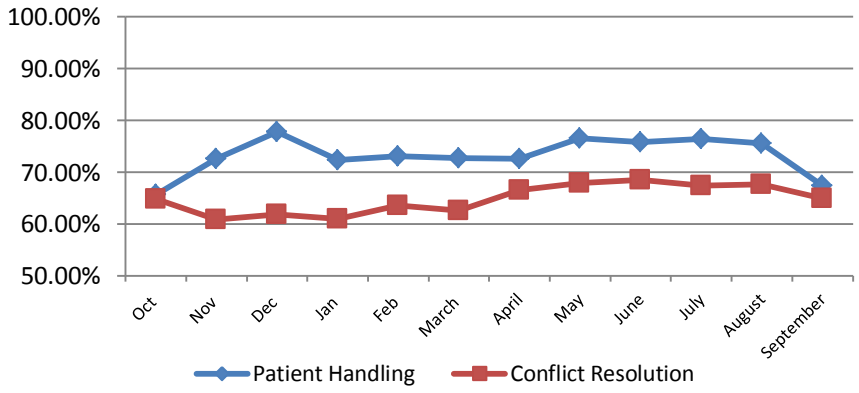
3c Core Mandatory Training, Specialist Training and Corporate Induction

Mandatory Training

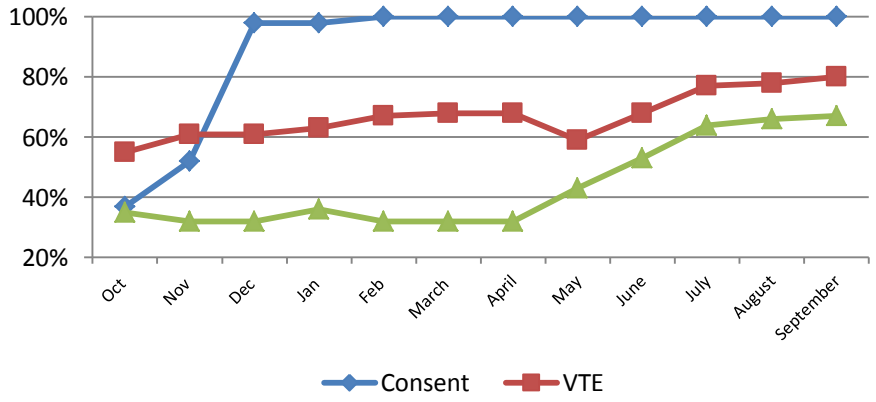
Core Mandatory Training



Patient Handling and Conflict Resolution Compliance



e-learning Modules Compliance

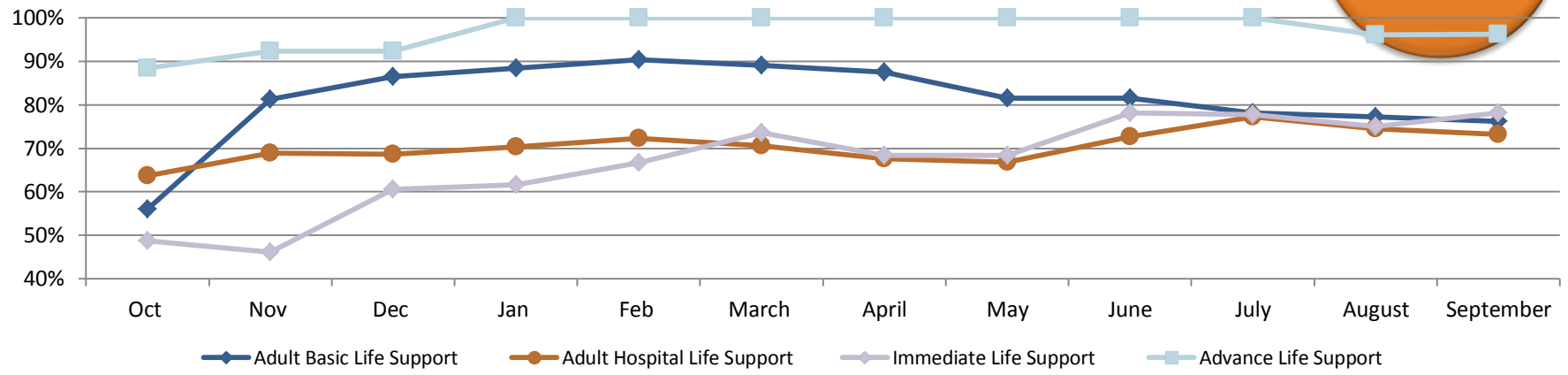


Mandatory Training

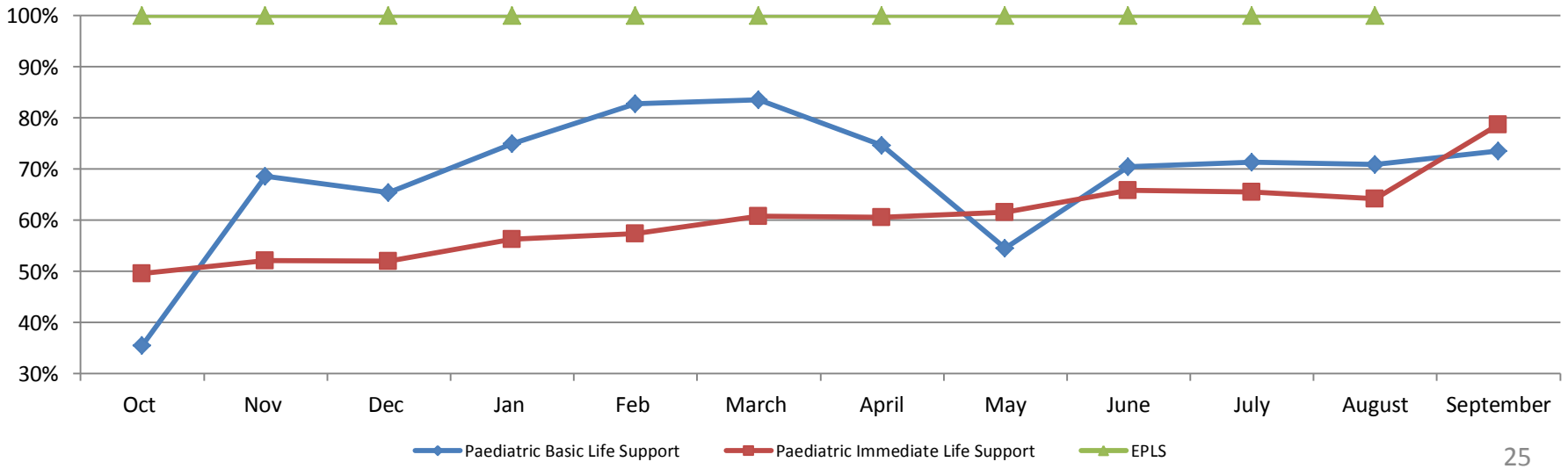
3 Workforce Learning and Development

3c.1 Resuscitation Training

Adult Resuscitation Training



Paediatric Resuscitation Training



INFORMATION

Core Mandatory Training – the Trust remained above 90% for the month of September, but slipped below its performance target of 92% for the first time this year. 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%.

There has been a slow increase in people completing the core mandatory training modules online – with around 10% of completions being online to date.

CMT for Bank / Temp staff has been maintained at a level of over 90% for 4 months.

Role Specific Mandatory training –

The Trust Resuscitation training compliance level for adults still hovers just under 80%. Encouragingly, paediatric resuscitation has seen a steady increase to 80% over the last few months. Resuscitation standards and governance processes have recently been reviewed and updated . The risk for resuscitation training compliance figures is monitored through the quality and safety group.

There have been slight deteriorations in September both in conflict resolution and patient handling compliance, and both are still non-compliant. This has been raised with the clinical quality group, and a small focus group is to be created to explore solutions.

VTE / Insulin – There have been good improvements in compliance following the IT issues being resolved during May. Improvements have been seen in staff completing insulin, and VTE has been noted following the review of requirements.

ACTIONS FOR IMPROVEMENTS / LEARNING

Core mandatory training :– Mandatory training streamlining / CIP project continues. There has been positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information.

Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place

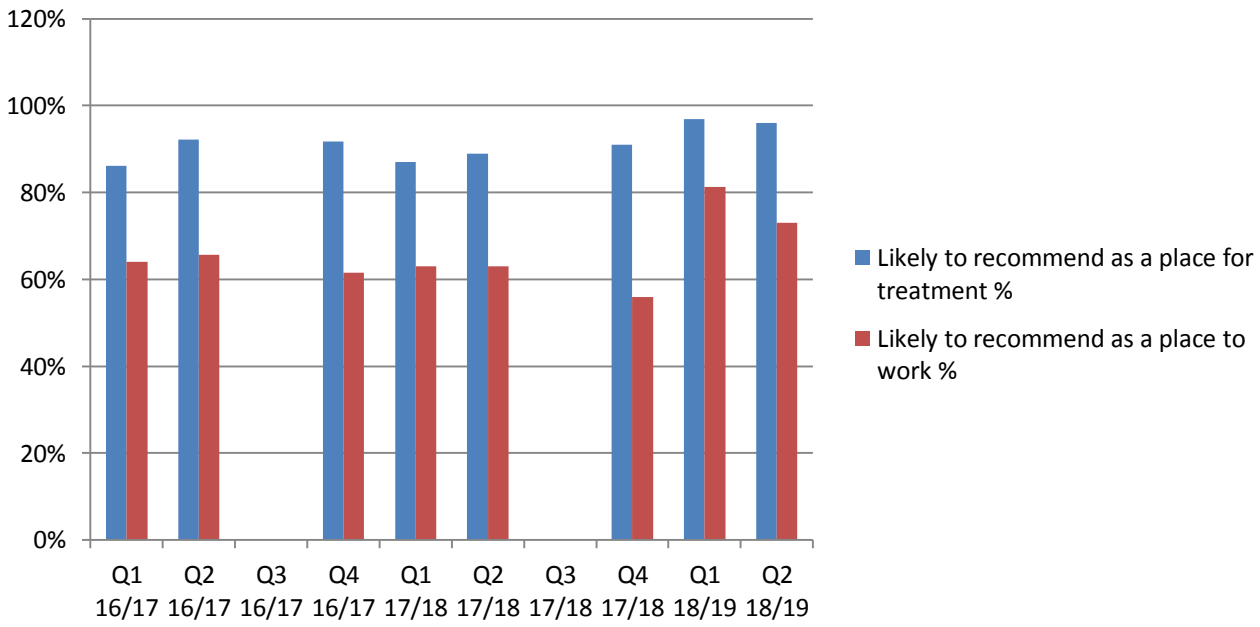
VTE/Insulin online modules: the e-learning facilitator is working closely with subject matter lead to increase compliance, creating learning paths in ESR, and spending time in theatres to support key staff. It has been agreed that medical staff do not need to complete the insulin modules as they do not administer.

RISKS/ISSUES

Staff booking onto and completing their role specific mandatory training modules is low.
Resuscitation levels still too low
In house trainers for resus and patient handling are needed – their absence is reducing availability to support training .

4	Workforce – Experience and Engagement
4a	Friends and Family Test Survey

FFT

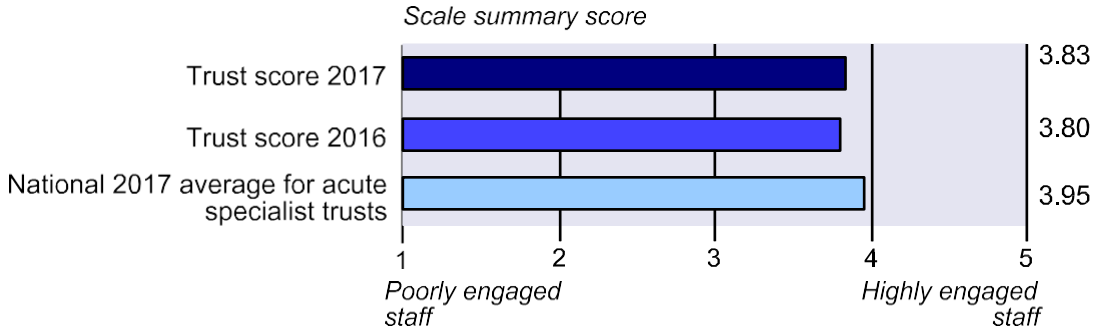


The overall Staff Engagement Score in Quarter Two 2018/2019 is **4.09** which compares favourably to the 2018 Score of 3.88.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

Employee Engagement

OVERALL STAFF ENGAGEMENT

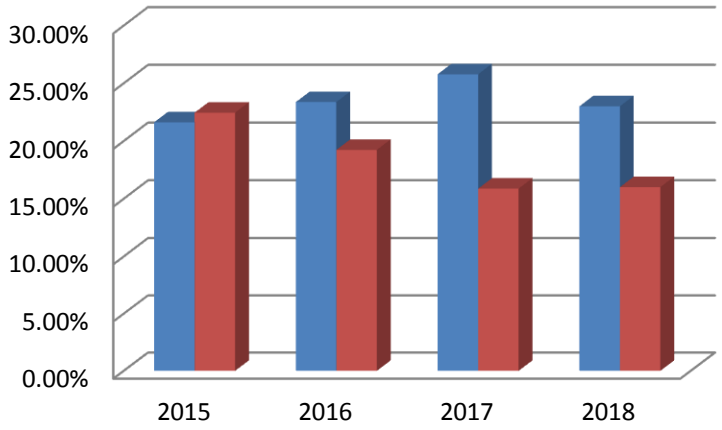


		Your Trust in 2017	Average (median) for acute specialist trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	79%	86%	69%
Q21b	"My organisation acts on concerns raised by patients / service users"	79%	81%	73%
Q21c	"I would recommend my organisation as a 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

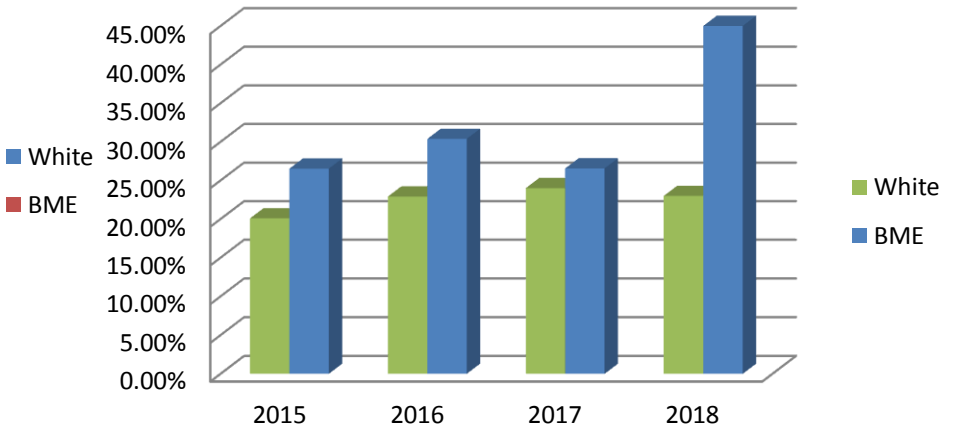
4	Workforce – Experience and Engagement
4c	WRES Indicators

WRES Indicators

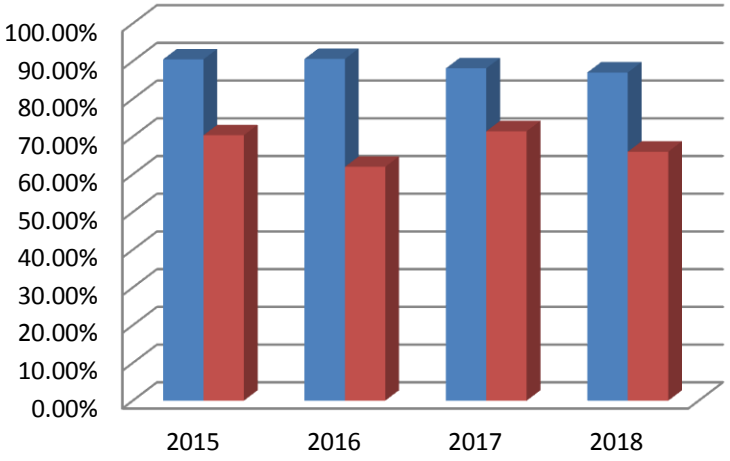
Indicator 5: Experiencing bullying from patients



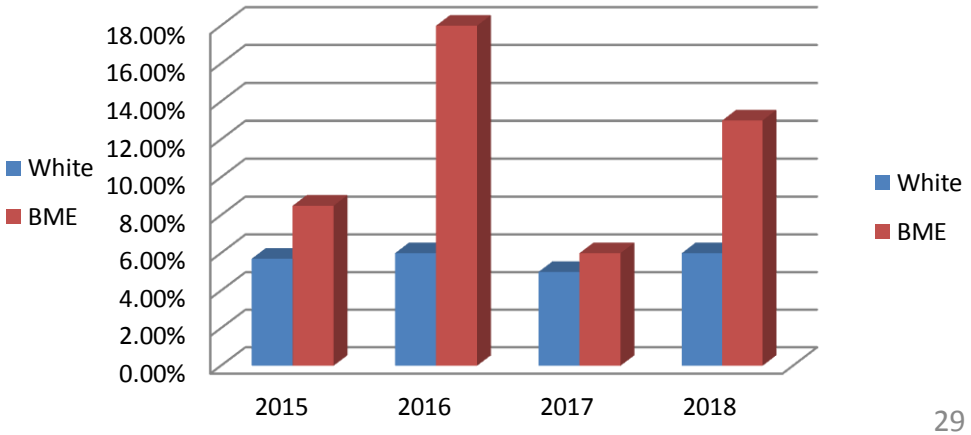
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION
National survey and Friends and Family Test FFT - Q2 survey results shows stable data. October report in SE&OD information pack shows key observations. National survey launched in October 4th and will run for two months. Current completion rate is 21%. **Engagement and Job Satisfaction** – Speak Up and Join in brand is still being established. Even better if… sessions being rolled out across teams. **Equality and Diversity–** The latest data for WRES has now been compiled with an action plan to address different areas. These actions are included in the Equality and Diversity action plan. Progress is being made with forming the new Equality and Diversity network group.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions to encourage survey completion to improve data reliability Ensure feedback from staff from E&D forums and network meetings is used to inform E&D action plan for 2019 Look at ways to engage BME staff members to shape E&D agenda e.g. through the E&D network
RISKS/ISSUES
Completion rate for National Staff survey (NSS) affects the reliability of the data as a representation of staff views

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 6 March 2019

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 6 March 2019 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** 6 March 2019: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(MR)
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	Service Improvement story – Flow Academy	Presentation	JW
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 9 January 2019: *for approval*	ROHTB (1/19) 012	Chair
1127h	5	Trust Board action points: *for assurance*	ROHTB (1/19) 012 (a)	SGL
1130h	6	Board Assurance Framework: *for assurance*	ROHTB (3/19) 001 ROHTB (3/19) 001 (a)	SGL
1135h	7	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (3/19) 002 ROHTB (3/19) 002 (a)	YB/PA
	7.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	PA
	7.2	Briefing on plans for Brexit 'no deal' scenario. BAF REF: FP3	Verbal	SW/PB
1145h	8	Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (3/19) 003 ROHTB (3/19) 003 (a)	JW

TIME	ITEM	TITLE	PAPER	LEAD
QUALITY & PATIENT SAFETY				
1155h	9	Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (3/19) 004 ROHTB (3/19) 005	KS
1200h	11	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (3/19) 006	GM
1210h	12	'Flu vaccination update: *for assurance*	ROHTB (3/19) 007 ROHTB (3/19) 007 (a)	GM
1205h	13	Infection Control annual report: *for assurance*	ROHTB (3/19) 008 ROHTB (3/19) 008 (a)	GM
FINANCE AND PERFORMANCE				
1210h	14	Update from the Finance & Performance Committee: *for assurance*	ROHTB (3/19) 009 ROHTB (3/19) 010	TP
1215h	15	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (3/19) 011	SW
WORKFORCE				
1225h	16	Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (3/19) 012 ROHTB (3/19) 013	RP
1230h	17	Workforce overview: *for assurance*	ROHTB (3/19) 014	PA
OTHER MATTERS				
1240h	18	Update from the Audit Committee: *for assurance*	ROHTB (3/19) 015	RA
1245h	19	Update from the Charitable Funds Committee and approved minutes: *for information*	ROHTB (3/19) 016 ROHTB (3/19) 016 (a)	DG
1250h	20	CQC action plan update: *for assurance*	ROHTB (3/19) 017 ROHTB (3/19) 017 (a)	GM
1255h	21	Trust Board workplan for 2019/20: *for approval*	ROHTB (3/19) 018 ROHTB (3/19) 018 (a)	SGL
MATTERS FOR INFORMATION				
1300h	22	Meeting effectiveness and relfection on adherence to Trust Values	Verbal	ALL
	23	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 3rd April 2019 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** 9 January 2019: 1100h – 1300h

Members attending:

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

Minutes	Paper Reference
1 Apologies	Verbal
Apologies were received from Kathryn Sallah.	
2 Declarations of interest	Verbal
It was noted that the register of interests was available on request from the Company Secretary.	
3 Minutes of Public Board Meeting held on the 7 November 2018: *for approval*	ROHTB (11/18) 016
The minutes of the meeting held on 7 November were accepted as a true and accurate reflection of discussions held.	
4 Trust Board action points: *for assurance*	ROHTB (11/18) 016 (a)

The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
5 Board Assurance Framework	ROHTB (1/19) 001 ROHTB (1/19) 001 (a)
The Associate Director of Governance & Company Secretary presented the latest version of the Board Assurance Framework. It was proposed that one risk be de-escalated, that being around the operational model in theatres given that it was now seen to be working well. It was also proposed that a new risk be added which streamlined the previous two cyber security risks. It was suggested that the risk around income associated with the transfer of Paediatric services be reframed, which the Interim Director of Finance agreed to do. The Board approved the proposed changes to the Board assurance Framework.	
ACTION: SW to reframe the paediatric transition risk relating to income	
6 Chairman's & Chief Executive's update: *for information and assurance*	ROHTB (1/19) 002 ROHTB (1/19) 002 (a)
The Acting Chief Executive reported that in terms of the recently publicised Long Term Plan for the NHS, the financial and operational plan for ROH would be presented at the meeting in March. It was noted that the press has been positive about the NHS Long Term Plan overall. The workforce issues remained the area of high focus, with particular attention to the recruitment and retention of the staff. In terms of new service models outlined in the Long Term Plan, there was more choice and there was a plan to better join up parts of the system, including primary and community care. The Plan also outlined the ambition to avoid up to a third of GP attendances. The second chapter of the Plan concerned prevention and targeting interventions to the areas of highest need. Chapter 3 related to care quality outcomes including the relative priorities within this. Short waits for planned care was an area of focus, including reducing the number of patients who were waiting for treatment in excess of 52 weeks. Chapter 4 detailed the plan to tackle workforce pressures, although there was little in the way of solutions discussed aside from work with universities. There was a focus on expanding international recruitment, including national initiatives. There	

would be a detailed national implementation programme.

Chapter 5 concerned upgrading technology, including provision of wider digital access and sharing information more easily.

Chapter 6 dealt with the funding settlement. The modelling for the plans was reported to be based on using the additional £20.5bn for the NHS by 2023/24 for three areas: current financial pressures; continuing demand growth; and new priorities. To put the NHS on a sustainable path, the Plan set out five 'stretching but feasible commitments', these being: The NHS (including providers) will return to financial balance, this hinging on rebased Control Totals for 2019/20 and the availability of Financial Recover Fund for providers who may struggle to achieve financial balance without this support; the NHS will achieve cash-releasing productivity growth of at least 1.1% per year; the NHS will reduce growth in demand for care through better integration; unjustified variation in performance will reduce; and better use will be made of capital investment and its existing assets to drive transformation. The competition and procurement regulatory constraints were reported to be also discussed in this section.

Chapter 7 outlined the next steps, including the expectation that local plans would be developed by organisations to deliver the overall ten-year plan.

In terms of targets, there may be new ones that may be introduced and a new oversight regime may be developed by NHS Improvement. The local economic drivers and research locally were noted to not be reflected in the plan. In terms of the workforce challenges at the ROH, it was suggested that the internal recruitment needed to be ethical to ensure that the ROH was not recruiting from countries that could not afford to lose their own healthcare professionals. A closer relationship would be developed with the local technical colleges to assist with addressing the workforce issues.

In terms of the ROH's operational and financial plan for 2019/20, the key gateways needed to be clarified. It was noted that at each meeting of the Finance & Performance Committee and Trust Board an update on the operational plan would be given. The main draft would be completed by the March 2019 Board meeting.

The Acting Chief Executive reported that in terms of the staff awards, it was pleasing that there had been so many nominations and reminded the Non Executive Directors that they had been invited to the event.

The Executive Director of Strategy & Delivery reported that the site was smoke free as of 1 January 2019. The implementation of the policy had been received well to date.

The Chairman advised that since the previous meeting she had:

- Helped with some more NED interviews at another local trust

• Undertaken a walkabout with Karen Hughes, Staff Governor • Attended the Christmas Ball at Tally Ho on 30 November. The staff organising the event were thanked for their work. • Attended the first meeting of Birmingham Hospitals Board • Distributed Christmas Chocolates to some of the teams across the hospital • Attended a launch event for a new centre of Health and Social Care Leadership on 10 December at University of Birmingham • Although she could not attend the celebration, the Chairman wished to recognise the retirement of Arthur and Brenda Wall who had worked as volunteers for 40 years at the hospital • Met with some of the applicants for the Medical Director post which was currently being recruited into following Mr Pearson stepping down from this role The Chairman thanked the staff working over Christmas and the New Year for their dedicated work and she also thanked Steve Washbourne for walking round the hospital on Christmas morning. The great job that the volunteers do was noted formally. An update was given on Dr Carmalt who had recently retired. He would be invited back to the Trust to formally celebrate with his colleagues. The outpatient manager would also retire at the end of the financial year after 40 years of service.	
ACTION: SW to present the draft financial and operational plan at the March 2019 meeting of the Trust Board	
6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	Verbal
The Interim Chief Operating Officer reported that in terms of the Orthopaedic Alliance, patients from Heartlands, Good Hope and Solihull Hospitals continued to be received. Many of these patients had been treated, with c. 170 individuals having undergone surgery to date. Much work had been undertaken in terms of bone infection and discussions would be held with the local Clinical Commissioning Group (CCG) as to how this would work across the system. It was reported that there had been a visit from the 'Getting it Right First Time' team, who were impressed at the JointCare pathway and had, on the back of this, discussed with University Hospitals Birmingham NHSFT, the concept of redesigning the orthopaedics pathway across the region.	
6.2 Briefing on plans for Brexit 'no deal' scenario BAF REF: FP3	Verbal

It was reported that there was a regular meeting of the Brexit subcommittee. The ROH was not stockpiling drugs but there was effort given to ensure that there was adequate stock. There was a plan to ensure that there could be no break in the service. There was noted to be a region wide process and a Birmingham-wide procurement arrangement would assist with this. The NHS Improvement self-assessment had been submitted prior to Christmas and neighbouring trust collaboration would ensure that supplies were uninterrupted. There were noted to be a couple of drugs where there was a risk and there could not be an absolute guarantee that the ROH would be unaffected, including any impact on the cost of the drugs.	
7 Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	**ROHTB (1/19) 003** **ROHTB (1/19) 003 (a)**
The Board received and noted the update on Paediatric service transition. It was highlighted that there was a delay to the original timetable since the Board had last considered the plans in public. This delay was a concern for the Board. The level of staffing on the paediatric ward was also a concern, however there was work underway with Birmingham Children's Hospital to mitigate this risk. Staff affected by the plans had been professional and were thanked. The Medical Director reported that the service at the ROH continued to be safe and patient safety remained the main consideration behind the plans. No further private paediatric patients were undergoing surgery on the ROH site.	
8 Update from the Freedom to Speak Up Guardian: *for assurance*	**Presentation**
The Board was joined by Roger Bishton, Acting Freedom to Speak Up Guardian (FTSUG). He delivered a presentation on the work he had been doing in his capacity as the Freedom to Speak Up Guardian and talked through some of the highlights from the first annual report prepared by the national Freedom to Speak Up Guardian's office. Mr Bishton was asked whether there were patient safety concerns raised through the FTSU. He advised that safety incidents were generally picked up, in addition to through the FTSUG route, by the incident reporting system (Ulysses) and during his tenure, there had been no feedback where the FTSUG had been asked to intervene. It was noted that staff were very quick to raise issues when they occurred. It was suggested that there needed to be better communication around the good things that the Trust did to address issues. It was noted that there was good progress with the work of the FTSUG across all areas. The Board noted the self-assessment that it had completed together with the FTSUG. It was noted that the responses needed to be as current as possible	

however, as some reflected past circumstances. The Board agreed that the FTSUG role was working well and was established. The Associate Director of Governance & Company Secretary was thanked for his support to the work. In terms of benchmarking, it was noted that the Trust performed well in terms of the level of concerns raised against other trusts. This was a matter of interest for the CQC and would be picked up under the Well Led Framework assessment. To improve the effectiveness of the FTSUG role further, it was suggested that better detailed assurance was needed that the patient safely issues raised were being addressed and raised. This would be picked up by a report to the Quality & Safety Committee. It was noted that in many of the areas where concerns had been raised previously there were no concerns and an eye needed to be kept on any key trends. It was suggested that the boundaries between HR and FTSUG needed to be better defined.	
ACTION: SGL to arrange for a detailed report on the FTSU concerns to be presented to the Quality & Safety committee	
9 Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (1/19) 004
The Chair of the Quality & Safety Committee reported that the national shortage of the Hepatitis B vaccination had been highlighted at the last meeting, however the vaccination was available now and staff needing to be inoculated were being recalled. Staffing in the clinical governance team was noted to be a risk, however there were plans to fill the vacant positions now. An update on the Human Tissue Authority (HTA) visit had been discussed; there had been a number of non-conformities raised, with which the Committee was concerned. There would be a further assurance report back to the Quality & Safety Committee at a future meeting. The quality assurance walkabouts into Outpatients had been discussed where an 'Inadequate' rating had been raised. An action plan was underway to address the areas of shortfall identified. The lack of attendance at the Infection Control meeting by the estates and facilities individuals had been raised as a concern. Another concern to highlight was the adequacy of the report back from the Water	

Safety Group, where the action plan to achieve compliance with the water safety regulations needed to be strengthened to provide better assurance around the plans. The bible of policies for water safety would be presented in May. The water was routinely tested which provided current assurance over the quality of water. It was reported that the plans for Pathology services was to be discussed at the next meeting of the Quality & Safety Committee. There had been a discussion around consent, including the possibility of using a generic consent form. It was noted that there was a suggestion that electronic consenting was a possibility and this was being investigated. It was highlighted that the requirements for biobanking needed to be considered; this would be part of the HTA action plan. It was noted that the plans to achieve a reduction of Outpatient 'Did Not Attend' cases was planned at the next Finance & Performance Committee.	
10 Patient Safety & Quality report: *for assurance* BAF Ref: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (1/19) 005
The Executive Director of Nursing & Clinical Governance reported that there had been one death, which was a patient that had been discharged. No inquest was planned. There were no serious incidents reported from June to October, although the VTEs not previously reported had now been retrospectively included in figures at the request of regulators. There had been two Grade 2 pressure ulcers reported. Twelve complaints had been reported, taking the year to date figure to 97. The new Patient Experience and Engagement Group would scrutinise complaints more closely. For the first time, the mandated 35% response rate had been achieved for the Friends and Family Test. The 'I Want Great Care' position had improved. It was noted that PALS contacts had reduced, however complaints had increased. There were no current trends to highlight however. Staff attitude and communication had been an issue and now 'customer care' training had been reintroduced. It was noted that the level of claims was static and the NHSLA premiums had reduced from previous years.	
11 Update from the Finance & Performance Committee: *for assurance*	ROHTB (1/19) 007
The Chair of the Finance and Performance Committee reported that the financial	

position was behind plan at present however he noted that the position remained better than the same period during the previous year. The introduction of the cost:income ratio would be included in future version of the Finance and Performance overview. The delivery of the cost improvement plan was a concern and it was suggested that there needed to be a realistic target set for next year. A discussion around the sickness absence spike had been remitted to the Staff Experience & OD Committee. The implications of a 'no deal' Brexit had been discussed. Performance against the Referral to Treatment time target was 87.24%. It was also good to see Paediatrics and foot and ankle specialities achieve the 92% national target.	
12 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (1/19) 008
The Interim Director of Finance commented that it had been a frustrating month as the underlying performance had improved, yet there had been a shortfall against the plan. The December position was a planned deficit of £1m and it was anticipated that this would claw back some of the shortfall from November. In terms of patients waiting over 52 weeks, there were 14. The diagnostic target had been met. Length of stay continued to decrease and was now c. 4.1 days. Overall, it was a positive position. Meeting the overall plan was dependent on the position concerning paediatrics.	
13 Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (1/19) 009
The Chair of the Staff Experience & OD Committee reported that the committee was now performing more effectively. Vacancies had been discussed and would be discussed again at the next meeting, particularly some of the risks to filling these. It was highlighted that this was the first time that the workforce overview was available to the Board. A series of staff experience walkabouts had been arranged and the first had been arranged in December. The plan as to how the outcome of these was presented back was being worked through, including how this gelled with the remit of the	

Executives. The conditions in which the finance and informatics teams were working was raised as a concern and this needed to be considered as part of the capital plan.	
14 Workforce overview: *for assurance*	ROHTB (1/19) 009
All were asked to review the workforce overview and provide any comments back to the Acting Chief Executive. In terms of staff turnover, the staff in post position had improved. As a bigger risk, sickness levels had risen. It was noted that in terms of the table around vacancies, there had been concerns over the data accuracy of this information which was being picked up.	
15 Meeting effectiveness	Verbal
It was agreed that the meeting had been effective and the Freedom to Speak Up presentation was well received in particular. It was pleasing that the workforce overview was now in a position to be able to be made available to the Trust Board.	
16 Any Other Business	Verbal
There was none.	
Details of next meeting	
The next meeting is planned for Wednesday 6 March 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 6 March 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 1.03.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
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. Ongoing discussions around therapies with commisisoners, thereby not in a position to be able to present updated strategy until Spring 2019.	
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~~ 03/04/2019	Scheduled for the ~~November~~ April meeting	
ROHTBACT. 068	Board Assurance Framework	ROHTB (1/19) 001 ROHTB (1/19) 001 (a)	09/01/2019	Reframe the paediatric transition risk relating to income	SW	06-Mar-19	Reframed on the current version of the Board Assurance Framework	
ROHTBACT. 069	Chairman's & Chief Executive's update	ROHTB (1/19) 002 ROHTB (1/19) 002 (a)	09/01/2019	Present the draft financial and operational plan at the March 2019 meeting of the Trust Board	SW	06-Mar-19	Included on the agenda of the March private session	
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	Clinical audit discussed together with consent at the January meeting of the Audit Committee	
ROHTBACT. 070	Update from the Freedom to Speak Up Guardian	Presentation	09/01/2019	Arrange for a detailed report on the FTSU concerns to be presented to the Quality & Safety committee	SGL	29-May-19	ACTION NOT YET DUE	

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:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6 March 2019**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at February 2019.

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

Two risks are prosed for de-escalation from the BAF:-

- 293 – Risks relates to the achievement of financial surplus
- CO1 – Lack of a Cancer operational tracking system

Both were recently de-escalated from CRR after recent review at Exec Team meeting

The following risk has seen a reduction in its current mitigated score:-

- CO2 – reduced from 9 to 6

The following risk has seen an increase in its current mitigated score:-

- WF1 – increased from 20 to 16

.

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

REPORT RECOMMENDATION:

Trust Board is asked to:

- Review the Board Assurance Framework
- Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- APPROVE the proposed changes to the Board Assurance Framework

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

Note and accept	Approve the recommendation	Discuss
X	X	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:

Trust Board on 9 January 2019 and Audit Committee on 25 January 2019.

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 Planning permission approved for theatre expansion	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	4	20	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. A further medium term financial plan will be required for submission by NHSI during 2019/20.	Dec-19	3	4	12
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	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	FPC reports; Board approval for cash borrowing; Finance & Performance overview	3	4	12	↔	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	2	3	6
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. NHSI/E continued oversight of system response Regular briefings to CQC and oversight of actions being taken BWCH senior nursing staff supporting weekly oversight of staffing and associated quality levels	Minutes of stakeholder oversight meeting	4	4	16	↔	Joint work continuing to support transfer of services from July 19, at which point risk will be mitigated	Jul-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 trajectory to deliver 92% performance is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for January is 84.86 % with only 10 patients (Excluding spinal deformity)over 40 weeks , however plans are in place to meet trust forecasted position for delivery of 92% in February 2019 for Arthroplasty , Spinal, Paediatrics , Foot and ankle , Hands and CSS . A revised trajectory has been developed for the delivery of 92% in all specialties. Additional capacity is planned for the YAH service commencing in February 2019 with a refreshed demand and capacity plan for spinal deformity incorporating the impact of any delay in transition of Paediatric inpatient services . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway.	Ongoing	3	4	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	5	3	15	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Water Safety Group minutes presented to IPC Group meeting.	2	3	6	↔	Water safety plan is in development.	Aug-19	1	5	5
WF2	WFOD	Paul Athey	Failure to identify future workforce models which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment		Highly motivated, skilled and inspiring colleagues	SE & OD Committee	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	3	4	12	↔	Workforce design to become an integral part of HR Business Partner discussions. Middle grade workforce group is meeting to develop model.	Jan-21	2	4	8

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	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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs	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	In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All patients monitored at weekly PTL - plans in place for all patients over 40 weeks Full RCA and harm review for all patients over 52 weeks presented monthly at harm review board. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.	Weekly updates to Exec Team; updates to Trust Board.	3	4	12	↔	A revised trajectory was submitted to NHSI/E (19/2/19). Work is still ongoing with the aim to clear all patients by the end of March 2019.	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. Junior Fellow posts have been re advertised with a revised 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 . The draft Job Description for the alternative medical workforce has been agreed . A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator commenced in December 2018 and is now focusing on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is now being monitored by the CSMS and reported to a monthly meeting to monitor spend, chaired by the deputy COO.	Ongoing	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	↔	Risk remains unchanged with Trust waiting for planning permission decision regarding theatre expansion.	Ongoing	1	5	5
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	2	3	6	↓	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 .All project are managed via Perfecting Pathway framework and all project current on trace. Feb 19 - Good progress has been made with all the projects and a monthly tracking system is in place and reporting through F&P Committee	Q4 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 support 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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 continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. 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 function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	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	↔	An information analyst has been recruited and is due to start at the trust early 2019 . The recruitment of the Business Intelligence Systems Manager had been delayed due to budget issues, but the post will now go to advert early 2019.	Q4 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 ratified -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	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	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. Full transition plan now in place with BWCH	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Clinical review of proposed Oncology strategy is still outstanding. If the outcome of this is positive, this will support the alignment of the strategy across all providers	Jul-19	2	3	6
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	Risk remains unchanged. CYPHDU is staffed 24/7 with a minimum of 1 RNC and 1 RN with HDU paediatric competencies. Weekly meeting held with the Senior Sister and Matron, HON and chaired by the executive Director of Nursing & Clinical Governance. This meeting review staffing across CYP HDU, adult HDU and ward 11. Staffing and vacancy position discussed at HDU Management Meeting and included in the Divisional Condition Report to Division 2 DMB and CQG. Block booked agency staff to support service provision.	Q&S Report	3	4	12	↔	Ongoing recruitment programme. Bespoke adverts for HDU to try new approach to recruitment to attract candidates. Open days also being planned for early 2019.	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. Further support and oversight provided by BWCH and a further weekly meeting instigated from February 2019. Operationally the service has been reviewed and bed capacity reduced to 12 beds to support staffing requirements – Operational SOP being drafted to support measures put in place. Rostering reviewed and CYPHDU/Ward 11 amalgamated to provide further oversight and support both areas. Scheduling tool developed to provide better oversight of activity booked for both areas.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	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 Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	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	↔	Continued oversight by NHSI/E & CQC	Jul-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 has received transitional funding during 2018/19 to support the additional costs of paediatric provision.	Q4 2018/19	1	4	4
MD1	Clinical	Matthew Revell	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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
5799	Strat	Phil Begg	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	Work is underway to develop the strategy for 2019/20 to 2023/24 and beyond. A workshop was held for the Board on 6 February 2019 at which the Board was presented with the proposed routes for enagement with the stratgey for staff, stakeholders and the public.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case; slides from strategy session for the Board on 6/3/19	2	3	6	↔	A strategy working group will be established to specifically focus on: - How we engage with all teams in the development of the new strategy - How we share key headlines from this year's annual plans - What we think the key elements of the strategy need to be - How we align all Trust plans/strategies to this document	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	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. Implementation of HealthAssure system will provide additional technological functionality to strengthen core governance systems.	Q1 2019/20	1	3	3
1298	**Finance & Performance**	**Steve Washbourne**	**There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:**		**Safe, efficient processes that are patient-centred**	**Finance & Performance Committee**	**4**	**4**	**16**	**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. 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.**		**4**	**4**	**16**	↔	**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. 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**	**2**	**4**	**8**

FP4	Finance & Performance	Steve Washbourne	There is a risk that the full quantum of cost saving as outlined in the 2018/19 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Managed service for theatres due to be delivered by financial year end which is a significant scheme in the overall programme.		4	4	16	NEW RISK	Continued identification of new opportunities for cost saving and income generation.	Mar-19	3	4	12
FP5	Finance & Performance	Steve Washbourne	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.		4	4	16	NEW RISK	Planning application due to be considered by Birmingham City Council in February 2019.	Oct-19	3	4	12
FP6	Finance & Performance	Steve Washbourne	There is a risk that the Financial Control Total will not be met in 2018/19		Safe and efficient processes that are patient-centred	Finance & Performance Committee	3	4	12	The 2018/19 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery. Clinical Audit day has been cancelled in February to allow more work to be undertaken. Revised activity plan distributed which identities performance levels required for recovery.		3	3	9	NEW RISK	Further focus in March to deliver increased activity.	Oct-19	3	3	9

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

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 March 2019**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

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

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

Note and accept	Approve the recommendation	Discuss
x		x

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (3/19) 002 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 6th March 2019

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 9th January 2019.

2 STP UPDATE

2.1 The last STP Board meeting, prior to the finalisation of this report, took place on 7th January 2019. There was no Board meeting in February

2.2 At the January meeting, the Board members received a presentation from colleagues at the University of Birmingham (UOB) who have been commissioned to undertake an evidence review of the STP strategy. The aim of the review is to identify proposed actions that are supported by a strong evidence base and those where the evidence base would suggest that elements should be re-considered.

2.3 The evidence review to date has considered over 600 publications but, due to the volume of evidence to consider, the Board were asked whether UoB should prioritise an in-depth review of a small number of specific interventions or to provide a broader overview across a wider range of areas.

2.4 The former option was generally supported however UoB were asked to complete a brief overview of the full strategy in order to inform which areas would benefit from more in-depth work.

2.5 The Board also received an update paper on the NHSE/I feedback from the STP Estates strategy, which was only rated as Fair. The overall assessment of the strategy was that it "highlights all the key priorities for the STP but could be more concise and evidence the governance and reporting arrangements in an easier format". Specific recommendations were included around:

- Strengthening stakeholder engagement
- Reviewing and/or clarifying governance arrangements and prioritisation processes

- Greater links to the Carter metrics and clarity on plans to address backlog maintenance
- Developing more detail on impacts of back-office rationalisation and digital transformation

2.6 The next STP Board meeting is taking place on 4th March and a verbal update will be provided at the Trust Board on 6th March.

2.7 In the absence of the STP Board in February, the STP CEOs met and reviewed the following areas:

- The NHS Long Term plan and it's alignment with the STP strategy
- Resource planning for 2019/20
- An update on the CCG deep dive review into learning from deaths & mortality
- Brexit Planning

3 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

3.1 The BHA Board met for the second time on 12th February 2019, with the majority of the meeting set aside for work on aligning the strategies of each of the three member Trusts.

3.2 Each Trust presented their current strategic vision and objectives, which informed a wider discussion on BHA strategic priorities. It was felt that early work on aligning and progressing priority enablers such as digital, estates and workforce should be high on the BHA agenda.

3.3 In addition to this discussion, the Board also received a presentation on the alignment work currently underway between UHB and BWCH within Gynaecology services and also formally approved the Birmingham Hospital Alliance Memorandum of Understanding

4 MEDICAL DIRECTOR APPOINTMENT

4.1 Following Andrew Pearson's decision to stand down from the role of Medical Director, I can formally confirm that Matthew Revell has been appointed into the role. Due to the work described in section 5 below, Matthew's transition into the role has been accelerated and he formally started as Medical Director on 18th February 2019.

5 ORTHOPAEDICS IN BIRMINGHAM AND SOLIHULL

5.1 The ROH has been working closely with colleagues at UHB to help improve orthopaedic services across Birmingham and Solihull. Prior to returning to a full time

clinical role, we are grateful that Andrew Pearson has agreed to support a programme of work across Heartlands, Good Hope and Solihull hospitals ('HGS') that will review the productivity of elective orthopaedic services at HGS, align clinical pathways across the city and ensure an equitable provision of support services. The overall aim of the programme to is ensure that all orthopaedic care across Birmingham and Solihull is delivered to the same clinical and operational standards.

6 STAFF SURVEY

6.1 Our 2018 national staff survey results were published on 26th February 2019 and show significant improvement across a range of areas.

6.2 41% of ROH staff completed the survey, with scores improving in over 75% of the individual questions. The improvement included key areas such as:

- Relationship between senior management and staff
- Enthusiasm with your role
- Treatment of staff reporting incidents
- Support from immediate managers
- Appraisals – regularity & effectiveness
- Standards of care

6.3 The improvements in 2018 now mean that the ROH compares favourably in the majority of areas when compared to our peer group of specialist acute hospitals, and very favourably when compared to other local providers.

7 STAFF AWARDS

7.1 On 8th February 2019, the Trust held our 2019 "Leading Lights" Staff Awards at the Botanical Gardens.

7.2 21 awards were presented with around 200 members of staff and patients attending. The ceremony has received very positive feedback from those who attended and thanks should be recorded to the Learning & Development and Communication teams who ensured the evening was such a success.

8 JOINTCARE FORMAL LAUNCH & MEDIA COVERAGE

8.1 The Trust formally launched our JointCare programme in February, following three months of "soft" rollout since November 2018. In addition to increasing communication with local GPs and stakeholders, we were also pleased that BBC Midlands Today included a feature on the programme on 11th February.

8.2 The JointCare portal is now available through the ROH website, including videos and animations outlining what patients can expect and the benefits of following the JointCare Programme.

9 POLICY APPROVAL

9.1 The Chief Executive, on the advice of the Executive Team has approved the following policies since the Trust Board last sat:

- Supported mealtime and use of red tray policy
- Hand hygiene policy
- Carbapenemase producing enterobateriaceae (CPE) policy
- Carers' 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
6th March 2019

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:	**Janet Davies, Clinical Service Manager / Project Lead for the Paediatric Transition**
DATE OF MEETING:	**6 March 2019**

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:

- An update regarding the revised timeline for the transfer of Paediatric Services to BWC (1st July 2019)
- Details agreed for the Oncology Quality Assurance Evaluation
- Governance infrastructure supporting transition
- Main risks
- Communication with stakeholders

REPORT RECOMMENDATION:

The Board is asked to accept 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		Communications & Media	x
Business and market share	x	Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services.

PREVIOUS CONSIDERATION:

Last considered as part of the Trust Board public agenda in January 2019

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Paediatric Service Update – March 2019

UPDATE TO THE TRUST BOARD ON 6 MARCH 2019

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:

- Transfer date 1st July 2019
- BWC Theatre Trajectory
- Oncology Quality Assurance Evaluation
- Revised timeline for the service transfer to BWC
- Governance infrastructure supporting transition
- Main risks
- Communication with stakeholders

2 Transition of Service

Both Trusts remain committed to securing the safe and timely transition of services to the BWC site and are working closely with NHS Improvement (NHSI) and NHS England (NHSE). BWC have confirmed at their February Board that they are committed to working towards the 1st July 2019 as the new transition date.

The following remain the crucial factors in transitioning the Paediatric services on the 1st July 2019

- BWC recruiting sufficient numbers of theatre staff to support the additional activity
- BWC undertaking an External Oncology Quality Assurance Evaluation (as this is not a service they currently provide)

BWC are on track with their trajectory for staffing recruitment having recruited 5 new theatre staff. The oversight meeting will continue to review their progress with theatre staff recruitment.

The Oncology Quality Assurance Evaluation has been planned for the 11th and 12th March 2019 and will include representation from NHSE and both Trusts presenting the proposed pathway.

BWC have recruited Professor Ian Lewis to lead the evaluation. He is a Paediatric Oncologist by background; he was previously Medical Director at Alderhay Children's Hospital and currently Non-Executive Director at Leeds Community Healthcare NHS Trust.

BWC have asked Prof Lewis to present the report at their next Quality Committee. ROH will expect to see the report findings back by the end of March for the Oversight meeting in April 2019.

The main risks to the ROH as a result of the delay are the paediatric nursing staff levels on ward 11 and HDU and CQC regulatory inspection of these areas. Currently both nursing teams at ROH and BWC are working together and are providing assurance that the service will be retained on the ROH site until the revised transitional date. This risk has been downgraded as a result of the changes that have been implemented but continues to be monitored weekly at the Paediatric Transition meeting. The CQC together with NHSI and NHSE have been kept fully informed with the delay.

All other paediatric support has been extended included the paediatrician support from both BWC and UHB (Heartlands Hospital) which was originally in place to the end of January 2019 and the ongoing Associate Medical Director cover from BWC.

3 Revised timeline for service transfer to BWC

Both Trusts are working towards a new transition date of the 1st July 2019. The critical path has been adjusted for this new date for all services to be transitioned (including Oncology):

- BWC to submit staffing recruitment timeline NHSI and NHSE – Mid Jan 2019 / Feb oversight meeting to review the progress made with recruitment - completed.
- Update Stakeholders of delay, including ROH website – Jan 2019 - completed
- BWC - Additional nursing / theatre / admin staff recruited – ongoing
- Theatre and Ward refurbishment Jan 2019 (on track)
- IT Pathways to be agreed – March 2019
- Post-transition clinical pathways signed off –March 2019 (excluding Oncology)
- Job plans signed off –April 2019
- Oncology Quality Assurance Quality Assurance Evaluation completion –11th / 12th March 2019
- Update from BWC Board to review finding of above - Feb 2019 – delayed until evaluation has been complete
- HR TUPE Transfer – April 2019
- The revised project plan is working to a new revised time line for all services to transfer to BWC of 1st July 2019 (excluding Oncology other specialties could be brought forward depending on BWC recruitment)

4 Governance

There remains a strong governance structure to oversee the process of transferring the paediatric inpatient & day case surgery service:

The Strategic Oversight Group Meeting co-chaired by Non-Executive Directors Kathryn Sallah (ROH) and Alan Edwards (BWC) continues to meet monthly with oversight by NHS England and NHSI to ensure the milestones for the transition are delivered. This also ensures system wide support and ownership for the transition of the service and a framework to support provider escalation should any of the critical milestones fail to be delivered.

5 Risks

ROH & BWC have developed a joint risk register to record, assess & monitor the risks associated with this complex service transition.

The risks can be summarised as follows:

- Risk of insufficient theatre staff numbers recruited to at BWC
- Unknown recommendations following the Oncology assurance evaluation
- Unknown CQC inspection at ROH

All of the above may result in further delays or cessation of services in the region. As discussed in the paper there is a focus on managing & militating against these risks through the governance structure outlined in section 4.

6. Communications

Key to the process continues to be our communication with stakeholders, therefore we will ensure that we remain focused on providing support to those staff impacted by the transition of service and ensure we engage with patients, families and stakeholders with key information about the service transition**.** The COST Campaign submitted additional questions to the Trust following the original transitional date delay. These questions have been answered by both Trusts and the reply was sent on the 22nd Feb 2019.

Authors: Janet Davies Clinical Service Manager / Project Lead for the Paediatric transition
1st March 2019

ROHTB (3/19) 004

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 30 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that the national shortage of Hepatitis B vaccinations had been resolved and staff needing these would be identified and recalled by Occupational Health. • There remained vacancies in the clinical governance team, however these were to be addressed shortly as staff took up post. • The update of the 'flu vaccine was reported to be below that of the previous year, which has an impact on the achievement of the CQUIN targets. • The Committee was concerned to learn that there was at present no dedicated named doctor for paediatric safeguarding. Cover was at present provided from elsewhere in the region. It was agreed that this issue needed to be resolved as a matter of priority. • It was reported that there were difficulties with ensuring that required staff attended the patient handling training; a new four day session was being arranged and could link into the clinical audit session.	• Include a discussion around the clinical risk associated with the paediatric transfer to the agenda of the next meeting. • Present a further update on the implementation of the HealthAssure system at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• An update on the time to recruit issue was received, which had been discussed at the Staff Experience & OD Committee meeting – this was to be a Key Performance Indicator which would be monitored through the workforce dashboard and would be of focus for the new Associate Director of HR, Workforce & OD. • An update on the transfer of the Pathology service was presented; the service would move to University Hospitals Birmingham on 1 April 2019. • The number of overall incidents had reported was noted to have reduced. • The number of patients waiting 52 weeks or over was noted to have reduced to 11.	• The Committee approved the Patient Experience and Engagement Group's terms of reference. • The Committee received and approved the revised terms of reference for the medico-legal forum.

• There was reported to be a plan to reduce the number of 'Did Not Attend' instances. • The contract performance notice associated with the 18 weeks Referral to Treatment Time target performance was noted to have been lifted. • A positive assurance report on the work of the Accountable Officer for Controlled Drugs was received, which highlighted that the scrutiny and governance around the management of Controlled Drugs was sound. • The Committee received a draft version of the Patient Experience strategy which include an approach to volunteering. • The Clinical Quality Group was noted to be working effectively and there was good representation across operations and clinical staff groups. • The Committee received some good assurance as to the effectiveness of the safeguarding team in handling more complex and numerous cases. • The effectiveness of the Health & Safety Committee was reported to have improved and this was now being chaired by the Executive Director of Strategy & Delivery. • It was reported that an audit of ligature points was planned, with support from the local Mental Health trust. • It was reported that at present there were no significant clinical risks to mitigate in relation to Brexit.	

Chair's comments on the effectiveness of the meeting: It was agreed that the meeting was effective and there were some good pieces of assurance, particularly around the safeguarding team and Controlled Drugs.

ROHTB (3/19) 005

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 27 February 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There remained some concern over the difficulties with understanding the size of the cohort of individuals who needed to receive the Hepatitis B inoculation. The matter was being escalated to those with overall responsibility for the provision of Hepatitis B vaccinations. • The Committee was advised that there had been two moderate harm incidents reported, including a potential Grade 3 pressure ulcer, which needed to be verified. The other moderate harm concerned the loss of spinal monitoring during a procedure leading to the individual being transferred out of the Trust.	• Add a risk around Hepatitis B vaccinations to the workforce risk register • Water and hydration audit information is to be presented at the next meeting. • A narrative summary of the Trust's controls to prevent *C. difficile* cases is to be presented at the next meeting. • A demonstration of the Health Assure system is to be scheduled into a future meeting. • An update on Bone Infection is to be presented to the Trust Board at a future meeting. • The water safety action plan is to be transferred into the corporate template. • A further update on the implementation of national guidance in relation to VTE is to be provided at the next meeting. • The Board would be updated on PROMs at its next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was good assurance provided that the transition of paediatric service was running to schedule, with a proposed date of 1 July having been set for the movement of the service. Given the additional support from Birmingham Children's Hospital (BCH), the paediatric ward was running well. • The risk around staffing in the clinical governance team was noted to have been resolved, with new staff due to start on 1 April. • Length of stay was noted to have reduced considerably, although this had led to a shift in the time of discharge of some patients who were fit to go home on the day after surgery. • The number of patients waiting in excess of 52 weeks for treatment had reduced to 5 against a trajectory of 33. Every effort was being made to clear all cases by 31 March 2019.	• It was agreed that cancer patients waiting in excess of 104 days for treatment needed to be highlighted specifically to the Quality & Safety Committee which would upwardly report to the Trust Board on these.

• A positive presentation was delivered on the plans to develop the Bone Infection service, the plans being supported by the Clinical Commissioning Group. The plans would set the ROH up as a centre of excellent for this specialist service. • The Committee agreed that there was now greater assurance as to the Trust's water safety processes. • The role of the Drugs and Therapeutics Committee in reviewing the protocols for JointCare was agreed to be positive.	

Chair's comments on the effectiveness of the meeting: It was agreed that the quality and organisation of the papers relating to the Drugs and Therapeutics Committee needed to be more fit for purpose. Although two Non Executive members of the Committee had tendered their apologies, the Chairman joined the meeting therefore the level of challenge and discussion remained robust.

ROHTB (3/19) 006

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

February 2019

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.

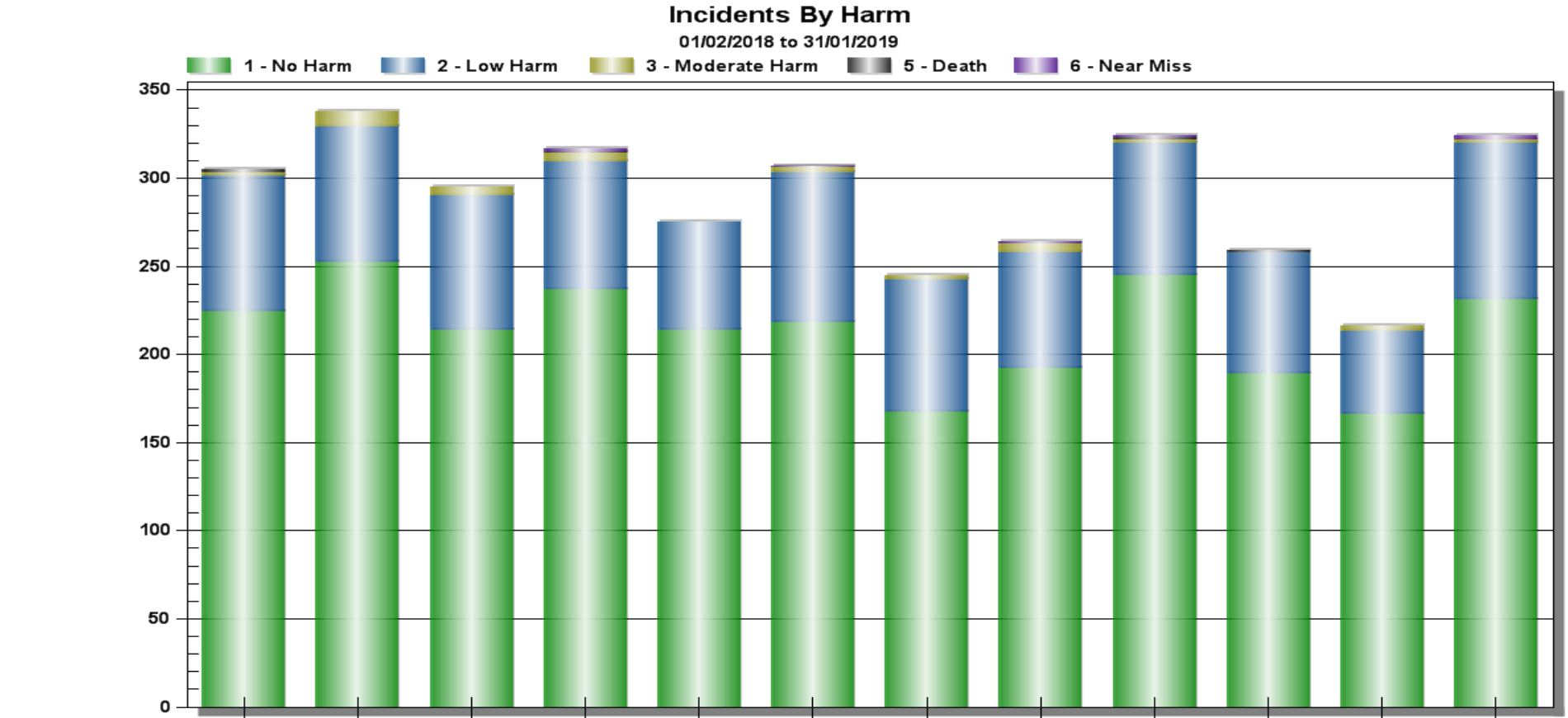
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019
1 - No Harm	224	252	214	237	214	218	167	192	245	189	166	231
2 - Low Harm	77	77	76	72	61	85	75	66	75	69	47	89
3 - Moderate Harm	2	9	5	5	0	3	3	5	2	0	3	2
5 - Death	2	0	0	1	0	0	0	0	1	1	0	0
6 - Near Miss	0	0	0	2	0	1	0	1	1	0	0	2

INFORMATION

In January 2019, there were a total of 324 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

231 – No Harm
89 – Low Harm
2 – Moderate Harms
0 – Severe Harm
2 – Near Miss
0 – Death

In January 2019, there were a total of 9208 patient contacts. There were 324 incidents reported, which amounts to 3.5 per cent of the total patient contacts resulting in an incident. Of those 324 reported incidents, 50 incidents resulted in harm which is 0.98 per cent of the total patient contact.

ACTIONS FOR IMPROVEMENTS / LEARNING

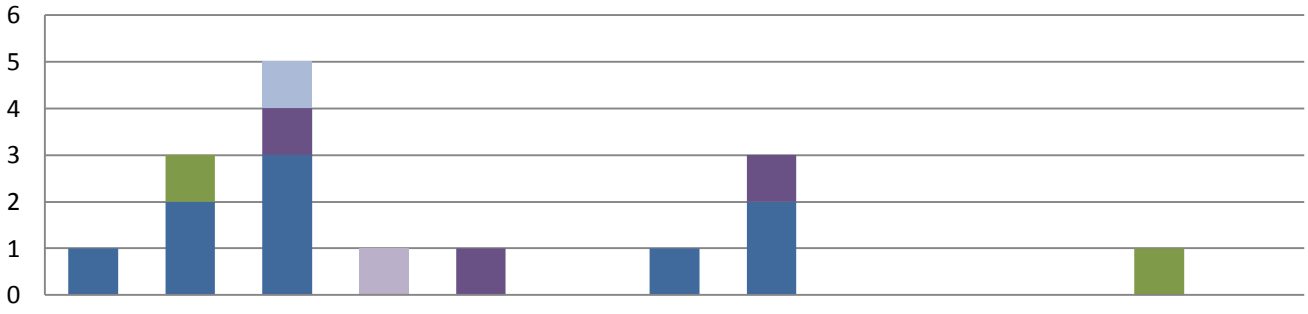
- Implementation of the Health Assure system – NICE and CAS systems to go live 1st February 2019.
- Work with communications underway to officially launch the learning from incident methodology and new incident reporting policy.
- Ulysses training package to be developed

RISKS / ISSUES

- Risk 265 - Engagement and adherence with staff around learning from incidents and never events.
- Risk 1193 - Staffing and capacity within the team with two vacancies (current risk score 12). 1 agreed start date for the Clinical Governance Facilitator post and 1 offer made to an apprentice to support the team.
- Risk 1194 - Lack of skill in the Trust on the Ulysses system (current risk score 12).

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 2019

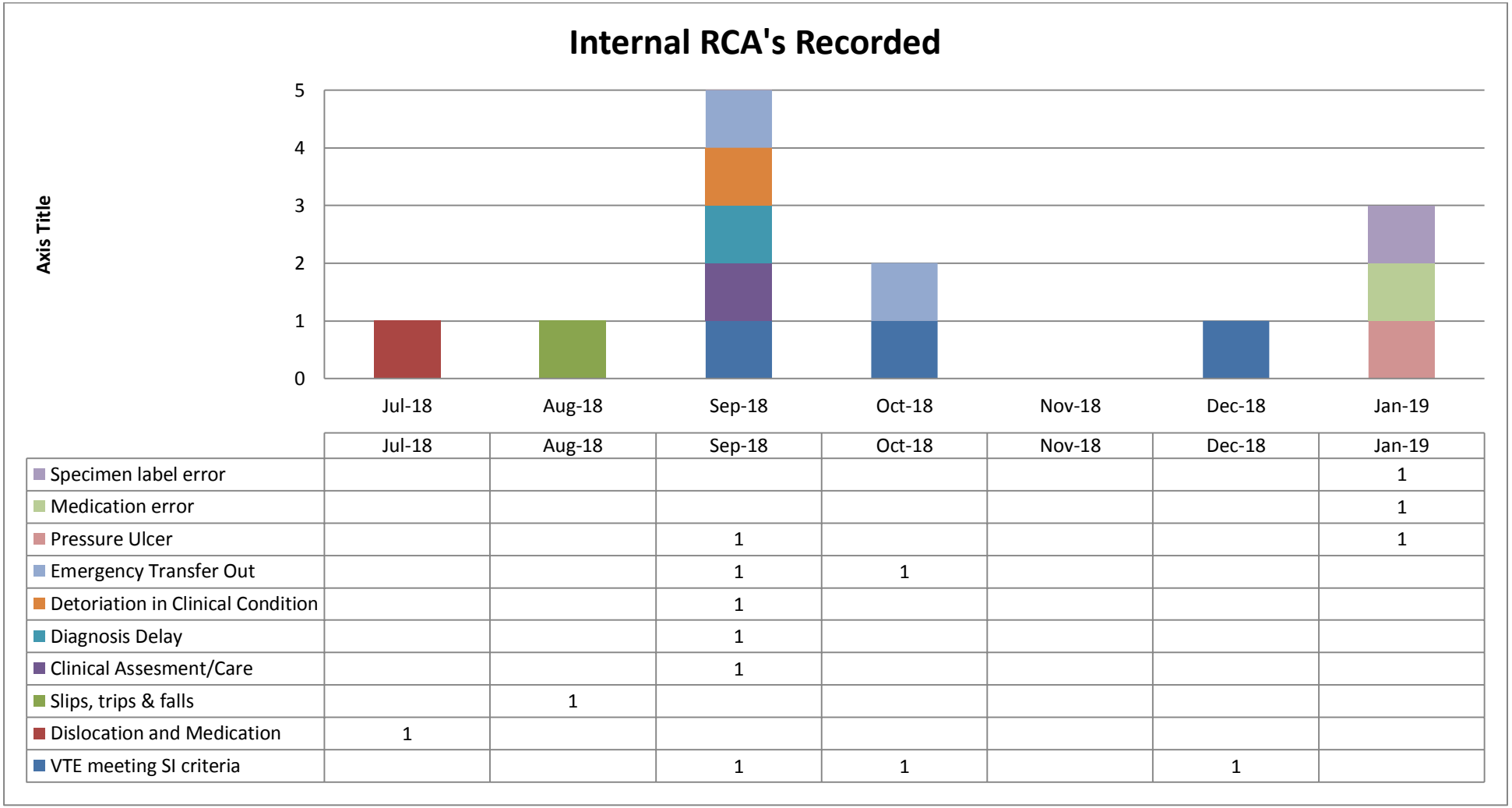


	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Transfer out				1									
Unexpected Injury													
RTT Harm review													
Information Governance Missing Laptop			1										
Retained object													
Wrong side injection													
Slips, trips & falls			1		1			1					
Pressure Ulcers		1										1	
VTE meeting SI criteria	1	2	3				1	2					

INFORMATION

No Serious Incidents were reported in January 2019; It has been agreed with the CCG that all avoidable VTEs will be declared as Serious Incidents. After investigation three VTEs previously declared were deemed as avoidable. These have now been declared with the commissioners as serious incidents.
ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incidents was closed in January 2019. T
RISKS / ISSUES
None

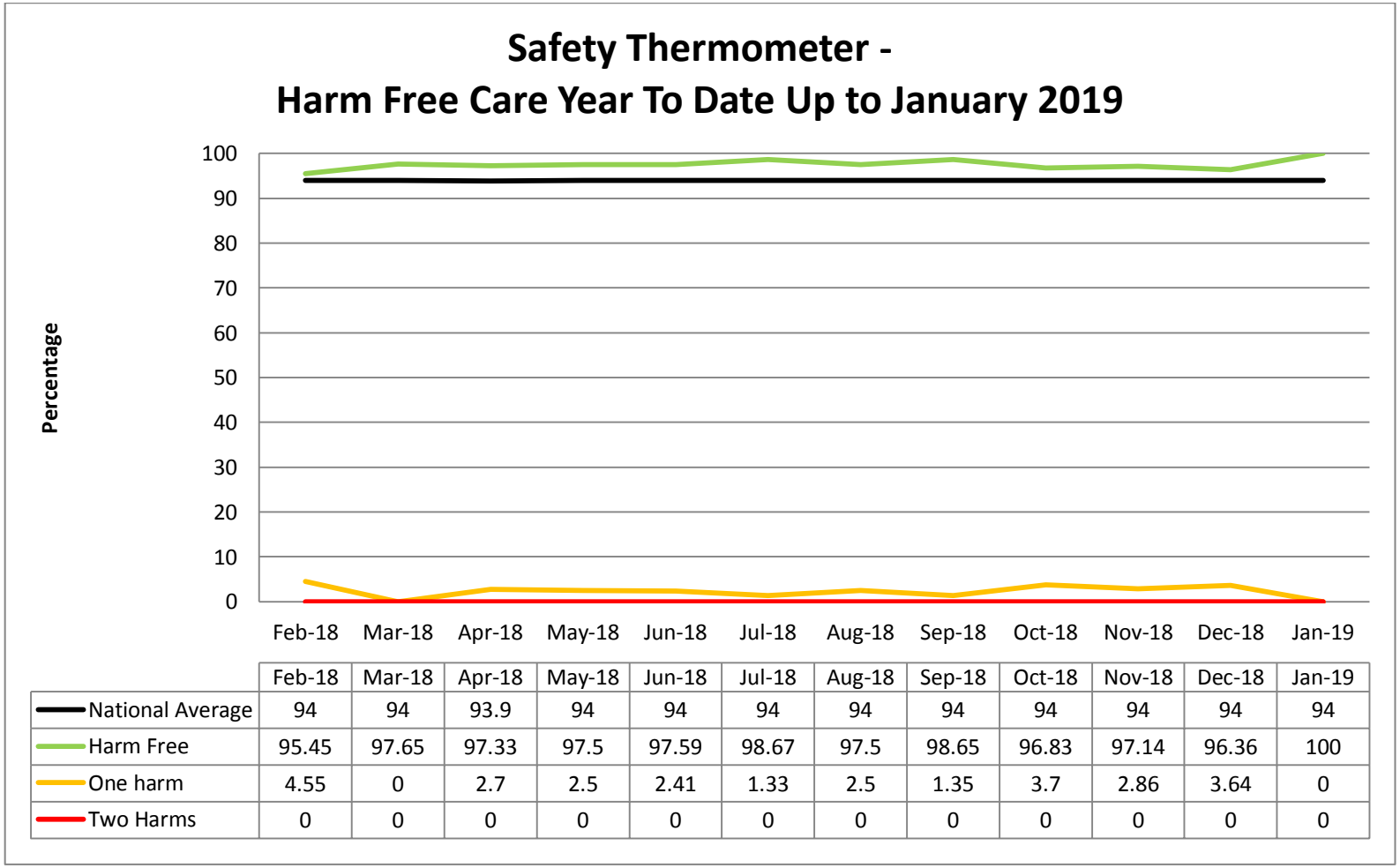
4. Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision that a heightened level of response is needed for these incidents.



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Specimen label error							1
Medication error							1
Pressure Ulcer			1				1
Emergency Transfer Out			1	1			
Detoriation in Clinical Condition			1				
Diagnosis Delay			1				
Clinical Assesment/Care			1				
Slips, trips & falls		1					
Dislocation and Medication	1						
VTE meeting SI criteria			1	1		1	

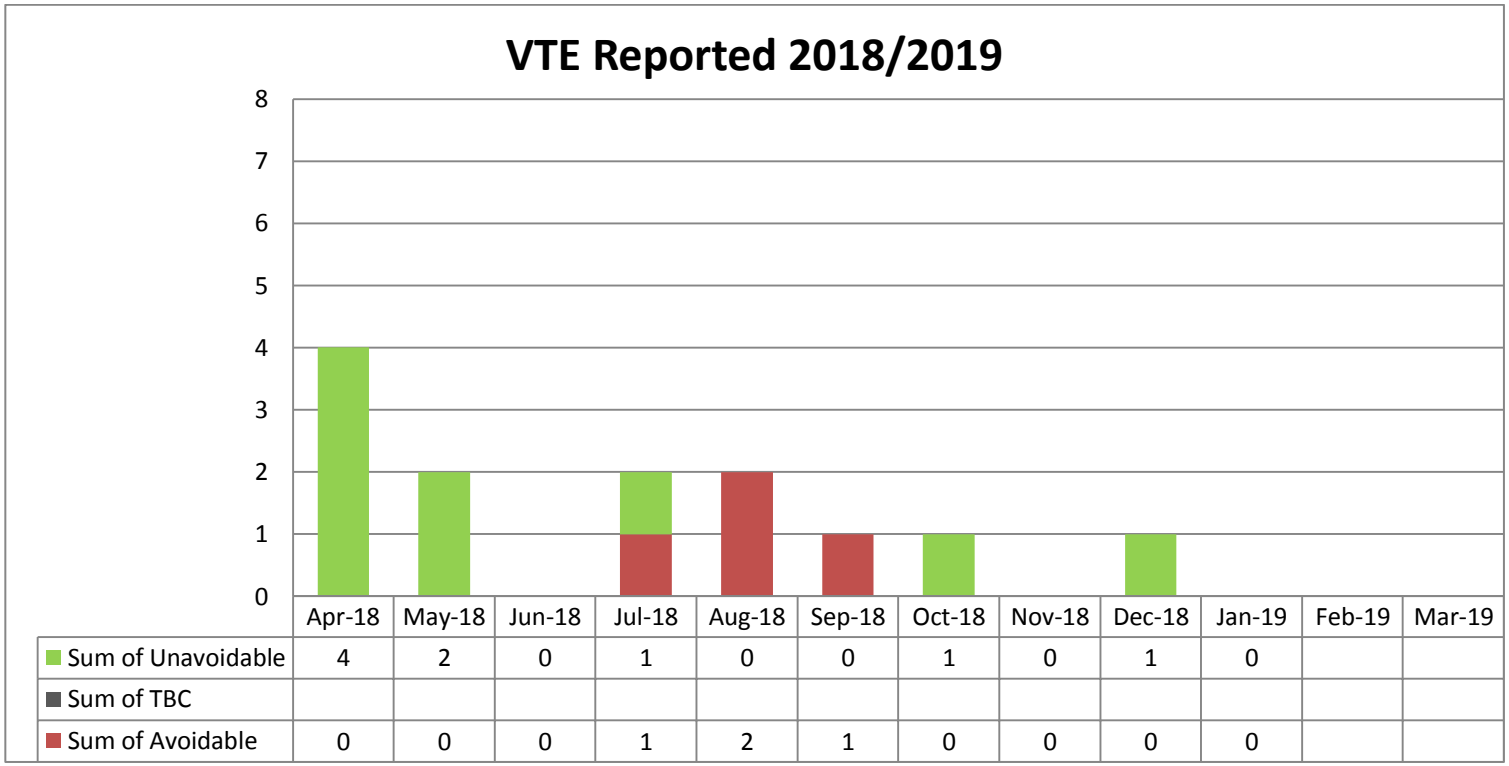
INFORMATION
Three incidents reported in Janaury 2019 2018 will be undertaken as an internal RCA. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.
ACTIONS FOR IMPROVEMENTS / LEARNING
No RCAs were closed in January 2019
RISKS / ISSUES
None

5. **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-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
National Average	94	94	93.9	94	94	94	94	94	94	94	94	94
Harm Free	95.45	97.65	97.33	97.5	97.59	98.67	97.5	98.65	96.83	97.14	96.36	100
One harm	4.55	0	2.7	2.5	2.41	1.33	2.5	1.35	3.7	2.86	3.64	0
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

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).**

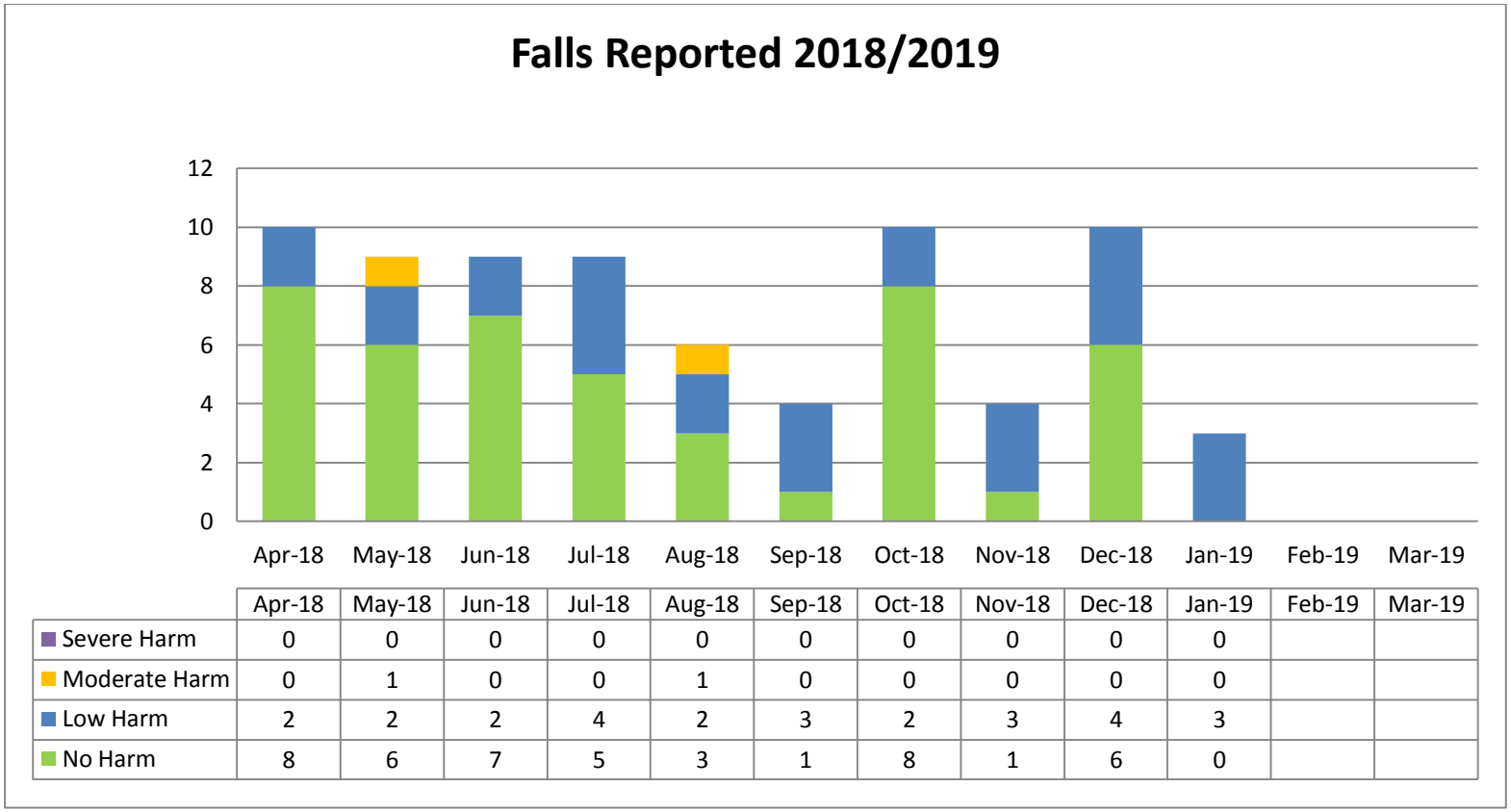


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	4	2	0	1	0	0	1	0	1	0		
Sum of TBC												
Sum of Avoidable	0	0	0	1	2	1	0	0	0	0		

total		Avoidable
17/18	33	10
18/19	13	4

INFORMATION
There was no VTE incidents reported in January 2019. This is compared to the 1 reported in January 2018. All avoidable VTEs are now reportable again to the CCG. Themes in those deemed avoidable to date are BMI >30, omitted enoxaparin dose post-operative, lack of documented 24 hour re-assessment. Action plans are in place for all. Due to the on-going national shortage of the Clexane brand of Enoxaparin Sodium the Trust has changed to the brand Inhixa. This has been n uneventful change over.
ACTIONS FOR IMPROVEMENTS / LEARNING
NICE VTE Prevention Guidance –Updated March 2018 We continue to follow previous NICE VTE prevention guidance, in line with many other Trusts. There is no risk to patients as a result of continuing to follow 2010 guidance until a consensus decision is reached regarding how/if this is adopted. VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement 95%): This continues to exceed the minimum requirement. This is being scrutinised by the VTE lead monthly as now this is a mandatory field within PICS we should achieve 100% compliance. 24 hours re-assessment compliance is now available via IMT reporting. This has been requested monthly and will be scrutinised by the VTE Lead until compliance is 100%, as this is a mandatory field. = January : 89.5%
RISKS / ISSUES
National shortage of Sequential Compression Device sleeves-being closely monitored by Theatre Leads.

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.**

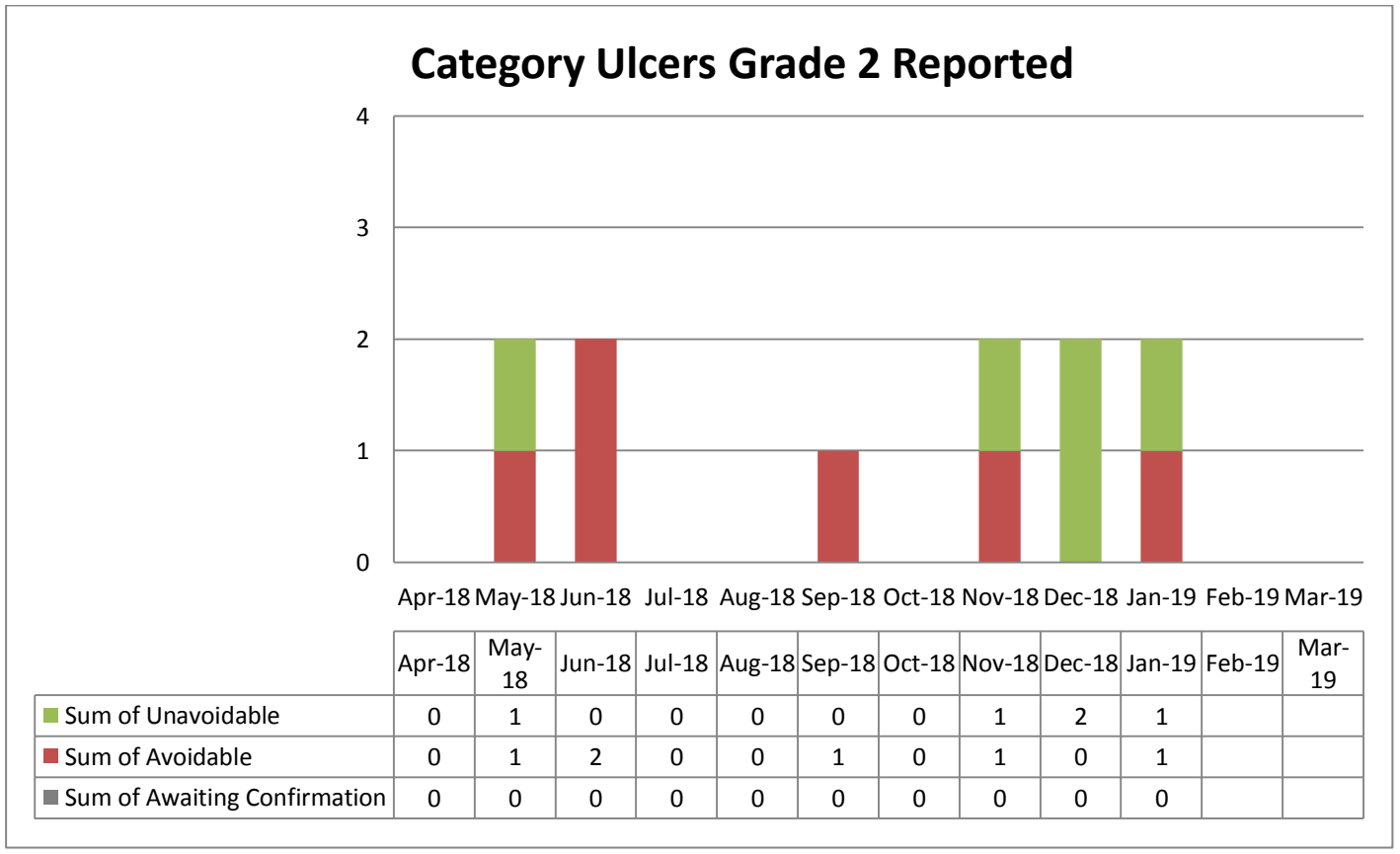


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Severe Harm	0	0	0	0	0	0	0	0	0	0		
Moderate Harm	0	1	0	0	1	0	0	0	0	0		
Low Harm	2	2	2	4	2	3	2	3	4	3		
No Harm	8	6	7	5	3	1	8	1	6	0		

total	
17/18	125
18/19	74

INFORMATION
There were 3 patient fall-related incidents reported across the Trust in January all were related to adult patients. 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 a bi monthly upward report and the Divisional Condition reports. They 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
• Falls working group now reviewing and scrutinizing all incidents and management actions. Incidents then either closed by group or additional information requested • New falls lead identified Alison Woodbridge – deputy head of therapy services from 31.12.18 • Falls risk register reviewed and updated by group • Discussed management of falls incidents at Ward Managers meeting on 3.12.18 • Falls training continues on clinical skills update day for qualified and unqualified staff
RISKS / ISSUES
• Sara Steady training now taught on patient handling but due to 2 year rolling programme, retained on risk register • Management of falls incidents found to be variable and lacking detail • Medical review following a fall template not being utilised by medical colleagues effectively.

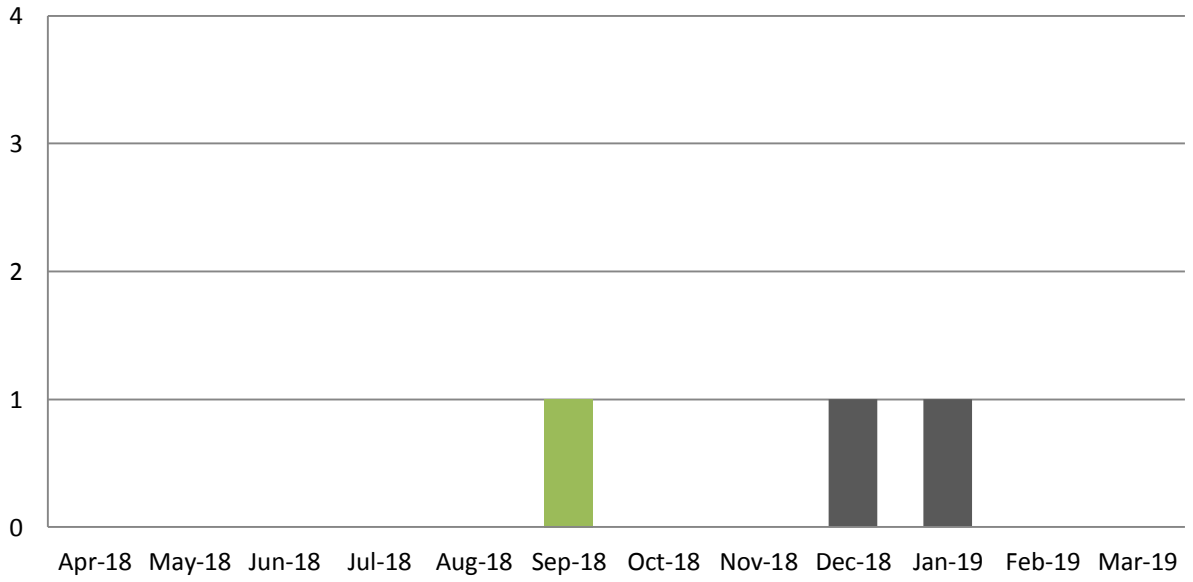
8. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open 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	0	1	2	1		
Sum of Avoidable	0	1	2	0	0	1	0	1	0	1		
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0		

total	Avoidable
17/18	6
18/19	6

Category 3 and 4 Pressure Ulcers Reported



	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	0	0	0	1	1		
Unavoidable G4	0	0	0	0	0	0	0	0	0	0		
Unavoidable G3	0	0	0	0	0	1	0	0	0	0		
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0		
Grade 3 (Avoidable)	0	0	0	0	0	0	0	0	0	0		

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

INFORMATION

In January 2019, there were three pressure ulcers recorded. This compares to the two Category 3's reported in January 2018.

January 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	X 1 Avoidable Ward 1 – 26309
Category – 2 (Device)	X 1 Unavoidable – Ward 1 – 26275
Category – 1	0
Suspected Deep Tissue Injury	A Category 3 Pressure Ulcer –Query Avoidable.
Moisture Associated Skin Damage (MASD)	0
Patients admitted with PU's	Category 1 x 5 (1 = MDRPU) Category 2 x1 St Michaels Hospice Category 3 x2 One - Alexandra Hospital (WHAT) and One - Pt's own home Number of patients with moisture associated skin damage (MASD) x 0

Avoidable Pressure Ulcer CCG Contracts KPI

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	5
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2017/2018:

2017/2018	
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

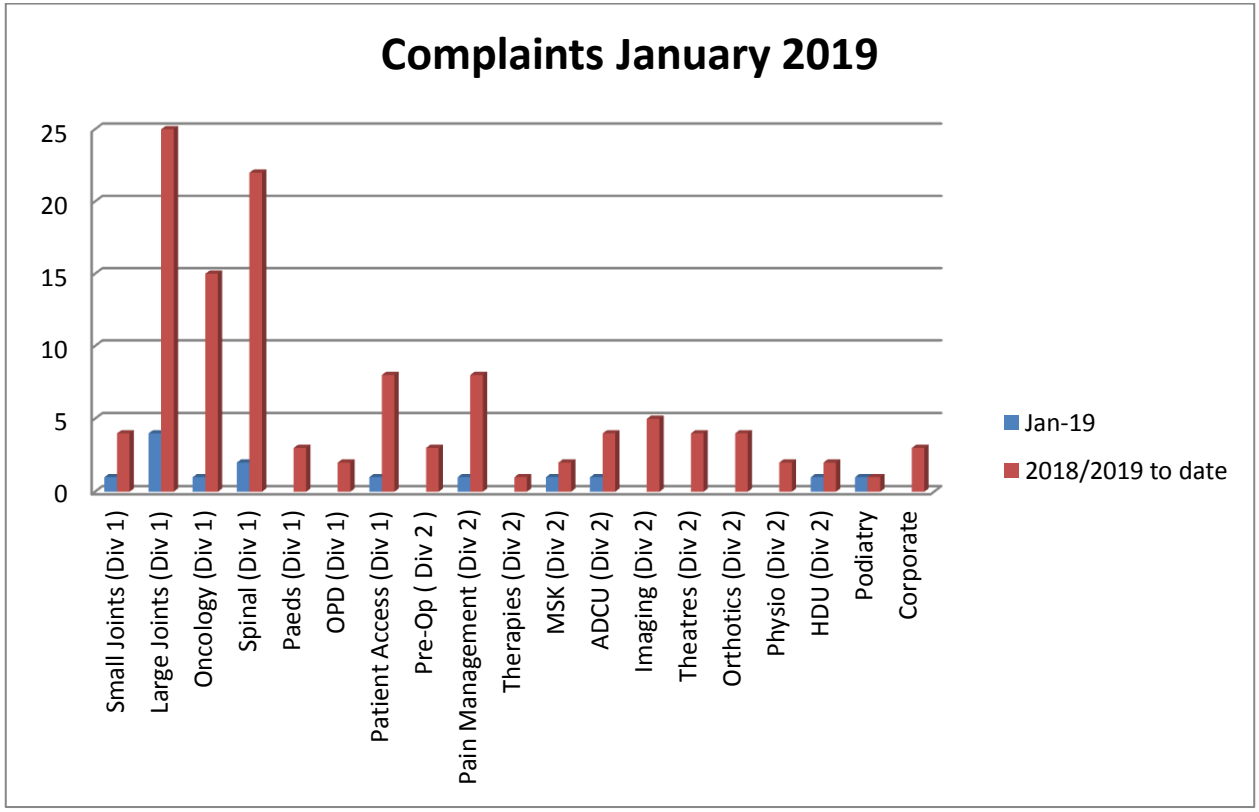
Current Actions

- Plaster of Paris (POP) care plan under review and will be amended to enable clearer and concise documentation.
- TV lead Nurse presented to the Clinical Quality Group Committee on 11/1/19The committee were re-assured that changes in practice and documentation are taking place regarding the care of patients with POPs and those wearing anti-embolic stockings. The new user-friendly documentation has been reviewed and will reflect the need for re-assessment.
- Gap analysis update re NHSI PU changes – only changes left to make are competency documents which are currently under review,
  Due to the new NHSI (2018) PU curriculum that has been distributed to Trusts.
- Gap analysis re NICE guidance reviewed Nov 2018 - ROH is compliant re all current standards of care. NICE recommend PU assessment within 6
  admission. Other Trusts 2-4 hours. ROH CQG committee agreed with the current 6 hours as per NICE guidance.

RISKS / ISSUES

None

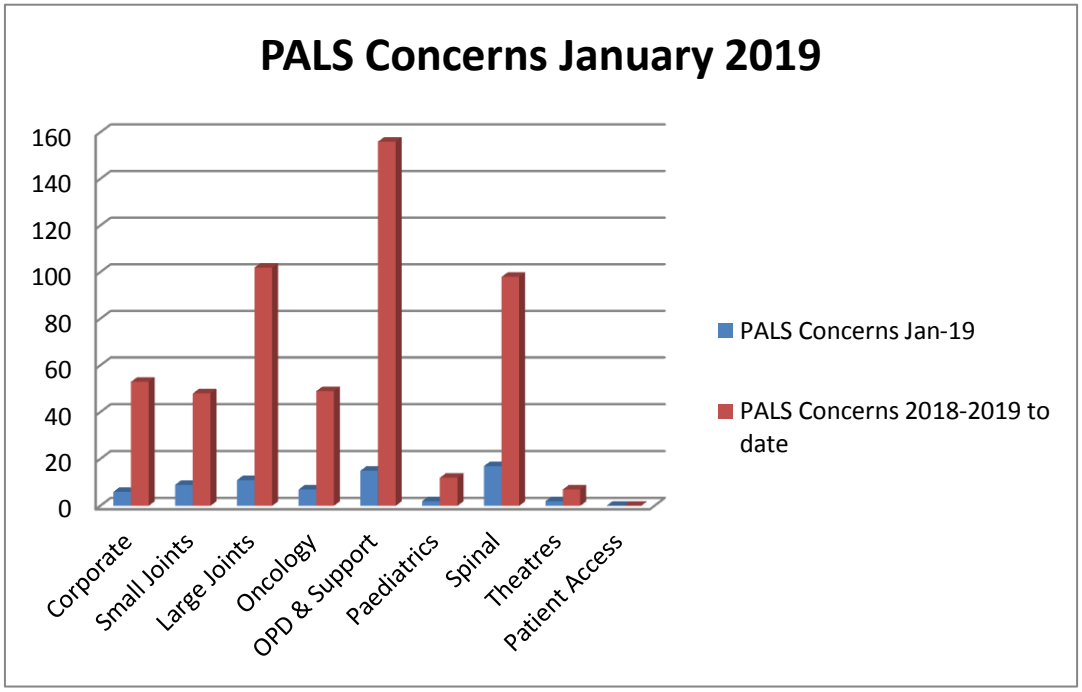
9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



INFORMATION

PALS

The PALS department handled 111 contacts during January 2019 of which 69 classified as concerns. This is a significant reduction in calls compared to the same time last year (420 contacts in January 2018) and a reduction in the level of concerns (83 concerns in January 2018). The main themes in the PALS data relate to queries about appointments; either length of wait for or cancellations. 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. 95% of enquires and 87% of concerns were handled within the agreed timescales, meeting this internal KPI



Compliments

There were 313 compliments recorded in January 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments January 2019
Div. 1	270
Div. 2	42
Corporate	1

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 receive a request monthly to submit their compliments for central logging.

Complaints

There were 14 formal complaints made in January 2019, bringing the total number of complaint to 118 for the year to date. All were initially risk rated amber or yellow. This is less than last year (16 complaints in January 2018)

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

- Care on Ward - developed pressure sore at home (Div.1, Large Joints)
- Duty of candour not followed; catheter pulled out (Div.2, HDU)
- Delays to planned surgery (Div.1, Large Joints)
- Repeated cancellation of appointments (Div.1, Patient Access)
- Delay in surgery (Div.1, Spinal)

Initially Risk Rated Yellow:

- Unhappy with clinical decision (Div.2, Pain Management)
- Unhappy with consultation; staff attitude (Div.2, MSK)
- Unhappy with progression of treatment (Div.1, Oncology)
- Unhappy with treatment (Div.1, Large Joints)
- Care under podiatry/orthotics/ heel pain (Div.2, Podiatry)
- Approach of Consultant; treatment plan (Div.1, Spinal)
- Infection following partial knee replacement (Div.1, Large Joints)
- Outcome of bunion surgery (Div.1, Small Joints)
- Wait in ADCU for injection (Div.2, ADCU)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 13 complaints closed in January 2019, 12 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 January 2019 was 30 days, which is within normal limits.

Learning identified and actions taken as a result of complaints closed in January 2019 include:

- Trust did not have a SOP for the management of wound drains
  Action: SOP created and is currently being approved

- Number of issues identified on one ward requiring improvement
  Action: Ward action plan created, being monitored by the Matron and Head of Nursing

- Frist floor outpatient reception not open causes confusion for patients when told to report there
  Action: Recruitment underway; information updated

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS
1 comeback received in January 2019. • Patient does not accept clinical view as being correct. Has asked for further review (Div.1, Large Joints)

10. 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 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 agreed internal targets for all areas and as a result, the data is 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 requested 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 recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In January 2019, 17 concerns were identified from the 1553 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 main areas of concern in January 2019 related to Clinical Treatment and Values & Behaviour of Staff. Information is 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 of 20% for Outpatient services was met this month. 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 Jan 2019**	**% of people who would NOT recommend the department in Jan 2019**	**Number of Reviews submitted in Jan 2019 (previous month in brackets)**	**Number of Individuals who used the Department in Jan 2019**	**Department Completion Rate (Mandated at 35%)**
Ward 1	95.0%	1.4%	60 (73)	142	42.3%
Ward 2	98.4%	0.0%	64 (65)	130	49.2%
Ward 3	97.1%	5.9%	35 (17)	73	47.9%
Ward 12	93.9%	0.0%	33(25)	66	50.0%
Ward 11 (CYP)	100.0%	0.0%	17(60)	76	22.4%
ADCU	97.5%	0.0%	159(148)	557	28.5%
HDU	95.0%	0.0%	20(22)	88	22.7%
CYP HDU	100.0%	0.0%	2 (2)	10	20.0%
Overall Trust Inpatient Response Rate for January 2019					36.7%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Jan 2019**	**% of people who would NOT recommend the department in Jan 2019**	**Number of Reviews submitted in Jan 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.6%	0.8%	1141 (879)	21.7%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Jan 2019**	**% of people who would NOT recommend the department in Jan 2019**	**Number of Reviews submitted in Jan 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	95.5%	4.5%	22 (39)	14.6%

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 January - 31 January

Your average score for all questions this period

1 2 3 4 5 **4.89**

Reviews this period

1553

Your recommend scores

5 Star Score

4.85

% Likely to recommend

95.9%

% Unlikely to recommend

0.6%

11. Duty of Candour – *The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.*

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. Litigation

New Claims

No new claims against the Trust were received in January 2019

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*

3 new requests for Pre-Application Disclosure of medical records were received in January 2019.

*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 were no Inquest held

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; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases =815 The total WHO compliance for Theatres January 2019 **= 100%** **CT area** Total cases = 94 The total WHO compliance for CT area January 2019 **= 100%** **ADCU** The total WHO compliance for ADCU area for January 2019 = **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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in January 2019 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	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

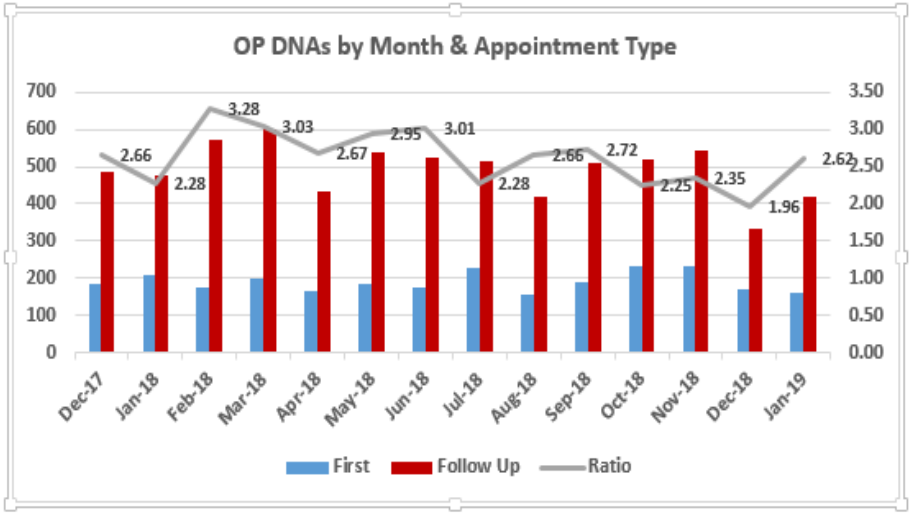
11 IP recorded incidents in January, 2019 (8 no harm, 3 low harm – all either under review or closed).

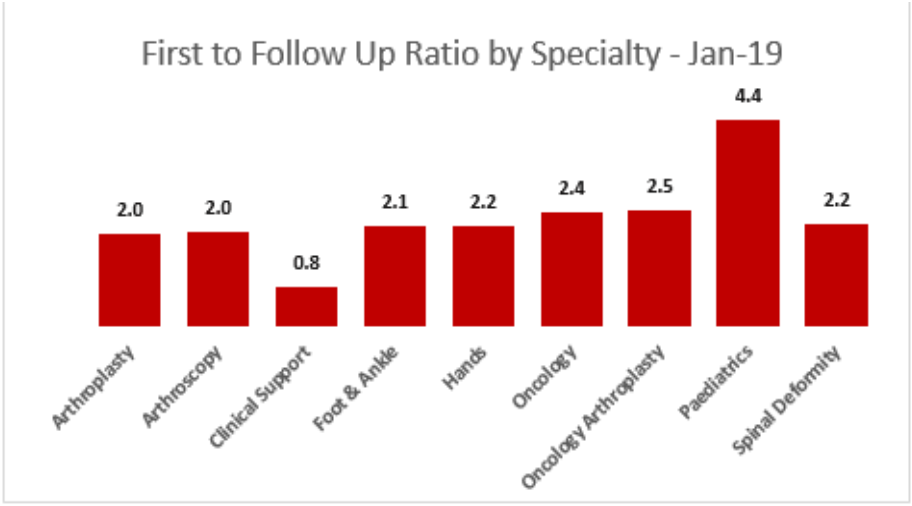
RISKS / ISSUES

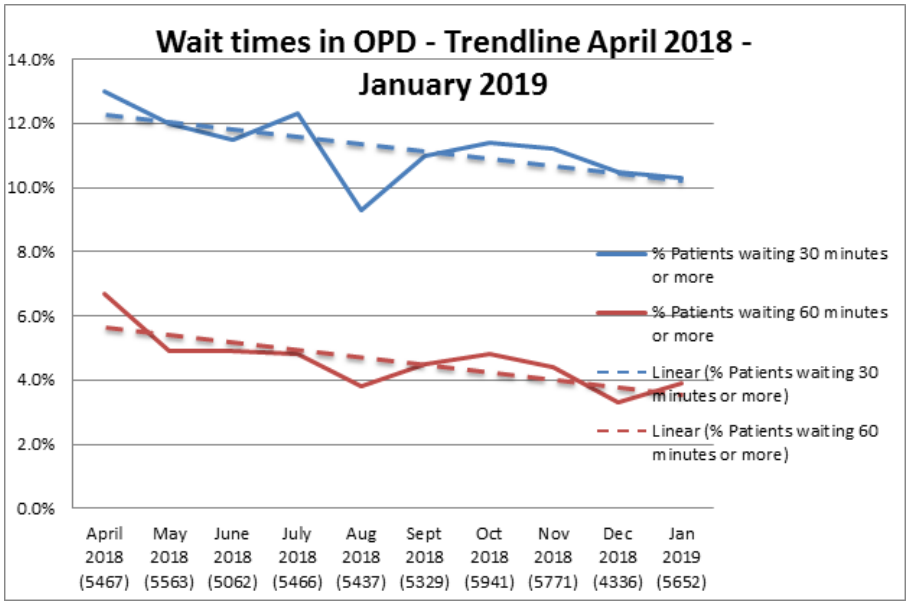
ROH is presently awaiting a position statement from Occupational Health regarding the re-calling of staff for Hepatitis B vaccinations. This is being lead by HR who manage the agreed service for ROH.

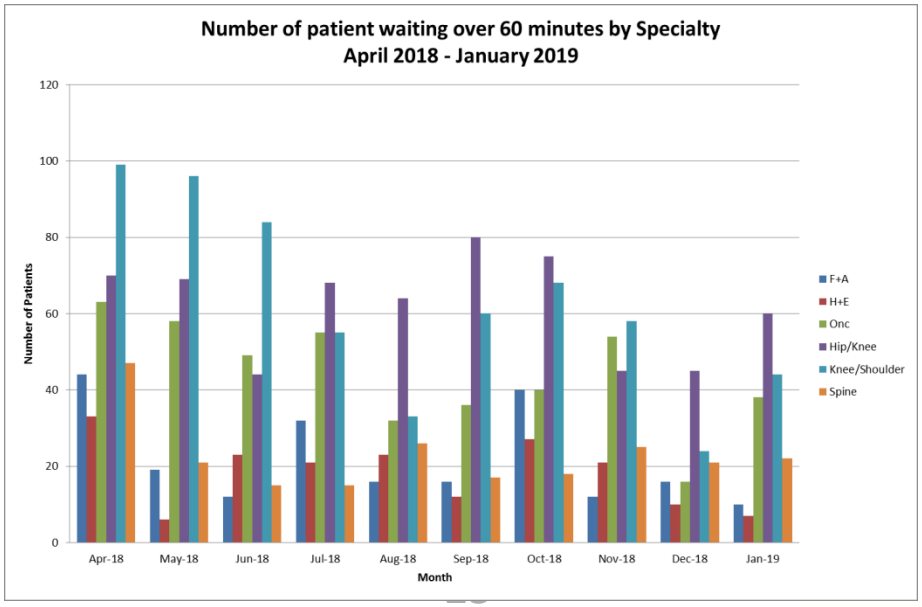
SSI Surveillance HCA on maternity leave. Interim appointed to backfill for 12/12 however, Q4 SSI data will not be submitted due to absence in this role. This does not pose a risk to ROH as required annual data has been submitted.

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









RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

INFORMATION

In January there were 10.3% of patients waiting over 30 minutes which is a slight improvement on last month, however the target for 30 minute delays has still not been achieved , focussed work is ongoing to continue to improve this position . 3.9% of patients were waiting over 1 hour which achieves the target of below 5%.

A new 6-4-3 meeting commenced in December and is held every Wednesday and produces room allocation timetables 4 – 6 weeks ahead. This meeting is evolving and will be used to review clinics and clinic templates with the operational management team to ensure clinics are well utilised and populated appropriately, to support a reduction in delays for patients attending clinic . Radiology are due to Join this meeting from March 2019 to review communication between clinics and Radiology and optimise patient flow.

The Matron for outpatients will continue to reiterate the importance of reporting all incidents relating to clinic delays and analysing the reasons for delays to improve practice . The department is now fully recruited, both for qualified and non qualified nursing staff . The current senior nurse for outpatients is retiring in March and a replacement is already in post to enable a full handover to take place.

A number of initiatives are being developed to improve the OP experience for patients and staff and full details of these projects will be discussed with key stakeholders at the OP away day planned for March 2019. This meeting will agree the priorities for this area and support required across a range of service improvement initiatives in line with recent NHSI recommendations .

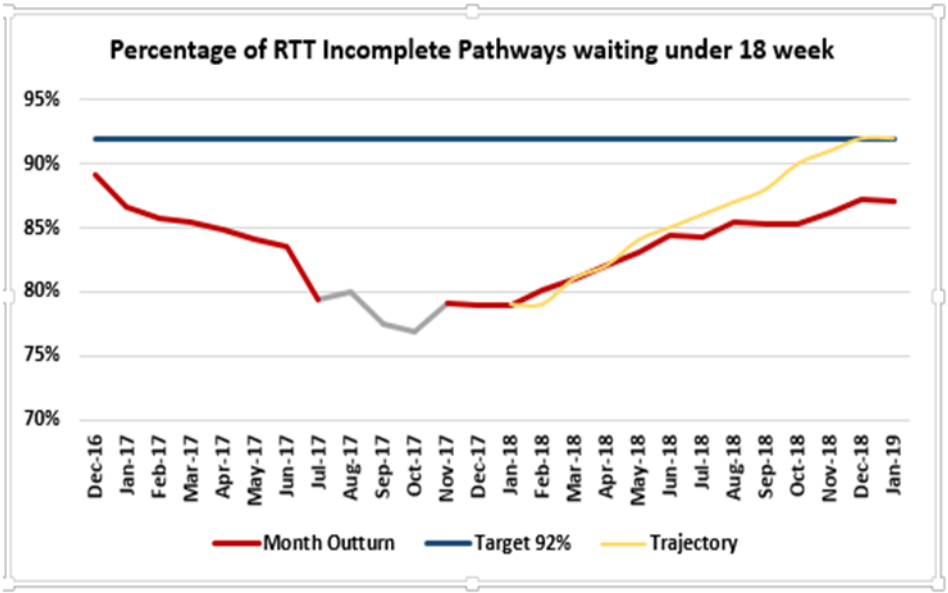
ACTIONS FOR IMPROVEMENTS / LEARNING

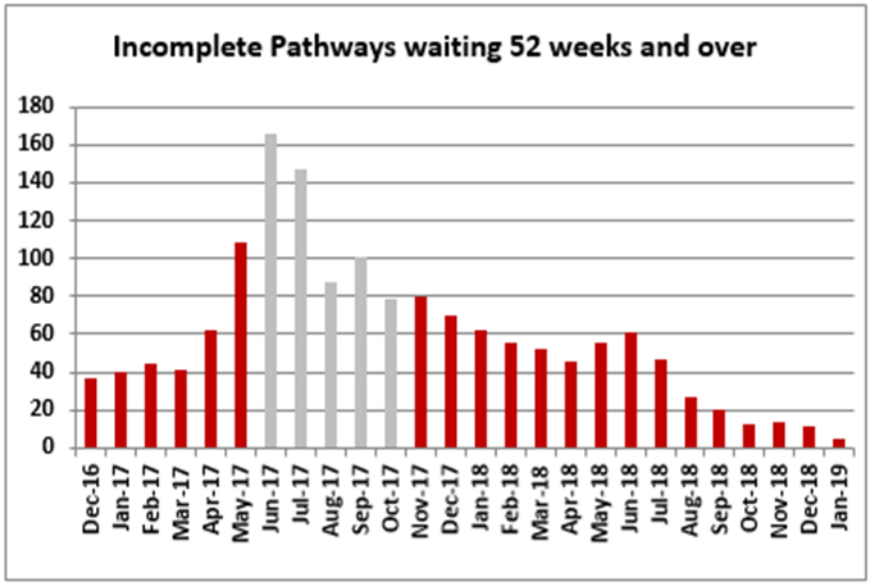
- Reiterate the importance of submitting incident forms with the staff
- Develop the 6-4-3 meeting to review problem clinics with the OPS team
- Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available
- Investigation of partial booking processes to reduce clinic rescheduling and overbooking

- Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. A visit has taken place to Heartlands Hospital to review their processes for partial booking with the intention of implementing this at the ROH. This may require additional staff resource in the appointments team which will be addressed through a business case in the next 6 months.

17. 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%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1,254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1,245	1,252	99.4%
Dec-18	698	115	346	1,159	843	224	367	1,434	11	1,148	1,159	99.1%
Jan-19	728	123	416	1,267	897	253	472	1,622	4	1,263	1267	99.7%



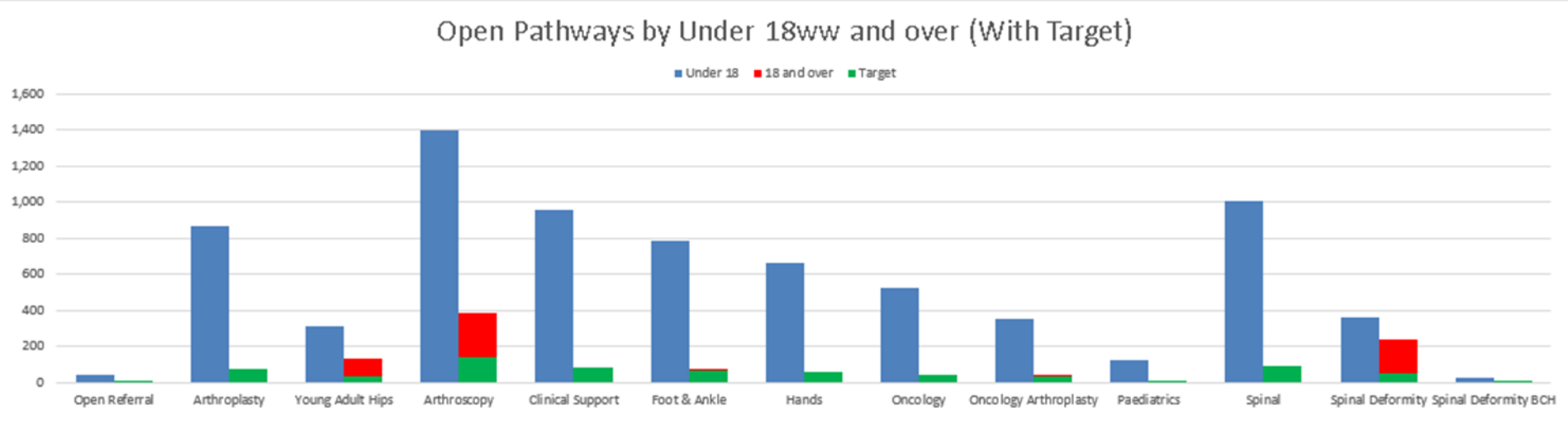


		Indicative	Reported Month									Reported Quarter 2017/18			
Target Name	National Standard	Jan-19	Dec-18	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	98.5%	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	85.7%	93.8%	100%	100%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	90.0%	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	75.0%	94.70%	90.5%	88.9%	77.8%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days			2	1		1			1						

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	**3,480**	36	400	139	638	494	344	338	277	153	57	441	156	7
7-13	**2,812**	5	349	126	523	361	311	240	155	145	56	409	120	12
14-17	**1,119**	2	117	45	236	101	131	83	93	56	12	153	86	4
18-26	**846**	1	69	75	283	49	74	40	16	29	4	75	127	4
27-39	**300**	0	6	53	102	7	3	0	7	15	0	6	96	5
40-47	**17**	0	0	2	3	1	0	0	0	1	0	1	8	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**5**	0	0	0	0	1	0	0	0	0	0	0	3	1
Total	**8,582**	44	941	440	1,785	1,014	863	701	548	399	129	1,085	599	34

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	**7,411**	43	866	310	1,397	956	786	661	525	354	125	1,003	362	23
18 and over	**1,171**	1	75	130	388	58	77	40	23	45	4	82	237	11
Target	**687**	**4**	**75**	**35**	**143**	**81**	**69**	**56**	**44**	**32**	**10**	**87**	**48**	**3**

	86.36%	**97.73%**	**92.03%**	**70.45%**	**78.26%**	**94.28%**	**91.08%**	**94.29%**	**95.80%**	**88.72%**	**96.90%**	**92.44%**	**60.43%**	**67.65%**



Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**783**	1	137	48	132	62	52	110	65	52	17	77	25	5
7-13	**885**	0	208	51	198	58	40	85	39	67	23	87	19	10
14-17	**398**	1	73	21	108	25	30	28	15	34	5	39	17	2
18-26	**401**	0	51	38	170	16	14	29	12	14	0	27	27	3
27-39	**171**	0	5	26	82	3	2	0	4	7	0	3	34	5
40-47	**9**	0	0	0	2	0	0	0	0	0	0	0	6	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
Total	**2,652**	2	474	184	692	164	138	252	135	174	45	233	133	26

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**2,066**	2	418	120	438	145	122	223	119	153	45	203	61	17
18 and over	**586**	0	56	64	254	19	16	29	16	21	0	30	72	9
Target	**212**	**0**	**38**	**15**	**55**	**13**	**11**	**20**	**11**	**14**	**4**	**19**	**11**	**2**

	77.90%	**100.00%**	**88.19%**	**65.22%**	**63.29%**	**88.41%**	**88.41%**	**88.49%**	**88.15%**	**87.93%**	**100.00%**	**87.12%**	**45.86%**	**65.38%**

Select Pathway Type: Non-Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,697**	35	263	91	506	432	292	228	212	101	40	364	131	2
7-13	**1,927**	5	141	75	325	303	271	155	116	78	33	322	101	2
14-17	**721**	1	44	24	128	76	101	55	78	22	7	114	69	2
18-26	**445**	1	18	37	113	33	60	11	4	15	4	48	100	1
27-39	**129**	0	1	27	20	4	1	0	3	8	0	3	62	0
40-47	**8**	0	0	2	1	1	0	0	0	1	0	1	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**3**	0	0	0	0	1	0	0	0	0	0	0	1	1
Total	**5,930**	42	467	256	1,093	850	725	449	413	225	84	852	466	8

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,345**	41	448	190	959	811	664	438	406	201	80	800	301	6
18 and over	**585**	1	19	66	134	39	61	11	7	24	4	52	165	2
Target	**474**	**3**	**37**	**20**	**87**	**68**	**58**	**36**	**33**	**18**	**7**	**68**	**37**	**1**

	90.13%	**97.62%**	**95.93%**	**74.22%**	**87.74%**	**95.41%**	**91.59%**	**97.55%**	**98.31%**	**89.33%**	**95.24%**	**93.90%**	**64.59%**	**75.00%**

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and predicts that the Trust will return to 92% at an aggregated level by October 2019.

January 2019 performance is 86.36%

It is expected that Oncology Arthroplasty will achieve 92% in March 2019 with Young Adult Hip in June 19 and Arthroscopy in July 19. A refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been completed and we anticipate that they will achieve the standard in Qtr. 4 19/20 . Excluding Spinal Deformity the Trust now has 9 patients waiting over 40 weeks all with treatment plans.

In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.

Detailed below is our progress with our trajectory with a revised trajectory submitted to NHSI/E (19/2/19). Work is still ongoing with the aim to clear all patients by the end of March 2019.

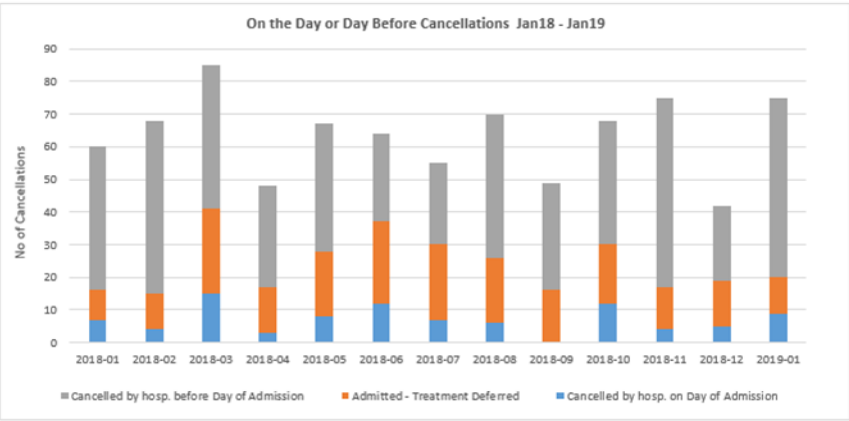
ROH 52 Week Trajectory Feb 2018

Over 52 Weeks	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
ROH Specialties excluding SD	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
ROH Adult Total	14	12	16	15	12	9	7	0	0	0	2	0	0	0	0
ROH Paediatrics Total	20	28	31	25	28	19	16	8	10	11	19	15	9	3	0
BWCH Paediatric Total	30	29	27	27	27	27	25	20	15	11	8	4	0	0	1
ROH Total	66	70	75	67	68	55	47	29	25	22	29	19	9	3	1
Actual Performance	**56**	**52**	**46**	**55**	**61**	**47**	**27**	**20**	**13**	**14**	**11**	**5**			
Revised Trajectory													3	1	2

ACTIONS FOR IMPROVEMENTS / LEARNING
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019
RISKS / ISSUES
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. 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 remains a concern.

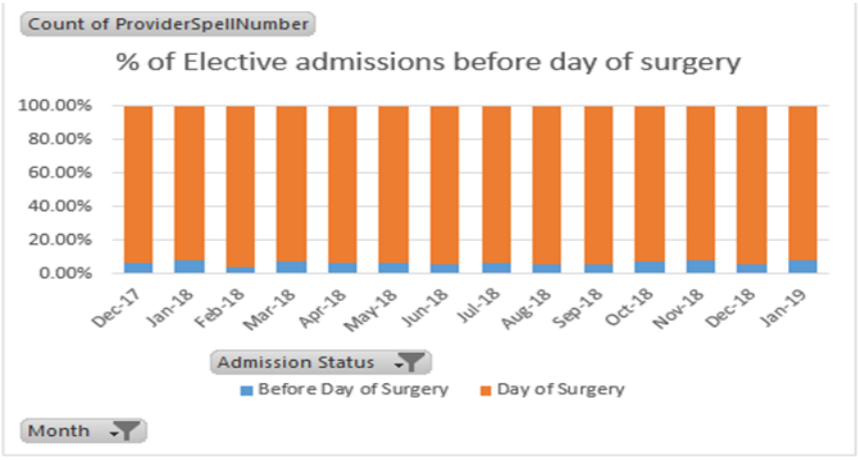
18. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

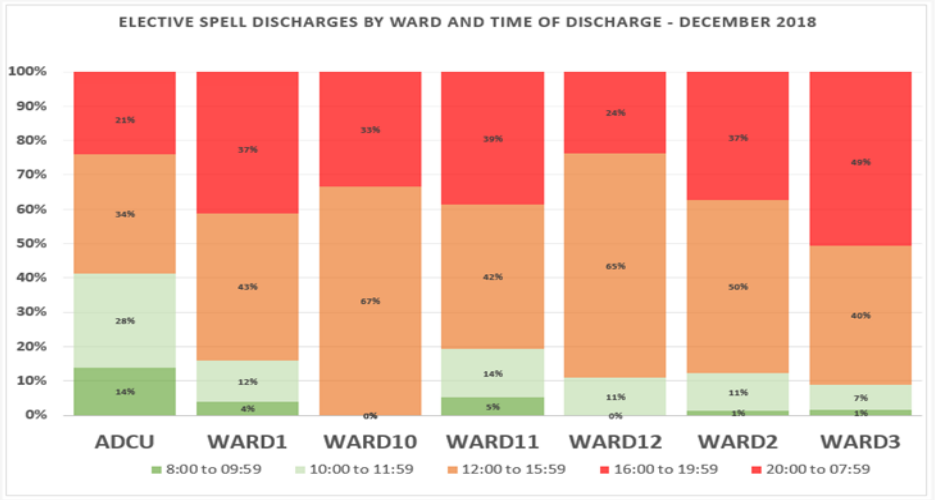
Hospital Cancellations



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
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	44	70	1
2018-09		16	33	49	0
2018-10	12	18	38	68	0
2018-11	4	13	58	75	0
2018-12	5	14	23	42	0
2019-01	9	11	55	75	0
Grand Total	92	220	514	826	2

Admission the day before surgery





INFORMATION

The number of cancellations on the day of admission for surgery in January was 9 patients, a slight increase on December. Patients admitted for surgery where treatment was deferred has reduced in month from 14 to 11. Analysis of the reasons for patients cancelled on the day prior to admissioninclude, Consultant illness and lack of theatre time. Patients admitted where treatment was deferred relate to equipment issues, cancellation to accommodate emergency patients and patients condition changing , where surgery is no longer required

Cancellations before the day of surgery have increased in month from 23 to 55. An analysis of the 55 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 patients declaring fitness issues on the 72 hour contact call . The increase in this number of patients is due to the robust process to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The 72 hour call process has now been strengthened and an extended hours contact service is being developed so patients can be contacted at evenings and weekends to improve compliance.

Work continues to strengthen the POAC process and a business case is being presented at DMB in February 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access.

The triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to pre – operative clinic to change the profile of triage to be delivered in the pre-operative clinic area, so that access to on the day triage can be expanded It is anticipated that the change in service will commence in April 2019.

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 :

- POAC representative now attends daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Improved links with Clinical team to support any clinical concerns raised during patient contact

RISKS / ISSUES
Existing ageing equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools have been purchased and full delivery of all items is expected by the end of March 2019. The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Influenza vaccination update**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Julie Gardner, Assistant Director of Finance (Contracting)**
DATE OF MEETING:	**6 March 2019**

EXECUTIVE SUMMARY:

A letter was issued to all Chief Executives in February from NHS Improvement, reminding them of the requirement to make public the organisation's position in terms of take up of the 'flu vaccination and the reasons, if any, staff had cited for not being inoculated. This letter is attached as ROHTB (3/19) 007 (b).

The attached report provides this update and is constructed according to the suggested format provided by NHS Improvement.

The CQUIN target for 2018/19 for vaccination of frontline staff is 75%.

The current position for vaccination of frontline staff is 58.07%

REPORT RECOMMENDATION:

The Board is asked to accept 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		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:

With safe, efficient processes that are patient centred

PREVIOUS CONSIDERATION:

Last considered as part of the Trust Board public agenda in November 2018.

The Royal Orthopaedic Hospital NHS Foundation Trust

Flu Vaccinations for Front Line Clinical Staff

2018-19 CQUIN Update

1 EXECUTIVE SUMMARY

1.1 The CQUIN target for 2018/19 for vaccination of frontline staff is **75%.**

1.2 The current position for vaccination of frontline staff is **58.07%.**

2 CQUIN Requirements

2.1 The 2 year CQUIN specification was issued as part of the national contract in 2017/18. The year one requirements included achieving an uptake of flu vaccinations by frontline clinical staff of 70% with this target rising to 75% in year two.

2.2 The rules for achievement in year two are –

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
<50%	No Payment
50% up to 59.99%	25% payment
60% up to 64.99%	50% payment
65% up to 74.99%	75% payment
70% or above	100% payment

3 The Royal Orthopaedic Hospital (ROH) Flu Vaccination March 19 Update

3.1 During the 2017/18 year one CQUIN ROH achieved 70.21% which resulted in the maximum award available.

3.2 The 2018/19 year two campaign started 1st October 2018 and finished on 28th February 2019. The current overall Trust vaccination percentage is 53.55% with the vaccination percentage for frontline staff higher at 58.07%. Various activities have taken place through the campaign which include –

- Monthly Flu Vaccination Group established including Infection Control, Human Resources, Finance and Communications to monitor progress

- A range of communication campaigns
- Increased access and availability of staff qualified to administer the vaccination

3.3 The guidance for the CQUIN is very explicit in explaining staff groups and inclusion and exemptions criteria. The Trust is confident that any employees that have been away from work between the flu campaign dates have been removed from the full staff list i.e. staff who are sick or on maternity leave.

3.4 A high number of forms have been received by employees declaring that they do not want to have the vaccination. 73 forms have been received but unfortunately the form is anonymous and it is unclear if these are forms from frontline staff or infrastructure support; some staff have listed more than one reason for rejecting the flu vaccination as see in the table below.

3.5 ROH Staff have been generally less willing to have the vaccination and while the flu vaccination team have been able to persuade a number of staff it has been a struggle.

Reasons for rejecting the offer of a flu vaccination

Reason for rejecting the offer of a flu vaccination	Number of reasons given
Concerned about side effects	20
I do not like needles	17
I was ill last time	6
No reason	5
Allergic	8
I don't believe the research	22
I don't think I will get flu	3
I do not want it in my body	1
I don't want it	1
I don't know where to get vaccinated	1
My immune system is stronger without it	1
Never had flu	1
Personal Choice	1
It is poison	1

3.6 The following tables detail percentage breakdowns to understand the current position.

Trust Wide Vaccinations (as of) 21st March 2019

Staff Groups	Count of Staff	Number of Staff Vaccinated	Percentage of staff group vaccinated
All Doctors	134	59	44.03%
All other professionally qualified clinical staff	145	85	58.62%
Support to Clinical Staff	310	190	61.29%
NHS Infrastructure Support	265	103	38.87%
Qualified Nurses	272	166	61.03%
Grand Total	**1128**	**603**	**53.46%**

Frontline Staff Vaccinations (as of) 21st March 2019

Staff Groups	Count of Staff	Number of Staff Vaccinated	Percentage of staff group vaccinated
All Doctors	134	59	44.03%
All other professionally qualified clinical staff	145	85	58.62%
Support to Clinical Staff	310	190	61.29%
Qualified Nurses	272	166	61.03%
Grand Total	**861**	**500**	**58.07%**

3.7 There are considerable differences across the Trust in relation to the take up of flu vaccinations. The following tables show the department/division and percentage of staff that have received the vaccination.

Corporate flu vaccination February 2019 update

Area of work	Percentage of staff vaccinated
Bank Directorate	**100.00%**
Board Directorate	**55.56%**
Corporate Directorate	**56.88%**
Communications Department	40.00%
CSU Management	60.00%
Education and Training Department	50.00%
EPMA Department	0.00%
Finance Department	47.62%
Governance Department	55.56%
GP Trainee	100.00%
Human Resources Department	41.94%
IM&T Department	73.08%
IPC	100.00%
Knowledge Management Department	44.44%
Management Offices	72.73%
Nursing Administration Corporate	50.00%
Research and Development	71.43%
Security	100.00%

Division 1 – Patient Services – February update

Area of work	Percentage of staff vaccinated
Division 1 - Patient Services	**47.44%**
Clinical Admin	**40.00%**
Appointments	35.71%
Medical Records	26.67%
Patient Access	66.67%
RTT	100.00%
Division 1 Management Dept	**30.77%**
Division 1 Management	30.77%
Large Joint	**51.38%**
Large Joints Junior Medical Staff	30.00%

Senior Medical Staff	25.00%
Large Joint Admin	35.71%
Ward 12	57.14%
Ward 2	68.18%
Discharge Lounge	100.00%
Large Joints Admin	57.14%
303 Oncology	**45.16%**
Oncology Junior Medical Staff	50.00%
Senior Medical Staff	44.44%
Oncology Admin	23.08%
Ward 3 - Oncology	60.87%
MacMillan Nurses	30.00%
Outpatients	**58.06%**
Junior Medical & Physicians	100.00%
ROCS	61.54%
Outpatients	52.94%
Paediatrics	**55.81%**
Paediatrics Junior Medical Staff	33.33%
Senior Medical Staff	0.00%
Paediatric Admin	25.00%
Paediatrics Outpatients	40.00%
Paediatrics Spinal Deformity	100.00%
Ward 11 Childrens	68.00%
Small Joint	**29.41%**
Senior Medical Staff	40.00%
Small Joints Junior Medical Staff	40.00%
Small Joint Admin	14.29%
Spinal Surgery	**43.33%**
Senior Medical Staff	42.86%
Spinal Junior Medical Staff	80.00%
Spinal Admin	33.33%
Ward 1	40.63%

Division 2 – Patient Support – February Update

Area of work	Percentage of staff vaccinated
Division 2 - Patient Support	**50.23%**
Histopathology	**15.00%**
Histopathology Junior Medical Staff	0.00%
Histopathology Medical Staff	0.00%
Haematology Team	33.33%
Histopathology	15.38%
Paediatrics	**100.00%**
paediatrics	100.00%
Patient Support Admin	**40.00%**
Clinical Support Admin	40.00%
Pharmacy	**35.29%**
Pharmacy	35.29%
Pre Admission Screening (POAC)	**60.00%**
Radiography	**62.79%**
Junior Medical Staff	0.00%
Senior Medical Staff	0.00%
MRI	77.78%

Radiology Administration	66.67%
Radiology Department	70.59%
Ultrasound	66.67%
Small Joint	**100.00%**
Small Joints Junior Medical Staff	100.00%
Theatres, Anaesthetics and Critical Care	**48.00%**
Anaesthetic Medical Staff	37.84%
TACC Physician Medical Staff	100.00%
Critical Care Service	100.00%
HDU	57.14%
Decontamination Unit	0.00%
TACC Directorate Admin	75.00%
Theatre	35.82%
Theatres Administration	50.00%
Theatres Plaster Room	50.00%
Theatres Portering	12.50%
Theatres Recovery	31.25%
ADCU Nursing	76.92%
Theatres, Anaesthetics and Critical Care	50.00%
Therapy Services	**56.99%**
Senior Medical Staff	33.33%
Clinical Support Admin	50.00%
Pain Management	25.00%
Occupational Therapy	66.67%
Orthotics	0.00%
Physiotherapy	63.08%
Podiatry	50.00%

Division 4 – Estates and Facilities – January Update

Area of work	**Percentage of staff vaccinated**
Division 4 - Estates and Facilities	**38.26%**
Estates Department	64.29%
ROH Car Parking	100.00%
Building & Engineering Staff	50.00%
Estates	100.00%
Health and Safety	0.00%
Facilities Department	34.65%
Facilities	66.67%
Domestics	32.69%
Catering Department	16.67%
Portering General	42.11%
Linen	100.00%
Transport Services	25.00%

3.8 High risk areas such as oncology and the paediatric ward have been monitored as designated high risk areas but no staff have been redeployed for refusing the vaccination.

Julie Gardner
Assistant Director of Finance
1st March 2019

From the office of Dale Bywater
Executive Regional Managing Director – Midlands and East

Cardinal Square – 4th Floor
10 Nottingham Road
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DE1 3QT
T: 0330 123 2605
E: nhsi.enquiries@nhs.net
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14th February 2019

All Midlands & East Provider CEOs

Sent via e-mail

Dear Colleagues

Reporting HCW Flu Vaccination Information

I know that you are focused on delivering great care through winter and staff flu vaccination is an important part of that. We are once again seeing record uptake of the flu vaccine amongst frontline healthcare workers this winter.

On 7 September 2018, all NHS Trusts and NHS Foundation Trusts were asked to publicly report information on frontline healthcare worker flu vaccination via your boards by February 2019. All NHS providers should report this information, although some details regarding higher-risk areas are only required from some organisations. The purpose of this collection is to help inform next year's healthcare worker flu vaccination policy.

If you have not yet published this information and do not have board meetings in February, please send this information directly to us in February and then publish it in your next board meeting.

The relevant passage from the letter states that:

"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."

To summarise, there are four pieces of information that we are expecting you to publish. In order to help you do this, a template for reporting this information is attached.

1. Total flu vaccination uptake and opt-out numbers and rates
2. A list of areas designated higher-risk and the uptake and opt-out rates for each
3. Details of actions taken to deliver the 100% uptake ambition
4. A breakdown of the reasons that staff have given for opting-out

Please let us know whether you have already published this information and are planning to do so in your February board papers, or whether you will need to contact us to supply this information separately. If you could reply to Nick Hardwick, Head of Performance at nick.hardwick@nhs.net that would be appreciated.

Thank you very much for your help and support with this.

Yours sincerely

Dale Bywater
Executive Regional Managing Director – Midlands and East

Encs.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Infection Prevention & Control Annual Report 2017/18**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh – Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Ange Howling – Head of Infection Prevention & Control**
DATE OF MEETING:	**3 March 2019**

EXECUTIVE SUMMARY:

The Annual Infection Prevention & Control Annual Report 2017/18 is presented to the Board for information. The report has been submitted to the Commissioners and has been published on the Trust's website.

This report has been approved by the Infection Prevention & Control Committee. Also present at the Committee were; the regional Lead for Infection Prevention & Control from NHS Improvement and the Lead for Infection Prevention & Control from the Commissioners who also approved the document.

REPORT RECOMMENDATION:

The Board is asked to receive and note the Infection Prevention & Control status at the Trust for 2017/18.

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

Note and accept	Approve the recommendation	Discuss
X		

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

Financial	**X**	Environmental	X	Communications & Media	
Business and market share	**X**	Legal & Policy	X	Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments: [*elaborate on the impact suggested above*]					

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

Safe, efficient processes that are patient centred.

PREVIOUS CONSIDERATION:

Infection Prevention & Control Committee and Quality & Safety Committee.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

The Royal Orthopaedic Hospital

Director of Infection Prevention and Control Annual Report 2017/18

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Director of Infection Prevention and Control ANNUAL REPORT 2017/2018

AUTHOR	Angela Howling – Head of Infection Prevention and Control
DIRECTOR OF INFECTION PREVENTION & CONTROL	Garry Marsh – Executive Director of Patient Services
APPROVED AT	Infection Prevention & Control Committee
DATE	2018

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

CONTENTS

Introduction from the Director of Infection Prevention and Control

Infection prevention and control (IPC) is fundamental in improving the safety and quality of care provided to patients. Healthcare Associated Infection (HCAI) can cause significant harm to those infected. As a result IPC remains a key priority for the Royal Orthopaedic Hospital NHS Foundation Trust (ROH). I am proud to be able to present the Director of Infection Prevention and Control's annual report for 2017/18.

The NHS continues to experience unprecedented challenges clinically, operationally, and economically. However, our staff have sustained a culture of continuous improvement which is both patient-centered and safety-focused. Our vision is to constantly provide the highest possible standards of care across our healthcare economy.

The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using services at ROH receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. The IPC agenda has continued to be strengthened with a highly visible and flexible Infection Prevention Team, led by the Head of Infection Prevention and Control, Angela Howling. The development of our IPC nurses is in line with the national core competency framework, developed by the Infection Prevention Society and endorsed by the Department of Health (2011).

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008 (updated 2015), at the heart of this law there are two principles:
To deliver continuous improvements of care
And that it meets the need of the patient

With this in mind patient safety remains the number one priority for the Trust. Infection Prevention is one of the key elements to ensure ROH has a safe environment and practice which is reflected in the Trust's vision, values and objectives with milestones turning the vision into a reality.

Improvements in health and care are linked and the NHS and its public, private, and voluntary sector partners can only provide the best and most effective service for patients and public when we work together to achieve their objectives.

This report summarises the combined activities, commitment and hard work of the IPC Team, Board colleagues, all staff, governors and volunteers across ROH, Clinical Commissioning Groups (CCG) and Public Health England (PHE) in relation to the prevention of HCAIs.

Garry Marsh
Executive Director of Patient Services and Director of Infection Prevention and Control

COMPLIANCE CRITERIA 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

1 The Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008). The DIPC will have the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable HCAIs at all levels in the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will offer commitment to quality and patient safety, good communication and reporting channels and access to people with expert prevention and control advice.

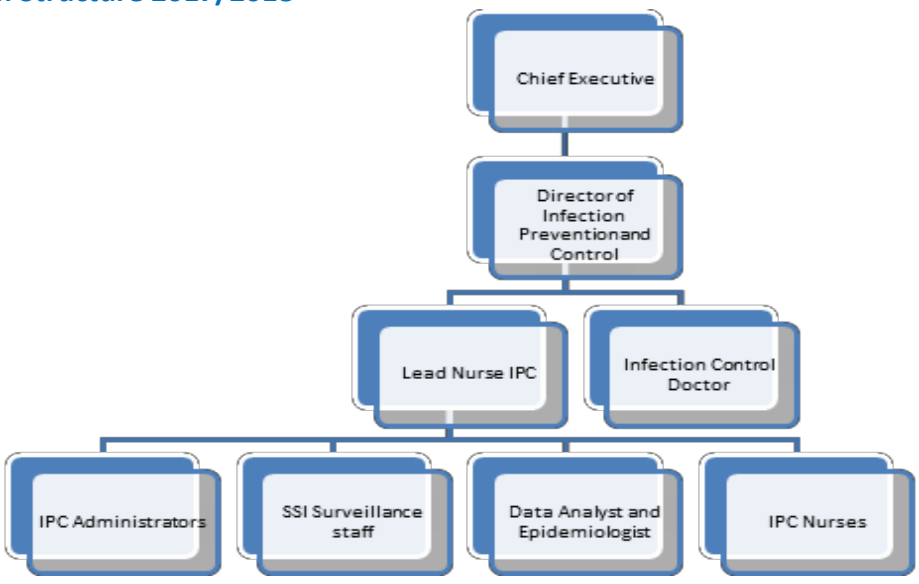
At the ROH the Executive Director of Patient Services holds the role of DIPC

2 The Infection Prevention and Control Team

The IPC Team is led by the Head of Infection prevention and Control and is supported by Infection Prevention Nurse Specialists, Surgical Site Surveillance Health Care Assistant and an Administrator. The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development, and review and service development. The Trust has 24 hour access to expert Consultant Microbiology advice and support via a Service Level Agreement (SLA) with the University Hospital Birmingham (UHB).

The DIPC has overall responsibility for the IPC team that works collaboratively alongside the front-line clinical leaders at the Trust.

IPC Team Structure 2017/2018



3 Committee Structures and Assurance Processes

3.1 Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive (CE)has overall responsibility for the control of infection at ROH. The DIPC meets with the CE regularly and attends Trust Board meetings with detailed updates on Infection Prevention and Control matters.

3.2 Quality and Safety Committee

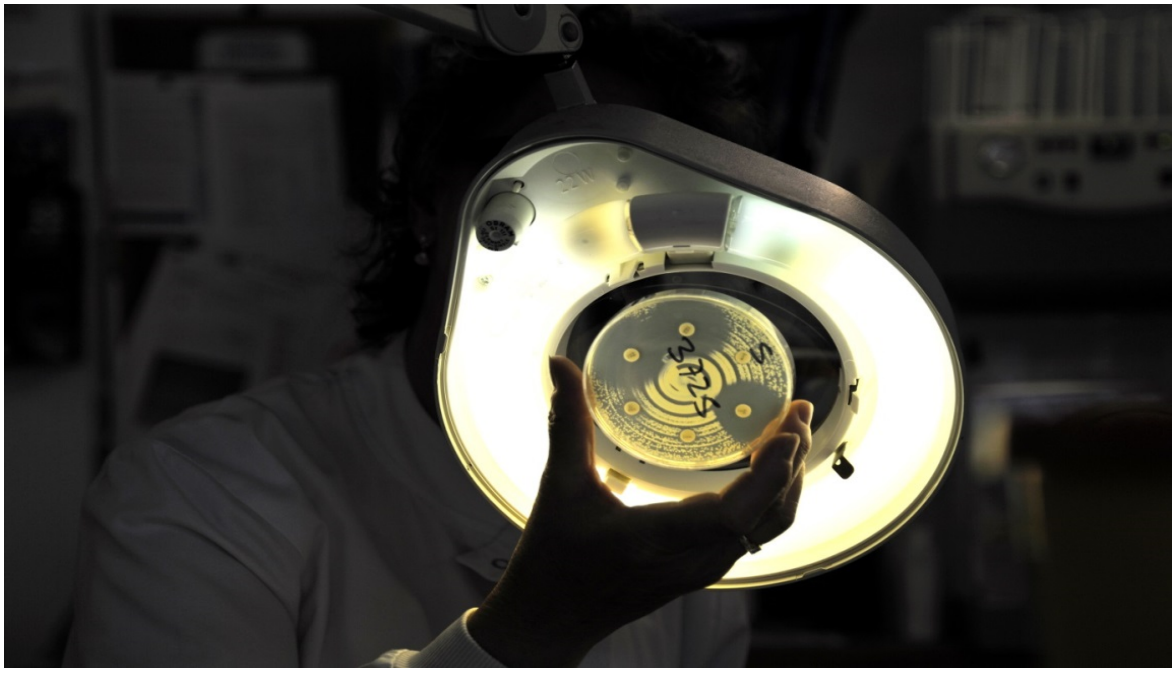
The Quality and Safety Committee (QSC), chaired by a Non - Executive Director (NED), is a sub-committee of the Trust Board which meets monthly is responsible for ensuring that there are processes for ensuring patient safety; and continuous monitoring and improvement in relation to IPC. The QSC receives assurance from the IPCC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IPC Team provide a monthly report on surveillance and outbreaks.

3.3 Infection Prevention and Control Committee

IPCC, chaired by the DIPC, provides direct assurance to the DIPC. The main objective of the IPCC is to provide a strategic drive in ensuring improved performance in relation to HCAIs.

4 Surveillance of Healthcare Associated Infection (HCAI)

4.1 METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS BLOOD STREAM INFECTIONS



Staphylococcus aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or during a medical procedure.

If the bacteria enter the body, illnesses which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves (endocarditis), pneumonia, and bacteraemia (blood stream infection).

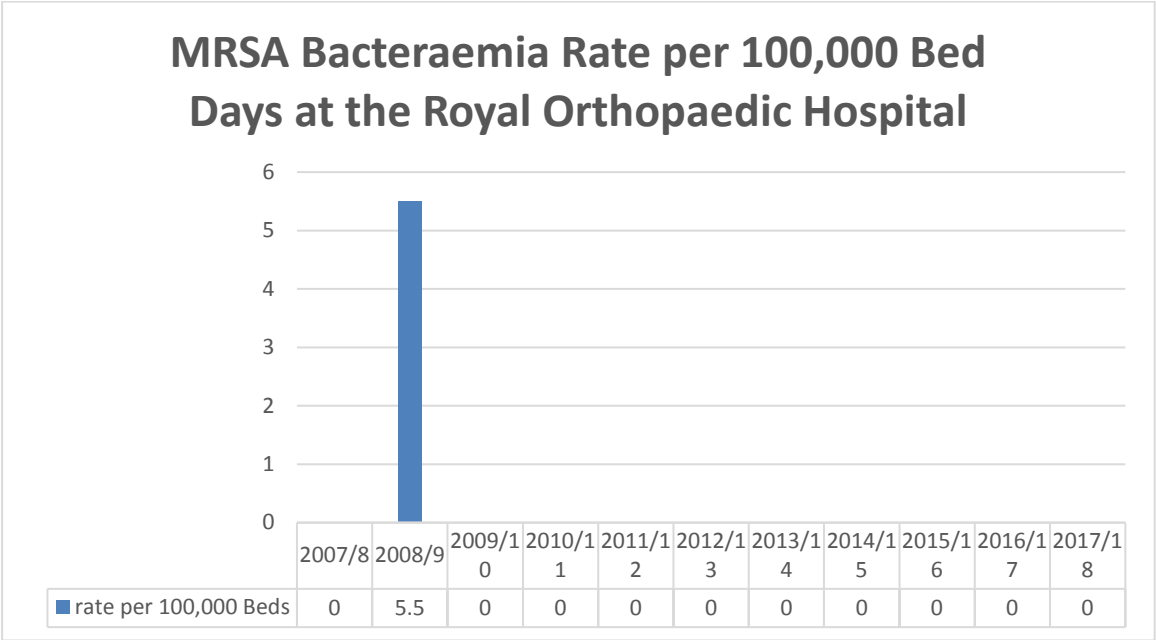
Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic meticillin are termed meticillin-resistant Staphylococcus aureus (MRSA) and often require different types of antibiotic to treat them. Those that are sensitive to meticillin are termed meticillin-susceptible Staphylococcus aureus (MSSA). MRSA and MSSA only differ in their degree of antibiotic resistance: other than that there is no real difference between them.

The Department of Health (DH) began mandatory surveillance of MRSA bloodstream infections (bacteraemia) in 2001. This includes all bloodstream infections with MRSA whether acquired in hospital or in the community and any that are considered to be a contaminant or not. Data is reported to the DH, via Public Health England (PHE) through the national HCAI database monthly.

There continues to be a national zero target for all MRSA bacteraemia, as part of this zero tolerance approach an in-depth Post Infection Review (PIR) is undertaken for all MRSA bloodstream infection cases which includes an external review, the purpose is to identify any possible lapses in care and to identify the organisation best placed to ensure improvements are made.

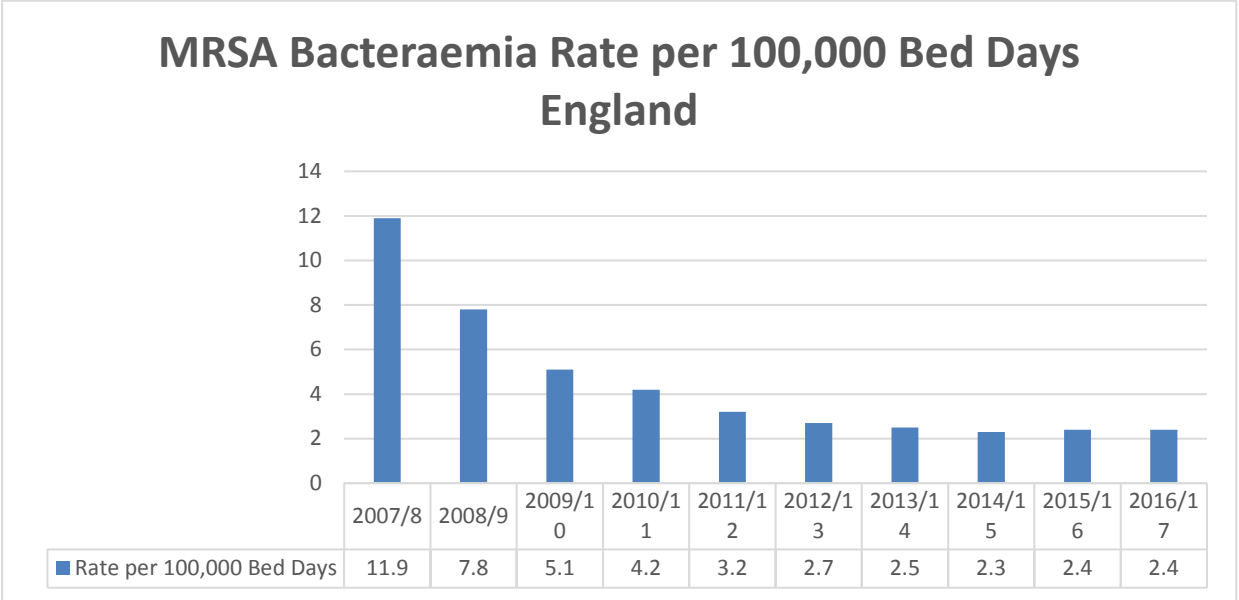
Trust apportioned cases are defined as blood culture taken “on or after the 3rd day of admission”.

For the period covered by this report there been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous year;



Source: https: //www.gov.uk/government/organisations/public-health-england

For the period covered by this report there have been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous year;



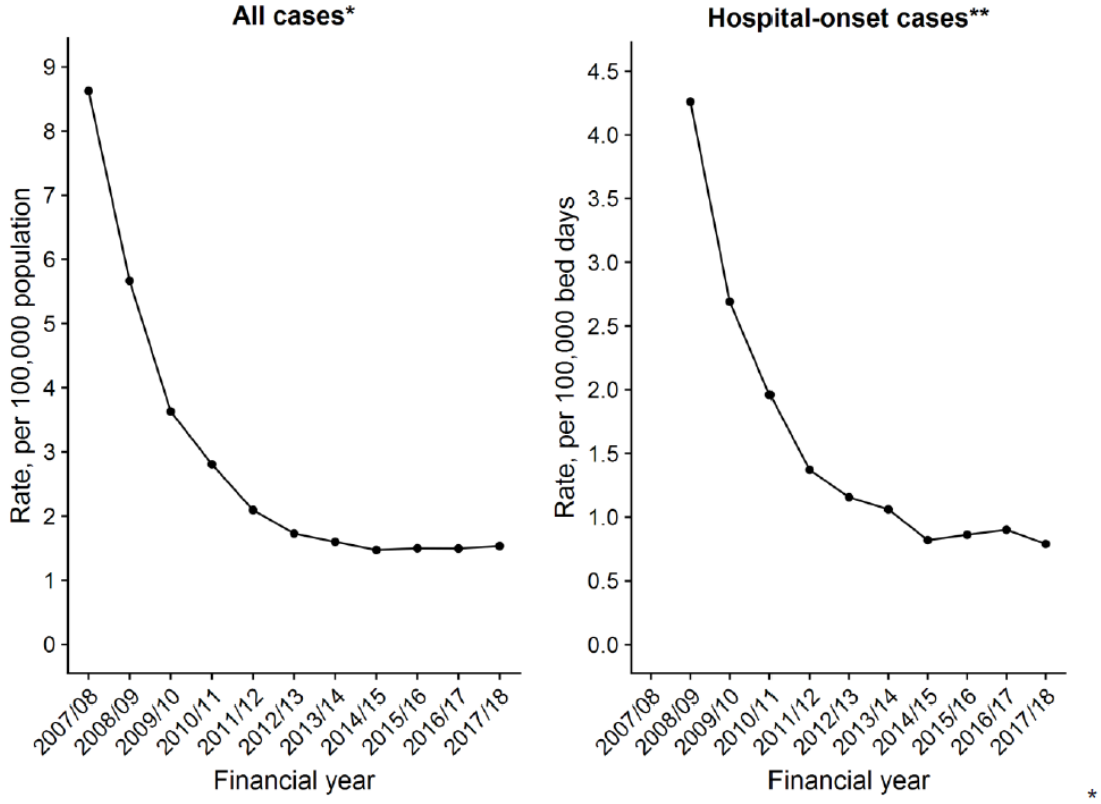
Source: https: //www.gov.uk/government/organisations/public-health-england

Since 2007/8, there has been a steady overall decrease in England.

Final Data

A total of 846 cases of MRSA bacteraemia were reported by acute NHS Trusts in England between 1 April 2017 and 31 March 2018. This is an increase of 2.5% from 2016/17 (n = 825), and a decrease of 81% from 2007/08 (n = 4,451). Figure 13 shows the trends in rates of MRSA cases for all cases and hospital-onset cases from 2007/08 to 2017/18. The rate of all MRSA cases per 100,000 populations, per year has fallen from 8.6 in 2007/08 to 1.5 in 2017/18 (Figure 13).

Figure 13: Trends in the all case and hospital-onset rate of MRSA bacteraemia in England



* Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2016/17 bed day data is an aggregate of quarters 1, 2 and 3 of 2017 and quarter 4 of 2016/17.

Although the MRSA all-case rate for the most recent year (1.5 per 100,000 population) is less than the rate in 2007/08 (8.6 per 100,000 population), it has remained relatively constant for the past 4 years.

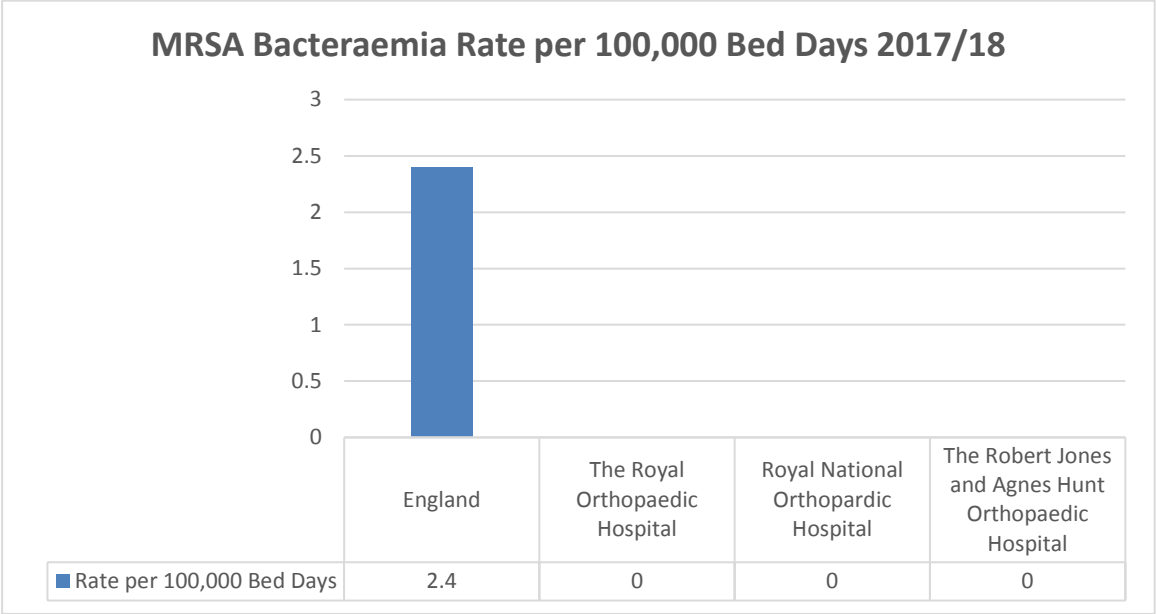
Of the 846 total cases reported in FY 2017/18, 274 were hospital-onset (0.8 per 100,000 bed-days). The rate of hospital-onset MRSA cases remained steady at 0.8 to 0.9 cases per 100,000 bed-days over the last four years (Table 15).

Table 15: MRSA counts and rates by financial year, England: 2007/08 to 2017/18*

Financial year	Mid-year population estimate	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2007/08	51,594,959	4,451	8.6	37,320,817		
2008/09	51,803,017	2,935	5.7	37,700,812	1,606	4.3
2009/10	52,306,371	1,898	3.6	37,326,212	1,004	2.7
2010/11	52,757,040	1,481	2.8	35,094,388	688	2.0
2011/12	53,312,604	1,116	2.1	34,502,306	473	1.4
2012/13	53,475,358	924	1.7	34,439,455	398	1.2
2013/14	53,976,973	862	1.6	34,327,781	364	1.1
2014/15	54,432,437	800	1.5	34,797,208	285	0.8
2015/16	55,018,884	823	1.5	34,576,351	298	0.9
2016/17	55,268,067	825	1.5	34,976,071	315	0.9
2017/18	55,268,067	846	1.5	34,708,849	274	0.8

* 2017/18 population data were not available at time of preparation and 2016/17 population data were used in place.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.



Source: https: //www.gov.uk/government/organisations/public-health-england

4.2 METICILLIN-SENSITIVE STAPHLOCOCCUS AUREUS BLOOD STREAM INFECTIONS

Meticillin-sensitive Staphylococcus aureus is a type of bacterium which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream.

Following a Secretary of State announcement on 5 October 2010, there was a mandatory requirement

for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.

MSSA blood stream infections cases continue to be monitored by ROH. Currently this data collection is part of national surveillance only. In total this year there have been zero hospital associated cases (post-48 hours after admission) reported.

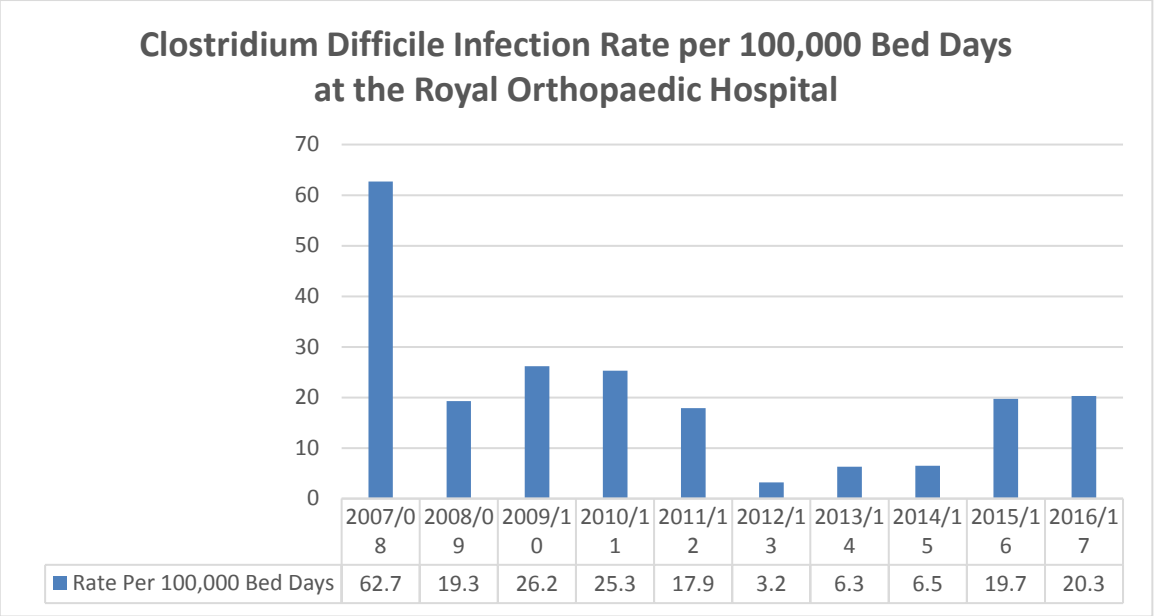
4.3 Clostridium Difficile Infection (CDI)

Up to and including 2017/18, NHS organisations have continued to be required to demonstrate year on year reductions in Clostridium difficile Infection (CDI) cases. However, as published data shows, the rate of improvement for CDI has slowed over recent years. Infection prevention and control experts from within the NHS and from Public Health England advise that this is likely to be due to a combination of factors, including the biology and epidemiology of the Clostridium difficile (CD) organism.

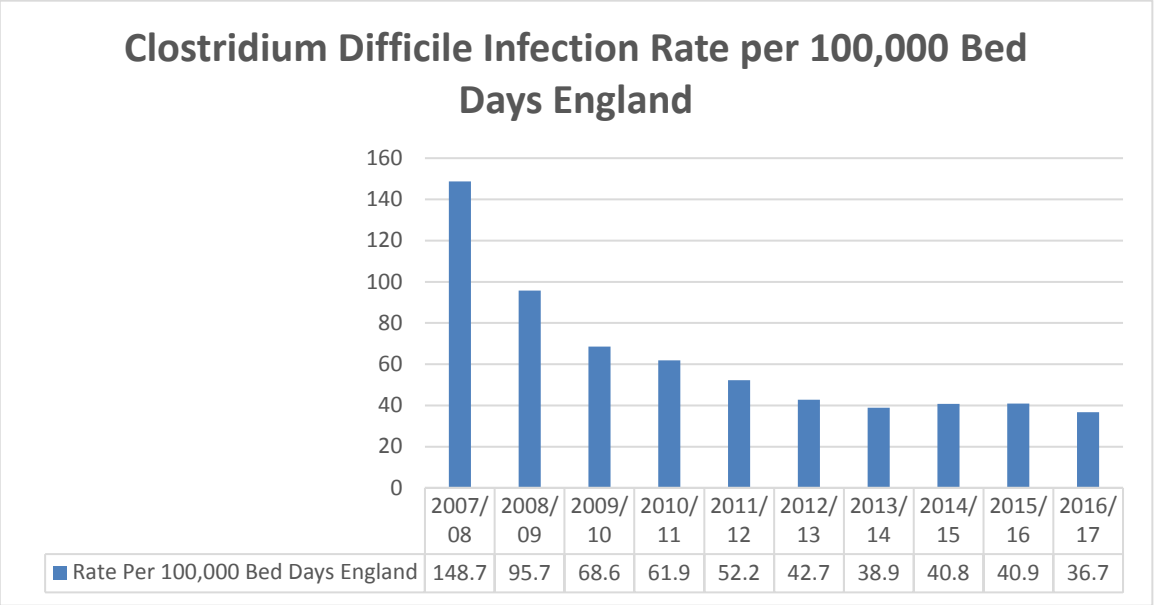
There are indications that, for some organisations at least, the level of CDIs may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided. This can occur due to the fact that some people carry CD in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. Put simply, some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

Cases of CDI that are considered to have been acquired in that the Trust are defined as sample taken "on or after 48 hours of admission".

The annual trajectory in 2017/18 for hospital-acquired cases of CDI was set at 2 cases for ROH. During The year there was 1 case identified of hospital-attributed Clostridium difficile. However, the Post infection review of the case identified that the case was unavoidable and no lapses in care were identified as part of the patient's care received at ROH. This demonstrates on improvement from the previous year which identified 4 cases all of which were deemed unavoidable.



Source: https: //www.gov.uk/government/organisations/public-health-england



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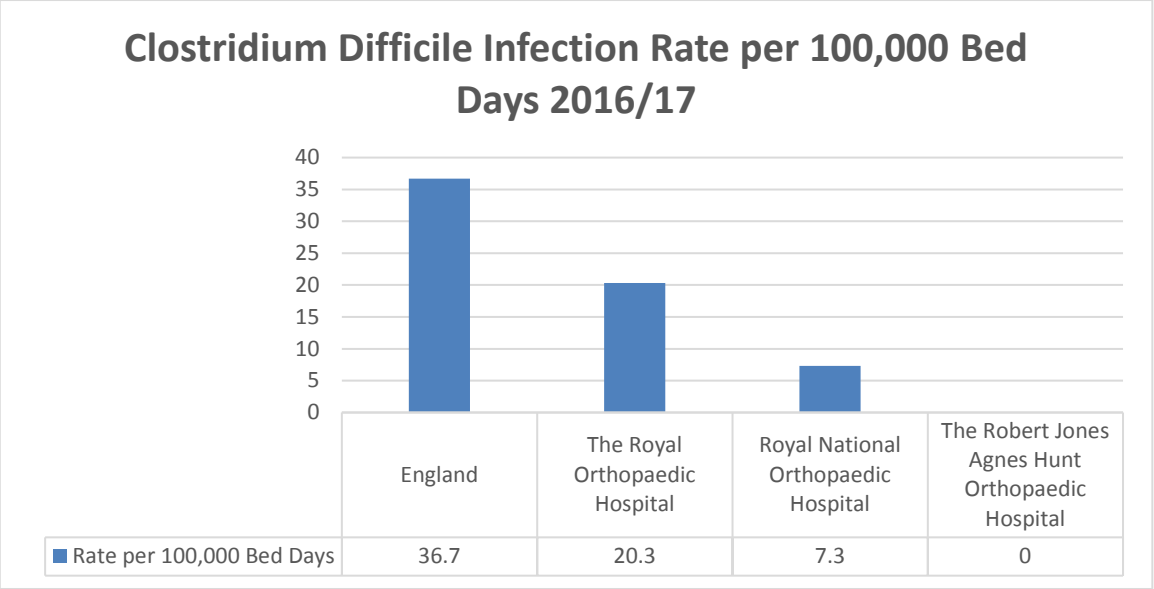


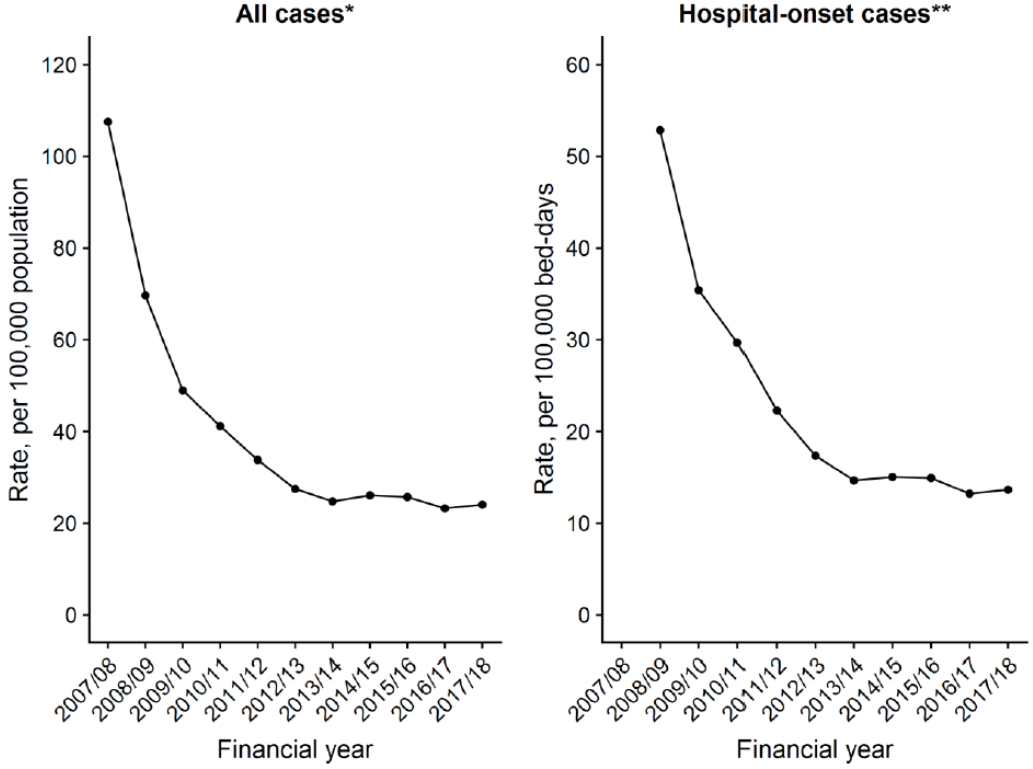
Source: https: //www.gov.uk/government/organisations/public-health-england

Final Data

Epidemiological analysis of *Clostridium difficile* Infection

A total of 13,286 cases of *Clostridium difficile* infection were reported by NHS Trusts in England between 1 April 2017 and 31 March 2018. This translates to a small increase of 3.4% from 2016/17 (n = 12,845), and a decrease of 76.1% from 2007/08 (n = 55,498). Figure 21 shows the trends in rates of CDI cases for all cases and hospital-onset cases from 2007/08 to 2016/17. The rate of all CDI cases per 100,000 populations, per year has fallen from 100.3 in 2007/08 to 24 in 2017/18.

Figure 21: Trends in the rate of *C. difficile* infection in England



* * Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.
** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017 and quarter 4 of 2016/17.

Of the 13,286 total cases reported in FY 2017/18, 4,739 were hospital-onset (13.7 per 100,000 bed-days). It should be noted that CDI cases are considered hospital-onset if they occur ≥ 4 days after admission to an acute trust, where day of admission is day 1. This is in contrast to ≥ 3 days for bacteraemia cases. The incidence rate for hospital-onset CDI cases mirrors the trends in incidence for all cases, with declining rates from 2007/08 to 2013/14 which then remained approximately stable to 2017/18. The rate of hospital-onset CDI cases increased slightly from 13.2 in 2016/17 to 13.7 in 2017/18, a change of 3.3% (Table 26).

Table 26: CDI counts and rates by financial year, England: 2007/08 to 2017/18*

Financial year	Mid-year population estimate	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2007/08	51,594,959	55,498	107.6	37,320,817	33,434	89.6
2008/09	51,803,017	36,095	69.7	37,700,812	19,927	52.9
2009/10	52,306,371	25,604	49.0	37,326,212	13,220	35.4
2010/11	52,757,040	21,707	41.1	35,094,388	10,417	29.7
2011/12	53,312,604	18,022	33.8	34,502,306	7,689	22.3
2012/13	53,475,358	14,694	27.5	34,439,455	5,980	17.4
2013/14	53,976,973	13,362	24.8	34,327,781	5,034	14.7
2014/15	54,432,437	14,193	26.1	34,797,208	5,233	15.0
2015/16	55,018,884	14,143	25.7	34,576,351	5,162	14.9
2016/17	55,268,067	12,845	23.2	34,976,071	4,622	13.2
2017/18	55,268,067	13,286	24.0	34,708,849	4,739	13.7

* Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017 and quarter 4 of 2016/17.

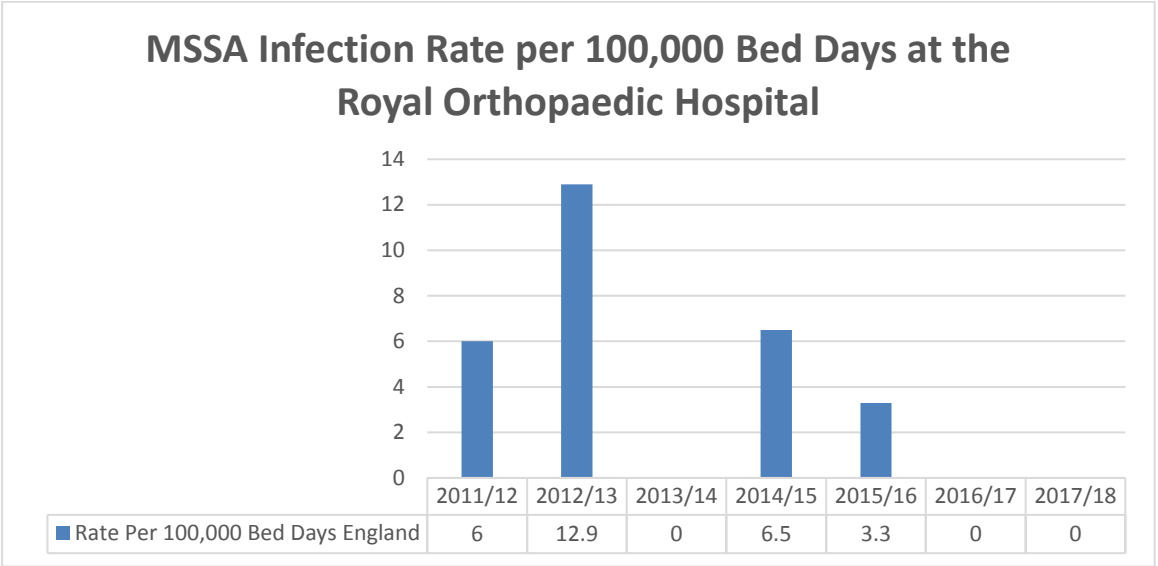
6.2.1 ROH CDI Action Plan

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (PCR positive).

All Hospital acquired CDI positive samples or cases where the patient has had a recent hospital stay at ROH are submitted to Public Health England for ribotyping. Samples with the same ribotype are then examined further variable number tandem repeat (VNTR). This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures, with decanting and deep-cleaning of the patient areas if necessary.

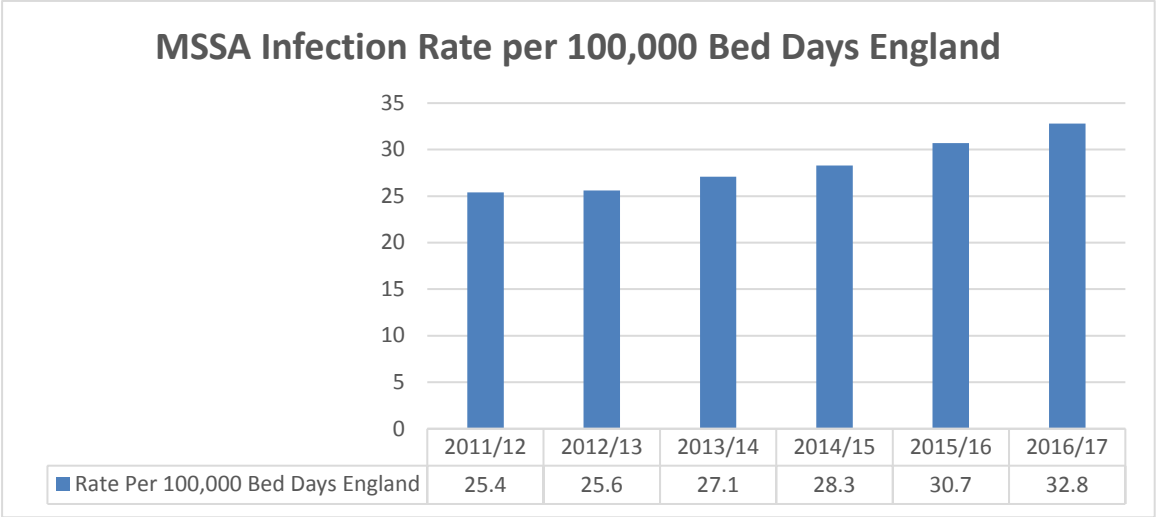
In all cases control measures are instigated immediately, and RCA's are reviewed. Each inpatient is reviewed by the IPC nurse regularly. In cases of Bone Infection Unit (BIU) patients, they form part of the weekly multi-disciplinary review where the patients' case is discussed including antibiotics and where necessary feedback to ward doctors. All HCAI CDI cases are subject to a post infection review and each case is discussed with the Lead IPC Nurse at Birmingham and Solihull Clinical Commissioning Group (BSolCCG) to determine the avoidability (lapses in care) with feedback given to IPCC and relevant Divisions. The Divisions action Duty of Candor where necessary.

ROH closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic Clostridium Difficile in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic Clostridium Difficile within a period of 28 days and associated with stay in the same ward or area.



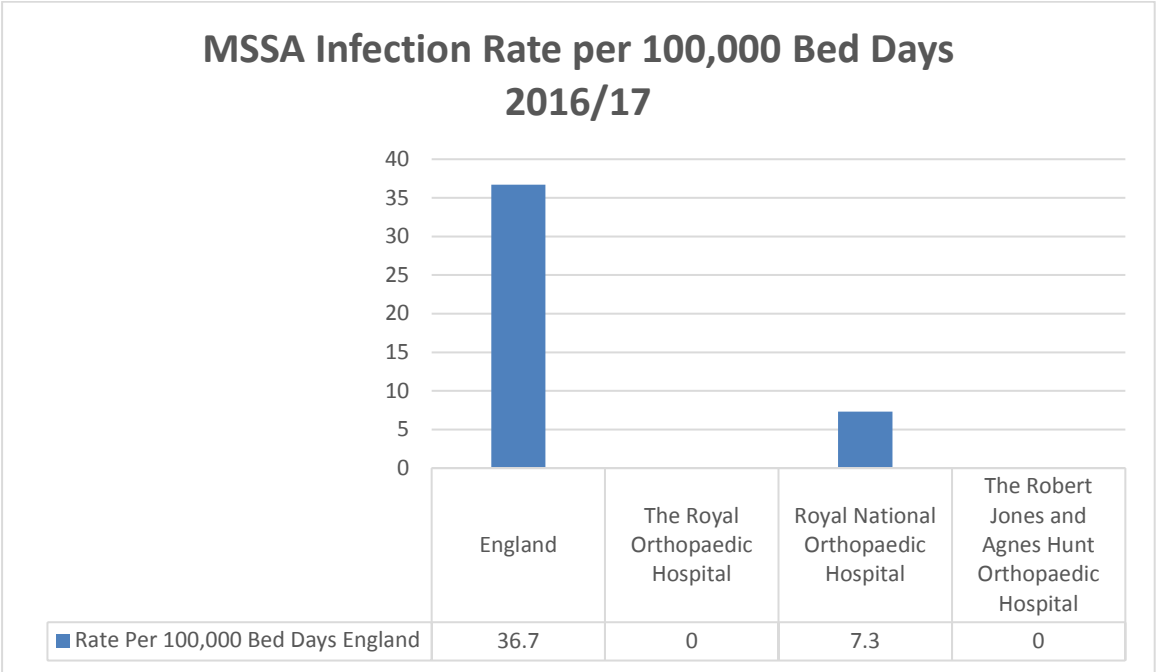
Source: https: //www.gov.uk/government/organisations/public-health-england

There has been a decrease in MSSA infection rates since 2014/15. In the period for this report there have been **zero** cases at ROH.



Source: https: //www.gov.uk/government/organisations/public-health-england

There has been an overall increase in MSSA infection rates on the whole in England.



Source: https: //www.gov.uk/government/organisations/public-health-england

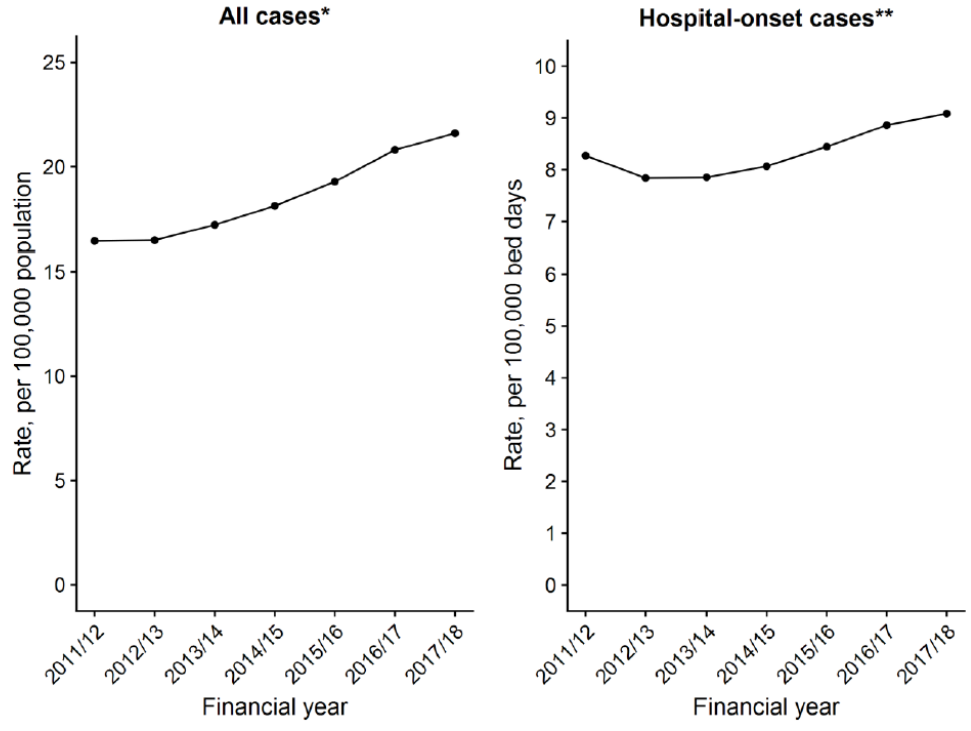
Final Data

Meticillin-susceptible *Staphylococcus aureus* bacteraemia

Total reports

A total of 11,938 cases of MSSA bacteraemia were reported by NHS acute Trusts in England between 1 April 2016 and 31 March 2018. This is an increase of 3.8% from 2016/17 (n = 11,499), and an increase of 36.2% from 2011/12 (n = 8,767). Figure 17 shows the trends in rates of MSSA cases for all cases and hospital-onset cases from 2011/12 to 2017/18. The rate of all MSSA cases per 100,000 population, per year has risen from 16.4 in 2011/12 to 21.6 in 2017/18.

Figure 17: Trends in the rate of MSSA bacteraemia in England



*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.
** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.

Hospital-onset reports

Of the 11,938 total cases reported in FY 2017/18, 3,153 were hospital-onset (9.1 per 100,000 bed-days). Similar to the all-MSSA case rate, the incidence rate for hospital-onset MSSA cases has increased steadily (from 7.8 in 2012/13 to 9.1 in 2017/18, a change of 15.9, Table 21).

Table 21: MSSA counts and rates by financial year, England: 2011/12 to 2017/18

Financial year	Mid-year population estimate	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2011/12	53,312,604	8,767	16.4	34,502,306	2,854	8.3
2012/13	53,475,358	8,812	16.5	34,439,455	2,700	7.8
2013/14	53,976,973	9,290	17.2	34,327,781	2,696	7.9
2014/15	54,432,437	9,862	18.1	34,797,208	2,807	8.1
2015/16	55,018,884	10,608	19.3	34,576,351	2,920	8.4
2016/17	55,268,067	11,499	20.8	34,976,071	3,099	8.9
2017/18	55,268,067	11,938	21.6	34,708,849	3,153	9.1

*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

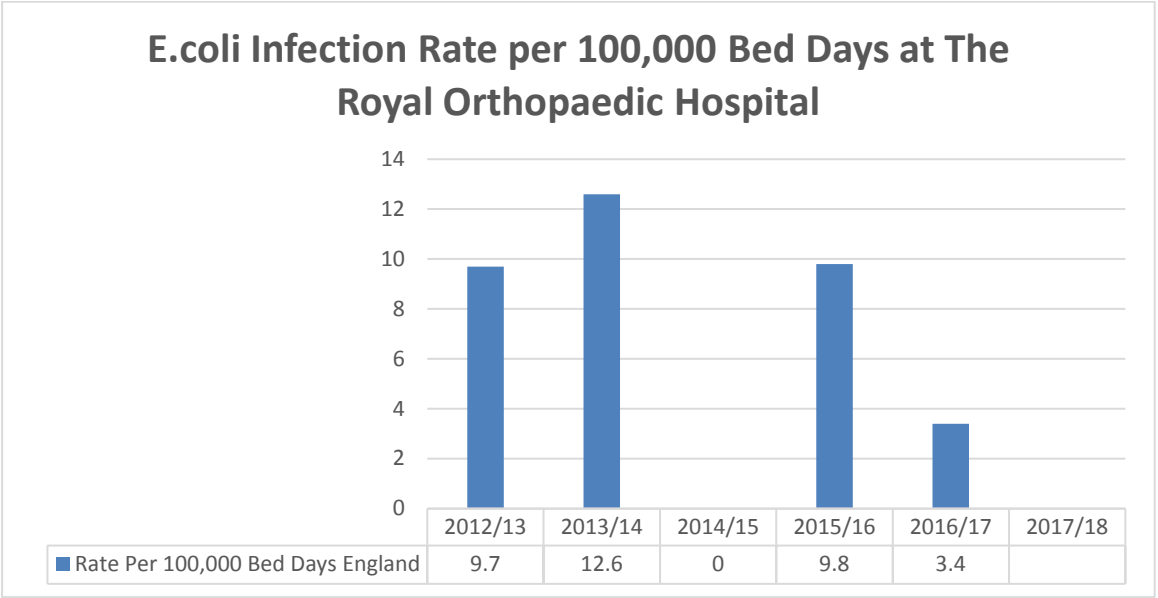
** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.

Gram negative – bloodstream infections – Escherichia coli (E-coli)

The Secretary of State for Health, (2017) launched an ambition to reduce healthcare associated Gram-negative bloodstream infections (BSIs) by 50% by 2021. Gram-negative BSIs are believed to have contributed to 5,500 NHS patient deaths in 2015. The initial focus to support this ambition is on E-coli BSI reduction. Enhanced surveillance of E. coli BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to PHE.

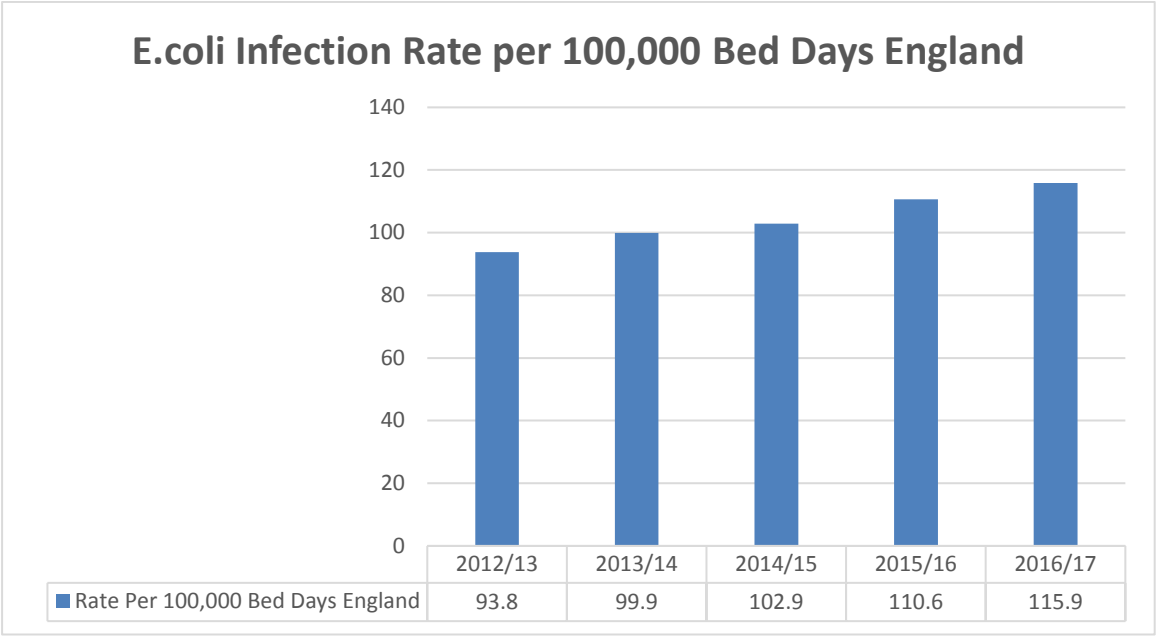
ROH have in place an action plan to support this ambition. In total this year there have been two hospital -associated cases (post-48 hours after admission).

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases.
The bacterium is found in faeces and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli BSI may be caused by primary infections spreading to the blood.



Source: https: //www.gov.uk/government/organisations/public-health-england

There has been a decrease in E.coli infection rates since 2015/16. In the period for this report there have been two cases at ROH.



Source: https: //www.gov.uk/government/organisations/public-health-england

There has been an increase in E.coli infection rates in England since 2012/13.

Final Data 2017/2018

E. coli bacteraemia

Total reports

A total of 41,060 cases of *E. coli* bacteraemia were reported by NHS Trusts in England between 1 April 2017 and 31 March 2018 (Table 1). Of the 41,060 *E. coli* cases, 7,704 (18.8%) were hospital-onset. The total number of cases reported in 2017/18 is an increase of 1.1% from 2016/17 (n = 40,630), and an increase of 27.1% from 2012/13 (n = 32,309). Figure 1 shows the trends in the rates of *E. coli* cases from 2012/13 to 2017/18. The rate of *E. coli* cases per 100,000 populations has risen from 60.4 in 2012/13 to 74.3 in 2017/18.

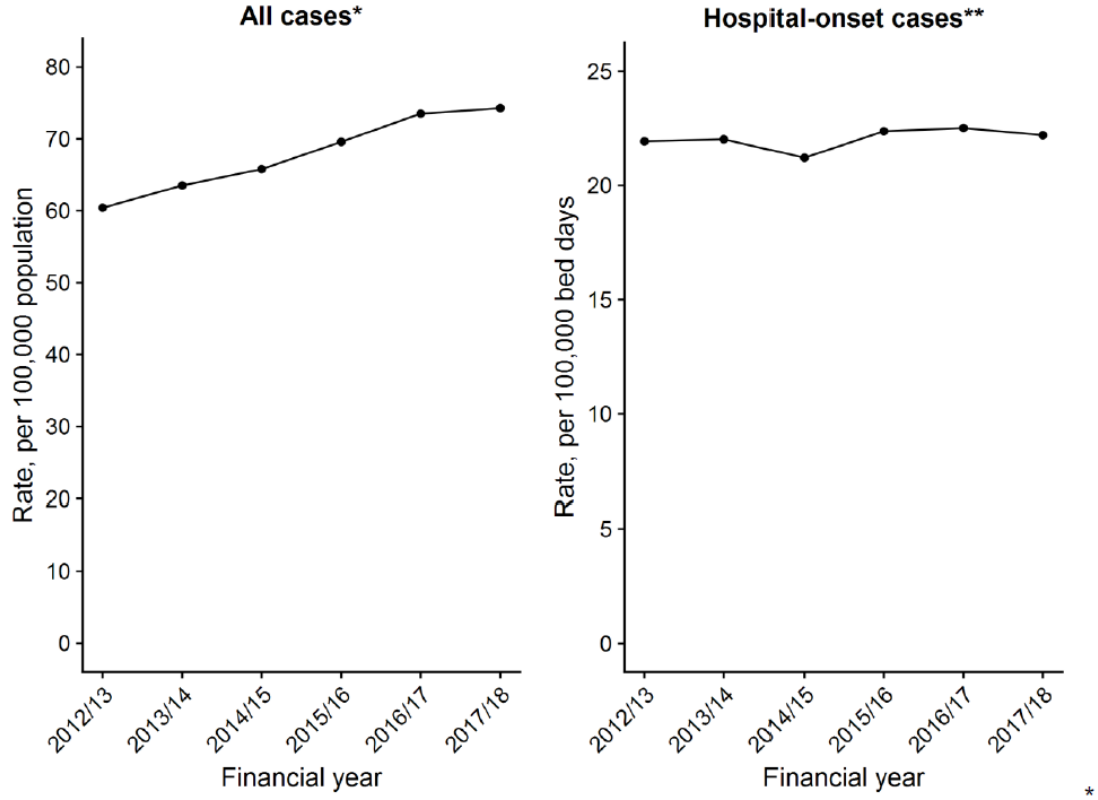
Table 1: *E. coli* counts and rates by financial year, England: 2012/13 to 2017/18

Financial year	Mid-year population estimate*	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2012/13	53,475,358	32,309	60.4	34,439,455	7,552	21.9
2013/14	53,976,973	34,286	63.5	34,327,781	7,558	22.0
2014/15	54,432,437	35,812	65.8	34,797,208	7,380	21.2
2015/16	55,018,884	38,288	69.6	34,576,351	7,735	22.4
2016/17	55,268,067	40,630	73.5	34,976,071	7,874	22.5
2017/18	55,268,067	41,060	74.3	34,708,849	7,704	22.2

*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

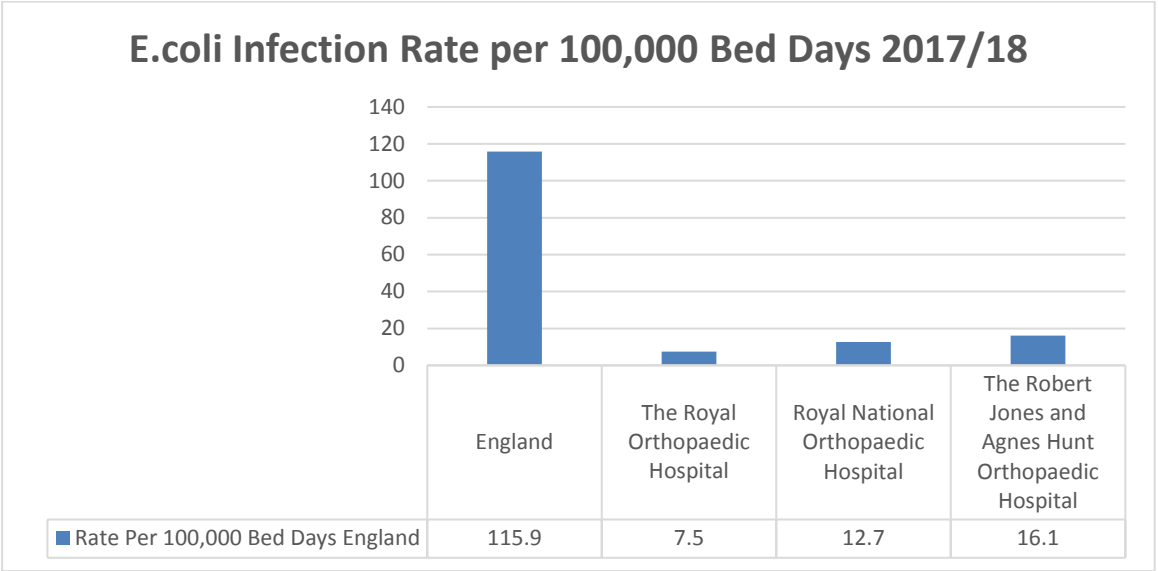
** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.

Figure 1: Trends in the rate of *E. coli* bacteraemia in England, 2012/13 to 2017/18



*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.



Source: https: //www.gov.uk/government/organisations/public-health-england

In comparison to other specialist Trusts in England, ROH had less reported cases of E.coli.

VANCOMYCIN/GLYCOPEPTIDES RESISTANT ENTEROCOCCI (VRE/GRE)

Enterococci bacteria are frequently found in the bowel of normal healthy individuals. There are many different species of enterococci, but only a few have the potential to cause infections in humans. They can cause a range of illnesses including urinary tract infections, bacteraemia, and wound infections.

Glycopeptide-resistant Enterococci (GRE) are enterococci that are resistant to glycopeptide antibiotics (vancomycin and teicoplanin). GRE are sometimes also referred to as VRE (Vancomycin-Resistant Enterococci). Infections caused by GRE mainly occur in hospital patients. However, GRE are sometimes found in the faeces of people who have never been in hospital or have not recently been given antibiotics.

The Department of Health advised that from 1 April 2013, VRE / GRE is no longer the subject of mandatory surveillance

For the period covered in this report there have been zero cases of GRE at ROH which is the same compared to the previous year.

CARBAPENEMASE PRODUCING ENTEROBATERIACEAE (CPE)

The use of many different types of antibiotics in hospitals creates evolutionary pressures that encourage the development and spread of antibiotic-resistant bacteria. This process is a natural consequence of the use of antibiotics and cannot be stopped, only managed.

Enterobacteriaceae are a group of bacteria carried in the gut of all humans and animals, which is perfectly normal. While they are usually harmless they may sometimes spread to other parts of the body such as the urinary tract or into the bloodstream (bacteraemia) where they can cause serious infections.

Public Health England published a toolkit for the early detection, management and control of CPE in December 2013. The toolkit provides expert advice on the management of CPE to prevent or reduce

spread of these bacteria into (and within) health care settings, and between health and residential care settings.

ROH adheres to the national guidance and toolkit and perform three screening episodes 48 hours apart. For the period covered in this report there have been zero cases of GRE at ROH which is the same compared to the previous year.

TUBERCULOSIS (TB)

Tuberculosis (TB) is an infection caused by a bacterium belonging to the Mycobacterium tuberculosis complex. TB is a notifiable disease in the UK. Suspected and confirmed diseases must be notified within three working days.

TB usually affects the lungs but can also affect almost any other area of the body. Most transmissions occur from some people with pulmonary or laryngeal TB and are infectious.

TB develops slowly and it usually takes several months for symptoms to appear.
ROH had zero cases of TB infection over 2017/18.

NOROVIRUS OUTBREAKS

Norovirus causes gastroenteritis and is highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another.

Outbreaks are common in semi-enclosed environments such as hospitals, nursing homes, schools, and cruise ships and can also occur in restaurants and hotels.

The virus lasts for one to two days. Symptoms include vomiting, diarrhoea, and fever. Most people make a full recovery within a couple of days but it can be dangerous for the very young, very sick, and elderly people.

ROH had zero cases of Norovirus outbreaks over 2017/18.

7 Audit programme to ensure key policies are implemented

The ROH has a programme of audits in place undertaken by both clinical areas and the IPC Team to provide assurance around practice and consistent compliance with evidence based practice and policies. Where a period if increased incidence occurs / risks are identified the IPC Team undertake additional audits in accordance with risk requirement. Action plans are devised by areas where issues are highlighted and these are managed and monitored within the divisions and escalated to IPCC and upwardly reported through the robust ROH Governance structure.

8 Audits of hand hygiene practice

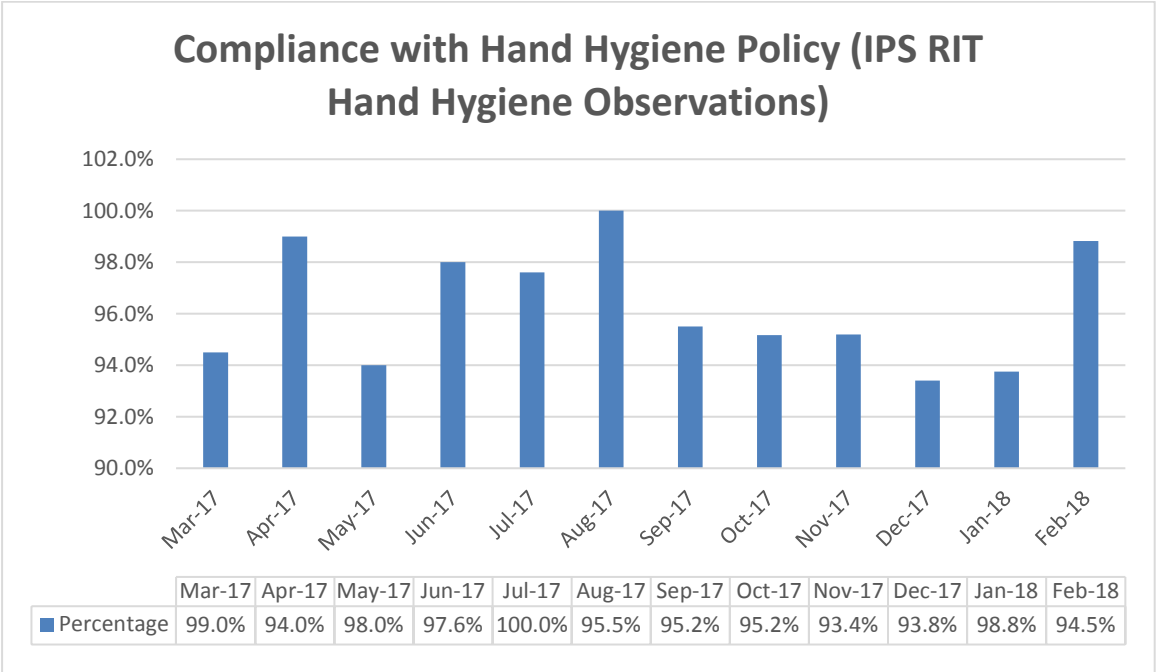
Hand hygiene remains central to the audit programme. The IPC Link Nurses perform 'Glow & Tell' training and assessments on hand hygiene within their areas.

The Link Nurses audit hand hygiene monthly by peer review. Other audits include;

Environment
Technique
Observation

The Trust continues to focus on four main components:

Alcohol hand rubs at point of care prominently positioned by each patient so that hands can be cleaned before and after care within the patient's view.
Audit of hand washing practice at least monthly. Wards that do not achieve 95% repeat the audit after 2 weeks.
Patients are encouraged to challenge staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.
Raised awareness of hand hygiene and the 'Bare below the elbow' dress code



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Percentage	99.0%	94.0%	98.0%	97.6%	100.0%	95.5%	95.2%	95.2%	93.4%	93.8%	98.8%	94.5%

ROH has been exceeding the threshold of 90% set by the Commissioners in 2017/18.

9 Staff information and training

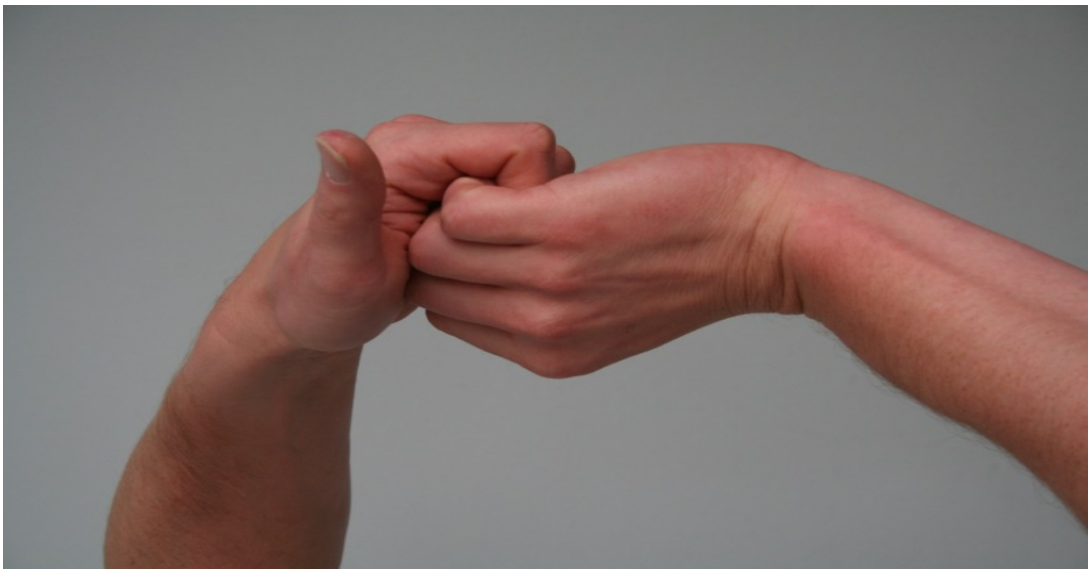
- The IPC team has provided mandatory hand hygiene training for all ROH employees through induction days, mandatory study days, and ward-based enhanced training.
- ROH hand hygiene provider, DEB UK, have standardized products, posters, dispensers across the Trust and have provided training and audit at operational level for all clinical areas.
- The induction IPC training package was updated to reflect the requirements of new employees to ROH.
- Communication of key messages via a number of media including social networks.
- The World Health Organisation (WHO) '-Five Moments of Hand Hygiene' is in use across ROH with the support from Communications. This campaign continues to be communicated both internally and externally with the support from social media.
- The IPC team continues to work collaboratively with suppliers and Estates and Facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment or processes.
- Additional on-going infection prevention surveillance and support continues across ROH with daily infection prevention visits to high risk areas.
- Bespoke infection prevention training has been developed, in line with HBN 00-09, for all preferred contractors coming into ROH. This training will be a pre-requisite for contractors to undertake prior to working on site and will be implemented in 2018/19.
- The IPC team continue to work with clinical staff and support clinical site managers with safe bed utilisation. A training package has been developed to support this and will be implemented in 2018/19.
- The IPC Team facilitated the national antibiotic awareness and hand hygiene days across ROH, this is in addition to promotional activities that they have supported throughout the year.

10 Seasonal Staff Influenza Vaccination Campaign

The seasonal influenza staff vaccination campaign is well established at ROH. The campaign officially commenced on 1st October 2016 with a wealth of information / videos available to staff on the Trust intranet, as well as the locally based influenza champions. The uptake for 2017/18 was 70.21% compared to 2016/17 which was 54%.

11 IPC Link Nurses

ROH, within each clinical area, has in place dedicated IPC Link Nurses. These nurses are supported by the IPC Team and attend monthly education / study days to support them in their roles. They provide advice, support, education and training to operational staff as well as monitoring compliance with the IPC agenda.

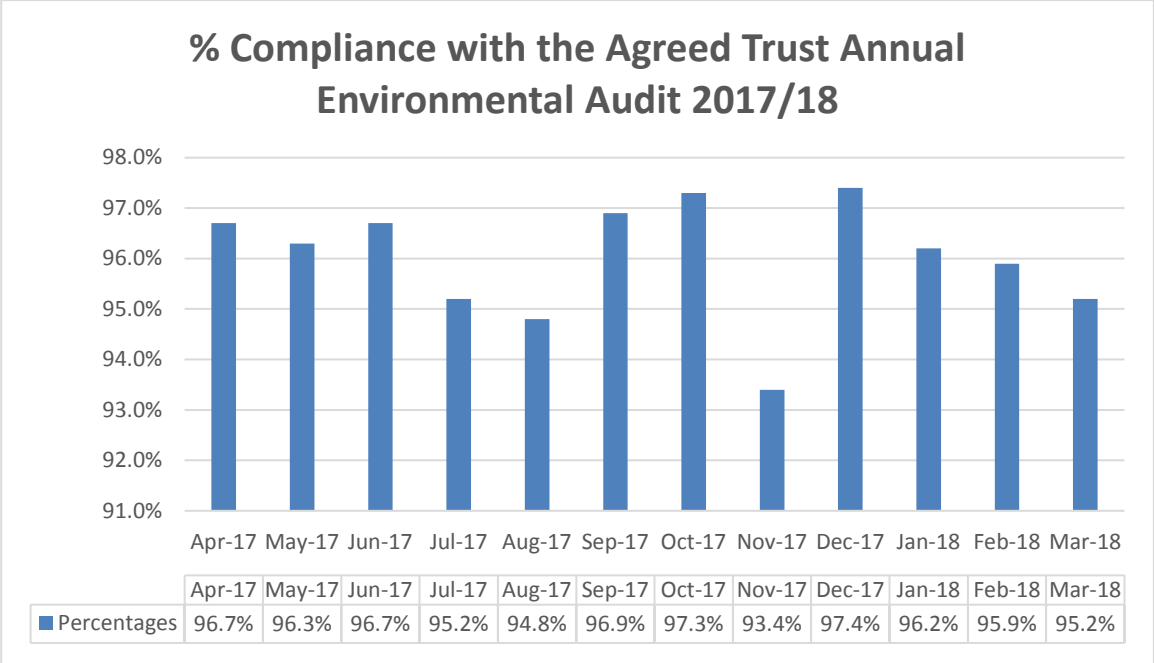


COMPLIANCE CRITERIA 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Providing a clean safe environment

- There is a designated Facilities Manager for cleaning services that are managed in house.
- The IPC Team support ROH bed management / clinical staff to ensure efficient / appropriate bed utilistion
- IPC Team are involved in capital planning schemes to support the needs of IP across ROH in refurbishments and new builds.
- The IPC Team oversees assurance of standards and reduction of risk in partnership with divisional management teams through audit, monitoring of standards, and shared learning.
- ROH use Bioquelle, a specialised decontamination method, for the removal of environmental contaminants to ensure a safe, clean environment.
- Domestic staff continue to provide cover in all patient areas until 20.30 hrs. seven days a week and then the rapid response team was employed within FGH and RLI to provide night cover.
- Training for domestic staff continues to be provided by British Institute for Cleaning Standards and is refreshed annually.
- Head of Infection Prevention meets, on a monthly basis with Head of Estates / Facilities to review cleanliness standards and any issues identified by monthly audits. Issues are discussed at IPOG and escalated, as required to IPCC.
- ROH contract out to an accredited facility for decontamination services.
- ROH theatres have a schedule of annual servicing of the ventilation systems. In addition regular microbial air count monitoring has taken place.
- ROH participate in the annual Patient Led Assessments of The Care Environment (PLACE).



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Percentages	96.7%	96.3%	96.7%	95.2%	94.8%	96.9%	97.3%	93.4%	97.4%	96.2%	95.9%	95.2%

Apart from August and November, ROH has been exceeding the threshold of 95% set by the

Commissioners in 2017/18.

Water Systems Management

- Following the Department of Health publication, 'Water sources and potential Pseudomonas aeruginosa contamination of taps and water systems: advice for augmented care units' (2012), ROH test and monitor waters from augmented care areas. Additional areas are tested if there was a clinical suspicion that waters may have been linked to a patient's infection or colonisation. The Consultant Microbiologists support this management process and provide advice / support as required.
- ROH Water Safety Group, with its dedicated AE for waters, is responsible for the oversight of water safety and continue to meet on a monthly basis.
- The Water Safety group is a sub group of IPCC and reports directly to IPCC. The group is chaired by the Head of Estates.
- Estates and Facilities, Consultant Microbiologists, and the IPC Team support the water management process across ROH.

Management of Decontamination

The management and compliance currently falls into three distinct areas;

- Estates – for medical device reprocessing equipment / scheduled maintenance where required
- Infection Prevention – for monitoring / audit of compliance of medical devices with Trust Policies
- User – to comply with Trust Policies and to ensure that decontamination of equipment is fit for use and subject to periodic testing and maintenance as advised by the manufacturer / contractual agreement

An external peer review was commissioned in May 2016 to review the Decontamination facilities at ROH. An action plan was subsequently developed with work undertaken as a result and almost completed by March 2018 with the removal of a decontamination unit, within the theatre space, being the only outstanding requirement.

11.1 Theatres Closure

All ten theatres were closed at ROH from 30th March, 2018 for a planned programme of maintenance and refurbishment. Elective surgery recommenced on Tuesday 9th April, 2018 post a deep clean and sign off by the IPC Team and Theatre Management Team.

COMPLIANCE CRITERIA 3
Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Sepsis and Antimicrobial Stewardship (AMS)

For the period 2017 /18 the ROH participated in a combined CQUIN with four components (2a-2d) with 2a and 2b focusing on sepsis recognition and screening, and 2c and 2d on antimicrobial prescription review and consumption within the Trust.

An AMS Committee was formed within ROH 2017/18 with a new dedicated Lead Antimicrobial Pharmacist appointed to review all patients on antimicrobials. Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends. This is reported to the Drugs and Therapeutics Committee (DTC) and IPCC and any areas of concern addressed with Microbiologists.

The current deteriorating/septic patient policy has been renamed as the Policy for the Escalation of the Deteriorating patient or patient with suspected sepsis. This is to ensure that when staff are conducting a search for sepsis on the intranet that the policy is easily identified. The Sepsis Six Pathway is embedded within ROH.

Sepsis audit identified that the screening of patients for sepsis was completed appropriately and in-line with the Trust policy. However the CQUIN was only partially achieved for Quarter 4 as less than 90% of patients were screened appropriately, which is lower when compared to the results for Quarter 3.

The AMS consumption data shows a greater than two-fold increase in Ertapenem usage, which is linked to issues to the BIU team to manage complicated infections and facilitate discharges. Local agreement to remove such issues from our antibiotic consumption reporting data has been agreed due to this. Therefore figures for issues including and excluding BIU have been reported.

Overall Meropenem usage decreased compared to the baseline data. Comparison of the grouped DDM data for Meropenem shows that a 7% reduction in usage has been achieved. An overall reduction of 8% in Carbapenem usage is reported (not including Ertapenem issues to the BIU service) which achieves the 2% reduction CQUIN requirement for this indicator.

Tazocin usage decreased compared to the baseline data, which is a positive result. A 9% reduction in the usage of Tazocin 4.5g vials, which achieves the 2% reduction CQUIN requirement for this indicator. Antibiotic consumption has reduced by 5% compared to 2016 based upon predicted DDD per 1000 admissions data (10% reduction if BIU antibiotic consumption is excluded).

COMPLIANCE CRITERIA 4
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion

Communications

- The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.
- The IPC Team work collaboratively with ROH Communications team who support dissemination of IPC communications both internally and externally as required.
- The IPC Team meet monthly to update each other on areas of work and plan ahead. All IPNs receive an annual appraisal.
- The IPC Team utilize social media accounts that enables communication internally and externally with the public and other organisations. This has proved beneficial with sharing of best practice and communicating to a wider health economy.
- The ROH Weekly Message from the CEO supports and cascades messages from the IPC team across the organisation.
- The Trust website promotes infection prevention issues and guides users to information on MRSA, Clostridium Difficile and other organisms.

COMPLIANCE CRITERIA 5
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because they can increase a patient's length of stay in hospital and "are associated with considerable morbidity and it has been reported that over one-third of postoperative deaths are related, at least in part, to SSI. However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition" NICE (2008)3.

Guidelines for the prevention of SSI were issued by the National Institute for Heath and Clinical Excellence (NICE) in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health. These guidelines are outlined in the following table.

Period	Action	Evidence	Introduced at ROHFT
Pre-operative	Showering	+ / -	x
	S.aureus decolonisation	+ / -	x
Peri-operative	Antibiotic prophylaxis	+	✓
	Skin preparation	+	✓
	No shaving with razors	+	✓
	Theatre environment/procedures	+	In part - ongoing
	Surgical technique	+	✓
	Normothermia	+	In part - ongoing
	Glucose control	+	✓
Post-operative	Wound management	+ / -	✓
	Surveillance and feedback of rates	+	✓

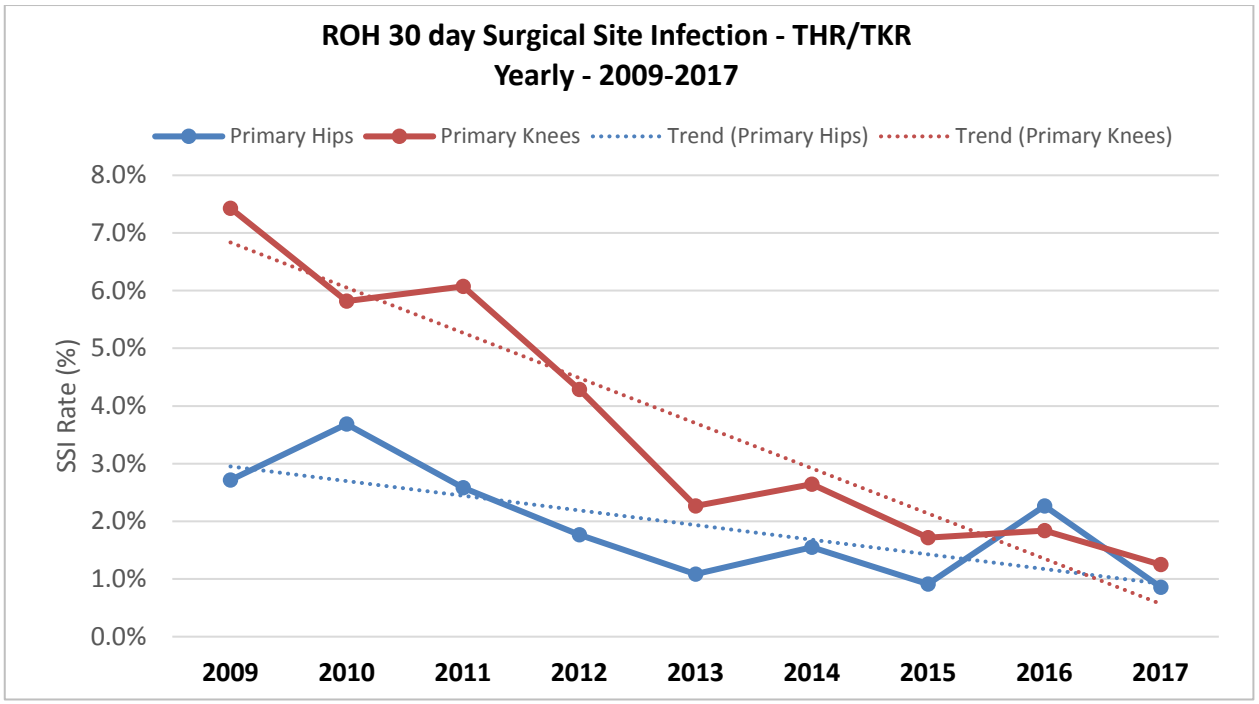
Many of these actions are in place, with the addition of others exceeding the National Guidance, at ROH. ROH have in place an established wound care helpline that can offer the patient an appointment at the SSI clinic, on the same day, should it be required This allows the review of patients by specialist staff allowing rapid treatment / admission where required avoiding the unnecessary prescribing of antibiotics by GPs.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice as necessary.

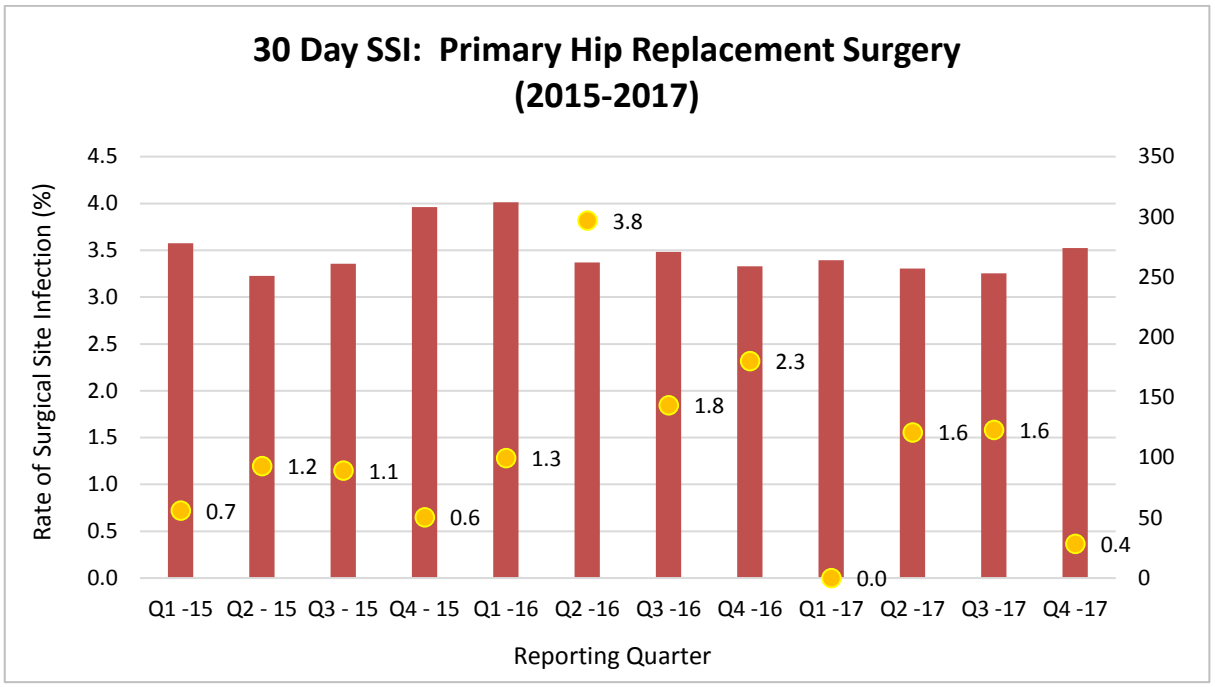
- hip replacement
- knee replacement
- repair of neck of femur
- reduction of long bone fracture

Primary arthroplasty surgery is constantly reviewed and montored as part of the SSI surveillance programme at ROH. SSI surveillance is routinely carried out according to Public Health England protocol at the point of discharge from hospital and at 30 days post primary hip and knee replacement surgery and has received close attention since 2009 when the 30 day surveillance was introduced.

The data presented within this report is a combination of Mandatory surveillance data for Surgical Site Infections identified following hip and knee replacement surgery carried out and wider analysis surgical site infections in other specialties where it is available. In addition to this there is also in- house data collected by the IPC Team, which looks at a number of other areas of interest. This enables the team to gain an informed understanding of SSI across all divisions and the potential for them to have longstanding implications for patients and significant financial implications for the Trust.



Source: ROH SSI Databases



Source: ROH SSI Databases

SSI Rate	2009	2010	2011	2012	2013	2014	2015	2016	2017	% Change from 09-17
Primary Hips	2.7%	3.7%	2.6%	1.8%	1.1%	1.6%	0.9%	2.3%	0.9%	-69.0%
Primary Knees	7.4%	5.8%	6.1%	4.3%	2.3%	2.6%	1.7%	1.8%	1.2%	-80.6%
No. of SSI	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	
Primary Hips	29	37	29	19	11	18	10	25	9	
Primary Knees	62	47	53	34	17	21	15	16	12	
No. of Procedures	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	
Primary Hips	1068	1004	1123	1074	1017	1160	1097	1104	1048	
Primary Knees	821	808	873	793	751	795	873	869	961	

Source: ROH SSI Databases

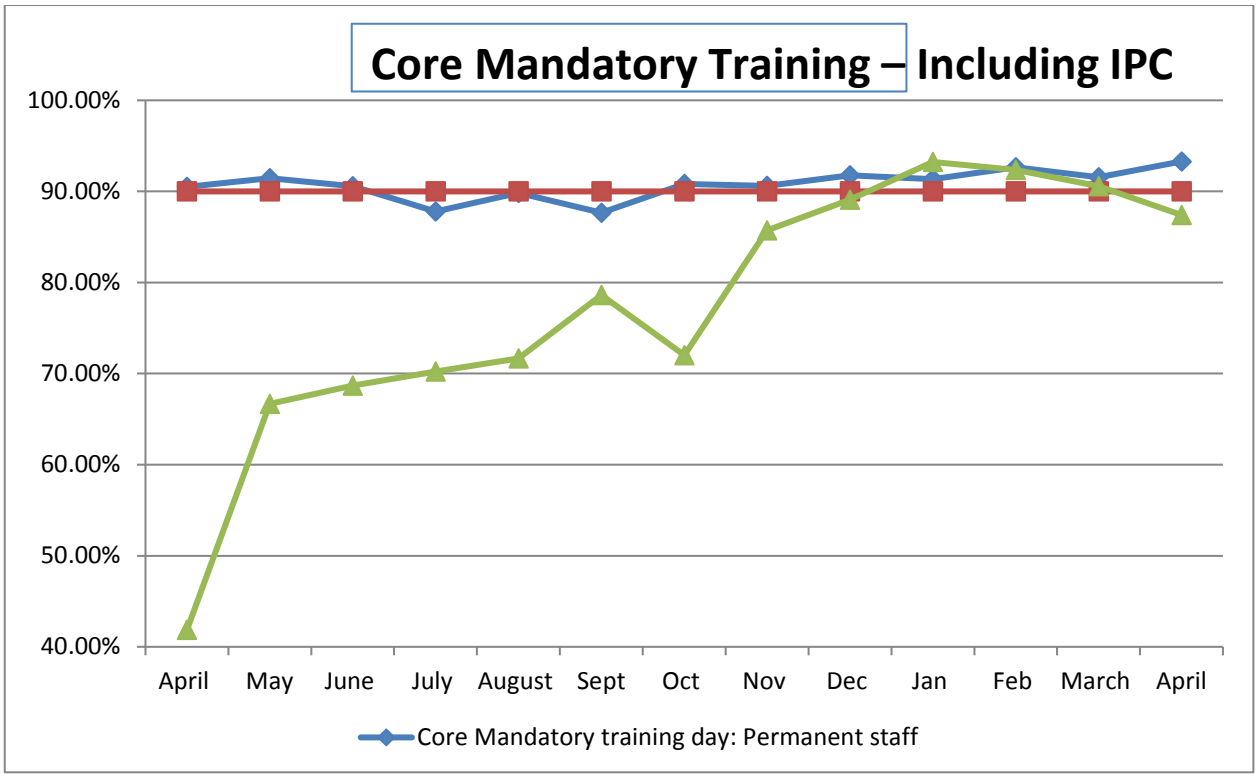
The 30 day post op SSI rates in Q1 for the primary hip replacements were 0.0% and 0.7% for primary knee replacements. There was a rise in SSI rates during Q2, primary hip replacements 2.1% and knee replacements 1.8%. In Q3 it was shown that there was a decrease in SSI rates for primary hip replacements at 1.6% but a continuing rising rate of SSI'S in primary knee replacements 2.3%. Bringing the surveillance to an end during Q4 there was and increase again in SSI rates for primary hip replacements at 2.0% and a continued SSI rate increase for primary knee replacements 3.1%.

COMPLIANCE CRITERIA 6

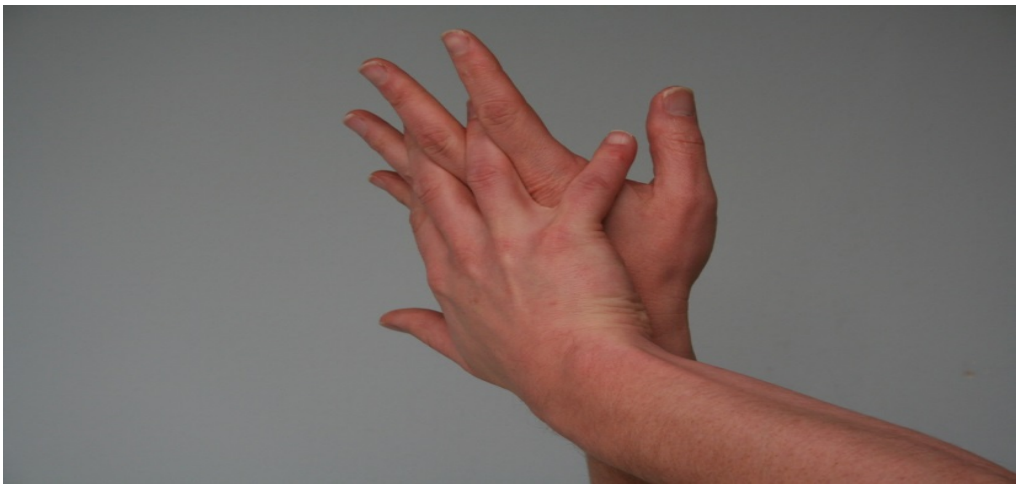
Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection

At ROH infection prevention is everyone's responsibility and is included in all job descriptions.

All clinical staff receive training and education in optimum infection prevention practices during mandatory training and Link Nurse teaching sessions.



A target of 90% set by the Commissioners was met / exceeded every month apart from July and September when training did not take place.



COMPLIANCE CRITERIA 7
Provide or secure adequate isolation facilities

Isolation Rooms

Wards

39 isolation rooms with en-suites.
3 isolation rooms without en-suite.

HDU

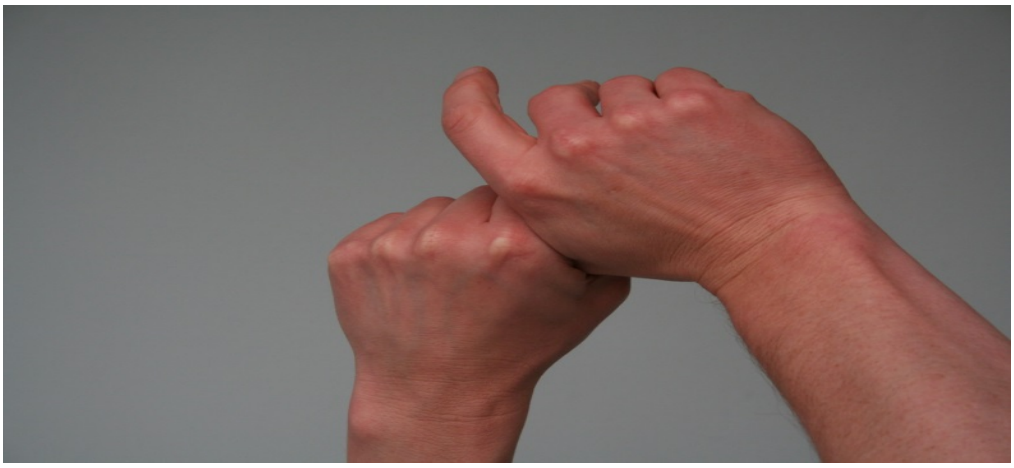
2 Adult Side Rooms without en-suites.
2 paediatric isolation rooms with ensuite.

COMPLIANCE CRITERIA 8
Secure adequate access to laboratory support as appropriate

Laboratory services for ROH are outsourced, located in the purpose built Pathology Laboratory at University Hospitals Birmingham. The Microbiology Laboratory has full Clinical Pathology Accreditation (CPA) and has been recommended for UKAS Accreditation to ISO Standard 15189.

COMPLIANCE CRITERIA 9
Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, procedures and manuals are available for staff to view on the Trust intranet. There is a formal Governance structure in place for reviewing and ratifying such documents within ROH and Clinical Governance has produced a directory of documents alerting when policies are due for update. Policies are also updated prior to review date if guidance is updated.



COMPLIANCE CRITERIA 10
Providers have a system in place to manage the occupational health needs of staff in relation to infection

All job descriptions include infection prevention responsibility and this message is reiterated during mandatory training. The IPC Team participates in mandatory updates for all staff groups (clinical and non-clinical). The IPC Team regularly meet with representatives of the Occupational Health service to ensure compliance with Criteria 10. A representative from the Occupational Health Service is a member of the IPCC under the TOR.

Occupational Health services are provided to staff via an SLA with the Heart of England Foundation Trust.

Summary

2017 - 2018 has been a busy and challenging year for ROH staff and for the IPC Team. I am delighted in the number of infection prevention improvements that continue to improve the patients' experience and strengthen patient safety processes and standards. These improvements demonstrate ROH's commitment to harm free care and reduction in avoidable health-care associated infections.

Together with our staff, governors and volunteers we have created vision and values which clearly state where we are going and how, as a team, we will behave towards each other, our patients, and partners.

Infection prevention and control is the responsibility of all of us and is fundamental when delivering the vision and values of ROH. Clinically effective infection prevention and control practice is an essential feature of patient protection. By incorporating the principles of infection prevention into routine daily clinical practice, patient safety can be enhanced and the risk of patients acquiring an infection during episodes of health care can be minimised.

Our staff demonstrate through practice that they care about patient safety. We should all be proud of the reductions made in harms, including reductions in hospital-acquired infections.

2018-19 provides an opportunity for us to work as a healthcare system to influence even bigger reductions in patient harms. A key area for us to focus on, over the coming year, will be the reduction in Gram-negative blood stream infections in the community and in hospital. Working as partners in care will enable us to achieve so much more than any part of the system could deliver in isolation.


Your 5 Moments
for Hand Hygiene
1 BEFORE TOUCHING A PATIENT
2 BEFORE CLEAN/ASEPTIC PROCEDURE
3 AFTER BODY FLUID EXPOSURE RISK
4 AFTER TOUCHING A PATIENT
5 AFTER TOUCHING PATIENT SURROUNDINGS

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

ROHTB (3/19) 009

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 28 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that the treatment plans for some of the red financial and performance risks did not appear to be effective given that the post mitigation scoring remained unchanged – the Executive would revisit these plans and update accordingly. • Pay costs were above expectations, largely driven by agency costs, despite this being on a downward trend. Pay associated with temporary medical staff was noted to be a particular issue. • Delivery of the Cost Improvement Programme remained behind plan. • Sickness absence remained a concern, however long term sickness was reducing. There was noted to be no link between the spike seen in October and the uptake of the 'flu vaccination or half term. • A date of 30 June had been set for the transition of paediatric services to the Birmingham Children's Hospital. In the meantime the arrangements between the two hospitals needed to be strengthened to provide an adequate level of support to running the services at ROH. • The ROH remained vigilant around any vulnerability associated with the potential for a no deal Brexit arrangement.	• An update on the development of the private services to be presented to the Trust Board when there is greater clarity on the offering. • Work to be done to identify the impact of additional activity using direct costs as a measure. • Brief the Board on the measures being taken to reduce DNAs when appropriate. • Ask to Board to sign up to the Control Total at the February 2019 workshop session.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received an update on the plans for marketing the services of the ROH, including the appointment of a GP Liaision Manager who would help with the promotion of the private patient offering and the JointCare service. • Work was reported to be underway with a large private provider of orthopaedic services to develop a partnership arrangement. • Inpatient activity was reported to be above plan and income overall was noted to be ahead of the same position during the previous year.	• None specifically.

• Length of stay had reduced. • The number of patients waiting in excess of 52 weeks was reported to have reduced below the trajectory. Work was underway to try to clear all patients in this cohort by the end of the financial year. • The committee received a positive update on the plans to reduce 'Did Not Attend' (DNA) rates, using new technology to allow patients to access their appointment letters and to use a text messaging reminder system. • The Board received an update on the latest planning guidance and the new funding arrangements. • A decision was awaited on the planning permission for the new modular theatres. • Overall, there was good progress with the 'Perfecting Pathways' programme. • It was reported that there was full compliance against the Emergency Preparedness, Resilience and Response requirements (EPRR)	
Chair's comments on the effectiveness of the meeting: The meeting had run to time and included some focussed discussion on key issues.	

ROHTB (3/19) 010

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 26 February 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was an overall shortfall against the financial plan, which needed to be recouped before the year end in order to meet the Control Total. • There remained underperformance with the delivery of the Cost improvement Programme (CIP), however every effort was being taken to identify new schemes where possible. • Performance against the 18 weeks Referral to Treatment Time target had dipped, this being particularly associated with the volume of patients in the arthroscopy speciality. The overall 92% target was anticipated to be achieved by the end of the calendar year. • In terms of 'Perfecting pathways', it was highlighted that the expected contribution of clinical coding to the delivery of the CIP was not as great as initially anticipated. • There continued to be discussions and plans for Brexit, these being informed by national and regional guidance.	• Update the Trust Board on 6 March on the plans for the modular theatre build. • Present the capital plan to the Trust board for approval. • A further update on private patient work is needed at the April 2019 meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was reported to be a slight improvement against the planned in month deficit position. • The Committee was pleased to hear that the planning permission for the new modular theatres had been obtained. • There had been a successful nursing recruitment campaign and every effort was being taken to keep individuals engaged up until when they started in post. • Length of stay was noted to have reduced significantly, with a number of patients being discharged on the day after surgery. • The Committee reviewed the draft operational and financial plan for 2019/20, the final version of which needs to be submitted in April 2019.	• None specifically.

• A date for the paediatric transition had been set of July 2019. The Paediatric Oncology review was planned for 11/12 March 2019. There remained good oversight of the arrangements. • Overall, there was good progress against the 'Perfecting Pathways' workstreams. • The Committee received a useful presentation on the plans for the Private Patient Unit and the opportunities to grow private services. It was agreed that consultant engagement was key to the plans, as was the need to consider the patient experience across the full pathway from admission to discharge. The new GP liaision manager would take responsibility for developing a business case to grow the private patient market.	

Chair's comments on the effectiveness of the meeting: The Chair noted that overall, there was good performance, both financially and operationally, notwithstanding some key challenges. There had been good progress with developing the operational plan. The meeting had covered all key issues, despite there being a degree of time pressure .

Finance and Performance Report

January 2019

CONTENTS

INTRODUCTION

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

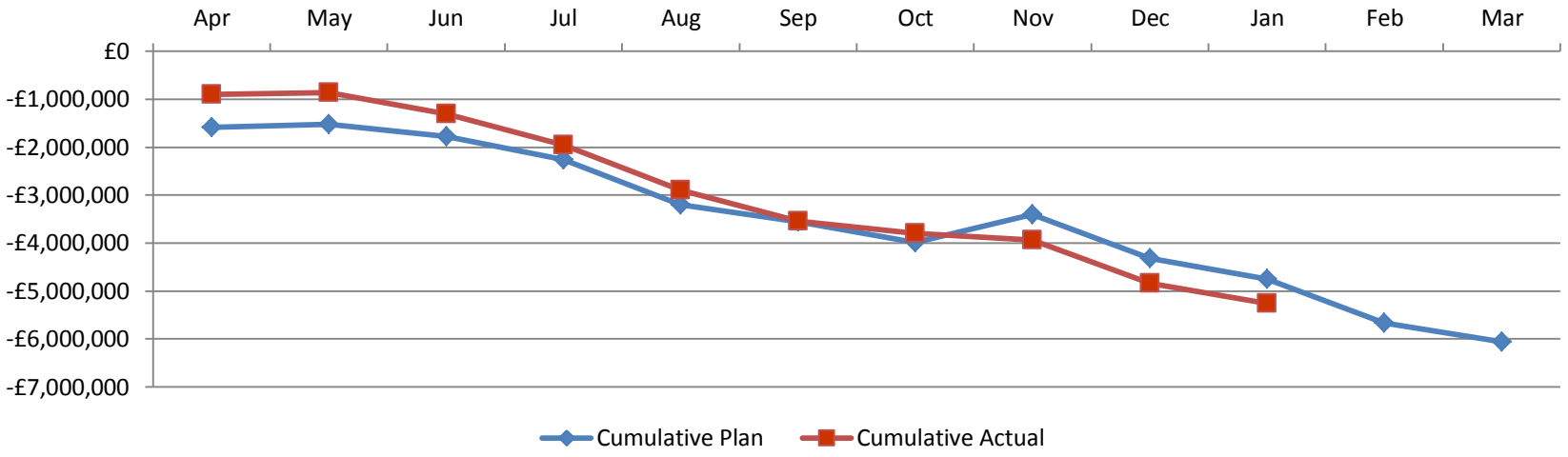
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

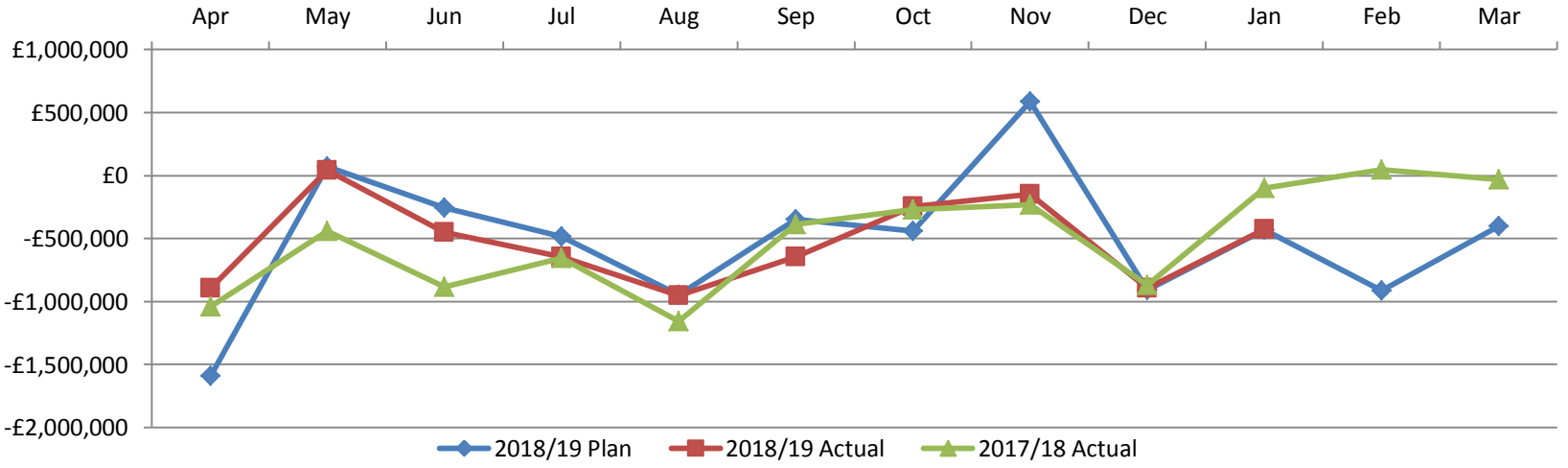
	YTD M10 Original Plan £'000	YTD M10 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	66,028	66,303	275
Other Operating Income	4,245	4,453	208
Total Income	**70,273**	**70,566**	**293**
Employee Expenses (inc. Agency)	(42,860)	(43,917)	(1,057)
Other operating expenses	(30,990)	(31,020)	(30)
Operating deficit	**(3,577)**	**(4,181)**	**(604)**
Net Finance Costs	(1,170)	(1,084)	**86**
Net deficit	**(4,747)**	**(5,265)**	**(518)**
Remove donated asset I&E impact	50	(138)	(188)
Adjusted financial performance (inc PSF)	**(4,697)**	**(5,403)**	**(706)**

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 £427k in January against a planned deficit of £432k, £5k favourable against plan. Year to date the Trust now has a deficit of £5,265k against a planned deficit of £4,747k; £518k adverse against plan which represents a small improvement from Month 9. However this includes a favourable adjustment of £185k which relates to the I&E impact of a capital donation which needs to be removed to asses performance against the control total. This gives a revised variance of £706k, which reduces to £450k behind plan excluding the impact of PSF. This is the value that the Trust needs to recover in the last two months.

Whilst this is a significant deterioration against plan, actual performance still represents a continued improvement in the last 2 months compared to previous months in the financial year. Planning for the rest of the year is prudent, therefore continued focus on activity delivery and cost control over the remaining two months should still result in achievement of the control total.

Admitted patient care activity ,and hence income fell below plan in January. Whilst this may initially seem disappointing, the failure of the lighting in one theatre resulted in reduced capacity for a period of weeks. This has now been replaced.

Expenditure was favourable to plan, as expected due to the reduced activity income performance.

CIP realisation remains challenging. £1,441k has now been delivered against a plan of £2,147k, £706k under-performance YTD (this reconciles to the adverse overall financial position against the plan) and it is unlikely that the Trust will deliver its CIP plan for 18-19. The forecasted CIP position for 18-19 is £1,725k against a £2,985k plan. (£1,259k forecasted under-performance against plan)

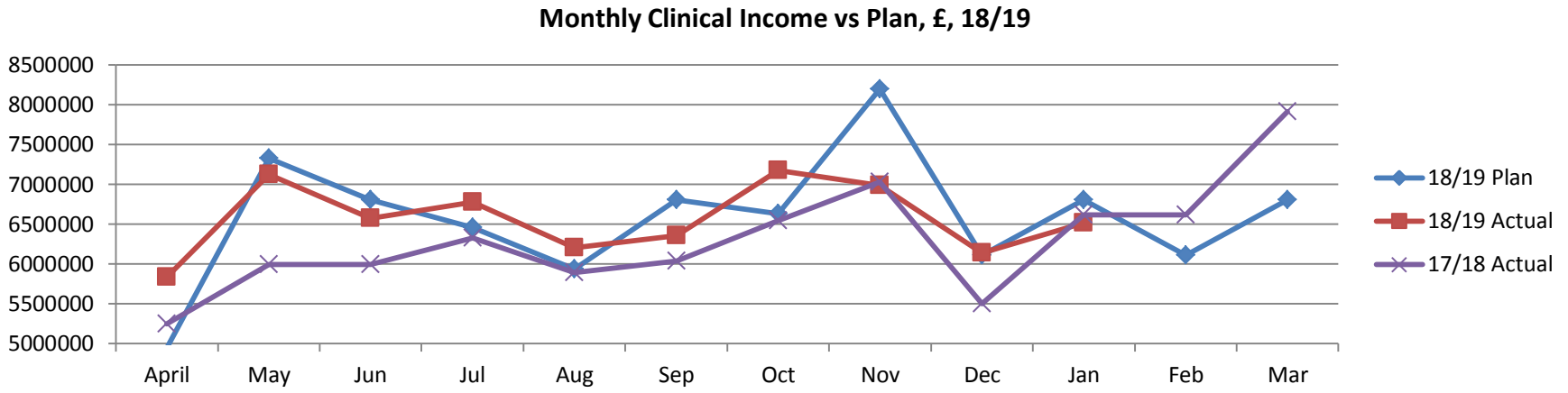
The Trust has a 19/20 CIP target of 1.1% in tariff plus further 0.5% for access to NHS Financial Recovery Funding for 19/20. This is a c. £1,400k target, not accounting for additions to this target based on the funding of 18/19 FYE and 19/20 cost-pressures. The teams are currently working on the identification and delivery of next-year schemes and have currently identified opportunities (£1,553k) exceeding the £1,400k plan. In order to ensure the 19-20 CIP plan is delivered, the Trust is changing its approach to CIP planning and delivery. There will be a number of Executive led cost improvement programmes, with operational , nursing and clinician led projects within each programme. Each project will have a number of key stakeholder, and each project team will work to deliver a project plan prior to 19-20, these plans will be amalgamated to deliver a CIP programme plan, that will be ultimately signed off and steered by the Executive responsible officer. The Trust is working to identify a stretch target and stretch opportunities for 19-20 to mitigate any slippage or under-performance against identified schemes, in order to prevent a repeat of the under-performance in 18-19; and as part of 19-20 CIP planning, is already identifying detailed CIP opportunities for 20-21.

ACTIONS FOR IMPROVEMENTS / LEARNING

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. Planning permission has recently been granted and the tenders for the enabling works have been received and opened. A further update will be presented at March Board.

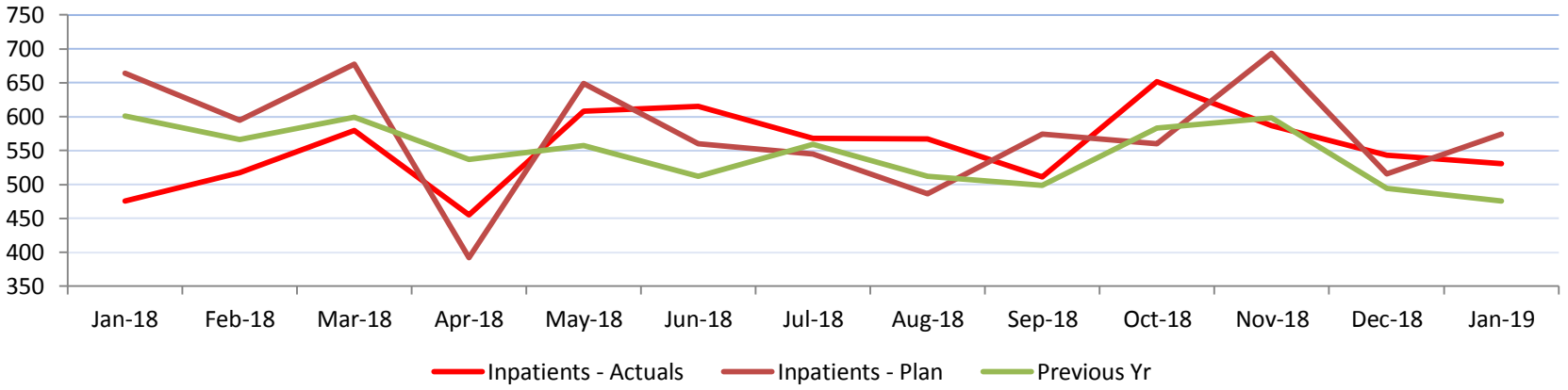
2. Income and Activity– This illustrates the total income generated by the Trust in 2018/19, including the split of income by category, in addition to the month's activity



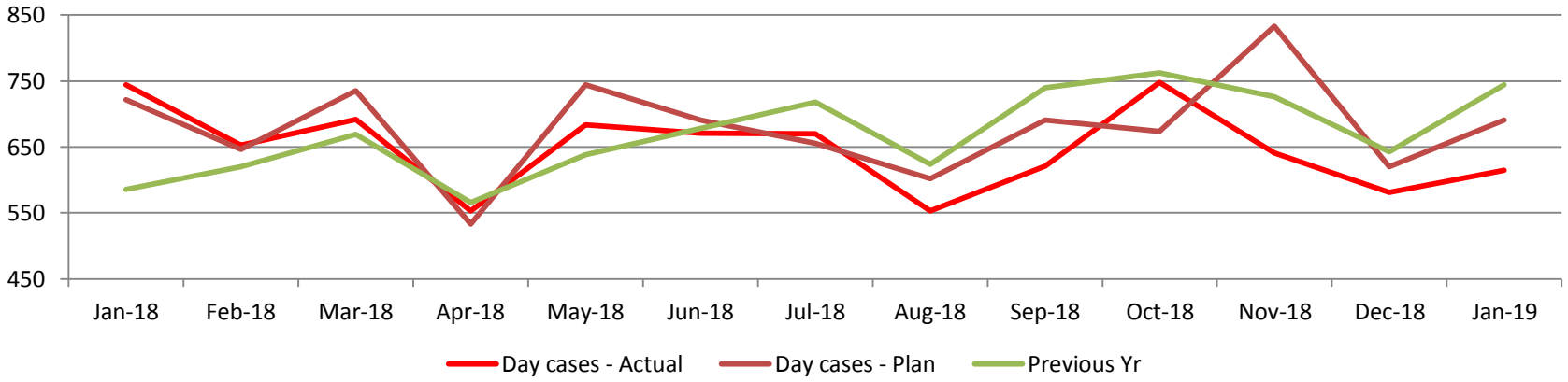
Clinical Income – January 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,595	3,238	-357
Excess Bed Days	42	37	-5
Total Inpatients	3,637	3,275	-362
Day Cases	856	797	-59
Outpatients	666	732	66
Critical Care	235	165	-70
Therapies	230	252	22
Pass-through income	216	178	-38
Other variable income	427	561	134
Block income	539	559	20
TOTAL	6,806	6,519	-287

Clinical Income – Year To Date 2018/19 £'000			
	Plan	Actual	Variance
Inpatients	34,876	32,669	-2,207
Excess Bed Days	405	683	278
Total Inpatients	35,281	33,352	-1,929
Day Cases	8,301	8,361	60
Outpatients	6,462	6,821	359
Critical Care	2,276	1,844	-432
Therapies	2,232	2,446	214
Pass-through income	2,098	2,278	180
Other variable income	4,144	5,016	872
Block income	5,228	5,584	356
TOTAL	66,022	65,702	-320

Inpatient Activity



Day Case Activity



Clinical income was slightly down on plan for January (circa 4% adverse). This compares to a slight overperformance in December (2% favourable). However, whilst Inpatient activity was lower than plan during the month (574 plan v 531 actual), this was still higher than the 476 delivered last January, and represents the second month in a row where this has happened. It I is now 64 ahead of plan YTD. Day case activity again underperformed (615 v plan of 691). This is now 397 behind plan YTD.

Outpatients activity and income continue to perform strongly and remain ahead of plan.

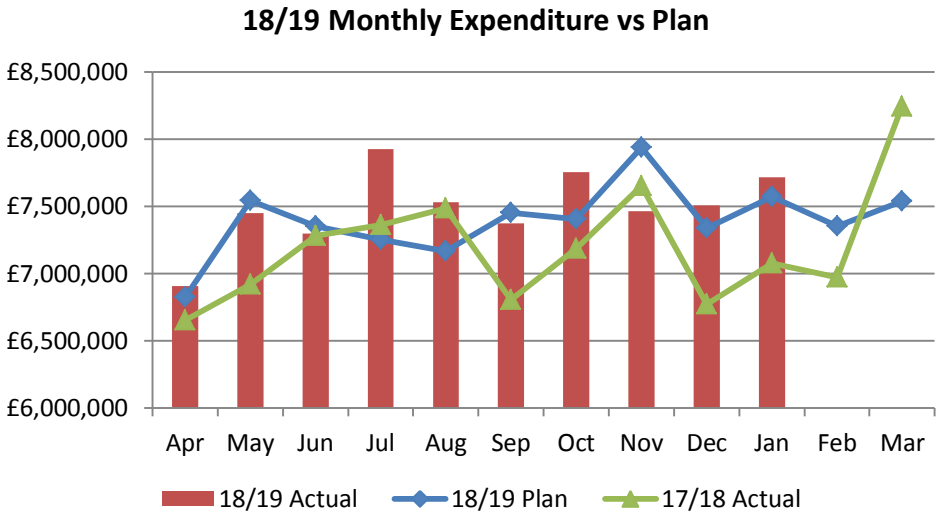
ACTIONS FOR IMPROVEMENT/LEARNING

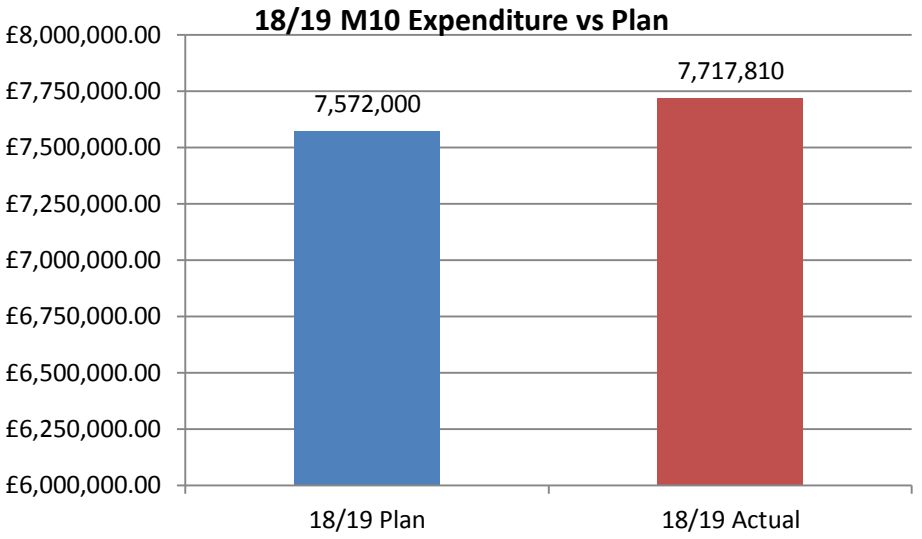
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

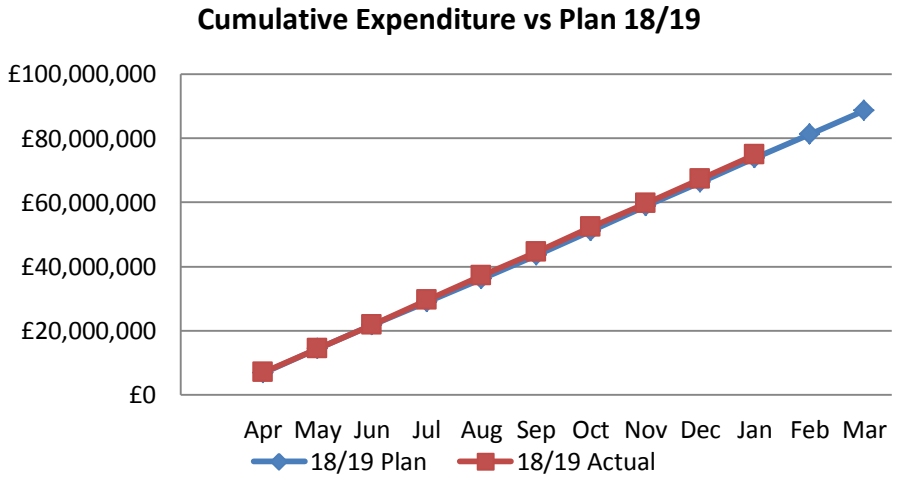
RISKS / ISSUES

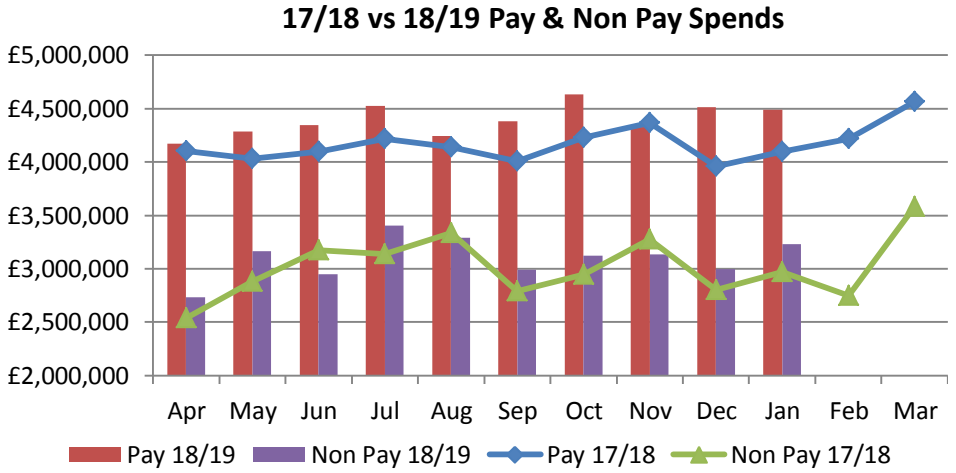
Given that the overall position at M10 is now behind plan, PSF has been removed for as a prudent measure. (circa £255k to M10 in total). This can still be claimed at the end of the quarter, or at year end if the control total is hit.

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









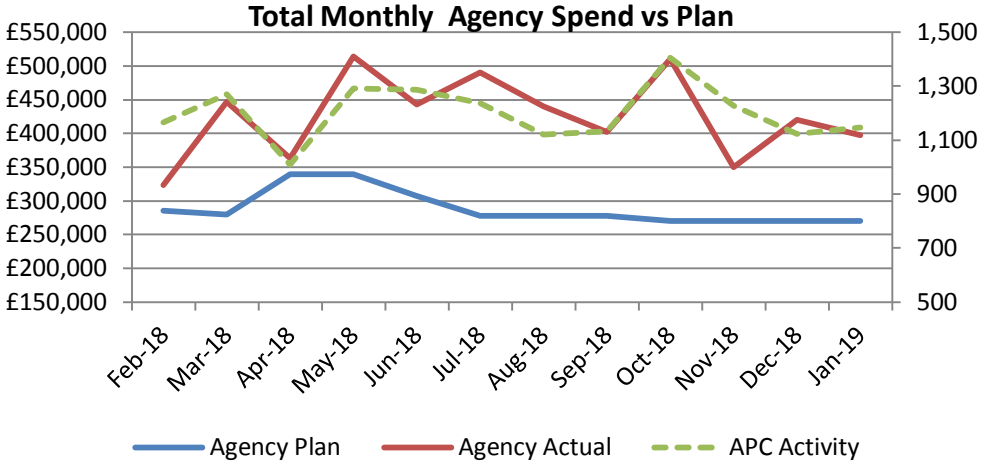
INFORMATION

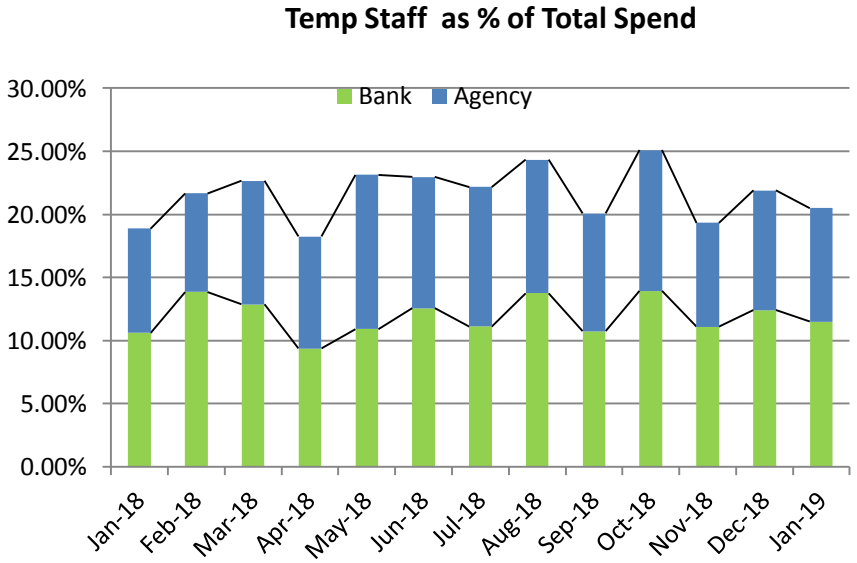
January expenditure was £7,718k, which was higher than a planned spend of £7,572k. However this includes a £91k adjustment to the YTD depreciation calculation

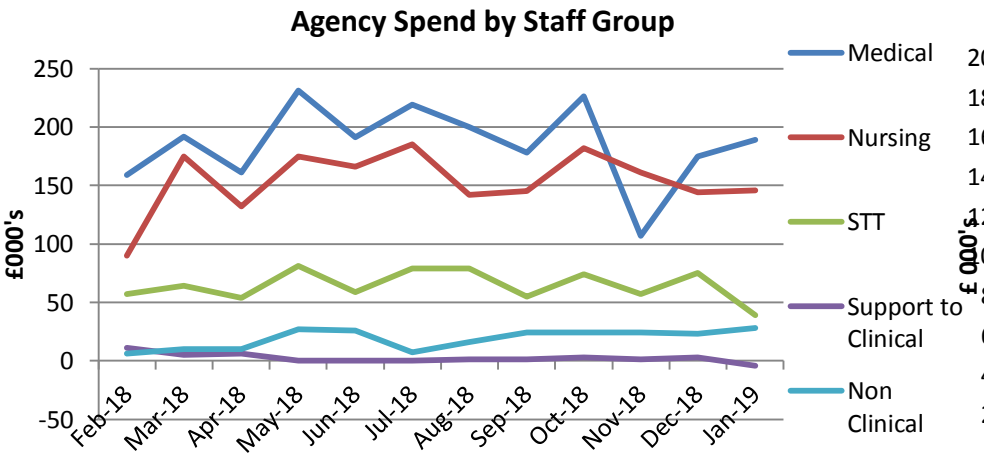
Pay however was slightly higher than planned (£76k) at £4.4m. Pressure remains on temporary staffing (medical staffing and nursing) with both showing a small increase on the December figure, although as a proportion of total pay usage has actually reduced from December

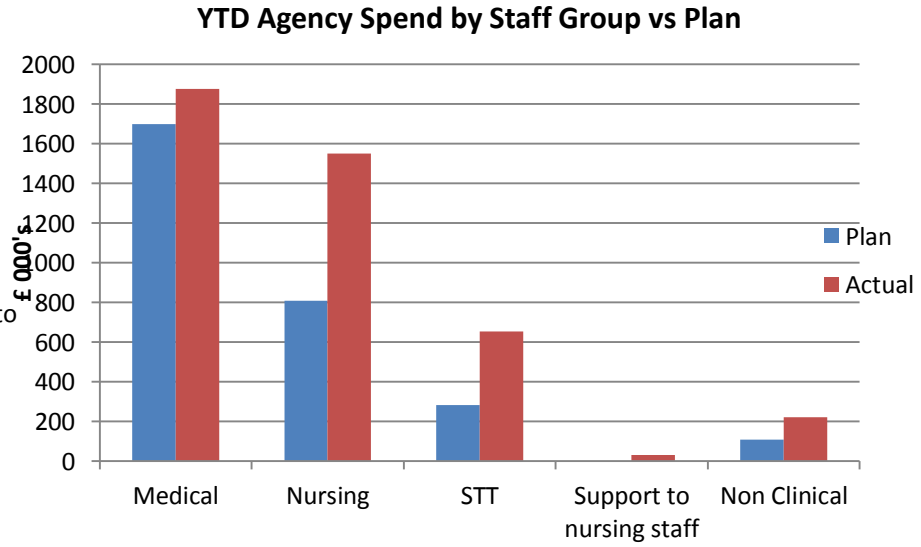
Non pay spend was £3,230k against a planned £3,160k with the main cause being the depreciation adjustment as described above. MRI activity has also been high in month with increased usage of the mobile scanner to help meet diagnostic waiting times.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Whilst total agency spend has reduced in month, Temporary spend for medics has remained high in January, although still lower than the trend for the majority of the year. The Trust continues to have challenges in the provision of junior doctor cover and work is ongoing around the development of alternative staffing models.

Nursing agency spend is consistent with last month, although has reduced as a proportion and again is reduced from earlier in the year of spend continues to reduce although this is still higher than anticipated given ward closures over Christmas. Bank usage has also reduced in month.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

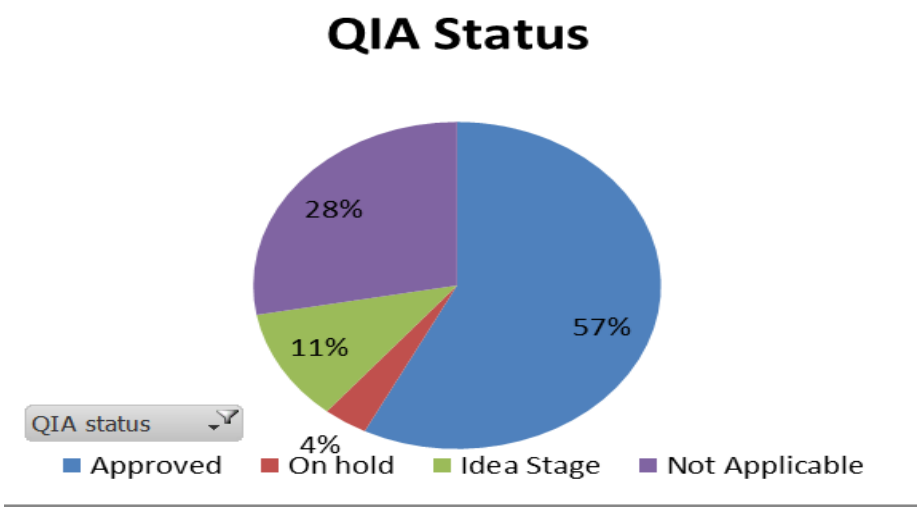
Review of e-Roster continues and shifts approved by the relevant Matron and head of Nursing.

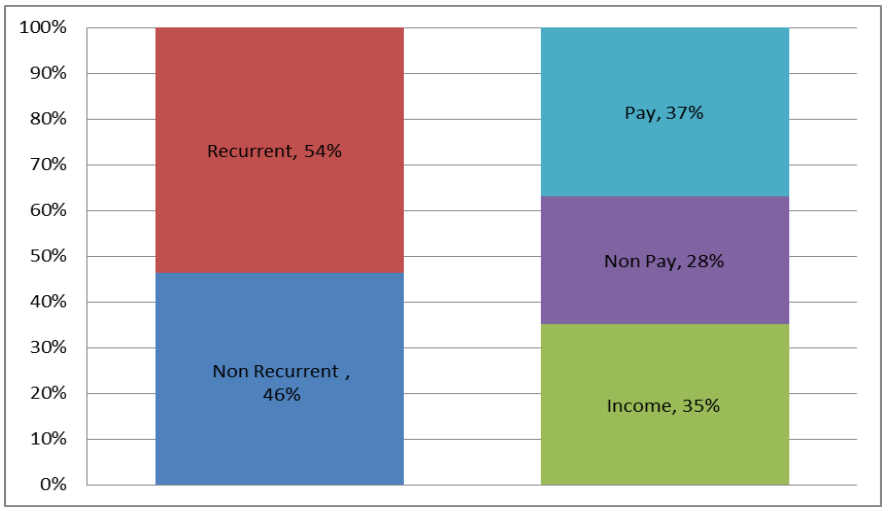
RISKS / ISSUES

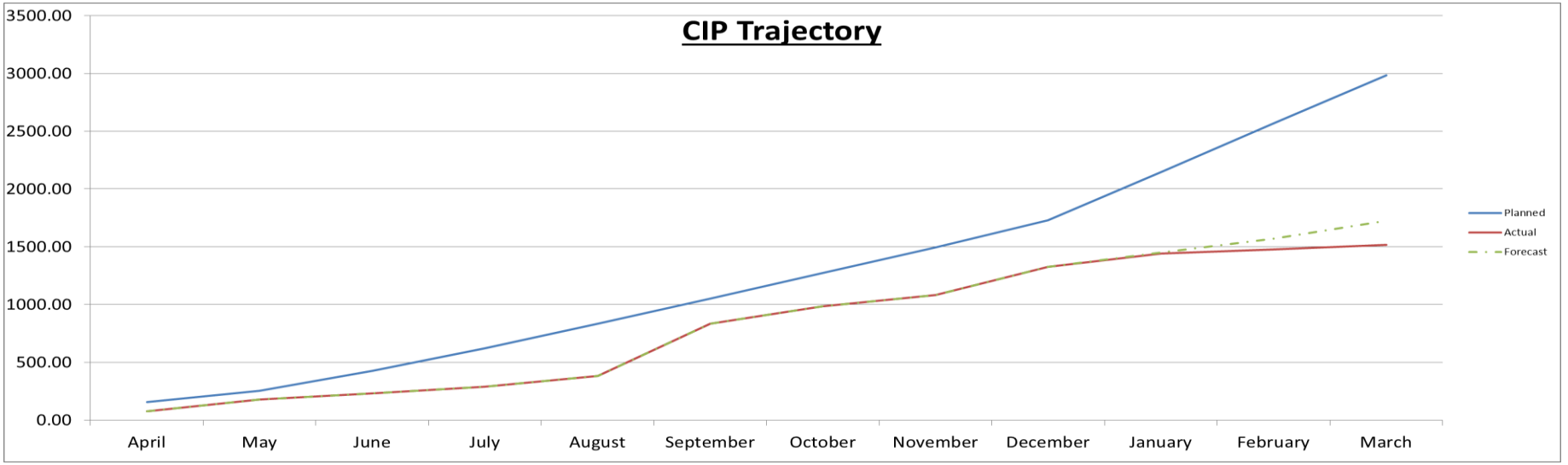
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

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) was identified/planned. As at month 10 £1,725k is forecasted for delivery in 18/19 (58% of identified/planned).

Row Labels	In-Month Plan	In-Month Actual	In-Month Variance	YTD Plan	YTD Actual	YTD Variance	18/19 Plan	18/19 FOT	18/19 Variance	18/19 FYE	18/19 FYE Variance
Corporate	94	28	(67)	902	650	(252)	1,090	800	(291)	696	(394)
Division 1	75	17	(57)	556	346	(211)	705	423	(282)	578	(127)
Division 2	245	64	(181)	666	421	(245)	1,157	468	(689)	159	(997)
Division 4	5	5	0	23	25	2	33	34	2	12	(21)
Grand Total	**419**	**114**	**(305)**	**2,147**	**1,441**	**(706)**	**2,985**	**1,725**	**(1,259)**	**1,446**	**(1,539)**

The summary reasons for YTD under-performance are below:

- Non-delivery and slippage against some clinical and operational saving schemes such as Implant rationalisation, GIRFT recommendations, LOS reduction and clinical pathway/process redesign savings
- Slippage and under-delivery against large scale savings schemes such as Theatres Stock control and Managed Service Contract (£550k planned in-year, this will slip to May 19) and Counting & Coding improvement schemes (forecasting £250k adverse to plan)
- YTD performance is significantly supported by fortuitous changes to national discount rates, enabling the present value reduction of provisions by £120k (this was captured as a non-recurrent CIP in Dec 18)

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved forecasted performance vs Q1-Q3, 46% of schemes forecasted in-year are non-recurrent, 53% of YTD delivery is as –such, 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, (engaging clinicians to support this) with focus also on demand and capacity management to deliver cost improvements
- Plans for 19-20 CIP's have been delivered; and a review of these are taking place, to explore the possibility of delivering some schemes in to 18/19

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the following schemes:

- Managed Service Contract for Theatres which has now been removed from the 18-19 forecast. Whilst a project group is driving this forward, it remains a challenging scheme; and is now unlikely to commence delivery until 19/20, due to non-conformance of the Trust decontamination provider to contracting arrangement requirements and NHSI delays for further clarification requirements by the body
- The counting & coding scheme is forecasted to deliver £234k, 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 at the monthly Quality and Steering committee meetings
- Focus on 19/20 Business Planning including 19/20 CIP scheme identification, however this has led to a reduced focus on (2018/19) in-year identification; now that the initial submission has been completed, there will need to be a renewed focus on CIP and recovery in 18-19

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M10 Plan £'000	M10 Actual £'000	Var £'000
Intangible Assets	764	578	186
Tangible Assets	48,118	48,442	(324)
Total Non-Current Assets	**48,882**	**49,020**	**(138)**
Inventories	4,858	5,150	(292)
Trade and other current assets	6,168	6,859	(691)
Cash	1,614	1,873	(259)
Total Current Assets	**12,640**	**13,882**	**(1,242)**
Trade and other payables	(12,989)	(14,954)	1,965
Borrowings	(1,266)	(399)	(867)
Provisions	(173)	(116)	(57)
Other liabilities	(207)	(548)	341
Total Current Liabilities	**(14,635)**	**(16,017)**	**1,382**
Borrowings	(7,479)	(8,732)	1,253
Provisions	(354)	(215)	(139)
Total Non-Current Liabilities	**(7,833)**	**(8,947)**	**1,114**
Total Net Assets Employed	**39,054**	**37,938**	**1,116**
Total Taxpayers' and Others' Equity	**39,054**	**37,938**	1,116

INFORMATION

Having been below plan in December for the first time this year, Cash at month 10 is now slightly above plan, although this is mainly due to timing of payments made.

The net impact between trade assets and trade payables remains negligible from month 9.

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.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £1,000k has been requested from the Department of Health (DoH) for January which is within the forecast for 2018/19.

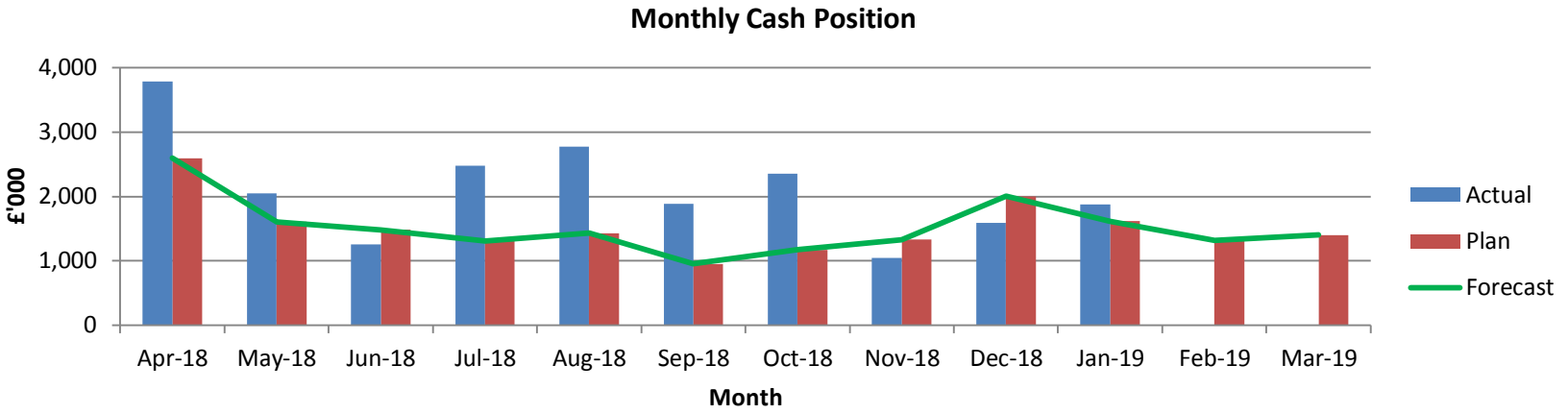
ACTIONS FOR IMPROVEMENTS / LEARNING

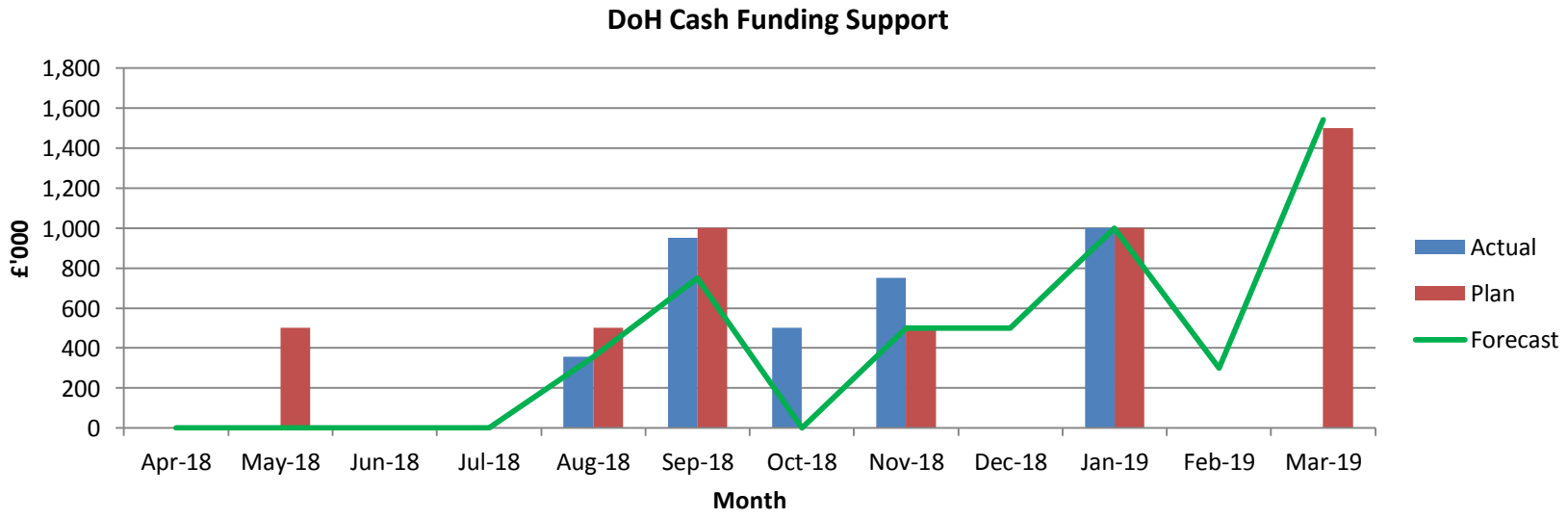
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

RISKS / ISSUES

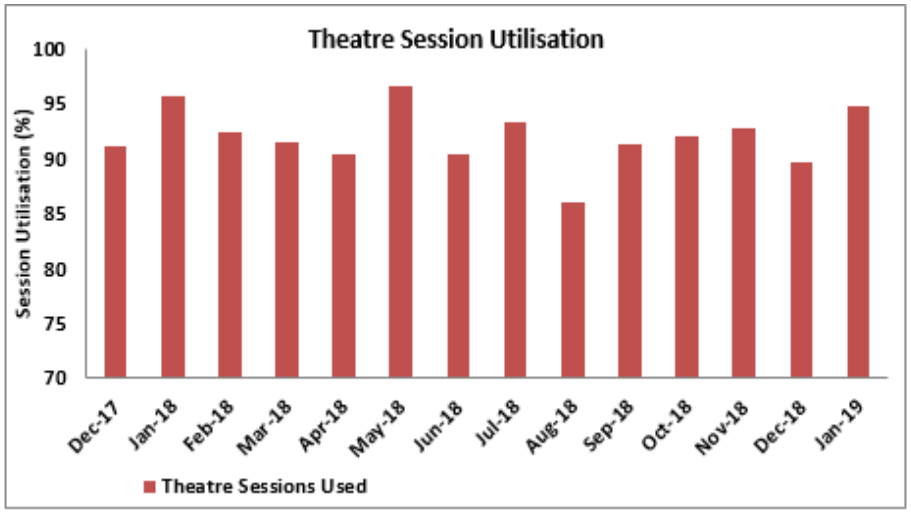
Despite the receipt of STF, cash remains tight for the remainder of the year with a projected cash balance at year end of £1.6m after an initially lower uptake of the borrowing facility at the beginning of the year than planned.

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





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

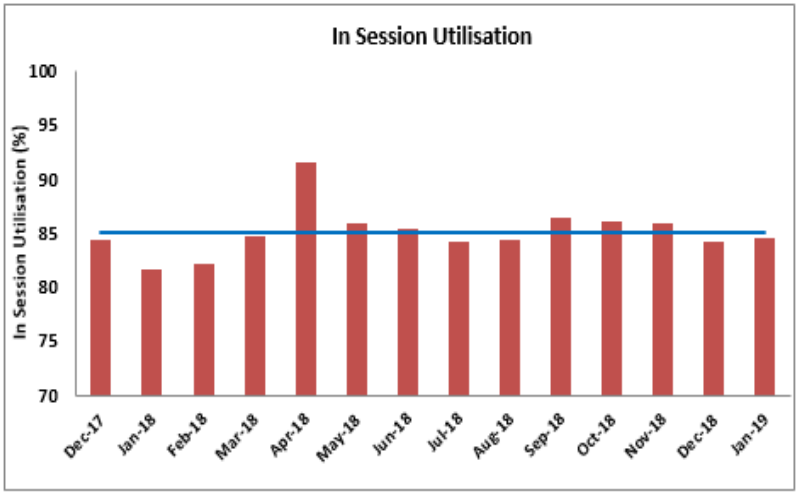
Session utilisation for January was 94.87% compared to December 18 which was 89.78%.

Average utilisation has increased slightly to 91.82% for the period April '18 – January '19.

RISKS / ISSUES

- Theatre recruitment to support future growth – successful open day in January 19 saw over 70 people attend with at least 20 offers being made on the day.
- 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

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 for January '19 was 84.47% compared to 84.15% in December.

In session utilisation remains consistent, running at an average of 86% for the period April '18 – January '18.

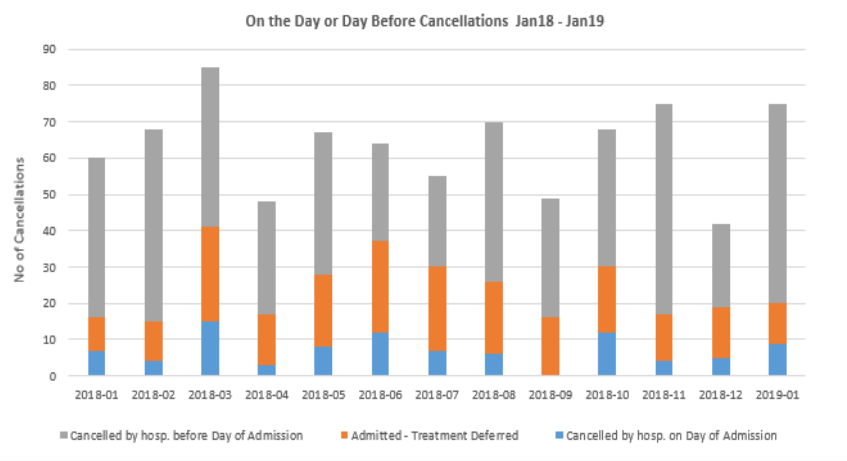
Changes in the admission process in ADCU have already seen improvements in the start times of theatres which will improve efficiency. An audit of how many theatres start on time (08:30 into the anaesthetic room) is being carried out monthly and monitored as part of the Jointcare improvement programme.

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
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

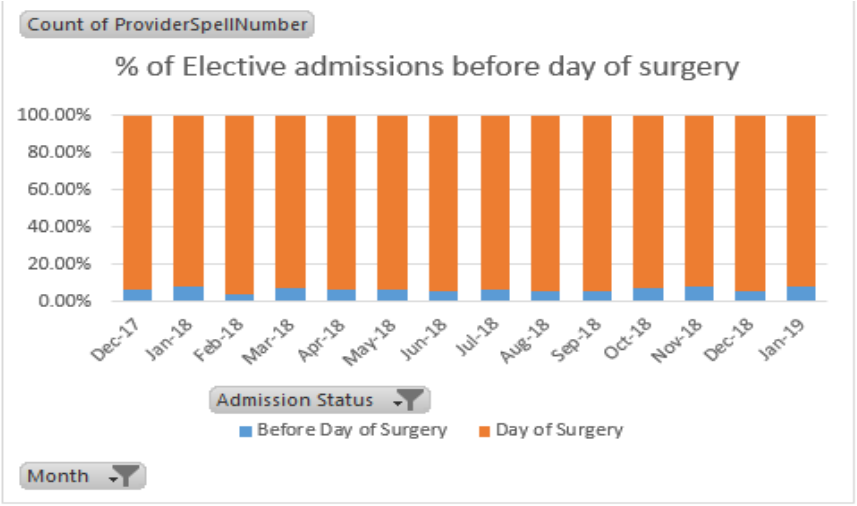
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

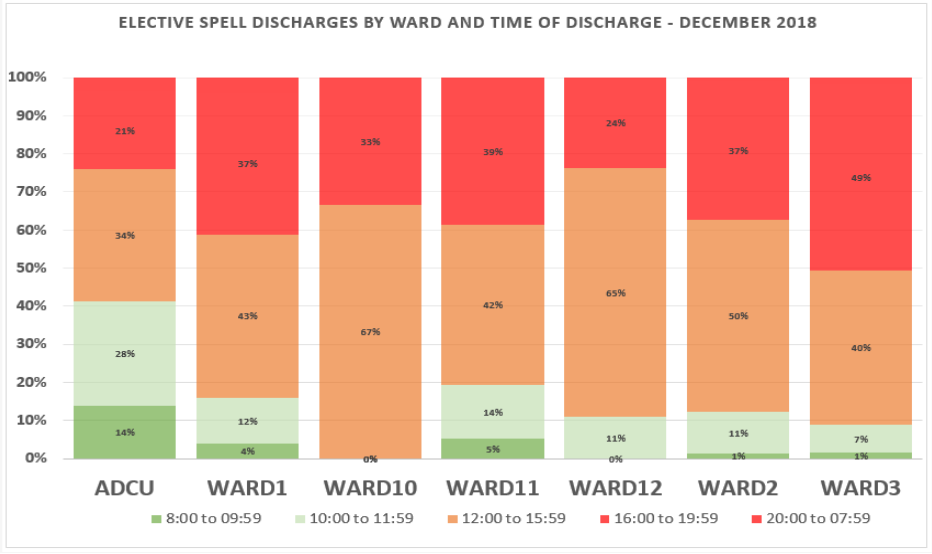
Hospital Cancellations



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
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	44	70	1
2018-09		16	33	49	0
2018-10	12	18	38	68	0
2018-11	4	13	58	75	0
2018-12	5	14	23	42	0
2019-01	9	11	55	75	0
Grand Total	92	220	514	826	2

Admission the day before surgery





The number of cancellations on the day of admission for surgery in January was 9 patients, a slight increase on December. Patients admitted for surgery where treatment was deferred has reduced in month from 14 to 11. Analysis of the reasons for patients cancelled on the day prior to admission include, Consultant illness and lack of theatre time. Patients admitted where treatment was deferred relate to equipment issues, cancellation to accommodate emergency patients and patients condition changing , where surgery is no longer required

Cancellations before the day of surgery have increased in month from 23 to 55. An analysis of the 55 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 patients declaring fitness issues on the 72 hour contact call . The increase in this number of patients is due to the robust process to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The 72 hour call process has now been strengthened and an extended hours contact service is being developed so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in February 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access.

The triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to pre – operative clinic to change the profile of triage to be delivered in the pre-operative clinic area, so that access to on the day triage can be expanded It is anticipated that the change in service will commence in April 2019.

ACTIONS FOR IMPROVEMENTS / LEARNING

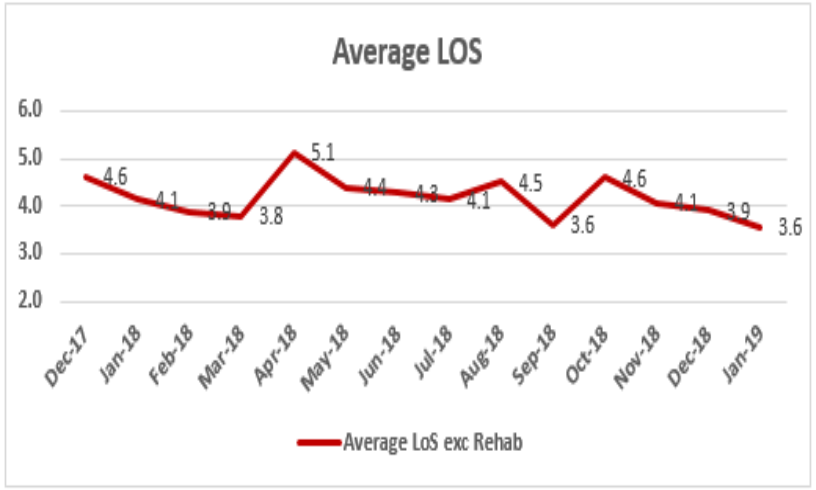
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

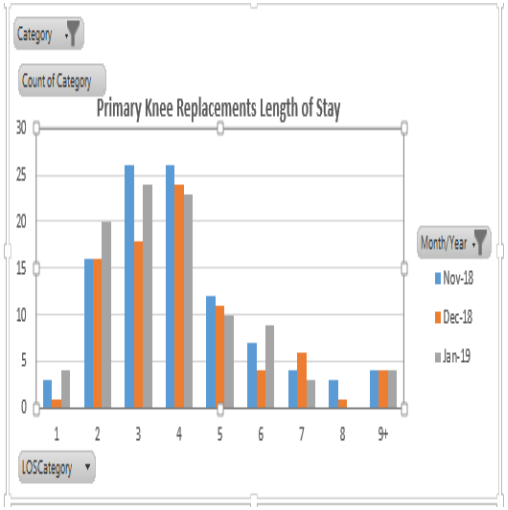
- POAC representative now attends daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Improved links with Clinical team to support any clinical concerns raised during patient contact

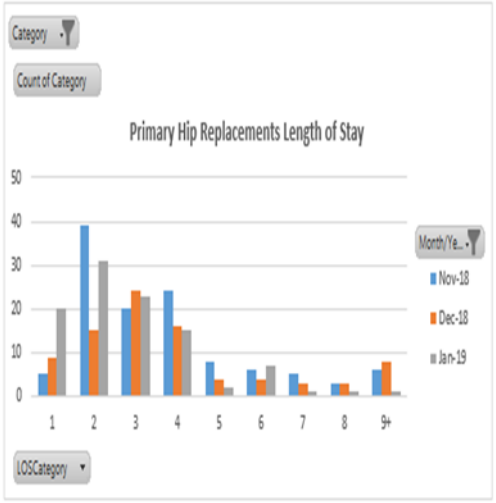
RISKS / ISSUES

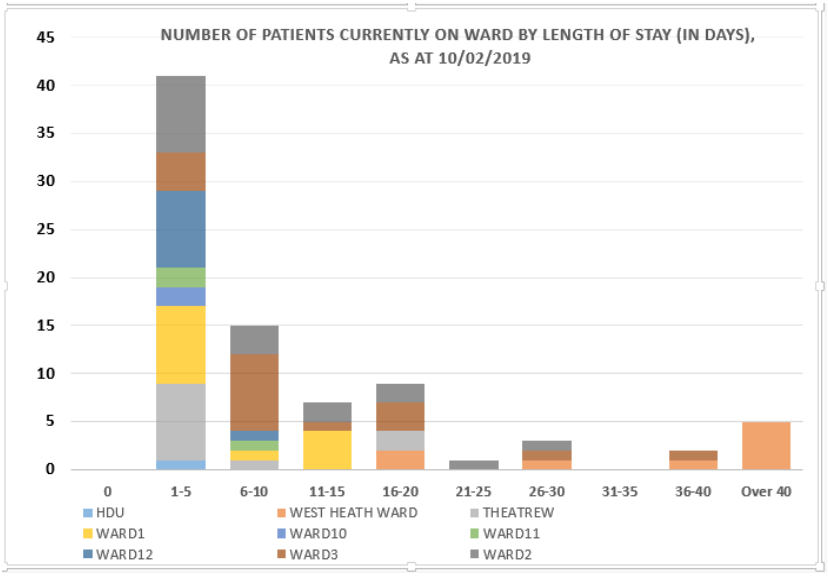
Existing ageing equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools have been purchased and full delivery of all items is expected by the end of March 2019. The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

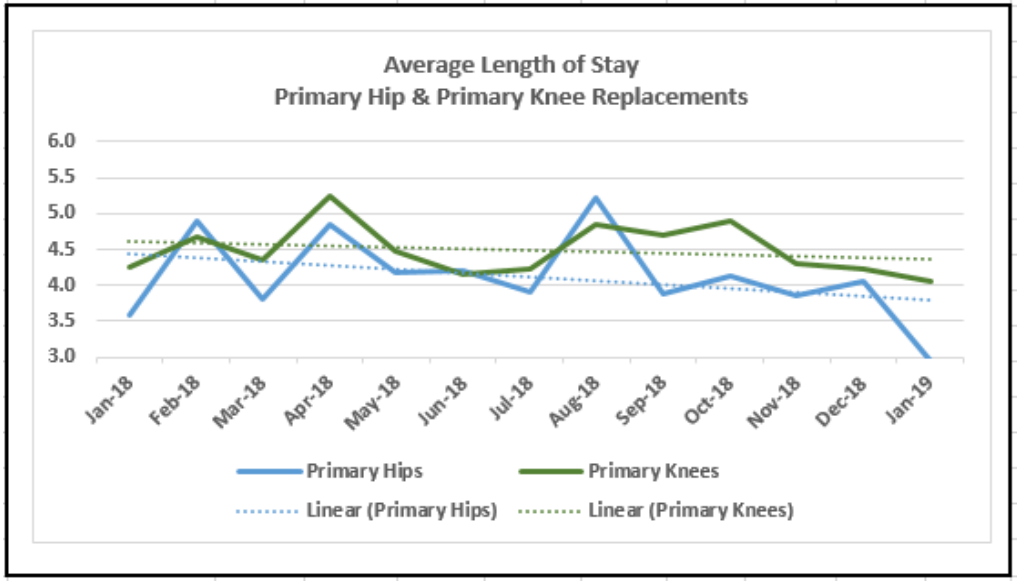
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS has reduced significantly in January 2019 and a number of initiatives are in place to continue to drive down length of stay including:

- 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 lounge staff to ensure timely discharge . The Senior Sisters across all inpatient wards are now implementing a 12: 30hrs review with all members of the MDT. The rationale for this is to strengthen the Red2Green initiative across all wards.
- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is developing local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- Joint care project to reduce length of stay for Hips & Knees continues to support reduced LOS .
- Production of a Jointcare performance dashboard to monitor a range of KPI's supporting reducing length of stay and a range of metrics is being developed
- The discharge lounge is well utilised by all adult inpatient wards.

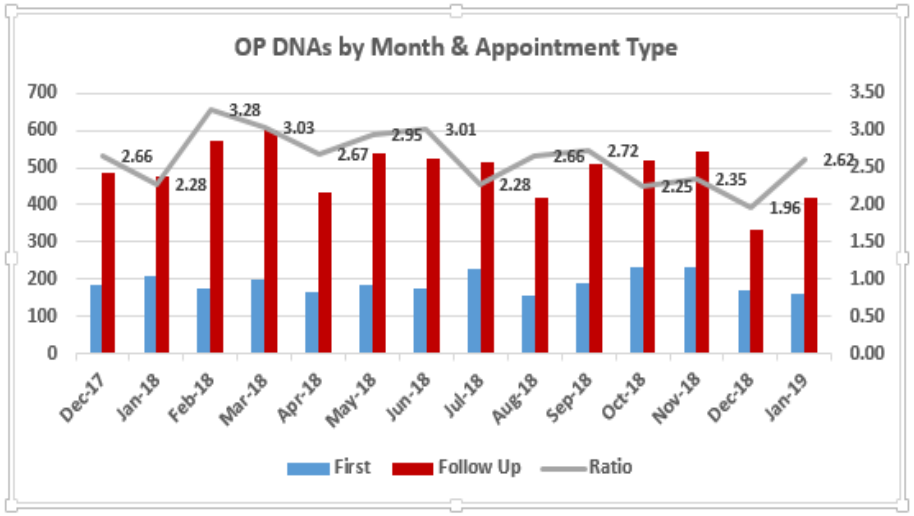
ACTIONS FOR IMPROVEMENTS / LEARNING

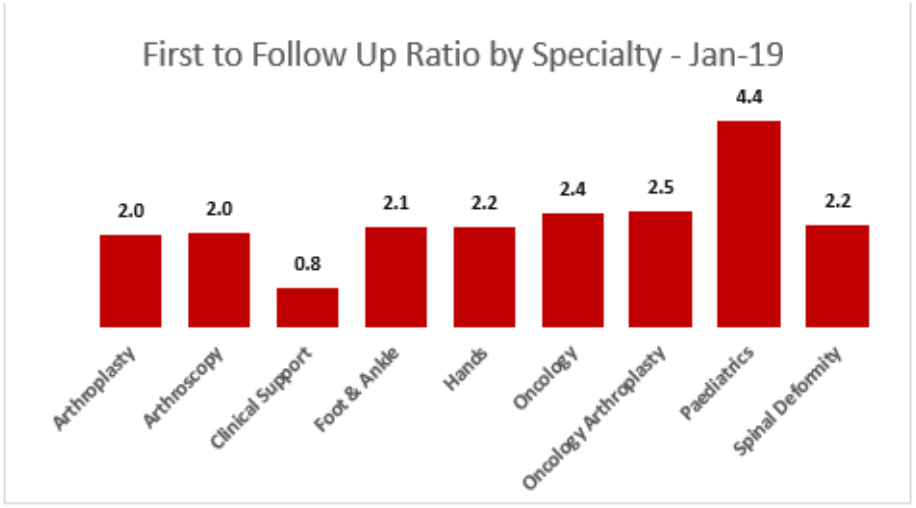
- The Red2Green dashboard development is now launched across all wards .
- The dashboard also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Options being explored include a 'floating ward clerk role ' out of hours to ensure timely recording of all ADTS .

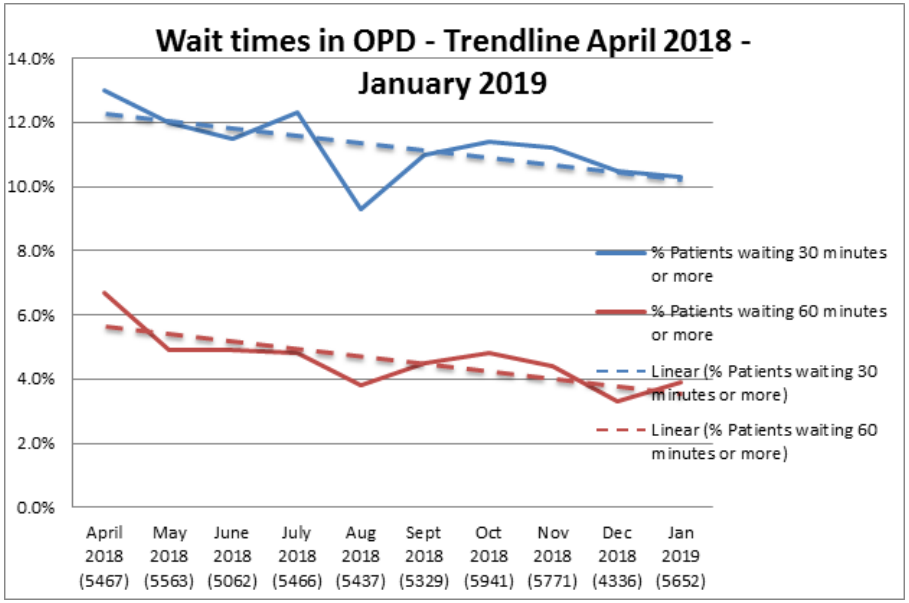
RISKS / ISSUES

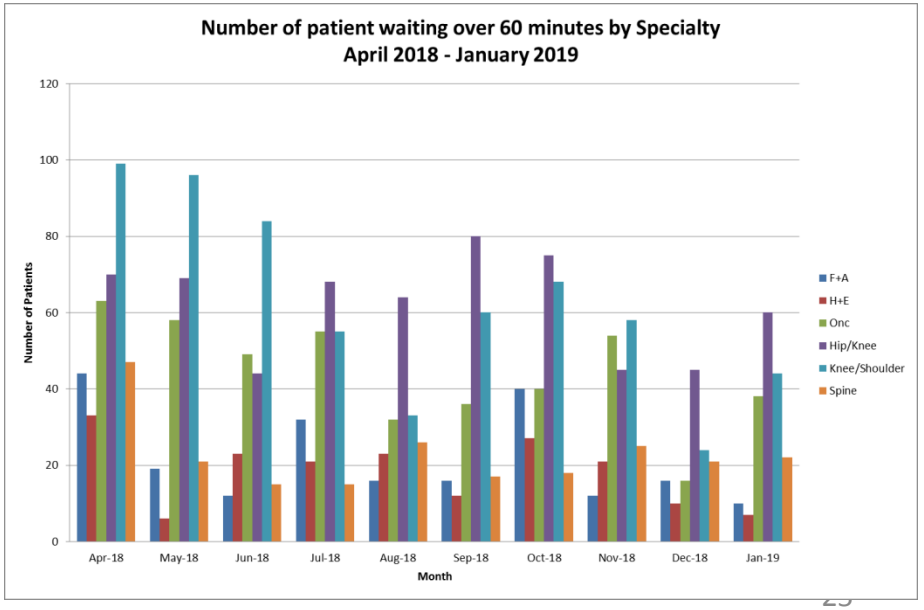
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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









INFORMATION

In January there were 10.3% of patients waiting over 30 minutes which is a slight improvement on last month, however the target for 30 minute delays has still not been achieved , focussed work is ongoing to continue to improve this position . 3.9% of patients were waiting over 1 hour which achieves the target of below 5%.

A new 6-4-3 meeting commenced in December and is held every Wednesday and produces room allocation timetables 4 – 6 weeks ahead. This meeting is evolving and will be used to review clinics and clinic templates with the operational management team to ensure clinics are well utilised and populated appropriately, to support a reduction in delays for patients attending clinic . Radiology are due to Join this meeting from March 2019 to review communication between clinics and Radiology and optimise patient flow.

The Matron for outpatients will continue to reiterate the importance of reporting all incidents relating to clinic delays and analysing the reasons for delays to improve practice . The department is now fully recruited, both for qualified and non qualified nursing staff . The current senior nurse for outpatients is retiring in March and a replacement is already in post to enable a full handover to take place.

A number of initiatives are being developed to improve the OP experience for patients and staff and full details of these projects will be discussed with key stakeholders at the OP away day planned for March 2019. This meeting will agree the priorities for this area and support required across a range of service improvement initiatives in line with recent NHSI recommendations .

ACTIONS FOR IMPROVEMENTS / LEARNING

- Reiterate the importance of submitting incident forms with the staff
- Develop the 6-4-3 meeting to review problem clinics with the OPS team
- Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available
- Investigation of partial booking processes to reduce clinic rescheduling and overbooking

- Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. A visit has taken place to Heartlands Hospital to review their processes for partial booking with the intention of implementing this at the ROH. This may require additional staff resource in the appointments team which will be addressed through a business case in the next 6 months.

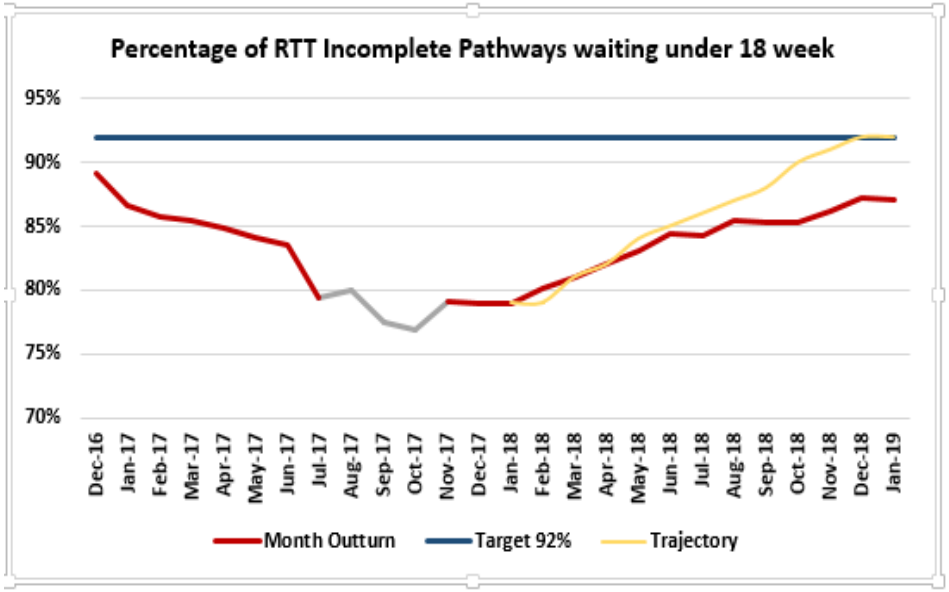
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

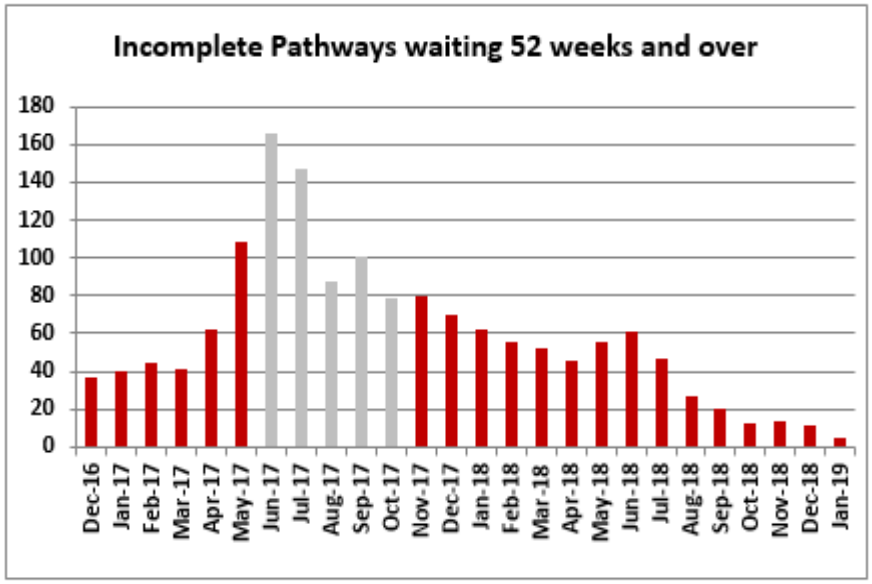
% of patients waiting <6weeks for Diagnostic test.

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%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1,254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1,245	1,252	99.4%
Dec-18	698	115	346	1,159	843	224	367	1,434	11	1,148	1,159	99.1%
Jan-19	728	123	416	1,267	897	253	472	1,622	4	1,263	1267	99.7%

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



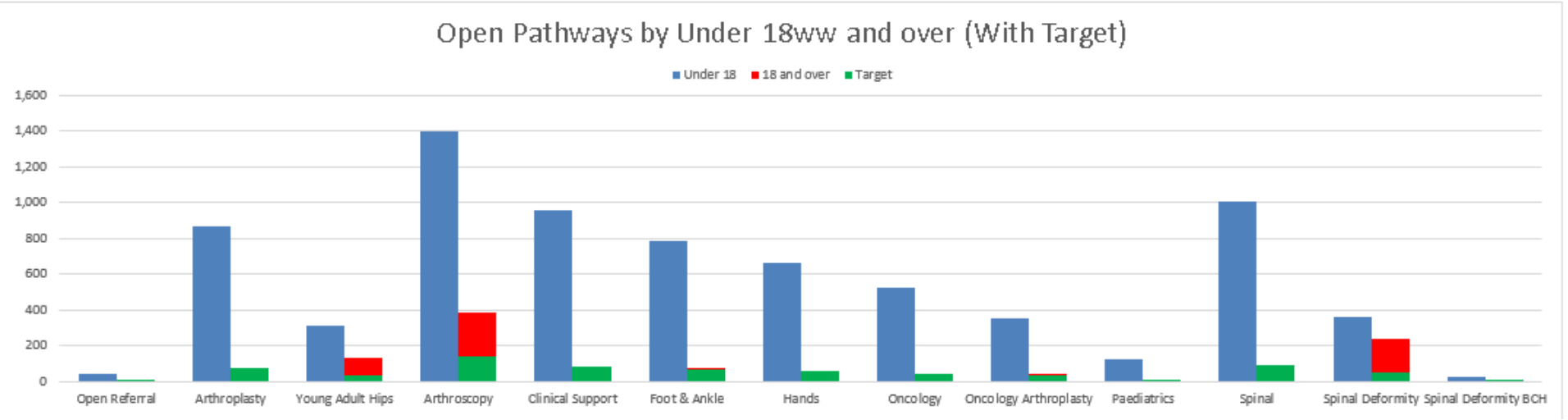


			Reported Month									Reported Quarter 2017/18			
		Indicative													
Target Name	**National Standard**	**Jan-19**	**Dec-18**	**Nov-18**	**Oct-18**	**Sep-18**	**Aug-18**	**Jul-18**	**Jun-18**	**May-18**	**Apr-18**	**Q4** (Jan, Feb, March)	**Q3** (Oct, Nov, Dec)	**Q2** (July, August, Sept)	**Q1** (Apr, May, June)
2ww	93%	*98.5%*	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*85.7%*	93.8%	100%	100%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	*90.0%*	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	*75.0%*	94.70%	*90.5%*	88.9%	77.8%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days			2	1		1			1						

13. Referral to Treatment snapshot as at 31st January 2019 (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	**3,480**	36	400	139	638	494	344	338	277	153	57	441	156	7
7-13	**2,812**	5	349	126	523	361	311	240	155	145	56	409	120	12
14-17	**1,119**	2	117	45	236	101	131	83	93	56	12	153	86	4
18-26	**846**	1	69	75	283	49	74	40	16	29	4	75	127	4
27-39	**300**	0	6	53	102	7	3	0	7	15	0	6	96	5
40-47	**17**	0	0	2	3	1	0	0	0	1	0	1	8	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**5**	0	0	0	0	1	0	0	0	0	0	0	3	1
Total	**8,582**	44	941	440	1,785	1,014	863	701	548	399	129	1,085	599	34

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	**7,411**	43	866	310	1,397	956	786	661	525	354	125	1,003	362	23
18 and over	**1,171**	1	75	130	388	58	77	40	23	45	4	82	237	11
Target	**687**	**4**	**75**	**35**	**143**	**81**	**69**	**56**	**44**	**32**	**10**	**87**	**48**	**3**
	86.36%	**97.73%**	**92.03%**	**70.45%**	**78.26%**	**94.28%**	**91.08%**	**94.29%**	**95.80%**	**88.72%**	**96.90%**	**92.44%**	**60.43%**	**67.65%**



13. Referral to Treatment snapshot as at 31th January 2019

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	**783**	1	137	48	132	62	52	110	65	52	17	77	25	5
7-13	**885**	0	208	51	198	58	40	85	39	67	23	87	19	10
14-17	**398**	1	73	21	108	25	30	28	15	34	5	39	17	2
18-26	**401**	0	51	38	170	16	14	29	12	14	0	27	27	3
27-39	**171**	0	5	26	82	3	2	0	4	7	0	3	34	5
40-47	**9**	0	0	0	2	0	0	0	0	0	0	0	6	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
Total	**2,652**	2	474	184	692	164	138	252	135	174	45	233	133	26

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	**2,066**	2	418	120	438	145	122	223	119	153	45	203	61	17
18 and over	**586**	0	56	64	254	19	16	29	16	21	0	30	72	9
Target	**212**	**0**	**38**	**15**	**55**	**13**	**11**	**20**	**11**	**14**	**4**	**19**	**11**	**2**
	77.90%	**100.00%**	**88.19%**	**65.22%**	**63.29%**	**88.41%**	**88.41%**	**88.49%**	**88.15%**	**87.93%**	**100.00%**	**87.12%**	**45.86%**	**65.38%**

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	**2,697**	35	263	91	506	432	292	228	212	101	40	364	131	2
7-13	**1,927**	5	141	75	325	303	271	155	116	78	33	322	101	2
14-17	**721**	1	44	24	128	76	101	55	78	22	7	114	69	2
18-26	**445**	1	18	37	113	33	60	11	4	15	4	48	100	1
27-39	**129**	0	1	27	20	4	1	0	3	8	0	3	62	0
40-47	**8**	0	0	2	1	1	0	0	0	1	0	1	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**3**	0	0	0	0	1	0	0	0	0	0	0	1	1
Total	**5,930**	42	467	256	1,093	850	725	449	413	225	84	852	466	8

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	**5,345**	41	448	190	959	811	664	438	406	201	80	800	301	6
18 and over	**585**	1	19	66	134	39	61	11	7	24	4	52	165	2
Target	**474**	**3**	**37**	**20**	**87**	**68**	**58**	**36**	**33**	**18**	**7**	**68**	**37**	**1**
	90.13%	**97.62%**	**95.93%**	**74.22%**	**87.74%**	**95.41%**	**91.59%**	**97.55%**	**98.31%**	**89.33%**	**95.24%**	**93.90%**	**64.59%**	**75.00%**

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and predicts that the Trust will return to 92% at an aggregated level by October 2019.

January 2019 performance is **86.36%**

It is expected that Oncology Arthroplasty will achieve 92% in March 2019 with Young Adult Hip in June 19 and Arthroscopy in July 19. A refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been completed and we anticipate that they will achieve the standard in Qtr. 4 19/20 . Excluding Spinal Deformity the Trust now has 9 patients waiting over 40 weeks all with treatment plans.

In January 2019 the Trust had **5** patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.

Detailed below is our progress with our trajectory with a revised trajectory submitted to NHSI/E (19/2/19). Work is still ongoing with the aim to clear all patients by the end of March 2019.

ROH 52 Week Trajectory Feb 2018

Over 52 Weeks	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
ROH Specialties excluding SD	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
ROH Adult Total	14	12	16	15	12	9	7	0	0	0	2	0	0	0	0
ROH Paediatrics Total	20	28	31	25	28	19	16	8	10	11	19	15	9	3	0
BWCH Paediatric Total	30	29	27	27	27	27	25	20	15	11	8	4	0	0	1
ROH Total	66	70	75	67	68	55	47	29	25	22	29	19	9	3	1
Actual Performance	**56**	**52**	**46**	**55**	**61**	**47**	**27**	**20**	**13**	**14**	**11**	**5**			
Revised Trajectory													3	1	2

ACTIONS FOR IMPROVEMENTS / LEARNING

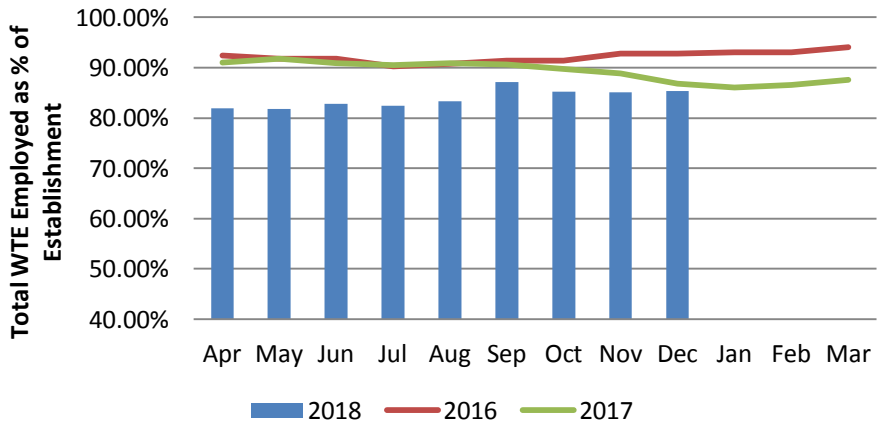
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019

RISKS / ISSUES

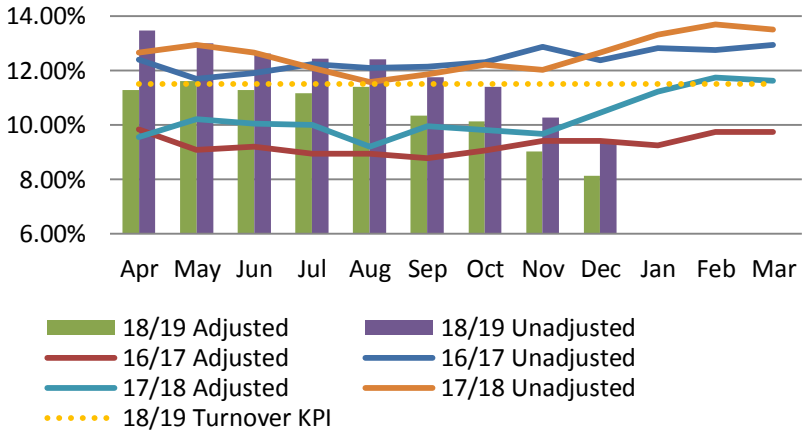
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds remains a concern.

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

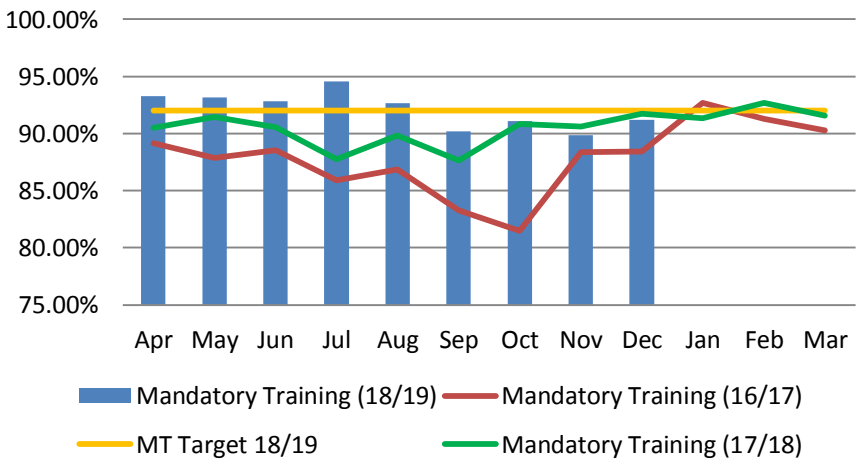
Staff in Post v Establishment



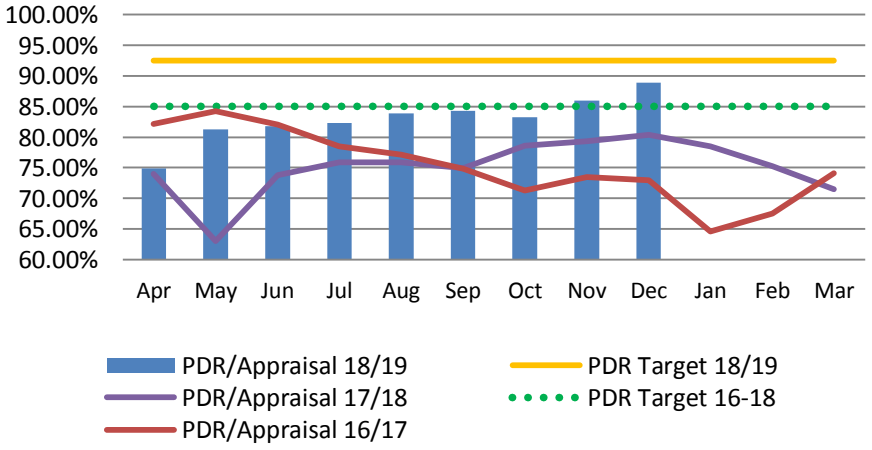
Staff Turnover



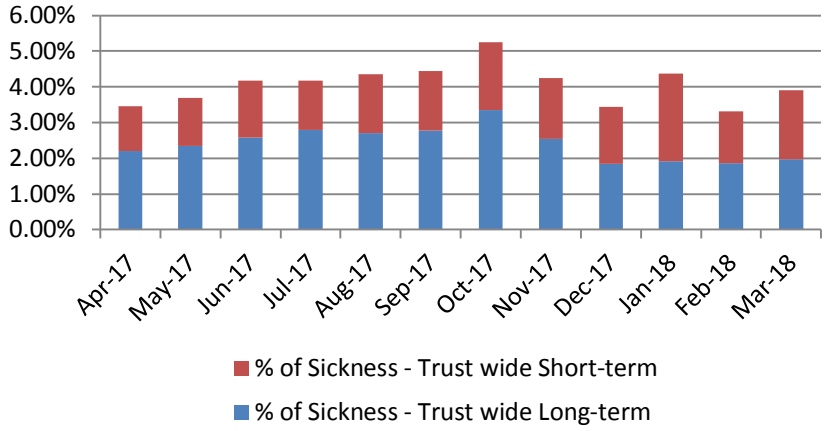
Mandatory Training



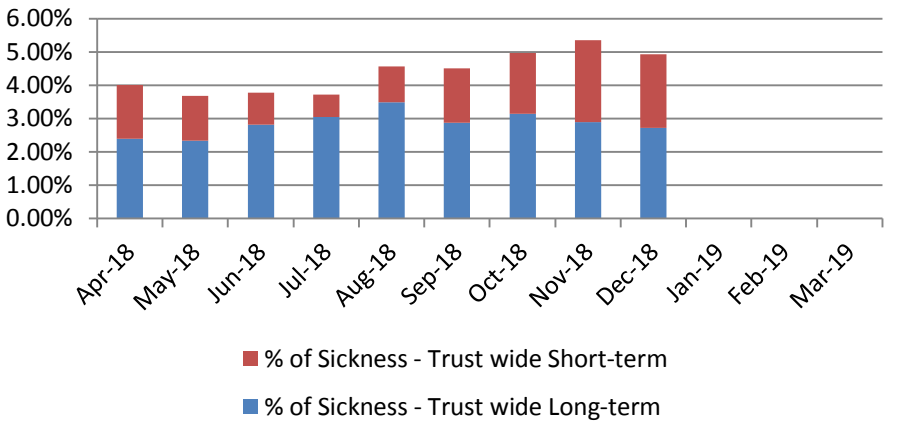
PDR/Appraisal



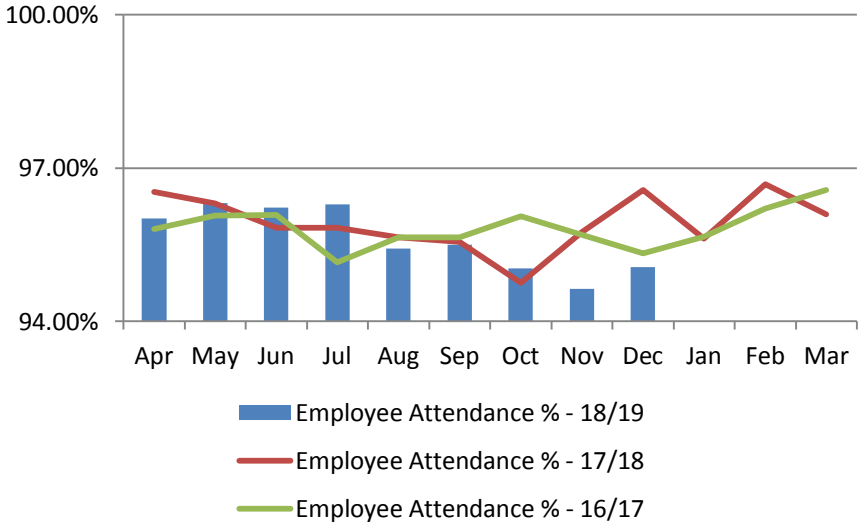
Sickness % - LT/ST (2017/18)



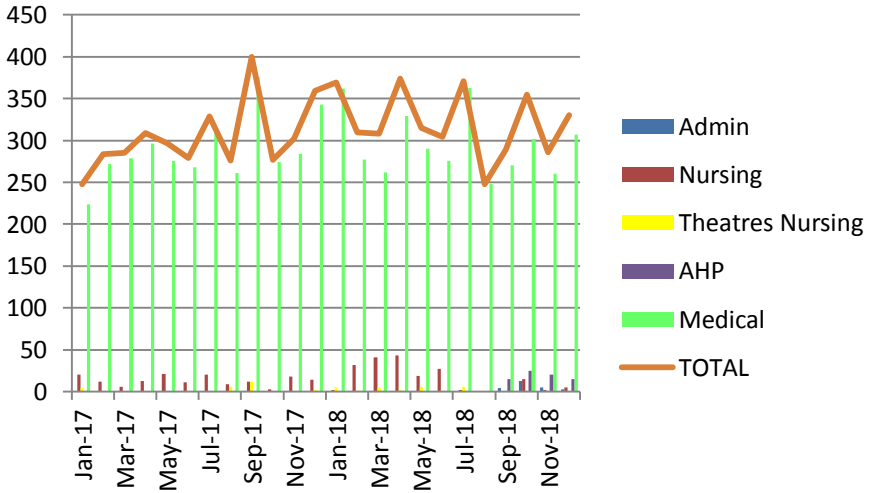
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

December saw a slight improvement in the vacancy position, an improvement in appraisal, a further reduction in turnover and an increase in the core mandatory training position. Sickness absence also reduced from the November 2018 spike.

This month the Trust's vacancy position saw a small increase (0.37%) as a percentage of WTE employed, with the figure 85.42% against a Trust target of 90%. The WTE number of staff on the payroll stood at 918.39, a decrease on the November position of circa 5 WTE but with a small reduction in the funded establishment for the Trust.

Monthly attendance moved downwards from November's high figure. In December, the position stood at 95.06%. A separate report into short term absence in November and potential correlations with influenza jabs and/ or half term holidays was provided to the SE&OD Committee in January – there is no factual evidence of either, although there is still a feeling that some individual staff members may seek to exploit a flu outbreak or claim sickness absence in half term.

The originally reported split between long and short term sickness for November is left in the graph above. However, whilst the overall percentage was correct at the time (5.36%), there does appear to have been some retrospective adjustment to the short term split in November. The effect of this is that the short term figure in December (2.22%) is now showing higher than November (1.93%) but the long term figure has moved down below 3% for the first time since July 2018 to reduce the overall figure.

Mandatory Training numbers saw an increase of 1.37% versus the November position, taking the Trust to 91.22%. This is still below the target of 92% for the 4th consecutive month - but is very much a step in the right direction.

December's appraisal performance increased to 88.89%, which is the highest performance since May 2014. Whilst this is still adrift from our stretch target of 92.5%, this represents real progress.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) reduced to 9.40%. The adjusted turnover figure (substantive staff leavers including retirements) increased slightly to 8.12% and both were green against a KPI of 11.5%.

In December, agency breaches increased from 286 to 330 shift breaches in total, with the increase explained by medical staff breaches (up to 307 from 260), with limited movement in other staff groups versus November's usage.

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

Given high sickness levels, there may still be pressure on mandatory training and appraisal percentages, at least in the next couple of months.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 9 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• An update on work being delivered to address the vacancy gaps in nursing was presented. The expertise in the Trust to introduce new roles and to undertake workforce planning were noted to be particular risks at present. A culture of working in silos was also a risk, as was the current timescale from offer of appointment to starting in post. The mitigations for treating these risks were outlined. • It was reported that work was underway to develop a staffing model for theatres, including covering the new modular set up. The current high level of vacancies in theatres was noted. The work of the 'Perfecting Pathways' programme would assist with this work. • Talent management and succession planning processes remained weak and would need to be addressed over coming months.	• It was agreed that continuous improvement should form the basis of a Staff Experience & OD Committee workshop in future and this was to be scheduled into the workplan. • A deep dive into the staff survey results was to be planned into the workshop scheduled for 6 March. • A further update on progress against the workforce process review actions is to be scheduled into the May 2019 meeting. • Include sickness absence as a point for review on the agendas of the next three meetings. • Present information around the time to recruit at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a presentation from a Management Gradate Trainee currently working in the Finance department. Overall, her experience was positive, although in some cases the reality of the role had not lived up to her expectations when she joined. The Executives present agreed to learn the lessons from this case for future trainees. • Although there was a degree of delay with the delivery of the People & OD strategy, there was acknowledged to be good progress overall. • The Committee was advised that the draft national staff survey results had been received which presented a more positive position against a number of the indicators. The results were noted to be embargoed at present. • The first Staff Experience walkabouts was reported to have been held, which had been undertaken by a number of the Non	• None specifically.

Executives who had visited IT, Finance and Informatics. Overall the visit was positive, although there were some estates and environmental issues which had been raised. • Adequate progress was being made with the actions raised from the workforce process review undertaken in 2018. • On request from the Finance & Performance Committee, there was a discussion around sickness absence and whether there was any correlation with the update of the 'flu vaccination or half term. There was no evidence to suggest that this might be the case, however the Committee agreed to review sickness absence for the next few meetings. • On request from the Quality & Safety Committee, the Committee received an update on the time to recruit. It was noted that from unconditional to conditional offer, the time was currently six weeks. Work was underway to improve this position.	
Chair's comments on the effectiveness of the meeting: The conversations had been productive and the agenda had dealt with a broader range of topics than the earlier meetings, which was seen to be positive.	

ROHTB (3/19) 013

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 6 February 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted as part of the Staff Experience story that the development opportunities for facilities staff were limited. • Talent management was agreed to need further embedding. • The Non Executive walkabout to estates, facilities and portering had highlighted a number of issues, including air conditioning and some staff not feeling respected – the Executives were aware of the issues and work was already underway to address them where possible. • The position against many of the Workforce Race Equality Scheme standards had deteriorated; it was noted that the advent of the equality and diversity network might assist and external input was being sought to inform the improvement plans. Of particular concern was the position against the indicator concerning bullying and harassment of Black and Minority Ethnic staff. • There was highlighted to be an increased risk of disruption in the HR department due to some leavers who were in key positions.	• An update on resuscitation training was needed at the next meeting. • Include sickness absence on the agenda of the next meeting. • A report on the wellbeing work would be considered at the next available meeting. • Widen the risk around the impact of Brexit to include workforce considerations.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a presentation from a member of the Blitz cleaning team; the staff member reported that his experience of working at the Trust was very positive overall and he had been provided with good opportunities after a period of personal adversity. • The staff turnover position had reduced. • It was suggested that the nurse development path could be marketed as a bespoke opportunity for individuals aspiring for a higher level role elsewhere. • The Committee was given assurance that work was underway to streamline the onboarding process and reduce the time from conditional to unconditional offers being issued.	• The position against the WRES standards could be published on the Trust's internet. • The session in March would focus on the Staff Survey, including the benchmarking information and how the findings aligned to the People & OD Strategy.

• There had been a successful recruitment event that would address some of the current vacancies in theatres, in particular. • An update was received on the plans to develop middle grade medical cover; the plans would be implemented by March 2021. • There had been a positive increase in the number of nominations for staff awards. • In terms of the nurse staffing update, it was reported that the Care Hours per Patient Day position had improved.	

Chair's comments on the effectiveness of the meeting: The discussions had been productive and the Staff Story was particularly well received.

Workforce Performance Report

January 2019

CONTENTS

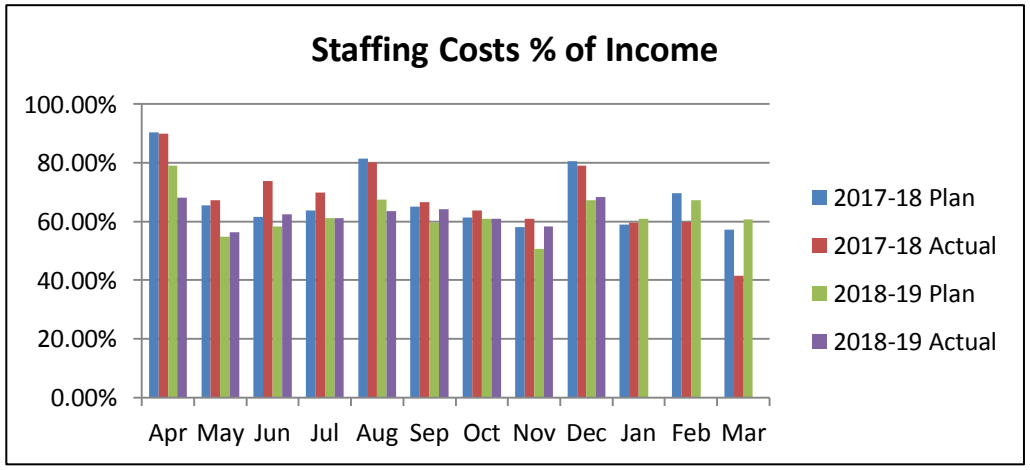
Staffing costs

1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	63016	
Actual Income YTD	63303	100%
Planned Pay Costs (YTD)	38538	
Actual Pay Costs (YTD)	39467	102%
Planned Substantive Pay Costs (YTD)	32410	
Actual Substantive Pay Costs (YTD)	30890	95%
Planned Bank Pay Costs (YTD)	3367	
Actual Bank Pay Costs (YTD)	4591	136%
Planned Agency Pay Costs (YTD)	2629	
Actual Pay Costs (YTD) Agency Staff	3933	150%
Planned Agency Pay Costs as % of total Pay costs (YTD)		6.8%
Actual Agency Pay Costs as % of total Pay costs (YTD)		9.8%

Total ADH Payments (Apr - Dec) £000s	1699

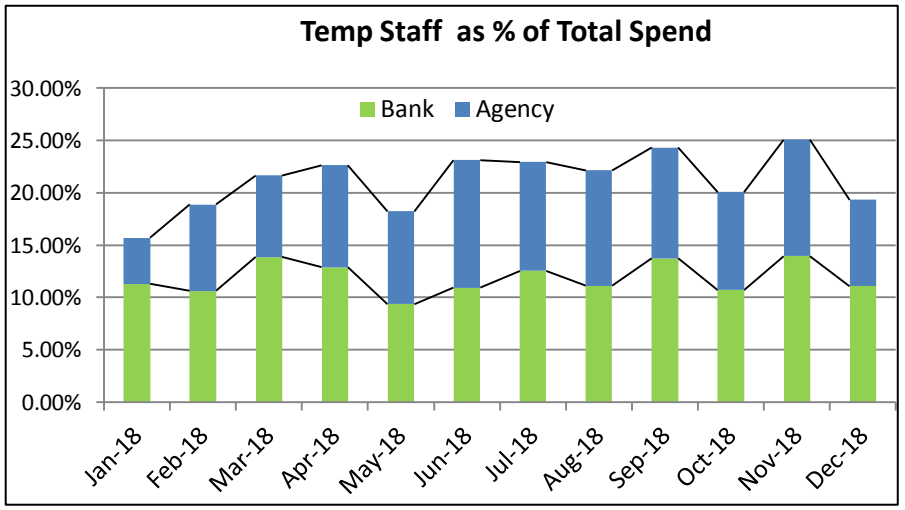


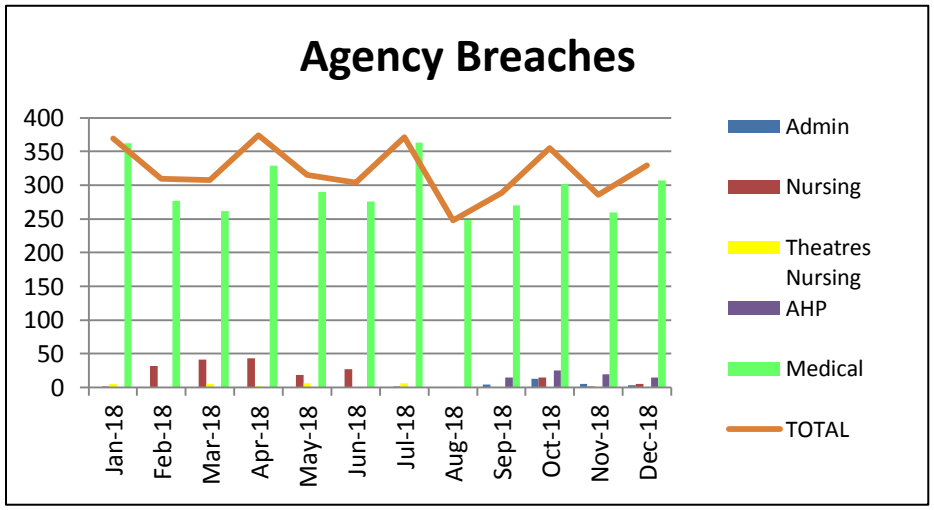
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	242	363
May	242	514
Jun	242	443
Jul	242	490
Aug	242	440
Sep	242	402
Oct	241	510
Nov	241	350
Dec	241	420

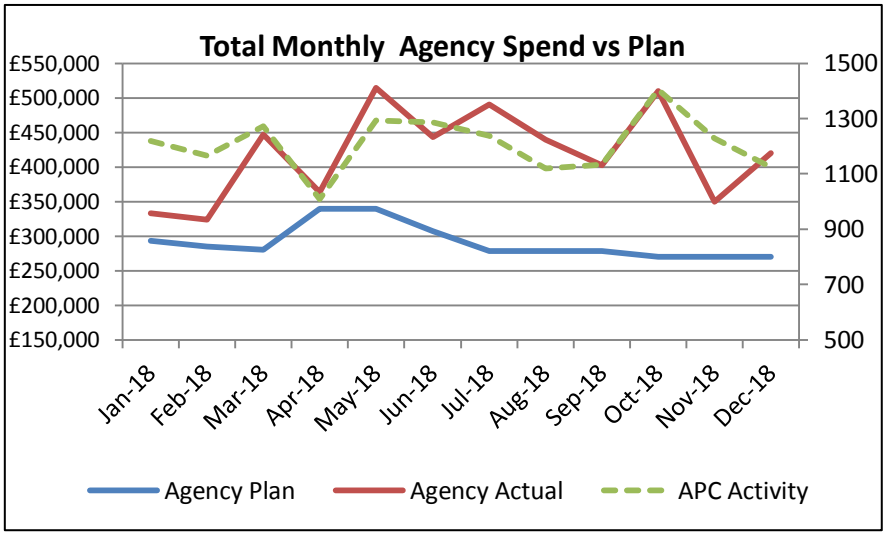
Data based upon December Management Accounts

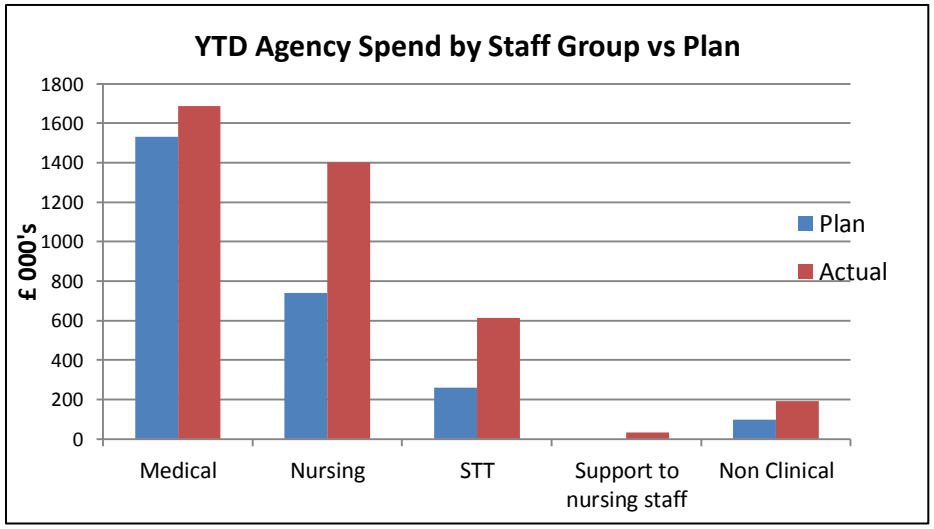
1 Workforce Composition and Cost

1a Temporary Staffing Analysis



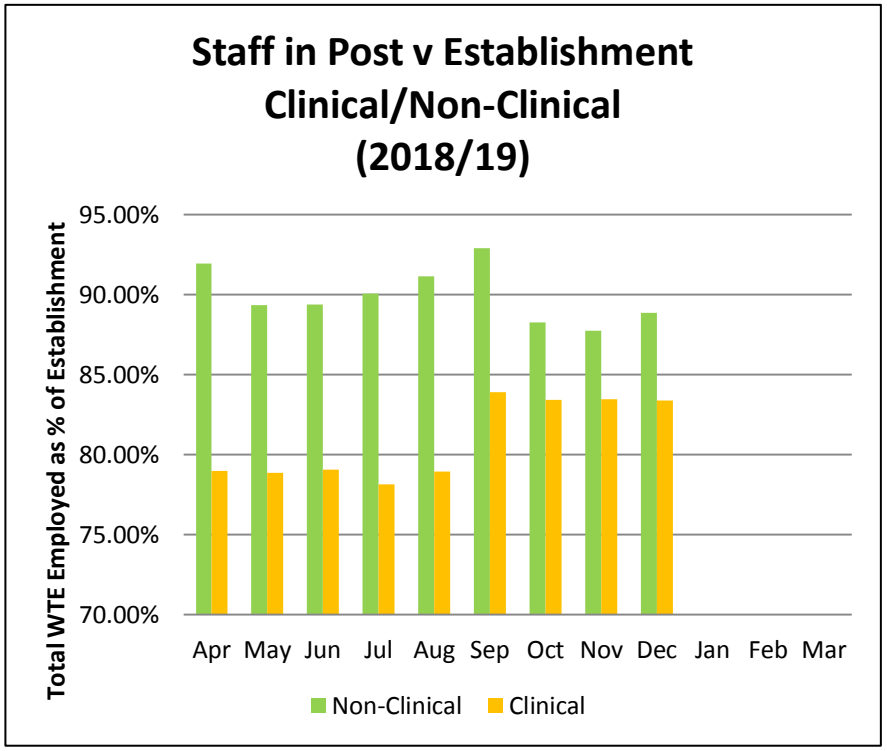


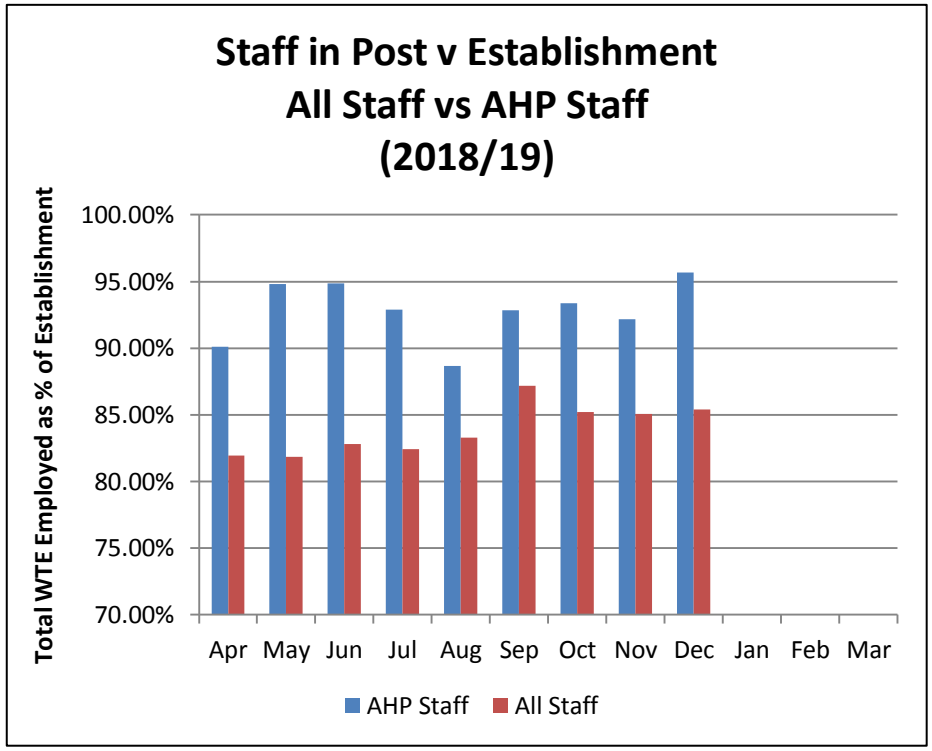




1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

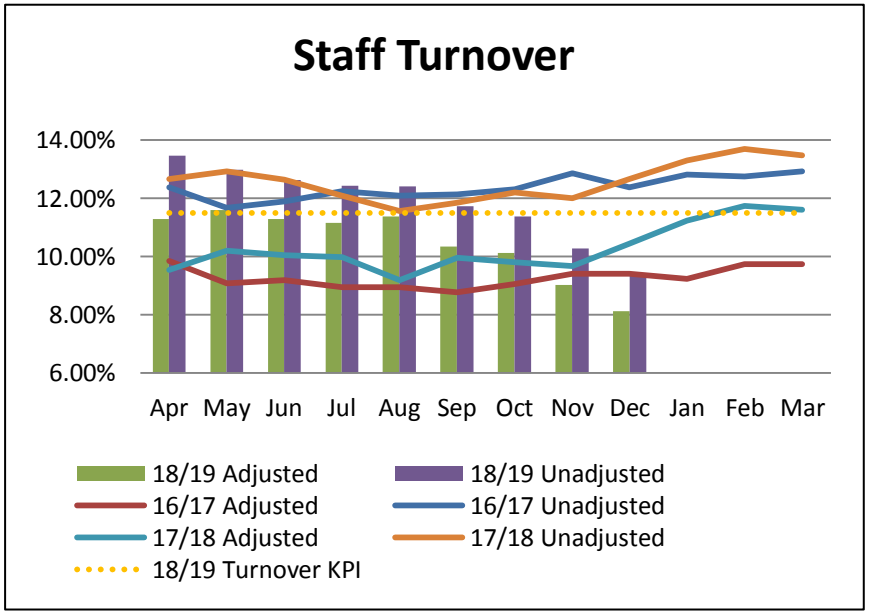
Establishment

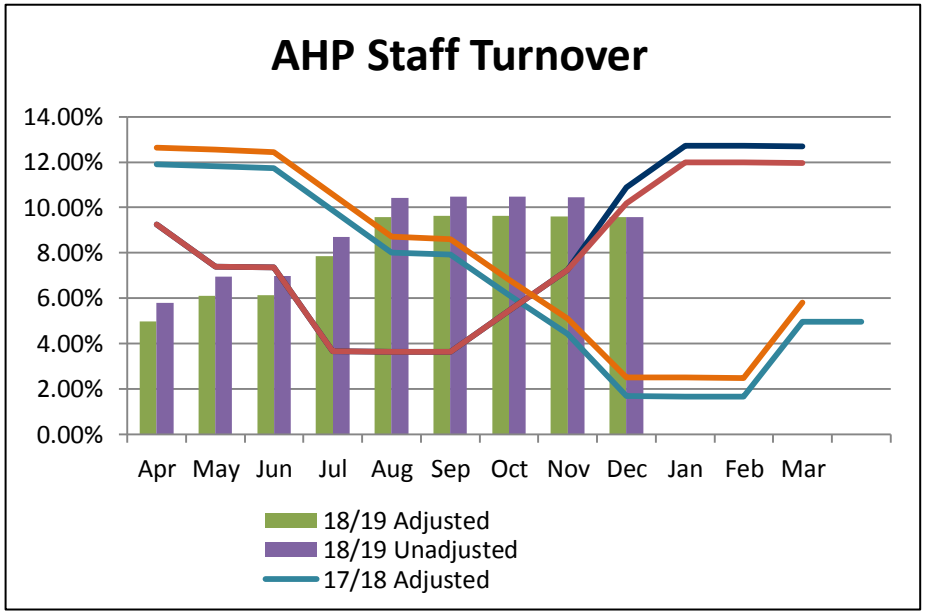




1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

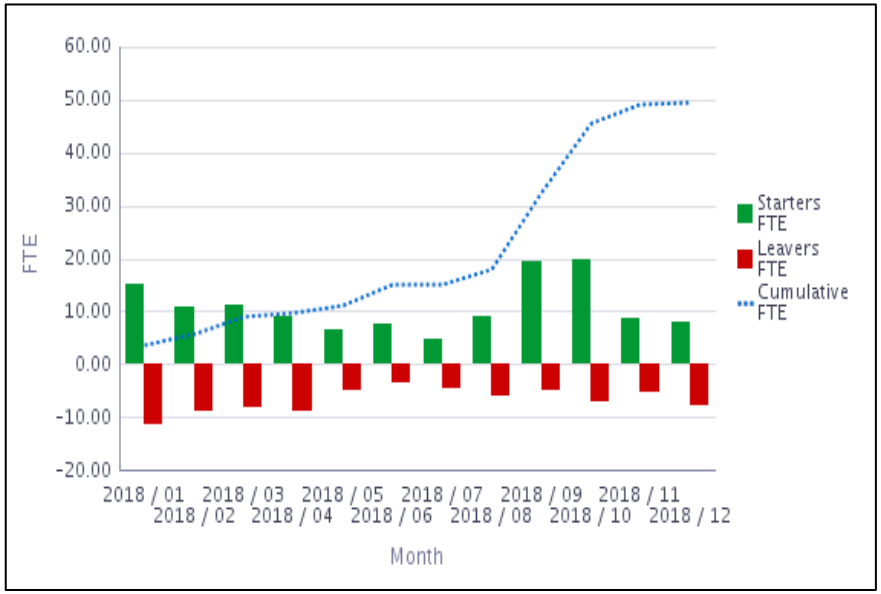
Turnover



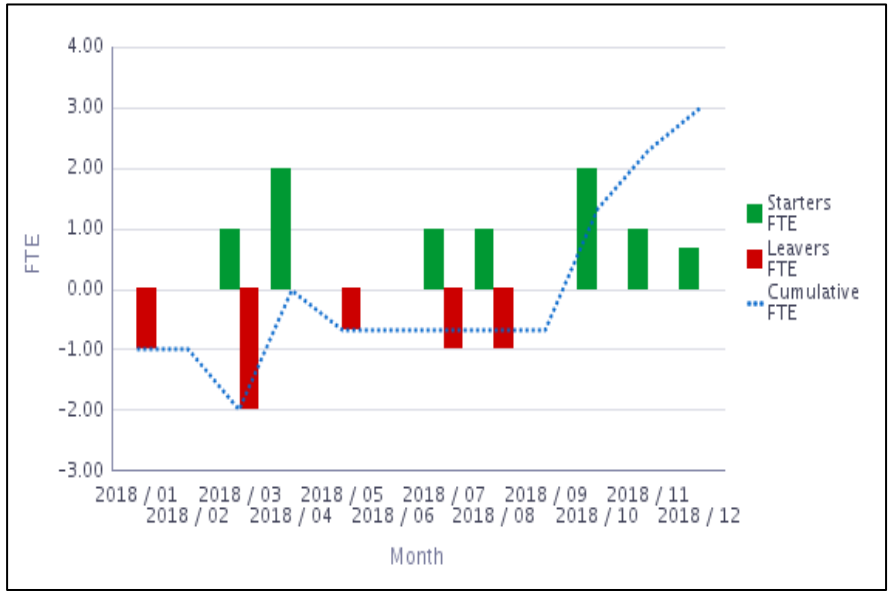


1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Starters / Leavers by Month - All Staff

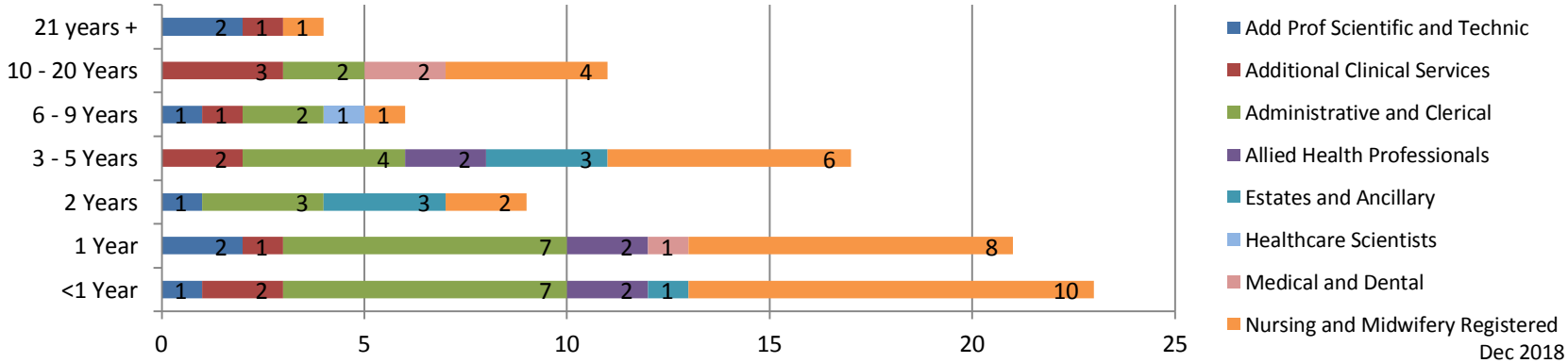


Starters / Leavers by Month – AHP Staff

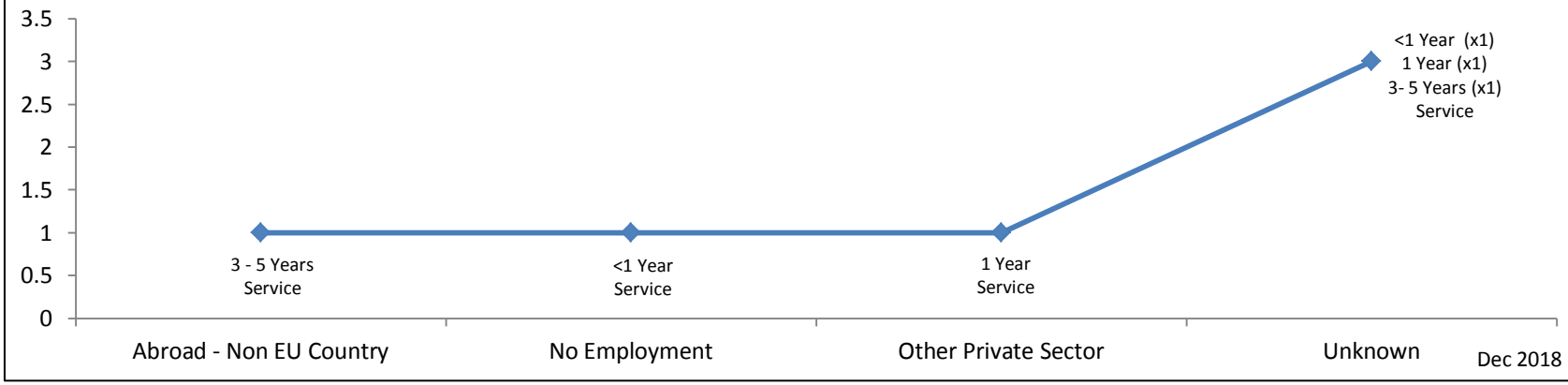


1	Workforce Composition , Resourcing and Cost
1d	Staff Turnover

Leavers by Length of Service (12 months)

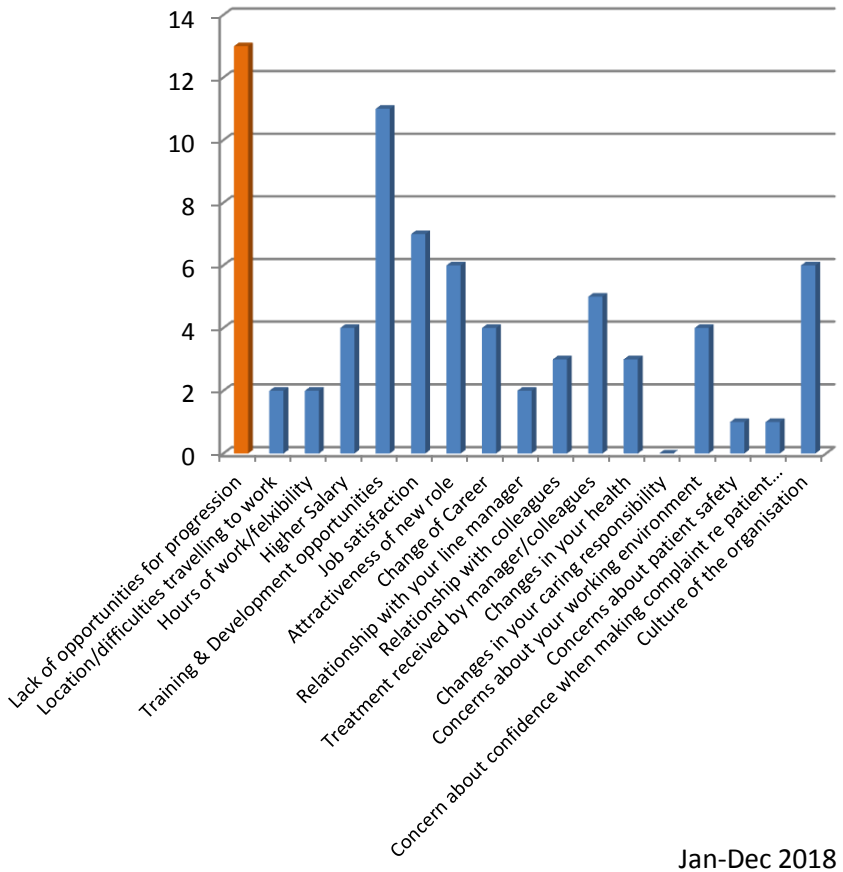


Leavers by Destination upon Leaving & Length of Service
AHP Staff



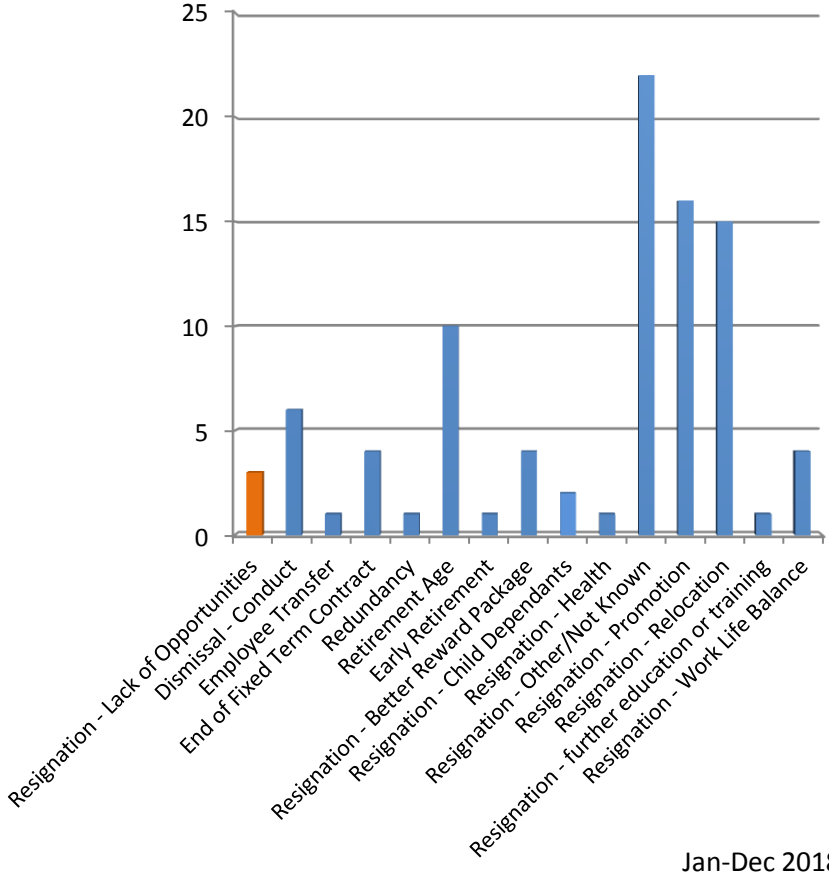
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

Exit Questionnaire Reason for Leaving



Jan-Dec 2018

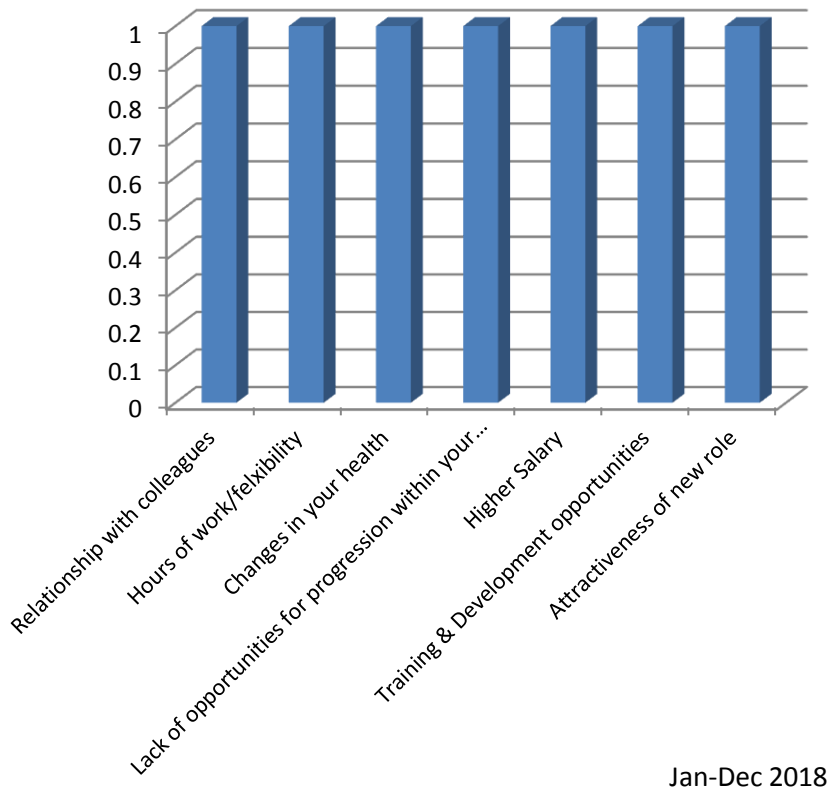
Reason for Leaving (ESR data)



Jan-Dec 2018

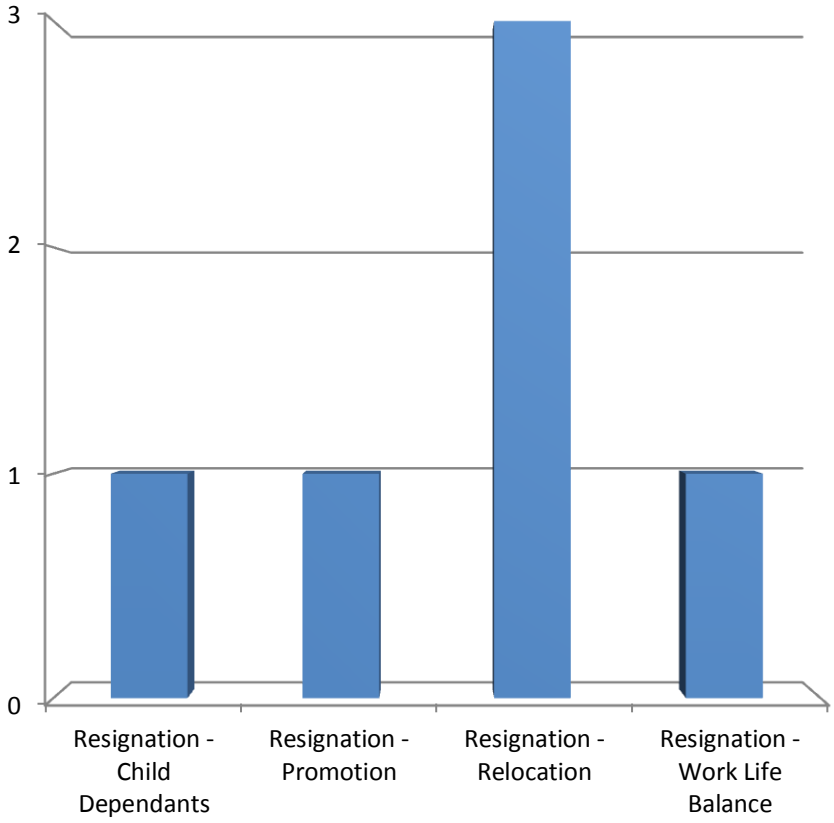
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

AHP Staff
Exit Questionnaire Reason for Leaving (Jan - Dec 18)



Jan-Dec 2018

AHP Staff Reason for Leaving (ESR data)

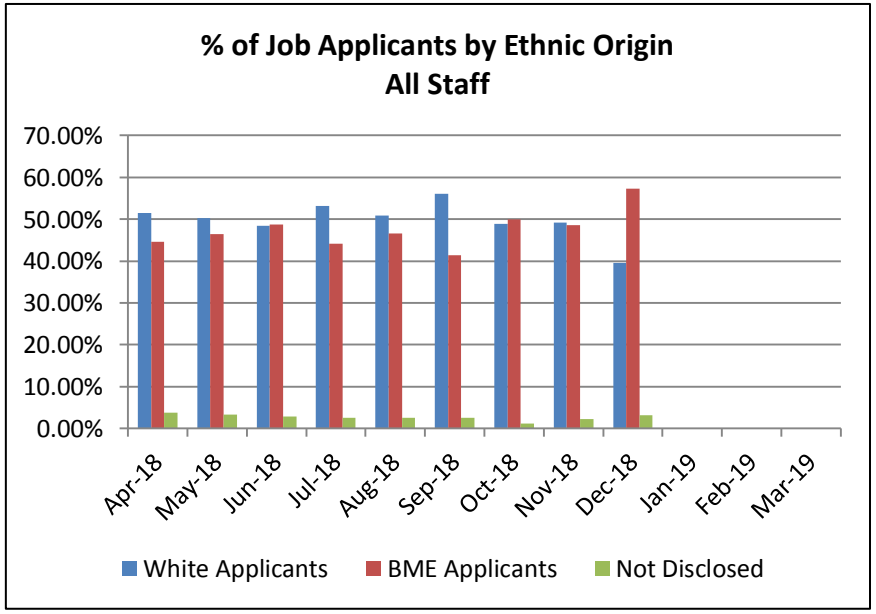


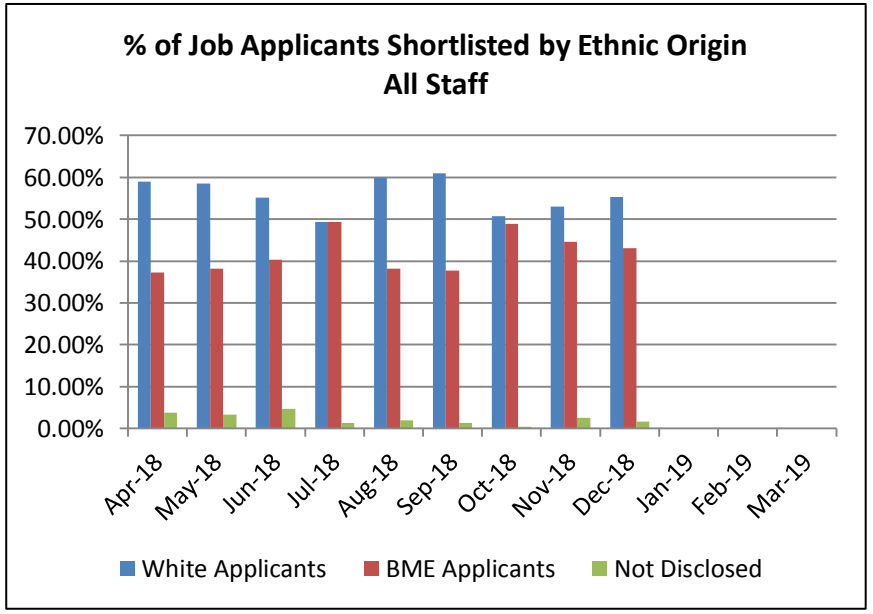
Jan-Dec 2018

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



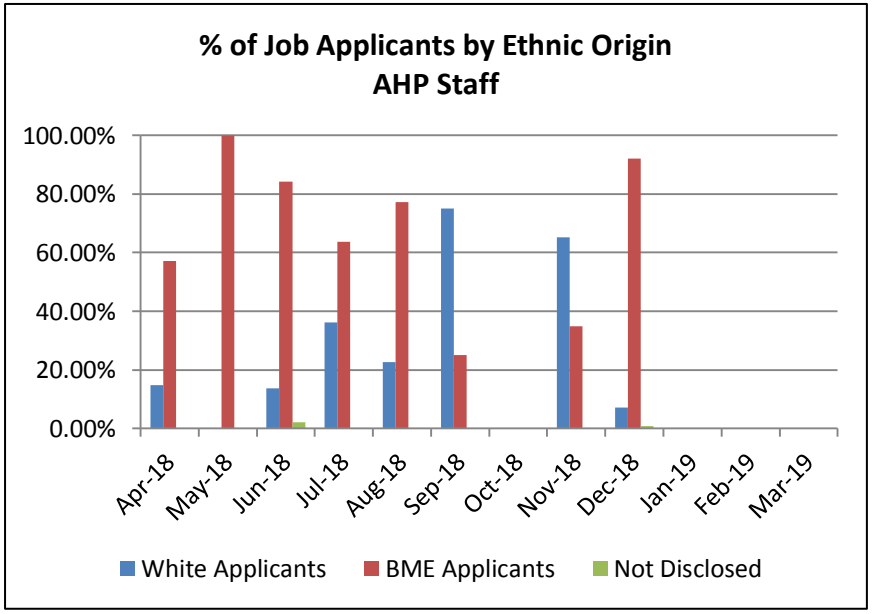


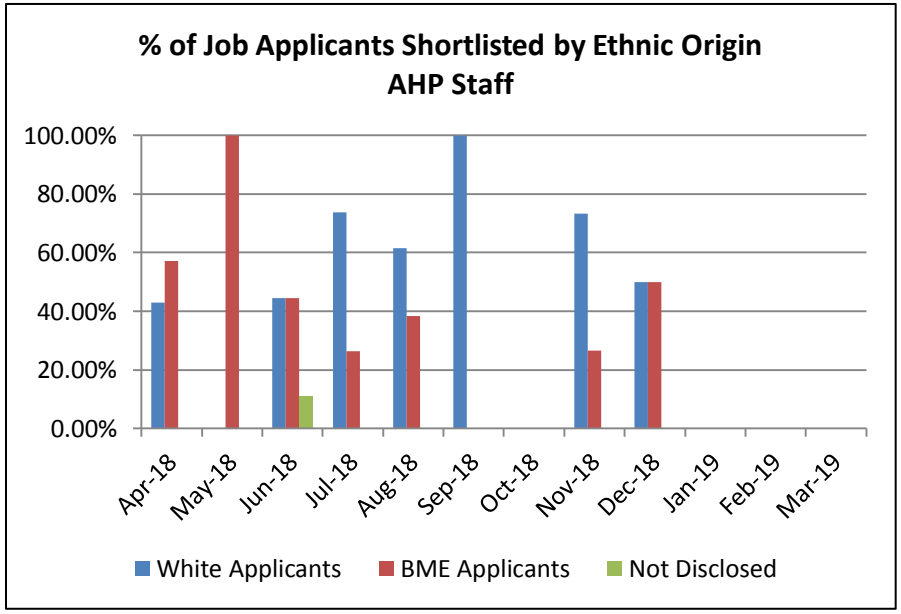
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.73	↓	+0.13	+ 0.09	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month
3.83

Workforce Composition, Resourcing and Cost

Staffing Costs – The actual spend on staffing was just above that planned in December, for both bank and agency staff, with the latter remaining considerably above plan across all staff groups. At face value, although the Trust has clearly been using some agency staff to deliver additional activity, this is slightly surprising for December, as the expected (reduced) amount of activity was delivered. There is further work being undertaken by finance colleagues to understand this more deeply: although December's sickness absence was high (almost 5% in month), there is a question about whether a disproportionate number of staff may have been released in month – but it is also clear that a lot of claims for additional activity were submitted for payment by Consultants in December which affect the financial position.

Turnover – the unadjusted turnover figure has now reduced for each of the last 11 months and is now reported as 9.40% for year to December 2018 (compared with the 12 month figure of 12.66% in December 2017). This is against the Trust target of 11.5%. The adjusted turnover position has improved (decreased) for each of the last 5 months and a December figure of 8.12%. Turnover has decreased for medical and nursing staff but more significantly for clerical and ancillary staff to drive this position.

The Trust is part of an NHSI externally facilitated programme for nursing staff in particular to share best practice and develop an action plan, for which work will continue in February and March 2019.

The Trust's size does mean that relatively small changes in numbers will affect the turnover position. In context, AHP's are the only staff group whose turnover has worsened in the last 12 months – with 7 leavers as opposed to 3 in the respective 12 month figures – so not a significant cause for concern.

The exit questionnaire data is interesting, and now covers a 12 month period: the ESR data offers unknown/ promotion/ relocation as the top three reasons, whilst the actual reasons put forward by respondents suggests a lack of opportunities for progression/ training and development opportunities and job satisfaction as the top three reasons. The consistent theme is that respondents seem to be leaving, as the Trust cannot meet their promotion or development aspirations (and possibly relocating to do so). This does pose a workforce challenge: whilst turnover rates are improving, the size of the Trust means flat structures in clinical jobs will be a challenge. The Trust has started an in house band 6 development programme for nurses, and has established a link with Keele University to reintroduce the Orthopaedic nursing course.

The graph on page 5 shows the remaining level of challenge, which has been updated to reflect the increased number of budgeted established posts and conversion from bank to agency (this does not reflect any potential changes resulting from the transfer of Paediatric Services or projected growth in Theatre capacity or therapy services). Based on a like for like comparison, there were circa 40 WTE more staff on the payroll in December 2018 than there were in December 2017, representing a growth of 4.5% in workforce numbers. These are encouraging signs – although it should be noted that the majority of this growth occurs in non-clinical posts.

Workforce Composition, Resourcing and Cost

Recruitment and Selection - Time to hire and streamlining

The figure for conditional offer letter to unconditional offer letter within 6 weeks is 82% based on 113 live records as at the end of January 2019. Whilst this figure is below the expected 95% Trust target, there is assurance that it is artificially low. Reasons for under reporting are overseas recruitment for medical staff and Filipino nurses, where visas are applied for but individuals are not in the country or are not yet in a position to meet entry requirements; and staff with deferred start dates (such as newly qualifying nurses), who are less speedy in undertaking checks such as DBS for posts which do not start until September.

Significant efforts continue to streamline recruitment processes whilst maintaining appropriate governance. In the last 12 months, references are now undertaken online and are factual only (up to and including band 7); for all non-medical staff, managers undertake identity checks at interview, meaning no pre-employment meetings are needed; standard letters are now electronically generated via NHS Jobs; staff joining the bank are encouraged to join the DBS update service, meaning that DBS checks take less time and a reminder regime is lighter touch; electronic personal files are being piloted with the nurse bank to save delays in transfers, and managers are being encouraged to scan and return interview notes where practical, again to save time.

Efforts continue to develop the ability to extract reports from the Trust's Vacancy Approval System, which it is intended will offer insights into any parts of the system which experience delays.

WRES Indicator 2 monitoring

December was an unusual month in that applications from BAME staff significantly outnumbered their white counterparts, yet at shortlisting stage (anonymous) BAME applicants were not shortlisted in the same proportion, which would suggest ambitious but less well qualified applicants. The 12 month figure for December was however down on September's reported position when it came to appointment (1.73 times more likely to be appointed versus 1.82 times in September report). Deeper analysis of this element is being undertaken as part of the Equality and Diversity plan following further direction from the Equality and Diversity Network.

ACTIONS FOR IMPROVEMENTS / LEARNING

NHSI Retention programme, development of ATR system, planned deeper dive into WRES data

RISKS/ISSUES

Unplanned staffing expenditure remains an issue, as does potential over-reliance on temporary staffing. Potential excessive working by established nursing staff through additional Bank hours.

Inadequacy of specific recruitment workforce data/ insufficiently developed systems make creation of a suite of recruitment KPIs a challenge.

2	Workforce Performance
2a	Staff Attendance

Staff Attendance

Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
95.54%	95.63%	↓	0.56%	96.10%

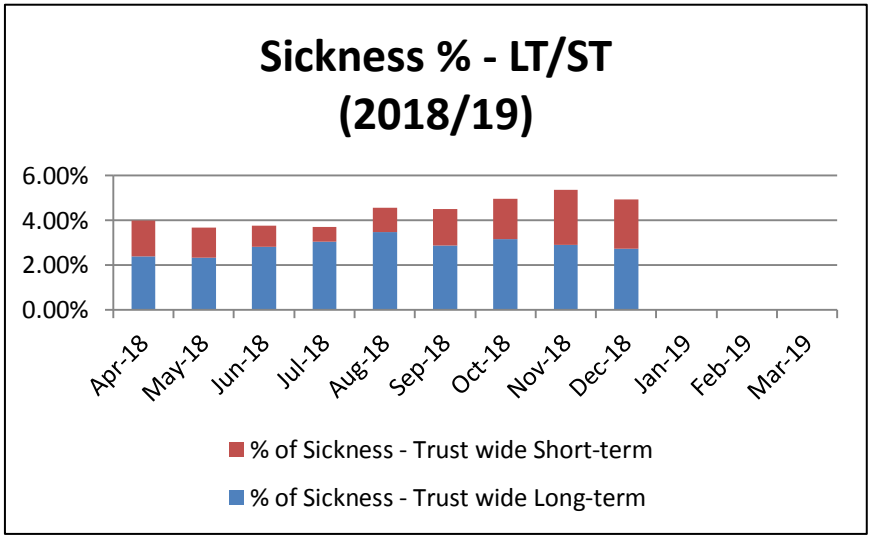
ALL STAFF

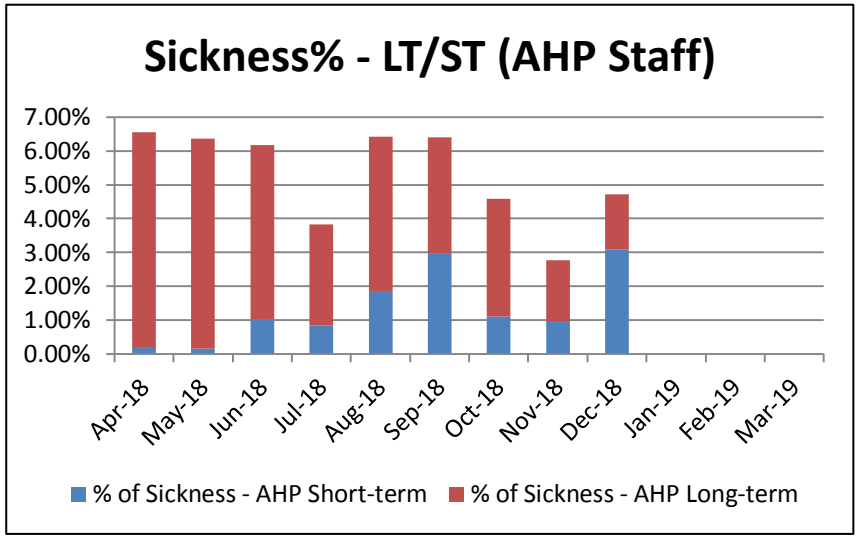
* 12 months to End of December 2018

Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
95.19%	95.30%	↓	0.91%	96.10%

AHP STAFF

* 12 months to End of December 2018





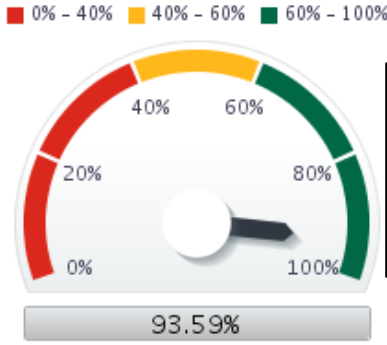
2 Workforce Performance

2b Staff attendance – short-term absence management

Staff Absence

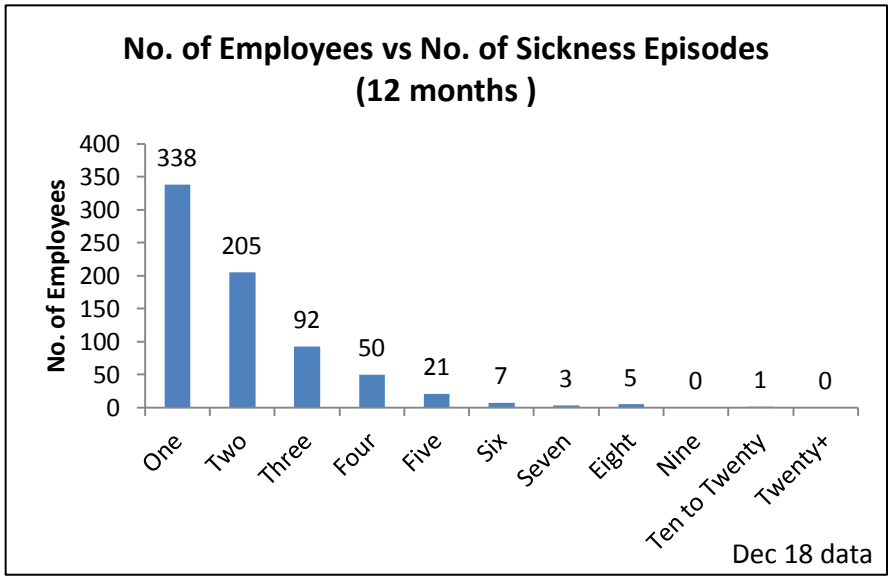
Return to Work Process Completion Rate (12 months) *Dec 18

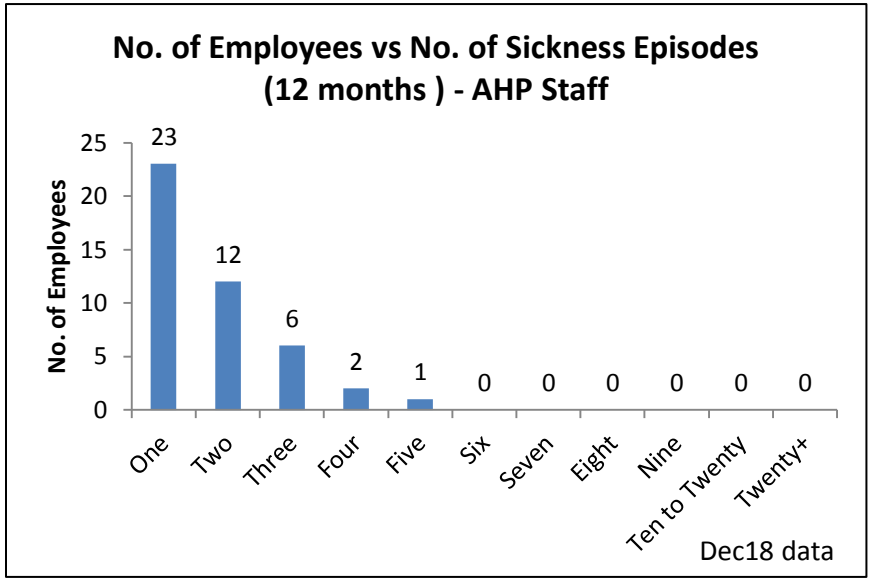
ALL STAFF



Return to Work Process Completion Rate (12 months) *Dec 18

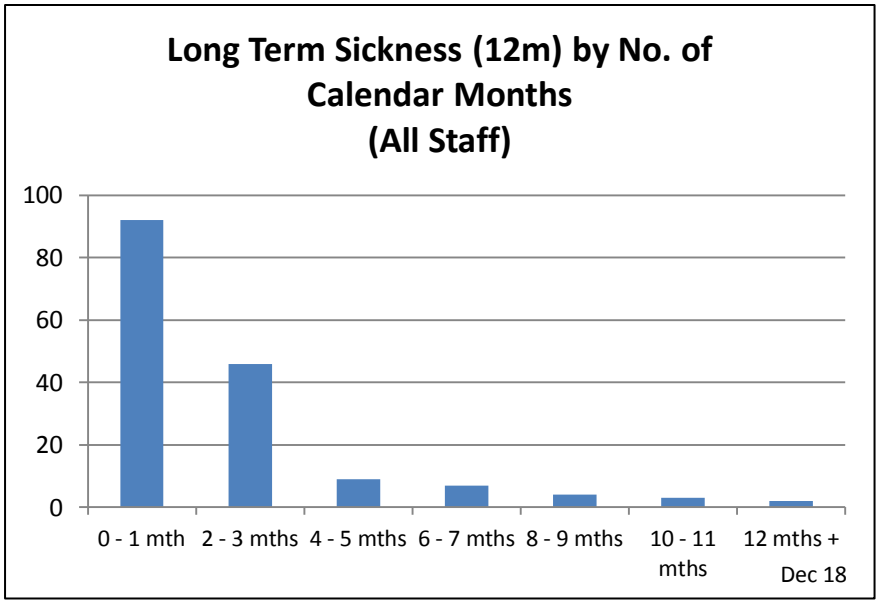
AHP STAFF

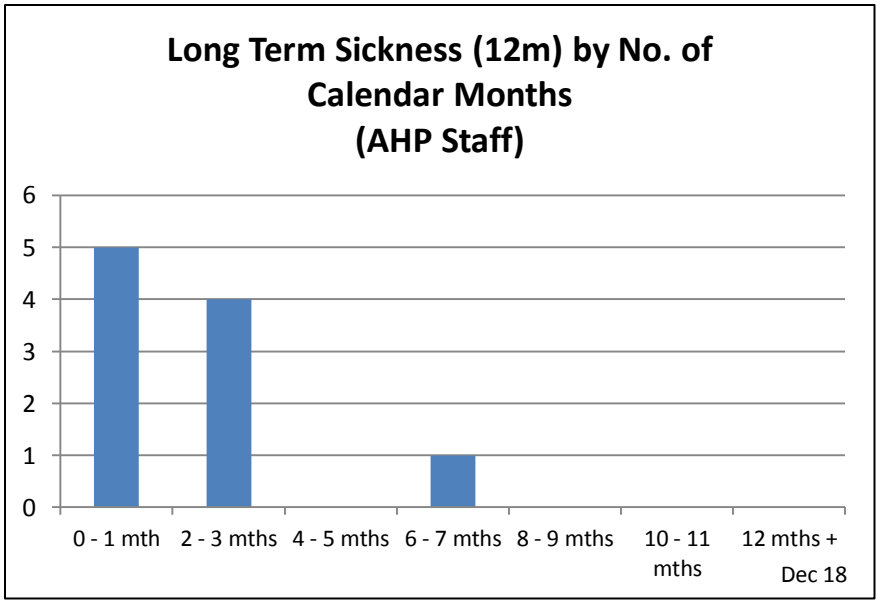




2	Workforce Performance
2c	Longer-term Staff Absence

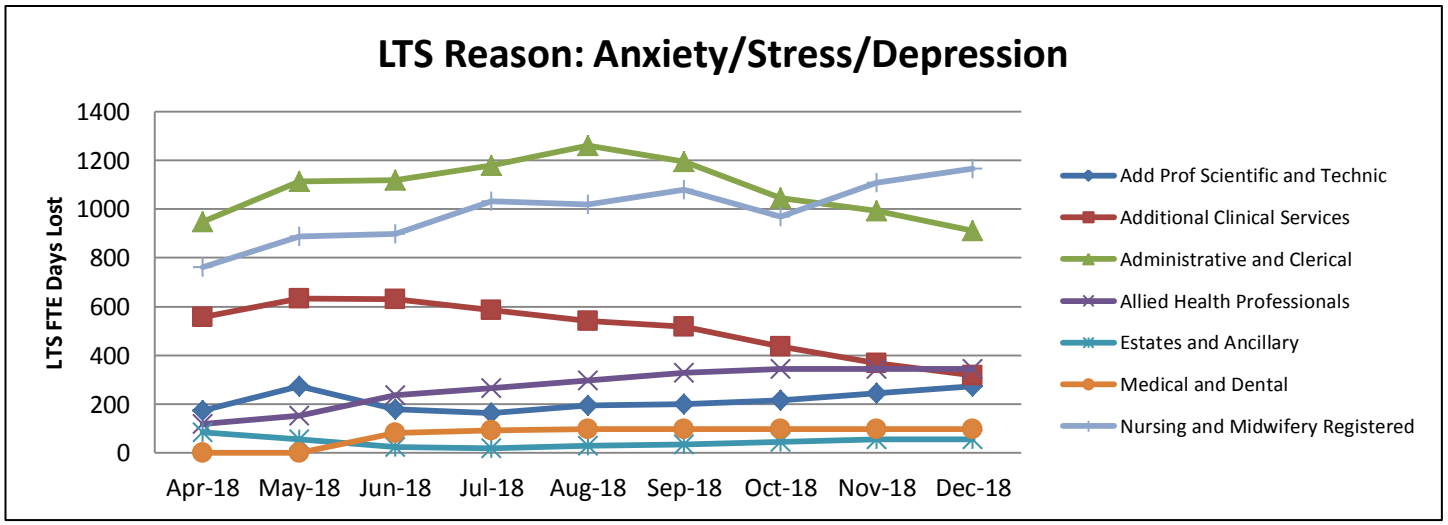
Long-term Staff Absence

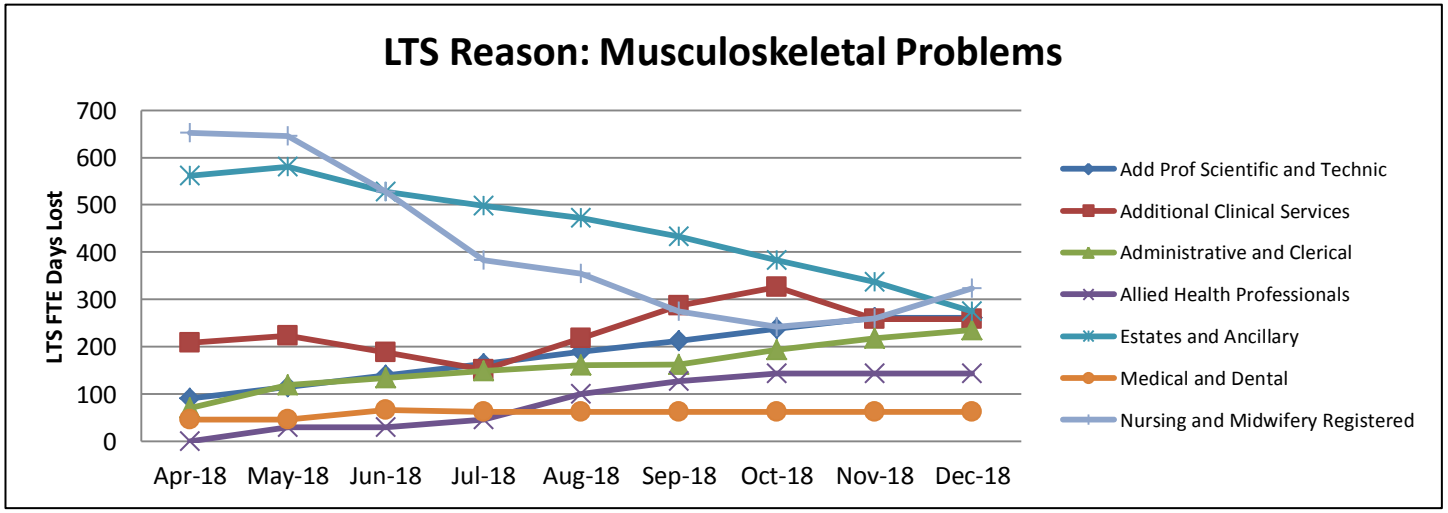




2 Workforce Performance

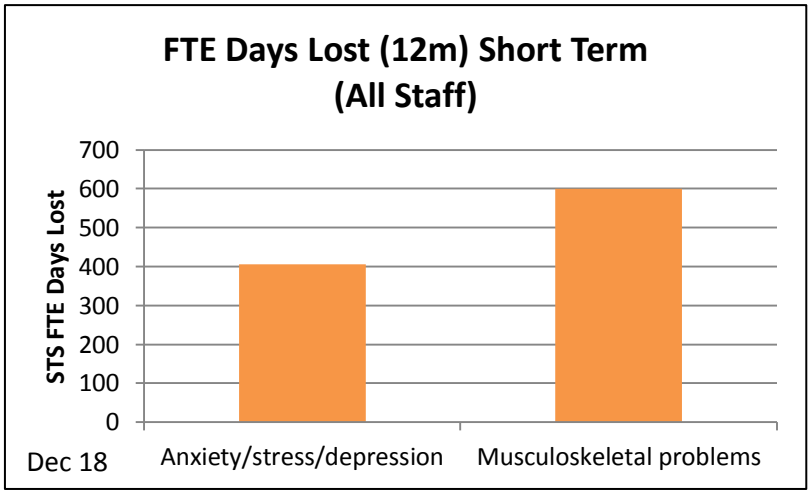
2c Longer-term Staff Absence

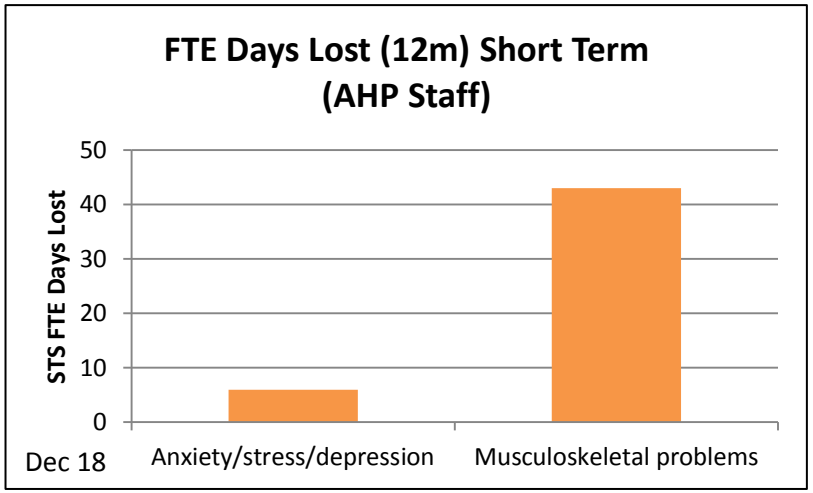


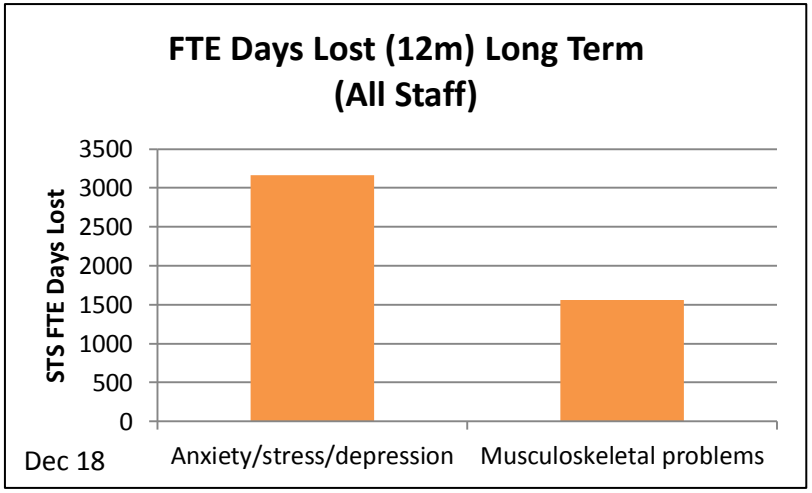


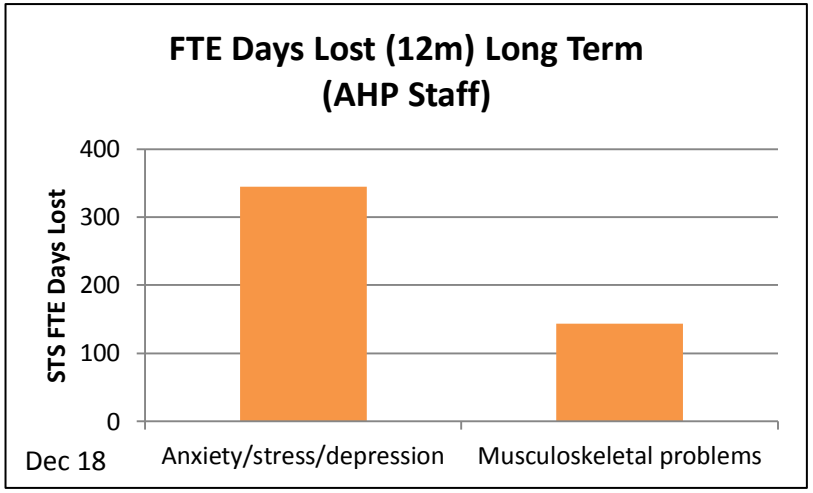
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary

Management of Performance

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	0	1	1	0	2	5

January 2019

INFORMATION
Staff Attendance – The rolling twelve month attendance rate reduced slightly year to December 2018 at 95.54% , 0.56% short of the 2018 KPI of 96.1% (3.9% absence). The graph shows that the vast majority of short term absence is spread among many staff, with a potential dismissal hearing arranged for the most frequent non-attender; and the long term graph is a 12 month position, meaning that anyone who has been absent for 12 months or more will show in the figures, even though they may have been returned or dismissed. In practice, there is no case of anyone absent for more than 10 months as at the end of December. The December in month rate for return to work meetings was just over 54%, which was the third highest figure in the last 12 months. This remains an area where focus is needed, however. **Formal Disciplinary and Capability** As at the end of January, there were 2 outstanding formal conduct cases either in investigation or hearing stage, and one capability case due to go to a hearing.
ACTIONS FOR IMPROVEMENTS / LEARNING
Procure new OH and EAP provision in line with STP recommendations and following Executive Team consideration. Succession planning and talent mapping processes to be developed and transacted in the medium term
RISKS/ISSUES

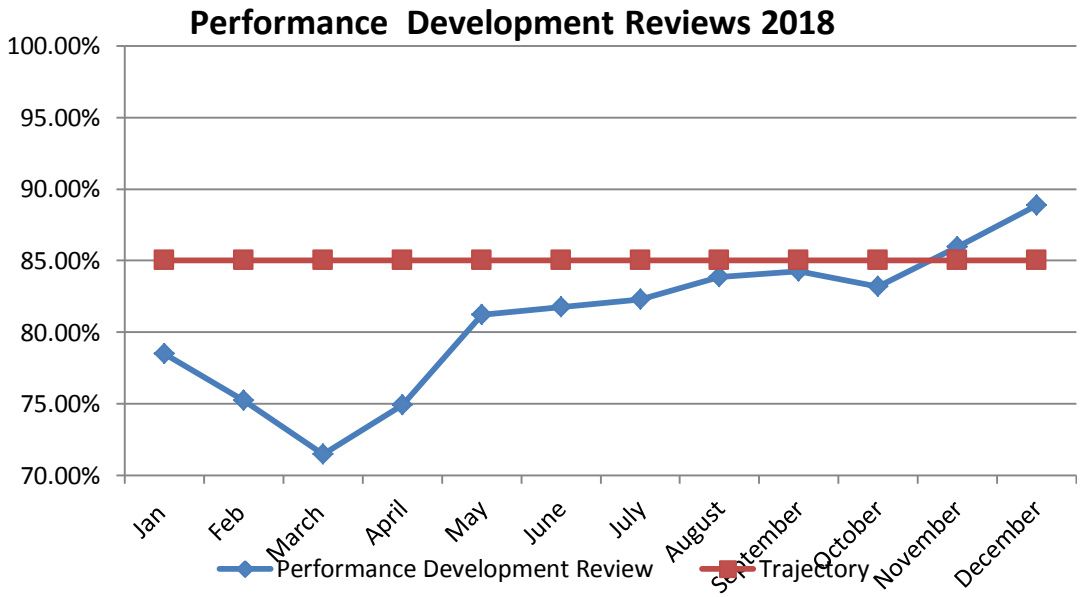
3 Workforce Learning and Development

3a Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NNS Engagement Question 2017	2017	2016	2015
20a	In the 12 months have you had an appraisal or annual review?	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	64%	74%	79%
20f	Were any training, learning or development needs identified?	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date

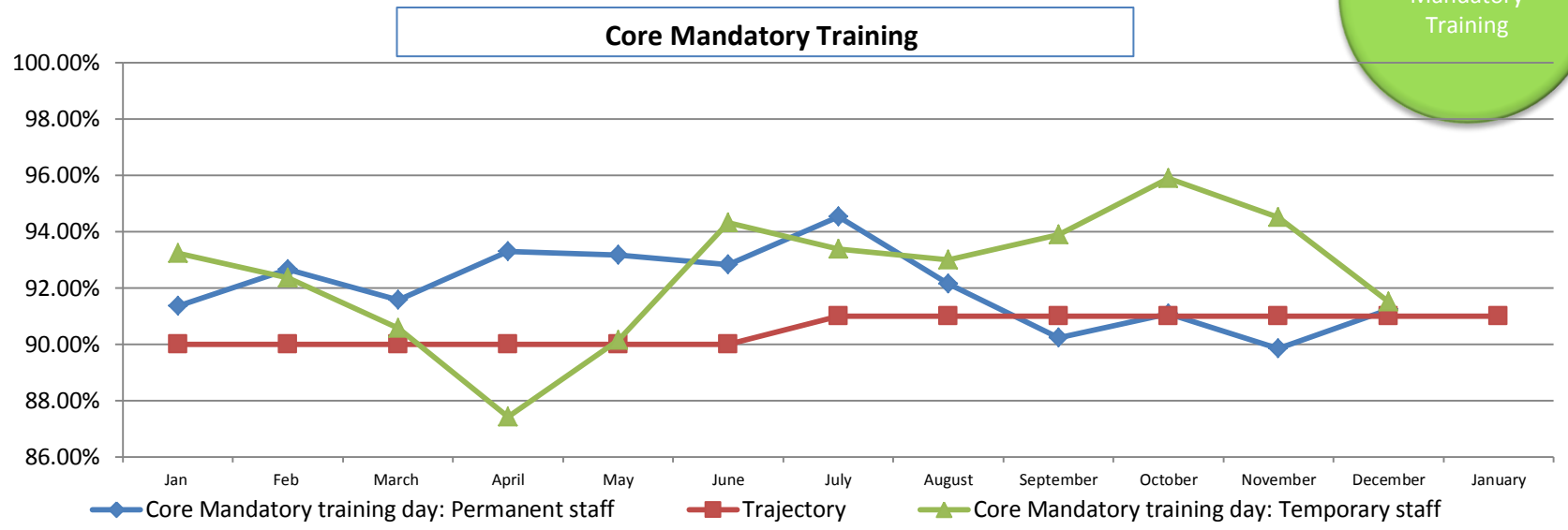


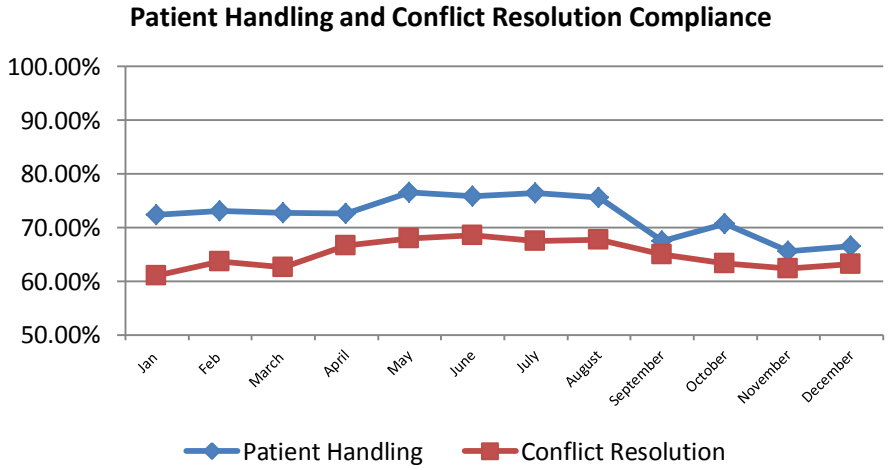
Outcomes from the National Staff Survey suggest that the Trust appraisal process occurs with staff at rates comparable with similar trusts, however the effectiveness of the process, the identification of behavioural and skills development needs and the management of these requires improvement. This links to the overall requirement to improve performance management processes within the Trust. These figures will be updated in March 2019

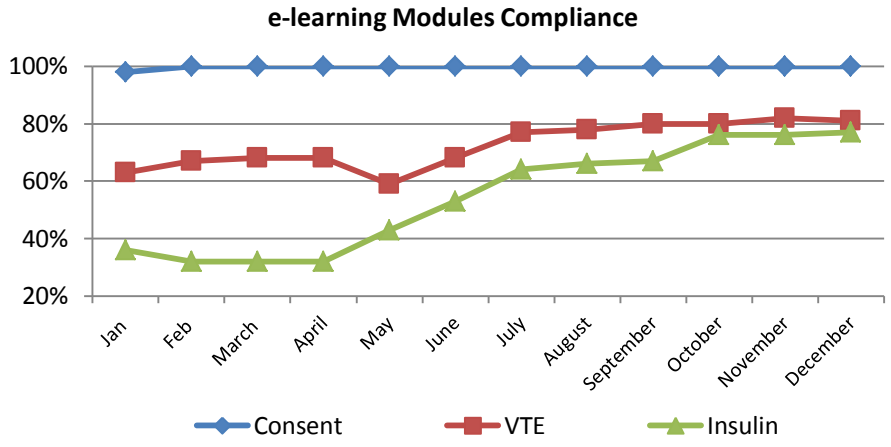
3 Workforce Learning and Development

3b Core Mandatory Training, Specialist Training and Corporate Induction

Core Mandatory Training



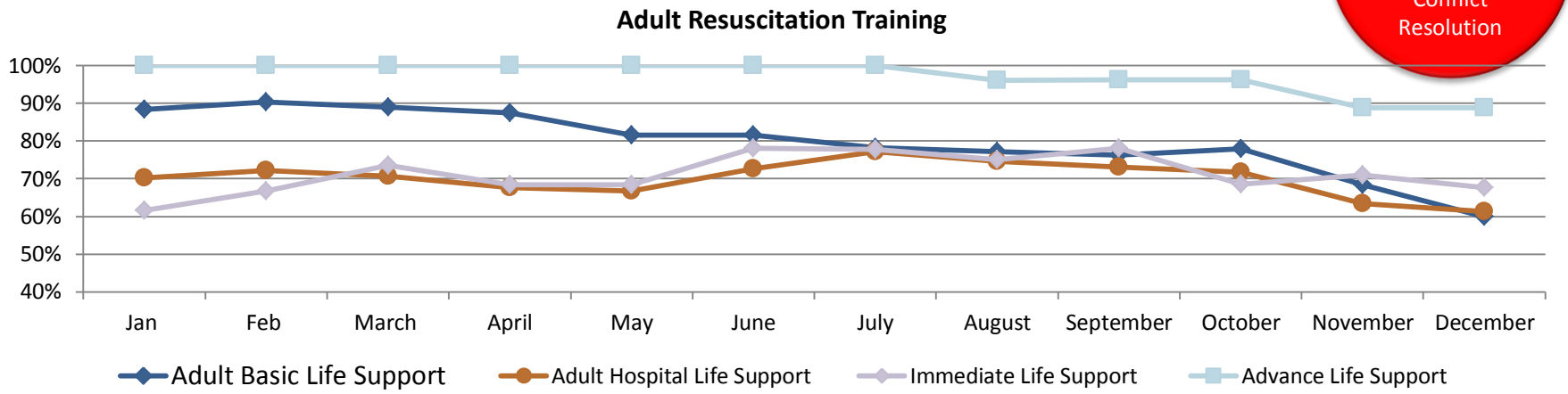


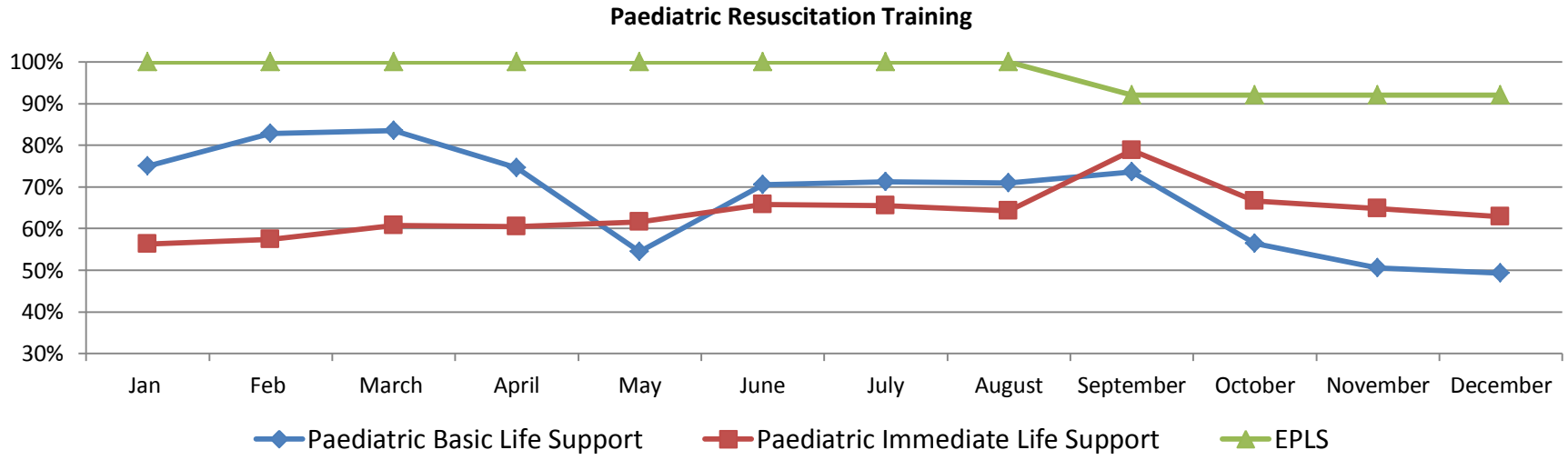


3 Workforce Learning and Development

3c Resuscitation Training

Role Specific Training: Resus, Patient Handling, Conflict Resolution

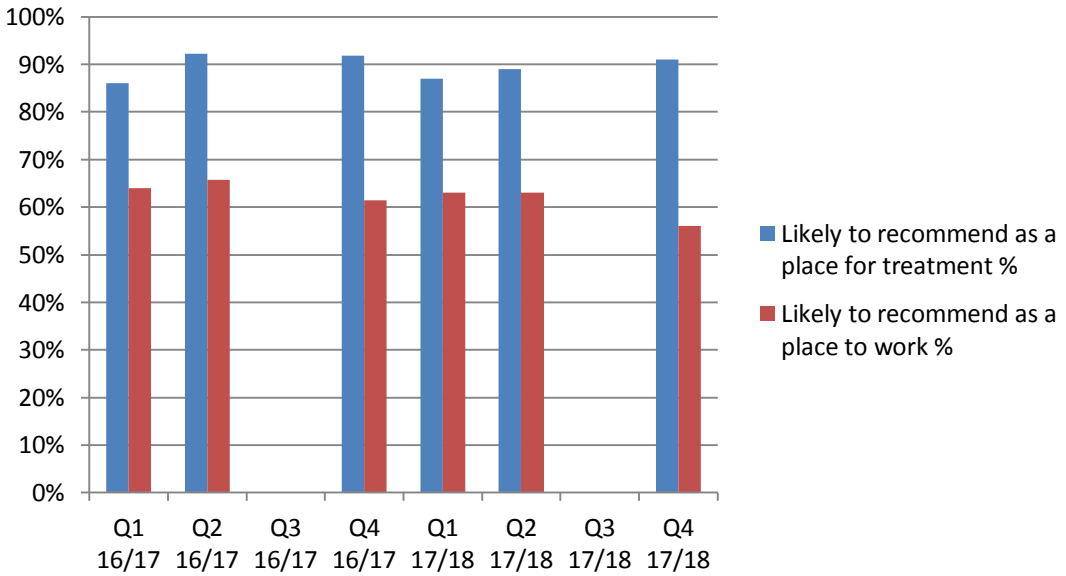




INFORMATION
Core Mandatory Training – Reported Core mandatory training attendance has achieved compliance again in December at 91.23%. Work continues on improving the content and delivery of the face to face training, and developing a more easily accessible e-learning approach. 10% of core mandatory training is currently completed on line. 2019 will see an increase in this figure. CMT for Bank / Temp staff has continued to maintain over 91% compliance for 7 months. **Role Specific Mandatory training –** The Trust Resus training compliance for Adults and Paediatrics has shown a steady decrease over the last 4 months. Twelve months ago in October 2017, the Trust had a push on adult and paediatric resus training, and those that became compliant during those months are subsequently becoming non-compliant as their annual update requirement comes around. Resuscitation standards and governance processes have recently been reviewed and updated recently, with the Director of Nursing committing to chair the Resus committee from November 2018. The Risk for resuscitation training compliance figures is monitored through the quality and safety group. Conflict resolution and patient handling compliance continues to hover around the 65% compliance area. This has been raised with the clinical quality group, and a small focus group has been created to review attendance requirements. VTE / Insulin –Improvements have been seen in staff completing insulin, and VTE has been noted following the review of requirements. Consent continues at 100% compliance however during January a review of requirements will be undertaken, and a 3 yearly repeat may be introduced.
ACTIONS FOR IMPROVEMENTS / LEARNING
Core mandatory training :– Mandatory training streamlining / CIP project continues. Positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information. Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place. VTE/Insulin online modules: E-learning facilitator working closely with Lead to increase compliance, creating learning paths in ESR. It has been agreed that medics do not need to complete the insulin modules as they do not administer.
RISKS/ISSUES
Staff booking onto and completing their role specific mandatory training modules is low. Resus levels still non compliant In house trainers for resus and patient handling reducing availability to support training. Attendance and DNAs on courses is still high. DNA charges will be introduced during 2019.

4	Workforce – Experience and Engagement
4a	Friends and Family Test Survey

FFT

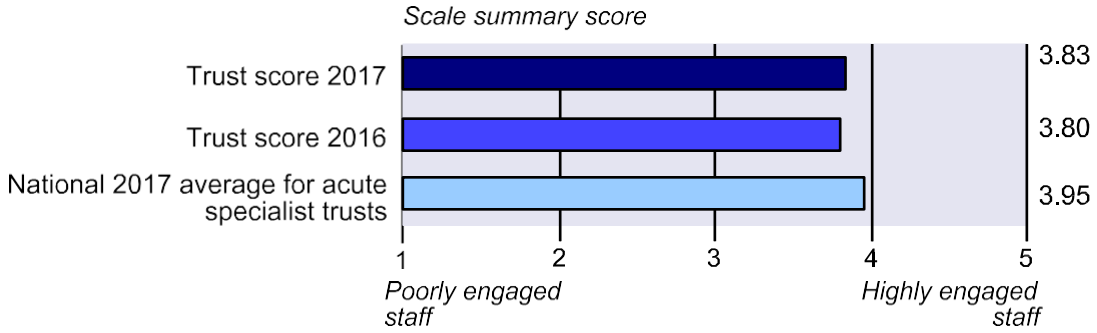


The overall Staff Engagement Score in Quarter Four 2017/2018 is **3.90** which compares favourably to the 2017 full survey overall Staff Engagement Score of 3.83.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

Employee Engagement

OVERALL STAFF ENGAGEMENT

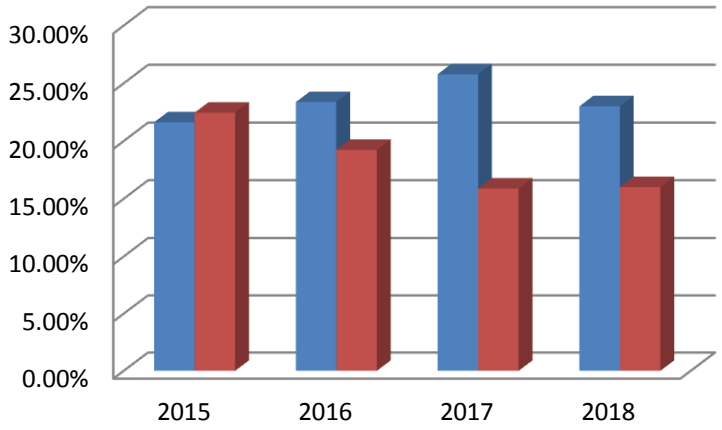


		Your Trust in 2017	Average (median) for acute specialist trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	79%	86%	69%
Q21b	"My organisation acts on concerns raised by patients / service users"	79%	81%	73%
Q21c	"I would recommend my organisation as a 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

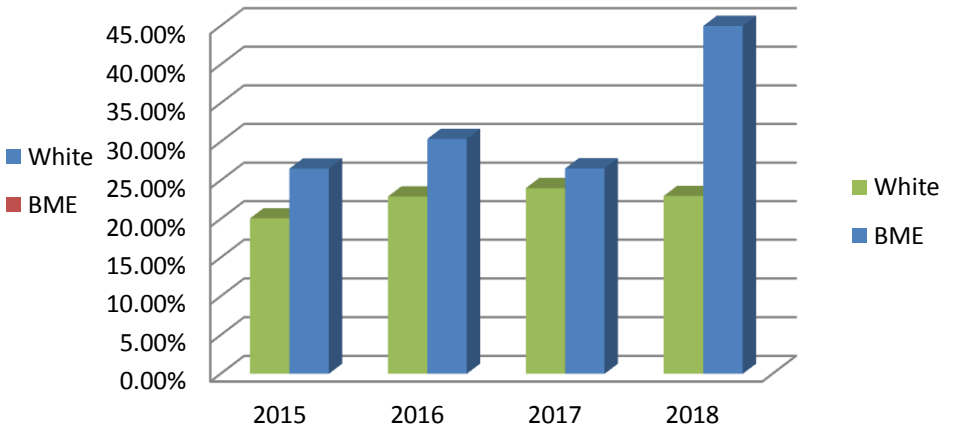
4	Workforce – Experience and Engagement
4c	WRES Indicators

WRES Indicators

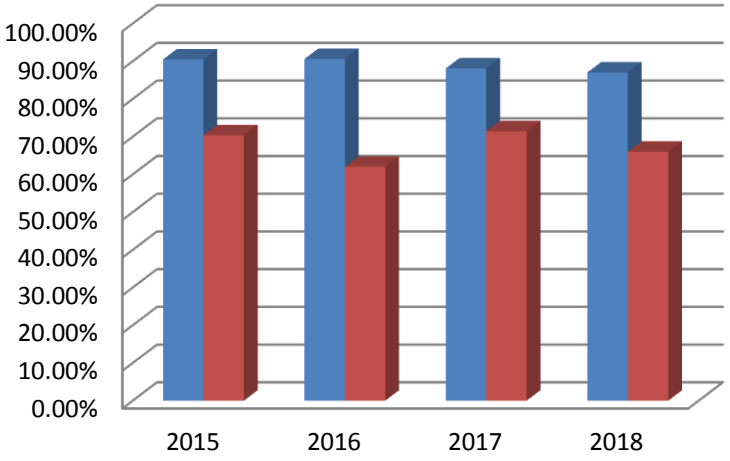
Indicator 5: Experiencing bullying from patients



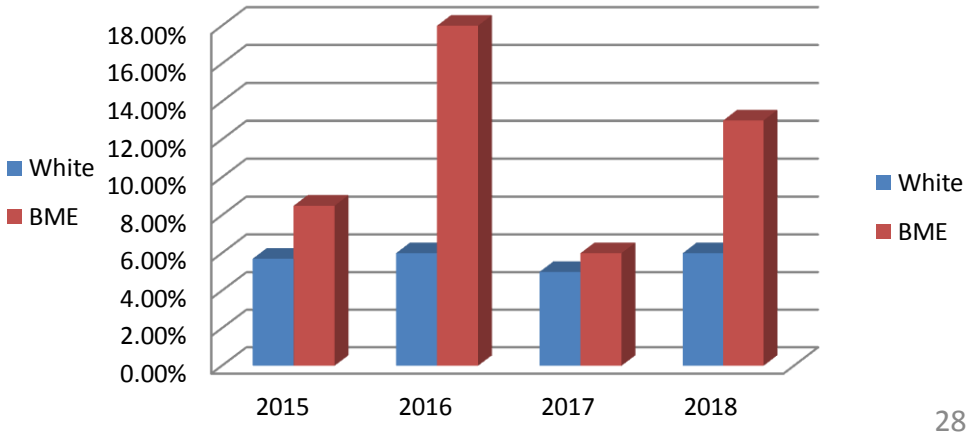
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION

National Staff Survey (NSS) – Draft information has been received for the national staff survey conducted October – December 2018. Information in this report will be refreshed from March onwards when the final weighted data is received from NHS England.

Friends and Family Test (FFT) – The FFT survey is being launched on 29th January 2019 for one month. A communications plan is in place including the February Team Brief.

Engagement and Job Satisfaction – Speak Up and Join in brand becoming increasing established. Even better if… sessions are now included in development programmes and teambuilding events.

Productive one to one conversations are key to the Performance Management refresh currently being developed. An engagement workshop is taking place in February with staff from around the Trust to discuss the importance of one to one conversation and how to embed in the Trust. The work fits with the Continuous Improvement work being completed by Jonathan Bamford

WRES Indicators – A separate report gives an update on actions identified at the time the WRES indicator results were published in September. Further information will be provided in March 2019 when information from the National Staff survey (NSS) can be used to update to update Indicators 5-8. The Trust's Equality and Diversity (E&D) annual report and action planEDS2 also includes actions linked to the WRES indicators.

E&D engagement

Sessions are currently being run across the Trust to review the E&D actions and priorities for 2019 with staff members.
The E&D network is now established with an elected Chair. Network meetings take place monthly. Any issues will be escalated to People Committee in the first instance

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions to encourage survey completion for Staff FFT to improve data reliability
Ensure feedback from staff from E&D forums is used to inform E&D action plan for 2018
Look at ways to engage BME staff members to shape E&D agenda

RISKS/ISSUES

Ensuring that staff members are given access to complete the Staff Friends and Family (FFT) test. Completion rate affects the reliability of the data as a representation of staff views. This also has an impact on some of the indicators for WRES

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 25 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that there was a risk over the lack of a register detailing the Service Level Agreements in place, although work was underway to address this by the Assistant Director of Finance. • It was noted that some of the issues picked up relating to stock management were matters which had been raised previously; the new managed theatres system would help with rectifying these issues. • The update from the Quality & Safety Committee suggested that two areas of risk that it was discussing included: compliance with water safety regulations and the Human Tissue Act.	• Update on the SLA register is to be presented at the next meeting. • A further update on stock management is to be presented at the next meeting. • A discussion on risk appetite was to be scheduled into the annual workplan for the Trust Board. • The fraud risk assessment was to be presented at the next meeting. • There needed to be a discussion around the strategic risk posed by current consent processes at Quality & Safety Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was confidence that the internal audit plan would be delivered as planned. • 'Reasonable assurance' was provided in connection with Controlled Drugs. The issues identified related to the timeliness of the closure of incidents and did not relate to the robustness of the processes to manage the Controlled Drugs. • It was noted that there was good progress against the actions arising from the self-assessment review tool (counterfraud). • There had been no counterfraud referrals and investigations. • There was noted to be good progress with closing down the actions on the recommendation tracker, although there was a need to provide evidence to justify the closure of some that were open at present. • The Committee received a presentation from the Medical Director on the steps being taken to improve the robustness of consent practices at the ROH. There remained some issues over documentation, however the Committee was of the view that the position had improved, particularly considering that taking consent	• The Committee approved the revisions to the internal audit plan proposed. • The Committee accepted the revised accounting policies. • It was agreed that the annual accounts could be prepared on a Going Concern basis.

on the day of surgery was now a rarity. • It was agreed that the Board Assurance Framework process was working well.	
Chair's comments on the effectiveness of the meeting: The discussions had been productive. It was noted that there was to be a change of Internal Audit partner, with Patrick Green being replaced by Mike Gennard.	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Group or Board met: 30 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that there had been a delay with completing the work to make the first dementia-friendly bathroom.	• Present an update on the take up of the Oncology care packs at the October meeting. • An update on the Throne project is to be scheduled in to the June 2019 Trust Board meeting. • A plan for spending the charitable funds is to be presented at the next meeting. • An update on the spend against the Dubrowsky legacy is to be presented at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was pleased to learn of the increased number of nominations for staff awards this year. • There had been a good level of response to funding requests for the Throne Project. • An update was received on the success of the Mindfulness initiative – 15 staff had been trained to deliver this and 120 people had participated in the sessions run. • The annual report and accounts for the charity was reviewed, which it was noted was of a better standard that that of previous years. • A positive update was presented on the fundraising activity, where it was highlighted that there had been an increase in the amount of funds raised through fundraising events.	• The Committee supported the bid for funding for the Staff Awards 2019, although it was agreed that greater effort would be directed into securing sponsorship for the event in 2020. • The Committee supported the bid for funding of the Oncology care packs for an initial period of six months. • The Committee agreed to release the funding for the full Throne Project works. • On the basis of the success of the Investment in Learning initiative, the Committee agreed that the request for additional funds should be granted to further the work. It was noted that there needed to be parity in terms of the development opportunities that staff were able to access.
Chair's comments on the effectiveness of the meeting: This was the first meeting chaired by Professor Gourevitch and the meeting had been well attended and had run to time. There was good time set aside for the consideration of the bids put forward.	

MINUTES

Charitable Funds Committee - APPROVED

Venue Boardroom, Trust Headquarters **Date** 3 October 2018: 1200h – 1230h

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 Apologies	**Verbal**
Prof Phil Begg tendered his apologies. It was noted that an external figurehead continued to be pursued to chair the ROH Charitable Funds Committee. It was suggested that the ROH alumni could be approached to canvas interest.	
2 Declarations of interest	**Verbal**
There were none.	
3 Minutes of the meeting held on the 15 June 2018: *for approval*	**ROHCF (10/18) 001**
The minutes of the Charitable Funds Committee meeting held on the 15 June 2018	

were accepted as a true and accurate record of discussions held.	
4 Financial report – Months 1-5 2018/19	**ROHCF (10/18) 002**
The Interim Director of Finance reported that the balance of funds was £2.2m and £9k of income had been received during the period. £1.5m was noted to be associated with the Dubrowsky legacy. Other funds were allocated against specific purposes and areas. There had been £45k of expenditure between 1 April and 31 August 2018. It was noted that after the transition of paediatric inpatient surgery to Birmingham Women's and Children's NHSFT, the fund currently allocated to Ward 11 would remain with the ROH given that an element of paediatric work would continue at the Trust.	
5 Bids for funding	**ROHCF (10/18) 003** **ROHCF (10/18) 004** **ROHCF (10/18) 005** **ROHCF (10/18) 006** **ROHCF (10/18) 007**
The Trustees considered a number of bids for funding, as follows: ***Recliner chairs*** - The purchase of recliner chairs was reported to be for the wellness room as part of the JointCare pathway. It was reported that these needed to be ordered from USA, given that they were specialist facilities and there was a plan to leave them in the facility for group therapy. These chairs were noted to be of a specification over and above the usual and therefore satisfied the criteria for accessing charitable funds. On this basis, the request for funding was approved. ***Throne project*** – it was reported that it had been identified that £48k was needed to complete the Throne Project over the next 12-18 months. It was noted that some of the furnishing to be purchased was standard equipment however, such as grab rails and therefore should be funded from exchequer funds rather than the charity. The expense associated with the change in the flooring was questioned. It was suggested that there needed to be confirmation of the funding need based on the number of dementia patients handled who would benefit from this change in flooring. The Trustees agreed that the bid needed to be refined to show the elements of 'over and above' standard specification and on this basis, the bid was not agreed at this stage. It was noted that there was specific fundraising for this project. ***Singing medicine*** – this was noted to be part of the therapy offering for children and the initiative was designed to show what patients currently being treated at ROH could expect at Birmingham Children's Hospital (BCH) once the service moved over. It was suggested that this could be widened to adults in due course. There	

was good evidence for wellbeing. This bid was approved and it was agreed that it should be charged against the Ward 11 fund. ***Artwork to mark the paediatric transition*** – it was proposed that a piece of artwork could be created to commemorate that the ROH had undertaken paediatric surgery after it had moved over to BCH. The funding was approved on the understanding that the artwork would be displayed at BCH. ***Wheelchair*** – a risk assessment for the use of wheelchairs was provided and a request had been submitted to fund a motorised wheelchair for the transportation of patients to the physiotherapy gym. It was suggested however, that there was little evidence that this was the correct use of charitable funds and therefore the bid was not approved. There was some debate around the governance of the request and the bid templates. It was suggested that the template needed to include both an Executive Lead and a checklist to demonstrate that the bid complied with the use of Charitable Funds according to the purpose of the Charity. The Associate Director of Governance and Company Secretary agreed to help address this.	
ACTION: SGL to refine the templates for the charitable funds bids	
6 Any other business	**Verbal**
There was none.	
7 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 31 October 2018 at 1330h – 1500h in the Boardroom, Trust HQ.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Responsive Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh; Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Stacey Keegan; Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**6th March 2019**

EXECUTIVE SUMMARY:

The attached CQC Responsive action plan presents an updated picture on all the issues which required actions for improvement following the Trust's CQC inspection in January 2018 and subsequent report published in May 2018.

The author communicates regularly with the accountable leads and provides a narrative update on progress.

On-going monitoring, escalation and oversight of this action plan is conducted in the following committees and meetings:

- Quality and Safety Committee.
- Executives meeting.
- Clinical Quality Group.
- Operational Management Board.

Where corporate risks exist they are aligned to the action plan. Associated delivery plans and evidence for assurance are embedded within the centrally stored master document.

REPORT RECOMMENDATION:

The Trust Board are asked to note the progress that has been made against delivery of the actions. However, although progress made, a number of actions have not delivered in line with the original timescale, therefore have been rag rated as red and detailed below:

- **Action 1B – Governance 'learning and sharing' methodology** – Work has been ongoing with the Communications team however some delay has occurred due to the vacancies/gaps with the Governance team. Launch of the improvement work and methodology is planned during March 2019.
- **Actions 2A-2C Mental health** – significant progress; the Trust has been working with BSMHFT to gain their expertise and help us scope our requirements as a Trust. All required actions are due for completion by the end of April/early May 2019.
- **Action 4C/D – Bone infection** – significant progress made and system wide working with a plan to develop a business case for the future service in April 2019 which aligns with the CQUIN.
- **Action 10A – Medical staffing escalation** – a non-urgent escalation tool is now drafted and out for consultation. Alongside this, in line with the launch of NEWS2 a revised escalation tool has been developed as part of the deteriorating patient improvement works.

- **Action 11A – Consent and adherence to policy** – improvements have been made and evidenced within the consent audits undertaken. The Medical Director is taking this action forward.
- **Action 16A – Accessible Information Standard** – A working group have taken the improvements required forward and a delivery plan outlines the work that has been completed. This action is an agenda item for the next Clinical Quality Group in April 2019 where it is anticipated the action will be closed with agreed ongoing assurances.
- **Action 17 A – Outpatient Clinic wait times** – Significant improvements seen in associated KPIs; these KPIs are reported and monitored in various meetings and committees. Operational forums are now in place to ensure a sustained and improved picture with an array of actions being taken. Currently there are discussions with the OPD management team regarding closure of this action with ongoing assurances.
- **Action 18A/B – Updated Trust policies and procedures** – A delay to completion due to the timelines of delivery and roll out for the new Health Assure system. This system will allow greater transparency of policies and the required review and named author. A monthly report on the status of clinical policies is received at the Clinical Quality Group.

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

Note and accept	Approve the recommendation	Discuss
X		

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

Financial	**X**	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments: [*elaborate on the impact suggested above*]					

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

CQC Responsive action plan aligned to Trust Corporate risk register.

PREVIOUS CONSIDERATION:

Quality and Safety Committee.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROH ACTION PLAN

NO	QUALITY IMPROVEMENT PROJECT	EXPECTED OUTCOME	KPI / MEASURE	EXECUTIVE LEAD	CLINICAL / PROJECT LEAD	MONITORING COMMITTEE	ROH ACTION NO	ACTION	FINAL DEADLINE	UPDATES Unsatisfactory Progress Slow Progress Satisfactory Progress Completed	RISK REGISTER	ONGOING ASSURANCE
Chief Executive Officer												
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	Chief Executive Officer	Associate Director of HR	S/E and O/D Committee	14a	April - Trust Board reviewed completed WRES report.	~~Aug-18~~ Oct-18	The WRES report was received by Trust Board in April 2018 and will be submitted to NHSE in late August 2018. Aug 2018 Update: WRES 6 month Interim Board Report will go to Staff Experience and Organisational Development Committee in October 2018. September 2018 Update: As above. October 2018 Update: Report with key data around 9 indicators and initial actions submitted to Staff Experience and Organisational Development Committee (SE&OD). Information approved by SE&OD Committee and will now be published on ROH website. Further information will be provided through Equality and Diversity update at November SE&OD Committee.		Agenda item at Staff Experience and Organisational Development Committee.
15	Ensure staff meet their training needs as agreed in their annual PDR	Staff meet their training needs	Staff Survey	Chief Executive Officer	Associate Director of HR	People Committee	15a	Refreshing the PDR method to a performace model	~~March-19~~ Sept-19	Refreshing performance manager approach. Qualifying of a career framework. Monitoring PDR compliance. Aug 2018 Update: Principles of revised management of performance approaches agreed. Implementation will follow a phased approach with early adopters in Quarter 3 / 4 2018/19. September 2018 Update: As above. October 2018 Update: Plan for the update and Performance Management refresh attached; approved at the Staff Experience and Organisational Development committee. December 2018 Update (Received from Clare Mair): Work continues with pilot phase. Coaching module to support this work is currently being designed with delivery to start in Febuary 2019. February 2019 Update (Received from Clare Mair): The Refresh for Performance Management is progressing but completion will be delayed until September 2019. Original completion dates were set when the previous Associate Director of Workforce and OD was still in post. This person who was Lead for the project left in October 2018. The new person started in January 2019 and will now lead on this project. Following a discussion at the SE&OD committee, it was agreed to delay completion. The 'one to one conversation' element which will inform how the new approach will be embedded, is on track.	Risk WF3. SE&OD Committee. *'Failure to maximise performance and support development through ineffective performance and development approaches. Significant contributing factor to employee engagement'*	Document
Executive Director of Nursing and Clinical Governance												

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 includes areas outside of where the incident happened	Closed and completed Ulysses action plan.	Executive Director of Patient Service	Head of Clinical Governance	CQG	1a	Closure of the Ulysses action plan to assure fit for purpose reporting and feedback system.	Jan-19	September 2018 Update: One outstanding action in relation to incidents module - Incident policy - awaiting ratification at CQG October 2018. October 2018 Update: Incident policy ratified and signed off by the Executive team. Ulysses action plan presented at Clinical Quality Group (CQG) in October 2018; outstanding items are related to risk and complaints modules; incident reporting actions now closed. Plan to audit closed actions to ensure fully complete and changes embedded. November 2018 Update (Received from Ash Tullett): Ulysses action plan on the work plan for Clinical Quality Group January 2019. December 2018 Update (Received from Stacey Keegan): Ulysses action plan to be handed over to Complaints and Risk leads with oversight from Governance Manager to address outstanding actions. January 2019 Update (Received from Ash Tullett): Ulysses are currently undertaking a 'health check' of the system (including the complaints and risk modules) to ensure the system is able to provide what the Trust requires in relation to complaints and risk management. February 2019 Update (Received from Ash Tullett): Ulysses actions are closed within the action plan that are related to learning and feedback. Action plan attached for assurance. Open actions are related to the risk and complaints modules, these modules allow data storage as opposed to learning and feedback.		U:\Documents\ CQC Evidence\ Ulysses action plan
			A governance communication strategy in place.			CQG	1b	Routine Communication of key incidents and learning methodology across the Trust to be reviewed.	~~Sept 18~~ Dec-18	Aug 2018 Update: Meeting held with Communications on the 13.7.18 to design a Governance Communication strategy to ensure lessons are shared across the Trust. Awaiting feedback. September 2018 Update: Comms intranet page developed/Case Study posters developed/Quality week to be arranged. October 2018 Update: 'Quality' week in planning for the first week in December 2018, relaunch of Governance Strategy planned and launch of Comms strategy (being finalised) for learning and communicating Trustwide. Scoping of Human factors and investigation training to take place during 'Quality week'. November 2018 Update (Received from Ash Tullett): 'Quality week' agenda confimed commencing 3.12.18 in conjunction with the Communications team. Trust policies and Strategy, road shows, stand and training incorporated. December 2018 Update (Received from Stacey Keegan): 'Quality week' took place as planned; paper to be presented to Quality and Safety Committee in February 2019 outlining methodolgy going forward. January 2019 Update (Received from Ash Tullett): Action as above with the paper being presented to the Quality and Safety Committee in March 2019.	Risk: 275 Clinical Quality Group *'There is a risk that the Trust is unable to consistently demonstrate learning from serious events, claims and complaints. This is due to insufficient evidence of robust action plan implementation, processes not being followed and staff awareness and changes to clinical practice not being fully embedded'.*	
			Standing agenda item on relevant meeting agendas.			CQG	1c	Trusts Quality Report to be presented at all relevant meetings to strengthen Ward to Board communication.	Aug-18	Aug 2018 Update: Governance manager and DDoN to review Divisional meeting structures w/c 6.8.18. September 2018 Update: Quality report presented at all forums/committees, including Divisions.		Standing agenda item at the following meetings/ committees to ensure Board to Ward communication: Ward and Departmental Managers. Senior Nurses. Divisional Boards. Clinical Quality Group. Divisional Performance. Quality and Safety Committee.

			100% compliance with Serious Incident Learning Audit			CQG	1d	Audit of serious incident learning to be undertaken; to ensure: Actions taken following serious incidents are fully completed in a timely way. Changes that are implemented as a result of a serious incident are fully embedded within the Trust.	Jan-19	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. Aug 2018 Update: Action trackers now in place for Division 1 and 2, and an agenda item on Divisional Governance meeting. This allows transparent progress for the Governance team to monitor and audit with escalation of any concerns to the DDoN. September 2018 Update: Audit underway by the Clinical Governance Manager to ensure closure of actions from Serious Incidents and internal Root Cause Analysis. Audit report to be prepared for October 2018. October 2018 Update: Audit completed; paper with findings to be reported to Clinical Quality Group in November 2018. Initial feedback positive and initial findings being reported back to the Divisions for any immediate actions. Embedding of actions to be audited and reviewed within the Divisions with findings reporting to Clinical Quality Group. November 2018 Update (Received from Ash Tullett): Agenda item will form part of the Governance Upward report at Clinical Quality Group scheduled for the 30.11.18. December 2018 Update (Received from Stacey Keegan): Update received at Clinical Quality Group and now forms part of the monthly Governance Upward report that is on the work plan to be presented monthly.		Standing agenda item at weekly Divisional Governance meetings with action trackers. Update received at Clinical Quality Group via the monthly Governance report.
			100% compliance with Stop before you block audit following previous Never Events and sharing of learning.			CQG	1e	Stop before you block Audit to be completed to provide an overview of the daily running of anaesthetic rooms and to identify any underlying factors that may impede safe patient care. Key audits are: Interruptions occuring during the induction of anaesthetic or administering blocks and why these interruptions occured. Environmental audits (signage visible and privacy shutters in use). Third person in the anaesthetic room.	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. Aug 2018 Update: Monthly report now completed by the Theatre Matron; July 2018 audit showed a significant improvement with 6 interuptions noted from an audit of 114 patients = 5.26%. Report monitored by the Divisional and upward eported to Clinical Quality Group. September 2018 Update: Awaiting August report - agenda item for October 2018 Clinical Quality Group. October 2018 Update: Report presented at October 2018 Clinical Quality Group - compliance showing <5% interuptions. Audit part of Clinical Quality Group workplan and monitoring will continue.		Ongoing assurance provided via Clinical Quality Group workplan.
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, procedures, and staff training to ensure staff have the confidence to support and care for patients with Mental Health	100% of patients with a Mental health illness will be supported to have full access to all Trust Services by trained and competent staff.			Safeguarding Committee	2a	Ensure the SLA in place is responsive to the Trusts needs.	~~June 18~~ Dec-18	SLA has been updated and it available to all staff. This will be communicated to all bleep holders and relevant staff. Aug 2018 Update: Further review of SLA completed by the DoN, mental health lead and DDoN, with queries passed to the Assisitant Director of Finance - contracting to take forward. September 2018 Update: SLA being reviewed to ensure responsive to the Trusts needs. October 2018 Update: Awaiting confirmation that SLA has Executive sign off. November 2018 Update (Received from Nathan Samuels/Lisa Newton): SLA in place up until March 2019, however concerns regarding out of hours service provision. Meeting arranged for w/c 19.11.18 to escalate the required review of the SLA with BSMHFT. If this meeting does not resolve the concerns, escalation to the Executive Director of Nursing and Clinical Governance. Scoping a further SLA wit BMHFT regarding use of bank RMN and telephone advice. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Meeting held with Angela Preston (BSMHFT); flow chart devised for use of section 5(2) - medics to detain. 24 hour advice be incorporated into SLA - escalated to Julie Gardner. February 2019 Update (Received from Lisa Newton): Draft flow chart for the use of section 5(2) in circulation for comment. Meeting arranged with Julie Gardener to review SLA to ensure it includes 24 hr provision as BSHMHFT have advised that this will involve SLA revision +/- additional fee for service.		

			Executive Director of Patient Service	In-patient Matron/LD Lead Nurse	Safeguarding Committee	2b	Develop and launch a Trust Mental Health Policy to support staff and patients.	~~Aug 18~~ ~~Oct 18~~ ~~Jan 19~~ April-19	October 2018 Update: Policy now on hold for finalisation due to working with UHB/Mental Health Trust and their policy ratification. The delay in the policy will not slow down the requirements the Trust needs to deliver. DDoN and leads to review current policies/legislation to ensure this does not pose a risk to the Trust. November 2018 Update (Received from Nathan Samuels/Lisa Newton): In conjunction with UHB/BSMHFT, newly formulated Mental Health Policy is in draft and will be shared with ROH for local adaption once ratified which is scheduled for December 2018. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Awaiting ratification from UHB to then locally adapt for ROH. February 2019 Update (Reeived from Lisa Newton): UHB policy going to policy review group for ratification 20.3.19 if ratified should be available to us early April 2019.	Risk 1286 Safeguarding Committee. 'Risk that the Trust does not have adequate policies, procedures or trained staff to provide the necessary level of care and support for patients with mental health issues'.	U:\Documents\ CQC Evidence\ Document in Copy
					Safeguarding Committee	2c	Ensure all relevant staff are trained in mental health.	~~Aug 18~~ ~~Oct 18~~ ~~Feb 19~~ April-19	Aug 2018 Update: There are 3 tiers of training: Awareness and tier 2 training to be delivered via NHSE E-learning package and face to face drop in sessions which are planned to commence Sept 2018. Tier 3 training (2 days) will be provided for bleep holders, senior nurses, and AHPs delivered by the lead nurses commencing in Oct 2018. October 2018 Update: Mental health first aid training (2 days) commences October 2018. Options for awareness training discussed at the Training and Development Group; competency for staff groups being defined on ESR. Action RAG rated as red due to training provision commencing in October but will not be completed for all relevant staff groups. November 2018 Update (Received from Nathan Samuels/Lisa Newton): Two further Mental health first aid training courses planned for December 2018 and February 2019; this will ensure all Clinical Site Coordinators and Duty Managers are trained. Tier 1 Mental Health awareness training to be incorporated into Trust Mandatory training day by April 2019. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Update as of November 2018, with 25 Mental Health First Aiders now trained within the Trust. February 2019 Update (Received from Lisa Newton): The Trust now has a total of 56 trained mental health first aiders, with a further 18 staff booked onto the the April 2019 training. The training has been targeted to include Clinical Site Coordinators, Duty Managers and those in key roles e.g. Safeguarding, Chronic pain etc. Mental Health Awareness training commences on the Mandatory training day for all staff on the 12.4.19. Training for medical colleagues will commence once the section 5(2) flow chart is ratified and SLA agreed.		
					Safeguarding Committee	2d	Launch of the Mental Health provision in the Trust, engaging with patients and staff.	~~Sept 18~~ Oct-18	Safeguarding Matron 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. A new icon on the intranet to be added to the homepage once actions are completed for ease of access for staff. Aug 2018 Update: Intranet site and resource folders currrently being reviewed ensuring all relevant documentation is available for staff. Patient pathways and flow charts to support staff decision making and referral processes. Process for the care of those patients under a long term section to be clarified including staffing requirement. Poster being designed to aid staff understanding of DOLS, MHA, and MCA. September 2018 Update: Intranet site and resource folders due to go live October 2018. October 2018 Update: Action on track to be completed by the end of October 2018. November 2018 Update (Received from Nathan Samuels/Lisa Newton): New Trust intranet page has been developed which has easy access, detailed descriptions of the most commom mental health conditions, their signs, symptoms, treatments and specific risk assessments and care plans.		
					Safeguarding Committee	2e	An audit to be completed for complex patients (included mental health) which includes the use of a flagging system and audit of individualised care planning.	~~Dec 18~~ April-19	Methodology to be designed when actions 2b to 2d achieved . December 2018 Update (Received from Stacey Keegan): Clarification being sought to confirm pre data requests from CQC and audits of care of patients with Mental Health as opposed to Policy/improvements audit. February 2019 Update (Received from Stacey Keegan): Action clarified and amended; audit forms part of the CQC data requests. Leads for Mental Health informed of the action and audit tool to be developed and launched with front line staff.		

3	Staff should have sufficient understanding of terms such as 'never event' and 'duty of candour'.	All clinical 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**	**CQG**	**3a**	Focussed educational engagement events with departments and wards	~~Aug-18~~ Dec-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 audits. September 2018 Update: New homepage on Ulysses system/New leaflets developed by Comms team/Quality week in planning to be included in the Governance learning strategy. October 2018 Update: As above with launch planned during 'Quality Week' planned for December 2018. November 2018 Update (Received from Ash Tullett): Engagement events and road shows planned for 'Quality week' commencing 3.12.18 factoring in Duty of Candour and Never Events. December 2018 Update (Received from Stacey Keegan): A focus on Never Events and Duty of Candour (definitions and examples of) took place in 'Quality week'; paper to be presented to Quality and Safety Committee in March 2019 outlining methodology going forward.		Understanding of Duty of Candour and Never Events shared within the Trust at: Trust Induction. On the Ulysses home page. Knowledge tested on Mandatory training day. Understanding measured on Trusts Quality and Safety walkabouts. Monthly Governance 'Learning messages'.
			Fit for purpose Mandatory training slides			**Training and Development Group**	**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. September 2018 Update: Mandatory training reviewed and commenced in September 2018.		Multiple choice question included in mandatory training session to evidence understanding and knowledge of staff.
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	A BIU Strategy and KPI metrics measuring outcomes.			**OMB**	**4a**	Review and strengthening of the organisational structure around Bone Infection Unit (BIU)	~~June-18~~ ~~Nov-18~~ Jan-19	Aug 2018 Update: Structure reviewed and evolving development plan in place. The BIU now has in place; • a Clinical Service Lead (on SLA from UHB) • Dedicated time from Consultant Microbiologist (SLA UHB) • Dedicated time from ROH Pharmacist • Dedicated time from IPCT • Dedicated time from Consultant Surgeons A nominated Operations manager is supporting the recruitment of a CSM (agreed secondment from UHB) , MDT Co-ordinator and a data analyst. September 2018 Update: • CSM (on secondment from UHB) in post • CSM presently reviewing the requirements of the B.I.Service in order to develop a strategy and clinical pathways • Post out to advert for a data analyst to support the B.I.Service • Job description under review, by CSM, for a MDT Co-ordinator November 2018 Update (Received from Rivie Mayele): MDT Co-ordinator appointed in October 2018, with an anticipated start date of January 2019. With the BI Data Analyst also on track to commence in January 2019, this will complete the team. December 2018 Update (Received from Garry Marsh): BI Nurse post now made substantive recognising the need for specialist nursing input. January 2019 Update (Received from Rivie Mayele): MDT Co-ordinator and Data Analyst commenced in post in January and now completes the organisation structure.		
						OMB	**4b**	Bone Infection MDT to be launched	~~July-18~~ Nov-18	Terms Of Reference drafted. To be approved. Aug 2018 Update: TOR to be reviewed and approved on appointment of CSM who will develop and implement the clinical pathways for BIU. September 2018 Update: CSM presently reviewing TOR and requirements of the service October 2018 Update: ToR yet to be approved; these have been recirculated. November 2018 Update (Received from Rivie Mayele): ToR now on version 4 following feedback from Clinicians, BI Development meeting due to be held on the 22 November 2018, with anticipated sign off by the wider BI team on the 29 November 2018. December 2018 Update (Received from Rivie Mayele): ToR now approved and BI MDT in place.		\\gamma\users$\root\Keegans\Desktop\BIS TOR

				Executive Director of Patient Service	Head of Infection Prevention Control	OMB	4c	SLA to be agreed with UHB for support services	~~Sept 18~~ ~~Dec 18~~ April-19	Service Level Agreement in place with UHB to provide Consultant Microbiologist support to both infection control and bone infection service, this is under review. September 2018 Update: SLA contract review to be held 11/09/18 for microbiologist service support to the B.I.Service October 2018 Update: Awaiting update. November 2018 Update (Received from Julie Gardner): SLA now drafted with a plan to be signed off by the end of November 2018. December 2018 Update (Received from Julie Gardner): The SLA for the Clinical Lead at HGS is agreed and awaiting a signed copy. The microbiologist SLA is not signed but we are currently receiving 2 PA's a week support, this will need review in line with the BI service requirements once agreed. January 2019 Update (Received from Julie Gardner): SLA to be agreed April 2019 in line with BI service requirements.		
						OMB	4d	Development of surgical pathways and blood monitoring Standard Operating Procedures (SOPs)	~~Sep 18~~ ~~Dec 18~~ April-19	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. Aug 2018 Update: These will be reviewed, developed bespokely for ROH and implemented on appointment of the CSM in line with clinical pathways. September 2018 Update: Newly appointed CSM to develop and implement required SOP's. This work is presently being scoped. October 2018 Update: SOPS - still under review. November 2018 Update (Received from Neil Jenkins): Draft patient pathways written Meeting 29th November 2018 with Medical Director, Clinical Service Leads and HGS surgeons. Launch 7th December 2018 at West Midlands Bone infection meeting. December 2018 Update (Received from Neil Jenkins): Pathways agreed and launched, next step is to finalise the governance processes for both ROH and UHB. February 2019 Update (Received from Neil Jenkins): Bone Infection pathway being presented at both ROH and HGS Quality and Safety Committees in February 2019.		
						IPCC	4e	Outpatient and Parenteral Antimicrobial Therapy policies to be updated	Dec-18	Clinical Lead assigned to lead this work. Aug 2018 Update: Now supported from the ROH Lead Antimicrobial Pharmacist. September 2018 Update: ROH Lead Pharmacist with support from UHB Microbiology Service have updated these policies and are awaiting comments from the AMR Strategy Group. October 2018 Update: Awaiting update. November 2018 Update (Received from, Daniel Hearsey): The Trust Antimicrobial guidelines and Stewardship Strategy has been developed and is available on the Trust Intranet. A 'handy hints' document has been produced alongside these.		As per policy and review date.
						OMB	4f	Develop and launch a BIU business model	~~Dec 18~~ April-19	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 Aug 2018 Update: CCG have agreed a CQUIN, with ROH, to support a 12 month plan for the BIU. This will support the appointments of required staff (CSM, Data Analyst and MDT Co-ordinator). September 2018 Update: Remains as above. October 2018 Update: Bone Infection Service Development Group has now been established and weekly meetings take place every Thursday 11.30-13.00. BI CSL will be leading along with Jonathan Stevenson to draft pathway. Stakeholder meeting arranged. December 2018 Update (Received from Rivie Mayele): The BIS development group are working with clinicians across the region to develop clinical and referral pathways to be submitted (as part of the business case) to the board in February 2019. The proposed date for submission will be April 2019 (as per CQUIN requirement).		

5	The Trust should ensure staff have access to relevant specialist training to carry out their roles effectively. All departments to ensure a Training needs analysis (TNA) is completed that highlights requirements of role and development aspirations.	All staff will have the relevant specialist training including oncology, mentorship and leadership courses.	Increased staff satisfaction in relation to access to training and development.	**Executive Director of Patient Service**	**Patient safety and Clinical Training Lead.**	**Training and Development Group**	**5a**	Develop and deliver a: Band 6 development programme. Management skills programme. Preceptorship. Specialist Courses. Fundamental skills.	~~Aug 18~~ Jan-19	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. September 2018 Update: Commencement of programme delayed until Jan 2019 due to Trust wide management programe being designed and concerns regarding possible overlap. This has now been resolved. October 2018 Update: Course dates booked and advertised. This is monitored via the Nurse Strategy meeting and Training and Development Group. Oncology, leadership and mentorship courses/development discussed at the Training and Development Group for assurance that this provision is in place. November 2018 Update (Received from Karen Hughes): Band 6 Development programme: due to start Jan 2019. Staff booking via ESR- a lot of interest across all departments including Therapies Orthopaedic Course: Funding and places confirmed for double module starting Jan 2019. Applications received by L&D Leadership courses are available and overseen by L&D/Clare Mair Mentorship course still currently available and staff accessing this training. Due to change in NMC requirements re need for this, this may change over the year. December 2018 Update (Received from Karen Hughes): Oncology academic programme available and delivered by the University of Birmingham.		U:\Documents\ CQC Evidence\ COC action plan
			Increased numbers of staff attending training and education.			**Training and Development Group**	**5b**	Specialist Training to be offered to staff	~~Jan 19~~ March-19	Aug 2018 Update: As part of the Clinical Workforce and Development Group; various work streams have been defined looking at education and development including new roles including Nurse Associates and Theatre Assistant Practitioners. September 2018 Update: Work streams for Nurse associates and TAPs continue. SE&OD have supported further scoping of NA role and buisness case submission for the TAP role. Places had been booked for staff to attend orthopaedic course at Wolverhampton starting Autumn 2018 but course is no longer being run. Confirmed with Staffordshire University their course will run Jan 2019. Confirmation re dates requested w/c 3/9/18 to enable booking of ROH staff onto this. Further discussions have not yet taken place with NAO as need to establish above development first. October 2018 Update: Wolverhampton have at short notice discontinued their orthopaedic course. It has been confirmed ROH can have places on Stafford courses-awaiting dates. Meeting with RJAH training lead 23/10/18 to discuss collaborative working further. Nurse Associate/TAP work continues-this is monitored via the Clinical workforce & Development Group. November 2018 Update (Received from Karen Hughes): Awaiting clarification on Oncology specialist courses; orthopaedic and spinal now progressed with Staffordshire University. December 2018 Update (Received from Stacey Keegan): A training needs analysis (TNA) is being completed by all departments as part of buisness planning for 2019/20. TNAs will be collated in February 2019 and reported to the Training and Development Group in March 2019.		
6	Public engagement required re-energising.	Patients and stakeholders are involved in decisions regarding the Trust and their care	Patient feedback			**CQG**	**6a**	Patient and Carers Forum to be reviewed	~~Aug 18~~ Nov-18	Aug 2018 Update: Lead attends the monthly meeting and is presently reviewing the future development, with the Chair of the group, in line with the NHSI Patient Experience Improvement Framework (2018). The TOR are presently under review and a work plan will be developed, by the end of Q2, to support the patients experience . September 2018 Update: Comments collated on TOR – to be reviewed by the group 27/09/18. Work plan to be supported by Healthwatch Birmingham Presently reviewing the diversity of the group and how to encourage membership. October 2018 Update: Strategic group to be established to oversee Patient and Carer Forum and Strategy workplan. Patient and Carer Forum ToR drafted but due to be finalised November 2018. November 2018 Update (Received from Stacey Keegan): ToR agreed at Patient and Carers Forum; on the Clinical Quality Group agenda for November 2018. DDoN currently drafting ToR and membership for Strategic Group (to be named). December 2018 Update (Received from Stacey Keegan): Patient and Carer Forum ToR approved at the Clinical Quality Group in November 2018. Draft ToR for Stategic Group completed and meeting dates being scheduled. January 2019 Update (Received from Stacey Keegan): Patient Engagement and Experience Group ToR approved at Quality and Safety Committee and meeting scheduled to commence in February 2019 - monthly and to upward report into Quality and Safety Committee.		U:\Documents\ CQC Evidence\Enc 028 Briefing paper \\gamma\users$\ root\keegans\ Desktop\Patient U:\Documents\ Patient Experience\ Terms of

			Executive Director of Patient Service	Patient Services Manager	CQG	6b	Develop and launch of a Patient Experience and Engagement strategy	Jan-19	September 2018 Update: Strategy to be supported by Healthwatch Birmingham ROH present PPI position to be benchmarked, in September, against the Healthwatch benchmarking tool Healthwatch Birmingham lead to attend the Patients and Carers Forum in October to support future work. October 2018 Update: Meeting held with Healthwatch, IPC lead, DDoN and Patient Experience Manager - benchmarking completed using Healthwatch PPI tool. Group now benchmarking organisation with the NHSI framework with a paper to Execs planned for November 2018 outlining gaps and proposed actions. November 2018 Update (Received from Stacey Keegan): PPI benchmarking on the agenda for November 2018 Clinical Quality Group. PPI and Experience Event planned for December 2018 to engage and steer the Strategy development. The Trust PPI and Experience Strategy to be presented at Quality and Safety Committee in January 2019. December 2018 Update (Received from Stacey Keegan): Benchmarking completed and presented, incorporating feedback. Patient and Public engagement event took place in December 2018 to gain views and input into the Trust Strategy. Draft Strategy completed and on track to present at the Clinical Quality Group and Quality and Safety Committee in January 2019. January 2019 Update (Received from Stacey Keegan): Involvement, Experience and Volunteering Strategy presented at Quality and Safety Committee. Launch of Strategy planned for February 2019.		\\gamma\users$\root\keegans\Desktop\Draft
					CQG	6c	Develop workplan that underpins the Strategy and report to Quality and Safety Committee	Jan-19	October 2018 Update: On completion of the Strategy document and KPI setting. November 2018 Update (Received from Stacey Keegan): Agenda item at January 2019 Quality and Safety Committee. December 2018 Update (Received from Stacey Keegan): As above. January 2019 Update (Received from Stacey Keegan): Workplan to be drafted and approved at the first Patient Engagement and Experience Group planned for February 2019, incorporating finding from the benchmarking and gap analysis completed.		

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	IMT Board	7a	Implementation of EPMA (electronic prescribing and decision support system) system Work towards the development of a 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. October 2018 Update: The draft gateway process is still in discussion and no agreement has yet been made. The clinical portal project has not started yet and no date agreed. November 2018 Update (received from Mark Bemrose): New systems policy now drafted and sent for board approval. No decision yet made on clinical portal – awaiting appointment of CCIO. December 2018 Update (Received from Mark Bemrose): The new systems policy has now been adopted. January 2019 Update (Received from Mark Bemrose): The clinical portal is awaiting the appointment of a CCIO which is a crucial role in the development of the Portal at the Trust. An initial meeting is to be arranged with UHB to discuss the project requirements in more detail.		
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	ative Director of Finance	tion Governance Manager	IMT Board	8a	Review and ensure the process and security of patient data is robust within the Outpatient Department.	Dec-18	Aug 2018 Update: Security review has been undertaken and actions particulary with regard to permissions are being implemented. October 2018 Update: Actions being reviewed by IG Manager with periodic walkabouts to check compliance. November 2018 Update (Received from Janette Carveth): Data security to be part of Quality and Safety walkabouts. December 2018 Update (Received from Janette Carveth): The cyber security risk assessment has recently been refreshed and has visibility at corporate and BAF level. A number of actions are planeed or started to ensure compliance with cyber security DPS standards which in turn increase the security of patient information.		

				Exec	Informa	IMT Board	8b	Audit the security of patient data within the Outpatient Department.	Feb-19	January 2019 Update (Received from Stacey Keegan): Request made to the Outpatient leadership team to conduct audit of patient data security (computers and patient notes) to establish improvements or further actions that are required. Audit to be conducted by the Trust Information Governance Manager.		
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	CQG	9a	Team Brief and Team Brief process to be reviewed on the WHO checklist	Oct-18	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. Aug 2018 Update: Brief and debrief elements of the WHO have been audited seperately to identify themes, participation and feedback - reports have been developed by the Theatre Matron. September 2018 Update: Upward reports now recieved at Clinical Quality Group and shared within Divisions - awaiting feedback from Stryker. October 2018 Update: Awaiting update from Stryker - early November 2018. Audits continue and reported by the Theatre Matron. Themes from brief and debrief fed back to relevant stakeholders for actions if required and learning. November 2018 Update: Awaiting update on audit cycle and progress with Stryker. December 2018 Update (Received from Tracey Rutter): WHO and WHO brief and debrief audits completed monthly and upward report shared with responsible clinicians. Audit to be conducted in CT as well as Theatres. Upward reports/audit results part of the Clinical Quality Group workplan.		Monthly audit cycle in place incorporating Theatres, CT and ADCU with upward reports to the Division and CQG workplan and included within the Trusts Quality Report.
			100% compliance with WHO checklist Audit	Executive Medical Director	Associate Medical Directors	CQG	9b	ADCU and CT to be included on the Theatreman system for the WHO	Oct-18	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. September 2018 Update: WHO completed via Theatreman for CT and will be reported via Theatre Matron report monthly from October 18 report. Awaiting communications from Trisoft regarding ADCU. October 2018 Update: WHO audit compliance reported in the Trust Quality Report. Theatres and CT reported from Theatreman (Trisoft); ADCU remains a paper based audit until phase 2 of Theatreman roll out. Audits reported as 100% for September 2018. November 2018 Update (Received from Tracey Rutter/Sue Cox): ADCU continues to be paper based process and audit, no date for Phase 2 roll out received. December 2018 Update: Paper based WHO process within ADCU that is audited monthly with no concerns escalated. All relevant elements of the WHO process are completed.		Theatres and CT WHO audited and reported monthly by the Theatre Matron. WHO conducted in ADCU audited by Matron and reported in Divisional Condition report/KPIs. WHO compliance forms part of the monthly Trust Quality Report.
10	The Trust should review medical cover at weekends to ensure adequate cover.	Medical staffing to meet the required cover for weekends with staff being aware of the rota and escalation process.	Patients and staff have access to appropriate medical staff.	Executive Medical Director	Associate Medical Director	CQG	10a	Devise escalation process to ensure staff are aware and supported when escalating patients for review.	~~Sept 18~~ ~~Dec 18~~ March-19	Escalation process to be devised for ward level staff and AHPs. September 2018 Update: Escalation process in draft to be circulated with the intention of ratification at CQG in October 2018. October 2018 Update: Escalation process in line with NEWS2 and the deteriorating patient policy is in draft overseen by the Sepsis Group. Roll out planned by December 2018. November 2018 Update (Received from Helen Allen): Deteriorating Patient Policy in draft and circulated for comment; including flow chart for escalation. December 2018 Update (Received from Stacey Keegan): Draft policy remains in circulation for comments; in addition, escalation process (non acute patient episode) to be formulated to assist in informing and empowering nursing teams. January 2019 Update (Received from Stacey Keegan): Non-acute patient episode escalation tool in draft, out for comment and for approval at Clinical Quality Group in February 2019.		

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	Consent audits and dictation turnaround metrics met.	**Executive Medical Director**	**Associate Medical Directors**	**CQG**	**11a**	Staff to adhere to the Consent policy.	Nov-18	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 is overseen by the Medical Director and Clinical Audit Committee. Consent is a quality priority for 2018/2019 Quality accounts. Audits show improving compliance. October 2018 Update: Discussion with AMD Division 1 - awaiting further assurance. November 2018 Update (Received from Mr Va Faye): New process is being considered for implementation. December 2018 Update (Received from Mr Pearson): Consent audit conducted and due to be presented to the medical body on the 24.1.19. Consent process is safe; further actions to improve patients receiving copy of the consent form and ensuring information that is given to the patient is clearly documented as such. February 2019 Update (Received by Stacey Keegan): Action handed over and discussed with the new Medical Director to review and take forward. January's consent audit attached, highlighting improvements.		U:\Documents\ CQC Evidence\ Patient Consent
11						**CQG**	**11b**	Digital Dictation upgrade and roll out of training to enable improved process for patient letters and turnaround times.	Nov-18	Aug 2018 Update: Upgrade completed in July 18 with a training progrmme in place to roll out. October 2018 Update: awaiting update. November 2018 Update (Received from Janet Campbell): Winscribe digital dictation upgrade went live on the 10 September 2018 and all staff training had been provided beforehand, prior to roll out. We now have a number of 'super users' who can provide ongoing training in future. The Winscribe system has now moved back to an operational function rather than a project and Matt Payne is the owner.		Winscibe reporting functionality being addressed however KPIs in place to monitior by speciality - these KPIs are monitored at Division 1 weekly operational meeting - confirmed with Matt Payne.
Executive Director of Strategy												
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**	**Training and Development Group**	**13a**	Mandatory training process to be reviewed to include online modules enabling different methods of access and learning.	Jan-19	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. Aug 2018 Update: 92.83% compliance for June 2018 therefore achieving Trust target. September 2018 Update: Maintaining MT compliance over 90% for substantive and bank staff. Streamlining project / CIP continues. The Trusts external contract with External Online learning provider has been cancelled as now internal provision with ESR is working effectively. All Subject matter experts are engaged with transferring to online modules, excluding Safeguarding adults and children. Although agreed suitable nationally, additional information is needed in the safeguarding online packages to include local information that the local leads are requesting. To include this it requires an IT intervention to enable links with ESR. This may delay complete transfer to online modules by the target date of January 2019. October 2018 Update: Progress remains as above - implementation plan attached. November 2018 Update (Received from David Richardson): Progress remains on track with no concerns to escalate. December 2018 Update (Received from David Richardson): Core Mandatory training modules are now available via a 1 day face to face course, or via E-learning for Health online modules. Both approaches are available to all employees within the Trust. Currently around 10% of staff access the e-learning option. 90% target still being exceeded on a monthly basis.		U:\Documents\ CQC Evidence\ Mandatory training
Executive Chief Operating Officer												

16	The Trust should ensure that the NHS England Accessible information standards are met.	The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The ROH will meet the Accessible Information standard.	Closure of the responsive Accessible Information Standards action plan.	**Chief Operating Officer**	**Operational Service manager**	**CQG**	**16a**	Closure of the Trust responsive Accessible Information Standards action plan.	~~Dec 18~~ April-19	The Trust currently have an accessible information improvement group with a responsive action plan. Progress of this action plan is monitored via the Clinical Quality Group and upward reports to the Quality and Safety Committee. November 2018 Update (Received by Matt Payne): An audit of patients attending ADCU for a week has been undertaken, asking all patients to fill in a survey on arrival asking if they consider themselves having any communication issues. I they do they were asked to then specify what these were. This information will be used to check if this has been recorded on both the Patient Administration System and the patient's notes. There will be another audit undertaken in the outpatient department once a similar question can be added to the self-check-in screens. This is being negotiated with InTouch currently. In addition the Patient Access Manager has also been to the Trust audit day to address the consultant body to ensure they were aware of the Accessible Information Standard and their obligation to collect information about patient communication needs. A business case to propose working with two external companies called DrDoctor and Synertec is being developed. These two companies are able to take on the Trusts communication with patients, initially around outpatient appointments, and patients will be able to highlight their own communication needs and Synertex will be able to send correspondence in the relevant formats. December 2018 Update (Received from Matt Payne): The action plan is now 90% complete and plans have been made to complete the last few actions by the end of the calendar year. A strategy / resource document is to be drawn up as a summary to the project of moving the Trust to compliance. February 2019 Update (Received from Matt Payne): Assurance document attached outlining compliance with the Accessible Information Standard. Agenda item for April 2019 Clinical Quality Group with a plan to sign off closed action plan.		U:\Documents\ CQC Evidence\ 20181213 U:\Documents\ CQC Evidence\ 20190131 AIS
		Staff at the ROH will be fully aware of what services are available, and have knowledge in how to access translation services.			**CQG**	**16b**	Translation services and how to access are communicated to the Trust.	Nov-18	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. October 2018 Update: as above. November 2018 Update (Received from Matt Payne): All systems previously report are still in place and remain affective. The second round of outpatient benchmarking is due to begin in the next 2 months and this will provide new information comparing the Trust against other providers and their use of translation service. It will also allow the Trust to compare itself against last years' data. December 2018 Update (Received from Lisa Kealey): Higher than average use of transalation services, no complaints, PALS or FFT concerns raised regarding translation services. DrDoctor system if progressed will further enhance this service for patients.		
17	The Trust should continue to improve the flow through the Outpatients Department so patients are not kept waiting for appointments.	Improved access, flow and efficiencies within the Outpatient Department avoiding and minimising excess wait times for patients and carers.	To meet the target/KPI for clinic wait times.	**Chief Operating Officer**	**Clinical Service Manager**	**Out-Patient Operational Group**	**17a**	Clinic templates reviewed for those clinics that continue to have delays and increased waiting times and human factors addressed if required.	~~Sept 18~~ Feb-19	September 2018 Update: In August there were 10.8% of patients waiting over 30 minutes and 3.8% waiting over 1 hour which is below the target of 5%. This is now the third month that the target of 5% has been achieved. The over 30 minute wait has improved from the previous month from 12.3% and is the lowest level so far. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month. October 2018 Update: September 2018 - 11.2% >30 minutes and 4.6% >1 hour - Quality Priority overseen at Clinical Quality Group. November 2018 Update (Received from Matt Payne): Waiting times in clinic continue to be monitored and have been steadily dropping. The Trust has achieved its target of less than 5% of patients waiting for longer than 60 minutes over the last 3 months and the over 30 minute delays have nearly reached the target of 10% and are currently being maintained below 12%. Further work is underway to try and make use of detailed reports from InTouch to identify areas of high clinic delays and take focused action. December 2018 Update (Received from Matt Payne): October 2018 saw an increase in wait times, rationale being an increase in clinic activity. November 2018 KPIs showed improvement and were reported as 11.2% >30 mins and 3.9% > 60 mins. January 2019 Update (Received from Stacey Keegan): Review previous Trust CQC responsive action plan with a plan to close action with assurances. February 2019 Update (Received from Stacey Keegan): Previous CQC Responsive action plans sent to the OPD operational team for review and to ensure these previous improvements have been embedded.		A Trust Quality Priority monitored at Clinical Quality Group. Clinic wait KPIs reported in monthly Finance and Performance and Quality reports. OPD 6-4-3 meeting now established to oversee operational efficiencies.
Associate Director of Governance & Company Secretary												

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	**Associate Director of Governance and Company Secretary**	**Corporate Governance Lead**	**S/E and O/D Committee**	**12a**	Review fit and proper persons act Trust process	~~Jul 18~~ Nov-18	Confirmation that there is a process in place and that all relevant staff will comply. Aug 2018 Update: Awaiting confirmation that this action is closed. September 2018 Update: FPPT policy is in place - awaiting confirmation of reviewer. October 2018 Update: FPPT policy is in place and will be updated by November 2018 to ensure that it accurately reflects current practice and the requirements of the regulation. December 2018 Update (Received from Simon Grainger-Lloyd): Policy reviewed, with confirmation being sought regarding DBS and how often this check is required. January 2019 Update (Received from Simon Grainger-Lloyd): FPPT policy reviewed and updated .		U:\Documents\ CQC Evidence\Fit Proper Persons
						S/E and O/D Committee	**12b**	All Staff meet the Fit and Proper person regulations	Aug-18	All executives have signed fit and proper persons self declaration as per Trust policy. Aug 2018 Update: Awaiting confirmation that this action is closed. September 2018 Update: All Execs and NEDs have been subject to the FPPT.		
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 within the agreed timescales.	Audit of compliance against policies and policy workplans.	**Associate Director of Governance & Company Secretary**	**Corporate Governance Lead**	**CQG**	**18a**	All polices to be up to date with a review period defined.	~~Sept 18~~ Dec-18	September 2018 Update: Policies to be the first module launched within the Allocate software. Module commencement starts mid September 2018 and due for completion by December 2018. October 2018 Update: Module commencement starts mid October 2018, with the cleanse of the policy list to ensure that authors and Executive Leads are accurate and due for completion by December 2018. Currently a report is received by Clinical Quality Group for oversight of clinical policies. November 2018 Update (Received from Adam Roberts): Project remains on track - internal policy cleanse is nearing completion. Updated policy spreadsheet will then be sent to Allocate ready for module build and configuration stage of project. A report continues to be received by Clinical Quality Group for oversight of clinical policies. December 2018 Update (Received from Adam Roberts): Internal policy cleanse (audit of all current policies & review dates, as well as review of relevant authors and Exec lead) has now been completed. Awaiting discussion with Allocate Project team to determine policy data they require in order for them to commence module build and configuration. A report continues to be received by Clinical Quality Group for oversight of clinical policies and work is due to commence shortly to ensure timely review and re-validation of corporate policies (such as Finance, HR, Estates etc.) February 2018 Update (Received from Stacey Keegan): Awaiting update on status of corporate policies and timeframe for completion.	Risk 791 Corporate Risk Register. *'There is a risk that safe practices and patient care are compromised by the large number of organisational policies which are overdue for renewal'.*	
						CQG	**18b**	Process for reviewing policies to be launched	~~Sept 18~~ ~~Dec 18~~ March-19	Current process for monitoring policies is manual. The new process will be designed in line with the electronic system Allocate. September 2018 Update: Policies to be the first module launched within the Allocate software. Module commencement starts mid September 2018 and due for completion by December 2018. October 2018 Update: Module commencement starts mid October 2018, with the cleanse of the policy list to ensure that authors and Executive Leads are accurate and due for completion by December 2018. November 2018 Update (Received from Adam Roberts): Project remains on track, internal policy cleanse is nearing completion. Updated policy spreadsheet will then be sent to Allocate ready for module build and configuration stage of project. December 2018 Update (Received from Adam Roberts): Internal policy cleanse (audit of all current policies & review dates, as well as review of relevant authors and Exec lead) has now been completed. Awaiting discussion with Allocate Project team to determine policy data they require in order for them to commence module build and configuration. February 2019 Update (Received from Stacey Keegan): Allocate module now built, meeting arranged with Adam Roberts and Allocate week commencing 4.3.19 to finalise training and agree launch/go live date.		

19	The Trust should ensure that the corporate risk register is reviewed by the full board.	The Trust Board is to be 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**	**Trust Board**	**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. Work also approved by the Audit Committee.		

ROHTB (3/19) 018

TRUST BOARD

DOCUMENT TITLE:	**Board Workplan 2019/20**
SPONSOR (EXECUTIVE DIRECTOR):	**Dame Yve Buckland, Chairman**
AUTHOR:	**Mr Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6 March 2019**

EXECUTIVE SUMMARY:

The attached presents a schedule of business for the Board to consider at its meetings during 2019/20.

The schedule is drawn from a review of previous Board agendas, statutory items and best practice examples, namely those from the Healthy Board (NHS Leadership Academy) and FT Provider's guidance.

REPORT RECOMMENDATION:

The Trust Board is asked to RECEIVE and APPROVE the suggested workplan.

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	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:

Aligns to all strategic objectives.

PREVIOUS CONSIDERATION:

None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

BOARD REPORTING CYCLE 2019/20

	Q1	Q2	Q3	Q4
Standing Reports				
Chief Executive's Update	✓	✓	✓	✓
Patient/Service Improvement Story	✓	✓	✓	✓
Finance and Performance Overview	✓	✓	✓	✓
Quality Report	✓	✓	✓	✓
Workforce Overview	✓	✓	✓	✓
Meeting Effectiveness	✓	✓	✓	✓
Committee updates	✓	✓	✓	✓
Quarterly Report				
Progress with the delivery of the Strategy	✓	✓	✓	✓
Board Assurance Framework Update	✓	✓	✓	✓
COG Update	✓	✓	✓	✓
Board Development Plan progress report	✓	✓	✓	✓
Annual Reports				
Quality & Safety				
National Inpatient Survey Results and action plan	✓			
Annual Complaints Report		✓		
Infection Control Annual Report		✓		
Health and Safety Annual Report		✓		
CQC action plan	✓	✓	✓	✓
Safe Staffing Report	✓		✓	
Workforce				
Gender Pay Gap analysis	✓			
Annual inclusion report (EDS2)	✓			
Freedom to Speak Up presentation			✓	
Annual Statement of Compliance - medical staff revalidation & Appraisal		✓		
Finance, Strategy and Operations				
Operational Plan & budget sign off	✓			
Approval of Annual Report & Accounts 2016/17	✓			
Sign off annual external audit plan	✓			
Self assessment against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR)		✓		
Mid year review of Annual Plan and Budget			✓	
Estates Strategy Review			✓	
Carbon Reduction Strategy update			✓	
Fire safety annual report			✓	
Perfecting Pathways update	✓	✓	✓	✓
Corporate Governance & Compliance				
NHSI Annual Declarations 2018/19	✓			
2020/21 Board Workplan				✓
ToR and membership of Board Committees	✓			
Committee Annual Reports	✓			
Approve changes to SOs/SFIs			✓	
Well Led Assessment update				✓
Freedom of Information Annual report	✓			
Declaration of compliance with CQC Fundamental Standards	✓			
Corporate Risk Register	✓		✓	

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 3 April 2019: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(MR)
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)	
Miss Stacey Keegan	Deputy Director of Nursing & Clinical Governance	(SK)	[for Garry Marsh]
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Patient story	Presentation	
1120h	2	Apologies – Garry Marsh	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 6 March 2019: *for approval*	ROHTB (3/19) 019	Chair
1227h	5	Trust Board action points: *for assurance*	ROHTB (3/19) 019 (a)	SGL
1130h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (4/19) 002 ROHTB (4/19) 002 (a)	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 and briefing on resilience exercise. BAF REF: FP3	Verbal	SW/PB
	6.3	Corporate and strategy extract of the Board Assurance Framework	ROHTB (4/19) 013 ROHTB (4/19) 013 (a)	PA/PB

TIME	ITEM	TITLE	PAPER	LEAD
QUALITY & PATIENT SAFETY				
1140h	7	Quality & Safety extract of the Board Assurance Framework*: for assurance*	ROHTB (4/19) 003 ROHTB (4/19) 003 (a)	SK/MR
1145h	8	Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (4/19) 005	KS
1155h	9	Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (4/19) 004 ROHTB (4/19) 004 (a)	JW
1205h	10	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (4/19) 006	SK
FINANCE AND PERFORMANCE				
1215h	11	Finance & Performance extract of the Board Assurance Framework*: for assurance*	ROHTB (4/19) 007 ROHTB (4/19) 007 (a)	SW/JW
1220h	12	Update from the Finance & Performance Committee: *for assurance*	ROHTB (4/19) 008	TP
1230h	13	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (4/19) 009	SW
WORKFORCE				
1240h	14	Workforce extract of the Board Assurance Framework*: for assurance*	ROHTB (4/19) 010 ROHTB (4/19) 010 (a)	PA
1245h	15	Update from the Staff Experience & OD Committee workshop: *for assurance*	Verbal	RP
1250h	16	Gender pay reporting: *for assurance*	ROHTB (4/19) 011 ROHTB (4/19) 011 (a)	PA
CORPORATE GOVERNANCE, RISK AND COMPLIANCE				
1255h	17	Compliance extract of the Board Assurance Framework*: for assurance*	ROHTB (4/19) 012 ROHTB (4/19) 012 (a)	PB/SGL
MATTERS FOR INFORMATION				
1300h	18	Meeting effectiveness	Verbal	ALL
	19	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 1st May 2019 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** 6 March 2019: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(MR)
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)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Service Improvement story – Flow Academy	**Presentation**
The Board was presented with an update on the work of the Flow Academy by Lorraine Simmonds and Rebecca Lloyd. The work had been reported as part of the 'Perfecting Pathways' programme and sat alongside the Quality and Service Improvement Redesign initiative. The team were thanked for their work to refine pre-operative processes, where there had been a demonstrable change in culture. It was noted to be positive to have a set methodology as this could be used across other clinical areas. It was reported that those that had been trained in the methodology were established as coaches and would join the faculty later and teach the methodology. It was noted that there was a time commitment involved in allowing those trained	

to impart their experience, however the skills could be used well. The team was asked where the Flow Academy methodology was seen to be most effective. They advised that the Flow Academy work was a combination of different methodologies which could be applied differently according to the circumstance and in this regard it was treated as a 'tool box'. There was a plan to sell further spaces on the course in future. It was suggested that some administration support would also be beneficial. There may be a case for using charitable funds. Mr Scrannage, present in the public gallery from Johnson & Johnson Ethicon advised that his company may be able to support this. The time on the course was spent between learning and developing the coaching skills in equal measure. The coaching was tailored to the needs of the tools. It was noted to be useful to build capacity across the region as a faculty. Ms Simmonds was thanked for providing places for the ROH and it was noted that the ROH joining the course had taken the opportunity in the right spirit. The application for further places was noted to be part of the annual planning process. It was highlighted that the next workshop for the Staff Experience & OD Committee would focus on continuous improvement and the team were invited to attend this.	
2 Apologies	
The Board was joined by Mr Neil Scrannage from Johnson and Johnson Ethicon. Matthew Revell was welcomed to his first public meeting as Medical Director. Thanks were expressed to Mr Andrew Pearson for his tenure as Medical Director. He was also thanked on behalf of the clinical body.	
3 Declarations of interest	**Verbal**
It was noted that the register was available on request from Company Secretary.	
4 Minutes of Public Board Meeting held on the 9 January 2019: *for approval*	**ROHTB (1/19) 012**
The minutes of the last public meeting were accepted as a true and accurate record of discussions held.	
5 Trust Board action points: *for assurance*	**ROHTB (1/19) 012 (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 (3/19) 001** **ROHTB (3/19) 001 (a)**

The Associate Director of Governance & Company Secretary presented the latest version of the Board Assurance Framework. He proposed that two risk were de-escalated: lack of a cancer tracking system; and achievement of a financial surplus Four risks were proposed for addition: a risk replacing the two previous risks around cyber security; the risk of not achieving the full Cost Improvement Programme; a risk of delay to the modular theatres scheme and the consequential impact on income; and the risk of not achieving the Control Total for the current financial year. It was noted to be that the risk around the Cost Improvement Programme and the modular theatres risk needed to be amended to reflect the current position. The Board approved the proposed changes to the Board Assurance Framework.	
ACTION: **SGL to ensure that changes are made to the BAF in line with comments made at the meeting**	
7 Chairman's & Chief Executive's update: ***for information and assurance***	**ROHTB (3/19) 002** **ROHTB (3/19) 002 (a)**
The Acting Chief Executive reported that there was discussion underway as to how the STP governance and administrative processes were resourced and a proposal was being developed for consideration. The STP Board had met and considered the suicide action plan and the new estates structures. A solution that worked for the city needed to be considered. An update on the ten year plan had been provided. It was reported that there had been a positive Birmingham Hospitals Alliance meeting in February and there was some commonality between providers in the enablers that had been discussed. The standardisation of orthopaedics across the system had been discussed. In terms of timescales, a progress report was due from the 'Getting it Right First Time' team in May with the reconfiguration taking place from November in advance of winter 2019. The learning from this journey needed to be captured, however this was noted to be a very positive development. The structure to support the activity process needed to be borne in mind so that growth was achieved. Increased project management skills were needed. The staff survey results had been received which were positive compared both to previous year's ROH results and to the benchmarked information. The support from immediate managers had improved significantly which reflected an improvement in the positivity of the culture and skill development. Against some of the individual questions, the ROH was reported to be rated within the top ten organisations in the country, with the position against the flexible working	

indicator being the highest in the country. The field work was reported to have been carried out in October 2018. The overall trend in results from 2015/16 was noted to be positive. The Chairman reported that she had been involved in recruitment, including the plans for the recruitment of a substantive Chief Executive at ROH. She had also been involved in the recruitment of the Medical Director and consultants. It was suggested that there was a good pool of candidates for consultant posts from across the STP and this needed to be accessed where possible. This extended to the anaesthetists as well as surgeons. The reasons for the Trust being able to attract a good number of high calibre consultants were in line with some of the feedback from the staff survey. It was suggsted that wide talent management processes across the region was needed. The Chairman had also been asked to support the recruitment of a chairman at Royal Wolverhampton Hospitals NHS Trust. Both the Chair and the Vice Chair had attended the STP Board meeting which they noted was a positive event. Some of the discussions had been around attracting capital and how estates were being used. It was noted that the ROH's funding bid for capital works had been unsuccessful.	
7.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was noted that this item had been covered as part of the Chief Executive's update.	
7.2 Briefing on plans for Brexit 'no deal' scenario BAF REF: FP3	**Verbal**
It was reported that there was a Brexit committee that met regularly. The ROH's ability to function in the event of a 'no deal' outcome was possible for a limited period. The Trust's business continuity plans would be tested on a scenario basis. There remained many challenges which would be monitored and stock levels remained under review. There was a regular teleconference with colleagues across the STP discussing plans for a 'no deal' Brexit. An increase in Freedom of Information requests had been seen regarding the ROH's preparedness and information was being shared as transparently as it could be. Mr Scrannage reported that supplies at his company were being maintained and the supply routes were being reviewed on a routine basis.	
8 Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986,	**ROHTB (3/19) 003** **ROHTB (3/19) 003 (a)**

PS1, MD1, CE4, FP2	
The Board was reminded that the proposed transfer date for paediatric services was 1 July 2019. There were two critical points that would determine whether this plan could be enacted: staff recruitment into theatres at Birmingham Children's Hospital (BCH) and secondly, the outcome of the Oncology service review which had been commissioned by BCH. This would take place on 11 & 12 March 2019. The report on this would be completed at the end of March and would be reviewed by the Stakeholder Oversight Group in April. It was reported that the paediatric ward and HDU at ROH were operating more effectively under a cohesive team that comprised BCH and ROH staff. The paediatrician support from Heartlands Hospital would continue. There had been a reduction in the number of beds and with support from BCH there was less temporary staffing being used. Confirmation had been received in terms of the new theatre lists at BCH and therefore job planning could now begin. The team was thanked for their support and hard work to keep the process on track.	
9 Update from the Quality & Safety Committee: ***for assurance and approval***	**ROHTB (3/19) 004** **ROHTB (3/19) 005**
It was reported that there were actions underway to address the concerns around the Hepatitis B vaccinations that some staff were outstanding. The two moderate harm incidents were being investigated. Assurance regarding water safety was reported to be much better and the revised action plan was to be presented to the Committee shortly. Following a presentation at the last Quality & Safety meeting it had been agreed that the bone infection service would report to the Board in due course as this demonstrated good working practices between partners. The Chairman asked for assurance around the length of stay of bone infection patients, noting that in addition to the quality angle, there were costs associated with keeping patients in hospital for any length of time. It was reported that the risk around the pathway and the governance arrangements for the service needed to be worked through so repatriation of patients back to the most appropriate setting and escalation if needed was effective. The support from the Royal Orthopaedic Community Scheme (ROCS) could assist. Prof Gourevitch agreed that the development of the service was good, however reiterated that costs associated with the service could	

be high and the optimal number of beds to support the service needed to be defined. It was suggested that a pool of consultants needed to be developed across the region to be able to treat this cohort of patients. It was noted that the local Clinical Commissioning Group (CCG) was supportive of the process and plans and were considering the appropriate tariff for the service. The fitness for purpose of the Drugs & Therapeutics Committee had been discussed, the issues with which were being taken forward by the Medical Director.	
10 Patient Safety & Quality report: *for assurance* BAF Ref: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	**ROHTB (3/19) 006**
The Director of Nursing & Clinical Governance reported that in terms of the moderate harm incidents, one was a pressure ulcer and the second related to a transfer out to paediatric intensive care at BCH. The pathway between ROH and BCH appeared to have worked well in this case. There had been no VTEs reported in January and at this point there were four year to date. In terms of pressure ulcers, it was reported that this had been a successful year, however there had been an increase in Grade 2 and Grade 3 cases recently. The avoidability of those reported during the month would be confirmed but the common themes would be reviewed, including documentation from other providers when patients were admitted from elsewhere and the care of patients in TED stockings. Trends would be provided for 'IWantGreatCare' in future. In terms of the Outpatients Friends and Family Test position, this was noted to be positive and reflected patients feeling engaged.	
11 Flu vaccination update: *for assurance*	**ROHTB (3/19) 007** **ROHTB (3/19) 007 (a)**
It was noted that the uptake of 'flu vaccines was lower than desired and was lower than the previous year when the profile of the impact of 'flu had been widely publicised. There remained a similar level of vaccinators as in previous years. It was noted that the Trust take up was also lower than elsewhere. The reasons for not taking the vaccination were discussed. To achieve an improved position for next year, it was reported that the 'flu group would continue to meet throughout the year, rather than at the start of the 'flu vaccination season.	

It was suggested that consideration needed to be given to the use of a media campaign around 'flu and suggested that different messaging was needed for the next year. The story of the recent 'flu case at ROH could be used as part of the promotion. It was suggested that non clinical areas needed to be targeted. It was also proposed that incentives and cards attached to identification could be used.	
12 Infection Control annual report: *for assurance*	**ROHTB (3/19) 008** **ROHTB (3/19) 008 (a)**
It was noted that the Infection Control report had been signed off previously and was already in the public domain. The layout of the report accorded with the hygiene code. There had been no MRSA bacteraemia and the *C difficile* cases reported were not associated with lapses in care; they were associated with antibiotic therapy for bone infection cases. There was an *E coli* reduction plan and there had been none of these infections reported last year. Hand hygiene scores were good and comparable to other organisations. The report was approved and underlined the role of the Director of Infection Prevention and Control.	
13 Update from the Finance & Performance Committee: *for assurance*	**ROHTB (3/19) 009** **ROHTB (3/19) 010**
It was reported that the January financial position reflected a shortfall year to date, with most of the pressure coming from delivery of the Cost Improvement Programme (CIP) and performance. Activity had been lower than planned in January, however was outperforming last year. Cost control was an issue but the position would be addressed by the year end. Length of stay had reduced significantly. Performance against the national Referral to Treatment Time target was slightly behind trajectory. Brexit had been discussed as had the plans for modular theatres. For next year, the ambition around the Cost Improvement Programme had been	

adjusted.	
14 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	**ROHTB (3/19) 011**
It was reported that the January financial position was affected by a number of technical adjustments. There needed to be an improvement by £450k to recoup some of the underperformance year to date. A prudent deficit was set for February but it was anticipated that this would be better than planned. In terms of CIP, the plan for 2019/20 was lower than the current target. It was suggested that under the new arrangements for 2019/20, there could be reinvestment back into departments achieving cost savings. The number of patients waiting in excess of 52 weeks had reduced significantly and by the end of March there would be none. This was noted to be an impressive achievement. The number of over 40 weeks was c. 25 patients, which again was a significant reduction. This would satisfy some of the regulatory pressures.	
15 Update from the Staff Experience & OD Committee: *for assurance*	**ROHTB (3/19) 012** **ROHTB (3/19) 013**
It was noted that the inclusion of the workforce report within Board papers was a positive development. There was noted to have been some good triangulation of issues between committees in terms of time to recruit and sickness absence. Both of these issues had been discussed and the latter would be a standing item for the next two months. The position against the Workforce Race Equality Standard (WRES) indicator for bullying and harassment for Black and Minority Ethnic (BME) staff was of concern and therefore there would be some triangulation with the findings of the staff survey. Some walkabouts had occurred and the process would be refined ahead of the next walkabout. All were invited to the workshop planned for later in the day and to the walkabouts. This was noted to be a positive report and the walkabouts were particularly welcomed across the Trust. The staff stories at the meeting were highlighted to be being very well received.	
16 Workforce overview: *for assurance*	**ROHTB (3/19) 014**

In terms of the recruitment and retention, the staff turnover position had reduced, therefore the staff in post position had improved. It was noted that there remained an issue around training and development opportunities which needed to be considered. It was suggested that the nursing leavers position needed to be seen as a positive in terms of the offering regarding preceptorship and mentoring. Conversations around opportunities for staff who were planning to leave the ROH after an initial period at the Trust and come back following development elsewhere were occurring with other providers. Sickness levels had increased in some areas and this was being given better focus to reduce this further. This would be part of the health and wellbeing strategy. Mandatory training needed to be improved in some areas, such as resuscitation.	
17 Update from the Audit Committee: *for assurance*	**ROHTB (3/19) 015**
It was reported that it had been a positive Audit Committee meeting in terms of the delivery of the internal and external audit plans and the work to reduce the number of outstanding audit recommendations. There was an improved assurance against the controlled drugs arrangements, stock management and consent although more work to do in all areas and as such the relevant Board committees would take oversight of improvements needed. Going Concern considerations had concluded that the preparation of the annual accounts could be on a Going Concern basis. Tim Pile left the meeting.	
18 Update from the Charitable Funds Committee and approved minutes: *for information*	**ROHTB (3/19) 016** **ROHTB (3/19) 016 (a)**
The update from the Charitable Funds Committee was received and noted. It was suggested that the nature of the bids needed to be made more diverse. Two slides had been included in the Team Brief to show which bids had been approved. It was suggested that a dedicated charitable funds fundraiser was needed.	
19 CQC action plan update: *for assurance*	**ROHTB (3/19) 017** **ROHTB (3/19) 017 (a)**
It was reported that the red ratings against some actions reflected that original timelines had been missed. It was suggested that there was a need to see realistic ambitions for the completion dates in future. The main issue was reported to be around mental health and a policy was being	

developed with Birmingham and Solihull Mental Health NHSFT and the website had been updated. There had been some cascade training in mental health first aid delivered and awareness training had been scheduled in from the new financial year. There had been improvements in the bone infection service. Medical cover at weekends had been reviewed and this had been reviewed by the former medical director. There was confidence that the deteriorating patient policy was being followed and more work was underway around more general out of hours queries. Outpatient waiting times continued to be reduced and consideration was being given as to whether this action could be closed. It was noted that there was new nursing leadership in the area who needed to establish themselves and agree the forward plan for the service. It was noted that the policies and procedures would be added into the Health Assure system.	
20 Trust Board workplan for 2019/20: *for approval*	**ROHTB (3/19) 018** **ROHTB (3/19) 018 (a)**
The Board reviewed its workplan for 2019/20 which it approved.	
21 Meeting effectiveness and reflection on adherence to Trust Values	**Verbal**
The meeting was noted to be inclusive and effective.	
22 Any Other Business	**Verbal**
It was noted that the 'sponsor a chair' event was planned to replace those in the lecture theatre at a cost of £240 per chair. There were noted to 119 seats. Board members were invited to sponsor a chair if they wished. The details of the evening meal to mark the conclusion of the former Medical Director's term of office were discussed. It was noted that it was International Women's Day shortly and this needed to be celebrated internally. The issue over knife crime was discussed and the work across the region needed to be borne in mind.	

Details of next meeting	
The next meeting is planned for Wednesday 3 April 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 3 April 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 29.03.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
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. Ongoing discussions around therapies with commisisoners, thereby not in a position to be able to present updated strategy until Spring 2019.	
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~~ 01/05/2019	Scheduled for the ~~November~~ May meeting	
ROHTBACT. 071	Board Assurance Framework	ROHTB (3/19) 001 ROHTB (3/19) 001 (a)	06/03/2019	Ensure that changes are made to the BAF in line with comments made at the meeting	SGL	03-Apr-19	Changes made and relfected in the verison of the BAF presented at the April meeting	
ROHTBACT. 068	Board Assurance Framework	ROHTB (1/19) 001 ROHTB (1/19) 001 (a)	09/01/2019	Reframe the paediatric transition risk relating to income	SW	06-Mar-19	Reframed on the current version of the Board Assurance Framework	
ROHTBACT. 069	Chairman's & Chief Executive's update	ROHTB (1/19) 002 ROHTB (1/19) 002 (a)	09/01/2019	Present the draft financial and operational plan at the March 2019 meeting of the Trust Board	SW	06-Mar-19	Included on the agenda of the March private session	

KEY:

	Verbal update at meeting
	Major delay with completion of action or significant issues likely to prevent completion to time
	Some delay with completion of action or likelihood of issues that may prevent completion to time
	Action that is not yet due for completion and there are no foreseen issues that may prevent delivery to time
	Action that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Paul Athey, Acting Chief Executive**
DATE OF MEETING:	**3 April 2019**

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 3rd April 2019

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 March 2019.

2 STP UPDATE

2.1 The last STP Board meeting, prior to the finalisation of this report, took place on 4th March 2019.

2.2 The meeting focused on two key areas; reviewing progress against the Birmingham suicide prevention action plan and reviewing the Birmingham & Solihull STP strategy and priorities against the requirements outlined in the NHS 10 year plan. The Board were pleased to note that the majority of our STP strategy fully supported the direction of travel outlined in the 10 year plan, and Programme Boards were asked to discuss and agree their key delivery priorities for 2019-20 in light of this.

2.3 The next STP Board meeting is taking place on 1st April and a verbal update will be provided at the Trust Board on 3rd April.

3 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

3.1 There have been no meetings of the BHA Board since the last ROH Board report

4 HISTOPATHOLOGY TRANSFER TO UNIVERSITY HOSPITALS BIRMINGHAM

4.1 As part of the NHS Improvement directives to consolidate pathology services into local networks, the ROH Histopathology service will transfer to University Hospitals Birmingham NHSFT (UHB) from 1st April 2019. This will bring it in line with a range of other pathology services that have been provided by UHB for many years.

4.2 Over time, this transfer aims to drive improvements to the service through the sharing of best practice and the standardisation of processes across the city, whilst also growing the resilience of what is currently a small, but highly skilled team.

4.3 It is recognised that, with the national shortage of workforce with the appropriate skills to deliver this specialist service, work needs to continue with National Orthopaedic Alliance partners to ensure that national bone tumour networks also continue to be developed to support and enhance the consolidated service to be provided in Birmingham and Solihull.

5 STAFF ENGAGEMENT

5.1 Following on from the results from our 2018 staff survey, it was pleasing to note that the Royal Orthopaedic Hospital was highlighted in a recent Health Service Journal article as showing one of the most improved hospitals in the country for our leadership and culture based on analysis undertaken by Listening into Action. (https://www.hsj.co.uk/leadership/exclusive-how-all-provider-trusts-rate-their-leaders-and-culture/7024663.article)

5.2 A scatter map plotting the ROH against 221 other NHS providers is attached to this paper. The x axis plots improvement or deterioration between 2017 and 2018 and the y axis plots the positive or negative variance against average results. The ROH can be found in the top right quadrant (cell 25,30).

6 LGBT+ AWARENESS WEEK

6.1 Between 25th & 29th March, the hospital celebrated our LGBT+ awareness week with a range of events and activities organised by the Equality & Diversity Network to promote the inclusive culture we value at the ROH.

6.2 The Equality & Diversity network, chaired by research nurse Claudette Jones, has been up and running for over 6 months now, and is really starting to make its mark thanks to the enthusiasm shown by its members. Further events are planned for the remainder of 2019.

7 POLICY APPROVAL

7.1 The Chief Executive, on the advice of the Executive Team has approved the following policies since the Trust Board last sat:

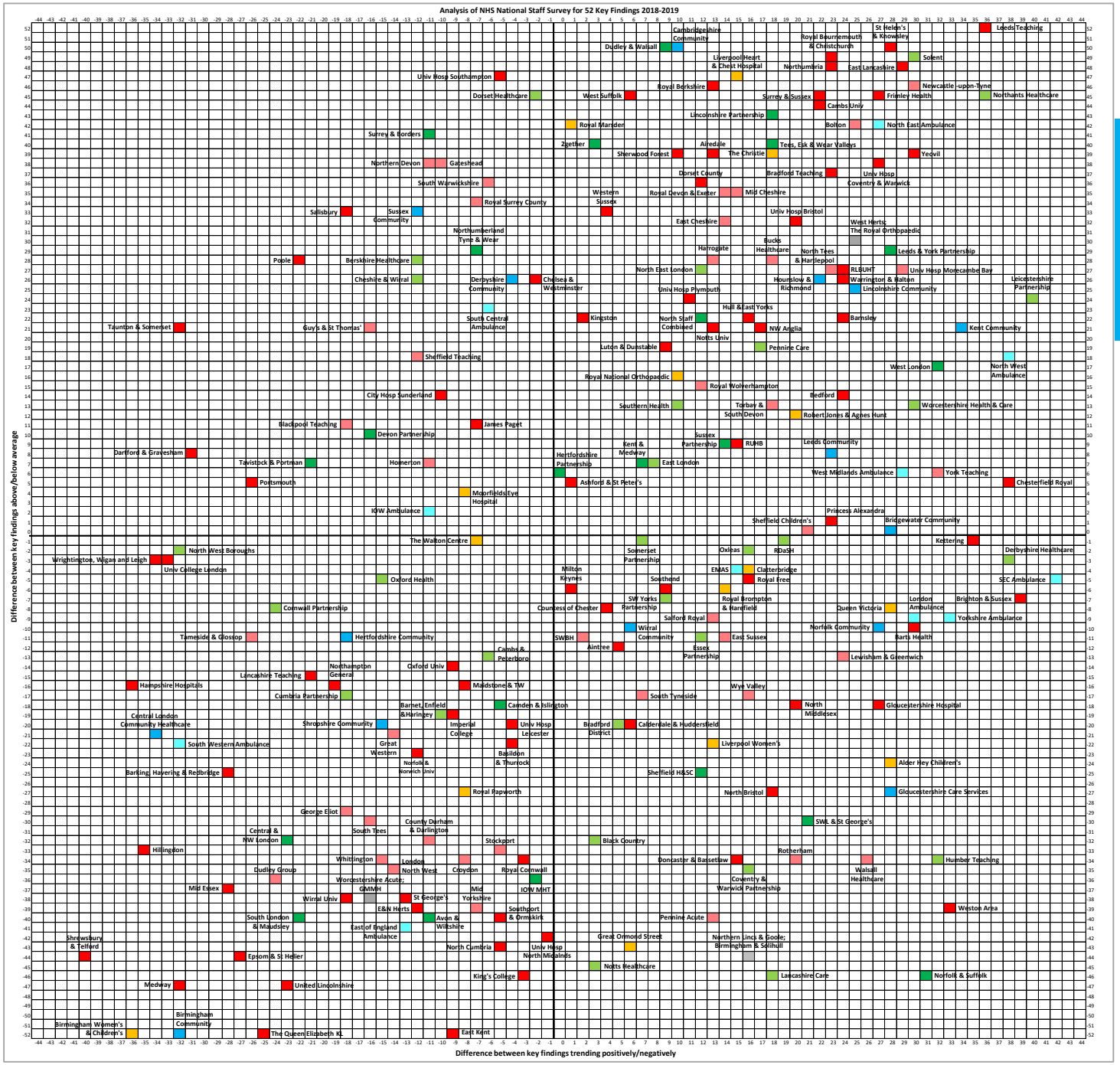
- Medical gas policy
- Decontamination policy

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
28 March 2019



Listening into Action

LiA Scatter Map 2018-19 for ALL NHS Provider Trusts

Contact: Gordon Forbes: 07734 812311

Key

- Acute
- Acute and Community
- Acute Specialist
- Mental Health / Learning Disability
- Mental Health / Learning Disability / Community
- Community
- Ambulance
- 2 Trusts of different types occupy same grid reference

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Corporate and Strategy extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3 April 2019**

EXECUTIVE SUMMARY:

The Board Assurance Framework includes 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 attached provides an overview of the corporate and strategy risks which the relevant Executive Director leads will present to the Board and discuss the current and planned mitigations.
.

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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • 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		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:					
Trust Board on 6 March 2019.					

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 Planning permission approved for theatre expansion	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	4	20	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. A further medium term financial plan will be required for submission by NHSI during 2019/20.	Dec-19	3	4	12
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. Full transition plan now in place with BWCH	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Clinical review of proposed Oncology strategy is still outstanding. If the outcome of this is positive, this will support the alignment of the strategy across all providers	Jul-19	2	3	6
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 Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	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	↔	Continued oversight by NHSI/E & CQC	Jul-19	2	3	6

S799	Strat	Phil Begg	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	Work is underway to develop the strategy for 2019/20 to 2023/24 and beyond. A workshop was held for the Board on 6 February 2019 at which the Board was presented with the proposed routes for enagement with the stratgey for staff, stakeholders and the public.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case; slides from strategy session for the Board on 6/3/19	2	3	6	↔	A strategy working group will be established to specifically focus on: - How we engage with all teams in the development of the new strategy - How we share key headlines from this year's annual plans - What we think the key elements of the strategy need to be - How we align all Trust plans/strategies to this document	Q1 2019/20	2	3	6

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quality & Safety extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3 April 2019**

EXECUTIVE SUMMARY:

The Board Assurance Framework includes risks are grouped into two categories:

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- 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 attached provides an overview of the quality & safety risks which the relevant Executive Director leads will present to the Board and discuss the current and planned mitigations.
.

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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • 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		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:					
Trust Board on 6 March 2019.					

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
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. NHSI/E continued oversight of system response Regular briefings to CQC and oversight of actions being taken BWCH senior nursing staff supporting weekly oversight of staffing and associated quality levels	Minutes of stakeholder oversight meeting	4	4	16	↔	Joint work continuing to support transfer of services from July 19, at which point risk will be mitigated	Jul-19	3	4	12
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 ratified -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

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	Risk remains unchanged. CYPHDU is staffed 24/7 with a minimum of 1 RNC and 1 RN with HDU paediatric competencies. Weekly meeting held with the Senior Sister and Matron, HON and chaired by the executive Director of Nursing & Clinical Governance. This meeting review staffing across CYP HDU, adult HDU and ward 11. Staffing and vacancy position discussed at HDU Management Meeting and included in the Divisional Condition Report to Division 2 DMB and CQG. Block booked agency staff to support service provision.	Q&S Report	3	4	12	↔	Ongoing recruitment programme. Bespoke adverts for HDU to try new approach to recruitment to attract candidates. Open days also being planned for early 2019.	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. Further support and oversight provided by BWCH and a further weekly meeting instigated from February 2019. Operationally the service has been reviewed and bed capacity reduced to 12 beds to support staffing requirements – Operational SOP being drafted to support measures put in place. Rostering reviewed and CYPHDU/Ward 11 amalgamated to provide further oversight and support both areas. Scheduling tool developed to provide better oversight of activity booked for both areas.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	Ongoing	1	4	4
MD1	Clinical	Matthew Revell	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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

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 (4/19) 005

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 27 March 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There remained a risk concerning outstanding staff inoculations; only a small number of staff remain without a plan to receive the vaccinations needed however. • There were two incidents reported which concerned transfers into and out of the Trust. In term of the patient who had been transferred into the Trust, this may have been an inappropriate admission; an audit of compliance with the admissions policy was planned to understand how often an inappropriate admission occurs • One patient that had waited for 104 days for treatment was highlighted – this was a shared breach between the ROH and another provider. The patient had arrived at the ROH at day 88. The patient would be reviewed under the harm review process. • Some gaps in the resuscitation framework at the Trust were highlighted, including poorer than desired levels of training in resuscitation and poor attendance at the resuscitation committee; work was underway to address these shortfalls	• Consider terming the initial incident harm assessment as 'provisional' rather than 'actual impact' to reflect that following an investigation, the level of harm might change • The detail of the near miss incidents is to be provided for the next meeting • Invite the Chair of the VTE Committee and the Lead Nurse for Tissue Viability to the April meeting of the Quality & Safety Committee • Trends are to be added into the Quality Report where they are apparent • Arrange for a demonstration of the HealthAssure system • Develop a set of metrics to use to judge progress with the delivery of the quality priorities
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There had been a reduction in the number of patients waiting over 52 weeks to zero; this was agreed to be a significant achievement • There was good progress with the development of the HealthAssure system, with a number of the modules going live shortly • There was reported to be good progress around creating systems for harnessing lessons learned from incidents • The vacancies in the clinical governance team were noted to be filled shortly • The Committee reviewed the progress with delivery against the quality priorities for 2018/19 and those suggested for 2019/20 which were supported	• .None specifically

• The Committee received an update on the process for identifying Cost Improvement Programme schemes; a further update on the potential impact of the schemes on quality was needed at a future meeting • An update on the open claims against the Trust was received which highlighted that although there was a higher number of claims, these were of a lower value; the clinical negligence premium for 2019/20 had reduced; there was evidence that the Trust robustly defended its position against claims made • The Committee noted that a positive report had been received from Healthwatch around the Outpatients waiting area	

Chair's comments on the effectiveness of the meeting: It was agreed that the meeting was effective but the invitation of medical consultants and other allied professionals to the meeting to showcase their work would enhance the discussions.

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:	**Janet Davies, Clinical Service Manager / Project Lead for the Paediatric Transition**
DATE OF MEETING:	**3 April 2019**

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:

- An update regarding the revised timeline for the transfer of Paediatric Services to BWC (1st July 2019)
- Details agreed for the Oncology Quality Assurance Evaluation
- Governance infrastructure supporting transition
- Main risks
- Communication with stakeholders

REPORT RECOMMENDATION:

The Board is asked to accept 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		Communications & Media	x
Business and market share	x	Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services.

PREVIOUS CONSIDERATION:

Last considered as part of the Trust Board public agenda on 6 March 2019.

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Paediatric Service Update – April 2019

UPDATE TO THE TRUST BOARD ON 3rd April 2019

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:

- Transfer date 1st July 2019
- Oncology Quality Assurance Evaluation and update on the main risks
- Communication with stakeholders
- Governance
- Main risks

2 Transition of Service

The Oncology Quality Assurance Evaluation took place as planned on the 11th and 12th March 2019. Professor Ian Lewis led the evaluation together with a parent representative, Sarah Dawson. BWC have shared the initial findings with their Trust Board at the end of March 2019 and support to proceed with plans to transition the Oncology service as planned on the 1st July 2019 has been agreed.

It has also been agreed as part of the Oncology pathway for the Interventional Biopsy CT pathway to be delivered at the ROH site. A detailed plan between both Trusts will be discussed and agreed over the next few weeks.

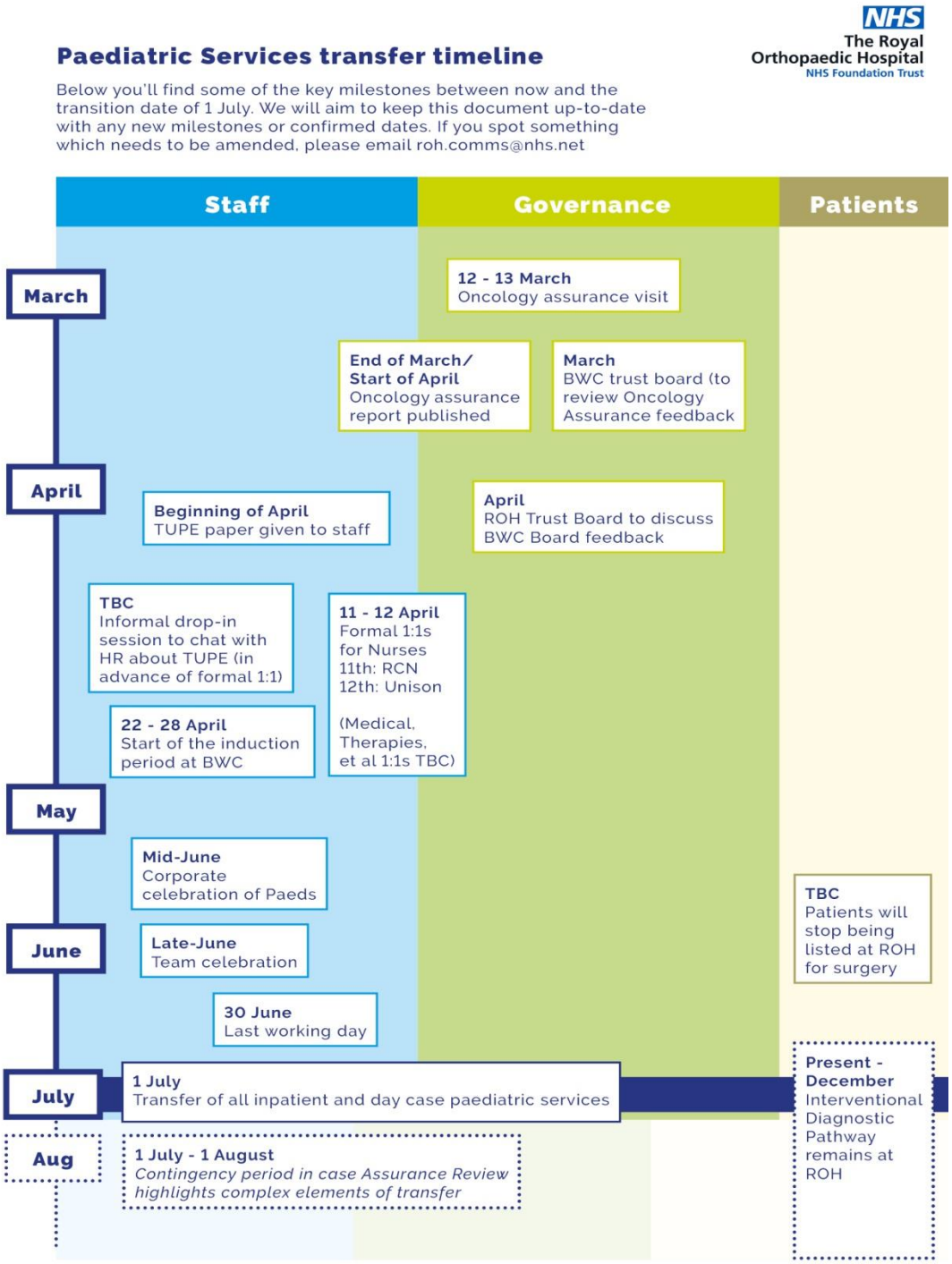
BWC remain on track with their trajectory for theatre staffing recruitment and have been confident to reduce the risk which may delay the transition of the service.

Both nursing teams at ROH and BWC are continuing to deliver safe staffing levels in order to maintain the paediatric inpatient services and there is confidence that this will continue at the ROH site until the 1st July date. All other paediatric support remains in place included the paediatrician support from both BWC and UHB (Heartlands Hospital) and the ongoing Associate Medical Director cover from BWC.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

3. Communications

A paediatric service timeline has been produced to help inform staff and other key stakeholders of the key milestones leading up to the transition date of the 1st July 2019. The timeline includes a contingency plan until August 2019 to allow for any complex element relating to the Oncology pathway. The Interventional Biopsy CT pathway will remain at the ROH with support from BWC.



4 Governance

There continues to be a strong governance structure to oversee the process of transferring the paediatric inpatient & day case surgery service:

The Strategic Oversight Group Meeting co-chaired by Kathryn Sallah (ROH) and Alan Edwards (BWC) and NHS improvement and NHS England to ensure the milestones for the transition are delivered. This will also ensure system wide support and ownership for the transition of the service.

5 Risks

The joint risk register between ROH & BWC has been updated to reflect the main risks associated with this complex service transition. As discussed in the paper there has been a reduction in the previously highlighted risks demonstrating greater assurance for the transition date of the 1st July 2019. These risks continue to be managed & mitigating actions against these risks monitored through the governance structure outlined in section 4.

Authors: Janet Davies Clinical Service Manager / Project Lead for the paediatric transition

29th March 2019

ROHTB (4/19) 006

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

March 2019

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.

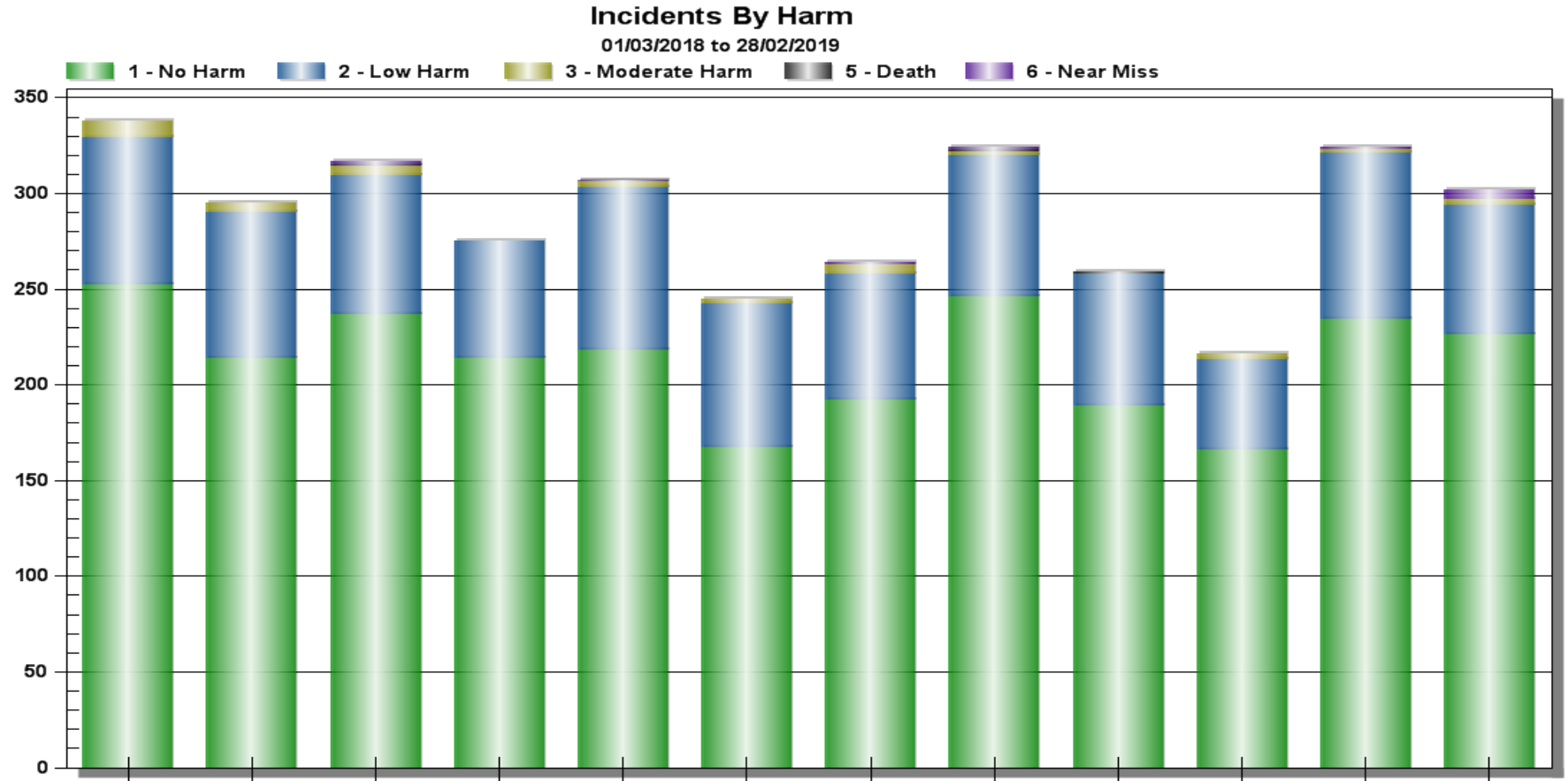
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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.

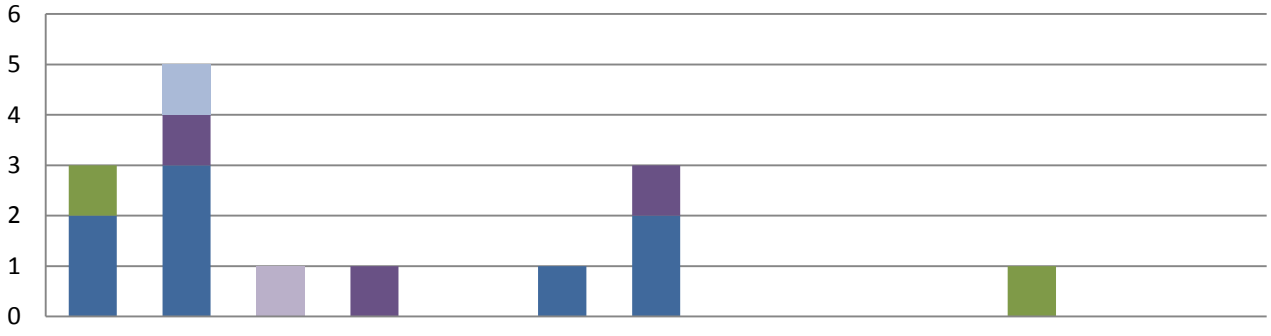


Month and Year	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
1 - No Harm	252	214	237	214	218	167	192	246	189	166	234	226
2 - Low Harm	77	76	72	61	85	75	66	74	69	47	87	68
3 - Moderate Harm	9	5	5	0	3	3	5	2	0	3	2	3
5 - Death	0	0	1	0	0	0	0	1	1	0	0	0
6 - Near Miss	0	0	2	0	1	0	1	1	0	0	1	5

INFORMATION
ACTIONS FOR IMPROVEMENTS / LEARNING
• Implementation of the Health Assure system - Project plan is on the agenda of Quality and Safety in March 2019 • New Incident management policy launched into the Trust via comms and via the Divisional Governance meetings • Ulysses training package developed. • NRLS data not released until March 2019 – Update will be included in the next Quality Report.
RISKS / ISSUES
• Risk 265 - Engagement and adherence with staff around learning from incidents and never events. • Risk 1193 - Staffing and capacity within the team with two vacancies (current risk score 12). 1 agreed start date for the Clinical Governance Facilitator post and 1 offer made to an apprentice to support the team. • Risk 1194 - Lack of skill in the Trust on the Ulysses system (current risk score 12).

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.

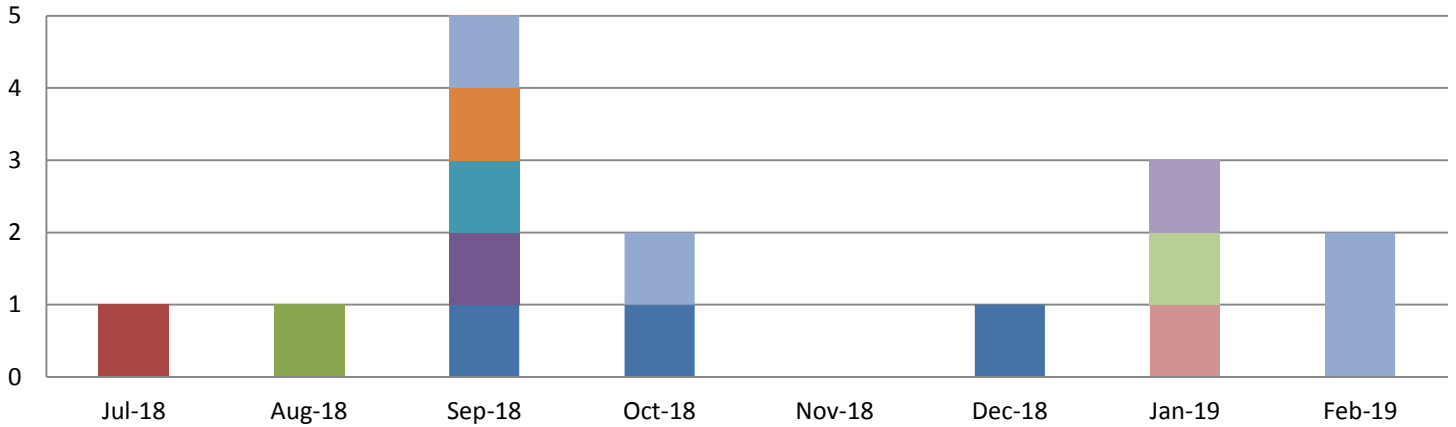
Serious Incidents Declared Year to Date to February 2019



	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Transfer out			1										
Unexpected Injury													
RTT Harm review													
Information Governance Missing Laptop		1											
Retained object													
Wrong side injection													
Slips, trips & falls		1		1			1						
Pressure Ulcers	1										1		
VTE meeting SI criteria	2	3				1	2						

INFORMATION
No Serious Incidents were reported in February 2019.
ACTIONS FOR IMPROVEMENTS / LEARNING
No Serious Incidents were closed in February 2019. The Trust currently has two Serious Incidents awaiting closure with the CCG.
RISKS / ISSUES
None

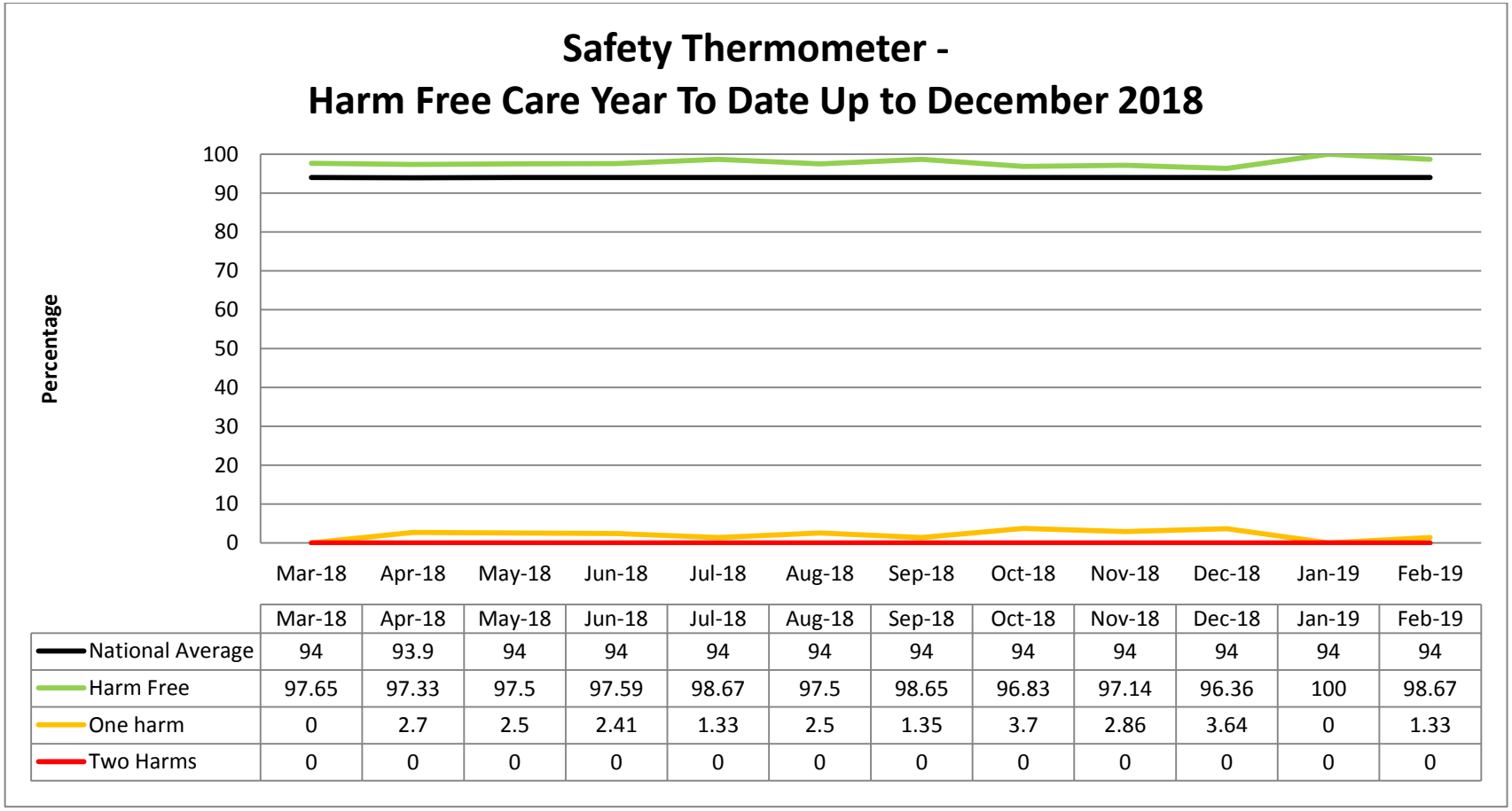
4. Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision that a heightened level of response is needed for these incidents.



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Specimen label error							1	
Medication error							1	
Pressure Ulcer			1				1	
Emergency Transfer			1	1				2
Detoriation in Clinical Condition			1					
Diagnosis Delay			1					
Clinical Assesment/Care			1					
Slips, trips & falls		1						
Dislocation and Medication	1							
VTE meeting SI criteria			1	1		1		

INFORMATION
Two incidents reported in February 2019 will be undertaken as an internal RCA. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.
ACTIONS FOR IMPROVEMENTS / LEARNING
No RCAs were closed in February 2019
RISKS / ISSUES
None

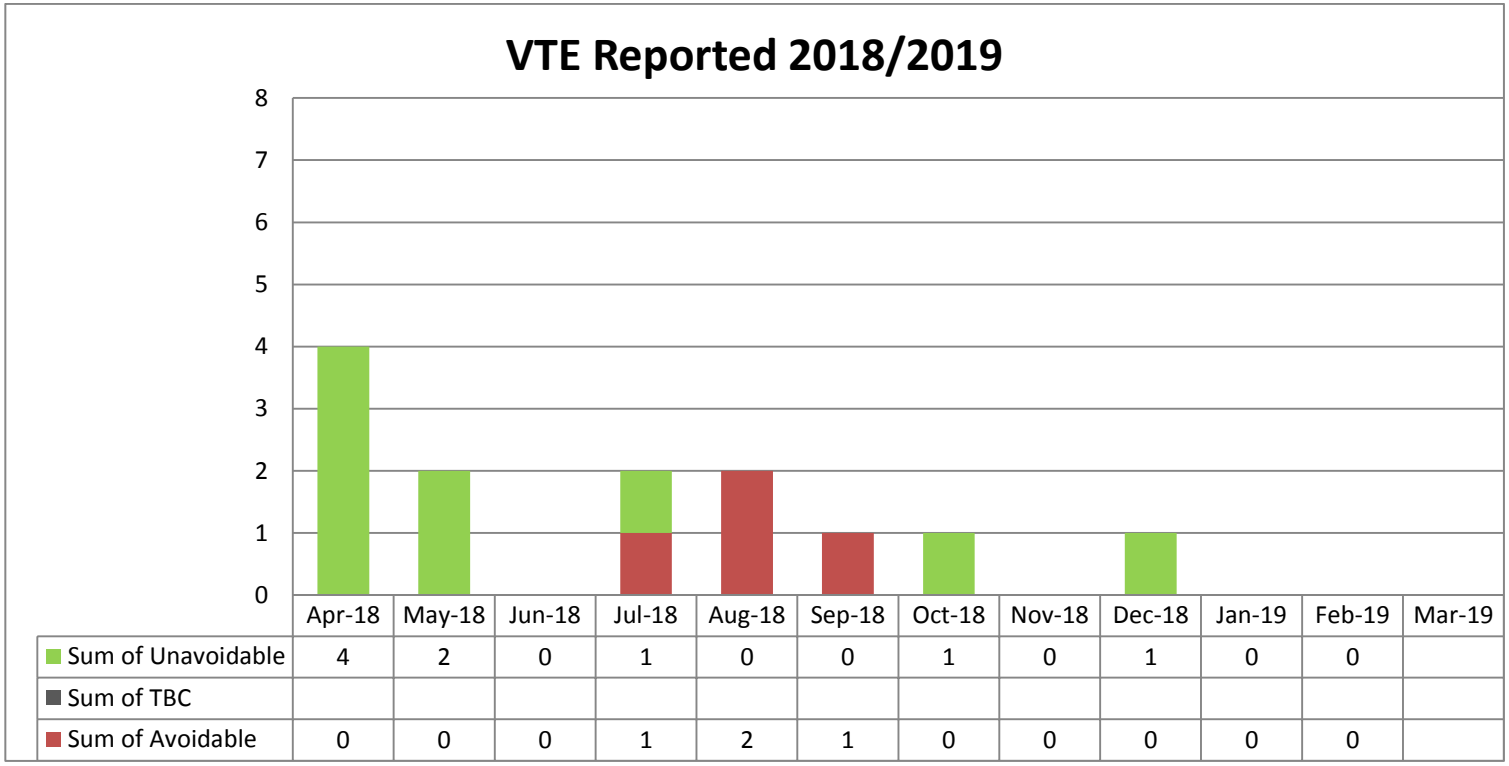
5. **NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
National Average	94	93.9	94	94	94	94	94	94	94	94	94	94
Harm Free	97.65	97.33	97.5	97.59	98.67	97.5	98.65	96.83	97.14	96.36	100	98.67
One harm	0	2.7	2.5	2.41	1.33	2.5	1.35	3.7	2.86	3.64	0	1.33
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

1 new harm = New UTI on Ward 3

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called 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	0	1	0	0	1	0	1	0	0	
Sum of TBC												
Sum of Avoidable	0	0	0	1	2	1	0	0	0	0	0	

total		Avoidable
17/18	33	10
18/19	13	4

INFORMATION

There were no VTE incidents reported in February 2019. This is compared to 2 reported in February 2018. There have been no reported VTE's to date in 2019.

Due to a national shortage of Clexane the Trust changed to Inhixa for VTE pharmacological prophylaxis in January 2019. This change has been uneventful.

From April 2019 the Trust also needs to report data on VTE risk assessment of inpatient's age 16 and 17 years of age. A meeting has been organised with Ward 11 manager to confirm requirements with staff.

ACTIONS FOR IMPROVEMENTS / LEARNING

NICE VTE Prevention Guidance –Updated March 2018
We continue to follow previous NICE VTE prevention guidance, in line with many other Trusts. There is no risk to patients as a result of continuing to follow 2010 guidance until a consensus decision is reached regarding how/if this is adopted.

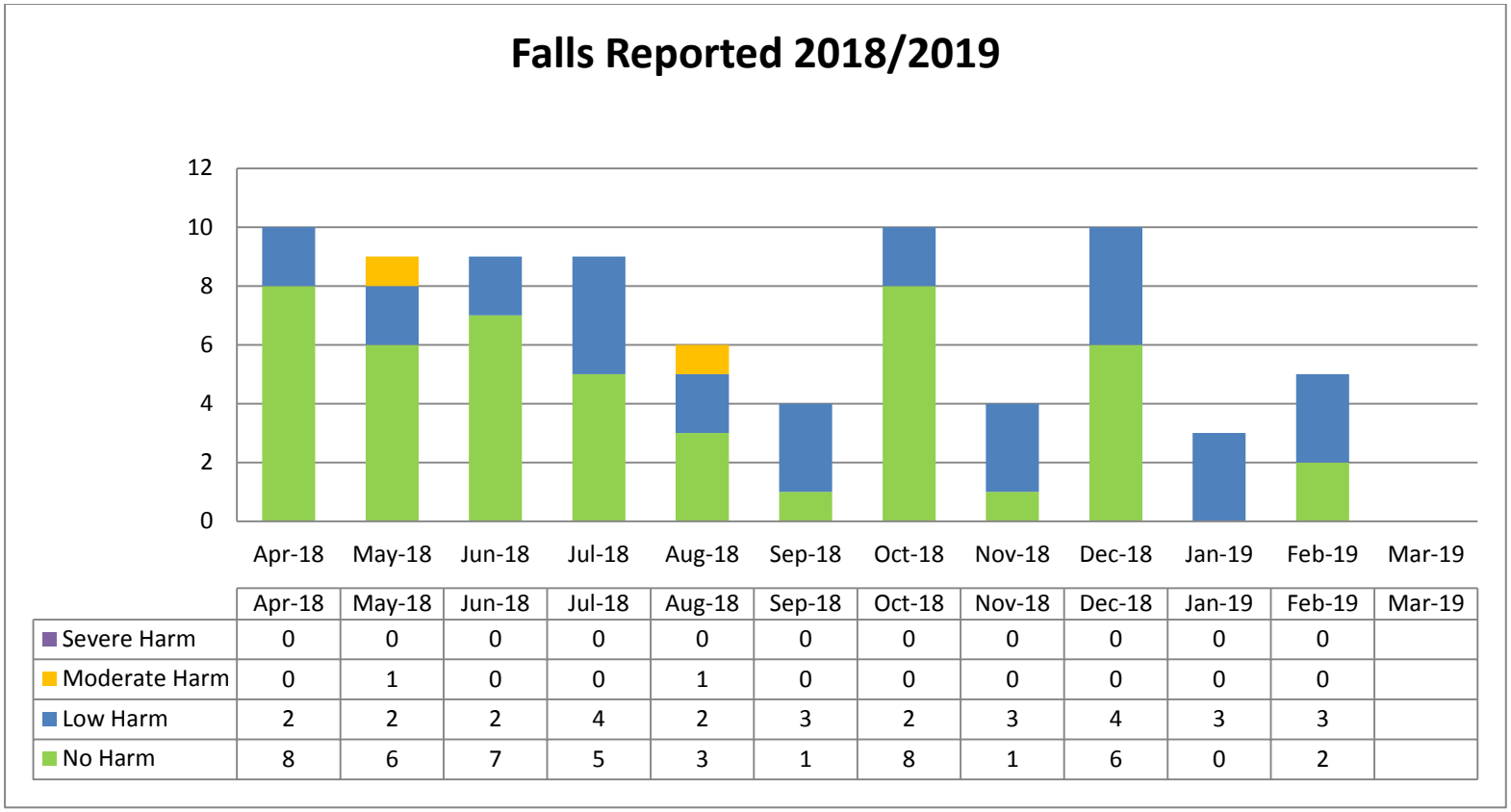
Potential introduction of a Hybrid regime presented by VTE Chair was discussed by VTE Advisory Group. An options appraisal paper is being produced which will outline proposal, risks and benefits.

VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement 95%): February's data is not available at the time of writing but has continued to exceed the minimum requirement. This is being scrutinised by the VTE lead monthly as now this is a mandatory field within PICS we should achieve 100% compliance. Issue identified with day case patients as mandatory field only triggered when medicines prescribed. This has been fed back to theatre teams as confirmation that VTE assessment has been completed and signed as reviewed is a WHO sign in question. This has been escalated at Clinical Quality Group.

RISKS / ISSUES

24 hours re-assessment compliance is now available via IMT reporting. This has been requested monthly and will be scrutinised by the VTE Lead until compliance is 100%, as this is a mandatory field. February=86.96%. This is a reduction from January =89.5%. Those staff who acknowledged the re-assessment required message but didn't action have been identified. The VTE lead is working closely with the PICS team to address this. This data will be shared with the Medical Director and Associate Medical Directors once scrutinised. This is on the risk register.

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-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	0	0	0	0	0	
Moderate Harm	0	1	0	0	1	0	0	0	0	0	0	
Low Harm	2	2	2	4	2	3	2	3	4	3	3	
No Harm	8	6	7	5	3	1	8	1	6	0	2	

total	
17/18	125
18/19	79

INFORMATION

There were 5 patient fall-related incidents reported across the Trust in February 2019. All but 1 incident involved adult patients. All incidents have been subject to a post-fall notes review by the ward manager or deputy and no significant harm found. Incident number 26823 is awaiting a review of the notes by the ward manager. There was 1 fall related incident involving a member of staff.

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

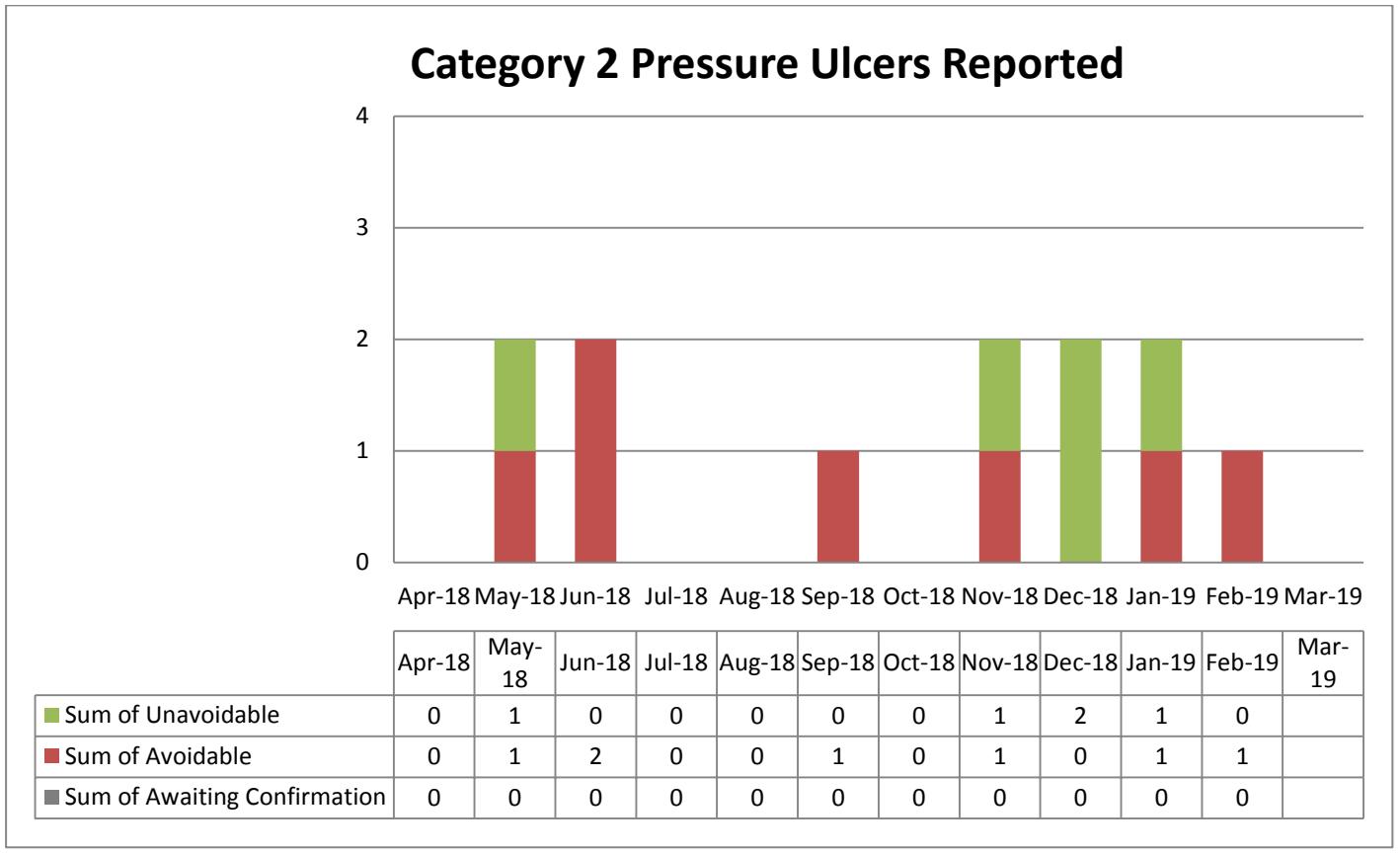
- Purchase of another Hover Jack, to be considered this year- plan to submit a capital bid – no change.
- Trust wide replacement of hoists delayed as funding is not in place. Request submitted to capital bid program for this year – no change, still awaiting outcome of funding
- Review of the benchmarking exercise of the WMQRS – looking at development of fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall.
- On-going development of Throne project.

Positive Assurance

- Staff training on the use of manual handling equipment such as Sara steady.
- Clinical skills update day reinstated to be delivered annually.
- Template for Medical review post fall
- Benchmarking of the WMQRS
- Development of combining falls and dementia working groups to facilitate joined up working – first meeting 27/3/19

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 financial year. When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Bid submitted to replace hoists Trust wide.

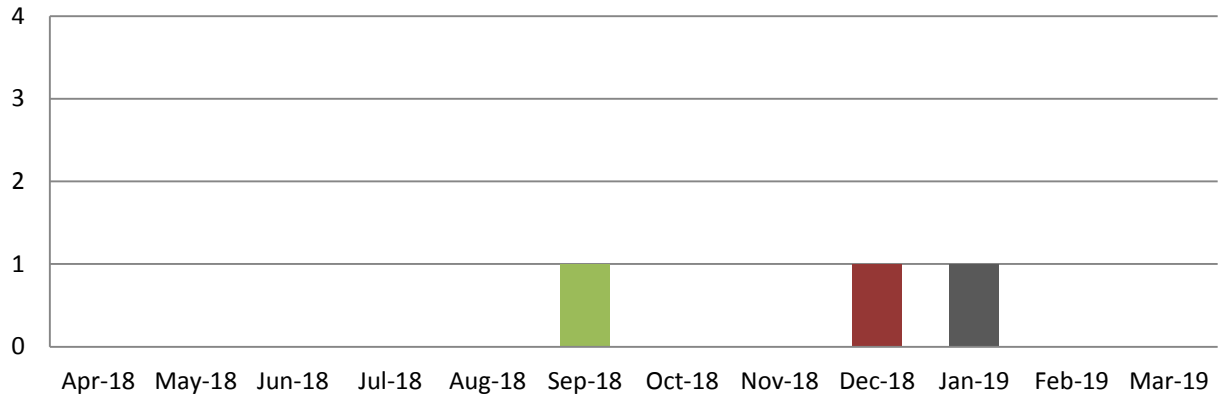
8. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open 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	0	1	2	1	0	
Sum of Avoidable	0	1	2	0	0	1	0	1	0	1	1	
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	

total	Avoidable
17/18	6
18/19	7

Category 3 and 4 Pressure Ulcers Reported



	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	0	0	0	0	1	0	
Unavoidable G4	0	0	0	0	0	0	0	0	0	0	0	
Unavoidable G3	0	0	0	0	0	1	0	0	0	0	0	
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	
Grade 3 (Avoidable)	0	0	0	0	0	0	0	0	1	0	0	

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	1
	G4	0

INFORMATION

In February 2019, there was one Category 2 ROH pressure ulcer recorded.

February 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	0
Category – 2 (Device)	1 x Category 2 – AES – Avoidable (Ward 3)
Category – 1	1 x Category 1 – did not develop further
Suspected Deep Tissue Injury	1
ROH Moisture Associated Skin Damage (MASD)	1
Patients admitted with PU's	Category 3 – Sandwell Category 2 – MDRPU (child) – own home PU's x2 – own homes – both have DN's

Avoidable Pressure Ulcer CCG Contracts KPI

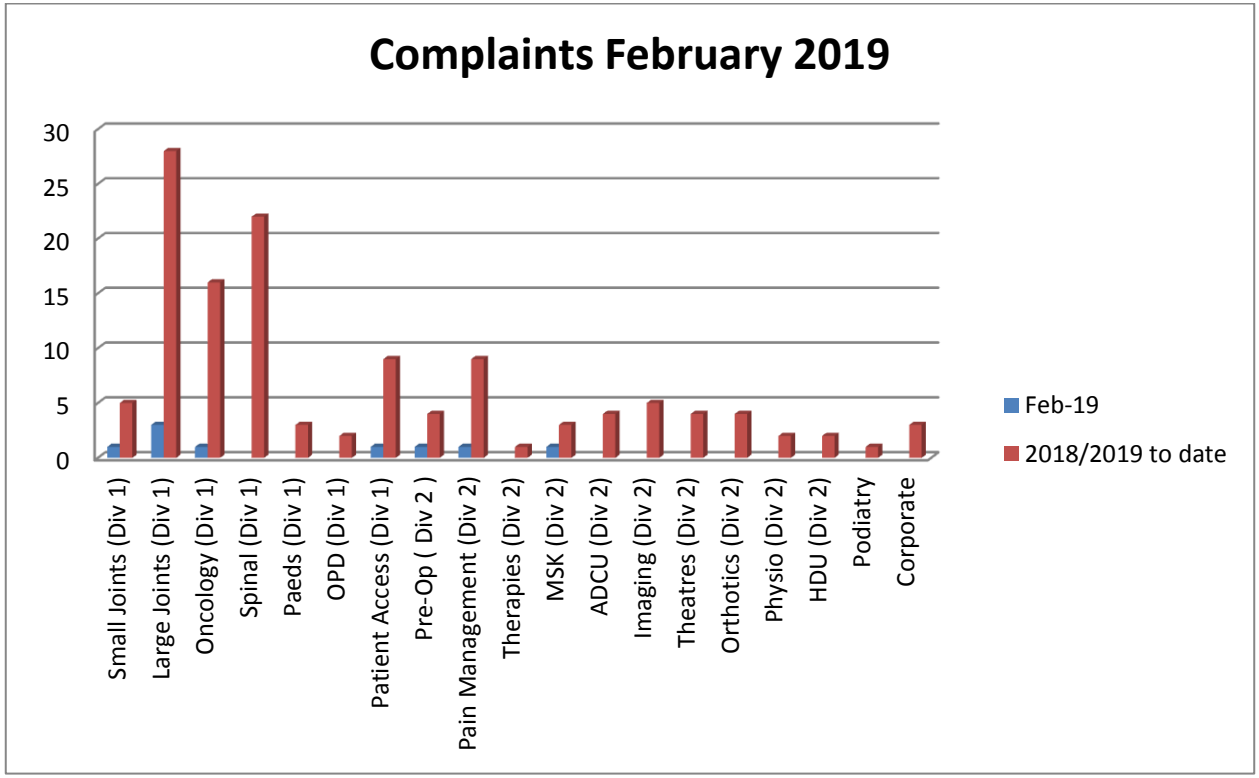
2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	1
Avoidable Grade 4 pressure Ulcers limit of 0	0

2017/2018:

2017/2018	
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 • Plaster of Paris (POP) care plan has been reviewed and has been sent out for comments this has been amended to enable clearer and concise documentation • The POP SOP is currently under review and extra training will be available for all staff during theatre shutdown week • Nursing documentation relating to care of patients wearing AES' has been reviewed and sent out for comments • NHSI PU Categorisation poster has been made available and will be incorporated into the PU Guidelines – once completed these will be available for distribution and comment shortly
RISKS / ISSUES
None

9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



INFORMATION

PALS

The PALS department handled 71 contacts during February 2019 of which 45 classified as concerns. This is a significant reduction in calls compared to the same time last year (337 contacts in February 2018) and a reduction in the level of concerns (54 concerns in February 2018). The main themes in the PALS data relate to queries about appointments; either length of wait for or cancellations. 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. 88% of enquires and 82% of concerns were handled within the agreed timescales, meeting this internal KPI.

PALS concerns by theme	Feb-19
Access to treatment	2
Admission & Discharge	1
Appointments	22
Clinical	8
Trust Administration	6
Values & Behaviours	5
Waiting times	1

Compliments

There were 756 compliments recorded in February 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments February 2018
Div. 1	535
Div. 2	219
Corporate	2

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 receive a request monthly to submit their compliments for central logging.

Complaints

There were 9 formal complaints made in February 2019, bringing the total number of complaint to 127 for the year to date. All were initially risk rated amber or yellow. This is less than last year (13 complaints in February 2018)

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Outcome of surgery (Div.1, Oncology)
- Post-operative care and treatment (Div.1, Large Joints)

Initially Risk Rated Yellow:

- Wait in OPD (Div.1, Patient Access)
- Wait for treatment (Div.1, Large Joints)
- Misdiagnosis of symptoms (Div.1, Large Joints)
- Incorrect clinic letter (Div.2, MSK)
- Approach of Consultant; waiting time for results (Div.1, Small Joints)
- Treatment under Pain Management (Div.2, Pain Management)
- Unnecessary cancellation of op (Div.2, Pre-op)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 6 complaints closed in February 2019, all 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 2019 was 25 days, which is within normal limits.

Learning identified and actions taken as a result of complaints closed in February 2019 include:

- Waiting times for Pain Management are longer than acceptable
  Action: Measures are being taken to reduce waiting list (additional clinics, redirecting patient to more local clinics, not accepting out of area)

- Patients requiring additional support are not always being identified by GP on referral
  Action: GP has been contacted for individual case. Minimum data sets for referral is a wider discussion being undertaken

- Communication regarding waits for spinal surgery are not always clear
  Action: Apology offered and review of communication undertaken

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

0 comebacks received in February 2019.

10. 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 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 agreed internal targets for all areas and as a result, the data is 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 requested 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 recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In February 2019, 10 concerns were identified from the 1602 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 main areas of concern in February 2019 related to Values & Behaviour of Staff and Communication. Information is 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 of 20% for Outpatient services was met this month. 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 Feb 2019**	**% of people who would NOT recommend the department in Feb 2019**	**Number of Reviews submitted in Feb 2019 (previous month in brackets)**	**Number of Individuals who used the Department in Feb 2019**	**Department Completion Rate (Mandated at 35%)**
Ward 1	96.5%	1.8%	57 (60)	134	42.5%
Ward 2	100.0%	0.0%	78 (64)	159	49.1%
Ward 3	100.0%	0.0%	36 (35)	69	52.2%
Ward 12	97.8%	0.0%	45(32)	85	52.9%
Ward 11 (CYP)	92.0%	0.0%	25(17)	67	37.3%
ADCU	96.4%	0.0%	138(159)	576	24.0%
HDU	95.5%	1.4%	25(20)	69	31.9%
CYP HDU	100.0%	0.0%	1 (2)	11	9.4%
Overall Trust Inpatient Response Rate for February 2019					39.3%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Feb 2019**	**% of people who would NOT recommend the department in Feb 2019**	**Number of Reviews submitted in Feb 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	96.5%	0.8%	1162 (1141)	24.5%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Feb 2019**	**% of people who would NOT recommend the department in Feb 2019**	**Number of Reviews submitted in Feb 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	97.4%	0%	38(22)	22.1%

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 February - 28 February

Your average score for all questions this period

★ 1 ★ 2 ★ 3 ★ 4 ★ 5 **4.88**

Reviews this period

1602

Your recommend scores

5 Star Score

4.83

% Likely to recommend

95.4%

% Unlikely to recommend

0.9%

11. Duty of Candour – *The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.*

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. Litigation

New Claims

3 new claims against the Trust were received in February 2019 the detail of which has been discussed by the Quality & Safety Committee

On-going claims

There are currently 33 on-going claims against the Trust.

32 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 February 2019.

*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 Inquests

There were no Inquests held in February 2019

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; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases =775 The total WHO compliance for Theatres I February 2019 **= 100%** **CT area** Total cases = 109 The total WHO compliance for CT in February 2019 **= 100%** **ADCU** The snapshot WHO audit compliance for ADCU in February 2019 = **100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
WHO checklist for ADCU 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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in February 2019 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	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

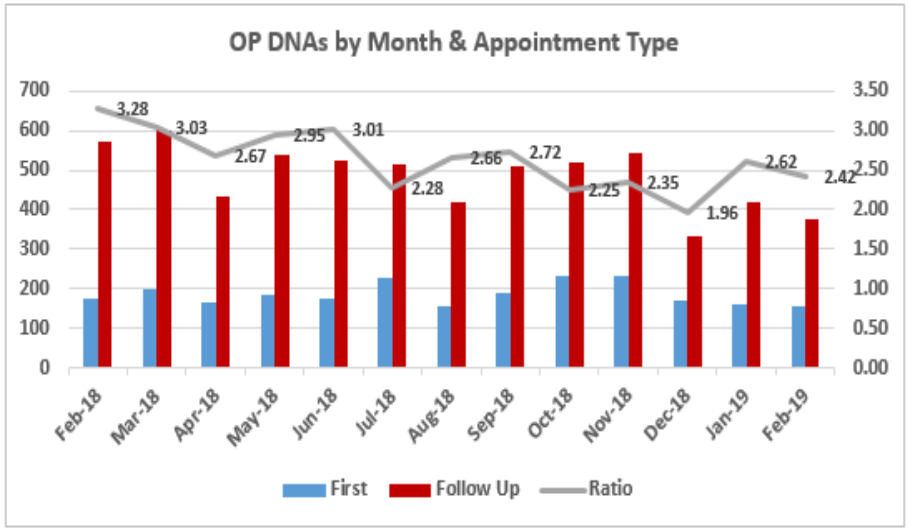
ACTIONS FOR IMPROVEMENTS / LEARNING

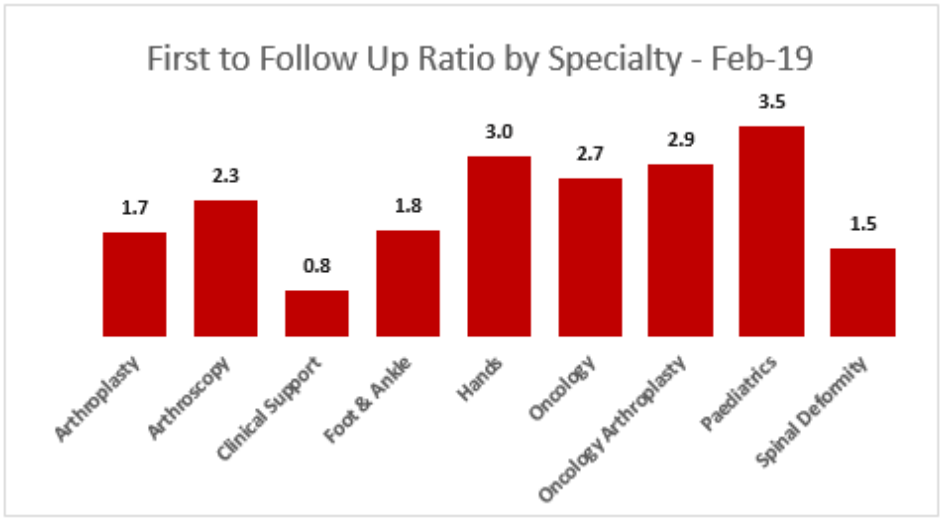
10 IP recorded incidents in February, 2019 (8 no harm, 2 low harm – all either under review or closed).

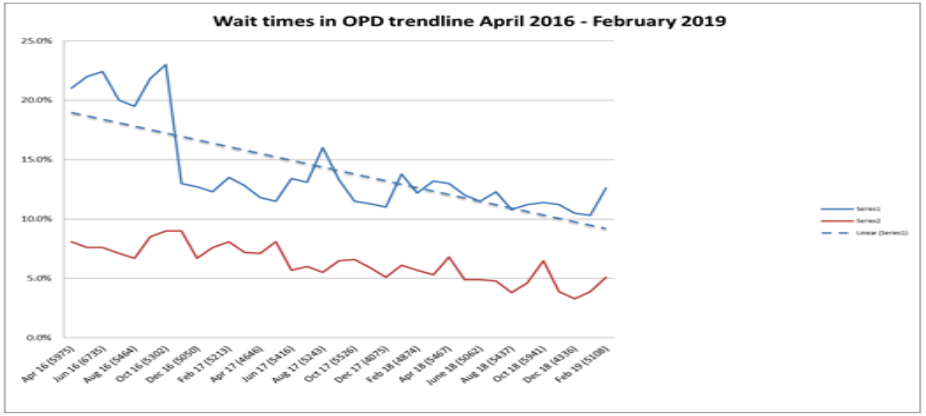
RISKS / ISSUES

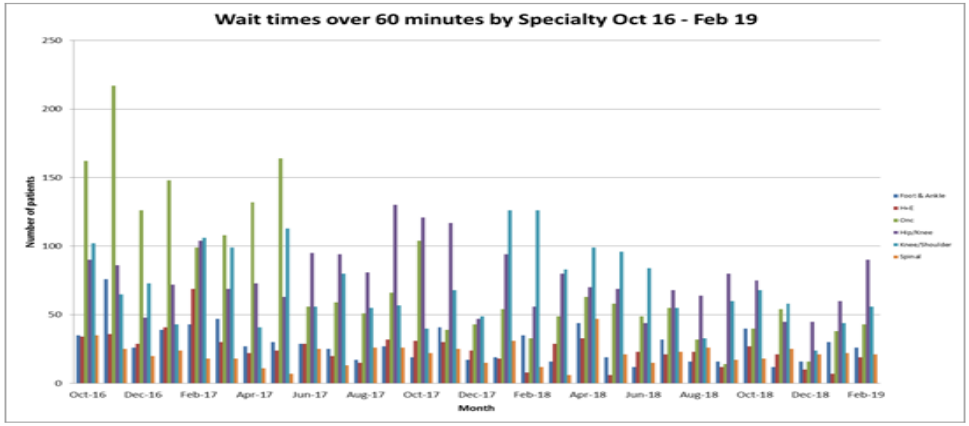
ROH is presently reviewing the status of staff requiring Hepatitis B vaccinations.

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



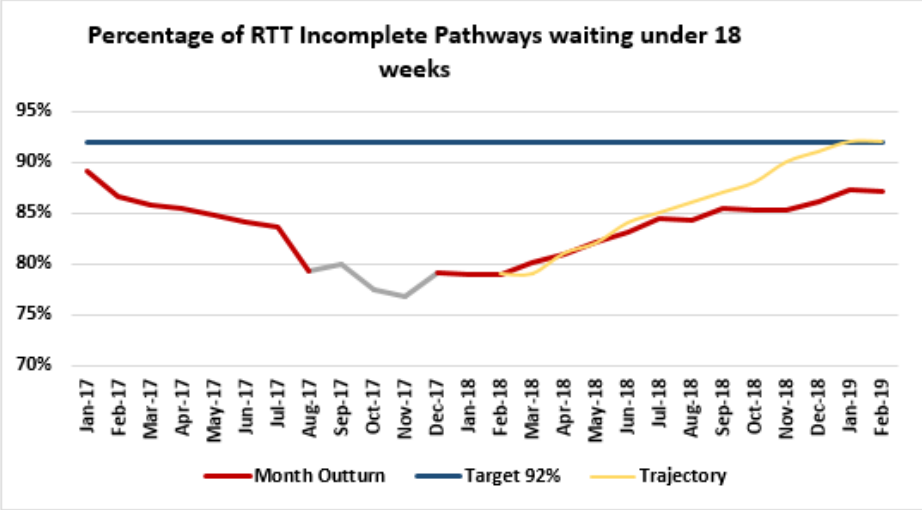


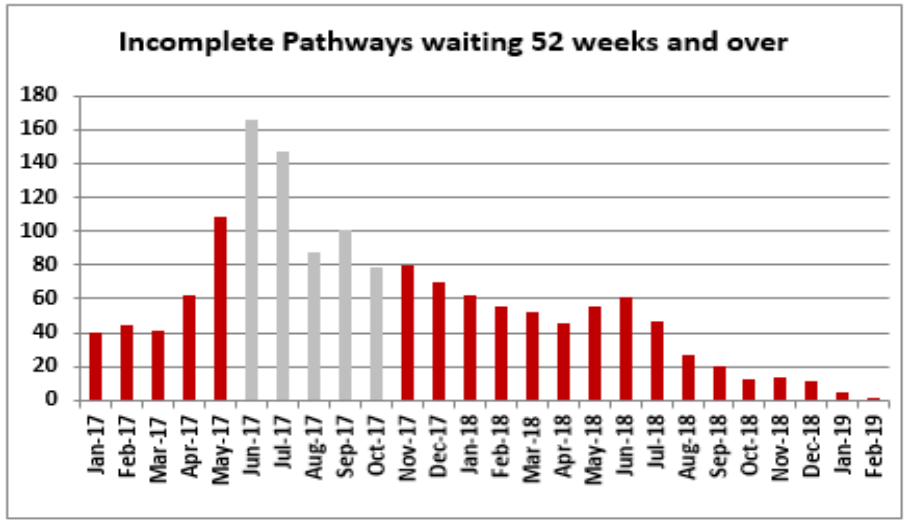




INFORMATION
In February there were 12.6% of patients waiting over 30 minutes which is an increase on last month. The target for 30 minute delays has still not been achieved. Focussed work is ongoing to continue to improve this position and 5.1% of patients were waiting over 1 hour which was just above the target of 5%. There is now a 6-4-3 meeting held every Wednesday, which produces room allocation timetables 4 – 6 weeks ahead. The master room allocation template has been sent to the operational management team to review and amend if necessary to ensure this is correct and will begin to allow analysis of room (or session) utilisation and ensure staffing is appropriate to support the reduction in delays for patients attending clinic. Radiology are now joining this meeting to review communication between clinics and Radiology and optimise patient flow. There were 16 incidents of clinic delays reported in February 2019 with the following breakdown. -6 clinics overbooked -4 complex patients -2 consultant / clinician delay -2 x-ray delays -2 other The Matron for outpatients will continue to reiterate the importance of reporting all incidents relating to clinic delays and the operational management team will analyse reasons for delays in order to improve practice . The New senior nurse for outpatients is now in post. There are now 2 notice boards in outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation . A number of initiatives are being developed to improve the OP experience for patients and staff. Full details of these projects will be discussed at the OP away day now planned for April 30th 2019. This day will agree the priorities and support a range of service improvement initiatives in line with recent NHSI recommendations.
ACTIONS FOR IMPROVEMENTS / LEARNING
Utilise the outreach clinics at Lordswood & possibly at West Heath
The process for partial booking will continue to be monitored as to the impact this may have on requiring additional staff in the appointments team. This may need a business case review with in the next 6 months.

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



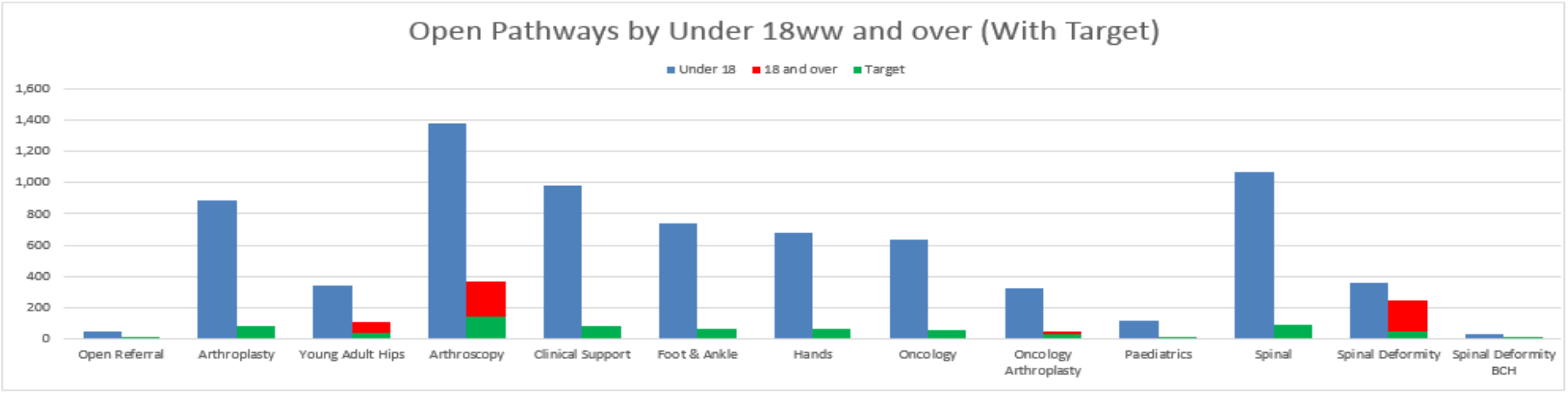


		Indicative	Reported Month										Reported Quarter 2017/18			
Target Name	National Standard	Feb	Jan-19	Dec-18	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	98%	100%	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	100%	90.9%	93.8%	100%	100%	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	n/a	n/a	n/a	n/a	n/a
62 day (traditional)	85%	100%	90%	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	87%	75.0%	94.70%	90.5%	88.9%	77.8%	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	n/a	n/a	n/a	n/a	n/a
No. patients treated 104+ days			1	2	1		1			1						

17. Referral to Treatment snapshot as at 28th February 2019 (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	**4,077**	31	486	173	734	520	383	369	371	182	60	588	168	12
7-13	**2,426**	12	267	118	432	369	262	214	173	87	40	344	101	7
14-17	**1,073**	1	137	51	211	94	96	92	87	53	18	138	86	9
18-26	**859**	1	65	66	262	46	58	54	25	35	9	74	159	5
27-39	**277**	0	6	39	99	10	4	2	10	13	2	9	76	7
40-47	**16**	0	0	3	2	0	0	0	1	0	0	0	10	0
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
Total	**8,731**	45	961	450	1,740	1,039	803	731	667	370	129	1,153	603	40

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	**7,576**	44	890	342	1,377	983	741	675	631	322	118	1,070	355	28
18 and over	**1,155**	1	71	108	363	56	62	56	36	48	11	83	248	12
Target	**698**	**4**	**77**	**36**	**139**	**83**	**64**	**58**	**53**	**30**	**10**	**92**	**48**	**3**
	86.77%	**97.78%**	**92.61%**	**76.00%**	**79.14%**	**94.61%**	**92.28%**	**92.34%**	**94.60%**	**87.03%**	**91.47%**	**92.80%**	**58.87%**	**70.00%**



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	**990**	1	182	65	188	85	59	114	83	47	18	114	24	10
7-13	**749**	0	140	46	174	72	44	83	31	41	11	79	22	6
14-17	**379**	0	77	17	86	29	14	48	17	26	7	34	16	8
18-26	**399**	0	54	36	146	8	15	29	13	23	6	31	36	2
27-39	**149**	0	6	24	62	5	1	2	7	6	1	6	22	7
40-47	**14**	0	0	3	2	0	0	0	1	0	0	0	8	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
Total	**2,681**	1	459	191	658	199	133	276	152	143	43	264	129	33

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	**2,118**	1	399	128	448	186	117	245	131	114	36	227	62	24
18 and over	**563**	0	60	63	210	13	16	31	21	29	7	37	67	9
Target	**214**	**0**	**37**	**15**	**53**	**16**	**11**	**22**	**12**	**11**	**3**	**21**	**10**	**3**
	79.00%	**100.00%**	**86.93%**	**67.02%**	**68.09%**	**93.47%**	**87.97%**	**88.77%**	**86.18%**	**79.72%**	**83.72%**	**85.98%**	**48.06%**	**72.73%**

Select Pathway Type: Non-Admit

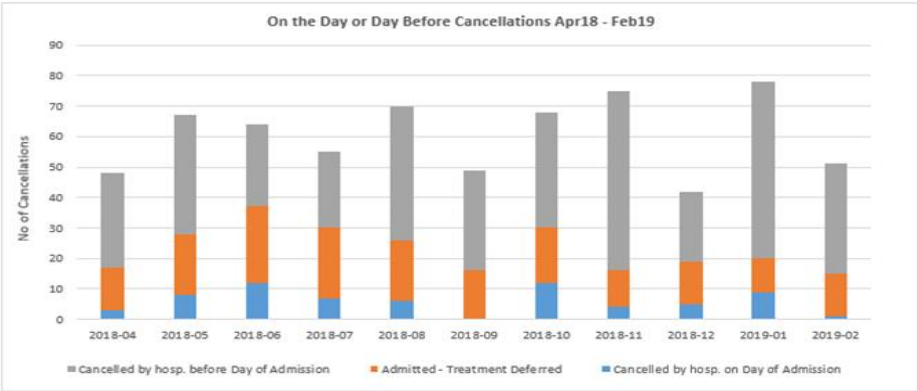
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**3,087**	30	304	108	546	435	324	255	288	135	42	474	144	2
7-13	**1,677**	12	127	72	258	297	218	131	142	46	29	265	79	1
14-17	**694**	1	60	34	125	65	82	44	70	27	11	104	70	1
18-26	**460**	1	11	30	116	38	43	25	12	12	3	43	123	3
27-39	**128**	0	0	15	37	5	3	0	3	7	1	3	54	0
40-47	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
Total	**6,050**	44	502	259	1,082	840	670	455	515	227	86	889	474	7

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	**5,458**	43	491	214	929	797	624	430	500	208	82	843	293	4
18 and over	**592**	1	11	45	153	43	46	25	15	19	4	46	181	3
Target	**484**	**4**	**40**	**21**	**87**	**67**	**54**	**36**	**41**	**18**	**7**	**71**	**38**	**1**
	90.21%	**97.73%**	**97.81%**	**82.63%**	**85.86%**	**94.88%**	**93.13%**	**94.51%**	**97.09%**	**91.63%**	**95.35%**	**94.83%**	**61.81%**	**57.14%**

INFORMATION
The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and predicts that the Trust will return to 92% at an aggregated level by October 2019. February 2019 performance is **86.77%** It is expected that Oncology Arthroplasty will achieve 92% in March 2019 with Young Adult Hip in June 19 and Arthroscopy in July 19. A refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been completed and we anticipate that they will achieve the standard in Qtr. 4 19/20 . Excluding Spinal Deformity the Trust now has 6 patients waiting over 40 weeks all with treatment plans. In February 2019 the Trust had **2** patients waiting over 52weeks the trajectory was 9. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. Detailed below is our progress against the trajectory. This has been resubmitted at the beginning of March 2019 to NHSI/E as the Trust can now confirm that it will have cleared all patients (2) over 52weeks by the end of March 2019.
ACTIONS FOR IMPROVEMENTS / LEARNING
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019
RISKS / ISSUES
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. 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 remains a concern.

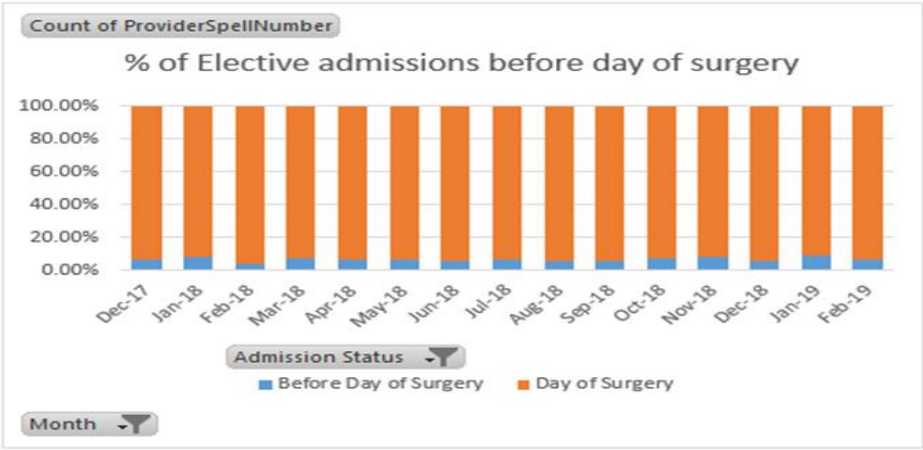
18. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

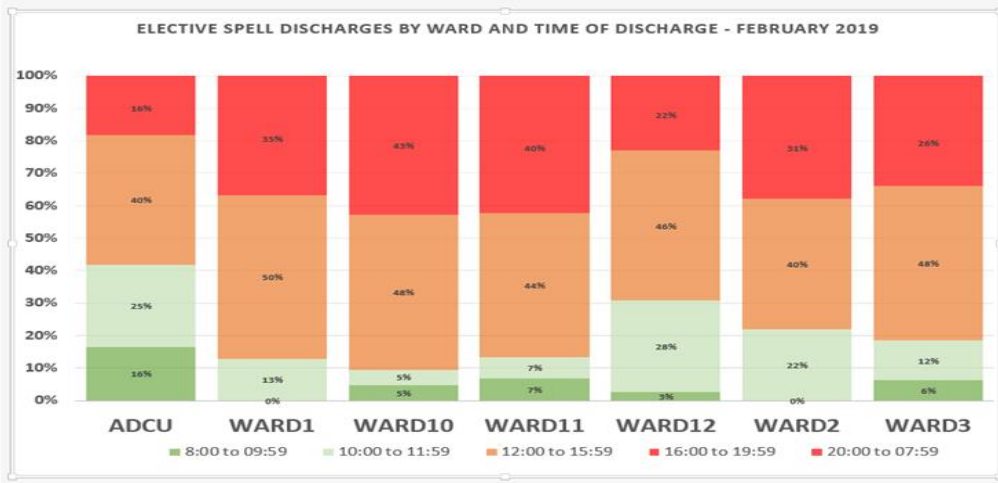
Hospital Cancellations



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
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	44	70	0
2018-09		16	33	49	1
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	1	14	36	51	0
Grand Total	67	187	413	667	1

Admission the day before surgery





INFORMATION

The number of cancellations on the day of admission for surgery in February was 1 patient , a decrease from January and one of the lowest in the past 12 month period. Patients admitted for surgery where treatment was deferred has increased slightly in month from 11 to 14. Analysis of patients admitted where treatment was deferred relate to, surgeon illness and lack of theatre time.

Cancellations before the day of surgery have also decreased in month from 58 to 36. An analysis of the 36 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 patients declaring fitness issues on the 72 hour contact call .

A robust process is now in place to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. This meeting will now include a financial breakdown of average loss of income from April 2019 relating to cancellations on the day The 72 hour call process has now been strengthened and an extended hours contact service is being developed so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in March 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre team will take place from April 2019. This will change the profile of triage to be delivered in the pre-operative clinic area, so that access to on the day triage can be expanded. This change in practice will be supported by a full communication strategy

ACTIONS FOR IMPROVEMENTS / LEARNING

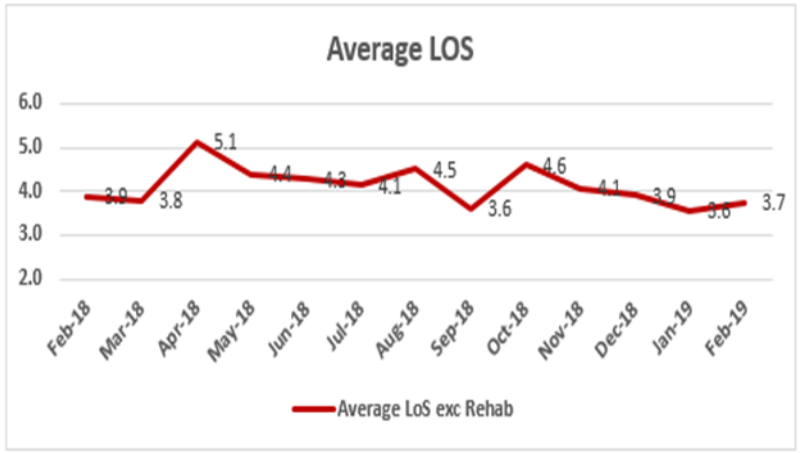
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

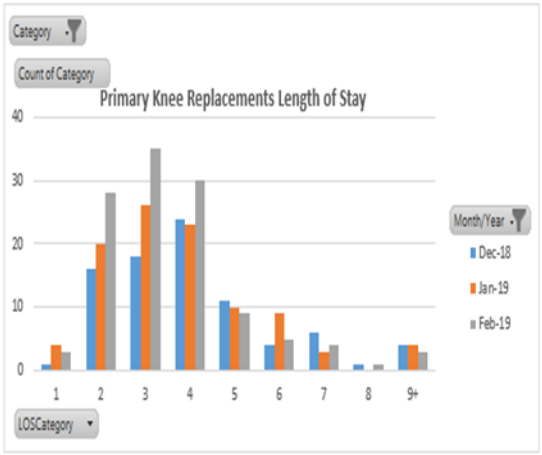
- POAC representative now attends daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Improved links with Clinical team to support any clinical concerns raised during patient contact

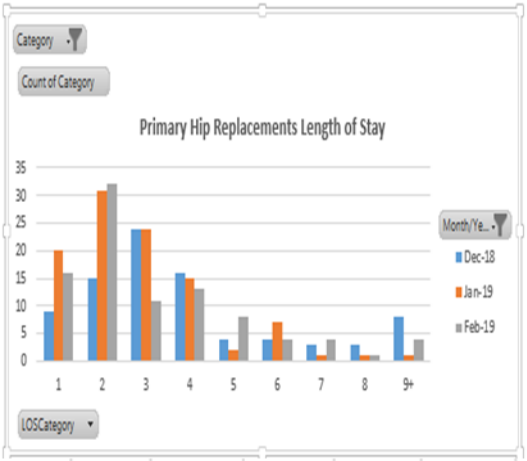
RISKS / ISSUES

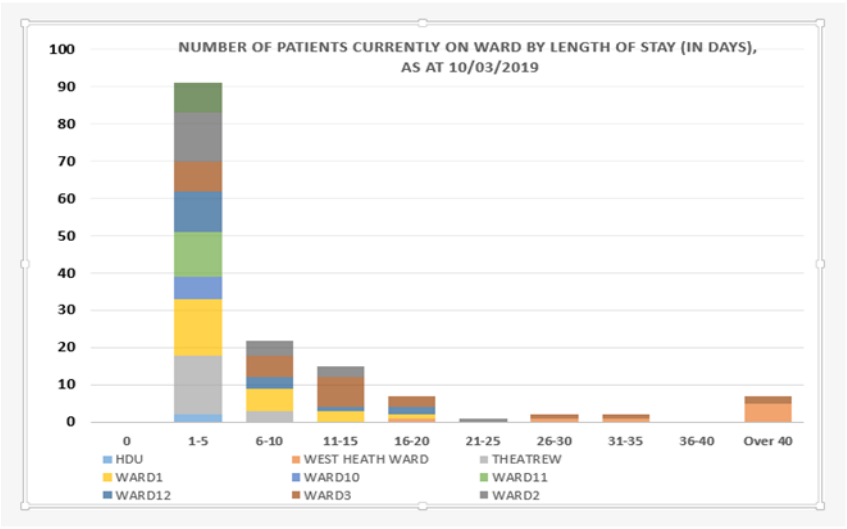
Existing ageing equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools have been purchased and full delivery of all items is expected by the end of March 2019. The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

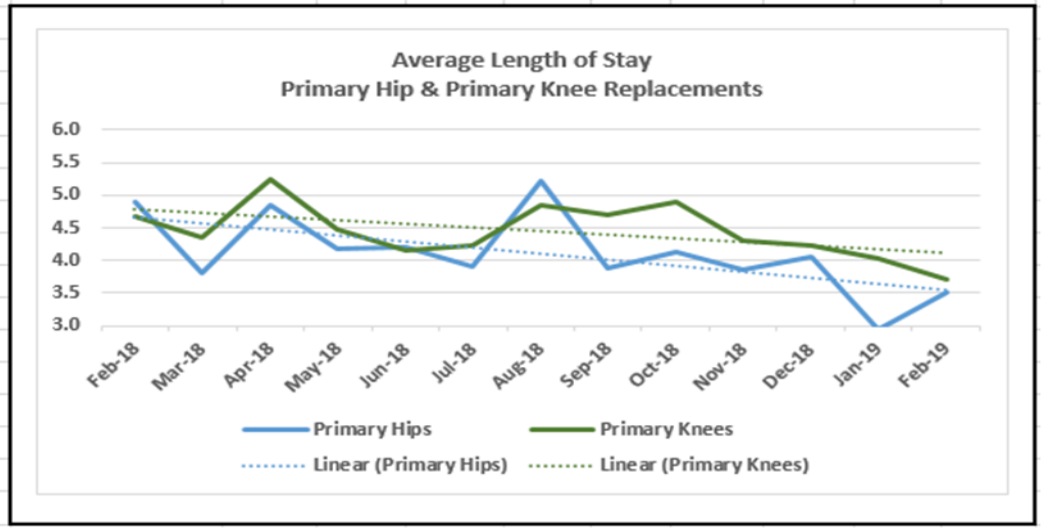
19. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in February was 3.7 days and a number of initiatives are in place to continue to drive down length of stay including:

- Jointcare continues to reduce length of stay for Hips & Knees and helps drive a reduction in LOS. A significant amount of patients are being discharged earlier (Day 2) with the support of the therapy classes and early mobilisation
- Production of a Jointcare performance dashboard to monitor a range of KPI's supporting reducing length of stay and a range of metrics is being developed – moving from quarterly to monthly data submission
- 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 lounge staff to ensure timely discharge . The Senior Sisters across all inpatient wards are now implementing a 12: 30hrs review with all members of the MDT. The rationale for this is to strengthen the Red2Green initiative across all wards.
- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is developing local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- The discharge lounge is well utilised by all adult inpatient wards.

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 on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Options being explored include a 'floating ward clerk role ' out of hours to ensure timely recording of all ADTS .

RISKS / ISSUES
A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity . Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Finance and Performance extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3 April 2019**

EXECUTIVE SUMMARY:

The Board Assurance Framework includes 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 attached provides an overview of the finance and performance risks which the relevant Executive Director leads will present to the Board and discuss the current and planned mitigations.
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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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • 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		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:					
Trust Board on 6 March 2019.					

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
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	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	FPC reports; Board approval for cash borrowing; Finance & Performance overview	3	4	12	↔	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	2	3	6
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 trajectory to deliver 92% performance is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for January is 84.86 % with only 10 patients (Excluding spinal deformity)over 40 weeks , however plans are in place to meet trust forecasted position for delivery of 92% in February 2019 for Arthroplasty , Spinal, Paediatrics , Foot and ankle , Hands and CSS . A revised trajectory has been developed for the delivery of 92% in all specialties. Additional capacity is planned for the YAH service commencing in February 2019 with a refreshed demand and capacity plan for spinal deformity incorporating the impact of any delay in transition of Paediatric inpatient services . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway.	Ongoing	3	4	12
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	In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All patients monitored at weekly PTL - plans in place for all patients over 40 weeks Full RCA and harm review for all patients over 52 weeks presented monthly at harm review board. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.	Weekly updates to Exec Team; updates to Trust Board.	2	4	8	↓	March 2019 - As at the end of March the Trust has zero patient waiting over 52weeks	Ongoing	2	4	8

27	Operations	Steve Washbourne	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. Junior Fellow posts have been re advertised with a revised 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 . The draft Job Description for the alternative medical workforce has been agreed . A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator commenced in December 2018 and is now focusing on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is now being monitored by the CSMS and reported to a monthly meeting to monitor spend, chaired by the deputy COO.	Ongoing	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	↔	Risk remains unchanged with Trust waiting for planning permission decision regarding theatre expansion.	Ongoing	1	5	5
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	2	3	6	↓	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 .All project are managed via Perfecting Pathway framework and all project current on trace. Feb 19 - Good progress has been made with all the projects and a monthly tracking system is in place and reporting through F&P Committee	Q4 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 support 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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 continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. 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 function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	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	↔	An information analyst has been recruited and is due to start at the trust early 2019 . The recruitment of the Business Intelligence Systems Manager had been delayed due to budget issues, but the post will now go to advert early 2019.	Q4 2018/19	2	4	8

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	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	Feb-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 has received transitional funding during 2018/19 to support the additional costs of paediatric provision.	Q4 2018/19	1	4	4
1298	Finance & Performance	Steve Washbourne	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:		Safe, efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	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. 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.	IM&T programme board papers	4	4	16	↔	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. 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	2	4	8

FP4	Finance & Performance	Steve Washbourne	There is a risk that the full quantum of cost saving as outlined in the 2018/19 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Whilst full delivery of the CIP schemes will not happen, this has been taken into account within the financial planning for the remainder of the year.	Finance and Performance overview; CIP programme board papers	4	4	16	↔	Much work has been undertaken in creating the CIP framework for 2019/20. The financial plan for 19/20 identifies a target of £1.4m, which is the level required as per the planning guidance. This is backed up by an internal plan which targets delivery of £2.3m with a further stretch target of circa £3m. The initial £1.4m is within the level of saving achieved during 2018/19, whilst further discussion are ongoing relating to how we potentially use incentive schemes to increase delivery up to the internal target of £2.3m and beyond.	Mar-19	3	4	12
FP5	Finance & Performance	Steve Washbourne	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.	Perfecting Pathways update; Finance & Performance overview	4	4	16	↔	Planning application due to be considered by Birmingham City Council in February 2019.	Oct-19	3	4	12
FP6	Finance & Performance	Steve Washbourne	There is a risk that the Financial Control Total will not be met in 2018/19		Safe and efficient processes that are patient-centred	Finance & Performance Committee	3	4	12	The 2018/19 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery. Clinical Audit day has been cancelled in February to allow more work to be undertaken. Revised activity plan distributed which identities performance levels required for recovery.	Finance and Performance overview	3	3	9	↔	Further focus in March to deliver increased activity.	Oct-19	3	3	9

ROHTB (4/19) 008

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 26 March 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was an overall shortfall against the financial plan, which needed to be recouped before the year end in order to meet the Control Total. • Expenditure was higher than planned, this being driven by high levels of agency staffing, mainly in nursing. • Delivery of the cost improvement programme continued to be behind plan, but c. £1.7m of savings was expected to be achieved by the year end. • The Committee reviewed the financial assumptions and workings behind the financial and operation plan for 2019/20. The Trust Board would be asked to sign up to the Control Total of £5.3m for the year, however at present there remained some uncertainties in terms of funding which needed to be worked through before the Board could take a view. • There was reported to be some risk associated with the processes to sign off the contract for the modular theatre scheme, with negotiations currently ongoing. • The trust was continuing with its preparations in the event of a 'no deal' Brexit, including conducting a resilience exercise to identify and weaknesses that needed to be addressed.	• Work to be undertaken to determine the effect on costs of rising activity levels (operational gearing) • An update on the plans for a 'no deal' Brexit to be shared with the Trust Board • Circulate the revised version of the operational plan to the Committee prior to the Board for review
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was reported to be a slight improvement against the planned in month deficit position. • There had been a successful open day to recruit theatre staff – the outcome would reduce the number of vacancies in theatres by over a half • There were plans to improve the pre-operative assessment centre processes which would reduce cancellations and improve patient experience	• None specifically.

• There had been only one hospital-instigated cancellation on the day of surgery, this being a significant reduction on previous performance. • A number of new initiatives were planned to improve the efficiency of the Outpatients processes; progress would be reported as part of the 'Perfecting Pathways' update in future • The number of patients waiting for treatment over 52 weeks had reduced to zero – this was noted to be a huge achievement by all involved. • Overall, progress with 'Perfecting Pathways' was good.	

Chair's comments on the effectiveness of the meeting: It was noted that the Committee had expected to have reviewed the final version of the finance and operational plan, yet a final version was not yet prepared. This would need to be seen prior to Trust Board review on 3 April 2019.

Finance and Performance Report

February 2019

CONTENTS

INTRODUCTION

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

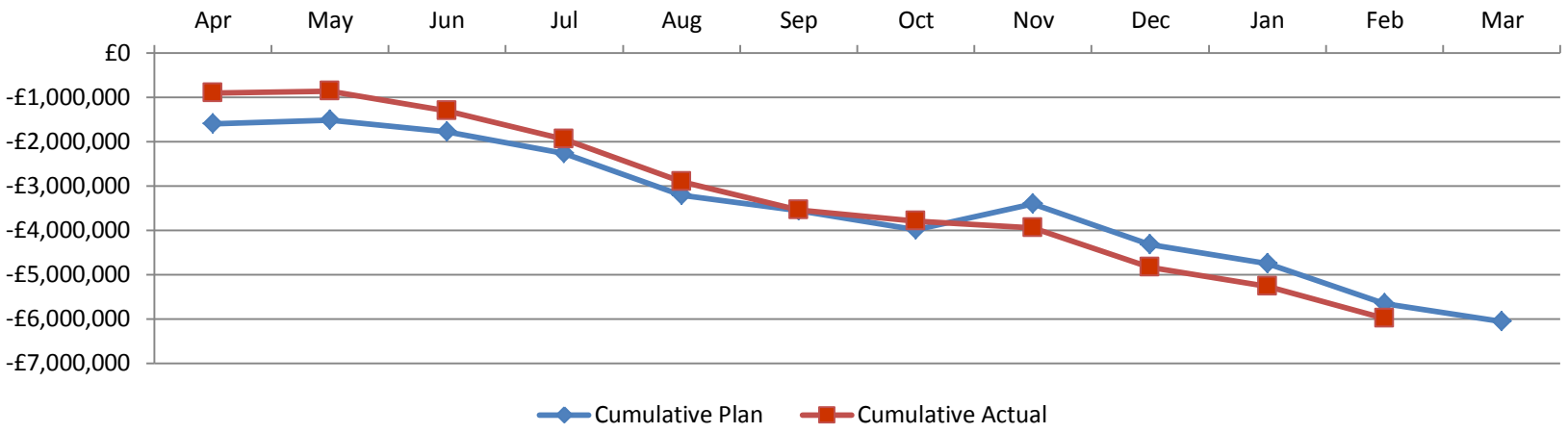
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

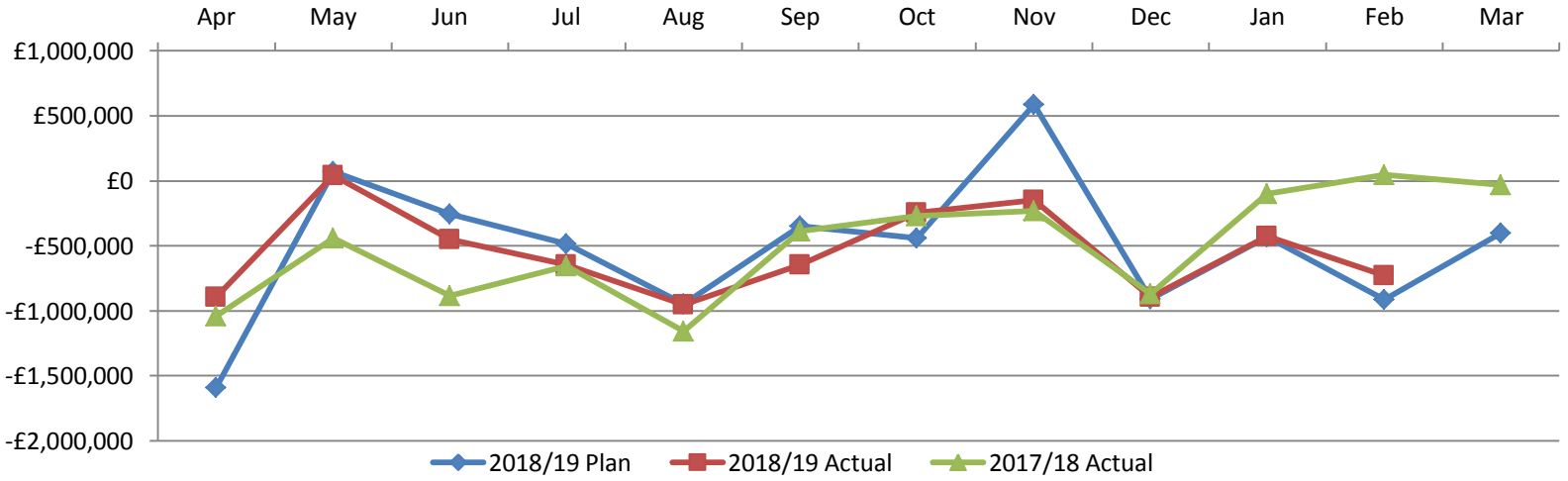
	YTD M11 Original Plan £'000	YTD M11 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	72,137	72,964	827
Other Operating Income	4,691	4,881	190
Total Income	**76,828**	**77,845**	**1,017**
Employee Expenses (inc. Agency)	(47,261)	(48,509)	(1,248)
Other operating expenses	(33,940)	(34,143)	(203)
Operating deficit	**(4,373)**	**(4,807)**	**(434)**
Net Finance Costs	(1,287)	(1,189)	**98**
Net deficit	**(5,660)**	**(5,996)**	**(336)**
Remove donated asset I&E impact	55	(133)	(188)
Adjusted financial performance (inc PSF)	**(5,605)**	**(6,129)**	**(524)**

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 £731k in February against a planned deficit of £913k, £182k favourable against plan. Year to date the Trust now has a deficit of £5,996k against a planned deficit of £5,660k; £336k adverse against plan which represents an improvement from Month 10. However this includes a favourable adjustment of £188k which relates to the I&E impact of a capital donation which needs to be removed to asses performance against the control total. This gives a revised variance of £524k, which reduces to £196k behind plan excluding the impact of PSF. This is the value that the Trust needs to recover in March to achieve the Trust's agreed control total.

Whilst this remains behind plan cumulatively, actual performance still represents a continued improvement in the last 3 months compared to previous months in the financial year. Planning for March is prudent, therefore continued focus on activity delivery and cost control over the final month should still result in achievement of the control total.

CIP realisation remains challenging. £1,539k has now been delivered against a plan of £2,566k, (£1,027k) under-performance YTD (M1 – M11) and it is unlikely that the Trust will deliver its CIP plan for 18-19. The forecasted CIP position for 18-19 is £1,716k against a £2,985k plan. (£1,268k forecasted under-performance against plan)

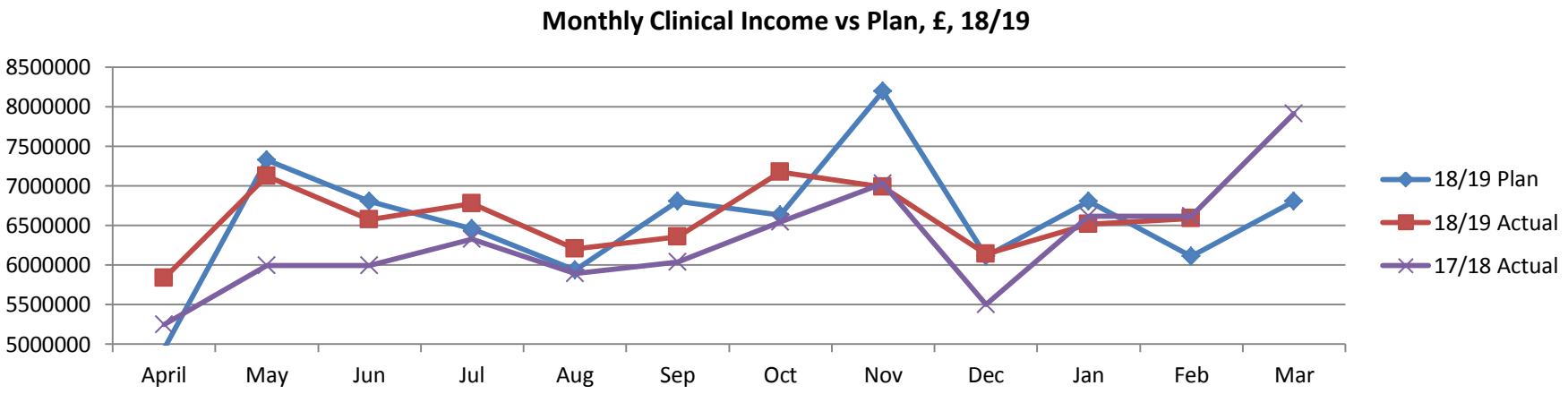
The Trust has a 19/20 CIP target of 1.1% in tariff plus further 0.5% for access to NHS Financial Recovery Funding for 19/20. This is a c. £1,419k target, not accounting for additions to this target based on the funding of 18/19 FYE and 19/20 cost-pressures. The teams are currently working on the identification and delivery of next-year schemes and have currently identified opportunities (£1,553k) exceeding the £1,419k plan. In order to ensure the 19-20 CIP plan is delivered, the Trust is changing its approach to CIP planning and delivery. There will be a number of Executive led cost improvement programmes, with operational , nursing and clinician led projects within each programme. Each project will have a number of key stakeholders, and each project team will work to deliver a project plan prior to 19-20, these plans will be amalgamated to deliver a CIP programme, that will be ultimately signed off and steered by the Executive responsible officer. The Trust is working to identify a stretch target and stretch opportunities for 19-20 to mitigate any slippage or under-performance against identified schemes, in order to prevent a repeat of the under-performance in 18-19; and as part of 19-20 CIP planning, is already identifying detailed CIP opportunities for 20-21.

ACTIONS FOR IMPROVEMENTS / LEARNING

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. Planning permission has recently been granted and the tenders for the enabling works have been received and opened. A further update will be presented at March Board.

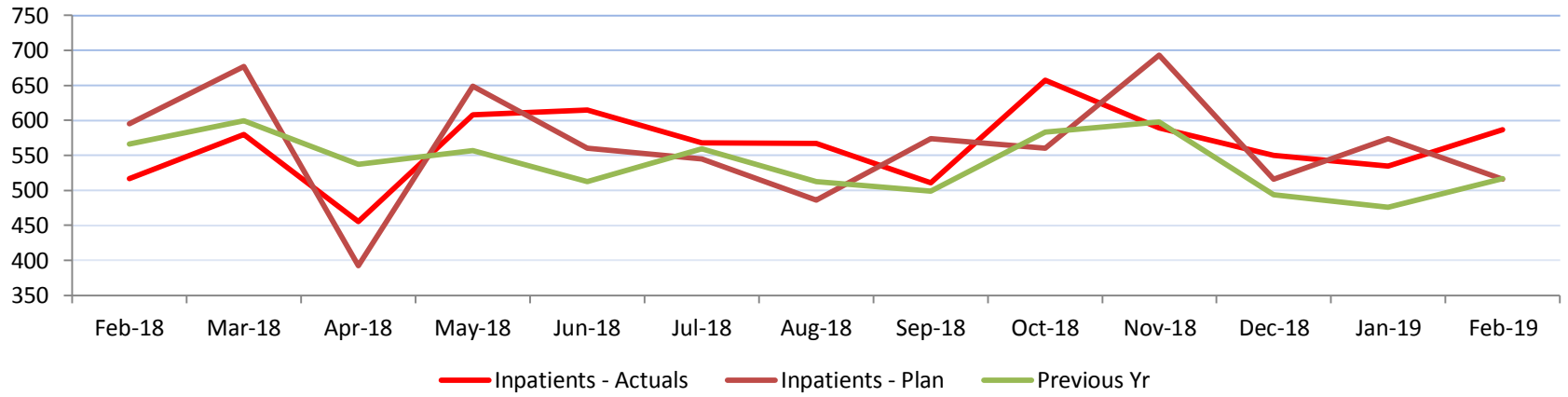
2. Income and Activity– This illustrates the total income generated by the Trust in 2018/19, including the split of income by category, in addition to the month's activity



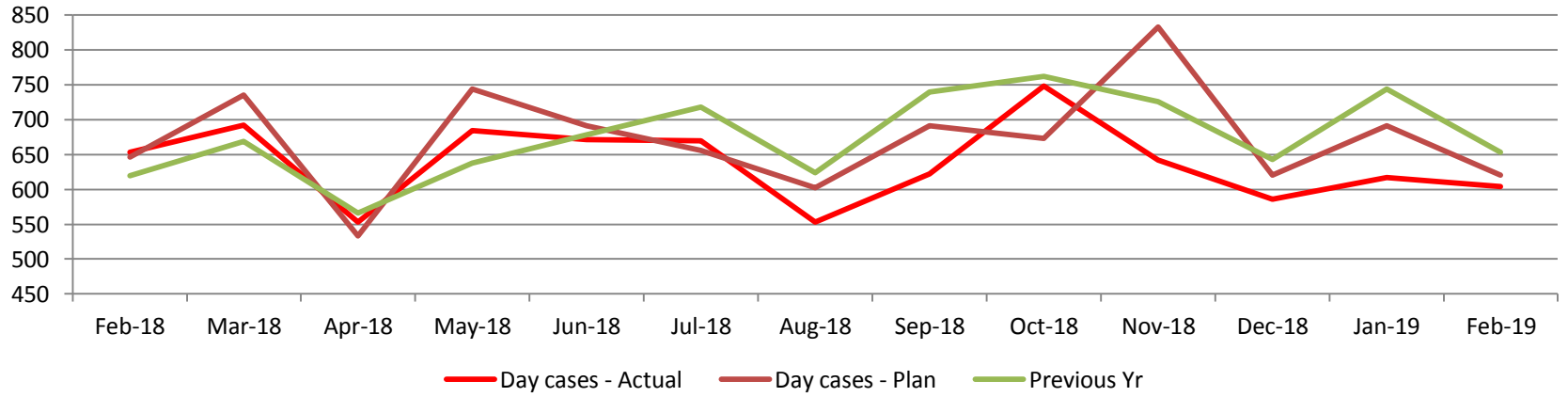
Clinical Income – February 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,228	3,283	55
Excess Bed Days	37	34	-3
Total Inpatients	3,265	3,317	52
Day Cases	768	758	-10
Outpatients	598	697	99
Critical Care	211	186	-25
Therapies	207	243	36
Pass-through income	194	291	97
Other variable income	382	539	157
Block income	484	559	75
TOTAL	6,109	6,590	481

Clinical Income – Year To Date 2018/19 £'000			
	Plan	Actual	Variance
Inpatients	38,104	35,951	-2,153
Excess Bed Days	442	717	275
Total Inpatients	38,546	36,668	-1,878
Day Cases	9069	9119	50
Outpatients	7060	7517	457
Critical Care	2486	2029	-457
Therapies	2439	2689	250
Pass-through income	2292	2569	277
Other variable income	4527	5675	1,148
Block income	5712	6142	430
TOTAL	72,131	72,408	277

Inpatient Activity



Day Case Activity



Clinical income was significantly higher against plan for February (circa 8% Favourable).
This represents an improved Elective and Non Elective activity against plan during the month (516 plan v 587 actual), however Day case Activity was slightly below plan (620 Plan v 604 actual).
Overall Inpatient activity remains behind plan by 227, with EL and NEL ahead by 177 while Day Case is behind plan by 404.

Outpatients activity and income continue to perform strongly and remain ahead of plan.

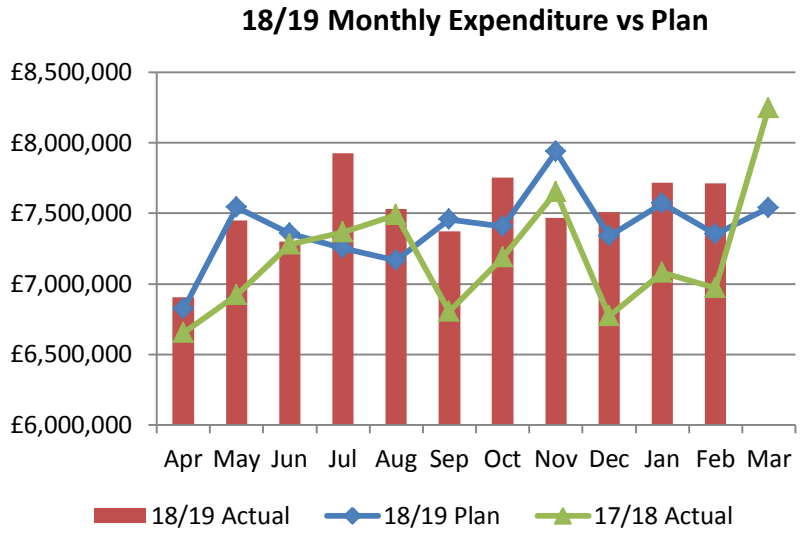
ACTIONS FOR IMPROVEMENT/LEARNING

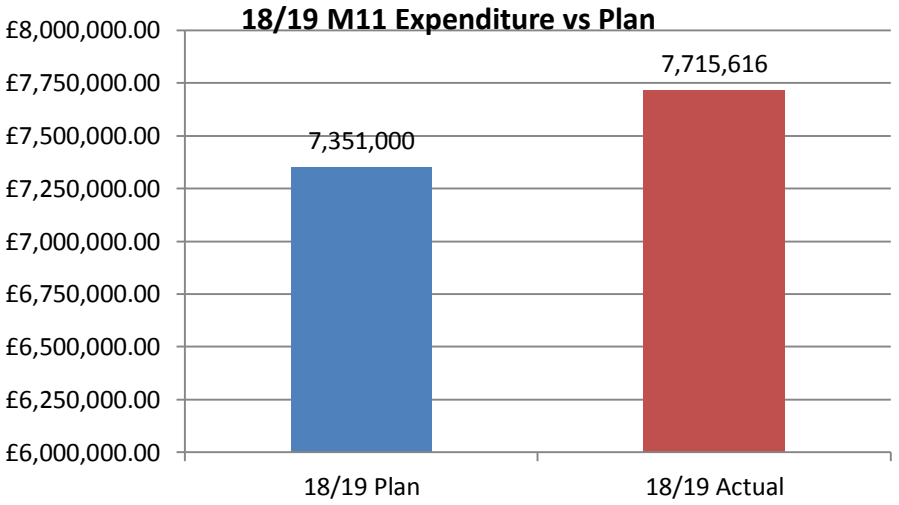
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

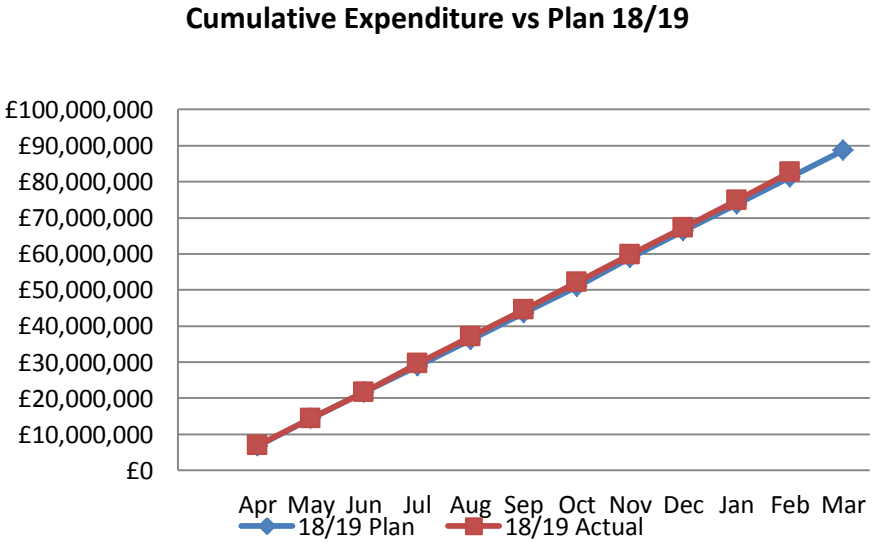
RISKS / ISSUES

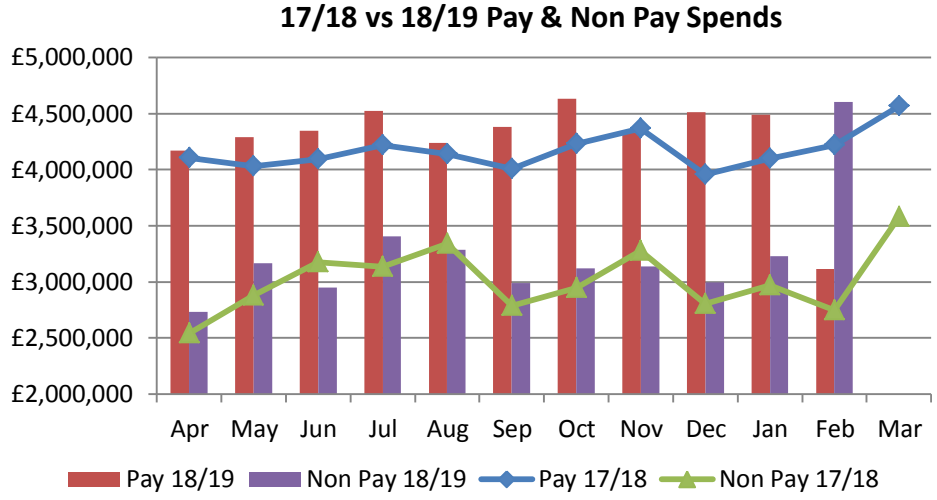
Given that the overall position at M11 is now behind plan, PSF has been removed for as a prudent measure. (circa £328k to M11 in total). This can still be claimed at the year end if the control total is achieved.

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









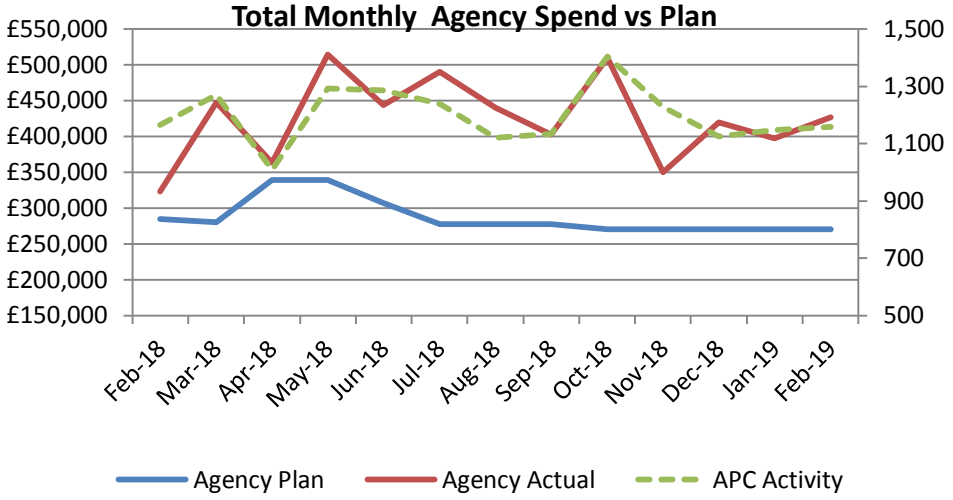
INFORMATION

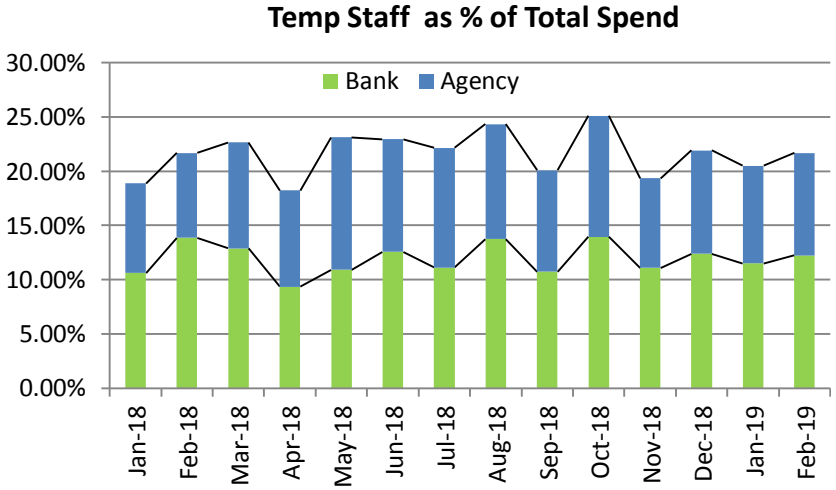
February expenditure was £7,716k, which was higher than a planned spend of £7,351k. This reflects the increase in activity performed in month.

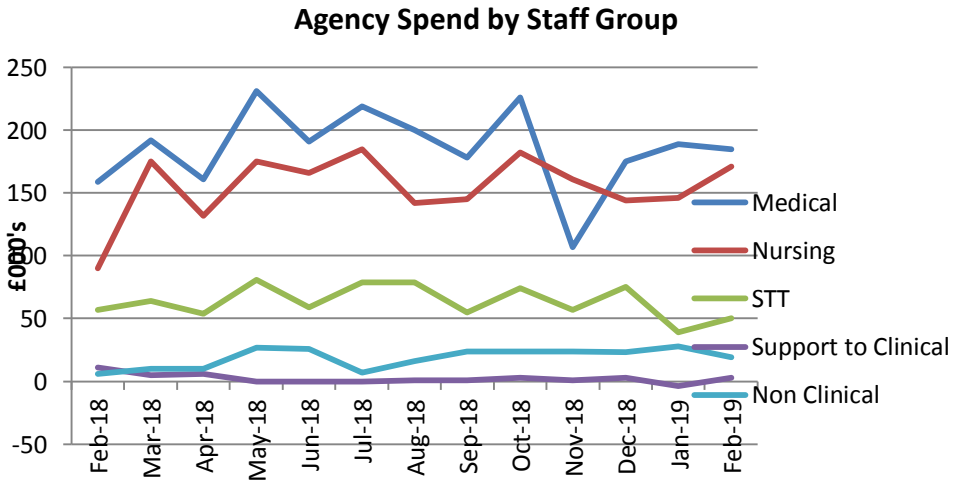
Pay was higher than plan (£191k) at £4.6m. Pressure remains on temporary staffing (medical staffing and nursing) which was an increased in mth of £29k to £426k overall.

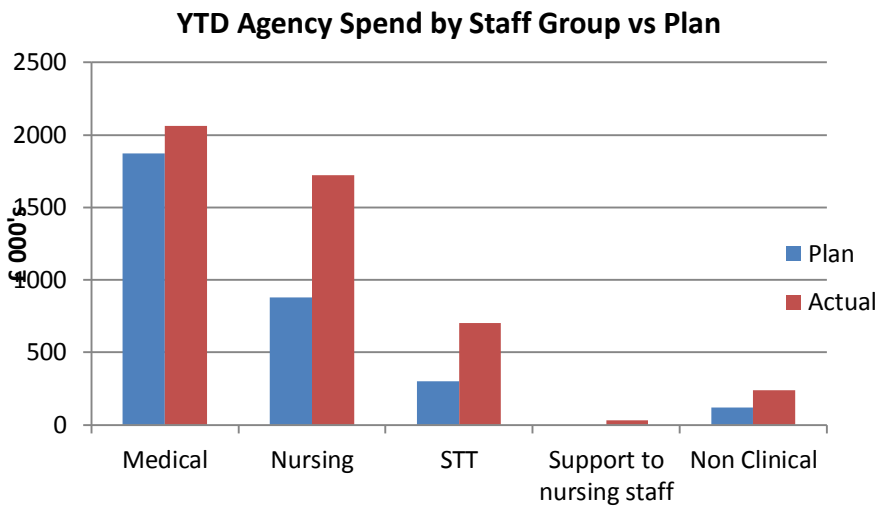
Non pay spend was £3,123k against a planned £2,950k, circa (£173k). Overall expenditure is above plan this month and corresponds to an overall increase in income due to the improved activity achieved in February.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Total agency spend has increased in month, to £426k from £397k in January. The Trust continues to have challenges in the provision of junior doctor cover and work is ongoing around the development of alternative staffing models.

Nursing agency spend has increased from last month circa £25k which mainly relates to ward cover. Bank usage has also increased in month by £44k and related mainly to medical staff payments to achieve increased activity.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

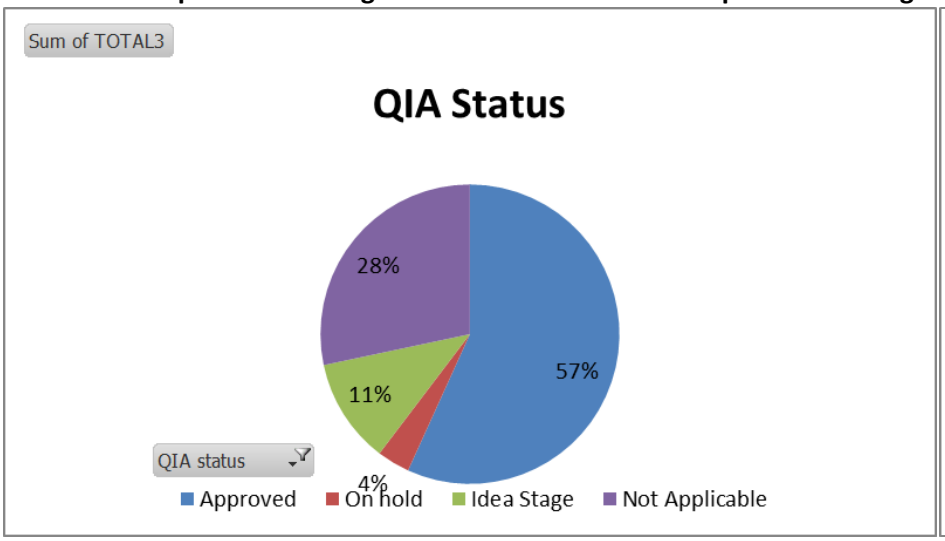
Review of e-Roster continues and shifts approved by the relevant Matron and head of Nursing.

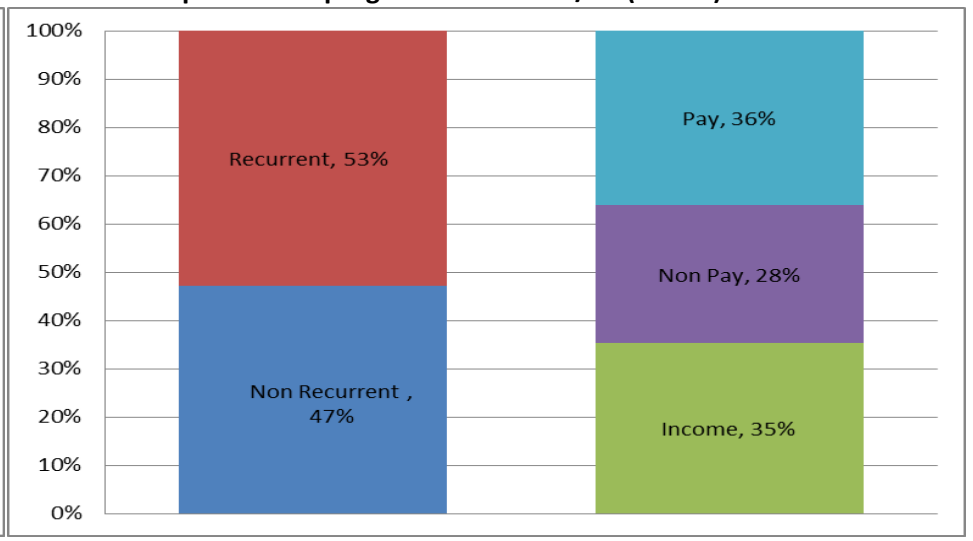
RISKS / ISSUES

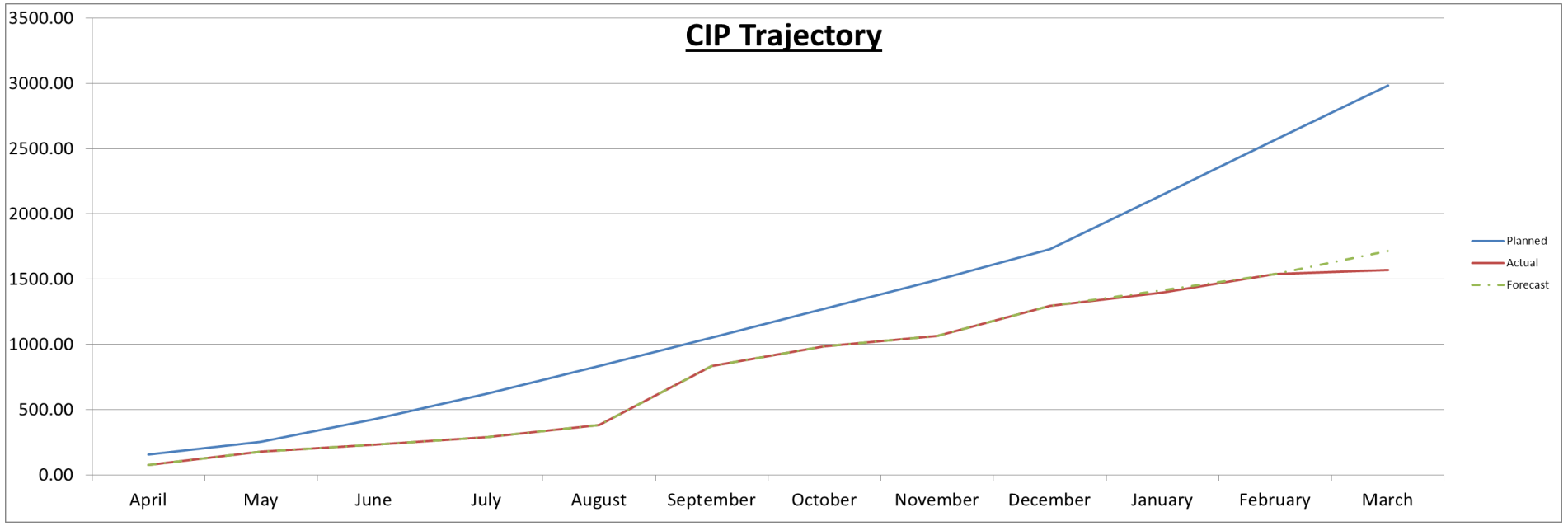
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

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)







RMATION

The CIP target for 2018/19 is £3,000k of which £2,985k (99% of target) was identified/planned. As at month 11 £1,716k is forecasted for delivery in 18/19 (58% of identified/planned).

Row Labels	In-Month Plan	In-Month Actual	In-Month Variance	YTD Plan	YTD Actual	YTD Variance	18/19 Plan	18/19 FOT	18/19 Variance	18/19 FYE	18/19 FYE Variance
Corporate	94	16	(78)	996	666	(330)	1,090	800	(290)	682	(408)
Division 1	75	68	(7)	631	369	(262)	705	392	(313)	578	(127)
Division 2	245	53	(192)	911	474	(437)	1,157	490	(667)	327	(829)
Division 4	5	5	0	28	30	2	33	34	2	12	(21)
Grand Total	**419**	**142**	**(276)**	**2,566**	**1,539**	**(1,027)**	**2,985**	**1,716**	**(1,268)**	**1,599**	**(1,385)**

The summary reasons for YTD under-performance are below:

- Non-delivery and slippage against some clinical and operational saving schemes such as Implant rationalisation, GIRFT recommendations, LOS reduction and clinical pathway/process redesign savings
- Slippage and under-delivery against large scale savings schemes such as Theatres Stock control and Managed Service Contract (£550k planned in-year, this will not be delivered in-year) and Counting & Coding improvement schemes (forecasting £250k adverse to plan)
- YTD performance is significantly supported by fortuitous changes to national discount rates, enabling the present value reduction of provisions by £120k (this was captured as a non-recurrent CIP in Dec 18)
- Minimal support networks (e.g. Procurement and project management teams) to support/drive CIP delivery; with CIP leads focusing on delivering Activity related/Patient care targets , compounded by an outdated CIP delivery model and culture led to minimal engagement in the whole process

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved forecasted performance vs Q1-Q3, 47% of schemes forecasted in-year are non-recurrent, thus the following is 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, (engaging clinicians to support this) with focus also on demand and capacity management to deliver cost improvements
- Plans for 19-20 CIP's have been delivered; and a review of these are taking place, to explore the possibility of delivering some schemes in to 18/19
- Review and change to the current CIP process to ensure a Trustwide engagement of CIP identification and delivery; and ensure adequate resource to support, challenge and drive CIP delivery for CIP stakeholders; focus on changing the culture towards CIP's at the Trust

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the following schemes:

- Managed Service Contract for Theatres has now been removed from the 18-19 forecast. Whilst a project group is driving this forward, it remains a challenging scheme; with significant risks which include non-conformance of the Trust decontamination provider to contracting arrangement requirements, HMRC VAT legislation change risks/exit risk impact assessments, potential impacts from the BSOL procurement collaboration
- The counting & coding scheme is forecasted to deliver £234k, 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 at the monthly Quality and Steering committee meetings
- Focus on 19/20 Business Planning including 19/20 CIP scheme identification, this has led to a reduced focus on (2018/19) in-year identification

7. 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
Intangible Assets	783	556	227
Tangible Assets	48,080	49,043	(963)
Total Non-Current Assets	**48,863**	**49,599**	**(736)**
Inventories	4,858	5,334	(476)
Trade and other current assets	5,466	6,234	(768)
Cash	1,322	2,004	(682)
Total Current Assets	**11,646**	**13,572**	**(1,926)**
Trade and other payables	(12,884)	(15,821)	2,937
Borrowings	(1,266)	(399)	(867)
Provisions	(173)	(116)	(57)
Other liabilities	(207)	(274)	67
Total Current Liabilities	**(14,530)**	**(16,610)**	**2,080**
Borrowings	(7,479)	(9,018)	1,539
Provisions	(354)	(215)	(139)
Total Non-Current Liabilities	**(7,833)**	**(9,233)**	**1,400**
Total Net Assets Employed	**38,146**	**37,328**	**818**
Total Taxpayers' and Others' Equity	**38,146**	**37,328**	818

INFORMATION

Tangible assets are below plan due to slippage on various schemes throughout the trust. The Assistant 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 on track to utilise all of the £5m loan facility by 31st March 2019 agreed for the Trust

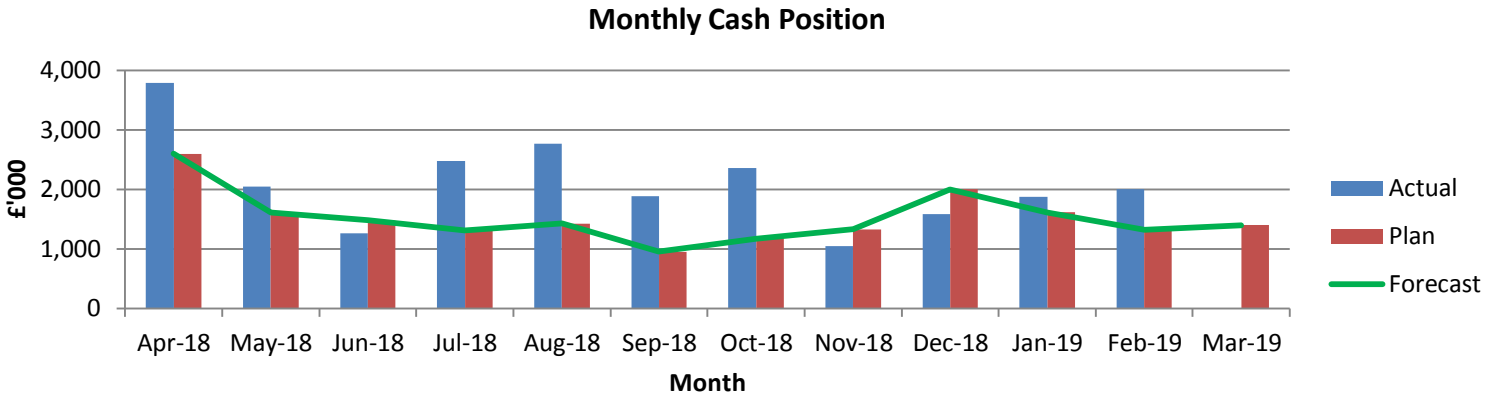
ACTIONS FOR IMPROVEMENTS / LEARNING

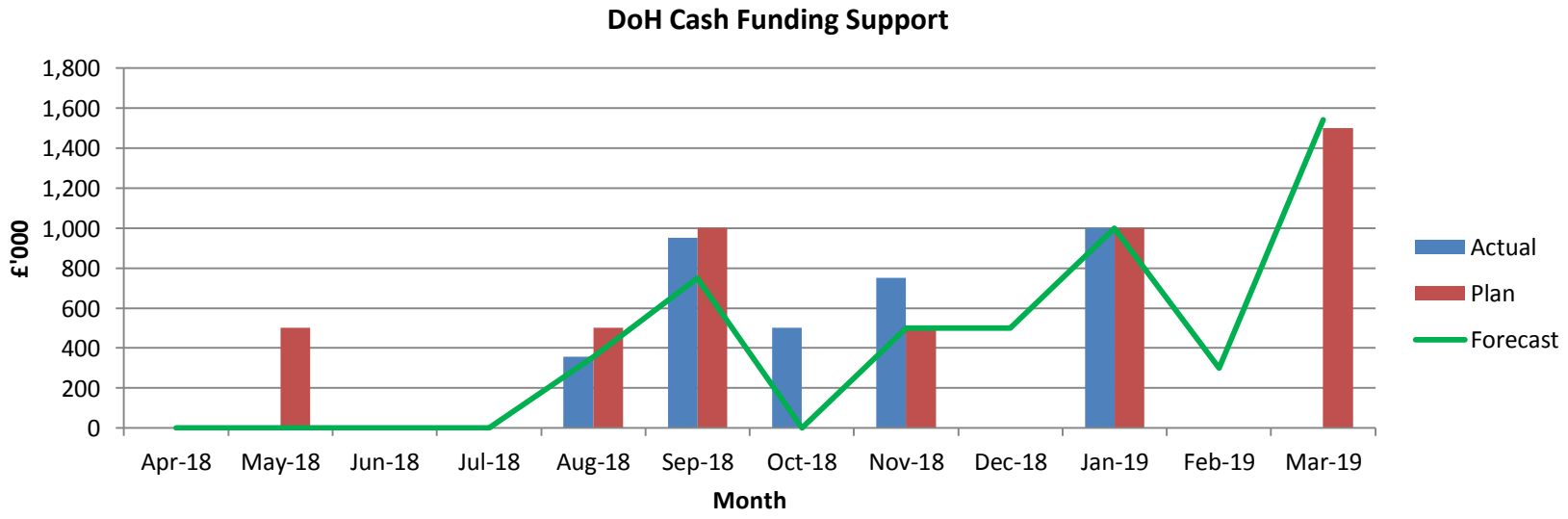
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

RISKS / ISSUES

Despite the receipt of STF, cash remains tight for the remainder of the year with a projected cash balance at year end of £1.4m after an initially lower uptake of the borrowing facility at the beginning of the year than planned.

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 £2,004k which is £682K higher than forecast. This is due to a reanalysis of payment profiles for the NHS Resolution insurance payments.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £1,543k has been requested from the Department of Health (DoH) for March which is within the forecast for 2018/19.

ACTIONS FOR IMPROVEMENTS / LEARNING

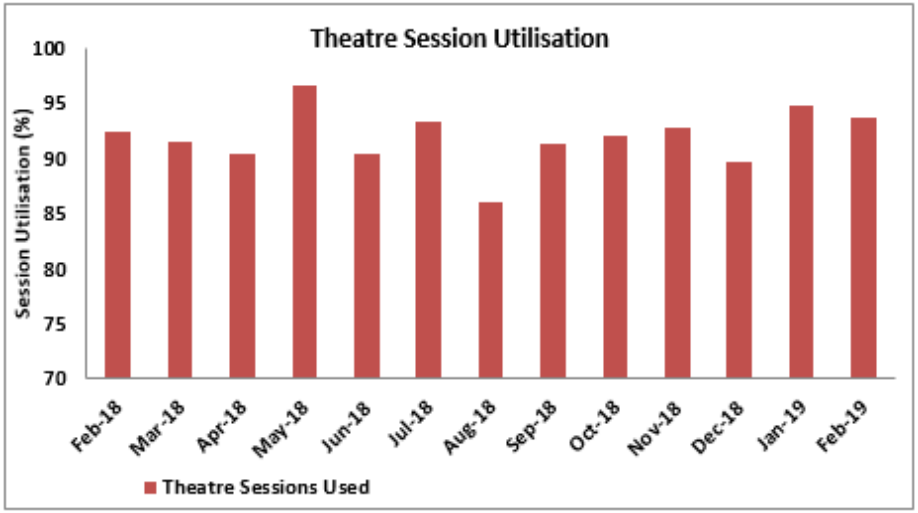
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2018/19. The Head of Financial Accounting has set up a monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team. The 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

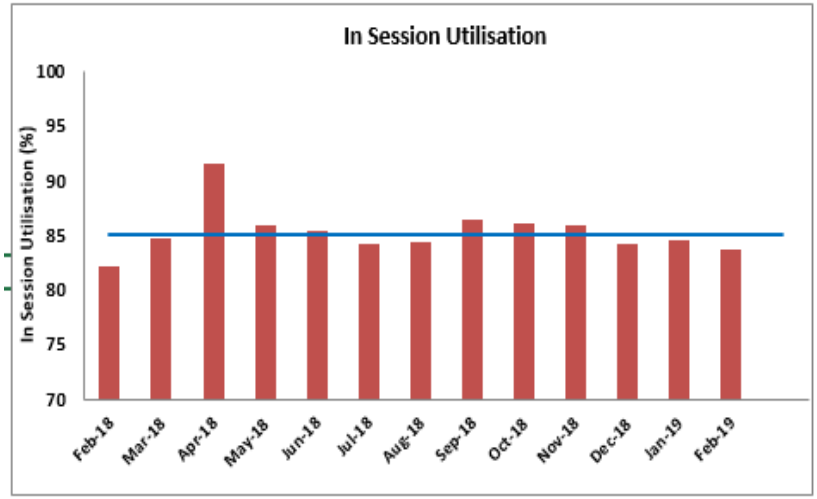
Session utilisation in February saw a slight reduction ending at 93.63% compared to January which was 94.87%.

Average utilisation has increased slightly to 91.98% for the period April '18 – February '19.

RISKS / ISSUES

- Theatre recruitment to support future growth – successful open day in January 19 saw over 70 people attend with at least 20 offers being made on the day, the team continue to "keep in touch" with candidates whilst the final recruitment checks take place.
- 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

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 for February was 83.76% compared to 84.47% in January

In session utilisation remains consistent, running at an average of 86% for the period April '18 – February '19.

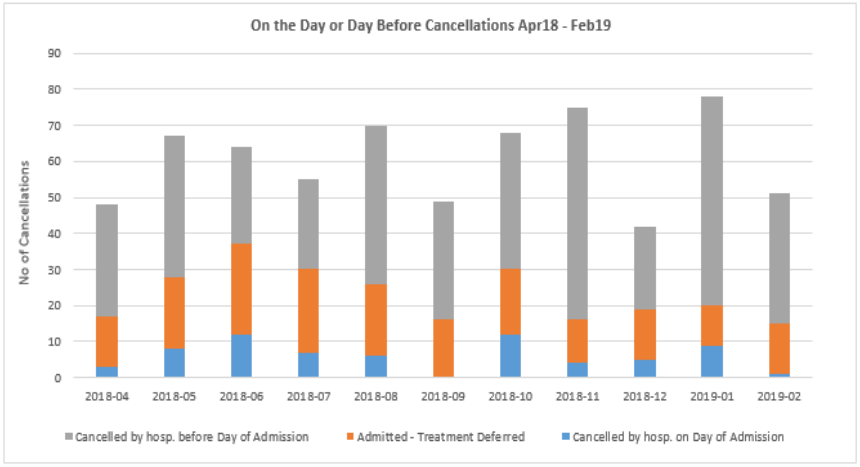
Changes in the POAC service which will come into effect from April 2019, along with improvements in delivery of the 72hr call service will help to improve utilisation of theatre lists going forward.

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
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

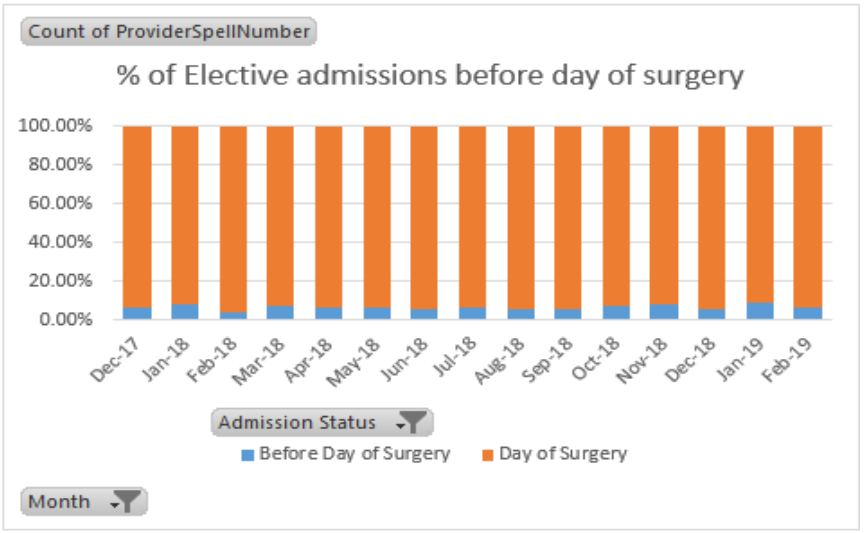
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

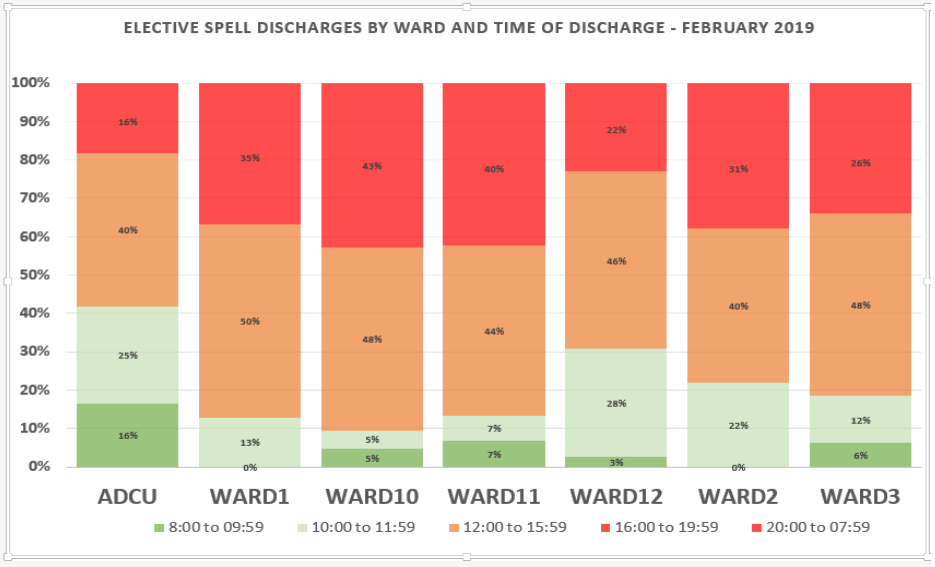
Hospital Cancellations



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
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	44	70	0
2018-09		16	33	49	1
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	1	14	36	51	0
Grand Total	67	187	413	667	1

Admission the day before surgery





The number of cancellations on the day of admission for surgery in February was 1 patient , a decrease from January and one of the lowest in the past 12 month period. Patients admitted for surgery where treatment was deferred has increased slightly in month from 11 to 14. Analysis of patients admitted where treatment was deferred relate to, surgeon illness and lack of theatre time.

Cancellations before the day of surgery have also decreased in month from 58 to 36. An analysis of the 36 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 patients declaring fitness issues on the 72 hour contact call .

A robust process is now in place to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. This meeting will now include a financial breakdown of average loss of income from April 2019 relating to cancellations on the day The 72 hour call process has now been strengthened and an extended hours contact service is being developed so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in March 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre team will take place from April 2019. This will change the profile of triage to be delivered in the pre-operative clinic area, so that access to on the day triage can be expanded. This change in practice will be supported by a full communication strategy

ACTIONS FOR IMPROVEMENTS / LEARNING

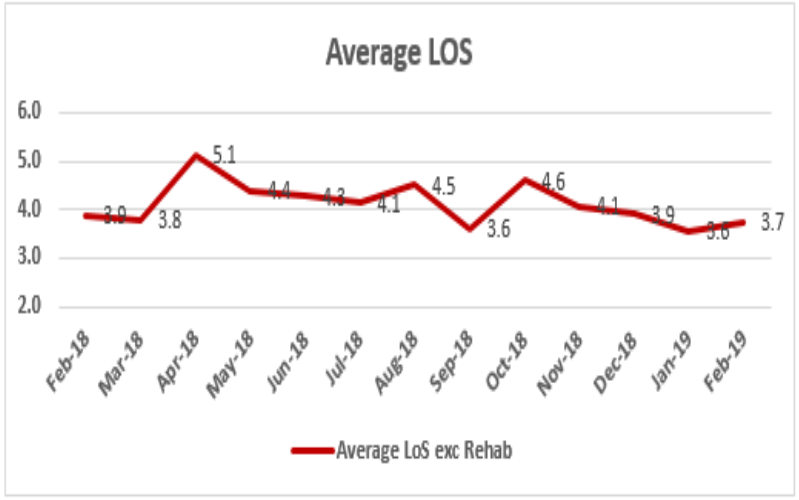
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

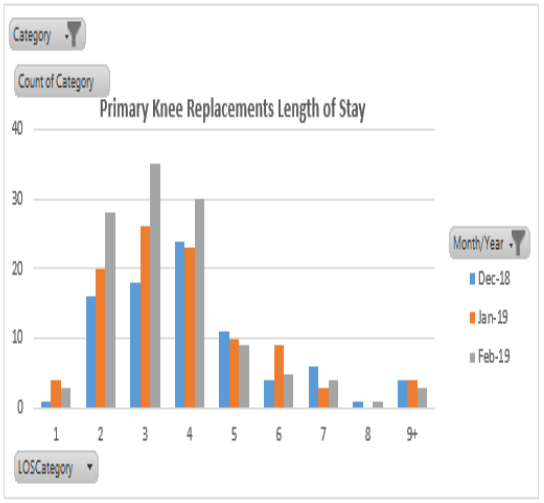
- POAC representative now attends daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Improved links with Clinical team to support any clinical concerns raised during patient contact

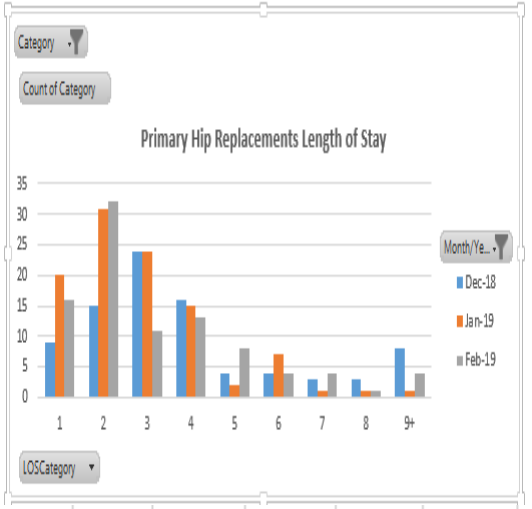
RISKS / ISSUES

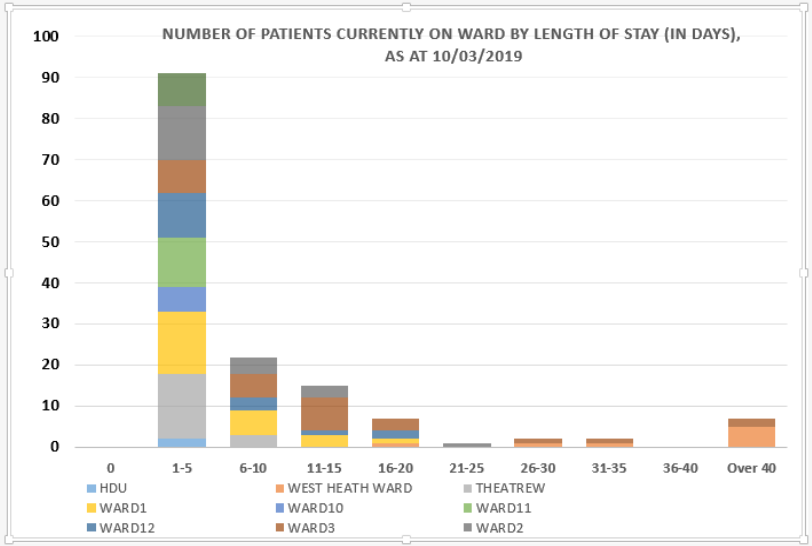
Existing ageing equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools have been purchased and full delivery of all items is expected by the end of March 2019. The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

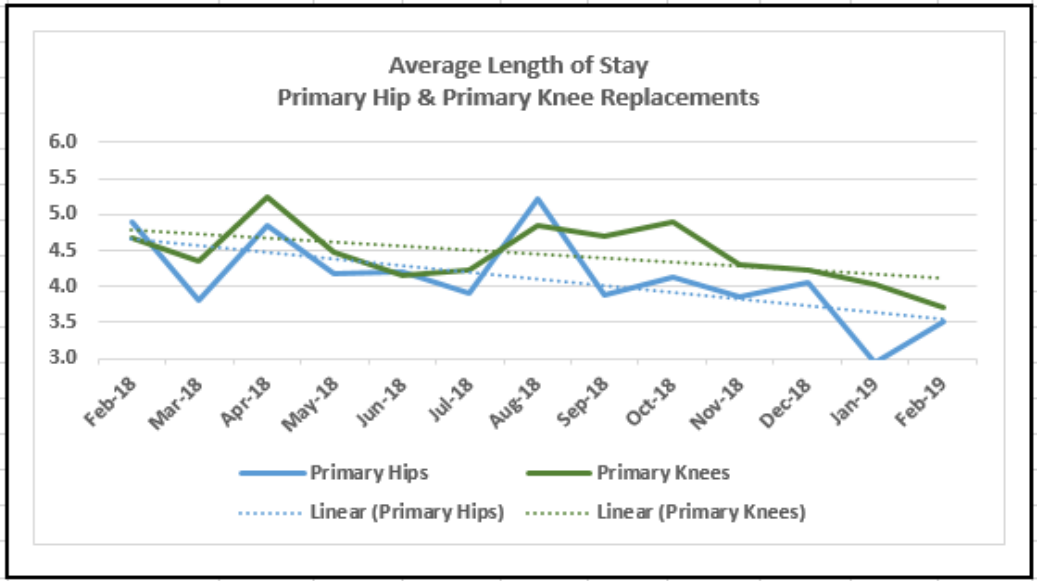
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in February was 3.7 days and a number of initiatives are in place to continue to drive down length of stay including:

- Jointcare continues to reduce length of stay for Hips & Knees and helps drive a reduction in LOS. A significant amount of patients are being discharged earlier (Day 2) with the support of the therapy classes and early mobilisation
- Production of a Jointcare performance dashboard to monitor a range of KPI's supporting reducing length of stay and a range of metrics is being developed – moving from quarterly to monthly data submission
- 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 lounge staff to ensure timely discharge . The Senior Sisters across all inpatient wards are now implementing a 12: 30hrs review with all members of the MDT. The rationale for this is to strengthen the Red2Green initiative across all wards.
- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is developing local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- The discharge lounge is well utilised by all adult inpatient wards.

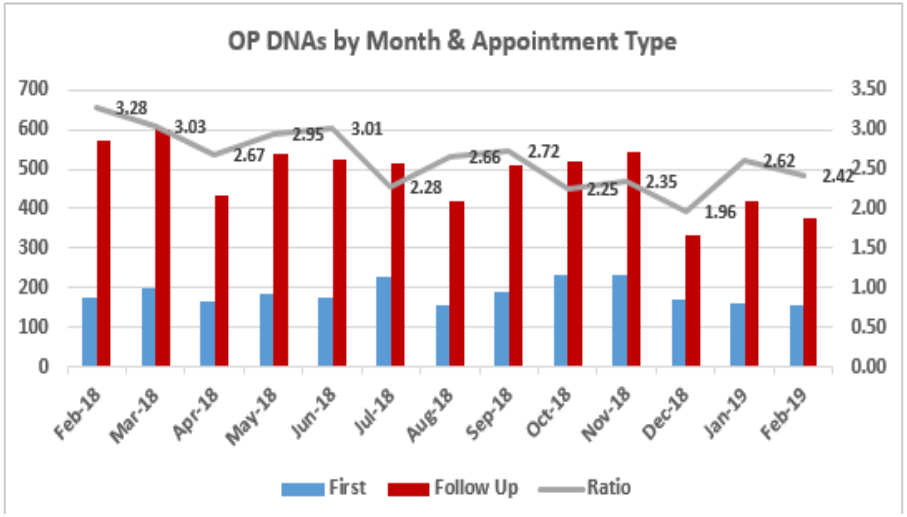
ACTIONS FOR IMPROVEMENTS / LEARNING

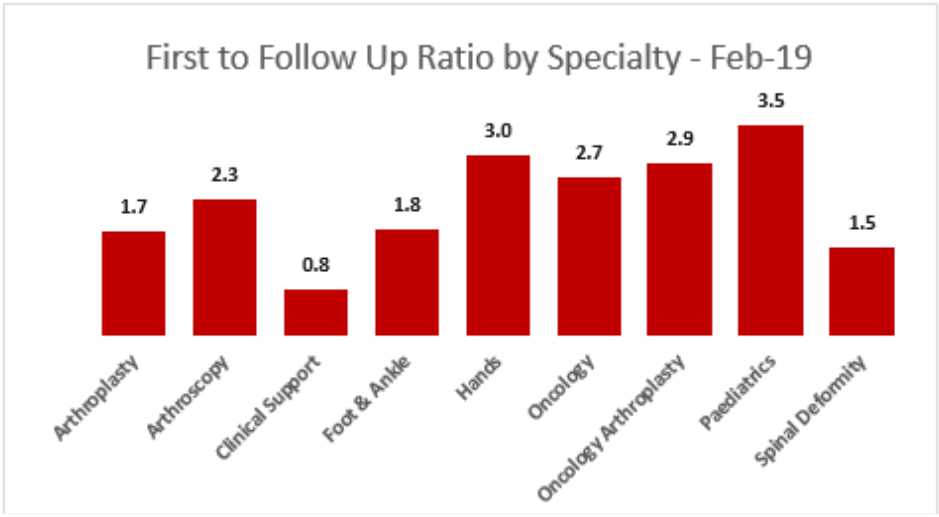
- The Red2Green dashboard development is now launched across all wards .
- The dashboard also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Options being explored include a 'floating ward clerk role ' out of hours to ensure timely recording of all ADTS .

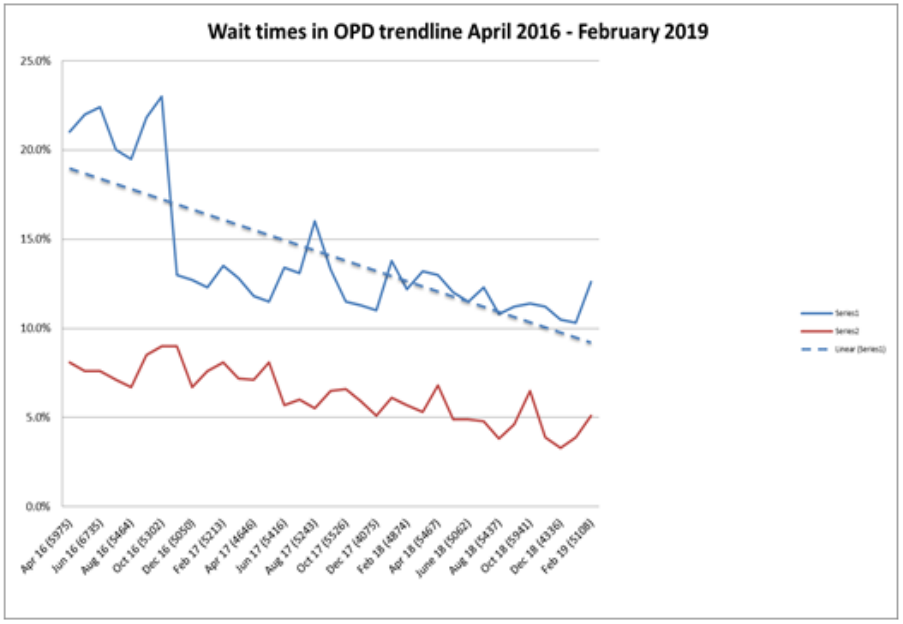
RISKS / ISSUES

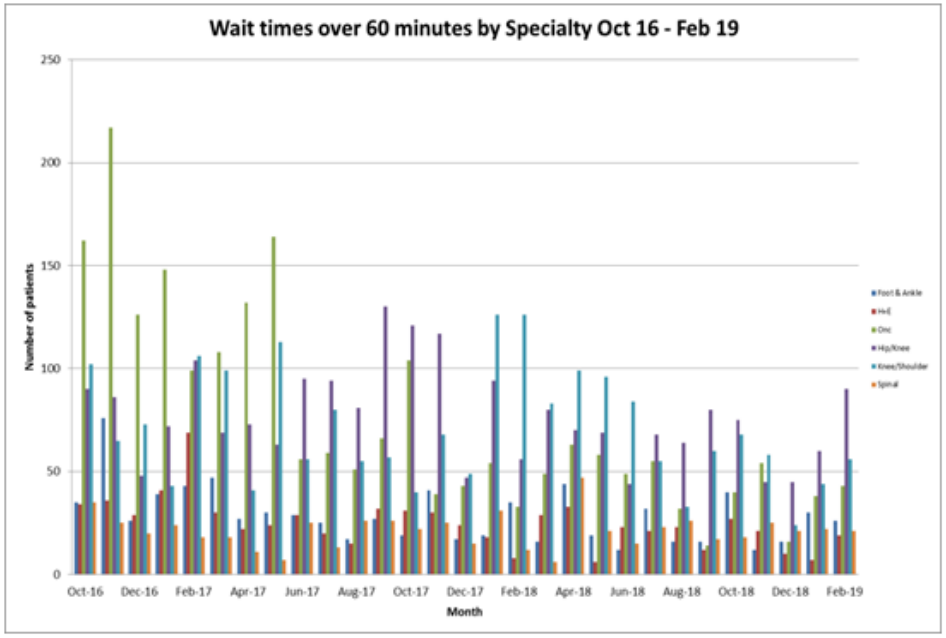
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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









INFORMATION

In February there were 12.6% of patients waiting over 30 minutes which is an increase on last month. The target for 30 minute delays has still not been achieved. Focussed work is ongoing to continue to improve this position and 5.1% of patients were waiting over 1 hour which was just above the target of 5%.

There is now a 6-4-3 meeting held every Wednesday, which produces room allocation timetables 4 – 6 weeks ahead. The master room allocation template has been sent to the operational management team to review and amend if necessary to ensure this is correct and will begin to allow analysis of room (or session) utilisation and ensure staffing is appropriate to support the reduction in delays for patients attending clinic. Radiology are now joining this meeting to review communication between clinics and Radiology and optimise patient flow.

There were 16 incidents of clinic delays reported in February 2019 with the following breakdown.

- 6 clinics overbooked
- 4 complex patients
- 2 consultant / clinician delay
- 2 x-ray delays
- 2 other

The Matron for outpatients will continue to reiterate the importance of reporting all incidents relating to clinic delays and the operational management team will analyse reasons for delays in order to improve practice . The New senior nurse for outpatients is now in post.

There are now 2 notice boards in outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation .

A number of initiatives are being developed to improve the OP experience for patients and staff. Full details of these projects will be discussed at the OP away day now planned for April 30th 2019. This day will agree the priorities and support a range of service improvement initiatives in line with recent NHSI recommendations .

ACTIONS FOR IMPROVEMENTS / LEARNING

- Utilise the outreach clinics at Lordswood & possibly at West Heath

- The process for partial booking will continue to be monitored as to the impact this may have on requiring additional staff in the appointments team. This may need a business case review with in the next 6 months.

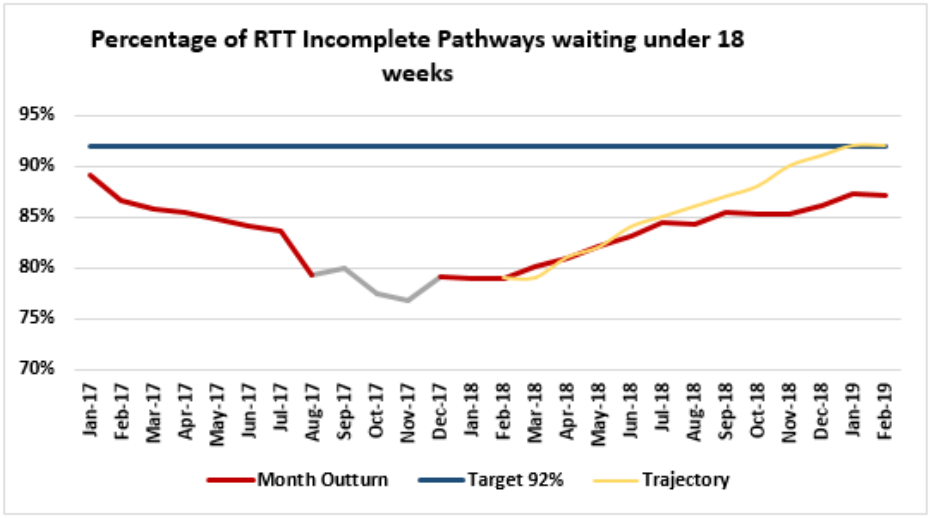
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

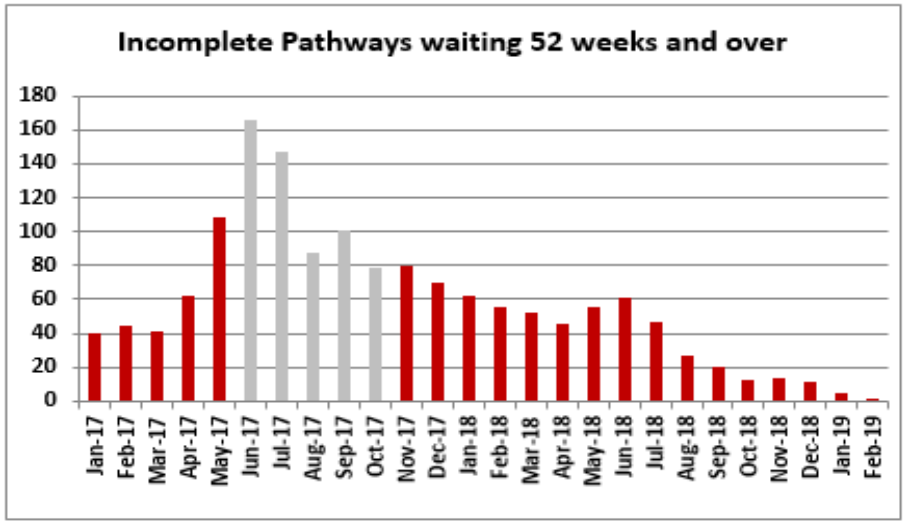
% of patients waiting <6weeks for Diagnostic test.

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	1155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1183	1,186	99.7%
Apr-18	1022	148	409	1,579	850	253	387	1,490	8	1571	1,579	99.5%
May-18	1002	136	353	1,491	725	236	373	1,334	1	1490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1256	1,261	99.6%
Jul-18	732	112	336	1,180	961	211	290	1,462	8	1172	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	1113	1,117	99.6%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1245	1,252	99.4%
Dec-18	698	115	346	1,159	843	224	367	1,434	11	1148	1,159	99.1%
Jan-19	728	123	416	1,267	897	253	472	1,622	4	1263	1,267	99.7%
Feb-19	844	134	386	1,364	854	248	436	1,538	3	1361	1,364	99.8%

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



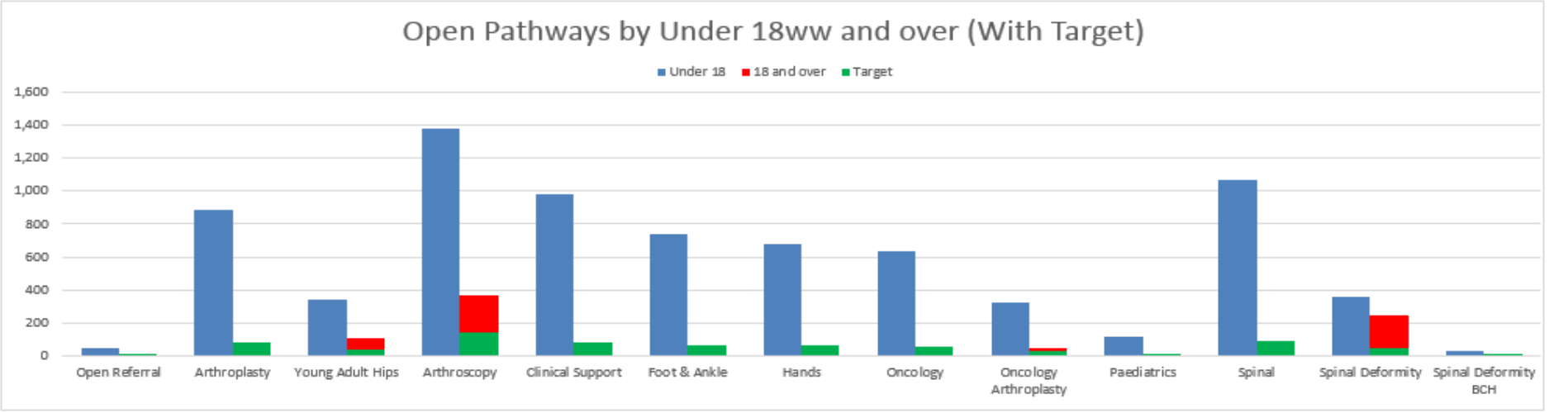


		Indicative	Reported Month										Reported Quarter 2017/18			
Target Name	National Standard	*Feb*	Jan-19	Dec-18	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	*98%*	100%	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*100%*	90.9%	93.8%	100%	100%	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	n/a	n/a	n/a	n/a	n/a
62 day (traditional)	85%	*100%*	90%	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	*87%*	75.0%	94.70%	90.5%	88.9%	77.8%	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	n/a	n/a	n/a	n/a	n/a
No. patients treated 104+ days			1	2	1		1			1						

13. Referral to Treatment snapshot as at 28th February 2019 (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	**4,077**	31	486	173	734	520	383	369	371	182	60	588	168	12
7-13	**2,426**	12	267	118	432	369	262	214	173	87	40	344	101	7
14-17	**1,073**	1	137	51	211	94	96	92	87	53	18	138	86	9
18-26	**859**	1	65	66	262	46	58	54	25	35	9	74	159	5
27-39	**277**	0	6	39	99	10	4	2	10	13	2	9	76	7
40-47	**16**	0	0	3	2	0	0	0	1	0	0	0	10	0
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
Total	**8,731**	45	961	450	1,740	1,039	803	731	667	370	129	1,153	603	40

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	**7,576**	44	890	342	1,377	983	741	675	631	322	118	1,070	355	28
18 and over	**1,155**	1	71	108	363	56	62	56	36	48	11	83	248	12
Target	**698**	**4**	**77**	**36**	**139**	**83**	**64**	**58**	**53**	**30**	**10**	**92**	**48**	**3**
	86.77%	**97.78%**	**92.61%**	**76.00%**	**79.14%**	**94.61%**	**92.28%**	**92.34%**	**94.60%**	**87.03%**	**91.47%**	**92.80%**	**58.87%**	**70.00%**



13. Referral to Treatment snapshot as at 28th February 2019

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	**990**	1	182	65	188	85	59	114	83	47	18	114	24	10
7-13	**749**	0	140	46	174	72	44	83	31	41	11	79	22	6
14-17	**379**	0	77	17	86	29	14	48	17	26	7	34	16	8
18-26	**399**	0	54	36	146	8	15	29	13	23	6	31	36	2
27-39	**149**	0	6	24	62	5	1	2	7	6	1	6	22	7
40-47	**14**	0	0	3	2	0	0	0	1	0	0	0	8	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
Total	**2,681**	1	459	191	658	199	133	276	152	143	43	264	129	33

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	**2,118**	1	399	128	448	186	117	245	131	114	36	227	62	24
18 and over	**563**	0	60	63	210	13	16	31	21	29	7	37	67	9
Target	**214**	**0**	**37**	**15**	**53**	**16**	**11**	**22**	**12**	**11**	**3**	**21**	**10**	**3**
	79.00%	**100.00%**	**86.93%**	**67.02%**	**68.09%**	**93.47%**	**87.97%**	**88.77%**	**86.18%**	**79.72%**	**83.72%**	**85.98%**	**48.06%**	**72.73%**

Select Pathway Type: Non-Admit

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	**3,087**	30	304	108	546	435	324	255	288	135	42	474	144	2
7-13	**1,677**	12	127	72	258	297	218	131	142	46	29	265	79	1
14-17	**694**	1	60	34	125	65	82	44	70	27	11	104	70	1
18-26	**460**	1	11	30	116	38	43	25	12	12	3	43	123	3
27-39	**128**	0	0	15	37	5	3	0	3	7	1	3	54	0
40-47	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
48-51	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
52 weeks and over	**1**	0	0	0	0	0	0	0	0	0	0	0	1	0
Total	**6,050**	44	502	259	1,082	840	670	455	515	227	86	889	474	7

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	**5,458**	43	491	214	929	797	624	430	500	208	82	843	293	4
18 and over	**592**	1	11	45	153	43	46	25	15	19	4	46	181	3
Target	**484**	**4**	**40**	**21**	**87**	**67**	**54**	**36**	**41**	**18**	**7**	**71**	**38**	**1**
	90.21%	**97.73%**	**97.81%**	**82.63%**	**85.86%**	**94.88%**	**93.13%**	**94.51%**	**97.09%**	**91.63%**	**95.35%**	**94.83%**	**61.81%**	**57.14%**

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and predicts that the Trust will return to 92% at an aggregated level by October 2019.

February 2019 performance is **86.77%**

It is expected that Oncology Arthroplasty will achieve 92% in March 2019 with Young Adult Hip in June 19 and Arthroscopy in July 19. A refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been completed and we anticipate that they will achieve the standard in Qtr. 4 19/20 . Excluding Spinal Deformity the Trust now has 6 patients waiting over 40 weeks all with treatment plans.

In February 2019 the Trust had **2** patients waiting over 52weeks the trajectory was 9. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. Detailed below is our progress against the trajectory. This has been resubmitted at the beginning of March 2019 to NHSI/E as the Trust can now confirm that it will have cleared all patients (2) over 52weeks by the end of March 2019.

Over 52 Weeks	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
ROH Specialties excluding SD	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
ROH Adult Total	14	12	16	15	12	9	7	0	0	0	2	0	0	0	0
ROH Paediatrics Total	20	28	31	25	28	19	16	8	10	11	19	15	9	3	0
BWCH Paediatric Total	30	29	27	27	27	27	25	20	15	11	8	4	0	0	1
ROH Total	66	70	75	67	68	55	47	29	25	22	29	19	9	3	1
Actual Performance	**56**	**52**	**46**	**55**	**61**	**47**	**27**	**20**	**13**	**14**	**11**	**5**			
Revised Trajectory													3	1	2
Trajectory 15/03/19													2	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

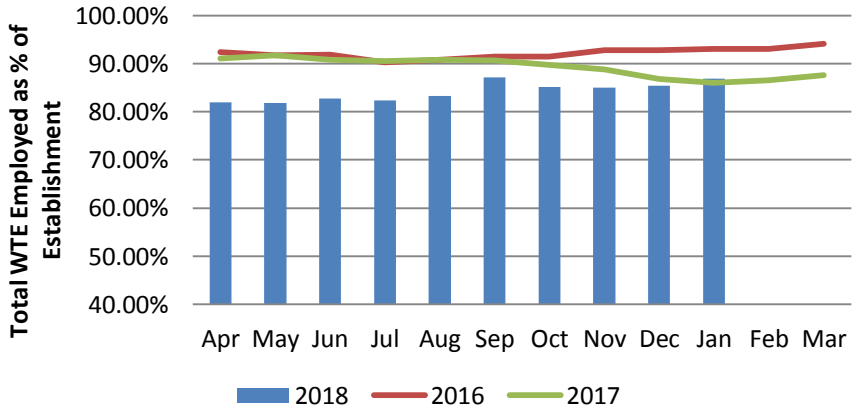
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019

RISKS / ISSUES

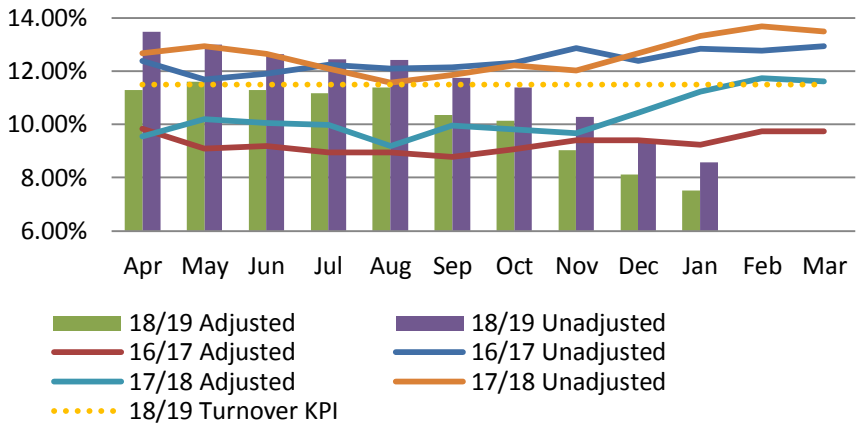
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds remains a concern.

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

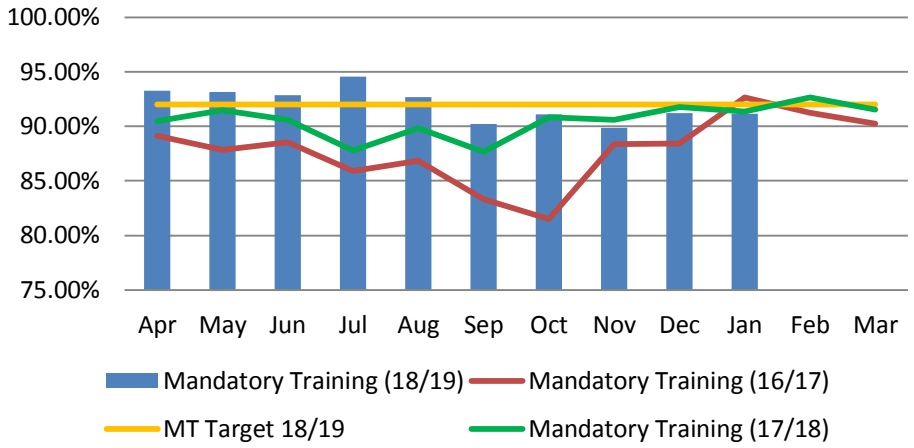
Staff in Post v Establishment



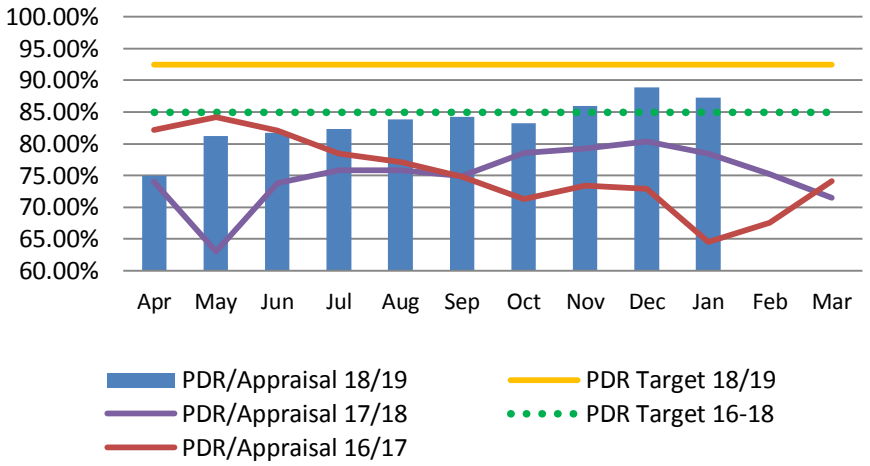
Staff Turnover



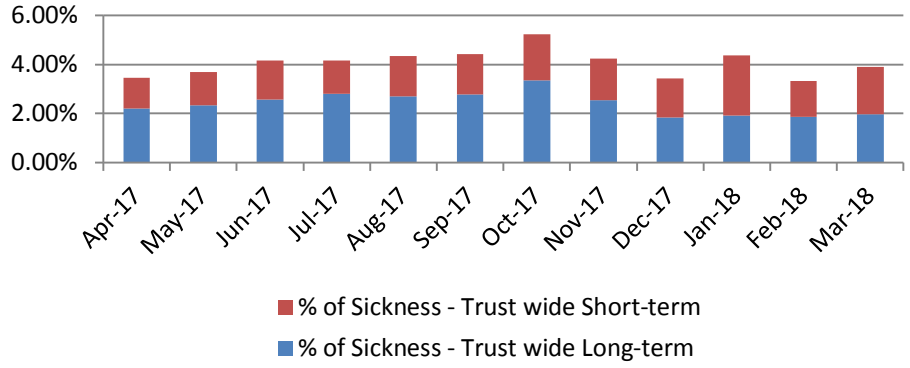
Mandatory Training



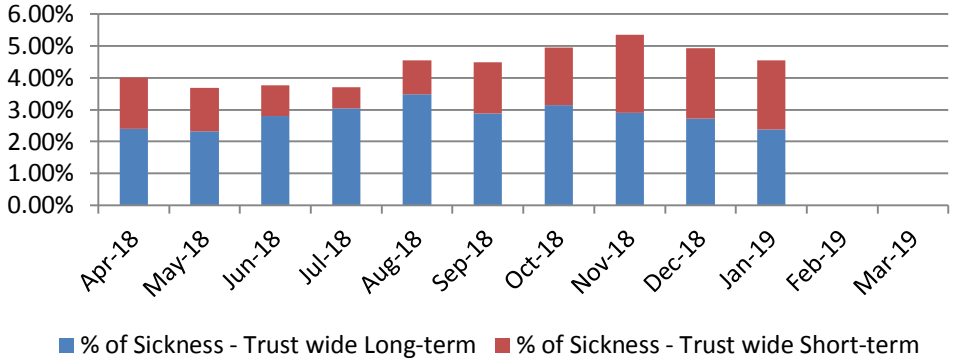
PDR/Appraisal



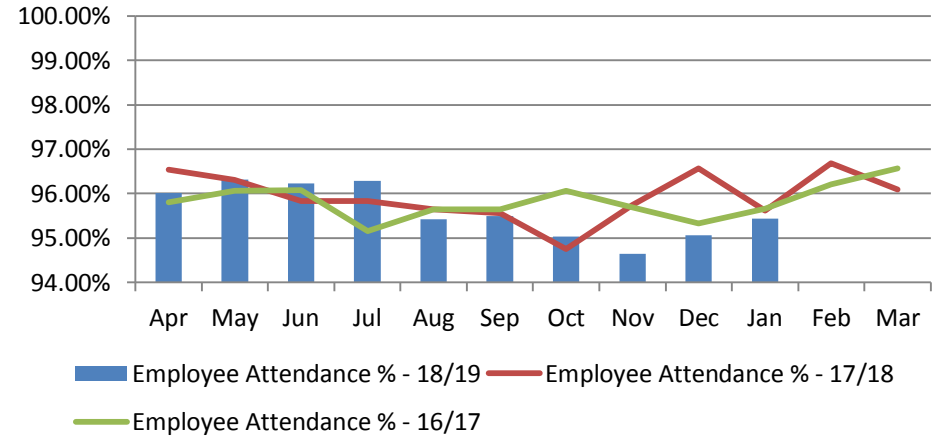
Sickness % - LT/ST (2017/18)



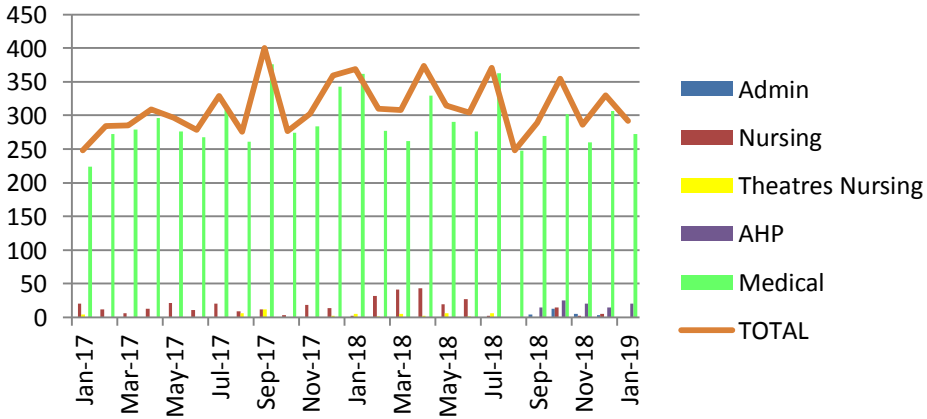
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

January saw an improvement in the vacancy position, a further reduction in turnover and a reduction in sickness absence for the third consecutive month. In contrast, the appraisal and mandatory training figures both decreased slightly.

This month, the Trust's vacancy position saw another increase (1.5%) as a percentage of WTE employed, with the figure now 86.92% against a Trust target of 90%. This is reflected in the WTE number of staff on the payroll, which stood at 929.84, an increase on the December position of circa 11 WTE, some of which were late new starters due to the early payroll cut-off date in December.

Monthly attendance increased slightly by 0.38%, although it was still red as the January position stood at 95.44% (versus a target of 96.1%). Whilst short term sickness absence remained almost identical between December and January, there was a reduction in the long term figure which improved the overall in month position. The 12 month average figure remained red at 95.54%, although this is expected to improve in the months ahead (probably in late Q2) as long term sickness is expected to reduce: last year seemed unusually high over the summer months.

Mandatory Training numbers saw a small decrease of 0.07% versus the December position at 91.15%. This is still below the Trust's internal target of 92% for the 5th consecutive month, although early indications are that this will improve in February's report. Whilst not a cause for significant concern, it does need to remain an area of focus for the Divisions.

January's appraisal performance declined by 1.5% to 87.30%, but it remained the second highest monthly figure of the year (and actually, since May 2014). Whilst this is still adrift from our stretch target of 92.5%, the Trust has seen significant progress in year in this area, as staff have reflected in the recent staff survey.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) reduced again to 8.57%. The adjusted turnover figure (substantive staff leavers including retirements) decreased to 7.52% and both were green against a KPI of 11.5%. It should be noted that staff who remain on the bank but have left substantive jobs are not counted as leavers – this has been checked via ESR specialist user groups and is true nationally.

In January, agency breaches decreased from 330 to 292 shift breaches in total, with the majority being medical usage (272) but this is a decrease from December's usage of 307. There were no nursing or admin breaches in month: the other 20 were AHP breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING

Continuing focus on mandatory training and appraisal will be helpful as the Trust nears year end.

RISKS / ISSUES

The drive to increase activity between January and March may mean that there are operational pressures which could affect these two indicators in particular.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Workforce extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3 April 2019**

EXECUTIVE SUMMARY:

The Board Assurance Framework includes 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 attached provides an overview of the workforce risks which the relevant Executive Director leads will present to the Board and discuss the current and planned mitigations.

.

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

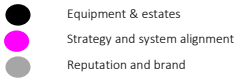
REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate					
ACTION REQUIRED (Indicate with 'x' the purpose that applies): **The receiving body is asked to receive, consider and:**					
Note and accept		**Approve the recommendation**		**Discuss**	
X		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:					
Trust Board on 6 March 2019.					

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
WF2	WFOD	Paul Athey	Failure to identify future workforce models which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment	Patient safety, Patient experience, Workforce capacity, capability and engagement	Highly motivated, skilled and inspiring colleagues	SE & OD Committee	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	3	4	12	↔	Workforce design to become an integral part of HR Business Partner discussions. Middle grade workforce group is meeting to develop model.	Jan-21	2	4	8
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	Patient safety, Patient experience, Workforce capacity, capability and 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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs	Jan-21	3	3	9

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Gender pay gap analysis
SPONSOR (EXECUTIVE DIRECTOR):	Paul Athey, Acting Chief Executive
AUTHOR:	Alex Moody, Associate Director of Workforce & OD
DATE OF MEETING:	3 April 2019

EXECUTIVE SUMMARY:

This report provides data for the period 1st April 2017 to 31st March 2018 in line with the Government Gender Pay reporting requirements. To inform this report we have used the Electronic Staff Record system to analyse pay data and meet our statutory obligations.

The results have been posted on the Government portal https://gender-pay-gap.service.gov.uk/ in accordance with our statutory duty.

REPORT RECOMMENDATION:

The Committee is asked to receive the update and note that the results have been published.

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

Note and accept	Approve the recommendation	Discuss
X		

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

Financial	x	Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	
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:

Compliance with legal requirements.

PREVIOUS CONSIDERATION:

Executive Team on 26 March 2019.

Royal Orthopaedic Hospital NHS Foundation Trust – Gender Pay Gap Report as at 30th March 2019

This report provides data for the period 1st April 2017 to 31st March 2018 in line with the Government Gender Pay reporting requirements. To inform this report we have used the Electronic Staff Record system to analyse pay data and meet our statutory obligations.

The results have been posted on the Government portal https://gender-pay-gap.service.gov.uk/ in accordance with our statutory duty.

Figure 1 provides the Gender Pay Gap for all staff (including bank-staff) working at the Royal Orthopaedic Hospital NHS Foundation Trust during the relevant period.

Figure 2 provides the Gender Pay Gap for all staff working (including bank-staff) at the Royal Orthopaedic Hospital NHS Foundation Trust during the relevant period, excluding our medical workforce.

The data is based on a total of 1073 staff employed at ROH as at 31st March 2018 comprising of the following split:

	Female	Male
Total Workforce	**69.9%**	**30.1%**
Medical Workforce as a % of Total Workforce	**1.83%**	**30.7%**

Figure 1: Gender Pay Gap as of March 2018 – *All ROH Trust staff (including bank-workers)*

Difference in mean hourly rate of pay – 36.2%

Difference in median hourly rate of pay – 27.8%

Employees by pay quartile

	Female	Male
Upper Quartile	**46.8%**	**53.2%**
Upper Mid Quartile	**79.1%**	**20.9%**
Lower Mid Quartile	**78.7%%**	**21.3%**
Lower Quartile	**72.4%**	**27.6%**

Bonus Payments

	Male	Female
% of employees who received a bonus	6.3%	0.3%

Difference in mean bonus* pay – **53.9%**

Difference in median bonus* pay – **62.2%**

*Total value of all bonus payments made in the relevant period

Figure 2: Gender Pay Gap as of March 2018 – *All ROH Trust staff excluding medical workforce*

Difference in mean hourly rate of pay – **5.9%**

Difference in median hourly rate of pay – **-0.9%**

Employees by pay quartile (excluding medical workforce)

	Female	Male
Upper Quartile	71.8%	28.2%
Upper Mid Quartile	80.1%	19.9%
Lower Mid Quartile	80.3%%	19.7%
Lower Quartile	70.6%	29.4%

Bonus Payments (excluding medical workforce)

	Male	Female
% of employees who received a bonus	0%	0%

Difference in mean bonus pay – **0%**

Difference in median bonus pay – **0%**

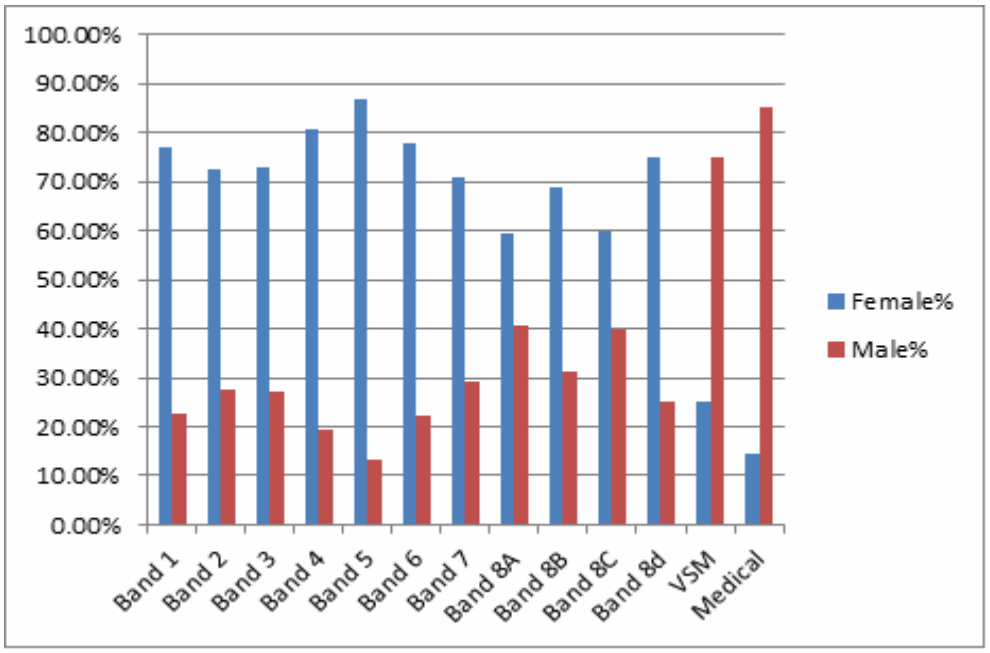
The only bonus payments made within the Trust are National and Local Clinical Excellence Awards (CEA) paid to Consultants in line with National NHS guidelines. The difference in bonus pay data is driven by the significantly higher ratio of male to female consultants. During the period the Trust employed 80 consultants of whom 76 were male and only 4 were female.

Contextual Information:

Gender pay reporting is different to equal pay which deals with the right for men and women to be paid the same when doing the same, or equivalent, work. The gender pay gap shows the difference in average pay of all men and average pay of all women within one organisation. It is therefore possible to have genuine equality of pay but still have a pay gap between genders. As a trust ROH, uses the Agenda for Change job evaluation framework to benchmark appropriate pay bandings to our roles, this in turn provides a process for paying staff equally for the same or equivalent work. Progression through pay steps under the Agenda for Change framework is based on time in post and satisfactory performance irrespective of gender.

The gender pay gap within the Trust is driven by the strong male bias in our medical workforce. This population of staff is generally our higher earning staff and makes up 8% of our total workforce. By comparison there is a strong female bias in our support roles which tend to be at the lower end of the pay range. As an acute NHS trust specialising in orthopaedics our medical workforce is reflective of the strong male bias in orthopaedic medical workforces nationally.

The chart below is used to illustrate how the composition of the workforce at ROH is distributed male to female by banding. What this shows is a significantly higher proportion of males in the highest two bands (VSM and Medical) while similarly at the lower bands the reverse is true with the proportion of females to males being significantly higher.



When our gender pay gap is recalculated removing the medical workforce the gap closes significantly to a gender pay gap of 5.9%, which is well below the national average of 17.9%. Furthermore the median pay gap is actually showing a negative at -0.9% for of our staff, excluding medical workforce, indicating that women are paid slightly more at the mid-point of pay than men. The median is often considered to be more statistically valid due to removing the extremes at either end of the pay scale. In addition while it has moved from -2.7% to -0.9% this can be seen as a positive shift towards pay parity.

The table below illustrates how ROH has much closer pay parity between the majority of our staff than our headline GPG figure suggests. Our data is skewed by the significantly higher pay rates of our medical workforce who are primarily male and reflected in the far higher GPG for the upper quartile group.

Mean Gender Pay Gap by pay quartile (entire workforce)

	Average Hourly Pay Female	Average Hourly Pay Male	% GPG
Upper Quartile	24.95	36.04	30.8%
Upper Mid Quartile	16.13	16.34	1.3%
Lower Mid Quartile	11.06	11.11	0.4%
Lower Quartile	8.35	8.42	0.9%

Why have we seen an increase in our GPG since we reported in March 2018?

Since we first reported our gender pay gap data in March 2018 we have seen an increase in our Mean GPG by 2.4% and in our median GPG by 1.6%. This is of course disappointing but it is important to remember that gender pay gap reporting and measures to address any such gap must be based on long-term initiatives.

The following observations from our data may help to explain the reported increase:

- 25% of all female starters who joined the trust on a permanent basis started on a salary of £20,000 or less, that is they started at the lowest bands.
- We lost 3 permanent consultants one of whom was female and recruited 4 permanent consultants all of whom were male.
- Of all new permanent staff recruited during the period 19% of male recruits joined on a salary of £60,000 or more while only 1% of all female recruits during the period joined on a salary of £60,000 or more.

Positive measures taken in 2018/19:

During the financial year 2018/19 ROH have been actively working on diversity, inclusion and equality activities to support the OD and wider Workforce Strategy. This has included:

- Leadership Development programmes including the NHS BAME Leadership Academy programme for women
- Establishment of an Equality & Diversity Network actively involved in events to support equality
- External career coaching programme to support senior females within ROH
- Implementation of a Band 6 Nursing Programme to enable professional development and grow our future leadership talent

Summary:

The Executive team and the Board remain fully committed to taking positive steps towards closing our gender pay gap while being mindful of the professional and societal influences which affect an acute specialist trust such as the ROH. As such we will try to identify ways in which we can become more involved in national work to encourage more women into the orthopaedic speciality at a senior medical level, working for example with the National Orthopaedic Alliance and the British Orthopaedic Association.

The Royal Orthopaedic Hospital NHS Foundation Trust is committed to respecting and promoting equality, diversity and inclusion across all aspects of the people agenda. In 2018 we established the Equality & Diversity Network group and we will continue to work closely with them as well as our People Committee and Staff Side to look at ways in which we can continue the good work undertaken in 2018/19 and further address the issues which underline our gender pay gap.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Corporate Governance & Compliance extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3 April 2019**

EXECUTIVE SUMMARY:

The Board Assurance Framework includes 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 attached provides an overview of the corporate governance and compliance risks which the relevant Executive Director leads will present to the Board and discuss the current and planned mitigations.
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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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • 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		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:					
Trust Board on 6 March 2019.					

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
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**	**5**	**3**	**15**	**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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.**	**Water Safety Group minutes presented to IPC Group meeting.**	**2**	**3**	**6**	↔	**Water safety plan is in development.**	**Aug-19**	**1**	**5**	**5**
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. Implementation of HealthAssure system will provide additional technological functionality to strengthen core governance systems.	Q1 2019/20	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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 6 March 2019: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(MR)
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	Service Improvement story – Flow Academy	Presentation	JW
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 9 January 2019: *for approval*	ROHTB (1/19) 012	Chair
1127h	5	Trust Board action points: *for assurance*	ROHTB (1/19) 012 (a)	SGL
1130h	6	Board Assurance Framework: *for assurance*	ROHTB (3/19) 001 ROHTB (3/19) 001 (a)	SGL
1135h	7	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (3/19) 002 ROHTB (3/19) 002 (a)	YB/PA
	7.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	PA
	7.2	Briefing on plans for Brexit 'no deal' scenario. BAF REF: FP3	Verbal	SW/PB
1145h	8	Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (3/19) 003 ROHTB (3/19) 003 (a)	JW

TIME	ITEM	TITLE	PAPER	LEAD
QUALITY & PATIENT SAFETY				
1155h	9	Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (3/19) 004 ROHTB (3/19) 005	KS
1200h	11	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (3/19) 006	GM
1210h	12	'Flu vaccination update: *for assurance*	ROHTB (3/19) 007 ROHTB (3/19) 007 (a)	GM
1205h	13	Infection Control annual report: *for assurance*	ROHTB (3/19) 008 ROHTB (3/19) 008 (a)	GM
FINANCE AND PERFORMANCE				
1210h	14	Update from the Finance & Performance Committee: *for assurance*	ROHTB (3/19) 009 ROHTB (3/19) 010	TP
1215h	15	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (3/19) 011	SW
WORKFORCE				
1225h	16	Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (3/19) 012 ROHTB (3/19) 013	RP
1230h	17	Workforce overview: *for assurance*	ROHTB (3/19) 014	PA
OTHER MATTERS				
1240h	18	Update from the Audit Committee: *for assurance*	ROHTB (3/19) 015	RA
1245h	19	Update from the Charitable Funds Committee and approved minutes: *for information*	ROHTB (3/19) 016 ROHTB (3/19) 016 (a)	DG
1250h	20	CQC action plan update: *for assurance*	ROHTB (3/19) 017 ROHTB (3/19) 017 (a)	GM
1255h	21	Trust Board workplan for 2019/20: *for approval*	ROHTB (3/19) 018 ROHTB (3/19) 018 (a)	SGL
MATTERS FOR INFORMATION				
1300h	22	Meeting effectiveness and relfection on adherence to Trust Values	Verbal	ALL
	23	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 3rd April 2019 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** 9 January 2019: 1100h – 1300h

Members attending:

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

Minutes	Paper Reference
1 Apologies	Verbal
Apologies were received from Kathryn Sallah.	
2 Declarations of interest	Verbal
It was noted that the register of interests was available on request from the Company Secretary.	
3 Minutes of Public Board Meeting held on the 7 November 2018: *for approval*	ROHTB (11/18) 016
The minutes of the meeting held on 7 November were accepted as a true and accurate reflection of discussions held.	
4 Trust Board action points: *for assurance*	ROHTB (11/18) 016 (a)

The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
5 Board Assurance Framework	ROHTB (1/19) 001 ROHTB (1/19) 001 (a)
The Associate Director of Governance & Company Secretary presented the latest version of the Board Assurance Framework. It was proposed that one risk be de-escalated, that being around the operational model in theatres given that it was now seen to be working well. It was also proposed that a new risk be added which streamlined the previous two cyber security risks. It was suggested that the risk around income associated with the transfer of Paediatric services be reframed, which the Interim Director of Finance agreed to do. The Board approved the proposed changes to the Board assurance Framework.	
ACTION: SW to reframe the paediatric transition risk relating to income	
6 Chairman's & Chief Executive's update: *for information and assurance*	ROHTB (1/19) 002 ROHTB (1/19) 002 (a)
The Acting Chief Executive reported that in terms of the recently publicised Long Term Plan for the NHS, the financial and operational plan for ROH would be presented at the meeting in March. It was noted that the press has been positive about the NHS Long Term Plan overall. The workforce issues remained the area of high focus, with particular attention to the recruitment and retention of the staff. In terms of new service models outlined in the Long Term Plan, there was more choice and there was a plan to better join up parts of the system, including primary and community care. The Plan also outlined the ambition to avoid up to a third of GP attendances. The second chapter of the Plan concerned prevention and targeting interventions to the areas of highest need. Chapter 3 related to care quality outcomes including the relative priorities within this. Short waits for planned care was an area of focus, including reducing the number of patients who were waiting for treatment in excess of 52 weeks. Chapter 4 detailed the plan to tackle workforce pressures, although there was little in the way of solutions discussed aside from work with universities. There was a focus on expanding international recruitment, including national initiatives. There	

would be a detailed national implementation programme.

Chapter 5 concerned upgrading technology, including provision of wider digital access and sharing information more easily.

Chapter 6 dealt with the funding settlement. The modelling for the plans was reported to be based on using the additional £20.5bn for the NHS by 2023/24 for three areas: current financial pressures; continuing demand growth; and new priorities. To put the NHS on a sustainable path, the Plan set out five 'stretching but feasible commitments', these being: The NHS (including providers) will return to financial balance, this hinging on rebased Control Totals for 2019/20 and the availability of Financial Recover Fund for providers who may struggle to achieve financial balance without this support; the NHS will achieve cash-releasing productivity growth of at least 1.1% per year; the NHS will reduce growth in demand for care through better integration; unjustified variation in performance will reduce; and better use will be made of capital investment and its existing assets to drive transformation. The competition and procurement regulatory constraints were reported to be also discussed in this section.

Chapter 7 outlined the next steps, including the expectation that local plans would be developed by organisations to deliver the overall ten-year plan.

In terms of targets, there may be new ones that may be introduced and a new oversight regime may be developed by NHS Improvement. The local economic drivers and research locally were noted to not be reflected in the plan. In terms of the workforce challenges at the ROH, it was suggested that the internal recruitment needed to be ethical to ensure that the ROH was not recruiting from countries that could not afford to lose their own healthcare professionals. A closer relationship would be developed with the local technical colleges to assist with addressing the workforce issues.

In terms of the ROH's operational and financial plan for 2019/20, the key gateways needed to be clarified. It was noted that at each meeting of the Finance & Performance Committee and Trust Board an update on the operational plan would be given. The main draft would be completed by the March 2019 Board meeting.

The Acting Chief Executive reported that in terms of the staff awards, it was pleasing that there had been so many nominations and reminded the Non Executive Directors that they had been invited to the event.

The Executive Director of Strategy & Delivery reported that the site was smoke free as of 1 January 2019. The implementation of the policy had been received well to date.

The Chairman advised that since the previous meeting she had:

- Helped with some more NED interviews at another local trust

• Undertaken a walkabout with Karen Hughes, Staff Governor • Attended the Christmas Ball at Tally Ho on 30 November. The staff organising the event were thanked for their work. • Attended the first meeting of Birmingham Hospitals Board • Distributed Christmas Chocolates to some of the teams across the hospital • Attended a launch event for a new centre of Health and Social Care Leadership on 10 December at University of Birmingham • Although she could not attend the celebration, the Chairman wished to recognise the retirement of Arthur and Brenda Wall who had worked as volunteers for 40 years at the hospital • Met with some of the applicants for the Medical Director post which was currently being recruited into following Mr Pearson stepping down from this role The Chairman thanked the staff working over Christmas and the New Year for their dedicated work and she also thanked Steve Washbourne for walking round the hospital on Christmas morning. The great job that the volunteers do was noted formally. An update was given on Dr Carmalt who had recently retired. He would be invited back to the Trust to formally celebrate with his colleagues. The outpatient manager would also retire at the end of the financial year after 40 years of service.	
ACTION: SW to present the draft financial and operational plan at the March 2019 meeting of the Trust Board	
6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	Verbal
The Interim Chief Operating Officer reported that in terms of the Orthopaedic Alliance, patients from Heartlands, Good Hope and Solihull Hospitals continued to be received. Many of these patients had been treated, with c. 170 individuals having undergone surgery to date. Much work had been undertaken in terms of bone infection and discussions would be held with the local Clinical Commissioning Group (CCG) as to how this would work across the system. It was reported that there had been a visit from the 'Getting it Right First Time' team, who were impressed at the JointCare pathway and had, on the back of this, discussed with University Hospitals Birmingham NHSFT, the concept of redesigning the orthopaedics pathway across the region.	
6.2 Briefing on plans for Brexit 'no deal' scenario BAF REF: FP3	Verbal

It was reported that there was a regular meeting of the Brexit subcommittee. The ROH was not stockpiling drugs but there was effort given to ensure that there was adequate stock. There was a plan to ensure that there could be no break in the service. There was noted to be a region wide process and a Birmingham-wide procurement arrangement would assist with this. The NHS Improvement self-assessment had been submitted prior to Christmas and neighbouring trust collaboration would ensure that supplies were uninterrupted. There were noted to be a couple of drugs where there was a risk and there could not be an absolute guarantee that the ROH would be unaffected, including any impact on the cost of the drugs.	
7 Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	**ROHTB (1/19) 003** **ROHTB (1/19) 003 (a)**
The Board received and noted the update on Paediatric service transition. It was highlighted that there was a delay to the original timetable since the Board had last considered the plans in public. This delay was a concern for the Board. The level of staffing on the paediatric ward was also a concern, however there was work underway with Birmingham Children's Hospital to mitigate this risk. Staff affected by the plans had been professional and were thanked. The Medical Director reported that the service at the ROH continued to be safe and patient safety remained the main consideration behind the plans. No further private paediatric patients were undergoing surgery on the ROH site.	
8 Update from the Freedom to Speak Up Guardian: *for assurance*	**Presentation**
The Board was joined by Roger Bishton, Acting Freedom to Speak Up Guardian (FTSUG). He delivered a presentation on the work he had been doing in his capacity as the Freedom to Speak Up Guardian and talked through some of the highlights from the first annual report prepared by the national Freedom to Speak Up Guardian's office. Mr Bishton was asked whether there were patient safety concerns raised through the FTSU. He advised that safety incidents were generally picked up, in addition to through the FTSUG route, by the incident reporting system (Ulysses) and during his tenure, there had been no feedback where the FTSUG had been asked to intervene. It was noted that staff were very quick to raise issues when they occurred. It was suggested that there needed to be better communication around the good things that the Trust did to address issues. It was noted that there was good progress with the work of the FTSUG across all areas. The Board noted the self-assessment that it had completed together with the FTSUG. It was noted that the responses needed to be as current as possible	

however, as some reflected past circumstances. The Board agreed that the FTSUG role was working well and was established. The Associate Director of Governance & Company Secretary was thanked for his support to the work. In terms of benchmarking, it was noted that the Trust performed well in terms of the level of concerns raised against other trusts. This was a matter of interest for the CQC and would be picked up under the Well Led Framework assessment. To improve the effectiveness of the FTSUG role further, it was suggested that better detailed assurance was needed that the patient safely issues raised were being addressed and raised. This would be picked up by a report to the Quality & Safety Committee. It was noted that in many of the areas where concerns had been raised previously there were no concerns and an eye needed to be kept on any key trends. It was suggested that the boundaries between HR and FTSUG needed to be better defined.	
ACTION: SGL to arrange for a detailed report on the FTSU concerns to be presented to the Quality & Safety committee	
9 Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (1/19) 004
The Chair of the Quality & Safety Committee reported that the national shortage of the Hepatitis B vaccination had been highlighted at the last meeting, however the vaccination was available now and staff needing to be inoculated were being recalled. Staffing in the clinical governance team was noted to be a risk, however there were plans to fill the vacant positions now. An update on the Human Tissue Authority (HTA) visit had been discussed; there had been a number of non-conformities raised, with which the Committee was concerned. There would be a further assurance report back to the Quality & Safety Committee at a future meeting. The quality assurance walkabouts into Outpatients had been discussed where an 'Inadequate' rating had been raised. An action plan was underway to address the areas of shortfall identified. The lack of attendance at the Infection Control meeting by the estates and facilities individuals had been raised as a concern. Another concern to highlight was the adequacy of the report back from the Water	

Safety Group, where the action plan to achieve compliance with the water safety regulations needed to be strengthened to provide better assurance around the plans. The bible of policies for water safety would be presented in May. The water was routinely tested which provided current assurance over the quality of water. It was reported that the plans for Pathology services was to be discussed at the next meeting of the Quality & Safety Committee. There had been a discussion around consent, including the possibility of using a generic consent form. It was noted that there was a suggestion that electronic consenting was a possibility and this was being investigated. It was highlighted that the requirements for biobanking needed to be considered; this would be part of the HTA action plan. It was noted that the plans to achieve a reduction of Outpatient 'Did Not Attend' cases was planned at the next Finance & Performance Committee.	
10 Patient Safety & Quality report: *for assurance* BAF Ref: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (1/19) 005
The Executive Director of Nursing & Clinical Governance reported that there had been one death, which was a patient that had been discharged. No inquest was planned. There were no serious incidents reported from June to October, although the VTEs not previously reported had now been retrospectively included in figures at the request of regulators. There had been two Grade 2 pressure ulcers reported. Twelve complaints had been reported, taking the year to date figure to 97. The new Patient Experience and Engagement Group would scrutinise complaints more closely. For the first time, the mandated 35% response rate had been achieved for the Friends and Family Test. The 'I Want Great Care' position had improved. It was noted that PALS contacts had reduced, however complaints had increased. There were no current trends to highlight however. Staff attitude and communication had been an issue and now 'customer care' training had been reintroduced. It was noted that the level of claims was static and the NHSLA premiums had reduced from previous years.	
11 Update from the Finance & Performance Committee: *for assurance*	ROHTB (1/19) 007
The Chair of the Finance and Performance Committee reported that the financial	

position was behind plan at present however he noted that the position remained better than the same period during the previous year. The introduction of the cost:income ratio would be included in future version of the Finance and Performance overview. The delivery of the cost improvement plan was a concern and it was suggested that there needed to be a realistic target set for next year. A discussion around the sickness absence spike had been remitted to the Staff Experience & OD Committee. The implications of a 'no deal' Brexit had been discussed. Performance against the Referral to Treatment time target was 87.24%. It was also good to see Paediatrics and foot and ankle specialities achieve the 92% national target.	
12 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (1/19) 008
The Interim Director of Finance commented that it had been a frustrating month as the underlying performance had improved, yet there had been a shortfall against the plan. The December position was a planned deficit of £1m and it was anticipated that this would claw back some of the shortfall from November. In terms of patients waiting over 52 weeks, there were 14. The diagnostic target had been met. Length of stay continued to decrease and was now c. 4.1 days. Overall, it was a positive position. Meeting the overall plan was dependent on the position concerning paediatrics.	
13 Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (1/19) 009
The Chair of the Staff Experience & OD Committee reported that the committee was now performing more effectively. Vacancies had been discussed and would be discussed again at the next meeting, particularly some of the risks to filling these. It was highlighted that this was the first time that the workforce overview was available to the Board. A series of staff experience walkabouts had been arranged and the first had been arranged in December. The plan as to how the outcome of these was presented back was being worked through, including how this gelled with the remit of the	

Executives. The conditions in which the finance and informatics teams were working was raised as a concern and this needed to be considered as part of the capital plan.	
14 Workforce overview: *for assurance*	ROHTB (1/19) 009
All were asked to review the workforce overview and provide any comments back to the Acting Chief Executive. In terms of staff turnover, the staff in post position had improved. As a bigger risk, sickness levels had risen. It was noted that in terms of the table around vacancies, there had been concerns over the data accuracy of this information which was being picked up.	
15 Meeting effectiveness	Verbal
It was agreed that the meeting had been effective and the Freedom to Speak Up presentation was well received in particular. It was pleasing that the workforce overview was now in a position to be able to be made available to the Trust Board.	
16 Any Other Business	Verbal
There was none.	
Details of next meeting	
The next meeting is planned for Wednesday 6 March 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 6 March 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 1.03.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
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. Ongoing discussions around therapies with commisisoners, thereby not in a position to be able to present updated strategy until Spring 2019.	
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~~ 03/04/2019	Scheduled for the ~~November~~ April meeting	
ROHTBACT. 068	Board Assurance Framework	ROHTB (1/19) 001 ROHTB (1/19) 001 (a)	09/01/2019	Reframe the paediatric transition risk relating to income	SW	06-Mar-19	Reframed on the current version of the Board Assurance Framework	
ROHTBACT. 069	Chairman's & Chief Executive's update	ROHTB (1/19) 002 ROHTB (1/19) 002 (a)	09/01/2019	Present the draft financial and operational plan at the March 2019 meeting of the Trust Board	SW	06-Mar-19	Included on the agenda of the March private session	
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	Clinical audit discussed together with consent at the January meeting of the Audit Committee	
ROHTBACT. 070	Update from the Freedom to Speak Up Guardian	Presentation	09/01/2019	Arrange for a detailed report on the FTSU concerns to be presented to the Quality & Safety committee	SGL	29-May-19	ACTION NOT YET DUE	

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:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6 March 2019**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at February 2019.

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

Two risks are prosed for de-escalation from the BAF:-

- 293 – Risks relates to the achievement of financial surplus
- CO1 – Lack of a Cancer operational tracking system

Both were recently de-escalated from CRR after recent review at Exec Team meeting

The following risk has seen a reduction in its current mitigated score:-

- CO2 – reduced from 9 to 6

The following risk has seen an increase in its current mitigated score:-

- WF1 – increased from 20 to 16

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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

REPORT RECOMMENDATION:

Trust Board is asked to:

- Review the Board Assurance Framework
- Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- APPROVE the proposed changes to the Board Assurance Framework

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

Note and accept	Approve the recommendation	Discuss
X	X	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:

Trust Board on 9 January 2019 and Audit Committee on 25 January 2019.

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 Planning permission approved for theatre expansion	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	4	20	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. A further medium term financial plan will be required for submission by NHSI during 2019/20.	Dec-19	3	4	12
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	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	FPC reports; Board approval for cash borrowing; Finance & Performance overview	3	4	12	↔	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	2	3	6
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. NHSI/E continued oversight of system response Regular briefings to CQC and oversight of actions being taken BWCH senior nursing staff supporting weekly oversight of staffing and associated quality levels	Minutes of stakeholder oversight meeting	4	4	16	↔	Joint work continuing to support transfer of services from July 19, at which point risk will be mitigated	Jul-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 trajectory to deliver 92% performance is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for January is 84.86 % with only 10 patients (Excluding spinal deformity)over 40 weeks , however plans are in place to meet trust forecasted position for delivery of 92% in February 2019 for Arthroplasty , Spinal, Paediatrics , Foot and ankle , Hands and CSS . A revised trajectory has been developed for the delivery of 92% in all specialties. Additional capacity is planned for the YAH service commencing in February 2019 with a refreshed demand and capacity plan for spinal deformity incorporating the impact of any delay in transition of Paediatric inpatient services . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway.	Ongoing	3	4	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	5	3	15	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Water Safety Group minutes presented to IPC Group meeting.	2	3	6	↔	Water safety plan is in development.	Aug-19	1	5	5
WF2	WFOD	Paul Athey	Failure to identify future workforce models which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment		Highly motivated, skilled and inspiring colleagues	SE & OD Committee	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	3	4	12	↔	Workforce design to become an integral part of HR Business Partner discussions. Middle grade workforce group is meeting to develop model.	Jan-21	2	4	8

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	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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs	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	In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All patients monitored at weekly PTL - plans in place for all patients over 40 weeks Full RCA and harm review for all patients over 52 weeks presented monthly at harm review board. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.	Weekly updates to Exec Team; updates to Trust Board.	3	4	12	↔	A revised trajectory was submitted to NHSI/E (19/2/19). Work is still ongoing with the aim to clear all patients by the end of March 2019.	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. Junior Fellow posts have been re advertised with a revised 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 . The draft Job Description for the alternative medical workforce has been agreed . A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator commenced in December 2018 and is now focusing on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is now being monitored by the CSMS and reported to a monthly meeting to monitor spend, chaired by the deputy COO.	Ongoing	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	↔	Risk remains unchanged with Trust waiting for planning permission decision regarding theatre expansion.	Ongoing	1	5	5
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	2	3	6	↓	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 .All project are managed via Perfecting Pathway framework and all project current on trace. Feb 19 - Good progress has been made with all the projects and a monthly tracking system is in place and reporting through F&P Committee	Q4 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 support 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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 continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. 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 function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	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	↔	An information analyst has been recruited and is due to start at the trust early 2019 . The recruitment of the Business Intelligence Systems Manager had been delayed due to budget issues, but the post will now go to advert early 2019.	Q4 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 ratified -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	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	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. Full transition plan now in place with BWCH	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Clinical review of proposed Oncology strategy is still outstanding. If the outcome of this is positive, this will support the alignment of the strategy across all providers	Jul-19	2	3	6
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	Risk remains unchanged. CYPHDU is staffed 24/7 with a minimum of 1 RNC and 1 RN with HDU paediatric competencies. Weekly meeting held with the Senior Sister and Matron, HON and chaired by the executive Director of Nursing & Clinical Governance. This meeting review staffing across CYP HDU, adult HDU and ward 11. Staffing and vacancy position discussed at HDU Management Meeting and included in the Divisional Condition Report to Division 2 DMB and CQG. Block booked agency staff to support service provision.	Q&S Report	3	4	12	↔	Ongoing recruitment programme. Bespoke adverts for HDU to try new approach to recruitment to attract candidates. Open days also being planned for early 2019.	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. Further support and oversight provided by BWCH and a further weekly meeting instigated from February 2019. Operationally the service has been reviewed and bed capacity reduced to 12 beds to support staffing requirements – Operational SOP being drafted to support measures put in place. Rostering reviewed and CYPHDU/Ward 11 amalgamated to provide further oversight and support both areas. Scheduling tool developed to provide better oversight of activity booked for both areas.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	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 Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	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	↔	Continued oversight by NHSI/E & CQC	Jul-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 has received transitional funding during 2018/19 to support the additional costs of paediatric provision.	Q4 2018/19	1	4	4
MD1	Clinical	Matthew Revell	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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
5799	Strat	Phil Begg	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	Work is underway to develop the strategy for 2019/20 to 2023/24 and beyond. A workshop was held for the Board on 6 February 2019 at which the Board was presented with the proposed routes for enagement with the stratgey for staff, stakeholders and the public.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case; slides from strategy session for the Board on 6/3/19	2	3	6	↔	A strategy working group will be established to specifically focus on: - How we engage with all teams in the development of the new strategy - How we share key headlines from this year's annual plans - What we think the key elements of the strategy need to be - How we align all Trust plans/strategies to this document	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	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. Implementation of HealthAssure system will provide additional technological functionality to strengthen core governance systems.	Q1 2019/20	1	3	3
1298	**Finance & Performance**	**Steve Washbourne**	**There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:**		**Safe, efficient processes that are patient-centred**	**Finance & Performance Committee**	**4**	**4**	**16**	**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. 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.**		**4**	**4**	**16**	↔	**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. 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**	**2**	**4**	**8**

FP4	Finance & Performance	Steve Washbourne	There is a risk that the full quantum of cost saving as outlined in the 2018/19 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Managed service for theatres due to be delivered by financial year end which is a significant scheme in the overall programme.		4	4	16	NEW RISK	Continued identification of new opportunities for cost saving and income generation.	Mar-19	3	4	12
FP5	Finance & Performance	Steve Washbourne	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.		4	4	16	NEW RISK	Planning application due to be considered by Birmingham City Council in February 2019.	Oct-19	3	4	12
FP6	Finance & Performance	Steve Washbourne	There is a risk that the Financial Control Total will not be met in 2018/19		Safe and efficient processes that are patient-centred	Finance & Performance Committee	3	4	12	The 2018/19 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery. Clinical Audit day has been cancelled in February to allow more work to be undertaken. Revised activity plan distributed which identities performance levels required for recovery.		3	3	9	NEW RISK	Further focus in March to deliver increased activity.	Oct-19	3	3	9

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

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 March 2019**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

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

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

Note and accept	Approve the recommendation	Discuss
x		x

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (3/19) 002 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 6th March 2019

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 9th January 2019.

2 STP UPDATE

2.1 The last STP Board meeting, prior to the finalisation of this report, took place on 7th January 2019. There was no Board meeting in February

2.2 At the January meeting, the Board members received a presentation from colleagues at the University of Birmingham (UOB) who have been commissioned to undertake an evidence review of the STP strategy. The aim of the review is to identify proposed actions that are supported by a strong evidence base and those where the evidence base would suggest that elements should be re-considered.

2.3 The evidence review to date has considered over 600 publications but, due to the volume of evidence to consider, the Board were asked whether UoB should prioritise an in-depth review of a small number of specific interventions or to provide a broader overview across a wider range of areas.

2.4 The former option was generally supported however UoB were asked to complete a brief overview of the full strategy in order to inform which areas would benefit from more in-depth work.

2.5 The Board also received an update paper on the NHSE/I feedback from the STP Estates strategy, which was only rated as Fair. The overall assessment of the strategy was that it "highlights all the key priorities for the STP but could be more concise and evidence the governance and reporting arrangements in an easier format". Specific recommendations were included around:

- Strengthening stakeholder engagement
- Reviewing and/or clarifying governance arrangements and prioritisation processes

- Greater links to the Carter metrics and clarity on plans to address backlog maintenance
- Developing more detail on impacts of back-office rationalisation and digital transformation

2.6 The next STP Board meeting is taking place on 4th March and a verbal update will be provided at the Trust Board on 6th March.

2.7 In the absence of the STP Board in February, the STP CEOs met and reviewed the following areas:

- The NHS Long Term plan and it's alignment with the STP strategy
- Resource planning for 2019/20
- An update on the CCG deep dive review into learning from deaths & mortality
- Brexit Planning

3 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

3.1 The BHA Board met for the second time on 12th February 2019, with the majority of the meeting set aside for work on aligning the strategies of each of the three member Trusts.

3.2 Each Trust presented their current strategic vision and objectives, which informed a wider discussion on BHA strategic priorities. It was felt that early work on aligning and progressing priority enablers such as digital, estates and workforce should be high on the BHA agenda.

3.3 In addition to this discussion, the Board also received a presentation on the alignment work currently underway between UHB and BWCH within Gynaecology services and also formally approved the Birmingham Hospital Alliance Memorandum of Understanding

4 MEDICAL DIRECTOR APPOINTMENT

4.1 Following Andrew Pearson's decision to stand down from the role of Medical Director, I can formally confirm that Matthew Revell has been appointed into the role. Due to the work described in section 5 below, Matthew's transition into the role has been accelerated and he formally started as Medical Director on 18th February 2019.

5 ORTHOPAEDICS IN BIRMINGHAM AND SOLIHULL

5.1 The ROH has been working closely with colleagues at UHB to help improve orthopaedic services across Birmingham and Solihull. Prior to returning to a full time

clinical role, we are grateful that Andrew Pearson has agreed to support a programme of work across Heartlands, Good Hope and Solihull hospitals ('HGS') that will review the productivity of elective orthopaedic services at HGS, align clinical pathways across the city and ensure an equitable provision of support services. The overall aim of the programme to is ensure that all orthopaedic care across Birmingham and Solihull is delivered to the same clinical and operational standards.

6 STAFF SURVEY

6.1 Our 2018 national staff survey results were published on 26th February 2019 and show significant improvement across a range of areas.

6.2 41% of ROH staff completed the survey, with scores improving in over 75% of the individual questions. The improvement included key areas such as:

- Relationship between senior management and staff
- Enthusiasm with your role
- Treatment of staff reporting incidents
- Support from immediate managers
- Appraisals – regularity & effectiveness
- Standards of care

6.3 The improvements in 2018 now mean that the ROH compares favourably in the majority of areas when compared to our peer group of specialist acute hospitals, and very favourably when compared to other local providers.

7 STAFF AWARDS

7.1 On 8th February 2019, the Trust held our 2019 "Leading Lights" Staff Awards at the Botanical Gardens.

7.2 21 awards were presented with around 200 members of staff and patients attending. The ceremony has received very positive feedback from those who attended and thanks should be recorded to the Learning & Development and Communication teams who ensured the evening was such a success.

8 JOINTCARE FORMAL LAUNCH & MEDIA COVERAGE

8.1 The Trust formally launched our JointCare programme in February, following three months of "soft" rollout since November 2018. In addition to increasing communication with local GPs and stakeholders, we were also pleased that BBC Midlands Today included a feature on the programme on 11th February.

8.2 The JointCare portal is now available through the ROH website, including videos and animations outlining what patients can expect and the benefits of following the JointCare Programme.

9 POLICY APPROVAL

9.1 The Chief Executive, on the advice of the Executive Team has approved the following policies since the Trust Board last sat:

- Supported mealtime and use of red tray policy
- Hand hygiene policy
- Carbapenemase producing enterobateriaceae (CPE) policy
- Carers' 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
6th March 2019

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:	**Janet Davies, Clinical Service Manager / Project Lead for the Paediatric Transition**
DATE OF MEETING:	**6 March 2019**

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:

- An update regarding the revised timeline for the transfer of Paediatric Services to BWC (1st July 2019)
- Details agreed for the Oncology Quality Assurance Evaluation
- Governance infrastructure supporting transition
- Main risks
- Communication with stakeholders

REPORT RECOMMENDATION:

The Board is asked to accept 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		Communications & Media	x
Business and market share	x	Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services.

PREVIOUS CONSIDERATION:

Last considered as part of the Trust Board public agenda in January 2019

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Paediatric Service Update – March 2019

UPDATE TO THE TRUST BOARD ON 6 MARCH 2019

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:

- Transfer date 1st July 2019
- BWC Theatre Trajectory
- Oncology Quality Assurance Evaluation
- Revised timeline for the service transfer to BWC
- Governance infrastructure supporting transition
- Main risks
- Communication with stakeholders

2 Transition of Service

Both Trusts remain committed to securing the safe and timely transition of services to the BWC site and are working closely with NHS Improvement (NHSI) and NHS England (NHSE). BWC have confirmed at their February Board that they are committed to working towards the 1st July 2019 as the new transition date.

The following remain the crucial factors in transitioning the Paediatric services on the 1st July 2019

- BWC recruiting sufficient numbers of theatre staff to support the additional activity
- BWC undertaking an External Oncology Quality Assurance Evaluation (as this is not a service they currently provide)

BWC are on track with their trajectory for staffing recruitment having recruited 5 new theatre staff. The oversight meeting will continue to review their progress with theatre staff recruitment.

The Oncology Quality Assurance Evaluation has been planned for the 11th and 12th March 2019 and will include representation from NHSE and both Trusts presenting the proposed pathway.

BWC have recruited Professor Ian Lewis to lead the evaluation. He is a Paediatric Oncologist by background; he was previously Medical Director at Alderhay Children's Hospital and currently Non-Executive Director at Leeds Community Healthcare NHS Trust.

BWC have asked Prof Lewis to present the report at their next Quality Committee. ROH will expect to see the report findings back by the end of March for the Oversight meeting in April 2019.

The main risks to the ROH as a result of the delay are the paediatric nursing staff levels on ward 11 and HDU and CQC regulatory inspection of these areas. Currently both nursing teams at ROH and BWC are working together and are providing assurance that the service will be retained on the ROH site until the revised transitional date. This risk has been downgraded as a result of the changes that have been implemented but continues to be monitored weekly at the Paediatric Transition meeting. The CQC together with NHSI and NHSE have been kept fully informed with the delay.

All other paediatric support has been extended included the paediatrician support from both BWC and UHB (Heartlands Hospital) which was originally in place to the end of January 2019 and the ongoing Associate Medical Director cover from BWC.

3 Revised timeline for service transfer to BWC

Both Trusts are working towards a new transition date of the 1st July 2019. The critical path has been adjusted for this new date for all services to be transitioned (including Oncology):

- BWC to submit staffing recruitment timeline NHSI and NHSE – Mid Jan 2019 / Feb oversight meeting to review the progress made with recruitment - completed.
- Update Stakeholders of delay, including ROH website – Jan 2019 - completed
- BWC - Additional nursing / theatre / admin staff recruited – ongoing
- Theatre and Ward refurbishment Jan 2019 (on track)
- IT Pathways to be agreed – March 2019
- Post-transition clinical pathways signed off –March 2019 (excluding Oncology)
- Job plans signed off –April 2019
- Oncology Quality Assurance Quality Assurance Evaluation completion –11th / 12th March 2019
- Update from BWC Board to review finding of above - Feb 2019 – delayed until evaluation has been complete
- HR TUPE Transfer – April 2019
- The revised project plan is working to a new revised time line for all services to transfer to BWC of 1st July 2019 (excluding Oncology other specialties could be brought forward depending on BWC recruitment)

4 Governance

There remains a strong governance structure to oversee the process of transferring the paediatric inpatient & day case surgery service:

The Strategic Oversight Group Meeting co-chaired by Non-Executive Directors Kathryn Sallah (ROH) and Alan Edwards (BWC) continues to meet monthly with oversight by NHS England and NHSI to ensure the milestones for the transition are delivered. This also ensures system wide support and ownership for the transition of the service and a framework to support provider escalation should any of the critical milestones fail to be delivered.

5 Risks

ROH & BWC have developed a joint risk register to record, assess & monitor the risks associated with this complex service transition.

The risks can be summarised as follows:

- Risk of insufficient theatre staff numbers recruited to at BWC
- Unknown recommendations following the Oncology assurance evaluation
- Unknown CQC inspection at ROH

All of the above may result in further delays or cessation of services in the region. As discussed in the paper there is a focus on managing & militating against these risks through the governance structure outlined in section 4.

6. Communications

Key to the process continues to be our communication with stakeholders, therefore we will ensure that we remain focused on providing support to those staff impacted by the transition of service and ensure we engage with patients, families and stakeholders with key information about the service transition**.** The COST Campaign submitted additional questions to the Trust following the original transitional date delay. These questions have been answered by both Trusts and the reply was sent on the 22nd Feb 2019.

Authors: Janet Davies Clinical Service Manager / Project Lead for the Paediatric transition
1st March 2019

ROHTB (3/19) 004

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 30 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that the national shortage of Hepatitis B vaccinations had been resolved and staff needing these would be identified and recalled by Occupational Health. • There remained vacancies in the clinical governance team, however these were to be addressed shortly as staff took up post. • The update of the 'flu vaccine was reported to be below that of the previous year, which has an impact on the achievement of the CQUIN targets. • The Committee was concerned to learn that there was at present no dedicated named doctor for paediatric safeguarding. Cover was at present provided from elsewhere in the region. It was agreed that this issue needed to be resolved as a matter of priority. • It was reported that there were difficulties with ensuring that required staff attended the patient handling training; a new four day session was being arranged and could link into the clinical audit session.	• Include a discussion around the clinical risk associated with the paediatric transfer to the agenda of the next meeting. • Present a further update on the implementation of the HealthAssure system at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• An update on the time to recruit issue was received, which had been discussed at the Staff Experience & OD Committee meeting – this was to be a Key Performance Indicator which would be monitored through the workforce dashboard and would be of focus for the new Associate Director of HR, Workforce & OD. • An update on the transfer of the Pathology service was presented; the service would move to University Hospitals Birmingham on 1 April 2019. • The number of overall incidents had reported was noted to have reduced. • The number of patients waiting 52 weeks or over was noted to have reduced to 11.	• The Committee approved the Patient Experience and Engagement Group's terms of reference. • The Committee received and approved the revised terms of reference for the medico-legal forum.

• There was reported to be a plan to reduce the number of 'Did Not Attend' instances. • The contract performance notice associated with the 18 weeks Referral to Treatment Time target performance was noted to have been lifted. • A positive assurance report on the work of the Accountable Officer for Controlled Drugs was received, which highlighted that the scrutiny and governance around the management of Controlled Drugs was sound. • The Committee received a draft version of the Patient Experience strategy which include an approach to volunteering. • The Clinical Quality Group was noted to be working effectively and there was good representation across operations and clinical staff groups. • The Committee received some good assurance as to the effectiveness of the safeguarding team in handling more complex and numerous cases. • The effectiveness of the Health & Safety Committee was reported to have improved and this was now being chaired by the Executive Director of Strategy & Delivery. • It was reported that an audit of ligature points was planned, with support from the local Mental Health trust. • It was reported that at present there were no significant clinical risks to mitigate in relation to Brexit.	

Chair's comments on the effectiveness of the meeting: It was agreed that the meeting was effective and there were some good pieces of assurance, particularly around the safeguarding team and Controlled Drugs.

ROHTB (3/19) 005

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 27 February 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There remained some concern over the difficulties with understanding the size of the cohort of individuals who needed to receive the Hepatitis B inoculation. The matter was being escalated to those with overall responsibility for the provision of Hepatitis B vaccinations. • The Committee was advised that there had been two moderate harm incidents reported, including a potential Grade 3 pressure ulcer, which needed to be verified. The other moderate harm concerned the loss of spinal monitoring during a procedure leading to the individual being transferred out of the Trust.	• Add a risk around Hepatitis B vaccinations to the workforce risk register • Water and hydration audit information is to be presented at the next meeting. • A narrative summary of the Trust's controls to prevent *C. difficile* cases is to be presented at the next meeting. • A demonstration of the Health Assure system is to be scheduled into a future meeting. • An update on Bone Infection is to be presented to the Trust Board at a future meeting. • The water safety action plan is to be transferred into the corporate template. • A further update on the implementation of national guidance in relation to VTE is to be provided at the next meeting. • The Board would be updated on PROMs at its next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was good assurance provided that the transition of paediatric service was running to schedule, with a proposed date of 1 July having been set for the movement of the service. Given the additional support from Birmingham Children's Hospital (BCH), the paediatric ward was running well. • The risk around staffing in the clinical governance team was noted to have been resolved, with new staff due to start on 1 April. • Length of stay was noted to have reduced considerably, although this had led to a shift in the time of discharge of some patients who were fit to go home on the day after surgery. • The number of patients waiting in excess of 52 weeks for treatment had reduced to 5 against a trajectory of 33. Every effort was being made to clear all cases by 31 March 2019.	• It was agreed that cancer patients waiting in excess of 104 days for treatment needed to be highlighted specifically to the Quality & Safety Committee which would upwardly report to the Trust Board on these.

• A positive presentation was delivered on the plans to develop the Bone Infection service, the plans being supported by the Clinical Commissioning Group. The plans would set the ROH up as a centre of excellent for this specialist service. • The Committee agreed that there was now greater assurance as to the Trust's water safety processes. • The role of the Drugs and Therapeutics Committee in reviewing the protocols for JointCare was agreed to be positive.	

Chair's comments on the effectiveness of the meeting: It was agreed that the quality and organisation of the papers relating to the Drugs and Therapeutics Committee needed to be more fit for purpose. Although two Non Executive members of the Committee had tendered their apologies, the Chairman joined the meeting therefore the level of challenge and discussion remained robust.

ROHTB (3/19) 006

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

February 2019

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.

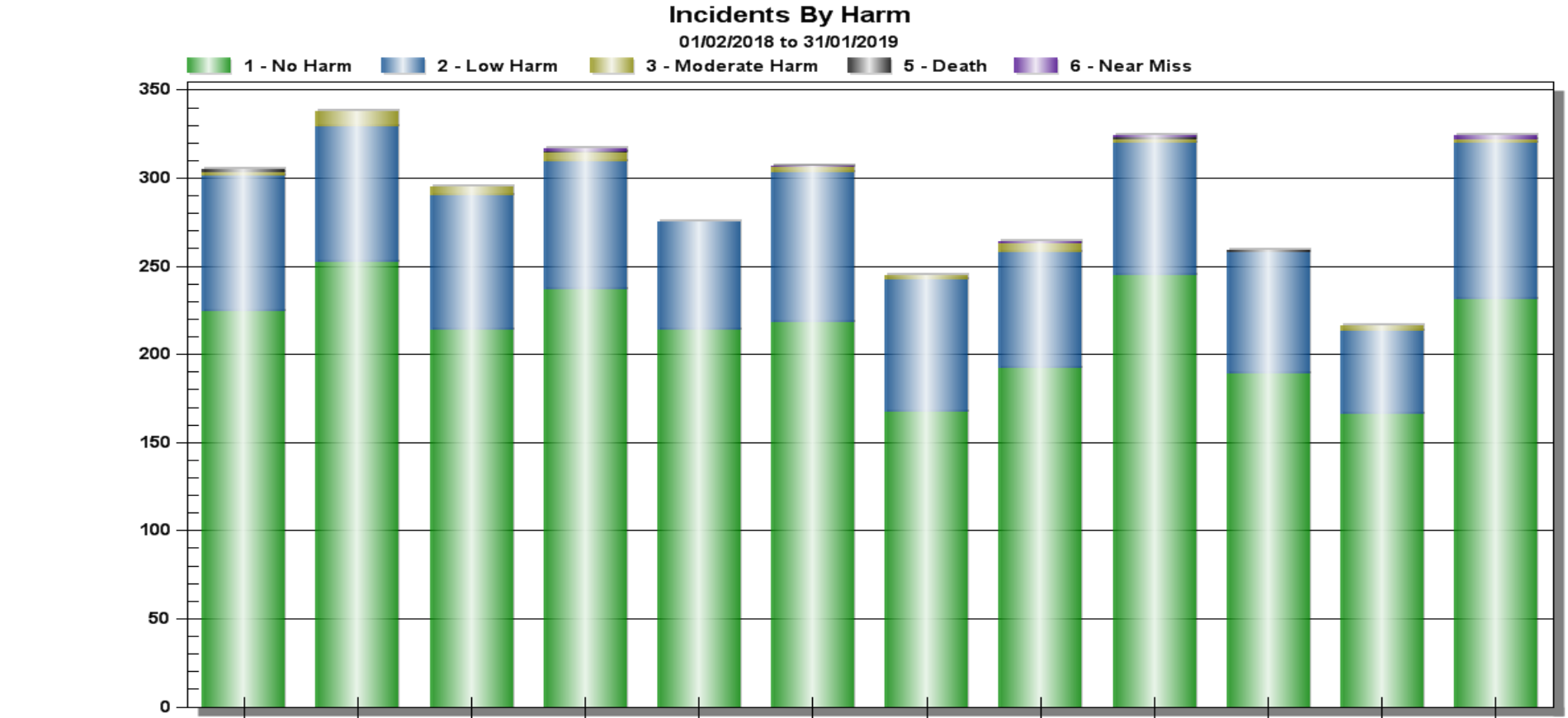
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019
1 - No Harm	224	252	214	237	214	218	167	192	245	189	166	231
2 - Low Harm	77	77	76	72	61	85	75	66	75	69	47	89
3 - Moderate Harm	2	9	5	5	0	3	3	5	2	0	3	2
5 - Death	2	0	0	1	0	0	0	0	1	1	0	0
6 - Near Miss	0	0	0	2	0	1	0	1	1	0	0	2

INFORMATION

In January 2019, there were a total of 324 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is as follows;

231 – No Harm
89 – Low Harm
2 – Moderate Harms
0 – Severe Harm
2 – Near Miss
0 – Death

In January 2019, there were a total of 9208 patient contacts. There were 324 incidents reported, which amounts to 3.5 per cent of the total patient contacts resulting in an incident. Of those 324 reported incidents, 50 incidents resulted in harm which is 0.98 per cent of the total patient contact.

ACTIONS FOR IMPROVEMENTS / LEARNING

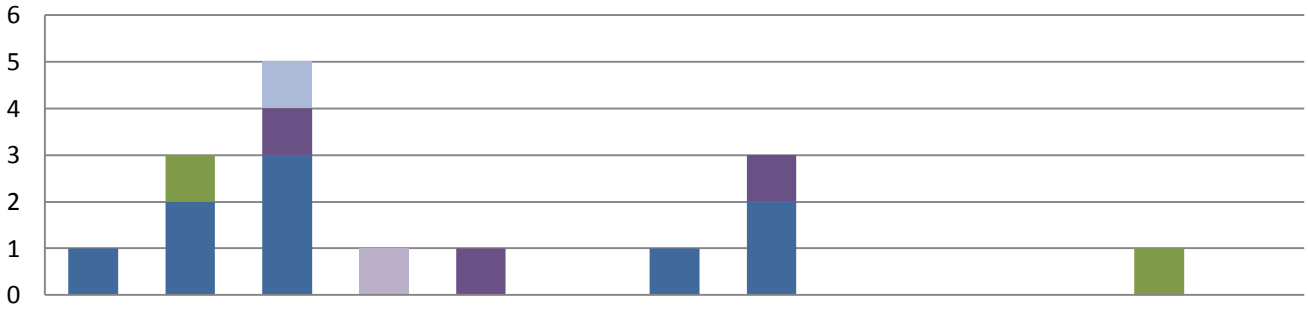
- Implementation of the Health Assure system – NICE and CAS systems to go live 1st February 2019.
- Work with communications underway to officially launch the learning from incident methodology and new incident reporting policy.
- Ulysses training package to be developed

RISKS / ISSUES

- Risk 265 - Engagement and adherence with staff around learning from incidents and never events.
- Risk 1193 - Staffing and capacity within the team with two vacancies (current risk score 12). 1 agreed start date for the Clinical Governance Facilitator post and 1 offer made to an apprentice to support the team.
- Risk 1194 - Lack of skill in the Trust on the Ulysses system (current risk score 12).

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 2019

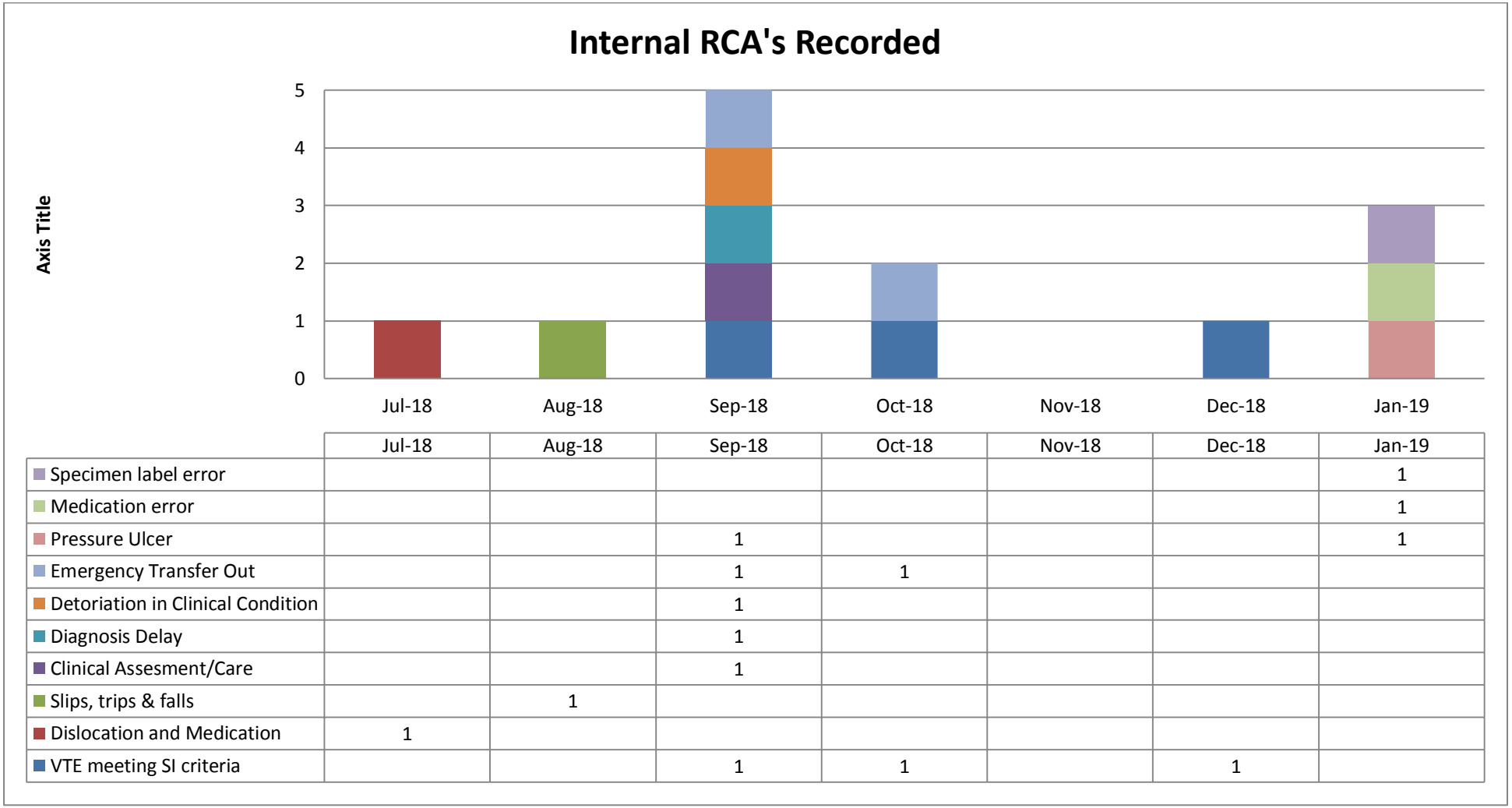


	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Transfer out				1									
Unexpected Injury													
RTT Harm review													
Information Governance Missing Laptop			1										
Retained object													
Wrong side injection													
Slips, trips & falls			1		1			1					
Pressure Ulcers		1										1	
VTE meeting SI criteria	1	2	3				1	2					

INFORMATION

No Serious Incidents were reported in January 2019; It has been agreed with the CCG that all avoidable VTEs will be declared as Serious Incidents. After investigation three VTEs previously declared were deemed as avoidable. These have now been declared with the commissioners as serious incidents.
ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incidents was closed in January 2019. T
RISKS / ISSUES
None

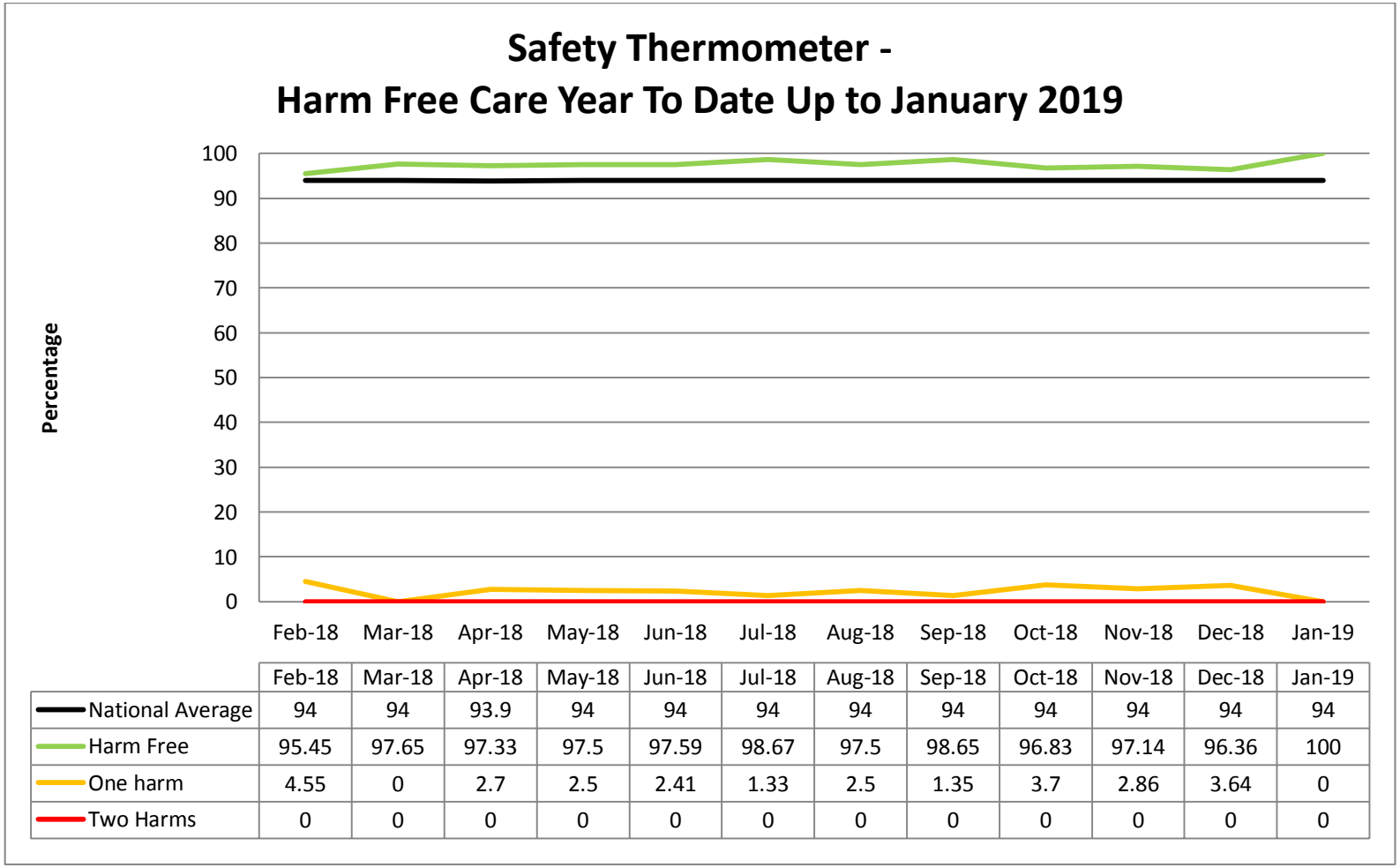
4. Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision that a heightened level of response is needed for these incidents.



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Specimen label error							1
Medication error							1
Pressure Ulcer			1				1
Emergency Transfer Out			1	1			
Detoriation in Clinical Condition			1				
Diagnosis Delay			1				
Clinical Assesment/Care			1				
Slips, trips & falls		1					
Dislocation and Medication	1						
VTE meeting SI criteria			1	1		1	

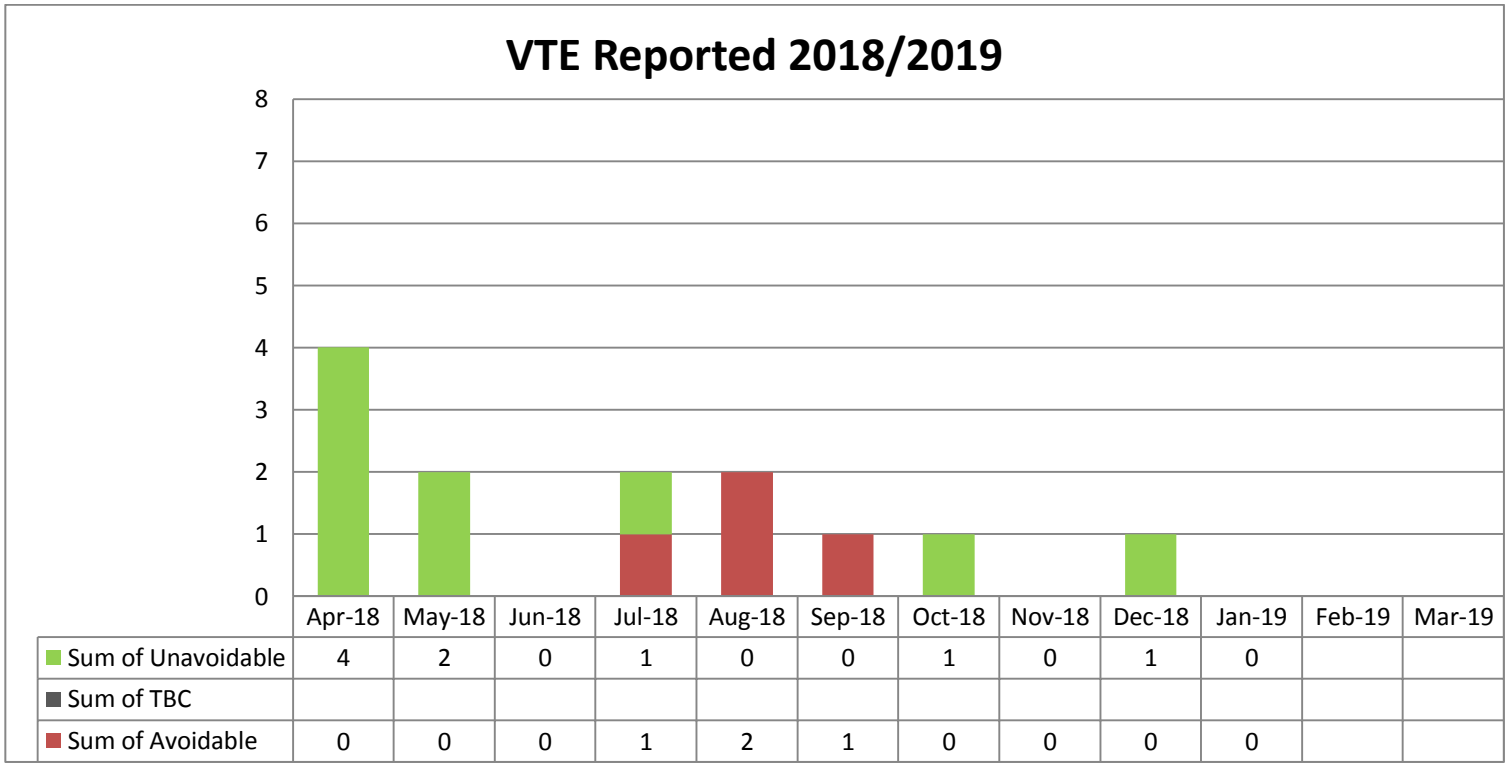
INFORMATION
Three incidents reported in Janaury 2019 2018 will be undertaken as an internal RCA. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.
ACTIONS FOR IMPROVEMENTS / LEARNING
No RCAs were closed in January 2019
RISKS / ISSUES
None

5. **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-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
National Average	94	94	93.9	94	94	94	94	94	94	94	94	94
Harm Free	95.45	97.65	97.33	97.5	97.59	98.67	97.5	98.65	96.83	97.14	96.36	100
One harm	4.55	0	2.7	2.5	2.41	1.33	2.5	1.35	3.7	2.86	3.64	0
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

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).**

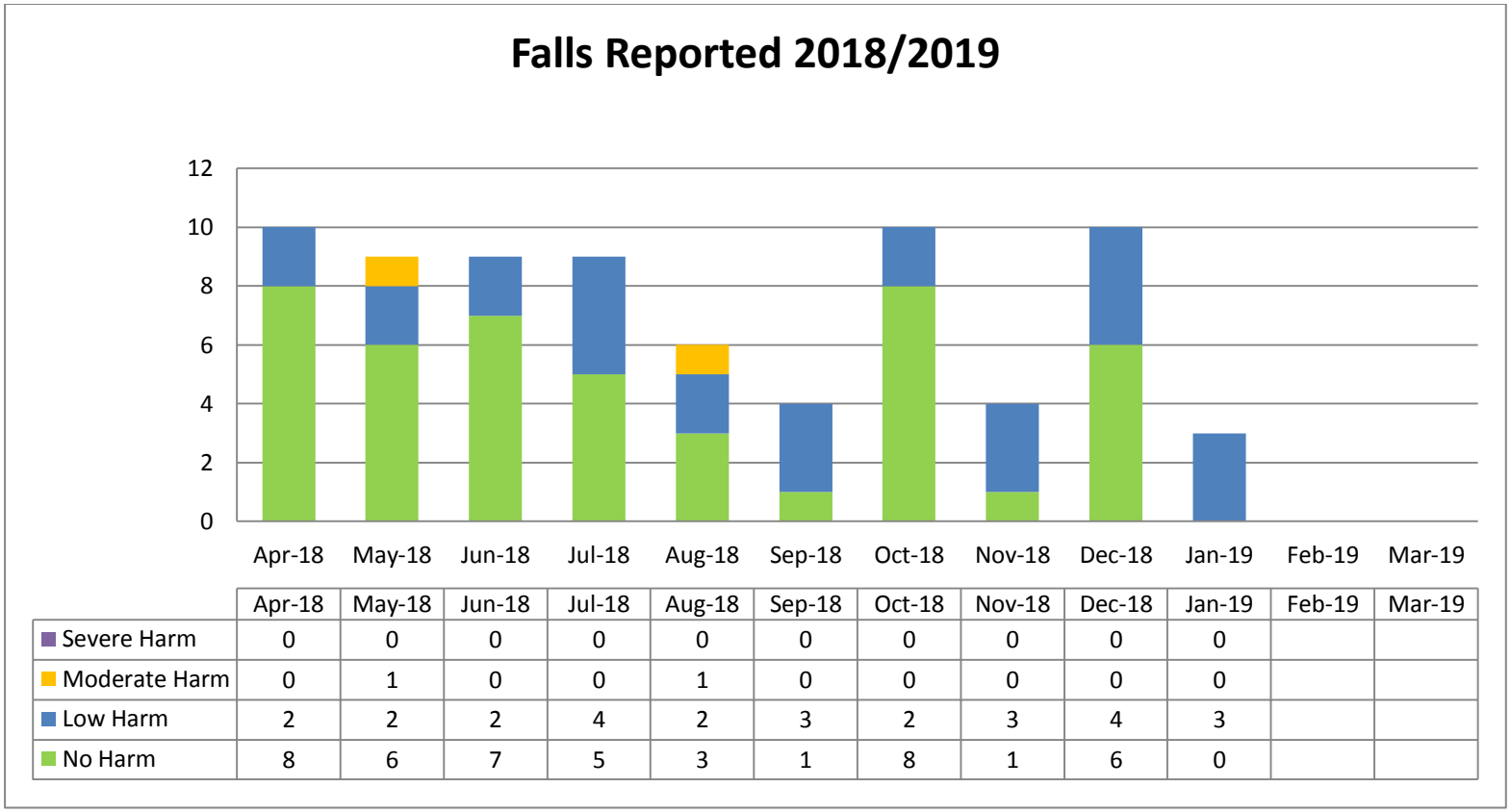


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	4	2	0	1	0	0	1	0	1	0		
Sum of TBC												
Sum of Avoidable	0	0	0	1	2	1	0	0	0	0		

total		Avoidable
17/18	33	10
18/19	13	4

INFORMATION
There was no VTE incidents reported in January 2019. This is compared to the 1 reported in January 2018. All avoidable VTEs are now reportable again to the CCG. Themes in those deemed avoidable to date are BMI >30, omitted enoxaparin dose post-operative, lack of documented 24 hour re-assessment. Action plans are in place for all. Due to the on-going national shortage of the Clexane brand of Enoxaparin Sodium the Trust has changed to the brand Inhixa. This has been n uneventful change over.
ACTIONS FOR IMPROVEMENTS / LEARNING
NICE VTE Prevention Guidance –Updated March 2018 We continue to follow previous NICE VTE prevention guidance, in line with many other Trusts. There is no risk to patients as a result of continuing to follow 2010 guidance until a consensus decision is reached regarding how/if this is adopted. VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement 95%): This continues to exceed the minimum requirement. This is being scrutinised by the VTE lead monthly as now this is a mandatory field within PICS we should achieve 100% compliance. 24 hours re-assessment compliance is now available via IMT reporting. This has been requested monthly and will be scrutinised by the VTE Lead until compliance is 100%, as this is a mandatory field. = January : 89.5%
RISKS / ISSUES
National shortage of Sequential Compression Device sleeves-being closely monitored by Theatre Leads.

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.**

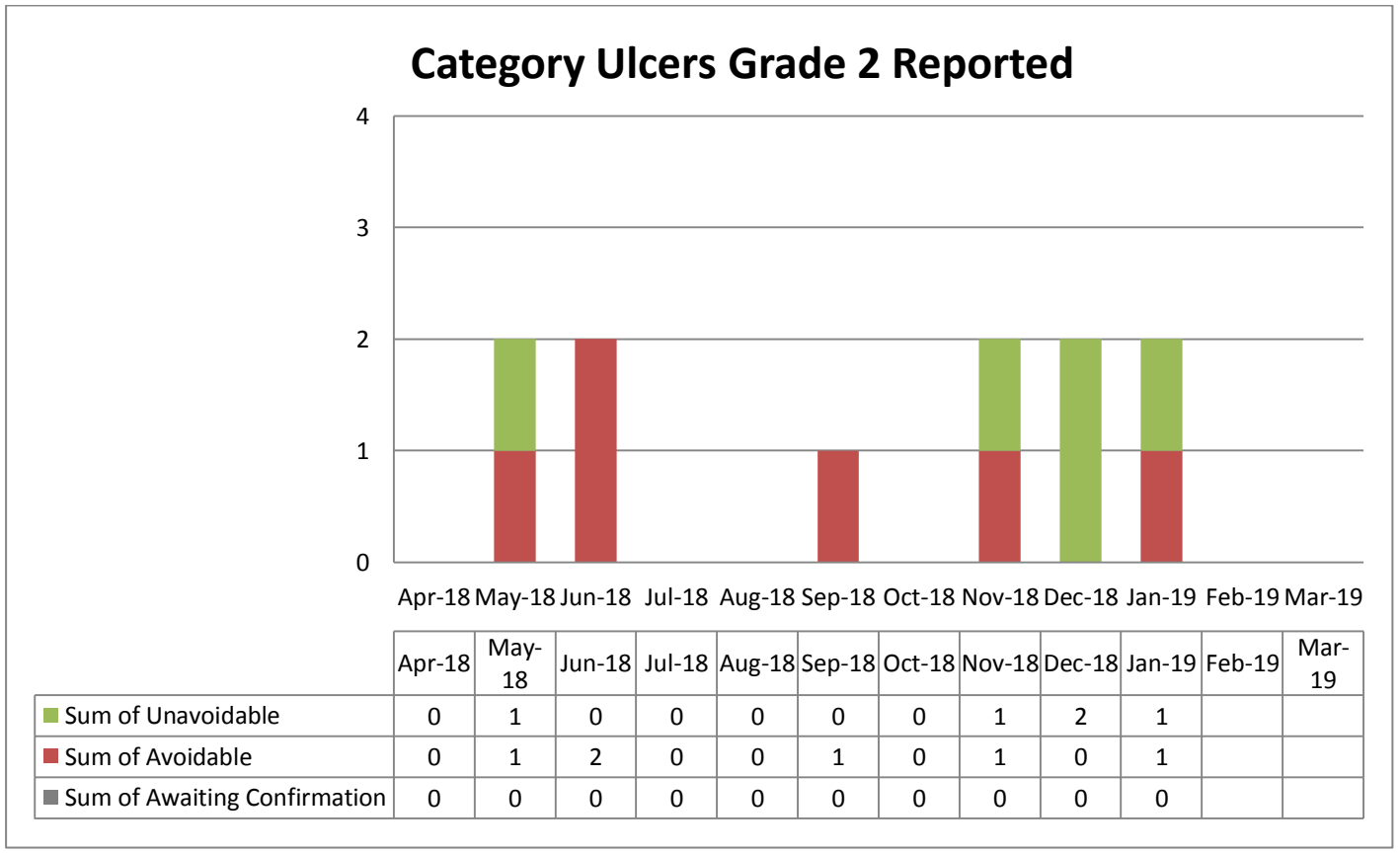


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Severe Harm	0	0	0	0	0	0	0	0	0	0		
Moderate Harm	0	1	0	0	1	0	0	0	0	0		
Low Harm	2	2	2	4	2	3	2	3	4	3		
No Harm	8	6	7	5	3	1	8	1	6	0		

total	
17/18	125
18/19	74

INFORMATION
There were 3 patient fall-related incidents reported across the Trust in January all were related to adult patients. 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 a bi monthly upward report and the Divisional Condition reports. They 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
• Falls working group now reviewing and scrutinizing all incidents and management actions. Incidents then either closed by group or additional information requested • New falls lead identified Alison Woodbridge – deputy head of therapy services from 31.12.18 • Falls risk register reviewed and updated by group • Discussed management of falls incidents at Ward Managers meeting on 3.12.18 • Falls training continues on clinical skills update day for qualified and unqualified staff
RISKS / ISSUES
• Sara Steady training now taught on patient handling but due to 2 year rolling programme, retained on risk register • Management of falls incidents found to be variable and lacking detail • Medical review following a fall template not being utilised by medical colleagues effectively.

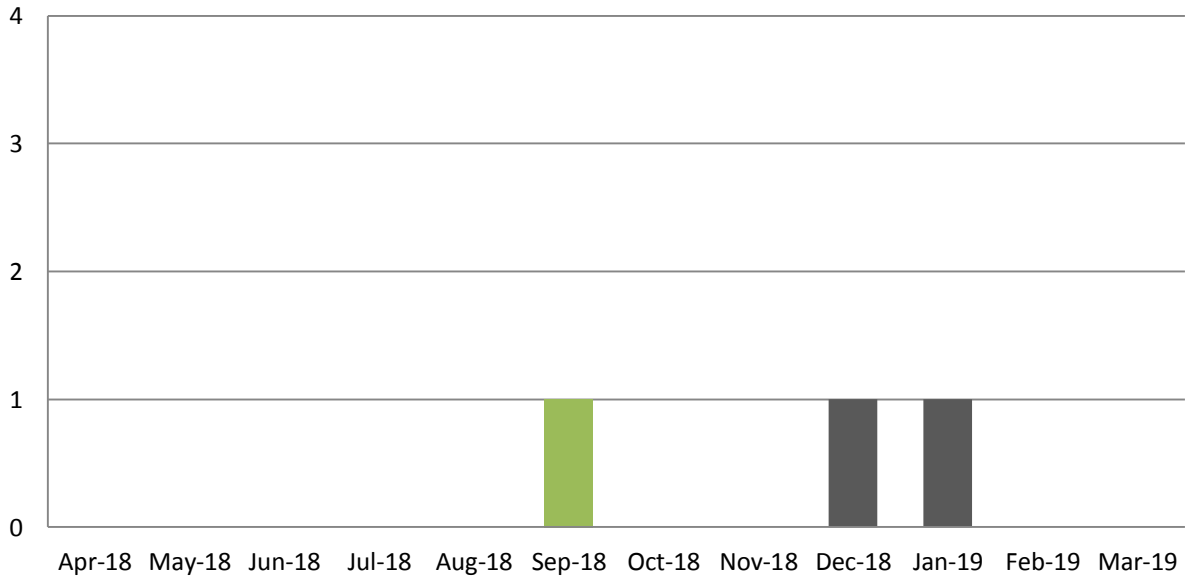
8. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open 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	0	1	2	1		
Sum of Avoidable	0	1	2	0	0	1	0	1	0	1		
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0		

total	Avoidable
17/18	6
18/19	6

Category 3 and 4 Pressure Ulcers Reported



	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	0	0	0	1	1		
Unavoidable G4	0	0	0	0	0	0	0	0	0	0		
Unavoidable G3	0	0	0	0	0	1	0	0	0	0		
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0		
Grade 3 (Avoidable)	0	0	0	0	0	0	0	0	0	0		

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	0
	G4	0

INFORMATION

In January 2019, there were three pressure ulcers recorded. This compares to the two Category 3's reported in January 2018.

January 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	X 1 Avoidable Ward 1 – 26309
Category – 2 (Device)	X 1 Unavoidable – Ward 1 – 26275
Category – 1	0
Suspected Deep Tissue Injury	A Category 3 Pressure Ulcer –Query Avoidable.
Moisture Associated Skin Damage (MASD)	0
Patients admitted with PU's	Category 1 x 5 (1 = MDRPU) Category 2 x1 St Michaels Hospice Category 3 x2 One - Alexandra Hospital (WHAT) and One - Pt's own home Number of patients with moisture associated skin damage (MASD) x 0

Avoidable Pressure Ulcer CCG Contracts KPI

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	5
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2017/2018:

2017/2018	
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

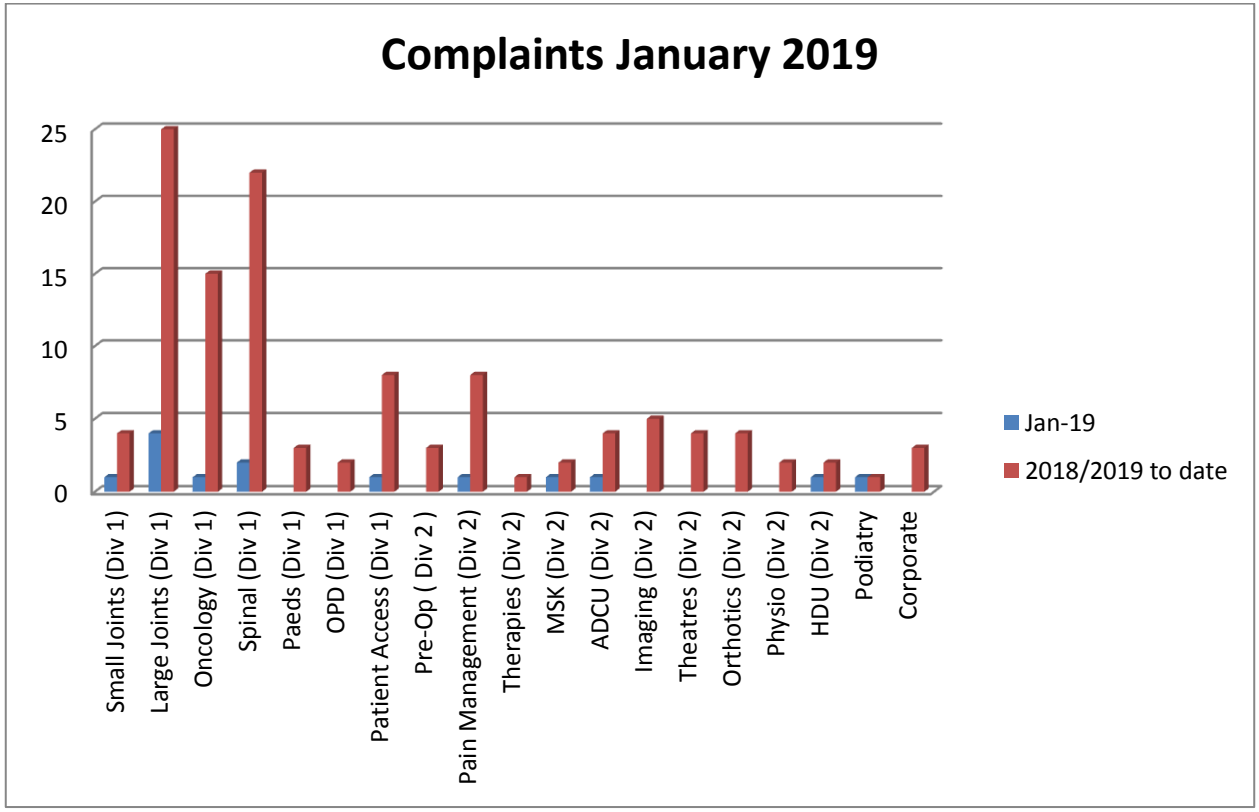
Current Actions

- Plaster of Paris (POP) care plan under review and will be amended to enable clearer and concise documentation.
- TV lead Nurse presented to the Clinical Quality Group Committee on 11/1/19The committee were re-assured that changes in practice and documentation are taking place regarding the care of patients with POPs and those wearing anti-embolic stockings. The new user-friendly documentation has been reviewed and will reflect the need for re-assessment.
- Gap analysis update re NHSI PU changes – only changes left to make are competency documents which are currently under review,
  Due to the new NHSI (2018) PU curriculum that has been distributed to Trusts.
- Gap analysis re NICE guidance reviewed Nov 2018 - ROH is compliant re all current standards of care. NICE recommend PU assessment within 6
  admission. Other Trusts 2-4 hours. ROH CQG committee agreed with the current 6 hours as per NICE guidance.

RISKS / ISSUES

None

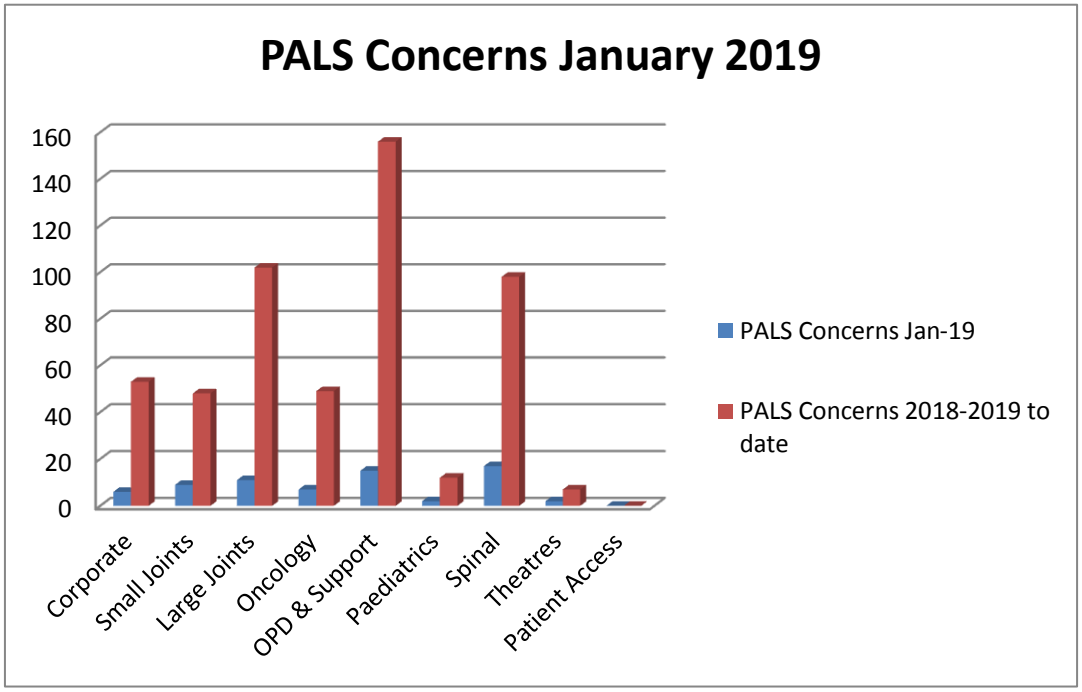
9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



INFORMATION

PALS

The PALS department handled 111 contacts during January 2019 of which 69 classified as concerns. This is a significant reduction in calls compared to the same time last year (420 contacts in January 2018) and a reduction in the level of concerns (83 concerns in January 2018). The main themes in the PALS data relate to queries about appointments; either length of wait for or cancellations. 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. 95% of enquires and 87% of concerns were handled within the agreed timescales, meeting this internal KPI



Compliments

There were 313 compliments recorded in January 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments January 2019
Div. 1	270
Div. 2	42
Corporate	1

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 receive a request monthly to submit their compliments for central logging.

Complaints

There were 14 formal complaints made in January 2019, bringing the total number of complaint to 118 for the year to date. All were initially risk rated amber or yellow. This is less than last year (16 complaints in January 2018)

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

- Care on Ward - developed pressure sore at home (Div.1, Large Joints)
- Duty of candour not followed; catheter pulled out (Div.2, HDU)
- Delays to planned surgery (Div.1, Large Joints)
- Repeated cancellation of appointments (Div.1, Patient Access)
- Delay in surgery (Div.1, Spinal)

Initially Risk Rated Yellow:

- Unhappy with clinical decision (Div.2, Pain Management)
- Unhappy with consultation; staff attitude (Div.2, MSK)
- Unhappy with progression of treatment (Div.1, Oncology)
- Unhappy with treatment (Div.1, Large Joints)
- Care under podiatry/orthotics/ heel pain (Div.2, Podiatry)
- Approach of Consultant; treatment plan (Div.1, Spinal)
- Infection following partial knee replacement (Div.1, Large Joints)
- Outcome of bunion surgery (Div.1, Small Joints)
- Wait in ADCU for injection (Div.2, ADCU)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 13 complaints closed in January 2019, 12 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 January 2019 was 30 days, which is within normal limits.

Learning identified and actions taken as a result of complaints closed in January 2019 include:

- Trust did not have a SOP for the management of wound drains
  Action: SOP created and is currently being approved

- Number of issues identified on one ward requiring improvement
  Action: Ward action plan created, being monitored by the Matron and Head of Nursing

- Frist floor outpatient reception not open causes confusion for patients when told to report there
  Action: Recruitment underway; information updated

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS
1 comeback received in January 2019. • Patient does not accept clinical view as being correct. Has asked for further review (Div.1, Large Joints)

10. 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 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 agreed internal targets for all areas and as a result, the data is 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 requested 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 recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In January 2019, 17 concerns were identified from the 1553 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 main areas of concern in January 2019 related to Clinical Treatment and Values & Behaviour of Staff. Information is 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 of 20% for Outpatient services was met this month. 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 Jan 2019**	**% of people who would NOT recommend the department in Jan 2019**	**Number of Reviews submitted in Jan 2019 (previous month in brackets)**	**Number of Individuals who used the Department in Jan 2019**	**Department Completion Rate (Mandated at 35%)**
Ward 1	95.0%	1.4%	60 (73)	142	42.3%
Ward 2	98.4%	0.0%	64 (65)	130	49.2%
Ward 3	97.1%	5.9%	35 (17)	73	47.9%
Ward 12	93.9%	0.0%	33(25)	66	50.0%
Ward 11 (CYP)	100.0%	0.0%	17(60)	76	22.4%
ADCU	97.5%	0.0%	159(148)	557	28.5%
HDU	95.0%	0.0%	20(22)	88	22.7%
CYP HDU	100.0%	0.0%	2 (2)	10	20.0%
Overall Trust Inpatient Response Rate for January 2019					36.7%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Jan 2019**	**% of people who would NOT recommend the department in Jan 2019**	**Number of Reviews submitted in Jan 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.6%	0.8%	1141 (879)	21.7%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in Jan 2019**	**% of people who would NOT recommend the department in Jan 2019**	**Number of Reviews submitted in Jan 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	95.5%	4.5%	22 (39)	14.6%

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 January - 31 January

Your average score for all questions this period

1 2 3 4 5 **4.89**

Reviews this period

1553

Your recommend scores

5 Star Score

4.85

% Likely to recommend

95.9%

% Unlikely to recommend

0.6%

11. Duty of Candour – *The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.*

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. Litigation

New Claims

No new claims against the Trust were received in January 2019

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*

3 new requests for Pre-Application Disclosure of medical records were received in January 2019.

*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 were no Inquest held

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; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases =815 The total WHO compliance for Theatres January 2019 **= 100%** **CT area** Total cases = 94 The total WHO compliance for CT area January 2019 **= 100%** **ADCU** The total WHO compliance for ADCU area for January 2019 = **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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in January 2019 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	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

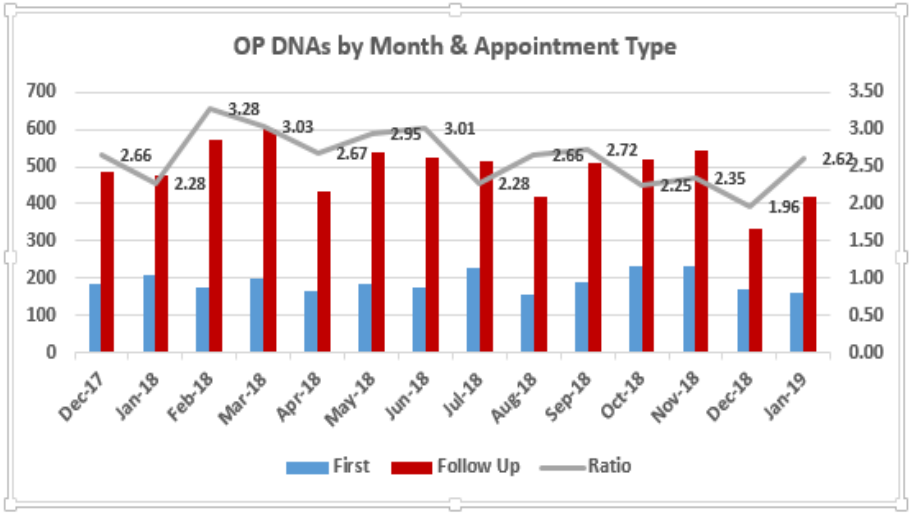
11 IP recorded incidents in January, 2019 (8 no harm, 3 low harm – all either under review or closed).

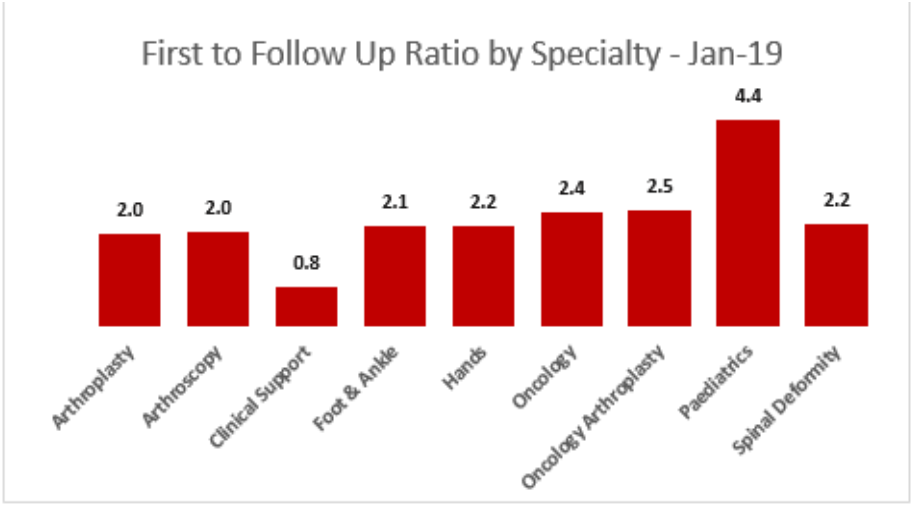
RISKS / ISSUES

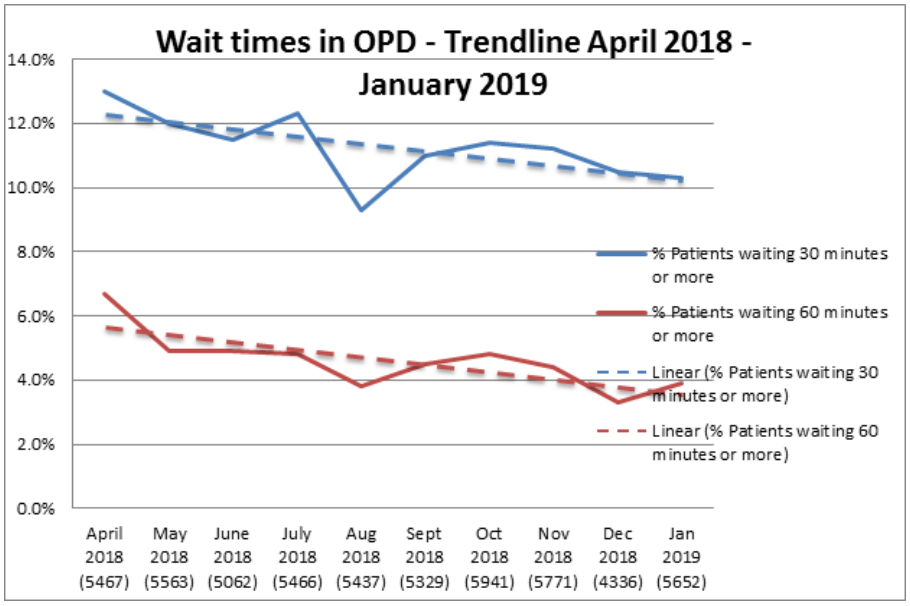
ROH is presently awaiting a position statement from Occupational Health regarding the re-calling of staff for Hepatitis B vaccinations. This is being lead by HR who manage the agreed service for ROH.

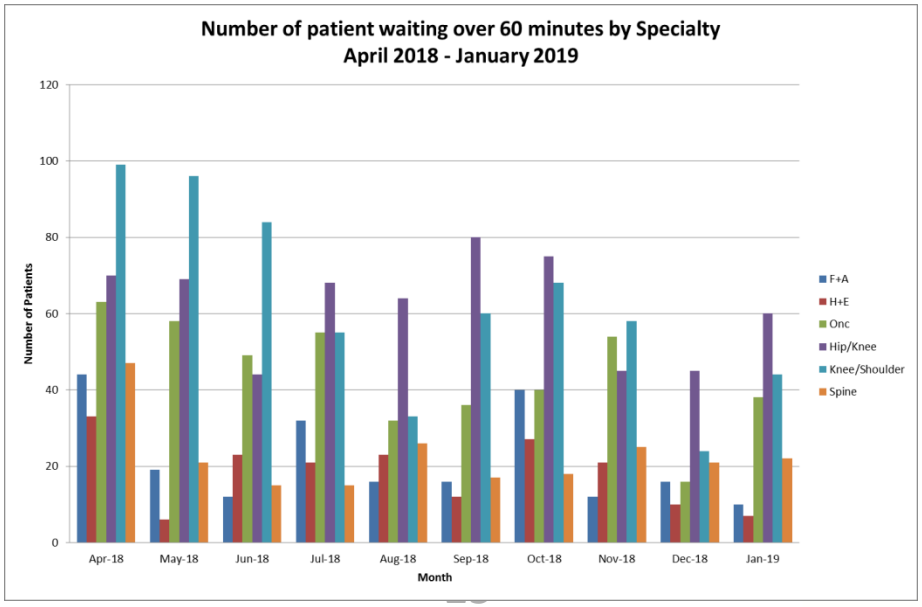
SSI Surveillance HCA on maternity leave. Interim appointed to backfill for 12/12 however, Q4 SSI data will not be submitted due to absence in this role. This does not pose a risk to ROH as required annual data has been submitted.

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









RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

INFORMATION

In January there were 10.3% of patients waiting over 30 minutes which is a slight improvement on last month, however the target for 30 minute delays has still not been achieved , focussed work is ongoing to continue to improve this position . 3.9% of patients were waiting over 1 hour which achieves the target of below 5%.

A new 6-4-3 meeting commenced in December and is held every Wednesday and produces room allocation timetables 4 – 6 weeks ahead. This meeting is evolving and will be used to review clinics and clinic templates with the operational management team to ensure clinics are well utilised and populated appropriately, to support a reduction in delays for patients attending clinic . Radiology are due to Join this meeting from March 2019 to review communication between clinics and Radiology and optimise patient flow.

The Matron for outpatients will continue to reiterate the importance of reporting all incidents relating to clinic delays and analysing the reasons for delays to improve practice . The department is now fully recruited, both for qualified and non qualified nursing staff . The current senior nurse for outpatients is retiring in March and a replacement is already in post to enable a full handover to take place.

A number of initiatives are being developed to improve the OP experience for patients and staff and full details of these projects will be discussed with key stakeholders at the OP away day planned for March 2019. This meeting will agree the priorities for this area and support required across a range of service improvement initiatives in line with recent NHSI recommendations .

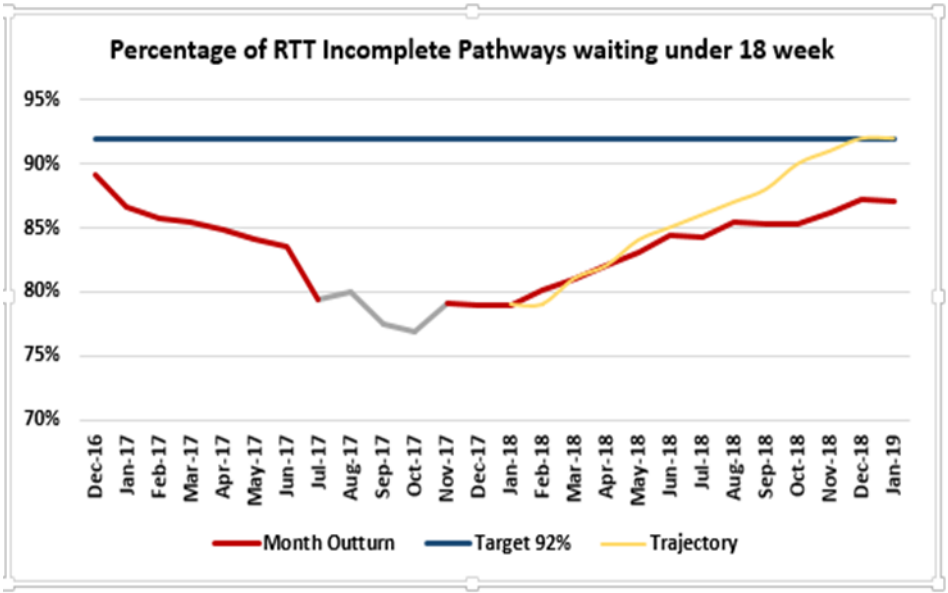
ACTIONS FOR IMPROVEMENTS / LEARNING

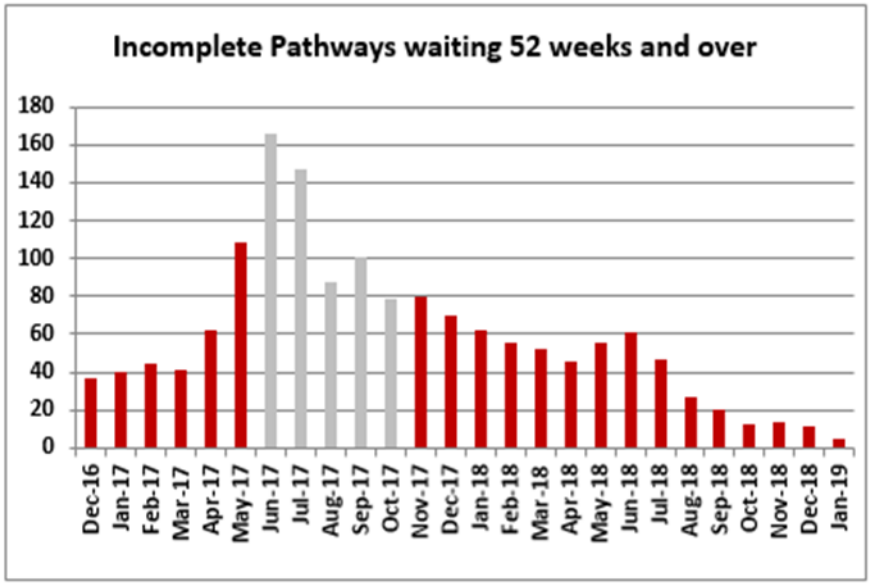
- Reiterate the importance of submitting incident forms with the staff
- Develop the 6-4-3 meeting to review problem clinics with the OPS team
- Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available
- Investigation of partial booking processes to reduce clinic rescheduling and overbooking

- Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. A visit has taken place to Heartlands Hospital to review their processes for partial booking with the intention of implementing this at the ROH. This may require additional staff resource in the appointments team which will be addressed through a business case in the next 6 months.

17. 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%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1,254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1,245	1,252	99.4%
Dec-18	698	115	346	1,159	843	224	367	1,434	11	1,148	1,159	99.1%
Jan-19	728	123	416	1,267	897	253	472	1,622	4	1,263	1267	99.7%



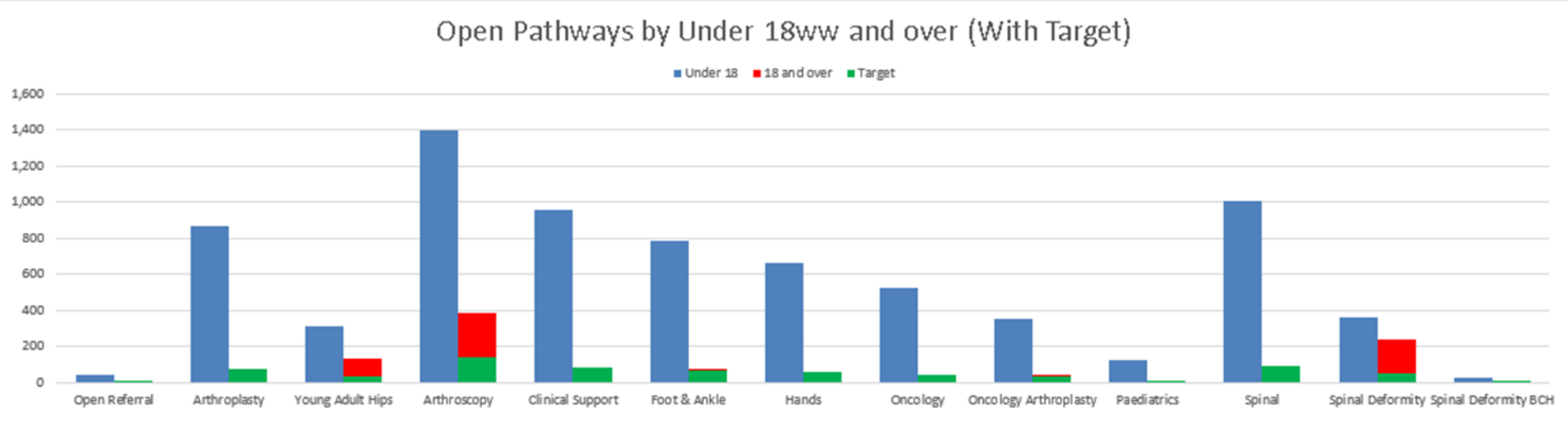


		Indicative	Reported Month									Reported Quarter 2017/18			
Target Name	National Standard	Jan-19	Dec-18	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Q4 (Jan, Feb, March)	Q3 (Oct, Nov, Dec)	Q2 (July, August, Sept)	Q1 (Apr, May, June)
2ww	93%	98.5%	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	85.7%	93.8%	100%	100%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	90.0%	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	75.0%	94.70%	90.5%	88.9%	77.8%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days			2	1		1			1						

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	**3,480**	36	400	139	638	494	344	338	277	153	57	441	156	7
7-13	**2,812**	5	349	126	523	361	311	240	155	145	56	409	120	12
14-17	**1,119**	2	117	45	236	101	131	83	93	56	12	153	86	4
18-26	**846**	1	69	75	283	49	74	40	16	29	4	75	127	4
27-39	**300**	0	6	53	102	7	3	0	7	15	0	6	96	5
40-47	**17**	0	0	2	3	1	0	0	0	1	0	1	8	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**5**	0	0	0	0	1	0	0	0	0	0	0	3	1
Total	**8,582**	44	941	440	1,785	1,014	863	701	548	399	129	1,085	599	34

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	**7,411**	43	866	310	1,397	956	786	661	525	354	125	1,003	362	23
18 and over	**1,171**	1	75	130	388	58	77	40	23	45	4	82	237	11
Target	**687**	**4**	**75**	**35**	**143**	**81**	**69**	**56**	**44**	**32**	**10**	**87**	**48**	**3**

	86.36%	**97.73%**	**92.03%**	**70.45%**	**78.26%**	**94.28%**	**91.08%**	**94.29%**	**95.80%**	**88.72%**	**96.90%**	**92.44%**	**60.43%**	**67.65%**



Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**783**	1	137	48	132	62	52	110	65	52	17	77	25	5
7-13	**885**	0	208	51	198	58	40	85	39	67	23	87	19	10
14-17	**398**	1	73	21	108	25	30	28	15	34	5	39	17	2
18-26	**401**	0	51	38	170	16	14	29	12	14	0	27	27	3
27-39	**171**	0	5	26	82	3	2	0	4	7	0	3	34	5
40-47	**9**	0	0	0	2	0	0	0	0	0	0	0	6	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
Total	**2,652**	2	474	184	692	164	138	252	135	174	45	233	133	26

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**2,066**	2	418	120	438	145	122	223	119	153	45	203	61	17
18 and over	**586**	0	56	64	254	19	16	29	16	21	0	30	72	9
Target	**212**	**0**	**38**	**15**	**55**	**13**	**11**	**20**	**11**	**14**	**4**	**19**	**11**	**2**

	77.90%	**100.00%**	**88.19%**	**65.22%**	**63.29%**	**88.41%**	**88.41%**	**88.49%**	**88.15%**	**87.93%**	**100.00%**	**87.12%**	**45.86%**	**65.38%**

Select Pathway Type: Non-Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
0-6	**2,697**	35	263	91	506	432	292	228	212	101	40	364	131	2
7-13	**1,927**	5	141	75	325	303	271	155	116	78	33	322	101	2
14-17	**721**	1	44	24	128	76	101	55	78	22	7	114	69	2
18-26	**445**	1	18	37	113	33	60	11	4	15	4	48	100	1
27-39	**129**	0	1	27	20	4	1	0	3	8	0	3	62	0
40-47	**8**	0	0	2	1	1	0	0	0	1	0	1	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**3**	0	0	0	0	1	0	0	0	0	0	0	1	1
Total	**5,930**	42	467	256	1,093	850	725	449	413	225	84	852	466	8

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthros copy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**5,345**	41	448	190	959	811	664	438	406	201	80	800	301	6
18 and over	**585**	1	19	66	134	39	61	11	7	24	4	52	165	2
Target	**474**	**3**	**37**	**20**	**87**	**68**	**58**	**36**	**33**	**18**	**7**	**68**	**37**	**1**

	90.13%	**97.62%**	**95.93%**	**74.22%**	**87.74%**	**95.41%**	**91.59%**	**97.55%**	**98.31%**	**89.33%**	**95.24%**	**93.90%**	**64.59%**	**75.00%**

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and predicts that the Trust will return to 92% at an aggregated level by October 2019.

January 2019 performance is 86.36%

It is expected that Oncology Arthroplasty will achieve 92% in March 2019 with Young Adult Hip in June 19 and Arthroscopy in July 19. A refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been completed and we anticipate that they will achieve the standard in Qtr. 4 19/20 . Excluding Spinal Deformity the Trust now has 9 patients waiting over 40 weeks all with treatment plans.

In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.

Detailed below is our progress with our trajectory with a revised trajectory submitted to NHSI/E (19/2/19). Work is still ongoing with the aim to clear all patients by the end of March 2019.

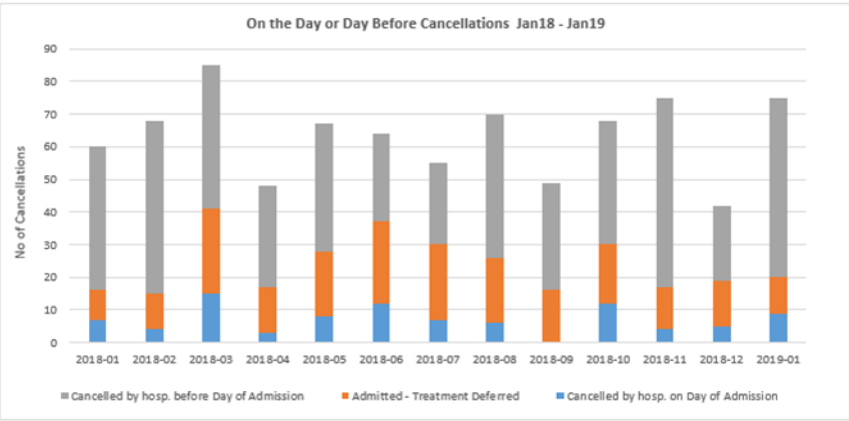
ROH 52 Week Trajectory Feb 2018

Over 52 Weeks	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
ROH Specialties excluding SD	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
ROH Adult Total	14	12	16	15	12	9	7	0	0	0	2	0	0	0	0
ROH Paediatrics Total	20	28	31	25	28	19	16	8	10	11	19	15	9	3	0
BWCH Paediatric Total	30	29	27	27	27	27	25	20	15	11	8	4	0	0	1
ROH Total	66	70	75	67	68	55	47	29	25	22	29	19	9	3	1
Actual Performance	**56**	**52**	**46**	**55**	**61**	**47**	**27**	**20**	**13**	**14**	**11**	**5**			
Revised Trajectory													3	1	2

ACTIONS FOR IMPROVEMENTS / LEARNING
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019
RISKS / ISSUES
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. 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 remains a concern.

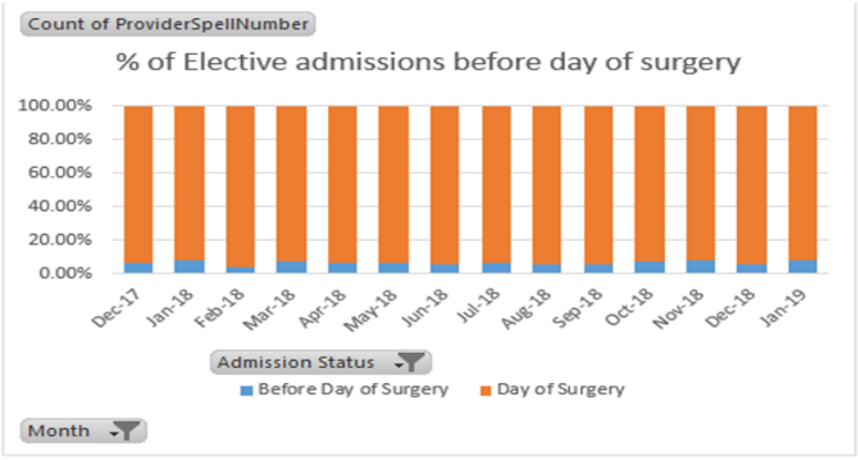
18. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

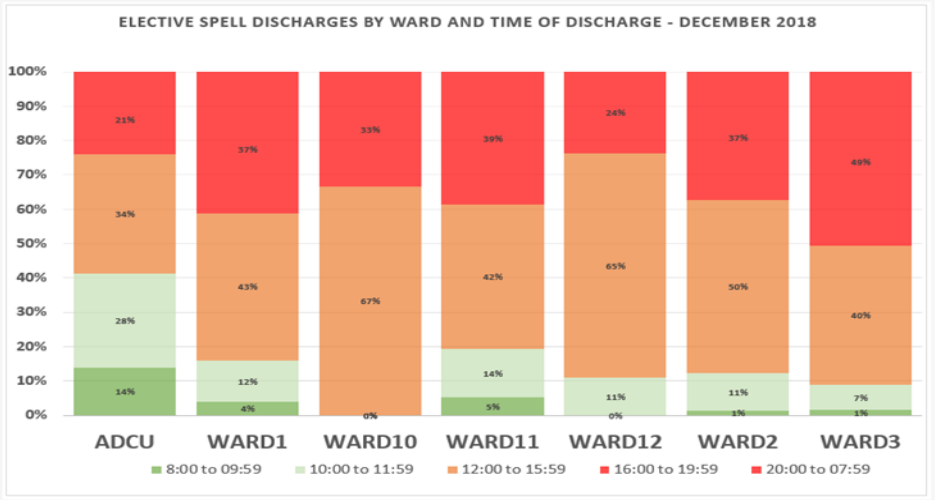
Hospital Cancellations



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
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	44	70	1
2018-09		16	33	49	0
2018-10	12	18	38	68	0
2018-11	4	13	58	75	0
2018-12	5	14	23	42	0
2019-01	9	11	55	75	0
Grand Total	92	220	514	826	2

Admission the day before surgery





INFORMATION

The number of cancellations on the day of admission for surgery in January was 9 patients, a slight increase on December. Patients admitted for surgery where treatment was deferred has reduced in month from 14 to 11. Analysis of the reasons for patients cancelled on the day prior to admissioninclude, Consultant illness and lack of theatre time. Patients admitted where treatment was deferred relate to equipment issues, cancellation to accommodate emergency patients and patients condition changing , where surgery is no longer required

Cancellations before the day of surgery have increased in month from 23 to 55. An analysis of the 55 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 patients declaring fitness issues on the 72 hour contact call . The increase in this number of patients is due to the robust process to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The 72 hour call process has now been strengthened and an extended hours contact service is being developed so patients can be contacted at evenings and weekends to improve compliance.

Work continues to strengthen the POAC process and a business case is being presented at DMB in February 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access.

The triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to pre – operative clinic to change the profile of triage to be delivered in the pre-operative clinic area, so that access to on the day triage can be expanded It is anticipated that the change in service will commence in April 2019.

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 :

- POAC representative now attends daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Improved links with Clinical team to support any clinical concerns raised during patient contact

RISKS / ISSUES
Existing ageing equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools have been purchased and full delivery of all items is expected by the end of March 2019. The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Influenza vaccination update**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Julie Gardner, Assistant Director of Finance (Contracting)**
DATE OF MEETING:	**6 March 2019**

EXECUTIVE SUMMARY:

A letter was issued to all Chief Executives in February from NHS Improvement, reminding them of the requirement to make public the organisation's position in terms of take up of the 'flu vaccination and the reasons, if any, staff had cited for not being inoculated. This letter is attached as ROHTB (3/19) 007 (b).

The attached report provides this update and is constructed according to the suggested format provided by NHS Improvement.

The CQUIN target for 2018/19 for vaccination of frontline staff is 75%.

The current position for vaccination of frontline staff is 58.07%

REPORT RECOMMENDATION:

The Board is asked to accept 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		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:

With safe, efficient processes that are patient centred

PREVIOUS CONSIDERATION:

Last considered as part of the Trust Board public agenda in November 2018.

The Royal Orthopaedic Hospital NHS Foundation Trust

Flu Vaccinations for Front Line Clinical Staff

2018-19 CQUIN Update

1 EXECUTIVE SUMMARY

1.1 The CQUIN target for 2018/19 for vaccination of frontline staff is **75%.**

1.2 The current position for vaccination of frontline staff is **58.07%.**

2 CQUIN Requirements

2.1 The 2 year CQUIN specification was issued as part of the national contract in 2017/18. The year one requirements included achieving an uptake of flu vaccinations by frontline clinical staff of 70% with this target rising to 75% in year two.

2.2 The rules for achievement in year two are –

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
<50%	No Payment
50% up to 59.99%	25% payment
60% up to 64.99%	50% payment
65% up to 74.99%	75% payment
70% or above	100% payment

3 The Royal Orthopaedic Hospital (ROH) Flu Vaccination March 19 Update

3.1 During the 2017/18 year one CQUIN ROH achieved 70.21% which resulted in the maximum award available.

3.2 The 2018/19 year two campaign started 1st October 2018 and finished on 28th February 2019. The current overall Trust vaccination percentage is 53.55% with the vaccination percentage for frontline staff higher at 58.07%. Various activities have taken place through the campaign which include –

- Monthly Flu Vaccination Group established including Infection Control, Human Resources, Finance and Communications to monitor progress

- A range of communication campaigns
- Increased access and availability of staff qualified to administer the vaccination

3.3 The guidance for the CQUIN is very explicit in explaining staff groups and inclusion and exemptions criteria. The Trust is confident that any employees that have been away from work between the flu campaign dates have been removed from the full staff list i.e. staff who are sick or on maternity leave.

3.4 A high number of forms have been received by employees declaring that they do not want to have the vaccination. 73 forms have been received but unfortunately the form is anonymous and it is unclear if these are forms from frontline staff or infrastructure support; some staff have listed more than one reason for rejecting the flu vaccination as see in the table below.

3.5 ROH Staff have been generally less willing to have the vaccination and while the flu vaccination team have been able to persuade a number of staff it has been a struggle.

Reasons for rejecting the offer of a flu vaccination

Reason for rejecting the offer of a flu vaccination	Number of reasons given
Concerned about side effects	20
I do not like needles	17
I was ill last time	6
No reason	5
Allergic	8
I don't believe the research	22
I don't think I will get flu	3
I do not want it in my body	1
I don't want it	1
I don't know where to get vaccinated	1
My immune system is stronger without it	1
Never had flu	1
Personal Choice	1
It is poison	1

3.6 The following tables detail percentage breakdowns to understand the current position.

Trust Wide Vaccinations (as of) 21st March 2019

Staff Groups	Count of Staff	Number of Staff Vaccinated	Percentage of staff group vaccinated
All Doctors	134	59	44.03%
All other professionally qualified clinical staff	145	85	58.62%
Support to Clinical Staff	310	190	61.29%
NHS Infrastructure Support	265	103	38.87%
Qualified Nurses	272	166	61.03%
Grand Total	**1128**	**603**	**53.46%**

Frontline Staff Vaccinations (as of) 21st March 2019

Staff Groups	Count of Staff	Number of Staff Vaccinated	Percentage of staff group vaccinated
All Doctors	134	59	44.03%
All other professionally qualified clinical staff	145	85	58.62%
Support to Clinical Staff	310	190	61.29%
Qualified Nurses	272	166	61.03%
Grand Total	**861**	**500**	**58.07%**

3.7 There are considerable differences across the Trust in relation to the take up of flu vaccinations. The following tables show the department/division and percentage of staff that have received the vaccination.

Corporate flu vaccination February 2019 update

Area of work	Percentage of staff vaccinated
Bank Directorate	**100.00%**
Board Directorate	**55.56%**
Corporate Directorate	**56.88%**
Communications Department	40.00%
CSU Management	60.00%
Education and Training Department	50.00%
EPMA Department	0.00%
Finance Department	47.62%
Governance Department	55.56%
GP Trainee	100.00%
Human Resources Department	41.94%
IM&T Department	73.08%
IPC	100.00%
Knowledge Management Department	44.44%
Management Offices	72.73%
Nursing Administration Corporate	50.00%
Research and Development	71.43%
Security	100.00%

Division 1 – Patient Services – February update

Area of work	Percentage of staff vaccinated
Division 1 - Patient Services	**47.44%**
Clinical Admin	**40.00%**
Appointments	35.71%
Medical Records	26.67%
Patient Access	66.67%
RTT	100.00%
Division 1 Management Dept	**30.77%**
Division 1 Management	30.77%
Large Joint	**51.38%**
Large Joints Junior Medical Staff	30.00%

Senior Medical Staff	25.00%
Large Joint Admin	35.71%
Ward 12	57.14%
Ward 2	68.18%
Discharge Lounge	100.00%
Large Joints Admin	57.14%
303 Oncology	**45.16%**
Oncology Junior Medical Staff	50.00%
Senior Medical Staff	44.44%
Oncology Admin	23.08%
Ward 3 - Oncology	60.87%
MacMillan Nurses	30.00%
Outpatients	**58.06%**
Junior Medical & Physicians	100.00%
ROCS	61.54%
Outpatients	52.94%
Paediatrics	**55.81%**
Paediatrics Junior Medical Staff	33.33%
Senior Medical Staff	0.00%
Paediatric Admin	25.00%
Paediatrics Outpatients	40.00%
Paediatrics Spinal Deformity	100.00%
Ward 11 Childrens	68.00%
Small Joint	**29.41%**
Senior Medical Staff	40.00%
Small Joints Junior Medical Staff	40.00%
Small Joint Admin	14.29%
Spinal Surgery	**43.33%**
Senior Medical Staff	42.86%
Spinal Junior Medical Staff	80.00%
Spinal Admin	33.33%
Ward 1	40.63%

Division 2 – Patient Support – February Update

Area of work	Percentage of staff vaccinated
Division 2 - Patient Support	**50.23%**
Histopathology	**15.00%**
Histopathology Junior Medical Staff	0.00%
Histopathology Medical Staff	0.00%
Haematology Team	33.33%
Histopathology	15.38%
Paediatrics	**100.00%**
paediatrics	100.00%
Patient Support Admin	**40.00%**
Clinical Support Admin	40.00%
Pharmacy	**35.29%**
Pharmacy	35.29%
Pre Admission Screening (POAC)	**60.00%**
Radiography	**62.79%**
Junior Medical Staff	0.00%
Senior Medical Staff	0.00%
MRI	77.78%

Radiology Administration	66.67%
Radiology Department	70.59%
Ultrasound	66.67%
Small Joint	**100.00%**
Small Joints Junior Medical Staff	100.00%
Theatres, Anaesthetics and Critical Care	**48.00%**
Anaesthetic Medical Staff	37.84%
TACC Physician Medical Staff	100.00%
Critical Care Service	100.00%
HDU	57.14%
Decontamination Unit	0.00%
TACC Directorate Admin	75.00%
Theatre	35.82%
Theatres Administration	50.00%
Theatres Plaster Room	50.00%
Theatres Portering	12.50%
Theatres Recovery	31.25%
ADCU Nursing	76.92%
Theatres, Anaesthetics and Critical Care	50.00%
Therapy Services	**56.99%**
Senior Medical Staff	33.33%
Clinical Support Admin	50.00%
Pain Management	25.00%
Occupational Therapy	66.67%
Orthotics	0.00%
Physiotherapy	63.08%
Podiatry	50.00%

Division 4 – Estates and Facilities – January Update

Area of work	**Percentage of staff vaccinated**
Division 4 - Estates and Facilities	**38.26%**
Estates Department	64.29%
ROH Car Parking	100.00%
Building & Engineering Staff	50.00%
Estates	100.00%
Health and Safety	0.00%
Facilities Department	34.65%
Facilities	66.67%
Domestics	32.69%
Catering Department	16.67%
Portering General	42.11%
Linen	100.00%
Transport Services	25.00%

3.8 High risk areas such as oncology and the paediatric ward have been monitored as designated high risk areas but no staff have been redeployed for refusing the vaccination.

Julie Gardner
Assistant Director of Finance
1st March 2019

From the office of Dale Bywater
Executive Regional Managing Director – Midlands and East

Cardinal Square – 4th Floor
10 Nottingham Road
Derby
DE1 3QT
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E: nhsi.enquiries@nhs.net
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14th February 2019

All Midlands & East Provider CEOs

Sent via e-mail

Dear Colleagues

Reporting HCW Flu Vaccination Information

I know that you are focused on delivering great care through winter and staff flu vaccination is an important part of that. We are once again seeing record uptake of the flu vaccine amongst frontline healthcare workers this winter.

On 7 September 2018, all NHS Trusts and NHS Foundation Trusts were asked to publicly report information on frontline healthcare worker flu vaccination via your boards by February 2019. All NHS providers should report this information, although some details regarding higher-risk areas are only required from some organisations. The purpose of this collection is to help inform next year's healthcare worker flu vaccination policy.

If you have not yet published this information and do not have board meetings in February, please send this information directly to us in February and then publish it in your next board meeting.

The relevant passage from the letter states that:

"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."

To summarise, there are four pieces of information that we are expecting you to publish. In order to help you do this, a template for reporting this information is attached.

1. Total flu vaccination uptake and opt-out numbers and rates
2. A list of areas designated higher-risk and the uptake and opt-out rates for each
3. Details of actions taken to deliver the 100% uptake ambition
4. A breakdown of the reasons that staff have given for opting-out

Please let us know whether you have already published this information and are planning to do so in your February board papers, or whether you will need to contact us to supply this information separately. If you could reply to Nick Hardwick, Head of Performance at nick.hardwick@nhs.net that would be appreciated.

Thank you very much for your help and support with this.

Yours sincerely

Dale Bywater
Executive Regional Managing Director – Midlands and East

Encs.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Infection Prevention & Control Annual Report 2017/18**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh – Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Ange Howling – Head of Infection Prevention & Control**
DATE OF MEETING:	**3 March 2019**

EXECUTIVE SUMMARY:

The Annual Infection Prevention & Control Annual Report 2017/18 is presented to the Board for information. The report has been submitted to the Commissioners and has been published on the Trust's website.

This report has been approved by the Infection Prevention & Control Committee. Also present at the Committee were; the regional Lead for Infection Prevention & Control from NHS Improvement and the Lead for Infection Prevention & Control from the Commissioners who also approved the document.

REPORT RECOMMENDATION:

The Board is asked to receive and note the Infection Prevention & Control status at the Trust for 2017/18.

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

Note and accept	Approve the recommendation	Discuss
X		

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

Financial	**X**	Environmental	X	Communications & Media	
Business and market share	**X**	Legal & Policy	X	Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments: [*elaborate on the impact suggested above*]					

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

Safe, efficient processes that are patient centred.

PREVIOUS CONSIDERATION:

Infection Prevention & Control Committee and Quality & Safety Committee.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

The Royal Orthopaedic Hospital

Director of Infection Prevention and Control Annual Report 2017/18

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Director of Infection Prevention and Control ANNUAL REPORT 2017/2018

AUTHOR	Angela Howling – Head of Infection Prevention and Control
DIRECTOR OF INFECTION PREVENTION & CONTROL	Garry Marsh – Executive Director of Patient Services
APPROVED AT	Infection Prevention & Control Committee
DATE	2018

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

CONTENTS

Introduction from the Director of Infection Prevention and Control

Infection prevention and control (IPC) is fundamental in improving the safety and quality of care provided to patients. Healthcare Associated Infection (HCAI) can cause significant harm to those infected. As a result IPC remains a key priority for the Royal Orthopaedic Hospital NHS Foundation Trust (ROH). I am proud to be able to present the Director of Infection Prevention and Control's annual report for 2017/18.

The NHS continues to experience unprecedented challenges clinically, operationally, and economically. However, our staff have sustained a culture of continuous improvement which is both patient-centered and safety-focused. Our vision is to constantly provide the highest possible standards of care across our healthcare economy.

The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using services at ROH receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. The IPC agenda has continued to be strengthened with a highly visible and flexible Infection Prevention Team, led by the Head of Infection Prevention and Control, Angela Howling. The development of our IPC nurses is in line with the national core competency framework, developed by the Infection Prevention Society and endorsed by the Department of Health (2011).

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008 (updated 2015), at the heart of this law there are two principles:
To deliver continuous improvements of care
And that it meets the need of the patient

With this in mind patient safety remains the number one priority for the Trust. Infection Prevention is one of the key elements to ensure ROH has a safe environment and practice which is reflected in the Trust's vision, values and objectives with milestones turning the vision into a reality.

Improvements in health and care are linked and the NHS and its public, private, and voluntary sector partners can only provide the best and most effective service for patients and public when we work together to achieve their objectives.

This report summarises the combined activities, commitment and hard work of the IPC Team, Board colleagues, all staff, governors and volunteers across ROH, Clinical Commissioning Groups (CCG) and Public Health England (PHE) in relation to the prevention of HCAIs.

Garry Marsh
Executive Director of Patient Services and Director of Infection Prevention and Control

COMPLIANCE CRITERIA 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

1 The Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008). The DIPC will have the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable HCAIs at all levels in the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will offer commitment to quality and patient safety, good communication and reporting channels and access to people with expert prevention and control advice.

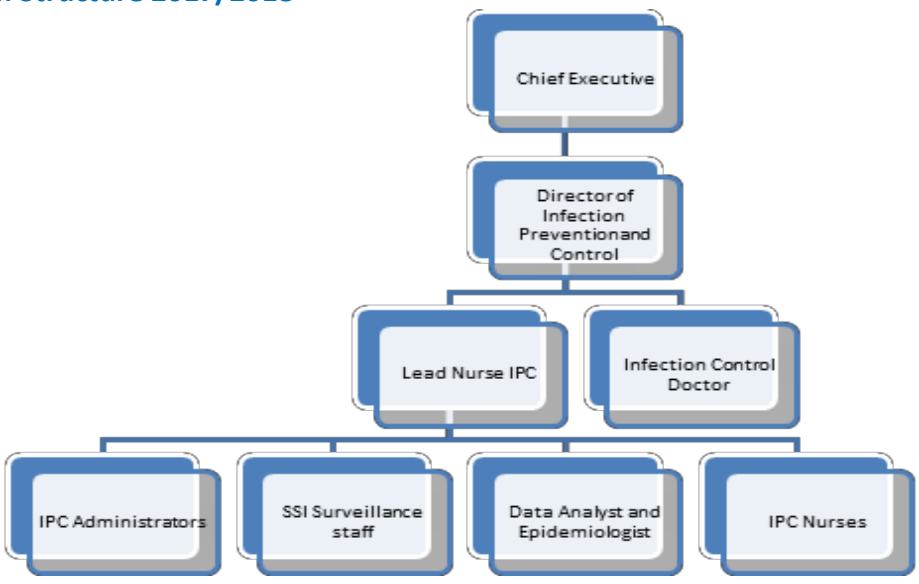
At the ROH the Executive Director of Patient Services holds the role of DIPC

2 The Infection Prevention and Control Team

The IPC Team is led by the Head of Infection prevention and Control and is supported by Infection Prevention Nurse Specialists, Surgical Site Surveillance Health Care Assistant and an Administrator. The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development, and review and service development. The Trust has 24 hour access to expert Consultant Microbiology advice and support via a Service Level Agreement (SLA) with the University Hospital Birmingham (UHB).

The DIPC has overall responsibility for the IPC team that works collaboratively alongside the front-line clinical leaders at the Trust.

IPC Team Structure 2017/2018



3 Committee Structures and Assurance Processes

3.1 Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive (CE)has overall responsibility for the control of infection at ROH. The DIPC meets with the CE regularly and attends Trust Board meetings with detailed updates on Infection Prevention and Control matters.

3.2 Quality and Safety Committee

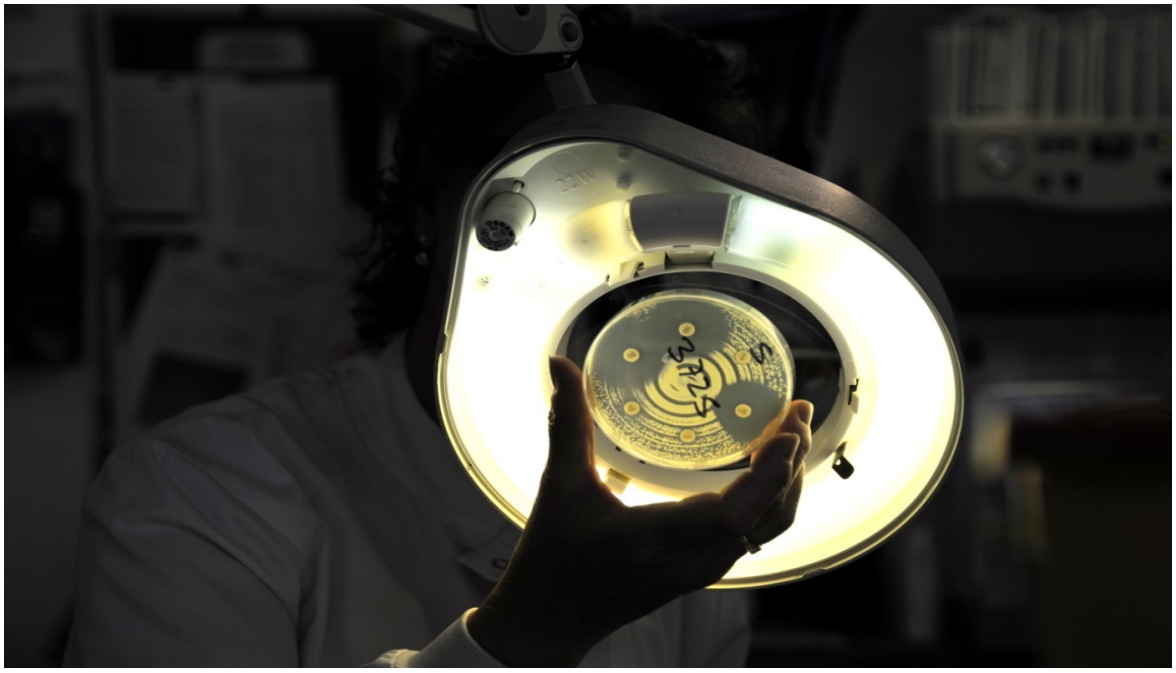
The Quality and Safety Committee (QSC), chaired by a Non - Executive Director (NED), is a sub-committee of the Trust Board which meets monthly is responsible for ensuring that there are processes for ensuring patient safety; and continuous monitoring and improvement in relation to IPC. The QSC receives assurance from the IPCC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IPC Team provide a monthly report on surveillance and outbreaks.

3.3 Infection Prevention and Control Committee

IPCC, chaired by the DIPC, provides direct assurance to the DIPC. The main objective of the IPCC is to provide a strategic drive in ensuring improved performance in relation to HCAIs.

4 Surveillance of Healthcare Associated Infection (HCAI)

4.1 METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS BLOOD STREAM INFECTIONS



Staphylococcus aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or during a medical procedure.

If the bacteria enter the body, illnesses which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves (endocarditis), pneumonia, and bacteraemia (blood stream infection).

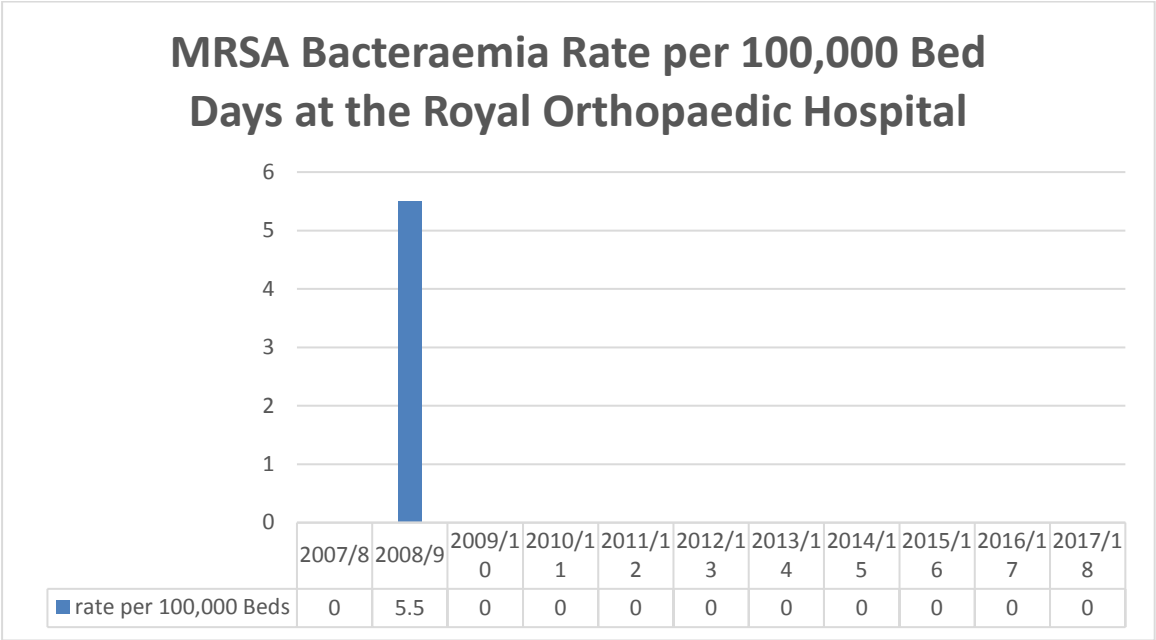
Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic meticillin are termed meticillin-resistant Staphylococcus aureus (MRSA) and often require different types of antibiotic to treat them. Those that are sensitive to meticillin are termed meticillin-susceptible Staphylococcus aureus (MSSA). MRSA and MSSA only differ in their degree of antibiotic resistance: other than that there is no real difference between them.

The Department of Health (DH) began mandatory surveillance of MRSA bloodstream infections (bacteraemia) in 2001. This includes all bloodstream infections with MRSA whether acquired in hospital or in the community and any that are considered to be a contaminant or not. Data is reported to the DH, via Public Health England (PHE) through the national HCAI database monthly.

There continues to be a national zero target for all MRSA bacteraemia, as part of this zero tolerance approach an in-depth Post Infection Review (PIR) is undertaken for all MRSA bloodstream infection cases which includes an external review, the purpose is to identify any possible lapses in care and to identify the organisation best placed to ensure improvements are made.

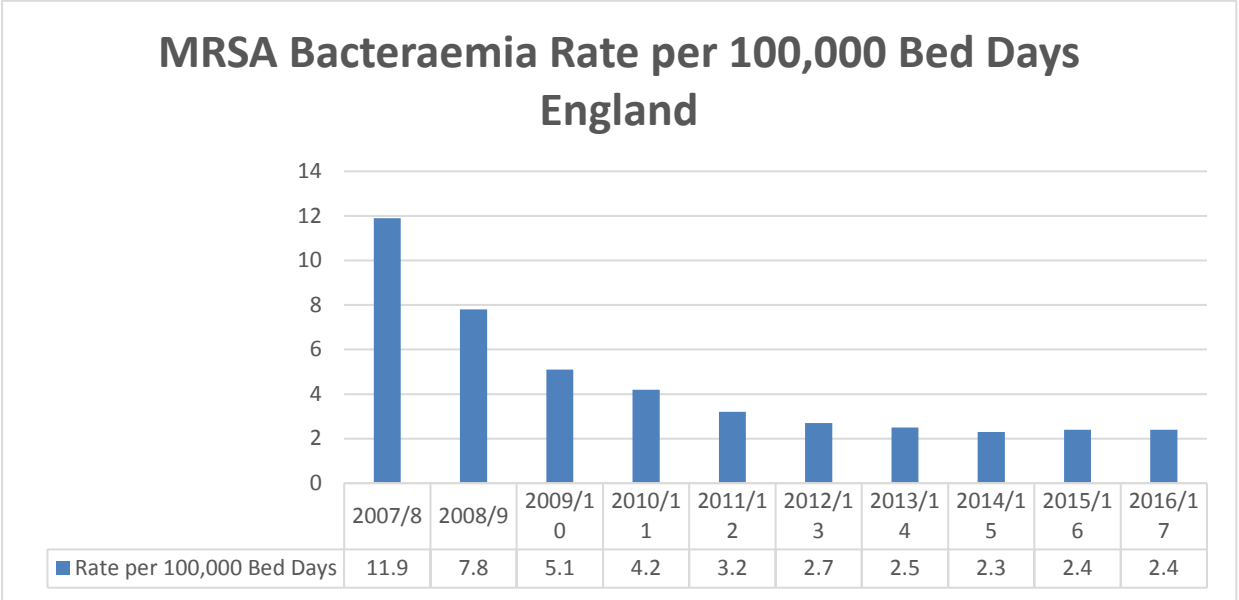
Trust apportioned cases are defined as blood culture taken “on or after the 3rd day of admission”.

For the period covered by this report there been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous year;



Source: https: //www.gov.uk/government/organisations/public-health-england

For the period covered by this report there have been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous year;



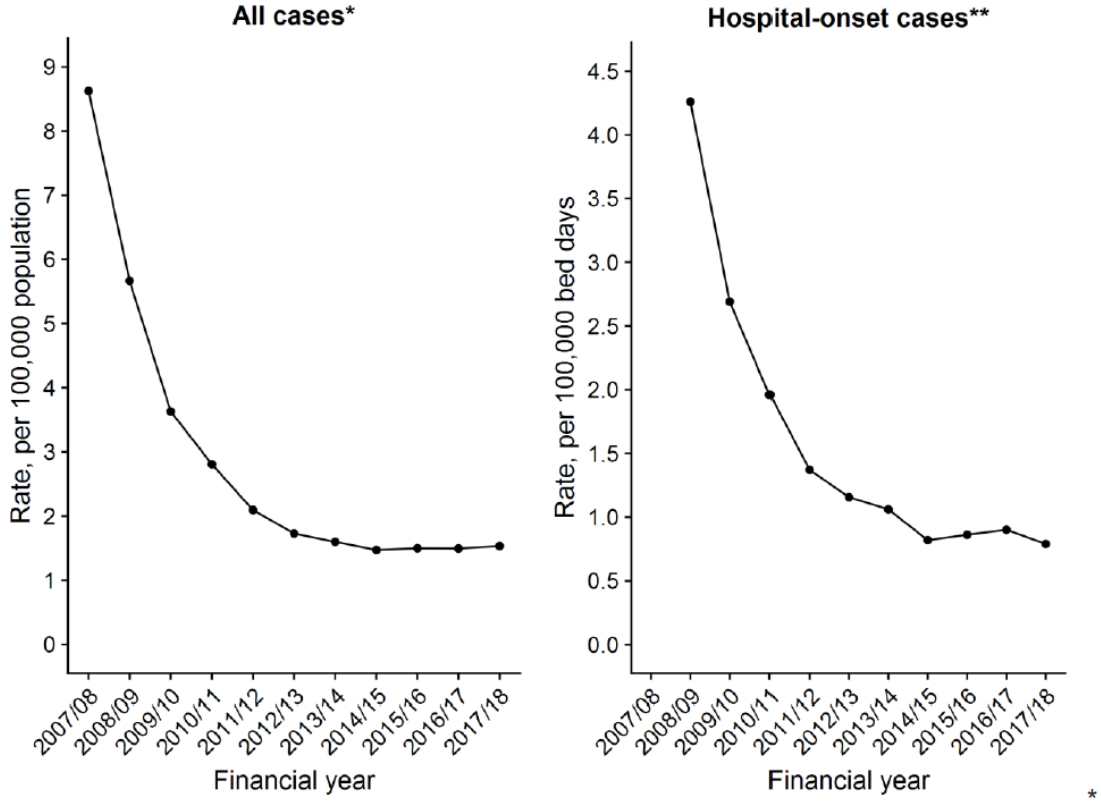
Source: https: //www.gov.uk/government/organisations/public-health-england

Since 2007/8, there has been a steady overall decrease in England.

Final Data

A total of 846 cases of MRSA bacteraemia were reported by acute NHS Trusts in England between 1 April 2017 and 31 March 2018. This is an increase of 2.5% from 2016/17 (n = 825), and a decrease of 81% from 2007/08 (n = 4,451). Figure 13 shows the trends in rates of MRSA cases for all cases and hospital-onset cases from 2007/08 to 2017/18. The rate of all MRSA cases per 100,000 populations, per year has fallen from 8.6 in 2007/08 to 1.5 in 2017/18 (Figure 13).

Figure 13: Trends in the all case and hospital-onset rate of MRSA bacteraemia in England



* Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2016/17 bed day data is an aggregate of quarters 1, 2 and 3 of 2017 and quarter 4 of 2016/17.

Although the MRSA all-case rate for the most recent year (1.5 per 100,000 population) is less than the rate in 2007/08 (8.6 per 100,000 population), it has remained relatively constant for the past 4 years.

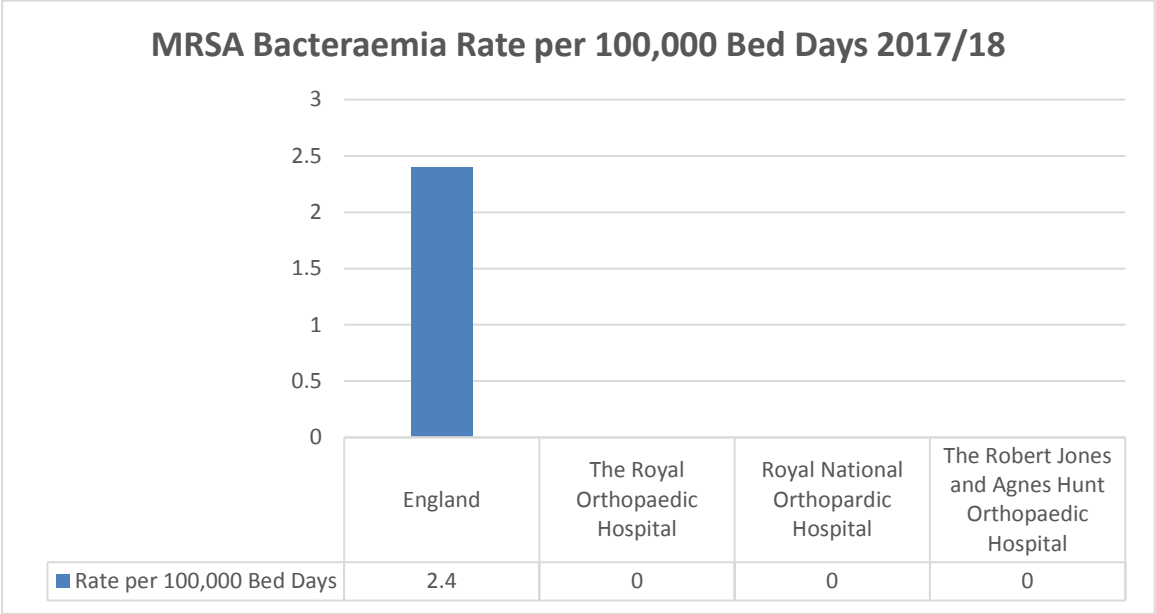
Of the 846 total cases reported in FY 2017/18, 274 were hospital-onset (0.8 per 100,000 bed-days). The rate of hospital-onset MRSA cases remained steady at 0.8 to 0.9 cases per 100,000 bed-days over the last four years (Table 15).

Table 15: MRSA counts and rates by financial year, England: 2007/08 to 2017/18*

Financial year	Mid-year population estimate	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2007/08	51,594,959	4,451	8.6	37,320,817		
2008/09	51,803,017	2,935	5.7	37,700,812	1,606	4.3
2009/10	52,306,371	1,898	3.6	37,326,212	1,004	2.7
2010/11	52,757,040	1,481	2.8	35,094,388	688	2.0
2011/12	53,312,604	1,116	2.1	34,502,306	473	1.4
2012/13	53,475,358	924	1.7	34,439,455	398	1.2
2013/14	53,976,973	862	1.6	34,327,781	364	1.1
2014/15	54,432,437	800	1.5	34,797,208	285	0.8
2015/16	55,018,884	823	1.5	34,576,351	298	0.9
2016/17	55,268,067	825	1.5	34,976,071	315	0.9
2017/18	55,268,067	846	1.5	34,708,849	274	0.8

* 2017/18 population data were not available at time of preparation and 2016/17 population data were used in place.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.



Source: https: //www.gov.uk/government/organisations/public-health-england

4.2 METICILLIN-SENSITIVE STAPHLOCOCCUS AUREUS BLOOD STREAM INFECTIONS

Meticillin-sensitive Staphylococcus aureus is a type of bacterium which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream.

Following a Secretary of State announcement on 5 October 2010, there was a mandatory requirement

for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.

MSSA blood stream infections cases continue to be monitored by ROH. Currently this data collection is part of national surveillance only. In total this year there have been zero hospital associated cases (post-48 hours after admission) reported.

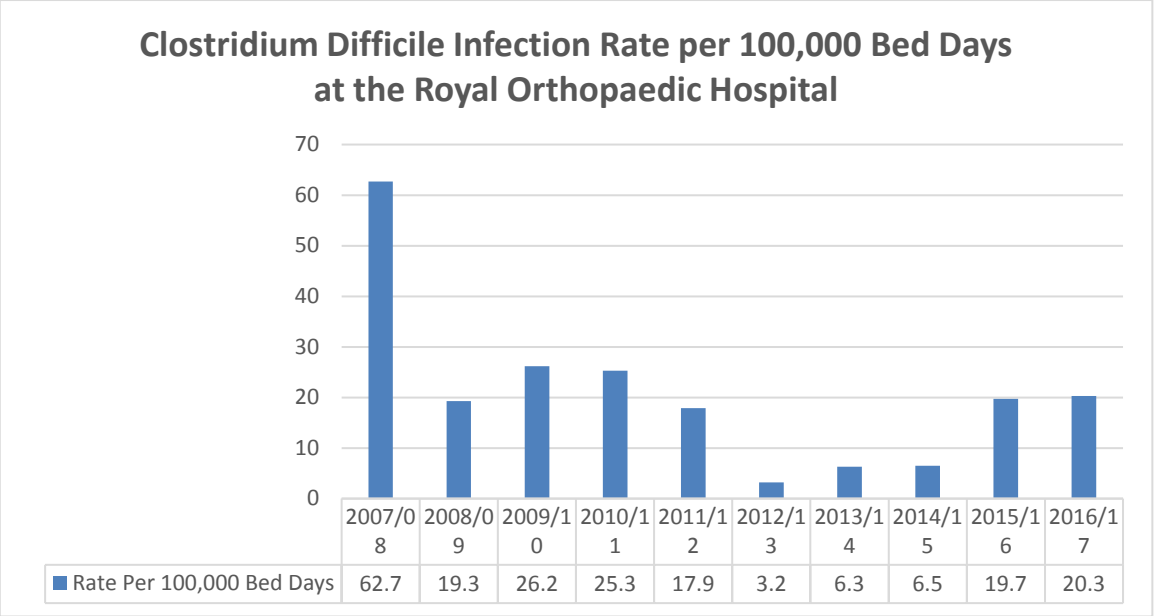
4.3 Clostridium Difficile Infection (CDI)

Up to and including 2017/18, NHS organisations have continued to be required to demonstrate year on year reductions in Clostridium difficile Infection (CDI) cases. However, as published data shows, the rate of improvement for CDI has slowed over recent years. Infection prevention and control experts from within the NHS and from Public Health England advise that this is likely to be due to a combination of factors, including the biology and epidemiology of the Clostridium difficile (CD) organism.

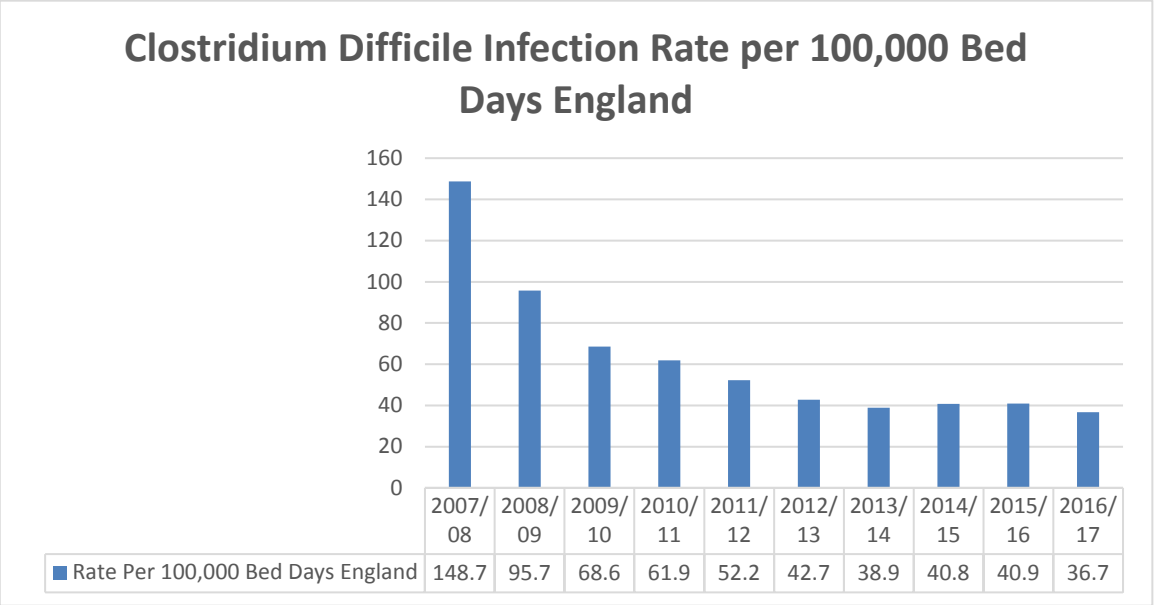
There are indications that, for some organisations at least, the level of CDIs may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided. This can occur due to the fact that some people carry CD in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. Put simply, some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

Cases of CDI that are considered to have been acquired in that the Trust are defined as sample taken "on or after 48 hours of admission".

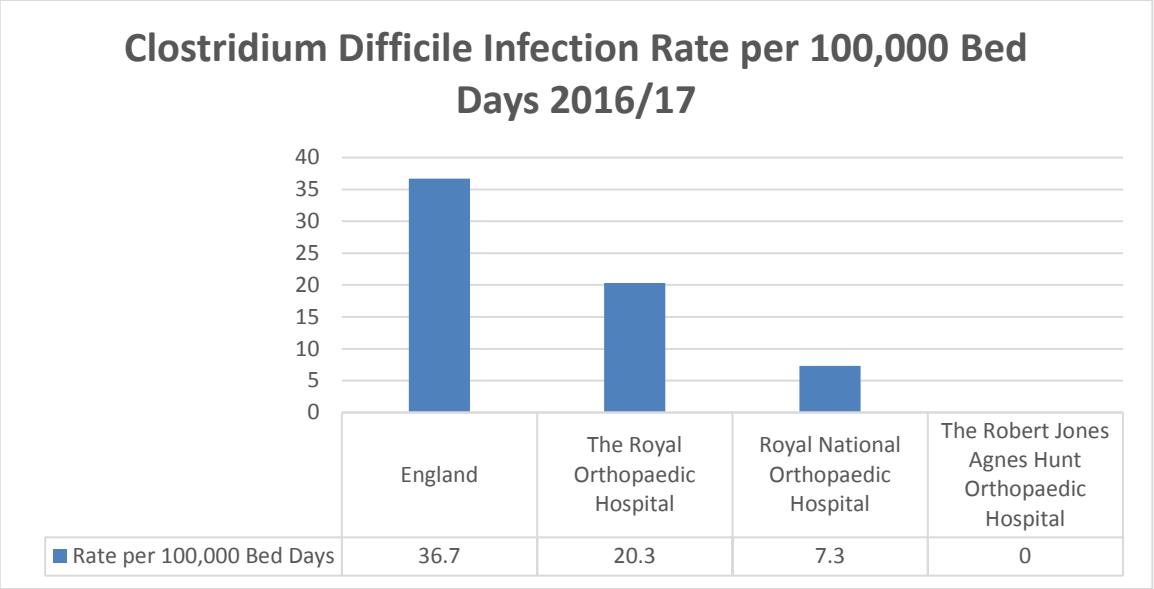
The annual trajectory in 2017/18 for hospital-acquired cases of CDI was set at 2 cases for ROH. During The year there was 1 case identified of hospital-attributed Clostridium difficile. However, the Post infection review of the case identified that the case was unavoidable and no lapses in care were identified as part of the patient's care received at ROH. This demonstrates on improvement from the previous year which identified 4 cases all of which were deemed unavoidable.



Source: https: //www.gov.uk/government/organisations/public-health-england



Source: https: //www.gov.uk/government/organisations/public-health-england



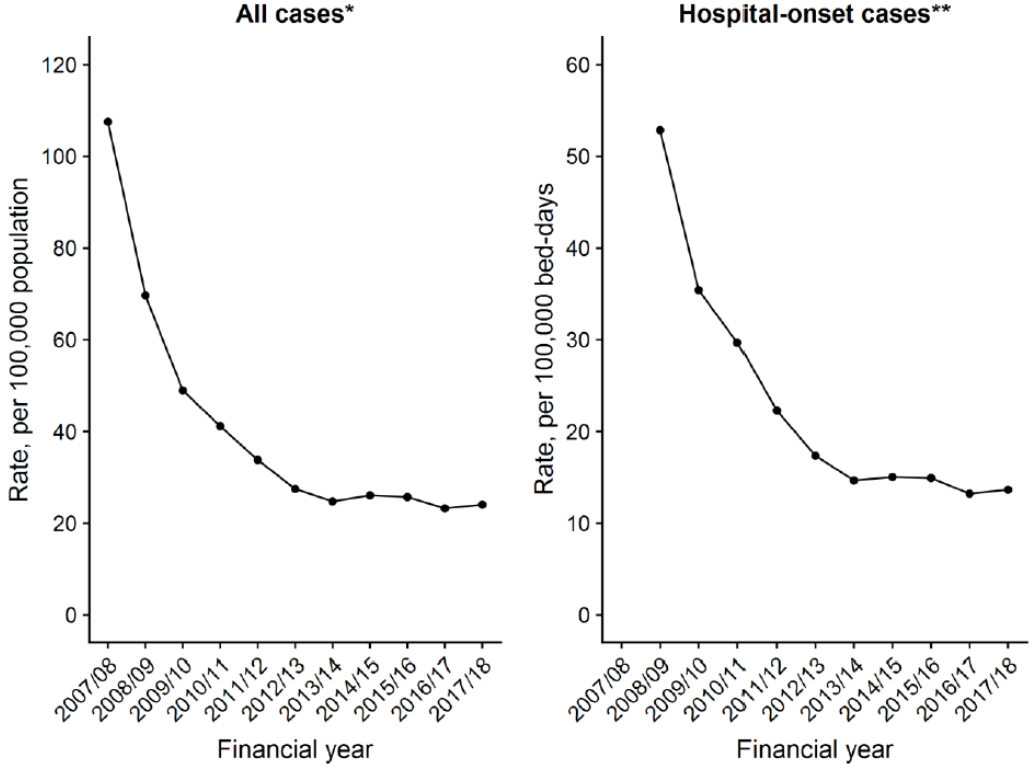
Source: https: //www.gov.uk/government/organisations/public-health-england

Final Data

Epidemiological analysis of *Clostridium difficile* Infection

A total of 13,286 cases of *Clostridium difficile* infection were reported by NHS Trusts in England between 1 April 2017 and 31 March 2018. This translates to a small increase of 3.4% from 2016/17 (n = 12,845), and a decrease of 76.1% from 2007/08 (n = 55,498). Figure 21 shows the trends in rates of CDI cases for all cases and hospital-onset cases from 2007/08 to 2016/17. The rate of all CDI cases per 100,000 populations, per year has fallen from 100.3 in 2007/08 to 24 in 2017/18.

Figure 21: Trends in the rate of *C. difficile* infection in England



* * Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.
** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017 and quarter 4 of 2016/17.

Of the 13,286 total cases reported in FY 2017/18, 4,739 were hospital-onset (13.7 per 100,000 bed-days). It should be noted that CDI cases are considered hospital-onset if they occur ≥ 4 days after admission to an acute trust, where day of admission is day 1. This is in contrast to ≥ 3 days for bacteraemia cases. The incidence rate for hospital-onset CDI cases mirrors the trends in incidence for all cases, with declining rates from 2007/08 to 2013/14 which then remained approximately stable to 2017/18. The rate of hospital-onset CDI cases increased slightly from 13.2 in 2016/17 to 13.7 in 2017/18, a change of 3.3% (Table 26).

Table 26: CDI counts and rates by financial year, England: 2007/08 to 2017/18*

Financial year	Mid-year population estimate	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2007/08	51,594,959	55,498	107.6	37,320,817	33,434	89.6
2008/09	51,803,017	36,095	69.7	37,700,812	19,927	52.9
2009/10	52,306,371	25,604	49.0	37,326,212	13,220	35.4
2010/11	52,757,040	21,707	41.1	35,094,388	10,417	29.7
2011/12	53,312,604	18,022	33.8	34,502,306	7,689	22.3
2012/13	53,475,358	14,694	27.5	34,439,455	5,980	17.4
2013/14	53,976,973	13,362	24.8	34,327,781	5,034	14.7
2014/15	54,432,437	14,193	26.1	34,797,208	5,233	15.0
2015/16	55,018,884	14,143	25.7	34,576,351	5,162	14.9
2016/17	55,268,067	12,845	23.2	34,976,071	4,622	13.2
2017/18	55,268,067	13,286	24.0	34,708,849	4,739	13.7

* Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017 and quarter 4 of 2016/17.

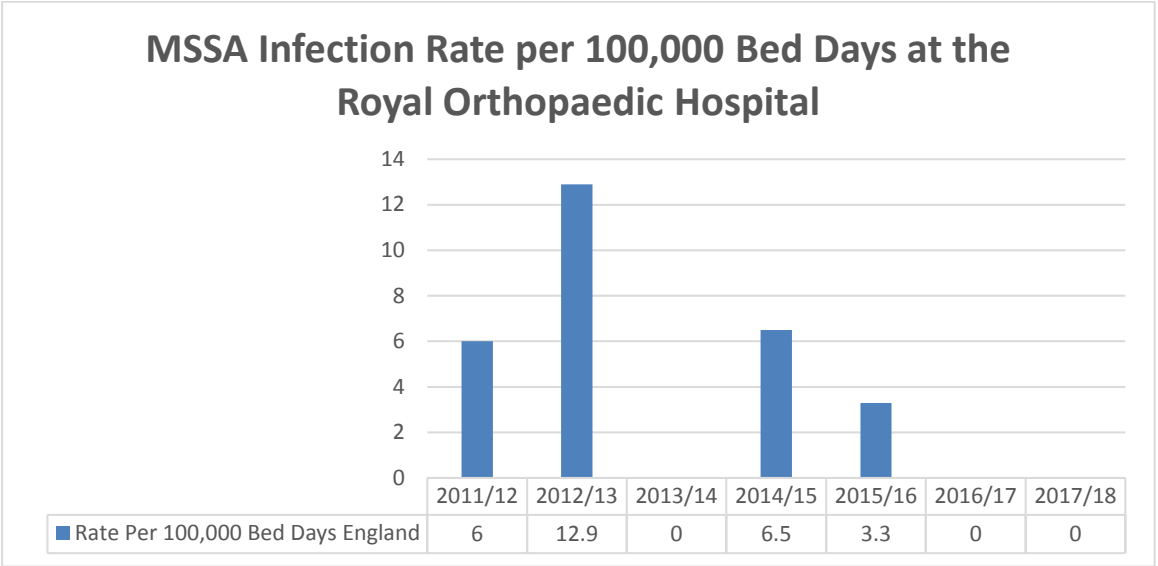
6.2.1 ROH CDI Action Plan

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (PCR positive).

All Hospital acquired CDI positive samples or cases where the patient has had a recent hospital stay at ROH are submitted to Public Health England for ribotyping. Samples with the same ribotype are then examined further variable number tandem repeat (VNTR). This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures, with decanting and deep-cleaning of the patient areas if necessary.

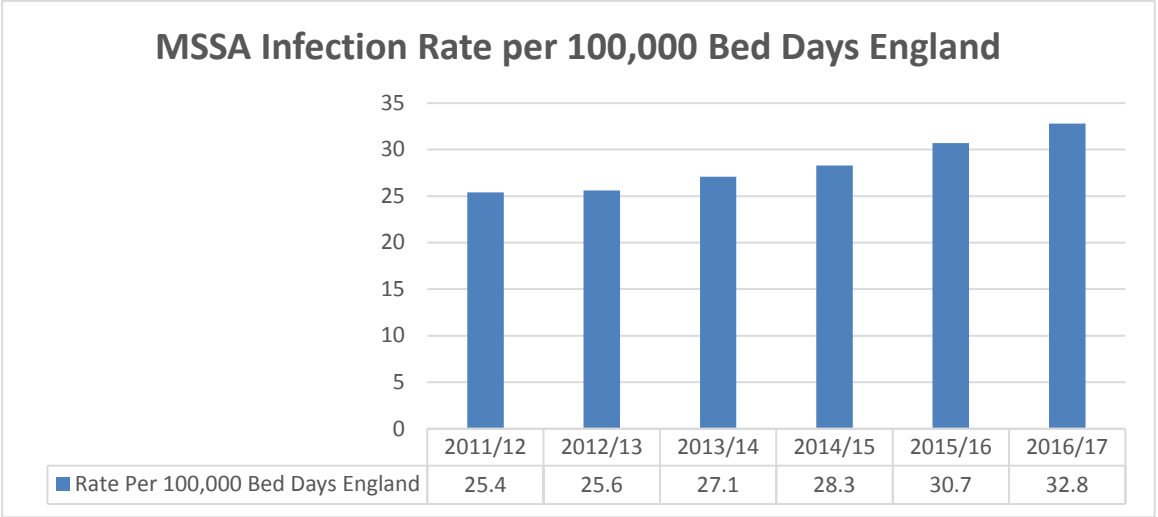
In all cases control measures are instigated immediately, and RCA's are reviewed. Each inpatient is reviewed by the IPC nurse regularly. In cases of Bone Infection Unit (BIU) patients, they form part of the weekly multi-disciplinary review where the patients' case is discussed including antibiotics and where necessary feedback to ward doctors. All HCAI CDI cases are subject to a post infection review and each case is discussed with the Lead IPC Nurse at Birmingham and Solihull Clinical Commissioning Group (BSolCCG) to determine the avoidability (lapses in care) with feedback given to IPCC and relevant Divisions. The Divisions action Duty of Candor where necessary.

ROH closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic Clostridium Difficile in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic Clostridium Difficile within a period of 28 days and associated with stay in the same ward or area.



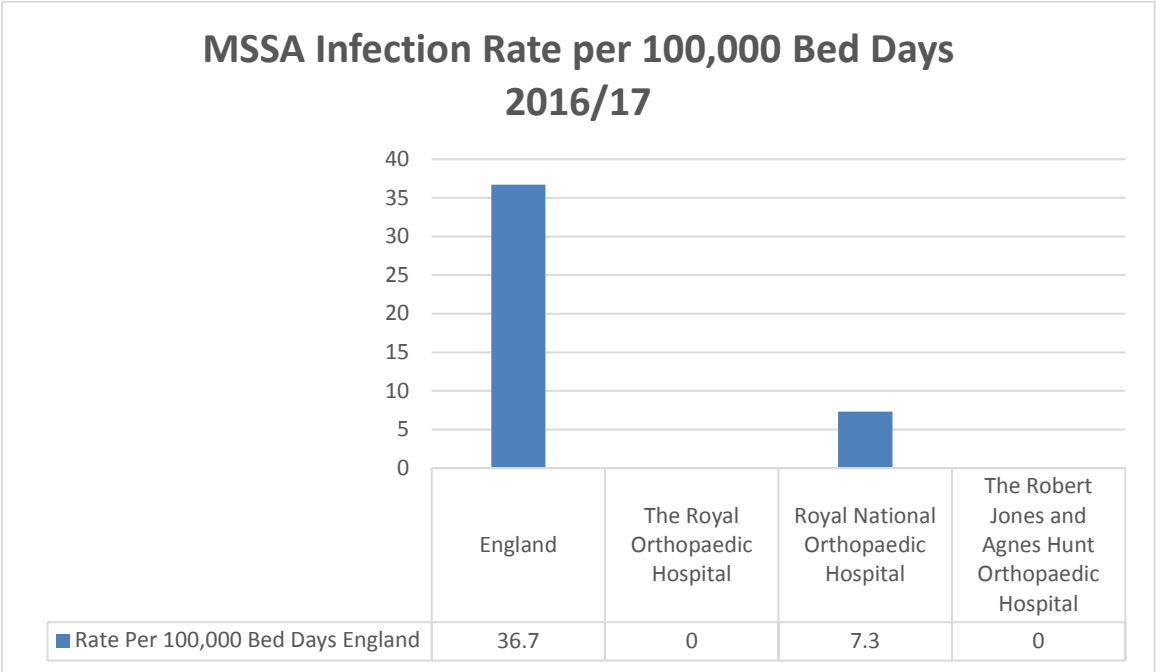
Source: https: //www.gov.uk/government/organisations/public-health-england

There has been a decrease in MSSA infection rates since 2014/15. In the period for this report there have been **zero** cases at ROH.



Source: https: //www.gov.uk/government/organisations/public-health-england

There has been an overall increase in MSSA infection rates on the whole in England.



Source: https: //www.gov.uk/government/organisations/public-health-england

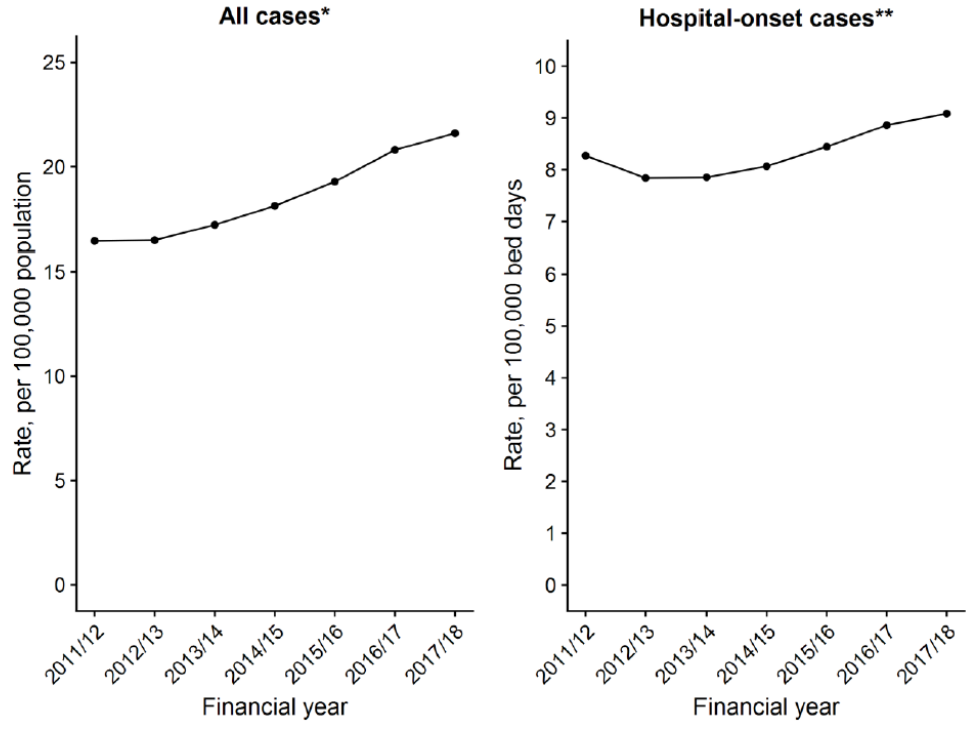
Final Data

Meticillin-susceptible *Staphylococcus aureus* bacteraemia

Total reports

A total of 11,938 cases of MSSA bacteraemia were reported by NHS acute Trusts in England between 1 April 2016 and 31 March 2018. This is an increase of 3.8% from 2016/17 (n = 11,499), and an increase of 36.2% from 2011/12 (n = 8,767). Figure 17 shows the trends in rates of MSSA cases for all cases and hospital-onset cases from 2011/12 to 2017/18. The rate of all MSSA cases per 100,000 population, per year has risen from 16.4 in 2011/12 to 21.6 in 2017/18.

Figure 17: Trends in the rate of MSSA bacteraemia in England



*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.
** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.

Hospital-onset reports

Of the 11,938 total cases reported in FY 2017/18, 3,153 were hospital-onset (9.1 per 100,000 bed-days). Similar to the all-MSSA case rate, the incidence rate for hospital-onset MSSA cases has increased steadily (from 7.8 in 2012/13 to 9.1 in 2017/18, a change of 15.9, Table 21).

Table 21: MSSA counts and rates by financial year, England: 2011/12 to 2017/18

Financial year	Mid-year population estimate	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2011/12	53,312,604	8,767	16.4	34,502,306	2,854	8.3
2012/13	53,475,358	8,812	16.5	34,439,455	2,700	7.8
2013/14	53,976,973	9,290	17.2	34,327,781	2,696	7.9
2014/15	54,432,437	9,862	18.1	34,797,208	2,807	8.1
2015/16	55,018,884	10,608	19.3	34,576,351	2,920	8.4
2016/17	55,268,067	11,499	20.8	34,976,071	3,099	8.9
2017/18	55,268,067	11,938	21.6	34,708,849	3,153	9.1

*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

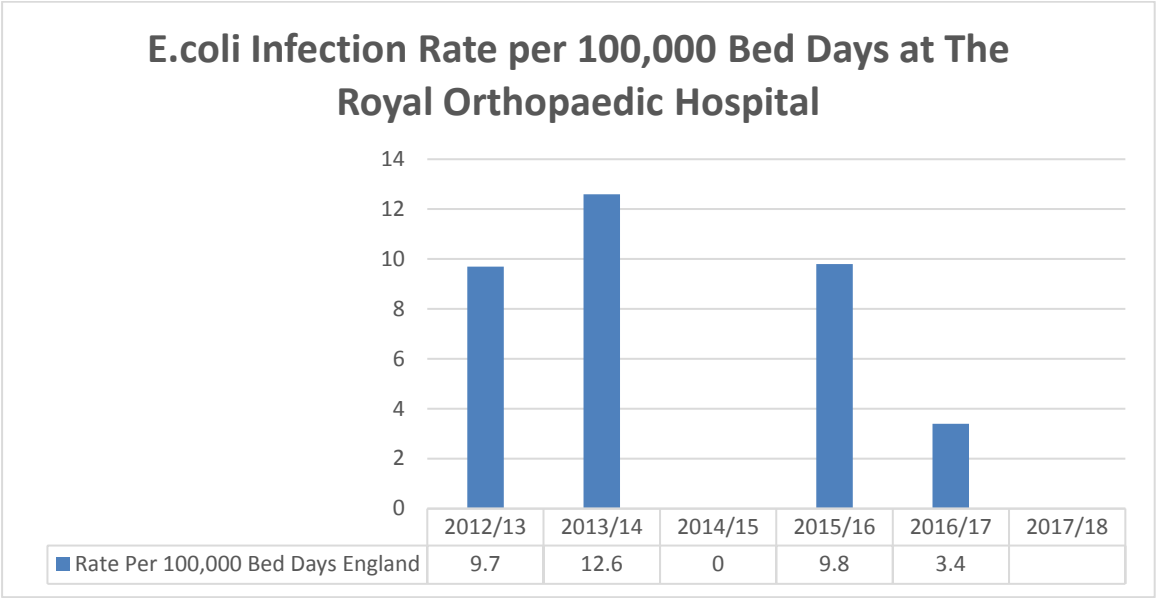
** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.

Gram negative – bloodstream infections – Escherichia coli (E-coli)

The Secretary of State for Health, (2017) launched an ambition to reduce healthcare associated Gram-negative bloodstream infections (BSIs) by 50% by 2021. Gram-negative BSIs are believed to have contributed to 5,500 NHS patient deaths in 2015. The initial focus to support this ambition is on E-coli BSI reduction. Enhanced surveillance of E. coli BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to PHE.

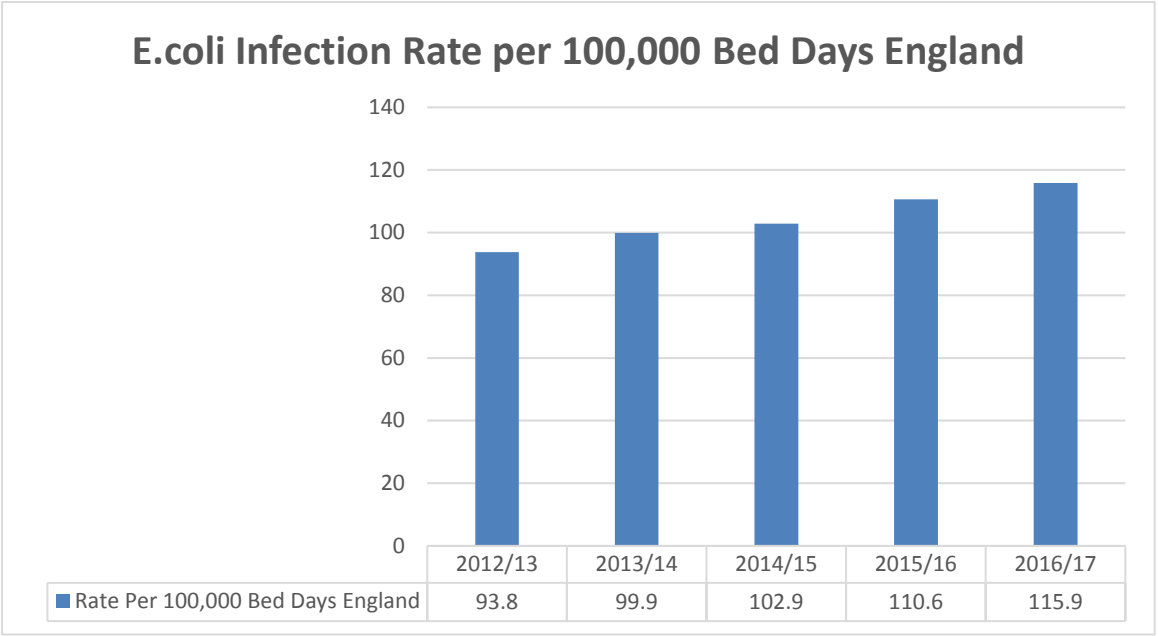
ROH have in place an action plan to support this ambition. In total this year there have been two hospital -associated cases (post-48 hours after admission).

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases.
The bacterium is found in faeces and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli BSI may be caused by primary infections spreading to the blood.



Source: https: //www.gov.uk/government/organisations/public-health-england

There has been a decrease in E.coli infection rates since 2015/16. In the period for this report there have been two cases at ROH.



Source: https: //www.gov.uk/government/organisations/public-health-england

There has been an increase in E.coli infection rates in England since 2012/13.

Final Data 2017/2018

E. coli bacteraemia

Total reports

A total of 41,060 cases of *E. coli* bacteraemia were reported by NHS Trusts in England between 1 April 2017 and 31 March 2018 (Table 1). Of the 41,060 *E. coli* cases, 7,704 (18.8%) were hospital-onset. The total number of cases reported in 2017/18 is an increase of 1.1% from 2016/17 (n = 40,630), and an increase of 27.1% from 2012/13 (n = 32,309). Figure 1 shows the trends in the rates of *E. coli* cases from 2012/13 to 2017/18. The rate of *E. coli* cases per 100,000 populations has risen from 60.4 in 2012/13 to 74.3 in 2017/18.

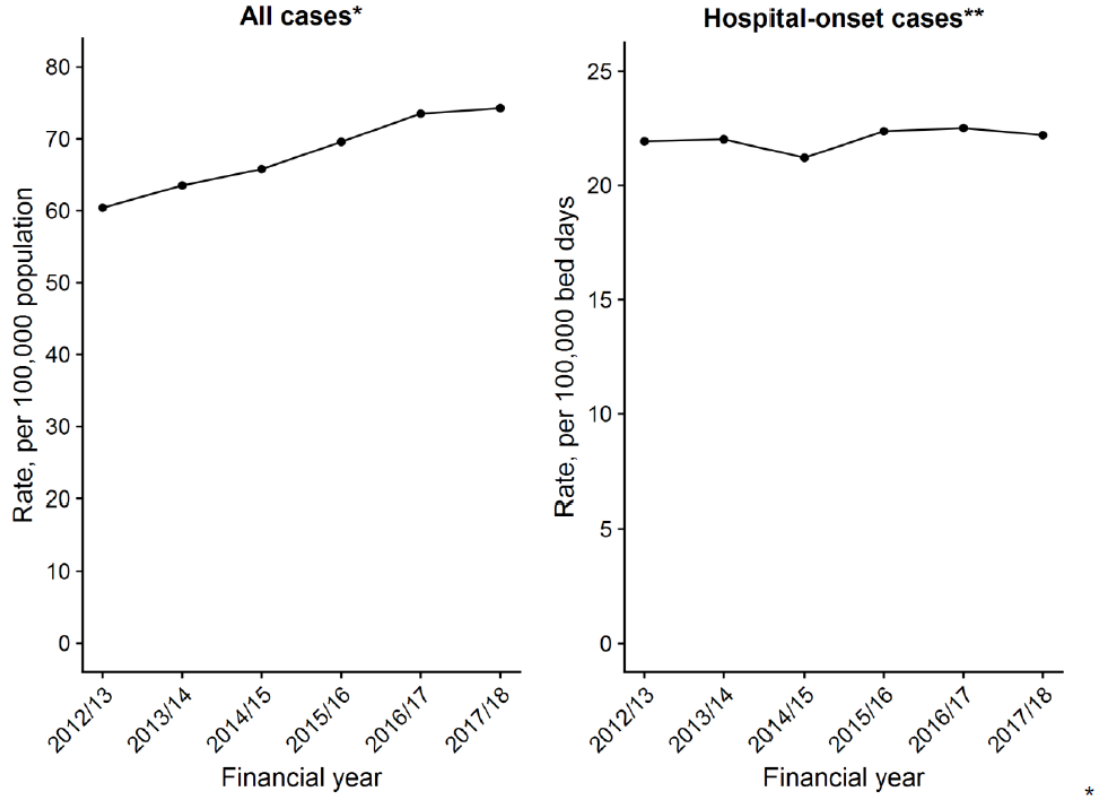
Table 1: *E. coli* counts and rates by financial year, England: 2012/13 to 2017/18

Financial year	Mid-year population estimate*	All reported cases	Rate (all reported cases per 100,000 population)	Total bed-days**	Hospital-onset cases	Rate (Hospital-onset cases per 100,000 bed-days)
2012/13	53,475,358	32,309	60.4	34,439,455	7,552	21.9
2013/14	53,976,973	34,286	63.5	34,327,781	7,558	22.0
2014/15	54,432,437	35,812	65.8	34,797,208	7,380	21.2
2015/16	55,018,884	38,288	69.6	34,576,351	7,735	22.4
2016/17	55,268,067	40,630	73.5	34,976,071	7,874	22.5
2017/18	55,268,067	41,060	74.3	34,708,849	7,704	22.2

*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

** Bed day data were not available for quarter 4 of FY 2017/18 (January to March, 2018). As a result, the 2017/18 bed day data is an aggregate of quarters 1, 2 and 3 of 2017/18 and quarter 4 of 2016/17.

Figure 1: Trends in the rate of *E. coli* bacteraemia in England, 2012/13 to 2017/18



*Mid-year population estimates for 2017/18 were not available at time of publication and so population data for 2016/17 were used as a proxy.

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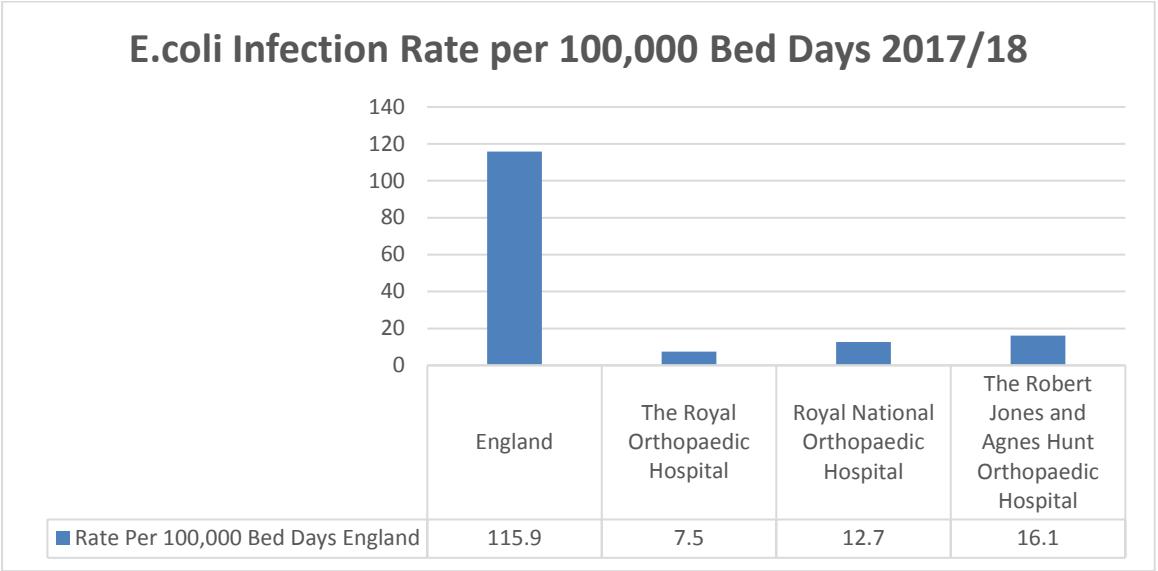


Source: https: //www.gov.uk/government/organisations/public-health-england

In comparison to other specialist Trusts in England, ROH had less reported cases of E.coli.

VANCOMYCIN/GLYCOPEPTIDES RESISTANT ENTEROCOCCI (VRE/GRE)

Enterococci bacteria are frequently found in the bowel of normal healthy individuals. There are many different species of enterococci, but only a few have the potential to cause infections in humans. They can cause a range of illnesses including urinary tract infections, bacteraemia, and wound infections.

Glycopeptide-resistant Enterococci (GRE) are enterococci that are resistant to glycopeptide antibiotics (vancomycin and teicoplanin). GRE are sometimes also referred to as VRE (Vancomycin-Resistant Enterococci). Infections caused by GRE mainly occur in hospital patients. However, GRE are sometimes found in the faeces of people who have never been in hospital or have not recently been given antibiotics.

The Department of Health advised that from 1 April 2013, VRE / GRE is no longer the subject of mandatory surveillance

For the period covered in this report there have been zero cases of GRE at ROH which is the same compared to the previous year.

CARBAPENEMASE PRODUCING ENTEROBATERIACEAE (CPE)

The use of many different types of antibiotics in hospitals creates evolutionary pressures that encourage the development and spread of antibiotic-resistant bacteria. This process is a natural consequence of the use of antibiotics and cannot be stopped, only managed.

Enterobacteriaceae are a group of bacteria carried in the gut of all humans and animals, which is perfectly normal. While they are usually harmless they may sometimes spread to other parts of the body such as the urinary tract or into the bloodstream (bacteraemia) where they can cause serious infections.

Public Health England published a toolkit for the early detection, management and control of CPE in December 2013. The toolkit provides expert advice on the management of CPE to prevent or reduce

spread of these bacteria into (and within) health care settings, and between health and residential care settings.

ROH adheres to the national guidance and toolkit and perform three screening episodes 48 hours apart. For the period covered in this report there have been zero cases of GRE at ROH which is the same compared to the previous year.

TUBERCULOSIS (TB)

Tuberculosis (TB) is an infection caused by a bacterium belonging to the Mycobacterium tuberculosis complex. TB is a notifiable disease in the UK. Suspected and confirmed diseases must be notified within three working days.

TB usually affects the lungs but can also affect almost any other area of the body. Most transmissions occur from some people with pulmonary or laryngeal TB and are infectious.

TB develops slowly and it usually takes several months for symptoms to appear.
ROH had zero cases of TB infection over 2017/18.

NOROVIRUS OUTBREAKS

Norovirus causes gastroenteritis and is highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another.

Outbreaks are common in semi-enclosed environments such as hospitals, nursing homes, schools, and cruise ships and can also occur in restaurants and hotels.

The virus lasts for one to two days. Symptoms include vomiting, diarrhoea, and fever. Most people make a full recovery within a couple of days but it can be dangerous for the very young, very sick, and elderly people.

ROH had zero cases of Norovirus outbreaks over 2017/18.

7 Audit programme to ensure key policies are implemented

The ROH has a programme of audits in place undertaken by both clinical areas and the IPC Team to provide assurance around practice and consistent compliance with evidence based practice and policies. Where a period if increased incidence occurs / risks are identified the IPC Team undertake additional audits in accordance with risk requirement. Action plans are devised by areas where issues are highlighted and these are managed and monitored within the divisions and escalated to IPCC and upwardly reported through the robust ROH Governance structure.

8 Audits of hand hygiene practice

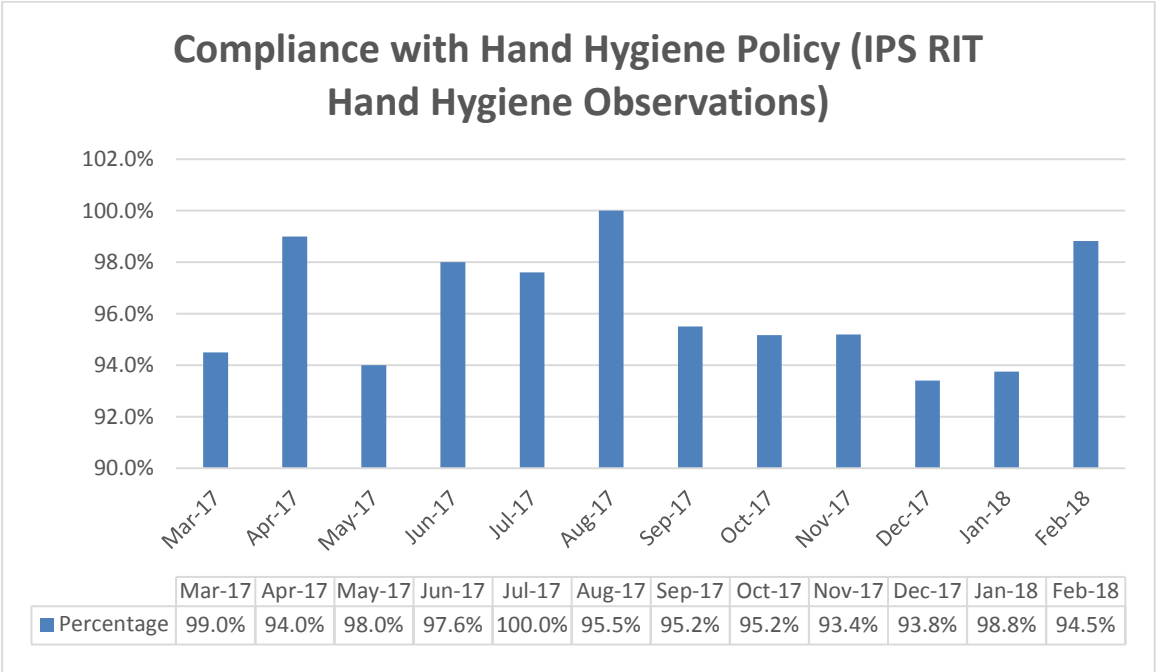
Hand hygiene remains central to the audit programme. The IPC Link Nurses perform 'Glow & Tell' training and assessments on hand hygiene within their areas.

The Link Nurses audit hand hygiene monthly by peer review. Other audits include;

Environment
Technique
Observation

The Trust continues to focus on four main components:

Alcohol hand rubs at point of care prominently positioned by each patient so that hands can be cleaned before and after care within the patient's view.
Audit of hand washing practice at least monthly. Wards that do not achieve 95% repeat the audit after 2 weeks.
Patients are encouraged to challenge staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.
Raised awareness of hand hygiene and the 'Bare below the elbow' dress code



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Percentage	99.0%	94.0%	98.0%	97.6%	100.0%	95.5%	95.2%	95.2%	93.4%	93.8%	98.8%	94.5%

ROH has been exceeding the threshold of 90% set by the Commissioners in 2017/18.

9 Staff information and training

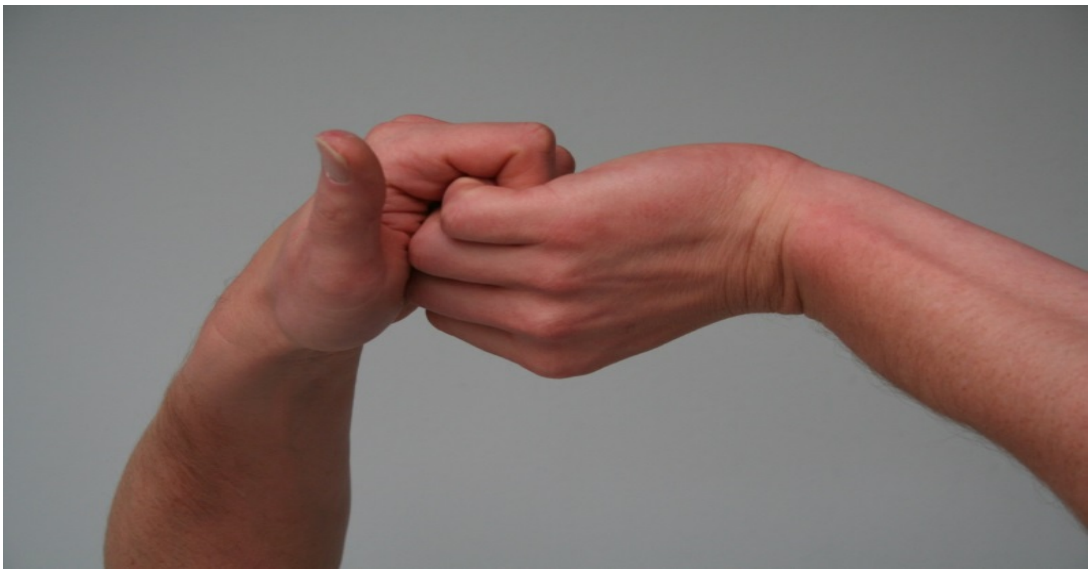
- The IPC team has provided mandatory hand hygiene training for all ROH employees through induction days, mandatory study days, and ward-based enhanced training.
- ROH hand hygiene provider, DEB UK, have standardized products, posters, dispensers across the Trust and have provided training and audit at operational level for all clinical areas.
- The induction IPC training package was updated to reflect the requirements of new employees to ROH.
- Communication of key messages via a number of media including social networks.
- The World Health Organisation (WHO) '-Five Moments of Hand Hygiene' is in use across ROH with the support from Communications. This campaign continues to be communicated both internally and externally with the support from social media.
- The IPC team continues to work collaboratively with suppliers and Estates and Facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment or processes.
- Additional on-going infection prevention surveillance and support continues across ROH with daily infection prevention visits to high risk areas.
- Bespoke infection prevention training has been developed, in line with HBN 00-09, for all preferred contractors coming into ROH. This training will be a pre-requisite for contractors to undertake prior to working on site and will be implemented in 2018/19.
- The IPC team continue to work with clinical staff and support clinical site managers with safe bed utilisation. A training package has been developed to support this and will be implemented in 2018/19.
- The IPC Team facilitated the national antibiotic awareness and hand hygiene days across ROH, this is in addition to promotional activities that they have supported throughout the year.

10 Seasonal Staff Influenza Vaccination Campaign

The seasonal influenza staff vaccination campaign is well established at ROH. The campaign officially commenced on 1st October 2016 with a wealth of information / videos available to staff on the Trust intranet, as well as the locally based influenza champions. The uptake for 2017/18 was 70.21% compared to 2016/17 which was 54%.

11 IPC Link Nurses

ROH, within each clinical area, has in place dedicated IPC Link Nurses. These nurses are supported by the IPC Team and attend monthly education / study days to support them in their roles. They provide advice, support, education and training to operational staff as well as monitoring compliance with the IPC agenda.

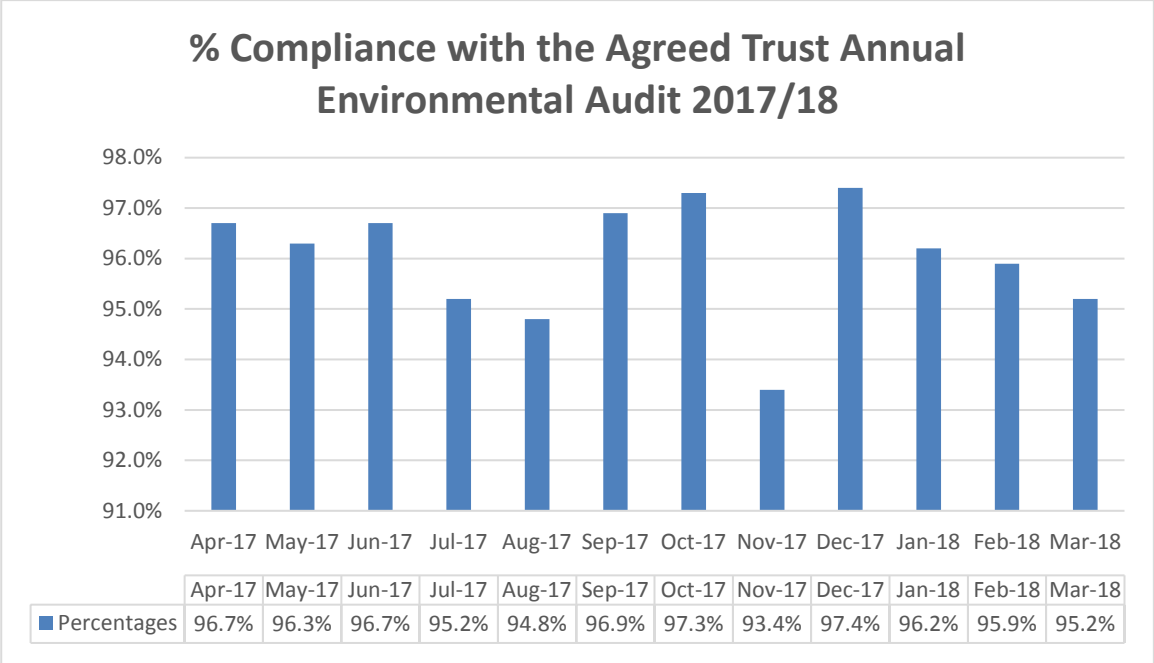


COMPLIANCE CRITERIA 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Providing a clean safe environment

- There is a designated Facilities Manager for cleaning services that are managed in house.
- The IPC Team support ROH bed management / clinical staff to ensure efficient / appropriate bed utilistion
- IPC Team are involved in capital planning schemes to support the needs of IP across ROH in refurbishments and new builds.
- The IPC Team oversees assurance of standards and reduction of risk in partnership with divisional management teams through audit, monitoring of standards, and shared learning.
- ROH use Bioquelle, a specialised decontamination method, for the removal of environmental contaminants to ensure a safe, clean environment.
- Domestic staff continue to provide cover in all patient areas until 20.30 hrs. seven days a week and then the rapid response team was employed within FGH and RLI to provide night cover.
- Training for domestic staff continues to be provided by British Institute for Cleaning Standards and is refreshed annually.
- Head of Infection Prevention meets, on a monthly basis with Head of Estates / Facilities to review cleanliness standards and any issues identified by monthly audits. Issues are discussed at IPOG and escalated, as required to IPCC.
- ROH contract out to an accredited facility for decontamination services.
- ROH theatres have a schedule of annual servicing of the ventilation systems. In addition regular microbial air count monitoring has taken place.
- ROH participate in the annual Patient Led Assessments of The Care Environment (PLACE).



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Percentages	96.7%	96.3%	96.7%	95.2%	94.8%	96.9%	97.3%	93.4%	97.4%	96.2%	95.9%	95.2%

Apart from August and November, ROH has been exceeding the threshold of 95% set by the

Commissioners in 2017/18.

Water Systems Management

- Following the Department of Health publication, 'Water sources and potential Pseudomonas aeruginosa contamination of taps and water systems: advice for augmented care units' (2012), ROH test and monitor waters from augmented care areas. Additional areas are tested if there was a clinical suspicion that waters may have been linked to a patient's infection or colonisation. The Consultant Microbiologists support this management process and provide advice / support as required.
- ROH Water Safety Group, with its dedicated AE for waters, is responsible for the oversight of water safety and continue to meet on a monthly basis.
- The Water Safety group is a sub group of IPCC and reports directly to IPCC. The group is chaired by the Head of Estates.
- Estates and Facilities, Consultant Microbiologists, and the IPC Team support the water management process across ROH.

Management of Decontamination

The management and compliance currently falls into three distinct areas;

- Estates – for medical device reprocessing equipment / scheduled maintenance where required
- Infection Prevention – for monitoring / audit of compliance of medical devices with Trust Policies
- User – to comply with Trust Policies and to ensure that decontamination of equipment is fit for use and subject to periodic testing and maintenance as advised by the manufacturer / contractual agreement

An external peer review was commissioned in May 2016 to review the Decontamination facilities at ROH. An action plan was subsequently developed with work undertaken as a result and almost completed by March 2018 with the removal of a decontamination unit, within the theatre space, being the only outstanding requirement.

11.1 Theatres Closure

All ten theatres were closed at ROH from 30th March, 2018 for a planned programme of maintenance and refurbishment. Elective surgery recommenced on Tuesday 9th April, 2018 post a deep clean and sign off by the IPC Team and Theatre Management Team.

COMPLIANCE CRITERIA 3
Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Sepsis and Antimicrobial Stewardship (AMS)

For the period 2017 /18 the ROH participated in a combined CQUIN with four components (2a-2d) with 2a and 2b focusing on sepsis recognition and screening, and 2c and 2d on antimicrobial prescription review and consumption within the Trust.

An AMS Committee was formed within ROH 2017/18 with a new dedicated Lead Antimicrobial Pharmacist appointed to review all patients on antimicrobials. Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends. This is reported to the Drugs and Therapeutics Committee (DTC) and IPCC and any areas of concern addressed with Microbiologists.

The current deteriorating/septic patient policy has been renamed as the Policy for the Escalation of the Deteriorating patient or patient with suspected sepsis. This is to ensure that when staff are conducting a search for sepsis on the intranet that the policy is easily identified. The Sepsis Six Pathway is embedded within ROH.

Sepsis audit identified that the screening of patients for sepsis was completed appropriately and in-line with the Trust policy. However the CQUIN was only partially achieved for Quarter 4 as less than 90% of patients were screened appropriately, which is lower when compared to the results for Quarter 3.

The AMS consumption data shows a greater than two-fold increase in Ertapenem usage, which is linked to issues to the BIU team to manage complicated infections and facilitate discharges. Local agreement to remove such issues from our antibiotic consumption reporting data has been agreed due to this. Therefore figures for issues including and excluding BIU have been reported.

Overall Meropenem usage decreased compared to the baseline data. Comparison of the grouped DDM data for Meropenem shows that a 7% reduction in usage has been achieved. An overall reduction of 8% in Carbapenem usage is reported (not including Ertapenem issues to the BIU service) which achieves the 2% reduction CQUIN requirement for this indicator.

Tazocin usage decreased compared to the baseline data, which is a positive result. A 9% reduction in the usage of Tazocin 4.5g vials, which achieves the 2% reduction CQUIN requirement for this indicator. Antibiotic consumption has reduced by 5% compared to 2016 based upon predicted DDD per 1000 admissions data (10% reduction if BIU antibiotic consumption is excluded).

COMPLIANCE CRITERIA 4
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion

Communications

- The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.
- The IPC Team work collaboratively with ROH Communications team who support dissemination of IPC communications both internally and externally as required.
- The IPC Team meet monthly to update each other on areas of work and plan ahead. All IPNs receive an annual appraisal.
- The IPC Team utilize social media accounts that enables communication internally and externally with the public and other organisations. This has proved beneficial with sharing of best practice and communicating to a wider health economy.
- The ROH Weekly Message from the CEO supports and cascades messages from the IPC team across the organisation.
- The Trust website promotes infection prevention issues and guides users to information on MRSA, Clostridium Difficile and other organisms.

COMPLIANCE CRITERIA 5
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because they can increase a patient's length of stay in hospital and "are associated with considerable morbidity and it has been reported that over one-third of postoperative deaths are related, at least in part, to SSI. However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition" NICE (2008)3.

Guidelines for the prevention of SSI were issued by the National Institute for Heath and Clinical Excellence (NICE) in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health. These guidelines are outlined in the following table.

Period	Action	Evidence	Introduced at ROHFT
Pre-operative	Showering	+ / -	x
	S.aureus decolonisation	+ / -	x
Peri-operative	Antibiotic prophylaxis	+	✓
	Skin preparation	+	✓
	No shaving with razors	+	✓
	Theatre environment/procedures	+	In part - ongoing
	Surgical technique	+	✓
	Normothermia	+	In part - ongoing
	Glucose control	+	✓
Post-operative	Wound management	+ / -	✓
	Surveillance and feedback of rates	+	✓

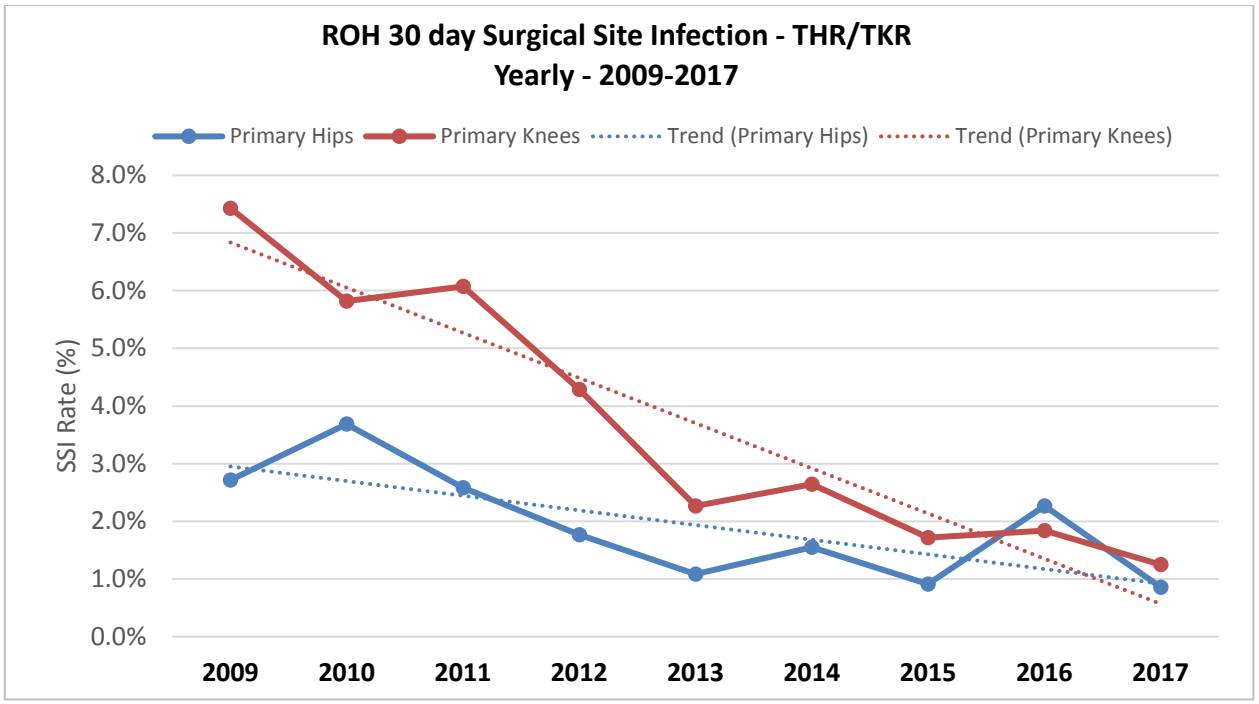
Many of these actions are in place, with the addition of others exceeding the National Guidance, at ROH. ROH have in place an established wound care helpline that can offer the patient an appointment at the SSI clinic, on the same day, should it be required This allows the review of patients by specialist staff allowing rapid treatment / admission where required avoiding the unnecessary prescribing of antibiotics by GPs.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice as necessary.

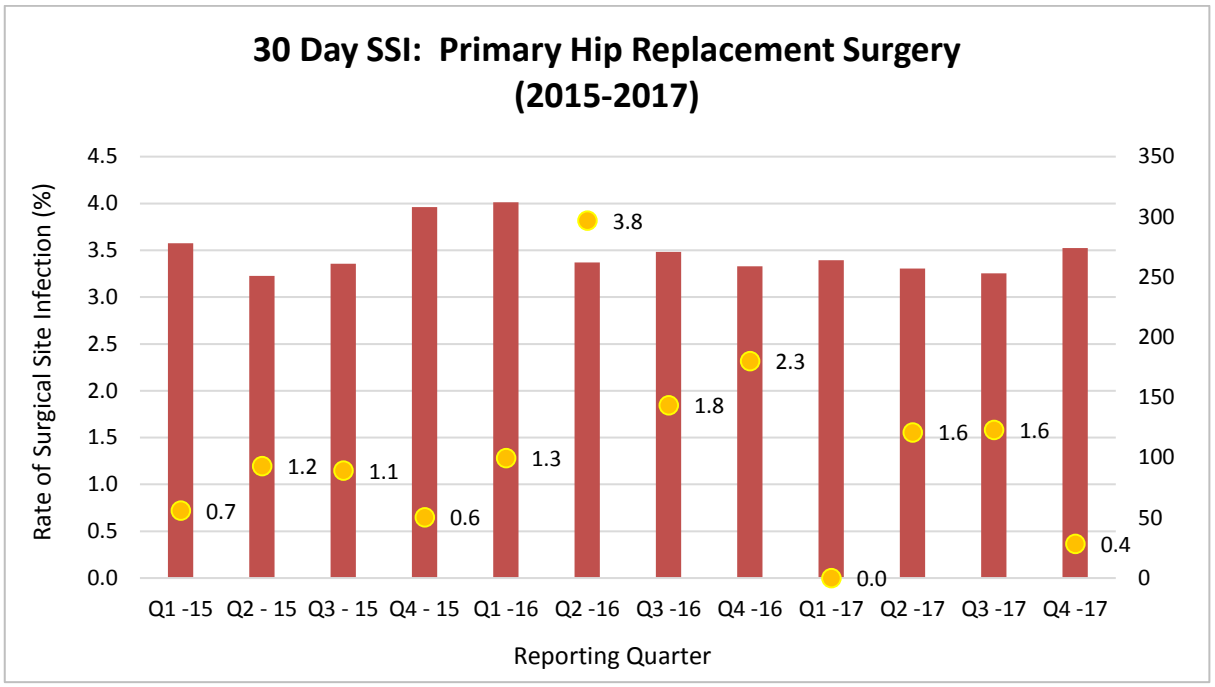
- hip replacement
- knee replacement
- repair of neck of femur
- reduction of long bone fracture

Primary arthroplasty surgery is constantly reviewed and montored as part of the SSI surveillance programme at ROH. SSI surveillance is routinely carried out according to Public Health England protocol at the point of discharge from hospital and at 30 days post primary hip and knee replacement surgery and has received close attention since 2009 when the 30 day surveillance was introduced.

The data presented within this report is a combination of Mandatory surveillance data for Surgical Site Infections identified following hip and knee replacement surgery carried out and wider analysis surgical site infections in other specialties where it is available. In addition to this there is also in- house data collected by the IPC Team, which looks at a number of other areas of interest. This enables the team to gain an informed understanding of SSI across all divisions and the potential for them to have longstanding implications for patients and significant financial implications for the Trust.



Source: ROH SSI Databases



Source: ROH SSI Databases

SSI Rate	2009	2010	2011	2012	2013	2014	2015	2016	2017	% Change from 09-17
Primary Hips	2.7%	3.7%	2.6%	1.8%	1.1%	1.6%	0.9%	2.3%	0.9%	-69.0%
Primary Knees	7.4%	5.8%	6.1%	4.3%	2.3%	2.6%	1.7%	1.8%	1.2%	-80.6%
No. of SSI	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	
Primary Hips	29	37	29	19	11	18	10	25	9	
Primary Knees	62	47	53	34	17	21	15	16	12	
No. of Procedures	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	
Primary Hips	1068	1004	1123	1074	1017	1160	1097	1104	1048	
Primary Knees	821	808	873	793	751	795	873	869	961	

Source: ROH SSI Databases

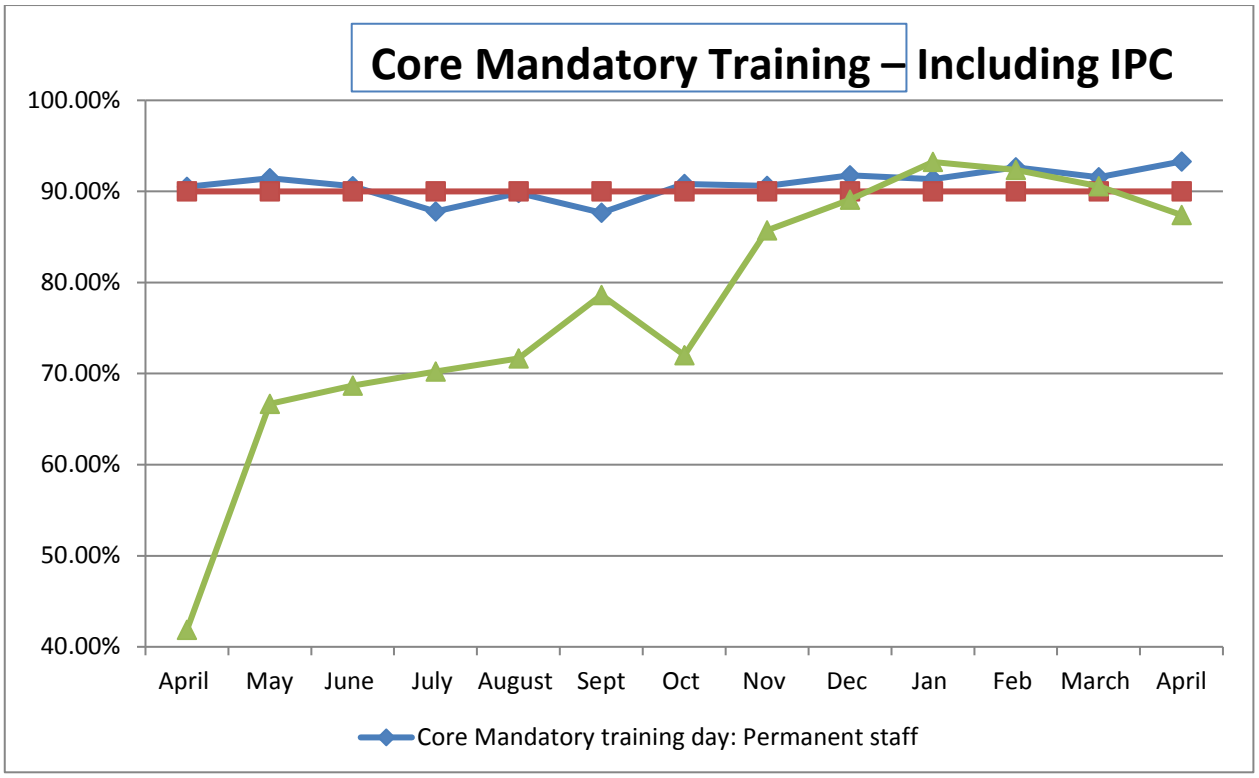
The 30 day post op SSI rates in Q1 for the primary hip replacements were 0.0% and 0.7% for primary knee replacements. There was a rise in SSI rates during Q2, primary hip replacements 2.1% and knee replacements 1.8%. In Q3 it was shown that there was a decrease in SSI rates for primary hip replacements at 1.6% but a continuing rising rate of SSI'S in primary knee replacements 2.3%. Bringing the surveillance to an end during Q4 there was and increase again in SSI rates for primary hip replacements at 2.0% and a continued SSI rate increase for primary knee replacements 3.1%.

COMPLIANCE CRITERIA 6

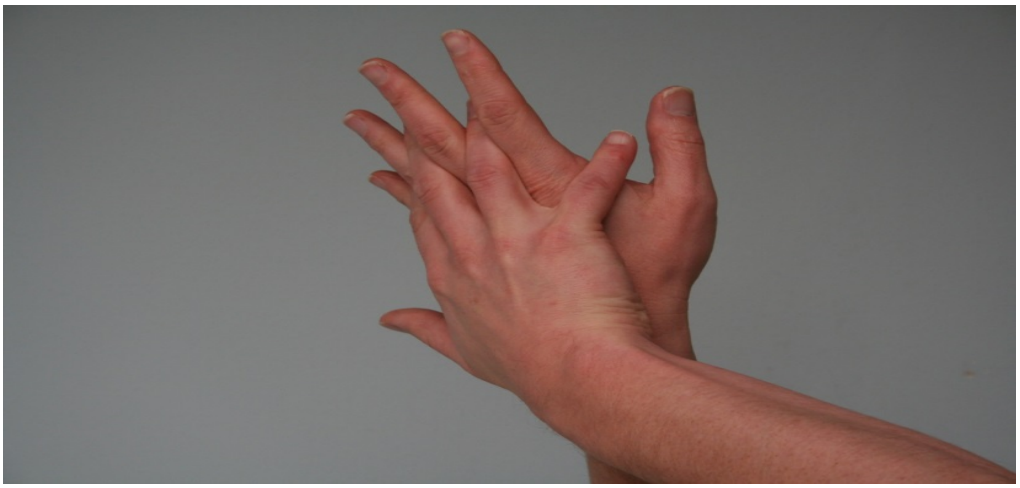
Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection

At ROH infection prevention is everyone's responsibility and is included in all job descriptions.

All clinical staff receive training and education in optimum infection prevention practices during mandatory training and Link Nurse teaching sessions.



A target of 90% set by the Commissioners was met / exceeded every month apart from July and September when training did not take place.



COMPLIANCE CRITERIA 7
Provide or secure adequate isolation facilities

Isolation Rooms

Wards

39 isolation rooms with en-suites.
3 isolation rooms without en-suite.

HDU

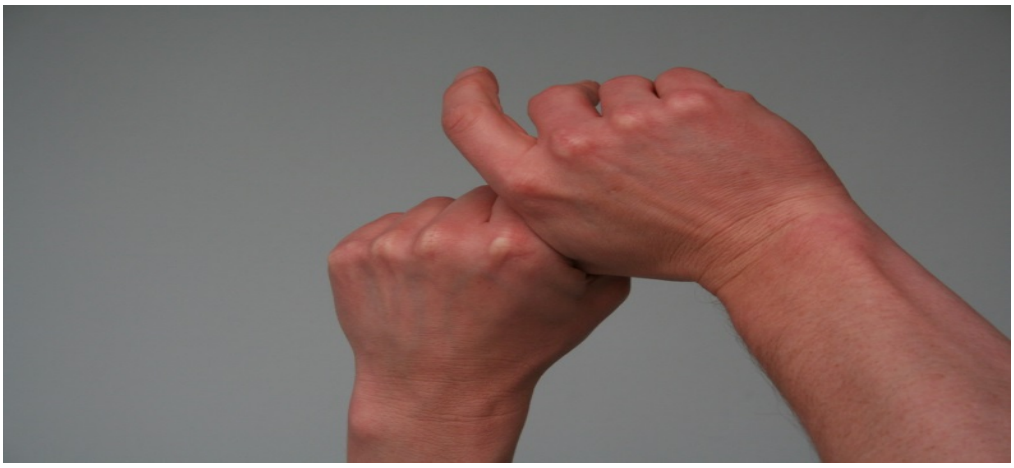
2 Adult Side Rooms without en-suites.
2 paediatric isolation rooms with ensuite.

COMPLIANCE CRITERIA 8
Secure adequate access to laboratory support as appropriate

Laboratory services for ROH are outsourced, located in the purpose built Pathology Laboratory at University Hospitals Birmingham. The Microbiology Laboratory has full Clinical Pathology Accreditation (CPA) and has been recommended for UKAS Accreditation to ISO Standard 15189.

COMPLIANCE CRITERIA 9
Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, procedures and manuals are available for staff to view on the Trust intranet. There is a formal Governance structure in place for reviewing and ratifying such documents within ROH and Clinical Governance has produced a directory of documents alerting when policies are due for update. Policies are also updated prior to review date if guidance is updated.



COMPLIANCE CRITERIA 10
Providers have a system in place to manage the occupational health needs of staff in relation to infection

All job descriptions include infection prevention responsibility and this message is reiterated during mandatory training. The IPC Team participates in mandatory updates for all staff groups (clinical and non-clinical). The IPC Team regularly meet with representatives of the Occupational Health service to ensure compliance with Criteria 10. A representative from the Occupational Health Service is a member of the IPCC under the TOR.

Occupational Health services are provided to staff via an SLA with the Heart of England Foundation Trust.

Summary

2017 - 2018 has been a busy and challenging year for ROH staff and for the IPC Team. I am delighted in the number of infection prevention improvements that continue to improve the patients' experience and strengthen patient safety processes and standards. These improvements demonstrate ROH's commitment to harm free care and reduction in avoidable health-care associated infections.

Together with our staff, governors and volunteers we have created vision and values which clearly state where we are going and how, as a team, we will behave towards each other, our patients, and partners.

Infection prevention and control is the responsibility of all of us and is fundamental when delivering the vision and values of ROH. Clinically effective infection prevention and control practice is an essential feature of patient protection. By incorporating the principles of infection prevention into routine daily clinical practice, patient safety can be enhanced and the risk of patients acquiring an infection during episodes of health care can be minimised.

Our staff demonstrate through practice that they care about patient safety. We should all be proud of the reductions made in harms, including reductions in hospital-acquired infections.

2018-19 provides an opportunity for us to work as a healthcare system to influence even bigger reductions in patient harms. A key area for us to focus on, over the coming year, will be the reduction in Gram-negative blood stream infections in the community and in hospital. Working as partners in care will enable us to achieve so much more than any part of the system could deliver in isolation.


Your 5 Moments
for Hand Hygiene
1 BEFORE TOUCHING A PATIENT
2 BEFORE CLEAN/ASEPTIC PROCEDURE
3 AFTER BODY FLUID EXPOSURE RISK
4 AFTER TOUCHING A PATIENT
5 AFTER TOUCHING PATIENT SURROUNDINGS

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

ROHTB (3/19) 009

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 28 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that the treatment plans for some of the red financial and performance risks did not appear to be effective given that the post mitigation scoring remained unchanged – the Executive would revisit these plans and update accordingly. • Pay costs were above expectations, largely driven by agency costs, despite this being on a downward trend. Pay associated with temporary medical staff was noted to be a particular issue. • Delivery of the Cost Improvement Programme remained behind plan. • Sickness absence remained a concern, however long term sickness was reducing. There was noted to be no link between the spike seen in October and the uptake of the 'flu vaccination or half term. • A date of 30 June had been set for the transition of paediatric services to the Birmingham Children's Hospital. In the meantime the arrangements between the two hospitals needed to be strengthened to provide an adequate level of support to running the services at ROH. • The ROH remained vigilant around any vulnerability associated with the potential for a no deal Brexit arrangement.	• An update on the development of the private services to be presented to the Trust Board when there is greater clarity on the offering. • Work to be done to identify the impact of additional activity using direct costs as a measure. • Brief the Board on the measures being taken to reduce DNAs when appropriate. • Ask to Board to sign up to the Control Total at the February 2019 workshop session.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received an update on the plans for marketing the services of the ROH, including the appointment of a GP Liaision Manager who would help with the promotion of the private patient offering and the JointCare service. • Work was reported to be underway with a large private provider of orthopaedic services to develop a partnership arrangement. • Inpatient activity was reported to be above plan and income overall was noted to be ahead of the same position during the previous year.	• None specifically.

• Length of stay had reduced. • The number of patients waiting in excess of 52 weeks was reported to have reduced below the trajectory. Work was underway to try to clear all patients in this cohort by the end of the financial year. • The committee received a positive update on the plans to reduce 'Did Not Attend' (DNA) rates, using new technology to allow patients to access their appointment letters and to use a text messaging reminder system. • The Board received an update on the latest planning guidance and the new funding arrangements. • A decision was awaited on the planning permission for the new modular theatres. • Overall, there was good progress with the 'Perfecting Pathways' programme. • It was reported that there was full compliance against the Emergency Preparedness, Resilience and Response requirements (EPRR)	
Chair's comments on the effectiveness of the meeting: The meeting had run to time and included some focussed discussion on key issues.	

ROHTB (3/19) 010

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 26 February 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was an overall shortfall against the financial plan, which needed to be recouped before the year end in order to meet the Control Total. • There remained underperformance with the delivery of the Cost improvement Programme (CIP), however every effort was being taken to identify new schemes where possible. • Performance against the 18 weeks Referral to Treatment Time target had dipped, this being particularly associated with the volume of patients in the arthroscopy speciality. The overall 92% target was anticipated to be achieved by the end of the calendar year. • In terms of 'Perfecting pathways', it was highlighted that the expected contribution of clinical coding to the delivery of the CIP was not as great as initially anticipated. • There continued to be discussions and plans for Brexit, these being informed by national and regional guidance.	• Update the Trust Board on 6 March on the plans for the modular theatre build. • Present the capital plan to the Trust board for approval. • A further update on private patient work is needed at the April 2019 meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was reported to be a slight improvement against the planned in month deficit position. • The Committee was pleased to hear that the planning permission for the new modular theatres had been obtained. • There had been a successful nursing recruitment campaign and every effort was being taken to keep individuals engaged up until when they started in post. • Length of stay was noted to have reduced significantly, with a number of patients being discharged on the day after surgery. • The Committee reviewed the draft operational and financial plan for 2019/20, the final version of which needs to be submitted in April 2019.	• None specifically.

• A date for the paediatric transition had been set of July 2019. The Paediatric Oncology review was planned for 11/12 March 2019. There remained good oversight of the arrangements. • Overall, there was good progress against the 'Perfecting Pathways' workstreams. • The Committee received a useful presentation on the plans for the Private Patient Unit and the opportunities to grow private services. It was agreed that consultant engagement was key to the plans, as was the need to consider the patient experience across the full pathway from admission to discharge. The new GP liaision manager would take responsibility for developing a business case to grow the private patient market.	

Chair's comments on the effectiveness of the meeting: The Chair noted that overall, there was good performance, both financially and operationally, notwithstanding some key challenges. There had been good progress with developing the operational plan. The meeting had covered all key issues, despite there being a degree of time pressure .

Finance and Performance Report

January 2019

CONTENTS

INTRODUCTION

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

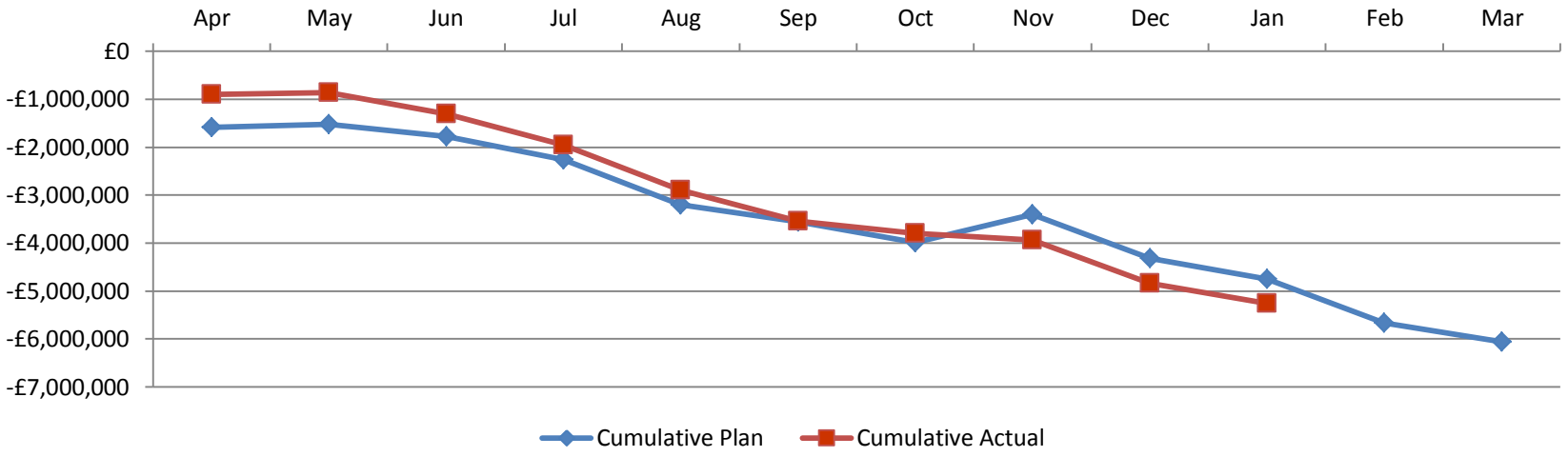
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

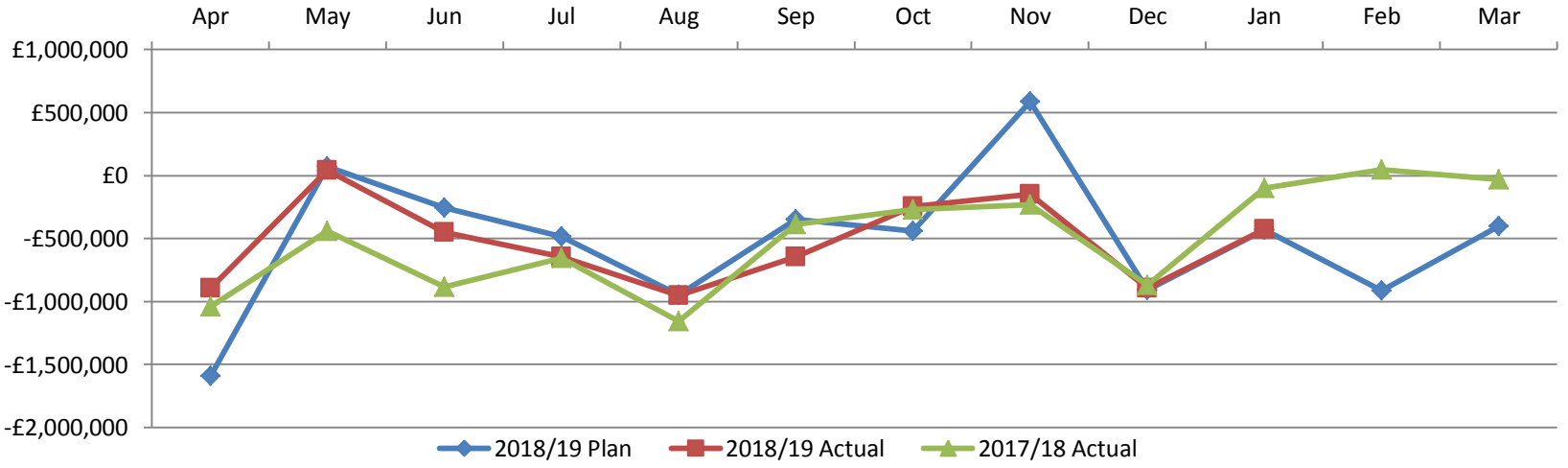
	YTD M10 Original Plan £'000	YTD M10 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	66,028	66,303	275
Other Operating Income	4,245	4,453	208
Total Income	**70,273**	**70,566**	**293**
Employee Expenses (inc. Agency)	(42,860)	(43,917)	(1,057)
Other operating expenses	(30,990)	(31,020)	(30)
Operating deficit	**(3,577)**	**(4,181)**	**(604)**
Net Finance Costs	(1,170)	(1,084)	**86**
Net deficit	**(4,747)**	**(5,265)**	**(518)**
Remove donated asset I&E impact	50	(138)	(188)
Adjusted financial performance (inc PSF)	**(4,697)**	**(5,403)**	**(706)**

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 £427k in January against a planned deficit of £432k, £5k favourable against plan. Year to date the Trust now has a deficit of £5,265k against a planned deficit of £4,747k; £518k adverse against plan which represents a small improvement from Month 9. However this includes a favourable adjustment of £185k which relates to the I&E impact of a capital donation which needs to be removed to asses performance against the control total. This gives a revised variance of £706k, which reduces to £450k behind plan excluding the impact of PSF. This is the value that the Trust needs to recover in the last two months.

Whilst this is a significant deterioration against plan, actual performance still represents a continued improvement in the last 2 months compared to previous months in the financial year. Planning for the rest of the year is prudent, therefore continued focus on activity delivery and cost control over the remaining two months should still result in achievement of the control total.

Admitted patient care activity ,and hence income fell below plan in January. Whilst this may initially seem disappointing, the failure of the lighting in one theatre resulted in reduced capacity for a period of weeks. This has now been replaced.

Expenditure was favourable to plan, as expected due to the reduced activity income performance.

CIP realisation remains challenging. £1,441k has now been delivered against a plan of £2,147k, £706k under-performance YTD (this reconciles to the adverse overall financial position against the plan) and it is unlikely that the Trust will deliver its CIP plan for 18-19. The forecasted CIP position for 18-19 is £1,725k against a £2,985k plan. (£1,259k forecasted under-performance against plan)

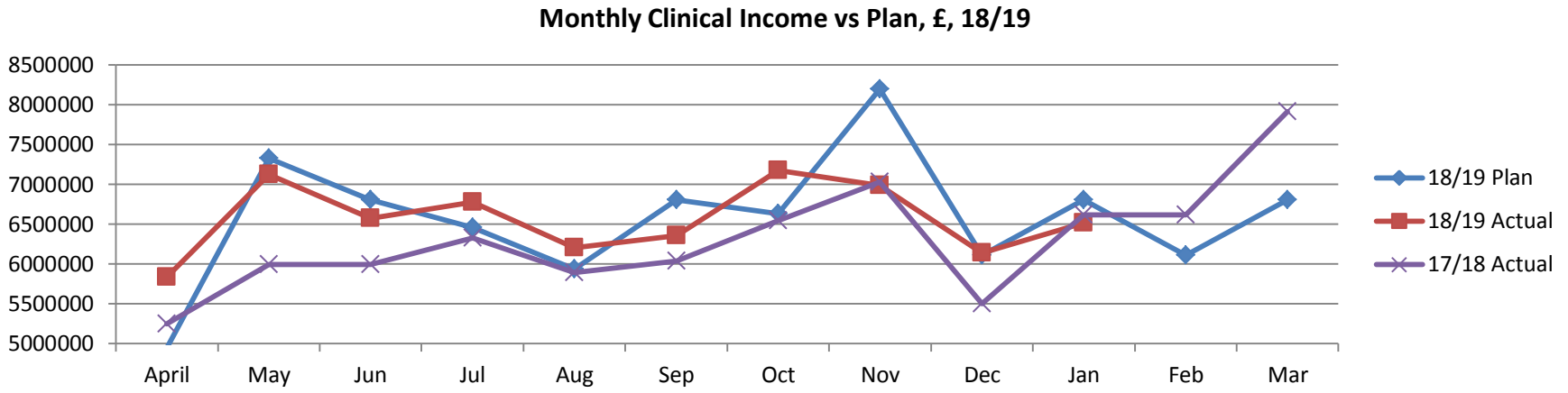
The Trust has a 19/20 CIP target of 1.1% in tariff plus further 0.5% for access to NHS Financial Recovery Funding for 19/20. This is a c. £1,400k target, not accounting for additions to this target based on the funding of 18/19 FYE and 19/20 cost-pressures. The teams are currently working on the identification and delivery of next-year schemes and have currently identified opportunities (£1,553k) exceeding the £1,400k plan. In order to ensure the 19-20 CIP plan is delivered, the Trust is changing its approach to CIP planning and delivery. There will be a number of Executive led cost improvement programmes, with operational , nursing and clinician led projects within each programme. Each project will have a number of key stakeholder, and each project team will work to deliver a project plan prior to 19-20, these plans will be amalgamated to deliver a CIP programme plan, that will be ultimately signed off and steered by the Executive responsible officer. The Trust is working to identify a stretch target and stretch opportunities for 19-20 to mitigate any slippage or under-performance against identified schemes, in order to prevent a repeat of the under-performance in 18-19; and as part of 19-20 CIP planning, is already identifying detailed CIP opportunities for 20-21.

ACTIONS FOR IMPROVEMENTS / LEARNING

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. Planning permission has recently been granted and the tenders for the enabling works have been received and opened. A further update will be presented at March Board.

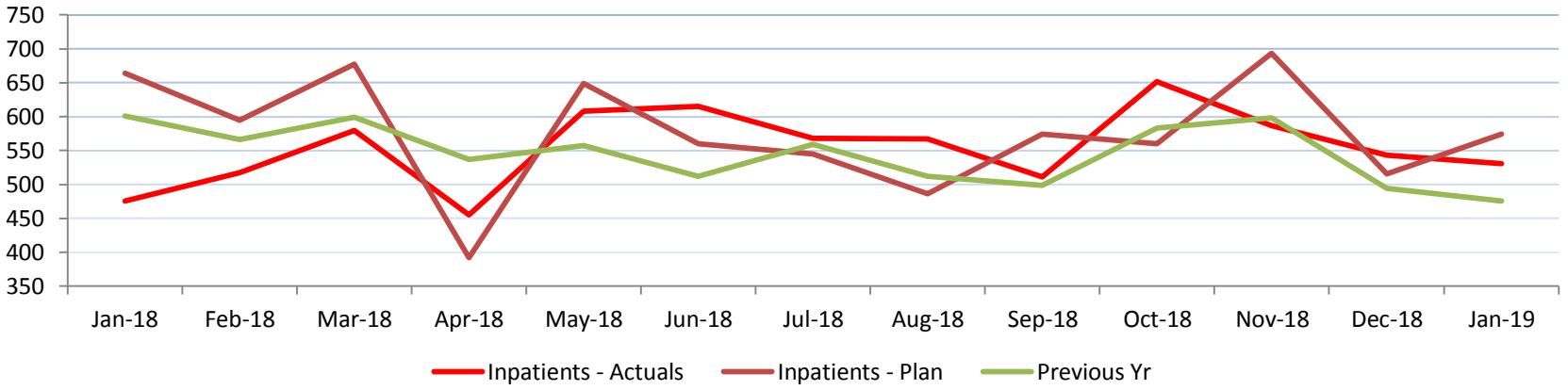
2. Income and Activity– This illustrates the total income generated by the Trust in 2018/19, including the split of income by category, in addition to the month's activity



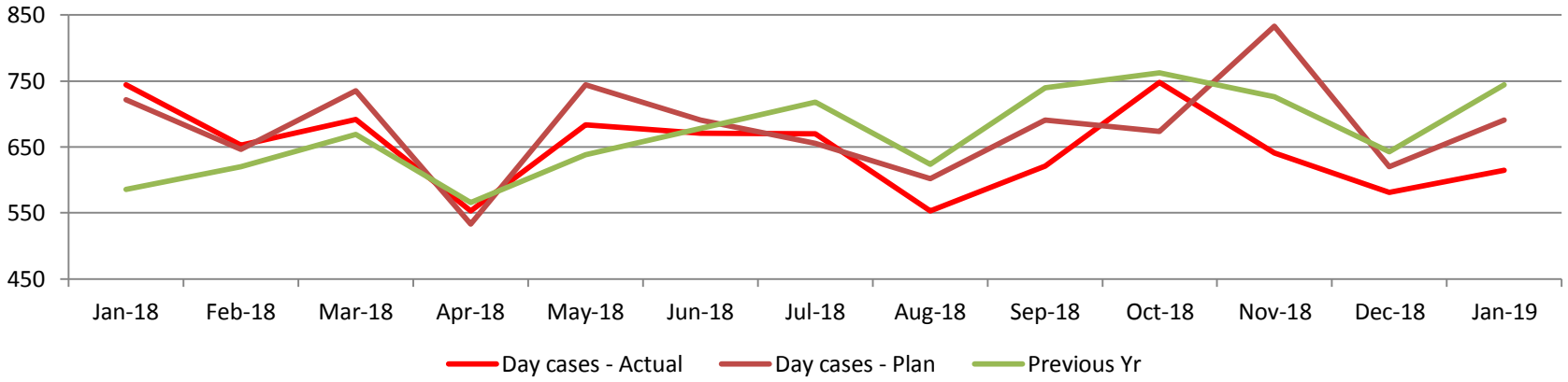
Clinical Income – January 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,595	3,238	-357
Excess Bed Days	42	37	-5
Total Inpatients	3,637	3,275	-362
Day Cases	856	797	-59
Outpatients	666	732	66
Critical Care	235	165	-70
Therapies	230	252	22
Pass-through income	216	178	-38
Other variable income	427	561	134
Block income	539	559	20
TOTAL	6,806	6,519	-287

Clinical Income – Year To Date 2018/19 £'000			
	Plan	Actual	Variance
Inpatients	34,876	32,669	-2,207
Excess Bed Days	405	683	278
Total Inpatients	35,281	33,352	-1,929
Day Cases	8,301	8,361	60
Outpatients	6,462	6,821	359
Critical Care	2,276	1,844	-432
Therapies	2,232	2,446	214
Pass-through income	2,098	2,278	180
Other variable income	4,144	5,016	872
Block income	5,228	5,584	356
TOTAL	66,022	65,702	-320

Inpatient Activity



Day Case Activity



Clinical income was slightly down on plan for January (circa 4% adverse). This compares to a slight overperformance in December (2% favourable). However, whilst Inpatient activity was lower than plan during the month (574 plan v 531 actual), this was still higher than the 476 delivered last January, and represents the second month in a row where this has happened. It I is now 64 ahead of plan YTD. Day case activity again underperformed (615 v plan of 691). This is now 397 behind plan YTD.

Outpatients activity and income continue to perform strongly and remain ahead of plan.

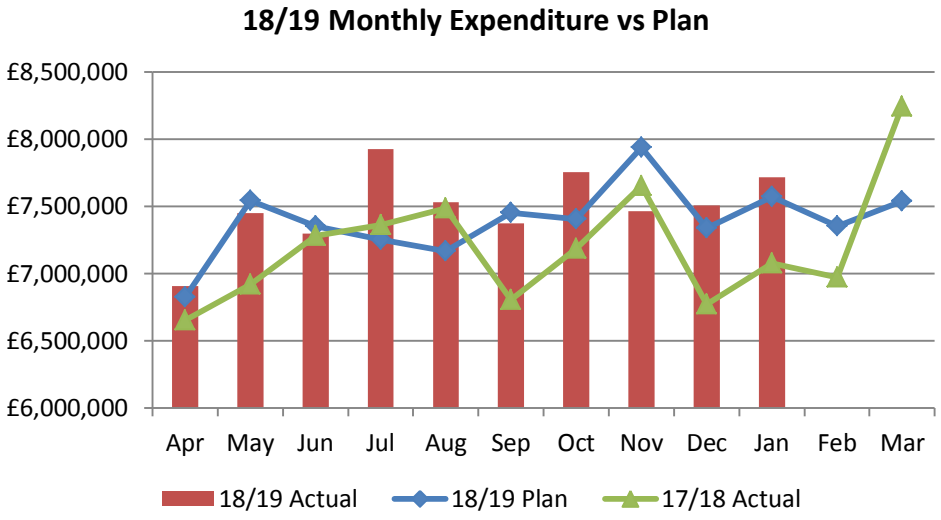
ACTIONS FOR IMPROVEMENT/LEARNING

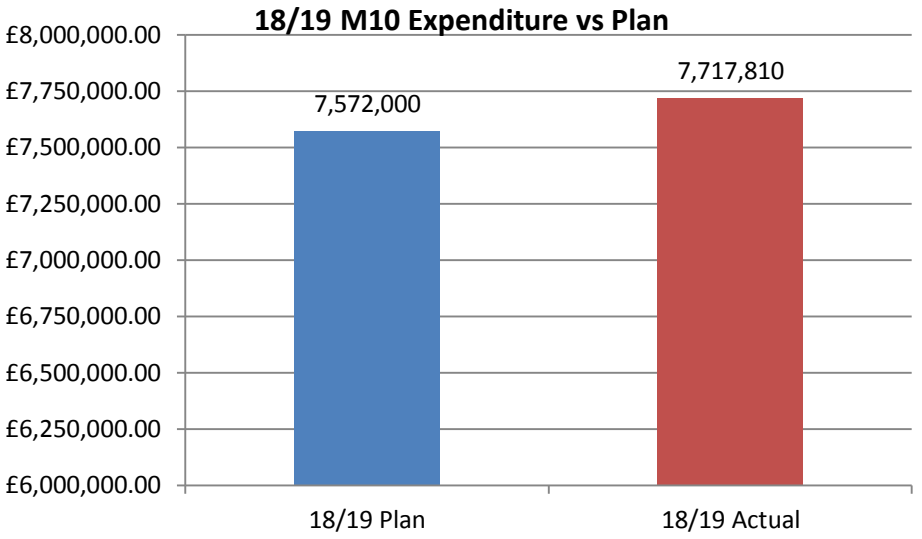
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

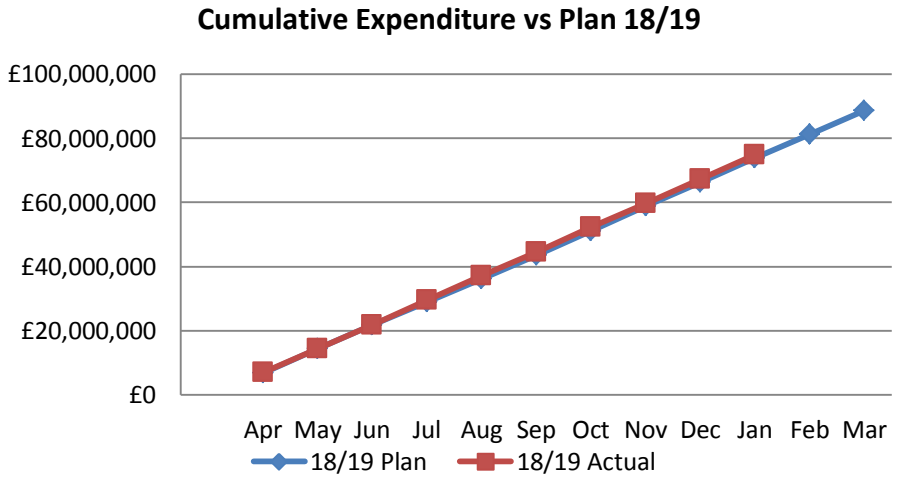
RISKS / ISSUES

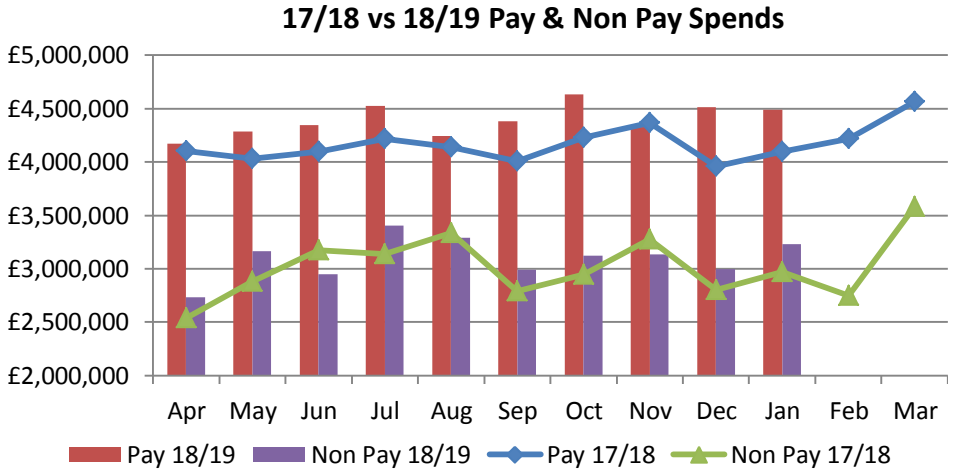
Given that the overall position at M10 is now behind plan, PSF has been removed for as a prudent measure. (circa £255k to M10 in total). This can still be claimed at the end of the quarter, or at year end if the control total is hit.

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









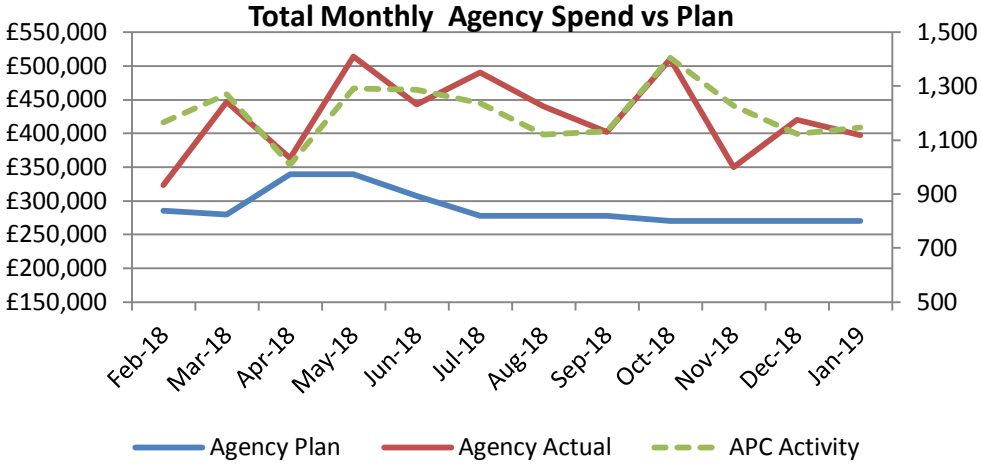
INFORMATION

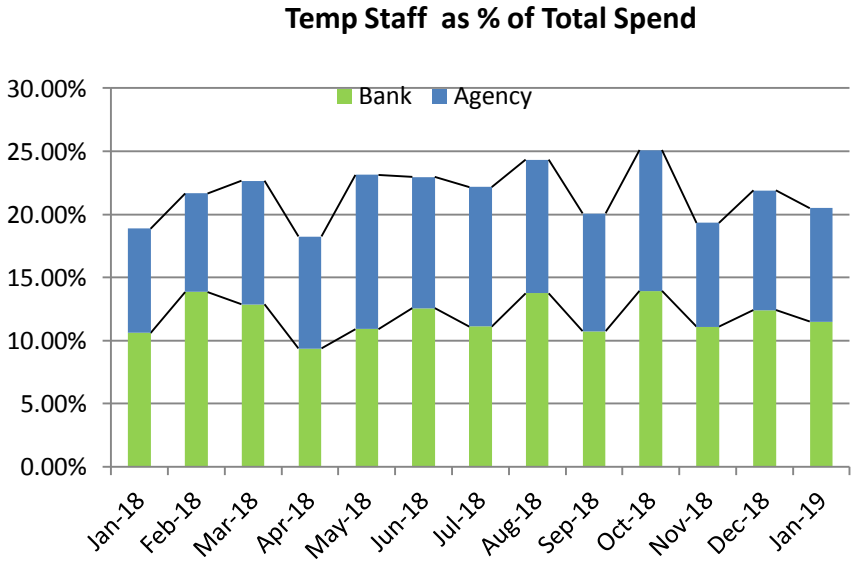
January expenditure was £7,718k, which was higher than a planned spend of £7,572k. However this includes a £91k adjustment to the YTD depreciation calculation

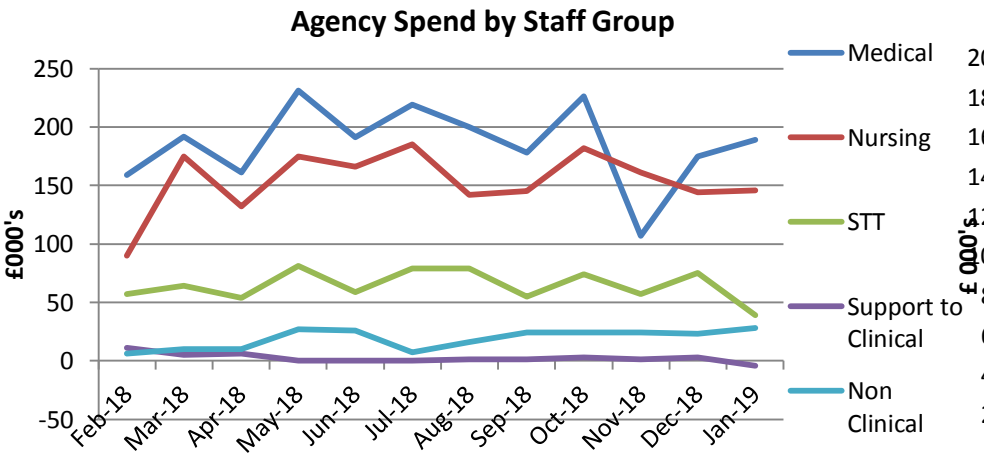
Pay however was slightly higher than planned (£76k) at £4.4m. Pressure remains on temporary staffing (medical staffing and nursing) with both showing a small increase on the December figure, although as a proportion of total pay usage has actually reduced from December

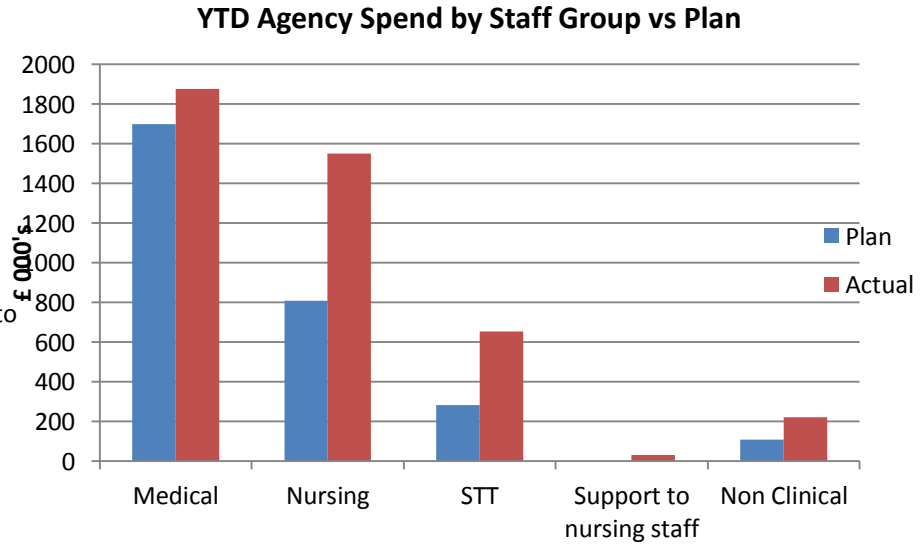
Non pay spend was £3,230k against a planned £3,160k with the main cause being the depreciation adjustment as described above. MRI activity has also been high in month with increased usage of the mobile scanner to help meet diagnostic waiting times.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Whilst total agency spend has reduced in month, Temporary spend for medics has remained high in January, although still lower than the trend for the majority of the year. The Trust continues to have challenges in the provision of junior doctor cover and work is ongoing around the development of alternative staffing models.

Nursing agency spend is consistent with last month, although has reduced as a proportion and again is reduced from earlier in the year of spend continues to reduce although this is still higher than anticipated given ward closures over Christmas. Bank usage has also reduced in month.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

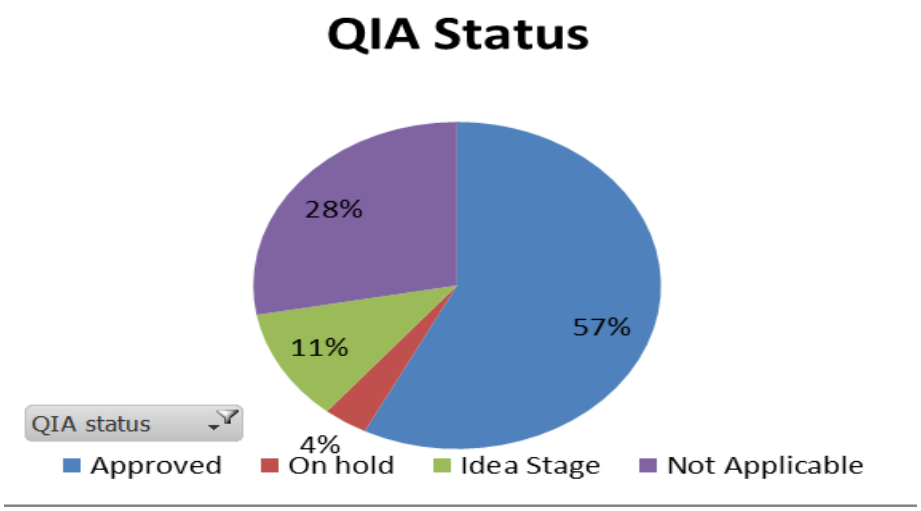
Review of e-Roster continues and shifts approved by the relevant Matron and head of Nursing.

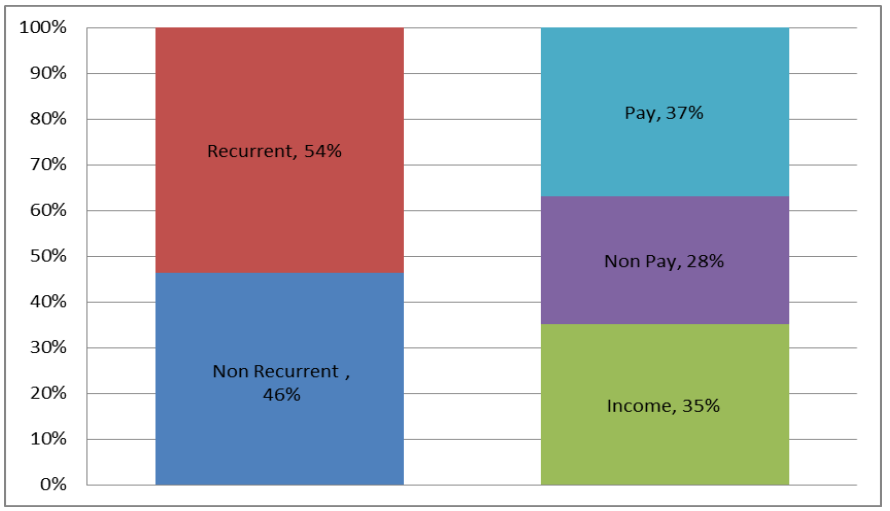
RISKS / ISSUES

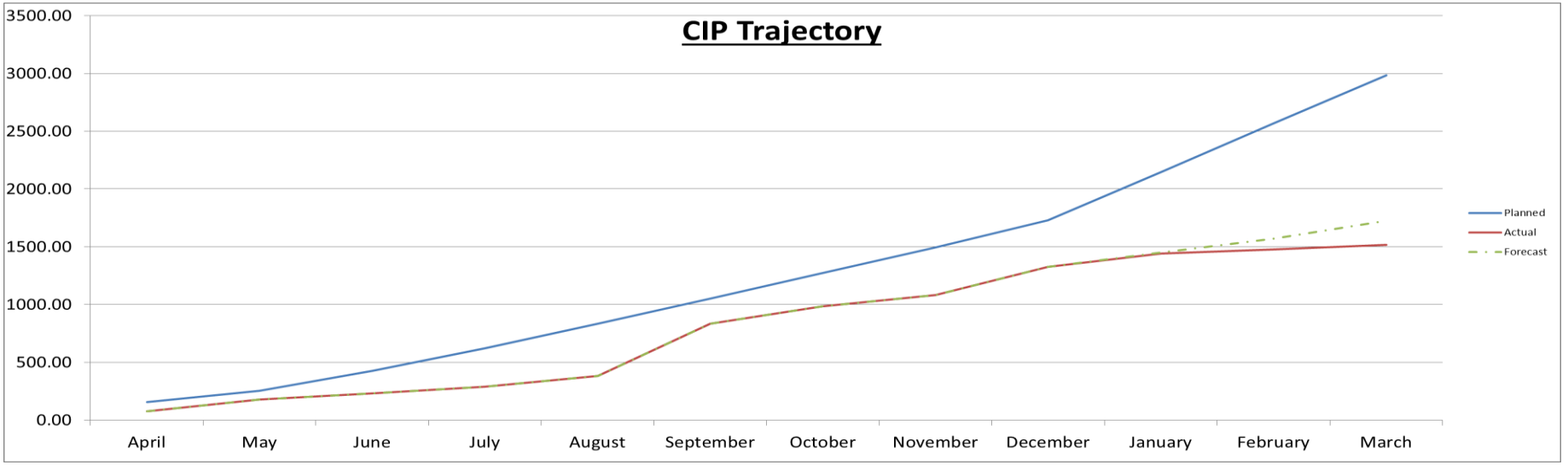
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

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) was identified/planned. As at month 10 £1,725k is forecasted for delivery in 18/19 (58% of identified/planned).

Row Labels	In-Month Plan	In-Month Actual	In-Month Variance	YTD Plan	YTD Actual	YTD Variance	18/19 Plan	18/19 FOT	18/19 Variance	18/19 FYE	18/19 FYE Variance
Corporate	94	28	(67)	902	650	(252)	1,090	800	(291)	696	(394)
Division 1	75	17	(57)	556	346	(211)	705	423	(282)	578	(127)
Division 2	245	64	(181)	666	421	(245)	1,157	468	(689)	159	(997)
Division 4	5	5	0	23	25	2	33	34	2	12	(21)
Grand Total	**419**	**114**	**(305)**	**2,147**	**1,441**	**(706)**	**2,985**	**1,725**	**(1,259)**	**1,446**	**(1,539)**

The summary reasons for YTD under-performance are below:

- Non-delivery and slippage against some clinical and operational saving schemes such as Implant rationalisation, GIRFT recommendations, LOS reduction and clinical pathway/process redesign savings
- Slippage and under-delivery against large scale savings schemes such as Theatres Stock control and Managed Service Contract (£550k planned in-year, this will slip to May 19) and Counting & Coding improvement schemes (forecasting £250k adverse to plan)
- YTD performance is significantly supported by fortuitous changes to national discount rates, enabling the present value reduction of provisions by £120k (this was captured as a non-recurrent CIP in Dec 18)

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved forecasted performance vs Q1-Q3, 46% of schemes forecasted in-year are non-recurrent, 53% of YTD delivery is as –such, 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, (engaging clinicians to support this) with focus also on demand and capacity management to deliver cost improvements
- Plans for 19-20 CIP's have been delivered; and a review of these are taking place, to explore the possibility of delivering some schemes in to 18/19

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the following schemes:

- Managed Service Contract for Theatres which has now been removed from the 18-19 forecast. Whilst a project group is driving this forward, it remains a challenging scheme; and is now unlikely to commence delivery until 19/20, due to non-conformance of the Trust decontamination provider to contracting arrangement requirements and NHSI delays for further clarification requirements by the body
- The counting & coding scheme is forecasted to deliver £234k, 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 at the monthly Quality and Steering committee meetings
- Focus on 19/20 Business Planning including 19/20 CIP scheme identification, however this has led to a reduced focus on (2018/19) in-year identification; now that the initial submission has been completed, there will need to be a renewed focus on CIP and recovery in 18-19

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M10 Plan £'000	M10 Actual £'000	Var £'000
Intangible Assets	764	578	186
Tangible Assets	48,118	48,442	(324)
Total Non-Current Assets	**48,882**	**49,020**	**(138)**
Inventories	4,858	5,150	(292)
Trade and other current assets	6,168	6,859	(691)
Cash	1,614	1,873	(259)
Total Current Assets	**12,640**	**13,882**	**(1,242)**
Trade and other payables	(12,989)	(14,954)	1,965
Borrowings	(1,266)	(399)	(867)
Provisions	(173)	(116)	(57)
Other liabilities	(207)	(548)	341
Total Current Liabilities	**(14,635)**	**(16,017)**	**1,382**
Borrowings	(7,479)	(8,732)	1,253
Provisions	(354)	(215)	(139)
Total Non-Current Liabilities	**(7,833)**	**(8,947)**	**1,114**
Total Net Assets Employed	**39,054**	**37,938**	**1,116**
Total Taxpayers' and Others' Equity	**39,054**	**37,938**	1,116

INFORMATION

Having been below plan in December for the first time this year, Cash at month 10 is now slightly above plan, although this is mainly due to timing of payments made.

The net impact between trade assets and trade payables remains negligible from month 9.

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.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £1,000k has been requested from the Department of Health (DoH) for January which is within the forecast for 2018/19.

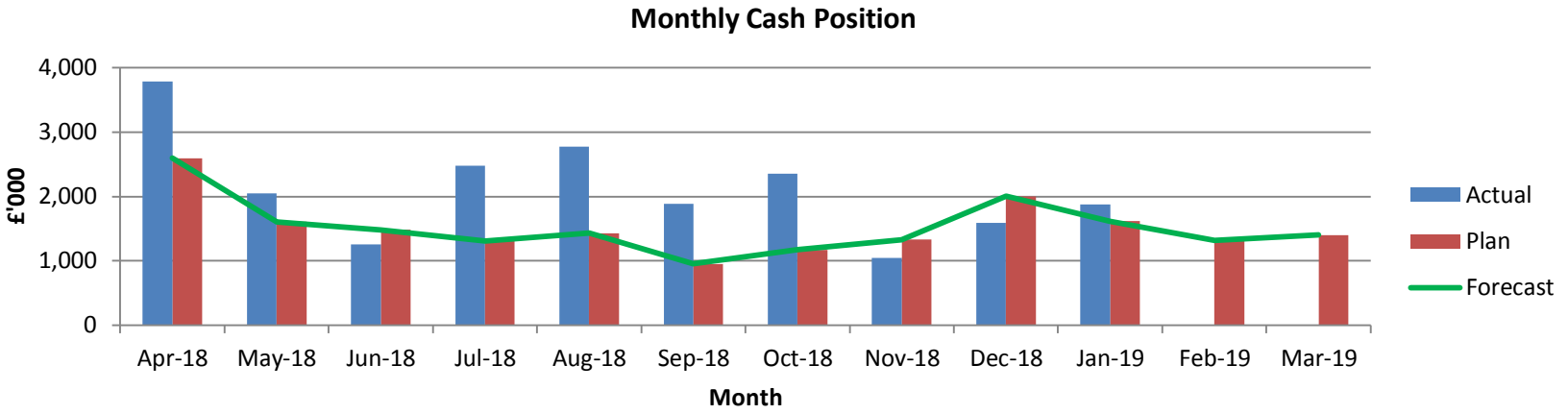
ACTIONS FOR IMPROVEMENTS / LEARNING

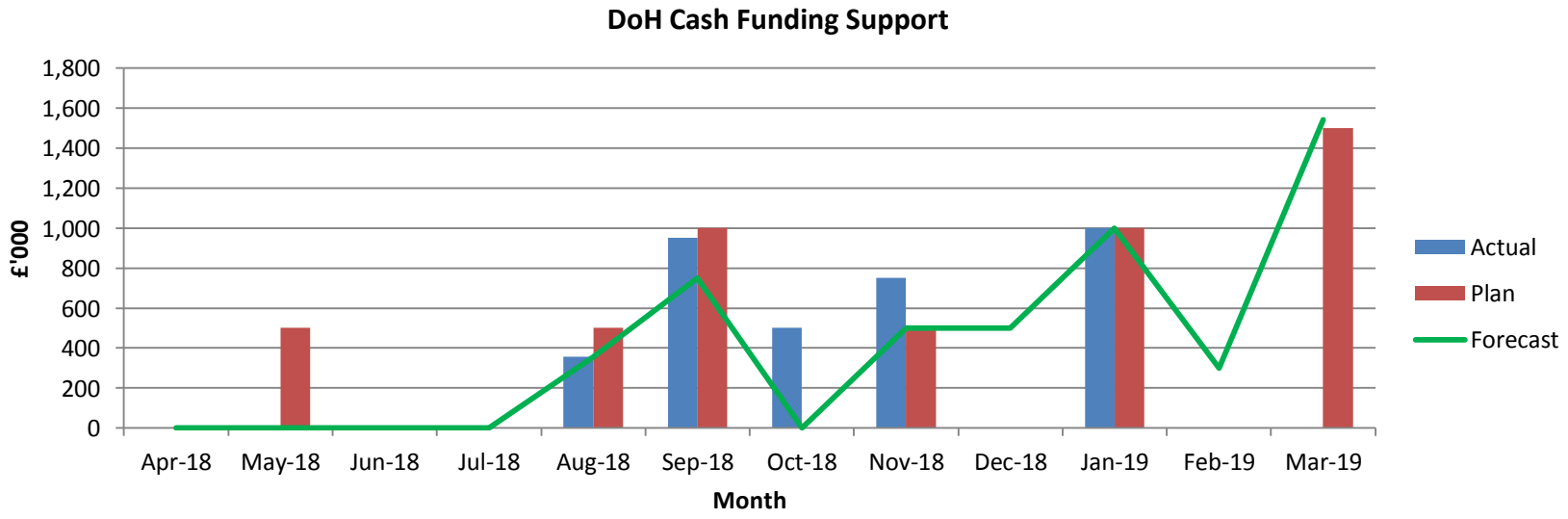
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

RISKS / ISSUES

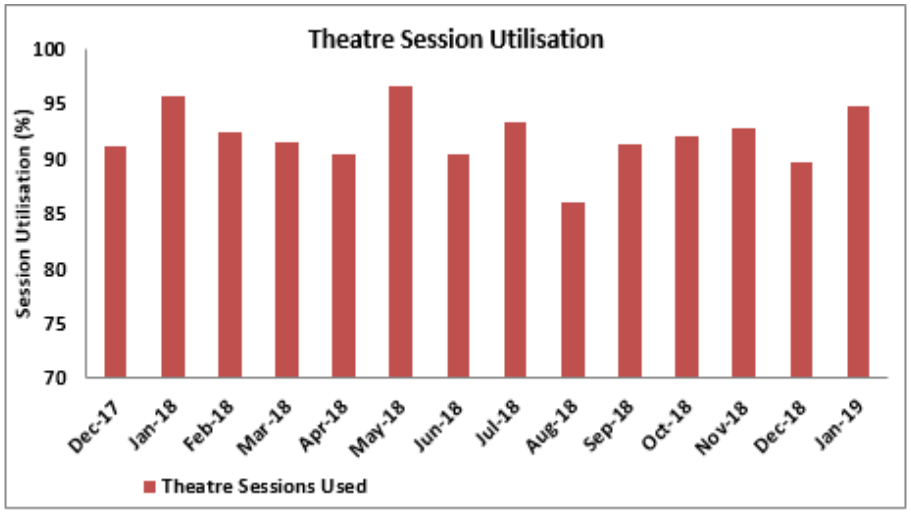
Despite the receipt of STF, cash remains tight for the remainder of the year with a projected cash balance at year end of £1.6m after an initially lower uptake of the borrowing facility at the beginning of the year than planned.

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





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

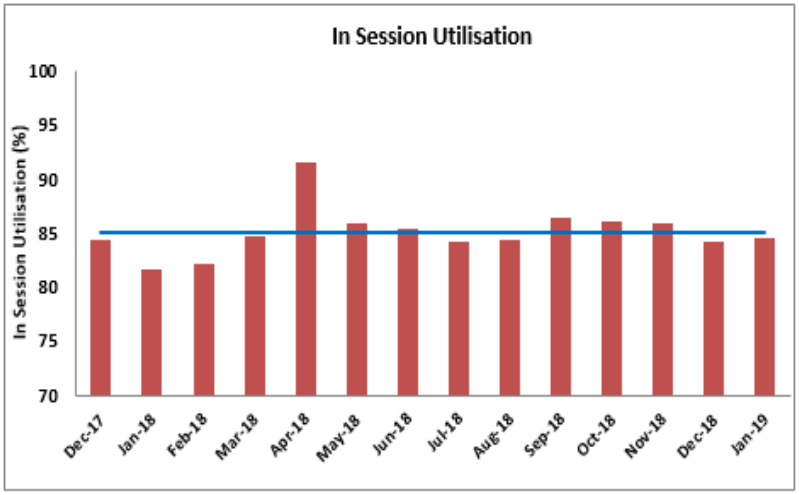
Session utilisation for January was 94.87% compared to December 18 which was 89.78%.

Average utilisation has increased slightly to 91.82% for the period April '18 – January '19.

RISKS / ISSUES

- Theatre recruitment to support future growth – successful open day in January 19 saw over 70 people attend with at least 20 offers being made on the day.
- 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

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 for January '19 was 84.47% compared to 84.15% in December.

In session utilisation remains consistent, running at an average of 86% for the period April '18 – January '18.

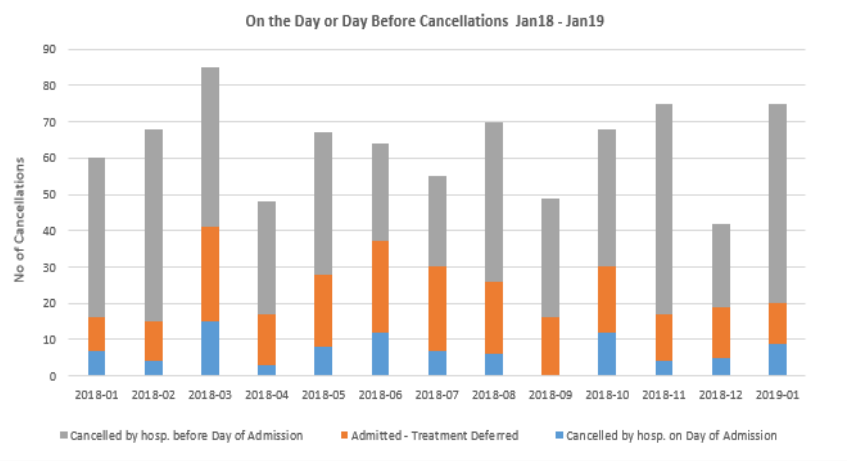
Changes in the admission process in ADCU have already seen improvements in the start times of theatres which will improve efficiency. An audit of how many theatres start on time (08:30 into the anaesthetic room) is being carried out monthly and monitored as part of the Jointcare improvement programme.

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
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

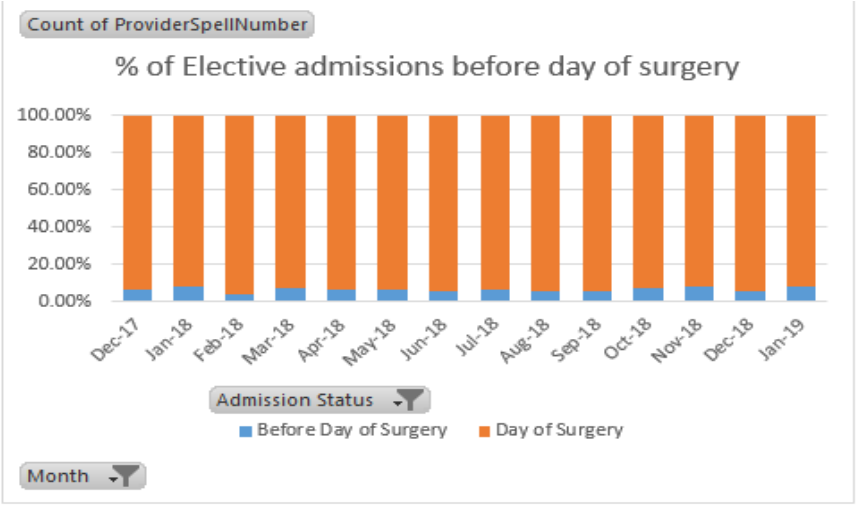
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

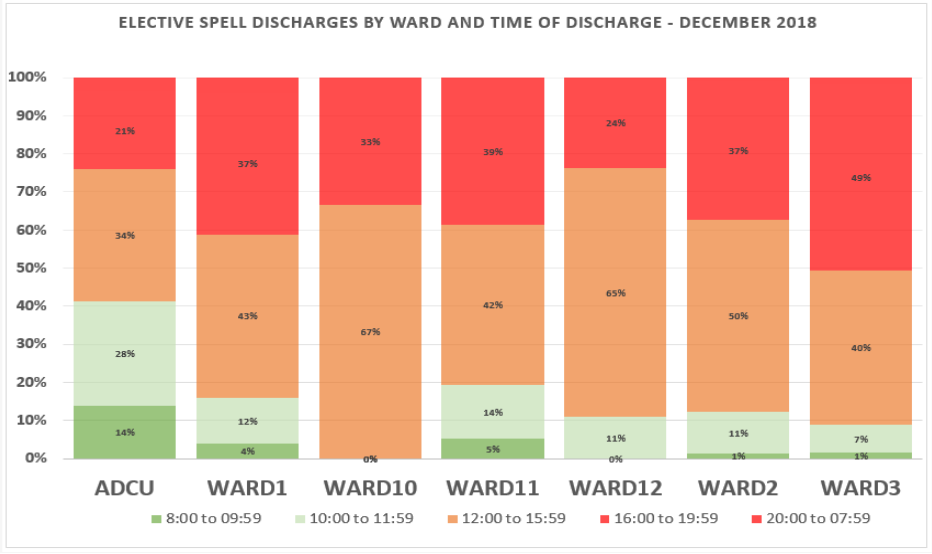
Hospital Cancellations



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
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	44	70	1
2018-09		16	33	49	0
2018-10	12	18	38	68	0
2018-11	4	13	58	75	0
2018-12	5	14	23	42	0
2019-01	9	11	55	75	0
Grand Total	92	220	514	826	2

Admission the day before surgery





The number of cancellations on the day of admission for surgery in January was 9 patients, a slight increase on December. Patients admitted for surgery where treatment was deferred has reduced in month from 14 to 11. Analysis of the reasons for patients cancelled on the day prior to admission include, Consultant illness and lack of theatre time. Patients admitted where treatment was deferred relate to equipment issues, cancellation to accommodate emergency patients and patients condition changing , where surgery is no longer required

Cancellations before the day of surgery have increased in month from 23 to 55. An analysis of the 55 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 patients declaring fitness issues on the 72 hour contact call . The increase in this number of patients is due to the robust process to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. The 72 hour call process has now been strengthened and an extended hours contact service is being developed so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in February 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access.

The triage model has now been rolled out and the team are working closely with Outpatients to increase the number of clinic rooms available to pre – operative clinic to change the profile of triage to be delivered in the pre-operative clinic area, so that access to on the day triage can be expanded It is anticipated that the change in service will commence in April 2019.

ACTIONS FOR IMPROVEMENTS / LEARNING

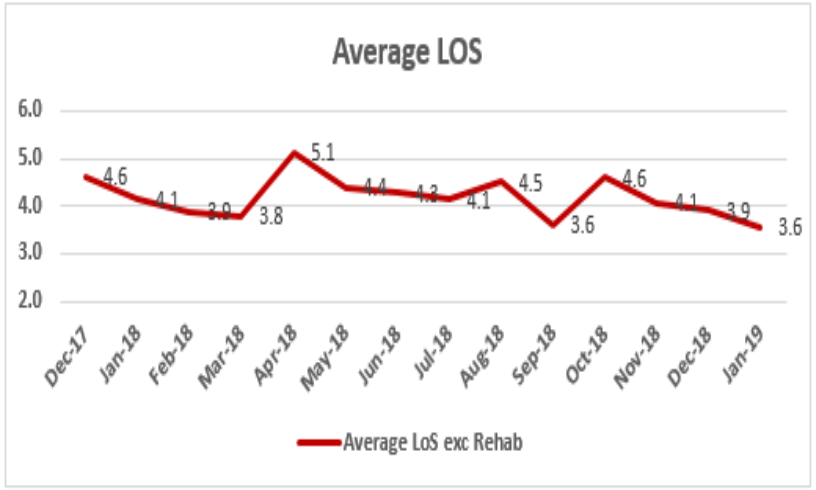
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

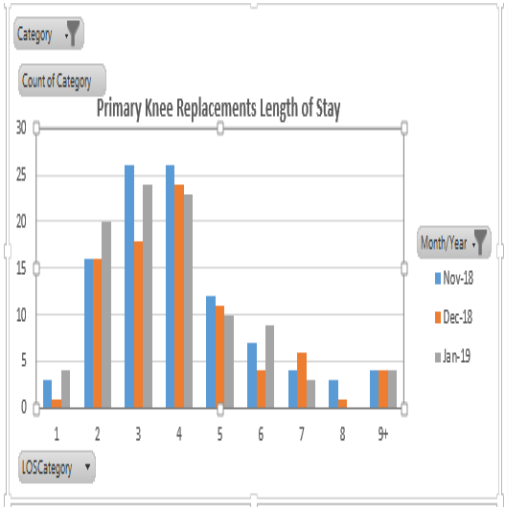
- POAC representative now attends daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Improved links with Clinical team to support any clinical concerns raised during patient contact

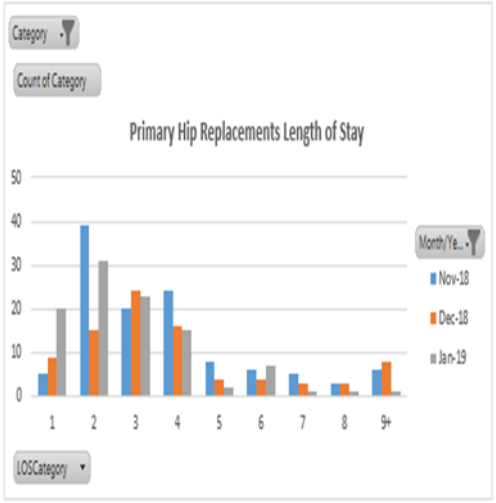
RISKS / ISSUES

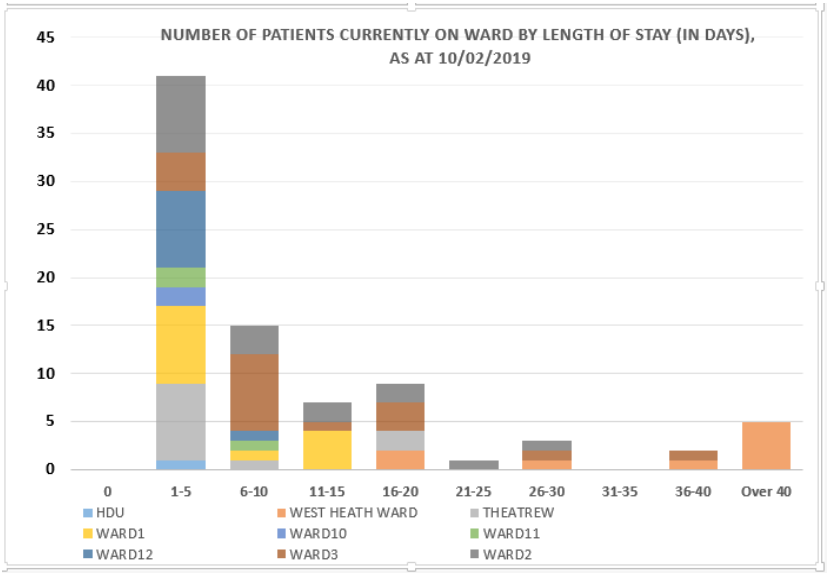
Existing ageing equipment asset base and the need to increase the number of power tools in Theatre. Additional power tools have been purchased and full delivery of all items is expected by the end of March 2019. The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

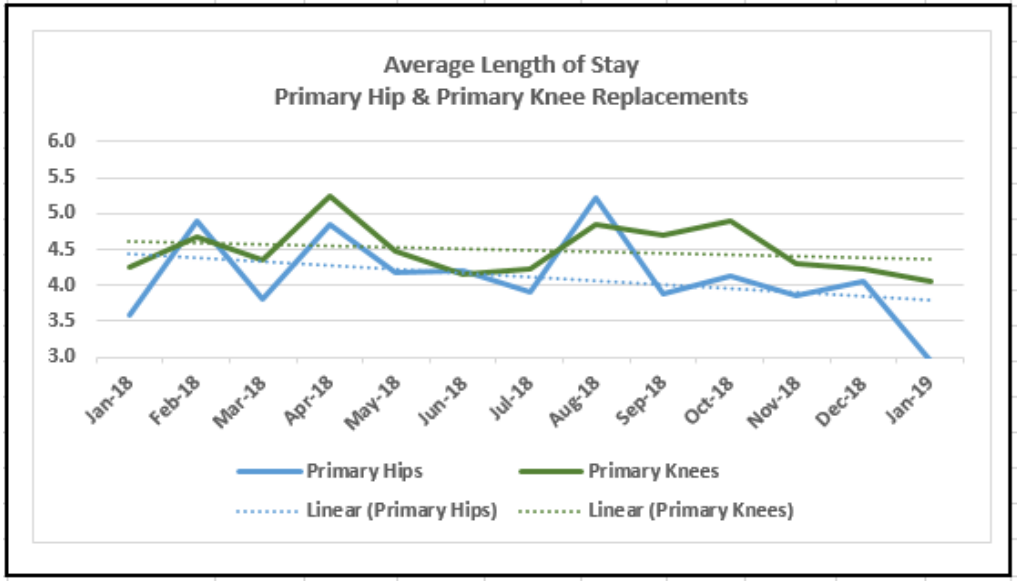
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS has reduced significantly in January 2019 and a number of initiatives are in place to continue to drive down length of stay including:

- 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 lounge staff to ensure timely discharge . The Senior Sisters across all inpatient wards are now implementing a 12: 30hrs review with all members of the MDT. The rationale for this is to strengthen the Red2Green initiative across all wards.
- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is developing local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- Joint care project to reduce length of stay for Hips & Knees continues to support reduced LOS .
- Production of a Jointcare performance dashboard to monitor a range of KPI's supporting reducing length of stay and a range of metrics is being developed
- The discharge lounge is well utilised by all adult inpatient wards.

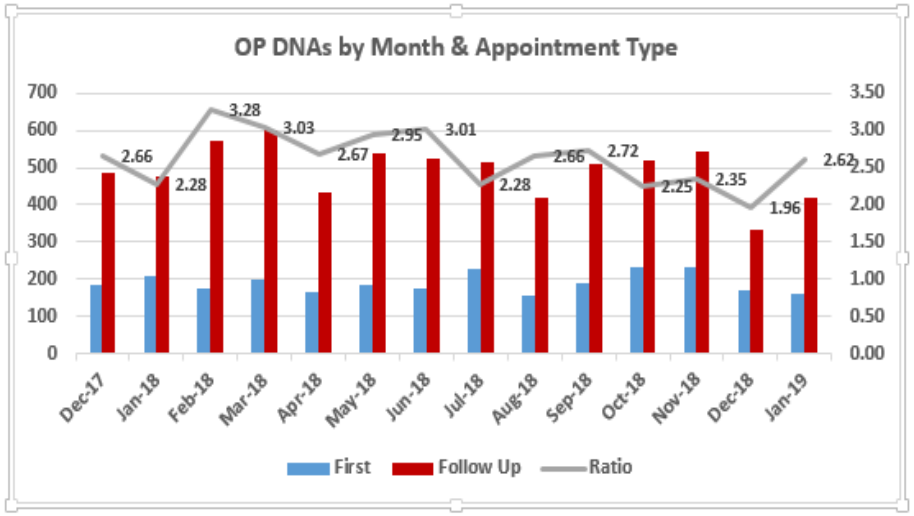
ACTIONS FOR IMPROVEMENTS / LEARNING

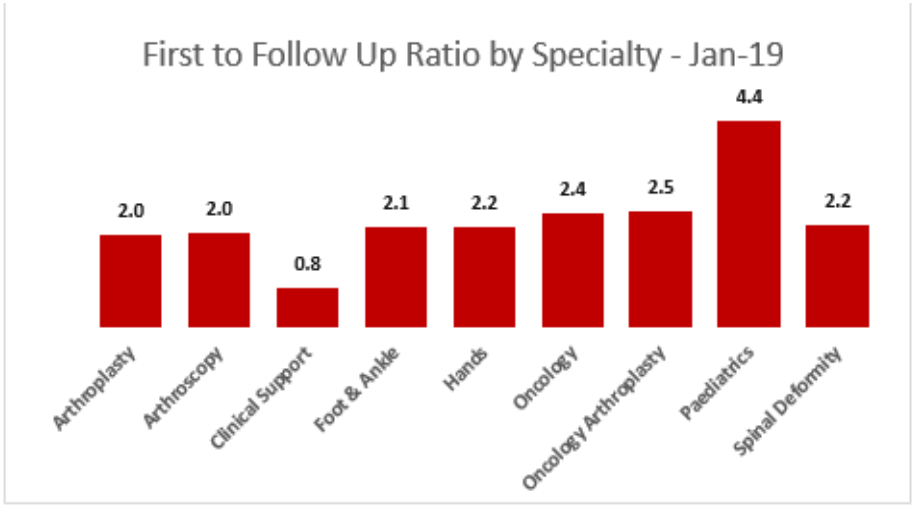
- The Red2Green dashboard development is now launched across all wards .
- The dashboard also records how many Green or Red days were recorded on the wards. This provides a continual visual focus on reducing LOS and supporting earlier discharge of appropriate patients .
- Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Options being explored include a 'floating ward clerk role ' out of hours to ensure timely recording of all ADTS .

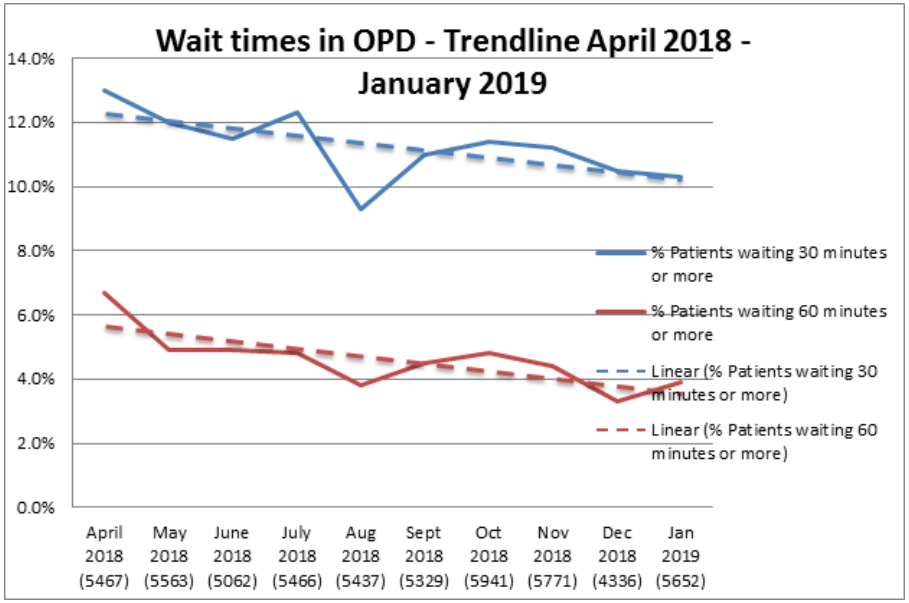
RISKS / ISSUES

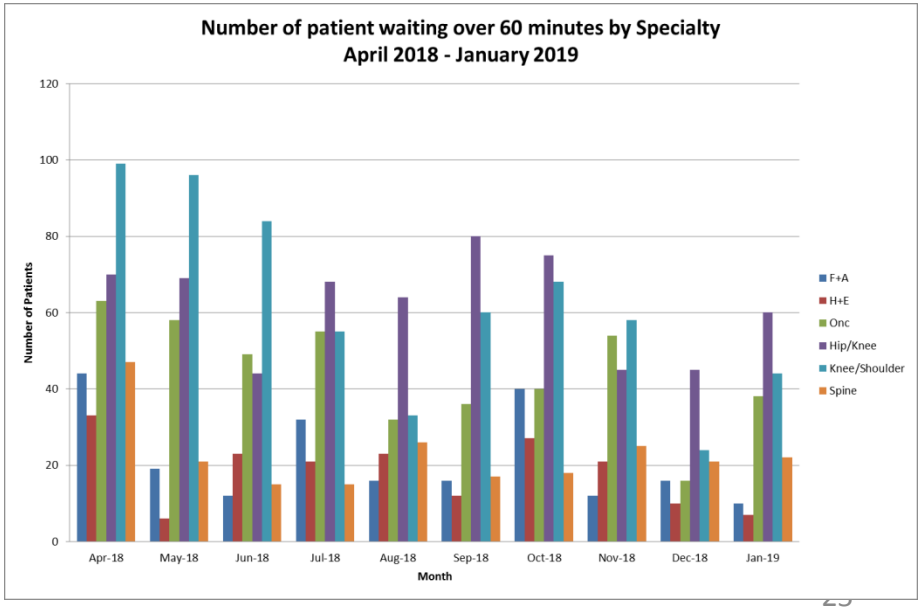
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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









INFORMATION

In January there were 10.3% of patients waiting over 30 minutes which is a slight improvement on last month, however the target for 30 minute delays has still not been achieved , focussed work is ongoing to continue to improve this position . 3.9% of patients were waiting over 1 hour which achieves the target of below 5%.

A new 6-4-3 meeting commenced in December and is held every Wednesday and produces room allocation timetables 4 – 6 weeks ahead. This meeting is evolving and will be used to review clinics and clinic templates with the operational management team to ensure clinics are well utilised and populated appropriately, to support a reduction in delays for patients attending clinic . Radiology are due to Join this meeting from March 2019 to review communication between clinics and Radiology and optimise patient flow.

The Matron for outpatients will continue to reiterate the importance of reporting all incidents relating to clinic delays and analysing the reasons for delays to improve practice . The department is now fully recruited, both for qualified and non qualified nursing staff . The current senior nurse for outpatients is retiring in March and a replacement is already in post to enable a full handover to take place.

A number of initiatives are being developed to improve the OP experience for patients and staff and full details of these projects will be discussed with key stakeholders at the OP away day planned for March 2019. This meeting will agree the priorities for this area and support required across a range of service improvement initiatives in line with recent NHSI recommendations .

ACTIONS FOR IMPROVEMENTS / LEARNING

- Reiterate the importance of submitting incident forms with the staff
- Develop the 6-4-3 meeting to review problem clinics with the OPS team
- Carry out a programme of data cleansing on PAS to ensure all clinics are set up correctly in relation to the capacity available
- Investigation of partial booking processes to reduce clinic rescheduling and overbooking

- Clinic Cancellation and Rescheduling – There is a need to update the process and better monitor the number of clinic appointment reschedules that take place. A visit has taken place to Heartlands Hospital to review their processes for partial booking with the intention of implementing this at the ROH. This may require additional staff resource in the appointments team which will be addressed through a business case in the next 6 months.

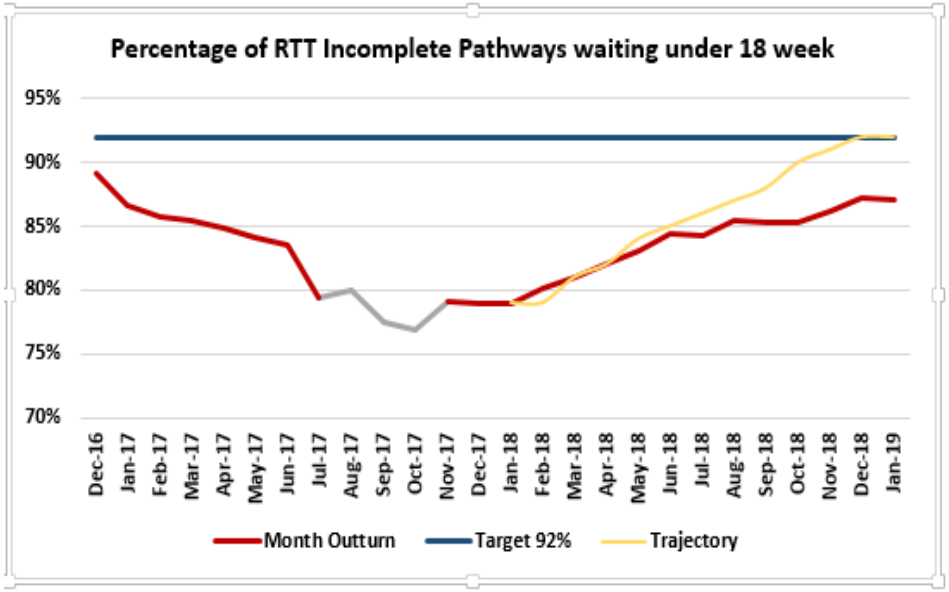
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

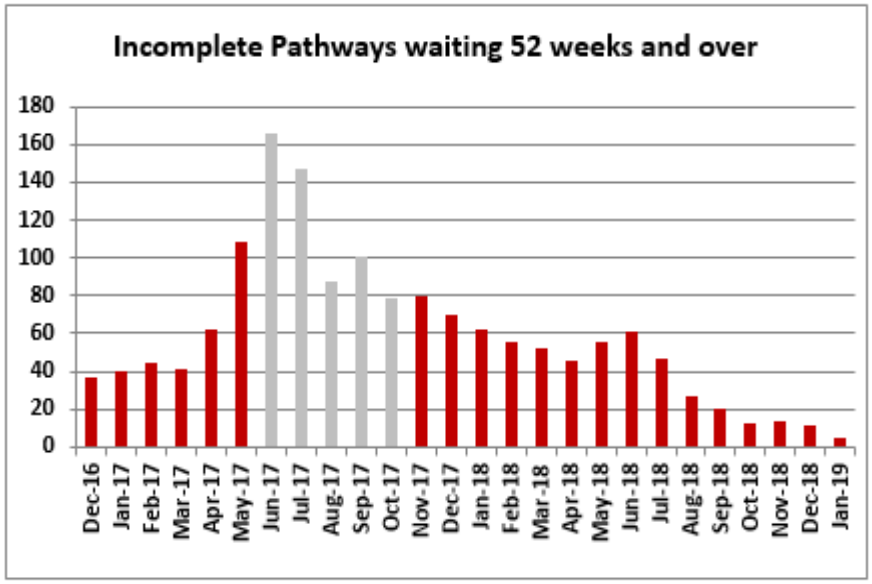
% of patients waiting <6weeks for Diagnostic test.

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%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1,254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1,245	1,252	99.4%
Dec-18	698	115	346	1,159	843	224	367	1,434	11	1,148	1,159	99.1%
Jan-19	728	123	416	1,267	897	253	472	1,622	4	1,263	1267	99.7%

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



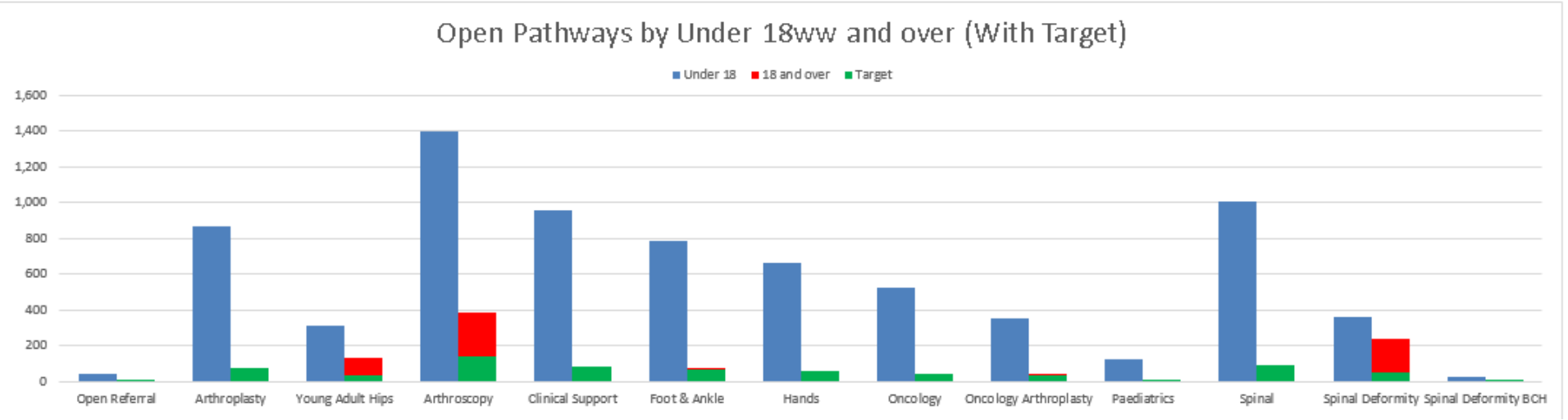


			Reported Month									Reported Quarter 2017/18			
		Indicative													
Target Name	**National Standard**	**Jan-19**	**Dec-18**	**Nov-18**	**Oct-18**	**Sep-18**	**Aug-18**	**Jul-18**	**Jun-18**	**May-18**	**Apr-18**	**Q4** (Jan, Feb, March)	**Q3** (Oct, Nov, Dec)	**Q2** (July, August, Sept)	**Q1** (Apr, May, June)
2ww	93%	*98.5%*	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	*100%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*85.7%*	93.8%	100%	100%	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	n/a	n/a	n/a	n/a
62 day (traditional)	85%	*90.0%*	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	*75.0%*	94.70%	*90.5%*	88.9%	77.8%	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	n/a	n/a	n/a	n/a
No. day patients treated 104+ days			2	1		1			1						

13. Referral to Treatment snapshot as at 31st January 2019 (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	**3,480**	36	400	139	638	494	344	338	277	153	57	441	156	7
7-13	**2,812**	5	349	126	523	361	311	240	155	145	56	409	120	12
14-17	**1,119**	2	117	45	236	101	131	83	93	56	12	153	86	4
18-26	**846**	1	69	75	283	49	74	40	16	29	4	75	127	4
27-39	**300**	0	6	53	102	7	3	0	7	15	0	6	96	5
40-47	**17**	0	0	2	3	1	0	0	0	1	0	1	8	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**5**	0	0	0	0	1	0	0	0	0	0	0	3	1
Total	**8,582**	44	941	440	1,785	1,014	863	701	548	399	129	1,085	599	34

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	**7,411**	43	866	310	1,397	956	786	661	525	354	125	1,003	362	23
18 and over	**1,171**	1	75	130	388	58	77	40	23	45	4	82	237	11
Target	**687**	**4**	**75**	**35**	**143**	**81**	**69**	**56**	**44**	**32**	**10**	**87**	**48**	**3**
	86.36%	**97.73%**	**92.03%**	**70.45%**	**78.26%**	**94.28%**	**91.08%**	**94.29%**	**95.80%**	**88.72%**	**96.90%**	**92.44%**	**60.43%**	**67.65%**



13. Referral to Treatment snapshot as at 31th January 2019

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	**783**	1	137	48	132	62	52	110	65	52	17	77	25	5
7-13	**885**	0	208	51	198	58	40	85	39	67	23	87	19	10
14-17	**398**	1	73	21	108	25	30	28	15	34	5	39	17	2
18-26	**401**	0	51	38	170	16	14	29	12	14	0	27	27	3
27-39	**171**	0	5	26	82	3	2	0	4	7	0	3	34	5
40-47	**9**	0	0	0	2	0	0	0	0	0	0	0	6	1
48-51	**3**	0	0	0	0	0	0	0	0	0	0	0	3	0
52 weeks and over	**2**	0	0	0	0	0	0	0	0	0	0	0	2	0
Total	**2,652**	2	474	184	692	164	138	252	135	174	45	233	133	26

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	**2,066**	2	418	120	438	145	122	223	119	153	45	203	61	17
18 and over	**586**	0	56	64	254	19	16	29	16	21	0	30	72	9
Target	**212**	**0**	**38**	**15**	**55**	**13**	**11**	**20**	**11**	**14**	**4**	**19**	**11**	**2**
	77.90%	**100.00%**	**88.19%**	**65.22%**	**63.29%**	**88.41%**	**88.41%**	**88.49%**	**88.15%**	**87.93%**	**100.00%**	**87.12%**	**45.86%**	**65.38%**

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	**2,697**	35	263	91	506	432	292	228	212	101	40	364	131	2
7-13	**1,927**	5	141	75	325	303	271	155	116	78	33	322	101	2
14-17	**721**	1	44	24	128	76	101	55	78	22	7	114	69	2
18-26	**445**	1	18	37	113	33	60	11	4	15	4	48	100	1
27-39	**129**	0	1	27	20	4	1	0	3	8	0	3	62	0
40-47	**8**	0	0	2	1	1	0	0	0	1	0	1	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**3**	0	0	0	0	1	0	0	0	0	0	0	1	1
Total	**5,930**	42	467	256	1,093	850	725	449	413	225	84	852	466	8

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	**5,345**	41	448	190	959	811	664	438	406	201	80	800	301	6
18 and over	**585**	1	19	66	134	39	61	11	7	24	4	52	165	2
Target	**474**	**3**	**37**	**20**	**87**	**68**	**58**	**36**	**33**	**18**	**7**	**68**	**37**	**1**
	90.13%	**97.62%**	**95.93%**	**74.22%**	**87.74%**	**95.41%**	**91.59%**	**97.55%**	**98.31%**	**89.33%**	**95.24%**	**93.90%**	**64.59%**	**75.00%**

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and predicts that the Trust will return to 92% at an aggregated level by October 2019.

January 2019 performance is **86.36%**

It is expected that Oncology Arthroplasty will achieve 92% in March 2019 with Young Adult Hip in June 19 and Arthroscopy in July 19. A refreshed capacity and demand plan for Spinal Deformity incorporating any impact with the delay of Paediatric Inpatients Services which had been completed and we anticipate that they will achieve the standard in Qtr. 4 19/20 . Excluding Spinal Deformity the Trust now has 9 patients waiting over 40 weeks all with treatment plans.

In January 2019 the Trust had **5** patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.

Detailed below is our progress with our trajectory with a revised trajectory submitted to NHSI/E (19/2/19). Work is still ongoing with the aim to clear all patients by the end of March 2019.

ROH 52 Week Trajectory Feb 2018

Over 52 Weeks	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
ROH Specialties excluding SD	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
ROH Adult Total	14	12	16	15	12	9	7	0	0	0	2	0	0	0	0
ROH Paediatrics Total	20	28	31	25	28	19	16	8	10	11	19	15	9	3	0
BWCH Paediatric Total	30	29	27	27	27	27	25	20	15	11	8	4	0	0	1
ROH Total	66	70	75	67	68	55	47	29	25	22	29	19	9	3	1
Actual Performance	**56**	**52**	**46**	**55**	**61**	**47**	**27**	**20**	**13**	**14**	**11**	**5**			
Revised Trajectory													3	1	2

ACTIONS FOR IMPROVEMENTS / LEARNING

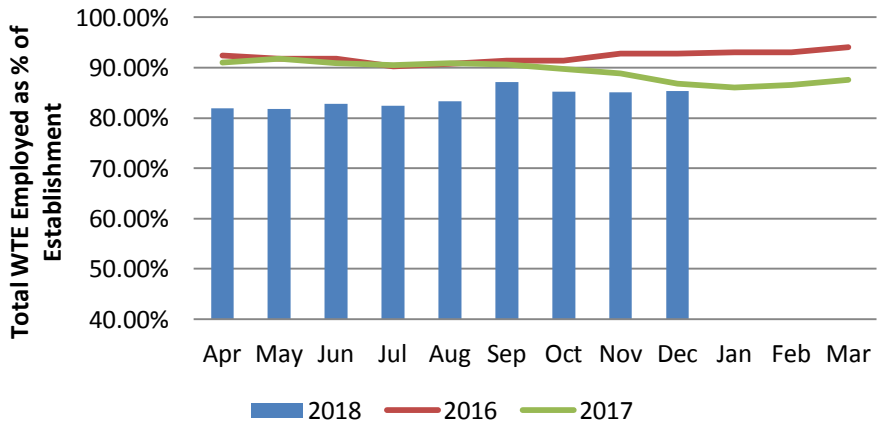
Good progress continues to be made by all the teams with good clinical engagement and support. Daily consultant performance continues to be shared improving compliance. Refresher training to support RTT data validation and awareness being designed to roll out in Qtr. 4 2018/2019

RISKS / ISSUES

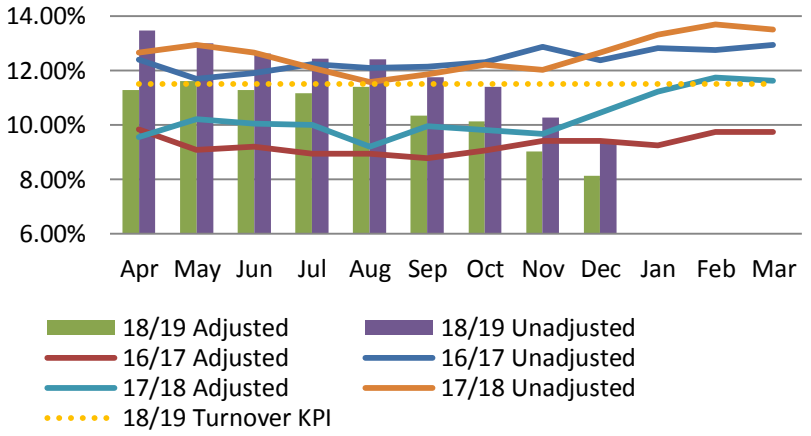
Spinal deformity remains a risk with regard to overall Trust performance and 52weeks breaches. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds remains a concern.

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

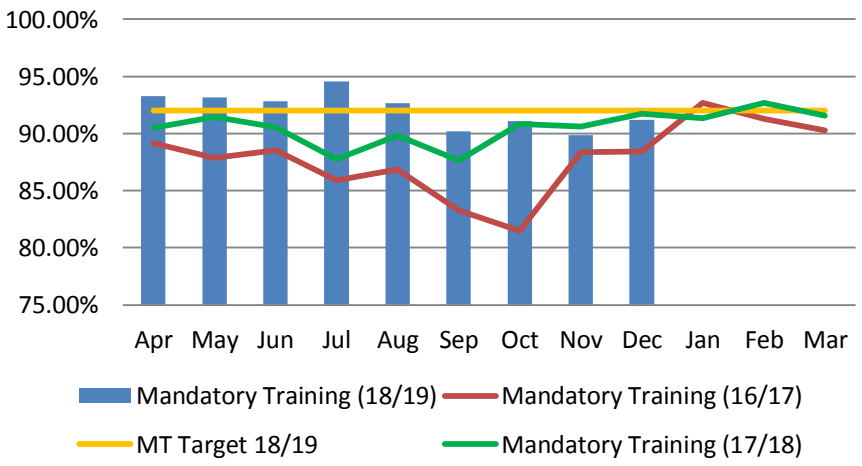
Staff in Post v Establishment



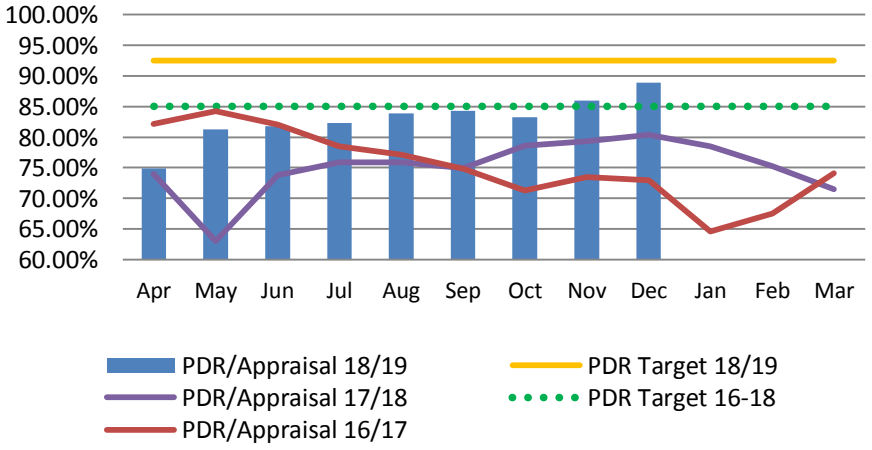
Staff Turnover



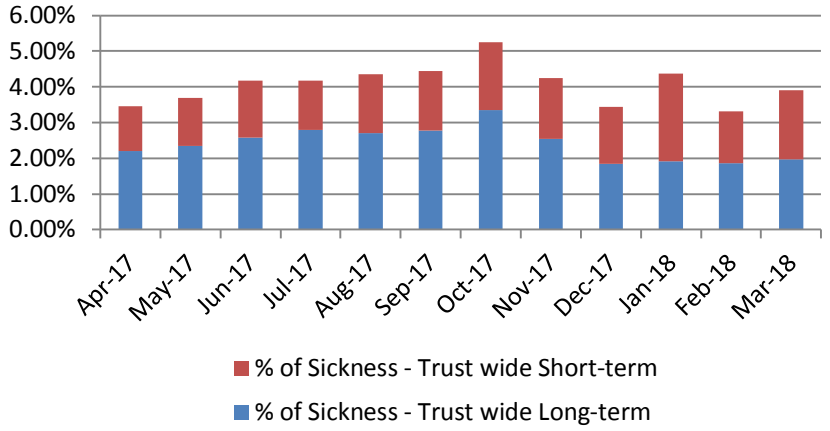
Mandatory Training



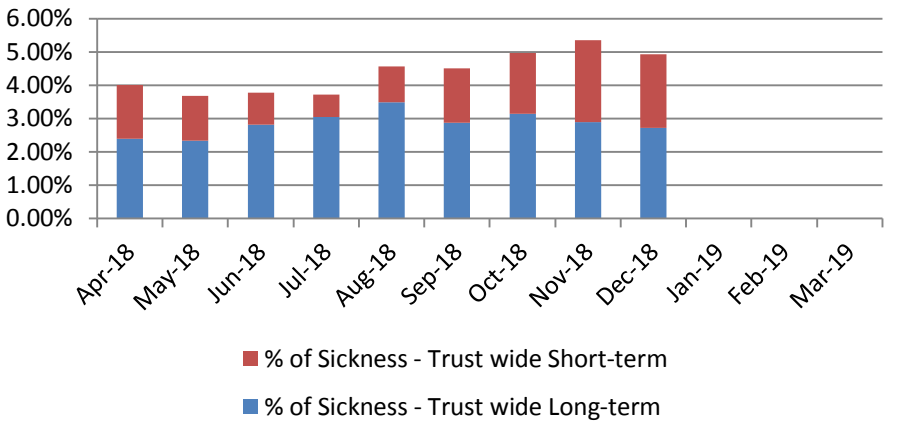
PDR/Appraisal



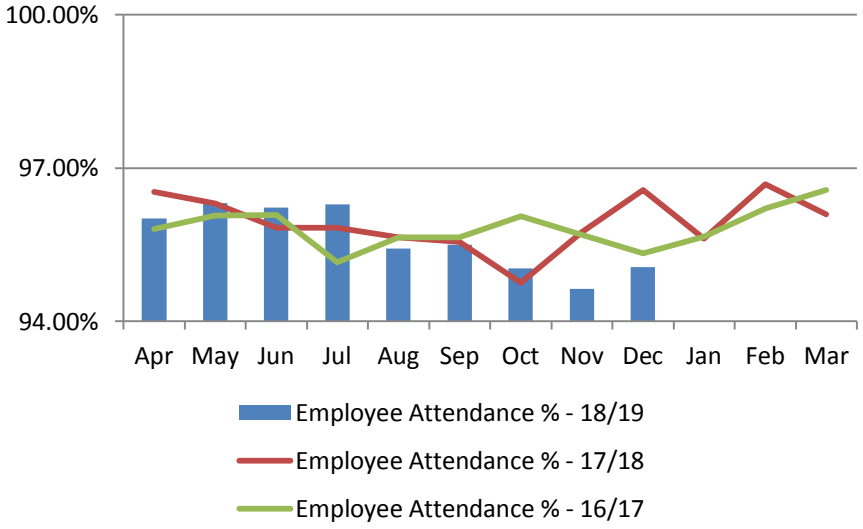
Sickness % - LT/ST (2017/18)



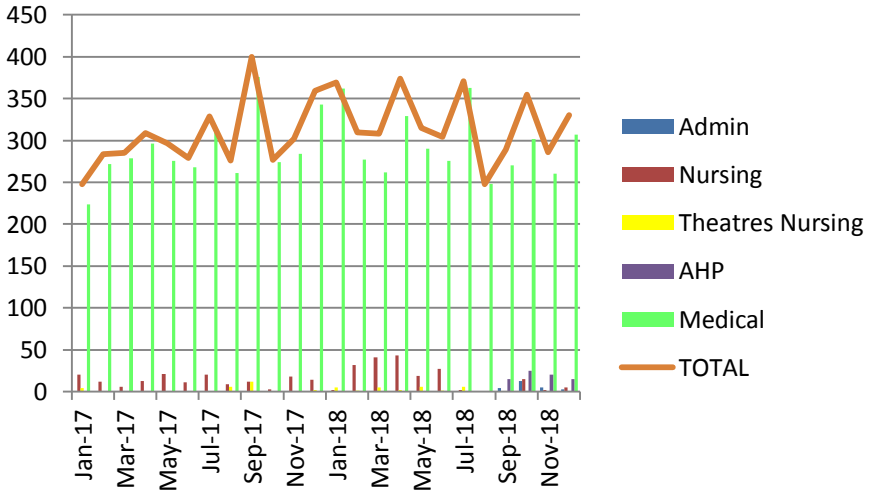
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

December saw a slight improvement in the vacancy position, an improvement in appraisal, a further reduction in turnover and an increase in the core mandatory training position. Sickness absence also reduced from the November 2018 spike.

This month the Trust's vacancy position saw a small increase (0.37%) as a percentage of WTE employed, with the figure 85.42% against a Trust target of 90%. The WTE number of staff on the payroll stood at 918.39, a decrease on the November position of circa 5 WTE but with a small reduction in the funded establishment for the Trust.

Monthly attendance moved downwards from November's high figure. In December, the position stood at 95.06%. A separate report into short term absence in November and potential correlations with influenza jabs and/ or half term holidays was provided to the SE&OD Committee in January – there is no factual evidence of either, although there is still a feeling that some individual staff members may seek to exploit a flu outbreak or claim sickness absence in half term.

The originally reported split between long and short term sickness for November is left in the graph above. However, whilst the overall percentage was correct at the time (5.36%), there does appear to have been some retrospective adjustment to the short term split in November. The effect of this is that the short term figure in December (2.22%) is now showing higher than November (1.93%) but the long term figure has moved down below 3% for the first time since July 2018 to reduce the overall figure.

Mandatory Training numbers saw an increase of 1.37% versus the November position, taking the Trust to 91.22%. This is still below the target of 92% for the 4th consecutive month - but is very much a step in the right direction.

December's appraisal performance increased to 88.89%, which is the highest performance since May 2014. Whilst this is still adrift from our stretch target of 92.5%, this represents real progress.

The unadjusted turnover figure (all leavers except doctors and retire/ returners) reduced to 9.40%. The adjusted turnover figure (substantive staff leavers including retirements) increased slightly to 8.12% and both were green against a KPI of 11.5%.

In December, agency breaches increased from 286 to 330 shift breaches in total, with the increase explained by medical staff breaches (up to 307 from 260), with limited movement in other staff groups versus November's usage.

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

Given high sickness levels, there may still be pressure on mandatory training and appraisal percentages, at least in the next couple of months.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 9 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• An update on work being delivered to address the vacancy gaps in nursing was presented. The expertise in the Trust to introduce new roles and to undertake workforce planning were noted to be particular risks at present. A culture of working in silos was also a risk, as was the current timescale from offer of appointment to starting in post. The mitigations for treating these risks were outlined. • It was reported that work was underway to develop a staffing model for theatres, including covering the new modular set up. The current high level of vacancies in theatres was noted. The work of the 'Perfecting Pathways' programme would assist with this work. • Talent management and succession planning processes remained weak and would need to be addressed over coming months.	• It was agreed that continuous improvement should form the basis of a Staff Experience & OD Committee workshop in future and this was to be scheduled into the workplan. • A deep dive into the staff survey results was to be planned into the workshop scheduled for 6 March. • A further update on progress against the workforce process review actions is to be scheduled into the May 2019 meeting. • Include sickness absence as a point for review on the agendas of the next three meetings. • Present information around the time to recruit at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a presentation from a Management Gradate Trainee currently working in the Finance department. Overall, her experience was positive, although in some cases the reality of the role had not lived up to her expectations when she joined. The Executives present agreed to learn the lessons from this case for future trainees. • Although there was a degree of delay with the delivery of the People & OD strategy, there was acknowledged to be good progress overall. • The Committee was advised that the draft national staff survey results had been received which presented a more positive position against a number of the indicators. The results were noted to be embargoed at present. • The first Staff Experience walkabouts was reported to have been held, which had been undertaken by a number of the Non	• None specifically.

Executives who had visited IT, Finance and Informatics. Overall the visit was positive, although there were some estates and environmental issues which had been raised. • Adequate progress was being made with the actions raised from the workforce process review undertaken in 2018. • On request from the Finance & Performance Committee, there was a discussion around sickness absence and whether there was any correlation with the update of the 'flu vaccination or half term. There was no evidence to suggest that this might be the case, however the Committee agreed to review sickness absence for the next few meetings. • On request from the Quality & Safety Committee, the Committee received an update on the time to recruit. It was noted that from unconditional to conditional offer, the time was currently six weeks. Work was underway to improve this position.	
Chair's comments on the effectiveness of the meeting: The conversations had been productive and the agenda had dealt with a broader range of topics than the earlier meetings, which was seen to be positive.	

ROHTB (3/19) 013

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 6 February 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted as part of the Staff Experience story that the development opportunities for facilities staff were limited. • Talent management was agreed to need further embedding. • The Non Executive walkabout to estates, facilities and portering had highlighted a number of issues, including air conditioning and some staff not feeling respected – the Executives were aware of the issues and work was already underway to address them where possible. • The position against many of the Workforce Race Equality Scheme standards had deteriorated; it was noted that the advent of the equality and diversity network might assist and external input was being sought to inform the improvement plans. Of particular concern was the position against the indicator concerning bullying and harassment of Black and Minority Ethnic staff. • There was highlighted to be an increased risk of disruption in the HR department due to some leavers who were in key positions.	• An update on resuscitation training was needed at the next meeting. • Include sickness absence on the agenda of the next meeting. • A report on the wellbeing work would be considered at the next available meeting. • Widen the risk around the impact of Brexit to include workforce considerations.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a presentation from a member of the Blitz cleaning team; the staff member reported that his experience of working at the Trust was very positive overall and he had been provided with good opportunities after a period of personal adversity. • The staff turnover position had reduced. • It was suggested that the nurse development path could be marketed as a bespoke opportunity for individuals aspiring for a higher level role elsewhere. • The Committee was given assurance that work was underway to streamline the onboarding process and reduce the time from conditional to unconditional offers being issued.	• The position against the WRES standards could be published on the Trust's internet. • The session in March would focus on the Staff Survey, including the benchmarking information and how the findings aligned to the People & OD Strategy.

• There had been a successful recruitment event that would address some of the current vacancies in theatres, in particular. • An update was received on the plans to develop middle grade medical cover; the plans would be implemented by March 2021. • There had been a positive increase in the number of nominations for staff awards. • In terms of the nurse staffing update, it was reported that the Care Hours per Patient Day position had improved.	

Chair's comments on the effectiveness of the meeting: The discussions had been productive and the Staff Story was particularly well received.

Workforce Performance Report

January 2019

CONTENTS

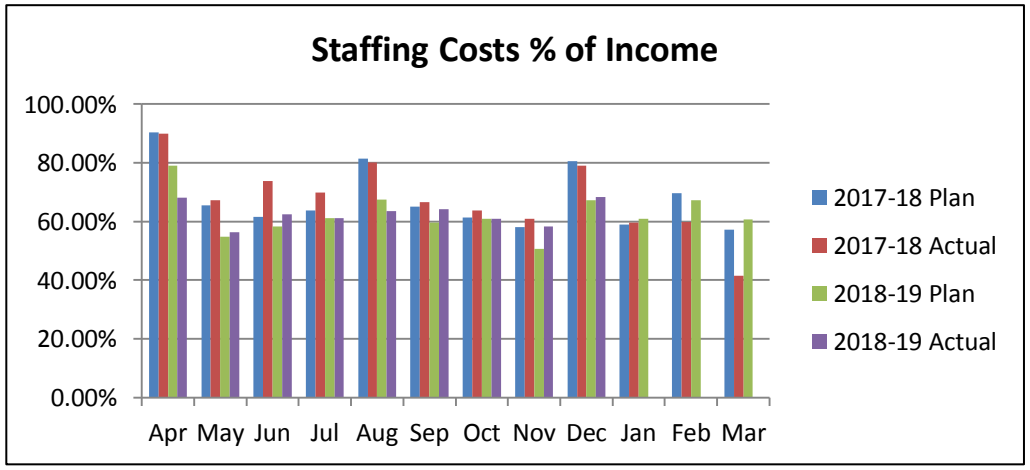
Staffing costs

1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	63016	
Actual Income YTD	63303	100%
Planned Pay Costs (YTD)	38538	
Actual Pay Costs (YTD)	39467	102%
Planned Substantive Pay Costs (YTD)	32410	
Actual Substantive Pay Costs (YTD)	30890	95%
Planned Bank Pay Costs (YTD)	3367	
Actual Bank Pay Costs (YTD)	4591	136%
Planned Agency Pay Costs (YTD)	2629	
Actual Pay Costs (YTD) Agency Staff	3933	150%
Planned Agency Pay Costs as % of total Pay costs (YTD)		6.8%
Actual Agency Pay Costs as % of total Pay costs (YTD)		9.8%

Total ADH Payments (Apr - Dec) £000s	1699

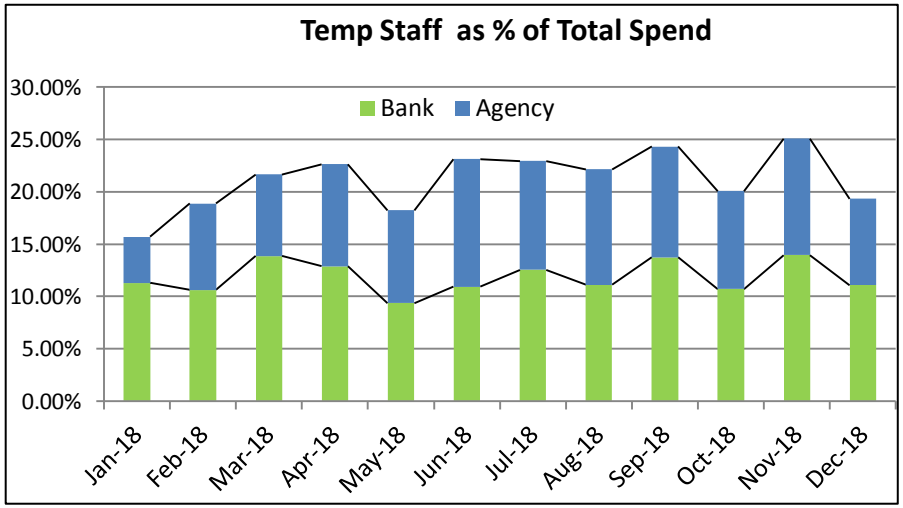


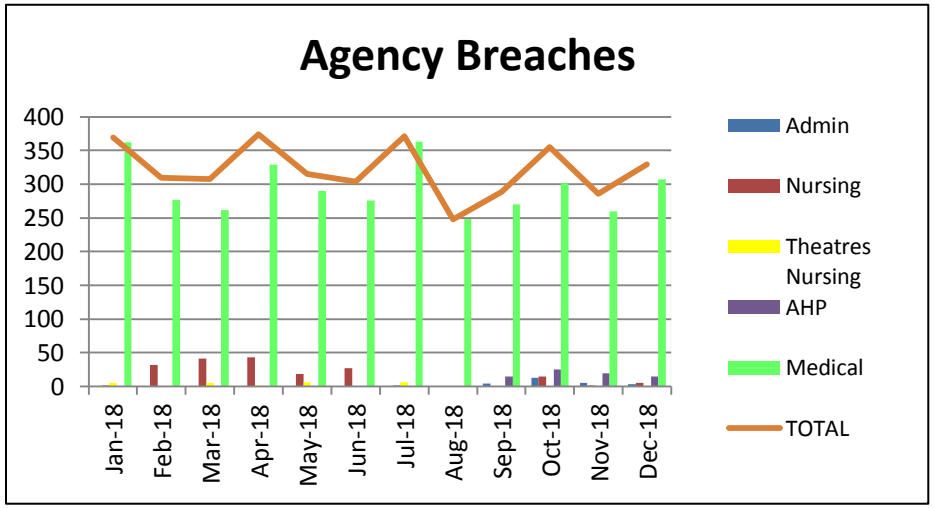
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	242	363
May	242	514
Jun	242	443
Jul	242	490
Aug	242	440
Sep	242	402
Oct	241	510
Nov	241	350
Dec	241	420

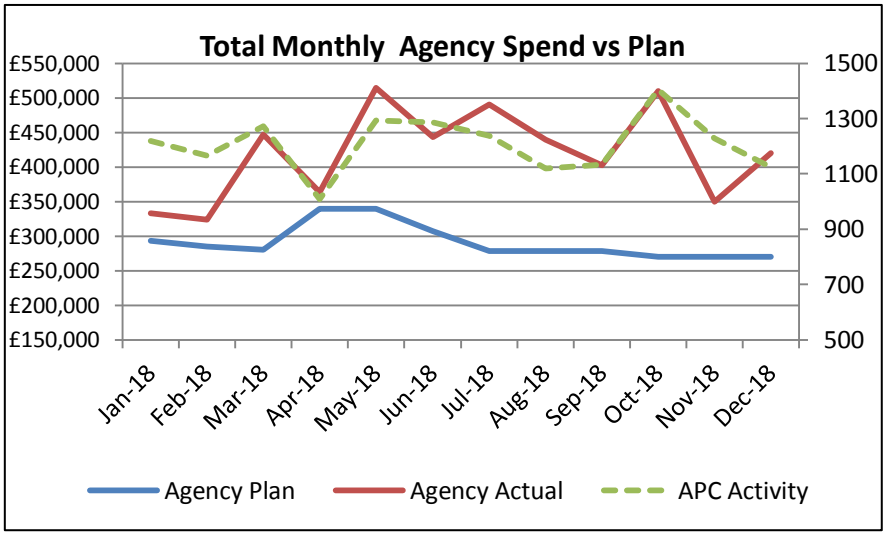
Data based upon December Management Accounts

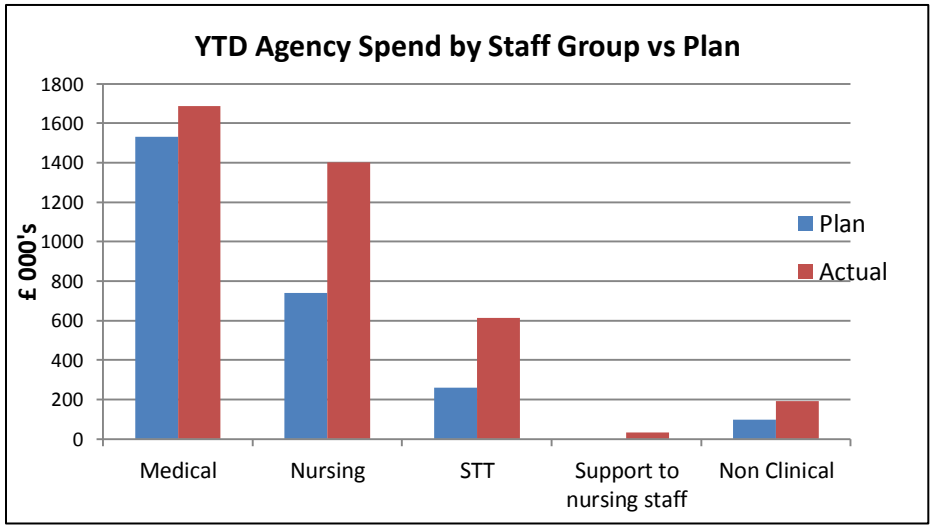
1 Workforce Composition and Cost

1a Temporary Staffing Analysis



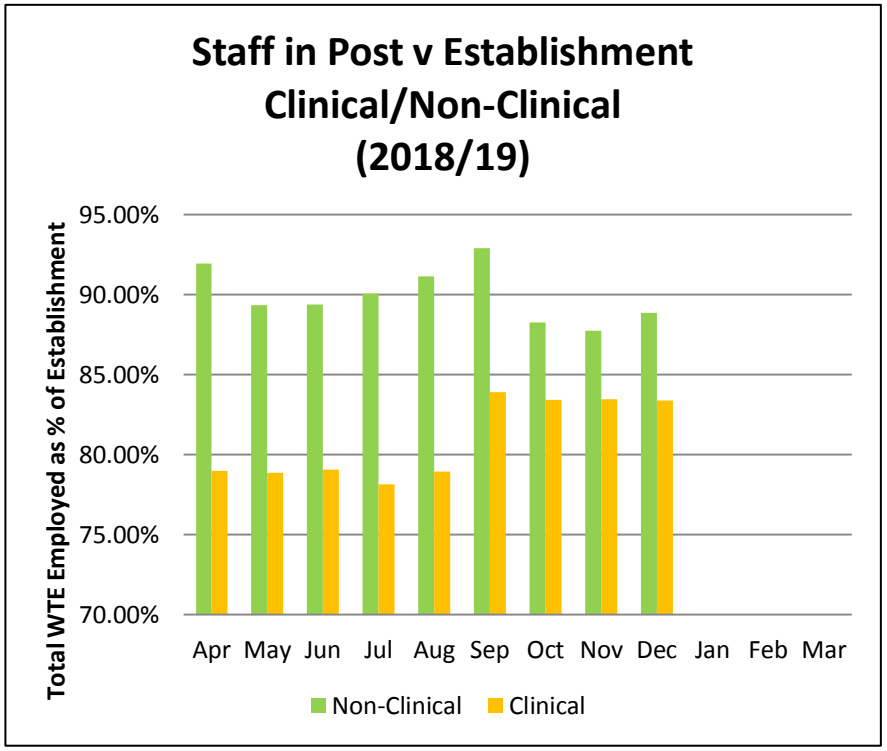


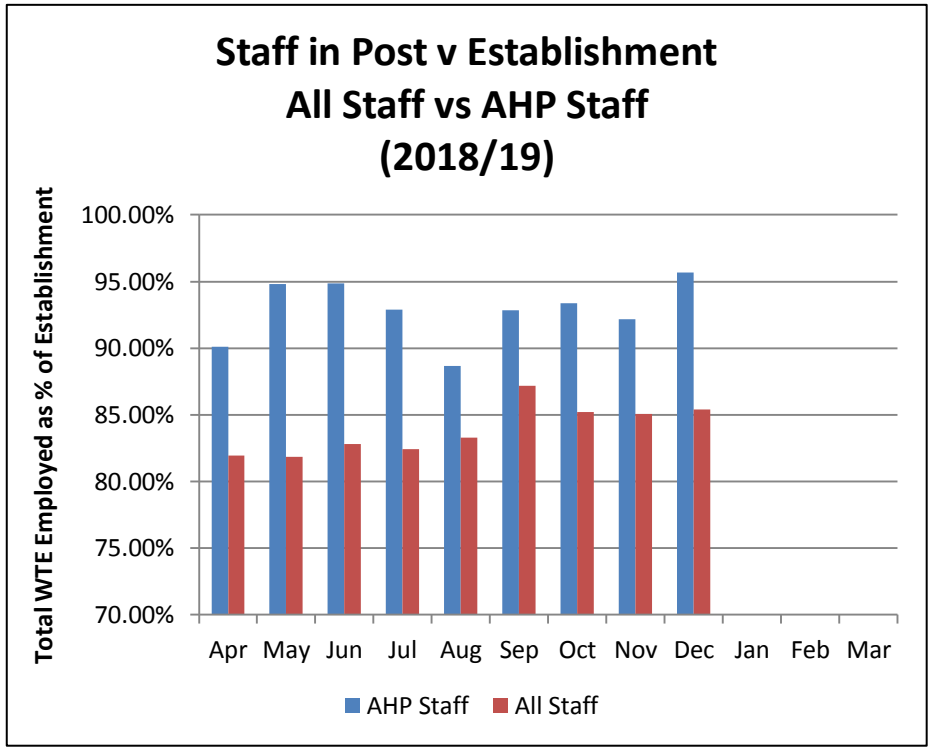




1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

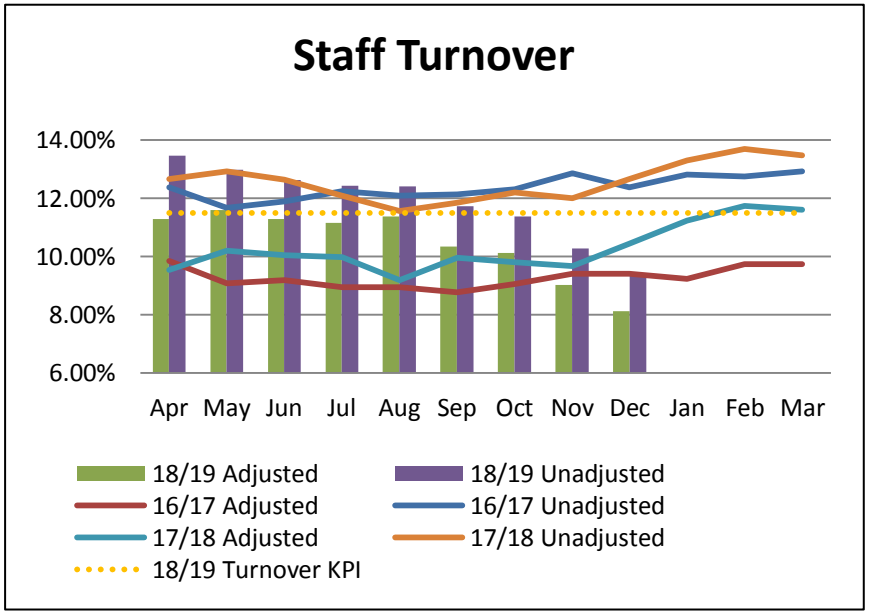
Establishment

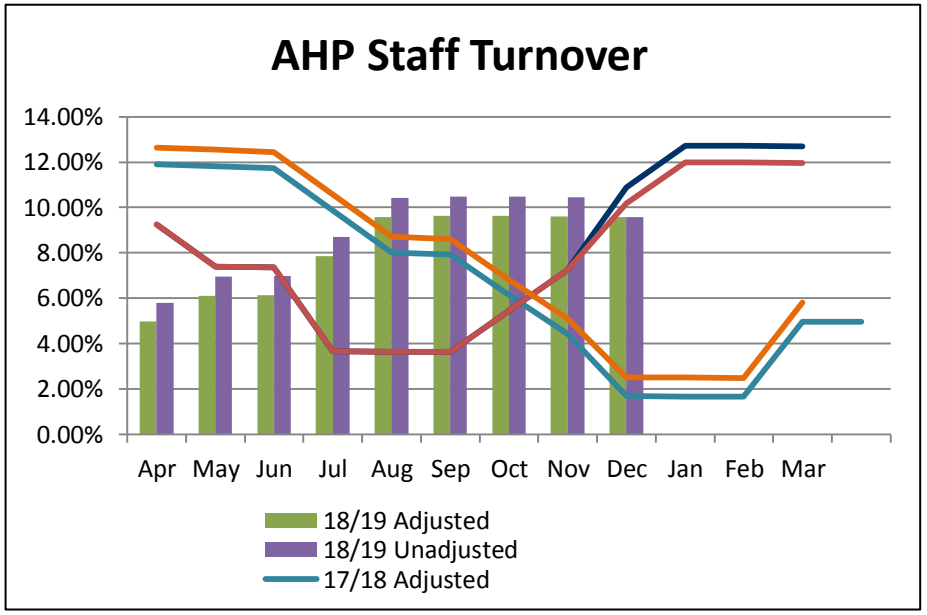




1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

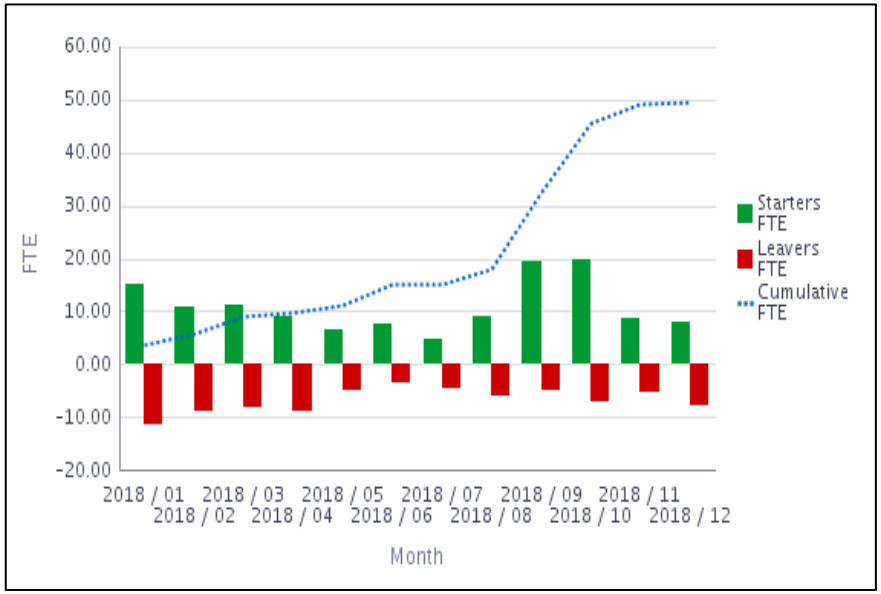
Turnover



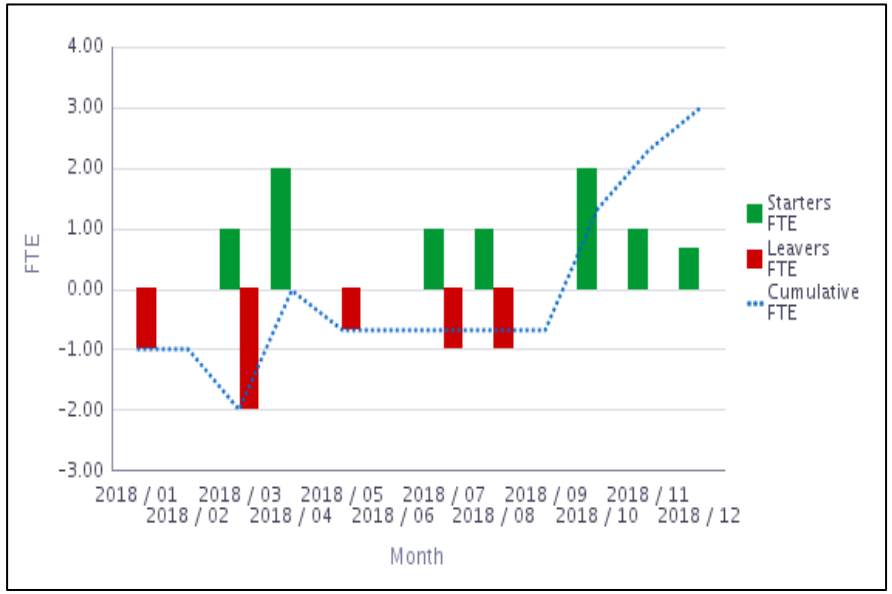


1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Starters / Leavers by Month - All Staff

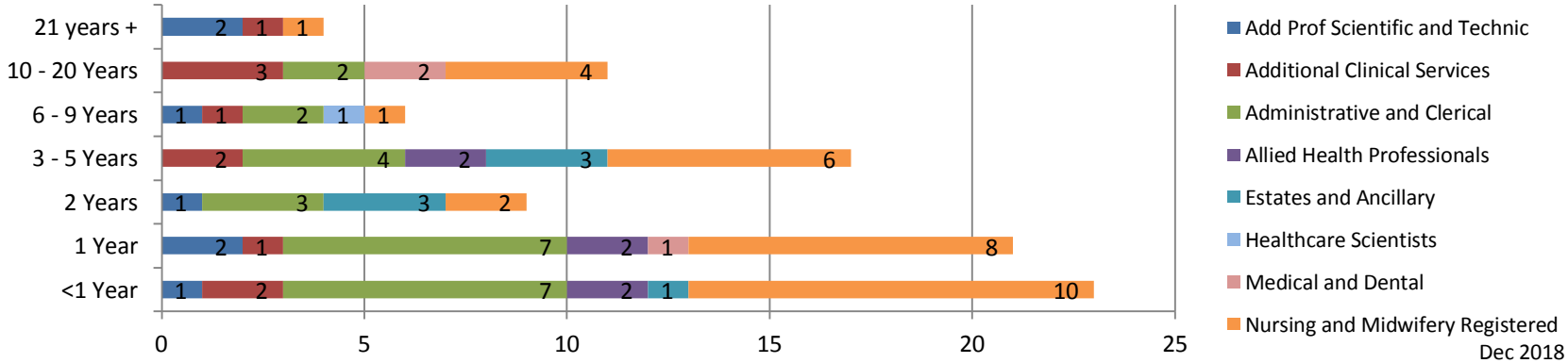


Starters / Leavers by Month – AHP Staff

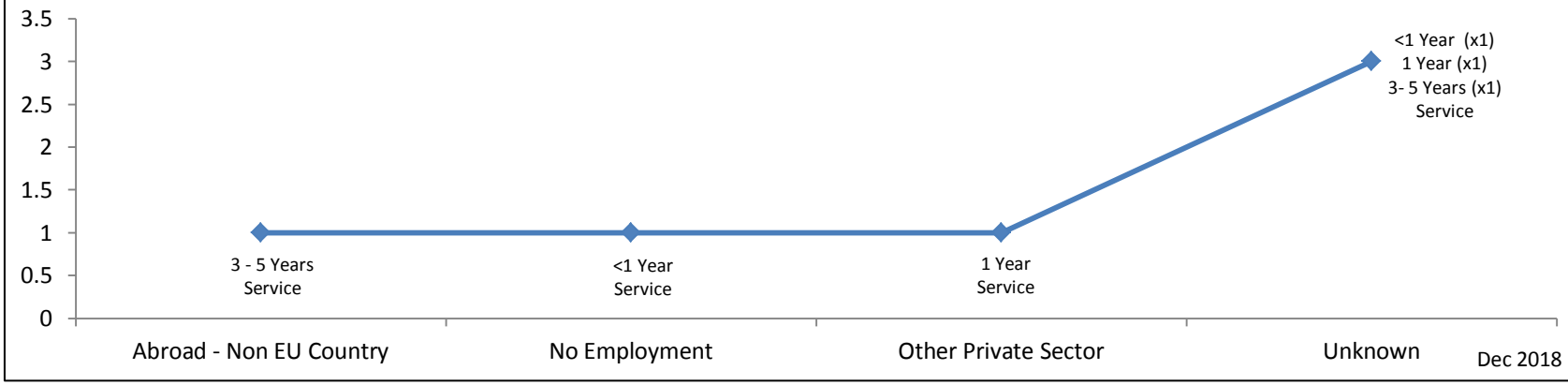


1	Workforce Composition , Resourcing and Cost
1d	Staff Turnover

Leavers by Length of Service (12 months)

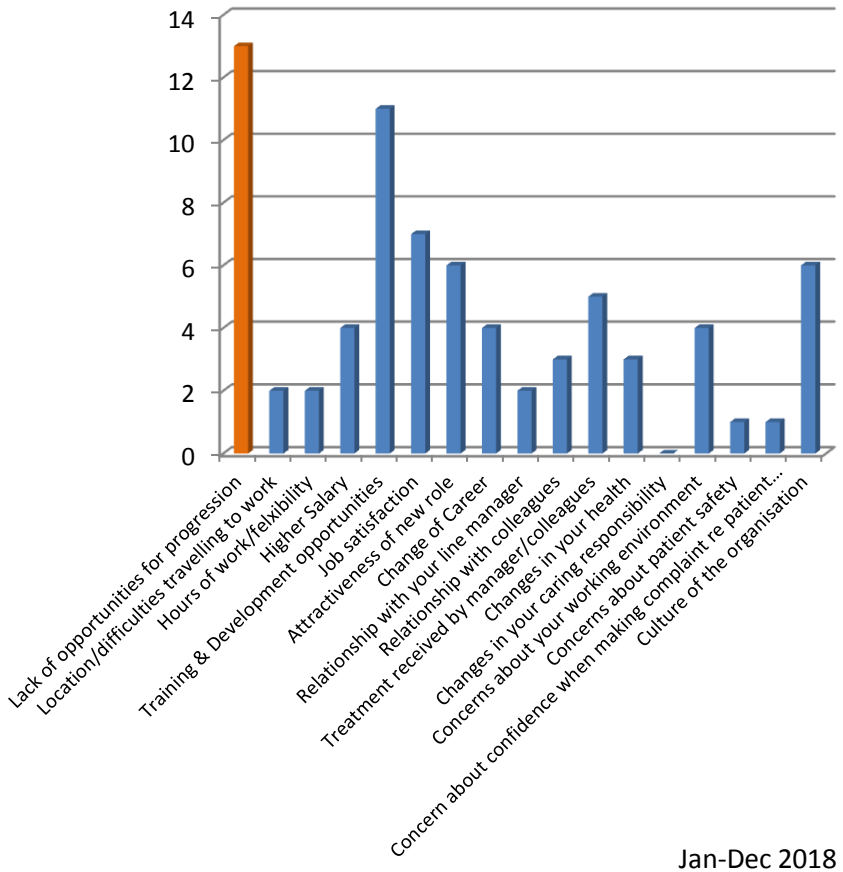


Leavers by Destination upon Leaving & Length of Service
AHP Staff



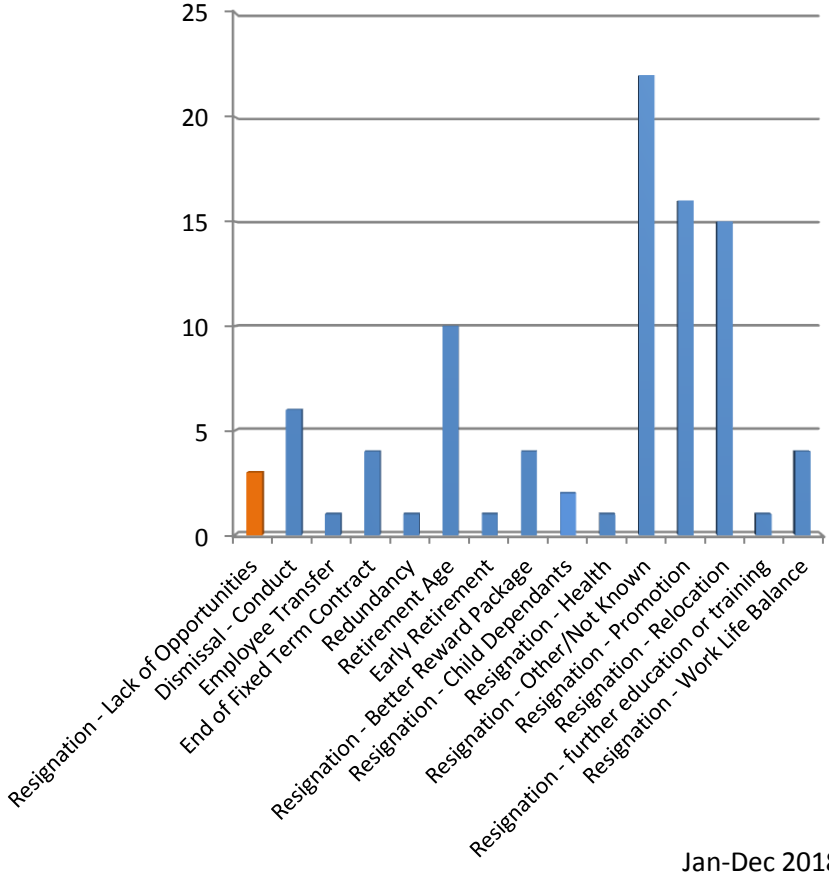
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

Exit Questionnaire Reason for Leaving



Jan-Dec 2018

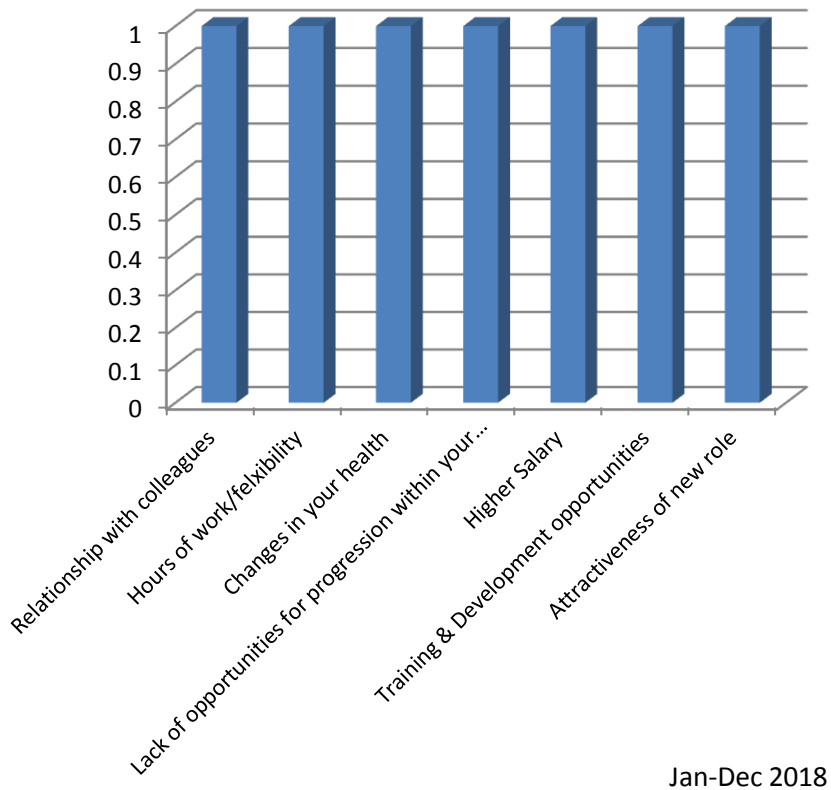
Reason for Leaving (ESR data)



Jan-Dec 2018

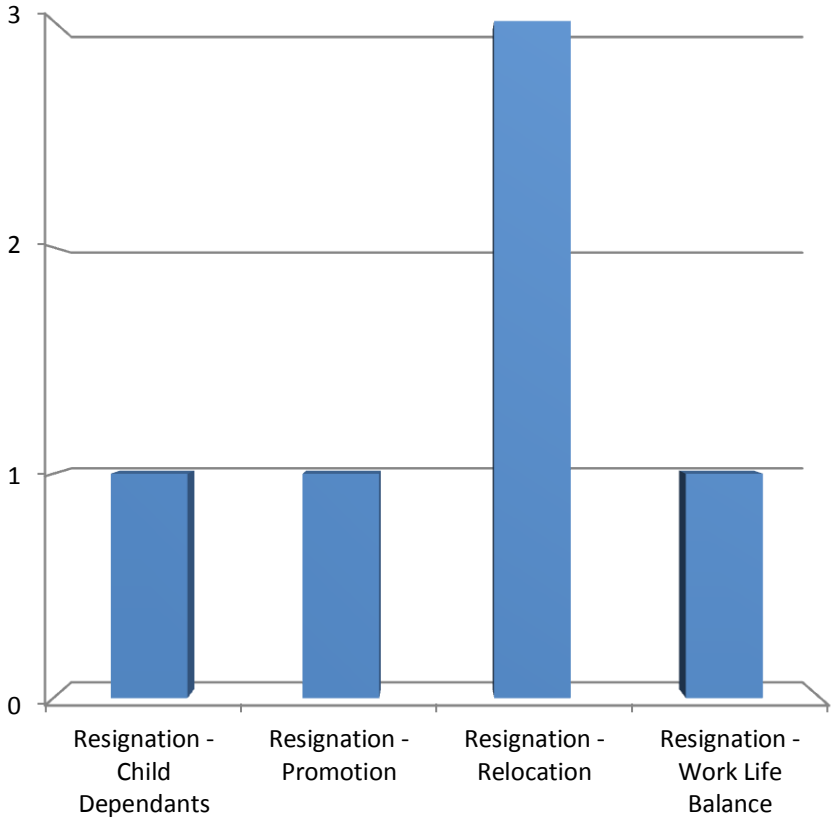
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

AHP Staff
Exit Questionnaire Reason for Leaving (Jan - Dec 18)



Jan-Dec 2018

AHP Staff Reason for Leaving (ESR data)

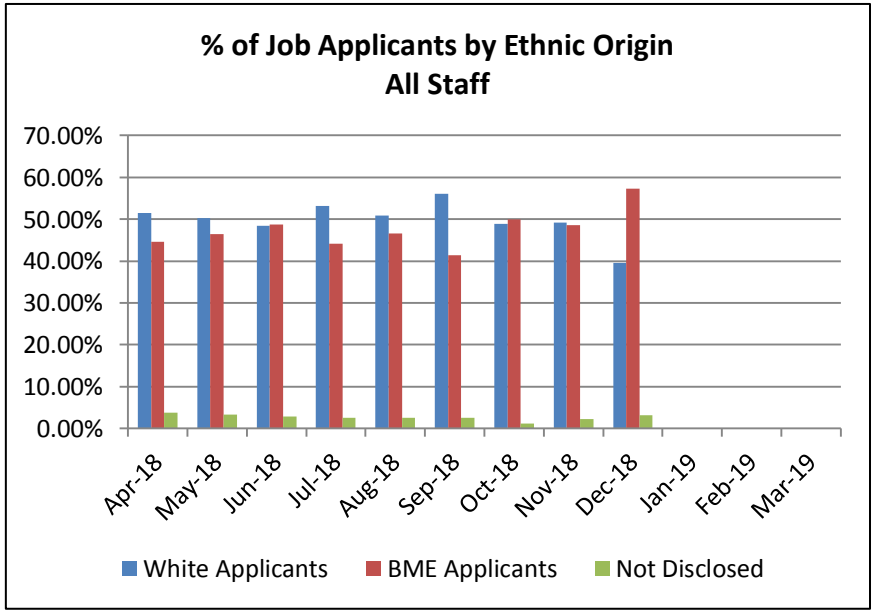


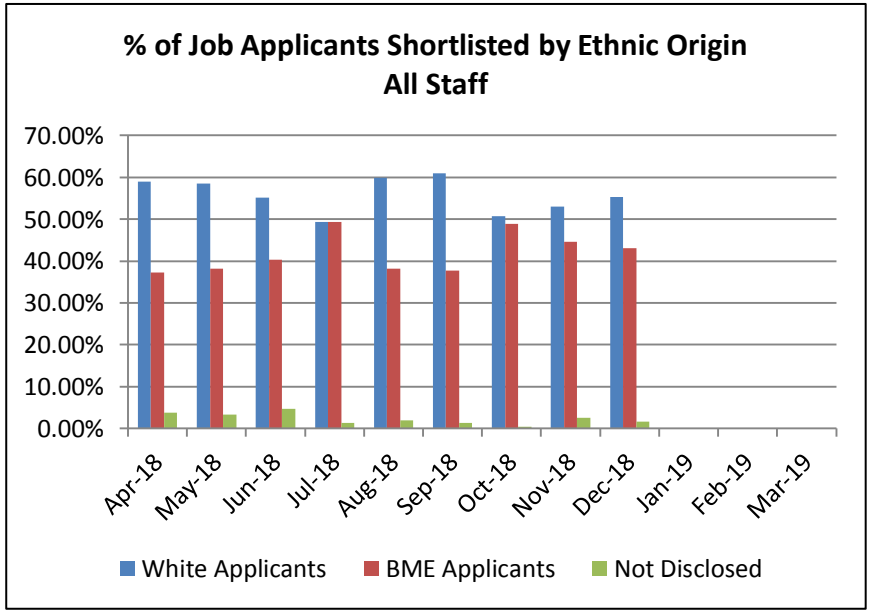
Jan-Dec 2018

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



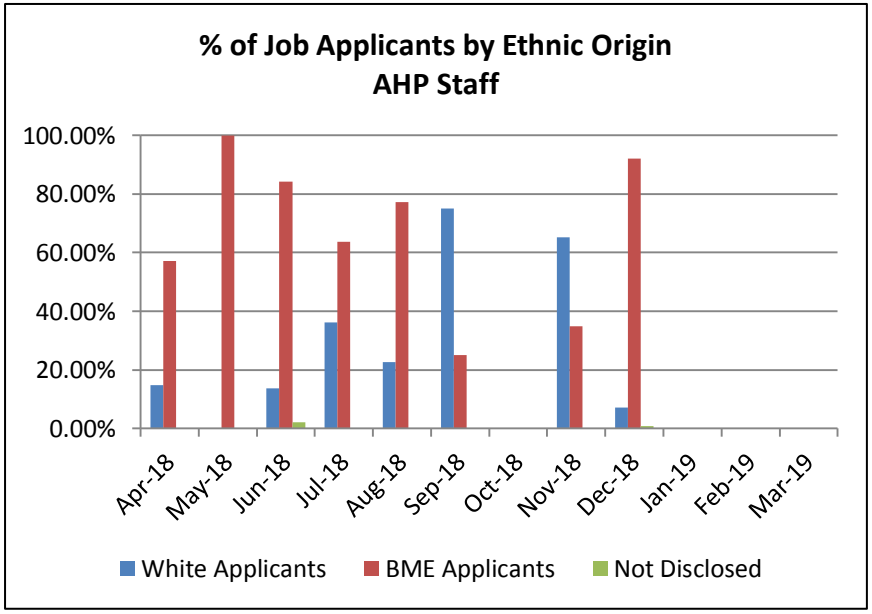


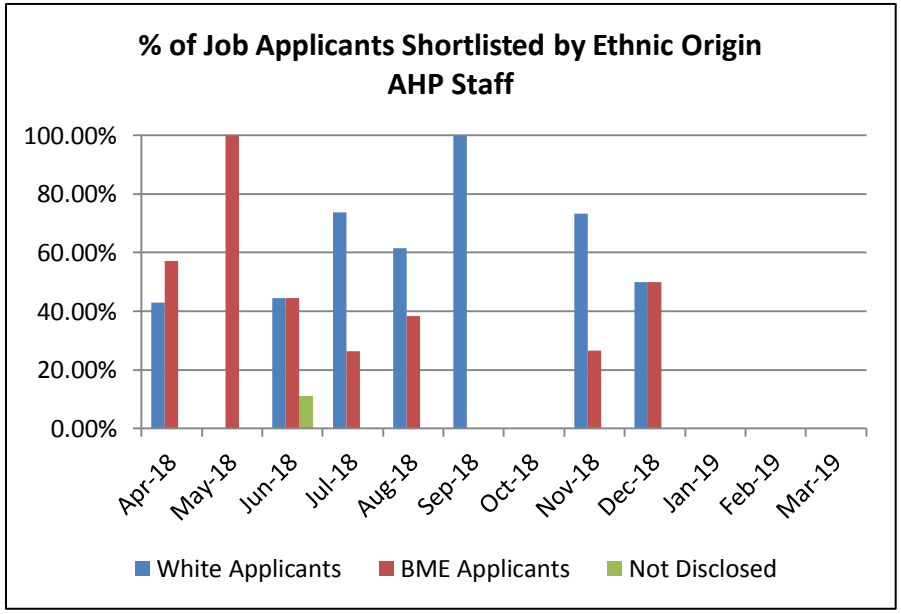
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.73	↓	+0.13	+ 0.09	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month
3.83

Workforce Composition, Resourcing and Cost

Staffing Costs – The actual spend on staffing was just above that planned in December, for both bank and agency staff, with the latter remaining considerably above plan across all staff groups. At face value, although the Trust has clearly been using some agency staff to deliver additional activity, this is slightly surprising for December, as the expected (reduced) amount of activity was delivered. There is further work being undertaken by finance colleagues to understand this more deeply: although December's sickness absence was high (almost 5% in month), there is a question about whether a disproportionate number of staff may have been released in month – but it is also clear that a lot of claims for additional activity were submitted for payment by Consultants in December which affect the financial position.

Turnover – the unadjusted turnover figure has now reduced for each of the last 11 months and is now reported as 9.40% for year to December 2018 (compared with the 12 month figure of 12.66% in December 2017). This is against the Trust target of 11.5%. The adjusted turnover position has improved (decreased) for each of the last 5 months and a December figure of 8.12%. Turnover has decreased for medical and nursing staff but more significantly for clerical and ancillary staff to drive this position.

The Trust is part of an NHSI externally facilitated programme for nursing staff in particular to share best practice and develop an action plan, for which work will continue in February and March 2019.

The Trust's size does mean that relatively small changes in numbers will affect the turnover position. In context, AHP's are the only staff group whose turnover has worsened in the last 12 months – with 7 leavers as opposed to 3 in the respective 12 month figures – so not a significant cause for concern.

The exit questionnaire data is interesting, and now covers a 12 month period: the ESR data offers unknown/ promotion/ relocation as the top three reasons, whilst the actual reasons put forward by respondents suggests a lack of opportunities for progression/ training and development opportunities and job satisfaction as the top three reasons. The consistent theme is that respondents seem to be leaving, as the Trust cannot meet their promotion or development aspirations (and possibly relocating to do so). This does pose a workforce challenge: whilst turnover rates are improving, the size of the Trust means flat structures in clinical jobs will be a challenge. The Trust has started an in house band 6 development programme for nurses, and has established a link with Keele University to reintroduce the Orthopaedic nursing course.

The graph on page 5 shows the remaining level of challenge, which has been updated to reflect the increased number of budgeted established posts and conversion from bank to agency (this does not reflect any potential changes resulting from the transfer of Paediatric Services or projected growth in Theatre capacity or therapy services). Based on a like for like comparison, there were circa 40 WTE more staff on the payroll in December 2018 than there were in December 2017, representing a growth of 4.5% in workforce numbers. These are encouraging signs – although it should be noted that the majority of this growth occurs in non-clinical posts.

Workforce Composition, Resourcing and Cost

Recruitment and Selection - Time to hire and streamlining

The figure for conditional offer letter to unconditional offer letter within 6 weeks is 82% based on 113 live records as at the end of January 2019. Whilst this figure is below the expected 95% Trust target, there is assurance that it is artificially low. Reasons for under reporting are overseas recruitment for medical staff and Filipino nurses, where visas are applied for but individuals are not in the country or are not yet in a position to meet entry requirements; and staff with deferred start dates (such as newly qualifying nurses), who are less speedy in undertaking checks such as DBS for posts which do not start until September.

Significant efforts continue to streamline recruitment processes whilst maintaining appropriate governance. In the last 12 months, references are now undertaken online and are factual only (up to and including band 7); for all non-medical staff, managers undertake identity checks at interview, meaning no pre-employment meetings are needed; standard letters are now electronically generated via NHS Jobs; staff joining the bank are encouraged to join the DBS update service, meaning that DBS checks take less time and a reminder regime is lighter touch; electronic personal files are being piloted with the nurse bank to save delays in transfers, and managers are being encouraged to scan and return interview notes where practical, again to save time.

Efforts continue to develop the ability to extract reports from the Trust's Vacancy Approval System, which it is intended will offer insights into any parts of the system which experience delays.

WRES Indicator 2 monitoring

December was an unusual month in that applications from BAME staff significantly outnumbered their white counterparts, yet at shortlisting stage (anonymous) BAME applicants were not shortlisted in the same proportion, which would suggest ambitious but less well qualified applicants. The 12 month figure for December was however down on September's reported position when it came to appointment (1.73 times more likely to be appointed versus 1.82 times in September report). Deeper analysis of this element is being undertaken as part of the Equality and Diversity plan following further direction from the Equality and Diversity Network.

ACTIONS FOR IMPROVEMENTS / LEARNING

NHSI Retention programme, development of ATR system, planned deeper dive into WRES data

RISKS/ISSUES

Unplanned staffing expenditure remains an issue, as does potential over-reliance on temporary staffing. Potential excessive working by established nursing staff through additional Bank hours.

Inadequacy of specific recruitment workforce data/ insufficiently developed systems make creation of a suite of recruitment KPIs a challenge.

2	Workforce Performance
2a	Staff Attendance

Staff Attendance

Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
95.54%	95.63%	↓	0.56%	96.10%

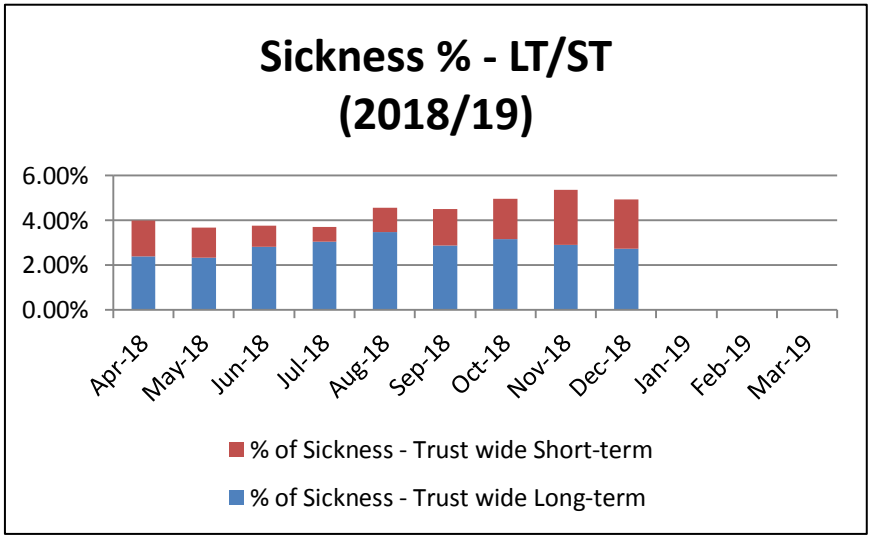
ALL STAFF

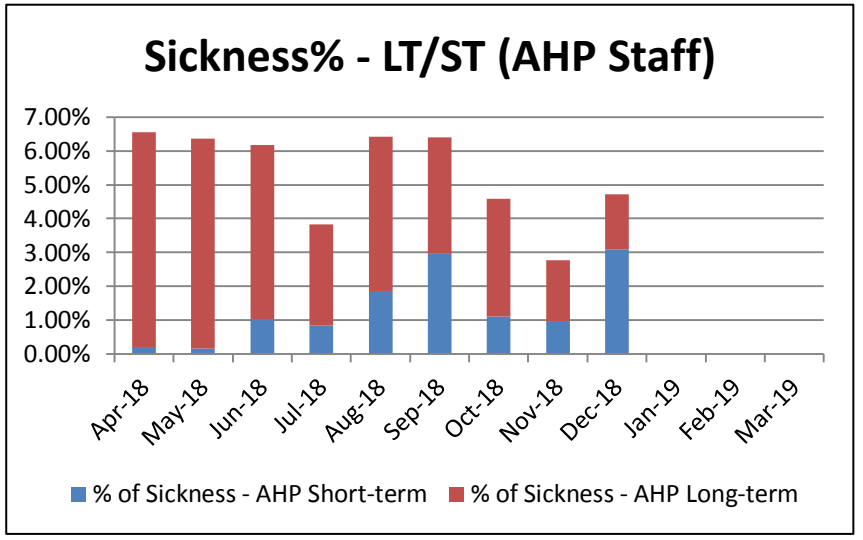
* 12 months to End of December 2018

Twelve Month Rolling Average	Twelve Month Rolling Average Last Calendar Month*	Trend	Variance to Trust KPI	Current Trust KPI
95.19%	95.30%	↓	0.91%	96.10%

AHP STAFF

* 12 months to End of December 2018





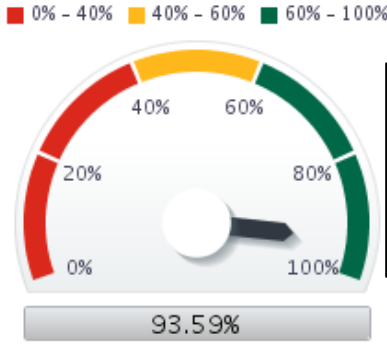
2 Workforce Performance

2b Staff attendance – short-term absence management

Staff Absence

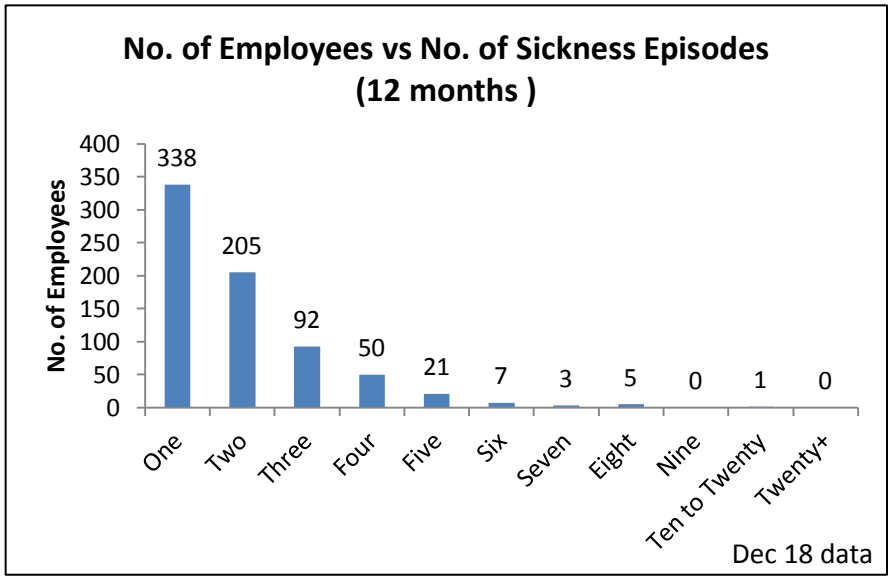
Return to Work Process Completion Rate (12 months) *Dec 18

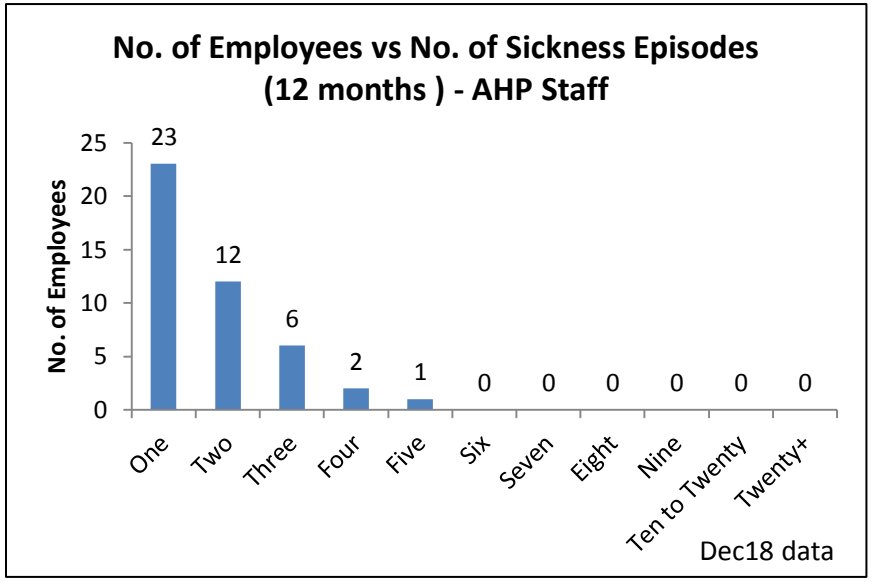
ALL STAFF



Return to Work Process Completion Rate (12 months) *Dec 18

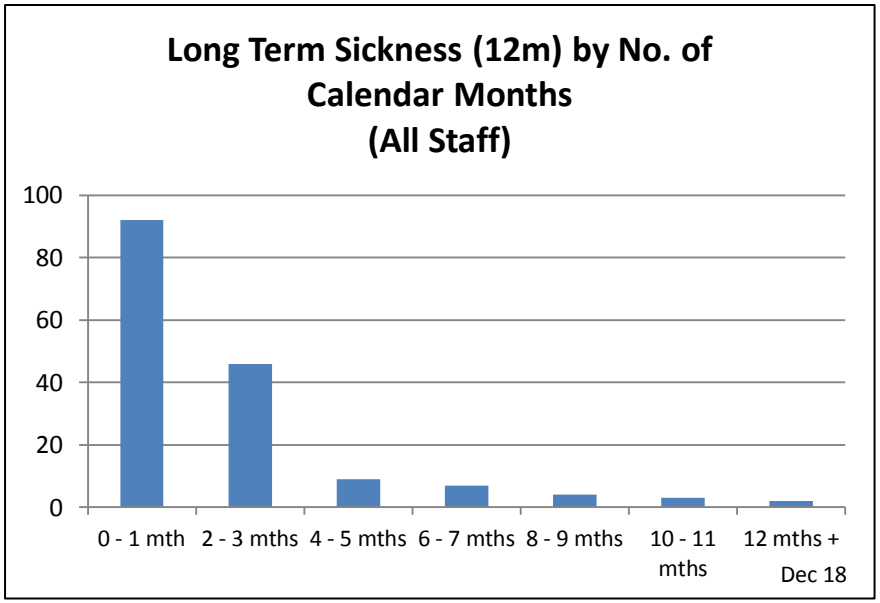
AHP STAFF

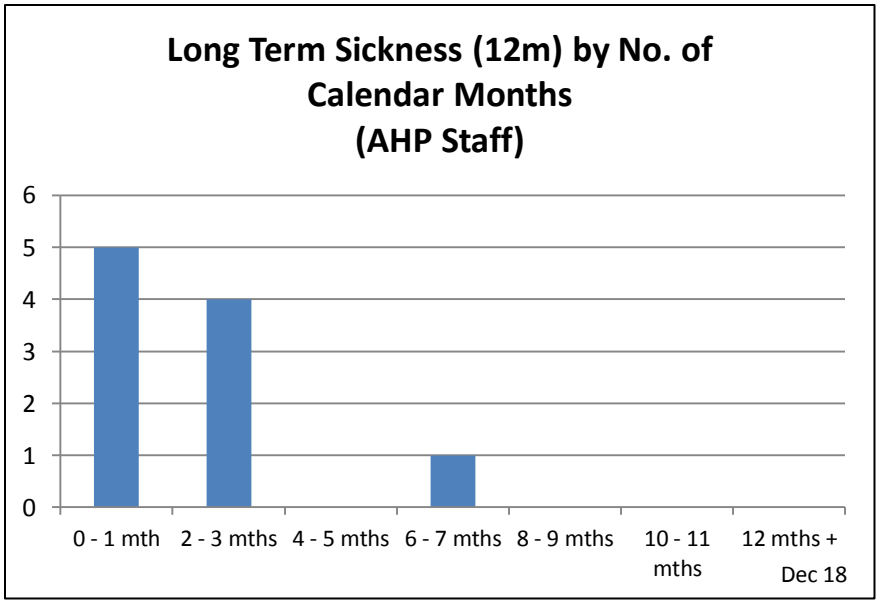




2	Workforce Performance
2c	Longer-term Staff Absence

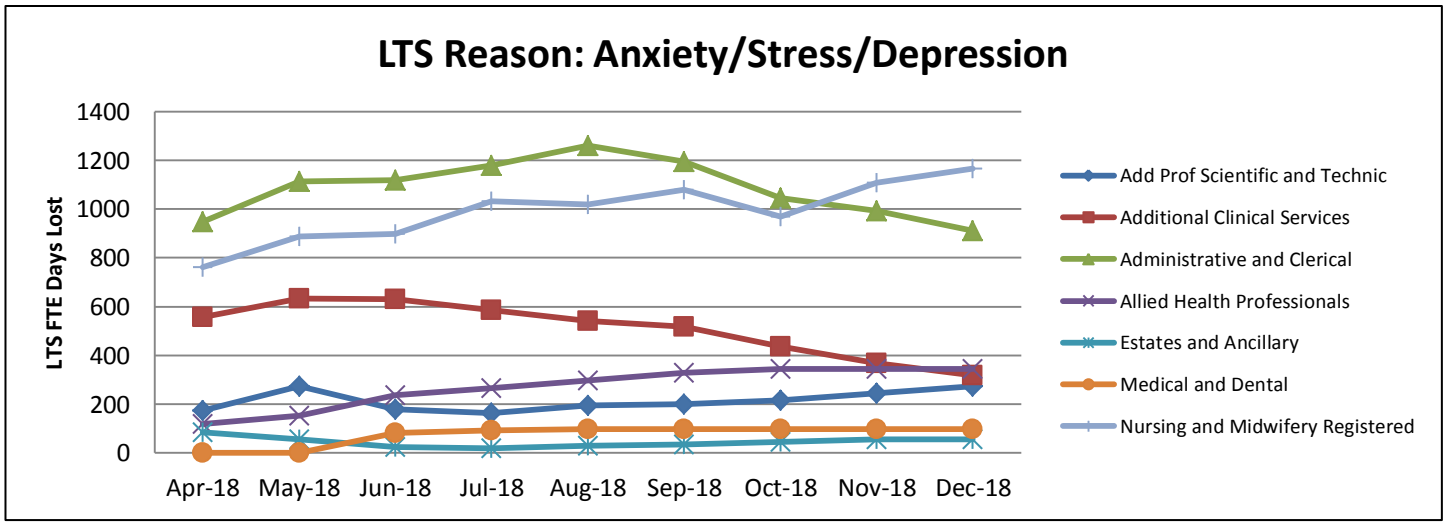
Long-term Staff Absence

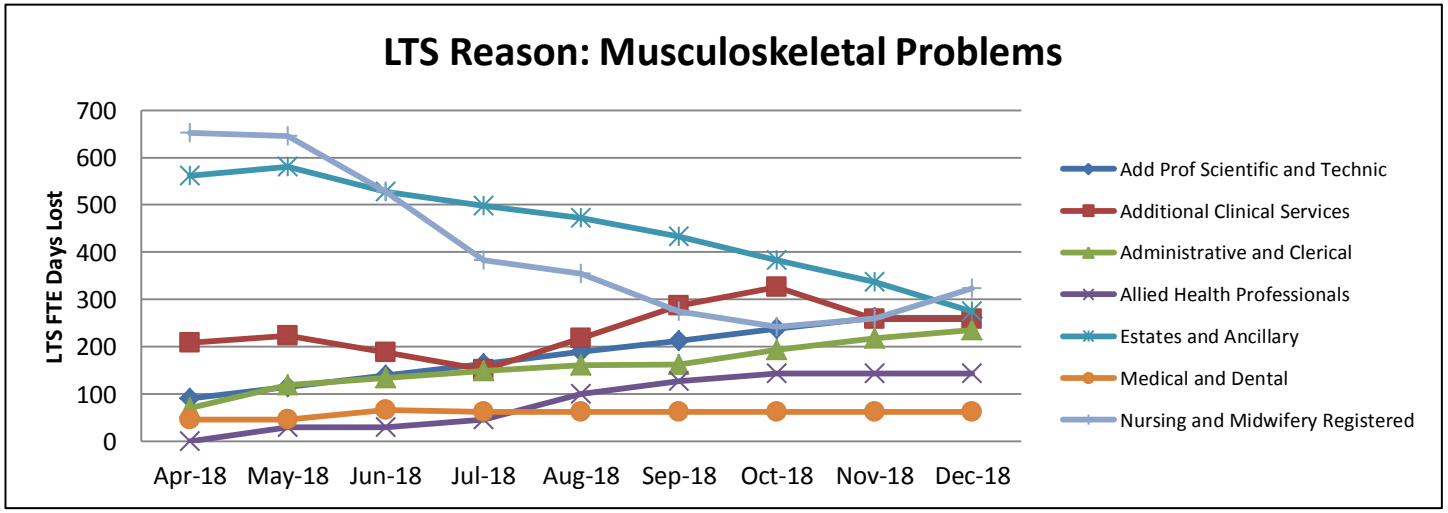




2 Workforce Performance

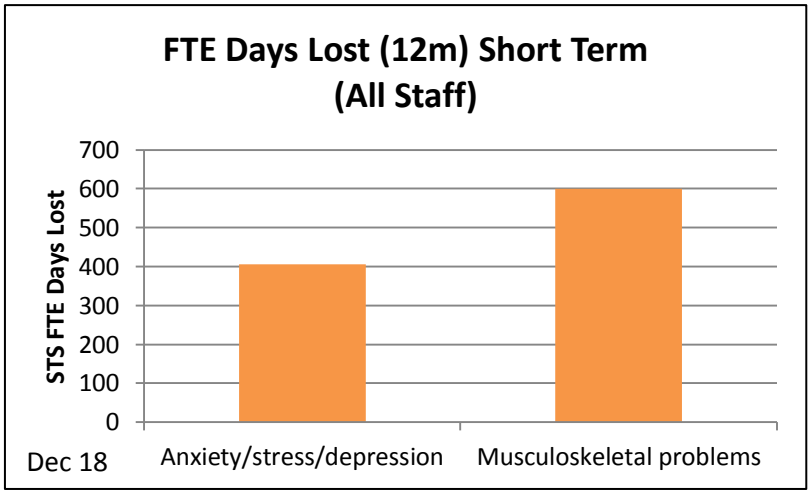
2c Longer-term Staff Absence

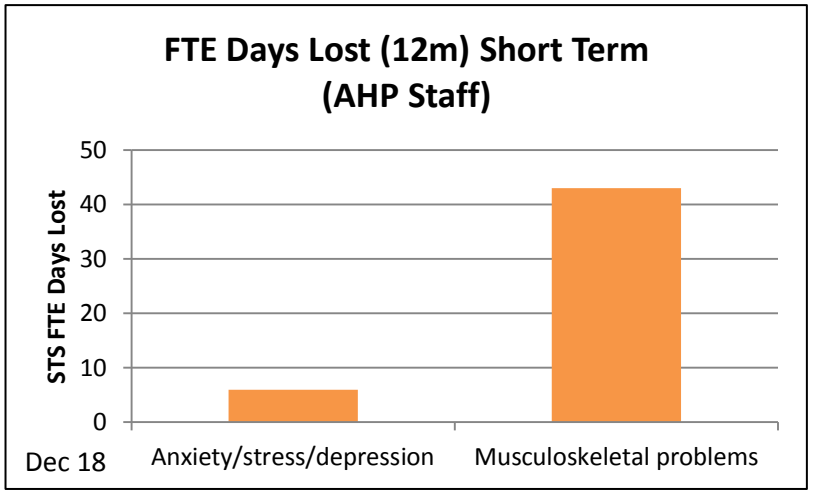


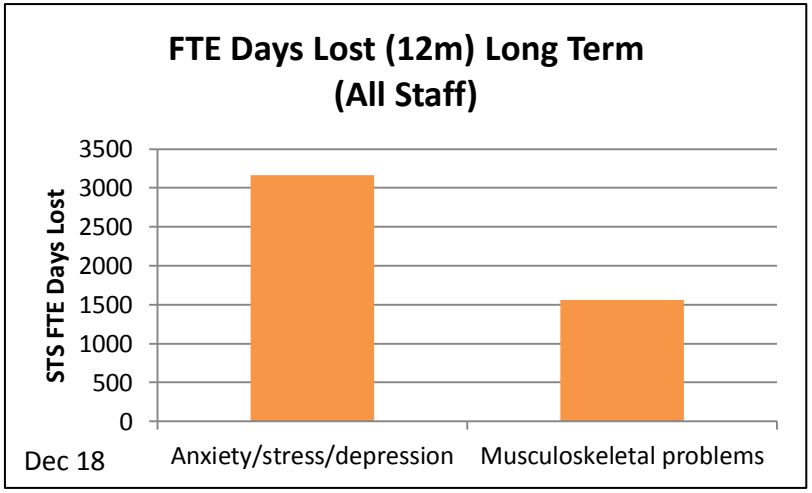


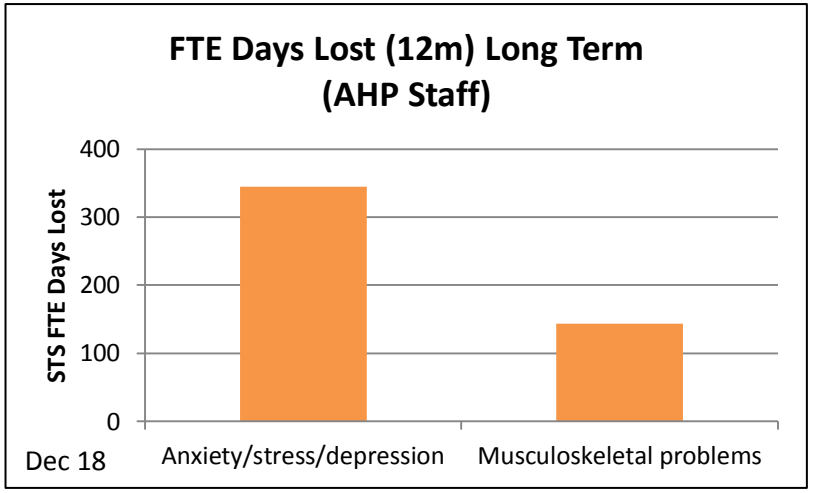
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary

Management of Performance

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	0	1	1	0	2	5

January 2019

INFORMATION
Staff Attendance – The rolling twelve month attendance rate reduced slightly year to December 2018 at 95.54% , 0.56% short of the 2018 KPI of 96.1% (3.9% absence). The graph shows that the vast majority of short term absence is spread among many staff, with a potential dismissal hearing arranged for the most frequent non-attender; and the long term graph is a 12 month position, meaning that anyone who has been absent for 12 months or more will show in the figures, even though they may have been returned or dismissed. In practice, there is no case of anyone absent for more than 10 months as at the end of December. The December in month rate for return to work meetings was just over 54%, which was the third highest figure in the last 12 months. This remains an area where focus is needed, however. **Formal Disciplinary and Capability** As at the end of January, there were 2 outstanding formal conduct cases either in investigation or hearing stage, and one capability case due to go to a hearing.
ACTIONS FOR IMPROVEMENTS / LEARNING
Procure new OH and EAP provision in line with STP recommendations and following Executive Team consideration. Succession planning and talent mapping processes to be developed and transacted in the medium term
RISKS/ISSUES

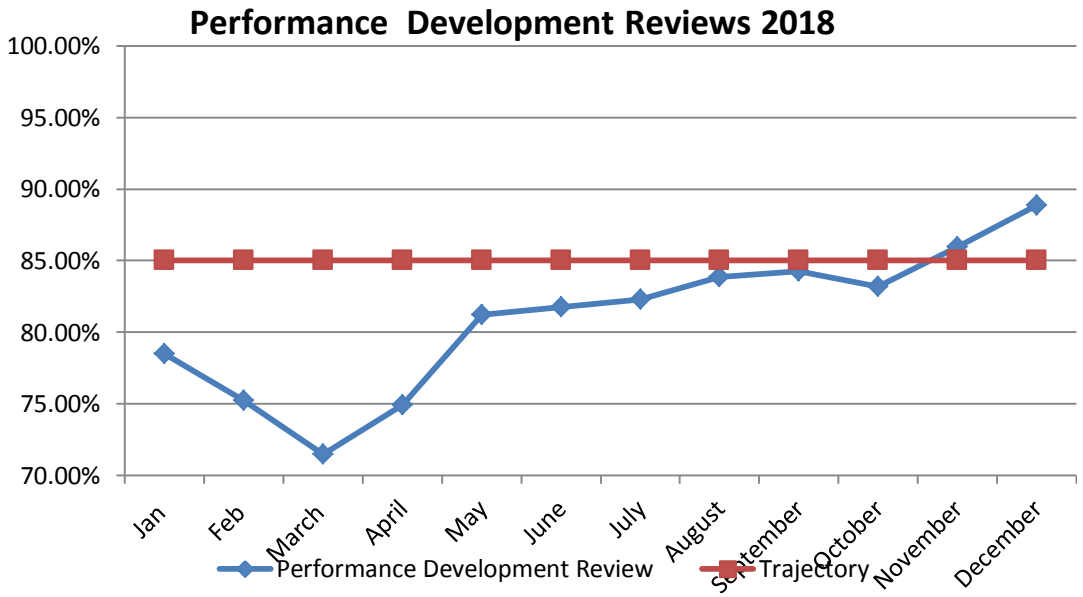
3 Workforce Learning and Development

3a Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NNS Engagement Question 2017	2017	2016	2015
20a	In the 12 months have you had an appraisal or annual review?	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	64%	74%	79%
20f	Were any training, learning or development needs identified?	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date

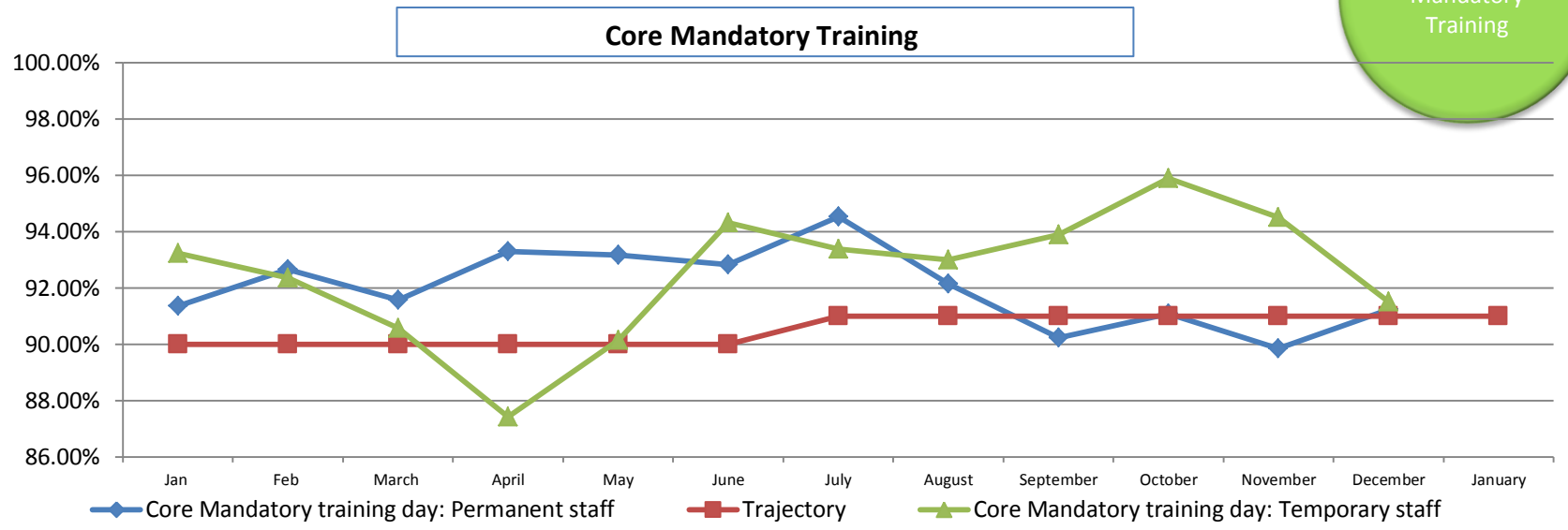


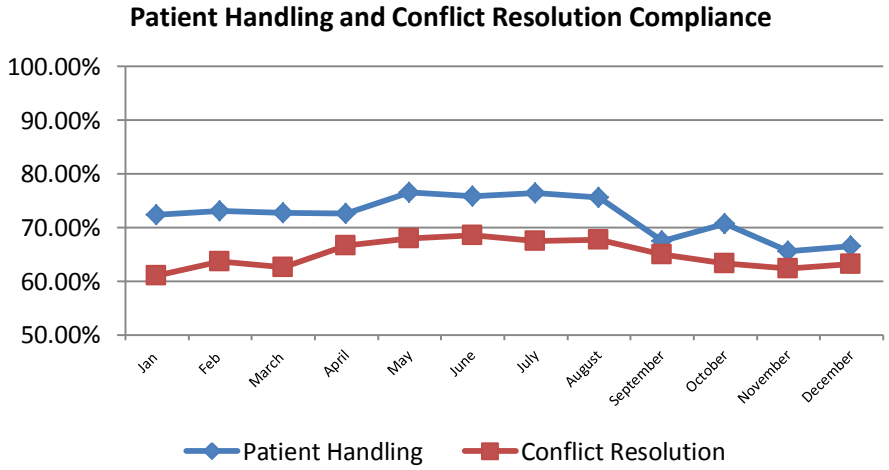
Outcomes from the National Staff Survey suggest that the Trust appraisal process occurs with staff at rates comparable with similar trusts, however the effectiveness of the process, the identification of behavioural and skills development needs and the management of these requires improvement. This links to the overall requirement to improve performance management processes within the Trust. These figures will be updated in March 2019

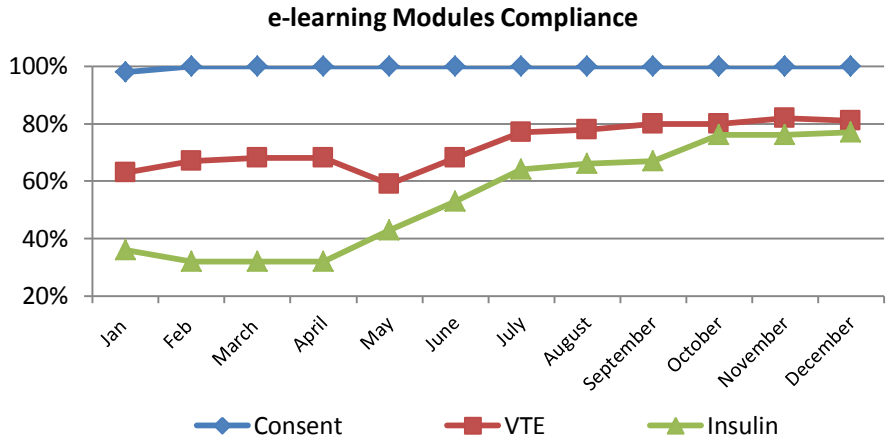
3 Workforce Learning and Development

3b Core Mandatory Training, Specialist Training and Corporate Induction

Core Mandatory Training



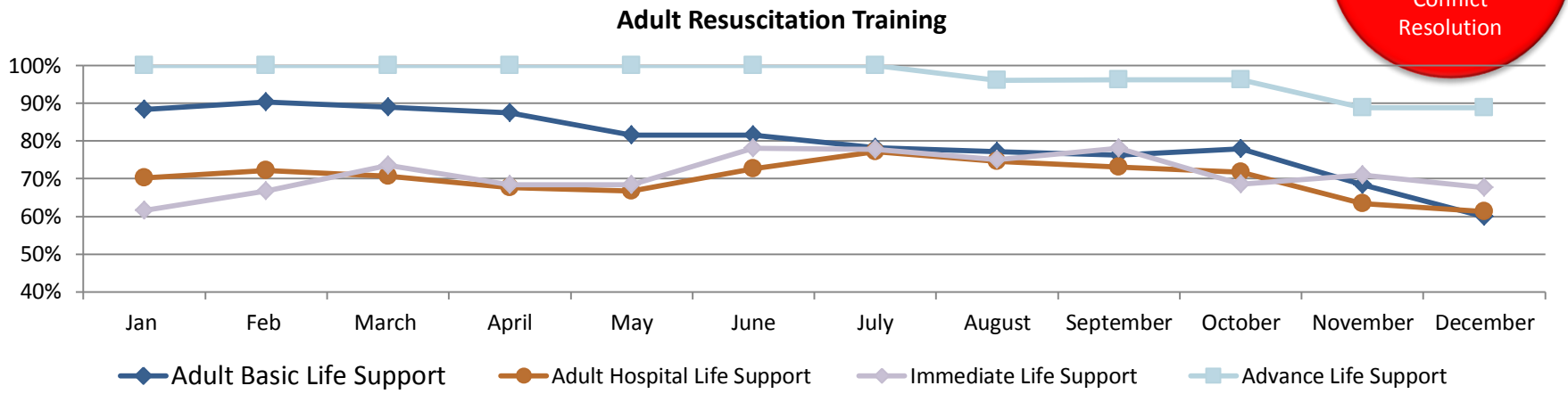


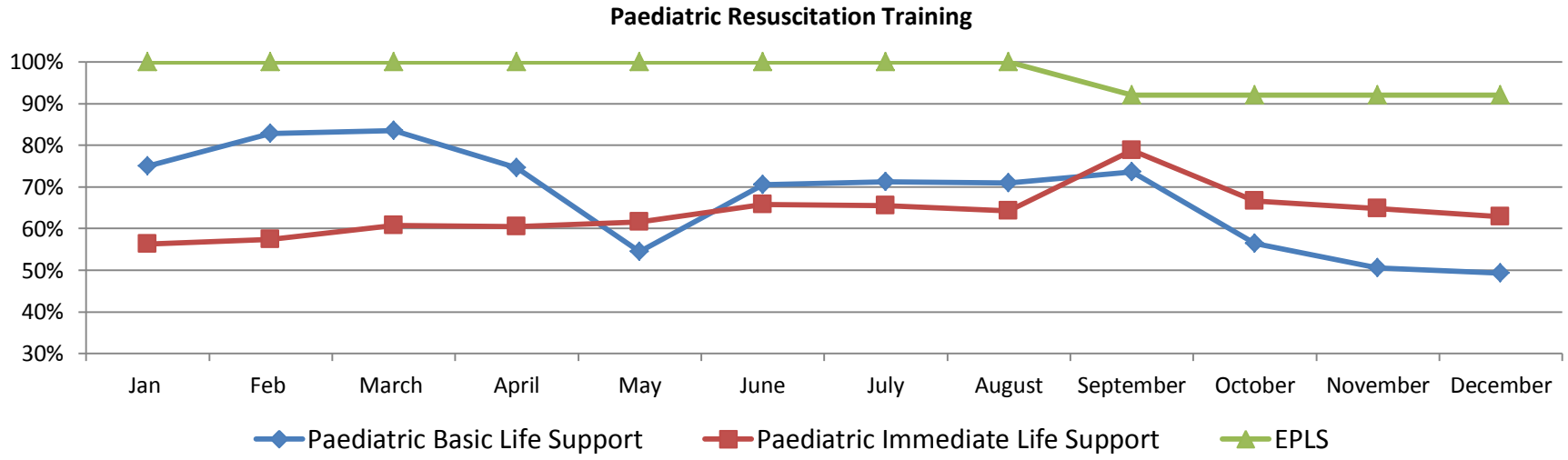


3 Workforce Learning and Development

3c Resuscitation Training

Role Specific Training: Resus, Patient Handling, Conflict Resolution

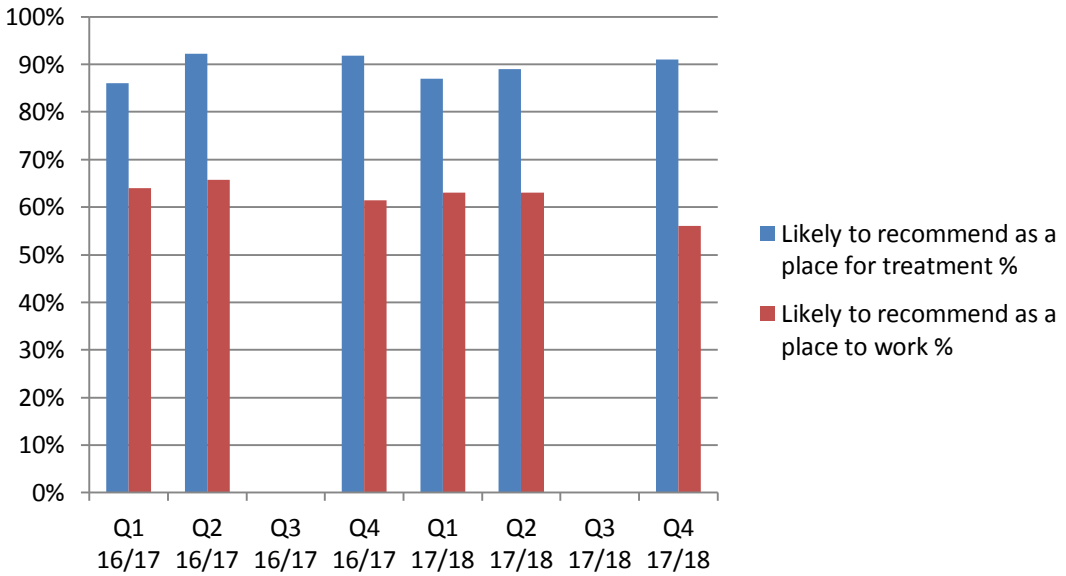




INFORMATION
Core Mandatory Training – Reported Core mandatory training attendance has achieved compliance again in December at 91.23%. Work continues on improving the content and delivery of the face to face training, and developing a more easily accessible e-learning approach. 10% of core mandatory training is currently completed on line. 2019 will see an increase in this figure. CMT for Bank / Temp staff has continued to maintain over 91% compliance for 7 months. **Role Specific Mandatory training –** The Trust Resus training compliance for Adults and Paediatrics has shown a steady decrease over the last 4 months. Twelve months ago in October 2017, the Trust had a push on adult and paediatric resus training, and those that became compliant during those months are subsequently becoming non-compliant as their annual update requirement comes around. Resuscitation standards and governance processes have recently been reviewed and updated recently, with the Director of Nursing committing to chair the Resus committee from November 2018. The Risk for resuscitation training compliance figures is monitored through the quality and safety group. Conflict resolution and patient handling compliance continues to hover around the 65% compliance area. This has been raised with the clinical quality group, and a small focus group has been created to review attendance requirements. VTE / Insulin –Improvements have been seen in staff completing insulin, and VTE has been noted following the review of requirements. Consent continues at 100% compliance however during January a review of requirements will be undertaken, and a 3 yearly repeat may be introduced.
ACTIONS FOR IMPROVEMENTS / LEARNING
Core mandatory training :– Mandatory training streamlining / CIP project continues. Positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information. Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place. VTE/Insulin online modules: E-learning facilitator working closely with Lead to increase compliance, creating learning paths in ESR. It has been agreed that medics do not need to complete the insulin modules as they do not administer.
RISKS/ISSUES
Staff booking onto and completing their role specific mandatory training modules is low. Resus levels still non compliant In house trainers for resus and patient handling reducing availability to support training. Attendance and DNAs on courses is still high. DNA charges will be introduced during 2019.

4	Workforce – Experience and Engagement
4a	Friends and Family Test Survey

FFT

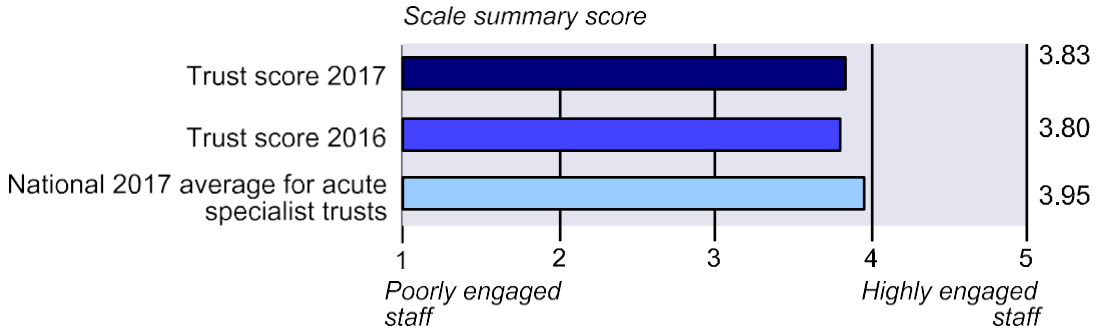


The overall Staff Engagement Score in Quarter Four 2017/2018 is **3.90** which compares favourably to the 2017 full survey overall Staff Engagement Score of 3.83.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

Employee Engagement

OVERALL STAFF ENGAGEMENT

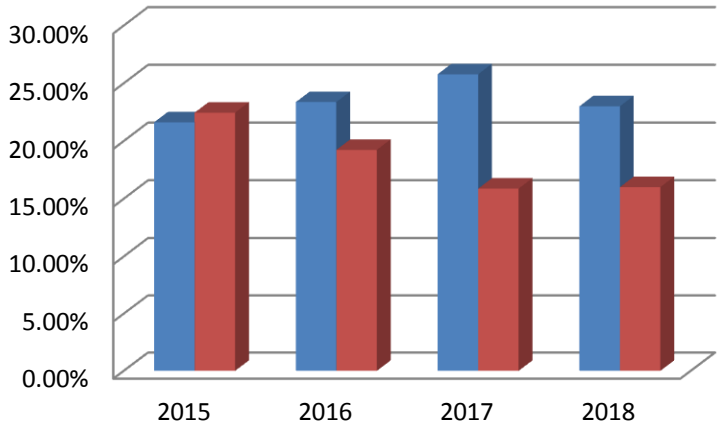


		Your Trust in 2017	Average (median) for acute specialist trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	79%	86%	69%
Q21b	"My organisation acts on concerns raised by patients / service users"	79%	81%	73%
Q21c	"I would recommend my organisation as a 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

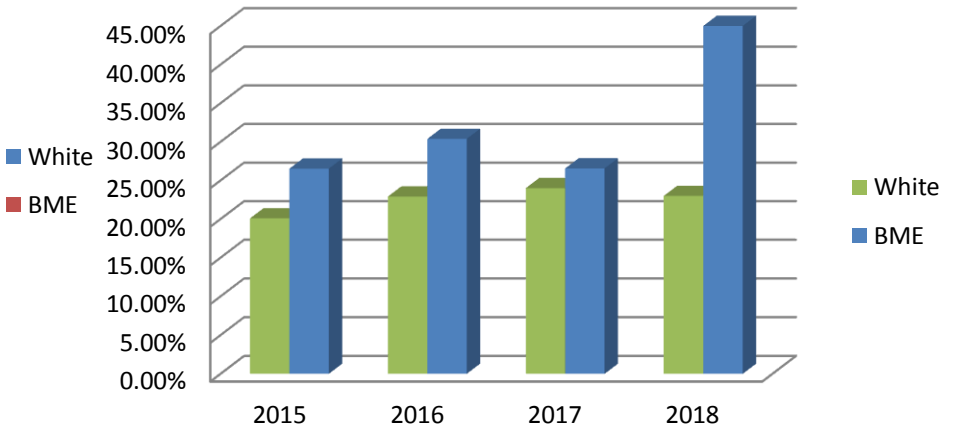
4	Workforce – Experience and Engagement
4c	WRES Indicators

WRES Indicators

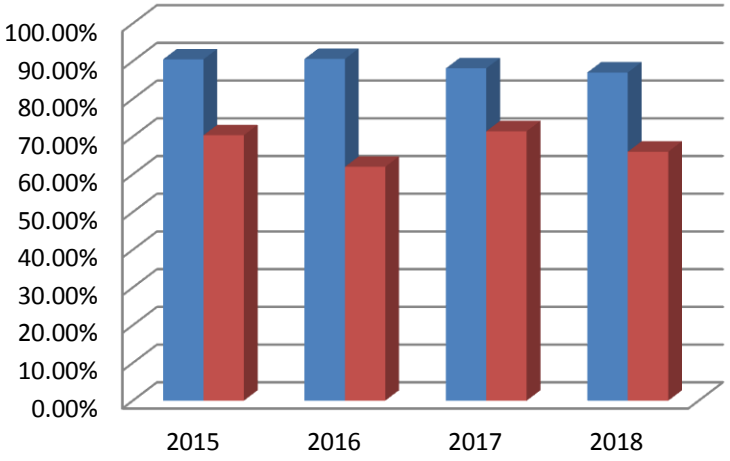
Indicator 5: Experiencing bullying from patients



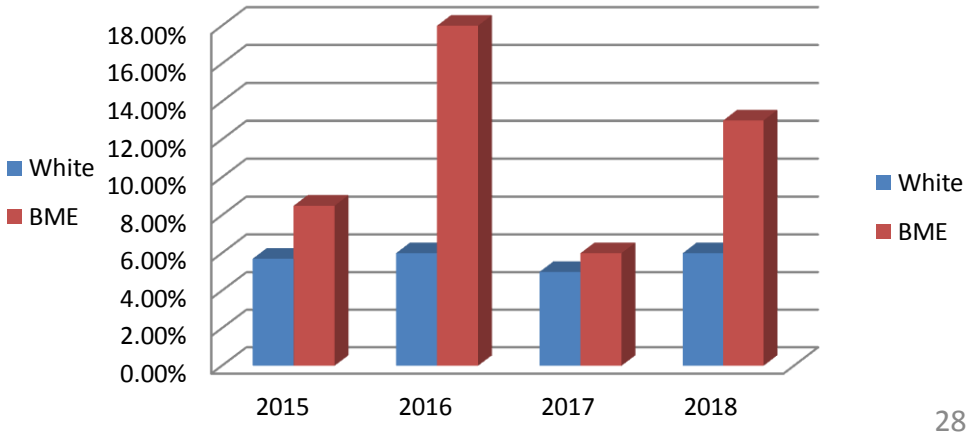
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION

National Staff Survey (NSS) – Draft information has been received for the national staff survey conducted October – December 2018. Information in this report will be refreshed from March onwards when the final weighted data is received from NHS England.

Friends and Family Test (FFT) – The FFT survey is being launched on 29th January 2019 for one month. A communications plan is in place including the February Team Brief.

Engagement and Job Satisfaction – Speak Up and Join in brand becoming increasing established. Even better if… sessions are now included in development programmes and teambuilding events.

Productive one to one conversations are key to the Performance Management refresh currently being developed. An engagement workshop is taking place in February with staff from around the Trust to discuss the importance of one to one conversation and how to embed in the Trust. The work fits with the Continuous Improvement work being completed by Jonathan Bamford

WRES Indicators – A separate report gives an update on actions identified at the time the WRES indicator results were published in September. Further information will be provided in March 2019 when information from the National Staff survey (NSS) can be used to update to update Indicators 5-8. The Trust's Equality and Diversity (E&D) annual report and action planEDS2 also includes actions linked to the WRES indicators.

E&D engagement

Sessions are currently being run across the Trust to review the E&D actions and priorities for 2019 with staff members.
The E&D network is now established with an elected Chair. Network meetings take place monthly. Any issues will be escalated to People Committee in the first instance

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions to encourage survey completion for Staff FFT to improve data reliability
Ensure feedback from staff from E&D forums is used to inform E&D action plan for 2018
Look at ways to engage BME staff members to shape E&D agenda

RISKS/ISSUES

Ensuring that staff members are given access to complete the Staff Friends and Family (FFT) test. Completion rate affects the reliability of the data as a representation of staff views. This also has an impact on some of the indicators for WRES

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 25 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that there was a risk over the lack of a register detailing the Service Level Agreements in place, although work was underway to address this by the Assistant Director of Finance. • It was noted that some of the issues picked up relating to stock management were matters which had been raised previously; the new managed theatres system would help with rectifying these issues. • The update from the Quality & Safety Committee suggested that two areas of risk that it was discussing included: compliance with water safety regulations and the Human Tissue Act.	• Update on the SLA register is to be presented at the next meeting. • A further update on stock management is to be presented at the next meeting. • A discussion on risk appetite was to be scheduled into the annual workplan for the Trust Board. • The fraud risk assessment was to be presented at the next meeting. • There needed to be a discussion around the strategic risk posed by current consent processes at Quality & Safety Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was confidence that the internal audit plan would be delivered as planned. • 'Reasonable assurance' was provided in connection with Controlled Drugs. The issues identified related to the timeliness of the closure of incidents and did not relate to the robustness of the processes to manage the Controlled Drugs. • It was noted that there was good progress against the actions arising from the self-assessment review tool (counterfraud). • There had been no counterfraud referrals and investigations. • There was noted to be good progress with closing down the actions on the recommendation tracker, although there was a need to provide evidence to justify the closure of some that were open at present. • The Committee received a presentation from the Medical Director on the steps being taken to improve the robustness of consent practices at the ROH. There remained some issues over documentation, however the Committee was of the view that the position had improved, particularly considering that taking consent	• The Committee approved the revisions to the internal audit plan proposed. • The Committee accepted the revised accounting policies. • It was agreed that the annual accounts could be prepared on a Going Concern basis.

on the day of surgery was now a rarity. • It was agreed that the Board Assurance Framework process was working well.	
Chair's comments on the effectiveness of the meeting: The discussions had been productive. It was noted that there was to be a change of Internal Audit partner, with Patrick Green being replaced by Mike Gennard.	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Group or Board met: 30 January 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that there had been a delay with completing the work to make the first dementia-friendly bathroom.	• Present an update on the take up of the Oncology care packs at the October meeting. • An update on the Throne project is to be scheduled in to the June 2019 Trust Board meeting. • A plan for spending the charitable funds is to be presented at the next meeting. • An update on the spend against the Dubrowsky legacy is to be presented at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was pleased to learn of the increased number of nominations for staff awards this year. • There had been a good level of response to funding requests for the Throne Project. • An update was received on the success of the Mindfulness initiative – 15 staff had been trained to deliver this and 120 people had participated in the sessions run. • The annual report and accounts for the charity was reviewed, which it was noted was of a better standard that that of previous years. • A positive update was presented on the fundraising activity, where it was highlighted that there had been an increase in the amount of funds raised through fundraising events.	• The Committee supported the bid for funding for the Staff Awards 2019, although it was agreed that greater effort would be directed into securing sponsorship for the event in 2020. • The Committee supported the bid for funding of the Oncology care packs for an initial period of six months. • The Committee agreed to release the funding for the full Throne Project works. • On the basis of the success of the Investment in Learning initiative, the Committee agreed that the request for additional funds should be granted to further the work. It was noted that there needed to be parity in terms of the development opportunities that staff were able to access.
Chair's comments on the effectiveness of the meeting: This was the first meeting chaired by Professor Gourevitch and the meeting had been well attended and had run to time. There was good time set aside for the consideration of the bids put forward.	

MINUTES

Charitable Funds Committee - APPROVED

Venue Boardroom, Trust Headquarters **Date** 3 October 2018: 1200h – 1230h

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 Apologies	**Verbal**
Prof Phil Begg tendered his apologies. It was noted that an external figurehead continued to be pursued to chair the ROH Charitable Funds Committee. It was suggested that the ROH alumni could be approached to canvas interest.	
2 Declarations of interest	**Verbal**
There were none.	
3 Minutes of the meeting held on the 15 June 2018: *for approval*	**ROHCF (10/18) 001**
The minutes of the Charitable Funds Committee meeting held on the 15 June 2018	

were accepted as a true and accurate record of discussions held.	
4 Financial report – Months 1-5 2018/19	**ROHCF (10/18) 002**
The Interim Director of Finance reported that the balance of funds was £2.2m and £9k of income had been received during the period. £1.5m was noted to be associated with the Dubrowsky legacy. Other funds were allocated against specific purposes and areas. There had been £45k of expenditure between 1 April and 31 August 2018. It was noted that after the transition of paediatric inpatient surgery to Birmingham Women's and Children's NHSFT, the fund currently allocated to Ward 11 would remain with the ROH given that an element of paediatric work would continue at the Trust.	
5 Bids for funding	**ROHCF (10/18) 003** **ROHCF (10/18) 004** **ROHCF (10/18) 005** **ROHCF (10/18) 006** **ROHCF (10/18) 007**
The Trustees considered a number of bids for funding, as follows: ***Recliner chairs*** - The purchase of recliner chairs was reported to be for the wellness room as part of the JointCare pathway. It was reported that these needed to be ordered from USA, given that they were specialist facilities and there was a plan to leave them in the facility for group therapy. These chairs were noted to be of a specification over and above the usual and therefore satisfied the criteria for accessing charitable funds. On this basis, the request for funding was approved. ***Throne project*** – it was reported that it had been identified that £48k was needed to complete the Throne Project over the next 12-18 months. It was noted that some of the furnishing to be purchased was standard equipment however, such as grab rails and therefore should be funded from exchequer funds rather than the charity. The expense associated with the change in the flooring was questioned. It was suggested that there needed to be confirmation of the funding need based on the number of dementia patients handled who would benefit from this change in flooring. The Trustees agreed that the bid needed to be refined to show the elements of 'over and above' standard specification and on this basis, the bid was not agreed at this stage. It was noted that there was specific fundraising for this project. ***Singing medicine*** – this was noted to be part of the therapy offering for children and the initiative was designed to show what patients currently being treated at ROH could expect at Birmingham Children's Hospital (BCH) once the service moved over. It was suggested that this could be widened to adults in due course. There	

was good evidence for wellbeing. This bid was approved and it was agreed that it should be charged against the Ward 11 fund. ***Artwork to mark the paediatric transition*** – it was proposed that a piece of artwork could be created to commemorate that the ROH had undertaken paediatric surgery after it had moved over to BCH. The funding was approved on the understanding that the artwork would be displayed at BCH. ***Wheelchair*** – a risk assessment for the use of wheelchairs was provided and a request had been submitted to fund a motorised wheelchair for the transportation of patients to the physiotherapy gym. It was suggested however, that there was little evidence that this was the correct use of charitable funds and therefore the bid was not approved. There was some debate around the governance of the request and the bid templates. It was suggested that the template needed to include both an Executive Lead and a checklist to demonstrate that the bid complied with the use of Charitable Funds according to the purpose of the Charity. The Associate Director of Governance and Company Secretary agreed to help address this.	
ACTION: SGL to refine the templates for the charitable funds bids	
6 Any other business	**Verbal**
There was none.	
7 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 31 October 2018 at 1330h – 1500h in the Boardroom, Trust HQ.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Responsive Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh; Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Stacey Keegan; Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**6th March 2019**

EXECUTIVE SUMMARY:

The attached CQC Responsive action plan presents an updated picture on all the issues which required actions for improvement following the Trust's CQC inspection in January 2018 and subsequent report published in May 2018.

The author communicates regularly with the accountable leads and provides a narrative update on progress.

On-going monitoring, escalation and oversight of this action plan is conducted in the following committees and meetings:

- Quality and Safety Committee.
- Executives meeting.
- Clinical Quality Group.
- Operational Management Board.

Where corporate risks exist they are aligned to the action plan. Associated delivery plans and evidence for assurance are embedded within the centrally stored master document.

REPORT RECOMMENDATION:

The Trust Board are asked to note the progress that has been made against delivery of the actions. However, although progress made, a number of actions have not delivered in line with the original timescale, therefore have been rag rated as red and detailed below:

- **Action 1B – Governance 'learning and sharing' methodology** – Work has been ongoing with the Communications team however some delay has occurred due to the vacancies/gaps with the Governance team. Launch of the improvement work and methodology is planned during March 2019.
- **Actions 2A-2C Mental health** – significant progress; the Trust has been working with BSMHFT to gain their expertise and help us scope our requirements as a Trust. All required actions are due for completion by the end of April/early May 2019.
- **Action 4C/D – Bone infection** – significant progress made and system wide working with a plan to develop a business case for the future service in April 2019 which aligns with the CQUIN.
- **Action 10A – Medical staffing escalation** – a non-urgent escalation tool is now drafted and out for consultation. Alongside this, in line with the launch of NEWS2 a revised escalation tool has been developed as part of the deteriorating patient improvement works.

- **Action 11A – Consent and adherence to policy** – improvements have been made and evidenced within the consent audits undertaken. The Medical Director is taking this action forward.
- **Action 16A – Accessible Information Standard** – A working group have taken the improvements required forward and a delivery plan outlines the work that has been completed. This action is an agenda item for the next Clinical Quality Group in April 2019 where it is anticipated the action will be closed with agreed ongoing assurances.
- **Action 17 A – Outpatient Clinic wait times** – Significant improvements seen in associated KPIs; these KPIs are reported and monitored in various meetings and committees. Operational forums are now in place to ensure a sustained and improved picture with an array of actions being taken. Currently there are discussions with the OPD management team regarding closure of this action with ongoing assurances.
- **Action 18A/B – Updated Trust policies and procedures** – A delay to completion due to the timelines of delivery and roll out for the new Health Assure system. This system will allow greater transparency of policies and the required review and named author. A monthly report on the status of clinical policies is received at the Clinical Quality Group.

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

Note and accept	Approve the recommendation	Discuss
X		

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

Financial	**X**	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments: [*elaborate on the impact suggested above*]					

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

CQC Responsive action plan aligned to Trust Corporate risk register.

PREVIOUS CONSIDERATION:

Quality and Safety Committee.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROH ACTION PLAN

NO	QUALITY IMPROVEMENT PROJECT	EXPECTED OUTCOME	KPI / MEASURE	EXECUTIVE LEAD	CLINICAL / PROJECT LEAD	MONITORING COMMITTEE	ROH ACTION NO	ACTION	FINAL DEADLINE	UPDATES Unsatisfactory Progress Slow Progress Satisfactory Progress Completed	RISK REGISTER	ONGOING ASSURANCE
Chief Executive Officer												
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	Chief Executive Officer	Associate Director of HR	S/E and O/D Committee	14a	April - Trust Board reviewed completed WRES report.	~~Aug-18~~ Oct-18	The WRES report was received by Trust Board in April 2018 and will be submitted to NHSE in late August 2018. Aug 2018 Update: WRES 6 month Interim Board Report will go to Staff Experience and Organisational Development Committee in October 2018. September 2018 Update: As above. October 2018 Update: Report with key data around 9 indicators and initial actions submitted to Staff Experience and Organisational Development Committee (SE&OD). Information approved by SE&OD Committee and will now be published on ROH website. Further information will be provided through Equality and Diversity update at November SE&OD Committee.		Agenda item at Staff Experience and Organisational Development Committee.
15	Ensure staff meet their training needs as agreed in their annual PDR	Staff meet their training needs	Staff Survey	Chief Executive Officer	Associate Director of HR	People Committee	15a	Refreshing the PDR method to a performace model	~~March-19~~ Sept-19	Refreshing performance manager approach. Qualifying of a career framework. Monitoring PDR compliance. Aug 2018 Update: Principles of revised management of performance approaches agreed. Implementation will follow a phased approach with early adopters in Quarter 3 / 4 2018/19. September 2018 Update: As above. October 2018 Update: Plan for the update and Performance Management refresh attached; approved at the Staff Experience and Organisational Development committee. December 2018 Update (Received from Clare Mair): Work continues with pilot phase. Coaching module to support this work is currently being designed with delivery to start in Febuary 2019. February 2019 Update (Received from Clare Mair): The Refresh for Performance Management is progressing but completion will be delayed until September 2019. Original completion dates were set when the previous Associate Director of Workforce and OD was still in post. This person who was Lead for the project left in October 2018. The new person started in January 2019 and will now lead on this project. Following a discussion at the SE&OD committee, it was agreed to delay completion. The 'one to one conversation' element which will inform how the new approach will be embedded, is on track.	Risk WF3. SE&OD Committee. *'Failure to maximise performance and support development through ineffective performance and development approaches. Significant contributing factor to employee engagement'*	Document
Executive Director of Nursing and Clinical Governance												

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 includes areas outside of where the incident happened	Closed and completed Ulysses action plan.	Executive Director of Patient Service	Head of Clinical Governance	CQG	1a	Closure of the Ulysses action plan to assure fit for purpose reporting and feedback system.	Jan-19	September 2018 Update: One outstanding action in relation to incidents module - Incident policy - awaiting ratification at CQG October 2018. October 2018 Update: Incident policy ratified and signed off by the Executive team. Ulysses action plan presented at Clinical Quality Group (CQG) in October 2018; outstanding items are related to risk and complaints modules; incident reporting actions now closed. Plan to audit closed actions to ensure fully complete and changes embedded. November 2018 Update (Received from Ash Tullett): Ulysses action plan on the work plan for Clinical Quality Group January 2019. December 2018 Update (Received from Stacey Keegan): Ulysses action plan to be handed over to Complaints and Risk leads with oversight from Governance Manager to address outstanding actions. January 2019 Update (Received from Ash Tullett): Ulysses are currently undertaking a 'health check' of the system (including the complaints and risk modules) to ensure the system is able to provide what the Trust requires in relation to complaints and risk management. February 2019 Update (Received from Ash Tullett): Ulysses actions are closed within the action plan that are related to learning and feedback. Action plan attached for assurance. Open actions are related to the risk and complaints modules, these modules allow data storage as opposed to learning and feedback.		U:\Documents\ CQC Evidence\ Ulysses action plan
			A governance communication strategy in place.			CQG	1b	Routine Communication of key incidents and learning methodology across the Trust to be reviewed.	~~Sept 18~~ Dec-18	Aug 2018 Update: Meeting held with Communications on the 13.7.18 to design a Governance Communication strategy to ensure lessons are shared across the Trust. Awaiting feedback. September 2018 Update: Comms intranet page developed/Case Study posters developed/Quality week to be arranged. October 2018 Update: 'Quality' week in planning for the first week in December 2018, relaunch of Governance Strategy planned and launch of Comms strategy (being finalised) for learning and communicating Trustwide. Scoping of Human factors and investigation training to take place during 'Quality week'. November 2018 Update (Received from Ash Tullett): 'Quality week' agenda confimed commencing 3.12.18 in conjunction with the Communications team. Trust policies and Strategy, road shows, stand and training incorporated. December 2018 Update (Received from Stacey Keegan): 'Quality week' took place as planned; paper to be presented to Quality and Safety Committee in February 2019 outlining methodolgy going forward. January 2019 Update (Received from Ash Tullett): Action as above with the paper being presented to the Quality and Safety Committee in March 2019.	Risk: 275 Clinical Quality Group *'There is a risk that the Trust is unable to consistently demonstrate learning from serious events, claims and complaints. This is due to insufficient evidence of robust action plan implementation, processes not being followed and staff awareness and changes to clinical practice not being fully embedded'.*	
			Standing agenda item on relevant meeting agendas.			CQG	1c	Trusts Quality Report to be presented at all relevant meetings to strengthen Ward to Board communication.	Aug-18	Aug 2018 Update: Governance manager and DDoN to review Divisional meeting structures w/c 6.8.18. September 2018 Update: Quality report presented at all forums/committees, including Divisions.		Standing agenda item at the following meetings/ committees to ensure Board to Ward communication: Ward and Departmental Managers. Senior Nurses. Divisional Boards. Clinical Quality Group. Divisional Performance. Quality and Safety Committee.

			100% compliance with Serious Incident Learning Audit			CQG	1d	Audit of serious incident learning to be undertaken; to ensure: Actions taken following serious incidents are fully completed in a timely way. Changes that are implemented as a result of a serious incident are fully embedded within the Trust.	Jan-19	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. Aug 2018 Update: Action trackers now in place for Division 1 and 2, and an agenda item on Divisional Governance meeting. This allows transparent progress for the Governance team to monitor and audit with escalation of any concerns to the DDoN. September 2018 Update: Audit underway by the Clinical Governance Manager to ensure closure of actions from Serious Incidents and internal Root Cause Analysis. Audit report to be prepared for October 2018. October 2018 Update: Audit completed; paper with findings to be reported to Clinical Quality Group in November 2018. Initial feedback positive and initial findings being reported back to the Divisions for any immediate actions. Embedding of actions to be audited and reviewed within the Divisions with findings reporting to Clinical Quality Group. November 2018 Update (Received from Ash Tullett): Agenda item will form part of the Governance Upward report at Clinical Quality Group scheduled for the 30.11.18. December 2018 Update (Received from Stacey Keegan): Update received at Clinical Quality Group and now forms part of the monthly Governance Upward report that is on the work plan to be presented monthly.		Standing agenda item at weekly Divisional Governance meetings with action trackers. Update received at Clinical Quality Group via the monthly Governance report.
			100% compliance with Stop before you block audit following previous Never Events and sharing of learning.			CQG	1e	Stop before you block Audit to be completed to provide an overview of the daily running of anaesthetic rooms and to identify any underlying factors that may impede safe patient care. Key audits are: Interruptions occuring during the induction of anaesthetic or administering blocks and why these interruptions occured. Environmental audits (signage visible and privacy shutters in use). Third person in the anaesthetic room.	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. Aug 2018 Update: Monthly report now completed by the Theatre Matron; July 2018 audit showed a significant improvement with 6 interuptions noted from an audit of 114 patients = 5.26%. Report monitored by the Divisional and upward eported to Clinical Quality Group. September 2018 Update: Awaiting August report - agenda item for October 2018 Clinical Quality Group. October 2018 Update: Report presented at October 2018 Clinical Quality Group - compliance showing <5% interuptions. Audit part of Clinical Quality Group workplan and monitoring will continue.		Ongoing assurance provided via Clinical Quality Group workplan.
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, procedures, and staff training to ensure staff have the confidence to support and care for patients with Mental Health	100% of patients with a Mental health illness will be supported to have full access to all Trust Services by trained and competent staff.			Safeguarding Committee	2a	Ensure the SLA in place is responsive to the Trusts needs.	~~June 18~~ Dec-18	SLA has been updated and it available to all staff. This will be communicated to all bleep holders and relevant staff. Aug 2018 Update: Further review of SLA completed by the DoN, mental health lead and DDoN, with queries passed to the Assisitant Director of Finance - contracting to take forward. September 2018 Update: SLA being reviewed to ensure responsive to the Trusts needs. October 2018 Update: Awaiting confirmation that SLA has Executive sign off. November 2018 Update (Received from Nathan Samuels/Lisa Newton): SLA in place up until March 2019, however concerns regarding out of hours service provision. Meeting arranged for w/c 19.11.18 to escalate the required review of the SLA with BSMHFT. If this meeting does not resolve the concerns, escalation to the Executive Director of Nursing and Clinical Governance. Scoping a further SLA wit BMHFT regarding use of bank RMN and telephone advice. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Meeting held with Angela Preston (BSMHFT); flow chart devised for use of section 5(2) - medics to detain. 24 hour advice be incorporated into SLA - escalated to Julie Gardner. February 2019 Update (Received from Lisa Newton): Draft flow chart for the use of section 5(2) in circulation for comment. Meeting arranged with Julie Gardener to review SLA to ensure it includes 24 hr provision as BSHMHFT have advised that this will involve SLA revision +/- additional fee for service.		

			Executive Director of Patient Service	In-patient Matron/LD Lead Nurse	Safeguarding Committee	2b	Develop and launch a Trust Mental Health Policy to support staff and patients.	~~Aug 18~~ ~~Oct 18~~ ~~Jan 19~~ April-19	October 2018 Update: Policy now on hold for finalisation due to working with UHB/Mental Health Trust and their policy ratification. The delay in the policy will not slow down the requirements the Trust needs to deliver. DDoN and leads to review current policies/legislation to ensure this does not pose a risk to the Trust. November 2018 Update (Received from Nathan Samuels/Lisa Newton): In conjunction with UHB/BSMHFT, newly formulated Mental Health Policy is in draft and will be shared with ROH for local adaption once ratified which is scheduled for December 2018. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Awaiting ratification from UHB to then locally adapt for ROH. February 2019 Update (Reeived from Lisa Newton): UHB policy going to policy review group for ratification 20.3.19 if ratified should be available to us early April 2019.	Risk 1286 Safeguarding Committee. 'Risk that the Trust does not have adequate policies, procedures or trained staff to provide the necessary level of care and support for patients with mental health issues'.	U:\Documents\ CQC Evidence\ Document in Copy
					Safeguarding Committee	2c	Ensure all relevant staff are trained in mental health.	~~Aug 18~~ ~~Oct 18~~ ~~Feb 19~~ April-19	Aug 2018 Update: There are 3 tiers of training: Awareness and tier 2 training to be delivered via NHSE E-learning package and face to face drop in sessions which are planned to commence Sept 2018. Tier 3 training (2 days) will be provided for bleep holders, senior nurses, and AHPs delivered by the lead nurses commencing in Oct 2018. October 2018 Update: Mental health first aid training (2 days) commences October 2018. Options for awareness training discussed at the Training and Development Group; competency for staff groups being defined on ESR. Action RAG rated as red due to training provision commencing in October but will not be completed for all relevant staff groups. November 2018 Update (Received from Nathan Samuels/Lisa Newton): Two further Mental health first aid training courses planned for December 2018 and February 2019; this will ensure all Clinical Site Coordinators and Duty Managers are trained. Tier 1 Mental Health awareness training to be incorporated into Trust Mandatory training day by April 2019. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Update as of November 2018, with 25 Mental Health First Aiders now trained within the Trust. February 2019 Update (Received from Lisa Newton): The Trust now has a total of 56 trained mental health first aiders, with a further 18 staff booked onto the the April 2019 training. The training has been targeted to include Clinical Site Coordinators, Duty Managers and those in key roles e.g. Safeguarding, Chronic pain etc. Mental Health Awareness training commences on the Mandatory training day for all staff on the 12.4.19. Training for medical colleagues will commence once the section 5(2) flow chart is ratified and SLA agreed.		
					Safeguarding Committee	2d	Launch of the Mental Health provision in the Trust, engaging with patients and staff.	~~Sept 18~~ Oct-18	Safeguarding Matron 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. A new icon on the intranet to be added to the homepage once actions are completed for ease of access for staff. Aug 2018 Update: Intranet site and resource folders currrently being reviewed ensuring all relevant documentation is available for staff. Patient pathways and flow charts to support staff decision making and referral processes. Process for the care of those patients under a long term section to be clarified including staffing requirement. Poster being designed to aid staff understanding of DOLS, MHA, and MCA. September 2018 Update: Intranet site and resource folders due to go live October 2018. October 2018 Update: Action on track to be completed by the end of October 2018. November 2018 Update (Received from Nathan Samuels/Lisa Newton): New Trust intranet page has been developed which has easy access, detailed descriptions of the most commom mental health conditions, their signs, symptoms, treatments and specific risk assessments and care plans.		
					Safeguarding Committee	2e	An audit to be completed for complex patients (included mental health) which includes the use of a flagging system and audit of individualised care planning.	~~Dec 18~~ April-19	Methodology to be designed when actions 2b to 2d achieved . December 2018 Update (Received from Stacey Keegan): Clarification being sought to confirm pre data requests from CQC and audits of care of patients with Mental Health as opposed to Policy/improvements audit. February 2019 Update (Received from Stacey Keegan): Action clarified and amended; audit forms part of the CQC data requests. Leads for Mental Health informed of the action and audit tool to be developed and launched with front line staff.		

3	Staff should have sufficient understanding of terms such as 'never event' and 'duty of candour'.	All clinical 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**	**CQG**	**3a**	Focussed educational engagement events with departments and wards	~~Aug-18~~ Dec-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 audits. September 2018 Update: New homepage on Ulysses system/New leaflets developed by Comms team/Quality week in planning to be included in the Governance learning strategy. October 2018 Update: As above with launch planned during 'Quality Week' planned for December 2018. November 2018 Update (Received from Ash Tullett): Engagement events and road shows planned for 'Quality week' commencing 3.12.18 factoring in Duty of Candour and Never Events. December 2018 Update (Received from Stacey Keegan): A focus on Never Events and Duty of Candour (definitions and examples of) took place in 'Quality week'; paper to be presented to Quality and Safety Committee in March 2019 outlining methodology going forward.		Understanding of Duty of Candour and Never Events shared within the Trust at: Trust Induction. On the Ulysses home page. Knowledge tested on Mandatory training day. Understanding measured on Trusts Quality and Safety walkabouts. Monthly Governance 'Learning messages'.
			Fit for purpose Mandatory training slides			**Training and Development Group**	**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. September 2018 Update: Mandatory training reviewed and commenced in September 2018.		Multiple choice question included in mandatory training session to evidence understanding and knowledge of staff.
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	A BIU Strategy and KPI metrics measuring outcomes.			**OMB**	**4a**	Review and strengthening of the organisational structure around Bone Infection Unit (BIU)	~~June-18~~ ~~Nov-18~~ Jan-19	Aug 2018 Update: Structure reviewed and evolving development plan in place. The BIU now has in place; • a Clinical Service Lead (on SLA from UHB) • Dedicated time from Consultant Microbiologist (SLA UHB) • Dedicated time from ROH Pharmacist • Dedicated time from IPCT • Dedicated time from Consultant Surgeons A nominated Operations manager is supporting the recruitment of a CSM (agreed secondment from UHB) , MDT Co-ordinator and a data analyst. September 2018 Update: • CSM (on secondment from UHB) in post • CSM presently reviewing the requirements of the B.I.Service in order to develop a strategy and clinical pathways • Post out to advert for a data analyst to support the B.I.Service • Job description under review, by CSM, for a MDT Co-ordinator November 2018 Update (Received from Rivie Mayele): MDT Co-ordinator appointed in October 2018, with an anticipated start date of January 2019. With the BI Data Analyst also on track to commence in January 2019, this will complete the team. December 2018 Update (Received from Garry Marsh): BI Nurse post now made substantive recognising the need for specialist nursing input. January 2019 Update (Received from Rivie Mayele): MDT Co-ordinator and Data Analyst commenced in post in January and now completes the organisation structure.		
						OMB	**4b**	Bone Infection MDT to be launched	~~July-18~~ Nov-18	Terms Of Reference drafted. To be approved. Aug 2018 Update: TOR to be reviewed and approved on appointment of CSM who will develop and implement the clinical pathways for BIU. September 2018 Update: CSM presently reviewing TOR and requirements of the service October 2018 Update: ToR yet to be approved; these have been recirculated. November 2018 Update (Received from Rivie Mayele): ToR now on version 4 following feedback from Clinicians, BI Development meeting due to be held on the 22 November 2018, with anticipated sign off by the wider BI team on the 29 November 2018. December 2018 Update (Received from Rivie Mayele): ToR now approved and BI MDT in place.		\\gamma\users$\root\Keegans\Desktop\BIS TOR

				Executive Director of Patient Service	Head of Infection Prevention Control	OMB	4c	SLA to be agreed with UHB for support services	~~Sept 18~~ ~~Dec 18~~ April-19	Service Level Agreement in place with UHB to provide Consultant Microbiologist support to both infection control and bone infection service, this is under review. September 2018 Update: SLA contract review to be held 11/09/18 for microbiologist service support to the B.I.Service October 2018 Update: Awaiting update. November 2018 Update (Received from Julie Gardner): SLA now drafted with a plan to be signed off by the end of November 2018. December 2018 Update (Received from Julie Gardner): The SLA for the Clinical Lead at HGS is agreed and awaiting a signed copy. The microbiologist SLA is not signed but we are currently receiving 2 PA's a week support, this will need review in line with the BI service requirements once agreed. January 2019 Update (Received from Julie Gardner): SLA to be agreed April 2019 in line with BI service requirements.		
						OMB	4d	Development of surgical pathways and blood monitoring Standard Operating Procedures (SOPs)	~~Sep 18~~ ~~Dec 18~~ April-19	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. Aug 2018 Update: These will be reviewed, developed bespokely for ROH and implemented on appointment of the CSM in line with clinical pathways. September 2018 Update: Newly appointed CSM to develop and implement required SOP's. This work is presently being scoped. October 2018 Update: SOPS - still under review. November 2018 Update (Received from Neil Jenkins): Draft patient pathways written Meeting 29th November 2018 with Medical Director, Clinical Service Leads and HGS surgeons. Launch 7th December 2018 at West Midlands Bone infection meeting. December 2018 Update (Received from Neil Jenkins): Pathways agreed and launched, next step is to finalise the governance processes for both ROH and UHB. February 2019 Update (Received from Neil Jenkins): Bone Infection pathway being presented at both ROH and HGS Quality and Safety Committees in February 2019.		
						IPCC	4e	Outpatient and Parenteral Antimicrobial Therapy policies to be updated	Dec-18	Clinical Lead assigned to lead this work. Aug 2018 Update: Now supported from the ROH Lead Antimicrobial Pharmacist. September 2018 Update: ROH Lead Pharmacist with support from UHB Microbiology Service have updated these policies and are awaiting comments from the AMR Strategy Group. October 2018 Update: Awaiting update. November 2018 Update (Received from, Daniel Hearsey): The Trust Antimicrobial guidelines and Stewardship Strategy has been developed and is available on the Trust Intranet. A 'handy hints' document has been produced alongside these.		As per policy and review date.
						OMB	4f	Develop and launch a BIU business model	~~Dec 18~~ April-19	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 Aug 2018 Update: CCG have agreed a CQUIN, with ROH, to support a 12 month plan for the BIU. This will support the appointments of required staff (CSM, Data Analyst and MDT Co-ordinator). September 2018 Update: Remains as above. October 2018 Update: Bone Infection Service Development Group has now been established and weekly meetings take place every Thursday 11.30-13.00. BI CSL will be leading along with Jonathan Stevenson to draft pathway. Stakeholder meeting arranged. December 2018 Update (Received from Rivie Mayele): The BIS development group are working with clinicians across the region to develop clinical and referral pathways to be submitted (as part of the business case) to the board in February 2019. The proposed date for submission will be April 2019 (as per CQUIN requirement).		

5	The Trust should ensure staff have access to relevant specialist training to carry out their roles effectively. All departments to ensure a Training needs analysis (TNA) is completed that highlights requirements of role and development aspirations.	All staff will have the relevant specialist training including oncology, mentorship and leadership courses.	Increased staff satisfaction in relation to access to training and development.	**Executive Director of Patient Service**	**Patient safety and Clinical Training Lead.**	**Training and Development Group**	**5a**	Develop and deliver a: Band 6 development programme. Management skills programme. Preceptorship. Specialist Courses. Fundamental skills.	~~Aug 18~~ Jan-19	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. September 2018 Update: Commencement of programme delayed until Jan 2019 due to Trust wide management programe being designed and concerns regarding possible overlap. This has now been resolved. October 2018 Update: Course dates booked and advertised. This is monitored via the Nurse Strategy meeting and Training and Development Group. Oncology, leadership and mentorship courses/development discussed at the Training and Development Group for assurance that this provision is in place. November 2018 Update (Received from Karen Hughes): Band 6 Development programme: due to start Jan 2019. Staff booking via ESR- a lot of interest across all departments including Therapies Orthopaedic Course: Funding and places confirmed for double module starting Jan 2019. Applications received by L&D Leadership courses are available and overseen by L&D/Clare Mair Mentorship course still currently available and staff accessing this training. Due to change in NMC requirements re need for this, this may change over the year. December 2018 Update (Received from Karen Hughes): Oncology academic programme available and delivered by the University of Birmingham.		U:\Documents\ CQC Evidence\ COC action plan
			Increased numbers of staff attending training and education.			**Training and Development Group**	**5b**	Specialist Training to be offered to staff	~~Jan 19~~ March-19	Aug 2018 Update: As part of the Clinical Workforce and Development Group; various work streams have been defined looking at education and development including new roles including Nurse Associates and Theatre Assistant Practitioners. September 2018 Update: Work streams for Nurse associates and TAPs continue. SE&OD have supported further scoping of NA role and buisness case submission for the TAP role. Places had been booked for staff to attend orthopaedic course at Wolverhampton starting Autumn 2018 but course is no longer being run. Confirmed with Staffordshire University their course will run Jan 2019. Confirmation re dates requested w/c 3/9/18 to enable booking of ROH staff onto this. Further discussions have not yet taken place with NAO as need to establish above development first. October 2018 Update: Wolverhampton have at short notice discontinued their orthopaedic course. It has been confirmed ROH can have places on Stafford courses-awaiting dates. Meeting with RJAH training lead 23/10/18 to discuss collaborative working further. Nurse Associate/TAP work continues-this is monitored via the Clinical workforce & Development Group. November 2018 Update (Received from Karen Hughes): Awaiting clarification on Oncology specialist courses; orthopaedic and spinal now progressed with Staffordshire University. December 2018 Update (Received from Stacey Keegan): A training needs analysis (TNA) is being completed by all departments as part of buisness planning for 2019/20. TNAs will be collated in February 2019 and reported to the Training and Development Group in March 2019.		
6	Public engagement required re-energising.	Patients and stakeholders are involved in decisions regarding the Trust and their care	Patient feedback			**CQG**	**6a**	Patient and Carers Forum to be reviewed	~~Aug 18~~ Nov-18	Aug 2018 Update: Lead attends the monthly meeting and is presently reviewing the future development, with the Chair of the group, in line with the NHSI Patient Experience Improvement Framework (2018). The TOR are presently under review and a work plan will be developed, by the end of Q2, to support the patients experience . September 2018 Update: Comments collated on TOR – to be reviewed by the group 27/09/18. Work plan to be supported by Healthwatch Birmingham Presently reviewing the diversity of the group and how to encourage membership. October 2018 Update: Strategic group to be established to oversee Patient and Carer Forum and Strategy workplan. Patient and Carer Forum ToR drafted but due to be finalised November 2018. November 2018 Update (Received from Stacey Keegan): ToR agreed at Patient and Carers Forum; on the Clinical Quality Group agenda for November 2018. DDoN currently drafting ToR and membership for Strategic Group (to be named). December 2018 Update (Received from Stacey Keegan): Patient and Carer Forum ToR approved at the Clinical Quality Group in November 2018. Draft ToR for Stategic Group completed and meeting dates being scheduled. January 2019 Update (Received from Stacey Keegan): Patient Engagement and Experience Group ToR approved at Quality and Safety Committee and meeting scheduled to commence in February 2019 - monthly and to upward report into Quality and Safety Committee.		U:\Documents\ CQC Evidence\Enc 028 Briefing paper \\gamma\users$\ root\keegans\ Desktop\Patient U:\Documents\ Patient Experience\ Terms of

			Executive Director of Patient Service	Patient Services Manager	CQG	6b	Develop and launch of a Patient Experience and Engagement strategy	Jan-19	September 2018 Update: Strategy to be supported by Healthwatch Birmingham ROH present PPI position to be benchmarked, in September, against the Healthwatch benchmarking tool Healthwatch Birmingham lead to attend the Patients and Carers Forum in October to support future work. October 2018 Update: Meeting held with Healthwatch, IPC lead, DDoN and Patient Experience Manager - benchmarking completed using Healthwatch PPI tool. Group now benchmarking organisation with the NHSI framework with a paper to Execs planned for November 2018 outlining gaps and proposed actions. November 2018 Update (Received from Stacey Keegan): PPI benchmarking on the agenda for November 2018 Clinical Quality Group. PPI and Experience Event planned for December 2018 to engage and steer the Strategy development. The Trust PPI and Experience Strategy to be presented at Quality and Safety Committee in January 2019. December 2018 Update (Received from Stacey Keegan): Benchmarking completed and presented, incorporating feedback. Patient and Public engagement event took place in December 2018 to gain views and input into the Trust Strategy. Draft Strategy completed and on track to present at the Clinical Quality Group and Quality and Safety Committee in January 2019. January 2019 Update (Received from Stacey Keegan): Involvement, Experience and Volunteering Strategy presented at Quality and Safety Committee. Launch of Strategy planned for February 2019.		\\gamma\users$\root\keegans\Desktop\Draft
					CQG	6c	Develop workplan that underpins the Strategy and report to Quality and Safety Committee	Jan-19	October 2018 Update: On completion of the Strategy document and KPI setting. November 2018 Update (Received from Stacey Keegan): Agenda item at January 2019 Quality and Safety Committee. December 2018 Update (Received from Stacey Keegan): As above. January 2019 Update (Received from Stacey Keegan): Workplan to be drafted and approved at the first Patient Engagement and Experience Group planned for February 2019, incorporating finding from the benchmarking and gap analysis completed.		

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	IMT Board	7a	Implementation of EPMA (electronic prescribing and decision support system) system Work towards the development of a 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. October 2018 Update: The draft gateway process is still in discussion and no agreement has yet been made. The clinical portal project has not started yet and no date agreed. November 2018 Update (received from Mark Bemrose): New systems policy now drafted and sent for board approval. No decision yet made on clinical portal – awaiting appointment of CCIO. December 2018 Update (Received from Mark Bemrose): The new systems policy has now been adopted. January 2019 Update (Received from Mark Bemrose): The clinical portal is awaiting the appointment of a CCIO which is a crucial role in the development of the Portal at the Trust. An initial meeting is to be arranged with UHB to discuss the project requirements in more detail.		
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	ative Director of Finance	tion Governance Manager	IMT Board	8a	Review and ensure the process and security of patient data is robust within the Outpatient Department.	Dec-18	Aug 2018 Update: Security review has been undertaken and actions particulary with regard to permissions are being implemented. October 2018 Update: Actions being reviewed by IG Manager with periodic walkabouts to check compliance. November 2018 Update (Received from Janette Carveth): Data security to be part of Quality and Safety walkabouts. December 2018 Update (Received from Janette Carveth): The cyber security risk assessment has recently been refreshed and has visibility at corporate and BAF level. A number of actions are planeed or started to ensure compliance with cyber security DPS standards which in turn increase the security of patient information.		

				Exec	Informa	IMT Board	8b	Audit the security of patient data within the Outpatient Department.	Feb-19	January 2019 Update (Received from Stacey Keegan): Request made to the Outpatient leadership team to conduct audit of patient data security (computers and patient notes) to establish improvements or further actions that are required. Audit to be conducted by the Trust Information Governance Manager.		
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	CQG	9a	Team Brief and Team Brief process to be reviewed on the WHO checklist	Oct-18	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. Aug 2018 Update: Brief and debrief elements of the WHO have been audited seperately to identify themes, participation and feedback - reports have been developed by the Theatre Matron. September 2018 Update: Upward reports now recieved at Clinical Quality Group and shared within Divisions - awaiting feedback from Stryker. October 2018 Update: Awaiting update from Stryker - early November 2018. Audits continue and reported by the Theatre Matron. Themes from brief and debrief fed back to relevant stakeholders for actions if required and learning. November 2018 Update: Awaiting update on audit cycle and progress with Stryker. December 2018 Update (Received from Tracey Rutter): WHO and WHO brief and debrief audits completed monthly and upward report shared with responsible clinicians. Audit to be conducted in CT as well as Theatres. Upward reports/audit results part of the Clinical Quality Group workplan.		Monthly audit cycle in place incorporating Theatres, CT and ADCU with upward reports to the Division and CQG workplan and included within the Trusts Quality Report.
			100% compliance with WHO checklist Audit	Executive Medical Director	Associate Medical Directors	CQG	9b	ADCU and CT to be included on the Theatreman system for the WHO	Oct-18	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. September 2018 Update: WHO completed via Theatreman for CT and will be reported via Theatre Matron report monthly from October 18 report. Awaiting communications from Trisoft regarding ADCU. October 2018 Update: WHO audit compliance reported in the Trust Quality Report. Theatres and CT reported from Theatreman (Trisoft); ADCU remains a paper based audit until phase 2 of Theatreman roll out. Audits reported as 100% for September 2018. November 2018 Update (Received from Tracey Rutter/Sue Cox): ADCU continues to be paper based process and audit, no date for Phase 2 roll out received. December 2018 Update: Paper based WHO process within ADCU that is audited monthly with no concerns escalated. All relevant elements of the WHO process are completed.		Theatres and CT WHO audited and reported monthly by the Theatre Matron. WHO conducted in ADCU audited by Matron and reported in Divisional Condition report/KPIs. WHO compliance forms part of the monthly Trust Quality Report.
10	The Trust should review medical cover at weekends to ensure adequate cover.	Medical staffing to meet the required cover for weekends with staff being aware of the rota and escalation process.	Patients and staff have access to appropriate medical staff.	Executive Medical Director	Associate Medical Director	CQG	10a	Devise escalation process to ensure staff are aware and supported when escalating patients for review.	~~Sept 18~~ ~~Dec 18~~ March-19	Escalation process to be devised for ward level staff and AHPs. September 2018 Update: Escalation process in draft to be circulated with the intention of ratification at CQG in October 2018. October 2018 Update: Escalation process in line with NEWS2 and the deteriorating patient policy is in draft overseen by the Sepsis Group. Roll out planned by December 2018. November 2018 Update (Received from Helen Allen): Deteriorating Patient Policy in draft and circulated for comment; including flow chart for escalation. December 2018 Update (Received from Stacey Keegan): Draft policy remains in circulation for comments; in addition, escalation process (non acute patient episode) to be formulated to assist in informing and empowering nursing teams. January 2019 Update (Received from Stacey Keegan): Non-acute patient episode escalation tool in draft, out for comment and for approval at Clinical Quality Group in February 2019.		

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	Consent audits and dictation turnaround metrics met.	**Executive Medical Director**	**Associate Medical Directors**	**CQG**	**11a**	Staff to adhere to the Consent policy.	Nov-18	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 is overseen by the Medical Director and Clinical Audit Committee. Consent is a quality priority for 2018/2019 Quality accounts. Audits show improving compliance. October 2018 Update: Discussion with AMD Division 1 - awaiting further assurance. November 2018 Update (Received from Mr Va Faye): New process is being considered for implementation. December 2018 Update (Received from Mr Pearson): Consent audit conducted and due to be presented to the medical body on the 24.1.19. Consent process is safe; further actions to improve patients receiving copy of the consent form and ensuring information that is given to the patient is clearly documented as such. February 2019 Update (Received by Stacey Keegan): Action handed over and discussed with the new Medical Director to review and take forward. January's consent audit attached, highlighting improvements.		U:\Documents\ CQC Evidence\ Patient Consent
11						**CQG**	**11b**	Digital Dictation upgrade and roll out of training to enable improved process for patient letters and turnaround times.	Nov-18	Aug 2018 Update: Upgrade completed in July 18 with a training progrmme in place to roll out. October 2018 Update: awaiting update. November 2018 Update (Received from Janet Campbell): Winscribe digital dictation upgrade went live on the 10 September 2018 and all staff training had been provided beforehand, prior to roll out. We now have a number of 'super users' who can provide ongoing training in future. The Winscribe system has now moved back to an operational function rather than a project and Matt Payne is the owner.		Winscibe reporting functionality being addressed however KPIs in place to monitior by speciality - these KPIs are monitored at Division 1 weekly operational meeting - confirmed with Matt Payne.
Executive Director of Strategy												
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**	**Training and Development Group**	**13a**	Mandatory training process to be reviewed to include online modules enabling different methods of access and learning.	Jan-19	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. Aug 2018 Update: 92.83% compliance for June 2018 therefore achieving Trust target. September 2018 Update: Maintaining MT compliance over 90% for substantive and bank staff. Streamlining project / CIP continues. The Trusts external contract with External Online learning provider has been cancelled as now internal provision with ESR is working effectively. All Subject matter experts are engaged with transferring to online modules, excluding Safeguarding adults and children. Although agreed suitable nationally, additional information is needed in the safeguarding online packages to include local information that the local leads are requesting. To include this it requires an IT intervention to enable links with ESR. This may delay complete transfer to online modules by the target date of January 2019. October 2018 Update: Progress remains as above - implementation plan attached. November 2018 Update (Received from David Richardson): Progress remains on track with no concerns to escalate. December 2018 Update (Received from David Richardson): Core Mandatory training modules are now available via a 1 day face to face course, or via E-learning for Health online modules. Both approaches are available to all employees within the Trust. Currently around 10% of staff access the e-learning option. 90% target still being exceeded on a monthly basis.		U:\Documents\ CQC Evidence\ Mandatory training
Executive Chief Operating Officer												

16	The Trust should ensure that the NHS England Accessible information standards are met.	The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The ROH will meet the Accessible Information standard.	Closure of the responsive Accessible Information Standards action plan.	**Chief Operating Officer**	**Operational Service manager**	**CQG**	**16a**	Closure of the Trust responsive Accessible Information Standards action plan.	~~Dec 18~~ April-19	The Trust currently have an accessible information improvement group with a responsive action plan. Progress of this action plan is monitored via the Clinical Quality Group and upward reports to the Quality and Safety Committee. November 2018 Update (Received by Matt Payne): An audit of patients attending ADCU for a week has been undertaken, asking all patients to fill in a survey on arrival asking if they consider themselves having any communication issues. I they do they were asked to then specify what these were. This information will be used to check if this has been recorded on both the Patient Administration System and the patient's notes. There will be another audit undertaken in the outpatient department once a similar question can be added to the self-check-in screens. This is being negotiated with InTouch currently. In addition the Patient Access Manager has also been to the Trust audit day to address the consultant body to ensure they were aware of the Accessible Information Standard and their obligation to collect information about patient communication needs. A business case to propose working with two external companies called DrDoctor and Synertec is being developed. These two companies are able to take on the Trusts communication with patients, initially around outpatient appointments, and patients will be able to highlight their own communication needs and Synertex will be able to send correspondence in the relevant formats. December 2018 Update (Received from Matt Payne): The action plan is now 90% complete and plans have been made to complete the last few actions by the end of the calendar year. A strategy / resource document is to be drawn up as a summary to the project of moving the Trust to compliance. February 2019 Update (Received from Matt Payne): Assurance document attached outlining compliance with the Accessible Information Standard. Agenda item for April 2019 Clinical Quality Group with a plan to sign off closed action plan.		U:\Documents\ CQC Evidence\ 20181213 U:\Documents\ CQC Evidence\ 20190131 AIS
		Staff at the ROH will be fully aware of what services are available, and have knowledge in how to access translation services.			**CQG**	**16b**	Translation services and how to access are communicated to the Trust.	Nov-18	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. October 2018 Update: as above. November 2018 Update (Received from Matt Payne): All systems previously report are still in place and remain affective. The second round of outpatient benchmarking is due to begin in the next 2 months and this will provide new information comparing the Trust against other providers and their use of translation service. It will also allow the Trust to compare itself against last years' data. December 2018 Update (Received from Lisa Kealey): Higher than average use of transalation services, no complaints, PALS or FFT concerns raised regarding translation services. DrDoctor system if progressed will further enhance this service for patients.		
17	The Trust should continue to improve the flow through the Outpatients Department so patients are not kept waiting for appointments.	Improved access, flow and efficiencies within the Outpatient Department avoiding and minimising excess wait times for patients and carers.	To meet the target/KPI for clinic wait times.	**Chief Operating Officer**	**Clinical Service Manager**	**Out-Patient Operational Group**	**17a**	Clinic templates reviewed for those clinics that continue to have delays and increased waiting times and human factors addressed if required.	~~Sept 18~~ Feb-19	September 2018 Update: In August there were 10.8% of patients waiting over 30 minutes and 3.8% waiting over 1 hour which is below the target of 5%. This is now the third month that the target of 5% has been achieved. The over 30 minute wait has improved from the previous month from 12.3% and is the lowest level so far. The largest number of incidents were reported in Hip / Knee and Shoulder specialties which is consistent with the previous month. October 2018 Update: September 2018 - 11.2% >30 minutes and 4.6% >1 hour - Quality Priority overseen at Clinical Quality Group. November 2018 Update (Received from Matt Payne): Waiting times in clinic continue to be monitored and have been steadily dropping. The Trust has achieved its target of less than 5% of patients waiting for longer than 60 minutes over the last 3 months and the over 30 minute delays have nearly reached the target of 10% and are currently being maintained below 12%. Further work is underway to try and make use of detailed reports from InTouch to identify areas of high clinic delays and take focused action. December 2018 Update (Received from Matt Payne): October 2018 saw an increase in wait times, rationale being an increase in clinic activity. November 2018 KPIs showed improvement and were reported as 11.2% >30 mins and 3.9% > 60 mins. January 2019 Update (Received from Stacey Keegan): Review previous Trust CQC responsive action plan with a plan to close action with assurances. February 2019 Update (Received from Stacey Keegan): Previous CQC Responsive action plans sent to the OPD operational team for review and to ensure these previous improvements have been embedded.		A Trust Quality Priority monitored at Clinical Quality Group. Clinic wait KPIs reported in monthly Finance and Performance and Quality reports. OPD 6-4-3 meeting now established to oversee operational efficiencies.
Associate Director of Governance & Company Secretary												

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	**Associate Director of Governance and Company Secretary**	**Corporate Governance Lead**	**S/E and O/D Committee**	**12a**	Review fit and proper persons act Trust process	~~Jul 18~~ Nov-18	Confirmation that there is a process in place and that all relevant staff will comply. Aug 2018 Update: Awaiting confirmation that this action is closed. September 2018 Update: FPPT policy is in place - awaiting confirmation of reviewer. October 2018 Update: FPPT policy is in place and will be updated by November 2018 to ensure that it accurately reflects current practice and the requirements of the regulation. December 2018 Update (Received from Simon Grainger-Lloyd): Policy reviewed, with confirmation being sought regarding DBS and how often this check is required. January 2019 Update (Received from Simon Grainger-Lloyd): FPPT policy reviewed and updated .		U:\Documents\ CQC Evidence\Fit Proper Persons
						S/E and O/D Committee	**12b**	All Staff meet the Fit and Proper person regulations	Aug-18	All executives have signed fit and proper persons self declaration as per Trust policy. Aug 2018 Update: Awaiting confirmation that this action is closed. September 2018 Update: All Execs and NEDs have been subject to the FPPT.		
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 within the agreed timescales.	Audit of compliance against policies and policy workplans.	**Associate Director of Governance & Company Secretary**	**Corporate Governance Lead**	**CQG**	**18a**	All polices to be up to date with a review period defined.	~~Sept 18~~ Dec-18	September 2018 Update: Policies to be the first module launched within the Allocate software. Module commencement starts mid September 2018 and due for completion by December 2018. October 2018 Update: Module commencement starts mid October 2018, with the cleanse of the policy list to ensure that authors and Executive Leads are accurate and due for completion by December 2018. Currently a report is received by Clinical Quality Group for oversight of clinical policies. November 2018 Update (Received from Adam Roberts): Project remains on track - internal policy cleanse is nearing completion. Updated policy spreadsheet will then be sent to Allocate ready for module build and configuration stage of project. A report continues to be received by Clinical Quality Group for oversight of clinical policies. December 2018 Update (Received from Adam Roberts): Internal policy cleanse (audit of all current policies & review dates, as well as review of relevant authors and Exec lead) has now been completed. Awaiting discussion with Allocate Project team to determine policy data they require in order for them to commence module build and configuration. A report continues to be received by Clinical Quality Group for oversight of clinical policies and work is due to commence shortly to ensure timely review and re-validation of corporate policies (such as Finance, HR, Estates etc.) February 2018 Update (Received from Stacey Keegan): Awaiting update on status of corporate policies and timeframe for completion.	Risk 791 Corporate Risk Register. *'There is a risk that safe practices and patient care are compromised by the large number of organisational policies which are overdue for renewal'.*	
						CQG	**18b**	Process for reviewing policies to be launched	~~Sept 18~~ ~~Dec 18~~ March-19	Current process for monitoring policies is manual. The new process will be designed in line with the electronic system Allocate. September 2018 Update: Policies to be the first module launched within the Allocate software. Module commencement starts mid September 2018 and due for completion by December 2018. October 2018 Update: Module commencement starts mid October 2018, with the cleanse of the policy list to ensure that authors and Executive Leads are accurate and due for completion by December 2018. November 2018 Update (Received from Adam Roberts): Project remains on track, internal policy cleanse is nearing completion. Updated policy spreadsheet will then be sent to Allocate ready for module build and configuration stage of project. December 2018 Update (Received from Adam Roberts): Internal policy cleanse (audit of all current policies & review dates, as well as review of relevant authors and Exec lead) has now been completed. Awaiting discussion with Allocate Project team to determine policy data they require in order for them to commence module build and configuration. February 2019 Update (Received from Stacey Keegan): Allocate module now built, meeting arranged with Adam Roberts and Allocate week commencing 4.3.19 to finalise training and agree launch/go live date.		

19	The Trust should ensure that the corporate risk register is reviewed by the full board.	The Trust Board is to be 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**	**Trust Board**	**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. Work also approved by the Audit Committee.		

ROHTB (3/19) 018

TRUST BOARD

DOCUMENT TITLE:	**Board Workplan 2019/20**
SPONSOR (EXECUTIVE DIRECTOR):	**Dame Yve Buckland, Chairman**
AUTHOR:	**Mr Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6 March 2019**

EXECUTIVE SUMMARY:

The attached presents a schedule of business for the Board to consider at its meetings during 2019/20.

The schedule is drawn from a review of previous Board agendas, statutory items and best practice examples, namely those from the Healthy Board (NHS Leadership Academy) and FT Provider's guidance.

REPORT RECOMMENDATION:

The Trust Board is asked to RECEIVE and APPROVE the suggested workplan.

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	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:

Aligns to all strategic objectives.

PREVIOUS CONSIDERATION:

None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

BOARD REPORTING CYCLE 2019/20

	Q1	Q2	Q3	Q4
Standing Reports				
Chief Executive's Update	✓	✓	✓	✓
Patient/Service Improvement Story	✓	✓	✓	✓
Finance and Performance Overview	✓	✓	✓	✓
Quality Report	✓	✓	✓	✓
Workforce Overview	✓	✓	✓	✓
Meeting Effectiveness	✓	✓	✓	✓
Committee updates	✓	✓	✓	✓
Quarterly Report				
Progress with the delivery of the Strategy	✓	✓	✓	✓
Board Assurance Framework Update	✓	✓	✓	✓
COG Update	✓	✓	✓	✓
Board Development Plan progress report	✓	✓	✓	✓
Annual Reports				
Quality & Safety				
National Inpatient Survey Results and action plan	✓			
Annual Complaints Report		✓		
Infection Control Annual Report		✓		
Health and Safety Annual Report		✓		
CQC action plan	✓	✓	✓	✓
Safe Staffing Report	✓		✓	
Workforce				
Gender Pay Gap analysis	✓			
Annual inclusion report (EDS2)	✓			
Freedom to Speak Up presentation			✓	
Annual Statement of Compliance - medical staff revalidation & Appraisal		✓		
Finance, Strategy and Operations				
Operational Plan & budget sign off	✓			
Approval of Annual Report & Accounts 2016/17	✓			
Sign off annual external audit plan	✓			
Self assessment against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR)		✓		
Mid year review of Annual Plan and Budget			✓	
Estates Strategy Review			✓	
Carbon Reduction Strategy update			✓	
Fire safety annual report			✓	
Perfecting Pathways update	✓	✓	✓	✓
Corporate Governance & Compliance				
NHSI Annual Declarations 2018/19	✓			
2020/21 Board Workplan				✓
ToR and membership of Board Committees	✓			
Committee Annual Reports	✓			
Approve changes to SOs/SFIs			✓	
Well Led Assessment update				✓
Freedom of Information Annual report	✓			
Declaration of compliance with CQC Fundamental Standards	✓			
Corporate Risk Register	✓		✓	

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 1 May 2019

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 May 2019 commencing at **1115h** 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 Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 1 May 2019: 1115h – 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)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Marie Peplow	Deputy Chief Operating Officer	(MPe)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Mr Matthew Payne	Clinical Service Manager	(MPa)	[Item 1]
Mr Amos Mallard	Head of Communications	(AM)	[Item 7]
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1115h	1	Service improvement story - Outpatients	Presentation	
1135h	2	Apologies – Richard Phillips	Verbal	Chair
1137h	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1140h	4	Minutes of Public Board Meeting held on 3 April 2019: *for approval*	ROHTB (4/19) 014	Chair
1142h	5	Trust Board action points: *for assurance*	ROHTB (4/19) 014 (a)	SGL
1145h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (5/19) 001 ROHTB (5/19) 001 (a) ROHTB (5/19) 001 (b)	YB/PA
	6.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	PA
1155h	7	Communications update	Presentation	AM

TIME	ITEM	TITLE	PAPER	LEAD
QUALITY & PATIENT SAFETY				
1210h	8	Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (5/19) 009	KS
1220h	9	Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (5/19) 002 ROHTB (5/19) 002 (a)	JW
1230h	10	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (5/19) 003	GM
FINANCE AND PERFORMANCE				
1240h	11	Update from the Finance & Performance Committee: *for assurance*	ROHTB (5/19) 004	TP
1250h	12	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (5/19) 005	SW
WORKFORCE				
1300h	13	Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (5/19) 006	SJ
1310h	14	Workforce overview: *for assurance*	ROHTB (5/19) 007	PA
CORPORATE GOVERNANCE, RISK AND COMPLIANCE				
1320h	15	Update from the Audit Committee: *for assurance*	ROHTB (5/19) 008	RA
MATTERS FOR INFORMATION				
1330h	16	Meeting effectiveness	Verbal	ALL
	17	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 5th June 2019 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** 4 April 2019: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(AP)
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)	
Miss Stacey Keegan	Deputy Director of Nursing & Governance	(SK)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient story	**Presentation**
Christian Ward, Head of Nursing and Laura Keil, Ward Manager of Ward 2 joined the meeting to present a patient story. It was noted that the work showcased the JointCare project from the perspective of the patient. The patient and his wife were particularly impressed with the care and treatment and the clarity of expectations. It was reported that 100% of those undergoing the JointCare pathway would	

recommend the Trust as a place to be treated using the Friends and Family Test. It was noted that relatives and patients were engaged with the plans for discharge so that they could plan their day and arrange the transfer home. The patient was advised at multiple points what was outstanding prior to discharge. In terms of points of learning, the patients had fed back that there was a long time between rising and their first hot drink. The hot drinks round had been altered to adjust. The team was asked whether there was wider learning that could be harnessed for other areas. Christian advised that after six months there would be a view taken about the lessons that could be learned. Regarding the MDT, there was noted to be much effort put into timing this appropriately. This work had been led by the Advance Nurse Practitioner. The MDT process and the ward round was now embedded. It was noted that the consultants were integral to the decision-making on the patients and the daily meetings were positive in this respect. Daily news letters were given out which was a positive innovation. Noting Laura's passion, the Acting Chief Executive asked whether the Healthcare Assistants and other staff shared this enthusiasm for the process. It was reported that this had not been the case at the start of the process but by being able to share the experience after the visit to Chicago this had been helpful and welcomed. It was noted that some staff now came to work earlier in the day, which worked well for those with childcare commitments. The team was thanked for hosting the team from Heartlands, Good Hope and Solihull Hospitals which had commended the process. The process amendments were noted to be very positive and the alignment of all parts of the process delivered ultimate efficiency. It was noted that the ROH discharged seven days per week, which was above that at Chicago. Laura and Christian were thanked for the presentation and their attendance. This was noted to be an example of great leadership and a good process improvement.	
2 Apologies	**Verbal**
Apologies were received from Garry Marsh and Sarah Marwick. The Board was joined by Neil Scrannage from Johnson and Johnson Ethicon and Tracey Cotterill, a candidate for the Chief Executive post.	

3 Declarations of interest	**Verbal**
It was noted that the register was available on request from Company Secretary.	
4 Minutes of Public Board meeting held on the 9 January 2019: *for approval*	**ROHTB (3/19) 019**
The minutes of public Board meeting held on the 9 January 2019 were accepted as a true and accurate record of discussions held.	
5 Trust Board action points: *for assurance*	**ROHTB (3/19) 019 (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 (4/19) 002** **ROHTB (4/19) 002 (a)**
The update from the STP Board on Monday 1 April was discussed. The Board had discussed the engagement events planned and ROH Board members were invited to attend. There was a consultation exercise planned on the future of Sandwell and West Birmingham CCG. The draft operational plan for the STP was presented, which would include the work with social care. The proposal to introduce a social values policy into each organisation had been discussed. The policy would apply on major procurement initiatives; there was more discussion planned and this would be presented to the Board for adoption when appropriate. It was reported that the Pathology service had transferred successfully from 1 April 2019 and Janet Davies, Clinical Service Manager was thanked for overseeing the transfer. It was noted that there had been no impact on service provision and the Pathology Manager would attend the weekly MDT at the ROH. The staff survey results were highlighted to be positive and showed an improvement in absolute terms; there had been a mention in national press. The Chairman echoed her support in the shift. The variance between the areas of the Trust were noted to have reduced showing a trustwide improvement. Based on a national analysis, the ROH was in a better position than peer trusts. The Chairman reported that she had been engaged in some consultant recruitment and there were had been a good number of appointments made. This was supported by the Medical Director who advised that those joining the ROH were excited. This was noted to be a huge improvement from previous years where there had been difficulty in attracting good calibre candidates. It was agreed that the orthopaedic pathway would benefit from this. It was noted that there was a good pool of candidates with a strategic influence. In terms of diversity, there remained further work to do, although it was highlighted that a female radiologist had been appointed	

recently. It was also noted that this reflected on the gender pay gap position. The use of fellows might need to be considered. The Medical Director agreed to consider this and report to the Staff Experience & OD Committee in due course. There was noted to have been good patient focus and flexible approach exhibited by candidates. It was suggested that the opportunity could be taken to revisit some of the unsuccessful candidates and help with interview preparation for future roles. It was reported that the LGBT week had been held which was well celebrated. The preparations for the substantive Chief Executive recruitment would culminate on 4 April 2019 The retirement of Amritpal Randhawa (Rani) was discussed and she was thanked for all her years over service at the ROH. There was reported to be new leadership in Outpatients. It was suggested that an honours board needed to be considered for staff such as Rani and Dr Carmalt who had been awarded the lifetime achievement at the last Staff Award ceremony.	
ACTION: SGL to arrange for an honours board to be established	
6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was reported that a meeting had been held with members of University Hospitals Birmingham NHSFT. The business case for the changes to the orthopaedic pathway would be presented to their Board shortly. This would 'kick start' the orthopaedic pathway re-engineering. It was agreed that this should be a formal update and Mr Pearson should bring the plan on a month by month basis when the work began.	
ACTION: SGL to invite Mr Pearson to the Trust Board when the orthopaedic pathway re-engineering work commenced	
6.2 Briefing on plans for Brexit 'no deal' scenario and briefing on resilience exercise BAF REF: FP3	**Verbal**
It was reported that the Trust's business continuity plan had been tested using a Brexit readiness exercise on 8 March 2019. The hypothetical scenario presented, related to issues with sourcing supplies from the continent and an incident was declared. The priorities were developed and position reviewed by the Operations team and other managers. This had been a good test and demonstrated resilience in the face of this situation. The stock levels had been tested and an action plan where there were gaps was being worked through. Daily and weekly updates were being submitted. Assurance that the Board was fully briefed had also been provided to the centre. Key Non Executives had also been briefed as part of the process.	

6.3 Corporate and strategy extract of the Board Assurance Framework	**ROHTB (4/19) 013** **ROHTB (4/19) 013 (a)**
It was noted that the risks around long term sustainability had been covered under other items, including the operational plan. In terms of strategy, there was a risk that related to the engagement and dissemination of the strategy and that the new methodology for engaging staff was being launched and an update was to be presented next month. It was suggested that an additional risk needed to be added to the Board Assurance Framework around the impact of planned growth and the modular theatres on ancillary staff and the estate. Workforce planning and access to capital resources risks were noted to be aligned with this risk. It was noted in the last year, there had been some significant commitments to improve the environment that had been honoured around the medical secretaries' areas and spinal house.	
ACTION: SGL to arrange for an additional risk around the impact of planned growth and modular theatres to be added to the Board Assurance Framework	
7 Quality & Safety extract of the Board Assurance Framework: *for assurance*	**ROHTB (4/19) 003** **ROHTB (4/19) 003 (a)**
It was noted that paediatric risks would be discussed under the paediatric update. The risk concerning learning lessons was noted to be covered by a recent update to the Quality & Safety Committee. In terms of engagement of medical staff with the paediatric transition, this was being managed as an integral part of the paediatric transition process.	
8 Update from the Quality & Safety Committee: *for assurance and approval*	**ROHTB (4/19) 005**
Kathryn Sallah provided an update from the Quality & Safety Committee following the meeting on 27 March 2019. It was noted that the staff inoculations position was improved, however there was more work planned identify any further staff impacted. The patient transfer process was reported to be being reviewed as a result of the recent incidents reported. A retrospective review of transfers was underway and the Medical Director updated the Board with the further steps that were planned. The transfers out were noted to be appropriate but there needed to be better linkage with other teams. It was noted that these were extreme cases and an audit of who was being transferred and by whom was planned.	

There were now no patients waiting in excess of 52 weeks, which the Board agreed was a huge achievement. There was good progress with identification and dissemination of lessons learned. The vacancies in the clinical governance team had been filled. There had been a positive report from Healthwatch around the experience of patients waiting for a clinic. It was suggested that Healthwatch would attend the new patient engagement and experience group.	
9 Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	**ROHTB (4/19) 004** **ROHTB (4/19) 004 (a)**
In terms of Paediatric transition, it was reported that there had been some key decisions made recently and meetings had been held to check that there was readiness for the transfer. There had been a review of the Oncology pathway which had involved a patient representative as part of the process. The report on this review was in draft, however there was acceptance that the service could now transfer at the end of June for spinal services and inpatients. Oncology would transfer in August. The TUPE document would be issued to staff affected shortly. The plans would be communicated to the CQC and the COST campaign. It was noted that staff needed to be supported with the next steps in the plan.	
10 Patient Safety & Quality report: *for assurance* BAF Ref: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	**ROHTB (4/19) 006**
It was reported that in terms of the clinical governance structure, the dissemination of lessons learned would be improved now that the governance team was fully populated. Avoidable VTEs and falls was reported to have reduced. It was noted that JointCare did not seem to be impacting on the falls position. There was a plan to purchase a further hoverjack. There had been an increase in avoidable pressure ulcers, some of this increase was thought to be reflective of poor documentation. The learning work would assist with this. It was noted that the Friends and Family Test response rate for the Children and Young People's High Dependency Unit was poor. Work was underway with the Patient & Public Service Manager to resolve this. It was suggested that more imaginative solutions and dialogue was needed. The response rate on Ward 11 was noted to have improved. It was reported that an away day was planned at the end of April to discuss Outpatient improvement work. It was highlighted that the improvements needed to	

be captured so that there was good evidence available should this be needed. There was a clinical walkabout improvement plan. In terms of cancellations, circa 330 patients were seen per week and the percentage of cancellations was a low proportion of these.	
11 Finance & Performance extract of the Board Assurance Framework: *for assurance*	**ROHTB (4/19) 007** **ROHTB (4/19) 007 (a)**
It was reported that there were some ongoing work to mitigate the risks around delivery of the CIP and cyber security. The risks had changed with time and it was noted that some need to be removed or refreshed. It was agreed that the provision of information risk could be removed. It was noted that the risk concerning the 52 week waits needed to be refined to reflect the current position. The risks around the theatres also needed to be refreshed. It was agreed that the Executive Team should refresh the risks on the Board Assurance Framework prior to it being presented to the Board again.	
ACTION: Executive Team to refresh the risks on the Board Assurance Framework	
12 Update from the Finance & Performance Committee: *for assurance*	**ROHTB (4/19) 008**
Tim Pile reported that the number of cancelled operations had reduced and Length of Stay was improving. There had been some successful nurse recruitment, however some vacancies existed. In terms of finances, the Director of Finance was asked if March had been better or worse than planned. He advised that activity and income had been in line with plan, however the expenditure position needed to be worked through, along with the adjustments required. The final position would be communicated to the Board when fully understood. The stocktake was complete and barcodes were being used to review stock. It was agreed that momentum remained good but cost control needed to be better in terms of cost improvement and expenditure on temporary staffing. As there was more activity there was more cost mainly associated with temporary staffing, therefore there was no benefit to the bottom line. This was highlighted to be known as operational gearing and needed to be addressed.	

There had been a good start to April with 335 patients being treated in the first week.	
13 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	**ROHTB (4/19) 009**
The report was received and noted. In terms of cancer performance, this was reported to be at 100% for the month and this was 88% for the quarter which was a big achievement.	
14 Workforce extract of the Board Assurance Framework: *for assurance*	**ROHTB (4/19) 010** **ROHTB (4/19) 010 (a)**
There were noted to be two risks around workforce models and there were workstreams in place to address the issues. In terms of the current gap between staffing and establishment, the Staff Experience & OD Committee would review the information that suggested that the staff in post position is improved. Vacancies were being reduced. In terms of the modular theatres, contracts would be signed shortly and they would be operational by Christmas. Some thinking was needed around the strategy for support staff in line with the new theatres, as the theatres environment was adequate but for the support staff there were some difficulties.	
15 Update from the Staff Experience & OD Committee workshop: *for assurance*	**Verbal**
It was reported that there was a workshop which had looked at the Staff Survey results. Professor Surinder Sharma had outlined how an anti-bullying and harassment culture had been fostered elsewhere. It was agreed that the end of the work undertaken by Professor Sharma had been reached. The Committee had split into three groups to look at how the Trust could improve on: bullying & harassment; performance management; and Health & Wellbeing. It was agreed that the session had worked well.	
16 Gender pay reporting: *for assurance*	**ROHTB (4/19) 010** **ROHTB (4/19) 010 (a)**
The report into the gender pay gap was received and it was noted that it had been published. The report was also being considered by the Staff Experience & OD Committee. The key impact was the number of male medical staff in post; there was some benchmarking work planned. In terms of the variances by Band it was noted that there appeared to be a skewed male vs. female ratio for Very Senior Managers,	

however the Board was advised that this related to only four individuals.	
17 Compliance extract of the Board Assurance Framework: *for assurance*	**ROHTB (4/19) 011** **ROHTB (4/19) 011 (a)**
It was reported that in terms of the risk around compliance with water safety regulations, the risk was to be resolved by August 2019. Presentation of the water safety bible was planned for the May meeting. The risk around governance systems was discussed and it was suggested that when the HealthAssure system and the work to refine Ulysses had been completed, this risk could be closed.	
18 Meeting effectiveness	**Verbal**
It was reported that a celebration had been held for the operations and nursing teams for the successes and achievements by the year end. It was agreed that the presentation showcasing this work would be circulated. This would also be presented to the Council of Governors at its next meeting.	
19 Any Other Business	**Verbal**
It was noted that the new Board Assurance Framework process had been well received but the pre and post scoring needed to be reviewed as in some instances there was little change after the treatment plan had been applied. The patient story presentation was had been received. It was agreed that a formal thank you was needed for the child who had donated her birthday money to the ROH; the Board agreed that it should send the child a birthday gift.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 1 May 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 1 May 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 26.04.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	~~05/09/2018~~ 05/06/2019	Update on therapy services planned for the private Board meeting in September, with the strategy due for presentation in November 2018. Ongoing discussions around therapies with commissioners, thereby not in a position to be able to present updated strategy until ~~Spring~~ June 2019.	
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~~ 01/05/2019	Attending at the May meeting of the Trust Board	
ROHTBACT. 072	Chairman's & Chief Executive's update	ROHTB (4/19) 002 ROHTB (4/19) 002 (a)	03/04/2019	Arrange for an honours board to be established	SGL	30-Jun-19	ACTION NOT YET DUE	
ROHTBACT. 073	Orthopaedic Services in the STP	Verbal	03/04/2019	Invite Mr Pearson to the Trust Board when the orthopaedic pathway re-engineering work commenced	SGL	05-Jun-19	ACTION NOT YET DUE	
ROHTBACT. 074	Corporate and strategy extract of the Board Assurance Framework	ROHTB (4/19) 013 ROHTB (4/19) 013 (a)	03/04/2019	Arrange for an additional risk around the impact of planned growth and modular theatres to be added to the Board Assurance Framework	SGL	05-Jun-19	To be included as part of the Board Assurance Framework refresh	
ROHTBACT. 075	Finance & Performance extract of the Board Assurance Framework	ROHTB (4/19) 007 ROHTB (4/19) 007 (a)	03/04/2019	Refresh the risks on the Board Assurance Framework	Exec	05-Jun-19	Board Assurance Framework refresh planned for May 2019	
ROHTBACT. 071	Board Assurance Framework	ROHTB (3/19) 001 ROHTB (3/19) 001 (a)	06/03/2019	Ensure that changes are made to the BAF in line with comments made at the meeting	SGL	03-Apr-19	Changes made and relfected in the version of the BAF presented at the April meeting - further work planned during May to refresh and overhaul the BAF and Corporate Risk Register	

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:	**1 May 2019**

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 1st May 2019

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 3rd April 2019.

2 STP UPDATE

2.1 The last STP Board meeting took place on 8th April 2019. Key areas of discussion are described below.

2.2 The Board debated the options outlined in the Sandwell & West Birmingham CCG consultation on future structures. A formal STP response has been submitted, which the ROH was able to contribute to and support. This has also been discussed at a recent Health Overview and Scrutiny Committee.

2.3 Regardless of the outcome of this consultation, it will be vital for our STP to work effectively and collaborative with our partners in West Birmingham and the Black Country. To support this, a Board-to-Board meeting between the two STPs has been scheduled to take place in June 2019.

2.3 The Board considered a proposal from Health Education England to deliver a system OD leadership programme. The proposal was supported in principle and the STP leader was asked to review and develop the detailed actions to be addressed from the programme.

2.4 Members of the STP were asked to support the implementation of a Social Value Policy. There was broad support for this, with local authority colleagues keen that the STP pushed itself further with regards to this agenda. The ROH will need to consider this policy through the usual approval routes.

2.5 The latest STP CEOs meeting took place on 18th April, which Jo Williams attended on behalf of the ROH. The key issue discussed was the ongoing work to review Occupational Health provision across the STP with the view of moving to one integrated service.

3 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

3.1 There have been no meetings of the BHA Board since the last ROH Board report

4 LEGISLATION

4.1 Appended to this paper is a copy of the NHS Providers analysis of the recent legislative changes that NHSE/I have proposed as a mechanism for supporting the delivery of the NHS 10-year plan.

4.2 The following areas are covered by the paper:

- Proposals 1-3 – Increasing the power of NHSE/I to approve mergers, make licence changes and set tariff without the need for CMA involvement/oversight
- Proposals 4-5 – Reducing the requirement in some circumstances for formal procurement of NHS services
- Proposals 6-8 – Creating greater flexibility and local discretion in pricing and tariffs
- Proposal 9 – Setting up Integrated Care Trusts
- Proposal 10 – Giving NHSI targeted powers to direct mergers or acquisitions where there are clear patient benefits
- Proposal 11 – Giving NHSI the power to set annual capital spending limits
- Proposals 12-20 – Supporting joint working between various healthcare bodies
- Proposals 21-23 – Reviewing the structure of national leadership and Arms-Length Bodies

4.3 Whilst some of these recommendations have more relevance to the ROH than others, it is clear that the proposals if implemented would represent a fundamental change in the way in which the health service is legislated.

5 JOINTCARE

5.1 Our JointCare team have been asked to present our new pathway at the NOA Quarterly meeting in May 2019, which is a great opportunity to showcase the work undertaken so far and to showcase best practice to our orthopaedic partners.

5.2 The patient story which was filmed by the BBC earlier in the year will form part of the presentation with the ROH Communication Team recently following up the patient who has had a fantastic recovery

6 POLICY APPROVAL

6.1 Since the Trust Board last sat, there have been no policies presented to the Chief Executive, on the advice of the Executive Team for approval.

6.2 Work in ongoing to strengthen the policy governance framework and the implementation of the new HealthAssure system will provide additional functionality for tracking policies and issuing reminders when policies are due for review.

7 RECOMMENDATION(S)

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

7.2 Note the contents of the report.

Paul Athey
Acting CEO
3rd April 2019

Proposals for possible changes to legislation

The NHS long term plan sets out NHS England's and NHS Improvement's (NHSE/I) view that the current policy direction towards collaboration and integration within local systems can "generally" be achieved within the current statutory framework, but that "legislative change would support more rapid progress". The plan included an overview of barriers to collaborative working which NHSE/I would like to address via legislative change. They have now published an engagement document, *Implementing the NHS long term plan: proposals for possible changes to legislation*, setting out their top level proposals for change. These were described in terms of the plan depending "mainly on collective endeavour", with local and national NHS bodies needing to work together to redesign care around patients.

There is an eight week period in which to submit responses to the proposals. This briefing document summarises NHSE/I's proposals and gives NHS Providers' initial analysis, as well as our press statement. We have also set out a number of questions for members, and would be grateful for your views and experiences – **please send any comments to Ferelith Gaze (ferelith.gaze@nhsproviders.org) by 22 March** to ensure they can be properly reflected in our response. You may also want to submit your own response – we suspect that different members may have different views on some of the proposals, depending on their particular circumstances.

NHS Providers' overall view

The passage of these proposals will unfold against the backdrop of a number of difficult realities facing NHS legislation. There is the practical issue of Brexit dominating the parliamentary timetable for some time to come. There is the political sensitivity for the Conservative government in bringing forward health legislation after the Lansley reforms. There is also the tension between wishing to avoid further upheaval for the frontline, even while current structures may be presenting unnecessary barriers.

The long term plan, and the Secretary of State, have been keen to argue that any proposals should come from the NHS itself, rather than be politically driven, and that there should be a consensus in taking them forward. For the same reason, the proposals make piecemeal rather than wholesale changes to NHS legislation.

However, NHS legislation on issues of integration (and therefore competition) and on the scale proposed here need detailed, robust and transparent scrutiny. In particular, we would note that the proposals introduce the potential for both greater integration, but also greater intervention by the NHS arm's length bodies. We also need to consider whether alternative, non-legislative approaches would, in some cases, be more reasonable and proportionate. Where legislation is the appropriate response, given the complexity and sensitivity of NHS legislation, further consideration is needed as to how to avoid unintended

consequences. This will be particularly important since any individual changes on particular issues need to work within and maintain the clarity and consistency of the existing wider legal framework which will remain unchanged.

NHS Providers would therefore welcome member views on the overall direction of travel of these proposals.

Summary and initial analysis of proposals

Below we summarise each of the proposals and give our initial analysis. We will develop this analysis in the coming weeks as we consider the implications of changes. We are seeking member feedback on the proposals, and your experiences of current legislation and regulations to develop the evidence base for our formal response to NHSE/I. We will also continue to seek to influence proposals, and involve trusts, over the coming weeks and months through a range of avenues. We are pleased that the document makes specific reference to the important of NHS Providers' involvement in the drafting process (para 41).

Collaboration and competition

Summary of proposals

NHSE/I are concerned that current competition requirements act as a drag on efforts to improve collaboration between NHS bodies and provide integrated care. The Competition and Markets Authority (CMA) has powers to investigate and intervene in proposed NHS mergers. As the NHS is a publicly funded service, democratically accountable to the Secretary of State and to Parliament, NHSE/I consider that the NHS should be able to make its own decisions in relation to mergers, taking into account the potential benefits for patients.

PROPOSAL 1: removing the CMA's function to review foundation trust mergers

NHS Improvement has concurrent powers with the CMA to apply UK and EU competition law to the provision of healthcare services in England. NHSE/I do not think it necessary for these powers to be held in parallel, and their removal would allow greater focus on oversight of and support for improvement. NHS Improvement would still be able (through licence conditions) to prevent anti-competitive behaviour in certain circumstances where it is against patients' interests.

PROPOSAL 2: removing NHS Improvement's competition powers and duties to prevent anti-competitive behaviour

Under the 2012 Act, where there are sufficient objections to proposed licence conditions or the national tariff payment system, NHS Improvement must either refer the relevant proposals to the CMA or consult on a revised set of proposals. NHSE/I consider that NHS Improvement (with NHS England in the case of the tariff) should be able to reach final decisions on these matters without referral to the CMA, provided it has consulted on the proposals and given any concerns raised proper consideration.

PROPOSAL 3: removing the need for NHS Improvement to refer contested licence conditions or national tariff provisions to the CMA

NHS Providers initial analysis

NHS Providers' view is that while competition can, in some circumstances, be one driver of quality and service improvement in the NHS, it must be applied carefully and sensibly to the ultimate benefit of patients. In other circumstances, over rigid application of competition principles can operate against the interest of patients. For example, a number of providers have been seeking to undertake mergers or acquisitions to address workforce challenges, enable better patterns of service delivery and drive efficiencies. However, the CMA's involvement in the merger approval process has, in the view of many providers, added unnecessary duplication, cost and complexity into the transaction process. We therefore think it likely that most providers will find it helpful to remove the CMA's duty to review provider mergers, as an overly stringent application of competition requirements to the NHS .

However, this proposal should be read in conjunction with proposal 10 (where NHS Improvement seeks the power to direct foundation trust mergers and acquisitions – see later in this document for our analysis). An unintended consequence could be that weakening the role of competition in the NHS also weakens provider board autonomy in the longer term, because the process of deciding service/institutional configurations is centrally directed rather than negotiated and there is no recourse to an independent third party

With regards to the proposal to remove the CMA's potential involvement in licence and tariff objections, this removes a final recourse for providers, albeit one mediated by NHS Improvement. The question to consider here is whether the presence of this backstop has the effect of encouraging robust and reasonable working practices by NHSE/I. It is worth remembering the scale of disagreement between the provider sector and NHSE/I on the framing of the tariff a few years ago when providers triggered the formal tariff objection mechanism. The Government has now amended the terms of that mechanism to make it much more difficult for providers to trigger. We assume members might want to try to secure a "quid pro quo" for the loss of the right of CMA referral, in the form of clear guarantees of what NHSE/I means when it says that it will seriously consider any objections.

Questions for members on proposals 1 to 3

- What elements of the presence of the CMA in the mergers process have been a) beneficial and b) disadvantageous?
- How concerned are you by the proposal to remove the requirements on NHS Improvement to refer to the CMA (a) contested licence conditions and (b) contested national tariff provisions?
- Please could you let us know about any occasions that you have contested, or considered contesting, your licence conditions.
- Do you have any further comments or concerns about these proposals?
- Would you agree with the idea of securing a "quid pro quo" for loss of the right of CMA referral?

Procurement rules

Summary of proposals

Procurement of healthcare services in the NHS is carried out under two sets of regulations: the Procurement, Patient Choice and Competition Regulations (PPCC regulations; made under powers in the 2012 Act), and the Public Contracts Regulations 2015 (implementing EU rules on public procurement).

NHSE/I consider that NHS commissioners should be able to arrange for NHS providers to provide services without necessarily seeking expressions of interest from the wider market. Under the current system, protracted procurement processes incur potentially wasteful legal and administrative costs, and it can be difficult for NHS organisations to collaborate and use their collective resources in the most effective way.

NHSE/I propose that, rather than a necessary procurement process, it would, instead, be for commissioners to use their discretion. The key test in awarding a contract would be whether NHS commissioners were: obtaining "best value" from their resources, in terms of the likely impact on quality of care and health outcomes; whether they were acting in the best interests of patients; and whether they were actively considering relevant issues in making any decisions.

PROPOSAL 4: regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced by a best value test
PROPOSAL 5: removing NHS commissioners and NHS providers from the scope of Public Contracts Regulations, and instead making NHS commissioners subject to a best value test, supported by statutory guidance

The way in which the Public Contracts Regulations 2015 can be changed will depend in part on how the UK exits the EU. It will also depend on other legislative proposals which affect the nature of arrangements between NHS commissioners and NHS providers.

In rescinding the PPCC regulations, requirements in relation to patient choice are intended to continue under the standing rules given to commissioners and licence conditions for providers. The power to set standing rules in primary legislation would also be explicitly amended to require inclusion of patient choice rights.

NHS Providers initial analysis

Careful analysis of these regulations is required. It would seem that greater commissioner discretion in procurement processes would be helpful in reducing the burden on trusts, particularly for community and mental health trusts whose services are more regularly subject to tendering. Yet further clarification is required in a number of areas. For example, there is considerable uncertainty about the nature of the amendments to the Public Procurement Regulations, and more widely, the extent to which competition rules will still apply to day-to-day procurement. The definition of and guidance around the "best value test"

will also need further clarification and consideration. Meanwhile, we should be mindful of the role of patient choice and how this would be enacted in absence of the regulations.

Questions for members on proposals 4 and 5

- Rescinding these regulations seems likely to reduce the burden on trusts for retendering, but please let us know if you are aware that there are any elements of these regulations that are beneficial and would otherwise be lost.
- Do you have any further comments or concerns about these proposals? Are you, for example, happy with a return / move to greater commissioner discretion on whether to tender or not?

National NHS payment systems

Summary of proposals

Changes to the national tariff have been made for 2019/20 with the stated objectives of supporting providers and commissioners to work more collaboratively and develop a more aligned system of payments and incentives. The national tariff also already provides for a degree of flexibility, with providers and commissioners able to agree local payment approaches. However, NHSE/I consider that legislative changes could help further this approach.

PROPOSAL 6: on the tariff: (a) national prices can be set as a formula rather than a fixed value; (b) a power for national prices to be applied only in specified circumstances; and (c) allow adjustments to provisions within the tariff to be made (subject to consultation) within a tariff period

Currently, providers can apply to NHS Improvement to make changes to tariff prices if agreement with local commissioners on modifications cannot be reached. NHSE/I view this as out of keeping with moves towards integrated care systems (ICSs) where commissioners and providers take shared responsibility for managing their collective financial resources.

PROPOSAL 7: once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed

It is not currently possible to set national tariff prices for section 7a public health services commissioned by NHS England or CCGs on behalf of the Secretary of State. This has created difficulties where these services are part of a patient pathway for a particular service, for example, screening newborn babies' hearing as part of their mothers' maternity care.

PROPOSAL 8: national tariff can include prices for section 7a public health services

NHS Providers initial analysis

We will clarify the terms of consultation in adjusting treatments in-year in the tariff. We will also consider further how the payment system would work in practice if prices are set as a formula rather than a fixed value and with national prices for certain circumstances.

We would also question whether it is an appropriate point to remove NHS Improvement's role in resolving disputes over local modifications to prices, even when ICSs are fully developed, as we can still foresee potential for provider / commissioner disagreement as long as there are separate, distinct, statutory entities. We would welcome member views on this. We agree with the ambition that modifications should be agreed locally. However, an emphasis on collaboration over competition and a drive towards integrated care systems are not sufficient drivers to ensure that disputes will not arise in the future. We are also aware that some trusts (for example University Hospitals Morecambe Bay) have used the local modification process to identify where a trust has a structural deficit that commissioners ought to be taking account of in its contracted pricing. We assume that this process will, in future, be part of each individual trust's discussion with NHSE/I on access to the new Financial Recovery Fund (FRF). But some might regard it as premature to remove this avenue for identifying a provider structural deficit before we can be sure that the FRF process will achieve a similar objective.

Questions for members on proposals 6 to 8

- Please let us know your views on proposal 6, and in particular, national prices being set as a formula, and the power for national prices to be applied only in specified circumstances.
- Please could you let us know of any occasions where you have applied to NHS Improvement to make local modifications to tariff prices and the result of this application.
- Do you have any further comments or concerns about these proposals?

Integrated care trusts

Summary of proposals

The integrated care provider (ICP) contract provides for a situation where local health systems wish to bring some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget. However, in some cases, it may be difficult for commissioners to identify an existing organisation that could take on responsibility for a contract of this kind. It could be that a group of local GP practices and a provider of community, mental health and/or hospital services wished to come together. However, the existing legislative framework doesn't lend itself to these circumstances as a new NHS foundation trust cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts. NHSE/I therefore propose that the Secretary of State be given the power to be able to set up new integrated care trusts.

PROPOSAL 9: Secretary of State to be able to set up new integrated care trusts

Integrated care trusts would only be established where local commissioners wished to bring services together under a single contract and where it is necessary to establish a new special purpose organisational vehicle to do so, and where there has been appropriate local engagement. The resulting ICP would:

- Have a contractual duty to deliver and improve health and care for a defined population
- Act as a provider of integrated care with the freedom to organise resources across a range of services
- Be run in a way that involves the local community and the full range of health care professionals

- Be accountable to commissioners for its performance

Taken together with the procurement proposals, this power to establish a new trust would also support the expectation in the long term plan that the ICP contract should be held by public statutory providers.

NHS Providers initial analysis

While we understand that this proposal could create some helpful flexibility within the system, we are cautious about its implementation. Whether created from existing entities or newly formed, establishing a new trust is a considerable undertaking. We need to be clear on when this would be pursued, and how this would be driven, and what consideration would be given to potentially valid alternatives (such as a merger). We would be keen to have assurances that new trusts would not be set up without the explicit support of all partners in the local health economy in question. There also need to be appropriate protections for existing NHS providers serving the area. There might, for example, be a possibility that the threat of creation of a new integrated trust could be used as leverage to get an existing trust to behave in a particular way. In our discussions with NHSE/I over this clause we asked for specific protection for providers but this has been translated as "appropriate local engagement".

The duties, autonomy, governance and accountabilities of a new form of trust require careful consideration, not least since the proposal is to create a new type of trust rather than a foundation trust, and enabling vertical integration between secondary and primary care may mean establishing an organisation with a different composition from the current model. We will also explore how these trusts will be able to integrate services across a local system, with primary care particularly in mind.

Questions for members on proposal 9

- To what extent do you think this proposal presents your local system with an opportunity, particularly to develop more integrated models of care?
- What provisions or protections for NHS trusts and foundation trusts would you consider important as part of taking this proposal forward?
- Do you have any further comments or concerns about these proposals?

Mergers and acquisitions

Summary of proposals

In some circumstances, NHSE/I believe that plans to improve the management of local health services through mergers and acquisitions can be frustrated by the reluctance of one local trust to consider such a change. NHS Improvement can already direct NHS trusts in this respect. However, it can only take equivalent action in relation to NHS foundation trusts in the event of trust special administration – that is, where there is a serious failure or risk of failure.

PROPOSAL 10: NHS Improvement to have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits

NHSE/I are proposing that NHS Improvement should have the power to direct NHS foundation trusts to:

- Enter into arrangements to consider and/or to prepare for a merger or acquisition with an NHS trust or other NHS foundation trust
- Merge with an NHS trust or other NHS foundation trust
- Be acquired by another NHS foundation trust

Such an approach would change organisational accountability in a local system, and is distinct from changes to service provision. Decisions on service changes would remain a matter for local commissioners and providers, subject to national tests (such as strong patient engagement, preservation of patient choice, a clear clinical benefit, and support from local clinical commissioners).

NHS Providers initial analysis

In our view, any proposal for NHS Improvement to hold a broad power of direction over foundation trust mergers and acquisitions would cut across the ability of FT boards to carry out their responsibilities and be held properly accountable to the public for the quality of care they provide. That said, we know there are circumstances in which some members would welcome greater direction from the centre with regard to the structure of the local providers in their area, particularly if circumstances arise where one trust is unreasonably preventing a change in organisational form that every other member of a local system supports.

We have been debating the scope of this power with NHSI for some time. We argued that a general power to direct was wholly inappropriate. The proposals therefore talk about a targeted power for use in specific circumstances only. We recognise, however, that some members are likely to still have concerns.

We believe that greater clarity is needed as to the circumstances under which this power would be used (for example, how is the need for a merger or acquisition determined and how does NHS Improvement become involved). Would the power, for example, be more acceptable, if NHSE/I committed that it would only be used after a trust had been given the opportunity to determine for itself whether it was sustainable in a standalone form, and NHSI and all other providers in the area disagreed with the answer. It therefore feels important to explore alternatives have been considered, and whether would it be more effective and appropriate for NHS Improvement to hold a role more akin to arbiter in the event of local system dispute than director of that system).

This proposal also needs to be considered in conjunction with a number of other proposals. These include proposal 1, as the CMA would not have a role in investigating and intervening such changes; proposal 9, and the ability to create new integrated care trusts; and proposal 11, relating to NHS Improvement's direction of FT capital spending given the further impact on governance and control.

Questions for members on proposal 10

- We would argue strongly against a broadly drawn power for NHS Improvement to direct mergers and acquisitions on the basis that it interferes with appropriate trust autonomy and accountability. Please could you tell us:
  - If you agree with that stance
  - If there are alternative approaches to such a power, such as an arbitration role for NHS Improvement, which you would consider to be more helpful in your local system
  - The circumstances, if any, under which you would consider an 'in extremis use' of this power to be appropriate
- Do you have any further comments or concerns about these proposals?

Capital spending

Summary of proposals

There is an urgent need to invest in NHS buildings and facilities, and a more coordinated and collaborative approach to planning capital investment is required to support this. NHSE/I see that, while parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care and the NHS, the lack of mechanisms to set capital spending for NHS foundation trusts is a barrier to a more collective approach. It can therefore be that, because of uncertainty around foundation trust capital spending, it is necessary to constrain or delay capital spending by trusts that may be more urgent or address higher priority needs. The inability of NHSE/I to control capital spend by FTs and, they argue, the inaccurate forecasting of such spend, also means that the risk of the NHS breaking its overall capital spending limit, is too great.

PROPOSAL 11: NHS Improvement to have powers to set annual capital spending limits for NHS foundation trusts

NHSE/I say they would want to avoid, where possible, cutting across the freedoms that FTs have to build up funding reserves or borrow money. The power to set annual spending limits would not prevent FTs from using their funding reserves for capital investment, but it would mean that they would need to agree with NHS Improvement, working with local health systems, when to make large capital investments.

NHS Providers initial analysis

Capital maintenance and investment is a key part of service delivery, and we question the circumstances under which NHS Improvement would be better placed to make a decision here than the trust board, especially bearing in mind that the consequences for under-investment will sit with the trust. Whilst we recognise the risks around breaking capital limits, we would argue that this risk has been elevated by the poor quality and opaqueness of the capital allocation process operated by NHSE/I and the Department of Health and Social Care. It is this, rather than trust failings, that is the largest contributor to inaccurate trust capital spend forecasting.

Subject to member views, NHS Providers intends to oppose this proposal. While appropriate controls over capital spending are necessary, we would question whether a legislative response which blurs trust autonomy and accountability is appropriate, especially when more proportionate and collaborative approaches could be pursued. For example, NHS Providers has argued for some time that a more robust capital bidding and prioritisation regime is needed in order to give trusts certainty over the coming years and frame their investments within a set of strategic priorities.

Questions for members on proposal 11

- Please could you let us know of any instances within your local system where there have been disputes around capital spending?
- Please could you let us know of any instances in your local area where NHS Improvement has used its powers in relation to NHS trusts (as opposed to NHS foundation trust) capital spending, and the results of this?
- What complications or opportunities do you foresee central direction of capital creating for your trust and/or local system?
- If there is a need for greater accuracy in forecasting capital expenditure to reduce the risk of exceeding the aggregate NHS capital limit, are there other ways in which this could be achieved that avoid the need for NHSI to have a power of direction over FT capital spending?
- Do you have any further comments or concerns about these proposals?

Provider and commissioner joint working

Summary of proposals

NHSE/I want NHS organisations to work with each other as ICSs to jointly plan and improve care delivery. However, they believe that establishing ICSs as distinct, new organisational entities would involve a complex reassignment of functions that currently sit with CCGs and trusts. Instead, they propose to change primary legislation to remove barriers to collaboration, and make legal provisions to allow CCGs and NHS providers to take joint decisions.

PROPOSAL 12: NHS providers and CCGs to be able to create joint committees

PROPOSAL 13: NHS England to be able to publish guidance on joint committee governance and appropriate delegation

Joint committees would not remove the existing responsibilities of CCGs and NHS providers. Joint committees would be required to act openly and transparently, and would need to work in a way that avoids conflicts of interests (for example, a commissioner would not be able to delegate to decisions on purchasing services to a joint committee).

NHSE/I also view it as sensible to allow NHS providers to form their own joint committees (CCGs can already do so). These could include representation from other bodies, such as primary care networks, GP practices or the voluntary sector. These committees could bring local care providers together to set up clinical services networks, a single estates strategy or shared IT, HR and pharmacy services.

Legislation currently specifies that CCG governing bodies must include a registered nurse and a doctor who is not a GP, neither of whom should be working for a provider where the CCG has commissioning arrangements. NHSE/I view it as inconsistent to allow GPs to sit on governing bodies but prevent the designated nurse and doctor from working for other local providers, and see this rule as too limiting for CCGs to plan services effectively.

PROPOSAL 14: allowing CCGs more freedom to have governing body members who work as clinicians for local providers

Joint roles may be a way of improving integrated care. While joint appointments can already be made, NHSE/I recognise that the legislation is ambiguous and organisations can leave themselves open to challenge in the future for the appointments they make.

PROPOSAL 15: making provision for CCGs and NHS providers to make joint appointments

NHS Providers initial analysis

The NHS is clearly in transition from a system focussed on individual CCGs / providers to one focussed on integrated local health and care systems. In the absence of legislation creating local health and care systems as formal legal entities to replace trusts and CCGs, we recognise the potential power of joint committees to help speed this transition. We believe there are currently two main uses of the joint committee approach: to bring groups of providers together into a common decision making structure; and as a means of cross system decision making covering both CCGs and providers in more advanced local systems.

However, as we understand the current proposals, the creation of a joint committee would mean that a trust could then be bound, potentially against its will, to decisions made by that committee even while the trust retains its accountability for those decisions. There will be some who are concerned by such a lack of clarity over how responsibilities are held, not least given the level of risk managed at trust level. Others might also highlight the potential absence of challenge within this model, as otherwise provided by non-executive directors (NEDs) within a trust's unitary board. The value of NEDs is recognised – and has been consistently strengthened over time – within the governance codes for the private sector, and we would encourage the same within the NHS.

We are therefore keen to understand how different members see the balance of benefit / risk here, weighing up the benefit of being able to speed the transition to integrated local systems against the risk of losing the clarity of accountability of current unitary trust boards. NHSE/I's proposals provide the protection that the creation of joint committees is a matter for local discretion. It would be helpful to understand if this is sufficient protection or whether this needs further definition (e.g. what happens if one member of a local system refuses to accept a joint committee all other members of that system support).

Regarding steps to enable joint provider-commissioner appointments, while we recognise the intention here to support system working, we need to be equally mindful that the purchaser-provider split is being maintained. Whether and where a joint appointment creates conflicts for the incumbent, or blurs board accountability, needs careful consideration.

Questions for members on proposals 12 to 15

- Have you explored the creation of a joint committee? If so, for what purpose and to what benefit? Equally, have you tried and failed to set up such a committee and if so, why did it fail?
- Are there any circumstances under which you can envisage your trust creating a joint committee (in any given combination of other trust(s) or CCG(s))? And what protections do you think are needed?
- Have you sought to make any joint appointments with a CCG to date? If so, please could you outline the key considerations for your trust in doing so.
- Do you have any further comments or concerns about these proposals?

Shared duties for providers and commissioners

Summary of proposals

NHS bodies are already bound by strong duties to provide or arrange high quality care and financial stewardship as individual organisations. However, NHSE/I do not believe that these are sufficient to ensure local systems plan and deliver care across organisational boundaries in ways that secure the best possible quality of care and health outcomes for local communities.

PROPOSAL 16: a shared duty for CCGs and NHS providers to promote the triple aim of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS

NHSE/I believe that this change would support the goal of strengthening the chain of accountability for managing public money within and between NHS organisations. The legal duties that currently apply might be amended or extended to ensure consistency and support this triple aim.

NHS Providers initial analysis

We suspect that whilst most members will be supportive of the policy intent of this proposal, some might have reservations about it being added to existing duties, even recognising that they may be refined in parallel. A shared duty in this manner might, to some, seem to be in tension with trust boards' accountabilities for their organisation and organisational delivery. Further general duties may generate conflicts and it may be prudent to re-emphasise existing legislation and its policy intent rather than adding an extra layer.

Questions for members on proposals

- If your existing duties remained as they are, do you foresee any conflicts arising from the addition of a triple aim duty shared across local systems, including with CCGs?
- Do you have any further comments or concerns about these proposals?

Joined up commissioning

Summary of proposals

Commissioning responsibilities are split across CCGs, NHS England and local authorities, meaning that public health, primary care, hospital care and specialist services are organised by different bodies. NHSE/I want to join up commissioning without major organisational restructuring.

PROPOSAL 17: removing the barriers that limit the ability of CCGs, local authorities and NHS England to work together and take decisions jointly

NHSE/I identify barriers to joined up commissioning as including:

- The inability of CCGs holding delegated functions (for example, commissioning primary medical care on behalf of NHS England) to then enter into formal joint decision-making arrangements for that function with neighbouring CCGs or local government (as this would constitute unlawful double delegation)
- The public health functions carried out by NHS England on behalf of the Secretary of State (such as national screening and immunisation programmes) cannot be jointly commissioned by NHS England and one or more CCGs, making it harder to take account of local issues
- CCGs working together cannot currently make joint decisions other than by formally merging.

PROPOSAL 18: (a) NHS England can allow groups of CCGs to collaborate to arrange services for their combined populations; (b) CCGs can carry out delegated functions as if they were their own; and (c) groups of CCGs in joint and lead commissioner arrangements can make decisions and pool funds across their functions

PROPOSAL 19: enable NHS England to jointly commission with CCGs, or delegate to groups of CCGs, the specific services currently commissioned under the section 7A agreement

These changes would empower CCGs to make joint decisions and promote integration, although NHS England would retain its overall responsibilities. NHS England would also be required to consult on any plans to delegate services to CCGs.

Services that form part of care pathways can include services commissioned variously by NHS England, CCGs or local authorities. For example, CCGs commission services for patients with kidney disease, NHS England for patients with kidney failure. Such splits can hinder efforts to organise care around the needs of patients, as has been the case in integrating specialist mental health services with community-based mental health and social care services. NHSE/I believe that CCGs should be more involved in decisions around specialised services, but the only mechanism currently available is for full responsibility for individual services to be transferred to all CCGs. Yet this would not be appropriate for services which need to be planned on a larger population scale.

PROPOSAL 20: NHS England can enter into formal joint commissioning arrangements with CCGs (and so support, for example, specialised commissioning arrangements)

NHS Providers initial analysis

NHS Providers has raised a number of concerns around fragmented commissioning pathways, especially relating to mental health and specialised services. We also note the success of pilots to transfer responsibility for specialised commissioning of some forensic mental health services to providers and the desire to speed up and extend this approach. We would therefore welcome steps to streamline commissioning and support improvements to patient care. Wee are also mindful of other concurrent changes taking place, particularly the closer working of NHS England and NHS Improvement with the appointment of joint regional directors, and the potential growing role for providers in undertaking tactical commissioning or lead provider roles. We will be interested to understand how powers would be shared between CCGs, local authorities and NHS England, and also to understand the impact of these proposals on the commissioner-provider relationship at every level. We will also urge that providers are appropriately consulted as CCGs work more closely together to promote service integration.

Questions for members on proposals

- If you have experienced joint commissioning by NHS England and a CCG, do you have any concerns arising from that process which may be relevant here? Have there been any benefits or lessons learned to feed into these changes?
- Do you have any further comments or concerns about these proposals?

National leadership

Summary of proposals

There are limits on how far NHS England and NHS Improvement can work together. For example, there is no provision to formally carry out functions jointly, there are constraints on sharing board members, and they have separate accountability arrangements to the Secretary of State. This causes unhelpful and cumbersome bureaucracy for both organisations. NHSE/I are instead looking to go further in speaking with one voice, setting consistent expectations across the health system, developing a single oversight and support framework, bringing together national work programmes, and using collective resources more efficiently.

PROPOSAL 21: NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to Secretary of State and Parliament

PROPOSAL 22: closer working should be achieved by: either (a) creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement; or (b) leaving the existing bodies as they are, but provide more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common

At present, there are different legislative arrangements for the accountability between the Secretary of State and each of NHS England, Monitor and the Trust Development Authority. If a single body were created, accountability would need to be appropriately defined. Moreover, the Health and Social Care

Select Committee has recommended that all national NHS arm's length bodies (ALBs) act in a more joined-up way, particularly on priority areas such as prevention of ill-health and workforce education and training. Responsibility for these issues sits in different organisations, specifically Public Health England and Health Education England.

PROPOSAL 23: enable wider collaboration between ALBs by establishing new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs

NHS Providers initial analysis

These proposals are a further significant shift in the way the NHS is led at a national level, with important implications for trusts and their leaders. While increased coordination and consistency is welcome, there remain significant risks within this approach which need careful consideration. These include the importance of understanding provider needs, risks and the task set for them, as well as a proportionate approach to regulation and support which take account of continuing lines of provider autonomy and accountability. There are also some who believe that the formal merger of NHSE/I would create a single organisation that was too large to function effectively and, potentially, represented too great a concentration of power. We are therefore interested in members' views on whether full; merger or greater working together is seen as preferable. We will seek greater clarity around these proposals and how NHSE/I would envisage their future relationship with the sector, whether they are acting as a single or more aligned entity.

While there is a logic for giving the Secretary of State greater power to transfer responsibility between arms length bodies we would be keen to hear from members if they think such an approach would bring increased risks or disadvantages.

Questions for members on proposals

- What is important for your trust in its relationship with NHS Improvement to see maintained in the future closer working arrangements of NHSE/I?
- Where would you see increased coordination and alignment as most beneficial to your trust?
- Would you prefer to see NHSE/I to fully merge or work more closely together, and why?
- What risks or disadvantages can you see to the Secretary of State having greater power to transfer responsibilities between arms length bodies?
- Do you have any further comments or concerns about these proposals?

Our press statement

Responding to the consultation on proposed legislative changes, the chief executive of NHS Providers, Chris Hopson said:

"The NHS has spent the last five years trying to find ways to create integrated local health and care systems within a legislative framework based on competition and individual institutions. This isn't a straightforward

task. It adds risk, uncertainty and complexity to the job of frontline leaders already grappling with significant financial, demand and workforce challenges.

"As the service works to fulfil the ambitions of the NHS long term plan, it makes sense to review whether we can make enabling changes through legislation, recognising that there are other possible ways of addressing the tensions between the current legislative framework and the desired direction of future travel.

"It is vital that we consider any changes carefully, work through the detail and co-create any changes with those affected, as the Health and Social Care Select Committee has suggested. We therefore welcome NHS England's and NHS Improvement's first step in announcing this engagement exercise and their commitment to a process of co-production.

"We will consult NHS foundation trusts and trusts, but we think there are proposals here that the provider sector will welcome and find helpful. We will wish to explore with providers the cumulative effect of the proposals, and we will want to talk to our members about two particular areas.

"First, the principle of trust boards being completely accountable for all that happens within their trust, and having the appropriate power and freedom to discharge that responsibility effectively, is central to the way the NHS currently works. It is the key governance mechanism to manage the level of safety, clinical, operational and financial risk inherent in the frontline delivery of hospital, mental health, community and ambulance services. As much as we all support integrated care within local health and care systems, we must approach anything that cuts across this clear trust board accountability with caution. We will therefore want to look very carefully at the proposals for NHSE/I to take powers to direct trust level merger and acquisition activity and set their capital limits.

"The second is how we manage the transition from an NHS legal framework based on competition and individual institutions to one of collaborative, integrated local health and care systems. The changes proposed are targeted as they seek to avoid a wholesale restructure and another top down re-organisation. However, they do create something of a halfway house and we must ensure that this half way house would deliver more effectively for patients than what we currently have, and that it would be robust, appropriate and consistent. We will therefore want, for example, to carefully consider proposals such as joint committee decision making between commissioners and providers and the ability of the Secretary of State to create new integrated trusts in this context."

Contact: Ferelith Gaze, senior public affairs manager Ferelith.Gaze@nhsproviders.org

ROHTB (5/19) 002

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 24 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The incidents that at first grading had caused moderate or severe harm were discussed, these being around a specimen error, a fall, a post-operative VTE and an expected death. • The Committee reviewed the information provided to the National Reporting and Learning System (NRLS) – the number of incidents reported had reduced and therefore a review was commissioned to benchmark the Trust's level with other organisations given that NRLS regard a higher number of incidents to reflect a good reporting culture. • There was reported to be further work to do to reaudit and look at the consistency of the application of the national policy regarding starvation prior to surgery. • The Committee was advised that a named doctor for child safeguarding was not in post and the issue had been raised to the regional Safeguarding Board and to Commissioners. Discussions were ongoing with Birmingham Children's Hospital to source an individual however in the meantime an interim plan was in place to provide this expertise when needed. • It was noted that when new legislation comes into force around Deprivation of Liberties, this would make the Trust an authority and legally accountable for enforcing the Safeguards.	• The governance around and process for disseminating and acting upon NICE guidance is to be presented at the next meeting. • It was suggested that an integrated performance report that served all committees should be produced. • A presentation on mental health work is to be presented to the Trust Board. • The annual workplan to achieve compliance with the Hygiene Code would be presented at a future meeting. • The co-chairs of the VTE Committee are to be invited to the next meeting. • An update on recycling was agreed to be required for the next Trust Board meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• An update on the plan to ensure that those who were outstanding Hepatitis B vaccinations received them was presented. There were reported to be two medical staff working in theatres who had been identified; one had a date for their vaccination and the other had been vaccinated. • The Committee received the draft quality account – this would be presented to the Board for approval at the end of May.	• None specifically.

• The estates lead from the local mental health trust has worked with the ROH's estates team to review the site for potential ligature points. An action plan had been developed to address any areas needing attention. • The Committee received a positive report from the Research & Development Committee which highlighted that the take up of research projects was now more multi-disciplinary. • There had been two cases of *C difficile* during the year, however a review of these suggested that these were not associated with lapses in care. • There was reported to be good progress with the CQC action plan.	
Chair's comments on the effectiveness of the meeting: It was agreed that the Committee was working effectively and the quality of the upward reports was improved	

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:	**Janet Davies, Clinical Service Manager / Project Lead for the Paediatric Transition**
DATE OF MEETING:	**1 May 2019**

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:

- An update regarding the revised timeline for the transfer of Paediatric Services to BWC (1st July 2019)
- Oncology review and recommendations
- Communications and timelines
- Details of services remaining at the ROH after the main transfer (as requested at the last meeting)
- Governance of the transfer
- Key risks

REPORT RECOMMENDATION:

The Board is asked to accept 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		Communications & Media	x
Business and market share	x	Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services.

PREVIOUS CONSIDERATION:
Last considered as part of the Trust Board public agenda on 3 April 2019.

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Paediatric Service Update – May 2019
UPDATE TO THE TRUST BOARD ON 1st May 2019

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:

- Oncology Quality Assurance Evaluation and recommendations
- Communication / Timeline updates
- Governance
- Main risks
- Services which remain on site at the ROH

2 Oncology update and Recommendations

The Oncology Quality Assurance Evaluation was published by Professor Ian Lewis on the 24th April 2019. The report made 7 recommendations between now and the transfer date of the 1st July 2019. BWC had already shared the initial findings of the report with their Trust Board at the end of March 2019 and had confirmed their commitment at this time to proceed with plans to transition the Oncology service as planned on the 1st July 2019. Both Trusts were aware of the recommendations and have already started to put plans in place.

4 out of the 7 recommendations related to the oncology the Interventional Biopsy CT pathway being delivered at the ROH site and work has already taken place to ensure the continuation of this pathway. It is planned that the ROH will provide the consultant anaesthetist till December 2019 and the Consultant Interventional Radiologist. From January 2020 BWC will cover the anaesthetic service (this is due to our consultants no longer able to keep their competencies with no surgery on site). A nursing model is being confirmed and is currently being agreed by both Trusts. Satish Rao (Deputy Chief Medical Officer BWC) and Matthew Revell (Medical Director ROH) are planned to meet with both clinical teams to confirm this and a future model.

Recommendation 4
ROH and BWC speedily develop a plan for IT linkage between the two main sites to enable transfer of clinical information and images. Remote access is already available and is currently being trailed by the clinical colleagues including access to PACS (imaging). Training is planned in May 2019 by BWC for ROH staff to be able to navigate the BWC systems.

Recommendation 5
ROH and BWC work together to ensure that the orthopaedic oncologists can maintain their current level of both adult and paediatric activity on both sites including maintaining continuity of care for individual patients. ROH have appointed 1 WTE additional consultant with an option to appoint a locum for 12 months. Job planning is scheduled for May 2019 for all specialties including Oncology.

Recommendation 7
The project team create multiple opportunities for the clinical teams from ROH and BWC to meet and help develop solutions jointly. A joint regular meeting will be set up with the Operational and Clinical teams across both Trusts. This meeting will provide a platform for both Trust to work together to deliver the service, manage the service level agreement (SLA) and work on transforming the service together now and beyond the transfer date.

3. Communications / Timeline updates

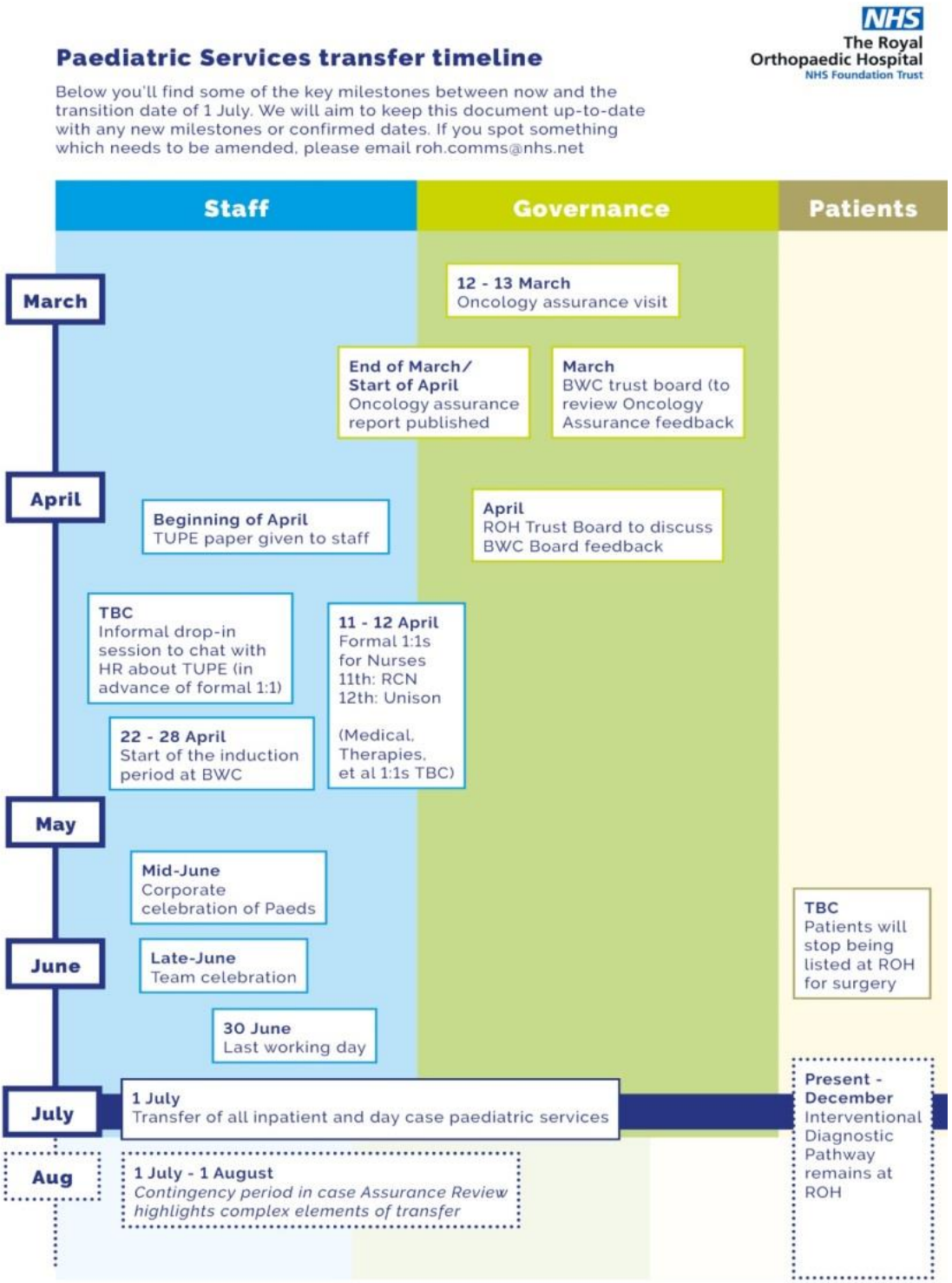
There have been no changes to the key milestones for the paediatric service transition (demonstrated in the transfer timeline below shared with staff in April 19). The transition date of the 1st July 2019 remains on track with no concerns noted from BWC regarding their trajectory for the recruitment of theatre staffing and ongoing assurance from ROH nursing teams that safe staffing levels to support the paediatric inpatient services will be maintained.

4. Outpatients (OPD) Paediatric Services at the ROH

The ROH will continue to provide on-site Paediatric Outpatient clinics and a weekly CT biopsy service to support the Oncology Pathway. The OPD will remain on Ward 11 and the COO and Director of Nursing and Clinical Governance will take the opportunity to review the clinical area at the beginning of May with the Estates team.

The CT biopsy list will continued to be delivered by the ROH on a Thursday and as described earlier it is planned that the ROH will provide the consultant anaesthetist till December 2019 and the Consultant Interventional Radiologist. From January 2020 BWC will cover the anaesthetic service. A nursing model is being confirmed and is currently being agreed by both Trusts. In the unlikely event that a child will be required to stay overnight they will be transferred to BWC. This has been reviewed and we estimate that this is likely to be approx. 5 children per year.

The Director of Nursing and Clinical Governance will work with the senior clinical nursing team to ensure that policies and procedures are refreshed to support the remaining services on site at the ROH.



The formal TUPE consultation process has commenced with all staff affected by the Paediatric transfer receiving the TUPE paper on the 5th April. Staff also received a measures letter which explained the main changes for staff; this was issued by BWC and shared with ROH staff on 9th April 2019.

The formal 1-1 meetings started on schedule on the 11th and 12th April 19 with the majority of nursing staff being seen on the two dates. All staff interviewed on the day was allocated their first choice of work place at BWC. Main themes declared during the 1-1 meetings related to:

- Parking charges
- Flexible working

All remaining staff have scheduled 1-1 appointments booked in May 19.

A comprehensive training programme together with early and long day buddy shifts has been arranged for the transitioning staff at BWC. Theatre shut down week (22nd April 2019) has been used to facilitate the release of staff to attend these days. The aim is to give staff the opportunity to be inducted into the Trust and to their new area of work and get to know their new colleagues.

4 Governance

There continues to be a strong governance structure to oversee the process of transferring the paediatric inpatient & day case surgery service:

The Strategic Oversight Group Meeting co-chaired by Kathryn Sallah (ROH) and Alan Edwards (BWC) and NHS improvement and NHS England to ensure the milestones for the transition are delivered. This continues to ensure system wide support and ownership for the transition of the service.

5 Risks

The joint risk register between ROH & BWC has been updated to reflect the main risks associated with this complex service transition. As discussed in the paper there has been a reduction in the previously highlighted risks demonstrating greater assurance for the transition date of the 1st July 2019. These risks continue to be managed & mitigating actions against these risks monitored through the governance structure outlined in section 4.

Authors: Janet Davies Clinical Service Manager / Project Lead for the Paediatric Transition
25th April 2019

ROHTB (5/19) 003

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

April 2019

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.

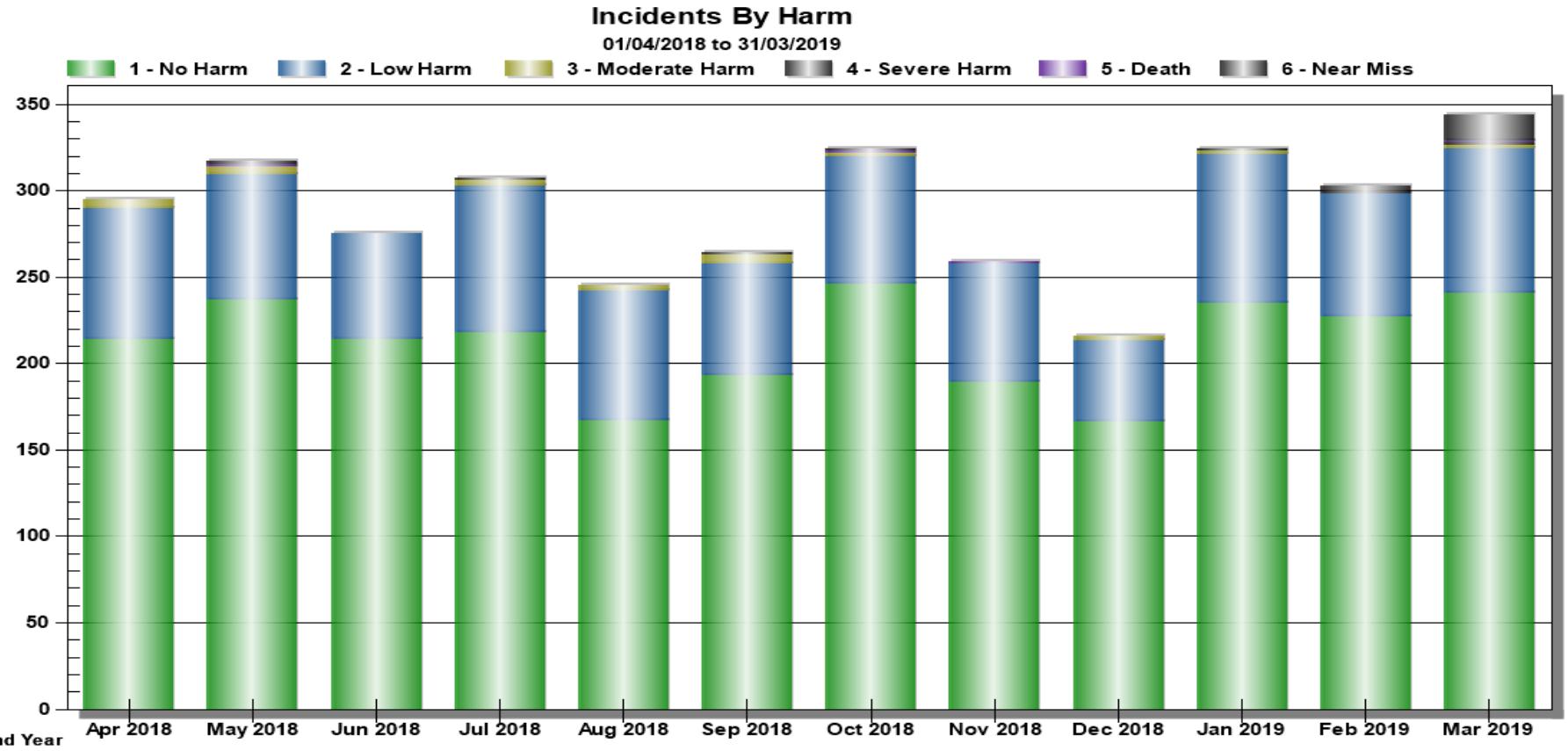
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
1 - No Harm	214	237	214	218	167	193	246	189	166	235	227	241
2 - Low Harm	76	72	61	85	75	65	74	69	47	86	71	83
3 - Moderate Harm	5	5	0	3	3	5	2	0	3	2	0	2
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	0	2
5 - Death	0	1	0	0	0	0	1	1	0	0	0	1
6 - Near Miss	0	2	0	1	0	1	1	0	0	1	5	15

INFORMATION

In March 2019, there were a total of 344 Incidents reported on the Ulysses incident management system.

The breakdown of those incidents is as follows;

241 – No Harm
83 – Low Harm
2 Moderate Harms
2(1 Duplicate) – Severe Harm
15 – Near Miss
1 – Death

The provisional harms reported were;

Department	Cause 1
Ward 1	Death (Expected)
Blood Bank, Bone Bank And Specimen Room	Specimen Request - Documentation Issue
Ward 3	Fall - Inpatient
ROCS	Thromboembolic Events (Known/Suspected)

Near Miss Incidents – Radiology incidents

All 15 of the near misses are in relation to X-Ray processes and radiology examinations not being processed in the RIS system. This leads to delays in reporting. None of the incidents reported are patient safety issues and have not led to a delay in diagnosis. All radiographers are aware of their professional standards and the need to complete the RIS events. The incident forms will promote a professional discussion with their line manager to ensure that they are aware of the incident and any further occurrences may lead to disciplinary action. This is a new process to drive improvement and will be monitored via the radiology teams. The new CRIS system is automated and will resolve the manual processing of examinations, therefore will resolve this issue.

Patient Contacts

In March 2019, there were a total of 9381 patient contacts. There were 344 incidents reported, which amounts to 3.7 per cent of the total patient contacts resulting in an incident. Of those 344 reported incidents, 88 incidents resulted in harm which is 0.9per cent of the total patient contact.

NRLS

The Trust uploaded to the NRLS for 6 out of 6 months between April 2018 and September 2018. The rate of Patient safety Incident per 1000 bed days was 21.42

Organisation name	Rate per 1,000 bed days
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	37.39
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	21.42

Downgraded Incidents

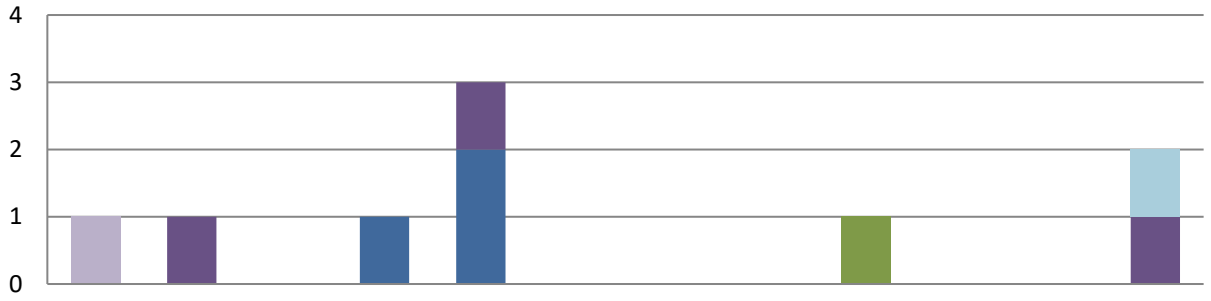
3 of the 3 reported moderate harms in the previous Quality report have been downgraded to No Harm.

Department	Cause 1
H D U	Emergency Transfer Into The Trust
Ward 1	Emergency Transfer Out Of Trust - Other

ACTIONS FOR IMPROVEMENTS / LEARNING
• Implementation of the Health Assure system - Project plan was on the agenda of Quality and Safety in March 2019 – Allocate had cancelled CQC module training in April 2019 causing delay to the project plan. Training in the process of being rescheduled. • New Incident management policy launched into the Trust via comms and via the Divisional Governance meetings
RISKS / ISSUES
• Risk 265 - Engagement and adherence with staff around learning from incidents and never events. (current risk score 8). • Risk 1193 - Staffing and capacity within the team with two vacancies (current risk score 12). 1 agreed start date for the Clinical Governance Facilitator post and 1 offer made to an apprentice to support the team. • Risk 1194 - Lack of skill in the Trust on the Ulysses system (current risk score 12).

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 2019



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medication												1
Transfer out	1											
Slips, trips & falls		1			1							1
Pressure Ulcers									1			
VTE meeting SI criteria				1	2							

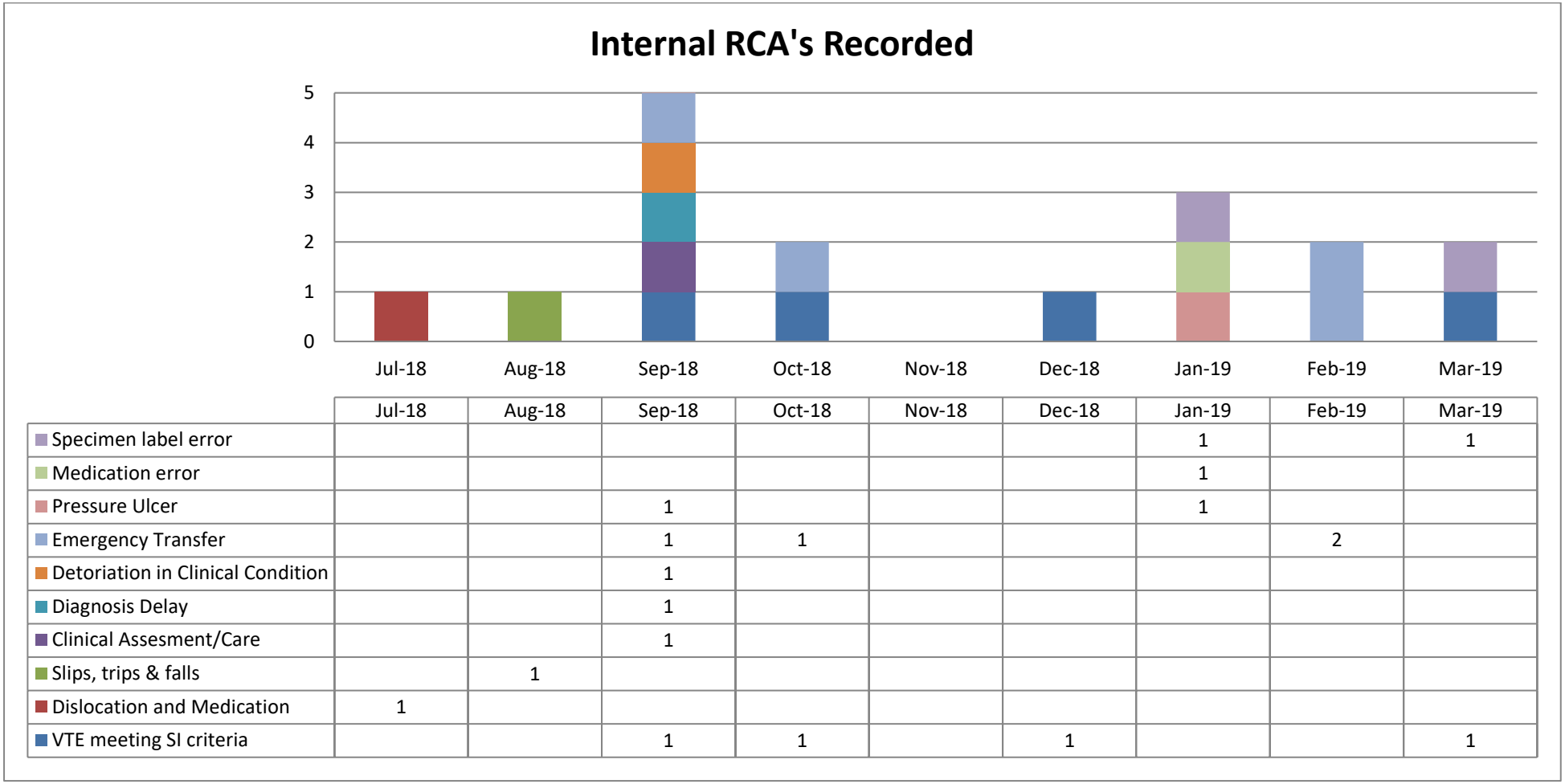
INFORMATION

2 Serious Incidents were reported in March 2019.

Department	Cause 1
Ward 3	Fall - Inpatient
Ward 3	Medication error

ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incident was closed in March 2019. **Lessons Learned** • It is acceptable for a nurse to cut the cast when a patient has complained of pain/burning underneath. • Regular Tissue Viability updates. • Documentation review to improve POP care plans as some sections appear confusing. • Reinforcement of importance to maintain good patient documentation. • The need for clearer guidelines on escalation of concerns.
RISKS / ISSUES
None

4. Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision that a heightened level of response is needed for these incidents.



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Specimen label error							1		1
Medication error							1		
Pressure Ulcer			1				1		
Emergency Transfer			1	1				2	
Detoriation in Clinical Condition			1						
Diagnosis Delay			1						
Clinical Assesment/Care			1						
Slips, trips & falls		1							
Dislocation and Medication	1								
VTE meeting SI criteria			1	1		1			1

INFORMATION

There were two internal RCAs Reported in March 2019

All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.

Department	Cause 1	Actions
Blood Bank, Bone Bank And Specimen Room	Specimen Request - Documentation Issue	**RCA and DoC lead nominated currently under investigation**
ROCS	Thromboembolic Events (Known/Suspected)	**RCA and DoC currently in progress by RoCs and Ward 1.**

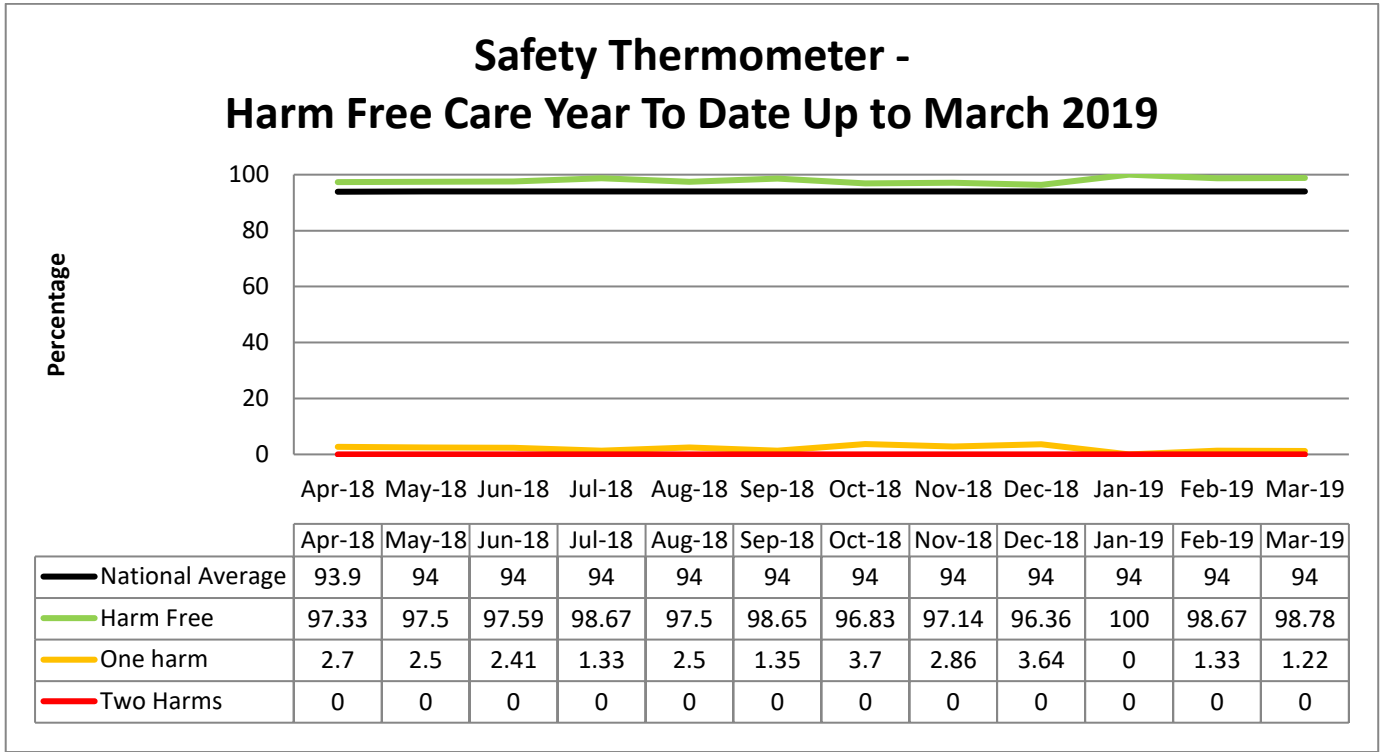
ACTIONS FOR IMPROVEMENTS / LEARNING

No RCAs were due for closure in March 2019.

RISKS / ISSUES

None

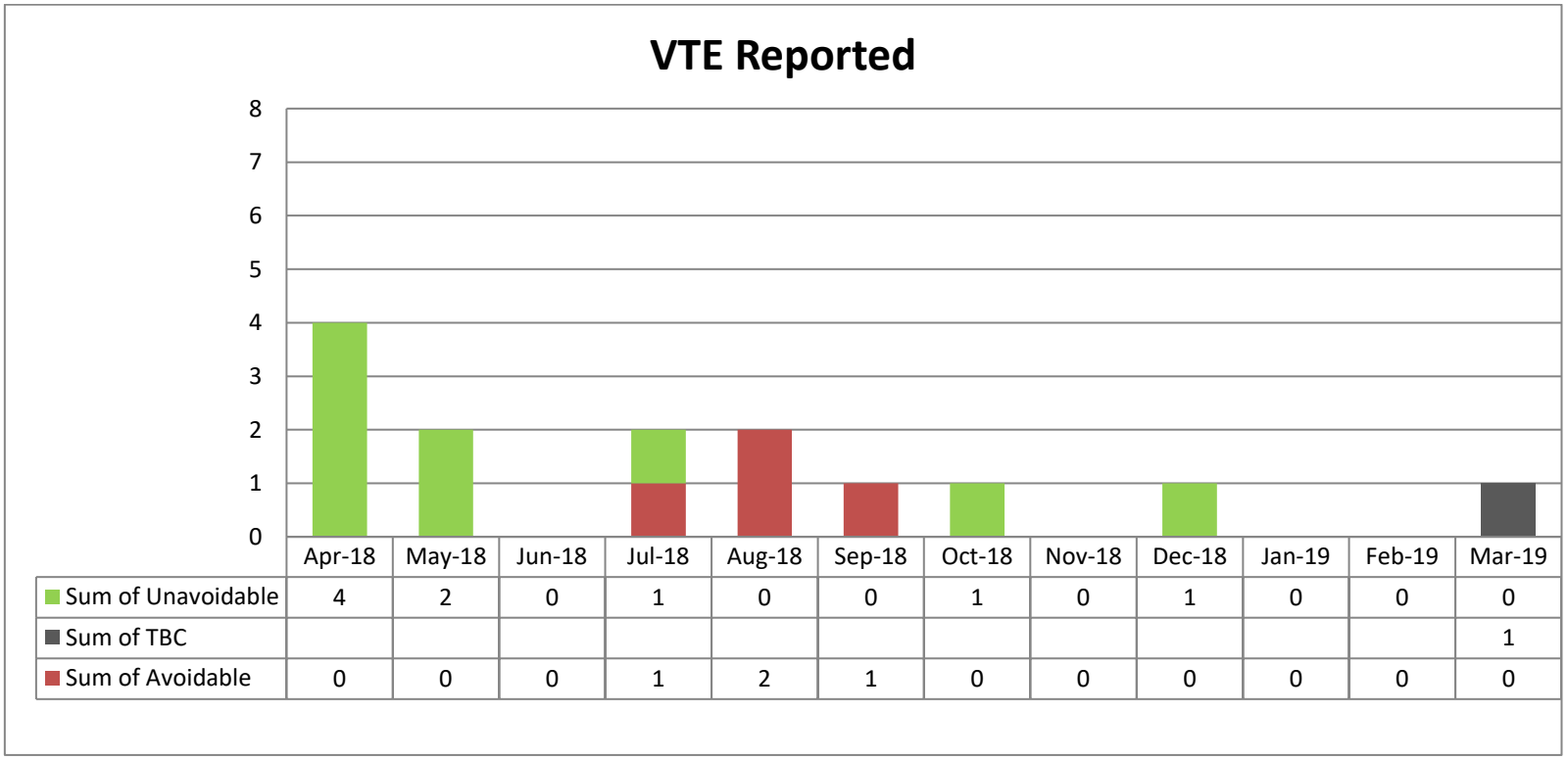
5. NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
National Average	93.9	94	94	94	94	94	94	94	94	94	94	94
Harm Free	97.33	97.5	97.59	98.67	97.5	98.65	96.83	97.14	96.36	100	98.67	98.78
One harm	2.7	2.5	2.41	1.33	2.5	1.35	3.7	2.86	3.64	0	1.33	1.22
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

1 harm = OLD PU on Ward 1

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).



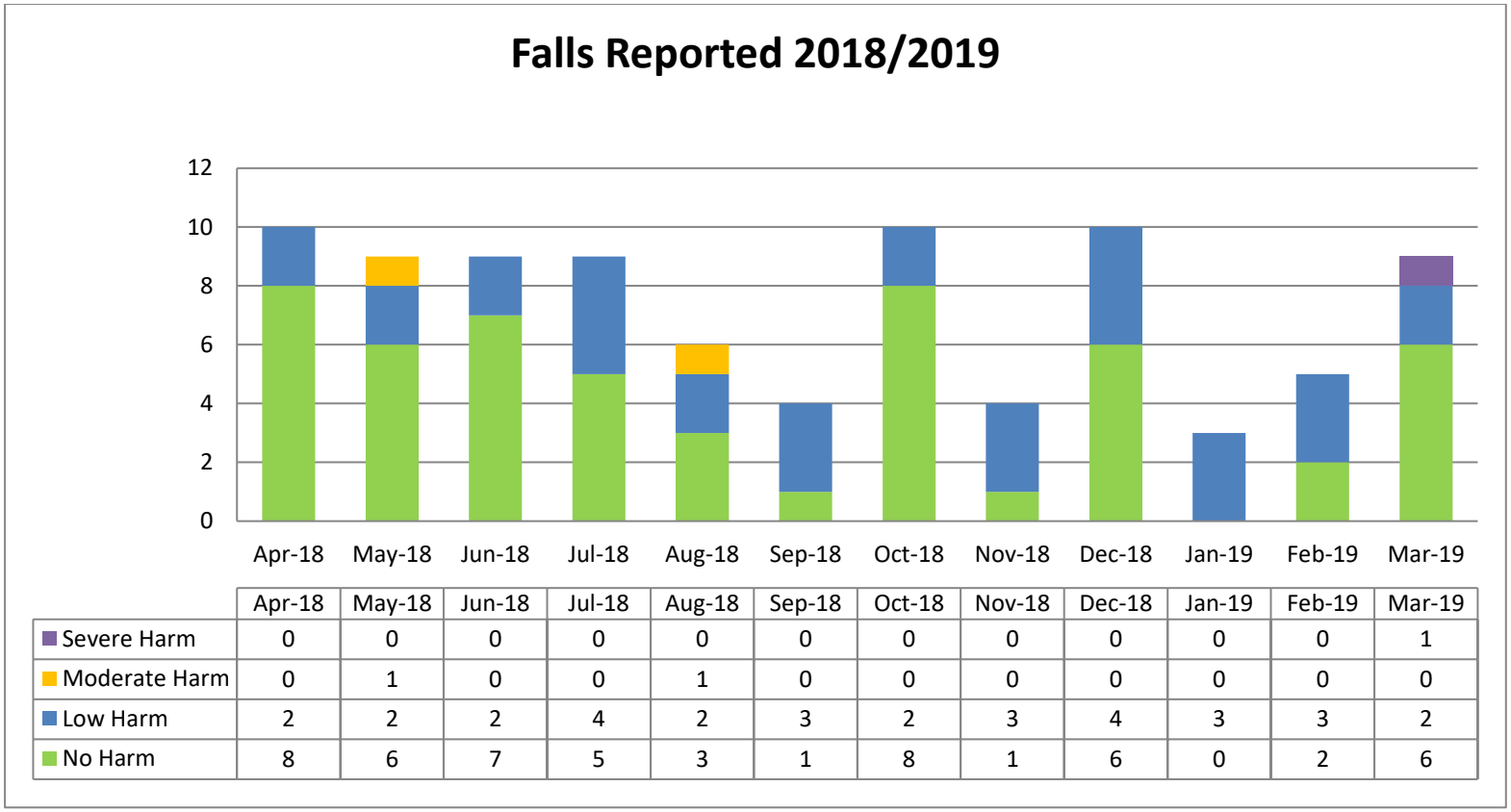
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	4	2	0	1	0	0	1	0	1	0	0	0
Sum of TBC												1
Sum of Avoidable	0	0	0	1	2	1	0	0	0	0	0	0

14

total		Avoidable
17/18	33	10
18/19	13	4

INFORMATION
There has been 1 hospital acquired VTE reported to date in 2019. This DVT occurred post discharge. RCA underway.
ACTIONS FOR IMPROVEMENTS / LEARNING
There is on-going work around the NICE guidance released in March 2019. As reported previously the exemplar network and other hospitals have raised concerns regarding some elements of the guidance. The group continue to benchmark against other Trusts and work with Clinical Service Leads on this. Assurance is provided that the prophylaxis offered to our patients is safe and appropriate. Due to national shortage a swap from Clexane to Inhixa was required. Risk assessments and training was provided. The swap over went smoothly without incident. VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement 95%): February's data is not available at the time of writing but has continued to exceed the minimum requirement. This is being scrutinised by the VTE lead monthly as now this is a mandatory field within PICS we should achieve 100% compliance. Issue identified with day case patients as mandatory field only triggered when medicines prescribed. This has been fed back to theatre teams as confirmation that VTE assessment has been completed and signed as reviewed is a WHO sign in question. This has been escalated at Clinical Quality Group.
RISKS / ISSUES
Poor compliance with mandatory 24 hour re-assessment . This has been escalated and continues to be monitored. Despite now being a mandatory field in PICS compliance is currently 89.5%. Reports obtained from PICS enable identification of who acknowledged/ignored the alerts. This has been escalated to the Medical Director and is being addressed.

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-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	0	0	0	0	0	1
Moderate Harm	0	1	0	0	1	0	0	0	0	0	0	0
Low Harm	2	2	2	4	2	3	2	3	4	3	3	2
No Harm	8	6	7	5	3	1	8	1	6	0	2	6

total	
17/18	125
18/19	88

INFORMATION

There were nine patient fall-related incidents reported across the Trust in March 2019. All the incidents have been subject to a post-fall notes review by the ward manager or deputy. Incident 27107 was reported as severe harm as detailed on Page 5 of this report.

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

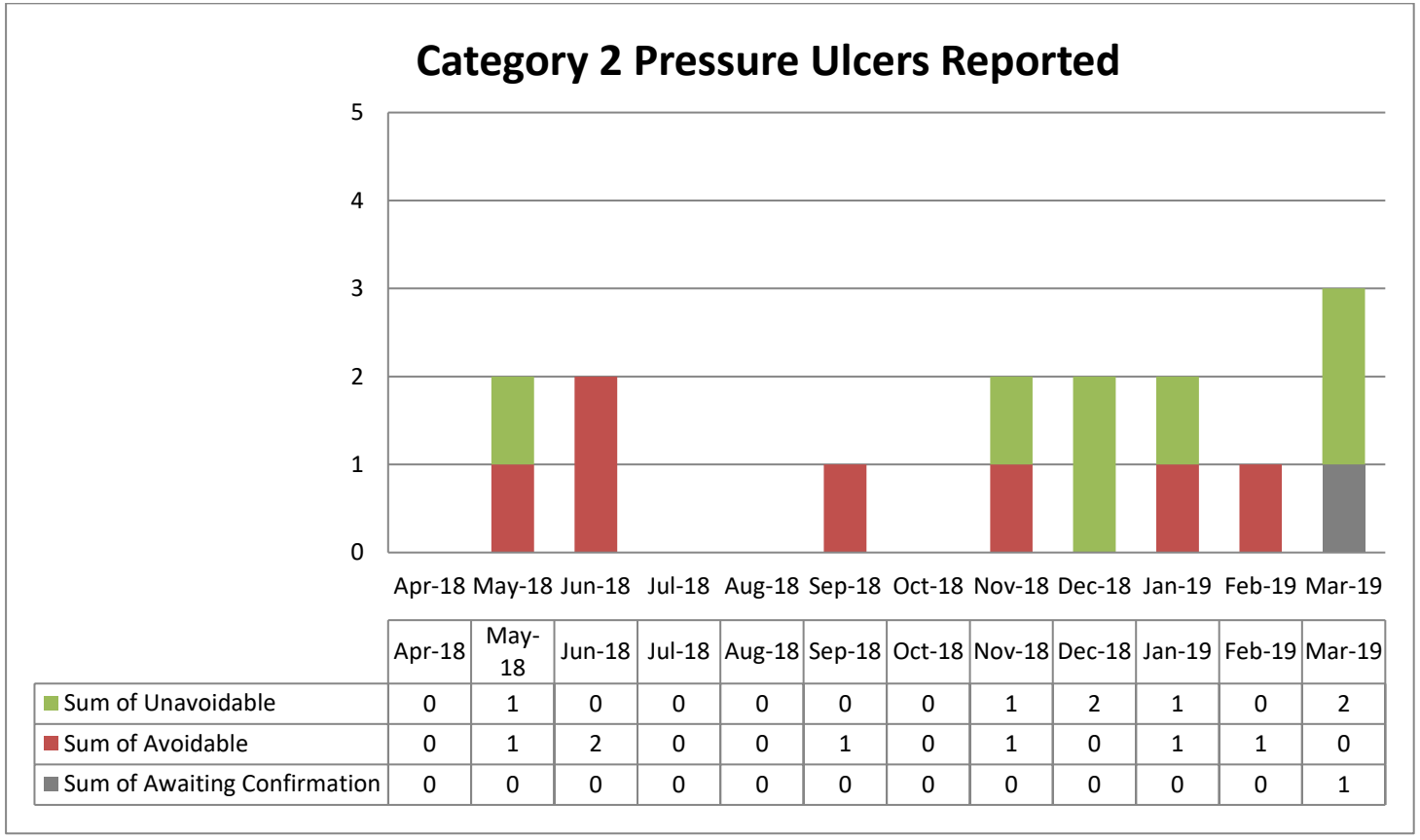
- Purchase of another Hover Jack, to be considered this year- plan to submit a capital bid – no change.
- Trust wide replacement of hoists delayed as funding is not in place. Request submitted to capital bid program for this year – no change, still awaiting outcome of funding
- Review of the benchmarking exercise of the WMQRS – looking at development of fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall.
- On-going development of Throne project.

Positive Assurance

- Staff training on the use of manual handling equipment such as Sara steady.
- Clinical skills update day reinstated to be delivered annually.
- Template for Medical review post fall
- Benchmarking of the WMQRS
- Development of combining falls and dementia working groups to facilitate joined up working – first meeting 27/3/19

RISKS / ISSUES
When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Bid submitted to replace hoists Trust wide.

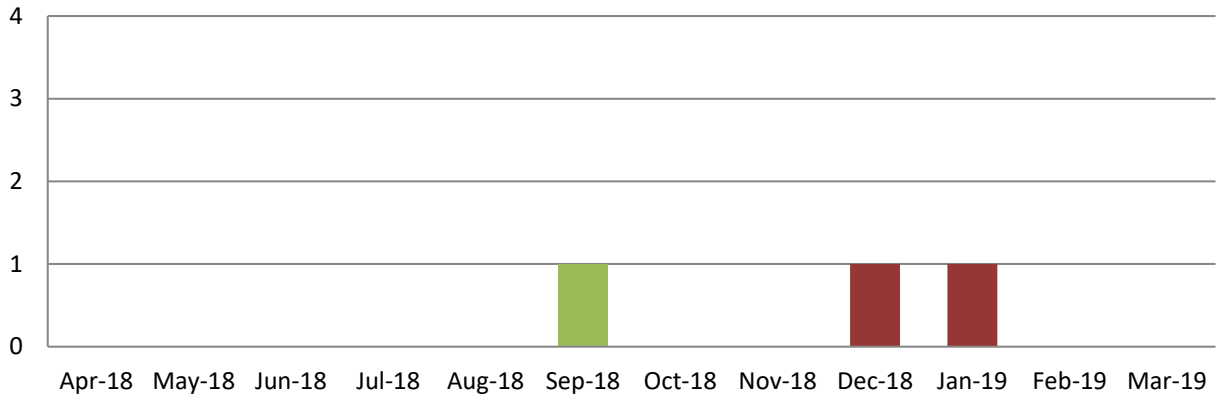
8. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open 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	0	1	2	1	0	2
Sum of Avoidable	0	1	2	0	0	1	0	1	0	1	1	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	1

total	Avoidable
17/18	6
18/19	7

Category 3 and 4 Pressure Ulcers Reported



	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	0	0	0	0	0	0	0
Unavoidable G4	0	0	0	0	0	0	0	0	0	0	0	0
Unavoidable G3	0	0	0	0	0	1	0	0	0	0	0	0
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	0	0	0	0	0	0	1	1	0	0

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	2
	G4	0

INFORMATION

In March 2019 – There was 3 x Category 2 pressure ulcers reports. There was 0 Category 3 / 4 reported.

March 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	Category 2 – x 2 unavoidable following scrutiny
Category – 2 (Device)	Category 2 – AES – Ward 12 – under review
Category – 1	Category 1 – x 1 did not develop further
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	ROH developed – x 3 (all resolved) Patients Admitted - x 7
Patients admitted with PU's	Category 3 – x 1 (patients home) Category 2 – x 1 (patients home)

Avoidable Pressure Ulcer CCG Contracts KPI

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

2017/2018:

2017/2018	
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

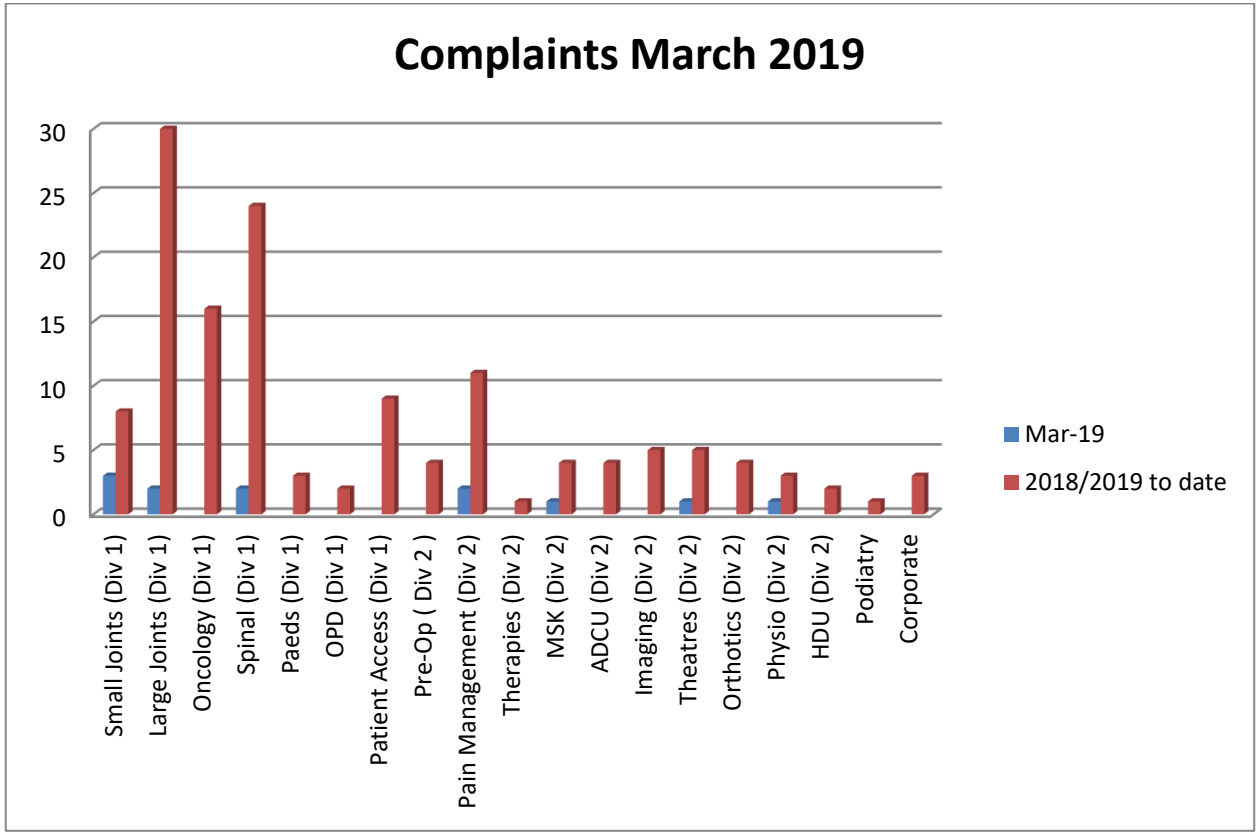
- The POP plaster cast care plan has been. Amended SOP in progress. Extra training to be given to staff during theatre shutdown week regarding plaster care and removal of POP.
- The MDT pathway documentation will be amended at general review in May 2019 to re make it clearer when Anti-embolic stockings are removed and skin checked.
- All Trusts were required to have implemented the NHSI recommendations 2018 for pressure ulcers: revised definition and measurement, by the end of March 2019. ROH was compliant from Sept 2018.
- Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (March 2019). ROH fully compliant
- Trust wide mattress audit to be undertaken on 25/4/19.
- National closed Facebook group- accessible for TVNs only, received a BJN national award for innovation – March 2019, TV team at ROH part of group.
- As a result of the investigations and RCAs related to an ROH developed category 3.

    1. 5 key message training given immediately
    2. Key information left on notice board
    3. TV team will give ongoing support
    4. ROH training to all staff updated
    5. Quality day with a focus on learning from TV incidents

RISKS / ISSUES

None

9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



INFORMATION

PALS

The PALS department handled 63 contacts during March 2019 of which 38 classified as concerns. This is a significant reduction in calls compared to the same time last year (343 contacts in March 2018) and a reduction in the level of concerns (70 concerns in March 2018). The main themes in the PALS data relate to queries about appointments (either length of wait for or cancellations) and administrative processes. 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 82% of concerns were handled within the agreed timescales, meeting this internal KPI.

PALS concerns by theme	Mar-19
Access to treatment	1
Admission & Discharge	4
Appointments	11
Clinical	5
Communication	2
Facilities	1
Trust Administration	10
Values & Behaviours	1
Waiting times	3

Compliments

There were 647 compliments recorded in March 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments March 2019
Div. 1	461
Div. 2	185
Div. 4	1

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 receive a request monthly to submit their compliments for central logging.

Complaints

There were 12 formal complaints made in March 2019, bringing the total number of complaint to 139 for the year to date. All were initially risk rated amber or yellow. This is less than last year (16 complaints in March 2018). Two complaints during the year were withdrawn, leaving 137 for the year. This is a 7% decrease on last year (148 in 2017/2018)

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Wait for spinal surgery (Div.1, Spinal)
- Treatment in pain management & shoulder service (Div.2, Pain Management)
- Management of special needs (Div.1, Spinal)
- Approach of administrator (Div.2, MSK)

Initially Risk Rated Yellow:

- Approach of Consultant (Div.1, Small Joint)
- Refused new crutches - wants refund for the new ones he bought (Div.2, Physio)
- Removed from injection list (Div.2, Pain Management)
- Aftercare from surgeon & sec (Div.1, Small Joints)
- Care under Consultant (Div.1, Large Joints)
- Loss of walking stick (Div.2, Theatres)
- Delays in clinic (Div.1, Small Joints)
- Treatment under young adult hip service (Div.1, Large Joints)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 14 complaints closed in March 2019, 12 within the agreed timescales. This gives an 86% completion on time rate and meets the KPI for the month. The average length of time to close complaints in March 2019 was 29.5 days, which is within normal limits.

Learning identified and actions taken as a result of complaints closed in March 2019 include:

- Process of obtaining new products to use via Medical Devices Group is not clear to Clinicians
  Action: Training is being planned at Clinical Audit

- Waiting times for Pain Management Appointments is high
  Action: Number of mitigation steps have been put in place: extra clinics, redirecting referrals, closing out of area referrals

- A member of staff did not provide service in line with Trust Values
  Action: Apology offered, professional conversation undertaken and reflective learning with department undertaken

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

0 comebacks received in March 2019.

10. 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 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 agreed internal targets for all areas and as a result, the data is 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 requested 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 recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In March 2019, 7 concerns were identified from the 1544 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 main areas of concern in March 2019 related to Staffing numbers and Clinical Issues. Information is 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 of 20% for Outpatient services was not met this month. 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 March 2019**	**% of people who would NOT recommend the department in March 2019**	**Number of Reviews submitted in March 2019 (previous month in brackets)**	**Number of Individuals who used the Department in March 2019**	**Department Completion Rate (Mandated at 35%)**
Ward 1	92.9%	1.4%	70 (57)	164	42.7%
Ward 2	100.0%	0.0%	62 (78)	165	37.6%
Ward 3	100.0%	0.0%	26 (36)	66	39.4%
Ward 12	97.4%	0.0%	77 (45)	100	77.0%
Ward 11 (CYP)	100.0%	0.0%	19 (25)	81	23.5%
ADCU	99.4%	1.4%	165 (138)	570	28.9%
HDU	100.0%	0.0%	18 (25)	64	28.1%
CYP HDU	100.0%	0.0%	1 (1)	9	11.1%
Overall Trust Inpatient Response Rate for March 2019					37.1%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2019**	**% of people who would NOT recommend the department in March 2019**	**Number of Reviews submitted in March2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.3%	0.6%	1069 (1162)	13.1%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2019**	**% of people who would NOT recommend the department in March 2019**	**Number of Reviews submitted in March 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	100%	0%	37(38)	28.0%

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 March - 31 March

Your average score for all questions this period

★1 ★2 ★3 ★4 ★5 **4.87**

Reviews this period

1544

Your recommend scores

5 Star Score

4.85

% Likely to recommend

97.2%

% Unlikely to recommend

0.5%

11. Duty of Candour – *The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.*

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. Litigation

New Claims

0 new claims against the Trust were received in March 2019

On-going claims

There are currently 33 on-going claims against the Trust.

32 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*

7 new requests for Pre-Application Disclosure of medical records were received in March 2019.

**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 Inquests

There were no Inquests held in March 2019

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; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases = 859 The total WHO compliance for Theatres in March 2019 **= 100%** **CT area** Total cases = 52 The total WHO compliance for CT in March 2019 **= 100%** **ADCU** The snapshot WHO audit compliance for ADCU in March 2019 = **100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
WHO checklist for ADCU 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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in March 2019 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	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

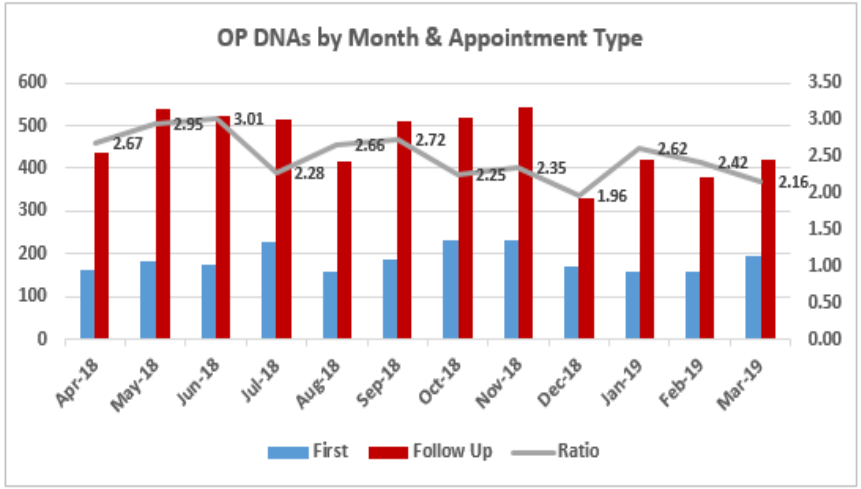
9 IP recorded incidents in March, 2019 (3 no harm, 6 low harm – all either under review or closed).

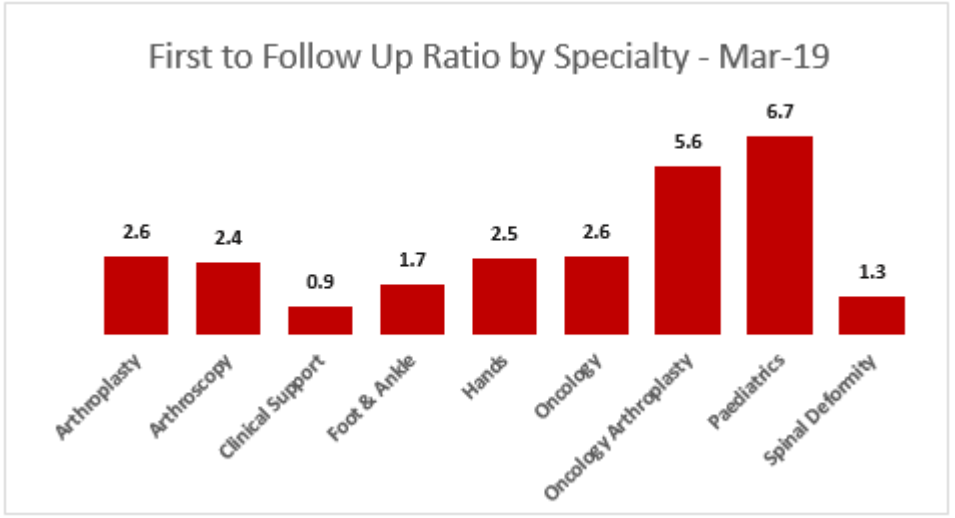
RISKS / ISSUES

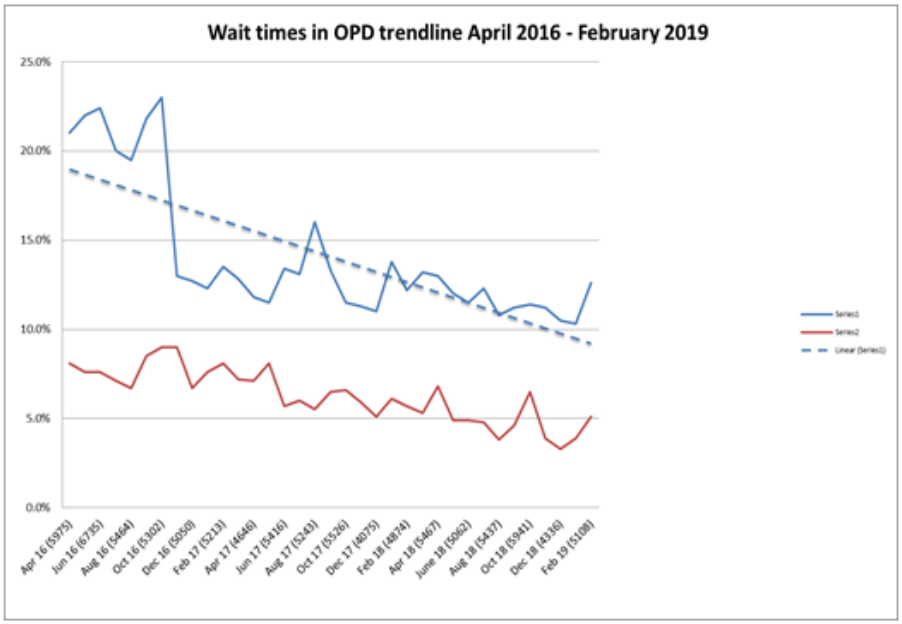
SSI data not submitted for Q4 due to SSI HCA vacancy. This does not pose a risk to ROH as previous 2 quarters had been submitted and required compliance is 1 quarter per annum. The vacancy has now been recruited to and monthly submissions will continue.

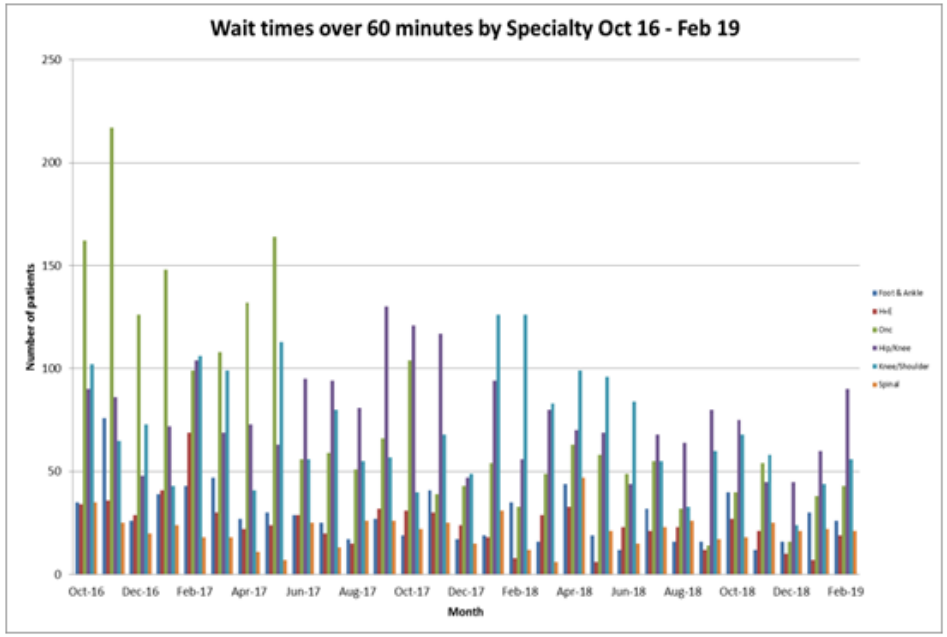
ROH continues to review the status of staff requiring Hepatitis B vaccinations and ensure vaccinations are provided where required.

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









In March there were 11% of patients waiting over 30 minutes which is an improvement from last month. The target for 30 minute delays has still not been achieved but progress has still been good from 22% in May 16. Focussed work is ongoing to continue to improve this position and 4.4% of patients were waiting over 1 hour which was below the target of 5% again.

In addition to the 643 meeting which is held every week to ensure complete room allocations 6 weeks ahead. This ensures that there are rooms available for all clinicians avoiding delays at the start of clinic. It will also help to provide utilisation data in the future at session level. There is an outpatient improvement project that is being set up with the support of the transformation team and this will include utilisation data. As part of this in session utilisation will also be included helping to further identify where, when and why clinic delays occur.

There were 13 incidents of clinic delays reported in March 2019 with the following breakdown.

- 7 complex patient
- clinic overbooked for number of staff
- other
- 1 consultant / clinician delay
- 1 x-ray

The Outpatient Department nursing team are now nearly fully established with the last few appointments awaiting a start date and this will leave just one outstanding qualified post.

There are now 2 notice boards in Outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation. This should further improve communications with clinical staff.

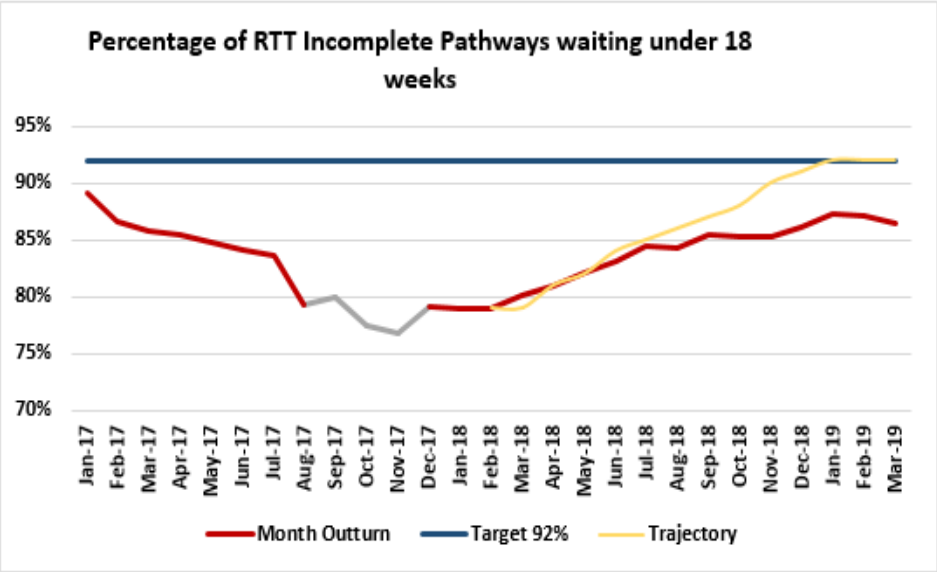
An Outpatient away day is to be held on the 26th of April where all future projects proposed to improve the outpatient service at the ROH will be discussed. This will ensure engagement with the staff about the road map with in the department and staff are being encouraged to raise concerns and ideas with the senior nursing staff.

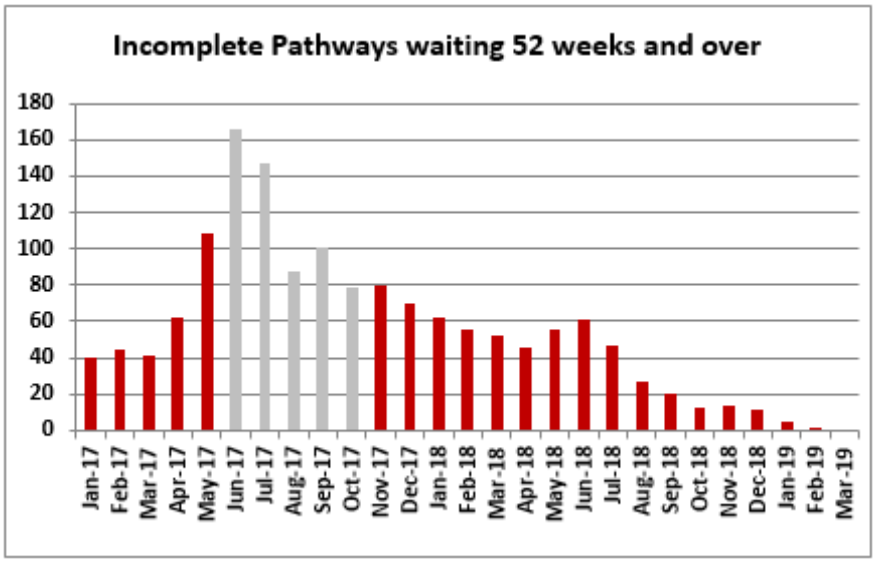
ACTIONS FOR IMPROVEMENTS / LEARNING

- Utilise the outreach clinics at Lordswood whilst investigating further options for additional space either at Lordswood or another site
- Set up the outpatient project improvement group

Risks
• The process for partial booking has been started as a pilot in Pain and this will continue to be monitored. This will need to be reviewed alongside the Appointments team workforce and should there be any impact this will be described with any impact in a business case

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





The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019.

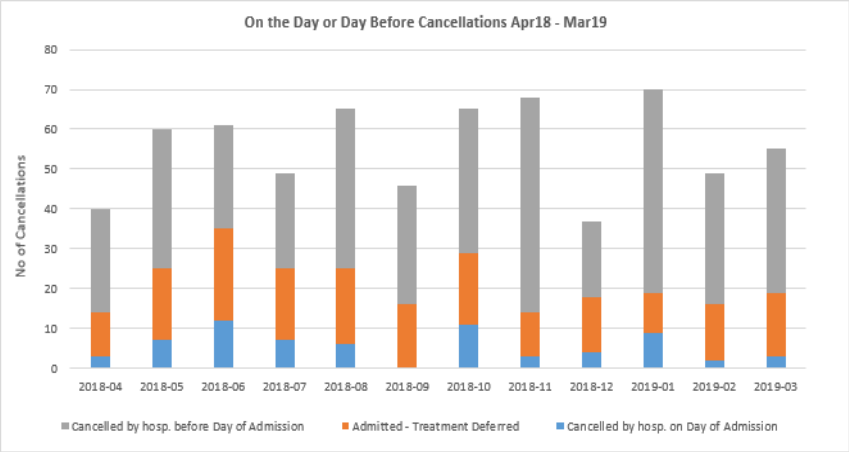
March 2019 performance is **87.37%**

In March the Trust had **0** patients over 52weeks which is a significant achievement for the Trust.

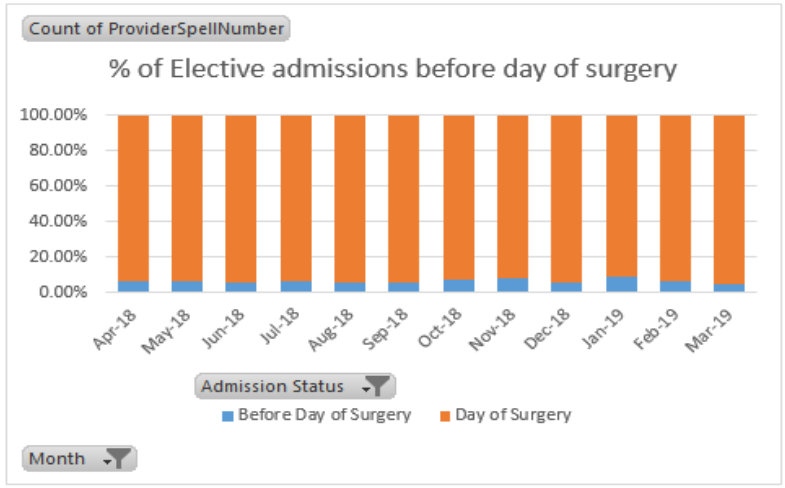
PERFORMANCE/IMPROVEMENTS / LEARNING
The Trust performance for the 62 day target in March is currently at **100%** - this data is due for submission at the beginning of May 2019. Strong performance in February and March has meant that the Trust will hit the target for Quarter 4 **88.2%** which has not historically been met (**Target 85%)** The Trust is also "shadow" monitoring the new 28 day Faster Diagnostic Standard which will be a national performance target in April 2020. The Trust is required to report this from April 2019. The target is **85%** and our performance in February was **82.22%.** The FDS will ensure that patients are told they have cancer, or that cancer is excluded , within a maximum of 28 days from referral. Good progress has been made across the action plan within Cancer Services with the majority of the action plan now being completed. A weekly tracking meeting is now fully embedded with Pathology and Radiology input, which is demonstrating an impact in our improved performance position Somerset IT system has been implemented and over the next few months the new reporting function which is currently being developed will enable more enhanced report to be shared with F&P
RISKS / ISSUES
With the transfer of the Inpatient Paediatric Service in July 2019 to BWC the team will continue to work closely with both teams to minimise any impact on our performance

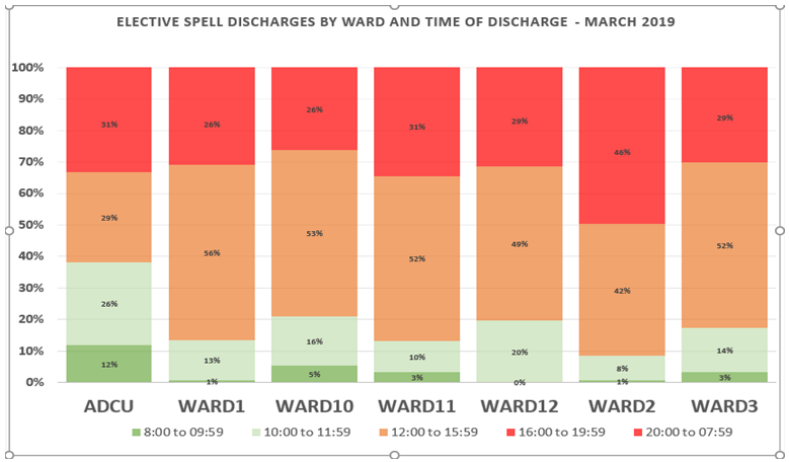
18. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

Hospital Cancellations
Admission the day before surgery



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
2018-04	3	11	26	40	0
2018-05	7	18	35	60	0
2018-06	12	23	26	61	0
2018-07	7	18	24	49	0
2018-08	6	19	40	65	0
2018-09		16	30	46	1
2018-10	11	18	36	65	0
2018-11	3	11	54	68	0
2018-12	4	14	19	37	0
2019-01	9	10	51	70	0
2019-02	2	14	33	49	0
2019-03	3	16	36	55	0
Grand Total	67	188	410	665	1





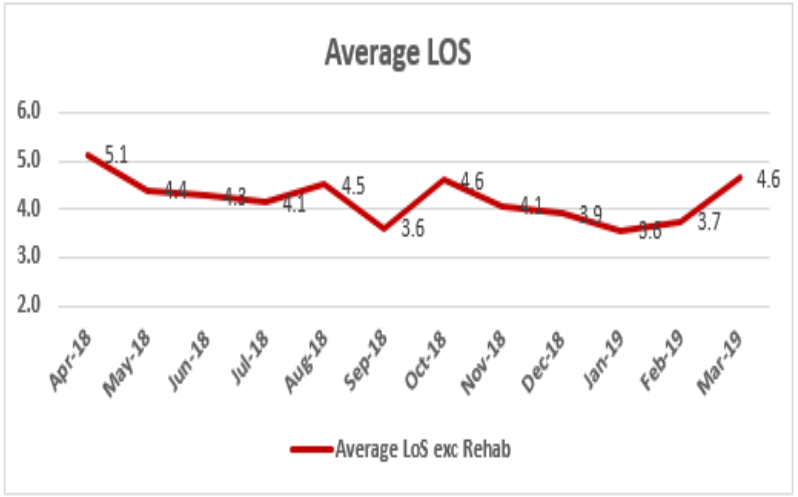
INFORMATION
The number of cancellations on the day of admission for surgery in March was 3 patients , maintaining consistent low figures. Patients admitted for surgery where treatment was deferred has increased slightly in month from 14 to 16. Analysis of patients admitted where treatment was deferred relate to, lack of theatre time and equipment availability. Cancellations before the day of surgery have increased slightly in month from 33 to 36. An analysis of the 36 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 patients declaring fitness issues on the 72 hour contact call . A robust process is now in place to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients . A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance . Work continues to strengthen the POAC process and a business case is being presented at DMB in May 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre was successfully launched on April 8th 2019. This change has been a significant achievement by the team and has already received a great deal of positive feedback from both staff and patients . A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.
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 • POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues • at source and further enhance the 72 hour process. • Escalation to CSM where patients cannot be contacted prior to surgery

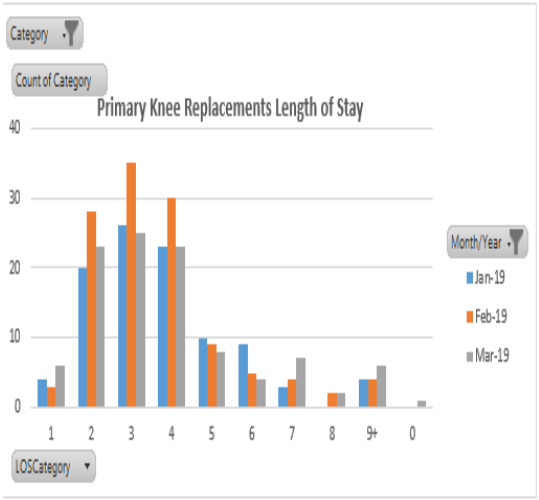
- Review of booking process by secretarial teams to develop a standard Operating procedure working closely with POAC and ADCU

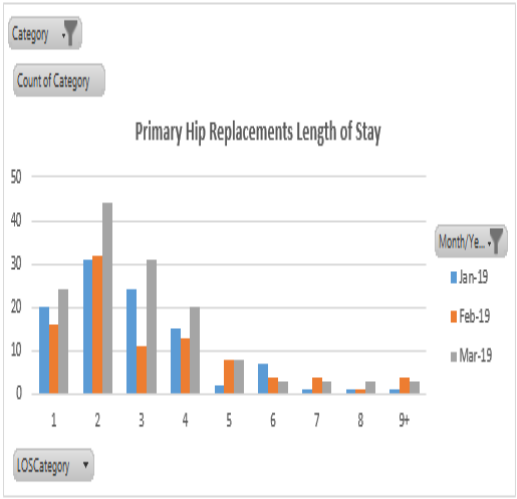
RISKS / ISSUES

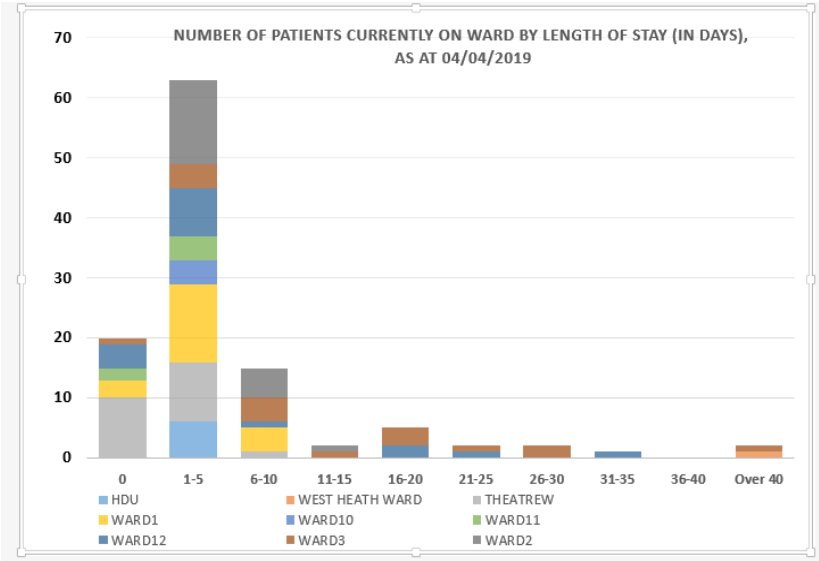
The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

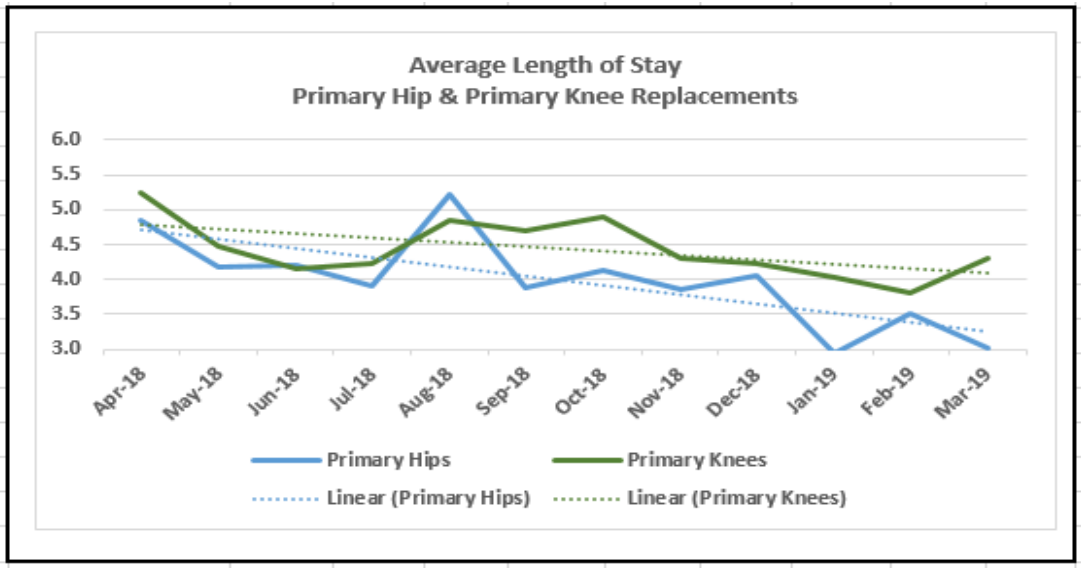
19. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in March was 4.6 days, this is an increase on February 2019 average which was 3.7days. The data gathered demonstrates that LOS for primary hips reduced in month whilst LOS for primary knees increased.

This increase is due to a small cohort of knee patients in month who had complex needs following their surgery resulting in an extended length of stay. In month Ward 3 had 2 primary knee replacements that went on to require intravenous antibiotics due to infection thus extending their length of stay. A further on Ward 3 and Ward 12 patient required complex discharge planning resulting in a delay.

It is therefore concluded that the mean average of 4.6 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives in place to continue to drive down length of stay including:

- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- The discharge lounge is well utilised by all adult inpatient wards. With 267 being discharged in March , and discharges before midday rose to 36% . This is the key focus now for all areas in order to improve efficiency and patient experience.

ACTIONS FOR IMPROVEMENTS / LEARNING
• Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate. • To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Funding secured and recruitment in progress to support out of ours ward clerk support to ensure timely ADT .
RISKS / ISSUES
• A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity . • Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

ROHTB (5/19) 004

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 26 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Expenditure for the month and the year was reported to have been higher than planned, this being driven largely by the heavy reliance on temporary staffing. It was noted that there was a plan for 2019/20 to address this through the use of the use of a mid-level provider model which relied on Advance Nurse Practitioners and Advance Clinical Practitioners. • £1.7m cost savings had been achieved, which was below the plan, but above the minimum expectations for 2019/20. The sign off to proceed with the Managed Service Contract was awaited from Regulators and HM Treasury. • The new faster diagnostic cancer targets which would come into force from April 2020 were described and it was noted that they would be challenging to achieve. The Trust was shadow reporting from April 2019. • It was noted that there was some delay with the implementation of Phase 2 of ePMA; this was currently outside the control of the ROH.	• Consider a means of communicating to all staff the operational and financial successes achieved during the year • Refresh the 'Perfecting Pathways' update to include new initiatives and remove those that had concluded
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was advised that the Control Total for 2018/19 had been met which was agreed to be a significant achievement for the Trust. • It was reported that the Trust would receive an additional £2.5m transitional funding in recognition of the complexity of the orthopaedic work that was handled • There had been a positive recruitment Open Day when 27 offers of employment had been made. This would impact positively on the Trust's use of agency staff in theatres in 2019/20. • Cash was above planned levels and it was reported to be unlikely that a cash loan from the Department of Health and Social Services would be needed for the coming year.	• None specifically

• There were only three cancelled operations during the month. The new pre-operative processes were working more efficiently. • Good performance against the diagnostics target was reported. • Performance against the 18 weeks Referral to Treatment Time target had improved to 87.37% which was slightly above the revised trajectory. Overall, it was noted that this was a significant improvement from the same period during the previous year. • Cancer performance was reported to be good, with the quarterly target having been met and the performance for the previous month being at 100%. • It was reported that sickness would no longer be considered as a standalone item at the Staff Experience & OD Committee given that there was sufficient assurance that this was being controlled and there had been a reduction from the peak noted in October 2018. • There was overall good performance against the 'Perfecting Pathways' projects, including the Clinical Coding element now being at green status. • There was reported to be an expectation that the contract for the Modular Theatres set up would be signed shortly, with the theatres 'going live' by Christmas 2019. • The effectiveness of the Brexit preparedness exercise was noted.	

Chair's comments on the effectiveness of the meeting: The meeting duration had been reduced to an hour, however it was felt that there was sufficient space for important discussions

Finance and Performance Report

March 2019

CONTENTS

INTRODUCTION

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

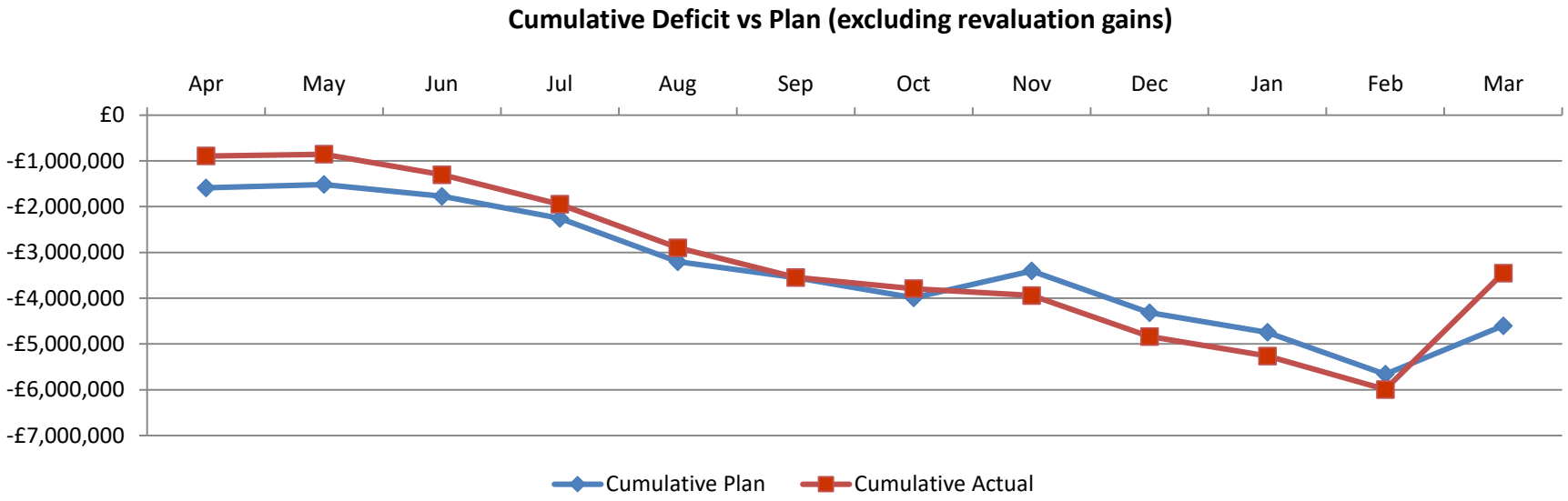
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

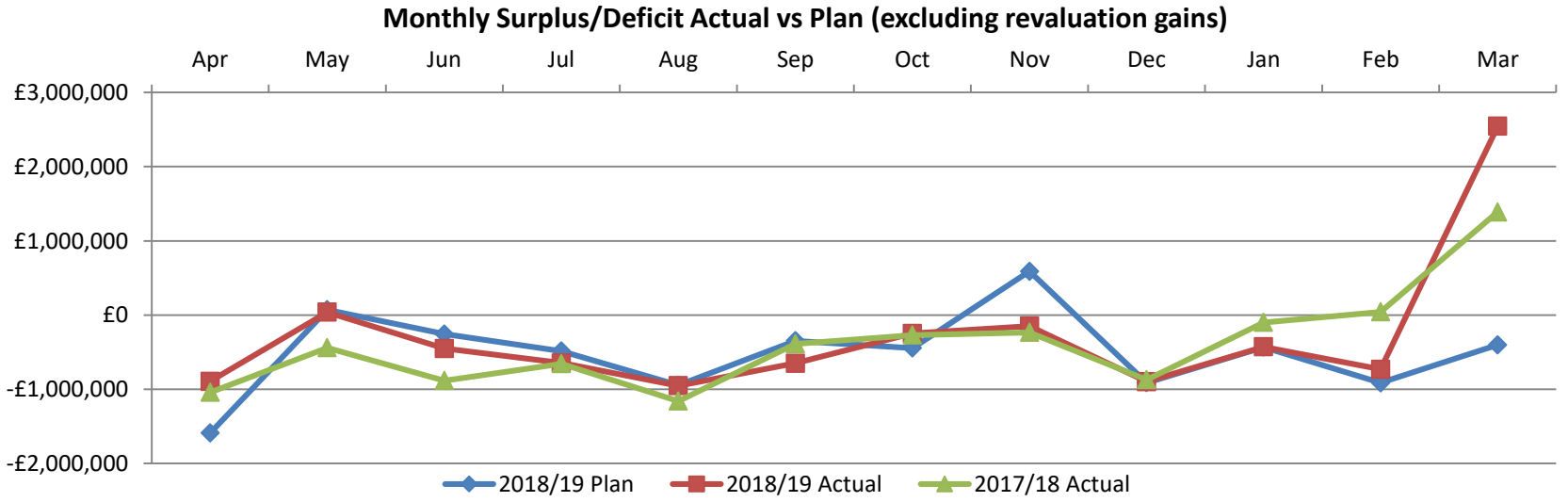
1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M12 Original Plan £'000	YTD M12 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	78,941	80,000	1,059
Other Operating Income	5,141	7,729	2,588
Total Income	**84,082**	**87,729**	**3,647**
Employee Expenses (inc. Agency)	-51,649	-53,597	-1,948
Other operating expenses	-37,091	-37,233	-142
Operating deficit	**-4,658**	**-3,101**	**1,557**
Net Finance Costs	-1,404	-1,132	**272**
Add Back Impairment	0	783	783
Net deficit	**-6,062**	**-3,450**	**2,612**
Remove donated asset I&E impact	60	-272	-332
Adjusted financial performance (inc PSF)	**-6,002**	**-3,722**	**2,280**

NB: Updated figures since F&P to reflect full amount of PSF received

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). This includes PSF.





INFORMATION

Prior to the award of PSF, the Trust delivered an in-month deficit of £90k in March against a planned deficit of £402k, £312k favourable against plan.

Excluding PSF this resulted in an in-year deficit of £6,187k against a control total of £6,615k, an improvement of £428k.

The Trust has also received additional PSF of £1,851k (£2,464k in total) as a result of obtaining it's control total, taking the Trust to a control total deficit of £3,722k, £2,280k ahead of control total including PSF.

The position has been driven by income and non-pay spend being favourable in month. Activity was strong in March, and in addition, following a full stock count at the year end, there was confirmation of an increase in the stock balance in year, which allowed a release of non-pay cost previously prudently recognised in the Income and Expenditure Statement. This was partially offset by an impairment in fixed assets as a result of the year end valuation.

CIP realisation was of a significant challenge in 18-19. £1,688k (57%) was delivered against a plan of £2,985k, (£1,296k) under-performance in-year. The Q4 forecasted CIP position for 18-19 was £1,716k, thus the year-end outturn was in-line with Q4 operational led expectations.

The Trust has a 19/20 CIP target of 1.1% in tariff plus further 0.5% for access to NHS Financial Recovery Funding for 19/20. This is a c. £1,419k target. The Trusts Operational and Clinical teams (alongside their Corporate Partners) are currently working on the delivery of next-year schemes and have identified opportunities (£1,553k) exceeding the £1,419k plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

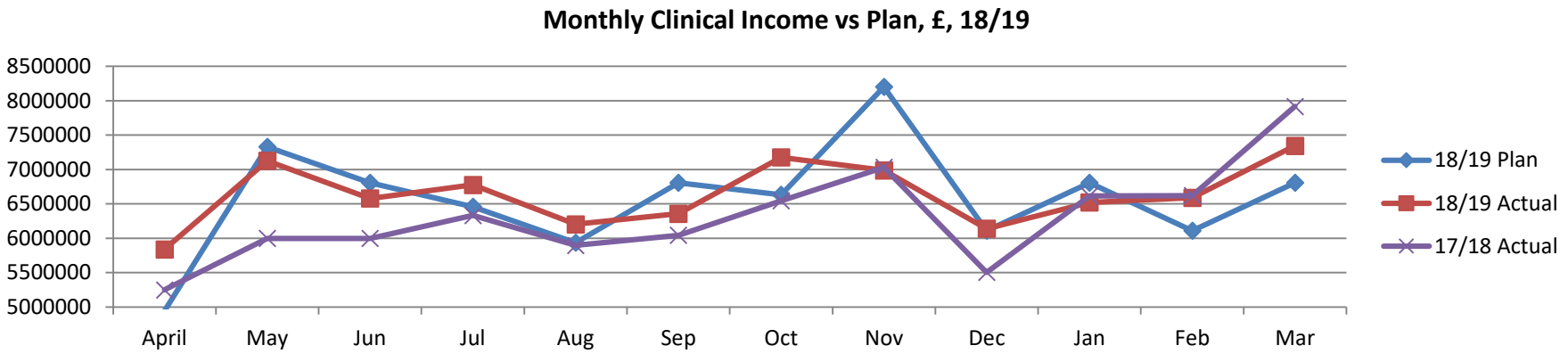
In order to ensure the 19-20 CIP plan is delivered, the Trust is changing its approach to CIP planning and delivery. There will be a number of Executive led cost improvement programmes, with operational, nursing and clinician led projects within each programme. Each project will have a number of key stakeholders, and each project team will work to deliver a project plan in May 19. These plans will be amalgamated to deliver a CIP programme, that will be ultimately signed off and steered by the Executive responsible officer. The Trust is working to identify a stretch target and stretch opportunities for 19-20 to mitigate any slippage or under-performance against identified schemes, in order to prevent a repeat of the under-performance in 18-19. As part of 19-20 CIP planning, the Trust is already identifying detailed CIP opportunities for 20-21.

In order to ensure ongoing monitoring and provide assurance of financial and quality benefits /mitigation to adverse performance, as part of the CIP process and initiation, each scheme will have clearly identified quantitative financial and quality targets to be reported on either monthly or during the PIR stage. (Post implementation Review) In order to ensure that focus on Quality as-well as financial benefits realisation, the 19-20 CIP at ROH will now be referred to as the QCIP (Quality & Cost Improvement Programme).

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. Planning permission has recently been granted and the tenders for the enabling works have been received and opened. A further update will be presented at May Board.

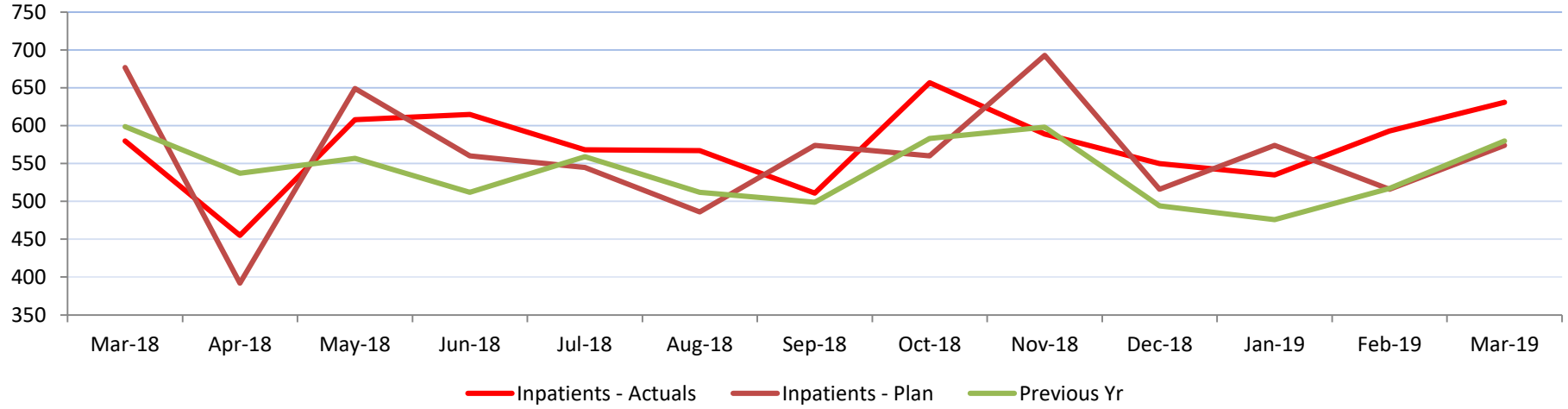
2. Income and Activity– This illustrates the total income generated by the Trust in 2018/19, including the split of income by category, in addition to the month's activity (excl PSF)



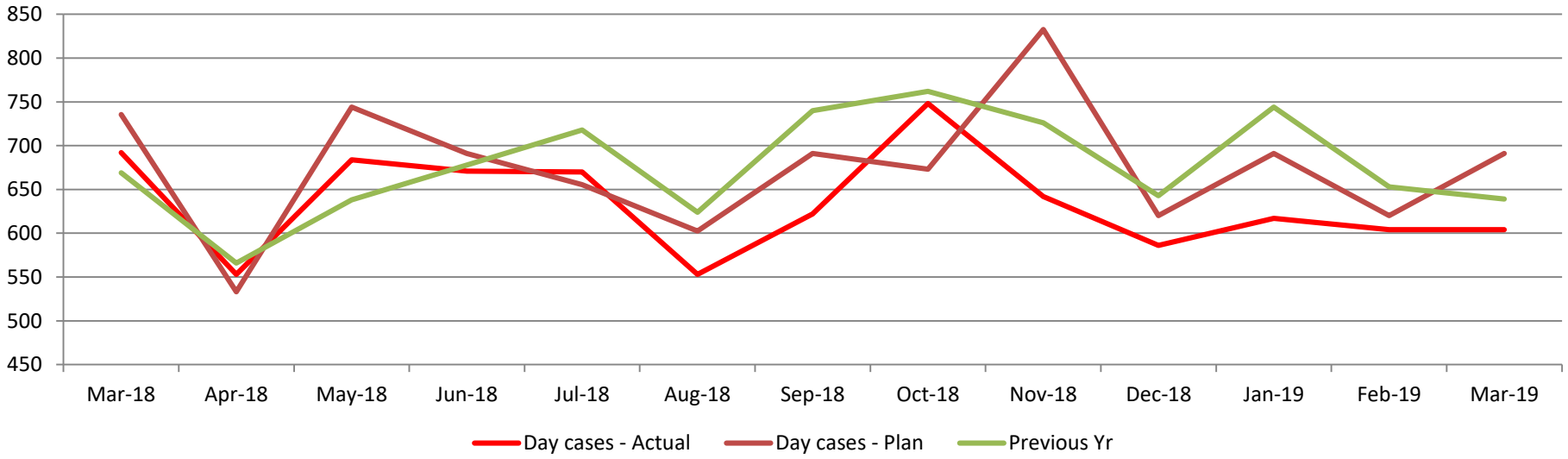
Clinical Income – March 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,595	3,591	-4
Excess Bed Days	42	231	189
Total Inpatients	3,637	3,822	185
Day Cases	856	832	-24
Outpatients	666	675	9
Critical Care	235	152	-83
Therapies	230	241	11
Pass-through income	216	245	29
Other variable income	427	818	391
Block income	539	559	20
TOTAL	6,806	7,344	538

Clinical Income – Year To Date 2018/19 £'000			
	Plan	Actual	Variance
Inpatients	41,699	39,512	-2,187
Excess Bed Days	484	978	494
Total Inpatients	42,183	40,490	-1,693
Day Cases	9925	9951	26
Outpatients	7726	8193	467
Critical Care	2721	2182	-539
Therapies	2669	2930	261
Pass-through income	2509	2814	305
Other variable income	4955	6493	1,538
Block income	6251	6701	450
TOTAL	78,939	79,754	815

Inpatient Activity



Day Case Activity



NHS Clinical income has over-performed against plan by 7.90% in March having over-performed by 7.89% in February. Cumulatively, the trust is now 1.03% above plan for the year.

The admitted patient care performance was slightly below plan financially and but up on activity levels, with discharged activity 46 above target. Average tariff for the period has decreased by £245 per case.

Day case activity underperformed financially and was below the target by 87 cases. The average tariff price for the period has increased by £82 per case.

Outpatients have over-performed year to date with and there has been a decrease in attendances against plan in March for first and follow up attendances . First to follow up ratio has remained steady year to date at 1.92:1.

Other variable income includes NHSE funding for the Paediatric project management and an increase in month of chargeable bespoke prosthesis.

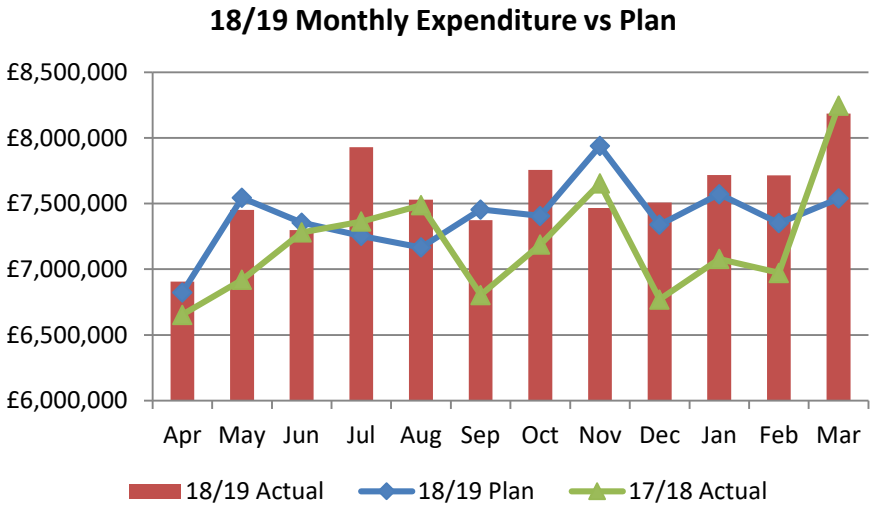
ACTIONS FOR IMPROVEMENT/LEARNING

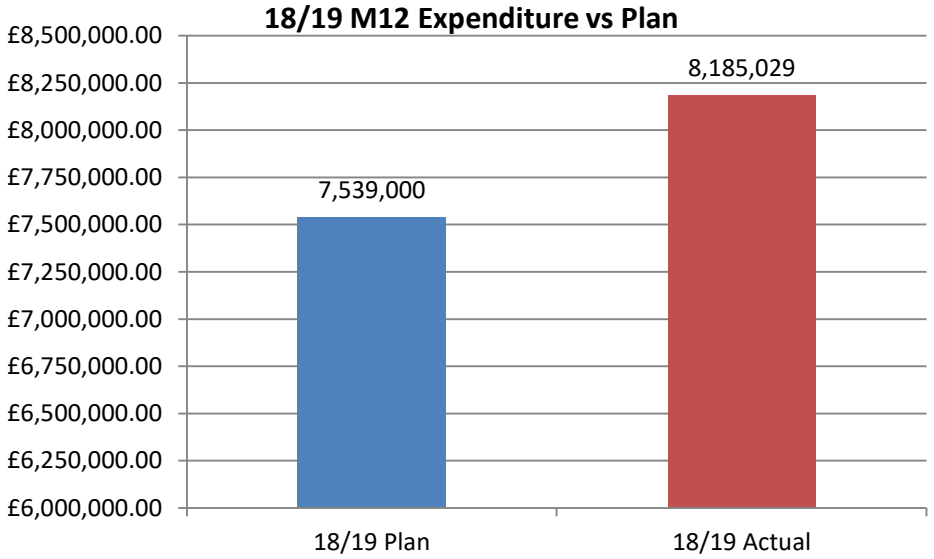
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

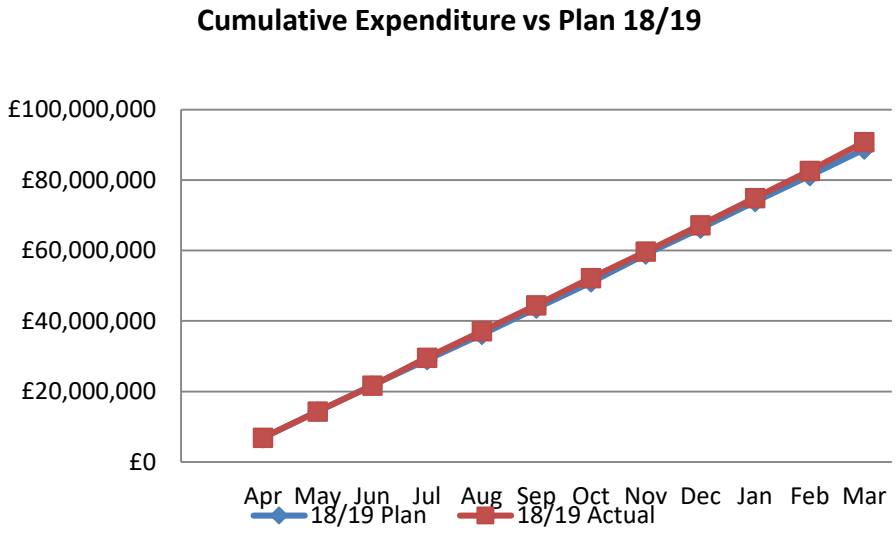
RISKS / ISSUES

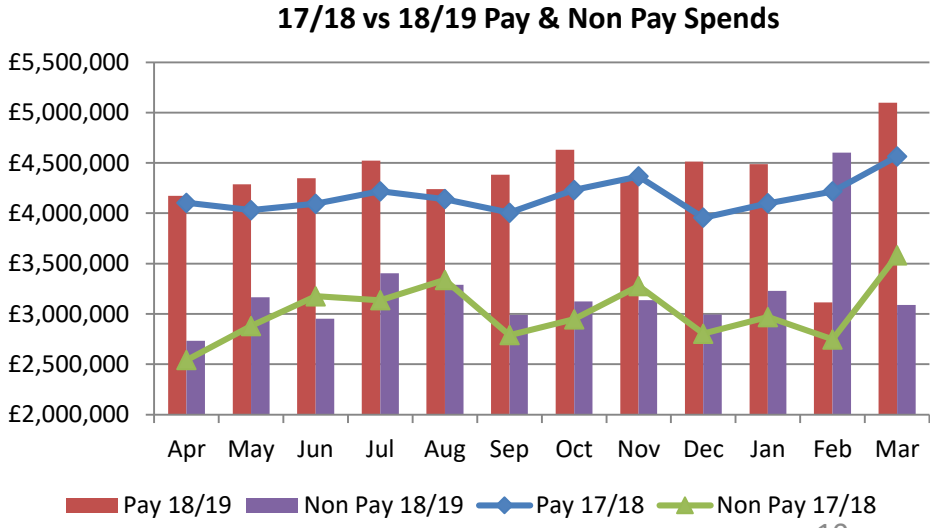
Given that the overall position at M11 is now behind plan, PSF has been removed for as a prudent measure. (circa £328k to M11 in total). This can still be claimed at the year end if the control total is achieved.

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









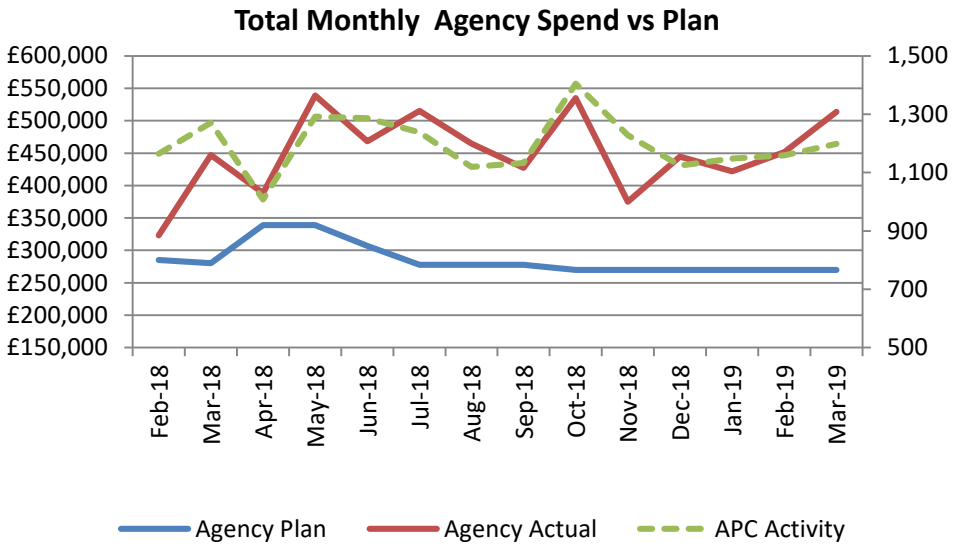
INFORMATION

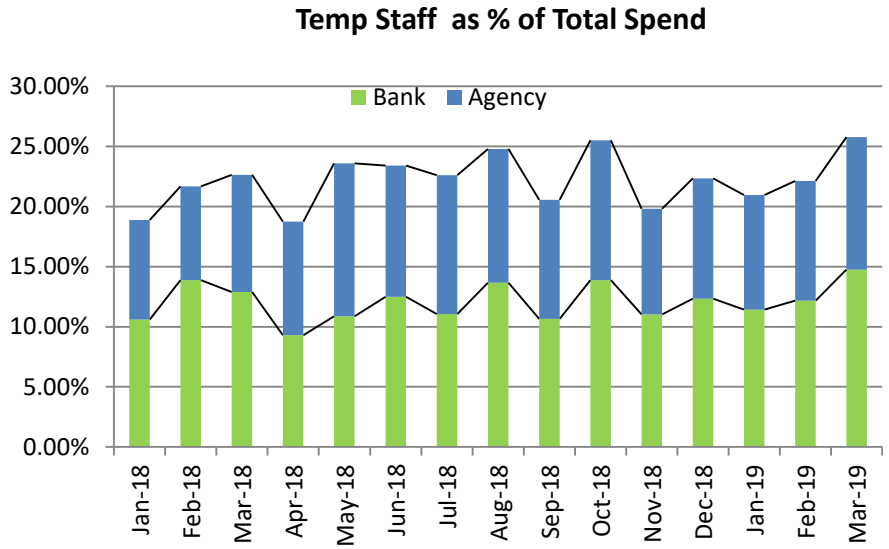
March's expenditure was £8,185k, which was higher than the planned spend of £7,539k. This reflects the increase in activity performed in month, in addition to an impairment in fixed assets as a result of the year end valuation, of which c.£800k was recognised in the Income and Expenditure Statement.

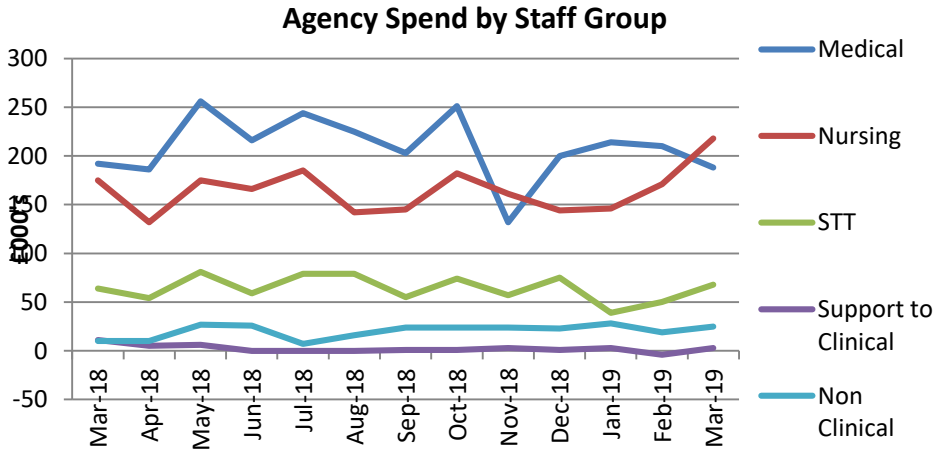
Pay was higher than plan by £698k. Pressure has remained on temporary staffing (medical staffing and nursing) which has increased in month as described on the next pages.

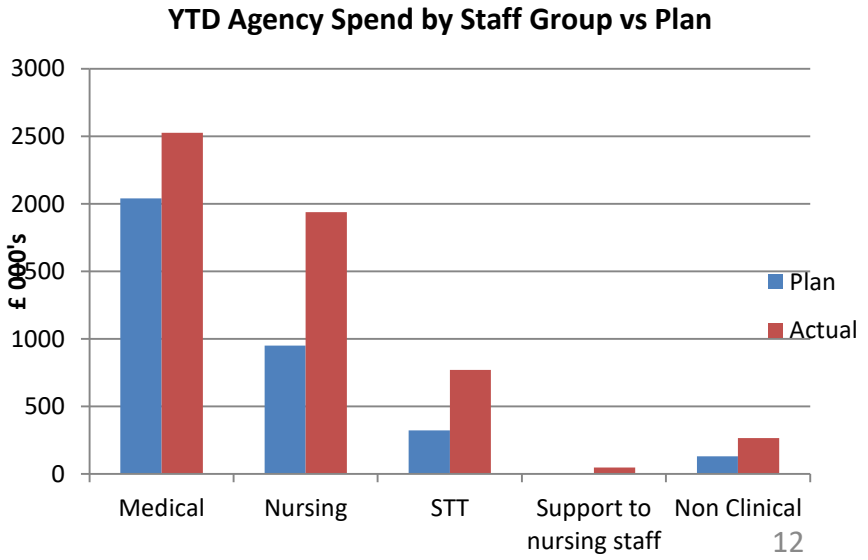
Non pay spend was in line with plan, but within this position there was a release in stock costs as a result of the year end stock count, offset by an impairment on fixed assets as a result of the valuation, and an increase in underlying costs due to the over performance in activity.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Total agency spend has increased in month by £63k, to £514k from £451k in February. The Trust continues to have challenges in the provision of junior doctor cover and as such this continues to be the largest spend on agency, although in month medical agency spend has reduced slightly.

Nursing agency spend has increased from last month circa £47k which mainly relates to ward cover and additional activity.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

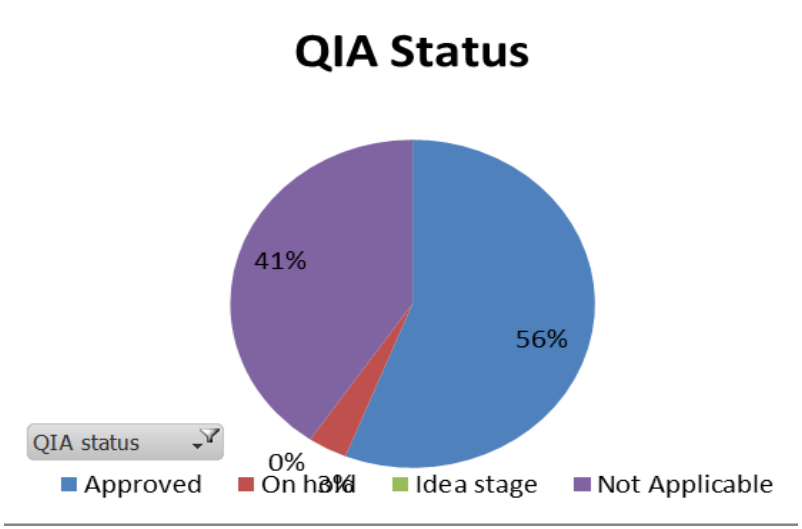
Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

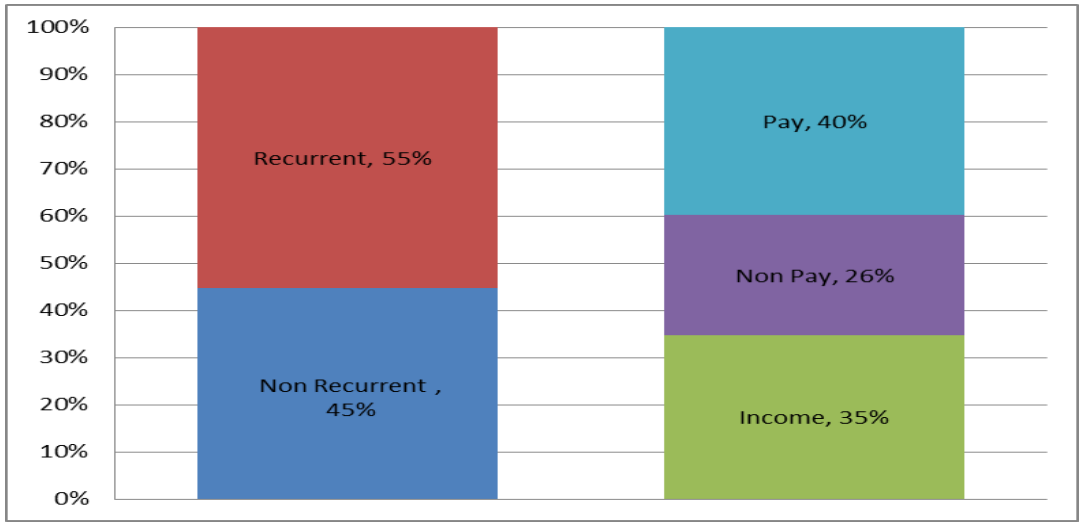
RISKS / ISSUES

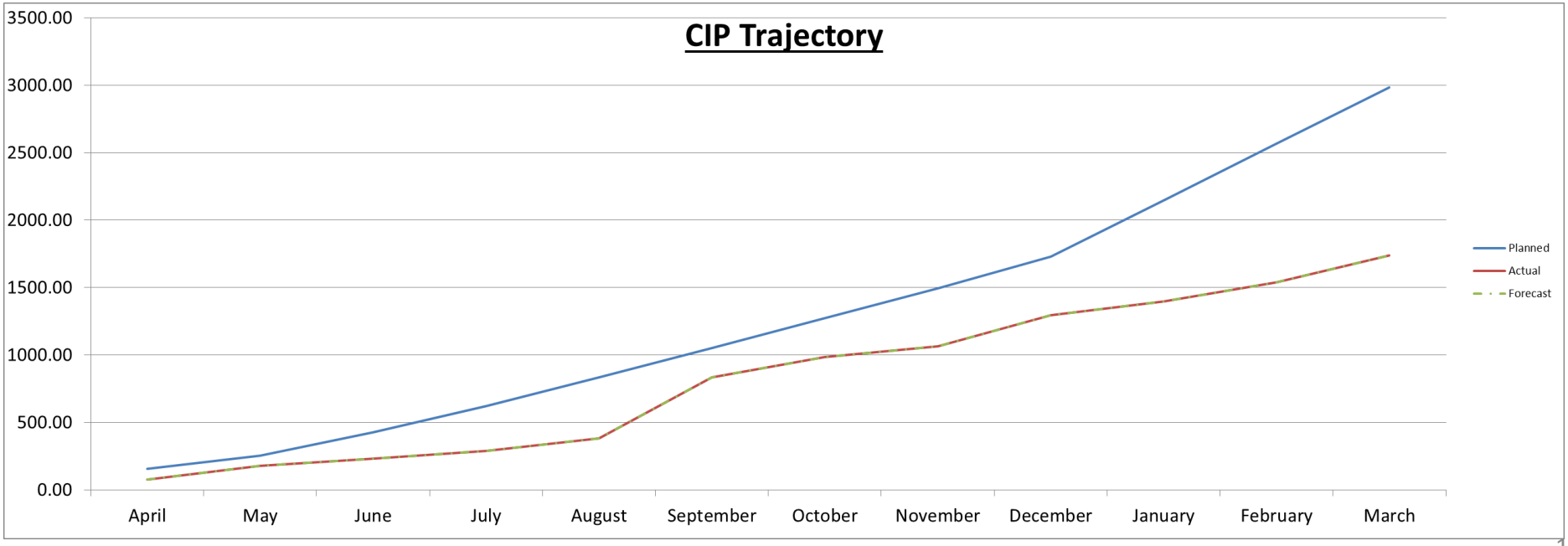
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

The agency cap for 2018/19 has been breached, and due to the pressures in medical spend in particular, it has been planned that the 2019/20 cap will also be breached. The Trust will however continue to consider different models of working in order to try and reduce reliance on agency spend.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2018/19 (£000's)







RMATION

The CIP target for 2018/19 is £3,000k of which £2,985k (99% of target) was identified/planned. ROH delivered £1,688k in 18/19 (57% of planned).

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 %
Corporate	94	17	(78)	1,090	683	(408)	1,090	683	(408)	63%
Division 1	75	12	(62)	705	381	(324)	705	381	(324)	54%
Division 2	245	115	(130)	1,157	589	(567)	1,157	589	(567)	51%
Division 4	5	5	1	33	35	2	33	35	2	108%
Grand Total	**419**	**149**	**(269)**	**2,985**	**1,688**	**(1,296)**	**2,985**	**1,688**	**(1,296)**	**57%**

The summary reasons for YTD under-performance are below:

- Non-delivery and slippage against some clinical and operational saving schemes such as Implant rationalisation, GIRFT recommendations, LOS reduction and clinical pathway/process redesign savings
- Slippage and under-delivery against large scale savings schemes such as Theatres Stock control and Managed Service Contract (£550k planned in-year, has now slipped into 19-20) and Counting & Coding improvement schemes (£312k adverse to plan)
- 18-19 performance is significantly supported by fortuitous changes to national discount rates, enabling the present value reduction of provisions by £120k (this was captured as a non-recurrent CIP in Dec 18) as-well as significant levels of non-recurrent workforce savings
- Minimal support networks (e.g. Procurement and project management teams) to support/drive CIP delivery; with CIP leads focusing on delivering Activity related/Patient care targets , compounded by an outdated CIP delivery model and culture led to minimal engagement in the whole process

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved performance in Q4 vs Q1-Q3, 45% of schemes delivered in-year are non-recurrent, thus the following is planned for 19-20:

- Larger focus on transformation (Outpatients, Theatres) and coding schemes, (engaging clinicians to support this) with focus also on demand and capacity management to deliver cost improvements
- Plans for 19-20 CIP's have been identified; and a review/work up of these are taking place
- Review and change to the current CIP process to ensure a Trustwide engagement of CIP identification and delivery; and ensure adequate resource to support, challenge and drive CIP delivery for CIP stakeholders; focus on changing the culture towards CIP's at the Trust
- Ongoing monitoring and management of CIP's and their impacts on finance and quality from scheme delivery will be actioned via a PIR (post implementation review) to assure the Trust and Quality & Assurance committees (Quality targets will be identified in the PID/initiation process)

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the following schemes:

- Managed Service Contract for Theatres has now been factored in the 19-20 programme. Whilst a project group is driving this forward, it remains a challenging scheme; with significant risks which include non-conformance of the Trust decontamination provider to contracting arrangement requirements, HMRC VAT legislation change risks/exit risk impact assessments, potential impacts from the BSOL procurement collaboration
- Significant workforce CIP schemes have been identified, primarily in Nursing areas via recruitment in 19-20 rather that changing of skill-mix/alternative workforce models
- Monthly operational led forecasting of CIP's and reporting of forecasts; early under-delivery will lead to early planning of recovery/mitigations

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	802	1,389	(587)
Tangible Assets	48,042	46,129	1,913
Total Non-Current Assets	**48,844**	**47,518**	**1,326**
Inventories	4,858	6,752	(1,894)
Trade and other current assets	6,165	6,818	(653)
Cash	1,401	2,655	(1,254)
Total Current Assets	**12,424**	**16,225**	**(3,801)**
Trade and other payables	(12,554)	(15,515)	2,961
Borrowings	(1,252)	(777)	(475)
Provisions	(173)	(84)	(89)
Other liabilities	(207)	(210)	3
Total Current Liabilities	**(14,186)**	**(16,586)**	**2,400**
Borrowings	(8,979)	(10,818)	1,839
Provisions	(354)	(215)	(139)
Total Non-Current Liabilities	**(9,333)**	**(11,033)**	**1,700**
Total Net Assets Employed	**37,749**	**36,124**	**1,625**
Total Taxpayers' and Others' Equity	**37,749**	**36,124**	1,625

INFORMATION

Tangible assets are below plan due to a valuation loss reported at year-end of £1.9m. Intangible assets are higher than plan mostly due to the capitalisation of the IT data centre licences which have been financed via a loan.

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. The Trust borrowed £5.3m from DHSC during 2018/19 and £0.7m in relation to the IT data centre licences.

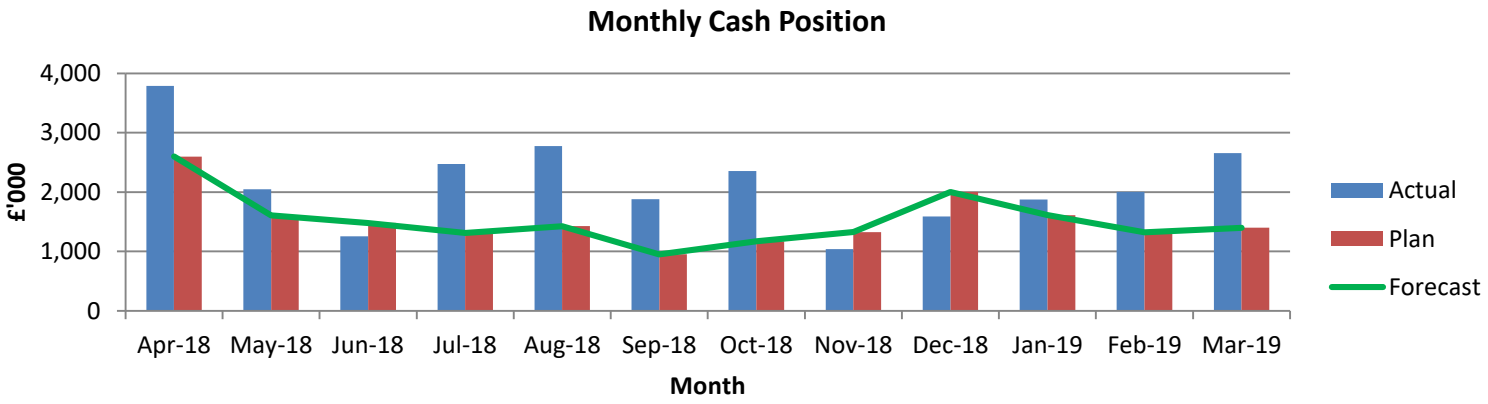
Cash is discussed in more detail on the following pages.

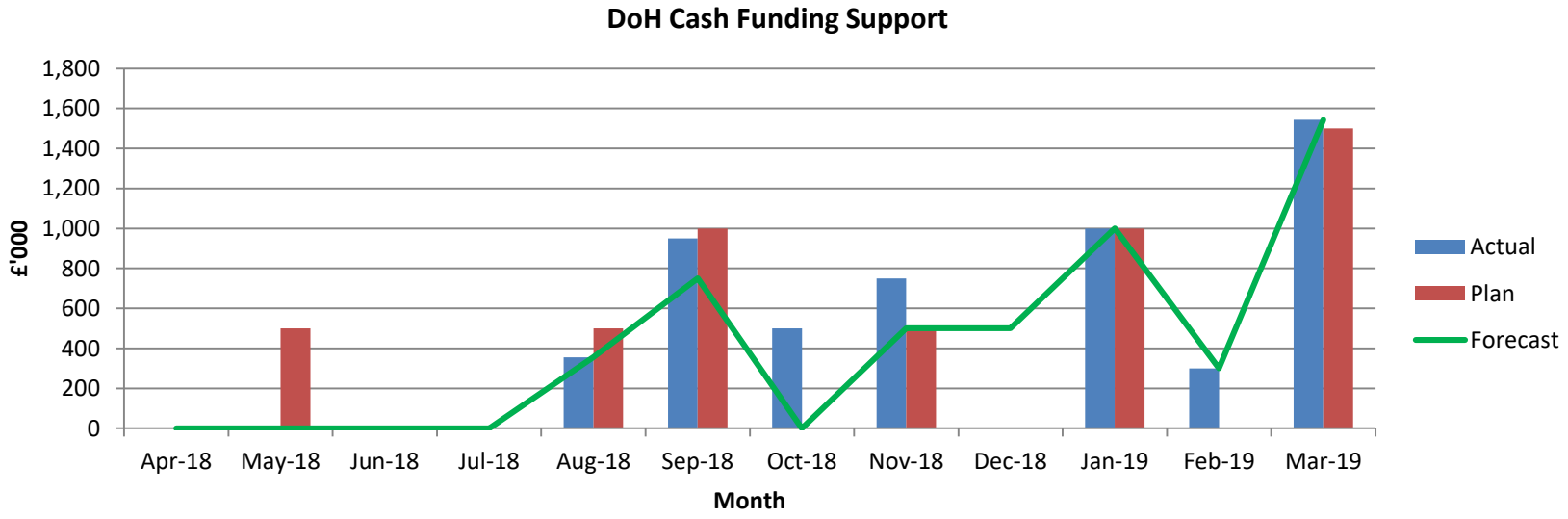
ACTIONS FOR IMPROVEMENTS / LEARNING

Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

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

Cash was £2,655k which is £1,254K higher than forecast. The forecast was made before the confirmation of the additional STF funding received this year, and as such the year end balance is in line with expectation.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

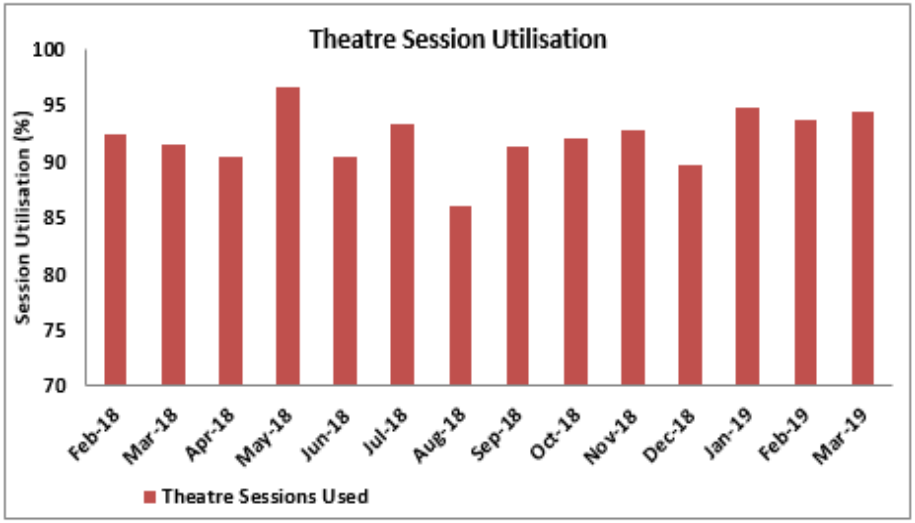
The Head of Financial Accounting continues to run cash control committees attended by the DDoF, and representatives from management accounts and the transaction team, to identify further areas for improvement with regards to cash management.

DoH cash support - Based on the feedback from NHS Improvement the information provided to request funding continues to be 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

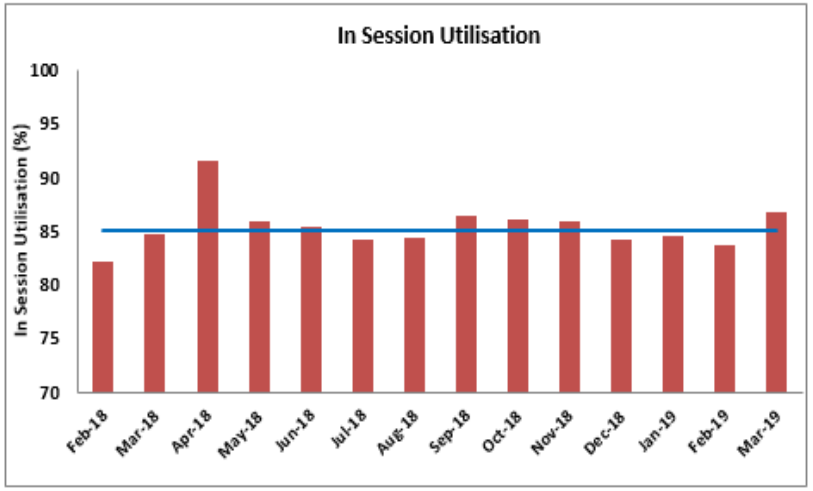
Session utilisation in March was 94.47% compared to February which was 93.63%

Average utilisation for the period April '18 – March '19 ended at 92.19% overall.

RISKS / ISSUES

- Theatre recruitment to support future growth – a successful open day in April 19 resulted in 8 offers being made on the day, building on the success of previous recruitment initiatives

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 saw an improvement for March at 86.76% compared to February which was 83.76%,

In session utilisation remains consistent, running at an average of 86% for the period April '18 – March'19.

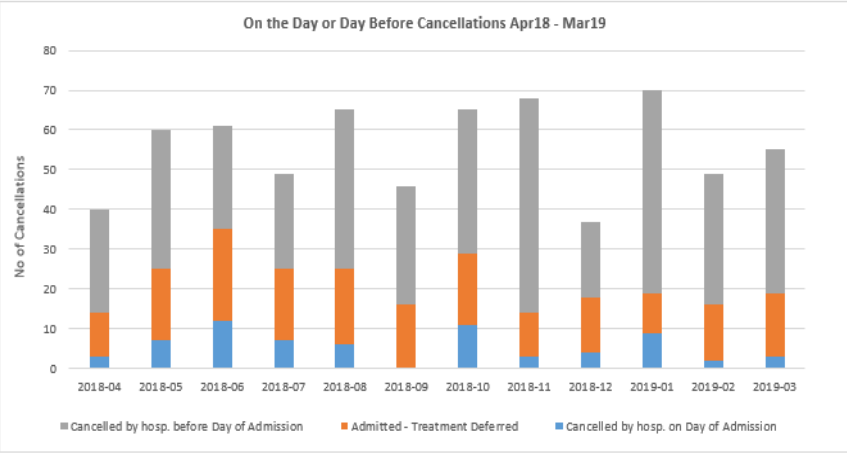
The reconfiguration of POAC, which went live on the 8th April, will have a positive impact on the efficiency of theatre lists going forward.

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
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

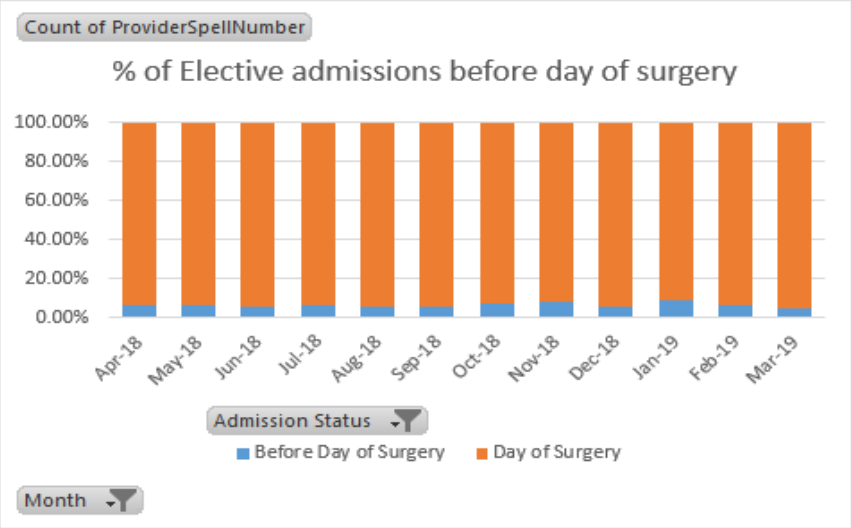
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

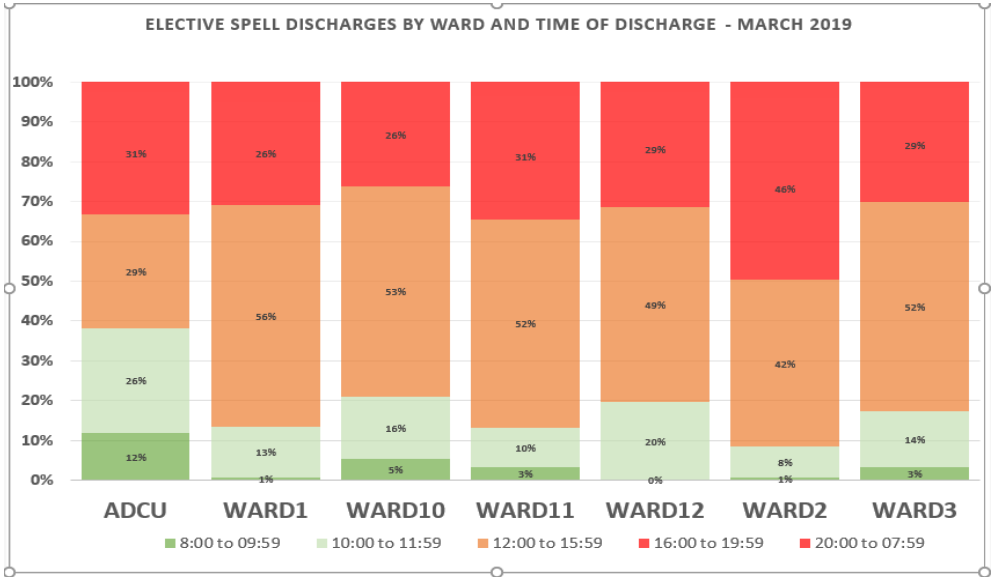
Hospital Cancellations



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
2018-04	3	11	26	40	0
2018-05	7	18	35	60	0
2018-06	12	23	26	61	0
2018-07	7	18	24	49	0
2018-08	6	19	40	65	0
2018-09		16	30	46	1
2018-10	11	18	36	65	0
2018-11	3	11	54	68	0
2018-12	4	14	19	37	0
2019-01	9	10	51	70	0
2019-02	2	14	33	49	0
2019-03	3	16	36	55	0
Grand Total	67	188	410	665	1

Admission the day before surgery





The number of cancellations on the day of admission for surgery in March was 3 patients , maintaining consistent low figures. Patients admitted for surgery where treatment was deferred has increased slightly in month from 14 to 16. Analysis of patients admitted where treatment was deferred relate to, lack of theatre time and equipment availability.

Cancellations before the day of surgery have increased slightly in month from 33 to 36. An analysis of the 36 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 patients declaring fitness issues on the 72 hour contact call .

A robust process is now in place to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in May 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre was successfully launched on April 8th 2019. This change has been a significant achievement by the team and has already received a great deal of positive feedback from both staff and patients .

A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

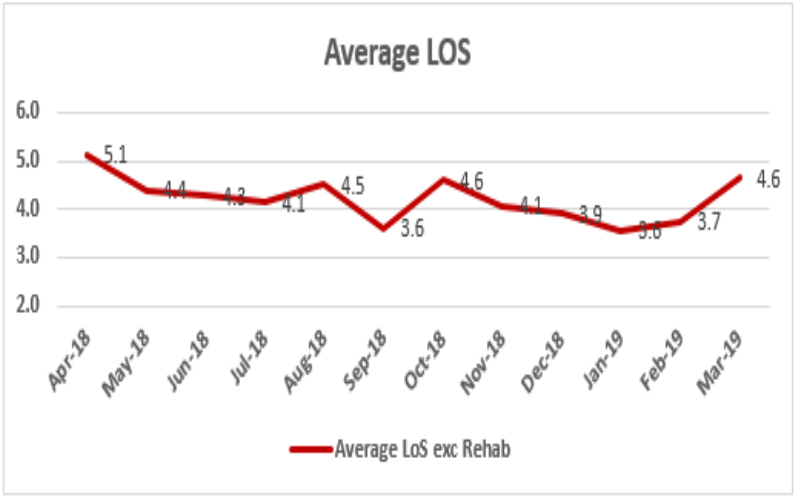
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

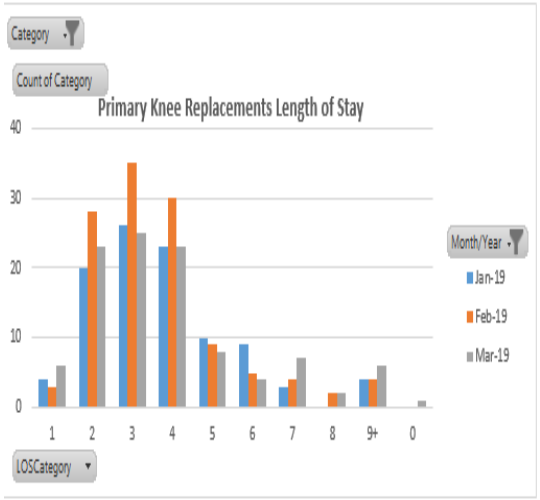
- POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Review of booking process by secretarial teams to develop a standard Operating procedure working closely with POAC and ADCU

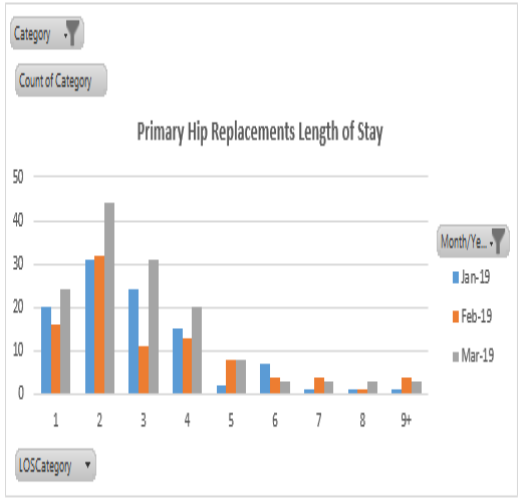
RISKS / ISSUES

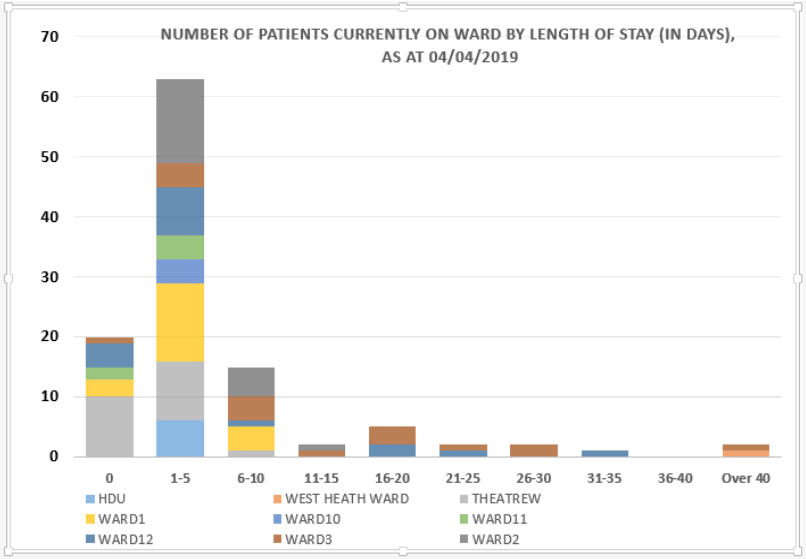
The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

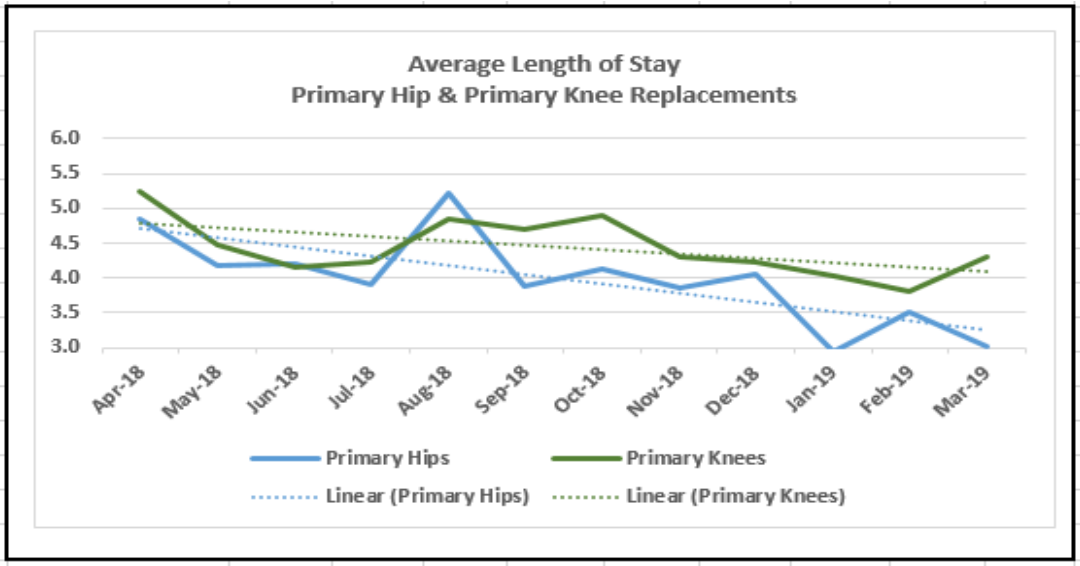
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in March was 4.6 days, this is an increase on February 2019 average which was 3.7days. The data gathered demonstrates that LOS for primary hips reduced in month whilst LOS for primary knees increased.

This increase is due to a small cohort of knee patients in month who had complex needs following their surgery resulting in an extended length of stay. In month Ward 3 had 2 primary knee replacements that went on to require intravenous antibiotics due to infection thus extending their length of stay. A further on Ward 3 and Ward 12 patient required complex discharge planning resulting in a delay.

It is therefore concluded that the mean average of 4.6 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives in place to continue to drive down length of stay including:

- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- The discharge lounge is well utilised by all adult inpatient wards. With 267 being discharged in March , and discharges before midday rose to 36% . This is the key focus now for all areas in order to improve efficiency and patient experience.

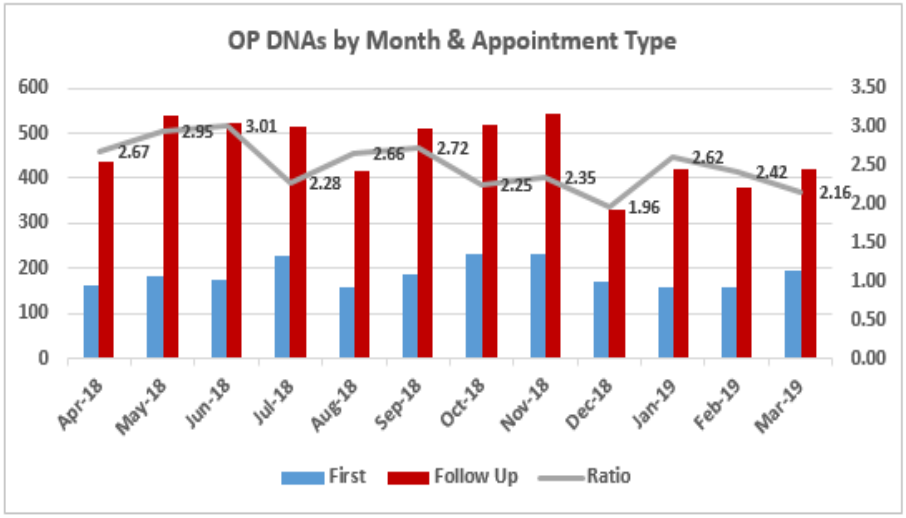
ACTIONS FOR IMPROVEMENTS / LEARNING

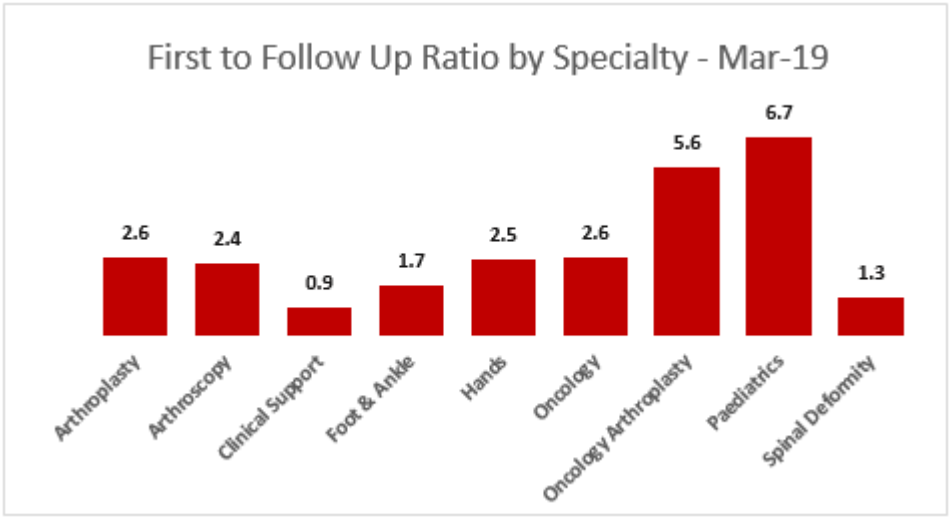
- Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Funding secured and recruitment in progress to support out of ours ward clerk support to ensure timely ADT .

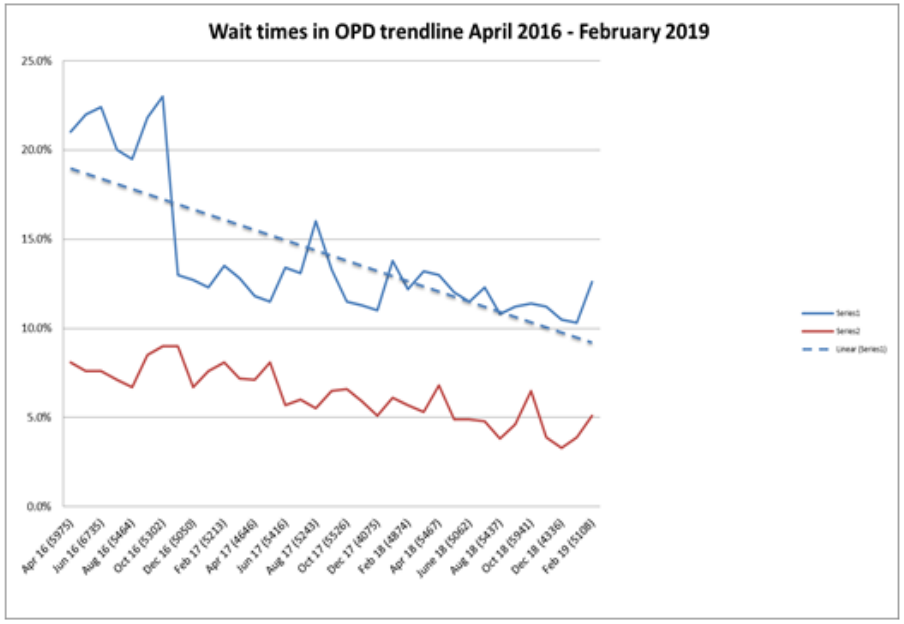
RISKS / ISSUES

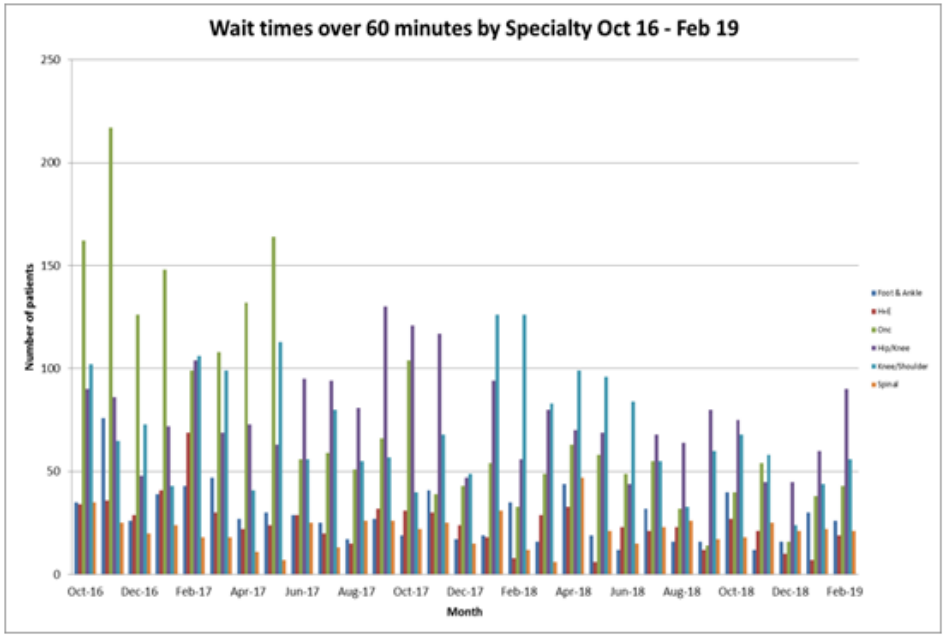
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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









INFORMATION

In March there were 11% of patients waiting over 30 minutes which is an improvement from last month. The target for 30 minute delays has still not been achieved but progress has still been good from 22% in May 16. Focussed work is ongoing to continue to improve this position and 4.4% of patients were waiting over 1 hour which was below the target of 5% again.

In addition to the 643 meeting which is held every week to ensure complete room allocations 6 weeks ahead. This ensures that there are rooms available for all clinicians avoiding delays at the start of clinic. It will also help to provide utilisation data in the future at session level. There is an outpatient improvement project that is being set up with the support of the transformation team and this will include utilisation data. As part of this in session utilisation will also be included helping to further identify where, when and why clinic delays occur.

There were 13 incidents of clinic delays reported in March 2019 with the following breakdown.

- 7 complex patient
- 2 clinic overbooked for number of staff
- 2 other
- 1 consultant / clinician delay
- 1 x-ray

The Outpatient Department nursing team are now nearly fully established with the last few appointments awaiting a start date and this will leave just one outstanding qualified post.

There are now 2 notice boards in Outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation. This should further improve communications with clinical staff.

An Outpatient away day is to be held on the 26th of April where all future projects proposed to improve the outpatient service at the ROH will be discussed. This will ensure engagement with the staff about the road map with in the department and staff are being encouraged to raise concerns and ideas with the senior nursing staff.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Utilise the outreach clinics at Lordswood whilst investigating further options for additional space either at Lordswood or another site
- Set up the outpatient project improvement group

- The process for partial booking has been started as a pilot in Pain and this will continue to be monitored. This will need to be reviewed alongside the Appointments team workforce and should there be any impact this will be described with any impact in a business case

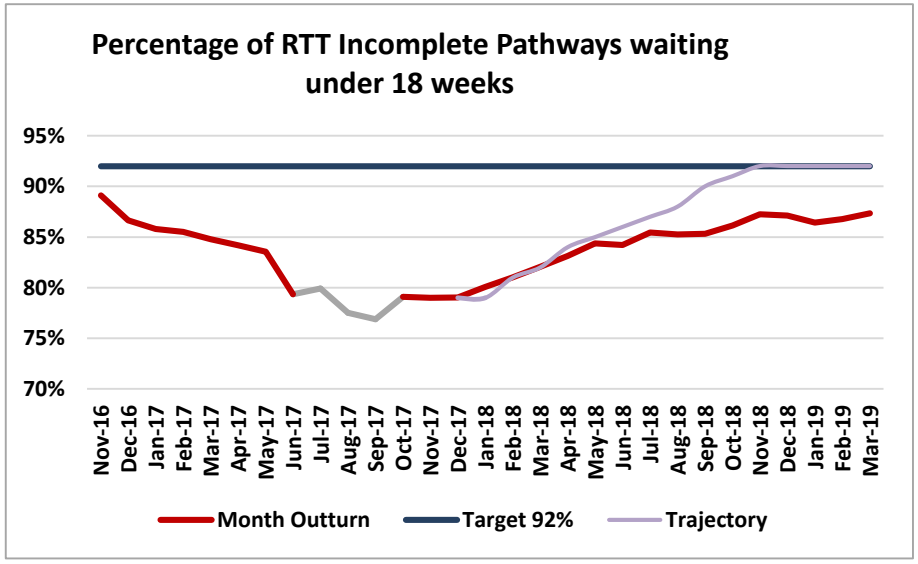
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

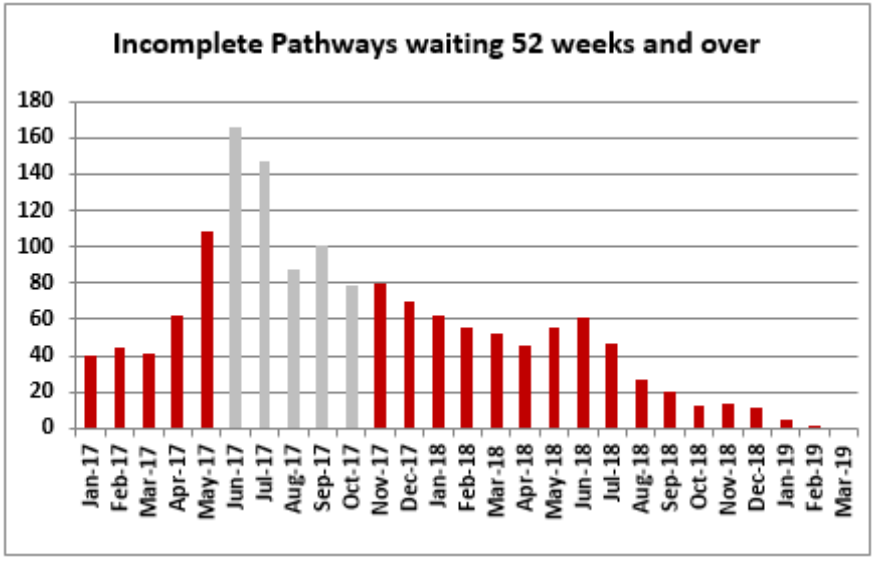
% of patients waiting <6weeks for Diagnostic test.

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	1155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1183	1,186	99.7%
Apr-18	1022	148	409	1,579	850	253	387	1,490	8	1571	1,579	99.5%
May-18	1002	136	353	1,491	725	236	373	1,334	1	1490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1256	1,261	99.6%
Jul-18	732	112	336	1,180	961	211	290	1,462	8	1172	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	1113	1,117	99.6%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1245	1,252	99.4%
Dec-18	698	115	346	1,159	843	224	367	1,434	11	1148	1,159	99.1%
Jan-19	728	123	416	1,267	897	253	472	1,622	4	1263	1,267	99.7%
Feb-19	844	134	386	1,364	854	248	436	1,538	3	1361	1,364	99.8%
Mar-19	776	133	461	1,370	868	271	410	1,549	1	1369	1,370	99.9%

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





The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019.

March 2019 performance is **87.37%**

In March the Trust had **0** patients over 52weeks which is a significant achievement for the Trust.

Royal Orthopaedic Hospital NHS Foundation Trust
Referral to Treatment Trajectory: Trust Wide Position

RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,477	7,510	7,542	7,570
Over 18 Weeks	1,080	1,086	1,084	1,057	992	928	864	796	729	649	603	558	518
Totals	8,436	8,360	8,365	8,356	8,329	8,302	8,275	8,245	8,216	8,126	8,113	8,100	8,087
RTT %	87.20%	87.01%	87.04%	87.36%	88.09%	88.82%	89.56%	90.34%	91.13%	92.02%	92.56%	93.11%	93.60%

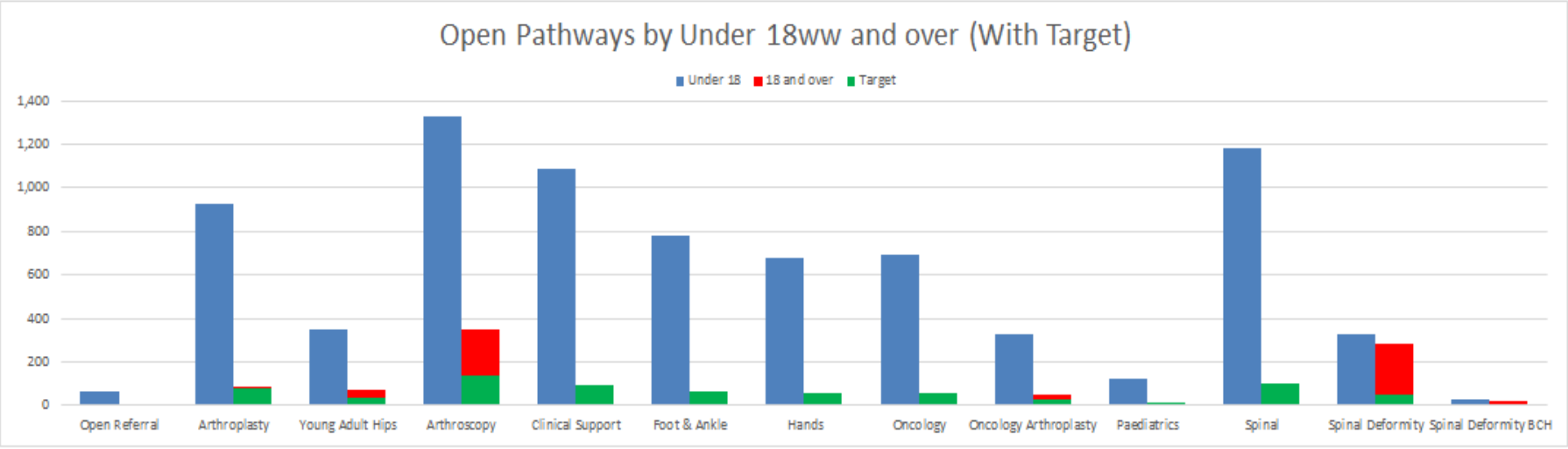
13. Referral to Treatment snapshot as at 31st March 2019 (Combined)

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	**4,102**	42	475	181	657	610	404	360	381	190	63	603	125	11
7-13	**2,689**	18	331	109	465	365	274	220	218	106	39	400	136	8
14-17	**1,103**	2	119	62	208	110	102	98	93	32	20	183	66	8
18-26	**829**	1	76	54	226	45	38	44	17	34	10	90	182	12
27-39	**277**	0	12	20	111	5	6	6	5	11	0	12	84	5
40-47	**34**	0	0	1	9	4	0	0	1	0	0	1	16	2
48-51	**1**	0	0	0	0	0	0	0	0	1	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9,035**	63	1,013	427	1,676	1,139	824	728	715	374	132	1,289	609	46

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	**7,894**	62	925	352	1,330	1,085	780	678	692	328	122	1,186	327	27
18 and over	**1,141**	1	88	75	346	54	44	50	23	46	10	103	282	19
Target	**723**	**5**	**81**	**34**	**134**	**91**	**66**	**58**	**57**	**30**	**11**	**103**	**49**	**4**

	87.37%	98.41%	91.31%	82.44%	79.36%	95.26%	94.66%	93.13%	96.78%	87.70%	92.42%	92.01%	53.69%	58.70%



13. Referral to Treatment snapshot as at 31st March 2019

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 Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
0-6	**697**	0	98	63	140	58	48	82	62	35	21	65	5	13	7
7-13	**859**	0	177	59	134	75	56	100	54	43	17	112	13	13	6
14-17	**241**	0	38	16	49	33	10	19	9	15	1	34	10	6	1
18-26	**394**	0	67	20	122	9	8	28	9	21	7	58	11	21	13
27-39	**148**	0	13	14	59	3	1	3	4	5	0	9	13	21	3
40-47	**11**	0	0	0	3	0	0	0	0	0	0	0	2	5	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,350**	0	393	172	507	178	123	232	138	119	46	278	54	79	31

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
Under 18	**1,797**	0	313	138	323	166	114	201	125	93	39	211	28	32	14
18 and over	**553**	0	80	34	184	12	9	31	13	26	7	67	26	47	17
Target	**188**	0	31	13	40	14	9	18	11	9	3	22	4	6	2
Variance from Target	**365**	**0**	**49**	**21**	**144**	**-2**	**0**	**13**	**2**	**17**	**4**	**45**	**22**	**41**	**15**
	76.47%		**79.64%**	**80.23%**	**63.71%**	**93.26%**	**92.68%**	**86.64%**	**90.58%**	**78.15%**	**84.78%**	**75.90%**	**51.85%**	**40.51%**	**45.16%**

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 Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
0-6	**3,598**	227	379	112	518	571	417	278	300	198	43	452	80	15	8
7-13	**2,189**	21	192	81	373	307	213	151	230	81	28	384	98	27	3
14-17	**642**	8	43	33	101	74	66	57	77	13	7	108	36	18	1
18-26	**618**	1	43	39	124	34	57	38	16	14	8	105	68	67	4
27-39	**145**	0	3	9	48	2	3	2	1	5	0	8	29	34	1
40-47	**15**	0	0	3	3	0	1	0	0	0	0	1	5	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**1**	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Total	**7,208**	257	660	277	1,167	988	757	526	625	311	86	1,058	316	163	17

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
Under 18	**6,429**	256	614	226	992	952	696	486	607	292	78	944	214	60	12
18 and over	**779**	1	46	51	175	36	61	40	18	19	8	114	102	103	5
Target	**577**	20	52	22	93	79	60	42	50	24	6	84	25	13	1
Variance from Target	**202**	**-19**	**-6**	**29**	**82**	**-43**	**1**	**-2**	**-32**	**-5**	**2**	**30**	**77**	**90**	**4**
	89.19%	**99.61%**	**93.03%**	**81.59%**	**85.00%**	**96.36%**	**91.94%**	**92.40%**	**97.12%**	**93.89%**	**90.70%**	**89.22%**	**67.72%**	**36.81%**	**70.59%**

14. Cancer Performance Targets

		Indicative		Reported Month										Reported Quarter 2017/18			
Target Name	National Standard	Q4	*Mar-19*	Feb-19	Jan-19	Dec-18	Nov-18	Oct-18	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%	*99.0%*	*98%*	98%	100%	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	94.0%	*100%*	81.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*94.9%*	*100%*	93.8%	90.9%	93.8%	100%	100%	100%	100%	100%	100%	100%	90%	98%	100%	97%	100%
62 day (traditional)	85%	*96.0%*	*100%*	100%	90%	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	88.20%	*100.0%*	89.5%	*75.0%*	94.70%	*90.5%*	88.9%	77.8%	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	n/a	n/a	n/a	n/a	n/a	n/a	n/a
28 day FDS	85%		*tbc*	82.20%														
No. patients treated 104+ days				1	1	2	1		1			1						

PERFORMANCE/IMPROVEMENTS / LEARNING

The Trust performance for the 62 day target in March is currently at **100%** - this data is due for submission at the beginning of May 2019. Strong performance in February and March has meant that the Trust will hit the target for Quarter 4 **88.2%** which has not historically been met (**Target 85%)**

The Trust is also "shadow" monitoring the new 28 day Faster Diagnostic Standard which will be a national performance target in April 2020. The Trust is required to report this from April 2019. The target is **85%** and our performance in February was **82.22%.**

The FDS will ensure that patients are told they have cancer, or that cancer is excluded , within a maximum of 28 days from referral.

Good progress has been made across the action plan within Cancer Services with the majority of the action plan now being completed. A weekly tracking meeting is now fully embedded with Pathology and Radiology input, which is demonstrating an impact in our improved performance position

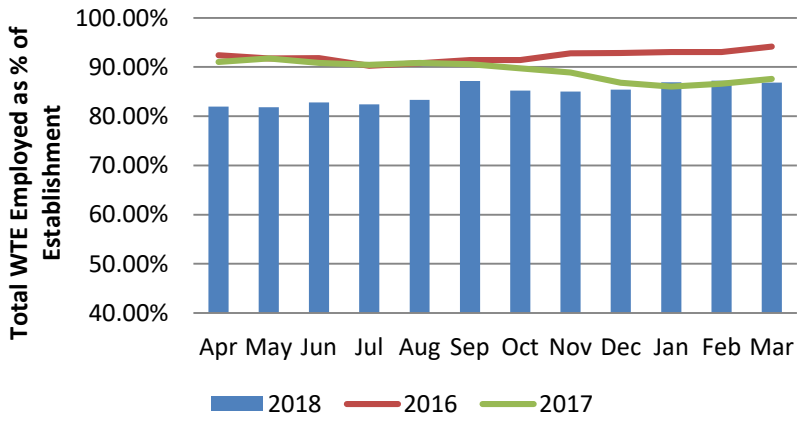
Somerset IT system has been implemented and over the next few months the new reporting function which is currently being developed will enable more enhanced report to be shared with F&P

RISKS / ISSUES

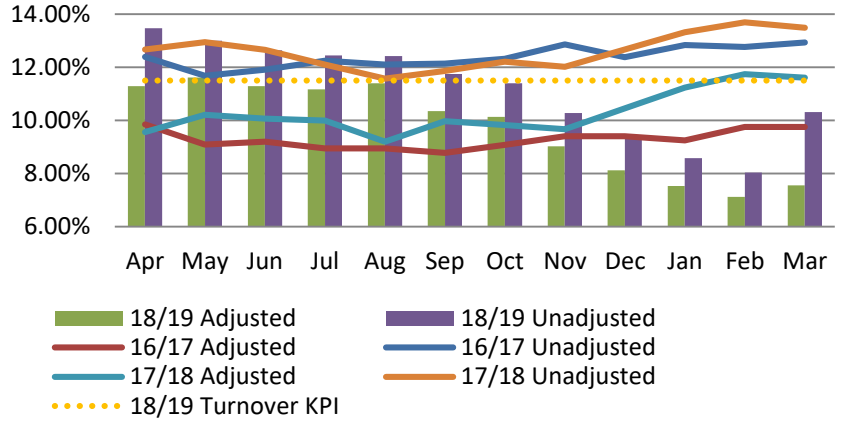
With the transfer of the Inpatient Paediatric Service in July 2019 to BWC the team will continue to work closely with both teams to minimise any impact on our performance

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

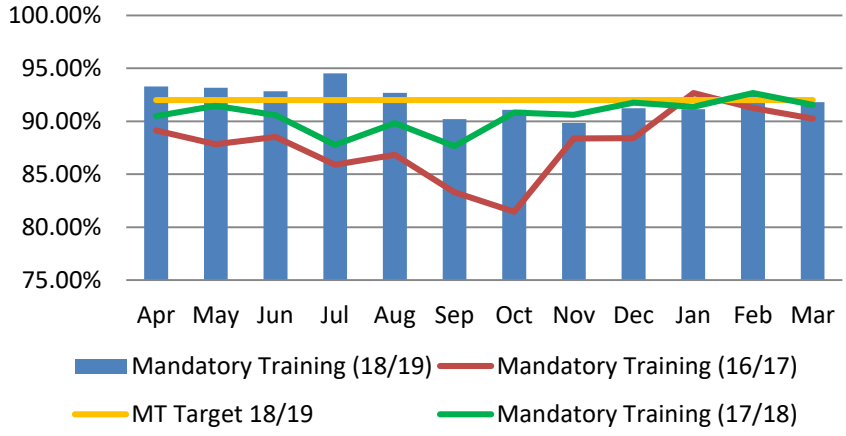
Staff in Post v Establishment



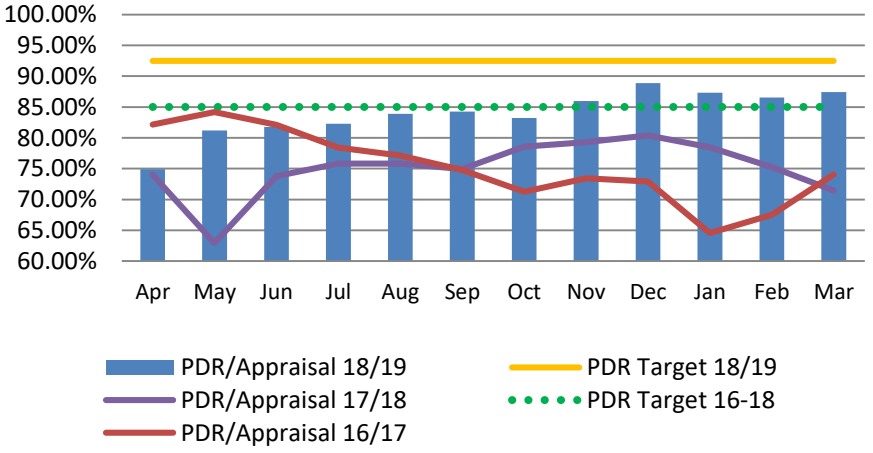
Staff Turnover



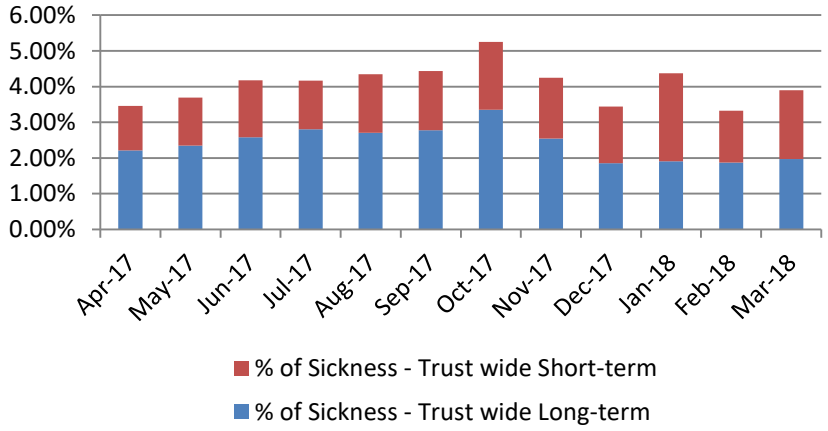
Mandatory Training



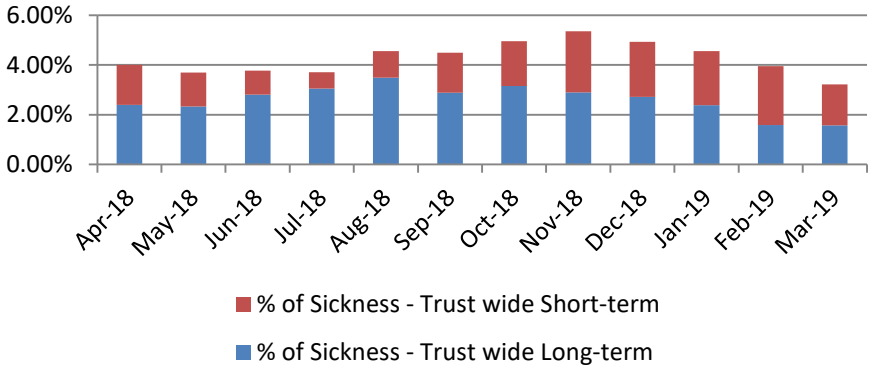
PDR/Appraisal



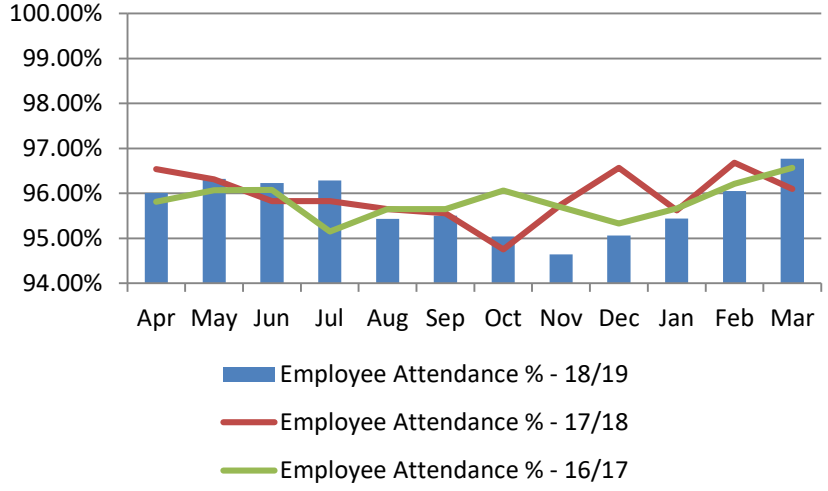
Sickness % - LT/ST (2017/18)



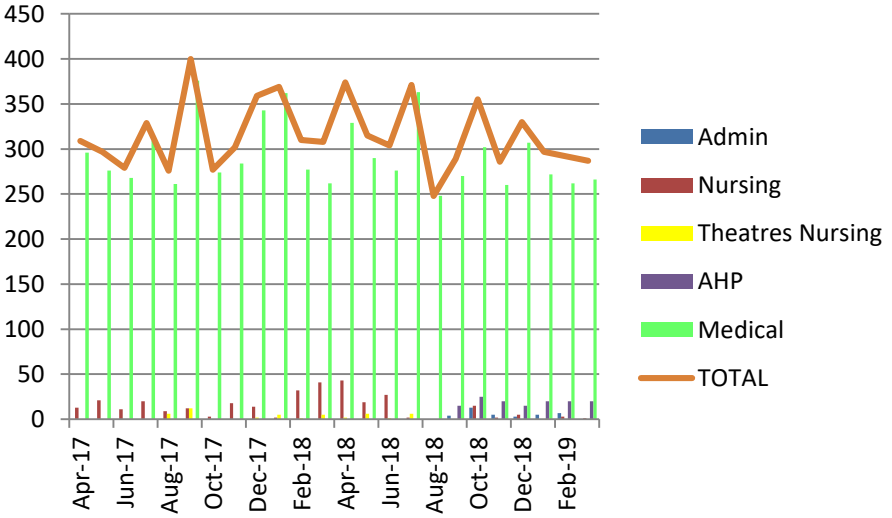
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

March has seen a variety of changes within workforce performance. Sickness absence and agency breaches decreased and appraisals increased. Whereas, statutory and mandatory training decreased and the vacancy position and turnover increased – although the latter have justifiable reasons.

This month the Trust's vacancy position saw a slight decrease this month (0.36%) as a percentage of WTE employed, with the figure for March at 86.84% against a Trust target of 90%. This is due to a slight increase in the budgeted establishment, the number of staff on the payroll is still increasing, which stood at 946.04, an increase on the February position of circa 5 WTE and so the number of staff at ROH continues to grow .

Monthly attendance increased again this month by a higher rate of 0.72% to 96.77%, the in month position improved to green in March, which is the first time since July last year. Short term sickness decreased from 2.37% to 1.65%, which is the lowest has been for the past 6 months. The 12 month sickness absence figure decreased to 4.45%.

Mandatory Training numbers saw a decrease of 0.76% versus February's figure. This month's position stands at 91.80%, which is below the Trust target of 92%, so returns to amber this month, but it is still higher than the figure for March 17 and March 18, which were 90.26% and 91.56% respectively.

March's appraisal performance increased to 87.41%, which is the second highest level since May 2014: but it is still distance from our internal stretch target of 92.5%, so operational focus needs to be maintained with Divisions in this area.

The unadjusted turnover figure (all leavers except doctors and retire/returners) increased to 10.31%. The adjusted turnover figure (substantive staff leavers including retirements) increased to 7.55% and but remain green against a KPI of 11.5%. This is due to the movement of the Histopatholgy department to our neighbouring Trust UHB.

In March, agency breaches decreased slightly from 292 to 287 shift breaches in total, with the majority still being medical usage (266), which increased slightly from 262 to 266 for March's usage. There was only 1 nursing breach and 0 admin breaches, the other 20 were AHP breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 3 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was agreed that the estates strategy needed to be revisited as currently there was little assurance around how this was being prioritised based on the Staff Experience walkabouts; it was noted that the age of the estate was challenging given that on occasion, there was unexpected maintenance required. • Two new risks had been added to the workforce risk register: one around outstanding Hepatitis B vaccinations and a second around the current storage arrangements for personnel files. • It was noted that there were a number of leavers who had served less than two years with the ROH, although the Committee agreed that this may be seen as a positive in terms of the preceptorship of nurses who took the opportunity to work at the ROH before moving onto a larger organisation.	• Devise a list of topics for forthcoming Staff Experience workshops. • Add an additional risk to the BAF around the impact of planned growth and modular theatres on the ancillary functions and estate. • Add capacity of the recruitment team to handle recruitment needed for the modular theatres to the workforce risk register. • Present the updated People & OD strategy to the Committee in July • The Staff Walkabouts to Estates, Facilities and Portering to be discussed at the next meeting. • Arrange for the Charitable Funds bid around support to overseas staff arriving to work at the ROH to be presented to the Charitable Funds Committee. • Add a risk to the workforce risk register around tax liabilities associated with consultant contracts.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received an enlightening staff story from the Senior Sister in HDU who described some cultural challenges that she had faced as part of her roles at the ROH and how she had managed to improve morale and processes in her departments. • The improved governance around resuscitation was described, including training and the operation of the resuscitation committee. • Good progress was reported against the actions in the People & OD strategy. • The Committee was joined by the Interim Director of Finance who outlined the actions he had taken in response to the Staff Experience walkabouts in Finance, IT, Clinical Coding and Business Intelligence. • A report was considered on medical education. It was noted that those undergraduates and post graduates had a very positive experience at the ROH and communications around this should be developed.	• It was agreed that having reviewed sickness absence specifically on a number of occasions, the Committee was assured that there were good processes around managing this and there had been a decline in sickness absence overall since October and therefore this would not be considered as a standing item on future agendas.

• It was noted that the recent nurse recruitment Open Day had been very effective and there had been a good level of expressions of interest.	

Chair's comments on the effectiveness of the meeting: The staff presentation was agreed to have been excellent. The staff experience walkabouts were a useful source of assurance. It was agreed that the balance of the meeting was much better.

Workforce Performance Report

February 2019

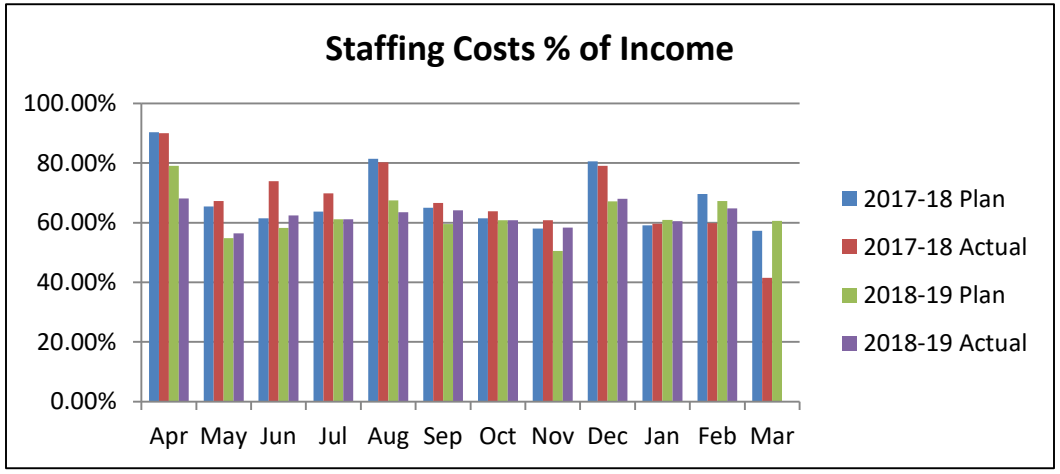
CONTENTS

Staffing costs

1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	76828	
Actual Income YTD	77845	101%
Planned Pay Costs (YTD)	47371	
Actual Pay Costs (YTD)	48547	102%
Planned Substantive Pay Costs (YTD)	39821	
Actual Substantive Pay Costs (YTD)	38013	95.5%
Planned Bank Pay Costs (YTD)	4108	
Actual Bank Pay Costs (YTD)	5649	137.5%
Planned Agency Pay Costs (YTD)	3169	
Actual Pay Costs (YTD) Agency Staff	4756	150%
Planned Agency Pay Costs as % of total Pay costs (YTD)		6.7%
Actual Agency Pay Costs as % of total Pay costs (YTD)		9.8%



Total ADH Payments (Apr - Feb)	£2,229,000

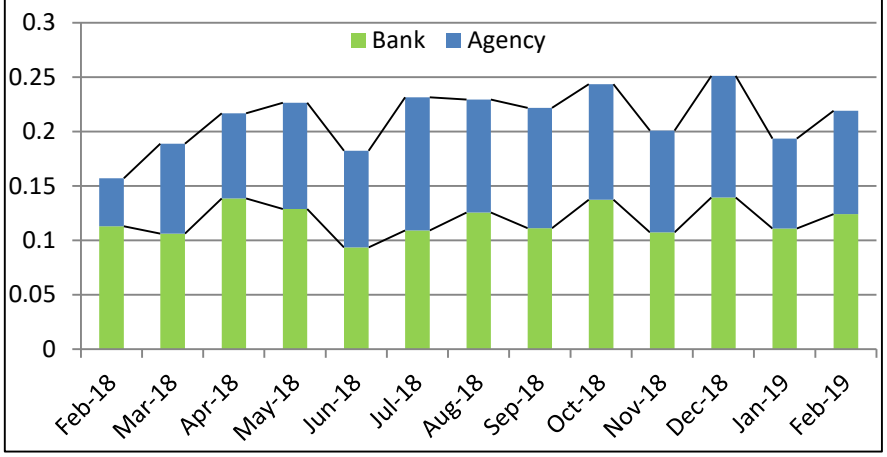
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	242	363
May	242	514
Jun	242	443
Jul	242	490
Aug	242	440
Sep	242	402
Oct	241	510
Nov	241	350
Dec	241	420
Jan	241	398
Feb	241	428

Data based upon February Management Accounts

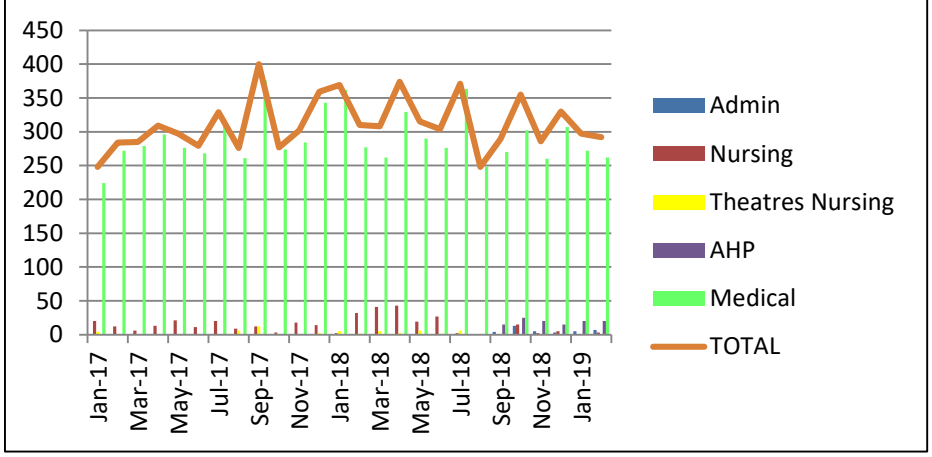
1 Workforce Composition and Cost

1a Temporary Staffing Analysis

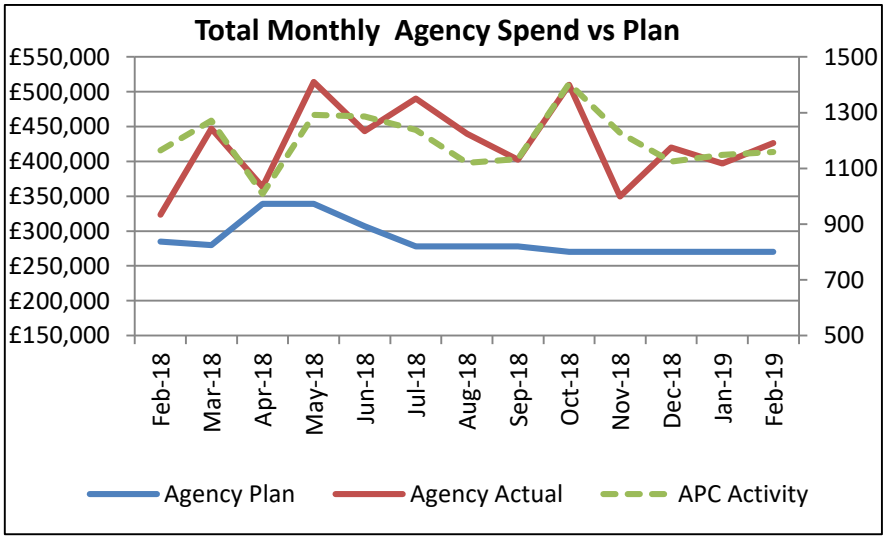
Temp Staff as % of Total Spend



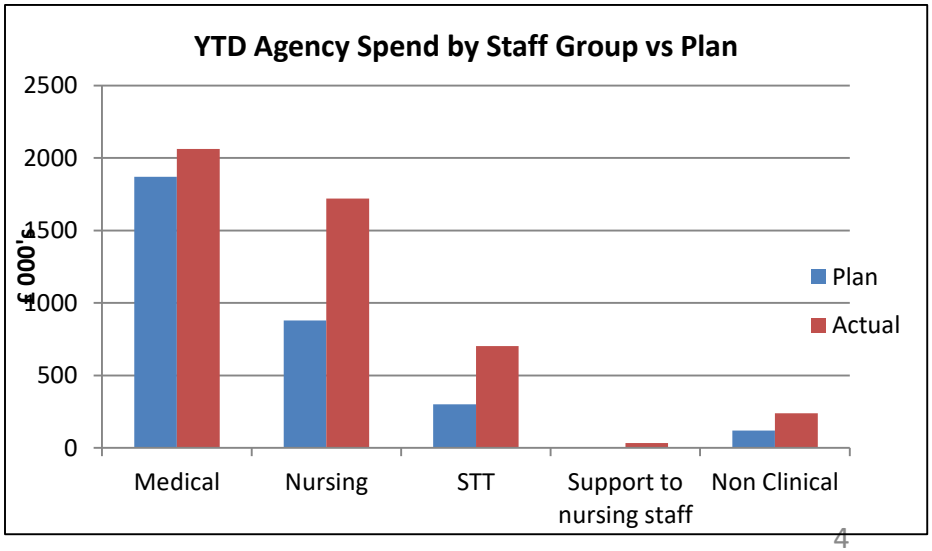
Agency Breaches



Total Monthly Agency Spend vs Plan

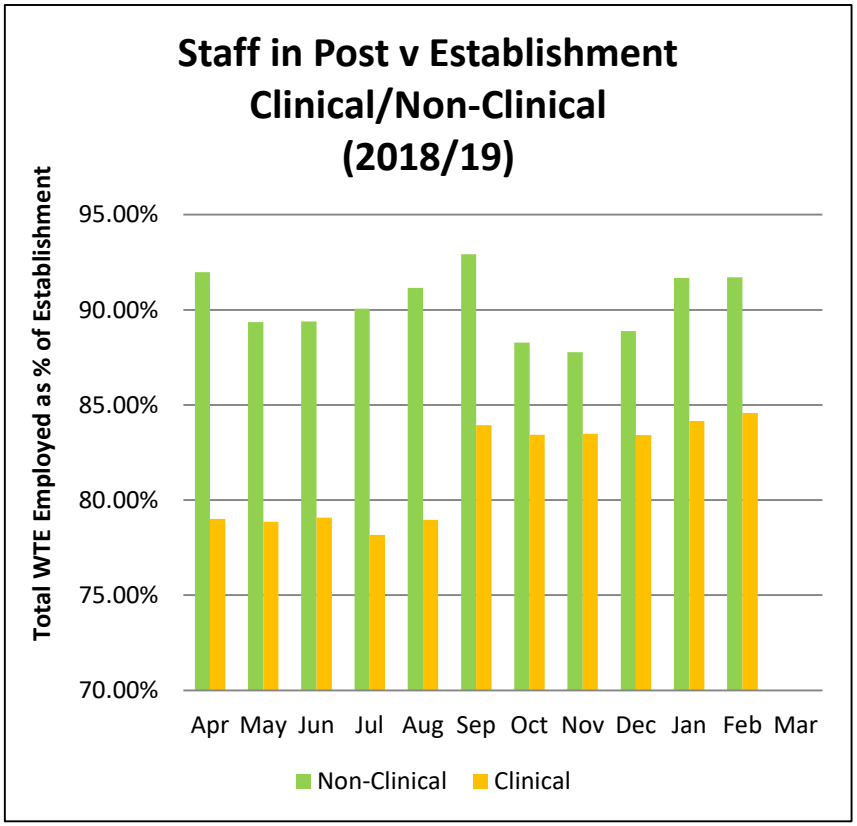


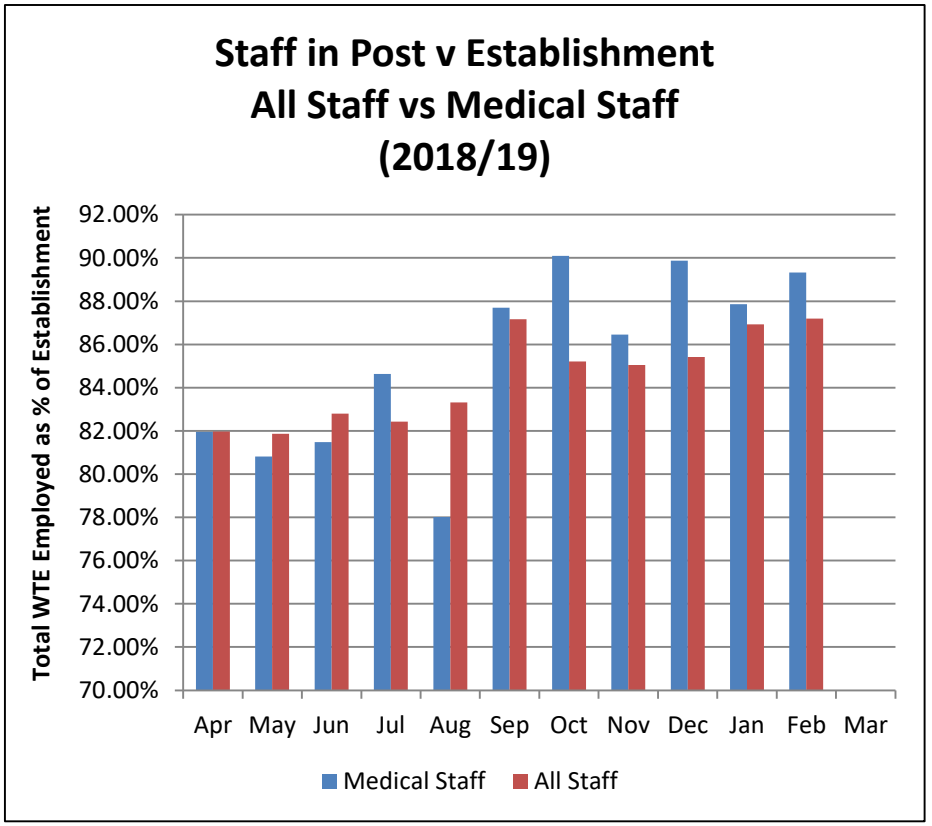
YTD Agency Spend by Staff Group vs Plan



1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

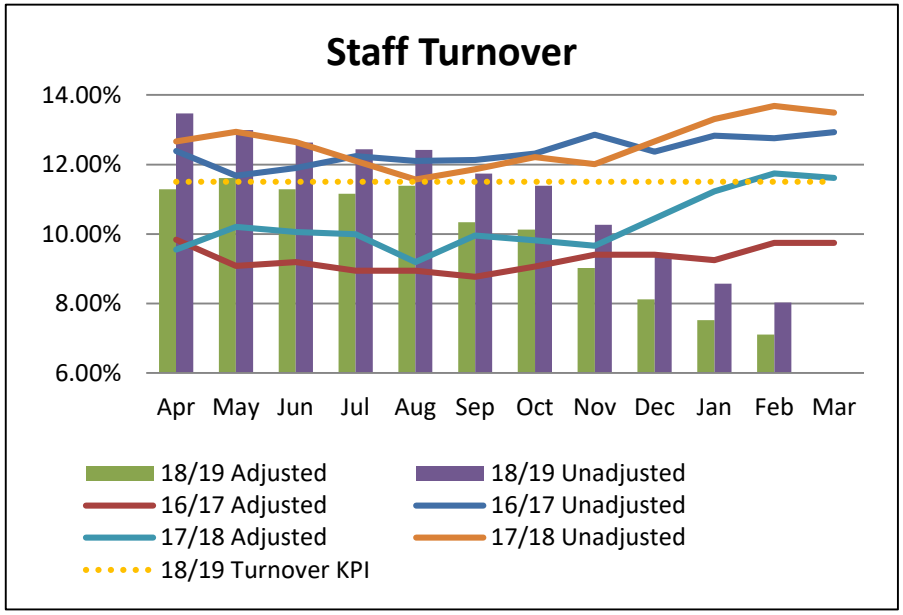
Establishment

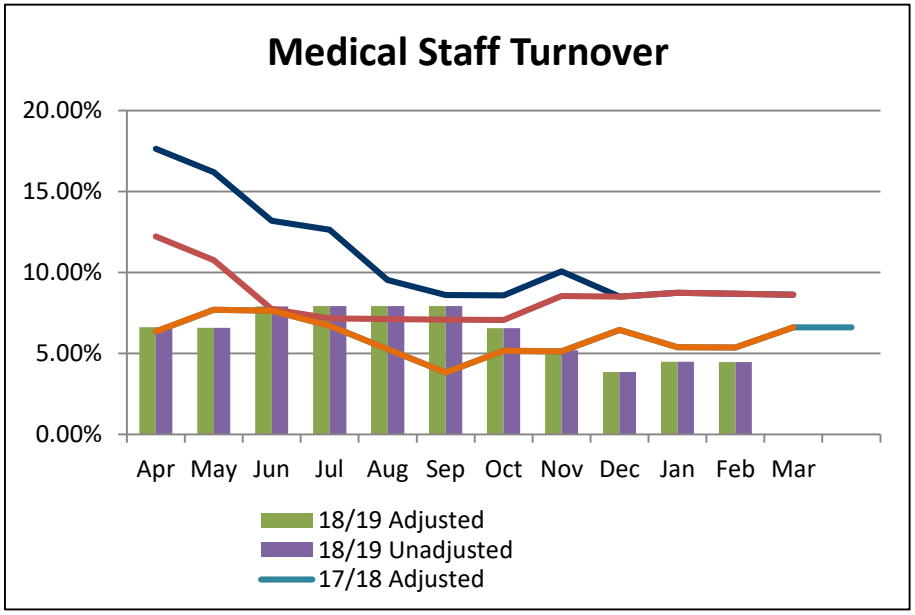




1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

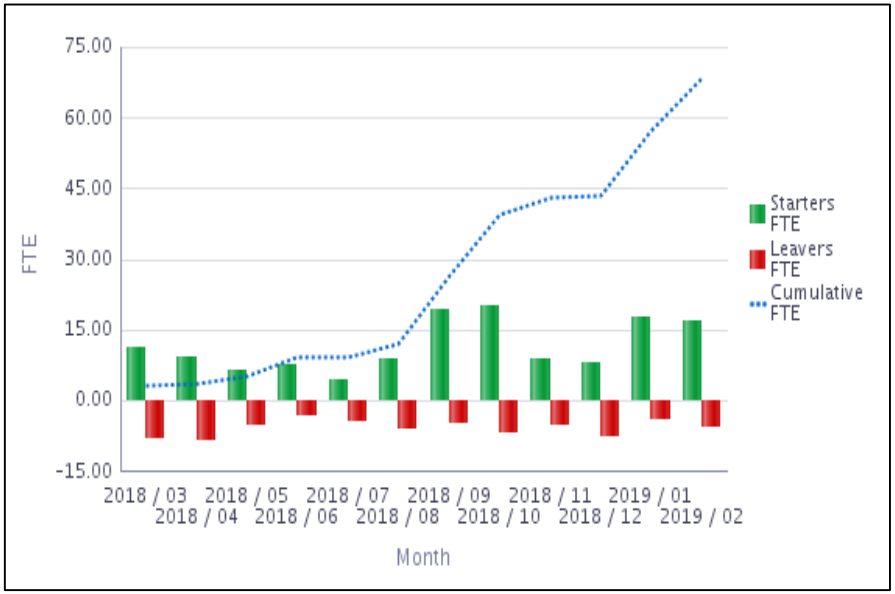
Turnover



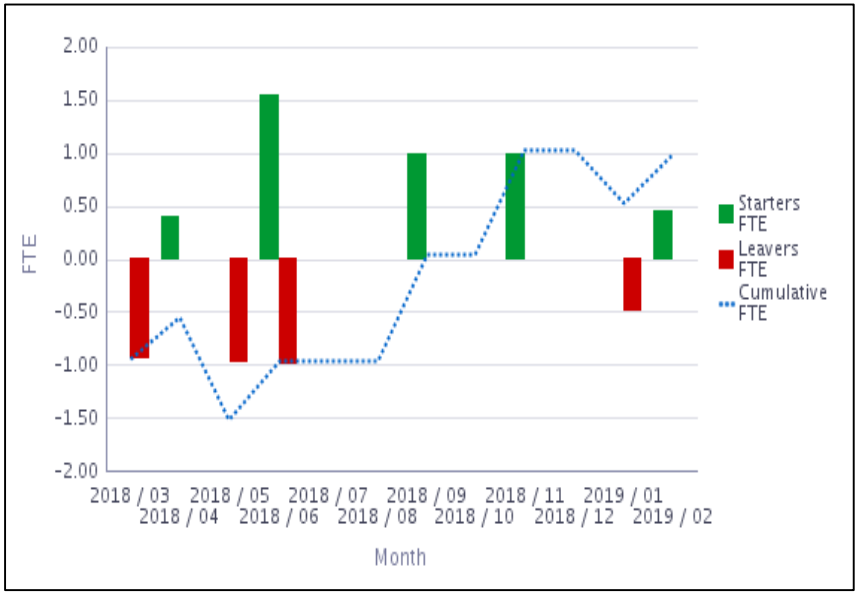


1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Starters / Leavers by Month - All Staff

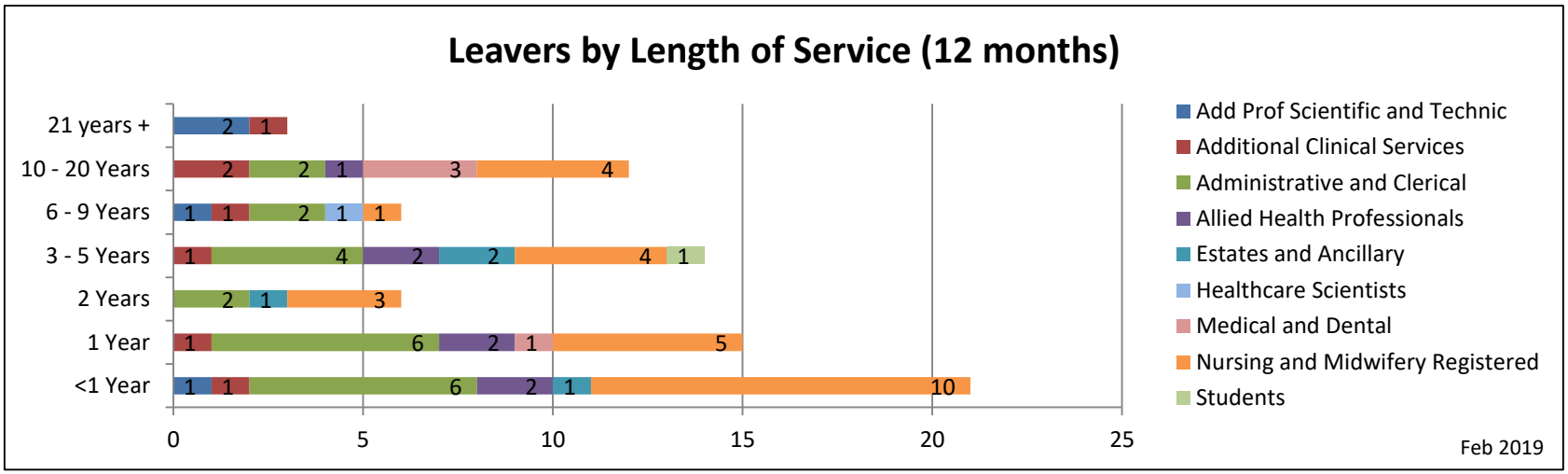


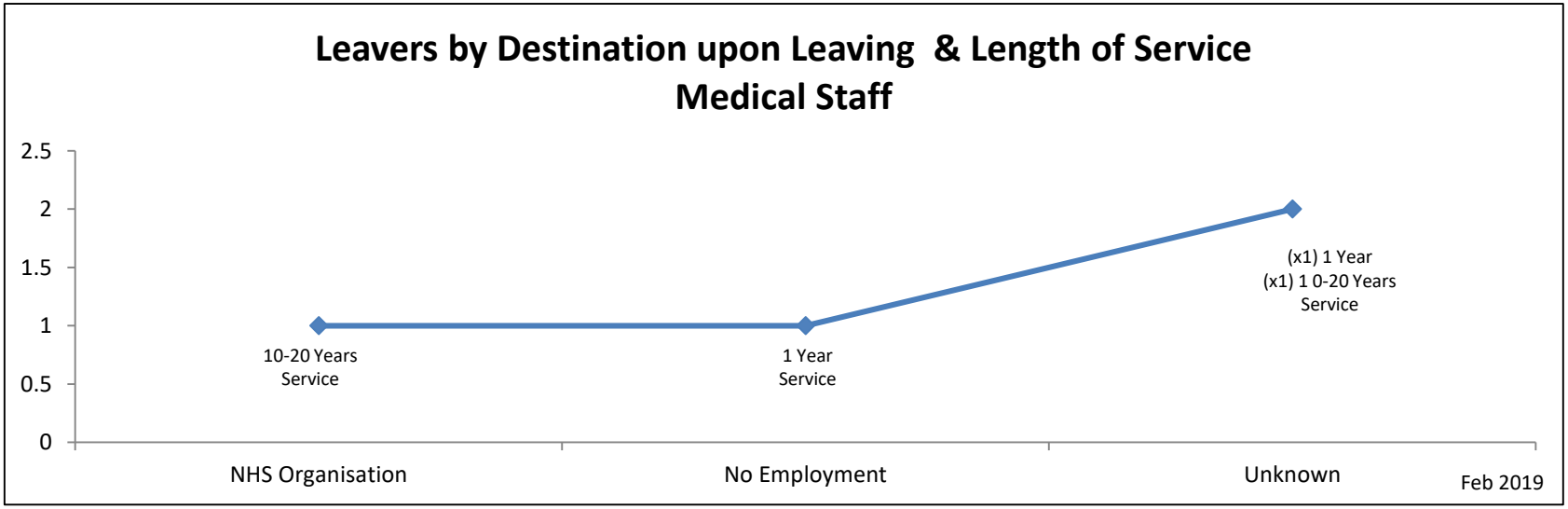
Starters / Leavers by Month – Medical Staff



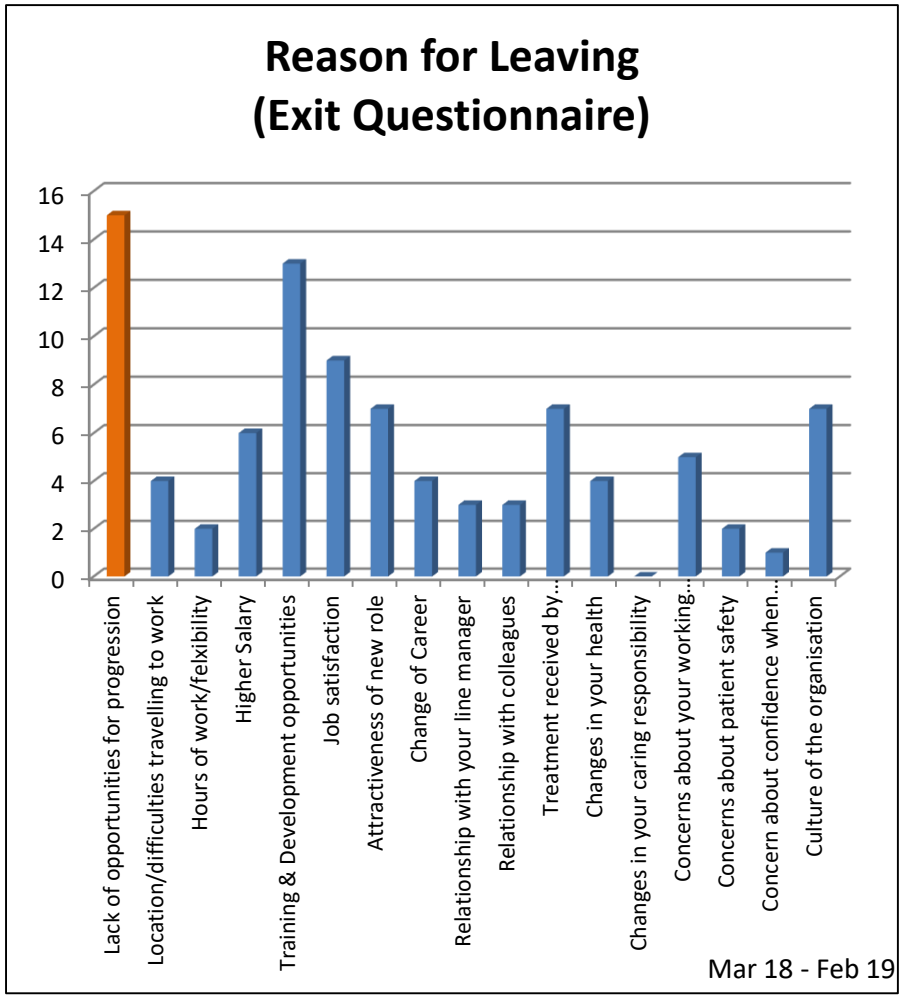
1 Workforce Composition , Resourcing and Cost

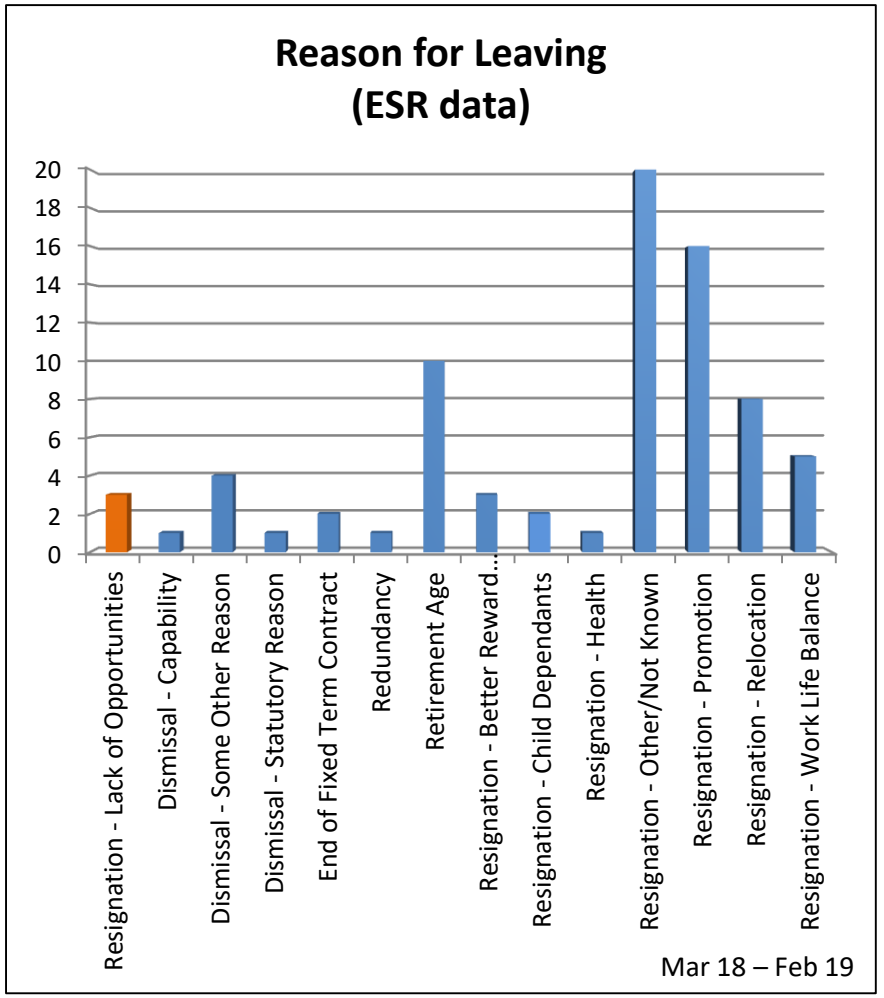
1c Staff Turnover





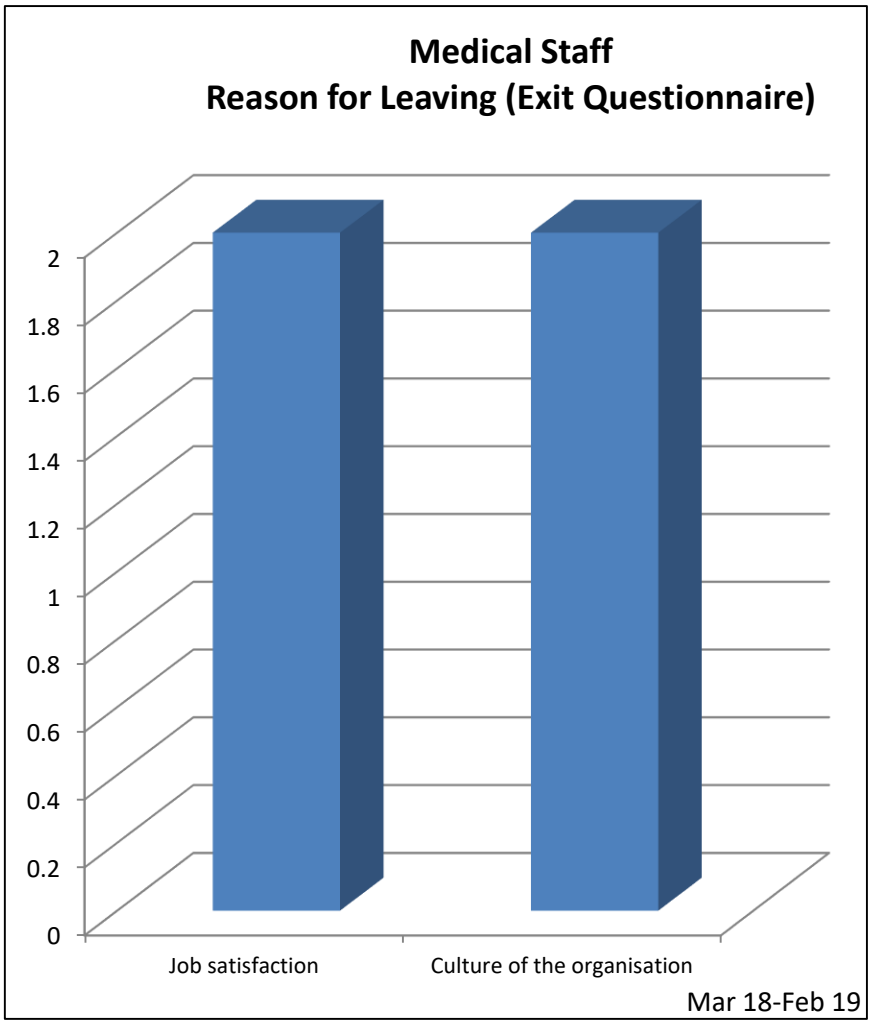
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

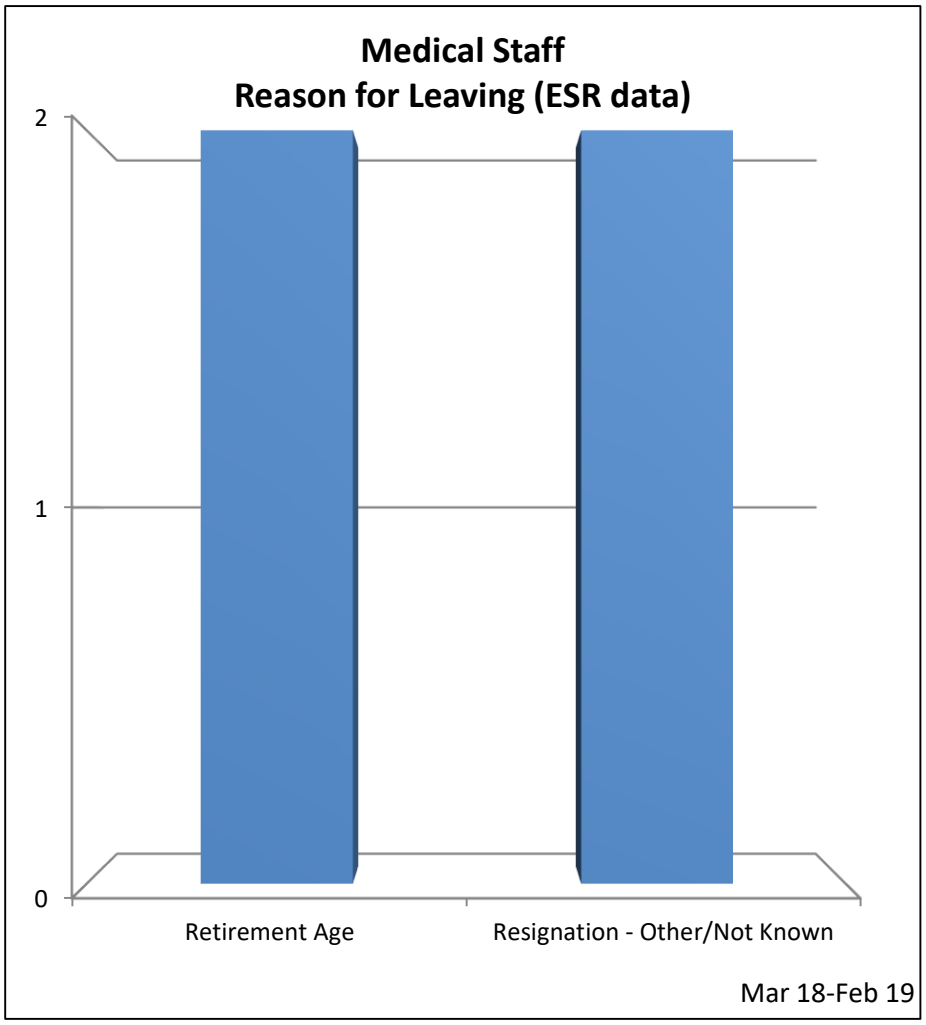




1 Workforce Composition , Resourcing and Cost

1d Exit Questionnaire Information

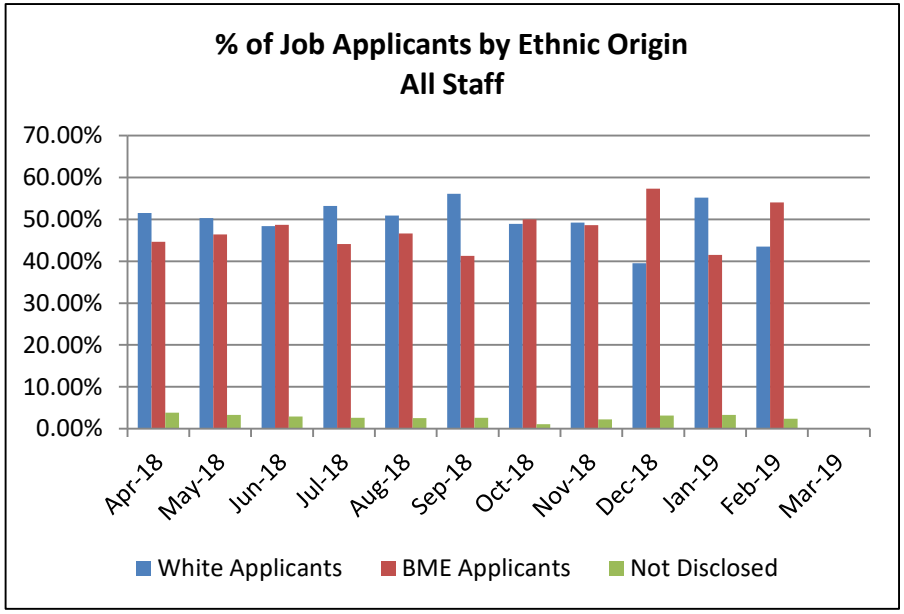


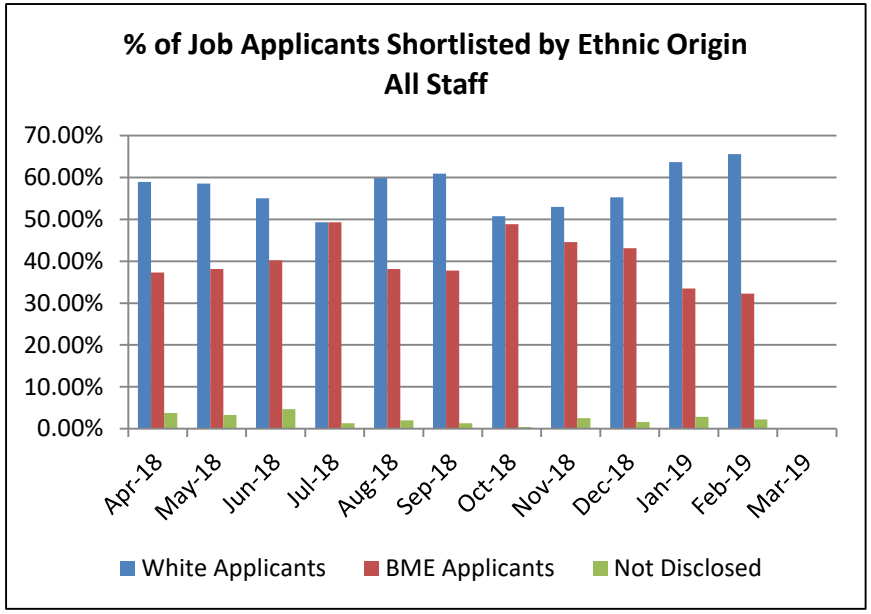


1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



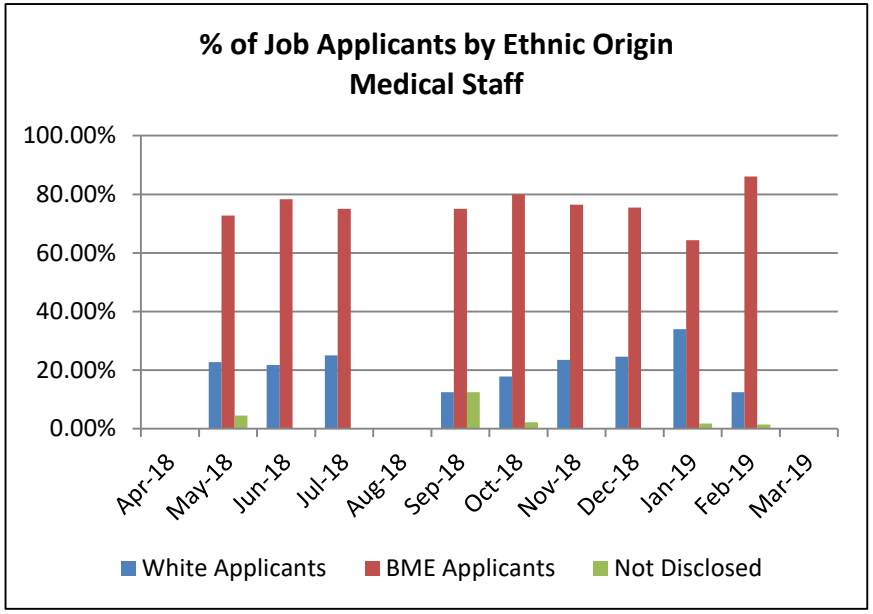


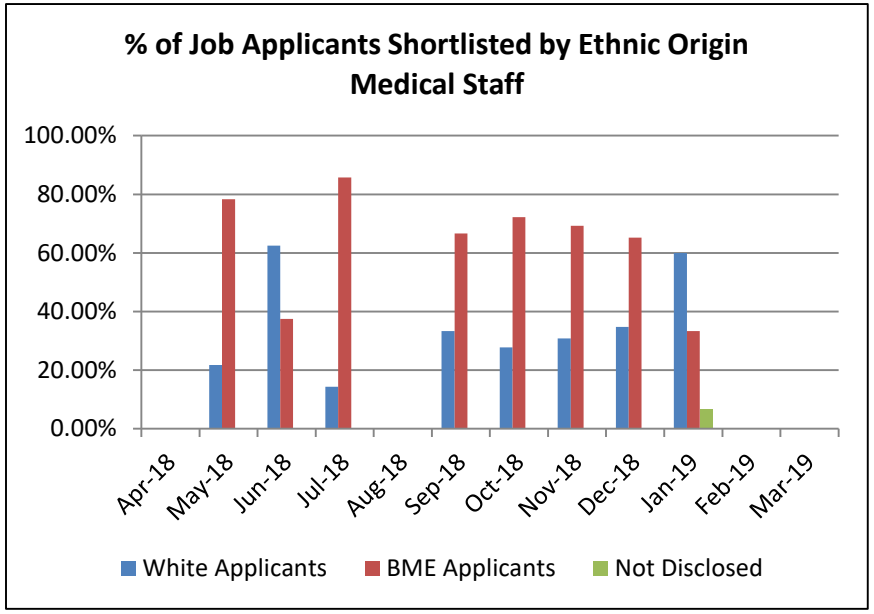
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.69	↓	+0.09	+ 0.05	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month
2.09

Workforce Composition, Resourcing and Cost

Staffing Costs – The actual spend on staffing was above that planned in February, with an underspend on substantive pay being exceeded for both bank and agency staff, the latter across all staff groups.

In part however, this is mitigated by an increase in income to the Trust. The Trust has clearly been using some agency staff to deliver additional activity and the average ADH payments to Consultants also increased since December 2018.

Turnover – the unadjusted turnover figure has now reduced for each of the last 13 months and is now reported as 8.03% for the 12 month period to February 2019. This is against the Trust target of 11.5%. The adjusted turnover position has improved (decreased) for each of the last 7 months and the February 2019 figure was 7.11%. Turnover has decreased for nursing staff (down to 11.47% in February versus 15.91% in March 2018, when data collection commenced) but more significantly for clerical, ancillary and unregistered support staff to drive this position.

NHSI visited the Trust in February as part of their national retention support programme and a plan has been submitted following that visit, for which feedback is awaited: although the informal view on the day of the visit was a recognition that the Trust is considering the right areas.

Workforce Composition, Resourcing and Cost

Recruitment and Selection - Time to hire and streamlining

Efforts continue to develop the ability to extract reports and develop KPIs from the Trust's Vacancy Approval System, which it is intended will offer insights into those parts of the system which experience delays. Activity has been extremely high in recruitment since the turn of the year, particularly in theatres and in resource intensive Consultant recruitment, in addition to the usual junior doctor changeover and corporate nursing recruitment. Whilst accurate tracker data is not currently available due to current recruitment volume, raw data suggests that 79% of staff are achieving the conditional to unconditional offer letter 6 week standard. The actual figure will be higher than this due to (for instance) student or overseas nurses whose clearances typically take longer, as they will be joining us later in the year.

There is an intention to revisit and critically examine the existing recruitment process for consultants to explore streamlining and additional areas of best practice.

WRES Indicator 2 monitoring

The rolling 12 month figure as at February's was a slightly improved position since December's report. The Trust reduced the likelihood of non-BAME staff being appointed (1.69 times less likely, as opposed to 1.73 in December), which is closer to the national benchmark of 1.6 times less likely. This is a move in the right direction, although not a cause for great satisfaction.

February was similar to December in that there were more BAME applicants who applied (57%) but of shortlists, only 32% of candidates were from BAME backgrounds. Deeper analysis of this element is being undertaken by the Head of OD and Inclusion as part of the Equality and Diversity plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

Feedback awaited from the NHSI Retention programme, Consultant recruitment process review, deeper dive into WRES data.

RISKS/ISSUES

Unplanned staffing expenditure remains an issue, as does potential over-reliance on temporary staffing. Potential excessive working by established nursing staff through additional Bank hours is also a risk (reference the increase I short term sickness absence later in the report).

Inadequacy of specific recruitment workforce data/ insufficiently developed systems continue to make creation of a suite of recruitment KPIs a challenge. Work continues to develop this.

2 Workforce Performance

2a Staff Attendance

Staff Attendance

Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
95.48%	95.50%	↓	0.62%	96.10%

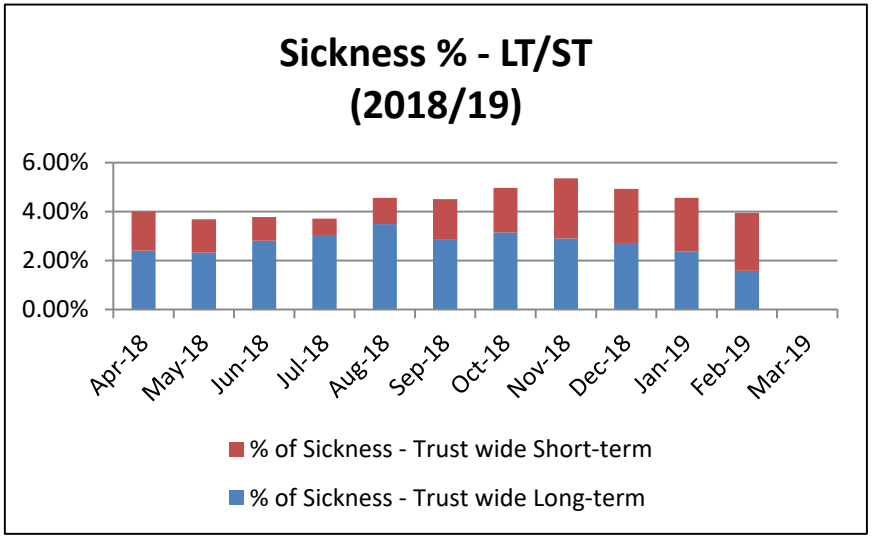
ALL STAFF

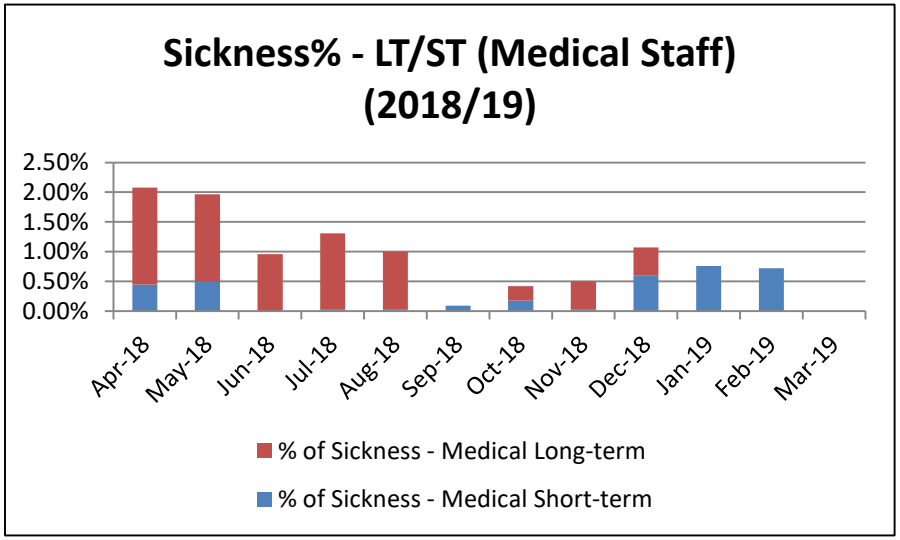
* 12 months to End of February 2019

Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
98.97%	98.78%	↑	-2.87%	96.10%

MEDICAL STAFF

* 12 months to End of February 2019

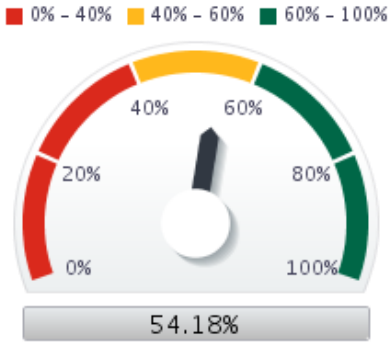




2 Workforce Performance

2b Staff attendance – short-term absence management

Staff Absence

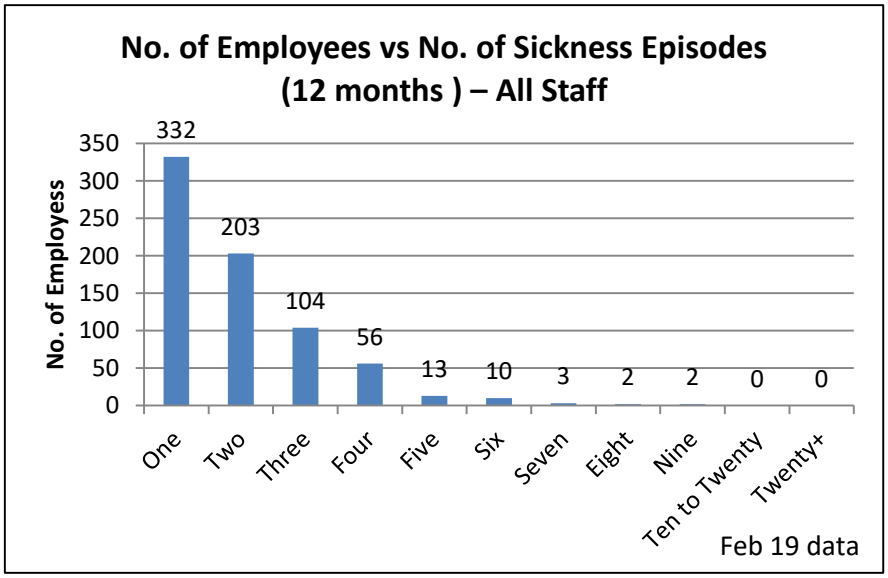


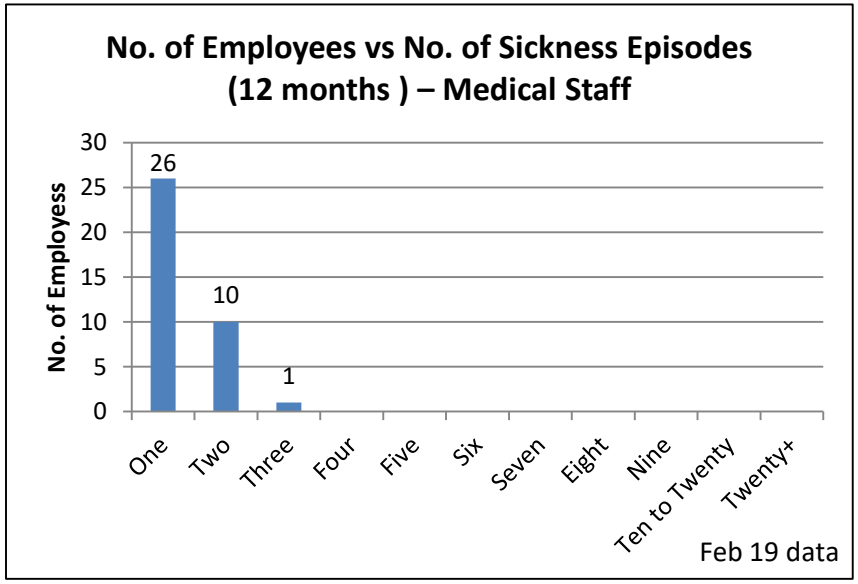
Return to Work Process Completion Rate (12 months) *Feb 19

ALL STAFF

Return to Work Process Completion Rate (12 months) *Feb 19

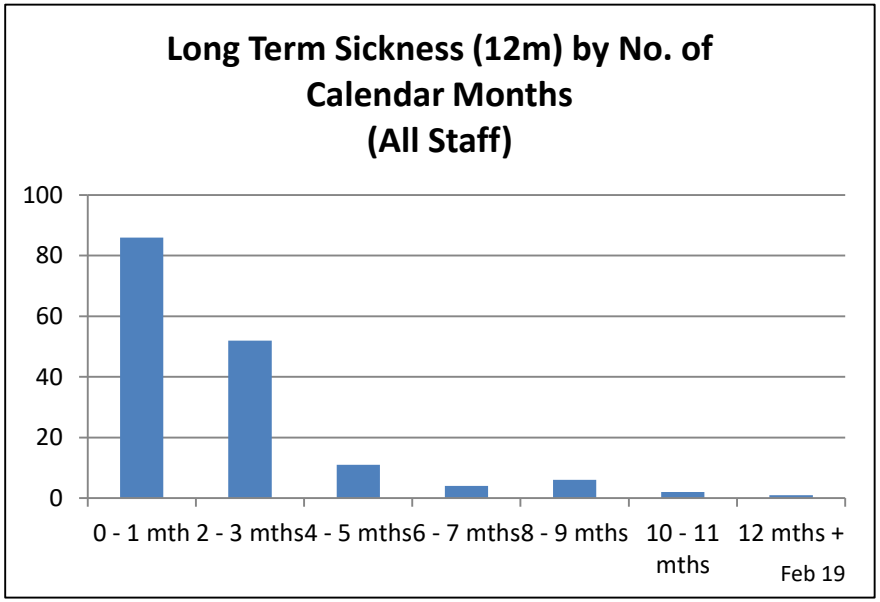
MEDICAL STAFF

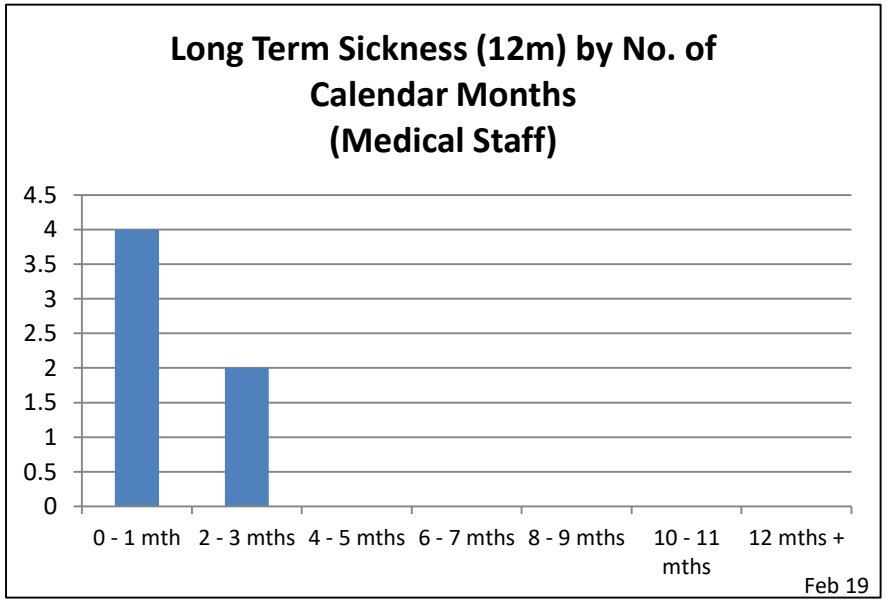




2	Workforce Performance
2c	Longer-term Staff Absence

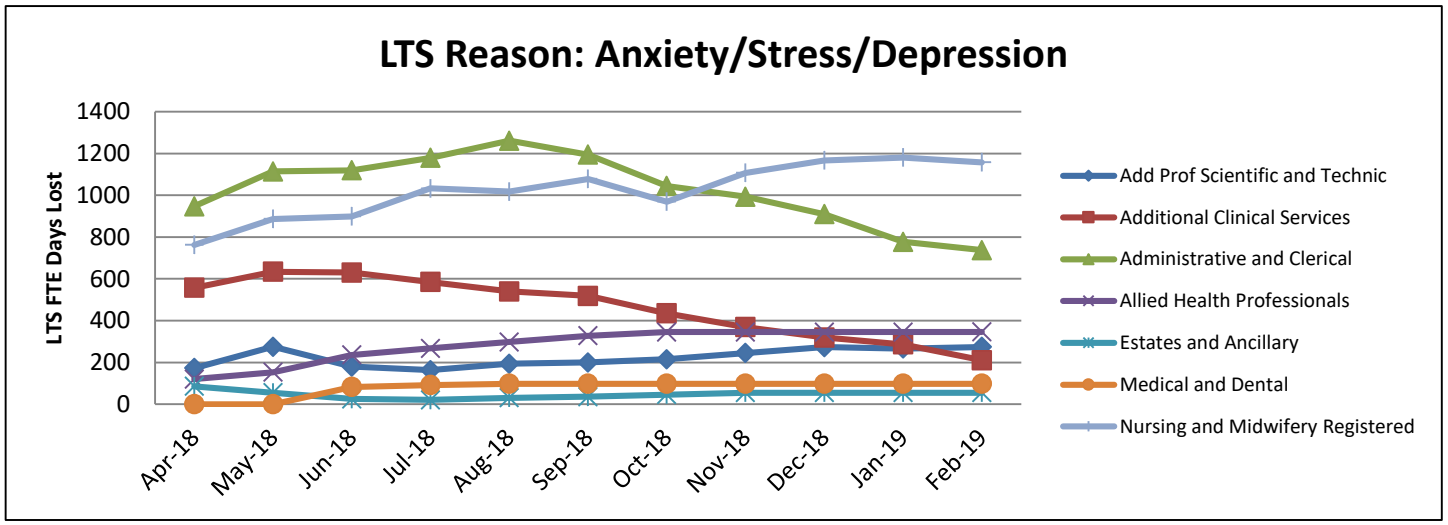
Long-term Staff Absence

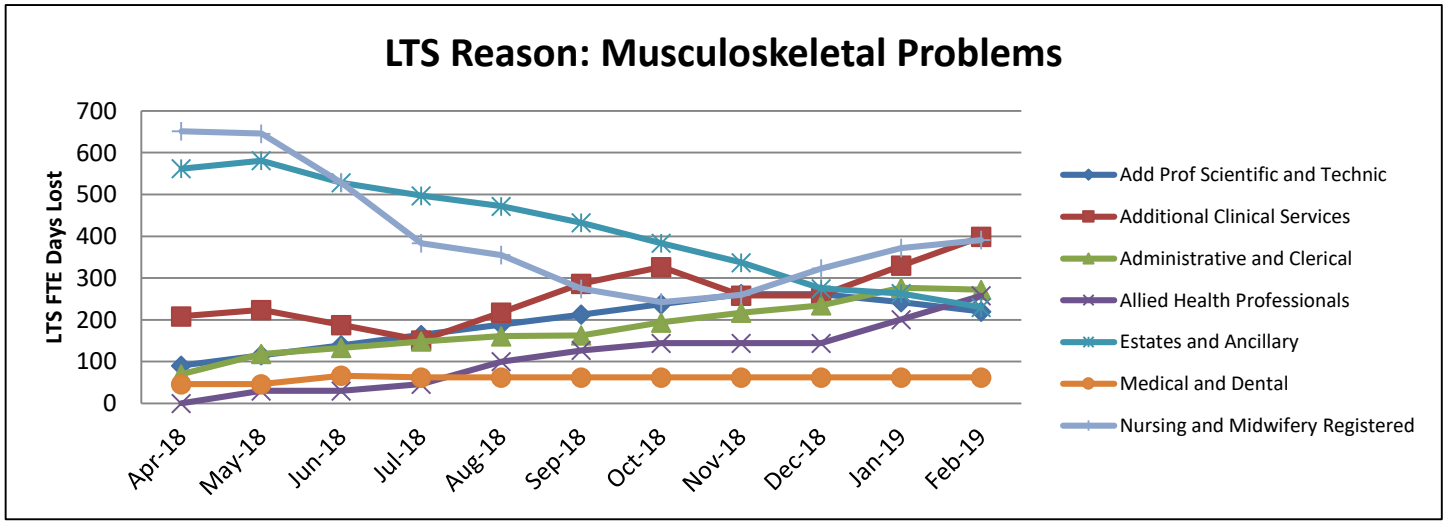




2 Workforce Performance

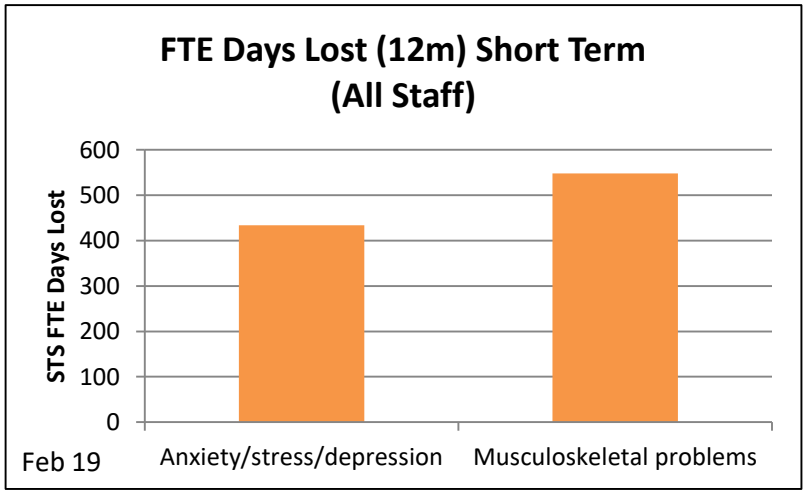
2c Longer-term Staff Absence

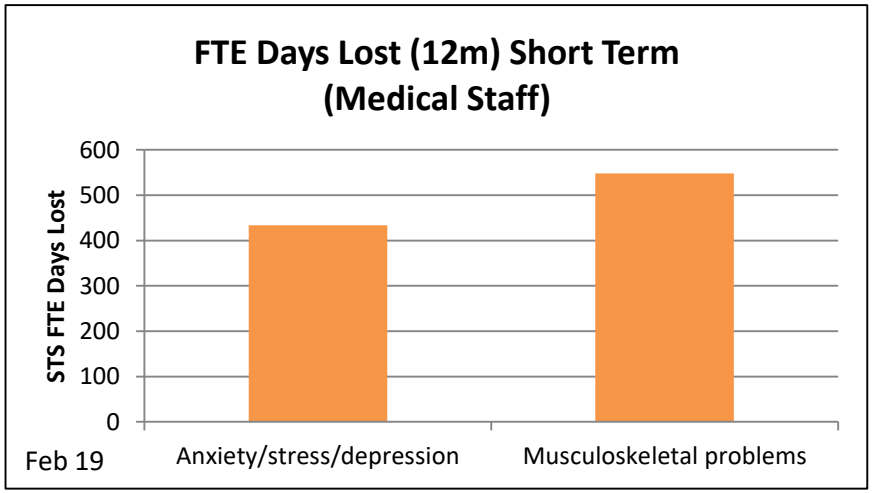


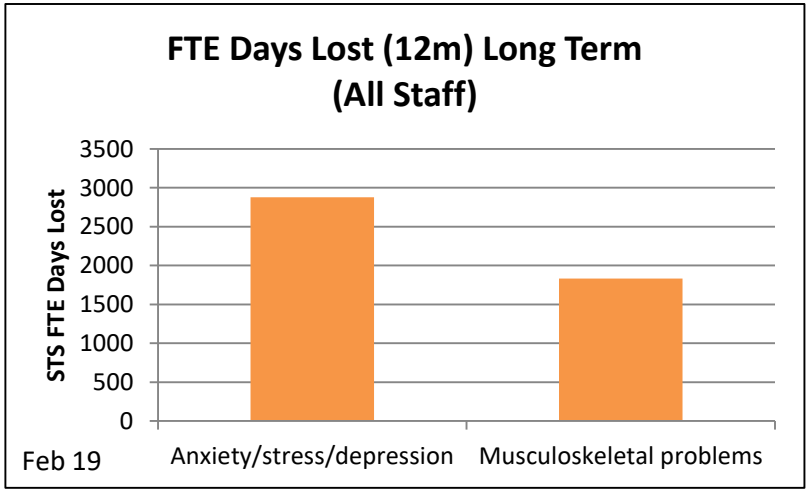


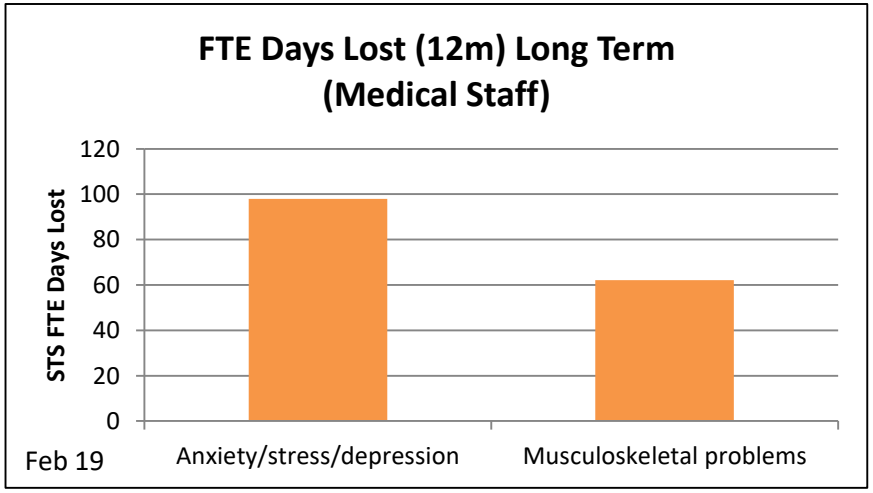
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary/ Capability

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	1	0	0	2	2	5

February 2019

INFORMATION

Staff Attendance

The Trust has not always experienced the seasonal variation in sickness absence which many Trusts experience in winter months, but it does appear to have been the case in the 2018/19 year. In February the Trust's monthly headline figure decreased for the 4th consecutive month.

The rolling twelve month attendance rate reduced slightly since December's report at 95.50% - but this is short of the Trust's our KPI target of 96.1% (3.9% absence). The encouraging news is that long term sickness absence has declined for each of the last 5 months, meaning that the in month figures are likely to reduce more quickly. Reduction in the 12 month figure is more likely to occur in Q2 and Q3 of 2019/20 if this continues.

Despite the improving picture, short term absence has remained high since November to a point where it exceeds the long term rate. This is rare (it has only happened once before in the last 6 years, for a 2 month period linked to the flu outbreak in Dec 2017/Jan 2018). It will remain an area of interest, with an ongoing focus maintained on return to work meetings. The encouraging news in this area is that there is a reported increase in these in the 12 month figure, up from 51% to 54% since the last report. The operational divisions offer assurance that the figure is higher than this but that electronic records are not always updated to reflect practice.

Formal Disciplinary and Capability

As at the end of February, there were 2 outstanding formal conduct cases in investigation stage.

ACTIONS FOR IMPROVEMENTS / LEARNING

Procure new OH and EAP provision in line with STP recommendations and following Executive Team consideration.
Succession planning and talent mapping processes to be developed and transacted in the medium term
Divisions to continue to conduct and report return to work meetings

RISKS/ISSUES

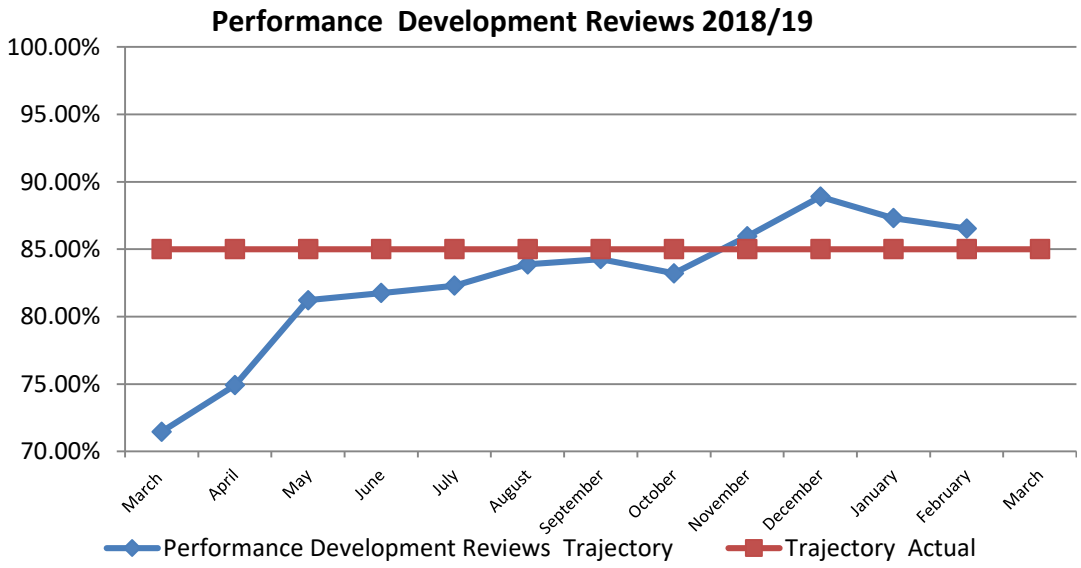
3 Workforce Learning and Development

3a Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NSS Staff Survey: Engagement Question 2018	2018	2017	2016	2015
20a	In the 12 months have you had an appraisal or annual review?	91%	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	63%	64%	74%	79%
20f	Were any training, learning or development needs identified?	66%	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date



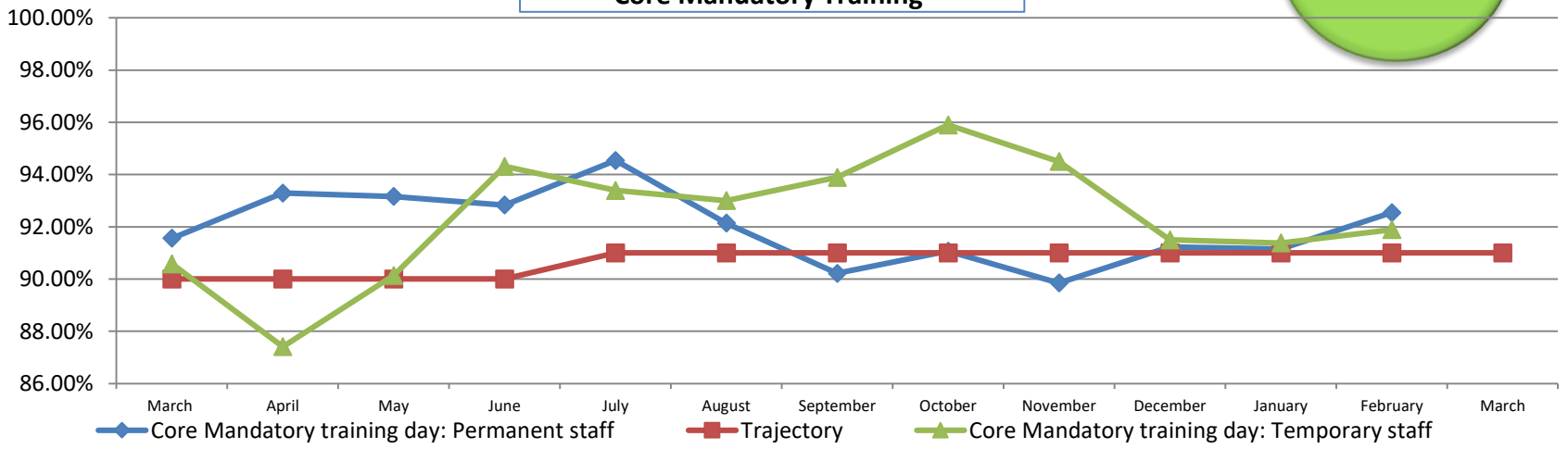
The most recent results from the National Staff Survey show positive feedback from staff on the quality of annual appraisals received. Work will continue to refresh management of performance at the Trust including training needs and talent management.

3 Workforce Learning and Development

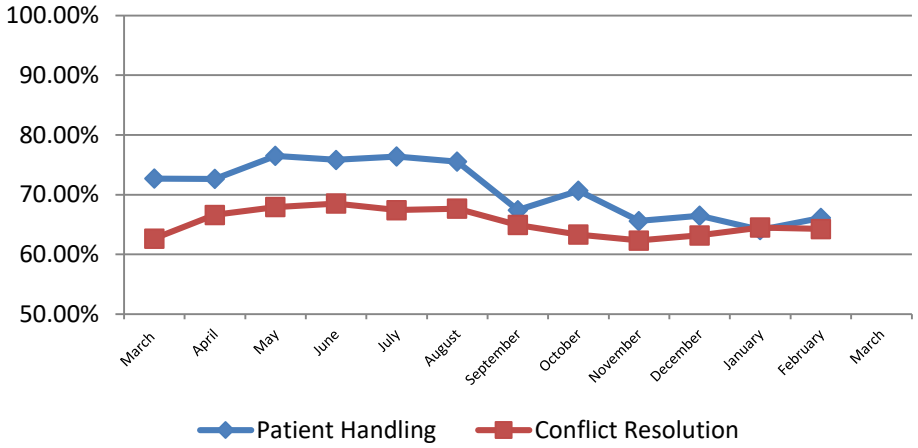
3b Core Mandatory Training, Specialist Training and Corporate Induction

Core Mandatory Training

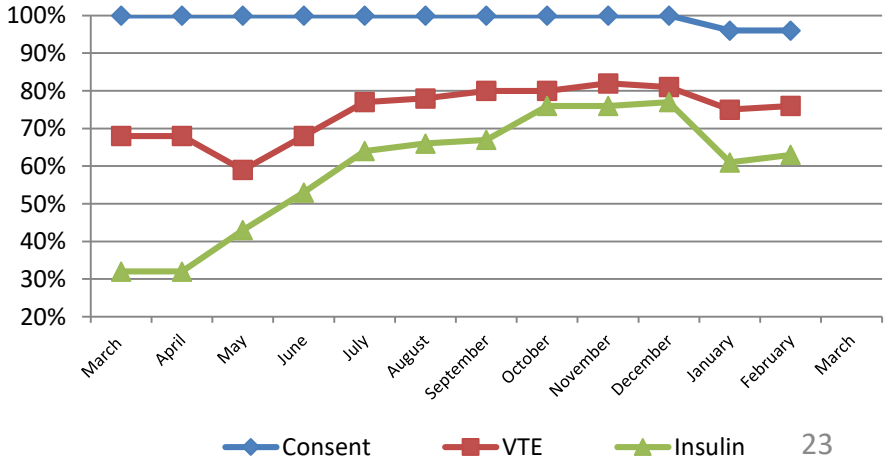
Core Mandatory Training



Patient Handling and Conflict Resolution Compliance



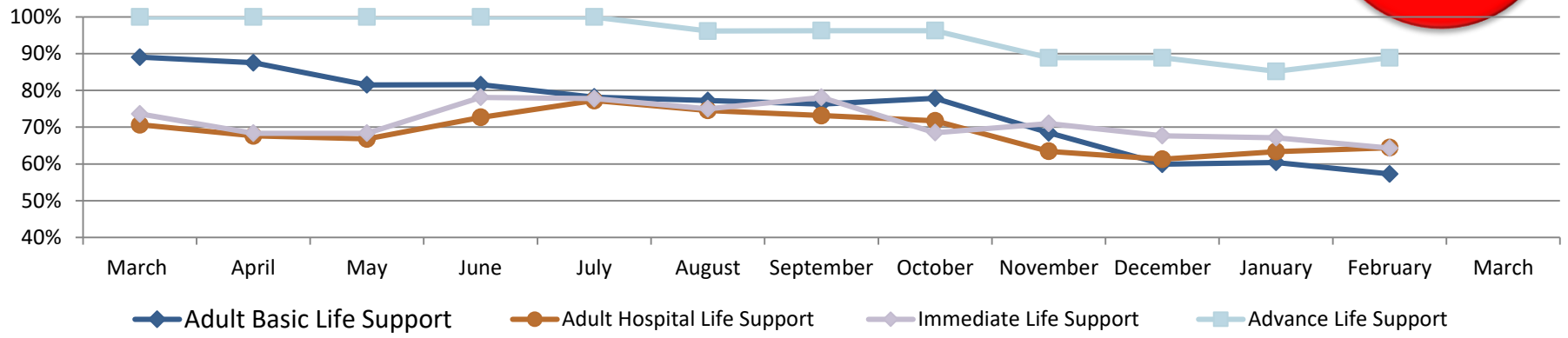
e-learning Modules Compliance



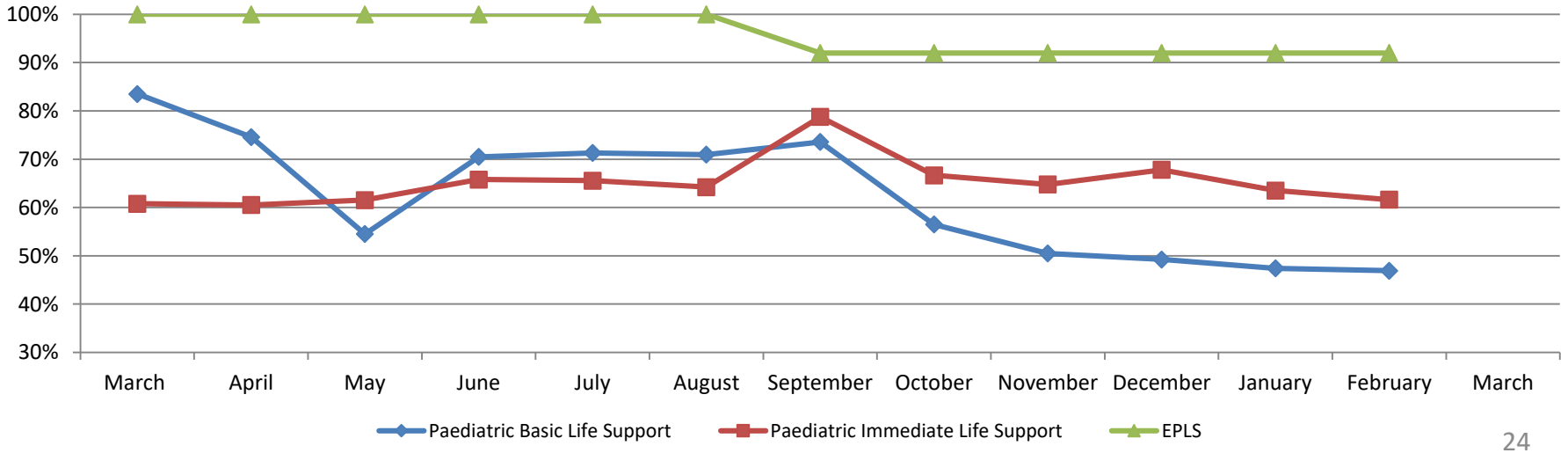
3	Workforce Learning and Development
3c	Resuscitation Training

Resuscitation Training

Adult Resuscitation Training



Paediatric Resuscitation Training



INFORMATION

Core Mandatory Training – Reported Core mandatory training attendance has achieved above compliance for 3 months. Work continues on improving the content and delivery of the face to face training, and developing a more easily accessible e-learning approach. 10% of core mandatory training is currently completed on line. 2019 will see an increase in this figure.
CMT for Bank / Temp staff has continued to maintain over 91% compliance for 10 months.

Role Specific Mandatory training –
The Trust Resus training compliance for Adults and Paediatrics has shown a steady decrease over the last 6 months. In October 2017, the Trust had a push on adult and paediatric resus training, and those that became compliant during those months are subsequently becoming non-compliant as their annual update requirement comes around.
Resuscitation standards and governance processes have recently been reviewed and updated recently, with the Director of Nursing committing to chair the Resus committee from November 2018. The Risk for resuscitation training compliance figures is monitored through the quality and safety group.
Conflict resolution and patient handling compliance continues to hover around the 65% compliance area. This has been raised with the clinical quality group, and a small focus group has been created to review attendance requirements.
VTE / Insulin –Improvements have been seen in staff completing insulin and VTE however the delegate group was reviewed in January with additional staff included, which has resulted in a drop in compliance figures. .
Following a review of the consent module compliance, additional names have been included which has reduced compliance by 4%, those individuals have been contacted directly.

ACTIONS FOR IMPROVEMENTS / LEARNING

Core mandatory training :– Mandatory training streamlining / CIP project continues. Positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information.
Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place.

VTE/Insulin online modules: E-learning facilitator working closely with Lead to increase compliance, creating learning paths in ESR. It has been agreed that medics do not need to complete the insulin modules as they do not administer.

Consideration will be given to the inclusion of role specific mandatory training in Agenda for Change performance management processes in 2019/20.

RISKS/ISSUES

Staff booking onto and completing their role specific mandatory training modules is low.
Resus levels still non compliant
In house trainers for resus and patient handling reducing availability to support training.
Attendance and DNAs on courses is still high. DNA charges will be introduced during 2019.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

OVERALL STAFF ENGAGEMENT

The most recent National staff survey results have seen a positive move on the overall staff engagement score from 3.83 to 3.97. The score is made up of the questions shown below:

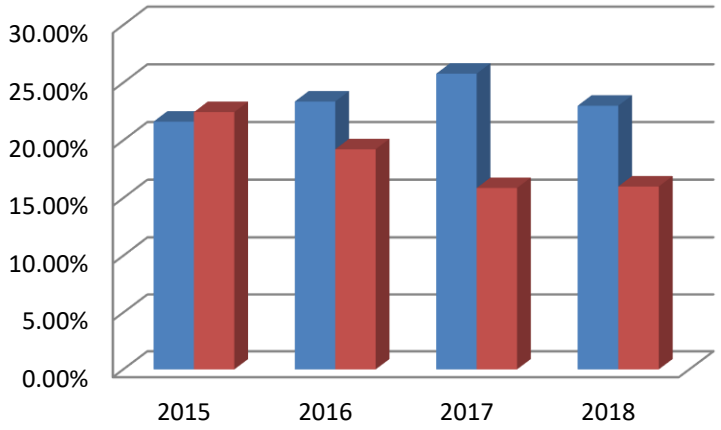
	Questions linked to ROH engagement score	2018 ROH	2018 Average	2017 ROH	2016 ROH
21a	Care of patients is my organisation's top priority	86%	86%	79%	69%
21b	My organisation acts on concerns raised by patients	83%	81%	79%	73%
21c	I would recommend my organisation as a place to work	73%	72%	62%	56%
21d	I would recommend the standard of care provided by this organisation	91%	89%	83%	77%

4 Workforce – Experience and Engagement

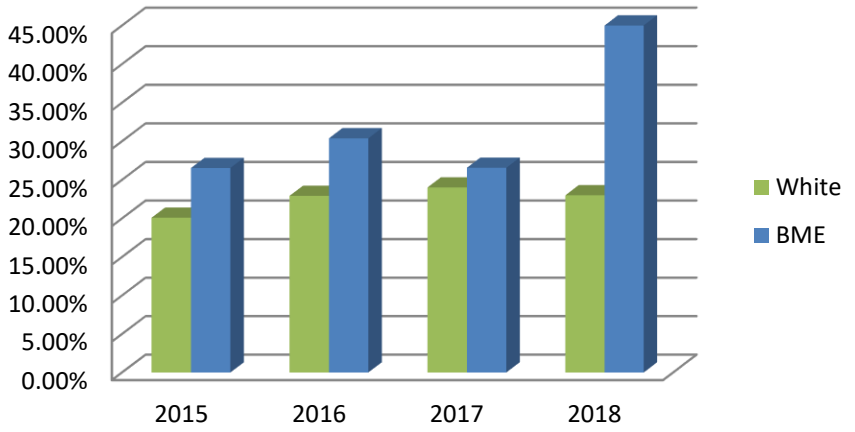
4c WRES Indicators

WRES Indicators

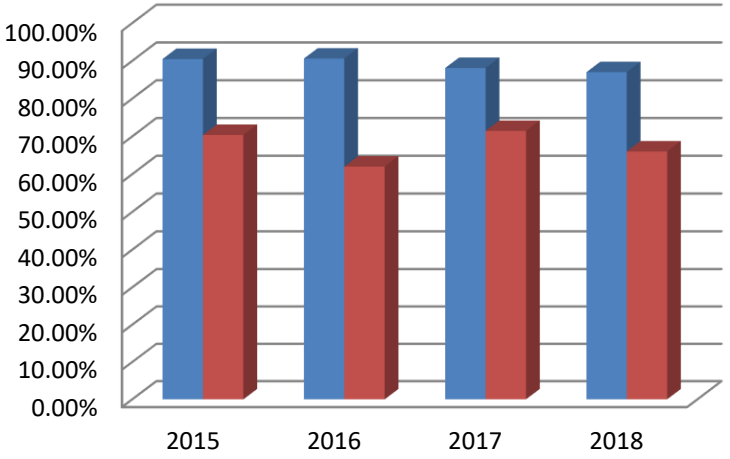
Indicator 5: Experiencing bullying from patients



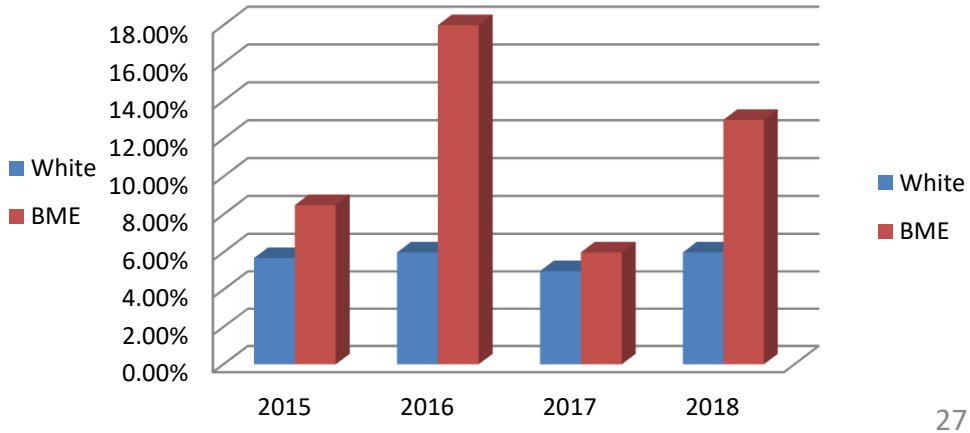
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION
Friends and Family Test (FFT) – The Trust is still awaiting the final information from Capita People Solution on the Staff FFT from Q4. This will be presented at the next SE&OD committee **Engagement and Job Satisfaction** – Speak Up and Join in brand becoming increasing established. Even better if… sessions being rolled out across teams. Information from the National Staff survey results is being communicated across the Trust and team will be asked in April 2019 to compile local actions based on the survey results **WRES Indicators –** Whilst the overall response rate to the 2017 was low, the proportion of BME staff completing the 2017 was comparable. WRES indicators informed by 2017 National Staff Survey show significant differentiation between white and BME staff. Whist some indicators may be evidence of greater confidence in reporting concerns, further action is required. The Trusts E&D annual report and grading of E&D outcomes under EDS2 will be informed by WRES indicators. Data for WRES 2018 will start to be collected in April 2019.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions to encourage survey completion to improve data reliability Ensure all staff are sighted on the positive staff survey results and are able to suggest local improvements
RISKS/ISSUES
Part of the WRES data is sourced from the NHS National Staff survey. Completion rate affects the reliability of the data as a representation of staff views

ROHTB (5/19) 008

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 26 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that there had been an undervaluation of stock identified as part of the annual auditing work; this had been detected as part of sample testing initially and then upwards extrapolation from a wider review. The Committee was concerned that this was an issue that had been reported during the previous two years and was keen to see the matter resolved during the next year as a priority. It was reported that a new stock management system that was anticipated to be introduced shortly would assist with this. • There had been six internal audits which had provided only partial assurance. • Some shortfalls in terms of process had been highlighted by the audit into the implementation and handling of NICE guidance. It was noted that the new HealthAssure system would help to address these weaknesses. • It was reported that the Trust had achieved a Use of Resources score of 3. The recurrent deficit of the Trust drove a 4 in the first three elements, whilst performance against the agency cap also resulted in a 4. Overall financial performance against plan was a 1, which resulted in an overall score of 3.	• Present the contracts database at the July meeting of the Audit Committee. • NICE guidance internal audit is to be presented to the Quality & Safety Committee. • Further update on plans to tighten stock management to be presented at the next meeting. • Present the progress with the Data Protection Toolkit action plan at the next meeting. • Include an in depth review of the recommendation trackers at the July 2019 meeting
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• External Audit had begun initial testing of the quality indicators (mandatory and local) in the Quality Account. • The Head of Internal Audit's opinion concluded that there was an adequate system of internal control at the ROH, but with potential to improve this further. • It was highlighted that overall the Internal Audit programme focussed on areas where the Trust knew there was some weakness, however there was evidence of good engagement by the Executive team in addressing the recommendations raised by the audits.	• The Committee approved the proposal to submit the Counterfraud self-assessment review toolkit

• The Committee received the updated workplan for Counterfraud, which it was agreed was useful and provided a clearer view of the scope of the work that that of previous years. • The outcome of the Counterfraud self-assessment review toolkit was positive overall. • The draft annual accounts were considered which showed that the Trust had met its Control Total for 2018/19. • It was noted that there had been a positive increase in income associated with private patient work. • External Audit commented that it was pleasing to have a comprehensive set of accounts at this point in the year and noted that there had been good co-operation with the finance team. The high quality of the draft Annual Governance Statement and draft Quality Account was also noted and those producing them were thanked. • The Annual Governance Statement was considered, which did not highlight any major weaknesses in internal control beyond that of the loss of an encrypted laptop at the beginning of the financial year. • The Committee reviewed the draft Quality Account which highlighted a number of operational and quality achievements in 2018/19. • The Committee received a positive update on compliance with the Data Protection Toolkit; where there was a shortfall there was confidence that this could be rectified by the time that a further update to NHS Digital was required.	
Chair's comments on the effectiveness of the meeting: The meeting agenda had been heavy however it was agreed that the major points for discussion had been given adequate space.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 17 May 2019

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 22 May 2019 at 1400h to transact the business detailed on the attached agenda.

Members of the press and public are welcome to attend the public part of the agenda.

Questions for the Council of Governors should be received by the Associate Director of Governance & Company Secretary no later than 24hrs prior to the meeting by post or e-mail to Associate Director of Governance & Company Secretary, Simon Grainger-Lloyd, Trust Headquarters or via email s.grainger-lloyd@nhs.net

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 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** 22 May 2019 : 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 16 January 2019 and 4 April 2019	ROHGO (1/19) 009 ROHGO (4/19) 001	Chair
1410h	4	Update on actions arising from previous meeting	Verbal	SGL
1415h	5	Chief Executive's and Chair's update including paediatric transition and Birmingham Hospitals Alliance	Verbal	JW/YB
	5.1	Extension of the terms of office of Simone Jordan and Tim Pile	Verbal	YB
1435h	6	Developing the Trust's strategy	ROHGO (5/19) 004	RL
1450h	7	Staff survey results	ROHGO (5/19) 003	KS/CM
1505h	8	Update from the Trust Board and Board Committees: • Trust Board • Audit Committee • Quality & Safety Committee • Finance & Performance Committee and Staff Experience & OD Committee	ROHGO (5/19) 005 - 007 ROHGO (5/19) 008 ROHGO (5/19) 009 ROHGO (5/19) 010 & 011	YB RA KS RA/KS
1520h	9	Governor Matters (raised in pre-meet): • Feedback	Verbal	All
1525h	10	DRAFT Annual Report (including Quality Account) & Accounts 2017 (PRIVATE ITEM)	ROHGO (5/19) 012 ROHGO (5/19) 012 (a) ROHGO (5/19) 012 (b) ROHGO (5/19) 012 (c)	
1545h	11	For information: • Finance & Performance Overview • Quality & Patient Safety Report • Workforce Overview • Board Assurance Framwork	ROHGO (5/19) 013 ROHGO (5/19) 014 ROHGO (5/19) 015 ROHGO (5/19) 016	

12	Any other business	Verbal
Date of next meeting: Thursday 10 October 2019 @ 1400h – 1600h in Trust Headquarters, after which follows the Annual General Meeting		

MINUTES

Council of Governors - Version

Venue Boardroom, Trust Headquarters **Date** 16 January 2019 @ 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
Robert Talboys	Public Governor	RT
Arthur Hughes	Public Governor	AH
Kennedy Iroanusi	Public Governor	KI
Karen Hughes	Staff Governor	KH
Gavin Newman	Staff Governor	GN
David Richardson	Staff Governor	DR
David Robinson	Stakeholder Governor	PS
Hannah Abbott	Stakeholder Governor	HA
Liz Clements	Stakeholder Govenor	LC

In attendance

Simone Jordan	Associate Non Executive Director	SJ	
Rod Anthony	Non Executive Director	RA	
Paul Athey	Acting Chief Executive	PA	
Jo Williams	Interim Chief Operating Officer	JW	
Simon Grainger-Lloyd	Associazte Director of Governance and Company Secretary	SGL	[Secretariat]

Minutes	**Paper Ref**
1 Proposal to award a cost of living payrise to Chairman and Non Executives (PRIVATE ITEM)	**ROHGO (1/19) 002** **ROHGO (1/19) 002 (a)**
Without the Chairman and Non Executives present, the Council of Governors was asked to approve a proposed 2% pay uplift for these Board members. It was noted that the pay uplift was in line with that awarded to other staff groups under Agenda for Change and was also at a similar level to that proposed for	

staff on a Very Senior Manager arrangement. It was noted that care needed to be taken to ensuring that the pay of the Non Executives and Chairman were of a level that would attract good calibre candidates in the future and to retain those currently in post. On the basis of the discussions, the Council of Governors approved the 2% pay uplift.	
2 Apologies and welcome	**Verbal**
The Chairman, Acting Chief Executive and Non Executives joined the meeting. Apologies were received from, Dr Dagmar Scheel-Toellner, Adrian Gardner, Richard Burden.	
3 Declarations of interest	**Verbal**
There were none.	
4 Minutes of previous meeting on 4 October 2018	**ROHGO (10/18) 012**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held.	
5 Update on actions arising from previous meeting	**Verbal**
The Associate Director of Governance & Company Secretary advised that at the last meeting, the lead governor had been asked to seek views on the proposed extension to Tim Pile's term of office. The governors had unanimously agreed that this was appropriate and on this basis Mr Pile would stay with the Trust until 31 December 2019. The action around the Non Executives being given greater visibility across the Trust had been addressed by their participation in quality assurance walkabouts and the new staff experience walkabouts that had started. In terms of reporting back on the Birmingham Hospitals work, this was included on the agenda of the meeting.	
6 Chief Executive's update	**ROHGO (1/19) 003** **ROHGO (1/19) 003 (a)**
The Acting Chief Executive reported that in terms of planning for 2019/20, the national operational planning guidance had been released, so there was clarity on what needed to be delivered. The orthopaedics tariff had been improved. The Control Total for the year had been set and this was a deficit of £5.2m. This was a lower deficit than had been achieved before, therefore this was a stretching target. A one year financial plan would be submitted and measures would be taken to encourage the provider sector to return back into balance. There was a clear expectation that all providers should be back in balance by 2013/14, but the majority should be breaking even within the next two years.	

The Trust could access some funding centrally and a five year plan needed to be submitted. The system response to the NHS Long Term Plan was being developed. The financial consequences were noted to be challenging from an income and a cost control perspective. There was noted to be a limit on the ROH's capacity to deliver additional activity and as the tariff to cover the work previously did not reflect the current costs on a like for like basis, there was essentially a £4.5m shortfall in funding. Robotic surgery could not be used for NHS work. The Acting Chief Executive was asked whether there was an option to shrink activity to minimise the impact of tariff. He advised that this was an opportunity but then commissioners would have to place this work elsewhere. There were few procedures on which the Trust lost money, therefore doing less work would mean that the level of overheads required to deliver the work would be out of kilter and would mean a loss of some of the Trust's world renowned surgeons. It was suggested that the considerations around the growth of the Trust need to be shared with the Council of Governors and this would be done as part of the update on the Trust's financial position. In terms of trends in commissioning, commissioners were reluctantly placing more and more work into the private sector to address long waiting times. There was a plan for this trend to be reversed by the STP, although patient choice needed to be borne in mind. Work from Heartlands Hospital was being diverted into the ROH at a level of c. 50 patients per month. It was noted that Circle was planning a new hospital, so there was a risk that some traditional NHS work would be commissioned at this facility. Some of its work would also come from some of the other private organisations. It was noted that there had been difficulty in gaining referrals and therefore more work with GP liaison was planned. It was noted that there was generally no better outcome for the patient if a procedure was undertaken in the private sector. Commissioners and GPs were looking at opportunities to rationalise the referrals and first contact practitioners were being installed to promote musculoskeletal (MSK) offerings to determine if a referral into secondary care was needed. This was an opportunity for the ROH's MSK team and this service was being offered out of West Heath GP practice at present, with a plan to expand this to other locations. The GP out of hours service was noted to be going well and the expansion of the service was being considered, such as phlebotomy. Seven of the local GPs used the opportunity. It was suggested that the GP liasion manager would benefit from the contact with patients and that patient case studies could be captured on the website. It was reported that the staff awards ceremony was planned for 8 February and there had been a good number of nominations. This backed up some of the early findings of the staff survey. Governors were pleased with the engagement around the staff awards and the 'living the values' stories that had been seen.	

Thanks were given to the organisers.	
7 Birmingham Hospitals update and STP key messages	**Verbal**
It was noted that the ROH had good traction in the Birmingham Hospitals arrangements and the ROH remained as member at the STP Board meetings. There was reported to have been the development of a Birmingham Hospitals Alliance involving ROH, University Hospitals Birmingham NHSFT and Birmingham Women's and Children's NHSFT. This had become important as part of the long term plan. On 3 December, there had been a productive discussion between these providers, chaired by Jacqui Smith. There had been a discussion around maternity services and procurement in particular. The importance of orthopaedics had been discussed. There was a lack of clarity at present around what integration might look like. It was noted that there had been much joint working with UHB and Heartlands, Good Hope and Solihull Hospitals (HGS) recently and a proposal had been made to continue partnership work through these settings. It was suggested that a concordat would be developed to shape this arrangement. There was a need for the ROH's specialist expertise to improve orthopaedics at the other side of the city. It was noted that the brand of the ROH needed to be protected and sustained through this arrangement. The ROH had been visited by the Getting it Right First Time (GRIFT) team to review how the orthopaedics pathways might be standardised. They reviewed the Joint Care pathway and proposed that there should be some collaborative work to develop services across Birmingham. This will provide an exemplar for changes in the future. It was noted that full integration included prevention and social care. The environmental impact across the NHS was noted to be important. Petro Nicolaides left the meeting.	
8 Modular theatres plans	**Presentation**
It was noted that the background to the modular theatres work had been discussed in previous items. A presentation on the plans was delievered. Liz Clements noted that the residents meeting around the plans had been productive and the follow up e-mail from Prof Begg especially with regard to parking had been encouraging. It was noted that the building configuration and design had been patient-led. It was noted that there was optimism that the facility would be commissioned in October 2018 and would also assist with managing some of the pressures in acute settings elsewhere. From staff perspective, it was suggested that the vacancies position was a	

concern for staff. It was also suggested that the process for admissions needed to be considered for the facility. It was reported that some current activities would be moved into Outpatients and times for admission would be set. For the majority of days, currently all ten theatres were being used and therefore this was a constraining factor for activity growth but the beds that were not being routinely filled now could be. There were different options in terms of the use of theatres to utilise all the capacity initially, including supporting trusts elsewhere. In terms of the forthcoming February planning meeting, the Council would be looking to see that any concerns raised had been addressed. The residents meeting would be useful evidence of discussion and engagement. In terms of the workforce, there was a wider regional discussion given the concerns. At a local level, there was a need to market the offering at the ROH. The assumptions around activity in the business case were noted to be prudent and there was a feeling that the income associated with the facility was likely to be met or exceeded. Private work may be ringfenced. It was noted that any new consultant could not be offered a theatre list at present due to the constraints and the modular theatres arranagements created an opportunity to do this. It was noted that Finance and Performance Committee was the key oversight committee for this.	
9 Paediatrics services update	**Verbal**
It was reported that the initial plan for the transfer of paediatric services was for the inpatient element to move to BCH on 31 January 2019. Following discussions between ROH and BCH however, it was agreed that there were risks associated with the movement of the service to these timescales on the basis that there was a need to secure sufficient staffing for theatres at BCH, a review of the Oncology service was planned and a ward and theatre needed to be renovated at BCH. It was noted that four more staff were needed to ensure that the paediatric ward at ROH could be supported. There were noted to be daily conversations to ensure that the ward was adequately staffed and there was work with BCH to help address any staffing vulnerabilities when identified. It was reported that an e-mail had been issued to all consultants to advise that the number of beds on the ward would reduce to ensure that the service could be adequately staffed until the end of June 2019. The High Dependency Unit (HDU) would be moved onto Ward 11. It was noted that the discussions around staffing were time consuming and complex. There was noted to have been some good support from BCH with the arrangements. Karen Hughes joined the meeting. It was reported that there was less patient resistance to the plans than	

previously and those expressing disquiet were kept up to date and listened to.	
10 Membership update	**Presentation**
Elaine Chapman joined the meeting and delivered a presentation to describe the plans for engaging the membership over coming months. It was suggested that the new appointment kiosks could be used to capture contact preferences. In terms of the membership newsletter, it was suggested that a phased approach was needed where members were advised that the production was being moved onto a digital platform. It was agreed that there needed to be a balance between having good engagement with a small number of people as opposed to a large number of people with low quality engagement. It was suggested that students were a useful group to engage. It was noted that there was access for members to NHS Discounts. The ethnicity of the membership was needed in future.	
11 Update from the Board Committees: • **Staff Experience & OD Committee** • **Audit Committee**	**Verbal**
Simone Jordan highlighted that there were challenges around the workforce as had been discussed elsewhere on the agenda. A comprehensive workforce report was now available to the Staff Experience & OD Committee which provided assurance against a range of key workforce metrics. The data was maturing and prompted the Committee to ask questions. There was a plan of business for the Committee and a staff story was delivered as the first item at each meeting which was well received. Once a quarter a workshop was held. There was reported to have been a spike in sickness absence and the Finance and Performance Committee had remitted the scrutiny of this to the Staff Experience & OD Committee. A broader approach to workforce development was now evident and there was a wider focus beyond the Nurse Staffing assurance report led by the Deputy Director of Nursing & Clinical Governance. The staff experience walkabouts were well received. The speaking up culture was also developing well. The plans around improving diversity were questioned. In response, it was reported that there was much work on the Workforce Race and Equality Standards (WRES) in terms of an action to address any shortfalls identified and the intention was that the equality, diversity and inclusion agenda should be being better lived. Professor Surinder Sharma, an expert in equality and diversity matters was working with the Board. It was agreed that his recommendation report would be presented at a future meeting. It was suggested that there might be staffing issues on Ward 2, but these had not been on the radar previously and therefore some work had been undertaken to equalise the number of permanent staff across the wards to address the issue. It was noted that there were different issues with the wards	

at different times. It was suggested that some of the areas had block booked agency staff which created a degree of stability now and allowed staff to be released for training. There were a number of other meetings where trends such as this were monitored. In terms of Audit Committee, Rod Anthony reported that this had continued to undertake work according to plan. The year end accounts were being thought through, including the basis on which the ROH prepared the accounts. A plan of audit work would be worked through. It was noted that Garry Marsh was now chairing the resuscitation committee, which created some better focus. There was also close working with the other committees. In terms of the challenge from CCGs around clinical revenue, this was a generic risk and not a specific comment in relation to the ROH.	
12 Governor Matters: • **Representation on the Estates Strategy & Delivery Group –** it was highlighted that a new governor representative needed. Petro Nicolaides and David Robinson offered their services for this. • **Governor drop in sessions –** it was noted that in the pre-meet, it had been agreed that retiming these to fit in with the busiest times should be explored and these should be varied according to whether they were staff for public sessions	**Verbal**
13 For information: • **Quality & Patient Safety Report** • **Finance & Performance Overview** • **Workforce Overview**	**ROHGO (1/19) 006** **ROHGO (1/19) 007** **ROHGO (1/19) 008**
These were accepted and noted.	
14 Any other business	**Verbal**
It was suggested that Prof Begg be invited to the next meeting to discuss car parking and transportation plans.	
15 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 22 May 2019 at 1400h – 1600h in the Boardroom, Trust Headquarters (premeet with the Lead Governor and Chairman @ 1300h).	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Council of Governors - DRAFT Version 0.3

Venue Chief Executive's Office, Trust Headquarters **Date** 4 April 2019: 1715h – 1730h

Members participating:

Dame Yve Buckland	Chairman	(YB)
Mr Brian Toner	Lead Governor	(BT)
Mr Arthur Hughes	Public Governor	(AH)
Mrs Marion Betteridge	Public Governor	(SJ)
Mr David Robinson	Stakeholder Governor	(DRo)
Dr Dagmar Scheel-Toellner	Stakeholder Governor	(DS-T)
Mr David Richardson	Staff Governor	(DRi)
Miss Karen Hughes	Staff Governor	(KH)

In attendance:

Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Petro Nicolaides, Carol Cullimore, Richard Burden, Lindsey Hughes, Hannah Abbott, Sue Arnott, Kennedy Iroanusi. It was noted that there was a quorum of members to make a decision.	
2 Chief Executive's appointment	**Verbal**
The Council of Governors received a recommendation from the Nominations and Remuneration Committee of the Trust Board that Joanne Williams be appointed as the substantive Chief Executive, following a competitive interview process involving external candidates. Those above had participated either in the carousels or the main panel and the Associate Director of Governance had confirmed with the remaining governors that they were happy to delegate approval of the appointment to the quorum involved.	`

On this basis and based on their experience as part of the interview process, the appointment was approved. It was noted that the main interview panel and all carousels had concluded that Mrs Williams, out of the two appointable, was the best candidate for the role.	
3 Any Other Business	**Verbal**
There was none.	

2019 - 2024
CO-DESIGN AND LAUNCH STRATEGY

OUR VISION

TO BE FIRST CHOICE FOR ORTHOPAEDIC CARE

OUR VALUES

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

OUR GOALS

THESE FIVE GOALS WILL BE OUR MAIN FOCUS FOR THE NEXT FIVE YEARS AND BEYOND

PATIENTS	PEOPLE	PARTNERSHIP	PROCESS	PERFORMANCE
SAFE HIGH QUALITY PATIENT CARE	A DIVERSE, HIGHLY SKILLED & WELL SUPPORTED WORKFORCE	IMPROVED & INTEGRATED SERVICES	PRODUCTIVE & EFFICIENT PROCESSES	A SUSTAINABLE FUTURE THROUGH GROWTH & FINANCIAL STABILITY

ENABLERS

- A CLINICAL STRATEGY
- INVOLVEMENT, EXPERIENCE & VOLUNTEERING STRATEGY
- DEVELOPING OUR ESTATE
- THE RIGHT I.T. & TECHNOLOGY
- MARKETING OUR SERVICES
- DELIVERING OUR PEOPLE STRATEGY
- DELIVERING OUR KNOWLEDGE STRATEGY

ENGAGE WITH STAFF TO REFLECT ON PROGRESS AND PLAN FOR NEXT STEPS

WHAT SUCCESS LOOKS LIKE

PATIENTS	OUTSTANDING CARE EXCEPTIONAL PATIENT EXPERIENCE AND OUTCOMES
PEOPLE	EMPLOYER OF CHOICE ENGAGED WORKFORCE
PARTNERSHIP	LEADERS IN ORTHOPAEDIC INNOVATION LOCAL AND NATIONAL PARTNERSHIPS
PROCESS	MODERN TECHNOLOGY AND PROCESSES CULTURE OF CONTINUOUS IMPROVEMENT
PERFORMANCE	FINANCIAL SUSTAINABILITY ORTHOPAEDIC CENTRE OF EXCELLENCE

YOUR ROLE

PARTICIPATE: SPEAK UP & JOIN IN! YOUR VOICE IS IMPORTANT

INNOVATE: LOOK FOR OPPORTUNITIES TO MAKE IMPROVEMENTS

COLLABORATE: LOOK AT THE BIGGER PICTURE AND WORK IN PARTNERSHIP

The Staff Survey

SPEAK UP
& JOIN IN!

General feedback: highlights

74%

The percentage of questions we made improvements in since the last survey

Out three biggest areas of improvement

- Relationship between staff and their immediate or senior managers
- Enthusiasm for your role
- Treatment of staff reporting incidents

We scored the highest percentage of staff satisfied with flexible working out of all NHS trusts in the UK!

We compare really well against other local hospitals in the area for staff engagement (see slide 6)

General feedback: improvement since the last survey

- Feedback this year has been largely positive
- The number of people who contributed to the survey increased since the last survey
- We improved in 59 out of the 79 questions asked and deteriorated in 10.

Of the 59 that ROH improved in, 9 improved by over 10%. Themes included

- Relationship between senior management and staff
- Enthusiasm with your role
- Treatment of staff reporting incidents

23 improved by between 6% and 9%. Themes included:

- Support from immediate managers
- Awareness of senior management
- Appraisals – regularity and effectiveness
- Standards of care

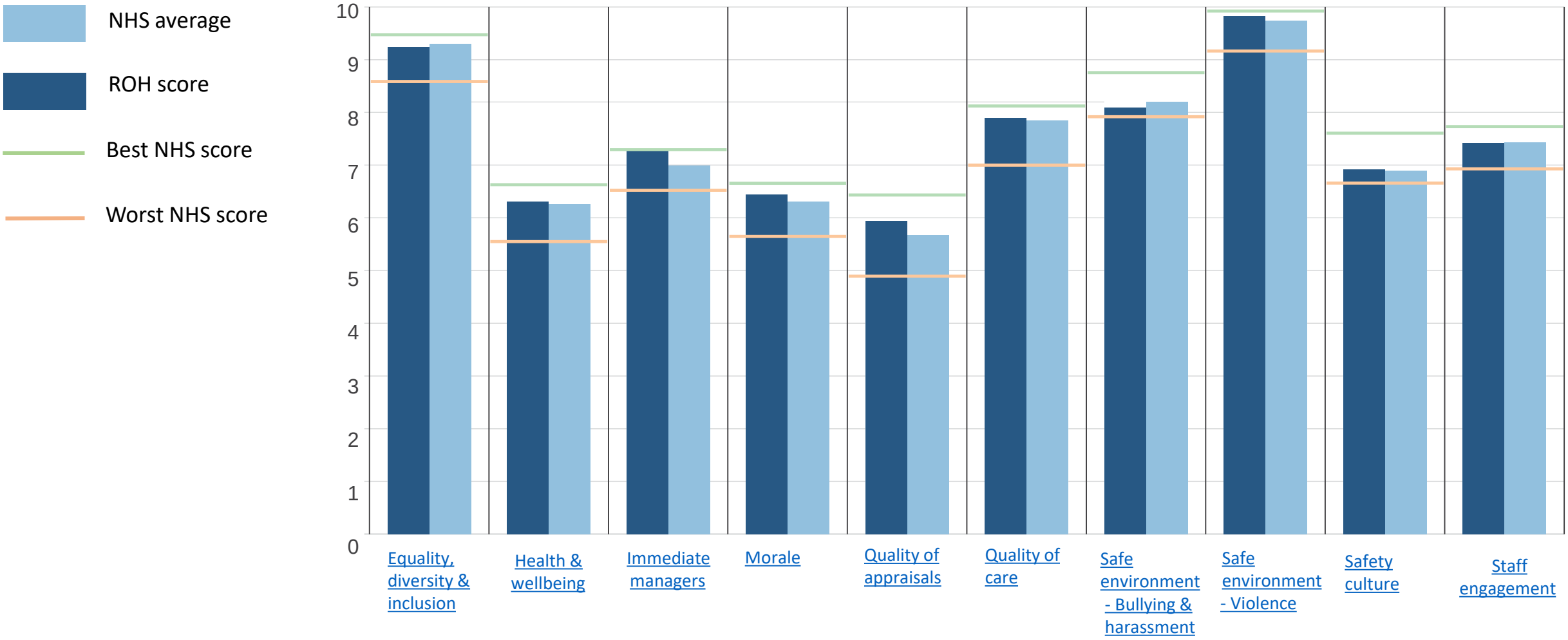
1 area deteriorated by over 5%. Theme:

- Reporting of incidents of physical violence

General feedback: biggest improvements

Big improvements by at least 10%		2018	2017	
9b	Communication between senior management and staff is effective	47%	35%	**12%**
19f	My appraisal identified training needs	66%	54%	**12%**
9d	Senior managers act on staff feedback	38%	27%	**11%**
17a	My organisation treats staff who are involved in an error, near miss or incident fairly	64%	53%	**11%**
2a	I look forward to going to work	64%	54%	**10%**
2b	I am enthusiastic about my job	78%	68%	**10%**
5g	Satisfied with "My level of pay"	47%	37%	**10%**
17d	We are given feedback about changes made in response to reported errors, near misses and incidents	60%	50%	**10%**
21c	I would recommend my organisation as a place to work	73%	63%	**10%**

General feedback: our results against themes



How we compare with Birmingham & Solihull partners

“Staff recommendation of the organisation as a place to work or receive treatment”
ROH – 4.0
Others – Between 3.58 and 3.81

“Staff satisfaction with the quality of work and care they are able to deliver”
ROH - 4.12
Others – Between 3.82 and 3.96

“Recognition and value of staff by managers and the organisation”
ROH – 3.72
Others – Between 3.40 and 3.52

“Organisation and management interest in and action on health and wellbeing”
ROH – 3.75
Others – Between 3.46 and 3.59

“Overall engagement score”
ROH – 3.97
Others – Between 3.69 and 3.80

86%

When compared to neighbouring hospitals we rank higher in 86% of all questions asked: your feedback suggests you are more satisfied with your organisation than all other local Trusts

Survey feedback: where can we make improvements?

Feedback was positive this year, but there are always opportunities for improvement. Three trends emerge where your feedback suggests more could be done to offer you support:

Managing performance
You feedback suggests more could be done to support the Personal Development Review (PDRs) process.

Bullying and harassment
Your feedback suggests that in some areas, colleagues still face incidents of bullying and/or harassment.

Wellbeing
Your feedback suggests you would like more activities and initiatives to support your wellbeing at work.

Response to these trends will be prioritised. Work is already underway in all three areas. We will ensure you're aware of this work and how you can engage with it.

What's next? Developing action plans together

- This information is being shared with staff members in a number of different ways
- We will be asking teams to look at the results and decide on actions that will help their areas improve even more
- All actions will be integrated into the work being under on the Trust Strategy through the 5Ps
- Information will be shared with key partners

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM TRUST BOARD TO COUNCIL OF GOVERNORS

Date Group or Board met: 6 March 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Board received an update on the plans to transfer paediatric inpatient services out of the ROH and over to BCH. A key piece of work was highlighted to be the paediatric oncology review which would be held on 11/12 March and would include a patient representative – if there was insufficient assurance that the service could be delivered without compromising patient care then a risk summit would be held with commissioners and other key stakeholders. • The Board considered the draft operational and financial plan for 2019/20. It was noted that the plan contained some element of risk, particularly around the loss of income around paediatric services, the planned growth as a result of the modular theatre set up and the impact of tariff. • The Board was made aware of the plans to strengthen the effectiveness of the Drugs and Therapeutics Committee which reported up to the Quality & Safety Committee. • The Board was given an update on the plans to address the risk associated with some staff requiring Hepatitis B vaccinations. Staff impacted had been recalled and those at highest risk were being identified and prioritised. • It was noted that there was a concern picked up on walkabouts over the administration of analgesia; the Board was given an update on the plans to ensure that adequate pain management was administered in a consistent way in future. • An update on the uptake of the 'flu vaccine was provided; this was lower than in other organisations, therefore work was underway to better prepare for the coming year to ensure that the position was improved.	• It was suggested that a dedicated fundraiser was needed to support the work of the charity.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The Board was updated on a number of promising opportunities for partnership being pursued with commercial organisations which may benefit patients by offering a different range of treatments • There were some positive assurances given that the paediatric ward and HDU was operating with a more robust staffing model and the leadership of the ward provided by BCH was working well. Staff morale was also higher. • The Board was advised that planning permission had been granted for the modular theatres build and the Trust had been recognised for its engagement with stakeholders and local residents. Cllr Liz Clements and Richard Burden MP were thanked for the support they had provided. • There was reported to be positive progress with the 'Perfecting Pathways' programme and in particular the JointCare initiative which was helping to reduce overall length of stay. • The positive progress against a number of quality priorities set out in the draft annual operational and financial plan was highlighted. • The Board discussed the progress with the development of revised orthopaedic pathways across the STP. • The development of the Birmingham Hospitals Alliance was discussed. • The Board received a positive Service Improvement story on the work of the Flow Academy, the work of which was based on a concept of Continuous Improvement. There was noted to have been a good benefit of applying this approach to pre-operative processes. • The Board was advised that the staff survey results had been received which showed a positive improvement across a range of areas. • An update on the plans for Brexit was provided. • The reduction in the number of patients waiting in excess of 52 weeks was noted to be very encouraging. • The staff in post position was reported to have improved.	• A full update on partnership opportunities to be presented at the April meeting • The draft annual financial and operation plan is to be presented at the April meeting • The Board acting as the corporate trustee for the charity approved funding for an introductory package of support for staff arriving from overseas. • The Board approved the Infection Control annual report. • The Board approved its workplan for 2019/20.

• It was reported that the Audit Committee had concluded that the annual accounts be made up on an Going Concern basis. • There was overall good progress against the CQC action plan	

Chair's comments on the effectiveness of the meeting: The meetings were noted to have been very productive with some good discussion and a high level of assurance provided by the upward committees of the Board.

ROHGO (5/19) 006

UPWARD REPORT FROM TRUST BOARD TO COUNCIL OF GOVERNORS

Date Group or Board met: 4 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Trust again considered the financial and operational plan for 2019/20. The main risk was cited to concern the receipt of funding promised from NHS England in recognition of the complexity of the orthopaedic work handled by the ROH. • It was suggested that an additional risk around the impact of the plan for growth on the ancillary functions of the Trust needed to be reflected on the Board Assurance Framework • A report was received which showed a difference in pay between genders at the ROH. It was noted that this was largely due to the high number of male medical staff working at the ROH but further steps were being considered to address this where possible.	• For the next meeting, provide an update on which residual elements of the paediatric services would remain after the main transfer at the end of June • Update on GP liaison work to be presented to the Finance & Performance Committee • Establish an 'honours' board for staff retiring • Invite Mr Pearson to the Trust Board to present progress with the orthopaedics work across the city • The Board Assurance Framework to be refreshed to reflect the current context and plans
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• An update on discussions at the STP Board was provided, which included proposed boundary changes for commissioning of work in Sandwell and West Birmingham. • Good feedback had been received from regulators around the reduction in the number of patients waiting in excess of 52 weeks to zero. • An encouraging report was discussed around the potential partnership opportunities available with third parties and educational establishments which had potential benefits for patient pathways and would contribute to the ongoing work to refresh and relaunch the Trust's strategy. • It was reported that there had been a series of meetings held around the movement of paediatric services, with there now being more clarity now around the plans. • An update on the plans to improve the effectiveness and productivity of the Private Patient Unit was given. There were also plans to improve the engagement with GPs across the area, which would help	• Noting the risks around the financial and operational plan, the Board approved its submission to NHS Improvement on 4 April

with the Trust's plans for growth and the achievement of sustainability. • The Board received a further update on the continued development of the Birmingham Hospitals Alliance. • The Board received a very positive story from the Ward Manager of Ward 2 which described the successes of the JointCare programme. There had been some positive national and regional press interest in the pathway and the patients' experience. • It was noted that there had been some good consultant appointments made recently. • The Board was pleased at the success with LGBT+ week. • An update on the plans for a Brexit 'no deal' outcome was presented, including a major incident business continuity exercise that had been held. • Good progress was reported to be being made to ensure that all staff had up to date Hepatitis B vaccinations. • A positive report from Healthwatch had been received which described the experience of patients waiting to be seen in Outpatients. • The Board was pleased to learning that an Outpatient 'Away Day' was planned to discuss how improvements in the area may be achieved. • Good progress was being made to progress the modular theatres plans. • There had been a positive celebration of the achievements made during the year which would be shared more widely with the Trust and governors.	
Chair's comments on the effectiveness of the meeting: The patient story had been received well. It was agreed that in terms of the Board Assurance Framework, the pre and post mitigation scoring needed to be reviewed to assess the effectiveness of the treatment plans being applied.	

ROHGO (5/19) 007

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM TRUST BOARD TO COUNCIL OF GOVERNORS

Date Group or Board met: 1 May 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Board was made aware of a risk around the impact of the annual tax allowance set by HMRC on the pension arrangements of some staff • The Audit Committee had been made aware of an issue with the rigour of stock management in theatres; work was underway to introduce new systems to address this. The Committee had also noted some shortfalls in the way NICE guidance was being handled in the Trust; the actions to address this were described to the Board.	• Gain a further briefing for the Board on the pensions issues • An update on the hydrotherapy service was requested for a future meeting • A formal Board to Board with BCH was suggested to confirm the details of the transfer of paediatric services • A number of suggestions to the strategy infographic were suggested which needed to be built into the final version for staff • Arrange for a routine update on communications to be presented. • Arrange for the work being done on mental health to be presented to the Trust Board. • Present an update on the Trust's role in environmental sustainability at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Paul Athey was thanked for his time as Acting Chief Executive and Jo Williams was welcomed as the incoming substantive Chief Executive • The Board discussed the paediatric oncology review report and the Trust's response to the recommendations contained within. On the basis of the report, all paediatric inpatients services would move to BCH on 30 June. The CT biopsy service and outpatients services would remain on the ROH site for the immediate future. • An update on the development of the Trust's strategy was presented; the strategy would be divided into a set of core 'pillars': patients, people, partnerships, process and performance (the 5 'Ps') • There was further discussion around the future relationship with local hospitals and with UHB NHSFT in particular • The Board received an update of the planned improvements in the Outpatients area, some of which had been discussed in the recent Outpatients 'away day'	• None specifically

• It was noted that the contract for the modular theatres had been signed. • The Board received an update on the work of the Communications Team and the plans for the service in future, include the introduction of a unified communications system. • The Board was pleased to learn that the financial Control Total had been met and the final position was better than planned. The risk around not receiving the transitional funding had not been realised. • There was reported to have been a strong performance against most operational targets and indicators as at the year end. • The Audit Committee had received the draft Annual Accounts, Quality Account and Annual Governance Statement and was pleased with the quality of the documents to date	

Chair's comments on the effectiveness of the meeting: It was agreed that there had been some good debate at the meetings and in particular, the strategy discussion had helped formulate the next iteration of the strategic infographic. It was however noted that the meeting had overrun slightly.

ROHGO (5/19) 008

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 26 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that there had been an undervaluation of stock identified as part of the annual auditing work; this had been detected as part of sample testing initially and then upwards extrapolation from a wider review. The Committee was concerned that this was an issue that had been reported during the previous two years and was keen to see the matter resolved during the next year as a priority. It was reported that a new stock management system that was anticipated to be introduced shortly would assist with this. • There had been six internal audits which had provided only partial assurance. • Some shortfalls in terms of process had been highlighted by the audit into the implementation and handling of NICE guidance. It was noted that the new HealthAssure system would help to address these weaknesses. • It was reported that the Trust had achieved a Use of Resources score of 3. The recurrent deficit of the Trust drove a 4 in the first three elements, whilst performance against the agency cap also resulted in a 4. Overall financial performance against plan was a 1, which resulted in an overall score of 3.	• Present the contracts database at the July meeting of the Audit Committee. • NICE guidance internal audit is to be presented to the Quality & Safety Committee. • Further update on plans to tighten stock management to be presented at the next meeting. • Present the progress with the Data Protection Toolkit action plan at the next meeting. • Include an in depth review of the recommendation trackers at the July 2019 meeting
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• External Audit had begun initial testing of the quality indicators (mandatory and local) in the Quality Account. • The Head of Internal Audit's opinion concluded that there was an adequate system of internal control at the ROH, but with potential to improve this further. • It was highlighted that overall the Internal Audit programme focussed on areas where the Trust knew there was some weakness, however there was evidence of good engagement by the Executive team in addressing the recommendations raised by the audits.	• The Committee approved the proposal to submit the Counterfraud self-assessment review toolkit

• The Committee received the updated workplan for Counterfraud, which it was agreed was useful and provided a clearer view of the scope of the work that that of previous years. • The outcome of the Counterfraud self-assessment review toolkit was positive overall. • The draft annual accounts were considered which showed that the Trust had met its Control Total for 2018/19. • It was noted that there had been a positive increase in income associated with private patient work. • External Audit commented that it was pleasing to have a comprehensive set of accounts at this point in the year and noted that there had been good co-operation with the finance team. The high quality of the draft Annual Governance Statement and draft Quality Account was also noted and those producing them were thanked. • The Annual Governance Statement was considered, which did not highlight any major weaknesses in internal control beyond that of the loss of an encrypted laptop at the beginning of the financial year. • The Committee reviewed the draft Quality Account which highlighted a number of operational and quality achievements in 2018/19. • The Committee received a positive update on compliance with the Data Protection Toolkit; where there was a shortfall there was confidence that this could be rectified by the time that a further update to NHS Digital was required.	
Chair's comments on the effectiveness of the meeting: The meeting agenda had been heavy however it was agreed that the major points for discussion had been given adequate space.	

ROHGO (5/19) 009

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 24 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The incidents that at first grading had caused moderate or severe harm were discussed, these being around a specimen error, a fall, a post-operative VTE and an expected death. • The Committee reviewed the information provided to the National Reporting and Learning System (NRLS) – the number of incidents reported had reduced and therefore a review was commissioned to benchmark the Trust's level with other organisations given that NRLS regard a higher number of incidents to reflect a good reporting culture. • There was reported to be further work to do to reaudit and look at the consistency of the application of the national policy regarding starvation prior to surgery. • The Committee was advised that a named doctor for child safeguarding was not in post and the issue had been raised to the regional Safeguarding Board and to Commissioners. Discussions were ongoing with Birmingham Children's Hospital to source an individual however in the meantime an interim plan was in place to provide this expertise when needed. • It was noted that when new legislation comes into force around Deprivation of Liberties, this would make the Trust an authority and legally accountable for enforcing the Safeguards.	• The governance around and process for disseminating and acting upon NICE guidance is to be presented at the next meeting. • It was suggested that an integrated performance report that served all committees should be produced. • A presentation on mental health work is to be presented to the Trust Board. • The annual workplan to achieve compliance with the Hygiene Code would be presented at a future meeting. • The co-chairs of the VTE Committee are to be invited to the next meeting. • An update on recycling was agreed to be required for the next Trust Board meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• An update on the plan to ensure that those who were outstanding Hepatitis B vaccinations received them was presented. There were reported to be two medical staff working in theatres who had been identified; one had a date for their vaccination and the other had been vaccinated. • The Committee received the draft quality account – this would be presented to the Board for approval at the end of May.	• None specifically.

• The estates lead from the local mental health trust has worked with the ROH's estates team to review the site for potential ligature points. An action plan had been developed to address any areas needing attention. • The Committee received a positive report from the Research & Development Committee which highlighted that the take up of research projects was now more multi-disciplinary. • There had been two cases of *C difficile* during the year, however a review of these suggested that these were not associated with lapses in care. • There was reported to be good progress with the CQC action plan.	
Chair's comments on the effectiveness of the meeting: It was agreed that the Committee was working effectively and the quality of the upward reports was improved	

ROHGO (5/19) 010

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 26 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Expenditure for the month and the year was reported to have been higher than planned, this being driven largely by the heavy reliance on temporary staffing. It was noted that there was a plan for 2019/20 to address this through the use of the use of a mid-level provider model which relied on Advance Nurse Practitioners and Advance Clinical Practitioners. • £1.7m cost savings had been achieved, which was below the plan, but above the minimum expectations for 2019/20. The sign off to proceed with the Managed Service Contract was awaited from Regulators and HM Treasury. • The new faster diagnostic cancer targets which would come into force from April 2020 were described and it was noted that they would be challenging to achieve. The Trust was shadow reporting from April 2019. • It was noted that there was some delay with the implementation of Phase 2 of ePMA; this was currently outside the control of the ROH.	• Consider a means of communicating to all staff the operational and financial successes achieved during the year • Refresh the 'Perfecting Pathways' update to include new initiatives and remove those that had concluded
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was advised that the Control Total for 2018/19 had been met which was agreed to be a significant achievement for the Trust. • It was reported that the Trust would receive an additional £2.5m transitional funding in recognition of the complexity of the orthopaedic work that was handled • There had been a positive recruitment Open Day when 27 offers of employment had been made. This would impact positively on the Trust's use of agency staff in theatres in 2019/20. • Cash was above planned levels and it was reported to be unlikely that a cash loan from the Department of Health and Social Services would be needed for the coming year.	• None specifically

• There were only three cancelled operations during the month. The new pre-operative processes were working more efficiently. • Good performance against the diagnostics target was reported. • Performance against the 18 weeks Referral to Treatment Time target had improved to 87.37% which was slightly above the revised trajectory. Overall, it was noted that this was a significant improvement from the same period during the previous year. • Cancer performance was reported to be good, with the quarterly target having been met and the performance for the previous month being at 100%. • It was reported that sickness would no longer be considered as a standalone item at the Staff Experience & OD Committee given that there was sufficient assurance that this was being controlled and there had been a reduction from the peak noted in October 2018. • There was overall good performance against the 'Perfecting Pathways' projects, including the Clinical Coding element now being at green status. • There was reported to be an expectation that the contract for the Modular Theatres set up would be signed shortly, with the theatres 'going live' by Christmas 2019. • The effectiveness of the Brexit preparedness exercise was noted.	

Chair's comments on the effectiveness of the meeting: The meeting duration had been reduced to an hour, however it was felt that there was sufficient space for important discussions

ROHGO (5/19) 011

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 3 April 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was agreed that the estates strategy needed to be revisited as currently there was little assurance around how this was being prioritised based on the Staff Experience walkabouts; it was noted that the age of the estate was challenging given that on occasion, there was unexpected maintenance required. • Two new risks had been added to the workforce risk register: one around outstanding Hepatitis B vaccinations and a second around the current storage arrangements for personnel files. • It was noted that there were a number of leavers who had served less than two years with the ROH, although the Committee agreed that this may be seen as a positive in terms of the preceptorship of nurses who took the opportunity to work at the ROH before moving onto a larger organisation.	• Devise a list of topics for forthcoming Staff Experience workshops. • Add an additional risk to the BAF around the impact of planned growth and modular theatres on the ancillary functions and estate. • Add capacity of the recruitment team to handle recruitment needed for the modular theatres to the workforce risk register. • Present the updated People & OD strategy to the Committee in July • The Staff Walkabouts to Estates, Facilities and Portering to be discussed at the next meeting. • Arrange for the Charitable Funds bid around support to overseas staff arriving to work at the ROH to be presented to the Charitable Funds Committee. • Add a risk to the workforce risk register around tax liabilities associated with consultant contracts.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received an enlightening staff story from the Senior Sister in HDU who described some cultural challenges that she had faced as part of her roles at the ROH and how she had managed to improve morale and processes in her departments. • The improved governance around resuscitation was described, including training and the operation of the resuscitation committee. • Good progress was reported against the actions in the People & OD strategy. • The Committee was joined by the Interim Director of Finance who outlined the actions he had taken in response to the Staff Experience walkabouts in Finance, IT, Clinical Coding and Business Intelligence. • A report was considered on medical education. It was noted that those undergraduates and post graduates had a very positive experience at the ROH and communications around this should be developed.	• It was agreed that having reviewed sickness absence specifically on a number of occasions, the Committee was assured that there were good processes around managing this and there had been a decline in sickness absence overall since October and therefore this would not be considered as a standing item on future agendas.

• It was noted that the recent nurse recruitment Open Day had been very effective and there had been a good level of expressions of interest.	

Chair's comments on the effectiveness of the meeting: The staff presentation was agreed to have been excellent. The staff experience walkabouts were a useful source of assurance. It was agreed that the balance of the meeting was much better.

Finance and Performance Report

March 2019

CONTENTS

INTRODUCTION

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

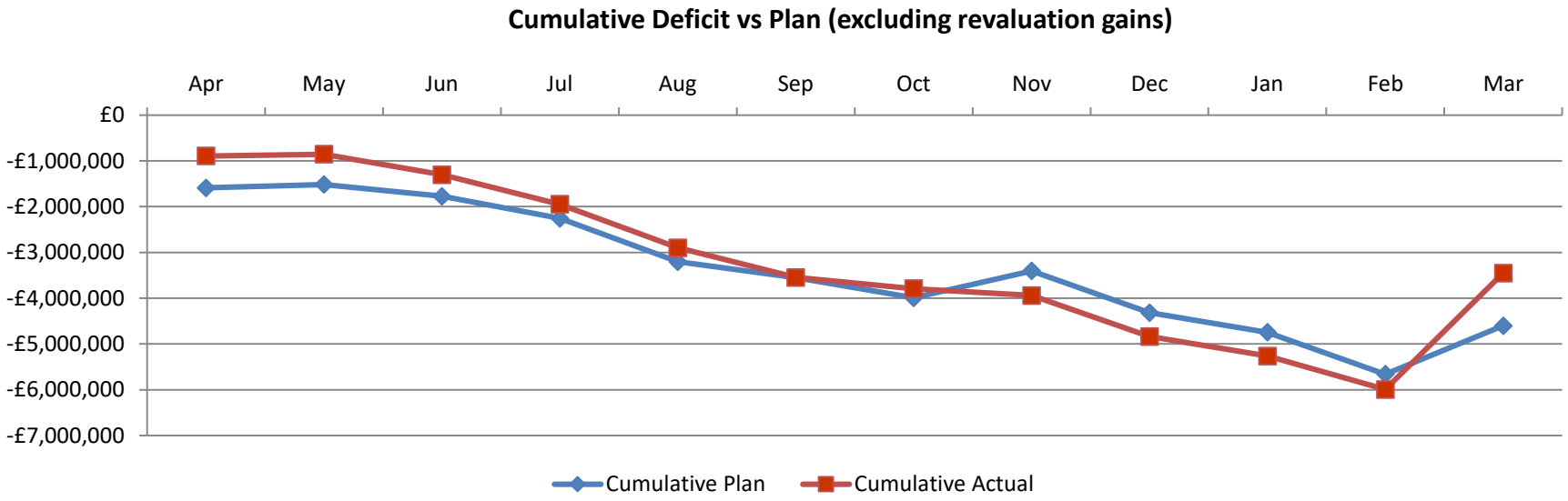
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

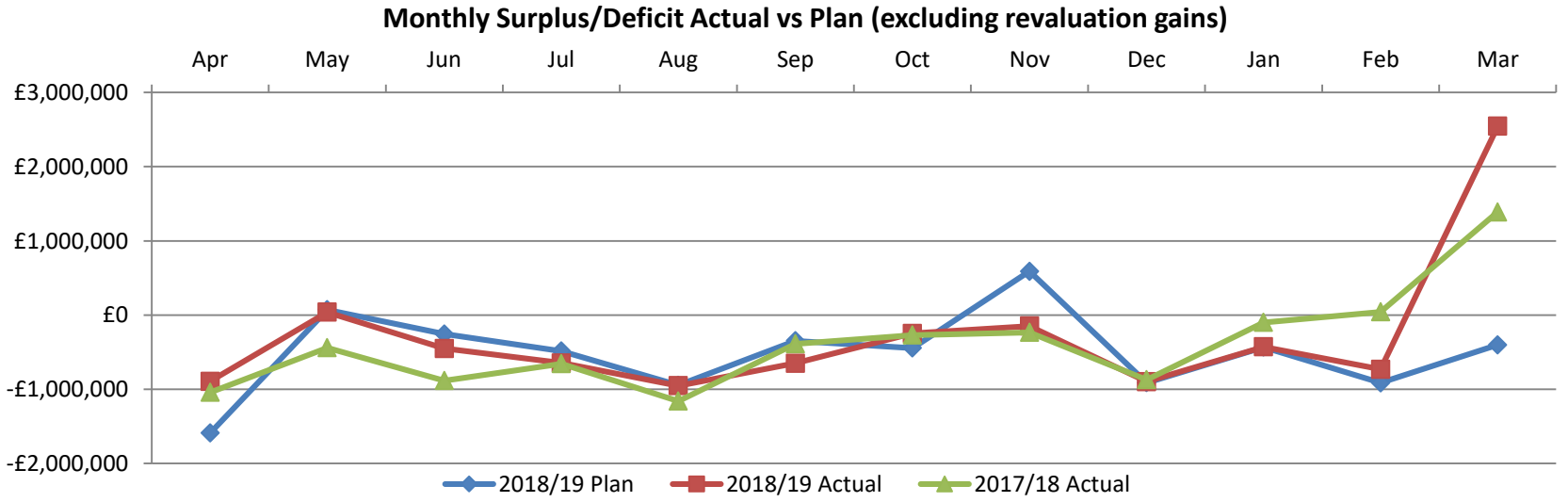
1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M12 Original Plan £'000	YTD M12 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	78,941	80,000	1,059
Other Operating Income	5,141	7,729	2,588
Total Income	**84,082**	**87,729**	**3,647**
Employee Expenses (inc. Agency)	-51,649	-53,597	-1,948
Other operating expenses	-37,091	-37,233	-142
Operating deficit	**-4,658**	**-3,101**	**1,557**
Net Finance Costs	-1,404	-1,132	**272**
Add Back Impairment	0	783	783
Net deficit	**-6,062**	**-3,450**	**2,612**
Remove donated asset I&E impact	60	-272	-332
Adjusted financial performance (inc PSF)	**-6,002**	**-3,722**	**2,280**

NB: Updated figures since F&P to reflect full amount of PSF received

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). This includes PSF.





INFORMATION

Prior to the award of PSF, the Trust delivered an in-month deficit of £90k in March against a planned deficit of £402k, £312k favourable against plan.

Excluding PSF this resulted in an in-year deficit of £6,187k against a control total of £6,615k, an improvement of £428k.

The Trust has also received additional PSF of £1,851k (£2,464k in total) as a result of obtaining it's control total, taking the Trust to a control total deficit of £3,722k, £2,280k ahead of control total including PSF.

The position has been driven by income and non-pay spend being favourable in month. Activity was strong in March, and in addition, following a full stock count at the year end, there was confirmation of an increase in the stock balance in year, which allowed a release of non-pay cost previously prudently recognised in the Income and Expenditure Statement. This was partially offset by an impairment in fixed assets as a result of the year end valuation.

CIP realisation was of a significant challenge in 18-19. £1,688k (57%) was delivered against a plan of £2,985k, (£1,296k) under-performance in-year. The Q4 forecasted CIP position for 18-19 was £1,716k, thus the year-end outturn was in-line with Q4 operational led expectations.

The Trust has a 19/20 CIP target of 1.1% in tariff plus further 0.5% for access to NHS Financial Recovery Funding for 19/20. This is a c. £1,419k target. The Trusts Operational and Clinical teams (alongside their Corporate Partners) are currently working on the delivery of next-year schemes and have identified opportunities (£1,553k) exceeding the £1,419k plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

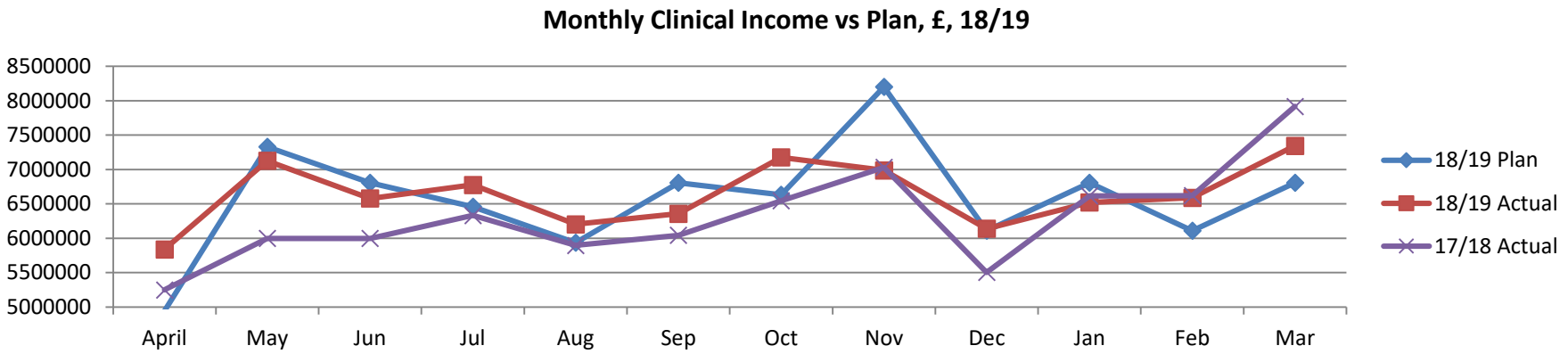
In order to ensure the 19-20 CIP plan is delivered, the Trust is changing its approach to CIP planning and delivery. There will be a number of Executive led cost improvement programmes, with operational, nursing and clinician led projects within each programme. Each project will have a number of key stakeholders, and each project team will work to deliver a project plan in May 19. These plans will be amalgamated to deliver a CIP programme, that will be ultimately signed off and steered by the Executive responsible officer. The Trust is working to identify a stretch target and stretch opportunities for 19-20 to mitigate any slippage or under-performance against identified schemes, in order to prevent a repeat of the under-performance in 18-19. As part of 19-20 CIP planning, the Trust is already identifying detailed CIP opportunities for 20-21.

In order to ensure ongoing monitoring and provide assurance of financial and quality benefits /mitigation to adverse performance, as part of the CIP process and initiation, each scheme will have clearly identified quantitative financial and quality targets to be reported on either monthly or during the PIR stage. (Post implementation Review) In order to ensure that focus on Quality as-well as financial benefits realisation, the 19-20 CIP at ROH will now be referred to as the QCIP (Quality & Cost Improvement Programme).

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. Planning permission has recently been granted and the tenders for the enabling works have been received and opened. A further update will be presented at May Board.

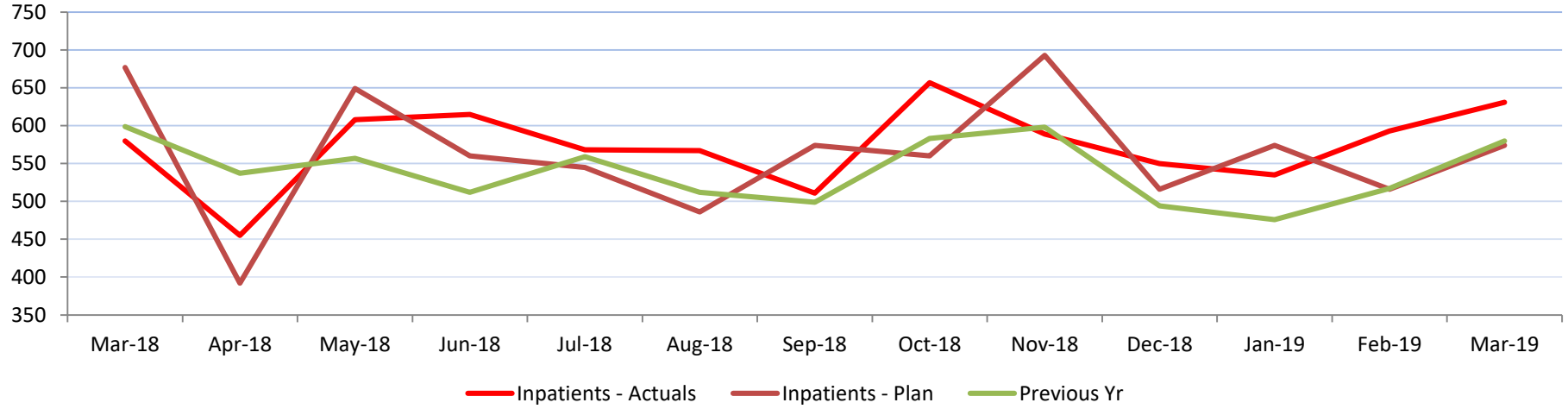
2. Income and Activity– This illustrates the total income generated by the Trust in 2018/19, including the split of income by category, in addition to the month's activity (excl PSF)



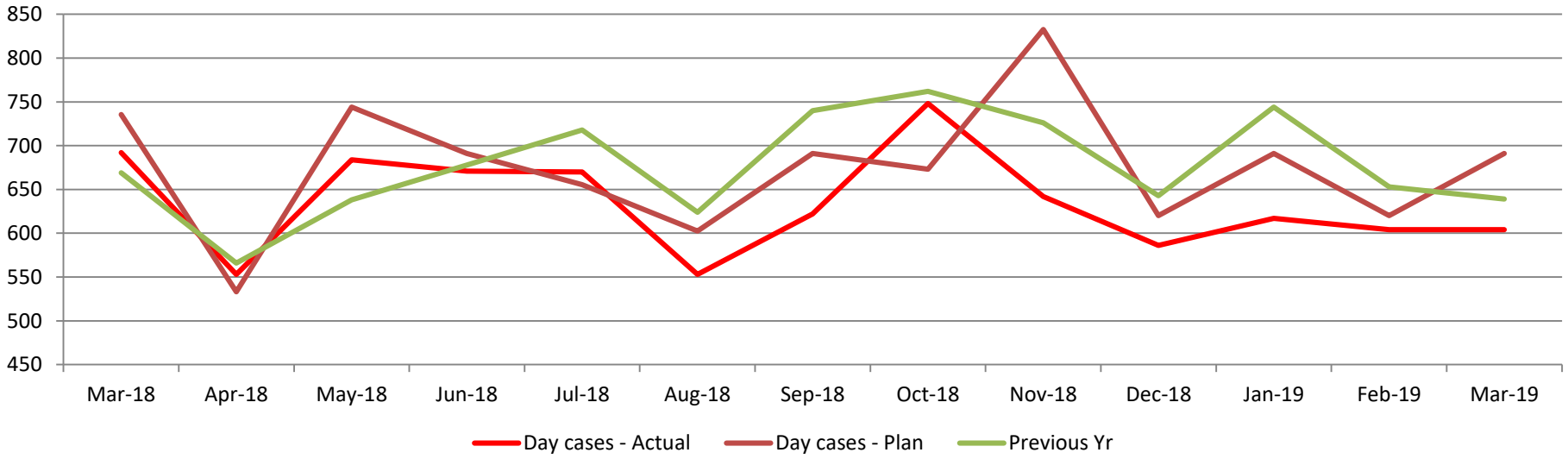
Clinical Income – March 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,595	3,591	-4
Excess Bed Days	42	231	189
Total Inpatients	3,637	3,822	185
Day Cases	856	832	-24
Outpatients	666	675	9
Critical Care	235	152	-83
Therapies	230	241	11
Pass-through income	216	245	29
Other variable income	427	818	391
Block income	539	559	20
TOTAL	6,806	7,344	538

Clinical Income – Year To Date 2018/19 £'000			
	Plan	Actual	Variance
Inpatients	41,699	39,512	-2,187
Excess Bed Days	484	978	494
Total Inpatients	42,183	40,490	-1,693
Day Cases	9925	9951	26
Outpatients	7726	8193	467
Critical Care	2721	2182	-539
Therapies	2669	2930	261
Pass-through income	2509	2814	305
Other variable income	4955	6493	1,538
Block income	6251	6701	450
TOTAL	78,939	79,754	815

Inpatient Activity



Day Case Activity



NHS Clinical income has over-performed against plan by 7.90% in March having over-performed by 7.89% in February. Cumulatively, the trust is now 1.03% above plan for the year.

The admitted patient care performance was slightly below plan financially and but up on activity levels, with discharged activity 46 above target. Average tariff for the period has decreased by £245 per case.

Day case activity underperformed financially and was below the target by 87 cases. The average tariff price for the period has increased by £82 per case.

Outpatients have over-performed year to date with and there has been a decrease in attendances against plan in March for first and follow up attendances . First to follow up ratio has remained steady year to date at 1.92:1.

Other variable income includes NHSE funding for the Paediatric project management and an increase in month of chargeable bespoke prosthesis.

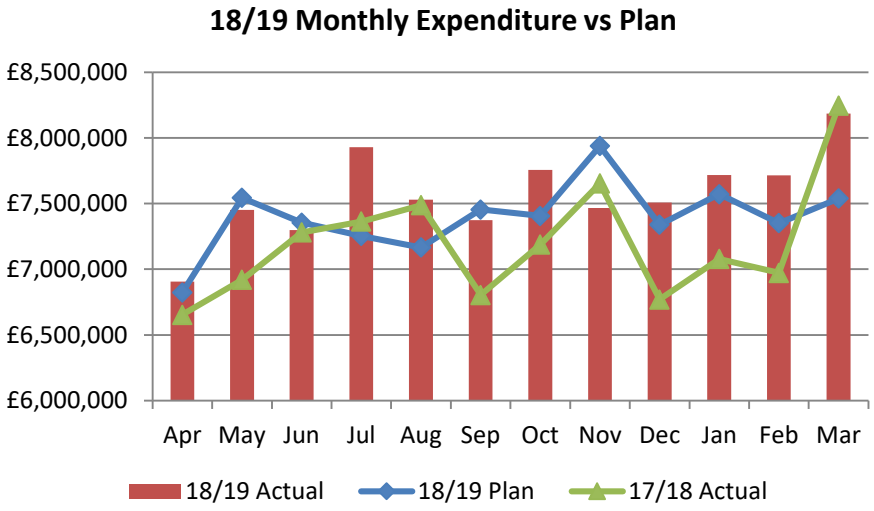
ACTIONS FOR IMPROVEMENT/LEARNING

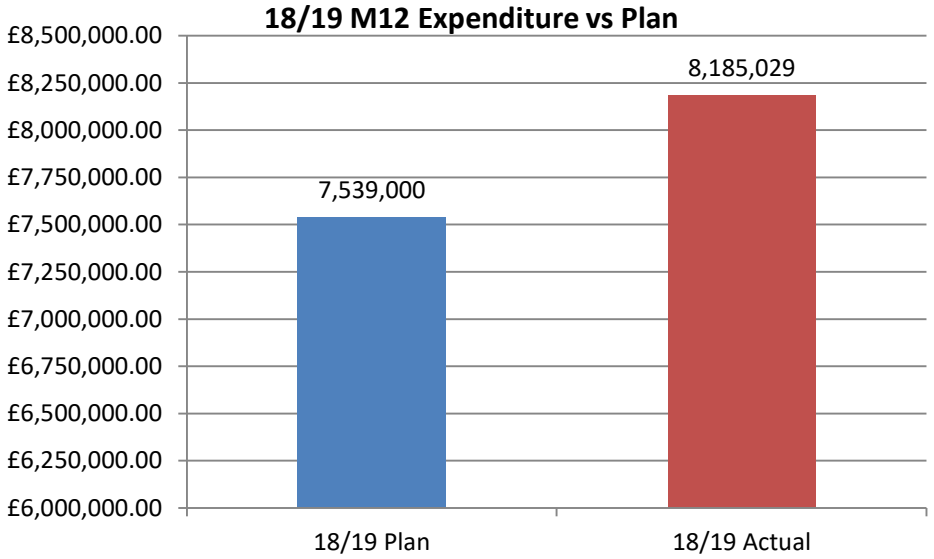
Finance and clinicians are working together to ensure that co-morbidities are being recorded and therefore maximising the income.

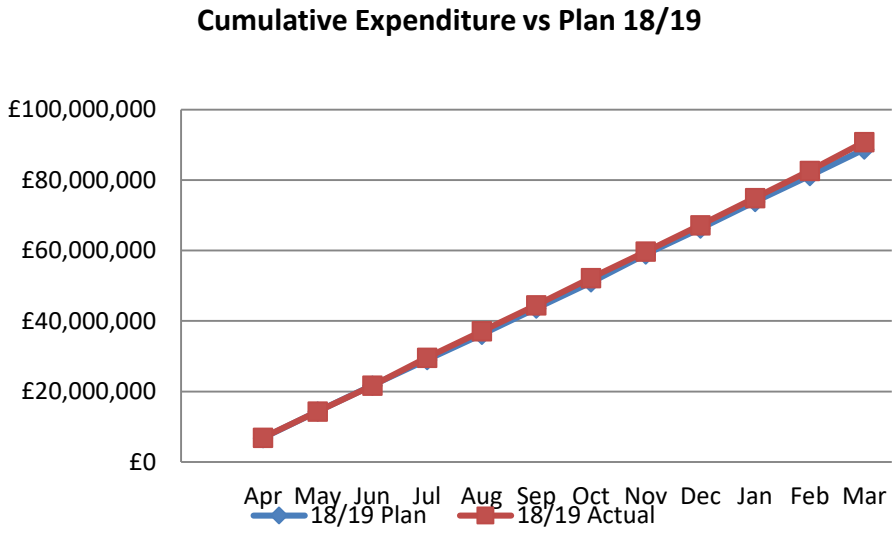
RISKS / ISSUES

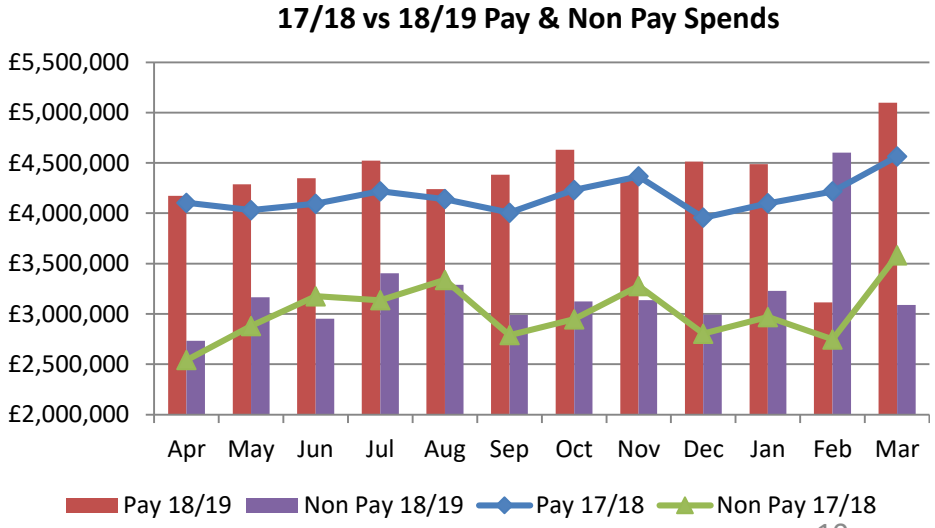
Given that the overall position at M11 is now behind plan, PSF has been removed for as a prudent measure. (circa £328k to M11 in total). This can still be claimed at the year end if the control total is achieved.

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









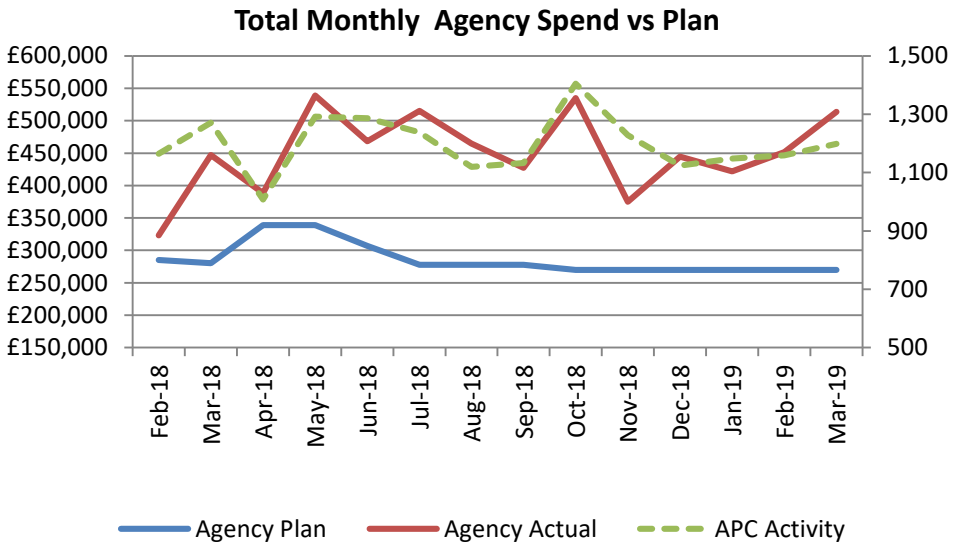
INFORMATION

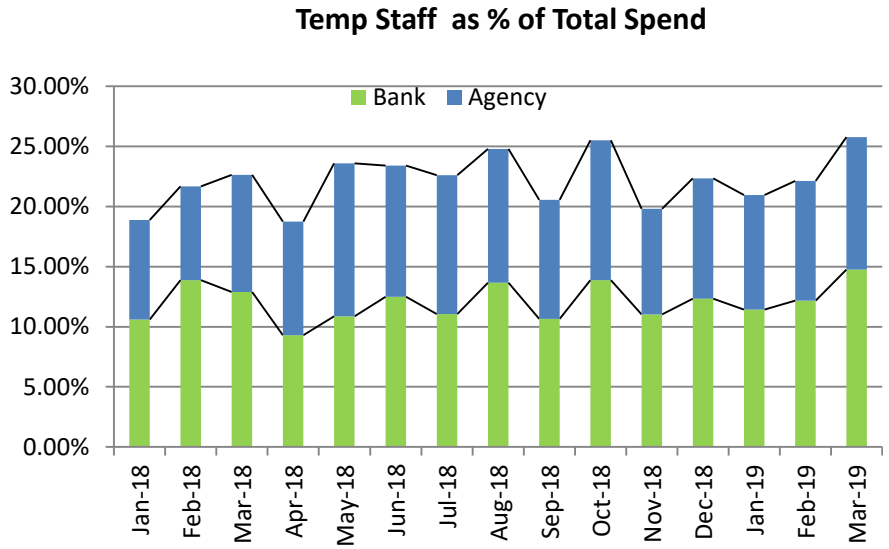
March's expenditure was £8,185k, which was higher than the planned spend of £7,539k. This reflects the increase in activity performed in month, in addition to an impairment in fixed assets as a result of the year end valuation, of which c.£800k was recognised in the Income and Expenditure Statement.

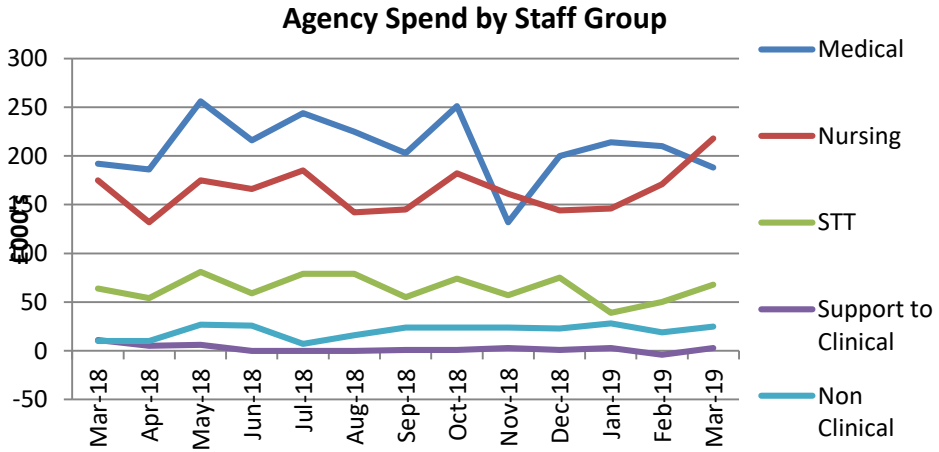
Pay was higher than plan by £698k. Pressure has remained on temporary staffing (medical staffing and nursing) which has increased in month as described on the next pages.

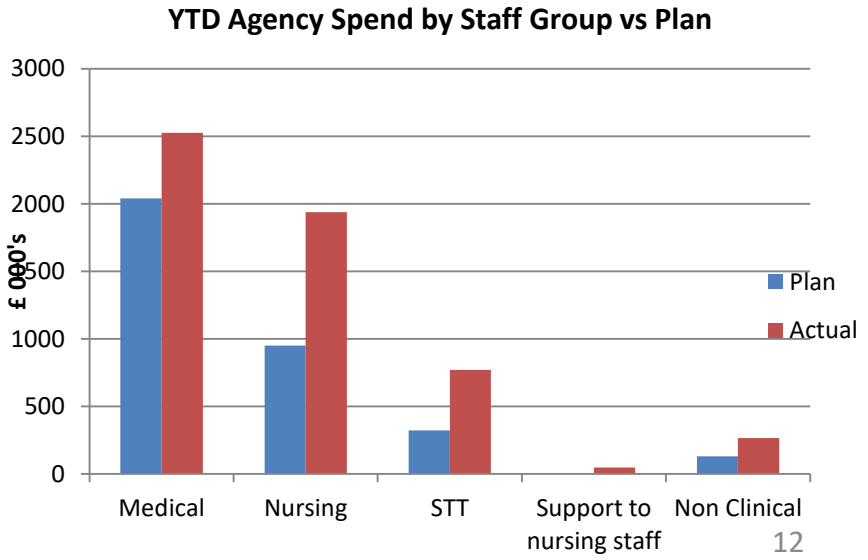
Non pay spend was in line with plan, but within this position there was a release in stock costs as a result of the year end stock count, offset by an impairment on fixed assets as a result of the valuation, and an increase in underlying costs due to the over performance in activity.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Total agency spend has increased in month by £63k, to £514k from £451k in February. The Trust continues to have challenges in the provision of junior doctor cover and as such this continues to be the largest spend on agency, although in month medical agency spend has reduced slightly.

Nursing agency spend has increased from last month circa £47k which mainly relates to ward cover and additional activity.

ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

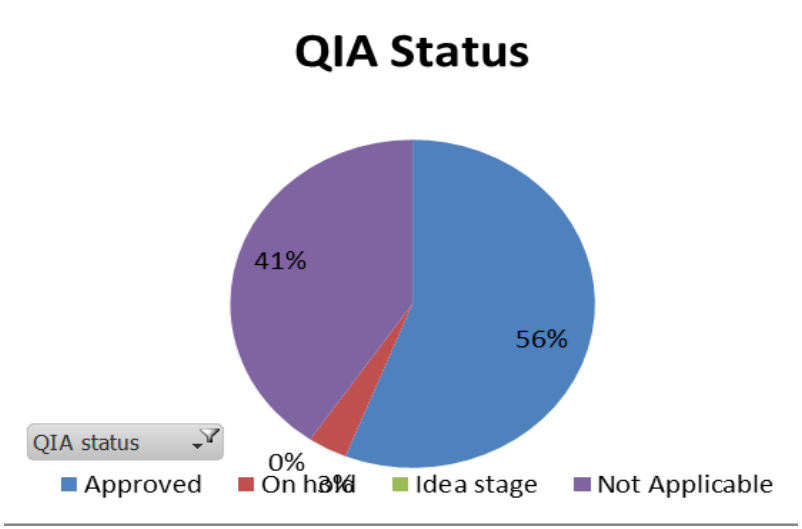
Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

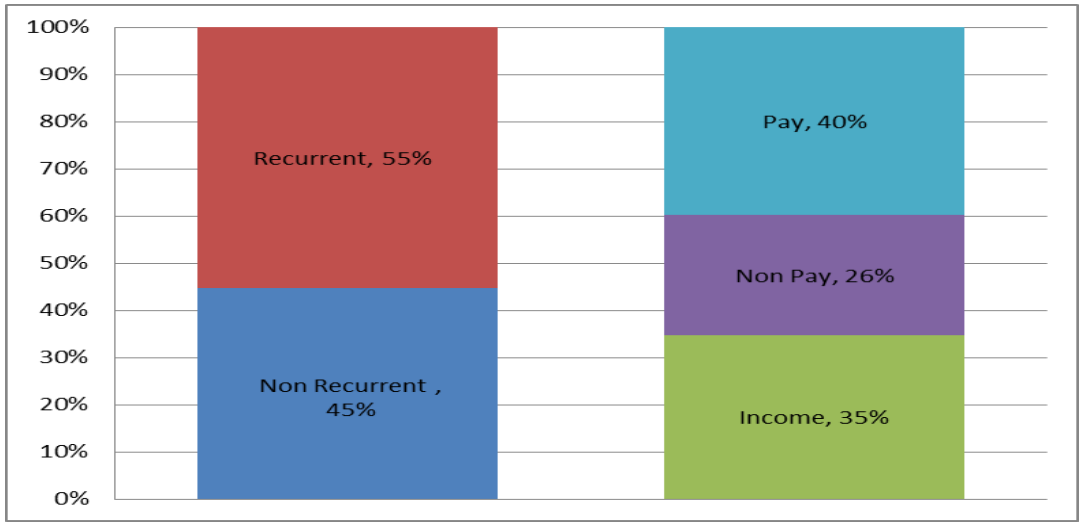
RISKS / ISSUES

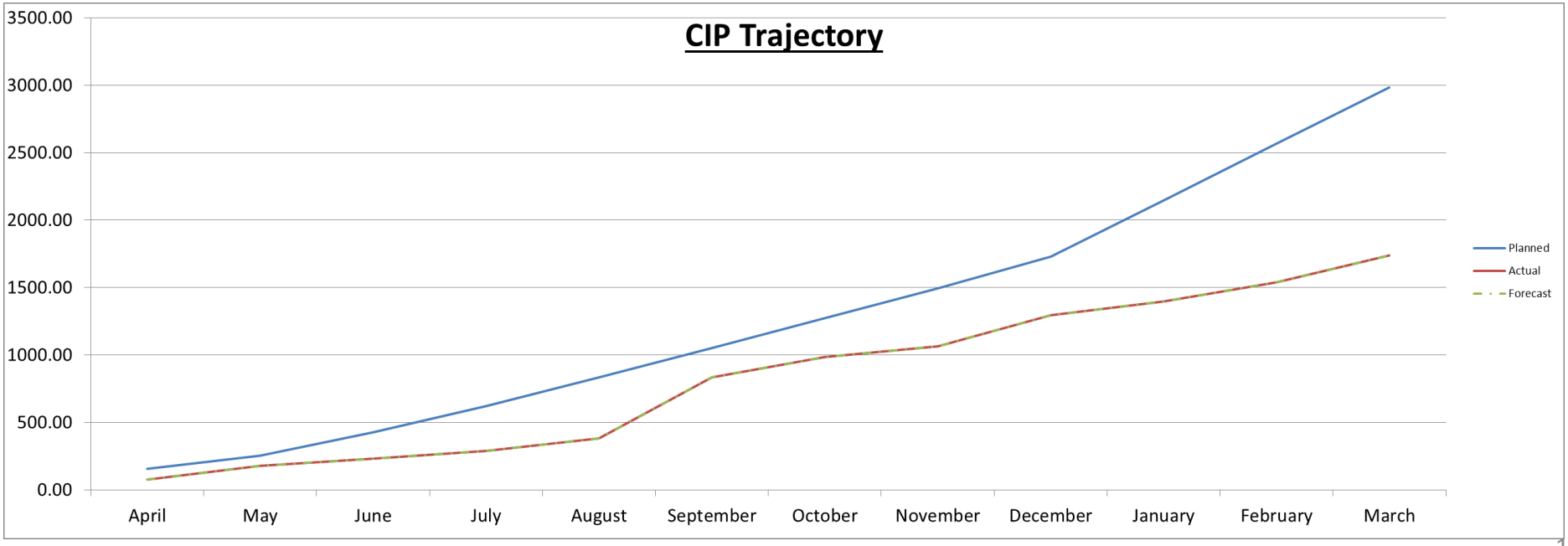
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory is having a direct impact on our regulator ratings.

The agency cap for 2018/19 has been breached, and due to the pressures in medical spend in particular, it has been planned that the 2019/20 cap will also be breached. The Trust will however continue to consider different models of working in order to try and reduce reliance on agency spend.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2018/19 (£000's)







RMATION

The CIP target for 2018/19 is £3,000k of which £2,985k (99% of target) was identified/planned. ROH delivered £1,688k in 18/19 (57% of planned).

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 %
Corporate	94	17	(78)	1,090	683	(408)	1,090	683	(408)	63%
Division 1	75	12	(62)	705	381	(324)	705	381	(324)	54%
Division 2	245	115	(130)	1,157	589	(567)	1,157	589	(567)	51%
Division 4	5	5	1	33	35	2	33	35	2	108%
Grand Total	**419**	**149**	**(269)**	**2,985**	**1,688**	**(1,296)**	**2,985**	**1,688**	**(1,296)**	**57%**

The summary reasons for YTD under-performance are below:

- Non-delivery and slippage against some clinical and operational saving schemes such as Implant rationalisation, GIRFT recommendations, LOS reduction and clinical pathway/process redesign savings
- Slippage and under-delivery against large scale savings schemes such as Theatres Stock control and Managed Service Contract (£550k planned in-year, has now slipped into 19-20) and Counting & Coding improvement schemes (£312k adverse to plan)
- 18-19 performance is significantly supported by fortuitous changes to national discount rates, enabling the present value reduction of provisions by £120k (this was captured as a non-recurrent CIP in Dec 18) as-well as significant levels of non-recurrent workforce savings
- Minimal support networks (e.g. Procurement and project management teams) to support/drive CIP delivery; with CIP leads focusing on delivering Activity related/Patient care targets , compounded by an outdated CIP delivery model and culture led to minimal engagement in the whole process

ACTIONS FOR IMPROVEMENTS / LEARNING

Despite the improved performance in Q4 vs Q1-Q3, 45% of schemes delivered in-year are non-recurrent, thus the following is planned for 19-20:

- Larger focus on transformation (Outpatients, Theatres) and coding schemes, (engaging clinicians to support this) with focus also on demand and capacity management to deliver cost improvements
- Plans for 19-20 CIP's have been identified; and a review/work up of these are taking place
- Review and change to the current CIP process to ensure a Trustwide engagement of CIP identification and delivery; and ensure adequate resource to support, challenge and drive CIP delivery for CIP stakeholders; focus on changing the culture towards CIP's at the Trust
- Ongoing monitoring and management of CIP's and their impacts on finance and quality from scheme delivery will be actioned via a PIR (post implementation review) to assure the Trust and Quality & Assurance committees (Quality targets will be identified in the PID/initiation process)

RISKS / ISSUES

A significant amount of work remains to be completed to deliver the following schemes:

- Managed Service Contract for Theatres has now been factored in the 19-20 programme. Whilst a project group is driving this forward, it remains a challenging scheme; with significant risks which include non-conformance of the Trust decontamination provider to contracting arrangement requirements, HMRC VAT legislation change risks/exit risk impact assessments, potential impacts from the BSOL procurement collaboration
- Significant workforce CIP schemes have been identified, primarily in Nursing areas via recruitment in 19-20 rather that changing of skill-mix/alternative workforce models
- Monthly operational led forecasting of CIP's and reporting of forecasts; early under-delivery will lead to early planning of recovery/mitigations

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	802	1,389	(587)
Tangible Assets	48,042	46,129	1,913
Total Non-Current Assets	**48,844**	**47,518**	**1,326**
Inventories	4,858	6,752	(1,894)
Trade and other current assets	6,165	6,818	(653)
Cash	1,401	2,655	(1,254)
Total Current Assets	**12,424**	**16,225**	**(3,801)**
Trade and other payables	(12,554)	(15,515)	2,961
Borrowings	(1,252)	(777)	(475)
Provisions	(173)	(84)	(89)
Other liabilities	(207)	(210)	3
Total Current Liabilities	**(14,186)**	**(16,586)**	**2,400**
Borrowings	(8,979)	(10,818)	1,839
Provisions	(354)	(215)	(139)
Total Non-Current Liabilities	**(9,333)**	**(11,033)**	**1,700**
Total Net Assets Employed	**37,749**	**36,124**	**1,625**
Total Taxpayers' and Others' Equity	**37,749**	**36,124**	1,625

INFORMATION

Tangible assets are below plan due to a valuation loss reported at year-end of £1.9m. Intangible assets are higher than plan mostly due to the capitalisation of the IT data centre licences which have been financed via a loan.

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. The Trust borrowed £5.3m from DHSC during 2018/19 and £0.7m in relation to the IT data centre licences.

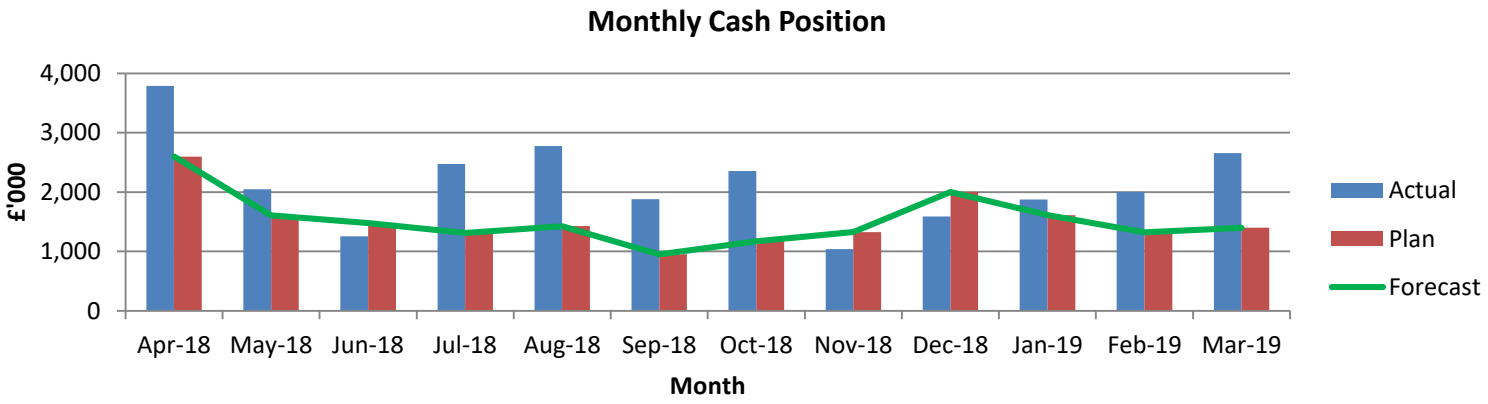
Cash is discussed in more detail on the following pages.

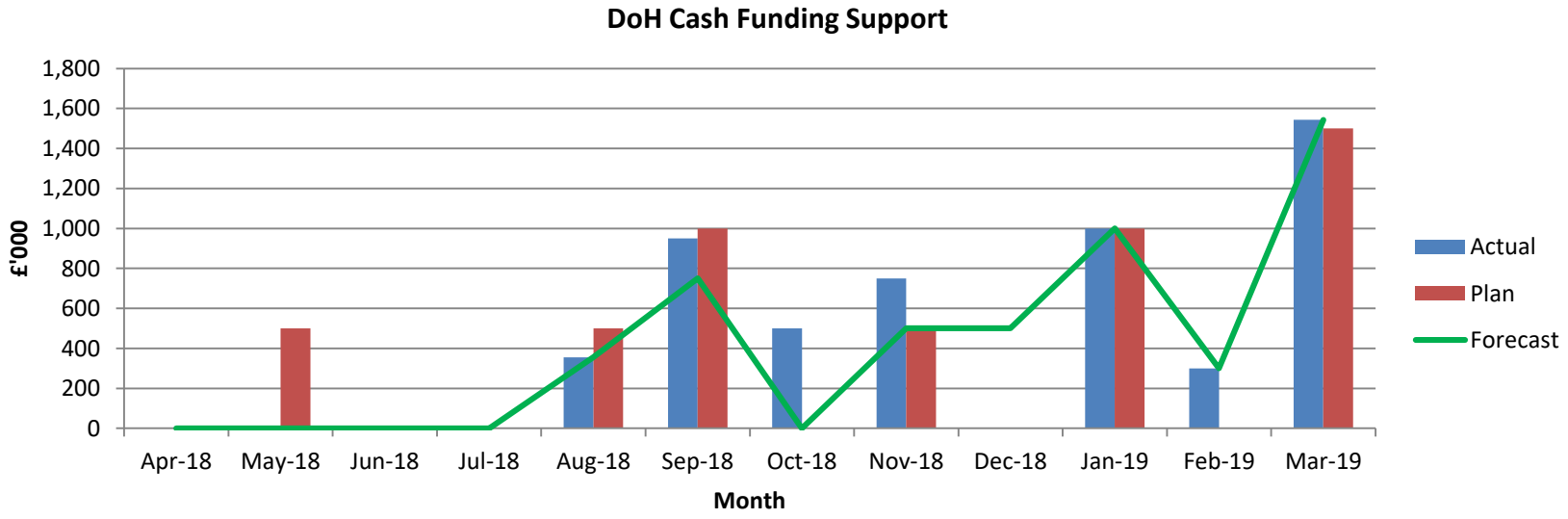
ACTIONS FOR IMPROVEMENTS / LEARNING

Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

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

Cash was £2,655k which is £1,254K higher than forecast. The forecast was made before the confirmation of the additional STF funding received this year, and as such the year end balance is in line with expectation.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

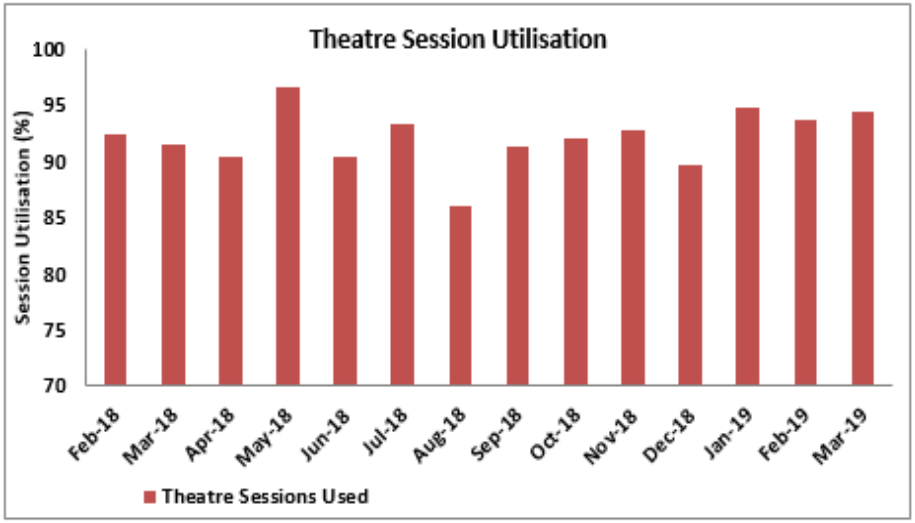
The Head of Financial Accounting continues to run cash control committees attended by the DDoF, and representatives from management accounts and the transaction team, to identify further areas for improvement with regards to cash management.

DoH cash support - Based on the feedback from NHS Improvement the information provided to request funding continues to be 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

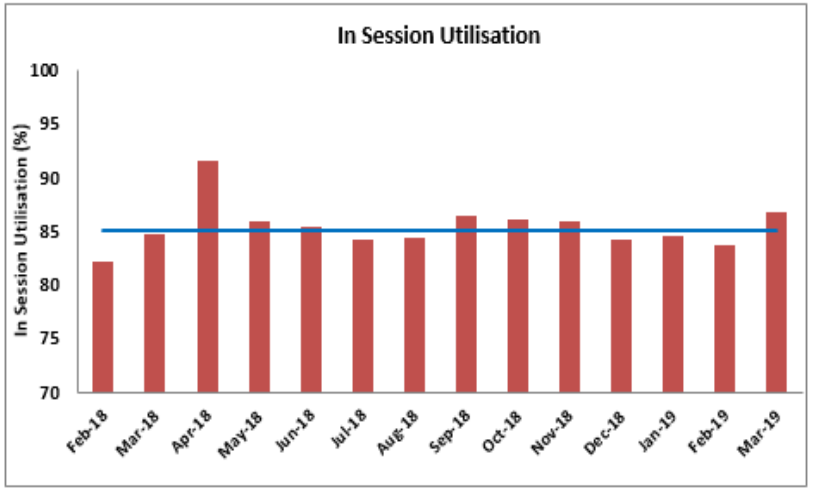
Session utilisation in March was 94.47% compared to February which was 93.63%

Average utilisation for the period April '18 – March '19 ended at 92.19% overall.

RISKS / ISSUES

- Theatre recruitment to support future growth – a successful open day in April 19 resulted in 8 offers being made on the day, building on the success of previous recruitment initiatives

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 saw an improvement for March at 86.76% compared to February which was 83.76%,

In session utilisation remains consistent, running at an average of 86% for the period April '18 – March'19.

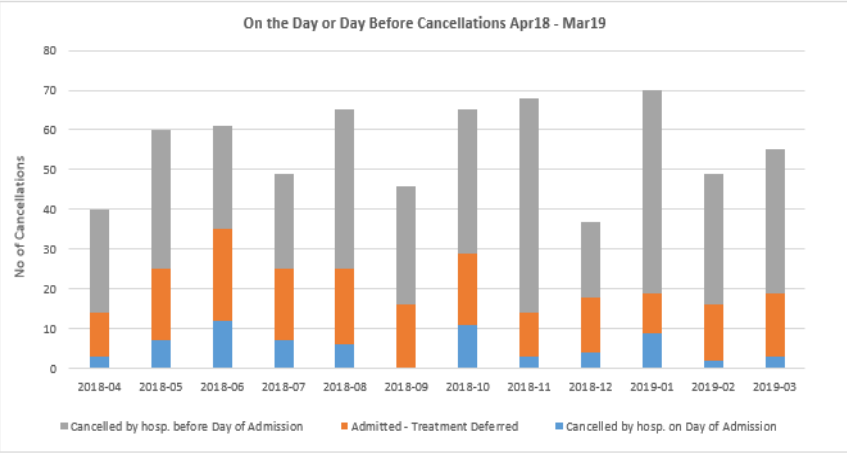
The reconfiguration of POAC, which went live on the 8th April, will have a positive impact on the efficiency of theatre lists going forward.

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
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

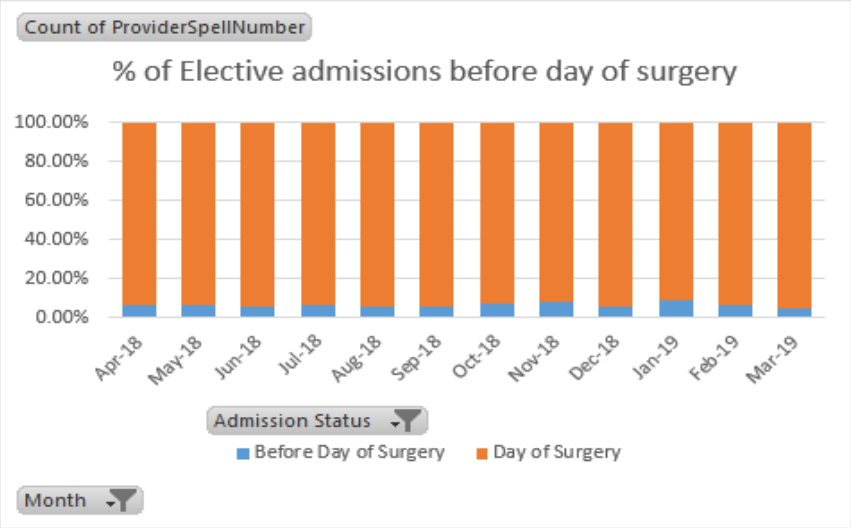
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

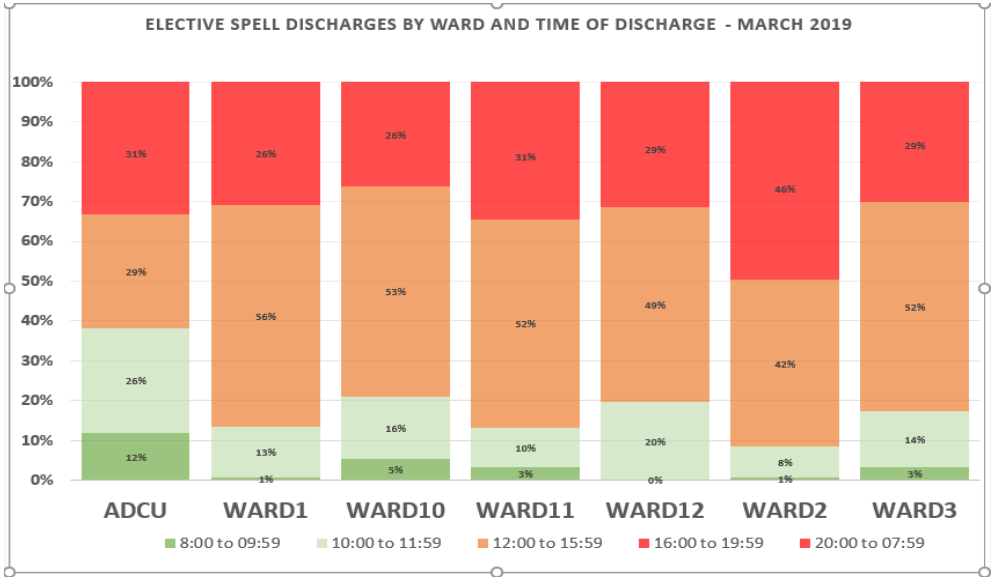
Hospital Cancellations



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
2018-04	3	11	26	40	0
2018-05	7	18	35	60	0
2018-06	12	23	26	61	0
2018-07	7	18	24	49	0
2018-08	6	19	40	65	0
2018-09		16	30	46	1
2018-10	11	18	36	65	0
2018-11	3	11	54	68	0
2018-12	4	14	19	37	0
2019-01	9	10	51	70	0
2019-02	2	14	33	49	0
2019-03	3	16	36	55	0
Grand Total	67	188	410	665	1

Admission the day before surgery





The number of cancellations on the day of admission for surgery in March was 3 patients , maintaining consistent low figures. Patients admitted for surgery where treatment was deferred has increased slightly in month from 14 to 16. Analysis of patients admitted where treatment was deferred relate to, lack of theatre time and equipment availability.

Cancellations before the day of surgery have increased slightly in month from 33 to 36. An analysis of the 36 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 patients declaring fitness issues on the 72 hour contact call .

A robust process is now in place to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients .

A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in May 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre was successfully launched on April 8th 2019. This change has been a significant achievement by the team and has already received a great deal of positive feedback from both staff and patients .

A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

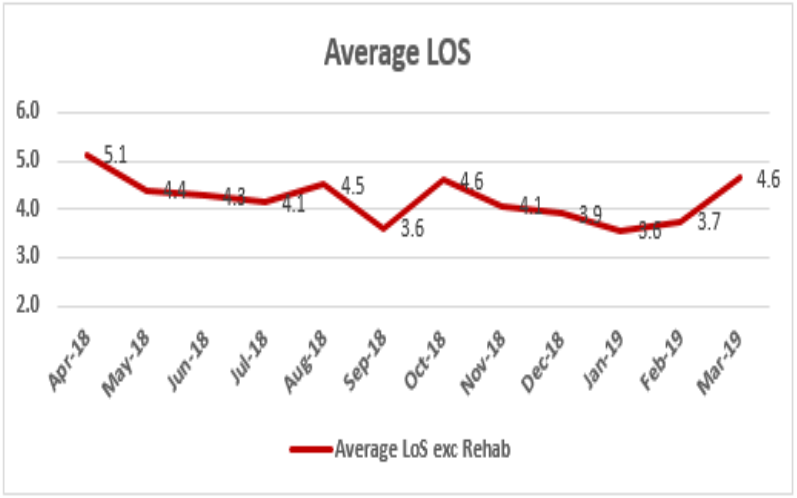
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

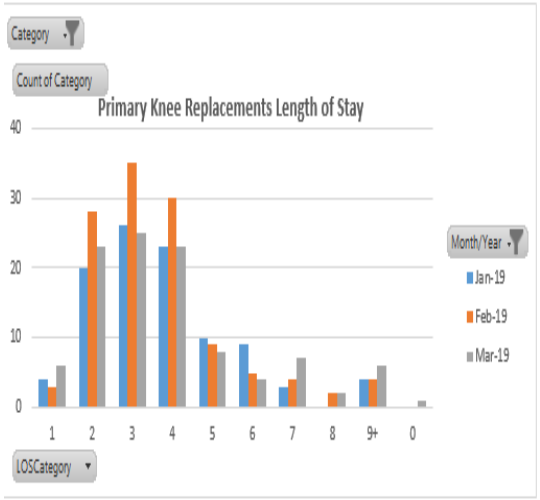
- POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Review of booking process by secretarial teams to develop a standard Operating procedure working closely with POAC and ADCU

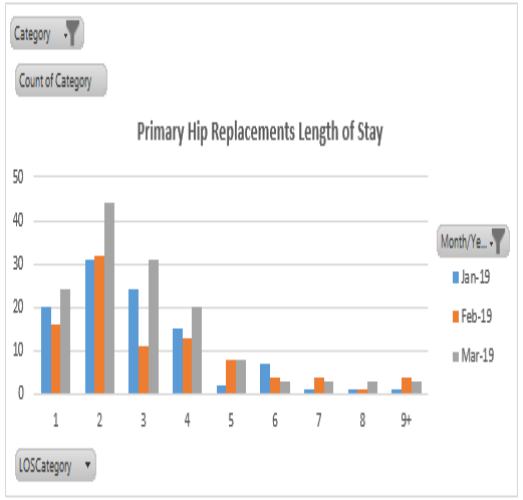
RISKS / ISSUES

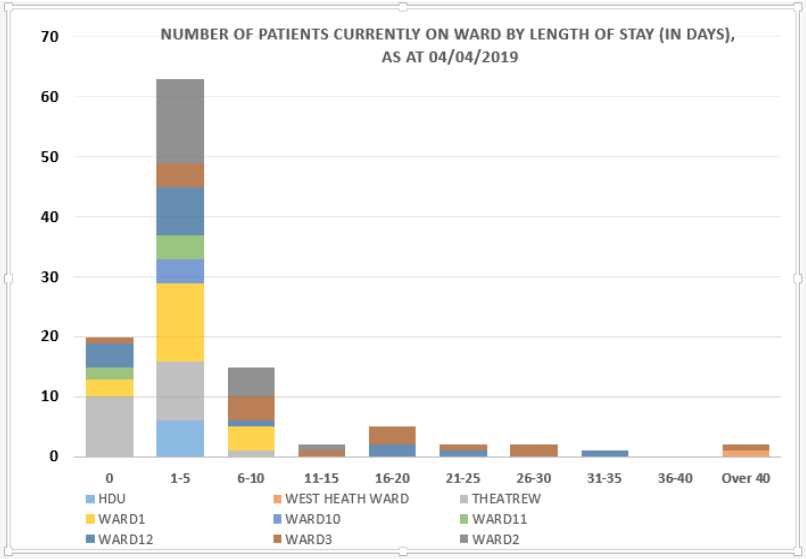
The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

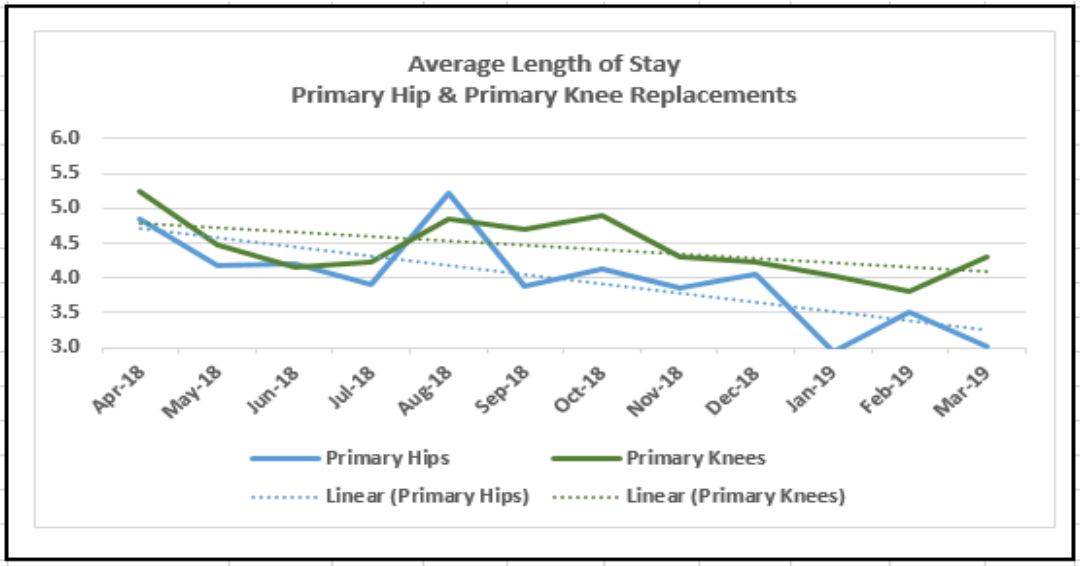
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in March was 4.6 days, this is an increase on February 2019 average which was 3.7days. The data gathered demonstrates that LOS for primary hips reduced in month whilst LOS for primary knees increased.

This increase is due to a small cohort of knee patients in month who had complex needs following their surgery resulting in an extended length of stay. In month Ward 3 had 2 primary knee replacements that went on to require intravenous antibiotics due to infection thus extending their length of stay. A further on Ward 3 and Ward 12 patient required complex discharge planning resulting in a delay.

It is therefore concluded that the mean average of 4.6 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives in place to continue to drive down length of stay including:

- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- The discharge lounge is well utilised by all adult inpatient wards. With 267 being discharged in March , and discharges before midday rose to 36% . This is the key focus now for all areas in order to improve efficiency and patient experience.

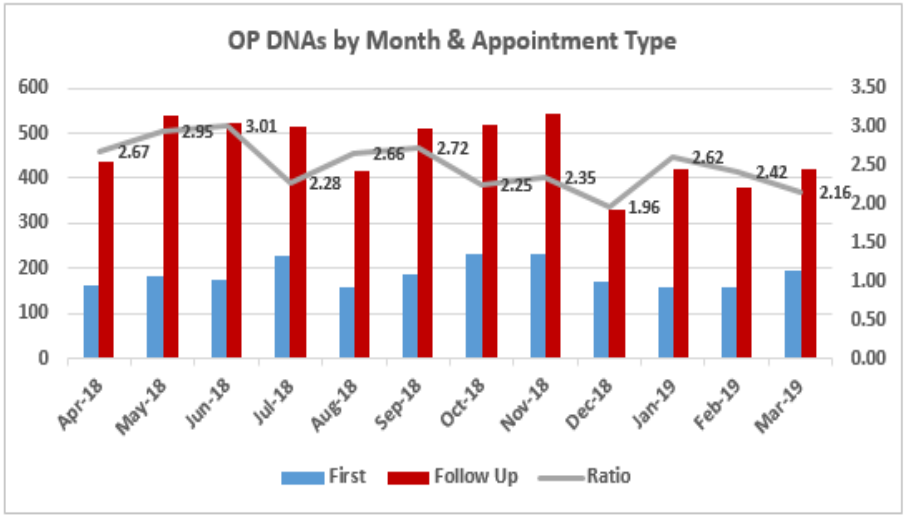
ACTIONS FOR IMPROVEMENTS / LEARNING

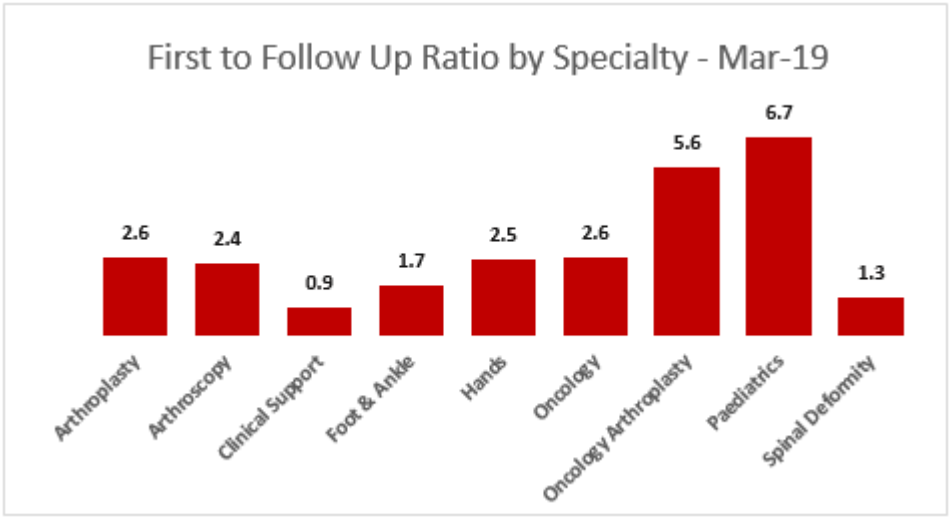
- Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Funding secured and recruitment in progress to support out of ours ward clerk support to ensure timely ADT .

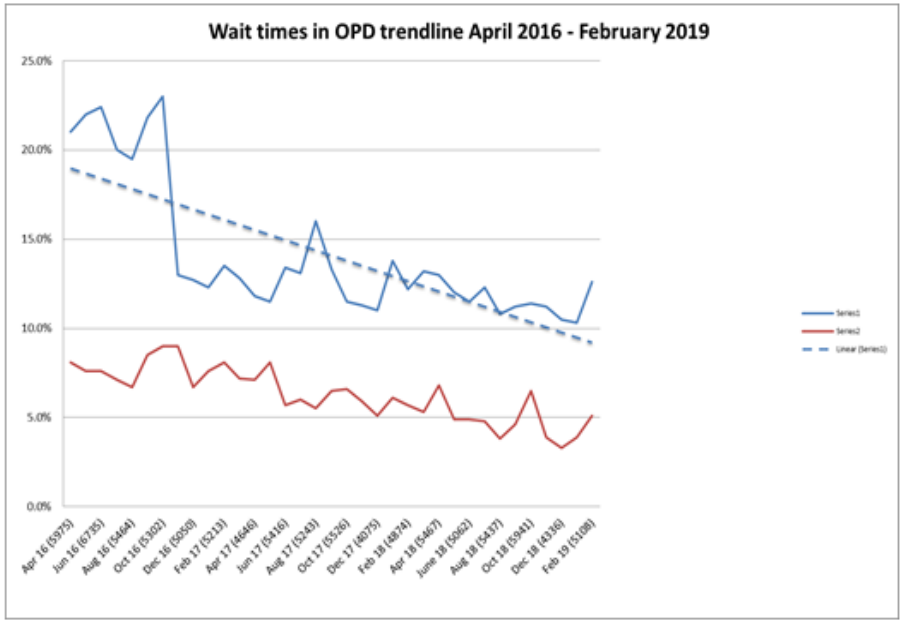
RISKS / ISSUES

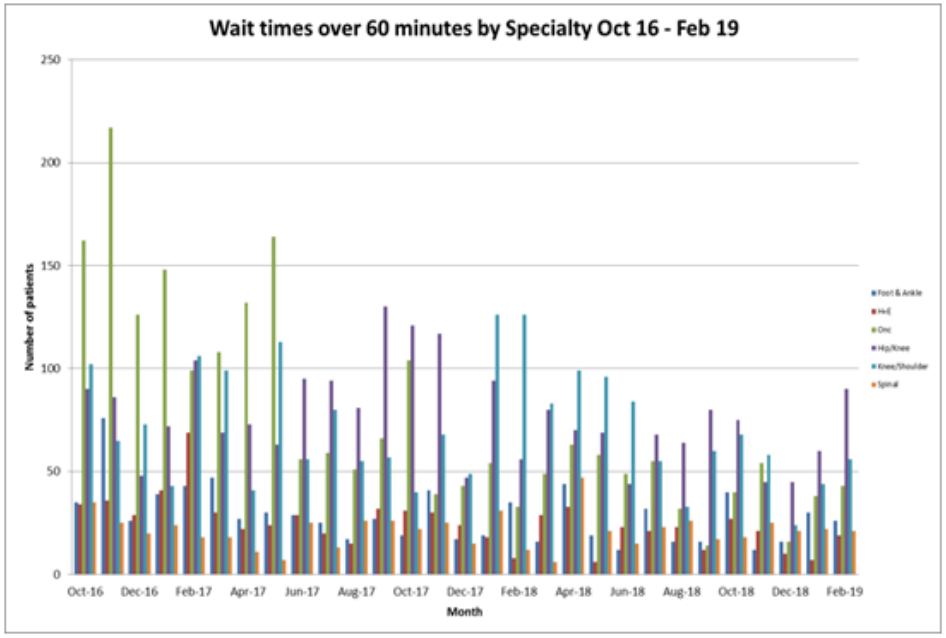
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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









INFORMATION

In March there were 11% of patients waiting over 30 minutes which is an improvement from last month. The target for 30 minute delays has still not been achieved but progress has still been good from 22% in May 16. Focussed work is ongoing to continue to improve this position and 4.4% of patients were waiting over 1 hour which was below the target of 5% again.

In addition to the 643 meeting which is held every week to ensure complete room allocations 6 weeks ahead. This ensures that there are rooms available for all clinicians avoiding delays at the start of clinic. It will also help to provide utilisation data in the future at session level. There is an outpatient improvement project that is being set up with the support of the transformation team and this will include utilisation data. As part of this in session utilisation will also be included helping to further identify where, when and why clinic delays occur.

There were 13 incidents of clinic delays reported in March 2019 with the following breakdown.

- 7 complex patient
- 2 clinic overbooked for number of staff
- 2 other
- 1 consultant / clinician delay
- 1 x-ray

The Outpatient Department nursing team are now nearly fully established with the last few appointments awaiting a start date and this will leave just one outstanding qualified post.

There are now 2 notice boards in Outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation. This should further improve communications with clinical staff.

An Outpatient away day is to be held on the 26th of April where all future projects proposed to improve the outpatient service at the ROH will be discussed. This will ensure engagement with the staff about the road map with in the department and staff are being encouraged to raise concerns and ideas with the senior nursing staff.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Utilise the outreach clinics at Lordswood whilst investigating further options for additional space either at Lordswood or another site
- Set up the outpatient project improvement group

- The process for partial booking has been started as a pilot in Pain and this will continue to be monitored. This will need to be reviewed alongside the Appointments team workforce and should there be any impact this will be described with any impact in a business case

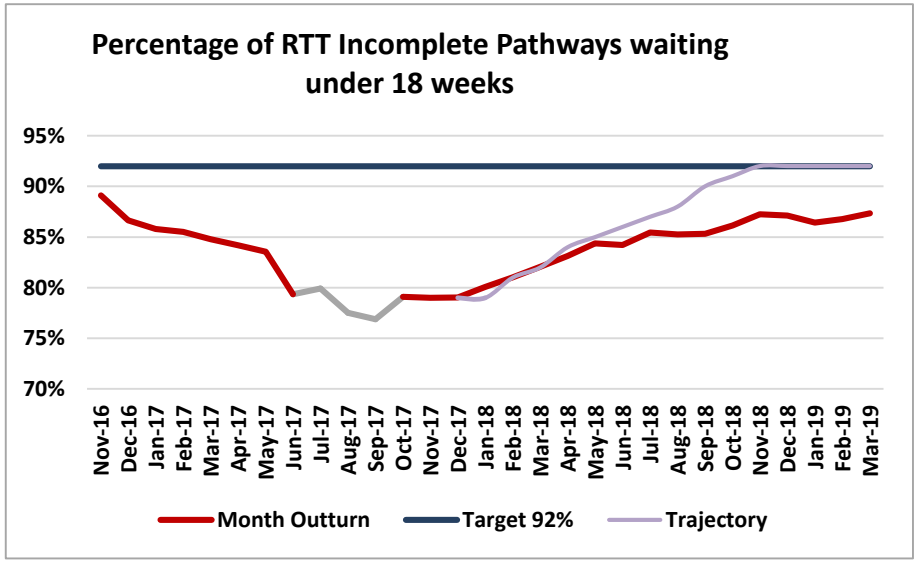
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

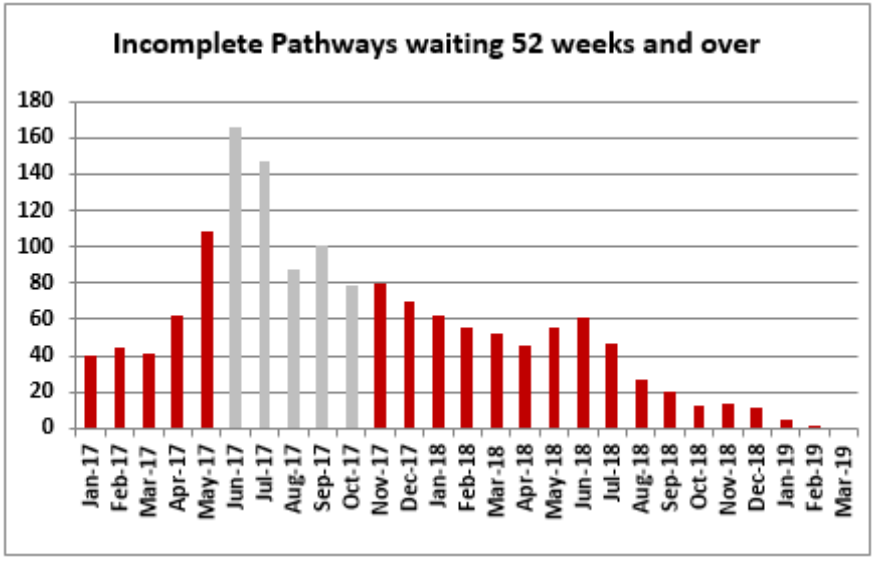
% of patients waiting <6weeks for Diagnostic test.

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	1155	1,159	99.7%
May-17	784	79	296	1,159	781	176	326	1,283	4	1155	1,159	99.7%
Jun-17	830	101	402	1,333	877	217	354	1,448	5	1328	1,333	99.6%
Jul-17	785	94	404	1,283	737	177	316	1,230	7	1276	1,283	99.5%
Aug-17	871	85	386	1,342	749	202	395	1,346	4	1338	1,342	99.7%
Sep-17	915	103	390	1,408	838	225	379	1,442	1	1407	1,408	99.9%
Oct-17	912	99	416	1,427	768	216	353	1,337	4	1423	1,427	99.7%
Nov-17	789	106	469	1,364	977	226	441	1,644	12	1352	1,364	99.1%
Dec-17	864	131	437	1,432	922	194	381	1,497	7	1425	1,432	99.5%
Jan-18	743	95	366	1,204	923	256	441	1,620	4	1200	1,204	99.7%
Feb-18	725	93	434	1,252	825	204	352	1,381	10	1242	1,252	99.2%
Mar-18	722	115	349	1,186	781	180	307	1,268	3	1183	1,186	99.7%
Apr-18	1022	148	409	1,579	850	253	387	1,490	8	1571	1,579	99.5%
May-18	1002	136	353	1,491	725	236	373	1,334	1	1490	1,491	99.9%
Jun-18	789	96	376	1,261	762	220	360	1,342	5	1256	1,261	99.6%
Jul-18	732	112	336	1,180	961	211	290	1,462	8	1172	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	1113	1,117	99.6%
Oct-18	781	110	370	1,261	725	247	344	1,316	7	1254	1,261	99.4%
Nov-18	736	135	381	1,252	801	243	406	1,450	7	1245	1,252	99.4%
Dec-18	698	115	346	1,159	843	224	367	1,434	11	1148	1,159	99.1%
Jan-19	728	123	416	1,267	897	253	472	1,622	4	1263	1,267	99.7%
Feb-19	844	134	386	1,364	854	248	436	1,538	3	1361	1,364	99.8%
Mar-19	776	133	461	1,370	868	271	410	1,549	1	1369	1,370	99.9%

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





The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019.

March 2019 performance is **87.37%**

In March the Trust had **0** patients over 52weeks which is a significant achievement for the Trust.

Royal Orthopaedic Hospital NHS Foundation Trust
Referral to Treatment Trajectory: Trust Wide Position

RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,477	7,510	7,542	7,570
Over 18 Weeks	1,080	1,086	1,084	1,057	992	928	864	796	729	649	603	558	518
Totals	8,436	8,360	8,365	8,356	8,329	8,302	8,275	8,245	8,216	8,126	8,113	8,100	8,087
RTT %	87.20%	87.01%	87.04%	87.36%	88.09%	88.82%	89.56%	90.34%	91.13%	92.02%	92.56%	93.11%	93.60%

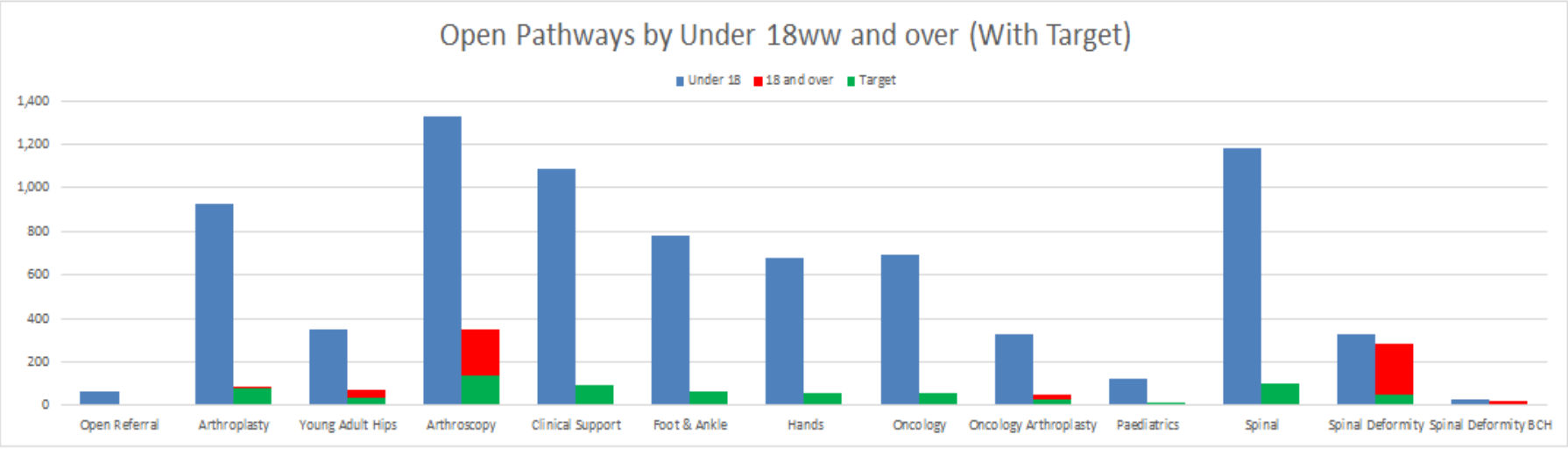
13. Referral to Treatment snapshot as at 31st March 2019 (Combined)

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	**4,102**	42	475	181	657	610	404	360	381	190	63	603	125	11
7-13	**2,689**	18	331	109	465	365	274	220	218	106	39	400	136	8
14-17	**1,103**	2	119	62	208	110	102	98	93	32	20	183	66	8
18-26	**829**	1	76	54	226	45	38	44	17	34	10	90	182	12
27-39	**277**	0	12	20	111	5	6	6	5	11	0	12	84	5
40-47	**34**	0	0	1	9	4	0	0	1	0	0	1	16	2
48-51	**1**	0	0	0	0	0	0	0	0	1	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9,035**	63	1,013	427	1,676	1,139	824	728	715	374	132	1,289	609	46

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	**7,894**	62	925	352	1,330	1,085	780	678	692	328	122	1,186	327	27
18 and over	**1,141**	1	88	75	346	54	44	50	23	46	10	103	282	19
Target	**723**	**5**	**81**	**34**	**134**	**91**	**66**	**58**	**57**	**30**	**11**	**103**	**49**	**4**

	87.37%	98.41%	91.31%	82.44%	79.36%	95.26%	94.66%	93.13%	96.78%	87.70%	92.42%	92.01%	53.69%	58.70%



13. Referral to Treatment snapshot as at 31st March 2019

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 Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
0-6	**697**	0	98	63	140	58	48	82	62	35	21	65	5	13	7
7-13	**859**	0	177	59	134	75	56	100	54	43	17	112	13	13	6
14-17	**241**	0	38	16	49	33	10	19	9	15	1	34	10	6	1
18-26	**394**	0	67	20	122	9	8	28	9	21	7	58	11	21	13
27-39	**148**	0	13	14	59	3	1	3	4	5	0	9	13	21	3
40-47	**11**	0	0	0	3	0	0	0	0	0	0	0	2	5	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,350**	0	393	172	507	178	123	232	138	119	46	278	54	79	31

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
Under 18	**1,797**	0	313	138	323	166	114	201	125	93	39	211	28	32	14
18 and over	**553**	0	80	34	184	12	9	31	13	26	7	67	26	47	17
Target	**188**	0	31	13	40	14	9	18	11	9	3	22	4	6	2
Variance from Target	**365**	**0**	**49**	**21**	**144**	**-2**	**0**	**13**	**2**	**17**	**4**	**45**	**22**	**41**	**15**
	76.47%		**79.64%**	**80.23%**	**63.71%**	**93.26%**	**92.68%**	**86.64%**	**90.58%**	**78.15%**	**84.78%**	**75.90%**	**51.85%**	**40.51%**	**45.16%**

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 Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
0-6	**3,598**	227	379	112	518	571	417	278	300	198	43	452	80	15	8
7-13	**2,189**	21	192	81	373	307	213	151	230	81	28	384	98	27	3
14-17	**642**	8	43	33	101	74	66	57	77	13	7	108	36	18	1
18-26	**618**	1	43	39	124	34	57	38	16	14	8	105	68	67	4
27-39	**145**	0	3	9	48	2	3	2	1	5	0	8	29	34	1
40-47	**15**	0	0	3	3	0	1	0	0	0	0	1	5	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**1**	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Total	**7,208**	257	660	277	1,167	988	757	526	625	311	86	1,058	316	163	17

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity Under 16	Spinal Deformity Over 15	Spinal Deformity BCH
Under 18	**6,429**	256	614	226	992	952	696	486	607	292	78	944	214	60	12
18 and over	**779**	1	46	51	175	36	61	40	18	19	8	114	102	103	5
Target	**577**	20	52	22	93	79	60	42	50	24	6	84	25	13	1
Variance from Target	**202**	**-19**	**-6**	**29**	**82**	**-43**	**1**	**-2**	**-32**	**-5**	**2**	**30**	**77**	**90**	**4**
	89.19%	**99.61%**	**93.03%**	**81.59%**	**85.00%**	**96.36%**	**91.94%**	**92.40%**	**97.12%**	**93.89%**	**90.70%**	**89.22%**	**67.72%**	**36.81%**	**70.59%**

14. Cancer Performance Targets

		Indicative		Reported Month										Reported Quarter 2017/18			
Target Name	National Standard	Q4	*Mar-19*	Feb-19	Jan-19	Dec-18	Nov-18	Oct-18	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%	*99.0%*	*98%*	98%	100%	98%	98%	100%	100%	100%	100%	100%	98%	98%	97%	98%	99%	98%
31 day first treatment	96%	94.0%	*100%*	81.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	96%	97%	97%
31 day subsequent (surgery)	94%	*94.9%*	*100%*	93.8%	90.9%	93.8%	100%	100%	100%	100%	100%	100%	100%	90%	98%	100%	97%	100%
62 day (traditional)	85%	*96.0%*	*100%*	100%	90%	0.0%	53.8%	100.0%	62.5%	57.1%	90%	89%	90%	67%	82%	82%	72%	67%
62 day (Cons Upgrade)	n/a	88.20%	*100.0%*	89.5%	*75.0%*	94.70%	*90.5%*	88.9%	77.8%	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	n/a	n/a	n/a	n/a	n/a	n/a	n/a
28 day FDS	85%		*tbc*	82.20%														
No. patients treated 104+ days				1	1	2	1		1			1						

PERFORMANCE/IMPROVEMENTS / LEARNING

The Trust performance for the 62 day target in March is currently at **100%** - this data is due for submission at the beginning of May 2019. Strong performance in February and March has meant that the Trust will hit the target for Quarter 4 **88.2%** which has not historically been met (**Target 85%)**

The Trust is also "shadow" monitoring the new 28 day Faster Diagnostic Standard which will be a national performance target in April 2020. The Trust is required to report this from April 2019. The target is **85%** and our performance in February was **82.22%.**

The FDS will ensure that patients are told they have cancer, or that cancer is excluded , within a maximum of 28 days from referral.

Good progress has been made across the action plan within Cancer Services with the majority of the action plan now being completed. A weekly tracking meeting is now fully embedded with Pathology and Radiology input, which is demonstrating an impact in our improved performance position

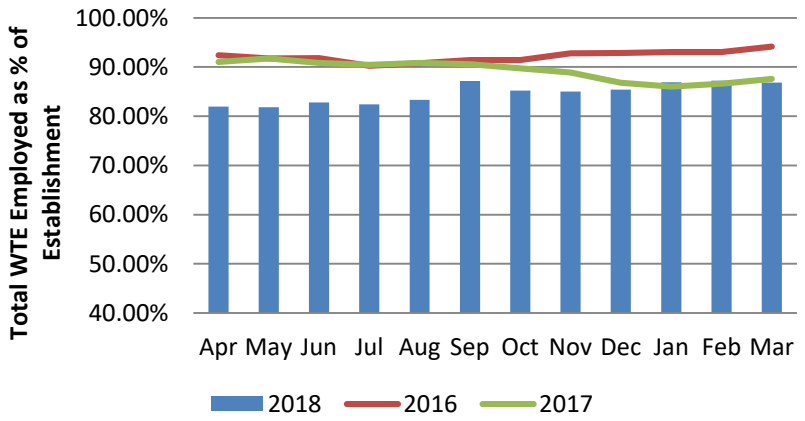
Somerset IT system has been implemented and over the next few months the new reporting function which is currently being developed will enable more enhanced report to be shared with F&P

RISKS / ISSUES

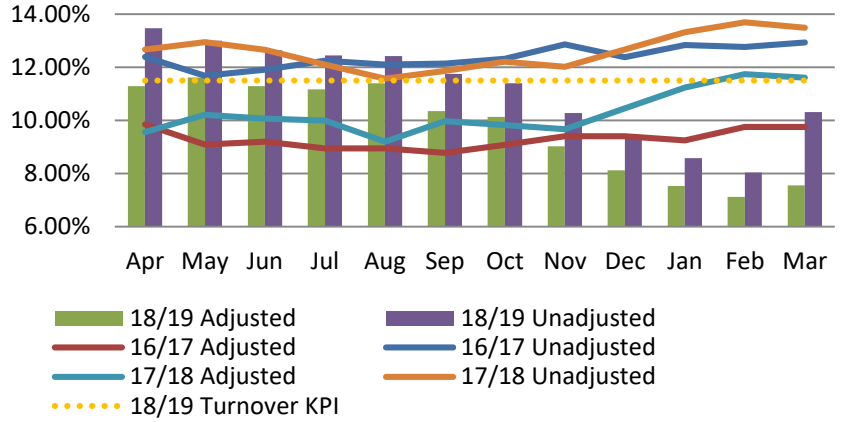
With the transfer of the Inpatient Paediatric Service in July 2019 to BWC the team will continue to work closely with both teams to minimise any impact on our performance

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

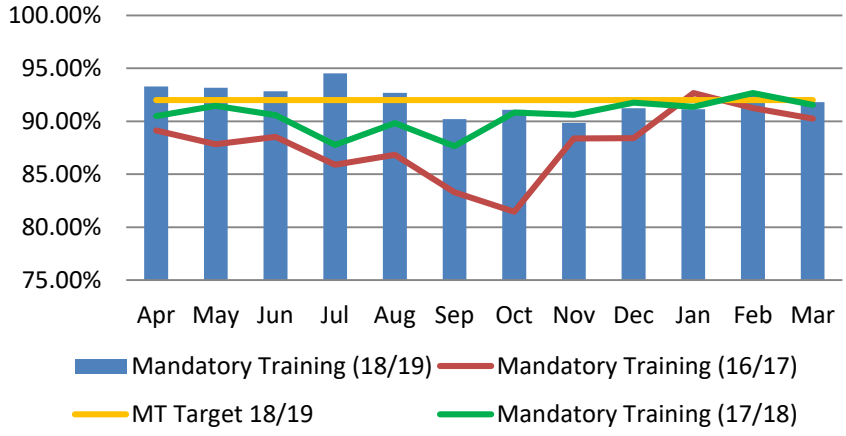
Staff in Post v Establishment



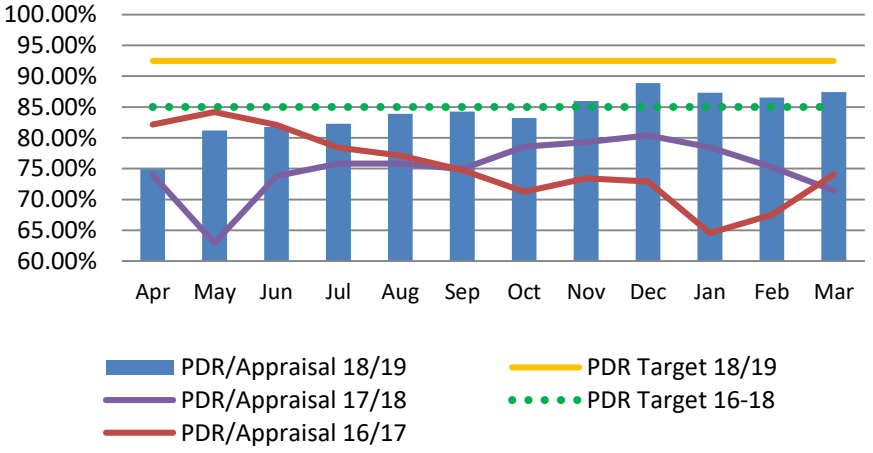
Staff Turnover



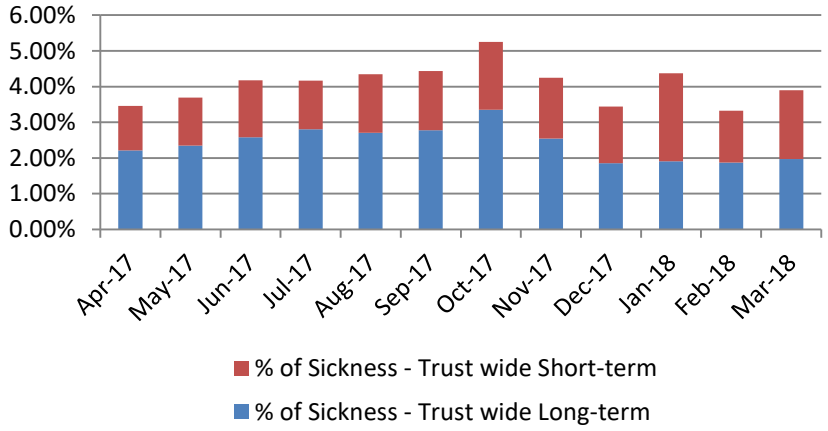
Mandatory Training



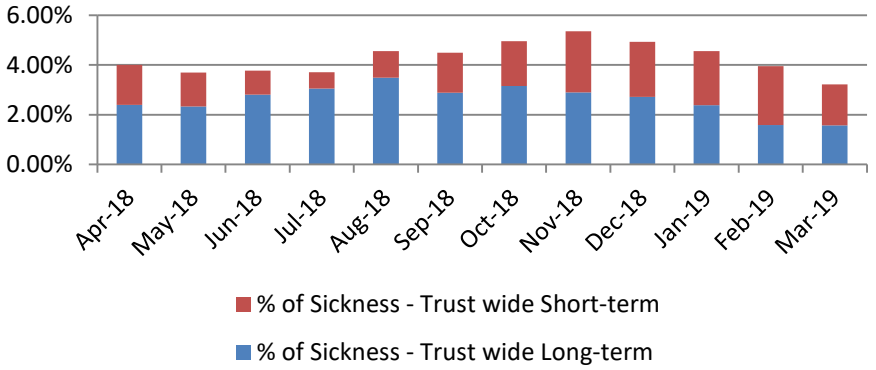
PDR/Appraisal



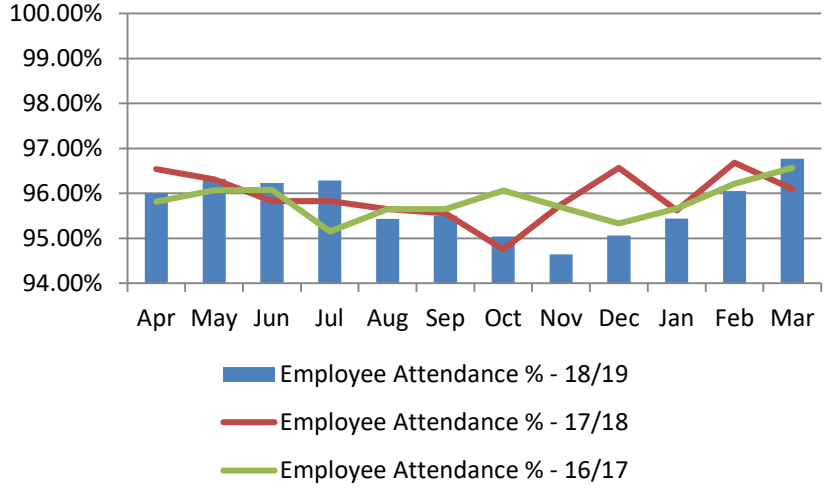
Sickness % - LT/ST (2017/18)



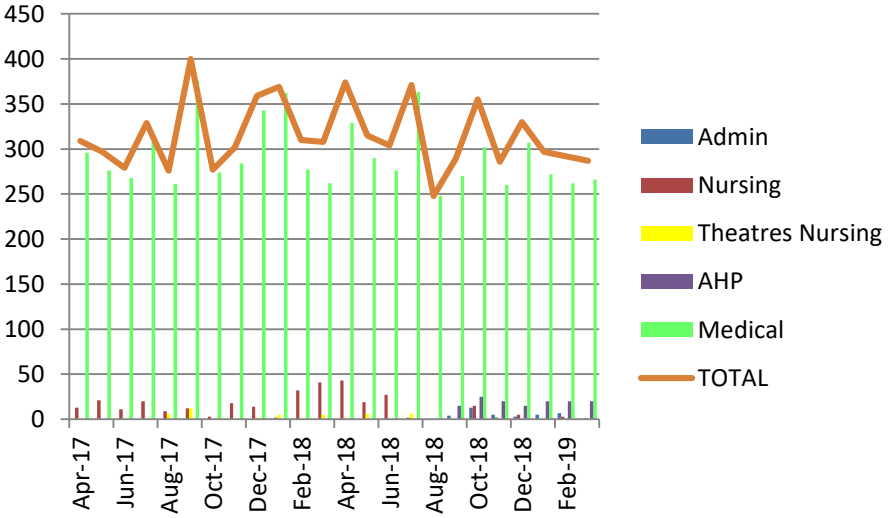
Sickness % - LT/ST (2018/19)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

March has seen a variety of changes within workforce performance. Sickness absence and agency breaches decreased and appraisals increased. Whereas, statutory and mandatory training decreased and the vacancy position and turnover increased – although the latter have justifiable reasons.

This month the Trust's vacancy position saw a slight decrease this month (0.36%) as a percentage of WTE employed, with the figure for March at 86.84% against a Trust target of 90%. This is due to a slight increase in the budgeted establishment, the number of staff on the payroll is still increasing, which stood at 946.04, an increase on the February position of circa 5 WTE and so the number of staff at ROH continues to grow .

Monthly attendance increased again this month by a higher rate of 0.72% to 96.77%, the in month position improved to green in March, which is the first time since July last year. Short term sickness decreased from 2.37% to 1.65%, which is the lowest has been for the past 6 months. The 12 month sickness absence figure decreased to 4.45%.

Mandatory Training numbers saw a decrease of 0.76% versus February's figure. This month's position stands at 91.80%, which is below the Trust target of 92%, so returns to amber this month, but it is still higher than the figure for March 17 and March 18, which were 90.26% and 91.56% respectively.

March's appraisal performance increased to 87.41%, which is the second highest level since May 2014: but it is still distance from our internal stretch target of 92.5%, so operational focus needs to be maintained with Divisions in this area.

The unadjusted turnover figure (all leavers except doctors and retire/returners) increased to 10.31%. The adjusted turnover figure (substantive staff leavers including retirements) increased to 7.55% and but remain green against a KPI of 11.5%. This is due to the movement of the Histopatholgy department to our neighbouring Trust UHB.

In March, agency breaches decreased slightly from 292 to 287 shift breaches in total, with the majority still being medical usage (266), which increased slightly from 262 to 266 for March's usage. There was only 1 nursing breach and 0 admin breaches, the other 20 were AHP breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

ROHGO (5/19) 014

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

April 2019

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.

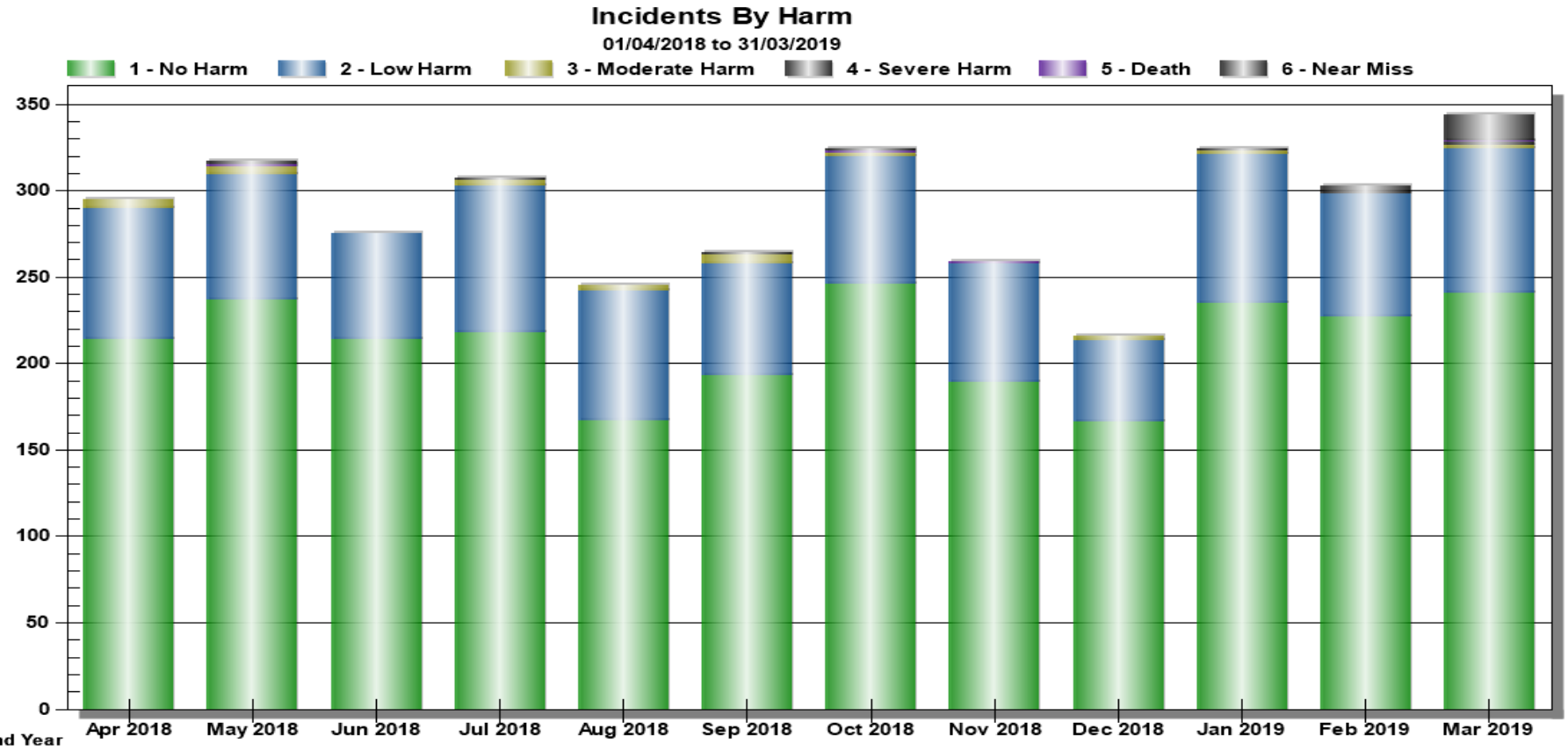
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
1 - No Harm	214	237	214	218	167	193	246	189	166	235	227	241
2 - Low Harm	76	72	61	85	75	65	74	69	47	86	71	83
3 - Moderate Harm	5	5	0	3	3	5	2	0	3	2	0	2
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	0	2
5 - Death	0	1	0	0	0	0	1	1	0	0	0	1
6 - Near Miss	0	2	0	1	0	1	1	0	0	1	5	15

INFORMATION

In March 2019, there were a total of 344 Incidents reported on the Ulysses incident management system.

The breakdown of those incidents is as follows;

241 – No Harm
83 – Low Harm
2 Moderate Harms
2(1 Duplicate) – Severe Harm
15 – Near Miss
1 – Death

The provisional harms reported were;

Department	Cause 1
Ward 1	Death (Expected)
Blood Bank, Bone Bank And Specimen Room	Specimen Request - Documentation Issue
Ward 3	Fall - Inpatient
ROCS	Thromboembolic Events (Known/Suspected)

Near Miss Incidents – Radiology incidents

All 15 of the near misses are in relation to X-Ray processes and radiology examinations not being processed in the RIS system. This leads to delays in reporting. None of the incidents reported are patient safety issues and have not led to a delay in diagnosis. All radiographers are aware of their professional standards and the need to complete the RIS events. The incident forms will promote a professional discussion with their line manager to ensure that they are aware of the incident and any further occurrences may lead to disciplinary action. This is a new process to drive improvement and will be monitored via the radiology teams. The new CRIS system is automated and will resolve the manual processing of examinations, therefore will resolve this issue.

Patient Contacts

In March 2019, there were a total of 9381 patient contacts. There were 344 incidents reported, which amounts to 3.7 per cent of the total patient contacts resulting in an incident. Of those 344 reported incidents, 88 incidents resulted in harm which is 0.9per cent of the total patient contact.

NRLS

The Trust uploaded to the NRLS for 6 out of 6 months between April 2018 and September 2018. The rate of Patient safety Incident per 1000 bed days was 21.42

Organisation name	Rate per 1,000 bed days
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	37.39
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	21.42

Downgraded Incidents

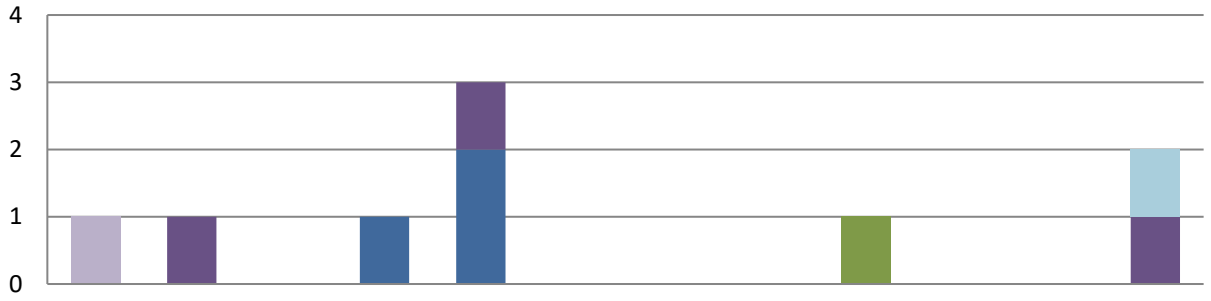
3 of the 3 reported moderate harms in the previous Quality report have been downgraded to No Harm.

Department	Cause 1
H D U	Emergency Transfer Into The Trust
Ward 1	Emergency Transfer Out Of Trust - Other

ACTIONS FOR IMPROVEMENTS / LEARNING
• Implementation of the Health Assure system - Project plan was on the agenda of Quality and Safety in March 2019 – Allocate had cancelled CQC module training in April 2019 causing delay to the project plan. Training in the process of being rescheduled. • New Incident management policy launched into the Trust via comms and via the Divisional Governance meetings
RISKS / ISSUES
• Risk 265 - Engagement and adherence with staff around learning from incidents and never events. (current risk score 8). • Risk 1193 - Staffing and capacity within the team with two vacancies (current risk score 12). 1 agreed start date for the Clinical Governance Facilitator post and 1 offer made to an apprentice to support the team. • Risk 1194 - Lack of skill in the Trust on the Ulysses system (current risk score 12).

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 2019



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medication												1
Transfer out	1											
Slips, trips & falls		1			1							1
Pressure Ulcers									1			
VTE meeting SI criteria				1	2							

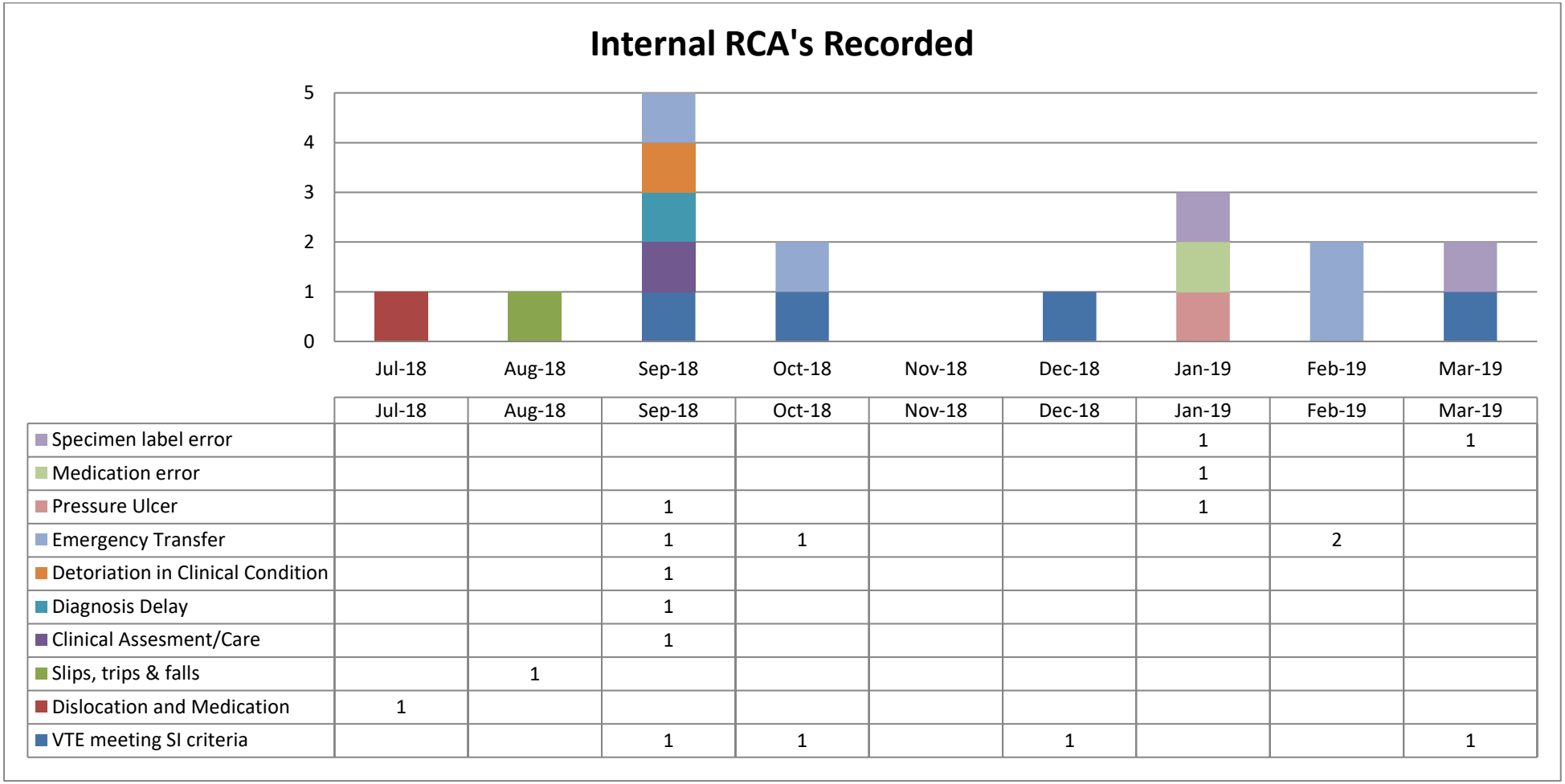
INFORMATION

2 Serious Incidents were reported in March 2019.

Department	Cause 1
Ward 3	Fall - Inpatient
Ward 3	Medication error

ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incident was closed in March 2019. **Lessons Learned** • It is acceptable for a nurse to cut the cast when a patient has complained of pain/burning underneath. • Regular Tissue Viability updates. • Documentation review to improve POP care plans as some sections appear confusing. • Reinforcement of importance to maintain good patient documentation. • The need for clearer guidelines on escalation of concerns.
RISKS / ISSUES
None

4. Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision that a heightened level of response is needed for these incidents.



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Specimen label error							1		1
Medication error							1		
Pressure Ulcer			1				1		
Emergency Transfer			1	1				2	
Detoriation in Clinical Condition			1						
Diagnosis Delay			1						
Clinical Assesment/Care			1						
Slips, trips & falls		1							
Dislocation and Medication	1								
VTE meeting SI criteria			1	1		1			1

INFORMATION

There were two internal RCAs Reported in March 2019

All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions make a decision, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.

Department	Cause 1	Actions
Blood Bank, Bone Bank And Specimen Room	Specimen Request - Documentation Issue	**RCA and DoC lead nominated currently under investigation**
ROCS	Thromboembolic Events (Known/Suspected)	**RCA and DoC currently in progress by RoCs and Ward 1.**

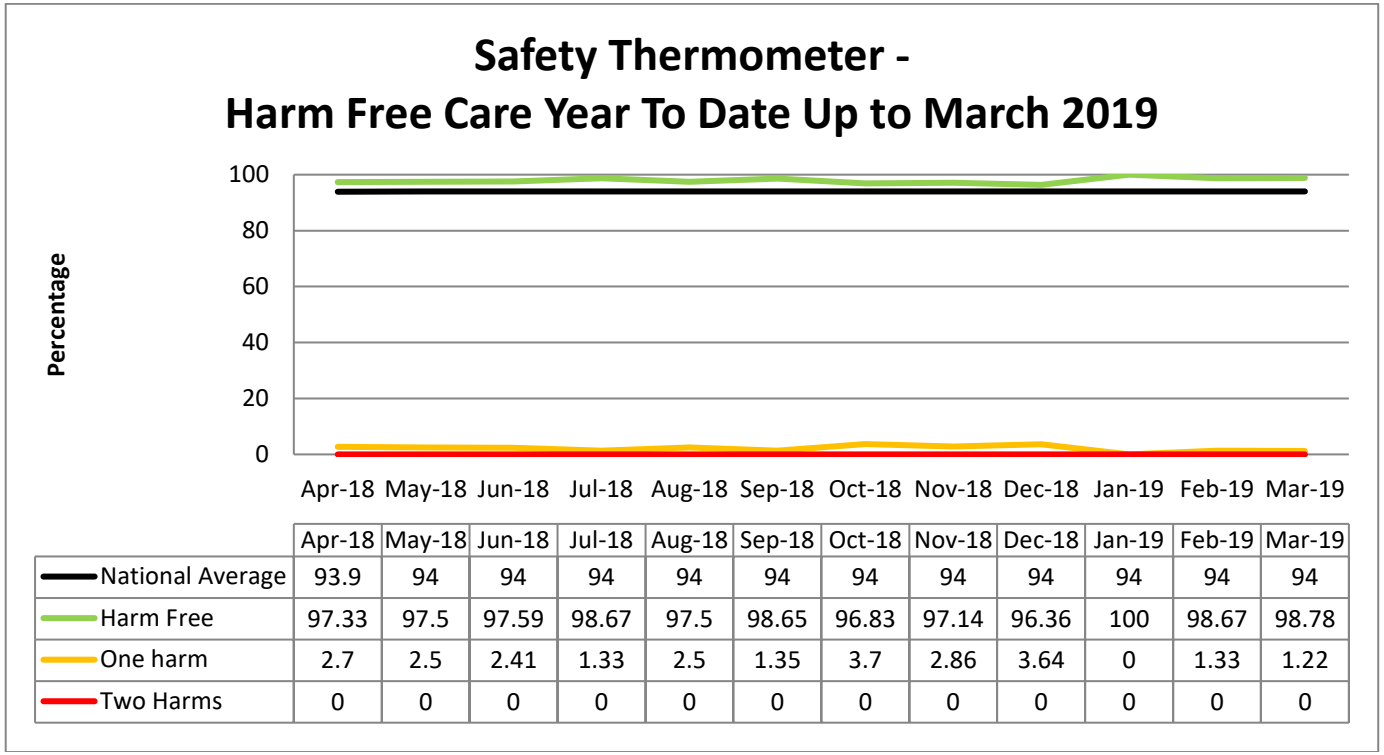
ACTIONS FOR IMPROVEMENTS / LEARNING

No RCAs were due for closure in March 2019.

RISKS / ISSUES

None

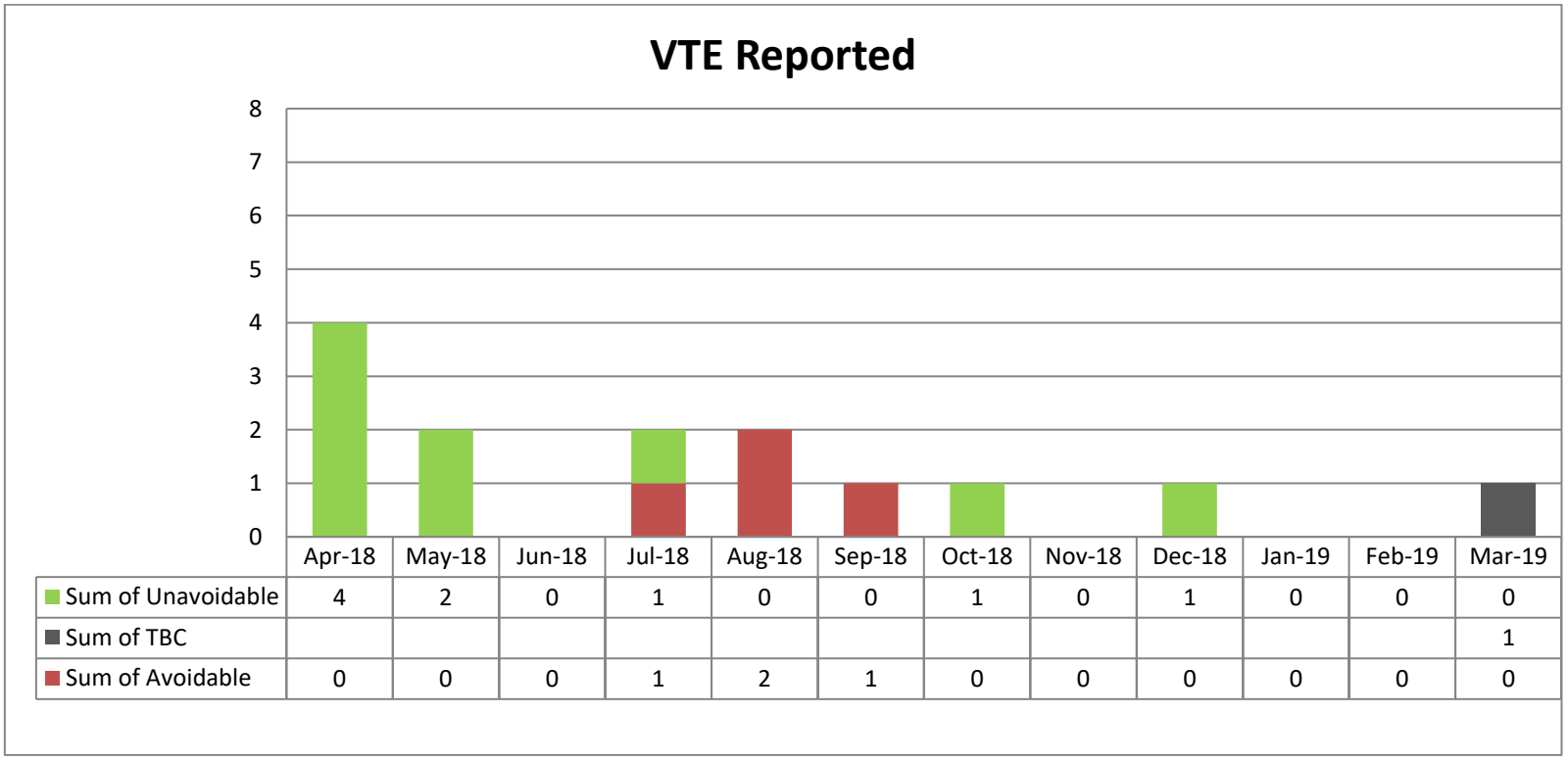
5. NHS Safety Thermometer - provides a 'temperature check' on the harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
National Average	93.9	94	94	94	94	94	94	94	94	94	94	94
Harm Free	97.33	97.5	97.59	98.67	97.5	98.65	96.83	97.14	96.36	100	98.67	98.78
One harm	2.7	2.5	2.41	1.33	2.5	1.35	3.7	2.86	3.64	0	1.33	1.22
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

1 harm = OLD PU on Ward 1

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).



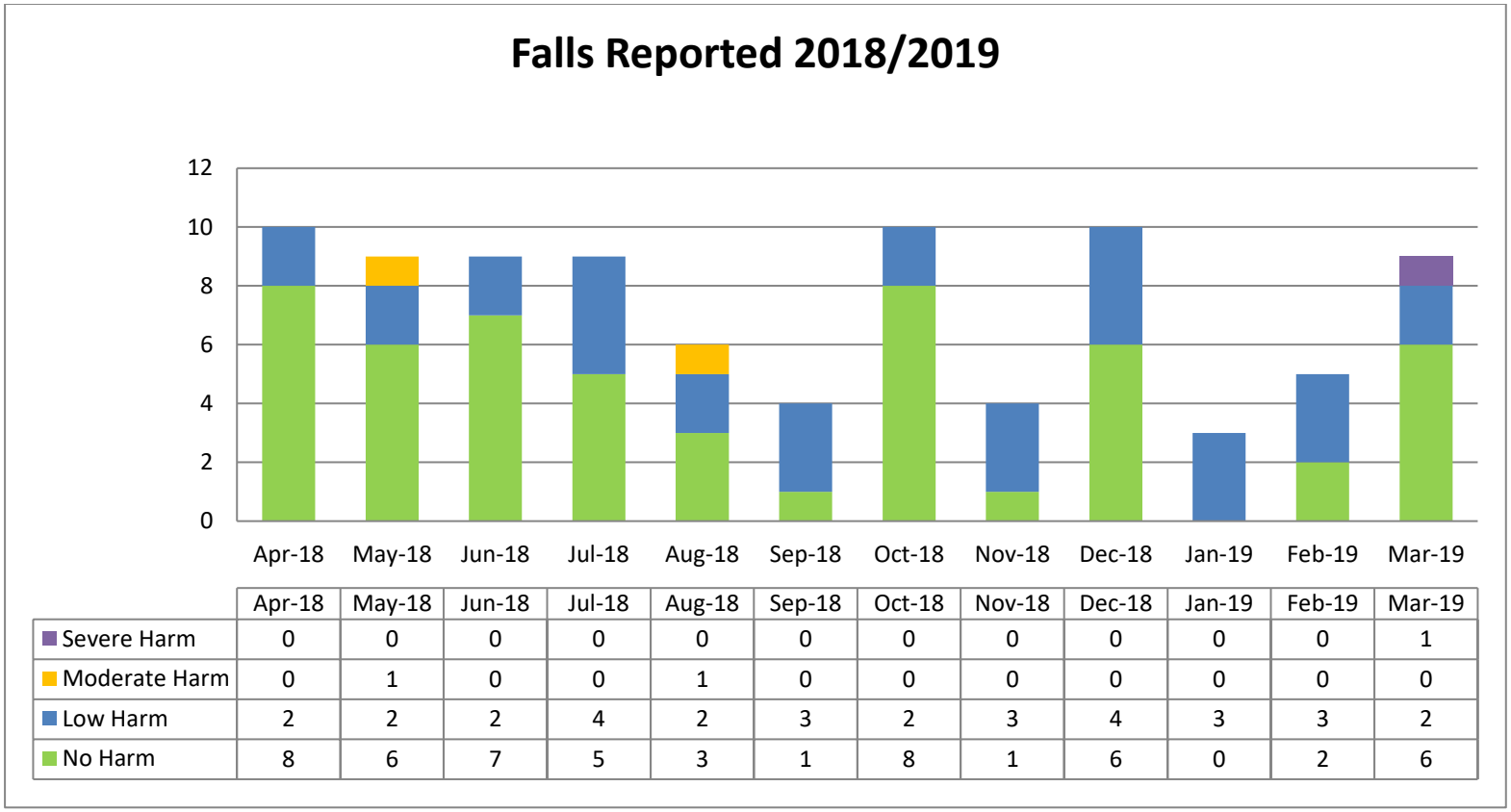
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sum of Unavoidable	4	2	0	1	0	0	1	0	1	0	0	0
Sum of TBC												1
Sum of Avoidable	0	0	0	1	2	1	0	0	0	0	0	0

14

total		Avoidable
17/18	33	10
18/19	13	4

INFORMATION
There has been 1 hospital acquired VTE reported to date in 2019. This DVT occurred post discharge. RCA underway.
ACTIONS FOR IMPROVEMENTS / LEARNING
There is on-going work around the NICE guidance released in March 2019. As reported previously the exemplar network and other hospitals have raised concerns regarding some elements of the guidance. The group continue to benchmark against other Trusts and work with Clinical Service Leads on this. Assurance is provided that the prophylaxis offered to our patients is safe and appropriate. Due to national shortage a swap from Clexane to Inhixa was required. Risk assessments and training was provided. The swap over went smoothly without incident. VTE commissioner reporting requirements for 2018/19: VTE risk assessment (minimum requirement 95%): February's data is not available at the time of writing but has continued to exceed the minimum requirement. This is being scrutinised by the VTE lead monthly as now this is a mandatory field within PICS we should achieve 100% compliance. Issue identified with day case patients as mandatory field only triggered when medicines prescribed. This has been fed back to theatre teams as confirmation that VTE assessment has been completed and signed as reviewed is a WHO sign in question. This has been escalated at Clinical Quality Group.
RISKS / ISSUES
Poor compliance with mandatory 24 hour re-assessment . This has been escalated and continues to be monitored. Despite now being a mandatory field in PICS compliance is currently 89.5%. Reports obtained from PICS enable identification of who acknowledged/ignored the alerts. This has been escalated to the Medical Director and is being addressed.

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-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	0	0	0	0	0	1
Moderate Harm	0	1	0	0	1	0	0	0	0	0	0	0
Low Harm	2	2	2	4	2	3	2	3	4	3	3	2
No Harm	8	6	7	5	3	1	8	1	6	0	2	6

total	
17/18	125
18/19	88

INFORMATION

There were nine patient fall-related incidents reported across the Trust in March 2019. All the incidents have been subject to a post-fall notes review by the ward manager or deputy. Incident 27107 was reported as severe harm as detailed on Page 5 of this report.

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

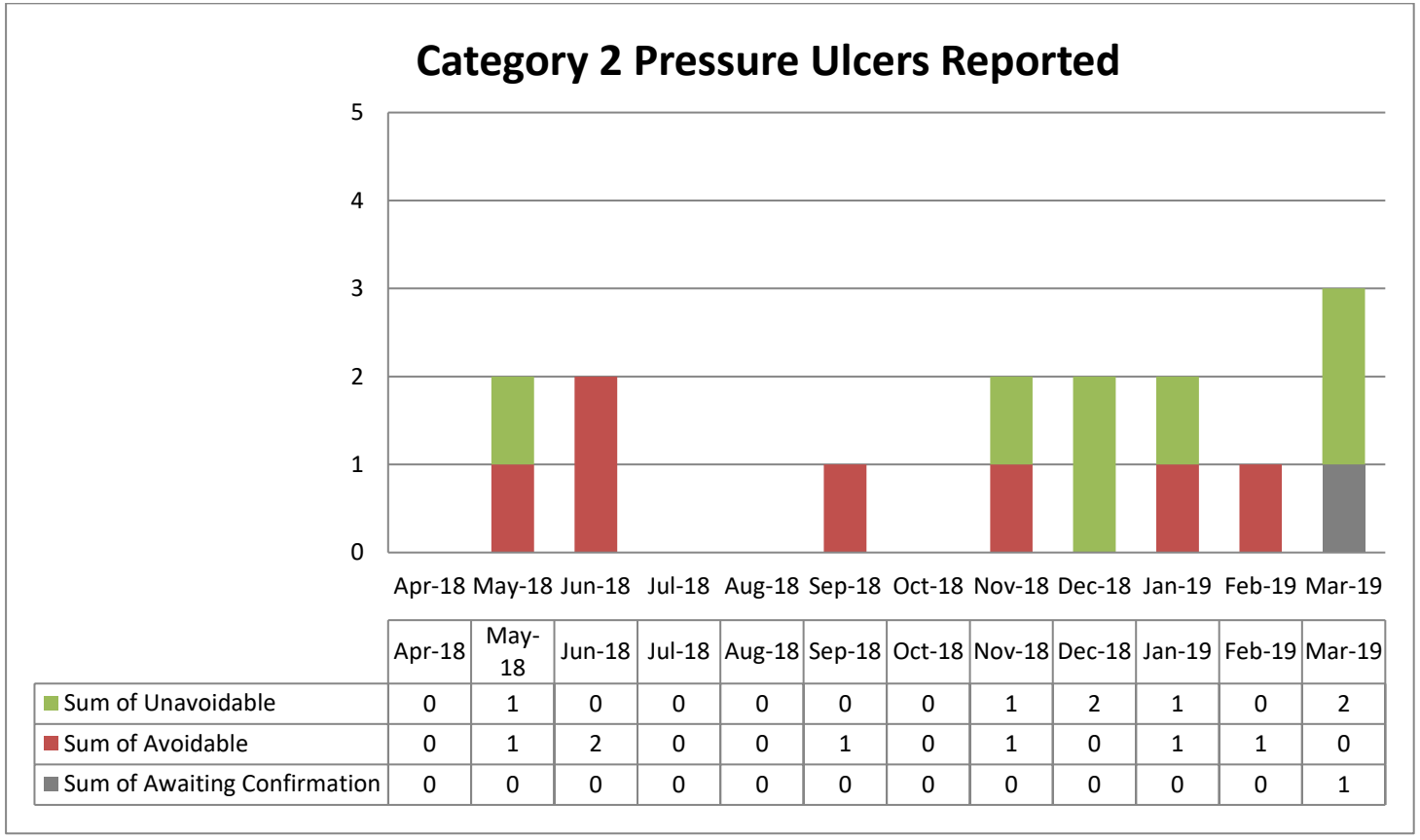
- Purchase of another Hover Jack, to be considered this year- plan to submit a capital bid – no change.
- Trust wide replacement of hoists delayed as funding is not in place. Request submitted to capital bid program for this year – no change, still awaiting outcome of funding
- Review of the benchmarking exercise of the WMQRS – looking at development of fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall.
- On-going development of Throne project.

Positive Assurance

- Staff training on the use of manual handling equipment such as Sara steady.
- Clinical skills update day reinstated to be delivered annually.
- Template for Medical review post fall
- Benchmarking of the WMQRS
- Development of combining falls and dementia working groups to facilitate joined up working – first meeting 27/3/19

RISKS / ISSUES
When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Bid submitted to replace hoists Trust wide.

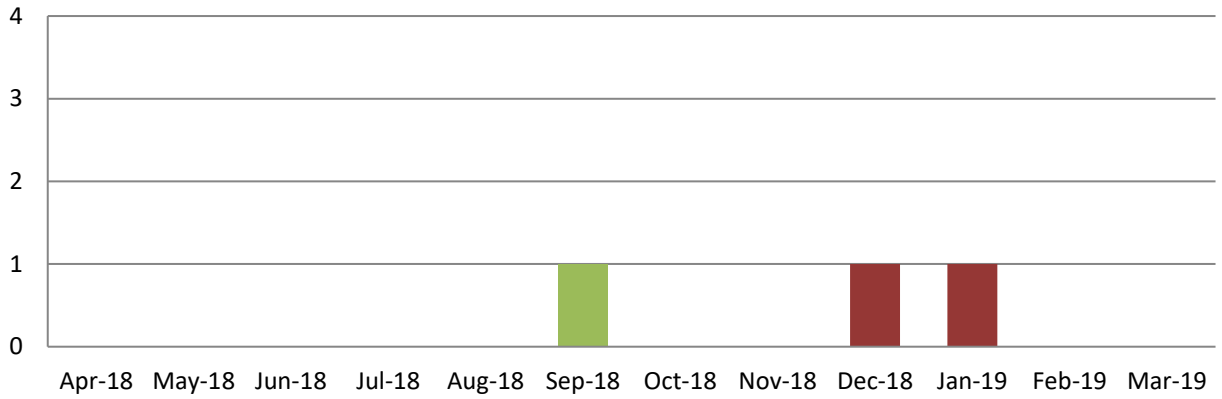
8. **Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open 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	0	1	2	1	0	2
Sum of Avoidable	0	1	2	0	0	1	0	1	0	1	1	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	1

total	Avoidable
17/18	6
18/19	7

Category 3 and 4 Pressure Ulcers Reported



	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	0	0	0	0	0	0	0
Unavoidable G4	0	0	0	0	0	0	0	0	0	0	0	0
Unavoidable G3	0	0	0	0	0	1	0	0	0	0	0	0
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	0	0	0	0	0	0	1	1	0	0

total		Avoidable
17/18	G3	3
	G4	0
18/19	G3	2
	G4	0

INFORMATION

In March 2019 – There was 3 x Category 2 pressure ulcers reports. There was 0 Category 3 / 4 reported.

March 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	Category 2 – x 2 unavoidable following scrutiny
Category – 2 (Device)	Category 2 – AES – Ward 12 – under review
Category – 1	Category 1 – x 1 did not develop further
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	ROH developed – x 3 (all resolved) Patients Admitted - x 7
Patients admitted with PU's	Category 3 – x 1 (patients home) Category 2 – x 1 (patients home)

Avoidable Pressure Ulcer CCG Contracts KPI

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

2017/2018:

2017/2018	
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

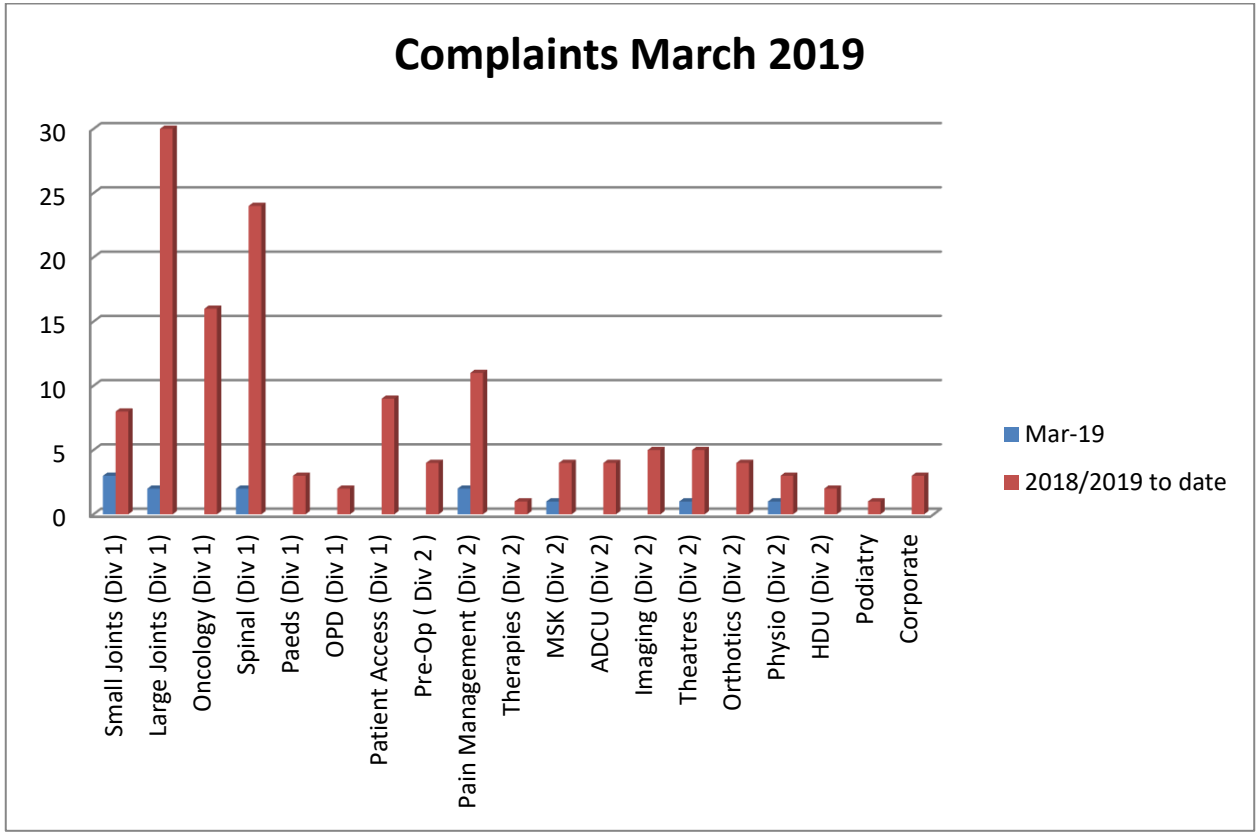
- The POP plaster cast care plan has been. Amended SOP in progress. Extra training to be given to staff during theatre shutdown week regarding plaster care and removal of POP.
- The MDT pathway documentation will be amended at general review in May 2019 to re make it clearer when Anti-embolic stockings are removed and skin checked.
- All Trusts were required to have implemented the NHSI recommendations 2018 for pressure ulcers: revised definition and measurement, by the end of March 2019. ROH was compliant from Sept 2018.
- Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (March 2019). ROH fully compliant
- Trust wide mattress audit to be undertaken on 25/4/19.
- National closed Facebook group- accessible for TVNs only, received a BJN national award for innovation – March 2019, TV team at ROH part of group.
- As a result of the investigations and RCAs related to an ROH developed category 3.

    1. 5 key message training given immediately
    2. Key information left on notice board
    3. TV team will give ongoing support
    4. ROH training to all staff updated
    5. Quality day with a focus on learning from TV incidents

RISKS / ISSUES

None

9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



INFORMATION

PALS

The PALS department handled 63 contacts during March 2019 of which 38 classified as concerns. This is a significant reduction in calls compared to the same time last year (343 contacts in March 2018) and a reduction in the level of concerns (70 concerns in March 2018). The main themes in the PALS data relate to queries about appointments (either length of wait for or cancellations) and administrative processes. 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 82% of concerns were handled within the agreed timescales, meeting this internal KPI.

PALS concerns by theme	Mar-19
Access to treatment	1
Admission & Discharge	4
Appointments	11
Clinical	5
Communication	2
Facilities	1
Trust Administration	10
Values & Behaviours	1
Waiting times	3

Compliments

There were 647 compliments recorded in March 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments March 2019
Div. 1	461
Div. 2	185
Div. 4	1

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 receive a request monthly to submit their compliments for central logging.

Complaints

There were 12 formal complaints made in March 2019, bringing the total number of complaint to 139 for the year to date. All were initially risk rated amber or yellow. This is less than last year (16 complaints in March 2018). Two complaints during the year were withdrawn, leaving 137 for the year. This is a 7% decrease on last year (148 in 2017/2018)

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Wait for spinal surgery (Div.1, Spinal)
- Treatment in pain management & shoulder service (Div.2, Pain Management)
- Management of special needs (Div.1, Spinal)
- Approach of administrator (Div.2, MSK)

Initially Risk Rated Yellow:

- Approach of Consultant (Div.1, Small Joint)
- Refused new crutches - wants refund for the new ones he bought (Div.2, Physio)
- Removed from injection list (Div.2, Pain Management)
- Aftercare from surgeon & sec (Div.1, Small Joints)
- Care under Consultant (Div.1, Large Joints)
- Loss of walking stick (Div.2, Theatres)
- Delays in clinic (Div.1, Small Joints)
- Treatment under young adult hip service (Div.1, Large Joints)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 14 complaints closed in March 2019, 12 within the agreed timescales. This gives an 86% completion on time rate and meets the KPI for the month. The average length of time to close complaints in March 2019 was 29.5 days, which is within normal limits.

Learning identified and actions taken as a result of complaints closed in March 2019 include:

- Process of obtaining new products to use via Medical Devices Group is not clear to Clinicians
  Action: Training is being planned at Clinical Audit

- Waiting times for Pain Management Appointments is high
  Action: Number of mitigation steps have been put in place: extra clinics, redirecting referrals, closing out of area referrals

- A member of staff did not provide service in line with Trust Values
  Action: Apology offered, professional conversation undertaken and reflective learning with department undertaken

RISKS / ISSUES

None Identified.

COMEBACK COMPLAINTS

0 comebacks received in March 2019.

10. 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 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 agreed internal targets for all areas and as a result, the data is 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 requested 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 recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In March 2019, 7 concerns were identified from the 1544 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 main areas of concern in March 2019 related to Staffing numbers and Clinical Issues. Information is 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 of 20% for Outpatient services was not met this month. 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 March 2019**	**% of people who would NOT recommend the department in March 2019**	**Number of Reviews submitted in March 2019 (previous month in brackets)**	**Number of Individuals who used the Department in March 2019**	**Department Completion Rate (Mandated at 35%)**
Ward 1	92.9%	1.4%	70 (57)	164	42.7%
Ward 2	100.0%	0.0%	62 (78)	165	37.6%
Ward 3	100.0%	0.0%	26 (36)	66	39.4%
Ward 12	97.4%	0.0%	77 (45)	100	77.0%
Ward 11 (CYP)	100.0%	0.0%	19 (25)	81	23.5%
ADCU	99.4%	1.4%	165 (138)	570	28.9%
HDU	100.0%	0.0%	18 (25)	64	28.1%
CYP HDU	100.0%	0.0%	1 (1)	9	11.1%
Overall Trust Inpatient Response Rate for March 2019					37.1%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2019**	**% of people who would NOT recommend the department in March 2019**	**Number of Reviews submitted in March2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.3%	0.6%	1069 (1162)	13.1%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in March 2019**	**% of people who would NOT recommend the department in March 2019**	**Number of Reviews submitted in March 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	100%	0%	37(38)	28.0%

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 March - 31 March

Your average score for all questions this period

★1 ★2 ★3 ★4 ★5 **4.87**

Reviews this period

1544

Your recommend scores

5 Star Score

4.85

% Likely to recommend

97.2%

% Unlikely to recommend

0.5%

11. Duty of Candour – *The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.*

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. Litigation

New Claims

0 new claims against the Trust were received in March 2019

On-going claims

There are currently 33 on-going claims against the Trust.

32 of the claims are clinical negligence claims.

1 claim is a staff claim

Pre-Application Disclosure Requests*

7 new requests for Pre-Application Disclosure of medical records were received in March 2019.

**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 Inquests

There were no Inquests held in March 2019

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; • form evident in notes • Sign in Section • Timeout section • Sign out section **Theatres** Total cases = 859 The total WHO compliance for Theatres in March 2019 **= 100%** **CT area** Total cases = 52 The total WHO compliance for CT in March 2019 **= 100%** **ADCU** The snapshot WHO audit compliance for ADCU in March 2019 = **100%**
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
WHO checklist for ADCU 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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in March 2019 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	2
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

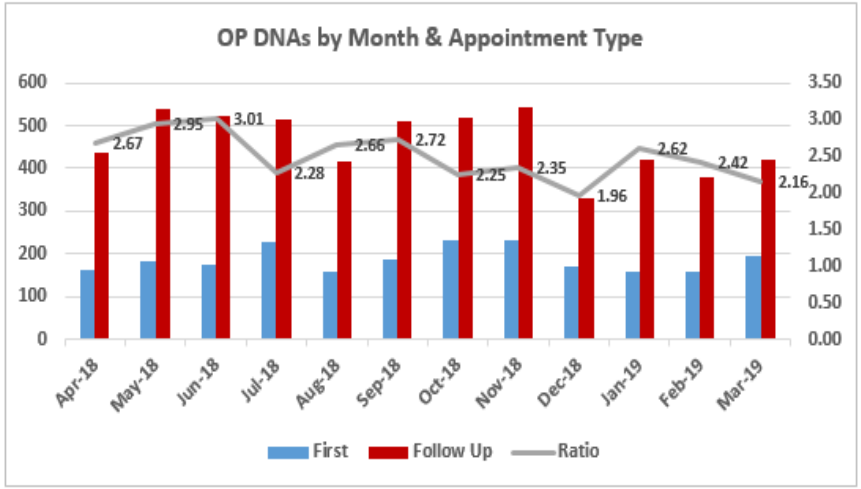
9 IP recorded incidents in March, 2019 (3 no harm, 6 low harm – all either under review or closed).

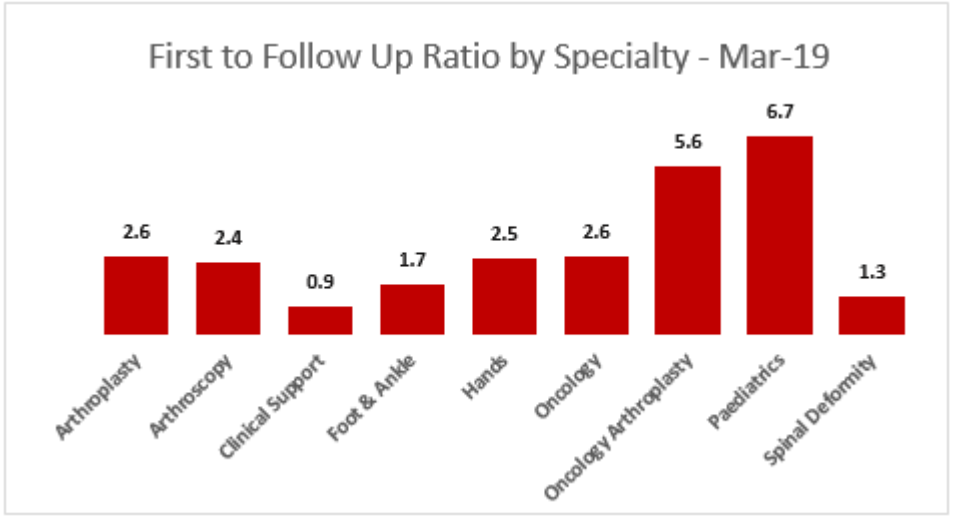
RISKS / ISSUES

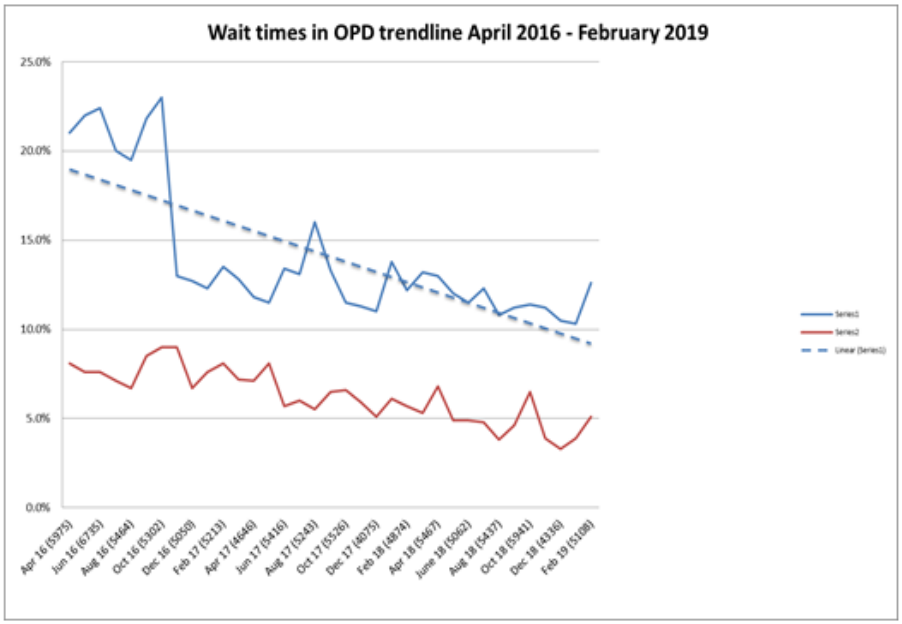
SSI data not submitted for Q4 due to SSI HCA vacancy. This does not pose a risk to ROH as previous 2 quarters had been submitted and required compliance is 1 quarter per annum. The vacancy has now been recruited to and monthly submissions will continue.

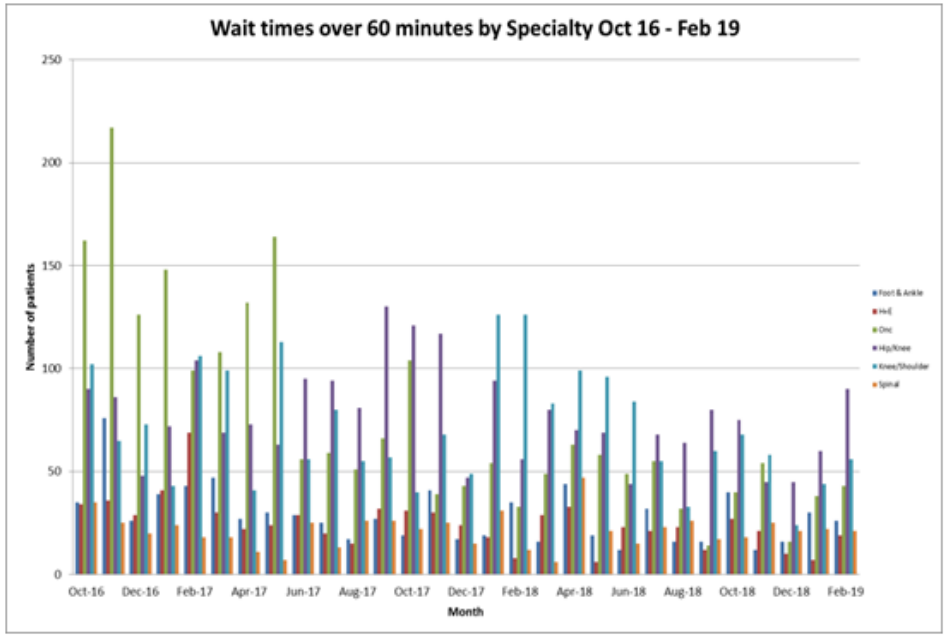
ROH continues to review the status of staff requiring Hepatitis B vaccinations and ensure vaccinations are provided where required.

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









In March there were 11% of patients waiting over 30 minutes which is an improvement from last month. The target for 30 minute delays has still not been achieved but progress has still been good from 22% in May 16. Focussed work is ongoing to continue to improve this position and 4.4% of patients were waiting over 1 hour which was below the target of 5% again.

In addition to the 643 meeting which is held every week to ensure complete room allocations 6 weeks ahead. This ensures that there are rooms available for all clinicians avoiding delays at the start of clinic. It will also help to provide utilisation data in the future at session level. There is an outpatient improvement project that is being set up with the support of the transformation team and this will include utilisation data. As part of this in session utilisation will also be included helping to further identify where, when and why clinic delays occur.

There were 13 incidents of clinic delays reported in March 2019 with the following breakdown.

- 7 complex patient
- clinic overbooked for number of staff
- other
- 1 consultant / clinician delay
- 1 x-ray

The Outpatient Department nursing team are now nearly fully established with the last few appointments awaiting a start date and this will leave just one outstanding qualified post.

There are now 2 notice boards in Outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation. This should further improve communications with clinical staff.

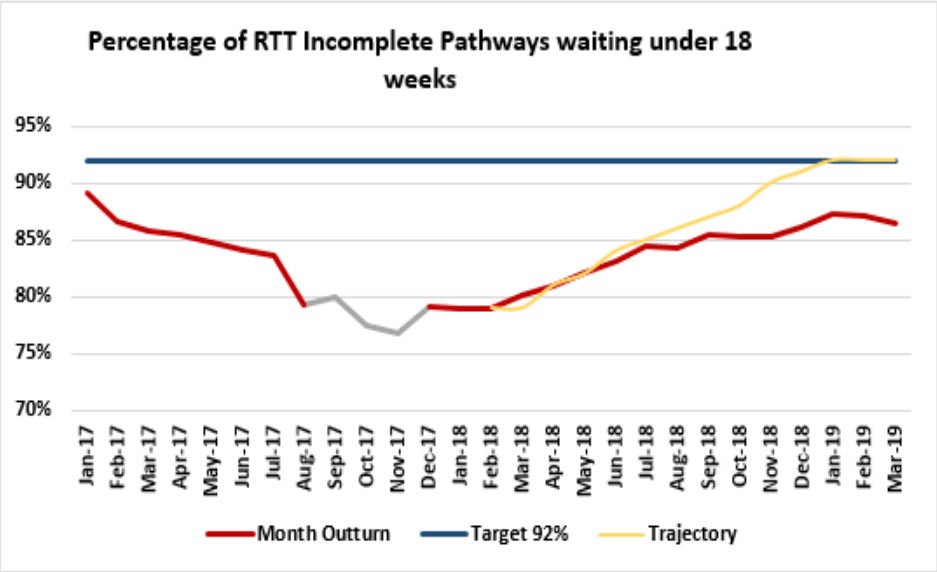
An Outpatient away day is to be held on the 26th of April where all future projects proposed to improve the outpatient service at the ROH will be discussed. This will ensure engagement with the staff about the road map with in the department and staff are being encouraged to raise concerns and ideas with the senior nursing staff.

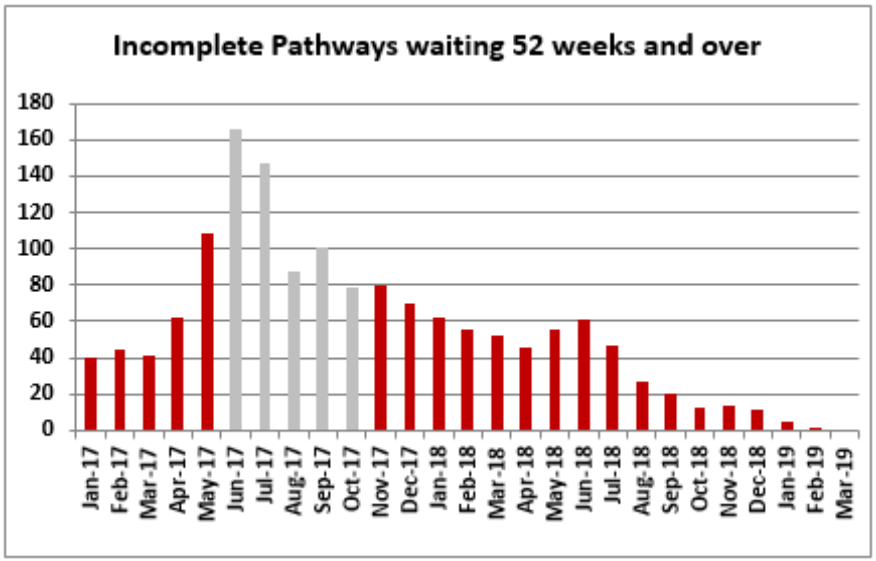
ACTIONS FOR IMPROVEMENTS / LEARNING

- Utilise the outreach clinics at Lordswood whilst investigating further options for additional space either at Lordswood or another site
- Set up the outpatient project improvement group

Risks
• The process for partial booking has been started as a pilot in Pain and this will continue to be monitored. This will need to be reviewed alongside the Appointments team workforce and should there be any impact this will be described with any impact in a business case

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





The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019.

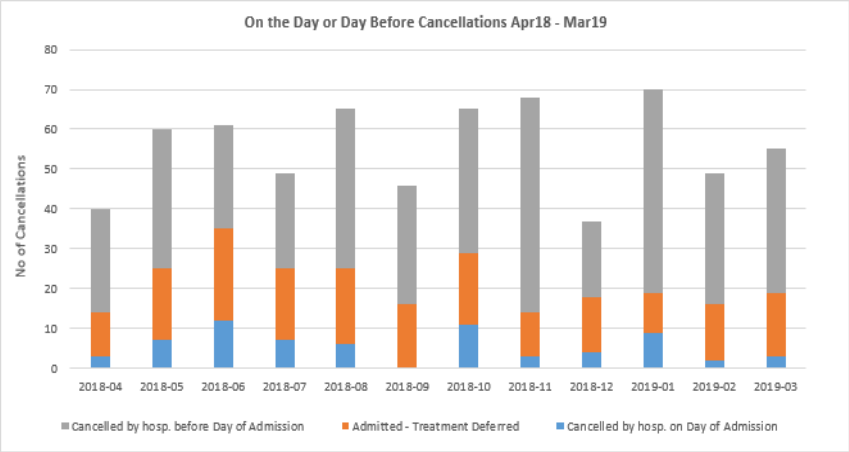
March 2019 performance is **87.37%**

In March the Trust had **0** patients over 52weeks which is a significant achievement for the Trust.

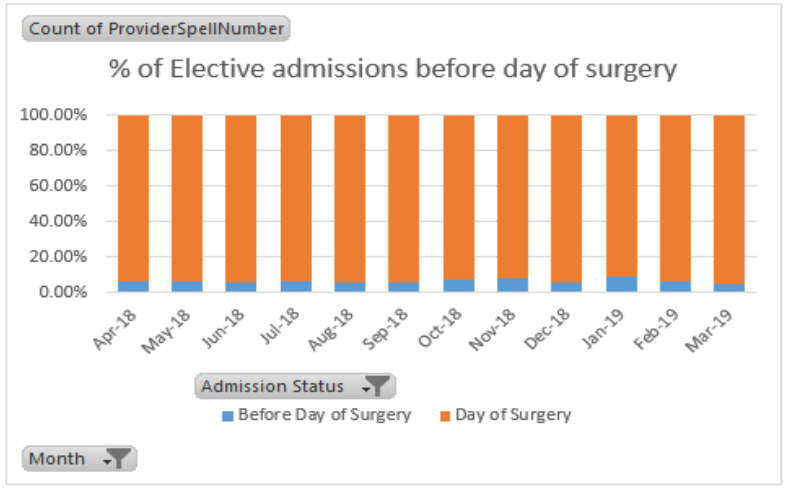
PERFORMANCE/IMPROVEMENTS / LEARNING
The Trust performance for the 62 day target in March is currently at **100%** - this data is due for submission at the beginning of May 2019. Strong performance in February and March has meant that the Trust will hit the target for Quarter 4 **88.2%** which has not historically been met (**Target 85%)** The Trust is also "shadow" monitoring the new 28 day Faster Diagnostic Standard which will be a national performance target in April 2020. The Trust is required to report this from April 2019. The target is **85%** and our performance in February was **82.22%.** The FDS will ensure that patients are told they have cancer, or that cancer is excluded , within a maximum of 28 days from referral. Good progress has been made across the action plan within Cancer Services with the majority of the action plan now being completed. A weekly tracking meeting is now fully embedded with Pathology and Radiology input, which is demonstrating an impact in our improved performance position Somerset IT system has been implemented and over the next few months the new reporting function which is currently being developed will enable more enhanced report to be shared with F&P
RISKS / ISSUES
With the transfer of the Inpatient Paediatric Service in July 2019 to BWC the team will continue to work closely with both teams to minimise any impact on our performance

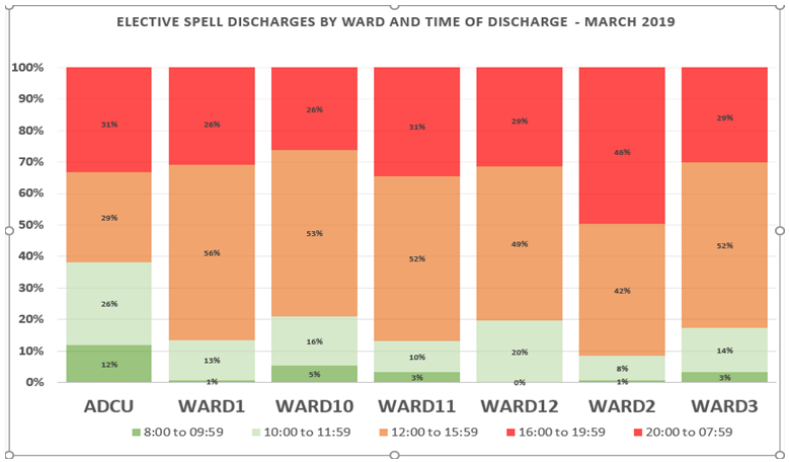
18. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

Hospital Cancellations
Admission the day before surgery



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
2018-04	3	11	26	40	0
2018-05	7	18	35	60	0
2018-06	12	23	26	61	0
2018-07	7	18	24	49	0
2018-08	6	19	40	65	0
2018-09		16	30	46	1
2018-10	11	18	36	65	0
2018-11	3	11	54	68	0
2018-12	4	14	19	37	0
2019-01	9	10	51	70	0
2019-02	2	14	33	49	0
2019-03	3	16	36	55	0
Grand Total	67	188	410	665	1





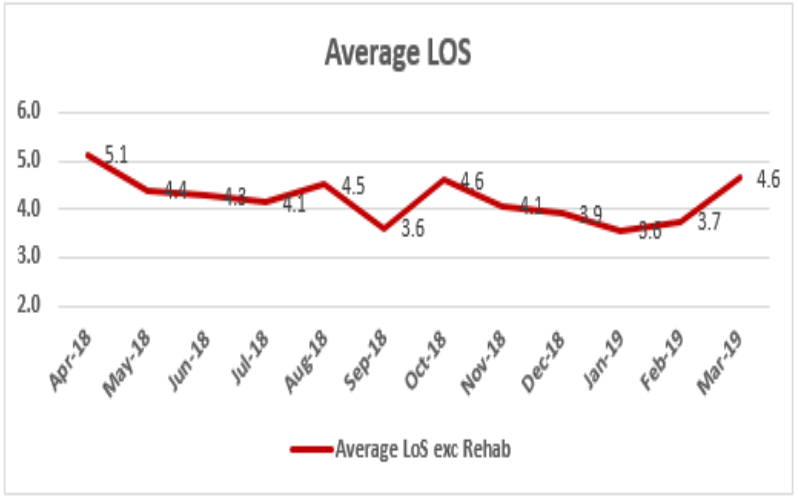
INFORMATION
The number of cancellations on the day of admission for surgery in March was 3 patients , maintaining consistent low figures. Patients admitted for surgery where treatment was deferred has increased slightly in month from 14 to 16. Analysis of patients admitted where treatment was deferred relate to, lack of theatre time and equipment availability. Cancellations before the day of surgery have increased slightly in month from 33 to 36. An analysis of the 36 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 patients declaring fitness issues on the 72 hour contact call . A robust process is now in place to ensure all patients are now contacted 72 hours in advance of surgery , therefore any issues are being highlighted during these calls and patients reconvened appropriately, thus avoiding cancellations on the day for these patients . A weekly analysis of cancellations at the Theatre Look back meeting continues with representation from Clinicians, Theatres and Clinical Service Managers. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance . Work continues to strengthen the POAC process and a business case is being presented at DMB in May 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre was successfully launched on April 8th 2019. This change has been a significant achievement by the team and has already received a great deal of positive feedback from both staff and patients . A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.
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 • POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues • at source and further enhance the 72 hour process. • Escalation to CSM where patients cannot be contacted prior to surgery

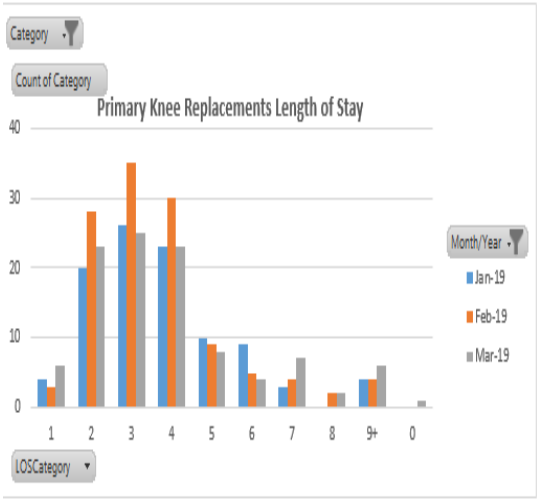
- Review of booking process by secretarial teams to develop a standard Operating procedure working closely with POAC and ADCU

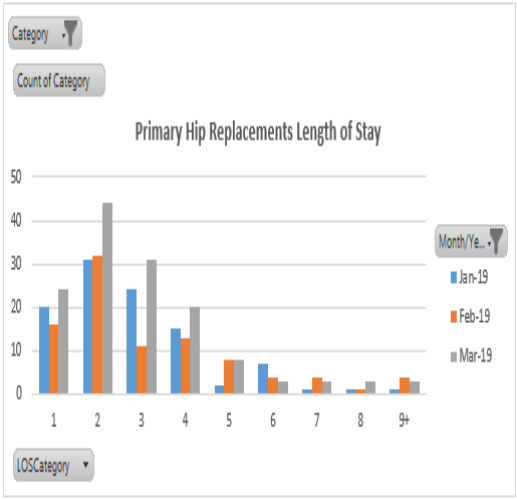
RISKS / ISSUES

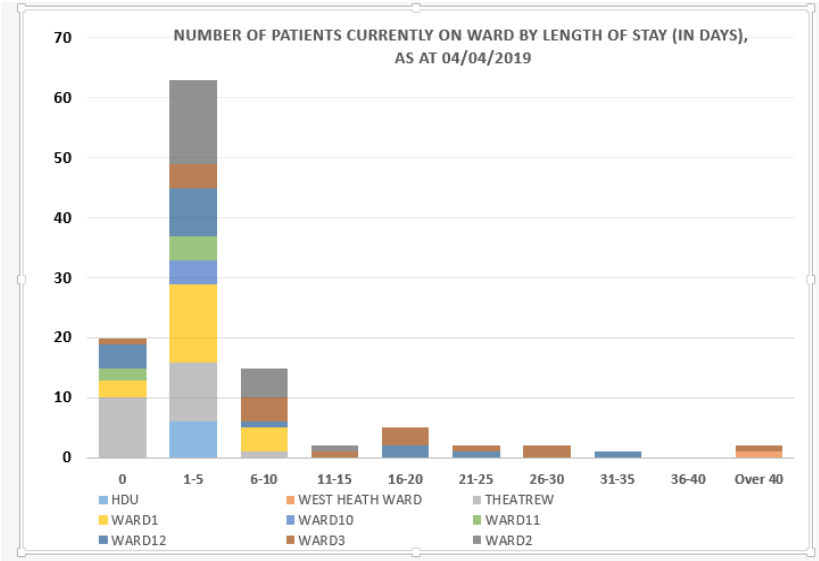
The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

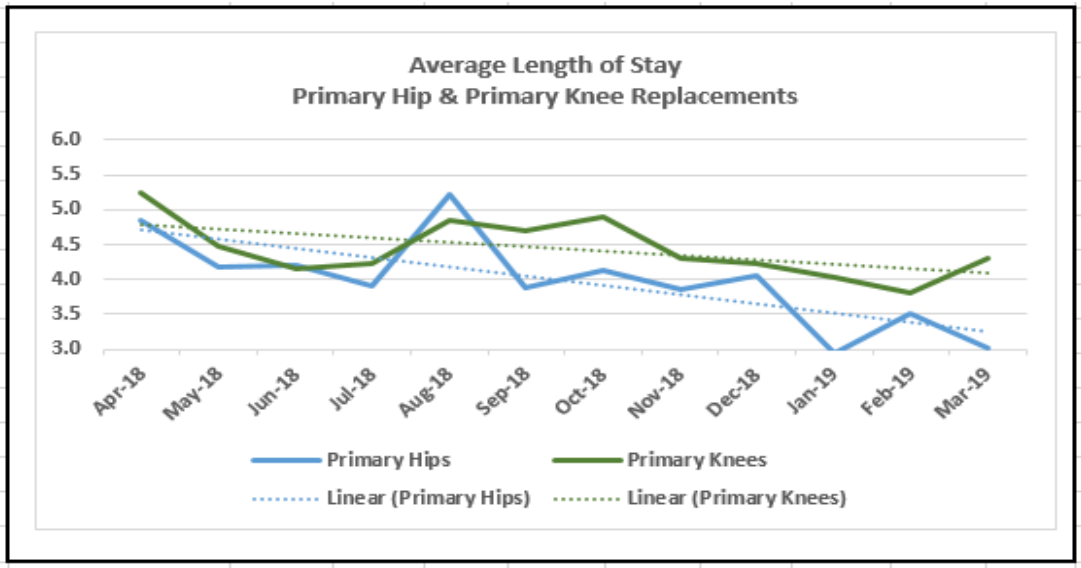
19. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in March was 4.6 days, this is an increase on February 2019 average which was 3.7days. The data gathered demonstrates that LOS for primary hips reduced in month whilst LOS for primary knees increased.

This increase is due to a small cohort of knee patients in month who had complex needs following their surgery resulting in an extended length of stay. In month Ward 3 had 2 primary knee replacements that went on to require intravenous antibiotics due to infection thus extending their length of stay. A further on Ward 3 and Ward 12 patient required complex discharge planning resulting in a delay.

It is therefore concluded that the mean average of 4.6 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives in place to continue to drive down length of stay including:

- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy.
- The discharge lounge is well utilised by all adult inpatient wards. With 267 being discharged in March , and discharges before midday rose to 36% . This is the key focus now for all areas in order to improve efficiency and patient experience.

ACTIONS FOR IMPROVEMENTS / LEARNING
• Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate. • To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Funding secured and recruitment in progress to support out of ours ward clerk support to ensure timely ADT .
RISKS / ISSUES
• A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity . • Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

Workforce Performance Report

February 2019

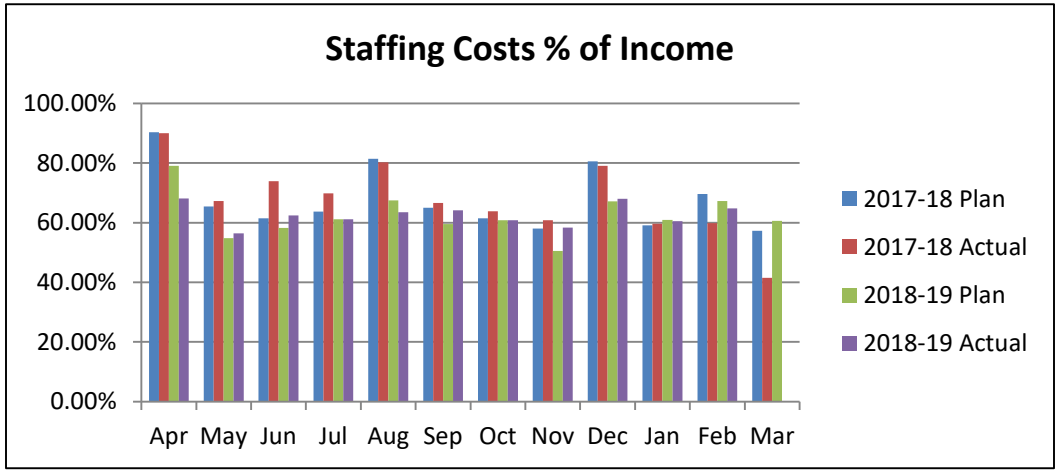
CONTENTS

Staffing costs

1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	76828	
Actual Income YTD	77845	101%
Planned Pay Costs (YTD)	47371	
Actual Pay Costs (YTD)	48547	102%
Planned Substantive Pay Costs (YTD)	39821	
Actual Substantive Pay Costs (YTD)	38013	95.5%
Planned Bank Pay Costs (YTD)	4108	
Actual Bank Pay Costs (YTD)	5649	137.5%
Planned Agency Pay Costs (YTD)	3169	
Actual Pay Costs (YTD) Agency Staff	4756	150%
Planned Agency Pay Costs as % of total Pay costs (YTD)		6.7%
Actual Agency Pay Costs as % of total Pay costs (YTD)		9.8%



Total ADH Payments (Apr - Feb)	£2,229,000

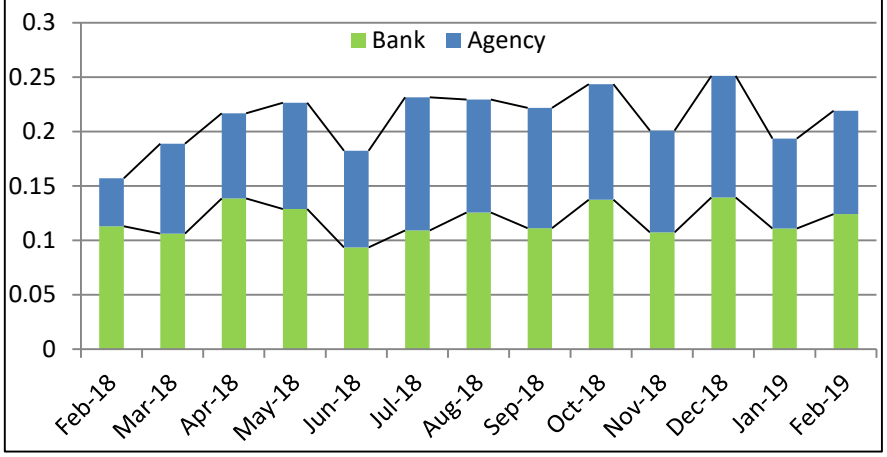
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	242	363
May	242	514
Jun	242	443
Jul	242	490
Aug	242	440
Sep	242	402
Oct	241	510
Nov	241	350
Dec	241	420
Jan	241	398
Feb	241	428

Data based upon February Management Accounts

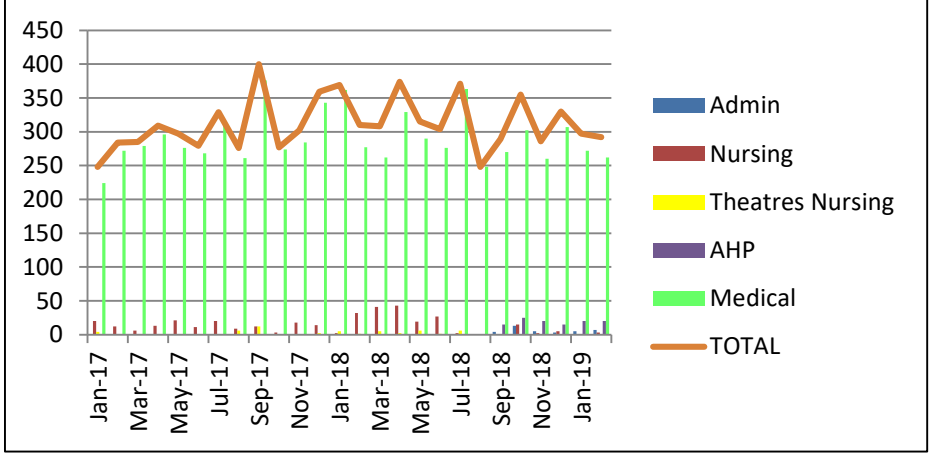
1 Workforce Composition and Cost

1a Temporary Staffing Analysis

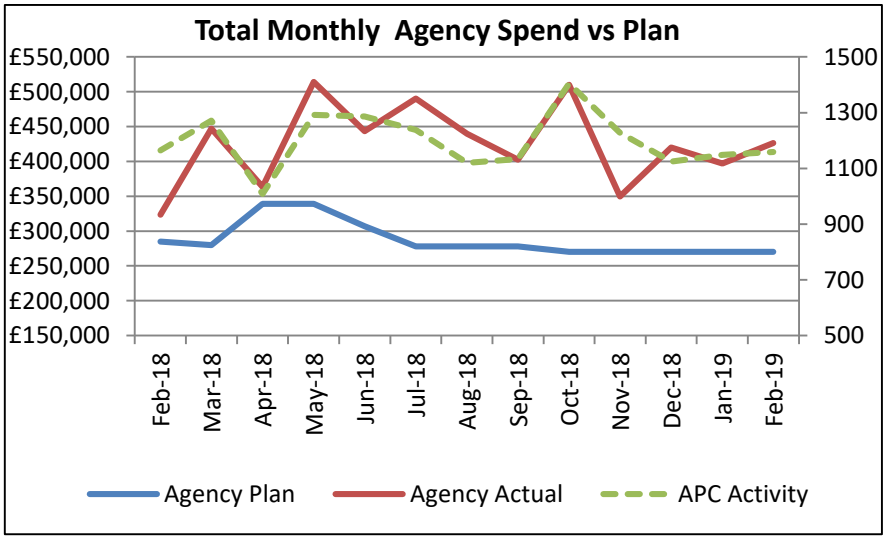
Temp Staff as % of Total Spend



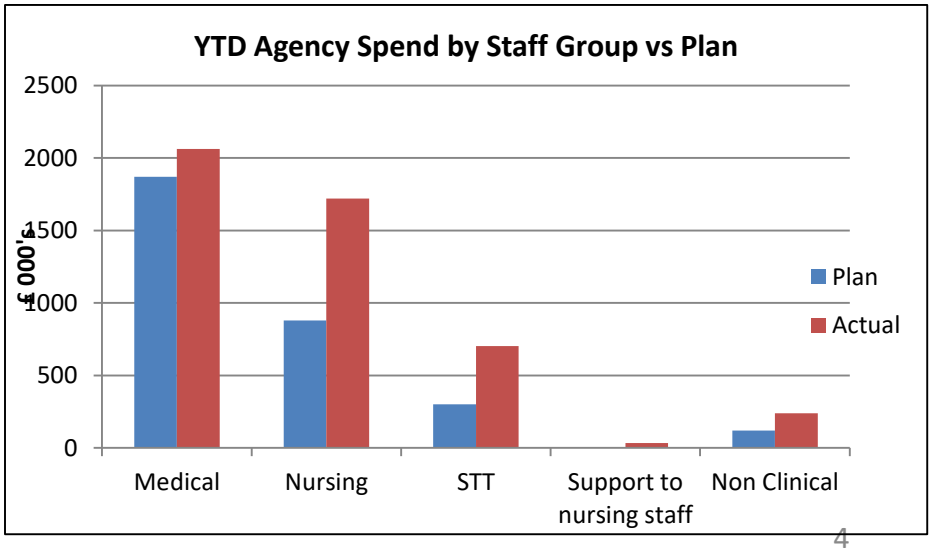
Agency Breaches



Total Monthly Agency Spend vs Plan

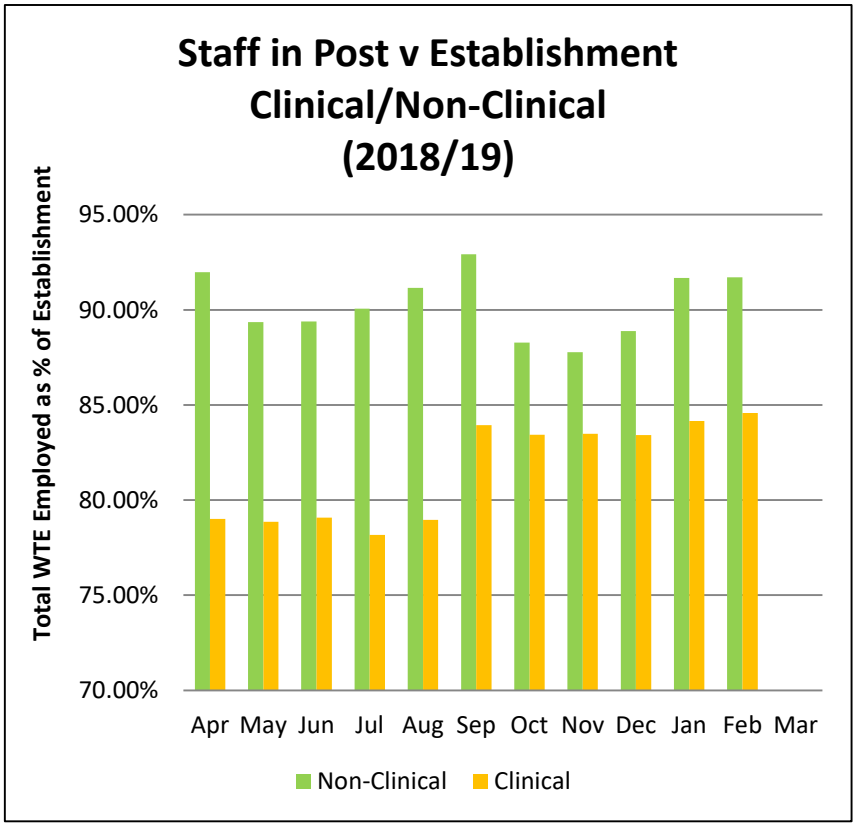


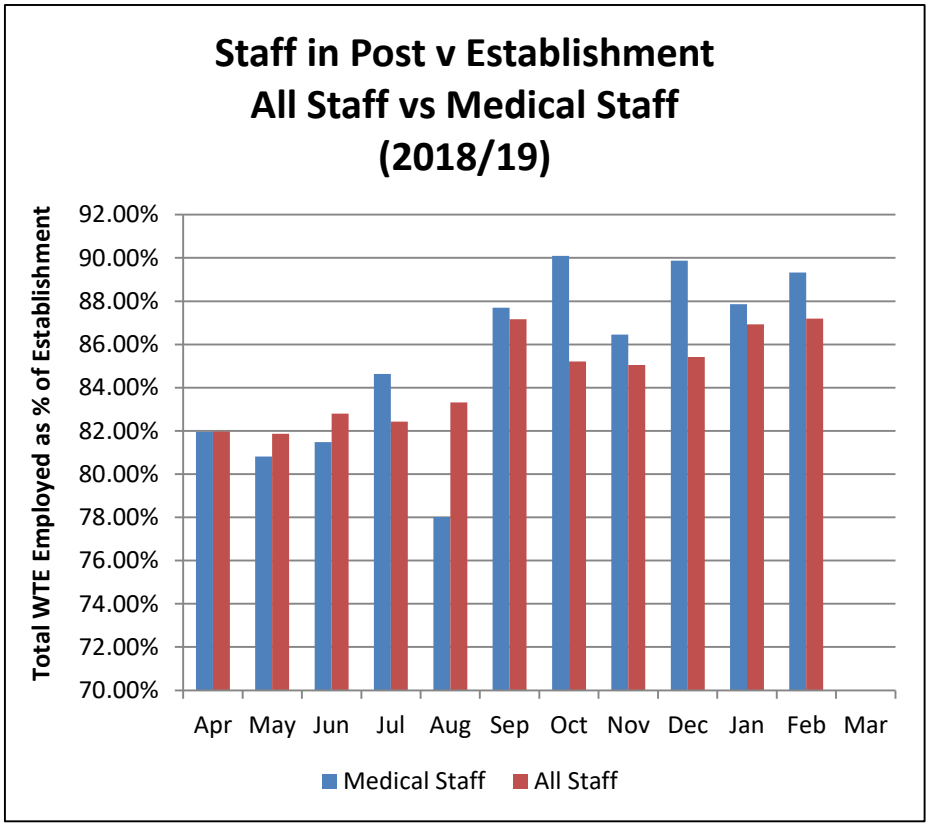
YTD Agency Spend by Staff Group vs Plan



1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

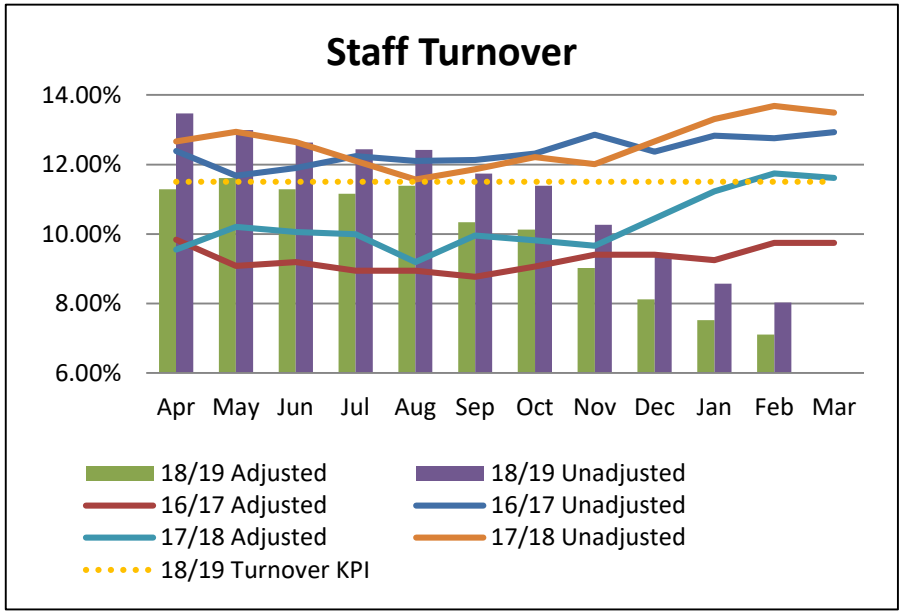
Establishment

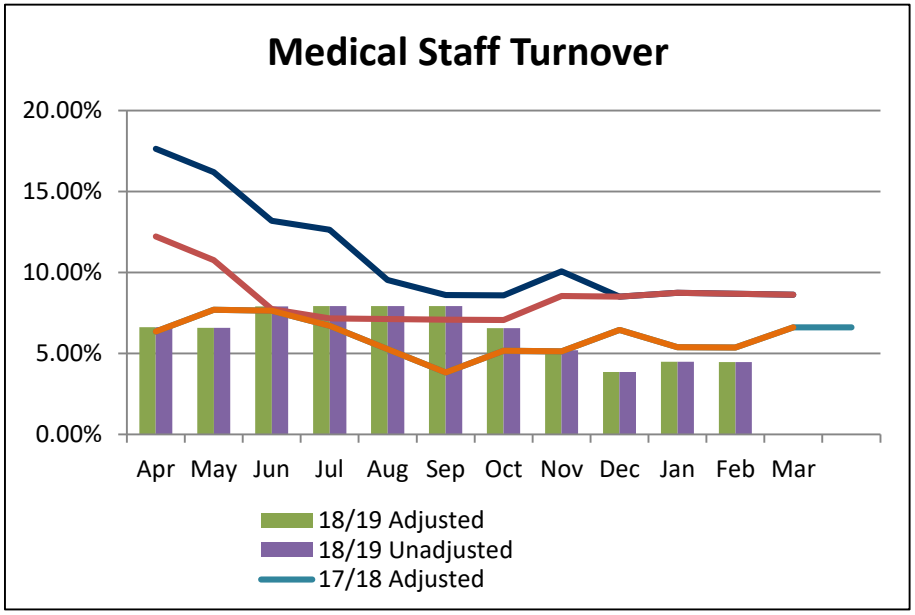




1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

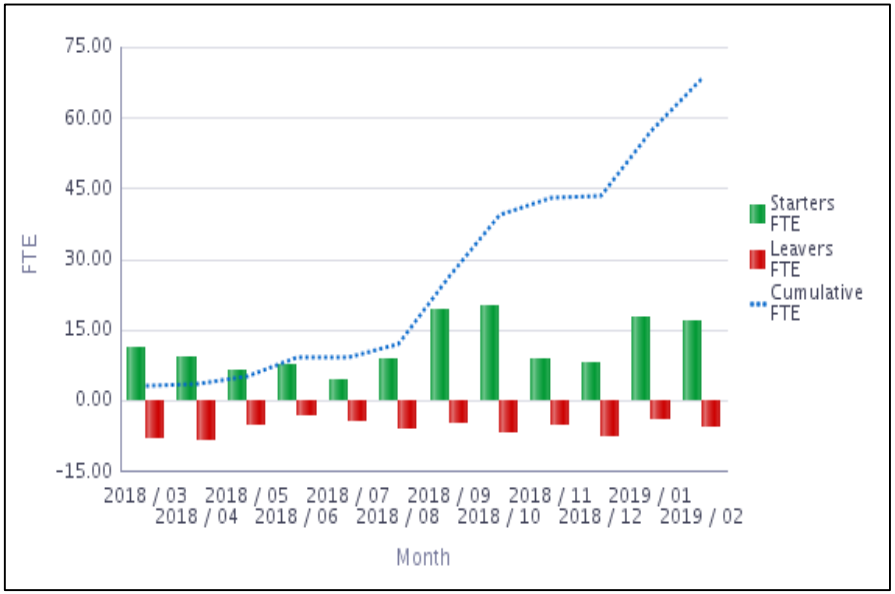
Turnover



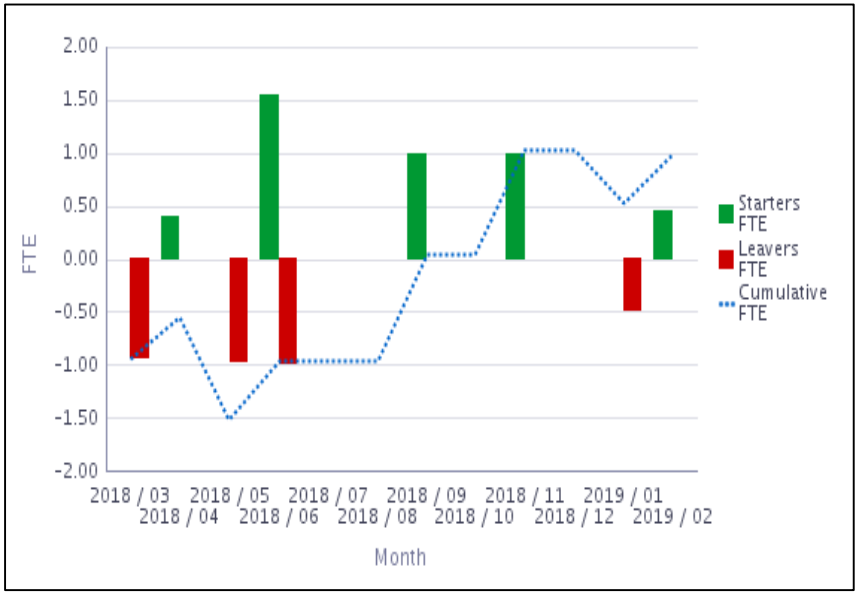


1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Starters / Leavers by Month - All Staff

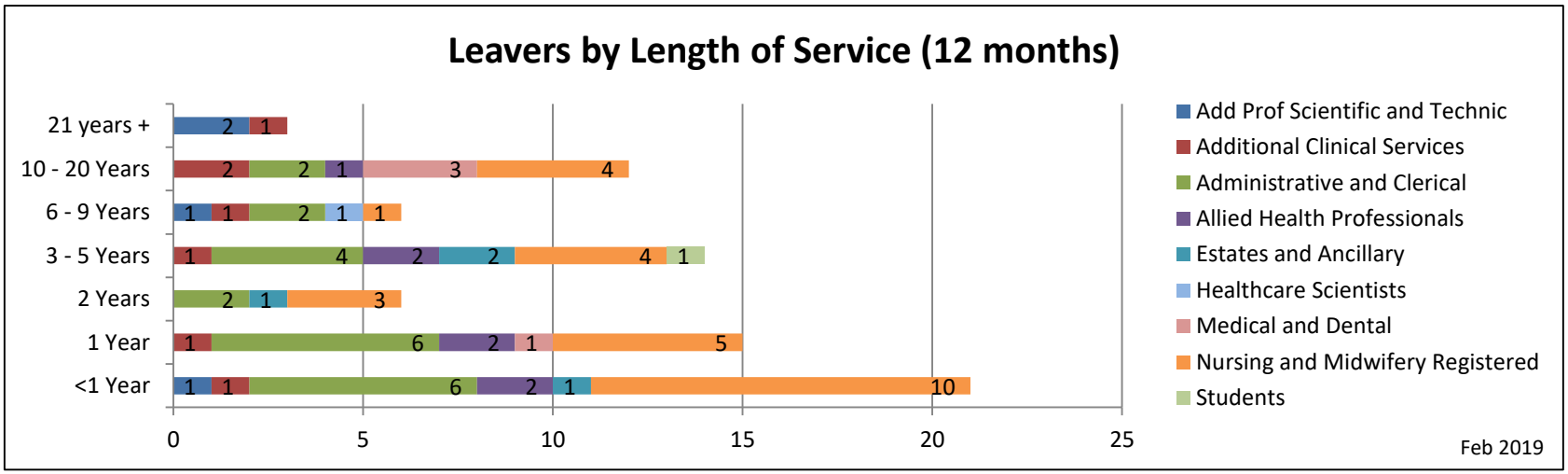


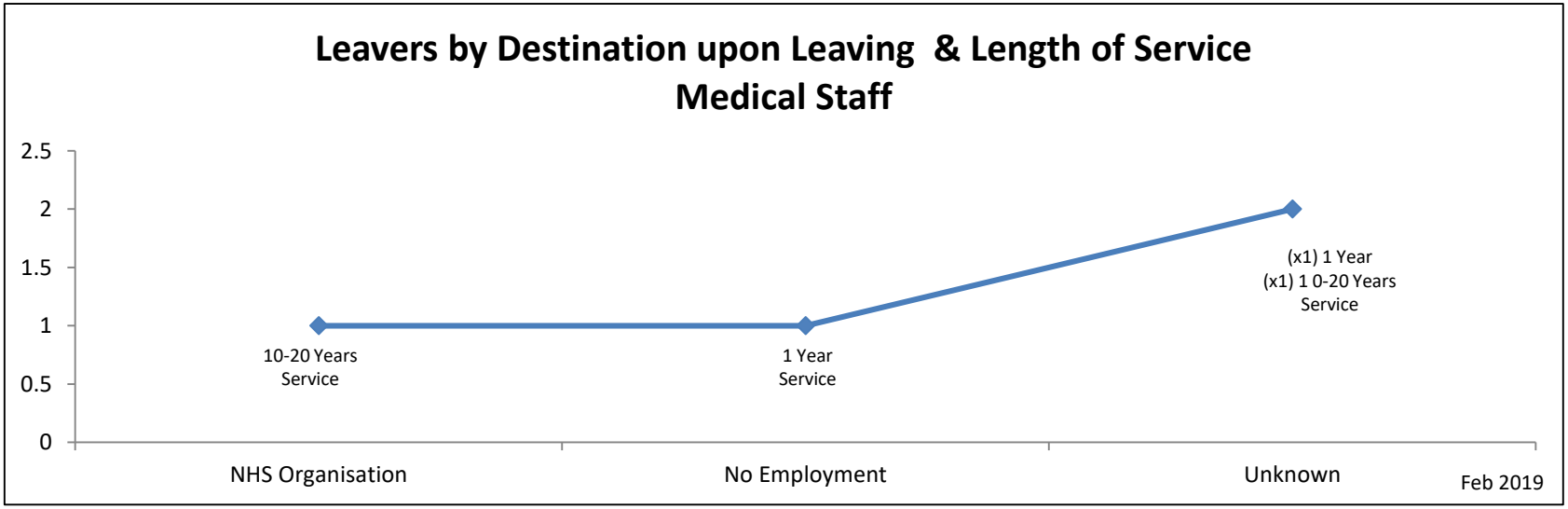
Starters / Leavers by Month – Medical Staff



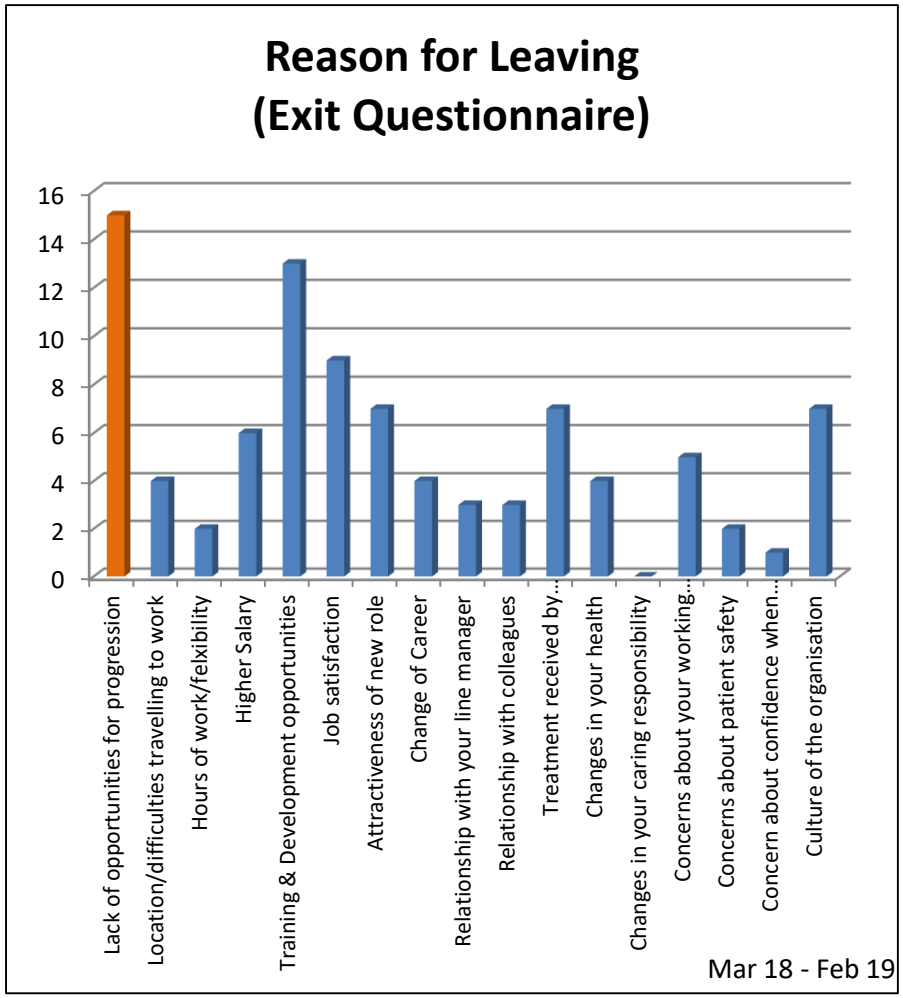
1 Workforce Composition , Resourcing and Cost

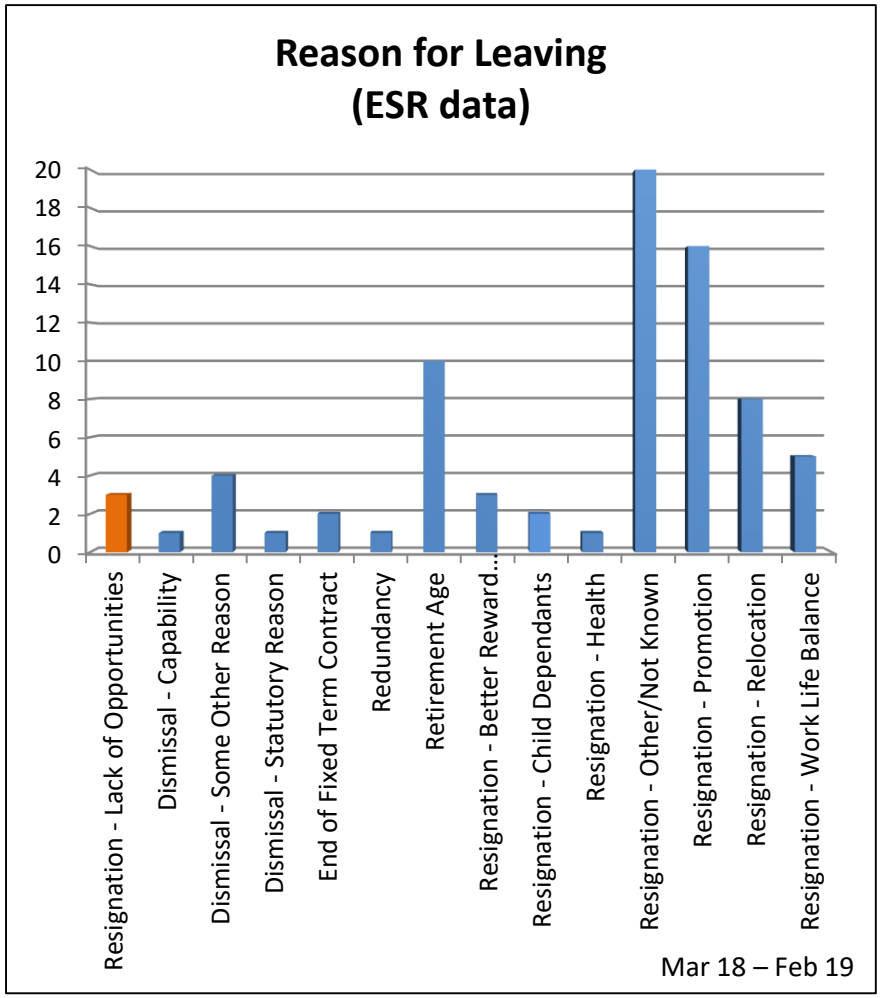
1c Staff Turnover





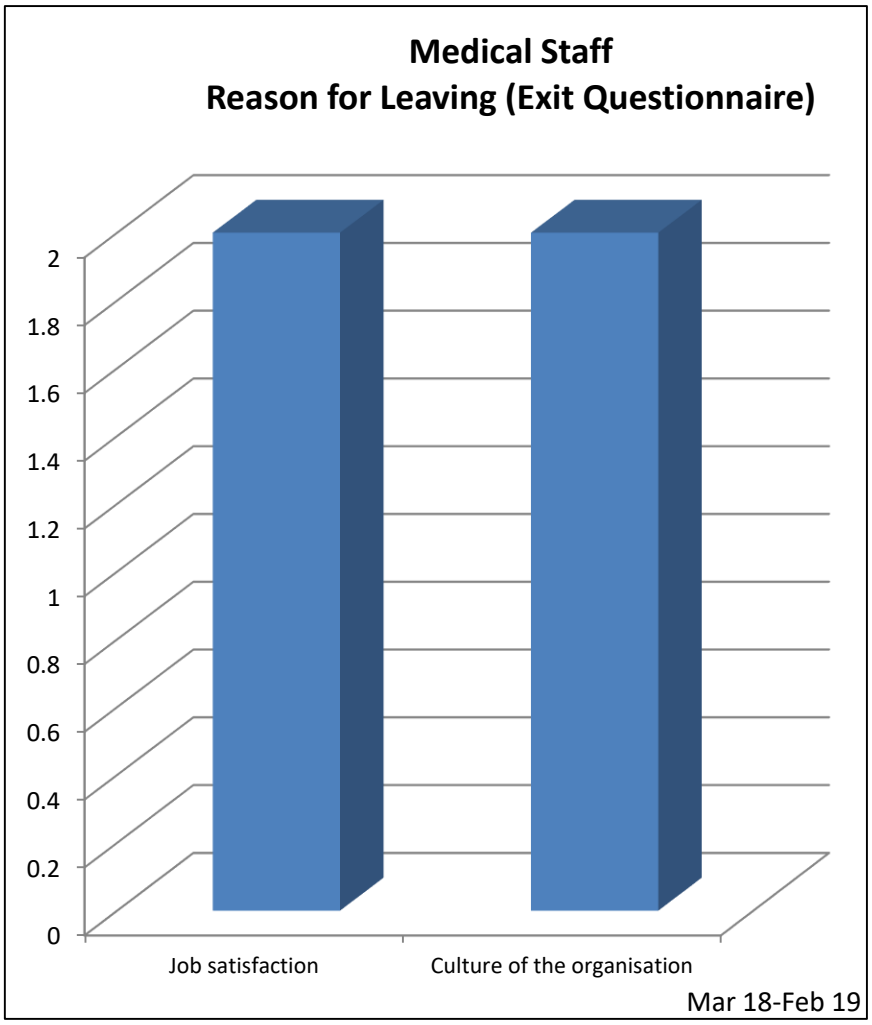
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

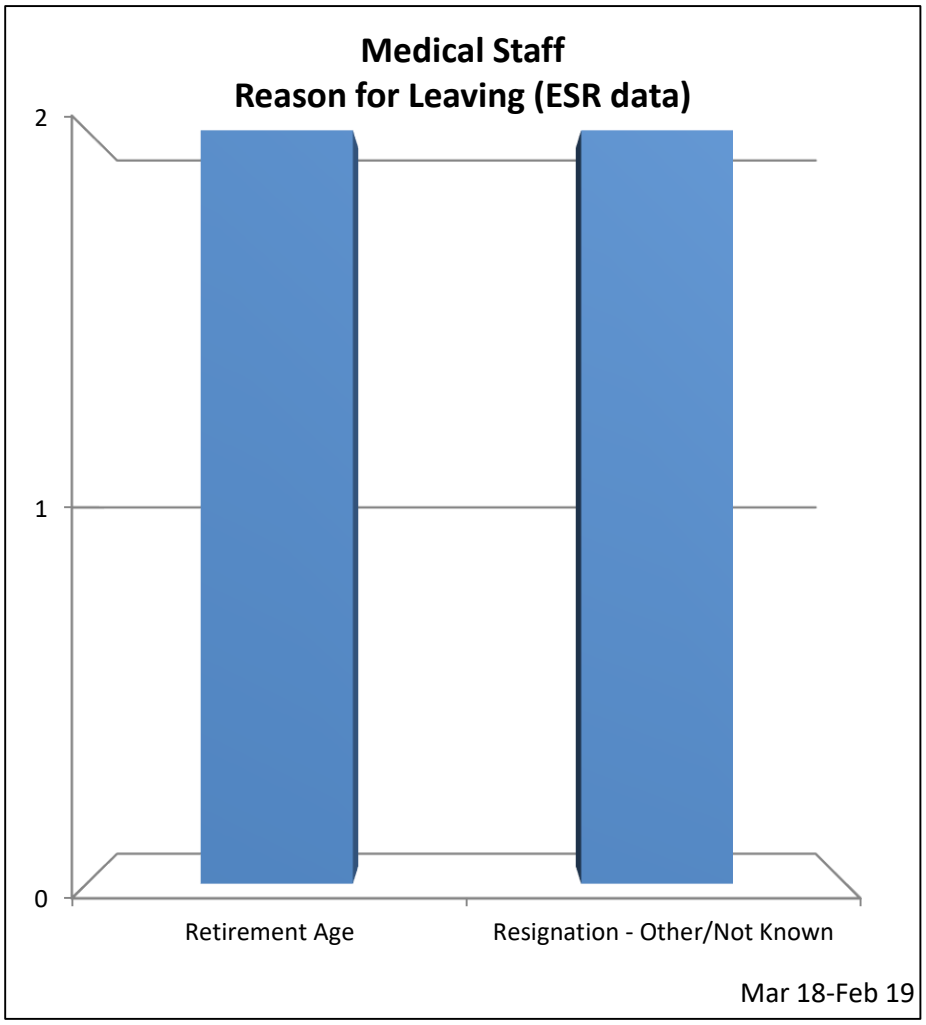




1 Workforce Composition , Resourcing and Cost

1d Exit Questionnaire Information

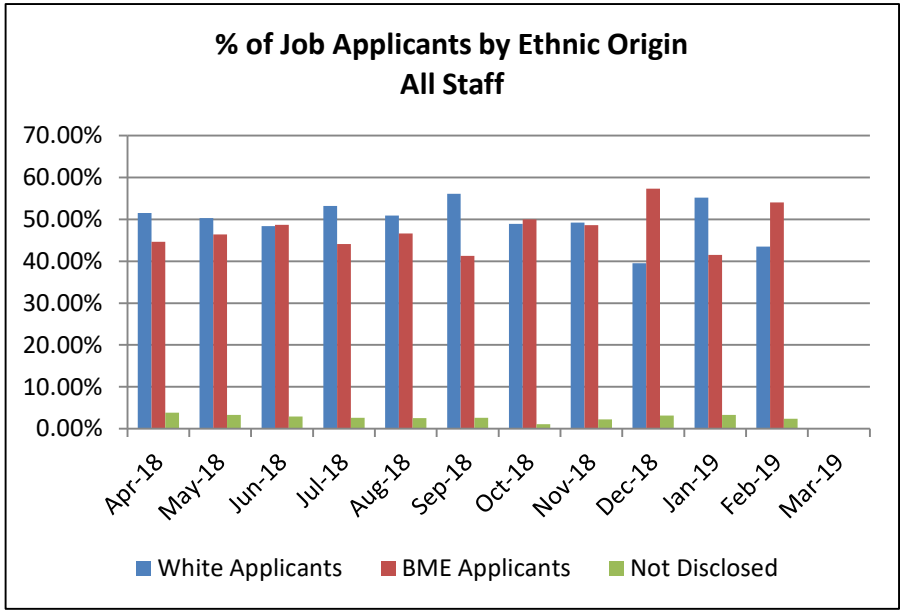


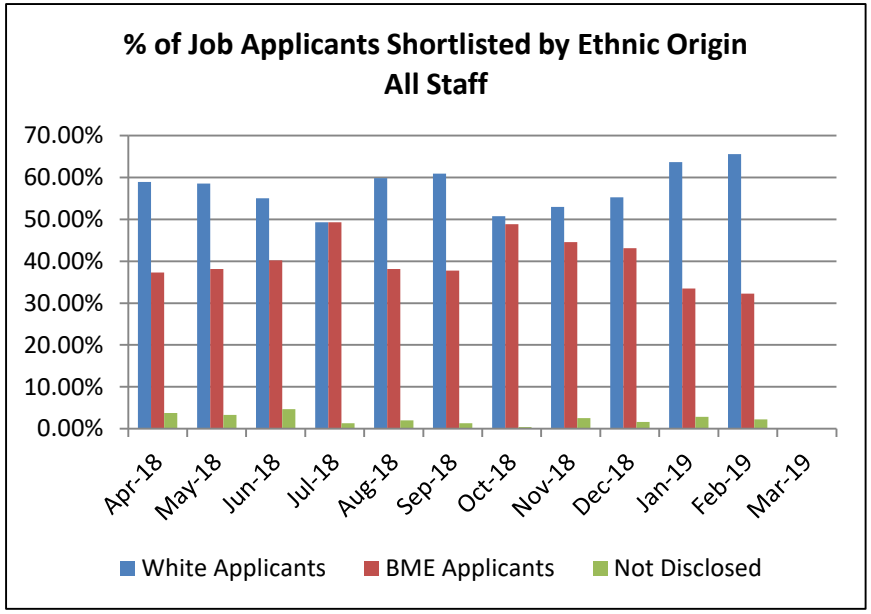


1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



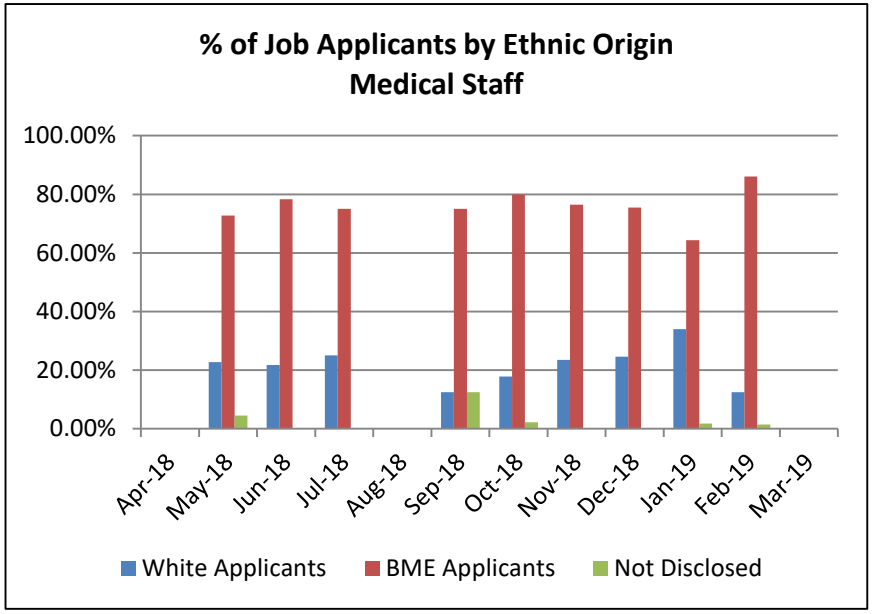


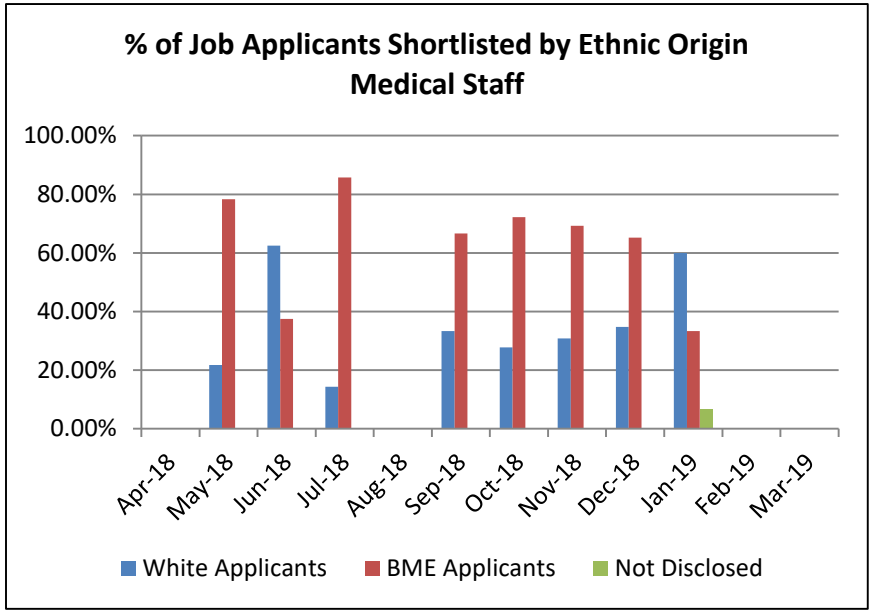
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.69	↓	+0.09	+ 0.05	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month
2.09

Workforce Composition, Resourcing and Cost

Staffing Costs – The actual spend on staffing was above that planned in February, with an underspend on substantive pay being exceeded for both bank and agency staff, the latter across all staff groups.

In part however, this is mitigated by an increase in income to the Trust. The Trust has clearly been using some agency staff to deliver additional activity and the average ADH payments to Consultants also increased since December 2018.

Turnover – the unadjusted turnover figure has now reduced for each of the last 13 months and is now reported as 8.03% for the 12 month period to February 2019. This is against the Trust target of 11.5%. The adjusted turnover position has improved (decreased) for each of the last 7 months and the February 2019 figure was 7.11%. Turnover has decreased for nursing staff (down to 11.47% in February versus 15.91% in March 2018, when data collection commenced) but more significantly for clerical, ancillary and unregistered support staff to drive this position.

NHSI visited the Trust in February as part of their national retention support programme and a plan has been submitted following that visit, for which feedback is awaited: although the informal view on the day of the visit was a recognition that the Trust is considering the right areas.

Workforce Composition, Resourcing and Cost

Recruitment and Selection - Time to hire and streamlining

Efforts continue to develop the ability to extract reports and develop KPIs from the Trust's Vacancy Approval System, which it is intended will offer insights into those parts of the system which experience delays. Activity has been extremely high in recruitment since the turn of the year, particularly in theatres and in resource intensive Consultant recruitment, in addition to the usual junior doctor changeover and corporate nursing recruitment. Whilst accurate tracker data is not currently available due to current recruitment volume, raw data suggests that 79% of staff are achieving the conditional to unconditional offer letter 6 week standard. The actual figure will be higher than this due to (for instance) student or overseas nurses whose clearances typically take longer, as they will be joining us later in the year.

There is an intention to revisit and critically examine the existing recruitment process for consultants to explore streamlining and additional areas of best practice.

WRES Indicator 2 monitoring

The rolling 12 month figure as at February's was a slightly improved position since December's report. The Trust reduced the likelihood of non-BAME staff being appointed (1.69 times less likely, as opposed to 1.73 in December), which is closer to the national benchmark of 1.6 times less likely. This is a move in the right direction, although not a cause for great satisfaction.

February was similar to December in that there were more BAME applicants who applied (57%) but of shortlists, only 32% of candidates were from BAME backgrounds. Deeper analysis of this element is being undertaken by the Head of OD and Inclusion as part of the Equality and Diversity plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

Feedback awaited from the NHSI Retention programme, Consultant recruitment process review, deeper dive into WRES data.

RISKS/ISSUES

Unplanned staffing expenditure remains an issue, as does potential over-reliance on temporary staffing. Potential excessive working by established nursing staff through additional Bank hours is also a risk (reference the increase I short term sickness absence later in the report).

Inadequacy of specific recruitment workforce data/ insufficiently developed systems continue to make creation of a suite of recruitment KPIs a challenge. Work continues to develop this.

2 Workforce Performance

2a Staff Attendance

Staff Attendance

Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
95.48%	95.50%	↓	0.62%	96.10%

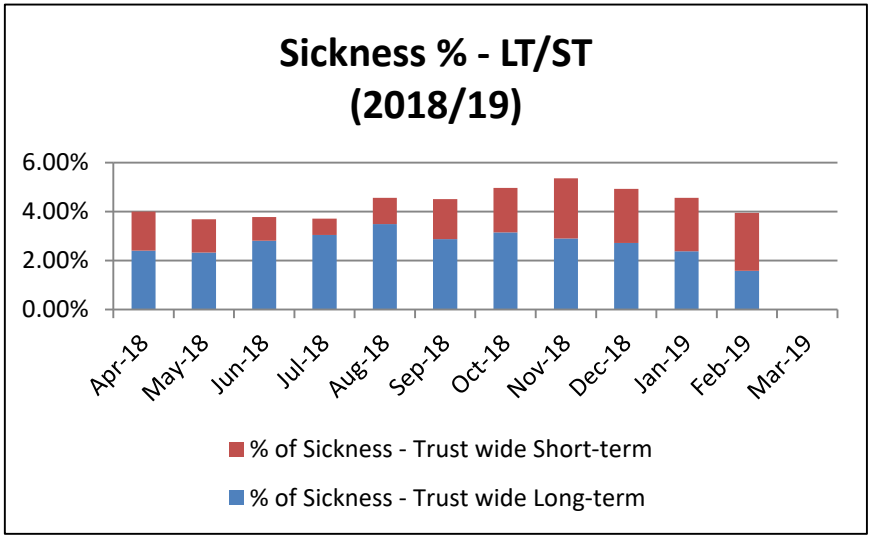
ALL STAFF

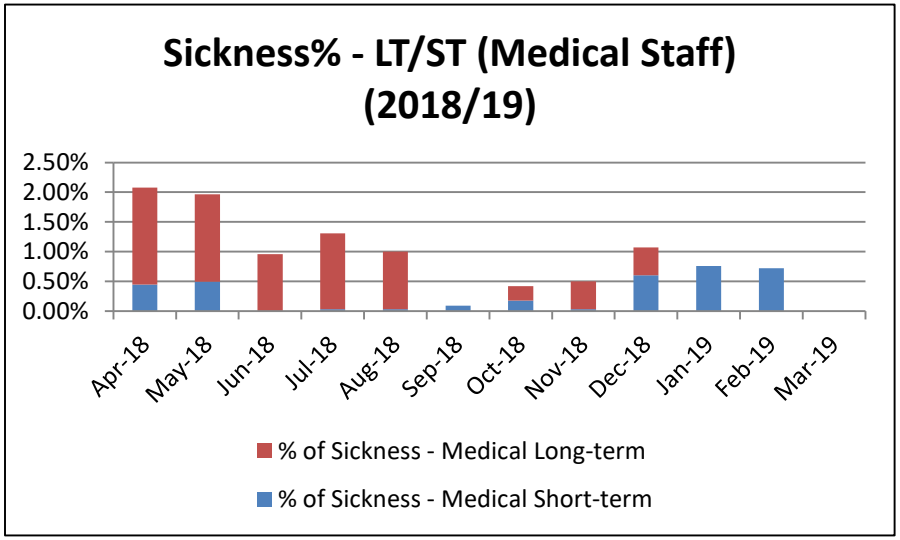
* 12 months to End of February 2019

Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
98.97%	98.78%	↑	-2.87%	96.10%

MEDICAL STAFF

* 12 months to End of February 2019

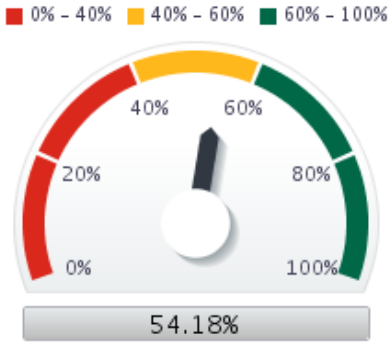




2 Workforce Performance

2b Staff attendance – short-term absence management

Staff Absence

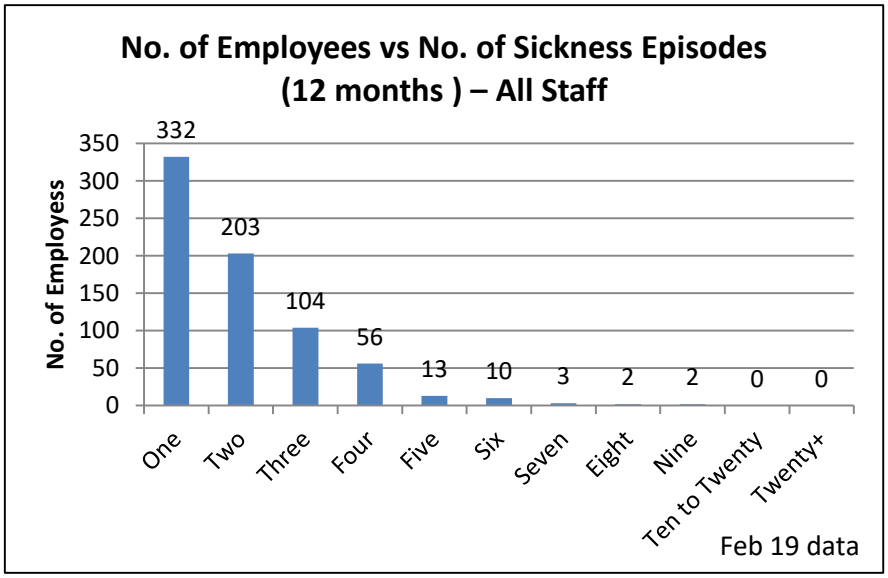


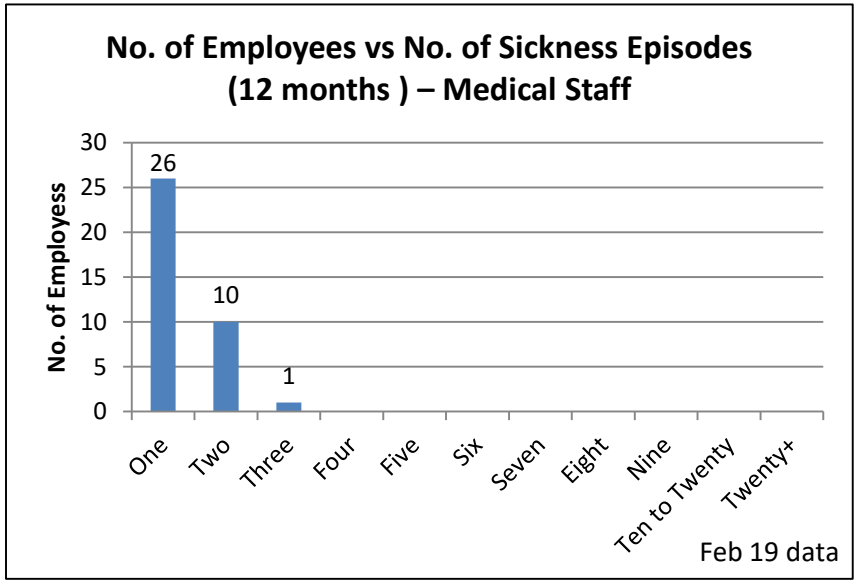
Return to Work Process Completion Rate (12 months) *Feb 19

ALL STAFF

Return to Work Process Completion Rate (12 months) *Feb 19

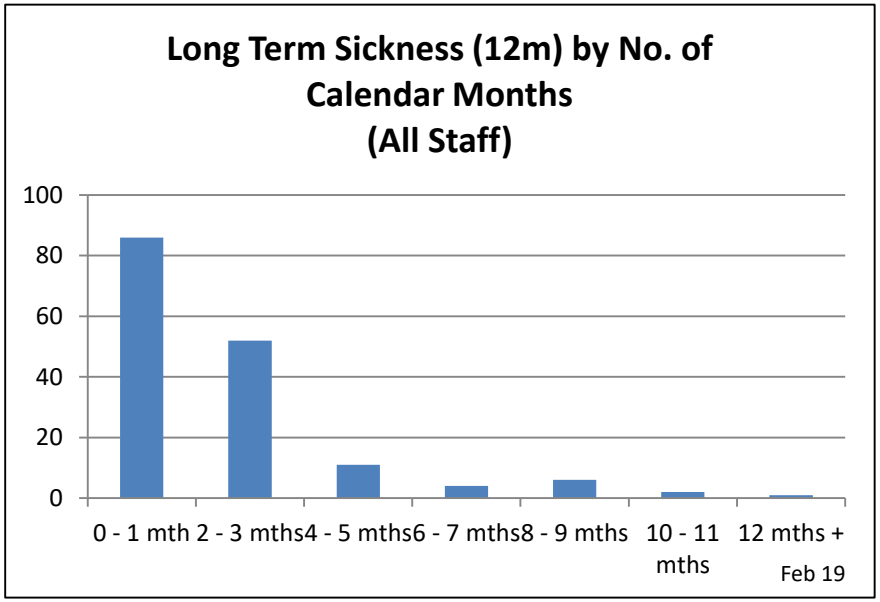
MEDICAL STAFF

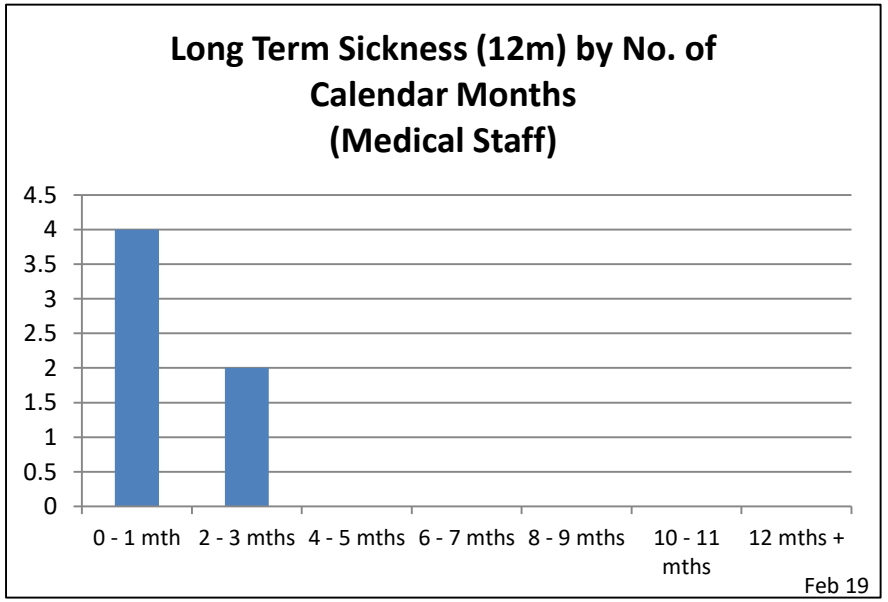




2	Workforce Performance
2c	Longer-term Staff Absence

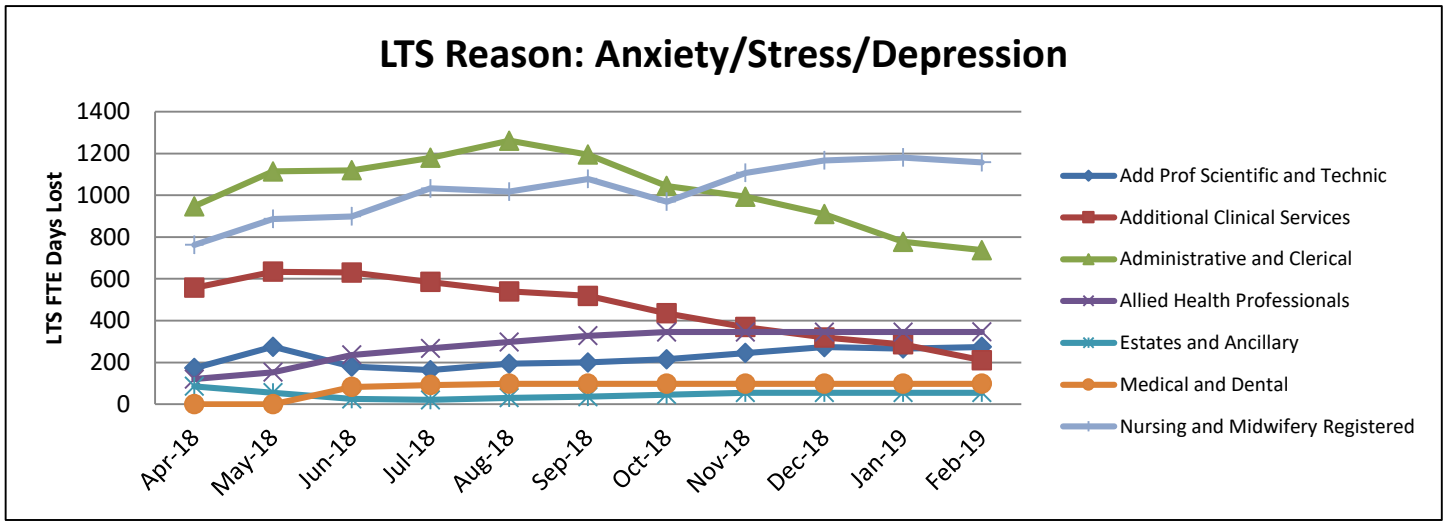
Long-term Staff Absence

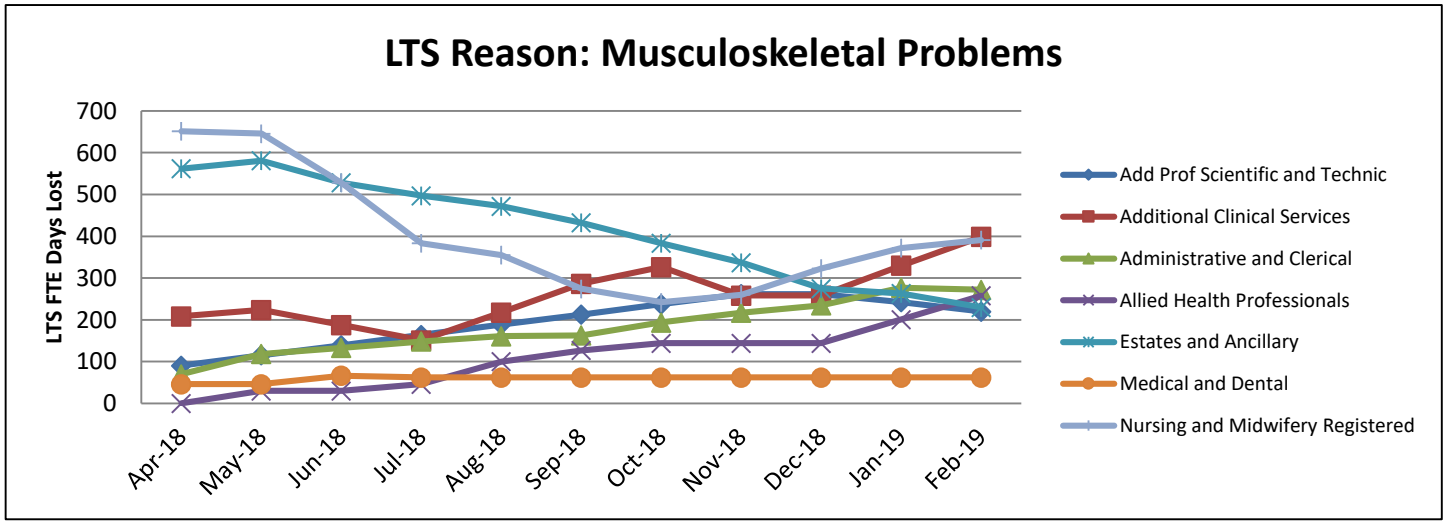




2 Workforce Performance

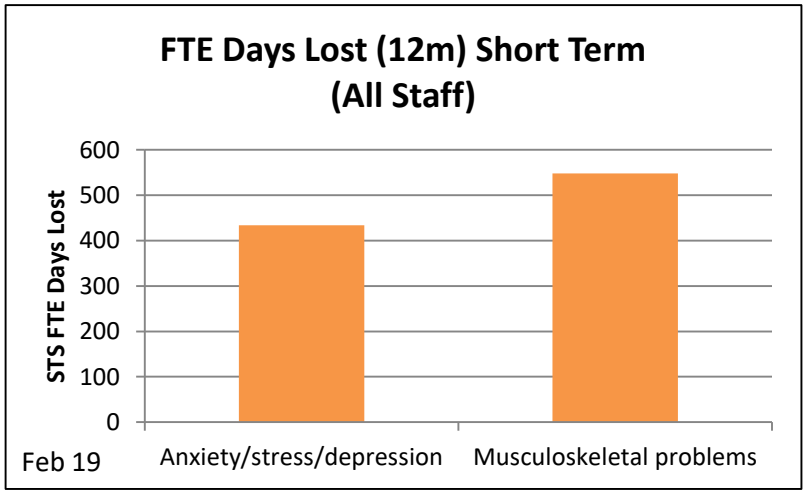
2c Longer-term Staff Absence

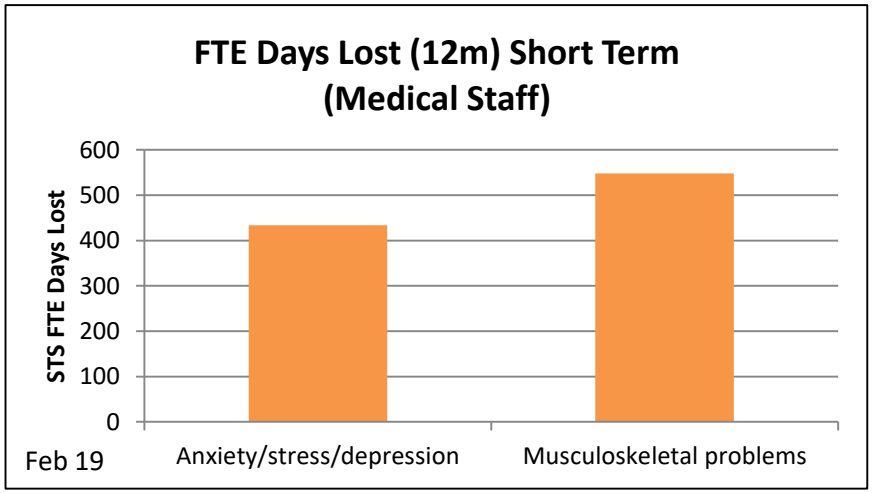


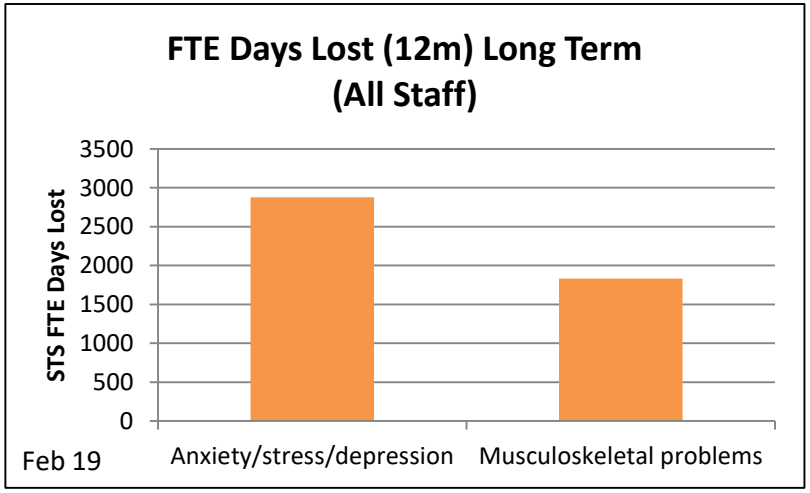


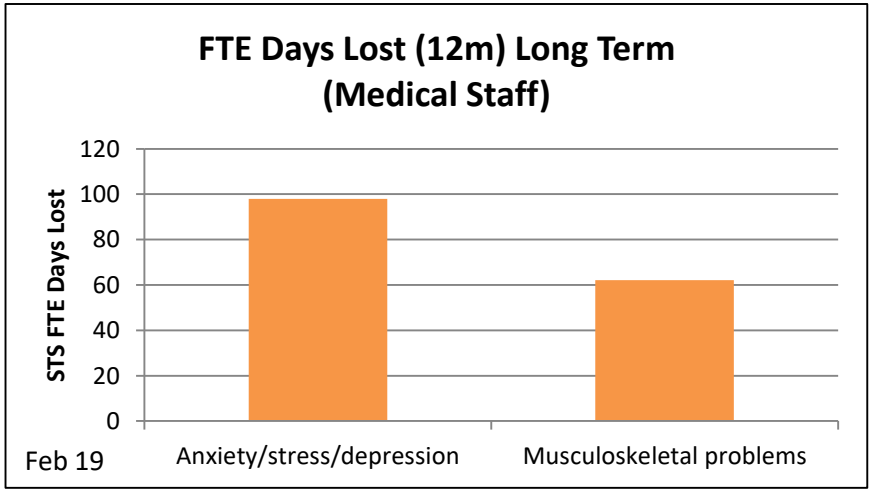
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary/ Capability

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	1	0	0	2	2	5

February 2019

INFORMATION

Staff Attendance

The Trust has not always experienced the seasonal variation in sickness absence which many Trusts experience in winter months, but it does appear to have been the case in the 2018/19 year. In February the Trust's monthly headline figure decreased for the 4th consecutive month.

The rolling twelve month attendance rate reduced slightly since December's report at 95.50% - but this is short of the Trust's our KPI target of 96.1% (3.9% absence). The encouraging news is that long term sickness absence has declined for each of the last 5 months, meaning that the in month figures are likely to reduce more quickly. Reduction in the 12 month figure is more likely to occur in Q2 and Q3 of 2019/20 if this continues.

Despite the improving picture, short term absence has remained high since November to a point where it exceeds the long term rate. This is rare (it has only happened once before in the last 6 years, for a 2 month period linked to the flu outbreak in Dec 2017/Jan 2018). It will remain an area of interest, with an ongoing focus maintained on return to work meetings. The encouraging news in this area is that there is a reported increase in these in the 12 month figure, up from 51% to 54% since the last report. The operational divisions offer assurance that the figure is higher than this but that electronic records are not always updated to reflect practice.

Formal Disciplinary and Capability

As at the end of February, there were 2 outstanding formal conduct cases in investigation stage.

ACTIONS FOR IMPROVEMENTS / LEARNING

Procure new OH and EAP provision in line with STP recommendations and following Executive Team consideration.
Succession planning and talent mapping processes to be developed and transacted in the medium term
Divisions to continue to conduct and report return to work meetings

RISKS/ISSUES

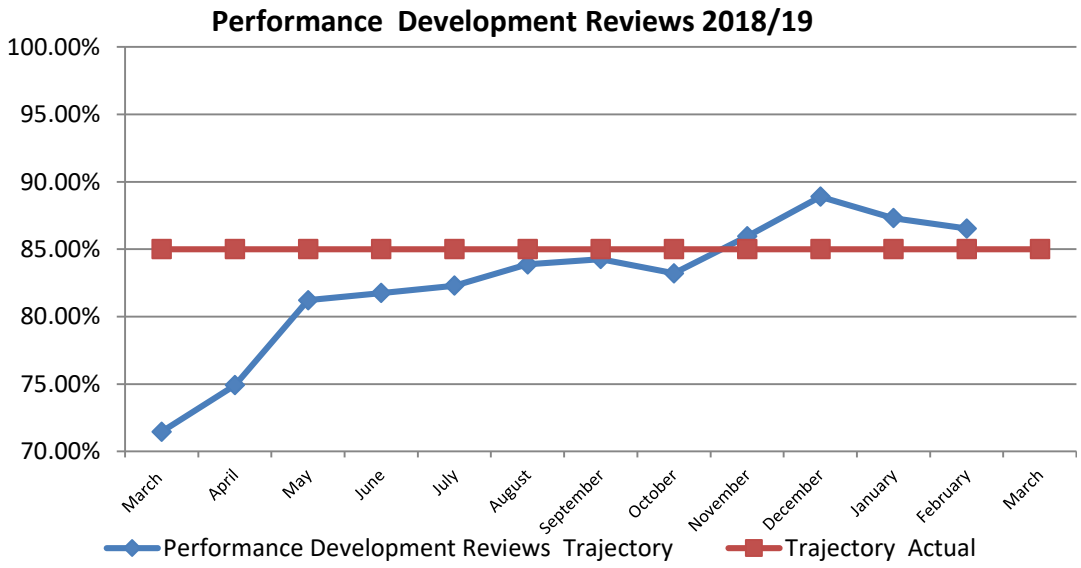
3 Workforce Learning and Development

3a Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NSS Staff Survey: Engagement Question 2018	2018	2017	2016	2015
20a	In the 12 months have you had an appraisal or annual review?	91%	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	63%	64%	74%	79%
20f	Were any training, learning or development needs identified?	66%	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date



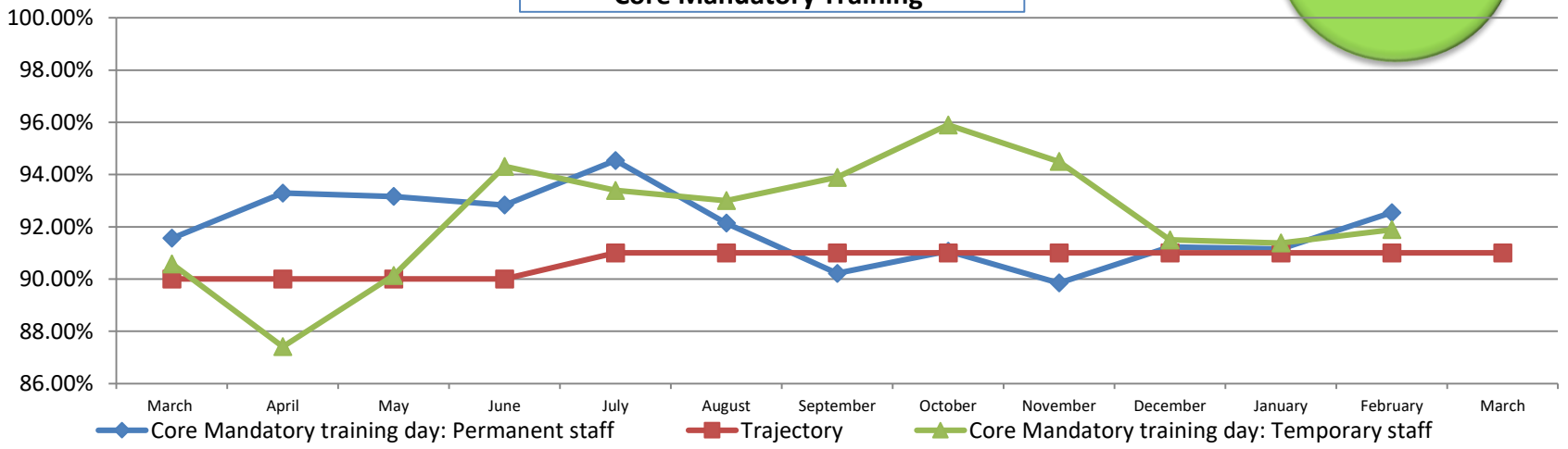
The most recent results from the National Staff Survey show positive feedback from staff on the quality of annual appraisals received. Work will continue to refresh management of performance at the Trust including training needs and talent management.

3 Workforce Learning and Development

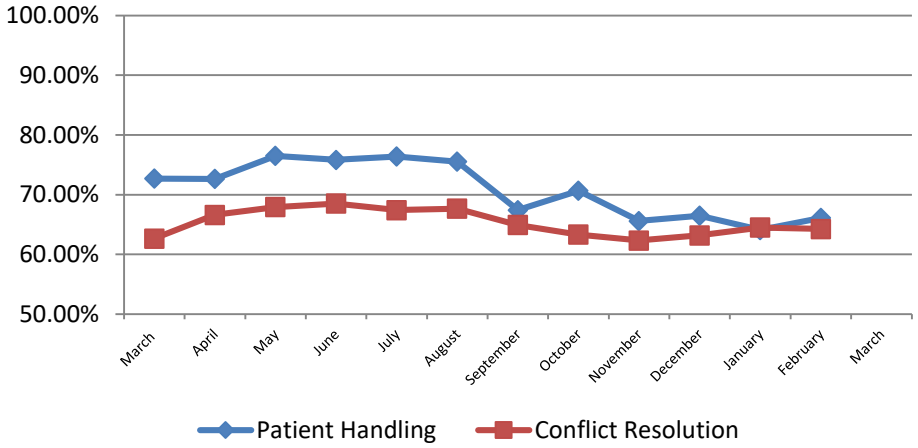
3b Core Mandatory Training, Specialist Training and Corporate Induction

Core Mandatory Training

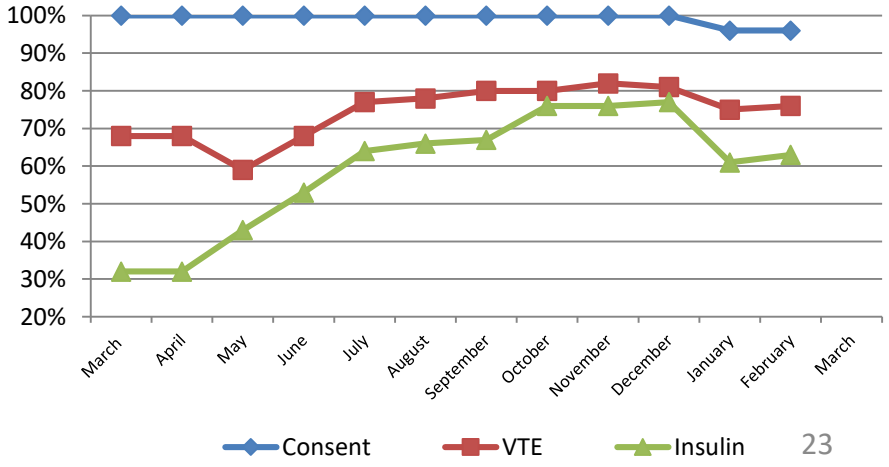
Core Mandatory Training



Patient Handling and Conflict Resolution Compliance



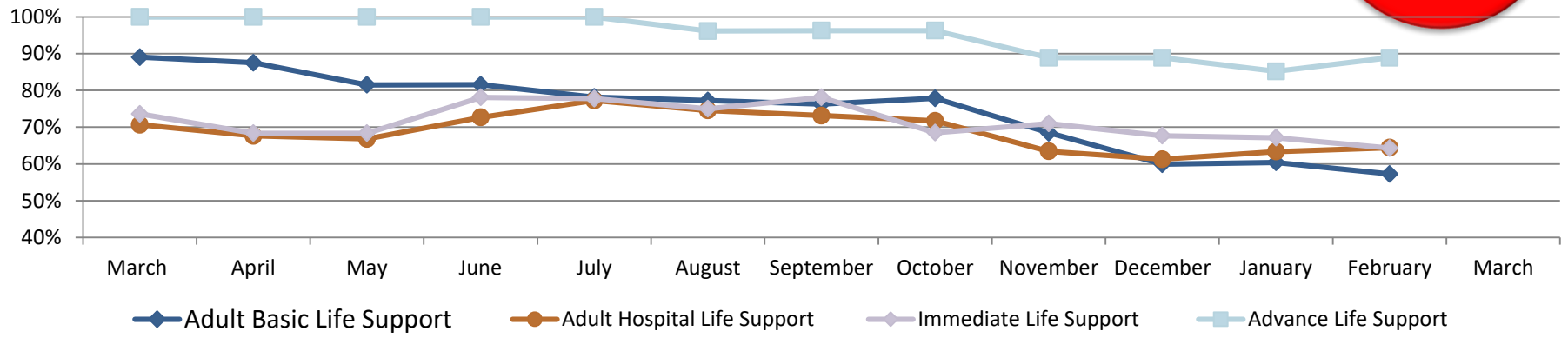
e-learning Modules Compliance



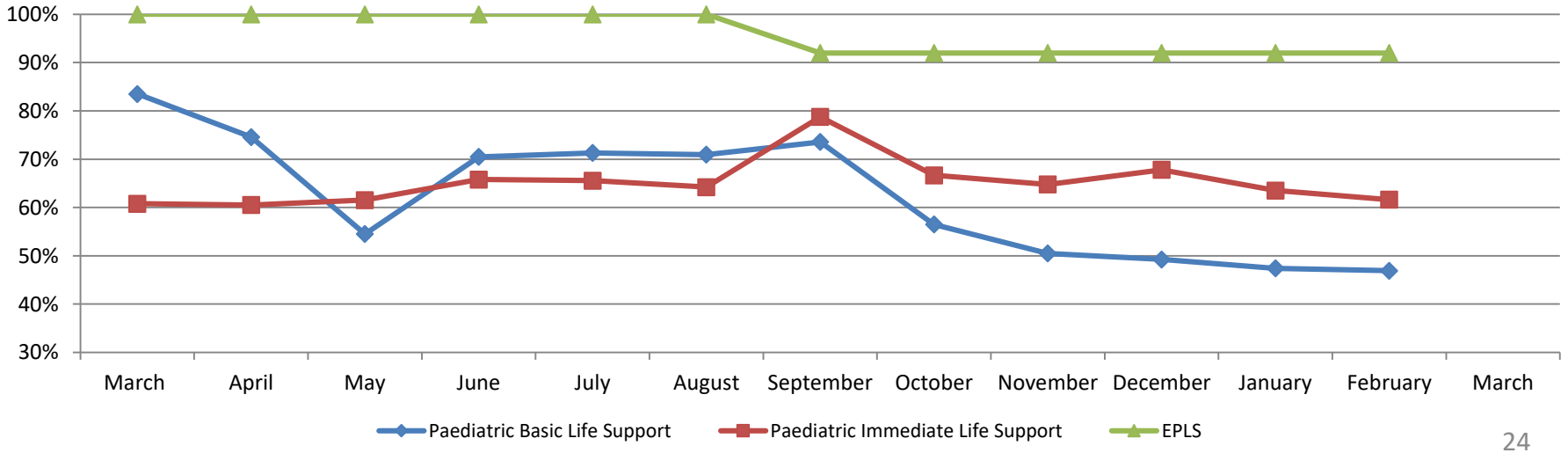
3	Workforce Learning and Development
3c	Resuscitation Training

Resuscitation Training

Adult Resuscitation Training



Paediatric Resuscitation Training



INFORMATION

Core Mandatory Training – Reported Core mandatory training attendance has achieved above compliance for 3 months. Work continues on improving the content and delivery of the face to face training, and developing a more easily accessible e-learning approach. 10% of core mandatory training is currently completed on line. 2019 will see an increase in this figure.
CMT for Bank / Temp staff has continued to maintain over 91% compliance for 10 months.

Role Specific Mandatory training –
The Trust Resus training compliance for Adults and Paediatrics has shown a steady decrease over the last 6 months. In October 2017, the Trust had a push on adult and paediatric resus training, and those that became compliant during those months are subsequently becoming non-compliant as their annual update requirement comes around.
Resuscitation standards and governance processes have recently been reviewed and updated recently, with the Director of Nursing committing to chair the Resus committee from November 2018. The Risk for resuscitation training compliance figures is monitored through the quality and safety group.
Conflict resolution and patient handling compliance continues to hover around the 65% compliance area. This has been raised with the clinical quality group, and a small focus group has been created to review attendance requirements.
VTE / Insulin –Improvements have been seen in staff completing insulin and VTE however the delegate group was reviewed in January with additional staff included, which has resulted in a drop in compliance figures. .
Following a review of the consent module compliance, additional names have been included which has reduced compliance by 4%, those individuals have been contacted directly.

ACTIONS FOR IMPROVEMENTS / LEARNING

Core mandatory training :– Mandatory training streamlining / CIP project continues. Positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information.
Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place.

VTE/Insulin online modules: E-learning facilitator working closely with Lead to increase compliance, creating learning paths in ESR. It has been agreed that medics do not need to complete the insulin modules as they do not administer.

Consideration will be given to the inclusion of role specific mandatory training in Agenda for Change performance management processes in 2019/20.

RISKS/ISSUES

Staff booking onto and completing their role specific mandatory training modules is low.
Resus levels still non compliant
In house trainers for resus and patient handling reducing availability to support training.
Attendance and DNAs on courses is still high. DNA charges will be introduced during 2019.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

OVERALL STAFF ENGAGEMENT

The most recent National staff survey results have seen a positive move on the overall staff engagement score from 3.83 to 3.97. The score is made up of the questions shown below:

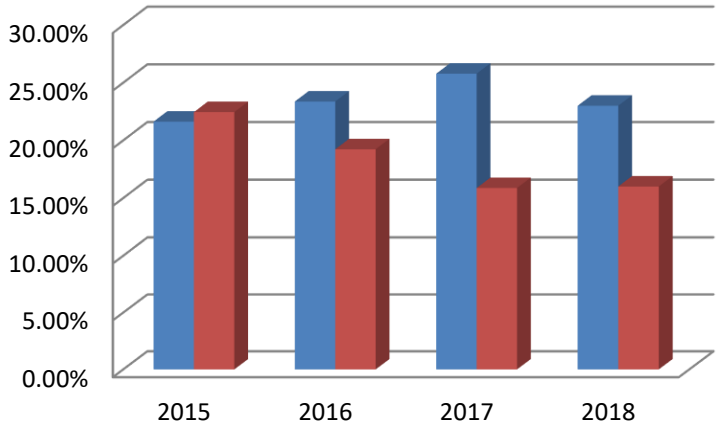
	Questions linked to ROH engagement score	2018 ROH	2018 Average	2017 ROH	2016 ROH
21a	Care of patients is my organisation's top priority	86%	86%	79%	69%
21b	My organisation acts on concerns raised by patients	83%	81%	79%	73%
21c	I would recommend my organisation as a place to work	73%	72%	62%	56%
21d	I would recommend the standard of care provided by this organisation	91%	89%	83%	77%

4 Workforce – Experience and Engagement

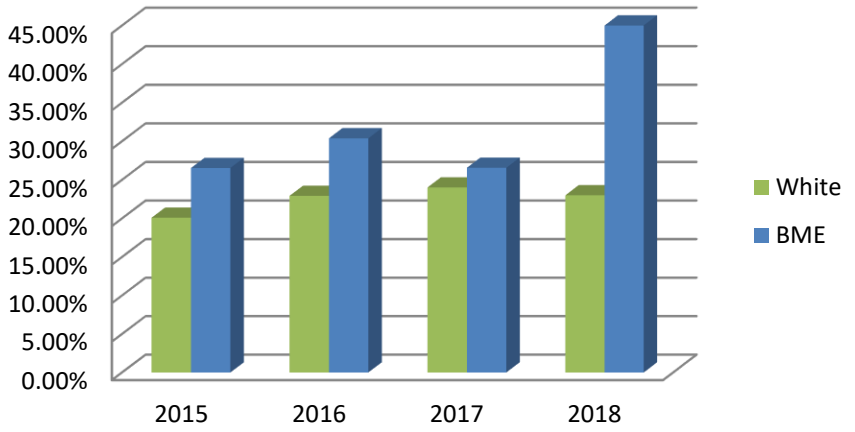
4c WRES Indicators

WRES Indicators

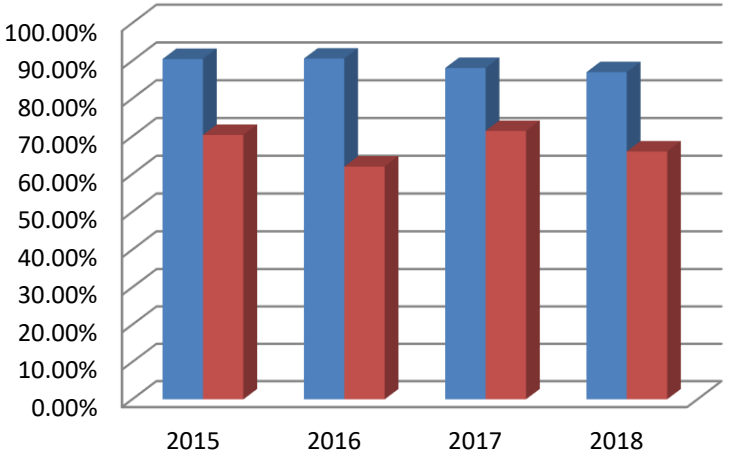
Indicator 5: Experiencing bullying from patients



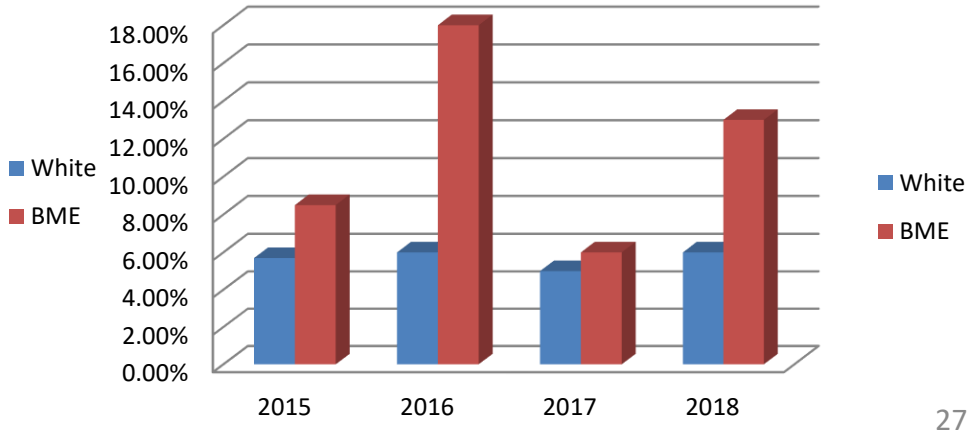
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION
Friends and Family Test (FFT) – The Trust is still awaiting the final information from Capita People Solution on the Staff FFT from Q4. This will be presented at the next SE&OD committee **Engagement and Job Satisfaction** – Speak Up and Join in brand becoming increasing established. Even better if… sessions being rolled out across teams. Information from the National Staff survey results is being communicated across the Trust and team will be asked in April 2019 to compile local actions based on the survey results **WRES Indicators –** Whilst the overall response rate to the 2017 was low, the proportion of BME staff completing the 2017 was comparable. WRES indicators informed by 2017 National Staff Survey show significant differentiation between white and BME staff. Whist some indicators may be evidence of greater confidence in reporting concerns, further action is required. The Trusts E&D annual report and grading of E&D outcomes under EDS2 will be informed by WRES indicators. Data for WRES 2018 will start to be collected in April 2019.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions to encourage survey completion to improve data reliability Ensure all staff are sighted on the positive staff survey results and are able to suggest local improvements
RISKS/ISSUES
Part of the WRES data is sourced from the NHS National Staff survey. Completion rate affects the reliability of the data as a representation of staff views

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 Planning permission approved for theatre expansion	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	4	20	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. A further medium term financial plan will be required for submission by NHSI during 2019/20.	Dec-19	3	4	12
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	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	FPC reports; Board approval for cash borrowing; Finance & Performance overview	3	4	12	↔	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	2	3	6
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. NHSI/E continued oversight of system response Regular briefings to CQC and oversight of actions being taken BWCH senior nursing staff supporting weekly oversight of staffing and associated quality levels	Minutes of stakeholder oversight meeting	4	4	16	↔	Joint work continuing to support transfer of services from July 19, at which point risk will be mitigated	Jul-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 trajectory to deliver 92% performance is monitored weekly at the Ptl meetings and reported monthly in line with national requirements . Current reported position for January is 84.86 % with only 10 patients (Excluding spinal deformity)over 40 weeks , however plans are in place to meet trust forecasted position for delivery of 92% in February 2019 for Arthroplasty , Spinal, Paediatrics , Foot and ankle , Hands and CSS . A revised trajectory has been developed for the delivery of 92% in all specialties. Additional capacity is planned for the YAH service commencing in February 2019 with a refreshed demand and capacity plan for spinal deformity incorporating the impact of any delay in transition of Paediatric inpatient services . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway.	Ongoing	3	4	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	5	3	15	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Water Safety Group minutes presented to IPC Group meeting.	2	3	6	↔	Water safety plan is in development.	Aug-19	1	5	5
WF2	WFOD	Paul Athey	Failure to identify future workforce models which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment		Highly motivated, skilled and inspiring colleagues	SE & OD Committee	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	3	4	12	↔	Workforce design to become an integral part of HR Business Partner discussions. Middle grade workforce group is meeting to develop model.	Jan-21	2	4	8

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	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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs	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	In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All patients monitored at weekly PTL - plans in place for all patients over 40 weeks Full RCA and harm review for all patients over 52 weeks presented monthly at harm review board. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.	Weekly updates to Exec Team; updates to Trust Board.	2	4	8	↓	March 2019 - As at the end of March the Trust has zero patient waiting over 52weeks	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. Junior Fellow posts have been re advertised with a revised 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 . The draft Job Description for the alternative medical workforce has been agreed . A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator commenced in December 2018 and is now focusing on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is now being monitored by the CSMS and reported to a monthly meeting to monitor spend, chaired by the deputy COO.	Ongoing	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	↔	Risk remains unchanged with Trust waiting for planning permission decision regarding theatre expansion.	Ongoing	1	5	5
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	2	3	6	↓	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 .All project are managed via Perfecting Pathway framework and all project current on trace. Feb 19 - Good progress has been made with all the projects and a monthly tracking system is in place and reporting through F&P Committee	Q4 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 support 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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 continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. 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 function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	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	↔	An information analyst has been recruited and is due to start at the trust early 2019 . The recruitment of the Business Intelligence Systems Manager had been delayed due to budget issues, but the post will now go to advert early 2019.	Q4 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 ratified -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 and experience an adverse impact on areas which are dependent on overseas staffing in the event of a "no-deal" Brexit, resulting in operations being cancelled and long lead times for securing overseas staff		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. Internal analysis of workforce risk suggests that there is likely to be little disruption to staffing level in the event of a 'no deal' Brexit		3	4	12	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	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. Full transition plan now in place with BWCH	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Clinical review of proposed Oncology strategy is still outstanding. If the outcome of this is positive, this will support the alignment of the strategy across all providers	Jul-19	2	3	6
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	Risk remains unchanged. CYPHDU is staffed 24/7 with a minimum of 1 RNC and 1 RN with HDU paediatric competencies. Weekly meeting held with the Senior Sister and Matron, HON and chaired by the executive Director of Nursing & Clinical Governance. This meeting review staffing across CYP HDU, adult HDU and ward 11. Staffing and vacancy position discussed at HDU Management Meeting and included in the Divisional Condition Report to Division 2 DMB and CQG. Block booked agency staff to support service provision.	Q&S Report	3	4	12	↔	Ongoing recruitment programme. Bespoke adverts for HDU to try new approach to recruitment to attract candidates. Open days also being planned for early 2019.	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. Further support and oversight provided by BWCH and a further weekly meeting instigated from February 2019. Operationally the service has been reviewed and bed capacity reduced to 12 beds to support staffing requirements – Operational SOP being drafted to support measures put in place. Rostering reviewed and CYPHDU/Ward 11 amalgamated to provide further oversight and support both areas. Scheduling tool developed to provide better oversight of activity booked for both areas.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	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 Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	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	↔	Continued oversight by NHSI/E & CQC	Jul-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 has received transitional funding during 2018/19 to support the additional costs of paediatric provision.	Q4 2018/19	1	4	4
MD1	Clinical	Matthew Revell	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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
5799	Strat	Phil Begg	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	Work is underway to develop the strategy for 2019/20 to 2023/24 and beyond. A workshop was held for the Board on 6 February 2019 at which the Board was presented with the proposed routes for enagement with the stratgey for staff, stakeholders and the public.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case; slides from strategy session for the Board on 6/3/19	2	3	6	↔	A strategy working group will be established to specifically focus on: - How we engage with all teams in the development of the new strategy - How we share key headlines from this year's annual plans - What we think the key elements of the strategy need to be - How we align all Trust plans/strategies to this document	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	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. Implementation of HealthAssure system will provide additional technological functionality to strengthen core governance systems.	Q1 2019/20	1	3	3
1298	**Finance & Performance**	**Steve Washbourne**	**There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:**		**Safe, efficient processes that are patient-centred**	**Finance & Performance Committee**	**4**	**4**	**16**	**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. 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.**	**IM&T programme board papers**	**4**	**4**	**16**	↔	**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. 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**	**2**	**4**	**8**

FP4	Finance & Performance	Steve Washbourne	There is a risk that the full quantum of cost saving as outlined in the 2018/19 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Whilst full delivery of the CIP schemes will not happen, this has been taken into account within the financial planning for the remainder of the year.	Finance and Performance overview; CIP programme board papers	4	4	16	↔	Much work has been undertaken in creating the CIP framework for 2019/20. The financial plan for 19/20 identifies a target of £1.4m, which is the level required as per the planning guidance. This is backed up by an internal plan which targets delivery of £2.3m with a further stretch target of circa £3m. The initial £1.4m is within the level of saving achieved during 2018/19, whilst further discussion are ongoing relating to how we potentially use incentive schemes to increase delivery up to the internal target of £2.3m and beyond.	Mar-19	3	4	12
FP5	Finance & Performance	Steve Washbourne	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.	Perfecting Pathways update; Finance & Performance overview	4	4	16	↔	Planning application due to be considered by Birmingham City Council in February 2019.	Oct-19	3	4	12
FP6	Finance & Performance	Steve Washbourne	There is a risk that the Financial Control Total will not be met in 2018/19		Safe and efficient processes that are patient-centred	Finance & Performance Committee	3	4	12	The 2018/19 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery. Clinical Audit day has been cancelled in February to allow more work to be undertaken. Revised activity plan distributed which identities performance levels required for recovery.	Finance and Performance overview	3	3	9	↔	Further focus in March to deliver increased activity.	Oct-19	3	3	9

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 5 June 2019

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 5 June 2019 commencing at **1100h** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust Headquarters.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 5 June 2019: 1100h – 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)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Interim Executive Director of Finance	(SW)
Mrs Marie Peplow	Acting Executive Chief Operating Officer	(MP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive (NHSI NExT scheme)	(SM)	
Miss Stacy Keegan	Deputy Director of Nursing & Clinical Governance	(SK)	[Items 13 & 14]
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Service improvement story – JointCare follow up	Presentation	
1120h	2	Apologies – Professor 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 1 May 2019: *for approval*	ROHTB (5/19) 010	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (5/19) 010 (a)	SGL
1135h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (6/19) 001 ROHTB (6/19) 001 (a)	YB/JW
	6.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	JW
	6.2	Hospital Management Group: terms of reference: *for approval*	ROHTB (6/19) 002 ROHTB (6/19) 002 (a)	JW
	6.3	Update from the Council of Governors meeting held on 22 May 2019	Verbal	YB

TIME	ITEM	TITLE	PAPER	LEAD
		QUALITY & PATIENT SAFETY		
1155h	7	Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (6/19) 003	KS
1205h	8	Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (6/19) 004 ROHTB (6/19) 004 (a)	JW
1215h	9	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (6/19) 005	GM
		FINANCE AND PERFORMANCE		
1225h	10	Update from the Finance & Performance Committee: *for assurance*	To be tabled	TP
1235h	11	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (6/19) 007	SW
		WORKFORCE		
1245h	12	Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (6/19) 008	SJ
1255h	13	Safe Nurse Staffing report: *for assurance & approval*	ROHTB (6/19) 009 ROHTB (6/19) 009 (a) ROHTB (6/19) 009 (b)	SK
1305h	14	Nurse revalidation: *for information*	ROHTB (6/19) 010 ROHTB (6/19) 010 (a)	SK
		CORPORATE GOVERNANCE, RISK AND COMPLIANCE		
1315h	15	Annual declarations: Corporate Governance Licence Condition and Governor training: *for assurance*	ROHTB (6/19) 011 ROHTB (6/19) 011 (a) ROHTB (6/19) 011 (b) ROHTB (6/19) 011 (c)	SGL
		MATTERS FOR INFORMATION		
1320h	16	Meeting effectiveness	Verbal	ALL
	17	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 3rd July 2019 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.

MEMBER	MEETING DATE										TOTAL
	3/4/2019	1/5/2019	5/6/2019	3/7/2019	4/9/2019	2/10/2019	6/11/2019	4/12/2019	5/2/2019	4/3/2019	
Yve Buckland (Ch)	✓	✓									/10
Tim Pile	✓	A									/10
Kathryn Sallah	✓	✓									/10
Rod Anthony	✓	✓									/10
Richard Phillips	✓	A									/10
David Gourevitch	✓	✓									/10
Simone Jordan	✓	✓									/10
Paul Athey #1	✓	✓									2/2
Jo Williams #2	✓	✓									/10
Matthew Revell	✓	✓									/10
Garry Marsh	A	✓									/10
Phil Begg	✓	✓									/10
Marie Peplow											/8
Stephen Washbourne	✓	✓									/10

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		
#1	Acting Chief Executive until 6 May 2019	#2	Chief Executive from 6 May 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 1 May 2019: 1115h – 1330h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Jo Williams	Interim Chief Operating Officer	(JW)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Marie Peplow	Deputy Chief Operating Officer	(MPe)	
Mr Matthew Payne	Clinical Service Manager	(MPa)	[Item 1]
Mr Amos Mallard	Head of Communications	(AM)	[Item 7]
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Service improvement story – Outpatients	**Presentation**
Matthew Payne, Clinical Services Manager, joined the Board to present an overview of the improvements in the Outpatients area. It was noted that there was some national influence on the Outpatients changes. Partial booking was discussed which it was reported, may reduce the number of times appointments were rescheduled and allowed short term cancellations to be managed. The DrDoctor system would be used to allow patients to interactively respond to appointments which would generate a cost reduction, in addition to a reduction in 'Did Not Attend' instances (DNAs) and improved patient	

communication. There was a plan to use Amplitude more effectively. An upgrade of InTouch was scheduled and clinicians could use to this to help manage patient flow. Other projects included an upgrade of the Patient Administration System (PAS), implementation of Winscribe voice recognition, delivery of Phase 2 and 3 of Prescribing Information and Communications System (PICS), use of virtual/video consultation, improved patient flow into radiology from Outpatients and Access Able. The process to achieve this improvement would be through the Quality, Service Improvement and Redesign (QSIR) framework. There was reported to have been an Outpatients away morning which allowed staff to raise issues that may have been otherwise difficult to raise as part of the day to day environment. Some benchmarking was planned and staff and patient feedback was being sought as part of this. Identifying measures of success were suggested to be critical; it was noted that this was important for being able to assess the journey. The work to think through what the service might look like and the use of a clinical champion would be used to generate this engagement. There was already good grip on the operational processes and there was confidence that the work planned ahead was ready to go. It was noted that the plans were aspirational but the resourcing of the work needed to be given attention. Mrs Sallah suggested that the work would resolve some of the complaints around the process and appointments. This needed to be communicated to the complaints department who would be able to publicise the plans and respond to any criticism appropriately. The overriding need for team work within the setting needed to be articulated and pride in the work needed to be shown and shared. It was noted that this had been part of the away day in terms of how this was communicated to patients. Some of the workforce transformation also needed to be part of this. It was noted that the away day had been effective and there was confidence in the Outpatient team. This was noted to be a significant improvement from when the CQC last inspected. It was noted that it was pleasing to see the quality improvement methodology being used. It was suggested that patients needed to be involved in the improvement where possible. It was suggested that year-long placements were sought by some local universities who may provide individuals to support the work. The use of volunteers also needed to be considered which was noted to be a big part of the Outpatient environment.	
2 Apologies	**Verbal**

Apologies were received from Richard Phillips and Tim Pile. Marie Peplow was welcomed to her first meeting as Acting Chief Operating Officer.	
3 Declarations of interest	**Verbal**
It was noted that the register was available on request from Company Secretary. Dame Yve reported that she had been asked to undertake an initial six month stint at Dudley Group of Hospitals NHS Foundation Trust as interim chair.	
4 Minutes of Public Board Meeting held on the 3 April 2019: *for approval*	**ROHTB (4/19) 014**
The minutes of the last meeting were accepted as a true and accurate record of discussions held.	
5 Trust Board action points: *for assurance*	**ROHTB (4/19) 014 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
6 Chairman's & Chief Executive's update: *for information and assurance*	**ROHTB (5/19) 001** **ROHTB (5/19) 001 (a)** **ROHTB (5/19) 001 (b)**
The Acting chief Executive asked the Board to note the legislative changes planned as a result of the NHS Long Term Plan. These were under consultation at present. The role of regulators in influencing structures was noted to be changing which impacted on some of the freedoms provided to foundation trusts. The implications on procurement processes were also highlighted which might impact on some of the Musculoskeletal (MSK) service plans. It was reported that the modular theatres contract had been signed and Steve Washbourne, Interim Director of Finance, was thanked for his work to achieve this. There was much work to do to complete the estates and operational work. Jo Williams was congratulated for her appointment as the new substantive Chief Executive. Thanks were given to Paul Athey for his time as Acting Chief Executive at a time of great challenge to the Trust. It was noted that the support of the Executive Team had helped to achieve this level of improvement. Paul was noted to have been very popular and his humility and honesty was appreciated. Paul had chosen to continue his financial career. Paul advised that he was proud of all the achievements and he commented that an excellent appointment had been made in Jo Williams.	

6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was reported that work continued with partners in the STP and some pilot work with GP partners in terms of triaging and MSK was underway. The bone infection work was progressing well and the work to standardise the joint replacement work across the city continued. Mr Pearson, who was leading this work, was to present to the Board at the next meeting.	
7 Communications update	**Presentation**
Amos Mallard, Communications Manager, joined the meeting to present an update on the communications work, particularly in terms of marketing and PR. There had been some good achievements but there were also some barriers, including capacity being limited to deliver the work. Plans were in place to address these issues. It was reported that a project that would initially be directed around telephony via VoiceComms but then the development of unified communications system would be implemented. Some of the recent media attention was described. Future plans included development of website metrics, sentiment analysis and target updates. It was suggested that the outcomes and performance figures could be tweeted. Some live tweeting from Board meetings was suggested. The positive benefits of Twitter were discussed. It was agreed that a routine update on communications was needed. Thanks were given to Amos and team for their responsiveness and dedication.	
ACTION: SGL to build a routine update on communications into the Board workplan	
8 Update from the Quality & Safety Committee: *for assurance and approval*	**ROHTB (5/19) 009**
Mrs Sallah, Chair of the Quality & Safety Committee presented the key highlights from the last meeting. It was reported that the incidents at first grading would be discussed as part of the full report and there was some work underway to confirm the incident grading processes at a divisional level. The named doctor for paediatric safeguarding remained unfilled; this had been an issue for over a year. It was noted that this was a region wide issue. An individual was being approached to take on this role, however in the meantime mitigating arrangements were in	

place in lieu of a substantive individual; medical input was available if required. It was reported that an internal audit report had been received which provided partial assurance. There were some inconsistencies identified with handling NICE guidance. The co-chairs of the VTE Committee would be received at the next meeting to present an update on the implementation of the NICE guidance reacted to VTE. It was agreed that the work around mental health needed to be presented to the Board. The Research and Development Committee had reported back positively. It was agreed that an update on environmental sustainability should be presented at a future meeting.	
ACTION: **SGL to arrange for an update on Mental Health to be provided at a future meeting** **ACTION:** **PB to provide an update on environmental sustainability at a future meeting**	
9 Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	**ROHTB (5/19) 002** **ROHTB (5/19) 002 (a)**
It was reported that the quality assurance report had been received, following the recent paediatric oncology review, which included a number of recommendations to which the Trust was responding. All inpatient services would transfer on from 30 June 2019. It was reported that all staff had had an opportunity to meet the teams at Birmingham Children's Hospital (BCH) and some staff were excited about the opportunity presented by the transfer. The formal TUPE transfer had now been issued. There would be close oversight of the services which would remain on the ROH site. The only element outstanding from BCH point of view was around water quality in their theatres but there was confidence that this could be resolved ahead of July. All consultants impacted had received a one to one meeting with clinical service leads and job plans had been developed. Arrangements for consultants from outside the area were being considered.	

The commissioning arrangements were being worked through to understand the impact on income for non-oncology work. For oncology work there had been discussions with NHS England to work through the financial implications. Theatre duration time for instance needed to be modelled. The overall assumption was that there was to be no material financial impact. An external individual had been commissioned to support staff emotionally with the change and a formal event would be held to mark the service. Thanks were given to all involved with the work. The Board was clear that any risks associated with the retained service would be given close scrutiny. A Board to Board event was to be planned to understand how the governance arrangements would work. It was noted that there was an amber/green downgrading of the paediatric transition element within the 'Perfecting Pathways' programme status. The flow chart for the process was noted to be useful.	
10 Patient Safety & Quality report: *for assurance* BAF Ref: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	**ROHTB (5/19) 003**
It was reported that there had been one expected death in March and this case would be reviewed through the Learning from Death process. There had been two moderate harm incidents, a VTE and a mislabelling of a specimen resulting in a patient having to return for a repeat biopsy. The severe harm incident related to a fall as the individual had to return to theatres as a result of early mobilisation. The learning from this was that an individual member of staff did not adhere to a post-operative set of instructions. There were two Serious Incidents, including the fall and medication that had been taken home which was not for the patient who then experienced some side effects. The immediate discharge medication process was robust therefore work was underway with individuals to understand the failure to follow process. There had been a VTE reported and there had been four avoidable VTEs for the year against ten the previous year. There had been 88 patient falls against 125 in the previous year. Modernisation of toilets was planned. It was suggested that a patient governor could be used to provide a view on the proposed modifications. There had been three pressure ulcers, taking the number to eight, two higher than the previous year overall. There had been a second year of no avoidable Grade 4 pressure ulcers, which the Board agreed was a good achievement.	

There had been no notifiable infections in the month and the Quality & Safety Committee had considered the report into the two *C difficile* cases. It had been concluded that there had been no significant lapses in care.	
11 Update from the Finance & Performance Committee: *for assurance*	**ROHTB (5/19) 004**
In Tim Pile's absence, Rod Anthony reported that at the last Finance & Performance Committee meeting there had been a chance to review the year end performance in terms of finance and operations. The Control Total had been met and the transitional funding had been received. There had been good progress with the modular theatres scheme. Agency and temporary staff costs remained high, however the recent recruitment Open Day had been successful. There was an overall aim to deliver growth and the impact on income and expenditure needed to be assessed. The full quantum of the Cost Improvement Plan (CIP) had not been delivered as planned.	
12 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	**ROHTB (5/19) 005**
It was reported that the Control Total of £6.6m deficit had been met, with a deficit of £6.2m having been achieved. £2.4m Provider Sustainability Funding (PSF) had been provided as a result. £600k of this was the core PSF, £427k was provided as an incentive and £475k had been granted for exceeding the control total with the remainder as general distribution. The underlying position was discussed, this being around £6.2m but a Control Total of £5.0m deficit had been signed up to for 2019/20. This included a complexity adjustment from NHS England of £2.5m. It was reported that there would be changes that would be happening as a result of modular theatres and this would be closely monitored for impact. For 2019/20, the PSF was reported to reduce, however if the Control Total was met this would be received, in addition to access to Financial Recovery Funding, which could help the Trust achieve financial breakeven. The working assumption on paediatrics was that there would be no material change on the overall position. In terms of CIP, the minimum target to deliver the financial plan was noted to be	

less than that delivered this year. A process for 2019/20 was in place which included a stretch target and incentivisation. One of the most significant elements related to rationalisation of spinal products; there would be benefits of the new procurement collaborative and the managed service contract. A business case would be brought back to Trust Board. It was noted that five additional GPs were expected plus a further two junior doctors. There was a good opportunity to implement the new middle level provider model over coming months, including the introduction of two Advanced Clinical Practitioners. There was an overperformance on income associated with inpatients particularly. Day cases were below plan, which was assumed to be a correction from the last year. The diagnostic six-week target had been met at 99.9% which was a significant achievement. The Referral to Treatment Time trajectory had been met and there were no patients waiting in excess of 52 weeks for treatment. In terms of Cancer performance, the 62-day target had been achieved at 100% for March and the quarterly target had been achieved for the first time. There was a 28-day faster diagnostic target that was being introduced. This was in shadow form at present, and the Trust was performing at 83% against the 85% target. In terms of length of stay, this had deteriorated slightly this being due to a small cohort of patients staying for a long time. It was agreed that a celebration of success for the range of achievements was needed. A document would be produced for all staff to show and celebrate these.	
13 Update from the Staff Experience & OD Committee: *for assurance*	**ROHTB (5/19) 006**
It was reported that the staff experience walkabout were raising issues around the estate and the impact of the theatres expansion on estates and ancillary services was being considered. There were two new risks around Hepatitis B vaccinations and storage of staff files that had been added to the workforce risk register. It was noted that there were a number of leavers who had served less than two years. This was being investigated to understand the reasons. It was noted that this was mainly nursing staff and this could be promoted as a positive unique selling point in terms of preceptorship. It was noted that the Committee was maturing and was moving into a more assurance-based mode. It was agreed that workforce was a significant issue and needed to be given	

additional focus over coming months.	
14 Workforce overview: *for assurance*	**ROHTB (5/19) 007**
It was noted that as described earlier in the agenda, potential GP trainees would assist with agency costs. There were a higher number of starters than leavers, moving the staff in post position closer to full establishment and reducing reliance on temporary staff. Sickness absence had reduced. There was a continued risk around some role-specific training such as resuscitation and patient handling. There were a variety of groups giving oversight to this.	
15 Update from the Audit Committee: *for assurance*	**ROHTB (5/19) 008**
It was reported that the Committee had been impressed with the quality of the draft accounts, Annual Governance Statement and Quality Account. The Head of Internal Audit's opinion was that there was an adequate system of internal control in place, but with room for improvement. The internal audit plan was seen as a positive in that it was risk based. The counterfraud report had been positive. There remained an issue around stock management that had been raised by external audit. Consignment stock was well handled but there were some errors in terms of the lower valued consumables. It was noted that this was unlikely to be material. It was reported that in terms of stock items that had been misvalued, this was c.£24k which had been extrapolated to a projected error value of £0.5m. There were a number of lines of stock not attributed to a value. Despite this observation, there was no request to adjust the accounts based on this. A new stock management system would be secured during the next year and would assist. The NICE guidelines audit had highlighted some inconsistencies, however the HealthAssure system would introduce a more robust process. The Use of Resources rating was 3. Deloitte had been complimentary about the relationship and support received as part of the audit process. Thanks were given to those in the finance department who had been involved in the work to date.	

16 Meeting effectiveness	**Verbal**
It was agreed that there had been some good debate which had been helpful. The meeting had overrun due to the need to explore some items in more detail than anticipated.	
17 Any Other Business	**Verbal**
It was suggested that the nurse portraits in the Outpatients corridor should be reinstated.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 5 June 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 5 June 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 31.05.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	~~05/09/2018~~ ~~05/06/2019~~ 03/07/2019	Update on therapy services planned for the private Board meeting in September, with the strategy due for presentation in November 2018. Ongoing discussions around therapies with commissioners, thereby not in a position to be able to present updated strategy until ~~Spring~~ ~~June~~ July 2019. (Deferred to July from June due to annual leave).	
ROHTBACT. 073	Orthopaedic Services in the STP	Verbal	03/04/2019	Invite Mr Pearson to the Trust Board when the orthopaedic pathway re-engineering work commenced	SGL	05-Jun-19	Rearranged for the July meeting to allow a more comprehensive update to be given	
ROHTBACT. 074	Corporate and strategy extract of the Board Assurance Framework	ROHTB (4/19) 013 ROHTB (4/19) 013 (a)	03/04/2019	Arrange for an additional risk around the impact of planned growth and modular theatres to be added to the Board Assurance Framework	SGL	05-Jun-19	To be included as part of the Board Assurance Framework refresh. Refresh to be ready for the July meeting.	
ROHTBACT. 075	~~Finance &~~ Performance extract of the Board Assurance Framework	ROHTB (4/19) 007 ROHTB (4/19) 007 (a)	03/04/2019	Refresh the risks on the Board Assurance Framework	Exec	05-Jun-19	Board Assurance Framework refresh planned for May 2019. Refresh to be ready for the July meeting.	
ROHTBACT. 072	Chairman's & Chief Executive's update	ROHTB (4/19) 002 ROHTB (4/19) 002 (a)	03/04/2019	Arrange for an honours board to be established	SGL	30-Jun-19	ACTION NOT YET DUE	
ROHTBACT. 076	Communications update	Presentation	01/05/2019	Build a routine update on communications into the Board workplan	SGL	05-Jun-19	Added as a quarterly update into the workplan	
ROHTBACT. 077	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Arrange for an update on Mental Health to be provided at a future meeting	SGL	04-Sep-19	ACTION NOT YET DUE	
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~~ 01/05/2019	Attended at the May meeting of the Trust Board	
ROHTBACT. 078	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Provide an update on environmental sustainability at a future meeting	PB	03-Jul-19	Added to the agenda of the July 2019 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):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**5 June 2019**

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 Public Trust Board on 5th June 2019

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 1st May 2019 from the Chief Executive's position. This includes an overall update, news specific to the ROH and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 On Tuesday 21st May, the Trust appointed a new Spinal Deformity Surgeon. He is currently completing his fellowship in New Zealand and plans to start at the Trust in January 2020.

2.2 We have agreed to hold the annual staff awards at the Botanical Garden Birmingham on Friday 7th February 2020 and we have increased the attendance from 200 to 300 people. Further information will be shared over the coming months.

2.3 We have received the National Inpatient Survey (2018) which is embargoed until 20th June 2019. The full report will be considered by the Quality and Safety Committee in July 2019. We will work with the Communications Team to ensure that all staff are briefed and the results are celebrated.

2.4 We have commenced the recruitment process for a substantive Chief Operating Officer. Candidates are being long listed for interview on 24th June 2019. The process will include a wide range of stakeholders, which will also include Non/Executive Directors and Governors.

2.5 Throughout May 2019, the Executive Team joined various staff celebrations, including International Nurses Day, Operating Department Practitioner (ODP) Day and 20 & 40 years long service awards.

2.6 There is a proposal to establish a Hospital Management Group (HMG) which will be a monthly forum for the Executives and senior leaders across the organisation to meet. The terms of reference are provided in the public Trust Board papers for approval later on the agenda. The first meeting of the Group is scheduled for the end of July 2019. My monthly Chief Executive's Board report will provide a summary of the discussions at each meeting.

2.7 The Collaborations for Leadership in Applied Health Research and Care (CLAHRC), which is a partnership between universities (Birmingham, Warwick and Keele) and a number of health and social care organisations in the West Midlands, delivered a training session at the ROH on the creation and use of statistical process control charts. The presentation covered good practice for Trust Board and Committee papers and a small group has been established to redesign and review our current performance packs with the aim to have these in use for Quarter 3 2019/2020.

2.8 Interserve and ModuleCo have commenced on site with weekly project construction meetings in place to manage the complex theatre expansion programme. A lunchtime feature regarding the expansion was covered on BBC Midlands today. On Friday 24th June we held a small event with all parties to celebrate the project commencing.

3 NETWORKS

3.1 Matthew Hopkins, CEO at Worcestershire Acute NHS Foundation Trust, is visiting the ROH at the beginning of July 2019. This should help to build key relationships across the Executive Teams at both organisations.

3.2 The Jointcare team presented at the National Orthopaedic Alliance (NOA) quarterly meeting. Following their fantastic presentation they have been asked to facilitate a visit for Wrightington, Wigan and Leigh NHS Foundation Trust at the ROH in June.

3.3 We hosted our first Jointcare reunion meeting at Bournville ExtraCare village for our post-op patients. The meeting was well attended and the team received some fantastic feedback which will help inform the pathway and service going forward. These are all booked monthly for the rest of this year.

3.4 On Friday 7th June, we are holding an event at the ROH to promote the work of the medical technology industry, in line with European MedTech week 2019. The event will showcase medical technology already having an impact at the Hospital. MedTech week provides a platform for local initiatives to promote the work of medical technology and many others.

3.5 On 28th May 2019 Chase De Vere financial advisors, acting on behalf of the BMA, attended the ROH to present an overview of the annual pension allowances and final pensions schemes for consultants. The session was well attended and provided a useful opportunity for individuals to gain clarity around any impact on their current job plans, additional work and private practice.

4 BSoL STP UPDATE

4.1 The last BSoL STP CEO meeting took place on 9th May 2019. Key areas of discussion are described below.

4.2 The meeting was held at Norman Power Centre, which is an offsite facility with a Ward currently being run by UHB. The CEOs were invited to meet the integrated discharge team with staff from UHB, Birmingham City Council and Birmingham Community Trust. The project is being supported by Newton with the aim of getting patients discharged home with appropriate support and a rapid integrated response.

4.3 Richard Cowell, Assistant Director Birmingham Council presented the Development plan and there was a discussion around the health requirements for the growth. 60,000 new homes will be built in Birmingham and there was a concern raised about this and other growth including for example, HS2 and the Commonwealth Games. It was agreed that we would review the impact for health.

6 NHSI/NHSE

6.1 On 15th May all Chairs and CEOs were invited to a NHSI/E Midlands and East meeting with Dale Bywater (Regional Director). In attendance was Simon Stevens (CEO NHS England) and Dido Harding (Chair NHS England). The event was well attended. Simon Steven's presentation concentrated around the financial challenge for the NHS, capital funding challenges and the implementation of the long-term plan.

6.2 Dido Harding presented an overview of the interim workforce plan which is due to be published over the coming weeks. She described how NHSE/I has to focus around the people agenda which is equally as important as financial and operational performance.

7 WEST MIDLANDS CEOs' MEETING

7.1 The West Midlands CEOs' meeting was held on 10th May. Key areas of discussion at the meeting are detailed below.

7.2 Julian Hartley (CEO Leeds NHS Foundation Trust) presented the work he had been leading with Dido Harding and NHSE over the last 10 weeks to develop the interim workforce plan to support the long-term plan.

7.3 Dale Bywater attended the meeting and provided a regional perspective on finance and operational performance for Midlands and East. He also expressed concern around the regions A&E performance and the focus around Cancer 62-day performance and patients on a cancer pathway over 104days; both now are a priority for the region. He congratulated the region on the performance around RTT and 52-week reduction.

7.4 There was a discussion around the financial plans submitted and the challenges across the region. A letter was received on the 10th May 2019 which was sent to all trusts to review their capital and costs efficient plans and some were asked to resubmit their plans. The ROH has not been ask to review its plan.

7.5 The issue around annual allowance and the current impact on operational delivery was escalated to Dale. The CEOs have agreed to each review the impact for their

organisation and a collective response would be sent to Dale, who was equally concerned but gave assurance that NHSE and Treasury are working through the implications.

8 POLICY APPROVAL

8.1 Since the Trust Board last sat, the following policies were approved by the Chief Executive, on the advice of the Executive Team for approval:

- Deteriorating adult patients 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.

Jo Williams

Chief Executive

30th May 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Hospital Management Group terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**5 June 2019**

EXECUTIVE SUMMARY:

The attached presents proposed terms of reference for a forum comprising the Executive Team and senior leaders of the organisation.

The body, known as the Hospital Management Group (HMG), is to be established to ensure that there is a mechanism and forum for discussion, planning and implementation of the systems and processes associated with the development of our local integrated care system, the Birmingham Hospitals Alliance and the STP.

This work will run in parallel with our own strategic ambitions such as theatre expansion, private patients and the plans to continue to grow.

It is proposed that the HMG meets monthly the week before Trust Board to allow upward reporting of the key points of discussion and decisions as part of the Chief Executive's routine report.

The first meeting is scheduled for Wednesday 31st July 2019.

REPORT RECOMMENDATION:

As the HMG will report upwardly to the Trust Board, the Board is asked to approve the terms of reference attached.

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	x	Workforce	x

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

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

The HMG will 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:
Executive Team on 14 May 2019.

The Royal Orthopaedic Hospital NHS Foundation Trust

HOSPITAL MANAGEMENT GROUP

Terms of Reference

1 POWERS AND AUTHORITY

1.1 The Hospital Management Group (HMG) has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Group is authorised 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 Group.

2 PURPOSE

2.1 The primary purpose of the HMG is to ensure there is operational delivery of the Trust's vision through clarity of direction for the Divisions and corporate departments and alignment of their work to the strategic objectives.

2.2 The Group will provide senior management support and advice to the Chief Executive in exercising the decision making delegated to her by the Trust Board.

3 MEMBERSHIP

3.1 The membership of the Group will comprise:

- Chief Executive
- Executive Director of Finance and Performance
- Executive Director of Nursing & Clinical Governance
- Executive Medical Director
- Chief Operating Officer
- Executive Director of Strategy & Delivery
- Associate Director of Governance/Company Secretary
- Associate Director of Workforce, HR & OD
- Clinical Service Leads
- Deputy Chief Operating Officer
- Deputy Director of Nursing & Clinical Governance
- Heads of Nursing
- Associate Medical Directors

3.2 A quorum will be five members, including two Executive Directors.

3.3 The Chair of the Group will be the Chief Executive and if the Chair is absent from the meeting then another Executive Director shall preside.

4 ATTENDANCE

4.1 Staff members who are not members of the Group, may attend for all or part of the meeting to provide specialist advice by prior agreement with the Chair of the Group.

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

4.3 The PA to Chief Executive shall be secretary to the Group and will provide administrative support and advice. The duties of the secretariat in this regard are:

- Agreement of the agenda with the Chair of the Group and attendees with the collation of connected papers

- Taking the minutes and keeping a record of matters arising and issues to be carried forward

5 FREQUENCY OF MEETINGS

5.1 Meetings will be held monthly and the duration will be for two hours.

6 DUTIES

The Group shall:

6.1 Promote effective alignment and collaboration between divisions/departments, two-way communication with staff and the promotion of multidisciplinary working

6.2 Shape and develop proposals on the Trust's vision and values, purpose and strategic direction

6.3 Review strategies, strategic development proposals and proposals for major service change ahead of submissions for Chief Executive or Trust Board approval as appropriate

6.4 Identify at each meeting any quality and safety concerns that should be referred to the Quality & Safety Committee or one of its advisory groups

6.5 Review overall performance on a monthly basis to inform monthly performance reporting to the Finance & Performance Committee

6.6 Review and discuss overall performance against a range of workforce metrics, including any trends of significance and remedial actions plans where needed

6.7 Agree the prioritisation of the annual internal audit programme prior to approval by the Audit Committee

6.8 Agree the prioritisation of the annual capital programme

6.9 Discuss and agree the addition of any risks of sufficient severity as to warrant inclusion on the corporate risk register or Board Assurance Framework

6.10 Review business cases for investment (including major service and strategy developments, estates proposals and new consultant posts) ahead of approval by the Trust Board. The Group will also review business cases ahead of Executive approval where the proposal would benefit from a wider stakeholder debate.

6.11 Consider all new and substantially amended Trustwide policies and offer advice to the Chief Executive whose authority is needed for their approval

7 REPORTING

7.1 Following each meeting, the minutes shall be drawn up by the secretary. The draft minutes will then be presented at the next meeting for approval.

7.2 The approved minutes of all meetings of the Group shall be recorded and submitted, together with recommendations where appropriate, to the Trust Board. A summary of the key matters discussed, including any action commissioned will be presented by the Chief Executive using the standard upward report template appended to the routine update from the Chief Executive.

8 REVIEW

8.1 The terms of reference of the Group shall be reviewed by the Trust Board annually.

Date of adoption: June 2019

Date of review: June 2020

ROHTB (6/19) 003

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 29 May 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The water safety action plan was not presented as planned. It was agreed that the water safety action plan needed to be discussed by the Executive Team given the potential risks associated with the effective running of the new modular theatre set up. • A number of risks were highlighted in the upward report from the Health & Safety Committee. The delay in rectifying the issues associated with monkey bars was noted to be unacceptable. The current effectiveness of the panic alarms in Outpatients also needed to be considered. Compliance with patient handling training was highlighted to be poor and it was agreed that this needed to be rectified as soon as possible. • A radiology safety incident had occurred which had been reported to the Care Quality Commission. The action plan and Root Cause Analysis would be presented to the CQC in June 2019. • The Committee was disappointed at the time being taken to resolve the issue over the implementation of the VTE NICE guidance.	• Water safety action plan to be received by the Executive Team. • Ensure that a report is provided to the Executive Medical Director that allowed him to challenge those who repeatedly did not adhere to the requirement to undertake a 24-hour risk assessment for VTE • The Executive Team to review progress of the Throne Project • Present the outcome of the ligature point risk assessment at a future meeting. • The gap analysis of health and safety national guidance to be presented at a future meeting. • Presentation of the Health Records audit to be presented at a future meeting. • Presentation of the cancer peer review at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was assured that the plans to ensure that those remaining individuals who were outstanding a Hepatitis B vaccination were robust. • A sample dashboard had been added to the start of the Patient Safety and Quality report which was well received, however it was suggested that the report needed to include a rolling 12-month performance against the key quality metrics. • Good assurance was provided around the plan to handle NICE guidance more robustly in the Trust, this being to use the new HealthAssure system more effectively for prompting relevant staff to assess the relevance and implications for implementation within a	• None specifically.

four-week period, with escalation to the relevant accountable leads if necessary. • The Committee received a positive update on the work to strengthen the knowledge and training of staff around management of pressure ulcers. The use of the 'apple' analogy for training was seen to be a useful tool. • The Committee received an update from one of the co-chairs of the VTE Advisory Group which highlighted that although the Trust was compliant with the VTE NICE guidance, additional options for prophylaxis could be used, including aspirin. The VTE policy was currently being refreshed to set out the process if this alternative was offered to patients. • Readmissions was reported to have steadied at 1.4% despite a number of patients on the JointCare pathway being discharged and mobilised earlier. • Performance against CQUINs was reported to be improved and there was a good action plan in place to address performance against those that had not been achieved last year.	

Chair's comments on the effectiveness of the meeting: It was agreed that the discussions had been productive and there had been good challenge on the issues which presented a risk to the organisation.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Paediatric transition update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Janet Davies, Clinical Service Manager / Project Lead for the Paediatric Transition**
DATE OF MEETING:	**5 June 2019**

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:

- Key workstream updates
- Timeline updates
- Governance
- Services which remain on site at the ROH

REPORT RECOMMENDATION:

The Board is asked to accept 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		Communications & Media	x
Business and market share	x	Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services.

PREVIOUS CONSIDERATION:

Last considered as part of the Trust Board public agenda on 1 May 2019.

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Paediatric Service Update – June 2019
UPDATE TO THE TRUST BOARD ON 5th JUNE 2019

1 Executive Summary

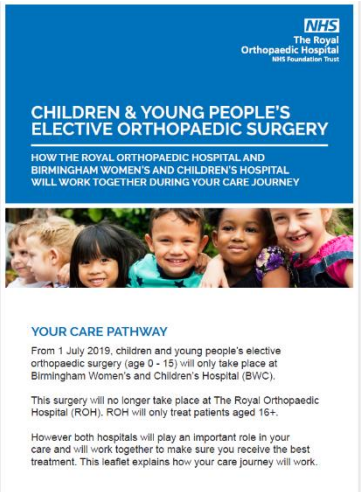
This paper provides an update on the transition of paediatric inpatient & day case surgery from The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) to Birmingham Women's & Children's NHS Foundation Trust (BWC), and includes:

- Key workstream updates
- Timeline updates
- Governance
- Services which remain on site at the ROH

2. Key workstream updates

Communications

Joint communications between ROH and BWC has been shared with key stakeholders and added to the ROH website. The below information leaflet has been produced for patients attending clinic guiding them to the most up to date information on our website and provide them with contact details for each site.


NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

CHILDREN & YOUNG PEOPLE'S ELECTIVE ORTHOPAEDIC SURGERY

HOW THE ROYAL ORTHOPAEDIC HOSPITAL AND BIRMINGHAM WOMEN'S AND CHILDREN'S HOSPITAL WILL WORK TOGETHER DURING YOUR CARE JOURNEY

YOUR CARE PATHWAY

From 1 July 2019, children and young people's elective orthopaedic surgery (age 0 - 15) will only take place at Birmingham Women's and Children's Hospital (BWC).

This surgery will no longer take place at The Royal Orthopaedic Hospital (ROH). ROH will only treat patients aged 16+.

However both hospitals will play an important role in your care and will work together to make sure you receive the best treatment. This leaflet explains how your care journey will work.

In addition, an information letter will be sent out to the current patients who are waiting for their surgery reminding them of the change of venue for their surgery. Contact details for both ROH and BWC will be provided in both the letter and leaflet.

Information transfer

The early testing of the transfer of clinical information and images has been successful. Clinical testing will continue into June 2019 by our clinical colleagues and will include the access to PACS (imaging).

HR & Workforce

The formal TUPE consultation process has been completed with all staff (including the medical staff) having completed their 1-1 consultation meeting. Formal communication regarding the end of consultation will be sent during the 1st week of June 2019. All staff have been verbally given their first choice of work place at BWC, but this information will also be confirmed within the end of consultation letter.

The Nursing and Therapy staff have now completed at least one shift and their induction at BWC. There has been positive feedback from staff regarding the training programme, all have gained insight to their new area of work and met their new colleagues.

3. Timeline updates

There have been no changes to the key milestones for the paediatric service transition. The transition date of the 1st July 2019 remains on track with no concerns noted from either Trust.

With 4 weeks remaining until the transfer date, the following actions are planned for delivery on a week by week basis:

3rd June 2019

- An Information leaflet (for clinic patients) and an information letter to be sent to patients on the current admitted pathway confirming the new venue for their surgery will be released
- Finalisation of Job Plans for the Spinal and Oncology teams
- The start of pre-assessment clinics at BWC for Spinal Deformity patients
- Theatre lists planned with BWC for the 1st July 2019
- Implementation of the Information transfer pathway
- Information leaflet given out to new patients listed for surgery
- Spinal deformity teams to test the remote ROH PAC's access at BWC

10th June 2019

- The implementation of the CT Biopsy pathway at ROH with the core staff who will provide the service post 1st July 2019 – 31st December 2019
- Change workshop held at ROH for Ward 11, HDU, Nursing and Therapy staff

17th June 2019

- The start of Pre-assessment clinics at BWC for Oncology patients
- Change workshop held at ROH for Ward 11, HDU, Nursing and Therapy staff

24th June 2019 – Final week

- Celebration of paediatric services on Wednesday 26th June 2019 in the Knowledge Hub
- Day Case surgery plus urgent elective cases only. Transfer of any paediatric patients remaining in the trust on **Friday 28th June 2019**.

4 Governance

The Governance teams from both Trusts are meeting to agree the governance models post transition.

The proposed model is one of a Partnership model and this would form part of the SLA between the two Trusts. The Partnership model proposes that ROH have responsibility for the services that they provide and BCH have responsibility for the services they provide. Neither organisation would be considered as the lead partner and reporting would continue through normal commissioning routes. Joint governance arrangements for shared learning and to facilitate response and learning from incidents would be agreed.

The June 2019 Strategic Oversight Group Meeting co-chaired by Kathryn Sallah (ROH) and Alan Edwards (BWC) and NHS improvement and NHS England is planned to be brought forward from the last week of June 2019 to ensure the milestones for the transition are delivered. The Governance will be reviewed at this meeting.

Beyond the transition date a joint regular meeting will be set up with the Operational and Clinical teams across both Trusts. This meeting will provide a platform for both Trusts to work together to review and deliver the service, manage the service level agreement (SLA) and work on transforming the service together.

5. Services that will remain on site at the ROH

Outpatients (OPD) and CT Guided Biopsy Paediatric Services

ROH will continue to provide on-site Paediatric Outpatient clinics and a weekly CT biopsy service post 1st July 2019. The OPD will remain on Ward 11 and the first bay will be open (Thursdays only) to recover the CT biopsy pathway patients. The COO and Director of Nursing have taken the opportunity to review the OPD and remaining clinical areas on Ward 11 and have suggested improvements which are currently being worked up by the Estates team.

The Director of Nursing and Clinical Governance will be responsible together with the senior clinical nursing team to ensure that policies and procedures are refreshed to support the remaining services on site at the ROH.

The CT biopsy pathway has been discussed and agreed with all the key stakeholders. Dr Satish Rao (Deputy Chief Medical Officer BWC) and Mr Matthew Revell (Medical Director ROH) have met with clinical teams to confirm this and a future model.

As described in previous reports it is planned that the ROH will provide the Consultant Anaesthetist, the Consultant Interventional Radiologist and support staff till December 2019. From January 2020 BWC will cover the anaesthetic and support services at ROH.

The Paediatric CT Biopsy list will be delivered by the ROH on a Thursday and plans have been implemented to include the unlikely event that a child will be required to stay overnight they will be transferred to BWC. This has been reviewed and we estimate that this is likely to be approx. 5 children per year. Implementation of this pathway is planned before the transfer date in June 2019, with the staff who will continue to provide the service post transition.

Author: Janet Davies Clinical Service Manager / Project Lead for the Paediatric Transition
30th May 2019

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

May 2019

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

Dashboard

	March 2019	April 2019	2019/2020 YTD	2018/2019
Incidents	344	310 (↓)		
Serious Incidents	2	0 (↓)	0	9
Internal RCA investigations	2	0 (↓)		
Safety Thermometer (Harm Free Care)	98%	98% (↔)		
VTEs	1	0 (↓)	0	14
Falls	9	11 (↑)	11	88
Pressure Ulcers: Cat 2	3	0 (↓)	0	15
Pressure Ulcers: Cat 3	0	0 (↔)	0	3
Complaints	12	11 (↓)	11	139
PALS	63	85 (↑)		
Compliments	647	453 (↓)		
FFT Score	97.2%	96.3% (↓)		
FFT Response	37.1%	37.2% (↑)		
Duty of Candour	10	8 (↓)		
Litigation	0	0 (↔)		
Coroners	0	0 (↔)		
WHO	100%	100% (↔)		
Infections	0	1 (↑)	1	3

(↑) (↓)(↔) Symbolise the trend from the previous month March 2019.

CONTENTS

1. 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.

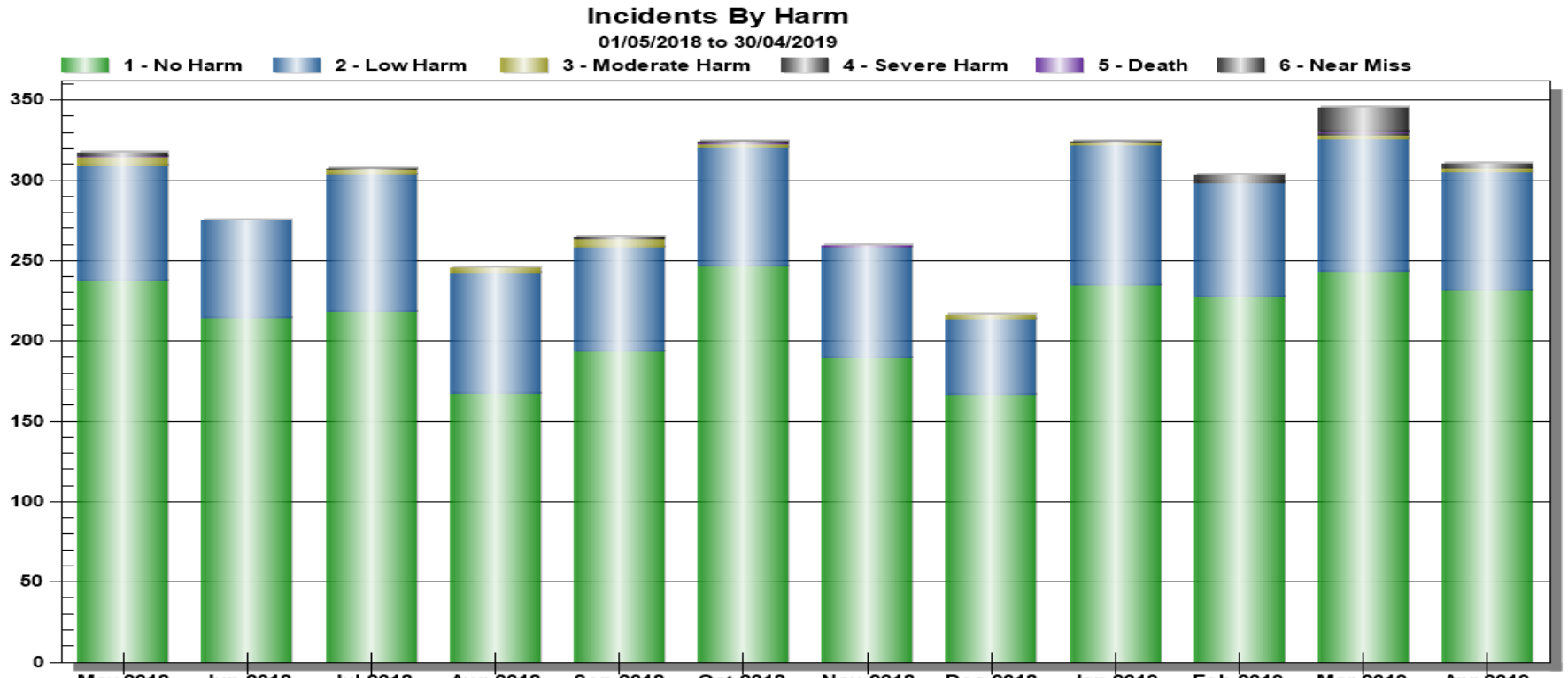
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
1 - No Harm	237	214	218	167	193	246	189	166	234	227	243	231
2 - Low Harm	72	61	85	75	65	74	69	47	87	71	82	74
3 - Moderate Harm	5	0	3	3	5	2	0	3	2	0	2	2
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	2	0
5 - Death	1	0	0	0	0	1	1	0	0	0	1	0
6 - Near Miss	2	0	1	0	1	1	0	0	1	5	15	3

Data source – Ulysses

INFORMATION

In April 2019, there were a total of 310 Incidents reported on the Ulysses incident management system. This is within the normal reporting limits.
The breakdown of those incidents is as follows;

230 – No Harm
74 – Low Harm
2 - Moderate Harms
0 - Severe Harm
3 – Near Miss
0 – Death

The provisional harms reported were;

- Emergency Transfer Out Of Trust
- Emergency Transfer to HDU

Near Miss Incidents – Radiology incidents

All of the near misses are in relation to X-Ray processes and radiology examinations not being processed in the RIS system. This is a new process to drive improvement and will be monitored via the radiology teams. The Governance team are meeting with the Head of Imaging to discuss how these should be reported.

Patient Contacts

In April 2019, there were a total of 8926 patient contacts. There were 310 incidents reported, which amounts to 3.7 per cent of the total patient contacts resulting in an incident. Of those 310 reported incidents, 77 incidents resulted in harm which is 0.9 per cent of the total patient contact.

Downgraded Incidents

0 of the 4 reported harms in the previous Quality report have been downgraded.

ACTIONS FOR IMPROVEMENTS / LEARNING

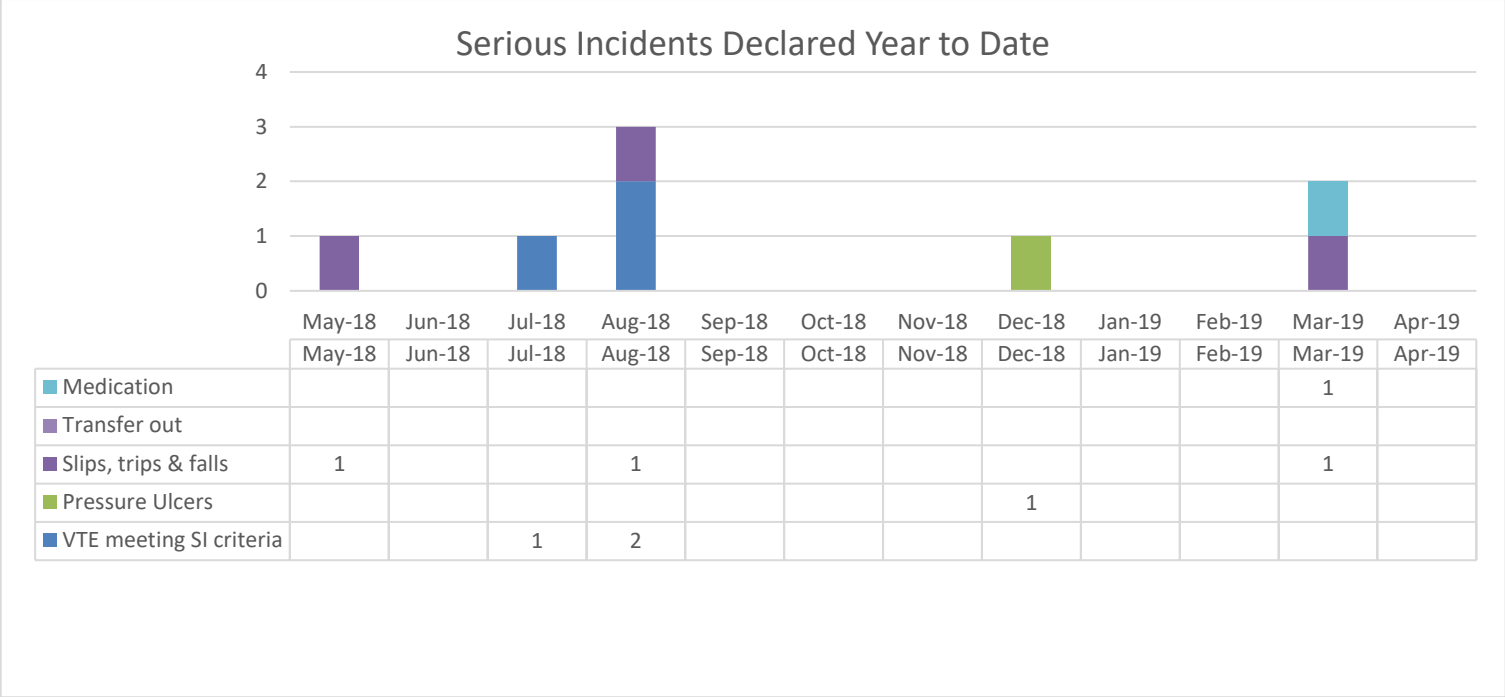
- Implementation of the Health Assure system - Project plan was on the agenda of Quality and Safety in March 2019 – Allocate had cancelled CQC module training in April 2019 causing delay to the project plan. Training rescheduled for May 2019.
- New Serious Incident Pro Forma introduced to support the divisions with the Serious Incident Framework.

RISKS / ISSUES

- Risk 1193 - Staffing and capacity within the team with two vacancies (current risk score 12). Induction for new staff underway. Risk changed to incorporate the skill and inexperience of a new team.
- Risk 1194 - Lack of skill in the Trust on the Ulysses system (current risk score 12). Training arranged for all modules of Ulysses.

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.**

Year Totals	
18/19	9
19/20	0

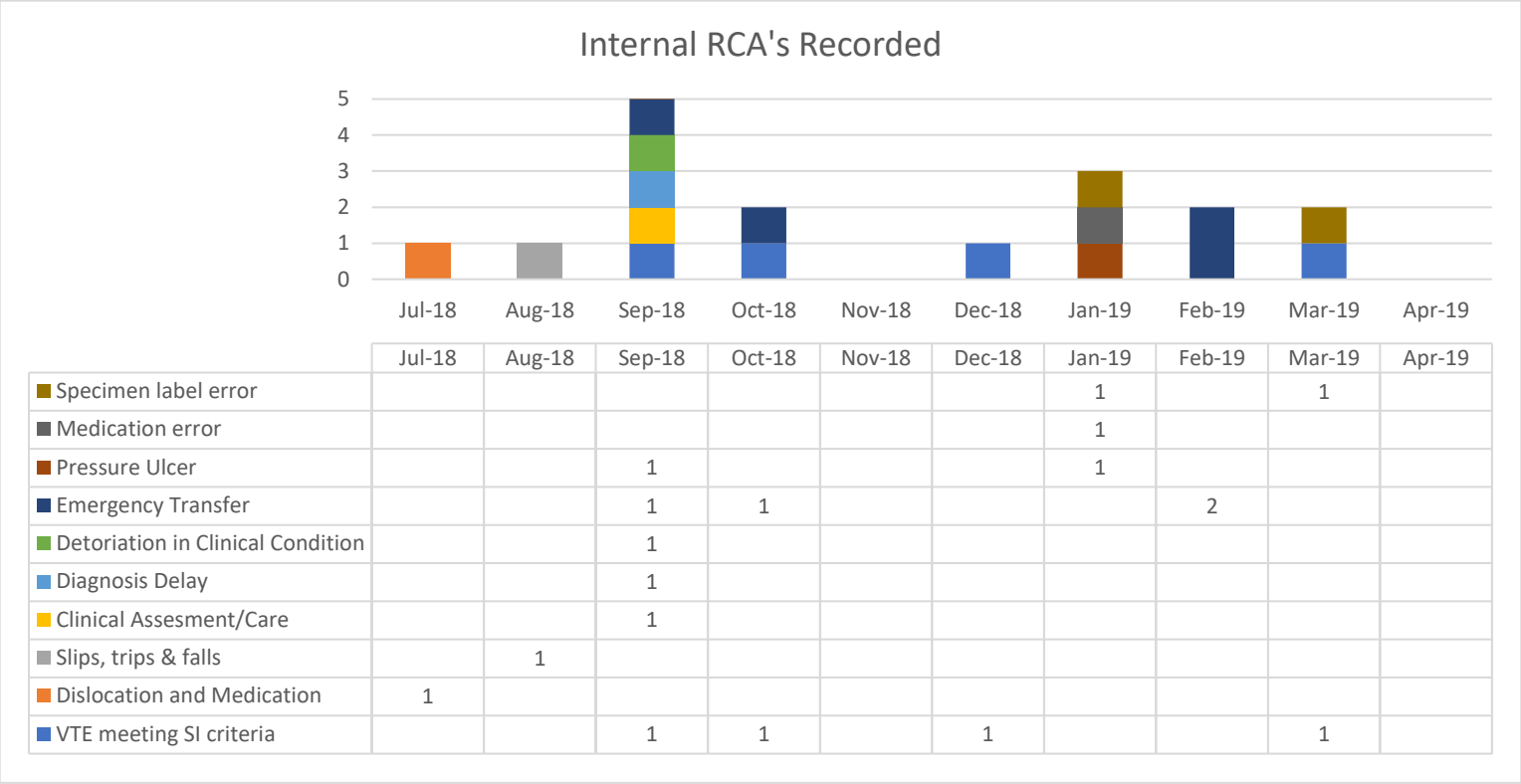


	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Medication											1	
Transfer out												
Slips, trips & falls	1			1							1	
Pressure Ulcers								1				
VTE meeting SI criteria			1	2								

Data Source – STEIS

INFORMATION
No Serious Incidents were reported in April 2019. A new serious incident pro forma to support the divisions in the review of potential Serious Incidents has been developed and now in use. The proformas will be presented and reviewed weekly for Executive Director sign off.
ACTIONS FOR IMPROVEMENTS / LEARNING
No Serious Incidents were closed by the CCG in April 2019 A new serious incident pro forma to support the divisions in the review of potential Serious Incidents has been developed and now in use. The proformas will be reviewed weekly for executive sign off.
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**

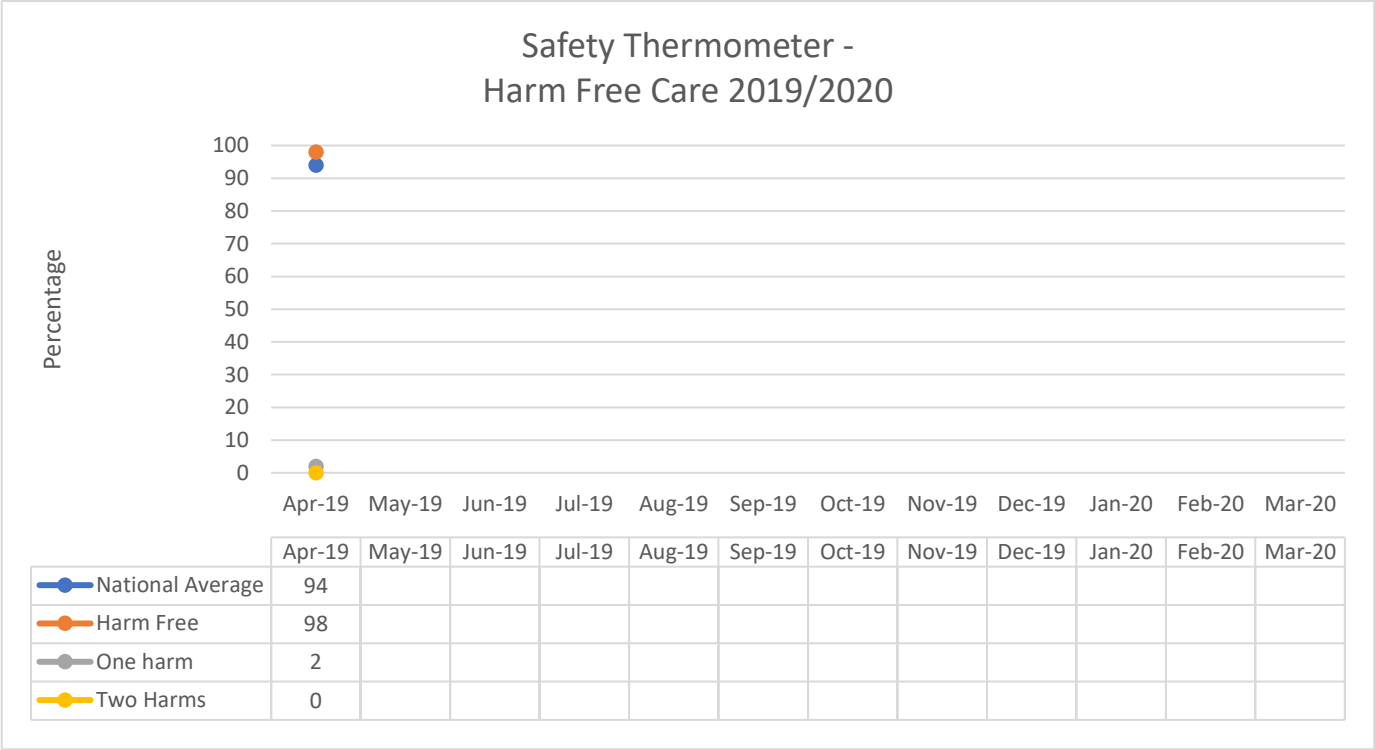


	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Specimen label error							1		1	
Medication error							1			
Pressure Ulcer			1				1			
Emergency Transfer			1	1				2		
Detoriation in Clinical Condition			1							
Diagnosis Delay			1							
Clinical Assesment/Care			1							
Slips, trips & falls		1								
Dislocation and Medication	1									
VTE meeting SI criteria			1	1		1			1	

Data Source – Internal RCA tracker

INFORMATION
There was no internal RCA's reported in April 2019
ACTIONS FOR IMPROVEMENTS / LEARNING
One internal RCA was closed; **Root Causes identified** 1. Failure to take a transfusion sample to NPSA standards due to poor practice 2. Failure of monitoring compliance to training requirements for taking transfusion samples **Lessons Learned** Lesson 1 – This incident demonstrates the importance of the 2-sample rule for transfusion samples. Blood bank at QEHB is no longer releasing blood components unless a patient has had two transfusion samples taken on two separate occasions. Lesson 2 – NPSA standards for taking transfusion samples were introduced to improve patient safety by reducing the number of wrong blood in tubes. This incident demonstrates the importance of compliance to this training, as bad practices develop. Lesson 3 – This incident demonstrates that there should be robust process in place that ensure that not only doctors are aware that they have to complete their blood transfusion training, they know how to access this training and it is monitored if they fail to complete it.
RISKS / ISSUES
None

5. **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.**

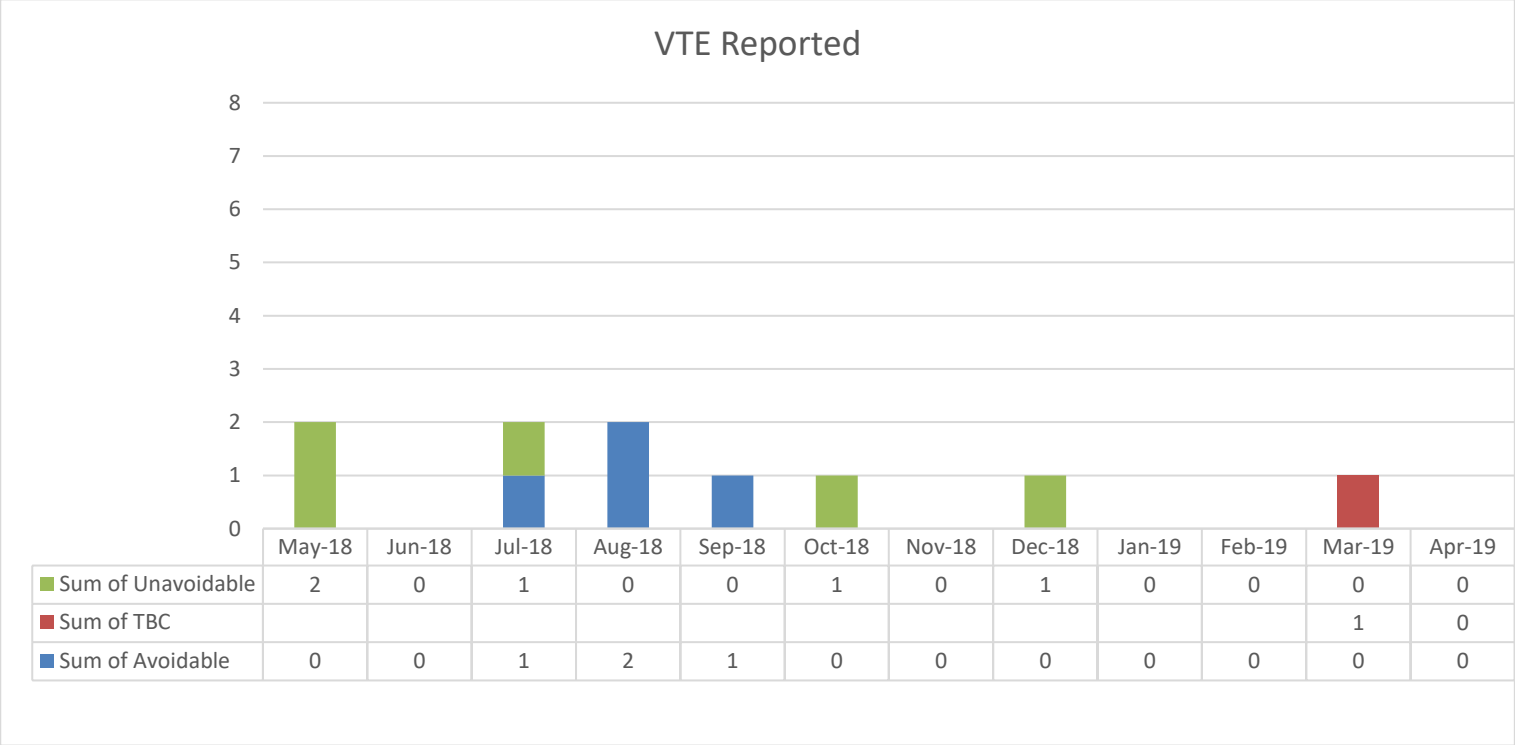


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
National Average	94											
Harm Free	98											
One harm	2											
Two Harms	0											

Harm: 1 x New UTI recorded on Ward 3

Data Source – Informatics

6. **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).**



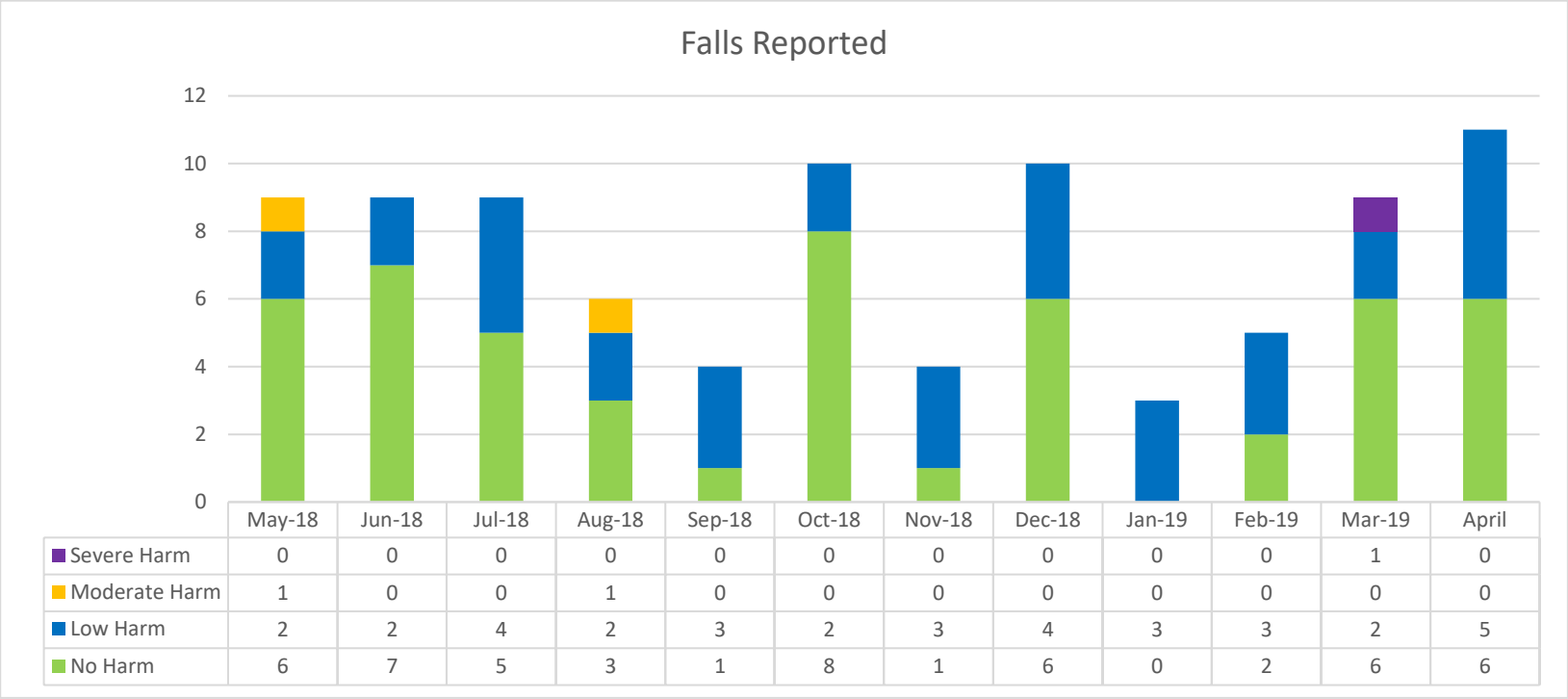
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Sum of Unavoidable	2	0	1	0	0	1	0	1	0	0	0	0
Sum of TBC											1	0
Sum of Avoidable	0	0	1	2	1	0	0	0	0	0	0	0

Year Totals	
18/19	14
19/20	0

INFORMATION
There have been 0 hospital acquired VTEs reported in April. On admission risk assessment was >98% in April 2019
ACTIONS FOR IMPROVEMENTS / LEARNING
There is on-going work around the NICE guidance released in March 2018. The VTE Advisory Group continue to benchmark against other Trusts. An options appraisal document is being developed by the VTE chair. Assurance is provided that the prophylaxis offered to our patients is safe and appropriate. Despite actions taken previously, compliance with the 24 hour VTE risk assessment has deteriorated in April 2019-83%. A report has been produced and shared with the Medical Director whose support has been requested to address with repeat offenders.
RISKS / ISSUES
Poor compliance with mandatory 24 hour re-assessment . This has been escalated and continues to be monitored. Despite now being a mandatory field in PICS compliance has decreased from 89.5% in March to 83% in April . Reports obtained from PICS enable identification of who acknowledged/ignored the alerts. This has been escalated to the Medical Director and further communications and support has been provided by the PICS team.

Data Source – Ulysses and VTE leads

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



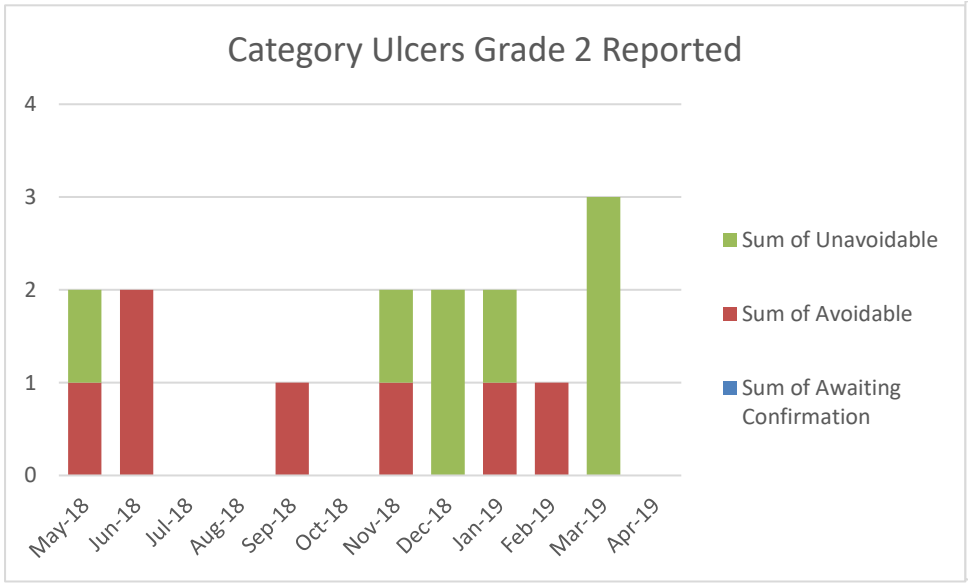
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	April
Severe Harm	0	0	0	0	0	0	0	0	0	0	1	0
Moderate Harm	1	0	0	1	0	0	0	0	0	0	0	0
Low Harm	2	2	4	2	3	2	3	4	3	3	2	5
No Harm	6	7	5	3	1	8	1	6	0	2	6	6

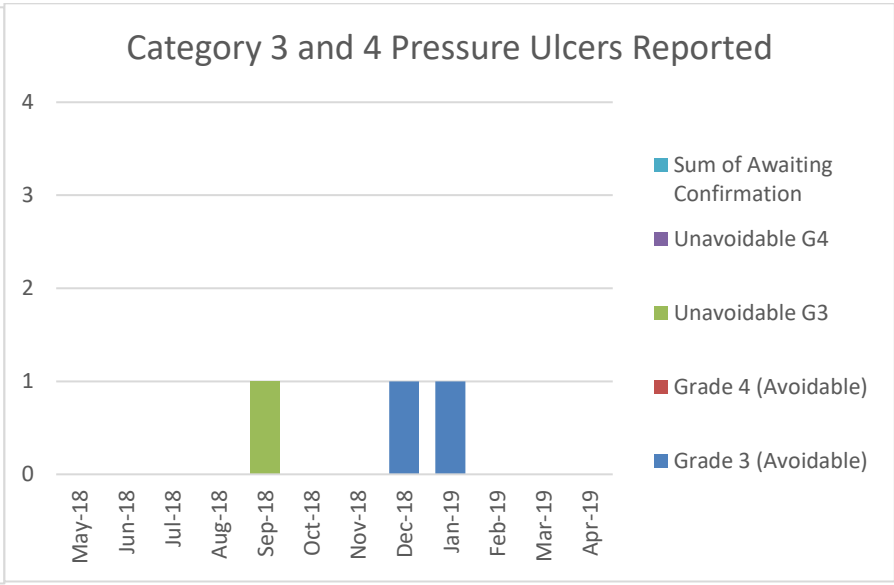
Year Totals	
18/19	88
19/20	11

Data Source – Ulysses and Falls Group

INFORMATION
11 incidents relating to Falls reported in April 2019; 10 involving in-patients and 1 involving an out-patient. All reported as either no or low harm incidents. Themes: unwitnessed falls of patients in the bathroom and patients not calling for assistance to mobilise.
ACTIONS FOR IMPROVEMENTS / LEARNING
• Combining Falls and Dementia group • Terms of reference for combined falls/dementia group developed for approval • Review of the benchmarking exercise of the WMQRS – shows we need to look at the development of a fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall • On-going development of Throne project • Now providing a training session for falls on the clinical update days for both HCA's and qualified nurses. • Training on the use of the Sara steady has now been included on the manual handling training sessions.
RISKS / ISSUES
When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Only one Hover Jack available for the trust, this is also used for training, capital bid has been raised. Also, looking at alternative option of Raizer lifting device which could be used to assist non-spinal patients up from the floor, reducing reliance on the Hover Jack.

8. **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.**





Year Total	Cat 2	Cat 3
18/19	15	3
19/20	0	0

Data Source – Ulysses and TV team

INFORMATION

In April 2019 – There were 0 Category 2 or 3 pressure ulcers reported.

April 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	0
Category – 2 (Device)	0
Category – 1	Category 1- x 2 Pressure Ulcers ROH acquired
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	MASD Incontinence- x2 ROH acquired MASD Intertriginous- x3 ROH acquired MASD Peri wound- x1 ROH acquired
Patients admitted with PU's	Cat 2 externally acquired- x2 (both patient's own home) Cat 3 externally acquired- x1 (patient's own home)

Avoidable Pressure Ulcer CCG Contracts KPI

2019/2020	
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	0

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

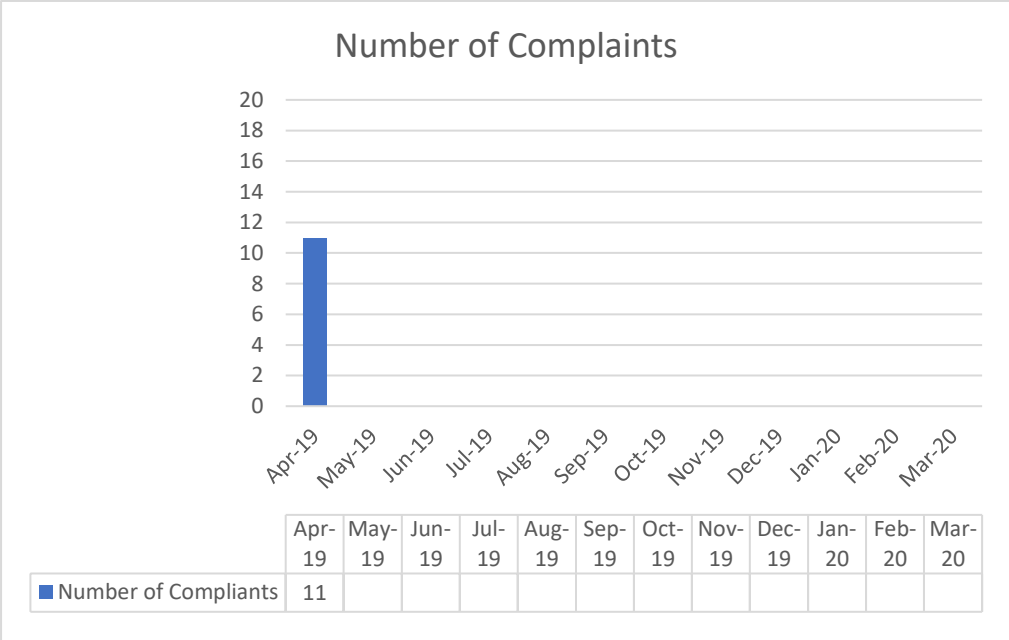
Current Actions

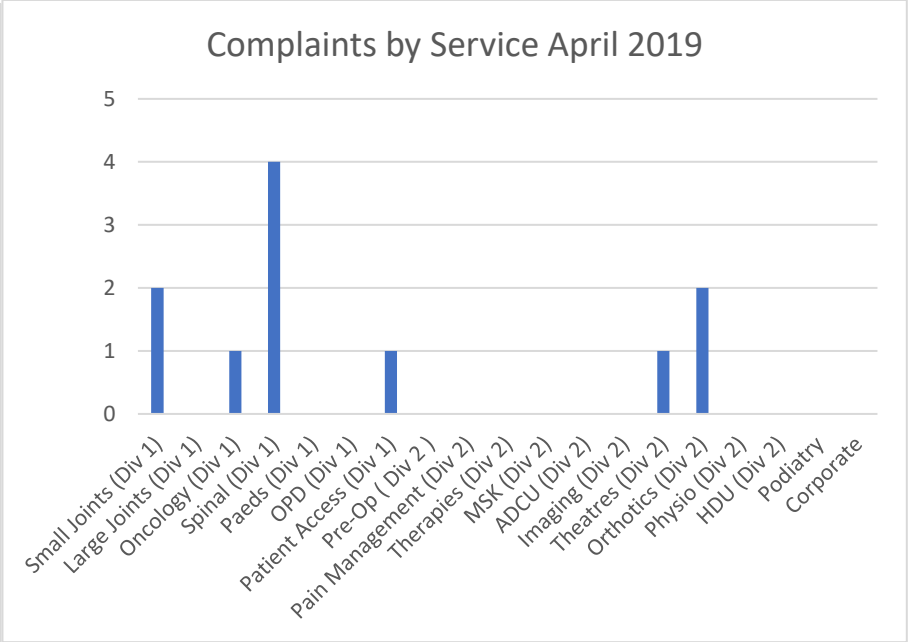
- The POP plaster cast care plan has been. Amended SOP in progress. Extra training to be given to staff during theatre shutdown week regarding plaster care and removal of POP.
- The MDT pathway documentation will be amended at general review in May 2019 to re make it clearer when Anti-embolic stockings are removed and skin checked.
- All Trusts were required to have implemented the NHSI recommendations 2018 for pressure ulcers: revised definition and measurement, by the end of March 2019. ROH was compliant from Sept 2018.
- Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (March 2019). ROH fully compliant
- Trust wide mattress audit to be undertaken on 25/4/19.
- National closed Facebook group- accessible for TVNs only, received a BJN national award for innovation – March 2019, TV team at ROH part of group.

RISKS / ISSUES

None

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.





Complaint Year Totals	
18/19	139
19/20	11

Data Source – Patient Experience team

INFORMATION

Complaints

There were 11 formal complaints made in April 2019. All were initially risk rated amber or yellow. This is less than last year (12 complaints in April 2018).
The themes of this month's complaints were:

Complaints	Apr-19
Access to treatment	1
Appointments	4
Clinical	3
Communication	6
Facilities	
Patient Care	
Trust Administration	1
Values & Behaviours	2
Waiting times	3

PALS

The PALS department handled 85 contacts during April 2019 of which 61 classified as concerns. This is a significant reduction in calls compared to the same time last year (278 contacts in April 2018) but an increase in the level of concerns (52 concerns in April 2018). The main themes in the PALS data relate to queries about appointments (either length of wait for or cancellations), clinical queries and administrative processes. 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. 87.5% of enquires and 82% of concerns were handled within the agreed timescales, meeting this internal KPI.

PALS Concerns	Apr-19
Access to treatment	1
Appointments	21
Clinical	12
Communication	1
Facilities	3
Patient Care	2
Trust Administration	10
Values & Behaviours	3
Waiting times	8

Compliments

There were 453 compliments recorded in April 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments April 2019
Div. 1	341
Div. 2	109
Div. 4	2
Corporate	1

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 receive a request monthly to submit their compliments for central logging.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 10 complaints closed in April 2019, 9 within the agreed timescales. This gives an 90% completion on time rate and meets the KPI for the month.
The average length of time to close complaints in April 2019 was 24 days, which is within normal limits.

3 complaints were fully upheld, 5 were partially upheld and 2 were not upheld

Learning identified and actions taken as a result of complaints closed in April 2019 include:

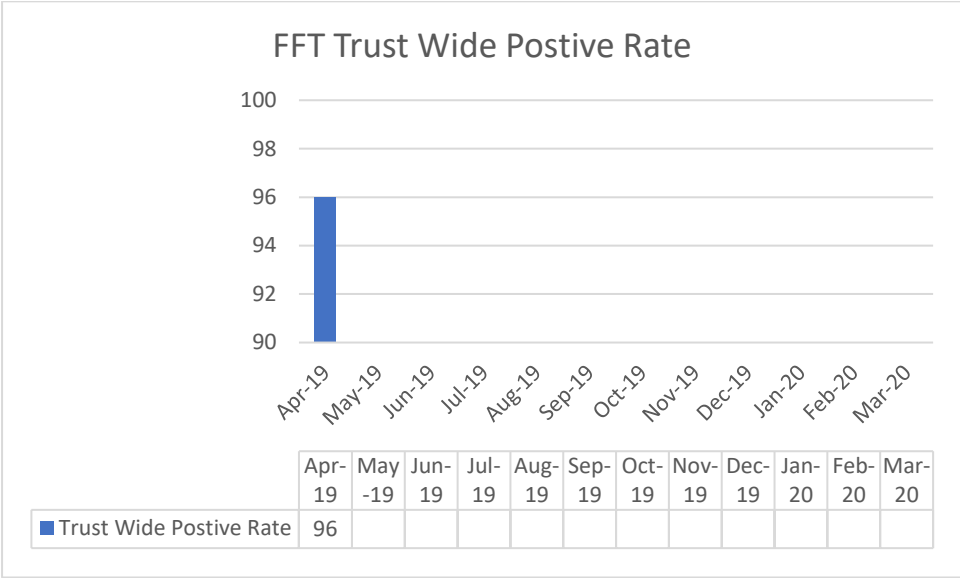
- Duty of Candour process was not clear to all staff within a department
  Action: Refresher training has been provided across all specialities

- Patients and Staff can find discussion around smoking difficult
  Action: Patient Leaflet is being developed and additional material has been sourced.

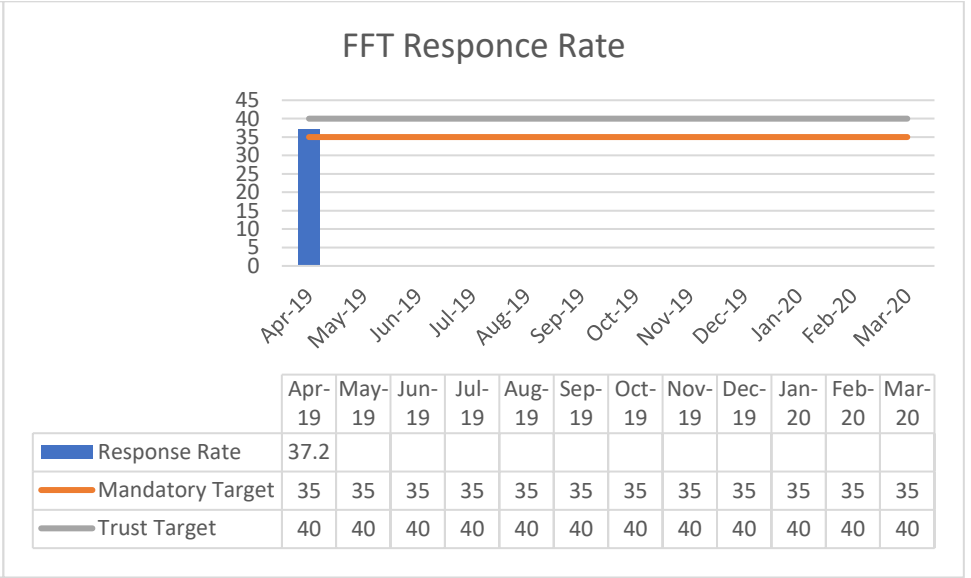
- Not all staff were aware of the protocols for managing the injection waiting list
  Action: Training has been provided.

RISKS / ISSUES
None Identified.
COMEBACK COMPLAINTS
0 comebacks received

10. Friends and Family Test Results (collected in the iwantgreatcare system)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Trust Wide Postive Rate	96											



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Response Rate	37.2											
Mandatory Target	35	35	35	35	35	35	35	35	35	35	35	35
Trust Target	40	40	40	40	40	40	40	40	40	40	40	40

Data Source – Patient Experience team 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

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 agreed internal targets for all areas and as a result, the data is 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 requested 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

The team are recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In April 2019, 8 concerns were identified from the 1387 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 main areas of concern in April 2019 related to Communication and Administration. Information is 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 of 20% for Outpatient services was met this month. 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 April 2019**	**% of people who would NOT recommend the department in April 2019**	**Number of Reviews submitted in April 2019 (previous month in brackets)**	**Number of Individuals who used the Department in April 2019**	**Department Completion Rate (Mandated at 35%)**
Ward 1	97.8%	0.0%	46 (70)	99	46.5%
Ward 2	90.3%	0.0%	31 (62)	101	30.7%
Ward 3	97.2%	0.0%	36 (26)	76	47.4%
Ward 12	96.5%	0.0%	57 (77)	106	53.8%
Ward 11 (CYP)	100.0%	0.0%	12 (19)	70	17.1%
ADCU	97.7%	0.8%	129(165)	546	23.6%
HDU	100.0%	0.0%	17(18)	62	27.4%
CYP HDU	0%	0.0%	0 (1)	6	0%
Overall Trust Inpatient Response Rate for April 2019					37.2%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in April 2019**	**% of people who would NOT recommend the department in April 2019**	**Number of Reviews submitted in April 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	96.3%	0.6%	981 (1069)	22.2%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in April 2019**	**% of people who would NOT recommend the department in April 2019**	**Number of Reviews submitted in April 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic	97.4%	1.3%	78(37)	60.0%

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.

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 8 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. New Claims

New claims

0 new claims against the Trust were received in April 2019

On-going claims

There are currently 33 on-going claims against the Trust.
32 of the claims are clinical negligence claims.
1 claim is a staff claim

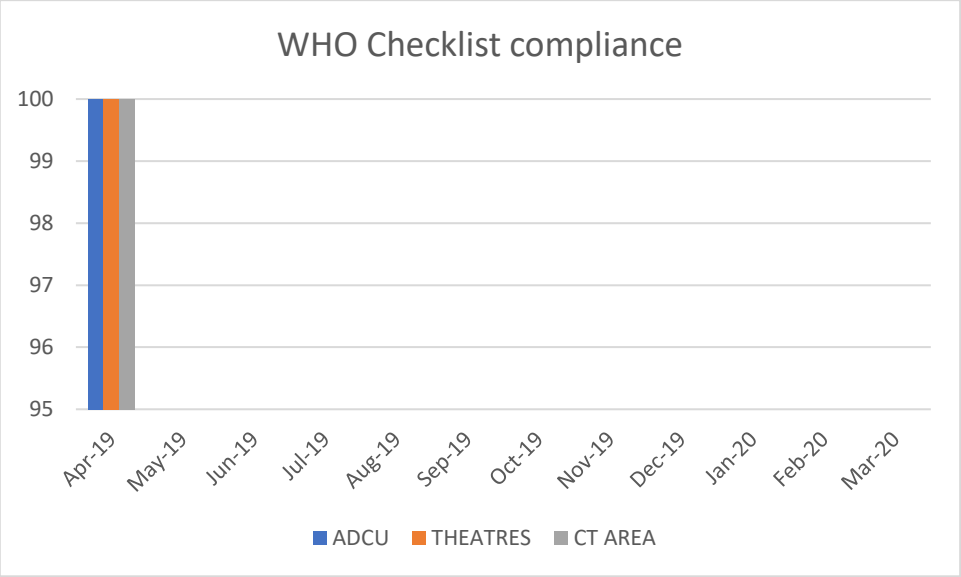
Pre-Application Disclosure Requests*
7 new requests for Pre-Application Disclosure of medical records were received in April 2019.

**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 General Data Protection Regulations 2018 and the Access to Health Records Act 1990).*

13. Coroner's Inquests

There were no Inquests held in April 2019

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.



Data Source – Theatreman and local audits

INFORMATION
The data is retrieved from Theatre man. On review of the audit process, the incomplete 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 = 673 The total WHO compliance for Theatres in April 2019 = 100% **CT area** Total cases = The total WHO compliance for CT in April 2019 = 100% **ADCU** The snapshot WHO audit compliance for ADCU in April 2019 = 100%
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
WHO checklist for ADCU 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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in April 2019 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	1	1

ACTIONS FOR IMPROVEMENTS / LEARNING

9 IP recorded incidents in April, 2019 (6 no harm, 3 low harm – all either under review or closed).

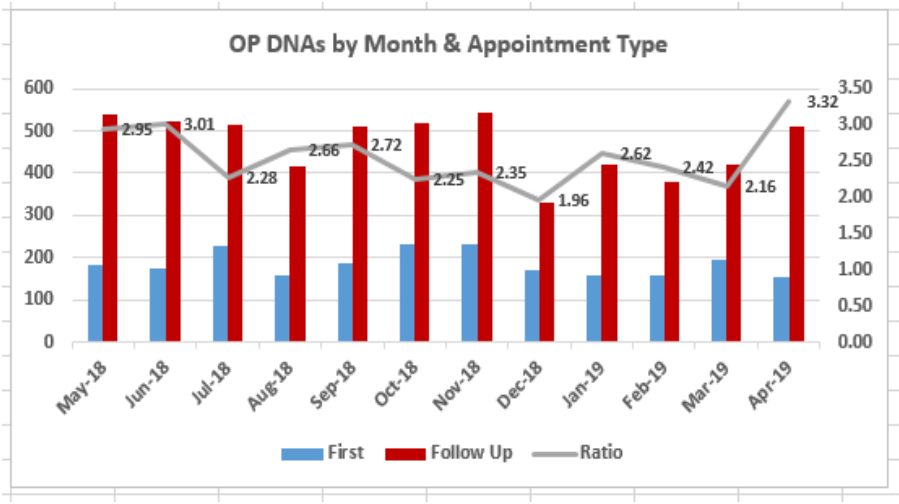
Pseudomonas aeruginosa BSI (post 48hours) – presently under PIR.

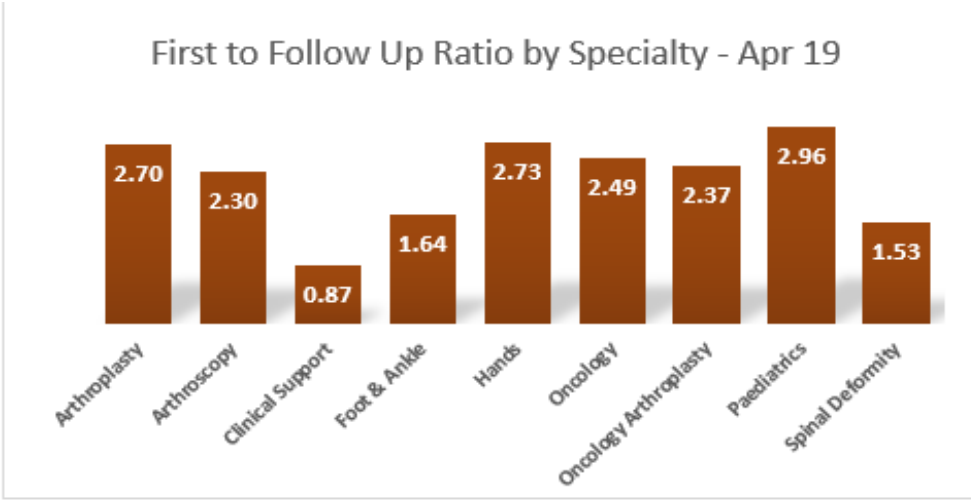
RISKS / ISSUES

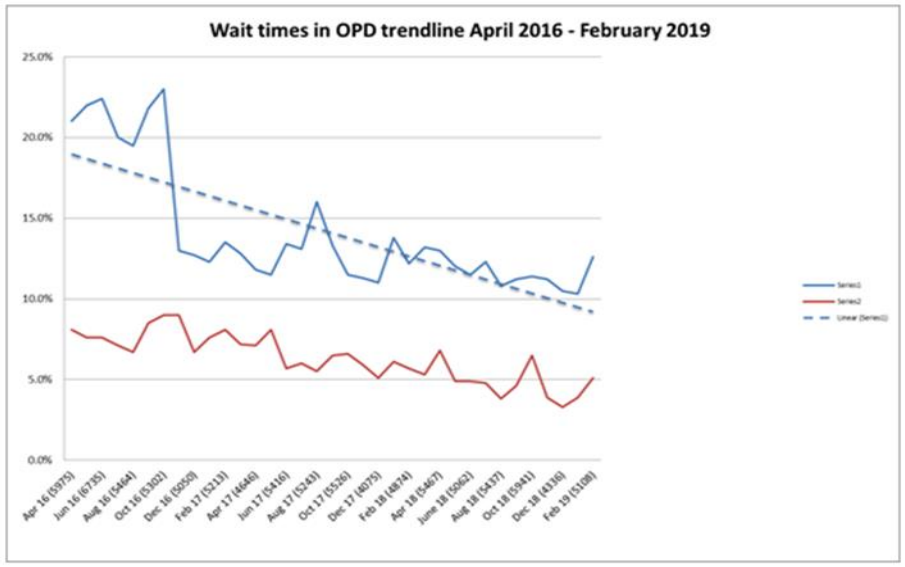
ROH continues to review the status of staff requiring Hepatitis B vaccinations and ensure vaccinations are provided where required.

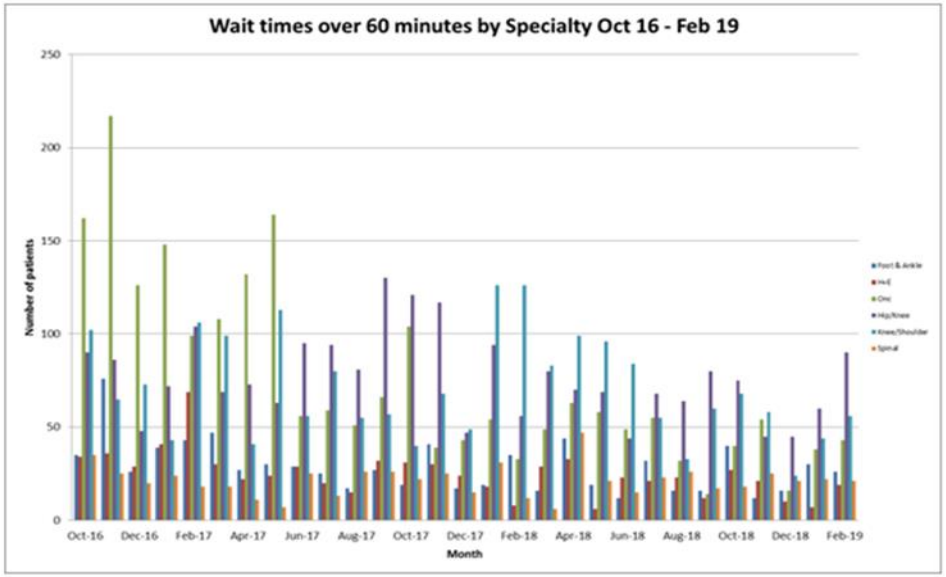
***Data Source – IPC team and Ulysses**

16. 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 11.1% of patients waiting over 30 minutes which is a very small deterioration on last month (from 11%). The target for 30 minute delays has not been achieved but progress is being made . The over 60 minute delays have improved since last month to 3.4% from 4.4% and again remain below the target of 5%. This is now the 10th month in the last year that the over 60 minute target has been achieved.

An accurate master timetable of the outpatient department clinics now exists and the 643 meetings continue to take place every Wednesday. Over the last few weeks there has been representation from the imaging department at this meeting which they have feedback they have round useful. This meeting has also manged to reduce the number of times clinicians attended clinic with no allocated room further avoiding delayed clinic start times. This reduction is anecdotal as previously there was no category of clinic delay incident of “Room Availability”. This has now been created so issues surrounding room allocation can be monitored in the future.

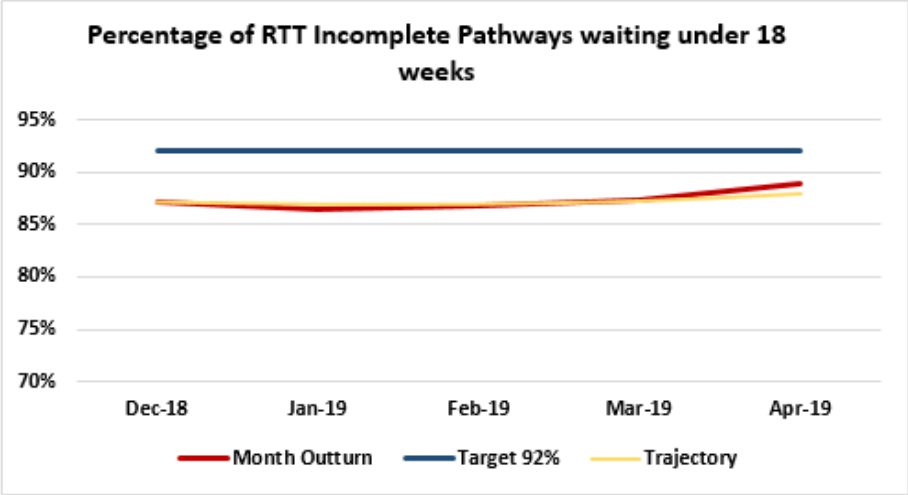
There were 12 incidents of clinic delays reported in April 2019 with the following breakdown.

- 5 Other
- 2 Room availability
- 2 Clinic Overbooked for Number of Staff
- 1 Clinic Overbooked
- 1 Complex patient
- 1 Consultant / clinician delay

Allocate – the electronic annual leave requesting platform has been introduced to the medical teams with a planned go live date of 21st May 2019. By booking leave electronically it is expected that this will improve the process of authorisation and ensuring clinics are reduced appropriately.
There are now 2 notice boards in Outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation. This should further improve communications with clinical staff.

ACTIONS FOR IMPROVEMENTS / LEARNING
• Utilise the outreach clinics at Lordswood whilst investigating further options for additional space either at Lordswood or another site • Set up the outpatient project improvement group as part of the Continuous improvement 'Perfecting Pathways' projects. • Review of clinic space for "new adult clinics" moving from the paediatric outpatients
RISKS / ISSUES
• The process for partial booking has been started as a pilot in Pain and this will continue to be monitored. This will need to be reviewed alongside the Appointments team workforce to inform the resources required in future Business case for full roll out .

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



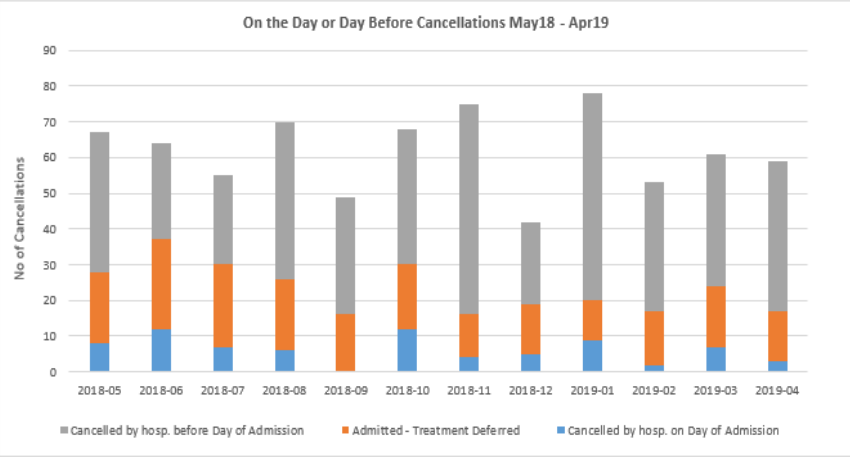
Referral to Treatment Trajectory: Trust Wide Position

RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,478	7,511	7,543	7,571
Over 18 Weeks	1,080	1,091	1,089	1,062	997	931	867	799	732	651	605	560	520
Totals	8,436	8,365	8,370	8,361	8,334	8,305	8,278	8,248	8,219	8,129	8,116	8,103	8,090
RTT %	87.20%	86.96%	86.99%	87.30%	88.03%	88.79%	89.53%	90.31%	91.09%	92.00%	92.54%	93.09%	93.58%

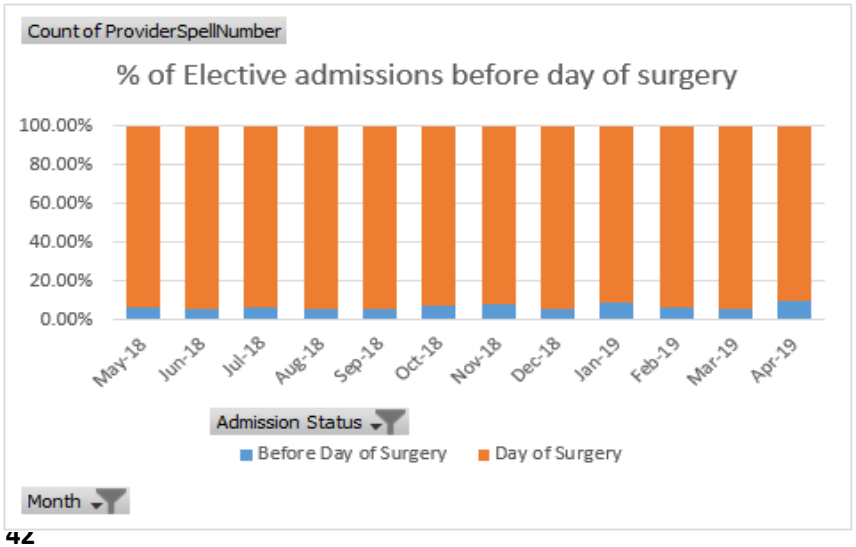
INFORMATION
In April the Trust had 0 patients over 52 weeks which is a significant achievement for the Trust. There were 21 patients over 40 weeks and these patients are monitored weekly to track progress and ensure treatment plans are in place.
ACTIONS FOR IMPROVEMENTS / LEARNING
The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019. April 2019 performance is 88.05% against a trajectory of 88.03%
RISKS / ISSUES

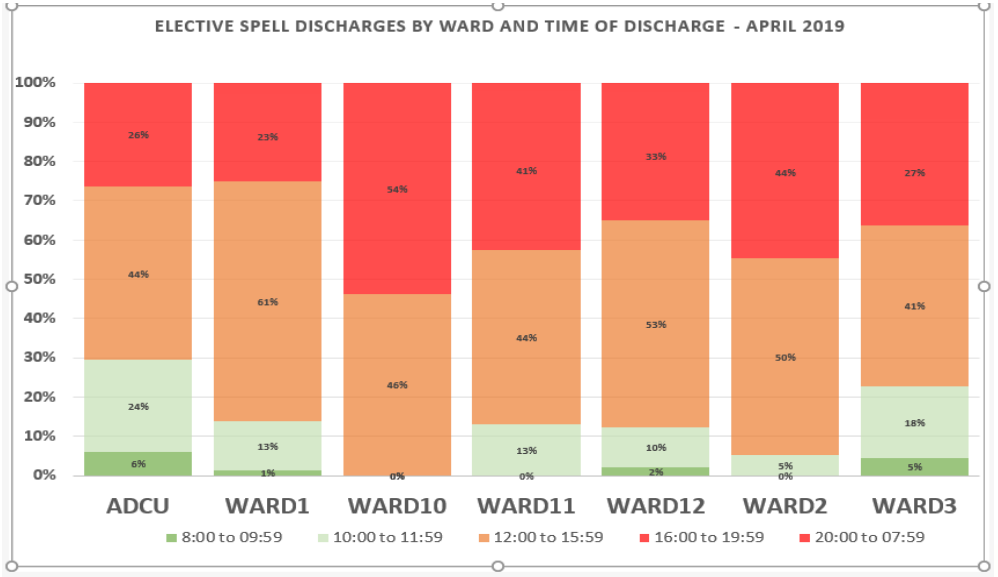
18. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

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
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	44	70	0
2018-09		16	33	49	1
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	42	59	0
Grand Total	75	205	461	741	1





INFORMATION

The number of cancellations on the day of admission for surgery in April was 3 patients. Two were patient choice and did not wish to proceed and one was a patient unfit needing further investigations.
Patients admitted for surgery where treatment was deferred improved slightly in month from 16 to 14. Analysis of patients admitted where treatment was deferred relates to, lack of theatre time, medically unfit and equipment availability and patients who had not followed fasting instructions.

Cancellations before the day of surgery have increased slightly in month from 33 to 36. An analysis of the 36 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, consultant unwell and patient medically unfit following preassessment.

The 72 hour call to patients has been embedded as a standard process and continues to work well highlighting any issues before surgery. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in May 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre was successfully launched on April 8th 2019. This change has been a significant achievement by the team and has already received a great deal of positive feedback from both staff and patients .

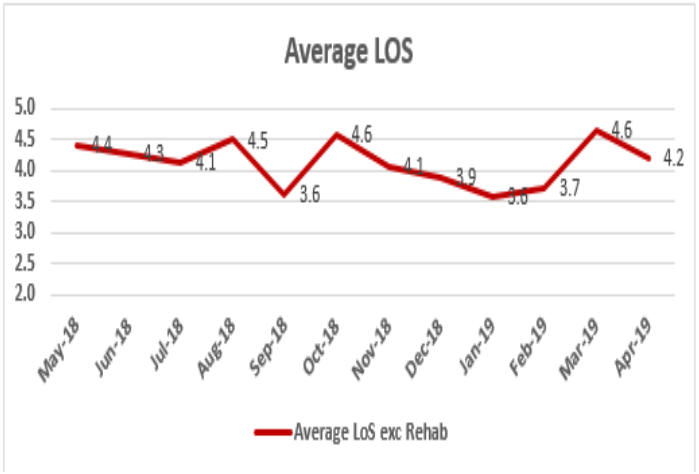
A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements

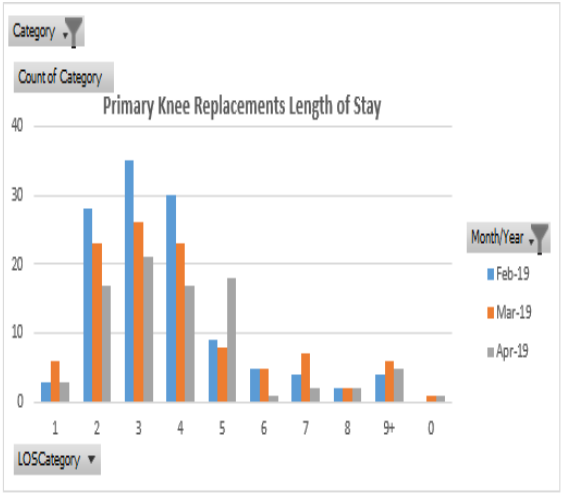
ACTIONS FOR IMPROVEMENTS / LEARNING

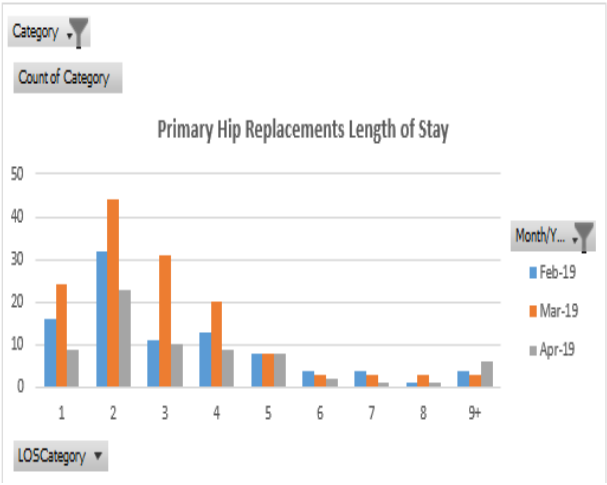
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :
POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
Escalation to CSM where patients cannot be contacted prior to surgery

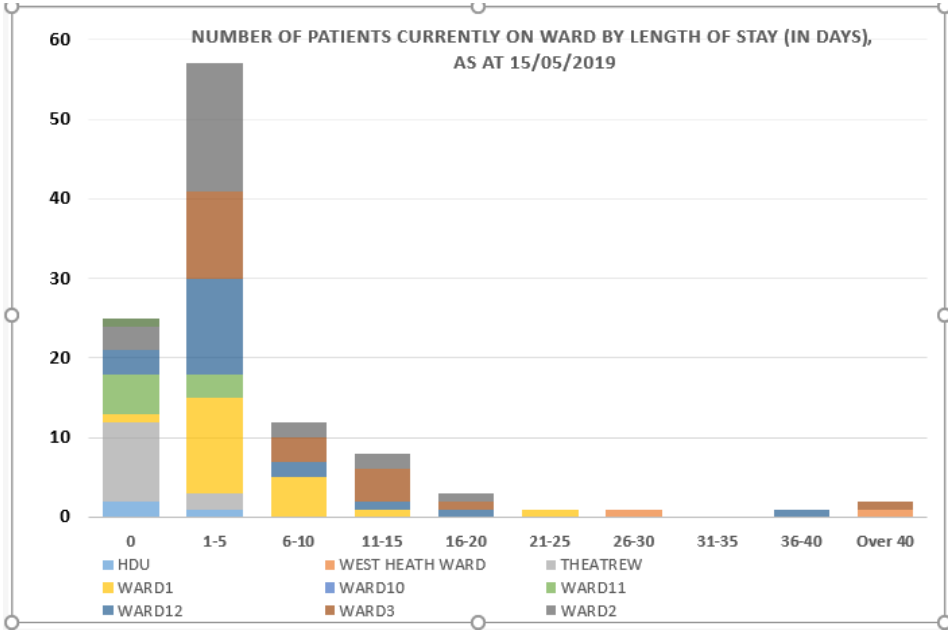
Review of booking process by secretarial teams to develop a standard Operating procedure working closely with POAC and ADCU
RISKS / ISSUES
The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

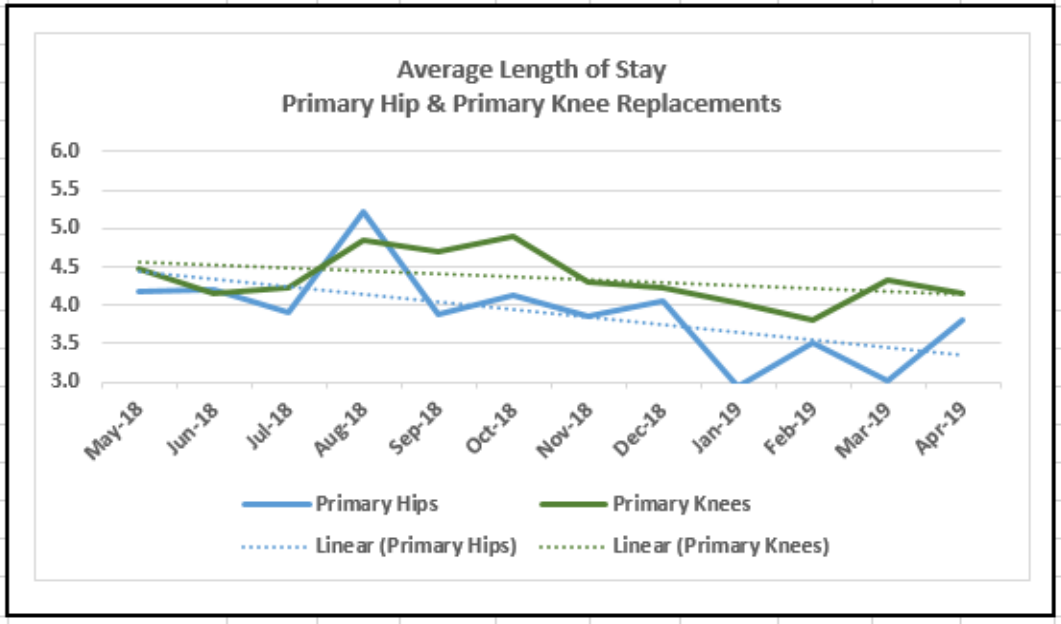
19. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in April was 4.2 days and improvement from March at 4.6 days.
The data gathered demonstrates that LOS for primary hips increase in month whilst LOS for primary knees decreased.

April's data includes the theatre shutdown and also a considerable number of patients which social packages and additional medical needs that impacted on the average LOS in month.

It is therefore concluded that the mean average of 4.2 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives in place to continue to drive down length of stay including:

- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy and a pilot will be rolled out in June led by the CSL.
- The discharge lounge is well utilised by all adult inpatient wards. With 267 being discharged in April and discharges before midday rose to 36% . This is the key focus now for all areas in order to improve efficiency and patient experience.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Review the format for reviewing LOS to demonstrate more meaningful data- correlating with joint care data.
- Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Funding secured and recruitment in progress to support out of ours ward clerk support to ensure timely ADT .

RISKS / ISSUES
• A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity . • Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

Finance and Performance Report

April 2019

CONTENTS

INTRODUCTION

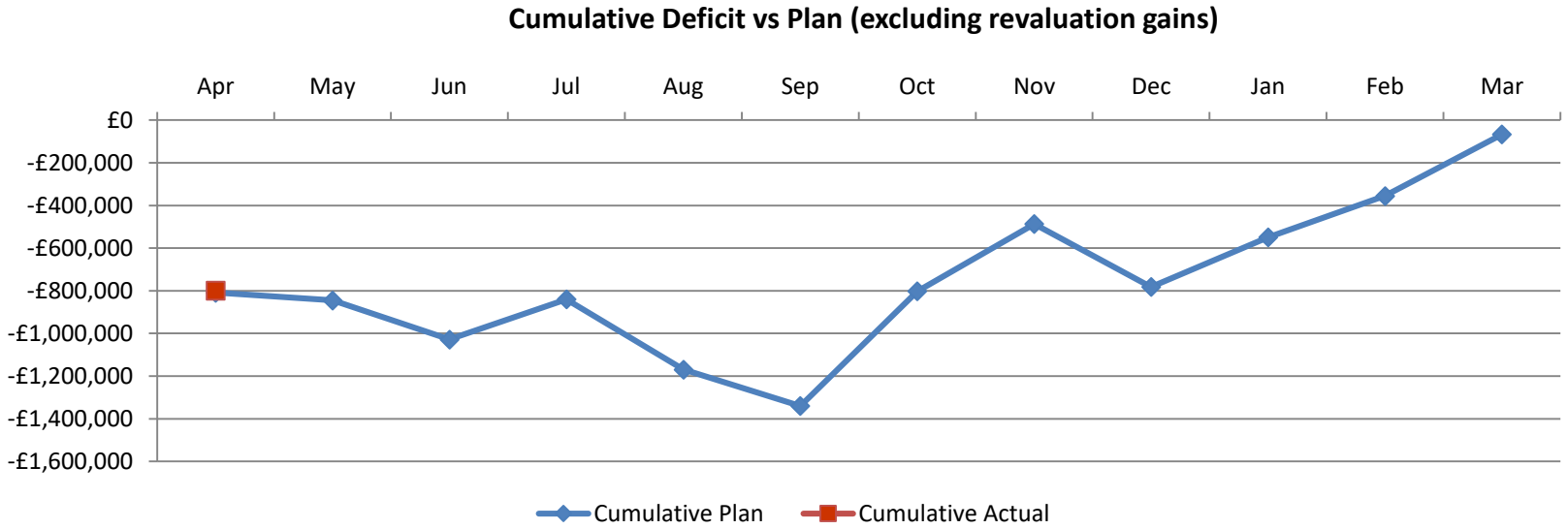
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

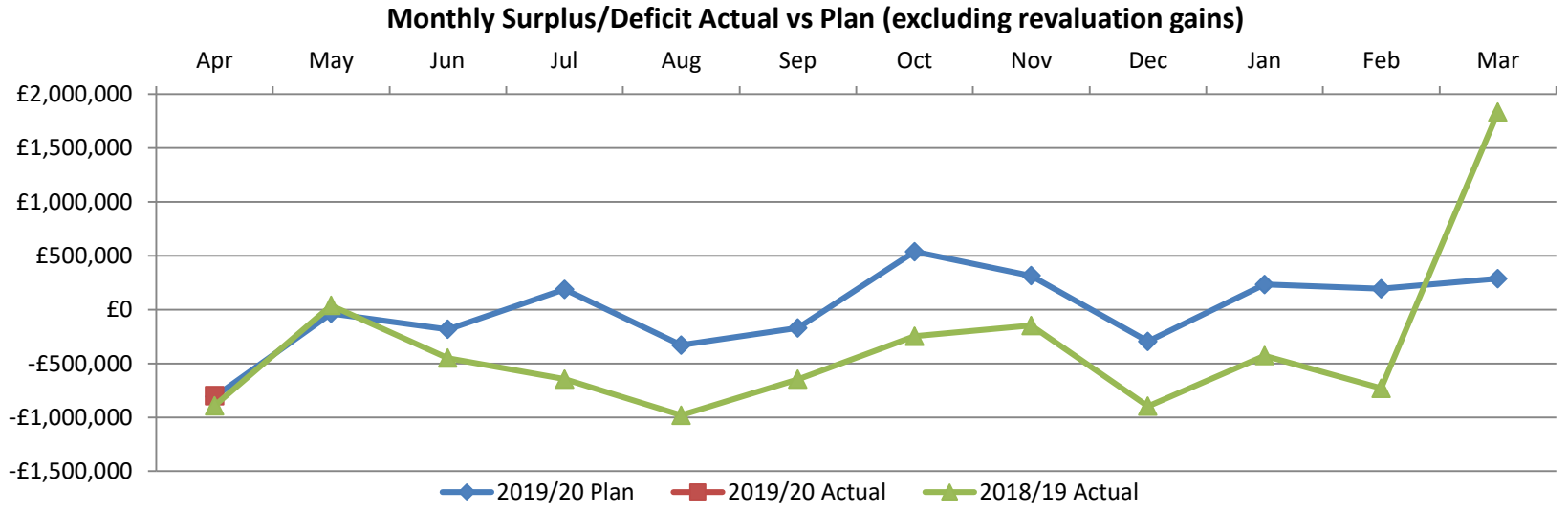
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M01 Original Plan £'000	YTD M01 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	6,025	6,220	195
Other Operating Income	648	636	-12
Total Income	**6,673**	**6,856**	**183**
Employee Expenses (inc. Agency)	-4,564	-4,659	-95
Other operating expenses	-2,803	-2,891	-88
Operating deficit	-694	-694	0
Net Finance Costs	-115	-105	10
Net deficit	-809	-799	10
Remove donated asset I&E impact	5	5	0
Adjusted financial performance (inc PSF& FRF)	-804	-794	10

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). This includes PSF & FRF





INFORMATION

Trust delivered an in-month deficit of £799k in April against a planned deficit of £809k, £10k favourable against plan.

Clinical income has overperformed by £195k against plan in April mainly due to increased IP activity which is offset by an increase in both pay and non pay expenditure incurred to deliver this activity at £95k and £88k respectively.

Pay spend relates to Agency and Bank usage in particular continued use of Agency Radiographers due to vacancies and sickness.

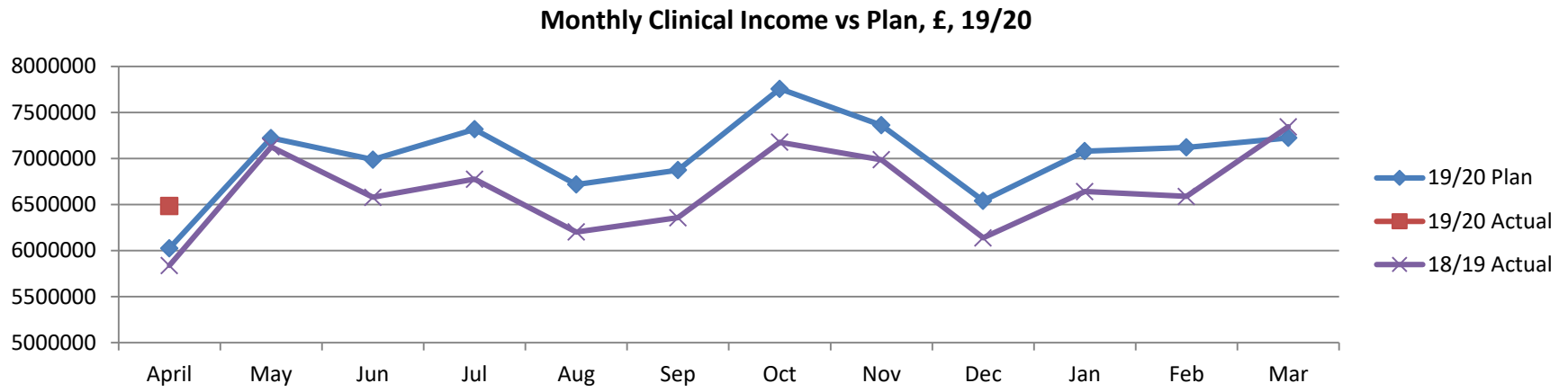
Non Pay is driven by the activity and subsequent clinical supply costs.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

Month 2 has a challenging financial target at a surplus of c.£36k.

2. Income and Activity– This illustrates the total income generated by the Trust in 2019/20, including the split of income by category, in addition to the month's activity (Inc PSF & RFF)



Clinical Income – April 2019 £'000			
	Plan	Actual	Variance
Inpatients	2,862	3,119	257
Excess Bed Days	33	56	23
Total Inpatients	2,895	3,175	280
Day Cases	731	770	39
Outpatients	709	658	-51
Critical Care	168	183	15
Therapies	193	236	43
Pass-through income	183	225	42
Other variable income	611	438	-173
Block income	535	535	0
TOTAL	6,025	6,220	195

Clinical Income – Year To Date 2019/20 £'000			
	Plan	Actual	Variance
Inpatients	2,862	3,119	257
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Total Inpatients	2,895	3,175	280
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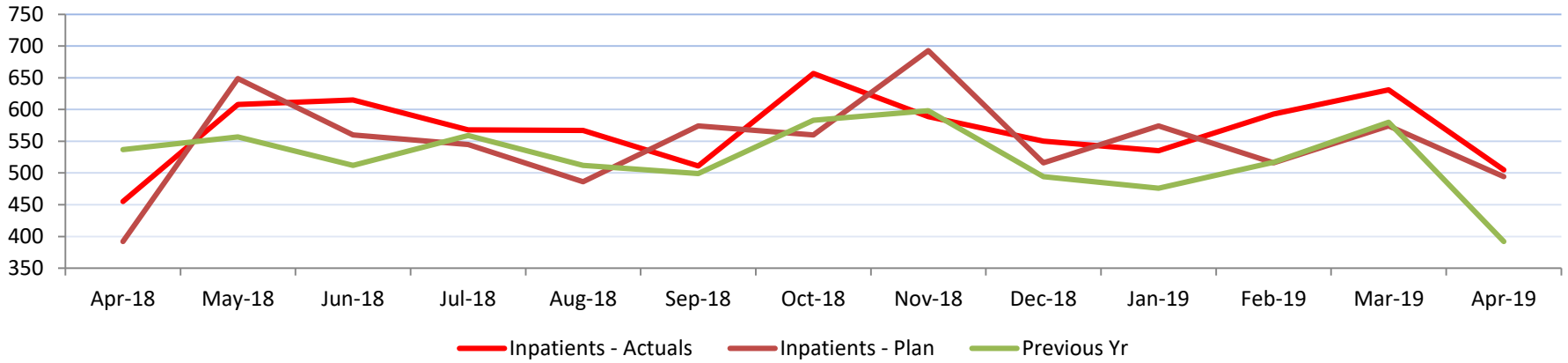
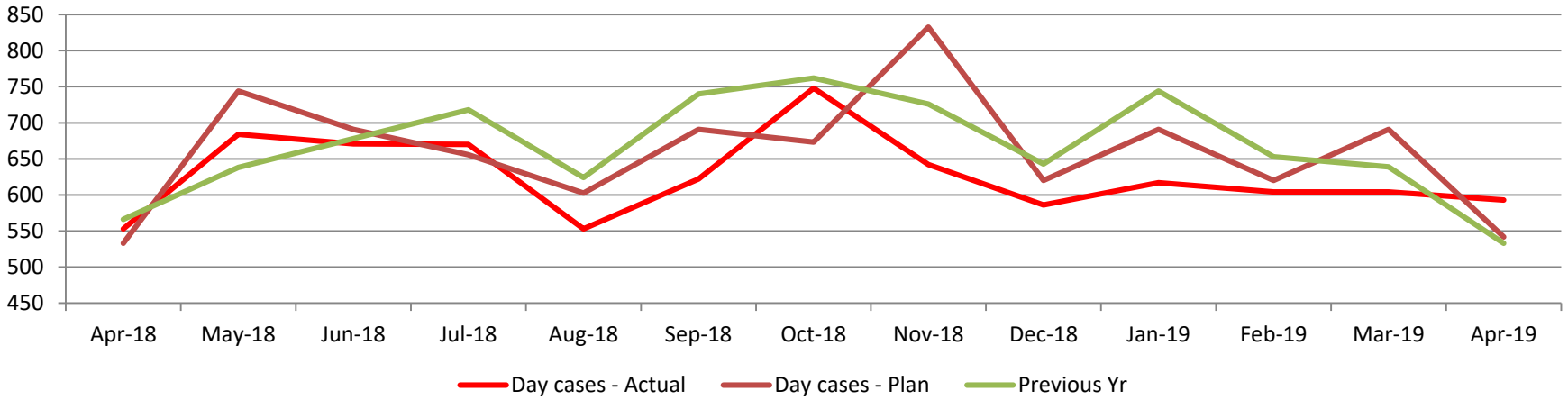
TOTAL	6,025	6,220	195

Inpatient Activity



Day Case Activity



NHS Clinical income has over-performed against plan by 3.2% in April, Circa £195k.

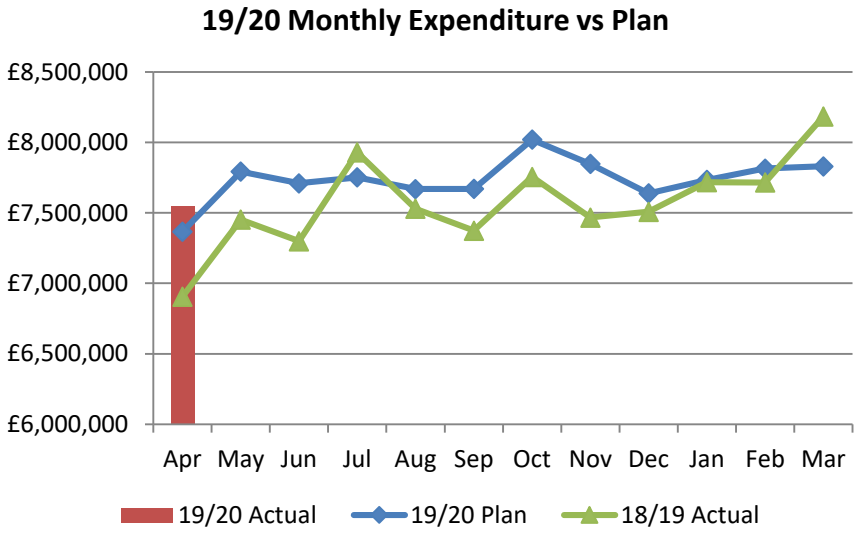
Inpatient income has overperformed by £319k at £3,945k against a plan of £3,636k relating to a combined overperformance on activity of 1098 against a plan of 1036. Therapies and pass through income has also overperformed by £43k and £42k respectively.
This is offset by a reduced Outpatient target of (£51k) and reduced other variable income such as Diagnostic Imaging, Pre Op and the ROC's service (£173k)

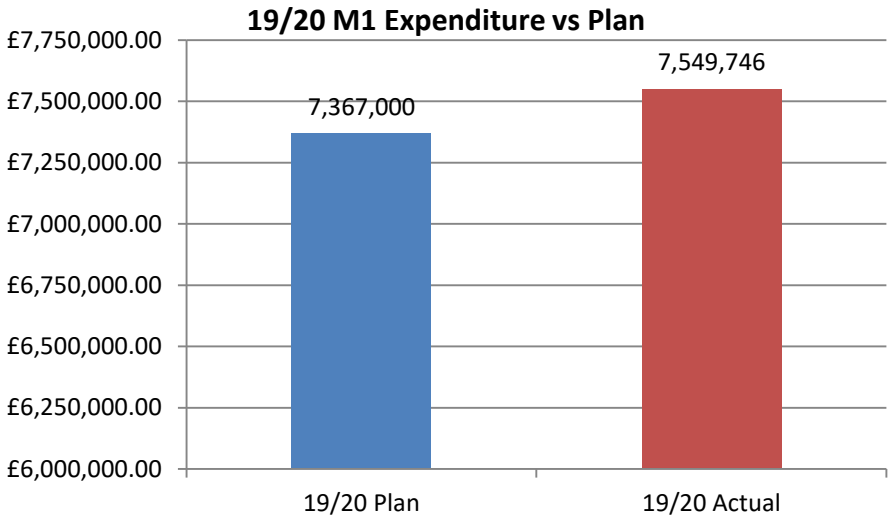
ACTIONS FOR IMPROVEMENT/LEARNING

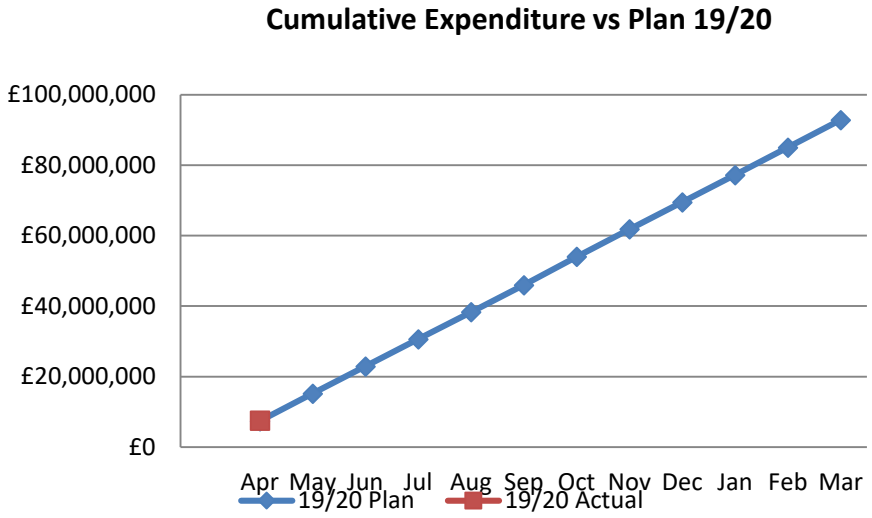
RISKS / ISSUES

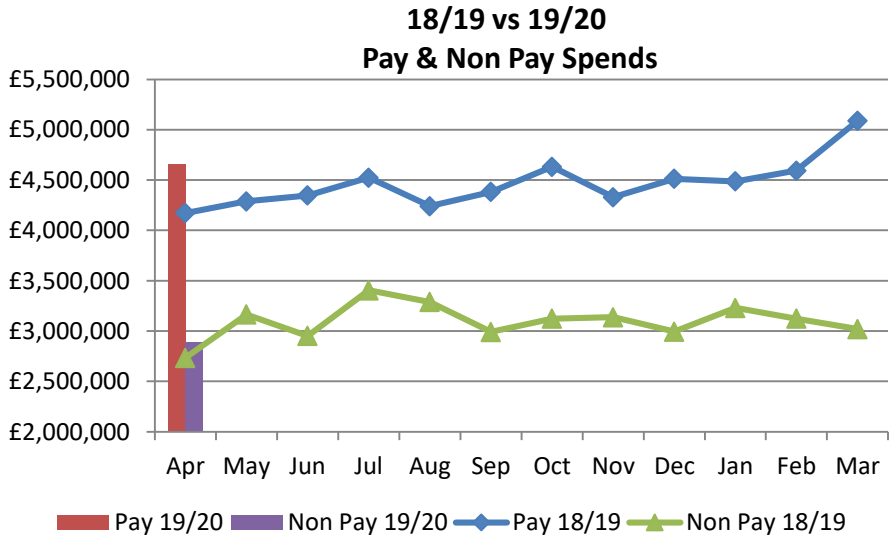
Inpatient plan for May is 1237 which is an increase against April's performance of 139 which will prove challenging given the initial activity recorded upto the 26th May being 953 with a future plan of 161 for the final week.

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









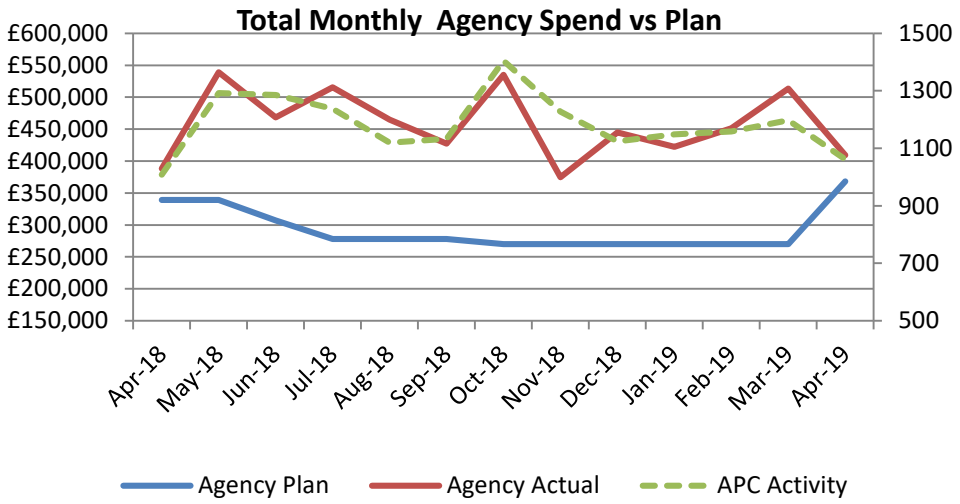
INFORMATION

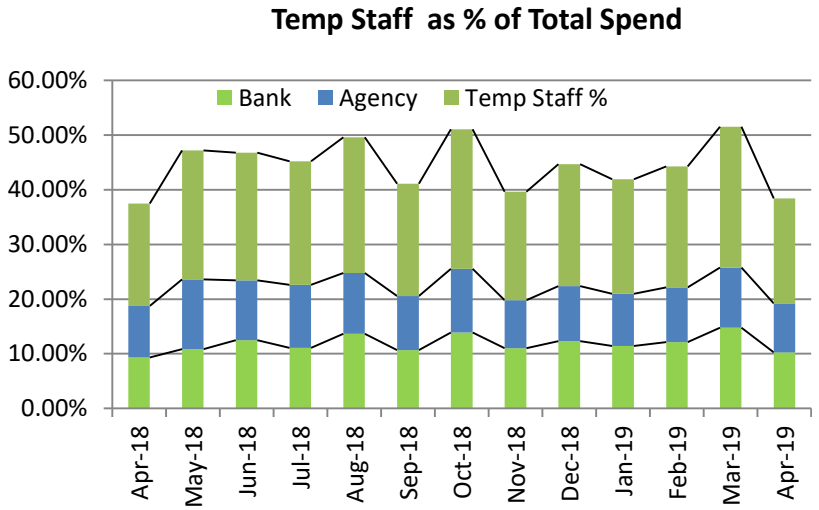
April's expenditure was £7,550k, which was higher than the planned spend of £7,367k. This reflects the increase in activity performed in month

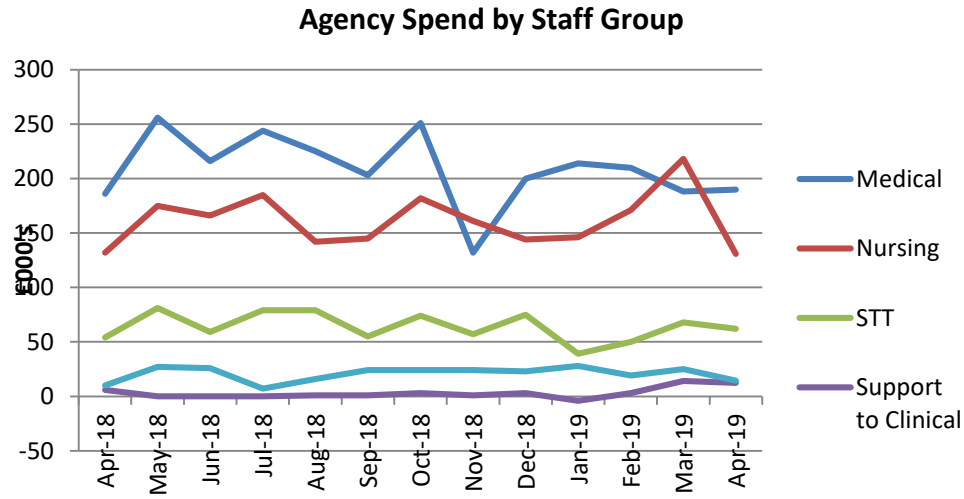
Pay was higher than plan by £95k. Which is mainly reflected in an increase against plan for agency and bank.

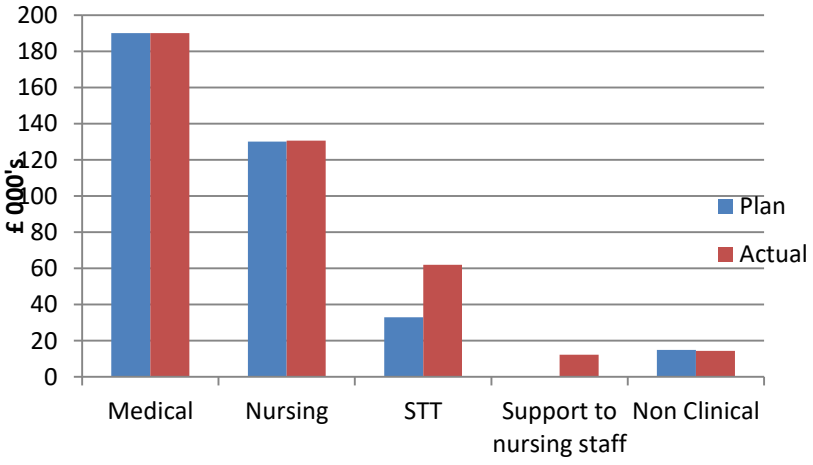
Non pay spend was higher than plan circa £88k which again reflects the increase in planned activity.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

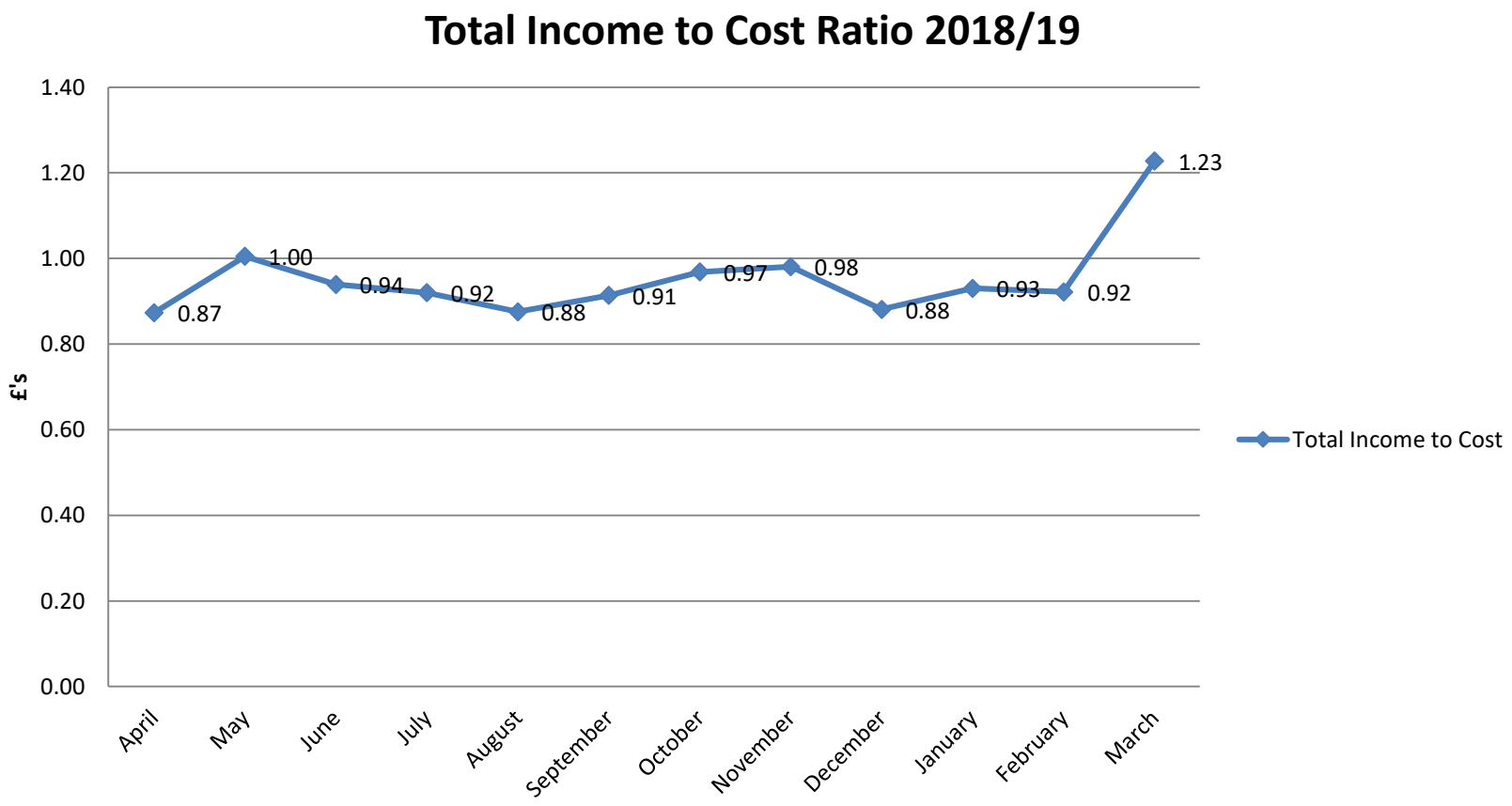
Total agency spend for April was £410k against a plan of £368k relating to a continued use of Radiographer agency to cover vacancies and sickness. There has been an overall reduction in agency costs compared to March 19, this is reflected in a reduced use of agency Nursing across all wards.

Bank spend in month was £464k against a plan of £425k, main variance to plan centres around Admin and Clerical bank being used.

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 are approved by the relevant Matron and head of Nursing.


Total Income to Cost Ratio 2018/19
1.40
1.20
1.00
0.80
0.60
0.40
0.20
0.00
£'s
0.87
1.00
0.94
0.92
0.88
0.91
0.97
0.98
0.88
0.93
0.92
1.23
April
May
June
July
August
September
October
November
December
January
February
March
Total Income to Cost

INFORMATION

The graphs above, and the associated narrative, relate to the year 2018-19.

The first slide is shows the contribution each Directorate is generating, currently the Trust target is set at >20%.

The next two graphs show at a total contribution level for the year, which HRGs bring the highest contribution to the trust, and conversely the largest negative contribution. Major hips and knees perform well, whereas it can be seen that spinal work can be quite mixed, and that more 'minor' procedures such as biopsies and aspirations can contribute negative contributions for the hospital.

The Final slide shows the ratio of income generated per cost expended, this highlights that on average for every £1 that has been spent only £0.95p of income was generated.

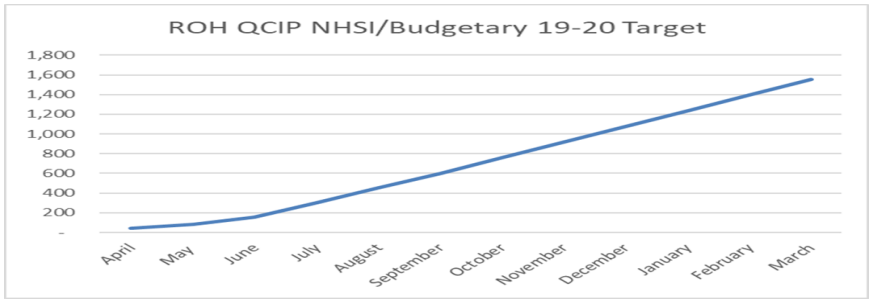
ACTIONS FOR IMPROVEMENTS / LEARNING

It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

RISKS / ISSUES

The costing team remains a small team , and as such significant pieces of work (such as the costing returns) are at risk of having an impact on the ability for the function to maintain constant presence with the operational and clinical teams. This is continuing to be reviewed with a view to cross cover and training to improve resilience.

5.Cost improvement Programme – This illustrates the plan for the 2019-20 cost improvement programmes (£000's)



Row Labels	Sum of 19-20 NHSI CIP Plan	Sum of 19-20 Internal ROH Plan
1	590	732
2	826	1,080
4	71	118
Corporate	66	363
Grand Total	**1,553**	**2,294**

Row Labels	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	19-20 Total
1	14	14	24	58	58	58	61	61	61	61	61	61	590
2	23	23	36	79	79	79	85	85	85	85	85	85	826
4	3	3	5	5	6	6	7	7	7	7	7	7	71
Corporate	2	2	6	6	6	6	6	6	6	6	6	6	66
Grand Total	**42**	**42**	**71**	**148**	**149**	**149**	**159**	**159**	**159**	**159**	**159**	**159**	**1,553**

The Trust QCIP (Quality and Cost Improvement Programme) target was identified at £1.553m for 19-20. In 18-19 the Trust target was identified at £2.985m, however only £1.688m (57%) was delivered. Thus, during the 19-20 business planning (and QCIP) round, schemes up-to £2.294m have been identified as opportunities for this year. (With the difference being a stretch target for the Trusts divisions) Many of the schemes amounting to the Trust target (£1.553m) have been costed, however some (including the stretch target schemes) remain aspirational at present and costings are ongoing.

All of the schemes identified at present are recurrent schemes, QCIP PID/QIA (project initiation documentation including costings and quality impact assessment) completion is currently ongoing, with an internal completion target date for the Trusts divisional teams set at 7th June 2019. (Date of 2nd QCIP board for 19-20)

The Trust has delivered its April 2019 CIP plan (£42k) and is on track to deliver its May 2019 plan. (£42k) However the significant increase to the plan post June 2019 creates a financial risk to the Trust, mitigation plans to prevent under-delivery (as per 18-19) are in-place (stretch targets/already scoping additional opportunities) along with greater support, collaborative working (Executive led and project focused delivery of QCIP schemes) and divisional approved forecasts commencing early June 2019.

6. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M1 Plan £'000	M1 Actual £'000	Var £'000
Intangible Assets	1,408	1,408	0
Tangible Assets	46,416	46,416	0
Total Non-Current Assets	**47,824**	**47,824**	**0**
Inventories	7,063	7,063	0
Trade and other current assets	8,246	8,246	0
Cash	2,000	2,000	0
Total Current Assets	**17,308**	**17,308**	**0**
Trade and other payables	(15,568)	(15,568)	0
Borrowings	(726)	(726)	0
Provisions	(84)	(84)	0
Other liabilities	0	0	0
Total Current Liabilities	**(16,378)**	**(16,378)**	**0**
Borrowings	(10,808)	(10,808)	0
Provisions	(215)	(215)	0
Total Non-Current Liabilities	**(11,023)**	**(11,023)**	**0**
Total Net Assets Employed	**37,731**	**37,731**	**0**
Total Taxpayers' and Others' Equity	**37,731**	**37,731**	0

INFORMATION

Month 1 plan and actual are the same as they are based on the revised plan submission to NHSI on the 15th May 2019 which meant the month 1 actual figures were included as plan.

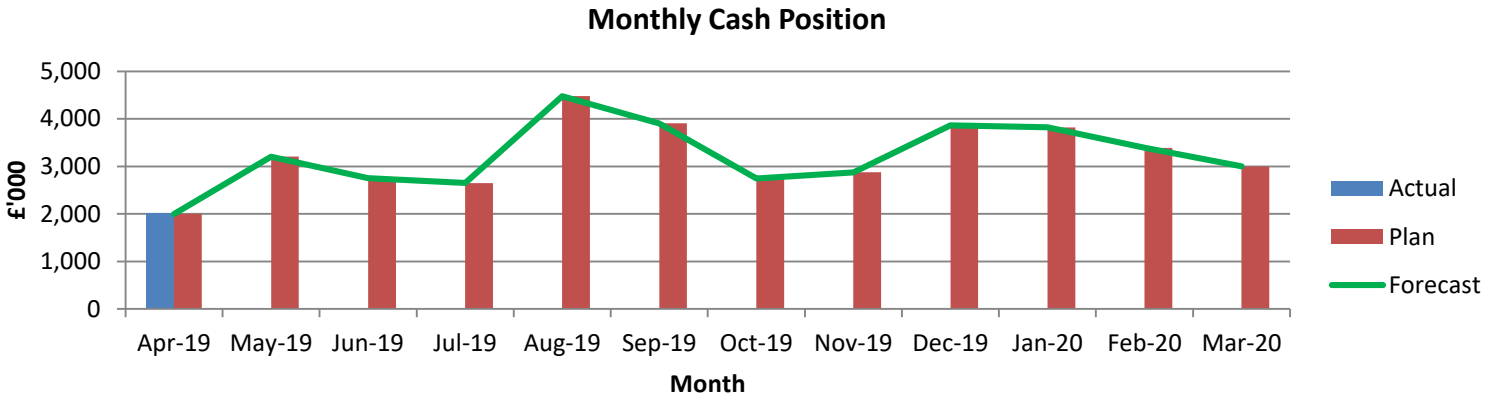
Based on the original plan submission, cash was lower by £0.2m. This was due to 2 SLA payments being received in the first week of May rather than the mandated date of the 15th of April. Inventories are £1.7m higher due to the year end adjustment now being included and a further uplift of stock in month 1. All other balances are broadly in line.

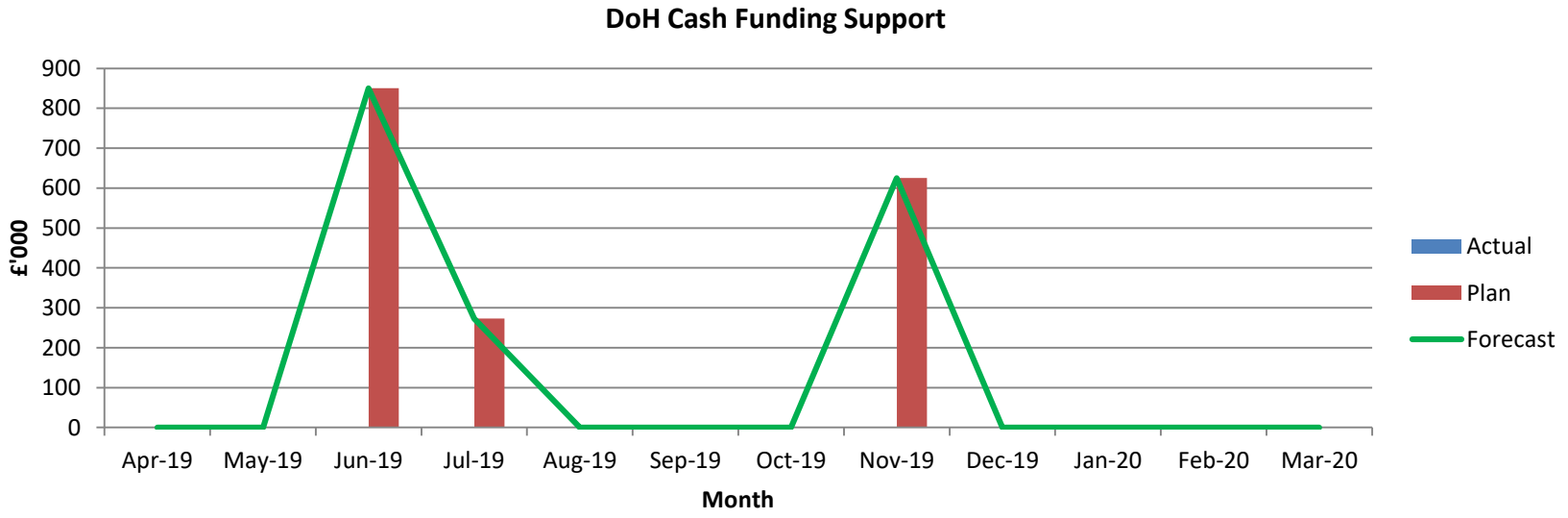
ACTIONS FOR IMPROVEMENTS / LEARNING

Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

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

Cash for month 1 ended at £2m, this broadly in line with plan except for 2 missing SLA payments amounting to £0.2m which were received in the first week of May due to an issue at the CCG.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £850k has been requested from the Department of Health (DoH) for June which is within the plan for 2019/20.

ACTIONS FOR IMPROVEMENTS / LEARNING

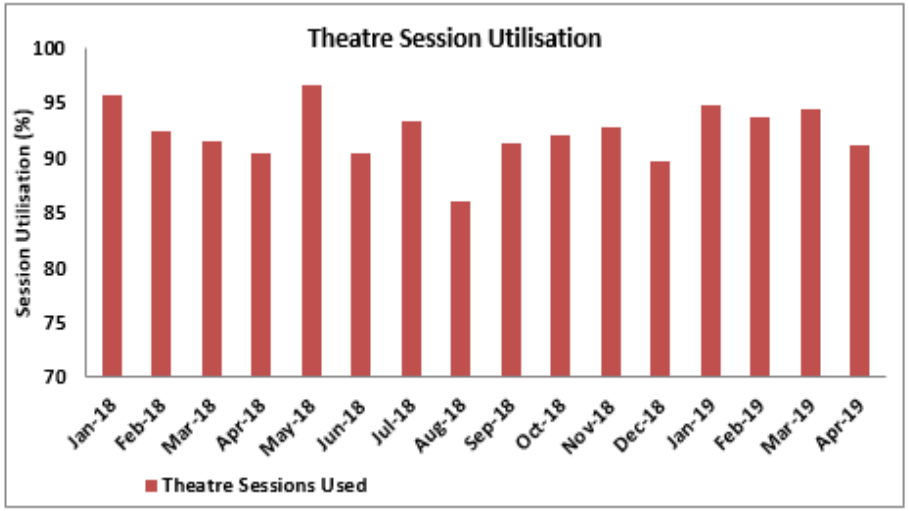
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2019/20. The Head of Financial Accounting continues to hold monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team. 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

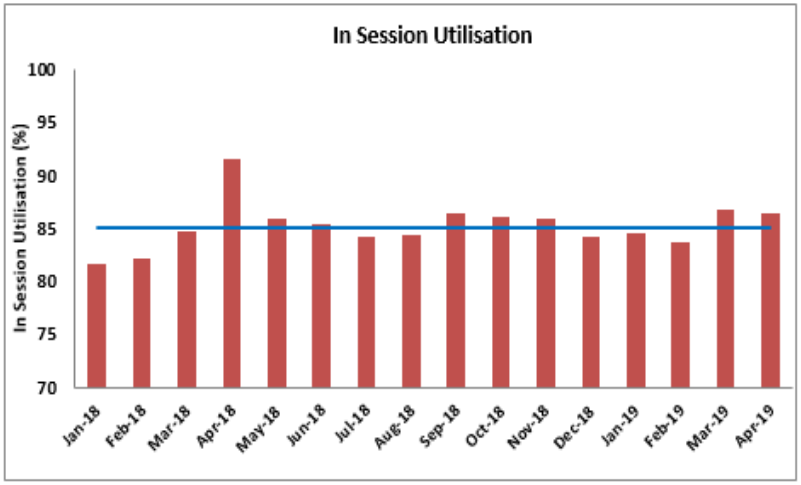
Target 90%

Session utilisation in April was 91.14 compared to March which was 94.47%. The was primary due to consultant leave.

RISKS / ISSUES

- Reduction in recycling of lists due to reduction in extra ADH activity. Due to the pension / tax challenge.
- Theatre recruitment to support future growth – a successful open day in April 19 resulted in 8 offers being made on the day, building on the success of previous recruitment initiatives

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.

On a Tuesday in the pre 642 meet the teams are now carrying out a forward look to reduce the number of patients being listed for surgery who are marked as not fit for surgery on CRD in POAC which should in turn decrease medical cancellations on the day.

ACTIONS FOR IMPROVEMENTS / LEARNING

Target 85%
In session utilisation for April was 86.45%. Achieving above the 85% target for last two months.

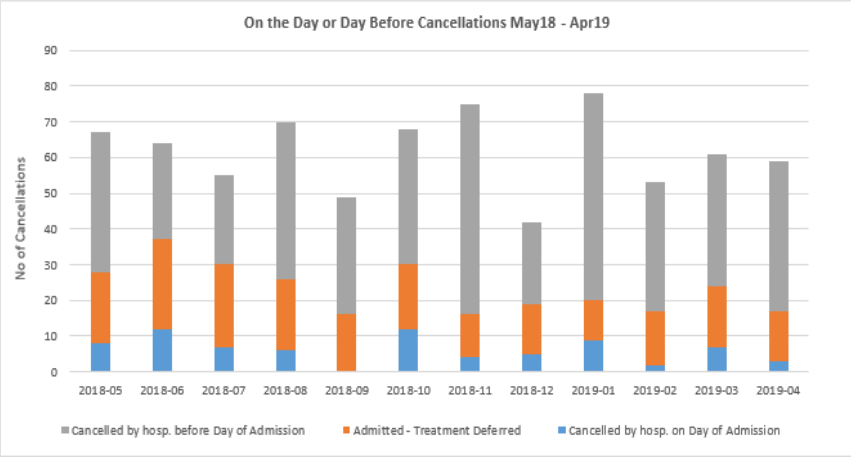
The reconfiguration of POAC, which went live on the 8th April, will have a positive impact on the efficiency of theatre lists going forward.

RISKS / ISSUES

- Last minute changes to lists impact on the efficient running and planning of theatre lists - risk being reduced due to introduction of lock down process and learning from theatre lookback meetings
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

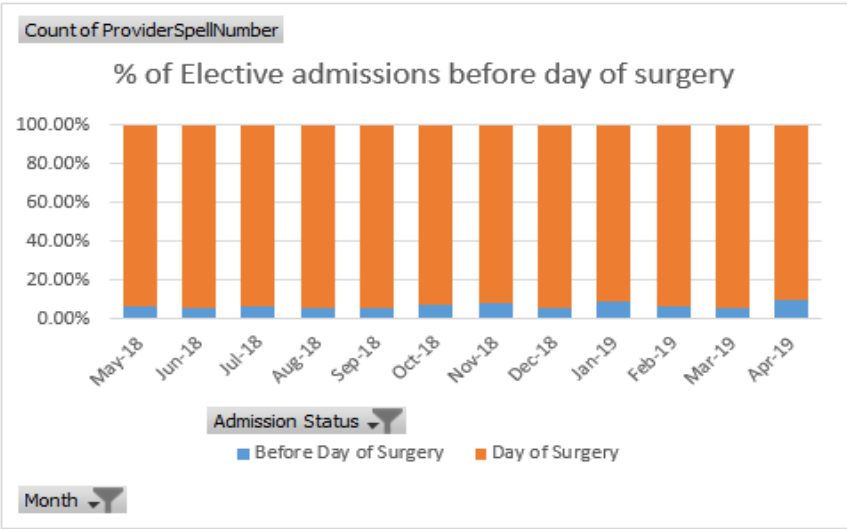
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

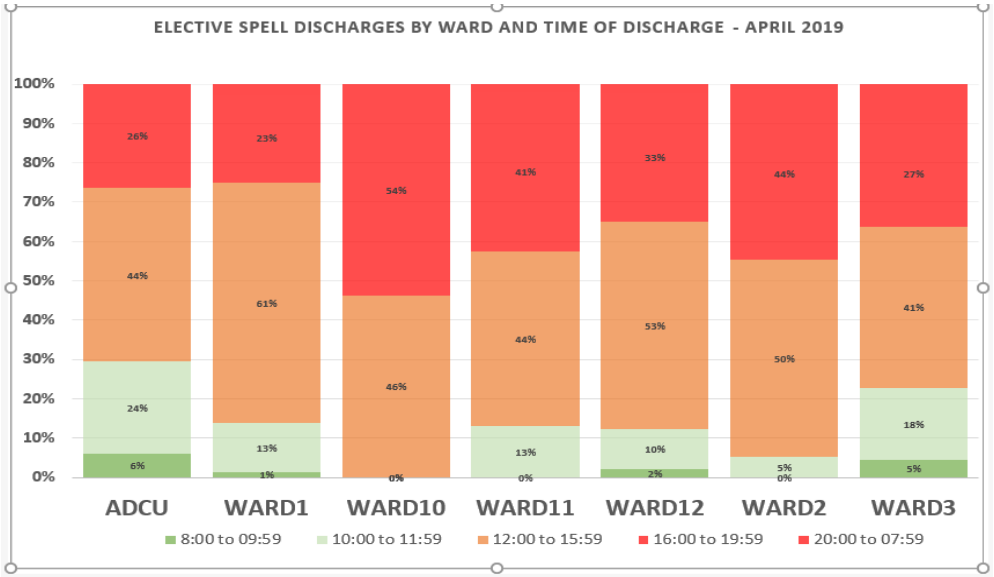
Hospital Cancellations



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
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	44	70	0
2018-09		16	33	49	1
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	42	59	0
Grand Total	75	205	461	741	1

Admission the day before surgery





The number of cancellations on the day of admission for surgery in April was 3 patients. Two were patient choice and did not wish to proceed and one was a patient unfit needing further investigations.
Patients admitted for surgery where treatment was deferred improved slightly in month from 16 to 14. Analysis of patients admitted where treatment was deferred relates to, lack of theatre time, medically unfit and equipment availability and patients who had not followed fasting instructions.

Cancellations before the day of surgery have increased slightly in month from 33 to 36. An analysis of the 36 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, consultant unwell and patient medically unfit following preassessment.

The 72 hour call to patients has been embedded as a standard process and continues to work well highlighting any issues before surgery. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance .

Work continues to strengthen the POAC process and a business case is being presented at DMB in May 2019 to incorporate a full workforce plan which supports the move to over recruitment of staff in preparation to expand activity and improve access. The pathway model is now in place and the roll out of the new triage pre-op centre was successfully launched on April 8th 2019. This change has been a significant achievement by the team and has already received a great deal of positive feedback from both staff and patients .

A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

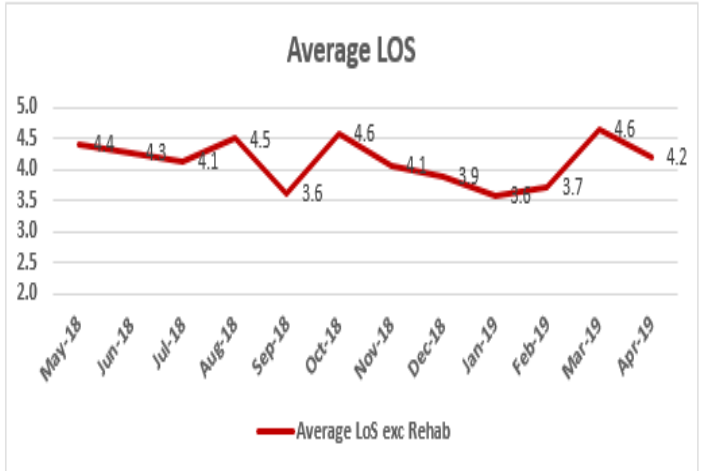
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

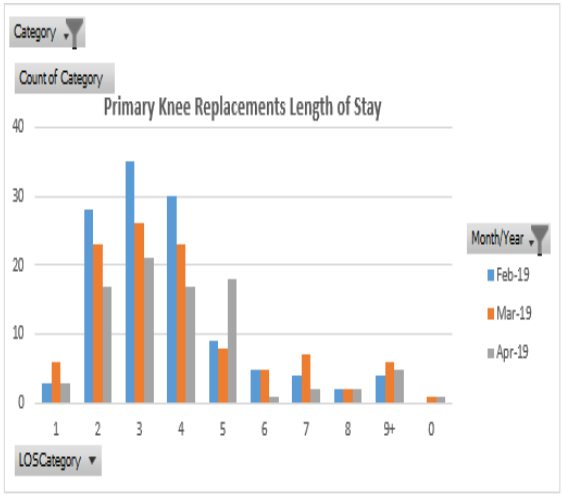
- POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- Review of booking process by secretarial teams to develop a standard Operating procedure working closely with POAC and ADCU

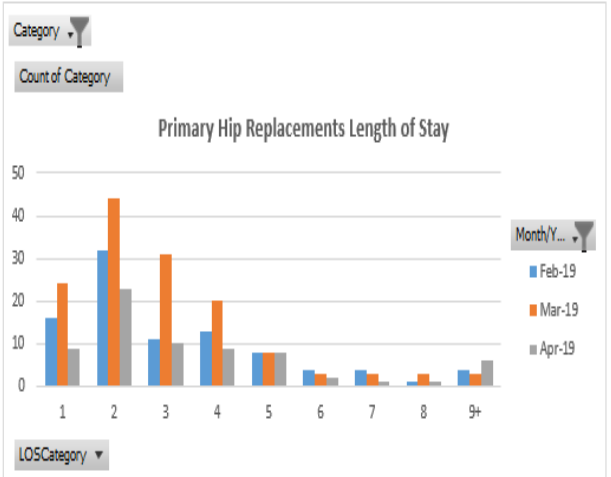
RISKS / ISSUES

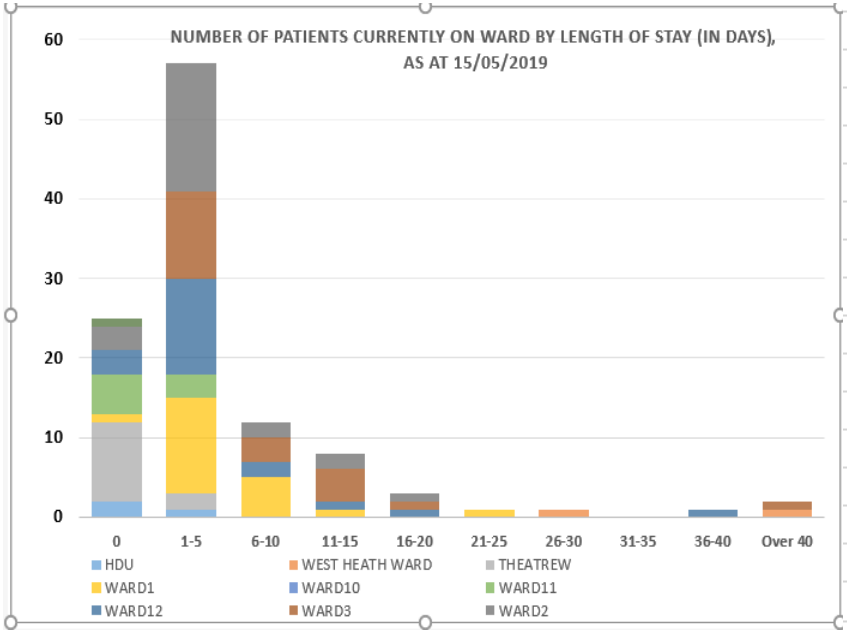
The Managed Service Contract is being developed to support delivery of a rolling replacement programme for all theatre equipment.

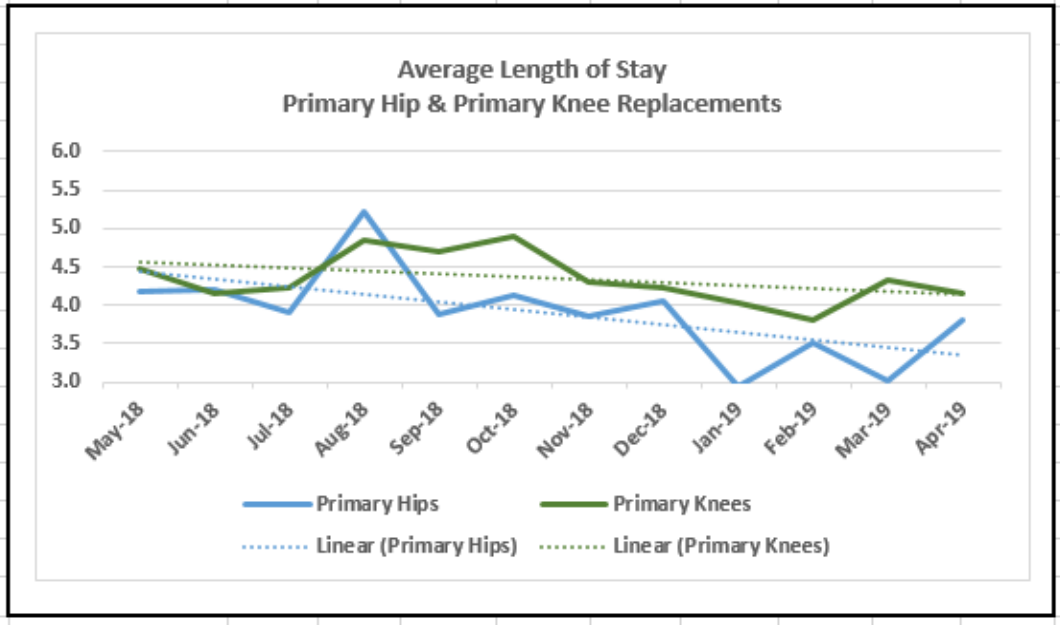
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in April was 4.2 days and improvement from March at 4.6 days.
The data gathered demonstrates that LOS for primary hips increase in month whilst LOS for primary knees decreased.

April's data includes the theatre shutdown and also a considerable number of patients which social packages and additional medical needs that impacted on the average LOS in month.

It is therefore concluded that the mean average of 4.2 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives in place to continue to drive down length of stay including:

- A 1300hrs 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 diagnostics, 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. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- 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. Ward 12 is currently developing a daily ward round with the support of the Consultant team in Arthroscopy and a pilot will be rolled out in June led by the CSL.
- The discharge lounge is well utilised by all adult inpatient wards. With 267 being discharged in April and discharges before midday rose to 36% . This is the key focus now for all areas in order to improve efficiency and patient experience.

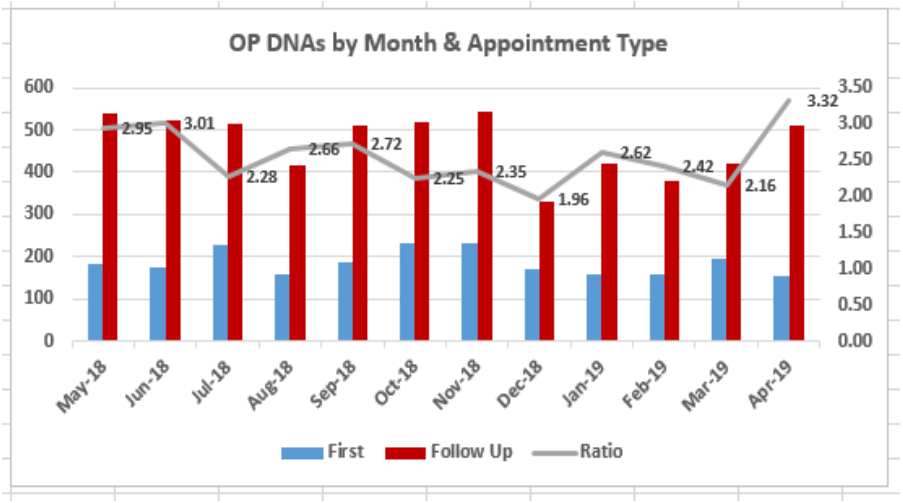
ACTIONS FOR IMPROVEMENTS / LEARNING

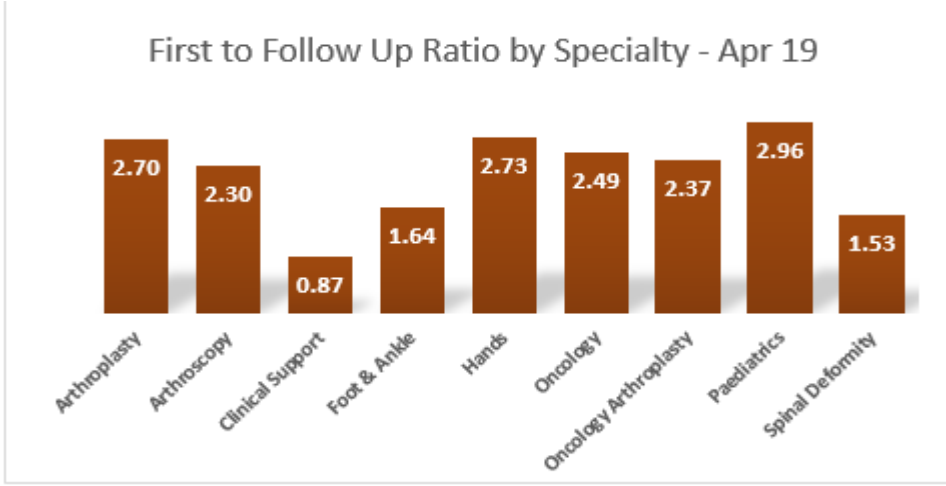
- Review the format for reviewing LOS to demonstrate more meaningful data- correlating with joint care data.
- Consultant led ward rounds on Ward 12 are progressing with Arthroscopy patients being cohorted onto ward 12 to support progress . Ongoing discussions in place with AMD and CSM to facilitate.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Funding secured and recruitment in progress to support out of ours ward clerk support to ensure timely ADT .

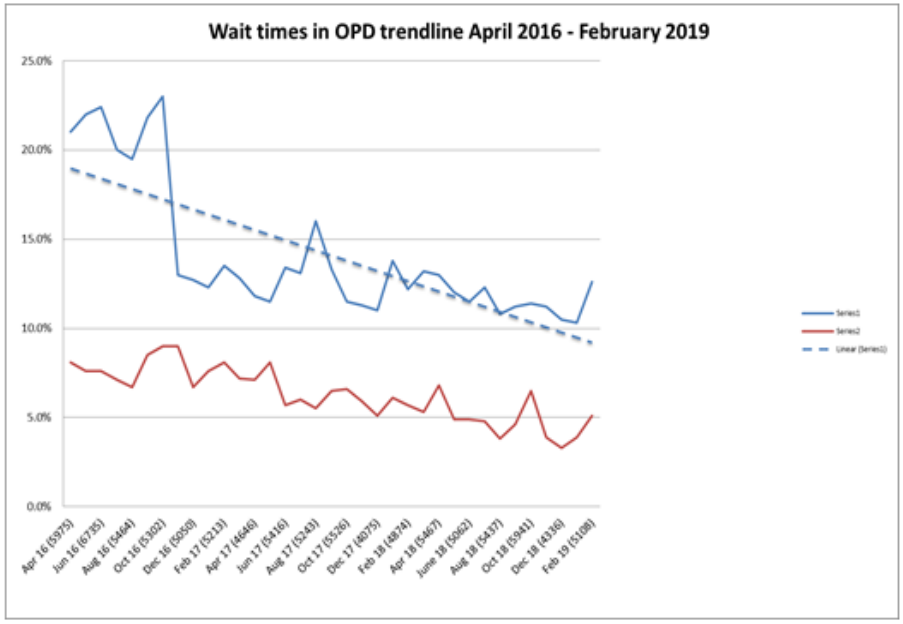
RISKS / ISSUES

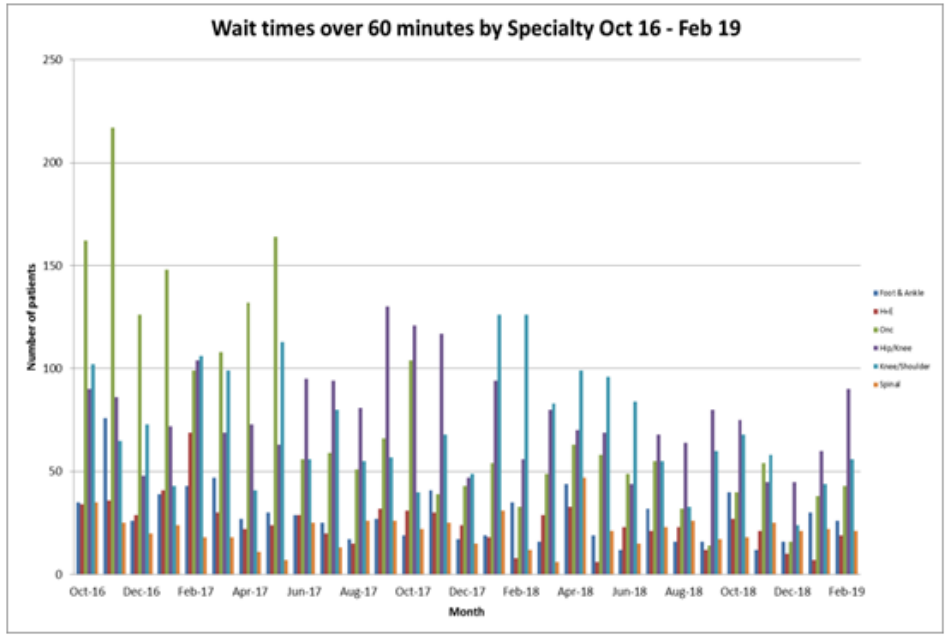
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

12. 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 11.1% of patients waiting over 30 minutes which is a very small deterioration on last month (from 11%). The target for 30 minute delays has not been achieved but progress is being made . The over 60 minute delays have improved since last month to 3.4% from 4.4% and again remain below the target of 5%. This is now the 10th month in the last year that the over 60 minute target has been achieved.

An accurate master timetable of the outpatient department clinics now exists and the 643 meetings continue to take place every Wednesday. Over the last few weeks there has been representation from the imaging department at this meeting which they have feedback they have round useful. This meeting has also manged to reduce the number of times clinicians attended clinic with no allocated room further avoiding delayed clinic start times. This reduction is anecdotal as previously there was no category of clinic delay incident of "Room Availability". This has now been created so issues surrounding room allocation can be monitored in the future.

There were 12 incidents of clinic delays reported in April 2019 with the following breakdown.

5 Other
2 Room availability
2 Clinic Overbooked for Number of Staff
1 Clinic Overbooked
1 Complex patient
1 Consultant / clinician delay

Allocate – the electronic annual leave requesting platform has been introduced to the medical teams with a planned go live date of 21st May 2019. By booking leave electronically it is expected that this will improve the process of authorisation and ensuring clinics are reduced appropriately.
There are now 2 notice boards in Outpatients where the room allocations for the current and following week are displayed to inform the clinical staff of the room utilisation. This should further improve communications with clinical staff.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Utilise the outreach clinics at Lordswood whilst investigating further options for additional space either at Lordswood or another site
- Set up the outpatient project improvement group as part of the Continuous improvement perfecting pathways projects.
- Review of clinic space for "new adult clinics" moving from the paediatric outpatients

- The process for partial booking has been started as a pilot in Pain and this will continue to be monitored. This will need to be reviewed alongside the Appointments team workforce to inform the resources required in future Business case for full roll out .

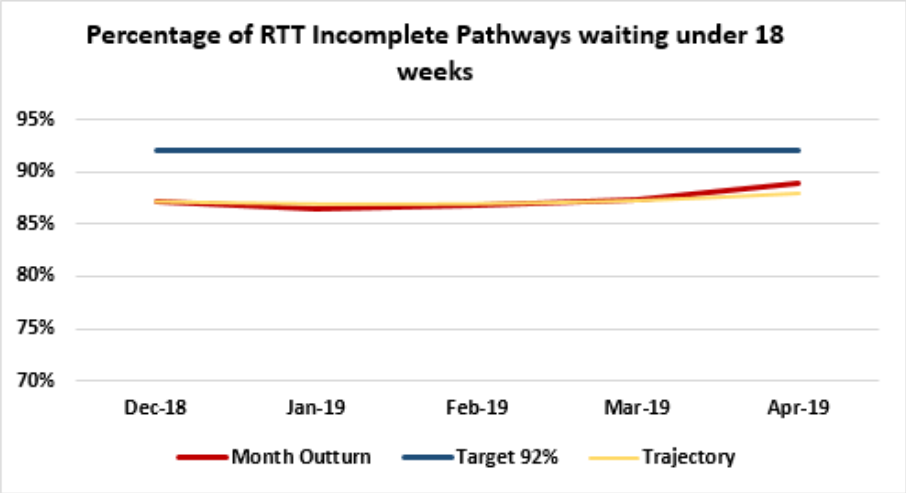
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

Pending - Patients still waiting at month end								Activity			
	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Apr-18	1022	148	409	1,579	8	1571	99.5%	850	253	387	1,490
May-18	1002	136	353	1,491	1	1490	99.9%	725	236	373	1,334
Jun-18	789	96	376	1,261	5	1256	99.6%	762	220	360	1,342
Jul-18	732	112	336	1,180	8	1172	99.3%	961	211	290	1,462
Aug-18	568	107	301	976	9	967	99.1%	682	165	290	1,137
Sep-18	696	110	311	1,117	4	1113	99.6%	778	208	394	1,380
Oct-18	781	110	370	1,261	7	1254	99.4%	725	247	344	1,316
Nov-18	736	135	381	1,252	7	1245	99.4%	801	243	406	1,450
Dec-18	698	115	346	1,159	11	1148	99.1%	843	224	367	1,434
Jan-19	728	123	416	1,267	4	1263	99.7%	897	253	472	1,622
Feb-19	844	134	386	1,364	3	1361	99.8%	854	248	436	1,538
Mar-19	776	133	461	1,370	1	1369	99.9%	868	271	410	1,549
Apr-19	835	89	414	1,338	6	1332	99.6%	894	244	419	1,557

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



The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019.

April 2019 performance is **88.05% against a trajectory of 88.03%**

In April the Trust had **0** patients over 52weeks which is a significant achievement for the Trust. There were 21 patients over 40 weeks and these patients are monitored weekly to track progress and ensure treatment plans are in place.

Referral to Treatment Trajectory: Trust Wide Position

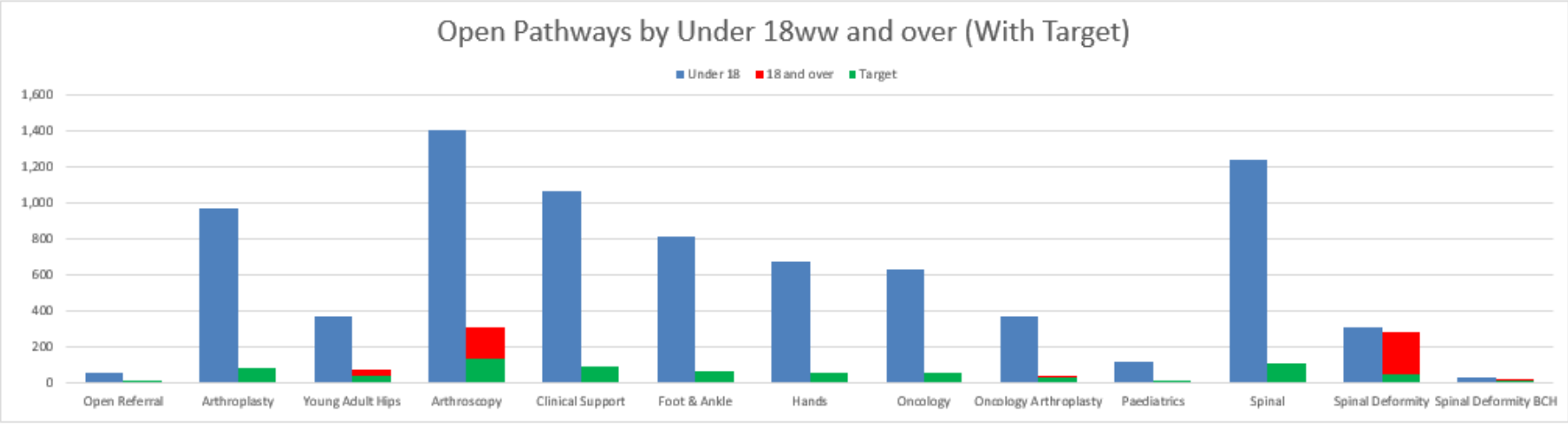
RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,478	7,511	7,543	7,571
Over 18 Weeks	1,080	1,091	1,089	1,062	997	931	867	799	732	651	605	560	520
Totals	8,436	8,365	8,370	8,361	8,334	8,305	8,278	8,248	8,219	8,129	8,116	8,103	8,090
RTT %	87.20%	86.96%	86.99%	87.30%	88.03%	88.79%	89.53%	90.31%	91.09%	92.00%	92.54%	93.09%	93.58%

13. Referral to Treatment snapshot as at 30th April 2019 (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	**3,920**	29	434	172	698	556	455	321	293	227	63	565	96	11
7-13	**3,145**	16	401	154	518	412	281	269	257	124	43	512	144	14
14-17	**981**	13	131	40	185	100	74	87	83	20	11	163	71	3
18-26	**797**	1	66	53	210	57	47	44	15	32	5	78	175	14
27-39	**274**	0	14	16	95	1	3	5	2	9	0	26	97	6
40-47	**21**	0	0	3	5	1	0	0	2	1	0	0	8	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9,138**	59	1,046	438	1,711	1,127	860	726	652	413	122	1,344	591	49

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	**8,046**	58	966	366	1,401	1,068	810	677	633	371	117	1,240	311	28
18 and over	**1,092**	1	80	72	310	59	50	49	19	42	5	104	280	21
Target	**731**	**5**	**84**	**35**	**137**	**90**	**69**	**58**	**52**	**33**	**10**	**108**	**47**	**4**
	88.05%	**98.31%**	**92.35%**	**83.56%**	**81.88%**	**94.76%**	**94.19%**	**93.25%**	**97.09%**	**89.83%**	**95.90%**	**92.26%**	**52.62%**	**57.14%**

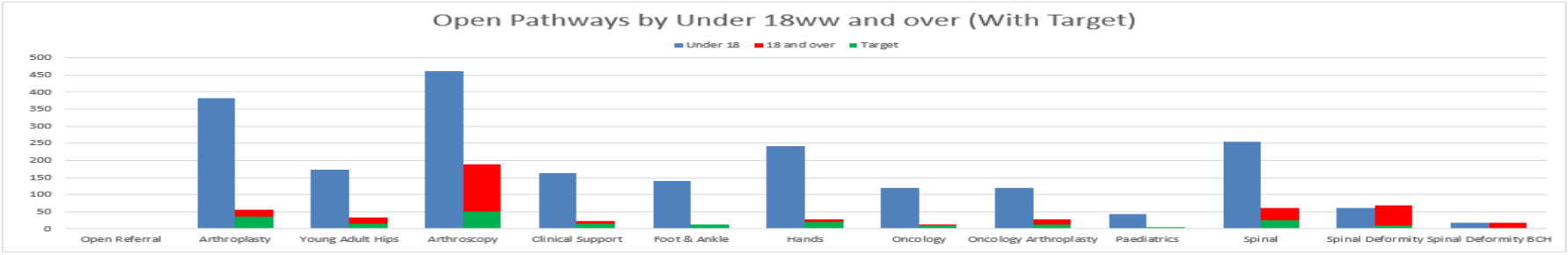


13. Referral to Treatment snapshot as at 30th April 2019

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	**832**	0	118	78	206	47	49	75	67	59	23	83	21	6
7-13	**963**	1	194	80	184	77	67	115	34	43	17	118	22	11
14-17	**379**	0	69	14	70	40	23	52	18	17	4	53	17	2
18-26	**372**	0	44	21	122	23	13	26	10	20	3	46	32	12
27-39	**145**	0	13	9	62	1	0	1	1	7	0	15	32	4
40-47	**12**	0	0	2	4	0	0	0	1	0	0	0	4	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,703**	1	438	204	648	188	152	269	131	146	47	315	128	36

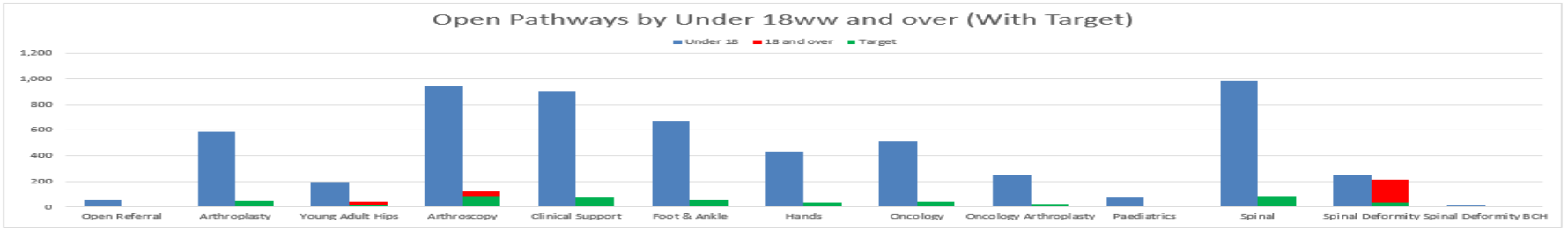
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**2,174**	1	381	172	460	164	139	242	119	119	44	254	60	19
18 and over	**529**	0	57	32	188	24	13	27	12	27	3	61	68	17
Target	**216**	**0**	**35**	**16**	**52**	**15**	**12**	**22**	**10**	**12**	**4**	**25**	**10**	**3**
	80.43%	**100.00%**	**86.99%**	**84.31%**	**70.99%**	**87.23%**	**91.45%**	**89.96%**	**90.84%**	**81.51%**	**93.62%**	**80.63%**	**46.88%**	**52.78%**



Select Pathway Type: Non-Adm

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	**3,088**	29	316	94	492	509	406	246	226	168	40	482	75	5
7-13	**2,182**	15	207	74	334	335	214	154	223	81	26	394	122	3
14-17	**602**	13	62	26	115	60	51	35	65	3	7	110	54	1
18-26	**425**	1	22	32	88	34	34	18	5	12	2	32	143	2
27-39	**129**	0	1	7	33	0	3	4	1	2	0	11	65	2
40-47	**9**	0	0	1	1	1	0	0	1	1	0	0	4	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6,435**	58	608	234	1,063	939	708	457	521	267	75	1,029	463	13

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	**5,872**	57	585	194	941	904	671	435	514	252	73	986	251	9
18 and over	**563**	1	23	40	122	35	37	22	7	15	2	43	212	4
Target	**515**	**5**	**49**	**19**	**85**	**75**	**57**	**37**	**42**	**21**	**6**	**82**	**37**	**1**
	91.25%	**98.28%**	**96.22%**	**82.91%**	**88.52%**	**96.27%**	**94.77%**	**95.19%**	**98.66%**	**94.38%**	**97.33%**	**95.82%**	**54.21%**	**69.23%**



13. Cancer Performance Targets

		Indicative	Reported Month							Reported Quarter 2017/18			
Target Name	**National Standard**	**Apr-19**	**Q4 2018/19**	**Mar-19**	**Feb-19**	**Jan-19**	**Q3 2018/19**	**Q2 2018/19**	**Q1 2018/19**	**Q4 (Jan, Feb, March)**	**Q3 (Oct, Nov, Dec)**	**Q2 (July, August, Sept)**	**Q1 (Apr, May, June)**
2ww	93%	*95.5%*	**98.8%**	**98%**	**98%**	**100%**	**99%**	**100%**	**99%**	**97%**	**98%**	**99%**	**98%**
31 day first treatment	96%	*100%*	**94.4%**	**100%**	**81.8%**	**100%**	**100%**	**100%**	**100%**	**90%**	**96%**	**97%**	**97%**
31 day subsequent (surgery)	94%	*100%*	**95.2%**	**100%**	**93.8%**	**90.9%**	**98%**	**100%**	**97%**	**98%**	**100%**	**97%**	**100%**
62 day (traditional)	85%	*100%*	**96%**	**100%**	**100%**	**90%**	**51.3%**	**69.9%**	**82%**	**82%**	**82%**	**72%**	**67%**
62 day (Cons Upgrade)	n/a	*93%*	83.70%	*100.0%*	89.5%	***75.0%***	**91.37%**	**92.6%**	**94%**	**84%**	**82%**	**89%**	**100%**
28 day FDS	85%	80.7%		*83.0%*	82.20%								
No. patients treated 104+ days					1	1	3	1	**1**				

PERFORMANCE/IMPROVEMENTS / LEARNING

The Trust performance for the 62 day target in April is currently at 100% **(data submission closes 4th June 2019)**. This is the fourth consecutive month that the target has been achieved. Strong performance in Jan to March has meant that the Trust has hit the target for Quarter 4 (**Target 85%).**

The Trust is also "shadow" monitoring the new 28 day Faster Diagnostic Standard which will be a national performance target in April 2020. The Trust is required to report this from April 2019. The target is 85% and our performance in April was 80.7% (11 patients not compliant). Patient pathways and attainment of key clinical milestones continue to be monitored rigorously through the weekly Cancer PTL meetings.

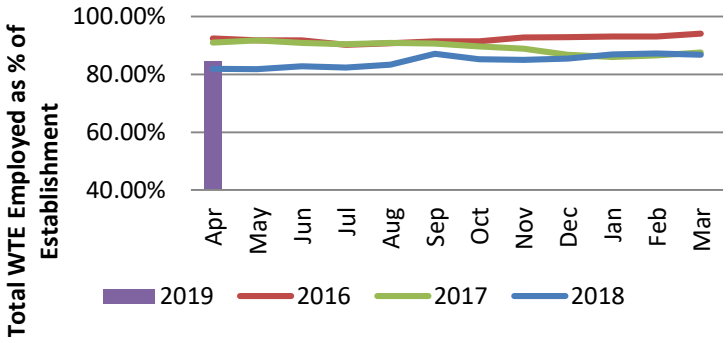
The Trust's Business Intelligence Service, with advice and help from the UHB Deputy Cancer Services Manager, have developed the first proto-type of bespoke cancer reports from the Somerset cancer management system. They are now visible on the performance dashboard and the Cancer Services Team are currently testing to make sure the information is accurate and timely.

RISKS / ISSUES

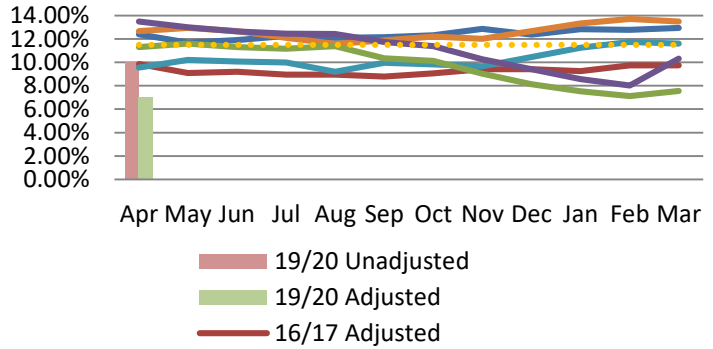
With the transfer of the Inpatient Paediatric Service in July 2019 to BWC the team will continue to work closely with both teams to minimise any impact on our performance

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

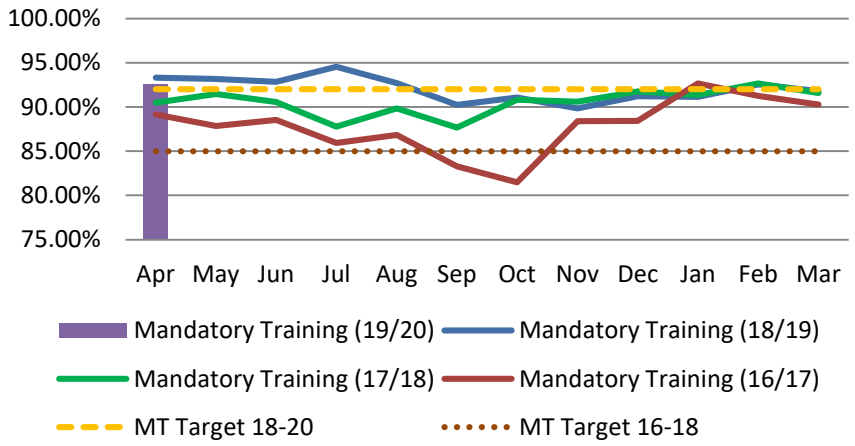
Staff in Post v Establishment



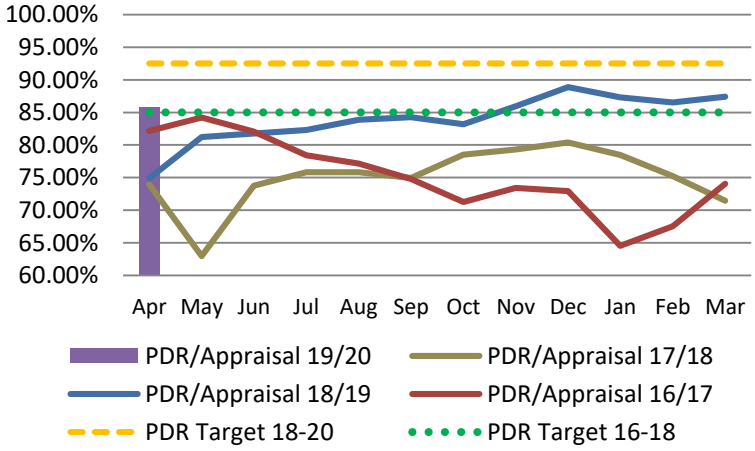
Staff Turnover



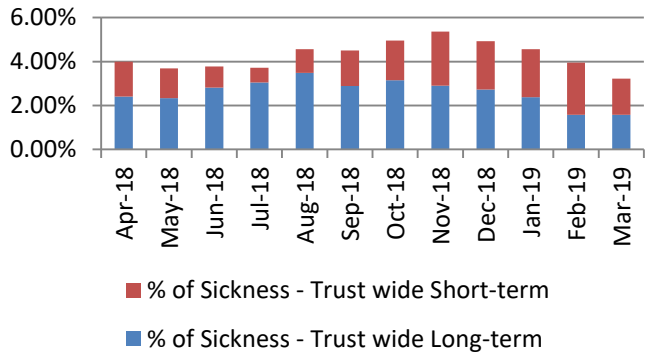
Mandatory Training



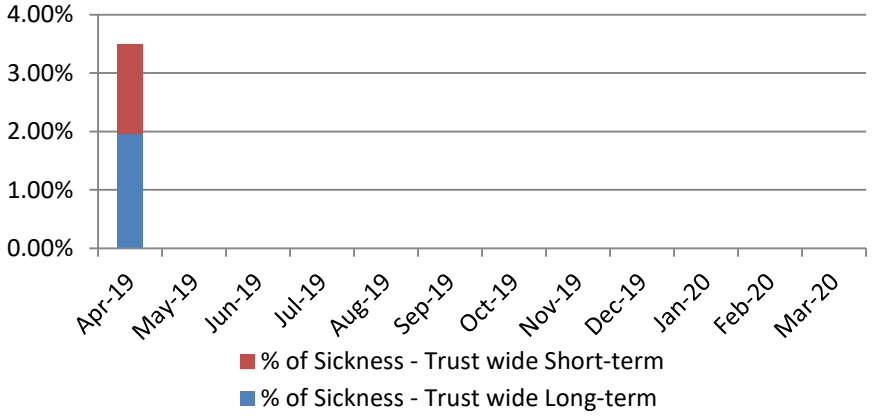
PDR/Appraisal



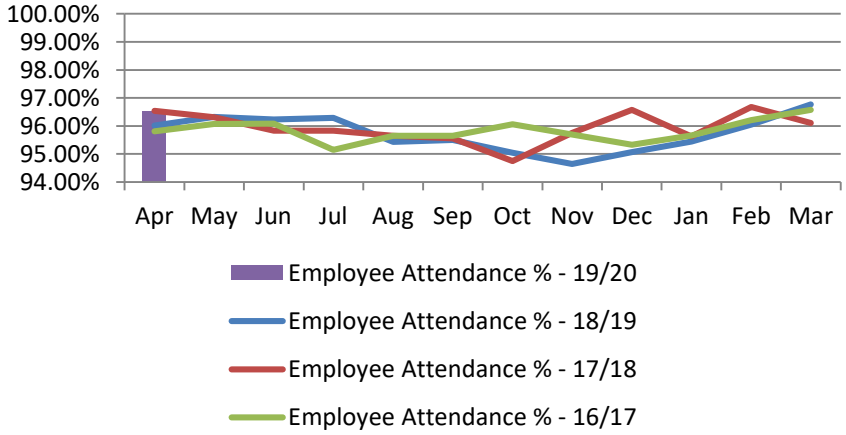
Sickness % - LT/ST (2018/19)



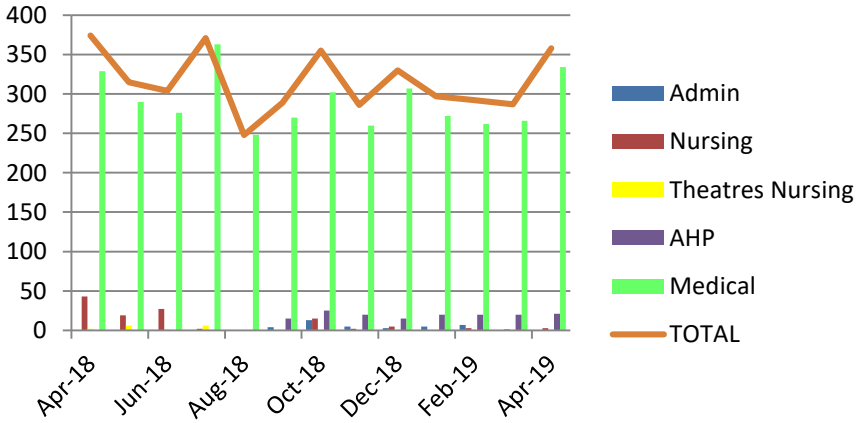
Sickness % - LT/ST (2019/20)



Employee Monthly Attendance %



Agency Breaches



INFORMATION

April saw an improvement in mandatory training and a reduction in turnover; however, this is set against an increase in the vacancy position, a decrease in staff attendance, and a decrease in staff appraisals.

This month the Trust's vacancy position saw an increase of 2.17%, as a percentage of WTE employed, with the figure for March at 86.84% against a Trust target of 90%. This is due to an increase of circa 17 wte in the budgeted establishment, the number of staff on the payroll, which stood at 938.39 has also decreased this month due to the Histopathology TUPE.

In April, monthly attendance decreased slightly by 0.27% to 96.50%, but is above our target therefore remained green. The underlying 12 month average sickness absence figure decreased again this month to 4.39% and turned amber, which is the first time since October last year. Short term sickness decreased again in April from 1.65% to 1.53%, which is the lowest it has been since August 2018.

Coincidentally Mandatory Training numbers has returned to the figure it was in February; 92.56%, which is above the Trust target of 92%, so returns to green again this month. The L&D Team are continuing to encourage staff to book onto courses but are increasingly encouraging staff to carry out their Mandatory Training via e-learning.

April's appraisal performance declined by 1.62% taking the position to 85.79%, which is still the highest level for the month of April since April 2014: but it is still a distance from our internal stretch target of 92.5%, operational focus needs to be maintained with Divisions in this area.

The unadjusted turnover figure (all leavers except junior doctors and retire/returners) reduced to 9.99%. The adjusted turnover figure (substantive staff leavers including retirements) also saw a decrease to 7.02% and remains green against a KPI of 11.5%. A change in process may see an increase to our turnover figures in the future due to the method of terminating employees who wish to remain on the bank.

In April, agency breaches increased from 287 to 358 shift breaches in total, with the large majority still being medical usage (334), which increased from 266 to 334. There were 3 nursing breaches, 21 AHP breaches but no 0 admin breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 1 May 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that there was a risk around pensions liability associated with some senior staff, such as consultants and this was impacting on some medics' willingness to work additional hours. Regionwide and national discussions were underway to identify a solution. • There was a discussion around how the current estate was impacting staff experience. A heatmap of the key risks around the estate would be prepared for the July meeting.	• Present the updated workforce process review at the next meeting. • Present the estates heatmap in July. • Consider communicating the success of apprenticeships via Twitter. • Prepare a guide to Multi Professional Education and Training including numbers of trainees, expenditure and equity of access to training. • Arrange for the MPET update to be considered by an executive forum prior to consideration at the Staff Experience & OD Committee. • The Staff Experience & OD Committee workplan needed to be updated as did the workforce governance structure.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a positive story from the Matron for Theatres who described the work undertaken in the area around recruitment, addressing working patterns and restructuring where required. It was noted that as a result of the style of leadership in the area there had been an encouraging culture change and staff were motivated and energised. • The Committee was informed that a Facilities Improvement Group had been established to assist with engaging with the ancillary staff who may otherwise be hard to reach given lack of access to e-mail. • The Committee was advised that the Trust's use of apprentices was seen regionwide as best practice. The diversity implications of recruiting apprentices was discussed. • A presentation was given by the Practice Placement Lead on the new NMC standards for Education and Training. Some of the standards were markedly different from those currently in place for nurses. There was an emphasis on the practice supervisor role which had replaced the mentors. The Committee took significant assurance that the ROH was well placed to embrace the new standards.	• None specifically.

• The Committee was advised that the equality and diversity network was meeting regularly and was working well. In terms of EDS2, there was little movement from the previous year's position, although there appeared to be more individuals who were comfortable with sharing their sexual orientation. The Committee agreed that overall, there was good progress with the equality and diversity agenda.	
Chair's comments on the effectiveness of the meeting: The meeting had included sufficient time for discussion on key points, despite being a shorter meeting than usual. The staff story was well received.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Safe Nursing Staffing Report
SPONSOR (EXECUTIVE DIRECTOR):	Garry Marsh; Executive Director of Nursing and Clinical Governance
AUTHOR:	Stacey Keegan; Deputy Director of Nursing and Clinical Governance
DATE OF MEETING:	5th June 2019

EXECUTIVE SUMMARY:

This nurse staffing report details the Trust position against the requirement of the National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance 2016, the NQB Speciality Guidance 2018, and the NHS Improvement (NHSI) Developing Workforce Safeguards guidance published October 2018. As part of "safe staffing" governance the guidance recommends that the Board of Directors receive a bi-annual report on Nurse Staffing in order to comply with CQC fundamental standards across the five domains of Safe; Effective; Caring; Responsive and Well-led.

Following a review of the national nurse staffing guidance documents, this report provides assurances that the Trust complies with this guidance and provides an update on the nursing workforce position at the end of April 2019, reflecting the changes since the last Board report in September 2017. The report outlines and shows the actions being taken; and provides assurance on the effectiveness of the actions to support the overall nursing workforce across the Trust by attracting, retaining and developing the right people with the right skills in the right roles.

REPORT RECOMMENDATION:

Trust Board is asked to:

- Note the nursing and care staffing information provided in line with national safe staffing guidance.
- Note the partial compliance in relation to workforce planning.
- To approve the Quality Impact Assessment for the introduction of trainee nursing Associates (appendix 1)
- Receive a bi-annual Safe Nursing Staffing 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	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:
Aligned to People Strategy, workforce metrics and risks as stipulated within the paper.
PREVIOUS CONSIDERATION:
Trust Board - September 2017.

ROHTB (6/19) 009 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

SAFE NURSING STAFFING REPORT

REPORT TO THE TRUST BOARD JUNE 2019

1 INTRODUCTION

This nurse staffing report details the Trust position against the requirement of the National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance 2016, the NQB Speciality Guidance 2018, and the NHS Improvement (NHSI) Developing Workforce Safeguards guidance published October 2018. As part of "safe staffing" governance the guidance recommends that the Board of Directors receive a bi-annual report on Nurse Staffing in order to comply with CQC fundamental standards across the five domains of Safe; Effective; Caring; Responsive and Well-led.

In addition to this requirement, the Staff Experience and Organisational Development Trust Board sub-committee receive a monthly nurse staffing report detailing the requirements of the national nurse staffing guidance.

Following a review of the national nurse staffing guidance documents, this report provides assurances that the Trust complies with this guidance and provides an update on the nursing workforce position at the end of April 2019, reflecting the changes since the last Board report in September 2017. The report outlines and shows the actions being taken; and provides assurance on the effectiveness of the actions to support the overall nursing workforce across the Trust by attracting, retaining and developing the right people with the right skills in the right roles.

2 NATIONAL CONTEXT

Nationally, the nursing workforce supply remains challenging with the shortfall in registered nurses being a well-documented challenge for the whole of the NHS. NHS Improvement report in excess of 41,000 registered nurse vacancies.

In January 2019, NHS England published the NHS Long Term Plan (LTP) setting out the overall vision for how the NHS should change over the next ten years. The plan acknowledged the key role that staff have in health care delivery and a workforce implementation plan is due to be published later in 2019. It is anticipated that this plan will provide clarity on funding available to support additional investment in workforce, training and education, and continuing professional development (CPD).

The plan acknowledges that the NHS needs to increase the workforce supply of registered nurses and aims to reduce the nursing vacancy rate to 5% by 2028.

3 LOCAL BIRMINGHAM AND SOLIHULL CONTEXT

The Birmingham and Solihull NHS Trusts' (BSOL) have established a working group with three local University providers, Birmingham City University (BCU), University of Birmingham (UoB) and Coventry to ensure a robust level of scrutiny around all previously commissioned non-medical undergraduate provision. The aim of this collaboration is to ensure clarity regarding the numbers of undergraduates Trusts' require for their workforce needs, drive up recruitment to all programmes and improve retention and completion on time particularly across all nursing programmes.

Applications to undergraduate nursing courses in England in 2017/18 dropped by 23% when compared to 2016/17 and this is largely attributed to the removal of the bursary payments in 2016.

The table below demonstrates the data from BCU and UoB.

TABLE 1: UNDERGRADUATE NURSING NUMBERS 2018.

PROVIDER	FIELD	APPLICATIONS RECEIVED	CHANGES FROM PREVIOUS YEAR (UP/DOWN)	% VARIANCE
UoB	Common Foundation	1289	-170	13%
BCU	Adult	1620	-563	35%
BCU	Child	758	-264	35%
BCU	Learning Disability	74	-25	44%
BCU	Mental Health	520	-147	29%
Total		4261	-1169	31%

The data in table 1 demonstrates that there has been a significant reduction in applications for undergraduate nursing programmes across both BCU and UoB on a similar level to that seen nationally. The highest reduction is seen in the adult and common foundation fields.

Continued work to collect and interrogate student data allows insight into hotspots and a combined approach to understanding student behaviour, demographics with the aim of continuing to improve the student experience and in turn positively impact on recruitment and retention. A targeted campaign to improve recruitment of men and 24-30-year olds has commenced; both groups of

which have fallen in numbers significantly following the education reforms and abolition of tuition and bursary funding.

In addition to this, funding for Learning Beyond Registration (LBR) has also reduced by an average of 22%; for the Royal Orthopaedic NHS Foundation Trust almost 50%, affecting Trust's ability to invest in the development of post registration nurses.

4 REGISTERED NURSE VACANCIES

TABLE 2: TRUST WIDE REGISTERED NURSE AND ODP VACANCIES

MONTH	VACANCY (WTE)	POSTS IN RECRUITMENT PROCESS
End of March 2019	* **54.9 wte	*42.03 wte

*Vacancies inclusive of Operating Department Practitioners (ODPs)

** Vacancies excluding theatre/ward expansion

Table 2 above demonstrates the overall vacancy position at the end of March 2019 for registered nurses and operating department practitioners. The vacancy gap within wards and departments is currently mitigated with the use of temporary staffing, both bank and agency. Further mitigations have taken place, for example movement of substantive staff to other wards where vacancy and or skill mix have proven challenging.

5 NURSE STAFFING REPORTING

5.1 AVERAGE FILL RATES

Unify data is the reported metric of nursing staff actually on duty against the staff who are planned to work in all inpatient areas. There is a national requirement to report this measure and each month this is reviewed and approved by the Executive Director of Nursing and Clinical Governance following validation by the Matron for inpatient services.

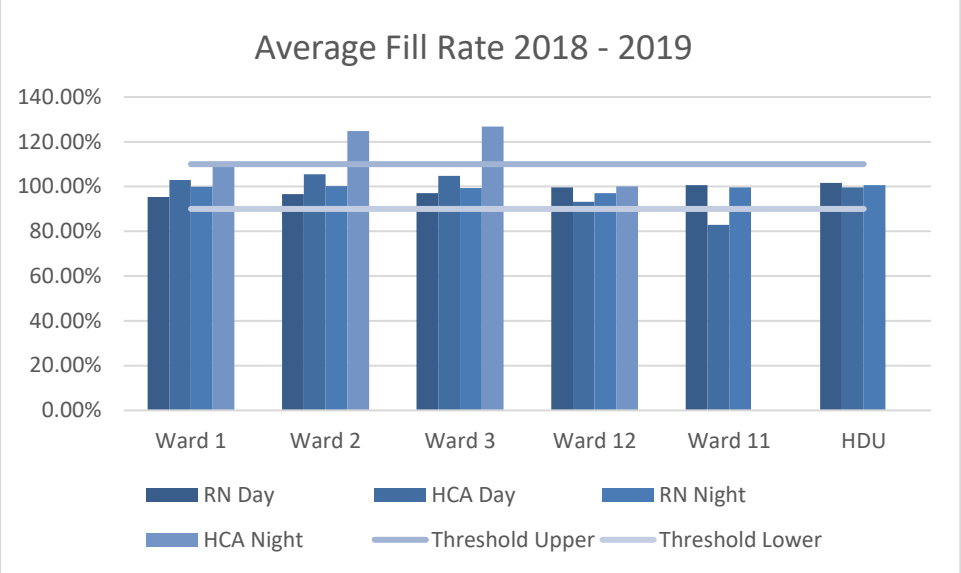
The Unify data is submitted monthly to NHSI detailing planned and actual staffing levels, reported as average fill rates for registered nurse and care staff for both day and night. This information is extracted from the Allocate Health Rostering system.

The planned staffing hours are based on funded establishments which provides a minimum ratio of 1 to 8 on both day and night shifts. While there is no nationally set guidance on nurse staffing, NICE guidance identified evidence of increased risk of harm associated with a registered nurse caring for more than eight patients during a shift. The Trust adopted this standard in 2016.

Planned hours are adjusted each month to allow for the number of days in the month. Planned hours per ward area are reduced in response to occupancy allowing a more reflective picture of safe staffing.

Graph 1 below shows the overall nurse staffing position in relation to average fill rates for 2018/19.

GRAPH 1: AVERAGE FILL RATES, REGISTERED NURSE AND HEALTH CARE ASSISTANT 2018/19



Throughout 2018/19 fill rates have exceeded the 90% threshold in all but the Health Care Assistant (HCA) cover on ward 11 during day shifts. This has been due to a template (data) error on Health Roster as opposed to a shortage of HCA cover.

A fill rate of over 100% is predominately linked to the requirements of additional HCA cover to support patients requiring enhanced levels of observation, for example Deprivation of Liberty Safeguards (DoLS).

5.2 CARE HOURS PER PATIENT DAY (CHPPD)

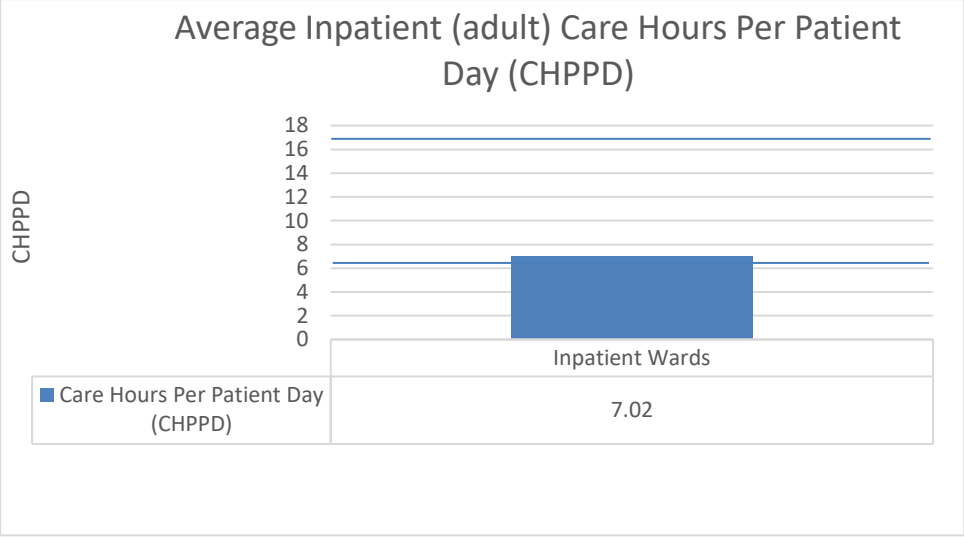
In February 2016, Lord Carter of Coles published his report into Operational Productivity and Performance within the NHS in England. In this report, Lord Carter describes one of the obstacles to eliminating unwarranted variation in nursing and care staff distribution across and within the NHS provider sector as being due to the absence of a single means of consistently recording, reporting and monitoring staff deployment. This led to the development of benchmarks and indicators to enable comparison across peer Trusts' as well as wards and the introduction of the Care Hours per Patient Day (CHPPD) measure is in line with the second of Lord Carter's recommendations. CHPPD has since become the principle measure of nursing, midwifery and healthcare support staff

deployment on inpatient wards. This replaces the 'planned versus actual' methodology used previously.

As part of the Unify data return, CHPPD are included within this and also taken from the Health Roster system.

The agreed national variation for CHPPD is between 6.3 and 16.8; graph 2 below demonstrates that the Trust sits within this agreed variation at 7.02 CHPPD.

GRAPH 2: AVERAGE CARE HOURS PER PATIENT DAY 2018/19



CHPPD provides a number that needs to be considered alongside other qualitative and quantitative information such as;

- Establishment levels;
- Vacancy rates, sickness and absence levels;
- Patient acuity;
- Skill mix (level of experience of the nursing staff);
- Level of bed occupancy;
- The physical layout of a ward;
- Care Hours Per Patient Day;
- Leadership – quality and consistency;
- Quality metrics and Key Performance Indicators (KPIs).

It is important not to reach conclusions by considering this number and its trends in isolation; all of the above information is considered in context alongside an over arching professional judgement. Also, whilst patient harms such as avoidable hospital acquired pressure ulcers, falls etc. are of

serious concern, for the purposes of safe staffing analysis, an assessment needs to be undertaken to establish whether any of these harms are linked to staffing levels, either as a direct/related consequence or not.

To ensure triangulation of staffing, quality and performance data, the Trust Health Check (an at a glance status of quality, workforce and performance targets for each ward and department) is included within the monthly nurse staffing report.

CHPPD does not provide the granular detail of who has undertaken the shifts and if they are substantive, bank or agency; this detail is provided by ward in the monthly nurse staffing report and is broken down by skill mix of our substantive staff and bank and agency.

NHS Improvement's Model Hospital website provides comparison information pertaining to CHPPD and other associated quality metrics. However, Trusts are not yet permitted to use this data or publish them until they are confirmed as being reliable.

6 NURSING RED FLAGS

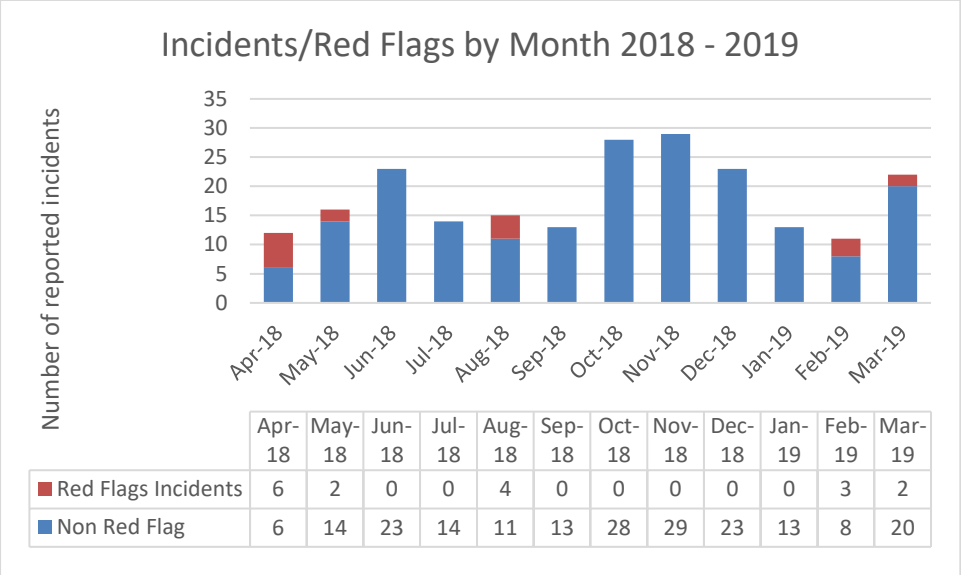
All shortfalls in nurse staffing are reported as an incident on the Trust incident reporting system, Ulysses. Incorporated into Ulysses are a number of 'Nursing Red Flags' as determined by the National Institute for Health and Clinical Excellence (NICE) Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals (2014).

Essentially 'red flags' are intended to record a delay/omission in care, a 25% shortfall in registered nurse hours or fewer than two registered nurses present on a ward during any shift. The guidance was published to act as an alert to the nurse in charge of shifts that they must act immediately to ensure they have enough staff to meet the needs of patients on that ward.

The guidance allows local 'red flags' to be introduced if a Trust feels they are required or want to implement 'red flags' into non-adult ward settings.

Graph 3 below summarises nurse staffing incidents and 'red flags' reported between April 2018 and March 2019.

GRAPH 3: NURSE STAFFING INCIDENTS AND REPORTED RED FLAGS 2018/19



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Red Flags Incidents	6	2	0	0	4	0	0	0	0	0	3	2
Non Red Flag	6	14	23	14	11	13	28	29	23	13	8	20

The significant increase in reporting in October 2018 was in relation to the Theatre Matron actively encouraging reporting to reflect the daily challenges of moving staff between theatre lists to ensure all planned activity takes place.

The majority of other incidents throughout the year have been attributed to the challenges associated in providing registered children's nurses to fulfil the services across both ward 11 and CYPHDU.

Nurse staffing incidents reported on Ulysses, including those that have triggered a 'red flag' are reported monthly in the nurse staffing report. All incidents are reviewed in line with the incident management system and process by the department manager and matron. The Deputy Director of Nursing and Clinical Governance reviews all staffing incidents and reported red flags as part of the monthly nurse staffing paper to confirm level of harm. During 2018/19 there was no harm to patients attributed from nurse staffing.

7 OPERATIONAL ASSURANCES

Divisional daily reviews of nurse staffing requirements take place, chaired by a matron. Escalation processes are in place to mitigate the impact of when planned staffing levels are not achieved. This escalation process is supported within the Trusts Safe Staffing Escalation policy.

Where registered nurse fill rates cannot be achieved, staff are often redeployed from other clinical areas with the matron or clinical site co-ordinator (out of hours) considering clinical risk and safety, and acuity and dependency, using this information to inform professional judgement.

Controls and escalation are in place to mitigate the usage of temporary staffing. Bank shifts are approved by the ward manager against the agreed staffing requirements (template). All agency requests are authorised by the Head of Nursing or Executive on call (out of hours) to ensure robust reviews across the wards and departments, patient numbers and acuity are taking place before authorisation.

In the event of off framework agency requests being required, authorisation and approval is sought from the Chief Executive Officer (CEO) ensuring all measures to avoid this request are carried out and escalated prior to seeking this approval.

Health Roster check and challenge meetings with individual ward and departments were introduced in 2019 to ensure staffing efficiencies through good roster management.

Twice weekly Nurse Agency review meetings with Heads of Nursing and the Deputy Director of Nursing and Clinical Governance take place to oversee agency usage and mitigate the requirements.

8 RECRUITMENT AND RETENTION

The Clinical Workforce and Development Group commenced in July 2018 and replaced the Nursing and Operating Department Practitioner (ODP) Workforce Meeting. The group meet on a monthly basis with current Terms of Reference. The group is chaired by the Deputy Director of Nursing and Clinical Governance and an upward report is provided to People Committee and the Executive Director of Nursing's monthly Senior Nurse Meeting.

There are seven key work streams that focus on recruitment and retention that feed into the group with leads assigned; upward reports are presented.

To fulfil the objectives and actions required of the group, the Clinical Workforce and Development Group requires the support from the Trust and other departments to enable cohesive working and aligned aims.

The Trust has made significant positive progress with the recruitment of registered nurses through the Clinical Workforce and Development Group; actions taken are reported monthly within the upward report and the monthly nurse staffing report. In January 2019, a Workforce Matron commenced in post on a temporary (seconded) basis. This post has been key to deliver the necessary actions required to improve the nurse vacancy position.

8.1 NURSING ASSOCIATES

In January 2019 the Nursing and Midwifery Council (NMC) opened the register for the Nursing Associate role (NA). Nursing Associates take two years to train on an apprenticeship basis and the role is designed to bridge the gap between health care assistants and registered nurses, this role will

widen participation in terms of access to careers in healthcare by opening up new routes to training that have not previously existed.

In March 2019, a business case was approved by the Trusts Executive team for Nursing Associates at the Royal Orthopaedic NHS Foundation Trust and in April 2019 our first three trainees commenced with plans to recruit a further twenty trainees in the next scheduled intake planned for October 2019.

The Developing Workforce Safeguards (NHSI, 2018) guidance states that any skill mix changes or introduction of new roles must be informed by a comprehensive assessment using a quality impact assessment (QIA) and must be signed off at Executive level. Appendix 1 contains the QIA for Trainee Nursing Associates.

8.2 NHS IMPROVEMENT NURSE RETENTION DIRECT SUPPORT PROGRAMME

In December 2018, the Trust enrolled with the NHS Improvement Retention Support Programme Cohort 4; the programme is designed to support NHS Trusts' in improving retention of registered nurses in response to the supply challenges faced at a national level.

As part of the programme the Trust has developed and submitted a Retention Improvement plan with the aim to see improvements in registered nurse turnover rates in the next 12 months. The plan is overseen at the Clinical Workforce and Development Group.

9 NURSING ESTABLISHMENT REVIEWS

The NQB (2016) and Developing Workforce Safeguards (NHSI 2018) guidance requires Trusts' to review Nursing establishments and skill mix a minimum of twice a year in order to ensure that these are appropriate and relevant to meet the current needs/acuity of patients.

The establishment reviews will take the following factors into consideration;

- Existing rota establishment and actual position;
- Safe Care; a validated acuity/dependency tool;
- Shift patterns in use;
- Compliance with Health Roster rules and Nursing, ODP and AHP E-Rostering policy.
- Training needs analysis/compliance;
- Number of active mentors for student nurse support;
- Number of apprentices and other trainees;
- Overarching professional judgement.

Currently these are taking place with Heads of Nursing, Matrons, Ward and Departmental managers and our Finance accountants, with a plan for these to have been concluded in June 2019.

In July 2019, meetings have been arranged with the Executive Director of Nursing and Clinical Governance and Director of Finance to approve and sign off these reviews.

10 STAFFING RISKS

Table 3 below gives sight of the Divisional and Corporate risks associated with nurse staffing; these risks sit within the Executive Director of Nursing and Clinical Governance portfolio.

TABLE 3: DIVISIONAL AND CORPORATE RISKS ASSOCIATED WITH NURSE STAFFING

RISK REFERENCE	RISK STATEMENT	INITIAL RISK SCORE	CONTROLLED RISK SCORE
1279	Risk to sustainability of adult HDU service delivery and compliance with critical care standards due to lack of adult HDU nurses following redeployment of paediatric competent nurses to support CYP HDU prior to transition of service to BWCH.	15 (5LX3C)	15 (5LX3C)
169	Due to the level of theatre nursing / ODP vacancies, combined with a higher commissioned level of activity for 2016-17, there is a risk that staff will be expected to work additional hours, specifically in the context of over running theatre lists, and that this may cause tiredness / fatigue, and ultimately further issues with recruitment and retention.	12 (4LX3C)	12 (4LX3C)
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 (3LX4C)	12 (4LX3C)
1276	There is a risk that patient care/safety may be compromised as we do not have enough staff/ a large number of vacancies on Wards 2, 10 & 12.	15 (5LX3C)	9 (3LX3C)

11 STAFFING GUIDANCE SHORTFALLS

11.1 WORKFORCE PLANNING

Effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users. Developing Workforce Safeguards (NHSI,

2018) guidance state *"Trusts **must** have an effective workforce plan that is updated annually and signed off by the Chief Executive and executive leaders. The board should discuss the workforce plan in a public meeting.*

Although currently in the Trust, workforce planning forms part of annual business planning undertaken by the Divisions; following a review of the recommendations within the guidance it is of the opinion that the Trust is not fully compliant with this guidance due to the absence of a workforce planning model, agreed approach and review periods defined throughout the year.

12 RECOMMENDATION

The Trust Board is asked to:

1. Note the nursing and care staffing information provided in line with national safe staffing guidance.
2. Note the partial compliance in relation to workforce planning.
3. To approve the Quality Impact Assessment for the introduction of trainee Nursing Associates (Appendix 1)
4. Receive a bi-annual Nurse Staffing report.

Stacey Keegan; Deputy Director of Nursing and Clinical Governance.

30th May 2019.

The Royal Orthopaedic Hospital NHS Foundation Trust

Appendix 1

QIA Record

This QIA record is intended for use as part of the CIP scheme management process but can also be used to support business cases, and other change activities. ***Complete all section questions using N/A to indicate those that are not applicable or 'none' as appropriate****.*

Note: The QIA process should include patient input where changes to patient services including access are proposed.

Directorate	Division 1	Scheme Ref no	
Scheme Title	Band 4- Nursing Associates (NA)		

Scheme Description

From April 2019 we plan to commence training and recruit Registered Band 4 Nursing Associates into Ward Areas. In essence, the Band 4 will release monies currently spent on covering Band 5 vacancies within areas which are largely currently covered by Agency Nursing Staff.

The recruitment and implementation of Nursing Associates aim to place a single NA on each shift, early, late, night. Dependant on interest and recruitment we would aim to have 5.2 WTE per ward from April 2019.

What is the likely overall impact on service quality of this scheme? *Please cross one*

Reduces Quality		Improves Quality	X	Maintains Quality	

Scheme Impact (both positive and negative impacts should be recorded)

Safety impact

Positive:

Due to all inpatient ward areas carrying large band 5 vacancies that are currently covered by agency staff this scheme has the potential to create a stable workforce that can provide continuity of care without paying the elevated 'agency' fees we are currently incurring.

The NMC skillset for Nursing Associates is largely identical to the current Band 5 skillset with the exception that Nursing Associates may not Lead a Nursing Team nor can they prescribe nursing care (but can evaluate and provide prescribed nursing care). This fits well within our organisation with many elective prescribed nursing pathways.

Registered Nursing Associates will be real change agents/role models for band 2's looking to develop as Trainee Nurse Associates.

Negative:

We would eventually have a workforce that is less qualified/skilled than the most recent NMC nurse skillset. Scheme has potential to create 'expensive' health care assistants if we do not clearly define and manage our expectations of this new role.

Does this scheme impact patient and staff experience?

Nursing Associates would replace band 5 staff nurses resulting in a different skill set on the ward. Staff experience could be positively impacted as this would result in less vacancies/unfilled shifts/agency staff that do not know the Trust. It would support the Trust strategy and ambition in relation to development

and retention of staff. However, it would also put additional pressure on band 5's/6's as they would be expected to change the way they work to ensure they support and oversee the work of the band 4 and are consistently working to the 'top of licence'

Is this scheme likely to result in a worse or improved clinical outcome for patients?

Patients will be nursed by a team of nurses and nursing associates who have the knowledge and skills collectively to meet all of the patient's needs, there will be less unfilled/vacant shifts and less unfamiliar agency nurses all of which has the potential to improve patient outcomes.

Staff will be familiar with Trust process and policy.

Access/waiting times

More regular/consistent staffing structure has the potential to improve efficiency.

Impact across the Trust and wider health economy

New way of working for ward areas, band 5's in particular will be expected to take on more of a leadership role.

Role required to meet the national shortage of registered nurses.

Equality & Diversity

Nursing associate posts will be advertised and the recruitment process will be followed to ensure recruits have a fair and equal chance of being successful.

Risk

Description of any risk to quality identified

Short term

Risk that newly registered nursing associates will not get the support/supervision/teaching they require in the ward areas due to the wards carrying large numbers of vacancies.

Long term

Skill mix depleted. Less registered nurses on duty.

Evaluate the consequence and likelihood of the risk identified using the matrix and record the score below

Further guidance is provided in the QIA process and guidance document

Likelihood	3
Consequence	3
Overall Risk Rating	9

1–3	Low risk
4–6	Moderate risk
8–12	High risk
15–25	Extreme risk

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Is there an entry on the Trust or Divisional Risk Register relating to this Scheme? N

If Yes, please provide reference:

How is the risk being managed?

Through a planned and structured programme, allocating nursing associates to wards that can support them fully.
Communications and awareness of the role.
A review of policies and procedures to ensure the role is clear.
Additional Clinical Educator hours for support.
A Nursing Associate work stream that feeds into the Clinical Workforce and Development group.

Detail any performance measures or quality metrics that will be used to monitor the impact of this scheme.

Financial- savings on agency staff/cost of trainees
Quality- patient experience/patient harms/ complaints/compliments/incidents/ safe staffing figures.

Evaluate the consequence and likelihood of the risk identified after mitigation, and the target risk

Likelihood	3
Consequence	2
Overall Mitigated Risk Rating	6

Likelihood	2
Consequence	2
Overall Target Risk Rating	4

Directorate Sign off	
Clinical Lead for this scheme: Stacey Keegan and Christian Ward	Project lead for this scheme: Karen Hughes
Contributors to QIA: Christian Ward Lisa Newton	QIA Process used 1-1 meeting
Date of initial QIA: March 2019	Date for Post implementation QIA review: September 2019

	Clinical Director / Clinical Lead	Directorate Manager	Matron
Name:			
Signature:			
Date:			

Executive sign off

Implement scheme		Hold scheme pending agreed action		Withdraw scheme indefinitely	

Name:		
Signature:		
Date:		

Executive Comments (if applicable)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Registered Nurse Revalidation
SPONSOR (EXECUTIVE DIRECTOR):	Garry Marsh; Executive Director of Nursing and Clinical Governance
AUTHOR:	Stacey Keegan; Deputy Director of Nursing and Clinical Governance
DATE OF MEETING:	5th June 2019

EXECUTIVE SUMMARY:

The Nursing and Midwifery Council (NMC) introduced revalidation in April 2015 to strengthen the three-yearly registration process and increase professionalism.

This paper provides the governance arrangements and Trust compliance for registered nurse revalidation.

Since the introduction of revalidation in 2015; there have been no registered nurses at the Royal Orthopaedic NHS Foundation Trust subjected to fitness to practice concerns based on the revalidation process.

REPORT RECOMMENDATION:

Trust Board is asked to:

- Note, accept and receive this report.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
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:

Workforce aligned to professional body.

PREVIOUS CONSIDERATION:

None

ROHTB (6/19) 010 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

REGISTERED NURSE REVALIDATION

REPORT TO THE TRUST BOARD JUNE 2019

1 INTRODUCTION

The Nursing and Midwifery Council (NMC) introduced revalidation in April 2015 to strengthen the three-yearly registration renewal process and increase professionalism.

Whilst revalidation is the responsibility of the nurse or midwife, employers have a key role in helping to provide supportive environments and resources to ensure staff successfully revalidate and are registered to work in settings.

2 WHAT IS REVALIDATION?

Revalidation is the process that allows nurses and midwives to maintain their registration with the NMC.

As part of this process, all nurses and midwives need to meet a range of requirements designed to show that they are keeping up to date and actively maintaining their ability to practice safely and effectively. Nurses and midwives need to collect evidence and maintain records to demonstrate to a confirmer that they have met the revalidation requirements.

Every three years all nurses and midwives are asked to apply for revalidation using the NMC online system as a means of renewing their registration.

Completing the revalidation process is the responsibility of nurses and midwives themselves. They are the owners of their own revalidation process.

Revalidation is not an assessment of a nurse or midwives' fitness to practice, a new way to raise fitness to practice concerns or an assessment against the requirements of their current or former employment.

3 THE PURPOSE OF REVALIDATION

The purpose of revalidation is to improve public protection by making sure that nurses and midwives demonstrate their continued ability to practice safely and effectively throughout their career.

One of the main strengths of revalidation is that it encourages nurses and midwives to use the Code in their day to day practice and personal development. It is important for employers to be aware of the Code and the standards expected of registered nurses and midwives in their professional practice.

Revalidation includes requirements which encourages nurses and midwives to seek feedback from patients, service users and colleagues. It requires them to consider the role of their Code in their

practice by having a reflective discussion with another nurse or midwife and seeking confirmation that they have met those requirements from an appropriate person. It encourages engagement in professional networks and discussions and reduces professional isolation.

Revalidation enhances employer's engagement with the nurses and midwives they employ and increases their awareness of how, as regulated professionals, they meet the regulatory standards. It can encourage early discussions about practice concerns before they escalate or potentially require referral to the NMC and increase access to and participation in appraisal and professional development.

4 REVALIDATION RESOURCES

The Trust produced and has a suite of resources to assist and sign post staff to fulfil their revalidation. This was produced by the Practice Placement manager. The resources can be found on the Trust Intranet under NMC Nursing Revalidation.

5 TRUST COMPLIANCE/GOVERNANCE ARRANGEMENTS

At the Trust, Electronic Staff Records (ESR) central governance feed from the NMC systems which generates notifications, to ensure staff and their managers get notice of their re-registration date including when their revalidation is due.

These reminders are generated at six months, three months and then one month prior to the re-registration/revalidation date.

NMC registration information is also held within Health Roster; registered nursing staff are unable to be allocated rostered shifts without confirmation from the manager/system user that the registered nurse has completed the necessary requirements for re-registration/revalidation.

Since the introduction of revalidation in 2015; there have been no nurses at the Royal Orthopaedic NHS Foundation Trust subjected to fitness to practice concerns based on the revalidation process.

6 RECOMMENDATION

The Trust Board is asked to:

1. Receive this report.

Stacey Keegan; Deputy Director of Nursing and Clinical Governance.

30th May 2019.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Declaration to NHS Improvement – General Condition 6 – systems for compliance with licence conditions**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive & Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**5 June 2019**

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 '**Confirmed**' to the statement that the provider has complied with required governance arrangements, largely on the basis that the majority of enforcement undertakings concerning governance imposed by NHSI Improvement in 2017 were lifted during the year.

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 24 May, but is attached as Appendix C for completeness in public. It was published 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 declarations proposed
- Note the licence conditions declaration which was agreed on 24 May 2019.
- 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 2019 and specifically compliance with the Trust's licence to operate.

PREVIOUS CONSIDERATION:

The licence condition declaration was discussed at the May private session on 24 May 2019.

This template may be used by 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

Insert name of organisation

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"

Financial Year to which self-certification relates 2018/19 Please Respond

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

	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 foreseen risks identified to compliance with this statement.	#REF!
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 foreseen risks identified to compliance with this statement.	#REF!
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.	Confirmed	There are no foreseen risks identified to compliance with this statement.	#REF!
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.	Confirmed	There are no foreseen risks identified to compliance with this statement.	#REF!
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.	Confirmed	There are no foreseen risks identified to compliance with this statement.	#REF!
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 remains some residual risk around compliance with this statement on the basis of the current high vacancy rate for substantive nurse and medical staffing. The Trust has made a good number of job offers recently, however, which will address this. New staffing models will also be introduced during the year, further mitigating any risk around gaps in workforce.	#REF!

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 Jo Williams **Name** Yve Buckland

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates | Please Respond

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.

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	Jo Williams	**Name**	Yve Buckland
Capacity	Chief Executive	**Capacity**	Chairman
Date	05 June 2019	**Date**	05 June 2019

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.** • **Judgements under the Single Oversight Framework by NHS Improvement.** Currently Segment 3 • **Head of Internal Audit Opinion 2018/19** 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 use of the Board Assurance Framework and risk management systems & processes. **Trust Board agendas showing how items link to entries on the Board Assurance Framework and how the BAF is now carved up between Accountable Executive Leads. Ulysses action plan.**	DCA&CS
The Board has regard to such		• **CEO reports to Board highlighting new guidance issued.**	DCA&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
guidance on good corporate governance as may be issued by NHS Improvement from time to time		• **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 Staff Experience & OD Committee for oversight of workforce, staff engagement, leadership and development being embedded. Nominations and Remuneration Committee refreshed and revised terms of reference developed. **Committee structure in the Annual Governance Statement. Paper to Trust Board proposing the creation on the new Nominations and Remuneration Committee.** • 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** 2018/19 outlines the Board & Committee structure. • The Board and most Committees have **annual workplans**. • The **meetings structure chart** has been revised during the year	DCA&CS
	(b) Clear responsibilities for its Board, for committees reporting to the	• The Trust has a **Scheme of Delegation** in place which sets out the matters reserved to the Board. • The **terms of reference for the Committees** have been reviewed and amended during the year.	DCA&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	Board and for staff reporting to the Board and those committees;	• **Governance review** commissioned by the Chairman and reported back by a Non Executive at the June 2018 Board meeting. **Progress updates on actions within the governance review to Staff Experience & OD Committee.** • **CQC report** highlights that the governance arrangements in respect of the Board and its Committees is overall sound. **CQC action plan to show how any shortfalls are being addressed.** • 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 Board continued to be supported by an Interim Chief Operating Officer and Interim Director of Finance & Performance. **Job descriptions for Executive Directors. Objectives of the Executive Directors. Minutes of the Nominations and Remuneration Committee. Paper presented to the June 2018 meeting of the Nominations & Remuneration Committee around Executive Team structures.** • The Director of Corporate Affairs & 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 Director of Corporate Affairs & Company Secretary. Objectives of the Director of Corporate Affairs & Company Secretary.** • **A replacement 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.** • The Trust has an established divisional structure in place for clear accountability. **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.** • **Corporate governance framework** • **Board and committee workplans.**	CE
The Board is satisfied that the Trust effectively implements	(a) To ensure compliance with the Licensee's duty to operate	• **Internal and External Audit opinions considered by Audit Committee** • **Going Concern statement in Annual Report and paper to Audit Committee on Going Concern.**	DOF/CE

systems and/or processes:	efficiently, economically and effectively;	• **Finance & Performance Committee meeting papers demonstrating the detail considered to assess efficiency and effectiveness.** • **Papers on partnership working and STP.** • **Modular theatres business case.** • **Annual Report and Accounts 2018/19 showing that the Trust ended the year performing better than planned.**	
	(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 2018/19 by the embedding of the Staff Experience & OD Committee. • **Board meeting agendas.**	Ch/ DCA&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. The Trust was inspected in Quarter 4 2018/19 against the new CQC framework, with the outcome moving the trust from 'Requires Improvement' to 'Good' overall, with a 'Good' rating in each of the five CQC domains. An action plan to address any areas of shortfall identified by the CQC has been developed and progress is monitored through the Quality & Safety Committee, Executive Team meetings and Clinical Quality Group. • **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 contract meetings. Non adherence to agreed standards will lead to increased scrutiny/re-medial action plans and breach of contract notices/fines if non adherence to the contracts continues. Assurance of contractual compliance with Quality Standards is measured and gained through the **Patient Safety & Quality Report** scrutinised at Quality & Safety Committee and a **specific monthly report on performance against contract quality requirements considered quarterly by the Quality & Safety Committee**. • **Board and Statutory Regulators of health care professionals**: All registered NHS professionals are bound to their code of conduct and the rules and requirements of their registration therein. Failure to comply with their expected professional standards would lead to disciplinary action via the Trust's disciplinary policy and in some cases removal from their professional register. 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 Nurse**	CE/DN&CG/COO

		staffing updates to Staff Experience & OD Committee. Workforce overview to Staff Experience & OD Committee.	
	(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 and Trust Board.** • 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. **Agendas and minutes for these meetings may be used to evidence this.** • The Audit Committee considers Going Concern status and recommends statements for the annual report and accounts. **Going Concern paper to Audit Committee.** • The Trust has **Standing Financial Instructions** in place and any breaches of these are reported to the Audit Committee as part of its annual workplan**. Papers to Audit Committee.** • 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.**	DOF

		• The Trust during the year, has needed to seek cash support in the form of a loan from the Department of Health and Social Care. **Finance and Performance overview.**	
	(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.	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 24 May 2019, 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.**	Ch/ DCA&CS
	(g) To generate and monitor delivery of business plans	• Trust Board approves the **annual budget and operational plan**.	ALL

	(including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	• 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. **Agendas for these meetings may be used to evidence this.** • Internal Audit review key areas of interest and report findings to Audit Committee. **Internal Audit plan. Internal Audit progress reports.** • Delivery of audit recommendations is monitored at Audit Committee via **recommendation tracking reports.** There were concerns raised previously 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. • A summary of the internal audit plan and the level of assurance that the reviews have found is considered at the April meeting of the Audit Committee as part of the Head of Internal Audit's opinion. **Paper to the April 2019 meeting.**	
	(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.	ALL
"The Board is satisfied that the systems and/or	(a) That there is sufficient capability at	• 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 supported by an Associate Non-Executive Director, with a skill set in	Ch

processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:	Board level to provide effective organisational leadership on the quality of care provided;	workforce and improvement to strengthen the Board's expertise in this area. **Board member profiles in annual report.** • During the year the Board continued to be supported by an Interim Chief Operating Officer, whose initial remit was to address shortfalls in operational performance. There also continued to be an Interim Director of Finance to backfill the post vacated by the Acting Chief Executive. **Board structure in annual report.** • The Board's composition includes a Medical Director who is a practicing clinician, a registered nurse and two Non Executives with a clinical background. **Board structure in annual report.**	
	(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• 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 Interim 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.	DN&CG
	(c) The collection of accurate, comprehensive	• 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.	DN&CG

	, timely and up to date information on quality of care;	• Detailed reports into specific quality indicators are considered by the Quality & Safety Committee. **WHO compliance, VTE reports, mortality reports, consent and NICE guidance implementation**. • The Board considers a monthly **Finance & Performance Overview**, which includes a set of metrics including key national priority indicators and regulatory requirements. • A **Workforce Overview** has been developed which provides a suite of information which is scrutinised by the Staff Experience & OD Committee on alternate months. • Work is planned to develop a new integrated dashboard which provides a standard set of metrics to be considered by each of the Board Committees.	
	(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, consent and NICE guidance implementation**. • A formal quality assurance walkabout schedule has been in place during year which involves a number of staff from across a range of disciplines and areas. The outputs of these are considered by the Clinical Quality Group, with any exceptions being presented to the Quality & Safety Committee. **Updates from the Clinical Quality Group.** • 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.**	DN&CG

	(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into 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** • A new Patient Experience & Engagement Group has been established during the year to provide a more strategic focus on matters which involve patients. **Establishment request and terms of reference.**	DN&CG
	(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for	• 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 Nursing & Clinical Governance, the Medical Director, the Chief Operating Officer and the Chief Executive. **Terms of Reference for Quality & Safety Committee.** • The Trust has in place a Clinical Quality Group, chaired by the Deputy Director of Nursing & Clinical Governance which is attended by a range of clinical and non-clinical	DN&CG

	escalating and resolving quality issues including escalating them to the Board where appropriate	senior staff from across the Trust. **Agendas and terms of reference for Clinical Quality Group.** • 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. **Upward reports to Quality & Safety Committee from the Clinical Audit & Effectiveness Committee. Structure of the Knowledge Hub.**	
The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure		• 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 supported by an Associate Non Executive Director during the year with specific skills in workforce and improvement. This addresses a gap identified by the Board. A replacement Associate Director of Workforce, HR & OD has also been recruited during the year to strengthen the oversight of workforce matters. **Board structure in annual report.** • The Staff Experience & OD 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.	Ch/CE

compliance with the conditions of its NHS provider licence.		• 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. Following a number of successful recruitment events, a number of offers were made to individuals who will come into post later in 2019.	

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 latest of these has been around litigation and claims. The Council considered at its May 2018 meeting, a paper which refreshed the minds of the governors as to their statutory responsibilities. A self-assessment of the governors was undertaken during the year which highlighted the following positive areas in terms of the operation of the Council of Governors: • skill mix of governors; • governors working in accordance to the Trust's values; • there being processes in place to ensure sufficient debate for major decisions or contentious issues; • quality of discussion and debate; • quality of general information and papers provided to governors; • support to the Council of Governors; • understanding of the key points in the annual report and accounts and the mechanisms in place to be able to ask relevant questions before they are finalised; • understanding of the principal purpose of the Trust; • the evolving processes to enable to governors to hold the Non Executives to account; • governors being able to identify the key performance challenges of the Trust This evidences that the Council feels comfortable with its standard duties. Further work is planned during 2019/20 to strengthen the partnerships with governors of other peer organisations and to formalise a training plan. **Minutes from Council of Governors meetings. Training material on Litigation and Claims. Council of Governors self-assessment.**	DCA&CS

KEY:

Abbreviation	Job Title
CEO	Chief Executive Officer
COO	Chief Operating Officer
DOF	Director of Finance
DPS	Director of Nursing & Clinical Governance
DCA&CS	Director of Corporate Affairs and Company Secretary
Emboldened text indicates evidence available to confirm compliance	

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.	Confirmed	OK

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:

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	Jo Williams	**Name**	Yve Buckland
Capacity	Chief Executive	**Capacity**	Chairman
Date	24 May 2019	**Date**	24 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 3 July 2019

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 3 July 2019 commencing at **1100h** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust Headquarters.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 3 July 2019: 1100h – 1330h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and Non Executive Director	(TP)
Mr Rod Anthony	Non Executive Director	(RA)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Interim Executive Director of Finance	(SW)
Mrs Marie Peplow	Acting Executive Chief Operating Officer	(MP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
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	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]
Mrs Julie Gardner	Assistant Director of Finance	(JG)	[Item 1]
Prof Surinder Sharma	Specialist Adviser on Equality & Diversity	(SS)	[Item 14]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Service improvement story – Bone Infection service	Presentation	JG
1120h	2	Apologies – Kathryn Sallah	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 5 June 2019: *for approval*	ROHTB (6/19) 012	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (6/19) 012 (a)	SGL
1135h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (7/19) 001 ROHTB (7/19) 001 (a)	YB/JW
	6.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	JW
		QUALITY & PATIENT SAFETY		
1155h	7	Update from the Quality & Safety Committee: *for assurance and approval*	ROHTB (7/19) 002	DG
1205h	8	Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	ROHTB (7/19) 003 ROHTB (7/19) 003 (a)	JW

TIME	ITEM	TITLE	PAPER	LEAD
1215h	9	Patient Safety & Quality report: *for assurance* BAF REF: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	ROHTB (7/19) 004	GM
		FINANCE AND PERFORMANCE		
1225h	10	Update from the Finance & Performance Committee: *for assurance*	ROHTB (7/19) 005	TP
1235h	11	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (7/19) 006	SW
1245h	12	Proposal to use the Trust Seal: *for approval*	ROHTB (7/19) 007	SGL
		WORKFORCE		
1255h	13	Update from the Staff Experience & OD Committee workshop: *for assurance*	Verbal	RP
1300h	14	Equality & Diversity at the ROH: *for assurance & approval*	Presentation	SS
		MATTERS FOR INFORMATION		
1320h	15	Meeting effectiveness	Verbal	ALL
	16	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 4th September 2019 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.

MEMBER	MEETING DATE										TOTAL
	3/4/2019	1/5/2019	5/6/2019	3/7/2019	4/9/2019	2/10/2019	6/11/2019	4/12/2019	5/2/2019	4/3/2019	
Yve Buckland (Ch)	✓	✓	✓								/10
Tim Pile	✓	A	✓								/10
Kathryn Sallah	✓	✓	✓								/10
Rod Anthony	✓	✓	✓								/10
Richard Phillips	✓	A	✓								/10
David Gourevitch	✓	✓	✓								/10
Simone Jordan	✓	✓	✓								/10
Paul Athey #1	✓	✓									2/2
Jo Williams #2	✓	✓	✓								/10
Matthew Revell	✓	✓	✓								/10
Garry Marsh	A	✓	✓								/10
Phil Begg	✓	✓	A								/10
Marie Peplow			✓								/8
Stephen Washbourne	✓	✓	✓								/10

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		
#1	Acting Chief Executive until 6 May 2019	#2	Chief Executive from 6 May 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 6 June 2019: 1100h – 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)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(AP)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Marie Peplow	Acting Chief Operating Officer	(MP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Dr Sarah Marwick	Shadow Non Executive Director	(SM)	
Miss Stacey Keegan	Deputy Director of Nursing & Clinical Governance	(SK)	[Items 13 & 14]
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient story – JointCare follow up	**Presentation**
A video was shown which featured a patient that had undergone treatment through the JointCare pathway. The patient described how they had recovered well and was well supported to regain his mobility following surgery. It was noted that the recent JointCare reunion had worked well and was well received by all those that had attended. All involved in the JointCare work to date were congratulated and thanked for the success to date of the process. It was agreed that a full review of JointCare would be presented to the Board later in the year.	
ACTION: SGL to schedule in a presentation about JointCare into the Board	

workplan	
2 Apologies	
Apologies were received from Professor Phil Begg. The Board welcomed a potential candidate for the Chief Operating Officer post and representatives from Johnson Johnson Ethicon.	**Verbal**
3 Declarations of interest	**Verbal**
It was noted that the register was available on request from Company Secretary.	
4 Minutes of Public Board Meeting held on the 1 May 2019: *for approval*	**ROHTB (5/19) 010**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held on 1 May 2019.	
5 Trust Board action points: *for assurance*	**ROHTB (5/19) 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 (6/19) 001** **ROHTB (6/19) 001 (a)**
The Chief Executive reported that the staff awards were now scheduled for 7 February 2019 and further information would be issued shortly. The embargoed national inpatient survey results had been received and would be discussed by the Quality & Safety Committee at a future meeting. It was noted that a proposal to establish a Hospital Management Group would be received later on the agenda. This forum was designed to facilitate communication between the Executive Team and the most senior clinical staff and would assist with strategy development where needed. The Group would meet on a monthly basis. A team had visited the ROH to discuss how a set of control charts could feed into Board reporting processes. A demonstration of this would be established for the beginning of a future Board meeting. Work had started for the modular theatres set up, with the enabling works now underway. There was positive progress on a number of fronts and thanks were extended to all involved.	

It was noted that the detail in the CEO report was welcome and it was good to see that the report covered the STP relationships and pathways across the city. The Chairman reported that she had Joined the 'Breaking Ground' event for the new modular theatres and had hosted the farewell event for Paul Athey, former Acting Chief Executive. It was reported that the recent Council of Governors meeting had been positive and the governors wanted to thank the Executive Team for their work to generate such a sound and engaged environment. It was noted that it was good to see some positive engagement with the contractors delivering the modular theatres set up.	
ACTION: JW to organise for a demonstration of control charts to be presented to the Board	
6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was reported that there was an intention to develop JointCare across the city and Mr Pearson, former Medical Director and consultant surgeon was leading the work. There were some relationships created as a result of some cross working between ROH and Heartlands, Good Hope and Solihull hospitals. A new organisational structure was in place at University Hospitals Birmingham NHSFT (UHB) and the new relationships were being worked through and were anticipated to deliver some traction with the work. It was noted that some other organisations would visit the Trust and the Trust was being established as a reference site for JointCare.	
6.2 Hospital Management Group: terms of reference: *for approval*	**ROHTB (6/19) 002** **ROHTB (6/19) 002 (a)**
It was reported that there was an intention to amalgamate the Clinical Service Leads group and the Executive Team to facilitate some joint communication and engagement in decision making. It was critical that the senior clinical individuals were part of the journey and this would assist. It would meet monthly and report upwardly to the Trust Board as part of the Chief Executive's report. It was suggested that the estates function and some other corporate departments could be involved. The Board was advised that guests could be requested by invitation but the intention was to keep the core group of individuals small initially. In the context of leadership, it was suggested that a responsibility around role modelling and leadership of culture should be added into the terms of reference.	

The terms of reference were approved subject to this addition.	
ACTION: SGL to amend the terms of reference for the Hospital Management Group in line with suggestions made	
6.3 Update from the Council of Governors meeting held on 22 May 2019	**Verbal**
The Chairman reported that the key items of discussion at the meeting of the Council of Governors held on 22 May 2019 had been: • Summary of progress with the paediatric transition and Birmingham Hospitals Alliance • The extension to the terms of office of Simone Jordan and Tim Pile, which had been agreed • Overview of the strategy on a page • Summary of the recent staff survey results • Consideration of the draft annual report and accounts • Update from the Board committees It was noted that the governors were working effectively and were a high quality set of individuals.	
7 Update from the Quality & Safety Committee: *for assurance and approval*	**ROHTB (6/19) 003**
Mrs Sallah presented the key points of discussion from the meeting of the Quality & Safety Committee that had been held on 29 May 2019. She reported that there had been a discussion about water safety. The action plan around this was to be presented at the last meeting, however the Executive Team was to review this prior to the next meeting. It was emphasised that the safety of water was not in question however the governance of the processes to safeguard water safety needed to be strengthened. It was noted that the Infection Control Lead and the Associate Director of Estates & Facilities were aligned on this work. The issues raised as part of the health and safety update were noted. These were being discussed by the Executive Team and the reporting processes would be reviewed. There was good work around the handling of NICE guidance and the new HealthAssure system was working well. There was some question over the timeliness of the handling to date of some of the guidance that had arrived prior to	

the new processes, however the Board was reassured that there were no patient safety issues as a result of the delay.	
8 Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	**ROHTB (6/19) 004** **ROHTB (6/19) 004 (a)**
It was reported that the team had been working on the communication of the transfer of services, given that the plans were due to culminate shortly. There were no changes to the milestones in the plan, however on the Friday before the service closed any inpatients would be transferred to Birmingham Children's Hospital (BCH) by ambulance. The staff would hold a celebratory event to mark the service; this was an opportunity to say farewell to the team. There was some thought being given to arranging some structured support sessions to staff remaining at the ROH. The services that remained on the ROH site included the CT biopsy pathway. The new pathway would be presented to the BCH Children's Board for agreement. Any urgent requirement to support children on this site would be via an emergency transfer to BCH. The ambulance service had been made aware. It was agreed that representatives of the BCH Board should be invited to visit as part of the final phase of the project.	
9 Patient Safety & Quality report: *for assurance* BAF Ref: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	**ROHTB (6/19) 005**
It was reported that the patient safety and quality report had been scrutinised by the Quality & Safety Committee on 29 May 2019. There had been a decrease in the number of incidents during the month which may be related to the planned theatre closure. There were two provisional moderate harms cases and the Root Cause Analyses (RCAs) were being undertaken to understand the incidents, however initial reviews did not identify any key shortfalls. There had been no Serious Incidents reported during the month and no RCAs had been closed. There were no reported VTEs. There had been 11 falls reported, all of which scored as causing low or no harm. It was suggested that the Throne Project needed to be closed at some point. There were no reported pressure ulcers in April and an in-depth action plan for	

Tissue Viability had been presented to the Quality & Safety Committee. The themes from complaints were noted to be covered by existing action plans. 451 compliments had been reported to have been received which was very positive. It was suggested that a 'thank you' wall be established. There was 100% compliance with the WHO checklist, which was pleasing. There was one pseudomonas infection reported which was a reportable case. The RCA was underway to understand the reasons behind this. It was noted that the quality report was currently largely focussed on nursing indicators at present, however it would include other measures in due course. These would include medical indicators, such as outcomes and other information currently publicly available. It was noted that some of the audit results were to be presented at a future meeting of the Quality & Safety Committee.	
10 Update from the Finance & Performance Committee: *for assurance*	**Hard copy**
Tim Pile reported that the financial position was broadly positive, although cautioned that this only reflected the first month of the year to date. There was evidence of good grip including on the Cost Improvement Programme and operational delivery. It was noted that in terms of 'Perfecting Pathways', there was good progress across all aspects. The impact of the pensions issue on the Control Total was noted to be a key risk. It was noted that there was good progress with nurse recruitment. 190 job offers were being processed. Those responsible for organising the recruitment fayres were congratulated.	
11 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	**ROHTB (6/19) 007**
The Director of Finance reported that the financial position was encouraging: an in-month deficit of £799k had been achieved against a planned deficit of £809k. It was reported that there was an expectation that the financial position improved towards the end of the year due to the receipt of the Financial Recovery Funds. There had been a national directive from NHS Improvement for trusts to resubmit	

their plans. The ROH's plan had been reprofiled and resubmitted, yet the Trust had not been asked to reset its financial targets.

In terms of opportunities for the year ahead, it was noted that there was a realistic Cost Improvement Programme (CIP) that had been set. This was £1.5m which was less than previous years. There was also a stretch target and incentivisation plans were being considered. The managed theatres schemes was noted to be a significant element of the overall CIP. A business case would be brought back to the Board for approval in due course.

There was also expected to be a benefit from Procurement via the new collaborative arrangements.

Cash was noted to be in line with plan, although there was little flexibility in this position. Some of the payments from the Clinical Commissioning Group (CCG) had been delayed which had impacted to some degree. These payments had now been made however if this occurred again, then the issue would be escalated.

In terms of operations, the theatre utilisation target had been met.

Cancellations on the day had reduced to 0.3%. The 72-hour call was being embedded and was working well. Length of Stay was reducing and work was underway to define specifically the benefits of JointCare. Outpatient waiting times were reducing well.

There was strong performance against the diagnostics targets and Quality Standard for Imaging accreditation was being sought.

The trajectory for the Referral to Treatment Time target had been exceeded. For May, it was expected that the Oncology Arthroplasty speciality would meet the national standard.

Cancer performance was good, with all targets being met. There was shadowing against the faster diagnostic target and performance was good to date and better than the national position. There was a focus on 62-days targets and 104-day waiting times. The Somerset tracker was working well.

There were no patients waiting in excess of 52 weeks and there was a reduction in the patients waiting 40 weeks and over. There was no harm associated with these patients waiting a long time and where needed these individuals were reviewed through the harm review process.

Overall the morale of consultants was good.

An internal peer review of cancer had been undertaken which provided some

positive view.	
12 Update from the Staff Experience & OD Committee: *for assurance*	**ROHTB (6/19) 008**
Simone Jordan reported that the pension issues had been considered and also the issue around estates had been considered. There had been some good achievements through the apprenticeships work which was acknowledged region-wide as best practice. The Trust had used all its levy and was promoting these opportunities positively. Thanks were given to David Richardson, Head of Education & Training for this work. The new Nursing and Midwifery Council (NMC) standards for education and training had been discussed, which introduced some markedly different standards and requirements for staff. Thanks were given to Steph Mawson, Practice Placement Manager. It was noted that the mandatory training position had improved. Appraisals would be given additional focus. It was suggested that there were plans to revise the appraisal process.	
13 Safe Nurse Staffing report: *for assurance and approval*	**ROHTB (6/19) 009** **ROHTB (6/19) 009 (a)** **ROHTB (6/19) 009 (b)**
The Committee welcomed Stacey Keegan, Deputy Director of Nursing and Clinical Governance. She presented a report to describe the work to gain compliance with national guidance associated with nurse staffing. This Board was advised that the report was a statutory requirement to sight the Board on nurse staffing standards. In terms of students and universities, there was a challenge associated with withdrawal of the Learning Beyond Registration (LBR) funding. The support arrangements for staff as they started needed to be considered. Good progress had been made to fill the nurse vacancy gaps, particularly in theatres. In terms of reporting nurse staffing to regulators, average fill rates were reported to NHS Improvement monthly. These were met and exceeded above the 90% threshold each month. In terms of Care Hours Per Patient Day (CHPPD), there was a nationally agreed variation and on an average basis this was filled at the ROH. The metrics were reviewed in conjunction with sickness, skill mix and bank and agency usage. It was noted that the Trust used tools, such as SafeCare and the Sheldon tool in support of professional judgement around nurse staffing levels. The use of 'Red Flags' was noted to be in place. Ulysses was used for this and the	

Allocate System would be used in future. There had been no concerns around harm over the past twelve months. The Ward Healthcheck was used as part of the Quality Report. A daily staffing huddle was held. Processes and escalation was in place for the use of temporary staffing. Check and challenge sessions were reported to be held around rostering processes. A business case for nursing associates was noted to have been approved in March and these individuals would join the Trust in future. Assessing any impact on quality was noted to be integral to these plans. Retention rates for nursing were noted to be good but an improvement to this had been set as an ambition. Career pathways and health and wellbeing offerings were being considered. It was noted that nursing establishments should be reviewed twice yearly and signed off by the Executive Director of Nursing. The Board reviewed the risks associated with nurse staffing. Two of these would be closed when paediatric services moved. It was suggested that the work needed to dovetail into the overall workforce planning process. At present there was no standard model for workforce planning and this needed to be addressed. It was noted that there was a particular skillset associated with this and expert training needed to be considered where appropriate. In terms of the reduction in the use of agency staff, it was noted that there had been good investment in nursing. Assessing the impact of seven-day activity on establishments was underway. It was noted that the matrons carried corporate roles and therefore were not included in the nursing establishments. There were improvements in quality metrics associated with nursing care. It was noted the use of degree apprenticeships might be considered as part of the workforce plans in future. Miss Keegan was thanked for her work on nurse workforce planning.	
14 Nurse revalidation: *for information*	**ROHTB (6/19) 010** **ROHTB (6/19) 010 (a)**
It was noted that the report was presented to the Board for information. The first three-year revalidation cycle had been completed following the	

introduction of the guidelines. This had strengthened the standard appraisal process. From a compliance and governance perspective, the Electronic Staff Record (ESR) was used for monitoring registration and revalidation. Notifications were issued to managers and individuals. There had been no concerns raised in terms of fitness to practice.	
15 Annual declarations: Corporate Governance Licence Condition and Governor training: *for assurance*	**ROHTB (6/19) 011** **ROHTB (6/19) 011 (a)** **ROHTB (6/19) 011 (b)** **ROHTB (6/19) 011 (c)**
The Director of Corporate Affairs & Company Secretary advised that it was a requirement of the governance condition of the Trust's licence that the Trust published a statement within three months of the end of the financial year setting out whether it believed it had 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 The Board's attention was drawn to an appendix to the paper presented, which outlined the rationale and core evidence that the Board could rely on in order to confirm or otherwise, the declaration relating to the Corporate Governance statement and the other declaration. It was proposed to declare '**Confirmed**' to the statement that the provider had complied with required governance arrangements, largely on the basis that the majority of enforcement undertakings concerning governance imposed by NHS Improvement in 2017 were lifted during the year. It was reported that NHS Improvement also required 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 was recommended to make a declaration of '**Confirmed**' in respect of Governor training. The Board was advised that foundation trusts were also required to make annual declarations to NHS Improvement regarding their systems for compliance with	

provider licence conditions (General Condition G6). The Board was reminded that the licence condition declaration had been discussed at the May private session on 24 May, but was provided for completeness in public. It was published on 31 May in line with the required deadline. It was noted that all of these declarations must be made 'having regard to the views of governors'. The Board was asked to note that although the meeting cycle for the Council of Governors had not permitted discussion at a formal meeting, the proposed declarations had been circulated to the Council of Governors for comment; to date all governors who had responded had agreed with the proposed declarations. Any further feedback received would be taken into account ahead of the formal publication at the end of June. On the basis of the evidence provided, the Board approved the suggested responses to the declarations.	
16 Meeting effectiveness	**Verbal**
The meeting had finished earlier than planned. It was noted that there was a Board Development session planned for October. The balance of the meeting was agreed to be good.	
17 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 3 July 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 3 July 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 28.06.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	~~05/09/2018~~ ~~05/06/2019~~ 03/07/2019	Update on therapy services planned for the private Board meeting in September, with the strategy due for presentation in November 2018. Ongoing discussions around therapies with commissioners, thereby not in a position to be able to present updated strategy until ~~Spring~~ ~~June~~ July 2019. (Deferred to July from June due to annual leave).	
ROHTBACT. 073	Orthopaedic Services in the STP	Verbal	03/04/2019	Invite Mr Pearson to the Trust Board when the orthopaedic pathway re-engineering work commenced	SGL	05-Jun-19	Rearranged for the July meeting to allow a more comprehensive update to be given	
ROHTBACT. 074	Corporate and strategy extract of the Board Assurance Framework	ROHTB (4/19) 013 ROHTB (4/19) 013 (a)	03/04/2019	Arrange for an additional risk around the impact of planned growth and modular theatres to be added to the Board Assurance Framework	SGL	05-Jun-19	To be included as part of the Board Assurance Framework refresh. Refresh to be ready for the ~~July~~ September meeting.	
ROHTBACT. 075	Finance & Performance extract of the Board Assurance Framework	ROHTB (4/19) 007 ROHTB (4/19) 007 (a)	03/04/2019	Refresh the risks on the Board Assurance Framework	Exec	05-Jun-19	Board Assurance Framework refresh planned for May 2019. Refresh to be ready for the ~~July~~ September meeting - Executive Team workshop planned for 9 July to discuss.	
ROHTBACT. 077	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Arrange for an update on Mental Health to be provided at a future meeting	SGL	04-Sep-19	ACTION NOT YET DUE	
ROHTBACT. 078	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Provide an update on environmental sustainability at a future meeting	PB	04-Sep-19	Added to the agenda of the September 2019 meeting	
ROHTBACT. 079	Patient story – JointCare follow up	Presentation	05/06/2019	Schedule in a presentation about JointCare into the Board Workplan	SGL	06-Nov-19	Added to the November Board meeting agenda	
ROHTBACT. 080	Chairman's & Chief Executive's update	ROHTB (6/19) 001 ROHTB (6/19) 001 (a)	05/06/2019	Organise for a demonstration of control charts to be presented to the Board	JWI	02-Oct-19	Added into the October workshop agenda	
ROHTBACT. 076	Communications update	Presentation	01/05/2019	Build a routine update on communications into the Board workplan	SGL	05-Jun-19	Added as a quarterly update into the workplan	
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~~ 01/05/2019	Attended at the May meeting of the Trust Board	
ROHTBACT. 081	Hospital Management Group	ROHTB (6/19) 002 ROHTB (6/19) 002 (a)	05/06/2019	Amend the terms of reference for the Hospital Management Group in line with suggestions made	SGL	03-Jul-19	Amended to reflect the need to role model and to lead the culture	

KEY:

	Verbal update at meeting
	Major delay with completion of action or significant issues likely to prevent completion to time
	Some delay with completion of action or likelihood of issues that may prevent completion to time
	Action that is not yet due for completion and there are no foreseen issues that may prevent delivery to time
	Action that has been completed since the last meeting

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**3 July 2019**

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 Public Trust Board on 3rd July 2019

1 EXECUTIVE SUMMARY

1.1 This paper provides an update on some of the most noteworthy events and updates since the last Board on 5th June 2019 from the Chief Executive's position. This includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 After receiving our National Inpatient survey (2018) results the Trust was subsequently notified that we had performed "better than average" and placed the Trust in the top 8 across the Country (Appendix 1). This is a fantastic achievement which reflects the commitment of the ROH staff across the Trust.

2.2 We held the first stage of interviews on the 24th June 2019 for the substantive Chief Operating Officer post for those who had been long listed (eight candidates). Four candidates have been shortlisted and the process will be concluded by the beginning of August 2019.

2.3 On Wednesday 26th June 2019 a commemorative event was held to celebrate 200 years of paediatric services at the ROH. Staff received a commemorative badge to acknowledge the part they have played in delivering paediatric services. Representatives from the COST campaign delivered a patient / parent tribute to the services they had received over the years on ward 11. The event was well received by all the staff.

2.4 The ROH Inpatient Paediatric Service transferred to Birmingham Women & Children's NHS Foundation Trust (BWC) on Friday 28th June 2019. The new service will commence at BWC on Monday 1st July 2019 with a formal meeting structure in place with the ROH to support the transition and ongoing operational performance.

2.5 The reunion meeting as part of the Jointcare pathway, continues to be successful seeing over 80 people attend the second session at Bournville Gardens.

2.6 On Monday 24th June 2019 we launched the Health and Wellbeing programme at the ROH as part of my 'Start of the Week'. The message included how we want to create a "the health and wellbeing hospital" and describes how we will develop this to include a set of key principles: -

i) We will prioritise the mental and physical health and wellbeing of staff and volunteers

ii) We will provide a programme of wellbeing activities, resources and opportunities, tailored to the needs of our workforce

iii) We will recruit a wellbeing officer and properly resource the programme to drive forward the wellbeing agenda

iv) We will encourage everyone to participate, share and lead in recognition of the fact that wellbeing is a collective responsibility

v) We will measure the impact of wellbeing initiatives to assess how to improve the support we offer and demonstrate the impact of prioritising wellbeing

Further information will be shared with the teams over the next few weeks with a programme of activity to follow.

2.7 On Wednesday 26th June the Trust went live with a new system partnership to improve our communication with patients. DrDoctor is an external IT provider who supply and manage electronic communications with patients around clinic appointments. These notifications will contain the phone number to the appointments team as well as a hyperlink that takes patients to the DrDoctor website and asks them to create an account. It will also provide an option for the patient to reply to the text typing the word "CHANGE" if the appointment is not convenient. If they do this then a member of the appointments team will contact them to rearrange their appointment for a convenient time.

2.8 The Trust has had the honour of hosting a little boy who is related to a member of the ROH family. He has a rare and life-threatening immune system disorder and needs a transplant. On Tuesday 25th June the charity DKMS visited the Trust to ask volunteers to be swabbed for a potential match. The boy and his parents have received a lot of media interest to help find a match and Sky News filmed live at the Trust to raise the profile of the campaign. We had over 230 members of staff participate and the parents were heartened by the welcome and response by the Trust.

3 STP UPDATE

3.1 Professor Phil Begg attended the Birmingham and Solihull STP (BSol) away day on the 5th June 2019 to discuss plans from moving from the current STP form, to an Integrated Care System (ICS) in line with government strategies for health and social care.

3.2 The timeline for the establishment of an ICS is that each system should be in a position to launch its ICS by 1st April 2021. The attachment, represents the notes from the day and the discussions that ensued throughout the day.

3.3 A GP has confirmed that he will attend the STP CEO's meeting on behalf of primary care which is a pivotal to ensure that general practice is involved in the STP partnership and system wide solutions.

4 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

4.1 There have been no meetings of the BHA Board since the last ROH Board report.

4.2 The BHA collaborative procurement hub will commence in July 2019.

5 NHSI/NHSE

5.1 Appended to this paper is a copy of the letter which we have received from NHSI/E providing feedback on our operational plan for 2019/2020.

6 POLICY APPROVAL

6.1 Since the Trust Board last sat, there have been no policies presented to the Chief Executive, on the advice of the Executive Team for approval.

7 RECOMMENDATION(S)

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

7.2 Note the contents of the report.

Jo Williams

Chief Executive

28th June 2019

Care Quality Commission
151 Buckingham Palace Road
London
SW1W 9SZ

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

17 June 2019

Joanne Williams

Chief Executive Officer

The Royal Orthopaedic Hospital NHS Foundation Trust

Publication of CQC's 2018 Inpatient Survey

Dear Mrs Williams,

We plan to publish national results for the 2018 Adult Inpatient Survey on 20th June 2019, which looked at the experiences of 76,668 respondents who were treated and cared for in hospital as an inpatient during July 2018.

The survey asked patients for their views on aspects of their care, such as whether they felt they were treated with dignity and respect and whether they had confidence and trust in staff.

I am writing to you as we also intend to publish a separate report on the same day that focuses on variation in results at trust-level. I am pleased to inform you that your trust was identified as performing **'much better than expected'** compared to other trusts within the survey. This was because a higher proportion of patients responded positively about the care they had received.

The report will be available at the following link:
www.cqc.org.uk/inpatientsurvey

The statistical method used to identify positive patient experience focuses on the most positive response option a patient can select for any scored question. Patients at your trust gave the most positive answers to questions, across the whole survey, more frequently than the England average (66%).

We will continue to reflect your trust's performance on this survey within our Insight products as part of the information we have on how trusts are performing.

While I am sure you will want to share the results of this survey with your staff, the national level results in the Inpatient Survey statistical release, highlighted a substantial number of areas which could be improved. We, therefore, would also encourage you to look at your benchmark report, in order to identify any areas where you can continue to support further improvement.

We will shortly be advising NHS Improvement of the positive findings from your survey results by sharing a copy of this letter.

Yours sincerely

Professor Ted Baker

Chief Inspector of Hospitals

CC

Lisa Kealey (Public and Patient Services Manager, and Trust Survey Lead)

Michelle French (PALS Manager)

Siobhan Taylor (CQC Inspector)

Zoe Robinson (CQC Inspection Manager)

Julia Holding (NHS Improvement)

Ian Baker (NHS Improvement)

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Joanne Williams
Chief Executive
The Royal Orthopaedic Hospital
NHS Foundation Trust

Paul Jennings
Accountable Officer
NHS Birmingham and Solihull CCG

26 June 2019

Dear Joanne and Paul,

Operational Planning 2019/20: Feedback

Please note the letter below combines feedback to each provider and its lead commissioner in order to ensure consistent messaging.

Thank you for submitting your Operational Plan for 2019/20. I am writing to acknowledge receipt of your plan, recognise the significant work that has gone into developing a clear plan for 2019/20 and to highlight the next steps that will need to be taken during a challenging period for the NHS.

It is critical that the Trust and Clinical Commissioning Group meets the commitments in its annual plan to deliver safe, high quality services and the agreed access standards for patients within the resources available. I look forward to working with you during this year to ensure that these ambitions can be delivered.

NHS England and NHS Improvement integrated locality teams have undertaken a detailed review of your submitted plan. As part of this review, I would like to draw your attention to the following points:

Finance:

- We are pleased with the stabilisation of the Trust's financial position and the achievement of the control total over the last two years. Having reviewed your 2019/20 plan we are confident that you have sufficient resource and opportunity available to deliver, therefore we consider your plan to be of low financial risk.
- You should continue to build your system relationships and use this as a vehicle to deliver financial improvement both within your own and wider system. In particular, efficiency programmes should be focused on delivering sustained productivity improvements and recurrent cost reductions, with organisations continuing to work with STP partners across the system to

support the development and delivery of productivity and transformational service improvements at system level.
- We expect you to rigorously prioritise capital spend for 2019/20, ensuring only essential capital spend is incurred, by re-prioritising and deferring spend where safe and appropriate to do so.

Elective Care:

- The Trust should continue to manage and monitor its total waiting list size and as a minimum, deliver RTT performance in line with the submitted trajectories, this includes zero 52ww. Please advise us of any material impact to your waiting list and performance trajectory once the service transfer to Birmingham Women's and Children's Foundation Trust is finalised.
- Your contribution to the STP elective care transformation programme is important to ensure delivery of these initiatives, which will be monitored through the STP.

Quality:

- We have previously provided you with feedback on your quality plans and the need for a comprehensive approach to quality improvement, leadership and governance.
- We will continue to have oversight of the safety and quality of your services and the impact on patient and carer experience, including gaining understanding of: how the Trust is addressing the implementation and reporting of achieving 7 day services; what specific areas of the Long Term Plan that the Trust and the wider system will focus on; and further understanding of your QIA process and the oversight of cumulative impact of multiple efficiencies.

Workforce and Agency:

- We recognise the hard work that has taken place to reduce agency expenditure over recent years; this will need to continue this financial year to secure delivery of your agency plan and ceiling.

It is our intention to utilise your final, submitted, Operational Plan for 2019/20 as the basis on which we assess and measure your performance for 2019/20. Alongside this, my team and I will continue to work with you to ensure you have the necessary support to strengthen your capability and capacity to deliver your Operational Plan for 2019/20 and in doing so to deliver safe, high quality services.

If you have any questions about the content of this letter, please do not hesitate to contact me or your relationship manager.

Yours truly

Rebecca Farmer
Acting Director of Strategic Transformation, West Midlands
NHS England and NHS Improvement

Cc: Paul Jennings, Birmingham and Solihull STP Lead
Philip Johns, NHS Birmingham and Solihull CCG

ROHTB (7/19) 002

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 26 June 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There had been three incidents reported which included similar complications. Assurance was given that these were unrelated and there were no systemic issues that had caused these. In addition to the usual Root Cause Analysis process, the Medical Director would be undertaking a themed review. • The Committee was made aware that there had been a Never Event reported. There had been no harm to the patient. A full investigation and statutory notifications were underway. • There had been six formal complaints received. The Committee was advised that due to issues with resources within the complaints team, it was temporarily challenging to meet the required timescales for issuing complaints responses. The local Clinical Commissioning Group would be made aware. • Three new claims had been received by the Trust, all of which were already being investigated as part of a complaint or incident. • There was further work planned to formalise a Service Level Agreement for diabetes support, this being in line with NICE guidance. In the meantime there was access to a diabetologist if and when needed. • There was a gap in provision of assurance up to the Drugs and Therapeutics Committee in respect of medical gas safety. Work was underway with the estates function to rectify this. • Inconsistent attendance by the estates function at the Infection Control Committee was raised as a concern.	• Present an update on the outcome of the review of the vascular incidents at the August meeting. • Provide an update on resuscitation training levels at the next meeting. • Chief Executive to discuss the concerns raised by the Chair of the Drugs and Therapeutics Committee around the control of FP10 prescription pads in the out of hours GP environment. • The business case for hydrotherapy was being developed. • Confirm whether the Associate Director for Estates and Facilities was being invited to the Drugs & Therapeutics Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The water safety action plan had been reviewed by the Executive Team and it was clear that the work was on track. The plan would be	• Given that there was sufficient assurance provided over the plans to ensure that all relevant staff were vaccinated against Hepatitis B, the matter no longer needed to be included on the Committee's agenda. It

received at the August meeting of the Committee when it was anticipated that it would be completed. • Work was underway between the Chief Executive and the Director of Strategy & Delivery to refine the Health & Safety processes and accountabilities. • There had been no pressure ulcers reported in May. • 511 compliments had been received. • There was sound operational performance against the range of key metrics, including the Referral to Treatment Time target, the trajectory for which had been met. • There remained low levels of cancellations on the day of surgery. • There had been some good progress in clearing the backlog incidents on Ulysses.	would be remitted to the Staff Experience & OD Committee for an annual update.
• **Chair's comments on the effectiveness of the meeting: It was agreed that a deputy for the Medical Director should attend in the event that he could not attend in person.**	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Paediatric transition update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Janet Davies, Clinical Service Manager / Project Lead for the Paediatric Transition**
DATE OF MEETING:	**3 July 2019**

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:

- Key workstream updates
- Timeline updates
- Governance
- Services which remain on site at the ROH

REPORT RECOMMENDATION:

The Board is asked to accept 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		Communications & Media	x
Business and market share	x	Legal & Policy		Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

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

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

There are a number of risks on the corporate risk register and Board Assurance Framework that relate to the transfer of Paediatric services.

PREVIOUS CONSIDERATION:

Last considered as part of the Trust Board public agenda on 5 June 2019.

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Paediatric Service Update

UPDATE TO THE TRUST BOARD ON 3rd JULY 2019

1 Executive Summary

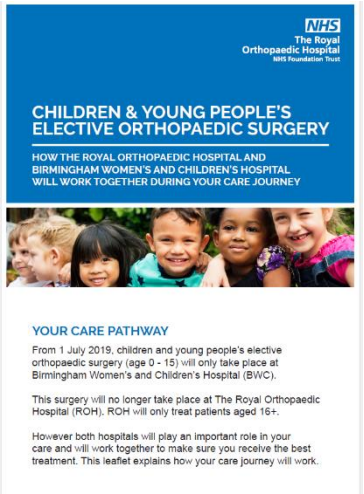
This paper provides an update on the transition of paediatric inpatient & day case surgery from The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) to Birmingham Women's & Children's NHS Foundation Trust (BWC), and includes:

- Key workstream updates
- Timeline updates
- Governance
- Services which remain on site at the ROH

2. Key workstream updates

Communication and Engagement

As shared at the last board meeting joint communications between ROH and BWC has been shared with key stakeholders and added to the ROH website. The below information leaflet is given out to patients attending clinic guiding them to the most up to date information on our website and provide them with contact details for each site.


NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

CHILDREN & YOUNG PEOPLE'S ELECTIVE ORTHOPAEDIC SURGERY

HOW THE ROYAL ORTHOPAEDIC HOSPITAL AND BIRMINGHAM WOMEN'S AND CHILDREN'S HOSPITAL WILL WORK TOGETHER DURING YOUR CARE JOURNEY

YOUR CARE PATHWAY

From 1 July 2019, children and young people's elective orthopaedic surgery (age 0 - 15) will only take place at Birmingham Women's and Children's Hospital (BWC).

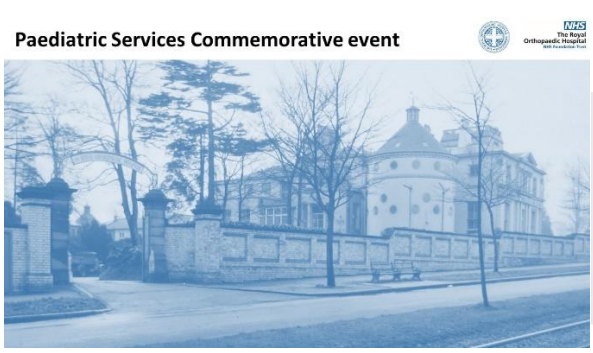
This surgery will no longer take place at The Royal Orthopaedic Hospital (ROH). ROH will only treat patients aged 16+.

However both hospitals will play an important role in your care and will work together to make sure you receive the best treatment. This leaflet explains how your care journey will work.

In addition, an information letter will be sent out to the current patients who are waiting for their surgery reminding them of the change of venue for their surgery. Contact details for both ROH and BWC will be provided in both the letter and leaflet.

We will continue to work with BWC to ensure our websites adequately reflect the patient journey so that all patients receive consistent and accurate information.

A Commemorative event was held on Wednesday 26th June to celebrate 200 years of paediatric services chaired by Yve Buckland and Jo Williams. Staff received a commemorative badge to acknowledge the part they have played in delivering paediatric services. Kieran and Beth from the COST campaign delivered a patient / parent tribute to the services they had received over the years on ward 11. The event was well received by all the staff.



Information transfer

Clinical information and images transfer processes have been fully tested across both sites, including access to PACS (imaging). Staff working at BWC are able to remote access to ROH to view ROH images. Further improvements to this process are being planned in July 19 to enable direct access to the PACS system via their BWC login rather than going in via ROH remote access. Testing of this is will commence on July 1st and be rolled out in the month of July.

HR & Workforce

All staff involved in the TUPE transfer have received the confirmation letter informing of their new place of work at BWC. This now completes the TUPE process. Honorary contracts have been finalised with all the clinical staff that will be required to work across both sites.

3. Timeline updates

The following actions have been delivery in the final week:

24th June 2019 – Final week

- Confirmation that all Spinal patients that have been listed for July have had a pre-assessment check.

- Confirmation that all Oncology and Spinal lists in July have been fully populated and patients aware of their operation date
- Confirmation that the new Theatre and clinic Schedules have been finalised and implemented at both Trust
- New Spinal and Oncology On call rotas will commence on the 1st July.
- The implementation of the CT Biopsy pathway at ROH with the core staff who will provide the service post has been successfully trialled
- Celebration of paediatric services on Wednesday 26th June 2019 in the Knowledge Hub
- Successful transfer of two remaining paediatric patients to BWC on **Friday 28th June 2019**.
- Official closure of Ward 11 to inpatient and day case services on **Friday 28th June 2019**

1st July 2019 – Ongoing

- Testing of ROH PACS access via BWC login
- Ongoing weekly Tuesday Paediatric transition Meeting with new terms of reference to review those services remaining on site and Ward 11 / HDU venue
- Thursday 4th July Oversight Call Conference with NHSI and NHS England
- Friday 12th July Joint Oversight Meeting both Trusts Chaired by Steve Cumley (BWC) and Marie Peplow (ROH)

4 Governance

The Governance teams from both Trusts are meeting to agree the governance models post transition.

The governance model has been agreed between the two trusts. It has been agreed that a Partnership model will be adopted and will be included within the SLA between the two Trusts. The Partnership model proposes that ROH have responsibility for the services that they provide and BCH have responsibility for the services they provide. Neither organisation would be considered as the lead partner and reporting would continue through normal commissioning routes. Joint governance arrangements for shared learning and to facilitate response and learning from incidents would be agreed.

The Strategic Oversight Group Meeting co-chaired by Kathryn Sallah (ROH) and Alan Edwards (BWC) and NHS improvement and NHS England met for the last time prior to transition on the 28th June 2019. Beyond the transition date a joint regular meeting will be set up with the Operational and Clinical teams across both Trusts. This meeting will provide a platform for both Trusts to work together to review and deliver the service, manage the service level agreement (SLA) and work on transforming the service together.

5. Services that will remain on site at the ROH

Outpatients (OPD) and CT Guided Biopsy Paediatric Services

ROH will continue to provide on-site Paediatric Outpatient clinics and a weekly CT biopsy service post 1st July 2019. The OPD will remain on Ward 11 and the first bay will be open (Thursdays only) to recover the CT biopsy pathway patients. The COO and Director of Nursing have reviewed the OPD and remaining clinical areas on Ward 11 and have suggested improvements which are currently being worked up by the Estates team.

The Director of Nursing and Clinical Governance will be responsible together with the senior clinical nursing team to ensure that policies and procedures are refreshed to support the remaining services on site at the ROH.

As described in previous reports it is planned that the ROH will provide the Consultant Anaesthetist, the Consultant Interventional Radiologist and support staff till December 2019. From January 2020 BWC will cover the anaesthetic and support services at ROH.

The Paediatric CT Biopsy list will be delivered by the ROH on a Thursday and plans have been implemented to include the unlikely event that a child will be required to stay overnight they will be transferred to BWC. This has been reviewed and we estimate that this is likely to be approx. 5 children per year. This pathway has been successfully introduced prior to the transfer date with the staff who will continue to provide the service post transition. All stakeholders are happy with the pathway post transition. The first interventional pathway will take place on Thursday 4th July 2019

Author: Janet Davies Clinical Service Manager / Project Lead for the Paediatric Transition 28th June 2019

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

June 2019

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

Dashboard

	April 2019	May 2019	2019/2020 YTD	2018/2019
Incidents	310	321 (↑)		
Serious Incidents	0	2 (↑)	2	9
Internal RCA investigations	0	3 (↑)		
Safety Thermometer (Harm Free Care)	98%	98% (↔)		
VTEs (Avoidable)	0	0 (↔)	0	4 (Avoidable)
Falls (all falls)	11	3 (↓)	14	88 (Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	0 (↔)	0	7 (Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0 (↔)	0	2 (Avoidable)
Complaints	11	6 (↓)	17	139
PALS	85	74 (↓)		
Compliments	453	511 (↑)		
FFT Score	96.3%	96.3% (↔)		
FFT Response	37.2%	30%(↓)		
Duty of Candour	9	9 (↔)		
Litigation	0	3 (↑)		
Coroners	0	0		
WHO	100%	100% (↔)		
Infections	1	0 (↓)	1	3

(↑) (↓)(↔) Symbolise the trend from the previous months April 2019.

CONTENTS

1. 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.

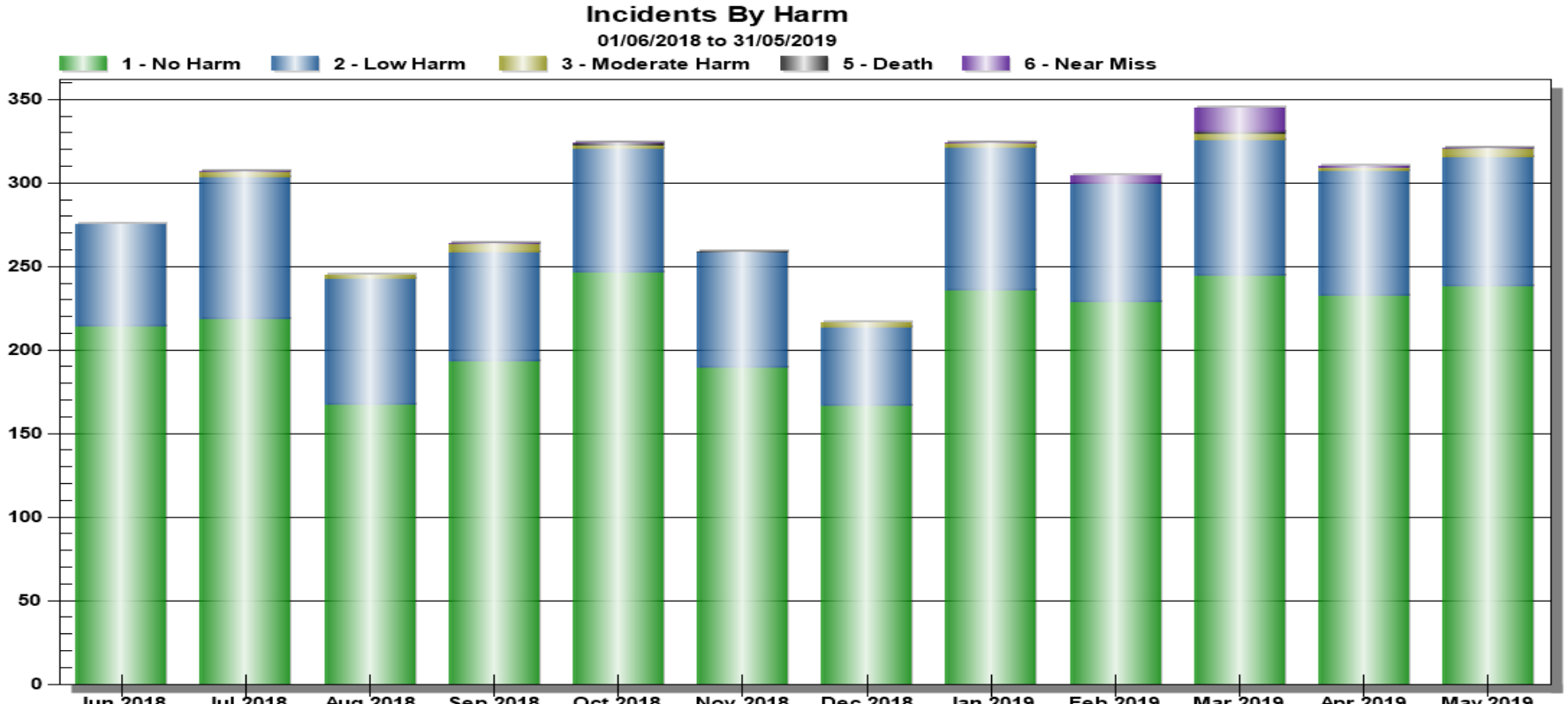
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019
1 - No Harm	214	218	167	193	246	189	166	235	228	244	232	238
2 - Low Harm	61	85	75	65	74	69	47	86	71	81	75	77
3 - Moderate Harm	0	3	3	5	2	0	3	2	0	4	2	5
5 - Death	0	0	0	0	1	1	0	0	0	1	0	0
6 - Near Miss	0	1	0	1	1	0	0	1	5	15	1	1

Data source – Ulysses

INFORMATION

In May 2019, there were a total of 321 Incidents reported on the Ulysses incident management system. This is within the normal reporting limits.
The breakdown of those incidents is as follows;

238 – No Harm
77 – Low Harm
5 - Moderate Harms
0 - Severe Harm
1 – Near Miss
0 – Death

The provisional harms reported were;

- Emergency Transfer Out Of Trust – Other
- Surgical Error
- Emergency Transfer Out Of Trust - Level 3
- Radiation Incidents
- VTE

Patient Contacts

In May 2019, there were a total of 9134 patient contacts. There were 321 incidents reported, which amounts to 3.5 per cent of the total patient contacts resulting in an incident. Of those 321 reported incidents, 82 incidents resulted in harm which is 0.9 per cent of the total patient contact.

Downgraded Incidents

After investigation two of the two reported harms in the previous Quality report have been downgraded.

- Emergency Transfer Out Of Trust – No shortfalls in care.
- Emergency Transfer to HDU - No shortfalls in care.

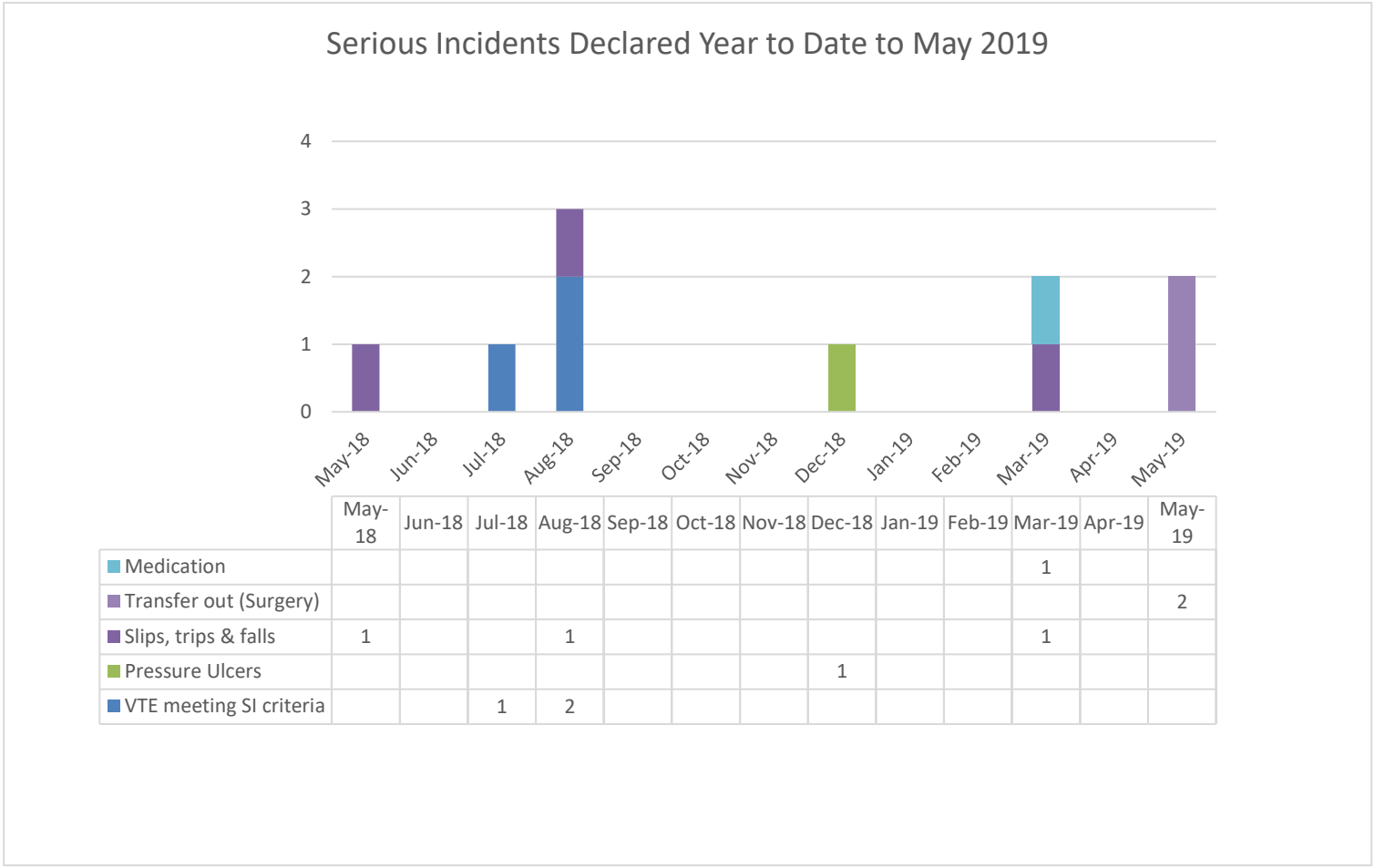
ACTIONS FOR IMPROVEMENTS / LEARNING

- Implementation of the Health Assure system - Project plan was on the agenda of Quality and Safety in March 2019.
- New Serious Incident Proforma introduced to support the divisions with the Serious Incident Framework.

RISKS / ISSUES

- Risk 1193 - Staffing and capacity within the team with two vacancies (current risk score 12). Induction for new staff underway. Risk changed to incorporate the skill and inexperience of a new team.
- Risk 1194 - Lack of skill in the Trust on the Ulysses system (current risk score 12). Training arranged for all modules of Ulysses.

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.**



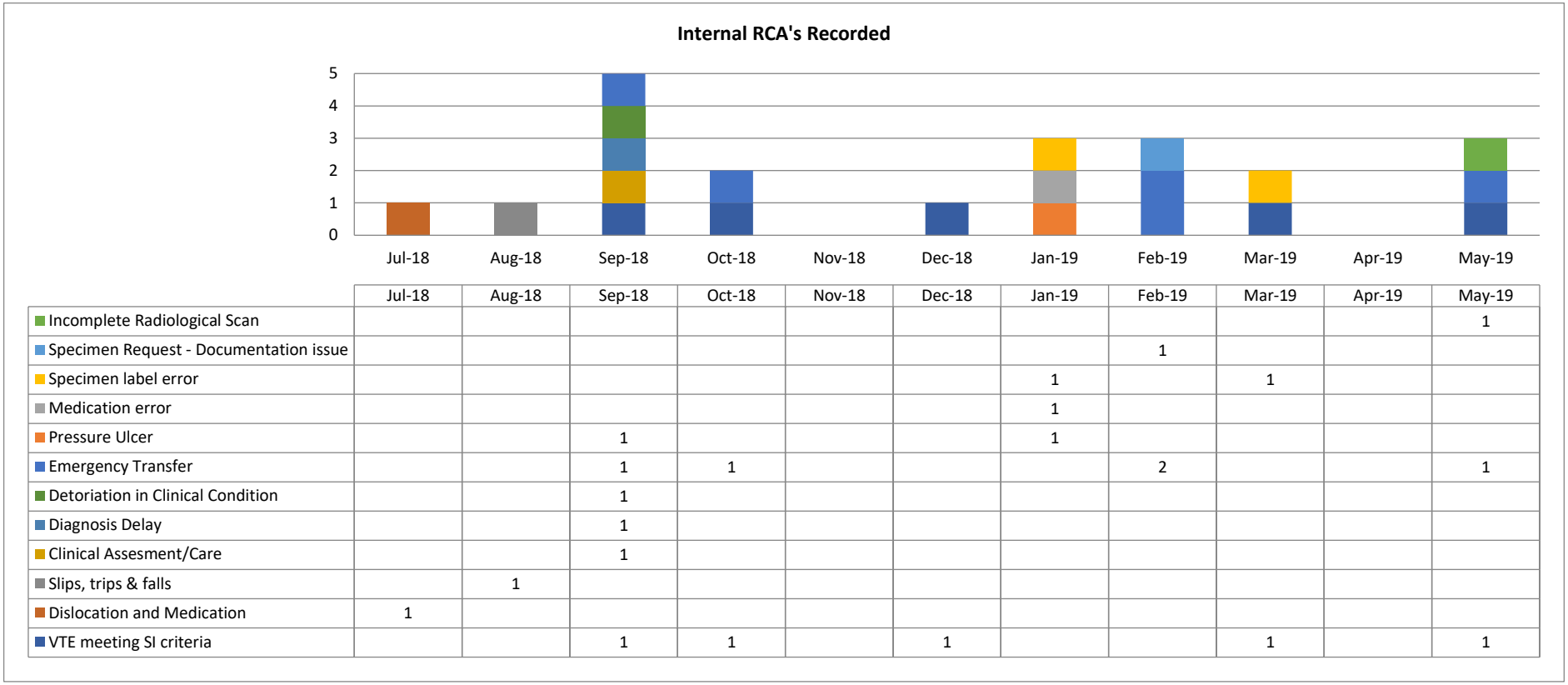
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Medication											1		
Transfer out (Surgery)													2
Slips, trips & falls	1			1							1		
Pressure Ulcers								1					
VTE meeting SI criteria			1	2									

Year Totals	
18/19	9
19/20	2

Data Source – STEIS

INFORMATION
Two Serious Incidents were reported in May 2019: • Surgical Error • Emergency Transfer Out Of Trust - Level 3
ACTIONS FOR IMPROVEMENTS / LEARNING
No Serious Incidents were closed by the CCG in May 2019
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCAs incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Incomplete Radiological Scan											1
Specimen Request - Documentation issue								1			
Specimen label error							1		1		
Medication error							1				
Pressure Ulcer			1				1				
Emergency Transfer			1	1				2			1
Detoriation in Clinical Condition			1								
Diagnosis Delay			1								
Clinical Assesment/Care			1								
Slips, trips & falls		1									
Dislocation and Medication	1										
VTE meeting SI criteria			1	1		1			1		1

Data Source – Internal RCA tracker

INFORMATION

There were 3 internal RCAs reported in May 2019:

- Radiation incidents
- Emergency Transfer Out Of Trust – Other
- VTE

ACTIONS FOR IMPROVEMENTS / LEARNING

One RCA was closed in May 2019;

Wrong patient label used on Bone Scan request resulting in patient receiving unnecessary scan.

Root causes

Clinician did not check that the correct label had been placed on the patient's scan request form

Lessons Learned

That patient labels can sometimes come loose from the correct notes and be inserted into the wrong medical records. Therefore, it is not safe to assume that the labels contained within a patient's medical records definitely belong to the patient in question.

Recommendations

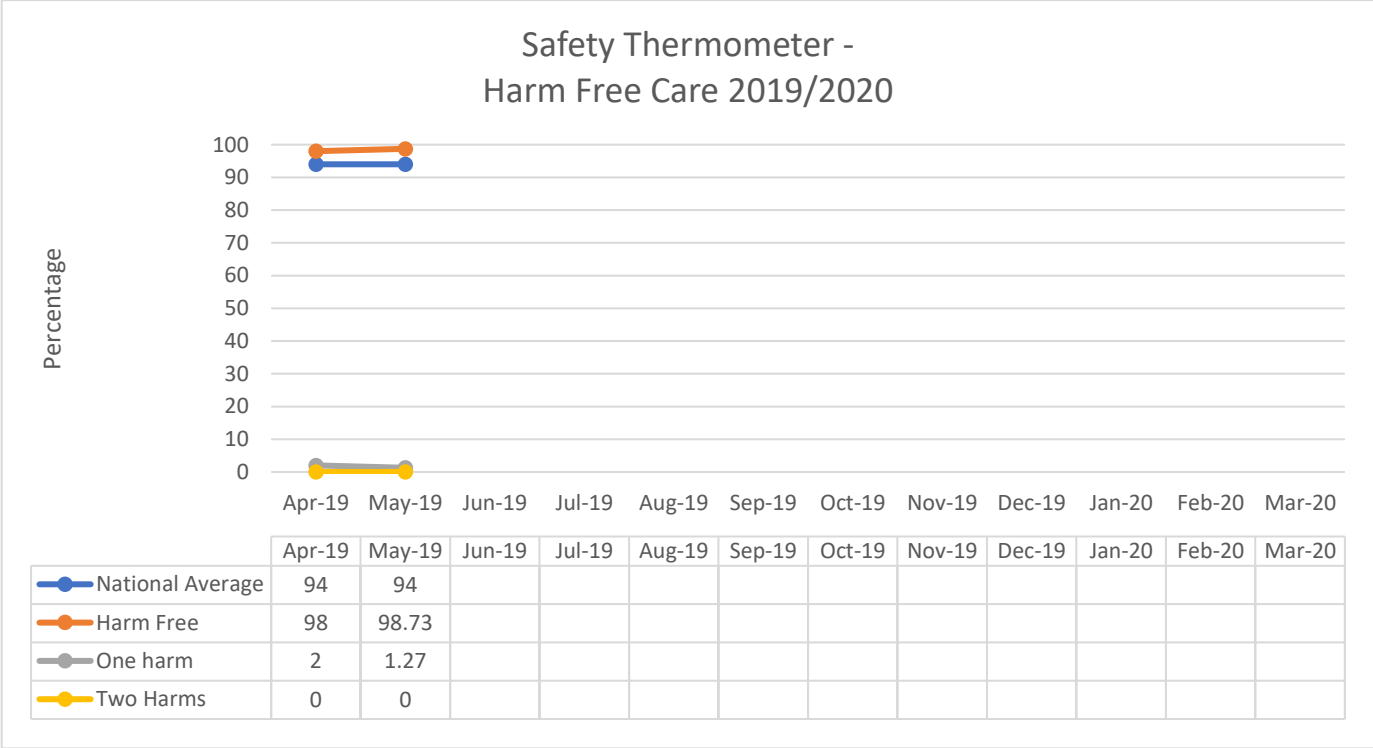
1. Clinicians completing scan request forms should check that the label used on the request form correlates with the patient they are referring for a scan. They are now required to sign the demographic label to demonstrate that they have checked the patient's identity with the label. This has implemented by UHB and no request will be accepted by them until this confirmation is present.

2. Electronic requesting would eliminate the need for demographic labels and paper requests

RISKS / ISSUES

None

5. **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.**

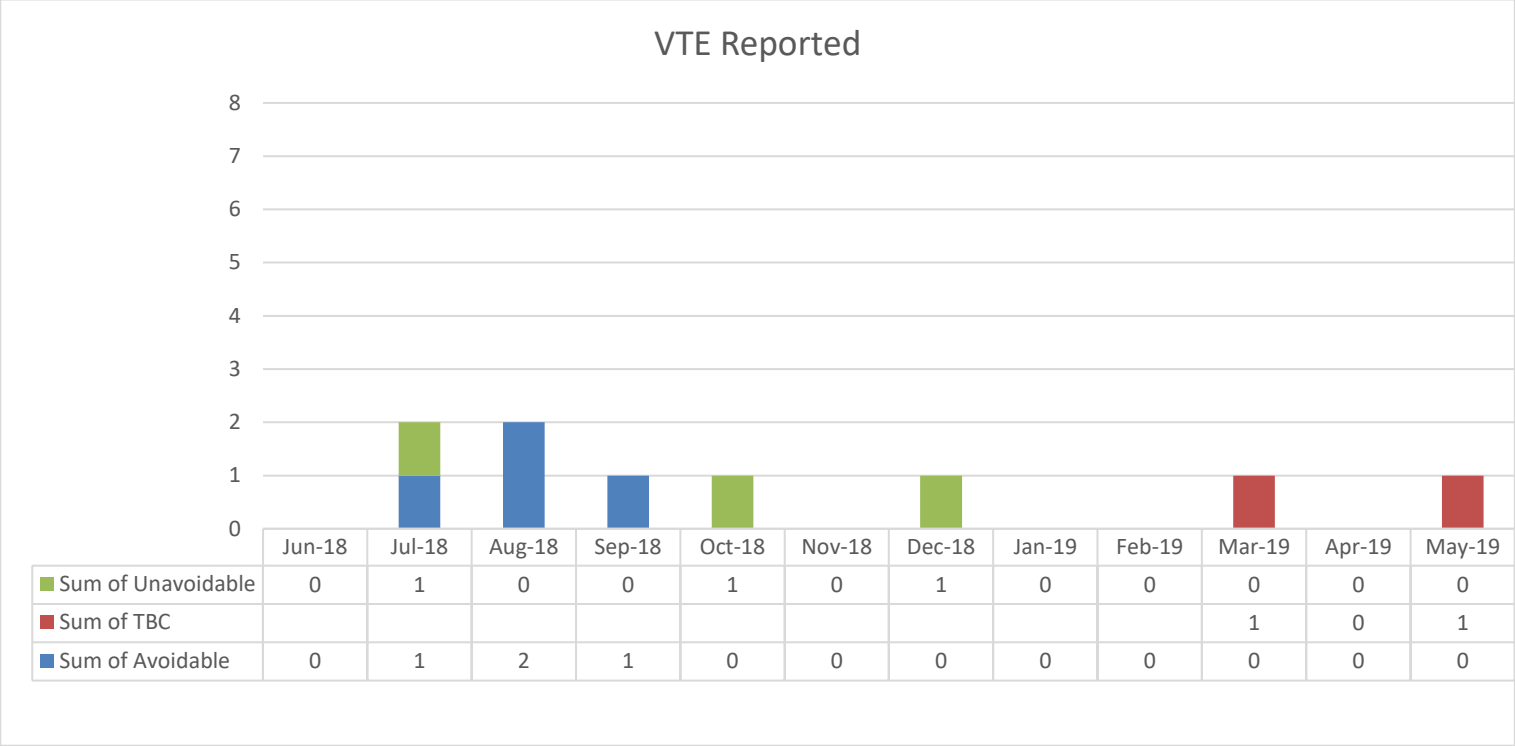


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
National Average	94	94										
Harm Free	98	98.73										
One harm	2	1.27										
Two Harms	0	0										

Harm: 1 x Old Pressure Ulcer on Ward 1

Data Source – Informatics

6. **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).**



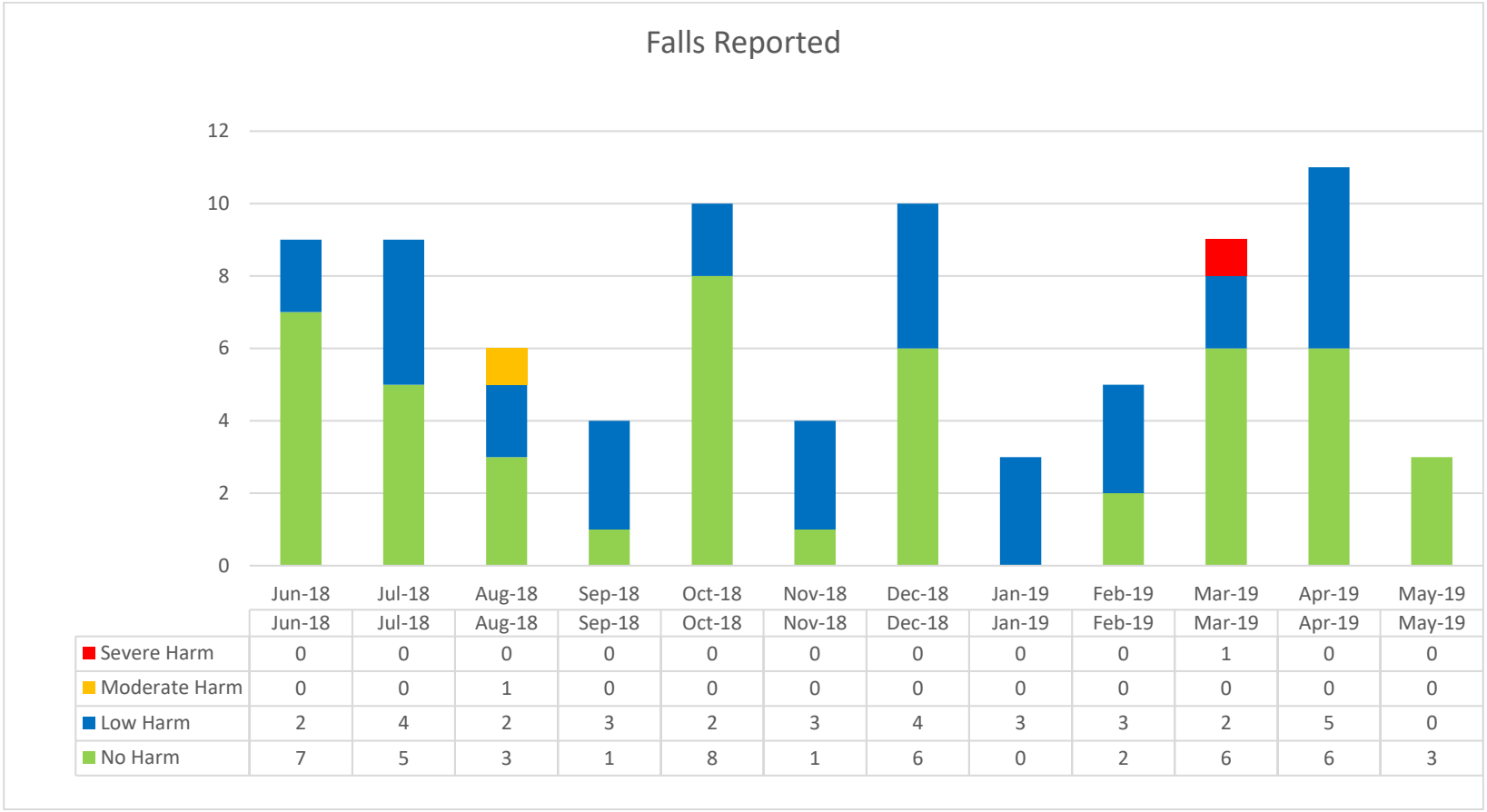
	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sum of Unavoidable	0	1	0	0	1	0	1	0	0	0	0	0
Sum of TBC										1	0	1
Sum of Avoidable	0	1	2	1	0	0	0	0	0	0	0	0

Avoidable Year Totals	
18/19	4
19/20	0

INFORMATION
There was one hospital-acquired VTE reported in May 2019. On admission risk assessment was >98% in May 2019. 24 hour re-assessment increased slightly from 83% in April to 85% in May. There is on-going work around the updated NICE guidance released in March 2018. This was discussed at May's Quality and Safety Committee meeting where concern was raised by the Chair that a decision had not yet been made regarding the implementation of some elements of the guidance at ROH. Elements of the NICE guidance continue to be challenged and questioned by thrombosis experts from other Trusts and the Exemplar network, of which ROH are a member. Benchmarking continues and ROH is not an outlier. Internal discussions regarding updated NICE prophylaxis options in THR and TKRs did not result in consensus. Assurance continues to be provided that the prophylaxis offered to our patients is safe and appropriate.
ACTIONS FOR IMPROVEMENTS / LEARNING
Despite actions taken previously, compliance with the 24 hour VTE risk assessment has only marginally improved. Information from PICS enables staff responsible for not completing the assessment to be identified and learning addressed. This information has been shared with the Medical Director who has delegated responsibility for addressing this with individuals to key medical leads. A meeting is being arranged between VTE leads, Medical Director and Director of nursing and Clinical Governance to discuss the March 2018 NICE and agree what if any changes are to be made to current Trust guidance
RISKS / ISSUES
Poor compliance with mandatory 24 hour re-assessment . This has been escalated and continues to be monitored.

Data Source – Ulysses and VTE leads

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



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Severe Harm	0	0	0	0	0	0	0	0	0	1	0	0
Moderate Harm	0	0	1	0	0	0	0	0	0	0	0	0
Low Harm	2	4	2	3	2	3	4	3	3	2	5	0
No Harm	7	5	3	1	8	1	6	0	2	6	6	3

Year Totals	
18/19	88
19/20	11

Data Source – Ulysses and Falls Group

INFORMATION

There were 3 patient fall-related incidents reported across the Trust in May 2019:

- Ward 2, patient found on bathroom floor
- Ward 12, unwitnessed fall off commode chair
- Ward 12, unwitnessed fall, patient trying to reach frame upon getting out of bed

Theme of falls are patients trying to mobilise without calling for assistance when needed. There were 2 fall related incidents involving staff members.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions Underway

- Purchase of another Hover Jack - capital bid rejected, to consider sourcing funding from charitable funds as alternative.
- Trust wide replacement of hoists on-going. Request submitted to capital bid program for this year – no change, bid to be resubmitted.
- Looking at development of fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall.
- Development of combined dementia/falls notification in pre-op assessment to identify patients at risk at an early stage.
- Terms of reference developed for new combined dementia and falls group, to be submitted for approval to next Clinical Quality Group meeting.
- Further documented training on use of the Sara steady to be provided by Derby training group on the 24/6/19, training to be ward based to maximise uptake.

Positive Assurance

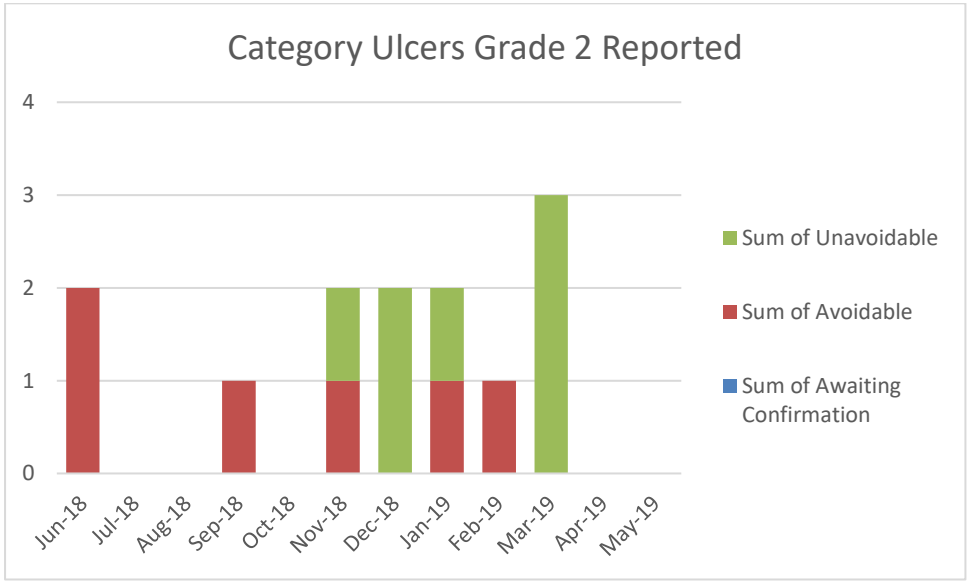
- Initial phase of Throne project complete, sufficient funds now raised to allow roll-out to other wards.
- Benchmarking of the WMQRS.
- Documented training on use of the Sara Steady completed for in-patient therapists and some ward 3 staff.
- First combined meeting of dementia/falls group took place 22/5/19

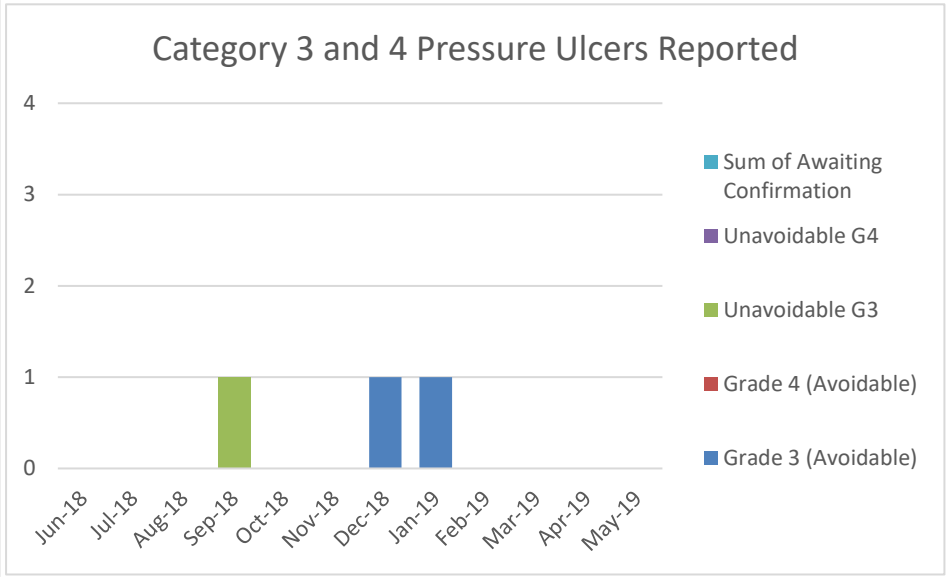
RISKS / ISSUES

Following a previous patient incident involving use of the Sara Steady, there is little documented evidence of staff receiving training in its use. Currently removed from use with patients except by Therapists and some Ward 3 staff as detailed above who have received documented training. Plan going forward for provision of further training as detailed above, under actions underway.

Only one Hover Jack available for the trust, this is also used for training, capital bid rejected, to look at option of using charitable funds.
When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Bid submitted to replace hoists Trust wide.

8. **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.**





Year Total	Cat 2	Cat 3
18/19	15	3
19/20	0	0

Data Source – Ulysses and TV team

INFORMATION

In May 2019 – There was 0 Category 2 or 3 pressure ulcers reported.

May 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	0
Category – 2 (Device)	0
Category – 1	PU ROH x1 Cat 1 MDRPU PU ROH x1 Cat 1
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	MASD x1 Intertriginous dermatitis
Patients admitted with PUs	Cat 2 externally acquired- x2 (both patient's own home) Cat 3 externally acquired- x1 (patient's own home)

Avoidable Pressure Ulcer CCG Contracts KPI

2019/2020	
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	0

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

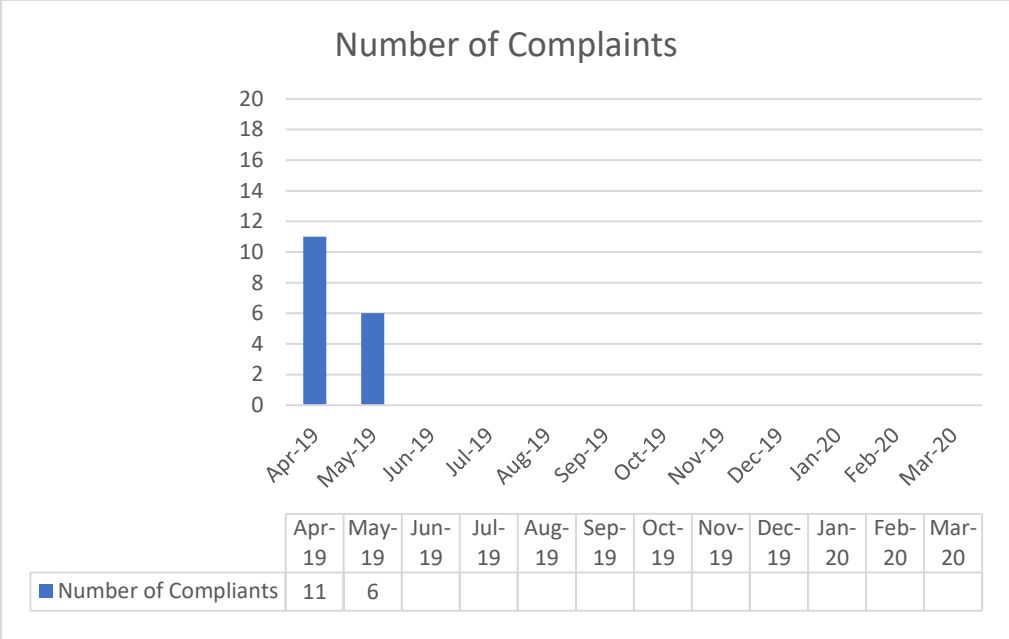
Current Actions

- The MDT pathway documentation has been amended at general review in May 2019 to re make it clearer when Anti-embolic stockings are removed and skin checked
- Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (March 2019). ROH fully compliant
- Trust wide mattress audit was undertaken on 25/4/19
- PU Policy has been amended and has been sent out for comments
- Apples and PU's #itsmorethanabruise SDTI training continues where needed
- All HCAs within Trust will receive skin assessment training
- RCA feedback and continued learning from the last 2 Cat 3 PU's incorporated into all PUP training to all staff

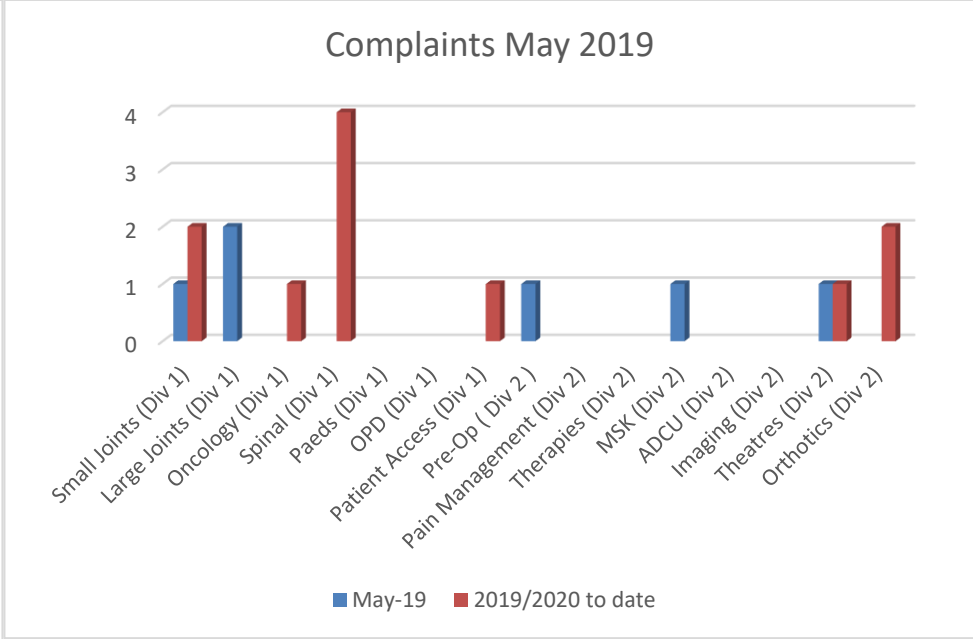
RISKS / ISSUES

None

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Number of Compliants	11	6										



Complaint Year Totals	
18/19	139
19/20	17

Data Source – Patient Experience team

INFORMATION

Complaints

There were 6 formal complaints made in May 2019. All were initially risk rated yellow. This is less than last year (14 complaints in May 2018).
The themes of this month's complaints were:

Complaints	May-19
Access to treatment	1
Appointments	1
Clinical	3
Communication	3
Waiting times	1

PALS

The PALS department handled 74 contacts during May 2019 of which 41 classified as concerns. This is a significant reduction in calls compared to the same time last year (202 contacts in May 2018) and a decrease in the level of concerns (83 concerns in May 2018). The main themes in the PALS data continue to relate to queries about appointments (either length of wait for or cancellations). 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. 76% of enquires and 37% of concerns were handled within the agreed timescales, meaning that this was not met in May 2019. This was due to the sudden loss of a team member.

PALS Concerns	
	May-19
Access to treatment	5
Admissions & Discharges	2
Appointments	20
Clinical	5
Trust Administration	5

Compliments

There were 511 compliments recorded in May 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments May 2019
Div. 1	325
Div. 2	185
Corporate	1

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 receive a request monthly to submit their compliments for central logging.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 3 complaints closed in May 2019, all within the agreed timescales. This gives an 100% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in May 2019 was 33 days, which is slightly higher than normal
1 complaint was fully upheld, 1 was partially upheld and 1 was not upheld

Learning identified and actions taken as a result of complaints closed in May 2019 include:

- Patients are not always clear about the management of care in Orthotics
  Action: Team are reviewing processes and updating patient information

- A member of staff (non-clinical) answered a query without consulting the clinical team
  Action: Staff member has been reminded to check any clinical queries with Consultant via their Secretary.

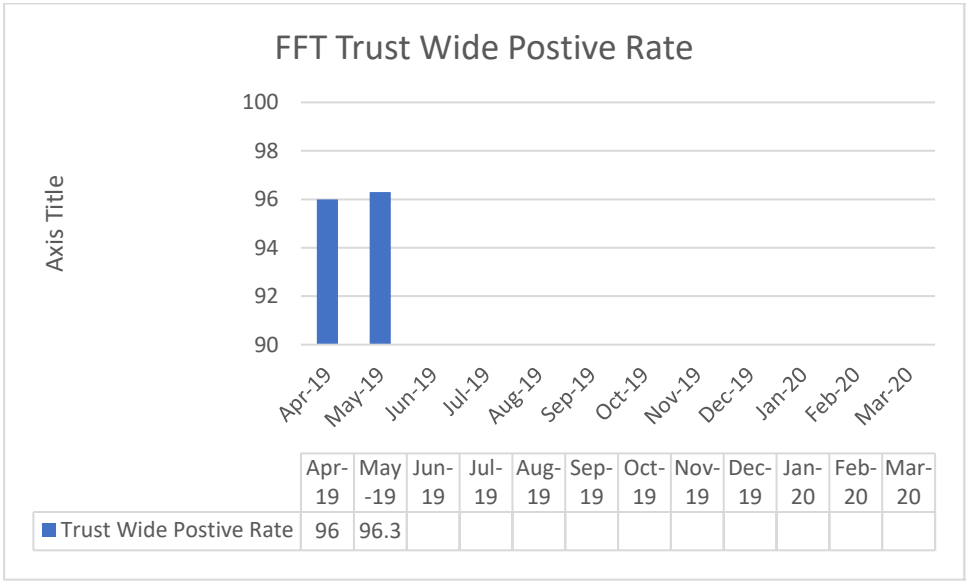
RISKS / ISSUES

None Identified.

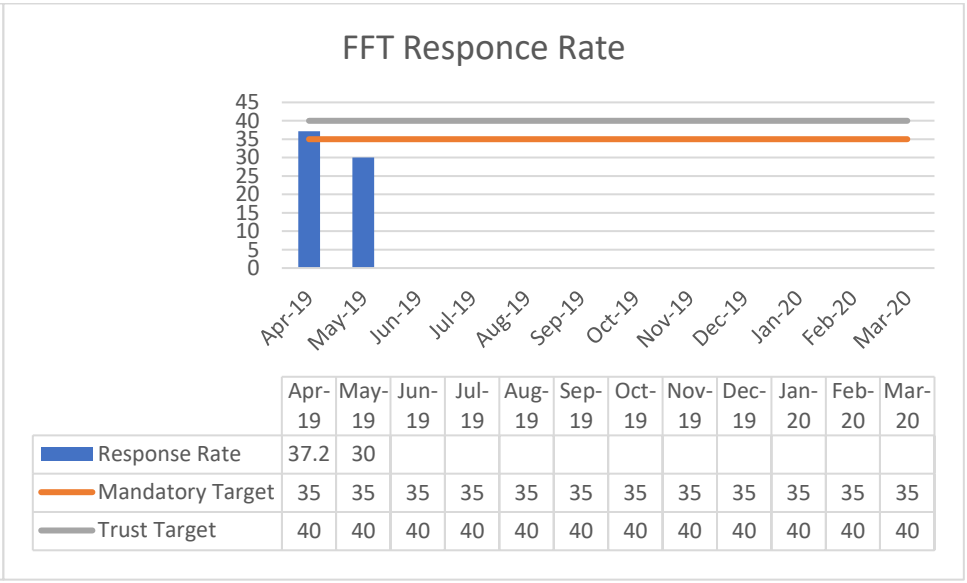
COMEBACK COMPLAINTS

1 comeback received in May 2019. Patients daughter is not happy with explanations and feels that there has been inaccurate information given

10. Friends and Family Test Results (collected in the iwantgreatcare system)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Trust Wide Postive Rate	96	96.3										



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Response Rate	37.2	30										
Mandatory Target	35	35	35	35	35	35	35	35	35	35	35	35
Trust Target	40	40	40	40	40	40	40	40	40	40	40	40

Data Source – Patient Experience team 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

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 agreed internal targets for all areas and as a result, the data is 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 requested 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

The team are recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In May 2019, 4 concerns were identified from the 1395 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 main areas of concern in May 2019 related to Clinical Queries, Communication and Administration. Information is 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 did not meet the mandated 35% response rate for Inpatient Services this month. The internally set target of 20% for Outpatient services was met this month. This information has been shared with Departmental and Directorate Leads

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would**	**% of people who would**	**Number of Reviews**	**Number of Individuals**	**Department Completion**
Ward 1	100.0%	0.0%	35(46)	124	28.2%
Ward 2	97.1%	0.0%	68(31)	158	43%
Ward 3	94.1%	0.0%	34(36)	77	44.2%
Ward 12	96.3%	1.9%	54(57)	120	45%
Ward 11 (CYP)	100.0%	0.0%	16(12)	67	23.9%
ADCU	98.4%	0.0%	128(129)	467	27.4%
HDU	100.0%	0.0%	16(17)	59	27.1%
CYP HDU	0%	0.0%	0 (0)	9	0%
Overall Trust Inpatient Response Rate for May 2019					30%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in May 2019**	**% of people who would NOT recommend the department in May 2019**	**Number of Reviews submitted in May 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.0%	0.9%	999 (981)	22.2%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in May 2019**	**% of people who would NOT recommend the department in May 2019**	**Number of Reviews submitted in May 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	93.3%	0%	45(78)	30.0%

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.

11. **Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.**

There are currently 12 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. **Litigation**

New claims

3 new claims against the Trust were received in May 2019

On-going claims

There are currently 29 on-going claims against the Trust.
28 of the claims are clinical negligence claims.
1 claim is a staff claim

Pre-Application Disclosure Requests*

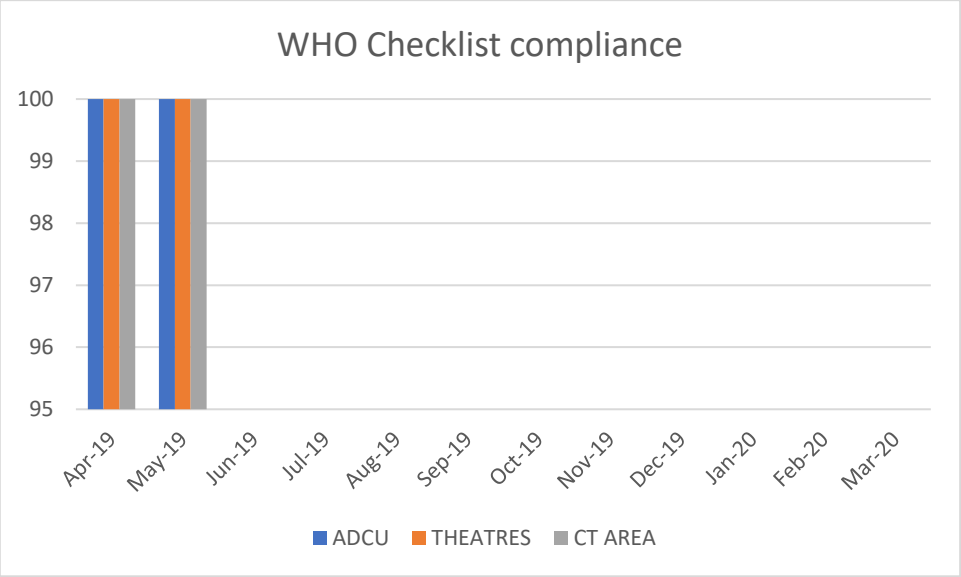
2 new requests for Pre-Application Disclosure of medical records were received in May 2019.

**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 General Data Protection Regulations 2018 and the Access to Health Records Act 1990)*

13. **Coroner's Inquests**

There were no Inquests held in May 2019

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.



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete 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 = 673

The total WHO compliance for Theatres in May 2019 = 100%

CT area

Total cases =

The total WHO compliance for CT in May 2019 = 100%

ADCU

The snapshot WHO audit compliance for May 2019 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

Any non- compliance will be reported back to the relevant clinical area.

RISKS / ISSUES

WHO checklist for ADCU 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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in May 2019 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	1

ACTIONS FOR IMPROVEMENTS / LEARNING

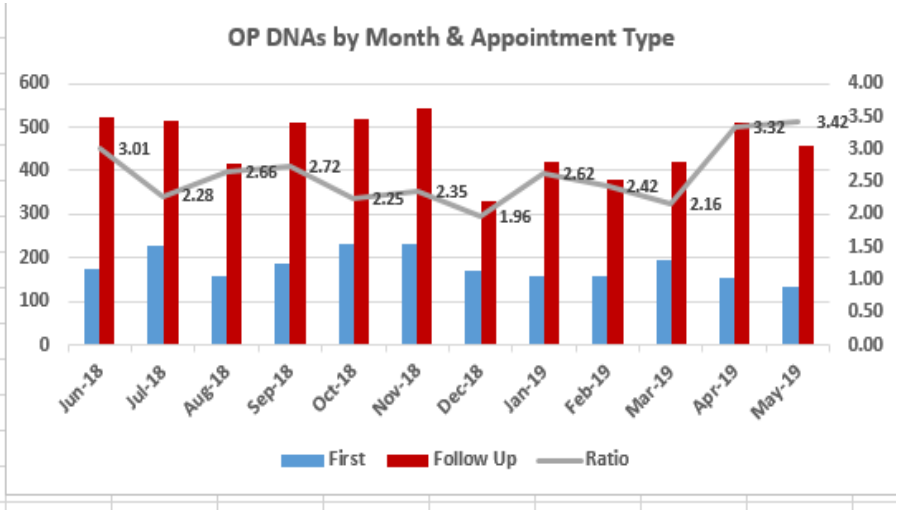
10 IP recorded incidents in May, 2019 (4 no harm, 6 low harm – all either under review or closed).

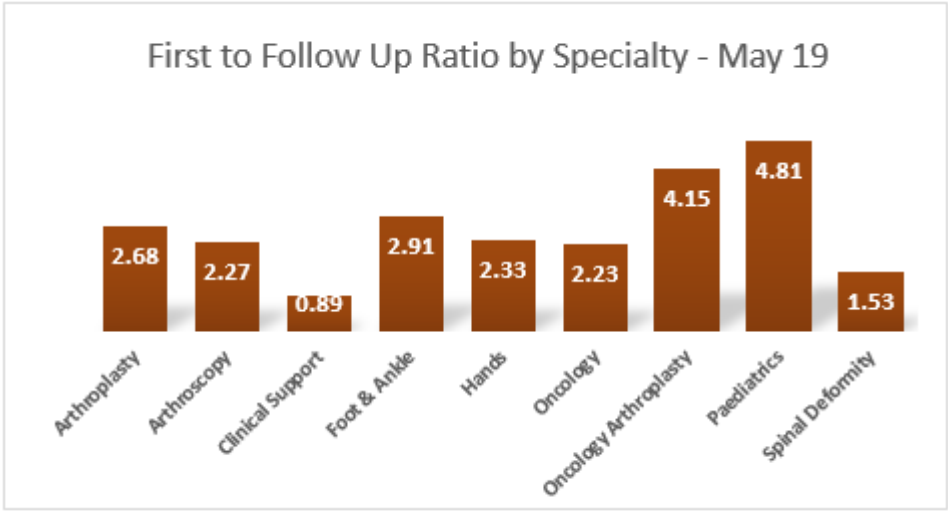
RISKS / ISSUES

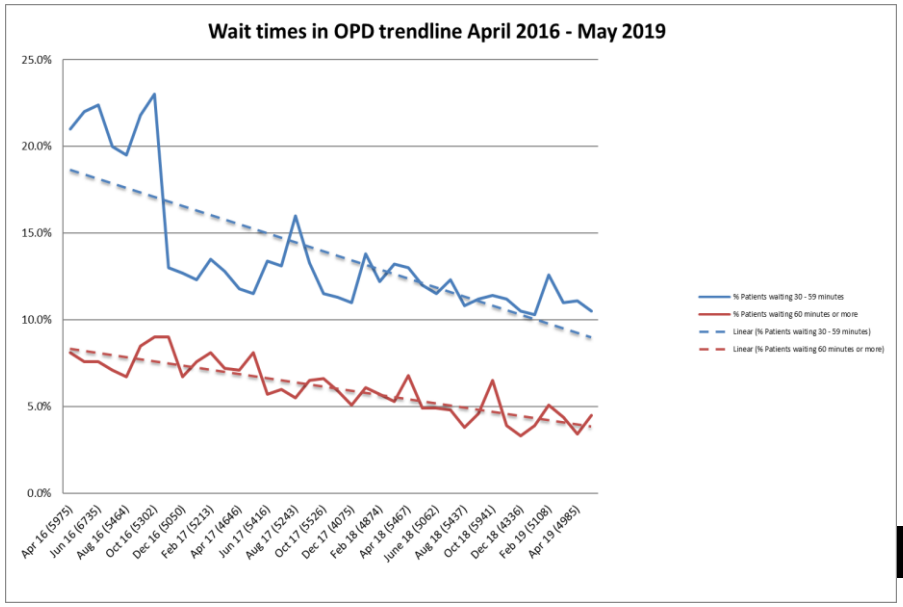
ROH continues to review the status of staff requiring Hepatitis B vaccinations and ensure vaccinations are provided where required.

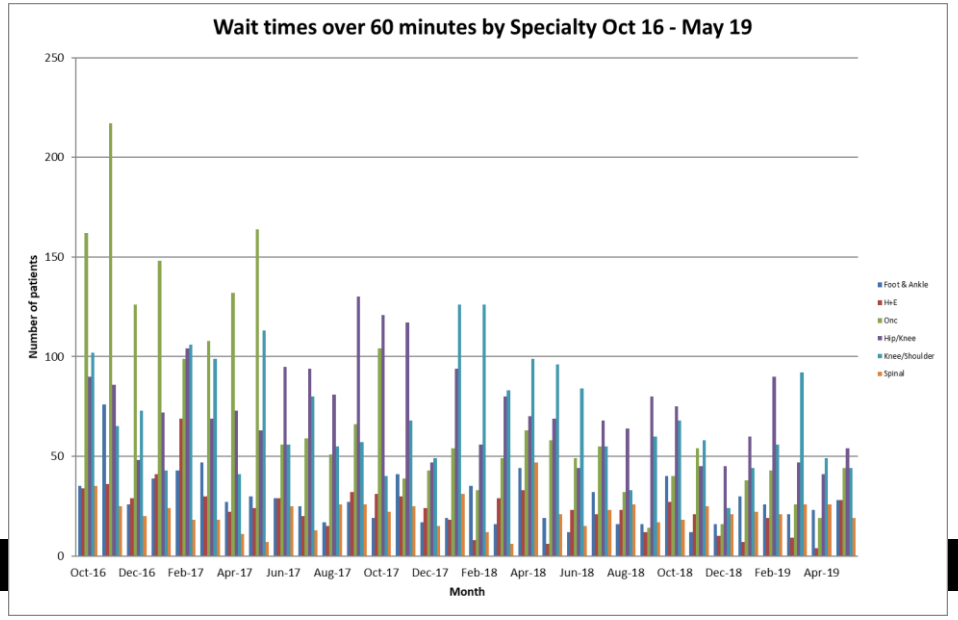
***Data Source – IPC team and Ulysses**

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









In May there were 10.5% of patients waiting over 30 minutes which is an improvement on last month (from 11.1%). The target for 30 minute delays has not been achieved but progress is being maintained. The over 60 minute delays continue to be maintained under the target of 5% with a level of 4.5% for May. This is now the 12th month out of last 13 that the over 60 minute target has been achieved.
Room allocations each week continue to be managed well and there has only been 2 incidents of no room available in May. One of these incidents relates to an occasion where a room had been allocated but the clinician felt it was not suitable. The 643 meeting is to be expanded to include discussion about the number of patients booked on each session and will follow on from the 642 theatre meeting. The attendance of this meeting will also be increased to include Imaging and operational or office managers.
There were 15 incidents of clinic delays reported in May 2019 with the following breakdown.
6 Other
3 Complex patient
2 Clinic Overbooked for Number of Staff
2 Consultant / clinician delay
1 Delay in medical notes
1 X-ray delay

Allocate – the electronic annual leave requesting platform has now gone live and is being used by all medical staff which should reduce the number of patients and clinics being rescheduled within 6 weeks.
Consideration is being given to upgrading the InTouch system to enable the Health Informatics team to improve reporting from the system. Better data would allow trends of clinic delays to be identified and the data used to inform changes to clinic templates which could then be discussed with the clinicians and specialty managers.

ACTIONS FOR IMPROVEMENTS / LEARNING

The outpatient operational group needs to evolve to include monitoring of projects within and affecting the outpatient department

RISKS / ISSUES

- The process for partial booking has been started as a pilot for new appointments in Pain and Spinal Deformity. This will inform the Business case.
- The main outreach site for the Trust is Lordswood surgery and this is now full utilised. Scoping is ongoing to ensure outpatient capacity meets future demand.

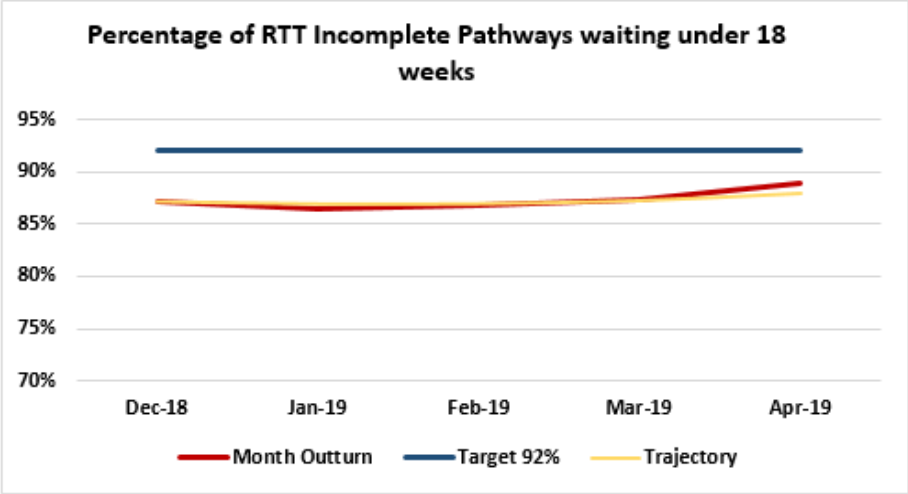
17. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories

% of patients waiting <6 weeks for a diagnostic test

National standard is 99%

Pending - Patients still waiting at month end								Activity			
	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Apr-18	1022	148	409	1,579	8	1571	99.5%	850	253	387	1,490
May-18	1002	136	353	1,491	1	1490	99.9%	725	236	373	1,334
Jun-18	789	96	376	1,261	5	1256	99.6%	762	220	360	1,342
Jul-18	732	112	336	1,180	8	1172	99.3%	961	211	290	1,462
Aug-18	568	107	301	976	9	967	99.1%	682	165	290	1,137
Sep-18	696	110	311	1,117	4	1113	99.6%	778	208	394	1,380
Oct-18	781	110	370	1,261	7	1254	99.4%	725	247	344	1,316
Nov-18	736	135	381	1,252	7	1245	99.4%	801	243	406	1,450
Dec-18	698	115	346	1,159	11	1148	99.1%	843	224	367	1,434
Jan-19	728	123	416	1,267	4	1263	99.7%	897	253	472	1,622
Feb-19	844	134	386	1,364	3	1361	99.8%	854	248	436	1,538
Mar-19	776	133	461	1,370	1	1369	99.9%	868	271	410	1,549
Apr-19	835	89	414	1,338	6	1332	99.6%	894	244	419	1,557
May-19	807	94	337	1,238	1	1237	99.9%	914	270	478	1,662

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



The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019.

May 2019 performance is **88.92% against a trajectory of 88.79%**

In May the Trust had **0** patients over 52weeks which is a significant achievement for the Trust. There were 9 patients over 40 weeks and these patients are monitored weekly to track progress and ensure treatment plans are in place. This number is a reduction on April from 21 pts over 40 weeks. To note that oncology arthroplasty achieved RTT compliance in May at 93.18%

Referral to Treatment Trajectory: Trust Wide Position

RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,478	7,511	7,543	7,571
Over 18 Weeks	1,080	1,091	1,089	1,062	997	931	867	799	732	651	605	560	520
Totals	8,436	8,365	8,370	8,361	8,334	8,305	8,278	8,248	8,219	8,129	8,116	8,103	8,090
RTT %	87.20%	86.96%	86.99%	87.30%	88.03%	88.79%	89.53%	90.31%	91.09%	92.00%	92.54%	93.09%	93.58%

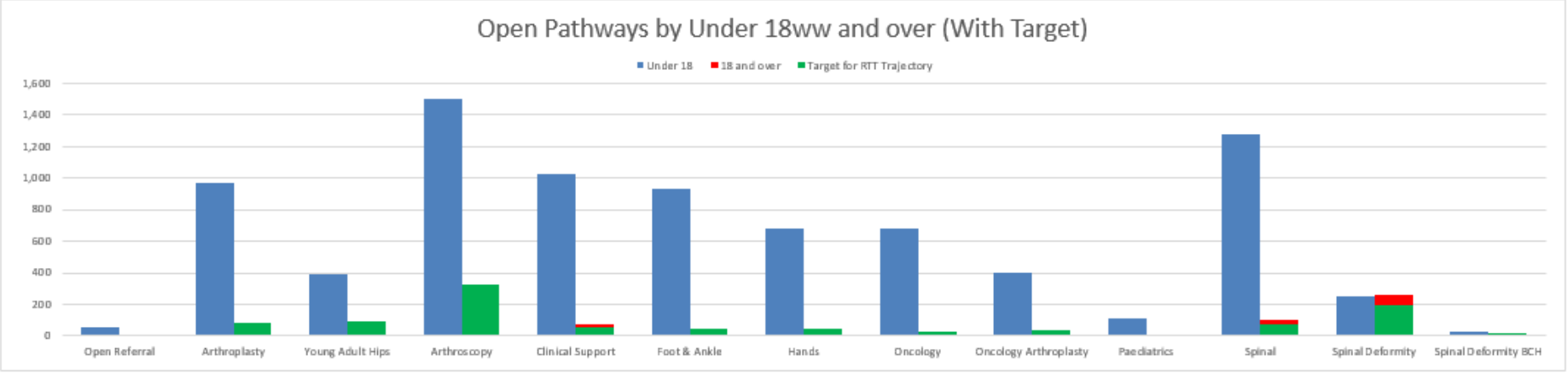
17. Referral to Treatment snapshot as at 31 May 2019 (combined)

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	**3,679**	27	426	165	714	419	455	328	338	179	52	515	55	6
7-13	**3,410**	20	383	171	567	499	387	277	235	166	42	540	109	14
14-17	**1,198**	7	161	58	220	107	85	70	109	51	17	222	84	7
18-26	**715**	1	66	39	188	64	46	43	19	20	6	85	133	5
27-39	**309**	1	13	11	98	10	3	7	3	9	0	21	121	12
40-47	**9**	0	0	1	2	1	1	0	0	0	0	0	3	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9,320**	56	1,049	445	1,789	1,100	977	725	704	425	117	1,383	505	45

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	**8,287**	54	970	394	1,501	1,025	927	675	682	396	111	1,277	248	27
18 and over	**1,033**	2	79	51	288	75	50	50	22	29	6	106	257	18
Target for RTT Trajectory	**1044**	1	83	96	325	51	48	48	32	33	2	74	198	17
Target for RTT 92%	**745**	**4**	**83**	**35**	**143**	**88**	**78**	**58**	**56**	**34**	**9**	**110**	**40**	**3**

Month End RTT %	88.92%	96.43%	92.47%	88.54%	83.90%	93.18%	94.88%	93.10%	96.88%	93.18%	94.87%	92.34%	49.11%	60.00%



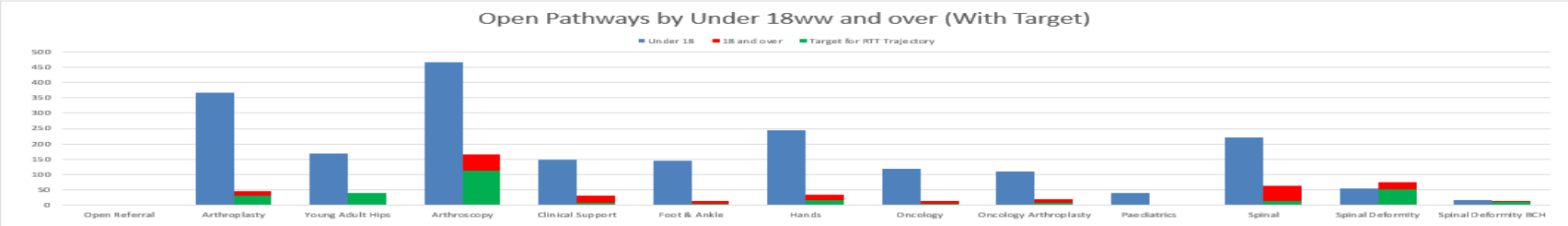
17. Referral to Treatment snapshot as at 31st May 2019

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	**706**	1	113	40	178	32	43	91	67	31	20	65	20	5
7-13	**944**	0	157	95	201	72	69	117	34	52	14	102	23	8
14-17	**452**	2	96	33	86	44	34	35	18	27	7	54	11	5
18-26	**338**	1	38	13	98	29	12	31	10	13	1	50	38	4
27-39	**160**	0	9	5	67	2	1	5	3	6	0	15	37	10
40-47	**6**	0	0	1	1	1	1	0	0	0	0	0	1	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,606**	4	413	187	631	180	160	279	132	129	42	286	130	33

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	**2,102**	3	366	168	465	148	146	243	119	110	41	221	54	18
18 and over	**504**	1	47	19	166	32	14	36	13	19	1	65	76	15
Target for RTT Trajectory	**292**	0	33	40	114	8	7	18	6	10	1	15	51	12
Target for RTT 92%	**208**	**0**	**33**	**14**	**50**	**14**	**12**	**22**	**10**	**10**	**3**	**22**	**10**	**2**

Month End RTT %	80.66%	75.00%	88.62%	89.84%	73.69%	82.22%	91.25%	87.10%	90.15%	85.27%	97.62%	77.27%	41.54%	54.55%

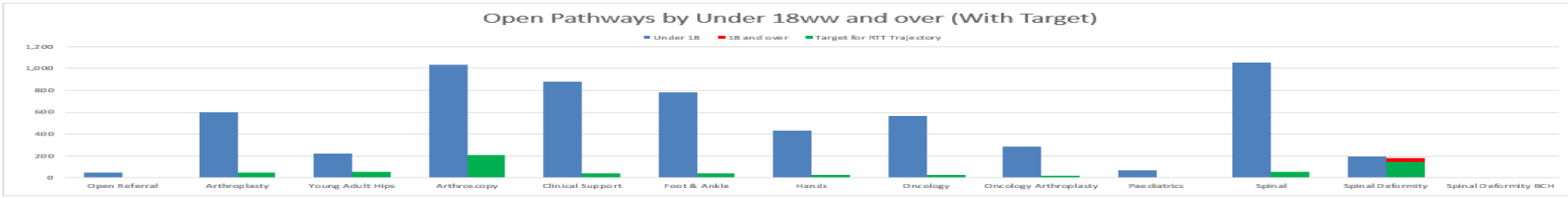


Select Pathway Type: Non-Admit

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	**2,973**	26	313	125	536	387	412	237	271	148	32	450	35	1
7-13	**2,466**	20	226	76	366	427	318	160	201	114	28	438	86	6
14-17	**746**	5	65	25	134	63	51	35	91	24	10	168	73	2
18-26	**377**	0	28	26	90	35	34	12	9	7	5	35	95	1
27-39	**149**	1	4	6	31	8	2	2	0	3	0	6	84	2
40-47	**3**	0	0	0	1	0	0	0	0	0	0	0	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6,714**	52	636	258	1,158	920	817	446	572	296	75	1,097	375	12

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	**6,185**	51	604	226	1,036	877	781	432	563	286	70	1,056	194	9
18 and over	**529**	1	32	32	122	43	36	14	9	10	5	41	181	3
Target for RTT Trajectory	**752**	1	50	55	210	42	40	29	26	23	1	58	147	4
Target for RTT 92%	**537**	**4**	**50**	**20**	**92**	**73**	**65**	**35**	**45**	**23**	**6**	**87**	**30**	**0**

Month End RTT %	92.12%	98.08%	94.97%	87.60%	89.46%	95.33%	95.59%	96.86%	98.43%	96.62%	93.33%	96.26%	51.73%	75.00%



17. Cancer Performance Targets

		Indicative	Reported Month					Reported Quarter 2017/18			
Target Name	**National Standard**	**May-19**	**Apr-19**	**Q4 2018/19**	**Q3 2018/19**	**Q2 2018/19**	**Q1 2018/19**	**Q4** (Jan, Feb, March)	**Q3** (Oct, Nov, Dec)	**Q2** (July, August, Sept)	**Q1** (Apr, May, June)
2ww	93%	*98.60%*	***95.6%***	**98.8%**	**99%**	**100%**	**99%**	**97%**	**98%**	**99%**	**98%**
31 day first treatment	96%	*91.00%*	***100%***	**94.4%**	**100%**	**100%**	**100%**	**90%**	**96%**	**97%**	**97%**
31 day subsequent (surgery)	94%	*100.00%*	***100%***	**95.2%**	**98%**	**100%**	**97%**	**98%**	**100%**	**97%**	**100%**
62 day (traditional)	85%	*76.90%*	***100%***	**96%**	**51.3%**	**69.9%**	**82%**	**82%**	**82%**	**72%**	**67%**
62 day (Cons Upgrade)	n/a	*100.00%*	*92.9%*	83.70%	**91.37%**	**92.6%**	**94%**	**84%**	**82%**	**89%**	**100%**
28 day FDS	85%	*85.10%*	81.0%								
No. patients treated 104+ days		*1*	1	2	3	1	**1**				

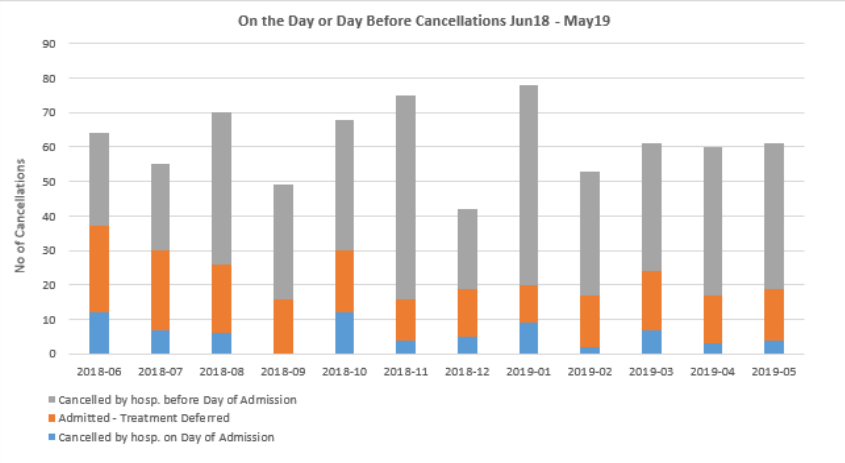
PERFORMANCE/IMPROVEMENTS/LEARNING

April's performance met all nationally measured indicators. In May the draft position for 62-day standard is currently 76.9%. This is due to 1.5 breaches.

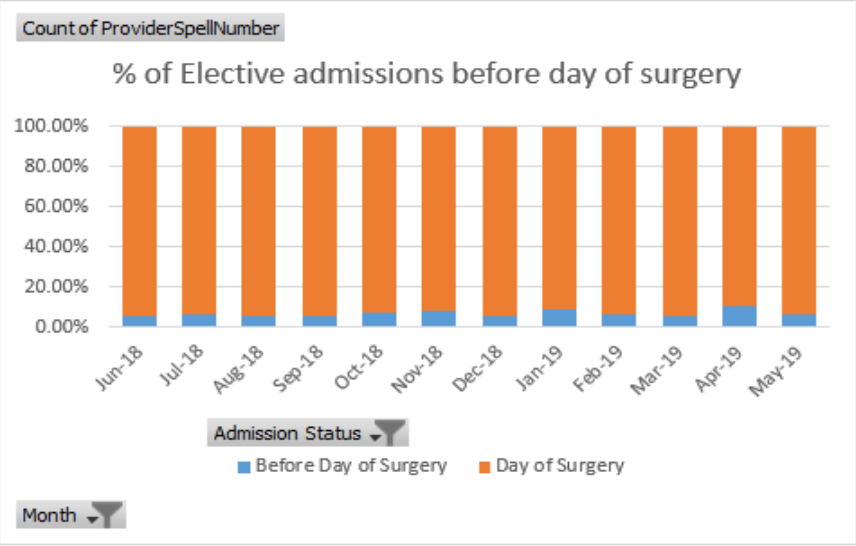
RISKS / ISSUES

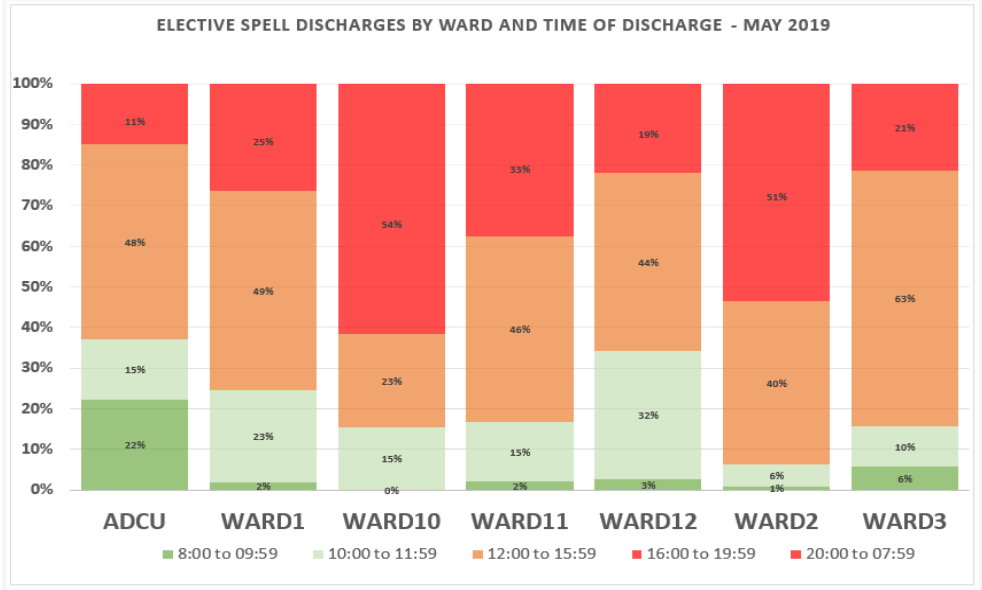
The Oncology Team along with Histology and Imaging colleagues, continue to work collaboratively to ensure patients are moving promptly through their cancer pathway. The information compiled for The Birmingham Children's Hospital, will highlight paediatric patients who are being admitted for a suspected or confirmed cancer. The BCH have agreed to adopt our procedure to 'red sticker' biopsy samples so pathology can prioritise diagnosis.

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
2018-06	12	25	27	64	0
2018-07	7	23	25	55	0
2018-08	6	20	44	70	0
2018-09		16	33	49	0
2018-10	12	18	38	68	1
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	43	60	0
2019-05	4	15	42	61	0
Grand Total	71	200	465	736	1





INFORMATION

The number of cancellations on the day of admission for surgery in May was 4 patients. One admin error, two patients unfit and one patient self cancelled.

There were 15 admitted for surgery where treatment was deferred. Analysis of patients admitted where treatment was deferred relates to, lack of theatre time, medically unfit and equipment availability and patients who had not followed fasting instructions.

Cancellations before the day of surgery have decreased slightly in month from 43 to 42. An analysis of the 42 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, consultant unwell and patient medically unfit following preassessment.

The 72 hour call to patients has been embedded as a standard process and continues to work well highlighting any issues before surgery. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance .

The POAC business case was presented at DMB in May 2019 and is to be presented to the Executive Meeting in July.

A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.

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 :

- POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery

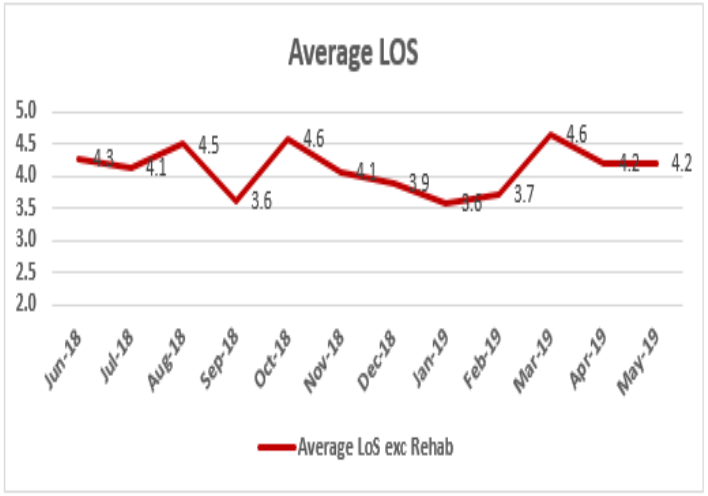
24

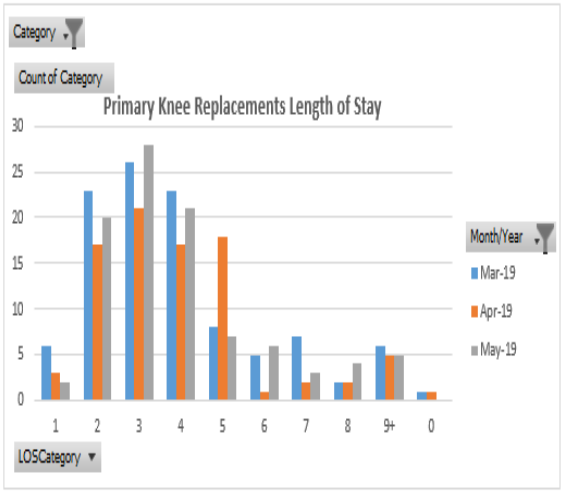
- The Standard Operating Procedure for bookings in now in place.

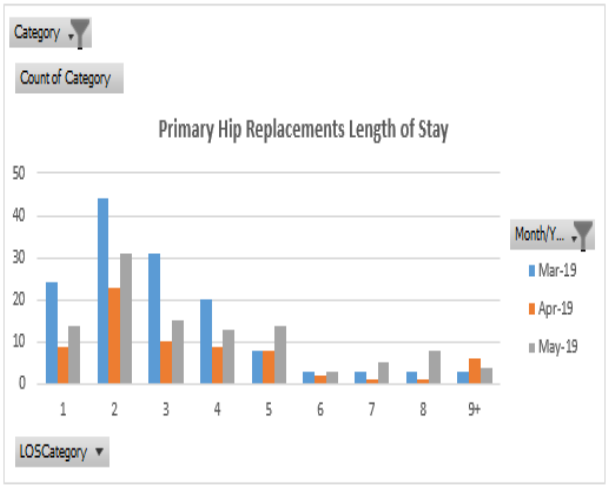
RISKS / ISSUES

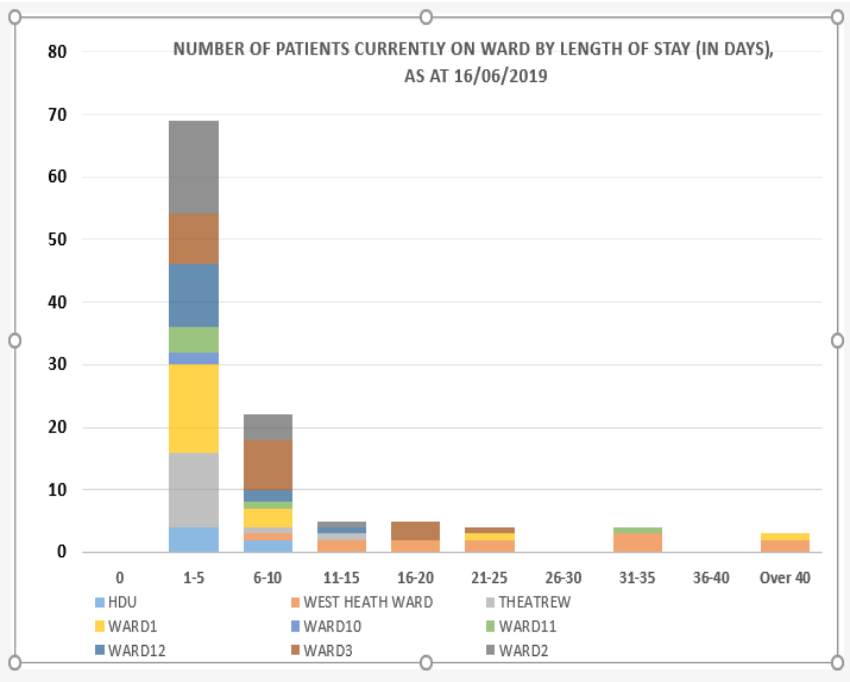
The Managed Service Contract is progressing to completion.

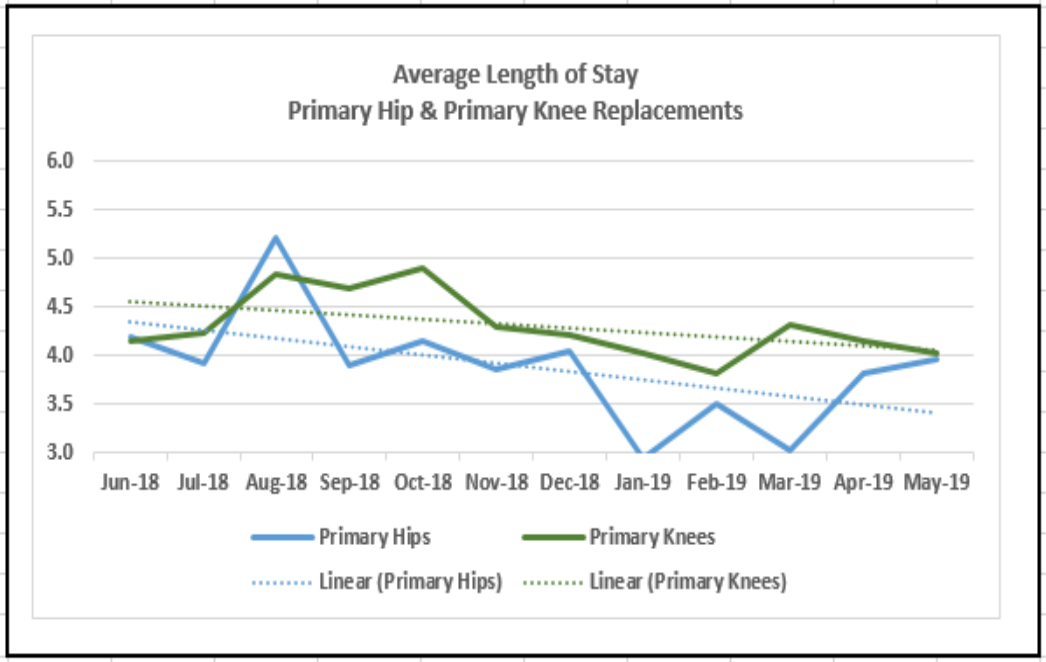
19. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in May remains static at 4.2 days

The data demonstrates that LOS for primary hips increased in month whilst LOS for primary knees decreased. This is a similar trend to last month but with the rate of increasing LOS in Hips reduced.

May's data includes a considerable number of patients with social packages and additional medical needs that impacted on the average LOS in month. Upper individual LOS included over 30 patients with LOS 29-98 days.

It is therefore concluded that the mean average of 4.2 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives to refocus reduction in length of stay including:

- The Trust experienced delays in the biochemistry result service provided by UHB which has resulted in delays in discharge. This has been escalated and the issues have now been resolved with weekly monitoring processes in place.
- A 1300hrs weekday matron led daily adult ward meeting under the auspices of R2G is now in place with minuted actions in place. This is overseen by the Head of Nursing for Division 1 to ensure any barriers to discharge are resolved quickly
- 'Passport to Home' - This includes a patient/ROH agreement regarding Estimated Date of Discharge (EDD), provision of patients own clothes (#PJParalysis) and transport arrangements. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- Ward 12 has now instituted a daily ward round. This is being piloted by the CSL with a view to rolled out following completion of the trial. The Trust strategic intentions includes daily MDT ward rounds in all wards and this is being monitored as part of Trust strategy..
- The discharge lounge is well utilised by all adult inpatient wards with 288 being discharged in May and discharges before midday rose to 41% . This is the key focus now for all areas in order to improve efficiency and patient experience.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The joint care data is now to be included in the integrated board which is being developed.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Recruitment in progress to support out of ours ward clerk support.
- Contract review meeting for Pathology services scheduled for July.

RISKS / ISSUES
• A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity . • Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

20. – CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Reference	Alert Title	Originated By	Date Issued by MHRA	Status	Deadline
MDA/2019/022	Aisys and Aisys CS2 anaesthesia devices with E1 Control option and software versions 11, 11SP01 and 11DP02 – risk of patient awareness due to inadequate anaesthesia. *Manufactured by GE Healthcare – device may fail to deliver the set agent concentration in End Tidal Control mode.*	MHRA	30 May 19	Not Relevant *Confirmed by EBME.*	30 July 19
NHS/PSA/RE/2019/002	Assessment and management of babies who are accidentally dropped in hospital. *When a baby is accidentally dropped in hospital the immediate response is vital to ensuring any injuries are detected and treated as quickly as possible, but as automatic transfer of the baby to the emergency department is not always appropriate, clinical staff need easily accessible practical advice in managing this situation.* *This alert provides a resource to support providers to develop or update a tailored local guide on the initial actions to take when a baby has been accidentally dropped.*	NHS Improvement	09 May 19	Not Relevant *Issued for info only.*	08 Nov 19
MDA/2019/021	Updated: Nellix Endovascular Aneurysm Sealing (EVAS) System - Device recall and enhanced patient surveillance *Endologix has stopped selling the Nellix EVAS device and is recalling unused stock. MHRA recommends enhanced patient surveillance due to a high risk of graft failure beyond 2 years after implementation. This Alert updates guidance previously given in MDA/2019/002 issued 25 January 2019.*	MHRA	01 May 19	Not Relevant	22 May 19

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 26 June 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee agreed that the financial performance in Month 2 was disappointing with a deficit of c. £600k greater than plan being achieved. The underperformance was driven by a complex set of issues but essentially there had been a failure to meet the monthly control total target due to activity casemix issues (10 less high value procedures than forecast) and therefore and assumption had been made that there would be a £300k Financial Recovery Fund 'hit' for the month. It is anticipated that this position can be recovered over coming months. • A dip in day case activity had also been seen, although this had less of a significant impact on income. This reflected unique circumstances in the small team of individuals responsible for this work and included the impact of the pension tax liability issue. Short term alternative resources and a recruitment plan into these posts was highlighted to be mitigation to this situation. • Expenditure on pay was reported to be higher than plan, this being driven by the use of temporary staffing in nursing and medical posts. • There had been some issues regarding the provision of blood results which had impacted on length of stay this month, although these had now been resolved. • Indicative performance against the cancer targets suggested that there may be 1.5 breaches reported, one being shared with another provider. • There was a discussion on preparedness for a 'no deal' Brexit outcome and the impact on supplies.	• Refresh the narrative in the financial overview to more clearly articulate the reasons for the financial under performance in the month. • Present to the Board the plans for the Managed Service programme. • Prepare an update on 'Perfecting Pathways' for the Trust Board.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The recruitment plans to fill vacancies were progressing well and were expected to deliver a reduction in agency expenditure. A number of GP trainees had also been secured which would reduce medical locum spend. • There was good progress to date with the delivery of the Cost Improvement Programme. There was anticipated to be some positive savings as a result of the region-wide procurement plans. • Theatre utilisation was noted to be positive and there was good recycling of lists that would otherwise be left fallow. • The Committee was advised that there was some good work in the Pre-Operative Assessment Centre to refine processes. • A new electronic system for the management of annual leave for medics had been launched which was reducing the need to reschedule clinic appointments. • There was positive performance against the workforce metrics, with better performance against mandatory training, attendance and appraisals.	• The Committee supported the establishment of a 'Perfecting Pathways' programme board, which would systematise the management of projects within the Trust and reduce the number of different fora through which projects were discussed and monitored.

Chair's comments on the effectiveness of the meeting: Nothing specifically highlighted. The Committee again welcomed the Assistant Director of Finance to the meeting to observe the discussions following her return from maternity leave.

Finance and Performance Report

May 2019

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 and/or issues that are being highlighted.

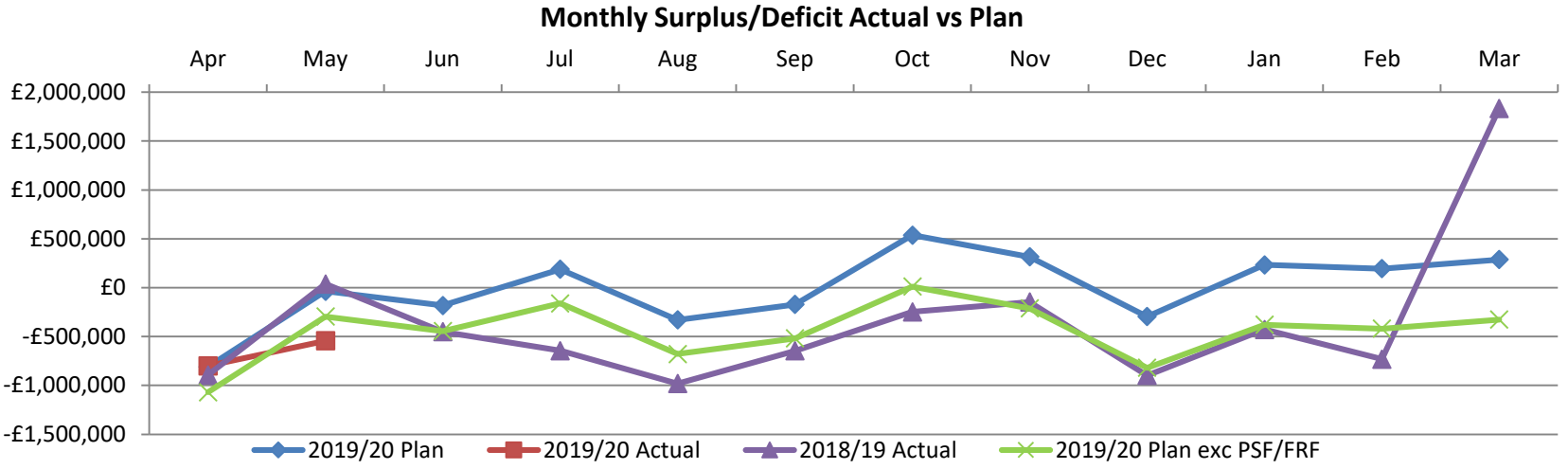
1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

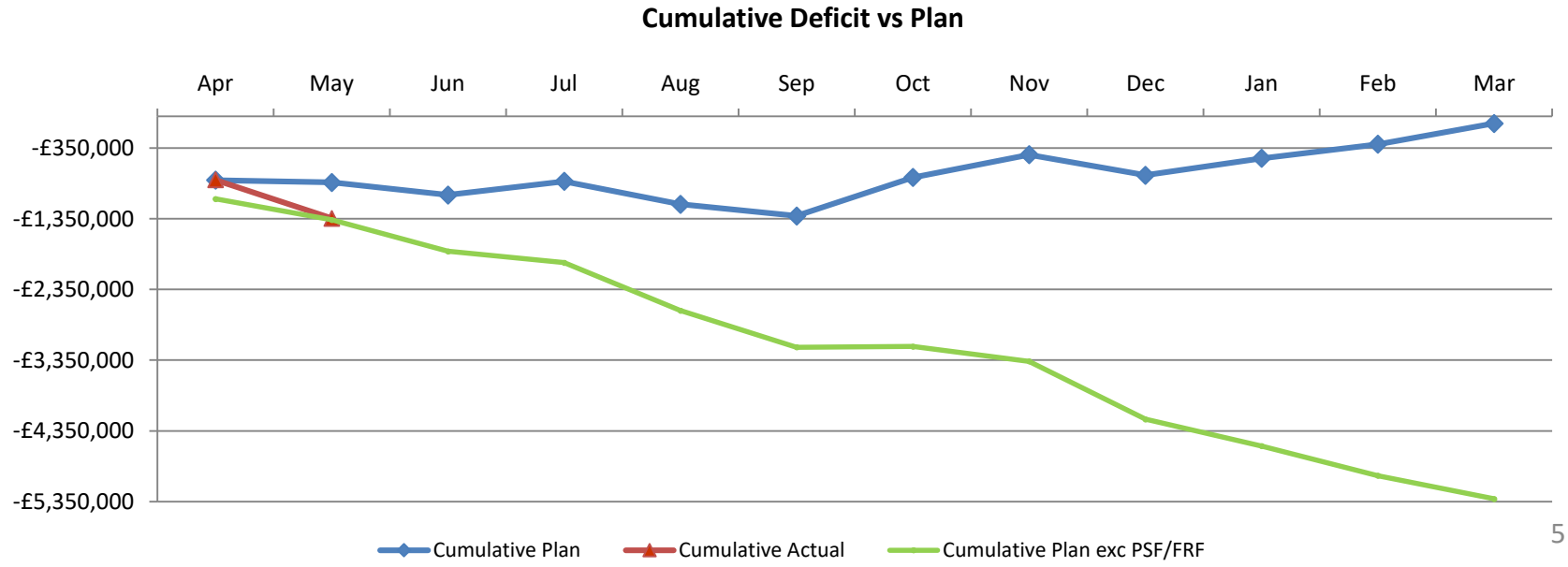
	YTD M02 Original Plan £'000	YTD M02 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	13,246	13,034	(212)
Other Operating Income	1,297	1,117	(180)
Total Income	**14,543**	**14,151**	**(392)**
Employee Expenses (inc. Agency)	(9,097)	(9,308)	(211)
Other operating expenses	(6,063)	(5,976)	88
Operating deficit	**(617)**	**(1,133)**	**(516)**
Net Finance Costs	(228)	(209)	19
Net deficit	**(845)**	**(1,342)**	**(497)**
Remove donated asset I&E impact	10	(107)	(117)
Financial Performance surplus/(deficit) excluding PSF & FRF (Control Total)	**(1,365)**	**(1,704)**	**(339)**

During May as the control total was not met a prudent assumption was made to exclude PSF and FRF from the M2 position. The below position includes PSF & FRF within the plan for M1 & M2 but the actual position only includes PSF/FRF of £265k for M1.

Adjusted financial performance (Including PSF & FRF)	**(835)**	**(1,449)**	**(614)**

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). This includes PSF & FRF





INFORMATION

Trust delivered an in-month deficit of £644k in May against a planned deficit of £31k, £348k underperformance against plan. A year to date deficit position of £1,342k against a deficit plan of £845k, causing an underperformance of £497k.

Clinical income has underperformed by £411k against plan in May mainly due to decreased level of elective inpatient activity (£375k under plan).

Pay spend is £211k higher than plan with temporary staffing spend £158k above plan, due to vacancies and sickness.

ACTIONS FOR IMPROVEMENTS / LEARNING

Workforce planning is underway to identify actions that can be taken to reduce temporary staffing levels. A reduction in medical agency spend is expected from August onwards with 3 GP trainees posts to be filled in the SHO rota which were previously covered by agency medics. A significant reduction in nursing agency is expected until Dec 2019 with the go-live of Theatres Expansion Phase 1 at ROH, due to significant recruitment levels expected over the coming months. A project is underway to create one trust-wide establishment and recruitment trajectory, which will support the basis for recruitment planning and management going forth. This is expected to be complete across all staffing levels by August 2019.

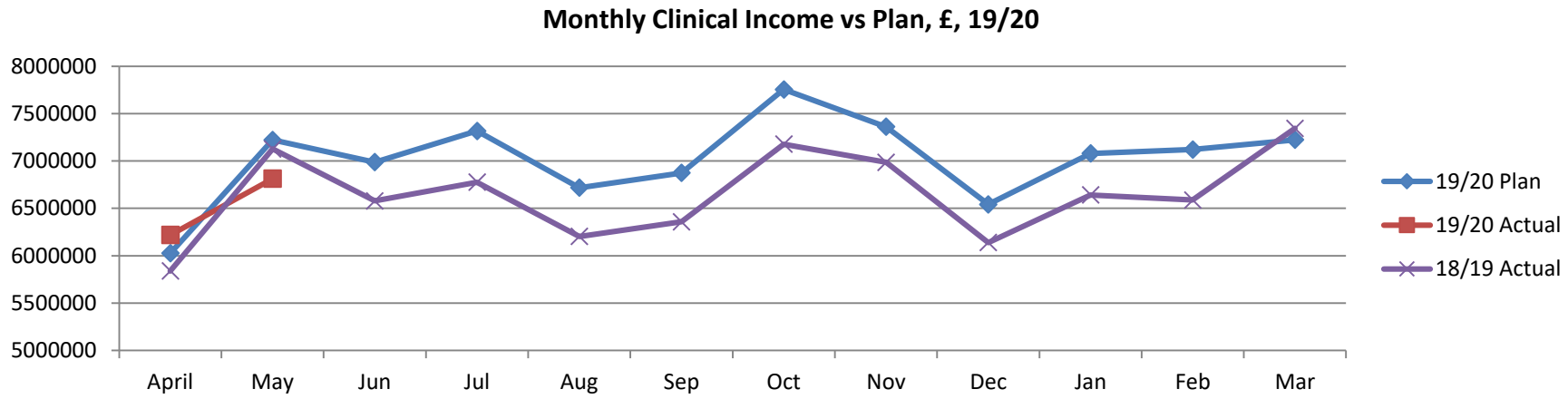
A review of activity plans is underway to gain assurance of activity achievement against plan for the remainder of the year.

RISKS / ISSUES

June has a planned deficit of £183k in month and cumulative deficit of £1,028.

CIP delivery; despite assurance and delivery of M1 and M2 CIP, the June and ongoing CIP target increases by c. £30k and £100k accordingly per month. Furthermore operational and clinical sign-off regarding CIP's and financial impacts remain incomplete at present, a revised deadline of July 19th is presented to all teams. Underperformance risks are being mitigated this year by planning an internal stretch target and schemes, although again in 19/20 the largest CIP is the Theatres Managed Service Contract, with a planned go-live from July 2019, which now looks likely to be delayed to August 2019.

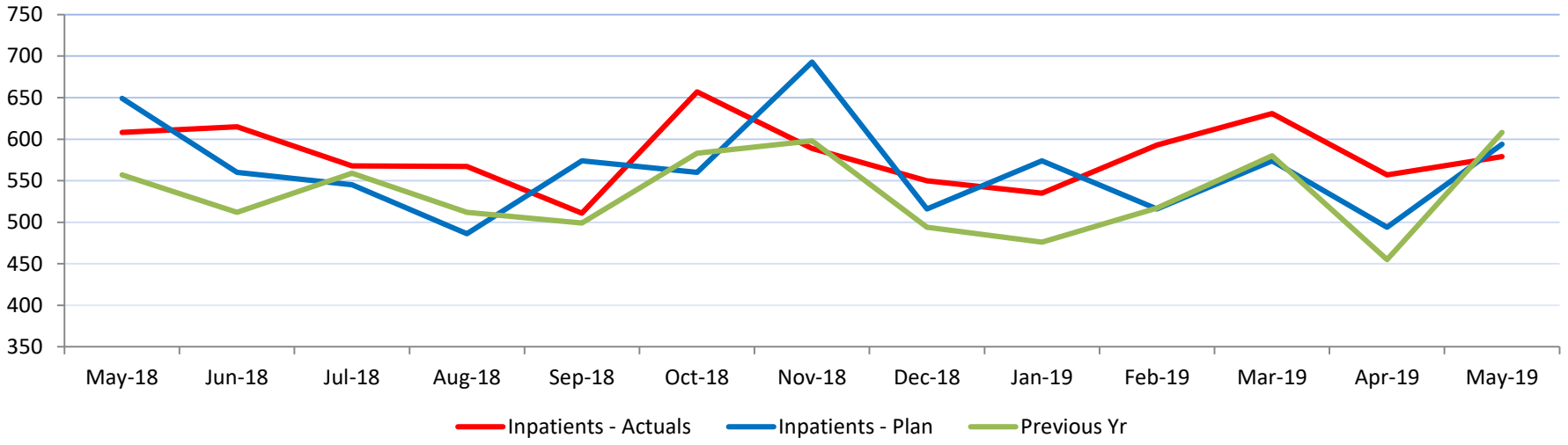
2. Income and Activity– This illustrates the total income generated by the Trust in 2019/20, including the split of income by category, in addition to the month's activity (Inc PSF & RFF)



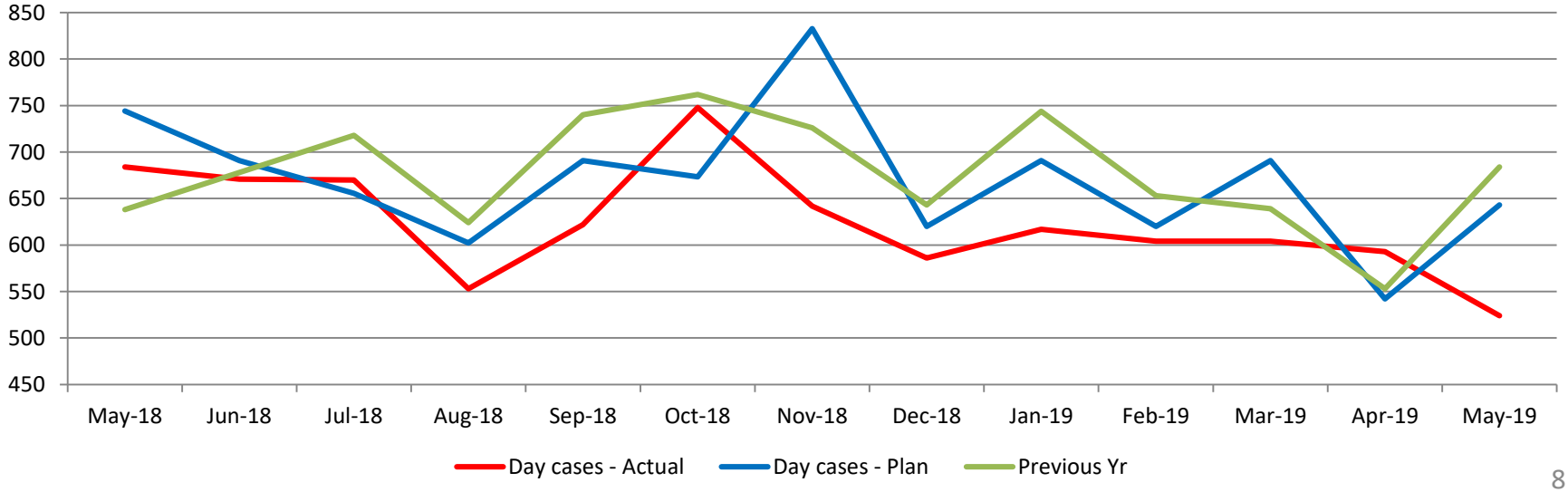
Clinical Income – May 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,517	3,266	-251
Excess Bed Days	71	79	8
Total Inpatients	3,588	3,345	-243
Day Cases	867	815	-52
Outpatients	765	687	-78
Critical Care	208	145	-63
Therapies	258	298	40
Pass-through income	226	233	7
Other variable income	701	752	51
Block income	608	535	-73
TOTAL	7,221	6,810	-411

Clinical Income – Year To Date 2019/20 £'000			
	Plan	Actual	Variance
Inpatients	6,354	6,381	27
Excess Bed Days	129	135	6
Total Inpatients	6,483	6,516	33
Day Cases	1,598	1,586	-12
Outpatients	1,474	1,345	-129
Critical Care	384	328	-56
Therapies	476	534	58
Pass-through income	419	458	39
Other variable income	1,292	1,190	-102
Block income	1,120	1,070	-50
TOTAL	13,246	13,027	-219

Inpatient Activity



Day Case Activity



NHS Clinical income has under-performed against plan by 5.7% in May having over-performed in April by 7.09%. Cumulatively, the trust is 1.65% below plan. The admitted patient care performance was below plan financially and discharged activity was higher than in April but still below plan. Day case activity underperformed financially and was below the activity target by 68 cases. Case-mix in May was 48% for day cases 49% for electives. Non Elective make up the other 3%.

Outpatients have under-performed for May. There has been a decrease in attendances against plan in May for first and follow up attendances . First to follow up ratio is 2.3:1.

ACTIONS FOR IMPROVEMENT/LEARNING

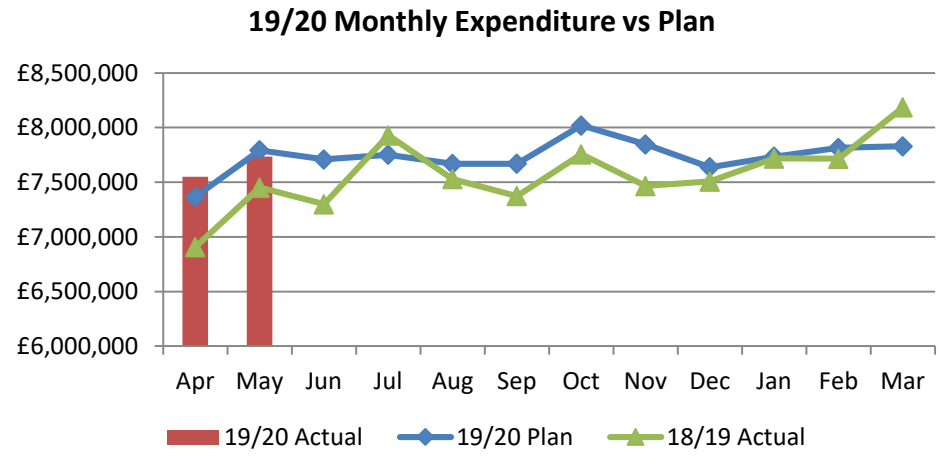
Clinical Service Managers are reviewing theatre lists to ensure they are fully maximised.

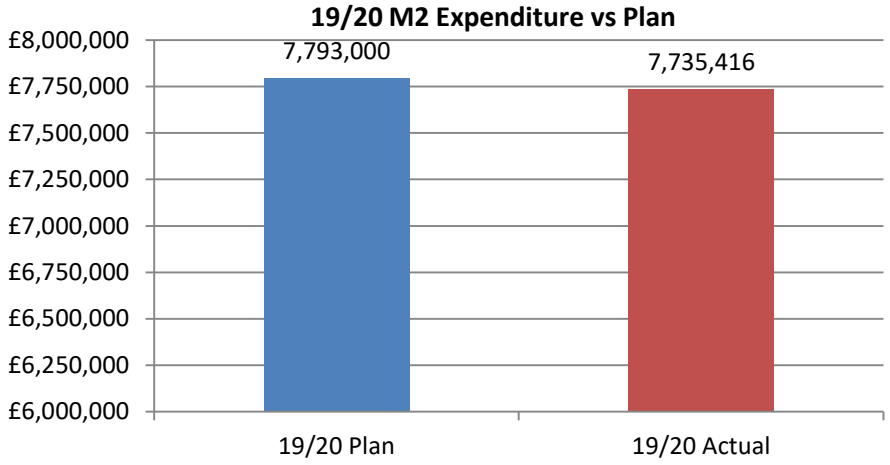
Finance and clinicians are working together to insure that co-morbidities are being recorded and therefore maximising the income.

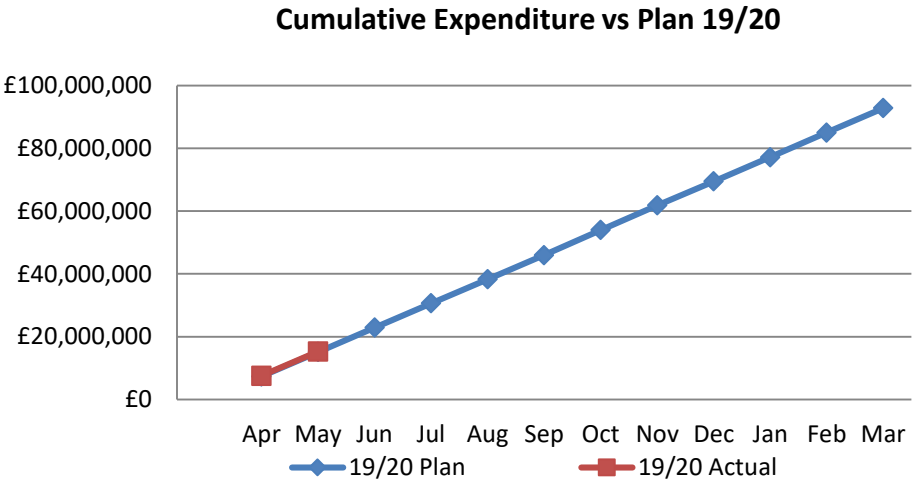
RISKS / ISSUES

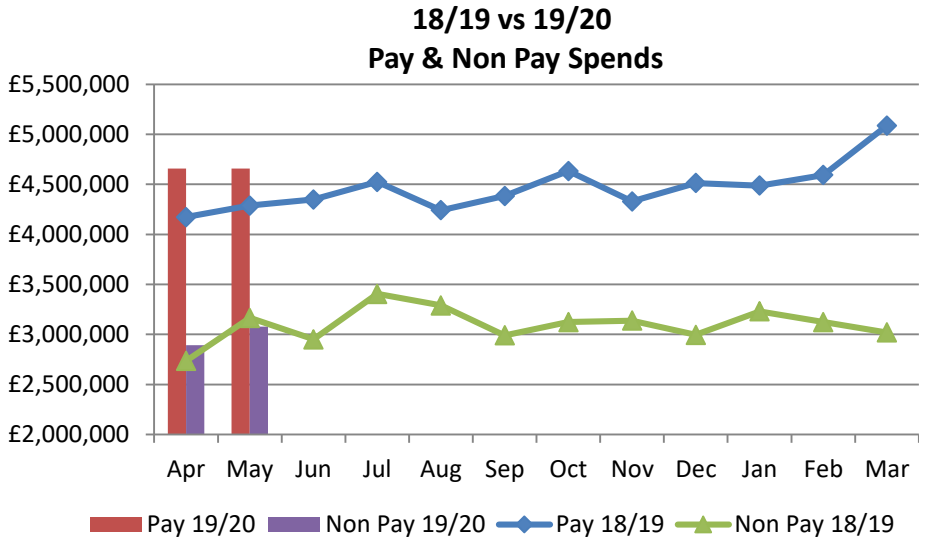
Inpatient plan for June is £6,987k with 1,187 inpatients planned (638 day cases and 549 inpatients) during the month.

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









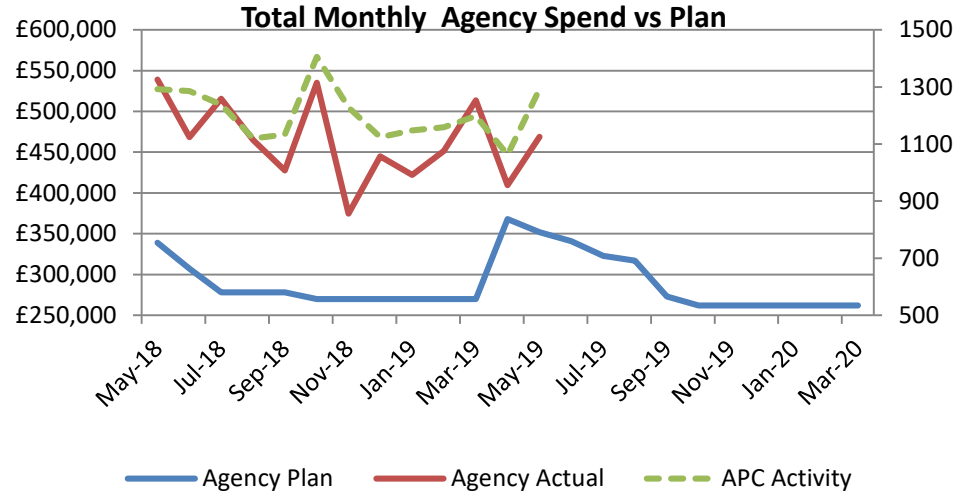
INFORMATION

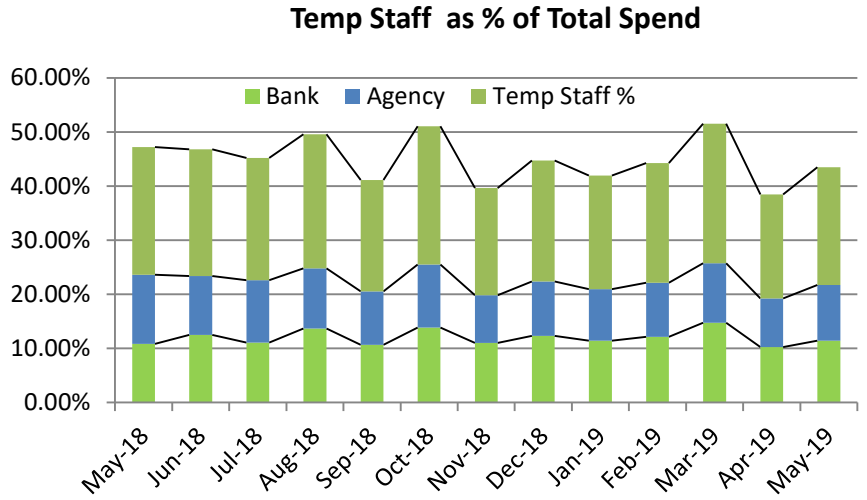
Expenditure in May was £7,735k, which was higher than the planned spend of £7,793k, equating to a difference of £57k.

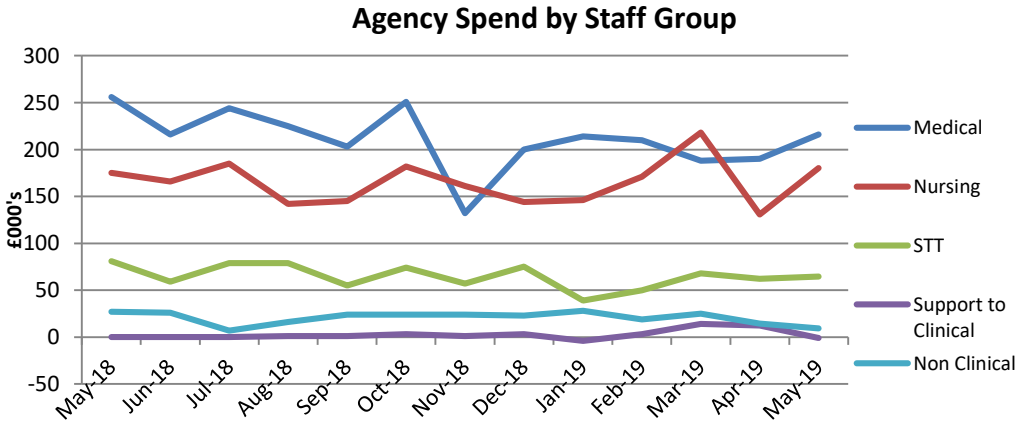
Pay in May was similar to the spend in April.

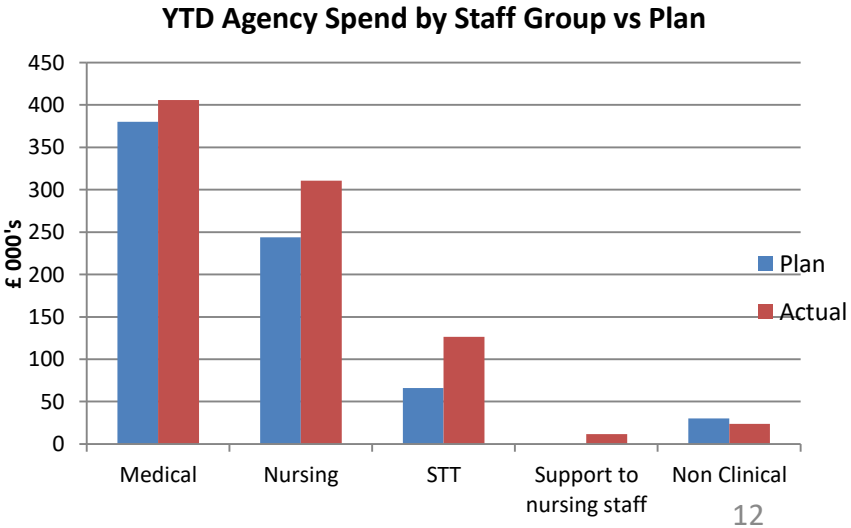
Non pay spend in May was higher than in April by £185k due to Theatres stock and Pharmacy drug spend.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Total agency spend for May was £468k against a plan of £352k, with cumulative spend of £878k against a cumulative plan of £720k. There has been an overall increase in agency costs compared to April 19, with the largest increase in Nursing of £49k. This increase can be attributed to the reopening of the 2 wards which were closed during April.

Bank spend in month was £528k against a plan of £398k mainly due to vacancies.

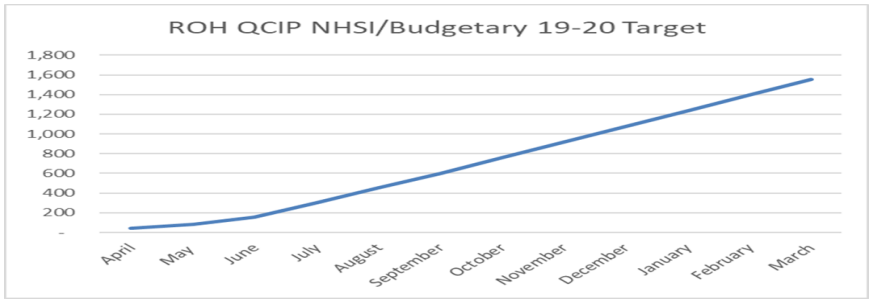
ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

Recruitment to vacancies continue with a projected 7wte qualified nurses to start during June/July.

6.Cost improvement Programme – This illustrates the plan for the 2019-20 cost improvement programmes (£000's)



Row Labels	Sum of 19-20 NHSI CIP Plan	Sum of 19-20 Internal ROH Plan
1	590	732
2	826	1,080
4	71	118
Corporate	66	363
Grand Total	**1,553**	**2,294**

Row Labels	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	19-20 Total
1	14	14	24	58	58	58	61	61	61	61	61	61	590
2	23	23	36	79	79	79	85	85	85	85	85	85	826
4	3	3	5	5	6	6	7	7	7	7	7	7	71
Corporate	2	2	6	6	6	6	6	6	6	6	6	6	66
Grand Total	**42**	**42**	**71**	**148**	**149**	**149**	**159**	**159**	**159**	**159**	**159**	**159**	**1,553**

The Trust QCIP (Quality and Cost Improvement Programme) target was identified at £1.553m for 19-20. In 18-19 the Trust target was identified at £2.985m, however only £1.688m (57%) was delivered. Thus, during the 19-20 business planning (and QCIP) round, schemes up-to £2.294m have been identified as opportunities for this year. (With the difference being a stretch target for the Trusts divisions) Many of the schemes amounting to the Trust target (£1.553m) have been costed, however some (including the stretch target schemes) remain aspirational at present and costings are ongoing.

All of the schemes identified at present are recurrent schemes, QCIP PID/QIA (project initiation documentation including costings and quality impact assessment) completion is currently ongoing, with an internal completion target date for the Trusts divisional teams initially set at 7th June 2019, due to delays this has now been extended to a final deadline of 19th July 2019 for all identified schemes to date.

The Trust has delivered its April 2019 and May 2019 CIP plan (£42k) and is on track to deliver its June 2019 plan. (£17k) However the significant increase to the plan post June 2019 creates a financial risk to the Trust, mitigation plans to prevent under-delivery (as per 18-19) are in-place (stretch targets/already scoping additional opportunities) along with greater support, collaborative working (Executive led and project focused delivery of QCIP schemes) and divisional approved forecasts commencing early June 2019.

The 2 largest schemes for 19-20 include the Theatres MSC and workforce recruitment, the latter based on current trajectories is likely to deliver, however the former is likely to slip from July 2019 to October2019, although the financial benefits of this scheme are likely to deliver significantly larger savings than planned based on the current valuations/calculations being discussed.

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	YTD Plan	YTD Actual	VAR
	£'000	£'000	£'000
Intangible Assets	1494	1365	-129
Tangible Assets	46346	45971	-375
Total Non-Current Assets	**47840**	**47336**	-504
Inventories	7063	6912	-151
Trade and other current assets	9353	8219	-1134
Cash	3203	2529	-674
Total Current Assets	**19619**	**17660**	-1959
Trade and other payables	-17414	-16089	1325
Borrowings	-726	-726	0
Provisions	-85	-84	1
Other liabilities	-514	-387	127
Total Current Liabilities	**-18739**	**-17286**	1453
Borrowings	-10794	-10794	0
Provisions	-215	-215	0
Total Non-Current Liabilities	**-11009**	**-11009**	0
Total Net Assets Employed	**37711**	**36701**	-1010
Total Taxpayers' and Others' Equity	**37711**	**36701**	-1010

INFORMATION

Tangible assets are below plan due to slippage on various schemes throughout the trust. Work is underway to ratify the capital plan to ensure it accurately reflect the capital purchased planned for the year.

Cash is currently behind plan mainly as a result of delays in FRF/PSF payment relating to 2018/19.

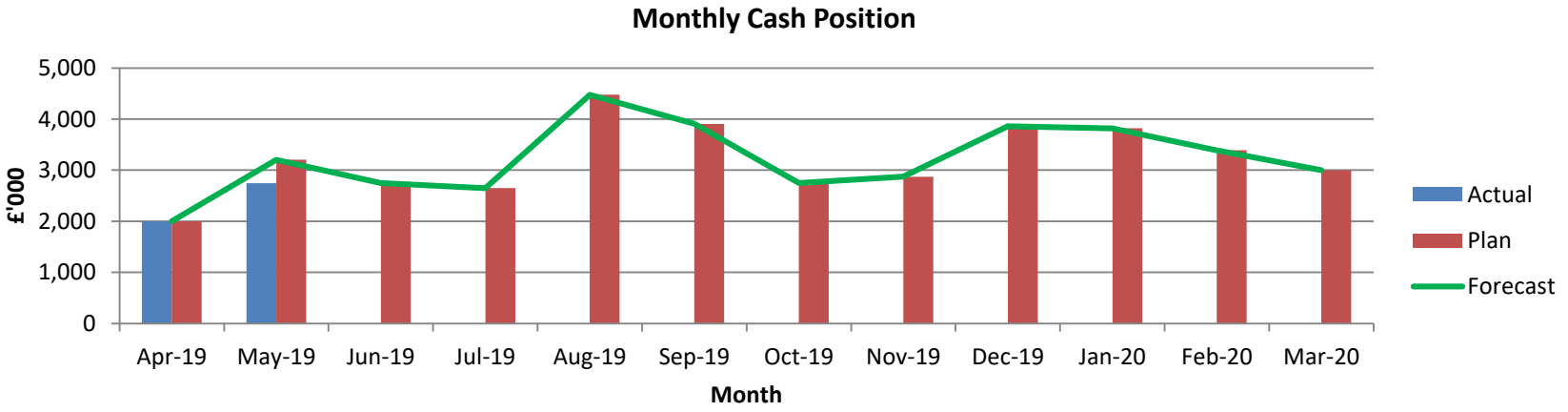
ACTIONS FOR IMPROVEMENTS / LEARNING

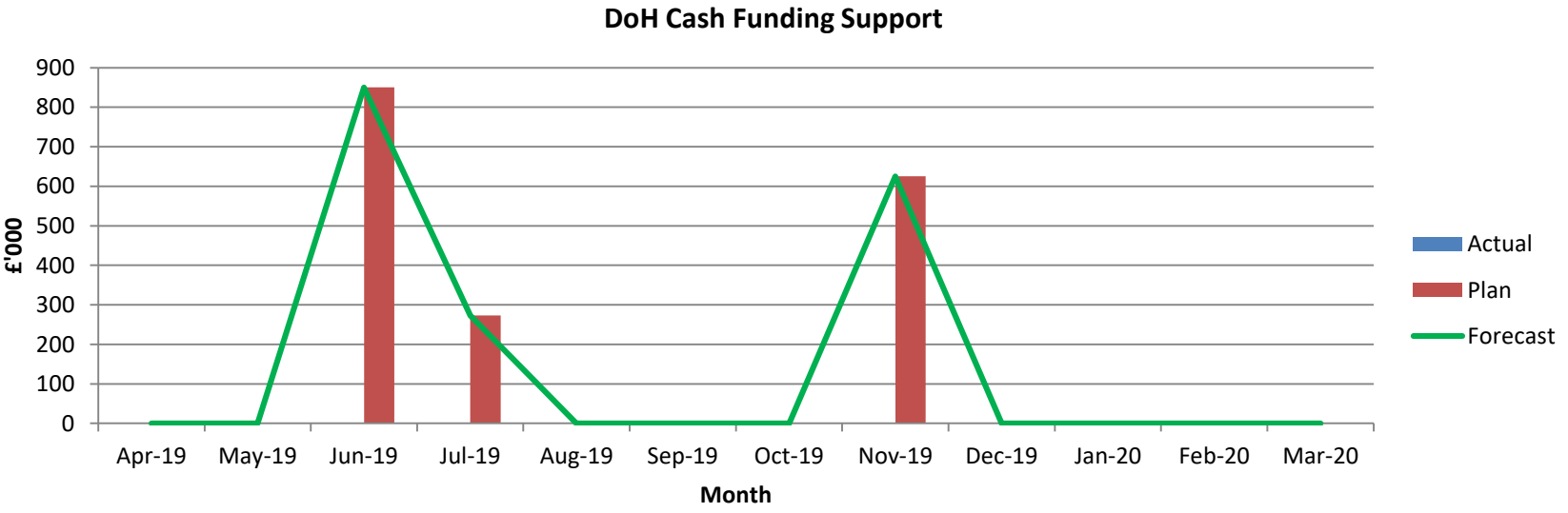
Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

RISKS / ISSUES

The clarity of the rules of payment and unknown timings of PSF/FRF is causing an issue with accurate cashflow forecasting.

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 for month 2 ended at £2.74m, which is behind plan by £0.46m.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level, cash support of £850k has been requested from the Department of Health (DoH) for June which is within the plan for 2019/20.

ACTIONS FOR IMPROVEMENTS / LEARNING

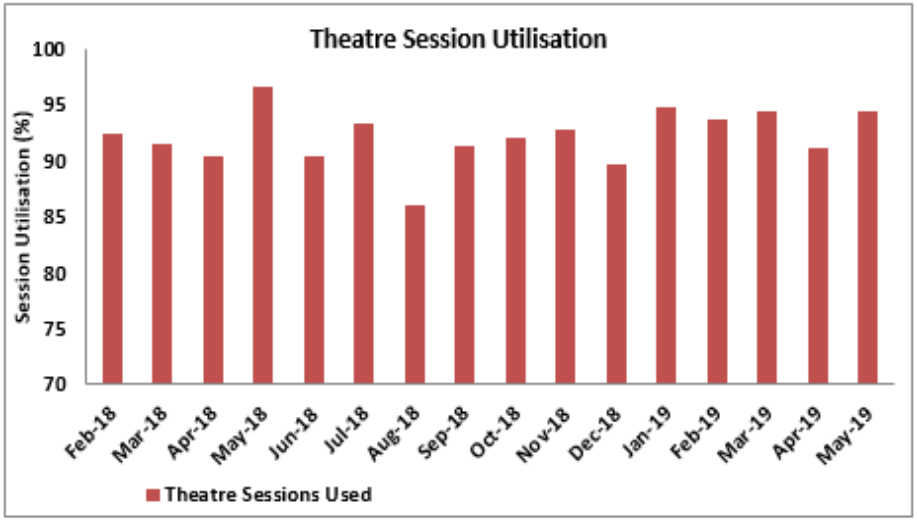
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2019/20. The Head of Financial Accounting continues to hold monthly cash control committee attended by the DDoF, and representatives from management accounts and the transaction team. 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

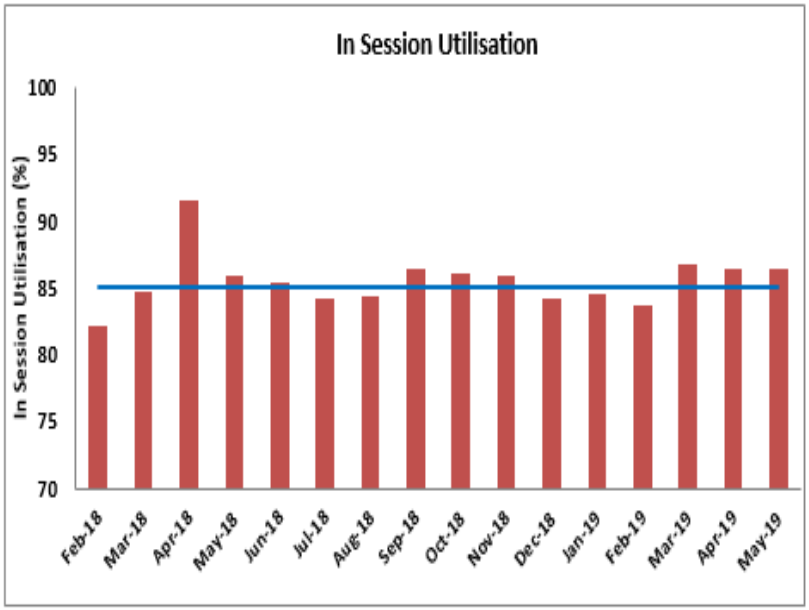
Target 90%

Session utilisation increased to 94.38% in May compared to 91.14% in April.

RISKS / ISSUES

- Ongoing discussions with medical groups regarding the pension/tax issue continue
- A successful open day in June 19 resulted in 16 offers being made on the day, building on the success of previous recruitment initiatives

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



ACTIONS FOR IMPROVEMENTS / LEARNING

Target 85%

In session utilisation for May was 86.42% compared to 86.45% in April.

RISKS / ISSUES

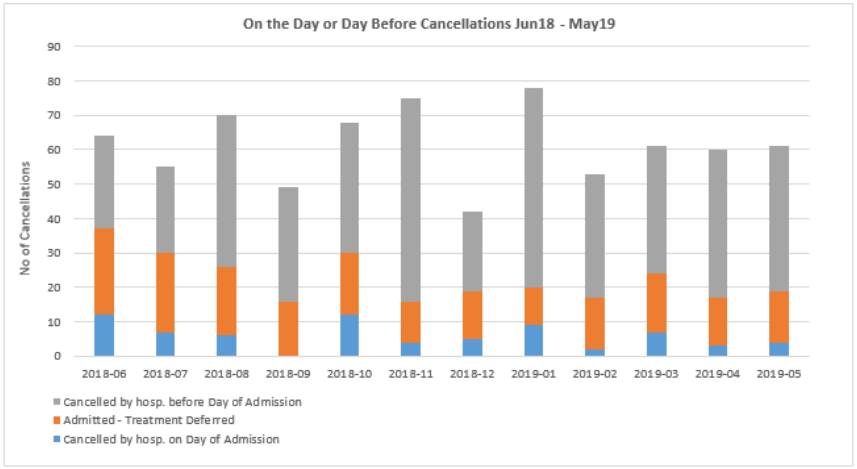
- Last minute changes to lists impact on the efficient running and planning of theatre lists - risk being reduced due to introduction of lock down process and learning from theatre lookback meetings
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

INFORMATION

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.

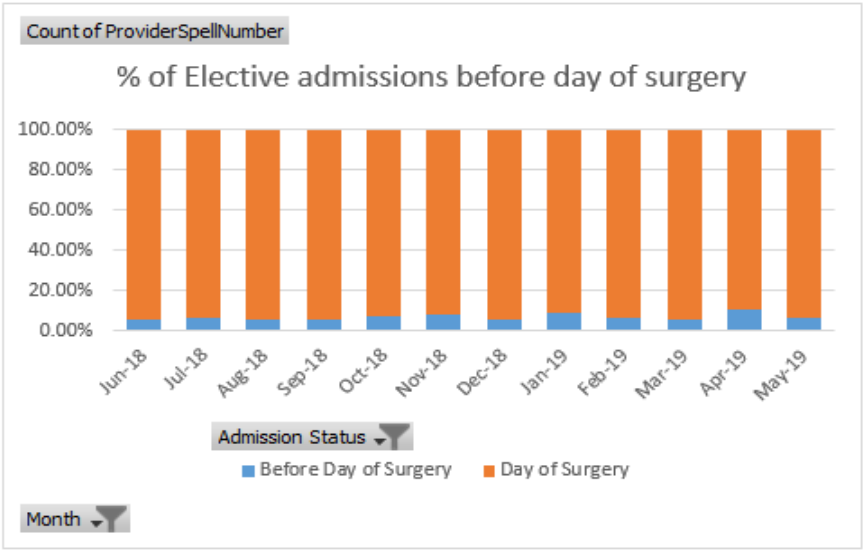
10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

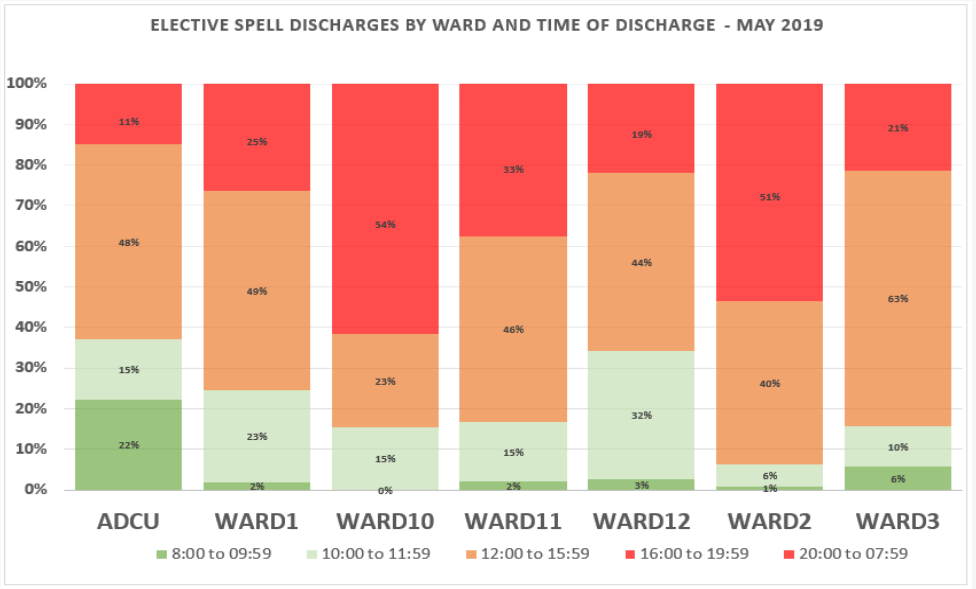
Hospital Cancellations



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
2018-06	12	25	27	64	0
2018-07	7	23	25	55	0
2018-08	6	20	44	70	0
2018-09		16	33	49	0
2018-10	12	18	38	68	1
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	43	60	0
2019-05	4	15	42	61	0
Grand Total	71	200	465	736	1

Admission the day before surgery





The number of cancellations on the day of admission for surgery in May was 4 patients. One admin error, two patients unfit and one patient self cancelled.
There were 15 admitted for surgery where treatment was deferred. Analysis of patients admitted where treatment was deferred relates to, lack of theatre time, medically unfit and equipment availability and patients who had not followed fasting instructions.

Cancellations before the day of surgery have decreased slightly in month from 43 to 42. An analysis of the 42 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, consultant unwell and patient medically unfit following preassessment.

The 72 hour call to patients has been embedded as a standard process and continues to work well highlighting any issues before surgery. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance .

The POAC business case was presented at DMB in May 2019 and is to be presented to the Executive Meeting in July

A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

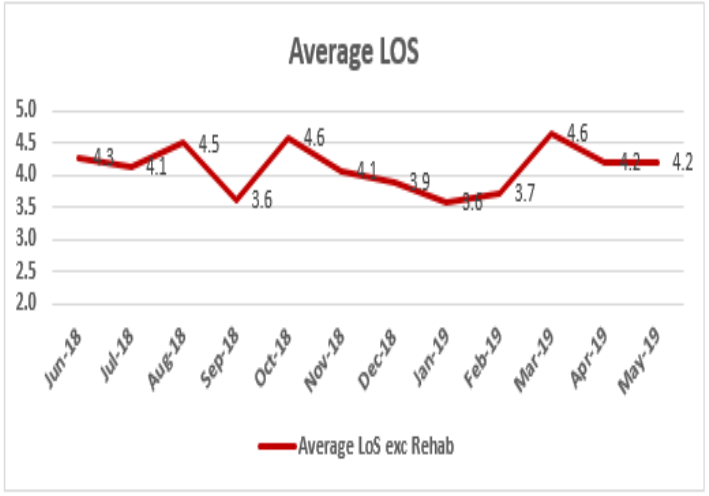
Additional focus is being delivered in the following areas as a result of themes highlighted in review of cancellation on the day data :

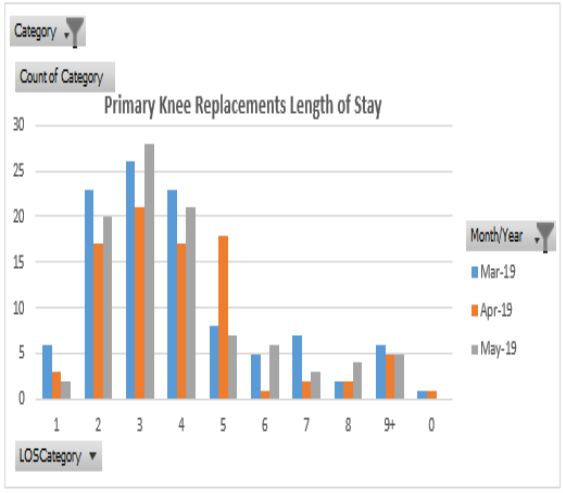
- POAC representative continues to play an active role in the daily Huddle to address any pre-operative issues at source and further enhance the 72 hour process.
- Escalation to CSM where patients cannot be contacted prior to surgery
- The Standard Operating Procedure for bookings in now in place.

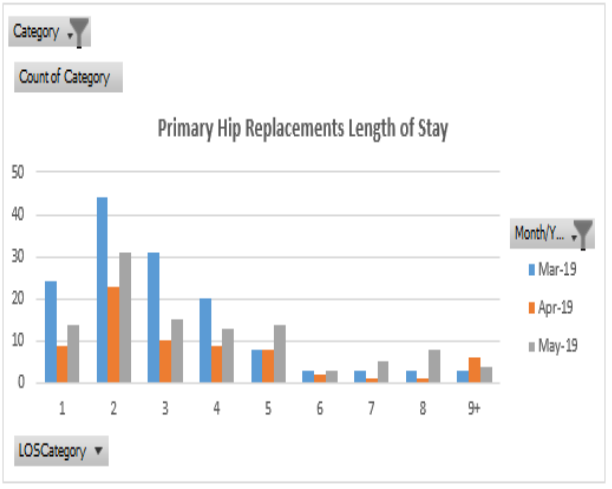
RISKS / ISSUES

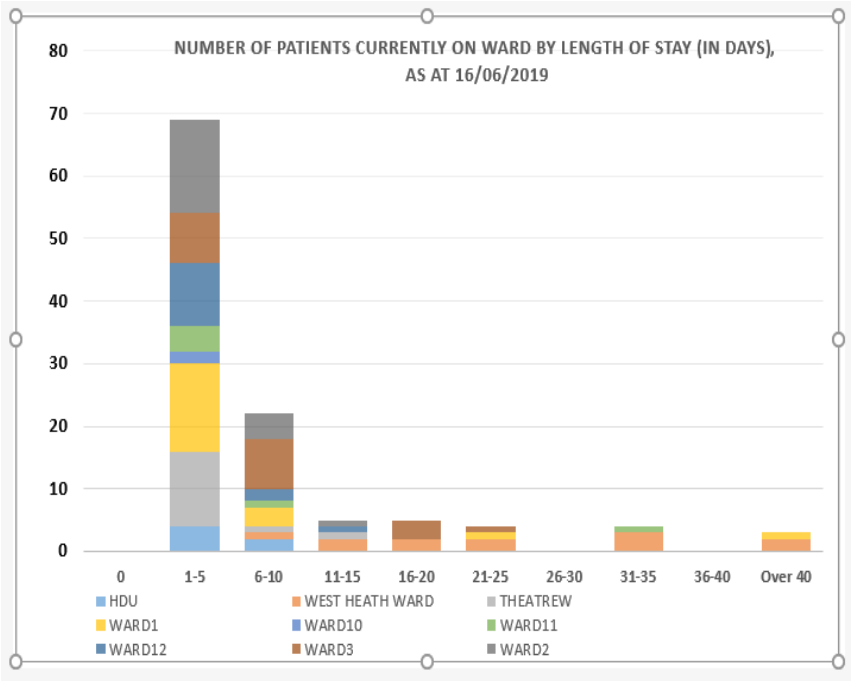
The Managed Service Contract is progressing to completion.

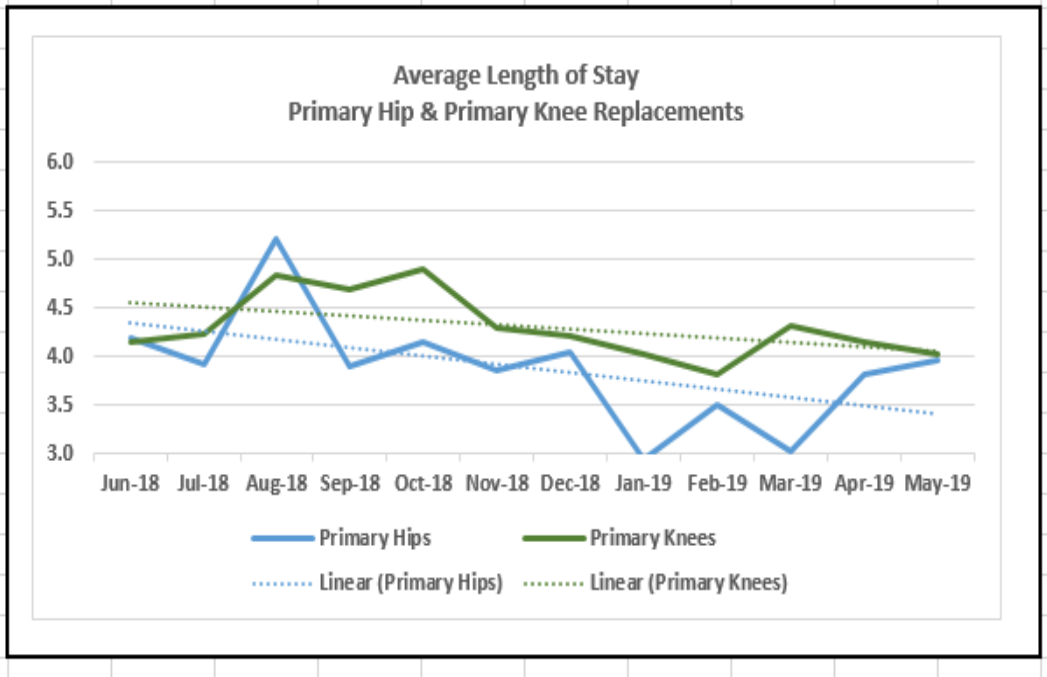
11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in May remains static at 4.2 days
The data demonstrates that LOS for primary hips increased in month whilst LOS for primary knees decreased. This is a similar trend to last month but with the rate of increasing LOS in Hips reduced.

May's data includes a considerable number of patients with social packages and additional medical needs that impacted on the average LOS in month. Upper individual LOS included over 30 patients with LOS 29-98 days.

It is therefore concluded that the mean average of 4.2 days is not representative of the 'average patient' and the deviation in the result is attributable to a small number of patients who had a protracted length of stay due to clinical complexity.

There are a number of initiatives to refocus reduction in length of stay including:

- The Trust experienced delays in the biochemistry result service provided by UHB which has resulted in delays in discharge. This has been escalated and the issues have now been resolved with weekly monitoring processes in place.
- A 1300hrs weekday matron led daily adult ward meeting under the auspices of R2G is now in place with minuted actions in place. This is overseen by the Head of Nursing for Division 1 to ensure any barriers to discharge are resolved quickly
- 'Passport to Home' - This includes a patient/ROH agreement regarding Estimated Date of Discharge (EDD), provision of patients own clothes (#PJParalysis) and transport arrangements. Quality and Safety Walk Arounds highlight this process is not fully embedded across all wards. Each Senior Sister is continuing to develop local strategies to embed this process.
- Ward 12 has now instituted a daily ward round. This is being piloted by the CSL with a view to rolled out following completion of the trial. The Trust strategic intentions includes daily MDT ward rounds in all wards and this is being monitored as part of Trust strategy..
- The discharge lounge is well utilised by all adult inpatient wards with 288 being discharged in May and discharges before midday rose to 41% . This is the key focus now for all areas in order to improve efficiency and patient experience.

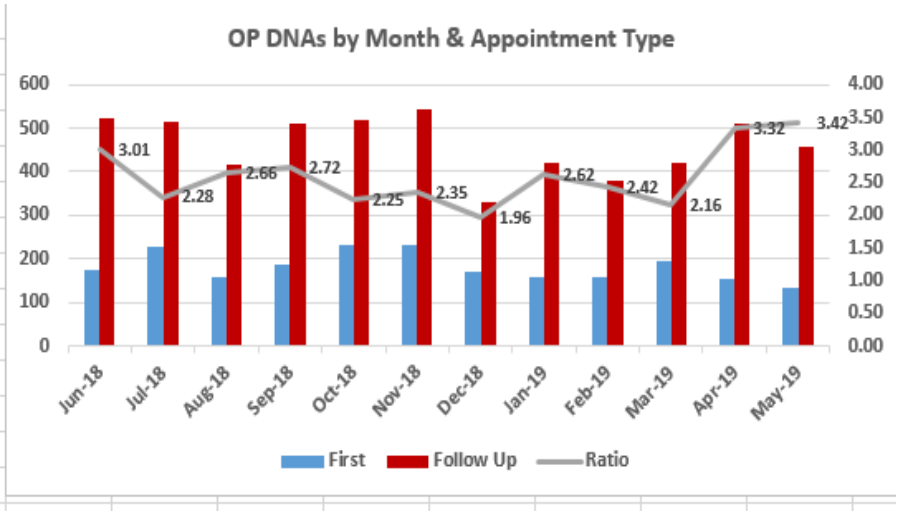
ACTIONS FOR IMPROVEMENTS / LEARNING

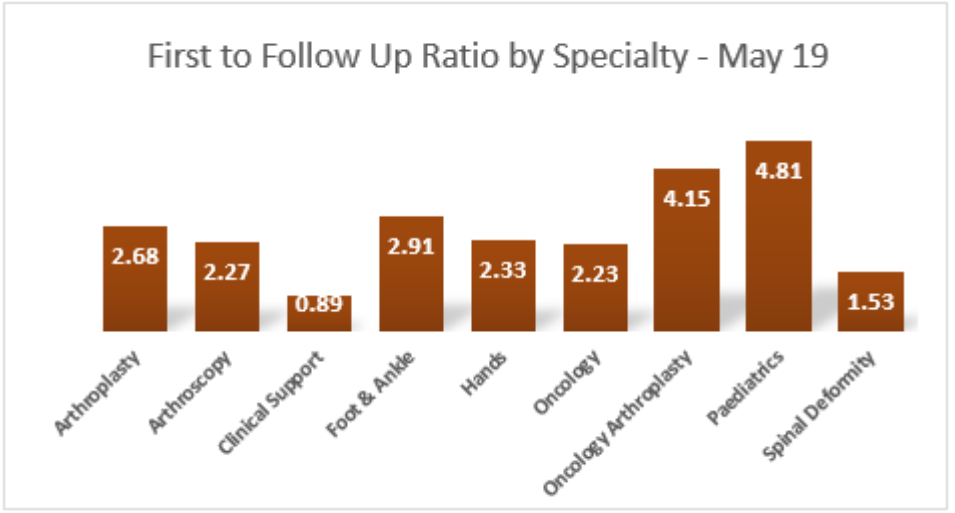
- The joint care data is now to be included in the integrated board which is being developed.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Recruitment in progress to support out of ours ward clerk support.
- Contract review meeting for Pathology services scheduled for July.

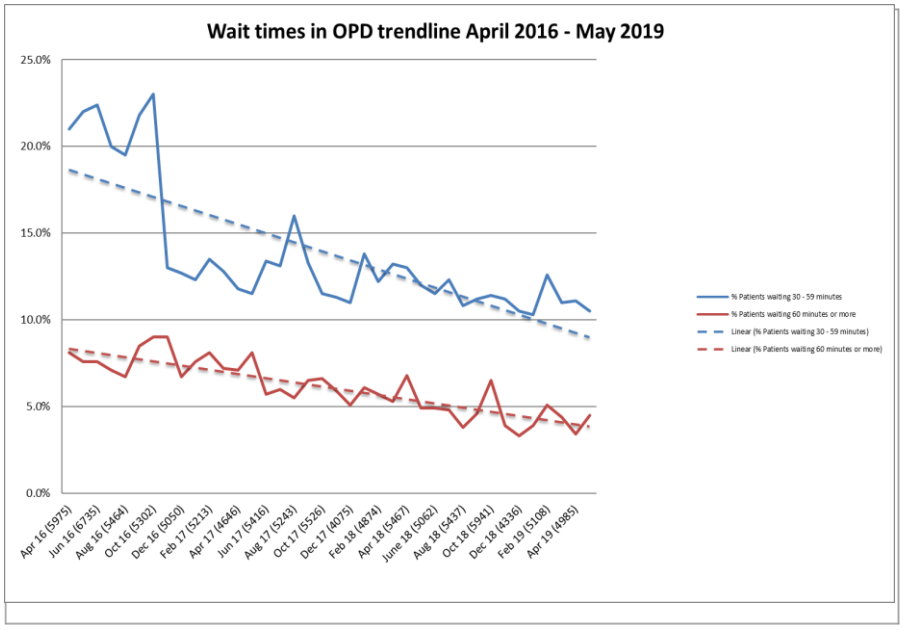
RISKS / ISSUES

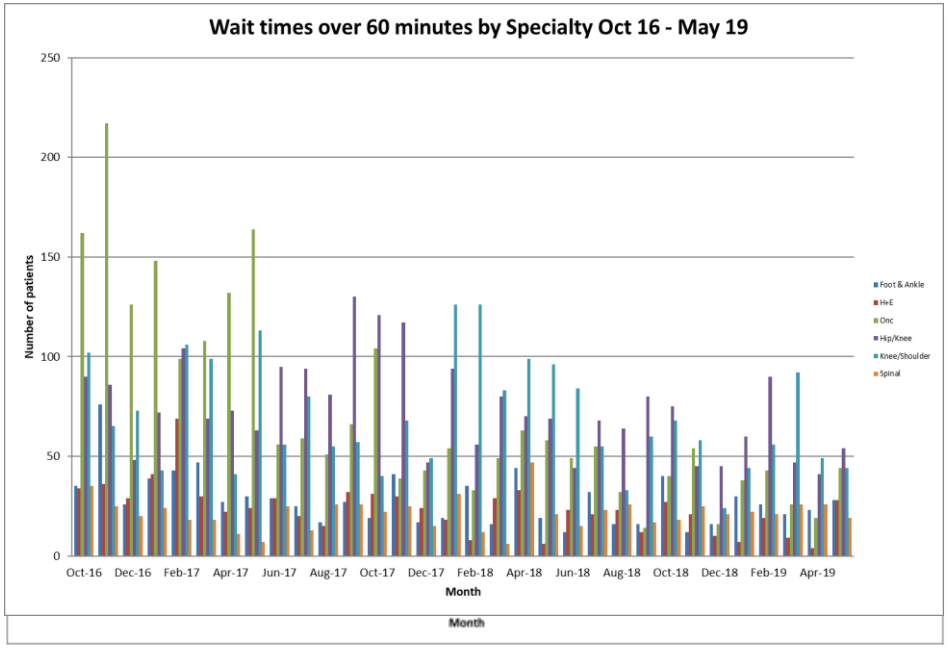
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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 10.5% of patients waiting over 30 minutes which is an improvement on last month (from 11.1%). The target for 30 minute delays has not been achieved but progress is being maintained. The over 60 minute delays continue to be maintained under the target of 5% with a level of 4.5% for May. This is now the 12th month out of last 13 that the over 60 minute target has been achieved.

Room allocations each week continue to be managed well and there has only been 2 incidents of no room available in May. One of these incidents relates to an occasion where a room had been allocated but the clinician felt it was not suitable. The 643 meeting is to be expanded to include discussion about the number of patients booked on each session and will follow on from the 642 theatre meeting. The attendance of this meeting will also be increased to include Imaging and operational or office managers.

There were 15 incidents of clinic delays reported in May 2019 with the following breakdown.
6 Other
3 Complex patient
2 Clinic Overbooked for Number of Staff
2 Consultant / clinician delay
1 Delay in medical notes
1 X-ray delay

Allocate – the electronic annual leave requesting platform has now gone live and is being used by all medical staff which should reduce the number of patients and clinics being rescheduled within 6 weeks.
Consideration is being given to upgrading the InTouch system to enable the Health Informatics team to improve reporting from the system. Better data would allow trends of clinic delays to be identified and the data used to inform changes to clinic templates which could then be discussed with the clinicians and specialty managers.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The outpatient operational group needs to evolve to include monitoring of projects within and affecting the outpatient department

- The process for partial booking has been started as a pilot for new appointments in Pain and Spinal Deformity. This will inform the Business case.
- The main outreach site for the Trust is Lordswood surgery and this is now full utilised. Scoping is ongoing to ensure outpatient capacity meets future demand.

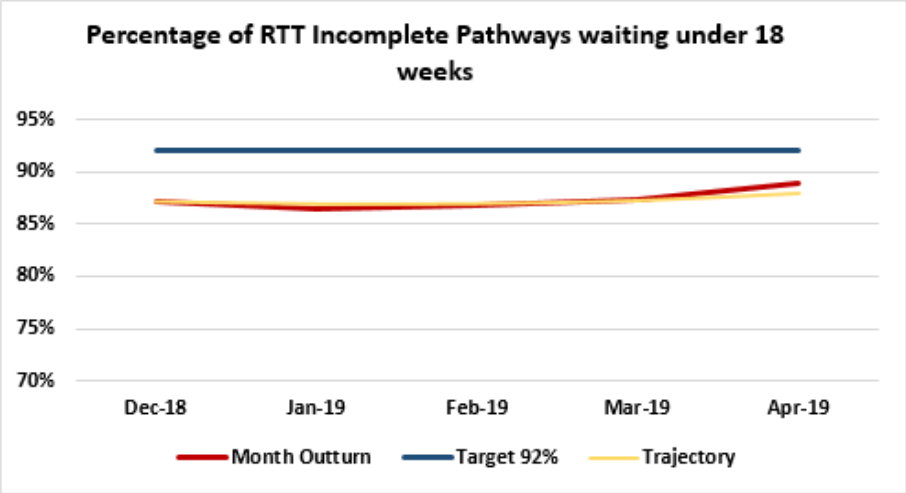
13. Treatment targets – This illustrates how the Trust is performing against national treatment target –

% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending - Patients still waiting at month end							Activity			
	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Apr-18	1022	148	409	1,579	8	1571	99.5%	850	253	387	1,490
May-18	1002	136	353	1,491	1	1490	99.9%	725	236	373	1,334
Jun-18	789	96	376	1,261	5	1256	99.6%	762	220	360	1,342
Jul-18	732	112	336	1,180	8	1172	99.3%	961	211	290	1,462
Aug-18	568	107	301	976	9	967	99.1%	682	165	290	1,137
Sep-18	696	110	311	1,117	4	1113	99.6%	778	208	394	1,380
Oct-18	781	110	370	1,261	7	1254	99.4%	725	247	344	1,316
Nov-18	736	135	381	1,252	7	1245	99.4%	801	243	406	1,450
Dec-18	698	115	346	1,159	11	1148	99.1%	843	224	367	1,434
Jan-19	728	123	416	1,267	4	1263	99.7%	897	253	472	1,622
Feb-19	844	134	386	1,364	3	1361	99.8%	854	248	436	1,538
Mar-19	776	133	461	1,370	1	1369	99.9%	868	271	410	1,549
Apr-19	835	89	414	1,338	6	1332	99.6%	894	244	419	1,557
May-19	807	94	337	1,238	1	1237	99.9%	914	270	478	1,662

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



The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. A revised trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019.

May 2019 performance is **88.92% against a trajectory of 88.79%**

In May the Trust had **0** patients over 52weeks which is a significant achievement for the Trust. There were 9 patients over 40 weeks and these patients are monitored weekly to track progress and ensure treatment plans are in place. This number is a reduction on April from 21 pts over 40 weeks. To note that oncology arthroplasty achieved RTT compliance in May at 93.18%

Referral to Treatment Trajectory: Trust Wide Position

RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,478	7,511	7,543	7,571
Over 18 Weeks	1,080	1,091	1,089	1,062	997	931	867	799	732	651	605	560	520
Totals	8,436	8,365	8,370	8,361	8,334	8,305	8,278	8,248	8,219	8,129	8,116	8,103	8,090
RTT %	87.20%	86.96%	86.99%	87.30%	88.03%	88.79%	89.53%	90.31%	91.09%	92.00%	92.54%	93.09%	93.58%

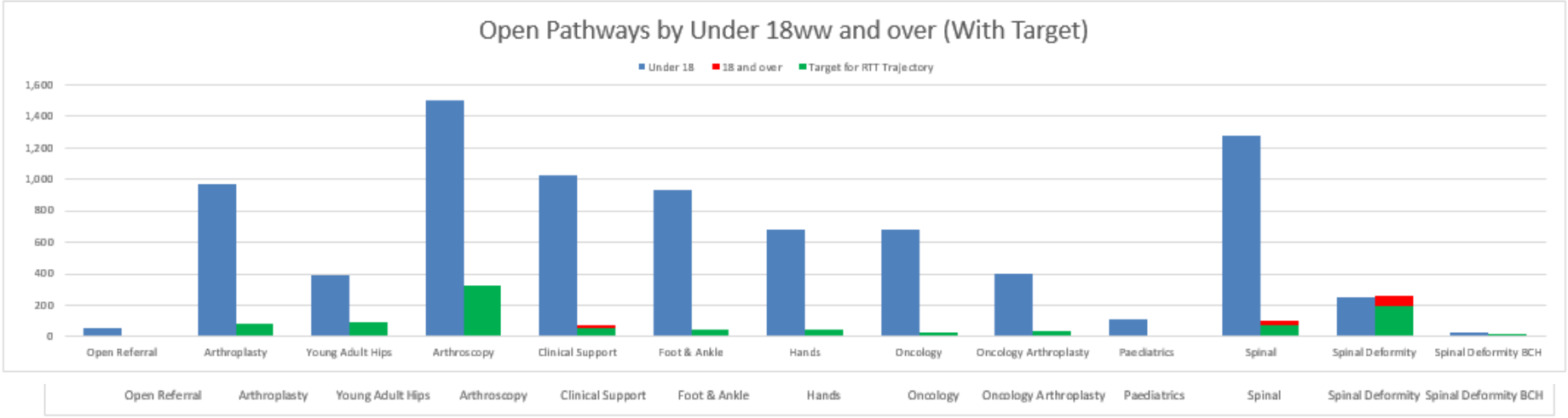
13. Referral to Treatment snapshot as at 31st May 2019 (Combined)

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	**3,679**	27	426	165	714	419	455	328	338	179	52	515	55	6
7-13	**3,410**	20	383	171	567	499	387	277	235	166	42	540	109	14
14-17	**1,198**	7	161	58	220	107	85	70	109	51	17	222	84	7
18-26	**715**	1	66	39	188	64	46	43	19	20	6	85	133	5
27-39	**309**	1	13	11	98	10	3	7	3	9	0	21	121	12
40-47	**9**	0	0	1	2	1	1	0	0	0	0	0	3	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9,320**	56	1,049	445	1,789	1,100	977	725	704	425	117	1,383	505	45

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	**8,287**	54	970	394	1,501	1,025	927	675	682	396	111	1,277	248	27
18 and over	**1,033**	2	79	51	288	75	50	50	22	29	6	106	257	18
Target for RTT Trajectory	**1044**	1	83	96	325	51	48	48	32	33	2	74	198	17
Target for RTT 92%	**745**	**4**	**83**	**35**	**143**	**88**	**78**	**58**	**56**	**34**	**9**	**110**	**40**	**3**

Month End RTT %	88.92%	96.43%	92.47%	88.54%	83.90%	93.18%	94.88%	93.10%	96.88%	93.18%	94.87%	92.34%	49.11%	60.00%

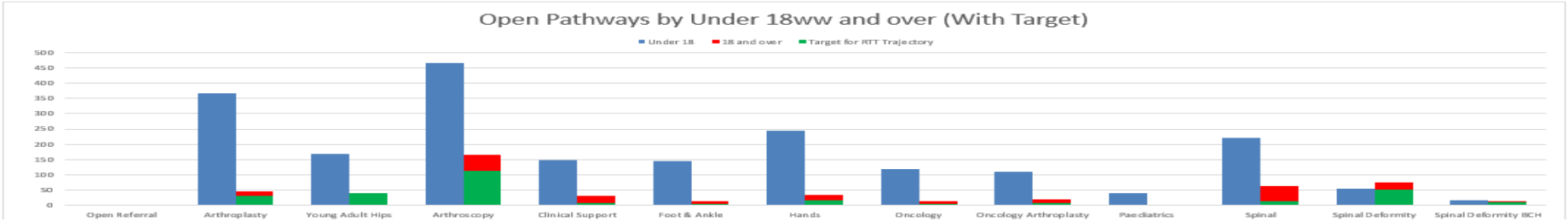


13. Referral to Treatment snapshot as at 31st May 2019

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	**706**	1	113	40	178	32	43	91	67	31	20	65	20	5
7-13	**944**	0	157	95	201	72	69	117	34	52	14	102	23	8
14-17	**452**	2	96	33	86	44	34	35	18	27	7	54	11	5
18-26	**338**	1	38	13	98	29	12	31	10	13	1	50	38	4
27-39	**160**	0	9	5	67	2	1	5	3	6	0	15	37	10
40-47	**6**	0	0	1	1	1	1	0	0	0	0	0	1	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,606**	4	413	187	631	180	160	279	132	129	42	286	130	33

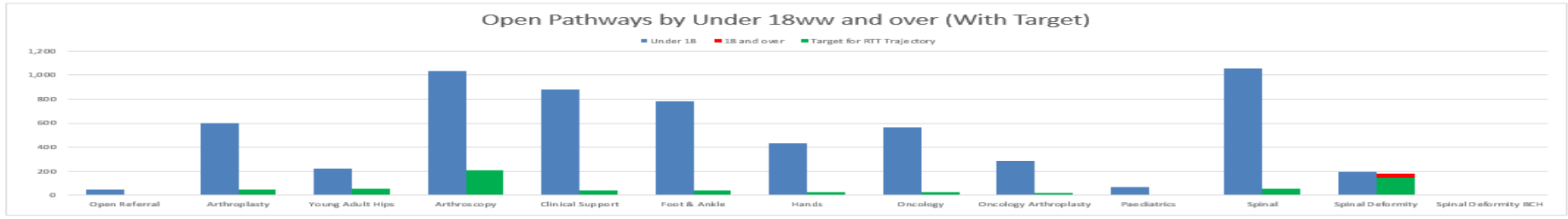
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity	Spinal Deformity BCH
Under 18	**2,102**	3	366	168	465	148	146	243	119	110	41	221	54	18
18 and over	**504**	1	47	19	166	32	14	36	13	19	1	65	76	15
Target for RTT Trajectory	**292**	0	33	40	114	8	7	18	6	10	1	15	51	12
Target for RTT 92%	**208**	**0**	**33**	**14**	**50**	**14**	**12**	**22**	**10**	**10**	**3**	**22**	**10**	**2**
Month End RTT %	80.66%	75.00%	88.62%	89.84%	73.69%	82.22%	91.25%	87.10%	90.15%	85.27%	97.62%	77.27%	41.54%	54.55%



Select Pathway Type: Non-Admit

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	**2,973**	26	313	125	536	387	412	237	271	148	32	450	35	1
7-13	**2,466**	20	226	76	366	427	318	160	201	114	28	438	86	6
14-17	**746**	5	65	25	134	63	51	35	91	24	10	168	73	2
18-26	**377**	0	28	26	90	35	34	12	9	7	5	35	95	1
27-39	**149**	1	4	6	31	8	2	2	0	3	0	6	84	2
40-47	**3**	0	0	0	1	0	0	0	0	0	0	0	2	0
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6,714**	52	636	258	1,158	920	817	446	572	296	75	1,097	375	12

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	**6,185**	51	604	226	1,036	877	781	432	563	286	70	1,056	194	9
18 and over	**529**	1	32	32	122	43	36	14	9	10	5	41	181	3
Target for RTT Trajectory	**752**	1	50	55	210	42	40	29	26	23	1	58	147	4
Target for RTT 92%	**537**	**4**	**50**	**20**	**92**	**73**	**65**	**35**	**45**	**23**	**6**	**87**	**30**	**0**
Month End RTT %	92.12%	98.08%	94.97%	87.60%	89.46%	95.33%	95.59%	96.86%	98.43%	96.62%	93.33%	96.26%	51.73%	75.00%



13. Cancer Performance Targets

		Indicative	Reported Month					Reported Quarter 2017/18			
Target Name	**National Standard**	**May-19**	**Apr-19**	**Q4 2018/19**	**Q3 2018/19**	**Q2 2018/19**	**Q1 2018/19**	**Q4** (Jan, Feb, March)	**Q3** (Oct, Nov, Dec)	**Q2** (July, August, Sept)	**Q1** (Apr, May, June)
2ww	93%	*98.60%*	***95.6%***	**98.8%**	**99%**	**100%**	**99%**	**97%**	**98%**	**99%**	**98%**
31 day first treatment	96%	*91.00%*	***100%***	**94.4%**	**100%**	**100%**	**100%**	**90%**	**96%**	**97%**	**97%**
31 day subsequent (surgery)	94%	*100.00%*	***100%***	**95.2%**	**98%**	**100%**	**97%**	**98%**	**100%**	**97%**	**100%**
62 day (traditional)	85%	*76.90%*	***100%***	**96%**	**51.3%**	**69.9%**	**82%**	**82%**	**82%**	**72%**	**67%**
62 day (Cons Upgrade)	n/a	*100.00%*	*92.9%*	83.70%	**91.37%**	**92.6%**	**94%**	**84%**	**82%**	**89%**	**100%**
28 day FDS	85%	*85.10%*	81.0%								
No. patients treated 104+ days		*1*	1	2	3	1	**1**				

PERFORMANCE/IMPROVEMENTS/LEARNING

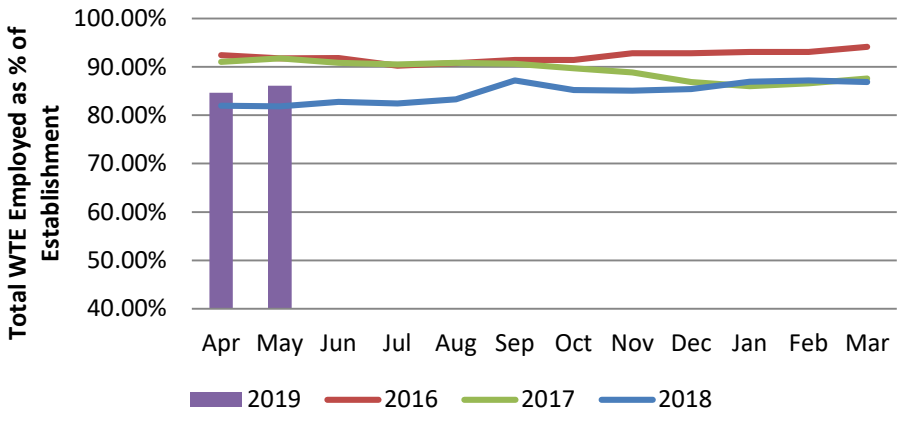
April's performance met all nationally measured indicators. In May the draft position for 62 day standard is currently 76.9%. This is due to 1.5 breaches.

RISKS / ISSUES

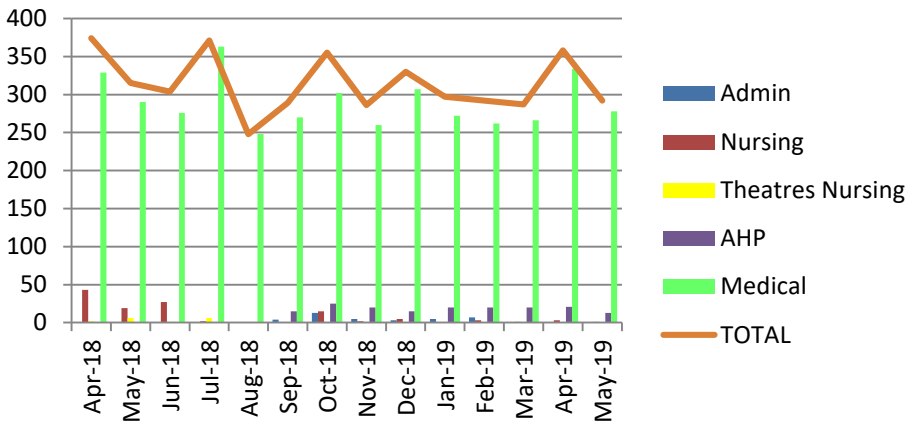
The Oncology Team along with Histology and Imaging colleagues, continue to work collaboratively to ensure patients are moving promptly through their cancer pathway. The information compiled for The Birmingham Children's Hospital, will highlight paediatric patients who are being admitted for a suspected or confirmed cancer. The BCH have agreed to adopt our procedure to 'red sticker' biopsy samples so pathology can prioritise diagnosis.

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

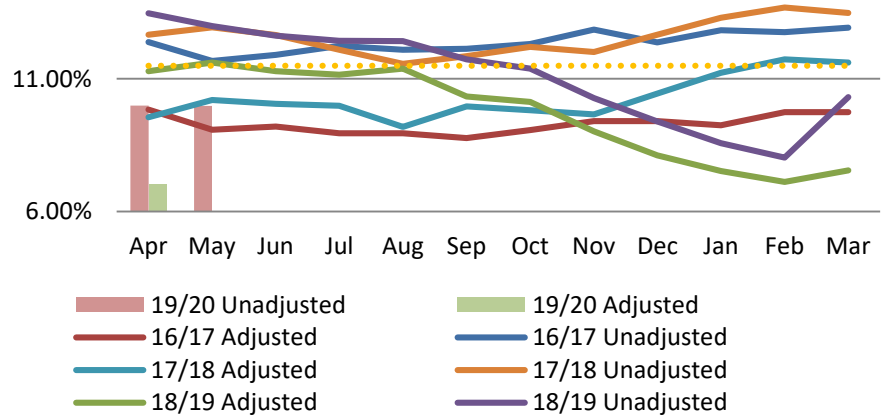
Staff in Post v Establishment



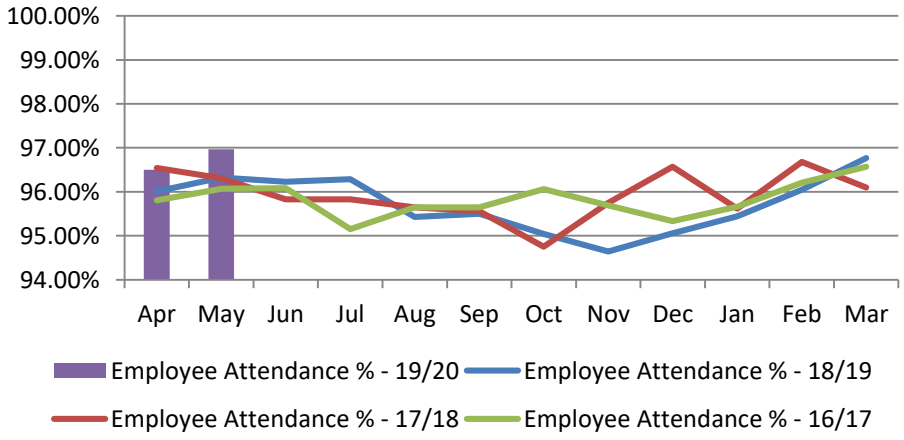
Agency Breaches



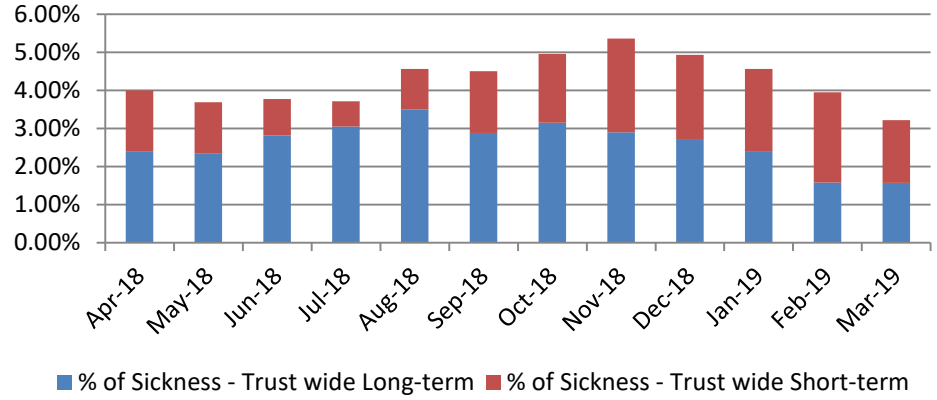
Staff Turnover



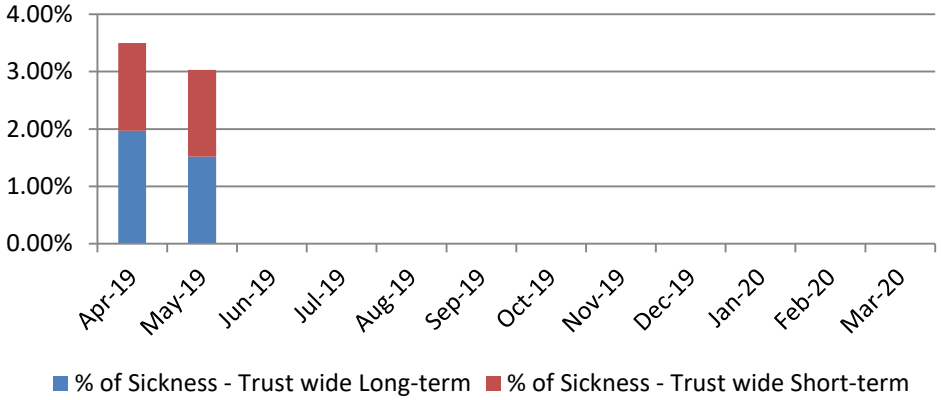
Employee Monthly Attendance %



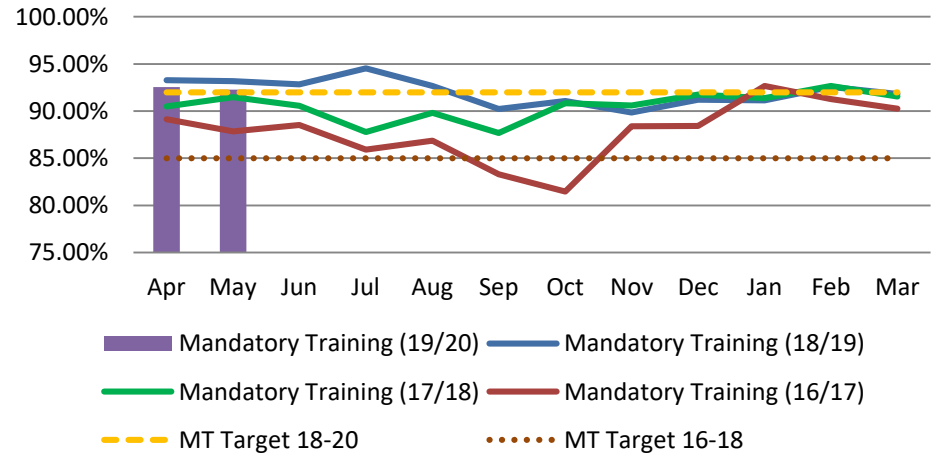
Sickness % - LT/ST (2018/19)



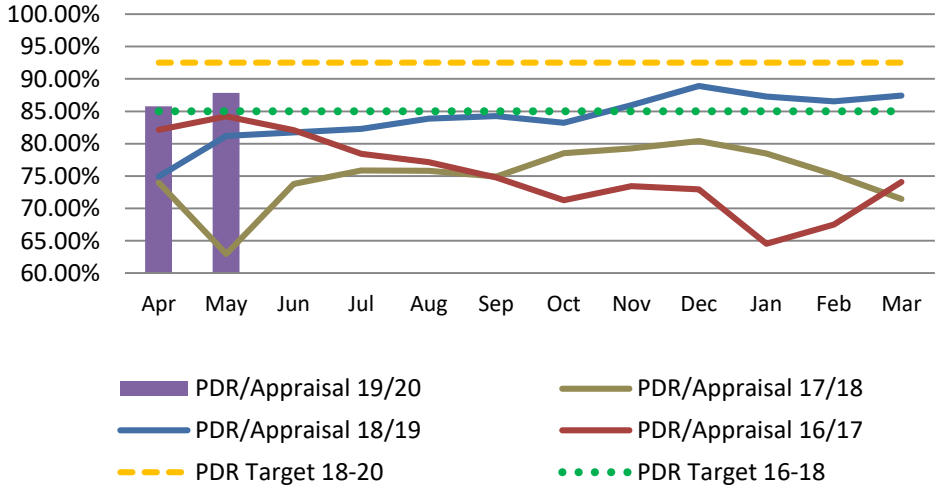
Sickness % - LT/ST (2019/20)



Mandatory Training



PDR/Appraisal



INFORMATION

May was an encouraging month for workforce performance, it saw an improvement in attendance, a decrease in the vacancy position, a reduction in turnover; an increase in appraisals.

This month the Trust's vacancy position saw a decrease of 1.41%, as a percentage of WTE employed, with the figure for May at 86.08% against a Trust target of 90%. This is reflected in the number of staff on the payroll, which stood at 946.45 (full time equivalent), an increase of circa 8 fte, compared to April.

In May, monthly attendance increased slightly by 0.47% to 96.97%, and remains above our target of 96.1%. The underlying 12-month average sickness absence figure decreased again this month to 4.28% and continues to be amber, against the Trust target for attendance of 96.1%. Short term sickness decreased very slightly from 1.53% in April to 1.51% in May, Long Term sickness also decreased from 1.97% in April to 1.52% in May.

Mandatory Training has decreased marginally by 0.27% to 92.29%, this remains above the Trust target of 92%, so remains green. The L&D Team are continuing to encourage staff to book onto courses but are increasingly encouraging staff to carry out their Mandatory Training via e-learning.

Appraisal performance this month increased by 2.04% taking the position to 87.83%, which is the highest it has been since the start of the calendar year, operational focus needs to be maintained with Divisions in this area.

The unadjusted turnover figure (all leavers except junior doctors and retire/returners) reduced to 9.98% against a KPI of 11.5%. The adjusted turnover figure (substantive staff leavers including retirements) has not been available this month due to an ESR/IBM reporting issue.

In May, Agency Breaches decreased from 358 to 292 shift breaches in total, with the large majority still being medical usage (278), which decreased from 334 to 278. There was 1 nursing breach, 13 AHP breaches but no 0 admin breaches

ACTIONS FOR IMPROVEMENTS / LEARNING LEARNING

RISKS/ISSUES

ROHTB (7/19) 007

TRUST BOARD	
DOCUMENT TITLE:	Application of the Trust Seal
SPONSOR (EXECUTIVE DIRECTOR):	Jo Williams, Chief Executive
AUTHOR:	Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary
DATE OF MEETING:	3 July 2019

EXECUTIVE SUMMARY:

The Board will recall that Pathology services transferred over to UHB Trust from 1 April 2019.

Before the rental charges for the premises from which the Pathology services will be delivered are assumed by UHB, the lease which is currently still assigned to the ROH, needs to transfer to UHB.

The documents to transfer the lease, these being a lease to assign and a deed of surrender (otherwise known as TR1) have been prepared by the ROH's legal services provider and require execution. To do this, the Trust's common seal needs to be applied in the presence of two authorised signatories.

According to the Trust's Scheme of Reservation & Delegation, the agreement to use the Trust Seal is a matter reserved to the Trust Board. The Trust's constitution requires that the Chief Executive or another Executive (Voting) Director be attest the application of the seal.

REPORT RECOMMENDATION:

Trust Board is asked to:

- APPROVE the application of the Trust's common seal

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

Note and accept	Approve the recommendation	Discuss
	X	

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

Financial	X	Environmental		Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	
Clinical		Equality and Diversity		Workforce	
Comments: [*elaborate on the impact suggested above*]					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
None specifically – point of policy.
PREVIOUS CONSIDERATION:
None.

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 4 September 2019

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 4 September 2019 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.

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

Date: 30 August 2019

Notice of a meeting of the Board of Directors

Notice is hereby given to all of the members of the Board of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Trust Board will be held in the Board Room, Trust HQ on 4 September 2019:

Meeting	**Timing**
Non Executives' pre-meet	0800h – 0820h
Nominations & Remuneration Committee (Executives)	0820h – 0900h
Private Board meeting	0900h – 1030h
Public Board meeting	1030h – 1500h
Board session on CQC preparation	1515h – 1615h

Other Board-level meetings have been added into the schedule for completeness.

The business to be transacted is provided on the private and public agendas enclosed or attached with this letter.

Signed

Y. H Buckland.

Dame Yve Buckland
Chairman

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (IN PUBLIC)

Venue Board Room, Trust Headquarters **Date** 4 September 2019: 1030h – 1500h

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)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Jo Williams	Chief Executive	(JWI)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Interim Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Sandra Millward	Head of Imaging	(SM)	[Item 1]
Mrs Lisa Kealey	Patient Services Manager	(LK)	[Item 1]
Mr Nathan Samuels	Lead Nurse for Learning Disabilities & Mental Health	(NS)	[Item 12]
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1030h	1	Patient story	Presentation	
1050h	2	Apologies	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 3 July 2019: *for approval*	ROHTB (7/19) 008	Chair
1057h	5	Trust Board action points: *for assurance*	ROHTB (7/19) 008 (a)	SGL
1100h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (9/19) 001 ROHTB (9/19) 001 (a)	YB/JW
	6.1	Orthopaedic services in the STP. BAF REF: CE1 & S799	Verbal	MR
	6.2	Corporate extract of the Board Assurance Framework: *for assurance and approval of changes*	ROHTB (9/19) 002 ROHTB (9/19) 002 (a)	JW

TIME	ITEM	TITLE	PAPER	LEAD
		QUALITY & PATIENT SAFETY		
1115h	7	Quality & Safety extract of the Board Assurance Framework*: for assurance and approval to changes*	ROHTB (9/19) 003 ROHTB (9/19) 003 (a)	GM/MR
1120h	8	Update from the Quality & Safety Committee and annual report: *for assurance*	ROHTB (9/19) 004 (i) ROHTB (9/19) 004 (ii) ROHTB (9/19) 004 (a)	KS
1130h	9	Quality report: *for assurance* BAF REF: 1137, 275, 986, PS1, MD1	ROHTB (9/19) 005	GM
1140h	10	Patient experience update: *for information and assurance* BAF REF: 269	ROHTB (9/19) 006 ROHTB (9/19) 006 (a) ROHTB (9/19) 006 (b)	GM
1150h	11	Annual complaints report: *for assurance and approval* BAF REF: 275	ROHTB (9/19) 007 ROHTB (9/19) 007 (a)	GM
1205h	12	Mental Health update: *for assurance*	ROHTB (9/19) 008 ROHTB (9/19) 008 (a)	NS
1215h	13	Annual report from the Director of Infection Prevention and Control: *for assurance and approval* BAF REF: 1137	ROHTB (9/19) 009 ROHTB (9/19) 009 (a)	GM
1225h	14	Mortality update (Learning from Deaths): *for assurance*	ROHTB (9/19) 010 ROHTB (9/19) 010 (a)	MR
		FINANCE AND PERFORMANCE		
1235h	15	Finance & Performance extract of the Board Assurance Framework*: for assurance and approval of changes*	ROHTB (9/19) 011 ROHTB (9/19) 011 (a)	SW/MP
1245h	16	Update from the Finance & Performance Committee: *for assurance*	ROHTB (9/19) 012 (i) ROHTB (9/19) 012 (ii)	TP
1255h	17	Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	ROHTB (9/19) 013	SW/MP
		LUNCH		
		WORKFORCE		
1325h	18	Workforce extract of the Board Assurance Framework*: for assurance and approval of changes*	ROHTB (9/19) 014 ROHTB (9/19) 014 (a)	JW
1335h	19	Update from the Staff Experience & OD Committee: *for assurance*	ROHTB (9/19) 015	RP
1345h	20	Workforce overview: *for assurance* BAF REF: WF2, HR10, WF1, WF20, 27	ROHTB (9/19) 016	JW

1355h	21	Guardian of Safe Working update: *for assurance*	Verbal	MR
1400h	22	Nominations & Remuneration Committee terms of reference: *for approval*	ROHTB (9/19) 018 ROHTB (9/19) 018 (a)	YB
		STRATEGY & PLANNING		
1405h	23	Strategy and Delivery extract of the Board Assurance Framework: *for assurance and approval of changes*	ROHTB (9/19) 019 ROHTB (9/19) 019 (a)	PB
1410h	24	Carbon Reduction Strategy annual report: *for assurance*	ROHTB (9/19) 020 ROHTB (9/19) 020 (a)	PB
1415h	25	Emergency Preparedness Resilience and Response: *for approval*	ROHTB (9/19) 021 ROHTB (9/19) 021 (a)	PB
		CORPORATE GOVERNANCE, RISK AND COMPLIANCE		
1420h	26	Update from the Audit Committee and annual report: *for assurance*	ROHTB (9/19) 022 ROHTB (9/19) 022 (a)	RA
1430h	27	Corporate Risk Register: *for assurance*	ROHTB (9/19) 023 ROHTB (9/19) 023 (a)	SGL
1440h	28	CQC action plan update: *for assurance*	ROHTB (9/19) 024 ROHTB (9/19) 024 (a)	GM
		MATTERS FOR INFORMATION		
1450h	29	Meeting effectiveness	Verbal	ALL
	30	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 6th November 2019 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.

MEMBER	MEETING DATE										TOTAL
	3/4/2019	1/5/2019	5/6/2019	3/7/2019	4/9/2019	2/10/2019	6/11/2019	4/12/2019	5/2/2019	4/3/2019	
Yve Buckland (Ch)	✓	✓	✓	✓							/10
Tim Pile	✓	A	✓	✓							/10
Kathryn Sallah	✓	✓	✓	A							/10
Rod Anthony	✓	✓	✓	✓							/10
Richard Phillips	✓	A	✓	✓							/10
David Gourevitch	✓	✓	✓	✓							/10
Simone Jordan	✓	✓	✓	✓							/10
Paul Athey #1	✓	✓									2/2
Jo Williams #2	✓	✓	✓	✓							/10
Matthew Revell	✓	✓	✓	✓							/10
Garry Marsh	A	✓	✓	✓							/10
Phil Begg	✓	✓	A#3	✓							/10
Marie Peplow			✓	✓							/8
Stephen Washbourne	✓	✓	✓	✓							/10

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		
#1	Acting Chief Executive until 6 May 2019	#2	Chief Executive from 6 May 2019
#3	Planned absence – ROH work commitment		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 3 July 2019: 1100h – 1330h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and Non Executive Director	(TP)
Mr Rod Anthony	Non Executive Director	(RA)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Interim Director of Finance	(SW)
Mrs Marie Peplow	Acting Chief Operating Officer	(MP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]
Prof Lee Jeys	Consultant Surgeon	(LJ)	[Item 1]
Mr George Cooper	Consultant Surgeon	(GC)	[Item 1]
Mrs Julie Gardner	Assistant Director of Finance	(JG)	[Item 1]
Prof Surinder Sharma	Specialist Adviser on Equality & Diversity	(SS)	[Item 14]

Minutes	**Paper Reference**
1 Service improvement story – Bone Infection service	**Presentation**
The Board was joined by Professor Lee Jeys, Mr George Cooper and Julie Gardner. It was reported that bone and joint infection treatment was currently undertaken in an unsystematised way. Cases were sent across the region, with an increasing number of complex cases being sent to the ROH. The Bone Infection unit was reported to have been established six years ago and a bone infection Multi Disciplinary Team (MDT) had been implemented with more resources and input from a range of disciplines including microbiology. Going forward there was a national move to centralise the service into a series of centres. An example of a patient story was provided which demonstrated that following a	

poor experience, the treatment at the ROH had proved successful and had avoided an amputation. There was overall good patient feedback about the service.

The Board was advised that there had been a significant and steady growth in the number of bone infection cases treated, with most patients being between 51 – 80 years of age. 90% of these had had infected hips and knees and the rest related to infections in other joints.

It was reported that length of stay had reduced to 14 days from 20 days, due to the possibility of administering Intravenous antibiotics at home.

There were noted to be some ongoing negotiations with NHS England in terms of funding, given that at present, there was a significant gap between the tariff and cost of providing the service. In 2018/19 the service had made a £1.3m loss. In addition to this, the time that patients were required in theatres was lengthy.

It was reported that there were discussions with commissioners around the tariff and funding for a bone infection co-ordinator. The value of the Commissioning for Quality & Innovation (CQUIN) scheme associated with bone infection in 2018/19 was reported to have been £180k and it was £387k in 2019/20.

The Board was advised that 31 different commissioners sent bone infection cases to the Trust and therefore a case for change would be presented to the local Clinical Commissioning Group (CCG).

Coding was noted to be complex at present.

It was reported that as of December, the patient pathways were now worked through, with the more complex staged revision being treated through the MDT at the ROH. The standards for the treatment had been agreed to regulate the care of the patients.

The in-house work undertaken to date was noted to have generated great efficiency. There needed to be more work done nationally however, to develop a costing model per patient this being over above the standard tariff. Standards also needed to be set including access to specialised ringfenced beds, equipment and a network.

Overall it was noted that there were some positive conversations with commissioners, including top slice funding.

The bone infection network was noted to be a positive development for the ROH.

It was agreed that the offering was compelling and powerful. A critical mass of commissioners needed to be identified to drive through the case for change; this

should include the Black Country. The Board agreed that the work was the right thing to do for patients, particularly as the success rates were noted to be excellent and delivered a good patient experience. The outcomes for the primary knee replacements were also good compared to those of other organisations. The Board supported the work and building the ROH at the centre of the service. It was noted that in due course, a proposal for the infrastructure to support the work would be presented to the Board. This would also be considered by the Finance & Performance Committee and Quality & Safety Committee.	
2 Apologies	
Apologies were received from Kathryn Sallah.	**Verbal**
3 Declarations of interest	**Verbal**
The Director of Corporate Affairs & Company Secretary reported that he was undertaking a short piece of work to review the Board and Committee governance arrangements at Dudley Group NHS Foundation Trust. It was noted that the full register was available on request from the Company Secretary.	
4 Minutes of Public Board Meeting held on the 5 June 2019: *for approval*	**ROHTB (6/19) 012**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held.	
5 Trust Board action points: *for assurance*	**ROHTB (6/19) 012 (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 (7/19) 001** **ROHTB (7/19) 001 (a)**
The Chief Executive reported that the Care Quality Commission (CQC) national inpatient survey results had been received and the Trust was regarded as performing much better than expected. This was against the national trend and therefore this was a positive piece of news to celebrate. It was reported that a commemorative event had been held to mark the movement of the paediatrics services to the Birmingham Children's Hospital. The Chairman asked that formal thanks be recorded for the paediatric services transition. This service move had been the largest in the region for some time. The service had been passed on without deficit or a large waiting list and the relationship between the two hospitals was collaborative. Janet Davies, Acting	

Deputy Chief Operating Officer was thanked for her work. The JointCare pathway was discussed and the second reunion event had been held. The planned Health and Wellbeing programme had been promoted and had been received well by staff. It was reported that the DrDoctor technology had gone live which would assist with communication with patients in connection to their appointments. The Chairman's key updates included that she had: • Undertaken meetings and phonecalls with candidates for the Chief Operating Officer role, the final appointment panel being convened for 7 August • Joined the presentations by the longlist of individuals for the Chief Operating Officer role on 24 June • Attended a Board to Board meeting between Birmingham & Solihull STP and Black Country & West Birmingham STP on 12 June • Met with Barry Henley, the new Chair of Birmingham Community NHSFT • Met with the Chief Executives of the ROH and University Hospitals Birmingham NHSFT (UHB) to discuss future working relationships	
6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was reported that good links had been made with the new team at UHB which would create traction with the delivery of the region-wide orthopaedic services work.	
7 Update from the Quality & Safety Committee: *for assurance and approval*	**ROHTB (7/19) 002**
Professor Gourevitch reported that compliance with the World Health Organisation (WHO) checklist was currently at 100%. The handling of NICE guidance had been discussed at the last meeting of the Quality & Safety Committee. It was noted that there were some changes needed to the Venous Thrombo Embolism (VTE) policy to reflect the new guidance. The Board was assured however that patients had not been placed at undue risk of developing a VTE under the existing policy as the prophylaxis practice was beyond the national minimal standards. It was noted that mandatory training for porters in manual handling was to be	

addressed. The water safety action plan was awaited and was due for completion in August 2019. The Board was advised that a Never Event had been reported.	
8 Paediatric transition update: *for assurance* BAF REF: CE2, FP1, 7, CE3, 986, PS1, MD1, CE4, FP2	**ROHTB (7/19) 003** **ROHTB (7/19) 003 (a)**
It was reported that the paediatric inpatient service had been successfully transitioned to Birmingham Children's Hospital (BCH) and the service had been closed at the ROH on Friday 28 June. Staff moving over had been welcomed and an event had been organised. Outpatients services remained on site, along with the CT guided biopsy service. The pathway for the latter had been signed off by all clinical teams. The governance model for services that involved both BCH and ROH was agreed through the Children's Board. It was noted that the paediatric transition programme board meetings would continue for the next month. Additional resources had been provided to support the work on Mondays at BCH to support the Oncology team particularly. It was suggested that the learning from the experience should be captured and offered for similar transitions. It was reported that this would be written up within six months, although the immediate learning would be documented. The policies, procedures and the signage around the hospital which referred to the Paediatric service would be removed as soon as possible. The Board noted that the paediatric High Dependency Unit (HDU) would be closed. Re-opening this facility as an adult HDU would be discussed by the Executives. The commemorative event was held successfully and the Chairman and Chief Executive were thanked for their sensitive words. The Non Executives from both the BCH and the ROH were also thanked for their support. It was noted that the emotional resilience of Janet Davies, Acting Deputy Chief Operating Officer who had overseen the programme was to be praised. Staff had been complimentary of her management of the work.	
9 Patient Safety & Quality report: *for assurance* BAF Ref: 1117, 1137, 7, 275, 986, PS1, S800, HRD1, HRD2	**ROHTB (7/19) 004**

The Director of Nursing & Clinical Governance advised that there had been five moderate harm events reported during the month: three surgical incidents, one radiation incident (a repeat scan) and a VTE. Two of the surgical errors were serious incidents. All five of these would be subjected to a Root Cause Analysis. Two of the moderate harm incidents in the previous month had been downgraded and there was no evidence of lapses of care. There had been two Pressure Ulcers reported. There had been six complaints in months and there had been a lapse in the performance against the Key Performance Indicator due to the loss of a member of staff in the complaints team; more resource had been added as mitigation. The Friends and Family Test response rate had been 30% against a statutory rate of 35%, this underperformance being driven by the movement of the paediatric services. As discussed previously, the WHO checklist compliance was at 100% and a review of the audit process connected to this was planned by staff outside of theatres. There would also be some observations undertaken. It was noted that the detail of the incidents reported had been discussed in the private session.	
10 Update from the Finance & Performance Committee: *for assurance*	**ROHTB (7/19) 005**
Tim Pile reported that there was good operational performance but financial performance was below plan due to the activity casemix. The impact of the pensions tax liability was also cited as being a further issue, the financial impact of which was to be identified. It was noted that additional resource was being identified to offset this impact. An independent session concerning pensions had been held for consultants to explain the issue in some detail. It was suggested that the new managed service proposal and the 'Perfecting Pathways' work should be discussed at the next meeting.	
11 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	**ROHTB (7/19) 006**
The Interim Director of Finance reported that the financial position stated reflected the assumptions made as to whether Financial Recovery Funding (FRF) or Provider Sustainability Funding (PSF) was received or not, this being dependent on the achievement of the monthly control total. If the control total was met then the FRF/PSF would be received.	

The Board was advised thaqt if the plan was met overall by Month 6, then FRF/PSF payments would be made for months 1-6 even if the control totals of the individual months had not been met. The plan was noted to be low risk according to NHS Improvement, although there was a degree of risk around the transfer of paediatrics and the impact of the modular theatres scheme. The overriding risk remained over the organisation's ability to maintain activity levels. Operational performance was discussed. It was reported that day case activity was reduced in a significant way. There were also a small number of complex procedures which had not been undertaken as anticipated. These were high value cases however and therefore the financial impact on the Trust had been significant. The assumption in the plan was around the level of these cases undertaken last year which had not materialised. The plan for the rest of the year would see the number of these cases rise to compensate for this underperformance however. Operational performance was noted to be positive overall.	
12 Use of the Trust Seal	**ROHTB (7/19) 007**
The Director of Corporate Affairs reported that according to the Board's Scheme of Delegation, the agreement to use the Trust Seal was a matter reserved to the Board. The Trust had received a number of documents associated with the recent transfer of the Pathology service which required the application of the seal. The Board approved the application of the Trust seal to the Pathology facilities' documentation.	
13 Update from the Staff Experience & OD Committee: *for assurance*	**Verbal**
Richard Phillips reported that the meeting schedule of the Staff Experience & OD Committee included a set of workshops, with the last one being around Health and Wellbeing. The plans for this were noted to be in line with the intentions of the NHS England. There was reported to be a plan to recruit a dedicated wellbeing officer and nominate a Board-level Health and Wellbeing champion, this being Kathryn Sallah. The workforce metrics for the month were reported to be positive, including the progress with the recruitment of new staff for modular theatres. A recruitment weekend had been held and as a result, the new theatres were fully established. A further open day would be held for staff wanting to join the ROH and the	

expectations of the Trust and an individual during the first 100 days in post would be drawn up.	
14 Equality & Diversity at the ROH: *for assurance and approval*	**Presentation**
Prof Surinder Sharma joined the Board to present an overview of his work to date on equality and diversity at the ROH. It was noted that there had been much national work at the recent NHS Confederation meeting around equality and diversity, including a discussion around the NHS Employers diversity and inclusion programme. Morecombe Bay NHSFT had also undertaken some good work and the Trust would share with the ROH their plans, including sharing the responsibility for equality & diversity between the Executive Directors. There needed to be a focus on disability and bringing more people into the ROH in a positive way. It was noted that there was a lack of diversity across the senior leadership in the NHS overall, however it was within the gift of the Trust to address the position at the ROH. In terms of the Equality and Diversity Network, there were some proposals to assist with the addressing the equality and diversity issues identified. The awareness days were being well received and there was much energy in the network. It was noted that the HR Team would develop plans using the diagnostic from Professor Sharma to inform this work. A self-assessment against the observations needed to be developed initially. This would be presented back to the Staff Experience & OD Committee. The Board needed to receive this at a future meeting. It was noted that there had been a move to improve the position over the last year overall. Professor Sharma was thanked for this work.	
ACTION: SGL to arrange for the Staff Experience & OD Committee to consider the plans for improving the framework for equality and diversity at a future meeting	
15 Meeting effectiveness	**Verbal**
It was agreed that there had been some good discussions and the Board was acting	

as a mature unitary body. It was suggested that there had been too many presentations at this meeting however and there needed to be a check on the duplication between agendas. The presentation on Bone Infection was agreed to have been very good and powerful; this needed to be folded into the wider orthopaedic pathway work. There was evidence of a real passion from the clinical team.	
16 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 4 September 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 4 September 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 30.08.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 058	Orthopaedic services in the STP	Verbal	02/05/2018	Arrange for the therapies strategy to be presented in September	JWI	~~05/09/2018~~ ~~05/06/2019~~ 03/07/2019	~~private Board meeting in September, with the strategy due for presentation in November 2018. Ongoing discussions around therapies with commissioners, thereby not in a position to be able to present updated strategy until Spring June July 2019. (Deferred to July from June due to annual leave).~~ Update presented in July 2019.	
ROHTBACT. 073	Orthopaedic Services in the STP	Verbal	03/04/2019	Invite Mr Pearson to the Trust Board when the orthopaedic pathway re-engineering work commenced	SGL	05-Jun-19	~~Rearranged for the July meeting to allow a more comprehensive update to be given.~~ Update presented in July 2019.	
ROHTBACT. 074	Corporate and strategy extract of the Board Assurance Framework	ROHTB (4/19) 013 ROHTB (4/19) 013 (a)	03/04/2019	Arrange for an additional risk around the impact of planned growth and modular theatres to be added to the Board Assurance Framework	SGL	05-Jun-19	~~To be included as part of the Board Assurance Framework refresh. Refresh to be ready for the July September meeting.~~ Included within Risk FP5.	
ROHTBACT. 075	Finance & Performance extract of the Board Assurance Framework	ROHTB (4/19) 007 ROHTB (4/19) 007 (a)	03/04/2019	Refresh the risks on the Board Assurance Framework	Exec	05-Jun-19	Board Assurance Framework refresh planned for May 2019. Refresh to be ready for the ~~July~~ September meeting - Executive Team workshop planned for 9 July to discuss. Included on the agenda of the September 2019 meeting.	
ROHTBACT. 077	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Arrange for an update on Mental Health to be provided at a future meeting	SGL	04-Sep-19	Included on the agenda of the September 2019 meeting.	
ROHTBACT. 078	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Provide an update on environmental sustainability at a future meeting	PB	04-Sep-19	Added to the agenda of the September 2019 meeting	
ROHTBACT. 079	Patient story – JointCare follow up	Presentation	05/06/2019	Schedule in a presentation about JointCare into the Board Workplan	SGL	06-Nov-19	Added to the November Board meeting agenda	
ROHTBACT. 080	Chairman's & Chief Executive's update	ROHTB (6/19) 001 ROHTB (6/19) 001 (a)	05/06/2019	Organise for a demonstration of control charts to be presented to the Board	JWI	02-Oct-19	Added into the October workshop agenda	
ROHTBACT. 082	Equality & Diversity at the ROH	Presentation	03/07/2019	Arrange for the Staff Experience & OD Committee to consider the plans for improving the framework for equality and diversity at a future meeting	SGL	31-Dec-19	Preliminary work considered at the July meeting of the Staff Experience & OD Committee including the compliance against the public sector equality duty. Further discussions planned for the November 2019 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):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**4 September 2019**

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 Trust Board in Public on 4th September 2019

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 3rd July 2019 from the Chief Executive's position, this includes an overall update, wider ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 The last stage of the competitive selection process for the substantive Chief Operating Officer (COO) was completed in August 2019. Four candidates underwent a formal interview panel at the beginning of August 2019, comprising Tim Pile (Vice Chair), Jo Williams (Chief Executive), Simone Jordan (Associate Non Executive) and Alex Moody (Associate Director of Workforce). The candidates had also been required to present to a small set of internal stakeholders, namely the Executive Team and a staff governor. The panel was unanimous and supported the appointment of Marie Peplow who is currently the acting COO at the ROH.

2.2 University Hospitals Birmingham (UHB) has developed for the ROH a Human Factors training session for Theatres which will be delivered at the end of September 19. Human Factors concern the interaction between people and technical components in complex systems. It is associated with a maturation of wider system safety management and can make an important contribution to equipment design, safety assurance, system management and incident investigation such as Never Events.

It is recognised that Human Factors can provide enormous benefits to patient safety through better understanding of human related clinical tasks and risks and the people element of clinical processes, including cognitive, social and behavioural elements. It is envisaged that the multi-disciplinary team at UHB will support our staff to develop their skills as part of the Flow Academy so we can develop our own in-house trainers.

2.3 The Trust has been notified that it has been shortlisted as a finalist for the Health service Journal (HSJ) Trust of the Year award. The next stage requires members of the judging panel to visit the Trust which is scheduled for 10th September 2019. On Monday 30th September, three members of the team are required to attend the final stage to present our entry to the judging panel explain the reasons why we should win

with all finalists being notified at the awards evening on Wednesday 6th November at Battersea Evolution, London.

2.4 JointCare has been nominated for a Forward Healthcare Awards by Leading Healthcare which celebrates and shares great work across health and care in the category specialist/acute service redesign. All nominees will be notified on September 25th September 2019.

2.5 On Monday 29th July, the Chief Executive, Director of Nursing & Clinical Governance and Director of Corporate Affairs & Company Secretary met with our CQC relationship manager/inspector. They updated the Trust on the internal changes within the team and their restructuring, meaning we would have a new team for the ROH. We discussed all the issues raised as part of our previous inspection, current incidents, Never Events and all the progress since our last visit. The meeting was extremely positive.

The CQC has also issued the Provider Information Request (PIR) which is used to direct the focus of their inspection. This was completed on 7th August 2019. Our submission was comprehensive and it was that clear in many areas that the Trust had improved since its last submission of the data.

In readiness for the Well-Led and unannounced inspection, the teams have presented a self-assessment to the Executive Team, a booklet has been designed and issued to support front line staff to aid the inspection and the Director of Nursing & Clinical Governance has held various meetings with the nursing team across the organisation.

As part of the data request the Trust submitted our assessment of our rating, which has rated the Trust as 'Good' in all domains with 'Outstanding' for Caring.

2.6 The Trust has been accepted as a Phase 1 pilot site for NHS Leadership Academy's Talent Management Diagnostic. As one of the first national adopter sites, the Trust will play a vital role in ensuring that the tool is fully fit for purpose for wider roll out across the NHS later this year, whilst helping to further develop our talent management programme with a range of toolkits to support the Trust.

2.7 The week commencing 9th September 2019 is the launch of our Health and Wellbeing week, with events being held throughout the week. On Tuesday 10th September we launch our Wellbeing Hospital with a range of speakers across the Trust and on Wednesday 11th September, BBC Sports presenter and strictly come dancing finalist Chris Hollins will formally launch our programme. Full details can be found in Appendix 1

We have also successfully appointed to our new Health and Wellbeing Officer and she is due to commence towards the end of September. She is currently working for the BBC and will bring to the Trust a wealth of knowledge around inclusion and diversity, whilst developing her passion and ideas for wellbeing at the ROH.

2.8 We have received notification from NHS Improvement that we can revert to our original capital budget following the recent announcement from the Prime Minster regarding capital expenditure in the NHS.

2.9 A small group of staff from Theatres and the Executive Team has visited ModuleCo to see the final build stage of the Ward, Recovery and Theatres, before transportation to the ROH at the beginning of October. A full implementation plan has been prepared to support the installation programme which will commence 4th October 2019. This will include alternative staff parking arrangement for one week to minimise disruption.

3.0 STP UPDATE

3.1 The latest STP Chief Executive's meeting took place on 11th July 2019 with the key areas of discussion being the implementation of the Integrated Care System (ICS) and the Long Term plan funding and implementation. The STP has been unsuccessful with its bid to be a pilot site, but it was agreed that it needed to establish a vision for our ICS and the proposed governance model given our ambition to shadow monitor the ICS in April 2019. The group would be chaired by the Chief Executive of Birmingham Women's and Children's NHSFT (BWC), Sarah -Jayne Marsh, and colleagues would be asked to support key lines of work.

3.2 One key workstream which was agreed was the digital agenda and the 5G pilot being led by UHB. It was agreed that digital should be at the forefront of any transformation projects and be led by the experts across the STP i.e. UHB. The Chief Executives agreed that we need to look at how we bring our teams together to lead this across Birmingham and Solihull foot print (BSoL). A group had already been formed to agree the system plan for the long term plan and this would be presented in draft on 27th September 2019, with a final plan for the STP Board to sign off on 15th November 2019; this also includes system allocation of the 5 year funding.

3.3 The last STP Board meeting took place on 5th August 2019. Key areas of discussion are described below.

The Board discussed the next steps for the ICS and acknowledged that we need to ensure that the priorities for our ICS are defined and that there is a consensus around challenging ourselves to ensure that we work and behaviour differently to enact real change. The STP Chair confirmed that the workstream lead would need to present this back to the STP Board for final approval. There was a discussion around the benefits around digital transformation and this mirrored the conversation at the STP CEOs meeting.

4 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

4.1 The BHA met on 6th August 2019 and was attended by the Vice Chair and Chief Executive. Two key areas were discussed, digital agenda and BWC site redevelopment/capital.

4.1 The Board received a presentation from UHB's, Director of Corporate Strategy, and Planning & Performance regarding the potential for 'Digital First Healthcare'. There are clear benefits for the BHA to work together to use technology to find and deliver effective solutions to ensure that care is received in the right setting whilst reducing footfall in many areas. It was agreed that there were clear economies of scale which could be leveraged across the wider system. It was agreed that the STP Digital Group would identify the scope of the work, the funding model and the governance model. This work will also compare and contrast respective digital agendas across the BHA and will outline needs and requirements across the providers within BSoL STP

The Executive Finance Lead for the BHA and Deputy Chief Executive Officer for Birmingham Women's and Children's, David Melbourne presented an outline of the recent BWC Estates review that was considered at their June Board meeting. This included the imperative to redevelop the Women's & Children's hospitals.

5.0 NHSI/NHSE

5.1 On Friday 30th August 2019 a system review meeting is being held with all BSoL partners chaired by NHS Improvement. This is the first meeting which has been held to hold the system to account. The ROH has asked that NHS Improvement raises with the system, the provision of Orthopaedic services in the private sector and the requirement to bring this back into NHS BSoL providers and what role we can play in the system through winter 2019/2020.

6.0 PAEDIATRIC ONCOLOGY SERVICES AT BCH

6.1 On 20th August 2019, the Chief Executive was alerted by the Clinical Service Lead for Oncology about two clinical incidents at BCH involving paediatric patients. Full investigations are underway and the scrutiny of the incidents and any actions agreed between BCH and ROH will be through the Quality & Safety Committee.

7 POLICY APPROVAL

7.1 Since the Trust Board last sat, the following policies have been approved by the Chief Executive on the advice of the Executive Team:

- Diahorrea and Vomiting
- Safe Management of Contractors
- Multi Drug Resistant Organisms
- Consent
- Safe Surgery

- Clinical Record Keeping Standards

8 RECOMMENDATION(S)

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

8.2 Note the contents of the report.

Jo Williams
Chief Executive

29th August 2019

NHS
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NHS Foundation Trust

WELLBEING WEEK

ROH BE WELL STAFF WELLBEING

9 - 13TH SEPTEMBER

On the 9 - 13th of September it's WELLBEING WEEK at ROH! Get involved and find out more about what's on offer in the new staff wellbeing programme.

WHAT'S ON

Make sure you pop to these events in the Knowledge Hub - there are a lot of freebies and activities to participate in!

MON 9 SEPT

- Stress management workshop
- Yoga taster
- Mindfulness taster session
- Keep learning stall
- Win a FitBit! Sign up at the Wellbeing Raffle

TUES 10 SEPT

- Mindfulness session
- Free buffet
- Yoga taster
- Keep learning stall
- Flexible working
- Sustainability & active travel
- 'Becoming the wellbeing hospital' (in the Lecture Theatre

WED 11 SEPT

All taking palce in the Knowledge Hub:

- Come and dance with Strictly winner, Chris Hollins
- Have a go on the dance machine
- Take part in the 'Brum2Brum&Back' step challenge
- Free massage
- 30% discount on Northfield Gym and much more...

THURS 12 SEPT

- Slimming world
- Flexible drop in session
- Yoga & the benefits of physical exercise
- Mindfulness session
- Lunchtime walk

FRI 13 SEPT

- Equality and Diversity
- Slimming world
- Mindfulness session
- FTSU & Contact Officers
- Keep learning
- Prize draw!

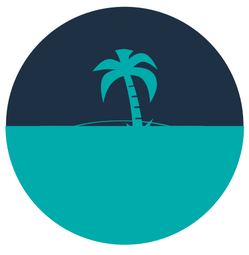
GET INVOLVED!

Pick up your free goodie bag

Pick up your staff wellbeing programme

Win a FitBit

Free healtly snack (and some treats as well!)



Mindfulness sessions

Come and dance with 'Strictly' winner Chris Hollins

A massive 30% discount on Northfield Leisure Centre (gym and swim

Chair yoga sessions

Free mini mindfulness and puzzle book

Come and find out about SlimPod

Free massage

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Chief Executive's extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

Over the summer, the Executive Team has overhauled and updated both the Corporate Risk Register and Board Assurance Framework to reflect the latest view of the key risks facing the Trust. Those risks shaded in blue are recommended for closure or de-escalation to local risk registers.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate • Agree to close or de-escalate those risks suggested					
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:					
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:					
Executive Team in July 2019					

BOARD ASSURANCE FRAMEWORK - QUARTER 1 & 2

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	CEO	The Trust does not currently have a clear financial and operational plan in place 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 2019/20. The Trust has support to access cash resources to continue business in the short term The Trust has a 5 year strategy to become the first choice for orthopaedic care. This strategy has been refreshed and updated into a new format, being based around the five 'Ps': performance, people, process, partnerships and patients. A Strategic Outline Case was developed and 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 Theatre expansion work is currently underway.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update	5	4	20	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. A further medium term financial plan will be required for submission by NHSI during 2019/20.	Dec-19	3	4	12
CE2	Corporate	CEO	The effectiveness of the governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience , potential harm and reputational damage.		Developing services to meet changing needs, through partnership where appropriate	Trust Board/Quality & Safety Committee	5	5	25	Reporting mechanisms in place and escalation to identify key leads that the governance arrangements are not effective or there is potential for harm to be caused by a patient.	Minutes of stakeholder oversight meeting	4	4	16	↔	Continue to monitor effectiveness of governance framework	On-going	3	4	12
CE3	Corporate	CEO	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. Full transition plan now in place with BWCH	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Clinical review of proposed Oncology strategy is still outstanding. If the outcome of this is positive, this will support the alignment of the strategy across all providers	Jul-19	2	3	6

CE4	Corporate	CEO	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 Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	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	↔	Continued oversight by NHSI/E & CQC	Jul-19	2	3	6
S800	Governance	CEO	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 electronic governance solution for better management of Trustwide policies and creation of additional dashboards of performance against key quality metrics.	Q1 2019/20	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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

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SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
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X		X		X	
KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
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Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
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PREVIOUS CONSIDERATION:					
Executive Team in July 2019					

BOARD ASSURANCE FRAMEWORK - QUARTER 1 AND 2

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
1137	Infection Control	Exec Dir - N&G	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	5	3	15	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Water Safety Group minutes presented to IPC Group meeting.	2	3	6	↔	Completion of the water safety plan	Aug-19	1	5	5
275	Governance	Exec Dir - N&G	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 Trust Quality Priority for 2018-2019 has been achieved and closed. A paper detailing the evidence of closure was presented to the Quality and Safety Committee detailing the new methodology and improvements in March 2019. The CCG have decreased the Trusts contracts meeting to quarterly due to the adequate assurance they receive from the Trust. Each month following thematic review of RCA's and incidents, the Governance team will devise patient safety case studies, outlining the learning from this incidents, complaints and litigation. Working with the communication team the learning will be shared Trust wide. The Staff Survey shows improvements on the Patient Safety metrics in terms of incidents, feedback and outcomes. Weekly meetings have been established with Governance, Medical Director, Director of Nursing and Heads of Nursing	Q4 2019/20	2	2	4

986	Nursing	Exec Dir - N&G	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	Fill rates are achieved but a high reliance on agency staff. Most of which are regularly booked staff. No Harm incidents have been reported in the last 6 months linked to the staffing levels. Paeds services cease in July 2019	Q&S Report	3	4	12	↔		Ongoing	1	4	4
PS1	Nursing	Exec Dir - N&G	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. Further support and oversight provided by BWCH and a further weekly meeting instigated from February 2019. Operationally the service has been reviewed and bed capacity reduced to 12 beds to support staffing requirements – Operational SOP being drafted to support measures put in place. Rostering reviewed and CYPHDU/Ward 11 amalgamated to provide further oversight and support both areas. Scheduling tool developed to provide better oversight of activity booked for both areas.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	Ongoing	1	4	4
MD1	Clinical	Exec Medical Director	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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

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

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UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 31 July 2019 (ASSURANCE BRIEFING)

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee considered Quality report, which included the detail of two Never Events.	• The external review into the serious incidents to report to the Quality & Safety Committee and the Trust Board when completed. • Trends relating to complaints to be provided on a financial year basis.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Following the Never Events, it was reported that the Head of OD & Inclusion had held some focus sessions with staff in theatres to identify if there was reluctance for staff to speak up or whether staff were operating in 'auto pilot' mode. In both cases there was positive assurance provided that staff were confident to speak up when needed and were vigilant. Professional conversations had been arranged with those involved and a Human Factors training event had been arranged. • It was reported that an external review had been commissioned into practice in theatres in connection to some cases that had required support from expertise in vascular services at a neighbouring trust. The review would review the need for future support for vascular services and also test the robustness of the decision-making around the Multi Disciplinary Team that handled these cases. • The compliance with the WHO checklist was at 100%.	• None specifically
• **Chair's comments on the effectiveness of the meeting:** It was agreed that the assurance briefing had been useful and necessary given the set of incidents outlined.	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 28 August 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee discussed the detail of two Never Events and two cases when paediatric patients being operated on at Birmingham Children's Hospital (BCH) had developed an infection, which had lead to an adverse outcome. Joint discussions with BCH were underway, however the decision had been taken to suspend the element of this service until actions had been agreed to minimise any further risks. • It was noted that an increasing trend of Urinary Tract Infections had been detected and was being investigated to understand the reasons. An audit of 150 JointCare patients was underway as part of this review. • It was reported that the 24-hour VTE reassessment rate had deteriorated. Work was underway under the remit of the Medical Director to target key groups of staff, including new junior doctors to reinforce the practice. The use of the Prescribing Information and Communications System (PICS) to identify non-compliance would also be used. • There had been an increase in the number of complaints, with 27 having been reported during the month. A number related to rescheduling of appointments. The Committee was advised that this would be addressed through the introduction of partial booking. • It was highlighted that the CQC had noted that the Trust appeared to close over half of Central Alerting System (CAS) alerts late and therefore work was underway to identify the accuracy of this assessment and if so, the systems and processes in the Trust that were causing this apparent delay. • Capacity in the patient experience team was noted to be a concern, given the intention to widen the remit of the team in line with the patient experience and engagement agenda.	• An update on the VTE process to be presented at the next meeting • Update on CAS alerts to be provided at the next meeting. • An update on Patient Reported Outcome Measures (PROMS) to be presented following additional scrutiny by the Executives

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The Committee considered the clinical element of the revised Corporate Risk Register, which it was noted reflected closure of a number of risks associated with paediatric service transfer. • The VTE policy had been amended to be aligned to the national NICE guidelines around VTE prophylaxis. • Compliance with the WHO checklist was at 100%. • An overview of Safeguarding cases was included in the Quality Report to provide additional oversight on behalf of the Board. • Operational performance was noted to be largely good, although the trajectory for the Referral to Treatment Time target had not been met, this being associated with the ongoing issues with arranging consultants to cover additional lists as a result of the tax liabilities concerning pension payments. • There was reported to be good progress with the development of the HealthAssure system. • The audit of groups reporting up to the Quality & Safety Committee showed that there was overall a sound system of governance and escalation. Where there were identified gaps in assurance, these would be addressed directly with the chairs of the groups. • An update on the Trust's mortality and learning from deaths was considered. The overall position suggested that the Trust was not an outlier when compared to a number of other similar organisations. The learning from deaths process was working well, with good quality discussions around deaths included in clinical audit days and literature issues across the organisation. There was also noted to be good support from the clinical governance team around the mortality process. • The Committee received the updated IR(ME)R (ionising radiation) action plan; both outstanding actions had been closed. • The annual complaints report as reviewed which showed an overall decline in the number of complaints received. A key theme concerned appointments and this would be addressed through the	• It was agreed that a demonstration of the HealthAssure system would be provided at the Trust Board workshop in October • It was agreed that the annual report for the Quality & Safety Committee should be presented to the Trust Board. This should reflect the discussion around the need for staff to adhere to paper submission deadlines. • The Committee approved its revised workplan.

Trust's quality priorities. All externally mandated key performance indicators had been met. • The Committee received and noted the annual workplan to achieve compliance with the Hygiene Code • The annual report from the Director of Infection Prevention and Control was received. It was noted that the level of infections was low, although the spike in Surgical Site Infections was being investigated. • The Committee received the water safety action plan which was now presented in the corporate action plan format. There was positive assurance around the processes in place to ensure that the Trust operated with safe water conditions, however there were two outstanding actions which would not be closed until the Autumn (water safety bible and the Legionella Risk Assessment). • It was noted that the Human Tissue Authority (HTA) had signed off the action plan to achieve compliance with the HTA licence. • The Committee was advised that a Root Cause Analysis had been interpreted into a patient's first language. • The resuscitation arrangements in the Trust had been strengthened, including around standardising equipment, training and policies. • The Committee was pleased to receive an update form the inaugural meeting of the Patient Experience & Engagement Group, which demonstrated that patients would be involved more fully in service redesign and the decision-making in the organisation. A particular positive development was the implementation of a patient group for learning disabilities. • An Oncology 2020 plan had been developed, the delivery of which would be monitored through the 'Perfecting Pathways' Programme Board. • The value of the closed claims was noted to be significantly below the level of settlement expected; this would assist with reducing future clinical negligence premia • Good progress had been made with the delivery of the CQC action plan	

- **Chair's comments on the effectiveness of the meeting:** It was agreed that the level of discussion at the meeting was appropriate, with a deep dive into detail when needed. It was suggested that the assurances to the Committee were now provided more proactively, which was a positive development from the position previously.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2018/19

1.0 Introduction

1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Quality & Safety Committee during 2018/19 and update the Board on its work to date in 2019/20.

1.2 The Quality & Safety Committee reviewed its Terms of Reference in October 2018, which were received and approved by the Board of Directors in November 2018. The changes updated the titles of key members, reflected that some the Committee receives the Infection Control and Complaints annual reports and streamlined the attendance at meetings, and as a result of strengthened divisional governance arrangements, the Heads of Nursing were stood down as standing invitees.

1.3 During the year, the Chair of the Quality & Safety Committee was Kathryn Sallah. Professor Gourevitch is also a member of the Trust's Audit Committee and routinely reports on the work of the Quality & Safety Committee at each meeting. Th e Committee specifically remitted consideration of how NICE guidance was handled in the Trust to the Audit Committee during the year which was then built into the annual internal audit plan.

2.0 Meetings

2.1 During 2018/19 the Quality & Safety Committee met on eleven occasions, with the December meeting being an assurance briefing which focussed singularly on the Quality Report.

2.2 The attendance at these meetings is as below:

MEMBER	MEETING DATE											TOTAL
	25/4/18	30/5/18	27/6/18	29/8/18	26/9/18	31/10/18	28/11/18	28/12/18*	30/1/19	27/2/19	27/3/19	
Kathryn Sallah (Ch)	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	**10/11**
David Gourevitch	A	✓	✓	✓	A	✓	✓	A	✓	A	✓	**7/11**
Simone Jordan	✓	✓	✓	✓	✓	A	✓	A	✓	A	✓	**8/11**
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	**10/11**

Paul Athey	✓	A	✓	A	✓	A	✓	A	✓	✓	✓	**7/11**
Andrew Pearson	A	✓	✓	A	A	✓	✓	A	✓			**5/9**
Matthew Revell										✓	✓	**2/2**
Jo Williams	✓	✓	A	✓	✓	✓	A	A	✓	✓	✓	**8/11**

KEY:

✓	Attended	A	Apologies tendered
	Not in post/not required	*	The December meeting was an assurance meeting by telephone conference

2.3 Meetings are also attended routinely by a public governor as an observer, which proves an effective way of helping the Council of Governors discharge its duty of holding the Non Executives to account for the performance of the Trust.

2.4 The Secretariat to the Committee is the Director of Corporate Affairs & Company Secretary.

2.5 The Quality & Safety Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, risks noted & matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2018/19

The Committee dealt with the following key matters:

Routine Work

The Committee received upward reports from the Trust's Clinical Governance Committees, namely:

- Clinical Quality Group
- Drugs & Therapeutics Committee
- Safeguarding Committee
- Infection Control Committee
- Safeguarding Committee
- Research & Development Committee
- Cancer Board
- Clinical Audit & Effectiveness Committee
- Children's Board
- Health & Safety Committee

In year the process for systematising the upward reporting was strengthened and widened to larger set of groups, including a routine cycle for the Committee leads to attend the Quality & Safety Committee and the introduction of a revised standard template to ensure that

reports upwards were consistent in content and highlighted only focussed on the key points of interest to the Quality & Safety Committee.

The Committee during the year has received routine update reports on:

- Quality & Patient Safety report
- CQC action plan progress
- Litigation and claims subsequently subsumed into the Quality & Patient safety report
- Complaints including Annual complaints report
- Annual infection prevention & control report
- Annual safeguarding report
- Divisional governance key highlights
- Patient Related Outcome Measures (PROMS), particularly focussing on the need to improve the scores that placed the Trust as an outlier compared to peer organisations
- Mortality
- Controlled Drugs Accountable Officer report
- Nurse staffing
- Contract scorecard and CQUINs
- Quality & Safety risks on the corporate risk register

Single issue or non-routine reports

During the year, the Committee received some specific reports providing assurance on particular key issues, these being:

- Resuscitation training
- Nutrition
- Human Tissue Act compliance
- Quality Assurance walkabouts
- Freedom to Speak Up update
- Performance management of agency staff
- Kerrison equipment
- Coroners inquest
- IR(ME)R inspection
- Bone infection services
- Report into patient burns
- Mental Health update
- National patient survey and action plan
- Tissue viability
- Customer care training
- Hepatitis B inoculations
- Plans for Pathology services
- Implementation of the Allocate HealthAssure system
- Patient experience strategy
- Brexit readiness assessment

- Relaunch of the medico-legal forum
- Quality Impact Assessment register and process
- Healthwatch report on Outpatient waiting area

4.0 2019/20 Work Plan

4.1 For 2019/20, the Quality & Safety Committee continues with its routine work as well dealing with ad hoc requirements that will emerge from time to time or remitted from the Board and/or Audit Committee.

4.2 As discussed in 2018/19, there are plans to widen the scope of the Quality & Safety report to cover performance against key indicators related to medical and operational areas.

4.3 Additions to the workplan include a routine update from the Patient Experience & Engagement Group and the Radiation Safety Advisory Group. A regular update on compliance with the Human Tissue Act licence will also be considered.

4.4 The revised workplan will be presented to the Quality & Safety Committee for its approval in August 2019.

4.5 There will remain a focus on improving the effectiveness of the Committee during 2019/20, with particular focus on seeking appropriate assurance on matters within its remit, understanding how lessons learned from incidents, complaints, litigation and clinical audit are disseminated & acted upon and strengthening the upward reporting from the Trust's Clinical Governance committees.

5.0 Quality & Safety Committee Effectiveness

5.1 An item is included on the agenda of each meeting to review the effectiveness of the meeting and of the Committee in general. As a result of these discussions, a number of suggestions were made to the operation of the Committee:

- Given the breadth of the agenda the time slot for the meetings was extended
- More focussed reporting from the upwardly reporting groups was needed so that robust assurance could be provided upwardly to the Trust Board
- If there were matters that required detailed debate, the agenda was constructed such that sufficient time was allowed for the item to be fully considered
- Meeting papers needed to be provided by authors by the deadline set.

6.0 Conclusion

6.1 The Quality & Safety Committee has functioned well during 2018/19 and is now operating effectively, providing clear and adequate assurance upwards to the

Trust Board across a comprehensive range of matters of a quality & patient safety nature.

Kathryn Sallah
Chair of Quality & Safety Committee

August 2019

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

August 2019

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

Dashboard

	June 2019	July 2019	2019/2020 YTD	2018/2019
Incidents	365	365 (↔)		
Serious Incidents	1	1 (↔)	4	9
Internal RCA investigations	6	3 (↓)		
Safety Thermometer (Harm Free Care)	98	97 (↓)		
VTEs (Avoidable)	0	0 (↔)	0	4 (Avoidable)
Falls (all falls)	13	8 (↓)	35	88 (Total)
Pressure Ulcers: Cat 2 (Avoidable)	1	0 (↓)	1	7 (Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0 (↔)	0	2 (Avoidable)
Complaints	10	27 (↑)	54	139
PALS	73	116 (↑)		
Compliments	488	468 (↓)		
FFT Score	96.4	96.2 (↓)		
FFT Response	24.6%	58.8% (↑)		
Duty of Candour	15	16 (↑)		
Litigation	2	0 (↓)		
Coroners	0	0 (↔)		
WHO	100	100 (↔)		
Infections	1	0 (↓)	2	3

(↑) (↓)(↔) Symbolise the trend from the previous month.

CONTENTS

1. 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.

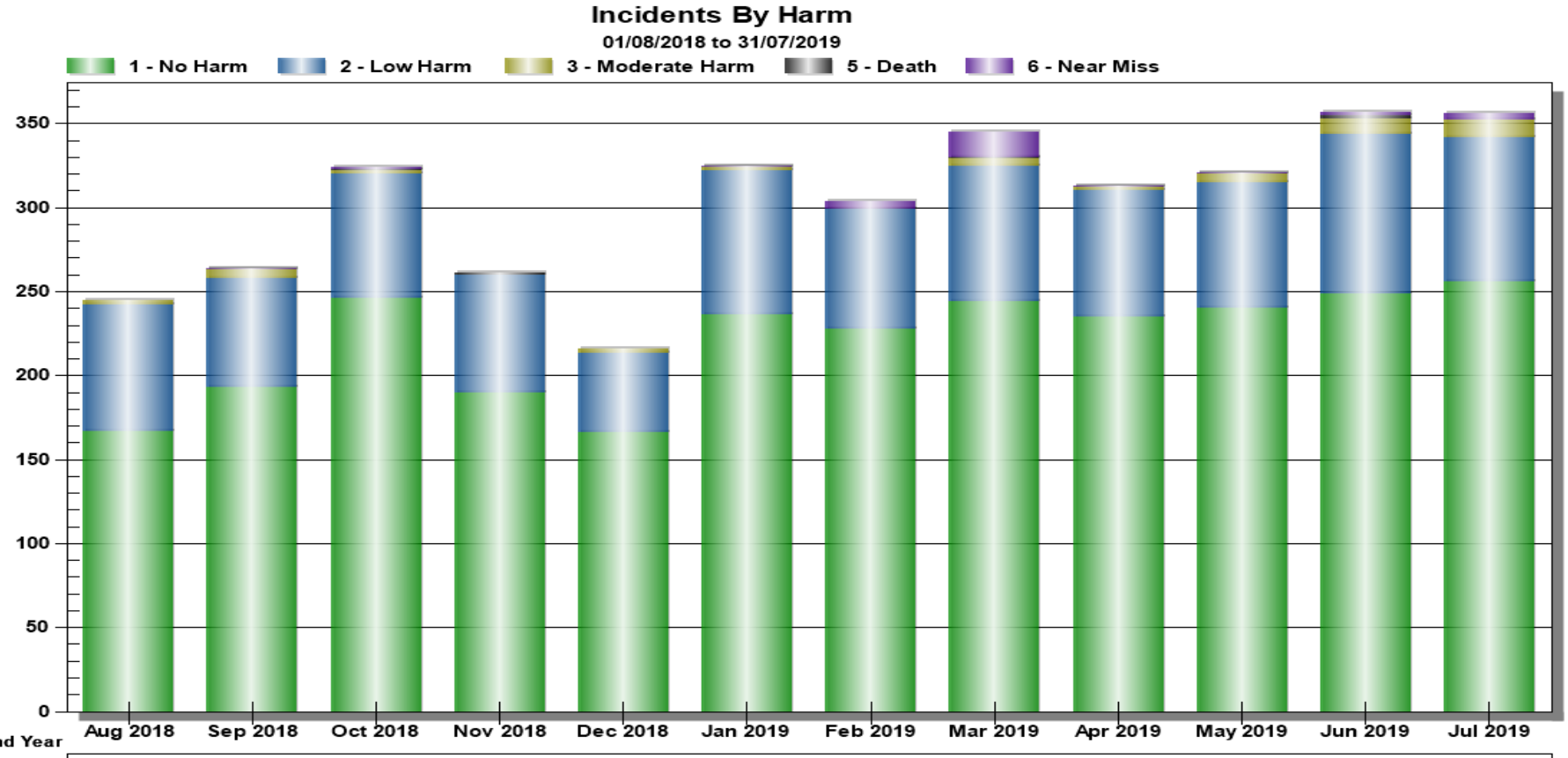
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019
1 - No Harm	167	193	246	190	166	236	228	244	235	240	249	256
2 - Low Harm	75	65	74	70	47	86	71	81	75	75	95	86
3 - Moderate Harm	3	5	2	0	3	2	0	4	2	5	9	10
5 - Death	0	0	1	1	0	0	0	1	0	0	2	0
6 - Near Miss	0	1	1	0	0	1	5	15	1	1	2	4

Data source – Ulysses

INFORMATION

In July 2019, there were a total of 356 Incidents reported on the Ulysses incident management system. This is within the normal reporting limits.
The breakdown of those incidents is as follows;

256 – No Harm
86 – Low Harm
10 - Moderate Harms
0 - Severe Harm
4 – Near Miss
0 – Death

Patient Contacts

In July 2019, there were a total of 9859 patient contacts. There were 356 incidents reported, which amounts to 3.61 per cent of the total patient contacts resulting in an incident. Of those 356 reported incidents, 100 incidents resulted in harm which is 1.01 per cent of the total patient contact.

Downgraded Incidents

0 of the 9 reported harms in the previous Quality report have been downgraded.

These were; 2 x VTEs, 1 x unconfirmed VTE/Death 1 x wrong level spinal surgery, 1 x Wrong side surgery, 2 x deteriorating patients, 1 Transfer out and 1 x Tissue viability skin burn.

ACTIONS FOR IMPROVEMENTS / LEARNING

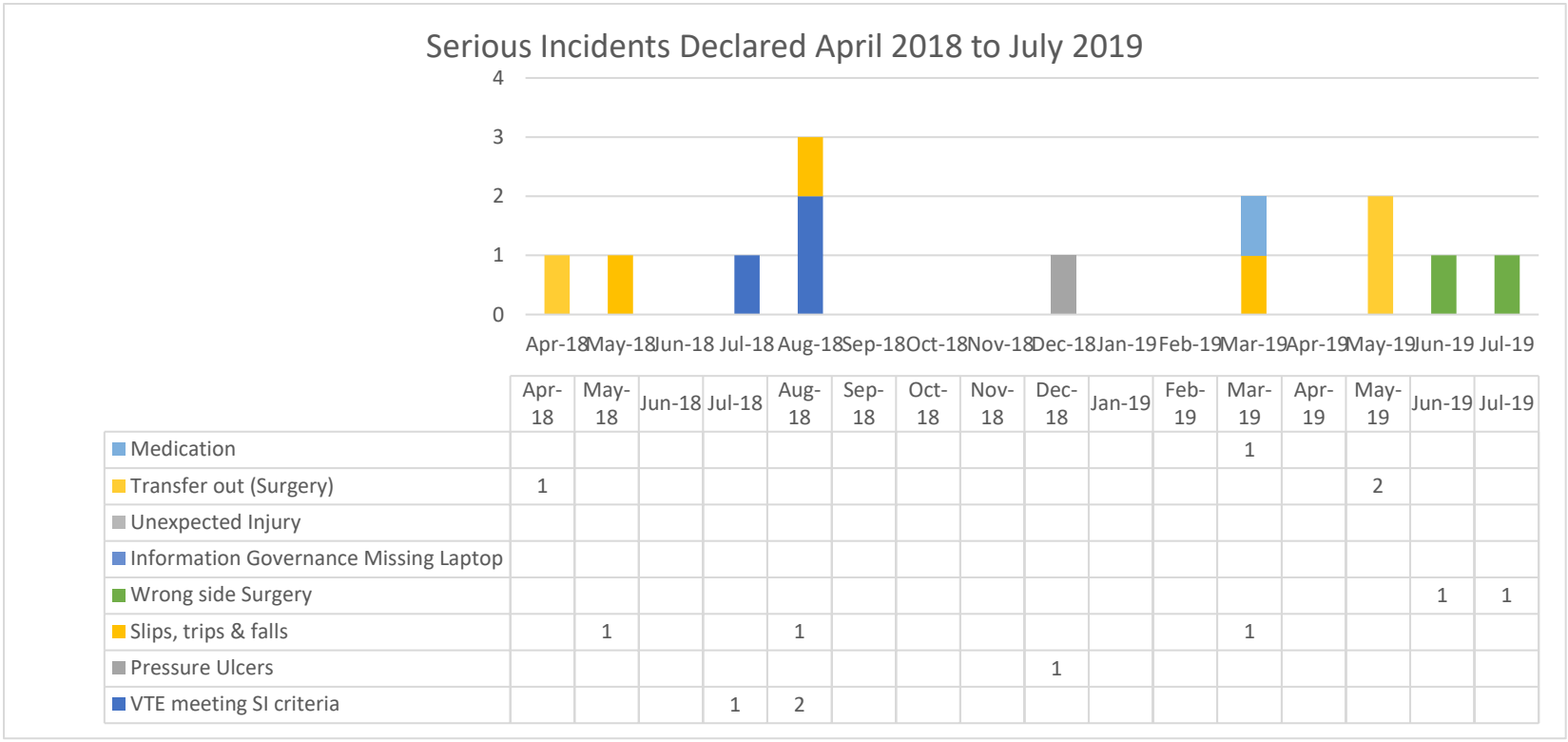
Duty of Candour/Never Event awareness sessions planned for OPD and Therapies. Futher dates to be confirmed for other areas

Case studies for Never Events and Serious Incidents to be sent out for shared learning. These will also be including in divisional meetings

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.**



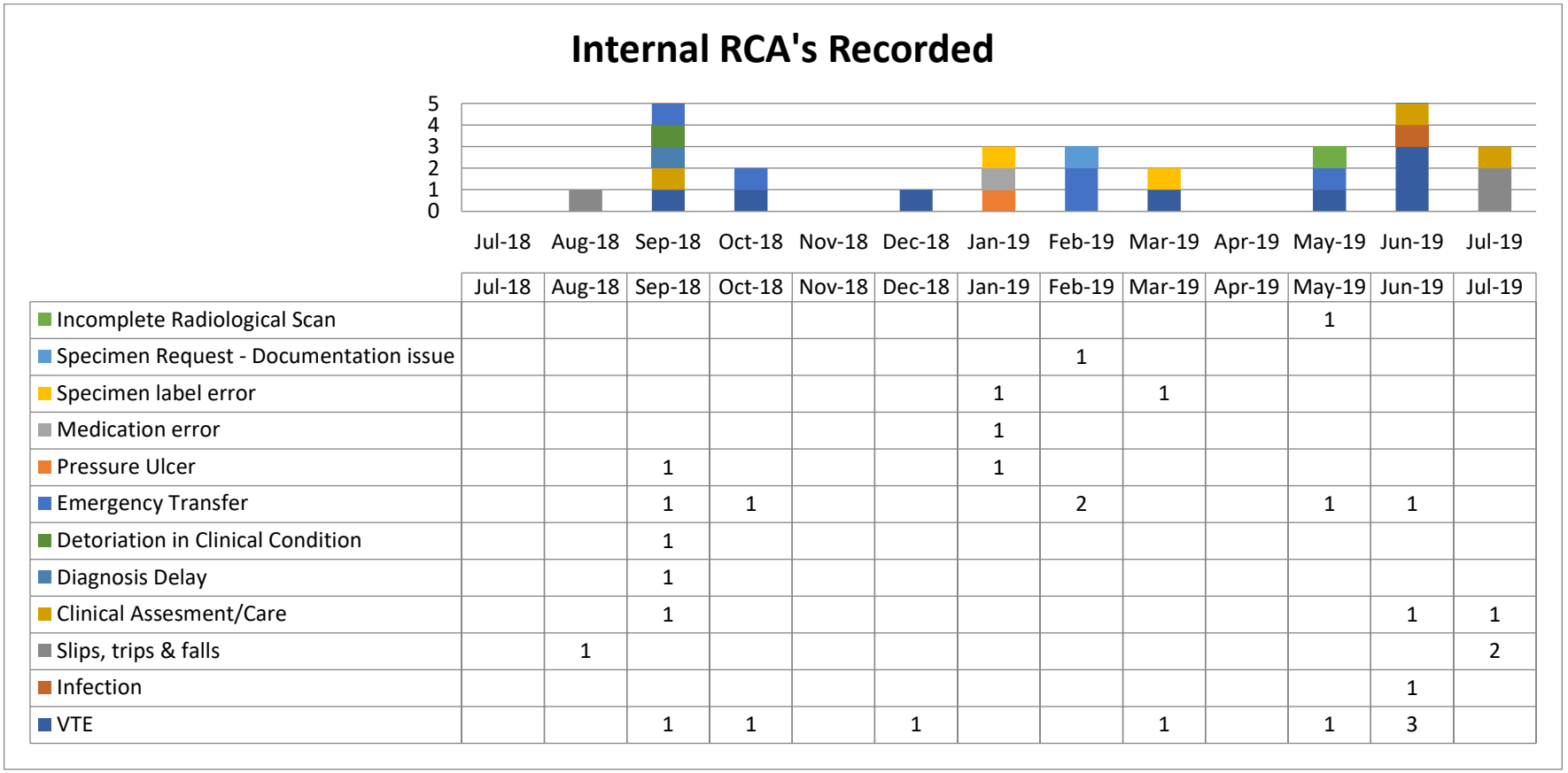
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Medication												1				
Transfer out (Surgery)	1													2		
Unexpected Injury																
Information Governance Missing Laptop																
Wrong side Surgery															1	1
Slips, trips & falls		1			1							1				
Pressure Ulcers									1							
VTE meeting SI criteria				1	2											

Year Totals	
18/19	9
19/20	4

Data Source – STEIS

INFORMATION
One Serious Incident was reported in July 2019.
ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incident was closed by the CCG in July 2019 **Following review, the recommended actions were as follows:** 1. During the Ward 3 morning huddle, patient safety issues will be discussed as well the general themes and topics that are currently discussed. 2. A stock of cricket pad splints to be kept outside orthotics for inpatient use 3. Staff to be made aware of this report and findings. Failure to follow Trust policy to be addressed in accordance with Trust Disciplinary procedure. 4. Ward 3 falls link nurse to complete e-learning. 5. Physiotherapy staff to document in post-operative pathway MDT book, not just TIARA.
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Incomplete Radiological Scan											1		
Specimen Request - Documentation issue								1					
Specimen label error							1		1				
Medication error							1						
Pressure Ulcer			1				1						
Emergency Transfer			1	1				2			1	1	
Detoriation in Clinical Condition			1										
Diagnosis Delay			1										
Clinical Assesment/Care			1									1	1
Slips, trips & falls		1											2
Infection												1	
VTE			1	1		1			1		1	3	

Data Source – Internal RCA tracker

INFORMATION

3 Internal RCAs were declared in August 2019

Category	Directorate
Fall - Fractured Hip	OPD & Support Services
Fall - Dislocated Hip	Ward 3
NGT problems	HDU

ACTIONS FOR IMPROVEMENTS / LEARNING

One RCA was closed in July 2019

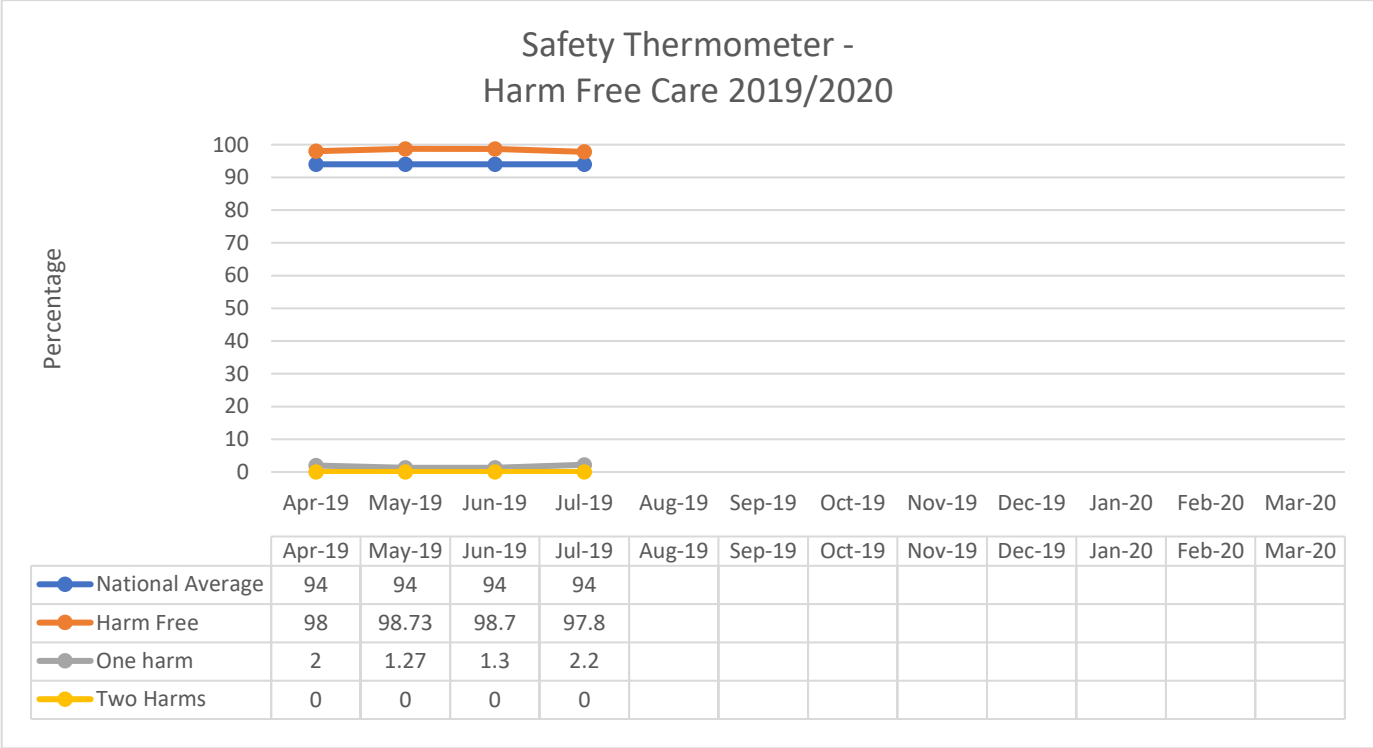
The Lessons Learned from the RCA are:

• In some cases, the insertion kit and not the implant are being check prior to surgery providing false reassurance during the WHO team brief. (Not noted in this case but occurred in the case prior where stock levels were not escalated).
• Implant range and sizes stock list are not present with implants in theatre.
• Clear documentation of whether stock has been reordered and where in the journey the stock is – ordered, pending, received… is not easily accessible.
• If in doubt regarding kit or implant the theatre team should check the kit and implants with the surgeon before the list begins and document they have done so.

RISKS / ISSUES

None

5. **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.**



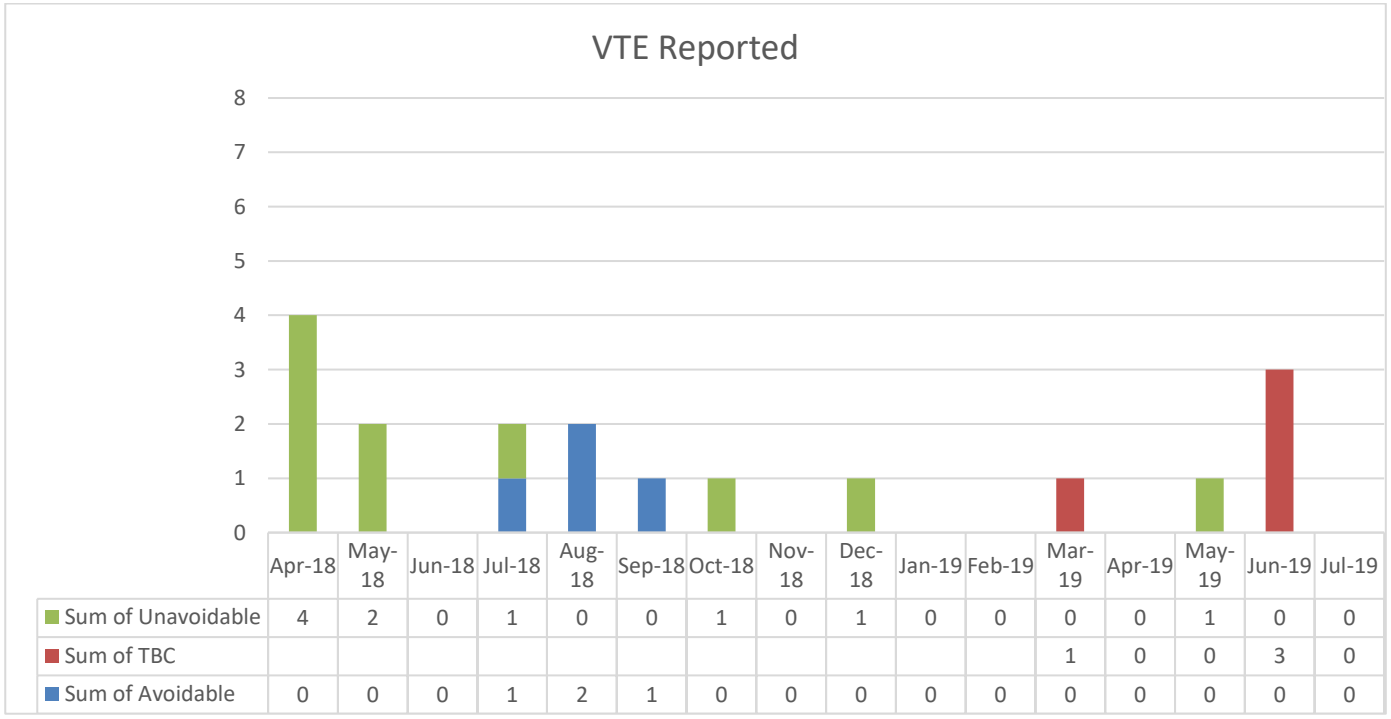
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
National Average	94	94	94	94								
Harm Free	98	98.73	98.7	97.8								
One harm	2	1.27	1.3	2.2								
Two Harms	0	0	0	0								

The Harms reported were;

2 x Cat 2 Pressure ulcers on Ward 12 and a New UTI on Ward 12

Data Source – Informatics

6. **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).**



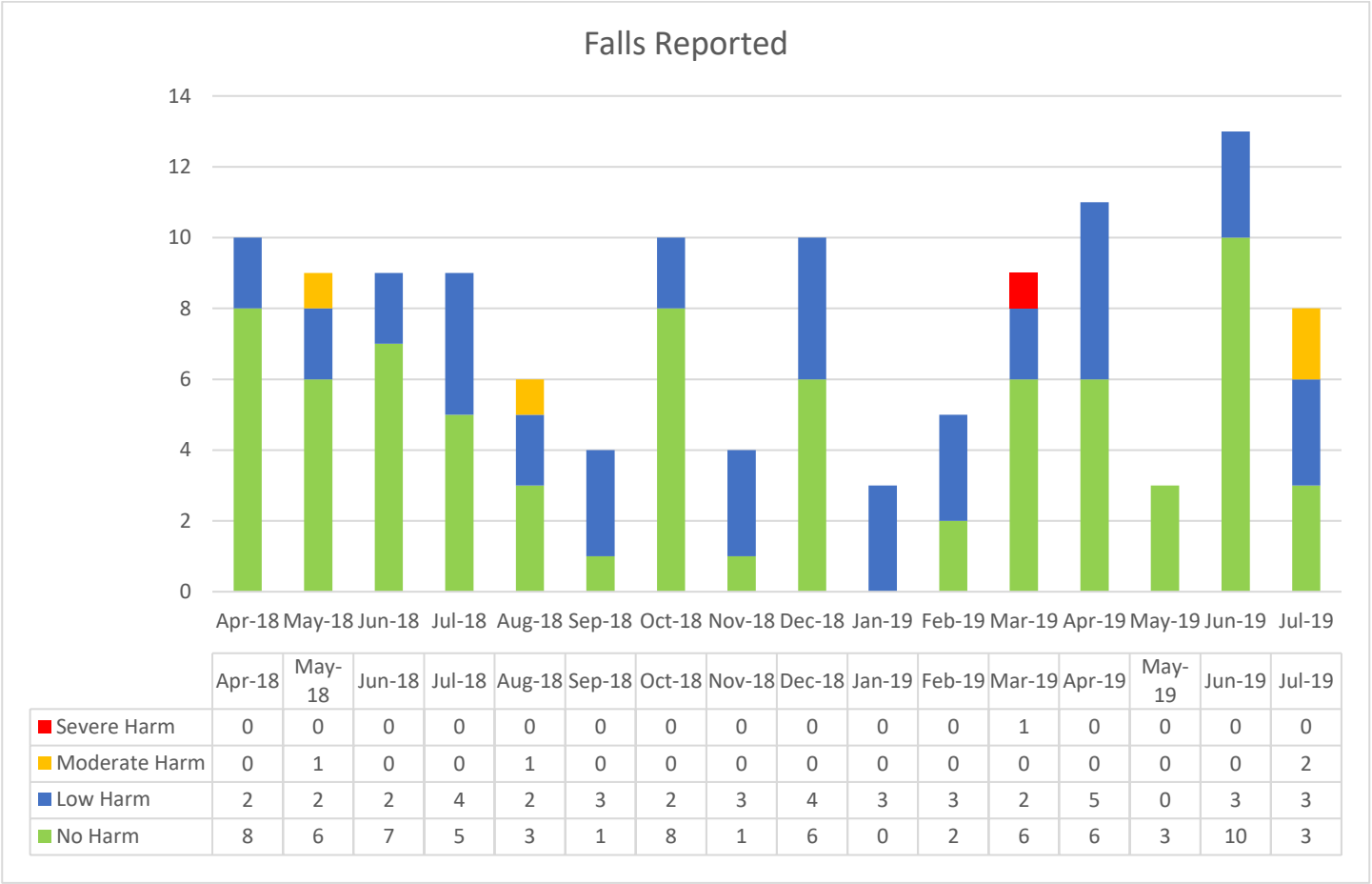
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Sum of Unavoidable	4	2	0	1	0	0	1	0	1	0	0	0	0	1	0	0
Sum of TBC												1	0	0	3	0
Sum of Avoidable	0	0	0	1	2	1	0	0	0	0	0	0	0	0	0	0

Avoidable Year Totals	
18/19	4
19/20	0

INFORMATION
There were zero hospital acquired VTEs reported in July 2019. An RCA is underway following a post-discharge death which has now been confirmed as PE. An inquest is being held in September 2019. 24-hour re-assessment was 88.4% in July (89.6% in June).
ACTIONS FOR IMPROVEMENTS / LEARNING
Compliance with the 24-hour VTE risk assessment has decreased in July . Information from PICS enables staff responsible for non-completion to be obtained and shared with key medical leads who have been given delegated responsibility for addressing this by the medical director. This requirement was emphasised during new doctors' induction. On admission risk assessment is consistently above the nationally required 95% however we should be aiming for 100% compliance. This is a mandated field in PICS when medicines need to be prescribed however some are being missed on day case patient who do not require prescription of any medicines. There is also a question on the WHO Sign-in which prompts the need to ensure this has been completed. ADCU are encouraged to incident report in order that this can be followed up with individual surgeons.
RISKS / ISSUES
Poor compliance with mandatory 24-hour re-assessment . Patients being discharged without confirmation of VTE risk assessment.

Data Source – Ulysses and VTE leads

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 fall's 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	Apr-19	May-19	Jun-19	Jul-19
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Moderate Harm	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	2
Low Harm	2	2	2	4	2	3	2	3	4	3	3	2	5	0	3	3
No Harm	8	6	7	5	3	1	8	1	6	0	2	6	6	3	10	3

Year Totals	
18/19	88
19/20	35

Data Source – Ulysses and Falls Group

INFORMATION

There were 13 incidents reported across the Trust in July 2019 relating to Falls, 1 of these was a staff member in theatres slipping on a wet floor. Of the remaining 12 incidents, 4 were not actual falls:

- 28324 – Physio Out-Patients, reporting of near miss - unsafe practice of using door for patients to lean against to perform exercises, which if the release button was pressed could result in the patient falling
- 28450 – Ward 12, unwitnessed near fall, patient mobilising without supervision against instructions given and fell against locker
- 28386 – Ward 12, patient twisted hip in bed, no actual fall
- 28303 – Ward 3, patient lowered self to floor when lost balance

8 Actual Falls Incidents:

- 28286 – Ward 12, unwitnessed fall in the bathroom
- 28332 – Ward 2, unwitnessed fall in the bathroom
- 28239 – Ward 1, unwitnessed fall in the bathroom
- 28456 – ADCU, post-operative patient turned and shoe stuck to floor causing a fall
- 28415 – Ward 12, patient lost balance mobilising back from toilet under supervision
- 28514 – Ward 1, unwitnessed fall, patient lost balance trying to push cupboard back to wall
- 28401 – Ward 1, unwitnessed fall, patient lost balance trying to put shorts on
- 28529 – Ward 3, unwitnessed fall by ROH staff but witnessed by relatives, patient fell whilst mobilising to toilet, resulting in dislocated hip & subsequent surgery to relocate the hip – RCA to be completed

Theme of falls was mainly unwitnessed falls either in the bathroom or when the patient was mobilising to the toilet. Clinical staff are being reminded on the clinical skills update training sessions to advise patients to use their call bell if they need assistance rather than risk falling.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions Underway

- Purchase of another Hover Jack - capital bid rejected, to explore sourcing funding from charitable funds as alternative.
- Looking at development of fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall.
- Development of combined dementia/falls notification in pre-op assessment to identify patients at risk at an early stage.
- Looking at patient engagement around Falls and how best we approach this, including patient representation on Falls/Dementia working group.
- Reviewing information on Falls notice boards.
- Ensure 'Call before you fall' posters are visible in all bathrooms.

Positive Assurance

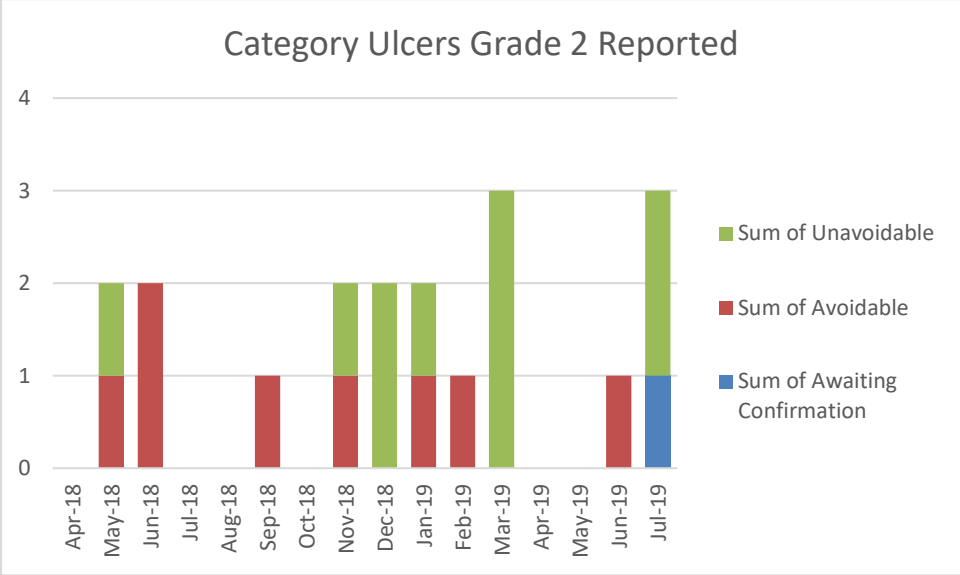
- Terms of reference developed for new combined dementia and falls group, submitted for approval to Clinical Quality Group.
- On-going training around Falls awareness on clinical skills update days.
- Extra training on the use of the Sara Steady Hoist carried out on 24/6/19 by Derby manual handling training group to ward based groups of staff – now need to scope level of training across ward areas to ensure sufficient numbers trained.

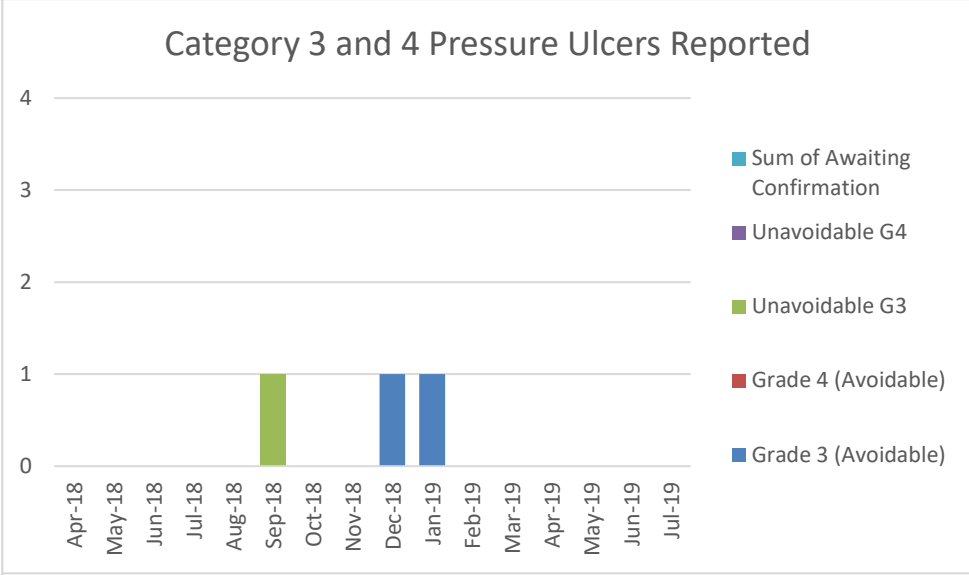
RISKS / ISSUES

Only one Hover Jack available for the trust, this is also used for training, capital bid rejected, to look at option of using charitable funds.

When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Bid submitted to replace hoists Trust wide – rejected, no change in status.

8. **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.**





Data Source – Ulysses and TV team

Year Total	Cat 2	Cat 3
18/19	15	3
19/20	2	0

INFORMATION

July 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	2
Category – 2 (Device)	Cat 2- 1
Category – 1	PU ROH x2 Cat 1 MDRPU PU ROH x2 Cat 1
Suspected Deep Tissue Injury (SDTI)	PU admitted with SDTI- x1
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Intertriginous dermatitis – x1 MASD ROH Incontinence- x2 MASD admitted with Intertriginous dermatitis x2 MASD admitted with Incontinence- 0
Patients admitted with PUs	PU admitted with Cat 1- 0 PU admitted with Cat 2- x3 PU admitted with Cat 3- 0 PU admitted with Cat 4- 0

Avoidable Pressure Ulcer CCG Contracts KPI

2019/2020	
Avoidable Grade 2 pressure Ulcers limit of 12	1
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

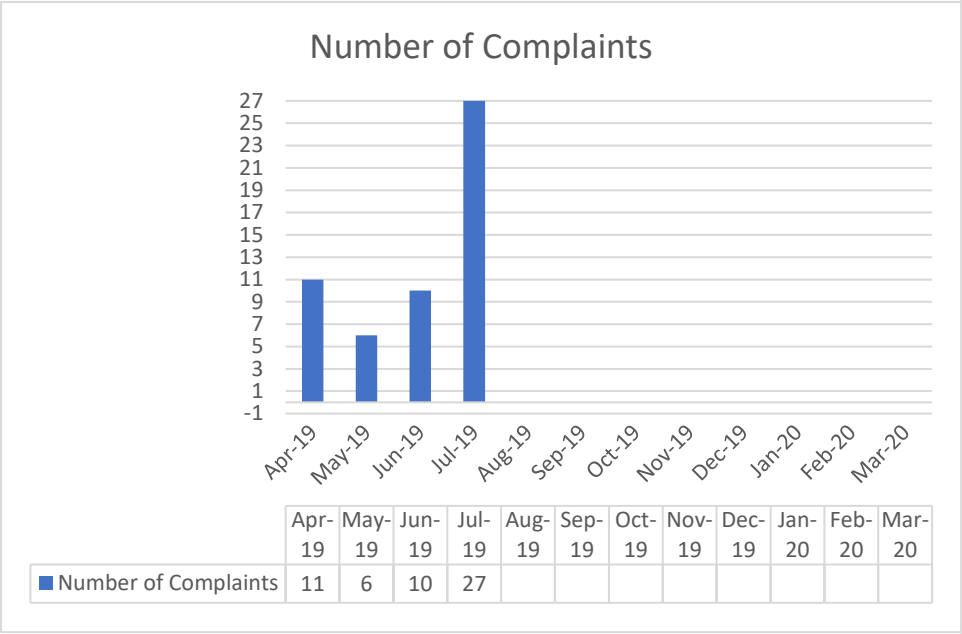
Current Actions

- PU Policy has been amended again to reflect the care of patients with dementia and will be sent out for comments as soon as it is formatted
- Incident – MDRPU related to tourniquet management intra-operatively being investigated and practice has changed
- Apples and PUs #itsmorethanabruise - SDTI training continue where needed
- All HCAs within Trust will receive skin assessment training

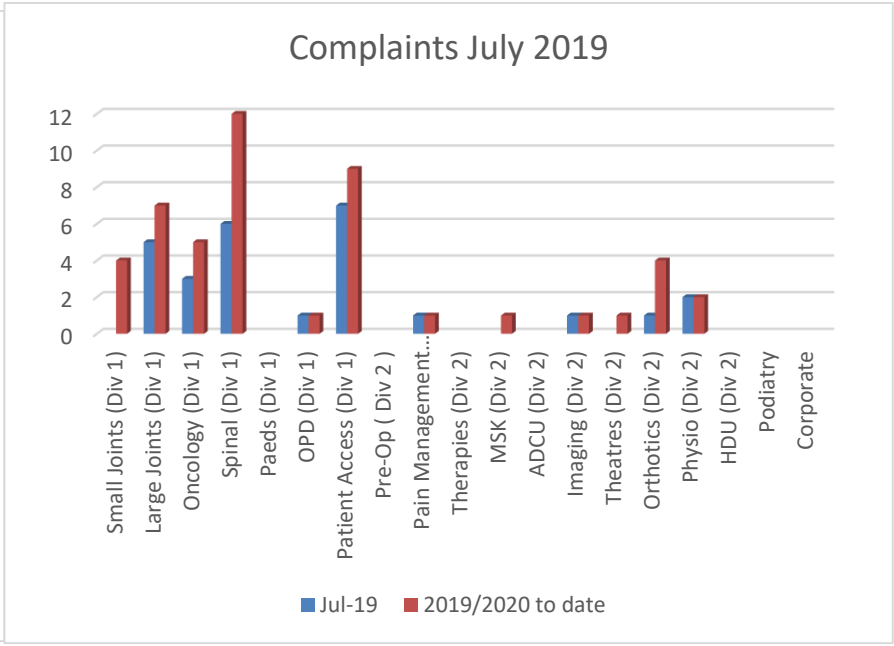
RISKS / ISSUES

None

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Number of Complaints	11	6	10	27								



Complaint Year Totals	
18/19	139
19/20	54

Data Source – Patient Experience team

INFORMATION

Complaints

There were 27 formal complaints made in July 2019. All were initially risk rated amber or yellow. This is higher than last year (15 complaints in July 2018). It is possible that more concerns are becoming formal complaints as a result of the reduced staffing within the PALS and Complaints Department. Complaints can include more than one theme and this is captured in the graph below.
The themes of this month's complaints were:

Complaints July 2019	
Appointments	10
Admissions & Discharges	1
Clinical	6
Communication	8
Patient Care	7
Prescribing	2
Privacy & Dignity	1
Values & Behaviours	6
Waiting times	3

PALS

The PALS department handled 116 contacts during July 2019 of which 70 classified as concerns. This is a reduction in calls compared to the same time last year (214 contacts in July 2018) with roughly the same number of concerns (68 concerns in July 2018). The main themes in the PALS data continue to relate to queries about appointments (either length of wait for or cancellations). 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. 87% of enquires and 87% of concerns were handled within the agreed timescales, meeting this KPI.

PALS Concerns	Jul-19	2019-2020 to date
Access to treatment	2	9
Admissions & Discharges	2	4
Appointments	39	106
Clinical	10	36
Communication	9	13
Facilities	1	6
Patient Care		4
Trust Administration	2	19
Transport	1	2
Values & Behaviours	1	6
Waiting times	2	11
Other	1	1
	70	217

Compliments

There were 468 compliments recorded in July 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments July 2019
Div. 1	418
Div. 2	50

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 receive a request monthly to submit their compliments for central logging.

When compliment data is submitted to the Patient Services Team, it is now themed using the same coding as the rest of the data. Overwhelmingly staff are complimented on Values & Behaviours (98% of recorded compliments in July 2019) with a small number of compliments about Communication (2% in July 2019)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 11 complaints closed in July 2019, 9 within the agreed timescales. This gives an 82% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in July 2019 was 33 days, which is higher than normal. This has been caused by reduced staffing in the PALS and Complaints Team, as well as the transition to complaints being managed within the Divisions.

5 complaints were fully upheld, 1 was partially upheld and 5 were not upheld.

Learning identified and actions taken as a result of complaints closed in July 2019 include:

- Transition of paediatric patients to BWCH has caused anxiety for some families
  Action: Individual Support has been offered to those that need this
- Patients do not always understand lifestyle risk factors in decision to proceed with surgery
  Action: New leaflet on effect of smoking has been produced.
- Implementation of Partial Booking has caused anxiety for some patients
- Letter to patients in next phase of implementation has been reviewed for clarity

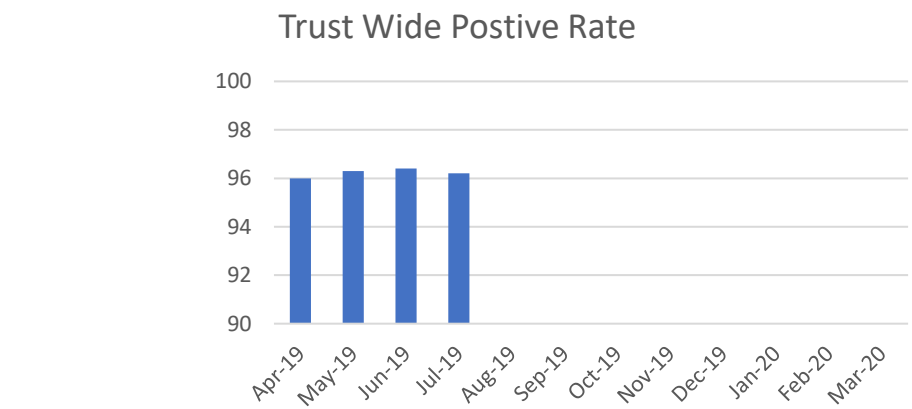
RISKS / ISSUES

Reduced Staffing in PALS and Complaints Service is presenting a risk in the high-quality service that ROH provides and expects for patients

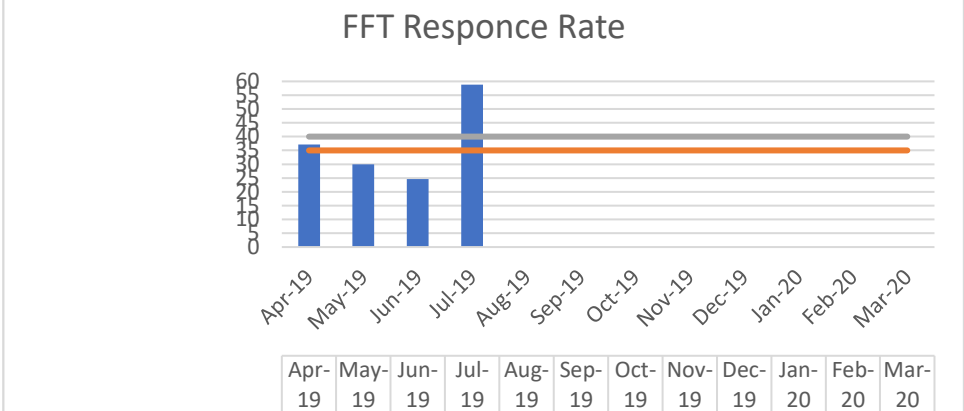
COMEBACK COMPLAINTS

No comebacks passed to Patient Services Team

10. Friends and Family Test Results (collected in the iwantgreatcare system)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Trust Wide Postive Rate	96	96.3	96.4	96.2								



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Response Rate	37.2	30	24.6	58.8								
Mandatory Target	35	35	35	35	35	35	35	35	35	35	35	35
Trust Target	40	40	40	40	40	40	40	40	40	40	40	40

Data Source – Patient Experience team 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

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 agreed internal targets for all areas and as a result, the data is 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 requested 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

The team are recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In July 2019, 79 concerns were identified from the 1383 individual pieces of feedback we received. This is a substantial increase but is as a result of better recording and monitoring, rather than an increase in actual concerns. As these are anonymous, it is not always possible to track this back to individual patients but they are shared with the relevant teams and managers as additional feedback.

FFT Concerns July 2019	
Access to treatment	1
Admissions & Discharges	2
Appointments	8
Clinical	7
Communication	11

Facilities	15
Patient Care	7
Staffing Numbers	2
Trust Administration	3
Values & Behaviours	12
Waiting times	10
Other	1

Information is 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 and the Trust Internal target of 40% for Inpatient Services this month. The internally set target of 20% for Outpatient services was also met this month. This information has been shared with Departmental and Directorate Leads

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would**	**% of people who would**	**Number of Reviews**	**Number of Individuals**	**Department Completion**
Ward 1	97.3%	0.0%	37(29)	69	53.6%
Ward 2	94.5%	1.8%	55(49)	57	96.5%
Ward 3	86.1%	2.8%	36(18)	71	50.7%
Ward 12	90.6%	0.0%	53(30)	47	112.8%
ADCU	94.7%	1.1%	95(130)	591	16.1%
HDU	100%	0%	16(15)	69	23.2%
Overall Trust Inpatient Response Rate for July 2019					58.8%

A review of Ward 12 FFT return has been undertaken. It is thought that some reviews from the previous month were not submitted on time to be included and these have been submitted in the July return. As there was a lower number of patients on the ward in July, it has had a greater impact on the return rate. The issue should resolve next month.

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in July 2019**	**% of people who would NOT recommend the department in July 2019**	**Number of Reviews submitted in July 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	97.8%	0.8%	1055 (1035)	34.0%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in July 2019**	**% of people who would NOT recommend the department in July 2019**	**Number of Reviews submitted in July 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	97.2%	0.0%	36(50)	133.0%

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.

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. There are plans to audit the duty of candour process.

12. **Litigation**

New claims

0 new claims against the Trust were received in July 2019

On-going claims

There are currently 29 on-going claims against the Trust.
26 of the claims are clinical negligence claims.
3 claims are staff claims

Pre-Application Disclosure Requests*

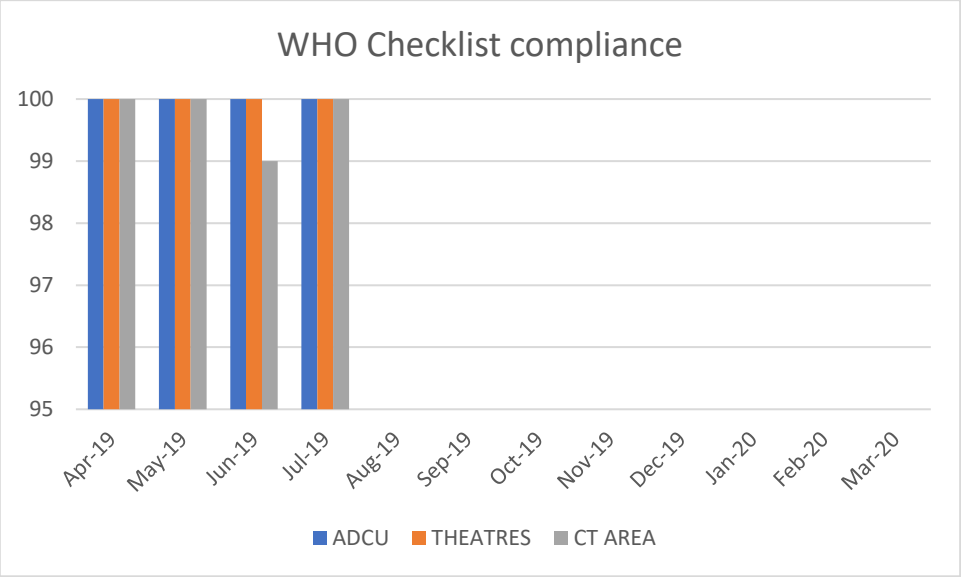
6 new requests for Pre-Application Disclosure of medical records were received in July 2019.

**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 General Data Protection Regulations 2018 and the Access to Health Records Act 1990)*

13. **Coroner's Inquests**

There were no Inquests held in July 2019

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.



Data Source – Theatreman and local audits

INFORMATION
The data is retrieved from Theatre man. On review of the audit process, the incomplete 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 = 804 The total WHO compliance for Theatres in July 2019 = 100% **CT area** Total cases = 94 The total WHO compliance for CT in July 2019 = 100% **ADCU** The snapshot WHO audit compliance for July 2019 = 100%
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
WHO checklist for ADCU 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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in July 2019 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	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	1

ACTIONS FOR IMPROVEMENTS / LEARNING

4 IP recorded incidents in July, 2019:

- 1 no harm –bare below elbow challenge
- 1 low harm – wound care helpline
- 1 low harm – concerns regarding occupational health service
- 1 low harm - infected patient

RISKS / ISSUES

- ROH continues to review the status of staff requiring Hepatitis B vaccinations and ensure vaccinations are provided where required. This is being led by Janet Campbell.
- Scheme of planned building works, for new theatres, poses an increased risk of cross contamination. Additional IPC precautions in place across site to reduce risk.
- Increase in physical environmental concerns, that have infection prevention implications, have been recorded under “estates” as incidents.

***Data Source – IPC team and Ulysses**

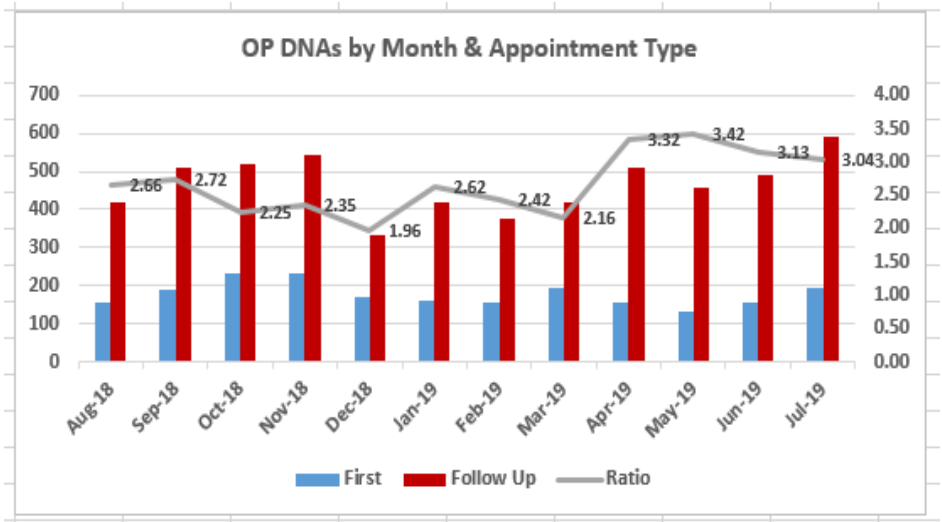
16. Safegaurding

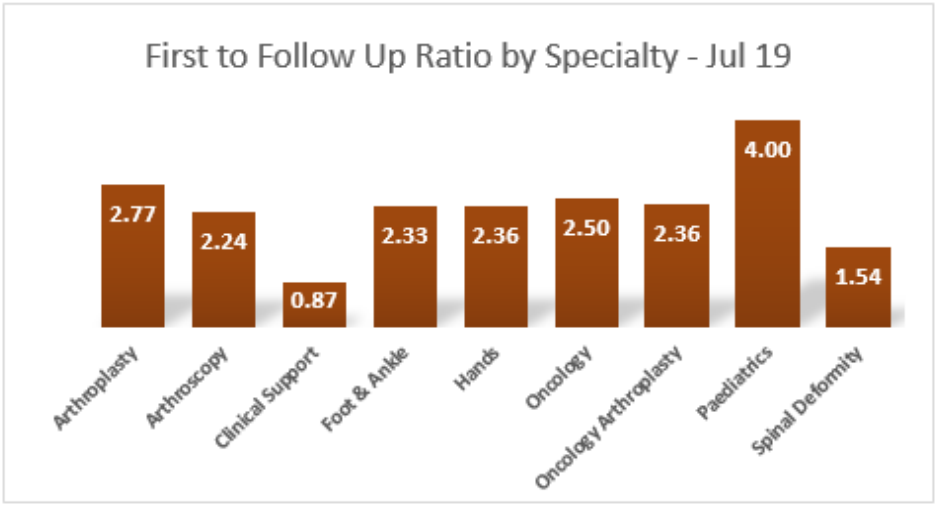
INFORMATION

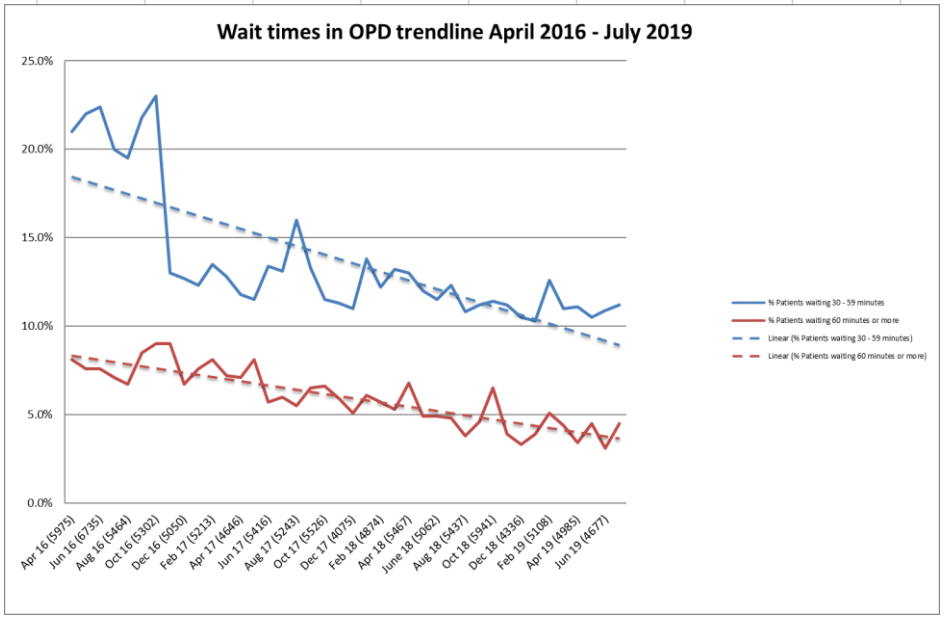
KPI	July 2019
Safeguarding Adult Notifications	24
Safeguarding Paediatric Notifications	47
Mental Health Incidents	9+3
LD Adult	8
LD Paeds	28
Adult Level 2 Training	Data not available from system at time of report production
Adult Level 3 Training	Data not available from system at time of report production
Safeguarding Level 4 Training	Data not available from system at time of report production
Child Level 2 Training	Data not available from system at time of report production
Child Level 3 Training	Data not available from system at time of report production
CE	0
FGM	0
DOLS	4 (0) authorised
MCA	3
PIPOT cases	0
Domestic Abuse	1 Child
PREVENT Notifications	0
WNB	29 + 1 Adult
Child in Care	3
Early Help	0

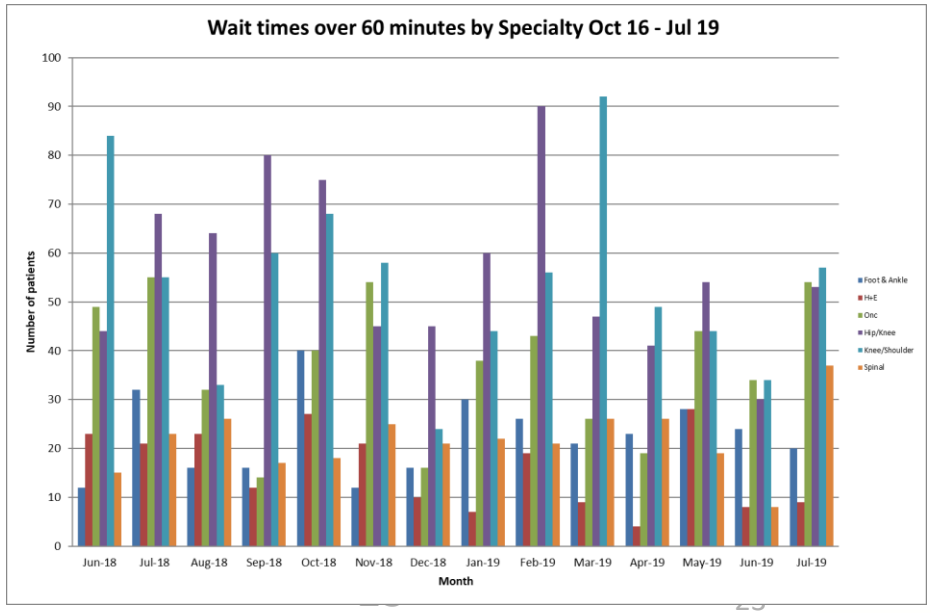
ACTIONS FOR IMPROVEMENTS / LEARNING
The Safe Recruitment policy, Missing persons policy, Chaperone and Children's Safeguarding policy are all under review.
RISKS / ISSUES
There has been a fall in training rates for WRAP, prevent and Safeguarding level 3 training; this is due to a review undertaken against the new training requirements for staff. The Trust does not have a named Safeguarding Doctor and is currently in the process of recruitment.

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









INFORMATION

In July there were 11.2% of patients waiting over 30 minutes which is a 0.3% increase from last month. The over 60 minute delays continue to be achieve under the target of 5% with a level of 4.5% for July. This KPI is now consistently being achieved.

Room allocations each week continue to be managed well and there have been no room availability incidents submitted in July. The 643 meetings have now been expanded and continue on after the weekly 642 meeting on a Wednesday. The Clinical Service and Support Managers are invited to attend as well as representation from Outpatients and the imaging department. There is a regular agenda that includes discussion of activity booked, capacity available in the coming weeks and rescheduling requests received with less than 6 weeks notice.

There were 19 incidents of clinic delays reported in July 2019 with the following breakdown.

5 Complex Patient
3 Consultant / Clinician Delay
3 Delay in Medical Notes
3 Other
4 Clinic Overbooked
1 X-ray delay

The upgrade of InTouch is still being planned but there is now some project management resource available from a member of staff that is on a management training course that requires them to plan and deliver a project.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The outpatient operational group continues to meet but additional project management resource is required to help move projects forward. The Transformation team are currently recruiting and this will provide additional resource to help deliver OPD projects
- The InTouch system needs to be upgraded in order to implement electronic outcomes and this is underway. Initial meetings have been held and a demo of the new system is being arranged
- DrDoctor has been implemented across all specialties, except Oncology where there have been some issues with patients receiving notifications before nursing staff could contact them. This system is working well and DNA rates will be monitored going forward

RISKS / ISSUES

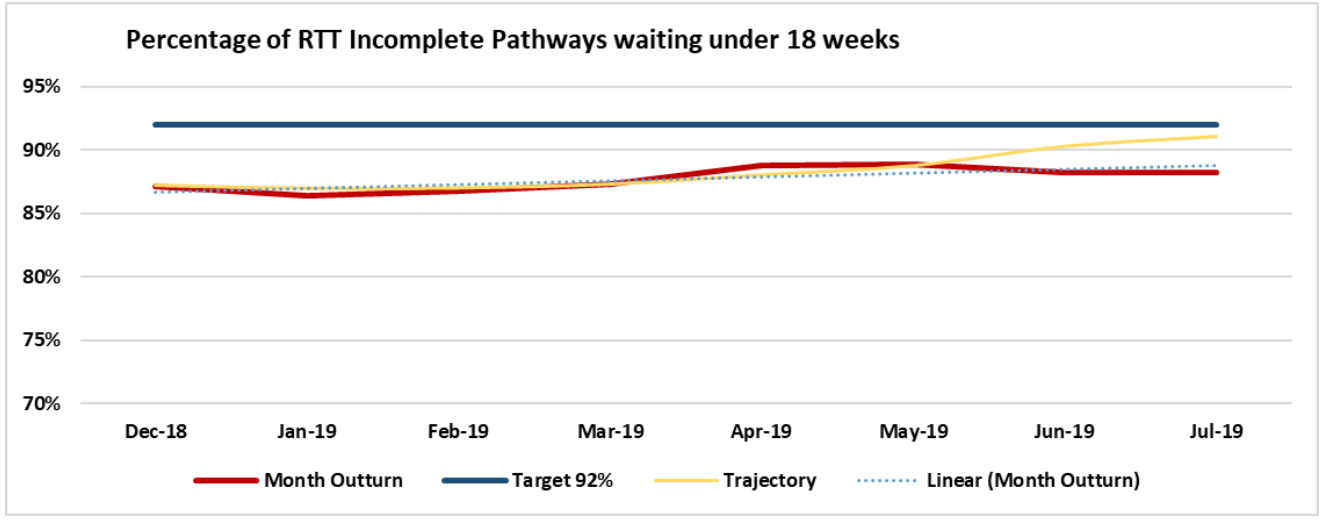
A meeting has been held with the Deputy Director of Operations to discuss the lack of space in the main outpatients department and further meeting has been arranged for September. Consideration is being given to reviewing current Follow up protocols to ensure they are effective and the use of alternative follow up frameworks including virtual clinics and non face to face clinics as part of the out patient transformation project.

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

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**3,715**	4	378	161	713	391	468	360	351	245	39	388	217
7-13	**2,891**	4	325	136	511	369	371	239	232	145	32	298	229
14-17	**1,095**	0	137	46	188	118	123	80	68	69	11	142	113
18-26	**832**	0	61	23	212	73	66	45	17	36	4	82	213
27-39	**195**	0	4	10	74	7	4	3	4	4	0	4	81
40-47	**6**	0	0	0	3	0	0	0	0	0	0	0	3
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8,734**	8	905	376	1,701	958	1,032	727	672	499	86	914	856

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,701**	8	840	343	1,412	878	962	679	651	459	82	828	559
18 and over	**1,033**	0	65	33	289	80	70	48	21	40	4	86	297
Target for RTT Trajectory	**846**	0	72	47	252	44	50	48	30	38	2	49	306
Target for RTT 92%	**698**	**0**	**72**	**30**	**136**	**76**	**82**	**58**	**53**	**39**	**6**	**73**	**68**

Month End RTT %	**88.17%**	**100.00%**	**92.82%**	**91.22%**	**83.01%**	**91.65%**	**93.22%**	**93.40%**	**96.88%**	**91.98%**	**95.35%**	**90.59%**	**65.30%**
31/07/2019 Trajectory RTT %	90.31%	96.70%	92.01%	87.48%	85.17%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	64.20%
Variance from Target to meet Trajectory	187	0	-7	-14	37	36	20	0	-9	2	2	37	-9
Variance from target 92%	335	0	-7	3	153	4	-12	-10	-32	1	-2	13	229

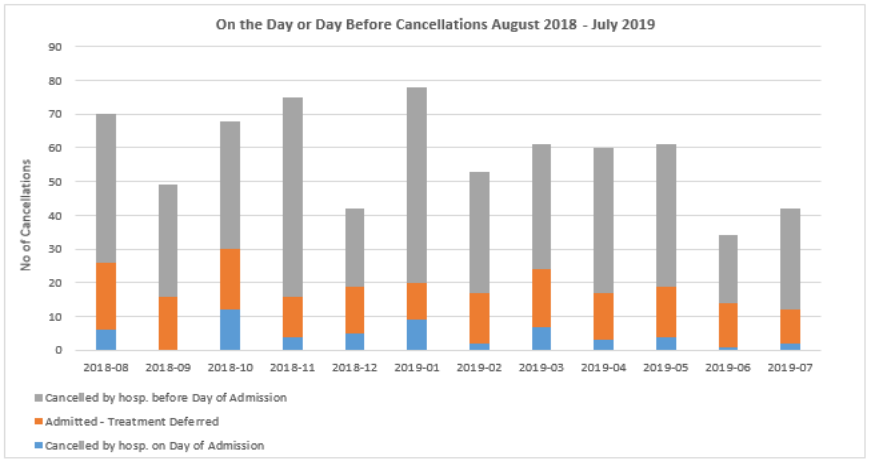


INFORMATION
The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. The current trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019. This trajectory is currently being revisited in line with current capacity challenges relating to reduction in ADH capacity. The July position is **88.17%** lower than NHSI trajectory forecasted position of **90.31%.** The position from last month therefore remains stable notwithstanding the ongoing activity challenges. In July the Trust had **0** patients over 52weeks. There are **6** patients over 40 weeks against last month's position of **26.** In July Arthroplasty ,paediatrics, Hands, F&A, Oncology met the 92% target. An updated briefing paper was included in the F&P pack for full details of the recovery plan. Detailed activity monitoring by individual specialty is shared weekly with the Executive Team and F&P Committee
ACTIONS FOR IMPROVEMENTS / LEARNING
We failed to meet the June performance for 62 day standard. This is due to 1 patient breaching as he was treated on day 85 of his pathway. The delay was down to additional pathology tests to confirm diagnosis and second opinion from American histopathologist. 28 day FDS continues to achieve 80%.
RISKS / ISSUES
Post paediatric transition, risks around delivery of cancer pathways at BCH to be reviewed and updated to ensure there is oversight and mitigations in place.

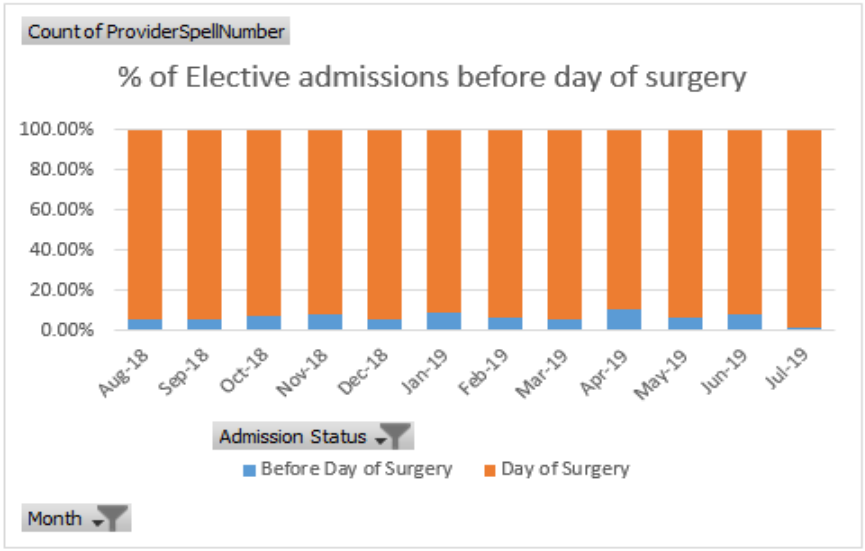
19. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

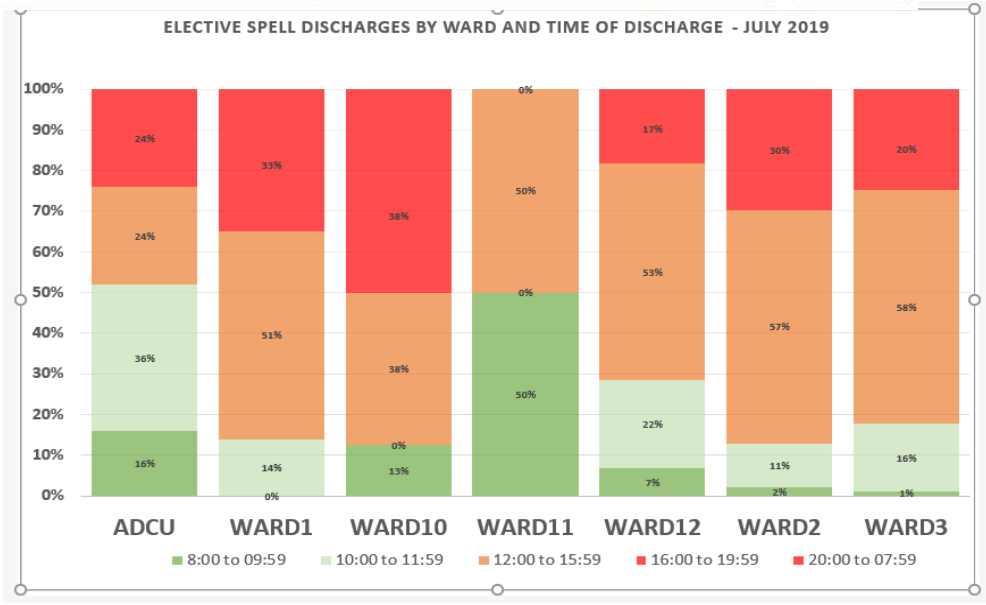
Hospital Cancellations

Admission the day before surgery



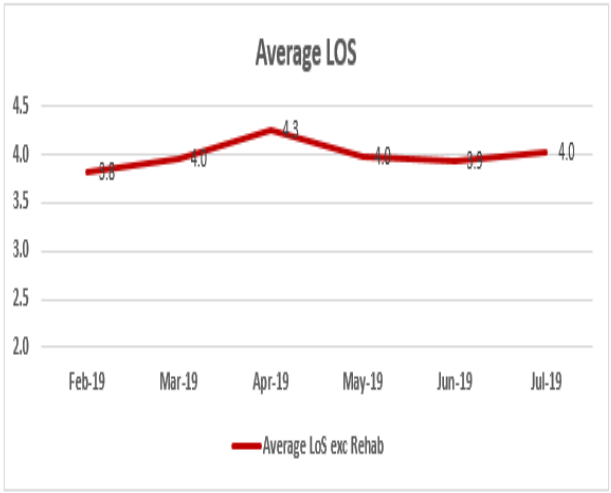
Sum of Total	Cancellation Categ				
Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
2018-08	6	20	44	70	0
2018-09		16	33	49	1
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	43	60	0
2019-05	4	15	42	61	0
2019-06	1	13	20	34	0
2019-07	2	10	30	42	
Grand Total	55	175	463	693	1

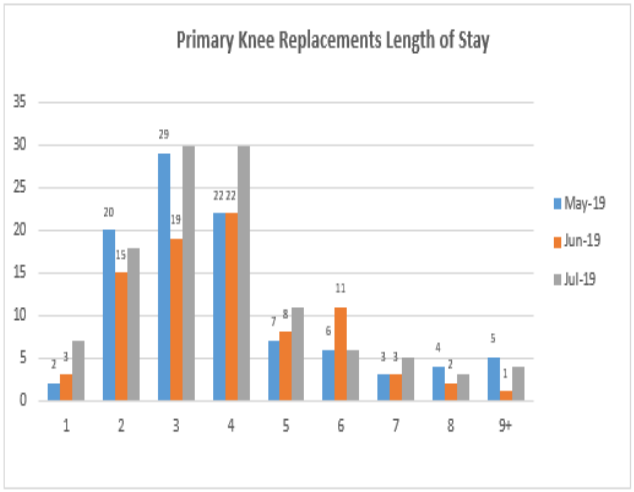


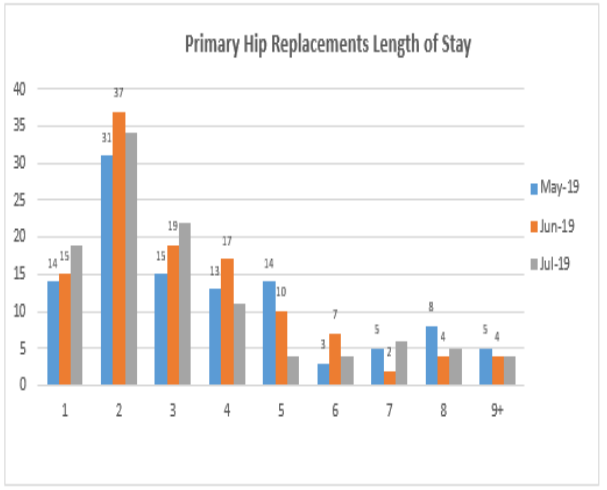


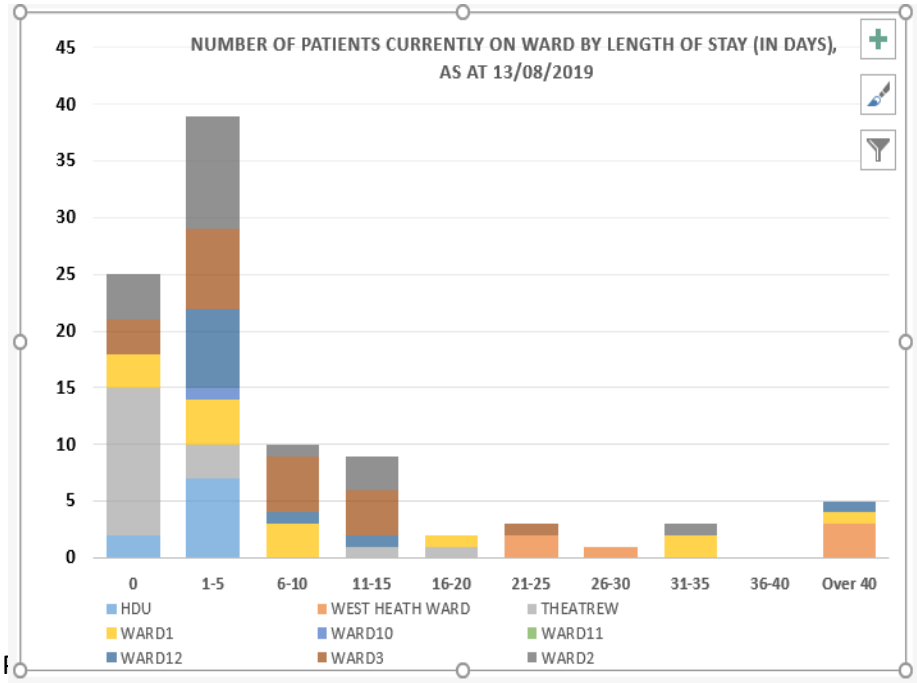
INFORMATION
The number of cancellations on the day of admission for surgery in July was 12 patients. Analysis of these cancellations on the day identified that 3 patients were cancelled due to equipment, 4 for lack of theatre time, 3 for an emergency patient, and 2 were administration error. Therefore 10 patient cancelled on the day overall. Cancellations before the day of surgery for July were 30 which has increased since last month but this remains below the last 12 month average of 39. An analysis of the 30 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, and patient medically unfit following preassessment. The 72 hour call to patients continues as business as usual and continues to work well. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance. The escalation process has also been strengthened to ensure any cancellations are picked up in a timely manner. A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.
ACTIONS FOR IMPROVEMENTS / LEARNING
As a result of POAC now attending the morning huddle, escalation processes improvements and the SOP for bookings implemented, this has resulted in better communication between POAC and secretarial teams
RISKS / ISSUES
The Managed Service Contract is progressing to completion.

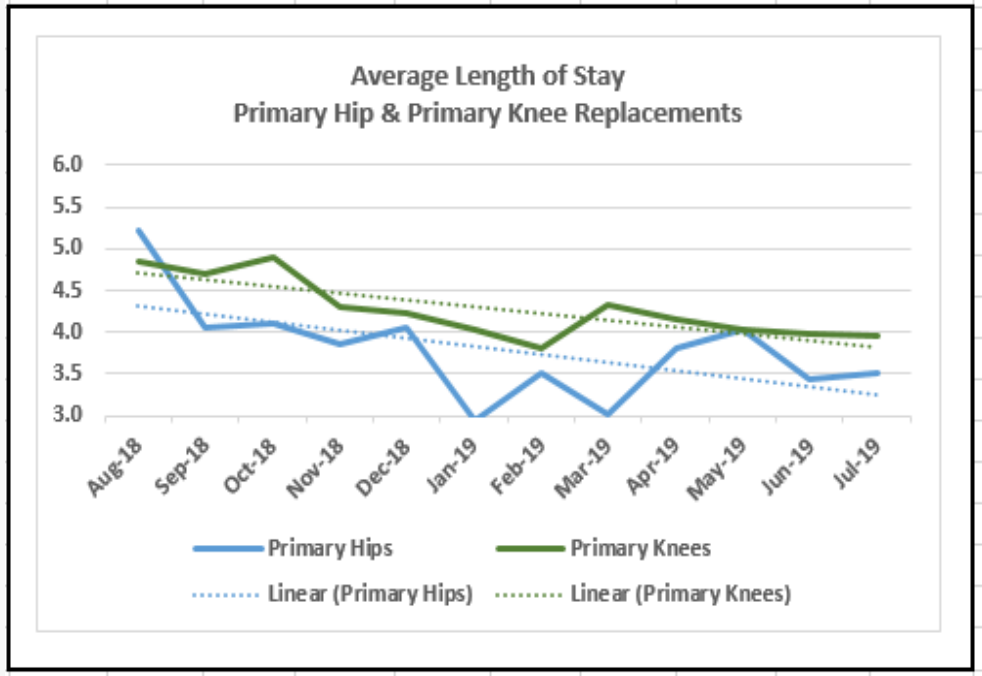
20. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION
Average LOS in July has risen from 3.9 to 4 days July's data includes a considerable number of patients requiring social packages and additional medical needs that impacted on the average LOS in month. The overall trend remains a falling LOS for primary hips and knee patients.
ACTIONS FOR IMPROVEMENTS / LEARNING
There are a number of initiatives agreed to refocus reduction in length of stay including: A weekly review by Division 1 Operations team into LOS and activity. A review of the Red to Green data as it matures as a dataset (trends are POC on Ward 1, physio assessment IV Abs and x-ray on Ward 2, wound reviews on Ward 3 and POC on Ward 12. Daily review of patients with LOS greater than expected LOS. With the support of the Medical Director renew need for senior review on a daily basis on every patient (currently auditing senior review). Continue to utilise Discharge Lounge – noting that usage has increased month on month. The joint care data is now to be included in the integrated board which is being developed. To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Out of hours roaming Admin to support timely discharge. Pathology issues still being raised via Ulysses when delays occur and escalated appropriately – no current issues identified. Review LOS dataset combining with GIRFT dataset looking at LOS against prevalent operation codes in speciality.
RISKS / ISSUES
A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity . Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Patient Experience Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh; Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Stacey Keegan; Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**4th September 2019**

EXECUTIVE SUMMARY:

The Royal Orthopaedic Hospital NHS Foundation Trust has, year on year, been found to be within the top NHS Trust's for positive patient experience (National Inpatient Survey); again, this year being reported as achieving 'much better than expected', demonstrating consistently high levels of positive patient experience (2018).

The process of involvement at the Royal Orthopaedic Hospital NHS Foundation Trust has been established for many years and there are many examples of good practice already evident. What has been missing is a cohesive approach to ensure all the good work already being undertaken is captured and built upon to create a fully inclusive experience across all areas of the Trust.

This report outlines the key documents and activities completed to form the Trust's Involvement, Experience and Volunteering Strategy (2019-2021); the governance framework to support patient experience and an update on progress made to date.

REPORT RECOMMENDATION:

The report is to assure the Trust Board, and they are asked to:

- Note and 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		

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

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

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

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

Aligned to the Trust Strategy, and the CQC Responsive action plan.

PREVIOUS CONSIDERATION:

Quality and Safety Committee.

FOR INFORMATION
FOR ASSURANCE

ROHTB (9/19) 006 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

PATIENT EXPERIENCE UPDATE

REPORT TO THE TRUST BOARD SEPTEMBER 2019

1 INTRODUCTION

Good experience of, and involvement in care, treatment and support is an essential part of an excellent health service, alongside its clinical effectiveness and safety.

Improving patient experience is not simple. As well as effective leadership and a receptive culture, Trust's need a whole systems approach to collecting, analysing, using and learning from patient feedback for quality improvement. Without such an approach it is almost impossible to track, measure and drive quality improvement.

The Royal Orthopaedic Hospital NHS Foundation Trust has, year on year, been found to be within the top NHS Trust's for positive patient experience (National Inpatient Survey); again, this year being reported as achieving 'much better than expected', demonstrating consistently high levels of positive patient experience (2018).

The process of involvement at the Royal Orthopaedic Hospital NHS Foundation Trust has been established for many years and there are many examples of good practice already evident. What has been missing is a cohesive approach to ensure all the good work already being undertaken is captured and built upon to create a fully inclusive experience across all areas of the Trust.

As an NHS Trust there are a number of legal requirements which must be considered and fulfilled;

- We have a legal responsibility under the terms of the Health and Social Care Act (2008) to ensure that we make arrangements to involve the users of our services either directly or through representatives.
- Take account of the NHS Constitution, ensuring patients have greater control of their care, be involved in decisions about their care and be involved in the development of services.
- Ensure we fulfil the Care Quality Commission (CQC) standard, regulation 9: person-centred care.
- Offer all patients the opportunity to provide feedback via the mandated Friends and Family Test (FFT).
- Undertake annual Patient Led Assessments of the Care Environment (PLACE), involving patient assessors who have received appropriate training and support.

Following the Care Quality Commission (CQC) inspection in January 2018, and their subsequent report that was published in May 2018 they found that "the Trust had improved patient and public engagement since our last inspection however; the Board recognised further work was required including a formal engagement strategy".

The Deputy Director of Nursing and Clinical Governance took the lead on the improvement actions required relating to patient experience following her appointment in July 2018.

2 PATIENT EXPERIENCE IMPROVEMENT FRAMEWORK

NHS Improvement published the Patient Experience Improvement Framework in June 2018; the framework is designed to enable organisations to carry out a diagnostic to establish how far patient experience is embedded in its leadership, culture and operational processes. It is divided into six sections, each sub-divided and listing the characteristics and processes of organisations that are effective in continuously improving the experience of patients.

The framework was developed using the NHS Trust Development Authority (TDA) *patient experience development framework* (which was co-produced with over twenty Trust's) and the National Quality Board (NQB) *Improving experiences of care: our shared understanding and ambition* (2015).

The Patient Experience Improvement Framework supports NHS Trust's to achieve good and outstanding ratings in their Care Quality Commission (CQC) inspections.

The framework should be implemented using quality improvement methodology and embracing the principle of continual learning.

In November 2018, the Deputy Director of Nursing and Patient Services Manager undertook an initial self-assessment of the standards outlined in the framework and RAG rated the Trust against each standard providing our current position and high-level actions that were required to meet each standard. The self-assessment was then shared with the Patient and Carer Forum and the Clinical Quality Group and through consultation with frontline staff the document was revised incorporating all feedback.

Gaps within the findings of the self-assessment consisted of:

- An absence of a Trust Strategy co-produced with patients and frontline staff, consulted upon, and signed off by the Board.
- A strategic patient experience forum that oversees delivery of a strategy workplan and provides Board to ward reporting.
- Patient experience that is fully aligned with and integral to quality improvement.
- Analytical and intelligence support for all patient experience data that is helpful for frontline staff to use.

- Patient experience embedded in all aspects of leadership development and in the Trust's approach to all staff training.
- Patients and service users being involved in the design stage of any service change with evidence of co-production.
- Communication strategies being in place about how we share information about patient experience.

The assessment and gap analysis provided the Trust with a basis to inform the Trust's Strategy.

4 HEALTHWATCH BIRMINGHAM QUALITY STANDARD

Alongside the NHS Improvement Patient Experience gap analysis, the Trust engaged with Healthwatch Birmingham to gain their expertise in patient and public involvement. Healthwatch Birmingham developed a Quality Standard for using patient and public insight, experience and involvement to reduce health inequality. The Standard provides Trusts with a framework for ensuring that patient and public involvement is carried out to the highest standards. The Standard outlines 'what good patient and public involvement looks like' and is supported by a tool to enable Trust's to benchmark their current patient engagement activity.

In conjunction with Healthwatch Birmingham the Deputy Director of Nursing and Clinical Governance and Patient Services Manager completed their benchmarking tool, self-assessing the Trust and current services against their objectives. This resulted in a Patient and Public Insight, Experience and Involvement action plan, this again provided structure and a methodical approach to the priorities for the Trust Strategy and workplan.

5 INVOLVEMENT, EXPERIENCE AND VOLUNTEERING STRATEGY 2019-2021

The Trust's Involvement, Experience and Volunteering Strategy was approved at the Quality and Safety Committee on the 30th January 2019. The Strategy articulates our vision for the development of effective involvement strategies for patients, carers, families, partners and volunteers over the next three years.

Our aim is and has been to develop a truly inclusive culture where patients become partners not only in their care, but in the development of services, pathways and facilities, with our ultimate aim being to further enhance and ensure a positive experience.

The Strategy has been developed by:

- Guidance documents and requirements that as an NHS Foundation Trust we must consider and fulfil.
- The views and ideas from volunteers, patients and the public following an engagement event held in December 2018, seeking to understand 'what matters to them'.
- Our Patient and Carer Forum.

- Gaining the views from and involving our staff with the consultation on the draft document.
- Undertaking and incorporating the findings from the NHS Improvement (2018) Patient Experience Improvement self-assessment tool.
- Undertaking and incorporating the findings from Healthwatch Birmingham's Quality Standards for Patient and Public Involvement.
- Discussion and feedback from our Clinical Commissioning Group (CCG) Patient Experience lead.
- A review of CQC rated 'outstanding' organisations and their Patient Experience Strategy(s).

Following this engagement and involvement with stakeholders, the Trust identified seven key strategic objectives for 2019-2021;

We aim to work in partnership with patients, carers, families and volunteers to:

1. Support us to develop internal governance systems which ensure that patients, carers, families, partners and volunteer views are sought and used to influence every decision relating to service development and delivery.
2. Develop services which meet the needs of patients, carers, families, partners and volunteers.
3. Ensure we have engagement routes which are easily accessible to patients, carers, families, partners and volunteers and the views and experiences collected from them are representative of the patient population.
4. Listen and respond to feedback at the earliest possible opportunity.
5. Involve, support and communicate with carers.
6. Redesign our Volunteer Service to ensure that the services provided align with this Strategy and that volunteers play a key role in the Trust.
7. Demonstrate and share the impact of the changes that this Strategy will make and celebrate our success.

The full Involvement, Experience and Volunteering strategy can be found in appendix 1; this document outlines how we propose to achieve our objectives and commitments.

6 PATIENT ENGAGEMENT AND EXPERIENCE GROUP

To strengthen the governance framework and oversight of patient involvement and experience in the Trust, the first Patient Engagement and Experience group was held in May 2019. This meeting is chaired by the Deputy Director of Nursing and Clinical Governance and takes place on a monthly basis.

The Accountable Executive lead is the Executive Director of Nursing and Clinical Governance.

The purpose of the group is to provide assurance to the Quality and Safety Committee of patient, public and carer involvement and experience within the Trust; this is done via a quarterly upward report. The diagram below outlines the reporting structure.

Current Terms of Reference are in place and membership consists of internal and external stakeholders, both clinical and non-clinical, patients and public Governors.

7 STRATEGY PROGRESS TO DATE

- Trust Strategy launch in planning, both internally and externally with our Clinical Commissioning Group (CCG), anticipated September 2019.
- Review of and recruitment to the Patient and Carer Forum; reviewing other engagement and involvement mechanisms.
- Carers Policy written, approved and launched, with Carers week being promoted at the Trust in conjunction with and involvement from Birmingham Carers Hub.
- Reintroduction of the 'Real Time Patient Survey'; providing the Trust with the ability to monitor specific actions from department themes, National Inpatient Survey actions, projects etc.
- Complaints handling and training for Divisional teams; reviewing the complaints process to ensure Divisional and clinical ownership to embed and sustain improvements from patient feedback.
- JointCare reunions; involving patients in changes to pathways and design, and gaining feedback face to face.
- Launch of a Learning Disability User Group; first meeting held in August 2019, enabling patients to shape learning disability care at the Trust.
- Healthwatch Birmingham, patients experience of hospital waiting rooms; the Trust took part in their study and this evaluated positively.
- Engagement with Helpforce, a National learning network, to aid our development of an innovative volunteer service to improve patient and staff experience.

8 RECOMMENDATION

The Trust Board is asked to:

1. Note and accept the report.

Stacey Keegan; Deputy Director of Nursing and Clinical Governance.

29th August 2019.

ROHTB (9/19) 006 (b)

The Royal Orthopaedic Hospital NHS Foundation Trust

Involvement, Experience and Volunteering Strategy 2019-2021

Executive Summary

This Strategy articulates our vision for the development of effective involvement strategies for patients, carers, families, partners and volunteers over the next three years. It has been developed with the views of patients and the public and best practice from outstanding NHS Organisations, partner organisations including Healthwatch and NHS Improvement guidance (2018). We aim to develop a truly inclusive culture where patients become partners not only in their own care, but in the development of services and facilities.

We aim to work in partnership with patients, carers, families, partners and volunteers to:

1. Support us to develop internal governance systems which ensure that patients, carers, families, partners and volunteer views are sought and used to influence every decision relating to service development and delivery.
2. Develop services which meet the needs of patients, carers, families, partners and volunteers.
3. Ensure we have engagement routes which are easily accessible to patients, carers, families, partners and volunteers and the views and experiences collected from them are representative of the patient population.
4. Listen and respond to feedback at the earliest possible opportunity.
5. Involve, support and communicate with carers.
6. Redesign our Volunteer Service to ensure that the services provided align with this Strategy and that volunteers play a key role in the Trust.
7. Demonstrate and share the impact of the changes that this Strategy will make and celebrate our success.

Introduction

The process of involvement at the Royal Orthopaedic Hospital NHS Foundation Trust has been established for many years and there are many examples of good practice already evident. It is clear that there is much good will and positive relationships within the Trust.

What has been missing is a cohesive approach to ensure that all of the good work already being undertaken is captured and built upon to create a fully inclusive experience across all areas. This Strategy is designed to support this vision.

Involvement starts with our staff. We are rightly proud of our previous work, but we are ambitious to build on the existing foundations, to strengthen partnerships and to keep our focus on changing services, organisational culture and to be the first choice for Orthopaedic Care.

This Strategy takes into account the things we must do as an NHS Organisation to implement the new Patient Experience Improvement Framework, published by NHS Improvement in June 2018.

It also incorporates the information supplied by 83 patients and members of the public who provided their views about what is important to them when they come to the hospital during a consultation event undertaken in December 2018.

Our approach embodies our core values as a Trust. We want and welcome our patients, carers, volunteers, partners and staff to engage with us to truly shape our facilities going forward and to develop our services of the future.

Patients have told us that they want:

- Staff that are kind, compassionate and listen to their concerns with empathy.
- To not feel rushed and to be communicated with in a manner that they understand.
- To be involved in decisions about the hospital that affects them.
- To be allowed to offer suggestions for solutions to issues affecting them.
- An increased focus on issues that matter to them personally such as mental health and support for their carers.

Volunteers have told us that they want:

- To be as involved as much as possible with activities that improve patient visits.
- To be allowed to do more activities, including those that involve providing aspects of care where appropriate.
- To feel part of the team that they work in.

The Trust has also undertaken a benchmarking assessment of the current position using two tools; the NHSI Patient Experience Improvement Self-assessment Tool and the Healthwatch Birmingham's Quality Standards for Public and Patient Involvement. These have been amalgamated to provide a baseline which will inform the specific actions under each objective of this Strategy.

In addition, the Patient and Carer forum have been integral to the development of the approach of this strategy. We aim to continue discussions with all of our partners and patients throughout the life of this Strategy to ensure that our plans remain relevant and our objectives are realised.

As an NHS Organisation, there are a number of requirements and guidance documents which must be considered and fulfilled;

- We have legal responsibilities under the terms of the Health and Social Care Act (2008) to ensure that we make arrangements to involve the users of our services, either directly or through representatives (this can be in any suitable way, including provision of information and consultation).
- We must ensure that we meet the Care Quality Commission Standard (Regulation 9: person-centred care) around involvement in care and shaping services. We must also ensure that the quality of our services are monitored using suitable feedback methods.
- We must offer all patients the opportunity to provide feedback via the Friends and Family Test.
- We must undertake PLACE assessments (Patient Led Assessments of the Care Environment) every year and these must involve patient assessors, who have received appropriate support and training.
- We must take account of the NHS Constitution that states that the patient should have greater control over their care, including being involved in decisions about care and development of services.

Our Strategic Objectives 2019-2021

1. **Support us to develop internal governance systems which ensure that patients, carers, families, partners and volunteer views are sought and used to influence every decision relating to service development and delivery.**
    - Creation of a Trust Group/Committee for Involvement, Engagement and Volunteering to ensure that all three aspects are considered in conjunction with each other.
    - Ensure the membership of the Group/Committee represents all patient groups, for example Learning disabilities.
    - Involve our Volunteers, Commissioners and Healthwatch Birmingham in the Group/Committee.
    - Link the work of the Group/Committee to the Patient and Carer forum.
    - Ensure a Ward to Board reporting structure.

- Create a central database of all involvement activity as a resource for professionals wishing to gather feedback.
- Ensure patient engagement and experience Key Performance Indicators (KPIs) are monitored and reported for all departments.
- Patient involvement and experience will form part of mandatory training for all staff, ensuring that patient and carer experience is a key part of Learning and Development through induction, staff development programmes and support to teams.

2. **Develop services which meet the needs of patients, carers, families, partners and volunteers.**
    - The Trust will develop a more co-ordinated and strategic approach to working with patients, carers and volunteers to shape services.
    - All services will be expected to discuss service/pathway changes with patients, carers and other interested parties during the planning phase to ensure genuine co-production.
    - We will seek to involve patients in the Commissioning processes of the Trust.
    - Patient Involvement must be recorded and should be approved at the Patient Engagement and Experience Group.
    - The Trust will explore the involvement of patients, carers and volunteers in initiatives designed to improve the quality of care provided such as recruitment, staff induction and quality walk-arounds.

3. **Ensure we have engagement routes which are easily accessible to patients, carers, families, partners and volunteers and the views and experiences collected from them are representative of the patient population.**
    - Review engagement routes and methods across the Trust to ensure different options are available that are easily accessible for all.
    - Develop systems for routinely collecting and recording demographic information from all patients, carers, families, partners and volunteers sharing their views and experiences.
    - Carry out a comparison analysis on an annual basis of patient engagement and patient demographic data to identify underrepresented groups.
    - Develop specific engagement plans to ensure seldom heard groups have an opportunity to share their views and experiences.
    - Develop a variety of engagement routes to support inclusion, e.g. questionnaires, online surveys, focus groups, online discussion groups and Healthwatch Birmingham Feedback Widget.

4. **Listen and respond to feedback at the earliest possible opportunity.**

- All teams will collect and respond to feedback. We will focus on areas where there are known concerns or where feedback is appearing difficult to collect.
- All feedback will be collated and analysed.
- All FFT feedback will be published on the Iwantgreatcare website.
- All services will be expected to use their feedback to identify any areas of good practice and concern. Changes made to services as a direct result of feedback will be recorded and publically shared on our website.
- Stories from patients, carers and families will be used throughout the Trust to illustrate the quality of our services, identify areas for improvement and celebrate good practice.

5. **Involve, support and communicate with carers.**
    - We will implement our new Carer Policy.
    - Carers will be involved in the provision of care for their loved one whilst in the Trust as much as possible in line with the carer, family and patient's wishes.
    - Services will be expected to show how they have explicitly sought the views of carers when discussing service development or changes.
    - Carer information and signposting will be visible within the Trust.

6. **Redesign our Volunteer Service to ensure that the services provided align with this Strategy and that volunteers play a key role in the organisation.**
    - We will promote volunteering in a way that ensures we attract a diverse mix from our local communities.
    - We will work to ensure our volunteers feel part of the team and their skills fully utilised.
    - A co-ordinated approach to volunteering across the Trust with clear recruitment, training, support, and role descriptions so that volunteers can play a valuable role safely and effectively across the full breadth of our services; both clinical and non-clinical.
    - We will review our current roles in line with Volunteering England and NHS Improvement guidance to ensure that we are offering the best opportunities for the benefit of our patients as well as our volunteers.
    - We will ensure that all volunteers are suitably trained for the roles that they undertake.
    - We will explore virtual volunteer opportunities to allow a wider pool of people to actively engage with the Trust.

- We will further develop our volunteer programmes to ensure that volunteers can use their service as a stepping stone into different opportunities, careers and experiences if this is their aim.
- We will ensure volunteer presence at the Patient Engagement and Experience Group.
- We will raise the profile of the volunteer service within the hospital and ensure that their work is openly shared and visible.

7. **Demonstrate and share the impact of the changes that this Strategy will make and celebrate our success**
    - Develop a range of quantative and qualitative measures to demonstrate the impact of involvement, experience and volunteering.
    - Stories from patients, carers and their families will be used throughout the Trust – for example in staff meetings, in Trust publications and the website. These will demonstrate the quality of our service, identify areas of improvement and share poor and good practice.
    - We will explore the use of social media within Patient Involvement.
    - We will regularly publish information both internally and externally about the work being undertaken.

Impact

Successful delivery of this Strategy will enable the Trust to fulfil its commitment to work in partnership with patients, carers, families, partners and volunteers to shape our services of the future. We will measure to evidence:

- Involvement has helped shape future services or our policies, practices, new facilities or services which meet the specific needs of patients, carers, families, partners and volunteers.
- Involvement has led to increased and improved engagement with Trust staff, patients, carers, families, partners and volunteers.
- Feedback has led to changes in services which meet the specific needs of patients, carers, families, partners and volunteers.
- Volunteers feel that their contribution has made a difference leading to greater volunteer satisfaction.
- Carers feel that their input is heard and valued.
- Trust Staff feel that involving patients, carers, families, partners and volunteers has made a positive difference to their working environment.

Evaluation

We will undertake the following actions to ensure that this Strategy is effectively implemented, reviewed and monitored:

- Engage with patients, carers, families, partners and volunteers on an annual basis to evaluate whether objectives outlined within this Strategy have successfully been implemented.
- Routinely evaluate changes made as a result of patient or carer involvement to ensure service improvement.
- An annual work plan will be created for the Patient Engagement and Experience Group to oversee the actions identified in the benchmarking exercise and this Strategy.
- The work plan will be monitored by the Patient Engagement and Experience Group with monthly exception reporting made to the Quality and Safety Committee.
- Updates on the progress of the Strategy will be made to the Trust Board quarterly.
- Progress will be published on the Trusts website every six months.

Stacey Keegan; Deputy Director of Nursing and Clinical Governance.

Lisa Kealey; Patient Services Manager.

16th January 2019.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Complaints report 2018/19**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh; Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Lisa Kealey; Patient Services Manager**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

Successful resolution, smooth handling and learning from complaints will improve the quality of services that the Trust provides. Accurate adherence to the Policy, based on Good Practice guidelines and changes to the regulatory and monitoring processes will minimise reputational and financial risks to the Trust as a result of complaints.

This report provides assurance that the requirements of the NHS Complaint Regulations 2009 have been met, through the production of a Trust Annual Complaints report.

The report provides an overview of the complaints process, the numbers and trends in complaints, actions taken as a result of and learning from complaints. It will also provide a summary of achievement against the complaint priorities for 2018/19 and outline the complaints priorities for 2019/20.

Of note, there has been a 7% decrease in complaints during the year to 137, compared with 148 the previous year.

All internal and external agreed Key Performance Indicators for the year were met.
All complaints were risk-rated in line with the Trust's Risk Management Guidelines.
The level of satisfaction with the way we have handled complaints has remained high.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- Note the annual complaints report
- Approve the report and its publication

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Safe and efficient processes that are patient centred.
PREVIOUS CONSIDERATION:
Executive Team on 6 August 2019 and Quality & Safety Committee on 28 August 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Annual Complaints Report 2018/19

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 regards to complaints received by the Royal Orthopaedic Hospital NHS Foundation Trust between 01/04/2018 and 31/03/2019. 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 2018/2019 were agreed as listed below:

- 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.

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 Deputy Director of Nursing. The Executive Director of Nursing & Governance 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. Compliments, PALS Concerns and FFT Concerns are also entered on the same module. This has enabled more accurate and responsive trend and theme analysis across all Patient Experience data 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 process is still heavily reliant on the Patient Services Team and the management and ownership of complaints within the Directorate will form part of the developmental work in 2019 /2020

5.0 Number of complaints

In 2018/2019, ROH received 138 formal complaints. 1 was withdrawn leaving a total of 137 to be investigated and formally responded to.

Figure 1 below shows the total number of formal complaints received over a three-year period.

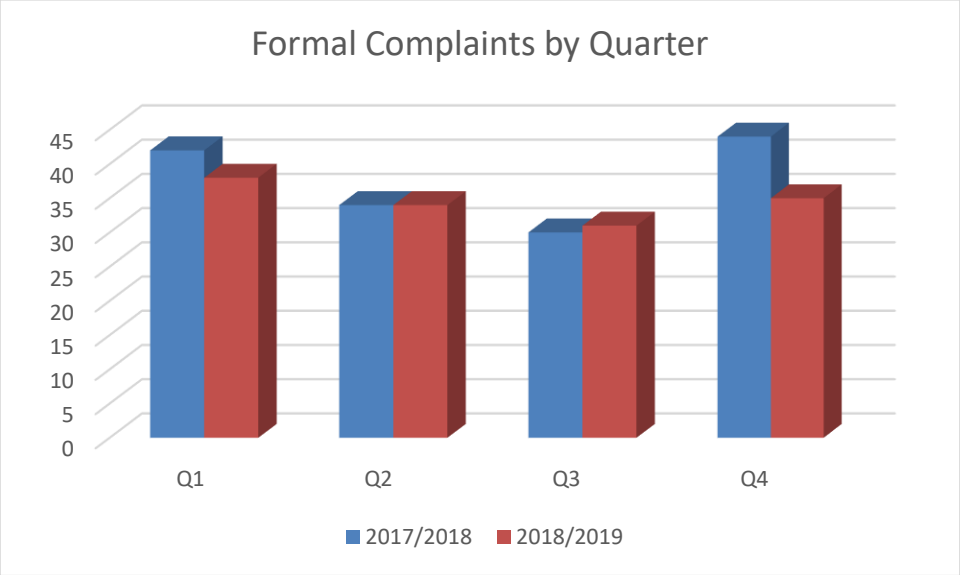
Figure 1: Numbers of complaints received 2018/2019

Formal Complaints	2016/2017	2017/2018	2018/2019
	167	148	137

Formal complaints experienced a 7% decrease compared to the previous year

Figure 2 details the number of complaints by quarter in 2018/19 with the previous year's data for comparison.

Figure 2: Number of complaints by quarter

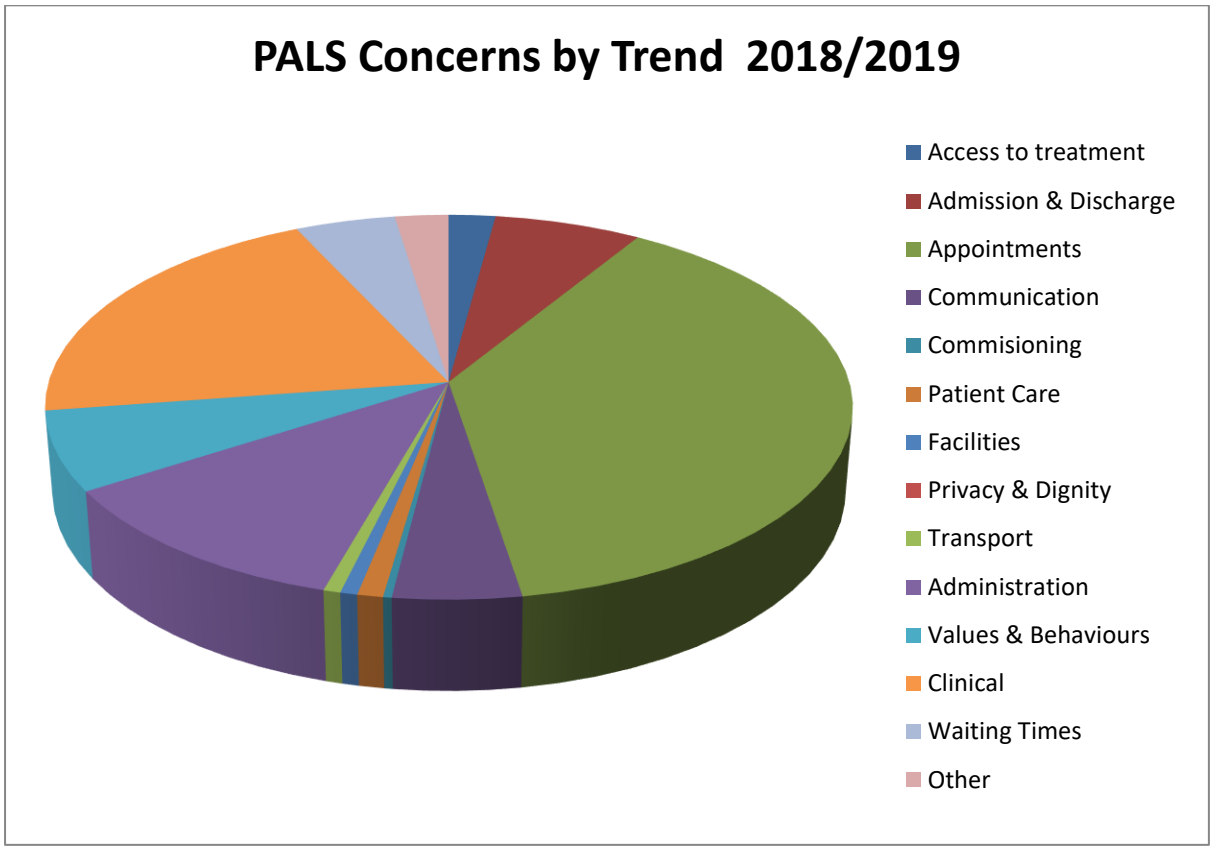


6.0 PALS Contacts during 2018/2019

The PALS department has handled 1531 individual contacts in the last twelve months, which has greatly reduced as planned from last year, due to the removal of the PALS number from every letter leaving the Trust. This was identified as not helpful for patients as the majority of the calls were enquiries, which needed to be passed onto other departments, resulting in a less efficient service for patients. The letters were changed to ensure that patients are signposted to the right service for help, thereby streamlining their experience and leaving the PALS department to manage calls relating to concerns and assistance more effectively. This has been achieved; 41% of PALS calls this year were concerns that required more assistance, compared with 22% the previous year.

Figure 3 below shows the themes recorded for PALS Concerns in the year.

Figure 3: Number of PALS Concerns by Trend



The most common concerns expressed via PALS in 2018/2019 were:

- Appointments: including length of wait for appointments and cancellations
- Clinical advice: including pre and post- operative advice/questions
- Administration queries: including clinic letters and referral letters

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 2018/2019

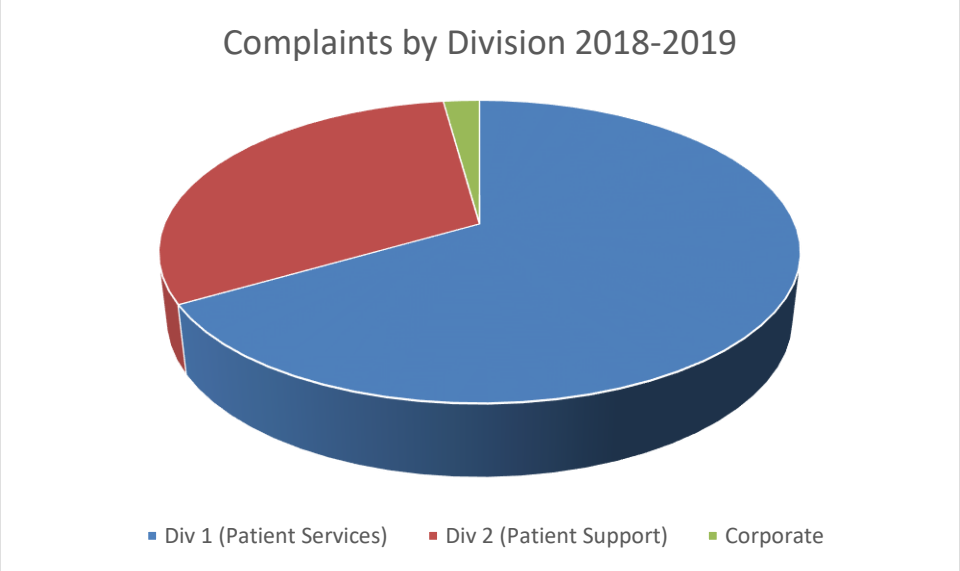
	2018/2019	2017/2018
Inpatient Attendances		
Inpatient Complaints	57	74
Inpatient Episodes	14,444	14,646
Complaints per 100 inpatient episodes	0.39%	0.51%
Outpatient Attendances		
Outpatient Complaints	81	74
Outpatient Episodes	70,735	66,642
Complaints per 1000 outpatient attendance	0.11%	0.11%

The Trust has seen a decrease in Inpatient Complaints and no change in Outpatient Complaints over the year. It should also be noted however that a significant increase in outpatient appointments did not generate an increase in outpatient complaints.

8.0 Number of Complaints by Division

Figure 5 below illustrates the number of formal complaints by each Division in 2018/2019.

Figure 5: Number of Complaints by Division 2018/2019

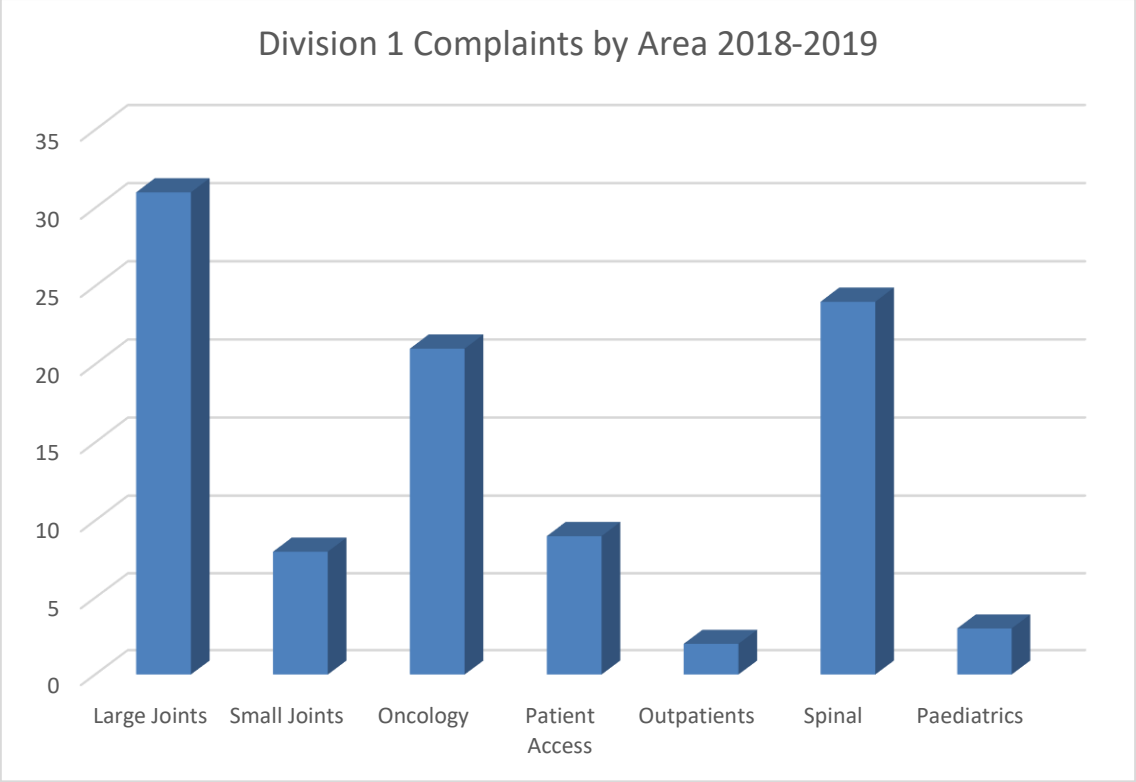


The majority of complaints (67%) relate to the Patient Services Division which is to be expected since this Division oversees all inpatient areas and outpatient departments, compared to Division 2 which oversees Theatres & HDU, the Admission and Day Care Unit, Pre-operative Assessment, all Therapy Services and all Imaging Services. This

is a slight decrease from 70% last year. The two areas with the highest number of complaints in 2018/19 were the Large Joint (19%) and Spinal Services (14%).

Figures 6 below provides an in-depth breakdown of complaints within Division 1

Figure 6: Number of Complaints by area in Division 1 2018/2019



The largest numbers of complaints in Division 1 related to concerns about the Large Joints Service (35% of Div.1 complaints this year). These related to all aspects of the service, including clinical treatment, care provided and administration processes.

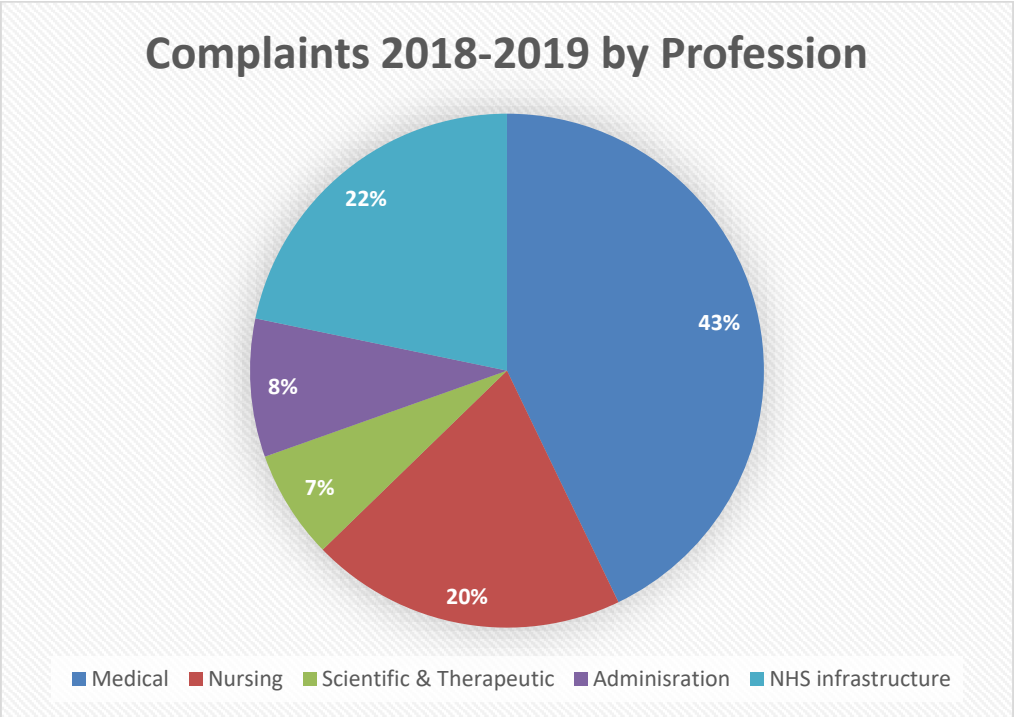
8.1 Spinal Service complaints

The spinal service has received a lower number of complaints about paediatric spinal patients this year. (17% of complaints about the spinal service in 2018/2019 relate to children and young people, compared to 46% in 2017/2018) 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.

In addition, the Trust undertook a focussed approach to ensuing that patients who had been waiting over 52 weeks for surgery were listed and treated by 2019, which has meant that people are experiencing less waiting time, which was a major source of complaint previously.

9.0 Complaints by Profession

Figure 7: Number of Complaints by Profession 2018/2019



Medical Staff were the largest professional area complained about in 2018/2019. This is reflective of the more complex and specialist activity carried out in the Trust. Many of these complaints are made by patients who have been referred from other hospital for a second or third opinion. The complaints received during this year raised concerns about surgical outcome (not happy with the result), complications (usually known, discussed and consented for), clinical opinions (different clinical opinion about condition) and treatment options (e.g. wanting surgery but this is not an option).

This is like the last two years, although the number of complaints relating to infrastructure support within the hospital has continued to increase, such as the management of referrals and typing of clinic letters) It is believed that this is related to more accurate coding of complaints, whereby long waits for appointments or rescheduling are recorded under this area, rather than to the actions of a specific administrator or clinician.

10.0 Complaints by Subject

Figure 8: Complaints by Subject 2018/2019

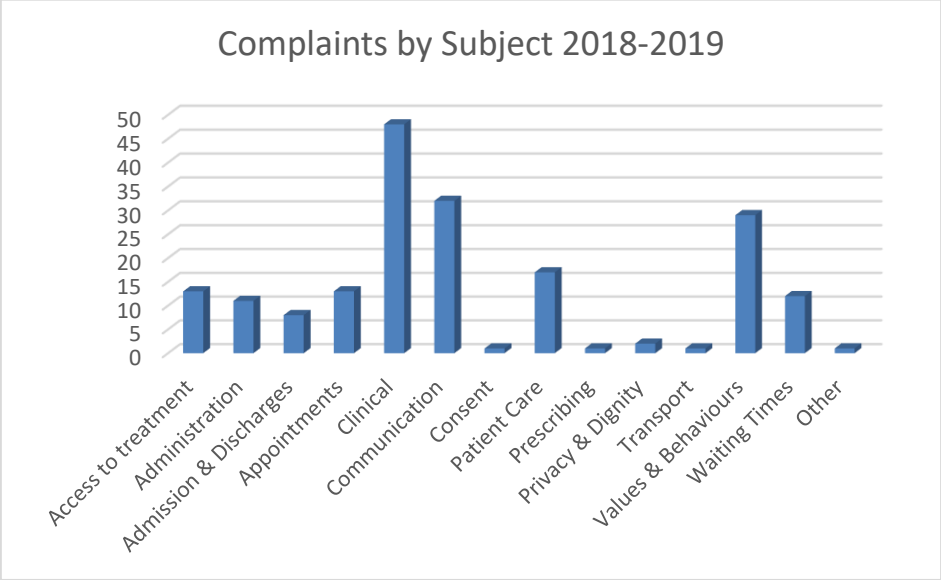
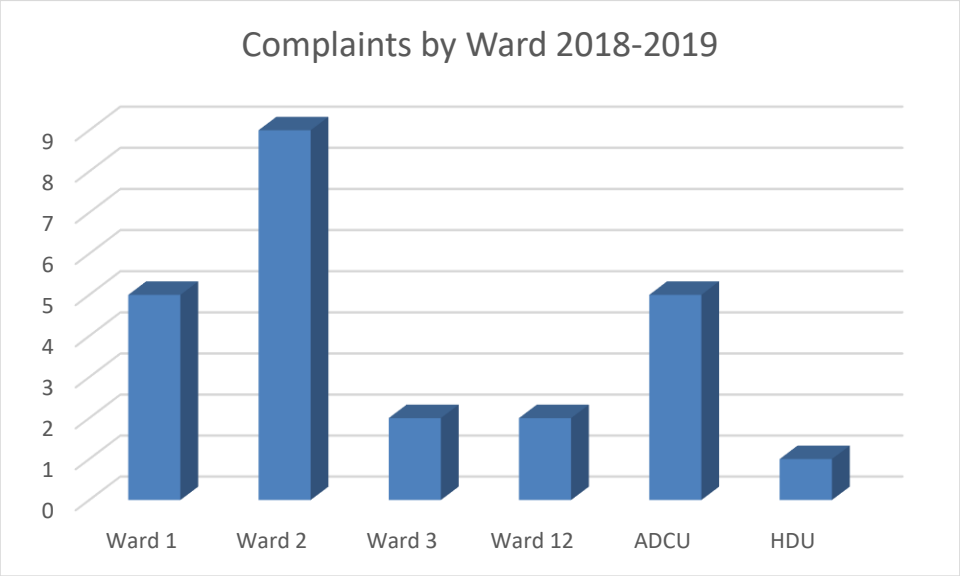


Figure 8 shows the main causes for complaints in 2018-2019, with dissatisfaction with clinical treatment, communication with patients/others and values & behaviours of staff being the highest reasons. These themes show changes from last year and as such provides some assurance that actions are being taken to address identified issues

A review of complaints mentioning values & behaviours of staff is being undertaken to identify any areas of commonality. Additional actions such as training or monitoring will be undertaken where appropriate.

11. Complaints by Ward during 2018/2019

Figure 9: Complaints by Ward 2018/2019



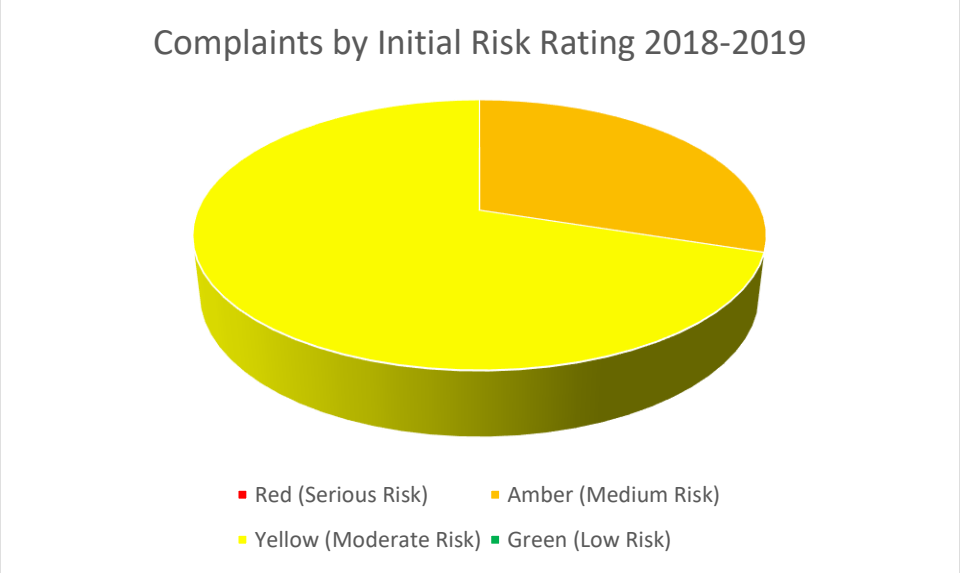
Concerns about aspects of ward care or treatment has been mentioned in 17.5% of complaints this year, which is lower than last year (24%). This local indicator was

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 to be maintained.

It should be noted that Ward 2 looked after the most inpatients in 2018-2019, which may explain the higher number of complaints received.

12. Risk Ratings of Complaints during 2018/2019

Figure 10: Initial Risk Rating of Complaints 2018/2019



The Trust has a robust system of tracking and monitoring complaints. Part of this tracking involves the logging of an initial risk rating. The Patient Services Manager monitors these risk ratings and the Deputy Director of Nursing 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 2018/19 the Trust had 2 contractual complaints KPI's which were reported to the Trust Board, via the Quality Report and the Commissioners, via contractual reporting 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 ROH complaints procedure states that an acknowledgement should be made within three 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 three. 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 2018/2019 were acknowledged verbally or by e-mail within the correct timescale, thereby meeting the KPI.

95% of complaint letters were formally acknowledged by letter within the agreed timescale. This KPI was met.

All complaints received via Commissioners were responded to within the timescale agreed with them. 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 Deputy Director of Nursing, 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 agree 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 at 93%.

14.0 Outcome of complaints made in 2018/2019

Figure 11: outcome of complaints 2018/2019

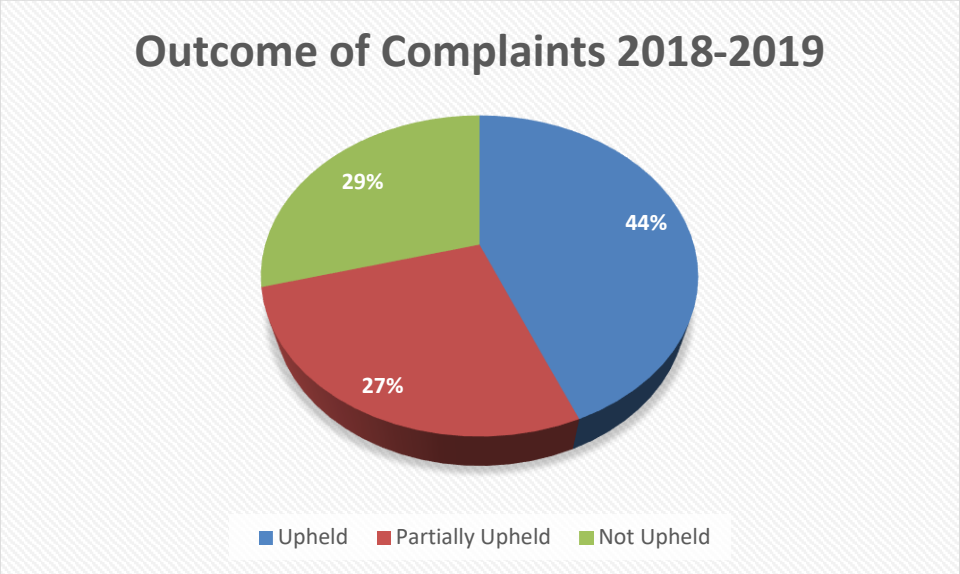


Figure 11 shows the outcome of complaints made in 2018/2019. The Trust upheld some aspects of 71% of the complaints made in this year, which is slightly lower than last year (78%). Complaints are coded in line with the guidance from NHS Digital and there may be more than one aspect in each complaint. 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 2018/2019, a total of 43 satisfaction surveys were returned by complainants representing 31% 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 handling of their complaint was 100%, which is an increase from last year. In addition, 95% of respondents indicated that they felt that the complaints staff were helpful, sympathetic and professional.

There was a reduction in complainants being happy with the time taken to answer their concerns to 65% (compared to 87% last year). This will be reviewed in 2019/2020

The information from the full satisfaction survey will continue to be reviewed and used to inform further improvement work in 2019/2020.

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 2018/2019, the PHSO requested information about 4 complaints made to the Trust. 1 was not upheld and 1 was declined by the PHSO for investigation. 2 are still under investigation currently and the outcome is not yet known.

17.0 Listening and Learning from Complaints

Patient Story

Ms X made a formal complaint about aspects of the care that she was receiving on a Ward. She was concerned about another patient opposite whom she felt was isolated and had no-one to speak up for her, which she also added into her complaint. She stated that other patients whom she had been in a bay with had the same concerns. This information was taken by the PALS Manager who had visited Ms X on the ward at her request.

The PALS Manager discussed all of the concerns with the Patient Services Manager and then contacted the Head of Nursing for Patient Services. He immediately went to the Ward concerned and discussed Ms X's concerns with her directly. He then took the opportunity to talk to all of the other patients in the same bay.

Together with the Ward Manager, the Head of Nursing took some immediate actions to offer assurance to all of the patients involved that their feedback had been taken seriously.

Ms X felt very happy that action had been taken so swiftly and was assured enough to accept that information about the other patients could not be shared with her.

As a result of Ms X's complaint and information taken from the other patients, a ward action plan was created and monitored by the Head of Nursing. This was shared with

Ms X as part of her complaint response, together with an expression of thanks for sharing her concerns which enabled corrective action to be taken.

Complaints are reviewed and signed off at senior level within the Trust 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 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 2018/2019, 12 individual action plans were created. A further 34 complaints had actions that were completed prior to the response being sent. 10 responses had actions that were part of a larger work stream and 3 had the actions incorporated into a more in-depth Governance investigation. 1 complaint resulted in a HR investigation.

Learning and actions taken as a result of Complaints in 2018/2019 include:

Learning	Action
RCA had not been completed as thoroughly as expected (historical)	RCA reviewed, redone and shared with complainant with apologies
Changes to pre-operative protocol for aspirin in spinal patients has not been communicated to pre-op	Teams have met to address this
Some miscommunication has occurred as a result of the changes to Non-Emergency Patient Transport and eligibility for reimbursement	Position has been clarified and all relevant departments notified
Stand-alone IT equipment was not all encrypted; IG threat identified when laptop was stolen	Information Commissioner notified; all patients contacted; all stand-alone equipment checked and encrypted; all security reviewed

Patients arriving for biopsy were not aware that they may be waiting for a prolonged period of time	Biopsy Leaflets are being reviewed and amended
There is a possibility that Privacy & Dignity could be compromised with the current curtains on some wards	New curtains are currently being trialled and the old ones will be replaced
Escalation process for concerns about biopsy patients to their Consultant was not robust	All biopsy patients now see the on-call Doctor before discharge
Policy for discharging DNA patient's is being applied differently in different departments	Teams have been reminded of current policy and Clinical Service Manager for Patient Access informed
Staff supplied correct information regarding safety but did so in an inappropriate manner	Reflective session undertaken and training provided
Trust did not have a SOP for the management of wound drains	SOP created and has been approved
Frist floor outpatient reception not open causes confusion for patients when told to report there	Recruitment underway; information updated

17.0 Looking ahead to 2019/2020

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 2019/2020:

- Work will be undertaken with Divisional Leads to further in-bed ownership of complaint investigation and action planning
- Complaint investigation and report writing training will be available in house for staff that require it
- The KPI of 80% of complaints completed within the agreed timescale will be achieved.
- The coding of compliments will be altered to the same system for complaints to allow for direct comparison of all Patient Experience data.

18.0 Conclusion

At the ROH, we remain committed to investigating, learning from and acting 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 2017/2018 priorities for the Complaints Department

Priority	Status	Detail
The Ulysses system will be further modified to allow all complaints reports to be pulled directly from this system.	Partially Achieved	Thematic reporting is now pulled directly and information for Departments. KO41a is still not available and will be rectified in the coming year
Complaint investigation and report writing training will continue to be provided for staff that require it.	Achieved	All Directorate Leads and Senior Staff have received training.
The KPI of 80% of complaints completed within the agreed timescale will be achieved.	Achieved	Data is submitted monthly
The coding of PALS Concerns will be altered to the same system for complaints to allow for direct comparison of the data.	Achieved	All data is now coded and shared monthly with Departments

Appendix B

Trust Risk Rating Matrix

	SEVERITY				
LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM riskRed = HIGH risk**

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Mental Health Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Lisa Newton., Matron and Nathan Samuels, Lead Nurse of Learning Disabilities and Mental Health**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

In January 2019 the Trust had a CQC inspection which highlighted gaps in the Mental Health provision within the Trust. An action plan was devised to address their findings. These actions will be discussed in this paper under the following headings

- Background
- Our Approach
- Mental Health First Aid
- Mental Health Awareness Training
- Mental Health Information and Resources
- Mental Health Policy and Procedure
- Governance
- Mental Health Incidents
- Risk Register
- Current Position

REPORT RECOMMENDATION:

The Trust Board is asked to note and receive assurance on work that has been carried out in the Trust in relation to Mental Health.

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

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

Mental Health provision in Trust included as a risk on Safeguarding risk register.
PREVIOUS CONSIDERATION:
The Quality & Safety Committee has previously been updated on the work underway to strengthen the provision of Mental Health services in the Trust.

FOR ASSURANCE

ROHTB (9/19) 008 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

Mental Health Update

Update to Trust Board on 4th September 2019

1.0 Background

In January 2018 the Trust had a CQC inspection which highlighted gaps in the Mental Health provision in the Trust.

In their report the CQC wrote:

Staff were not knowledgeable or confident in providing care to patients detained under the Mental Health Act. There was a lack of supporting information, policies and guidance for staff to follow to ensure patients additional mental health needs were met.

It went on to say:

The Trust should review their policies and procedures for caring for patients with mental-ill health including those detained under the Mental Health Act

The Trust should ensure all staff have the necessary training and understanding to appropriately care for patients with mental illness

Lisa Newton- Matron (Division 1) and Nathan Samuels- Learning Disabilities Lead were tasked with addressing these shortfalls and a CQC action plan was devised.

2.0 Our Approach

The Trust have tasked Nathan Samuels as operational Mental Health lead due to his Mental Health nursing background and experience. In addition to this the Trust have tasked Lisa Newton as Corporate Mental Health lead to provide Corporate insight and assurance around Mental Health having previously developed mental health resource within the Trust in a previous role. In September 2018, Nathan provided an initial Mental Health Action Plan which has become the foundation of the subsequent work that has been done throughout the Trust around Mental Health.

3.0 Mental Health First Aid

In their respective positions, both Nathan Samuels (Learning Disabilities Lead) and Lisa Newton (Matron- Division 1) have undertaken additional training which has subsequently provided them with a nationally recognised qualification in Mental Health First Aid and enabled them to become accredited Mental Health First Aid instructors. This has resulted in the Trust having two individual MHFA leads who are qualified to train staff and manage Mental Health First Aid going forwards within the Trust appropriately. At present,

- The Trust have trained 98 staff members who are now qualified Mental Health First Aiders

- There are 3 further training courses scheduled for September 2019, November 2019 and February 2020 providing up to 48 further additional Mental Health First Aiders
- The Trust have designated Mental Health First Aider contact lists within all patient areas.
- Mental Health First Aid site managers are also highlighted on the Duty Operational Manager (DOM) rota providing continuous 24-hour cover.
- All mental Health First Aid training is recorded on ESR

4.0 Mental Health Awareness Training

In addition to the 98 Mental Health First Aiders, the Trust Mental Health leads have worked closely with University Hospital Birmingham compatriots and have developed basic Mental Health Awareness training. The training has been developed in line with tier 1 of the Mental Health Core Skills Education and Training Framework and covers a wide range of basic mental health core topics relevant to all staffing groups with some additional information relating to the Royal Orthopaedic Hospital specifically. The Mental Health Core Skills Education and Training Framework is a national standard framework developed by Health Education England which states all NHS staff groups should receive Tier 1 training according to the framework and the Trust are now in a position where we fully comply with this requirement.

The training session is 1 hour long and comprises of both theory and activity-based learning. The session was introduced to Core Mandatory training on 8th August 2019 and will run for at least 12 months ensuring all staff members within the Trust receive required training level with no current plan to remove the training.

5.0 Mental Health Information and Resources

The Trust Mental Health leads have worked with Birmingham and Solihull Mental Health Foundation Trust colleagues to develop a new Trust Mental Health Intranet site. The site now contains up to date information on Mental Health, the differing mental health illnesses and conditions, available treatment options, what to do if you need help around supporting a patient or staff member with a Mental Health related difficulty and where to go to access Mental Health support services. In addition to this, the Trust intranet page now also includes Royal Orthopaedic Hospital specific risk assessments and care plans which are available to support patients with Mental Health illness accessing services within the Trust. A hard copy of the Intranet site content is also present in all clinical areas throughout the Trust.

6.0 Mental Health Act Policy and Procedure

The CQC action plan devised following their previous visit identified a number of actions, these were: -

6.1 Trust to have clear guidance on Mental Health Act and its application to practice within the acute hospital setting

The Trust is not registered with the CQC to detain patients under the Mental Health Act. However, we could use section 5.2 (Doctors holding power) in an emergency and when the patient is not subject to detention. This would give us ability to detain someone for up to 72hrs whilst awaiting a formal Mental health assessment provided under Trusts SLA with BSHMHFT.

Mental health posters and intranet site have flow chart clearly outlining process to be followed if section 5.2 (Drs holding power is required). This is also discussed at Mental health working group, ward and department managers day and for band 6 away day.

6.2 The Trust to have easy access to information on the relevant sections of the Mental Health Act and guidance on its application to practice within the acute hospital

Mental health intranet site contains information on Mental Health Act, and Mental Health posters display how to use section 5.2.

6.3 The Trust to have easy access referral pathways to organisations/ services who can provide help and support to those suffering with mental ill health or requiring further information

SLA with BSHMHFT currently being revised for 19/20 additional SLA with Forward thinking Birmingham being created as BSHMHFT will on see people 18 + year however forward-thinking Birmingham will support patients up to the age of 21.

6.4 The Trust to have a valid Mental health policy

Mental health policy from UHB was ratified and approved in July 2019, we propose adopting this policy to ensure collaborative working and ensuring patients cared for at UHB and ROH are managed along the same pathway to ensure continuity and safety for these patients.

6.5 The Trust to gain expert and evidence-based advice on all mental health provision

Revised SLA outlines requirement to provide 2hrs on site per month from identified mental health professional to provide input on documentation, policies and incidents.

6.6 The Trust risk register to reflect current mental health position

Mental health added to risk register under safeguarding

7.0 Governance

A mental health working group has been created to meet quarterly, terms of reference have been devised to demonstrate the responsibilities of the working group to cascade info from group to their teams. This group has initially been created for Mental Health First Aiders within the Trust however the group will discuss a wide range of issues in Mental Health expanding beyond the Mental Health First Aid agenda with particular focus on Mental Health activity within the Trust and updates on work being done.

In addition to this, Mental Health First Aid England are due to release the first official Mental Health First Aid accredited refresher course which Trust leads will be expected to complete in order to ensure all Mental Health First Aiders within the Trust receive required formal update of knowledge and skills going forwards.

Paper on mental health is submitted by Lisa Newton and Nathan Samuels to safeguarding committee and Clinical Quality Group.

Staff support is currently under discussion with HR as to whether we restrict MHFA to staff.

8.0 Mental Health Incidents

Since the beginning of the new year (January 2019), the Trust have begun to gather data around the Mental Health specific patient contacts within the Trust. These are defined as incidents where a patient or staff member has been suffering with their mental health or been in/near Mental Health crisis on site within the Trust and action has been taken by Trust staff to support them. Numbers are highlighted below

- January 2019 – 4
- February 2019 – 8
- March 2019 – 13
- April 2019 – 7
- May 2019 – 12
- June 2019 – 10

Although numbers vary month by month, there has generally been an increase in the number of mental health contacts within the Trust as training, information available and staff confidence has all increased. There have been some challenges in collecting exact data due to not having a specific dedicated way to report incidents however this is being addressed by the introduction of a Mental Health notification system. This system will mirror the current Learning Disability notification system the Trust have in place and will provide staff with one easy format to record any Mental Health action they have been involved in and will also provide the Trust with one centralised way to gather and collate Mental Health activity data for record, review and auditing purposes.

9.0 Risk Register

In September 2018, the Trust risk register was updated to reflect the level of risk posed by the challenged in Mental Health provision that the Trust was experiencing. A risk rating of moderate was identified, with a score of 12 under the likely consequence rating. The risk details are described as

Description - Trust does not have adequate policies, procedures or trained staff to provide necessary level of care & support for patients with mental health issues
Causes - Lack of up to date policies, procedures and lack of staff training/awareness
Consequences - Poor patient care, patient & staff safety, non-compliance with regulatory body standards and legal claims against the Trust

Action – In November 2018 an action update was added to produce a Mental Health Policy to support the application of the required sections of the Mental Health Act 1983 with a set completion date of September 2019.

In November 2018 an action was added around the Trust securing the appropriate staff training, development, Mental Health application guidance and information/resources.
In April 2019, the risk register was updated to reflect the Trusts position in providing the appropriate training, resources and Mental Health guidance as previously identified.
In July 2019, the risk register was updated to reflect the Trusts position in securing a Mental Health Act Policy

Following a safety alert regarding ligature risks an assessment was completed by Lisa Newton and Carl Measey (Health and Safety Lead) in conjunction with colleagues from BSHMHFT. This was approved at the executive meeting in August 2019.

10.0 Current Position

The Trust is clearly in a stronger position than when visited in 2018. Staff confidence, an issue highlighted as a concern by CQC, is now much better with staff generally understanding how they can go about accessing further support for either a patient or a staff member suffering with their mental health. Mental health awareness has risen greatly across the Trust and the Mental Health posters within all clinical areas consolidate this.

The Trust now has 24-hour Mental Health Crisis first response available which is supported by clear guidance for how to action any concern highlighted. In addition to this, The Trust have ensured where this first response is not sufficient alternative support can be accessed through clear guidance on the application of the Mental Health Act which is also supported by a robust Mental Health Act Application Policy.

Information and Resources on mental health throughout the Trust have been significantly developed with dedicated Mental Health Information Boards in all clinical areas, a dedicated Mental Health Intranet page with a wealth of staff and patient information and evidenced based, affective staff training for all staff groups ensuring the Trusts vision of being a Mental Health friendly organisation is shared by all.

The action plan developed around the lack of Mental Health provision within the Trust now looks a stark contrast to when it was first developed reflecting the work that has been done within the Trust and the healthier position the Trust now finds itself in around Mental Health.

To conclude, the Trust currently have a Service Level Agreement with Birmingham & Solihull Mental Health Foundation Trust. This SLA is around continuous advisory support and input in relation to our Mental Health provision which also includes a minimum of 2 hours contact per month. However, the current SLA does require further clarity around the support we receive as a Trust during out of hours instances. The Trust mental health leads have already submitted the required amendments to finalise the SLA and this along side the formal release of our Mental Health Act Policy will be completed within the next 6 weeks.

Lisa Newton- Matron Division 1

Nathan Samuels – Learning Disabilities and Mental Health Lead

28 August 2019

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Report from the Director of Infection Prevention & Control**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Ange Howling, Head of Infection Prevention & Control**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

The attached report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The IPC agenda has continued to be strengthened with a highly visible and flexible Infection Prevention Team (Infection Prevention Nurses, Surgical Site Infection HCA and an administrator) led by the Head of Infection Prevention and Control, Angela Howling. The development of our IPC nurses is in line with the national core competency framework, developed by the Infection Prevention Society and endorsed by the Department of Health (2011).

REPORT RECOMMENDATION:

The Board is asked to:

- Receive and note the attached report
- Approve the report and its publication on the Trust's internet site

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X	X	

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

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

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

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

With safe and efficient processes

PREVIOUS CONSIDERATION:

Infection Prevention & Control Committee and Quality & Safety Committee on 28 August 2019.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

DIRECTOR OF INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2018/2019

Author	Angela Howling
Director of IPC	Garry Marsh, Executive Director of Nursing & Governance
Approved at	Infection Prevention & Control Committee
Date of approval	2019

Introduction from the Director of Infection Prevention and Control

Infection prevention and control (IPC) is fundamental in improving the safety and quality of care provided to patients. Healthcare Associated Infection (HCAI) can cause significant harm to those infected. As a result, IPC remains a key priority for the Royal Orthopaedic Hospital NHS Foundation Trust (ROH). I am proud to be able to present the Director of Infection Prevention and Control's annual report for 2018/19.

The NHS continues to experience unprecedented challenges clinically, operationally, and economically. However, our staff have sustained a culture of continuous improvement which is both patient-centered and safety-focused. Our vision is to constantly provide the highest possible standards of care across our healthcare economy.

The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using services at ROH receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (see table of criteria on following page). The IPC agenda has continued to be strengthened with a highly visible and flexible Infection Prevention Team (Infection Prevention Nurses, Surgical Site Infection HCA and an administrator) led by the Head of Infection Prevention and Control, Angela Howling. The development of our IPC nurses is in line with the national core competency framework, developed by the Infection Prevention Society and endorsed by the Department of Health (2011).

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008 (updated 2015), at the heart of this law there are two principles:
To deliver continuous improvements of care and that it meets the need of the patient.

With this in mind patient safety remains the number one priority for the Trust. Infection Prevention is one of the key elements to ensure ROH has a safe environment and practice which is reflected in the Trust's vision, values and objectives with milestones turning the vision into a reality.

Improvements in health and care are linked and the NHS and its public, private, and voluntary sector partners can only provide the best and most effective service for patients and public when we work together to achieve their objectives.

This report summarises the combined activities, commitment and hard work of the IPC Team, Board colleagues, all staff, governors and volunteers across ROH, Clinical Commissioning Groups (CCG) and Public Health England (PHE) in relation to the prevention of avoidable HCAIs.

Garry Marsh
Director of Nursing and Governance / Director of Infection Prevention and Control

Compliance criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

1. The Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008). The DIPC will have the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable HCAIs at all levels in the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing

details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will offer commitment to quality and patient safety, good communication and reporting channels and access to people with expert prevention and control advice.

At the ROH the Director of Nursing and Governance holds the role of DIPC.

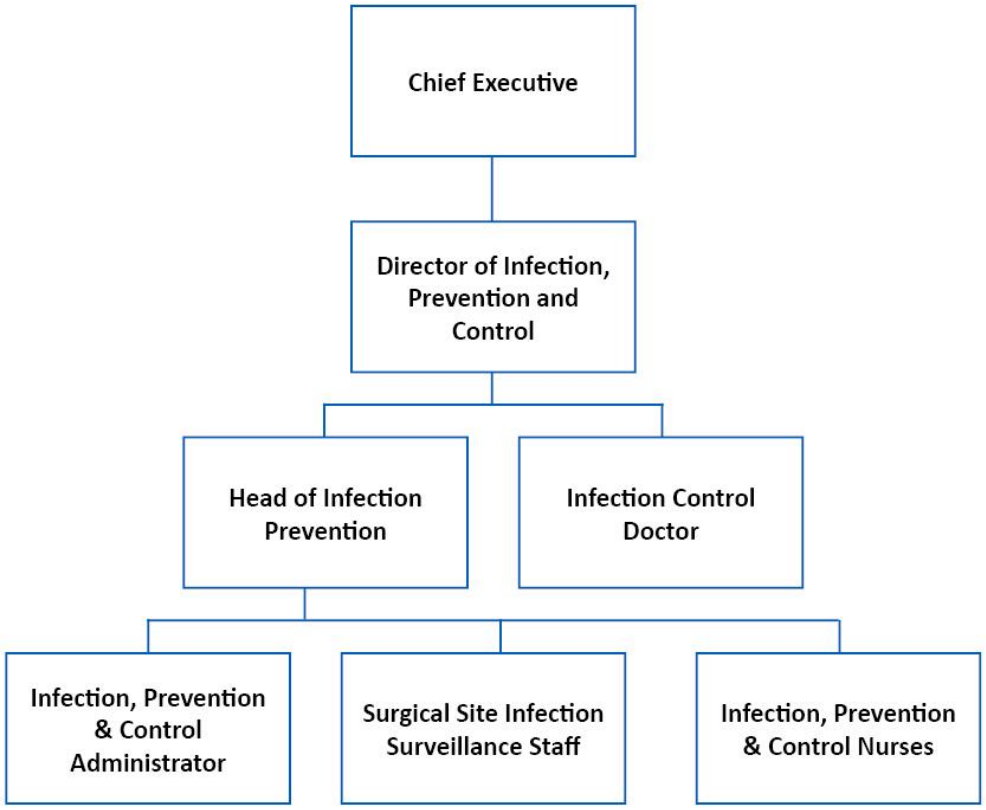
2. The Infection Prevention and Control Team

The IPC Team is led by the Head of IPC and is supported by Infection Prevention Nurse Specialists, Surgical Site Surveillance Health Care Assistant and an Administrator.

The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development. The Trust has 24 hour access to expert Consultant Microbiology advice and support via a Service Level Agreement (SLA) with the University Hospital Birmingham (UHB).

The DIPC has overall responsibility for the IPC Team that works collaboratively alongside the front-line clinical leaders at the Trust.

IPC Team Structure 2018/2019



3. Committee Structures and Assurance Processes

3.1. Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive (CE) has overall responsibility for the control of infection at ROH. IPC matters.

3.2. Quality and Safety Committee

The Quality and Safety Committee (QSC), chaired by a Non - Executive Director (NED), is a sub-committee of the Trust Board which meets monthly is responsible for ensuring that there are processes for ensuring patient safety and continuous monitoring and improvement in relation to IPC. The QSC receives assurance from the IPCC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IPC Team provide a monthly report on surveillance and outbreaks within the Quality Account.

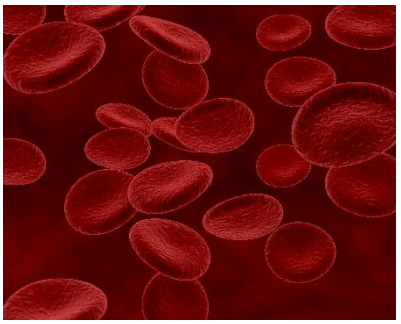
3.3. Infection Prevention and Control Committee

IPCC, chaired by the DIPC, provides direct assurance to the DIPC. The main objective of the IPCC is to provide a strategic drive in ensuring improved performance in relation to HCAIs.

4. Surveillance of Healthcare Associated Infection (HCAI)

Surveillance is undertaken on a number of alert organisms and mandatory reporting to PHE is undertaken. Performance is monitored by Birmingham and Solihull Clinical Commissioning Group (CCG). Overall performance at ROH is excellent.

4.1. Meticillin resistant staphylococcus aureus blood stream infections



S. aureus is an organism harmlessly carried by around 30% of the healthy population. Its importance is that it is a leading cause of surgical site infection (post operative wound infection).

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality. The risk of prosthetic joint infection and other orthopaedic implants is a particular concern in the patient population that ROH treats.

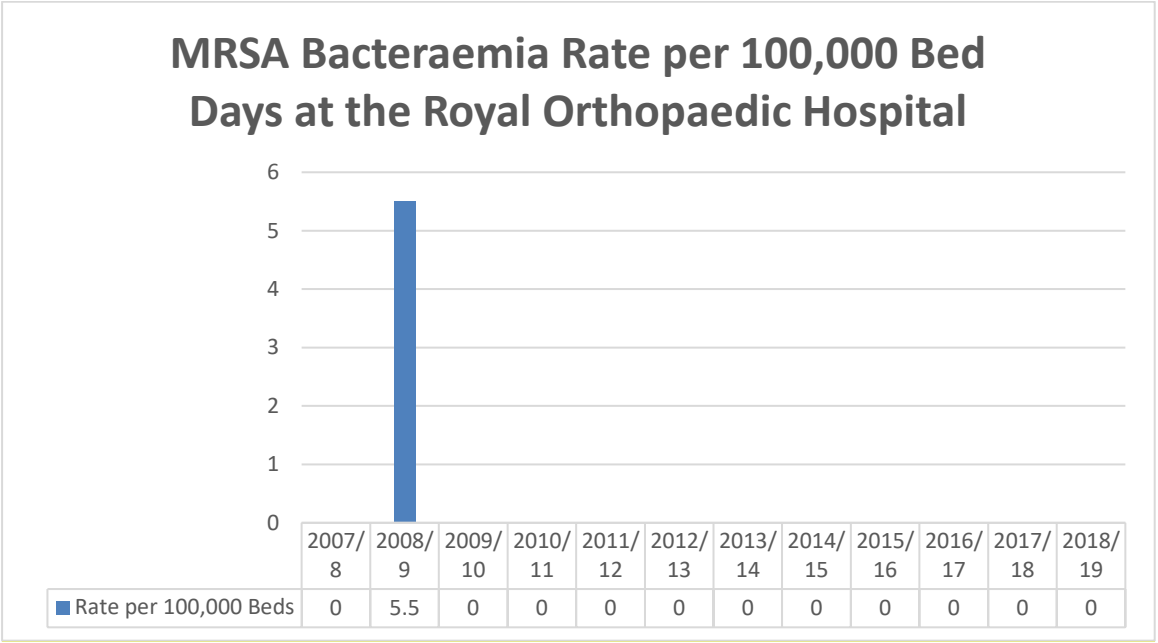
MRSA is a type of staph aureus that is resistant to the most commonly used group of antibiotics for perioperative prophylaxis i.e. prevention of post operative wound infection. It is less commonly carried than the more sensitive strains.

ROH continues to mitigate the risk of MRSA infection by active pre admission screening and isolation of colonized patients, in keeping with national guidance. Screening results also enables effective use of appropriate prophylactic antibiotics in colonized patients.

The ROH IPC also comply with national guidance to reduce the risk of blood stream infection. Low rates of blood stream infection therefore offer assurance of:

- Effective screening strategies
- Management and care of devices
- Antibiotic prophylaxis
- Compliance with national guidance

For the period covered by this report there have been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous year;



Source: https: //www.gov.uk/government/organisations/public-health-england

For the period covered by this report there have been zero cases of MRSA bacteraemia at ROH which is the same compared to the previous year;

Figure 4b: Quarterly rates of hospital-onset MRSA bacteraemia: April to June 2008 to January to March 2019

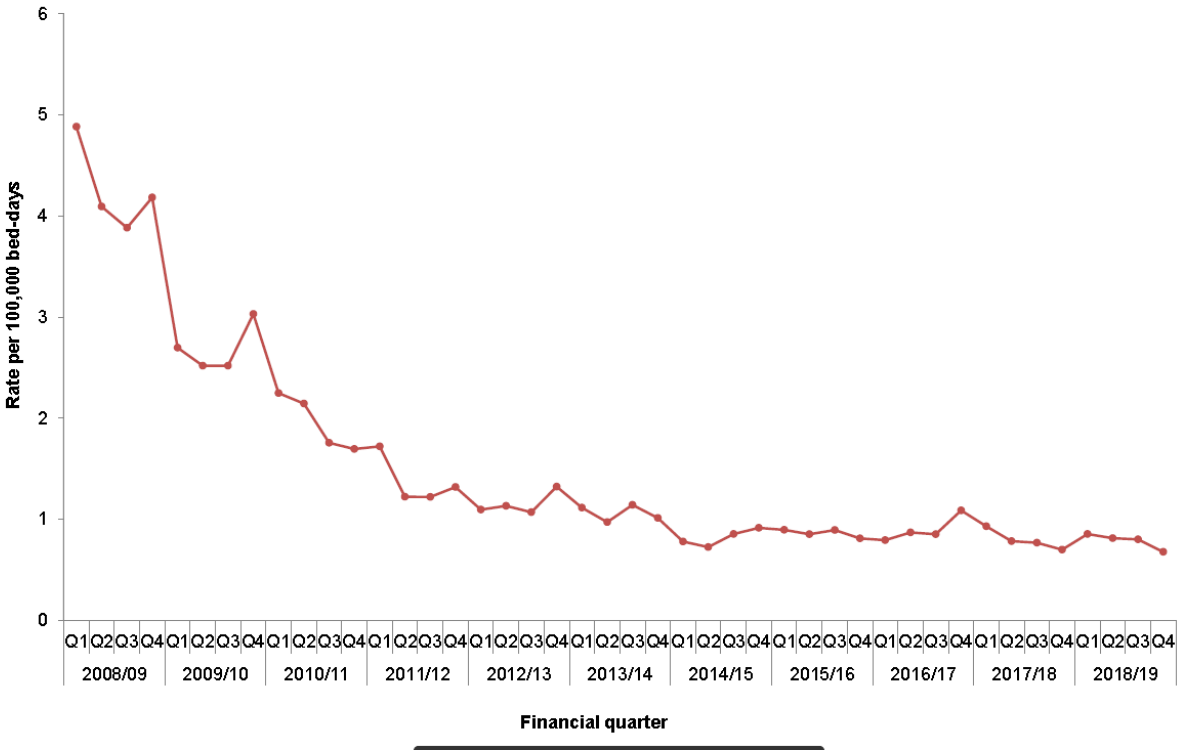
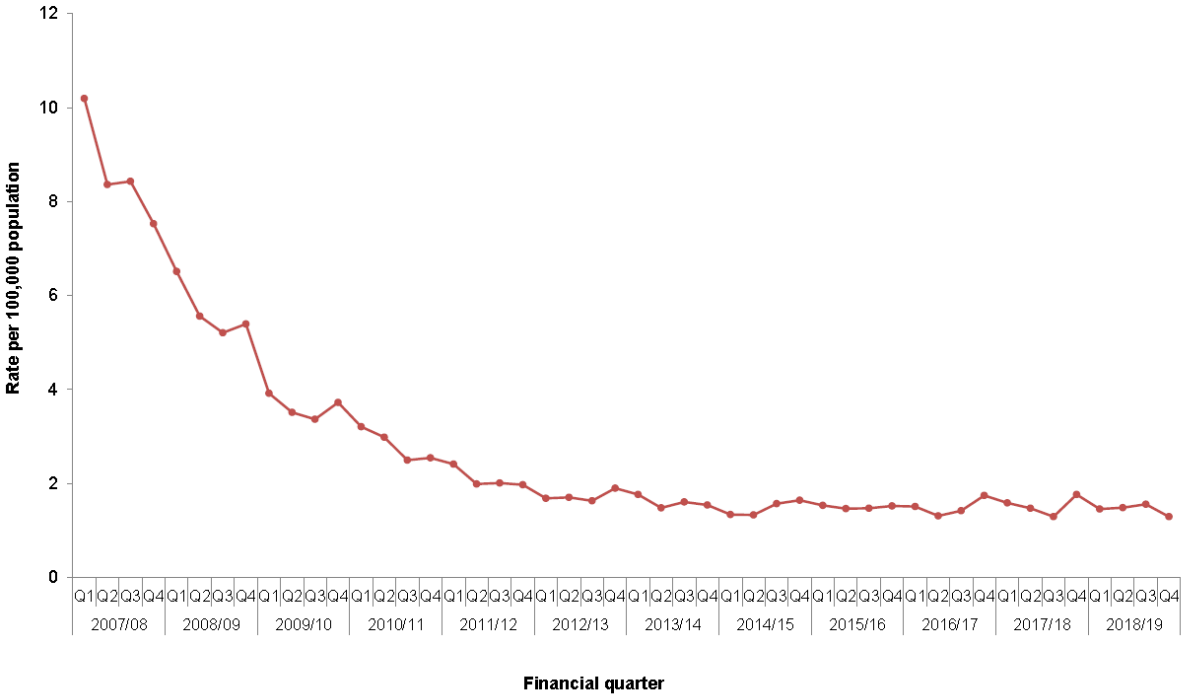


Figure 4a: Quarterly rates of all reported MRSA bacteraemia: April to June 2007 to January to March 2019



Source: https: //www.gov.uk/government/organisations/public-health-england

Epidemiological analyses of *Staphylococcus aureus* bacteraemia data in England

MRSA bacteraemia (England)

There has been a considerable decrease in the incidence rate of all reported MRSA bacteraemia since the enhanced mandatory surveillance of methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia began in April 2007 (figures 4a, table S4a). The incidence rate of all reported cases fell by 85% from 10.2 cases per 100,000 population April to June 2007 to 1.5 cases per 100,000 population in January to March 2014. The rate has subsequently decreased to 1.3 cases per 100,000 population between January to March 2014 and January to March 2019.

A similar trend was observed with the incidence rate of hospital-onset cases (figures 4b, table S4a). There was a steep decrease of 79% from 4.9 cases per 100,000 bed-days in April to June 2008 to 1.0 cases per 100,000 bed-days in January to March 2014. Subsequently, between January to March 2014 and January to March 2019, the rate has subsequently decreased to 0.9 cases per 100,000 bed-days.

Comparing the most recent quarter (January to March 2019) to the same period in the previous year (January to March 2018) shows a 26.9% decrease in the count of all reported cases from 242 to 177, while the incidence rate decreased 26.9% from 1.8 to 1.3 cases per 100,000 population. Community-onset MRSA bacteraemia cases decreased 35.0% from 180 to 117, while the community-onset incidence rate decreased 35.0% from 1.3 to 0.9 cases per 100,000 population. The count and incidence rate of hospital-onset MRSA bacteremia remained broadly similar between the 2 periods

4.2 Meticillin-sensitive staphlococcus aureus blood stream infections

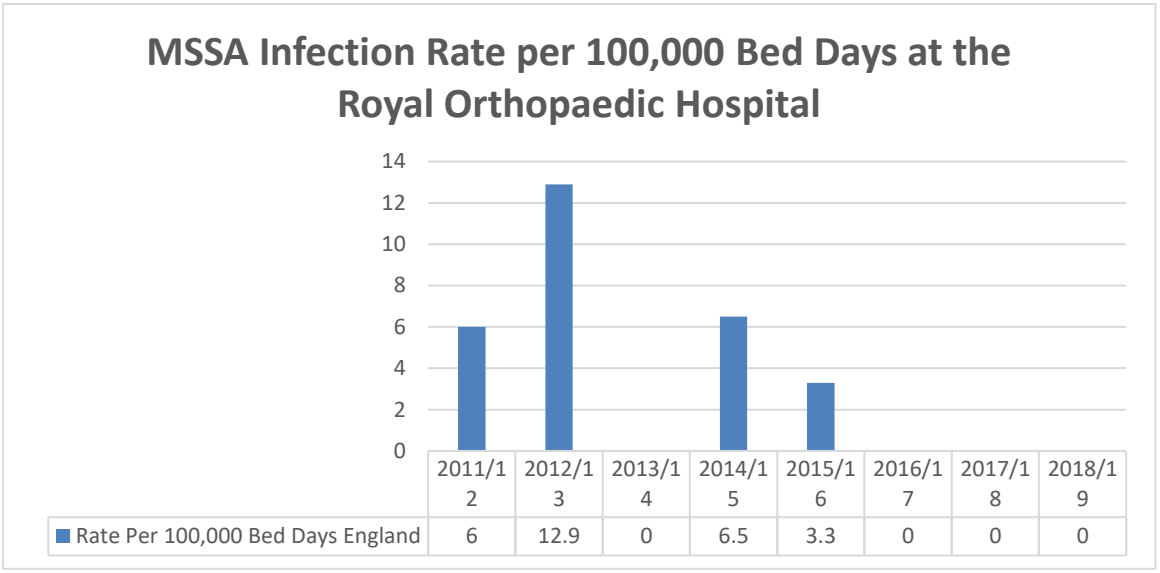
Meticillin-sensitive Staphylococcus aureus is a type of bacterium which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream.

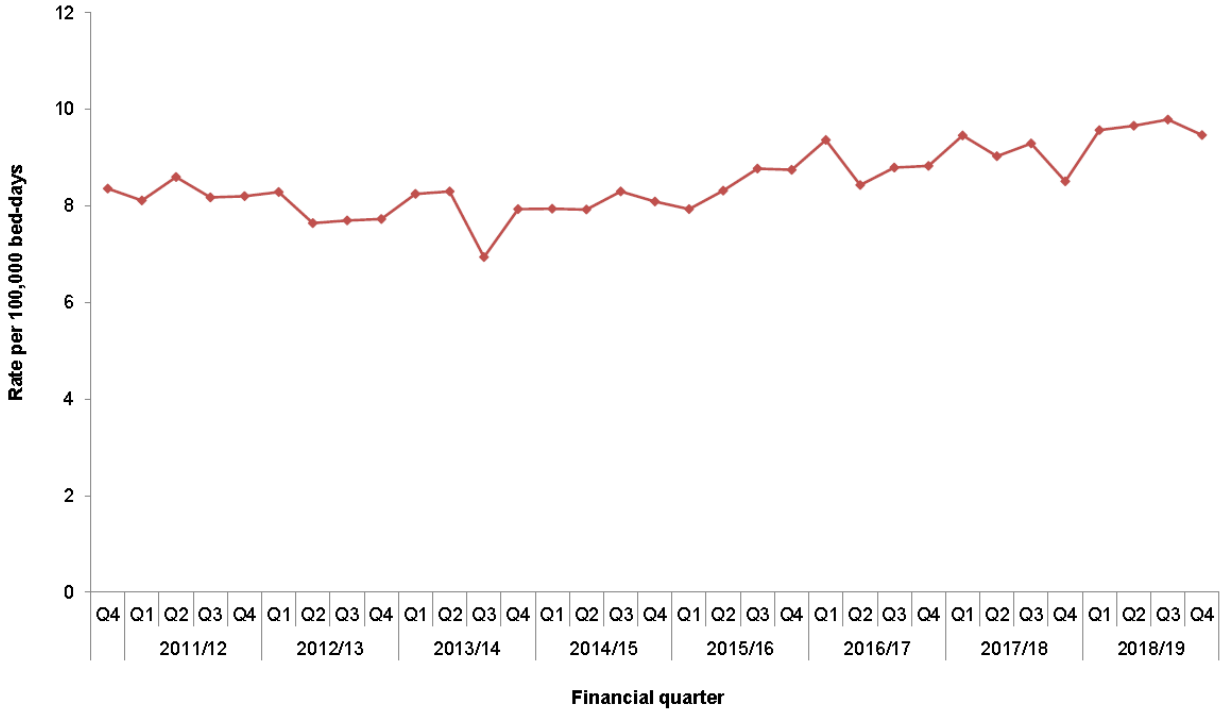
Following a Secretary of State announcement on 5 October 2010, there was a mandatory requirement for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.

MSSA blood stream infections cases continue to be monitored by ROH. Currently this data collection is part of national surveillance only. In total this year there have been zero hospital associated cases (post-48 hours after admission) reported and 1 pre - 48hour case reported.



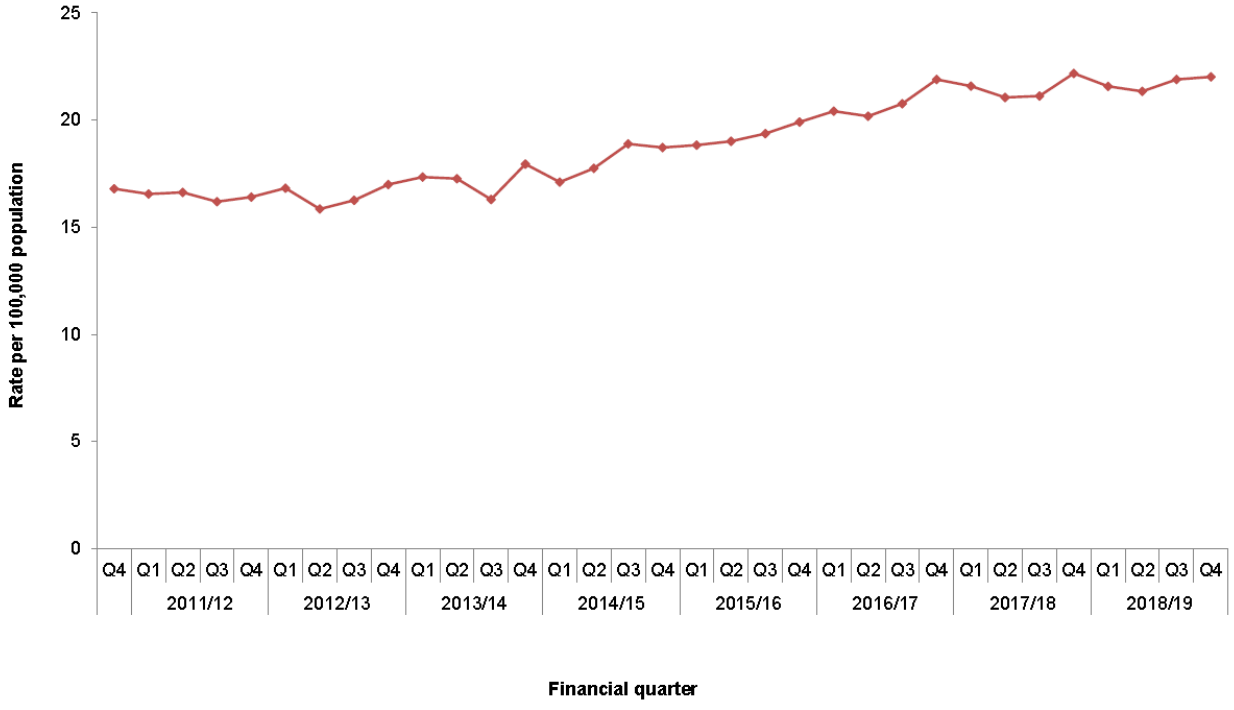
Source: https: //www.gov.uk/government/organisations/public-health-england

Figure 5b: Quarterly rates of hospital-onset MSSA bacteraemia: January to April 2011 to January to March 2019



Source: https: //www.gov.uk/government/organisations/public-health-england

Figure 5a: Quarterly rates of all reported MSSA bacteraemia: January to April 2011 to January to March 2019



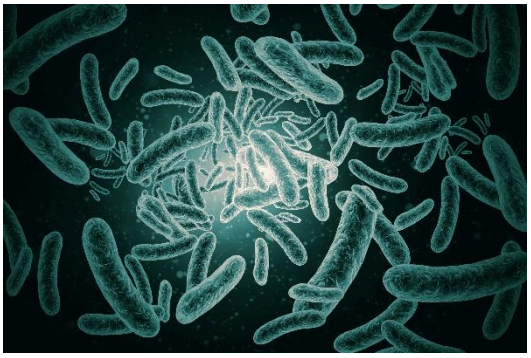
MSSA bacteraemia (England)

Since the mandatory reporting of methicillin-susceptible *Staphylococcus aureus* (MSSA) bacteraemia began in January 2011 there has been a general trend of increasing counts and incidence rates. The count of all reported cases of MSSA bacteraemia increased by 37.3% from 2,199 to 3,020 between January to March 2011 and January to March 2019. This was accompanied by a 31.1% increase in incidence rate from 16.8 cases per 100,000 population to 22.0 (figure 5a, table S5a).

These increases are primarily driven by the increase in community-onset cases. Between January 2011 to March 2019, the count and the incidence rate of community-onset cases increased by 48.9% and 42.2% respectively from 1,464 to 2,180 cases and from 11.2 to 15.9 cases per 100,000 population. Over the same period, the count of hospital-onset cases increased by 14.3% from 735 to 840 cases, while the incidence rate increased 13.3% from 8.4 cases per 100,000 bed-days to 9.5 (figure 5a and 5b, table S5a).

Comparing the most recent quarter (January to March 2019) to the same period in the previous year (January to March 2018) shows the count of all reported cases and the incidence rate remained broadly similar. While there was no change overall, hospital-onset MSSA bacteraemia cases increased 11.3% from 755 to 840 which corresponds to an incidence rate increase of 11.3% from 8.5 to 9.5 per 100,000 bed-days. In contrast, community-onset MSSA bacteraemia cases decreased 4.7% from 2,287 to 2,180, while the community-onset incidence rate decreased 4.7% from 16.7 to 15.9 per 100,000 population.

4.3 Clostridium Difficile Infection (CDI)



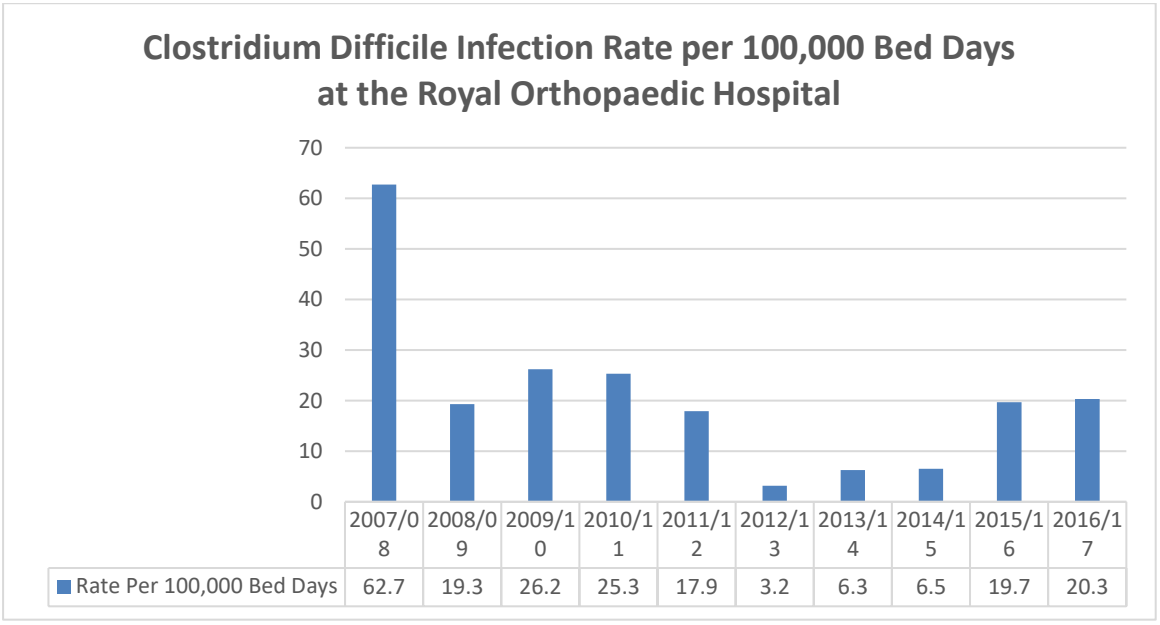
Up to and including 2018/19, NHS organisations have continued to be required to demonstrate year on year reductions in Clostridium difficile Infection (CDI) cases. However, as published data shows, the rate of improvement for CDI has slowed over recent years. Infection prevention and control experts from within the NHS and from Public Health England advise that this is likely to be due to a combination of factors, including the biology and epidemiology of the Clostridium difficile (CD) organism.

There are indications that, for some organisations at least, the level of CDIs may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided. This can occur due to the fact that some people carry CD in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. Put simply, some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

Cases of CDI that are considered to have been acquired in that the Trust are defined as sample taken “on or after 48 hours of admission”.

One case was apportioned to the Trust, and a lapse in care declared due to concerns regarding the standard of ward cleanliness. CCG representative noted good practices and was pleased with the promptness of specimen collection, treatment and adherence to infection prevention and control requirements.

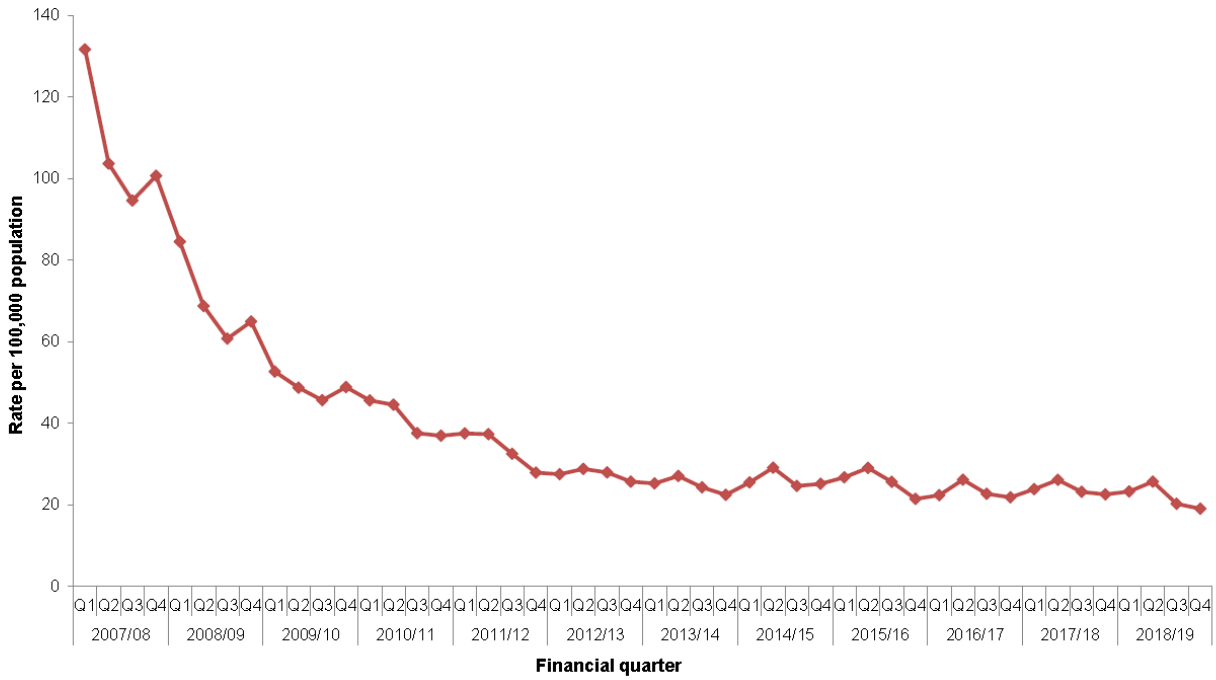
The second case was apportioned to the Trust, a lapse in care was declared due to the lack of symptom assessment on the 12/12/18 and the lack of stool sample collection following that symptomatic episode. However, the lapse in care did not contribute to the development or acquisition of C-Diff. Antibiotics were prescribed as per Trust Policy; an action plan has been formulated that addresses the need for robust assessment, communication and documentation to be in place regarding stool assessment and sampling.



Source: https: //www.gov.uk/government/organisations/public-health-england

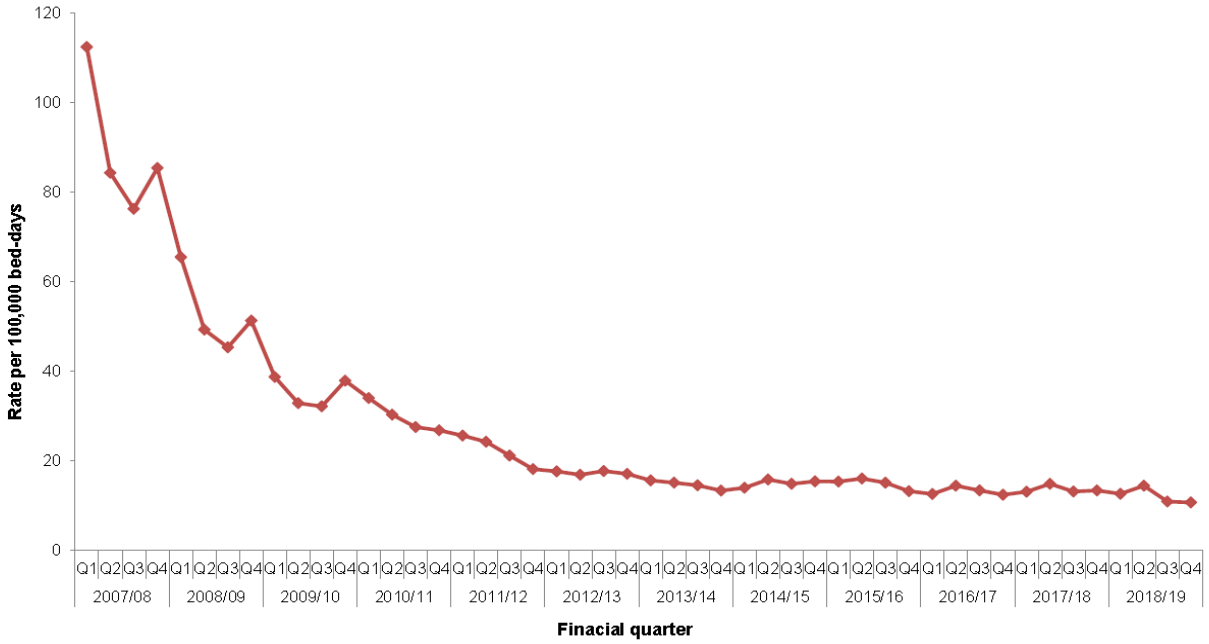
There were 2 reported C diff cases at ROH between April 2018- April 2019

Figure 6a: Quarterly rates of all reported *C. difficile:* April to June 2007 to January to March 2019



Source: https: //www.gov.uk/government/organisations/public-health-england

Figure 6b: Quarterly rates of hospital-onset *C. difficile*: April to June 2007 to January to March 2019



Source: https: //www.gov.uk/government/organisations/public-health-england

Epidemiological analyses of *Clostridium difficile* infection data (England)

Since the initiation of *Clostridium difficile* infection (CDI) surveillance in April 2007, there has been an overall decrease in the count and associated incidence rate of both all-reported and hospital-onset cases of CDI (figure 6a, 6b and table S6).

Most of the decrease in the incidence rate occurred between April to June 2007 and January to March 2012 with a 78% decrease in all-reported cases of CDI from 16,864 to 3,711 cases and an associated 79% reduction in incidence rate from 131.6 cases per 100,000 population to 27.9. Subsequently, between January to March 2012 and January to March 2019, the count of all-reported cases decreased a further 29.6% from 3,711 to 2,611 cases and the incidence rate reduced by 31.8% from 27.9 cases per 100,000 population to 19.0.

There were similar, but greater, reductions among hospital-onset CDI cases with an 85% reduction in count of cases between April to June 2007 and January to March 2012 from 10,436 to 1,613 cases and 84% reduction in the incidence rate from 112.5 per 100,000 bed-days to 18.2. This was followed by a further 41.0% decrease in the count of cases from 1,613 to 951 cases and a decrease of 41.0% in the incidence rate from 18.2 cases per 100,000 bed-days to 10.7 between January to March 2012 and January to March 2019.

Comparing the most recent quarter (January to March 2019) to the same period in the previous year

(January to March 2018) shows a 15.5% decrease in the count of all reported cases from 3,090 to 2,611, while the incidence rate decreased 15.5% from 22.5 cases per 100,000 population to 19.0. Hospital-onset CDI cases decreased 20.2% from 1,191 to 951 which corresponds to an incidence rate decrease of 20.2% from 13.4 cases per 100,000 bed-days to 10.7. Community-onset CDI cases also decreased by 12.6% from 1,899 to 1,660, while the community-onset incidence rate decreased 12.6% from 13.8 per 100,000 population to 12.1.

6.2.1 ROH CDI Action Plan

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (PCR positive).

In all cases control measures are instigated immediately, and RCA's are reviewed. Each inpatient is reviewed by the IPC nurse regularly. In cases of Bone Infection Service (BIS) patients, they form part of the weekly multi-disciplinary review where the patients' case is discussed including antibiotics and where necessary feedback to ward doctors. All HCAI CDI cases are subject to a post infection review and each case is discussed with the Lead IPC Nurse at Birmingham and Solihull Clinical Commissioning Group (BSolCCG) to determine the avoidability (lapses in care) with feedback given to IPCC and relevant Divisions. The Divisions action Duty of Candor where necessary.

ROH closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic Clostridium Difficile in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic Clostridium Difficile within a period of 28 days and associated with stay in the same ward or area. Should this occurr samples are obtained and submitted to Public Health England for ribotyping. Samples with the same ribotype are then examined further variable number tandem repeat (VNTR). This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures, with decanting and deep-cleaning of the patient areas if necessary.

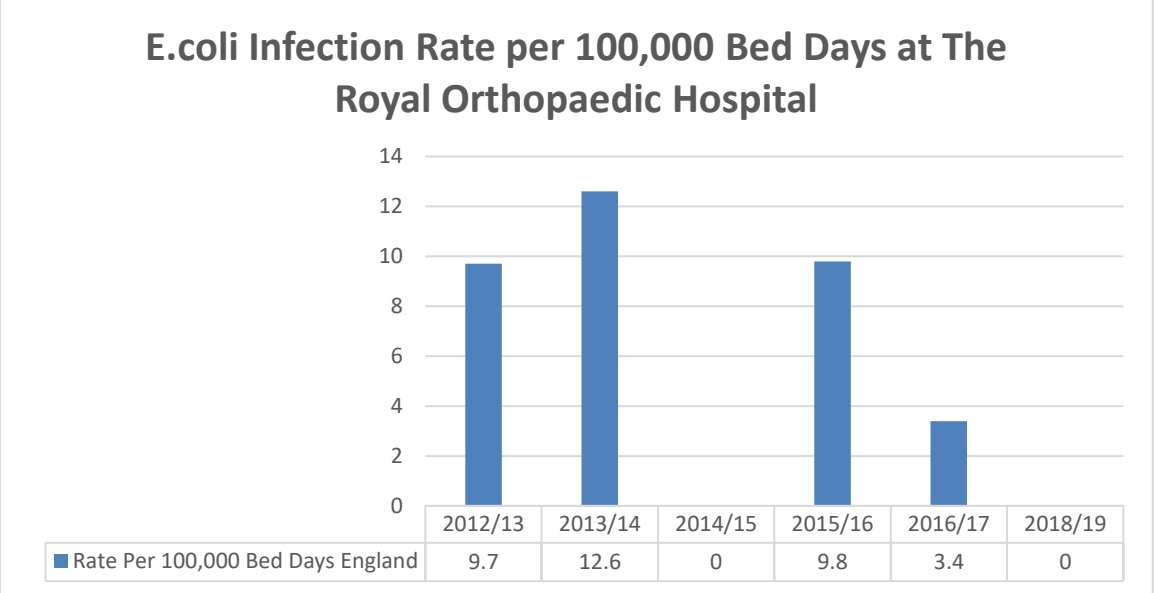
Gram negative – bloodstream infections – Escherichia coli (E-coli)

Gram negatives (GN) are a group of organisms that form part of the normal gut flora.
They are particulary associated with urinary tract infection (UTI) which may also lead to blood stream infection (BSI). This risk may be increased by inappropriate care and use of urinary catheters. The very nature of orthopaedic surgery entails use of urinary catheters and therefore the stringent management of catheters is paramount to clean safe care. E-Coli is the most commonly seen representative in this group.

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli BSI may be caused by primary infections spreading to the blood.

The Secretary of State for Health, (2017) launched an ambition to reduce healthcare associated GN bloodstream infections (BSIs) by 50% by 2021. Gram-negative BSIs are believed to have contributed to 5,500 NHS patient deaths in 2015. The initial focus to support this ambition is on E-coli BSI reduction. Enhanced surveillance of E. coli BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to PHE.

ROH has seen a decrease in contrast to the national picture of increased reported cases.



Source: https: //www.gov.uk/government/organisations/public-health-england

There has been a decrease in E.coli infection rates since 2015/16. In the period for this report there have been zero cases at ROH.

Figure 1a: Quarterly rates of all reported *E. coli* bacteraemia: July to September 2011 to January to March 2019

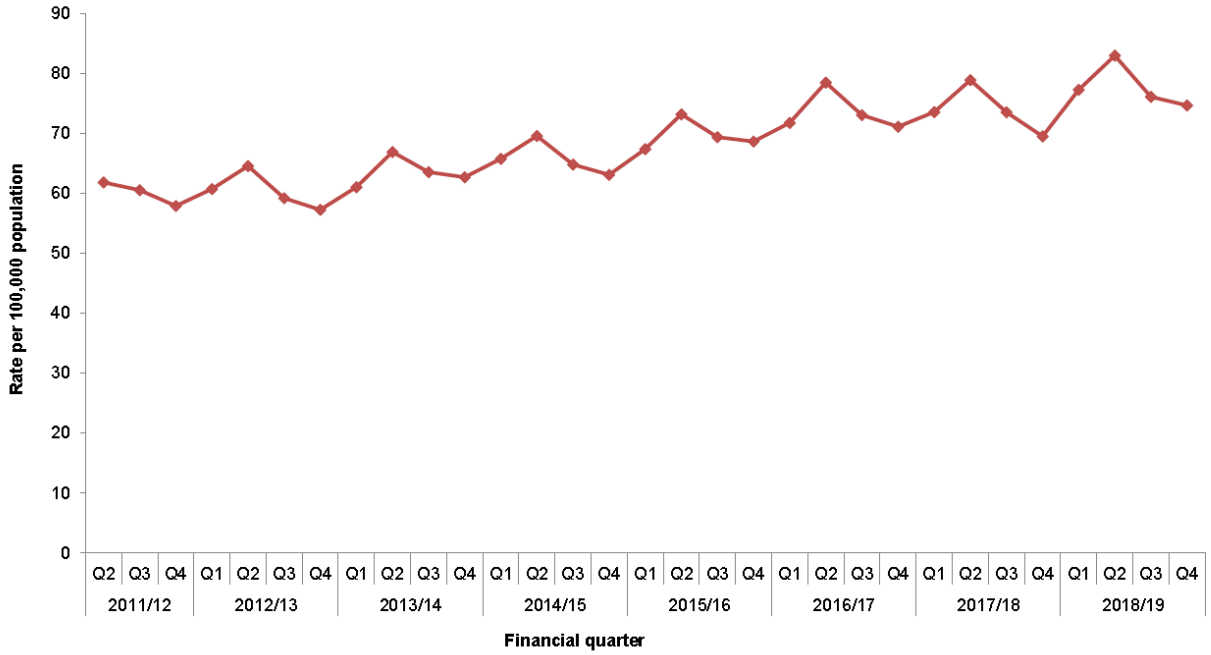
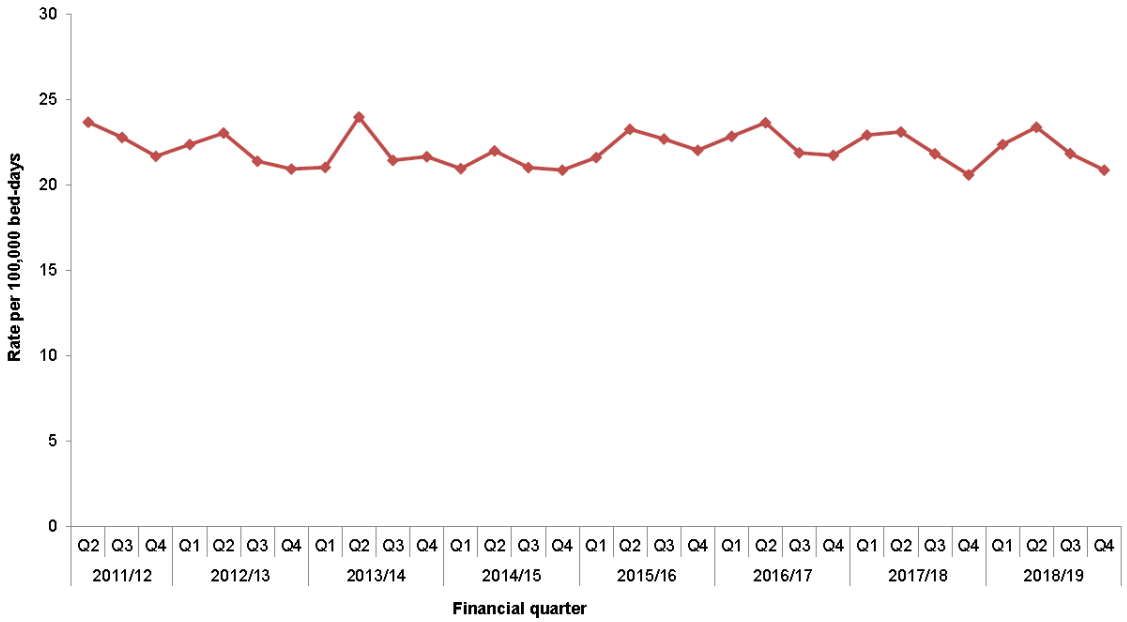


Figure 1b: Quarterly rates of hospital-onset *E. coli* bacteraemia: July to September 2011 to January to March 2019



Source: https: //www.gov.uk/government/organisations/public-health-england

Epidemiological analyses of Gram- negative bacteraemia data (England)

E. coli bacteraemia

The incidence rate of all reported Escherichia coli bacteraemia has continued to increase each year since the initiation of mandatory surveillance of *E. coli* bacteraemia in July 2011 (figure 1a). This is primarily driven by the increase in the rate of community-onset cases (table S1a). In contrast, the incidence rate of hospital-onset cases has been relatively stable within the same period (figure 1b). Between July to September 2011 and January to March 2019, the count of cases and the incidence rate of all reported cases of *E. coli* bacteraemia increased by 23.7% from 8,275 cases to 10,239 and from 61.8 to 74.7 cases per 100,000 population. Similarly, over the same period, the count of community-onset cases increased by 33.6% from 6,279 to 8,387, while the incidence rate increased 30.4% from 46.9 cases per 100,000 population to 61.2.
The incidence rate of hospital-onset cases decreased 7.2% between July to September 2011 and January to March 2019 from 23.7 per 100,000 bed-days (n=1,996) to 20.9 per 100,000 bed-days (n=1,852).

Comparing the most recent quarter (January to March 2019) to the same period in the previous year (January to March 2018) shows a 7.4% increase in the count of all reported cases from 9,530 to 10,239, while the incidence rate increased 7.4% from 69.5 per 100,000 population to 74.7. Community-onset *E. coli* bacteraemia cases increased 8.9% from 7,703 to 8,387 per 100,000 bed-days, while the community-onset incidence rate increased 8.9% from 56.2 per 100,000 population to 61.2 (figure 1a and 1b, table S1). Hospital-onset *E. coli* bacteremia cases and incidence rate were broadly similar between the 2 periods.

Vancomycin/glycopeptides resistant enterococci (vre/gre)

Enterococci are part of the normal bowel flora and can cause urinary tract and blood stream infections.

VRE/GRE may be found in the healthy population thought to reflect inappropriate use of antibiotics in farming.

Mandatory surveillance was discontinued in 2013.

For the period covered in this report there have been zero cases of GRE at ROH which is the same compared to the previous year.

Carbapenemase producing enterobateriaceae (cpe)

These are a sub-set of gram negatives (see above section) which are particularly resistant to antibiotics. They are seen commonly in the Indian subcontinent and in some Medeteranean countries which have historically had a poor record on antimicrobial stewardship and IPC.

There is an increasing concern nationally about their spread in healthcare.

PHE published a toolkit in 2013 to control the spread in healthcare and onwards in the community. ROH adhere to the toolkit.

For the period covered in this report there have been zero cases of CPE at ROH which is the same compared to the previous year.

Tuberculosis (tb)

Tuberculosis (TB) is an infection caused by a bacterium belonging to the Mycobacterium tuberculosis complex. TB is a notifiable disease in the UK. Suspected and confirmed diseases must be notified within three working days. It is a serious disease that can affect most organs but often presents as a lung infection. In the context of ROH practice it can also cause joint, bone and spinal infection.

For the period covered in this report ROH had zero cases of TB infection.

Norovirus outbreaks

Norovirus causes diarrhea and is highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another or from their environment through contamination. In hospital this environmental risk is considerable and outbreaks are common. Management therefore relies on prompt recognition of symptoms, robust isolation and IPC procedures as well as fastidious environmental cleaning.

For the period covered in this report ROH had one confirmed case of Norovirus which was appropriately managed and did not result in further cases.

7. Audit programme to ensure key policies are implemented

The ROH has a programme of audits in place undertaken by both clinical areas and the IPC Team to provide assurance around practice and consistent compliance with evidence-based practice and policies. Where a period if increased incidence occurs / risks are identified the IPC Team undertake additional audits in accordance with risk requirement. Action plans are devised by areas where issues are highlighted and these are managed and monitored within the divisions and escalated to IPCC and upwardly reported through the robust ROH Governance structure.

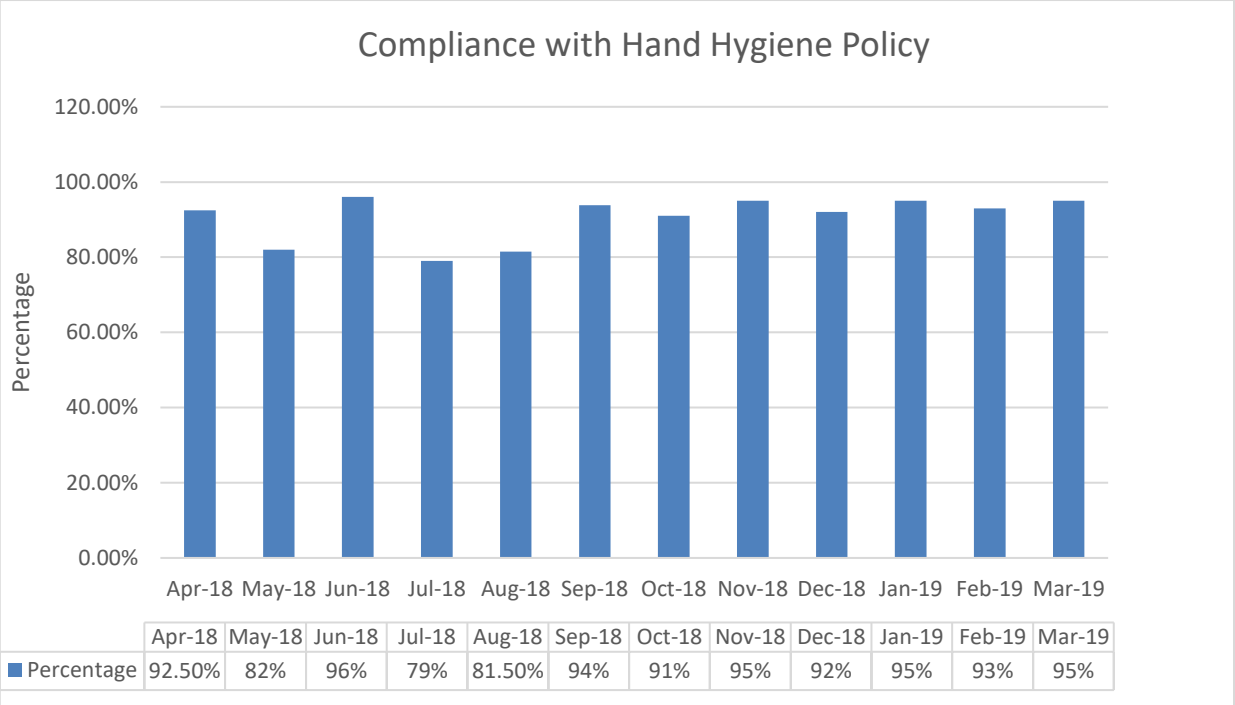
8. Audits of hand hygiene practice

Hand hygiene continues to be included in the audit programme. The IPC Link Nurses perform 'Glow & Tell' training and assessments on hand hygiene within their areas.

Hand hygiene is audited across all wards and departments, on a monthly basis, following the WHO 5Moments of Hand Hygiene.

The Trust continues to focus on four main components:

Alcohol hand rubs at point of care prominently positioned by each patient so that hands can be cleaned before and after care within the patient's view.
Audit of hand washing practice at least monthly.
Patients are encouraged to challenge staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.
Raised awareness of hand hygiene and the 'Bare below the elbow' dress code



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Percentage	92.50%	82%	96%	79%	81.50%	94%	91%	95%	92%	95%	93%	95%

ROH has been exceeding the threshold of 90% set by the Commissioners in 2018/19 with the exception of July and August. This was due to the introduction of a more robust audit that demonstrated lower levels of compliance than previously reported.

Quarter 2 saw the implementation, post education and training sessions for auditing staff, of the WHO 5Moments audit tool. Staff at ROH are now audited on technique and appropriateness of hand hygiene application.

An exception report, on the lower levels of compliance, was presented to the CCG who appreciated the need for change in practice and accepted the initial reduction in figures whilst the new auditing process was embedded.

9. Staff information and training

- The IPC Team has provided mandatory hand hygiene training for all ROH employees through induction days, mandatory study days, and ward-based enhanced training.
- The IPC Team facilitate bi-monthly meetings for infection prevention link staff (from each ward and department)
- The IPC Team facilitate an annual study day for all interested employees from ROH.
- Grab Packs for hand hygiene, Influenza, MRSA, personal protective equipment and CPE have been developed and implemented across ROH to support staff with effective application from theory to practice within their areas of work.
- A bespoke hand hygiene training session has been developed for estates and facilities which will be implemented in 2019/20.
- The IPC Team continues to work collaboratively with suppliers and Estates and Facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment or processes.

- ROH hand hygiene provider, DEB UK, have standardized products, posters, dispensers across the Trust and continue to provide training and audit at operational level for all clinical areas.
- The induction IPC training package was updated to reflect the requirements of new employees to ROH.
- Communication of key messages via a number of media including social networks.
- The World Health Organisation (WHO) '-Five Moments of Hand Hygiene' is in use across ROH with the support from Communications. This campaign continues to be communicated both internally and externally with the support from social media.
- Additional on-going infection prevention surveillance and support continues across ROH with daily infection prevention visits to high risk areas.
- Bespoke infection prevention training has been developed, in line with HBN 00-09, for all preferred contractors coming into ROH.
- The IPC Team continue to work with clinical staff and support clinical site managers with safe bed utilisation.
- The IPC Team facilitated the national antibiotic awareness and hand hygiene days across ROH, this is in addition to promotional activities that they have supported throughout the year.

10. Seasonal Staff Influenza Vaccination Campaign

The seasonal influenza staff vaccination campaign is well established at ROH. The campaign officially commenced on 1st October 2018 with a wealth of information available to staff on the Trust intranet, information boards across the site and locally based influenza champions. The uptake for 2018/19 was 50.8% compared to previous years 2017/18 of 70.21% and 2016/17 which was 54%. However, the uptake shows that there is relatively poor uptake amongst certain groups that will be require additional support for the 2019/20 campaign.

11. IPC Link Workers

ROH, within each clinical area, has in place dedicated IPC Link Workers these include registered nurses, healthcare assistants and allied health care professionals. . These staff are supported by the IPC Team and attend bi-monthly meetings alongside education / study days to support them in their roles. They provide advice, support, education and training to operational staff as well as monitoring compliance with the IPC agenda.

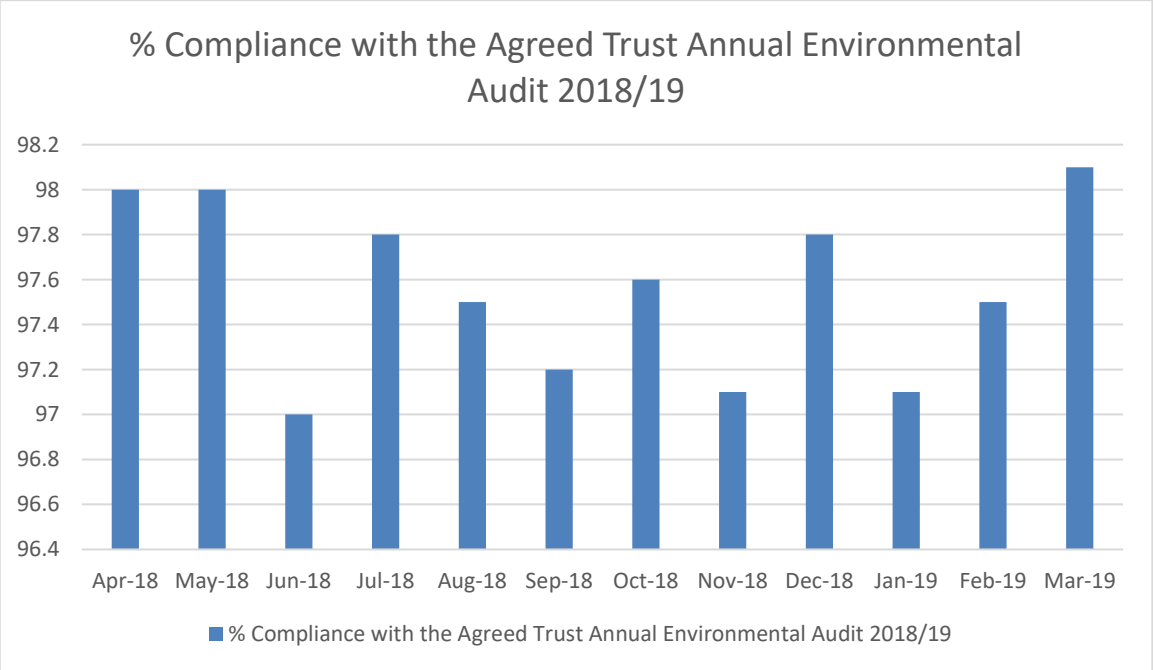
Compliance criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Providing a clean safe environment:

- There is a designated Facilities Manager for cleaning services that are managed in house.

- The IPC Team support ROH bed management / clinical staff to ensure efficient / appropriate bed utilistion
- IPC Team are involved in capital planning schemes to support the needs of IP across ROH in refurbishments and new builds.
- The IPC Team oversees assurance of standards and reduction of risk in partnership with divisional management teams through audit, monitoring of standards, and shared learning.
- ROH use Bioquelle (hydrogen peroxide vapour), a specialised decontamination method, for the removal of environmental contaminants to ensure a safe, clean environment.
- Domestic staff continue to provide cover in all patient areas from 6am until 9pm. (Monday – Friday) and 8.30am – 7pm (weekends and bank holidays).
- Training for domestic staff continues to be provided by British Institute for Cleaning Standards and is refreshed annually.
- Head of Infection Prevention meets, on a monthly basis with Head of Estates / Facilities to review cleanliness standards and any issues identified by monthly audits. Issues are discussed at IPOG and escalated, as required to IPCC.
- ROH contract out to an accredited facility for decontamination services.
- ROH theatres have a schedule of annual shutdown for general maintenance and cleaning.
- ROH participate in the annual Patient Led Assessments of The Care Environment (PLACE).



ROH has been exceeding the threshold of 95% set by the Commissioners in 2018/19.

Water Systems Management

- Following the Department of Health publication, 'Water sources and potential Pseudomonas aeruginosa contamination of taps and water systems: advice for augmented care units' (2012), ROH test and monitor waters from augmented care areas. Additional areas are tested if there was a clinical suspicion that waters may have been linked to a patient's infection or colonisation. The Consultant Microbiologists support this management process and provide advice / support as required.
- ROH Water Safety Group, which includes a dedicated Authorised Engineer for waters, is responsible for the oversight of water safety and continue to meet on a bi-monthly basis.

- The Water Safety group is a sub group of IPCC and reports directly to IPCC. The group is chaired by the Head of Estates.
- Estates and Facilities, Consultant Microbiologists, and the IPC Team support the water management process across ROH.

Management of Decontamination

The management and compliance currently falls into three distinct areas;

- Estates – for medical device reprocessing equipment / scheduled maintenance where required
- Infection Prevention – for monitoring / audit of compliance of medical devices with Trust Policies.
- User – to comply with Trust Policies and to ensure that decontamination of equipment is fit for use and subject to periodic testing and maintenance as advised by the manufacturer / contractual agreement.
- No local decontamination is undertaken on site – ROH contract out to BBraun, accredited decontamination service, for full management of surgical instrumentation.

11.1. Theatres Closure

All ten theatres were closed at ROH from 30th March, 2018 for a planned programme of maintenance and refurbishment. Elective surgery recommenced on Tuesday 9th April, 2018 post a deep clean and sign off by the IPC Team and Theatre Management Team.

2019 annual planned closure, for maintenance and refurbishment, is set for closure on Friday 19th April, 2019 with re-commencement of surgery om Monday 29th April, 2019.

Compliance criterion 3

Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Sepsis and Antimicrobial Stewardship (AMS)

The Antimicrobial Stewardship (AMS) Group formed in 2017/18 and has produced an Antimicrobial Stewardship Strategy to outline the roles and responsibilities of all members of staff within the Trust at tackling Antimicrobial Resistance. Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends by the Lead Antimicrobial Pharmacist. A number of audits have been completed to assess appropriateness of antimicrobial usage and also the review of antimicrobial antibiotics used within the Trust. This is reported to the Drugs and Therapeutics Committee (DTC) and IPCC and any areas of concern addressed with Microbiologists.

The antimicrobial guidelines were updated by the Lead Antimicrobial Pharmacist and Microbiologists at the University of Hospitals Birmingham Trust. These were uploaded to the Trust's intranet and launched within the Trust; a summary card was produced to improve staff awareness and compliance with the guidelines. The current deteriorating/septic patient policy is in process of being updated and has been renamed as the Policy for the Escalation of the Deteriorating adult. This contains the new updates to the early warning scoring system, NEWS2, which has been adopted in all areas across the Trust, excluding Paediatrics.

Continuing on from the previous year, ROH participated in a combined CQUIN for 2018/19 with four components (2a-2d); with 2a and 2b focusing on sepsis screening and management, and 2c and 2d on antimicrobial prescription review and consumption within the Trust. The CQUIN audit identified that the screening of patients for sepsis was completed appropriately and in-line with the Trust policy. We are appropriately screening out patients, and have achieved 100% of patients screened using the NEWS2 system. However, the 2b element was only partially achieved for Quarter 4 as less than 90% of patients were managed appropriately due to delays in antibiotic administration.

We have achieved 2c of the CQUIN requirements for Quarter 4 for ensuring at least 90% of all antibiotic prescriptions started for sepsis management; 90.6% (n=29) of antibiotic prescriptions started for sepsis were reviewed by least one of the senior staff members listed (ID, Infection pharmacist or clinical team) within 72 hours of initiation.

The antibiotic consumption report is compiled and continues to exclude issues to the BIU team to manage complicated infections and facilitate discharges. The local agreement to remove such issues from our antibiotic consumption reporting data is still in place due to this. Overall Meropenem usage has maintained from last year and decreased compared to the baseline data (2016/17) and achieved the required reduction. An overall reduction in Carbapenem usage has been reported (not including Ertapenem issues to the BIU service) which achieves the 2% reduction CQUIN requirement for this indicator.

Total antibiotic consumption has maintained the reductions seen in 2017/18 therefore should achieve the overall consumption reduction target of 1% set from 2018/19. Changes to the antimicrobial guidelines and antimicrobial prescribing practices have contributed to reducing the use of antimicrobials. The Trust's usage of antimicrobials from the AWaRE list has increased to 53% from baseline (43%), which is more than 3 percentage points from baseline and therefore achieves the CQUIN target.

Compliance criterion 4

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion

Communications:

- The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.
- The IPC Team work collaboratively with ROH Communications team who support dissemination of IPC communications both internally and externally as required.
- The IPC Team meet monthly to update each other on areas of work and plan ahead.
- The IPC Team provide a quarterly news letter across the Trust.
- All wards / departments have an IPC information board for patients / visitors which is updated monthly.
- IPC information stalls are used across site quarterly with time specific information for staff, patients and visitors to the Trust.
- All Infection Prevention Nurses undergo an annual appraisal.
- The IPC Team utilise social media that enables communication internally and externally with the public and other organisations. This has proved beneficial with sharing of best practice and communicating to a wider health economy.
- The ROH Weekly Message from the CEO supports and cascades messages from the IPC Team across the organization and gives prominence to Executive leadership and support of IPC activities, supporting “Board to Ward”.
- The IPC Team have dedicated space on the Trust Intranet and on the Trust Internet site.
- The Trust Intranet promotes infection prevention issues and guides users to information on MRSA, Clostridium Difficile and other organisms.

Compliance criterion 5

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because they can increase a patient’s length of stay in hospital and “are associated with considerable morbidity and it has been reported that over one-third of postoperative deaths are related, at least in part, to SSI. However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition” National Institute for Health and Clinical excellence (NICE) (2008)3.

Guidelines for the prevention of SSI were issued by NICE in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health. These guidelines are outlined in the following table.

Period	Action	Evidence	Introduced at ROHFT
Pre-operative	Showering	+ / -	x
	S.aureus decolonisation	+ / -	✓
Peri-operative	Antibiotic prophylaxis	+	✓
	Skin preparation	+	✓
	No shaving with razors	+	✓
	Theatre environment/procedures	+	✓
	Surgical technique	+	✓
	Normothermia	+	In part - ongoing
	Glucose control	+	✓
Post-operative	Wound management	+ / -	✓
	Surveillance and feedback of rates	+	✓

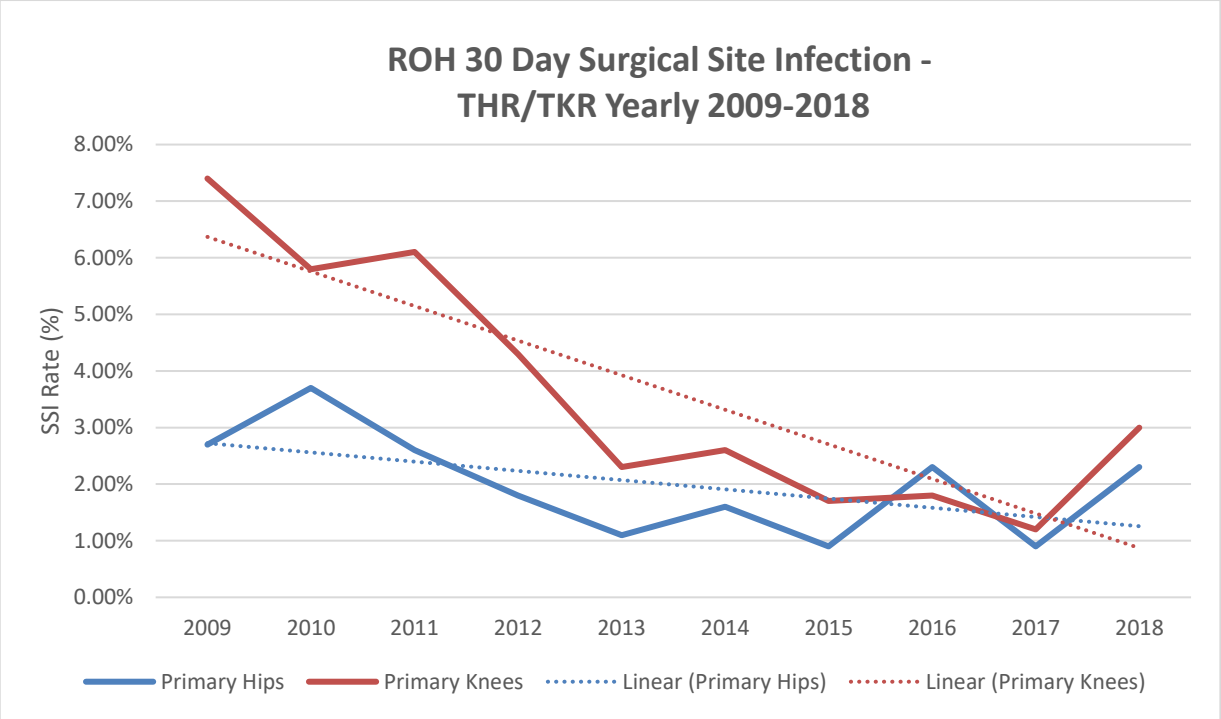
Many of these actions are in place, with the addition of others exceeding the National Guidance, at ROH. ROH have in place an established wound care helpline that can offer the patient an appointment at the SSI clinic, on the same day, should it be required This allows the review of patients by specialist staff allowing rapid treatment / admission where required avoiding visits to the GP and unnecessary prescribing of antibiotics.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice as necessary.

- hip replacement
- knee replacement
- repair of neck of femur
- reduction of long bone fracture

Primary arthroplasty surgery is constantly reviewed and monitored as part of the SSI surveillance programme at ROH. SSI surveillance is routinely carried out according to Public Health England protocol at the point of discharge from hospital and at 30 days post primary hip and knee replacement surgery and has received close attention since 2009 when the 30 day surveillance was introduced.

The data presented within this report is a combination of Mandatory surveillance data for Surgical Site Infections identified following hip and knee replacement surgery carried out and wider analysis surgical site infections in other specialties where it is available. In addition to this there is also in- house surveillance scheme conducted by the IPC Team, which looks at a number of other areas of interest. This enables the team to gain an informed understanding of SSI across all divisions and the potential for them to have longstanding implications for patients and significant financial implications for the Trust.



Source: ROH SSI Databases

SSI Rate	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Primary Hips	2.7%	3.7%	2.6%	1.8%	1.1%	1.6%	0.9%	2.3%	0.9%	2.3%
Primary Knees	7.4%	5.8%	6.1%	4.3%	2.3%	2.6%	1.7%	1.8%	1.2%	3.0%
No. of SSI	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Primary Hips	29	37	29	19	11	18	10	25	9	11
Primary Knees	62	47	53	34	17	21	15	16	12	13
No. of procedures	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Primary Hips	1068	1004	1123	1074	1017	1160	1097	1104	1048	487
Primary knees	821	808	873	793	751	795	873	869	961	434

Source: ROH SSI Databases

There has been an overall decrease in the SSI rate for both hips and knees since 2009. However, in most recent years there was a rise in the SSI rate for primary hips in 2016 and 2018. There was also a rise in SSI rate for primary knees in 2018.

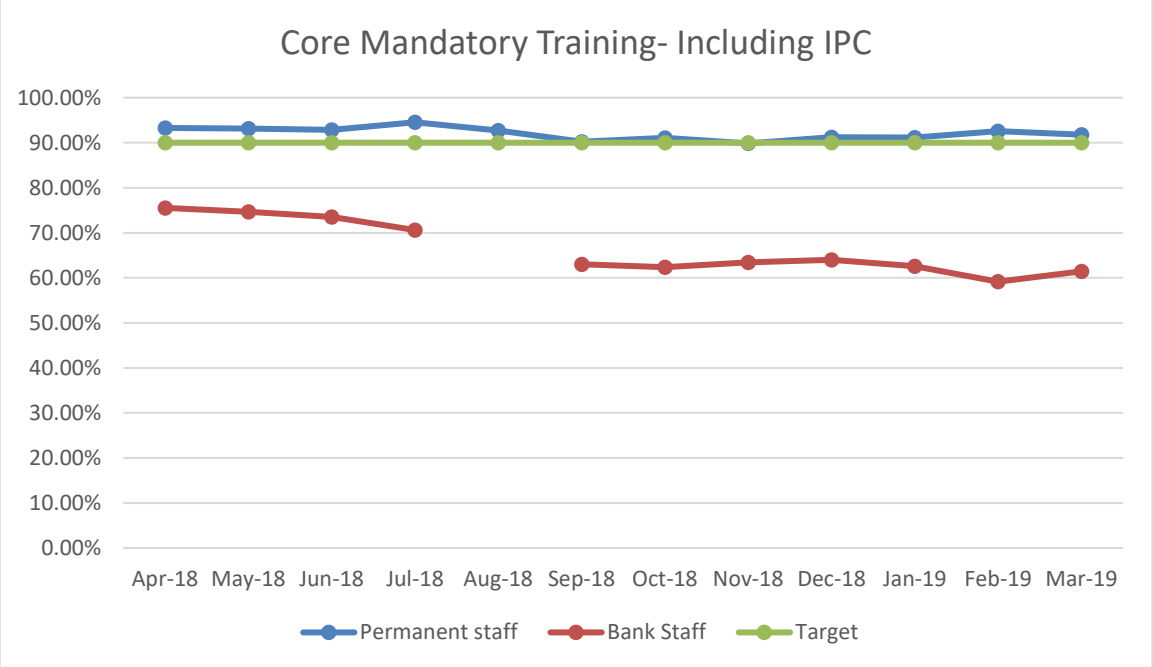
The SSI rate for primary hips has risen from 0.9% in 2017 to 2.3% in 2018. The SSI rate for primary knees has risen from 1.2% in 2017 to 3.0% in 2018.

Compliance criterion 6

Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection

At ROH infection prevention is everyone's responsibility and is included in all job descriptions.

All clinical staff receive training and education in optimum infection prevention practices during induction and mandatory training and Link Workers teaching sessions. Additional bespoke training is provided to wards and departments as necessary and in response to shared learning.



A target of 90% set by commissioners was met by permanent staff.
*No data was collected for August 2018 for Bank staff

Compliance criterion 7

Provide or secure adequate isolation facilities

Isolation Rooms

Wards
39 isolation rooms with en-suites.
3 isolation rooms without en-suite.

HDU
2 Adult Side Rooms without en-suites.
2 paediatric isolation rooms with ensuite.

Isolation room numbers have been sufficient to meet the needs of safe clean service provision over 2018/19.

Compliance criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for ROH are outsourced, located in the purpose built Pathology Laboratory at University Hospitals Birmingham. The Microbiology Laboratory has full (UKAS) accreditation ISO Standard 15189. ROH has electronic access to results to facilitate patient care.

Compliance criterion 9

Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, procedures and manuals are available for staff to view on the Trust Intranet. There is a formal Governance structure in place for reviewing and ratifying such documents within the Trust and Clinical Governance has produced a directory of documents alerting when policies are due for update. Policies are also updated prior to review date if guidance is updated.

Compliance criterion 10

Providers have a system in place to manage the occupational health needs of staff in relation to infection

All job descriptions include infection prevention responsibility and this message is reiterated during mandatory training. The IPC Team participates in mandatory updates for all staff groups (clinical and non-clinical). A representative from the Occupational Health Service is a member of the IPCC.

Occupational Health services are provided to staff via an SLA with the University Hospitals Birmingham (UHB). Occupational Health staff travel from UHB to ROH to provide one session (1 day) per week to support the Occupational Health requirements.

Summary

2018- 2019 has been a busy and challenging year for ROH staff and for the IPC Team. I am delighted in the number of infection prevention improvements that continue to improve the patients' experience and strengthen patient safety processes and standards. These improvements demonstrate ROH's commitment to harm free care and reduction in avoidable health-care associated infections. Performance on mandatory surveillance is exemplary compared to national data, perhaps reflecting the elective nature of our work, but there is no room for complacency. CQUIN performance shows engagement and again we have achieved our targets.

Together with our staff, governors and volunteers we have created vision and values which clearly state where we are going and how, as a team, we will behave towards each other, our patients, and partners.

Infection prevention and control is the responsibility of all of us and is fundamental when delivering the vision and values of ROH. By incorporating the principles of infection prevention into routine daily clinical practice, patient safety can be enhanced and the risk of patients acquiring an infection during episodes of health care can be minimised.

Our staff demonstrate through practice that they care about patient safety. We should all be proud of the reductions made in harms, including reductions in hospital-associated infections.

2019-2020 provides an opportunity for us to work as a healthcare system to influence even bigger reductions in patient harms. A key area for us to continue to focus on, over the coming year, will be the reduction in Gram-negative blood stream infections in the community and in hospital. Despite our strong performance in mandatory surveillance we continue to believe that we have a contribution to make to the health economy through collaborative working. Working as partners in care will enable us to achieve so much more than any part of the system could deliver in isolation.

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2018/2019

The Royal Orthopaedic Hospital NHS Foundation Trust
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The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Mortality Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Medical Director**
AUTHOR:	**Matthew Revell, Medical Director**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

This paper outlines the Trusts approach to deaths that occur in the peri-operative period and reviews information in the public domain about our mortality rates.
Section 1 Summarises the learning from deaths process and discusses the hospital dashboard
Section 2 Summarises the historical position from the HED database at UHB and Model Hospital.

As a result of this analysis we are able to provide assurance around the Learning from Deaths process and around our historical mortality figures.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- Note the future work planned
- Note the assurances provided that the Learning from Deaths process is embedded in the Trust's governance 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		

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**

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

Safe and efficient processes that are patient centred.
Excellent outcomes. Safety.

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 28 August 2019

FOR ASSURANCE

ROHTB (9/19) 010 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

Mortality Update

Report to the Trust Board on 4 September 2019

1.0 Learning From deaths.

1.1 Process in Brief

Deaths in hospital are known, however those following a transfer out or post-discharge have to be actively chased. This responsibility is shared by clinicians and informatics. For our Trust, all deaths within 30 days of surgery are included in the learning from deaths process, regardless of whether the death is in hospital or outside the hospital.

The clinician caring for the patient fills in a brief form confirming cause of death. This screening form also indicates whether the case is a coroner's case and whether there has been any possibility there has been a safeguarding issue.

The clinical service lead then fills in a screening tool – a set of criteria that would indicate a potential concern. This is known as a front line review. In larger trusts, this is used as a triage tool to indicate whether a full Structured Judgement Review should take place. In our hospital, all deaths within 30 days of surgery are progressed as routine and the front line review is made available to the final reviewer.

An associate medical director then examines the written record, breaking an analysis down by phases of care. In this structured judgement review each phase of care is examined and judgement statements generated about any notable features of care. The reviewer commits also to an adjudication about the quality of care for each phase and overall whether there was a component of avoidability in the death. If there was, then a full Root Cause Analysis (RCA) is carried out.

The Clinical Governance Team maintains a tracker that ensures the process is completed in a timely way and that cases are presented by clinicians in the monthly morbidity and mortality meeting.

A weekly meeting of the Directors of Nursing and Clinical Governance, Medical Director, Heads of Nursing, Associate Medical Directors and Heads of Nursing means that in general, learning and immediate actions / mitigations can be put in place and communicated effectively in parallel as matters arise. The intention is to report learning in Governance newsletters more frequently.

Trusts are encouraged to publicly display their data in a dashboard provided by NHS England. The ROH dashboard is shown in Fig 1 below. This runs by financial year, so, to date, we have recorded 11 deaths Apr 2018 - Apr 2019 and 2 deaths so far from Apr 2019. The tracker that informs the dashboard entries is shown in Figs 2 & 3.

1.2 Findings in Brief

Themes identified in the reviews to date include:

- Examples of excellent palliative and end of life care, which have invited positive feedback to the team.

- 2 instances where transfers into the Trust were suboptimal but care thereafter was appropriate. All consultants have been contacted with a reminder that our care, though limited and to some extent vicarious to begin with, must begin at the moment of referral. There is shared responsibility for transfers and an added responsibility on us at ROH as we know the facilities we have available to receive patients.

- There have also been cases where learning was focused more at individual level and on occasion there have been associated professional discussions around practice.

Figure 1 Extract From Learning From Deaths Dashboard at https://www.roh.nhs.uk/about-us/publications/reports/learning-from-deaths

The Royal Orthopaedic NHS Foundation Trust : Learning from Deaths Dashboard - August 2019-20

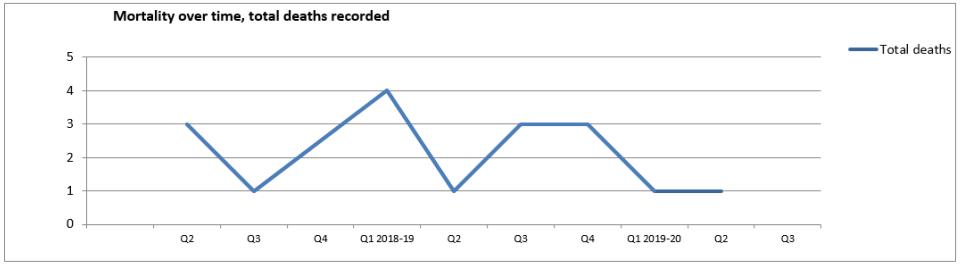
Department of Health

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	1	0	1	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	11	1	11	0	1

Time Series:	Start date	2017-18	Q2	End date	2019-20	Q4



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	100.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	100.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%

Inclusion Cirteria All in-patient and 30 day post discharge deaths to undergo a Structured Judgement Review. RCA triggered if appropriate at any stage.																				
No	**Hosp. No**	**Incident No**	**Date of Death**	**Place of Death**	**Consultant**	**Service**	**Pre-existing Risks/Learning Disability**	**Procedure**	**Complications**	**Cause of Death**	**Coroner's Inquest**	**Premilinary Screening Form**	**Mortality Review via CSL (Within 1 week)**	**SJR Findings (1-6) Within two weeks**	**2nd Stage Review**	**RCA Lead**	**Date Presented at Clinical Audit**	**Organisational Learning**	**Action Plan**	**Completed**
1	Rxxxxxx	23197	18.04.18	QEH	Mr ---	Arthroscopy	Falls risk, Recent TKR, Confusion, Warfarin for AF	Elective TKR		1(a) Hypovolaemia, 1(b) Retroperitoneal haematoma, 1(c) Pelvic fracture, 2 Anticoagulation	02.07.18 **Verdict: Accidental Death**, underlying cause was fall, inadequate assessment of falls risk, lack of 1 to 1 observation	Process not in place.	Process not in place.		n/a	YES	31.07.2018	1. Falls Policy to be reviewed and updated, 2. Proforma for medical review of patient after a fall, 3. Falls booklet for all patients		Yes
2	Rxxxxxx	23624	11.04.18	Royal Shrewsbury	Mr ---	Oncology	Chronic Obstructive Pulmonary Disease, Lower Respiratory Tract Infections, Breast Cancer, Tourette's Syndrome	Elective TKR	AKI, Sepsis	1(a) Multi organ failure, 1(b) Bronchopneumonia, 1(c) Elective TKR	14.09.18 **Verdict: Narrative**, "Patient died as a result of complications of surgery"	Process not in place.	Process not in place.	Good care	n/a	YES	Not Presented	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		
3	Rxxxxxx	24072	05.05.18	ROH	Mr ---	Spinal		Scoliosis Surgery	Collapse	1(a) Pulmonary Embolism, 1(b) DVT, 2 Acute Kidney Injury	No inquest	Process not in place.	Process not in place.	Good care	n/a	YES	29.06.2019	1. Review of 24 hour re-assessment for VTE risk,		
4	Rxxxxxx	24901	31.05.18	ROH	Mr ---	Oncology		Palliative	expected death	1(a) metastatic breast cancer	No inquest	Process not in place.	Process not in place.	Good care	n/a	N/A	30/07/2019	1. Review of End of Life Policy, 2. Oncology service to review transfer in criteria		
5	Rxxxxxx	25520	09.10.18	Sandwell	Mr ---	Spinal	Barrett's Oesophagus, Episodes of confusion	Metastic cord compression	Sepsis/Bowel Perforation	1 (a) Severe Septic Shock, 1 (b) Bowel Perforation, 2 metastatic Renal Cancer	TBC	Received	Received	in Progress	TBC	YES	To be presented in September 2019	1. Case study launced part of dessimination of learning		
6	Rxxxxxx	25736	29.10.18	ROH	Mr ---	Oncology	Parkinsons Disease, Metatastic Soft Tissue Sarcoma, Hypertension	Palliative	expected death	1(a) Hospital acquired pneumonia, 1(b) Parkinsons Disease, 2 Metastatic Soft Tissue Sarcoma & Hypertension	No Inquest	Received	Received	in Progress	TBC	N/A	30/07/2019	Personal communication to consultant and team to thank them for level of care in a palliative setting		
7	Rxxxxxx	25838	09.11.18	Patients Home	Mr ---	Arthroscopy	Carcinoma of the prostate, Resection of bladder tumour, Knee osteoarthritis	Elective TKR	unexpected death	1a. Acute Left Ventrculare Failure, 1b. Ischaemic Heart Disease, 1c. Coronary Artery Atehroma	No inquest	Received	Received	Adequate Care	Roundtable completed 14.08.2019, case discussed, panel agreed ROH did not contribute towards patienet death but some learning identified		Case presentation in progress and will present at next meeting 10/9/19	Professional conversation with consultant and action to support MD ward rounds. Actions for pharmacy around proposing medication rules in POAC and confirming start and finishes for discharge medication		
8	Rxxxxxx	28076	24.07.18	WHH	Dr ---	Oncology	Dementia	Endoprosthetic replacement of bone.	aortic valve disease	1a) Hospital Acquired puemonia 2) Dementia Aortic stenosis	No Inquest	Received	Received	Excellent Care	NO		30/09/2019			
9	Rxxxxxx Rxxxxxx Rxxxxxx Rxxxxxx	26691	19.02.2019	QEH	Mr ---	Spinal	Breast CA 2015	CT Guided Biopsy		1(a) Metastatic Breast Cancer	No Inquest	N/A	Received	Received	Adequate Care	YES	29.08.2019	Feedback to referring hospital MD (MR) around condition of the patient. All Consultants reminded of joint responsibility to manage transfer. Boarding Card process and policy already underway to accommodate Refer a Patient.	TBC	N/A
10	Rxxxxxx	27063	18.03.2019	ROH	Mr ---	Spinal	Metastatic Lung Cancer	Decompression of Spine		1a) Pulminary Embolism 1b)Lung Cancer 1c)Paralplegia	No Inquest	N/A	Received	Received	Excellent Care	No	31.05.2019	Personal communication to consultant and team to thank them for level of care in a palliative setting	N/A	N/A
11	Rxxxxxx Rxxxxxx Rxxxxxx	26405	11.02.2019	**Sandwell Hospital** (Death discovered incidentally whilst going through Emergency Transfer Tracker midtune 2019 and consultant informed for LFD on **26.06.2019**	Mr ---	Spinal	Non Hodgkin Lymphona	Posterior intrumented fusion of thoracic spine		1a) Cardiac Arrest 1b) Non Hodgkin	Unknown		Received 15.07.2019	Received 09.07.19	Review being carried out by Dr Toogood		30/07/2019	TBC	TBC	TBC

Figure 2 Learning from Deaths Tracker for Financial Year Apr 2018 - Apr 2019

Learning from Deaths April 2019 - Present

Inclusion Cirteria All in-patient and 30 day post discharge deaths to undergo a Structured Judgement Review. RCA triggered if appropriate at any stage.

No	Hosp. No	Incident No	Date of Death	Place of Death	Consultant	Service	Pre-existing Risks/ Learning Disability	Procedure	Complications	Cause of Death	Coroner's Inquest	RCA Lead	Premilinary Screening Form	Mortality Review via CSL	SJR Findings (1-6) Within two weeks	2nd Stage SJR	Date Presented at Clinical Audit	Organisational Learning	Action Plan	Completed
1	Rxxxxxx	28023	31.05.2019	QEH	Mr ---	ADCU		Bilateral Knee Athroplasty and Chondroplasty		TBC	Formal Inquest	yes	Received 04.07.2019	Received 01.07.19	Poor care	YES	Will present after coroner inquest	VTE RCA in progress	TBC	TBC
3	Rxxxxxx	28621/28622	02/08/2019	Alexander Hospital ICU	Mr ---	HDU	Diabetes			1a) Multi Ogan Failure, 1b)Septic Shock, 1c) Vancomycin resistant enterococcus infection in total hip replacement, 2) Diabetes Mellitus	Formal Inquest 5th December 2019		Sent on 08.08.2019	Received 21.08.2019						

Figure 3 Learning from Deaths Tracker from Apr 2019

Section 2 – Trust Benchmarking.

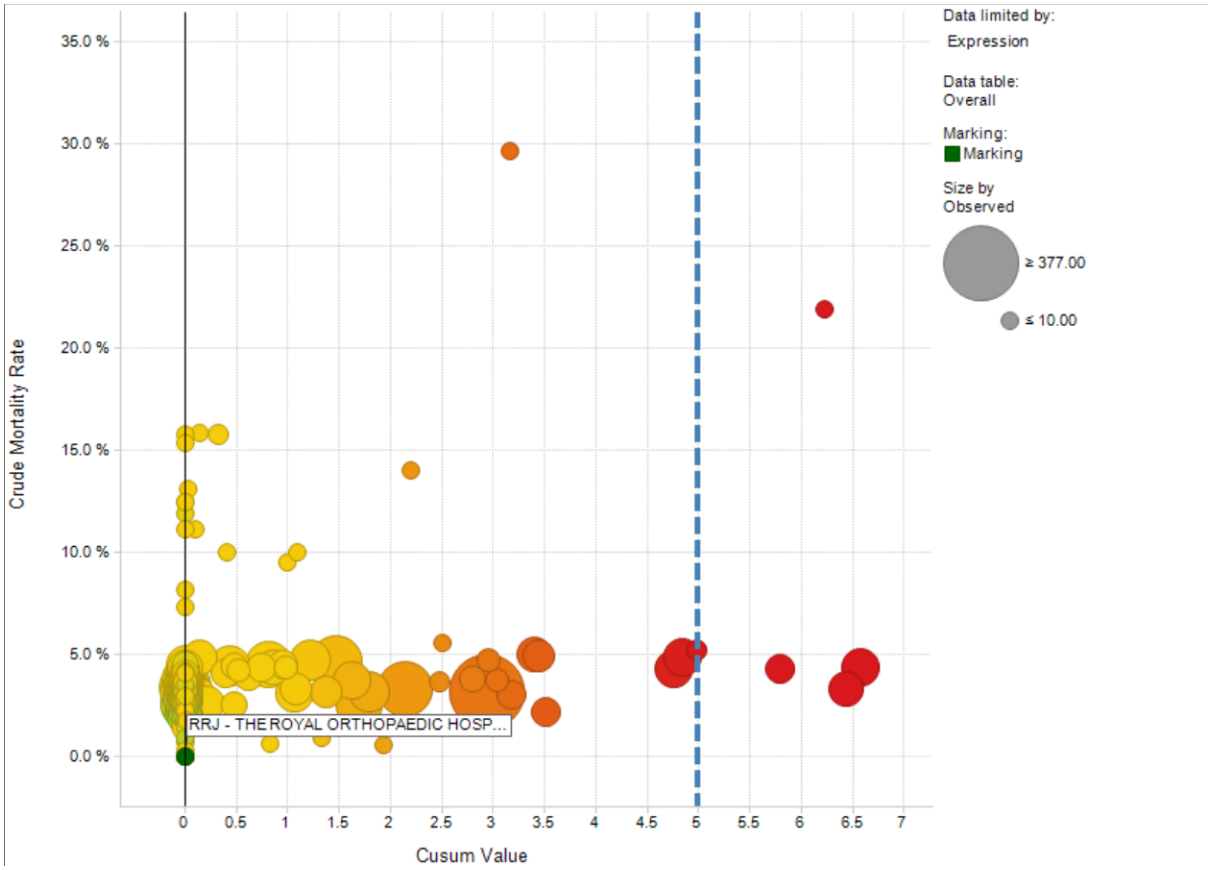


Figure 4 Crude Mortality Rate against CuSUM value for May 2019 with control threshold set at 5 to define mortality outliers

The Trust's crude mortality rate is low as one would expect. (Source UHB's Health Evaluation Data (HED) dashboard.) The method used for this diagram is the CuSUM CQC technique. All diagnostic codes used as opposed to 56 diagnostic codes in HSMR. A statistical process control threshold set at 5 times the expected rate for the patient group. The method identifies negative swings in performance and HED provides graphs on a monthly basis approximately 3 months in areas. Using either the 56 diagnostic codes or all codes and across many months sampled using the tool the ROH position remains similar, with low crude mortality and a clear distance from a statistical breach.

Standardised Mortality Ratio Benchmarking against other Trusts over time

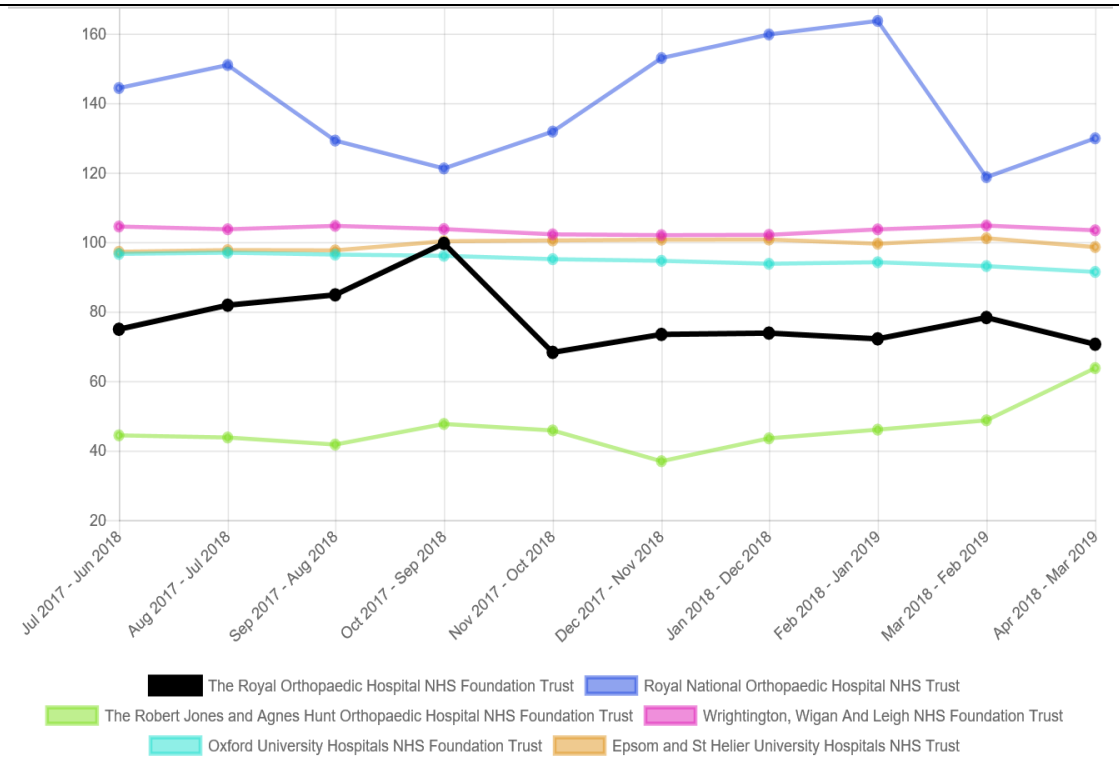


Figure 5 Comparison with other Orthopaedic Trusts – 12 month rolling average

Figure 6 SMR

The Trust has performed well compared with other specialist orthopaedic Trusts in terms of the Standardised Mortality Ratio. The tracker confirms a high number of Cancer cases at the ROH which are not generally seen at Robert Jones and Agnes Hunt in such large numbers. The fairest comparison would be with the Royal National Orthopaedic NHS Trust, the other large national bone tumour centre.

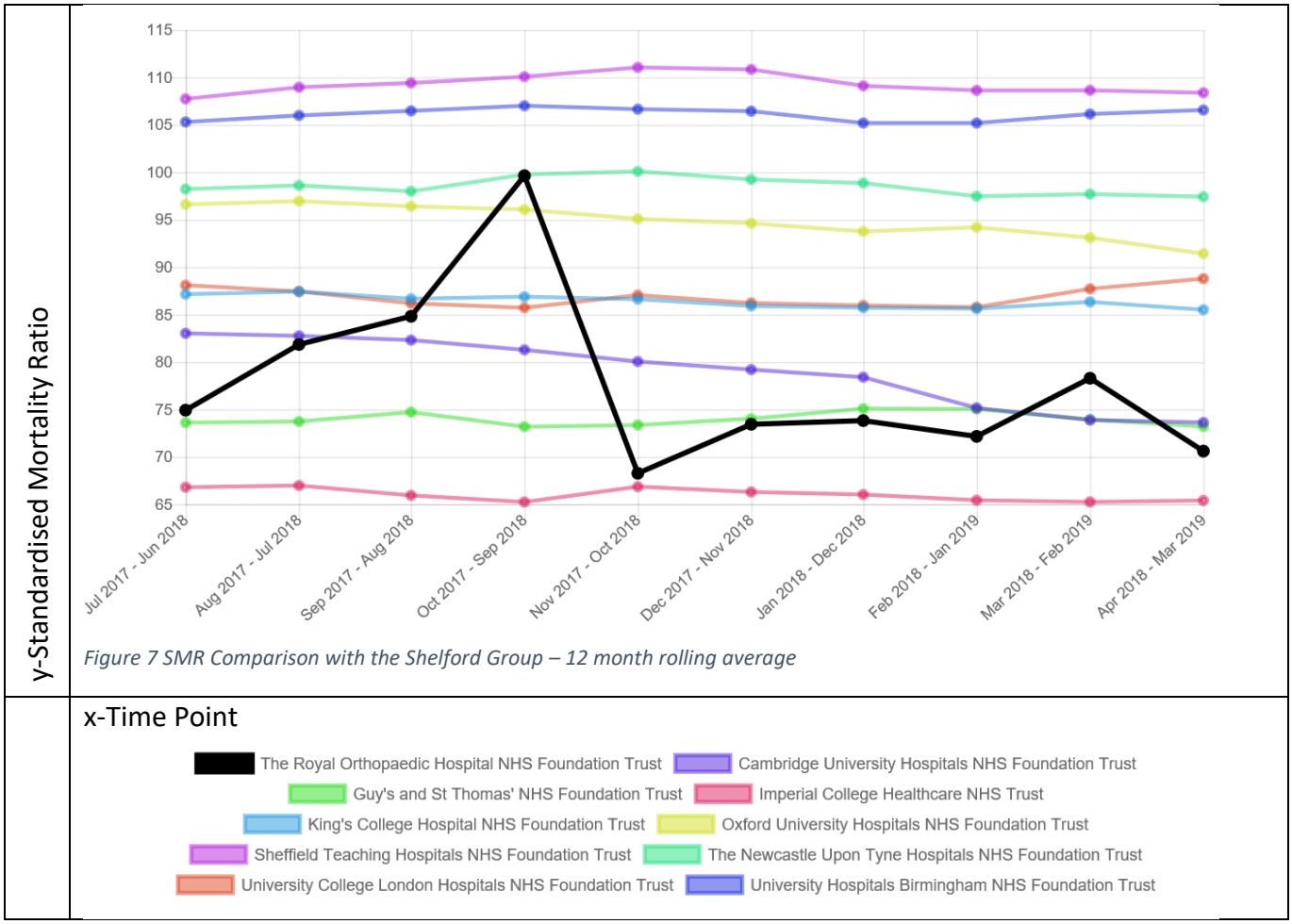


Figure 7 SMR Comparison with the Shelford Group – 12 month rolling average

2.0 Recommendation

2.1 The Trust Board is asked to:

RECEIVE and NOTE the update, noting that whilst improvements continue to be made, we are able to provide assurance around the functionality of the learning from deaths process and around historical mortality figures.

Mr Matthew Revell
Medical Director

30 August 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Finance & Performance extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

Over the summer, the Executive Team has overhauled and updated both the Corporate Risk Register and Board Assurance Framework to reflect the latest view of the key risks facing the Trust. Those risks shaded in blue are recommended for closure or de-escalation to local risk registers.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate • Agree to close or de-escalate those risks suggested					
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:					
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:					
Executive Team in July 2019					

BOARD ASSURANCE FRAMEWORK - QUARTER 1 AND 2

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
FP1	Finance	Exec Dir - F&P	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	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	FPC reports; Board approval for cash borrowing; Finance & Performance overview	3	4	12	↔	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	Dec-19	2	3	6
1089	Operations	COO	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 all services to deliver 92% submitted to NHSI describing how these services will be recovered to meet 18 week RTT. Ongoing demand and capacity measurements identify any gaps in service capacity to meet demand with plans put in place . RTT position sent monthly to CCG for information.	Weekly report to Exec Team & Ops Board	3	4	12	↔	The Trust trajectory to deliver 92% performance is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for May is 88.92 % with only 9 patients over 40 weeks , plans are in place to meet trust forecasted position for delivery of 92% trust wide in September 2019 and currently Arthroplasty , Spinal, , Foot and ankle , Hands, Oncology Arthroplasty and CSS are meeting the 92% target . A revised trajectory has been agreed with NHSI for the delivery of 92% in all specialties. Additional capacity is in place for the YAH service which is improving the current position (88.54%). Following the paediatric transition at the end of June demand and capacity plans are currently being reviewed to ensure delivery in spinal deformity in January 2020 . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway. Additional Consultant capacity is in place to ensure sustained delivery of RTT compliance in line with the theatre expansion programme. Progress is monitored weekly at PTL meeting chaired by the Deputy COO.	Ongoing	3	4	12

1117	Operations	COO	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 in line with agreed Trust process, chaired by DIV 1 AMD . 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 be implemented and monitored via the Operational team to support improved data quality.	Ongoing	3	4	12
7	Operations	COO	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	In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All patients monitored at weekly PTL - plans in place for all patients over 40 weeks Full RCA and harm review for all patients over 52 weeks presented monthly at harm review board. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.	Weekly updates to Exec Team; updates to Trust Board.	2	4	8	↔	March 2019 - As at the end of March the Trust has zero patient waiting over 52weeks	Ongoing	2	4	8
27	Operations	COO	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.	Updates to Staff Experience & 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. Junior Fellow posts have been re advertised with a revised 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 . The draft Job Description for the alternative medical workforce has been agreed . A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator commenced in December 2018 and is now focusing on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is now being monitored by the CSMS and reported to a monthly meeting to monitor spend, chaired by the deputy COO.	Ongoing	2	3	6
770	Operations	COO	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.		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	↔	The theatre expansion programme is underway with phase 1 of the expansion programme due to be delivered in December 2019 , at this point the risk will be reviewed.	Ongoing	1	5	5

CO2	Operations	COO	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	2	3	6	↓	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. The Perfecting Pathway Programme Board will be launched in September 2019. All programmes will be tracked and progress reviewed on a monthly basis at this board which will report monthly to F and P committee to ensure support is in place to deliver the programme of service changes and redesign. Structure is in place to support the team and substantive COO has now been appointed.	Q4 2018/19	2	3	6
269	Operations	COO	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	↔	Delivery of the integrated action plan round 18 weeks RTT, cancer services and spinal deformity continues to support delivery of agreed activity plans . Development and delivery of recovery plan. Modular theatre set up anticipated to become functional in December 2019, which creates additional capacity for activity. Continued joint working with Heartlands, Good Hope and Solihull Hospitals to support standardisation of pathway across STP and agree activity levels at the ROH and Solihull elective centres. Work also underway for ROH to support winter pressures at HGS . Pathway work is also being scoped with the spinal teams across ROH and UHB.	Q1 2019/20	2	4	8
270	Finance	Exec Dir - F&P	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 is 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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 continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. A specific review of BIU activity is ongoing.	Ongoing	2	4	8

804	Finance	Exec Dir - F&P	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 function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	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	↔	An information analyst has been recruited and is due to start at the trust early 2019 . The recruitment of the Business Intelligence Systems Manager had been delayed due to budget issues, but the post will now go to advert early 2019.	Q4 2018/19	2	4	8
FP3	Finance	Exec Dir - F&P	The Trust may experience supply chain disruption and experience an adverse impact on areas which are dependent on overseas staffing in the event of a "no-deal" Brexit, resulting in operations being cancelled and long lead times for securing overseas staff		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. Internal analysis of workforce risk suggests that there is likely to be little disruption to staffing level in the event of a 'no deal' Brexit		3	4	12	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	Oct-19	2	3	6
FP2	Finance	Exec Dir - F&P	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 has received transitional funding during 2018/19 to support the additional costs of paediatric provision.	Q4 2018/19	1	4	4

MD1	Clinical	Exec Medical Director	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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
1298	Finance & Performance	Exec Dir - F&P	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:		Safe, efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	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. 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.	IM&T programme board papers	4	4	16	↔	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. 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	2	4	8
FP4	Finance & Performance	Exec Dir - F&P	There is a risk that the full quantum of cost saving as outlined in the 2019/20 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Whilst full delivery of the CIP schemes will not happen, this has been taken into account within the financial planning for the remainder of the year.	Finance and Performance overview; CIP programme board papers	4	4	16	↔	Much work has been undertaken in creating the CIP framework for 2019/20. The financial plan for 19/20 identifies a target of £1.4m, which is the level required as per the planning guidance. This is backed up by an internal plan which targets delivery of £2.3m with a further stretch target of circa £3m. The initial £1.4m is within the level of saving achieved during 2018/19, whilst further discussion are ongoing relating to how we potentially use incentive schemes to increase delivery up to the internal target of £2.3m and beyond.	Mar-20	3	4	12

FP5	Finance & Performance	Exec Dir - F&P	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy and that the modular theatres will place a strain on the supportive infrastructure		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.	Perfecting Pathways update; Finance & Performance overview	4	4	16	↔	The theatre build project is currently on schedule and monitoring arrangements to detect strain on the Trust's supporting infrastructure are being developed	Dec-19	3	4	12
FP6	Finance & Performance	Exec Dir - F&P	There is a risk that the Financial Control Total will not be met in 2019/20		Safe and efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	The 2019/20 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery. Clinical Audit day has been cancelled in February to allow more work to be undertaken. Revised activity plan distributed which identities performance levels required for recovery.	Finance and Performance overview	3	3	9	↔	Further focus to deliver increased activity.	Mar-20	3	3	9

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

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 23 July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee was advised that the financial position had deteriorated. It had been assumed that as the control total for the month had not been met, that the Provider Sustainability Funding would not be awarded. If the month 6 position was achieved however then the funding would be allocated. • The reason for the shortfall in the financial related to lower than planned levels of elective inpatient activity. • The position in spinal services was noted to be particularly impacted by the reluctance of consultants to undertake additional work as a result of the potential tax liabilities associated with pension payments. This additional work had been a key assumption in the operational plan. Pain management and arthroplasty services were also impacted by the same issue. • The Cost Improvement Plan (CIP) was slightly behind plan, some of which was associated with the slippage in the managed theatres scheme. • The Referral to Treatment Time performance was below trajectory, this being associated with the lower levels of activity being handled.	• Clarify the length of stay position associated with JointCare patients, distinctly from other patients.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The efforts being undertaken to improve activity levels was described, which included recruitment of locums & substantive medical staff, introducing nurse-led clinics and better annual leave planning. • To overcome the issue around the pension tax liability alternative models through which the Trust could contract with the consultants for additional work were being considered and legal advice was being taken on these plans. • Expenditure was reported to be below plan, this being associated with the lower levels of activity being handled by the Trust.	• Convene a special meeting of the Finance and Performance Committee to review the revised operational plan in August.

• Length of stay was reported to have improved and was a positive trend overall. • There remain no patients waiting over 52 weeks for treatment and the number of patients waiting over 40 weeks was reducing. • As part of the 'Perfecting Pathways' project, it was reported that the implementation of the electronic prescribing and medicines administration system (ePMA) was progressing well and was now overseen by a new project manager.	

Chair's comments on the effectiveness of the meeting: It was noted that the meeting had been shorter than usual, however the key points needing debate had been covered adequately.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 15 August 2019 (ASSURANCE BRIEFING)

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that the financial position remained below plan, with the position in July having been £90k below the recovery plan. The financial position was £1,107k below the original plan year to date. • The managed service cost improvement programme scheme was noted to have slipped further, although other CIP schemes coming on line were offsetting the impact of this to some degree at present. • The Referral to Treatment Time position was reported to have remained static and was below the trajectory. • Performance against the 62 day cancer target was reported to be 77.8% - this shortfall related to one breach where a patient had needed a second opinion from overseas and therefore the pathway had been unavoidably extended. The position for July was expected to be 100% however. • Appraisal rates were reported to be below trajectory.	• Each element of the recovery plan is to be translated into activity and income. • Define the percentage increase in capacity associated with the new medical staff and identify the maximum baseline capacity, excluding additional duty hours (ADHs) • Develop a summary and reasons for the current financial and operational situation to ensure that it was clear why there was underperformance at present and the plans to mitigate the risks.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The revised financial and operational plan had not needed to be submitted to NHS Improvement as originally anticipated. • It was reported that there was an expectation that the financial position would improve in September, with a small surplus being anticipated. • New medical staff were planned to start shortly and a consultant was planning to run a series of three-day sessions. • Discussions were underway with NHS England/Improvement to secure additional funding to reimburse the Trust for inefficiencies and support associated with the provision of paediatric services across two sites (Birmingham Children's Hospital and the ROH).	• None specifically.

• A higher level of activity for day cases and elective cases had been delivered in July in comparison to the previous month. • There were continued discussions and plans to establish a Limited Liability partnership (LLP) through which the Trust could contract with medical staff to undertaken additional duty hours. Legal advice was being taken to support the plans and models in place elsewhere were also being reviewed for any lessons learned. • The theatre utilisation position was positive. • There remained no patients waiting over 52 weeks and there were reported to be only six patients waiting in excess of 40 weeks. • Mandatory training rates had improved.	
Chair's comments on the effectiveness of the meeting: It was noted that although there had not been a meeting scheduled for August, the discussions had been helpful to provide continued oversight of the current difficulties with the financial and operational performance.	

Finance and Performance Report

July 2019

Trust Board meeting – 4 September 2019

CONTENTS

INTRODUCTION

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

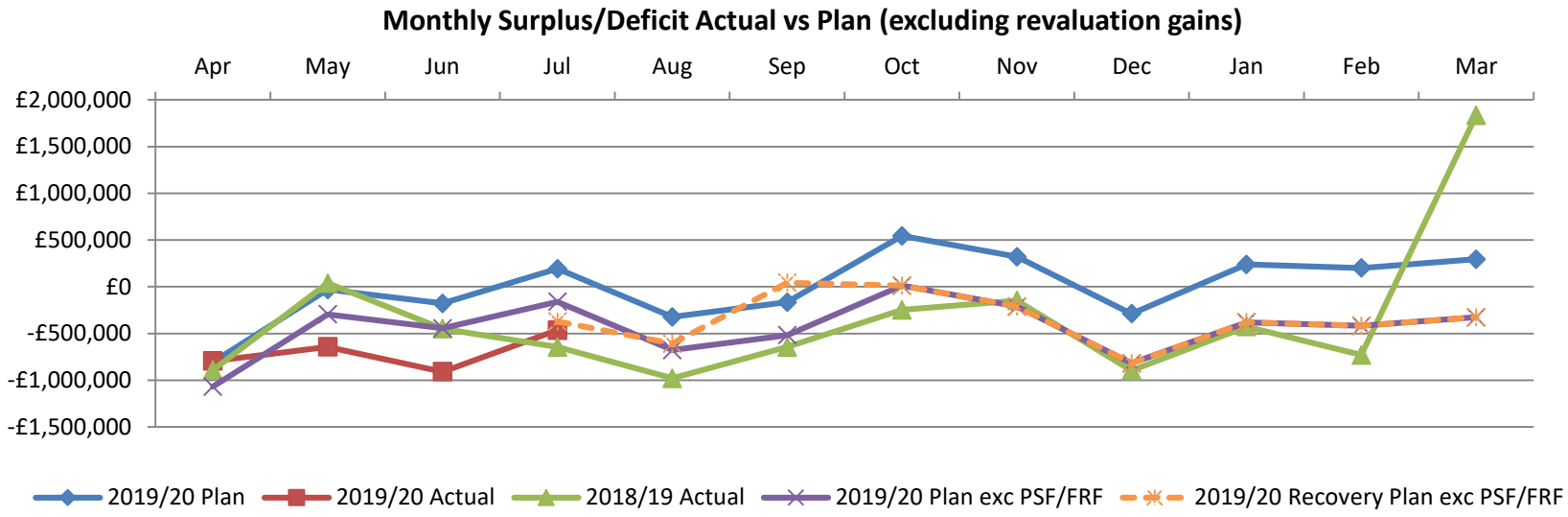
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

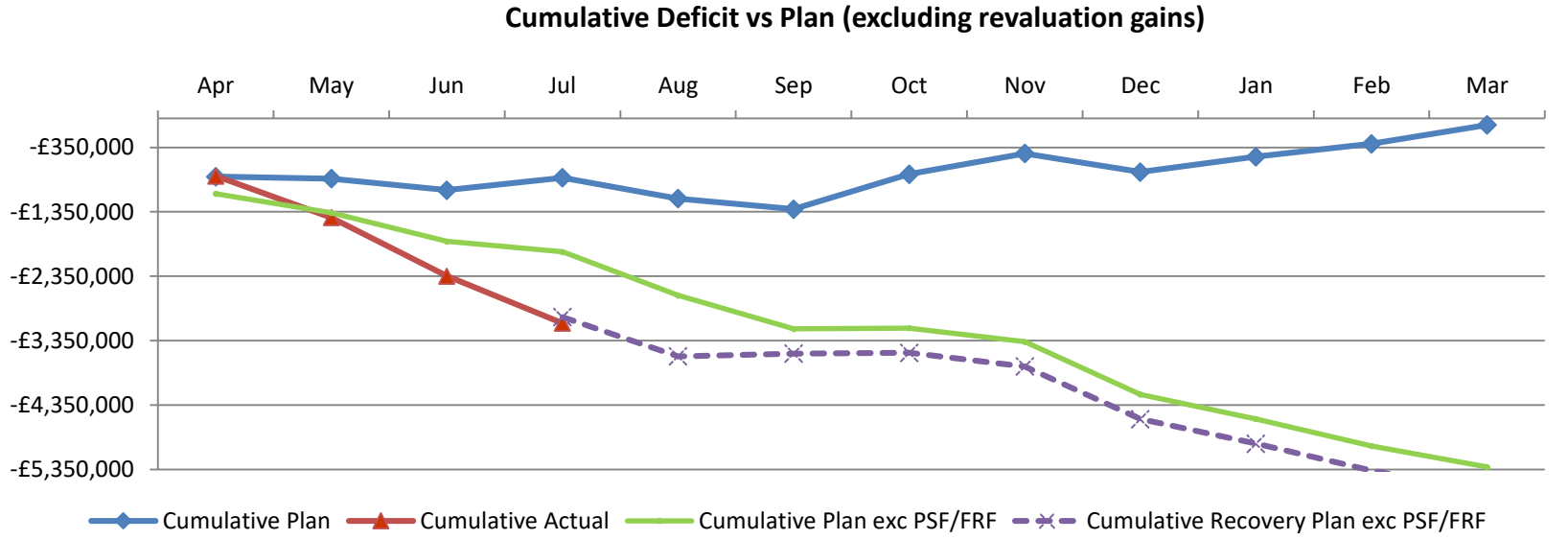
1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M04 Original Plan £'000	YTD M04 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	27,550	25,857	(1,693)
Other Operating Income	1,536	1,804	268
Total Income	**29,086**	**27,661**	**(1,425)**
Employee Expenses (inc. Agency)	(18,184)	(18,013)	171
Other operating expenses	(12,438)	(12,180)	258
Operating deficit	**(1,536)**	**(2,532)**	**(996)**
Net Finance Costs	(455)	(429)	26
Net deficit	**(1,991)**	**(2,961)**	**(970)**
Remove donated asset I&E impact	20	(117)	(137)
Financial Performance surplus/(deficit) excluding PSF & FRF	**(1,971)**	**(3,078)**	**(1,107)**
PSF/FRF monies	1,151	265	(886)
Adjusted financial performance (including PSF & FRF)	**(820)**	**(2,813)**	**(1,993)**

During May, June and July as the control total pre-PSF and FRF was not met, a prudent assumption was made to exclude PSF and FRF from the M2, M3 and M4 position. M1 PSF and FRF amounts to £265k only, the M1-M4 PSF and FRF monies available to the organisation amount to £1,151k.

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). This includes PSF & FRF





INFORMATION

Trust delivered an in-month deficit of £465k in July against a planned surplus of £188k (inc PSF / FRF) or a planned deficit of £161k (excl PSF / FRF), an underperformance of £304k against plan. The recovery plan assumed a deficit of £372k in month. This gives a year to date deficit position of £3,078k against a deficit plan of £1,971k (excl PSF/FRF) , causing an underperformance of £1,107k.

Clinical income has underperformed by £469k against the 19/20 NHSi plan in July due to decreased level of elective inpatient and day case activity and 18/19 actual for the same period. However there has been a significant increase from M3 to M4 although the recovery plan for July has not been achieved.

Pay spend is £171k lower than plan year to date with temporary staffing spend above plan by £640k, due to vacancies and sickness.

Overall expenditure to date is £429k lower than plan mainly due to paediatric inpatient transition to Birmingham Women's and Children's Hospital.

ACTIONS FOR IMPROVEMENTS / LEARNING

Workforce planning is underway to identify actions that can be taken to reduce temporary staffing levels. A reduction in medical agency spend is expected from August onwards with 3 GP trainees posts to be filled in the SHO rota which were previously covered by agency medics. A significant reduction in nursing agency is expected until Dec 2019 with the go-live of Theatres Expansion Phase 1 at ROH, due to significant recruitment levels expected over the coming months. A project is underway to create one trust-wide establishment and recruitment trajectory, which will support the basis for recruitment planning and management going forth. This is expected to be complete across all staffing levels by August 2019.

A review of activity plans is complete to provide a level of assurance of activity achievement against plan for the remainder of the year, as-well as providing a targeted recovery plan.

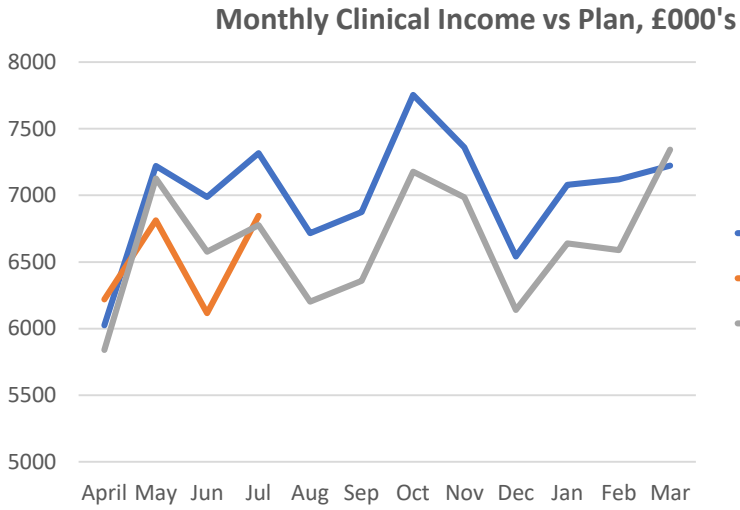
RISKS / ISSUES

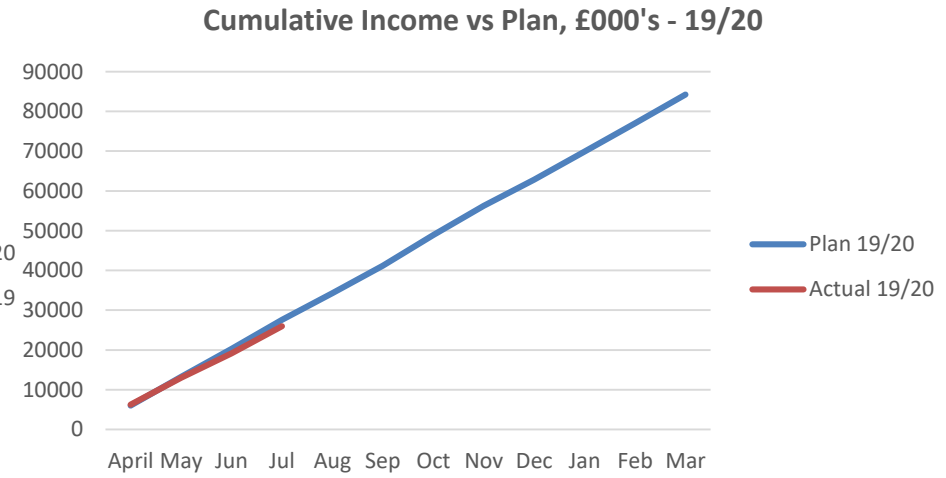
August has a planned deficit of £329k in month and cumulative deficit of £1,169k. The recovery plan assumes a deficit of £608k in month.

August NHSi income plan is £600k lower than that planned for July, however the August recovery income plan is only £137k lower than July income delivery. August is traditionally a lower activity month given annual leave and school holidays and as such delivery against this plan remains a concern. Recovery activity and income plan discussions are complete with the operational and clinical teams.

September has a recovery plan surplus of £43k against an initial planned deficit of £519k (exc PSF / FRF) generated by significant additional activity that is planned.

2. Income and Activity– This illustrates the total income generated by the Trust in 2019/20, including the split of income by category, in addition to the month's activity (Inc PSF & RFF)

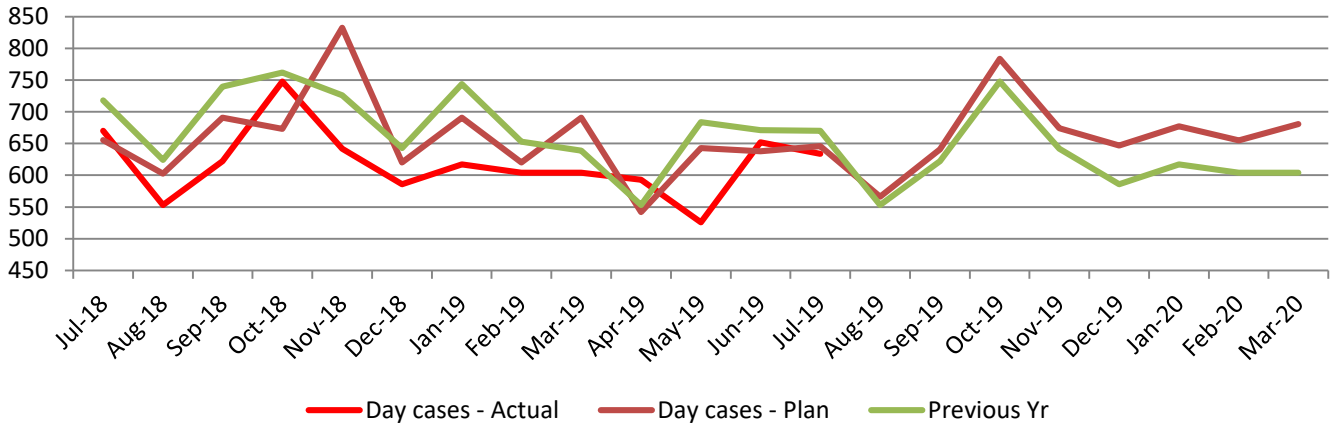




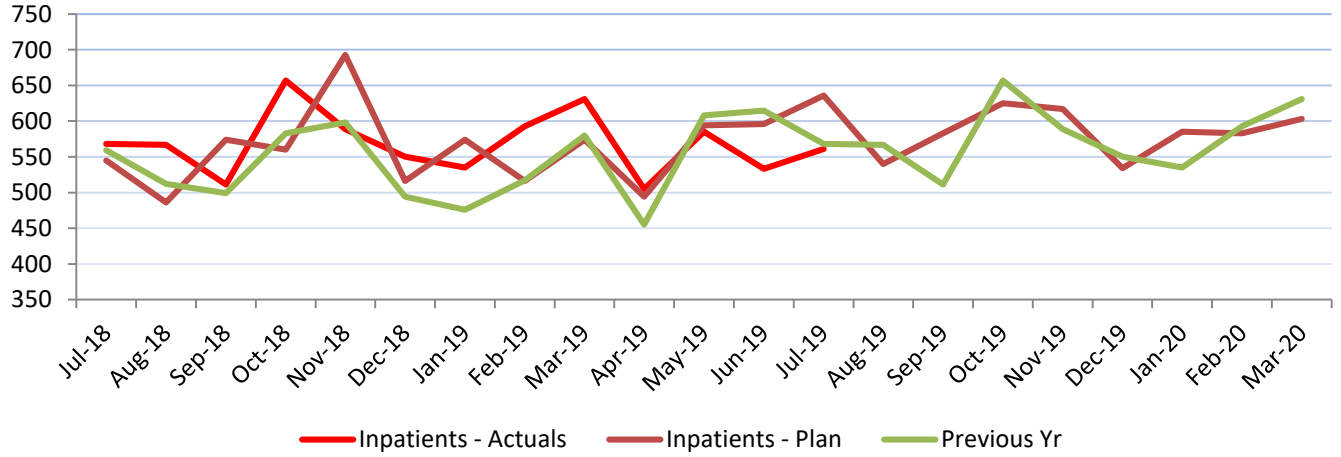
Clinical Income – July 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,713	3,747	34
Excess Bed Days	76	39	-37
Total Inpatients	3,789	3,786	-3
Day Cases	872	756	-116
Outpatients	792	768	-24
Critical Care	194	85	-109
Therapies	240	310	70
Pass-through income	212	77	-135
Other variable income	652	477	-175
Provision		0	0
Block income	566	589	23
TOTAL	7,317	6,848	-469

Clinical Income – July YTD 2019 £'000			
	Plan	Actual	Variance
Inpatients	13,593	12,690	-903
Excess Bed Days	276	174	-102
Total Inpatients	13,869	12,864	-1,005
Day Cases	3,331	3,111	-220
Outpatients	2,972	2,801	-171
Critical Care	768	553	-215
Therapies	951	1,119	168
Pass-through income	838	685	-153
Other variable income	2,582	2,621	39
Provision		0	0
Block income	2,239	2,240	1
TOTAL	27,550	25,994	-1,556

Day Case Activity



Inpatient Activity



Activity Performance including Recovery Plan Q1-Q2

POD	Plan	Sum of April	Sum of May	Sum of June	Sum of July	Sum of Augu	Sum of Sept	Q1	Q2	Total	Cumulative Deficit Q1 - Q2	Cumulative Deficit M1 - M4
Daycase	Actual	702	453	616	722			1,771	722	2,493		
	NHSI	668	554	601	708	517	798	1,823	2,022	3,845		
	Recovery	668	554	601	748	499	858	1,823	2,104	3,927		
	Recovery vs Actual	34	(101)	15	(26)			(52)	(26)	(78)	(78)	(78)
	Recovery vs Plan	0	0	0	40	(18)	60	0	82	82	82	40
Elective	Actual	545	465	487	600			1,497	600	2,097		
	NHSI	555	504	535	669	460	667	1,594	1,796	3,390		
	Recovery	555	504	535	644	456	751	1,594	1,851	3,445		
	Recovery vs Actual	(10)	(39)	(48)	(44)			(97)	(44)	(142)	(142)	(142)
	Recovery vs Plan	0	0	0	(25)	(4)	84	0	55	55	55	(25)
Non- Elective	Actual	37	35	34	41			106	41	147		
	NHSI	23	28	30	33	35	38	81	105	186		
	Recovery	23	28	30	33	35	38	81	105	186		
	Recovery vs Actual	14	7	4	8			25	8	34	34	34
	Recovery vs Plan	0	0	0	0	0	0	0	0	0	0	0
OP F/Up	Actual	4,027	3,034	3,266	4,097			10,327	4,097	14,424		
	NHSI	4,180	3,223	3,303	4,017	3,119	4,384	10,706	11,520	22,226		
	Recovery	4,180	3,223	3,303	4,017	3,119	4,384	10,706	11,520	22,226		
	Recovery vs Actual	(153)	(189)	(37)	80			(379)	80	(299)	(299)	(299)
	Recovery vs Plan	0	0	0	0	0	0	0	0	0	0	0
OP First	Actual	1,949	1,405	1,573	2,036			4,927	2,036	6,963		
	NHSI	2,042	1,579	1,605	2,314	1,606	2,417	5,226	6,337	11,563		
	Recovery	2,042	1,579	1,605	2,324	1,594	2,422	5,226	6,340	11,566		
	Recovery vs Actual	(93)	(174)	(32)	(288)			(299)	(288)	(586)	(586)	(586)
	Recovery vs Plan	0	0	0	10	(12)	5	0	3	3	3	10
OP Proc	Actual	611	401	419	398			1,431	398	1,829		
	NHSI	495	454	439	546	449	546	1,388	1,540	2,928		
	Recovery	495	454	439	546	449	546	1,388	1,540	2,928		
	Recovery vs Actual	116	(53)	(20)	(148)			43	(148)	(105)	(105)	(105)
	Recovery vs Plan	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**23,705**	**17,927**	**19,303**	**24,099**	**12,303**	**17,997**					

NHS Clinical income has under-performed against plan by 6.41% in July having under-performed in June by 12.4%. Cumulatively, the trust is 5.65% below plan. The admitted patient care performance was above plan financially though down on activity levels against plan, with discharged activity 69 below target. Day case activity underperformed financially and was below the activity target by 10 cases. Case-mix in July was 53% for day cases 44% for electives. Non Elective make up the other 3%. This has changed from June as electives made up 42% of the activity, an increase of 2%

Outpatients have under-performed for July. There has been a decrease in attendances against plan in May for first and follow up attendances . First to follow up ratio is 2.10:1 year to date.

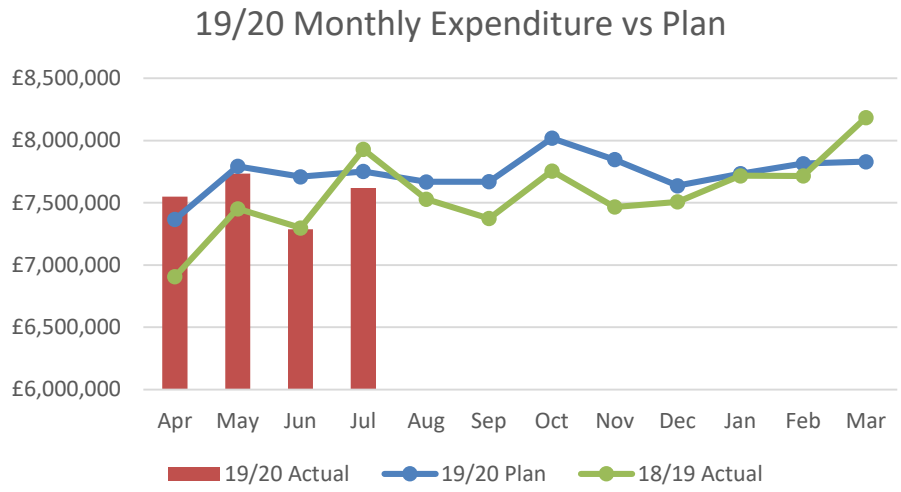
ACTIONS FOR IMPROVEMENT/LEARNING

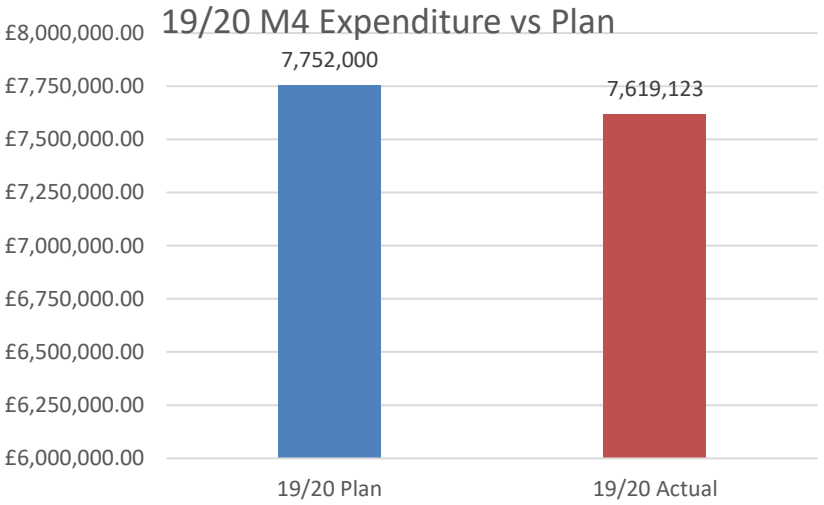
Recovery plan discussions are complete with the operational and clinical teams, with identified mitigating actions that are being taken. Clinical Service Managers are reviewing theatre lists to ensure they are fully maximised.

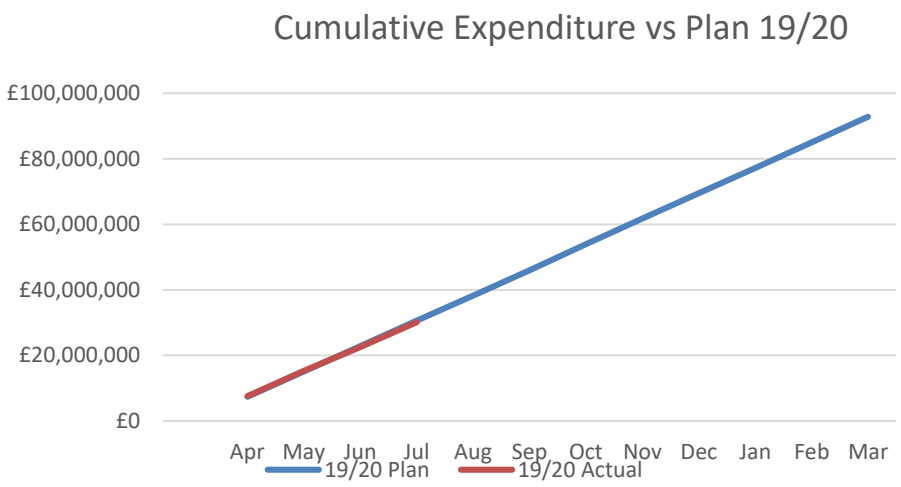
Finance and clinicians are working together to insure that co-morbidities are being recorded and therefore maximising the income.

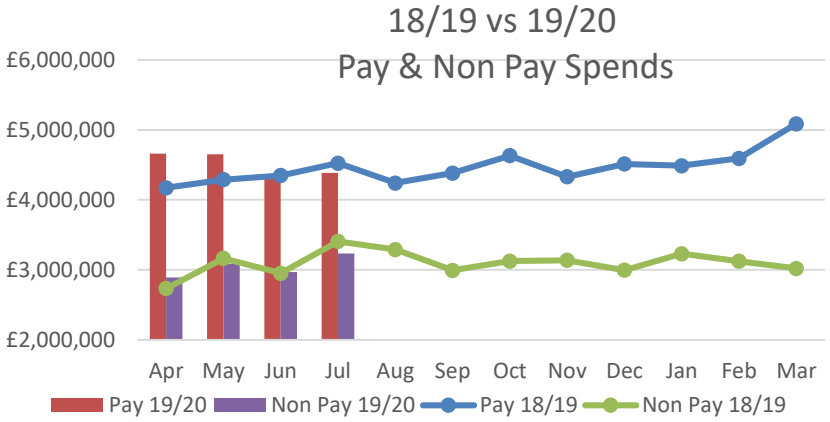
RISKS / ISSUES

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









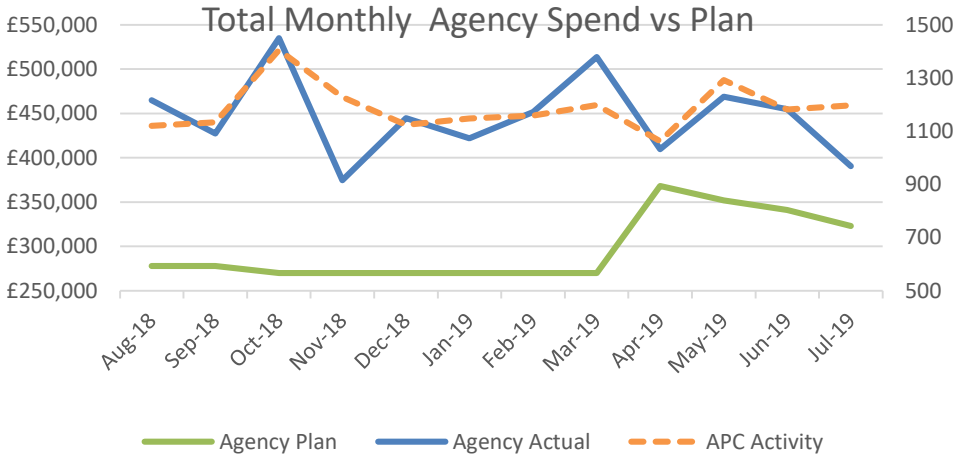
INFORMATION

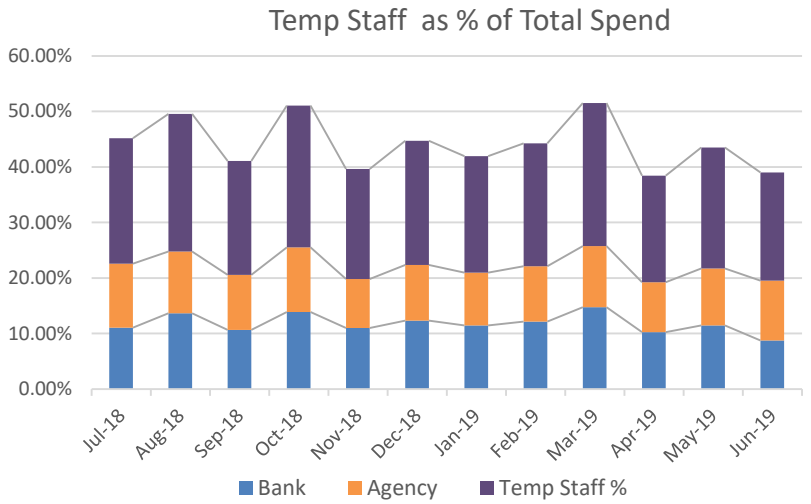
Expenditure in July was £7,619k, which was lower than the planned spend of £7,752k, equating to an in month variance of £133k. Year to date expenditure is £30,193k against a plan of £30,622k.

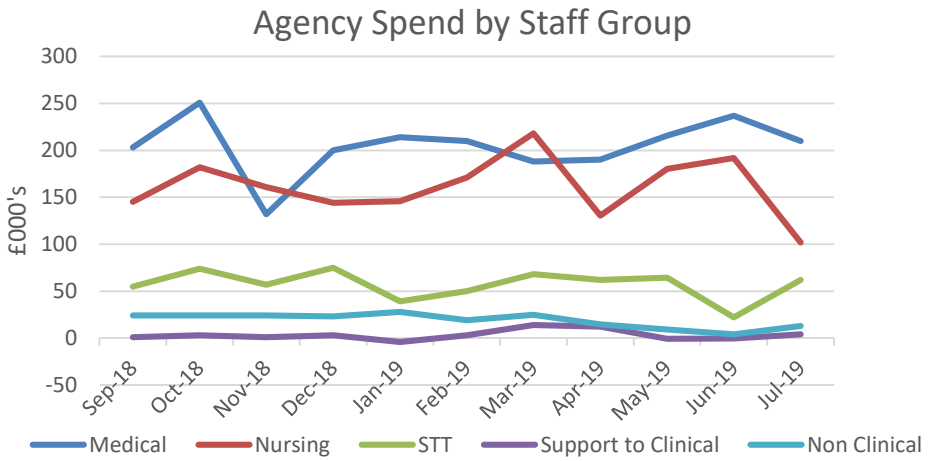
Pay in July was £4,386k which was £143k lower than plan.

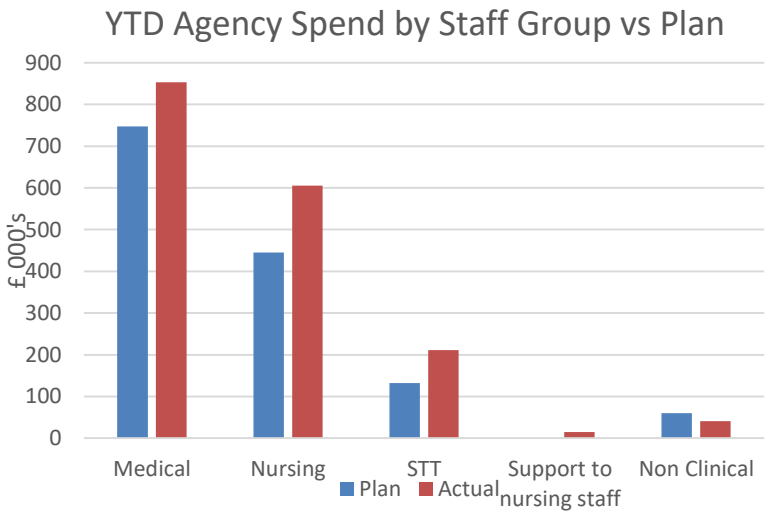
Non pay spend in July was £3,233k which is £10k higher than plan.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Total agency spend for July was £390k against a plan of £323k, with cumulative spend of £1,724k against a cumulative plan of £1,384k (£339k overspend).

Nursing agency has the highest spend above plan with £160k above plan year to date. Medical agency spend is £106k above plan year to date.

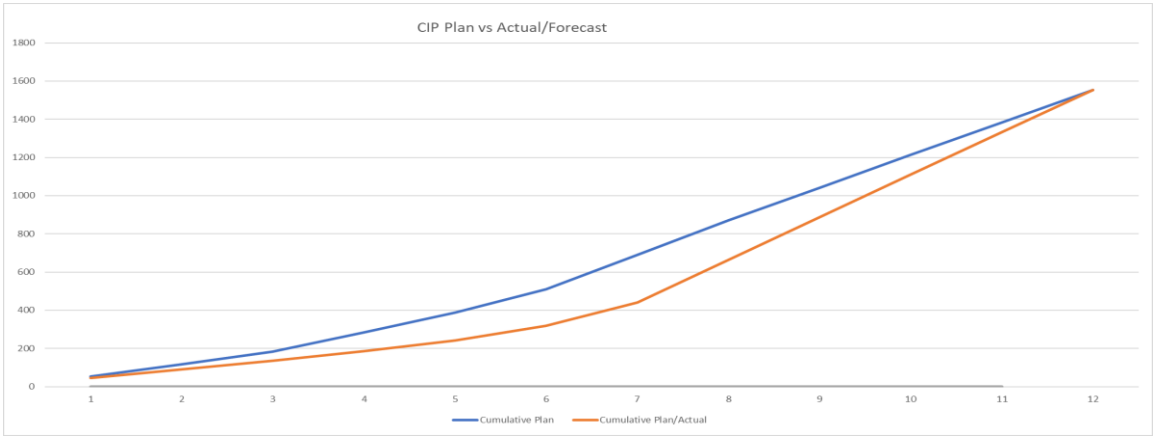
ACTIONS FOR IMPROVEMENTS / LEARNING

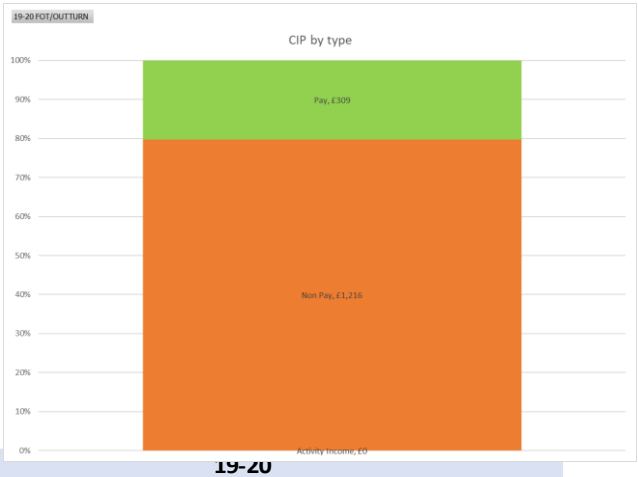
Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

Recruitment to vacancies continues with substantive fill rates expected to be significantly improved by October 2019, with a current fill rate of 85% increasing to 95% by October.

5.Cost improvement Programme – This illustrates the plan for the 2019-20 cost improvement programmes (£000's)





Row Labels	In-Month NHSI Plan	In-Month Actual	In-Month Var	YTD NHSI Plan	YTD Actual	Sum of YTD Var	19-20 NHSI Plan	19-20 FOT/OUTTURN	Sum of 19-20 Variance (FOT)
1	£40	£1	(£39)	£129	£1	(£128)	£472	£261	(£210)
2	£55	£37	(£18)	£131	£76	(£55)	£963	£847	(£116)
Corporate	£3	£29	£26	£12	£114	£102	£36	£361	£325
Estates & Facilities	£3	£4	£1	£12	£16	£4	£78	£55	(£23)
Grand Total	**£101**	**£70**	**(£30)**	**£284**	**£207**	**(£76)**	**£1,549**	**£1,525**	**(£24)**

The Trust QCIP (Quality and Cost Improvement Programme) target was identified at £1.553m for 19-20. In 18-19 the Trust target was identified at £2.985m, however only £1.688m (57%) was delivered. Thus, during the 19-20 business planning (and QCIP) round, schemes up-to £2.294m have been identified as opportunities for this year. (With the difference being a stretch target for the Trusts divisions) Many of the schemes amounting to the Trust target (£1.553m) have been costed, however some (including the stretch target schemes) remain aspirational at present and costings are ongoing.

All of the schemes identified at present are recurrent schemes, QCIP PID/QIA (project initiation documentation including costings and quality impact assessment) completion is currently ongoing, with a targeted completion date of 30th August 2019.

The Trust has a year to date variance of £76k under plan but it is expected the underperformance will be recovered to only a £24k under-achievement by the end of the year.

The 2 largest schemes for 19-20 include the Theatres MSC and workforce recruitment, the latter based on current trajectories will fully deliver the target, however the former is likely to slip from July 2019 to October 2019 due to delays in business case approval, vendor resolution and contract sign-off.

Despite the year-end forecasted under-performance in July 2019, additional mitigation opportunities are being discussed (and identified) in August 2019.

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	1,515	1,304	211
Tangible Assets	46,491	45,759	732
Total Non-Current Assets	**48,006**	**47,063**	**943**
Inventories	7,063	7,225	(162)
Trade and other current assets	9,081	13,977	(4,896)
Cash	2,648	4,616	(1,968)
Total Current Assets	**18,792**	**25,818**	**(7,026)**
Trade and other payables	(16,240)	(23,998)	7,758
Borrowings	(726)	(726)	0
Provisions	(86)	(58)	(28)
Other liabilities	0	0	0
Total Current Liabilities	**(17,052)**	**(24,782)**	**7,730**
Borrowings	(11,804)	(12,547)	743
Provisions	(215)	(220)	5
Total Non-Current Liabilities	**(12,019)**	**(12,767)**	**748**
Total Net Assets Employed	**37,727**	**35,332**	**2,395**
Total Taxpayers' and Others' Equity	**37,727**	**35,332**	2,395

INFORMATION

As at July 2019 net assets employed are lower than plan by £2.4m.

Capital is behind plan by £0.9m, this is due to the final phased plan by type of expenditure and timing was only finalised at the beginning of August, due to the requirement to revise the original plan at the request of DHSC. Due to this there will be ongoing variances throughout the year.

Trade receivables are significantly higher than plan, however this is mainly due to a change to the date at which the SLA invoices are raised in order to improve the cash flow for the Trust. Instead of being raised in the first week of the month the payment is due they are now being raised on the 25th. This is offset with the income being deferred so it is not double counted and has led to the significant increase in trade payables.

Trade payables are also higher due to delays in receiving monthly SLA payments from the CCG has lead to payments to suppliers being delayed. There are also delays in some areas in relation to invoices being approved for payment within the Trust. The finance team are devising reports and working with these areas to try and improve processes.

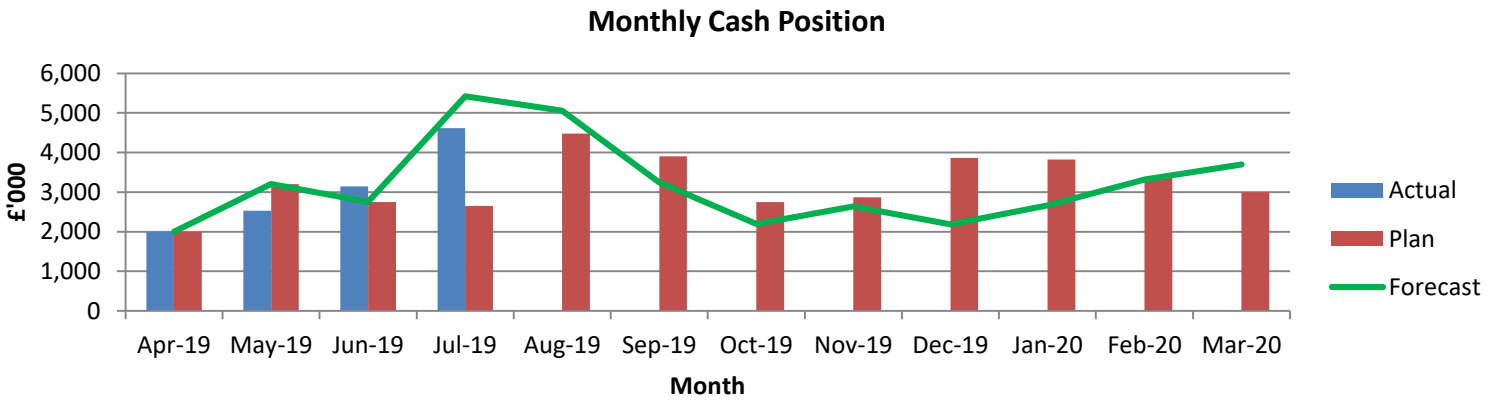
Cash is higher than plan by £2m. During July the Trust took a cash loan from DHSC for £1.1m as the 2018/19 PSF of £2.2m had not been paid and DHSC had advised that they could not guarantee the payment during July. The PSF was then paid in July resulting in more cash reserves than planned. Due to this no loan's have been taken during August.

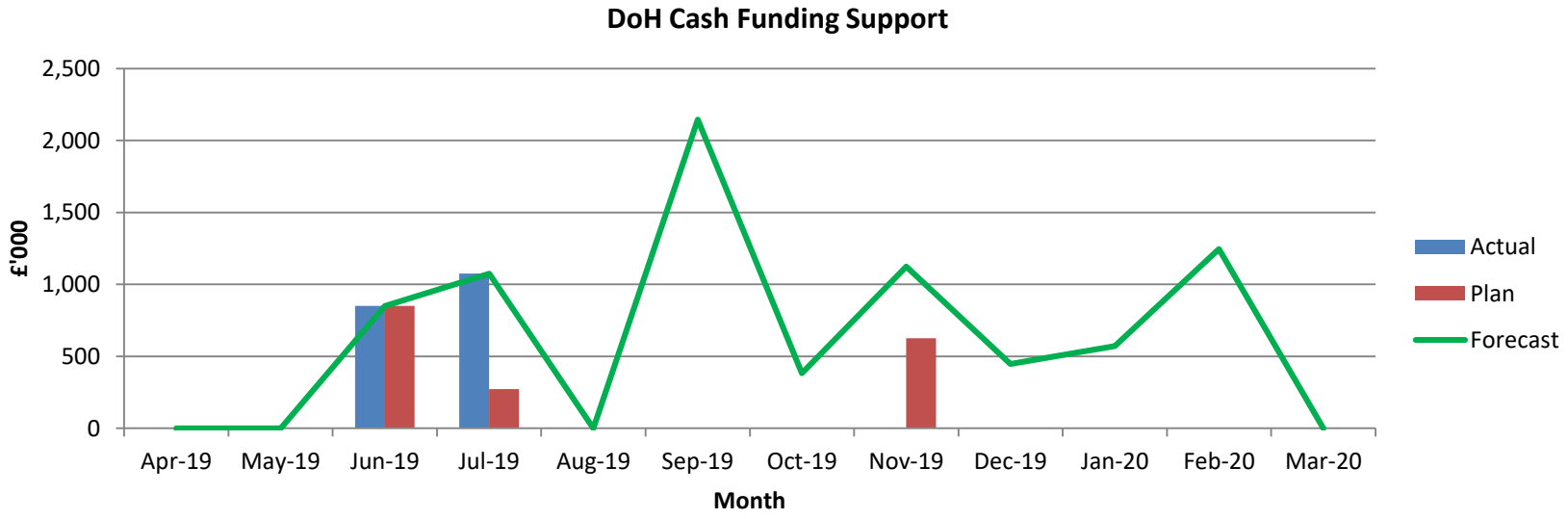
ACTIONS FOR IMPROVEMENTS / LEARNING

Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

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

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Going forward we are now forecasting the need for additional loans to be taken out that were not in the original plan. This is purely down to the uncertainty around the timing of receiving FRF funding. The plan assumed that this would be paid quarterly but this hasn't been the case and no notification has been received regarding the mechanism for accessing these funds as yet.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

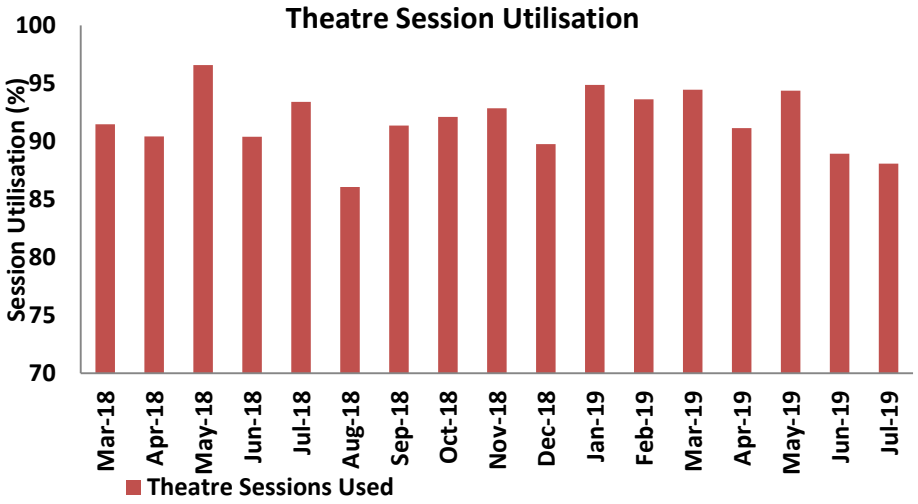
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2019/20. The Head of Financial Accounting continues to hold regular cash control committee attended by the Assistant Director's of Finance, and representatives from management accounts 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.

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

Target 90%

July utilisation was down against target at 88.09% compared to 88.94% in June.

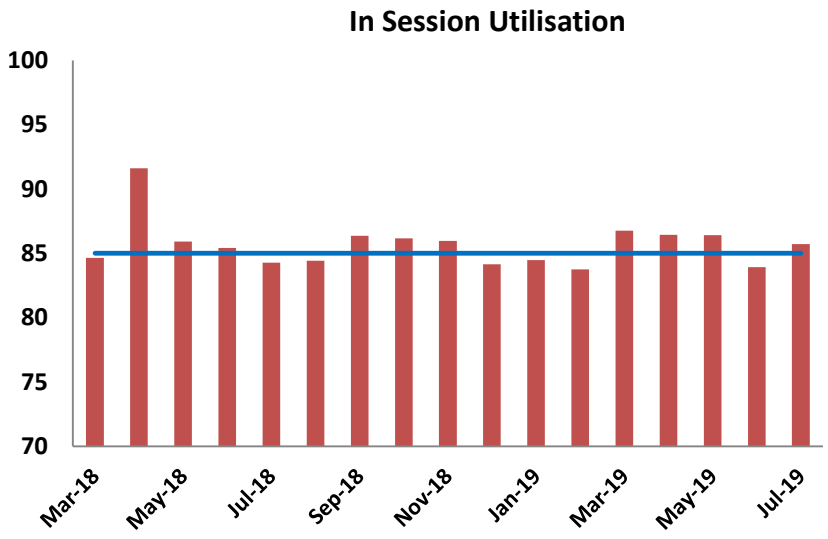
July's unused sessions totalled 65. This is primarily due to a decrease in activity as a result of Consultants not taking up ADH's.

Collaborative working with the UHB NHSFT, has resulted in UHB activity being undertaken in fallow lists at the ROH, generating income via rental charges.

RISKS / ISSUES

- Ongoing discussions with medical groups regarding the pension/tax issue continue

8. 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 preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

Target 85%

In session utilisation increased in July at 85.71% compared to 83.92% in June.

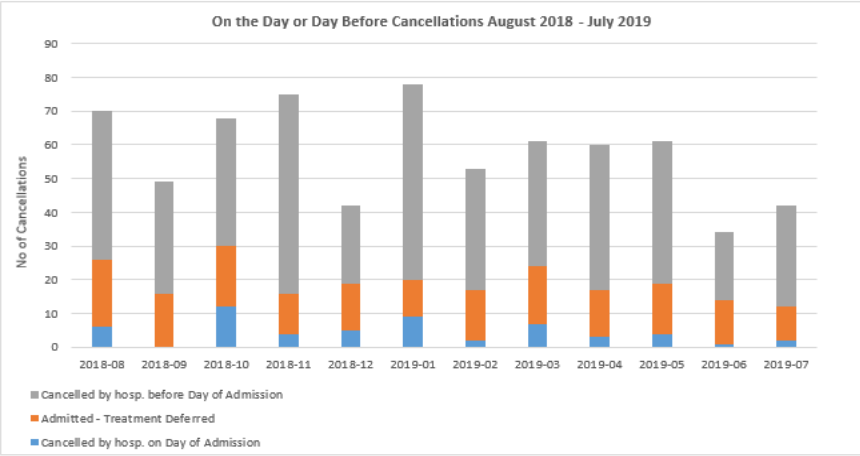
Utilisation continues to be pro actively managed at 642 meetings to maximise utilisation.

RISKS / ISSUES

- Last minute changes to lists impact on the efficient running and planning of theatre lists - risk being reduced due to introduction of lock down process and learning from theatre lookback meetings
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

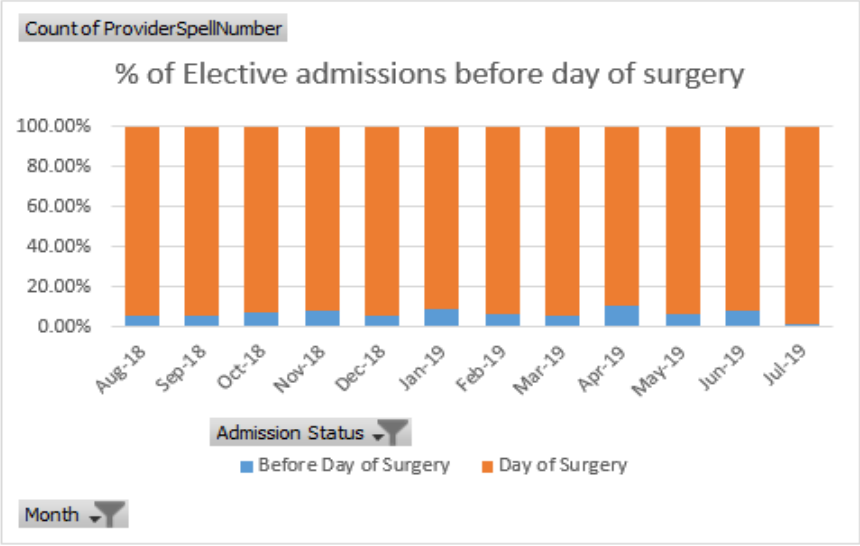
9. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

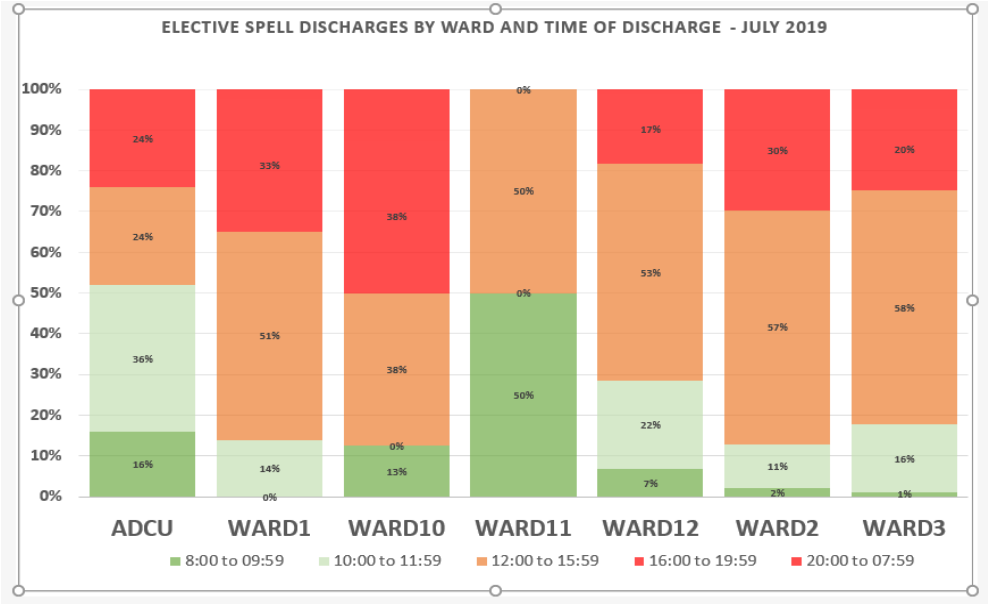
Hospital Cancellations



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
2018-08	6	20	44	70	0
2018-09		16	33	49	1
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	43	60	0
2019-05	4	15	42	61	0
2019-06	1	13	20	34	0
2019-07	2	10	30	42	
Grand Total	55	175	463	693	1

Admission the day before surgery





The number of cancellations on the day of admission for surgery in July was 12 patients.

Analysis of these cancellations on the day identified that 3 patients were cancelled due to equipment, 4 for lack of theatre time, 3 for an emergency patient, and 2 were administration error. Therefore 10 patient cancelled on the day overall.
Cancellations before the day of surgery for July were 30 which has increased since last month but this remains below the last 12 month average of 39. An analysis of the 30 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, and patient medically unfit following preassessment.

The 72 hour call to patients continues as business as usual and continues to work well. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance . The escalation process has also been strengthened to ensure any cancellations are picked up in a timely manner.

A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.

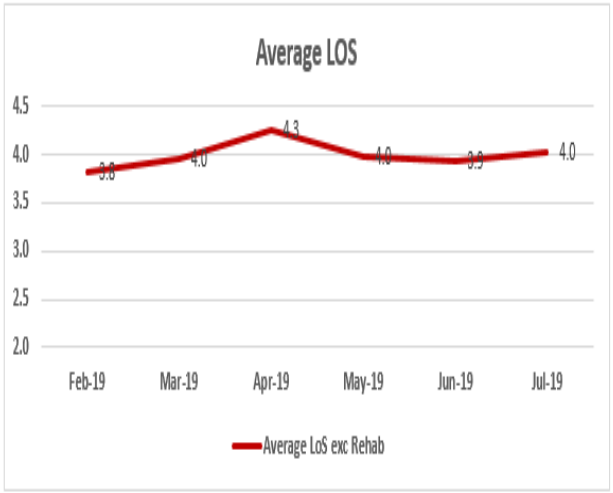
ACTIONS FOR IMPROVEMENTS / LEARNING

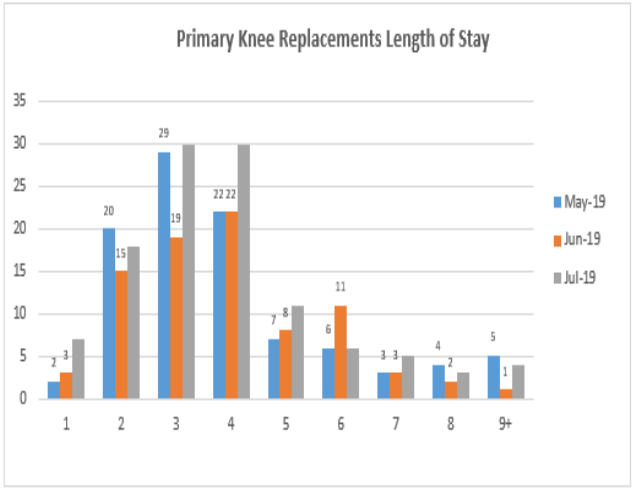
As a result of POAC now attending the morning huddle, escalation processes improvements and the SOP for bookings implemented, this has resulted in better communication between POAC and secretarial teams

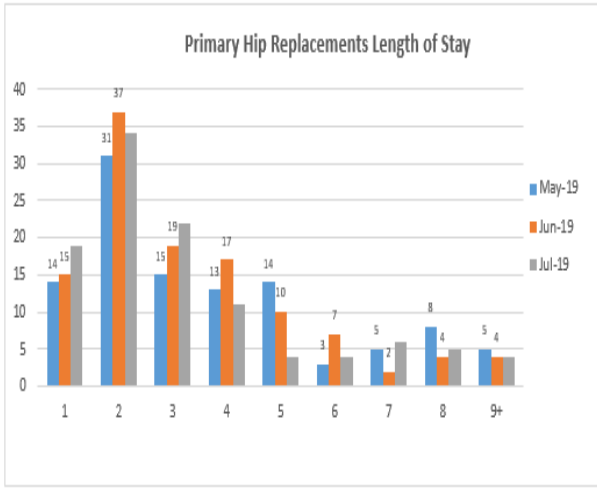
RISKS / ISSUES

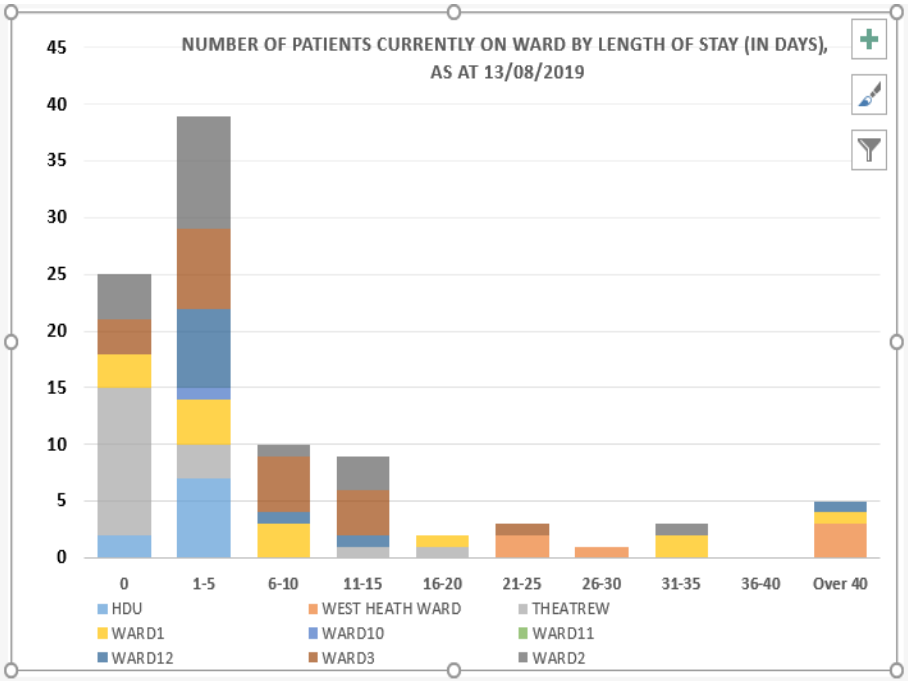
The Managed Service Contract is progressing to completion.

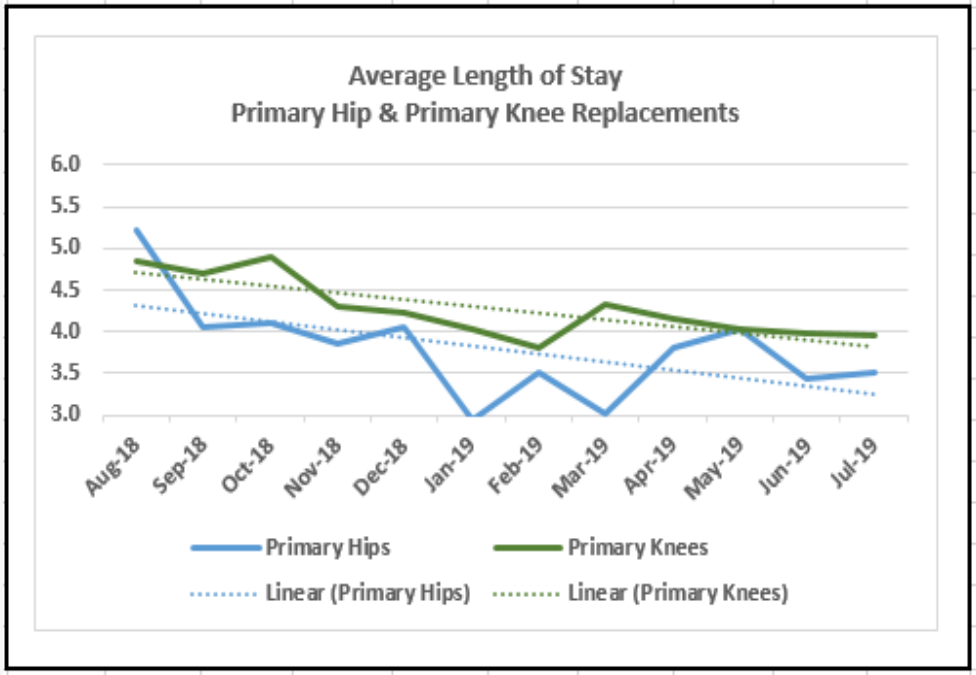
10. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in July has risen from 3.9 to 4 days

July's data includes a considerable number of patients requiring social packages and additional medical needs that impacted on the average LOS in month.

The overall trend remains a falling LOS for primary hips and knee patients.

ACTIONS FOR IMPROVEMENTS / LEARNING

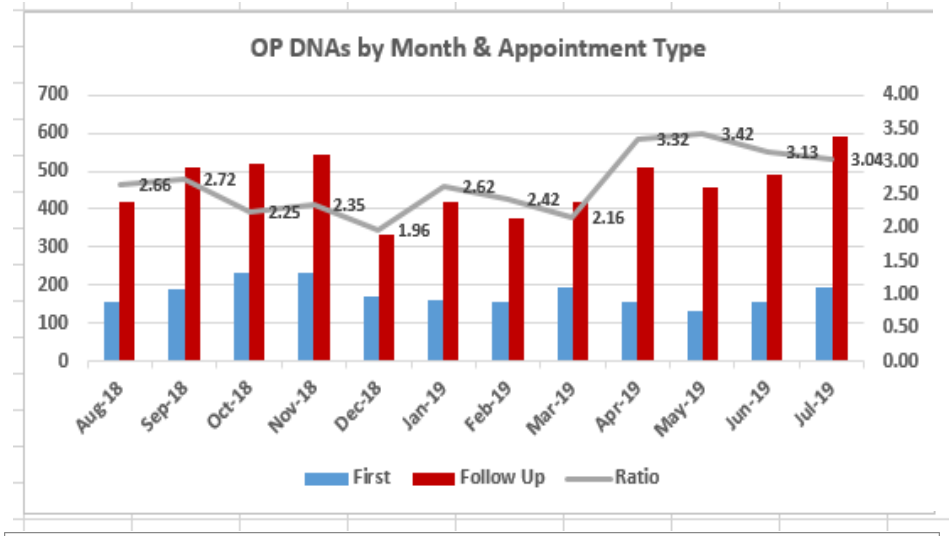
There are a number of initiatives agreed to refocus reduction in length of stay including:

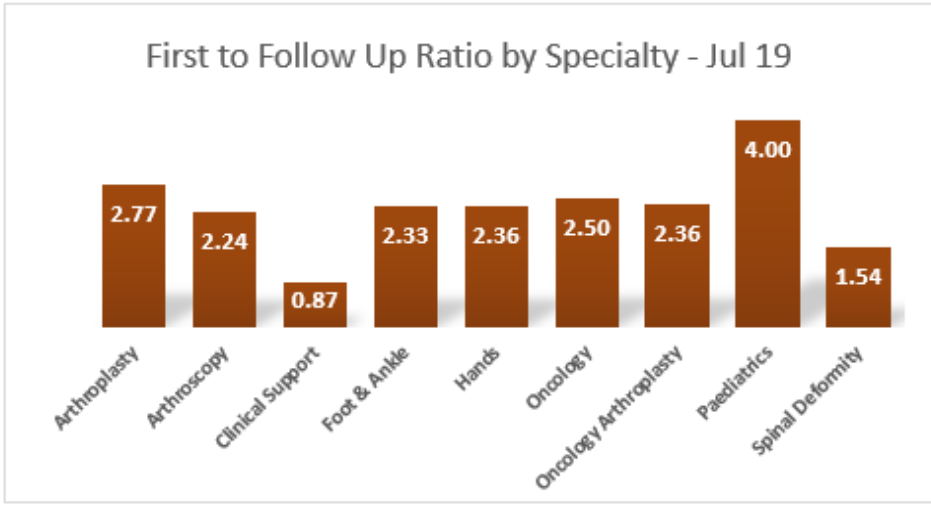
- A weekly review by Division 1 Operations team into LOS and activity.
- A review of the Red to Green data as it matures as a dataset (trends are POC on Ward 1, physio assessment IV Abs and x-ray on Ward 2, wound reviews on Ward 3 and POC on Ward 12.
- Daily review of patients with LOS greater than expected LOS.
- With the support of the Medical Director renew need for senior review on a daily basis on every patient (currently auditing senior review).
- Continue to utilise Discharge Lounge – noting that usage has increased month on month.
- The joint care data is now to be included in the integrated board which is being developed.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Out of hours roaming Admin to support timely discharge.
- Pathology issues still being raised via Ulysses when delays occur and escalated appropriately – no current issues identified.
- Review LOS dataset combining with GIRFT dataset looking at LOS against prevalent operation codes in speciality.

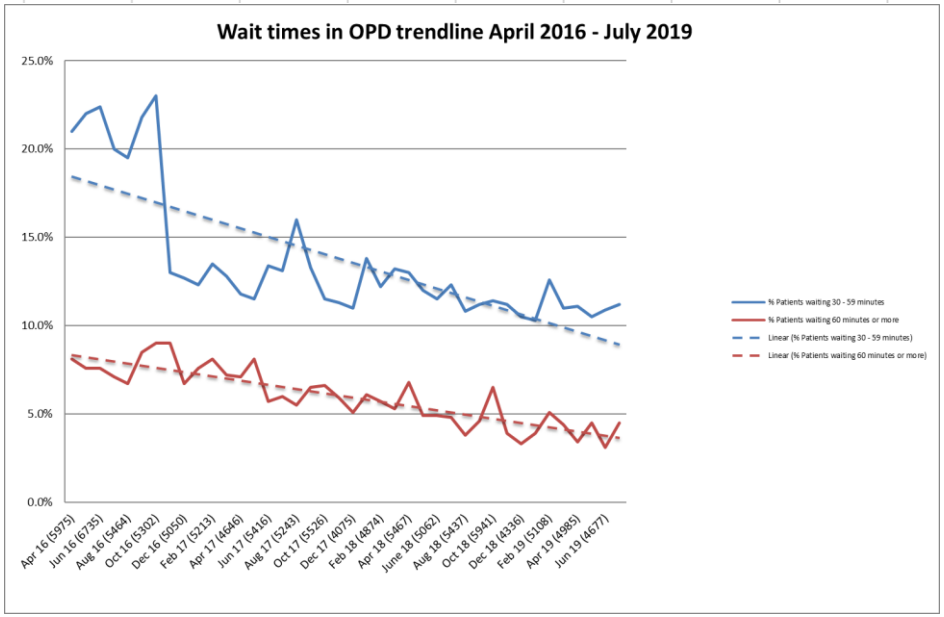
RISKS / ISSUES

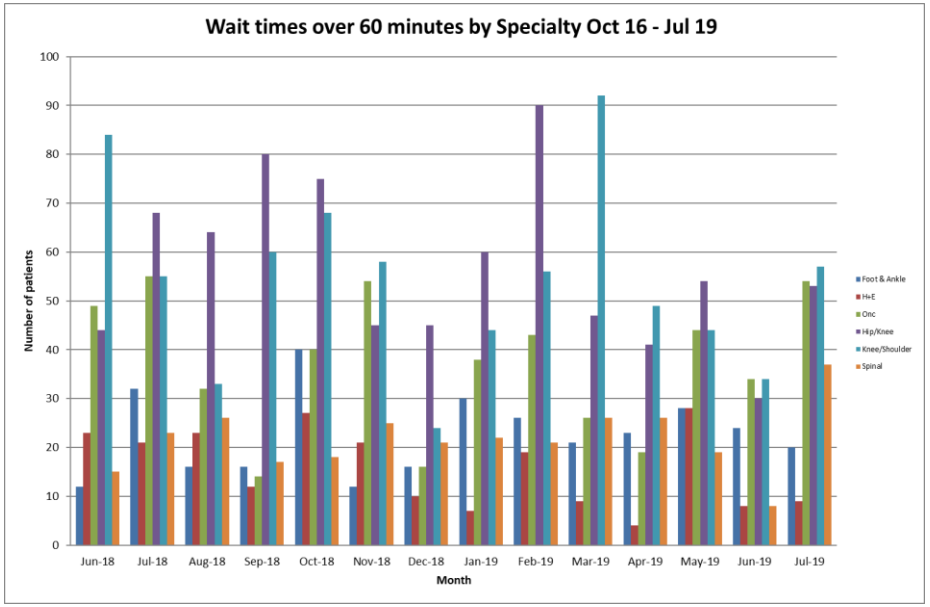
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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









INFORMATION

In July there were 11.2% of patients waiting over 30 minutes which is a 0.3% increase from last month. The over 60 minute delays continue to be achieve under the target of 5% with a level of 4.5% for July .This KPI is now consistently being achieved.

Room allocations each week continue to be managed well and there have been no room availability incidents submitted in July. The 643 meetings have now been expanded and continue on after the weekly 642 meeting on a Wednesday. The Clinical Service and Support Managers are invited to attend as well as representation from Outpatients and the imaging department. There is a regular agenda that includes discussion of activity booked, capacity available in the coming weeks and rescheduling requests received with less than 6 weeks notice.

There were 19 incidents of clinic delays reported in July 2019 with the following breakdown.

5 Complex Patient
3 Consultant / Clinician Delay
3 Delay in Medical Notes
3 Other
4 Clinic Overbooked
1 X-ray delay

The upgrade of InTouch is still being planned but there is now some project management resource available from a member of staff that is on a management training course that requires them to plan and deliver a project.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The outpatient operational group continues to meet but additional project management resource is required to help move projects forward. The Transformation team are currently recruiting and this will provide additional resource to help deliver OPD projects
- The InTouch system needs to be upgraded in order to implement electronic outcomes and this is underway. Initial meetings have been held and a demo of the new system is being arranged
- DrDoctor has been implemented across all specialties, except Oncology where there have been some issues with patients receiving notifications before nursing staff could contact them. This system is working well and DNA rates will be monitored going forward

RISKS / ISSUES

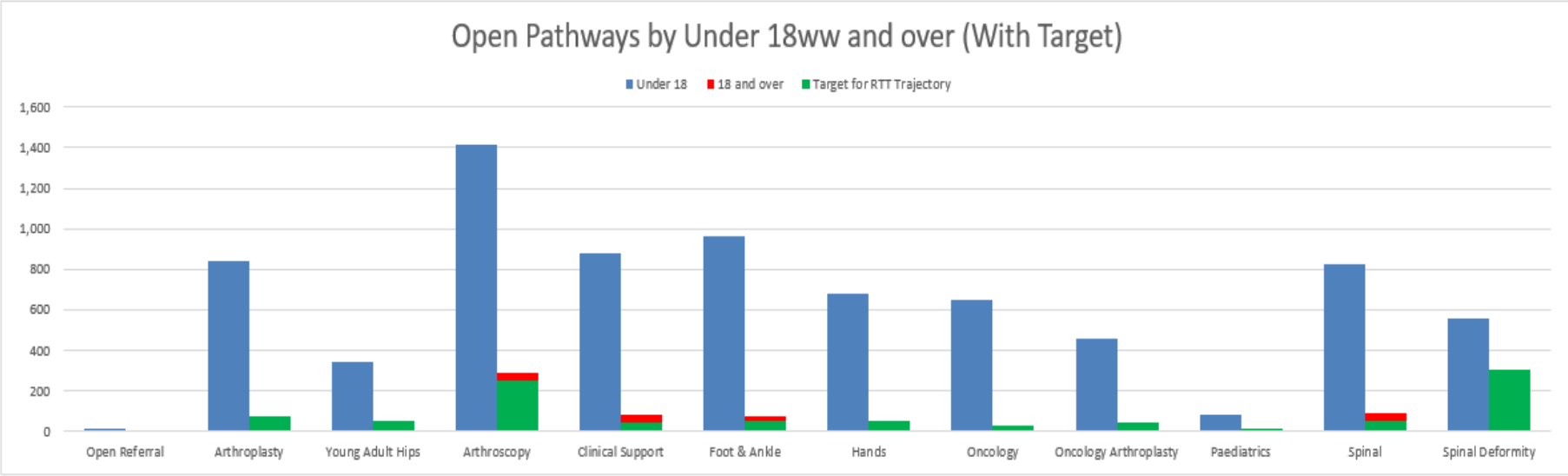
- A meeting has been held with the Deputy Director of Operations to discuss the lack of space in the main outpatients department and further meeting has been arranged for September. Consideration is being given to reviewing current Follow up protocols to ensure they are effective and the use of alternative follow up frameworks including virtual clinics and non face to face clinics as part of the out patient transformation project.

12. Referral to Treatment snapshot as at 30th June 2019 (Combined)

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**3,715**	4	378	161	713	391	468	360	351	245	39	388	217
7-13	**2,891**	4	325	136	511	369	371	239	232	145	32	298	229
14-17	**1,095**	0	137	46	188	118	123	80	68	69	11	142	113
18-26	**832**	0	61	23	212	73	66	45	17	36	4	82	213
27-39	**195**	0	4	10	74	7	4	3	4	4	0	4	81
40-47	**6**	0	0	0	3	0	0	0	0	0	0	0	3
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8,734**	8	905	376	1,701	958	1,032	727	672	499	86	914	856

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,701**	8	840	343	1,412	878	962	679	651	459	82	828	559
18 and over	**1,033**	0	65	33	289	80	70	48	21	40	4	86	297
Target for RTT Trajectory	**846**	0	72	47	252	44	50	48	30	38	2	49	306
Target for RTT 92%	**698**	**0**	**72**	**30**	**136**	**76**	**82**	**58**	**53**	**39**	**6**	**73**	**68**

Month End RTT %	**88.17%**	**100.00%**	**92.82%**	**91.22%**	**83.01%**	**91.65%**	**93.22%**	**93.40%**	**96.88%**	**91.98%**	**95.35%**	**90.59%**	**65.30%**
31/07/2019 Trajectory RTT %	90.31%	96.70%	92.01%	87.48%	85.17%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	64.20%
Variance from Target to meet Trajectory	187	0	-7	-14	37	36	20	0	-9	2	2	37	-9
Variance from target 92%	335	0	-7	3	153	4	-12	-10	-32	1	-2	13	229

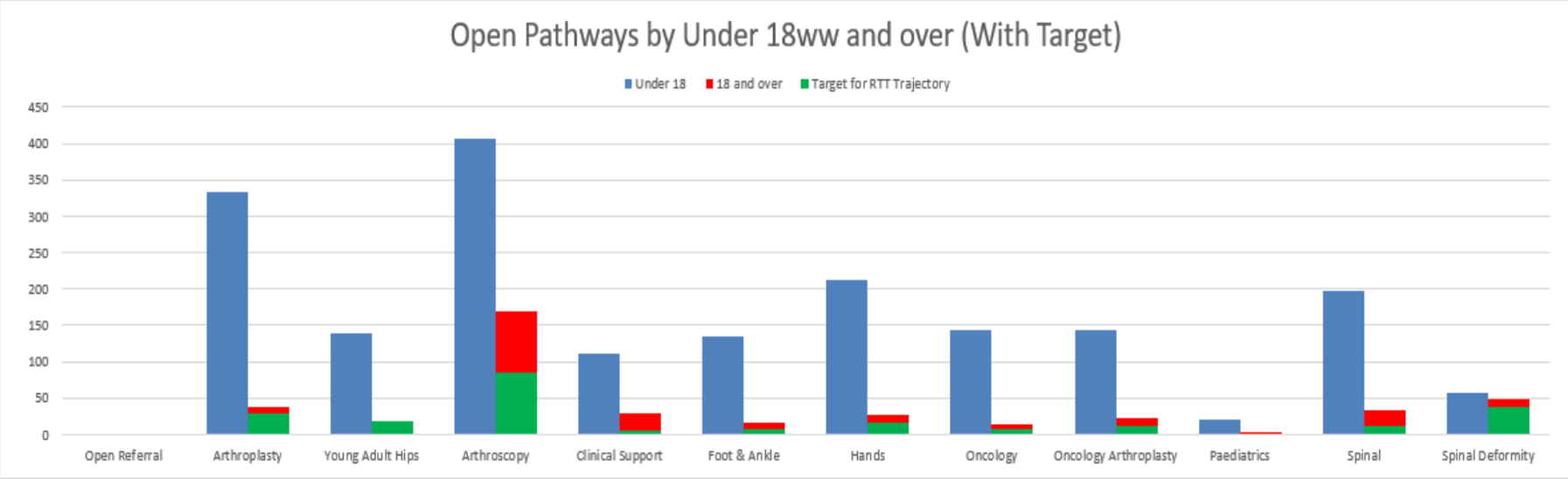


13. Referral to Treatment snapshot as at 30th June 2019 - Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**810**	0	130	62	161	40	69	98	85	53	9	79	24
7-13	**740**	0	142	52	173	33	50	79	50	55	10	74	22
14-17	**349**	0	61	25	72	37	16	35	9	36	2	45	11
18-26	**304**	0	36	7	111	27	15	24	10	19	1	33	21
27-39	**106**	0	2	6	57	2	2	2	3	4	0	1	27
40-47	**3**	0	0	0	2	0	0	0	0	0	0	0	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,312**	0	371	152	576	139	152	238	157	167	22	232	106

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,899**	0	333	139	406	110	135	212	144	144	21	198	57
18 and over	**413**	0	38	13	170	29	17	26	13	23	1	34	49
Target for RTT Trajectory	**224**	0	29	19	85	6	7	15	7	12	0	12	37
Target for RTT 92%	**184**	**0**	**29**	**12**	**46**	**11**	**12**	**19**	**12**	**13**	**1**	**18**	**8**

Month End RTT %	**82.14%**	n/a	**89.76%**	**91.45%**	**70.49%**	**79.14%**	**88.82%**	**89.08%**	**91.72%**	**86.23%**	95.45%	**85.34%**	**53.77%**
31/07/2019 Trajectory RTT %	90.31%	96.70%	92.01%	87.48%	85.17%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	64.20%
Variance from Target to meet Trajectory	189	0	9	-6	85	23	10	11	6	11	1	22	12
Variance from target 92%	229	0	9	1	124	18	5	7	1	10	0	16	41

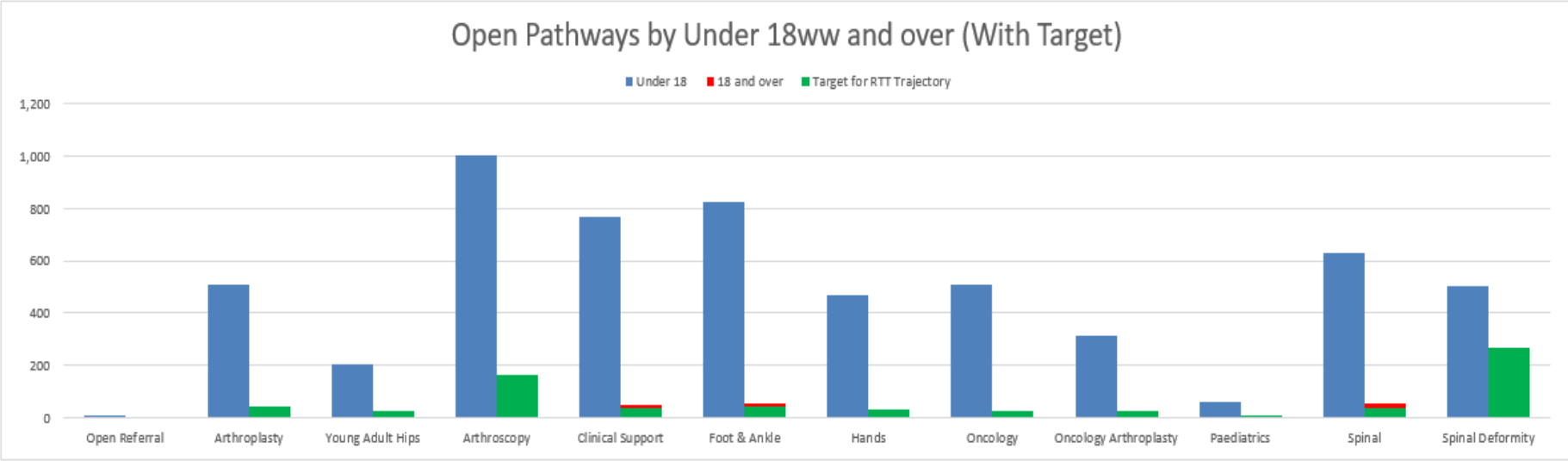


13. Referral to Treatment snapshot as at 30th June 2019 (non admitted)

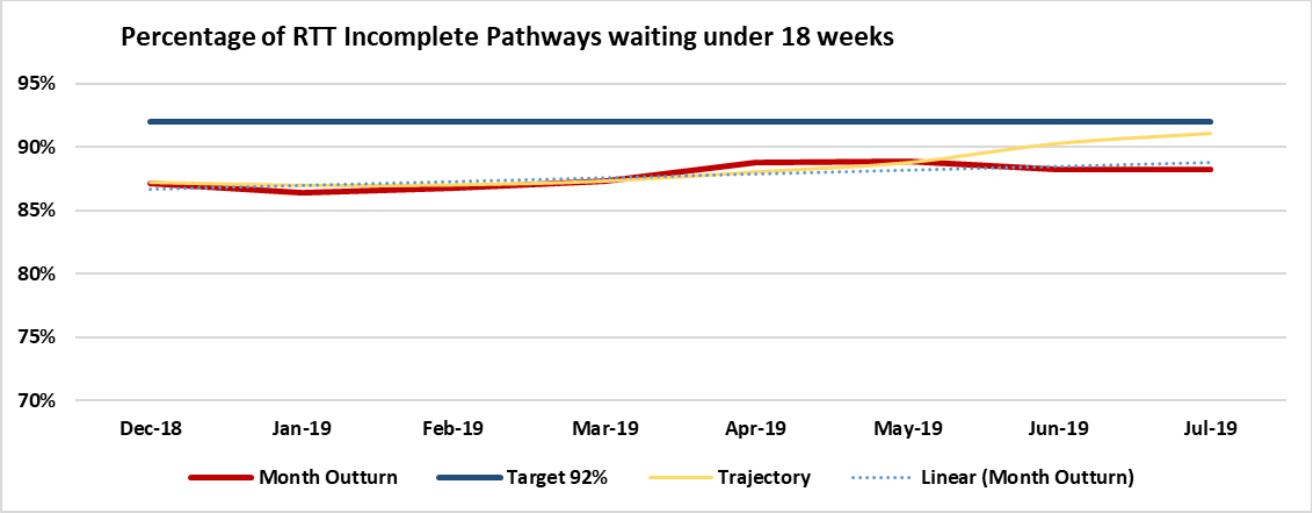
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**2,905**	4	248	99	552	351	399	262	266	192	30	309	193
7-13	**2,151**	4	183	84	338	336	321	160	182	90	22	224	207
14-17	**746**	0	76	21	116	81	107	45	59	33	9	97	102
18-26	**528**	0	25	16	101	46	51	21	7	17	3	49	192
27-39	**89**	0	2	4	17	5	2	1	1	0	0	3	54
40-47	**3**	0	0	0	1	0	0	0	0	0	0	0	2
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6,422**	8	534	224	1,125	819	880	489	515	332	64	682	750

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,802**	8	507	204	1,006	768	827	467	507	315	61	630	502
18 and over	**620**	0	27	20	119	51	53	22	8	17	3	52	248
Target for RTT Trajectory	**622**	0	42	28	166	38	43	32	23	25	1	36	268
Target for RTT 92%	**513**	**0**	**42**	**17**	**90**	**65**	**70**	**39**	**41**	**26**	**5**	**54**	**60**

Month End RTT %	**90.35%**	**100.00%**	**94.94%**	**91.07%**	**89.42%**	**93.77%**	**93.98%**	**95.50%**	**98.45%**	**94.88%**	**95.31%**	**92.38%**	**66.93%**
31/07/2019 Trajectory RTT %	90.31%	96.70%	92.01%	87.48%	85.17%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	64.20%
Variance from Target to meet Trajectory	-2	0	-15	-8	-47	13	10	-10	-15	-8	2	16	-20
Variance from target 92%	107	0	-15	3	29	-14	-17	-17	-33	-9	-2	-2	188



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



RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,478	7,511	7,543	7,571
Over 18 Weeks	1,080	1,091	1,089	1,062	997	931	867	799	732	651	605	560	520
Totals	8,436	8,365	8,370	8,361	8,334	8,305	8,278	8,248	8,219	8,129	8,116	8,103	8,090
RTT %	87.20%	86.96%	86.99%	87.30%	88.03%	88.79%	89.53%	90.31%	91.09%	92.00%	92.54%	93.09%	93.58%

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. The current trajectory for all specialties has been developed and is detailed below, it predicts that the Trust will return to 92% at an aggregated level by September 2019. This trajectory is currently being revisited in line with current capacity challenges relating to reduction in ADH capacity.

The July position is **88.17%** lower than NHSI trajectory forecasted position of **90.31%.** The position from last month therefore remains stable notwithstanding the ongoing activity challenges. In July the Trust had **0** patients over 52weeks. There are **6** patients over 40 weeks against last month's position of **26.** In July Arthroplasty ,paediatrics, Hands, F&A, Oncology met the 92% target. An updated briefing paper was included in the F&P pack for full details of the recovery plan. Detailed activity monitoring by individual specialty is shared weekly with the Executive Team and F&P Committee

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 - Patients still waiting at month end							Activity			
	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Jul-18	732	112	336	1,180	8	1172	99.3%	961	211	290	1,462
Aug-18	568	107	301	976	9	967	99.1%	682	165	290	1,137
Sep-18	696	110	311	1,117	4	1113	99.6%	778	208	394	1,380
Oct-18	781	110	370	1,261	7	1254	99.4%	725	247	344	1,316
Nov-18	736	135	381	1,252	7	1245	99.4%	801	243	406	1,450
Dec-18	698	115	346	1,159	11	1148	99.1%	843	224	367	1,434
Jan-19	728	123	416	1,267	4	1263	99.7%	897	253	472	1,622
Feb-19	844	134	386	1,364	3	1361	99.8%	854	248	436	1,538
Mar-19	776	133	461	1,370	1	1369	99.9%	868	271	410	1,549
Apr-19	835	89	414	1,338	6	1332	99.6%	894	244	419	1,557
May-19	807	94	337	1,238	1	1237	99.9%	914	270	478	1,662
Jun-19	874	100	380	1,354	1	1353	99.9%	793	266	399	1,458
Jul-19	776	98	361	1,235	7	1,228	99.4%	1001	270	435	1,706

13. Cancer Performance Targets

		Indicative	Reported Month							Reported Quarter 2017/18			
Target Name	**National Standard**	***Jul-19***	***Jun-19***	**May-19**	**Apr-19**	**Q4 2018/19**	**Q3 2018/19**	**Q2 2018/19**	**Q1 2018/19**	**Q4** (Jan, Feb, March)	**Q3** (Oct, Nov, Dec)	**Q2** (July, August, Sept)	**Q1** (Apr, May, June)
2ww	93%	*97.7%*	**100%**	***98.6%***	***95.6%***	**98.8%**	**99%**	**100%**	**99%**	**97%**	**98%**	**99%**	**98%**
31 day first treatment	96%	*89.0%*	**100%**	**83.3%**	***100%***	**94.4%**	**100%**	**100%**	**100%**	**90%**	**96%**	**97%**	**97%**
31 day subsequent (surgery)	94%	*100.0%*	**100%**	***100.0%***	***100%***	**95.2%**	**98%**	**100%**	**97%**	**98%**	**100%**	**97%**	**100%**
62 day (traditional)	85%	*100.0%*	**77.8%**	**72.7%**	***100%***	**96%**	**51.3%**	**69.9%**	**82%**	**82%**	**82%**	**72%**	**67%**
62 day (Cons Upgrade)	n/a	78.6%	***100.0%***	***100.0%***	***92.9%***	83.70%	**91.37%**	**92.6%**	**94%**	**84%**	**82%**	**89%**	**100%**
28 day FDS	85%	70.3%	80%	85.1%	81.0%								
No. patients treated 104+ days		*1*	0	*1*	1	2	3	1	**1**				

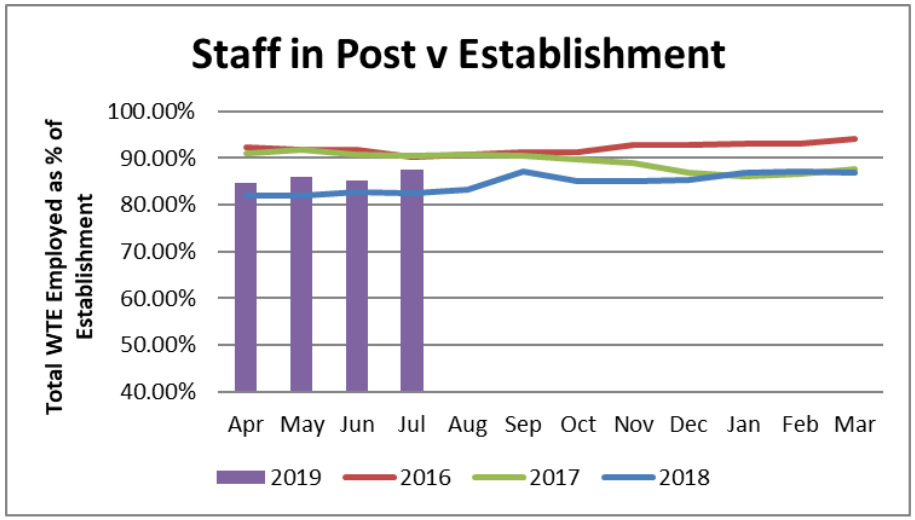
PERFORMANCE/IMPROVEMENTS/LEARNING

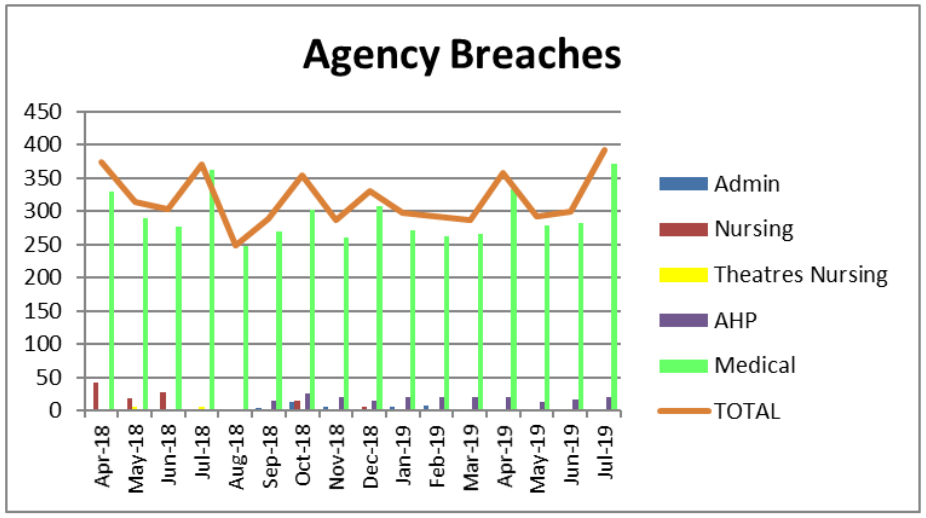
We failed to meet the June performance for 62 day standard. This is due to 1 patient breaching as he was treated on day 85 of his pathway. The delay was down to additional pathology tests to confirm diagnosis and second opinion from American histopathologist. 28 day FDS continues to achieve 80%.

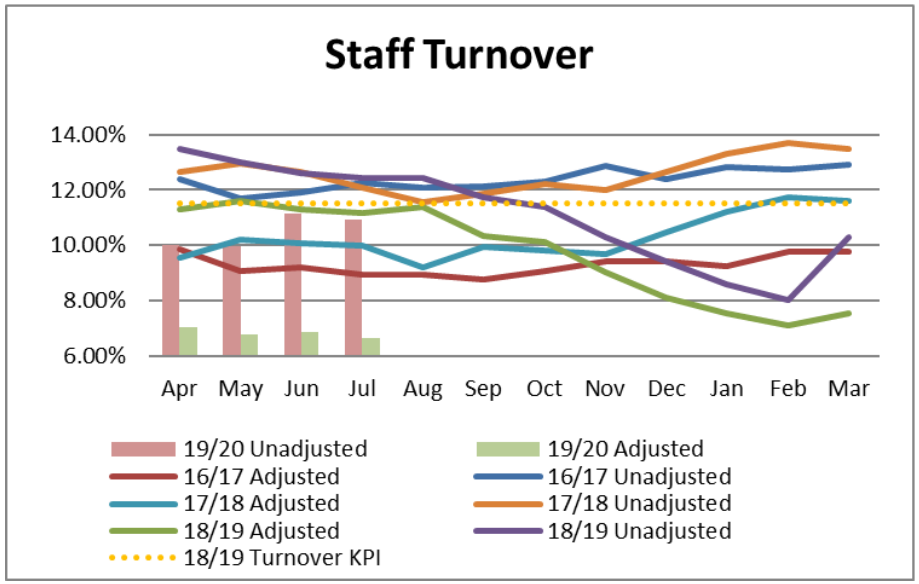
RISKS / ISSUES

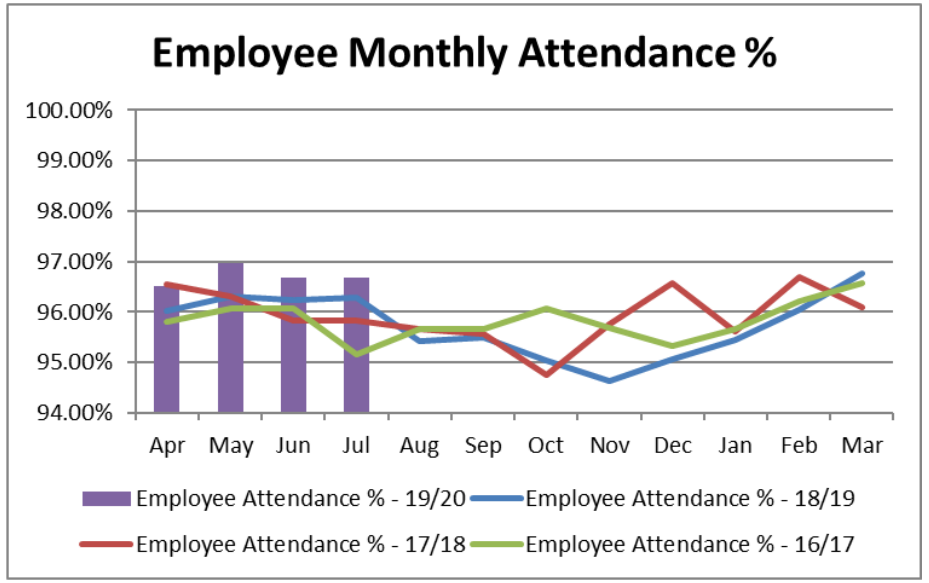
Post paeds transition, risks around delivery of cancer pathways at BCH to be reviewed and updated to ensure there is oversight and mitigations in place.

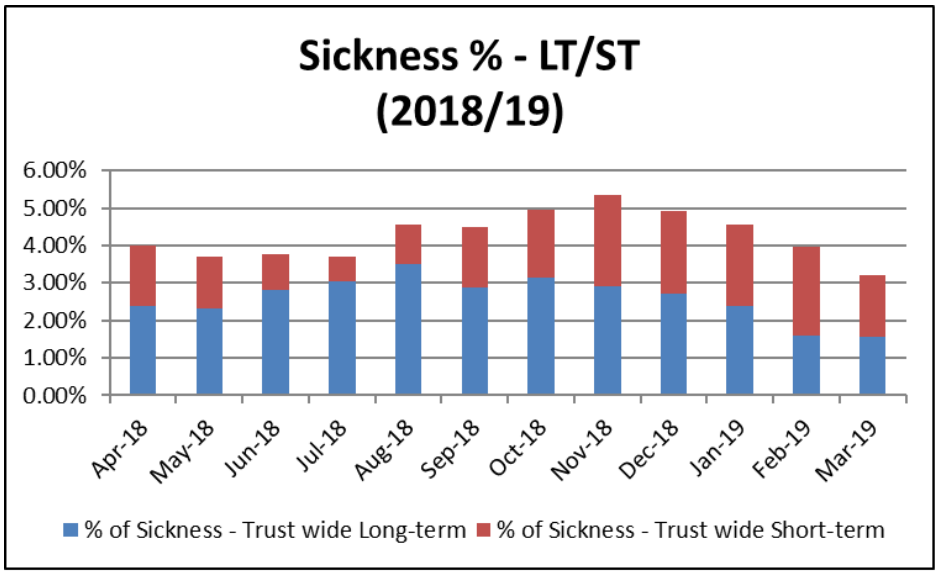
13. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training.

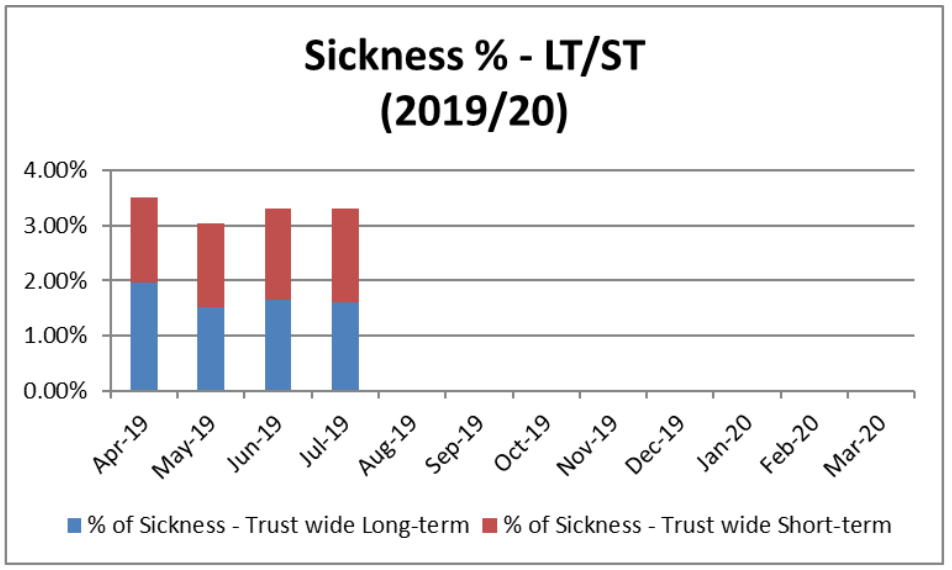


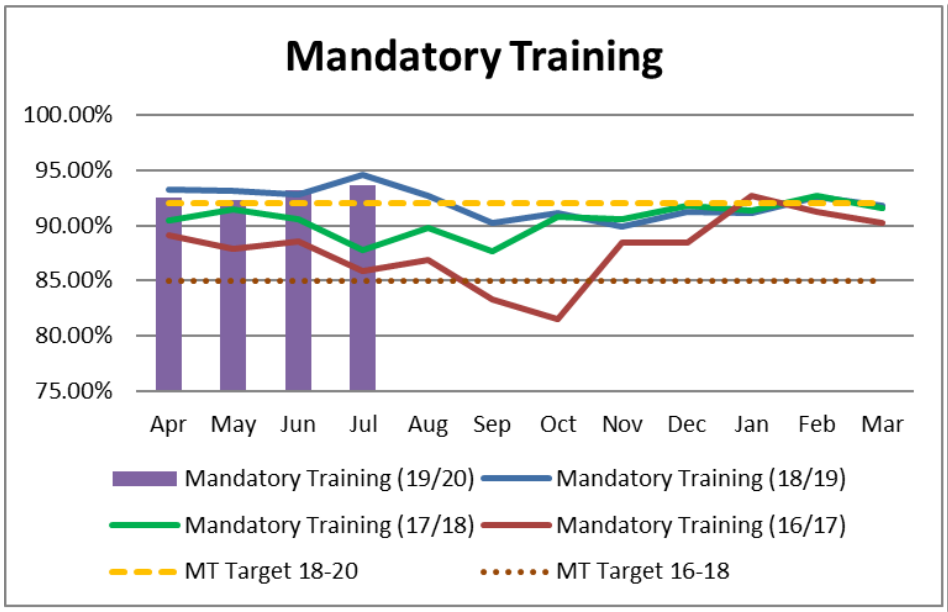


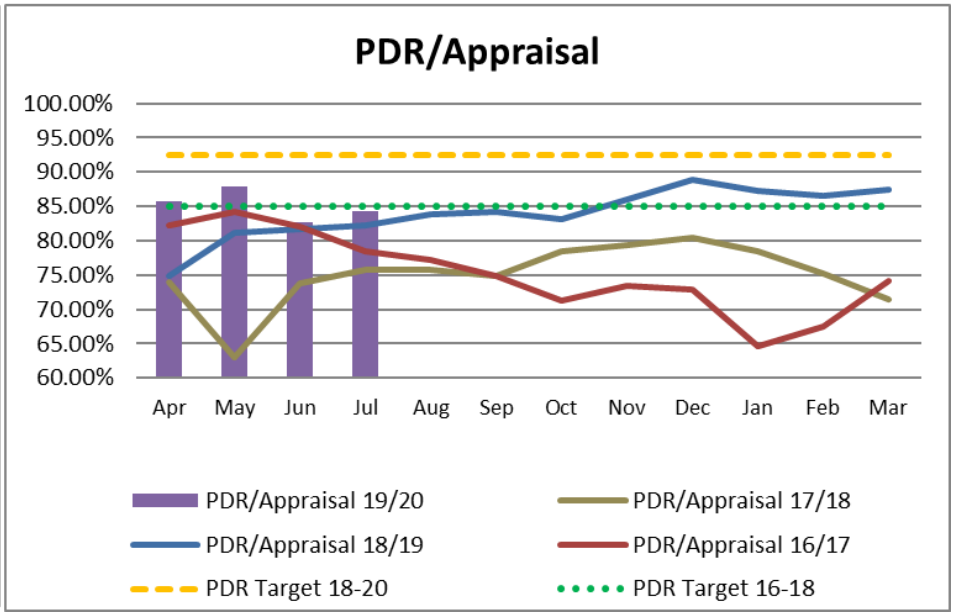





Sickness % - LT/ST (2018/19)
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term


Sickness % - LT/ST (2019/20)
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term


Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Mandatory Training (19/20)
Mandatory Training (18/19)
Mandatory Training (17/18)
Mandatory Training (16/17)
MT Target 18-20
MT Target 16-18


PDR/Appraisal
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
PDR/Appraisal 19/20
PDR/Appraisal 17/18
PDR/Appraisal 18/19
PDR/Appraisal 16/17
PDR Target 18-20
PDR Target 16-18

INFORMATION

July was an encouraging month for Workforce performance it saw a decrease in turnover, which subsequently lead to a decrease in vacancies, an increase in mandatory training compliance and an increase in appraisal completion. Sickness absence maintained the same percentage as June 19.

This month the Trust's vacancy position saw a relevant decrease of 2.35%, as a percentage of WTE employed, with the figure for June at 87.50% against a Trust target of 90%. The funded establishment decreased this month by circa 45 fte, due to the transfer of paediatric services. The number of staff on the payroll, stood at 935.34 (full time equivalent), which saw an decrease of circa 11 fte, compared to June, this again is mainly affected by the paediatric staff transfer.

In July, monthly attendance stagnated at 96.69% so, remains green above our target of 96.1%. The underlying 12-month average sickness absence figure decreased again this month to 4.12 % this is the lowest it has been since June 2011. This has been achieved due to Long Term sickness decreasing month on month, it stood at 1.60% in July 19 compared to 3.05% in July 18. Short term sickness increased very slightly this month from 1.66% in June to 1.70% in July.

Mandatory Training has increased slightly from 93.23% to 93.64%, the figure remains green and above the Trust target of 92%. The L&D Team are continuing to encourage staff to book onto courses via ESR, to support staff to carry out their Mandatory Training via e-learning. Some changes are being discussed and implemented in relation renewal periods, further information will be provided once the changes have been agreed.

This month Appraisal performance has increased by 1.59% from 82.65% in June to 84.24% in July, but is also a huge improvement of 8.40% compared to the figure in July 2017 of 75.84%. Nonetheless, further work is still required to meet our stretched target of 92%, ESR Workshops are continuing to be advertised to assist with ESR usage and efforts are still being maintained to produce operational focus within Divisions.

The unadjusted turnover figure (all leavers except junior doctors and retire/returners) decreased by 0.24% to 10.90%, the figure remains green against a Trust KPI of 11.5%. The adjusted turnover figure (substantive staff leavers including retirements) also decreased by 0.22% to 6.62% in July. Work is underway to revise our exit questionnaire/interview process to enable us to better understand the reasons for leaving.

In July, Agency Breaches increased from 299 to 392 shift breaches in total, with the vast majority being utilised with medical usage (282), which increased from 282 to 372. On the other hand, there were no nursing breaches at all in July, which is the first time since August 2018. There were 20 AHP breaches but also no 0 admin breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING

Further work is required to improve PDR completion rates and work is also underway to improve the performance management process.
Work is currently underway to review the exit process and to review the quality and quantity of information the Trust receives about peoples reasons for leaving.

RISKS / ISSUES

PDR completion rates remain a challenge

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Workforce extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

Over the summer, the Executive Team has overhauled and updated both the Corporate Risk Register and Board Assurance Framework to reflect the latest view of the key risks facing the Trust. Those risks shaded in blue are recommended for closure or de-escalation to local risk registers.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate • Agree to close or de-escalate those risks suggested					
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:					
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:					
Executive Team in July 2019					

BOARD ASSURANCE FRAMEWORK - QUARTER 1 AND 2

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
WF2	WFOD	CEO	Workforce models identified may not deliver benefits which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment		Highly motivated, skilled and inspiring colleagues	SE & OD Commitee	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC and ACP to be recruited. TAPS have been recruited. Nurse Associates planned to join the Trust. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	2	4	8	↔	Workforce design to become an integral part of HR Business Partner discussions. Middle grade workforce group is meeting to develop model.	Jan-21	2	4	8
HR10	WFOD	CEO	HR team has limited capacity to effectively support resourcing of Modular Theatre & Ward expansion		Highly motivated, skilled and inspiring colleagues	People Committee/SE & OD Committee	5	4	20	Concerns initally raised regarding capability of recruitment team to effectively support the increased volume of recruitment required by the expansion of theaatres and wards. Recruitment team have processed a large number of offers and the process is working well. Regular meetings between HR and Director of Nursing & Clinical Governance to monitor progress.	SE&ODC papers. Nurse staffing reports. People Committee reports. Notes of meetings between HR & Directors.	3	4	12	↓	Good progress contunues to be made and staff are due to come on Board from September onwards.	Oct-19	2	4	8

WF1	WFOD	CEO	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	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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs	Jan-21	3	3	9
WF20	Workforce and Staff Experience/Finance	Associate Director of Workforce & OD/Direcotr of Finance & Performance	There is a risk that as a consequence of the current tax liability associated with pension arranmgements of some senior clinical individuals that there will be a reluctance to cover additional duty hours and therefore the Trust will fall short of its activity target and financial control total		Delivered by highly motivated, skilled and inspiring colleagues	Finance & Performance Committee and Staff Experience & OD Committee	5	4	20	Nation al guidance is to do nothing until an agreed positon is issued by the government and a decision has been taken as to the national action.	Board meeting minutes. Finance & Performance overview. Minutes of Finance & Performance Committee.	5	4	20	NEW RISK	Locally, NHS trusts are taking their own decision based on the anticipated timeframe of national outcomes. A solution is currently being worked through for the ROH based on models in place elsewhere.	Oct-19	2	4	8

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 3 July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that there remained further work to do to attract and offer posts to candidates from a Black and Minority Ethic background. Ensuring that there was representation in the Trust's staff from those with a disability was also to be given focus. • Further work had been identified around the need to capture training needs for staff. • Adult resuscitation training rates were noted to have deteriorated. This would be picked up as part of the work to strengthen the resuscitation committee. • It was noted that there had been limited progress with talent management and succession planning.	• The estates heatmap was noted to be under development. • The reasons for the increased rate of long-term sickness absence associated with musculoskeletal issues to be reported back at the next meeting. • Workforce management information to be reviewed to ensure that appropriate metrics were being considered by the Committee at an appropriate frequency. • The proposals around frequency of reporting to Staff Experience & OD Committee to be considered by the Executive. • For the next iteration of the equality & diversity action plan, evidence to support the ratings is to be clearer. • Consider the terms of reference at the next meeting, particularly to discuss attendance at the meetings.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a positive and inspiring staff story from a project manager, who had previously worked in the IT department. The story illustrated the development opportunities within the Trust and the culture of bond & unity at the ROH. • The overall staff in post position had improved and recruitment into posts to support the new modular theatres was progressing well. The plans to streamline the recruitment processes overall were discussed. Recruitment open days were proving effective. • Sickness absence was reported to have reduced for the third consecutive month, although return to work interviews were not happening as robustly as they could be. • The work to improve the Trust's position against its equality & diversity duties was outlined. This included the support provided by the specialist adviser on equality & diversity that the Trust had engaged.	• The Committee approved the publication of the information to demonstrate the Trust's compliance with the Public Sector Equality Duty.

Chair's comments on the effectiveness of the meeting: It was agreed that the schedule of meetings needed to be revisited and moved to a different and more convenient day; the Director of Corporate Affairs would review options.

Workforce Performance Report

As at 31st May 2019

CONTENTS

Staffing costs

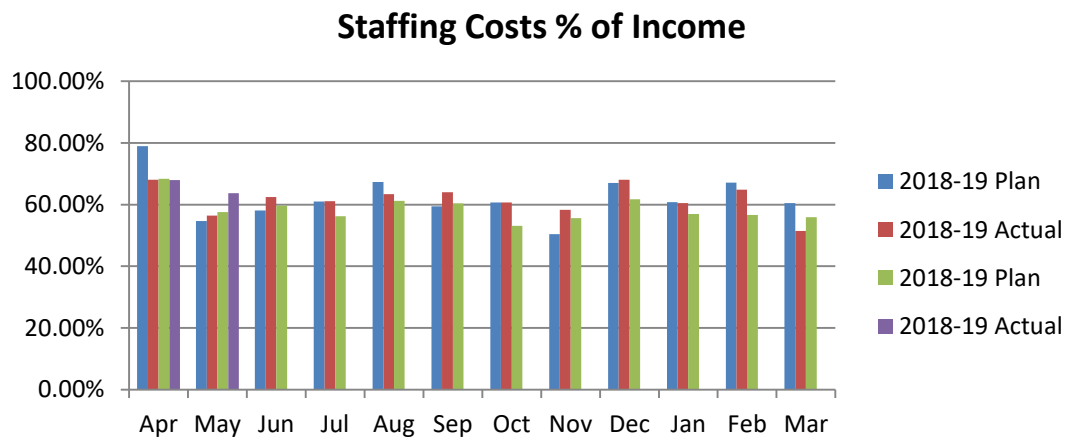
1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	6673	
Actual Income YTD	6857	101%
Planned Pay Costs (YTD)	4564	
Actual Pay Costs (YTD)	4659	102%
Planned Substantive Pay Costs (YTD)	3760	
Actual Substantive Pay Costs (YTD)	3780	101%
Planned Bank Pay Costs (YTD)	425	
Actual Bank Pay Costs (YTD)	464	109%
Planned Agency Pay Costs (YTD)	368	
Actual Pay Costs (YTD) Agency Staff	410	111%
Planned Agency Pay Costs as % of total Pay costs (YTD)		8.06%
Actual Agency Pay Costs as % of total Pay costs (YTD)		8.80%

Total ADH Payments (Apr - Dec) £000s	210

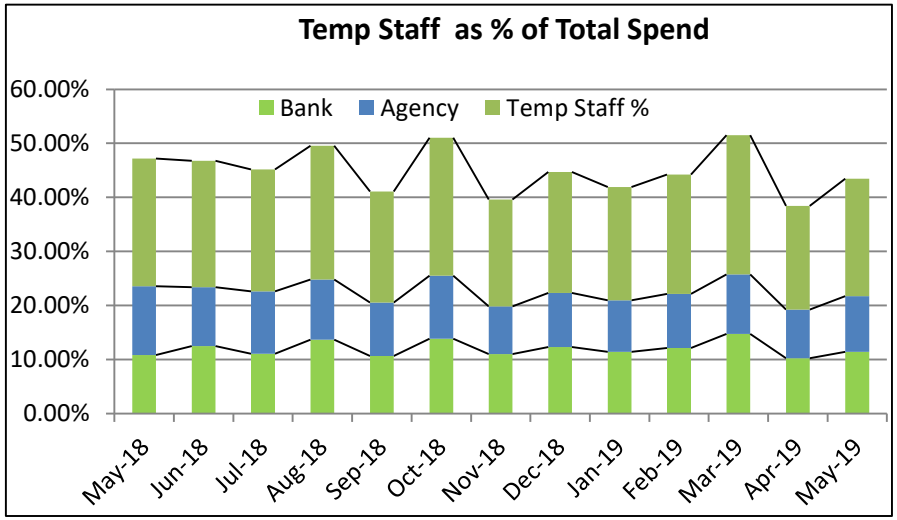
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	241	410
May		
Jun		
Jul		
Aug		
Sep		
Oct		
Nov		
Dec		
Jan		
Feb		

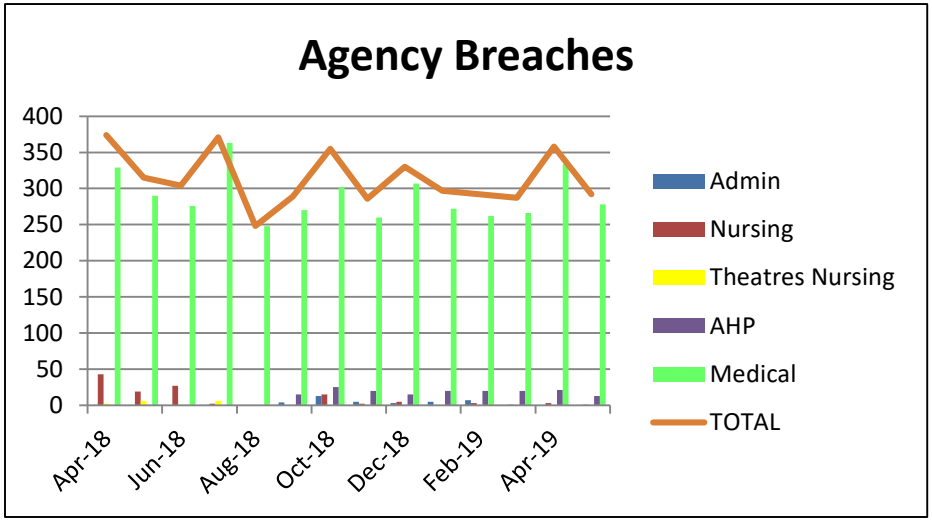


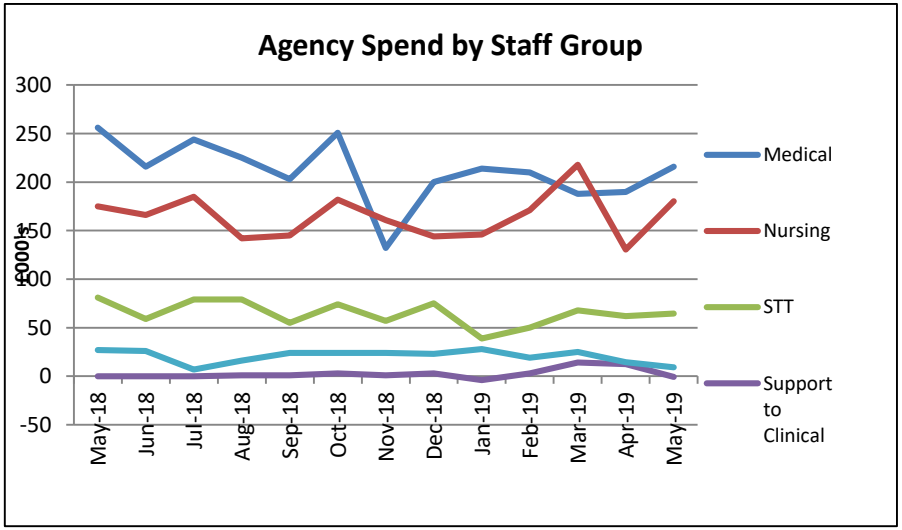
Data based upon April 2019 Management Accounts

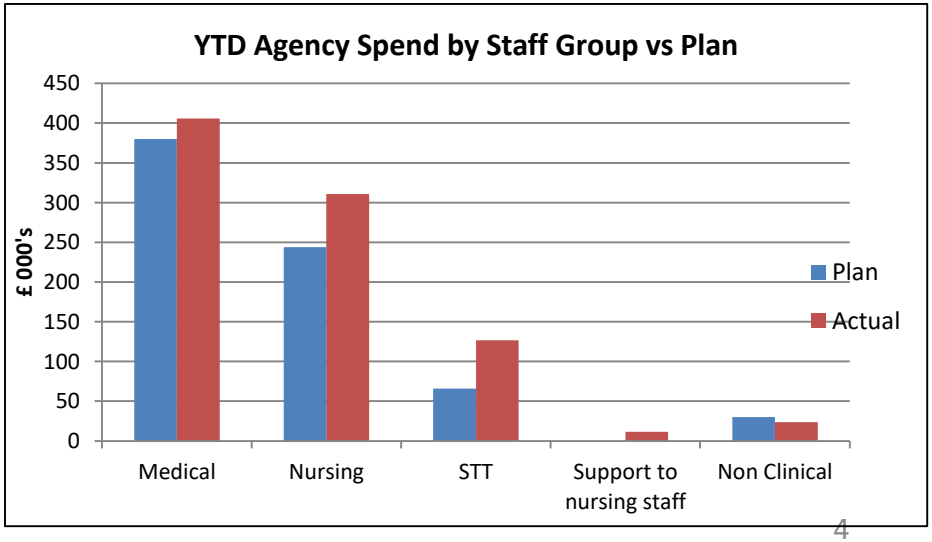
1 Workforce Composition and Cost

1a Temporary Staffing Analysis



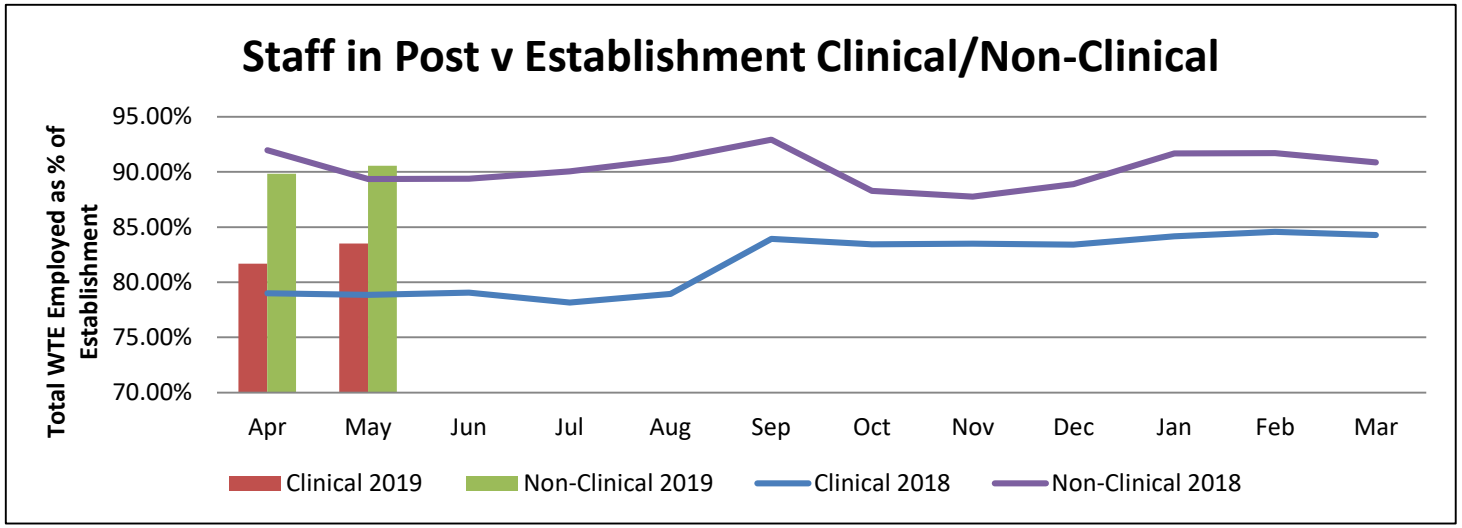


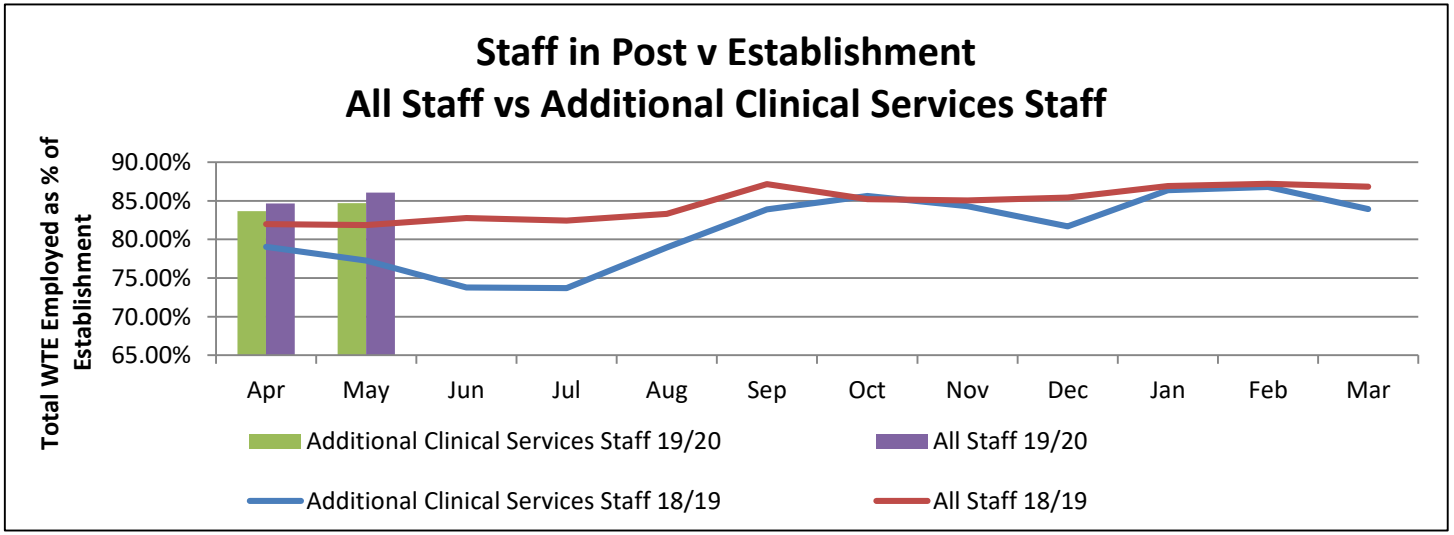




1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

Establishment

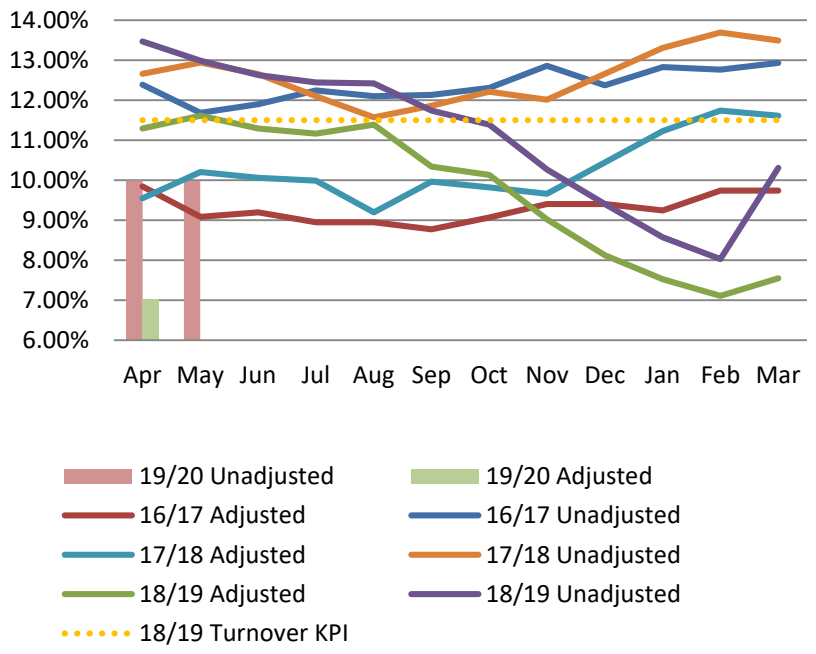




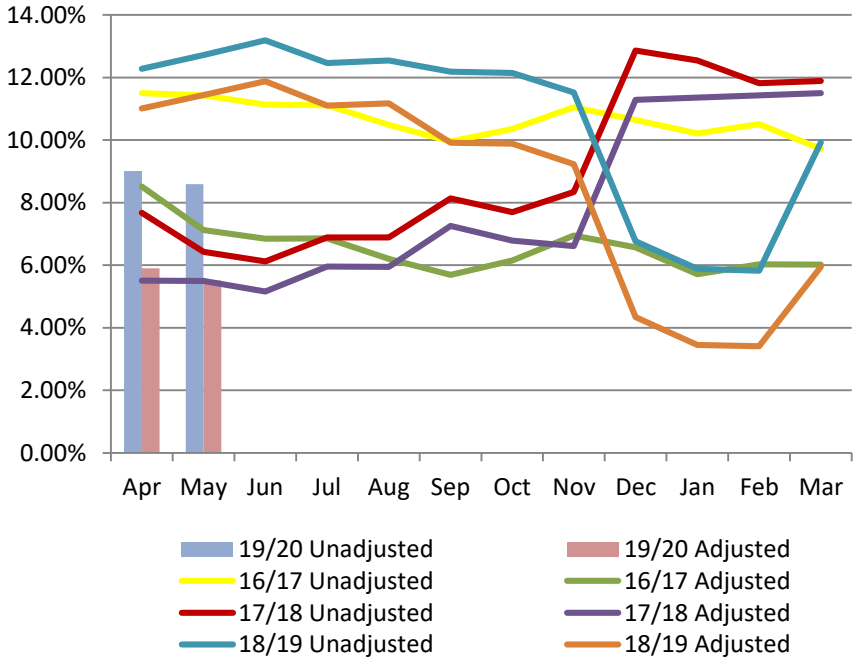
1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Turnover

Staff Turnover

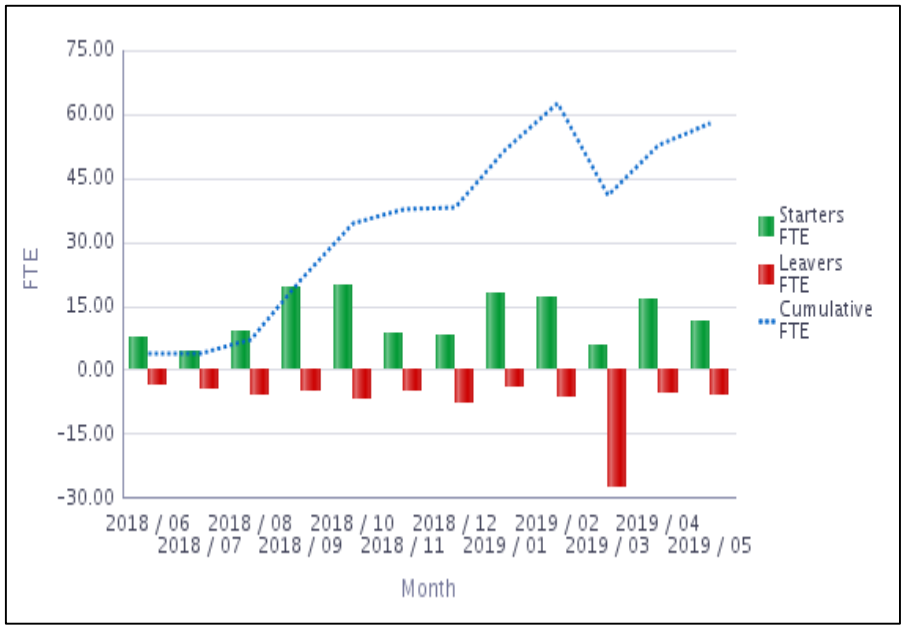


Additional Clinical Services Staff Turnover

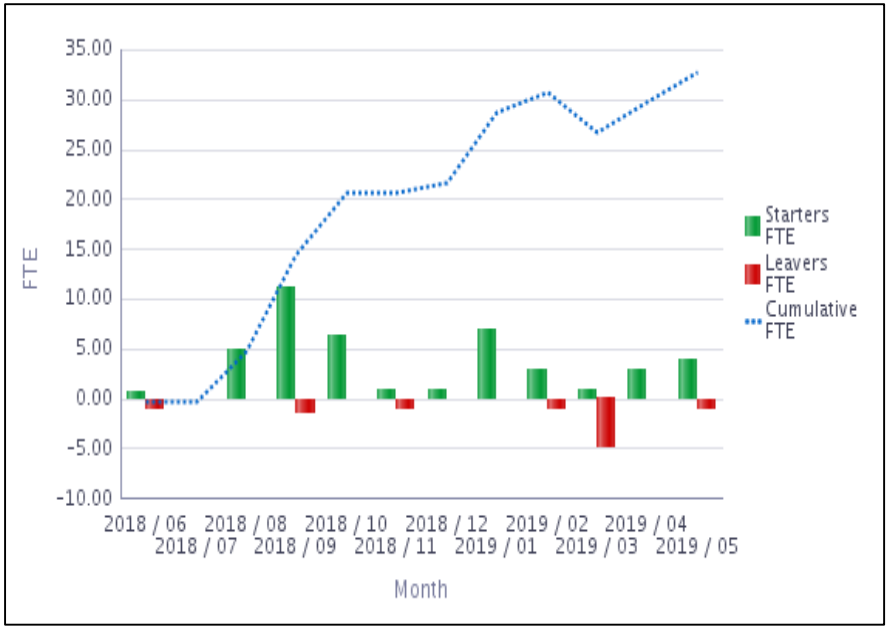


1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Starters / Leavers by Month
All Staff

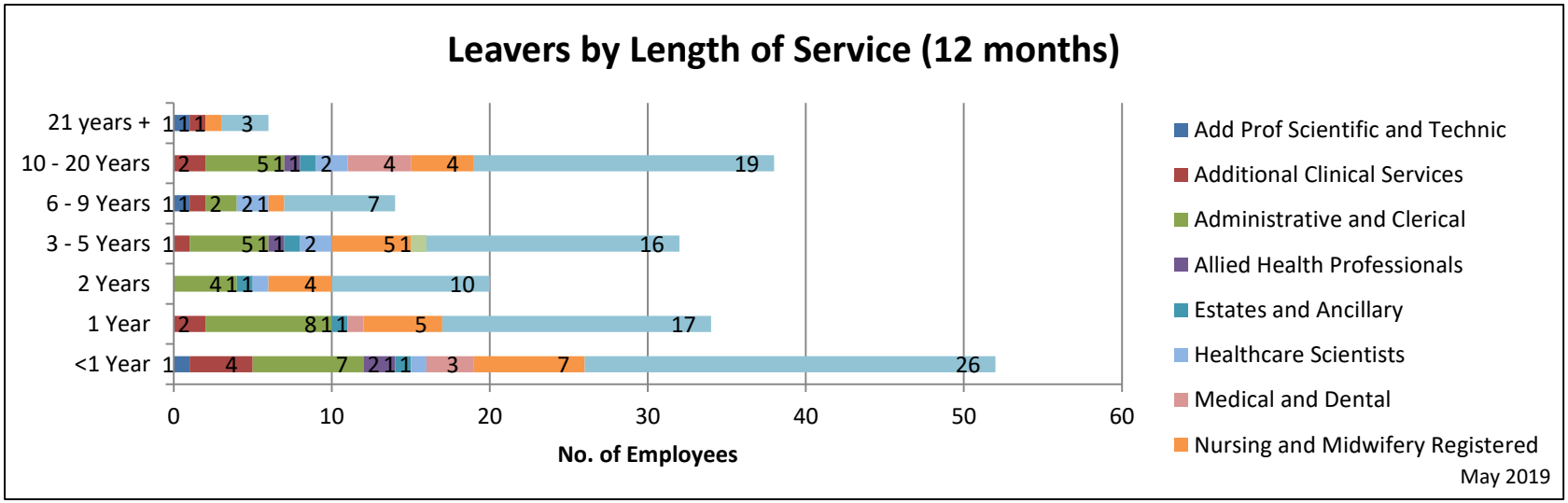


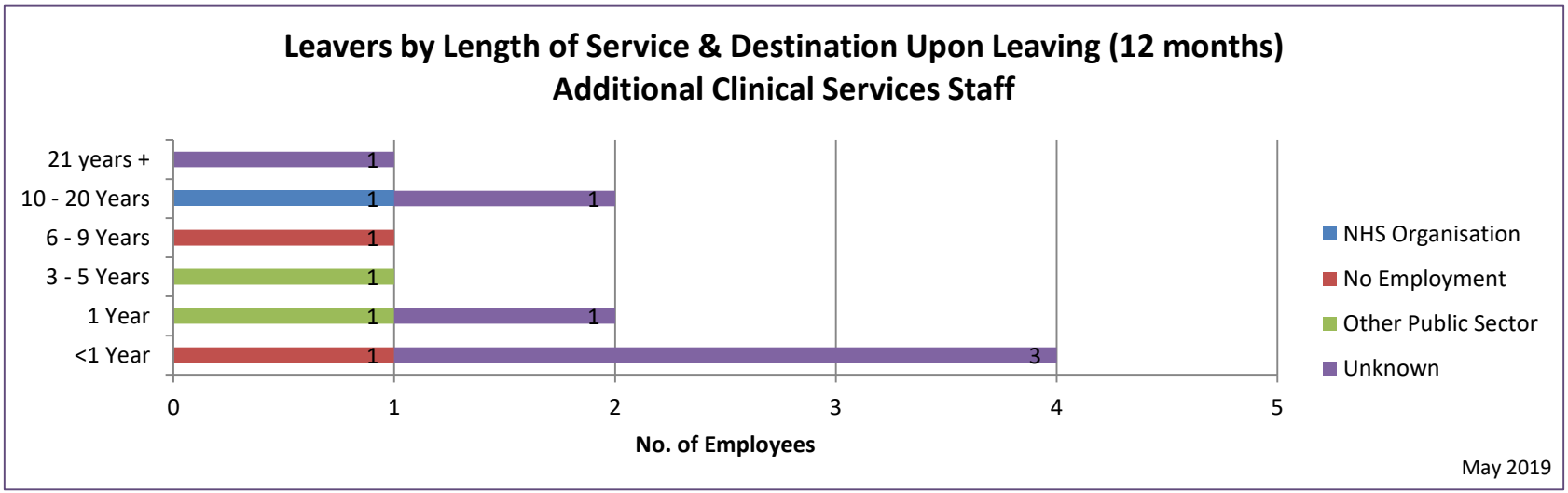
Starters / Leavers by Month
Additional Clinical Services Staff



1 Workforce Composition , Resourcing and Cost

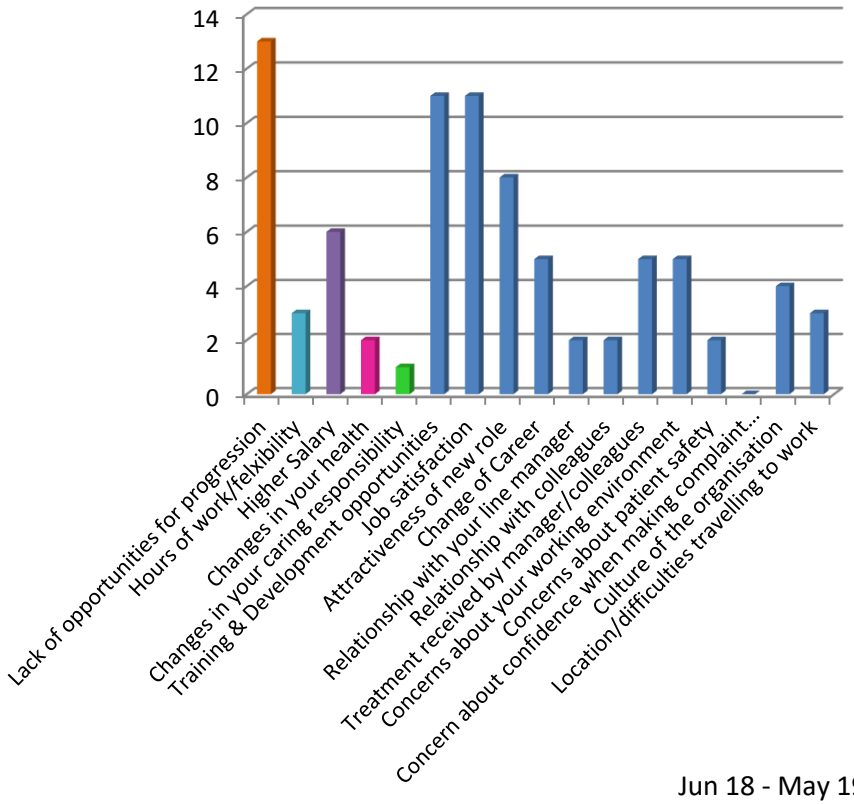
1d Staff Turnover





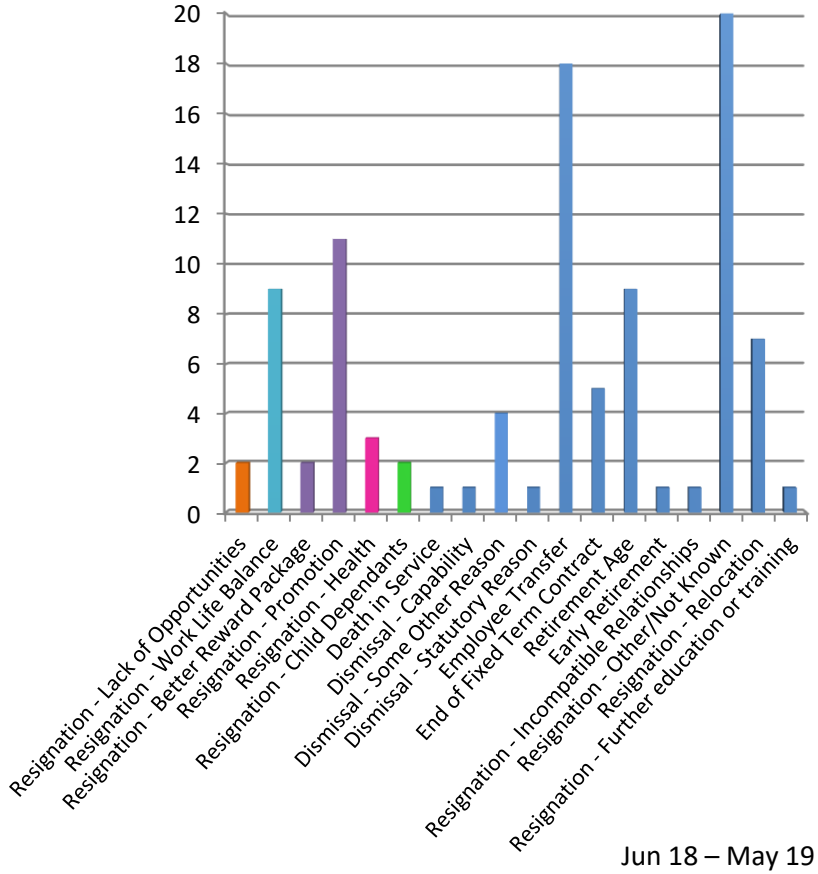
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

Reason for Leaving (All Staff) Exit Questionnaire



Jun 18 - May 19

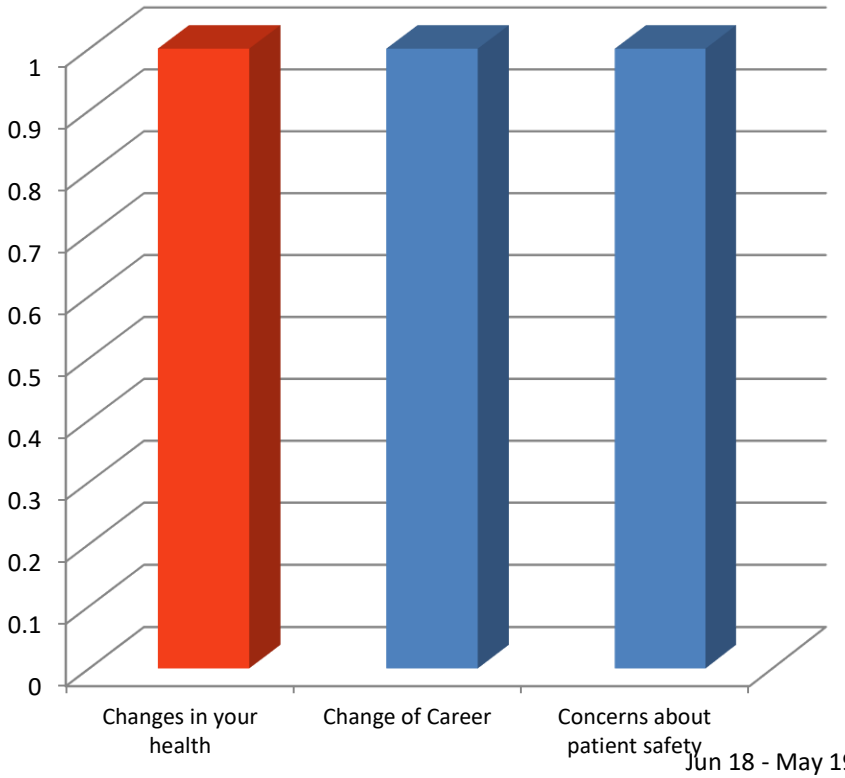
Reason for Leaving (ESR data)



Jun 18 – May 19

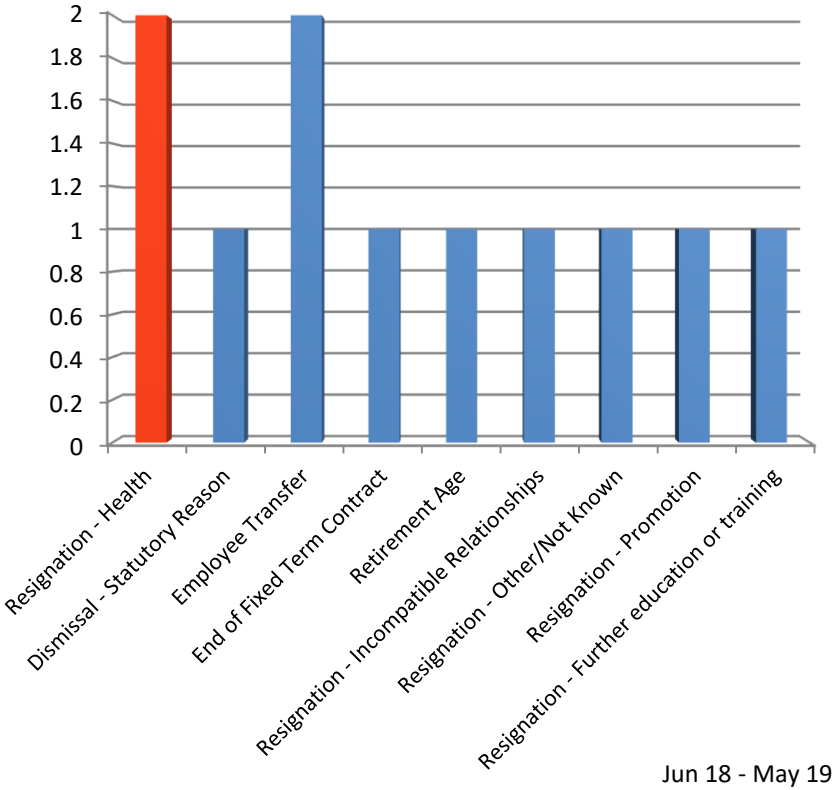
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

Reason for Leaving (Additional Clinical Services Staff) Exit Questionnaire Data



Jun 18 - May 19

Reason for Leaving Additional Clinical Services Staff (ESR data)

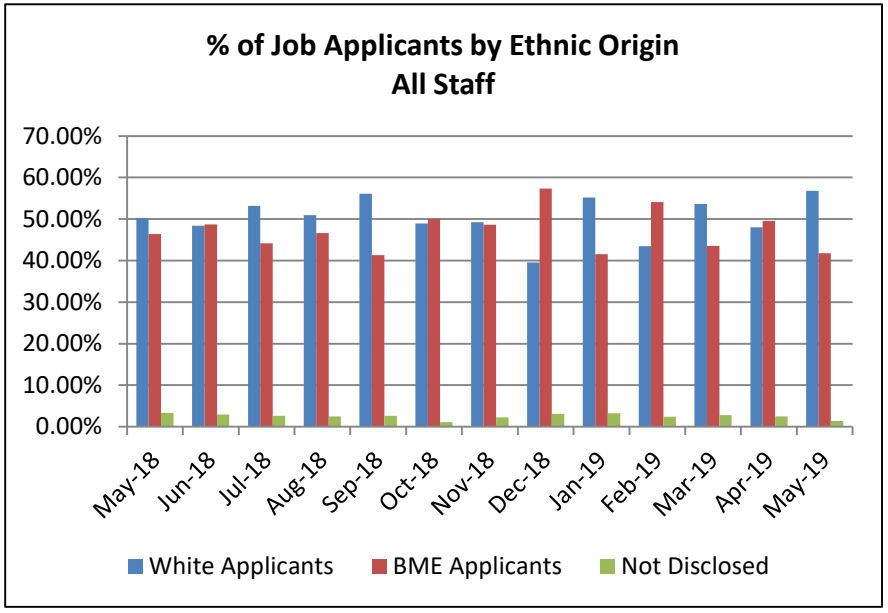


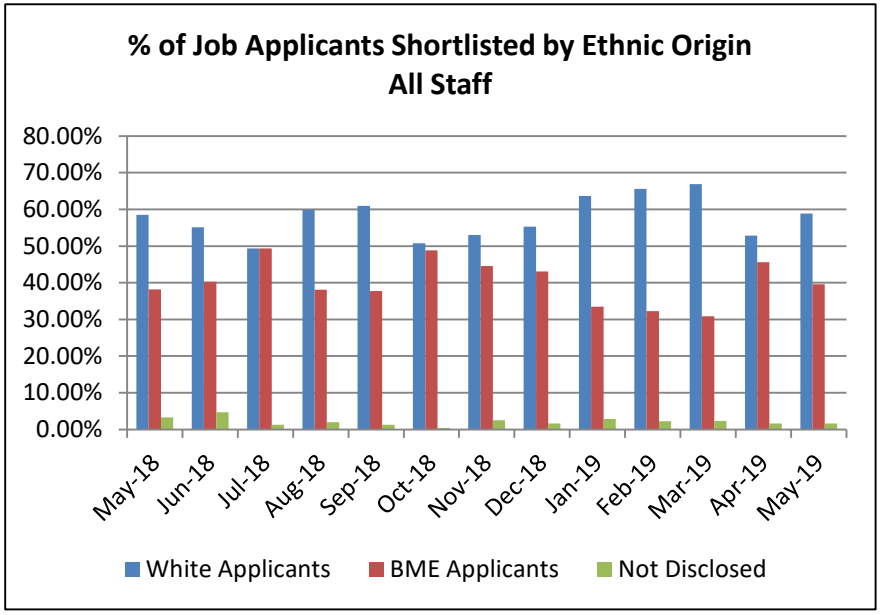
Jun 18 - May 19

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



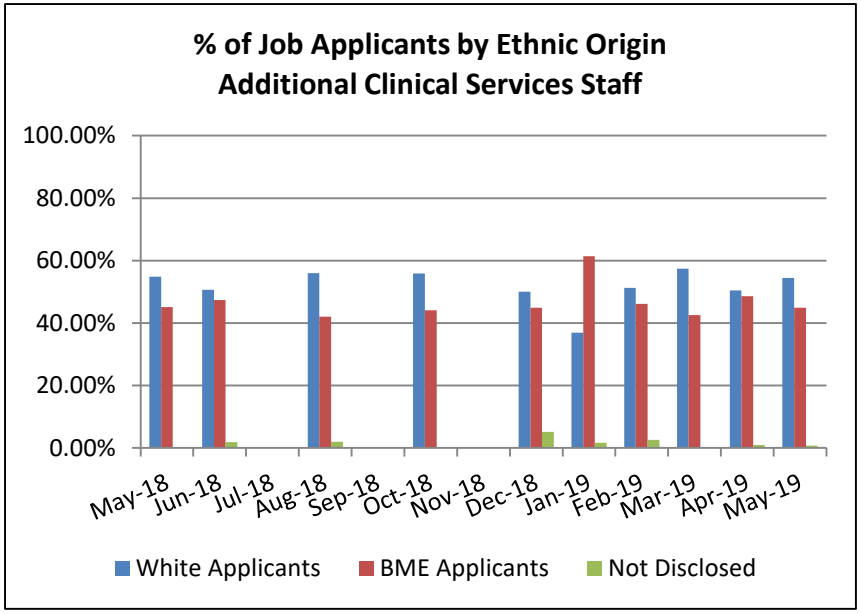


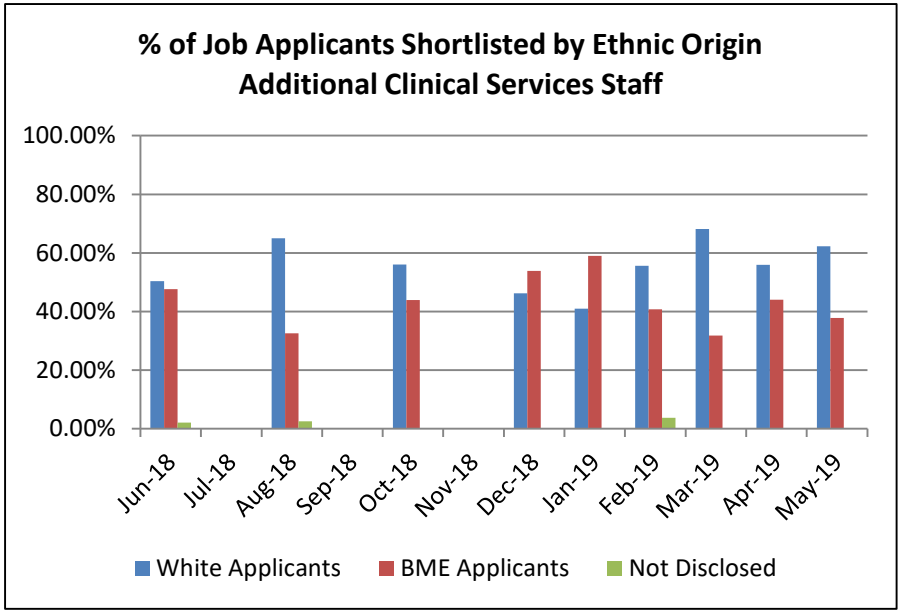
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.66	↓	+0.06	+ 0.02	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month
1.38

Workforce Composition, Resourcing and Cost

Staffing Costs

- Total agency spend for May was £468k against a plan of £352k, with cumulative spend of £878k against a cumulative plan of £720k. There has been an overall increase in agency costs compared to April 19, with the largest increase in Nursing of £49k. This increase can be attributed to the reopening of the 2 wards which were closed during April.

- Bank spend in month was £528k against a plan of £398k mainly due to vacancies.

- Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

- Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

- Recruitment to vacancies continue with a projected 7wte qualified nurses to start during June/July.

Turnover

- The unadjusted turnover figure has increased since the last report in February 2019, from 7.11% to 9.98% in May 2019. This can be attributed to the Histopathology TUPE transfer to UHB which has taken place in May 2019. This is still below the Trust target of 11.5%.
- It has not been possible to provide the adjusted turnover figures for this reporting period due to a repotting issue , which IBM are currently trying to resolve and it is hoped that we will have data available for the next reporting period.
- Turnover has significantly decreased for Additional Clinical Staff in the last 12 months from 11.43% in May 2018 in to 5.51% May 201 This is most probably due to staff being retained on the bank rather than completely leaving the organisation.

Exit Data

- The top 3 reasons for staff leaving the organisation according to our exit questionnaire are Lack of Opportunities for Progression, Training and Development opportunities and Job Satisfaction. In comparison data from ESR suggests the top 3 reasons are Resignation – not known, Employee Transfer and Resignation –promotion (this data relates to the previous 12 months inclusive of May 2019). This theme has remained consistent to previous reporting periods.
- - Work is being undertaken to improve the quality and quantity of exit data being received.

Staff in post

- The graphs on page 5 show an upward trend in staff in post as a percentage of the establishment for non-clinical staff, specifically showing an increase of 0.72% since April 2019. This is a 1.2% increase from 2018.
- The figures for clinical staff are promising and show an increase of 1.82% in April 2019 to May 2019 and an increase of 4.65%% from May 2018 to May 2019.

Workforce Composition, Resourcing and Cost

Recruitment and Selection - Streamlining

A significant amount of work has been taking place to ensure that candidates are unconditionally offered as speedily as possible. In April 2019 the team had 191 offers in progress which at the end of May 2019 had reduced to 128. Although this is a slower rate than desired, efforts are being made to ensure that systems and processes to process candidates are reliable and effective. The team are actively calling and chasing candidates and referees and managers are being encouraged to 'Keep in Touch' with candidates too.

The introduction of the Workforce Matron post is showing benefit and this post holder is working closely with the recruitment team and Head of HR to ensure timely recruitment to high priority areas.

The most significant delays in recruitment seem to be at ATR stage and references and work will be established to consider how these areas can be streamlined further working with colleagues from across the Trust.

WRES Indicator 2 monitoring

May 2019 saw 41.77% BME applicants compared to 56.79% White. The % of BME applicants being shortlisted was 39.57% compared to 58.82% representing a decrease in the proportion of BME applicants being shortlisted compared to the previous reporting period (reducing to a conversion rate of 1.66 from 1.69 in the previous period).

ACTIONS FOR IMPROVEMENTS / LEARNING

NHSI Retention programme, development of ATR system, planned deeper dive into WRES data

RISKS/ISSUES

Unplanned staffing expenditure remains an issue, as does potential over-reliance on temporary staffing. Potential excessive working by established nursing staff through additional Bank hours.

Inadequacy of specific recruitment workforce data/ insufficiently developed systems make creation of a suite of recruitment KPIs a challenge.

2 Workforce Performance

2a Staff Attendance

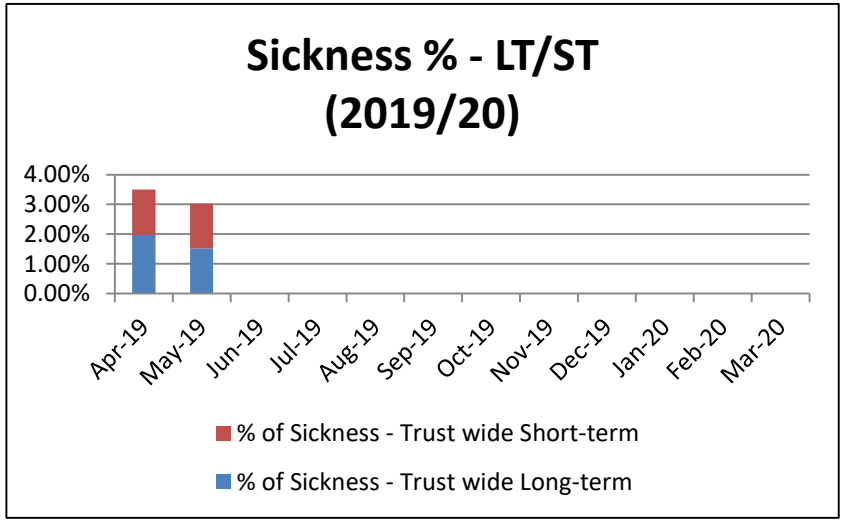
Staff Attendance

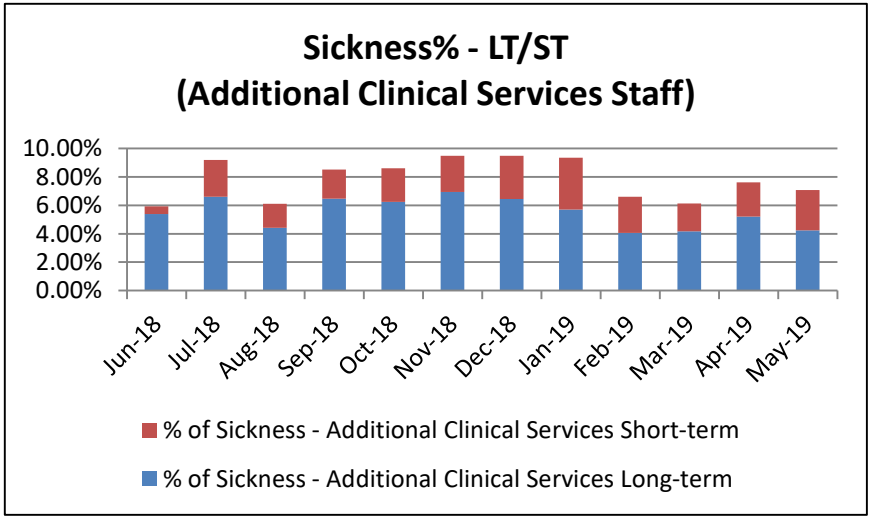
Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
95.72%	95.61%	⇧	0.38%	96.10%

ALL STAFF * 12 months to End of May 19

Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
92.14%	92.14%	N/A	3.96%	96.10%

ADDITIONAL CLINICAL SERVICES STAFF * 12 months to End of May 19





2 Workforce Performance

2b Staff attendance – short-term absence management

Staff Absence

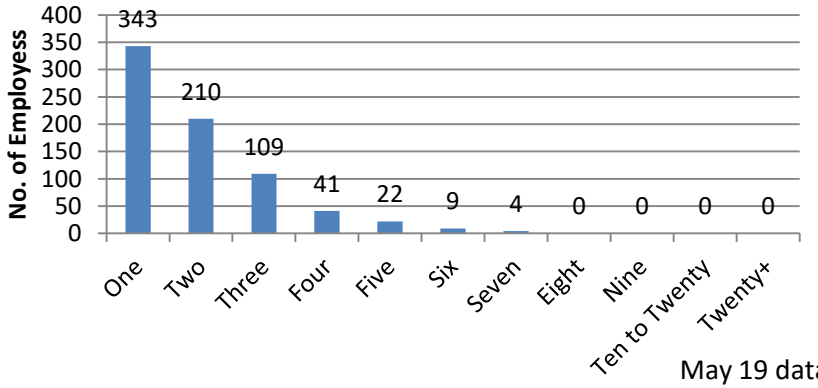
Return to Work Process Completion Rate (12 months) *May 19

ALL STAFF

Return to Work Process Completion Rate (12 months) *May 19

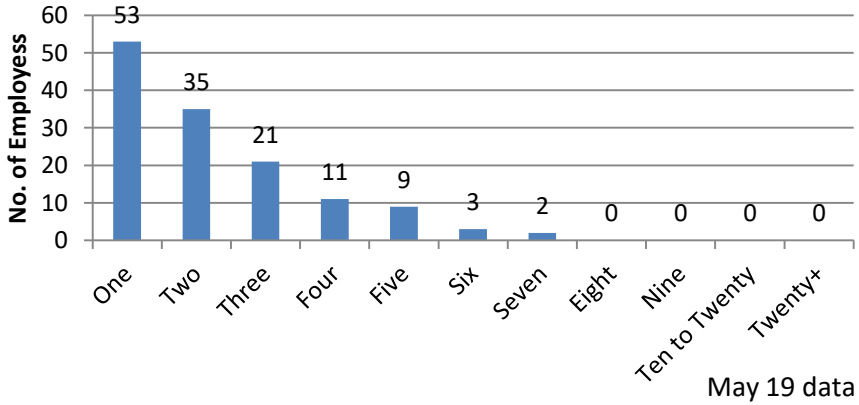
ADDITIONAL CLINICAL SERVICES STAFF

No. of Employees vs No. of Sickness Episodes (12 months)



May 19 data

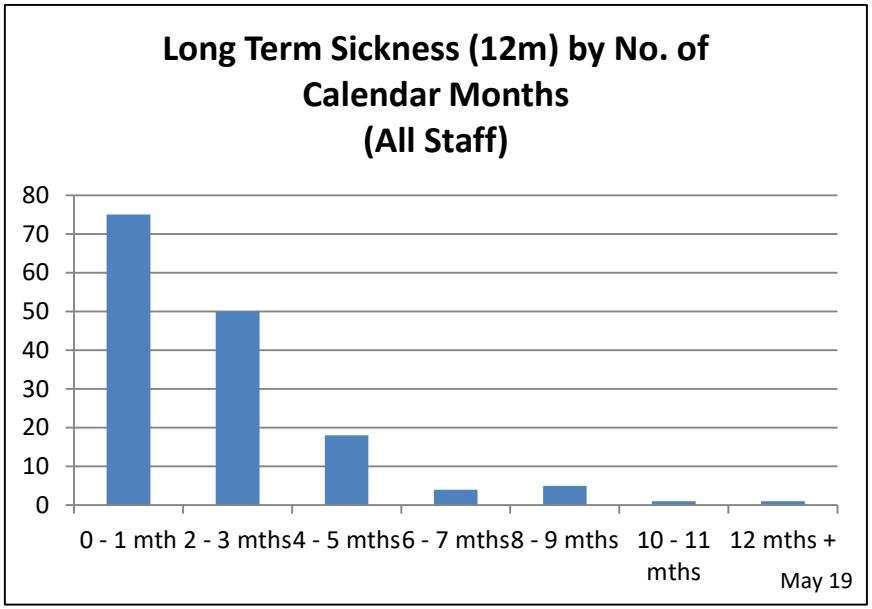
No. of Employees vs No. of Sickness Episodes (12 months) Additional Clinical Services Staff

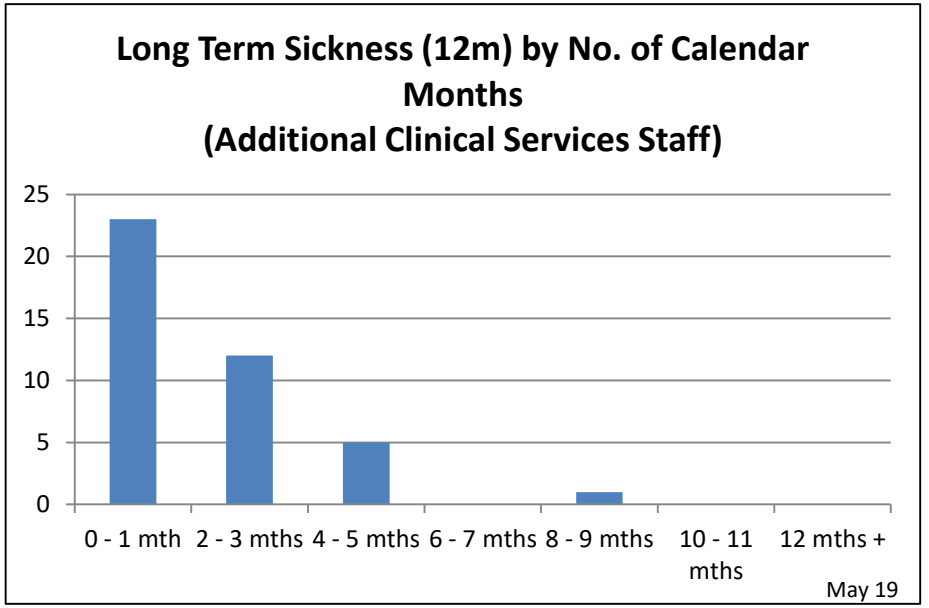


May 19 data

2	Workforce Performance
2c	Longer-term Staff Absence

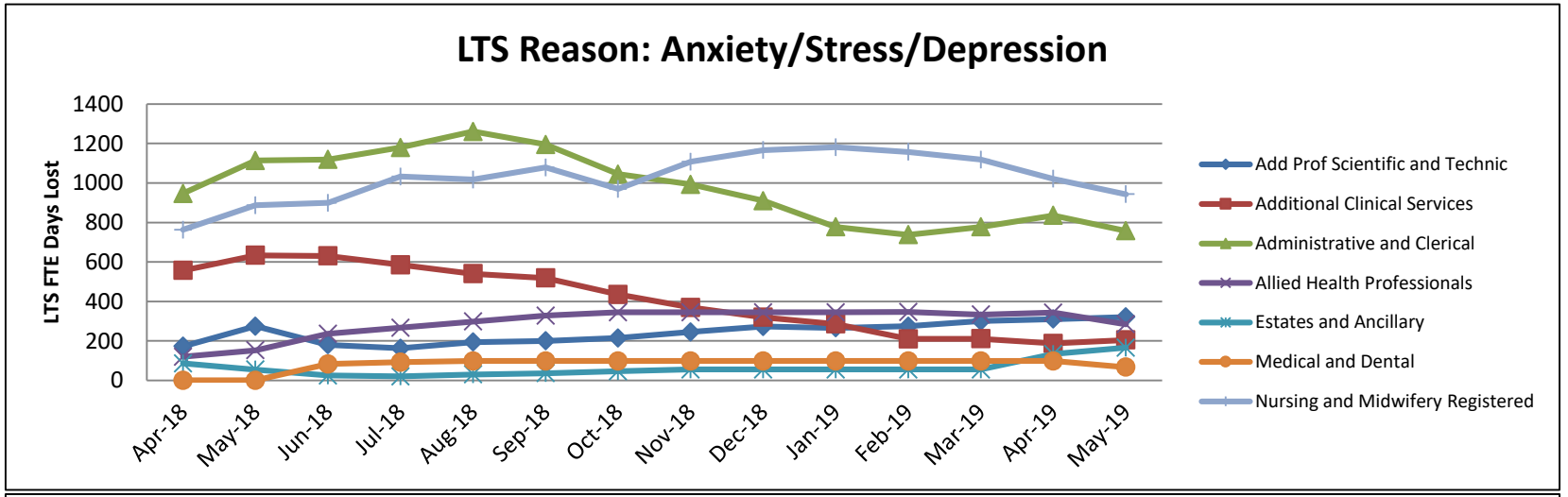
Long-term Staff Absence

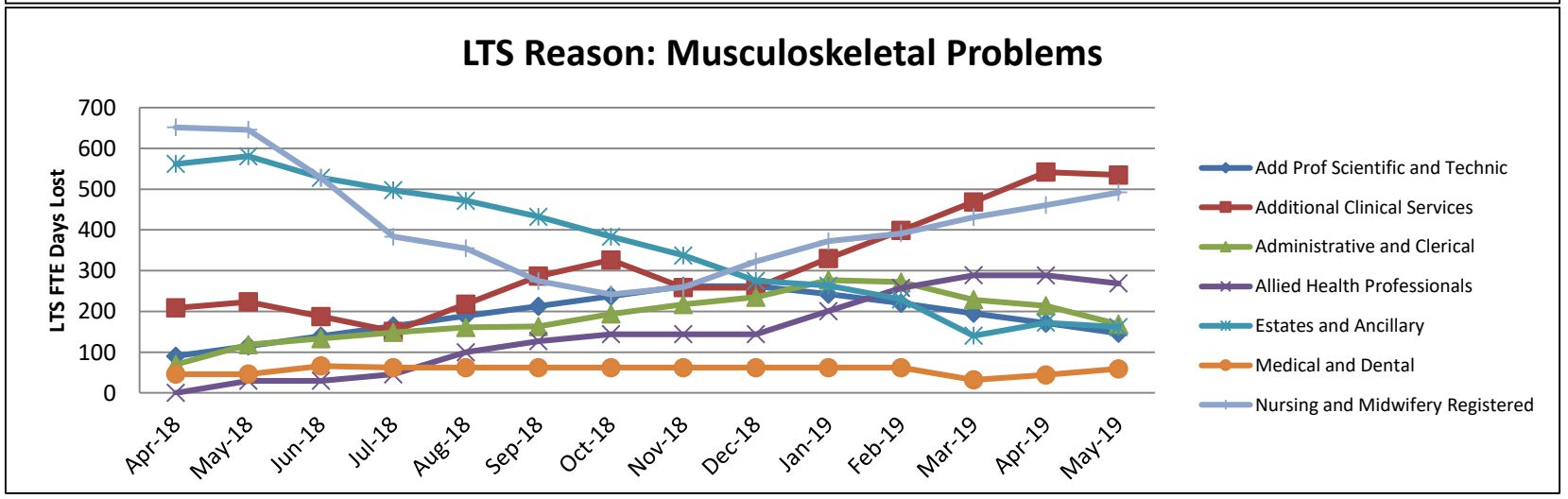




2 Workforce Performance

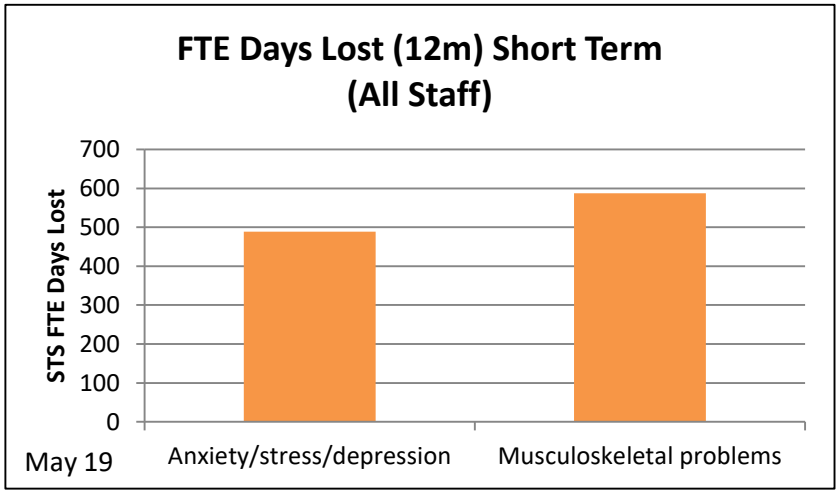
2c Longer-term Staff Absence

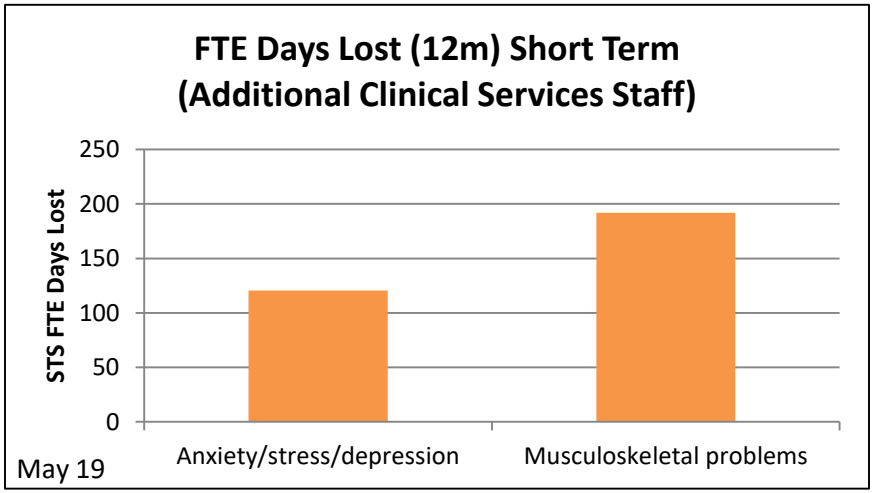


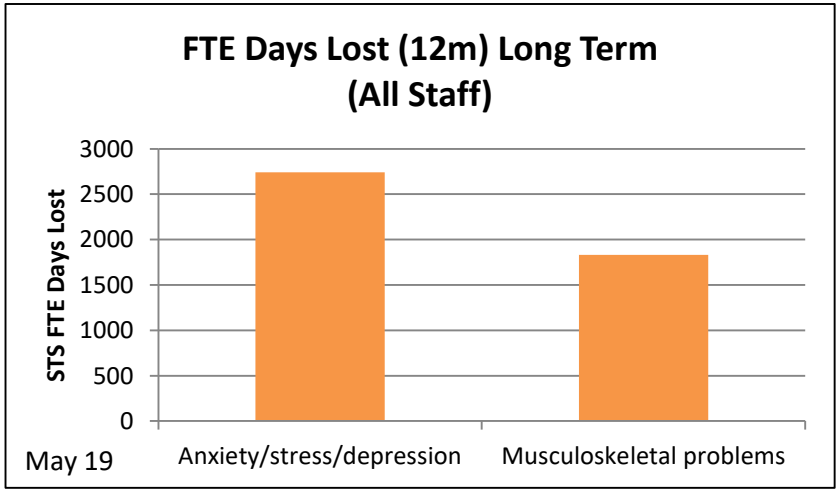


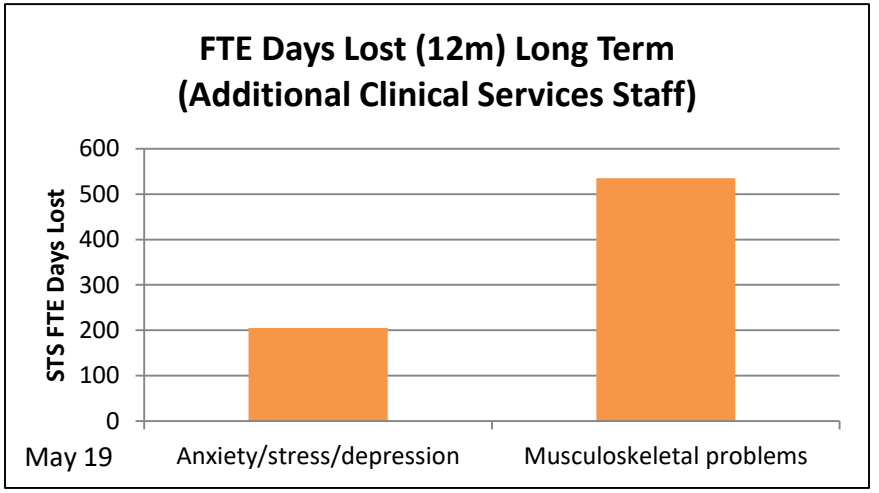
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary

Management of Performance

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	2	0	0	1	3	2

May 2019

INFORMATION

Staff Attendance

The rolling 12 month attendance figure for all staff has increased from 95.48% in February 2019 to 95.72% in May 2019 showing a variance of 0.38% to the Trust KPI of 96.10%. Figures for Additional Clinical Services staff are not as positive presenting a variance of 3.96% against the trust target, currently standing at 92.14% of which the majority is long term absence.

Return to work completion rates for all staff remain below the target of 80% at 56.10% and for Additional Clinical Services Staff, 41.9%. Further work needs to be undertaken to review the current return to work process in order to increase compliance and welfare conversations before an employees return to work. It is anticipated that he Trusts focus on employee health and wellbeing will positively impact on engagement with this process.

The most common reason for short term absence for all staff is 'Musculoskeletal' and for long term absence, Anxiety/Stress/Depression. In Additional Clinical Services, the picture is different and 'Musculoskeletal' is the main reason for both lengths of sickness absence.

Formal Disciplinary and Capability

As at the end of May 2019, there were 2 suspensions and 3 conduct cases. Further work is needed to be undertaken with colleagues across the Trust to ensure that HR are being informed of action being taken.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Explore how additional clinical services staff can be supported with tackling the main causes for absence.
- Understand whether 'mental health' related absence is due to work or non-work related issues.

RISKS/ISSUES

- Return to works not being completed therefore risk not being managed appropriately.

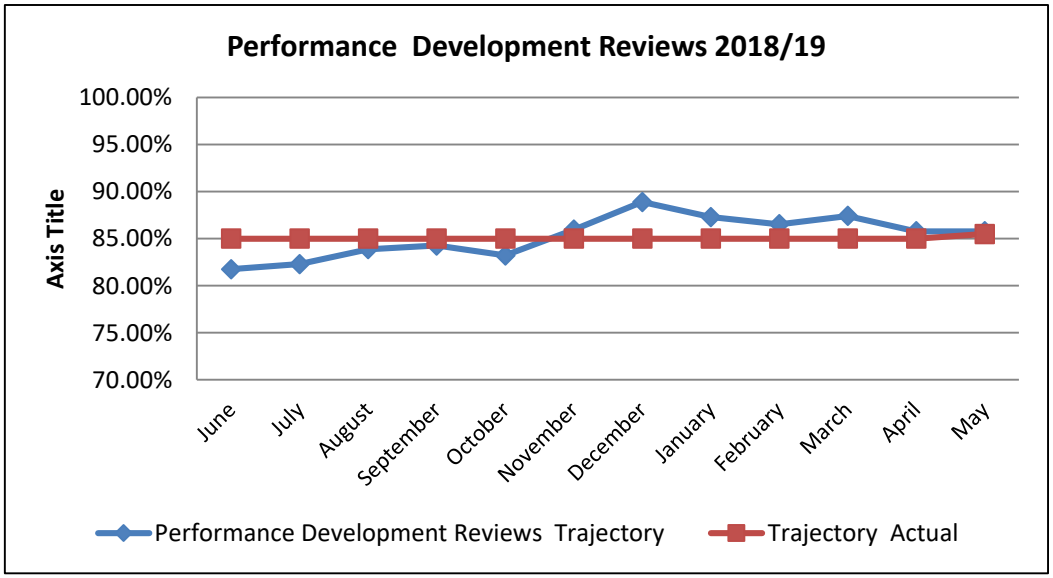
3 Workforce Learning and Development

3a Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NNS Engagement Question 2017	2018	2017	2016	2015
19a	In the 12 months have you had an appraisal or annual review?	91%	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	63%	64%	74%	79%
19f	Were any training, learning or development needs identified?	66%	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date



Staff survey results in 2018, show a 5% increase from 2017 in staff reporting they have received an annual appraisal, and a 12% increase in effectiveness in identifying learning and development needs during this process.

However, there has been a 1% decrease in staff reporting they have had access to learning and development opportunities over the last 12 months. The reduction in available funding to support professional development has been identified as a risk within the Trust, and a cost pressure has been raised to support this.

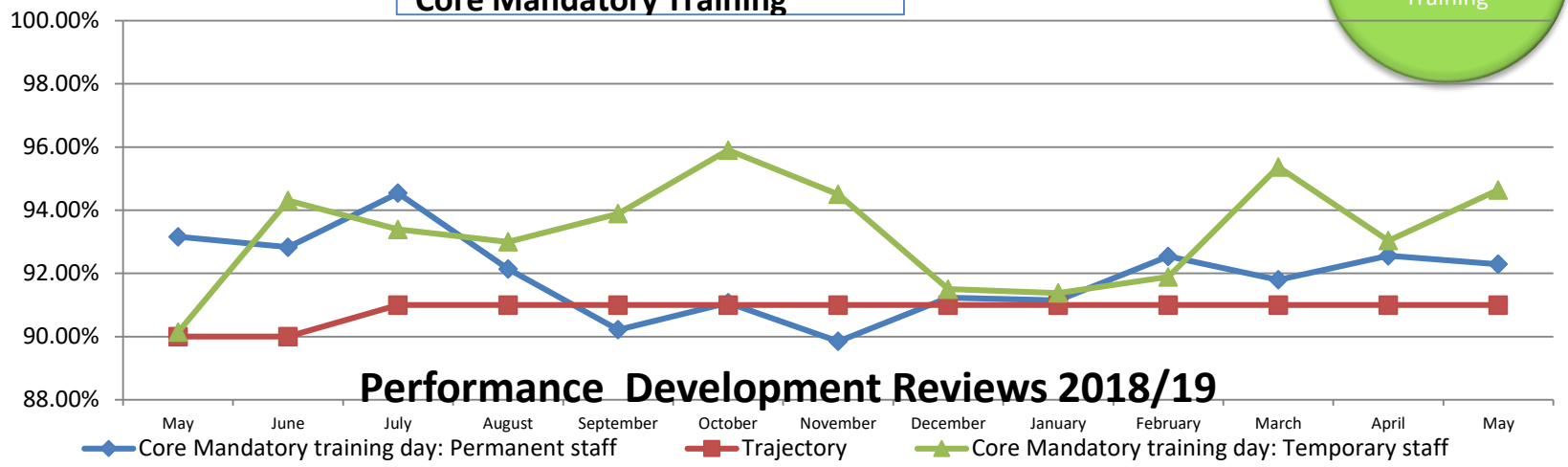
Workforce development funding has been received from HEE but this has reduced by 70% over the last 3 years, impacting on access to professional development and qualifications.

3 Workforce Learning and Development

3b Core Mandatory Training, Specialist Training and Corporate Induction

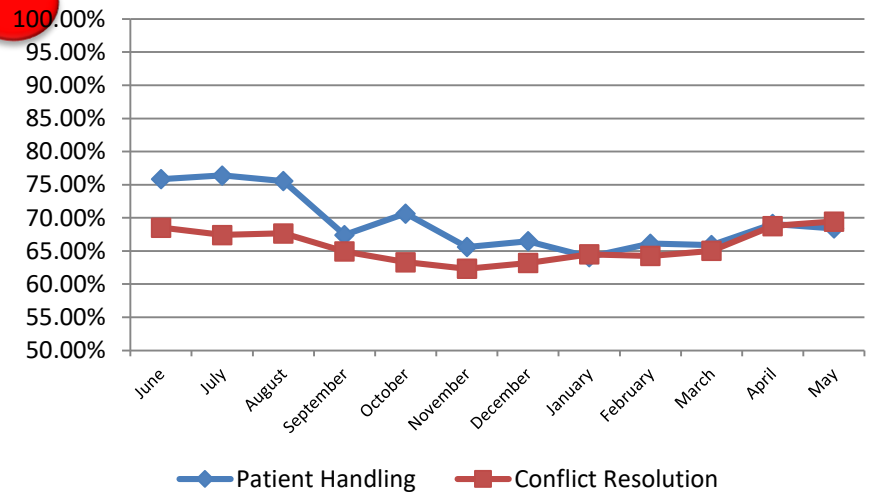
Core Mandatory Training

Core Mandatory Training

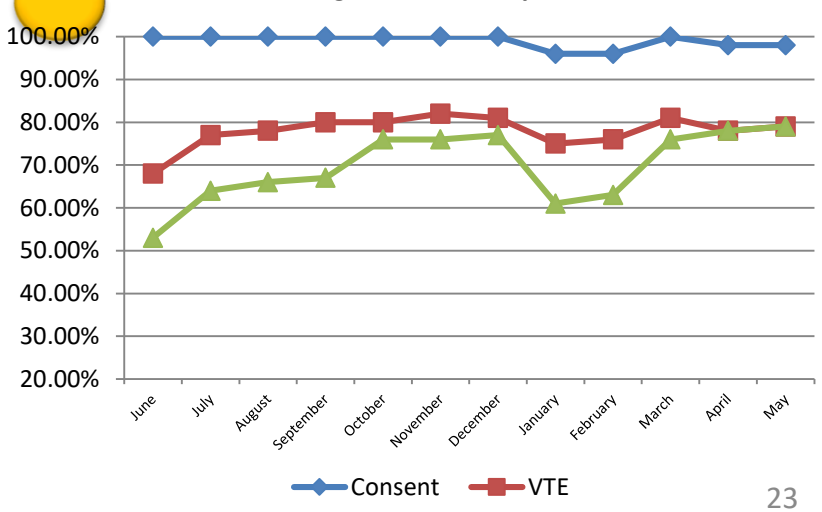


Performance Development Reviews 2018/19

Patient Handling and Conflict Resolution Compliance

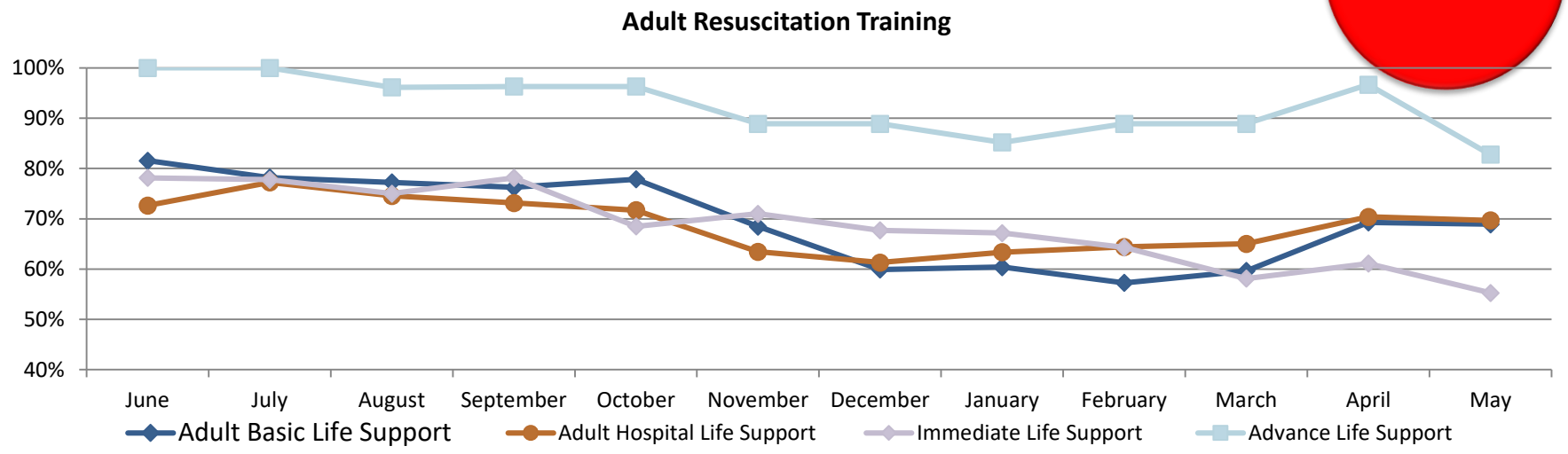


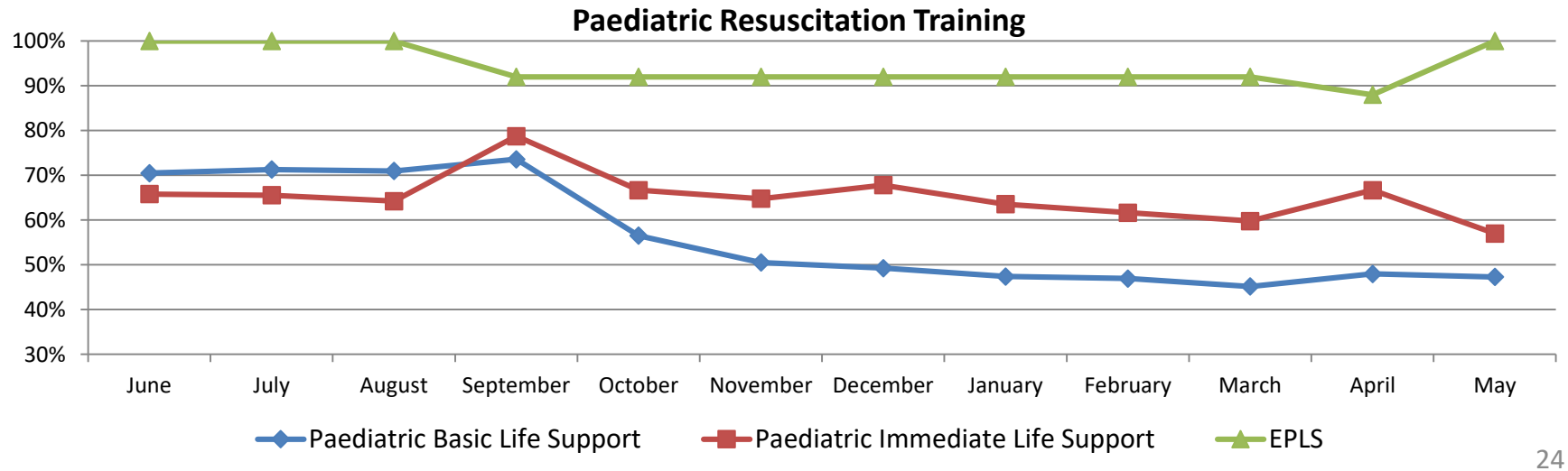
e-learning Modules Compliance



3	Workforce Learning and Development
3c	Resuscitation Training

Resuscitation Training





INFORMATION

Core Mandatory Training – Reported Core mandatory training attendance has achieved above compliance for 5 months. Work continues on improving the content and delivery of the face to face training, and developing a more easily accessible e-learning approach. 10% of core mandatory training is currently completed on line. 2019 will see an increase in this figure.
CMT for Bank / Temp staff has continued to maintain over 91% compliance for over 12 months.

Role Specific Mandatory training –
The Trust Resus training compliance for Adults and Paediatrics has shown an increase last month due to increased volume of training activity during the Theatre Close Down week..
Resuscitation standards and governance processes have recently been reviewed and updated recently, with the Director of Nursing committing to chair the Resus committee from November 2018. The Risk for resuscitation training compliance figures is monitored through the quality and safety group.
Conflict resolution and patient handling compliance also showed a slight increase due to activity during theatre close down week. This has been raised with the clinical quality group, and a small focus group has been created to review attendance requirements.
VTE / Insulin –Improvements have been seen in staff completing insulin and VTE however the delegate group was reviewed in January with additional staff included, which has resulted in the initial drop in compliance figures at the start of the year.
Following a review of the consent module compliance, additional names have been included which initially reduced compliance. Those individuals are being liaised with directly.

ACTIONS FOR IMPROVEMENTS / LEARNING

Core mandatory training :– Mandatory training streamlining / CIP project continues. Positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information. Meeting held in April to review Mandatory training requirements and seek opportunities to reduce the burden.
Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place.

VTE/Insulin online modules: E-learning facilitator working closely with Lead to increase compliance, creating learning paths in ESR. It has been agreed that medics do not need to complete the insulin modules as they do not administer.

L&D team are monitoring cancellations and DNAs on courses, to provide monthly reports back to departments to identify key reasons for not attendance.

RISKS/ISSUES

Staff booking onto and completing their role specific mandatory training modules is low.
Resus levels still non compliant
In house trainers for resus and patient handling reducing availability to support training.
Attendance and DNAs on courses is still high. DNA charges will be introduced during 2019.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

OVERALL STAFF ENGAGEMENT

The most recent National staff survey results have seen a positive move on the overall staff engagement score from 3.83 to 3.97. The score is made up of the questions shown below:

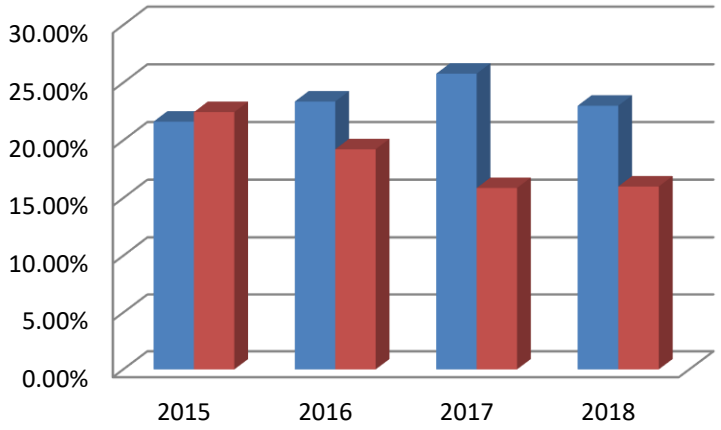
	Questions linked to ROH engagement score	2018 ROH	2018 Average	2017 ROH	2016 ROH
21a	Care of patients is my organisation's top priority	86%	86%	79%	69%
21b	My organisation acts on concerns raised by patients	83%	81%	79%	73%
21c	I would recommend my organisation as a place to work	73%	72%	62%	56%
21d	I would recommend the standard of care provided by this organisation	91%	89%	83%	77%

4 Workforce – Experience and Engagement

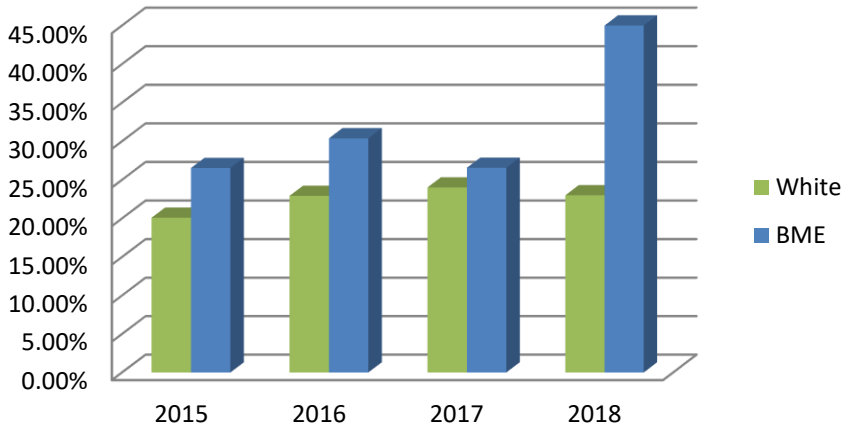
4c WRES Indicators

WRES Indicators

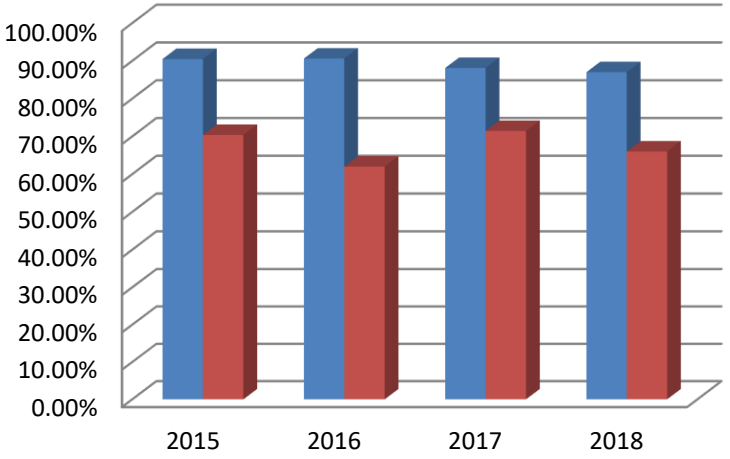
Indicator 5: Experiencing bullying from patients



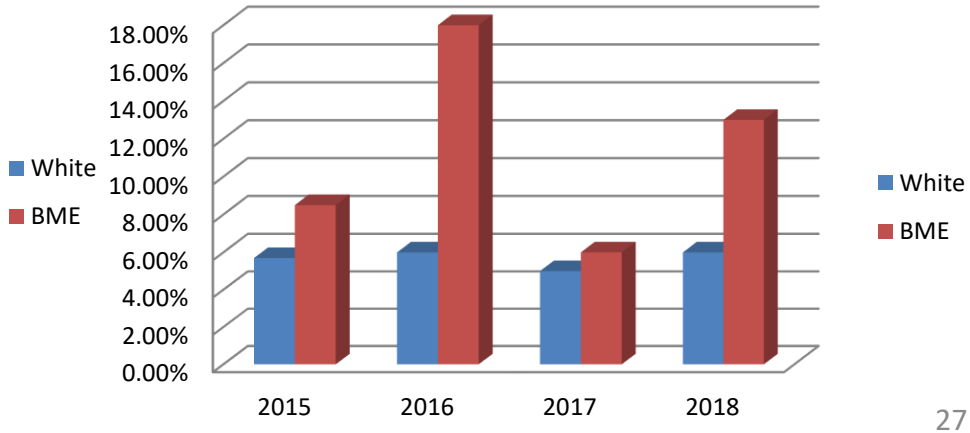
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION
Friends and Family Test (FFT) – The Trust is still awaiting the final information from Capita People Solution on the Staff FFT from Q1. This will be presented at the next SE&OD committee **Engagement and Job Satisfaction** – Speak Up and Join in brand becoming increasing established. Even better if… sessions being rolled out across teams. Information from the National Staff survey results is being communicated across the Trust and team will be asked in April 2019 to compile local actions based on the survey results **WRES Indicators –** Whilst the overall response rate to the 2017 was low, the proportion of BME staff completing the 2017 was comparable. WRES indicators informed by 2017 National Staff Survey show significant differentiation between white and BME staff. Whist some indicators may be evidence of greater confidence in reporting concerns, further action is required. The Trusts E&D annual report and grading of E&D outcomes under EDS2 will be informed by WRES indicators. Data for WRES 2018 will start to be collected in April 2019
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions to encourage survey completion to improve data reliability Ensure all staff are sighted on the positive staff survey results and are able to suggest local improvements
RISKS/ISSUES
Part of the WRES data is sourced from the NHS National Staff survey. Completion rate affects the reliability of the data as a representation of staff views

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Nominations & Remuneration Committee terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Dame Yve Buckland, Trust Chair**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs and Company Secretary**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

In line with the requirement to review the Board Committees' terms of reference on an annual basis, the attached are the latest version with some minor changes suggested:

- Amendment to the title of the Director of Corporate Affairs & Company Secretary

Beyond this minor change, there are no other suggested amendments.

The Board is invited to note that there has been sound compliance with the terms of reference during the year and the decision-making for the appointment of the Chief Executive and Chief Operating Officer has been conducted in line with the requirements of these terms of reference.

The Nominations & Remuneration Committee has received a report providing assurance on the Fit and Proper Persons process, which fulfils the obligations under Section 2.1 of the terms of reference.

REPORT RECOMMENDATION:

The Board is asked to:

- APPROVE the minor change to the terms of reference

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	x
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:

Delivered by highly motivated, skilled and inspiring colleagues

PREVIOUS CONSIDERATION:

Nominations & Remuneration Committee on 4 September 2019

NOMINATIONS AND REMUNERATION COMMITTEE (EXECUTIVE DIRECTORS)

Terms of Reference

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~~ Corporate Affairs 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~~September 2019

13. Date of Review

~~June 2019~~September 2020

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Strategy extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

Over the summer, the Executive Team has overhauled and updated both the Corporate Risk Register and Board Assurance Framework to reflect the latest view of the key risks facing the Trust. Those risks shaded in blue are recommended for closure or de-escalation to local risk registers.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:					
Trust Board is asked to: • Review the Board Assurance Framework extract • Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate • Agree to close or de-escalate those risks suggested					
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:					
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:					
Executive Team in July 2019					

BOARD ASSURANCE FRAMEWORK - QUARTER 1 AND 2

S799	Strat	Exec Dir - S&D	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	Work is underway to develop the strategy for 2019/20 to 2023/24 and beyond. A workshop was held for the Board on 6 February 2019 at which the Board was presented with the proposed routes for engagement with the strategy for staff, stakeholders and the public.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case; slides from strategy session for the Board on 6/3/19	2	3	6	↔	A strategy working group will be established to specifically focus on: - How we engage with all teams in the development of the new strategy - How we share key headlines from this year's annual plans - What we think the key elements of the strategy need to be - How we align all Trust plans/strategies to this document	Q1 2019/20	2	3	6

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Carbon Reduction Strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Stuart Lovack, Associate Director of Estates & Facilities**
DATE OF MEETING:	**4 September 2019**

EXECUTIVE SUMMARY:

The Trust is working towards the Government's NHS carbon reduction target of 20% by 2020 from its base year of 2006. The current status is the Trust is above the National Targets in all four metrics, these being Gas Consumption, Electricity Consumption, Staff Travel and Water Consumption.

The investment in new technology and new gas fired plant has resulted in a reduction in gas consumption bring it more in line with the National Target.

Electricity consumption is our biggest challenge and continues to rise, to achieve the National Target it would require a 23% reduction in our current usage.

The development of new Theatres and a Ward will further impact on consumption rates which will increase our gas, electricity and water consumption throughout 2019/20 and beyond.

REPORT RECOMMENDATION:

The Trust Board is asked to note the content of this report which is based on the Trust's current position as at 31st March 2019.

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		Legal & Policy	**X**	Patient Experience	**X**
Clinical	**X**	Equality and Diversity	**X**	Workforce	**X**

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

The Trust continues to perform above the National Targets. Currently there are no financial penalties for the Trust not delivering by the 20% reduction by 2020.

PREVIOUS CONSIDERATION:

None.

FOR ASSURANCE

ROHTB (9/19) 020 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

Carbon Reduction Strategy Annual report

Report to the Trust Board on 4 September 2019

1.0 Summary and Background

1.1 The Trust's strategy has been to work towards meeting the government's target for carbon reduction by reducing its carbon footprint from our base year in 2006 by 10% by 2015, with a revision made by the government to reduce by 20% by 2020.

1.2 The Good Corporate Citizen's Group (GCCG) is the management group to oversee the drive to reduce carbon emissions on site.

2.0 Detail

2.1 The GCCG is chaired by the Associate Director - Estates and Facilities and meets bi-monthly. Attendance at the meetings continues to be minimal and with few areas represented.

2.2 Ideally a 'Green Champion' would be nominated in each ward/department to help promote energy/carbon reduction initiatives throughout all areas of the Trust. Through events staff are encouraged to participate in all aspects of good housekeeping, which will make a small contribution in driving down the Trust's energy usage and carbon footprint.

2.3 In 2018/19 as per previous years, ambitious targets were set to continue to move towards and achieve the 2020 national target for carbon footprint savings of a 20% reduction. Progress is as follows:

	Baseline 2006/07	Actual 12/13	Actual 13/14	Actual 15/16	Actual 16/17	Actual 17/18	Actual 18/19	National Target 2020
Gas (tonnes)	1420	1171	1528	1677	1478	1161	1221	1136
Electricity (tonnes)	1539	1427	1555	1612	1608	1607	1608	1231
Staff travel (tonnes)	1100	845	974	1006	1006	1006	1006	880
Water (M3)	29,374	22314	24691	27000	22430	28514	28522	23,459

2.4 Following the installation of the magnetic rings to our incoming gas mains on two of the hospital buildings and the installation on two new boilers this has seen gas usage reduced with the national target almost being met.

2.5 Electricity usage continues to remain high with no significant reduction in this area over the last 12 months. A bid was made for grant funding to further install LED lighting around the site. The scheme was oversubscribed with £112.3m requested by 163 organisations. With only £30m of funding, the hospital was not successful. It has been advised that those not receiving funding would be able to use the national Salix Funding scheme.

2.6 Since the targets were originally set, the size of the Trust's estate has increased due to the Outpatient Building being completed in 2011, and more recently with the commissioning of the Admissions and Day Case Unit in 2013. There is an additional mobile MRI scanner on-site which visits twice a month and a new development of 4 theatres with a recovery area and ward which is planned for 2019, this will result in increased energy usage on site. These factors will continue to put further pressure on the Trust's ability to meet the national targets specifically for electricity and water usage.

2.7 The Trust continues to segregate its waste stream and has introduced the non-infectious or Tiger waste streams into all ward areas, POAC, ADCU and Outpatients. Please find below details below for the last 12 months:

Health Care Related Waste	**Tonnes**
Soft Bagged Healthcare Waste (Alternative Treatment)	106.78
Sharps Waste (Incineration)	8.68
Pharmacy (Non-Haz Meds)	1.19
Anatomical Waste	2.28
Gypsum Waste (incineration)	0.24
Non-Infectious Waste	20.00
Commerical Waste	
General Waste (Baseline 2006/07 139 tonnes)	97.716
Dry Mixed Recycling	30.923
Cardboard	34.21
Inert Waste (Non-Hazardous, Skip)	11.30
Metal Only (Skip)	0.7
Glass Only	2.7
Confidential Waste	39.4

2.8 The staff travel aspect has not changed since last year due to demand for car parking with both on-site and off-site waiting lists increasing.

2.9 Sustainability reporting in the NHS has been mandatory from 2012/13; the NHS Manual for Accounts has been updated to reflect this. The Trust reports on sustainability both nationally and in its Annual Report.

2.10 The Sustainable Development Assessment Tool was undertaken in July 2018, whereby the Trust received an overall score of 45%. This assessment has 296

questions covering 10 categories: Corporate Approach: Asset Management and Utilities: Travel and Logistics: Adaptation; Capital Projects; Green Space and Biodiversity; Sustainable Care Models; Our People; Sustainable Use of Resources; Carbon/GHG's.

2.11 During 2018/19, the use of non-recycle items, such as single use disposable cups and takeaway food containers, has reduced with bio-degradable products being used by Café Royale (containers contaminated with food cannot be recycled).

2.12 The Theatre Department stopped purchasing single use cups for their staff to use, and encouraged them to either bring in their own mug/cup or purchase a Trust 'I want tibia a little greener' reusable cup Trust wide the cup proved successful.

2.13 The Knowledge Hub also suggested selling the 'Pokito', a collapsing cup, to their students as well as the ROH branded cup.

2.14 During the 2018 Cycle to Work Week, those staff cycling were offered either a voucher for Café Royale for a breakfast sandwich, healthy flapjack and a banana.

3.0 Timescales

3.1 Work is being undertaken to develop a Sustainable Development Management Plan and Climate Adaptation Plan using the Sustainability Development Unit (SDU) Benchmarking tools and publish in the format suggested by the SDU and NHS Improvement. This will identify areas that we are doing well and not so well in, and assist in formulating a plan for the next five years.

3.2 Consideration of using the National Union of Students Green Impact campaign to encourage staff to make small changes to reduce our overall impact on the environment would be beneficial and has proven successful at other NHS Trust's and Universities.

3.3 This will help to achieve the national target of a 20% reduction by 2020, with a required target of 80% reduction by 2050.

4.0 Financial Considerations

4.1 There has been no published information on any financial penalties for not achieving the 2020 national targets.

5.0 Revenue Consequence Implications

5.1 Further work is required on reducing our carbon footprint as this will have a direct effect on revenue savings for the Trust. An investment on available technologies to reduce usage and the re-introduction of staff awareness training at Mandatory Training should be considered by the Trust in order to reduce usage, improve efficiency and potentially make cost savings.

5.2 Salix Funding is available for hospital projects where a clear cost saving and reduction in usage is shown.

5.3 The cost associated with the Green Impact programme is approximately a one-off cost £8500. Cost for annual reviews can vary depending on the hospital's requirements.

5.4 Investment in dedicated shower and changing facilities for staff that cycle to work. This could help with a modal change of travel for staff commuting as 48% staff live within 5 miles and 75% live with 10 miles (data from 2018 travel survey, 253 responders).

6.0 Risks

6.1 Failure to meet the 2020 national target, currently there are no perceived financial penalties.

6.2 Birmingham Clean Air Zone due to be implemented in August 2020. This will impact staff commuting to work and also those that travel to clinics and patient's homes.

7.0 Consultation

7.1 The work of the Good Corporate Citizen Group endeavour to keep carbon reduction in everybody's minds and promotes/consults with a wide audience across the Trust.

7.2 A series of stakeholder events will also be undertaken in conjunction with the production of a Sustainability Development Management Plan.

8.0 Conclusions

8.1 The Trust's main focus for 2018/19 has been to reduce its gas and electrical consumption and strive towards meeting the national target of a 20% reduction in carbon by 2020. As consumption remains high for electricity and water, at current usage levels it is unlikely this target will be met. Further energy awareness campaigns are planned as a reminder for staff of the targets in place that the Hospital must achieve.

8.2 The Hospital is required to correctly segregate waste, and although we hope this may overall reduce costs, the main aim is to ensure we meet the guidelines in place.

8.3 Sustainable travel events have taken place but the hospital has seen an increase in single occupancy car journeys for staff travelling to work. Events will continue to be planned as before but it is likely these will be held in tandem with national campaigns such as Bike to Work Week and Walk to Work week.

8.4 A travel survey is being undertaken in May 2019. This will give an opportunity to introduce a more' greener' active travel strategy to encourage those staff into using a mixture of travel modes, such as walking, cycling, public transport and car sharing. This would also fit in well with the Health and Well Being agenda.

8.5 Staff applying for car parking are now provided with a Personal Travel Plan to identify alternative ways of commuting to work, and where possible, to include business travel.

8.6 The Hospital has made a bid for a 4 week placement organised by the Sustainable Development Unit, for a student from Warwick University studying Sustainable Global Development. The student will review the information required for the Sustainable Development Assessment Tool, which will outline where the Trust is and what areas improvements are required. This information will assist in the production of a revised Sustainable Development Management Plan (SDMP) and Climate Adaptation Plan.

8.7 Further work is being undertaken on single use products within the Hospital and how we can minimise the amount used, by using items that can be reused or composted. To see if it is viable for our disposable cups to be sent to a specific cup recycling centre, the RVS Shop Manager is continuing to trial a cup bin (this was identified as the only area we can't minimise single use cups).

8.8 The Emergency Planning and Sustainability Officer is continuing to work with the Communications Team to publicise events, campaigns and looking at ways on how to improve on how we publicise the Sustainability Agenda to not only staff, but patients, visitors and other stakeholders. There is also continued collaboration with local and national hospital trusts, where knowledge is shared on how best to approach specific issues.

8.9 Annual targets are to ensure we reduce our carbon emissions to meet the 2020 target. More specific targets in the short, medium and long term will be formalised in the Sustainable Development Management Plan (SDMP).

8.10 The Trust Board is asked to:

RECEIVE and NOTE the annual report on progress against the Carbon Reduction strategy.

Stuart Lovack
Associate Director – Estates & Facilities

30 August 2019

ROHTB (9/19) 021

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2019 NHS Core Standards profile**
SPONSOR (EXECUTIVE DIRECTOR):	**Prof Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Mr Stuart Lovack, Associate Director - Estates & Facilities**
DATE OF MEETING:	**4th September 2019**

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 2019 NHS Core Standards profile.

The review process has identified 54 areas of full compliance (Green) and 1 areas of partial compliance (Amber).

The area of partial compliance is:

- 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 area identified as partially compliant.

The timescale identified for completion of these area 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 2019 NHS Core Standards, noting in particular the actions being taken to address the areas where compliance needs to be strengthened.
- APPROVE the action plan to achieve 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	**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 2018					

Please select type of organisation: **Specialist Providers**

Publishing Approval Reference: 000719

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	13	0	0
Command and control	2	2	0	0
Training and exercising	3	4	0	0
Response	5	5	0	0
Warning and informing	3	3	0	0
Cooperation	4	5	0	0
Business Continuity	9	8	1	0
CBRN	7	0	0	0
Total	55	48	1	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	15	0	0
Long Term adaptation planning	5	5	0	0
Ambulance Resilience	0	0	0	0
Total	20	20	0	0

Overall assessment:	Partially 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 & remaining columns in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG & remaining columns 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	NHS Ambulance Service Providers	Evidence - examples listed below
1	**Governance**	**Senior Leadership**	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	• Name and role of appointed individual
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 ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
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 • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan

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	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
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	• Process explicitly described within the EPRR policy statement
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	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations 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	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
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	Partners consulted with as part of the planning process are demonstrable in planning arrangements
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 defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
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 defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
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 heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

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	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
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.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
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 High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
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 arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty**	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 free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.

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 of 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	• Process explicitly described within the EPRR policy statement
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	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key 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	• Exercising Schedule • Evidence of post exercise reports and embedding learning
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	• Training records • Evidence of personal training and exercising portfolios for key staff
29	**Training and exercising**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards

31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans
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. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records
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	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
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	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings

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 partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
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	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 ‘duty to communicate with the public’.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
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	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of 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 reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established 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	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
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 business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	Severe Weather response	Overheating	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	The Trust's Heatwave Plan is up-to-date and includes details of the monitoring and escalation process. The plan includes trigger levels in accordance with the National Plan.	Fully compliant				
2	Severe Weather response	Overheating	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	The Trust has a Building Management System which is active 24/7 throughout the Trust, the BMS system monitors temperature and makes necessary adjustments where appropriate. Locally departments/wards have identified cooler areas of the Trust.	Fully compliant				
3	Severe Weather response	Staffing	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	The Trust has a cascade system in place for communicating with key staff, locally departments and wards have communicatrion plans in place. The Trust has a number of rooms available for staff in severe weather situations.	Fully compliant				
4	Severe Weather response	Service provision	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	The Heatwave and Cold Weather Plans identify patients which would be more at risk from severe weather, this ensures the Trust continues to delivery high quality care.	Fully compliant				
5	Severe Weather response	Discharge	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	The Trust works in conjunction with other Trust's/organisations in the discharge/transfer of patients. The development of a Mutual Aid Handbook enables information sharing between partner organisations.	Fully compliant				
6	Severe Weather response	Access	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	The Trust has an Inclement Weather Policy which is active. The Trust has arrangements in place for a third party to snow clear and grit the hospital roadways.	Fully compliant				
7	Severe Weather response	Assessment	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	The Trust receives hot and cold weather warning alerts togther with storm warnings from its utility provider. The information is assessed by the relevant people and communicated as appropriate.	Fully compliant				
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	The Estates Department has PPM's in place for its hospital systems. On-call procedures are in place for Estates personnel together with a third party provider for any drainage issues.	Fully compliant				
9	Severe Weather response	Flood response	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	The West Midlands Connurbation (WMC) and Local Resilience Forum (LRF) have detailed multi agency flood planning and response arrangements in place. Copies of the MAFP are obtainable.	Fully compliant				

10	**Severe Weather response**	**Warning and informin**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	The Trust has a Media Policy and Communication Strategy, the documents and plans identify roles and responsibilities. Arrangements are in place to send out communications 24/7 through the various routes. (Twitter, YouTube, Facebook)	Fully compliant				
11	**Severe Weather response**	**Flood response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	The Trust has carried our a flood assessment and documentation is in place.	Fully compliant				
12	**Severe Weather response**	**Risk assess**	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Key risks are identified in the Emergency Planning Risk Register and appropriate plans have been developed.	Fully compliant				
13	**Severe Weather response**	**Supply chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	The Trust is part of BHA Procurement Services which is a local NHS Procurement Hub, processes are in place for maintaining supply of goods and services.	Fully compliant				
14	**Severe Weather response**	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	During normal working hours and out-of-hours the hospitals systems of resilience have been tested and any learning has been incorporated into the arrangements/plans.	Fully compliant				
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	Regular testing of the IT Infrastruture takes place to ensure there is connectivity for all it's users.	Fully compliant				
Domain: long term adaptation planning												
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Climate changes environmental risks are included in the relevant risk register togther with likely mitigation plans.	Fully compliant				
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	The Trust has a Building Management System which is active 24/7 throughout the Trust, the BMS system monitors temperature and makes necessary adjustments where appropriate. Areas where temperature cannot be controlled automatically are covered by local assessments.	Fully compliant				
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	The Development Control Plan for the Trust identifies strategic changes to deal with adaptation to meet climate change.	Fully compliant				
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Areas identified on the hospital site and schemes implemented for antenuation including tanks and drainage systems for surface water.	Fully compliant				
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	Recent planning permission / approval included adaptation plans for drainage surface water treatment.	Fully compliant				
Domain: Ambulance Resilience												

1	**Ambulance Resilience**	**Telephony**	The trust can continue to receive calls following telephony system outage through fall back arrangements, with minimal disruption to user and patient experience / the Trusts ability to receive and respond to incidents	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • Arrangements in place to diagnose the fault and support recovery • Control room processes to fall back to alternative telephony systems • Reduction of impact on service delivery as a result of the fault • Process for restoration of normal working service • Appropriate processes for escalation to "buddy sites" and coordination of support **Business Continuity:** • Highly available systems • Diverse/resilient routing • Multiple technologies including digital and analogue • Service level agreements with third party suppliers that state system availability as a key performance metric and is measurable • Ability of system to work autonomously e.g. no reliance on remote data centre • Auditable staff refresher training • Evidence of exercise / practice scenarios	Not applicable					
2	**Ambulance Resilience**	**Telephony**	The trust can continue to receive and triage calls and dispatch Trust resources with minimal disruption to user and patient experience	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • Rebuild post event, for example, split brain • Automated alerting to service desk • Well documented and rehearsed "back up" systems of working such as paper-based process **Business Continuity**: • Highly available systems • Multiple instances and hardware systems available with geographic separation • Service level agreements with third party suppliers that state system availability as a key performance metric and is measurable. • Diverse and resilient network connecting data centres • Auditable staff refresher training • Evidence of exercise / practice scenarios						
3	**Ambulance Resilience**	**Data Centres**	The trust has a minimum of two data centres containing all pertinent systems which ensure minimal disruption to user and patient experience / the Trusts ability to receive and respond to incidents during outages	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • 24/7 "on call" arrangements for both Ops and ICT **Business Continuity:** • Failover tested regularly (minimum bi-annually) and run for a period of time that gives confidence in failover arrangement • Diverse and resilient network links • Evidence of exercise / practice scenarios • One or both data centres running in an externally hosted environment • Appropriate indications of server room state in controls – temp, mains/generator						
4	**Ambulance Resilience**	**EOC**	The trust can operate their control centres as autonomous centres with minimal disruption to user and patient experience / the Trusts ability to receive and respond to incidents during outages. These processes have been tested or exercised in the past 12 months	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of working locally • Spilt brain approach to rebuild post failure • Clear arrangements for passing calls between controls if dispatch required at remote control from where the call has been received **Business Continuity:** • Pre-plan arrangements with BT that ensure that in "local working" mode there is a reduction of cross control transferring of calls • Ability to switch between autonomous and virtual from the control room • Auditable staff refresher training • Evidence of exercise / practice scenarios						

5	**Ambulance Resilience**	**Radio**	The trust can continue to communicate with operational resources in the event of loss of radio communications with minimal disruption to user and patient experience / the Trusts ability to receive and respond to incidents during outages	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • Plan to reduce talk groups for operating desk top sets • Sufficient desk top sets available to maintain dispatch function • Bi-annual testing of failover scenarios **Business Continuity:** • Alternative communication arrangements – MDT, mobile phones • Connection to multiple fixed mobiles across Trust network for resilience • Evidence of exercise / practice scenarios						
6	**Ambulance Resilience**	**Telephony**	The trust can continue to undertake triage of emergency calls and assign appropriate response category accordingly in the event of triage system failure with minimal disruption to user and patient experience / the Trusts ability to receive and respond to incidents during outages	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • Local working in Pathways • Local working in AMPDS • Method in place to provide dispatch with ARP call category as well as triage determinant **Business Continuity:** • Highly available systems • Multiple instances and systems available • Evidence of exercise / practice scenarios	Not applicable					
7	**Ambulance Resilience**	**Data**	The trust can continue to send and receive information to / from operational resources in the event of mobile data failure with minimal disruption to user and patient experience / the Trusts ability to receive and respond to incidents during outages.	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • Clear plans to inform crews of situation • Processes to return to voice arrangements for passing of incidents and crew status updates **Business Continuity:** • Highly available systems • Multiple bearer availability • Server / data centre resilience	Not applicable					
8	**Ambulance Resilience**	**Resource tracking**	The trust can continue to track operational resources in the event of failure.	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • Clear plans to inform crews of situation **Business Continuity:** • Highly available systems • Server / data centre resilience • CAD ability to track MDT and Airwave devices	Not applicable					
9	**Ambulance Resilience**	**CAD**	The trust can receive calls (with minimal disruption) from other Trusts where the CAD to CAD and/or 111 ITK link fails or the Trust has suffered a complete CAD failure.	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of a failure • Dedicated contact numbers (telephony / ICCS) separate to incoming 999 lines • Regular testing of control channel on control room ICCS • Plans to inform Trusts nationally to pass manually • Demonstrate process to escalate nationally if appropriate **Business Continuity:** • Alerts indicating ITK failure (outbound) • SLAs in place with 111 providers	Not applicable					
10	**Ambulance Resilience**	**Mutual Aid**	The Trust can participate in a national response to a significant failure within another Trust control centre.	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take during request for mutual aid • Mutual aid processes • System capacity • Evidence of escalation processes during significant failure up to and including National Ambulance Coordination Centre (NACC) **Business Continuity:** • Evidence of participation in National BC group work stream on loss of an EOC • Evidence of active participation in planning for provision of mutual aid • Evidence of learning and actions following failure within own or other Trust • Evidence of providing mutual aid when requested	Not applicable					

11	**Ambulance Resilience**	**Evacuation**	The Trust has the capability to execute a coordinated evacuation and is able to establish capacity at the fall-back facilities and be operational within 1 hour	Y	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of an evacuation • Documented plans for staged evacuation • Documented plans for immediate escalation to other site / sites • Documented pre-plans covering how dispatch function will be taken up within other site / sites • Documented plans to inform "buddy" sites of potential support requirement and likely overflow of calls • Pre-plans to increase staffing levels (short term) in remaining site / sites • Plans to ensure sustainability of alternative site / sites during outage of failed site **Business Continuity:** • Evidence of exercise / practice scenarios	Not applicable					
12	**Ambulance Resilience**	**EOC**	The trust has arrangements for both short (less than 24 hrs) and longer term (greater than 24 hrs) loss of control room estate for each control room.	Y	**Disaster Recovery:** • Ability for each control to work autonomously • Appropriate arrangements for immediate and staged evacuation (see number 11 above) • Demonstrate an understanding of capacity, location and capability of fall-back desks • Pre-plans to increase staffing at alternative site (initial response) • Pre-plans to move staff from failing site to alternative site **Business Continuity:** • Failover tested regularly (minimum bi-annually) • Evidence of exercise / practice scenarios • The trust has sufficient fall-back capacity at alternative site / sites (including accommodating the loss of their largest control room for a sustained period of time e.g. days) • Sufficient dispatch positions with ICCS or desk top set access • All desks identified as part of the system always in a "ready" state for control room functions	Not applicable					
13	**Ambulance Resilience**	**Power**	The trust can withstand the loss of mains and secondary power to each control room site	Y	**Disaster Recovery:** • Multiple feeds from sub stations • Ability to bypass generator and/or UPS • Autonomy of generator • Autonomy of UPS • Dual powered equipment – server room and control room • UPS and generator maintenance records **Business Continuity:** • Appropriate indications of server room state in controls – temp, mains/generator • Regular documented testing of generator – online and off line • Regular testing of UPS system • Regular battery checks • Maintenance records	Not applicable					
14	**Ambulance Resilience**	**Staffing**	The trust has arrangements to manage a significant loss of control room and key support staff	Y	**Disaster Recovery:** • The Trust can demonstrate through its EPRR arrangements the ability to deal with a significant loss of staffing at a control site due to unplanned staff absence **Business Continuity:** • Virtual environment fully established	Not applicable					
15	**Ambulance Resilience**	**Testing**	The Trust tests plans related to these standards annually	Y	**Disaster Recovery:** • Evidence of testing of alternative sites / infrastructure • Evidence of practice for working without CAD (paper based etc) • Evidence of testing of site evacuation plans • Evidence of board level reporting and oversight **Business Continuity:** • Business continuity built into BAU arrangements	Not applicable					

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART										
Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y	Not applicable.					
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y	Not applicable.					
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	Not applicable.					
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y	Not applicable.					
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y	Not applicable.					
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y	Not applicable.					
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y	Not applicable.					
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y	Not applicable.					
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y	Not applicable.					
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	Not applicable.					
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	Not applicable.					
H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y	Not applicable.					
Domain: Administration										
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y	Not applicable.					
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y	Not applicable.					

H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y	Not applicable.					
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y	Not applicable.					
H17	**HART**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y	Not applicable.					
H18	**HART**	**Local risk assessments**	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	Not applicable.					
H19	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	Not applicable.					
H20	**HART**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y	Not applicable.					
H21	**HART**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y	Not applicable.					
H22	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y	Not applicable.					
Domain: Response time standards										
H23	**HART**	**Initial deployment requirement**	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y	Not applicable.					
H24	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y	Not applicable.					
H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y	Not applicable.					
H26	**HART**	**Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y	Not applicable.					
Domain: Logistics										
H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y	Not applicable.					
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	Not applicable.					
H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y	Not applicable.					
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y	Not applicable.					
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y	Not applicable.					
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Not applicable.					
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y	Not applicable.					
MTFA										
Domain: Capability										

M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y	Not applicable.					
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y	Not applicable.					
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y	Not applicable.					
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	Not applicable.					
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y	Not applicable.					
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y	Not applicable.					
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y	Not applicable.					
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y	Not applicable.					
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y	Not applicable.					
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y	Not applicable.					
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y	Not applicable.					
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	Not applicable.					
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	Not applicable.					
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y	Not applicable.					
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y	Not applicable.					
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y	Not applicable.					
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y	Not applicable.					
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	Not applicable.					
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	Not applicable.					
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y	Not applicable.					
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y	Not applicable.					

Domain: Response time standards										
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y	Not applicable.					
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y	Not applicable.					
Domain: Logistics										
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y	Not applicable.					
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y	Not applicable.					
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y	Not applicable.					
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y	Not applicable.					
M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Not applicable.					
CBRN **Domain: Capability**										
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y	Not applicable.					
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y	Not applicable.					
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y	Not applicable.					
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y	Not applicable.					
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y	Not applicable.					
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y	Not applicable.					
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y	Not applicable.					
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y	Not applicable.					
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y	Not applicable.					
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y	Not applicable.					
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y	Not applicable.					
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y	Not applicable.					
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y	Not applicable.					
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y	Not applicable.					
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y	Not applicable.					

B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y	Not applicable.					
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y	Not applicable.					
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y	Not applicable.					
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y	Not applicable.					
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y	Not applicable.					
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y	Not applicable.					
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y	Not applicable.					
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y	Not applicable.					
Domain: Response time standards										
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y	Not applicable.					
Domain: logistics										
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	Not applicable.					
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y	Not applicable.					
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y	Not applicable.					
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y	Not applicable.					
B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Not applicable.					
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y	Not applicable.					
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y	Not applicable.					
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y	Not applicable.					
Mass Casualty Vehicles										
Domain: Administration										
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y	Not applicable.					
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y	Not applicable.					
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y	Not applicable.					
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y	Not applicable.					
Domain: NHS England Mass Casualties Concept of Operations										
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.	Y	Not applicable.					
V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y	Not applicable.					
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y	Not applicable.					
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y	Not applicable.					
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y	Not applicable.					

V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y	Not applicable.					
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y	Not applicable.					
Command and control										
Domain: General										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y	Not applicable.					
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y	Not applicable.					
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y	Not applicable.					
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y	Not applicable.					
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y	Not applicable.					
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y	Not applicable.					
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y	Not applicable.					
C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y	Not applicable.					
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y	Not applicable.					
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y	Not applicable.					
Domain: Decision making										
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y	Not applicable.					
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y	Not applicable.					
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y	Not applicable.					
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y	Not applicable.					
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y	Not applicable.					

C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y	Not applicable.					
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y	Not applicable.					
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	Not applicable.					
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y	Not applicable.					
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	Not applicable.					
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	Not applicable.					
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	Not applicable.					
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	Not applicable.					
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y	Not applicable.					
C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y	Not applicable.					
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y	Not applicable.					
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y	Not applicable.					
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y	Not applicable.					
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y	Not applicable.					
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y	Not applicable.					
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y	Not applicable.					

C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y	Not applicable.					
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y	Not applicable.					
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y	Not applicable.					
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y	Not applicable.					
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y	Not applicable.					
JESIP Domain: Embedding doctrine										
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y	Not applicable.					
J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y	Not applicable.					
J3	**JESIP**	**Five JESIP principles for joint working**	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y	Not applicable.					
J4	**JESIP**	**Use of METHANE**	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y	Not applicable.					
J5	**JESIP**	**Joint Decision Model - advocate use of**	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y	Not applicable.					
J6	**JESIP**	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y	Not applicable.					
J7	**JESIP**	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y	Not applicable.					
Domain: Training										
J8	**JESIP**	**Awareness of JESIP - Responders**	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y	Not applicable.					
J9	**JESIP**	**Awareness of JESIP - control room staff**	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y	Not applicable.					
J10	**JESIP**	**Awareness of JESIP - Commanders and Control Room managers / supervisors**	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y	Not applicable.					
J11	**JESIP**	**Training records - staff requiring training**	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y	Not applicable.					
J12	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y	Not applicable.					
J13	**JESIP**	**Training records - annual refresh**	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y	Not applicable.					
J14	**JESIP**	**Commanders - interoperability command course**	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y	Not applicable.					
J15	**JESIP**	**Participation in multiagency exercise**	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y	Not applicable.					

J16	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y	Not applicable.					
J17	**JESIP**	**Training - review process**	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y	Not applicable.					
J18	**JESIP**	**JESIP trainers**	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y	Not applicable.					
Domain: Assurance										
J19	**JESIP**	**JESIP self-assessment survey**	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y	Not applicable.					
J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y	Not applicable.					
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y	Not applicable.					
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y	Not applicable.					
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y	Not applicable.					

Overall assessment:										
Ref	**Domain**	**Standard**	**Detail**	**Evidence - examples listed below**	**Organisation Evidence**	**Self assessment RAG** **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
50	Business Continuity	Data Protection & Security Toolkit	Organisation's Information technology Deaprtment certify that they are compliant with the Data Protection & Security Toolkit on an annual basis.	Statement of compliance.	The IT Department are working towards achieving full compliance, action plan developed and being monitored by Head of IT.	Amber (Partially Compliant)	Action Plan has been developed detailing the necessary steps to be taken to fully comply with the standard.	Head of IT	Six months	

ROHTB (9/19) 022

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 19 July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee received a presentation on Cyber Operational Readiness Support (CORS), where it was noted that there was a need to make a number of improvements to the Trust's cyber security processes and framework in order to meet the Cyber Security Plus standards. These actions covered Board level leadership, formal qualifications, policy development and embedding cybersecurity awareness within the culture of the organisation. • It was noted that the Trust was an outlier in terms of agency spend. • Given that the Executive was undertaking an overhaul of the Board Assurance Framework (BAF), the Committee did not have access to the usual update. The process by which the BAF was being updated was described by the Director of Corporate Affairs, with the final updated version to be available to the Trust Board at its next meeting.	• Progress with actions to ensure compliance with the Cyber Security Plus standard to be monitored through Audit Committee. • Counterfraud to work with the Director of Corporate Affairs to understand the organisation's awareness of the need to declare interests. • Update on the new procurement framework to be provided at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The final audit opinion of the annual accounts had been unqualified with the exception of the Use of Resources indicator. • The number of outstanding internal audit recommendations was reducing. • The NHS Procurement Counterfraud exercise was reported to have been completed and submitted on 12 July 2019. • There was good progress overall with the counterfraud work plan. • The counter fraud self-assessment had been submitted by the due date and had been rated as 'green'. • Good progress was noted on the actions related to audits in the Chief Operating Officer's portfolio, including cancer waiting times and Referral to Treatment Time targets. • The Audit Committee received and noted its annual report.	• The Committee approved the rescheduling of the estates management and effective recruitment internal audits.

• The Committee received a helpful paper concerning the Trust's key contracts – the main commissioner contracts had been signed and there were reported to be no queries related to these. The paper highlighted the activity and income associated with each contract.	
Chair's comments on the effectiveness of the meeting: The discussions had been productive and the CORS presentation was seen to be particularly helpful.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ANNUAL REPORT 2018/19

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 2018/19 and indicate its work plan for the financial year 2019/20.

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 October 2018 and minor changes were proposed to reflect that the Executive Director of Nursing & Clinical Governance was a regular attendee at the meetings of the Committee.

1.4 During the year, the Chair of the Audit Committee was Rod Anthony, a Non Executive Director with a professional background in finance and accountancy.

2.0 Meetings

2.1 During 2018/19 the Audit Committee met on five formal occasions.

2.2 The attendance at these meetings is as below:

MEMBER	MEETING DATE					TOTAL
	23/04/18	25/05/18	18/07/18	18/10/18	25/01/19	
Rod Anthony (Ch)	✓	✓	✓	✓	✓	**5/5**
Tim Pile	✓	✓	✓	✓	✓	**5/5**
David Gourevitch	A	A	A	✓	✓	**2/5**
Executive Directors in attendance						
Steve Washbourne	✓	✓	✓	✓	✓	**5/5**
Garry Marsh	✓	✓	A	✓	✓	**4/5**

KEY:

✓	Attended	A	Apologies tendered

2.3 During the year, Non Executive representation from the Quality & Safety Committee was from Professor 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 partial 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 at the meeting, matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2018/19

The Committee dealt with the following key matters:

Routine Work

The Committee:

- Reviewed and approved the Annual Report and Accounts for 2018/19, together with the Quality Account, Commentary, Head of Internal Audits report and Annual Governance Statement (and other disclosures) contained within.
- Received the 2018/19 Audit report from the External Auditors.
- Received and noted the timetable and proposed content for the Annual Report for 2018/19.
- Increased the focus on clearing outstanding audit recommendations, resulting in a review of all outstanding recommendations and an improvement in the closure of actions. This had dipped during the previous the year, prompting renewed scrutiny and a different approach to be adopted, whereby the Executive Directors now attend the meetings by rotation to present progress with addressing the review recommendations. During the year, the Committee received updates from the Interim Director of Finance & Performance; the Interim Chief Operating Officer; the Deputy Chief Operating Officer (on behalf of the Interim Chief Operating Officer); and the Medical Director.
- 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. During the year it remitted some items for further discussion and follow up by the Audit Committee given that they had a clinical focus.
- 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 2018/19.
- Received a benchmarking report of anti-fraud, which presented a positive picture of the robust control environment in respect of fraud in the Trust compared to elsewhere.

- 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 2019/20. This plan had been aligned to the Board Assurance Framework (BAF) and other risk mechanisms within the organisation.
- Received regular updates on the BAF including additional colour-coded categorisation of the risks to make it simpler to identify the nature of each entry. The Committee was also updated on the planned approach at Trust Board meetings whereby each Executive Director would present the risks relevant to their portfolio.
- 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 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.
- 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.
- Approved its revised workplan for 2019/20.

Briefings

- The Committee received regular reports and briefings from Deloitte and RSM regarding the risks facing the Trust, together with relevant issues and topics:
    - Global healthcare outlook 2018
    - The evolution of 'smart' healthcare
- The Interim Director of Finance and Performance provided an overview of the plans to rationalise the ordering catalogue (Integra)
- The Deputy Chief Operating Office provided an overview of the progress with job planning and the operation of the joint Finance and Theatres forum.

Ad hoc matters

- Received the outcome of an effectiveness review of the auditors, which did not highlight any significant areas of concern. Due to the limited responses to the effectiveness questionnaire it was agreed that the exercise would be repeated in 2019/20 to ensure that the results were meaningful.
- 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 2019/20.
- An overview of the new requirements of the Data Protection and Security Toolkit which came into force on 1 April 2018 was received.
- The Council of Governors during the year approved the extension of the external audit contract with Deloitte, although stipulated that a market testing exercise was needed when the extension was concluded.

4.0 2019/20 Work Plan

4.1 For 2019/20, 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 ongoing financial pressures at a national level and on the organisation, close scrutiny of the Trust's Going Concern status will remain also an area of prime focus during the year.

4.4 The Trust plans to receive an update on its state of preparedness for malicious cyber security attacks at one of the early meetings in 2019/20.

4.5 Presentations are scheduled into the workplan from:

- Information Governance Manager on progress with the Data Protection and Security Toolkit action plan.
- Freedom to Speak Up Guardian to discuss the effectiveness of the role and processes to allow staff to speak up if they have a patient safety concern.

5.0 Audit Committee Effectiveness

5.1 A full review of the effectiveness of the Audit Committee is next planned for October 2019, 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 corporate governance framework and continued success of the Trust.

Rod Anthony
Chair of Audit Committee

July 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Corporate Risk Register**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**4th September 2019**

EXECUTIVE SUMMARY:

It is acknowledged that it is good practice for the Trust Board periodically to see the full Corporate Risk Register (CRR) and indeed this was highlighted as a recommendation when the CQC last inspected in early 2018.

Although the full risk register is seen by the Board only twice per year, the Committees of the Board currently receive an extract of the CRR that it relevant to their remit so there is an opportunity to confirm and challenge the risks and mitigations.

The CRR contains a wider set of risks than those included on the Board Assurance Framework (BAF) and includes those that have been escalated from a divisional or trustwide group level given the scoring following risk assessment or because there is potential for the risk to escalate quickly and therefore is included as an early alert.

There is naturally some duplication between the CRR and the BAF, given that the most highly rated risks after mitigating actions have been taken are included on the BAF as these have a clear potential to impact on the delivery of the Trust's strategic objectives.

The CRR has been fully refreshed over the summer through a dedicated confirm and challenge session in July where each of the Executive Team presented the risks relevant to the own portfolio to other members of the team. As a result, it was agreed that a number of risks could be closed or de-escalated for local monitoring on other risk registers; these are shaded in blue on the attachment. The Board has earlier on this agenda considered whether to remove some of these from the BAF.

The usual cycle of review is six weekly by the Executive Team.

Work continues to be planned to systematise the operation of the risk management framework through the adaptation of the risk module of the Ulysses system. Agreement has been given from the Executive Team to bolster the corporate governance team who will take this forward once a new risk and policy officer is appointed.

REPORT RECOMMENDATION:

The Trust Board is asked to receive and note the full Corporate Risk Register and the plans to strengthen the risk management framework over the next few months.

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

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

Aligns to all strategic objectives of the Trust.

PREVIOUS CONSIDERATION:

Autumn 2018. Next scheduled for March 2020.

Risk Reference	Accountable Exec Lead	Oversight Committee	Risk Owner	Division	Risk Statement	Initial risk score			Summary of Risk Controls and Treatment Plan	Controlled residual risk score			Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Target risk score		
						Likelihood	Severity	Risk Rating (LxS)		Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
1088	COO	Exec Team	Marie Peplow	ALL	There is a risk that the organisation's reported position against the 92% target is inaccurate due to data quality issues	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	2	4	8	↔	The Trust trajectory to deliver 92% performance is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for May is 88.92 % with only 9 patients over 40 weeks , plans are in place to meet trust forecasted position for delivery of 92% trust wide in September 2019 and currently Arthroplasty , Spinal, , Foot and ankle , Hands, Oncology Arthroplasty and CSS are meeting the 92% target . A revised trajectory has been agreed with NHSI for the delivery of 92% in all specialties. Additional capacity is in place for the YAH service which is improving the current position (88.54%). Following the paediatric transition at the end of June demand and capacity plans are currently being reviewed to ensure delivery in spinal deformity in January 2020 . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway. Additional Consultant capacity is in place to ensure sustained delivery of RTT compliance in line with the theatre expansion programme. Progress is monitored weekly at PTL meeting chaired by the Deputy COO.	Ongoing	2	4	8
CE1	CEO	Finance & Performance Committee	Executive Director of Finance & Performance	Corporate	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	5	5	25	A two year financial and operational plan was signed off by the Trust Board for 2019/20. The Trust has support to access cash resources to continue business in the short term The Trust has a 5 year strategy to become the first choice for orthopaedic care. This strategy has been refreshed and updated into a new format, being based around the five 'Ps': performance, people, process, partnerships and patients. A Strategic Outline Case was developed and 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 Theatre expansion work is currently underway.	5	4	20	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. A further medium term financial plan will be required for submission by NHSI during 2019/20.	Dec-19	3	4	12
FP1	Executive Director of Finance & Performance Finance & Performance Committee		Executive Director of Finance & Performance	Finance	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	5	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	3	4	12	↔	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	Dec-19	2	2	6

Risk Reference	Accountable Exec Lead	Oversight Committee	Risk Owner	Division	Risk Statement	Initial risk score			Summary of Risk Controls and Treatment Plan	Controlled residual risk score			Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Target risk score		
						Likelihood	Severity	Risk Rating (LxS)		Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
CE2	CEO	Trust Board	Executive Team	Clinical	The effectiveness of the governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience , potential harm and reputational damage.	5	5	25	Reporting mechanisms in place and escalation to identify key leads that the governance arrangements are not effective or there is potential for harm to be caused by a patient.	#####	#####	#########	↔	Continue to monitor effectiveness of governance framework	Ongoing	3	4	12
1089	COO	Div 3	Marie Peplow	Exec Team	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	5	5	25	Trajectories have been developed for all services to deliver 92% submitted to NHSI describing how these services will be recovered to meet 18 week RTT. Ongoing demand and capacity measurements identify any gaps in service capacity to meet demand with plans put in place . RTT position sent monthly to CCG for information.	3	4	12	↔	The Trust trajectory to deliver 92% performance is monitored weekly at the Ptl meetings and reported monthly in line with national requirements . Current reported position for May is 88.92 % with only 9 patients over 40 weeks , plans are in place to meet trust forecasted position for delivery of 92% trust wide in September 2019 and currently Arthroplasty , Spinal, , Foot and ankle , Hands, Oncology Arthroplasty and CSS are meeting the 92% target . A revised trajectory has been agreed with NHSI for the delivery of 92% in all specialties. Additional capacity is in place for the YAH service which is improving the current position (88.54%). Following the paediatric transition at the end of June demand and capacity plans are currently being reviewed to ensure delivery in spinal deformity in January 2020 . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway. Additional Consultant capacity is in place to ensure sustained delivery of RTT compliance in line with the theatre expansion programme. Progress is monitored weekly at PTL meeting chaired by the Deputy COO.	Ongoing	3	4	12

Risk Reference	Accountable Exec Lead	Oversight Committee	Risk Owner	Division	Risk Statement	Initial risk score			Summary of Risk Controls and Treatment Plan	Controlled residual risk score			Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Target risk score		
						Likelihood	Severity	Risk Rating (LxS)		Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
1137	Executive Director of Strategy & Delivery	Infection Control Committee	Stuart Lovack	Estates & Facilities	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.	5	3	15	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	2	3	6	↔	Completion of the water safety plan	Aug-19	1	5	5
7	COO	Q&S Committee	Marie Peplow	ALL	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.	5	4	20	In May 2019 the Trust had 0 patients waiting over 52 weeks. This position has been sustained since March 2019. All patients are monitored weekly at the PTL to mitigate the risk of any patient waiting over 52 weeks and all patients identified at 40 weeks have a plan in place to ensure they do not breach 52 weeks . The paediatric service transferred to BWCH on the 1st July 2019 . All admitted patients are currently being transferred onto the BWCH . Non admitted patients continued to be monitored at the weekly PTL meeting .	######	######	######	↔	There are currently 0 patients waiting over 52 weeks and in May only 9 patients were waiting over 40 weeks. Robust monitoring of all patients occurs weekly at the PTL meeting chaired by the Deputy COO and all patients over 40 weeks have robust plans in place to ensure no patients breach 52 weeks.	Ongoing	2	4	8
WF1	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	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	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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs	01/01/2021	3	3	9

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770	Executive Director of Strategy & Delivery	Divisional Management Board	Stuart Lovack	4	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant operational impact on clinical services	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.	3	5	15	↔	The theatre expansion programme is underway with phase 1 of the expansion programme due to be delivered in December 2019 , at this point the risk will be reviewed.	Ongoing	1	5	5
804	Executive Director of Finance & Performance	Finance & Performance Committee	Enderjit Aujla	Finance	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	4	5	20	The business intelligence function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	3	4	12	↔	The Business Intelligence Systems Manager Post closed early April 2019 and shortlisting due to take place early/mid April 2019	Ongoing	2	4	8

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27	COO	Finance & Performance Committee	Marie Peplow	2	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.	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.	3	3	9	↔	Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. Junior Fellow posts have been re advertised with a revised 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 . The draft Job Description for the alternative medical workforce has been agreed . A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator commenced in December 2018 and is now focusing on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is now being monitored by the CSMS and reported to a monthly meeting to monitor spend, chaired by the deputy COO.	Ongoing	2	3	6
CO2	COO	Finance & Performance Committee	Jo Williams	Exec Team	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	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.	2	3	6	↓	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. The Perfecting Pathway Programme Board will be launched in September 2019. All programmes will be tracked and progress reviewed on a monthly basis at this board which will report monthly to F and P committee to ensure support is in place to deliver the programme of service changes and redesign. Structure is in place to support the team and substantive COO has now been appointed.	Ongoing	2	3	6
270	Executive Director of Finance & Performance	Finance & Performance Committee	Alex Gilder	Finance	National tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	4	4	16	The Trust is 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected shortly, which should help with setting out the plan for planning activities and budget setting.	4	4	16	↔	The Trust continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. A specific review of BIU activity is ongoing.	Ongoing	2	4	8

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WF3	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	High number of days lost due to stress and anxiety and MSK.	4	4	16	Attendance Policy, management guidance. Health and safety policies for stress and manual handling. Corporate training available. Occupational Health and Staff counselling services in place.	4	3	12	↔	Review of OH and counselling services to encompass possible contract change/ move towards an EAP, which may include 24/7 counselling provision. Task and finish group on mental well being has now become a substantive Trust Well Being Implementation Group: key action on mental health in year 1 is to develop branding, with launch in third week in January 2019. Baseline assessment undertaken, with gaps identified to inform longer term plan. Wider well being plan to be devised following staff engagement exercise undertaken in late January 2019.	Dec-19	2	3	6
OD1	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	Embedding of Equality, Diversity and Inclusion. Higher than average perceptions of bullying, harassment and inequity.	4	4	16	EDS2 Grading. 2017 WRES data. Despite Trust policies, network of contact Officers, freedom to Speak-up Guardian and evidence of relatively well embedded values the 2017 NSS survey suggests higher than wanted levels. Trust-wide campaign in 2017 Additional support from external E&D adviser to Board now in place	3	4	12	↔	Further analysis and focus groups planned to understand this further. Actions identified from Board Review. Improved Performance and development approaches. Transparency of pay banding. Continue to embed values. EDS2 Actions. Increased scrutiny and monitoring of WRES indicator 2. Preparation for EDS 2, WRES and WDES in March/ April 19	Oct-19	1	4	4

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OD2	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	Failure to maximise employee engagement	4	4	16	Results of NSS survey show early signs of improvement. Good level of analysis of NSS findings. Embedding of continuous improvement culture. Speak up and Join in Brand. NSS survey 19 currently being completed by staff members	2	4	8	↓	Multiple projects designed to improve engagement. Results from NSS survey are encouraging Speak Up and Join in initiative starting to be embedded in Trust communications Results reflect progress made in maximising staff engagement through NSS results	Oct-19	1	4	4
WF2	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	Failure to identify future workforce models which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Another batch of 6 planned for September 2019. 12 trainee nursing associates planned for 2019/20. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	3	4	12	↔	Workforce design to become an integral part of HR Business Partner discussions, if the Trust pursues a BP model. Middle grade workforce group is meeting to develop model.	Dec-19	2	4	8

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HR2	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	Failure to maximise performance and support development through ineffective performance and development approaches. Significant contributing factor to employee engagement.	4	4	16	Improving Trust PDR Rate. Manager as Coach programme launched. First cohort completed and being reviewed Feedback from NHS National survey on matters of quality of reviews and development.	3	4	12	↔	Launch of new Performance management approaches following full review and refresh is planned for Quarters 3-4. Investment discussions ongoing as part of overall financial planning. Manager masterclasses - Q3-4 Management programmes being launched in Q4 by OD, Learning and Development and Nursing One to one conversation work continues to be developed. Performance Management refresh delayed but will be restarted when Associate Director has started One to one conversation workshops started in February with feedback on future PM approach SE&OD workshop on staff survey results with focus session on future PM approach Improvement to PDR rate	Mar-20	2	3	6
FP3	Executive Director of Finance & Performance	Finance & Performance Committee	Executive Director of Finance & Performance	Finance	The Trust may experience supply chain disruption and experience an adverse impact on areas which are dependent on overseas staffing in the event of a "no-deal" Brexit, resulting in operations being cancelled and long lead times for securing overseas staff	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. Internal analysis of workforce risk suggests that there is likely to be little disruption to staffing level in the event of a 'no deal' Brexit	3	4	12	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	Oct-19	2	4	8
671	COO	Divisional Management Board	Sarah Carr-Cave	2	Theatres staffing. 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.	4	4	16	Theatre workforce and vacancy review completed. 11.0 wte Band 5 posts recruited to and awaiting start dates (includes 2.0 wte - overseas recruitment) . Training and rotation has commenced through spinal theatres - this work is being lead by Tracey Rutter - Matron. Active recruitment continues with currently 16 Band 5 Theatre Practitioners going through the recruitment process. Spinal being a high priority for training and rotation.	2	4	8	↔	Risk remains the same given the national shortage of qualified theatre staff. Recruitment continues as a rolling program	Ongoing	1	4	4

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275	Executive Director of Nursing & Clinical Governance	Q&S Committee	Ash Tullett	Nursing & Clinical Governance	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 organisation.	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;	2	3	6	↔	The Trust Quality Priority for 2018-2019 has been achieved and closed. A paper detailing the evidence of closure was presented to the Quality and Safety Committee detailing the new methodology and improvements in March 2019. The CCG have decreased the Trusts contracts meeting to quarterly due to the adequate assurance they receive from the Trust. Each month following thematic review of RCA's and incidents, the Governance team will devise patient safety case studies, outlining the learning from this incidents, complaints and litigation. Working with the communication team the learning will be shared Trust wide. The Staff Survey shows improvements on the Patient Safety metrics in terms of incidents, feedback and outcomes. Weekly meetings have been established with Governance, Medical Director, Director of Nursing and Heads of Nursing	Q4 19/20	2	2	4
1032	COO	DMB	Matt Payne	3	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.	5	3	15	The Medical Records department continue to work on destruction and are getting closer to being completely up to date with this process. There additional storage that contains archived x-ray films and options to remove these and store them off site while undertaking a program of destruction in line with Trust policies is underway. This will provide additional storage for records in the x-ray store by ward 1. New reports and processes have been implemented to improve and increase the number of notes being destroyed. Work is also underway with the specialty teams to redefine the category of notes for retention beyond national guidance. This is now meeting the current need for space and this will be monitored going forward.	2	3	6	↔	Destruction programme within Medical Records continues and remains on track to be up to date by the end of 2019. At this point further scrutiny will be undertaken in relation to archived records and a project to clear the x-ray room by ward 1 is also underway	Ongoing	1	3	3
1130	Executive Director of Nursing & Clinical Governance	CQG	Bruce Morland	Division 2	The WMQRS raised the concern that the Trust did not meet the standard for consultant paediatrician cover for a Level 2 unit. The standard for Level 2 paediatric critical care states 'If the consultant providing cover for the Level 2 PCC is not a paediatrician, 24 hour cover by a consultant paediatrician who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites is required.'	3	5	15	There is 7 day cover from paediatricians and anaesthetists who are competent and there have been no incidents reported for at least 12 months since the risk was entered. There is a resident anaesthetic SpR on site 24 hours per day with an APLS/EPALS provider status. Consultant anaesthetist on call who can attend in 30 minutes also with APLS/EPALS provider status. SLA in place with BWCH providing consultant paediatrician 5 days per week (Monday-Friday in hours). New CYP Lead Consultant employed by the Trust, present in the Trust 1 day per week. PEWS monitoring embedded in all CYP areas. This requires staff to escalate to the KIDS retrieval telephone advice service in the event of a deteriorating patient. There is always 1 RNC on duty with an adult nurse who has completed paediatric competencies. Additional support available from CYP ward staff. Case reviews of all CYP booked for CYPHDU performed by Bruce Morland, AMD and CYP matron on a weekly basis. Any high risk patients are triaged for suitability for surgery at ROH. CYP Matron EPAL and APLS instructor, PICU and retrieval background, has an over site of all CYP patients admitted to CYPHDU. Ward 11 Band 7 recruited with PICU and KIDS background. All CYP services staff will be upskilled to work in both areas. Additional paediatrician cover has been sourced from neighbouring trusts, thereby creating seven day medical cover.	3	5	15	↔	Trust Board agreed to cease provision of all Paediatric surgery, which is due to occur early Summer 2019 Since this decision, all stakeholders have been involved in the development of a transition plan towards delivery of the service in a Birmingham-based solution	01/06/2019	1	5	5

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CE3	CEO	Trust Board	Executive Team	Strategy	Risk that the plan for Paediatric is not aligned with the wider STP strategy for Orthopaedics	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. Full transition plan now in place with BWCH	######	######	######	↔	Clinical review of proposed Oncology strategy is still outstanding. If the outcome of this is positive, this will support the alignment of the strategy across all providers	Jul-19	2	3	6
1050	Executive Director of Nursing & Clinical Governance	Div 1/Children's Board	Alison Warren	Division 1	There is a risk that the services on Ward 11 are not up to required standards due to staffing	5	3	15	Weekly meetings occur and considers the staffing fill rates. Monthly fill rates show no issues and the skill mix of the department meets the national Guidance for % of RN's on duty. The Agency and Bank usage are within 25% and are block booked or ROH staff undertaking additional duties. The Service Ceases July 1st 2019.	4	3	12	↔	Relocation of children's in-patient services from 1/7/19. Plans continue to maintain the in-patient service until the evening of 28th June 2019 with a plan in place to transfer any remaining in-patients to BWCH on the Friday. Risk will require updating or a new risk placed for Children's outpatients and the once weekly diagnostics that will continue	Ongoing	2	3	6
1074	Executive Director of Finance & Performance	F & PMC	Alex Gilder	Finance	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	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 in 2019/20. R 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.	2	4	8	↔	Continued focus on efficiency and cost control through the recovery plan	Ongoing	2	4	8

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CE4	CEO	Trust Board	Paul Athey	Reputation	There is a risk to the ROH reputation should the Paediatric service not be transferred in a timely and safe manner	4	3	12	The Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	#####	#####	#########	↔	Continued oversight by NHSI/E & CQC	Jul-19	2	3	6
FP2	Executive Director of Finance & Performance	Finance & Performance Committee	Steve Washbourne	Finance	The Trust is likely to incur transitional costs with the transfer of Inpatient Paediatric Services	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.	#####	#####	#########	↔	The Trust has received transitional funding during 2018/19 to support the additional costs of paediatric provision.	Q3 2018/19	1	1	1
972	Executive Director of Finance & Performance	IM&T Committee	Stuart Lovack	Finance	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. The current SLA with UBH continues in place, after December 2016 parts availability cannot be guaranteed This could result in disruption to core Trust Services and potentially creating patient safety issues and loss of income through missed appointments	4	3	12	The risk remains unchanged since October 2016. Alternative options being considered.	4	3	12	↔	Further discussions are underway with our service provider to ascertain whether additional measures can be taken to make the system more resilient. Money available in 2019/20 Capital Programme for replacement telephone service, business case under development. A high level business case proposal has been developed with a specialist telecommunications company and discussions have taken place with a software company for a cloud based solution.	Q4 2019/20	2	3	6

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PS1	Executive Director of Nursing & Clinical Governance	Children's Board	Stacey Keegan	Nursing	There is a risk that patient care/safety may be compromised as we do not have enough Paediatric staff/vacancies on the ward.	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. Further support and oversight provided by BWCH and a further weekly meeting instigated from February 2019. Operationally the service has been reviewed and bed capacity reduced to 12 beds to support staffing requirements – Operational SOP being drafted to support measures put in place. Rostering reviewed and CYPHDU/Ward 11 amalgamated to provide further oversight and support both areas. Scheduling tool developed to provide better oversight of activity booked for both areas.	# # # # # #	# # # # # #	# # # # # #	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	Ongoing	1	4	4
986	Executive Director of Nursing & Clinical Governance	Q&S Committee	Sarah Carr-Cave	Nursing & Clinical Governance	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	3	4	12	Risk remains unchanged. CYPHDU is staffed 24/7 with a minimum of 1 RNC and 1 RN with HDU paediatric competencies. Weekly meeting held with the Senior Sister and Matron, HON and chaired by the executive Director of Nursing & Clinical Governance. This meeting review staffing across CYP HDU, adult HDU and ward 11. Staffing and vacancy position discussed at HDU Management Meeting and included in the Divisional Condition Report to Division 2 DMB and CQG. Block booked agency staff to support service provision.	3	4	12	↔	Ongoing recruitment programme. Bespoke adverts for HDU to try new approach to recruitment to attract candidates. Open days also being planned for early 2019.	Ongoing	1	4	4
1242	Executive Director of Strategy & Delivery		Stuart Lovack	Estates & Facilities	The Trust does not fully meet the HTM requirements for Medical Gases as follows: - No Medical Gas Policy - No formal Medical Gas Group - No Terms of Reference for Medical Gas Group - Limited organisational structure for authorising Medical Gas works	3	4	12	Medical Gas Policy implemented. Medical Gas Group established. TOR's available. Authorised Person to be appointed.	3	4	12	↔	Risk being managed through estates and 'Competence Person'.	Ongoing	2	4	8

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ET2	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	There is a risk that the Trust will be unable to support the professional development of our registered practitioners and wider staff, and therefore we will not be able to support career development and progression which may result in higher attrition rates.	4	3	12	Cost pressure identified - still to be agreed. Good use of Apprenticeship Levy Effective use of WDF funding - to support orthopaedic and spinal modules for nursing	4	3	12	↔	To be considered as part of short-term retention actions	Mar-19	2	1	2
791	CEO	Executive Team	Simon Grainger-Lloyd	Corp	There is a risk that safe practices and patient care are compromised by the large number of organisational policies which are overdue for renewal	4	3	12	The pathway for policy approval remains robust as per the Policy on policies approved by the Trust Board in February 2016. This policy continues to provide clarity on mechanisms for approval, both for new and/or substantially revised policies and for policies needing minor amendment. Oversight is provided by the Risk & Litigation Manager who reports to the Director of Corporate Affairs & Company Secretary.	3	3	9	↔	Good progress has been made with reducing the number of policies beyond their review date, with many of the HR, estates and clinical policies having now been extended pending full review as the current content does not present a risk to care or operations. Plans in place to load all policies onto the Allocate HealthAssure system by October 2019, with the full policy list being cleaned by the end of the financial year to ensure that each policy has the correctly assigned Executive Lead and Author.	Dec-19	2	3	6
MD1	Medical Director	Executive Team	Andrew Pearson	Medical staffing	There is a risk that there will be some clinical resistance to the change in the way Paediatric Services are delivered	4	3	12	Risk unlikely to change until paediatric services cease in 2019. 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.	########	########	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.	Jun-19	2	2	4

Risk Reference	Accountable Exec Lead	Oversight Committee	Risk Owner	Division	Risk Statement	Initial risk score			Summary of Risk Controls and Treatment Plan	Controlled residual risk score			Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Target risk score		
						Likelihood	Severity	Risk Rating (LxS)		Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
ET3	Executive Director of Strategy & Delivery	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	There is a risk that due to lack of capital for investment, the Knowledge Hub will not be fit for purpose when Aston Medical Students commence in 2020 and the trust will also not have capacity to deliver its own training requirements.	4	3	12	More detailed Aston Ready proposals considered by Executive Team in May 2018. Short term actions taken. Exec agreement in Jan 2019 for full architects plans to develop a mezzanine in the foyer to be scoped and costed.	3	3	9	↔	Revisit during 2019/20 capital planning.	31/03/2020	2	2	4
HR4	CEO	People Committee/SE & OD Committee	Associate Director of Workforce & OD	Corporate	Availability to report on high quality workforce data with current capacity in HR Operations and functionality (of Electronic Staff Record (ESR))	4	3	12	ESR manager and employee self-service in operation, so considerable local control over managerial and personal information. Regulatory reporting. Divisional reporting and SE/OD workforce reports. Evidence of difficulty to interrogate data at deeper levels. Some data acuity issues and some evidence of lack of line management engagement.	3	3	9	↔	ESRWokforce information Manager has attended higher enhanced BI reporting training and to ensure system capability is being maximised/ opportunities for streamlining are being taken. Workforce administrator role has been redesigned to incorporate greater data analysis and the post will be filled from 1 April 2019 (successful appointment made). This risk has increased in the short term due to capacity issues in the workforce information team - review in May 2019 In the longer term ADWF&OD to explore reporting Interfaces such Microsoft BI which may pull multiple data sources together for ease of data mining/ analysis.	Jan-21	1	4	4

Risk Reference	Accountable Exec Lead	Oversight Committee	Risk Owner	Division	Risk Statement	Initial risk score			Summary of Risk Controls and Treatment Plan	Controlled residual risk score			Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Target risk score		
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656	COO	Q&S Committee	Sandra Millward	2	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 (hence an impact to 6 week diagnostic standard, cancer performance, if the patient is being treated on a cancer pathway and overall 18 week RTT. Once the investigation takes place, sound systems are in place to ensure radiologist reporting takes place, however there is no electronic alert system to the requesting clinician that the report is available and again this is reliant on a paper-based repotting system with the same risk of loss and delay of those reports.	3	4	12	Risk remains static with no change until an electronic system is in place, Staff continue to incident report any request received more than 10 days after being written. Late forms continue to be incident reported, number has increased as Trust addresses 18 week pathway issues	2	4	8	↔	Electronic order Comms will be a functionality as part of ePMA. Revisit the risk when ePMA is implemented	Q2 2018/19	1	4	4
16	Executive Director of Nursing & Clinical Governance	Q&S Committee	Garry Marsh & Amr Revell	Nursing & Clinical Governance	CIPs Delivery of Cost Improvement Programme has an adverse impact on the quality of patient care.	2	4	8	Quality Impact Assessments of all CIP projects are carried out by the Medical Director and Dir. Of Nursing to ensure clinical impact is known	1	4	4	↔	Completion of QIAs on an ongoing basis	Ongoing	1	4	4

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1298	Executive Director of Finance & Performance	IM&T Programme Board	Janet Carveth/Mark Bemrose	Corporate	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:	4	4	16	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. 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.	4	4	16	↔	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. 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	2	4	8
FP4	Executive Director of Finance & Performance	FPC	Abdul Khalid	Finance	There is a risk that the full quantum of cost saving as outlined in the 2019/20 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Whilst full delivery of the CIP schemes will not happen, this has been taken into account within the financial planning for the remainder of the year.	4	4	16	↔	Much work has been undertaken in creating the CIP framework for 2019/20. The financial plan for 19/20 identifies a target of £1.4m, which is the level required as per the planning guidance. This is backed up by an internal plan which targets delivery of £2.3m with a further stretch target of circa £3m. The initial £1.4m is within the level of saving achieved during 2018/19, whilst further discussion are ongoing relating to how we potentially use incentive schemes to increase delivery up to the internal target of £2.3m and beyond.	Mar-20	3	4	12
FP5	Executive Director of Finance & Performance	FPC & Trust Board	Stuart Lovack/Marie Peplow	Finance	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy and that the modular theatres will place a strain on the supportive infrastructure	4	5	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.	4	4	16	↔	The theatre build project is currently on schedule and monitoring arrangements to detect strain on the Trust's supporting infrastructure are being developed	Dec-19	3	4	12

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FP6	Executive Director of Finance & Performance	FPC	Steve Washbourne	Finance	There is a risk that the Financial Control Total will not be met in 2019/20	4	4	16	The 2018/19 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery. Clinical Audit day has been cancelled in February to allow more work to be undertaken. Revised activity plan distributed which identities performance levels required for recovery.	3	3	9	↔	Further focus to deliver increased activity.	Mar-20	3	3	9
HR7	CEO	People Committee/SE & OD Committee	Alex Moody, Associate Director of Workforce and OD	Corporate	There is a risk that some of our clinical and medical staff are working without up to date vaccinations creating the potential for individuals to be adversely affected by diseases that they may come into contact with as part of their routine work	5	4	20	Up to date data provided by OH with list of affected staff. List has been validated. Additional OH clinics are being run at ROH in April for staff. Both individuals and their managers are being contacted to book directly into these clinics.	2	4	8	↔	HR will provide starter and leaver data to OH on an agreed quarterly basis to allow ongoing reconciliation with the Trust's employment records and their data records. HR standard recruitment process change to contact candidates and line managers in all instances where OH clearance to work is given but where a follow up appointment with OH is advised.	Oct-19	1	4	4
HR8	CEO	People Committee/SE & OD Committee	Alex Moody, Associate Director of Workforce and OD	Corporate	There is a risk of non-compliance with GDPR caused by lack of robust storage arrangements for staff personnel files	3	3	9	Scoping exercise completed to determine scale of issue	3	3	9	↔	Action group needs to be set up following start of new Head of HR Ops.	Jun-19	2	3	6

Risk Reference	Accountable Exec Lead	Oversight Committee	Risk Owner	Division	Risk Statement	Initial risk score			Summary of Risk Controls and Treatment Plan	Controlled residual risk score			Risk movement	Risk controls scheduled / not in place and associated actions	Completion date for actions	Target risk score		
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HR10	CEO	People Committee/SE & OD Committee	Alex Moody, Associate Director of Workforce and OD	Corporate	HR team has limited capacity to effectively support resourcing of Modular Theatre & Ward expansion	5	4	20	Concerns initally raised regarding capability of recruitment team to effectively support the increased volume of recruitment required by the expansion of theaatres and wards. Recruitment team have processed a large number of offers and the process is working well. Regular meetings between HR and Director of Nursing & Clinical Governance to monitor progress.	3	4	12	↔	Consideration of additional resource for Recruitment team once AM and Head of HR Ops have reviewed structure. Temporary staff member to be extended for April and Apprentice to be sourced.	Oct-19	2	4	8

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Responsive Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh; Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Stacey Keegan; Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**4th September 2019**

EXECUTIVE SUMMARY:

The attached CQC Responsive action plan presents an updated picture on all the issues which required actions for improvement following the Trust's CQC inspection in January 2018 and subsequent report published in May 2018.

The author communicates regularly with the accountable leads and provides a narrative update on progress.

On-going monitoring, escalation and oversight of this action plan is conducted in the following committees and meetings:

- Quality and Safety Committee.
- Executives meeting.
- Clinical Quality Group.
- Operational Management Board.

Where corporate risks exist they are aligned to the action plan. Associated delivery plans and evidence for assurance are embedded within the centrally stored master document.

REPORT RECOMMENDATION:

The Trust Board are asked to note the progress that has been made against delivery of the actions. However, although progress made, a number of actions have not delivered in line with the original timescale, therefore have been rag rated as red and detailed below:

- **Actions 2A/B Mental health** – significant progress; the Trust has been working with BSMHFT and UHB to gain their expertise and help us scope our requirements as a Trust. The Mental Health policy and procedures ratified at UHB are now in the process of adoption at the Trust to allow system working. Mental Health Service Level agreements are drafted and are in the process of agreement. These required actions are due for completion by the end of September 2019.
- **Action 4C/F – Bone infection** – significant progress; Bone Infection CQUIN agreed for 2019/20. On-going work with Commissioners with a case for change/final decision anticipated by the end of September 2019. Current Microbiology Service Level Agreement continues and will be reviewed in line with the agreed business model.
- **Action 11A – Consent and adherence to policy** – revised Consent policy approved; consent reports now available from informatics to monitor improvements. Key Performance Indicators (KPIs) will be reported to and monitored at the Clinical Audit and Effectiveness Committee.

- **Action 18A/B – Updated Trust policies and procedures** – A delay to completion due to the timelines of delivery and roll out for the new Health Assure system. This system will allow greater transparency of policies and the required review, named author and Executive sponsor. Policy reports sent to all Executive Directors outlining all policies overdue for review for their respective portfolios.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

Financial	**X**	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments: [*elaborate on the impact suggested above*]					

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

CQC Responsive action plan aligned to Trust Corporate risk register.

PREVIOUS CONSIDERATION:

Quality and Safety Committee.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROH ACTION PLAN

NO	QUALITY IMPROVEMENT PROJECT	EXPECTED OUTCOME	KPI / MEASURE	EXECUTIVE LEAD	CLINICAL / PROJECT LEAD	MONITORING COMMITTEE	ROH ACTION NO	ACTION	FINAL DEADLINE	UPDATES Unsatisfactory Progress Slow Progress Satisfactory Progress Completed	RISK REGISTER	ONGOING ASSURANCE
Chief Executive Officer												
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	Chief Executive Officer	Associate Director of HR	S/E and O/D Committee	14a	April - Trust Board reviewed completed WRES report.	~~Aug-18~~ Oct-18	The WRES report was received by Trust Board in April 2018 and will be submitted to NHSE in late August 2018. Aug 2018 Update: WRES 6 month Interim Board Report will go to Staff Experience and Organisational Development Committee in October 2018. September 2018 Update: As above. October 2018 Update: Report with key data around 9 indicators and initial actions submitted to Staff Experience and Organisational Development Committee (SE&OD). Information approved by SE&OD Committee and will now be published on ROH website. Further information will be provided through Equality and Diversity update at November SE&OD Committee.		Agenda item at Staff Experience and Organisational Development Committee.
15	Ensure staff meet their training needs as agreed in their annual PDR	Staff meet their training needs	Staff Survey		Associate Director of HR	People Committee	15a	Refreshing the PDR method to a performace model	~~March-19~~ Sept-19	February 2019 Update (Received from Clare Mair): The Refresh for Performance Management is progressing but completion will be delayed until September 2019. Original completion dates were set when the previous Associate Director of Workforce and OD was still in post. This person who was Lead for the project left in October 2018. The new person started in January 2019 and will now lead on this project. Following a discussion at the SE&OD committee, it was agreed to delay completion. The 'one to one conversation' element which will inform how the new approach will be embedded, is on track. June 2019 Update (Received from Clare Mair): 1.Staff survey results – The NSS 2018 data (41% completion rate) indicates that staff feel more supported by managers in terms of training needs: In the last 12 months, have you had an appraisal, annual review,development review, or Knowledge and Skills Framework (KSF) development review? 86.2%(2017) 92.0% (2018) Were any training, learning or development needs identified? 54.3% (2017) 66.0% (2018) My manager supported me to receive this training, learning or development 51.4% (2017) 57.1% (2018). 2. Managers were asked to review training needs in the Annual Business planning process for the first time. 3. Education and Training continue to support departments with an annual TNA exercise. 4. Training is now provided for ESR self service to increase accessibility for staff booking training. 5. The Training pages on the intranet contain more information on different development options. 6. A careers event is run by Training and Development every 6 months. 7. TNA now discussed at Divisional meetings. 8. PDR workshops include information about TNA, Talent and Succession planning. 9. Increased number of personal development courses aimed at all levels of staff. 10. Comms advertised development opportunities more frequently. 11. PDR rates have increased from last year 81% (May 2018) 85% (May 2019). The target for 2018 was 85%. It is now 92.5% for 2019.	Risk WF3. SE&OD Committee. '*Failure to maximise performance and support development through ineffective performance and development approaches. Significant contributing factor to employee engagement*'	PDR and training compliance is reported monthly and presented at: Divisional Management Board. Within the Divisional Condition reports and Ward and Departmental dashboards reporting to Clinical Quality Group. Within the Finance and Performance report presented at the Finance and Performance Committee. Within the Workforce Performance report presented at the Staff Experience and Organisational Development Committee. Document
Executive Director of Nursing and Clinical Governance												

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 includes areas outside of where the incident happened	Closed and completed Ulysses action plan.			CQG	1a	Closure of the Ulysses action plan to assure fit for purpose reporting and feedback system.	Jan-19	September 2018 Update: One outstanding action in relation to incidents module - Incident policy - awaiting ratification at CQG October 2018. October 2018 Update: Incident policy ratified and signed off by the Executive team. Ulysses action plan presented at Clinical Quality Group (CQG) in October 2018; outstanding items are related to risk and complaints modules; incident reporting actions now closed. Plan to audit closed actions to ensure fully complete and changes embedded. November 2018 Update (Received from Ash Tullett): Ulysses action plan on the work plan for Clinical Quality Group January 2019. December 2018 Update (Received from Stacey Keegan): Ulysses action plan to be handed over to Complaints and Risk leads with oversight from Governance Manager to address outstanding actions. January 2019 Update (Received from Ash Tullett): Ulysses are currently undertaking a 'health check' of the system (including the complaints and risk modules) to ensure the system is able to provide what the Trust requires in relation to complaints and risk management. February 2019 Update (Received from Ash Tullett): Ulysses actions are closed within the action plan that are related to learning and feedback. Action plan attached for assurance. Open actions are related to the risk and complaints modules, these modules allow data storage as opposed to learning and feedback.		U:\Documents\ CQC Evidence\ Ulysses action plan
			A governance communication strategy in place.			CQG	1b	Routine Communication of key incidents and learning methodology across the Trust to be reviewed.	~~Sept 18~~ Dec-18	Aug 2018 Update: Meeting held with Communications on the 13.7.18 to design a Governance Communication strategy to ensure lessons are shared across the Trust. Awaiting feedback. September 2018 Update: Comms intranet page developed/Case Study posters developed/Quality week to be arranged. October 2018 Update: 'Quality' week in planning for the first week in December 2018, relaunch of Governance Strategy planned and launch of Comms strategy (being finalised) for learning and communicating Trustwide. Scoping of Human factors and investigation training to take place during 'Quality week'. November 2018 Update (Received from Ash Tullett): 'Quality week' agenda confimed commencing 3.12.18 in conjunction with the Communications team. Trust policies and Strategy, road shows, stand and training incorporated. January 2019 Update (Received from Ash Tullett): Action as above with the paper being presented to the Quality and Safety Committee in March 2019. March 2019 Update (Received from Ash Tullett): Paper attached under on-going assurances outlines the actions taken to date and methodology going forward in relation to learning and sharing across the Trust. NHS Staff Survey 2018 results showed a significant statistical improvement in all questions relating to 'safety culture'.	Risk: 275 Clinical Quality Group *'There is a risk that the Trust is unable to consistently demonstrate learning from serious events, claims and complaints. This is due to insufficient evidence of robust action plan implementation, processes not being followed and staff awareness and changes to clinical practice not being fully embedded'.*	U:\Documents\ CQC Evidence\007 Learning from
			Standing agenda item on relevant meeting agendas.	Executive Director of Patient Service	Head of Clinical Governance	CQG	1c	Trusts Quality Report to be presented at all relevant meetings to strengthen Ward to Board communication.	Aug-18	Aug 2018 Update: Governance manager and DDoN to review Divisional meeting structures w/c 6.8.18. September 2018 Update: Quality report presented at all forums/committees, including Divisions.		Standing agenda item at the following meetings/ committees to ensure Board to Ward communication: Ward and Departmental Managers. Senior Nurses. Divisional Boards. Clinical Quality Group. Divisional Performance. Quality and Safety Committee.

			100% compliance with Serious Incident Learning Audit			CQG	1d	Audit of serious incident learning to be undertaken; to ensure: Actions taken following serious incidents are fully completed in a timely way. Changes that are implemented as a result of a serious incident are fully embedded within the Trust.	Jan-19	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. Aug 2018 Update: Action trackers now in place for Division 1 and 2, and an agenda item on Divisional Governance meeting. This allows transparent progress for the Governance team to monitor and audit with escalation of any concerns to the DDoN. September 2018 Update: Audit underway by the Clinical Governance Manager to ensure closure of actions from Serious Incidents and internal Root Cause Analysis. Audit report to be prepared for October 2018. October 2018 Update: Audit completed; paper with findings to be reported to Clinical Quality Group in November 2018. Initial feedback positive and initial findings being reported back to the Divisions for any immediate actions. Embedding of actions to be audited and reviewed within the Divisions with findings reporting to Clinical Quality Group. November 2018 Update (Received from Ash Tullett): Agenda item will form part of the Governance Upward report at Clinical Quality Group scheduled for the 30.11.18. December 2018 Update (Received from Stacey Keegan): Update received at Clinical Quality Group and now forms part of the monthly Governance Upward report that is on the work plan to be presented monthly.		Standing agenda item at weekly Divisional Governance meetings with action trackers. Update received at Clinical Quality Group via the monthly Governance report.
			100% compliance with Stop before you block audit following previous Never Events and sharing of learning.			CQG	1e	Stop before you block Audit to be completed to provide an overview of the daily running of anaesthetic rooms and to identify any underlying factors that may impede safe patient care. Key audits are: Interruptions occuring during the induction of anaesthetic or administering blocks and why these interruptions occured. Environmental audits (signage visible and privacy shutters in use). Third person in the anaesthetic room.	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. Aug 2018 Update: Monthly report now completed by the Theatre Matron; July 2018 audit showed a significant improvement with 6 interuptions noted from an audit of 114 patients = 5.26%. Report monitored by the Divisional and upward eported to Clinical Quality Group. September 2018 Update: Awaiting August report - agenda item for October 2018 Clinical Quality Group. October 2018 Update: Report presented at October 2018 Clinical Quality Group - compliance showing <5% interuptions. Audit part of Clinical Quality Group workplan and monitoring will continue.		Ongoing assurance provided via Clinical Quality Group workplan.
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, procedures, and staff training to ensure staff have the confidence to support and care for patients with Mental Health	100% of patients with a Mental health illness will be supported to have full access to all Trust Services by trained and competent staff.			Safeguarding Committee	2a	Ensure the SLA in place is responsive to the Trusts needs.	~~June 18~~ ~~Dec 18~~ ~~April 19~~ Sept-19	November 2018 Update (Received from Nathan Samuels/Lisa Newton): SLA in place up until March 2019, however concerns regarding out of hours service provision. Meeting arranged for w/c 19.11.18 to escalate the required review of the SLA with BSMHFT. If this meeting does not resolve the concerns, escalation to the Executive Director of Nursing and Clinical Governance. Scoping a further SLA wit BMHFT regarding use of bank RMN and telephone advice. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Meeting held with Angela Preston (BSMHFT); flow chart devised for use of section 5(2) - medics to detain. 24 hour advice be incorporated into SLA - escalated to Julie Gardner. February 2019 Update (Received from Lisa Newton): Draft flow chart for the use of section 5(2) in circulation for comment. Meeting arranged with Julie Gardener to review SLA to ensure it includes 24 hr provision as BSHMHFT have advised that this will involve SLA revision +/- additional fee for service. April 2019 Update (Received from Nathan Samuels/Lisa Newton): Meeting with Julie Gardener remains outstanding. Section 5(2) flowchart shared with BSMHFT, minor amendment required. Launch in planning for all ROH staff. Plan for action to be closed by end of April 2019. June 2019 Update (Received from Nathan Samuels): Minor amendments to the SLA remain outstanding (24/7 telephone support); escalated by the Deputy Director of Nursing and Clinical Governance. August 2019 Update (Received from Julie Gardner): SLA revised and costed including an additional SLA with Forward Thinking Birmingham (0-25 year olds); anticipating sign off by late August 2019.		

			Executive Director of Patient Service	In-patient Matron/LD Lead Nurse	Safeguarding Committee	2b	Develop and launch a Trust Mental Health Policy to support staff and patients.	~~Aug 18~~ ~~Oct 18~~ ~~Jan 19~~ ~~April 19~~ Sept-19	October 2018 Update: Policy now on hold for finalisation due to working with UHB/Mental Health Trust and their policy ratification. The delay in the policy will not slow down the requirements the Trust needs to deliver. DDoN and leads to review current policies/legislation to ensure this does not pose a risk to the Trust. November 2018 Update (Received from Nathan Samuels/Lisa Newton): In conjunction with UHB/BSMHFT, newly formulated Mental Health Policy is in draft and will be shared with ROH for local adaption once ratified which is scheduled for December 2018. February 2019 Update (Received from Lisa Newton): UHB policy going to policy review group for ratification 20.3.19 if ratified should be available to us early April 2019. April 2019 Update (Received from Nathan Samuels): Meeting held with Rebecca Hoskins on the 12.4.19 to progress the Mental Health policy; delay in ratifaction at UHB until 30.4.19 - decision to await policy for implementation at ROH. June 2019 Update (Received from Nathan Samuels): Still awaiting Mental Health policy from UHB as delays in ratification there; decision to continue to wait and adopt policy at the ROH to enable a system wide plan. August 2019 Update (Received from Nathan Samuels): UHB Mental Health policy now approved with permission to now utilise for the ROH; policy received in the Trust on the 16.8.19.	Risk 1286 Safeguarding Committee. 'Risk that the Trust does not have adequate policies, procedures or trained staff to provide the necessary level of care and support for patients with mental health issues'.	U:\Documents\ CQC Evidence\ Document in Copy
					Safeguarding Committee	2c	Ensure all relevant staff are trained in mental health.	~~Aug 18~~ ~~Oct 18~~ ~~Feb 19~~ April-19	November 2018 Update (Received from Nathan Samuels/Lisa Newton): Two further Mental health first aid training courses planned for December 2018 and February 2019; this will ensure all Clinical Site Coordinators and Duty Managers are trained. Tier 1 Mental Health awareness training to be incorporated into Trust Mandatory training day by April 2019. December 2018 Update (Received from Nathan Samuels/Lisa Newton): Update as of November 2018, with 25 Mental Health First Aiders now trained within the Trust. February 2019 Update (Received from Lisa Newton): The Trust now has a total of 56 trained mental health first aiders, with a further 18 staff booked onto the the April 2019 training. The training has been targeted to include Clinical Site Coordinators, Duty Managers and those in key roles e.g. Safeguarding, Chronic pain etc. Mental Health Awareness training commences on the Mandatory training day for all staff on the 12.4.19. Training for medical colleagues will commence once the section 5(2) flow chart is ratified and SLA agreed. April 2019 Update (Received from Lisa Newton/Nathan Samuels): The Trust now has a total of 74 trained mental health first aiders, with 2 further training sessions arranged. Awaiting confirmation from the Learning and Development department as to start date of the Mental Health Awareness training which didn't commence as planned in April 2019. June 2019 Update (Received from Nathan Samuels): Mental Health Awareness training to commence on Trust Mandatory day July 2019 for all staff groups.		
					Safeguarding Committee	2d	Launch of the Mental Health provision in the Trust, engaging with patients and staff.	~~Sept 18~~ Oct-18	Safeguarding Matron 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. A new icon on the intranet to be added to the homepage once actions are completed for ease of access for staff. Aug 2018 Update: Intranet site and resource folders currrently being reviewed ensuring all relevant documentation is available for staff. Patient pathways and flow charts to support staff decision making and referral processes. Process for the care of those patients under a long term section to be clarified including staffing requirement. Poster being designed to aid staff understanding of DOLS, MHA, and MCA. September 2018 Update: Intranet site and resource folders due to go live October 2018. October 2018 Update: Action on track to be completed by the end of October 2018. November 2018 Update (Received from Nathan Samuels/Lisa Newton): New Trust intranet page has been developed which has easy access, detailed descriptions of the most commom mental health conditions, their signs, symptoms, treatments and specific risk assessments and care plans.		

						Safeguarding Committee	2e	An audit to be completed for complex patients (included mental health) which includes the use of a flagging system and audit of individualised care planning.	~~Dec 18~~ April-19	Methodology to be designed when actions 2b to 2d achieved . December 2018 Update (Received from Stacey Keegan): Clarification being sought to confirm pre data requests from CQC and audits of care of patients with Mental Health as opposed to Policy/improvements audit. February 2019 Update (Received from Stacey Keegan): Action clarified and amended; audit forms part of the CQC data requests. Leads for Mental Health informed of the action and audit tool to be developed and launched with front line staff. March 2019 Update (Received from Stacey Keegan): Meeting held with leads for Dementia, Mental Health, Learning Disabilities and Safeguarding, complex care audit to be developed and shared and launched at the Ward/Departmental Managers meeting on the 25.3.19. April 2019 Update (Received from Stacey Keegan): Audit agreed and rolled out to Ward/Departmental managers in April 2019 for reporting to commence in May 2019. June 2019 Update (Received from Evelyn O'Kane): Audit tool completed and launched in May 2019 to commence monthly auditing by Ward Managers/Matrons in June 2019. Feedback to Heads of Nursing to be included in Divisional Condition reports. Audit tool attached for evidence.		Audit tool to be used for complex care patients and results/audit findings to be documented within Divisional condition reports and fed back to leads (e.g dementia, LD lead) C:\Users\keegans\Desktop\Copy of Complex Needs
3	Staff should have sufficient understanding of terms such as 'never event' and 'duty of candour'.	All clinical 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	CQG	3a	Focussed educational engagement events with departments and wards	~~Aug 18~~ Dec-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 audits. September 2018 Update: New homepage on Ulysses system/New leaflets developed by Comms team/Quality week in planning to be included in the Governance learning strategy. October 2018 Update: As above with launch planned during 'Quality Week' planned for December 2018. November 2018 Update (Received from Ash Tullett): Engagement events and road shows planned for 'Quality week' commencing 3.12.18 factoring in Duty of Candour and Never Events. December 2018 Update (Received from Stacey Keegan): A focus on Never Events and Duty of Candour (definitions and examples of) took place in 'Quality week'; paper to be presented to Quality and Safety Committee in March 2019 outlining methodology going forward.		Understanding of Duty of Candour and Never Events shared within the Trust at: Trust Induction. On the Ulysses home page. Knowledge tested on Mandatory training day. Understanding measured on Trusts Quality and Safety walkabouts. Monthly Governance 'Learning messages'.
			Fit for purpose Mandatory training slides			Training and Development Group	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. September 2018 Update: Mandatory training reviewed and commenced in September 2018.		Multiple choice question included in mandatory training session to evidence understanding and knowledge of staff.
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	A BIU Strategy and KPI metrics measuring outcomes.			OMB	4a	Review and strengthening of the organisational structure around Bone Infection Unit (BIU)	~~June 18~~ ~~Nov 18~~ Jan-19	Aug 2018 Update: Structure reviewed and evolving development plan in place. The BIU now has in place; • a Clinical Service Lead (on SLA from UHB) • Dedicated time from Consultant Microbiologist (SLA UHB) • Dedicated time from ROH Pharmacist • Dedicated time from IPCT • Dedicated time from Consultant Surgeons A nominated Operations manager is supporting the recruitment of a CSM (agreed secondment from UHB) , MDT Co-ordinator and a data analyst. September 2018 Update: • CSM (on secondment from UHB) in post • CSM presently reviewing the requirements of the B.I.Service in order to develop a strategy and clinical pathways • Post out to advert for a data analyst to support the B.I.Service • Job description under review, by CSM, for a MDT Co-ordinator November 2018 Update (Received from Rivie Mayele): MDT Co-ordinator appointed in October 2018, with an anticipated start date of January 2019. With the BI Data Analyst also on track to commence in January 2019, this will complete the team. December 2018 Update (Received from Garry Marsh): BI Nurse post now made substantive recognising the need for specialist nursing input. January 2019 Update (Received from Rivie Mayele): MDT Co-ordinator and Data Analyst commenced in post in January and now completes the organisation structure.		

					OMB	4b	Bone Infection MDT to be launched	~~July 18~~ Nov-18	Terms Of Reference drafted. To be approved. Aug 2018 Update: TOR to be reviewed and approved on appointment of CSM who will develop and implement the clinical pathways for BIU. September 2018 Update: CSM presently reviewing TOR and requirements of the service October 2018 Update: ToR yet to be approved; these have been recirculated. November 2018 Update (Received from Rivie Mayele): ToR now on version 4 following feedback from Clinicians, BI Development meeting due to be held on the 22 November 2018, with anticipated sign off by the wider BI team on the 29 November 2018. December 2018 Update (Received from Rivie Mayele): ToR now approved and BI MDT in place.		\\gamma\users$\root\Keegans\Desktop\BIS TOR
			Executive Director of Patient Service	Head of Infection Prevention Control	OMB	4c	SLA to be agreed with UHB for support services	~~Sept 18~~ ~~Dec 18~~ ~~April 19~~ Oct-19	Service Level Agreement in place with UHB to provide Consultant Microbiologist support to both infection control and bone infection service, this is under review. September 2018 Update: SLA contract review to be held 11/09/18 for microbiologist service support to the B.I.Service. December 2018 Update (Received from Julie Gardner): The SLA for the Clinical Lead at HGS is agreed and awaiting a signed copy. The microbiologist SLA is not signed but we are currently receiving 2 PA's a week support, this will need review in line with the BI service requirements once agreed. January 2019 Update (Received from Julie Gardner): SLA to be agreed April 2019 in line with BI service requirements. June 2019 Update (Received from Julie Gardner): There are two SLAs relating to the clinical input from different Trusts with Microbiologists from UHB and the Clinical lead for Bone Infection from HGS. The Clinical lead SLA is in draft and ready to sign and the Microbiologist SLA will be reviewed following a business case to Trust Board following a response from the case for change from the CCG. August 2019 Update (Received from Julie Gardner): The SLA for the Clinical Lead is agreed and ROH are waiting for a signed version to be sent from UHB. The Bone Infection Service is under review and ROH is closely working with Commissioners from BSOL CCG and NHSE to agree a case for change. Until we reach an agreement with the Commissioners regarding the future of bone infection services at ROH we will not revise the SLA for microbiologists as the current provision provided will continue until ROH agree a revised specification.		
					OMB	4d	Development of surgical pathways and blood monitoring Standard Operating Procedures (SOPs)	~~Sep 18~~ ~~Dec 18~~ April-19	August 2018 Update: These will be reviewed, developed bespokely for ROH and implemented on appointment of the CSM in line with clinical pathways. September 2018 Update: Newly appointed CSM to develop and implement required SOP's. This work is presently being scoped. November 2018 Update (Received from Neil Jenkins): Draft patient pathways written Meeting 29th November 2018 with Medical Director, Clinical Service Leads and HGS surgeons. Launch 7th December 2018 at West Midlands Bone infection meeting. December 2018 Update (Received from Neil Jenkins): Pathways agreed and launched, next step is to finalise the governance processes for both ROH and UHB. February 2019 Update (Received from Neil Jenkins): Bone Infection pathway being presented at both ROH and HGS Quality and Safety Committees in February 2019. June 2019 Update (Received from Julie Gardner): The Bone Infection Network across the STP is well established and well represented by all Trusts; the Network have now approved a clinical pathway which if approved by the CCG will result in hip and knee prosthetic joint infections being supported by the Bone Infection MDT hosted by ROH. August 2019 Update (Received from Julie Gardner): Clinical Pathways are approved and starting to be implemented, this is being monitored by the Clinical Lead.		

						IPCC	4e	Outpatient and Parenteral Antimicrobial Therapy policies to be updated	Dec-18	Clinical Lead assigned to lead this work. Aug 2018 Update: Now supported from the ROH Lead Antimicrobial Pharmacist. September 2018 Update: ROH Lead Pharmacist with support from UHB Microbiology Service have updated these policies and are awaiting comments from the AMR Strategy Group. October 2018 Update: Awaiting update. November 2018 Update (Received from, Daniel Hearsey): The Trust Antimicrobial guidelines and Stewardship Strategy has been developed and is available on the Trust Intranet. A 'handy hints' document has been produced alongside these.		As per policy and review date.
						OMB	4f	Develop and launch a BIU business model	~~Dec-18~~ ~~April-19~~ Oct-19	Assistant Director of Finance to lead on development of business model. Aug 2018 Update: CCG have agreed a CQUIN, with ROH, to support a 12 month plan for the BIU. This will support the appointments of required staff (CSM, Data Analyst and MDT Co-ordinator). October 2018 Update: Bone Infection Service Development Group has now been established and weekly meetings take place every Thursday 11.30-13.00. BI CSL will be leading along with Jonathan Stevenson to draft pathway. Stakeholder meeting arranged. December 2018 Update (Received from Rivie Mayele): The BIS development group are working with clinicians across the region to develop clinical and referral pathways to be submitted (as part of the business case) to the board in February 2019. The proposed date for submission will be April 2019 (as per CQUIN requirement). June 2019 Update (Received from Julie Gardner): The Bone Infection CQUIN for 2018-19 was 100% achieved and a buisness case for a local tariff relating to bone infection patients was submitted on the 24th May 2019 for Birmingham and Solihull CCG to consider. Birmingham and Solihull CCG have agreed a 2019-20 CQUIN to support the development of a case for change for the CCG and to support the costs of the Clinical Lead for ROH. August 2019 Update (Received from Julie Gardner): Ongoing work with Commissioners to understand capacity and demand modelling as well as financial modelling is well under way with a final decision/case for change expected end of September. Funding agreed to cover the cost of the Clinical Lead and MDT Coordinator has been agreed within the bone infection CQUIN for 19/20. Bone Infection 2 year strategy currently being drafted and will be circulated early September. Clinicians are currently discussing measures of success.		
5	The Trust should ensure staff have access to relevant specialist training to carry out their roles effectively. All departments to ensure a Training needs analysis (TNA) is completed that highlights requirements of role and development aspirations.	All staff will have the relevant specialist training including oncology, mentorship and leadership courses.	Increased staff satisfaction in relation to access to training and development.	**of Patient Service**	**linical Training Lead.**	**Training and Development Group**	**5a**	Develop and deliver a: Band 6 development programme. Management skills programme. Preceptorship. Specialist Courses. Fundamental skills.	~~Aug-18~~ Jan-19	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. September 2018 Update: Commencement of programme delayed until Jan 2019 due to Trust wide management programe being designed and concerns regarding possible overlap. This has now been resolved. October 2018 Update: Course dates booked and advertised. This is monitored via the Nurse Strategy meeting and Training and Development Group. Oncology, leadership and mentorship courses/development discussed at the Training and Development Group for assurance that this provision is in place. November 2018 Update (Received from Karen Hughes): Band 6 Development programme: due to start Jan 2019. Staff booking via ESR- a lot of interest across all departments including Therapies Orthopaedic Course: Funding and places confirmed for double module starting Jan 2019. Applications received by L&D Leadership courses are available and overseen by L&D/Clare Mair Mentorship course still currently available and staff accessing this training. Due to change in NMC requirements re need for this, this may change over the year. December 2018 Update (Received from Karen Hughes): Oncology academic programme available and delivered by the University of Birmingham.		U:\Documents\ CQC Evidence\ CQC action plan

			Increased numbers of staff attending training and education.	Executive Director	Patient safety and C	Training and Development Group	5b	Specialist Training to be offered to staff	~~Jan-19~~ March-19	September 2018 Update: Work streams for Nurse associates and TAPs continue. SE&OD have supported further scoping of NA role and buisness case submission for the TAP role. October 2018 Update: Wolverhampton have at short notice discontinued their orthopaedic course. It has been confirmed ROH can have places on Stafford courses-awaiting dates. Meeting with RJAH training lead 23/10/18 to discuss collaborative working further. Nurse Associate/TAP work continues-this is monitored via the Clinical workforce & Development Group. November 2018 Update (Received from Karen Hughes): Awaiting clarification on Oncology specialist courses; orthopaedic and spinal now progressed with Staffordshire University. December 2018 Update (Received from Stacey Keegan): A training needs analysis (TNA) is being completed by all departments as part of buisness planning for 2019/20. TNAs will be collated in February 2019 and reported to the Training and Development Group in March 2019. March 2019 Update (Received from David Richardson and Karen Hughes): Suite of development initiatives now available for all staff, ranging from specialist apprenticeship qualifications for trainee nurse associates, theatre assistant practitioner, health care support workers, and team leader qualifications. Specialist orthopaedic and spinal module being accessed through Stafford university. Bespoke in house development training for band 6 nurses in hand too to support career and professional development. Specialist Care of cancer modules available from BCU alongside MacMillan training.		
6	Public engagement required re-energising.	Patients and stakeholders are involved in decisions regarding the Trust and their care	Patient feedback			CQG	6a	Patient and Carers Forum to be reviewed	~~Aug-18~~ Nov-18	Aug 2018 Update: Lead attends the monthly meeting and is presently reviewing the future development, with the Chair of the group, in line with the NHSI Patient Experience Improvement Framework (2018). The TOR are presently under review and a work plan will be developed, by the end of Q2, to support the patients experience . September 2018 Update: Comments collated on TOR – to be reviewed by the group 27/09/18. Work plan to be supported by Healthwatch Birmingham Presently reviewing the diversity of the group and how to encourage membership. October 2018 Update: Strategic group to be established to oversee Patient and Carer Forum and Strategy workplan. Patient and Carer Forum ToR drafted but due to be finalised November 2018. November 2018 Update (Received from Stacey Keegan): ToR agreed at Patient and Carers Forum; on the Clinical Quality Group agenda for November 2018. DDoN currently drafting ToR and membership for Strategic Group (to be named). December 2018 Update (Received from Stacey Keegan): Patient and Carer Forum ToR approved at the Clinical Quality Group in November 2018. Draft ToR for Stategic Group completed and meeting dates being scheduled. January 2019 Update (Received from Stacey Keegan): Patient Engagement and Experience Group ToR approved at Quality and Safety Committee and meeting scheduled to commence in February 2019 - monthly and to upward report into Quality and Safety Committee.		U:\Documents\CQC Evidence\Enc 028 Briefing paper \\gamma\users$\root\keegans\Desktop\Patient U:\Documents\Patient Experience\Terms of
				Executive Director of Patient Service	Patient Services Manager	CQG	6b	Develop and launch of a Patient Experience and Engagement strategy	Jan-19	October 2018 Update: Meeting held with Healthwatch, IPC lead, DDoN and Patient Experience Manager - benchmarking completed using Healthwatch PPI tool. Group now benchmarking organisation with the NHSI framework with a paper to Execs planned for November 2018 outlining gaps and proposed actions. November 2018 Update (Received from Stacey Keegan): PPI benchmarking on the agenda for November 2018 Clinical Quality Group. PPI and Experience Event planned for December 2018 to engage and steer the Strategy development. The Trust PPI and Experience Strategy to be presented at Quality and Safety Committee in January 2019. December 2018 Update (Received from Stacey Keegan): Benchmarking completed and presented, incorporating feedback. Patient and Public engagement event took place in December 2018 to gain views and input into the Trust Strategy. Draft Strategy completed and on track to present at the Clinical Quality Group and Quality and Safety Committee in January 2019. January 2019 Update (Received from Stacey Keegan): Involvement, Experience and Volunteering Strategy presented at Quality and Safety Committee. Launch of Strategy planned for February 2019. March 2019 Update (Received from Stacey Keegan): Strategy shared with the Head of Strategy to ensure this work is aligned with the overall Trust Strategy. Launch planned with the Communications Team for April 2019 in line with the overall Trust 5 year Strategy.		U:\Documents\CQC Evidence\Involvement

						CQG	6c	Develop workplan that underpins the Strategy and report to Quality and Safety Committee	Jan-19	October 2018 Update: On completion of the Strategy document and KPI setting. November 2018 Update (Received from Stacey Keegan): Agenda item at January 2019 Quality and Safety Committee. December 2018 Update (Received from Stacey Keegan): As above. January 2019 Update (Received from Stacey Keegan): Workplan to be drafted and approved at the first Patient Engagement and Experience Group planned for February 2019, incorporating finding from the benchmarking and gap analysis completed. March 2019 Update (Received from Stacey Keegan): Workplan incorporating the benchmarking and gap analysis to be signed off at the April 2019 meeting of the Patient Engagement and Experience Group. May 2019 Update (Received from Stacey Keegan): Workplan aligned with Strategy, incorporating NHS Improvement and Birmingham Healthwatch benchmarking/gap analysis.		Workplan forms Terms of reference for the Patient Engagement and Experience and standing agenda item. Workplan aligned to years 1 to 3 and broken down by quarter with leads identified.
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	IMT Board	7a	Implementation of EPMA (electronic prescribing and decision support system) system Work towards the development of a 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	June 2018 Update: EPMA (Phase 1) went live in June 2018. November 2018 Update (received from Mark Bemrose): New systems policy now drafted and sent for board approval. No decision yet made on clinical portal – awaiting appointment of CCIO. December 2018 Update (Received from Mark Bemrose): The new systems policy has now been adopted. January 2019 Update (Received from Mark Bemrose): The clinical portal is awaiting the appointment of a CCIO which is a crucial role in the development of the Portal at the Trust. An initial meeting is to be arranged with UHB to discuss the project requirements in more detail. March 2019 Update (Received from Mark Bemrose): Clinical representatives now appointed and initial meeting with UHB scheduled in April 2019. June 2019 Update (Received from Mark Bemrose): Initial meeting took place on the 18th April 2019; ROH clinical colleagues have since met with clinical staff at UHB to discuss how the portal should be developed for the ROH. Further discussions planned at IMT Programme Board in June 2019 as key resources need to be identified. August 2019 Update (Received from Mark Bemrose): Project Board meeting for the Clinical Portal took place on the 8th August 2019; where the scope of the Portal was agreed. Delivery of the first phase of the Portal is quarter 1 of 2020. EPMA, phase 2 is scheduled for December 2019.		Clinical Portal Project Board meetings scheduled to oversee delivery of the project. Representatives on both the EPMA and Clinical Portal projects to closely align their development, due to heavy reliance.
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	inance	Manager	IMT Board	8a	Review and ensure the process and security of patient data is robust within the Outpatient Department.	Dec-18	Aug 2018 Update: Security review has been undertaken and actions particulary with regard to permissions are being implemented. October 2018 Update: Actions being reviewed by IG Manager with periodic walkabouts to check compliance. November 2018 Update (Received from Janette Carveth): Data security to be part of Quality and Safety walkabouts. December 2018 Update (Received from Janette Carveth): The cyber security risk assessment has recently been refreshed and has visibility at corporate and BAF level. A number of actions are planeed or started to ensure compliance with cyber security DPS standards which in turn increase the security of patient information.		

				Executive Director of F	Information Governance	IMT Board	8b	Audit the security of patient data within the Outpatient Department.	Feb-19	January 2019 Update (Received from Stacey Keegan): Request made to the Outpatient leadership team to conduct audit of patient data security (computers and patient notes) to establish improvements or further actions that are required. Audit to be conducted by the Trust Information Governance Manager. March 2019 Update (Received from Evelyn O'Kane): Audit underway in conjunction with the Trust's Information Governance manager. Additional actions taken; reception areas are now electronic swipe card entry only, to improve security. Morning and afternoon notes collection in place to move notes to secure storage facility. Digital lockable trollies being explored. April 2019 Update (Received from Janette Carveth): Audit completed with positive findings, minor actions being explored by the OPD management team. Await a copy of the completed action plan prior to closure on the CQC action plan. August 2019 Update (Received from Janette Carveth and Helen Alldrick): Further audit completed in June 2019 by the Trust's Information Governance manager (audit attached), showing significant improvements. OPD Information Governance action plan attached.	\\gamma.local\users$\root\keegans\Documents\CQC Evidence\IG Action Plan-OPD- June 2019 update .docx	\\gamma.local\users$\root\keegans\Documents\CQC Evidence\Outpatient Short audit - June 2019.docx
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	CQG	9a	Team Brief and Team Brief process to be reviewed on the WHO checklist	Oct-18	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. Aug 2018 Update: Brief and debrief elements of the WHO have been audited seperately to identify themes, participation and feedback - reports have been developed by the Theatre Matron. September 2018 Update: Upward reports now recieved at Clinical Quality Group and shared within Divisions - awaiting feedback from Stryker. October 2018 Update: Awaiting update from Stryker - early November 2018. Audits continue and reported by the Theatre Matron. Themes from brief and debrief fed back to relevant stakeholders for actions if required and learning. November 2018 Update: Awaiting update on audit cycle and progress with Stryker. December 2018 Update (Received from Tracey Rutter): WHO and WHO brief and debrief audits completed monthly and upward report shared with responsible clinicians. Audit to be conducted in CT as well as Theatres. Upward reports/audit results part of the Clinical Quality Group workplan.		Monthly audit cycle in place incorporating Theatres, CT and ADCU with upward reports to the Division and CQG workplan and included within the Trusts Quality Report.
			100% compliance with WHO checklist Audit	Executive Medical Director	Associate Medical Directors	CQG	9b	ADCU and CT to be included on the Theatreman system for the WHO	Oct-18	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. September 2018 Update: WHO completed via Theatreman for CT and will be reported via Theatre Matron report monthly from October 18 report. Awaiting communications from Trisoft regarding ADCU. October 2018 Update: WHO audit compliance reported in the Trust Quality Report. Theatres and CT reported from Theatreman (Trisoft); ADCU remains a paper based audit until phase 2 of Theatreman roll out. Audits reported as 100% for September 2018. November 2018 Update (Received from Tracey Rutter/Sue Cox): ADCU continues to be paper based process and audit, no date for Phase 2 roll out received. December 2018 Update: Paper based WHO process within ADCU that is audited monthly with no concerns escalated. All relevant elements of the WHO process are completed.		Theatres and CT WHO audited and reported monthly by the Theatre Matron. WHO conducted in ADCU audited by Matron and reported in Divisional Condition report/KPIs. WHO compliance forms part of the monthly Trust Quality Report.

10	The Trust should review medical cover at weekends to ensure adequate cover.	Medical staffing to meet the required cover for weekends with staff being aware of the rota and escalation process.	Patients and staff have access to appropriate medical staff.	**Executive Medical Director**	**Associate Medical Director**	**CQG**	**10a**	Devise escalation process to ensure staff are aware and supported when escalating patients for review.	~~Sept 18~~ ~~Dec 18~~ ~~March 19~~ April-19	September 2018 Update: Escalation process in draft to be circulated with the intention of ratification at CQG in October 2018. October 2018 Update: Escalation process in line with NEWS2 and the deteriorating patient policy is in draft overseen by the Sepsis Group. Roll out planned by December 2018. November 2018 Update (Received from Helen Allen): Deteriorating Patient Policy in draft and circulated for comment; including flow chart for escalation. December 2018 Update (Received from Stacey Keegan): Draft policy remains in circulation for comments; in addition, escalation process (non acute patient episode) to be formulated to assist in informing and empowering nursing teams. January 2019 Update (Received from Stacey Keegan): Non-acute patient episode escalation tool in draft, out for comment and for approval at Clinical Quality Group in February 2019. March 2019 Update (Received from Stacey Keegan): Escalation tool on the agenda for approval at April 2019 Clinical Quality Group. June 2019 Update (Received from Lisa Newton): Escalation tool approved and available on the Trust Intranet.		\\gamma.local\users$\root\keegans\Documents\CQC Evidence\Non-urgent medical escalation flow chart v2-2 Reviewed Jun 19 .pdf
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	Consent audits and dictation turnaround metrics met.	**Executive Medical Director**	**Associate Medical Directors**	**CQG**	**11a**	Staff to adhere to the Consent policy.	~~Nov 18~~ Oct-19	October 2018 Update: Discussion with AMD Division 1 - awaiting further assurance. November 2018 Update (Received from Mr Va Faye): New process is being considered for implementation. December 2018 Update (Received from Mr Pearson): Consent audit conducted and due to be presented to the medical body on the 24.1.19. Consent process is safe; further actions to improve patients receiving copy of the consent form and ensuring information that is given to the patient is clearly documented as such. February 2019 Update (Received by Stacey Keegan): Action handed over and discussed with the new Medical Director to review and take forward. January's consent audit attached, highlighting improvements. April 2019 Update (Received from Matt Revell): Further actions to be implemented in line with the Trust's Quality Priority for 2019/20; review of Trust consent policy, devise consent KPIs for monitoring and measuring improvement, patient information to support consent process and consent audits to be registered for 2019/20. Await timescale for implementation. May 2019 Update (Received from Matt Revell): Consent policy drafted and circulated for consultation. August 2019 Update (Received from Matt Revell): Consent policy passed at the Executive meeting; roll out expected August/September 2019. Revised consent forms under discussion. Consent reports now requested from Informatics; KPIs decided and will be reported via Clinical Audit and Effectiveness Committee upwardly reporting to Quality and Safety Committee.		U:\Documents\CQC Evidence\Patient Consent
11						**CQG**	**11b**	Digital Dictation upgrade and roll out of training to enable improved process for patient letters and turnaround times.	Nov-18	Aug 2018 Update: Upgrade completed in July 18 with a training progrmme in place to roll out. October 2018 Update: awaiting update. November 2018 Update (Received from Janet Campbell): Winscribe digital dictation upgrade went live on the 10 September 2018 and all staff training had been provided beforehand, prior to roll out. We now have a number of 'super users' who can provide ongoing training in future. The Winscribe system has now moved back to an operational function rather than a project and Matt Payne is the owner.		Winscibe reporting functionality being addressed however KPIs in place to monitior by speciality - these KPIs are monitored at Division 1 weekly operational meeting - confirmed with Matt Payne.

Executive Director of Strategy

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**	**Training and Development Group**	**13a**	Mandatory training process to be reviewed to include online modules enabling different methods of access and learning.	Jan-19	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. Aug 2018 Update: 92.83% compliance for June 2018 therefore achieving Trust target. September 2018 Update: Maintaining MT compliance over 90% for substantive and bank staff. Streamlining project / CIP continues. The Trusts external contract with External Online learning provider has been cancelled as now internal provision with ESR is working effectively. All Subject matter experts are engaged with transferring to online modules, excluding Safeguarding adults and children. Although agreed suitable nationally, additional information is needed in the safeguarding online packages to include local information that the local leads are requesting. To include this it requires an IT intervention to enable links with ESR. This may delay complete transfer to online modules by the target date of January 2019. October 2018 Update: Progress remains as above - implementation plan attached. November 2018 Update (Received from David Richardson): Progress remains on track with no concerns to escalate. December 2018 Update (Received from David Richardson): Core Mandatory training modules are now available via a 1 day face to face course, or via E-learning for Health online modules. Both approaches are available to all employees within the Trust. Currently around 10% of staff access the e-learning option. 90% target still being exceeded on a monthly basis.		U:\Documents\ CQC Evidence\ Mandatory training
Executive Chief Operating Officer												
16	The Trust should ensure that the NHS England Accessible information standards are met.	The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The ROH will meet the Accessible Information standard.	Closure of the responsive Accessible Information Standards action plan.	**Chief Operating Officer**	**Operational Service manager**	**CQG**	**16a**	Closure of the Trust responsive Accessible Information Standards action plan.	~~Dec 18~~ April-19	November 2018 Update (Received by Matt Payne): An audit of patients attending ADCU for a week has been undertaken, asking all patients to fill in a survey on arrival asking if they consider themselves having any communication issues. I they do they were asked to then specify what these were. This information will be used to check if this has been recorded on both the Patient Administration System and the patient's notes. There will be another audit undertaken in the outpatient department once a similar question can be added to the self-check-in screens. This is being negotiated with InTouch currently. In addition the Patient Access Manager has also been to the Trust audit day to address the consultant body to ensure they were aware of the Accessible Information Standard and their obligation to collect information about patient communication needs. A business case to propose working with two external companies called DrDoctor and Synertec is being developed. These two companies are able to take on the Trusts communication with patients, initially around outpatient appointments, and patients will be able to highlight their own communication needs and Synertex will be able to send correspondence in the relevant formats. December 2018 Update (Received from Matt Payne): The action plan is now 90% complete and plans have been made to complete the last few actions by the end of the calendar year. A strategy / resource document is to be drawn up as a summary to the project of moving the Trust to compliance. February 2019 Update (Received from Matt Payne): Assurance document attached outlining compliance with the Accessible Information Standard. Agenda item for April 2019 Clinical Quality Group with a plan to sign off closed action plan. April 2019 Update (Received from Matt Payne): The Trust responsive Accessible Information Standards action plan signed off as completed at the Clinical Quality Group in April 2019.		The Accessible Information Standards Group will continue to meet bi-monthly and upward report to the Clinical Quality Group. U:\Documents\ CQC Evidence\ 20181213 U:\Documents\ CQC Evidence\ 20190131 AIS
		Staff at the ROH will be fully aware of what services are available, and have knowledge in how to access translation services.				**CQG**	**16b**	Translation services and how to access are communicated to the Trust.	Nov-18	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. October 2018 Update: as above. November 2018 Update (Received from Matt Payne): All systems previously report are still in place and remain affective. The second round of outpatient benchmarking is due to begin in the next 2 months and this will provide new information comparing the Trust against other providers and their use of translation service. It will also allow the Trust to compare itself against last years' data. December 2018 Update (Received from Lisa Kealey): Higher than average use of transalation services, no complaints, PALS or FFT concerns raised regarding translation services. DrDoctor system if progressed will further enhance this service for patients.		

17	The Trust should continue to improve the flow through the Outpatients Department so patients are not kept waiting for appointments.	Improved access, flow and efficiencies within the Outpatient Department avoiding and minimising excess wait times for patients and carers.	To meet the target/KPI for clinic wait times.	**Chief Operating Officer**	**Clinical Service Manager**	**Out-Patient Operational Group**	**17a**	Clinic templates reviewed for those clinics that continue to have delays and increased waiting times and human factors addressed if required.	~~Sept 18~~ Feb-19	October 2018 Update: September 2018 - 11.2% >30 minutes and 4.6% >1 hour - Quality Priority overseen at Clinical Quality Group. November 2018 Update (Received from Matt Payne): Waiting times in clinic continue to be monitored and have been steadily dropping. The Trust has achieved its target of less than 5% of patients waiting for longer than 60 minutes over the last 3 months and the over 30 minute delays have nearly reached the target of 10% and are currently being maintained below 12%. Further work is underway to try and make use of detailed reports from InTouch to identify areas of high clinic delays and take focused action. December 2018 Update (Received from Matt Payne): October 2018 saw an increase in wait times, rationale being an increase in clinic activity. November 2018 KPIs showed improvement and were reported as 11.2% >30 mins and 3.9% > 60 mins. January 2019 Update (Received from Stacey Keegan): Review previous Trust CQC responsive action plan with a plan to close action with assurances. February 2019 Update (Received from Stacey Keegan): Previous CQC Responsive action plans sent to the OPD operational team for review and to ensure these previous improvements have been embedded. March 2019 Update (Received from Matt Payne and Evelyn O'Kane): Since April 2018, a month on month improvement evidenced via the clinic wait time KPIs. Assurances provided (documented within ongoing assurances) and action closed.	U:\Documents\ CQC Evidence\ Summary of OPD	Wait times data taken from the In Touch system monthly. Data reported to and discussd at Divisinal Ops and Divisional Board meetings. OPD Nursing staff submit incident forms if there are clinic waits/delays and these are reviewed at Divisional Governance meetings. OPD 6-4-3 and the OPD Operational Group meetings now established to oversee operational efficiencies. Clinic wait KPIs reported in monthly Finance and Performance and Quality reports for assurances to the Sub-Board committees.
Associate Director of Governance & Company Secretary												
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	**Associate Director of Governance and Company Secretary**	**Corporate Governance Lead**	**S/E and O/D Committee**	**12a**	Review fit and proper persons act Trust process	~~Jul 18~~ Nov-18	Confirmation that there is a process in place and that all relevant staff will comply. Aug 2018 Update: Awaiting confirmation that this action is closed. September 2018 Update: FPPT policy is in place - awaiting confirmation of reviewer. October 2018 Update: FPPT policy is in place and will be updated by November 2018 to ensure that it accurately reflects current practice and the requirements of the regulation. December 2018 Update (Received from Simon Grainger-Lloyd): Policy reviewed, with confirmation being sought regarding DBS and how often this check is required. January 2019 Update (Received from Simon Grainger-Lloyd): FPPT policy reviewed and updated .		U:\Documents\ CQC Evidence\Fit Proper Persons
						S/E and O/D Committee	**12b**	All Staff meet the Fit and Proper person regulations	Aug-18	All executives have signed fit and proper persons self declaration as per Trust policy. Aug 2018 Update: Awaiting confirmation that this action is closed. September 2018 Update: All Execs and NEDs have been subject to the FPPT.		
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 within the agreed timescales.	Audit of compliance against policies and policy workplans.	**nance & Company Secretary**	**vernance Lead**	**CQG**	**18a**	All polices to be up to date with a review period defined.	~~Sept 18~~ ~~Dec 18~~ ~~June 19~~ Oct-19	April 2019 Update (Received from Adam Roberts): Allocate Policy Module progressing well. Allocate Policy Module Training to take place on the 15.4.19. Addition of sub categories for clinical policies being discussed with Trust Project Lead and Allocate representative. Once submitted the next stages will be the final module build and testing before the final policy reporting pack can be agreed and configured. A report is being prepared for the Exec Team detailing the number of policies overdue for review for each Exec Directors area of responsibility. June 2019 Update (Received from Adam Roberts): Addition of sub categories for clinical policies sent to Allocate, final module build can now begin with testing and reporting workshop to follow. The means of monitoring compliance and governance around the completion of policy implementation plans discussed with an Allocate representative, with the ability to use the policy module to do so looking possible. Report sent to the Company Secretary detailing the number of policies overdue for each Executive Directors respective area of responsibility. Reports detailing clinical policy status continue to be submitted to the Clinical Quality Group (CQG), Infection Prevention and Control Committee (IPCC) and Drugs and Therapeutics Committee (DTC). August 2019 Update (Received from Adam Roberts): Policy module UAT (final approval checklist) call with Allocate took place in July. Unable to sign off the module as technical faults were discovered during the call. Sign off therefore delayed whilst Allocate rectified the errors. UAT sent back to Trust again via email on 16.08.2019 for final testing, training and sign off. Policy report send to all Exec Directors outlining all policies overdue for review for their respective portfolios. Policy reports also continue to be submitted to CQG, CYP Board, IPCC, Safeguarding Committee & DTC.	Risk 791 Corporate Risk Register. *'There is a risk that safe practices and patient care are compromised by the large number of organisational policies which are overdue for renewal'.*	

				Associate Director of Goveri	Corporate Go	CQG	18b	Process for reviewing policies to be launched	~~Sept 18~~ ~~Dec 18~~ ~~March 19~~ ~~June 19~~ Oct-19	December 2018 Update (Received from Adam Roberts): Internal policy cleanse (audit of all current policies & review dates, as well as review of relevant authors and Exec lead) has now been completed. Awaiting discussion with Allocate Project team to determine policy data they require in order for them to commence module build and configuration. February 2019 Update (Received from Stacey Keegan): Allocate module now built, meeting arranged with Adam Roberts and Allocate week commencing 4.3.19 to finalise training and agree launch/go live date. April 2019 Update (Received from Adam Roberts): Allocate Policy Module Training to take place on the 15.4.19. Addition of sub categories for clinical policies being discussed with Trust Project Lead and Allocate representative. Once submitted the next stages will be the final module build and testing before the final policy reporting pack can be agreed and configured. June 2019 Update (Received from Adam Roberts): Update as described in action 18a. August 2019 Update (Received from Adam Roberts): Policy module UAT (final approval checklist) call with Allocate took place in July. Unable to sign off the module as technical faults were discovered during the call. Sign off therefore delayed whilst Allocate rectified the errors. UAT sent back to Trust again via email on 16.08.2019 for final testing, training and sign off.		
19	The Trust should ensure that the corporate risk register is reviewed by the full board.	The Trust Board is to be 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	Trust Board	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. Work also approved by the Audit Committee.		

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

A G E N D A

Annual General Meeting of the Royal Orthopaedic Hospital NHS Foundation Trust, 2018/19 -
Thursday 10th October 2019
1700h
The Max Harrison Lecture Theatre
Knowledge Hub
Royal Orthopaedic Hospital
Birmingham
B31 2AP

1	**Welcome and introductions** • Yve Buckland & Brian Toner
2	**Minutes of the previous meeting held on 4 October 2018 – for approval** • Yve Buckland
3	**Review of the year, including Annual Report highlights** • Jo Williams, Chief Executive
4	**ROH: The Wellbeing Hospital**
5	**Performance Highlights** • Marie Peplow, Executive Chief Operating Officer
6	**Quality Report Highlights** • Garry Marsh, Executive Director of Nursing & Clinical Governance
7	**Financial Review and Annual Accounts highlights** • Stephen Washbourne, Executive Director of Finance
8	**Auditors Report** • Deloitte LLP
9	**Question and answer session**
10	**Closing remarks**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 4 October 2019

Notice of a meeting of the Council of Governors

Notice is hereby given to all members of the Council of Governors of the Royal Orthopaedic Hospital NHS Foundation Trust that a meeting of the Council of Governors will be held in the Board Room on Thursday 10 October 2019 at 1400h to transact the business detailed on the attached agenda.

Members of the press and public are welcome to attend the public part of the agenda which starts at 1440h.

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** 10 October 2019: 1400h – 1615h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1	Exclusion of the press and public	Verbal	SGL
1402h	2	Trust Chairman's appraisal[#1]	Verbal	BT
1415h	3	Non Executive appraisals	Verbal	Chair
1435h	4	Board appointments	ROHGO (10/19) 001 ROHGO (10/19) 001 (a) ROHGO (10/19) 001 (b) ROHGO (10/19) 001 (c)	Chair
1440h	5[#2]	Apologies and welcome	Verbal	Chair
1442h	6	Declarations of interest	Verbal	ALL
1445h	7	Minutes of previous meetings on 22 May 2019	ROHGO (5/19) 017	Chair
	8	Update on actions arising from previous meetings	Verbal	SGL
1450h	9	Chair and Chief Executive's update	ROHGO (10/19) 002 ROHGO (10/19) 002 (a)	YB/JW
1505h	10	STP and Birmingham Hospitals Alliance update	Verbal	YB/JW
1515h	11	Paediatric services update	Verbal	KS
1525h	12	Annual complaints report	ROHGO (10/19) 003 ROHGO (10/19) 003 (a)	KS
1535h	13	Feedback from the Patient & Carer's Forum	Verbal	MB

[#1] Excludes Chair of Council of Governors
[#2] Public, CEO and Non Executives join meeting

1545h	14	Fit & Proper Persons Test update	ROHGO (10/19) 004 ROHGO (10/19) 004 (a) ROHGO (10/19) 004 (b)	SGL
1550h	15	Updates from the Board and Board Committees	ROHGO (10/19) 005 - ROHGO (10/19) 011	Chair & NEDs
1600h	16	Governor updates	Verbal	ALL
1610h	17	For information: • Finance & performance update • Quality & Patient Safety update • Workforce update • Board Assurance Framework	ROHGO (10/19) 012 ROHGO (10/19) 013 ROHGO (10/19) 014 ROHGO (10/19) 015	Chair
	Date of next meeting: Wednesday 15 January 2020 @ 1400h – 1600h in Trust Headquarters			

[#1] Excludes Chair of Council of Governors
[#2] Public, CEO and Non Executives join meeting

MINUTES

Council of Governors - Version 0.2

Venue Boardroom, Trust Headquarters **Date** 22 May 2019 @ 1400h

Members present

Yve Buckland	Chairman	YB
Brian Toner	Lead Governor	BT
Marion Betteridge	Public Governor	MB
Lindsey Hughes	Public Governor	LH
Carol Cullimore	Public Governor	CC
Petro Nicolaides	Public Governor	PN
Arthur Hughes	Public Governor	AH
Kennedy Iroanusi	Public Governor	KI
Gavin Newman	Staff Governor	GN
Karen Hughes	Staff Governor	KH
David Richardson	Staff Governor	DR
Hannah Abbott	Stakeholder Governor	HA
Dr Dagmar Scheel-Toellner	Stakeholder Governor	DS-T

In attendance

Kathryn Sallah	Non Executive Director	KS	
Rod Anthony	Non Executive Director	RA	
Jo Williams	Chief Executive	JW	
Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	SGL	[Secretariat]

Minutes	**Paper Ref**
1 Apologies and welcome	**Verbal**
Apologies were received from Adrian Gardner, Liz Clements, Sue Arnott and Richard Burden. Jo Williams was welcomed as the new substantive Chief Executive and thanks and goodbye were extended to Paul Athey.	
2 Declarations of interest	**Verbal**
The Chairman advised that she had been appointed as interim chair of Dudley Group NHS Foundation Trust. The initial term of this appointment would be for six months.	
3 Minutes of previous meeting on 16 January 2019 and 4 April 2019	**ROHGO (1/19) 009**

	ROHGO (4/19) 001
The minutes of the previous meetings were accepted as a true and accurate reflection of discussions held.	
4 Update on actions arising from previous meeting	**Verbal**
It was noted that there were some actions raised for Associate Director of Governance & Company Secretary in the January pre-meet around providing upward reports from the Trust Board, so these were now included, as was the Board Assurance Framework so the governors could see what the key risks to the Trust were from the perspective of the Trust Board. It was also noted that Professor Begg had been invited to discuss car parking. He was currently overseas, but would join a future meeting where he would be invited to provide an update about the plans which also included the impact of the new modular theatres complex.	
5 Chief Executive's and Chair's update including paediatric transition and Birmingham Hopsitals Alliance	**Verbal**
The Chief Executive reported that the Paediatric Oncology review had been completed, which had been undertaken at the request of Birmingham Children's Hospital (BCH) as assurance on the delivery of this service when it moved. The formal TUPE transfer of staff had been completed. It was noted to be a difficult time on Ward 11 for some staff. There were two sessions planned to support staff and there would also be work undertaken to improve the outpatients environment. The relationship with BCH would continue to grow and there would be a monthly meeting to monitor the ongoing operational arrangements. An event was planned at the end of June to mark the transfer, celebrate the service and say goodbye to those staff leaving the ROH. Mrs Sallah commented that it was good to see things moving on and there was a good relationship with the Chief Operating Officer at BCH. Policies and procedures would be revised in line with the new arrangements; this would be an expectation of the CQC and was within the remit of the Director of Nursing & Clinical Governance to handle. In relation to the Birmingham Hospitals Alliance, there had been much development. There was an unwillingness to consider mergers and acquisitions and an appetite for working collaboratively was preferred. Maternity services and public health were key areas of focus. The integrated orthopaedic pathway was being developed, with Mr Pearson leading the strategic development of this. A Memorandum of Understanding with University Hospitals Birmingham NHSFT (UHB) would be being developed to formalise the relationship and the ROH Chief Executive would join the UHB Chief Executive's advisory group. There was confidence that the ROH voice was heard within the system and the collaborative working was good. There was clarity that the mental health and community trust also needed to be engaged with the system developments. The Pathology services had transferred and procurement would also be moved across to UHB. The approach was in line with the national plans set out in the	

Long Term Plan for the NHS. The governors were advised that the modular theatre contract had been signed and the work was underway. The last weekend in August would see the modular theatres arriving on site and they would be commissioned for the end of November. The theatre staffing recruitment plans were underway and the next focus was on expansion. The official 'breaking the earth' ceremony was planned shortly. There was reported to be a piece of work around operational gearing to look at the profitability of the work undertaken in the Trust. There would be some work to take on caseloads from Heartlands, Good Hope and Solihull hospitals.	
5.1 Extension of the terms of office of Simone Jordan and Tim Pile	**Verbal**
[redacted]	
6 Developing the Trust's strategy	**ROHGO (5/19) 004**
Rebecca Lloyd, Head of Strategy, joined the meeting. It was reported that the ROH was at the end of its five year strategy and there was a process underway to develop an updated version for the next five years. There was values based recruitment underway and the vision and values had been cemented and would be kept. It was noted that the new strategy was organised into the five 'Ps': patients, people, partnership, process and performance. These pillars were supported by the enabling strategies. The success indicators had been discussed by the Board.	

It was agreed that the process to update the strategy needed to be iterative. The strategy would be made live by real examples of how the the strategy was being lived by the staff. It was noted that an interim workforce plan was to be launched which included how the NHS was made an attractive place to work and to place people first. The Well Led Framework would also be aligned to this and moved away from being a governance framework. The governors praised the strategy and highlighted that it was pleasing that there was a real focus on how it applied to staff. The strategy would also be translated at a divisional and operational level. It was noted that there were some tangible outputs of the strategy. It was noted that there was some good feedback about governor involvement and making the Trust a great place to work. The strategy was noted to fit closely with the new Chief Executive's agenda. There was an ambition for the ROH to be outstanding for people. Rebecca was wished all the best for her forthcoming maternity leave.	
7 Staff survey results	**ROHGO (5/19) 003**
There was reported to have been good improvement in the staff survey results and the governors were reminded that a few years ago, the Trust was criticised for the low senior management visibility, a position which had been reversed. There was an evident step change since this time and there was also move in terms of quadrants, placing the Trust in a much better position relative other organisations. There was noted to remain more work to do but overall the results were very encouraging.	
8 Update from the Trust Board and Board Committees: • Trust Board • Audit Committee • Quality & Safety Committee • Finance & Performance Committee and Staff Experience and OD Committee	**ROHGO (5/19) 005 - 007** **ROHGO (5/19) 008** **ROHGO (5/19) 009** **ROHGO (5/19) 010 & 011**
The Trust Board upward reports were considered. In terms of the key risks, there was a risk around staff Heptatis B vaccinations, the national situation around pensions, the need to keep under review the impact of the estate and support services associated with growth and modular theatres and gender pay. There was good working as a unitary board. It was reported that the Audit Committee had met regularly and had tested the robustness of control for the Trust through the internal audit programme. There were reported to be some areas of partial assurance but these were being addressed. The external auditors were reported to be pleased at the	

engagement with the finance team but had highlighted the need to improve handling of stock control. The process for handling NICE guidelines was an area of improvement noted.

The key annual audit documents had been reviewed and the quality of the first draft of the documents was seen to be of high. Those responsible were thanked. The Audit Committee meeting scheduled for the end of the week would be expected to recommend to the Board the adoption and approval of the annual accounts and report.

It was noted that the Chairman had received good feedback on the quality of the chairmanship of the Audit Committee.

In terms of Finance & Performance Committee, this has been meeting throughout the year. There had been some good scrutiny over financial and operational performance. In terms of key areas of focus, a revised Cost Improvement Plan had been requested and the change in the national targets around cancer treatment would need to be given focus. The Trust now had no patients waiting in excess of 52 weeks and the longest wait was currently 47 weeks. The regulators were pleased that this has been achieved. It was suggested that thanks and congratulations should be communicated on behalf of the governors.

It was noted that merging the scrutiny committees with the walkabouts has developed an element of trust between individuals. This could be seen to be part of lessons learned.

The Quality & Safety Committee was reported to be meeting monthly and there was good information considered. The next step was to broaden its scope to include other quality measures and clinical outputs. The Medical Director was considering what measures would be most useful to consider. There were areas which had been audited and need a re-review, such as pre-operative fluid intake and NICE guidance. In terms of the latter, the internal auditors had undertaken a re-audit and identified a few housekeeping issues which needed to be addressed. There was work planned with the research team to understand the changes and impact this had had on practice. The membership of the committee was thought to be appropriate and staff joined to present updates. The focus of the meetings was reported to be more strategic now, rather than operational.

In terms of the Staff Experience & OD Committee, this was the newest Board committee. There was more information being considered which was 'RAG' rated to identify the hot spots. A staff presentation was held at each meeting and the staff experience walkabouts reported into these. Staff views on working conditions were canvassed as part of this. Any concerns were fed into the relevant directors. It was noted that at present, the committee may be overly concerned with the detail but this would change as time progressed. A workshop was held around the staff survey and any areas of improvement would be monitored through the Staff Experience & OD Committee. The value of the Finance & Performance Committee and the Staff Experience & OD

Committee was noted to be crucial. The focus on training and new roles was also valuable. It was noted that the People Committee that was the principal feed into the Staff Experience & OD Committee, needed to operate at pace and to create a focus on HR matters in particular.	
9 Governor Matters (raised in pre-meet)	**Verbal**
The following points were noted to have been raised in the pre-meet: The Chairman's contract extension to 2023 was agreed. Experience of involvement in the CEO recruitment process had been discussed and agreed to have been a positive experience. Based on a recent theatres visit it had been noted that the environment needed to be improved, a matter which would be addressed in part by the modular theatres set up. Agreement around the governor involvement in the Estates Strategy & Delivery Group had been discussed and agreed. It was reported that there had been some positive work around charitable fundraising. There had been some good discussions with the Research Director around collaboration including education. Governor involvement in the staff awards ceremony had worked well. Some governors had attended the JointCare Reunion at the ExtraCare facility.	
10 DRAFT Annual Report (including Quality Account) & Accounts 2018/19 (PRIVATE ITEM)	**ROHGO (5/19) 012** **ROHGO (5/19) 012 (a)** **ROHGO (5/19) 012 (b)** **ROHGO (5/19) 012 (c)**
The Council of Governors resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. The Chair reported that until the annual report and accounts had been laid before Parliament nothing could be published by the Trust for the wider public. A special Board meeting on Friday 24 May would be held to provide Board members with the final Annual Report and Accounts (AR&A) for their approval. [redacted]	

[redacted]

[redacted]	
11 For information: • Finance & Performance Overview • Quality & Patient Safety Report • Workforce Overview • Board Assurance Framework	**ROHGO (5/19) 013** **ROHGO (5/19) 014** **ROHGO (5/19) 015** **ROHGO (5/19) 016**
These reports were received for information.	
12 Any other business	**Verbal**
The governors noted that it was Paul Athey departure at the end of week. In terms of the death of the Patient Advisory and Liaison Service Manager, the Council of Governors expressed their condolences to the family. Brian Toner and Kathryn Sallah were thanked for their attendance at the recent JointCare initiative. It was noted that the long services awards had been held which had been a positive event. It was noted that the material uncertainty around Going Concern was agreed to be removed in the annual accounts based on feedback from the auditors, which was a positive measure for the Trust.	
14 Date of next meeting: The next meeting is planned for Thursday 10 October 2019, 1400h to 1600h in Trust Headquarters, after which follows the Annual General Meeting (premeeting with the Lead Governor and Chairman at 1330h).	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**10 October 2019**

EXECUTIVE SUMMARY:

This report provides an update to 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 4 September 2019

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors in Public on 10th October 2019

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates from the Chief Executive's position, this includes an overall update, wider ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 The last stage of the competitive selection process for the substantive Chief Operating Officer (COO) was completed in August 2019. Four candidates underwent a formal interview panel at the beginning of August 2019, comprising Tim Pile (Vice Chair), Jo Williams (Chief Executive), Simone Jordan (Associate Non Executive) and Alex Moody (Associate Director of Workforce). The candidates had also been required to present to a small set of internal stakeholders, namely the Executive Team and a staff governor. The panel was unanimous and supported the appointment of Marie Peplow who is currently the acting COO at the ROH.

2.2 University Hospitals Birmingham (UHB) has developed for the ROH a Human Factors training session for Theatres which was delivered at the end of September 19. Human Factors concern the interaction between people and technical components in complex systems. It is associated with a maturation of wider system safety management and can make an important contribution to equipment design, safety assurance, system management and incident investigation such as Never Events.

It is recognised that Human Factors can provide enormous benefits to patient safety through better understanding of human related clinical tasks and risks and the people element of clinical processes, including cognitive, social and behavioural elements. It is envisaged that the multi-disciplinary team at UHB will support our staff to develop their skills as part of the Flow Academy so we can develop our own in-house trainers.

2.3 The Trust has been notified that it has been shortlisted as a finalist for the Health service Journal (HSJ) Trust of the Year award. The next stage required members of the judging panel to visit the Trust on 10th September 2019. On Monday 30th September, three members of the team attended the final stage to present our entry to the judging panel explain the reasons why we should win with all finalists being notified at the awards evening on Wednesday 6th November at Battersea Evolution, London.

2.4 JointCare was nominated for a Forward Healthcare Awards by Leading Healthcare which celebrates and shares great work across health and care in the category specialist/acute service redesign. We were notified on September 25th September that we had won this award, which was a huge piece of positive news for the Trust and is testament to a lot of hard work by the JointCare team.

2.5 On Monday 29th July, the Chief Executive, Director of Nursing & Clinical Governance and Director of Corporate Affairs & Company Secretary met with our CQC relationship manager/inspector. They updated the Trust on the internal changes within the team and their restructuring, meaning we would have a new team for the ROH. We discussed all the issues raised as part of our previous inspection, current incidents, Never Events and all the progress since our last visit. The meeting was extremely positive.

The CQC has also issued the Provider Information Request (PIR) which is used to direct the focus of their inspection. This was completed on 7th August 2019. Our submission was comprehensive and it was that clear in many areas that the Trust had improved since its last submission of the data.

In readiness for the Well-Led and unannounced inspection, the teams have presented a self-assessment to the Executive Team, a booklet has been designed and issued to support front line staff to aid the inspection and the Director of Nursing & Clinical Governance has held various meetings with the nursing team across the organisation.

As part of the data request the Trust submitted our assessment of our rating, which has rated the Trust as 'Good' in all domains with 'Outstanding' for Caring.

We have been notified that the date for our Well Led inspection is on 12 November and has been scheduled for one day only, as the Trust is seen to be a 'low risk' organisation. The unannounced inspection that always precedes this will occur at some point between now and then.

2.6 The Trust has been accepted as a Phase 1 pilot site for NHS Leadership Academy's Talent Management Diagnostic. As one of the first national adopter sites, the Trust will play a vital role in ensuring that the tool is fully fit for purpose for wider roll out across the NHS later this year, whilst helping to further develop our talent management programme with a range of toolkits to support the Trust.

2.7 The week commencing 9th September 2019 was the launch of our Health and Wellbeing week, with events being held throughout the week. On Tuesday 10th September we launched our Wellbeing Hospital with a range of speakers across the Trust and on Wednesday 11th September, BBC Sports presenter and 'Strictly Come Dancing' finalist Chris Hollins formally launched our programme.

2.8 We have received notification from NHS Improvement that we can revert to our original capital budget following the recent announcement from the Prime Minster regarding capital expenditure in the NHS.

2.9 A small group of staff from Theatres and the Executive Team has visited ModuleCo to see the final build stage of the Ward, Recovery and Theatres, before transportation to the ROH at the beginning of October. A full implementation plan has been prepared to support the installation programme which has commenced. This will include alternative staff parking arrangement for one week to minimise disruption.

3.0 STP UPDATE

3.1 The latest STP Chief Executive's meeting took place on 11th July 2019 with the key areas of discussion being the implementation of the Integrated Care System (ICS) and the Long Term plan funding and implementation. The STP has been unsuccessful with its bid to be a pilot site, but it was agreed that it needed to establish a vision for our ICS and the proposed governance model given our ambition to shadow monitor the ICS in April 2020. The group would be chaired by the Chief Executive of Birmingham Women's and Children's NHSFT (BWC), Sarah -Jayne Marsh, and colleagues would be asked to support key lines of work.

3.2 One key workstream which was agreed was the digital agenda and the 5G pilot being led by UHB. It was agreed that digital should be at the forefront of any transformation projects and be led by the experts across the STP i.e. UHB. The Chief Executives agreed that we need to look at how we bring our teams together to lead this across Birmingham and Solihull foot print (BSoL). A group had already been formed to agree the system plan for the long term plan with a final plan for the STP Board to sign off on 15th November 2019; this also includes system allocation of the 5 year funding.

3.3 The last STP Board meeting took place on 5th August 2019. The Board discussed the next steps for the ICS and acknowledged that we need to ensure that the priorities for our ICS are defined and that there is a consensus around challenging ourselves to ensure that we work and behaviour differently to enact real change. The STP Chair confirmed that the workstream lead would need to present this back to the STP Board for final approval. There was a discussion around the benefits around digital transformation and this mirrored the conversation at the STP CEOs meeting.

4 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

4.1 The BHA met on 6th August 2019 and was attended by the Vice Chair and Chief Executive. Two key areas were discussed, digital agenda and BWC site redevelopment/capital.

4.1 The Board received a presentation from UHB's, Director of Corporate Strategy, and Planning & Performance regarding the potential for 'Digital First Healthcare'. There are clear benefits for the BHA to work together to use technology to find and deliver effective solutions to ensure that care is received in the right setting whilst reducing footfall in many areas. It was agreed that there were clear economies of scale which could be leveraged across the wider system. It was agreed that the STP Digital Group would identify the scope of the work, the funding model and the governance model. This work will also compare and contrast respective digital agendas across the BHA and will outline needs and requirements across the providers within BSoL STP

The Executive Finance Lead for the BHA and Deputy Chief Executive Officer for Birmingham Women's and Children's, David Melbourne presented an outline of the recent BWC Estates review that was considered at their June Board meeting. This included the imperative to redevelop the Women's & Children's hospitals.

5.0 NHSI/NHSE

5.1 On Friday 30th August 2019 a system review meeting was held with all BSoL partners chaired by NHS Improvement. This is the first meeting which has been held to hold the system to account. The ROH has asked that NHS Improvement raises with the system, the provision of Orthopaedic services in the private sector and the requirement to bring this back into NHS BSoL providers and what role we can play in the system through winter 2019/2020.

6.0 PAEDIATRIC ONCOLOGY SERVICES AT BCH

6.1 On 20th August 2019, the Chief Executive was alerted by the Clinical Service Lead for Oncology about two clinical incidents at BCH involving paediatric patients. Full investigations are underway and the scrutiny of the incidents and any actions agreed between BCH and ROH will be through the Quality & Safety Committee.

7 RECOMMENDATION(S)

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

7.2 Note the contents of the report.

Jo Williams
Chief Executive

4th October 2019

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Annual Complaints report 2018/19**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh; Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Lisa Kealey; Patient Services Manager**
DATE OF MEETING:	**10 October 2019**

EXECUTIVE SUMMARY:

Successful resolution, smooth handling and learning from complaints will improve the quality of services that the Trust provides. Accurate adherence to the Policy, based on Good Practice guidelines and changes to the regulatory and monitoring processes will minimise reputational and financial risks to the Trust as a result of complaints.

This report provides assurance that the requirements of the NHS Complaint Regulations 2009 have been met, through the production of a Trust Annual Complaints report.

The report provides an overview of the complaints process, the numbers and trends in complaints, actions taken as a result of and learning from complaints. It will also provide a summary of achievement against the complaint priorities for 2018/19 and outline the complaints priorities for 2019/20.

Of note, there has been a 7% decrease in complaints during the year to 137, compared with 148 the previous year.

All internal and external agreed Key Performance Indicators for the year were met.
All complaints were risk-rated in line with the Trust's Risk Management Guidelines.
The level of satisfaction with the way we have handled complaints has remained high.

REPORT RECOMMENDATION:

The Council of Governors is asked to:

- Note the annual complaints report

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

Note and accept	Approve the recommendation	Discuss
X		

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

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Safe and efficient processes that are patient centred.
PREVIOUS CONSIDERATION:
Executive Team on 6 August 2019 and Quality & Safety Committee on 28 August 2019. Approved by Trust Board on 4 September 2019.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Annual Complaints Report 2018/19

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 regards to complaints received by the Royal Orthopaedic Hospital NHS Foundation Trust between 01/04/2018 and 31/03/2019. 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 2018/2019 were agreed as listed below:

- 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.

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 Deputy Director of Nursing. The Executive Director of Nursing & Governance 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. Compliments, PALS Concerns and FFT Concerns are also entered on the same module. This has enabled more accurate and responsive trend and theme analysis across all Patient Experience data 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 process is still heavily reliant on the Patient Services Team and the management and ownership of complaints within the Directorate will form part of the developmental work in 2019 /2020

5.0 Number of complaints

In 2018/2019, ROH received 138 formal complaints. 1 was withdrawn leaving a total of 137 to be investigated and formally responded to.

Figure 1 below shows the total number of formal complaints received over a three-year period.

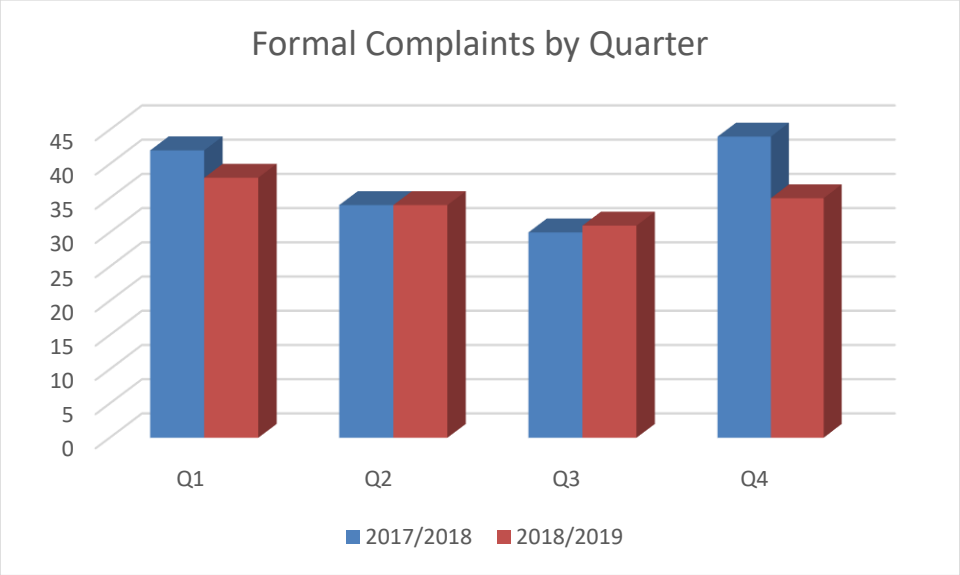
Figure 1: Numbers of complaints received 2018/2019

Formal Complaints	2016/2017	2017/2018	2018/2019
	167	148	137

Formal complaints experienced a 7% decrease compared to the previous year

Figure 2 details the number of complaints by quarter in 2018/19 with the previous year's data for comparison.

Figure 2: Number of complaints by quarter

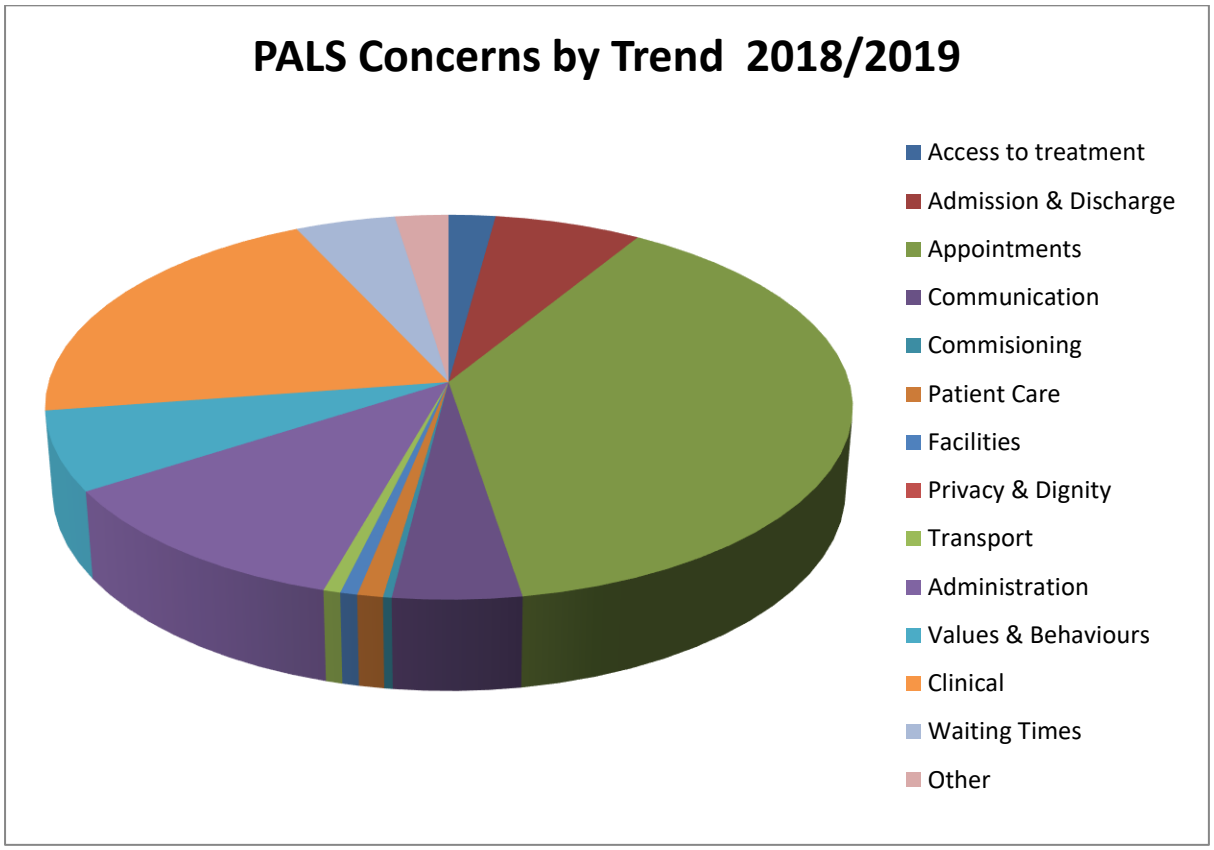


6.0 PALS Contacts during 2018/2019

The PALS department has handled 1531 individual contacts in the last twelve months, which has greatly reduced as planned from last year, due to the removal of the PALS number from every letter leaving the Trust. This was identified as not helpful for patients as the majority of the calls were enquiries, which needed to be passed onto other departments, resulting in a less efficient service for patients. The letters were changed to ensure that patients are signposted to the right service for help, thereby streamlining their experience and leaving the PALS department to manage calls relating to concerns and assistance more effectively. This has been achieved; 41% of PALS calls this year were concerns that required more assistance, compared with 22% the previous year.

Figure 3 below shows the themes recorded for PALS Concerns in the year.

Figure 3: Number of PALS Concerns by Trend



The most common concerns expressed via PALS in 2018/2019 were:

- Appointments: including length of wait for appointments and cancellations
- Clinical advice: including pre and post- operative advice/questions
- Administration queries: including clinic letters and referral letters

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 2018/2019

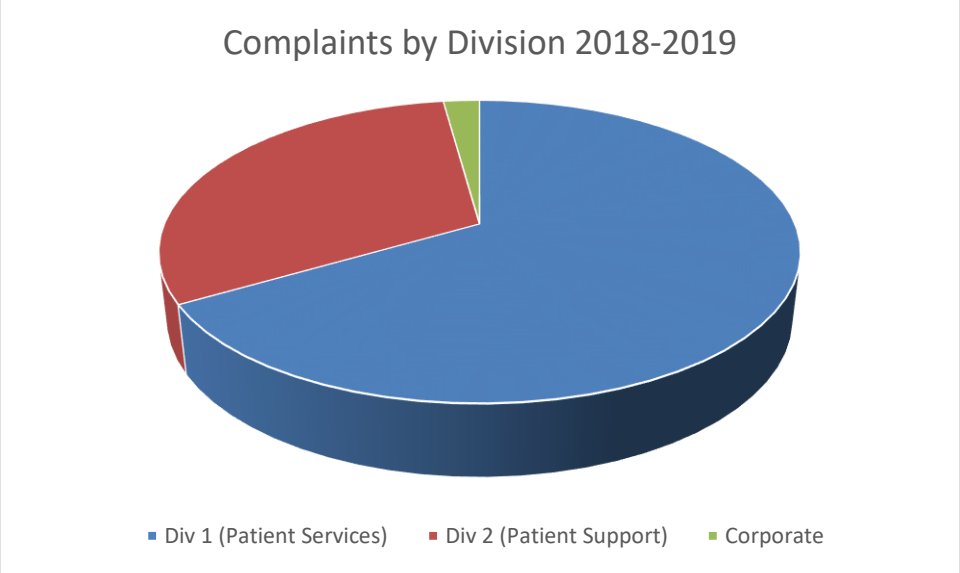
	2018/2019	2017/2018
Inpatient Attendances		
Inpatient Complaints	57	74
Inpatient Episodes	14,444	14,646
Complaints per 100 inpatient episodes	0.39%	0.51%
Outpatient Attendances		
Outpatient Complaints	81	74
Outpatient Episodes	70,735	66,642
Complaints per 1000 outpatient attendance	0.11%	0.11%

The Trust has seen a decrease in Inpatient Complaints and no change in Outpatient Complaints over the year. It should also be noted however that a significant increase in outpatient appointments did not generate an increase in outpatient complaints.

8.0 Number of Complaints by Division

Figure 5 below illustrates the number of formal complaints by each Division in 2018/2019.

Figure 5: Number of Complaints by Division 2018/2019

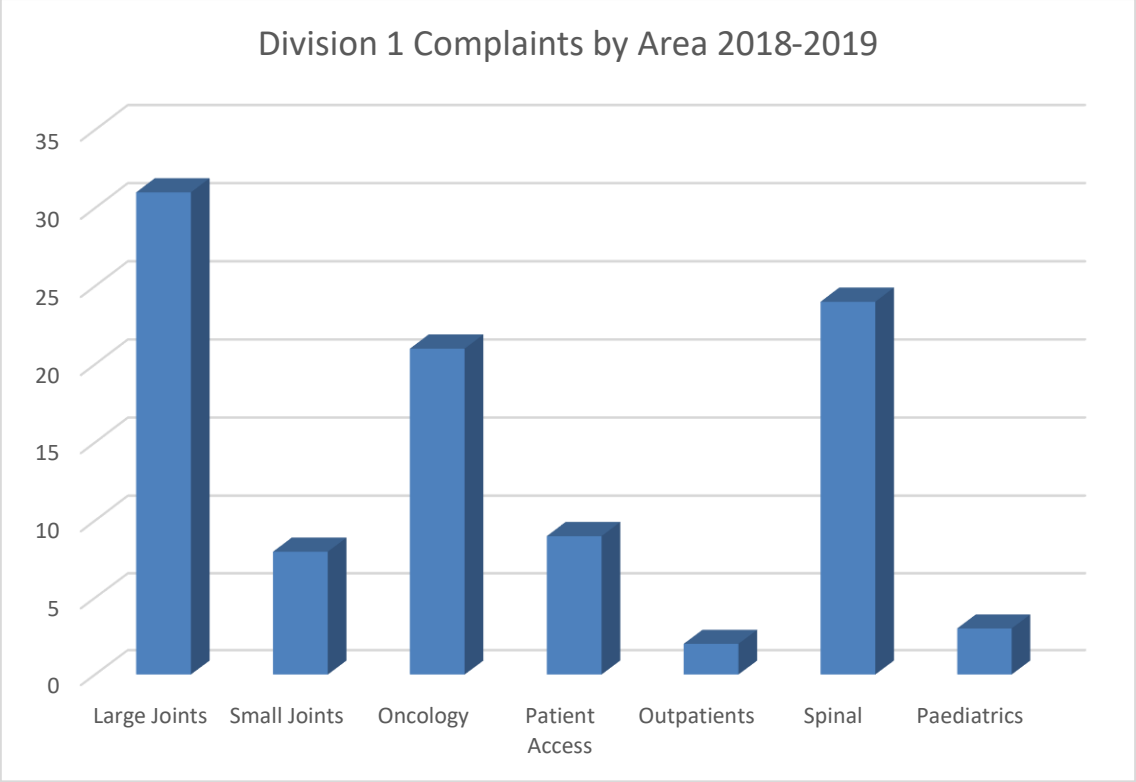


The majority of complaints (67%) relate to the Patient Services Division which is to be expected since this Division oversees all inpatient areas and outpatient departments, compared to Division 2 which oversees Theatres & HDU, the Admission and Day Care Unit, Pre-operative Assessment, all Therapy Services and all Imaging Services. This

is a slight decrease from 70% last year. The two areas with the highest number of complaints in 2018/19 were the Large Joint (19%) and Spinal Services (14%).

Figures 6 below provides an in-depth breakdown of complaints within Division 1

Figure 6: Number of Complaints by area in Division 1 2018/2019



The largest numbers of complaints in Division 1 related to concerns about the Large Joints Service (35% of Div.1 complaints this year). These related to all aspects of the service, including clinical treatment, care provided and administration processes.

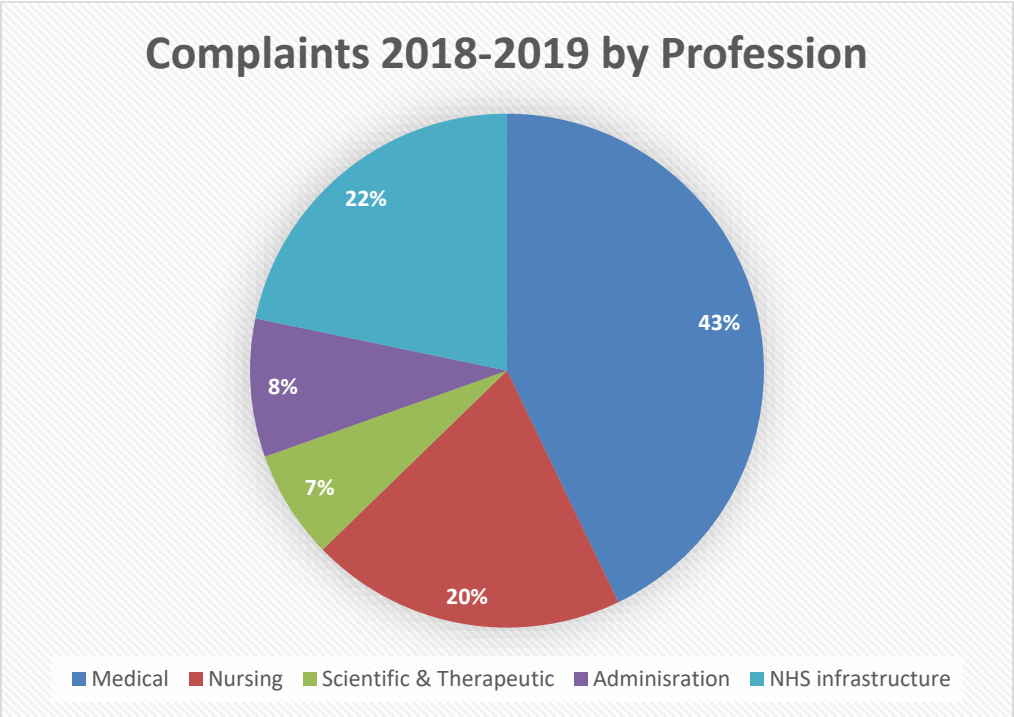
8.1 Spinal Service complaints

The spinal service has received a lower number of complaints about paediatric spinal patients this year. (17% of complaints about the spinal service in 2018/2019 relate to children and young people, compared to 46% in 2017/2018) 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.

In addition, the Trust undertook a focussed approach to ensuing that patients who had been waiting over 52 weeks for surgery were listed and treated by 2019, which has meant that people are experiencing less waiting time, which was a major source of complaint previously.

9.0 Complaints by Profession

Figure 7: Number of Complaints by Profession 2018/2019



Medical Staff were the largest professional area complained about in 2018/2019. This is reflective of the more complex and specialist activity carried out in the Trust. Many of these complaints are made by patients who have been referred from other hospital for a second or third opinion. The complaints received during this year raised concerns about surgical outcome (not happy with the result), complications (usually known, discussed and consented for), clinical opinions (different clinical opinion about condition) and treatment options (e.g. wanting surgery but this is not an option).

This is like the last two years, although the number of complaints relating to infrastructure support within the hospital has continued to increase, such as the management of referrals and typing of clinic letters) It is believed that this is related to more accurate coding of complaints, whereby long waits for appointments or rescheduling are recorded under this area, rather than to the actions of a specific administrator or clinician.

10.0 Complaints by Subject

Figure 8: Complaints by Subject 2018/2019

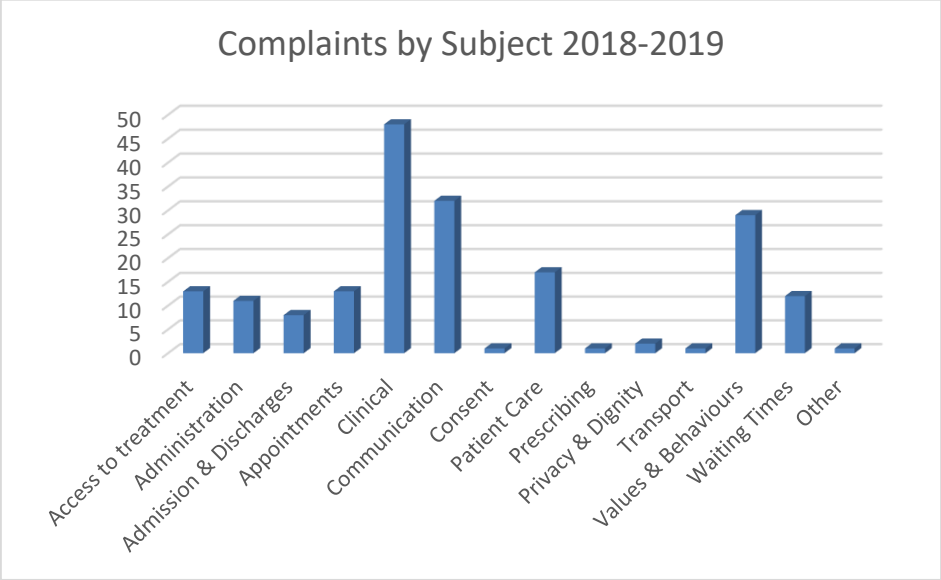
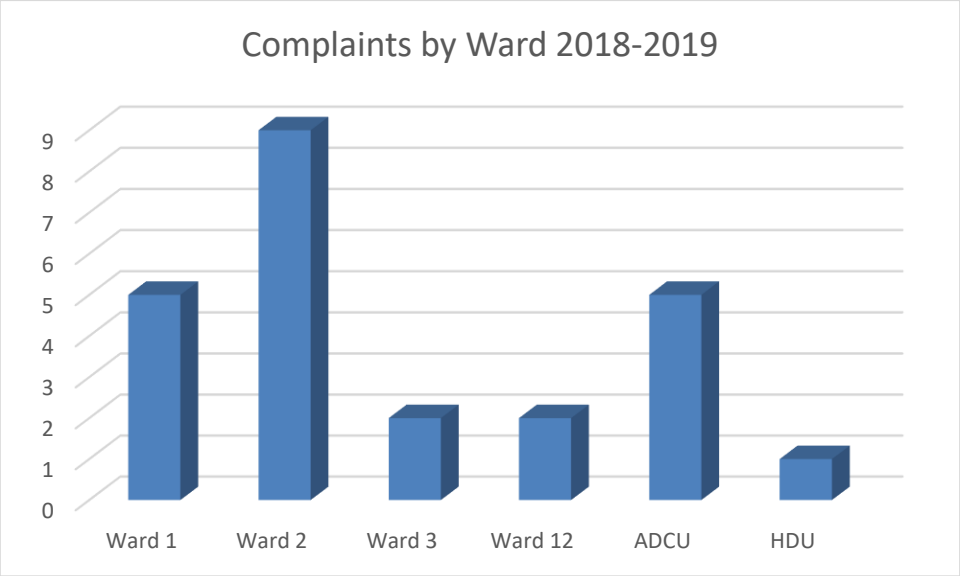


Figure 8 shows the main causes for complaints in 2018-2019, with dissatisfaction with clinical treatment, communication with patients/others and values & behaviours of staff being the highest reasons. These themes show changes from last year and as such provides some assurance that actions are being taken to address identified issues

A review of complaints mentioning values & behaviours of staff is being undertaken to identify any areas of commonality. Additional actions such as training or monitoring will be undertaken where appropriate.

11. Complaints by Ward during 2018/2019

Figure 9: Complaints by Ward 2018/2019



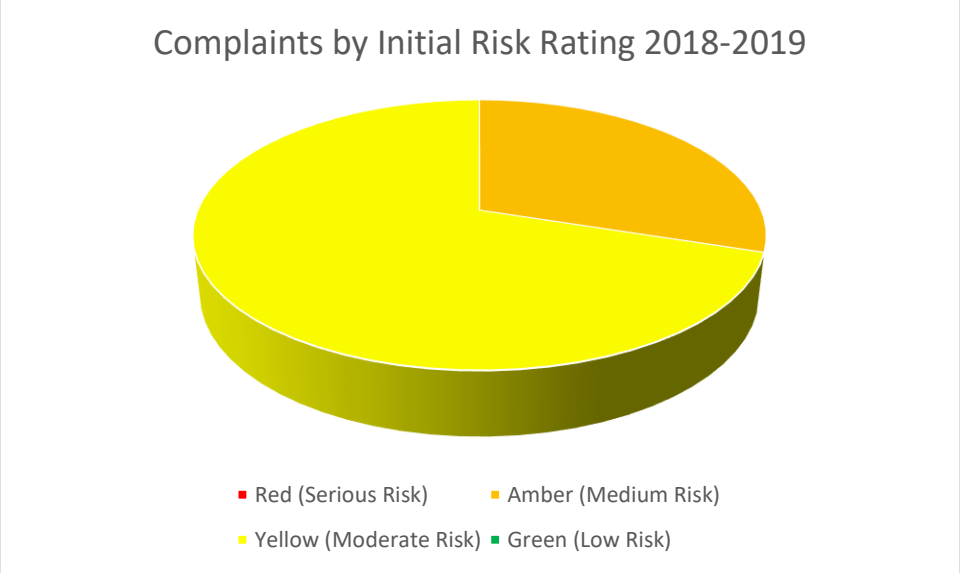
Concerns about aspects of ward care or treatment has been mentioned in 17.5% of complaints this year, which is lower than last year (24%). This local indicator was

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 to be maintained.

It should be noted that Ward 2 looked after the most inpatients in 2018-2019, which may explain the higher number of complaints received.

12. Risk Ratings of Complaints during 2018/2019

Figure 10: Initial Risk Rating of Complaints 2018/2019



The Trust has a robust system of tracking and monitoring complaints. Part of this tracking involves the logging of an initial risk rating. The Patient Services Manager monitors these risk ratings and the Deputy Director of Nursing 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 2018/19 the Trust had 2 contractual complaints KPI's which were reported to the Trust Board, via the Quality Report and the Commissioners, via contractual reporting 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 ROH complaints procedure states that an acknowledgement should be made within three 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 three. 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 2018/2019 were acknowledged verbally or by e-mail within the correct timescale, thereby meeting the KPI.

95% of complaint letters were formally acknowledged by letter within the agreed timescale. This KPI was met.

All complaints received via Commissioners were responded to within the timescale agreed with them. 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 Deputy Director of Nursing, 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 agree 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 at 93%.

14.0 Outcome of complaints made in 2018/2019

Figure 11: outcome of complaints 2018/2019

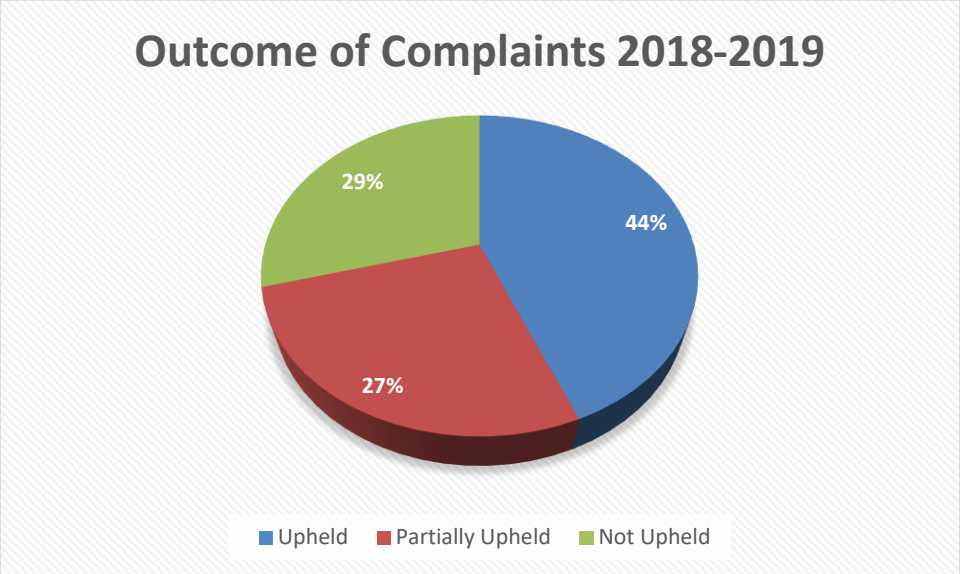


Figure 11 shows the outcome of complaints made in 2018/2019. The Trust upheld some aspects of 71% of the complaints made in this year, which is slightly lower than last year (78%). Complaints are coded in line with the guidance from NHS Digital and there may be more than one aspect in each complaint. 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 2018/2019, a total of 43 satisfaction surveys were returned by complainants representing 31% 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 handling of their complaint was 100%, which is an increase from last year. In addition, 95% of respondents indicated that they felt that the complaints staff were helpful, sympathetic and professional.

There was a reduction in complainants being happy with the time taken to answer their concerns to 65% (compared to 87% last year). This will be reviewed in 2019/2020

The information from the full satisfaction survey will continue to be reviewed and used to inform further improvement work in 2019/2020.

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 2018/2019, the PHSO requested information about 4 complaints made to the Trust. 1 was not upheld and 1 was declined by the PHSO for investigation. 2 are still under investigation currently and the outcome is not yet known.

17.0 Listening and Learning from Complaints

Patient Story

Ms X made a formal complaint about aspects of the care that she was receiving on a Ward. She was concerned about another patient opposite whom she felt was isolated and had no-one to speak up for her, which she also added into her complaint. She stated that other patients whom she had been in a bay with had the same concerns. This information was taken by the PALS Manager who had visited Ms X on the ward at her request.

The PALS Manager discussed all of the concerns with the Patient Services Manager and then contacted the Head of Nursing for Patient Services. He immediately went to the Ward concerned and discussed Ms X's concerns with her directly. He then took the opportunity to talk to all of the other patients in the same bay.

Together with the Ward Manager, the Head of Nursing took some immediate actions to offer assurance to all of the patients involved that their feedback had been taken seriously.

Ms X felt very happy that action had been taken so swiftly and was assured enough to accept that information about the other patients could not be shared with her.

As a result of Ms X's complaint and information taken from the other patients, a ward action plan was created and monitored by the Head of Nursing. This was shared with

Ms X as part of her complaint response, together with an expression of thanks for sharing her concerns which enabled corrective action to be taken.

Complaints are reviewed and signed off at senior level within the Trust 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 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 2018/2019, 12 individual action plans were created. A further 34 complaints had actions that were completed prior to the response being sent. 10 responses had actions that were part of a larger work stream and 3 had the actions incorporated into a more in-depth Governance investigation. 1 complaint resulted in a HR investigation.

Learning and actions taken as a result of Complaints in 2018/2019 include:

Learning	Action
RCA had not been completed as thoroughly as expected (historical)	RCA reviewed, redone and shared with complainant with apologies
Changes to pre-operative protocol for aspirin in spinal patients has not been communicated to pre-op	Teams have met to address this
Some miscommunication has occurred as a result of the changes to Non-Emergency Patient Transport and eligibility for reimbursement	Position has been clarified and all relevant departments notified
Stand-alone IT equipment was not all encrypted; IG threat identified when laptop was stolen	Information Commissioner notified; all patients contacted; all stand-alone equipment checked and encrypted; all security reviewed

Patients arriving for biopsy were not aware that they may be waiting for a prolonged period of time	Biopsy Leaflets are being reviewed and amended
There is a possibility that Privacy & Dignity could be compromised with the current curtains on some wards	New curtains are currently being trialled and the old ones will be replaced
Escalation process for concerns about biopsy patients to their Consultant was not robust	All biopsy patients now see the on-call Doctor before discharge
Policy for discharging DNA patient's is being applied differently in different departments	Teams have been reminded of current policy and Clinical Service Manager for Patient Access informed
Staff supplied correct information regarding safety but did so in an inappropriate manner	Reflective session undertaken and training provided
Trust did not have a SOP for the management of wound drains	SOP created and has been approved
Frist floor outpatient reception not open causes confusion for patients when told to report there	Recruitment underway; information updated

17.0 Looking ahead to 2019/2020

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 2019/2020:

- Work will be undertaken with Divisional Leads to further in-bed ownership of complaint investigation and action planning
- Complaint investigation and report writing training will be available in house for staff that require it
- The KPI of 80% of complaints completed within the agreed timescale will be achieved.
- The coding of compliments will be altered to the same system for complaints to allow for direct comparison of all Patient Experience data.

18.0 Conclusion

At the ROH, we remain committed to investigating, learning from and acting 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 2017/2018 priorities for the Complaints Department

Priority	Status	Detail
The Ulysses system will be further modified to allow all complaints reports to be pulled directly from this system.	Partially Achieved	Thematic reporting is now pulled directly and information for Departments. KO41a is still not available and will be rectified in the coming year
Complaint investigation and report writing training will continue to be provided for staff that require it.	Achieved	All Directorate Leads and Senior Staff have received training.
The KPI of 80% of complaints completed within the agreed timescale will be achieved.	Achieved	Data is submitted monthly
The coding of PALS Concerns will be altered to the same system for complaints to allow for direct comparison of the data.	Achieved	All data is now coded and shared monthly with Departments

Appendix B

Trust Risk Rating Matrix

	SEVERITY				
LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM riskRed = HIGH risk**

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS	
DOCUMENT TITLE:	**Fit and Proper Persons Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Dame Yve Buckland, Trust Chair**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs and Company Secretary**
DATE OF MEETING:	**10 October 2019**

EXECUTIVE SUMMARY:

In line with the Trust's Fit and Proper Persons Test (FPPT) Policy, the Nomination & Remuneration of the Trust Board is required to receive an annual report that provides assurance that all those covered by the regulation meet the required standards.

The report attached, provide a reminder of the detail of the regulation as a refresh for Committee members.

The report also provides assurance that the Trust is compliant with the regulation and the Trust's own policy and that there are currently no issues of concern relating to those covered by both; a matter confirmed by an audit of personal files over the summer.

The report outlines some ways in which there is a plan to strengthen the current practice in relation to the FPPT.

REPORT RECOMMENDATION:

The Committee is asked to:

- RECEIVE and NOTE the reminder of the background behind the Fit and Proper Persons Regulation
- NOTE the plan to include the annual report on Fit and Proper Persons within the routine appraisal update the Council of Governors
- NOTE and ACCEPT the assurances that the annual self-declaration process deems the Board members and Executive Team compliant with the requirements of the Fit and Proper Persons Test

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	x
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:

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Delivered by highly motivated, skilled and inspiring colleagues
PREVIOUS CONSIDERATION:
Nominations & Remuneration Committee of the Trust Board on 4 September 2019

FOR ASSURANCE

ROHGO (10/19) 004 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FIT AND PROPER PERSONS REGULATIONS

Report to Council of Governors – 10 October 2019

1 EXECUTIVE SUMMARY

1.1 It is a requirement of the Trust's Fit and Proper Persons Policy (attached) that an annual report is presented to the Nominations and Remuneration Committee of the Trust Board and Council of Governors to provide assurance that there is adherence to the policy and that all staff covered by the policy remain classified as Fit and Proper.

2 THE FIT AND PROPER PERSONS REGULATIONS

2.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the FPPR. The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at board meetings. These regulations were introduced in November 2014 and the fundamental standards came into force in April 2015.

2.2 The regulations (Section 1, Paragraph 5, or 'Regulation 5' as CQC refers to them in its guidance) place a duty on trusts to ensure that their directors, as defined above, are compliant with the FPPR. The regulations stipulate that trusts must not appoint or have in place an executive or a non-executive director unless they meet the standards set out in this regulation. While it is the trust's duty to ensure that they have fit and proper directors in post, CQC has the power to take enforcement action against the trust if it considers that the trust has not complied with the requirements of the FPPR. This may come about if concerns are raised to CQC about an individual or during the annual well-led review of the appropriate procedures.

2.3 Summary of requirements

According to the regulations trusts must not appoint a person to an executive or non-executive director level post unless, as stated in Paragraph 5 (3), they meet the following criteria:

- are of good character
- have the necessary qualifications, competence, skills and experience

- are able to perform the work that they are employed for after reasonable adjustments are made
- have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- can supply information as set out in Schedule 3 of the Regulations

When assessing whether a person is of good character, Paragraph 5 (4) of the regulation states that trusts should make every effort to ensure that, as a minimum, they seek all information to confirm the matters listed in Part 2 of Schedule 4.

In accordance with Part 2 of Schedule 4, a person will fail the good character test if they:

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

Part 1 of Schedule 4 lists categories of 'unfitness' that would prevent people from holding office or necessitate their removal from their position as a director, and for whom there is no discretion:

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

3 TRUST'S POLICY

3.1 The Trust is required to extend the Fit and Proper Persons checks to Director and 'Equivalent' positions, which at the ROH this is Board and Executive Team members, including associates and non-voting members and Associate Directors. This is in line with practice elsewhere.

3.2 In addition to the usual pre-employment checks for new starters, the Trust also employs the services of an external agent to undertake checks against the Disqualified Directors register and the bankruptcy and insolvency register. Individuals are also required to sign a self-declaration that they meet the requirements to be a Fit and Proper Person.

3.3 Disclosure and Barring Scheme (DBS) checks are sought on appointment and at present and in accordance with the Trust's recruitment policy for all other staff, there is no standard practice to renew these checks after a period of time in post. It is proposed however, as additional assurance, that DBS checks for those covered by the Fit and Proper Persons Test policy, checks are undertaken by routine every three years or on reappointment if appropriate.

3.4 Although the policy is clear that it is the onus on individuals to bring to the attention of the Chair or Chief Executive any issues which during the period of their tenure may compromise their ability to declare themselves Fit and Proper, an annual self-declaration is requests of individuals to confirm that they are Fit and Proper. This annual process has been completed for 2019, with all individuals returning a signed self-declaration providing assurance that they can be classed as Fit and Proper. Personal files of the Executive Team and Board members have been audited over the summer to confirm that the appropriate documentation is available to demonstrate that the Fit and Proper Persons Policy has been followed.

3.5 It is proposed that the Council of governors receive this assurance as an annual report, this being timed to coincide with the discussions around appraisal of the Non Executives in October each year.

4 CONCLUSION AND RECOMMENDATION

4.1 The Council of Governors is asked to:

RECEIVE and NOTE the background behind the Fit and Proper Persons Regulation

NOTE the plan to include the annual report on Fit and Proper Persons within the routine appraisal update the Council of Governors

NOTE and ACCEPT the assurances that the annual self-declaration process deems the Board members and Executive Team compliant with the requirements of the Fit and Proper Persons Test.

Simon Grainger-Lloyd
Director of Corporate Affairs & Company Secretary

4 October 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Fit & Proper Persons Policy

VERSION NUMBER	3
REVIEW DATE	January 2020
DATE PUBLISHED ON INTRANET	May 2019

Document Control Information

AUTHOR (POLICY FACILITATOR)	Associate Director of Governance and Company Secretary
DIRECTOR / POLICY SPONSOR	Chief Executive
RATIFIED BY (Committee/ Group) **DATE OF RATIFICATION**	Initially approved by the Trust Board on 4th February 2015. Version 2 (minor amendments) approved by Chief Executive in January 2019.
NAME OF LOCAL GROUP / FORUM APPROVING THE POLICY	Trust Board
DATE OF LOCAL GROUP APPROVAL	N/A

VERSION TRACKING

Version	Date	Author Name and Designation	Summary of Main Changes
1	26 January 2015	Kerry Pinker – HR Associate	Amendments as requested by Director of Workforce and OD
2	18 January 2019	Simon Grainger-Lloyd, Associate Director of Governance and Company Secretary	Change of policy author; removal of need to undertake DBS check on an annual basis; streamlining list of roles covered by FPPT
3	9 March 2019	Simon Grainger-Lloyd, Associate Director of Governance and Company Secretary	Removal of three posts from being covered by the FPPT Policy to align it better to other NHS policies

PROCEDURAL CHECKLIST

CONSULTATION COMPLETED	Y
CONSULTATION TRACKING SHEET COMPLETED	Y
VERSION CONTROL INFORMATION COMPLETED	Y
EXECUTIVE GOVERNANCE COMMITTEE CHECKLIST COMPLETED (APPENDIX M1)	Y
IMPLICATIONS FOR IMPLEMENTATION COMPLETED (APPENDIX M2)	Y
EQUALITY IMPACT ASSESSMENT COMPLETED AND DECLARATION FORM (APPENDIX M3)	Y
IMPLEMENTATION PLAN COMPLETED (APPENDIX M4) **DATE SUBMITTED TO POLICY COORDINATOR** **APPROVED BY POLICY COORDINATOR** **DATE APPROVED TO RATIFICATION COMMITTEE**	Y 26th January 2015 26th January 2015 4th February 2015

CONSULTATION TRACKING SHEET

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

Name of Policy, Procedure or Guideline: Fit & Proper Person Policy

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

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

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

PERFORMANCE MANAGEMENT OF THE POLICY

Responsible for Producing Action Plans if KPIs are Not Met	**Committee to Monitor These Action Plans**	**Frequency of Review (To be agreed by Committee)**
Associate Director of Governance and Company Secretary	Nomination Committee of Trust Board and Council of Governors	Annual updates & As necessary

Contents

1. Executive Summary

Policy Description

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

2. Introduction

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

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

3. Policy Objectives

The policy objectives are;

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

4. Scope

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

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

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

5. Duties / Responsibilities

5.1 Chair

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

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

5.2 Nominations and Remuneration Committee of Trust Board

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

5.3 Council of Governors

Receive an annual report on application of FPPR to Non-Executive Directors via an update from the Nominations and Remuneration Committee of the Council of Governors.

5.4 Associate Director of Governance and Company Secretary (ADGCS)

The ADGCS is responsible for:

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

5.5 Affected Individuals

Individuals who fall within the policy are responsible for:

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

5.6 Members of Staff

Raise issues of concern via appropriate processes and/or policies i.e. Freedom to Speak Up Policy.

6. General Principles

6.1 What is a "fit & proper person"?

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

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

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

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

Identified Position	Who (the delegate) with authority to approve a person as "fit & proper"
Chair	Lead Governor
Executive Directors	Chair
Non-Executive Director (excluding Chair)	Chair
Chief Executive	Chair

Executive Team members (other than the Executive Directors), Chief Information Officer and Chief Pharmacist	CEO

6.3 Fit & Proper Person Test

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

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

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

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

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

6.4 The Nolan Principles

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

7. Policy Procedures

Director & 'Equivalent' appointments

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

Disqualification

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

Decisions for Candidates

The Chair and/or Chief Executive will notify any prospective candidate for appointment as soon as is practicable if that person is determined to be ineligible under this Policy.

Existing Staff

Investigation

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

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

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

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

Fit & Proper Person Hearing

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

Fit & Proper Person Appeal Hearing

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

Evidence

The regulations require certain information to be available as evidence in respect of

persons employed or appointed by the Trust. The information required is described in *Schedule 3* of the Regulations (***see appendix 3***).

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

Confidentiality

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

8. Dissemination Process – all policies

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

9. Equality and Diversity

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

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

10. Supporting References

CQC Guidance for NHS Bodies November 2014	Regulation 5: Fit & Proper persons: directors and Regulation 20:duty of candour
Health & Social Care Act 2008 (Regulated Activities) Regulations 2014	SI 2014/2936, reg 20; SI 2014/2936, reg 5
NHS Guidance	NHS Employers Employment Checks etc
Professional Standards Authority	Standards November 2013
Charities Commission Guidance	2013/14
Disclosure & Barring identity Check Guidance	July 2014
Equality & Human Rights Commission	Employment Statutory Code of Practice

NHS Standard Contract 2014/15:	Updated Technical Guidance (Appendix 5: Contractual requirements relating to duty of Candour
NHS Patient Safety Agency, being Open Framework	Provision of guidance on communicating about patient safety incidents with patients, families and carers
National Patient Safety Agency,	Definitions of levels of harm
Seven Steps to Patient Safety	
CQC (Registration requirement) Regulations 2009	Regulations 16-18 outline the notifications required by CQC
NHS Litigation Authority	Saying Sorry
General Medical Council Guidance	Good Medical Practice 2001, Guidance on 'duty of candour'
Trust policies	Freedom to Speak Up Policy Safeguarding Policy Incident Management Policy Recruitment & Selection Policy Disciplinary Policy

11. Training

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

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

12. Appendices to this policy

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

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

- Chair
- Non-executive Directors
- Executive Directors, including Chief Executive

Equivalent Positions

- Associate Director of Governance and Company Secretary
- Associate Director of Workforce, HR and OD

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

Fit & Proper Persons Director/Equivalent Declaration

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

PART 1 Unfit person test

I hereby confirm that I am **NOT**

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

PART 2 Good Character

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

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

PART 3 General

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

Date:_____ Signature: _____

Print Name: _____

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

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

APPENDIX 4 – INDIVIDUAL CHECK SHEET

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

APPENDIX 5 – CQC GUIDANCE ON EVIDENCE TO MEET FPPR REGULATIONS

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

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

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

20(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing— • The provider must ensure that written notification is given to the relevant person following the notification that was given in	N/A	Compliance with following policies: • Incidents Policy • FPPR Policy

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

APPENDIX 6 – LIST OF NOLAN PRINCIPLES

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

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

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

12. Mandatory Appendices Bundle

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

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

Name of Policy Facilitator / Policy Sponsor: Director of Workforce & OD

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

Additional comments from the group approving the policy	none
Name of group approving the policy	**Board**

Chair of the group approving the policy	**Chair**
Signature on behalf of the group	

APPENDIX M2: Implication for implementation of this policy

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

Date: 26th January 2015

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

Name of Policy Facilitator: Associate Director of Governance and Company Secretary

Name of Policy Sponsor: Chief Executive

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

Staffing issues arising from implementation of this policy:

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

Training issues arising from implementation of this policy:

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

Funding/Cost Issues arising from implementation of this policy:

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

Barriers to implementation of this policy:

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

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

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

APPENDIX M3: Equality Impact Assessment Form

Equality Impact Assessment
Form A – Policy Screening Impact Assessment

Fit & Proper Person Test Policy	
The completion of appropriate checks to ensure that new appointments and existing personnel is essential to ensure that the statutory requirements (*Health & Social Care Act 2008 (Regulated Activities) Regulations 2014)* are met and that members of the Board and equivalent positions are carried out by fit and proper persons to safeguard quality of care.	
Name and details of those involved in the screening equality impact assessment	HR Associate
Date of screening assessment	26th January 2015

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

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

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

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

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

APPENDIX M4: Implementation Plan – Fit and Proper Persons Policy

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

ROHGO (10/19) 005

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM TRUST BOARD TO COUNCIL OF GOVERNORS

Date Group or Board met: 6 June 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• As part of the upward report from the Quality & Safety Committee, it was reported that there remained more work to do to develop the governance processes around water safety; the safety of the water used in the Trust was not in question however. • Further work was planned to strengthen the Trust's health and safety structures and processes. • The Board was alerted to the potential risk around achievement of the Control Total as a result of the pensions tax liability issue that affected some senior staff including consultants. As a consequence, there were a number of staff who were unwilling to undertake additional work, outside their contracted job plan which might create a shortfall in the amount of activity that was handled by the Trust. • The Board reviewed the risks around nurse staffing and noted that two of these would be closed when the paediatric services moved away from the ROH.	• The new Nursing & Midwifery standards for education and training had been discussed by the Staff Experience & OD Committee and there was good work underway to prepare for their introduction. • Update on JointCare to be presented at a future meeting. • A session on the use of control charts would be arranged for the Board.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Board watched a video of a patient who described his experience of the JointCare pathway, which was very positive. It was noted that the JointCare reunion events were working well and patients were receiving well the opportunity to meet up again. • It was reported that the work to implement the new modular theatres was progressing well. • The Board was advised that the Council of Governors wished to thank the Executive Team for their hard work to generate a sound and engaged environment at the ROH. • Work was continuing to develop the orthopaedics pathway across the STP and Mr Pearson, former medical director, was working with Heartlands, Good Hope and Solihull Hospitals to progress this work.	• The Board approved the establishment of a Hospital Management Group which could comprise the Clinical Service Leads and the Executive Team. It would meet monthly and report up to the Board through the Chief Executive's update. • The Board approved the annual declarations associated with the governance statement and that it had discharged its duty to provide adequate training to the Council of Governors.

• There was noted to be some good improvement in the way that NICE guidance was handled by the organisation. • Good progress was being made with the plans to transfer paediatric services to Birmingham Children's Hospital (BCH) and a celebratory event was planned to mark the transfer of the service and say farewell to staff that were transferring over. • There had been a reduction in the number of incidents reported during the month. There was also 100% compliance with the WHO checklist. • It was reported that the financial position was positive for the first month and there was evidence of good grip on the Cost improvement Programme. • There was good progress with the 'Perfecting Pathways' programme. • Excellent progress with the recruitment of new, substantive nurses to help staff the modular theatres was reported. • Cancellations on the day of surgery were noted to have reduced markedly. • There was strong performance against the diagnostics target and the Quality Standard for Imaging accreditation was being sought. • There remained no patients waiting for treatment in excess of 52 weeks. • The update from the Staff Experience & OD Committee reported that there was some good work to use apprenticeships within the Trust and this was acknowledged as best practice across the region. All the apprenticeship levy allocation had been used by the Trust. • The Board noted an improvement in the quality metrics associated with nursing care. • The Board received an update on nurse revalidation.	

Chair's comments on the effectiveness of the meeting: It was noted that the meeting had finished ahead of schedule. The balance of discussions was noted to be positive.

ROHGO (10/19) 006

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM TRUST BOARD TO COUNCIL OF GOVERNORS

Date Group or Board met: 3 July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Board was advised that there remained some amendments to the VTE policy that needed to be made based on new NICE guidance issued. It was reported however that no patients had been placed at undue risk of developing a VTE under the existing policy however as the current prophylaxis was beyond the national minimal standards. • Manual handling mandatory training for porters was noted to need to be delivered. • It was reported that a Never Event had occurred. There were reported to have been five moderate harm events during the month, all of which would be subject to a Root Cause Analysis. • Performance against the national operational targets was noted to be good, however the financial performance was below trajectory due to the activity casemix. The pensions tax issue continued to impact significantly on the position. Additional consultant resource was being secured to address this position.	• Managed service contract and an update on 'Perfecting Pathways' to be presented at the next meeting. • A number of proposals were considered around improving the equality & diversity culture at the ROH which would be progressed over coming months.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Board was joined by Professor Lee Jeys and Mr George Cooper, Consultant Surgeons and Julie Gardner, Assistant Director of Finance who presented an overview of the development of the Bone Infection Service. A patient story was discussed as part of this item which illustrated how the ROH's bone infection service had avoided an amputation. Average length of stay for patients was also noted to have reduced from 20 days to 14. There was reported to be ongoing discussion with commissioners around securing appropriate funding for the cases and establishing the ROH as a centre of excellence at a national level. • It was reported that according to the ROH's national inpatient survey results, the Trust was regarded as performing much better than	• The Board agreed to affix the Trust seal to the Pathology facilities' lease documentation.

expected. This was against the national trend and therefore this was particularly positive. • A commemorative event had been held with the paediatric team to say farewell to staff moving to Birmingham Children's Hospital and to mark the transfer of the inpatient service. Outpatients and the CT biopsy service would remain on the ROH site. • There was reported to be a plan to launch at Health & Wellbeing programme for staff. • It was reported that there had been a Staff Experience & OD Committee workshop held around Health & Wellbeing. A wellbeing officer had been appointed and Kathryn Sallah was nominated as the Health & Wellbeing Board-level champion. • There continued to be good progress with the recruitment of staff for the new modular theatre build. • The Board received a presentation from Professor Surinder Sharma outlining his work to understand the ROH's equality & diversity framework over the past few months.	

Chair's comments on the effectiveness of the meeting: It was agreed that there had been some good discussions at the meeting and the Board was acting well as a Unitary Body. It was suggested that there had been too many presentations at the meeting however and there needed to be care given to ensuring that any duplication between agendas was minimised. The presentation on the Bone Infection Service was praised specifically and was very powerful.

ROHGO (10/19) 007

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM TRUST BOARD TO COUNCIL OF GOVERNORS

Date Group or Board met: 4 September 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There was some delay reported in progressing the plans to create a single model of orthopaedic care across the STP. This delay had been caused by the need for partner organisations to address performance issues and some reconfiguration of the divisional management teams at University Hospital Birmingham NHSFT. It was anticipated that there would be better traction on the work in coming months. • The number of complaints around appointments was reported to have increased and work was underway to understand the reasons behind this spike. • The Board was advised that the activity position was below plan which had an adverse impact on the Trust's financial position. It was anticipated that the position would be addressed to some degree by new consultant locums and substantive staff over the next couple of months. • It was reported that the level of resuscitation training was below expectations and work was being undertaken to ensure that only those groups of staff needing the training were trained. • Appraisal rates were noted to have dipped and work was being undertaken within the divisions and corporate areas to address this and create sufficient focus.	• The presentation on the orthopaedic pathway due to be presented to the STP Board in November is to be shared with the Trust Board at its October Board workshop. • Arrange a training session in the Mental Health Act for the Board. • 'Right sizing' work was reported to be underway to understand the baseline capacity needed to meet the demand. • A further update from the Guardian of Safe Working is needed at the next meeting. • It was agreed that a drive for environmental sustainability in the Trust was needed. This would be taken forward by an environmental sustainability group. A further update on this work was needed at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Board was joined by Sandra Milward, Head of Imaging and Lisa Kealey, Public Services Manager who presented a patient story, where a child with learning difficulties had been treated by the Trust and a number of measures had been taken to ensure that the patient was comfortable and prepared for some diagnostic tests needed, including the use of a picture book to guide them through what they may see and experience at the hospital.	• It was agreed that the 'fly through' software to orientate patients through the hospital could be funded from charitable funds. • The Board approved the proposed changes to the Board Assurance Framework. • The Board approved the annual complaints report. • The Board approved the annual report from the Director of Infection Prevention & Control.

• It was reported that the Trust had been shortlisted for the Health Service Journal 'Trust of the Year' award, the outcome of which would be known in November 2019. • A meeting had been held with a child who had written to the Trust to encourage them to embrace the environmental sustainability agenda by using paper straws for instance. • There was reported to have been a challenge and confirm session around the Board Assurance Framework by the Executive Team, meaning that the version presented had been significantly refreshed. • The VTE policy was reported to have been amended in line with the NICE guidance issued. • Compliance with the WHO checklist was at 100%. • It was noted that it was likely that the clinical negligence premium was likely to be reduced given that the value of claims settled was lower than anticipated. • The Board was given an update on the work undertaken to improve the patient experience framework within the Trust. The use of volunteers was a key part of this work and a carers' strategy had been developed. A learning disability group had also been established and was being embedded. The Board agreed that this was a very positive update. • The Board was joined by Nathan Samuels, Lead Nurse for Learning Disability and Mental Health. The Board was advised that there had been much more work undertaken to improve the awareness of Mental Health in the Trust and to improve the mechanisms to offer support to patients with mental health issues. The current Service Level Agreement with Birmingham & Solihull Mental Health NHSFT was being strengthened. A mental health working group was reported to have been established and a patient representative would be invited to join the membership. • The Board was given an update on compliance with the Learning from Deaths process. There was good evidence of harnessing lessons learned from the few deaths seen at the ROH. Palliative care links were noted to be working well.	• Subject to minor amendment, the Board approved the revised terms of reference for the Nominations & Remuneration Committee. • It was agreed that the next iteration of the Emergency Preparedness Resilience and Response statement should be presented to the Operational Management Board at a future meeting.

• There was an upward trend in private patient income. There were plans to improve this further over the coming year. • There had not been a breach of the agency cap and there was an expectation that medical locum usage would reduce. • It was reported that the implementation of a forum whereby all Executives could discuss workforce matters was being considered. • There were reported to have been no concerns raised from the Guardian of Safe Working, aside from issues over compensatory rest for those junior doctors working across ROH and Birmingham Children's Hospital. • There was reported to be good progress with reducing the Trust's carbon footprint and it was reported that the new modular theatres would be energy efficient. The older parts of the estate presented difficulties however. Staff were committed to recycling. • It was reported that there was nearly complete compliance with the Emergency Preparedness Resilience and Response standards, with the only area of non-compliance being around the Data Protection & Security toolkit, a matter which was being addressed. • The Board reviewed the overall Corporate Risk Register. • Good progress was being made with the CQC action plan.	

Chair's comments on the effectiveness of the meeting: It was agreed that it had been good to hear from the lead nurse for Mental Health and the presentation from the Head of Imaging was also very positive. It was agreed that the Board continued to work well as a Unitary Body. The breakdown of the Board Assurance Framework into the relevant directors' areas was agreed to have been useful.

ROHGO (10/19) 008

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 28 August 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee discussed the detail of two Never Events and two cases when paediatric patients being operated on at Birmingham Children's Hospital (BCH) had developed an infection, which had lead to an adverse outcome. Joint discussions with BCH were underway, however the decision had been taken to suspend the element of this service until actions had been agreed to minimise any further risks. • It was noted that an increasing trend of Urinary Tract Infections had been detected and was being investigated to understand the reasons. An audit of 150 JointCare patients was underway as part of this review. • It was reported that the 24-hour VTE reassessment rate had deteriorated. Work was underway under the remit of the Medical Director to target key groups of staff, including new junior doctors to reinforce the practice. The use of the Prescribing Information and Communications System (PICS) to identify non-compliance would also be used. • There had been an increase in the number of complaints, with 27 having been reported during the month. A number related to rescheduling of appointments. The Committee was advised that this would be addressed through the introduction of partial booking. • It was highlighted that the CQC had noted that the Trust appeared to close over half of Central Alerting System (CAS) alerts late and therefore work was underway to identify the accuracy of this assessment and if so, the systems and processes in the Trust that were causing this apparent delay. • Capacity in the patient experience team was noted to be a concern, given the intention to widen the remit of the team in line with the patient experience and engagement agenda.	• An update on the VTE process to be presented at the next meeting • Update on CAS alerts to be provided at the next meeting. • An update on Patient Reported Outcome Measures (PROMS) to be presented following additional scrutiny by the Executives

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The Committee considered the clinical element of the revised Corporate Risk Register, which it was noted reflected closure of a number of risks associated with paediatric service transfer. • The VTE policy had been amended to be aligned to the national NICE guidelines around VTE prophylaxis. • Compliance with the WHO checklist was at 100%. • An overview of Safeguarding cases was included in the Quality Report to provide additional oversight on behalf of the Board. • Operational performance was noted to be largely good, although the trajectory for the Referral to Treatment Time target had not been met, this being associated with the ongoing issues with arranging consultants to cover additional lists as a result of the tax liabilities concerning pension payments. • There was reported to be good progress with the development of the HealthAssure system. • The audit of groups reporting up to the Quality & Safety Committee showed that there was overall a sound system of governance and escalation. Where there were identified gaps in assurance, these would be addressed directly with the chairs of the groups. • An update on the Trust's mortality and learning from deaths was considered. The overall position suggested that the Trust was not an outlier when compared to a number of other similar organisations. The learning from deaths process was working well, with good quality discussions around deaths included in clinical audit days and literature issues across the organisation. There was also noted to be good support from the clinical governance team around the mortality process. • The Committee received the updated IR(ME)R (ionising radiation) action plan; both outstanding actions had been closed. • The annual complaints report as reviewed which showed an overall decline in the number of complaints received. A key theme concerned appointments and this would be addressed through the	• It was agreed that a demonstration of the HealthAssure system would be provided at the Trust Board workshop in October • It was agreed that the annual report for the Quality & Safety Committee should be presented to the Trust Board. This should reflect the discussion around the need for staff to adhere to paper submission deadlines. • The Committee approved its revised workplan.

Trust's quality priorities. All externally mandated key performance indicators had been met. • The Committee received and noted the annual workplan to achieve compliance with the Hygiene Code • The annual report from the Director of Infection Prevention and Control was received. It was noted that the level of infections was low, although the spike in Surgical Site Infections was being investigated. • The Committee received the water safety action plan which was now presented in the corporate action plan format. There was positive assurance around the processes in place to ensure that the Trust operated with safe water conditions, however there were two outstanding actions which would not be closed until the Autumn (water safety bible and the Legionella Risk Assessment). • It was noted that the Human Tissue Authority (HTA) had signed off the action plan to achieve compliance with the HTA licence. • The Committee was advised that a Root Cause Analysis had been interpreted into a patient's first language. • The resuscitation arrangements in the Trust had been strengthened, including around standardising equipment, training and policies. • The Committee was pleased to receive an update form the inaugural meeting of the Patient Experience & Engagement Group, which demonstrated that patients would be involved more fully in service redesign and the decision-making in the organisation. A particular positive development was the implementation of a patient group for learning disabilities. • An Oncology 2020 plan had been developed, the delivery of which would be monitored through the 'Perfecting Pathways' Programme Board. • The value of the closed claims was noted to be significantly below the level of settlement expected; this would assist with reducing future clinical negligence premia • Good progress had been made with the delivery of the CQC action plan	

- **Chair's comments on the effectiveness of the meeting:** It was agreed that the level of discussion at the meeting was appropriate, with a deep dive into detail when needed. It was suggested that the assurances to the Committee were now provided more proactively, which was a positive development from the position previously.

ROHGO (10/19) 009

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 15 August 2019 (ASSURANCE BRIEFING)

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that the financial position remained below plan, with the position in July having been £90k below the recovery plan. The financial position was £1,107k below the original plan year to date. • The managed service cost improvement programme scheme was noted to have slipped further, although other CIP schemes coming on line were offsetting the impact of this to some degree at present. • The Referral to Treatment Time position was reported to have remained static and was below the trajectory. • Performance against the 62 day cancer target was reported to be 77.8% - this shortfall related to one breach where a patient had needed a second opinion from overseas and therefore the pathway had been unavoidably extended. The position for July was expected to be 100% however. • Appraisal rates were reported to be below trajectory.	• Each element of the recovery plan is to be translated into activity and income. • Define the percentage increase in capacity associated with the new medical staff and identify the maximum baseline capacity, excluding additional duty hours (ADHs) • Develop a summary and reasons for the current financial and operational situation to ensure that it was clear why there was underperformance at present and the plans to mitigate the risks.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The revised financial and operational plan had not needed to be submitted to NHS Improvement as originally anticipated. • It was reported that there was an expectation that the financial position would improve in September, with a small surplus being anticipated. • New medical staff were planned to start shortly and a consultant was planning to run a series of three-day sessions. • Discussions were underway with NHS England/Improvement to secure additional funding to reimburse the Trust for inefficiencies and support associated with the provision of paediatric services across two sites (Birmingham Children's Hospital and the ROH).	• None specifically.

• A higher level of activity for day cases and elective cases had been delivered in July in comparison to the previous month. • There were continued discussions and plans to establish a Limited Liability partnership (LLP) through which the Trust could contract with medical staff to undertaken additional duty hours. Legal advice was being taken to support the plans and models in place elsewhere were also being reviewed for any lessons learned. • The theatre utilisation position was positive. • There remained no patients waiting over 52 weeks and there were reported to be only six patients waiting in excess of 40 weeks. • Mandatory training rates had improved.	
Chair's comments on the effectiveness of the meeting: It was noted that although there had not been a meeting scheduled for August, the discussions had been helpful to provide continued oversight of the current difficulties with the financial and operational performance.	

ROHGO (10/19) 010

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

The Royal Orthopaedic Hospital NHS Foundation Trust

Date Group or Board met: 3 July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that there remained further work to do to attract and offer posts to candidates from a Black and Minority Ethic background. Ensuring that there was representation in the Trust's staff from those with a disability was also to be given focus. • Further work had been identified around the need to capture training needs for staff. • Adult resuscitation training rates were noted to have deteriorated. This would be picked up as part of the work to strengthen the resuscitation committee. • It was noted that there had been limited progress with talent management and succession planning.	• The estates heatmap was noted to be under development. • The reasons for the increased rate of long-term sickness absence associated with musculoskeletal issues to be reported back at the next meeting. • Workforce management information to be reviewed to ensure that appropriate metrics were being considered by the Committee at an appropriate frequency. • The proposals around frequency of reporting to Staff Experience & OD Committee to be considered by the Executive. • For the next iteration of the equality & diversity action plan, evidence to support the ratings is to be clearer. • Consider the terms of reference at the next meeting, particularly to discuss attendance at the meetings.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a positive and inspiring staff story from a project manager, who had previously worked in the IT department. The story illustrated the development opportunities within the Trust and the culture of bond & unity at the ROH. • The overall staff in post position had improved and recruitment into posts to support the new modular theatres was progressing well. The plans to streamline the recruitment processes overall were discussed. Recruitment open days were proving effective. • Sickness absence was reported to have reduced for the third consecutive month, although return to work interviews were not happening as robustly as they could be. • The work to improve the Trust's position against its equality & diversity duties was outlined. This included the support provided by the specialist adviser on equality & diversity that the Trust had engaged.	• The Committee approved the publication of the information to demonstrate the Trust's compliance with the Public Sector Equality Duty.

Chair's comments on the effectiveness of the meeting: It was agreed that the schedule of meetings needed to be revisited and moved to a different and more convenient day; the Director of Corporate Affairs would review options.

ROHGO (10/19) 011

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 19 July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee received a presentation on Cyber Operational Readiness Support (CORS), where it was noted that there was a need to make a number of improvements to the Trust's cyber security processes and framework in order to meet the Cyber Security Plus standards. These actions covered Board level leadership, formal qualifications, policy development and embedding cybersecurity awareness within the culture of the organisation. • It was noted that the Trust was an outlier in terms of agency spend. • Given that the Executive was undertaking an overhaul of the Board Assurance Framework (BAF), the Committee did not have access to the usual update. The process by which the BAF was being updated was described by the Director of Corporate Affairs, with the final updated version to be available to the Trust Board at its next meeting.	• Progress with actions to ensure compliance with the Cyber Security Plus standard to be monitored through Audit Committee. • Counterfraud to work with the Director of Corporate Affairs to understand the organisation's awareness of the need to declare interests. • Update on the new procurement framework to be provided at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The final audit opinion of the annual accounts had been unqualified with the exception of the Use of Resources indicator. • The number of outstanding internal audit recommendations was reducing. • The NHS Procurement Counterfraud exercise was reported to have been completed and submitted on 12 July 2019. • There was good progress overall with the counterfraud work plan. • The counter fraud self-assessment had been submitted by the due date and had been rated as 'green'. • Good progress was noted on the actions related to audits in the Chief Operating Officer's portfolio, including cancer waiting times and Referral to Treatment Time targets. • The Audit Committee received and noted its annual report.	• The Committee approved the rescheduling of the estates management and effective recruitment internal audits.

• The Committee received a helpful paper concerning the Trust's key contracts – the main commissioner contracts had been signed and there were reported to be no queries related to these. The paper highlighted the activity and income associated with each contract.	
Chair's comments on the effectiveness of the meeting: The discussions had been productive and the CORS presentation was seen to be particularly helpful.	

Finance and Performance Report

August 2019

CONTENTS

INTRODUCTION

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

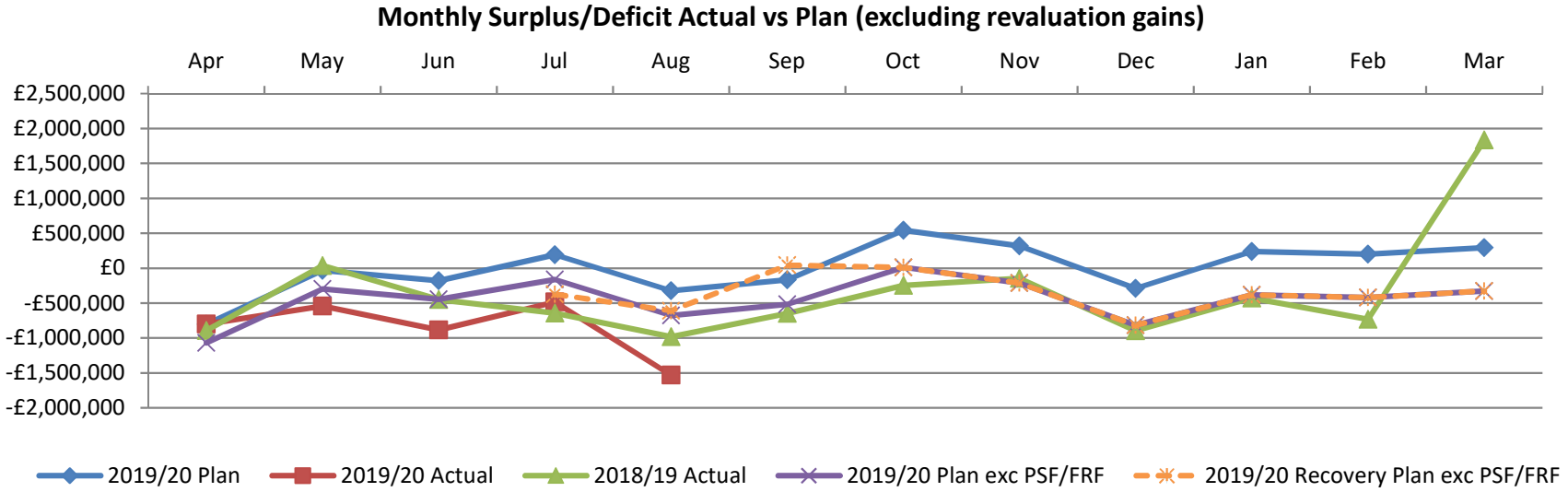
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

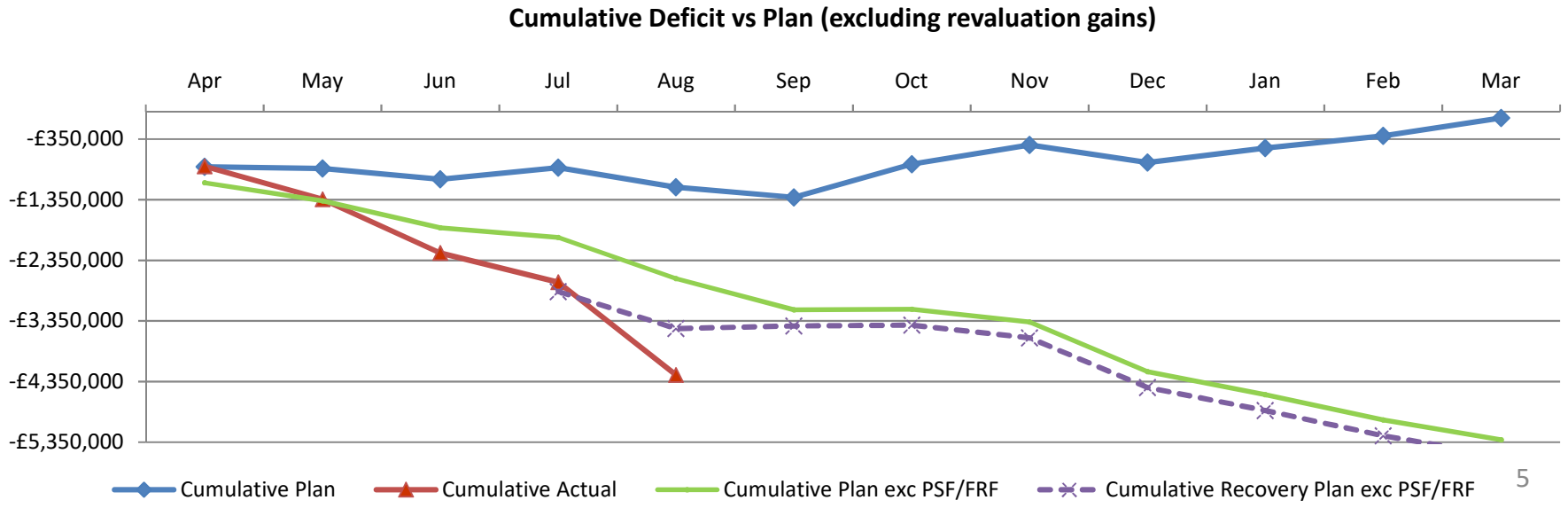
1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M05 Original Plan £'000	YTD M05 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	34,267	31,645	(2,622)
Other Operating Income	1,919	2,083	164
Total Income	**36,186**	**33,728**	**(2,458)**
Employee Expenses (inc. Agency)	(22,742)	(22,428)	314
Other operating expenses	(15,549)	(15,276)	273
Operating deficit	**(2,105)**	**(3,976)**	**(1,871)**
Net Finance Costs	(569)	(534)	35
Net deficit	**(2,674)**	**(4,510)**	**(1,836)**
Remove donated asset I&E impact	25	(110)	(135)
Adjusted financial performance (exc PSF & FRF)	**(2,649)**	**(4,619)**	**(1,970)**
PRF/FRF monies	1,505	265	(1,240)
Adjusted financial performance surplus/(deficit) including PSF & FRF	**(1,144)**	**(4,354)**	**(3,210)**

During May-August as the control total pre-PSF and FRF was not met, a prudent assumption was made to exclude PSF and FRF from the M2-M5 position. M1 PSF and FRF amounts to £265k only, the M1-M5 PSF and FRF monies available to the organisation amount to £1,505k.

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). This includes PSF & FRF





INFORMATION

The trust delivered an in-month deficit of £1,540k in August against a planned deficit of £165k (inc PSF / FRF) or a planned deficit of £519k (excl PSF / FRF), an underperformance of £1,021k against plan. The recovery plan assumed a deficit of £608k in month. This gives a year to date deficit position of £4,619k against a deficit plan of £2,649k (excl PSF/FRF); an underperformance of £1,970k.

Clinical income has underperformed by £1,073k against the 19/20 NHSi plan in August. This reasons for this are multifactorial; the issues regarding consultants being unwilling to work additional sessions due to a lack of clarity regarding the taxation of their pensions remains a strong factor, particularly over the summer where annual leave is usually higher. In addition, there has been a higher than usual level of consultant sickness, and annual leave. The paediatric transition to Birmingham Women's and Children's is currently also impacting theatre utilisation in a more significant manner than previously expected. Further work that quantifies these causes will be presented separately.

Pay spend is £314k lower than plan year to date with temporary staffing spend above plan by £561k, due to a mixture of vacancies and sickness. However, an analysis of bank and expenditure YTD shows a reduction of £400k from 18/19.

Overall expenditure to date is £587k lower than plan due to a combination of lower spend due to the underperformance in activity, in addition to the reduction in costs as a result of the paediatric inpatient transition.

ACTIONS FOR IMPROVEMENTS / LEARNING

There has been significant work undertaken from a manning perspective to review the baseline level of activity which can be delivered without the use, or with limited use, of additional sessions. The outcome of this work is starting to come to fruition with the recruitment of additional consultants and the use of locums, particularly within arthroplasty to help the trust deliver additional activity within the coming months.

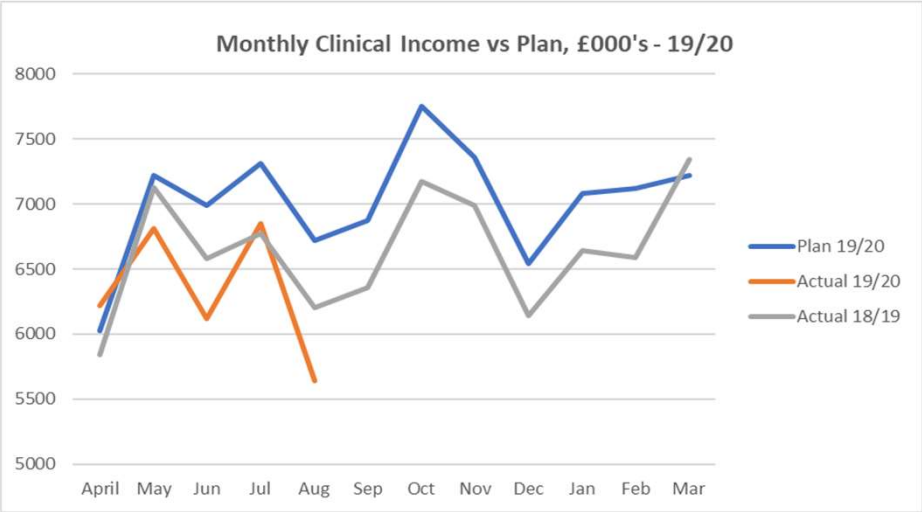
A piece of work has also been undertaken to review activity plans going forwards, particularly with regards to the new theatre facilities, to develop a revised recovery plan. The work to date will be shared within the meeting.

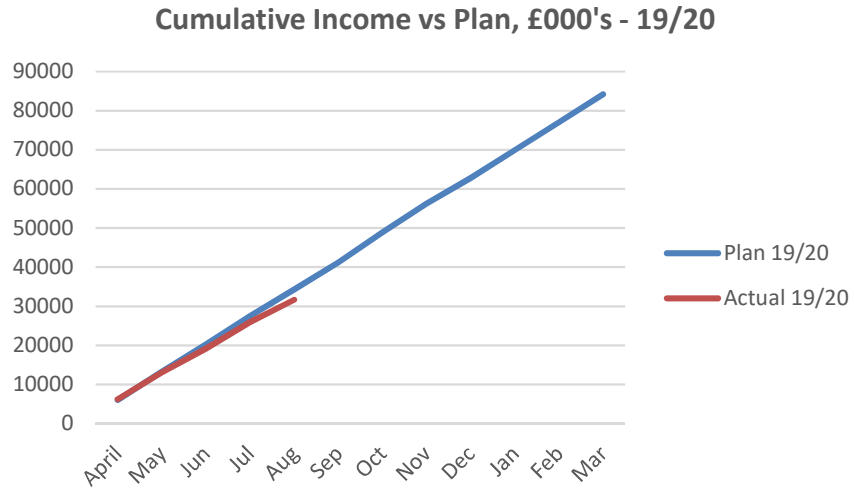
RISKS / ISSUES

September has planned deficit of £519k (exc PSF / FRF), which is expected to be challenging given some of the additional pressures discussed above.

As The Trust is currently £1,970k behind plan (exc. FRF and PSF), there is significant work to deliver the control total by the end of the year. Achievement of the control would result in funding of £5.3m being given to the Trust.

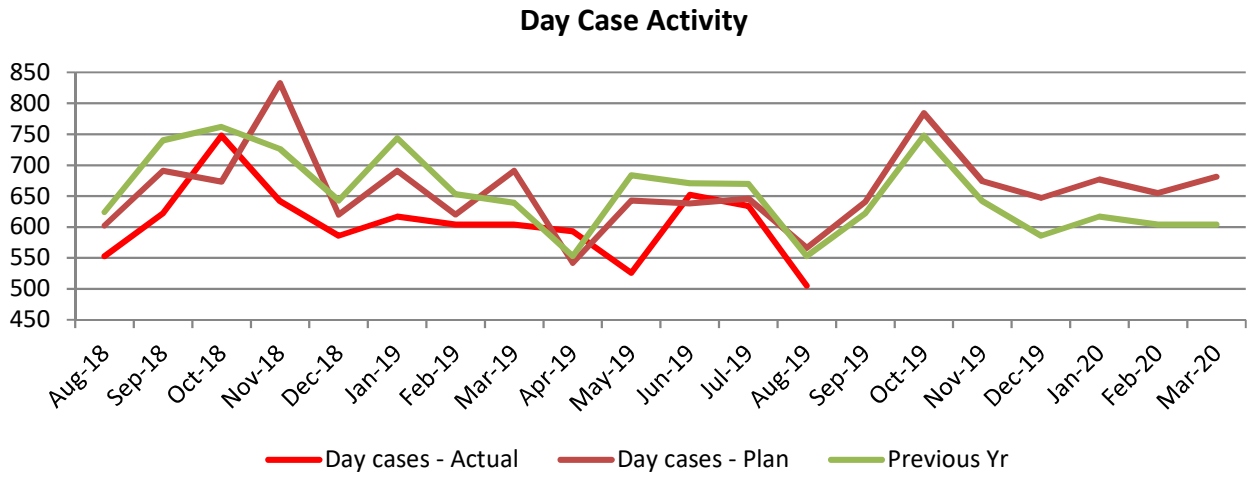
2. Income and Activity– This illustrates the total income generated by the Trust in 2019/20, including the split of income by category, in addition to the month's activity (Inc PSF & RFF)





Clinical Income – YTD 2019 £'000			
	Plan	Actual	Variance
Inpatients	16,882	15,533	-1,349
Excess Bed Days	343	174	-169
Total Inpatients	17,225	15,707	-1,518
Day Cases	4,096	3,735	-361
Outpatients	3,703	3,511	-192
Critical Care	962	713	-249
Therapies	1,192	1,394	202
Pass-through income	1,049	814	-235
Other variable income	3,234	3,066	-168
Provision		0	0
Block income	2,805	2,696	-109
TOTAL	34,266	31,636	-2,630

Clinical Income – August 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,289	2,804	-485
Excess Bed Days	67	39	-28
Total Inpatients	3,356	2,843	-513
Day Cases	765	625	-140
Outpatients	731	710	-21
Critical Care	194	160	-34
Therapies	241	275	34
Pass-through income	211	129	-82
Other variable income	652	445	-207
Provision		0	0
Block income	566	456	-110
TOTAL	6,716	5,643	-1,073


Day Case Activity
850
800
750
700
650
600
550
500
450
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
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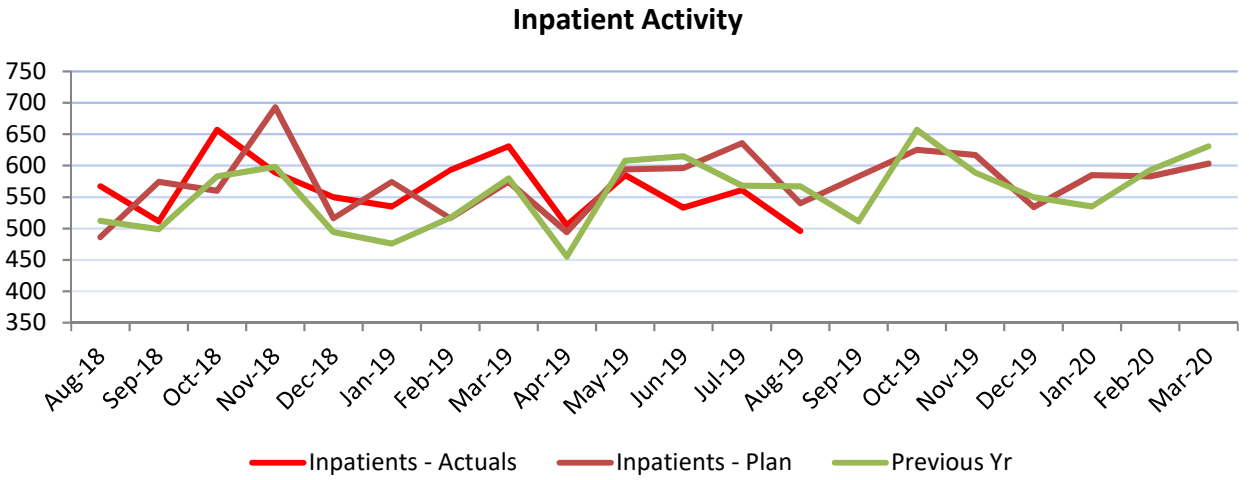
Jan-20
Feb-20
Mar-20
Day cases - Actual
Day cases - Plan
Previous Yr


Inpatient Activity
750
700
650
600
550
500
450
400
350
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Inpatients - Actuals
Inpatients - Plan
Previous Yr

NHS Clinical income has under-performed against plan by 15.98% in August having under-performed in July by 6.41%. Cumulatively, the trust is 7.68% below plan. The admitted patient care performance was below plan financially but up on activity levels against the revised activity plan (discussed with F&P last month), with discharged activity 5 above target. Day case activity underperformed financially but was up against the revised activity target by 6 cases. Case-mix in July was 50% for day cases, 46% for electives. Non Elective make up the other 4%. This has changed from July as electives made up 44% of the activity, an increase of 2%. Over the last two months elective activity has increased as a proportion of total activity raising from 42% in June to 46% in August.

Outpatients have slightly under-performed for August. There has been a decrease in attendances against plan in August for first and follow up attendances . First to follow up ratio is 2.13:1 year to date. The ratio has increased slightly from July (2.10:1).

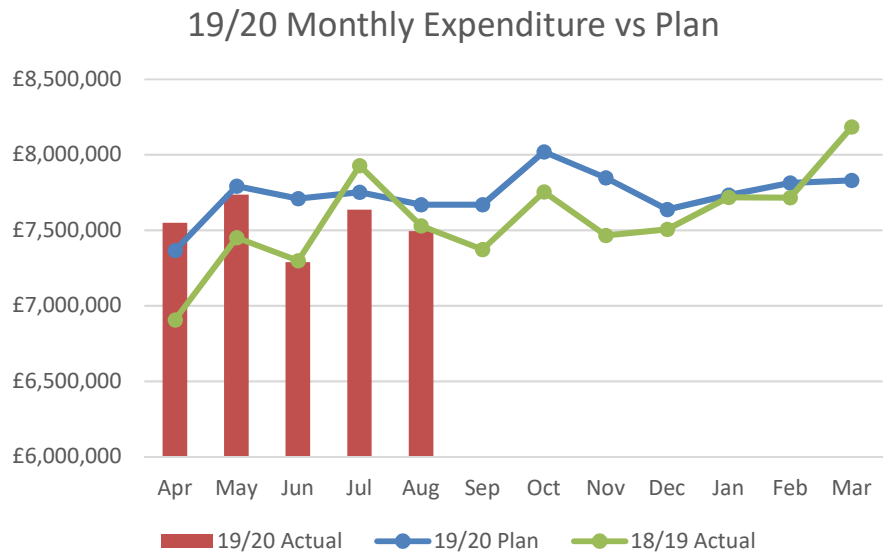
ACTIONS FOR IMPROVEMENT/LEARNING

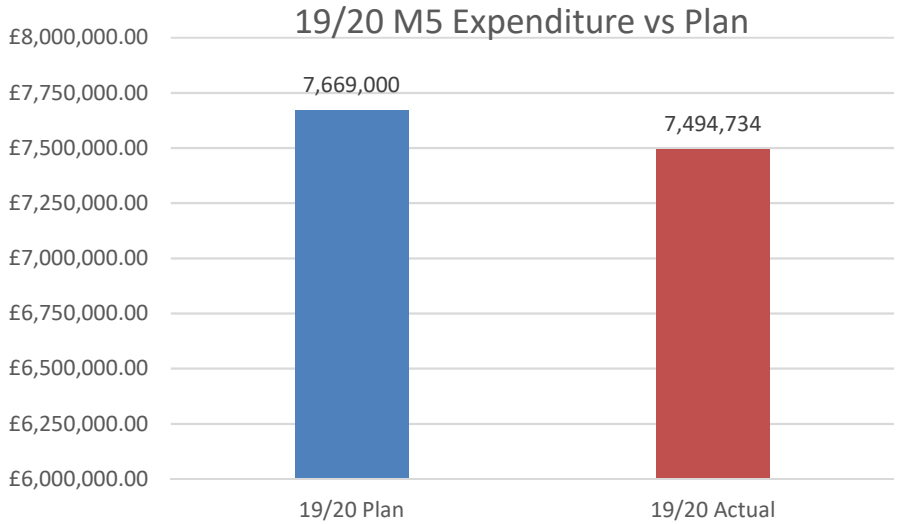
Recovery plan discussions are complete with the operational and clinical teams, with identified mitigating actions that are being taken. Clinical Service Managers are reviewing theatre lists to ensure they are fully maximised.

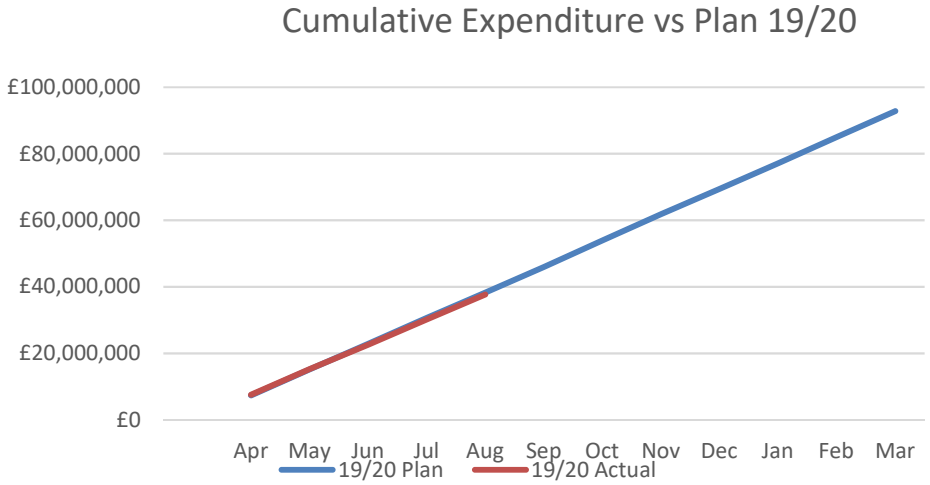
Finance and clinicians are working together to insure that co-morbidities are being recorded and therefore maximising the income.

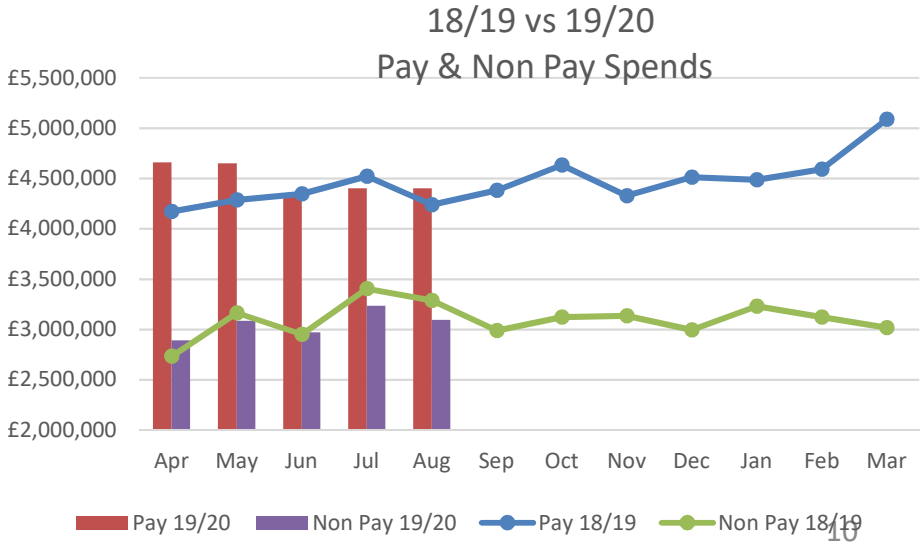
RISKS / ISSUES

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



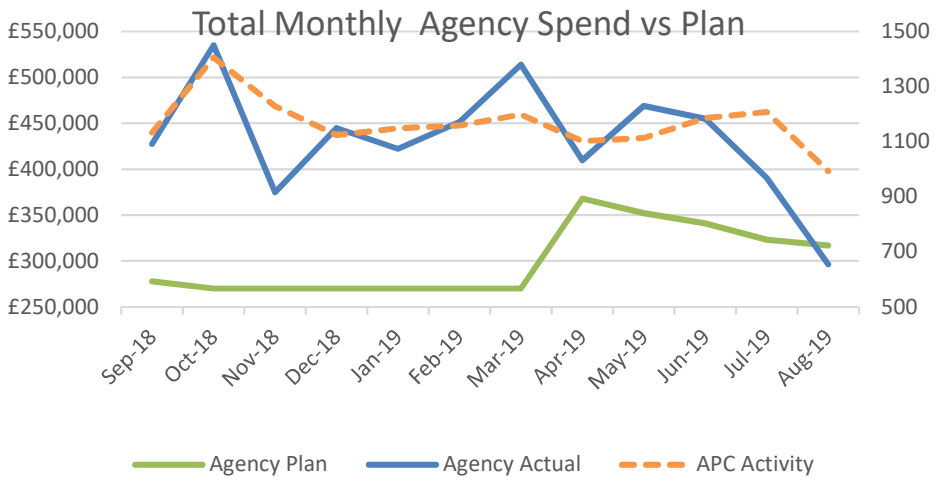


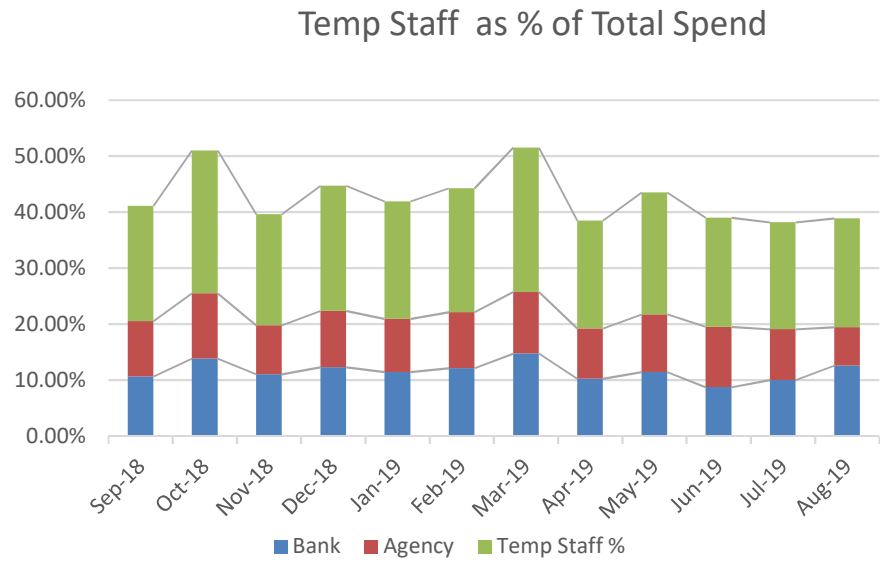


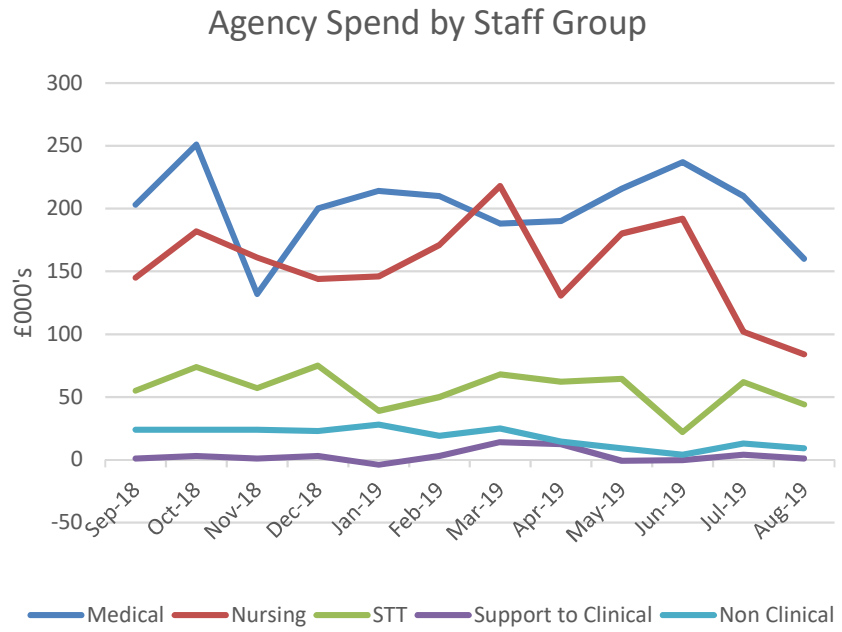


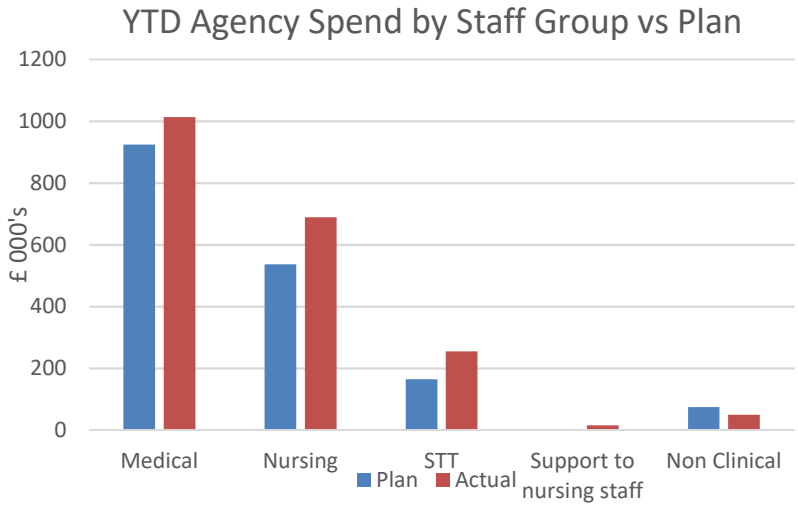
INFORMATION
Expenditure in August was £7,495k, which was £174k lower than the planned spend of £7,669k. Year to date expenditure is £37,704k against a plan of £38,291k, an underspend of £587k. Pay in August was £143k lower than plan, due to a significant reduction in agency usage. This has been a result of the strong recruitment across the organisation over the past several months, and is encouraging to see. Non pay spend in was in line with plan. There were reductions in some variable spend areas such as implants, however, this has not been to the level necessarily expected in line with the reduced activity.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements



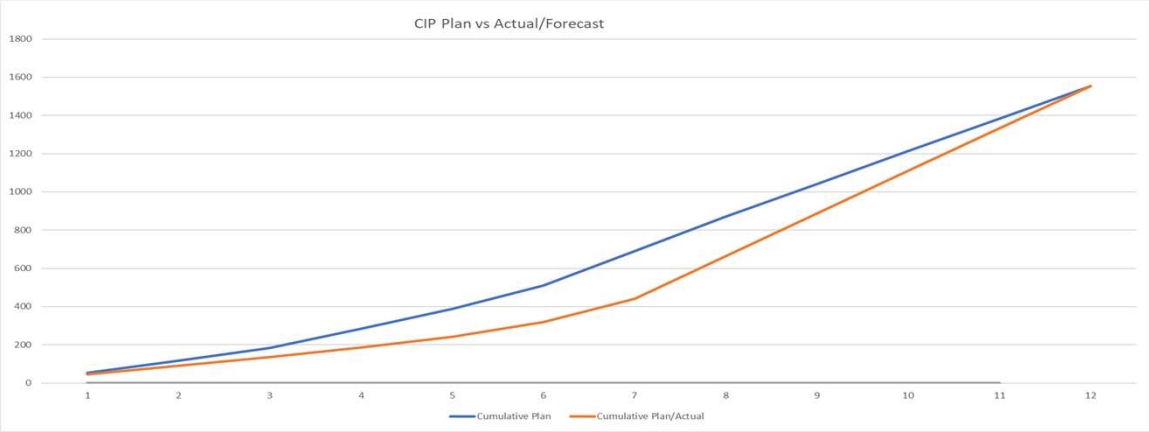


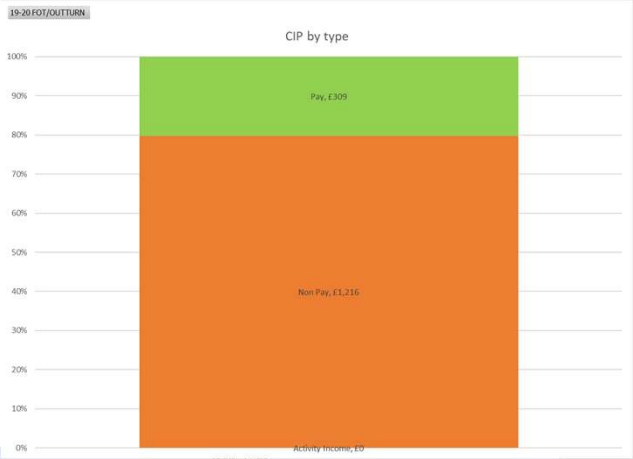




INFORMATION
Total agency spend for August was £296k against a plan of £317k, and the spend continues to show a significant downward trajectory (although some of this reduction will be due to the reduction in activity in the hospital during the month of August). Review of the different staff groups shows that this reduction is across all areas, with particular movement in nursing and medical agency spend. This is believed to be due to the strong recruitment efforts which have taken place across the hospital over the past months. It should be expected that this agency spend will rise slightly again once the new theatres are opened as the recruited staff are utilised within those lists.
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 are approved by the relevant Matron and head of Nursing. Recruitment to vacancies continues with substantive fill rates expected to be significantly improved by October 2019, with a current fill rate of 85% increasing to 95% by October.

6.Cost improvement Programme – This illustrates the plan for the 2019-20 cost improvement programmes (£000's)





Row Labels	In-Month NHSI Plan	In-Month Actual	In-Month Var	YTD NHSI Plan	YTD Actual	Sum of YTD Var	19-20 NHSI Plan	19-20 FOT/OUTTURN	Sum of 19-20 Variance (FOT)
1	£40	£1	(£39)	£129	£1	(£128)	£472	£261	(£210)
2	£55	£37	(£18)	£131	£76	(£55)	£963	£847	(£116)
Corporate	£3	£29	£26	£12	£114	£102	£36	£361	£325
Estates & Facilities	£3	£4	£1	£12	£16	£4	£78	£55	(£23)
Grand Total	**£101**	**£70**	**(£30)**	**£284**	**£207**	**(£76)**	**£1,549**	**£1,525**	**(£24)**

The Trust QCIP (Quality and Cost Improvement Programme) target was identified at £1.553m for 19-20. In 18-19 the Trust target was identified at £2.985m, however only £1.688m (57%) was delivered. Thus, during the 19-20 business planning (and QCIP) round, schemes up-to £2.294m have been identified as opportunities for this year. (With the difference being a stretch target for the Trusts divisions) Many of the schemes amounting to the Trust target (£1.553m) have been costed, however some (including the stretch target schemes) remain aspirational at present and costings are ongoing.

All of the schemes identified at present are recurrent schemes, QCIP PID/QIA (project initiation documentation including costings and quality impact assessment) completion is currently ongoing, with a targeted completion date of 30th August 2019.

The Trust has a year to date variance of £76k under plan but it is expected the underperformance will be recovered to only a £24k under-achievement by the end of the year.

The 2 largest schemes for 19-20 include the Theatres MSC and workforce recruitment, the latter based on current trajectories will fully deliver the target, however the former is likely to slip from July 2019 to October 2019 due to delays in business case approval, vendor resolution and contract sign-off.

Despite the year-end forecasted under-performance in July 2019, additional mitigation opportunities are being discussed (and identified) in August 2019.

7. Overall Financial Position – This illustrates the key metrics from the Statement of Financial Position at the end of the month

	M5 Plan £'000	M5 Actual £'000	Var £'000
Intangible Assets	1,500	1,278	222
Tangible Assets	46,481	45,657	824
Total Non-Current Assets	**47,981**	**46,935**	**1,046**
Inventories	7,063	7,259	(196)
Trade and other current assets	9,026	6,661	2,365
Cash	4,476	4,581	(105)
Total Current Assets	**20,565**	**18,501**	**2,064**
Trade and other payables	(18,362)	(18,982)	620
Borrowings	(726)	(726)	0
Provisions	(86)	(58)	(28)
Other liabilities	0	0	0
Total Current Liabilities	**(19,174)**	**(19,766)**	**592**
Borrowings	(11,792)	(12,135)	343
Provisions	(215)	(220)	5
Total Non-Current Liabilities	**(12,007)**	**(12,355)**	**348**
Total Net Assets Employed	**37,365**	**33,315**	**4,050**
Total Taxpayers' and Others' Equity	**37,365**	**33,315**	4,050

INFORMATION

As at August 2019 net assets employed are lower than plan by £4m.

Capital is behind plan by £1m, this is due to the final phased plan by type of expenditure and timing was only finalised at the beginning of August, due to the requirement to revise the original plan at the request of DHSC. Due to this there will be ongoing variances throughout the year.

Trade receivables are lower than plan mainly due to activity being behind.

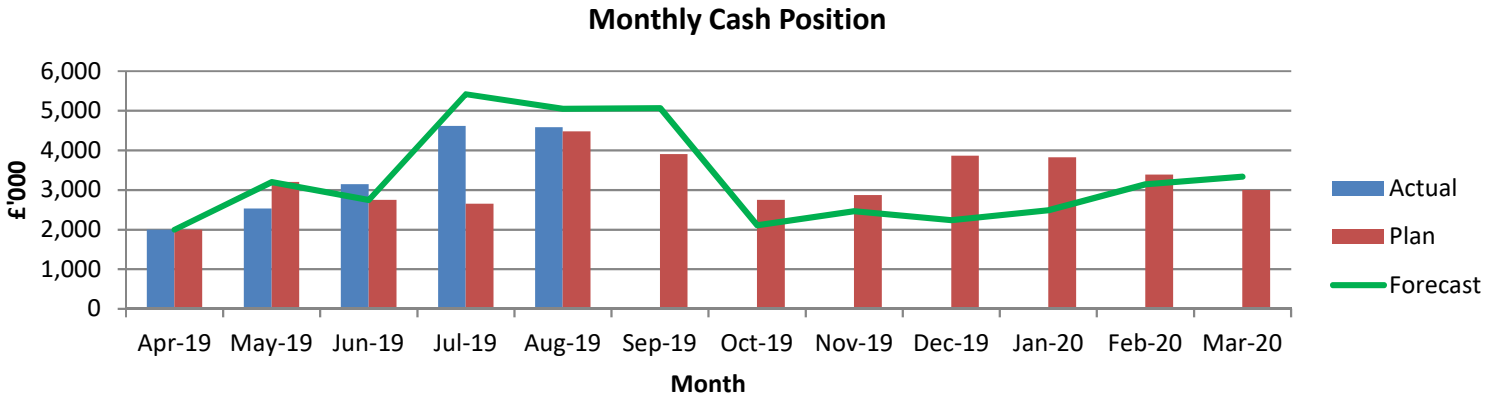
Borrowings have increased due to the Trust continuing to take deficit loans above those planned due timing differences in relation to working capital movements.

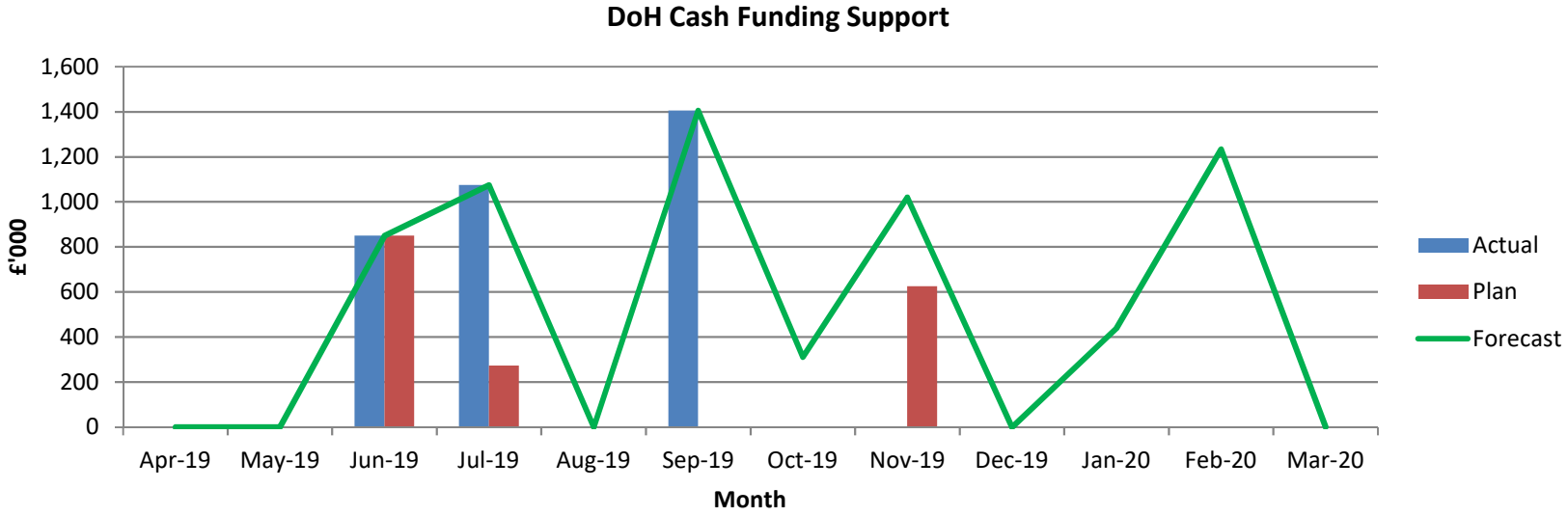
ACTIONS FOR IMPROVEMENTS / LEARNING

Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

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

Cash is lower than plan by £0.1m. During August the Trust did not draw any cash loans but did repay £398k which was received in the prior month for the PSF advance. For September a cash loan of £1.4m has been requested (and received at date of report).

Going forward we are now forecasting the need for additional loans to be taken out that were not in the original plan. This is purely down to the uncertainty around the timing of receiving FRF funding. The plan assumed that this would be paid quarterly but this hasn't been the case and no notification has been received regarding the mechanism for accessing these funds as yet.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

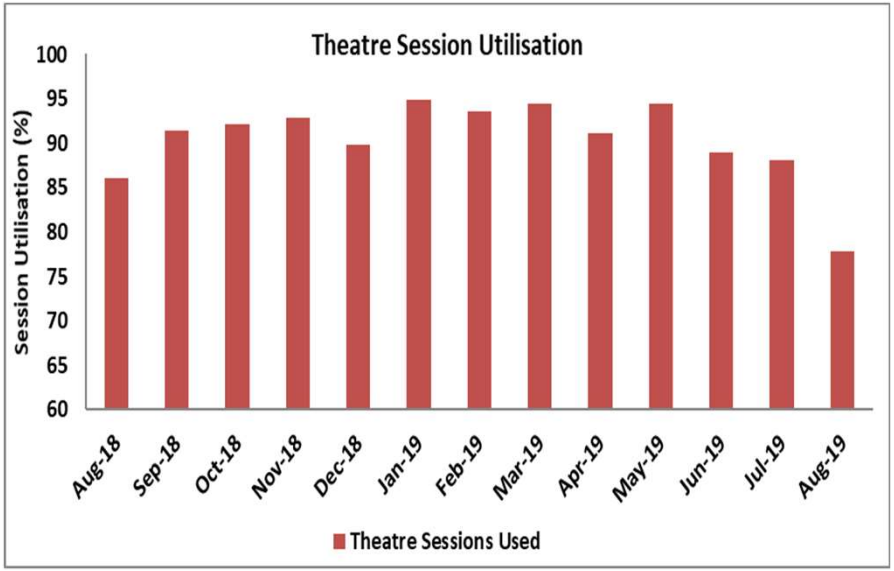
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2019/20. The Head of Financial Accounting continues to hold regular cash control committee attended by the Assistant Director's of Finance, and representatives from management accounts 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.

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

Target 90%

August utilisation was down to 77.78% compared to 88.09% in July.

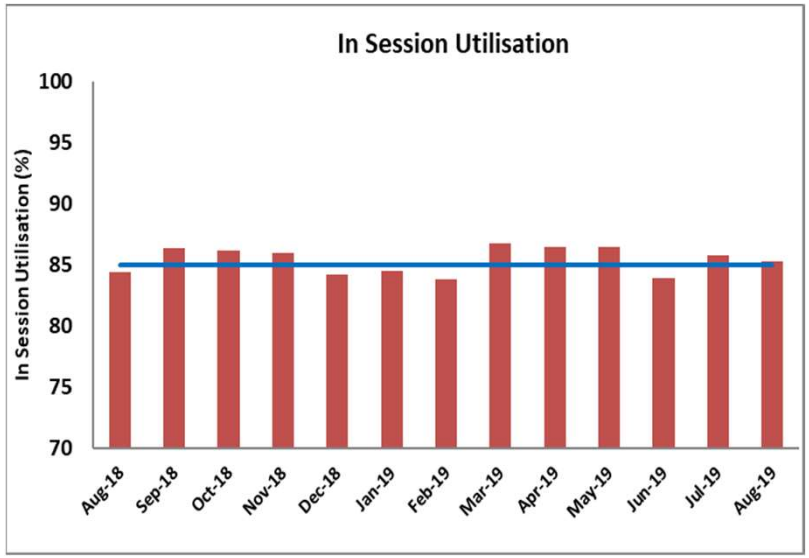
This is primarily due to a decrease in activity as a result of Consultants not taking up ADH's, but was also impacted by Consultant annual leave.

August's unused sessions totalled 83.

RISKS / ISSUES

- Ongoing discussions with medical groups regarding the pension/tax issue continue

8. 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 preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

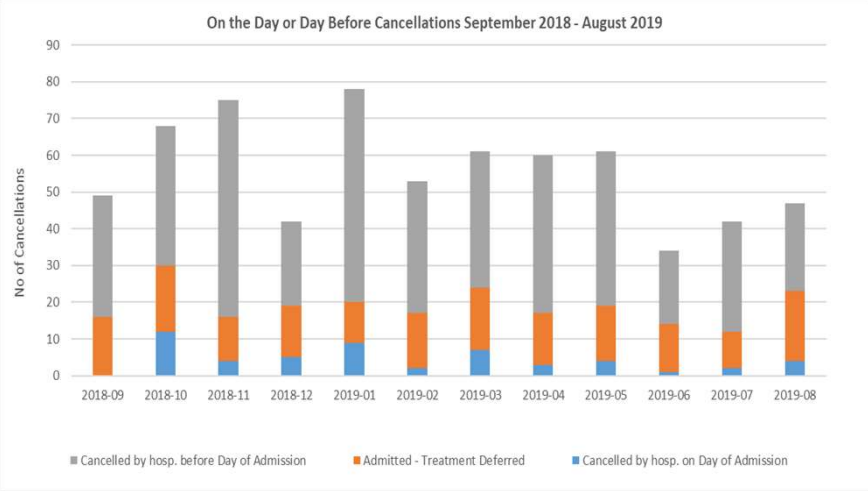
Target 85%

In session utilisation reduced slightly to 85.25% in August compared to 85.71% in July

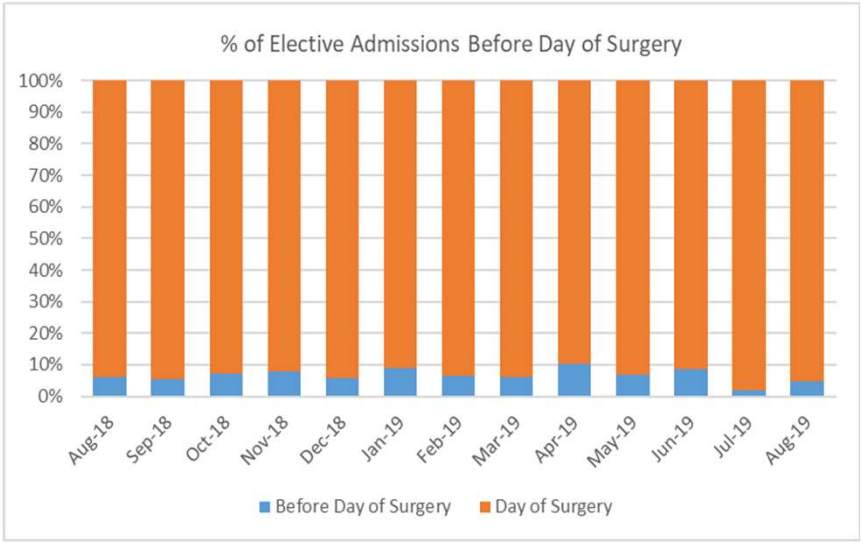
RISKS / ISSUES

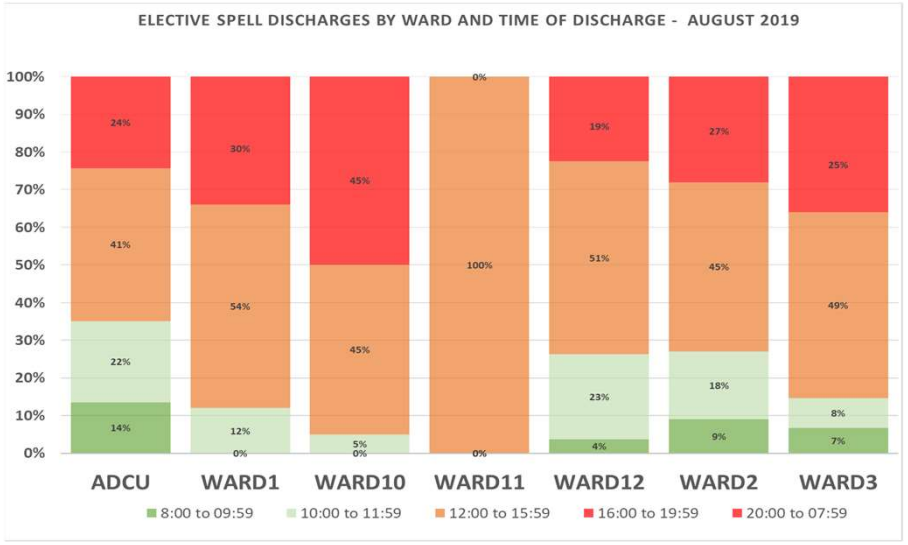
- Last minute changes to lists impact on the efficient running and planning of theatre lists - risk being reduced due to introduction of lock down process and learning from theatre lookback meetings
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

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



Sum of Total	Cancellation Category				
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
2018-09		16	33	49	1
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	43	60	0
2019-05	4	15	42	61	0
2019-06	1	13	20	34	0
2019-07	2	10	30	42	0
2019-08	2	16	24	42	**0**
Grand Total	**51**	**171**	**443**	**665**	1





The number of cancellations on the day of admission for surgery by hospital in August was 18 patients.

Analysis of these cancellations on the day identified that 5 patients were cancelled on the day because of a lack of theatre time, 4 due to patients requiring emergency operations, 4 because of a consultant surgeon being off sick (all on the same day), 3 due to admin errors and 2 due to preop clinical issues.

Cancellations before the day of surgery for August were 24 which has decreased since last month. Similar themes are noted for this group of patients: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, and patient medically unfit following preassessment.

The 72 hour call to patients continues as business as usual and continues to work well. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance . The escalation process has also been strengthened to ensure any cancellations are picked up in a timely manner.

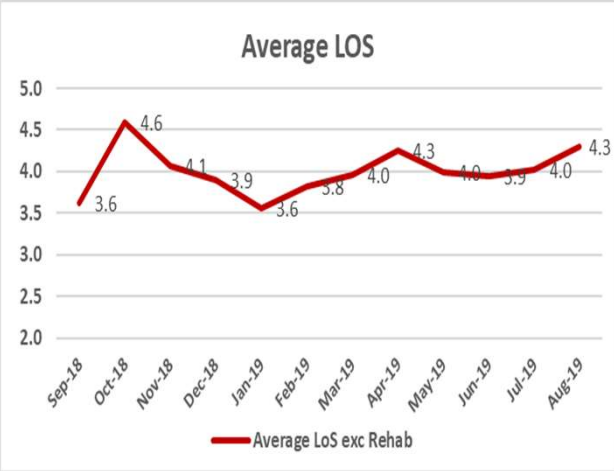
ACTIONS FOR IMPROVEMENTS / LEARNING

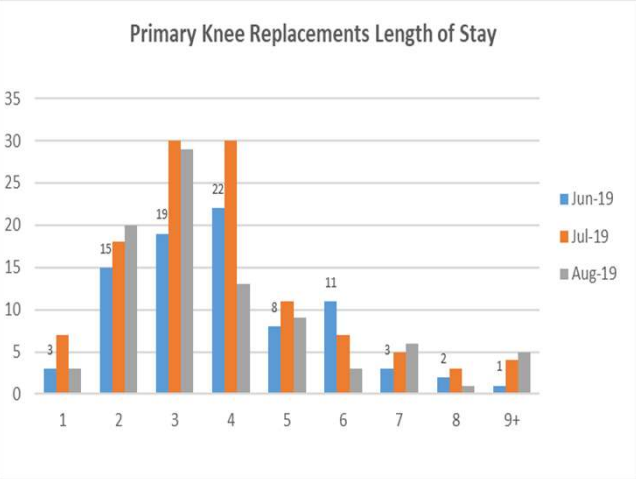
As a result of POAC now attending the morning huddle, escalation processes improvements and the SOP for bookings implemented, this has resulted in better communication between POAC and secretarial teams

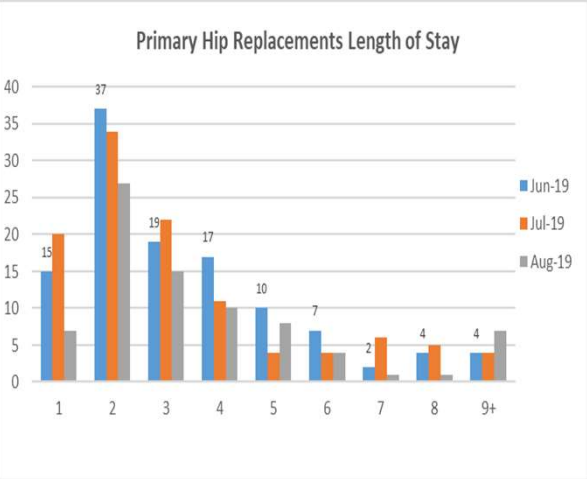
RISKS / ISSUES

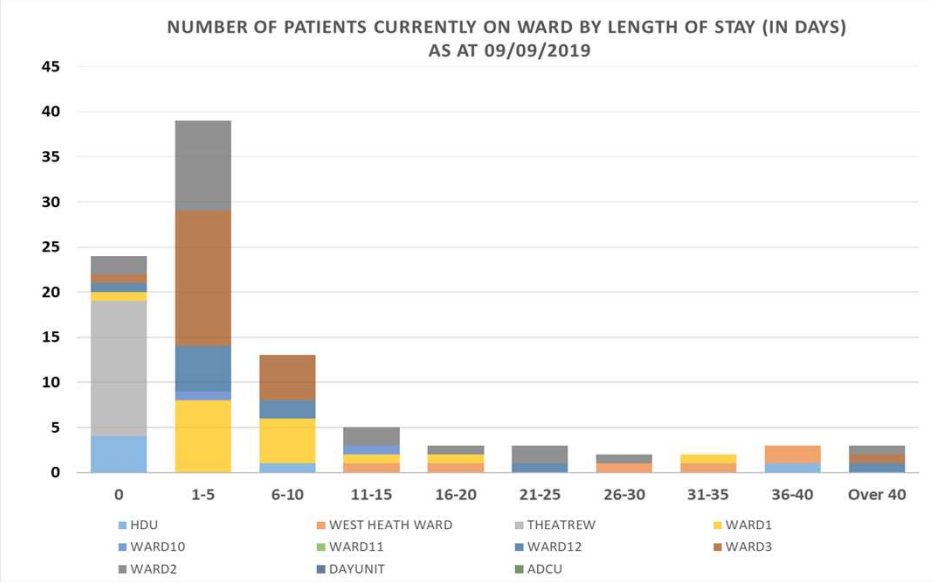
The Managed Service Contract is progressing to completion.

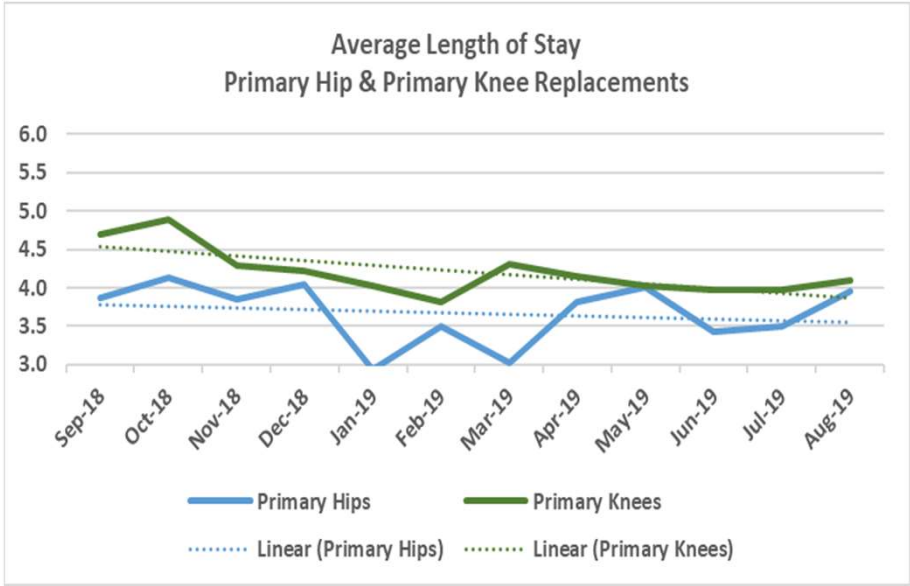
10. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in August has risen from 4 to 4.3 days

August data includes a considerable number of patients requiring social packages and additional medical needs that impacted on the average LOS in month.

A further analysis of the data suggests that oncology arthroplasty (28 patients) had a significant impact on length of stay data with an average LOS of 5.6 in comparison to 3.6 for non-oncology arthroplasty (141 patients). A further review of the upper 10% LOS indicates that over 10% (oncology arthroplasty) versus 2.8% (arthroplasty) of patients respectively will have a stay of 11 days or greater.

ACTIONS FOR IMPROVEMENTS / LEARNING

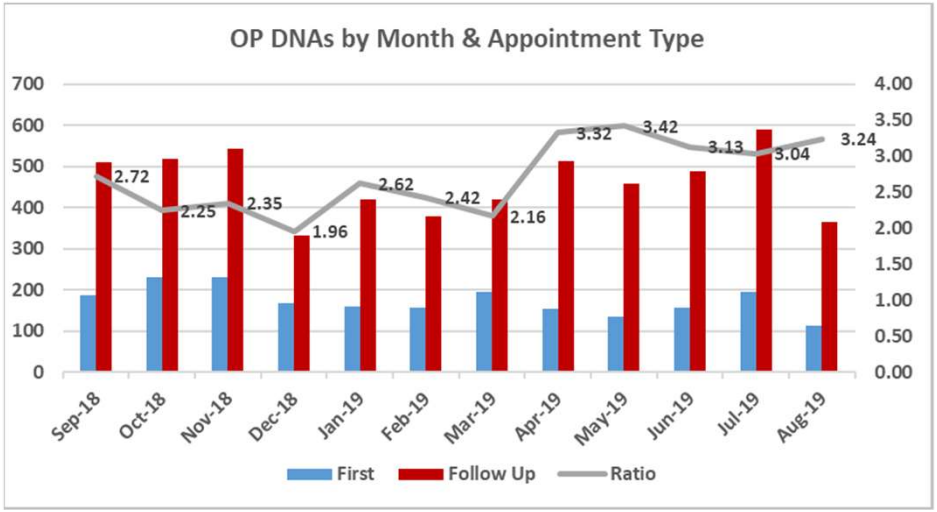
There are a number of initiatives agreed to refocus reduction in length of stay including:

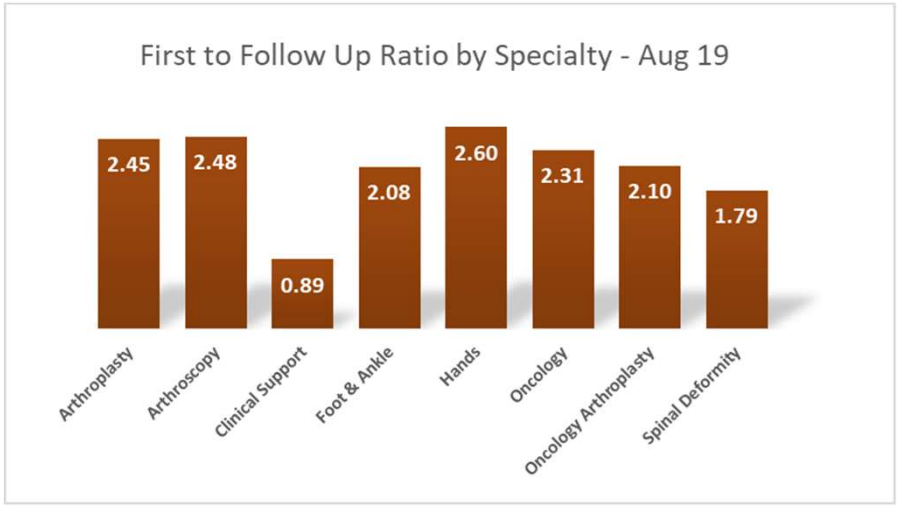
- A weekly review by Division 1 Operations team into LOS and activity.
- A review of the Red to Green data as it matures as a dataset (trends are POC on Ward 1, physio assessment IV Abs and x-ray on Ward 2, wound reviews on Ward 3 and POC on Ward 12.
- Daily review of patients with LOS greater than expected LOS.
- With the support of the Medical Director renew need for senior review on a daily basis on every patient (currently auditing senior review).
- Continue to utilise Discharge Lounge – noting that usage has increased month on month.
- The joint care data is now to be included in the integrated board which is being developed.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Out of hours roaming Admin to support timely discharge.
- Pathology issues still being raised via Ulysses when delays occur and escalated appropriately – no current issues identified.
- Review LOS dataset combining with GIRFT dataset looking at LOS against prevalent operation codes in speciality.

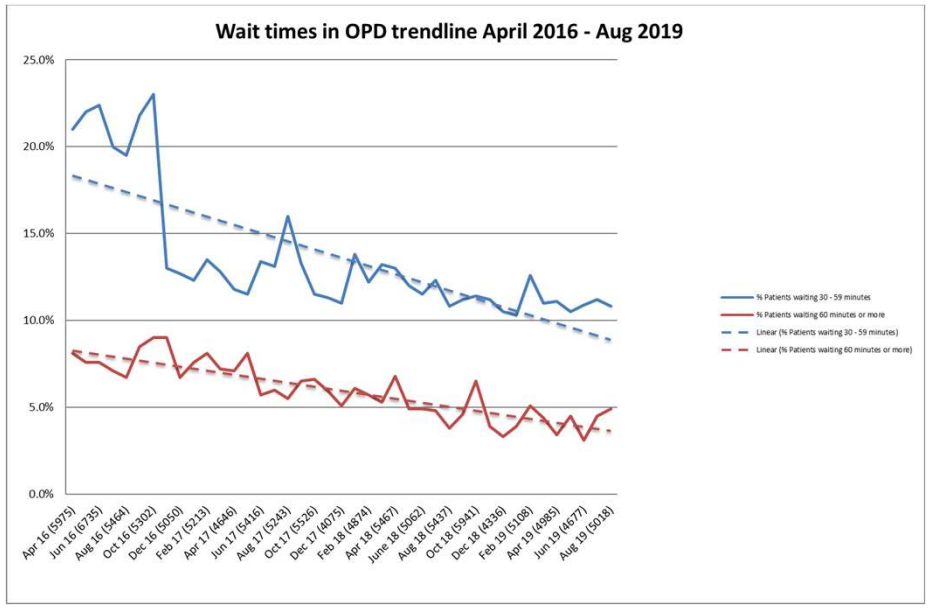
RISKS / ISSUES

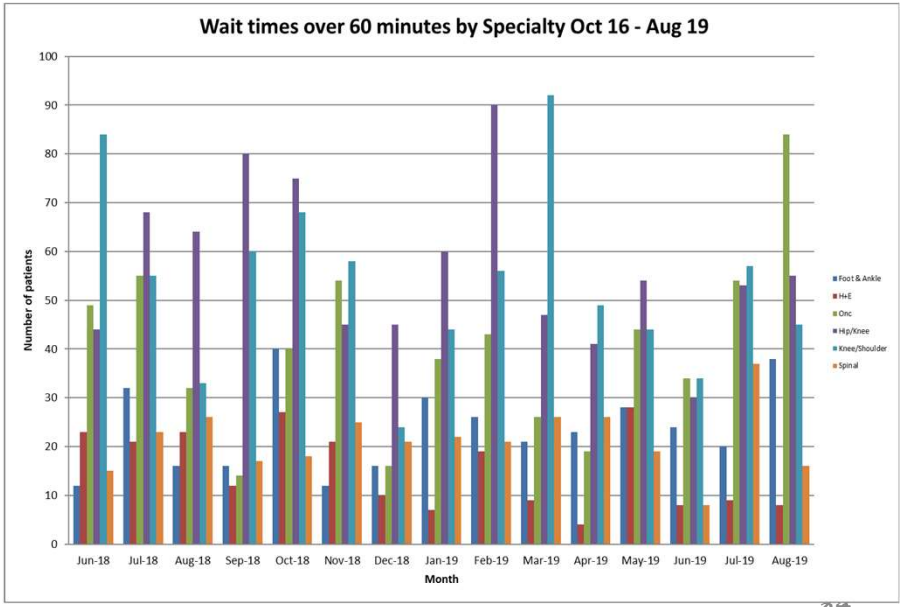
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

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









INFORMATION

In August there were 10.8% of patients waiting over 30 minutes which is a 0.4% decrease from last month. There was a slight increase of over 60 minute delays to 4.9% for August but this is still below the target of 5%. Recent more detailed analysis of the data does suggest that the percentage of patients waiting over 30 and 60 minutes may be being overstated, due to late arrivals not being taken into account. Further analysis of this data will be undertaken prior to the next F&P meeting in September.

Room allocations each week continue to be managed well and there have been no room availability incidents submitted in August. The 643 meetings have now been expanded and continue on after the weekly 642 meeting on a Wednesday. The Clinical Service and Support Managers are invited to attend as well as representation from Outpatients and the imaging department. There is a regular agenda that includes discussion of activity booked, capacity available in the coming weeks and rescheduling requests received with less than 6 weeks notice.

There were 22 incidents of clinic delays reported in August 2019. Acute staff shortages in imaging have contributed to the delays in Outpatients due to the chronology of appointment times being affected. The incidents were filtered by the following breakdown;

6 Complex Patient
5 Clinic Overbooked
4 Consultant / Clinician Delay
4 X-ray delay
3 other

There are a large number of projects that are either currently running, or being planned, around the improvement of the Outpatient Department at the Royal Orthopaedic Hospital. These are currently being managed on an individual basis but a coordinated approach is planned in order to deliver the “modernising outpatients” strategy (Cinderella project)

ACTIONS FOR IMPROVEMENTS / LEARNING

- The outpatient operational group continues to meet but additional project management resource is required to help move projects forward. The Transformation team are currently recruiting and this will provide additional resource to help deliver OPD projects
- The InTouch system needs to be upgraded in order to implement electronic outcomes and this is underway. Initial meetings have been held and a demo of the new system is being arranged
- DrDoctor has been implemented across all specialties, except Oncology where there have been some issues with patients receiving notifications before nursing staff could contact them. This system is working well and DNA rates will be monitored going forward

RISKS / ISSUES

- A meeting has been held with the Deputy Director of Operations to discuss the lack of space in the main outpatients department. This issue will be exacerbated when additional activity is required to serve the new theatre capacity after December 2019.

12. Referral to Treatment snapshot as at 31st August 2019 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/08/2019

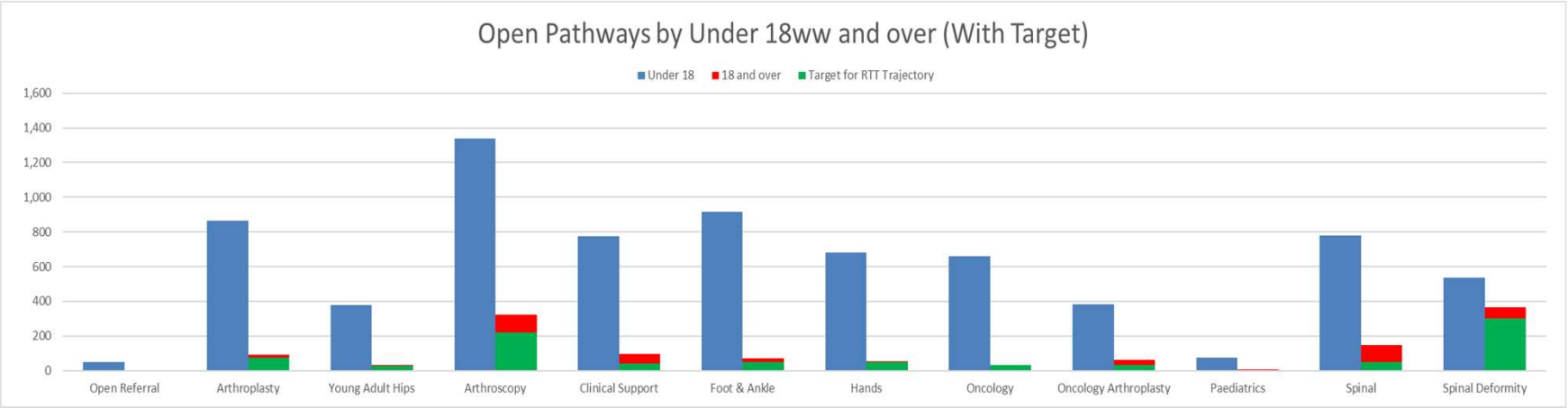
Est Over 18 Clock Stops Required		
To achieve	88.29%	336
To achieve	88.92%	405
To achieve	91.09%	634

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**3,254**	38	403	163	586	304	394	322	309	148	38	349	200
7-13	**2,962**	9	313	151	531	343	393	270	237	181	23	299	212
14-17	**1,214**	3	147	64	220	127	130	90	115	53	12	130	123
18-26	**980**	0	86	21	229	90	68	52	18	57	8	132	219
27-39	**277**	0	7	8	84	6	4	2	9	6	0	14	137
40-47	**21**	0	1	2	8	1	0	0	0	1	0	0	8
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8,708**	50	957	409	1,658	871	989	736	688	446	81	924	899

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,430**	50	863	378	1,337	774	917	682	661	382	73	778	535
18 and over	**1,278**	0	94	31	321	97	72	54	27	64	8	146	364
Target for RTT Trajectory	**775**	1	76	30	218	40	48	48	31	34	1	49	301
Target for RTT 92%	**696**	**4**	**76**	**32**	**132**	**69**	**79**	**58**	**55**	**35**	**6**	**73**	**71**

Month End RTT %	**85.32%**	**100.00%**	**90.18%**	**92.42%**	**80.64%**	**88.86%**	**92.72%**	**92.66%**	**96.08%**	**85.65%**	**90.12%**	**84.20%**	**59.51%**
31/08/2019 Trajectory RTT %	91.09%	96.70%	92.01%	92.49%	86.83%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	66.42%
Variance from Target to meet Trajectory	503	-1	18	1	103	57	24	6	-4	30	7	97	63
Variance from target 92%	582	-4	18	-1	189	28	-7	-4	-28	29	2	73	293



13. Referral to Treatment snapshot as at 31st August 2019 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/08/2019

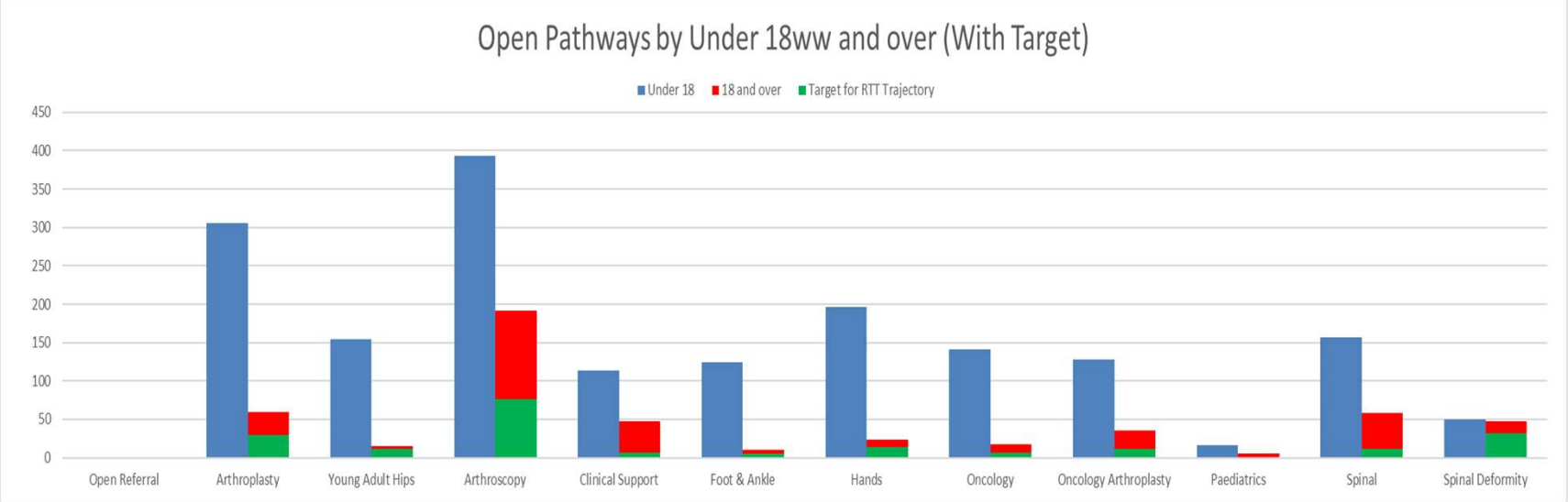
Est Over 18 Clock Stops Required		
To achieve	88.29%	316
To achieve	88.92%	333
To achieve	91.09%	388

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**628**	0	101	62	142	25	43	78	72	32	8	52	13
7-13	**786**	0	130	68	174	54	54	80	55	71	4	72	24
14-17	**365**	0	75	24	77	35	27	38	14	25	4	33	13
18-26	**379**	0	54	10	127	44	9	23	10	29	6	47	20
27-39	**121**	0	5	3	58	3	1	1	8	5	0	11	26
40-47	**11**	0	1	2	6	0	0	0	0	1	0	0	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,290**	0	366	169	584	161	134	220	159	163	22	215	97

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,779**	0	306	154	393	114	124	196	141	128	16	157	50
18 and over	**511**	0	60	15	191	47	10	24	18	35	6	58	47
Target for RTT Trajectory	**204**	0	29	12	76	7	6	14	7	12	0	11	32
Target for RTT 92%	**183**	**0**	**29**	**13**	**46**	**12**	**10**	**17**	**12**	**13**	**1**	**17**	**7**

Month End RTT %	**77.69%**	**n/a**	**83.61%**	**91.12%**	**67.29%**	**70.81%**	**92.54%**	**89.09%**	**88.68%**	**78.53%**	**72.73%**	**73.02%**	**51.55%**
31/08/2019 Trajectory RTT %	91.09%	96.70%	92.01%	92.49%	86.83%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	66.42%
Variance from Target to meet Trajectory	307	0	31	3	115	40	4	10	11	23	6	47	15
Variance from target 92%	328	0	31	2	145	35	0	7	6	22	5	41	40



13. Referral to Treatment snapshot as at 31st August 2019 (non admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 31/08/2019

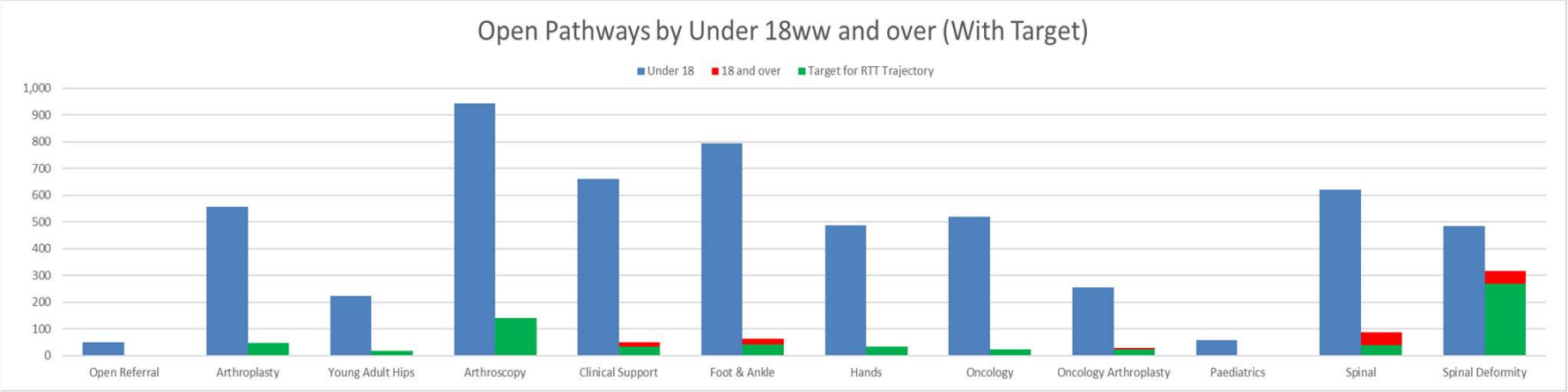
Est Over 18 Clock Stops Required		
To achieve	88.29%	20
To achieve	88.92%	72
To achieve	91.09%	246

Select Pathway Type: Non-Admit

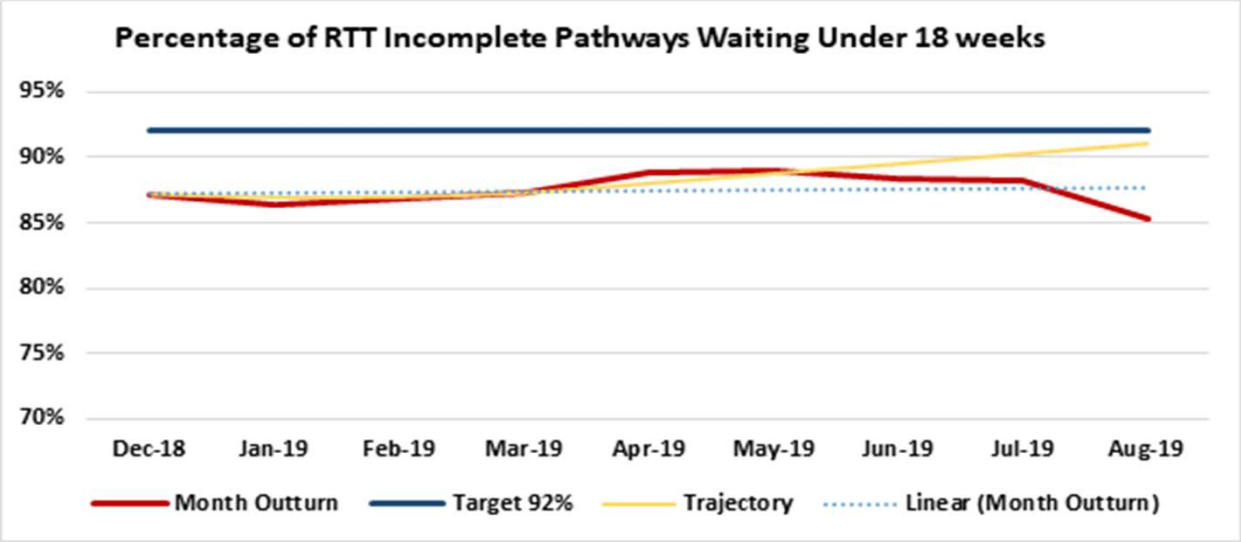
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young Adults	Spinal	Spinal Deformity
0-6	**2,626**	38	302	101	444	279	351	244	237	116	30	297	187
7-13	**2,176**	9	183	83	357	289	339	190	182	110	19	227	188
14-17	**849**	3	72	40	143	92	103	52	101	28	8	97	110
18-26	**601**	0	32	11	102	46	59	29	8	28	2	85	199
27-39	**156**	0	2	5	26	3	3	1	1	1	0	3	111
40-47	**10**	0	0	0	2	1	0	0	0	0	0	0	7
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6,418**	50	591	240	1,074	710	855	516	529	283	59	709	802

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,651**	50	557	224	944	660	793	486	520	254	57	621	485
18 and over	**767**	0	34	16	130	50	62	30	9	29	2	88	317
Target for RTT Trajectory	**571**	1	47	18	141	33	42	34	24	22	1	38	269
Target for RTT 92%	**513**	**4**	**47**	**19**	**85**	**56**	**68**	**41**	**42**	**22**	**4**	**56**	**64**

Month End RTT %	**88.05%**	**100.00%**	**94.25%**	**93.33%**	**87.90%**	**92.96%**	**92.75%**	**94.19%**	**98.30%**	**89.75%**	**96.61%**	**87.59%**	**60.47%**
31/08/2019 Trajectory RTT %	91.09%	96.70%	92.01%	92.49%	86.83%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	66.42%
Variance from Target to meet Trajectory	196	-1	-13	-2	-11	17	20	-4	-15	7	1	50	48
Variance from target 92%	254	-4	-13	-3	45	-6	-6	-11	-33	7	-2	32	253



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



RTT Trajectory	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Under 18 Weeks	7,356	7,274	7,282	7,299	7,337	7,374	7,412	7,449	7,487	7,478	7,511	7,543	7,571
Over 18 Weeks	1,080	1,091	1,089	1,062	997	931	867	799	732	651	605	560	520
Totals	8,436	8,365	8,370	8,361	8,334	8,305	8,278	8,248	8,219	8,129	8,116	8,103	8,090
RTT %	87.20%	86.96%	86.99%	87.30%	88.03%	88.79%	89.53%	90.31%	91.09%	92.00%	92.54%	93.09%	93.58%

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. The current trajectory for all specialties is currently being revisited in line with current capacity challenges relating to reduction in ADH capacity.
The August position is **85.32%** lower than NHSI trajectory forecasted position of **91.09%.** In August the Trust had **0** patients over 52weeks. There are **21** patients over 40 weeks. In August Young Adult Hips, Foot & Ankle, Hands and Oncology met the 92% target. An updated briefing paper will be shared at F&P pack for full details of the recovery plan. Detailed activity monitoring by individual specialty is shared weekly with the Executive Team and F&P Committee and specialties are reviewing their RTT forecasts in light of activity challenges to forecast delivery of 92% against the original trajectory.

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 - Patients still Waiting at Month End								Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Jul-18	732	112	336	1,180	8	1172	99.3%	961	211	290	1,462
Aug-18	568	107	301	976	9	967	99.1%	682	165	290	1,137
Sep-18	696	110	311	1,117	4	1113	99.6%	778	208	394	1,380
Oct-18	781	110	370	1,261	7	1254	99.4%	725	247	344	1,316
Nov-18	736	135	381	1,252	7	1245	99.4%	801	243	406	1,450
Dec-18	698	115	346	1,159	11	1148	99.1%	843	224	367	1,434
Jan-19	728	123	416	1,267	4	1263	99.7%	897	253	472	1,622
Feb-19	844	134	386	1,364	3	1361	99.8%	854	248	436	1,538
Mar-19	776	133	461	1,370	1	1369	99.9%	868	271	410	1,549
Apr-19	835	89	414	1,338	6	1332	99.6%	894	244	419	1,557
May-19	807	94	337	1,238	1	1237	99.9%	914	270	478	1,662
Jun-19	874	100	380	1,354	1	1353	99.9%	793	266	399	1,458
Jul-19	776	98	361	1,235	7	1228	99.4%	1001	270	435	1,706
Aug-19	836	80	362	1,278	8	1270	99.4%	858	237	375	1,470

Cancer Performance Targets

		Indicative	Reported Month					Reported Quarter 2018/19			
Target Name	**National Standard**	**Aug-19**	***Jul-19***	***Jun-19***	**May-19**	**Apr-19**	**Q1 2019/20**	**Q4** (Jan, Feb, March)	**Q3** (Oct, Nov, Dec)	**Q2** (July, August, Sept)	**Q1** (Apr, May, June)
2ww	93%	94%	**97.6%**	**100%**	***98.6%***	***95.6%***	***98.1%***	98.8%	99%	100%	99%
31 day first treatment	96%	100%	**92.3%**	**100%**	**83.3%**	***100%***	***94.3%***	94.4%	100%	100%	100%
31 day subsequent (surgery)	94%	100%	**100.0%**	**100%**	***100.0%***	***100%***	***100%***	95.2%	98%	100%	97%
62 day (traditional)	85%	90%	**100.0%**	**77.8%**	**72.7%**	***100%***	***80.8%***	96%	51%	70%	82%
62 day (Cons Upgrade)	n/a	80%	**78.6%**	***100.0%***	***100.0%***	***92.9%***	***97.1%***	83.70%	91%	93%	94%
28 day FDS	85%	89%	**70.3%**	80%	85.1%	81.0%	**82.2%**				
No. patients treated 104+ days			1	0	*1*	1	3	2	3	1	1

PERFORMANCE/IMPROVEMENTS/LEARNING

We achieved 100% in July's performance for 62 day standard.

We failed to meet the July performance for 31 day first treatment. This is due to 1 patient breaching due to a delay in the manufacturing and delivery of a custom made implant . 28 day FDS was not achieved this month, with 78.6% of patients in target. There were 64 patients who were subject to this standard and 19 of them were given their diagnosis after the 28 day target. Of the 19 breaches, 12 of these were due to late tertiary referrals.

RISKS / ISSUES

Post paeds transition, risks around delivery of cancer pathways at BCH to be reviewed and updated to ensure there is oversight and mitigations in place.

The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

September 2019

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

Dashboard

	July 2019	August 2019	2019/2020 YTD	2018/2019
Incidents	365	359(↓)		
Serious Incidents	1	0(↓)	4	9
Internal RCA investigations	3	3 (↔)		
Safety Thermometer (Harm Free Care)	97	97 (↔)		
VTEs (Avoidable)	0	0 (↔)	2	4 (Avoidable)
Falls (all falls)	8	10 (↑)	45	88 (Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	0 (↔)	1	7 (Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0 (↔)	0	2 (Avoidable)
Complaints	27	16(↓)	70	139
PALS	116	51(↓)		
Compliments	468	601 (↑)		
FFT Score	96.2	96.1(↓)		
FFT Response	58.8%	61.6 (↑)		
Duty of Candour	16	16(↔)		
Litigation	0	0(↔)		
Coroners	0	0(↔)		
WHO	100	100(↔)		
Infections	0	0(↔)	2	3

(↑) (↓)(↔) Symbolise the trend from the previous month.

CONTENTS

1. 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.

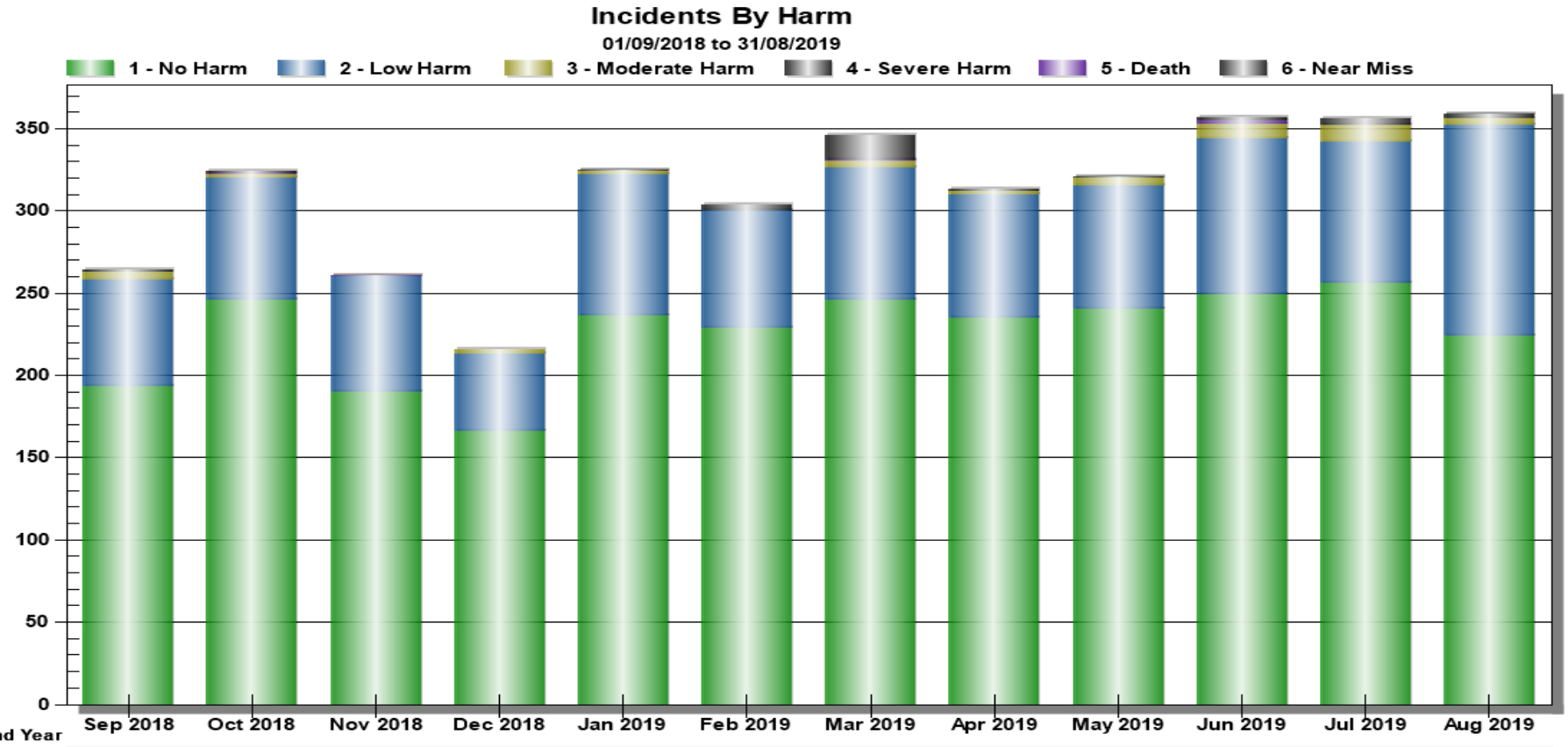
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019
1 - No Harm	193	246	190	166	236	229	246	235	240	249	256	224
2 - Low Harm	65	74	70	47	86	71	80	75	75	95	86	128
3 - Moderate Harm	5	2	0	3	2	0	4	2	5	9	10	4
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	0	2
5 - Death	0	1	1	0	0	0	1	0	0	2	0	0
6 - Near Miss	1	1	0	0	1	4	15	1	1	2	4	1

Data source – Ulysses

INFORMATION

In August 2019, there were a total of 359 Incidents reported on the Ulysses incident management system. This is within the normal reporting limits.
The breakdown of those incidents is as follows;

224 – No Harm
128 – Low Harm
4 - Moderate Harms
2 - Severe Harm
1 – Near Miss
0 – Death

Patient Contacts

In August 2019, there were a total of 8682 patient contacts. There were 359 incidents reported, which amounts to 4.13 per cent of the total patient contacts resulting in an incident. Of those 359 reported incidents, 135 incidents resulted in harm which is 1.5 per cent of the total patient contact.

Downgraded Incidents

7 of the 10 reported harms in the previous Quality report have been downgraded after investigation. These include 2 x potential delayed diagnosis, 3 x Transfers Out, 1 x Fall and 1 staff injury.

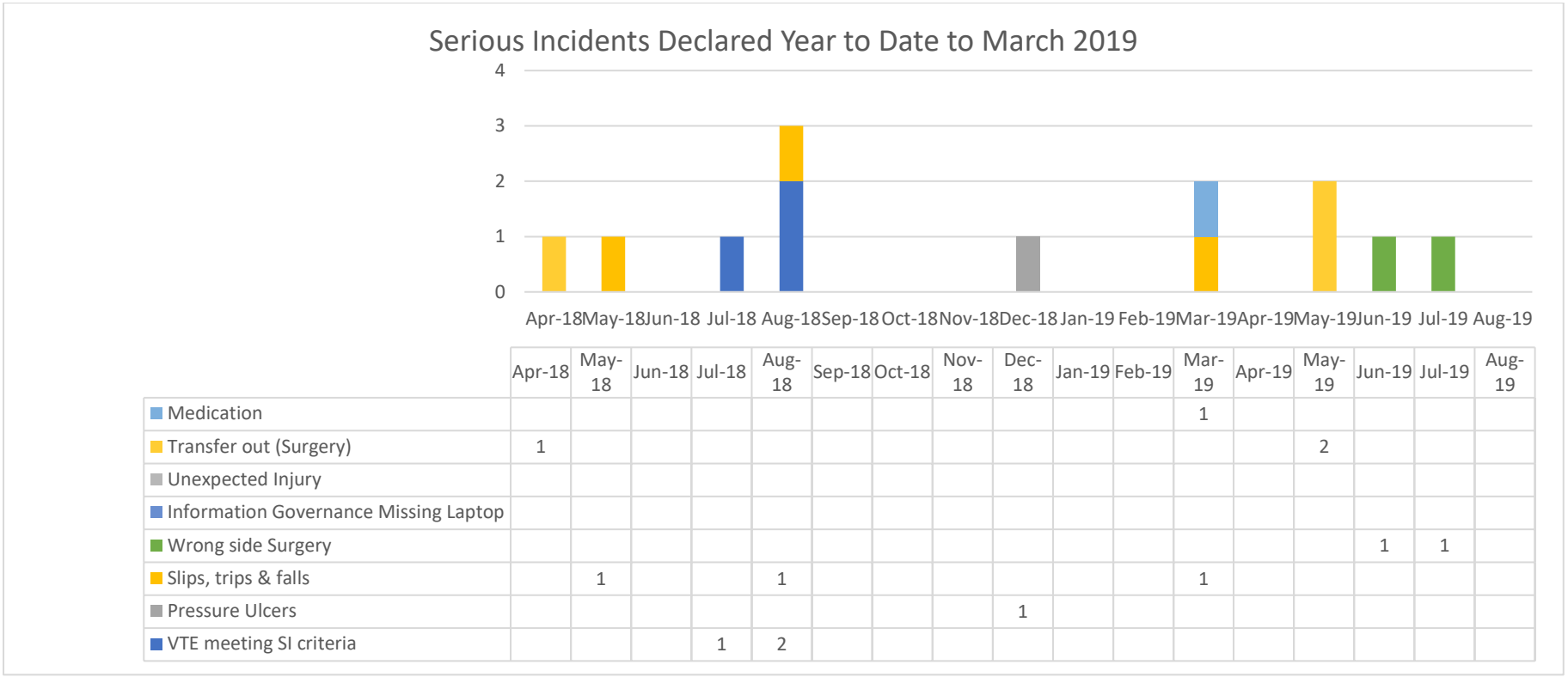
ACTIONS FOR IMPROVEMENTS / LEARNING

Case studies for the two Never Events reported this year have been developed and are to be sent out for shared learning. These were shared on the World Patient Safety Day.

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.**



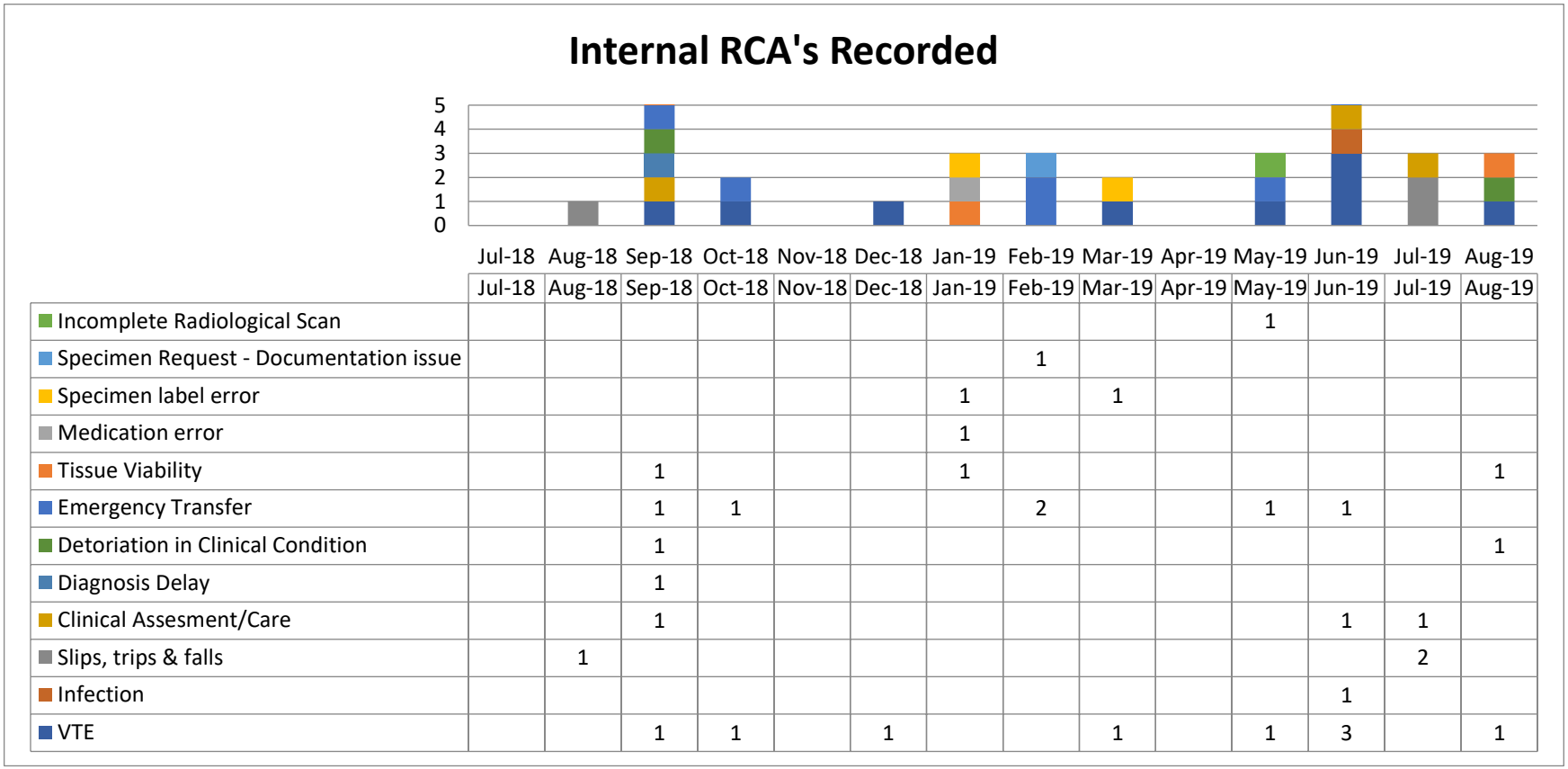
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Medication												1					
Transfer out (Surgery)	1													2			
Unexpected Injury																	
Information Governance Missing Laptop																	
Wrong side Surgery															1	1	
Slips, trips & falls		1			1							1					
Pressure Ulcers									1								
VTE meeting SI criteria				1	2												

Year Totals	
18/19	9
19/20	4

Data Source – STEIS

INFORMATION
No Serious Incidents were reported in August 2019.
ACTIONS FOR IMPROVEMENTS / LEARNING
Two Serious Incidents were submitted to the CCG for Closure (2x Vascular Incidents). No Serious Incidents were closed by the CCG in August 2019
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCA's incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Incomplete Radiological Scan											1			
Specimen Request - Documentation issue								1						
Specimen label error							1		1					
Medication error							1							
Tissue Viability			1				1							1
Emergency Transfer			1	1				2			1	1		
Detoriation in Clinical Condition			1											1
Diagnosis Delay			1											
Clinical Assesment/Care			1									1	1	
Slips, trips & falls		1											2	
Infection												1		
VTE			1	1		1			1		1	3		1

Data Source – Internal RCA tracker

INFORMATION

3 Internal RCAs were declared in August 2019

ACTIONS FOR IMPROVEMENTS / LEARNING

One RCA was closed in August 2019

Brief incident description:
The Patient triggered the sepsis pathway during her stay at ROH

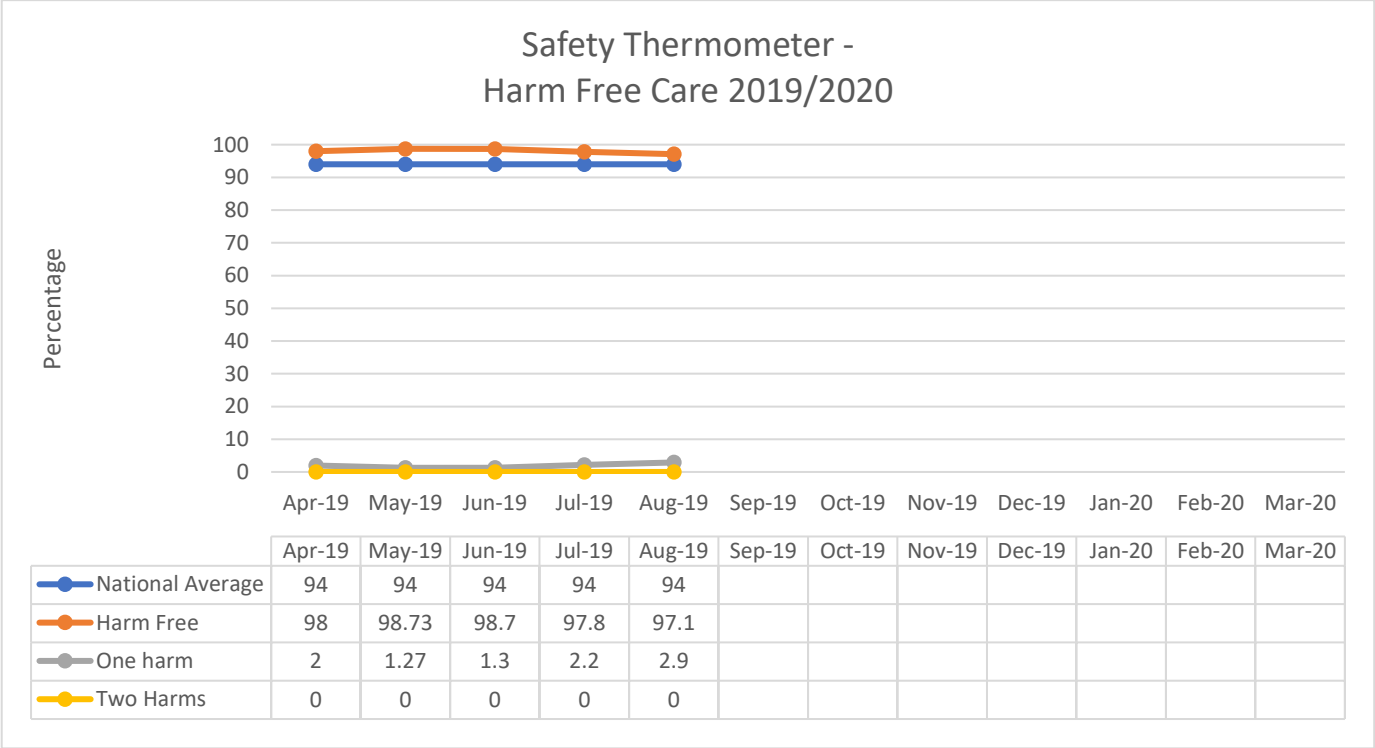
Lessons learned

- The transfer and boarding card documentation must be completed and filed in the patients notes as per ROH policy, this must include an assessment of any devices insitu at the time of transfer/admission.
- Any device should be removed upon transfer if there is a lack of assurance regarding ongoing monitoring of the device prior to admission or transfer to ROH, if the device cannot be removed due to clinical need this must be documented in the patients notes and reviewed daily.
- All PVC's must be flushed to maintain patency as per ROH policy and the device removed immediately if no longer needed for medication/ fluid administration or if the patient reports discomfort / pain at the insertion site.
- All clinical staff involved with PVC devices must ensure that documentation entries meet national/trust policy requirements regarding insertion, ongoing care and removal of the device.
- Registered nurses must ensure all documentation entries by a student nurse / non -registered staff are countersigned.
- All patients should have a clear and concise record of transfer and assessment of any devices present carried out by clinical and nursing staff documented in admitting notes.
- Student nurses must escalate NEWS scores to the registered nurse looking after the patient and document that this has been communicated, this must be countersigned by the registered nurse.
- All clinical staff note entries must be legible, dates documented, and signatures printed and signed.

RISKS / ISSUES

None

5. **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.**



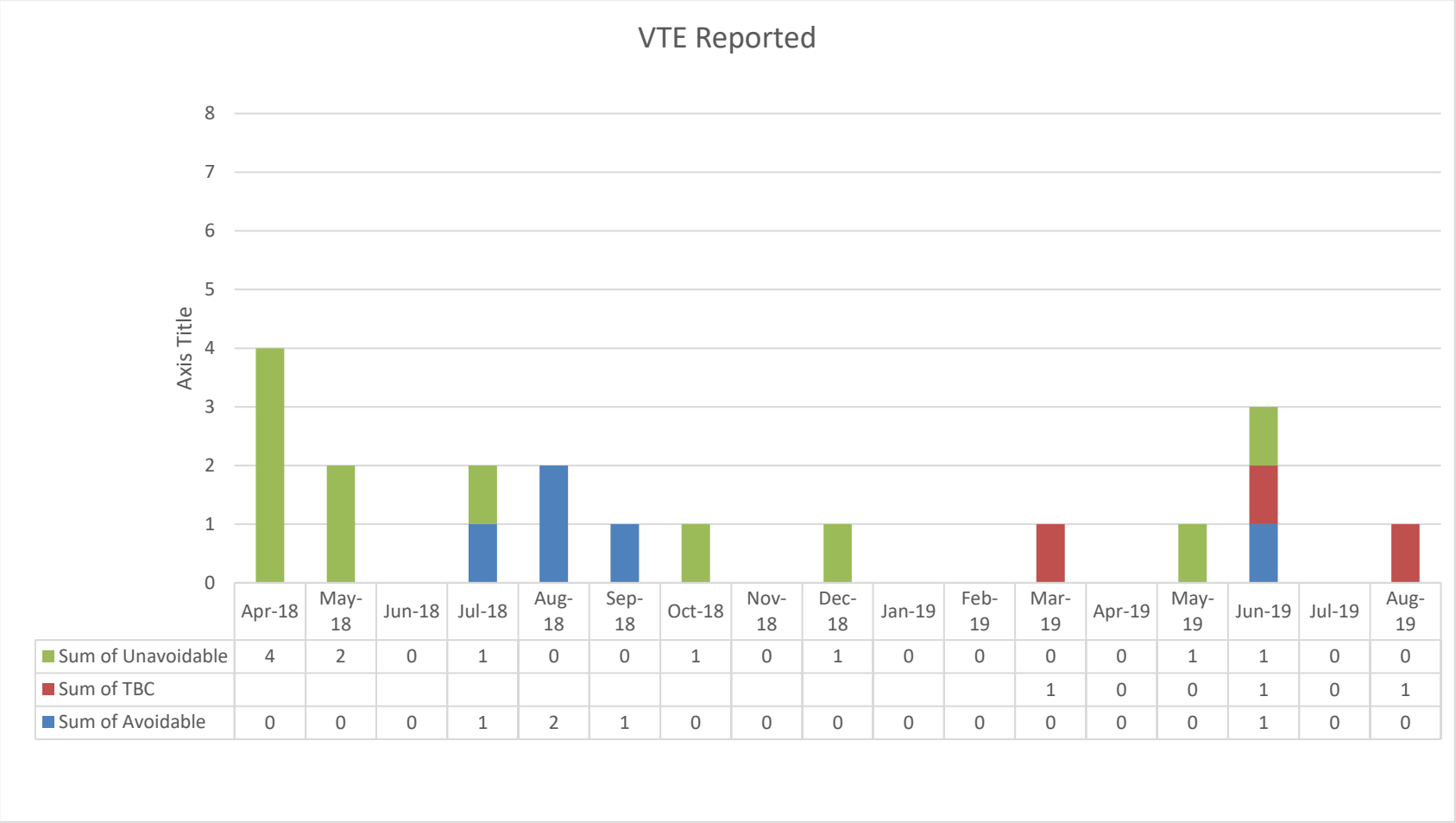
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
National Average	94	94	94	94	94							
Harm Free	98	98.73	98.7	97.8	97.1							
One harm	2	1.27	1.3	2.2	2.9							
Two Harms	0	0	0	0	0							

The Harms reported were;

2 x New Falls on Ward 2 and 3
1 x Old Pressure Ulcer on Ward 12
1 x New Pressure Ulcer on Ward 3

Data Source – Informatics

6. **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).**



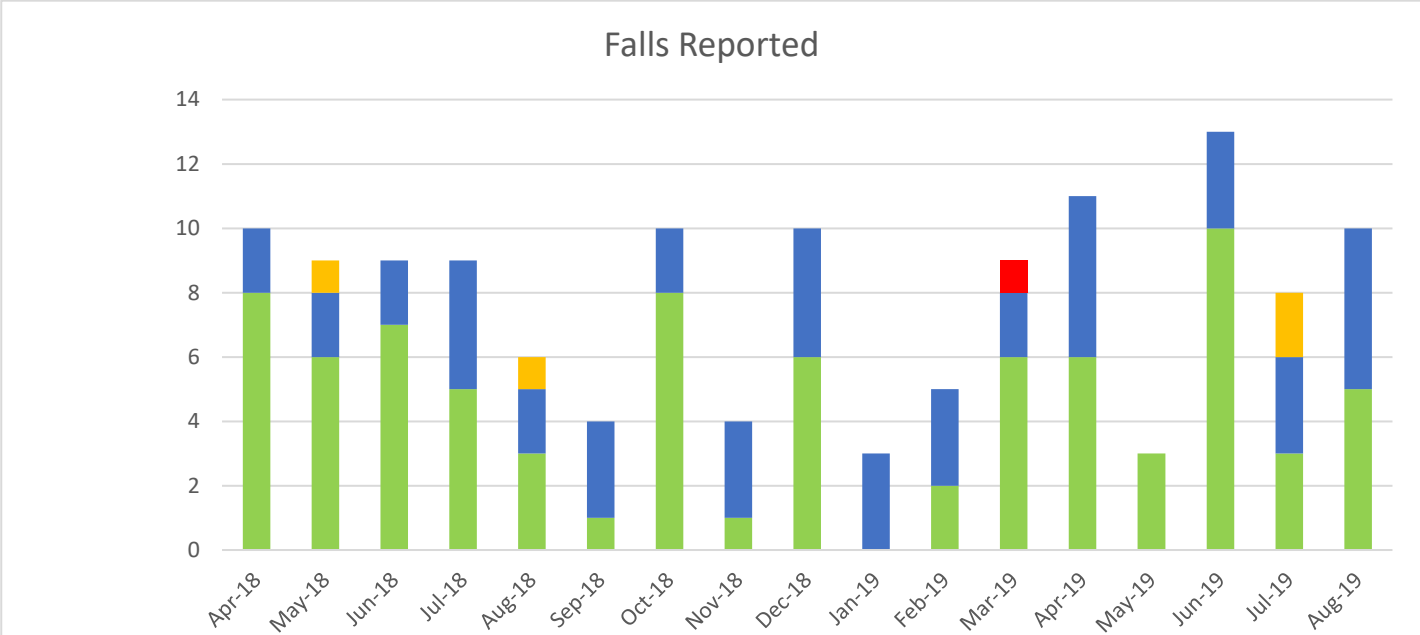
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sum of Unavoidable	4	2	0	1	0	0	1	0	1	0	0	0	0	1	1	0	0
Sum of TBC												1	0	0	1	0	1
Sum of Avoidable	0	0	0	1	2	1	0	0	0	0	0	0	0	0	1	0	0

Avoidable Year Totals	
18/19	4
19/20	2

INFORMATION
There was 1 hospital acquired VTE's reported in August 2019. The RCA is complete following the post-discharge death from a PE in a day case patient. The inquest is being held on the 19th September 2019. On-going non-compliance regarding 24-hour re-assessment was 83.29% in August (88.4% in July). Monthly reports are provided to the relevant leads who have been given delegated responsibility by the Medical Director to address this. Reduced compliance with on-admission risk assessment. National requirement >95%. ROH compliance for August 95.46%. Report identifying patients and their named surgeon shared with Divisional 2 leads and Medical Director-all the patients on the list are day cases. Agreement has been reached at Division 2 meetings that as of 30/09/19 no patient will leave ADCU until this mandatory requirement is complete. None completion means VTE risk not identified, patients are not fully admitted on PICS and that the discharge letter will be incomplete as a result.
ACTIONS FOR IMPROVEMENTS / LEARNING
Compliance with the 24-hour VTE risk assessment has decreased again in August 2019 . Actions and learning as detailed above On admission risk assessment is consistently above the nationally required 95%, however this has deteriorated and we should be aiming for 100% compliance. Actions and learning as above
RISKS / ISSUES
Non-compliance with on admission and 24 hour risk assessment as detailed above is not in line with national or Trust Guidance. A decision will need to be made on action if there is repeated non-compliance by individual medical staff. VTE leads will escalate this at Quality & Safety meeting in September where they have been asked to present. Planned actions regarding ensuring mandated requirement to complete on admission VTE risk assessment so reducing risk to patients: Some surgeons have stated this will slow down theatre lists. Divisional leads are aware of these concerns.

Data Source – Ulysses and VTE leads

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 fall's 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	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Moderate Harm	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0
Low Harm	2	2	2	4	2	3	2	3	4	3	3	2	5	0	3	3	5
No Harm	8	6	7	5	3	1	8	1	6	0	2	6	6	3	10	3	5

Year Totals	
18/19	88
19/20	45

Data Source – Ulysses and Falls Group

INFORMATION

There were 13 incidents reported across the Trust in August 2019 relating to Falls, 3 of these incidents involved patients being lowered to the floor.

Theme of falls was mainly unwitnessed falls in the bathroom. Clinical staff are being reminded on the clinical skills update training sessions to advise patients to use their call bell if they need assistance rather than risk falling. There were no avoidable falls.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions Underway

- Purchase of another Hover Jack - capital bid rejected, to explore sourcing funding from charitable funds as alternative.
- Looking at development of fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall.
- Development of combined dementia/falls notification in pre-op assessment to identify patients at risk at an early stage.
- Looking at patient engagement around Falls and how best we approach this, including patient representation on Falls/Dementia working group.
- Reviewing information on Falls notice boards.

Positive Assurance

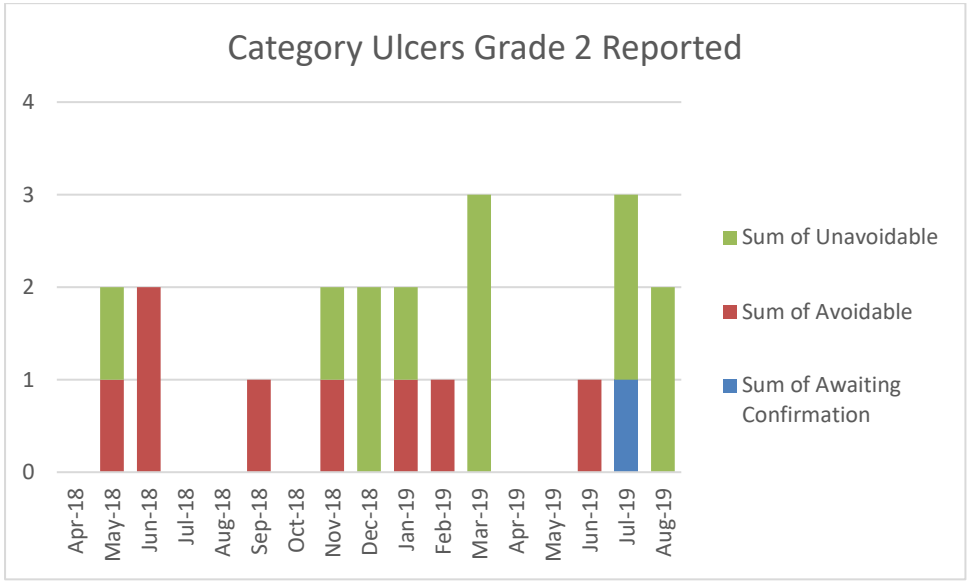
- On-going training around Falls awareness on clinical skills update days.
- Extra training on the use of the Sara Steady Hoist carried out on 24/6/19 by Derby manual handling training group to ward based groups of staff – now need to scope level of training across ward areas to ensure sufficient numbers trained.

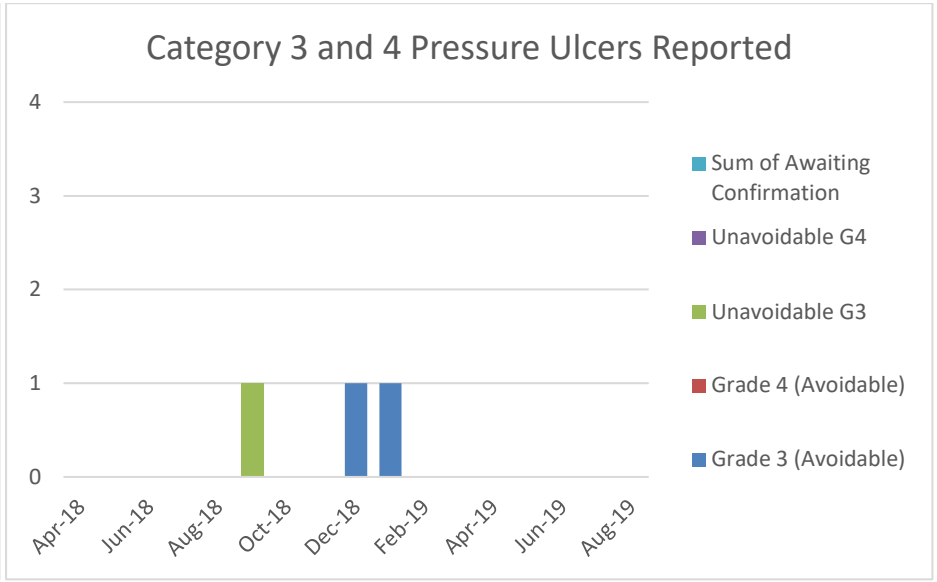
RISKS / ISSUES

When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Bid submitted to replace hoists Trust wide – rejected, no change in status. Two areas – ADCU & hydrotherapy are without hoists as they are obsolete, having to borrow from other areas.

Only one Hover Jack available for the trust, this is also used for training, capital bid rejected, to look at option of using charitable funds.

8. **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.**





Data Source – Ulysses and TV team

Year Total	Cat 2	Cat 3
18/19	15	3
19/20	6	0

INFORMATION

August 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	1 - unavoidable
Category – 2 (Device)	1 - unavoidable
Category – 1	2 - unavoidable 1- Avoidable
Suspected Deep Tissue Injury	1
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Intertriginous dermatitis – x4 MASD ROH Incontinence- 0 MASD admitted with Intertriginous dermatitis x1 (x1 Hereford) MASD admitted with Incontinence- 0

Patients admitted with PUs	PU admitted with Cat 1- 1 (x1 patients home) PU admitted with Cat 2- x4

Avoidable Pressure Ulcer CCG Contracts KPI

2019/2020	
Avoidable Grade 2 pressure Ulcers limit of 12	1
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

Current Actions

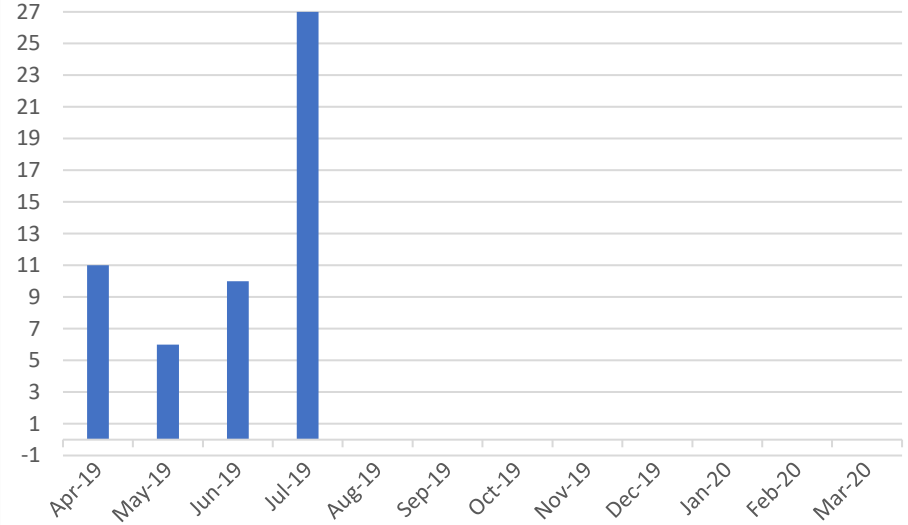
- PU Policy has been amended again to reflect the care of patients with dementia and will be sent out for comments as soon as it is formatted
- Incident – MDRPU related to tourniquet management intra-operatively being investigated and practice has changed
- Apples and PUs #itsmorethanabruise - SDTI training continue where needed
- All HCAs within Trust will receive skin assessment training
- TV team will now be delivering training on the new registered nurses induction weeks starting from November 2019

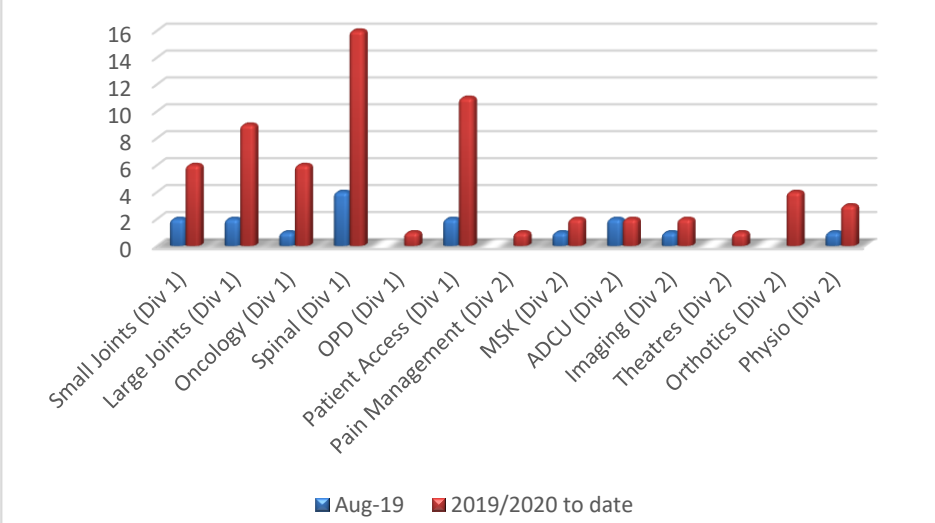
- Registered Nurses competency booklet has been updated with scenario questions relating to each type of pressure ulcer, MASD to increase knowledge.

RISKS / ISSUES

None

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.





Complaint Year Totals	
18/19	139
19/20	70

Data Source – Patient Experience team

INFORMATION

Complaints

There were 16 formal complaints made in August 2019. All were initially risk rated amber or yellow. This is higher than last year (11 complaints in August 2018). It is possible that more concerns are becoming formal complaints as a result of the reduced staffing within the PALS and Complaints Department. The themes of this month's complaints were:

Complaints August 2019	
Appointments	1
Clinical	4
Communication	4
Patient Care	2
Facilities	1
Values & Behaviours	2
Waiting times	5

PALS

The PALS department handled 51 contacts during August 2019 of which 28 classified as concerns. This is a reduction in calls compared to the same time last year (77 contacts in August 2018) with roughly the same number of concerns (30 concerns in August 2018). The main themes in the PALS data continue to relate to queries about appointments (either length of wait for or cancellations). 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. 39% of enquires and 61% of concerns were handled within the agreed timescales. This was caused by absence of the Patient Services Manager during the period, together with the ending of a temporary administrator contract at the same time.

PALS Concerns		
	Aug-19	2019-2020 to date
Access to treatment		9
Admissions & Discharges		4
Appointments	12	118
Clinical	6	42
Communication	3	16
Facilities		6
Patient Care	3	7
Trust Administration		19
Transport		2
Values & Behaviours		6
Waiting times	4	15
Other		1
	28	245

Compliments

There were 601 compliments recorded in August 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments Aug 2019
Div. 1	522
Div. 2	79
	601

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 receive a request monthly to submit their compliments for central logging.

When compliment data is submitted to the Patient Services Team, it is now themed using the same coding as the rest of the data. Overwhelmingly staff are complimented on Values & Behaviours (88% of recorded compliments in August 2019) with a small number of compliments about Communication and Patient Care (5% and 2% respectively in August 2019)

ACTIONS FOR IMPROVEMENTS / LEARNING

12 complaints were fully upheld and 3 were partially upheld

Learning identified and actions taken as a result of complaints closed in August 2019 include:
Transition to Partial Booking has caused some frustration and confusion for patient
Action: Individual Support has been offered to those that need this

Waiting times for appointments with members of the spinal team is causing frustration
Action: Spinal Service are reviewing allocation where necessary

Information about x-ray on in-touch system had potential to cause confusion
Action: In-touch system reviewed and wording changed for clarity

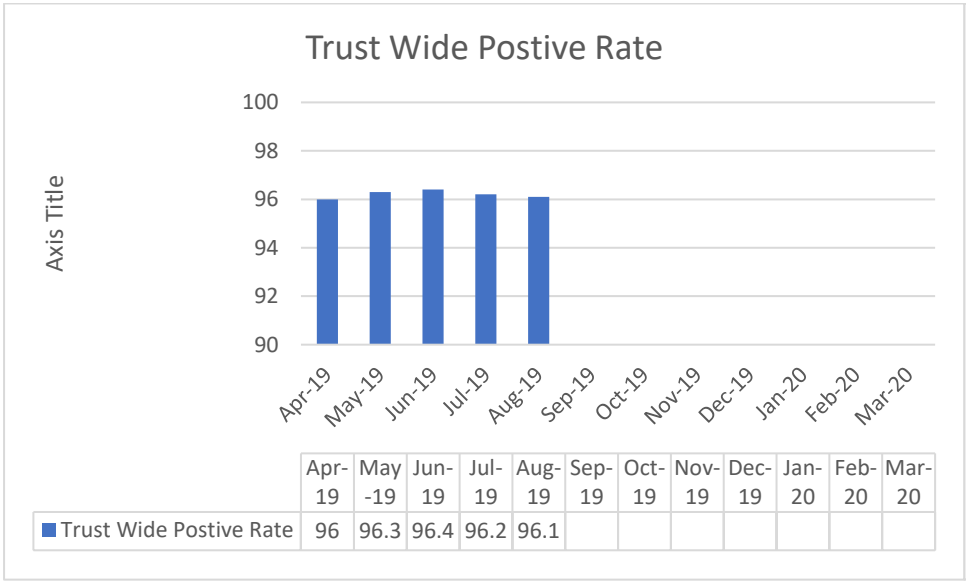
RISKS / ISSUES

Reduced Staffing in PALS and Complaints Service is presenting a risk in the high-quality service that ROH provides and expects for patients

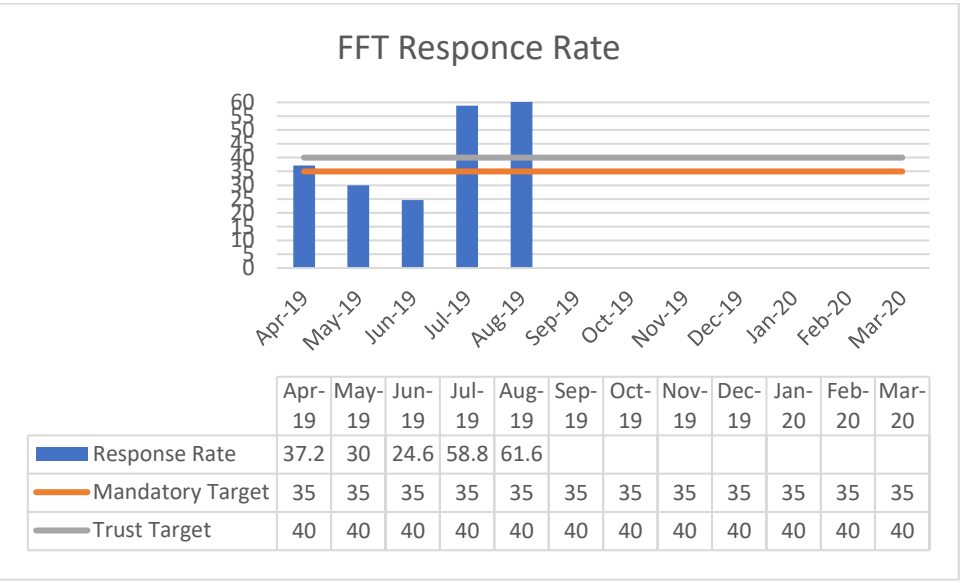
COMEBACK COMPLAINTS

No comebacks passed to Patient Services Team

10. Friends and Family Test Results (collected in the iwantgreatcare system)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Trust Wide Postive Rate	96	96.3	96.4	96.2	96.1							



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Response Rate	37.2	30	24.6	58.8	61.6							
Mandatory Target	35	35	35	35	35	35	35	35	35	35	35	35
Trust Target	40	40	40	40	40	40	40	40	40	40	40	40

Data Source – Patient Experience team 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

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 agreed internal targets for all areas and as a result, the data is 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 requested 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

The team are recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In August 2019, 51 concerns were identified from the 1709 individual pieces of feedback we received. This is a similar increase to last month but is as a result of better recording and monitoring, rather than an increase in actual concerns. As these are anonymous, it is not always possible to track this back to individual patients but they are shared with the relevant teams and managers as additional feedback.

FFT Concerns August 2019	
Access to treatment	2
Appointments	21
Communication	7
Facilities	5

Patient Care	6
Staffing Numbers	2
Values & Behaviours	5
Waiting times	2
Other	1

Information is 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 and the Trust Internal target of 40% for Inpatient Services this month. The internally set target of 20% for Outpatient services was also met this month. This information has been shared with Departmental and Directorate Leads

INPATIENT SERVICES AS REPORTED TO NHS DIGITAL					
Department	**% of people who would recommend the**	**% of people who would NOT recommend the**	**Number of Reviews submitted in August**	**Number of Individuals who used the**	**Department Completion Rate (Mandated at 35%)**
Ward 1	100.0%	0.0%	43(37)	50	86.0%
Ward 2	100.0%	0.0%	73(55)	73	100.0%
Ward 3	100.0%	0.0%	47(36)	72	65.3%
Ward 12	96.6%	3.4%	58(53)	66	87.9%
Ward 10	84.2%	5.3%	19	22	86.4%
ADCU	96.4%	0%	83(95)	484	17.1%
HDU	100%	0%	21(16)	69	30.4%
Overall Trust Inpatient Response Rate for August 2019					61.6%

OUTPATIENT SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in August 2019**	**% of people who would NOT recommend the department in August 2019**	**Number of Reviews submitted in August 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Outpatient Services	96.4%	1.0%	1337 (1055)	25.7%

COMMUNITY SERVICES AS REPORTED TO NHS DIGITAL				
Department	**% of people who would recommend the department in August 2019**	**% of people who would NOT recommend the department in August 2019**	**Number of Reviews submitted in August 2019**	**Department Completion Rate (no mandatory return but internal target set of 20%)**
Royal Orthopaedic Community Services	100.0%	0.0%	28(36)	103.0%

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.

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. There are plans to audit the duty of candour process.

12. **Litigation**

New claims

0 new claims against the Trust were received in August 2019

On-going claims

There are currently 29 on-going claims against the Trust.
26 of the claims are clinical negligence claims.
3 claims are staff claims

Pre-Application Disclosure Requests*

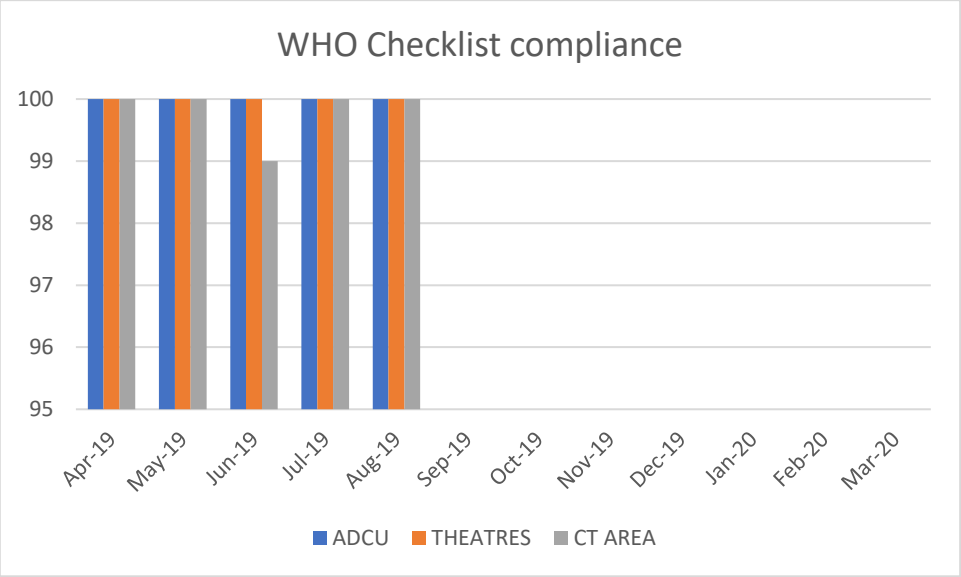
6 new requests for Pre-Application Disclosure of medical records were received in August 2019.

**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 General Data Protection Regulations 2018 and the Access to Health Records Act 1990)*

13. **Coroner's Inquests**

There were no Inquests held in August 2019. There is an Inquest hearing listed for the 19th September 2019.

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.



Data Source – Theatreman and local audits

INFORMATION

The data is retrieved from Theatre man. On review of the audit process, the incomplete 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 = 804

The total WHO compliance for Theatres in August 2019 = 100%

CT area

Total cases = 94

The total WHO compliance for CT in August 2019 = 100%

ADCU

The snapshot WHO audit compliance for August 2019 = 100%

ACTIONS FOR IMPROVEMENTS / LEARNING

Any non- compliance will be reported back to the relevant clinical area.

RISKS / ISSUES

WHO checklist for ADCU 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.

15. Infection Prevention Control – Reportable Infections

INFORMATION

Infections Recorded in August 2019 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	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	1

ACTIONS FOR IMPROVEMENTS / LEARNING

15 IP recorded incidents in August, 2019:

- 11 no harm – 6 failed commodes, 2 lines inappropriately managed, 1 uncollected waste, 1 visitor visiting a ward in healthcare uniform and 1 non-compliance to hand hygiene.
- 2 low harm – 1 sepsis incident and 1 non- compliance to MRSA screening.
- 2 severe harm – BCH associated patients.

RISKS / ISSUES

- ROH continues to review the status of staff requiring Hepatitis B vaccinations and ensure vaccinations are provided where required.
- Scheme of planned building works, for new theatres, poses an increased risk of cross contamination. Additional IPC precautions in place across site to reduce risk.

- Increase in physical environmental concerns, that have infection prevention implications, have been recorded under “estates” as incidents.
- All clinical areas, with the exception of CYP, failed the August commode audit. Actions with each area have been undertaken and will be reported and monitored via August IPOG and divisional conditional reports.
- 2 incidents relating to BCH associated patients presently under organisational incident review process.

***Data Source – IPC team and Ulysses**

16. Safeguarding

INFORMATION

Detailed is the Safeguarding KPI and figures. These were reported to the Safeguarding committee in September 2019.

	November 2018	December 2018	January 2019	February 2019	March 2019	April 2019	May 2019	June 2019	July 2019	August 2019
Safeguarding Adult Notifications	11	14	26	14	21	15	14	26	23	16
Safeguarding Paediatric Notifications	51	28	28	31	26	21	29	27	48	23
Mental Health Incidents	8	9	8	2	8	2	3	12	25	11
LD Adult	12	10	12	8	14	8	5	8	16	13
LD Paeds	26	24	28	25	24	21	46	28	49	26
Adult Level 2	98.08	98.08	98.08	98.08	98.08	98.08	97.56	97.44	98.42	-
Adult Level 3	83.33	83.33	83.33	83.33	83.33	83.33	81.31	74.89	70.41	-
Level 4	80	80	80	80	80	80	80	50	100	-
Child Level 2	98.07	98.07	98.07	98.07	98.07	98.07	97.55	97.43	98.60	-
Child Level 3	86.64	86.64	86.64	86.64	86.34	86.34	77.71	73.99	68.18	-
CE	0	0	0	0	0	0	0	0	0	0
FGM	0	1	0	2	0	2	1	0	0	0
DOLS	2	1	2	2	2	2	3	2	4	7
MCA	5	7	12	1	1	2	2	2	3	6
PIPOT cases	0	0	0	0	0	0	0	0	0	0
Domestic Abuse	0	0	0	2	4	1	1	0	1	1
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0

WNB	23	11	14	17	18	12	18	17	30	46
Child in Care	4	5	2	2	1	1	2	1	3	0
Early Help	0	0	0	1	0	0	0	0	0	1

ACTIONS FOR IMPROVEMENTS / LEARNING

The Safe Recruitment policy is under review.

- Missing persons policy has been approved
- Chaperone policy has been extended
- Children's Safeguarding is due to be signed off

RISKS / ISSUES

There has been a fall in training rates for WRAP, prevent and Safeguarding level 3 training; this is due to a review undertaken against the new training requirements for staff.

17. – CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Data not available

Reference	Alert Title	Originated By	Date Issued by MHRA	Status	Deadline
MDA/2019/028	Microneedling pens: Dermapen 3 and Dermapen CryoSterile single use needle cartridge tips for: Dermapen 3 - risk of injury or infection. Dermapen 3 devices are intended to stimulate the skin for natural collagen induction. Affected devices were manufactured after 30 May 2017. Dermapen Cryo devices are intended to treat skin tags, lesions, warts and benign moles. Do not use affected devices as they have been manufactured to unknown standards and their safety cannot be verified. Other trading names are as follows:	MHRA Medical Device Alerts	27-Aug-19	Action not Required	24 Sep 2019

	DermapenWorld Pty Ltd, Equipmed USA, Equipmed Europe Limited or Equipmed International Pty.				
SDA/2019/004	Emerade 500 microgram and 300 microgram adrenaline auto-injector devices Emerade 500 microgram and 300 microgram devices manufactured by Bausch & Lomb UK will be experiencing a short-term disruption in supply. Emerade 500 microgram is out of stock until the 28 August 2019. Emerade 300 microgram has limited supplies remaining but will be out of stock from early-mid August with further supplies expected by 30 September 2019. This alert sets out a management plan for organisations to follow in managing stock.	DHSC Supply Disruption Alert	01-Aug-19	Action not Required	30 Sep 2019

Outstanding Alerts

Reference	Alert Title	Originated By	Date Issued by MHRA	Status	Deadline
EFN/2019/01	Energy Networks Association (ENA) Various DINs, SOPs and NeDERs, issued since May 2018. The Energy Networks Association have issued a range of notifications which this alert provides links to. The issues raised by these notifications may be of relevance to providers of NHS services.	NHS Improvement Estates and Facilities	12-Jul-19	Assessing Relevance	31 Oct 2019

Workforce Performance Report

As at 31st May 2019

CONTENTS

Staffing costs

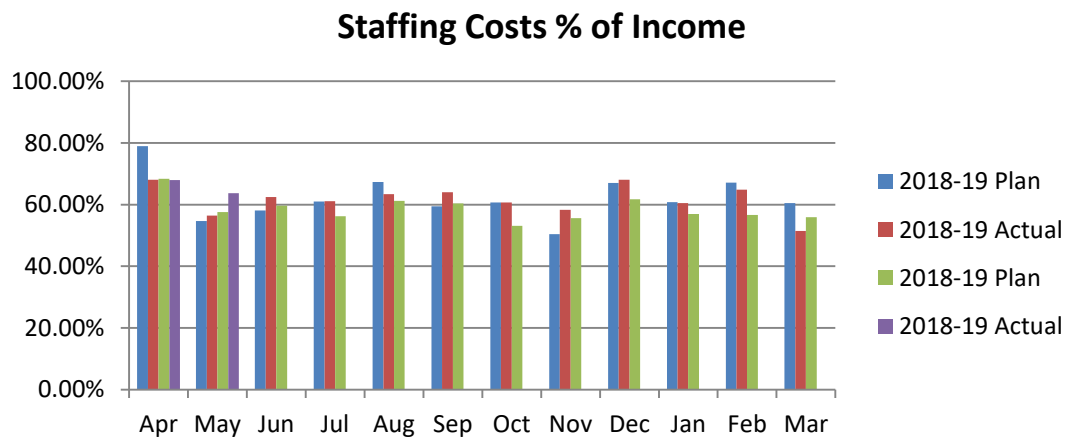
1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income YTD	6673	
Actual Income YTD	6857	101%
Planned Pay Costs (YTD)	4564	
Actual Pay Costs (YTD)	4659	102%
Planned Substantive Pay Costs (YTD)	3760	
Actual Substantive Pay Costs (YTD)	3780	101%
Planned Bank Pay Costs (YTD)	425	
Actual Bank Pay Costs (YTD)	464	109%
Planned Agency Pay Costs (YTD)	368	
Actual Pay Costs (YTD) Agency Staff	410	111%
Planned Agency Pay Costs as % of total Pay costs (YTD)		8.06%
Actual Agency Pay Costs as % of total Pay costs (YTD)		8.80%

Total ADH Payments (Apr - Dec) £000s	210

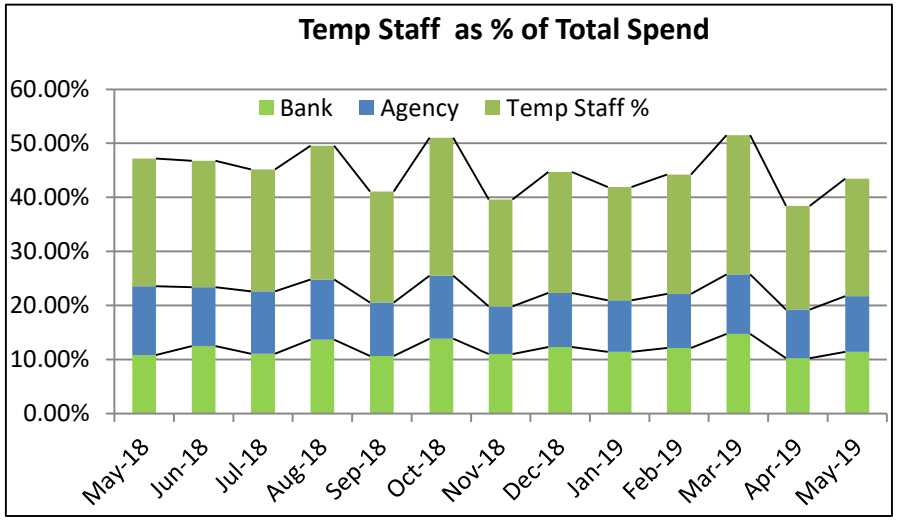
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	241	410
May		
Jun		
Jul		
Aug		
Sep		
Oct		
Nov		
Dec		
Jan		
Feb		

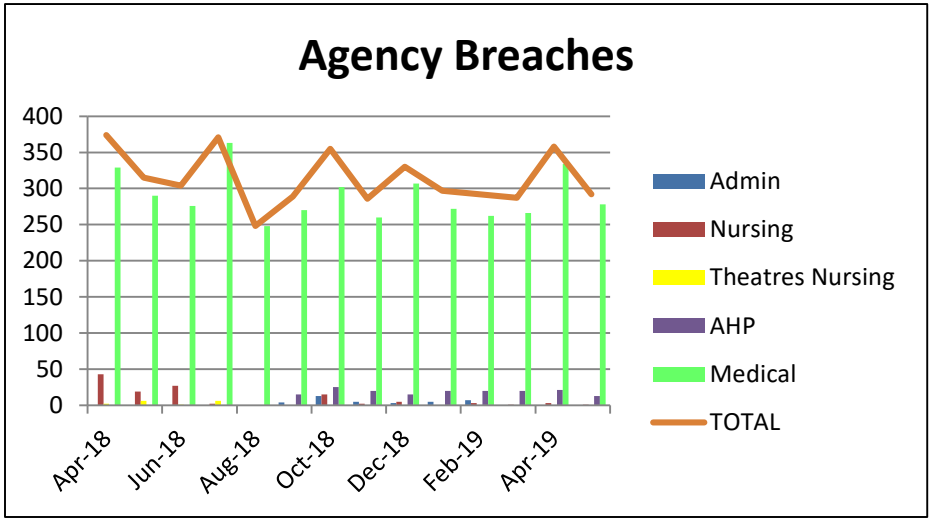


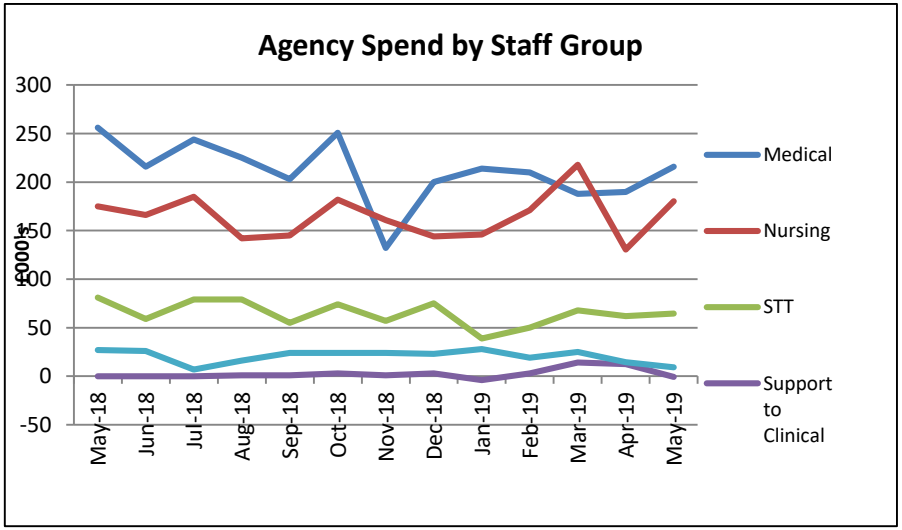
Data based upon April 2019 Management Accounts

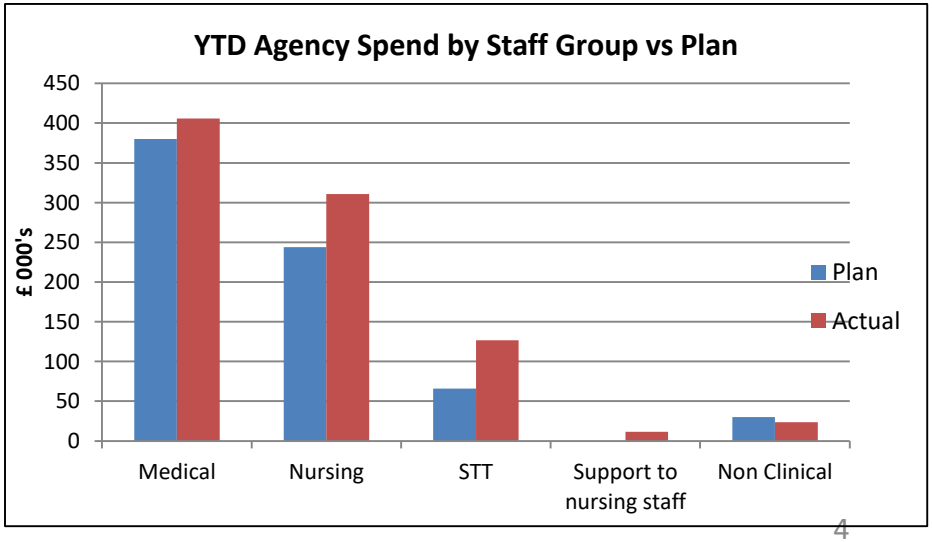
1 Workforce Composition and Cost

1a Temporary Staffing Analysis



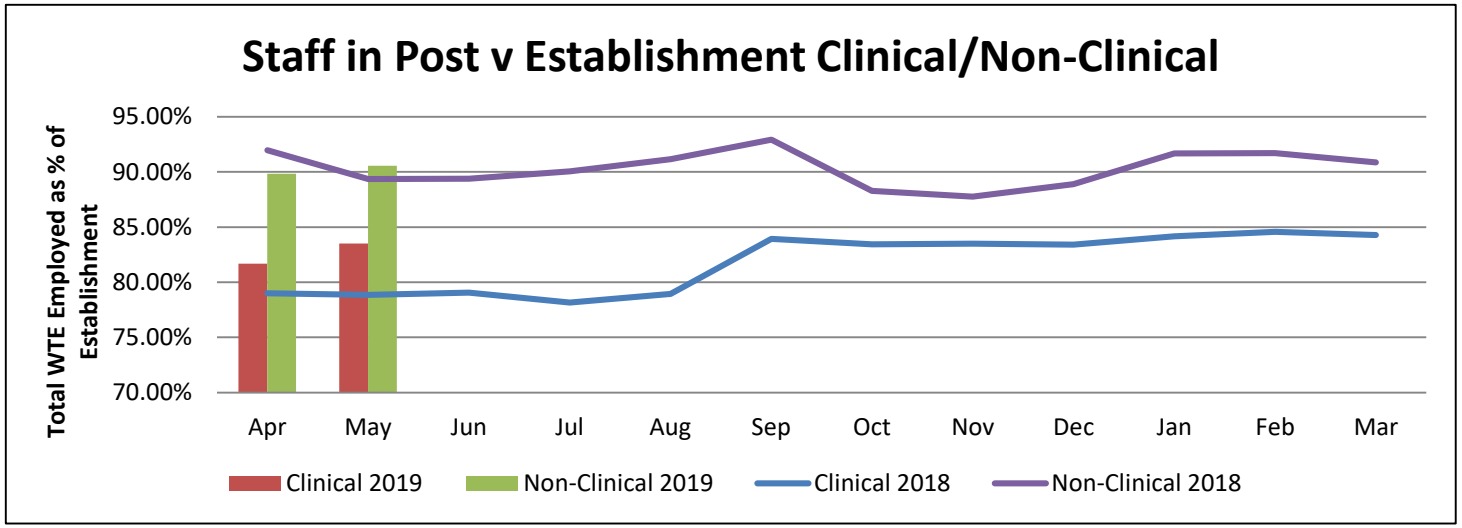


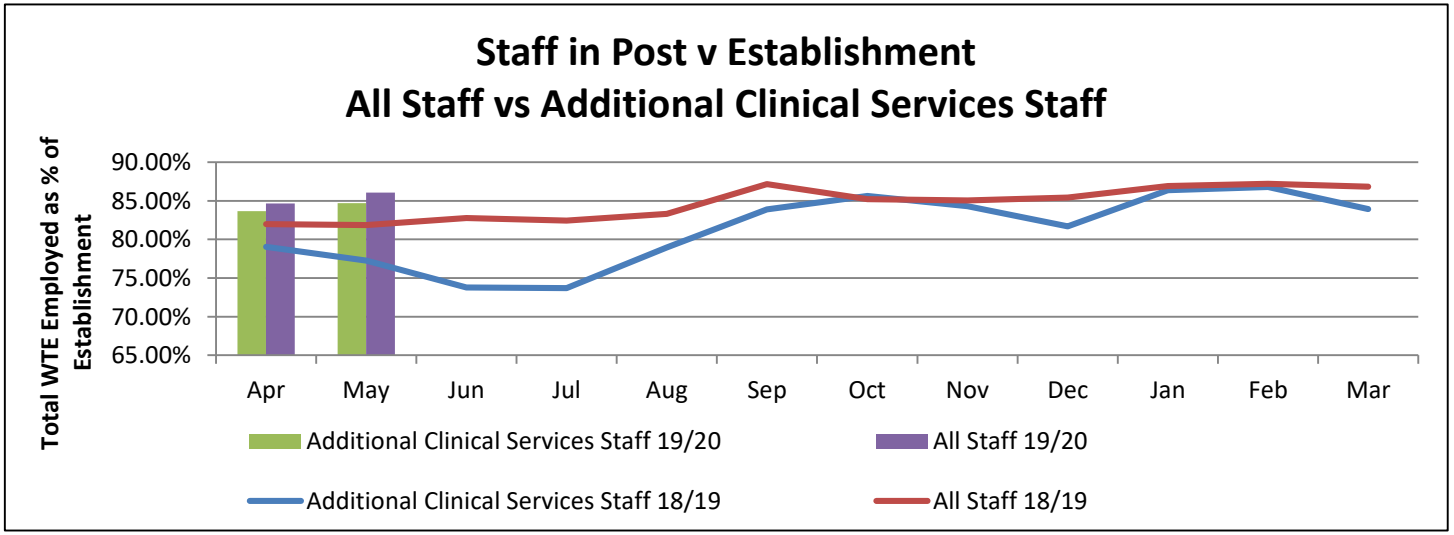




1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

Establishment

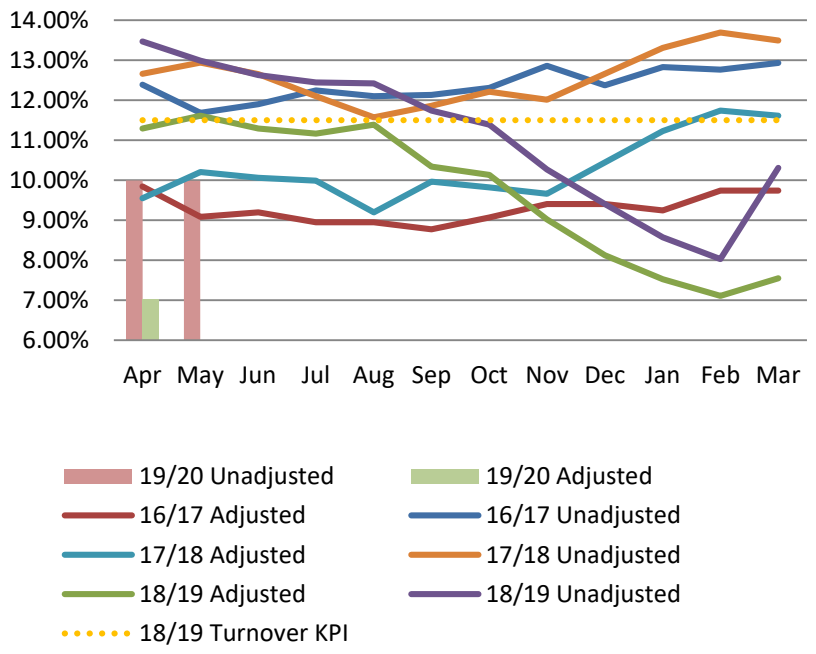




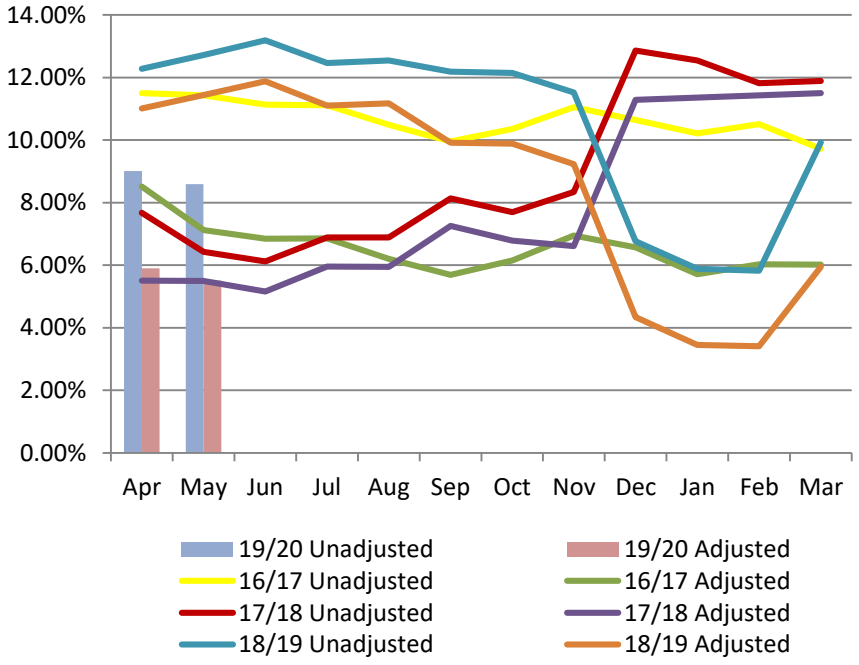
1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Turnover

Staff Turnover

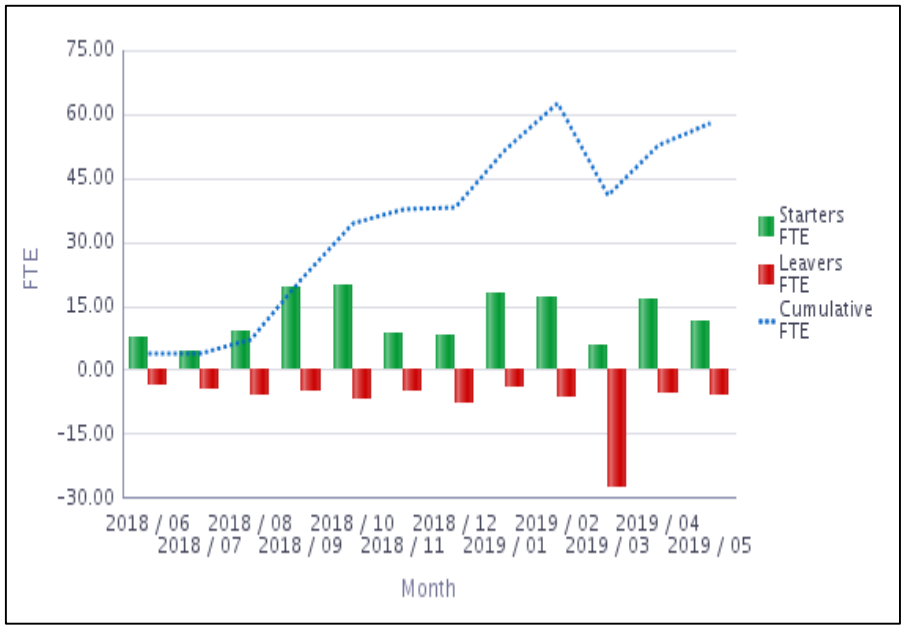


Additional Clinical Services Staff Turnover

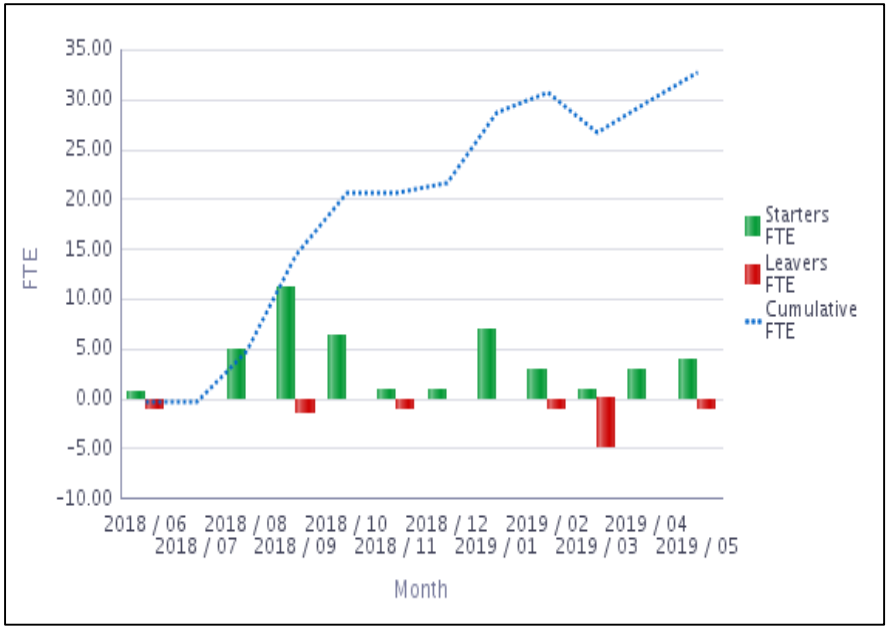


1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Starters / Leavers by Month
All Staff

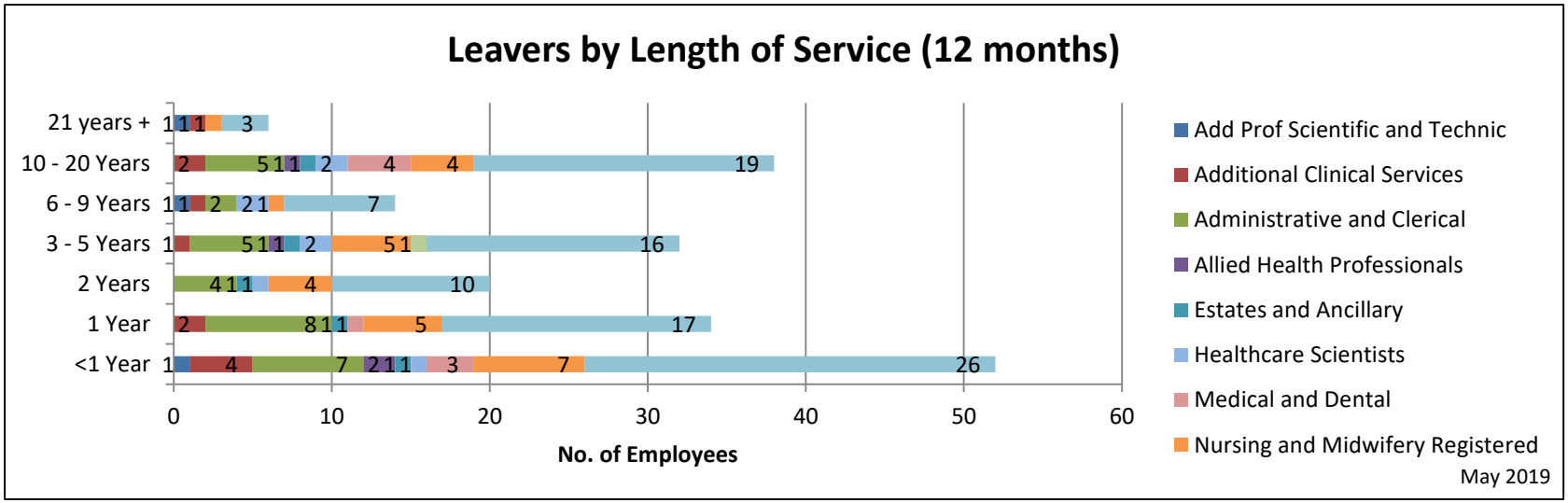


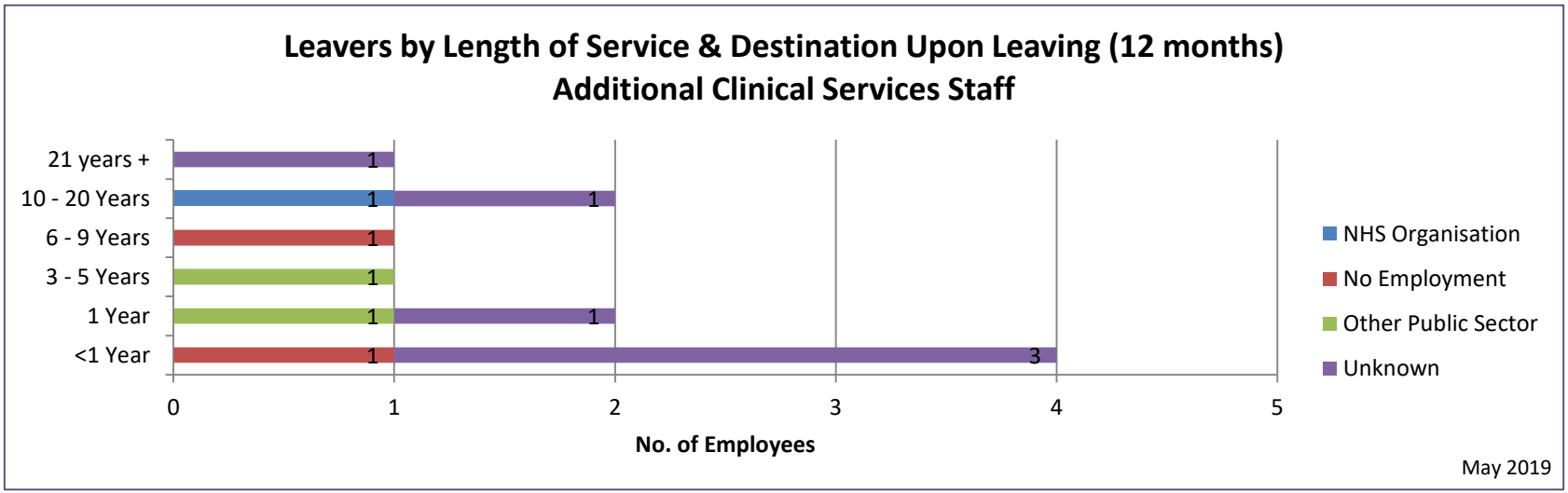
Starters / Leavers by Month
Additional Clinical Services Staff



1 Workforce Composition , Resourcing and Cost

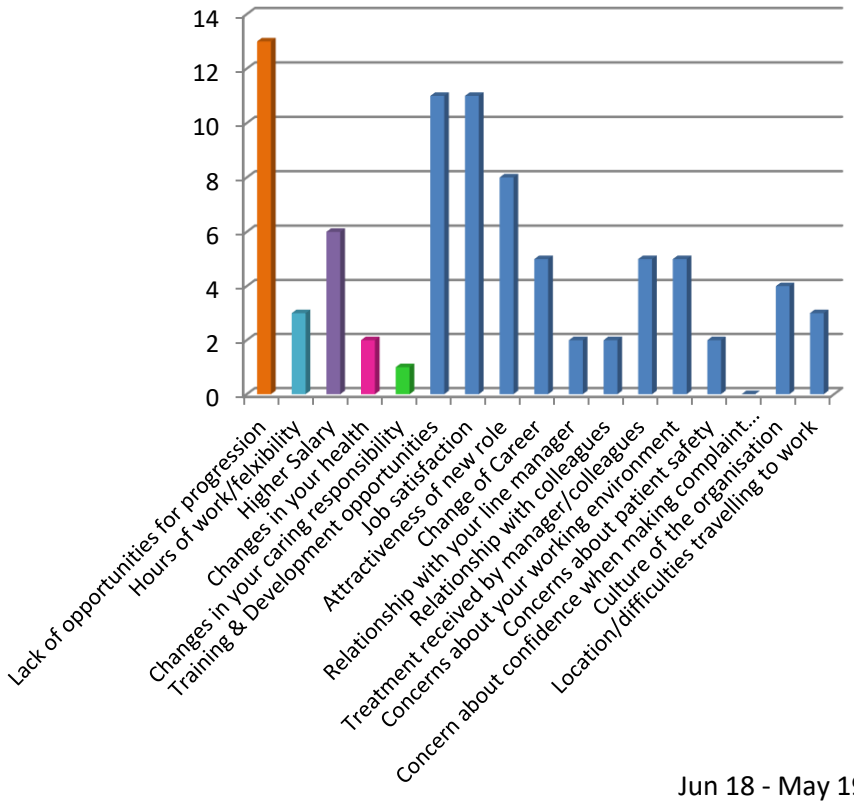
1d Staff Turnover





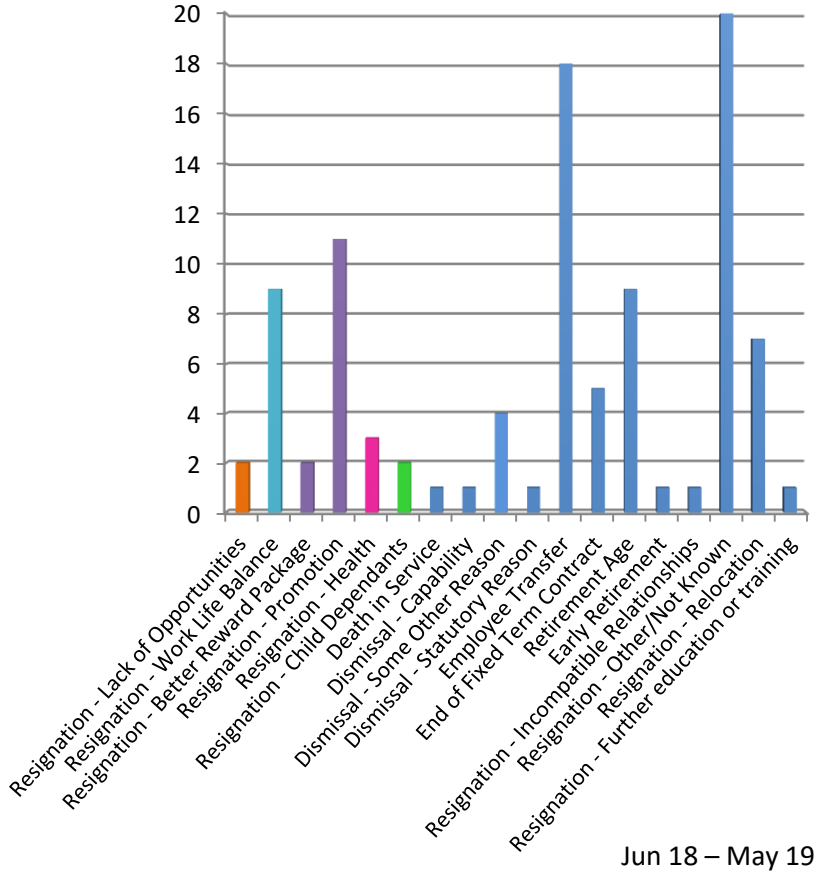
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

Reason for Leaving (All Staff) Exit Questionnaire



Jun 18 - May 19

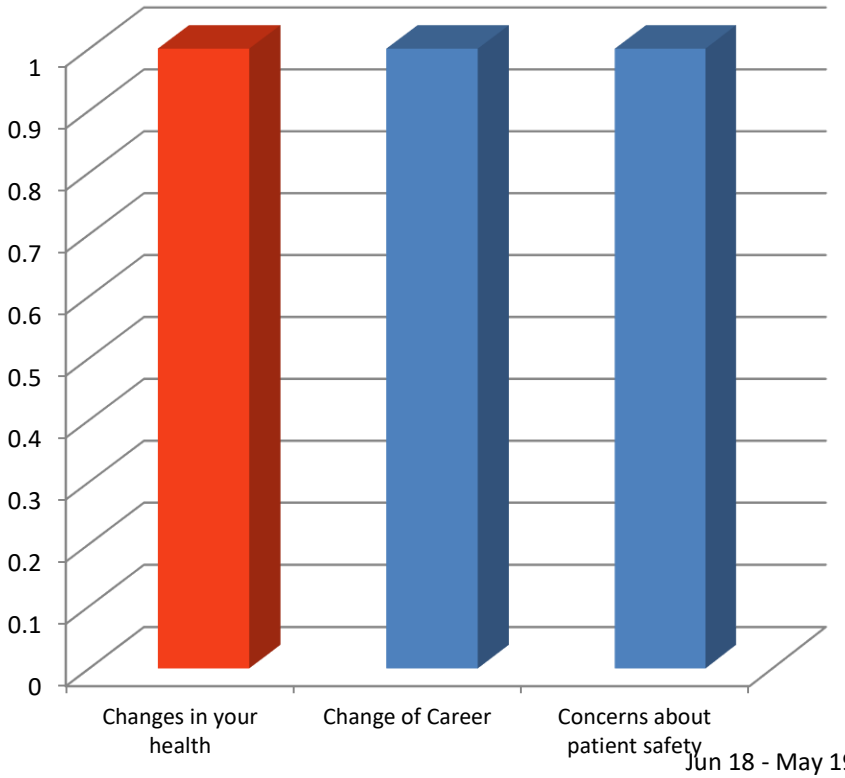
Reason for Leaving (ESR data)



Jun 18 – May 19

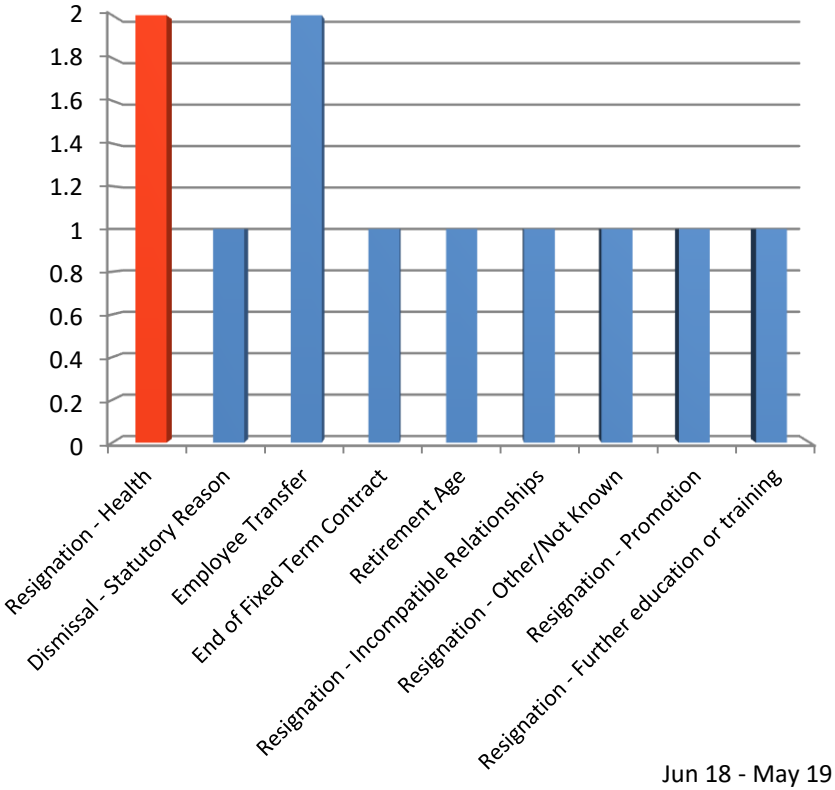
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

Reason for Leaving (Additional Clinical Services Staff) Exit Questionnaire Data



Jun 18 - May 19

Reason for Leaving Additional Clinical Services Staff (ESR data)

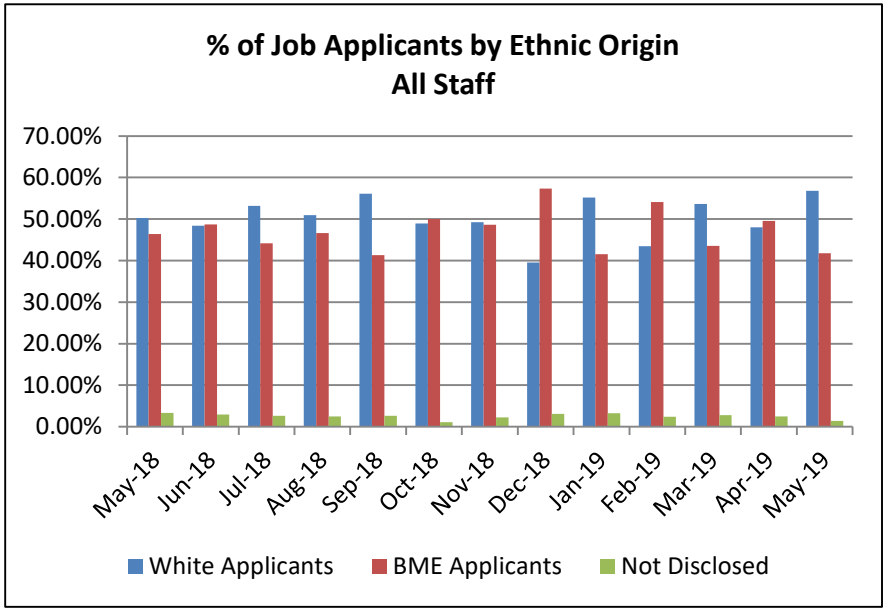


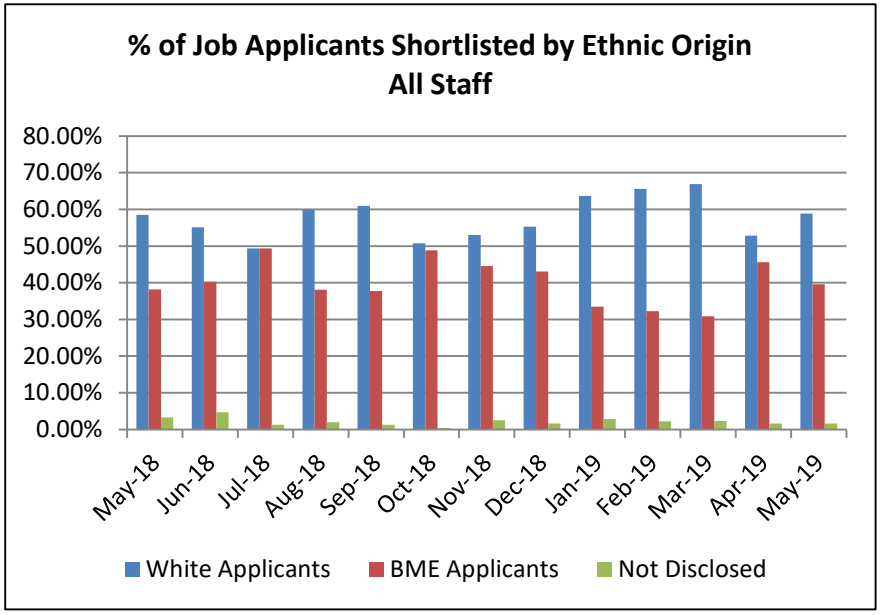
Jun 18 - May 19

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



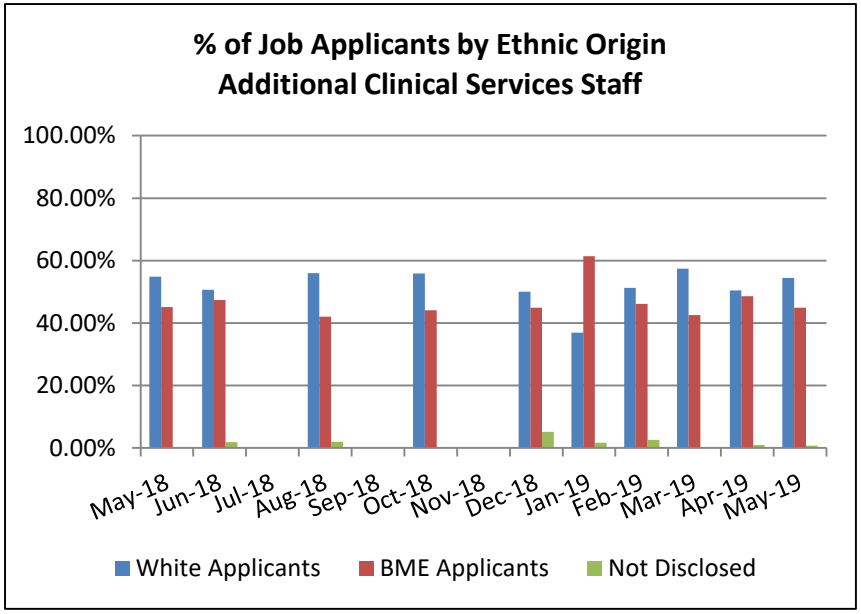


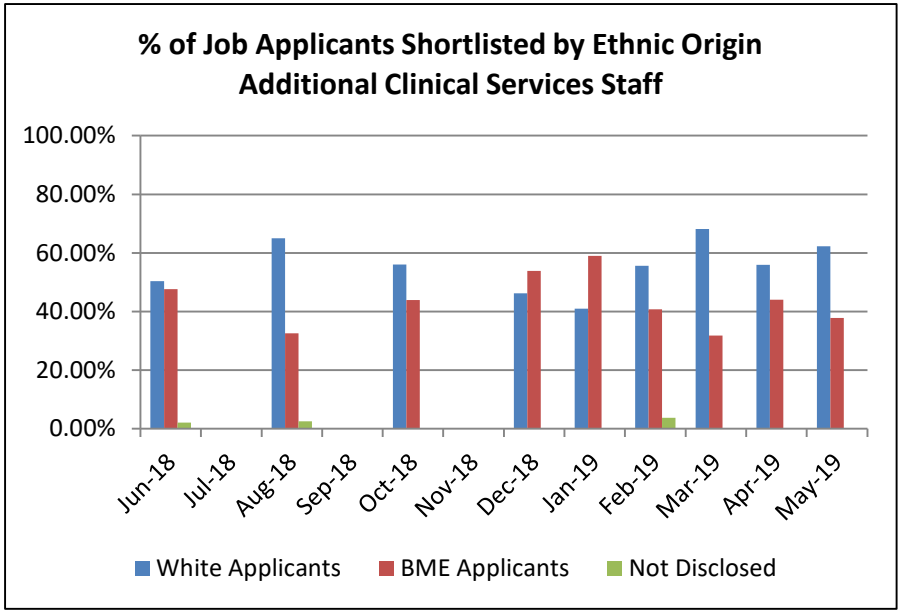
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2018	2017	2016	National Benchmark
1.66	↓	+0.06	+ 0.02	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month
1.38

Workforce Composition, Resourcing and Cost

Staffing Costs

- Total agency spend for May was £468k against a plan of £352k, with cumulative spend of £878k against a cumulative plan of £720k. There has been an overall increase in agency costs compared to April 19, with the largest increase in Nursing of £49k. This increase can be attributed to the reopening of the 2 wards which were closed during April.

- Bank spend in month was £528k against a plan of £398k mainly due to vacancies.

- Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

- Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

- Recruitment to vacancies continue with a projected 7wte qualified nurses to start during June/July.

Turnover

- The unadjusted turnover figure has increased since the last report in February 2019, from 7.11% to 9.98% in May 2019. This can be attributed to the Histopathology TUPE transfer to UHB which has taken place in May 2019. This is still below the Trust target of 11.5%.
- It has not been possible to provide the adjusted turnover figures for this reporting period due to a repotting issue , which IBM are currently trying to resolve and it is hoped that we will have data available for the next reporting period.
- Turnover has significantly decreased for Additional Clinical Staff in the last 12 months from 11.43% in May 2018 in to 5.51% May 201 This is most probably due to staff being retained on the bank rather than completely leaving the organisation.

Exit Data

- The top 3 reasons for staff leaving the organisation according to our exit questionnaire are Lack of Opportunities for Progression, Training and Development opportunities and Job Satisfaction. In comparison data from ESR suggests the top 3 reasons are Resignation – not known, Employee Transfer and Resignation –promotion (this data relates to the previous 12 months inclusive of May 2019). This theme has remained consistent to previous reporting periods.
- - Work is being undertaken to improve the quality and quantity of exit data being received.

Staff in post

- The graphs on page 5 show an upward trend in staff in post as a percentage of the establishment for non-clinical staff, specifically showing an increase of 0.72% since April 2019. This is a 1.2% increase from 2018.
- The figures for clinical staff are promising and show an increase of 1.82% in April 2019 to May 2019 and an increase of 4.65%% from May 2018 to May 2019.

Workforce Composition, Resourcing and Cost

Recruitment and Selection - Streamlining

A significant amount of work has been taking place to ensure that candidates are unconditionally offered as speedily as possible. In April 2019 the team had 191 offers in progress which at the end of May 2019 had reduced to 128. Although this is a slower rate than desired, efforts are being made to ensure that systems and processes to process candidates are reliable and effective. The team are actively calling and chasing candidates and referees and managers are being encouraged to 'Keep in Touch' with candidates too.

The introduction of the Workforce Matron post is showing benefit and this post holder is working closely with the recruitment team and Head of HR to ensure timely recruitment to high priority areas.

The most significant delays in recruitment seem to be at ATR stage and references and work will be established to consider how these areas can be streamlined further working with colleagues from across the Trust.

WRES Indicator 2 monitoring

May 2019 saw 41.77% BME applicants compared to 56.79% White. The % of BME applicants being shortlisted was 39.57% compared to 58.82% representing a decrease in the proportion of BME applicants being shortlisted compared to the previous reporting period (reducing to a conversion rate of 1.66 from 1.69 in the previous period).

ACTIONS FOR IMPROVEMENTS / LEARNING

NHSI Retention programme, development of ATR system, planned deeper dive into WRES data

RISKS/ISSUES

Unplanned staffing expenditure remains an issue, as does potential over-reliance on temporary staffing. Potential excessive working by established nursing staff through additional Bank hours.

Inadequacy of specific recruitment workforce data/ insufficiently developed systems make creation of a suite of recruitment KPIs a challenge.

2 Workforce Performance

2a Staff Attendance

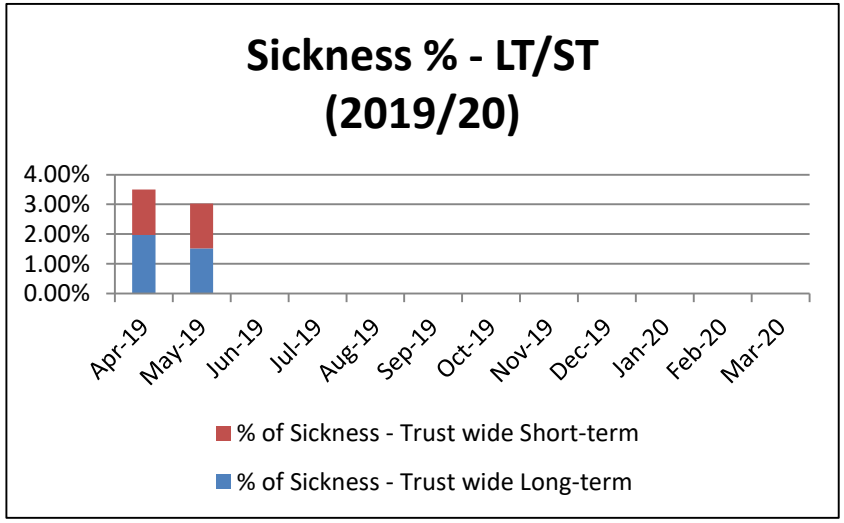
Staff Attendance

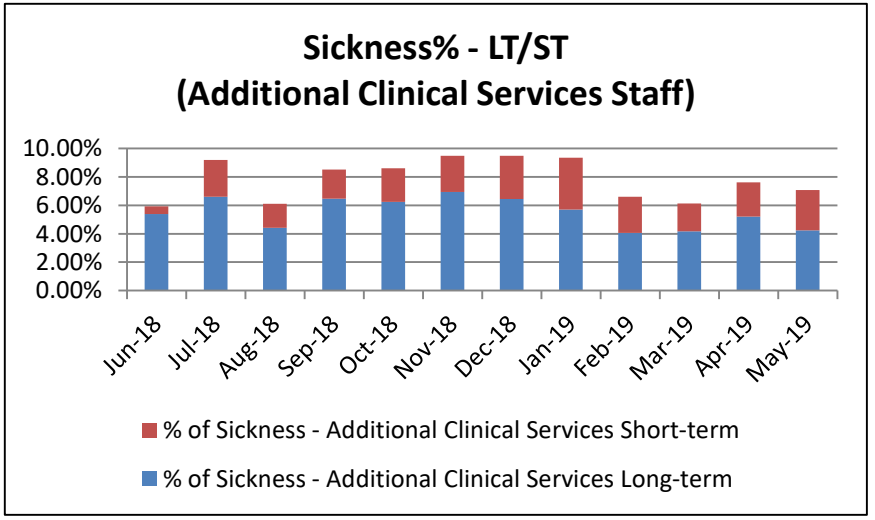
Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
95.72%	95.61%	⇧	0.38%	96.10%

ALL STAFF * 12 months to End of May 19

Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
92.14%	92.14%	N/A	3.96%	96.10%

ADDITIONAL CLINICAL SERVICES STAFF * 12 months to End of May 19





2 Workforce Performance

2b Staff attendance – short-term absence management

Staff Absence

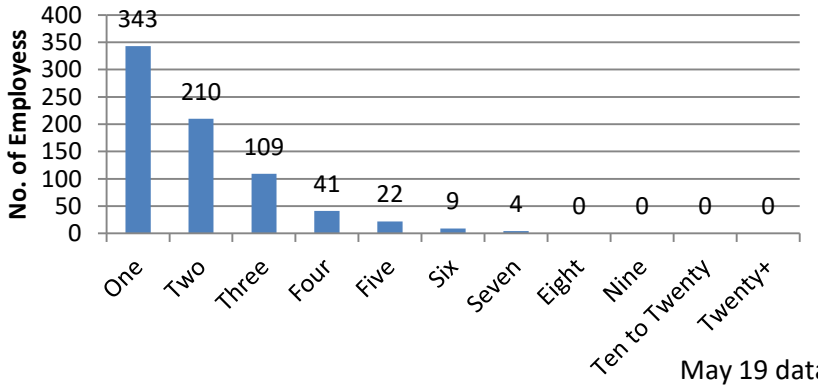
Return to Work Process Completion Rate (12 months) *May 19

ALL STAFF

Return to Work Process Completion Rate (12 months) *May 19

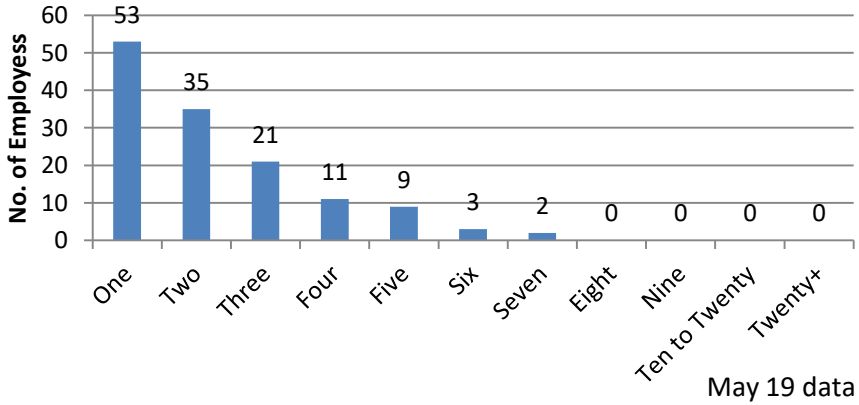
ADDITIONAL CLINICAL SERVICES STAFF

No. of Employees vs No. of Sickness Episodes (12 months)



May 19 data

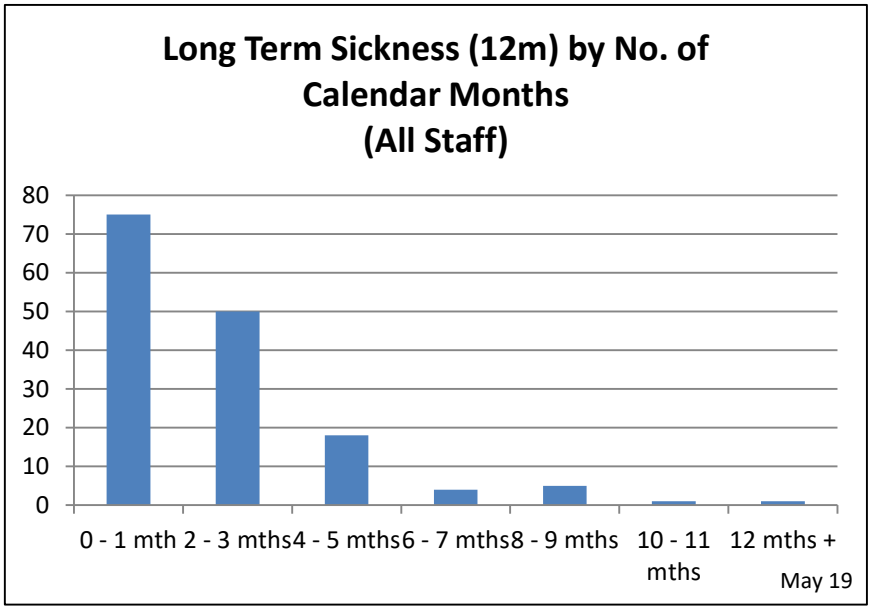
No. of Employees vs No. of Sickness Episodes (12 months) Additional Clinical Services Staff

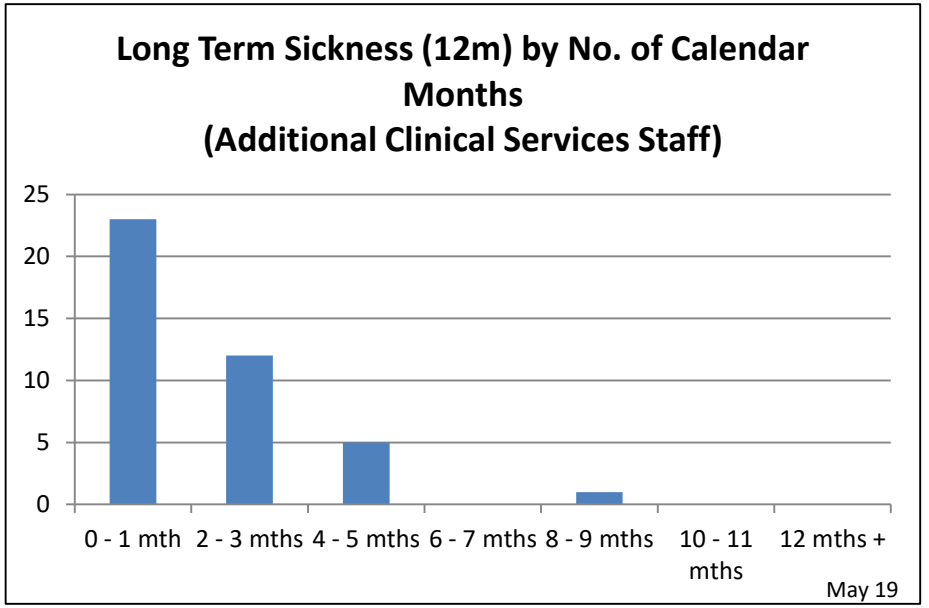


May 19 data

2	Workforce Performance
2c	Longer-term Staff Absence

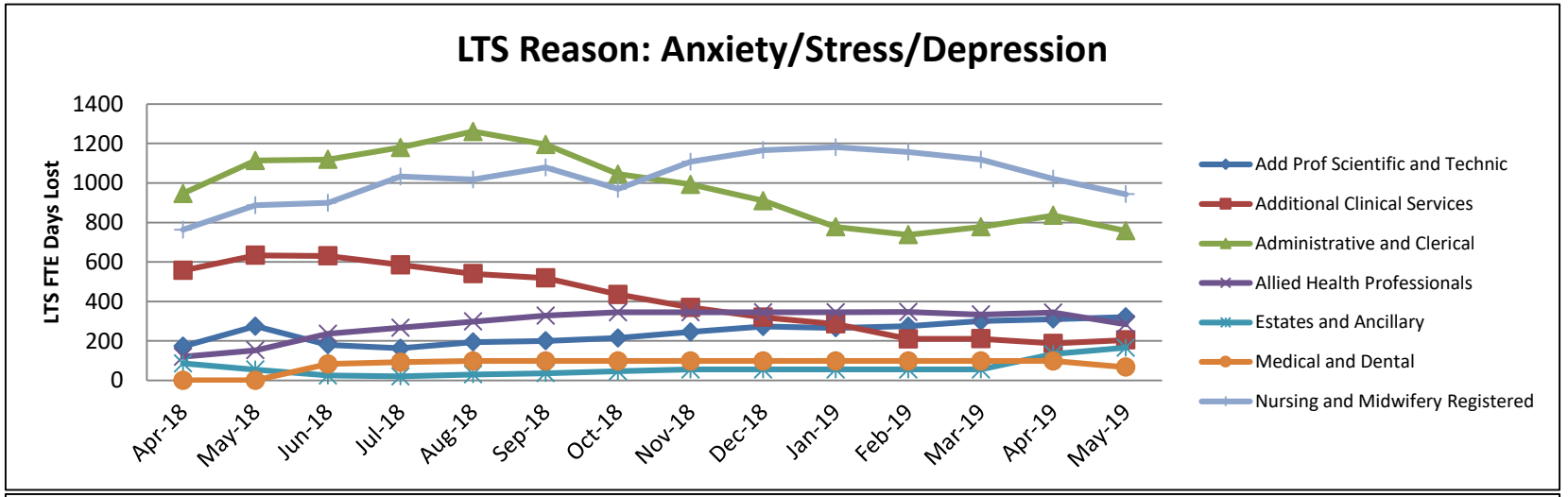
Long-term Staff Absence

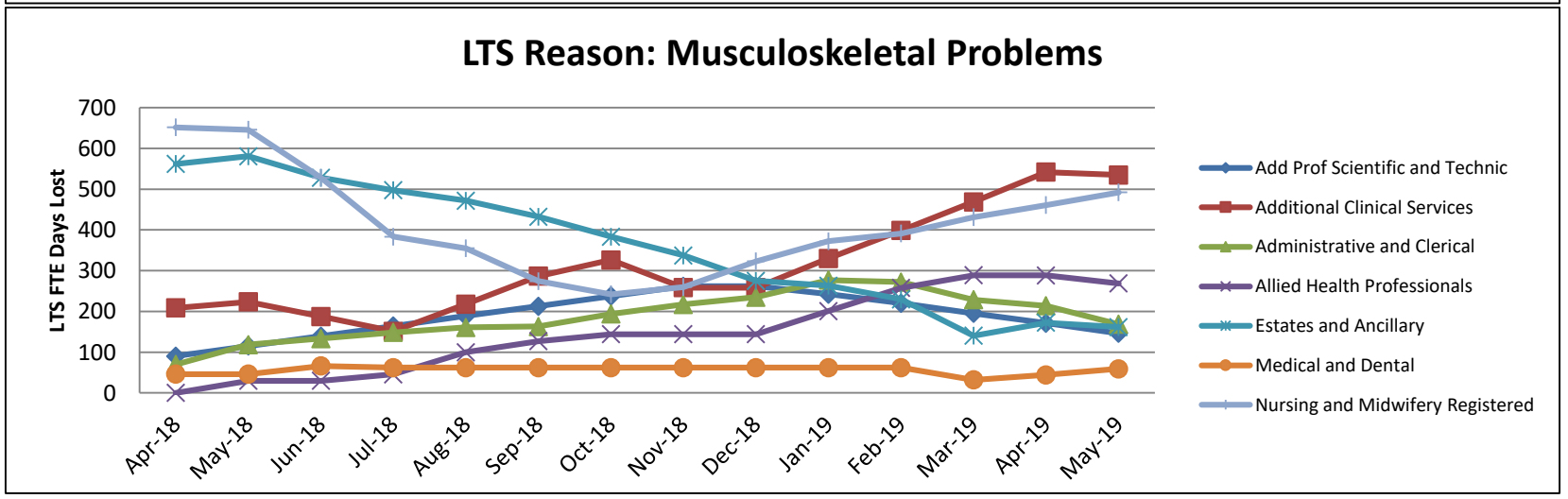




2 Workforce Performance

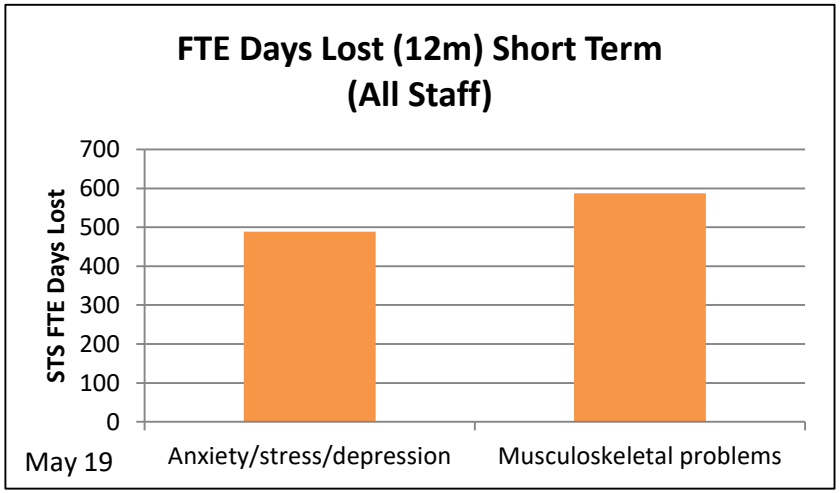
2c Longer-term Staff Absence

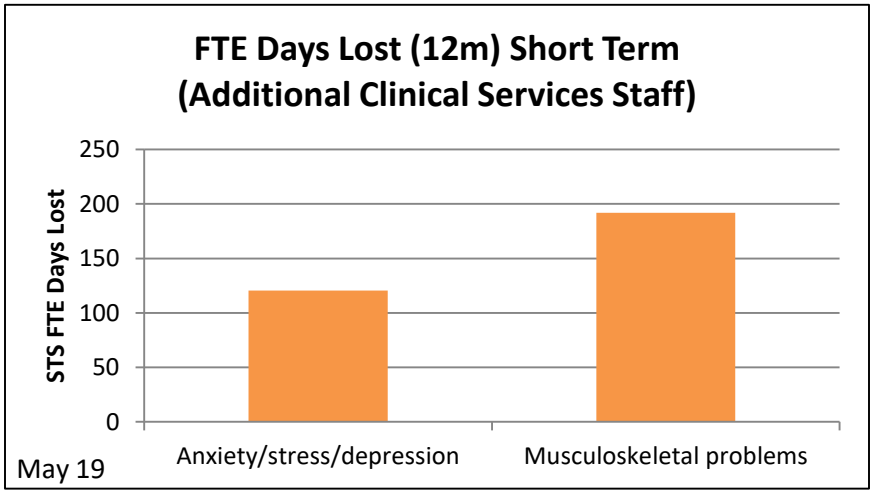


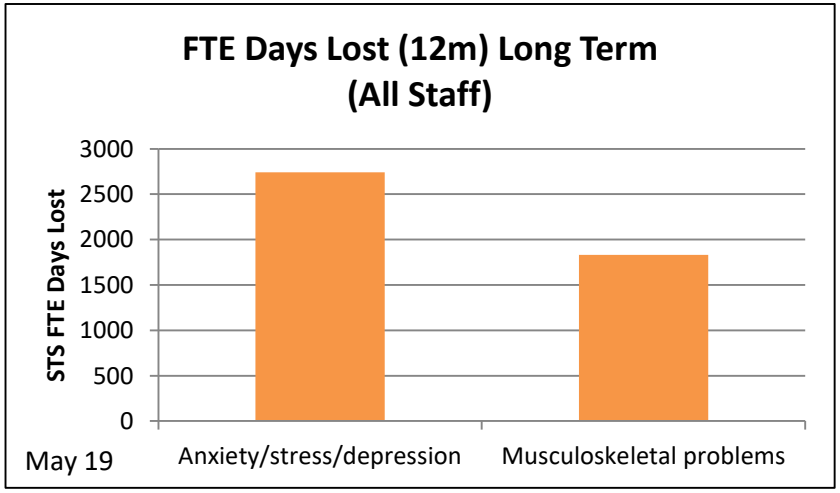


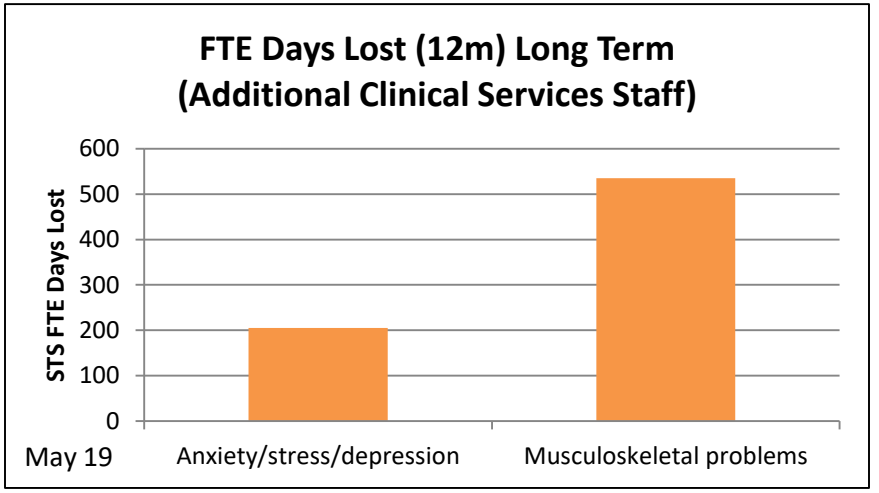
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary

Management of Performance

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	2	0	0	1	3	2

May 2019

INFORMATION

Staff Attendance

The rolling 12 month attendance figure for all staff has increased from 95.48% in February 2019 to 95.72% in May 2019 showing a variance of 0.38% to the Trust KPI of 96.10%. Figures for Additional Clinical Services staff are not as positive presenting a variance of 3.96% against the trust target, currently standing at 92.14% of which the majority is long term absence.

Return to work completion rates for all staff remain below the target of 80% at 56.10% and for Additional Clinical Services Staff, 41.9%. Further work needs to be undertaken to review the current return to work process in order to increase compliance and welfare conversations before an employees return to work. It is anticipated that he Trusts focus on employee health and wellbeing will positively impact on engagement with this process.

The most common reason for short term absence for all staff is 'Musculoskeletal' and for long term absence, Anxiety/Stress/Depression. In Additional Clinical Services, the picture is different and 'Musculoskeletal' is the main reason for both lengths of sickness absence.

Formal Disciplinary and Capability

As at the end of May 2019, there were 2 suspensions and 3 conduct cases. Further work is needed to be undertaken with colleagues across the Trust to ensure that HR are being informed of action being taken.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Explore how additional clinical services staff can be supported with tackling the main causes for absence.
- Understand whether 'mental health' related absence is due to work or non-work related issues.

RISKS/ISSUES

- Return to works not being completed therefore risk not being managed appropriately.

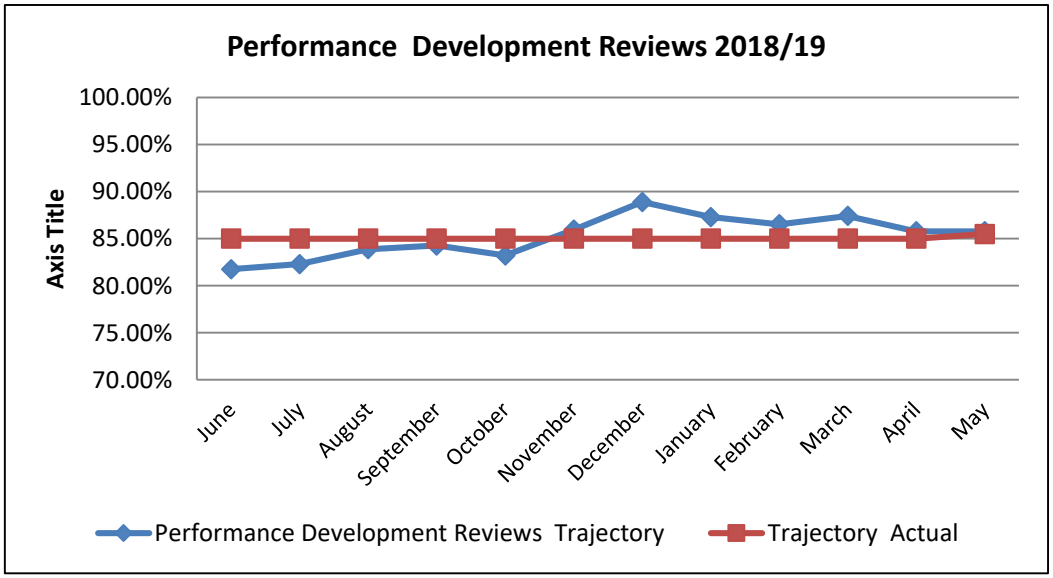
3 Workforce Learning and Development

3a Performance and Development Review

Performance and Development Review

NSS Engagement Reference	NNS Engagement Question 2017	2018	2017	2016	2015
19a	In the 12 months have you had an appraisal or annual review?	91%	86%	84%	93%
18a	Have you had any training, learning or development in the last 12 months?	63%	64%	74%	79%
19f	Were any training, learning or development needs identified?	66%	54%	61%	67%

Data is colour coded according to comparison against Specialist Acute Trust
- Below
- Equal
- Above
- Not benchmarked to date



Staff survey results in 2018, show a 5% increase from 2017 in staff reporting they have received an annual appraisal, and a 12% increase in effectiveness in identifying learning and development needs during this process.

However, there has been a 1% decrease in staff reporting they have had access to learning and development opportunities over the last 12 months. The reduction in available funding to support professional development has been identified as a risk within the Trust, and a cost pressure has been raised to support this.

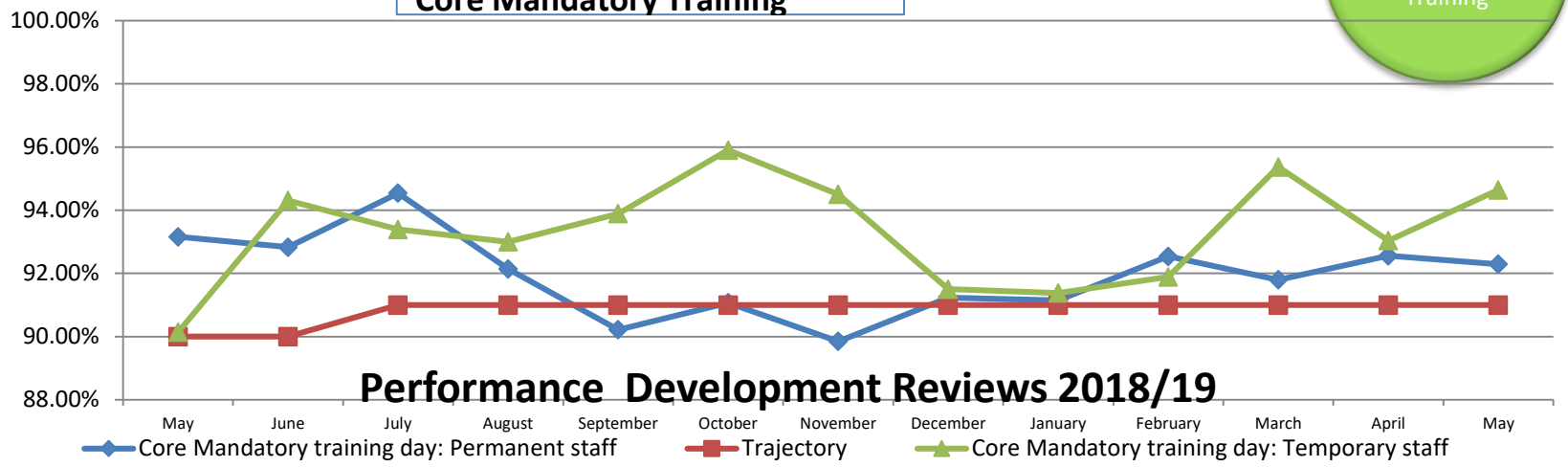
Workforce development funding has been received from HEE but this has reduced by 70% over the last 3 years, impacting on access to professional development and qualifications.

3 Workforce Learning and Development

3b Core Mandatory Training, Specialist Training and Corporate Induction

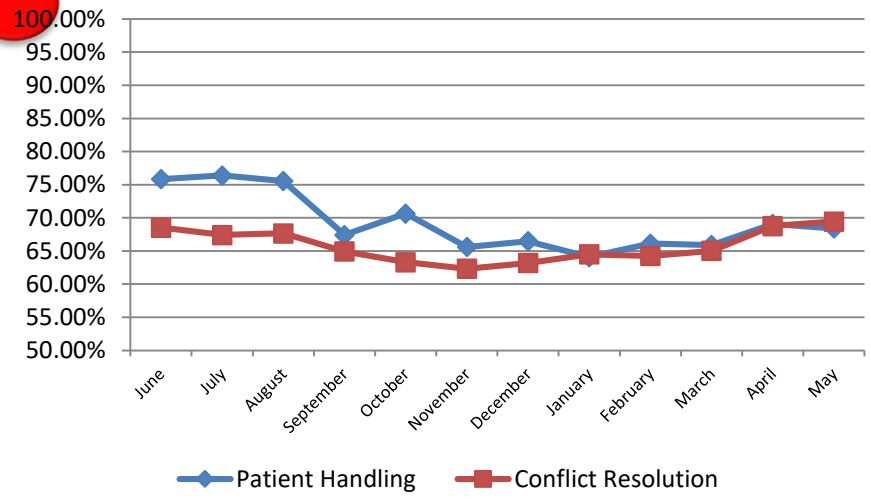
Core Mandatory Training

Core Mandatory Training

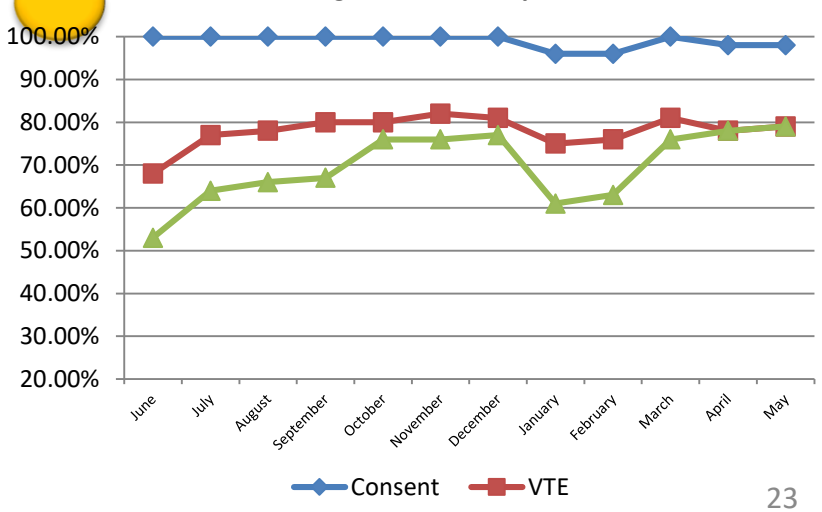


Performance Development Reviews 2018/19

Patient Handling and Conflict Resolution Compliance

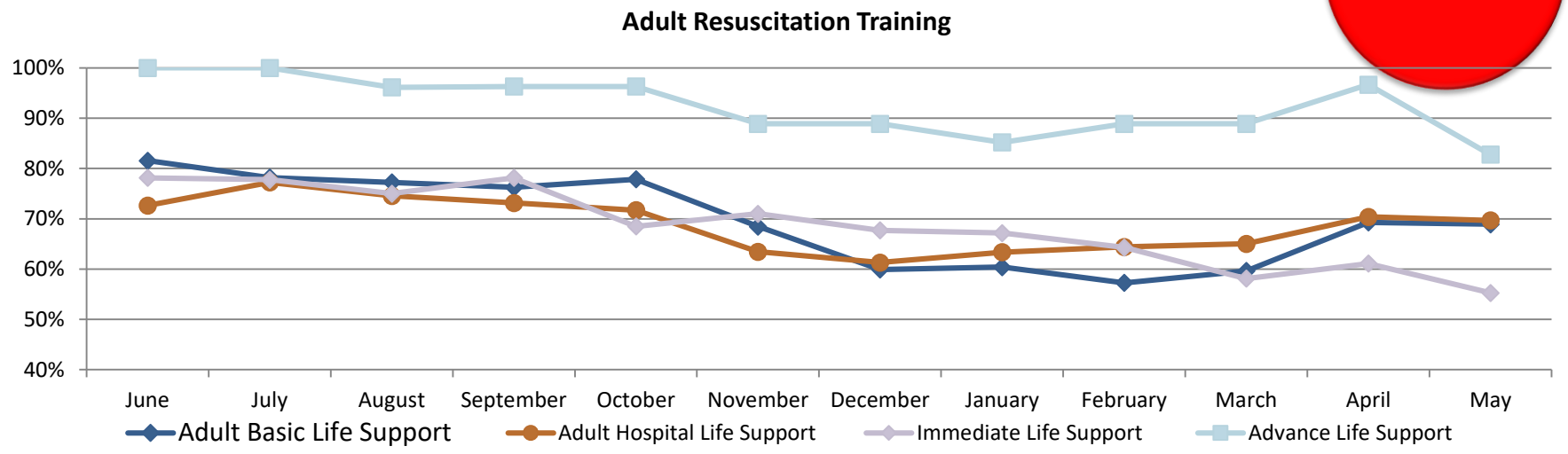


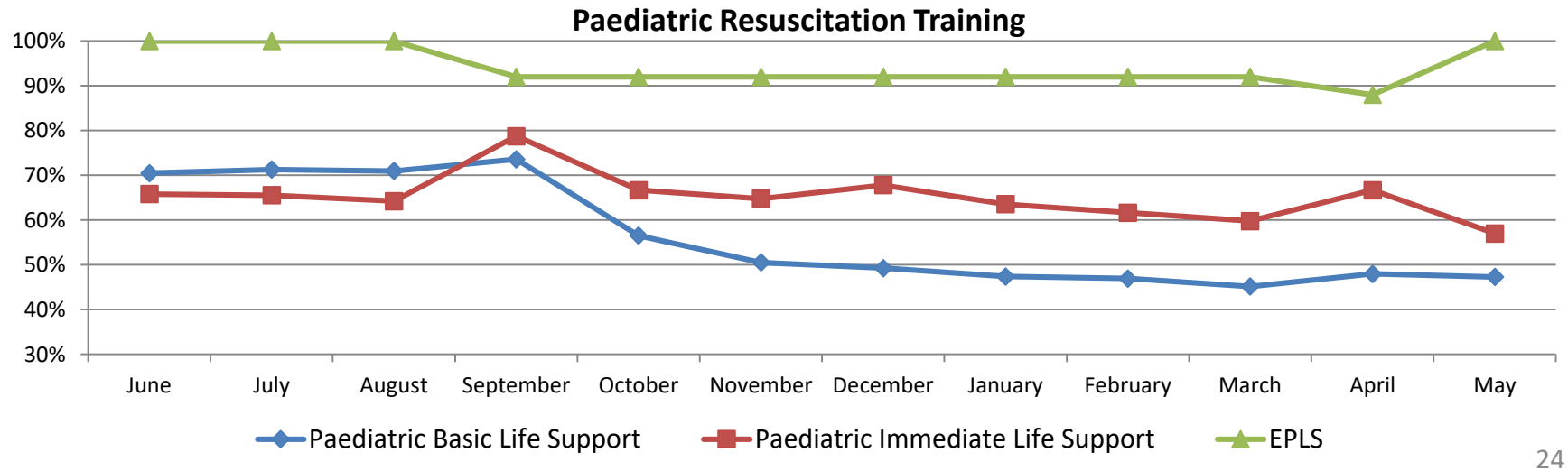
e-learning Modules Compliance



3	Workforce Learning and Development
3c	Resuscitation Training

Resuscitation Training





INFORMATION

Core Mandatory Training – Reported Core mandatory training attendance has achieved above compliance for 5 months. Work continues on improving the content and delivery of the face to face training, and developing a more easily accessible e-learning approach. 10% of core mandatory training is currently completed on line. 2019 will see an increase in this figure.
CMT for Bank / Temp staff has continued to maintain over 91% compliance for over 12 months.

Role Specific Mandatory training –
The Trust Resus training compliance for Adults and Paediatrics has shown an increase last month due to increased volume of training activity during the Theatre Close Down week..
Resuscitation standards and governance processes have recently been reviewed and updated recently, with the Director of Nursing committing to chair the Resus committee from November 2018. The Risk for resuscitation training compliance figures is monitored through the quality and safety group.
Conflict resolution and patient handling compliance also showed a slight increase due to activity during theatre close down week. This has been raised with the clinical quality group, and a small focus group has been created to review attendance requirements.
VTE / Insulin –Improvements have been seen in staff completing insulin and VTE however the delegate group was reviewed in January with additional staff included, which has resulted in the initial drop in compliance figures at the start of the year.
Following a review of the consent module compliance, additional names have been included which initially reduced compliance. Those individuals are being liaised with directly.

ACTIONS FOR IMPROVEMENTS / LEARNING

Core mandatory training :– Mandatory training streamlining / CIP project continues. Positive engagement with subject leads so far. E-learning modules are now available for all the core mandatory training subjects, excluding safeguarding where the subject leads are requesting additional information. Meeting held in April to review Mandatory training requirements and seek opportunities to reduce the burden.
Role Specific training:- Risk is monitored through Quality and safety / new governance meeting process put in place.

VTE/Insulin online modules: E-learning facilitator working closely with Lead to increase compliance, creating learning paths in ESR. It has been agreed that medics do not need to complete the insulin modules as they do not administer.

L&D team are monitoring cancellations and DNAs on courses, to provide monthly reports back to departments to identify key reasons for not attendance.

RISKS/ISSUES

Staff booking onto and completing their role specific mandatory training modules is low.
Resus levels still non compliant
In house trainers for resus and patient handling reducing availability to support training.
Attendance and DNAs on courses is still high. DNA charges will be introduced during 2019.

4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

OVERALL STAFF ENGAGEMENT

The most recent National staff survey results have seen a positive move on the overall staff engagement score from 3.83 to 3.97. The score is made up of the questions shown below:

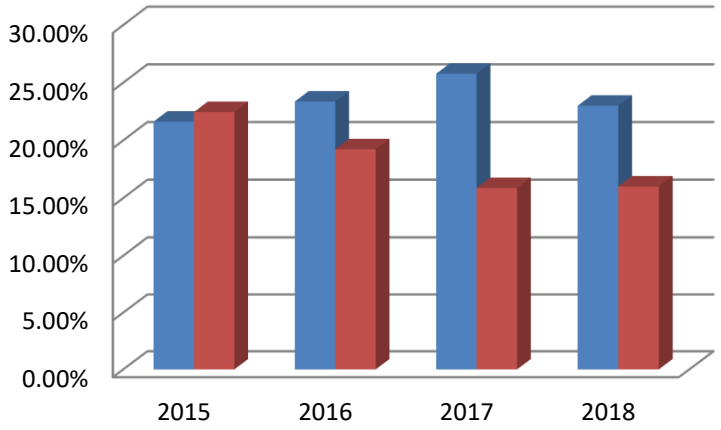
	Questions linked to ROH engagement score	2018 ROH	2018 Average	2017 ROH	2016 ROH
21a	Care of patients is my organisation's top priority	86%	86%	79%	69%
21b	My organisation acts on concerns raised by patients	83%	81%	79%	73%
21c	I would recommend my organisation as a place to work	73%	72%	62%	56%
21d	I would recommend the standard of care provided by this organisation	91%	89%	83%	77%

4 Workforce – Experience and Engagement

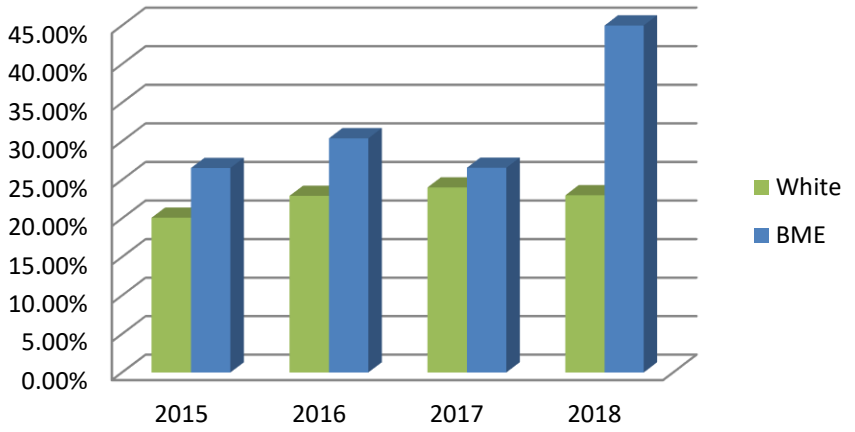
4c WRES Indicators

WRES Indicators

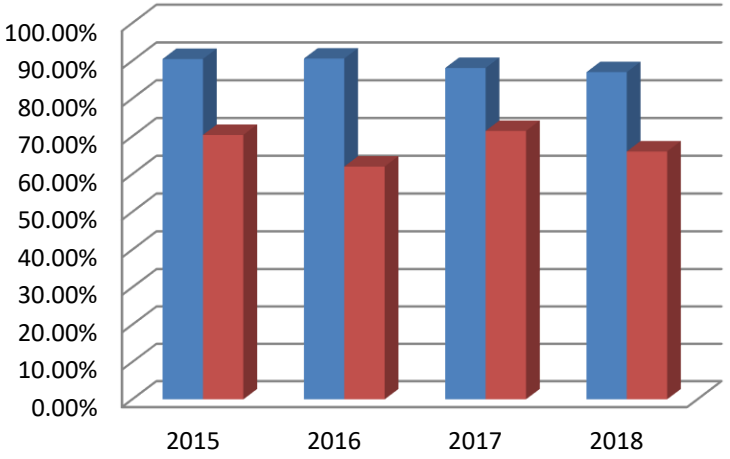
Indicator 5: Experiencing bullying from patients



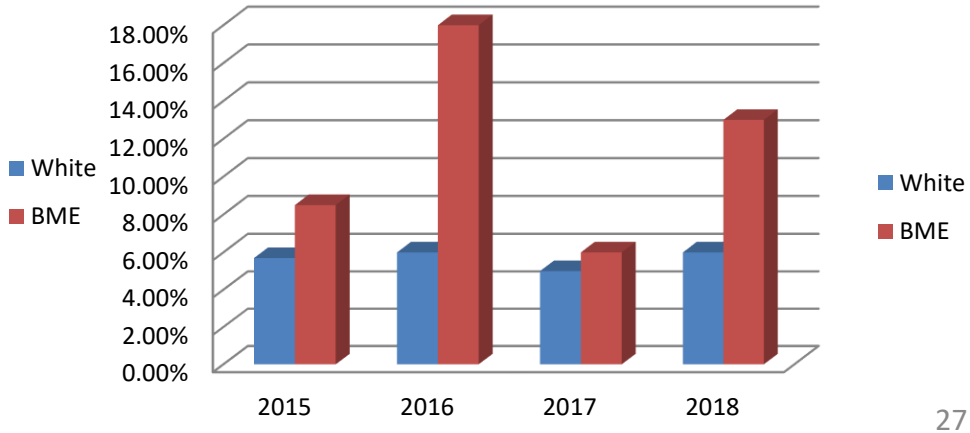
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION
Friends and Family Test (FFT) – The Trust is still awaiting the final information from Capita People Solution on the Staff FFT from Q1. This will be presented at the next SE&OD committee **Engagement and Job Satisfaction** – Speak Up and Join in brand becoming increasing established. Even better if… sessions being rolled out across teams. Information from the National Staff survey results is being communicated across the Trust and team will be asked in April 2019 to compile local actions based on the survey results **WRES Indicators –** Whilst the overall response rate to the 2017 was low, the proportion of BME staff completing the 2017 was comparable. WRES indicators informed by 2017 National Staff Survey show significant differentiation between white and BME staff. Whist some indicators may be evidence of greater confidence in reporting concerns, further action is required. The Trusts E&D annual report and grading of E&D outcomes under EDS2 will be informed by WRES indicators. Data for WRES 2018 will start to be collected in April 2019
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions to encourage survey completion to improve data reliability Ensure all staff are sighted on the positive staff survey results and are able to suggest local improvements
RISKS/ISSUES
Part of the WRES data is sourced from the NHS National Staff survey. Completion rate affects the reliability of the data as a representation of staff views

BOARD ASSURANCE FRAMEWORK - QUARTER 1

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	CEO	The Trust does not currently have a clear financial and operational plan in place 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 2019/20. The Trust has support to access cash resources to continue business in the short term The Trust has a 5 year strategy to become the first choice for orthopaedic care. This strategy has been refreshed and updated into a new format, being based around the five 'Ps': performance, people, process, partnerships and patients. A Strategic Outline Case was developed and 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 Theatre expansion work is currently underway.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update	5	4	20	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. A further medium term financial plan will be required for submission by NHSI during 2019/20.	Dec-19	3	4	12
FP1	Finance	Exec Dir - F&P	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	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	FPC reports; Board approval for cash borrowing; Finance & Performance overview	3	4	12	↔	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	Dec-19	2	3	6
CE2	Corporate	CEO	The effectiveness of the governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience , potential harm and reputational damage.		Developing services to meet changing needs, through partnership where appropriate	Trust Board/Quality & Safety Committee	5	5	25	Reporting mechanisms in place and escalation to identify key leads that the governance arrangements are not effective or there is potential for harm to be caused by a patient.	Minutes of stakeholder oversight meeting	4	4	16	↔	Continue to monitor effectiveness of governance framework	On-going	3	4	12

1089	Operations	COO	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 all services to deliver 92% submitted to NHSI describing how these services will be recovered to meet 18 week RTT. Ongoing demand and capacity measurements identify any gaps in service capacity to meet demand with plans put in place . RTT position sent monthly to CCG for information.	Weekly report to Exec Team & Ops Board	3	4	12	↔	The Trust trajectory to deliver 92% performance is monitored weekly at the PtI meetings and reported monthly in line with national requirements . Current reported position for May is 88.92 % with only 9 patients over 40 weeks , plans are in place to meet trust forecasted position for delivery of 92% trust wide in September 2019 and currently Arthroplasty , Spinal, , Foot and ankle , Hands, Oncology Arthroplasty and CSS are meeting the 92% target . A revised trajectory has been agreed with NHSI for the delivery of 92% in all specialties. Additional capacity is in place for the YAH service which is improving the current position (88.54%). Following the paediatric transition at the end of June demand and capacity plans are currently being reviewed to ensure delivery in spinal deformity in January 2020 . Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway. Additional Consultant capacity is in place to ensure sustained delivery of RTT compliance in line with the theatre expansion programme. Progress is monitored weekly at PTL meeting chaired by the Deputy COO.	Ongoing	3	4	12
1117	Operations	COO	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 in line with agreed Trust process, chaired by DIV 1 AMD . 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 be implemented and monitored via the Operational team to support improved data quality.	Ongoing	3	4	12
1137	Infection Control	Exec Dir - N&G	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	5	3	15	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Water Safety Group minutes presented to IPC Group meeting.	2	3	6	↔	Completion of the water safety plan	Aug-19	1	5	5

WF2	WFOD	CEO	Workforce models identified may not deliver benefits which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment		Highly motivated, skilled and inspiring colleagues	SE & OD Committee	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC and ACP to be recruited. TAPS have been recruited. Nurse Associates planned to join the Trust. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	2	4	8	↔	Workforce design to become an integral part of HR Business Partner discussions. Middle grade workforce group is meeting to develop model.	Jan-21	2	4	8
HR10	WFOD	CEO	HR team has limited capacity to effectively support resourcing of Modular Theatre & Ward expansion		Highly motivated, skilled and inspiring colleagues	People Committee/SE & OD Committee	5	4	20	Concerns initally raised regarding capability of recruitment team to effectively support the increased volume of recruitment required by the expansion of theaatres and wards. Recruitment team have processed a large number of offers and the process is working well. Regular meetings between HR and Director of Nursing & Clinical Governance to monitor progress.	SE&ODC papers. Nurse staffing reports. People Committee reports. Notes of meetings between HR & Directors.	3	4	12	↓	Good progress contunues to be made and staff are due to come on Board from September onwards.	Oct-19	2	4	8
WF1	WFOD	CEO	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	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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs	Jan-21	3	3	9

7	Operations	COO	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	In January 2019 the Trust had 5 patients waiting over 52weeks the trajectory was 33. All patients are dated and the trajectory has being reviewed in light of the delay in the service now not being transferred to BCH in February 2019. All patients monitored at weekly PTL - plans in place for all patients over 40 weeks Full RCA and harm review for all patients over 52 weeks presented monthly at harm review board. The pain management patient over 52weeks was treated on 4th February 2019 and was picked up by the validation team at the end of January 2019 as an incorrect clock stop. All patients over 40 weeks have been reviewed and a new trajectory has been submitted to NHSI to confirm any patients who may breach 52 weeks.	Weekly updates to Exec Team; updates to Trust Board.	2	4	8	↔	March 2019 - As at the end of March the Trust has zero patient waiting over 52weeks	Ongoing	2	4	8
27	Operations	COO	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.	Updates to Staff Experience & 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. Junior Fellow posts have been re advertised with a revised 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 . The draft Job Description for the alternative medical workforce has been agreed . A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development . The rota co-ordinator commenced in December 2018 and is now focusing on Weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is now being monitored by the CSMS and reported to a monthly meeting to monitor spend, chaired by the deputy COO.	Ongoing	2	3	6
770	Operations	COO	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.		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	↔	The theatre expansion programme is underway with phase 1 of the expansion programme due to be delivered in December 2019 , at this point the risk will be reviewed.	Ongoing	1	5	5

CO2	Operations	COO	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	2	3	6	↓	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. The Perfecting Pathway Programme Board will be launched in September 2019. All programmes will be tracked and progress reviewed on a monthly basis at this board which will report monthly to F and P committee to ensure support is in place to deliver the programme of service changes and redesign. Structure is in place to support the team and substantive COO has now been appointed.	Q4 2018/19	2	3	6
269	Operations	COO	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	↔	Delivery of the integrated action plan round 18 weeks RTT, cancer services and spinal deformity continues to support delivery of agreed activity plans . Development and delivery of recovery plan. Modular theatre set up anticipated to become functional in December 2019, which creates additional capacity for activity. Continued joint working with Heartlands, Good Hope and Solihull Hospitals to support standardisation of pathway across STP and agree activity levels at the ROH and Solihull elective centres. Work also underway for ROH to support winter pressures at HGS . Pathway work is also being scoped with the spinal teams across ROH and UHB.	Q1 2019/20	2	4	8
270	Finance	Exec Dir - F&P	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 is 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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 continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. A specific review of BIU activity is ongoing.	Ongoing	2	4	8

804	Finance	Exec Dir - F&P	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 function continues to mature. The data warehouse is providing invaluable information, highlighting a range of data quality issues regarding data completeness, accuracy, timeliness , inconsistencies, etc. The team continue to work with operational leads to put in place actions plans to address these data quality issues.	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	↔	An information analyst has been recruited and is due to start at the trust early 2019 . The recruitment of the Business Intelligence Systems Manager had been delayed due to budget issues, but the post will now go to advert early 2019.	Q4 2018/19	2	4	8
275	Governance	Exec Dir - N&G	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 Trust Quality Priority for 2018-2019 has been achieved and closed. A paper detailing the evidence of closure was presented to the Quality and Safety Committee detailing the new methodology and improvements in March 2019. The CCG have decreased the Trusts contracts meeting to quarterly due to the adequate assurance they receive from the Trust. Each month following thematic review of RCA's and incidents, the Governance team will devise patient safety case studies, outlining the learning from this incidents, complaints and litigation. Working with the communication team the learning will be shared Trust wide. The Staff Survey shows improvements on the Patient Safety metrics in terms of incidents, feedback and outcomes. Weekly meetings have been established with Governance, Medical Director, Director of Nursing and Heads of Nursing	Q4 2019/20	2	2	4
FP3	Finance	Exec Dir - F&P	The Trust may experience supply chain disruption and experience an adverse impact on areas which are dependent on overseas staffing in the event of a "no-deal" Brexit, resulting in operations being cancelled and long lead times for securing overseas staff		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. Internal analysis of workforce risk suggests that there is likely to be little disruption to staffing level in the event of a 'no deal' Brexit		3	4	12	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	Oct-19	2	3	6

CE3	Corporate	CEO	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. Full transition plan now in place with BWCH	STP Board minutes. SOC. Paediatric updates to Trust Board.	3	5	15	↔	Clinical review of proposed Oncology strategy is still outstanding. If the outcome of this is positive, this will support the alignment of the strategy across all providers	Jul-19	2	3	6
986	Nursing	Exec Dir - N&G	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	Fill rates are achieved but a high reliance on agency staff. Most of which are regularly booked staff. No Harm incidents have been reported in the in the last 6 months linked to the staffing levels. Paeds services cease in July 2019	Q&S Report	3	4	12	↔		Ongoing	1	4	4
P51	Nursing	Exec Dir - N&G	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. Further support and oversight provided by BWCH and a further weekly meeting instigated from February 2019. Operationally the service has been reviewed and bed capacity reduced to 12 beds to support staffing requirements – Operational SOP being drafted to support measures put in place. Rostering reviewed and CYPHDU/Ward 11 amalgamated to provide further oversight and support both areas. Scheduling tool developed to provide better oversight of activity booked for both areas.	Children's Board Report	3	4	12	↔	On-going rolling recruitment programme and Trust agreement to over recruit CYP nurses. Weekly meeting chaired by the Executive Director of Nursing to provide additional oversight of paediatric staffing. Staffing forward look completed until June 2019 for Ward 11 .	Ongoing	1	4	4
CE4	Corporate	CEO	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 Trust continues to work closely with all system stakeholders to ensure that services remain safe during the period of the service transfer, and that future pathways are designed and implemented with full clinical engagement and leadership to ensure a future sustainable model. Staff and patients are kept up to date with planned timescales, including any changes to the potential transfer date	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	↔	Continued oversight by NHSI/E & CQC	Jul-19	2	3	6

FP2	Finance	Exec Dir - F&P	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 has received transitional funding during 2018/19 to support the additional costs of paediatric provision.	Q4 2018/19	1	4	4
MD1	Clinical	Exec Medical Director	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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	Exec Dir - S&D	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	Work is underway to develop the strategy for 2019/20 to 2023/24 and beyond. A workshop was held for the Board on 6 February 2019 at which the Board was presented with the proposed routes for engagement with the strategy for staff, stakeholders and the public.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case; slides from strategy session for the Board on 6/3/19	2	3	6	↔	A strategy working group will be established to specifically focus on: - How we engage with all teams in the development of the new strategy - How we share key headlines from this year's annual plans - What we think the key elements of the strategy need to be - How we align all Trust plans/strategies to this document	Q1 2019/20	2	3	6

S800	Governance	CEO	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 electronic governance solution for better management of Trustwide policies and creation of additional dashboards of performance against key quality metrics.	Q1 2019/20	1	3	3
1298	Finance & Performance	Exec Dir - F&P	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:		Safe, efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	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. 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.	IM&T programme board papers	4	4	16	↔	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. 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	2	4	8

FP4	Finance & Performance	Exec Dir - F&P	There is a risk that the full quantum of cost saving as outlined in the 2019/20 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Whilst full delivery of the CIP schemes will not happen, this has been taken into account within the financial planning for the remainder of the year.	Finance and Performance overview; CIP programme board papers	4	4	16	↔	Much work has been undertaken in creating the CIP framework for 2019/20. The financial plan for 19/20 identifies a target of £1.4m, which is the level required as per the planning guidance. This is backed up by an internal plan which targets delivery of £2.3m with a further stretch target of circa £3m. The initial £1.4m is within the level of saving achieved during 2018/19, whilst further discussion are ongoing relating to how we potentially use incentive schemes to increase delivery up to the internal target of £2.3m and beyond.	Mar-20	3	4	12
FP5	Finance & Performance	Exec Dir - F&P	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.	Perfecting Pathways update; Finance & Performance overview	4	4	16	↔	Building work underway and currently on schedule	Dec-19	3	4	12
FP6	Finance & Performance	Exec Dir - F&P	There is a risk that the Financial Control Total will not be met in 2019/20		Safe and efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	The 2019/20 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery. Clinical Audit day has been cancelled in February to allow more work to be undertaken. Revised activity plan distributed which identities performance levels required for recovery.	Finance and Performance overview	3	3	9	↔	Further focus to deliver increased activity.	Mar-20	3	3	9

The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 6 November 2019

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 6 November 2019 commencing at **1100h** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust Headquarters.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (IN PUBLIC)

Venue Board Room, Trust Headquarters **Date** 6 November 2019: 1100h – 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)
Prof David Gourevitch	Non Executive Director	(DG)
Mrs Jo Williams	Chief Executive	(JWI)
Mr Matthew Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Interim Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Ms Ayodele Ajose	Associate Non Executive Director	(AA)	
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Patient story	Presentation	
1120h	2	Apologies	Verbal	Chair
	3	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	4	Minutes of Public Board Meeting held on 4 September 2019: *for approval*	ROHTB (9/19) 025	Chair
	5	Trust Board action points: *for assurance*	ROHTB (9/19) 025 (a)	SGL
1130h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (11/19) 001 ROHTB (11/19) 001 (a)	YB/JW
1140h	6.1	'Partnerships' extract of the Board Assurance Framework: *for assurance and approval of changes*	ROHTB (11/19) 002 ROHTB (11/19) 002 (a)	JW
1145h	6.2	Orthopaedic services in the STP. BAF REF: CE1, ST1	Verbal	MR

TIME	ITEM	TITLE	PAPER	LEAD
		WORKFORCE		
1150h	7	'People' extract of the Board Assurance Framework: *for assurance and approval of changes*	ROHTB (11/19) 003 ROHTB (11/19) 003 (a)	JW
1155h	8	Update from the Staff Experience & OD Committee – September & October: *for assurance*	ROHTB (11/19) 004 ROHTB (11/19) 005	RP
	8.1	Annual report: *for assurance*	ROHTB (11/19) 006	RP
	8.2	Terms of Reference: *for approval*	ROHTB (11/19) 007 ROHTB (11/19) 007 (a)	RP
1205h	9	Workforce report: *for assurance* BAF REF: WF21, 27	ROHTB (11/19) 008	JW
1215h	10	Update from the Guardian of Safe Working Hours: *for assurance*	ROHTB (11/19) 009 ROHTB (11/19) 009 (a)	MR
		QUALITY & PATIENT SAFETY		
1220h	11	'Patients' extract of the Board Assurance Framework: *for assurance and approval of changes*	ROHTB (11/19) 010 ROHTB (11/19) 010 (a)	GM/MR
1225h	12	Update from the Quality & Safety Committee – September & October: *for assurance*	ROHTB (11/19) 011 ROHTB (11/19) 012	KS
1230h	13	Quality report: *for assurance* BAF REF: OP1, CE2, 770	ROHTB (11/19) 013	GM
1240h	14	Healthcare workers 'flu vaccination update: *for assurance*	ROHTB (11/19) 014 ROHTB (11/19) 014 (a)	GM
1245h	15	CQC inspection – initial feedback and Trust response: *for assurance*	ROHTB (11/19) 015 ROHTB (11/19) 015 (a) ROHTB (11/19) 015 (b)	GM
		FINANCE AND PERFORMANCE		
1255h	16	'Performance' and 'Process' extracts of the Board Assurance Framework*: for assurance and approval of changes*	ROHTB (11/19) 016 ROHTB (11/19) 016 (a)	SW/MP
1300h	17	Update from the Finance & Performance Committee – September & October: *for assurance*	ROHTB (11/19) 017 ROHTB (11/19) 018	TP
	17.1	Annual report: *for assurance*	ROHTB (11/19) 019	TP
	17.2	Terms of Reference: *for approval*	ROHTB (11/19) 020 ROHTB (11/19) 020 (a)	TP
1310h	18	Finance & Performance report: *for assurance* BAF REF: OP1, CE2, 770	ROHTB (11/19) 021	SW/MP

CORPORATE GOVERNANCE, RISK AND COMPLIANCE				
1320h	19	Update from the Audit Committee – October: *for assurance* BAF REF: 1298	ROHTB (11/19) 022	RA
	19.1	Terms of Reference: *for approval*	ROHTB (11/19) 023 ROHTB (11/19) 023 (a)	RA
MATTERS FOR INFORMATION				
1325h	20	Meeting effectiveness	Verbal	ALL
	21	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 4th December 2019 at 1400h at Aston University.				

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.

ATTENDANCE REGISTER – UPDATED TO OCTOBER 2019

MEMBER	MEETING DATE										TOTAL
	3/4/2019	1/5/2019	5/6/2019	3/7/2019	4/9/2019	2/10/2019	6/11/2019	4/12/2019	5/2/2019	4/3/2019	
Yve Buckland (Ch)	✓	✓	✓	✓	✓	✓					/10
Tim Pile	✓	A	✓	✓	✓	✓					/10
Kathryn Sallah	✓	✓	✓	A	✓	✓					/10
Rod Anthony	✓	✓	✓	✓	✓	✓					/10
Richard Phillips	✓	A	✓	✓	✓	✓					/10
David Gourevitch	✓	✓	✓	✓	✓	✓					/10
Simone Jordan	✓	✓	✓	✓	✓	✓					/10
Ayo Ajose											/4
Paul Athey #1	✓	✓									2/2
Jo Williams #2	✓	✓	✓	✓	✓	✓					/10
Matthew Revell	✓	✓	✓	✓	✓	✓					/10
Garry Marsh	A	✓	✓	✓	✓	✓					/10
Phil Begg	✓	✓	A#3	✓	✓	✓					/10
Marie Peplow			✓	✓	✓	✓					/8
Stephen Washbourne	✓	✓	✓	✓	✓	✓					/10

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		
#1	Acting Chief Executive until 6 May 2019	#2	Chief Executive from 6 May 2019
#3	Planned absence – ROH work commitment		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.2

Venue Boardroom, Trust Headquarters **Date** 4 September 2019: 1030h – 1500h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair and Non Executive Director	(TP)
Mr Rod Anthony	Non Executive Director	(RA)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Mrs Jo Williams	Chief Executive	(JW)
Mr Matthew Revell	Executive Medical Director	(AP)
Mr Steve Washbourne	Interim Executive Director of Finance	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Garry Marsh	Executive Director of Nursing & Clinical Governance	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Sandra Millward	Head of Imaging	(SM)	[Item 1]
Mrs Lisa Kealey	Patient Services Manager	(LK)	[Item 1]
Mr Nathan Samuels	Lead Nurse for Learning Disabilities	(NS)	[Item 12]
Mrs Lisa Newton	Matron and Lead for Mental Health	(LN)	[Item 12]
Mr Simon Grainger-Lloyd	Director of Corporate Affairs & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Patient Story	**Presentation**
The Board was joined by Sandra Milward, Head of Imaging and Lisa Kealey, Patient Services Manager. They presented a story about a child that the Trust had treated, who had learning difficulties and due to childhood issues he also had issues with trusting people. The child had scoliosis and required a scan in the Imaging department. To help alleviate the child's anxiety, a document had been created to outline what he could expect when he came into the hospital and a unique time slot for the scan had been booked, so there was minimal disturbance from other patients. The patient's episode of care had occurred without any difficulties and the patient had been relaxed and put at ease by the process and adaptations.	

It was agreed by the Board that this was a very positive example of support to an individual patient's needs, which had been made possible by a number of members of staff who supported all the steps necessary. It was noted that this was a good story and any additional learning that could be applied elsewhere needed to be harnessed. It was reported by the Patient Services Manager that patients with hospital phobias were offered the opportunity to walk around the site before their treatment to help them understand the experience they would receive when they arrived for an inpatient episode. It was noted that this service was not actively promoted, however there was benefit in doing so as it was good for patients and their carers. It was also suggested that a similar approach could link into dementia care to show people what they would see and who they would meet when they came in. It was noted that there was a tool where a virtual 'fly through' the facilities was possible and it was agreed that this could be funded from Charitable Funds if a bid was submitted. The team was thanked for this impressive piece of work and it was agreed that the document for the patient with learning difficulties had been well written. This was good evidence that the treatment plan was based on the individual and that reasonable adjustments were made when necessary.	
2 Apologies	
The Board was joined by Rebecca Taylor from Liaison Workforce, Fiona Taylor, NHS Improvement NeXt candidate and Neil Scrannage from Johnson and Johnson Ethicon. Marie Peplow was congratulated on her appointment as substantive Chief Operating Officer and was welcomed to her first Board meeting in this capacity.	**Verbal**
3 Declarations of interest	**Verbal**
It was noted that the register was available on request from the Company Secretary. Garry Marsh reported that he had been appointed as an Executive Reviewer for the CQC's inspection team.	
4 Minutes of Public Board Meeting held on the 3 July 2019: *for approval*	**ROHTB (7/19) 008**
The minutes were confirmed as a true and accurate record of discussions held on 3 July 2019.	
5 Trust Board action points: *for assurance*	**ROHTB (7/19) 008 (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 (9/19) 001** **ROHTB (9/19) 001 (a)**
The Chief Executive reported that a Human Factors course was being developed, which would be delivered at the end of September. The Trust had been shortlisted for the Health Service Journal (HSJ) Trust of the Year award. The judges would visit the Trust during week commencing 9 September, which it was noted coincided with the Health and Wellbeing week. The criteria for making a judgement as to the Trust of the Year was discussed and it was suggested that this was more of a 'reality check' of the organisation than a strict criteria-based assessment. There was agreement that there should be great pride in being shortlisted regardless of the outcome. Effort would be made to include all staff on the day of the final awards ceremony. JointCare had also been nominated for an award for Forward Healthcare. A Health and Wellbeing Officer had been appointed. There had been a trip to see the new theatre modules and it was noted that the facilities were impressive. These were due to be installed on site during the first week of October. It was noted that there had been two paediatric oncology patients treated at Birmingham Children's Hospital, where there had been complications with the surgery. The investigations around these would be reported back to the Quality & Safety Committee. The Chairman reported that she had met with a patient who had written to the Chief Executive to encourage the Trust to reflect on its responsibilities around environmental sustainability, including removing all plastic straws. She had been made a sustainability champion and a connection with the local school around this work had been made. In terms of the Birmingham Hospitals Alliance meeting, there had been discussions around digital transformation and the development of the physical infrastructure support at Birmingham Women's and Children's NHSFT.	
6.1 Orthopaedic Services in the STP. BAF REF: CE1 & S799	**Verbal**
It was reported that a formal report to the STP on the orthopaedics pathway was	

planned for November. Understanding the clinical borders and organisational barriers was noted to be a key priority. Five meetings had been held with Heartlands, Good Hope and Solihull Hospitals (HGS) to look at the configuration across the sites, although the contribution from orthopaedics was relatively small as part of these. Meetings had also been held with the Clinical Lead for Orthopaedics and a shared understanding of the required approach had been discussed. Meetings had also been held with the Head of Strategy at University Hospitals Birmingham NHSFT (UHB) to ensure that the future direction of the organisations was aligned. An Interim Deputy Medical Director had been appointed who would support the medical leadership. Shared governance arrangements and informatics were being worked through. It was noted that the delay in progressing the orthopaedics work was as a result of focus being diverted into addressing performance issues at UHB and there had been some reconfiguration of the divisional structure. There was also effort being directed into preparing for a potential 'flu epidemic and to implementing measures to ensure that patients did not need to be directed into the private sector for treatment. HGS had been asked to commit to the number of patients to be repatriated for treatment at ROH. The Trust had agreed to be a pilot site for the Clinical Commissioning Group (CCG) to address the 26 weeks issue. The spinal oncology service was reported to be stable across UHB and ROH and a joint strategy had been developed. This was good evidence on a number of levels that the two trusts were working well. It was suggested that the implications of the work with HGS and the orthopaedics strategy needed to be discussed by the Board at its next meeting.	
6.2 Chief Executive's extract of the Board Assurance Framework: *for assurance and approval of changes*	**ROHTB (9/19) 002** **ROHTB (9/19) 002 (a)**
It was reported that there had been a challenge and confirm session around the Board Assurance Framework (BAF) by the Executive Team and the extracts from the BAF on today's agenda reflected the changes proposed.	
7 Quality & Safety extract of the Board Assurance Framework: *for assurance and approval to changes*	**ROHTB (9/19) 003** **ROHTB (9/19) 003 (a)**
It was reported that in terms of the risk around compliance with water safety regulations, there was assurance that the Trust operating with safe water. Two risks were proposed for closure, which were agreed.	
8 Update from the Quality & Safety Committee and annual report: *for assurance*	**ROHTB (9/19) 004 (i)** **ROHTB (9/19) 004 (ii)** **ROHTB (9/19) 004 (a)**

It was noted that the August Quality & Safety Committee meeting was a longer meeting than usual. Complaints were reported to have increased and these related to rescheduling of appointments. Partial booking would address this. It was noted that there had been a bereavement in the complaints team and, given the reduced capacity, patients were being asked to write in rather than address the concern over the phone which had led to a rise in the number of formal complaints being processed. It was noted that the closure of Central Alerts System (CAS) notifications was being investigated to understand why the CQC intelligence that had identified that over half of these alerts had been closed late. The Venous Thrombo Embolism (VTE) policy had been amended and a clear statement on this was being worked up as to what the practice meant in terms of antiembolism stocking and VTE prophylaxis. It was noted that the WHO checklist compliance was at 100%. The practice around the use of the WHO checklist in another organisation was described by the Chair. It was noted that although there could be learning from elsewhere, the checklist was not a panacea to avoid all issues in theatres however. The substantive Freedom to Speak Up Guardian had returned to the Trust and would raise any matters of patient safety. An audit of groups reporting to the Quality & Safety Committee had been undertaken. It was agreed that the Health Assure system demonstration would be scheduled for the October Board workshop. It was reported that the Clinical Negligence Scheme for Trusts (CNST) premia would be impacted positively by the value of the claims being settled at a lower level than initially anticipated. The annual report for the Quality & Safety Committee was received and noted.	
9 Quality report: *for assurance* BAF Ref: 1137, 275, 986, PS1, S800, MD1	**ROHTB (9/19) 005**
The highlights from the Quality Report were presented by the Director of Nursing & Clinical Governance. There had been a Never Event which related to a wrong-sided block. There had been two falls, these being a member of staff and a patient. There were no VTEs reported in July. One pressure ulcer was reported and classified as being avoidable. There had been	

no hospital acquired Grade 3 and 4 Pressure Ulcers. As described earlier in the meeting, there had been a spike of 27 complaints in month, many of which were around appointments. An appointment hot line was now in place. The electronic approval of leave was also noted to have been implemented and as this was linked to the clinical appointment schedule would avoid a number of rearranged appointments needing to be made. From a Friends and Family Test perspective, there had been an increase in response rates. There had been no notifiable infections in month. It was highlighted that the report now also included were the Safeguarding issues reported. The high level of issues was reported to be positive. Mental Health referrals were being seen associated with staff.	
10 Patient experience update: *for information and assurance* BAF REF 269	**ROHTB (9/19) 006** **ROHTB (9/19) 006 (a)** **ROHTB (9/19) 006 (b)**
It was reported that the CQC had previously been critical of the Trust's patient experience and engagement practices. However, a strategy was now in place which had been developed based on NHS Improvement's patient experience assessment frameworks. The CCG had also been offered the opportunity to comment on the strategy. The use of volunteers would also be heightened. A Patient Engagement and Experience Group was now in place which upwardly reported to the Quality & Safety Committee. A carer's strategy was also in place. There had been a review of complaint responses issued undertaken and it was noted that the quality of responses had improved. The membership of the Patient Engagement and Experience Group was largely staff from the ROH and there was an intention to invite more patient representatives. Kathryn Sallah echoed this view and suggested that the JointCare Reunion meetings could be a valuable source of service users. It was noted that the postcard that was used for comments from those at the Reunion meetings could be used and the content from these could be published. The Patient & Carers' Forum was integral to the work of the Patient Engagement and Experience Group and recognised the benefit of sighting the Board on their work through this arrangement and improving the diversity of the patient experience. A Learning Disability user group had been established which was noted to be a very positive development and there was a keenness from ROH staff to attend and be	

involved with this work. It was also noted that there were patient representatives on the estates strategy and delivery group. There was good community links and linkages with Healthwatch had been strengthened. It was suggested that the success of the work needed to be defined in terms of metrics and to achieve this there was a plan to link in with the Quality and Service Improvement framework. This work was recognised by the Board as a positive piece. The Deputy Director of Nursing & Clinical Governance was congratulated for this piece of work.	
11 Annual complaints report: *for assurance and approval* BAF REF: 275	**ROHTB (9/19) 007** **ROHTB (9/19) 007 (a)**
It was noted that there had been scrutiny of the report previously by the Quality and Safety Committee and Executive Team. There had been an overall reduction in the number of complaints and in particular the spinal services. There had also been overall decrease in ward care complaints including those relating to Ward 2 which handled the highest level of activity. It was suggested that there needed to be more benchmarked information included against peers in the future reports. This would be overseen by Quality & Safety Committee. The Board approved the report and agreed that it could be published on the Trust's internet site.	
ACTION: SGL to arrange for the annual complaints report to be published	
12 Mental Health update: *for assurance*	**ROHTB (9/19) 008** **ROHTB (9/19) 008 (a)**
The Board was joined by Nathan Samuels, Lead Nurse for Learning Disabilities and Lisa Newton, Matron and Lead Nurse for Mental Health. It was reported that there had been some significant conversations around Mental Health at Board previously, particularly linked to the CQC concerns raised as part of their previous inspection. It was reported that there had been much work to scope the relevance of the Mental Health Act to the Trust. This was particularly around patients who may need to be placed in a place of safety to get help and treatment required. The	

Service Level Agreement with Birmingham and Solihull Mental Health NHSFT (BSMHFT) was in place to support this. A policy to support the work was needed and this was sourced from BSMHFT and was being tailored to the needs of the ROH. The Board as advised that 98 Mental Health first aiders had been trained to provide an initial first response. The Mental Health core skills framework had been used to inform the training regime. It was noted that there was good appetite for Mental Health first aid from across the Trust. It was reported that there had been much training and awareness around Mental Health at the Trust and the intranet site had been updated significantly to reflect this. The different pieces of legislation were discussed in the training and there was scenario-based testing. It was reported that anecdotally, an individual who had participated in Mandatory Training had praised the Mental Health element over and above other training they had received. A Mental Health working group was being established to which a patient representative would be invited. The collection of Mental Health contacts data was also being formalised. The numbers were noted to be low, however as there was greater awareness this was expected to increase. Mental Health was included on the clinical governance risk register as it remained a concern as the policy was yet to be completed and the Service Level Agreement needed to be strengthened. There was confidence that the position around the concerns previously expressed by the CQC had been addressed. The Chief Executive noted that the work was positive for staff. The contacts from staff were noted to be low level at present, but there had been some signposting to other services were possible. There was noted to be linkages into the Health and Wellbeing work, supported by Human Resources. The conduciveness of the environment to handle patients with autism was questioned. It was reported that the Mental Capacity process would be followed. The reflection room was used as a safe and calm place if needed. It was agreed that training in Mental Health would be arranged for the Board. It was noted that there was good personal growth in the individuals responsible for the Mental Health work.	
ACTION: **SGL to arrange for the Trust Board to be trained in mental health requirements**	
13 Annual report from the Director of Infection Prevention and Control: *for*	**ROHTB (9/19) 009**

assurance and approval **BAF REF: 1137**	**ROHTB (9/19) 009 (a)**
It was reported that the annual report from the Director of Infection Prevention & Control had been considered by the Quality & Safety Committee at its last meeting and had also been scrutinised by the Infection Prevention and Control Committee. There had been no MRSA cases reported during the year. Two *C.difficile* cases had been reported, which had been the subject of a separate report to the Quality & Safety Committee. There was an *E.coli* reduction plan in place. There had been one Norovirus case reported. From a 'flu point of view, the campaign would be reinvigorated. There was a commitment to a scheduled shut down in theatres each year to allow for routine maintenance to occur. Compliance with the sepsis pathway was good and was linked to antibiotic administration. There was noted to be a spike in Surgical Site Infections (SSIs) associated with hips and knees which was being investigated, although there were no trends expected to be identified. The Board approved the report and agreed that it could be published on the Trust's internet site.	
ACTION: SGL to arrange for the annual report from the DIPC to be published	
14 Mortality update (Learning from Deaths): ***for assurance***	**ROHTB (9/19) 010** **ROHTB (9/19) 010 (a)**
The Medical Director reported that comparative to other acute organisations, the Trust's mortality position was low. As there were few deaths, all deaths were reviewed. The process to review the deaths was noted. The Department of Health's mortality tracker was reviewed, as was the comparative information to some other trusts, which showed that the position at the ROH was positive. The Trust was exempt from reporting against the Standardised Hospital Mortality Indicator (SHMI) as it was a specialist trust. It was agreed that this needed to be made clear in future reports to avoid any undue confusion. It was noted that the palliative care links were working well which was pleasing and there was improvement on the position reported previously. One of the new Oncology surgeons had also developed some policies and judgement frameworks for end of life care. It was noted that there were gaps in the evidence in the tracker and these were being addressed.	
15 Finance & Performance extract of the Board Assurance Framework: ***for***	**ROHTB (9/19) 011**

assurance and approval of changes	**ROHTB (9/19) 011 (a)**
It was proposed that the data quality risk and the long waiting times for spinal deformity risk should be de-escalated. This was agreed by the Board.	
16 Update from the Finance & Performance Committee: *for assurance*	**ROHTB (9/19) 012 (i)** **ROHTB (9/19) 012 (ii)**
It was reported that there had been a number of meetings of the Finance & Performance Committee since the Board had last met and there was a keen interest on activity. The June, July and August financial positions were reported to be behind plan, this being reflective of the activity position. Performance against the key operational metrics was noted to be sound and there was a plan to engage a number of additional staff to support the recovery plan. There had been a request by the Committee that the impact of the new starters and the recovery measures on the finance and activity positions be identified. It was noted that the issue last year related to theatre capacity; this year, the issue related to consultant capacity. It was noted that there had been a discussion which concluded that planning the year should not be on the basis on optimal delivery, such as factoring in additional duty hours (ADHs) but should be on the baseline capacity. A number of the actions to achieve recovery were described, which included the recruitment of new starters in the form of an arthroplasty surgeon, a spinal surgeon, and a further surgeon in October. Another consultant for spinal surgery would start in February 2020. A pain consultant had been recruited, however until this individual started, there were some additional lists being arranged. Some 'right sizing' work was being undertaken to match demand and capacity. This work was to handle the demands on the Trust from elsewhere and to handle the loss of capacity as a result of the pensions tax liability issue.	
17 Finance & Performance overview: *for assurance* BAF REF: CE1, FP1, 1089, 1088, 293, 7, CO1, CO2, 27, 269, 270, 804, 1074, FP2	**ROHTB (9/19) 013**
The Director of Finance reported that the financial performance in July had been challenging. The planned level of income and expenditure included the impact of paediatric services that had now transferred. The plan did not reflect additional income as a result of the modular theatres. The specific challenges around workforce were also not reflected in the plan. It was reported that the changes would be reflected in a paper that would be presented to the Finance &	

Performance Committee at the September meeting. The deficit for July was reported to be £465k against a plan of £161k. This was below the recovery plan. There was a cumulative adverse deficit of £1m. The forecast for August was that there would be a further deficit and in September there would be a small surplus as a result of additional consultant staff and other measures, which would address some of the shortfall. Activity in August was below plan by 119 cases, however the position was slightly above the revised position. A more significant impact was reported to be anticipated in September when there would be a greater level of higher value cases. In terms of private patient income, there was an upwards trend on the previous year. There was further scope to improve this over the next year by accessing some of the work currently being diverted into the private sector. A plan that covered the region would be developed which may have a beneficial impact on the ROH and other providers who would be held to account for their part in the work. It was noted that there was a mandate from the Board to reprioritise capital spend between Board meetings should there be an urgent need. The performance against the 92% Referral to Treatment Time (RTT) target position was below trajectory but was steady. There were no patients waiting in excess of 52 weeks. There had not been a breach of the agency cap for nursing and the medical locum usage would reduce. The staffing for the new modular theatres had been secured.	
18 Workforce extract of the Board Assurance Framework: *for assurance and approval of changes*	**ROHTB (9/19) 014** **ROHTB (9/19) 014 (a)**
It was proposed that a new risk around the pensions tax implications be added to the BAF which the Board agreed.	
19 Update from the Staff Experience & OD Committee: *for assurance*	**ROHTB (9/19) 015**
It was reported that all matters in the upwards report from the Committee had been discussed through other items. It was noted that the schedule of meetings had been changed to better suit members and colleagues. This would also work better with the Board cycle.	
20 Workforce Overview: for assurance BAF REF: WF2, HR10, WF1, WF20, 27	**ROHTB (9/19) 016**
The Chief Executive reported that not all Executives attended the Staff Experience & OD Committee however given that workforce was a critical area of focus,	

establishing a forum that the other Executives could join was being considered. In terms of resuscitation, a reassessment of training needs was being undertaken. The demand and capacity of training sessions was also being considered. Some training was undertaken in Basic Life Support in each area. One to one meetings with sisters of clinical areas had been held and there were some apparent mismatches between the information on the Electronic Staff Record (ESR) and the locally held information. Trajectories for compliance were being worked up. It was highlighted that compliance may have dropped, however there were few staff that had not received any resuscitation training at all so there was low risk. There was particular focus on Enhanced Paediatric Life Support (EPLS) in the area that treated paediatric patients and to determine whether there was a core skills available in other areas, such as in hydrotherapy, outpatients and biopsies. Appraisal rates was also an area of focus, with a view to improving the current position. The staff Friends and Family Test results had improved. It was reported that the divisions would present to the Staff Experience & OD Committee at its next meeting.	
21 Guardian of Safe Working update: *for assurance*	**Verbal**
The Medical Director reported that there had been no concerns to raise over the previous quarters from junior doctors, aside from compensatory rest for those working across both ROH and BCH. It was anticipated that this position would be resolved as a result of the paediatric transfer. The term of office of the Guardian of Safe Working was noted to be due for review shortly and expressions of interest were being sought. It was suggested that the Board needed to be refreshed on the role of the Guardian of Safe working. It was agreed that the formal processes around this needed to be strengthened and an update would be brought to the next meeting.	
ACTION: MR to present a refresh of the Guardian of Safe Working role and the plans to strengthen the formal processes at the next meeting	
22 Nominations and Remuneration Committee terms of reference: *for approval*	**ROHTB (9/19) 018** **ROHTB (9/19) 018 (a)**
The terms of reference for the Nominations and Remuneration Committee were	

reviewed and approved, subject to the removal of the Director of Strategy and Delivery from the regular attendees list.	
23 Strategy and Delivery extract of the Board Assurance Framework: *for assurance and approval of changes*	**ROHTB (9/19) 019** **ROHTB (9/19) 019 (a)**
In terms of the risk around the failure to embed the strategy into the day to day work of the Trust, it was noted that the approval of the strategy due in October would address this risk.	
24 Carbon Reduction Strategy annual report: *for assurance*	**ROHTB (9/19) 020** **ROHTB (9/19) 020 (a)**
The Director of Strategy and Delivery reported that the baseline carbon footprint for the ROH was from 2006 and since then there had been some significant changes to the site, including the addition of the Outpatients facility. There had been an ongoing programme to address the efficiency of the Trust, including electricity by changing to LED bulbs. The new modular theatres were energy-efficient, however the older estate was a key challenge. Reducing water usage was improving. In terms of sustainability, it was reported that more paper containers and straws were now used. There were noted to be solar panels on Outpatients which were out of action at present but were not being mended as a priority according to the capital plan. Staff were noted to be committed to recycling. It was suggested that a drive for environmental sustainability was needed in the Trust. It was noted that energy usage was the key issue to be challenged. An environmental sustainability group was being arranged. It was suggested that a project to create a carbon neutral hospital was needed and a plan was required which should be brought back to the Board at a future meeting. It was agreed that a further update would be presented when there had been linkage into the work across the West Midlands.	
ACTION: PB to present a plan to create a carbon-neutral hospital to the Board at a future meeting	
25 Emergency Preparedness Resilience and Response: *for approval*	**ROHTB (9/19) 021** **ROHTB (9/19) 021 (a)**
It was reported that there was an annual requirement for a plan to be created around Emergency Preparedness Resilience and Response which needed to be	

submitted centrally to the Local Health Resilience Forum. This also needed approval by the Trust Board. There was reported to be nearly full compliance with all standards, with the only area of non-compliance being around the Data Protection and Security Toolkit. As it was noted that the plan had already been submitted, the Board received and noted the plan. It was suggested that an evidence-base behind the toolkit was needed in future. It was suggested that as the Trust did not have an emergency preparedness forum in future the plan would be presented to the Operational Management Group prior to submission to the Trust Board.	
26 Update from the Audit Committee and annual report: *for assurance*	**ROHTB (9/19) 022** **ROHTB (9/19) 022 (a)**
The Chair of the Audit Committee reported that good progress had been made with the completing the audit recommendations. The Committee had received a good report on readiness for Cyber Security and there would be a focus on Board-level engagement and setting risk appetite. The annual report was also received and noted.	
27 Corporate Risk Register: *for assurance*	**ROHTB (9/19) 023** **ROHTB (9/19) 023 (a)**
It was noted to be good practice for the Board to see the entire Corporate Risk Register from time to time. There was reported to be some duplication between the Corporate Risk Register (CRR) and the Board Assurance Framework as the most severely rated risks from the CRR were a subset of the BAF risks. The CRR was reported to have been refreshed by the Executive over the summer. It was noted that the Board committees reviewed an extract of the CRR that pertained to their remit. The plans to strengthen the risk management framework over the coming months were noted and welcomed. The Board's appetite for risk appetite would be considered at the October Board workshop.	

28 CQC action plan update: *for assurance*	**ROHTB (9/19) 024** **ROHTB (9/19) 024 (a)**
It was reported that good progress was being made overall with the actions in the CQC action plan. A remaining issue concerned the tracking and auditing of new policies, which would be addressed by the HealthAssure system. In terms of the bone infection service, oversight through standardised dashboards for individuals in the service was difficult to create. There was an ambition to identify the ROH as a centre of excellence for handling bone infection. There was also an identified post holder and a Multi Disciplinary Team (MDT) was now in place. It was suggested that the CQC would look at the impact for patients. It was noted that the cost of patient care needed to be identified and discussions with Commissioners were underway. It was noted that the service would grow by reputation. It was reported that the work to strengthen the consent processes were underway and conversations around consent with patients were being strengthened. It was noted that the CQC would receive the updated action plan as part of the routine engagement meetings. The CQC at the July meeting had been updated on progress.	
29 Meeting effectiveness	**Verbal**
It was noted that it had been good to hear from the clinicians and the service leads for Mental Health. The presentation from the Head of Imaging was agreed to have been particularly good and her leadership was praised. It was suggested that the Board was working well as a Unitary Board and contributions were equal. The break down of the Board Assurance Framework into the individual elements was agreed to have been useful. It was noted that the members of the public were welcomed.	
30 Any Other Business	**Verbal**
There was none.	
31 Details of next meeting	**Verbal**

The next meeting is planned for Wednesday 6 November 2019 at 1100h in the Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 6 November 2019, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Updated: 1.11.2019

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 079	Patient story – JointCare follow up	Presentation	05/06/2019	Schedule in a presentation about JointCare into the Board Workplan	SGL	~~06/11/2019~~ 04/03/2020	Added to the ~~November~~ March Board meeting agenda	
ROHTBACT. 080	Chairman's & Chief Executive's update	ROHTB (6/19) 001 ROHTB (6/19) 001 (a)	05/06/2019	Organise for a demonstration of control charts to be presented to the Board	JWI	~~02/10/2019~~ 05/02/2020	Added into the ~~October~~ February workshop agenda	
ROHTBACT. 083	Mental Health update	ROHTB (9/19) 008 ROHTB (9/19) 008 (a)	04/09/2019	Arrange for the Trust Board to be trained in mental health requirements	SGL	31-Jan-19	ACTION NOT YET DUE	
ROHTBACT. 085	Guardian of Safe Working update	Verbal	04/09/2019	Present a refresh of the Guardian of Safe Working role and the plans to strengthen the formal processes at the next meeting	MR	06-Nov-19	Included on the agenda of the November 2019 meeting	
ROHTBACT. 086	Carbon Reduction Strategy annual report	ROHTB (9/19) 020 ROHTB (9/19) 020 (a)	04/09/2019	Present a plan to create a carbon-neutral hospital to the Board at a future meeting	PB	31-Mar-20	ACTION NOT YET DUE	
ROHTBACT. 075	Finance & Performance extract of the Board Assurance Framework	ROHTB (4/19) 007 ROHTB (4/19) 007 (a)	03/04/2019	Refresh the risks on the Board Assurance Framework	Exec	05-Jun-19	Board Assurance Framework refresh planned for May 2019. Refresh to be ready for the ~~July~~ September meeting - Executive Team workshop planned for 9 July to discuss. Included on the agenda of the September 2019 meeting.	
ROHTBACT. 077	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Arrange for an update on Mental Health to be provided at a future meeting	SGL	04-Sep-19	Included on the agenda of the September 2019 meeting.	
ROHTBACT. 078	Update from the Quality & Safety Committee	ROHTB (5/19) 009	01/05/2019	Provide an update on environmental sustainability at a future meeting	PB	04-Sep-19	Added to the agenda of the September 2019 meeting	
ROHTBACT. 082	Annual complaints report	ROHTB (9/19) 007 ROHTB (9/19) 007 (a)	04/09/2019	Arrange for the annual complaints report to be published	SGL	06-Sep-19	Report published on Trust internet site	
ROHTBACT. 084	Annual report from the Director of Infection Prevention and Control	ROHTB (9/19) 009 ROHTB (9/19) 009 (a)	04/09/2019	arrange for the annual report from the DIPC to be published	SGL	06-Sep-19	Report published on Trust internet site	

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 Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**6 November 2019**

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 Trust Board (in public session) on 6th November 2019

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last full public Board meeting held on 4 September 2019 from the Chief Executive's position. This includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 Following the Trust being shortlisted as a finalist for the Health Service Journal (HSJ) Trust of the Year award, 20 members of the Trust are attending the awards evening on Wednesday 6th November at Battersea Evolution, London. To celebrate this achievement, afternoon tea is being provided for all staff to recognise and acknowledge this accomplishment.

2.2 Stacey Keegan, Deputy Director of Nursing & Clinical Governance, has been appointed as the Executive Chief Nurse at Robert Jones Agnes Hunt NHS Foundation Trust (RJAH). The appointment is a secondment until September 2020. Stacey's contribution to nursing at the ROH can been seen across the organisation and her leadership with the Dementia Strategy, in particular and the nurse recruitment drive over the past few months has been highly successful. We all wish her well in her new role and look forward to continuing to strengthen our partnership relationship with RJAH through the NOA (National Orthopaedic Alliance).

2.3 The CQC (Care Quality Commission) conducted their unannounced inspection, arriving at the Trust on Tuesday 15th October for three days and inspected two core services: Surgery and HDU (High Dependency Unit). Staff across the areas felt that they had an opportunity to showcase their services and especially in HDU had confidence and pride in demonstrating areas where there has been significant improvement since our last inspection. Preparation for the one day Well Led review, which is scheduled for the 12th November is ongoing. The letter providing initial feedback and the Trust's initial response is provided in Garry Marsh's report later on the agenda.

2.4 The National Staff Survey has commenced and will run until the end of November 2019. At the end of October, 31% of staff had completed their survey. Last year, our

final completion rate was 41%. A variety of support and initiatives have been arranged to support staff to participate and encouraging staff to “Speak Up and Join In”.

2.5 ModuleCo and Interclass commenced the installation of the Phase 1 of the expansion of theatres, recovery and the new ward on the 4th October, which consisted of 28 modules. The installation was a huge success and despite the enormity of project phase, everyone supported patients and all staff were fantastic supporting initiatives such as parking off site and redirecting patients parking. Work continues with Birmingham City Council to support our commitment to the planning consent restrictions and the public consultation is due to commence to consult on parking restrictions for various streets surrounding the ROH.

2.6 Throughout October, we celebrated Black History Month with various staff taking part in celebrations throughout the month. Our Equality and Diversity Group committed their time and energy to making the celebrations a huge success.

2.7 On 23rd October, Birmingham City Council launched the Birmingham Food Conversation, a one-year conversation about food with its citizens, recognising that we sometimes shop, eat and throw away food without considering the consequences. **#TalkFoodBrum**. Dr Justin Varney, the National Strategic Advisor on Health and Work at Public Health England, confirmed “Our city wants to encourage people to make their relationship with food a more active one”.

To support the launch, the co-founder of Leon restaurants, Henry Dimbleby MBE, visited schools in Birmingham and the ROH as part of his role working with the government to review the food system so it is "safe, healthy and affordable". We look forward to working closer with the National Food Strategy team to support healthier food options for staff at the ROH and we are grateful to Dr Varney for involving us in the scheme.

2.8 Work continues with the Northfield Partnership hub and we continue to increase our contribution to the food bank. Throughout November as part of our Wellbeing agenda, we will focus on “giving” and we aim to collect donations to make 25 hampers for the hub to donate to local residents to support them through the Christmas period.

2.9 To celebrate World Menopause Day on 18th October the Trust promoted information for staff and raised awareness for the forthcoming conference and managers briefing session on 13th November. The day was a huge success and over 70 staff signed up on the day for the conference.

2.10 Work continues to raise the profile of the ‘flu vaccination campaign across the organisation. The Infection Control team has reviewed our action plan with best practice to ensure that we have incorporated all actions in the National Flu letter

which all Trust have received from NHS England. Performance at the end of October is 40%.

2.11 I attended a conference on 24th October, 'The Challenge of Culture Change'. The conference was jointly hosted by The King's Fund, NHS England and NHS Improvement, and it explored the type of cultures we want to nurture in the health and care system and why, through insights from experts working in the system.

2.12 On the 3rd October I attended a conference arranged by the West Midlands Leadership Academy, 'Going Beyond the Conversation'. The event was attended by CEO and Chairs across the Midlands and East region and provided support and clear leadership on equality, diversity and inclusion to trust boards. The content and speakers were excellent and they shared their reflections on the importance of the issues and the tools they are using to build a pipeline of compassionate, inclusive and engaging leaders to deliver on the ambitions set out in the NHS Long term plan and the People strategy.

Following the conference, the Academy will be supporting the Trust further in the New Year, initially with an Equality and Diversity Session at Trust Board planned for February 2020 delivered by Jagtar Singh, OBE Chair of Coventry & Warwickshire Partnership NHS Trust.

2.13 Working closer with West Midlands Leadership Academy we have agreed the following workstreams:

i). A three-day Executive Team development programme delivered over a series of days covering understanding self, five behaviours of a cohesive team, effective dialogue for maximum impact and reverse mentoring.

ii). NHS Improvement Culture Programme which is to enhance the work we have already undertaken at the ROH and will help to sustain continuous improvement, safe, high quality, compassionate care.

iii). Inclusive mind-set and unconscious bias training. The workshop examines how our brain processes information and how to manage our unconscious biases and make evidence-based decisions. The aim of the workshop is to roll this out across the senior leaders initially.

2.14 The Trust continues to engage nationally with preparations for Brexit and there is good engagement across the Trust to ensure that we have tested our business continuity plans across all the services.

2.15 The Trust has signed up to two national initiatives over the last few weeks:

i). Disability Confident Commitment Scheme (Level 1). The scheme helps employers to ensure that disabled people and those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations in workplaces.

ii). 'Thrive at Work' is a workplace commitment with criteria and guidelines on creating a workplace that promotes employee health and wellbeing, focusing on key organisational enablers such as health and safety, manager training etc., in addition to health areas such as mental, musculoskeletal and physical health and promoting healthy lifestyles. It is supported with a toolkit of available local and national resources, policies and services.

2.16 The QSIR (Quality Service Improvement & Redesign) programme commenced in June 2019 with an agreement to train 39 staff across three cohorts in the QSIR methodology. Since June 2019 to present, there have been 12 QSIR training sessions completed with 3 dates remaining to the end of November. We have agreed to continue the training and to provide a combination of QSIR Practitioner together with QSIR Fundamentals training, a one-day condensed version of the five-day program. The participants gain the same breadth of knowledge and it is hoped then that this can be rolled out to more staff across the organisations

3.0 SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP)

3.1 The latest STP CEO meeting took place on 17th October which we used as part of our pre-meet ahead of the system review meeting with all Birmingham & Solihull CEOs, chaired by NHS Improvement. Key areas of focus concerned 4-hour performance in Emergency Departments, implementation of the Integrated Care System (ICS) and the priorities, STP financial year end and financial planning for 2020/2021.

3.2 The last STP Board meeting took place on 7th October 2019. Key areas of discussion are described below. The Board discussed the next steps for the ICS and supported the priorities, which for our ICS are:

- An integrated model across health, social care and education to support vaccination and immunisation of all children and young people.
- A digital first model of access to urgent care, starting with all adults seeking urgent support from UHB, later expanding to be a whole system solution for Birmingham and Solihull.
- Rollout of the early Intervention teams already piloted in Edgbaston and Northfield to cover all Birmingham and Solihull older adults.

3.3 Work stream have been established and have identified key leads to shape each of the four ICS development programmes utilising expertise from across our organisations. NHSE/I will provide resources and expertise to support delivery.

Core Development Team				
Function			**Lead**	
Sponsor and ICS portfolio Chair			Sarah -Jane Marsh	
STP Portfolio Lead officer			Rachel O'Connor	
STP Strategy Lead officer			Matt Boazman	
STP Finance Lead			Phil Johns	
ICS Functional Area	**Core Dev Team**	**Chair**	**Clinical/ professional**	**Local Government**
Governance & Decision Making	Lawrence Tallon	Jacqui Smith	Dr. Richard Mendelsohn	Cllr. Karen Grinsell
Integrated Future Care Model	Rachel O'Connor	Bruce Keogh	Dr. Vish Ratnasuriya	Ruth Tennant
Change Management & Improvement	Suzanne Cleary	Yve Buckland	Michelle McLoughlin	Jonathan Tew
Strategic Commissioning & Delivery	Karen Helliwell	Sue Davis	Dr. Peter Ingham	Graeme Betts

4 BIRMINGHAM HOSPITALS ALLIANCE (BHA) UPDATE

4.1 The next BHA meeting is scheduled for 20th November 2019.

5 POLICY APPROVAL

5.1 Since the full Trust Board last sat, the following policies have been approved by the Chief Executive on the advice of the Executive Team:

- Media policy
- Enteral feeding policy
- Missing patient policy
- Paediatric Interventional Radiology policy
- Conscious sedation policy
- Transmissible Spongiform Encephalopathies (TSE) including *Creutzfeldt-Jakob Disease (CJD)* Policy
- Private patient policy
- TB policy
- Mental Health Act policy

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

31st October 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – PARTNERSHIPS extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

Following the Board workshop in October it was agreed that the Board Assurance Framework (BAF) should be realigned to the goals ('Five Ps) in the newly approved Trust strategy.

Attached is the **PARTNERSHIPS** extract of the BAF

Those risks shaded in **blue** are recommended for closure or de-escalation to local risk registers and those shaded **grey** are proposed for closure.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:

Trust Board is asked to:

- Review the Board Assurance Framework extract
- Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- Agree to close or de-escalate those risks suggested

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:					

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:

Executive Team on 15 and 29 October 2019.

Trust Board at its meeting on 4 September 2019.

Discussion held about restructuring BAF by the Trust Board on 2 October 2019 as part of a workshop.

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
PARTNERSHIP																				
ST1	Strategy	Chief Executive	The Trust fails to exert influence in the STP and on the plans to develop an Integrated Care System, leading to loss of identity and brand, which could impact on the level of referrals, lowering of staff morale and loss of key skills	Strategy and system alignment Reputation and brand Workforce capacity, capability and engagement	Developing services to meet changing needs, through partnership where appropriate	Trust Board	4	4	16	Attendance at STP Board meetings and Chairs/Chief Executives forums Ongoing work with the Birmingham Hospitals Alliance Development of a draft Memorandum of Understanding with University Hospitals Birmingham NHSFT to set out future working arrangements	Trust Board minutes and papers Presentations form STP meetings	3	4	12	NEW RISK	Further progress on development of ICS and agreed way of working across the region Finalisation of Memorandum of Understanding with UHB Agreement of the orthoapedic pathway across the STP	Dec-20	2	4	8
ST2	Strategy	Director of Strategy & Delivery	Innovation slows at the Trust as a result of reluctance to enter into commercial partnerships due to the uncertainty over the future influences of the Integrated Care System	Reputation and brand Strategy and system alignment Clinical excellence	Developing services to meet changing needs, through partnership where appropriate	Finance & Performance Committee	4	3	12	Trust is currently engaged with commercial partners to deliver JointCare initiative Active research programme is in place at ROH	Papers from R & D Committee 'Perfecting Pathways' programme board summaries to FPC JointCare promotional material	3	3	9	NEW RISK	Delivery of 'Perfecting Pathways' programme Delivery of the deliverables in the 'Partnerships' section of the Trust strategy Clarity around timescales and influence of the ICS on the future direction of the ROH	Dec-20	2	3	6

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – PEOPLE extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

Following the Board workshop in October it was agreed that the Board Assurance Framework (BAF) should be realigned to the goals ('Five Ps) in the newly approved Trust strategy.

Attached is the **PEOPLE** extract of the BAF

Those risks shaded in **blue** are recommended for closure or de-escalation to local risk registers and those shaded **grey** are proposed for closure.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:

Trust Board is asked to:

- Review the Board Assurance Framework extract
- Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- Agree to close or de-escalate those risks suggested

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:					

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:

Executive Team on 15 and 29 October 2019.

Trust Board at its meeting on 4 September 2019.

Discussion held about restructuring BAF by the Trust Board on 2 October 2019 as part of a workshop.

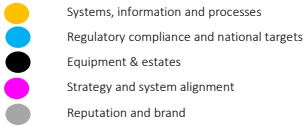
BOARD ASSURANCE FRAMEWORK - QUARTER 3

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
PEOPLE																				
WF2	WFOD	CEO	Workforce models identified may not deliver benefits which are sustainable and take advantage of new emerging roles and apprenticeship routes to employment		Highly motivated, skilled and inspiring colleagues	SE & OD Committee	4	4	16	New governance arrangements to identify and implement new workforce models now in place. Proposed new ACP model for POAC and ACP to be recruited. TAPS have been recruited. Nurse Associates planned to join the Trust. 3*ODP Assistant Practitioner Apprenticeships commenced in February 18. Greater understanding of Nursing Associate role within Trust. NMC registration. Potential future registration for PAs to be confirmed. HEE bid to support ACP Education for 5 ACPs won. ACP development requires significant investment.	SE&ODC papers. Nurse staffing reports. People Committee reports.	2	4	8	↔	Workforce design to become an integral part of HR Business Partner discussions. Middle grade workforce group is meeting to develop model. **DE-ESCALATE TO PEOPLE COMMITTEE RISK REGISTER**	Jan-21	2	4	8
HR10	WFOD	CEO	HR team has limited capacity to effectively support resourcing of Modular Theatre & Ward expansion		Highly motivated, skilled and inspiring colleagues	People Committee/SE & OD Committee	5	4	20	Concerns initally raised regarding capability of recruitment team to effectively support the increased volume of recruitment required by the expansion of theaatres and wards. Recruitment team have processed a large number of offers and the process is working well. Regular meetings between HR and Director of Nursing & Clinical Governance to monitor progress.	SE&ODC papers. Nurse staffing reports. People Committee reports. Notes of meetings between HR & Directors.	3	4	12	↓	Good progress contunues to be made and staff are due to come on Board from September onwards. **CLOSE**	Oct-19	2	4	8

WF1	WFOD	CEO	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	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. 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. Nursing staff. Nurse recruitment schedules are in place. Multiple offers of employment made to qualifying nurses. Recent evidence of rejection of some offers. Recruitment open days having positive impact on attraction of new staff 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. Links being built with educational institutions to ease pathway from education to employment	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]. Launch recruitment microsites and increase use of social media - will be an early priority for new ADWF&OD (March 2019) Brexit group sighted on potential immediate workforce risk, which is low numbers of existing staff Associate Director of Workforce & OD to undertake a review of workforce planning skills gaps and development needs. **CLOSE**	Jan-21	3	3	9
MD1	Clinical	Exec Medical Director	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	Risk unlikely to change until paediatric services cease in 2019. 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 engagement 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. **CLOSE**	Jan-19	2	2	4
WF21	Workforce	Chief Executive	The Trust fails to attract and retain the skills and number of staff to secure financial sustainability and to maintain a high quality service and environment for our patients		Highly motivated, skilled and inspiring colleagues	Staff Experience & OD Committee	5	3	15	Recruitment open days Repositioning job advertisements to provide clarity on the ROH's unique offering Development of new models of staffing - Nursing Associates, Theatre Assistant Practitioners, Mid Level Medical Staffing Health and Wellbeing programme Introduction of 100 days onboarding process	Staff Experience & OD Committee minutes and papers Health and Wellbeing week material Job adverts for key posts, including those for COO and CEO 100 induction 'road map'	5	2	10	NEW RISK	Further embedding of new staffing models Roll out of further Health & Wellbeing initiatives and the 100 days onboarding concept Rolling recruitment events	Mar-20	5	1	5

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 (11/19) 004

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The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 25 September 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The position regarding days lost and cost associated with sickness absence associated with musculoskeletal conditions was discussed. In the first six months of the year 1,827 days had been lost at a cost of £54,500. A task and finish group would be established to take forward the plans to reduce long terms sickness absence.	• Present the estates heat map at the November Trust Board meeting. • Arrange for a student to join the Staff Experience & OD Committee to present their experience. • Arrange for the Equality & Diversity Group to join the Staff Experience & OD Committee to talk about their work. • Present the equality and diversity plan to the Trust Board. • An update on talent management and succession planning to be presented in December.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• A standard operating procedure was being written to outline the requirements of storage and creation of staff personal files. • The Health and Wellbeing week was agreed to have been a success and very positive. • The Committee was joined by divisional representatives who presented information on vacancies, mandatory training, appraisal rates and other workforce Key Performance Indicators. Additional effort was being directed into improving the rate of resuscitation and safeguarding training. It was noted that the nurse recruitment into Division 2 had improved and the number of vacancies had reduced significantly. • It was reported that the Equality & Diversity Group was more established and working well. The group was engaged with a project around recruitment, looking at data from shortlisting to appointment. They were also looking at unconscious bias and best practice arrangements for interviews. The group was running an event for Black History month. A focus group for Black and Minority Ethnic staff had been organised which had been well received. • The first meeting of the disability forum had been held.	• The Committee supported its proposed revised terms of reference and agreed that they should be presented to the Trust Board for approval.

• Work was progressing on talent management and an interactive session with a diagnostic tool from NHS Improvement had been held with the Executive Team. • A new onboarding process had been developed, this being around the first 100 days in post. Following completion of this induction period, a reunion meeting was reported to be held for the new staff. • Good progress was reported on the use of apprenticeships in the Trust. 26 apprenticeships were hosted last year, with a target of 40 for the current year. • A target of 65% completion rate for the national staff survey had been set. • Preparations were reported to be underway to develop the Knowledge Hub ready for the increased number of students to be received from Aston University.	

Chair's comments on the effectiveness of the meeting: It was agreed to have been a positive meeting, however those guests attending needed to be better briefed as to the expectations of them at the meeting. The current 1.5 hours allocated was challenging to allow sufficient coverage of important items. Workshops need to be added into the workplan from 2020.

ROHTB (11/19) 005

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 30 October 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The reasons behind staff turnover in the estates and facilities department were being reviewed. • There remains a gap between application and shortlisting & appointment for individuals from a Black and Ethnic Minority background. Data from Open Days was not captured at present, however, which if taken into account within the WRES data, may improve the position. • There remained a significant number of working days lost as a result of sickness absence concerning musculoskeletal condition. A focussed piece of work was underway with the therapies team. • In terms of the areas where there was poor compliance with training requirements, these were known and understood by the Executive Team. The alignment to the new Training Needs Analysis would improve the position and in parallel divisions were being held to account on training compliance.	• There were plans to revise the structure and operation of the People Committee, to move it into an action-based group, rather than information sharing. The delivery of the NHS People Plan would be the focus of the People Committee in future. • Update from the Equality & Diversity Network to be rescheduled for the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was pleased to note that the costs associated with agency staffing were reducing as a result of the increased number of substantive staff that had been recruited. The time to recruit staff into posts was also noted to have reduced. • It was noted that the mandatory training information was presented in a more meaningful form, based on methodologies learned in the Quality Service Improvement & Redesign training. • The strengthened governance and processes around resuscitation were described, which included a focused approach to training and ensuring that staff whose competency had expired joined the required courses. • The Trust had hosted a visit by Henry Dimbleby MBE and the national food strategy team to review the Trust's food offering. As a result	• The Committee endorsed the establishment of a culture and leadership programme.

there were some planned changes, such as adjusting portion sizes and measures to reduce food waste. • The planned culture and leadership programme was outlined, which included a detailed diagnostic around the staff experience and the delivery of an action plan, with which staff of all levels would be engaged. It was agreed that the branding and messaging of this approach to staff needed to be carefully thought through. • The Committee received a positive update on the progress with rolling out the Quality Service Improvement and Redesign methodology. There were plans to extend the training programme to a wider group of staff and offer a 'fundamentals' one day course for staff not needing the full training. It was suggested that the training could be rolled out to Band 7 staff as well as those in more senior positions. • The feedback from the recent Staff Experience Walkabouts was presented, which was to the Knowledge Hub and the Litigation & Risk Manager. It was noted that morale was high and there had been positive accounts of leadership in the areas. Some buddying arrangements were to be put in place for individuals who were peerless in the organisation. Reporting back to the relevant Executives after the walkabouts was noted to be working well. • In terms of equality and diversity work, it was noted that the November Schwartz Round would focus on transgender issues. The launch of the Menopause awareness events had been well received and over 75 members of staff had signed up to attend the Menopause Conference. A Board training session was planned on Equality & Diversity by some members of the Equality & Diversity Group for the West Midlands. • The completion rate for the national staff survey was encouraging at 31% to date, this being ahead of the position in 2018. • The 100 day onboarding programme was outlined. • Over 100 nominations had been received for staff awards.	

Chair's comments on the effectiveness of the meeting: It was agreed that the meeting had seen good engagement from those present and that the quality of papers considered by the Committee was good.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STAFF EXPERIENCE AND OD COMMITTEE ANNUAL REPORT 2018/19

1.0 Introduction

1.1 The purpose of the paper is to formally report to the Board of Directors on the work of the Staff Experience Committee during 2018/19, and update the Board on its work to date in 2019/20.

1.2 The Staff Experience & OD Committee is due to review its terms of Terms of Reference in September, which will be presented to the Trust Board at its meeting in November 2019. The proposed changes are relatively minor in nature, although they do clarify the areas of focus for the Committee under the auspices of the Workforce strategy more clearly. Other changes reflect the need to align the work of the organisation to the NHS People Plan and some changes in titles of some of the committee attendees.

1.3 During the year, the Chair of the Staff Experience & OD Committee was Richard Phillips. Richard is also a member of the Trust's Finance & Performance Committee and routinely provides input from the perspective of the Staff Experience & OD Committee through discussions at the meetings, particularly around workforce metrics included in the overall finance and performance overview. Kathryn Sallah, Chair of the Quality & Safety Committee is also a member of the committee, which provides a good opportunity to triangulate performance against quality metrics considered by the Quality & Safety committee with the workforce trends and issues. Simone Jordan, Associate Non Executive Director is also a member of the Committee and chairs the meeting in Richard Phillips' absence. Simone has a background in workforce and continuous improvement.

1.4 There is also good linkage with the Finance & Performance Committee, with Richard Phillips, being a member of this committee. This linkage was beneficial, when, for example, the Finance & Performance Committee noted a spike in sickness absence when it was considering its monthly overview and remitted the detailed oversight of this to the Staff Experience & OD Committee. The Committee monitored the position for a number of months and reported back that it was satisfied that there was no underlying trend or concern that needed to be escalated further.

1.5 Also in attendance at meetings was a specialist adviser on equality and diversity who was engaged during the year to provide support and advice on the work being undertaken to improve the inclusion framework.

2.0 Meetings

2.1 During 2018/19 the Staff Experience & OD Committee met on ten occasions.

2.2 The attendance at these meetings is overleaf:

MEMBER	MEEETING DATE										TOTAL
	4/4/18	2/5/18	6/6/18	4/7/18	5/9/18	3/10/18	7/11/18	9/1/19	6/2/19	6/3/19	
Richard Phillips (Ch)	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	**9/10**
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Kathryn Sallah	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	**9/10**
Paul Athey	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	**9/10**
Phil Begg	✓	✓	✓	A	✓	A	✓	✓	✓	✓	**8/10**
Jo Williams	✓	✓	✓	A	✓	✓	✓	✓	A	✓	**8/10**
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	**9/10**
Matthew Revell[#1]										✓	**1/1**

KEY:

✓	Attended	A	Apologies tendered
	Not in post/not required to attend		

2.3 The May meeting was a workshop specifically arranged to consider the initial results from the National Staff Survey and form an initial response to any areas where there was clearly room for improvement.

2.4 The Secretariat to the Committee is the Director of Corporate Affairs & Company Secretary.

2.5 The Staff Experience & OD Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, risks noted & matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2018/19

The Committee dealt with the following key matters:

Routine Work

During the year, it was agreed that the Committee would receive upward reports from the People Committee, this being its key trustwide group from which to seek assurance.

The substantive report that the committee considers is a workforce overview which details the Trust's position against a range of workforce-related metrics, such as sickness absence, staff in post vs. establishment, turnover and formal cases in progress. The report also provides information on the staff Friends and Family Test and data on the diversity of the Trust's workforce. During the year, there has been a 'deep dive' into the information at a professional group level, including admin & clerical and nursing groups.

The Committee also has a workplan which is used to guide the planning of the agenda of the meetings, the routine content of which includes:

- Apprenticeship levy update
- Medical education
- Update on multi-professional education and training group
- Friends and Family Test results
- Equality Delivery System (EDS2)
- Workforce Race Equality Standards (WRES)
- HR, Workforce and OD risk register
- Gender Pay Gap report (annual)
- Update on general national workforce matters
- Nurse staffing update
- Library report (annual)

From October 2018, the Committee also considered at each meeting (apart from those designated as workshops) a presentation from a member of staff who describes how it felt to be part of the ROH, what was working well for them, improvements they had identified and what next steps they may wish to pursue in their career. During the year, the Committee heard from a Ward Manager, an NHS Management Graduate and a member of housekeeping. There has been universal agreement that these presentations provide a unique insight into the experiences of staff at the Trust.

Single issue or non-routine reports

During the year, the Committee received a number of reports providing assurance on key issues, these being:

- NHS staff contract refresh 2018
- Staff engagement update and an alternative approach to benchmarking
- Principles of refreshed performance and development approaches
- Recruitment review
- Theatre workforce review & development, including the theatre assistant practitioner role
- Workforce process review undertaken by an Associate Non Executive Director
- Outcome of the Clinical Excellence awards process
- Update on the plans to address vacancy gaps

In addition to the above, the Committee took the decision during the year to introduce a series of staff experience walkabouts, these being in part, analogous to those undertaken in clinical areas, known as quality assurance walkabouts.

The visits were undertaken by the Non Executive members of the Staff Experience Committee, although the Non Executives not part of this committee were also invited to participate.

The walkabouts to date have included visits to finance, informatics, clinical coding, IT, catering, portering and facilities. The forward schedule also plans visits to the governance team, communications, corporate secretariat and HR.

The committee has gleaned great value from these walkabouts, both from a Non Executive visibility point of view and, principally, as a further tool to capture intelligence around how staff feel it is to work at the ROH.

Some operational issues have been flagged as part of these walkabouts, particularly associated with concerns around the physical environment in which some staff are required to work. As such, a key output has been a request for an estates 'heat map' to show the areas in most need of backlog maintenance, and to understand the relative priorities of improving the environment as part of the capital planning process.

The findings of the walkabouts, and the plans to address any concerns raised, following discussion with the relevant Executive Leads, have featured on a number of committee agendas throughout the year.

4.0 2019/20 Work Plan

4.1 For 2019/20, the Staff Experience & OD Committee continues with its routine work as well dealing with ad hoc requirements that will emerge from time to time or remitted from the Board and the other committees.

4.2 Particular areas of focus for 2019/20 will be the oversight of the organisation's plans to improve the inclusion framework in the Trust, talent management, developing plans for a better onboarding, recruitment and retention process and staff appraisals and development plans.

4.3 Given the imperative of creating an effective health and wellbeing offering to staff, in line with the NHS People Plan, the committee will play a crucial role in oversight of this work.

4.4 There will remain a focus on improving the effectiveness of the Committee during 2019/20, particularly the upward reporting from the People Committee.

5.0 Staff Experience & OD Committee Effectiveness

5.1 An item is included on the agenda of each meeting to review the effectiveness of the meeting and of the Committee in general. As a result of these discussions, a number of suggestions were made to the operation of the Committee:

- A change to the schedule of meetings, such that they do not fall on the same day as Trust Board
- Segmentation of the agenda into strategic matters, operational matters and matters for information
- Invitation of the key workforce operational leads to present papers relevant to their remit

6.0 Conclusion

6.1 The Staff Experience & OD Committee has functioned well during 2018/19 and is now operating effectively, providing clear and adequate assurance upwards to the Trust Board across a comprehensive range of workforce matters. It is anticipated that over the coming year as the committee enters its second year of operation that the agenda and focus of the meetings will be refined and adapted to align with issues of national and local importance.

Richard Phillips
Chair of Staff Experience & OD Committee

September 2019

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NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Staff Experience & OD Committee terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Richard Phillips, Chair of Staff Experience & OD Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs and Company Secretary**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

In line with the requirement to review each Committee's terms of reference on an annual basis, the attached are the latest version of those from the Staff Experience & OD Committee with some minor changes suggested:

- Change to Executive Lead from the Director of Strategy & Delivery to the Chief Executive
- Amendment to the title of the Director of Corporate Affairs & Company Secretary
- Reflection that there is no meeting in August or December
- List of key areas of focus under the umbrella of a single workforce strategy
- Add in duty to report against the NHS People Plan
- Other changes which are cosmetic, rather than substantial

The Board is invited to note that there has been sound compliance with the terms of reference during the year through the delivery of the Committee's annual workplan.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the changes to the terms of reference

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	**x**	Environmental		Communications & Media	x
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:

Delivered by highly motivated, skilled and inspiring colleagues

PREVIOUS CONSIDERATION:
The terms of reference were considered by the Staff Experience & OD Committee on 25 September, where the proposed changes were supported and it was agreed that they could go forward for presentation to the Trust Board for approval.

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, the Associate Director of Workforce, HR & OD, the Deputy Director of Nursing & Clinical Governance and an Associate 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~~ Corporate Affairs & Company Secretary shall be secretary to the Committee and will provide administrative support and advice.

The duties of the ~~Associate~~ Director of ~~Governance~~ Corporate Affairs & 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~~Chief Executive 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 the exception of August and December, 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~~strategy, 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~~

- Talent Management
- Leadership
- OD and Staff Engagement
- Reward and recognition
- Succession planning

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 b~~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 People Plan, 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 health and 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~~9.11 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~~ the of ~~the~~ the workforce strategy, frameworks or plans~~ies~~ are adequately mitigated

Date of adoption: November 2019

Date of review: November 2020

Workforce Performance Report

As at 30th September 2019

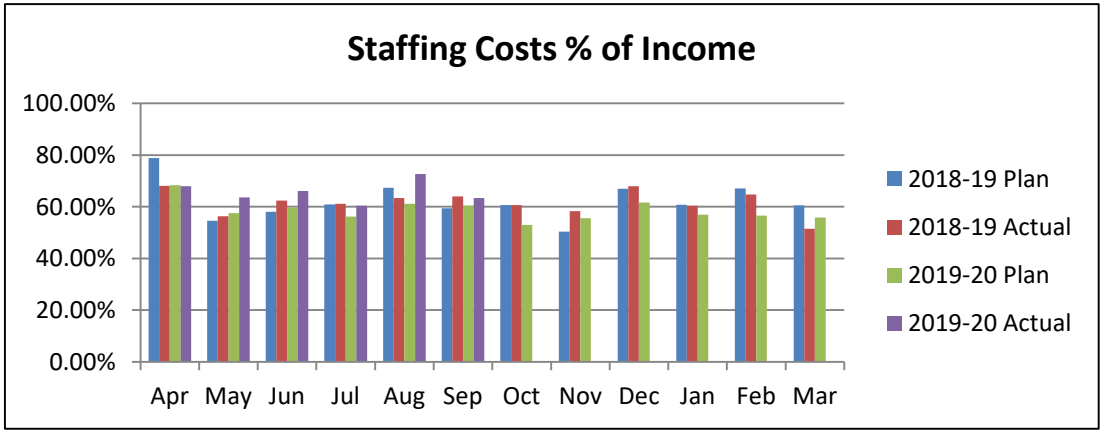
CONTENTS

Staffing costs

1 Workforce Composition and Cost

1a Planned v Actual Staffing Costs

Pay Cost Analysis	£'000's	Variance
Planned Income (YTD)	45312	
Actual Income (YTD)	40986	90.45%
Planned Pay Costs (YTD)	27341	
Actual Pay Costs (YTD)	26854	98%
Planned Substantive Pay Costs (YTD)	23190	
Actual Substantive Pay Costs (YTD)	21592	93%
Planned Bank Pay Costs (YTD)	2113	
Actual Bank Pay Costs (YTD)	2858	135%
Planned Agency Pay Costs (YTD)	1974	
Actual Pay Costs (YTD) Agency Staff	2326	118%
Planned Agency Pay Costs as % of total Pay costs (YTD)		7.22%
Actual Agency Pay Costs as % of total Pay costs (YTD)		8.66%



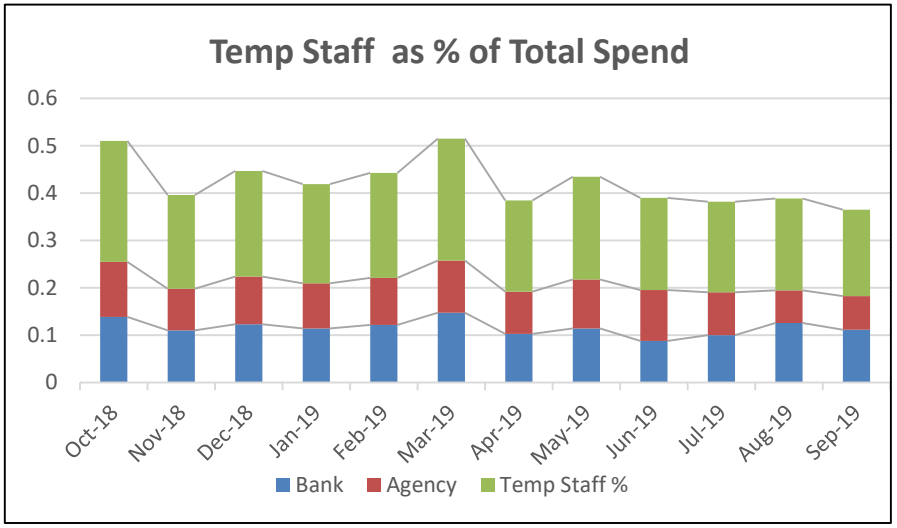
Total ADH Payments (Apr – Sep) £000s	1006

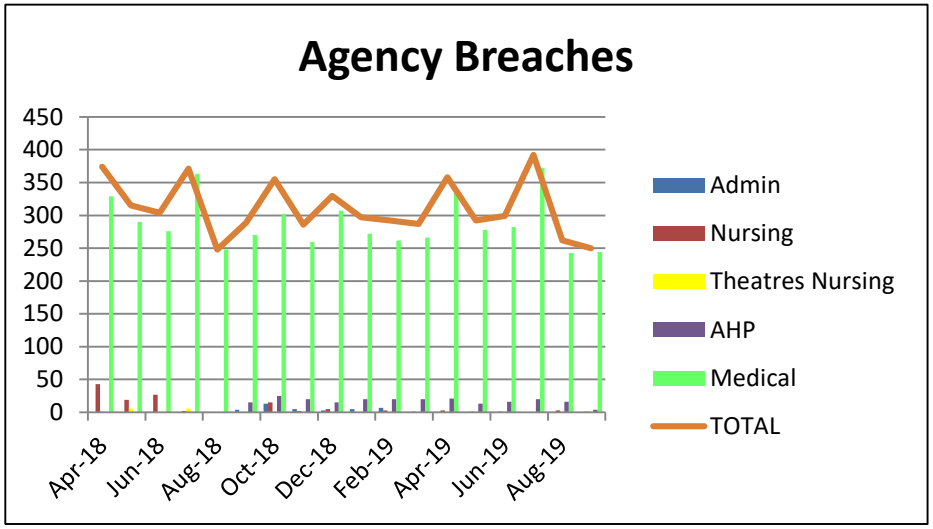
Monthly Agency Costs £000s	Agency Pay Cap	Actual
Apr	241	410
May	241	469
Jun	241	455
Jul	241	390
Aug	241	296
Sep	241	206
Oct		
Nov		
Dec		
Jan		
Feb		

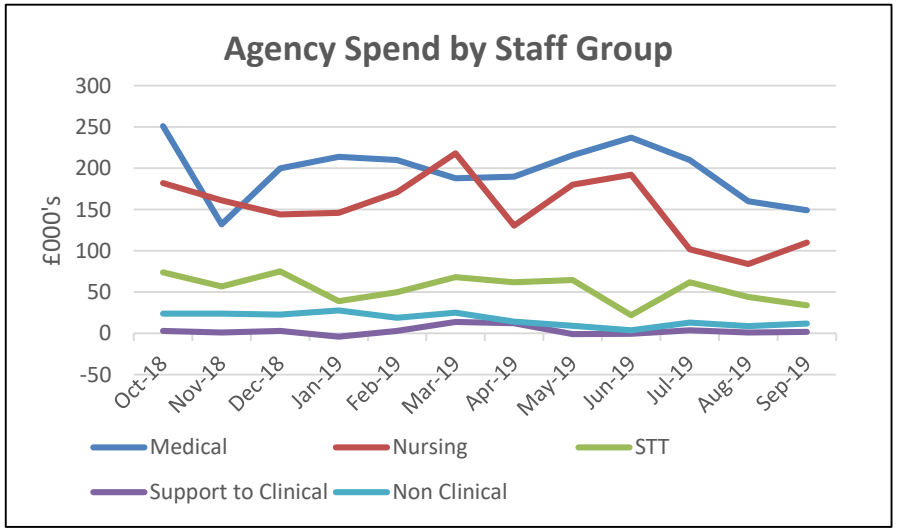
Data based upon September 2019 Management Accounts

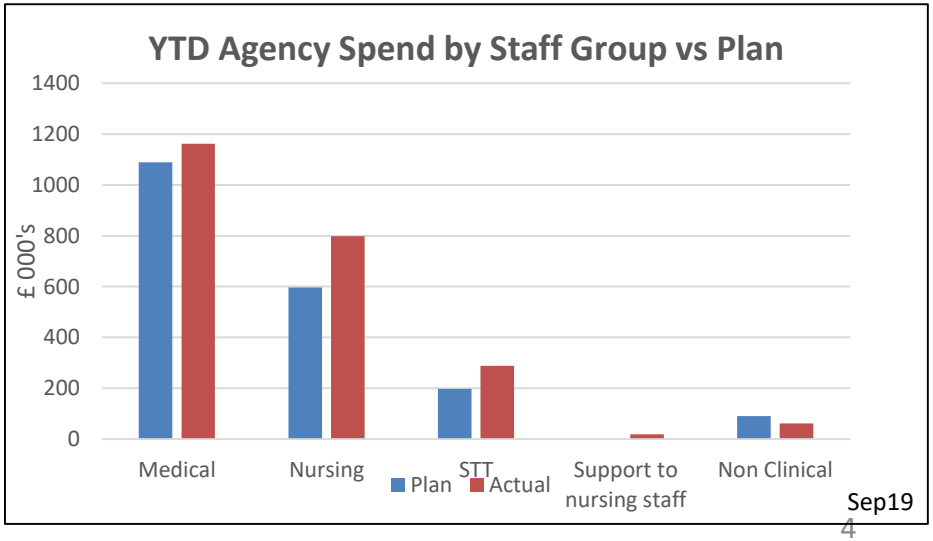
1 Workforce Composition and Cost

1a Temporary Staffing Analysis



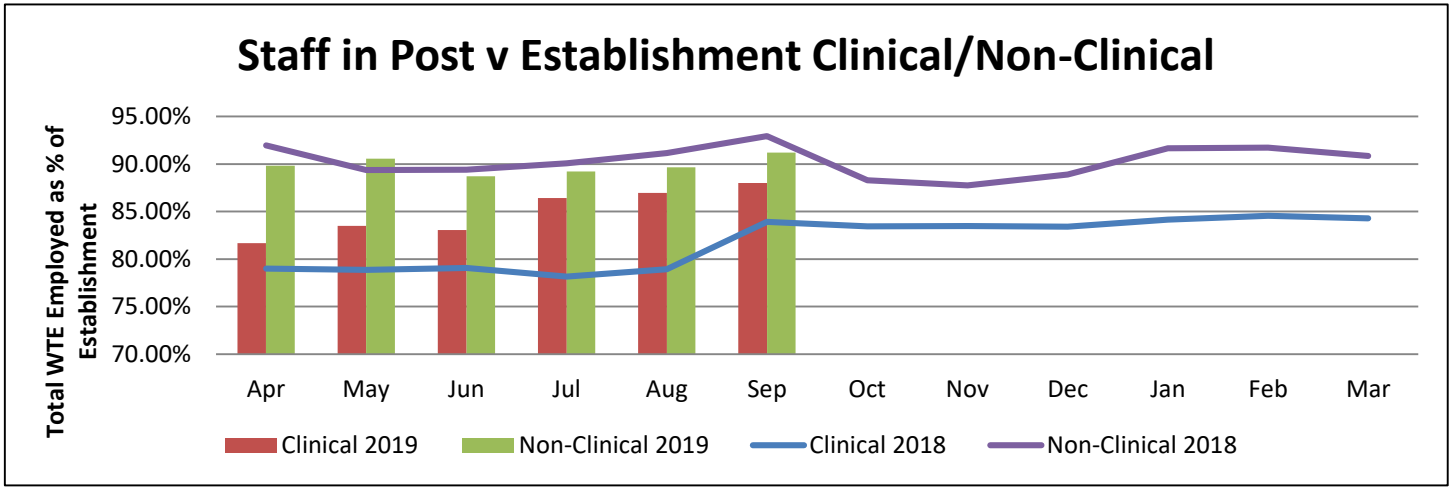


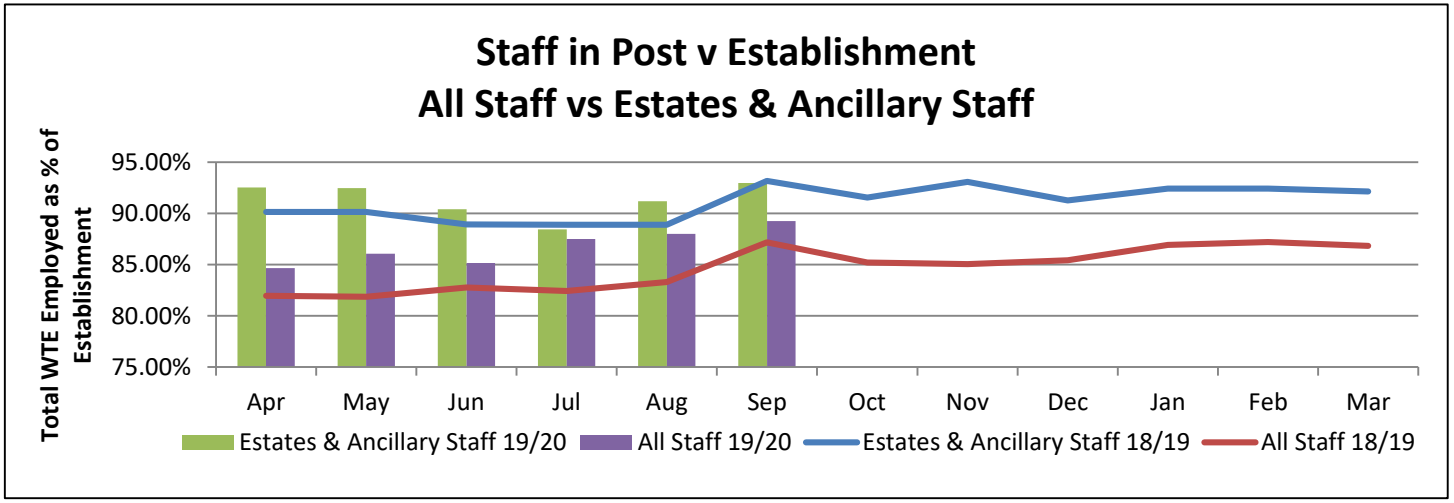




1	Workforce Composition , Resourcing and Cost
1b	Establishment and Vacancy Gap

Establishment

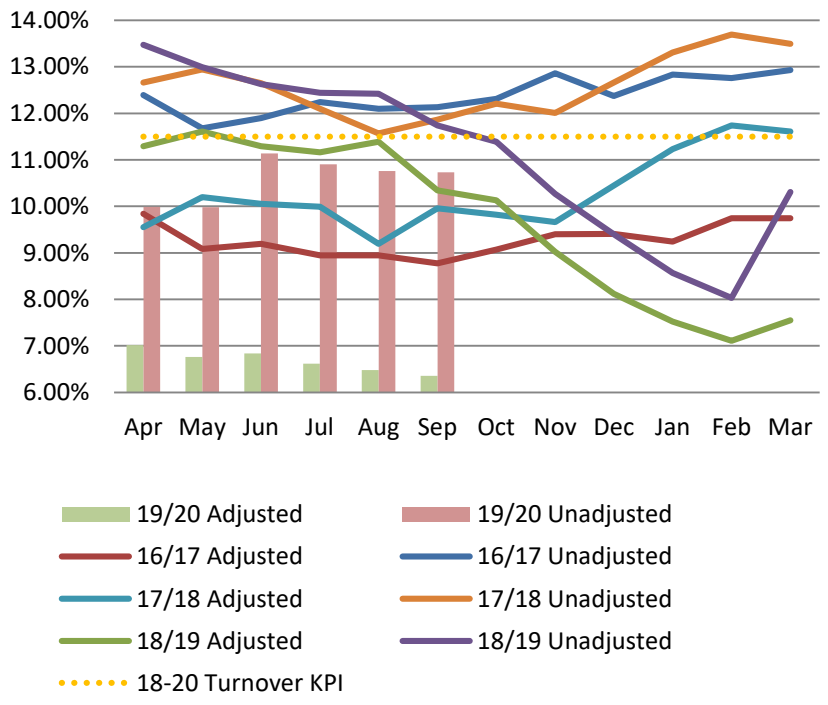




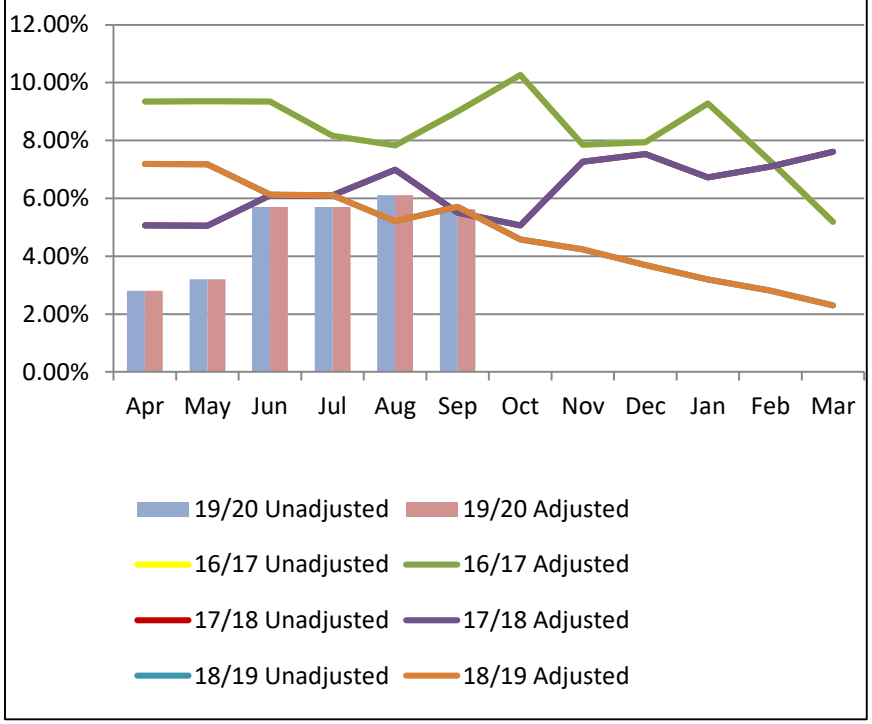
1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Turnover

Staff Turnover

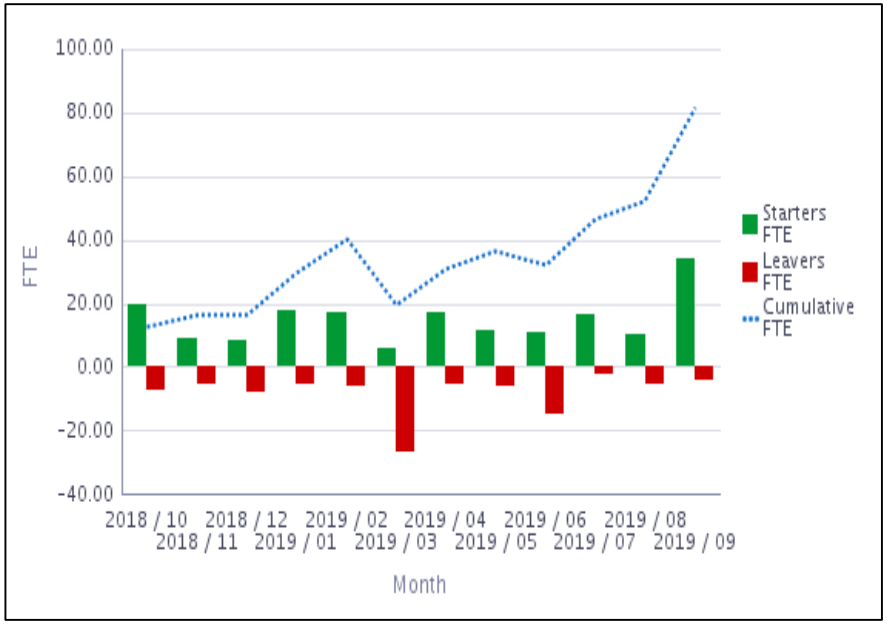


Estates & Ancillary Staff Turnover

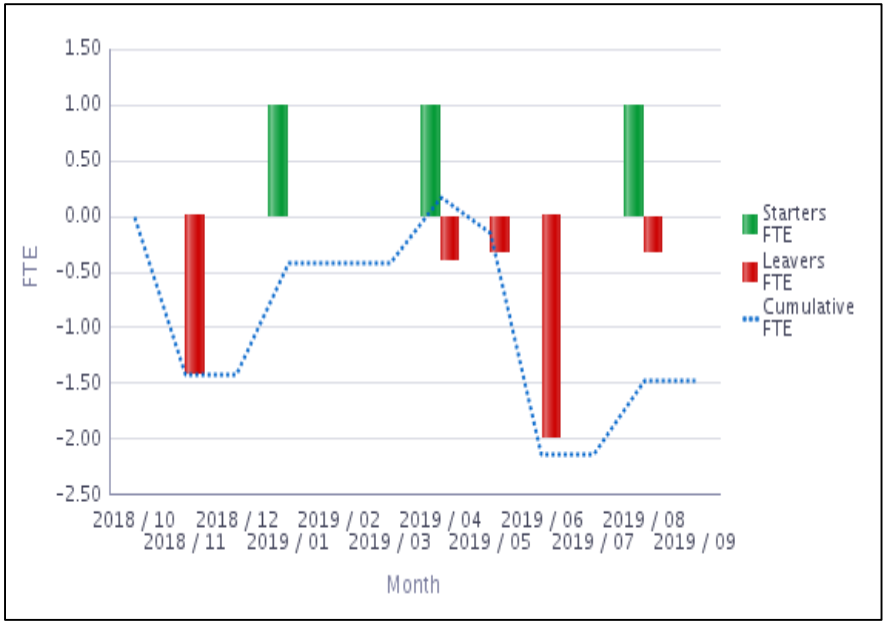


1	Workforce Composition , Resourcing and Cost
1c	Staff Turnover

Starters / Leavers by Month
All Staff

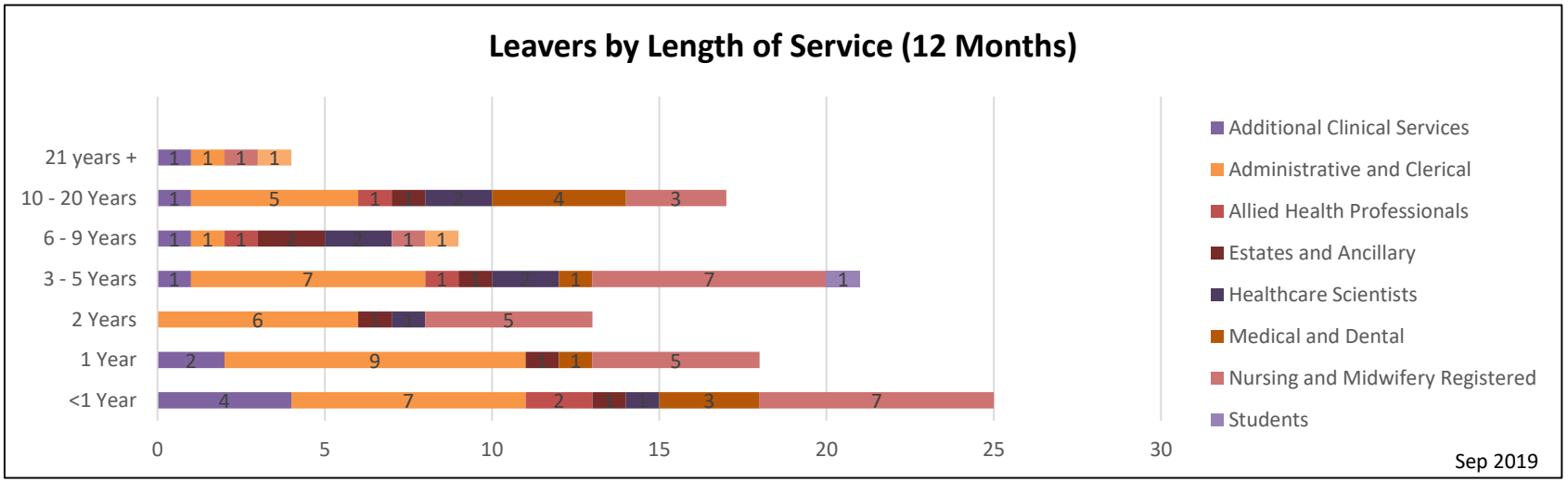


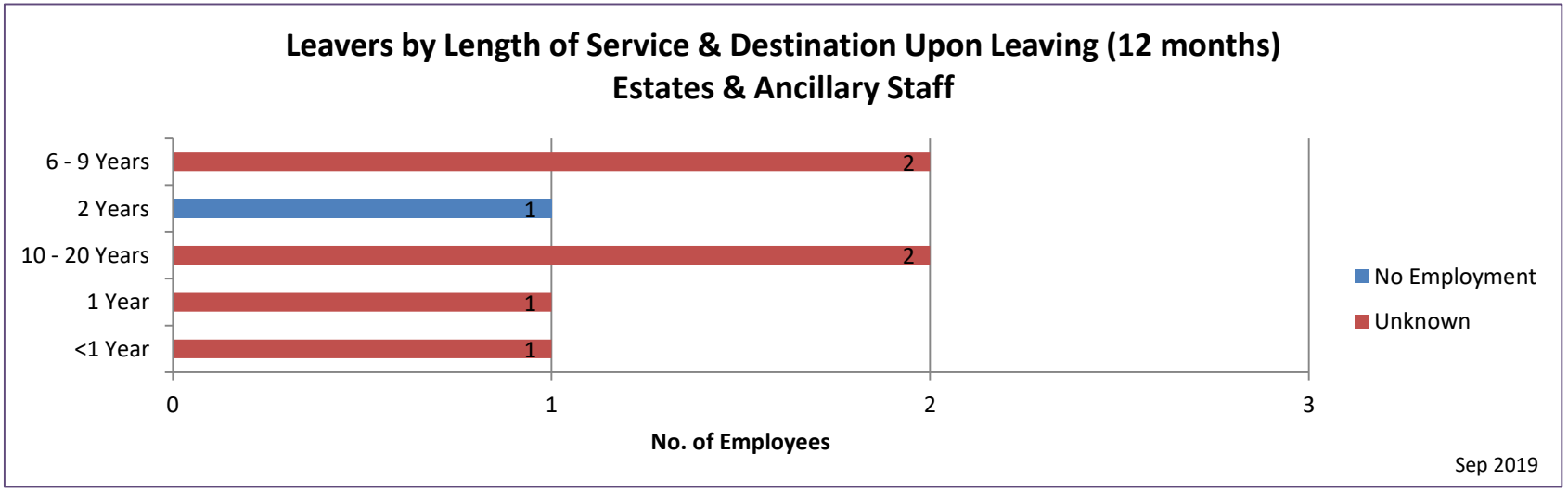
Starters / Leavers by Month
Estates & Ancillary Staff



1 Workforce Composition , Resourcing and Cost

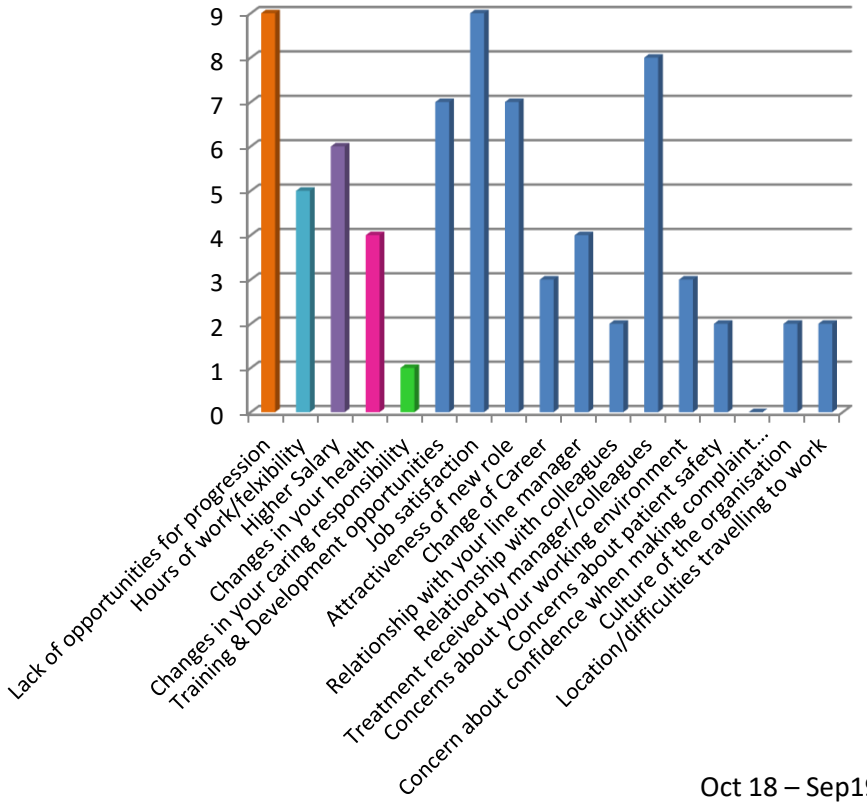
1d Staff Turnover





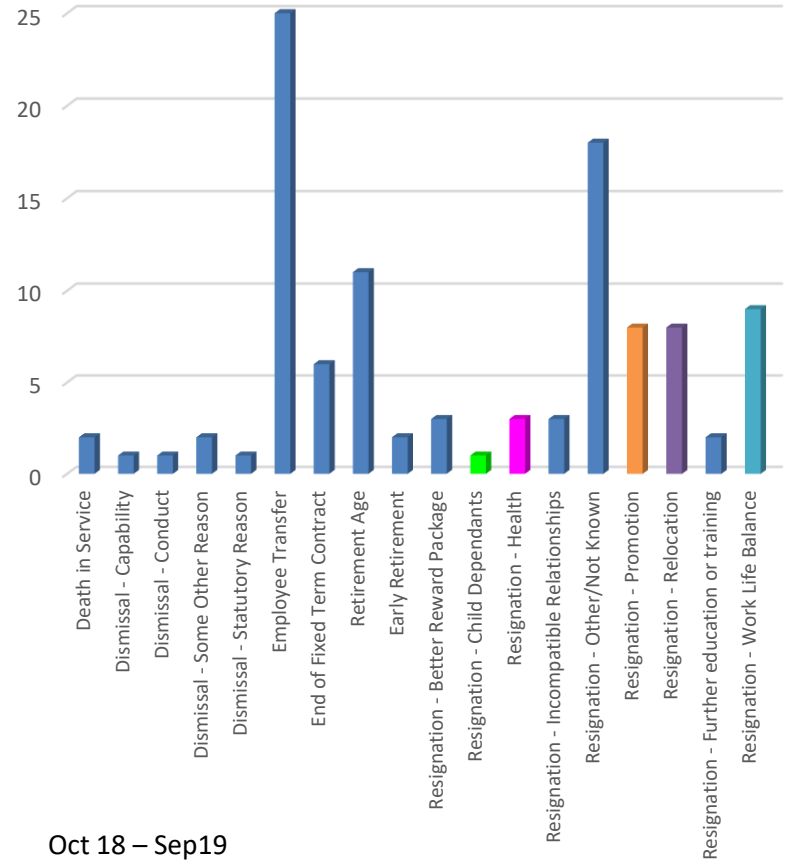
1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

Reason for Leaving (All Staff) Exit Questionnaire



Oct 18 – Sep19

Reason For Leaving (ESR Data)

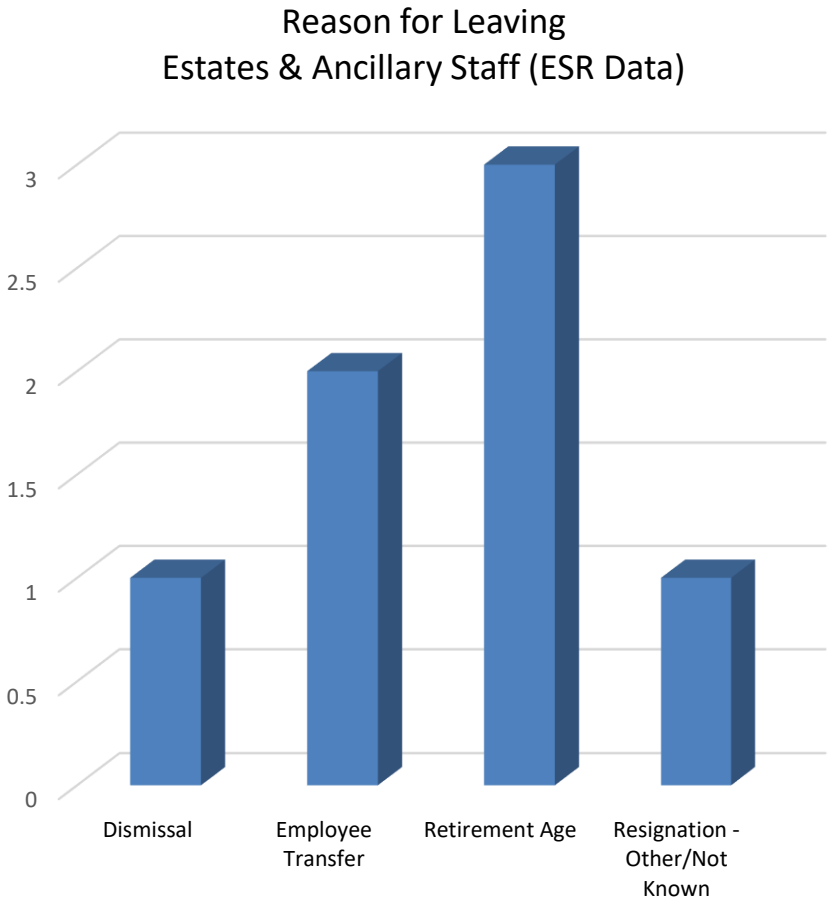


Oct 18 – Sep19

1	Workforce Composition , Resourcing and Cost
1d	Exit Questionnaire Information

We did not receive an exit questionnaire from any of the Estates and Ancillary Staff who left within the past 12 months

Oct 18 - Sep 19

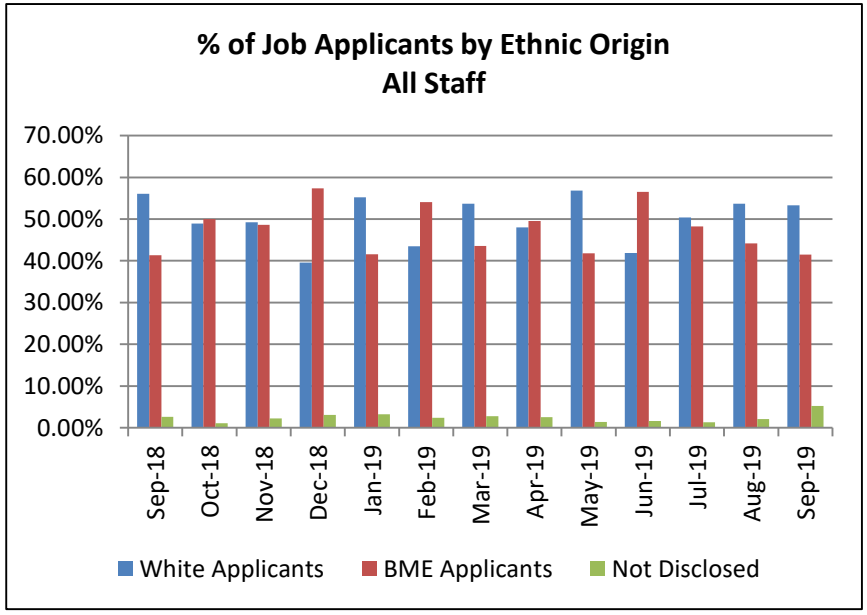


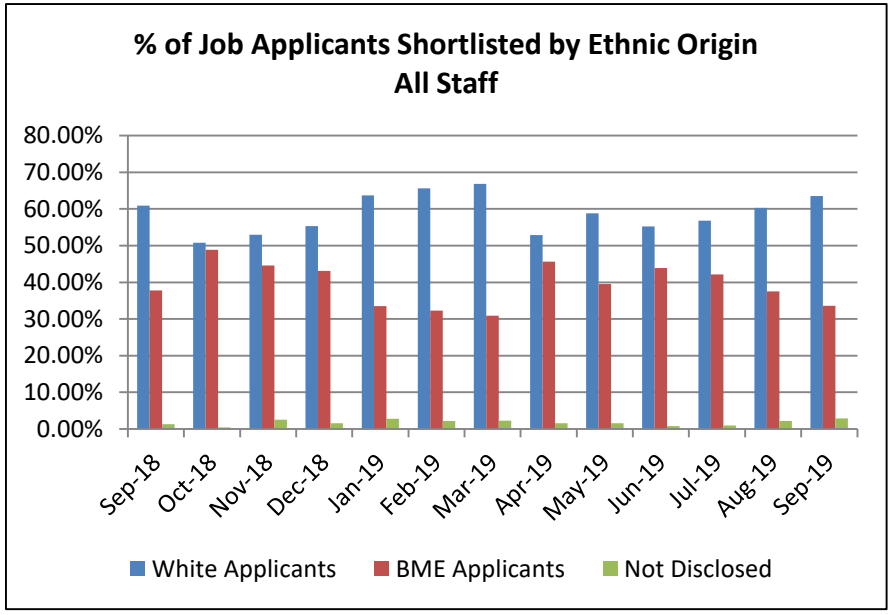
Oct 18 - Sep 19

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates



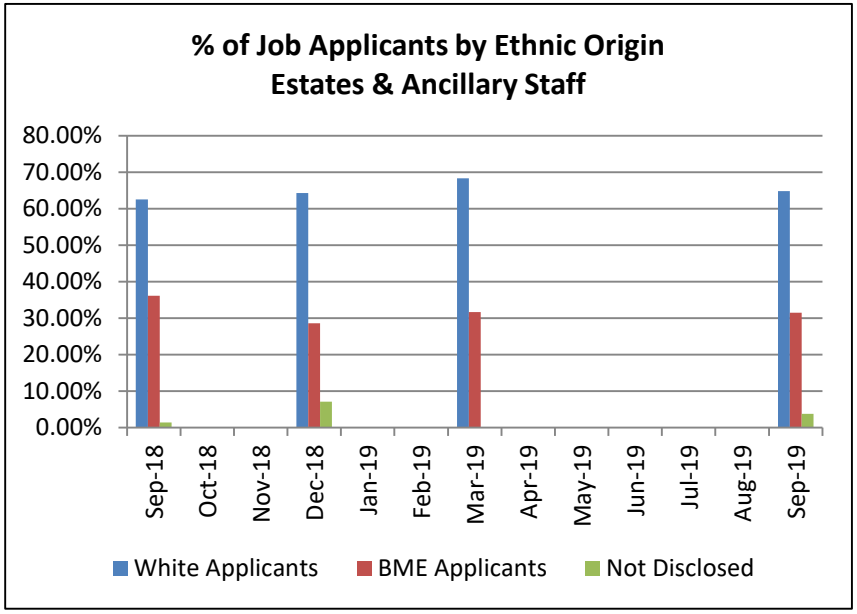


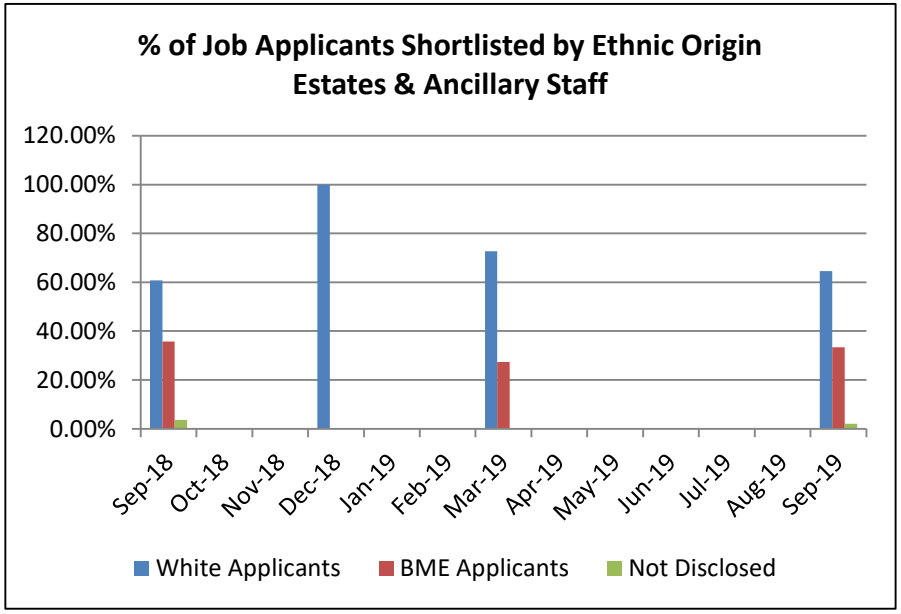
Rolling Twelve month	Trend	Variance to National benchmark	Variance to Last Annual Return	2019	2018	2017	2016	National Benchmark
1.37	↑	-0.23	- 0.33	1.70	1.64	1.45	1.99	1.6

1	Workforce Composition , Resourcing and Cost
1e	WRES Indicator 2

WRES Indicator 2

WRES Indicator 2 – Relative likelihood of a BME appointment from shortlisted candidates





Rolling Twelve month
-0.23

Workforce Composition, Resourcing and Cost

Turnover

- The unadjusted turnover figure has decreased slightly from 10.90% in July to 10.34% in September 2019, it is still below the Trust's KPI of 11.5% and has decreased even further compared to September 2018, which was recorded as 11.86%

- Turnover for Estates and Ancillary Staff has stabilised for at circa 6% since June 2019 and stood at 5.62% as at September 2019, this was a similar position in 2018, however has had a slight decreased from 2016/17, where the position was circa 9% in September 2016. This is most probably due to staff being retained on the bank rather than completely leaving the organisation.

Exit Data

- The top 3 reasons for staff leaving the organisation according to our exit questionnaire are Lack of Opportunities for Progression, Job Satisfaction and Treatment received by Manager/Colleagues. Data from ESR suggests the top 3 reasons are Resignation – not known, Employee Transfer and Retirement due to Age. This theme has remained consistent to previous reporting periods.
- Work is being undertaken to improve the quality and quantity of exit data being received and a further update will be provided in future reports.

Staff in post

- The graphs on page 5 as expected shows a peak, with a rise of all staff employed as % of the establishment rising from circa 85% in June 2019 to circa. 89% in September 2019. The percentage of Clinical staff has risen from 83.93% September 18 to 88.02% September 19. Non-Clinical staff has presented a slight decrease from 92% in September 2018 to 91% September 2019, but has increased from 88% in June this year to 91% in September.

Recruitment and Selection - Streamlining

- Work continues to take place to ensure that candidates are unconditionally offered as speedily as possible. The team continue to ensure that systems and processes are reliable and effective to process candidates. The team continue to actively call and chase candidates and referees and managers are being encouraged to 'Keep in Touch' with candidates. The team have processed 172 new starters since April 2019 to October 2019. A recruitment focus group is being held to understand the recruitment needs of the Trust, as well as to assist with the recruitment streamlining process.

WRES Indicator 2 monitoring

- September 2019 saw another increase in the number of BME applicants compared to White applicants which is encouraging.. The % of BME applicants being shortlisted still remains below the proportion of White applicants being shortlisted and this has remained consistent over previous months.

Workforce Composition, Resourcing and Cost
ACTIONS FOR IMPROVEMENTS / LEARNING
Further work is required to understand where the bottlenecks in the recruitment system are to enhance our sue of electronic applicants management systems.
RISKS/ISSUES
Only 1 substantive recruitment administrator although permanent recruitment assistant has now joined the team but is in the induction stage, so they are being supported by competent bank colleagues.

2 Workforce Performance

2a Staff Attendance

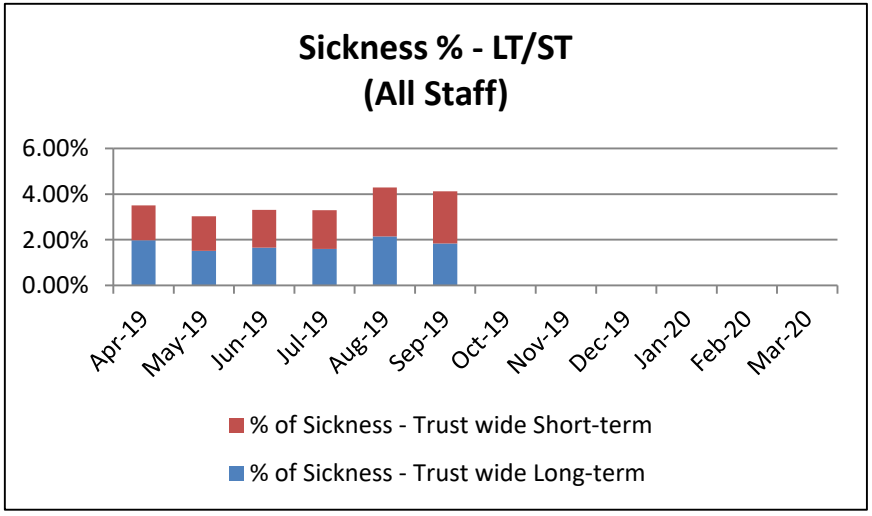
Staff Attendance

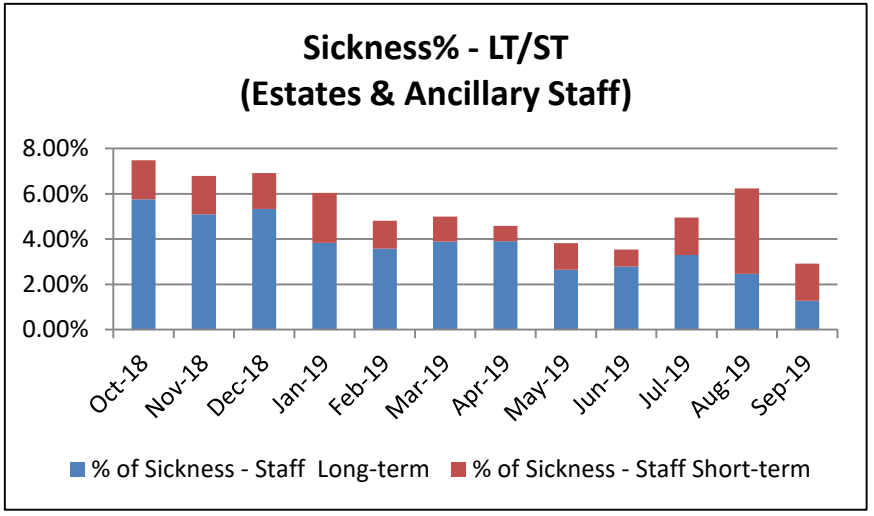
Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
95.91%	95.92%	↓	0.19%	96.10%

ALL STAFF * 12 months to End of September 19

Twelve Month Rolling Average*	Twelve Month Rolling Average Last Calendar Month	Trend	Variance to Trust KPI	Current Trust KPI
94.72%	94.48%	↑	1.38%	96.10%

ESTATES & ANCILLARY STAFF * 12 months to End of September 19

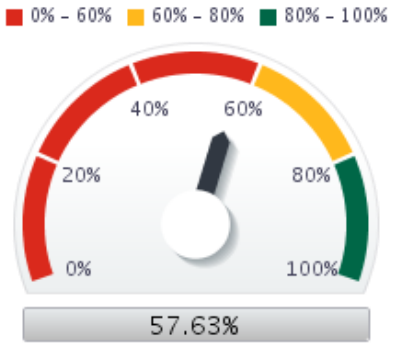




Staff Absence

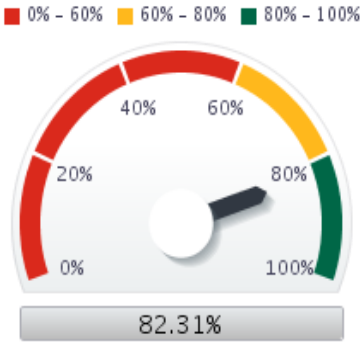
2 Workforce Performance

2b Staff attendance – short-term absence management



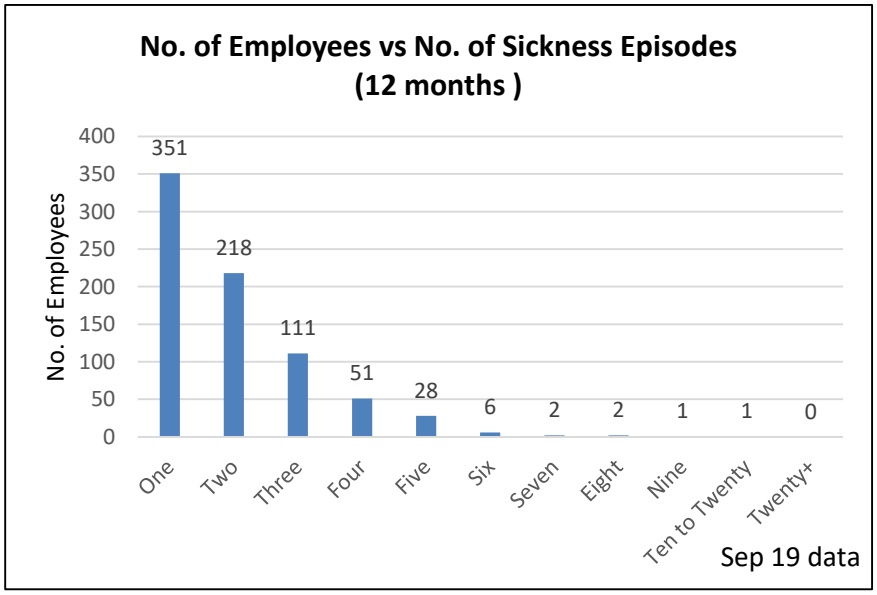
Return to Work Process Completion Rate (12 months) *Sep 19

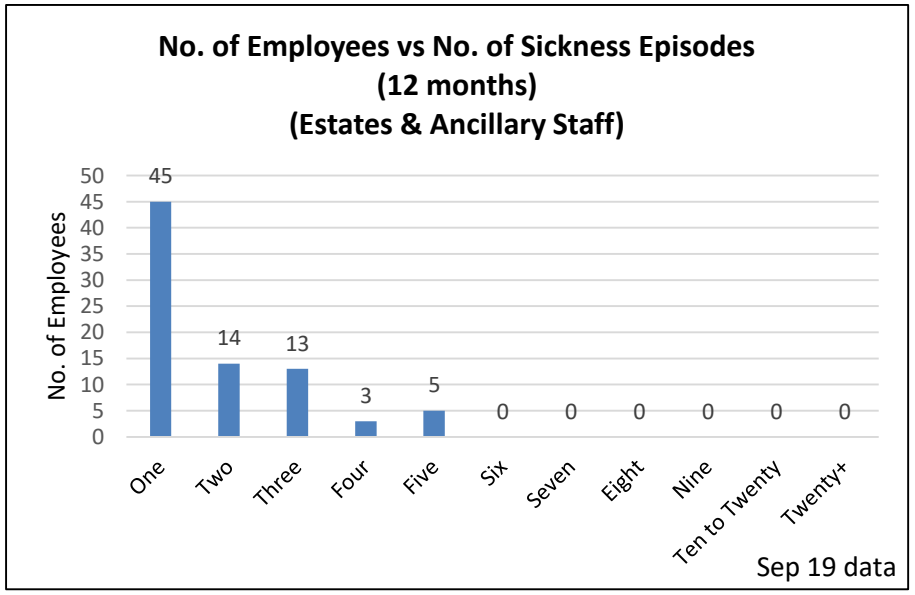
ALL STAFF



Return to Work Process Completion Rate (12 months) *Sep 19

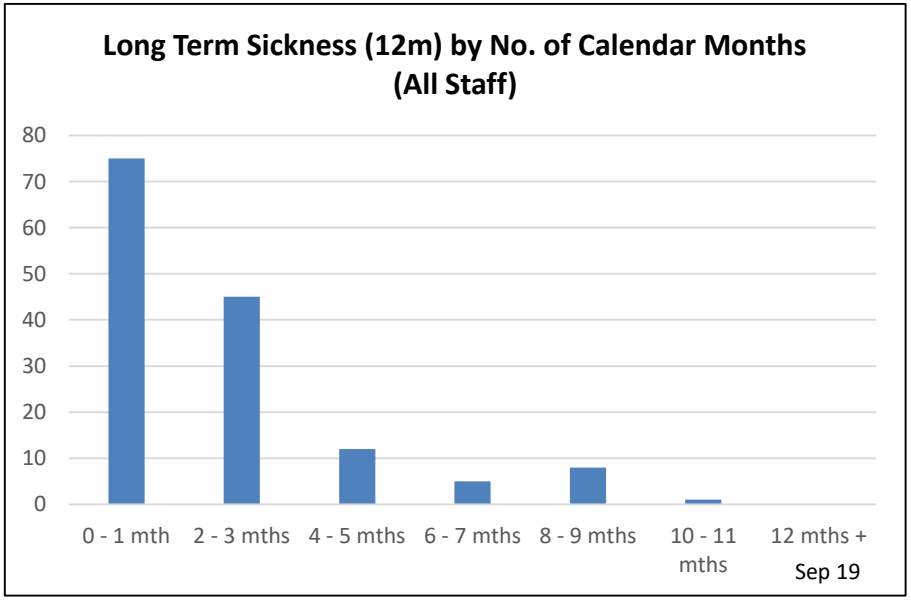
ESTATES & ANCILLARY STAFF

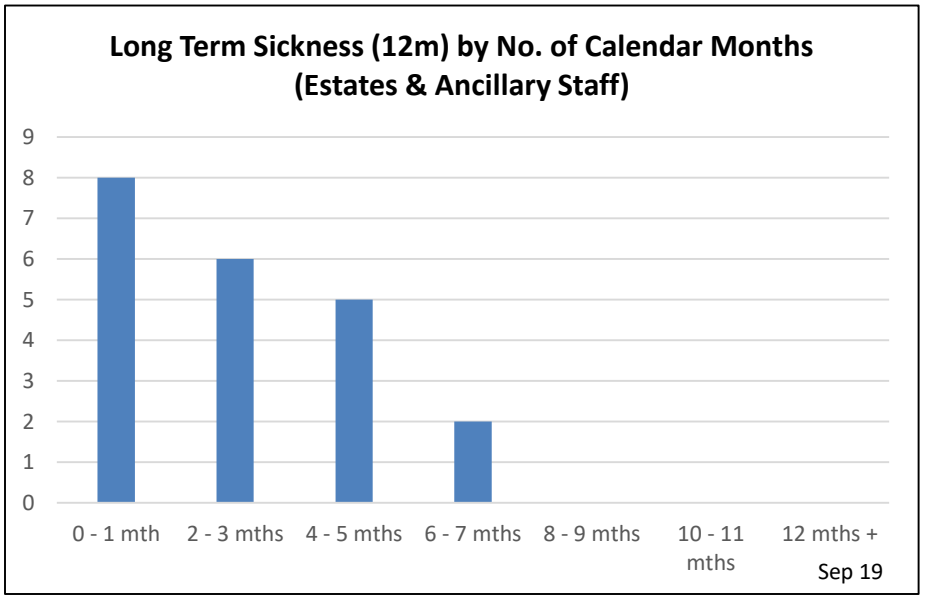




2	Workforce Performance
2c	Longer-term Staff Absence

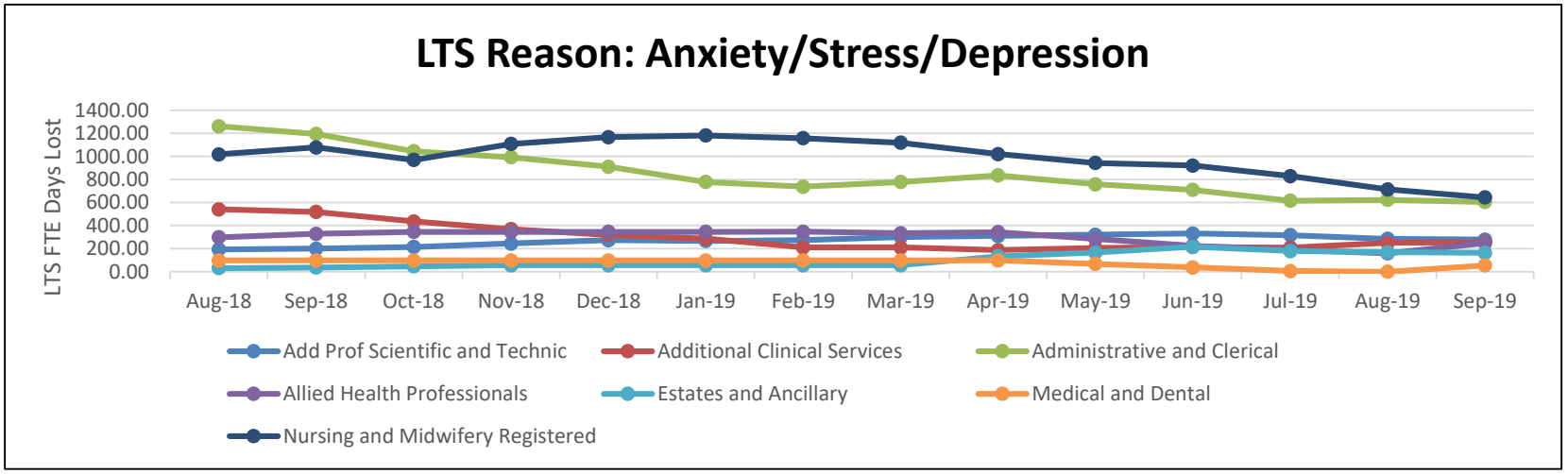
Long-term Staff Absence

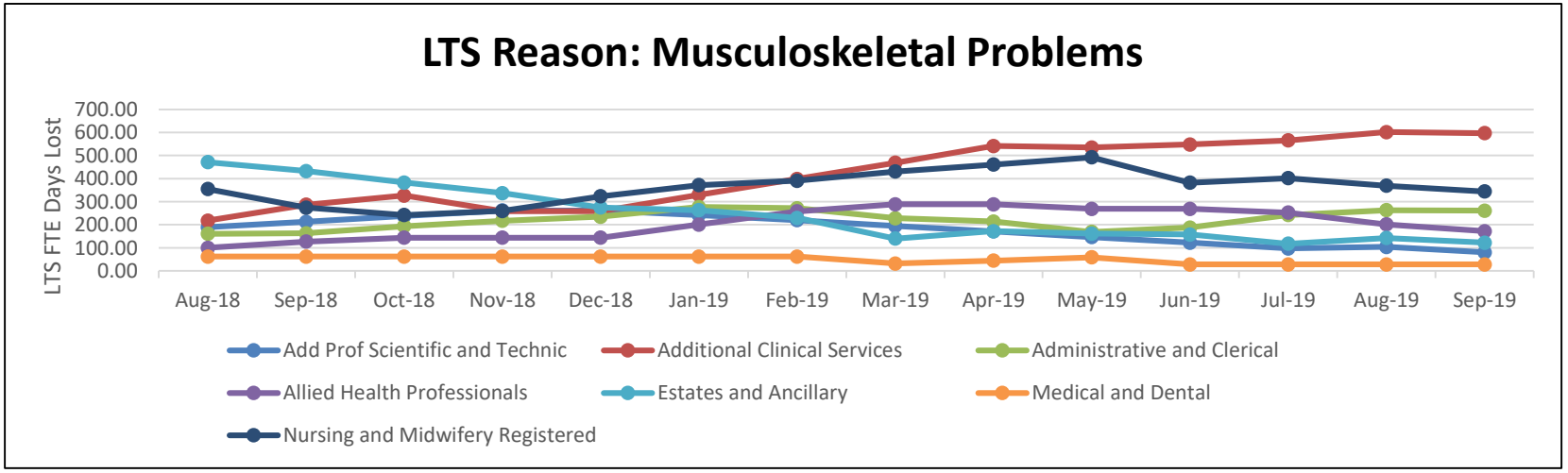




2 Workforce Performance

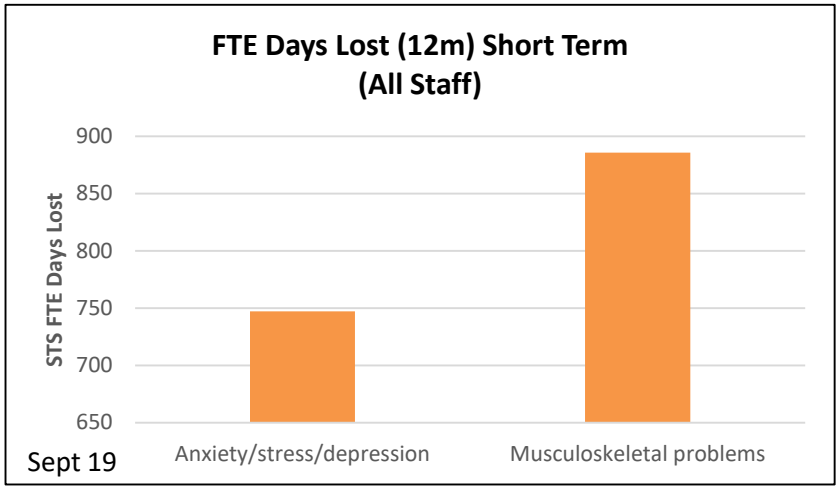
2c Longer-term Staff Absence

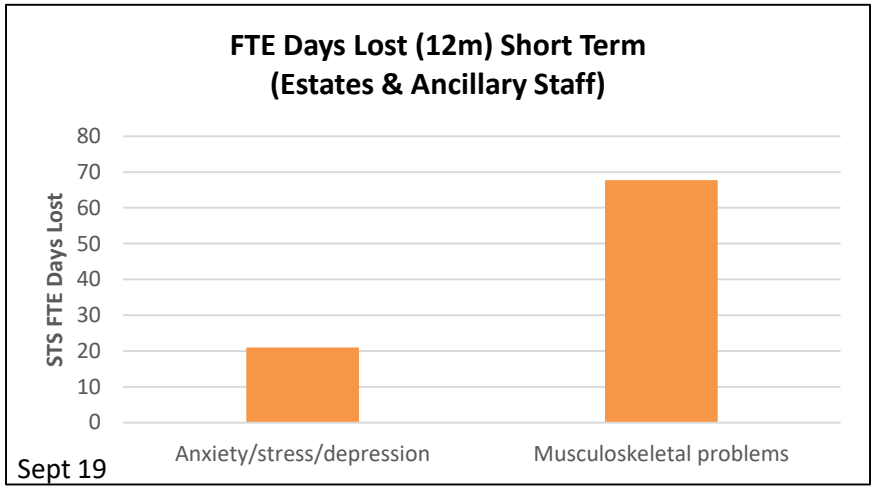


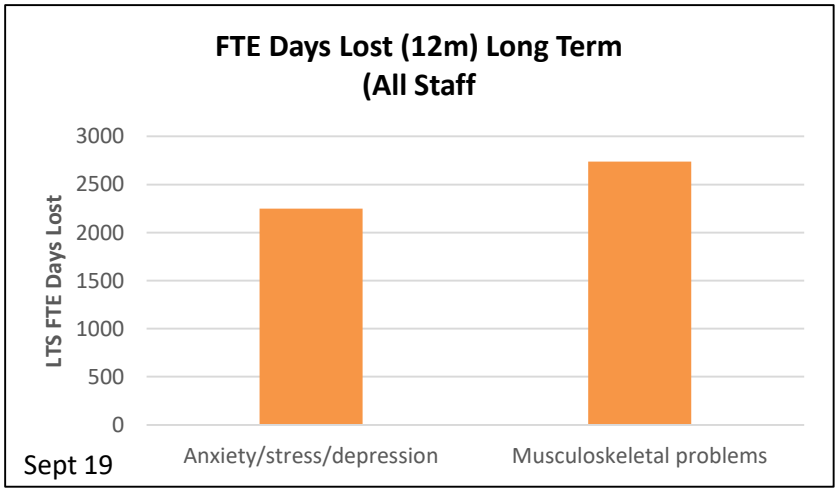


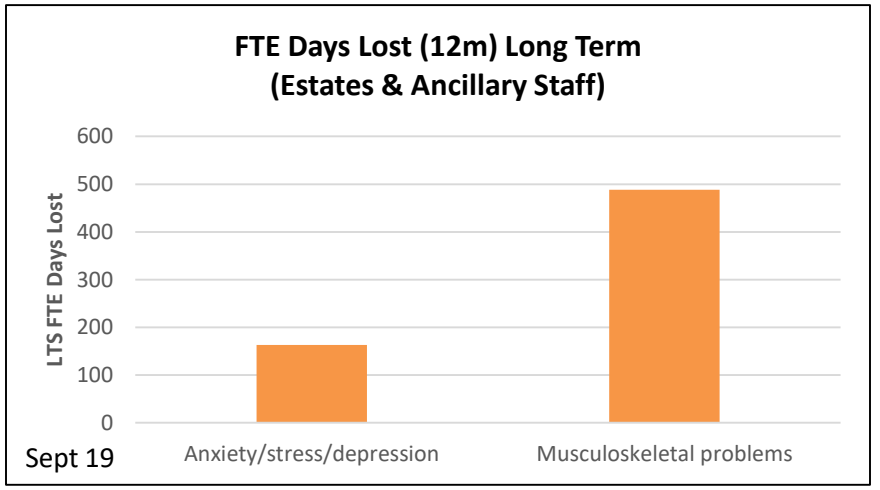
2 Workforce Performance

2c Staff Absence









2	Workforce Performance
2d	Formal Disciplinary

Management of Performance

	No. of Staff formally Suspended this report	No. of Staff formally Suspended previous report	Current Formal cases of capability this report	Current Formal cases of capability last report	Current Formal cases of conduct this report	Current Formal cases of conduct last report
No. of Staff	1	0	1	0	5	5

September 2019

INFORMATION

Staff Attendance

The rolling 12 month attendance figure for all staff has decreased marginally from 96.70% in July 2019 to 95.91% in September 2019 showing a variance of 0.19% to the Trust KPI of 96.10%. Figures for Estates and Ancillary staff improved from an attendance rate of 92.52% in October 2018 and 93.76% in August 2019 to 94.72%in September 2019, but they still present a variance of 1.38% against the trust target.

Return to work completion rates for all staff remain below the target of 80% at 57.63% but is an improvement from May's position of 56.10%. Estates and Ancillary Staff are above the Trust's target at 82.31%. Work is continuing to take place to support Divisions on the recording of return to works, to increase the compliance and to ensure welfare conversations take place before an employees return to work.

'Musculoskeletal' absence has a prevalent presence in both short term and long term absence for all staff and Estates and Facilities. Further work is to be undertaken to realise the trends in the most common absences for the past 12 months.

Formal Disciplinary and Capability

As at the end of September 2019, there was 1 suspension, 1 capability and 5 conduct cases. Further work is needed to be undertaken with colleagues across the Trust to ensure that HR are being informed of any action being taken.

ACTIONS FOR IMPROVEMENTS / LEARNING

- Explore top 5 main causes for absences across all staff and understand the potential causes for the increase in musculoskeletal absence.
- Understand whether 'mental health' related absence is due to work or non-work related issues.

RISKS/ISSUES

- Return to works not being completed therefore risk not being managed appropriately.

Statistical Review of Mandatory Training compliance from 1st April 2017 to 31st August 2019

MANDATORY TRAINING STATISTICAL PROCESS REVIEW CHARTS

Training compliance summary – 31st August 2019

Course	Compliance %age	Comments	RAG
Core Mandatory Training – Permanent Staff	94.26%	Positive shift in compliance observed over last 7 months	G
Core Mandatory Training – Temporary Staff	97.58%	Positive compliance maintained since January 2019	G
Performance and Development Reviews	82.39%	Positive shift in performance observed, however compliance not maintained	A
Adult Basic Life Support – Level 1	73.46%	Annual cycle of compliance identified, following improvements in Autumn 2017.	R
Hospital Life Support – Level 2	73.89%	Average cycle of compliance fluctuating around an average of 69% compliance .	R
Immediate Life Support	65.57%	Annual cycle of compliance identified, following improvement in process from Autumn 2017.	R
Advanced Life Support	85.71%	Compliance Maintained – Rapid Response team included in reporting from April 2019. Plan to achieve compliance by December 2019.	G
Paediatric Basic Life Support	43.30%	Annual cycle of compliance identified, following improvements in Autumn 2017. Joint Adult and Child module introduced in May 2019 with new trainers trained to support compliance	R
Paediatric Immediate Life Support	54.55%	Again a positive increase seen from Autumn 2017, although 12 months following compliance has shown a decrease.	R
Advanced Paediatric Life Support	100.00%	Compliance Maintained	G
Patient Handling	71.14%	Low level of compliance, however slow increase has been reported over the last 12 months	A
Conflict Resolution	80.12%	Low level of compliance, however change in frequency of renewal to once only introduced in June 2019, with a positive increase seen following	A
Consent	100.00%	Compliance maintained since implementation in December 2017	G
Safe use of Insulin	77.74%	Significant increase in compliance in last 12 months. Steady progress towards full compliance.	A
VTE	78.33%	Significant increase in compliance in the last 12 months Steady progress towards full compliance	A

Core Mandatory Training: Permanent and Temporary Staff

The top data chart shows the Core Mandatory training compliance figure for all substantive staff.

Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

Since January 2019, there has been a positive shift in compliance levels above the threshold level of 91%. With the Trust achieving it highest compliance figure of 94.3% at the end of August 2019.

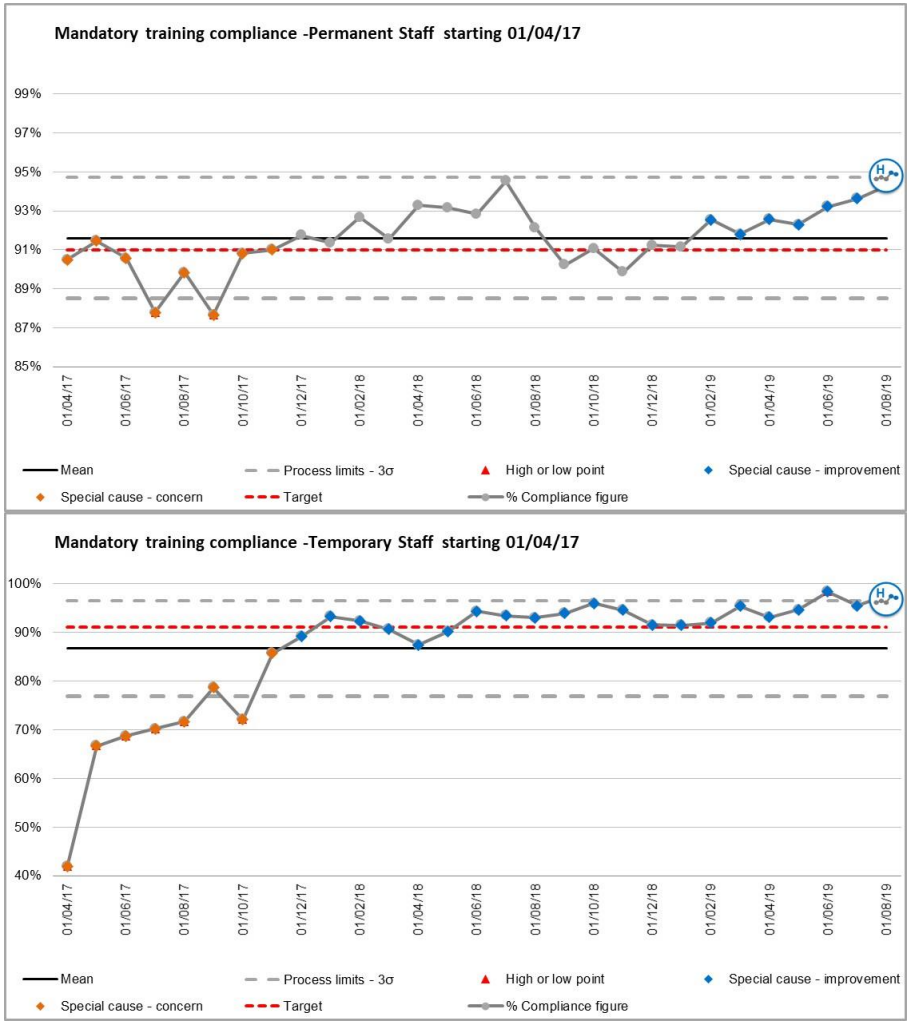
The lower data chart shows the Core Mandatory training compliance figure for Bank / Temporary staff.

Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

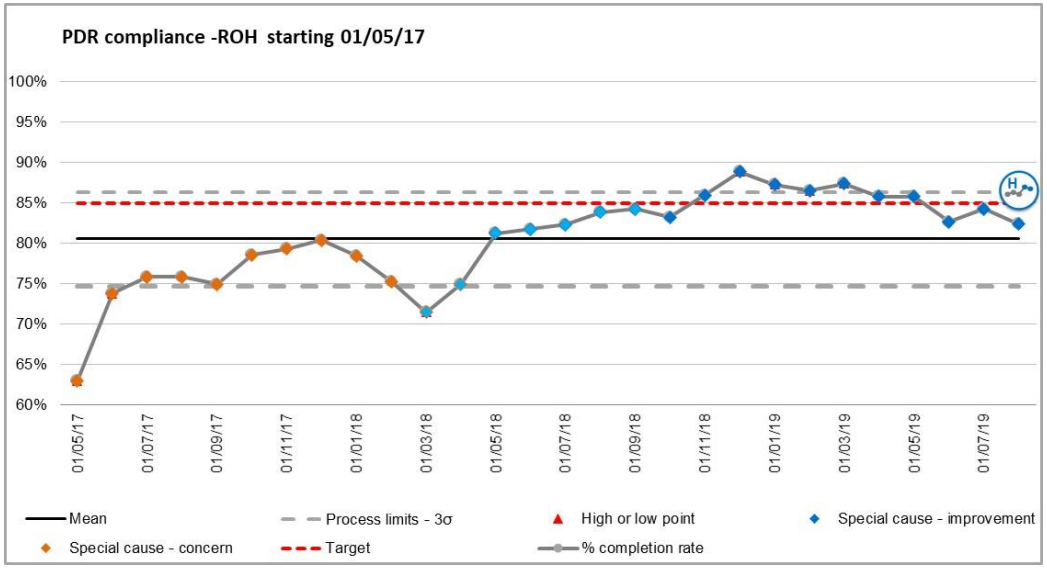
The graph shows an initial significant increase when monitoring first commenced in April 2017, and confirms a positive shift in compliance in this area.

Bank staff mandatory training compliance has achieved its threshold of 91% since January 2019.



Performance and Development Reviews

This data chart shows the Annual Performance and Development Review compliance figure for all Trust staff. This figure is taken from the ESR system, so only relates to information recorded in ESR. Local figures may be higher dependant on efficiency of ESR maintenance.



Data Observations:

When there is a run of 7 increasing sequential points this may indicate a significant change in the process.

From March 2018 we saw a 7 month positive trend in completion rates being recorded, showing a positive change in behaviour which has since been sustained.

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

Over the last 12 months, we can see each month was above the mean, confirming a significant change in the process of completing and recording PDRs.

On comparison with the Target figure of 85%, we are still not consistently achieving our set threshold figure, and have seen a general decrease with the last 3 months being under the Target.

Adult Basic Life Support – Level 1 and Adult Hospital Life Support – Level 2

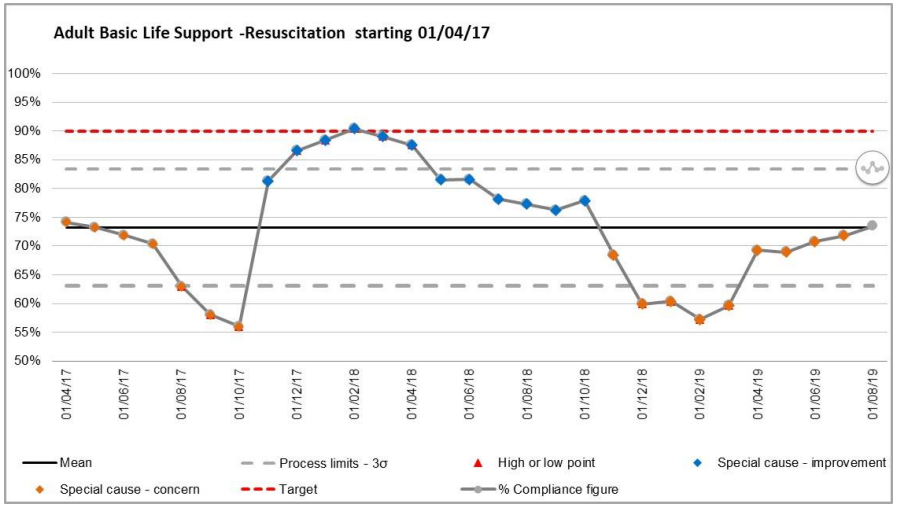
This top data chart shows the Adult Basic Life Support compliance figure for relevant Trust staff.

Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

From October 2017 to April 2018, and operational lead was designated to have a strong focus on resus training. The positive shift in compliance is seen during this time.

12 months following, from October 2018, a subsequent decrease in compliance can be seen, which has slowly been improving since then, with an increase in April following the Theatre Closedown week.

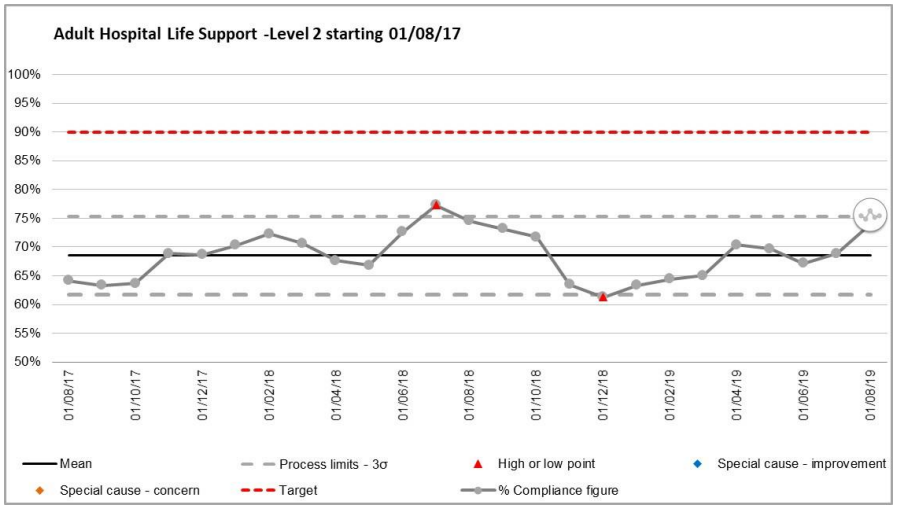


This lower data chart shows the Adult Hospital Life Support compliance figure for relevant Trust staff.

Data Observations:

Attendance and maintenance of HLS competence has remained around the average of 69% compliant during the reporting period.

There are no significant shifts in compliance during this time.



Adult Immediate Life Support and Adult Advanced Life Support

This top data chart shows the Adult Immediate Life Support compliance figure for relevant Trust staff.

Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

Attendance and maintenance of ILS showed a significant shift during 2018, however this has not been maintained during 2019, and the Trust is continues to achieve just above the average of 62%

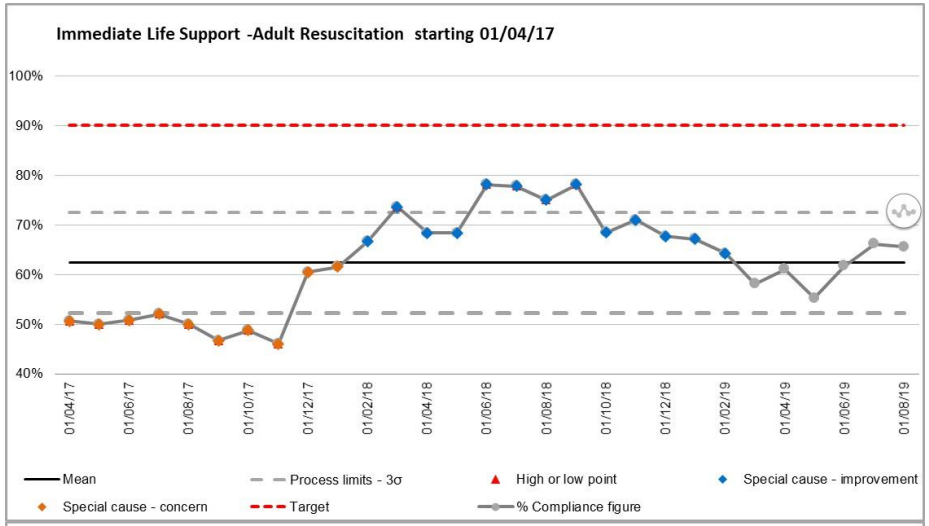
This lower data chart shows the Adult Advanced Life Support compliance figure for relevant Trust staff.

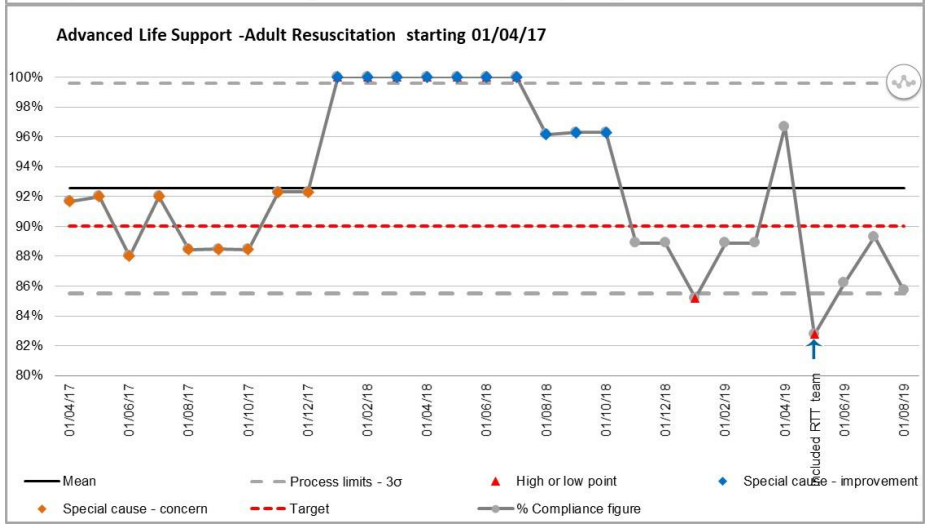
Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

Compliance with ALS training showed a significant shift during 2018, however this has not been maintained during 2019.

In April 2019, the requirement for the Trusts Rapid Response Team to be compliant with ALS was introduced, and these staff have courses planned during 2019, with an aim to be compliant by December 2019.





Paediatric Basic Life Support
Paediatric Immediate Life Support

This data chart shows the Paediatric Basic Life Support compliance figure for relevant Trust staff.

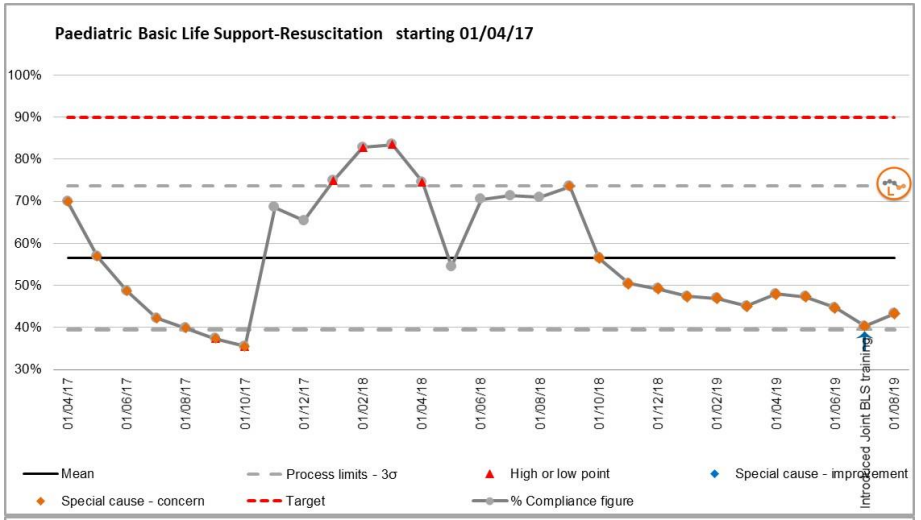
Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

From October 2017 to April 2018, an operational lead was designated to have a strong focus on resus training. The positive shift in compliance is seen during this time.

12 months following, from October 2018, a subsequent decrease in compliance can be seen, which has continued.

In June 2019, the Trust merged the Adult and Paediatric Basic Life Support training, whilst training inhouse trainers. Improvements are due be seen in the forthcoming months.

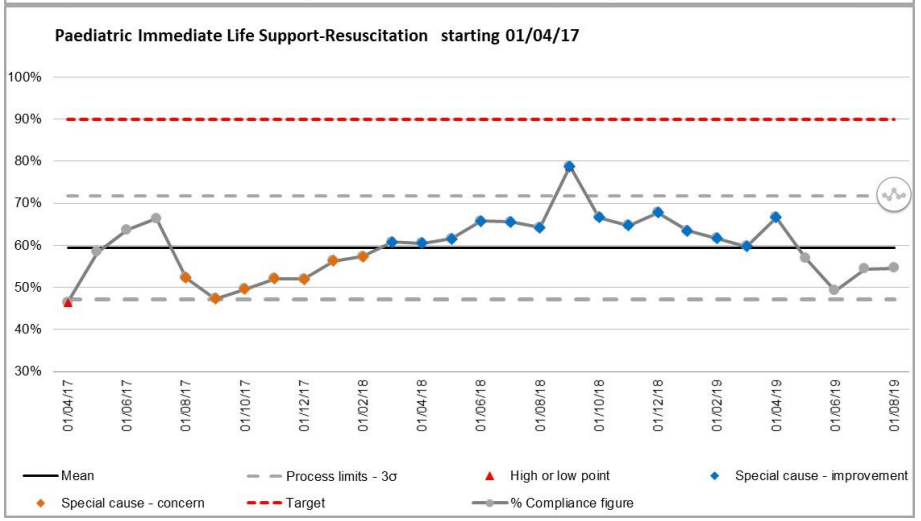


This lower data chart shows the Paediatric Immediate Life Support compliance figure for relevant Trust staff.

Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

From October 2017 to April 2018, an operational lead was designated to have a strong focus on resus training. The positive shift in compliance is seen from this time, with a general decrease from 12 months following.

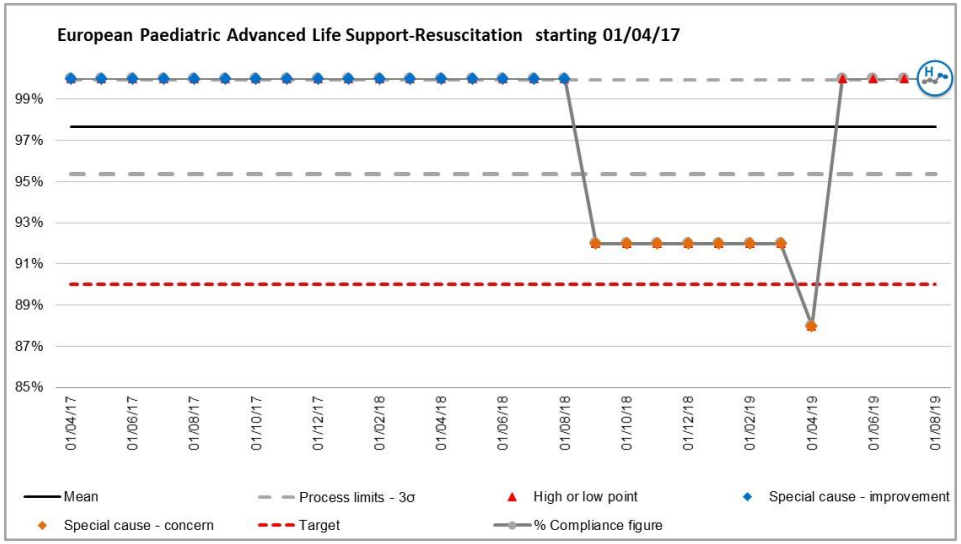


European Advanced Paediatric Life Support

This data chart shows the Paediatric Basic Life Support compliance figure for relevant Trust staff.

Data Observations:

Although compliance dropped from October 2018, competence was maintained by all relevant staff by maintaining compliance with PILS training during this time.



Patient Handling and Conflict Resolution Training Compliance

The top data chart shows the Patient Handling training compliance figure for all Trust staff. This training has a requirement to be repeated every two years.

Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

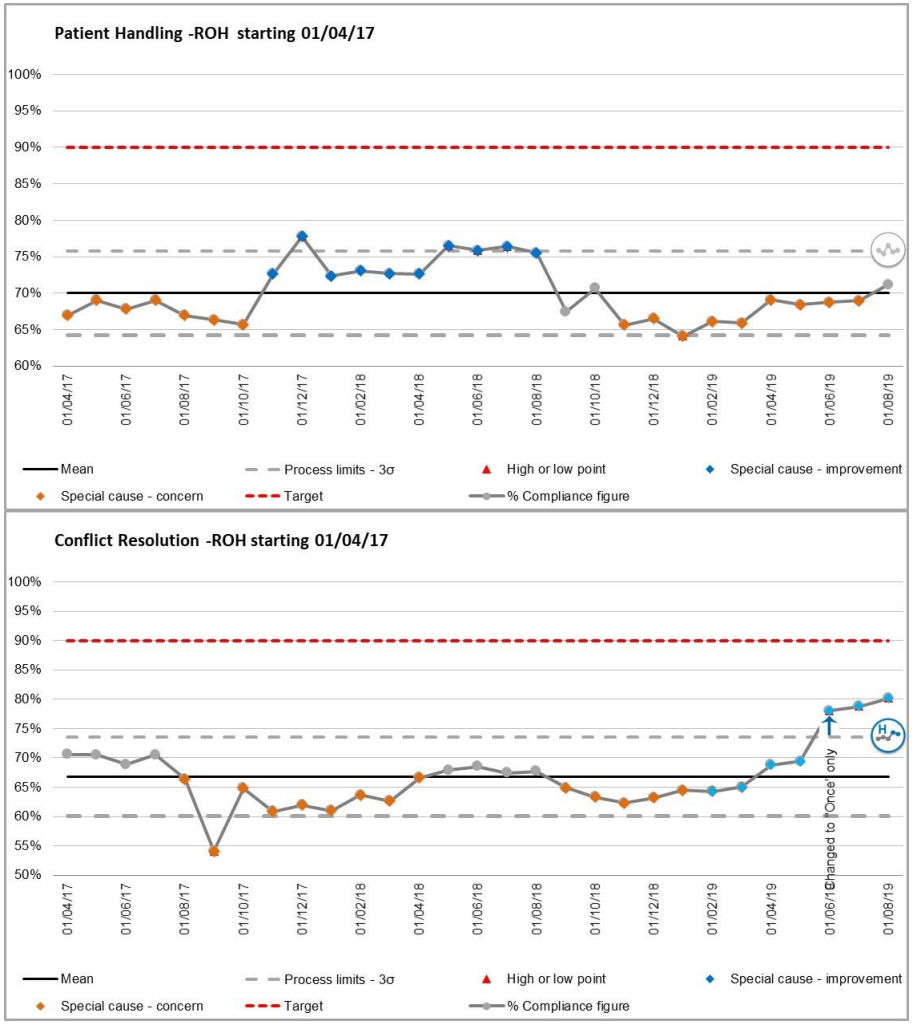
Recent figures would suggest a decrease in compliance over the last 12 months, however there are signs of slight improvements since April 2019.

This lower data chart shows the Conflict Resolution training compliance figure for all Trust staff. This training had a requirement to be repeated every three years, and in June 2019, following a Trust review, this was revised to Once only attendance required, with refresher sessions on a personal needs basis.

Data Observations:

When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in process.

From December 2018, a general increase in compliance can be seen, however following the change to a “Once only” requirement this has resulted in a significant positive change in compliance. This will continue to be monitored.



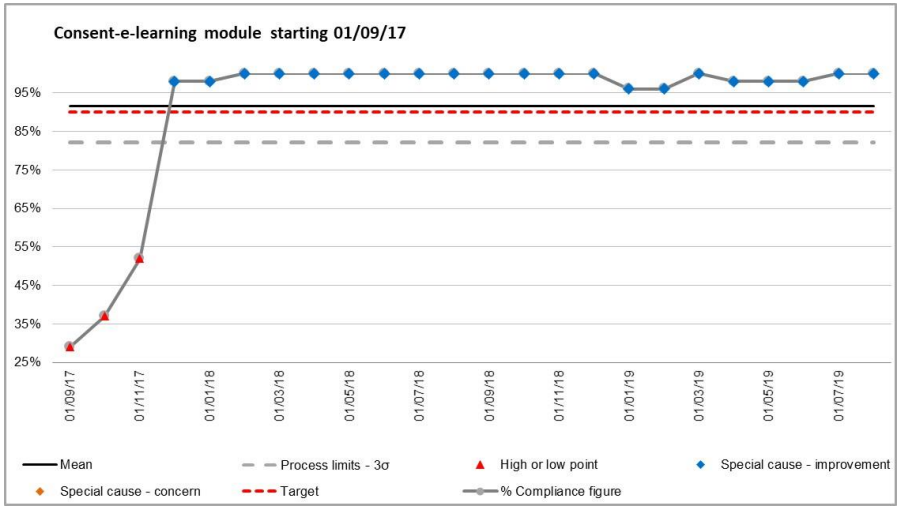
E-Learning Training Compliance

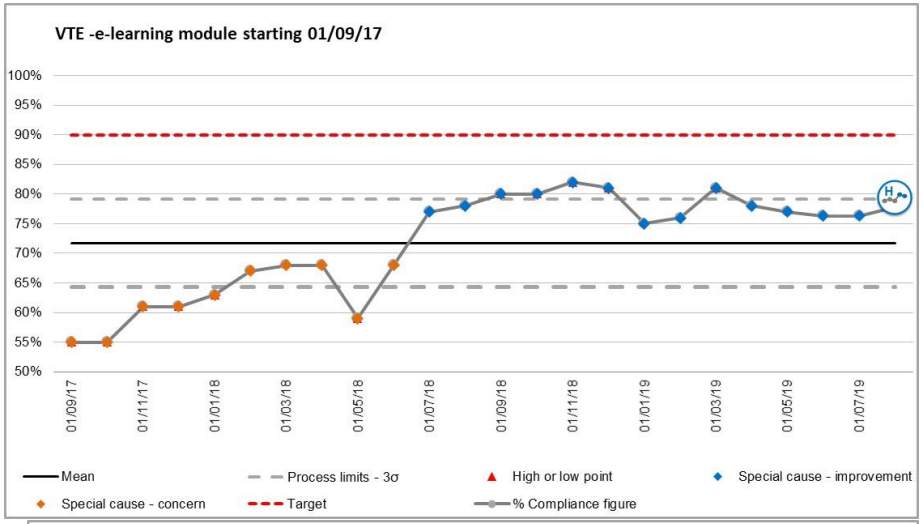
This data charts show the training compliance for the eLearning only training modules.

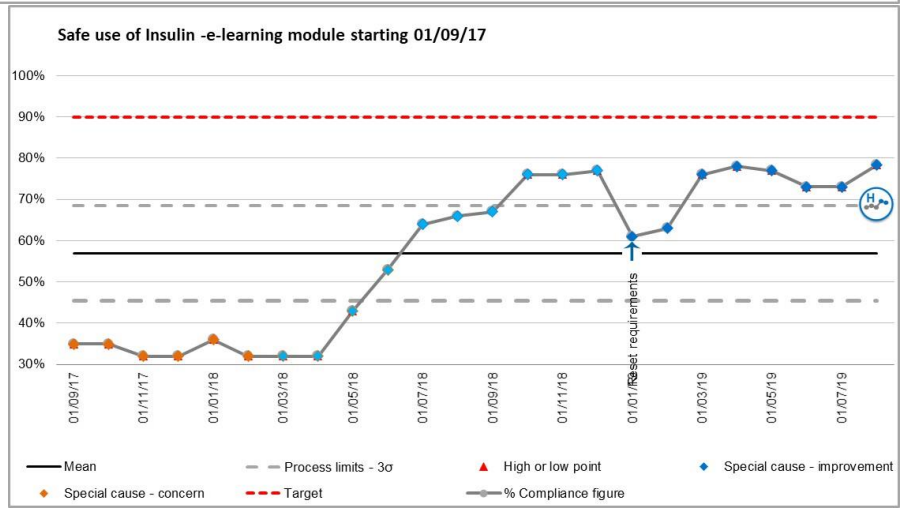
Data Observations:

Consent training: compliance has been maintained since implementation in December 2017.

Safe use of Insulin and VTE compliance figures show a significant positive increase in compliance up to January 2019, where the number of staff required to complete the module was reviewed and increase.







4	Workforce – Experience and Engagement
4b	Employee Engagement and Job Satisfaction

OVERALL STAFF ENGAGEMENT

The most recent National staff survey results have seen a positive move on the overall staff engagement score from 3.83 to 3.97. The score is made up of the questions shown below:

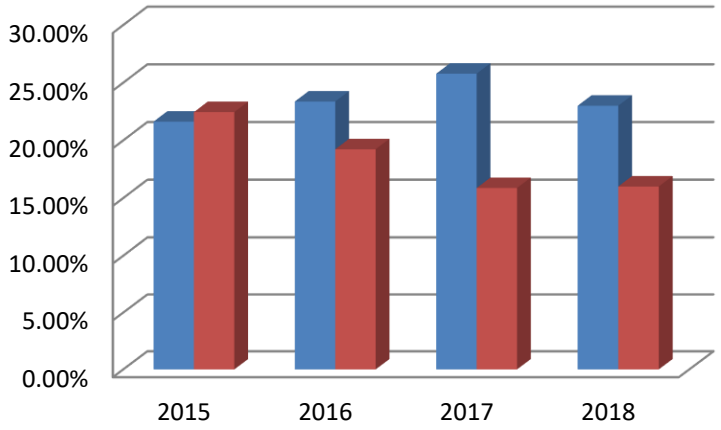
	Questions linked to ROH engagement score	2018 ROH	2018 Average	2017 ROH	2016 ROH
21a	Care of patients is my organisation's top priority	86%	86%	79%	69%
21b	My organisation acts on concerns raised by patients	83%	81%	79%	73%
21c	I would recommend my organisation as a place to work	73%	72%	62%	56%
21d	I would recommend the standard of care provided by this organisation	91%	89%	83%	77%

4 Workforce – Experience and Engagement

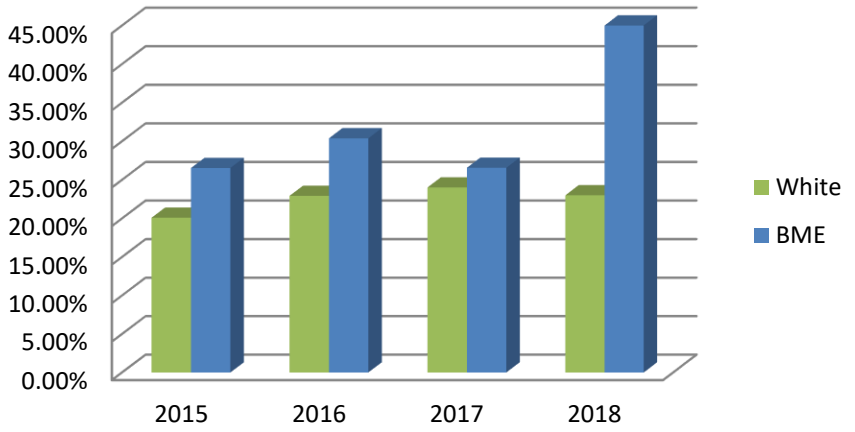
4c WRES Indicators

WRES Indicators

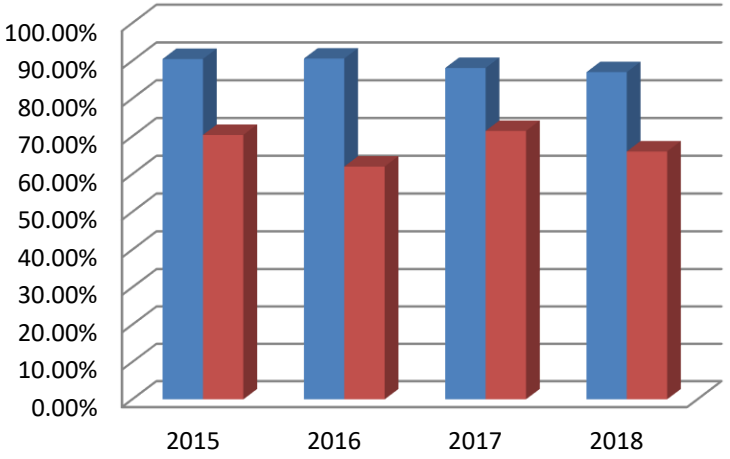
Indicator 5: Experiencing bullying from patients



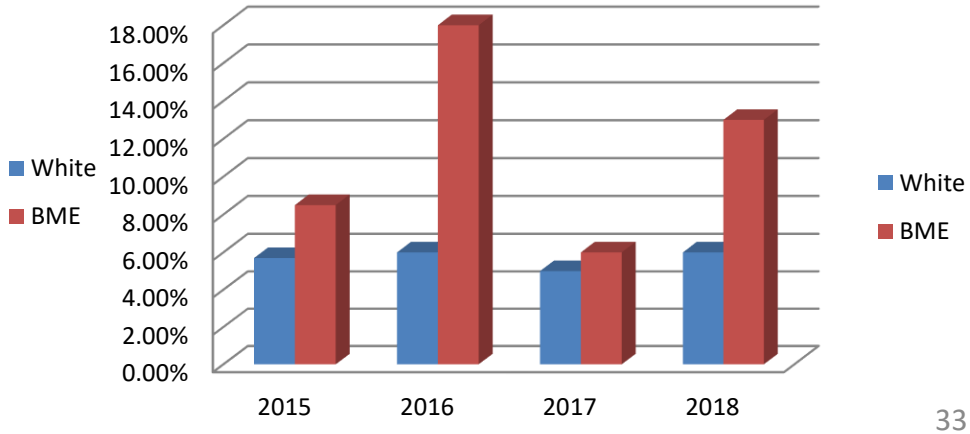
Indicator 6: Bullying, harassment by staff



Indicator 7: %age believing Trust provides equal opportunities



Indicator 8 Percentage of staff experiencing discrimination at work



INFORMATION
Friends and Family Test (FFT) – The results for Staff FFT Q2 have shown an improvement in both recommending the Trust as a place to work and a place for Care. The completion rate has also increased by 1% to 25%. **Engagement and Job Satisfaction** – Speak Up and Join in brand is becoming increasing established. Work undertaken during Health and Wellbeing work supported the engagement agenda across the Trust. The Trust is currently recruiting a Wellbeing officer to support the Engagement and Wellbeing programme in the future. The NHS National staff survey started on October 4th and already there is an increase in completion rates compared to 2018. **Equality and Diversity –**The Equality and Diversity report is progressing with review meetings planned for November and December including internal and external stakeholders. The WRES indicators are currently being updated and will be reported at SE&OD in November. A recruitment project to look at unconscious bias is due to start in December 2019.
ACTIONS FOR IMPROVEMENTS / LEARNING
Actions to encourage survey completion to improve data reliability Ensure all staff are sighted on the positive staff survey results and are able to suggest local improvements
RISKS/ISSUES
Part of the WRES data is sourced from the NHS National Staff survey. Completion rate affects the reliability of the data as a representation of staff views

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TRUST BOARD	
DOCUMENT TITLE:	**Update from the Guardian of Safe Working - Report for Q3 and Q4 2019**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Matthew Revell, Executive Medical Director**
AUTHORS:	**Matthew Revell, Executive Medical Director** **David Marks, Guardian for Safe Working** **Nas Uddin, Clinical Service Manager**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

The Guardian for Safe working has confirmed no concerns for the last three quarters with respect to the safety of junior doctors.

The document describes the team overseeing junior doctors working and the current work in progress to reduce reliance on locum staff in order to improve both patient and employee experience.

REPORT RECOMMENDATION:

The Trust Board is asked to:
RECEIVE and ACCEPT the assurances provided by the report
SUPPORT the following intentions:

- To provide continued support for the key individuals working to support junior doctors working conditions.
- To provide continued support for multidisciplinary integration.
- Further integration of the individual leads into the middle grade service provision planning in 'Perfecting Pathways'

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

Comments:

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

Aligned to the People domain of the Trust's strategy

BAF Risk WF21 – Failure to attract and retain the skills and number of staff to secure financial sustainability

The Royal Orthopaedic Hospital NHS Foundation Trust

PREVIOUS CONSIDERATION:
Verbal report was given by the Medical Director to the Trust Board at its meeting on 4 September 2019.

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FOR ASSURANCE

UPDATE FROM THE GUARDIAN OF SAFE WORKING

REPORT TO THE TRUST BOARD – 6 NOVEMBER 2019

1.0 Situation

1.0 The Guardian for Safe Working is required to raise concerns about Safe Working for Junior Doctors by exception. As of October 2019, he has reported that there have been no concerns for the last three quarters.

2.0 Background

2.1 Leadership Team

The current team looking after middle grade doctors has extensive input from the clinical service managers.

2.1.1 Clinical rotas are prepared by the Administrative Specialist Registrar (SpR) (nominated 6-monthly by the Regional Training Programme Director). Mr Newton Ede and Mr Politis support the Administrative SpR balancing the educational and training opportunities with the service requirement of the organisation. Naeil Lotfi is the current post holder of Administrative SpR. As well as the weekly timetable he arranges the teaching rota for GP trainees. Through regular contact and meetings with trainees and management, the leadership team ensure safe, effective and rewarding postgraduate training. This is monitored by the leadership team and a rapid and effective response is insured when concerns challenges and opportunities are identified. Formal feedback via the GMC trainee-satisfaction survey and the Job Evaluation Survey Tool (JEST) (now NETS – National Education and Training Survey) is similarly monitored and responded to.

2.1.2 The current consultant staff post holders are:

Mr Matthew Newton-Ede	Clinical Tutor	All postgraduate medical and surgical trainees (ST1+) at the Royal Orthopaedic Hospital
Mr Angelos Politis	Clinical Lead for Mid-Level Care Providers	Locum Drs & Fellows
Mr David Marks	Guardian for Safe Working	Safe working conditions of trainee doctors

2.1.3 There are regular junior workforce meetings arranged as part of normal operations.
In addition there is a regular junior doctors' forum attended by the leadership team and all junior doctors are invited.

2.1.4 The Post Graduate Medical Director (PGMD), Medical Director and Safeguarding lead attends the doctors' induction meetings. The Medical Director and Post Graduate Clinical Tutor each have 2-monthly meetings with the GP trainees and contribute to the training programme as speakers and medical educators.

2.1.5 All clinical supervisors and allocated educational supervisors are accredited as per the GMC and Academy of Medical Educators directive. Maintenance of accreditation is appraisee-led and recorded via the annual appraisal process. Consultants will be supported via a designated Educational Support Committee. This will have joint input from medical educators and appraisal experts.

3.0 Junior Doctor Establishment

3.1 *Specialist Registrars (SpRs) and Fellows Training in Orthopaedic Surgery*

3.1.1 There are presently 12 SpRs 1 LAS and 12 Fellows on the Royal Orthopaedic Hospital roster. All contribute significantly to the safe working of the Trust on a day to day basis, being timetabled for ward round cover, theatres and outpatient clinics. Fellows do not normally take part in the on call rota. However, during quarter 2 they were asked to cover Friday afternoons in order to ensure that SpRs are able to attend their regional training without interruption. This has been successfully implemented without incident.

3.2 *GP Trainees*

3.2.1 Historically there have been between two and four GP trainees allocated to the ROH who choose the ROH as a training location. Due to the hard work of the leadership team and the medical educators, we have now six GPs. With six GP trainees we are able to offer an optimal training experience. GPs get three formal teaching sessions per week including release for their regional teaching. Additionally, they are supported to attend their awayday residential teaching. They are timetabled for weekly teaching clinics and operating lists, and cover is in place to maximise their educational exposure.

3.2.2 Remaining posts at Senior House Officer level are filled with locums or, more preferably, substantive mid-level care providers (MLCPs) where possible. At present, the strongest areas for MLCPs are pre-operative assessment, specialist ward cover, outpatients and theatres.

3.2.3 The ROH reviewed rota requirements during Q2 2019 with a view to reducing the number of locum posts if possible. The main drivers were to improve opportunities for MLCPs to develop within the ROH and to improve patient and employee experience through a more stable and permanent workforce. The number of locum posts has therefore been taken down from 8 to 6 from August 2019.

4.0 About The Guardian for Safe Working Role

4.1 During negotiations on the junior doctor contract, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors.

4.2 All organisations employing or hosting 10 or more trainees are required to appoint a guardian. Organisations with fewer than 10 trainees must make one available through another NHS organisation.

4.3 The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. It should report into different management structures, including the local negotiating committee (LNC) and the trust board, but will also have a regular input into junior doctor forums. Regular liaison with your director of medical education (DME), educational supervisors and the champion of flexible working is required.

4.4 The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The post holder is to identify and either resolve or escalate problems, and act as a champion of safe working hours for junior doctors.

4.5 The guardian provides assurance to the employer or host organisation, that issues of compliance with safe working hours will be addressed, as they arise.

4.6 The guardian is accountable to the board and should not hold any other role within the management structure of the employer. The line management arrangements for the guardian be independent of the medical director and other medical managers to ensure appropriate independence. The reporting line should be to the appropriate executive director or equivalent, who will contribute to the annual appraisal of the guardian, in line with appraisal policy.

4.7 The post holder should have regular meetings with doctors in training, the champion of flexible training, the DME and any associate DMEs, educational, clinical and academic supervisors, the postgraduate dean, other senior staff within the HEE area office/deanery, the LNC, the junior doctors forum, and both executive and non-executive Board members. In some locations the guardian may need to liaise with colleagues undertaking similar roles for other local organisations which employ fewer than 10 trainees.

4.8 A sample job description for the guardian role is also available online: Guardian job description (NHS Employers)

4.9 The role of guardian is best filled by a senior doctor, either consultant, staff grade or associate specialist doctor or an equivalent clinical academic. The following skills and characteristics are useful in order to undertake the role successfully, but are not all essential:

– Experience of high-quality rota design – Track record of understanding and supporting junior doctors – Familiarity with the relevant IT systems – Prepared to resign or forego all other management responsibilities at the organisation (this is essential and required by the contract) – Familiarity with the doctors in question - for example, GP trainees or hospice doctors – Experience in medical education – Interest in patient safety and quality improvement.

4.10 The guardian is appointed by a panel of at least four, which should include the trust medical director, HR director and two junior doctor representatives. It is a contractual requirement that 50% of the panel is made up of junior doctors and that consensus on the appointment of the guardian is reached.

5.0 Analysis

A graph of agency spend on junior doctors is shown in Figure 1 below:

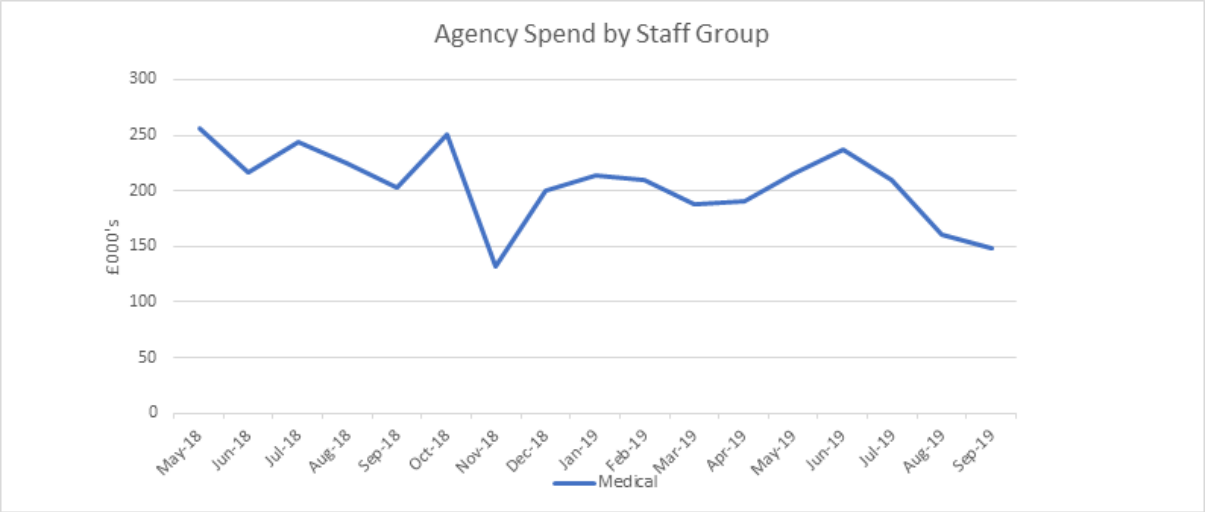


Figure 1 Agency Spend on Junior Doctors

The graph confirms a significant improvement from the summer. Spend was increased in the summer due to the need to cover maternity leave.

The reduction has resulted in no reported harm or concern to date and the projected Cost Improvement is c £150,000.

6.0 Recommendations and Ongoing Work

The Trust Board is asked to:
RECEIVE and ACCEPT the assurances provided by the report
SUPPORT the following intentions:

- To provide continued support for the key individuals working to support junior doctors working conditions.
- To provide continued support for multidisciplinary integration.
- Further integration of the individual leads into the middle grade service provision planning in 'Perfecting Pathways'

Matthew Revell, Executive Medical Director
David Marks, Guardian for Safe Working
Nas Uddin, Clinical Service Manager

31 October 2019

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – PATIENTS extract**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

Following the Board workshop in October it was agreed that the Board Assurance Framework (BAF) should be realigned to the goals ('Five Ps) in the newly approved Trust strategy.

Attached is the **PATIENTS** extract of the BAF

Those risks shaded in **blue** are recommended for closure or de-escalation to local risk registers and those shaded **grey** are proposed for closure.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:

Trust Board is asked to:

- Review the Board Assurance Framework extract
- Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- Agree to close or de-escalate those risks suggested

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:

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:

Executive Team on 15 and 29 October 2019.

Trust Board at its meeting on 4 September 2019.

Discussion held about restructuring BAF by the Trust Board on 2 October 2019 as part of a workshop.

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
PATIENTS																				
OP1	Operations	COO	The current suspension of the Paediatric Oncology service at BCH creates long delays for patients requiring surgery leading to poor patient experience, clinical outcomes and disenfrachisement of the oncology consultants	Patient experience Clinical excellence	With safe and efficient processes that are patient centred	Quality & Safety Committee and Trust Board	5	4	20	Teleconference held with the Bone Sarcoma network to agree the model for referring the current cohort patients waiting for surgery to other sites following the decision of the daily Multi Disciplinary Team (MDT) meetings. Root Cause Analyses around the paediatric cases treated at BCH which had prompted the decision to cease the service are being undertaken by BCH.	Weekly update to Executive Team. Minutes of Trust Board meeting in October 2019. Minutes of Children's Board.	4	4	16	NEW RISK	Outcome of Root Cause Analyses to be concluded and date agreed with BCH and Specialised Commissioning around when the service is to recommence. External independent review into the oncology service to be commissioned	Dec-19	1	4	4

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 (11/19) 011

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

The Royal Orthopaedic Hospital NHS Foundation Trust

Date Group or Board met: 25 September 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was reported that there had been two Serious Incidents reported by Birmingham Children's Hospital (BCH) that related to two of the ROH's patients. ROH staff were involved in the investigatory work. Until the investigations had been completed, the paediatric oncology service would remain suspended and patients requiring surgery would be directed to other providers. • There had been ten patient falls in August. A Hover Jack was being purchased using Charitable Funds; this would help mobilise patients after a fall. Staff were also contacting patients to invite them to an exercise to explore any themes associated with falls. • There was reported to be a deterioration in performance against the complaints Key Performance Indicator. Governance meetings were being held each week, which included a review of the complaint tracker and the themes from complaints. A repeated issue appeared to be around waiting times and rescheduling of appointments, which would be addressed by the introduction of partial booking. An appointments hotline was also in place. • It was noted to be disappointing that a pressure ulcer had occurred because a patient had not been able to reposition themselves. • It was reported as part of the upwards report from the Safeguarding Committee that compliance with Safeguarding Level 3 training had reduced, this being reflective of a change to the national requirements. Additional training days were reported to be being organised each month and the position would be monitored routinely. • It was highlighted that attendance at the Research & Development Committee meetings remained poor at present but individuals would be held to account based on their job plans which included the requirement to attend meeting such as these.	• There was reported to be continued development of the HealthAssure system. • It was suggested that the presentation of the clinical audit of High Dependency Unit transfers be presented to the Board at a future meeting. • Preparations had commenced for the launch of the 'flu campaign. An update on the position would be presented to the Trust Board in November. • Agree whether the Medical Safety Officer reports to the Drugs & Therapeutics Committee or directly to the Quality & Safety Committee. • Report detail of the Central Alerting System (CAS) alerts to the Quality & Safety Committee. • A risk assessment for staff working in small offices to be undertaken.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• There was reported to be 100% compliance with the WHO checklist. • It was agreed that there had been some good work to share learning from incidents and the Heath Records Advisory Group was also taking a role in reviewing the documentation that detailed incidents. • The Committee was joined by Dr Ben Smith, Anaesthetist, who delivered a presentation on the evaluation of critical care transfers from the ROH following major complex surgery. This was a significant clinical audit that had occurred at the Trust. The conclusion to the audit was that the transfer rate from the ROH Level 2 High Dependency Unit (HDU) to a unit providing a higher level of critical care (Level 3) was low when compared to other centres. This gave assurance to the Committee that pre-operative processes were sound and, by and large, only patients requiring only Level 2 support were being treated. • The Committee reviewed the Trust's Intensive Care National Audit & Research Centre (ICNARC) data. This showed that 732 patients were treated on HDU during 2018/19. Performance against all ICNARC indicators was noted to be very positive in comparison to other centres and was noted to be testament to the leadership in the area. • A named doctor for children's safeguarding was reported to have been identified, which the Committee agreed was very positive given that this post had been vacant for some time. • It was reported that the degenerative medicine laboratory would be opened shortly, which was a key asset for the ROH's research work. • There had been a ligature risk assessment undertaken in conjunction with Birmingham & Solihull Mental Health NHSFT. There remained more work to do to complete the action plan to minimise any risk associated with ligature points around the Trust.	• None specifically.

Chair's comments on the effectiveness of the meeting: It was agreed that there needed to be a review of the material being considered by the Committee to ensure that it was focussing on assurances rather than detail, particularly given that the Clinical Quality Group was working well. There had been a number of late papers for this meeting, a position which was unusual, but would not be tolerated in future. A suggestion was made that the Committee should meet bimonthly to allow for sufficient progress to be made on actions raised at meetings.

ROHTB (11/19) 012

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

The Royal Orthopaedic Hospital NHS Foundation Trust

Date Group or Board met: 30 October 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The external review of the paediatric oncology patient Serious Incidents at Birmingham Children's Hospital (BCH) was reported to be planned for 12-13 December 2019. In the meantime, the service remained suspended and patients requiring treatment were being diverted to other providers who could undertake the surgery. • The Committee was appraised of two other spinal surgery cases treated at BCH which were currently being investigated. Further information would be provided at the next meeting. • There was reported to have been one serious incident which related to a death associated with a VTE post surgery. The case had been referred to the Coroner who had ruled that although a tragic case, the death had occurred as a complication of surgery and the Trust had not been found negligent in its care of the patient. • There had been an increase in VTEs reported (6). The themes from the Root Cause Analyses would be reviewed to understand the reasons for this increase. • There continued to be a risk to the achievement of the complaints Key Performance Indicator. A trajectory was reported to be in place to achieve the target over coming months and a weekly governance meeting reviewed the complaints in detail. The planned review of the complaints policy was likely to instigate a review of the current process including the operational responsibility for writing complaints responses. • The Committee was disappointed that the planned update from the Chair of the VTE Committee was not received. The Medical Director would follow this up.	• Work was underway with ward sisters around maintaining standards of cannula care. • The Infection Prevention & Control Committee to consider the audit around Urinary Tract Infections (UTIs) • Invite the Clinical Effectiveness Manager to the next meeting to discuss the plans for Amplitude • Use the PROMs data as part of marketing the quality of services at the ROH

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The implementation of DrDoctor was reported to have created a marked reduction in Did Not Attend (DNA) cases • Length of Stay was reported to be reducing marginally. • The Committee considered some Patient Reported Outcome Measures (PROMs) data which highlighted that over 90% of patients receiving a hip replacement regarded the impact on their quality of life after surgery as good or better. • The Committee received a positive update from the Designated Individual for compliance with the Human Tissue Authority (HTA) licence. The action plan following the 2018 inspection was reported to have been completed. The Human Tissue Advisory Group was working well and discussed any regulatory alerts issued by the HTA. • The 2018 inpatient survey results presented a positive picture, with the Trust being one of eight trusts performing as 'Much Better Than Expected' by the CQC. The response rate to the survey was noted to be 67%, this being better than the previous year and much better than the national position. • The Committee received an update on the work undertaken to embed dementia care within the Trust by the Deputy Director of Nursing & Clinical Governance. This included the work to implement national guidance, upskill the workforce, update documentation, adapt the environment and refresh care plans. The work was noted to have been well received and the new processes and systems were working well. • The quality impact assessment processes for cost improvement schemes was noted to be working well. • The update from the Clinical Quality Group highlighted that the meeting was working well and there was a good level of challenge and there was good attendance from a range of nurses and medical staff. • The Committee welcomed the Head of Imaging who provided some sound assurance that the Trust was meeting its duties under the terms of the Ionising Radiation (Medical Exposure) Regulation (IR(ME)R).	• The Committee approved the terms of reference of the Human Tissue Advisory Group

• The letter from the CQC following the recent unannounced inspection of the High Dependency Unit and Surgery was reviewed and the immediate actions take to address any concerns raised by the regulator were outlined. It was noted that although there were no perceived safety issues with the beds that had been open on Ward 12, these had been closed immediately after the feedback from the inspection. An alternative model was being considered for the area. • The Committee reviewed a report received from the Clinical Commissioning Group following a recent unannounced inspection. This had focussed on safeguarding, governance and Mental Capacity arrangements. The report had been largely positive, although issues had been identified with compliance with training in Safeguarding Level 3, an issue with which the Trust was familiar and was addressing. • The Trust had not received any Contact Performance Notices (CPNs) and delivery against the CQUINs was at 100% for Quarters 1 and 2.	

Chair's comments on the effectiveness of the meeting: It was noted that having fewer guests had allowed the meeting to run more smoothly and the development of the future committee agendas needed to consider this. The presentation on dementia was seen to be well received. All agreed that there had been a good level of discussion.

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY REPORT

October 2019

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Nursing & Clinical Governance
AUTHOR:	Ash Tullett	Head of Clinical Governance

Dashboard

	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sep 2019	2019/2020 YTD	2018/2019
Incidents	310	321	365	365	359	339(↓)		
Serious Incidents	0	2	1	1	0	1(↑)	5	9
Internal RCA investigations	0	3	6	3	3	7(↑)		
Safety Thermometer (Harm Free Care)	98%	98%	98 %	97%	97.1%	97.6(↑)		
VTEs (Avoidable)	0	0	1	1	0	0 (↔)	2	4 (Avoidable)
Falls (all falls)	11	3	13	8	10	3(↓)	48	88 (Total)
Pressure Ulcers: Cat 2 (Avoidable)	0	0	1	0	0	0 (↔)	1	7 (Avoidable)
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0 (↔)	0	2 (Avoidable)
Complaints	11	6	10	27	16	10(↓)	80	139
PALS	85	74	73	116	51	31(↓)		
Compliments	453	511	488	468	601	456(↓)		
FFT Score	96.3%	96.3%	96.4%	96.2%	96.1%	96.5(↑)		
FFT Response	37.2%	30%	24.6%	58.8%	61.6%	58.8(↓)		
Duty of Candour	9	9	15	16	16	16(↔)		
Litigation	0	3	2	0	0	0(↔)		
Coroners	0	0	0	0	0	1(↑)		
WHO (Theatres)	100%	100%	100 %	100 %	100%	100(↔)		
Infections	1	0	1	0	0	0(↔)	2	3

(↑) (↓)(↔) Symbolise the trend from the previous month.

CONTENTS

1. 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.

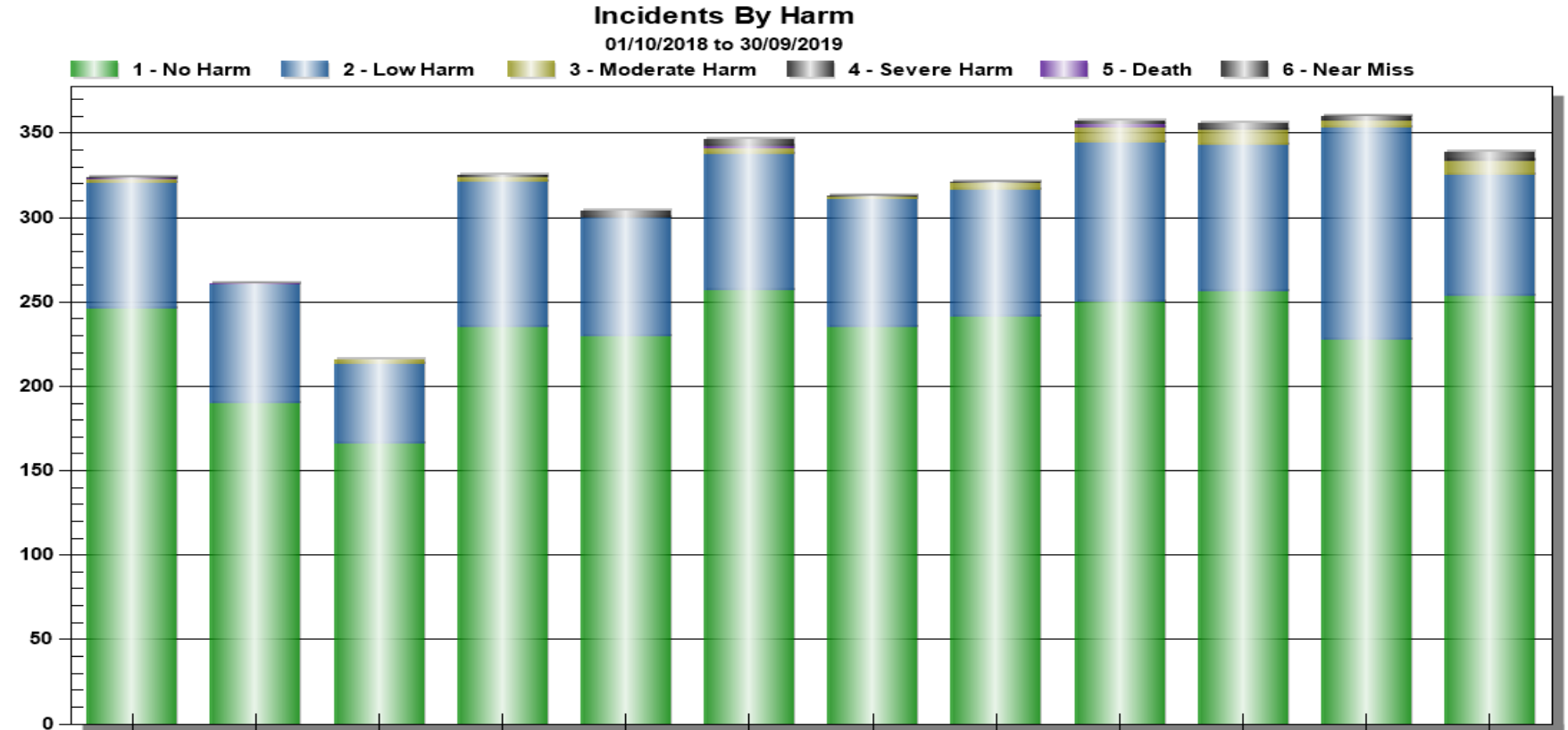
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019
1 - No Harm	246	190	166	235	229	257	235	241	250	256	227	253
2 - Low Harm	74	70	47	86	71	80	76	75	94	87	126	72
3 - Moderate Harm	2	0	3	3	0	4	1	4	9	9	4	8
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	2	1
5 - Death	1	1	0	0	0	1	0	0	2	0	0	0
6 - Near Miss	1	0	0	1	4	4	1	1	2	4	1	5

Data source – Ulysses

INFORMATION

In September 2019, there were a total of 339 Incidents reported on the Ulysses incident management system. This is within the normal reporting limits.
The breakdown of those incidents is as follows;

253 – No Harm
72 – Low Harm
8 - Moderate Harms
1 - Severe Harm
5 – Near Miss
0 – Death

The provisional harms reported were;

Patient Contacts

In September 2019, there were a total of 9996 patient contacts. There were 339 incidents reported, which amounts to 3.4 per cent of the total patient contacts resulting in an incident. Of those 339 reported incidents, 81 incidents resulted in harm which is 0.8 per cent of the total patient contact.

Downgraded Incidents

1 of the 6 reported harms in the previous Quality report have been downgraded after investigation

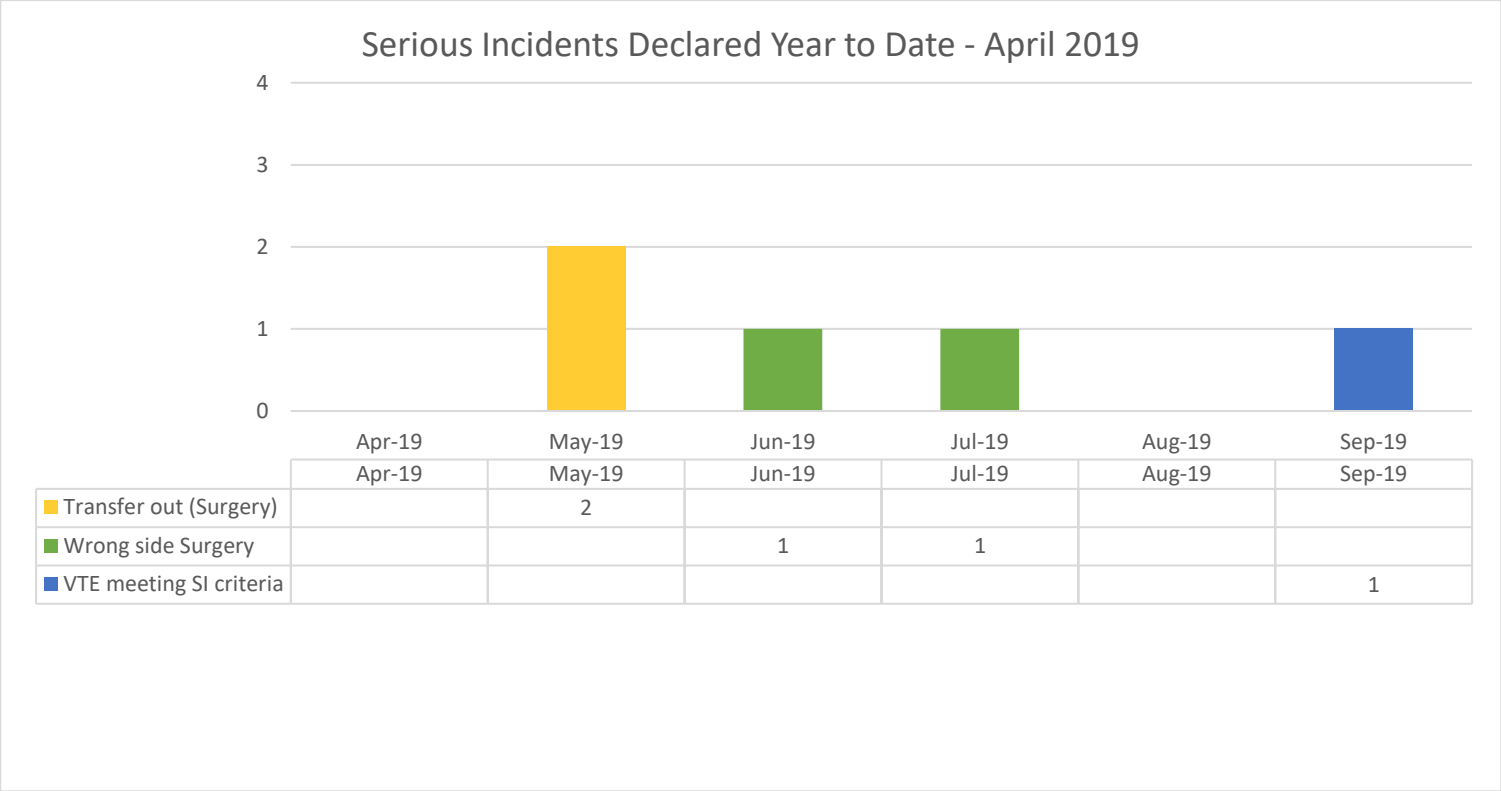
ACTIONS FOR IMPROVEMENTS / LEARNING

CCG unannounced visit – An unannounced visit from the CCG was undertaken within the Clinical Governance team. The CCG found that the Trust has a robust policy for ensuring policies are in date and are reviewed as required, this includes the Serious Incident (SI) policy. The CCG noted that there is a robust governance process in place to manage SIs, Learning from deaths and Duty of Candour.

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.**



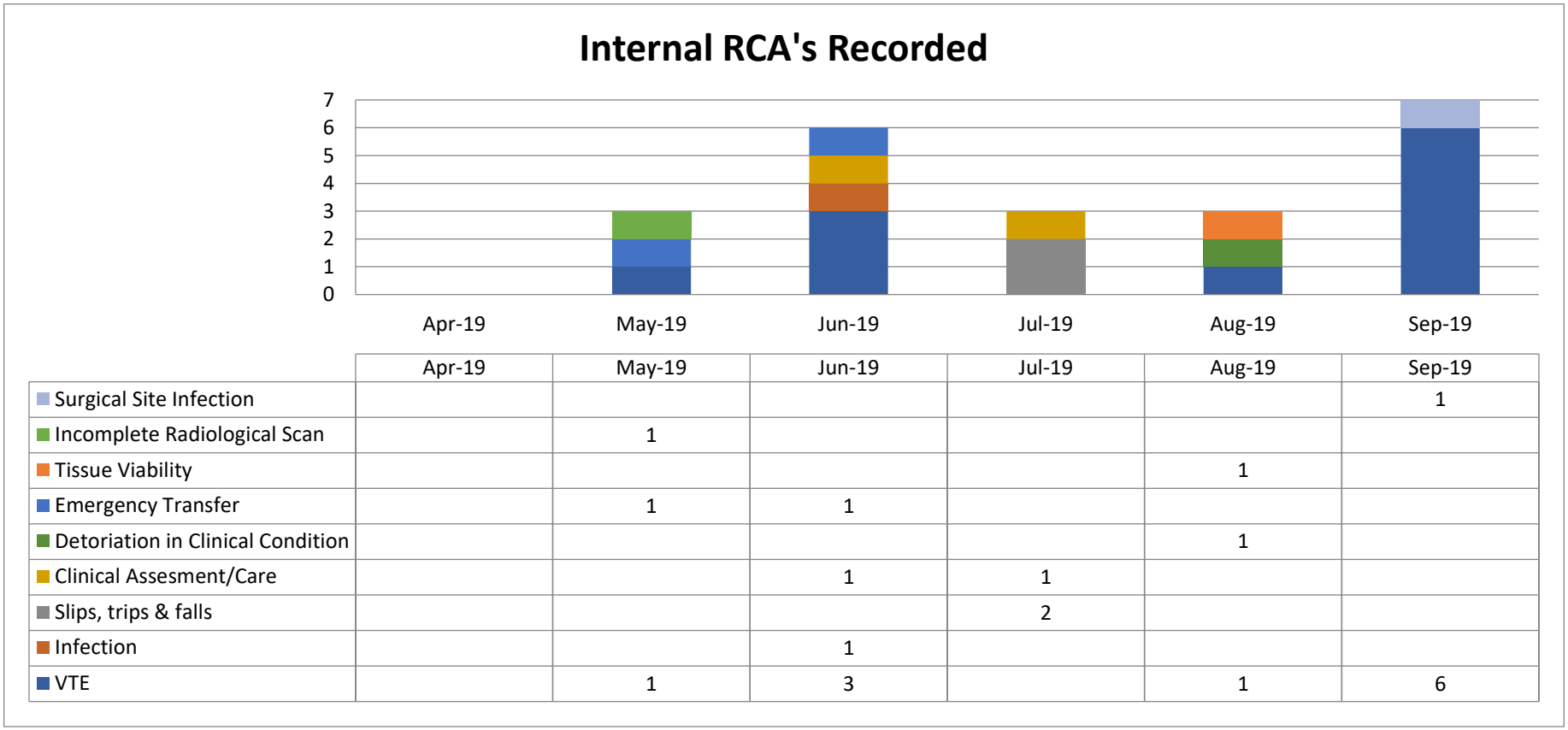
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Transfer out (Surgery)		2				
Wrong side Surgery			1	1		
VTE meeting SI criteria						1

Year Totals	
18/19	9
19/20	5

Data Source – STEIS

INFORMATION
There was one Serious Incident Reported. The detail has been scrutinised by the Quality & Safety Committee.
ACTIONS FOR IMPROVEMENTS / LEARNING
Four incidents are awaiting closure by the CCG. Two of the four have comeback from the CCG with further queries.
RISKS / ISSUES
None

4. **Internal RCAs - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All incidents declared as moderate harm or above are reviewed weekly at the Divisional Governance meetings. Each division makes a judgement based on the information available on whether an incident meets the serious incident framework. Internal RCAs incidents are not declared to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide, that a heightened level of response is needed for these incidents. Once investigated, if the incident is then deemed to meet the Serious Incident framework, it will be added to STEIS and reported to the CCG retrospectively.**

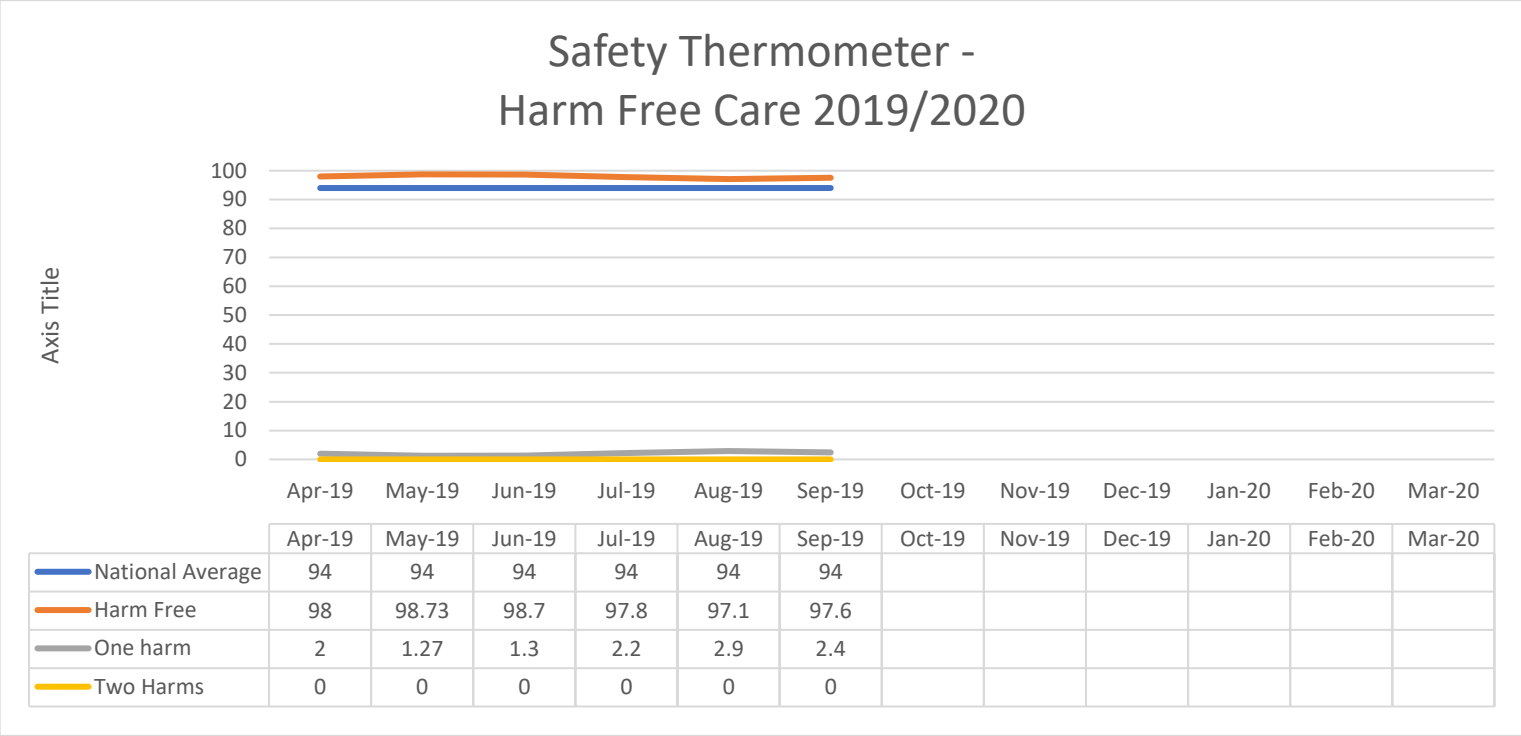


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Surgical Site Infection						1
Incomplete Radiological Scan		1				
Tissue Viability					1	
Emergency Transfer		1	1			
Detoriation in Clinical Condition					1	
Clinical Assesment/Care			1	1		
Slips, trips & falls				2		
Infection			1			
VTE		1	3		1	6

Data Source – Internal RCA tracker

INFORMATION
Seven internal RCAs were recorded.
ACTIONS FOR IMPROVEMENTS / LEARNING
Three RCAs were closed in September 2019. The detail, contributory factors, lessons learned and recommendations have been scrutinised by the Quality & Safety Committee.
RISKS / ISSUES
None

5. **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.**



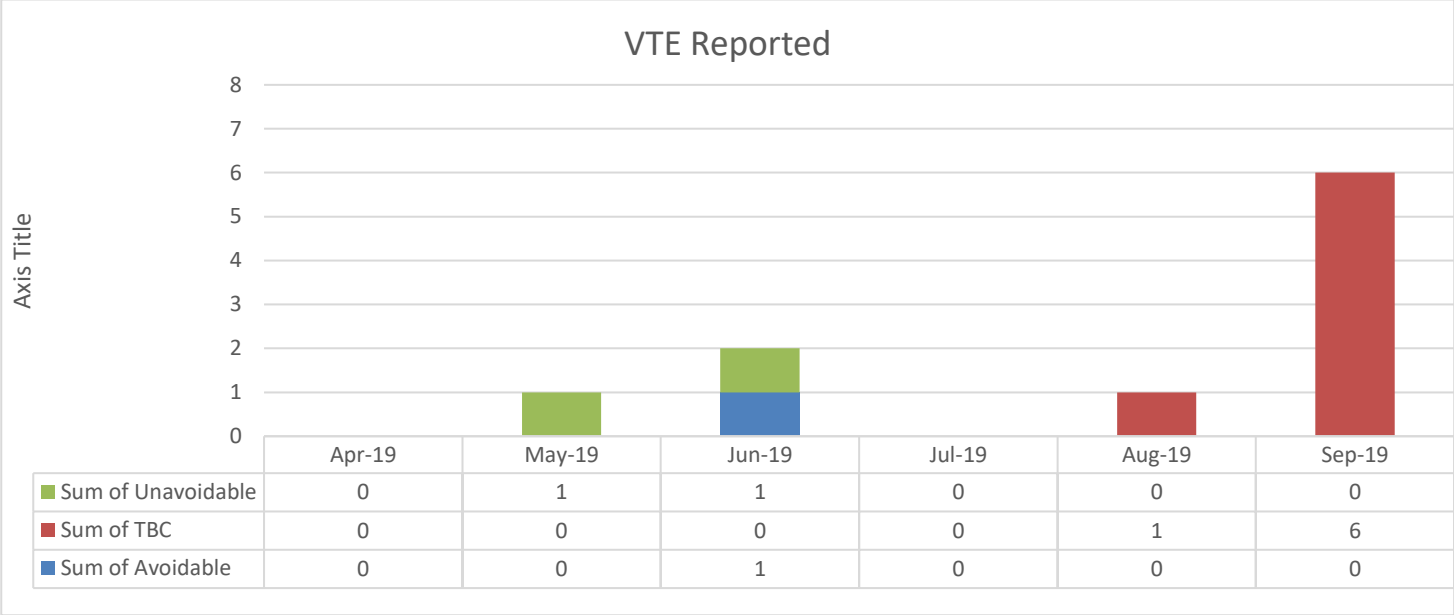
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
National Average	94	94	94	94	94	94						
Harm Free	98	98.73	98.7	97.8	97.1	97.6						
One harm	2	1.27	1.3	2.2	2.9	2.4						
Two Harms	0	0	0	0	0	0						

The Harms reported were;

5 x New no harm falls on Ward 3
1 x New Pressure Ulcer on Ward 12
1 x Old UTI on Ward 1
1 x Old PE on Ward 3

Data Source – Informatics

6. **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).**



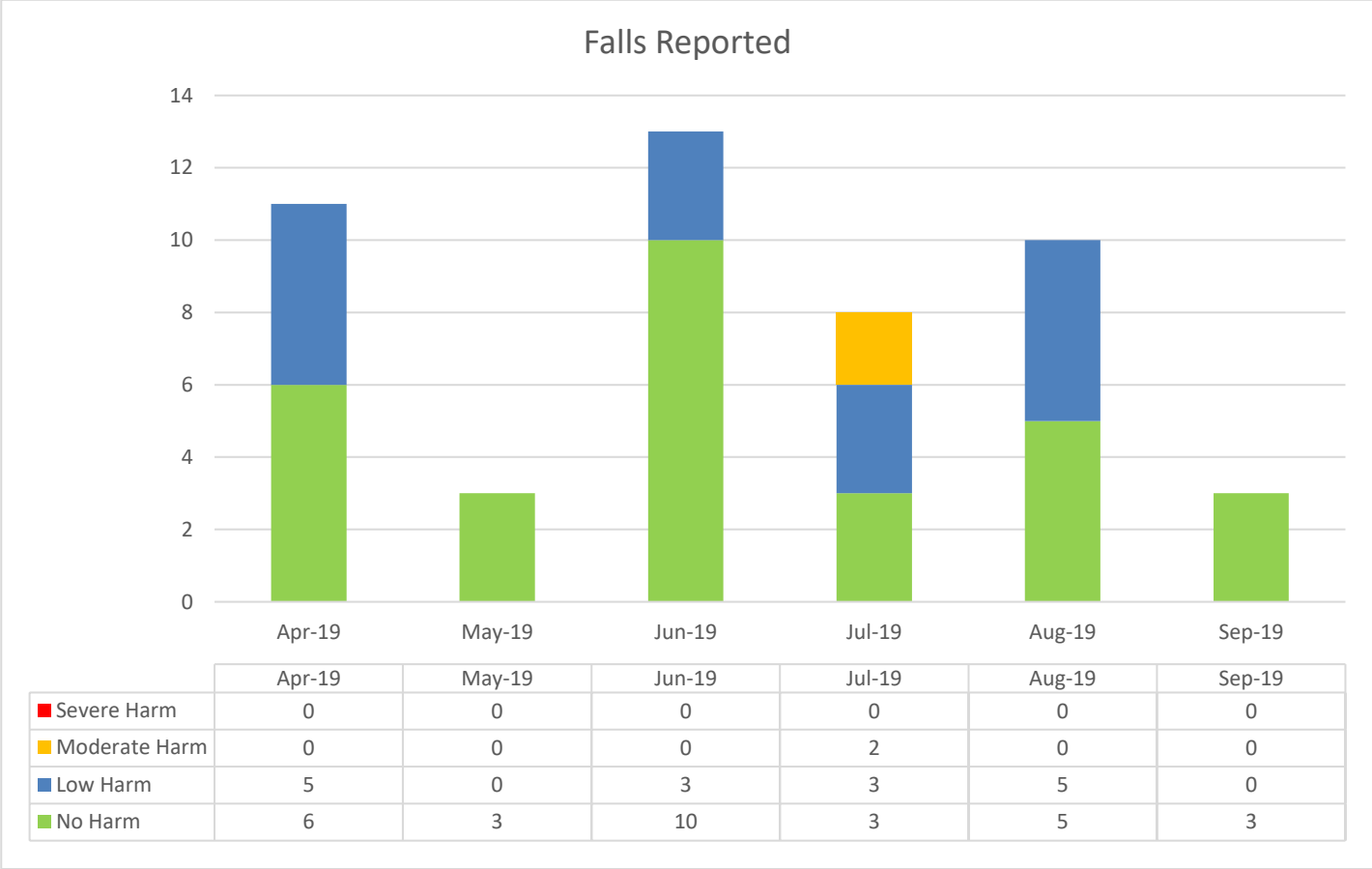
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Sum of Unavoidable	0	1	1	0	0	0
Sum of TBC	0	0	0	0	1	6
Sum of Avoidable	0	0	1	0	0	0

Avoidable Year Totals	
18/19	4
19/20	1

INFORMATION
There were six hospital-acquired VTEs reported in September 2019. On-going non-compliance regarding 24-hour re-assessment was 86.83% in September 2019 (83.23% in August). Monthly reports are provided to the relevant leads who have been given delegated responsibility by the Medical Director to address this. Compliance with on-admission risk assessment. The National requirement is >95%. ROH compliance for August was 98.08%. Report identifying patients and their named surgeon shared with Divisional leads and Medical Director-all the patients on the list are day cases.
ACTIONS FOR IMPROVEMENTS / LEARNING
On admission risk assessment is consistently above the nationally required 95%, however this has deteriorated and we should be aiming for 100% compliance. Actions and learning as above
RISKS / ISSUES
Non-compliance with on admission and 24-hour risk assessment as detailed above is not in line with national or Trust Guidance.

Data Source – Ulysses and VTE leads

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 fall's incident.**



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Severe Harm	0	0	0	0	0	0
Moderate Harm	0	0	0	2	0	0
Low Harm	5	0	3	3	5	0
No Harm	6	3	10	3	5	3

Year Totals	
18/19	88
19/20	48

Data Source – Ulysses and Falls Group

INFORMATION

There were 3 incidents reported across the Trust in September 2019 relating to Falls and 6 incidents involved patients being lowered to the floor:

1 x Out-Patient Falls Incident
2 x In-Patient Falls Incidents

No main theme to actual falls, although an increase in the number of patients lowering themselves to the floor. The incident involving the staff member was potentially avoidable.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions Underway

- Purchase of another Hover Jack – bid for funding from charitable funds made, committee due to review bid week beginning 21/10/19.
- Purchase of replacement hoists for the Trust – further capital bid successful but limit on funds, Marie Raftery, Deputy COO liaising with procurement around purchase.
- Looking at development of fragility fracture assessment upon admission or during pre-op for all patients at risk of a fall.
- Development of combined dementia/falls notification in pre-op assessment to identify patients at risk at an early stage.
- Continuing to look at patient engagement around Falls and how best we approach this.
- Reviewing information on Falls notice boards.
- Pro-active campaign around 'Call don't Fall' on the wards, looking at development of checklist to audit bathroom safety.

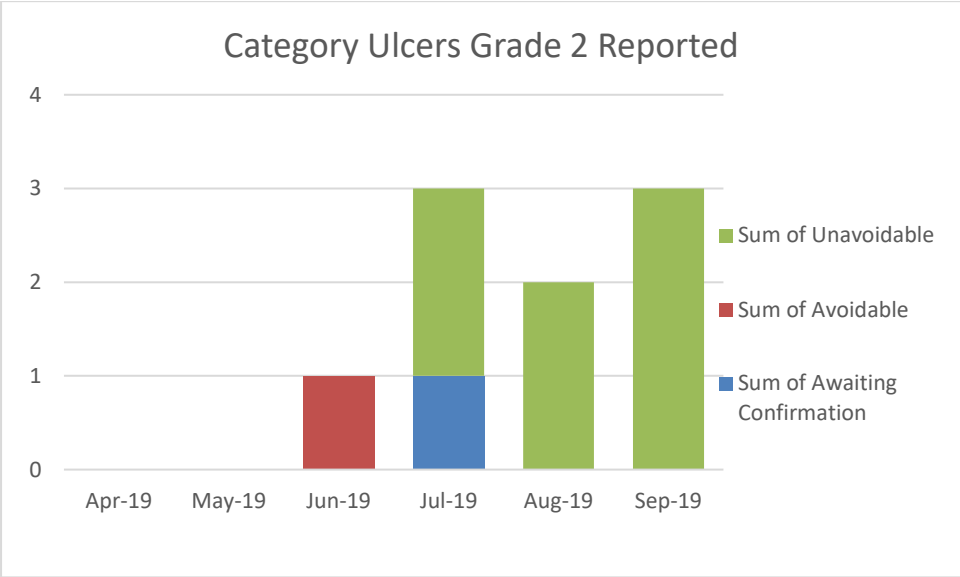
Positive Assurance

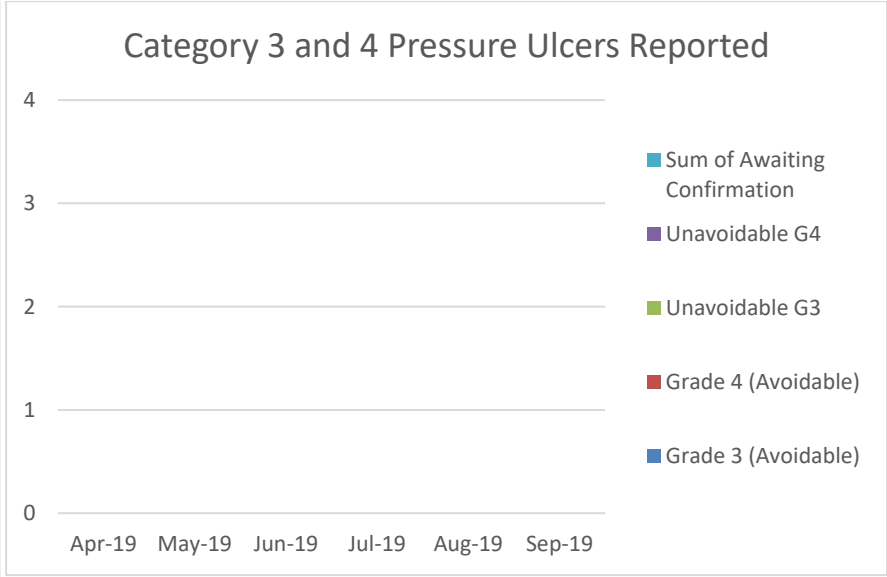
- Couple of patients expressed interest in providing representation on Falls/Dementia working group.
- On-going training around Falls awareness on clinical skills update days.

Email sent out to Trust membership to help identify how best to engage patients around Falls with positive feedback received.

RISKS / ISSUES
When current hoists fail/break no provision for replacement parts at present as now obsolete, will need to replace whole hoist, potential impact on staff/patient care if multiple hoists fail. Bid submitted to replace hoists Trust wide – now successful but limit on funds as above, procurement liaising. Only one Hover Jack available for the trust, this is also used for training, bid made to charitable funds, outcome awaited.

8. **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.**





Data Source – Ulysses and TV team

Year Total	Cat 2	Cat 3
18/19	15	3
19/20	1	0

INFORMATION

August 2019 Incidents – Hospital acquired

Category – 4	0
Category – 3	0
Category – 2 (Non-Device)	2 unavoidable
Category – 2 (Device)	1
Category – 1	2 unavoidable 1 avoidable
Suspected Deep Tissue Injury	2 under review
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Intertriginous dermatitis – 2 MASD ROH Incontinence- 2 MASD admitted with Intertriginous dermatitis 0 MASD admitted with Incontinence- 0

Patients admitted with PUs	PU admitted with Cat 1- 2 PU admitted with Cat 2- 3 PU admitted with Cat 3- 1 PU admitted with Cat 4- 0

Avoidable Pressure Ulcer CCG Contracts KPI

2019/2020	
Avoidable Grade 2 pressure Ulcers limit of 12	1
Avoidable Grade 3 pressure Ulcers limit of 0	0
Avoidable Grade 4 pressure Ulcers limit of 0	0

2018/2019	
Avoidable Grade 2 pressure Ulcers limit of 12	7
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENTS / LEARNING

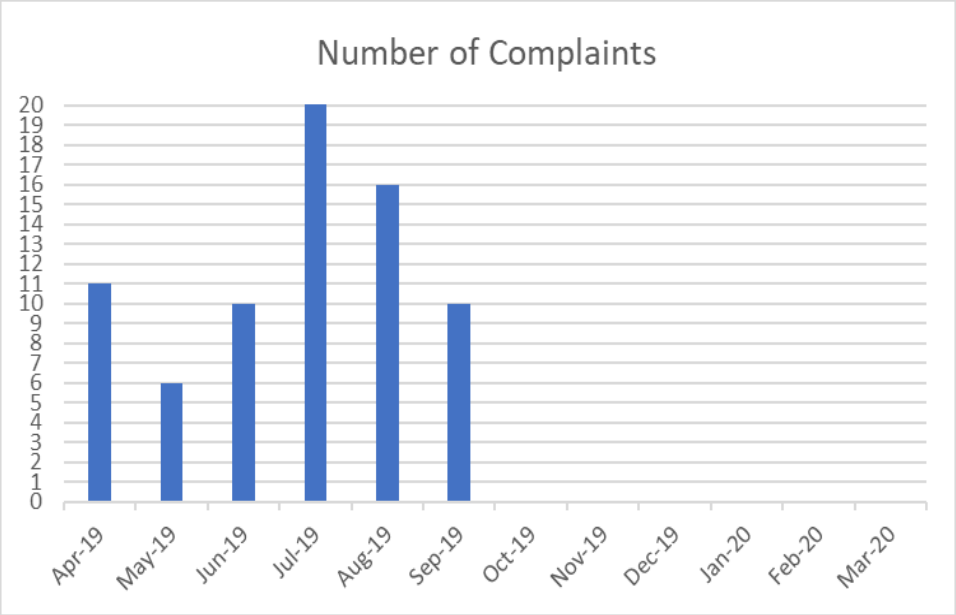
Current Actions

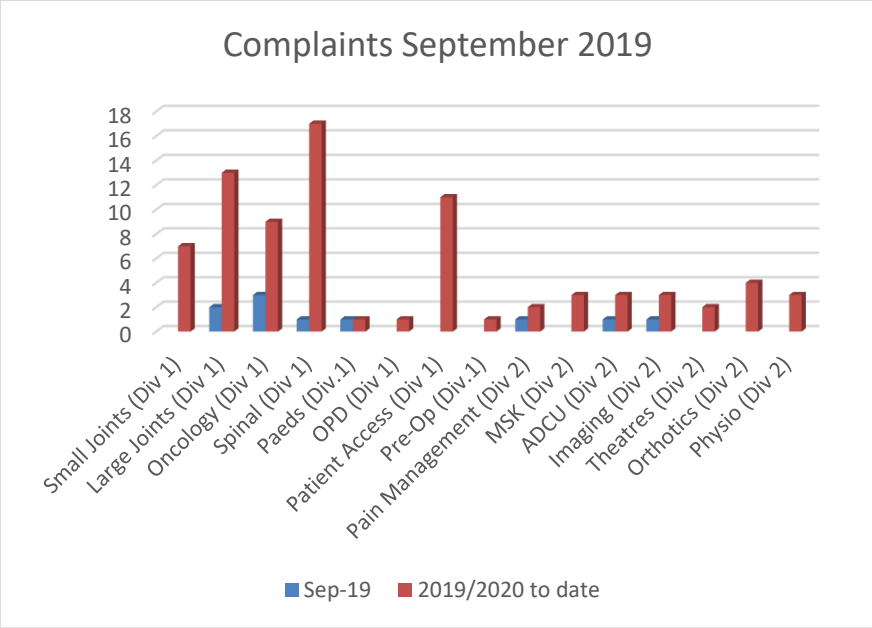
- Registered Nurses competency booklet has been updated with scenario questions relating to each type of pressure ulcer, MASD to increase knowledge.

RISKS / ISSUES

None

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.





Complaint Year Totals	
18/19	139
19/20	80

Data Source – Patient Experience team

INFORMATION

Complaints

There were 10 formal complaints made in September 2019. All were initially risk rated amber or yellow. This is lower than last year (15 complaints in September 2018).

Complaints September 2019	
Appointments	1
Clinical	1
Communication	5
Facilities	1
Prescribing	1
Privacy & Dignity	1
Trust Administration	3
Values & Behaviours	3
Waiting times	2

PALS

The PALS department handled 101 contacts during September 2019 of which 31 classified as concerns. This is an increase in calls compared to the same time last year (80 contacts in September 2018) with roughly the same number of concerns (34 concerns in September 2018). 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. In September 2019, 81% of enquires and 90% of concerns were handled within the agreed timescales, meeting the KPI.

PALS Concerns		
	Sep-19	2019-2020 to date
Access to treatment		9
Admissions & Discharges	4	8
Appointments	19	137
Clinical	3	45
Communication	2	18
Facilities	1	7

Patient Care		7
Trust Administration	1	20
Transport		2
Values & Behaviours		6
Waiting times		15
Other	1	2
	31	276

Compliments

There were 456 compliments recorded in September 2019, with the most recorded for Div. 1. The Patient Services Team now logs and record compliments expressed on the Friends and Family forms.

	Compliments Sept 2019
Div. 1	351
Div. 2	105
	456

Staff continue to be complimented on Values & Behaviours (64% of recorded compliments in September 2019) with an increasing number of compliments about Communication and Patient Care (both 17% respectively in September 2019).

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 13 complaints closed in September 2019, 9 within the agreed timescales. This gives an 69% completion on time rate and does not meet the KPI for the month, as indicated was probable in last month's report. This is due to a backlog of complaints created during the summer months due to capacity issues and it is likely that the KPI next month will also be affected as the backlog is addressed. The complaint process is being reviewed and the Executive Team have oversight of the issues and recovery plan.

The average length of time to close complaints in September 2019 was 36 days, which is higher than normal limits. This is due to the backlog previously mentioned and should resolve once this is cleared.

10 complaints were fully upheld, 2 were partially upheld and 1 was not upheld.

Learning identified and actions taken as a result of complaints closed in September 2019 include:

- Process for authorising referrals in Consultant absence is not always followed
  Action: Process is being reviewed with Clinical Lead and retraining will be provided

- Approach of Staff member not in keeping with Trust Values
  Action: Professional Conversation undertaken

- Appointment rescheduling can cause difficulties for patients
  Action: Patients offered more suitable appointment and partial booking system explained

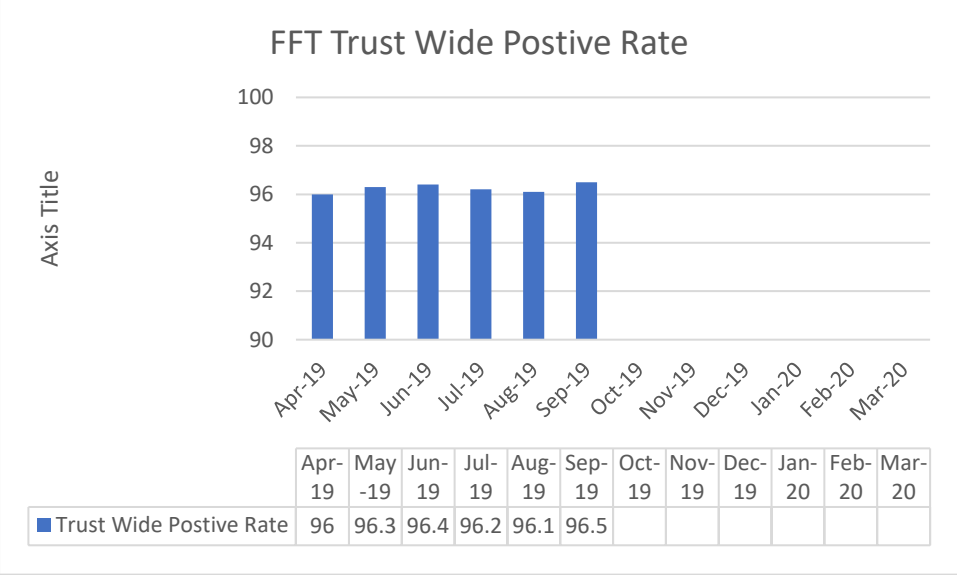
RISKS / ISSUES

Reduced Staffing in PALS and Complaints Service is presenting a risk in the high-quality service that ROH provides and expects for patients. A new member of staff has been appointed and should start with the team in the next two months.

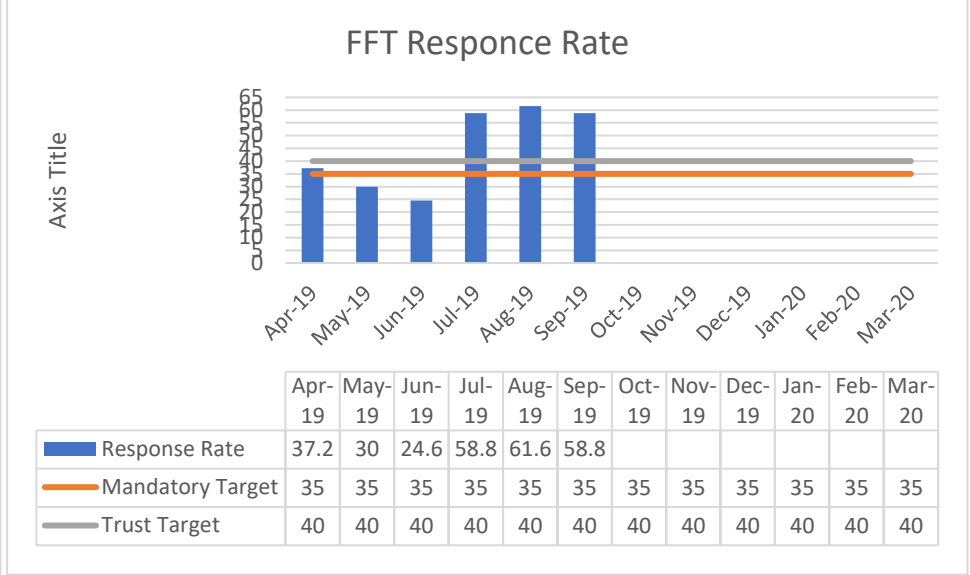
COMEBACK COMPLAINTS

No comebacks passed to Patient Services Team

10. Friends and Family Test Results (collected in the iwantgreatcare system)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Trust Wide Postive Rate	96	96.3	96.4	96.2	96.1	96.5						



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Response Rate	37.2	30	24.6	58.8	61.6	58.8						
Mandatory Target	35	35	35	35	35	35	35	35	35	35	35	35
Trust Target	40	40	40	40	40	40	40	40	40	40	40	40

Data Source – Patient Experience team and iwantgreatcare

INFORMATION

The Trust overall Inpatient response rate for September 2019 was 58.8%

ACTIONS FOR IMPROVEMENTS / LEARNING

The team are recording trends from FFT concerns and coding them with the Department of Health Complaint coding to allow comparison. In September 2019, 82 concerns were identified from the 1584 individual pieces of feedback we received. As these are anonymous, it is not always possible to track this back to individual patients but they are shared with the relevant teams and managers as additional feedback and to triangulate against other data.

FFT Concerns September 2019	
Admission & Discharge	7
Appointments	21
Clinical	7
Communication	9
Facilities	14
Patient Care	6
Staffing Numbers	4
Trust Administration	1
Values & Behaviours	7
Waiting times	5
Other	1

Information is 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 and the Trust Internal target of 40% for Inpatient Services this month. The internally set target of 20% for Outpatient services was also met this month. This information has been shared with Departmental and Directorate Leads

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. There are plans to audit the duty of candour process.

12. **Litigation**

New claims

0 new claims against the Trust were received in September 2019

On-going claims

There are currently 29 on-going claims against the Trust. 26 of the claims are clinical negligence claims. 3 claims are staff claims

Pre-Application Disclosure Requests*

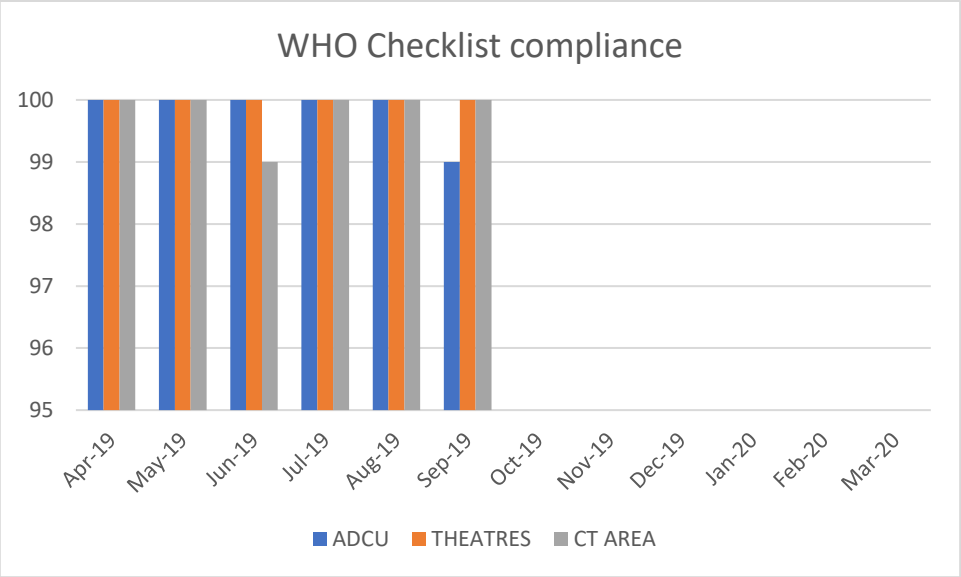
7 new requests for Pre-Application Disclosure of medical records were received in September 2019.

**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 General Data Protection Regulations 2018 and the Access to Health Records Act 1990)*

13. Coroner's Inquests

One inquest, the details of which were discussed by the Quality & Safety Committee. A narrative verdict was given by the Coroner and the Trust was not found to be negligent in its care of the patient.

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.



Data Source – Theatreman and local audits

INFORMATION
The data is retrieved from Theatre man. On review of the audit process, the incomplete 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 = 757 The total WHO compliance for Theatres in August 2019 = 100% **CT area** Total cases = 98 The total WHO compliance for CT in August 2019 = 100% **ADCU** The snapshot WHO audit compliance for August 2019 = 99%
ACTIONS FOR IMPROVEMENTS / LEARNING
Any non- compliance will be reported back to the relevant clinical area.
RISKS / ISSUES
WHO checklist for ADCU 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.

15. Infection Prevention Control – Statuary requirement/Reportable Infections. A detailed IPCC report is submitted to Quality and Safety quarterly.

INFORMATION

Infections Recorded in September 2019 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	1
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	1

ACTIONS FOR IMPROVEMENTS / LEARNING

3 IP recorded incidents in September, 2019:

RISKS / ISSUES

- Scheme of planned building works continues, for new theatres, poses an increased risk of cross contamination. Additional IPC precautions in place across site to reduce risk.
- 2 incidents relating to BCH associated patients presently under organisational incident review process.
- Hydrotherapy weekly water testing not undertaken since 12/9/19 due to media supplier issues at UHB. Estates Manager and ROH Authorised Expert for waters aware. Internal water quality tests continue for assurance.
- Increase in physical environmental concerns, that have infection prevention implications, have been recorded under “estates” as incidents.
- All clinical areas, with the exception of CYP, failed the August commode audit. Actions with each area have been undertaken and will be reported and monitored via August IPOG and divisional conditional reports.

***Data Source – IPC team and Ulysses**

16. Safegaurding

INFORMATION

Detailed is the Safeguarding KPI and figures. These were reported to the Safeguarding committee in September 2019.

	November 2018	December 2018	January 2019	February 2019	March 2019	April 2019	May 2019	June 2019	July 2019	August 2019	September 2019
Safeguarding Adult Notifications	11	14	26	14	21	15	14	26	23	16	19
Safeguarding Children and Young People Notifications	51	28	28	31	26	21	29	27	48	23	37
Mental Health Incidents	8	9	8	2	8	2	3	12	25	11	
LD Adult	12	10	12	8	14	8	5	8	16	13	
LD Children	26	24	28	25	24	21	46	28	49	26	
Adult Level 2	98.08	98.08	98.08	98.08	98.08	98.08	97.56	97.44	98.42	98.17	98.26
Adult Level 3	83.33	83.33	83.33	83.33	83.33	83.33	81.31	74.89	70.41	72.02	77.11
Level 4	80	80	80	80	80	80	80	50	100	100	100
Child Level 2	98.07	98.07	98.07	98.07	98.07	98.07	97.55	97.43	98.60	98.17	98.26
Child Level 3	86.64	86.64	86.64	86.64	86.34	86.34	77.71	73.99	68.18	71.22	75.52
Mental Capacity Act MCA						98.29	97.55	98.21	98.23	98.85	98.90
Deprivation of Liberty Safeguards DoLs						98.61	97.83	98.34	98.39	99.04	99.08
Prevent / WRAP							80.71		83.86	87.18	87.27
CE	0	0	0	0	0	0	0	0	0	0	0
FGM	0	1	0	2	0	2	1	0	0	0	0

DOLS	2	1	2	2	2	2	3	2	4	7	1
MCA	5	7	12	1	1	2	2	2	3	6	2
PIPOT cases	0	0	0	0	0	0	0	0	0	0	1
Domestic Abuse	0	0	0	2	4	1	1	0	1	1	3
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0
WNB	23	11	14	17	18	12	18	17	30	46	19
Child in Care	4	5	2	2	1	1	2	1	3	0	2
Early Help	0	0	0	1	0	0	0	0	0	1	1

ACTIONS FOR IMPROVEMENTS / LEARNING

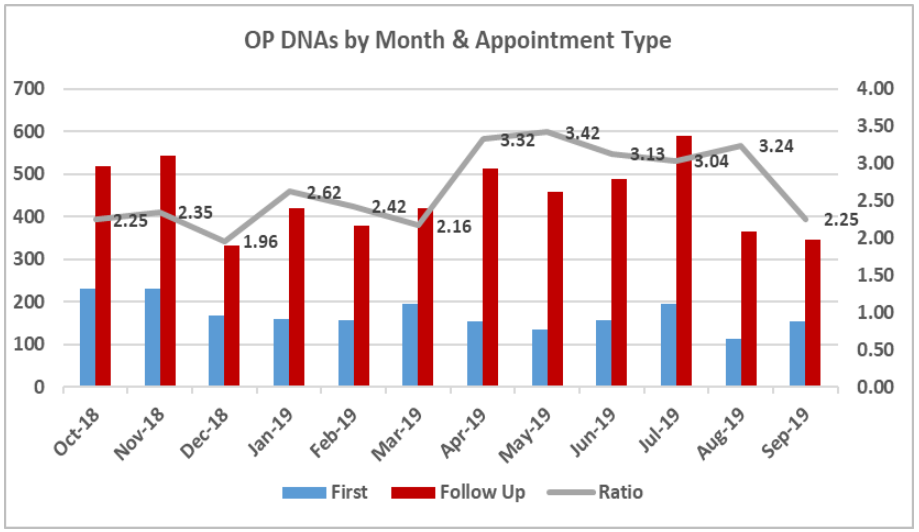
The Safe Recruitment policy is under review.

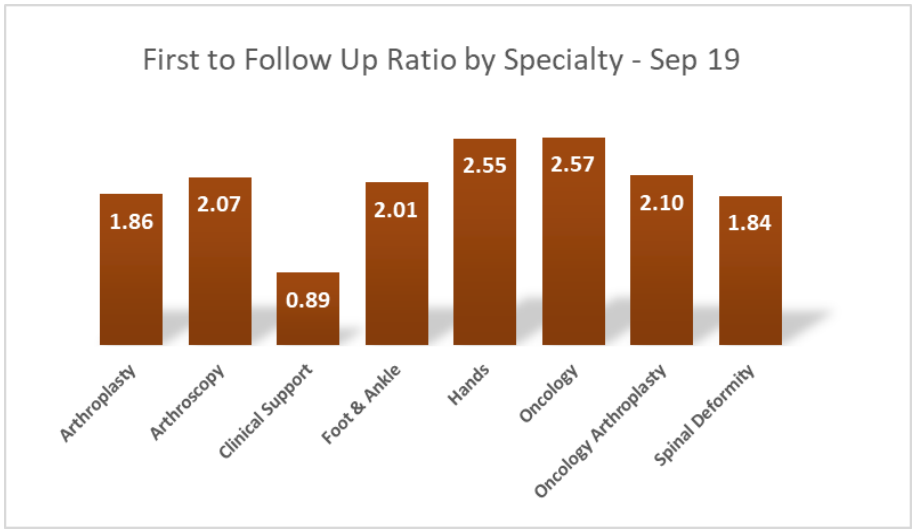
- Missing persons policy has been approved
- Chaperone policy has been extended

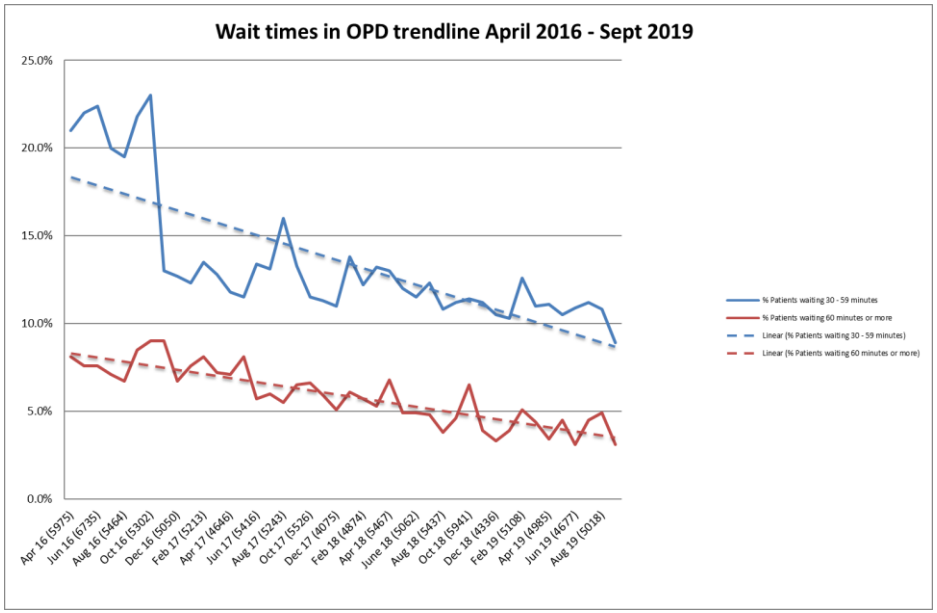
RISKS / ISSUES

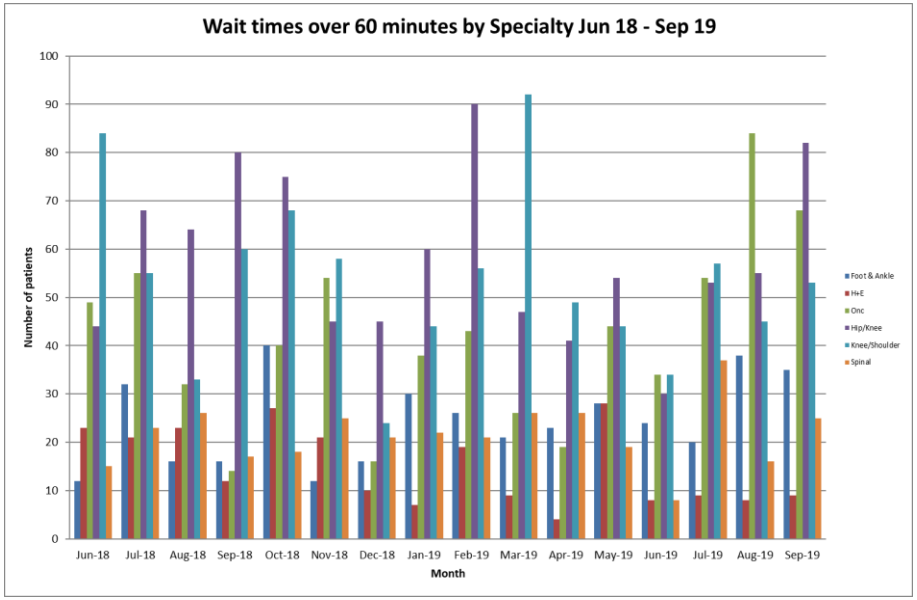
There has been a fall in training rates for WRAP, prevent and Safeguarding level 3 training; this is due to a review undertaken against the new training requirements for staff.

17. 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 8.9% of patients waiting over 30 minutes which is a 1.9% lower than the previous month. The over 60 minute delays continue to be achieve under the target of 5% with a level of 3.1% for July .This KPI is now consistently being achieved. A new method of creating the report is being used to take account of patients that arrive for their appointments late.

The 643 meeting is now maturing and is being held on a Thursday and there has been consistent representation from the imaging department. The Clinical Service and Support Managers are invited to attend as well as representation from Outpatients. There is a regular agenda that includes discussion of activity booked, capacity available in the coming weeks and rescheduling requests received with less than 6 weeks notice.

There were 22 incidents of clinic delays reported in September 2019 with the following breakdown.

5 Complex Patient
5 Other
4 X-ray delay
4 Clinic Overbooked
3 Consultant / Clinician Delay
1 Delay in Medical Records

Work is underway to review the co-ordination of clinics with Imaging capacity to reduce the number of delays associated with imaging and early work is encouraging with more patient receiving booked appointments within Radiology prior to their clinic appointments creating better flow in both areas and improving the patient experience.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The InTouch system needs to be upgraded in order to implement electronic outcomes and this is underway. Initial meetings have been held and a demo of the new system is being arranged
- DrDoctor has been implemented across all specialties, except Oncology. The DNA rate has dropped to under 8% for the last 2 months which would lead to more attendances from an average of 10% over the last year .

RISKS / ISSUES

- A meeting has been held with the Deputy Director of Operations to discuss the lack of space in the main outpatients department. A working group is to be set up and will run weekly to discuss the issue of clinic room capacity, particularly in relation to the extra capacity that will be needed when the new consultants arrive to fill the modular theatres. Alternative follow up methods are being scoped including virtual clinics and maximising the use of digital opportunities such as skype clinics.

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

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/09/2019

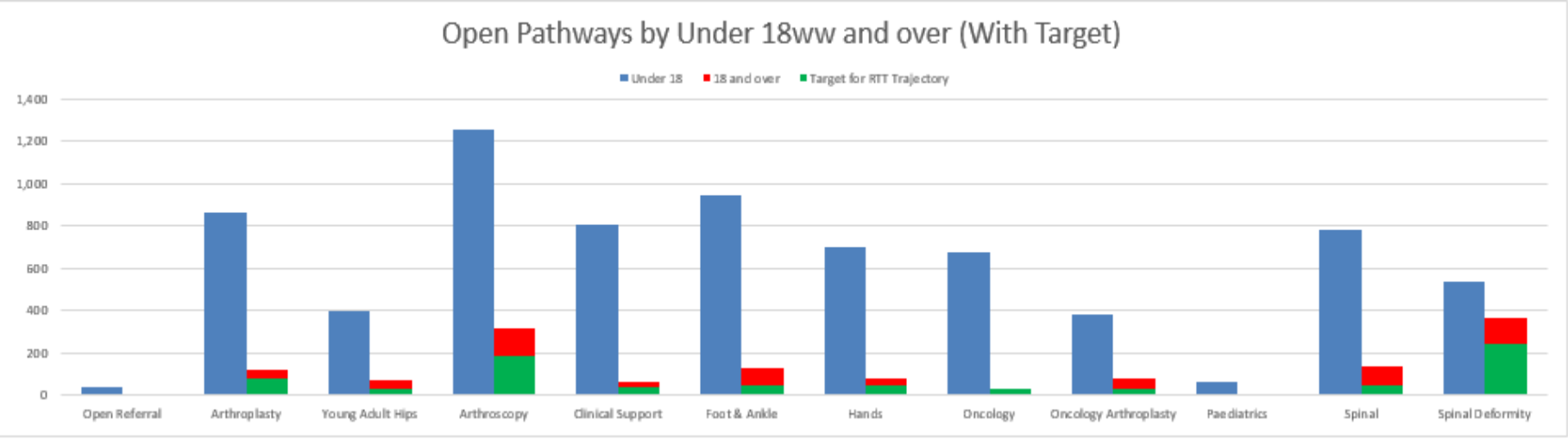
Est Over 18 Clock Stops Required		
To achieve	92.00%	883
To achieve	88.17%	479
To achieve	85.32%	154

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young	Spinal	Spinal Deformity
0-6	**3,506**	33	441	194	577	392	448	336	338	170	33	315	229
7-13	**2,798**	4	300	151	490	290	367	275	228	140	22	328	203
14-17	**1,148**	3	122	56	190	123	130	88	109	72	9	141	105
18-26	**1,072**	1	113	57	241	61	119	69	21	74	2	103	211
27-39	**326**	0	9	11	75	6	9	12	7	8	0	35	154
40-47	**18**	0	2	1	5	1	0	0	0	2	0	2	5
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8,868**	41	987	470	1,578	873	1,073	780	703	466	66	924	907

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,452**	40	863	401	1,257	805	945	699	675	382	64	784	537
18 and over	**1,416**	1	124	69	321	68	128	81	28	84	2	140	370
Target for RTT Trajectory	**790**	1	78	33	185	40	52	51	32	36	1	49	243
Target for RTT 92%	**709**	**3**	**78**	**37**	**126**	**69**	**85**	**62**	**56**	**37**	**5**	**73**	**72**

Month End RTT %	**84.03%**	**97.56%**	**87.44%**	**85.32%**	**79.66%**	**92.21%**	**88.07%**	**89.62%**	**96.02%**	**81.97%**	**96.97%**	**84.85%**	**59.21%**
30/09/2019 Trajectory RTT %	91.09%	96.70%	92.01%	92.94%	88.27%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	73.18%
Variance from Target to meet Trajectory	626	0	46	36	136	28	76	30	-4	48	1	91	127
Variance from target 92%	707	-2	46	32	195	-1	43	19	-28	47	-3	67	298



P

INFORMATION

The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. The current trajectory for all specialties is detailed above, it predicts that the Trust will return to 92% at an aggregated level by September 2019. This trajectory is currently being revisited in line with current capacity challenges relating to reduction in ADH capacity.

The September position is **84%**, this being lower than NHSI trajectory forecasted position of 92**%.** This shows a deterioration from last month. In September the Trust had **0** patients over 52weeks. There are **18** patients over 40 weeks against last month's position of **21.** An updated briefing paper was included in the F&P pack in July which detailed the details of the recovery plan. Detailed activity monitoring by individual specialty is shared weekly with the Executive Team and F&P Committee

ACTIONS FOR IMPROVEMENTS / LEARNING

All statutory targets achieved in August.

The patients who breached the consultant upgrade standard were down to complex pathways and delays in getting approval for Proton therapy.

Weekly Cancer PTL continues to monitor and track patients along the referral to treatment pathway

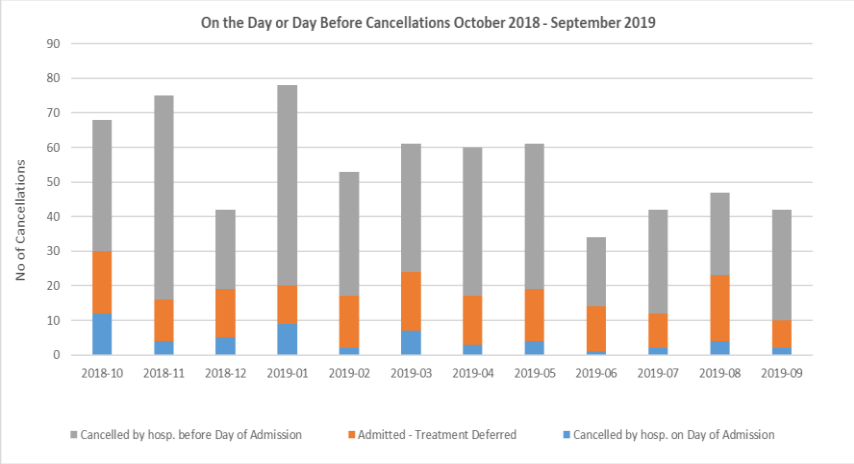
A review of the CT capacity to take place to ensure there is enough capacity to deliver the new target compliance of 28 FDS

RISKS / ISSUES

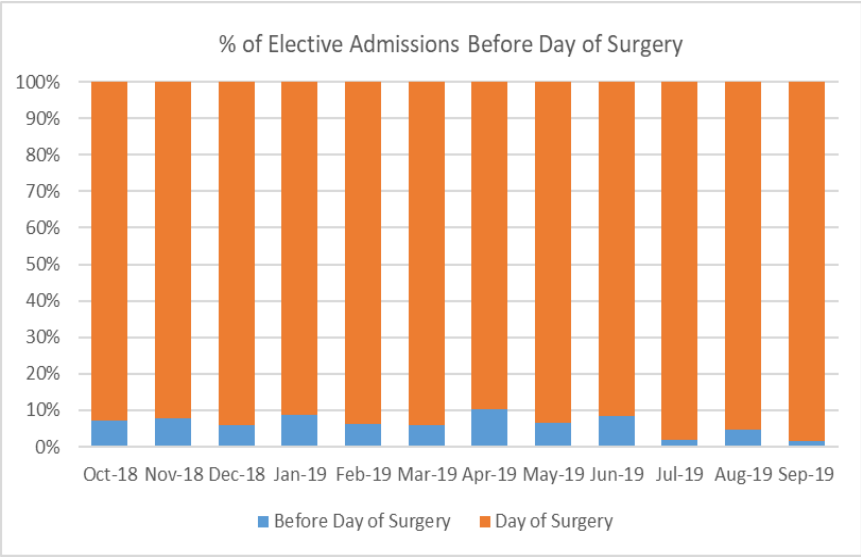
Paediatric Surgery has been suspended at Birmingham Children's Hospital. Predicted recommencement date is Jan 2020.

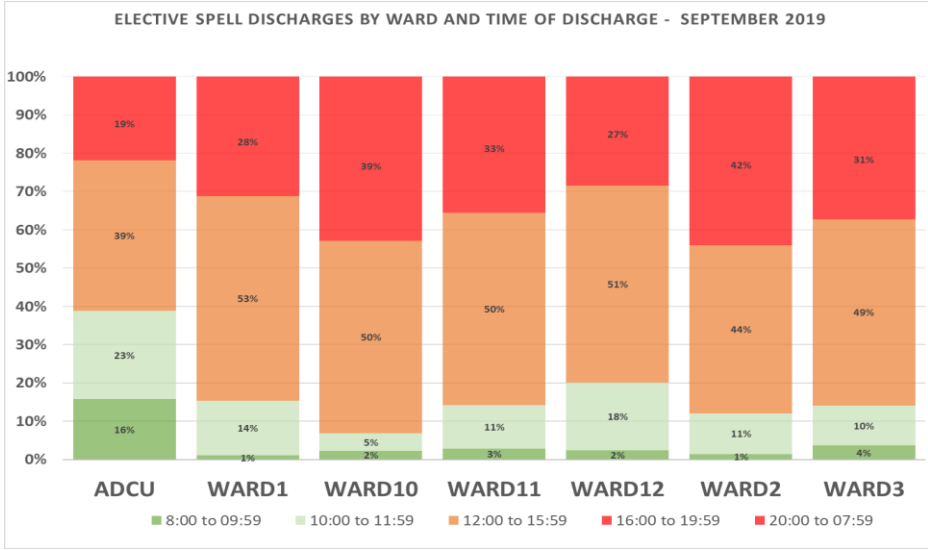
Oversight meeting with NHSI and the specialist commissioner are in place to ensure safe resumption of the service takes place. Patients with a planned date for surgery within this timeframe are being transferred to other specialist units across the UK. Predominantly Stanmore/ Oswestry will receive the majority of these patients.

19. 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



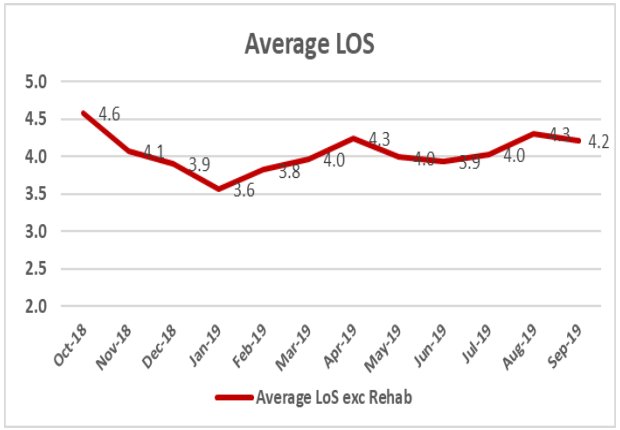
Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	43	60	0
2019-05	4	15	42	61	0
2019-06	1	13	20	34	0
2019-07	2	10	30	42	0
2019-08	4	19	24	47	0
2019-09	2	8	32	42	0
Grand Total	**55**	**166**	**442**	**663**	**0**

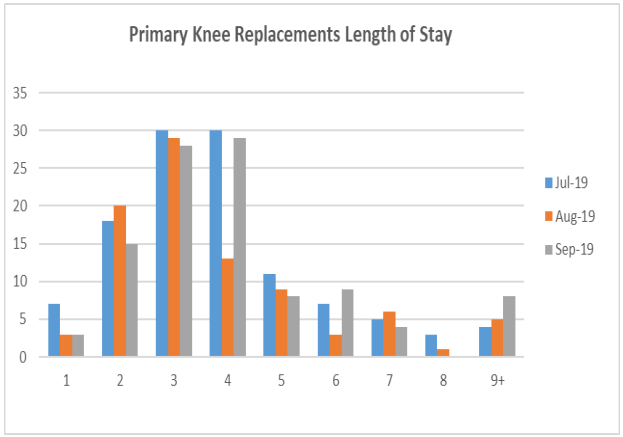


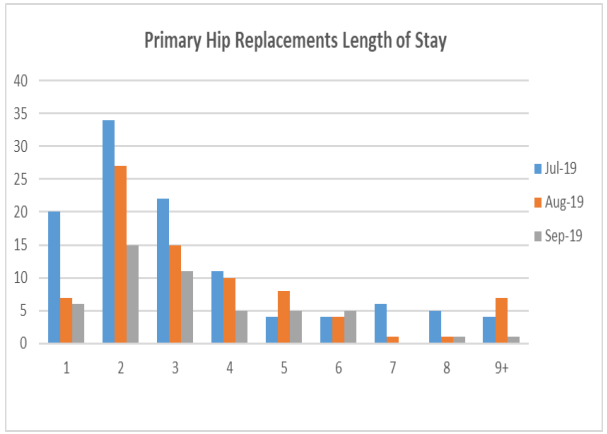


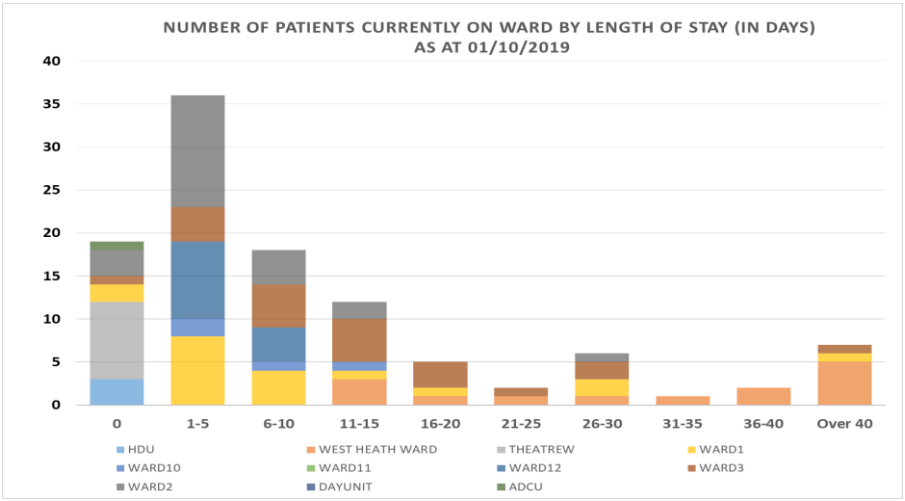
INFORMATION
The number of cancellations on the day of admission for surgery in September was 10 patients. Analysis of these cancellations on the day identified that 4 patients were cancelled due to lack of Theatre time, 2 for lack of theatre staff, 2 for admin errors, 1 because of a change in procedure on the day and 1 because a patient had no one to care for them at home. Cancellations before the day of surgery for September were 32 which has increased since last month but this remains below the last 12 month average of 37. An analysis of the 32 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, and patient medically unfit following preassessment. The 72 hour call to patients continues as business as usual and continues to work well. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day. The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance. The escalation process has also been strengthened to ensure any cancellations are picked up in a timely manner. A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.
ACTIONS FOR IMPROVEMENTS / LEARNING
As a result of POAC now attending the morning huddle, escalation processes improvements and the SOP for bookings implemented, this has resulted in better communication between POAC and secretarial teams
RISKS / ISSUES
The Managed Service Contract is progressing to completion.

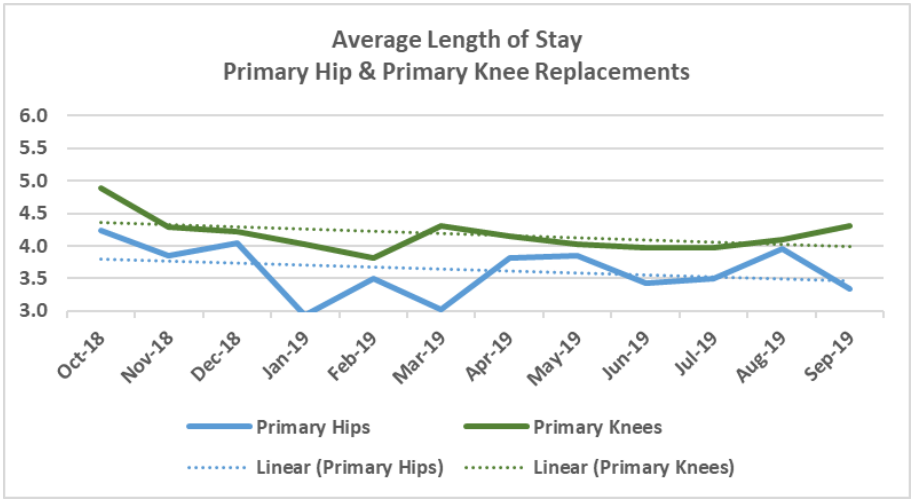
20. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Average LOS in September has fallen from 4.3 to 4.2 days

September data includes a considerable number of patients requiring social packages and additional medical needs that impacted on the average LOS in month.

A further analysis of the August data suggests that oncology arthroplasty had a significant impact on length of stay data with an average LOS of 5.6 in comparison to 3.6 for non-oncology arthroplasty. A further review of the upper 10% LOS indicates that over 10% (oncology arthroplasty) versus 2.8% (arthroplasty) of patients respectively will have a stay of 11 days or greater. This might suggest why the JointCare data is so different from the data produced via business intelligence. (Joint care data now included in pack)

A similar review of this months data (Sept 2019) shows a continued variation when primary arthroplasty data (hips and knee) were split on a arthroscopy/arthroplasty and oncology basis (3.2 days vs 6.3 days average LOS respectively).. This suggests further improvements on LOS within the JointCare patients month on month.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a number of initiatives agreed to refocus reduction in length of stay including:

- A weekly review by Division 1 Operations team into LOS and activity.
- A review of the Red to Green data as it matures as a dataset (trends are POC on Ward 1, physio assessment IV Abs and x-ray on Ward 2, wound reviews on Ward 3 and POC on Ward 12.
- Daily review of patients with LOS greater than expected LOS by senior ward and discharge nursing team.
- With the support of the Medical Director renew need for senior review on a daily basis on every patient.
- Continue to utilise Discharge Lounge – noting that usage increases month on month.
- The JointCare data is now to be included in the integrated performance dashboard which is currently being developed.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Out of hours roaming Admin to support timely discharge.
- Pathology issues still being raised via Ulysses when delays occur and escalated appropriately – no current ongoing issues identified.
- Review LOS dataset combining with GIRFT dataset looking at LOS against prevalent operation codes in speciality.
- Further improvements identified in the use of Ward 4 for JointCare to allow all arthroplasty patients to benefit from the service fully.

RISKS / ISSUES
• A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity. • Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

21. – CAS Alerts - The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

5 CAS alerts reported in September 2019

CAS ALERTS (1 Sep - 30 Sep 2019)

Reference	Originated By	Issue Date	Response	Deadline
MDA/2019/031	MHRA Medical Device Alerts	30-Sep-19	Action Not Required	28-Oct-19
EFA/2019/004	NHS Improvement Estates and Facilities	19-Sep-19	Action Not Required	17-Oct-19
MDA/2019/030	MHRA Medical Device Alerts	18-Sep-19	Action Not Required	11-Dec-19
CHT/2019/001	CAS Helpdesk Team	17-Sep-19	Disseminated to CAS team for information.	16-Dec-19

The following CAS Alert is being assessed for relevance;

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
MDA/2019/029	Deltec Gripper non-coring needles and PORT-A-CATH trays containing Gripper needles: recall due to risk of needle occlusion. Manufactured by Smiths Medical: due to a manufacturing process failure, needles may be occluded, potentially causing a delay to treatment.	MHRA Medical Device Alerts	12-Sep-19	Assessing Relevance. *Gripper needles held on Ward 3.* ***Awaiting response from ward manager*** *– 'check your batch numbers - are your needles affected'?*	05-Dec-19

ROHTB (11/19) 014

TRUST BOARD

DOCUMENT TITLE:	**Healthcare Worker Flu Vaccination**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Angela Howling, Head of Infection Prevention & Control**
DATE OF MEETING:	**6 November 2019**

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 2019. This self-assessment is attached as paper ROHTB (11/19) 014 (a).

The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families. Provider flu plans for 2018/19 saw a national uptake rate amongst front line staff of 70.3%, with some organisations vaccinating over 90% of staff. To support the improvements in vaccination uptake the healthcare worker flu vaccination CQUIN continues this year with new thresholds for payment set at 60% (minimum) and 80% (maximum).

Healthcare workers with direct patient contact need to be vaccinated because:
a) Flu contributes to unnecessary morbidity and mortality in vulnerable patients
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

Whilst the overall uptake of the vaccination has increased each year since 2015/16, there is significant variation in the uptake rates across trusts. In 2018/19 ROH achieved a frontline healthcare worker flu vaccination uptake rate of 58.1%. This put the Trust in the lower quartile of trusts.

Each trust that was in the bottom quartile for vaccination uptake (at 61.7% or below) in the published data (Immform in 2018/19) will be required, in 2019/20, to buddy with a higher uptake trust. It is suggested that working with them will provide an opportunity to learn how to prepare, implement and deliver a successful vaccination programme. The Trust's Head of Infection Prevention has a buddy system in place with the Lead for Infection Prevention from UHB. Progress will be reviewed weekly during the flu season by regional teams, for trusts in this quartile, in addition to the monthly reporting that is provided

to PHE via Immform. In addition, it is strongly recommended that trusts work with recognised professional organisations and trade unions to maximise uptake of the vaccine within the workforce.

An evaluation of last year's flu season showed that trusts that have developed a multicomponent approach have achieved higher uptake levels. Innovative methods to reach staff, going ward-to-ward, holding static and remote drop-in clinics and encouraging staff to contact vaccinators directly have been established. Trusts also used incentives however, above all Board and ward leadership are critically important to promote vaccination to staff, providing visibility and transparency.

REPORT RECOMMENDATION:

In order to support the improvements in healthcare worker flu vaccination the Board is asked to:

- RECEIVE and NOTE the update
- AGREE to provide positive leadership and support in taking the campaign forward and promoting the benefits of the vaccination programme.
- NOTE that the apportionment of vaccines over a scheduled time period may encourage staff to seek vaccination from other outlets e.g. GP, pharmacies, supermarkets. Whilst these numbers may be captured, for data recording, a reduction in uptake of vaccination given on Trust premises may be seen.

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:

BAF risk WF21 – the attraction and retention of staff

PREVIOUS CONSIDERATION:

This is the first update on the 2019/20 Flu campaign by the Trust Board.

The Royal Orthopaedic Hospital NHS Foundation Trust

FOR ASSURANCE

Healthcare Worker 'Flu Vaccination – Self-assessment as at October 2019

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. **This was commenced alongside 2019/20 flu vaccination campaign.**	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers. **700 vaccines ordered for the campaign. These were apportioned, by the dispensing company over a three month period (see below) to reduce stock piling and provide equity across the health economy.** **27/09/2019 25 250 vaccines** **18/10/2019 21 210 vaccines**	
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt. **Received from the Assistant Director of Finance.**	
A4	Agree on a board champion for flu campaign. **Director of Nursing and Governance / Director of Infection Prevention and Control.**	
A5	All board members receive flu vaccination and publicise this. **Board members received vaccinations and the publicity used to launch the flu campaign 2019/20.**	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives. **Flu campaign team formed prior to campaign commencement with two representatives from each ward and department.**	
A7	Flu team to meet regularly from September 2019. **Meetings scheduled monthly from April 2019 – September 2019 and weekly October 2019 – March 2020.**	

B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions. **Supported by required staff and regular publishing, provided by a dedicated Trust communication link, cascaded**.	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper. **Scheduled 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. **Board members received vaccinations and the publicity used to launch the flu campaign 2019/20. Senior managers receiving vaccinations, as part of on-going campaign.**	
B4	Flu vaccination programme and access to vaccination on induction programmes. **Vaccination information provided to HR, from the Head of Infection Prevention, to include in new starters packs and vaccinations available**	
B5	Programme to be publicised on screensavers, posters and social media. **Supported as B1.**	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups. **Provided by the dedicated communications link, via a "Flu-ometer" displayed on the Trust Intranet, with data support from 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. **Each ward and department has 2 named and trained peer vaccinators**.	
C2	Schedule for easy access drop in clinics agreed. **Flu vaccination clinics agreed, scheduled and advertised.**	
C3	Schedule for 24hour mobile vaccinations to be agreed. **Trained vaccinators available to cover the 24hour shift patterns.**	

D	Incentives	
D1	Board to agree on incentives and how to publicise this. • **Cake available at all flu vaccination clinics** • **On vaccination a red informative flu thankyou card given from the CEO** • **Monthly prize draw for staff vaccinated that month** • **End of campaign draw to include all staff vaccinated** • **End of campaign draw for highest vaccinator** **Information publicised by the dedicated communications link.**	
D2	Success to be celebrated weekly. **Provided by the dedicated communications link with data support from the Assistant Director of Finance.**	

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Inspection – 15th - 17th October 2019**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Nursing & Clinical Governance**
AUTHOR:	**Stacey Keegan, Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

The attached letter (ROHTB (11/19) 015 (a) dated the 18th October 2019 is a summary of the feedback received from the CQC following their unannounced inspection of the Royal Orthopaedic NHS Foundation Trust from the 15th to the 17th October 2019.

This letter does not replace the draft report and evidence appendix that the Trust will receive in due course, following the Well-led element of the inspection process that is planned for the 12th November 2019.

The CQC inspected two core services; surgery and critical care; the summary letter provides a breakdown of the positive findings and areas of concern (some of which remedial action was taken at the time), that the CQC fed back verbally to the Executive team on the 17th October 2019.

The Deputy Director of Nursing and Clinical Governance has developed a responsive action plan, attached as paper ROHTB (11/19) 015 (b). The key areas of focus include:

- Evidence of LocSIPS and NatSIPS within critical care

These are local and National standards for invasive procedures, that were developed to help Trust's provide safe care, and reduce the number of patient safety incidents related to invasive procedures, including those performed outside of the operating department.

- Inconsistency with staggered admissions; resulting in patients being fasted for longer than necessary.

The CQC recognised that this is one of the Trust's Quality Priorities for 2019/20.

- Gaps in Level 3 Safeguarding training.
- Ward 12 beds (two bays); privacy, dignity and safety concerns.

A risk assessment has been completed and documented by both the Matron and Health and Safety Advisor; no safety concerns have been identified in relation to the space and the ability to respond to an emergency/access a patient. Actions are in discussion regarding the use of the beds/space going forward.

REPORT RECOMMENDATION:

The Trust Board asked to:

- Note and accept this summary.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**X**	Environmental		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:					
Regulatory – CQC					
PREVIOUS CONSIDERATION:					
Quality & Safety Committee on 30 October 2019					

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

SENT BY EMAIL

Ms Jo Williams
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
West Midlands
B31 2AP

18 October 2019

CQC Reference Number: INS2-5468751521

Dear Ms Williams

Re: CQC inspection of The Royal Orthopaedic Hospital NHS Foundation Trust

Following your feedback meeting with Zoe Robinson, Inspection Manager, Matthew Corden, Inspector, Caroline Bell, Inspector, Sarah Hill, Assistant Inspector and Michael Perham, Analyst on 17 October 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Garry Marsh, Simon Grainger-Lloyd, Matthew Revell, Steve Washbourne and Marie Peplow at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 17 October 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

Surgery

- We found there was good learning from incidents and dissemination of learning.
- World Health Organisation (WHO) surgical checklists were well completed.

- Mandatory training was well managed.
- We noted a good multidisciplinary team approach to the management of the patients' care.
- Staff were observed to be very caring and there was good emotional support for patients with cancer.
- We noted examples of where services were adopted around the individual patients' need.
- There was a culture of empowerment and positivity. Staff felt valued and local leadership had been strengthened across the trust.
- The learning disability nurse had been mentioned several times on how they had progressed knowledge around supporting patients with learning disabilities and staff felt more confident when providing care as a result.

We also fed back some areas of concerns:

- We raised on 15 October 2019 issues regarding resuscitation trolleys not being tamper proof, we noted this has now been resolved.
- Cleaning checklists were inconsistently completed.
- Notes trollies were not locked consistently across the service. Patient information (admissions sheet from 14 October) was also found on ward 12 in the store area corridor.
- Feedback varied between wards and departments regarding visibility of the senior management team.
- There were two bays on ward 12 which did not adhere to Health Building Note guidance. We raised several issues around this including privacy and dignity being compromised. A further concern was that if a patient deteriorated, a patient in the next bed would need to be moved out of the bay to enable staff to take a resuscitation trolley to treat the deteriorating patient and delaying urgent treatment, as well as compromising privacy and dignity. Physiotherapy staff also raised the limited space around the beds was causing a problem when working with a patient. Staff told us this was on the risk register, but we were unable to see evidence of this. During the feedback, you expressed this would be on the ward risk register.

Critical Care

- Staffing levels had increased and a lot of work had been carried out regarding recruitment.
- Mandatory training had improved.
- Significant improvement to the environment was noted by the inspection team.
- There was a positive incident reporting culture and staff were aware of the processes to follow, with learning being shared.
- Intensive Care National Audit and Research Centre submissions are now completed.
- There was close working with the rapid response team. It was also noted there was good engagement at handovers and handovers took into account patient needs.
- We observed compassionate care and staff respected privacy and dignity needs.
- Leadership had clear lines of accountability with a clear vision in place.

- There was a good culture and morale within the service.
- The ward clerk on critical care unit was extremely passionate, they were dedicated to ensuring data quality was optimal.

We also fed back some areas of concerns:

- Out of seven patient records reviewed, two did not document whether the consultant reviews within 12 hours had been completed. On further investigation the inspection team found this had been done, therefore identifying a documentation issue.
- There was no evidence regarding LocSIPS and NatSIPS.
- Staff expressed anxiety around being taken over by another trust.

Complaints

- All complaints we reviewed were noted to be investigated and responded to in line with the trust policy.
- The complaints policy was due for review in September 2019, we were informed a six month extension had been given to review this, however we have not seen any evidence to confirm this.

Serious Incidents

- The duty of candour policy outlines clear responsibilities in line with regulation 20 of the Health and Social Care Act.

FPPR

- We noted annual self declarations were now being completed and this was evidenced in the files we reviewed.
- We reviewed 11 files in total, of which:
    - Six did not have a recorded Disclosure and Barring Service (DBS) number.
    - Two did not contain references.
    - One file contained limited information, no (DBS), no references, no employment history / curriculum vitae.
- The inspection team agreed to provide you with the names of the files with gaps in case this evidence is stored elsewhere.

Learning from Deaths

- The policy has been reviewed and amended slightly since our last inspection.
- A tracker was in place to ensure the process was followed appropriately and all actions / lessons learnt were highlighted as necessary.
- An update was given quarterly to trust board and we noted adherence to the reporting structure detailed within the policy.

At the time of the feedback meeting we also raised some queries, which you provided some clarity on:

Surgery

- Safeguarding children training for level 2 within the ward areas was not completed. You confirmed level two training was provided as mandatory

training, however there were identified gaps within level 3 which the executive team are aware of and a plan was in place.
- There was an inconsistent approach to day cases in the sense of no differentiation between morning and afternoon patients, therefore some patients were fasting for a longer period of time than required. It was confirmed this was a quality priority identified this year to start to stagger patients on admission although it has been identified that some clinicians are not adhering to this.

Serious Incidents

- We reviewed five route cause analsis's (RCA) and we had no concerns around the investigation process although it was noted two different formats of the RCAs were being used. You raised historically there had been two formats, however this was under review and changes were bring made to the template to aid improvements in the investigation process.

FPPR

- We reviewed the policy and noted annual DBS checks had been removed. It was confirmed it was being reinstated to carry out DBS checks for the executive team on a three year basis.

Learning from deaths

- Within an unexpected death review, there were concerns regarding documentation throughout including senior clinician, anaesthetic review perioperatively and pharmaceutical. The lack of documentation was noted in the standard judgement review form as an emerging theme, although only pharmacy was discussed at the roundtable discussion which may have been appropriate to not discuss specific concerns around an individual. Other actions taken are detailed in the tracker, although we raised how did you know the other actions had been carried out. It was confirmed relevant discussions had occurred with the relevant professional bodies and the clinician continued to be monitored.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Zena Young at NHS Improvement.

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.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
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If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Bernadette Hanney

Head of Hospitals Inspection

c.c. Dame Yve Buckland, Chair

Zena Young, NHS Improvement

Louise Grifferty, CQC regional communications manager

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Safeguarding Training Level 2 and 3 -CQC Action Plan – October 2019

Monitoring body (Internal and/or External):	Quality and Safety Committee
Reason for action plan:	CQC - Unannounced inspection – October 2019
Date of action plan approval:	29th October 2019 at the Executive Team meeting
Executive Sponsor:	Mr Garry Marsh – Executive Director of Nursing and Governance – Safeguarding Executive Lead
Operational Lead:	Evelyn O'Kane – Safeguarding Lead Nurse
Frequency of review:	Monthly
Date of last review:	22nd October 2019
Expected completion of action plan:	31st March 2020

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1	**Staff being able to describe having received - Level 2 training for Safeguarding**						
1.1	Level 2 training is delivered on core mandatory training – Presentation clearly indicates this at the beginning of the session for all staff Level 2 is the min level received by all staff updated annually Confirmed -and CQC provided with training presentation.	GM	EOK	31st October 2019			
1.2	Certificate of attendance for core mandatory will clearly indicate the Level of SG training.	GM	CF	1st November 2019			

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1.3	Add a Question to core mandatory training regarding level of training – to monitor staff response each session.	GM	JM	30th November 2019			
1.4	Trust wide communication to reinforce to staff the levels of training offered and why and how these are achieved.	GM	EOK	30th November 2019			
1.5	Ward/Departmental Managers to ensure as part of PDR review that the Level of SG training required and obtained is discussed and recorded as required per job role. Also confirmed on appointment to post as part of local induction and recorded.	GM	Ward/Departmental Managers	31st January 2020		L+D to be requested to put out comms and raise awareness, Consider to raise via team brief.	
2	**Safeguarding Level 3 – Children's Staff on inpatient wards caring for 16-18-year olds – CCG assurance visit recommendation -Oct 2019**						
2.1	An on-site Clinical Site Coordinator, trained at level 3, available 24 hours a day, 7 days a week for advice, knowledge and support.	GM	EOK	Completed prior to developing the action plan.		All Band 6 and 7 Nursing staff trained to level 3 prior to commencing on the Clinical Site Coordinator rota. Forms part of Trust Induction for this staff group.	

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
2.2	TNA for Level 3 training increase in staff eligible due to adult intercollegiate document, August 2018 (all registered nurses) Focusing on front door service areas: - • OPD • POAC • ROCS • ADCU and HDU Target to have all registered nurses trained to Level 3 by end of March 2020 Agreed with CCG for 19/20 contracting.	GM	EOK	31st December 2020	Monthly reporting to ward managers on progress and requirement for all staff to have date booked (Target 85%). Increased the numbers on each session to 20 to allow staff to get onto sessions. Monitoring DNA's directly with managers.	Current (Sept 19) compliance and trajectory of compliance achieved: • OPD- 87.50 %- Dec 2019 • POAC 100%- Sept 2019 • ADCU -awaiting confirmation. • ROCS-100% Sept 19 • HDU – 77.27% Dec 2019	
2.3	Additional *children only sessions* have been scheduled; Total of 7 session Targeting in patient ward registered nurses (Ward 1,2,3,12).	GM	JM	31st October 2019	Staff being released for training as health roster rota already completed – staff being reassigned to attend sessions booked by managers.	As of 22.10.19 = 70 staff booked Trajectory for compliance: • Ward 2- Dec 2019 • Ward 3- Nov 2019 • Ward 12 -Dec 2019 In first 4 sessions- attended staff = 37	
2.4	Increase in the training sessions to 2 full days per month for all staff requiring level 3 (Adults and Children).	GM	EOK	31st January 2020	Named Nurse leaves Trust end of Nov 2019, New appointment commences Jan 2020 Dec 2019 Named Nurse vacancy in the Trust L+D rooms availability for training to be planned for new year 2020	Continuity plans being worked up to ensure training is covered for Dec 19 in absence of Named Nurse.	

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
2.5	Compliance % to be monitored monthly and reported via Trust Safeguarding Quality report, and via workforce reports to divisional meetings, and variances actioned.	GM	ESR Team Divisional Managers	31st March 2020	ESR data; role and designation being accurate for reporting by L+D dept team.		

Key to initials of leads

GM	Garry Marsh- Executive Director of Nursing and Clinical Governance
CF	Claire Felkin – Learning and Development Manager
JM	Julie Mullis – Safeguarding Named Nurse
EOK	Evelyn O'Kane- Safeguarding Lead Nurse

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

Staggered Admissions - CQC Action Plan – October 2019

Monitoring body (Internal and/or External):	Quality and Safety Committee
Reason for action plan:	CQC - Unannounced inspection – October 2019
Date of action plan approval:	29th October 2019 at the Executive Team meeting
Executive Sponsor:	Mrs Marie Peplow; Chief Operating Officer
Operational Lead:	Sue Cox; Matron Will Overfield; Clinical Services Manager
Frequency of review:	Monthly
Date of last review:	28th October 2019
Expected completion of action plan:	31st March 2020

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
3	**Day Case patients fasting for unnecessary prolonged periods - Staggered Admissions; Quality Priority 2019/20.**						
3.1	An average waiting time per speciality report to be shared via the divisional operational groups on a monthly basis for review and monitoring. Where possible this report should also contain PALs information and results from the pre-operative water hydration audits.	MP	WO	30th November 2019		Reports now available from Informatics.	
3.2	Clinical service managers to review individual speciality booking processes. It would be beneficial for each speciality to provide guidance on best practice for staggering admissions.	MP	JD MR	31st December 2019			
3.3	To implement a two-time admission process for patients on diagnostic lists – trials of how this can be achieved are currently being undertaken between	MP	WO	31st January 2020			

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
	ADCU and CT. Work is required to progress.						
3.4	Extend the two-time admission process to the injection lists undertaken in ADCU.	MP	WO SC	31st March 2020			

Key to initials of leads

MP	Marie Peplow; Chief Operating Officer
WO	Will Overfield; Clinical Services Manager
SC	Sue Cox; Matron
MR	Marie Raftery; Deputy Chief Operating Officer
JD	Janet Davies; Deputy Chief Operating Officer

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

Local and National Standards for Invasive Procedures (Critical Care) - CQC Action Plan – October 2019

Monitoring body (Internal and/or External):	Quality and Safety Committee
Reason for action plan:	CQC - Unannounced inspection – October 2019
Date of action plan approval:	29th October 2019 at the Executive Team meeting
Executive Sponsor:	Mr Matthew Revell, Executive Medical Director
Operational Lead:	Simran Minhas; Clinical Service Lead
Frequency of review:	Monthly
Date of last review:	28th October 2019
Expected completion of action plan:	31st December 2019

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
4	**Evidence of LocSIPS and NatSIPS within Critical Care**						
4.1	Standard Operating Procedure (SOP) – Safe Invasive Procedures on the High Dependency Unit in draft; circulation for comments and ratification via the HDU Management meetings and to Clinical Quality Group.	MR	SM	12th December 2019		SOP currently in draft.	
4.2	Dissemination of approved SOP to clinical teams.	MR	SM SCC	31st December 2019			

Key to initials of leads

MR	Matthew Revell; Executive Medical Director
SM	Simran Minhas; Clinical Service lead
SCC	Sarah Carr-Cave; Head of Nursing Division 2

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

Ward 12 Beds; Adherence to Health Building Note - CQC Action Plan – October 2019

Monitoring body (Internal and/or External):	Quality and Safety Committee
Reason for action plan:	CQC- Unannounced inspection – October 2019
Date of action plan approval:	29th October 2019 at the Executive Team meeting
Executive Sponsor:	Mrs Marie Peplow; Chief Operating Officer Mr Garry Marsh; Executive Director of Nursing and Clinical Governance Professor Philip Begg; Executive Director of Strategy
Operational Lead:	Christian Ward; Head of Nursing Division 1.
Frequency of review:	Monthly
Date of last review:	28th October 2019
Expected completion of action plan:	6th December 2019

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
5	**Two bays on Ward 12; adherence to Health Building Note guidance. Privacy, dignity and access to the patient in the event of an emergency compromised.**						
5.1	Immediately review bed capacity and close beds 1-6 on Ward 12.	MP	LN	18th October 2019	• Activity vs Bed capacity • Effective bed management processes	Beds closed on the 18th October 2019.	
5.2	Immediately conduct a risk assessment to establish any clinical risk to the use of the 6 beds e.g. ability to respond to and get to the patient in the event of an emergency.	GM	CW CM	23rd October 2019		Risk assessment conducted; no risks identified to patient safety and access, in the event of an emergency. Privacy and dignity – risk added to Ward 12 risk register.	

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
5.3	Estates to review and cost the proposal of removing 2 of the 6 bed spaces to increase space and enhance the environment for patients (privacy and dignity).	PB	SL	30th November 2019			
5.4	A Standard Operating Procedure (SOP) to be developed with an escalation/approval process for the requirement to opening of these beds in the event of an increase in the need for capacity.	MP	JD CW	6th December 2019			

Key to initials of leads

MP	Marie Peplow; Chief Operating Officer
GM	Garry Marsh; Executive Director of Nursing and Clinical Governance
PB	Philip Begg; Executive Director of Strategy
CW	Christian Ward; Head of Nursing Division 1
CM	Carl Measey; Health and Safety Advisor
SL	Stuart Lovack; Assistant Director of Estates and Facilities
JD	Janet Davies; Deputy Chief Operating Officer
LN	Lisa Newton; Matron

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

Secure Patient Information (Surgery) - CQC Action Plan – October 2019

Monitoring body (Internal and/or External):	Quality and Safety Committee
Reason for action plan:	CQC- Unannounced inspection – October 2019
Date of action plan approval:	29th October 2019 at the Executive Team meeting
Executive Sponsor:	Mr Matthew Revell; Executive Medical Director
Operational Lead:	Lisa Newton; Matron
Frequency of review:	Monthly
Date of last review:	29th October 2019
Expected completion of action plan:	25th November 2019

REF	ACTION	SENIOR /EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
6	**Notes trollies were not locked consistently across the service (surgery)**						
6.1	All wards and departments to have key coded lockable notes trollies to store patient records securely.	MR	LN	Completed prior to developing the action plan.			
6.2	Reminder regarding secure storage of patient records to be sent out via: • Communication weekly email • Team Brief	MR	AM LN	22nd November 2019.		Communication email sent out to all staff on the 30.10.2019.	
6.3	Auditing of notes trollies to be introduced into the Matron daily walkabout, with exception reporting to form part of the Matron monthly Condition report to the Head of Nursing.	MR	LN LK SC	25th November 2019			

Key to initials of leads

MR	Matthew Revell; Executive Medical Director
LN	Lisa Newton; Matron
LK	Laura Keil; Matron

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

SC	Sue Cox; Matron
AM	Amos Mallard; Communications Manager

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Action revised

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – PERFORMANCE and PROCESS extracts**
SPONSOR (EXECUTIVE DIRECTOR):	**Trust Board**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

Following the Board workshop in October it was agreed that the Board Assurance Framework (BAF) should be realigned to the goals ('Five Ps) in the newly approved Trust strategy.

Attached is the **PERFORMANCE and PROCESS** extracts of the BAF

Those risks shaded in **blue** are recommended for closure or de-escalation to local risk registers and those shaded **grey** are proposed for closure.

The Board Assurance Framework includes 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 following coding system for the risk category is in place:

- 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

REPORT RECOMMENDATION:

Trust Board is asked to:

- Review the Board Assurance Framework extract
- Confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- Agree to close or de-escalate those risks suggested

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:					

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:

Executive Team on 15 and 29 October 2019.

Trust Board at its meeting on 4 September 2019.

Discussion held about restructuring BAF by the Trust Board on 2 October 2019 as part of a workshop.

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		
PROCESS																				
CE2	Corporate	CEO	The effectiveness of the clinical governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience, potential harm and reputational damage.		Developing services to meet changing needs, through partnership where appropriate	Trust Board/Quality & Safety Committee	3	5	15	Additional reporting mechanisms in place and escalation to identify to key leads that the governance arrangements are not effective or there is potential for harm to be caused by a patient.	Minutes of stakeholder oversight meeting	2	5	10	↓	Continue to monitor effectiveness of governance framework	On-going	1	5	5
1137	Infection Control	Exec Dir - N&G	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	5	3	15	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. Pseudomonas Aeruginosa risk assessment completed areas of the Trust have been identified as 'Augmented Care' by the Water Safety Group.	Water Safety Group minutes presented to IPC Group meeting.	2	3	6	↔	Completion of the water safety plan **CLOSE**	Aug-19	1	5	5
770	Operations	COO	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.		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	↔	The theatre expansion programme is underway with phase 1 of the expansion programme due to be delivered in December 2019 , at this point the risk will be reviewed.	Mar-20	1	5	5
CO2	Operations	COO	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	2	3	6	↓	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. The Perfecting Pathway Programme Board will be launched in September 2019. All programmes will be tracked and progress reviewed on a monthly basis at this board which will report monthly to F and P committee to ensure support is in place to deliver the programme of service changes and redesign. Structure is in place to support the team and substantive COO has now been appointed. **DE-ESCALATE TO OPERATIONAL MANAGEMENT BOARD RISK REGISTER**	Q4 2018/19	2	3	6

275	Governance	Exec Dir - N&G	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 Trust Quality Priority for 2018-2019 has been achieved and closed. A paper detailing the evidence of closure was presented to the Quality and Safety Committee detailing the new methodology and improvements in March 2019. The CCG have decreased the Trusts contracts meeting to quarterly due to the adequate assurance they receive from the Trust. Each month following thematic review of RCAs and incidents, the Governance team will devise patient safety case studies, outlining the learning from this incidents, complaints and litigation. Working with the communication team the learning will be shared Trust wide. The Staff Survey shows improvements on the Patient Safety metrics in terms of incidents, feedback and outcomes. Weekly meetings have been established with Governance, Medical Director, Director of Nursing and Heads of Nursing. **DE-ESCALATE TO CLINICAL QUALITY GROUP RISK REGISTER**	Q4 2019/20	2	2	4
FP3	Finance	Exec Dir - F&P	The Trust may experience supply chain disruption and experience an adverse impact on areas which are dependent on overseas staffing in the event of a "no-deal" Brexit, resulting in operations being cancelled and long lead times for securing overseas staff		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. Internal analysis of workforce risk suggests that there is likely to be little disruption to staffing level in the event of a 'no deal' Brexit	Updates to Finance & Performance Committee Central readiness returns Outcome of business continuity exercise reported to Trust Board	3	4	12	↔	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.BREXIT Leads group now been set up across STP to provide cross support.	Jan-20	2	3	6
S799	Strat	Exec Dir - S&D	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	Work is underway to develop the strategy for 2019/20 to 2023/24 and beyond. A workshop was held for the Board on 6 February 2019 at which the Board was presented with the proposed routes for engagement with the strategy for staff, stakeholders and the public.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case; slides from strategy session for the Board on 6/3/19	2	3	6	↔	A strategy working group will be established to specifically focus on: - How we engage with all teams in the development of the new strategy - How we share key headlines from this year's annual plans - What we think the key elements of the strategy need to be - How we align all Trust plans/strategies to this document **DE-ESCALATE TO STRATEGY RISK REGISTER**	Q1 2019/20	2	3	6

S800	Governance	CEO	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 electronic governance solution for better management of Trustwide policies and creation of additional dashboards of performance against key quality metrics. **DE-ESCALATE TO CLINICAL QUALITY GROUP RISK REGISTER**	Q1 2019/20	1	3	3
1298	Finance & Performance	Exec Dir - F&P	There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyberattack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training:		Safe, efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	The number of risks notified by CareCert each week means that significant effort is required across servers, networking and project teams. Cyber Operational Readiness Support (CORS) has been secured and a remediation plan has been developed 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. Cyber security Board level champion appointed and is creating networking opportunities with other organisations wiht a view to strengthening advice & support Steer given by Audit Committee that additional investment should be made into strengthening the Trust's cyber security framework	IM&T programme board papers Presentation from CORS team to Audit Committee Audit Committee minutes Information Governance Group minutes	4	4	16	↔	Additional investment into cyber security to be deployed Completion of CORS remedial action plan	Quarter 4 2019/20	3	4	12
PERFORMANCE																				

1089	Operations	COO	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	3	15	Trajectories have been developed for all services to deliver 92% submitted to NHSI describing how these services will be recovered to meet 18 week RTT. The Trust trajectory to deliver 92% performance is monitored weekly at the PTL meetings and reported monthly in line with national requirements Ongoing demand and capacity measurements identify any gaps in service capacity to meet demand with plans put in place . RTT position sent monthly to CCG for information. Pathway work is ongoing in all specialities and additional capacity is being delivered in focussed areas to reduce the waiting times for patient pathways where these services are critical to patients progression through the pathway. Additional Consultant capacity is in place to ensure sustained delivery of RTT compliance in line with the theatre expansion programme.	Weekly update to Exec Team & Ops Board	4	3	12	↔	Delivery of revised trajectory has been agreed with NHSI for the delivery of 92% in all specialties. Solution to the national pensions issue to be developed to ensure that there is sufficient recycling of fallow and additional theatre lists to ensure activity and theatre utilisation is maximised	Mar-20	2	3	6
CE1	Corporate	CEO	The Trust does not currently have a clear financial and operational plan in place 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	4	20	Whist a two year financial and operational plan was signed off by the Trust Board in 2019/20, the Trust has been working with the STP to develop a longer term System Sustainability Plan (five years), although both for the Trust and the STP, this plan is different to the current set of performance improvement trajectories recently identified by NHSI The SSP reflects the Trust's 5 year strategy to become the first choice for orthopaedic care, which has recently been refreshed and updated into a new format, being based around the five 'Ps': performance, people, process, partnerships and patients. An initial Strategic Outline Case was developed and 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 Theatre expansion work is currently underway.	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update	3	4	12	↔	As part of the financial planning for 2019/20, the Trust has been notified that it will receive £5m of Financial Recovery Funding, which will bring the Trust into a break even position, if the control total is hit during the year. However, achievement of the CT is contingent upon receiving £2.5m of transitional support tariff to adjust for the complexity of the work that the ROH undertake, whilst there is still some uncertainty on how FRF will be managed. Solution to the national pensions issue to be developed to ensure that there is sufficient recycling of fallow and additional theatre lists to ensure activity and theatre utilisation is maximised	Mar-20	2	4	8
FP2	Finance	Exec Dir - F&P	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 has received transitional funding during 2018/19 to support the additional costs of paediatric provision. **DE-ESCALATE TO CORPORATE RISK REGISTER**	Q4 2018/19	1	4	4

27	Operations	COO	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. Continued stringent controls for employing agency staffing in line with reviewed NHSI guidance (June 18) are in place. A presentation on implementation of the ACP role was presented to the SE and OD Committee in February 2019 and a strategy for the development of the middle grade workforce is now in development. A rota co-ordinator is in place and focuses on weekly vacancies/sickness monitoring working with the Operational Team and HR to improve the effective recruitment and co-ordination of the Medical Workforce. Monthly spend is monitored by the Clinical Service Managers and reported to a monthly meeting to monitor spend.	Updates to Staff Experience & 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	4	12	↔	Junior Fellow posts have been re advertised with a revised 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. The draft Job Description for the alternative medical workforce has been agreed	Mar-20	1	4	4
FP1	Finance	Exec Dir - F&P	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	4	20	The 2019/20 operational and financial plan will identify the reduction of income relating to the transfer of paediatric activity, but also a reduction in costs relating to the transfer. Where costs cannot be transferred, the ability to offset any staffing resource against current temporary staffing spend will be assessed, and a corresponding growth in adult activity to utilise capacity will be quantified	FPC reports; Board approval for cash borrowing; Finance & Performance overview	3	4	12	↔	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 **DE-ESCALATE TO CORPORATE RISK REGISTER**	Dec-19	2	3	6
269	Operations	COO	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. Risk elevated given impact of national pensions issue.	Integrated action plan; minutes of Trust Board & Finance & Performance Committee; Finance & Performance Overview; Executive Team papers. Perfecting Pathways papers. Modular theatre business case	4	4	16	↑	The national pensions issue is impacting on the Trust's ability to meet the activity plan and therefore a solution is being worked through to ensure that the recycled and additional theatre lists are taken up by consultants. Development and delivery of recovery plan. Modular theatre set up anticipated to become functional in December 2019, which creates additional capacity for activity. Continued joint working with Heartlands, Good Hope and Solihull Hospitals (HGS) to support standardisation of pathway across STP and agree activity levels at the ROH and Solihull elective centres. Work also underway for ROH to support winter pressures at HGS. Pathway work is also being scoped with the spinal teams across ROH and UHB.	Mar-20	2	4	8

270	Finance	Exec Dir - F&P	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 is 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 new tariff for 2019/20 and beyond, which may make financial planning and contract agreement with commissioners very challenging. A new tariff is expected 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	3	4	12	↓	The Trust continues to work with NHS Improvement to help influence appropriate tariffs to remunerate the trust for the work it performs. A specific review of BIU activity is ongoing. **DE-ESCALATE TO CORPORATE RISK REGISTER**	Ongoing	2	4	8
FP4	Finance & Performance	Exec Dir - F&P	There is a risk that the full quantum of cost saving as outlined in the 2019/20 CIP delivery plan will not be achieved thereby jeopardising the achievement of the organisation's statutory Control Total		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Interim Assistant Director of Finance in place to provide robust oversight of the delivery of CIPs. CIP Delivery Board meets on a regular basis where there is challenge on shortfalls in delivery and proactive identification of replacement schemes where possible. Whilst full delivery of the CIP schemes will not happen, this has been taken into account within the financial planning for the remainder of the year.	Finance and Performance overview; CIP programme board papers	3	4	12	↓	Much work has been undertaken in creating the CIP framework for 2019/20. The financial plan for 19/20 identifies a target of £1.4m, which is the level required as per the planning guidance. This is backed up by an internal plan which targets delivery of £2.3m with a further stretch target of circa £3m. The initial £1.4m is within the level of saving achieved during 2018/19, whilst further discussion are ongoing relating to how we potentially use incentive schemes to increase delivery up to the internal target of £2.3m and beyond. **DE-ESCALATE TO CORPORATE RISK REGISTER**	Mar-20	3	4	12
FP5	Finance & Performance	Exec Dir - F&P	There is a risk that the implementation of the new modular theatres will not occur with sufficient rapidity to offset the income required to compensate for the loss of paediatric services, thereby placing the Trust's future sustainability in jeopardy		Safe and efficient processes that are patient-centred	Finance & Performance Committee	5	4	20	Strong oversight of the plans through the Perfecting Pathways programme. Ongoing discussions with local residents and councillors around the planning application. Discussions with local providers to ensure that activity levels and therefore income streams are maintained. Proactive discussions with private companies to explore other opportunities for partnership and innovation. Continued focus on delivering private patient work to offset some shortfalls in NHS income.	Perfecting Pathways update; Finance & Performance overview	3	4	12	↔	Building work underway and currently on schedule and no delays foreseen. **CLOSE**	Dec-19	3	4	12

FP6	Finance & Performance	Exec Dir - F&P	There is a risk that the Financial Control Total will not be met in 2019/20		Safe and efficient processes that are patient-centred	Finance & Performance Committee	4	4	16	There are a number of risks that relate to achievement of the Control Total. Whilst this is primarily focused on a reduction in ADH Consultant availability (re pensions) it also includes the current inadequacy of national tariff to remunerate specialist work, the transfer of paediatric services to BWCH, and a continued risk around CIP delivery. The 2019/20 Financial Plan has prudent expectations of financial performance in the last quarter which gives an opportunity for over delivery and revised scenarios have been modelled to quantify likely activity and income levels for the last months of the year. Revised activity plan distributed which identities performance levels required for recovery. Post mitigation risk elevated to reflect impact of national pensions issue on the financial performance of the Trust.	Finance and Performance overview	5	4	20	↑	Further focus to deliver increased activity and solution to be developed to address the impact of the national pensions issue. This will be shared with Board and NHSI in any future request to change forecast.	Mar-20	3	3	9
WF20	Workforce and Staff Experience/Finance	Associate Director of Workforce & OD/Direcotr of Finance & Performance	There is a risk that as a consequence of the current tax liability associated with pension arranmgements of some senior clinical individuals that there will be a reluctance to cover additional duty hours and therefore the Trust will fall short of its activity target and financial control total		Delivered by highly motivated, skilled and inspiring colleagues	Finance & Performance Committee and Staff Experience & OD Committee	5	4	20	The Exec Team are working through a porffolio of options that could be offered to Conusltants including time off in lieu, additional salary contribuiton in lieu of employers pension conttribution, and alternate ways of working.	Board meeting minutes. Finance & Performance overview. Minutes of Finance & Performance Committee.	5	4	20	↔	Locally, NHS trusts are taking their own decision based on the anticipated timeframe of national outcomes. A solution is currently being worked through for the ROH based on models in place elsewhere.	Dec-19	2	4	8

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 (11/19) 017

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 24 September 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• A deficit of £1.5m in month was reported, this being £1m underperformance against plan. The year to date deficit was reported to be £4.6m against a plan of £2.6m, this being driven by lower than expected levels of activity and associated income. • The lower levels of activity were reflective of the reluctance of some consultants to cover additional duty hours given the current tax liability that was associated with the pension benefits gained when the additional work was undertaken. Activity was also impacted by higher than expected sickness absence. • The case mix of activity was noted to have changed, so that the level of high value cases had reduced. • The expenditure position had not reduced commensurate with the lower levels of activity. • The delivery of the Cost Improvement Programme was behind plan. Key to the delivery of this was the managed service in theatres; the business case would be presented in October. • Average length of stay had increased slightly. A number of initiatives were in place to reduce this over coming weeks. • Performance against the 18 weeks Referral to Treatment Time target had reduced to 85.32%. This deterioration was noted to be reflective of the lower levels of activity being handled at present. Spinal services and arthroplasty were the most challenged services. • It was highlighted that although the paediatric transfer had been assumed to be cost neutral, a retrospective review suggested that income had been impacted negatively, this being associated with the opportunity loss of surgeons not performing chargeable activity at ROH.	• Ensure that all consultant staff are aware of the financial and operational impact of not being able to cover the fallow and additional theatre sessions. • Arrange for the advice around the creation of a LLP to be presented at the Finance & Performance Committee's next meeting. • The Private Patient /GP Liaison Manager to be invited to the next meeting. • Present a paper on the system sustainability plan at the next meeting.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• Agency expenditure was noted to have reduced as a result of the recruitment of more substantive and locum staff. The recruitment of nursing staff was noted to be particularly successful. • Theatre utilisation was noted to have improved as a result of the new locum staff. • There was good performance against the cancer and diagnostics targets. • The Committee received a detailed recovery plan. The plan outlined the reasons for the financial shortfall and lower levels of activity, Key to the success of the plan was the recruitment of additional locum and substantive consultants. Further work was planned to model the impact of theatre expansion on the year end position; develop a workforce strategy for the consultant body; and scope the use of theatres to support winter pressures in the system. • It was noted that some advice was being taken around the risks and practicalities of establishing a Limited Liability Partnership (LLP) through which consultants could be contracted to cover additional sessions. • It was reported that good progress was being made with the development of the Private Patient Suite.	• None specifically.

Chair's comments on the effectiveness of the meeting: It was agreed to have been a productive meeting with some good assurance on the actions being taken to achieve recovery.

ROHTB (11/19) 018

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 22 October 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Year to date, the financial deficit was significantly greater than planned (£4,729k actual vs. £1,309k deficit plan). • In terms of service line reporting, Oncology was a key area of focus particularly given the current suspension of the paediatric service which had the potential to have an adverse financial impact. • The Committee reviewed a number of scenarios for the year end outturn position, with a revised deficit of £6.6m being the most likely. A formal request would need to be made to NHS Improvement to accept a revised position. • The Board was joined by representatives from KPMG which presented some advice around the risks of creating a Limited Liability Partnership (LLP) through which the Trust could contract with some consultants to cover some additional work. A key risk was the possibility that the arrangements would not be seen as favourable by HMRC and as such a further discussion around the advice and subsequent plans by the Executive was needed. • NHSE/I have recently shared each individual organisation's expected financial improvement trajectory and indicative Financial Recovery Fund allocation for the purposes of strategic planning. There was currently a significant gap between this and the STP generated financial plan which would need to be resolved prior to submission in mid-November.	• Present the draft integrated dashboard in December. • Present an upward report from the Model Hospital Group at a future meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There was reported to have been an improvement on the expected financial position in month (£379k deficit actual vs. £519k deficit plan), this being associated with the locum recruitment which had improved the level of activity being handled. • Although agency spend was higher than planned, there was a clear downward trend.	• The Committee, using the Board's delegated authority granted at the September Trust Board meeting, approved the managed service for theatres business case. Option 3 was approved - Managed theatre service with stock retained by the Trust.

• Recruitment of nurses was positive, with over 100 having been recruited since January 2019, a number of which would staff the new theatres. • Performance against the Cost Improvement Plan was improved; this assumed the approval of the managed theatres business case. • Theatre utilisation was reported to be at 85.46% which was an improvement on the previous position. • The introduction of the DrDoctor technology had reduced the level of 'Did Not Attend' cases. • No patients were waiting for treatment above 52 weeks and only 18 patients were waiting longer than 40 weeks. • Performance against the diagnostics target was 99.7%. • Planning for Phase 2 of the modular theatres build was now underway.	

Chair's comments on the effectiveness of the meeting: A significant portion of the meeting was used to discuss the advice from KPMG around the risks associated with the creation of a LLP. There was focussed discussion on other agenda items to accommodate them within the time allocated.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ANNUAL REPORT 2018/19

1.0 Introduction

1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Finance & Performance Committee during 2018/19 and update the Board on its work to date in 2019/20.

1.2 The Finance & Performance Committee is due to review its terms of Terms of Reference in September, which will be presented to the Trust Board at its meeting in November 2019. The proposed changes reflect the widened remit of the Committee to receive reports on the Trust's project and programme management activities via the upward report from the 'Perfecting Pathways' Programme Board, in addition to the oversight of the delivery of the estates strategy. The receipt of upward reports from the Information Governance Group is also reflected in the refreshed terms of reference. Other minor changes concern the titles of some attendees at the meeting.

1.3 During the year, the Chair of the Finance & Performance Committee was Tim Pile. Tim is also a member of the Trust's Audit Committee and routinely provides input from the perspective of the Finance & Performance Committee through discussions at the meetings, particularly around year end processes, financially-biased internal audit reports and matters concerning operational performance.

There is also good linkage with the Staff Experience & OD Committee, with Richard Phillips, the chair of this committee, being a member of the Finance & Performance Committee. This linkage was beneficial, when the Finance & Performance Committee noted a spike in sickness absence when it was considering its monthly overview and remitted the detailed oversight of this to the Staff Experience & OD Committee who monitored the position for a number of months and reported back that it was satisfied that there was no underlying trend or concern that needed to be escalated further.

2.0 Meetings

2.1 During 2018/19 the Finance & Performance Committee met on eleven occasions.

2.2 The attendance at these meetings is overleaf:

MEMBER	MEETING DATE											TOTAL
	24/4/18	1/6/18	26/6/18	24/7/18	25/9/18	26/10/18	27/11/18	18/12/18	28/1/19	26/2/19	26/3/19	
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**
Rod Anthony	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	**10/11**
Richard Phillips	✓	A	✓	✓	A	✓	✓	✓	A	✓	✓	**8/11**
Paul Athey	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/11**
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**
Jo Williams	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	A	**9/11**
Phil Begg	✓	✓	A	✓	✓	A	A	✓	✓	A	A	**6/11**

KEY:

✓	Attended	A	Apologies tendered

2.3 The Secretariat to the Committee is the Director of Corporate Affairs & Company Secretary.

2.5 The Finance & Performance Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, risks noted & matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2018/19

The Committee dealt with the following key matters:

Routine Work

During the year, it was agreed that the Committee would receive upward reports from a number of Trustwide operational, strategic and governance groups, namely:

- Operational Management Board
- IM&T Programme Board
- Estates Strategy and Delivery Group

It was also agreed that in the new financial year, the Committee would take oversight of the Trust's project and programme management framework in the Trust, over and above the large scale change projects in the 'Perfecting Pathways' programme, with a particular interest in the benefits realisation of individual schemes.

Although there was agreement that the Committee should receive the upward reports, there remains more work to do in 2019/20 to systematise this reporting and synchronise the reporting to better align to the meeting schedules of those upwardly reporting groups.

The substantive report that the committee considers is a finance and performance overview which details the Trust's financial position on both a monthly and cumulative basis. The report contains details of income and expenditure, Cost Improvement and has included detail on service line reporting. The report provides an overview of performance against key operational targets, such as Referral to Treatment Time and Cancer Waiting Times, in addition to internal targets such as theatre utilisation and clinic waiting times. The report also includes some detail on performance against key workforce metrics, such as sickness absence, turnover and staff in post vs. establishment.

The other routine report considered has been the progress with the 'Perfecting Pathways' Programme.

At each meeting, the Committee considers an extract from the Corporate Risk Register which is used to set the context of some of the discussions at the meeting and allows the adequacy of the mitigations against the financial and operational risks to be challenged.

In the light of the national developments associated with the plans for Brexit, the Committee also considered at all meetings from the May 2018 meeting onwards, the adequacy of the plans and preparedness of the organisation for a 'No Deal' outcome.

3.2 Single issue or non-routine reports

During the year, the Committee received some specific reports providing assurance on particular key issues and also some business cases, these being:

- Spinal deformity service operational performance
- Budget and plan
- Draft commentary on the annual accounts
- Internal audits remitted from the Audit Committee (RTT and Cancer waits)
- Cancellations
- Modular theatres build business case
- Outpatients hub business case
- Plans for the development of the private patient facility
- Procurement plans
- JointCare dashboard
- DNA reduction plan
- Planning for 2019/20

4.0 2019/20 Work Plan

4.1 For 2019/20, the Finance & Performance Committee continues with its routine work as well dealing with ad hoc requirements that will emerge from time to time or remitted from the Board and the other committees.

4.2 A key area of focus for 2019/20 will be the oversight of the organisation's plans to achieve the challenging Control Total set for the year. Of particular importance will be to monitor the activity flow through the organisation, especially given the national impact of the tax liabilities associated with pension payments to senior staff, including consultants, which has created a reluctance to cover additional duty hours during the past few months.

4.3 There are also plans to develop an integrated performance dashboard covering a comprehensive range of operational, financial, quality and workforce metrics. The aim is that this will allow efficient triangulation and linkages between the set of metrics which can inform more intelligent and directed challenge at a Board committee level.

4.4 There will remain a focus on improving the effectiveness of the committee during 2019/20, particularly the upward reporting from its trustwide subgroups.

5.0 Finance & Performance Committee Effectiveness

5.1 An item is included on the agenda of each meeting to review the effectiveness of the meeting and of the Committee in general. As a result of these discussions, a couple of suggestions were made to the operation of the Committee:

- If there were matters that required detailed debate, the agenda was constructed such that sufficient time was allowed for the item to be fully considered
- The time of the meeting was moved back by 30 minutes to allow sufficient time for crucial meeting attendees to participate from the start of the meeting

6.0 Conclusion

6.1 The Finance & Performance Committee has functioned well during 2018/19 and is now operating effectively, providing clear and adequate assurance upwards to the Trust Board across a comprehensive range of matters of a finance, operational and strategic nature.

Tim Pile
Chair of Finance & Performance Committee

September 2019

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Finance & Performance Committee terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Chair of Finance & Performance Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs and Company Secretary**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

The attached present some proposed changes to the terms of reference for the Finance & Performance Committee, these being:

- Amendment to the committee name being Finance and Performance Committee (removing Assurance from the title).
- Additional paragraphs being 3.2 and 3.2 under the heading 'Purpose'.
- Amendments to the membership now comprising of three Non-Executive Directors and title change from Director of Operations to Chief Operating Officer.
- Under the heading of number 5 'Attendance' change in job title for Simon Grainger-Lloyd.
- Under 7 'Duties' an additional four paragraphs, 7.13, 7.14, 7.15 and 7.16.

The Board is invited to note that there has been sound compliance with the terms of reference during the year through the delivery of the Committee's annual workplan.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the changes to the terms of reference

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	**x**	Environmental		Communications & Media	x
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:

BAF risks FP3, 1089, CE1, 27, 269, FP6 & WF20

The Royal Orthopaedic Hospital NHS Foundation Trust

PREVIOUS CONSIDERATION:

The terms of reference were considered by the Finance & Performance Committee on 24 September, where the proposed changes were supported and it was agreed that they could go forward for presentation to the Trust Board for approval.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE ~~ASSURANCE~~ COMMITTEE

Terms of Reference

1 CONSTITUTION

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

2 AUTHORITY

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

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

3 PURPOSE

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

3.2 The Committee shall also take responsibility on behalf of the Board, for oversight of the Trust's project management and Information Technology (including Information Governance) frameworks.

3.2 The Committee shall have oversight of the delivery of the Trust's estates strategy.

4 MEMBERSHIP

4.1 The Committee will comprise of three~~wo~~ Non-Executive Directors, the Chief Executive, the ~~-~~Executive Director of Finance & Performance, the Executive Director of Strategy & ~~-~~Delivery and the ~~Director of Operations~~Chief Operating Officer.

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

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

5 ATTENDANCE

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

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

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

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

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held monthly.

7 DUTIES

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

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

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

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

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

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

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

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

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

7.9 Review progress with the development of the Trust's Strategic Outline Case

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

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

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

7.13 Keep oversight of key financial and operational risks on behalf of the Board, seeking assurance on adequacy of mitigating actions where needed.

7.14 Review the framework for the management of Trustwide projects and programmes and receive detailed reports on the benefits realisation from initiatives according to the timetable of delivery and implementation.

7.15 Receive upward assurance reports from the Information Governance Group, seeking assurance on behalf of the Board that there is compliance with connected legislation and regulatory requirements.

7.16 Review progress with the delivery of the Trust's estates strategy, through a routine upward assurance report from the Estates Strategy & Delivery Group.

8 REPORTING

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

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

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

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

9 REVIEW

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

Date of adoption: November 2019

Date of review: November 2020

Finance and Performance Report

September 2019

CONTENTS

INTRODUCTION

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

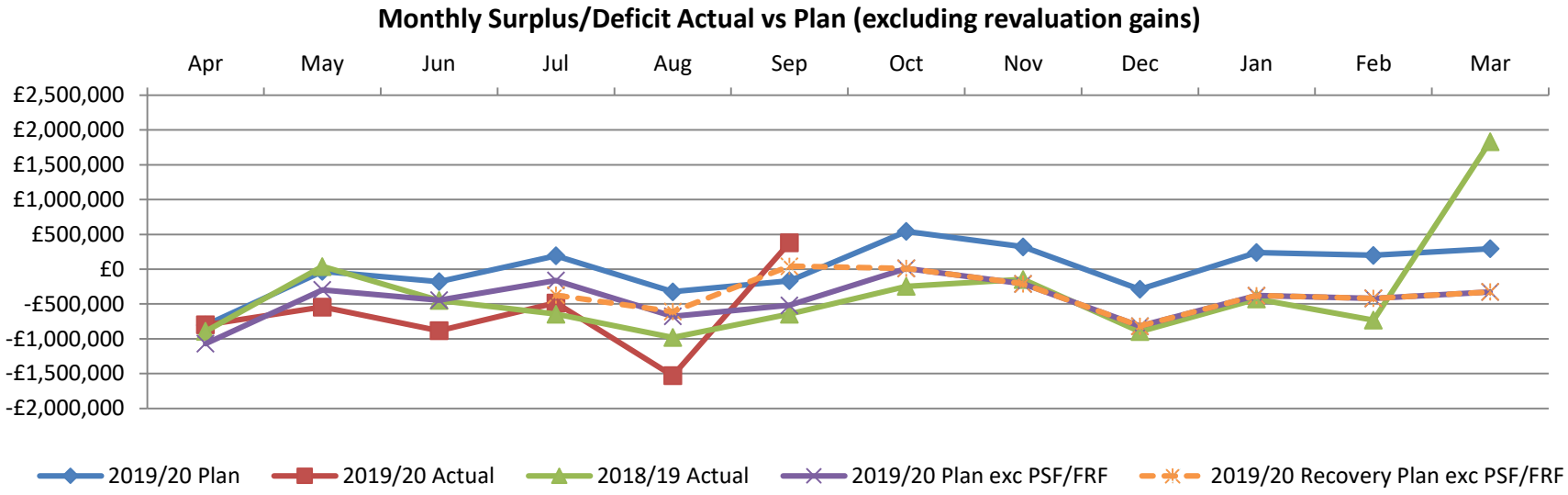
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement/learning and any risks and/or issues that are being highlighted.

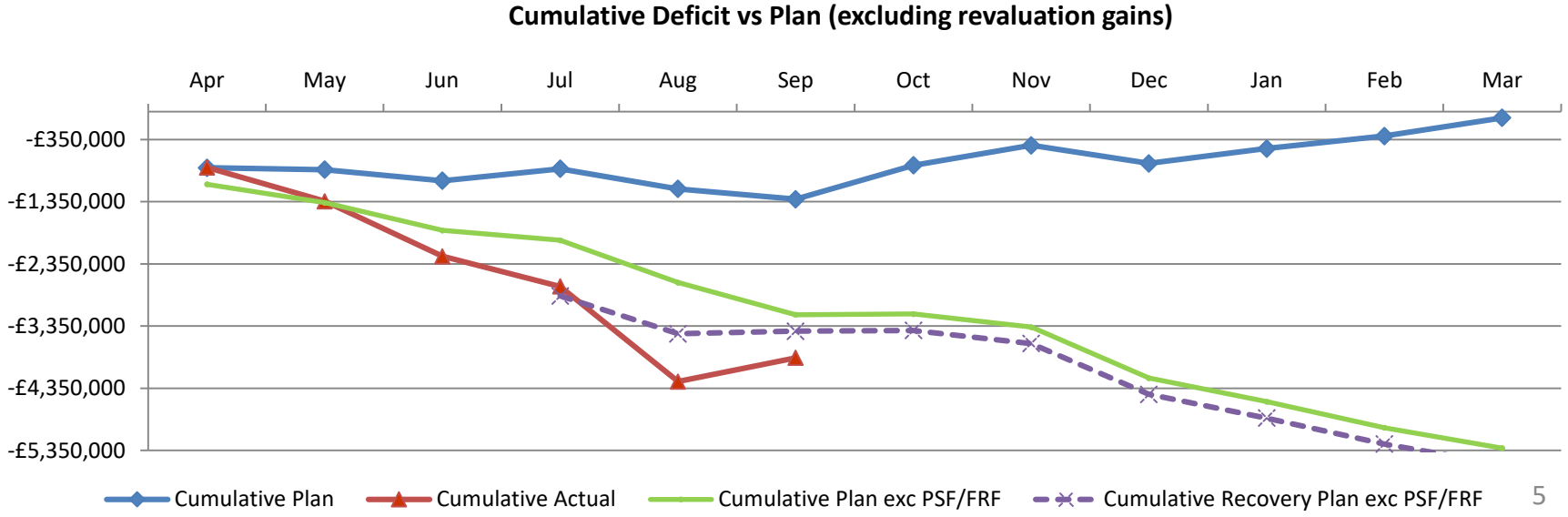
1. Overall Financial Performance – This illustrates the key metrics from the Statement of Comprehensive Income for the year to date

	YTD M06 Original Plan £'000	YTD M06 Actual £'000	Variance £'000
Operating Income from Patient Care Activities	41,141	38,274	(2,867)
Other Operating Income	2,303	2,432	129
Total Income	**43,444**	**40,706**	**(2,738)**
Employee Expenses (inc. Agency)	(27,341)	(26,854)	487
Other operating expenses	(18,620)	(18,057)	563
Operating deficit	**(2,517)**	**(4,205)**	**(1,688)**
Net Finance Costs	(682)	(686)	(4)
Net deficit	**(3,199)**	**(4,891)**	**(1,692)**
Remove donated asset I&E impact	31	(104)	(135)
Adjusted financial performance (exc PSF & FRF)	**(3,168)**	**(4,994)**	**(1,826)**
PRF/FRF monies	1,859	265	(1,594)
Adjusted financial performance surplus/(deficit) including PSF & FRF	**(1,309)**	**(4,729)**	**(3,420)**

During May-September as the control total pre-PSF and FRF was not met, a prudent assumption was made to exclude PSF and FRF from the M2-M6 position. M1 PSF and FRF amounts to £265k only, the M1-M6 PSF and FRF monies available to the organisation amount to £1,859k.

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). This includes PSF & FRF





INFORMATION

The trust delivered an in-month deficit of £376k in September against a planned deficit of £165k (inc PSF / FRF) or a planned deficit of £519k (excl PSF / FRF), an overperformance of £143k against plan. This gives a year to date deficit position of £4,729 against a deficit plan of £1,309k (excl PSF/FRF); an underperformance of £3,420k.

Clinical income has underperformed by £315k against the 19/20 NHSi plan in September. Whilst behind original plan for the year, activity was in line with the recovery plan, which was encouraging. There remain pressures on the performance of additional sessions as a result of the pensions taxation uncertainty for consultants, but it is felt that some of the recent substantive and locum recruitment is starting to have a positive impact on activity.

Pay spend is £487k lower than plan year to date with temporary staffing spend above plan, due to a mixture of vacancies and sickness. However, an analysis of bank and agency expenditure YTD shows a reduction of £393k from 18/19.

Overall expenditure to date is £1,050k lower than plan due to a combination of lower spend due to the underperformance in activity, in addition to a write back to non-pay as a result of the half yearly stock count process.

ACTIONS FOR IMPROVEMENTS / LEARNING

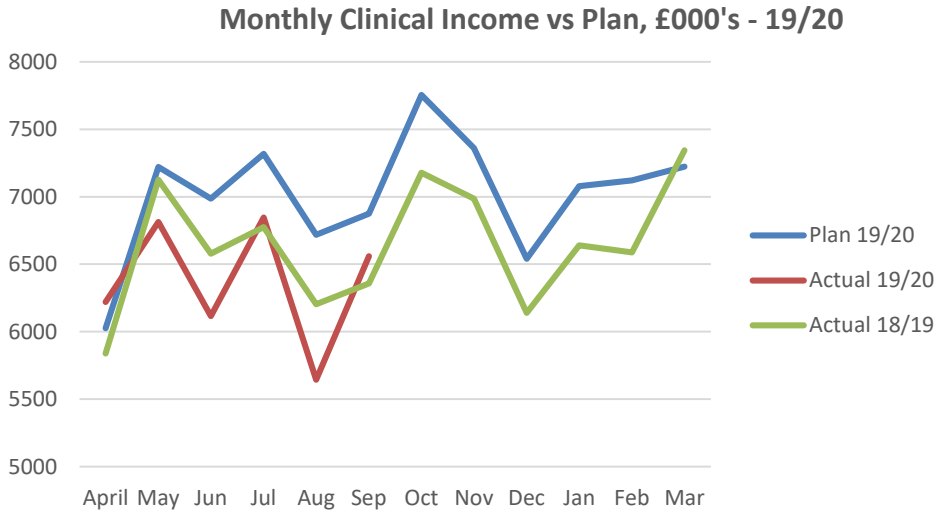
Significant work has been performed to estimate the likely activity for the remainder of the year given what is known with regards to recruitment and the theatre expansion. This information has been built into a review of the forecast outturn for the year. This will be presented separately to the Finance and Performance Committee.

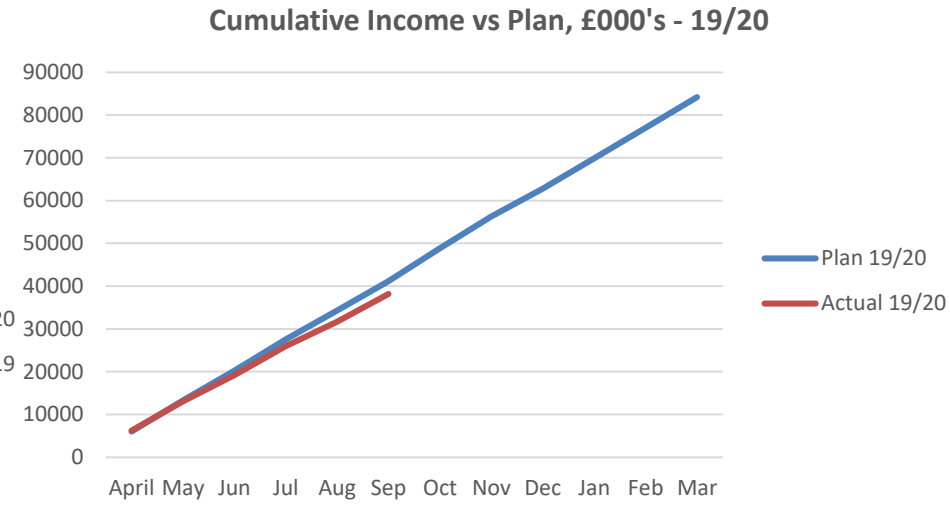
RISKS / ISSUES

October has planned surplus of £12k (exc PSF / FRF), which is expected to be challenging given some of the additional pressures discussed above.

As The Trust is currently £1,826k behind plan (exc. FRF and PSF), there is significant work to deliver the control total by the end of the year. Achievement of the control would result in funding of £5.3m being given to the Trust.

2. Income and Activity– This illustrates the total income generated by the Trust in 2019/20, including the split of income by category, in addition to the month's activity (Inc PSF & RFF)

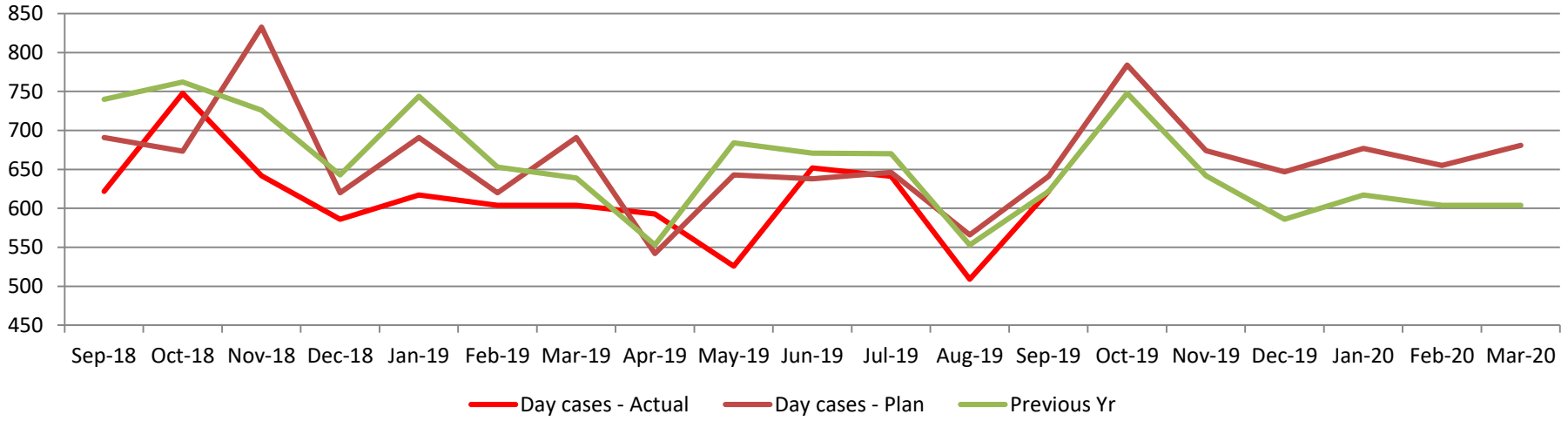




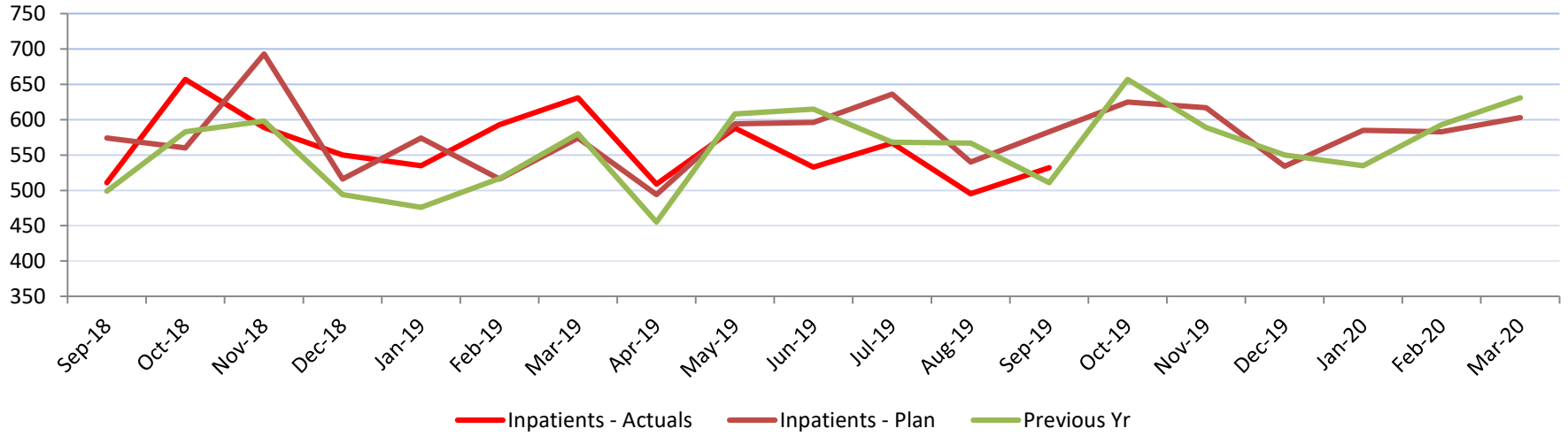
Clinical Income – YTD 2019 £'000			
	Plan	Actual	Variance
Inpatients	20,344	18,336	-2,008
Excess Bed Days	413	372	-41
Total Inpatients	20,757	18,708	-2,049
Day Cases	4,960	4,476	-484
Outpatients	4,494	4,242	-252
Critical Care	1,138	877	-261
Therapies	1,409	1,692	283
Pass-through income	1,243	1,039	-204
Other variable income	3,824	3,927	103
Provision		0	0
Block income	3,316	3,235	-81
TOTAL	41,141	38,196	-2,945

Clinical Income – September 2019 £'000			
	Plan	Actual	Variance
Inpatients	3,462	2,931	-531
Excess Bed Days	70	69	-1
Total Inpatients	3,532	3,000	-532
Day Cases	864	741	-123
Outpatients	791	732	-59
Critical Care	176	164	-12
Therapies	217	298	81
Pass-through income	194	225	31
Other variable income	590	861	271
Provision		0	0
Block income	511	539	28
TOTAL	6,875	6,560	-315

Day Case Activity



Inpatient Activity



INFORMATION

NHS Clinical income has under-performed against plan by 4.58% in September having under-performed in August by 15.98%. Cumulatively, the trust is 7.16% below plan. The admitted patient care performance was below plan financially and on activity levels against the revised activity plan, with discharged activity 257 below target. Day case activity underperformed financially and against the revised activity target by 236 cases. Case-mix in September was 54% for day cases, 44% for electives. Non Elective make up the other 2%. This has changed from August as electives made up 46% of the activity, an decrease of 2%. Over the last three months elective activity has remained steady as a proportion of total activity at 44%.

Outpatients have slightly under-performed for September. There has been a decrease in attendances against plan in August for first and follow up attendances . First to follow up ratio is 2.04:1 year to date. The ratio has decreased slightly from August (2.13:1).

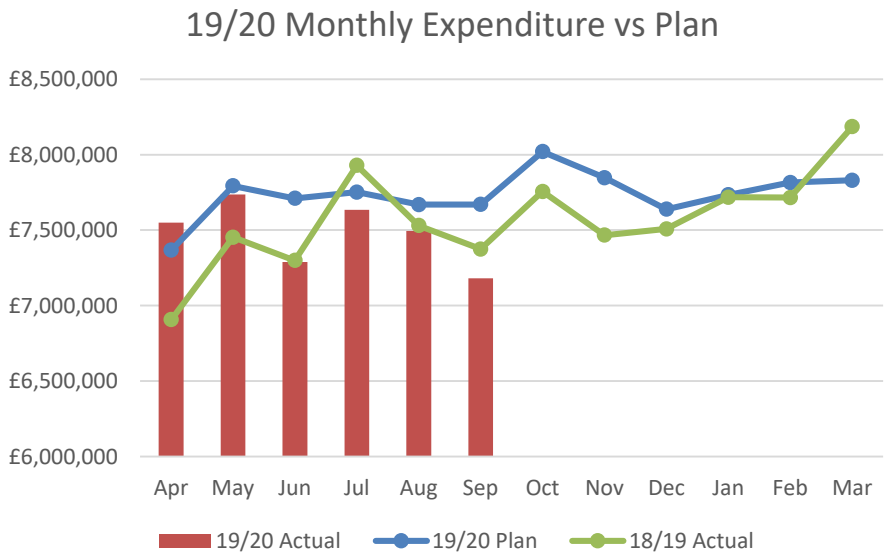
ACTIONS FOR IMPROVEMENT/LEARNING

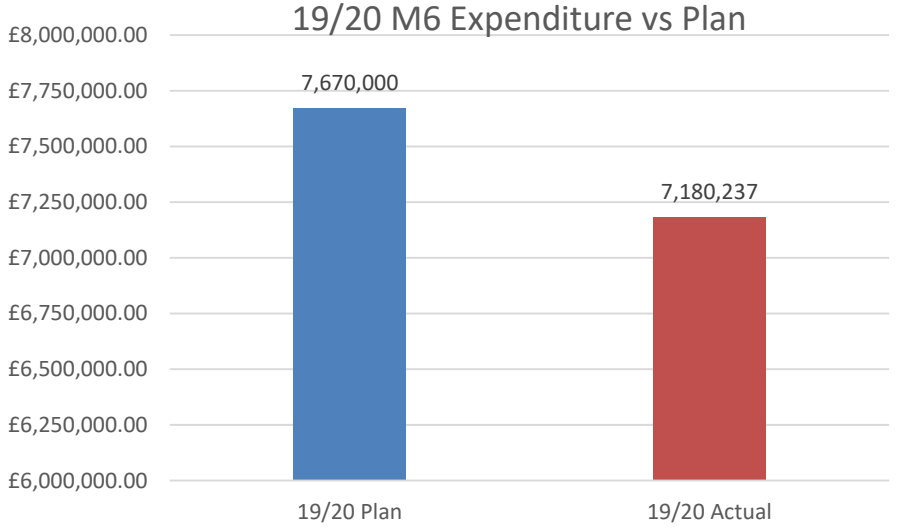
Recovery plan discussions are complete with the operational and clinical teams, with identified mitigating actions that are being taken. Clinical Service Managers are reviewing theatre lists to ensure they are fully maximised.

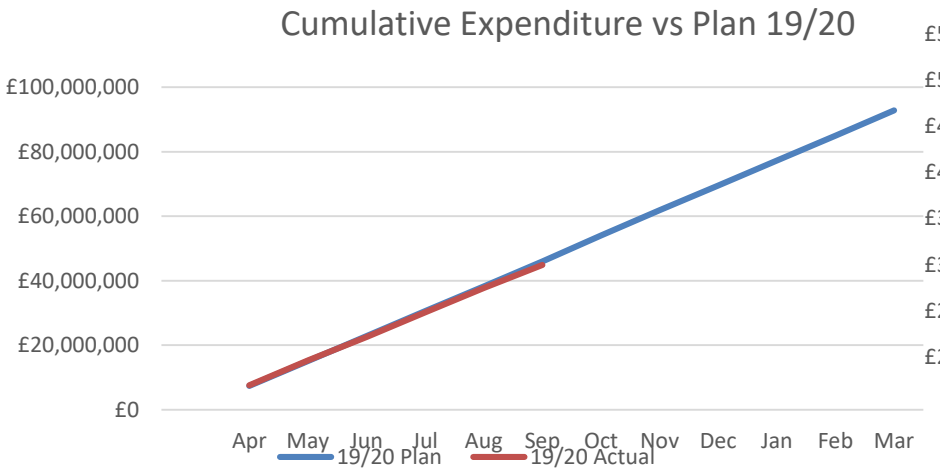
Finance and clinicians are working together to insure that co-morbidities are being recorded and therefore maximising the income.

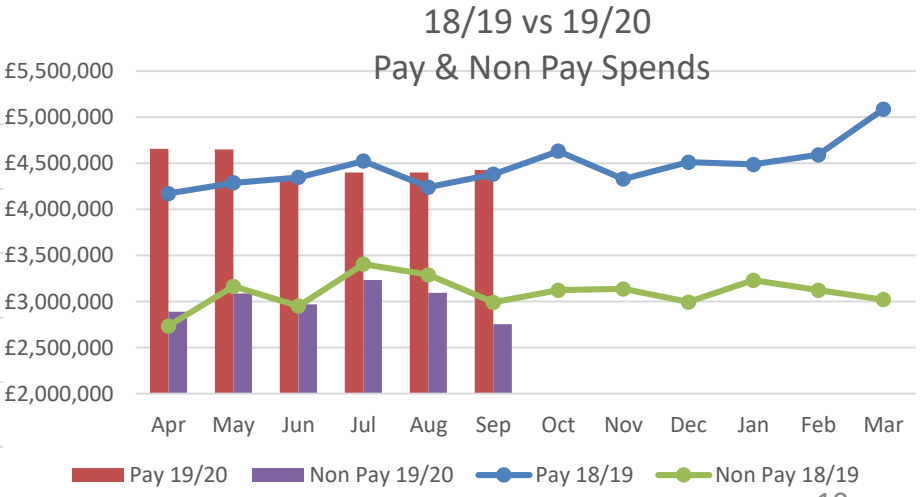
RISKS / ISSUES

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









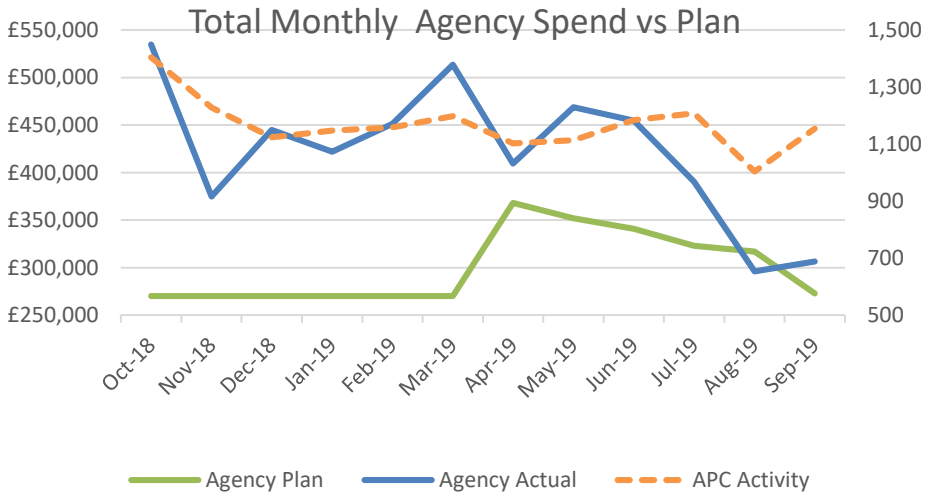
INFORMATION

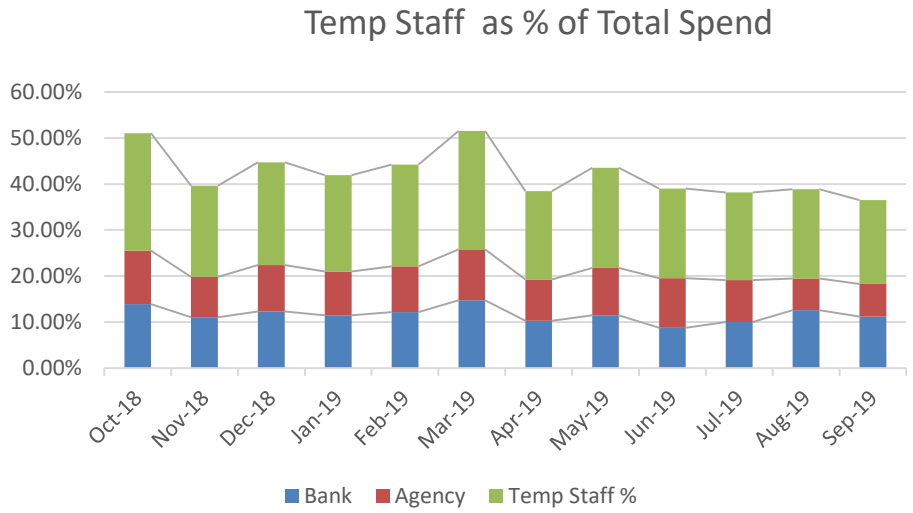
Expenditure in September was £7,180k, which was £490k lower than the planned spend of £7,670k. Year to date expenditure is £44,911k against a plan of £45,961k, an underspend of £1,050k.

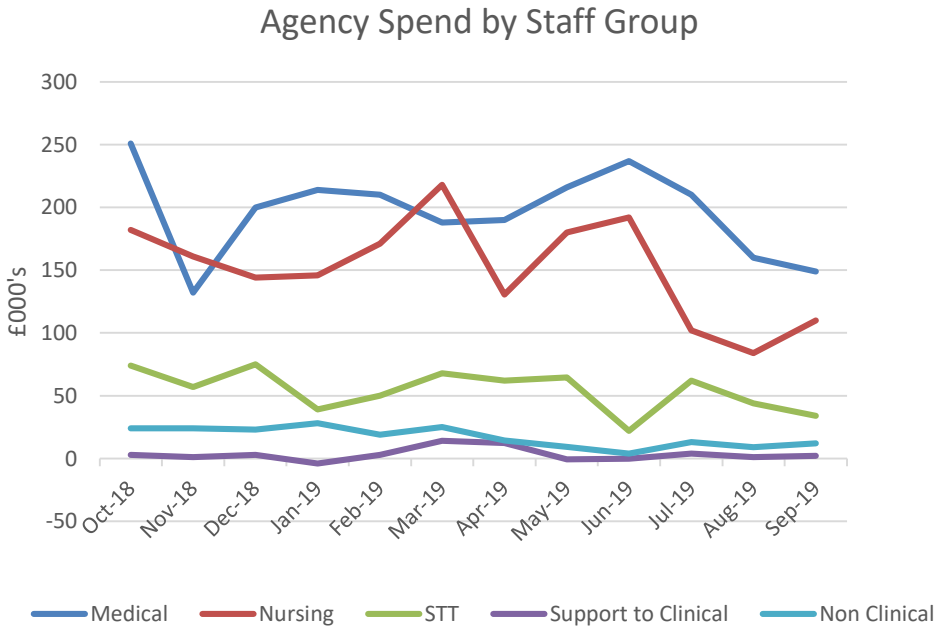
Pay in September was £172k lower than plan, due to a significant reduction in agency usage. This has been a result of the strong recruitment across the organisation over the past several months, and is encouraging to see.

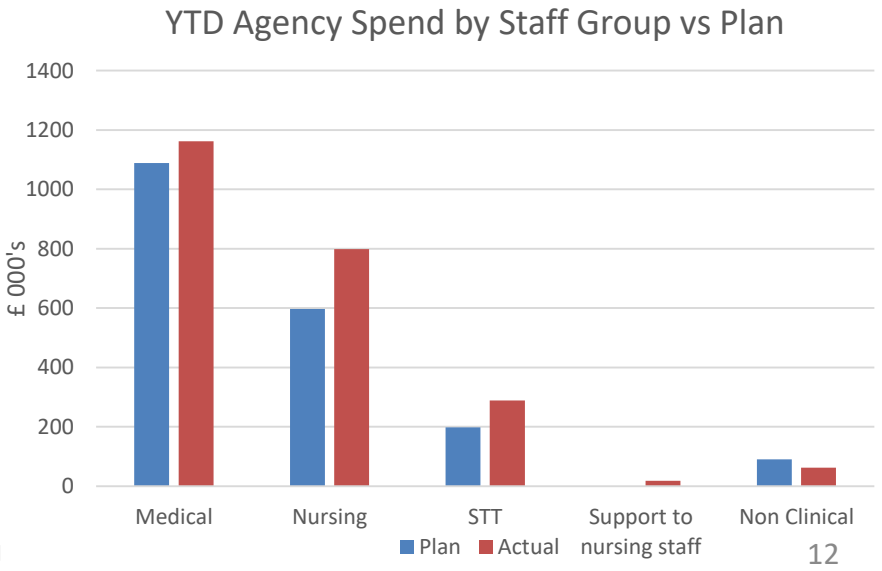
Non pay spend was £289k lower than plan. Underlying spend was roughly in line with plan, but a half yearly stock count was undertaken which established that the inventory balance was higher than year end, resulting in a write-back to non-pay costs in month.

4. Agency Expenditure – This illustrates expenditure on agency staffing for a 12 month rolling period, and performance against the NHSI agency requirements









INFORMATION

Total agency spend for September was £306k against a plan of £273k. This is slightly up on August, as would be expected given the lower activity in August, but continues a general downward trend on agency spend over the year.

Review of the different staff groups shows that there is an increase in nursing spend, although medical and STT agency spend have a significant downward trend. This is believed to be due to the strong recruitment efforts which have taken place across the hospital over the past months, particularly in light of the new theatre/ward development. In addition, there has been a reduction in agency in POAC as a result of utilisation of an ACP and additional junior doctors on the rota.

It should be expected that this agency spend will rise slightly again once the new theatres are opened as the recruited staff are utilised within those lists.

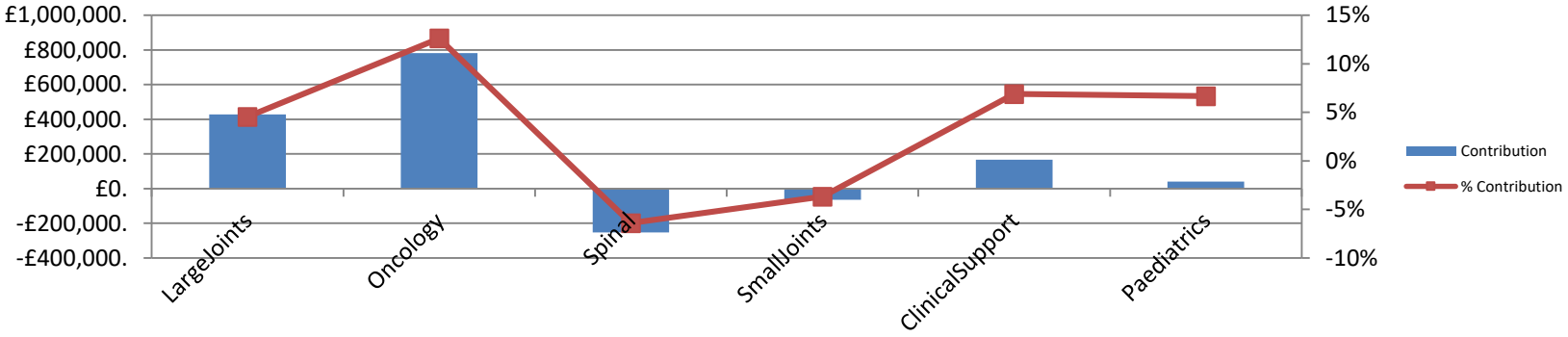
ACTIONS FOR IMPROVEMENTS / LEARNING

Agency bookings as a whole will continue to be tightly controlled and only utilised where necessary.

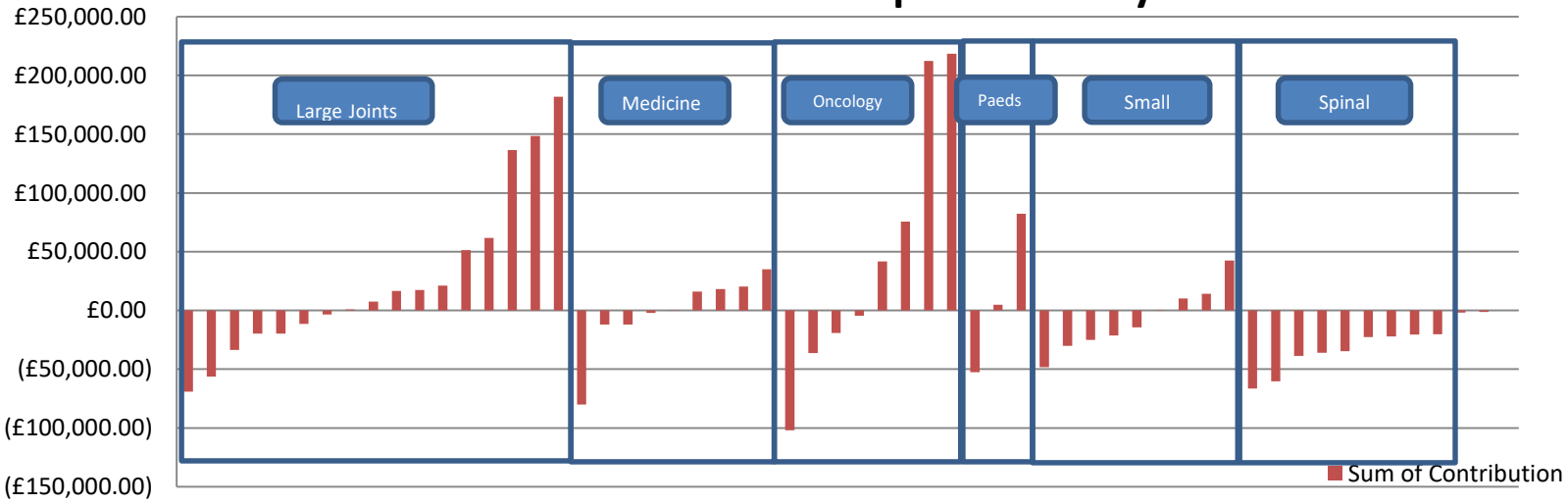
Review of e-Roster continues and shifts are approved by the relevant Matron and head of Nursing.

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

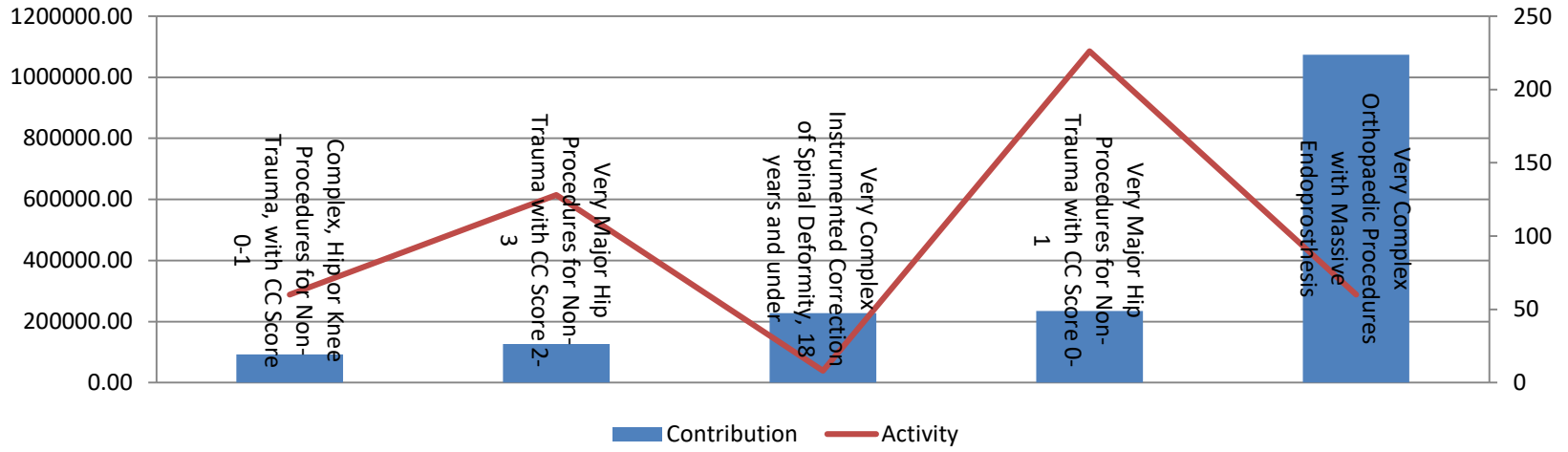
Total Contribution by Service
Cumulative to July 2019



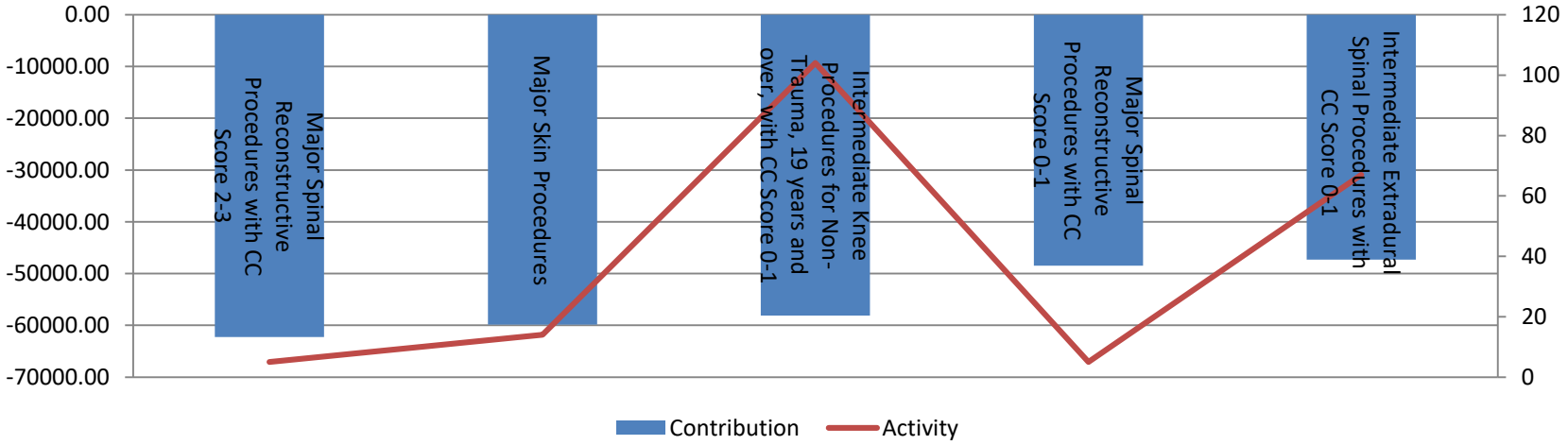
Consultant Contribution April 19 to July 2019



Bottom 5 HRGs making a Positive Contribution



Top 5 HRGs making a Negative Contribution



INFORMATION

The graphs above, and the associated narrative, relate to the year to July 2019.

The first slide is shows the contribution each Directorate is generating, currently the Trust target is set at >20%. Currently none of the services are meeting this target.

The next two graphs show at a total contribution level for the year to date, which HRGs bring the highest contribution to the trust, and conversely the largest negative contribution. Major hips and knees perform well, whereas it can be seen that spinal work can be quite mixed, and that more 'minor' procedures such as biopsies and aspirations can contribute negative contributions for the hospital.

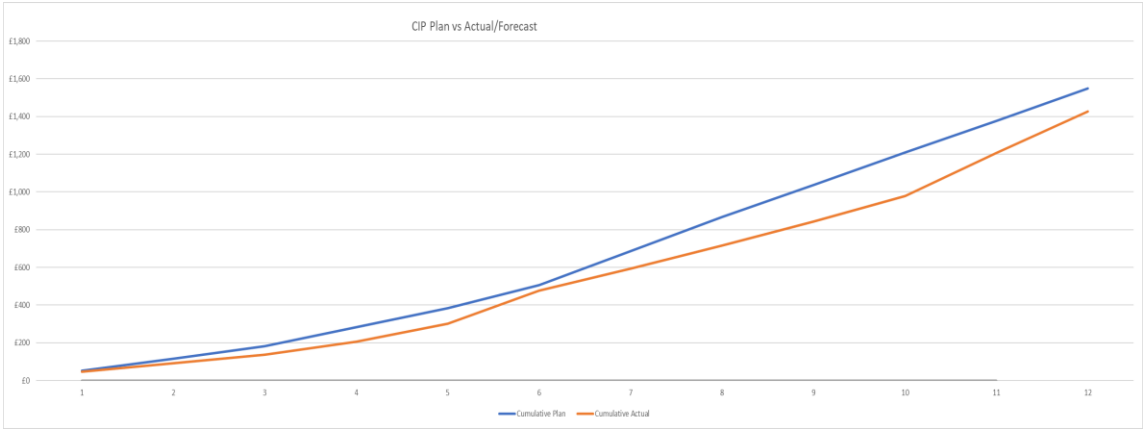
ACTIONS FOR IMPROVEMENTS / LEARNING

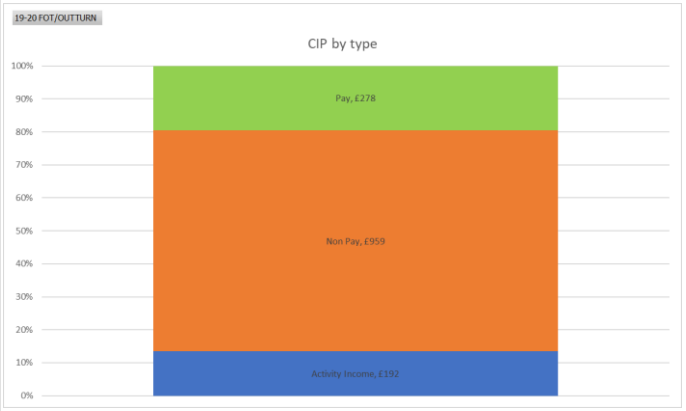
It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

RISKS / ISSUES

The costing team remains a small team , and as such significant pieces of work (such as the costing returns) are at risk of having an impact on the ability for the function to maintain constant presence with the operational and clinical teams. This is continuing to be reviewed with a view to cross cover and training to improve resilience.

6.Cost improvement Programme – This illustrates the plan for the 2019-20 cost improvement programmes (£000's)





	In-Month NHSI Plan	In-Month Actual	In-Month Var	YTD NHSI Plan	YTD Actual	YTD Var	19-20 NHSI Plan	19-20 FOT/OUTTURN	19-20 Variance (FOT)
1	£41	£115	£74	£208	£148	(£60)	£472	£336	(£136)
2	£75	£25	(£50)	£261	£124	(£137)	£963	£618	(£345)
Corporate	£3	£31	£28	£18	£184	£166	£36	£434	£398
Estates & Facilities	£5	£3	(£2)	£20	£21	£1	£78	£42	(£37)
Grand Total	**£124**	**£174**	**£50**	**£507**	**£477**	**(£30)**	**£1,549**	**£1,429**	**(£120)**

The Trust QCIP (Quality and Cost Improvement Programme) target was identified at £1.553m for 19-20. In 18-19 the Trust target was identified at £2.985m, however only £1.688m (57%) was delivered. Thus, during the 19-20 business planning (and QCIP) round, schemes up-to £2.294m have been identified as opportunities for this year. (With the difference being a stretch target for the Trusts divisions) Many of the schemes amounting to the Trust target (£1.553m) have been costed, however some (including the stretch target schemes) remain aspirational at present and costings are ongoing.

All of the schemes identified at present are recurrent schemes, QCIP PID/QIA (project initiation documentation including costings and quality impact assessment) completion is currently ongoing, with a targeted completion date of 18th October 2019. This has slipped from September 2019.

The Trust has a year to date variance of £30k under plan but it is expected to under-perform by £120k at the end of the year.

The 2 largest schemes for 19-20 include the Theatres MSC and workforce recruitment, the latter based on current trajectories will deliver, however the former is likely to slip from July 2019 to February 2019 (this scheme should save c. £90k per month) due to delays in the complexities of management of the new theatres, vendor resolution & contract sign-off.

Despite the year-end forecasted under-performance in September 2019, additional mitigation opportunities have been discussed with minimal identification to date.

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	1,485	1,252	233
Tangible Assets	46,419	45,536	883
Total Non-Current Assets	**47,904**	**46,788**	**1,116**
Inventories	7,063	7,933	(870)
Trade and other current assets	8,125	7,090	1,035
Cash	3,906	5,379	(1,473)
Total Current Assets	**19,094**	**20,402**	**(1,308)**
Trade and other payables	(17,101)	(19,270)	2,169
Borrowings	(726)	(726)	0
Provisions	(87)	(102)	15
Other liabilities	0	0	0
Total Current Liabilities	**(17,914)**	**(20,098)**	**2,184**
Borrowings	(11,703)	(13,452)	1,749
Provisions	(215)	(220)	5
Total Non-Current Liabilities	**(11,918)**	**(13,672)**	**1,754**
Total Net Assets Employed	**37,166**	**33,420**	**3,746**
Total Taxpayers' and Others' Equity	**37,166**	**33,420**	3,746

INFORMATION

As at September 2019 net assets employed are lower than plan by £4m.

Capital is behind plan by 1m, this is due to the final phased plan by type of expenditure and timing was only finalised at the beginning of August, due to the requirement to revise the original plan at the request of DHSC. Due to this there will be ongoing variances throughout the year.

Trade receivables are lower than plan mainly due to activity being behind.

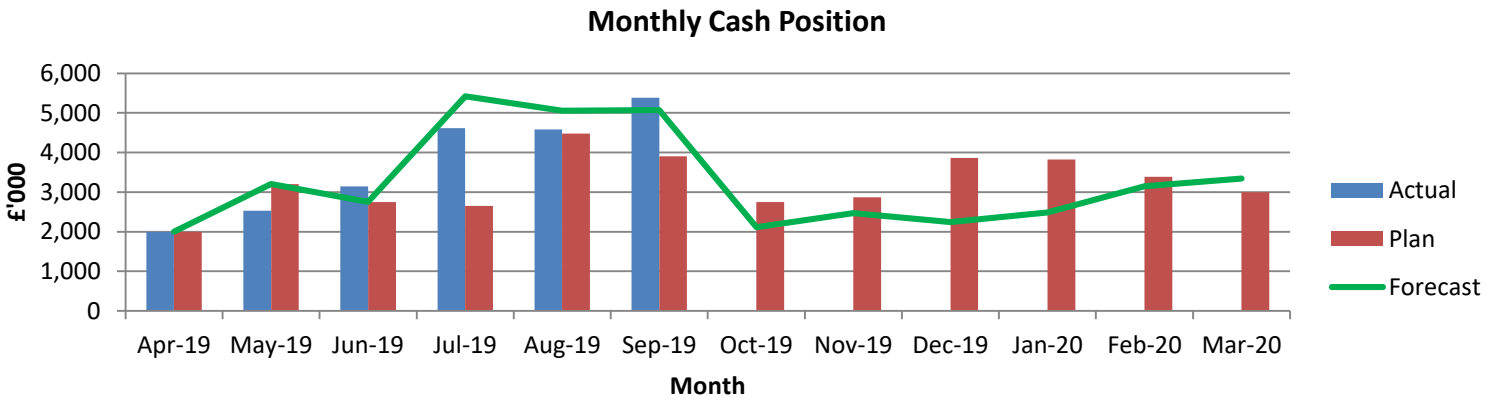
Borrowings have increased due to the Trust continuing to take deficit loans above those planned due timing differences in relation to working capital movements.

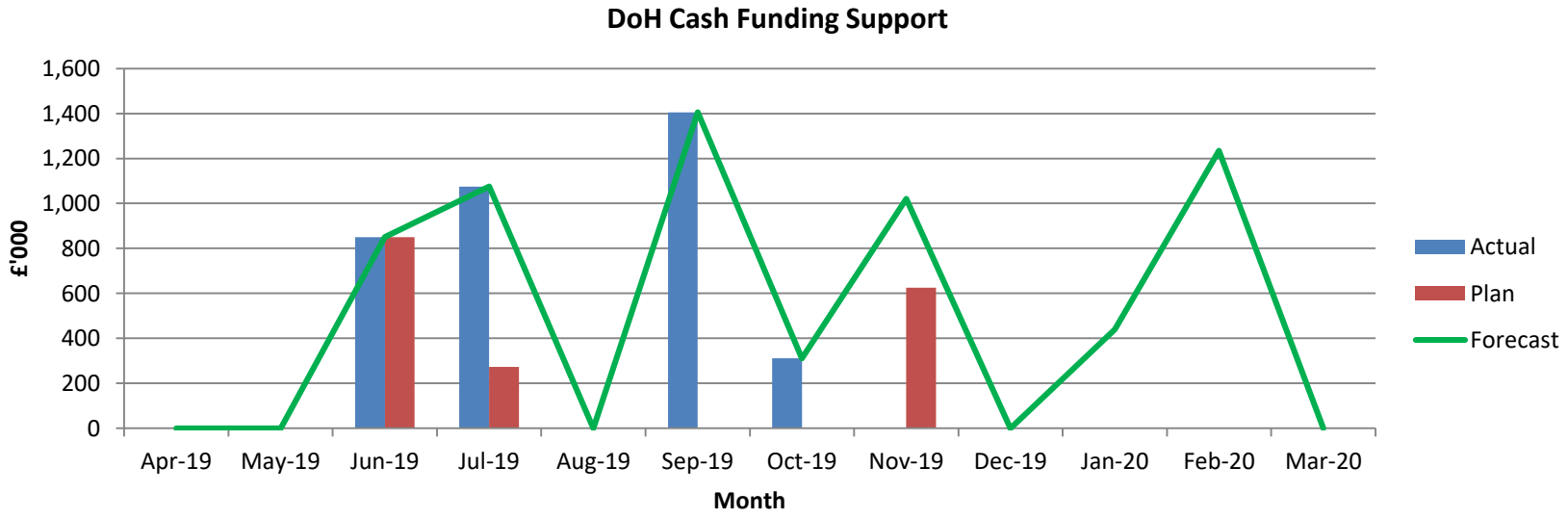
ACTIONS FOR IMPROVEMENTS / LEARNING

Further work is also being undertaken to review the accounts receivable and accounts payable balances, particularly in relation to aged balances.

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

Cash is higher than plan by £1.5m at the end of September 2019. This is due to cash funding being received of £1.4m to ensure the Trust does not fall below the minimum cash balance of £1m during October and November.

Going forward we are now forecasting the need for additional loans to be taken out that were not in the original plan. This is purely down to the uncertainty around the timing of receiving FRF funding. The plan assumed that this would be paid quarterly but this hasn't been the case and no notification has been received regarding the mechanism for accessing these funds as yet.

Liquidity levels within the Use of Resources Rating have remained at 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

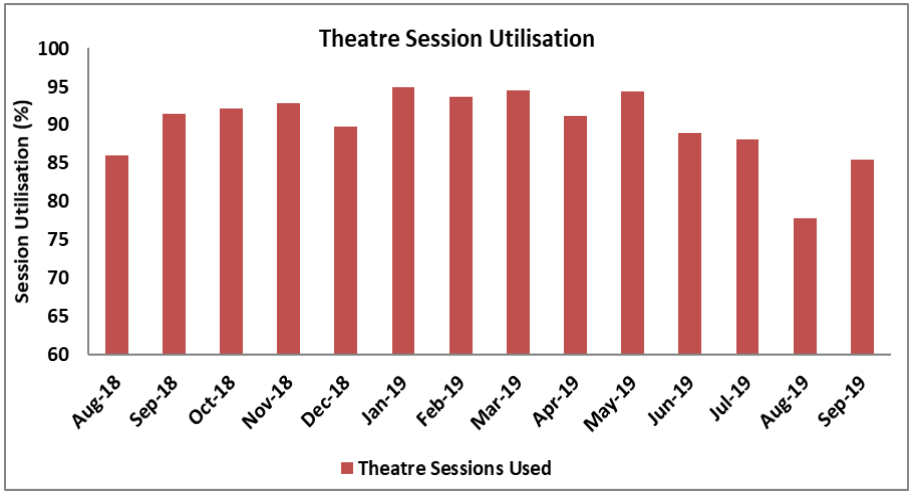
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in 2019/20. The Head of Financial Accounting continues to hold regular cash control committee attended by the Assistant Director's of Finance, and representatives from management accounts 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.

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

Target 90%

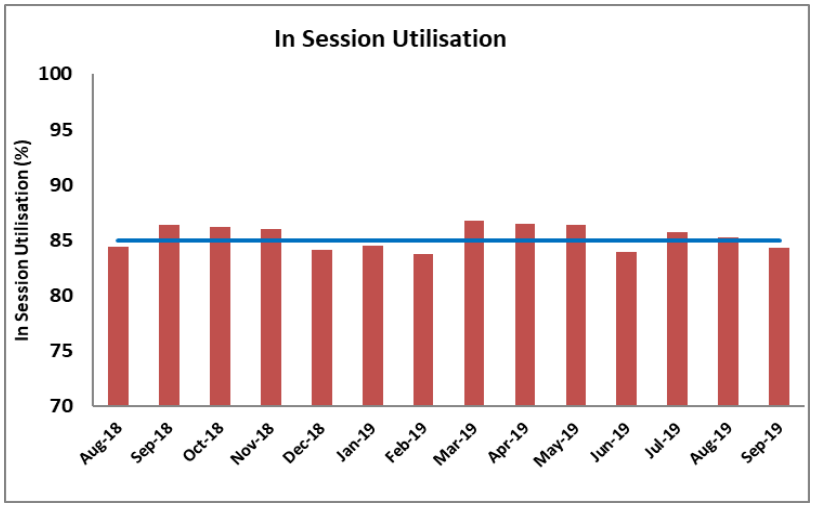
September utilisation was 85.46 compared to 77.78% in August

Unused sessions for September = 52. Implementation of the proposed LLP arrangements for Consultants is yet to be confirmed as the Trust awaits a legal review to be completed.

RISKS / ISSUES

- Ongoing discussions with medical groups regarding the pension/tax issue continue

8. 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 preparations to ensure smooth delivery of activity planned.

ACTIONS FOR IMPROVEMENTS / LEARNING

Target 85%

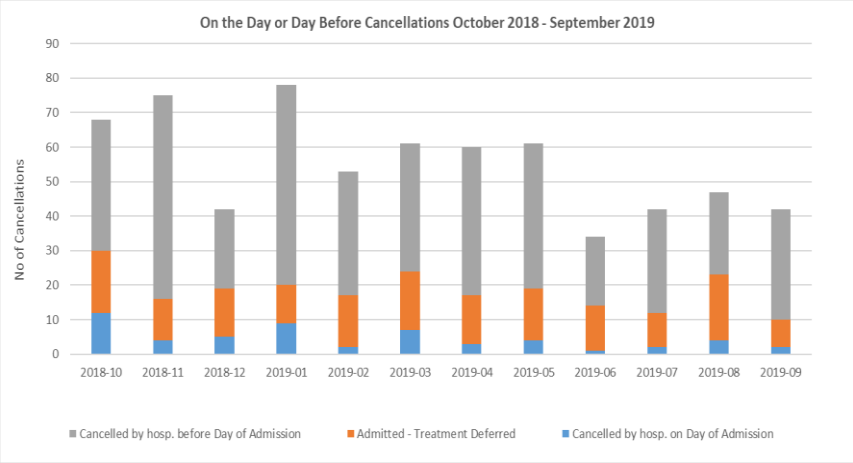
In session utilisation was slightly below target in September was 84.32% compared to 85.25% in August.

Utilisation continues to be pro actively managed at 642 meetings to maximise utilisation.

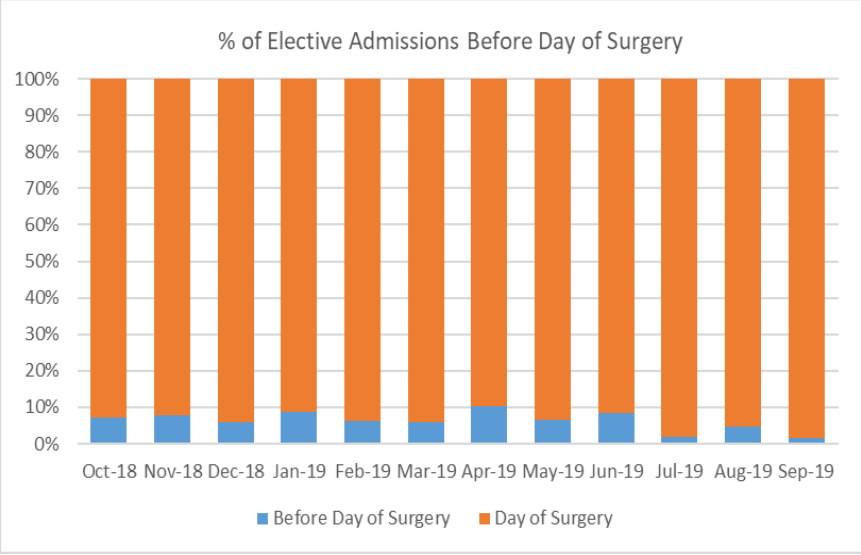
RISKS / ISSUES

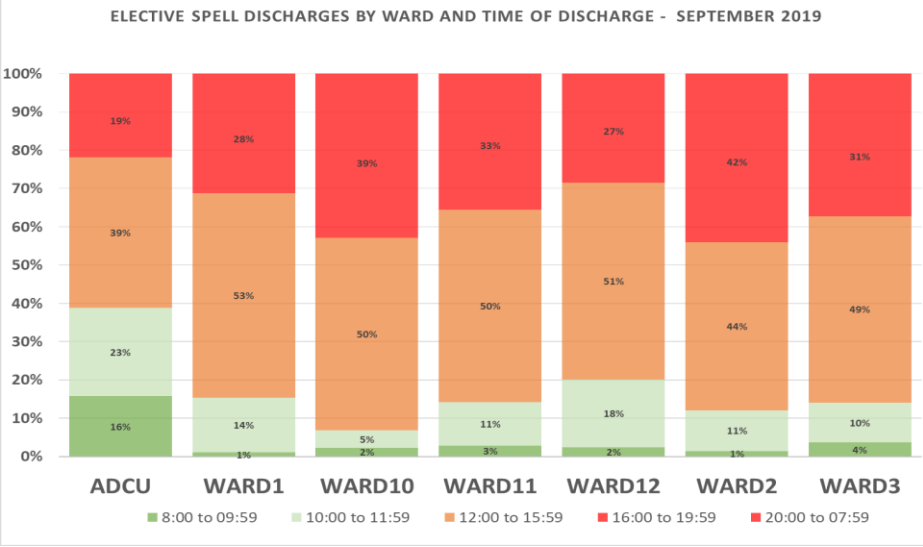
- Last minute changes to lists impact on the efficient running and planning of theatre lists - risk being reduced due to introduction of lock down process and learning from theatre lookback meetings
- Cancellations on the day – risk being better managed via look back meetings and service review which includes changes to the time patients are contacted as part of the 72hr call service.

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



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
2018-10	12	18	38	68	0
2018-11	4	12	59	75	0
2018-12	5	14	23	42	0
2019-01	9	11	58	78	0
2019-02	2	15	36	53	0
2019-03	7	17	37	61	0
2019-04	3	14	43	60	0
2019-05	4	15	42	61	0
2019-06	1	13	20	34	0
2019-07	2	10	30	42	0
2019-08	4	19	24	47	0
2019-09	2	8	32	42	0
Grand Total	**55**	**166**	**442**	**663**	**0**





The number of cancellations on the day of admission for surgery in September was 10 patients.

Analysis of these cancellations on the day identified that 4 patients were cancelled due to lack of Theatre time, 2 for lack of theatre staff, 2 for admin errors, 1 because of a change in procedure on the day and 1 because a patient had no one to care for them at home.
Cancellations before the day of surgery for September were 32 which has increased since last month but this remains below the last 12 month average of 37. An analysis of the 32 patients cancelled by the hospital before admission highlighted three main factors for cancellations prior to surgery: patients not medically fit declared at the 72 hour contact call, to accommodate emergency cases, and patient medically unfit following preassessment.

The 72 hour call to patients continues as business as usual and continues to work well. Patients are reconvened appropriately, thus avoiding cancellations on the day for these patients. Replacement patients can then be contacted to ensure theatre lists are fully utilised. This information then feeds in to the weekly Theatre Look back meeting where cancellations are discussed. This meeting now includes a financial breakdown of average loss of income from April 2019 relating to cancellations on the day . The 72 hour call process has now been strengthened and an extended hours contact service is in place so patients can be contacted at evenings and weekends to improve compliance . The escalation process has also been strengthened to ensure any cancellations are picked up in a timely manner.

A dashboard of activity data with service performance indicators is currently being developed and will be incorporated into future F & P information to demonstrate the significant measurable improvements.

ACTIONS FOR IMPROVEMENTS / LEARNING

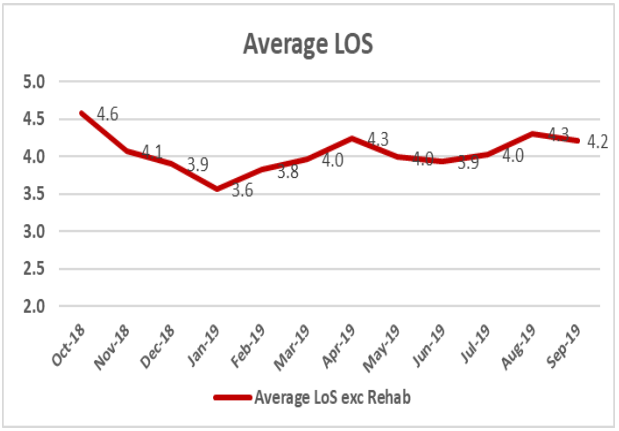
PERFECTING PATHWAYS

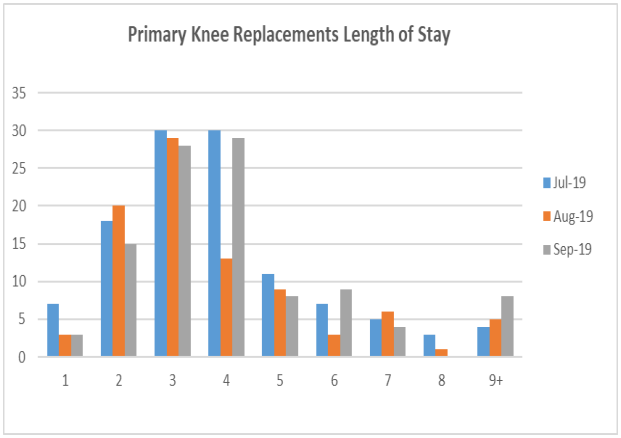
As a result of POAC now attending the morning huddle, escalation processes improvements and the SOP for bookings implemented, this has resulted in better communication between POAC and secretarial teams

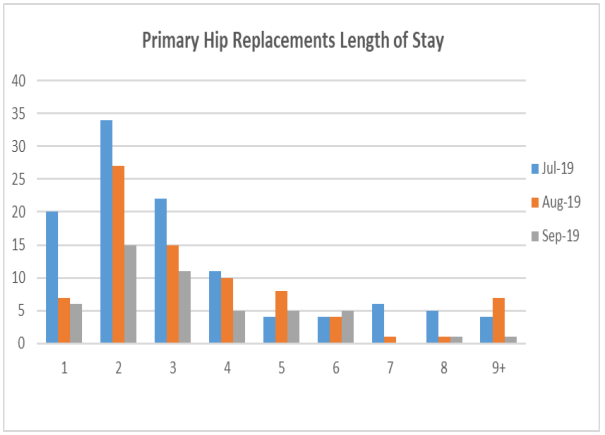
RISKS / ISSUES

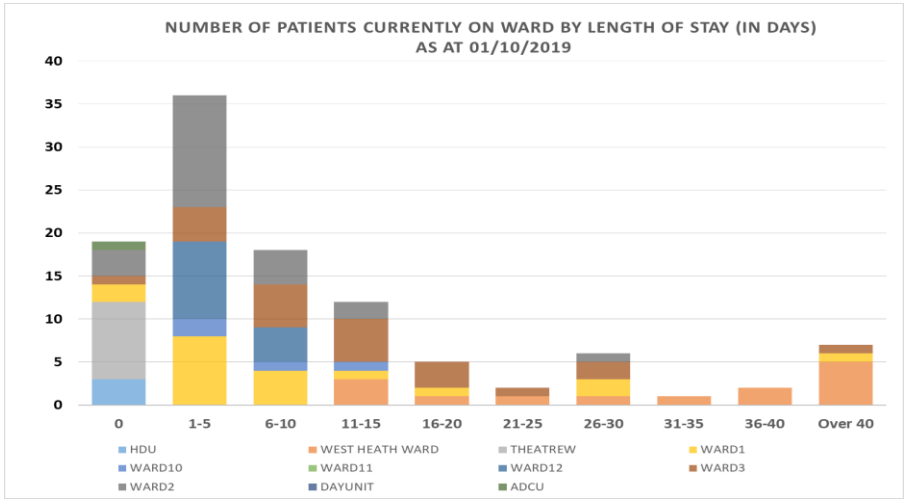
The Managed Service Contract is progressing to completion.

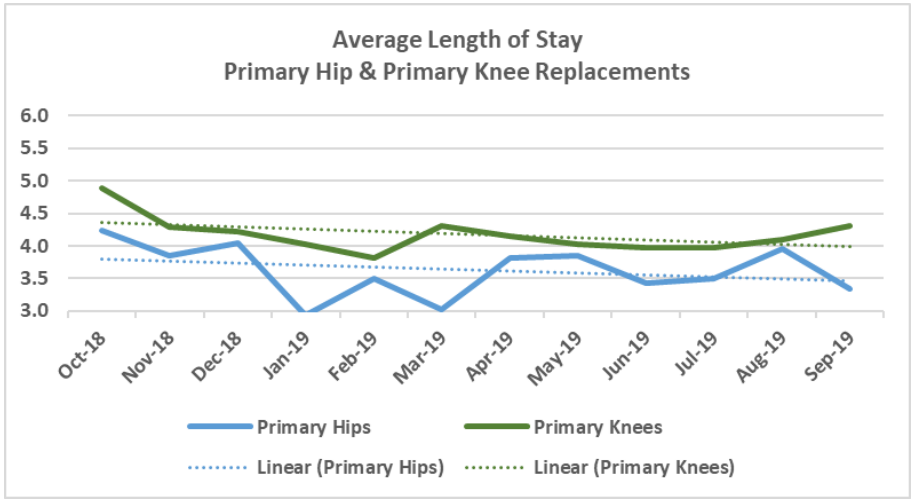
10. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways





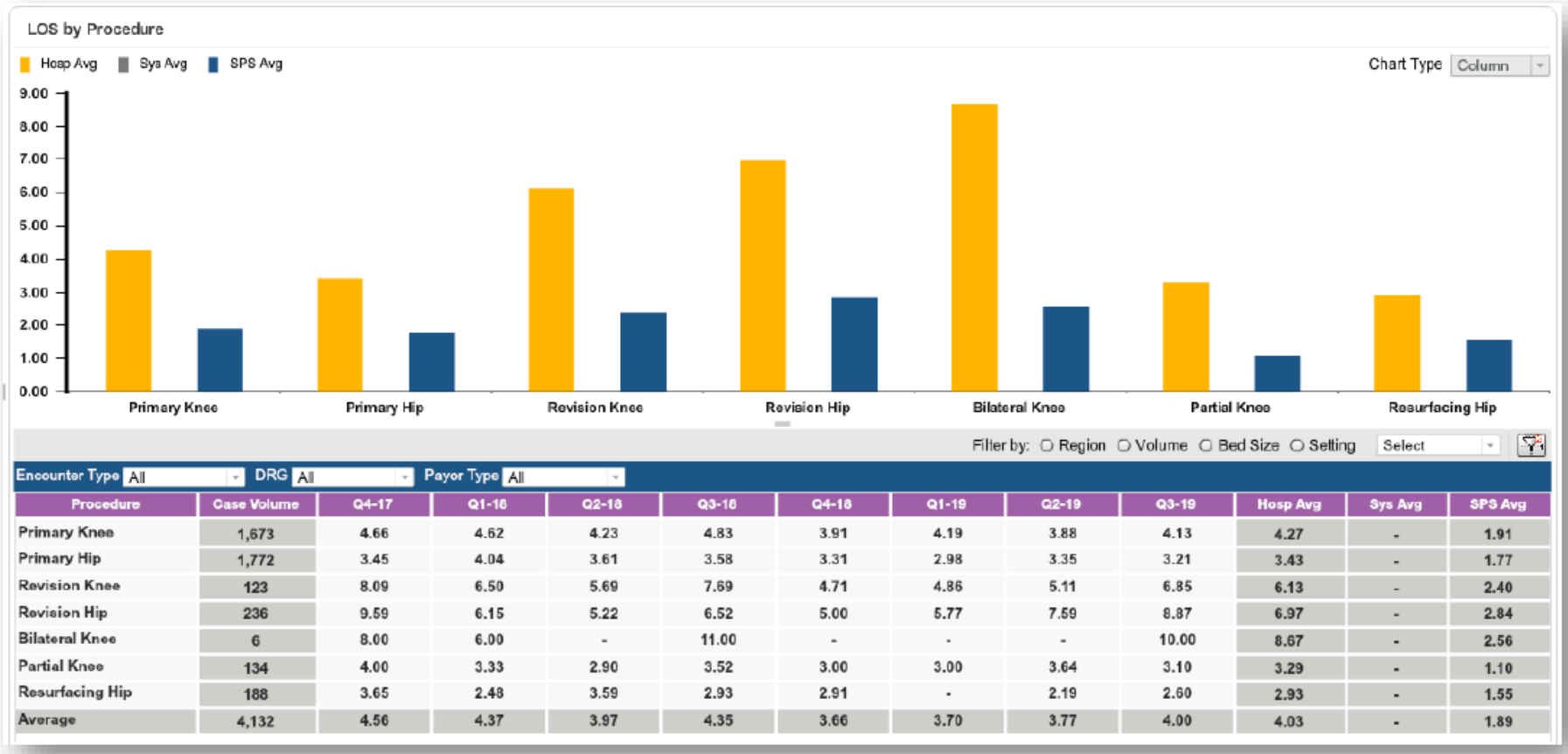






Jointcare – Arthroplasty Teams: LOS by procedure

Please note: Quarters are calendar year not financial year



Procedure	Case Volume	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Hosp Avg	Sys Avg	SPS Avg
Primary Knee	1,673	4.66	4.62	4.23	4.83	3.91	4.19	3.88	4.13	4.27	-	1.91
Primary Hip	1,772	3.45	4.04	3.61	3.58	3.31	2.98	3.35	3.21	3.43	-	1.77
Revision Knee	123	8.09	6.50	5.69	7.69	4.71	4.86	5.11	6.85	6.13	-	2.40
Revision Hip	236	9.59	6.15	5.22	6.52	5.00	5.77	7.59	8.87	6.97	-	2.84
Bilateral Knee	6	8.00	6.00	-	11.00	-	-	-	10.00	8.67	-	2.56
Partial Knee	134	4.00	3.33	2.90	3.52	3.00	3.00	3.64	3.10	3.29	-	1.10
Resurfacing Hip	188	3.65	2.48	3.59	2.93	2.91	-	2.19	2.60	2.93	-	1.55
Average	4,132	4.56	4.37	3.97	4.35	3.66	3.70	3.77	4.00	4.03	-	1.89

INFORMATION

Average LOS in September has fallen from 4.3 to 4.2 days

September data includes a considerable number of patients requiring social packages and additional medical needs that impacted on the average LOS in month.
A further analysis of the August data suggests that oncology arthroplasty had a significant impact on length of stay data with an average LOS of 5.6 in comparison to 3.6 for non-oncology arthroplasty. A further review of the upper 10% LOS indicates that over 10% (oncology arthroplasty) versus 2.8% (arthroplasty) of patients respectively will have a stay of 11 days or greater. This might suggest why the Jointcare data is so different from the data produced via business intelligence.(Joint care data now included in pack)
A similar review of this months data (Sept 2019) shows a continued variation when primary arthroplasty data (hips and knee) were split on a arthroscopy/arthroplasty and oncology basis (3.2 days vs 6.3 days average LOS respectively).. This suggests further improvements on LOS within the Jointcare patients month on month.

ACTIONS FOR IMPROVEMENTS / LEARNING

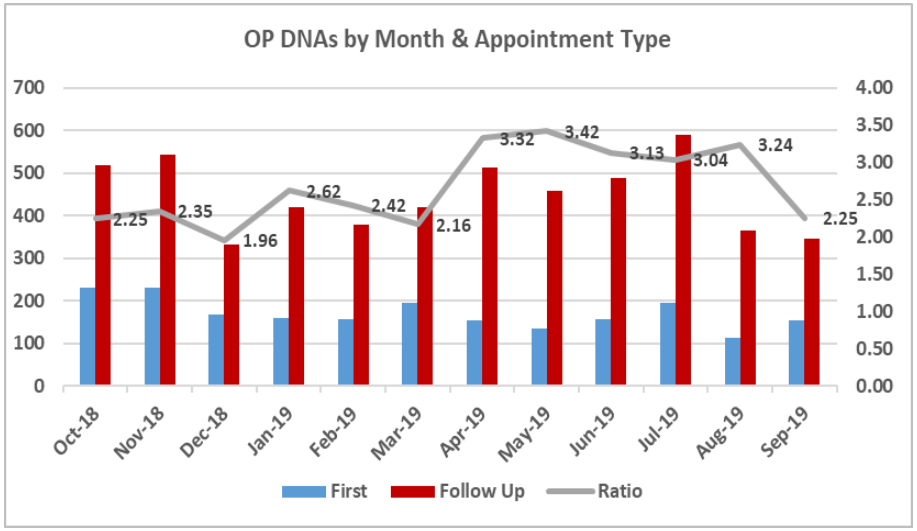
There are a number of initiatives agreed to refocus reduction in length of stay including:

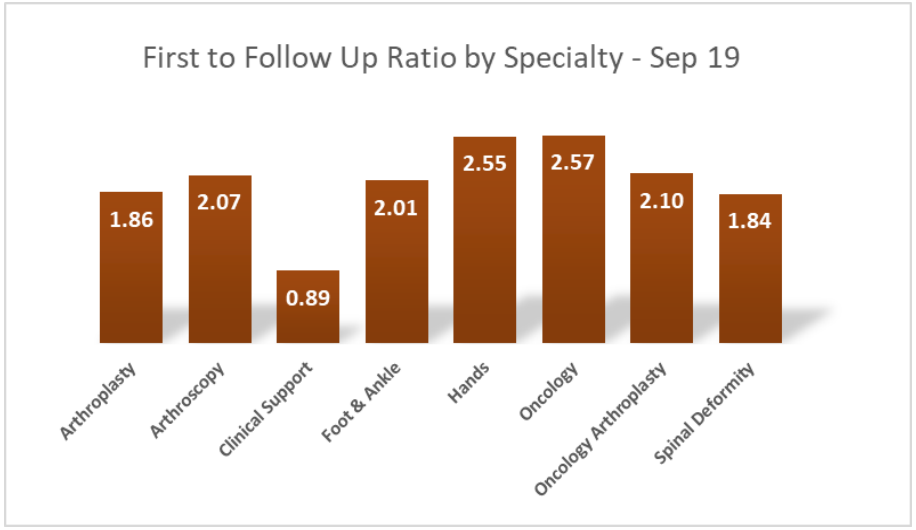
- A weekly review by Division 1 Operations team into LOS and activity.
- A review of the Red to Green data as it matures as a dataset (trends are POC on Ward 1, physio assessment IV Abs and x-ray on Ward 2, wound reviews on Ward 3 and POC on Ward 12.
- Daily review of patients with LOS greater than expected LOS by senior ward and discharge nursing team.
- With the support of the Medical Director renew need for senior review on a daily basis on every patient.
- Continue to utilise Discharge Lounge – noting that usage increases month on month.
- The joint care data is now to be included in the integrated performance dashboard which is currently being developed.
- To ensure accurate and timely ADT data, a working group led by the inpatient matron has been established. Out of hours roaming Admin to support timely discharge.
- Pathology issues still being raised via Ulysses when delays occur and escalated appropriately – no current ongoing issues identified.
- Review LOS dataset combining with GIRFT dataset looking at LOS against prevalent operation codes in speciality.
- Further improvements identified in the use of Ward 4 for Jointcare to allow all arthroplasty patients to benefit from the service fully.

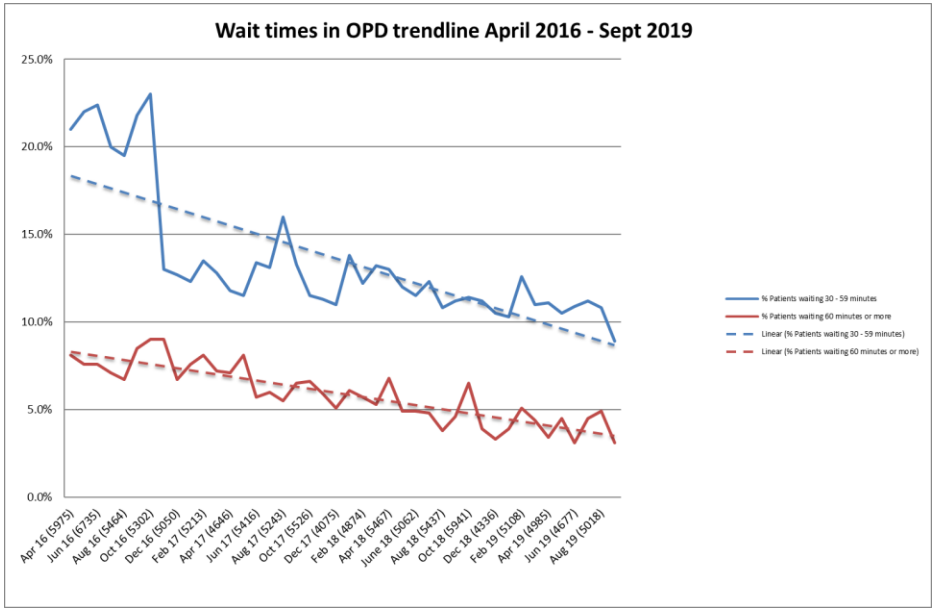
RISKS / ISSUES

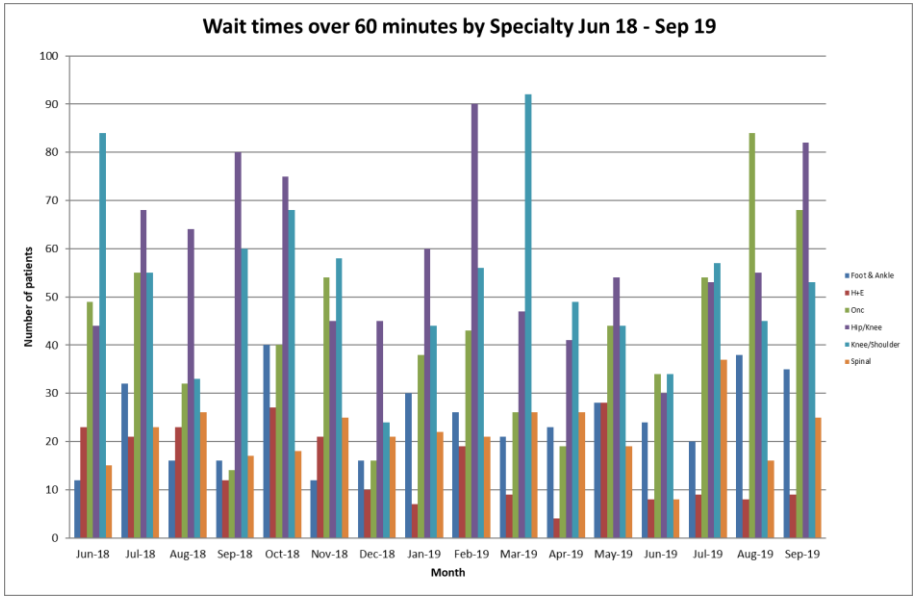
- A focussed approach to reducing length of stay is now in place supported by a number of key interventions maximising bed capacity and increased activity .
- Review of Hip and Knee data does suggest that oncology cases/ Bone infection have a significantly higher LOS and this is reflected in the LOS data monthly variation.

11. 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 8.9% of patients waiting over 30 minutes which is a 1.9% lower than the previous month. The over 60 minute delays continue to be achieve under the target of 5% with a level of 3.1% for July .This KPI is now consistently being achieved. A new method of creating the report is being used to take account of patients that arrive for their appointments late.
The 643 meeting is now maturing and is being held on a Thursday and there has been consistent representation from the imaging department. The Clinical Service and Support Managers are invited to attend as well as representation from Outpatients. There is a regular agenda that includes discussion of activity booked, capacity available in the coming weeks and rescheduling requests received with less than 6 weeks notice.

There were 22 incidents of clinic delays reported in September 2019 with the following breakdown.

5 Complex Patient
5 Other
4 X-ray delay
4 Clinic Overbooked
3 Consultant / Clinician Delay
1 Delay in Medical Records
Work is underway to review the co-ordination of clinics with Imaging capacity to reduce the number of delays associated with imaging and early work is encouraging with more patient receiving booked appointments within Radiology prior to their clinic appointments creating better flow in both areas and improving the patient experience.

ACTIONS FOR IMPROVEMENTS / LEARNING

- The InTouch system needs to be upgraded in order to implement electronic outcomes and this is underway. Initial meetings have been held and a demo of the new system is being arranged
- DrDoctor has been implemented across all specialties, except Oncology. The DNA rate has dropped to under 8% for the last 2 months which would lead to more attendances from an average of 10% over the last year .

RISKS / ISSUES

- A meeting has been held with the Deputy Director of Operations to discuss the lack of space in the main outpatients department. A working group is to be set up and will run weekly to discuss the issue of clinic room capacity, particularly in relation to the extra capacity that will be needed when the new consultants arrive to fill the modular theatres. Alternative follow up methods are being scoped including virtual clinics and maximising the use of digital opportunities such as skype clinics.

12. Referral to Treatment snapshot as at 30th September 2019 (Combined)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/09/2019

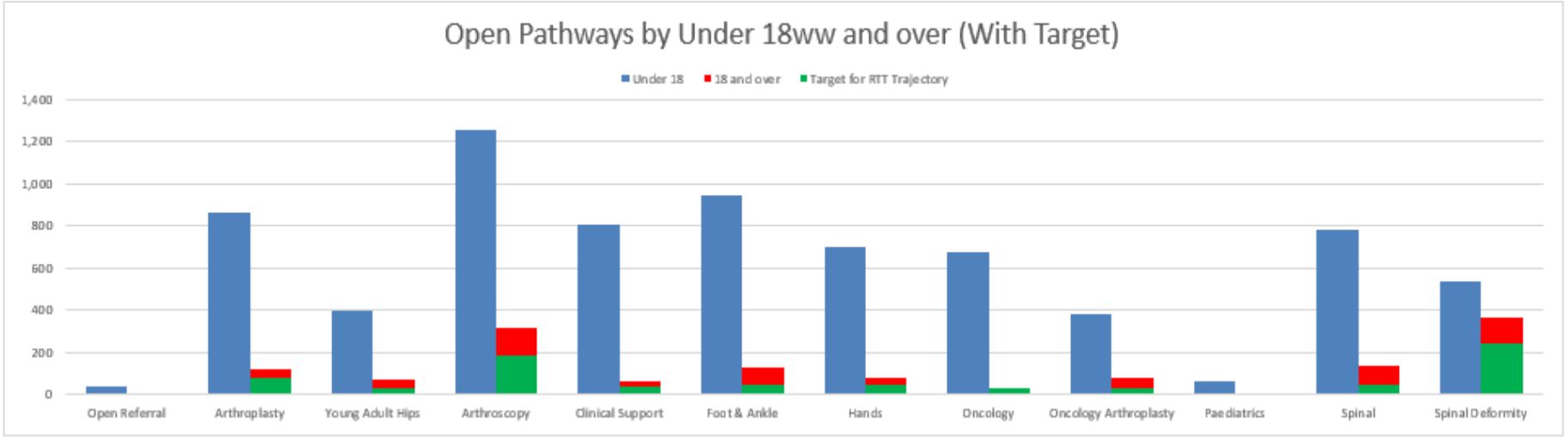
Est Over 18 Clock Stops Required		
To achieve	92.00%	883
To achieve	88.17%	479
To achieve	85.32%	154

Select Pathway Type: Both

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young	Spinal	Spinal Deformity
0-6	**3,506**	33	441	194	577	392	448	336	338	170	33	315	229
7-13	**2,798**	4	300	151	490	290	367	275	228	140	22	328	203
14-17	**1,148**	3	122	56	190	123	130	88	109	72	9	141	105
18-26	**1,072**	1	113	57	241	61	119	69	21	74	2	103	211
27-39	**326**	0	9	11	75	6	9	12	7	8	0	35	154
40-47	**18**	0	2	1	5	1	0	0	0	2	0	2	5
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8,868**	41	987	470	1,578	873	1,073	780	703	466	66	924	907

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**7,452**	40	863	401	1,257	805	945	699	675	382	64	784	537
18 and over	**1,416**	1	124	69	321	68	128	81	28	84	2	140	370
Target for RTT Trajectory	**790**	1	78	33	185	40	52	51	32	36	1	49	243
Target for RTT 92%	**709**	**3**	**78**	**37**	**126**	**69**	**85**	**62**	**56**	**37**	**5**	**73**	**72**

Month End RTT %	**84.03%**	**97.56%**	**87.44%**	**85.32%**	**79.66%**	**92.21%**	**88.07%**	**89.62%**	**96.02%**	**81.97%**	**96.97%**	**84.85%**	**59.21%**
30/09/2019 Trajectory RTT %	91.09%	96.70%	92.01%	92.94%	88.27%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	73.18%
Variance from Target to meet Trajectory	626	0	46	36	136	28	76	30	-4	48	1	91	127
Variance from target 92%	707	-2	46	32	195	-1	43	19	-28	47	-3	67	298



13. Referral to Treatment snapshot as at 30th September 2019 - Admitted

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/09/2019

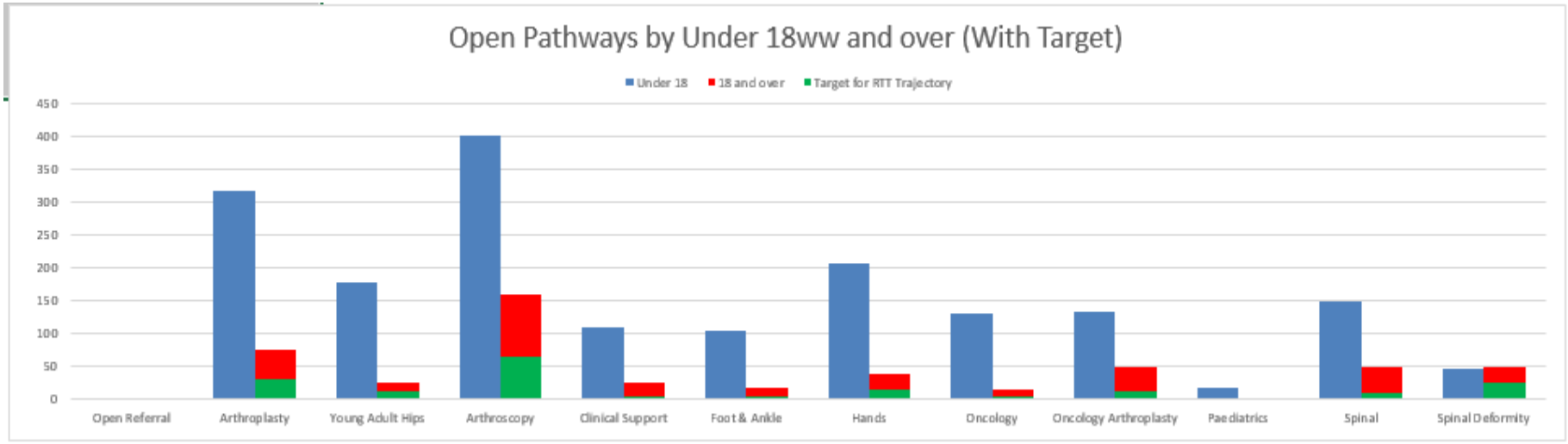
Est Over 18 Clock Stops Required		
To achieve	92.00%	410
To achieve	88.17%	313
To achieve	85.32%	235

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young	Spinal	Spinal Deformity
0-6	**677**	0	127	67	147	26	31	89	65	52	9	52	12
7-13	**742**	0	129	79	171	49	54	87	48	37	5	59	24
14-17	**376**	0	61	31	83	36	20	31	19	44	3	37	11
18-26	**394**	0	67	21	115	24	17	33	9	45	1	39	23
27-39	**110**	0	8	5	41	3	2	6	6	4	0	10	25
40-47	**9**	0	1	1	5	0	0	0	0	1	0	0	1
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,308**	0	393	204	562	138	124	246	147	183	18	197	96

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,795**	0	317	177	401	111	105	207	132	133	17	148	47
18 and over	**513**	0	76	27	161	27	19	39	15	50	1	49	49
Target for RTT Trajectory	**205**	0	31	14	65	6	6	16	6	14	0	10	25
Target for RTT 92%	**184**	**0**	**31**	**16**	**44**	**11**	**9**	**19**	**11**	**14**	**1**	**15**	**7**

Month End RTT %	**77.77%**	**n/a**	**80.66%**	**86.76%**	**71.35%**	**80.43%**	**84.68%**	**84.15%**	**89.80%**	**72.68%**	**94.44%**	**75.13%**	**48.96%**
30/09/2019 Trajectory RTT %	91.09%	96.70%	92.01%	92.94%	88.27%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	73.18%
Variance from Target to meet Trajectory	308	0	45	13	96	21	13	23	9	36	1	39	24
Variance from target 92%	329	0	45	11	117	16	10	20	4	36	0	34	42



13. Referral to Treatment snapshot as at 30th September 2019 (non admitted)

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at 30/09/2019

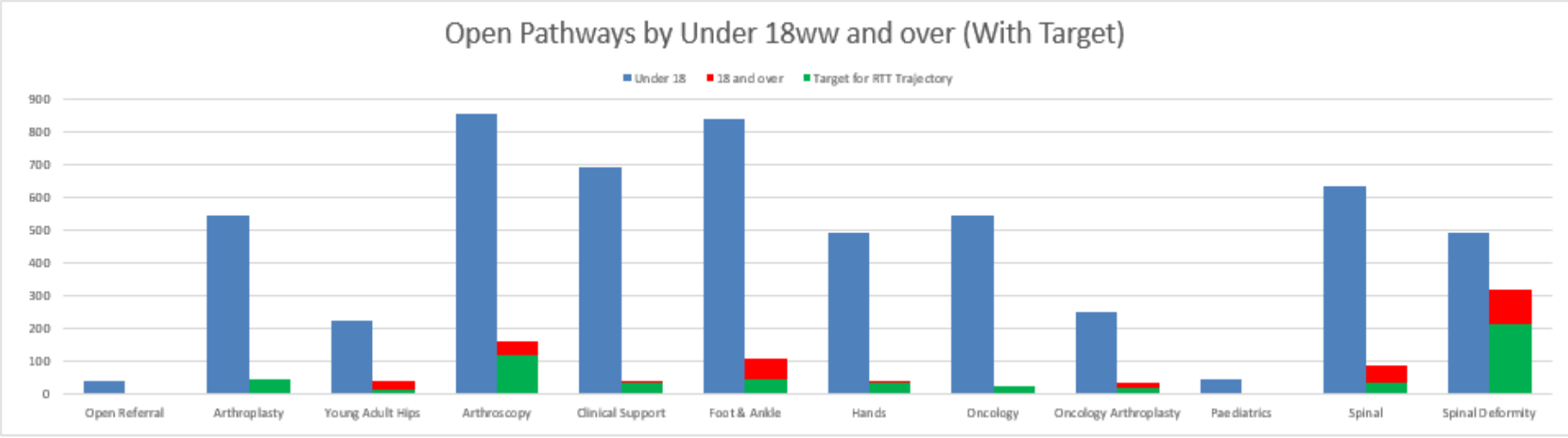
Est Over 18 Clock Stops Required		
To achieve	92.00%	473
To achieve	88.17%	166
To achieve	85.32%	-81

Select Pathway Type: Non-Admitt

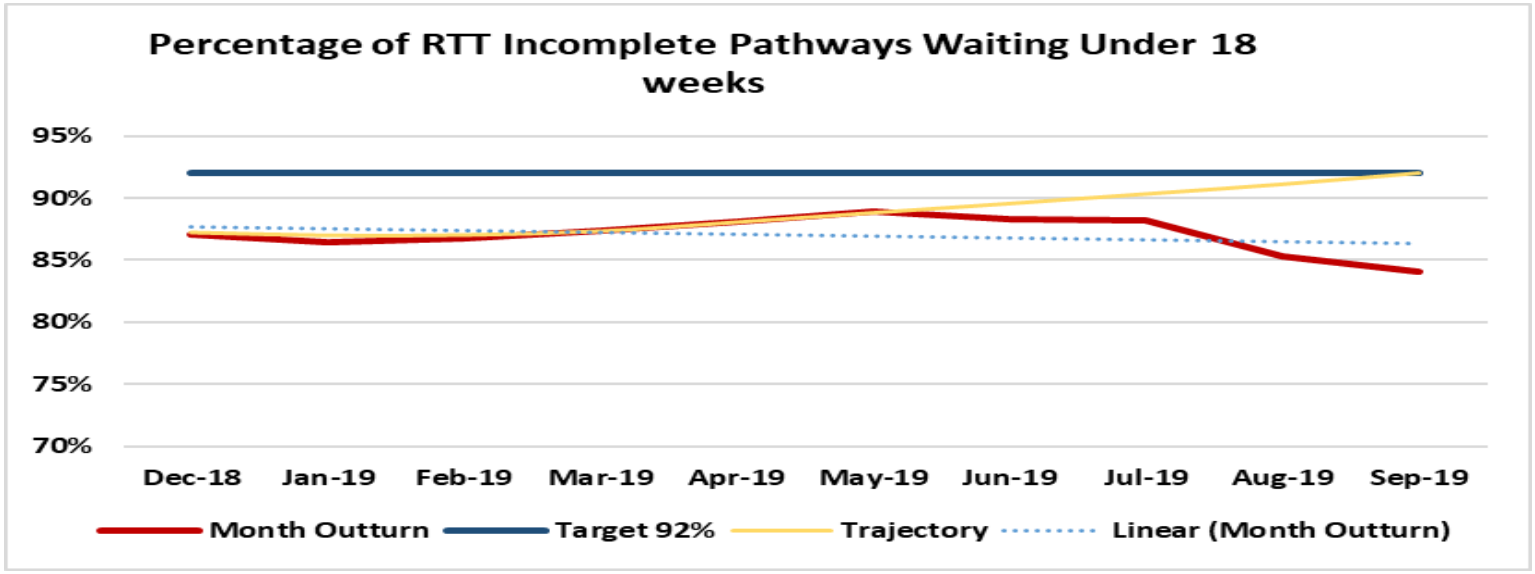
Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics & Young	Spinal	Spinal Deformity
0-6	**2,829**	33	314	127	430	366	417	247	273	118	24	263	217
7-13	**2,056**	4	171	72	319	241	313	188	180	103	17	269	179
14-17	**772**	3	61	25	107	87	110	57	90	28	6	104	94
18-26	**678**	1	46	36	126	37	102	36	12	29	1	64	188
27-39	**216**	0	1	6	34	3	7	6	1	4	0	25	129
40-47	**9**	0	1	0	0	1	0	0	0	1	0	2	4
48-51	**0**	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks and over	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6,560**	41	594	266	1,016	735	949	534	556	283	48	727	811

Weeks Waiting	Total	Open Referral	Arthroplasty	Young Adult Hips	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,657**	40	546	224	856	694	840	492	543	249	47	636	490
18 and over	**903**	1	48	42	160	41	109	42	13	34	1	91	321
Target for RTT Trajectory	**584**	1	47	18	119	34	46	35	25	22	1	39	217
Target for RTT 92%	**524**	**3**	**47**	**21**	**81**	**58**	**75**	**42**	**44**	**22**	**3**	**58**	**64**

Month End RTT %	**86.23%**	**97.56%**	**91.92%**	**84.21%**	**84.25%**	**94.42%**	**88.51%**	**92.13%**	**97.66%**	**87.99%**	**97.92%**	**87.48%**	**60.42%**
30/09/2019 Trajectory RTT %	91.09%	96.70%	92.01%	92.94%	88.27%	95.35%	95.08%	93.35%	95.43%	92.22%	97.56%	94.62%	73.18%
Variance from Target to meet Trajectory	319	0	1	24	41	7	63	7	-12	12	0	52	104
Variance from target 92%	379	-2	1	21	79	-17	34	0	-31	12	-2	33	257



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



The PTL (patient tracking list) is actively monitored on a daily basis with a formal weekly tracking meeting chaired by the Deputy Chief Operating Officer. The trajectory for all specialties is currently being revised as it predicted that the Trust returned to 92% by September 2019, which has not been possible due to the current activity challenges relating to reduction in ADH capacity and the revised trajectory will be included in the October Finance and Performance report.

The September position is 84%, this being lower than NHSI trajectory forecasted position of 92%. This shows a deterioration from last month. In September the Trust had 0 patients over 52weeks. There are 18 patients over 40 weeks against last month's position of 21. An updated briefing paper was included in the F&P pack in July which detailed the details of the recovery plan. Detailed activity monitoring by individual specialty is shared weekly with the Executive Team and F&P Committee.

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 - Patients still Waiting at Month End								Activity			
Month	MRI	CT	US	Total Waiting	Over 6 Weeks	Under 6 Weeks	% Under 6 Weeks	MRI	CT	US	Total Activity
Jul-18	732	112	336	1,180	8	1172	99.3%	961	211	290	1,462
Aug-18	568	107	301	976	9	967	99.1%	682	165	290	1,137
Sep-18	696	110	311	1,117	4	1113	99.6%	778	208	394	1,380
Oct-18	781	110	370	1,261	7	1254	99.4%	725	247	344	1,316
Nov-18	736	135	381	1,252	7	1245	99.4%	801	243	406	1,450
Dec-18	698	115	346	1,159	11	1148	99.1%	843	224	367	1,434
Jan-19	728	123	416	1,267	4	1263	99.7%	897	253	472	1,622
Feb-19	844	134	386	1,364	3	1361	99.8%	854	248	436	1,538
Mar-19	776	133	461	1,370	1	1369	99.9%	868	271	410	1,549
Apr-19	835	89	414	1,338	6	1332	99.6%	894	244	419	1,557
May-19	807	94	337	1,238	1	1237	99.9%	914	270	478	1,662
Jun-19	874	100	380	1,354	1	1353	99.9%	793	266	399	1,458
Jul-19	776	98	361	1,235	7	1228	99.4%	1001	270	435	1,706
Aug-19	836	80	362	1,278	8	1270	99.4%	858	237	375	1,470
Sep-19	973	80	363	1,416	4	1,412	99.7%	983	224	477	1,684

13. Cancer Performance Targets

		Indicative	Reported Month					2018/19			
Target Name	**National Standard**	***Sep-19***	***Aug-19***	**Jul-19**	***Jun-19***	**May-19**	**Apr-19**	**Q4 2018/19**	**Q3 2018/19**	**Q2 2018/19**	**Q1 2018/19**
2ww	93%	*tbc*	**96.1%**	**97.6%**	**100%**	***98.6%***	***95.6%***	**98.8%**	**99%**	**100%**	**99%**
31 day first treatment	96%	*tbc*	**100.0%**	**92.3%**	**100%**	**83.3%**	***100%***	**94.4%**	**100%**	**100%**	**100%**
31 day subsequent (surgery)	94%	*tbc*	**100.0%**	**100%**	**100%**	***100.0%***	***100%***	**95.2%**	**98%**	**100%**	**97%**
62 day (traditional)	85%	*tbc*	**100.0%**	**100%**	**77.8%**	**72.7%**	***100%***	**96%**	**51.3%**	**69.9%**	**82%**
62 day (Cons Upgrade)	n/a	*tbc*	*75.0%*	78.6%	***100.0%***	***100.0%***	***92.9%***	83.70%	**91.37%**	**92.6%**	**94%**
28 day FDS	85%	tbc	*85.7%*	70.3%	80%	85.1%	81.0%				
No. patients treated 104+ days		*tbc*	*2*	*1*	0	*1*	1	2	3	1	**1**

PERFORMANCE/IMPROVEMENTS/LEARNING

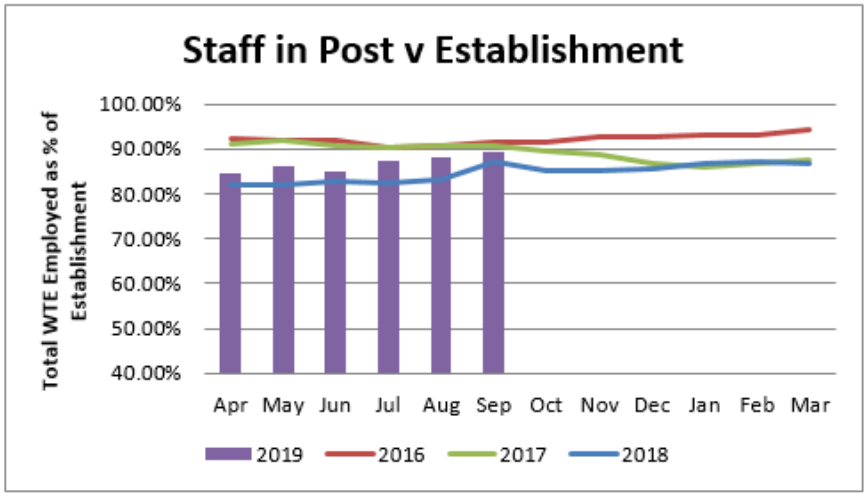
All statutory targets achieved in August.
The patients who breached the consultant upgrade standard were down to complex pathways and delays in getting approval for Proton therapy.

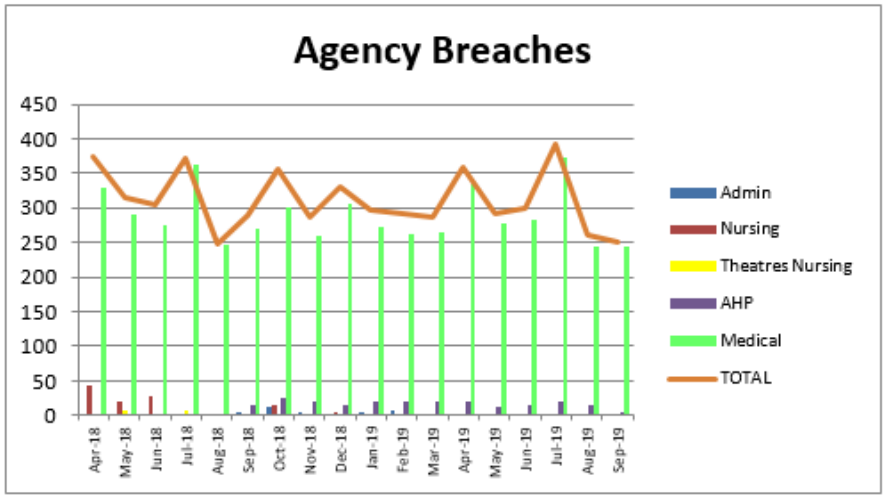
Weekly Cancer PTL continues to monitor and track patients along the referral to treatment pathway
A review of the CT capacity to take place to ensure there is enough capacity to deliver the new target compliance of 28 FDS

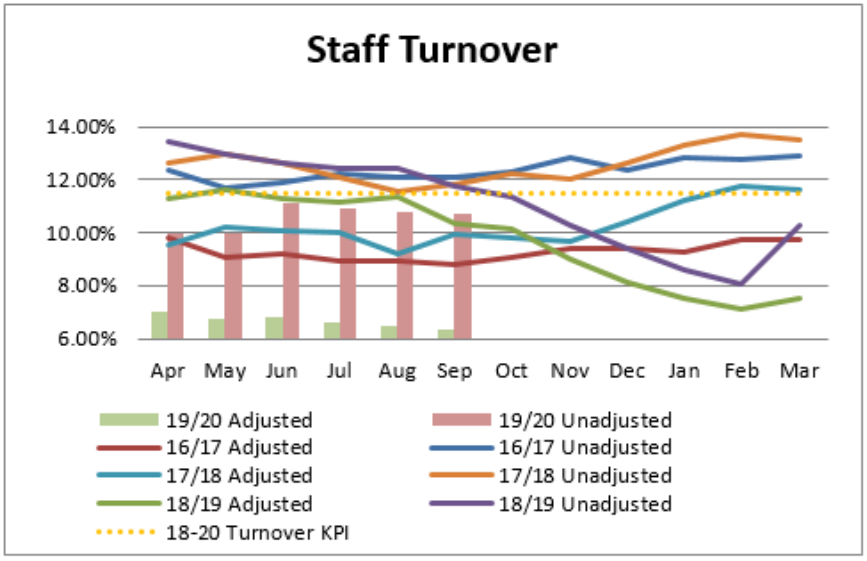
RISKS / ISSUES

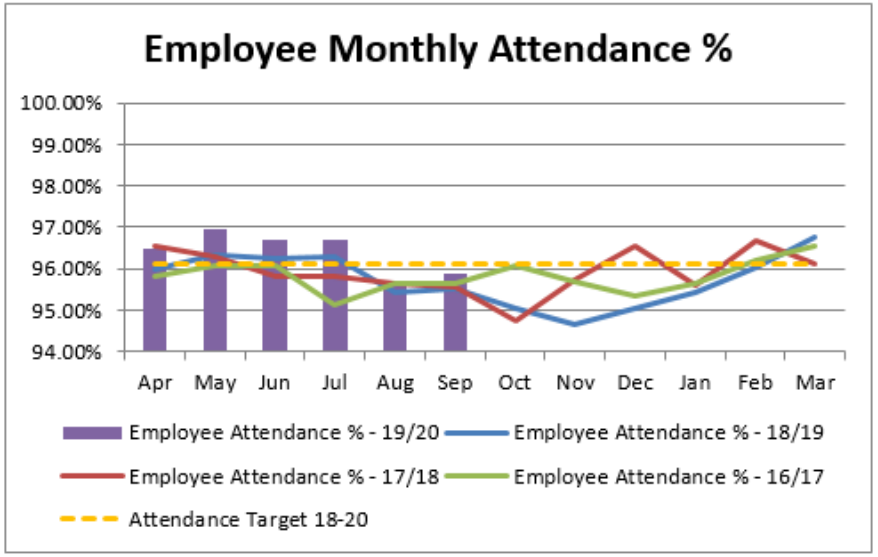
Paediatric Surgery has been suspended at Birmingham Children's Hospital. Predicted recommencement date is Jan 2020.
Oversight meeting with NHSI and the specialist commissioner are in place to ensure a safe resumption of the service takes place. Patients with a planned date for surgery within this timeframe are being transferred to other specialist units across the UK. Predominantly Stanmore/ Oswestry will receive the majority of these patients.

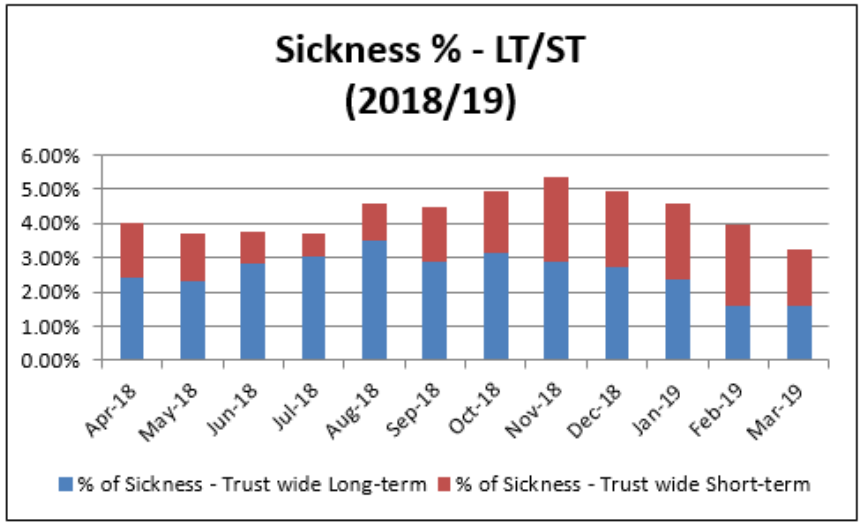
2. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training.

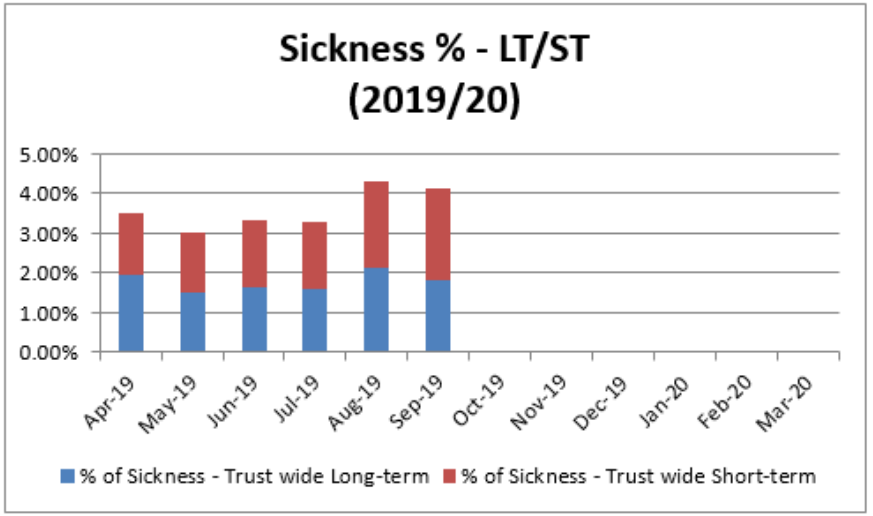


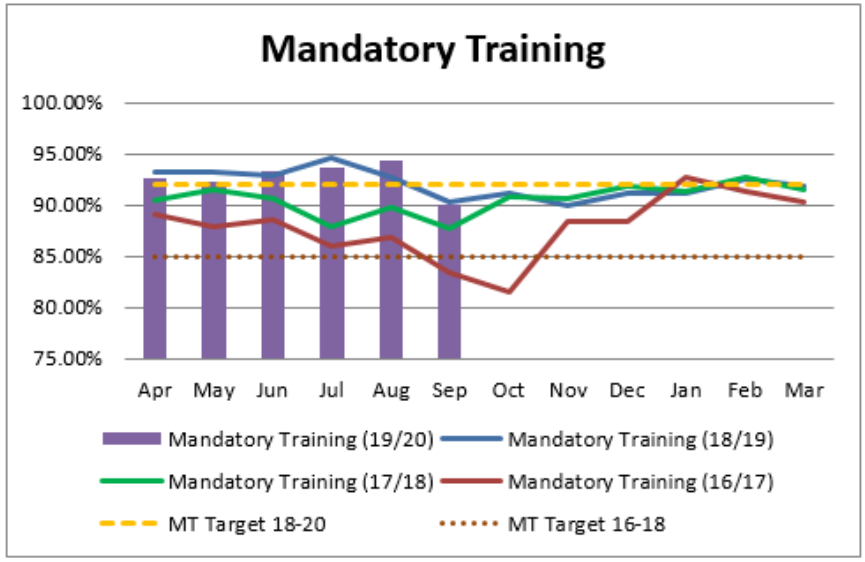


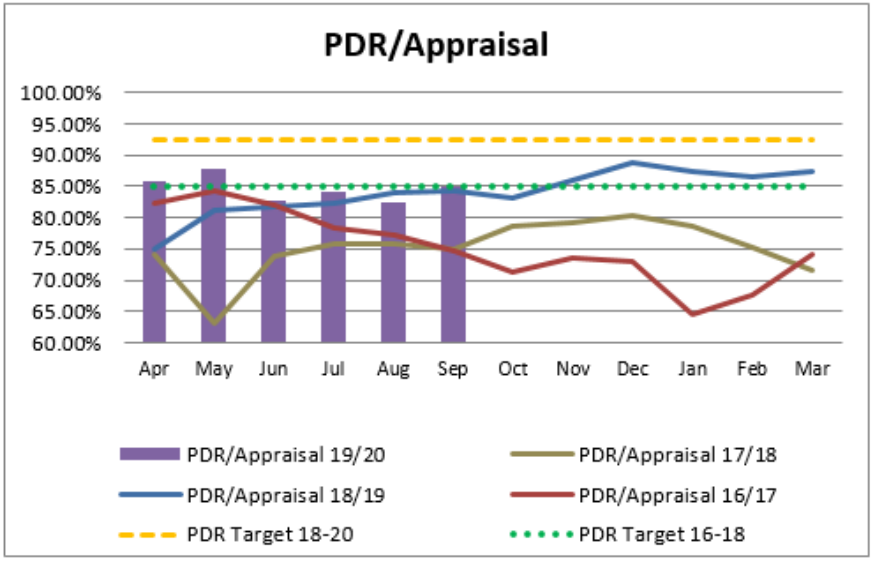





Sickness % - LT/ST
(2018/19)
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term


Sickness % - LT/ST
(2019/20)
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
% of Sickness - Trust wide Long-term
% of Sickness - Trust wide Short-term


Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Mandatory Training (19/20)
Mandatory Training (18/19)
Mandatory Training (17/18)
Mandatory Training (16/17)
MT Target 18-20
MT Target 16-18


PDR/Appraisal
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
PDR/Appraisal 19/20
PDR/Appraisal 17/18
PDR/Appraisal 18/19
PDR/Appraisal 16/17
PDR Target 18-20
PDR Target 16-18

INFORMATION

September was an improved month for Workforce performance it saw an improvement in Trust-wide monthly attendance, the recurring decrease in turnover, which subsequently lead to a decrease in vacancies and an increase in appraisal completion, unfortunately these improvements were slightly blighted by a decrease in mandatory training compliance.

This month the Trust's vacancy position saw an increase of 1.24%, as a percentage of WTE employed, with the figure for August at 89.24%, which is 3% away from the Trust target of 93%. The number of staff on the payroll, stood at 959.92 (full time equivalent), which saw a significant increase of circa 29 FTE, compared to August.

In September, monthly attendance increased slightly by 0.17% to 95.88% and has remained amber this month against our KPI of 96.1%, for the 3rd time this calendar year. The underlying 12-month average sickness absence figure increased this month by 0.01% to 4.09%. Long Term sickness data continues to decrease, it stood at 1.83% in September 19 compared to 2.14% in August 19 and in September 2018 it stood at 2.88%. On the other hand, short term sickness increased again this month by 0.14% from 2.15% to 2.29% in August.

Mandatory Training has decreased from 94.26% to 90.01%, the figure remains amber for the first time this financial year against the Trust target of 92%. The L&D Team believe this decrease is due to some of the competence requirements and renewal periods being changed. As competencies are reviewed, some further decreases may arise, before the upward trend re-emerges. They continue to encourage staff to book onto courses via ESR, to support staff to carry out their Mandatory Training via e-learning.

This month Appraisal performance has increased significantly by 2.52% from 82.39% in August to 84.91% in September, nonetheless, further work is still required as an improvement of 8.09% is required to meet our stretched target of 92%. The ESR team continue to promote ESR Drop-in sessions and communications with "crib" sheets have been circulated to Divisions along with clarifications to managers on ow and where to record PDR completion dates etc.

The unadjusted turnover figure (all leavers except junior doctors and retire/returners) decreased by 0.02% to 10.73%, the figure remains green against a Trust KPI of 11.5%. The adjusted turnover figure (substantive staff leavers including retirements) also decreased by 0.12% to 6.36% in September. Work is underway to revise our exit questionnaire/interview process to enable us to better understand the reasons for leaving, as well as to revise our termination on ESR process to ensure we receive a true reflection of our leavers.

In September, Agency Breaches decreased significantly from 262 to 250 shift breaches in total, with the vast majority continuing to be utilised with medical usage (244). There were 2 nursing breaches in September and 4 AHP breaches but no 0 admin breaches.

ACTIONS FOR IMPROVEMENTS / LEARNING

A proposal outlining approaches to how we might reduce MSK related absence is being developed with a view to taking a more preventative approach which should hopefully lead to reduced absences related to MSK issues.

RISKS / ISSUES

Although turnover is 10.73% it is very close to the cap of 11.5%. This needs to be closely monitored.
The momentum with increasing PDR rates needs to be maintained and support provided to managers and staff to ensure that PDRs are given the importance that they require.

ROHTB (11/19) 022

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 17 October 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was agreed that the Audit Committee needed to be kept sighted on the impact of the new accounting standards, such as IFRS16 which impacted on leased assets. • The internal audit around IT disaster recovery was noted to have provided only partial assurance. Back up restoration was noted to be a key concern. The work to achieve compliance with Cyber Essential standards would assist with addressing some of the recommendations in this report. • There was noted to have been slower than expected progress with addressing some of the work to strengthen the handling of NICE guidance received into the Trust. • The Committee was disappointed that the average time to turnaround draft reports had increased to 40 days, from a target of 10 days and urged this to be addressed. • There had been a deterioration in the timely completion of audit recommendations and the Committee asked the Director of Finance to raise this with Executive colleagues.	• Arrange for the long standing rolling contracts held by the Trust to be reviewed to ensure that the Trust was achieving value for money. • The Board Committees in future to receive an extract of the recommendation tracker relevant to their remit to monitor closure of the actions. • Introduce a more routine prompt for staff to declare gifts, hospitality and interests should be implemented. • Arrange for the Board to have a further update on the Trust's environmental and sustainability strategy
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received an update on the plans to strengthen the cybersecurity arrangements in the Trust and there was noted to be a higher degree of compliance now with the Data Protection and Security Toolkit. • There was good progress with the external audit planning process. • The theatres utilisation advisory internal audit had identified that the management of theatres was sound and performance on theatre utilisation was above the national benchmark. The Committee was of the view that to break down the position into the various stages of a procedure may be useful to identify where further efficiencies	• The Committee provided a strong steer that there needed to be increased investment in cybersecurity measures and that every effort needed to be directed into achieving compliance with Cyber Essential standards. • The Committee approved the proposed audit fees of £64,000, which was the same cost levied in 2018/19. • The Committee supported the proposed changes to its terms of reference.

could be made. The new theatres could also provide an opportunity to optimise utilisation. • The temporary staffing usage internal audit provided a positive opinion and the controls around authorisation of temporary staffing were stringent. • The Committee received a self-assessment of its performance which was largely positive but also highlighted the need for better induction of new Committee members, succession planning for Committee members and the need to continue discussions around risk management and appetite.	
Chair's comments on the effectiveness of the meeting: The meeting was noted to have included some good challenge around cybersecurity investment, contracts and deterioration of report turnaround and action closure	

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Audit Committee terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Rod Anthony, Chair of Audit Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Corporate Affairs and Company Secretary**
DATE OF MEETING:	**6 November 2019**

EXECUTIVE SUMMARY:

The attached presents a suggested revision to the terms of reference of the Audit Committee in line with the requirement for them to be reviewed annually.

The amendments are minor in nature and relate to formatting and the title of the secretary to the meeting.

The Board is invited to note that there has been sound compliance with the terms of reference during the year through the delivery of the Committee's annual workplan.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the changes to the terms of reference

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	x	Environmental		Communications & Media	x
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:

None specifically. Good governance.

PREVIOUS CONSIDERATION:

The terms of reference were considered by the Audit Committee on 17 October, where the proposed changes were supported and it was agreed that they could go forward for presentation to the Trust Board for approval.

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 AGS 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
Director of Corporate Affairs & 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
.

15 Review of terms of reference

This should be undertaken annually.

16 Date of adoption – 6 November 2019

17 Date of review – November 2020