The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 28.11.2019

MEETING
26 September 2019 11:00

PUBLISHED
23 November 2019

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	26/09/19		11:00
1. Part One - Public Meeting			
1.1. Minutes of the Previous Meeting		All	11:00
1.2. Matters Arising		All	
1.3. Declarations of Interest		All	
1.4. Chair and CEO Commendation		Chair and Chief Executive	11:05
1.5. Patient Story		Interim Director of Nursing	11:15
2. Chief Executive Update		Chief Executive	11:30
3. Quality & Safety			
3.1. Chair Report: Quality and Safety		Non Executive Director	11:40
3.2. Guardian of Safe Working Hours		Medical Director	11:45
3.3. Infection Control Quarterly Update		Interim Director of Nursing	11:50
3.4. Learning from Deaths		Medical Director	11:55
3.5. Flu Vaccination Update		Interim Director of Nursing	12:00
3.6. Controlled Drugs Accountable Officer Annual Report		Interim Director of Nursing	12:10

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	26/09/19		11:00
4. Performance & Governance			
4.1. Chair Report: Finance Planning and Digital Committee (verbal)		Non Executive Director	12:15
4.2. Performance Report M7		Director of Performance, Improvement and OD	12:20
4.3. Treasury Management Policy		Director of Finance and Planning	12:40
4.4. Clinical Excellence Awards Annual Report		Director of People	12:45
5. Items to note			12:50
5.1. Corporate Objectives and Board Assurance Framework		Trust Secretary	
5.2. Performance Report M6		Director of Performance, Improvement and OD	
5.3. Orthopaedic Institute Annual Report		Chief Executive	
5.4. NOA Annual Report		Chief Executive	
5.5. Governors Update (verbal)		Trust Secretary	
6. Any Other Business		All	13:05
6.1. Questions from the Public			
6.2. Next meeting: 30th January 2019			

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC SESSION
26 SEPTEMBER 2019

MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive	MB
Chris Beacock	Non-Executive Director	CB
Nia Jones	Director of Operations	NJ
David Gilburt	Non-Executive Director	DG
Harry Turner	Non-Executive Director	HT
Paul Kingston	Non-Executive Director	PK
Sarah Sheppard	Director of People	SS
Alastair Findlay	Non-Executive Director	AF
Steve White	Medical Director	SW
Craig Macbeth	Director of Finance	CM

In Attendance:

Hilary Pepler	Board Advisor	HP
Shelley Ramtuhul	Trust Secretary	SR
Kerry Robinson	Director of Performance, Improvement and Organisational Development	KR
Nicki Bellinger	Deputy Director of Nursing	NB

FC welcomed all Board members to the Public Board.

MINUTE NO	TITLE
26/09/1.0	**APOLOGIES** Sarah Bloomfield, Interim Director of Nursing
26/09/2.0	**MINUTES OF THE MEETING 25 JULY 2019** The minutes of the meeting held on the 25 July 2019 were agreed as an accurate representation of the meeting
26/09/3.0	**MATTERS ARISING** FC went through the actions which were noted to be completed or updates provided.
26/09/4.0	**DECLARATIONS OF INTEREST** DG has been invited to work for the four Cheshire CCGs to work on the governance of their QIPP plans
26/09/5.0	**STAFF STORY – ROB FOX, INPATIENT SPECIALIST PHYSIOTHERAPIST** Rob Fox attended to share his experience of the Great Wall Marathon. He provided an overview of the following: • His role in the organisation • His running achievements • The marathon route and terrain • He finished 7th out of 800 competitors and the first british runner across the line • His next adventure will be running to Everest base camp for which he will be raising money for the Veteran's Service FC commented on what a great achievement this was and wished him luck with his next challenge. The Board ***noted*** the presentation.

26/09/6.0	**MSK POPULATION HEALTH – MR GERAINT THOMAS, CONSULTANT ORTHOPAEDIC SURGEON AND SENIOR LECTURER IN POPULATION ORTHOPAEDICS** SW introduced Geraint Thomas (GT) and explained his recent appointment is a joint appointment with Keele University. GT provided an overview of the following: • Dame Sally Davies' vision for measuring improvement in health and the work being taken forward by the Office for National Statistics • Inter-relation between the speed of walking and health • The impact of musculoskeletal health on general health • Osteoarthritis statistics, its contribution to global disability and the economic burden • James Lind Alliance – priorities • The role of hip shape on the development of osteoarthritis • How to move research in this area forward through collaboration and a strengthened multi-disciplinary team SW commented that the Trust was the leader in rapid recovery but oxford studies have progressed and there is a need to change practice in line with this. GT commented that the clinical practice does not have to change drastically with the biggest change being in relation to managing the patient's expectations about how early they will be up and about and likely to be home. GT's view is that patients need to be up earlier as this is associated with better outcomes and a lower risk of deep vein thrombosis. There are various small things that can make this easier such as different walking frames. PK asked about being world leading class and the input of other professions. GT felt that delivery of a multi-disciplinary approach in collaboration with Keele University is possible through improved relationships. Surgeons are the least important part of a successful rapid recovery programme. MB echoed GT's comments about managing the patient's expectations and in addition the expectations of their families. KR asked about the research study looking at men only and whether there are plans for studies to be gender neutral. GT advised that his study on hip shape was based on women and that as of last year funding bodies have ensure this as funding was only available to organisations that demonstrated equality in their research. CB commented on the form health care will take in years to come and whether GT will be in a position to bring his authority to bear. GT advised that his focus is the reframing of orthopaedic research positioning to counter decisions that are being made which are not evidence based. It was important that interventions are both cost effective and improving patient health. SW advised the Trust has resisted the obesity measures with support from GT but this has been rejected and there is also a similar debate on shockwave therapy. The Board ***noted*** the presentation.
STRATEGY AND POLICY UPDATES	
26/09/7.0	**CHIEF EXECUTIVE UPDATE** MB provided an update on the following: • An outline of the Managing Director and Assistant Chief Nurse/Assistant Chief of Professions roles that have been appointed to as follows:

	○ Jo Downie, Managing Director for MSK who will start next week ○ Nia Jones, Managing Director for Specialist Services ○ Jo Banks, Managing Director for Clinical Support Services who will start in mid November ○ Laura Peill, Managing Director for Support Services ○ Nicki Bellinger, Assistant Chief Nurse for Specialist Services ○ Sara Ellis, Assistant Chief of Professions, Clinical Support Services MB went on to advise that the Assistant Chief Nurse role for MSK is being re-advertised. Work is underway to ensure a safe transition ahead of a formal change over to the new structure on 1 April 2020. MB extended thanks to everyone who had been involved in the recruitment process. • Celebration of Achievement Awards are being held on 23 November with the shortlist being published next week • The Trust has been shortlisted for the HSJ Award 'Acute and Specialist Trust of the Year' for third year running, in addition it has been shortlisted for a reservists support initiative award. Ceremony in November. • Last weekend saw the official opening of Horatio's Garden. It is recognised as a therapeutic space and a final visit for Board members to the garden was being organised before it would be closed to visitors. MB expressed thanks again to the Horatio's Garden charity. • On the 16th September the Trust celebrated the work of the latest cohort of Improvement Champions. There was a particularly interesting presentation on Artificial Intelligence. MB advised that the presenter will be invited to attend Board at a future date. • Congratulations to the Neuromuscular Team who have been recognised as centre of excellence • Also congratulations to Clinical Psychology Services and Hannah Richards, for receiving the Rising Star Medal for Spines • Well done to everyone who walked up Snowdon raising funds for the Veteran's Service • MB had represented the Trust at the memorial service for Annabelle Rutherford, former President of League of Friends • MB went to Keswick to join a group of Spinal Cord Injury patients at an outward bounds activity centre. This is a great example of how staff go above and beyond for the benefit of patients. • The Health Hero for August was Lisa Perry, Therapy Support Worker and for September Rachel Harris, Recovery nurse in Paediatrics **ACTION: Artificial Intelligence Presentation to be scheduled for a future Board** The Board ***noted*** the update.
QUALITY AND SAFETY	
26/09/8.0	**QUALITY AND SAFETY COMMITTEE CHAIR'S REPORT** CB highlighted the following: • The meeting was well attended • The Committee received a quality report from the Surgical Division and was assured overall on the quality of its services, there were some actions to take forward and an update on these were to be included in the next report • The Committee felt there had been satisfactory progress on CQC and Histopathology action plans • The Committee received an update on harms assessments and requested a report be presented at the next Board meeting in relation to the follow up backlog

	HT asked about the serious incident that had been reported and whether Duty of Candour had been complied with. CB confirmed the committee was assured that it had been and that a very patient centred approach was being taken. **ACTION: Report to Board on the Harms Assessment linked to follow up backlog** The Board ***noted*** the Chair's Report.
26/09/9.0	**PEOPLE COMMITTEE** PK highlighted the following: • The Committee had a received a report from the Guardian of Safe Working Hours • The Committee was assured on the Trust's freedom to speak up work but had requested a benchmarking exercise to see where the Trust sit compared to other organisations • It was agreed that disciplinary action would be reported through Committee for assurance around process • There were no risks identified to be escalated • The paper received on staff experience was excellent and it was pleasing to see the offer to staff being expanded. SS commented that the staff offering being worked up had previously been presented to the Board. There was a challenging project plan with wellbeing boosting activities underway such as walking clubs, weight watchers, yoga etc. SS advised there was also a big push on civility to ensure staff are treated appropriately. FC endorsed PK's comments on the benefits of the initiative. The Board ***noted*** the report.
26/09/10.0	**FREEDOM TO SPEAK UP REPORT** SS presented the report and emphasized how this work was a vitally important part of supporting staff to speak up. Liz Hammond was appointed as the Freedom to Speak Up Manager earlier in the year and has undertaken a lot of work to ensure the Trust is aligned with national initiatives. The numbers of concerns raised by staff are small with a number being raised anonymously. SS advised that October is Freedom to Speak Up month and this will be used to promote the Trust's approach throughout the organisation. Also this month, a review of the freedom to speak up systems is being undertaken to make sure the Trust is using the national toolkits and guidance. The results of this review will be reported to People Committee. HP commented that there had been a shift since last year where the majority of cases reported by staff were issues within their management line that had not been escalated through any other process, this has reduced greatly. HP commented on the number of anonymous reports and the difficulty the anonymity presents in investigating and feeding back on the concerns. If there is clear identification of where the problem lies the Trust has responded and dealt with the issue. The learning coming out the concerns raised shows that communication from line managers was still an issue. HP also felt that there is a need to build resilience in the workforce and an understanding of what is a proper and appropriate debate around performance CB asked if there was an understanding of why staff feel the need to be anonymous. SS advised that there is a belief that speaking up and being critical is going to put them

	in a difficult position. She felt it was better for concerns to be raised anonymously than not at all but it does decrease the ability to provide feedback. FC commented that there is less personal commitment and engagement in the process if the reporter is anonymous. FC asked if an individual can still request anonymity and SS confirmed that they can. She advised that on occasion HP has had meetings off site to help with privacy. MB commented that the approach of the Freedom to Speak Up Manager, Liz Hammond and the two supporting Guardians, Jan Greasley and HP has been very helpful and he extended his thanks to them. FC commented that on looking at the national data the breakdown of staff type reporting concerns very roughly reflects the profile of NHS workforce. The Board ***noted*** the report.
26/09/11.0	**CLINICAL AUDIT ANNUAL REPORT** SW extended his thanks to Cormac Kelly as Clinical Audit and Paul Jermin as NICE Lead for the work they do in these areas. He presented the Annual Report which described the work that had been undertaken over the last year and the work being taken forward. SW explained that for a long time the outcomes for hip and knee replacements have been measured but steps are now being taken by the National Joint Registry to capture shoulders and elbows. There has been good compliance so far from the Trust. Cruciate ligament reconstruction work has confirmed that early reconstruction prevents ongoing damage with 80% of patients having repairs within 3 months compared to 53% in 2013. The pre-operative assessment and patient experience has also improved. CB commented on the risks outlined and asked if there was more detail required. SW advised that there is more granular detail that sits under this; SW confirmed that he would feedback for the definition of the risks to be expanded. CB also commented that the audit programme was very medically dominated and asked whether there was a need to encourage the involvement of other staff types. SW commented that the medical staff are paid for time to do this type of work but not all staff groups are. SR advised that she was aware that this was something SB had already picked up with the nursing staff. The Board ***noted*** the report.
26/09/12.0	**GUARDIAN OF SAFE WORKING** SW presented the report prepared by Chris Marquis, Guardian of Safe Working Hours. SW confirmed that there had been no fines and there was good feedback received on the training programme. He therefore had no issues to report but recognised the importance of remaining vigilant and proactive to attract and retain the required staff. The Board ***noted*** the report.
26/09/13.0	**CONSULTANT APPRAISAL ANNUAL REPORT** SW presented the Consultant Appraisal Annual Report and highlighted the following which is indicative of a culture for doctors to develop and perform at the centre of which is the appraisal process: • The Trust was in the top 5% of Trusts in the Picker Survey for trust in doctors

	• The Trust achieves good patient outcome measures. • Good response to concerns and learning from incidents. SW advised that there is a local appraiser support group that meets three times a year and will assist with resolving concerns. HP advised she had recently been involved in with one of the appraiser support group meetings and she had been very impressed with the reflective learning of a clinician involved in a serious incident. SS advised that there is work the system on statutory and mandatory training to enable access to training across the system to increase options of availability. The Board ***noted*** the report.
26/09/14.0	**CQC ACTION PLAN** SR presented the action plan tracker and highlighted that all actions were on track save for following for which updates had been provided through the Quality and Safety Committee: • 15.1 – Review of Critical Care Outreach • 22.2 – Implementation of the Accessible Information Standard The Board ***noted*** the present position of the CQC actions.
26/09/15.0	**WORKFORCE RACE EQUALITY STANDARD REPORT** SS presented the Workforce Race Equality Standard Report which has been through the People Committee, overall the measures were encouraging. MB asked about some of the deterioration in section 4 of the report and whether these were statistically significant or numerator and denominator issues. SS agreed to take MB through the figures in more detail but acknowledged the numbers are small. SS commented that the Trust's BME staff tend to be in one particular staff group and it is recognised that there was a need for more work. PK confirmed this was discussed at People Committee. SS confirmed that it has been agreed by the People Committee that a sub-committee for equality, diversity and inclusion should be established. HT commented on the fact that the People Committee had discussed the benefit of having a nominated Non Executive Director lead for equality, diversity and inclusion. **ACTION: Discussion with MB and FC to take place to agree a Non-Executive lead for equality, diversity and inclusion.** The Board ***noted*** the report.
	PERFORMANCE AND GOVERNANCE
26/09/16.0	**CHAIRS REPORT FINANCE PLANNING AND DIGITAL COMMITTEE** AF presented the Chair's Report and highlighted the following: • The Committee had reviewed the service line financial performance • A presentation on the procurement strategy had been received and it was noted that procurement savings were a major contributor to the Trust's savings plans • The Committee received reports on theatres and job planning • The Committee received and considered the Veterans' Service Business Case

	which looked at investment for a dedicated facility and much needed outpatient facilities. This was not a typical business case as its preparation was to assist discussions with the charity funder and therefore it outlined the approach to the investment rather than requesting an investment decision. The Committee approved its use for that purpose but with a more detailed (revenue) financial assessment to be prepared to ensure due consideration of the Trust's financial liabilities. • The Committee received an update on the Trust's digital programme The Board noted the Chair's Report.
26/09/17.0	**PERFORMANCE REPORT – MONTH 5** KR presented the M5 performance report and highlighted the following: • Overall the Trust is performing well in the following areas: ○ staff voluntary turnover ○ no serious incidents for three consecutive month ○ waiting time targets for welsh diagnostics ○ significant green over the caring for patient KPIs • Absences remain above target at 4.86% • Delayed discharges reduced but are still outside target • English diagnostics are behind target but meeting the improvement trajectory • Theatre targets are behind the original plan but are on trajectory for the revised plan • M5 behind plan but exceeded the anticipated most likely position which is indicative of the actions being taken having a positive effect • The forward look for T&O is for October 81% have been booked and November 31% • Performance for English RTT and income has been impacted as a result of not meeting the original plan • Outpatient activity target not being met • There will be changes to the report next month to align with the 2019/20 single oversight framework *Caring for Staff* SS confirmed there remains a focus on sickness absence. There has been a review of the way this is managed, the Trust's policy has been refreshed and this is being communicated to stakeholders. The focus is on supporting staff through sickness absence but more importantly a more positive and supportive approach to keep staff well. FC commented that the absence data provides a blended position and asked whether the hotspots are being looked at. SS confirmed there is a lot of work with the hotspot areas, particularly as sickness is an indicator that other things are may not be good. *Caring for Patients* KR highlighted the following: • Delayed discharges are still not hitting target. SB and NJ have been working on the next steps with clear actions to be brought back next month **ACTION: Delayed discharge update to be brought back to the next meeting** MB advised that SB has been having discussion with local authority colleagues and is also strengthening the leadership in this area so the recording of these delays is much more accurate.

	HT commented on the dual responsibility in relation to delayed discharges and MB confirmed this is well recognised.
	
	SW highlighted the following:
	• 1 unexpected death will be looked into via Learning from Deaths process and will be presented to MDCAM in November
	• High performance with VTE risk assessment – 100%
	
	NJ presented the following:
	• RTT performance stood at 88.69% as a result of the impact of theatre activity
	• Outpatient activity and diagnostic waits remain an issue and an updated trajectory will be presented to the Board and FPD in October
	• 52 weeks standards have been sustained
	• MRI performance has improved and ultrasound capacity has short term solutions in place with sustainable plans taken through the Executive Team for a more sustainable capacity
	• Outpatient attendances – monitoring this closely through the PRMs for delivery against plans
	• DNA rates have improved to 4.09% with improvement actions in place and having effect
	
	Caring for Finances
	CM highlighted the following:
	• There has been an improved position in activity
	• The Trust fell short of the control total by 81k but this is in line with the forecast in the recovery plan. Drivers for the shortfall were outlined as follows:
	  ○ Income fell short by £231k. Although theatres were a little short there had been a big improvement. There was shortfall in the private patient sector and medicine outpatients
	  ○ The risk share from CCG resulted in a shortfall against the QIPP target at a cost of £57k
	• Costs were £150k under plan as the Trust was able to flex staffing costs with the closure of Powys Ward in August
	• Core agency spend was within the cap
	• The cost improvement programme was slightly above trajectory but 5% year to date to be recovered
	• £1.4m off the control total trajectory and so the focus remains on the recovery actions. Enhanced financial controls have been put in place until the end of the year and further mitigations are still being worked on.
	
	FC asked about the cash balances and CM confirmed the increase was due to a one off payment from the CCG.
	
	HT commented on the trajectory for the financial control total and whether there was a plan the end of the year. CM said that he would look at that.
	
	ACTION: Financial control total trajectory to be added to the end of the financial year
	
	DG commented that it was encouraging to see the measures taken having a positive impact.
	
	The Board ***noted*** the Performance Report.

26/09/18.0	**BOARD / COMMITTEE DATES**

	SR presented the proposed timetable for the Trust's Board and Committee dates for 2020/21. HT asked whether there would be an August Board date and it was agreed this would be scheduled for the last Thursday in August. **ACTION: Board date to be reserved for the last Thursday in August** SR raised the fact that the Trust had held two Policy Committee meetings which had successfully ratified around 40 policies. This has made a significant contribution to reducing the backlog and it has also proven beneficial to have one group of people looking through all of the policies for consistency checking. SR asked whether the Board would therefore approve a formally constituted meeting to meet no more than four times per year to consider policies. This would reduce the burden on the other committees and would support the continued work to reduce the backlog of overdue policies. The Board ***agreed*** to the proposal of a formally constituted Policy Committee
26/09/19.0	**STP UPDATE** MB advised that each organisation is taking the same presentation through their Boards. He drew the Board's attention to the document development and sign off process for the long term plan. MB advised that the Executive Team have been heavily involved in supporting the work on this and that it is not yet finalised. For example, there is a tertiary and specialist section to be included which MB is working on. It has also been agreed that individual organisations will not be asked to approve but to endorse the plan. MB advised that he had asked CB and AF to proof the document from a Trust perspective and for increased Non Executive support. MB acknowledged the concerns around process and the sovereignty of Boards. His current view is that there are no material issues at present but that this needs to be tested when the Board discusses the plan in full. FC commented on the climate statement and the fact it is outlined as an emergency situation. He also commented that he had raised with Sir Neil McKay his uncertainty around the statement regarding being an internationally recognised system for climate control. MB confirmed that both local authorities have declared climate control emergencies and that the statement is therefore linked to that. MB advised there will be an opportunity to discuss the plan in detail on 31 October. DG advised that he supported the insertion of a section on specialist services. He felt there needed to be further clarity regarding the governance arrangements. MB advised the governance issues is mirrored locally, regionally and nationally. The proposal paper was taken to the chairs yesterday and he will take the Board through this in detail on 31 October. PK felt there was an absence of mental health in the strategy. SW commented this was a focus of the Medical Director Forum he attended. MB commented there is a lot more detail in the document. The Board ***noted*** the update.
26/09/20.0	**EU EXIT BRIEFING** CM presented an update on the preparation work and assurance regarding the

	arrangements being put in place both locally and nationally for a no deal EU Exit. CM confirmed the main area of focus is the continuity of supplies and assurance has been sought from the Trust's suppliers with a number of contingency measures taken locally and nationally. There is further work to be done on operational processes to build a bit more lead time into deliveries. Support continues to be provided to the workforce affected albeit this is small numbers. NB commented that emergency planning core standards have been submitted which contain business continuity to cover EU Exit. The Board ***noted*** the briefing.
26/09/21.0	**PERFORMANCE REPORT M4** The Board ***noted*** the Performance Report for Month 4
26/09/22.0	**GOVERNORS UPDATE** SR provided an update on the Governor involvement over the last month. SR confirmed that the Governor Elections have been concluded with Sue Nassar and Jan Greasley re-elected. Victoria Sugden was appointed for Shropshire. SR put on record her recognition of the contribution Gill Pitcher had made during her term. SR also advised that the Governors have been involved in a number
26/09/23.0	**NHS CAPITAL FUNDING** The Board ***noted*** the update on NHS Capital Funding which was presented for information
26/09/24.0	**NHS OVERSIGHT FRAMEWORK** KR highlighted the system changes which mean any provider or commissioner with performance issues will be expected to seek system support. The triggers for potential support are a finance score of 3 and failure to meet operational standards and these have been tightened and would put the Trust in escalation. The Board ***noted*** the update
26/09/25.0	**QUESTIONS FROM THE PUBLIC** None
26/09/26.0	**AOB** FC placed on record the Board's appreciation to Nia Jones, Director of Operations as this would be her last meeting as she moves into her new role as Managing Director for Specialist Services. She has made an excellent contribution to the Board's debate and discussions and contributed to the oversight and delivery of some systemic operational challenges.
	DATE OF NEXT MEETING IN PUBLIC: Thursday 28 November at 11.00 in the Meeting Room 1.
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

26 SEPTEMBER 2019

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
25/04/6.0 RESEARCH UPDATE PK and SS to look at the people strategy around research with a particular focus on upskilling. KR and the team to give consideration to be given to the identity of the Research Department	Director of People Director of Improvement, Organisational Development and Performance	In progress Completed – to form part the Innovation Hub
Actions from Last Meeting	**Lead Responsibility**	**Progress**
26/09/7.0 CHIEF EXECUTIVE UPDATE Artificial Intelligence Presentation to be scheduled for a future Board	Trust Secretary	On the agenda for November Board
26/09/8.0 QUALITY AND SAFETY COMMITTEE CHAIR'S REPORT Report to Board on the Harms Assessment linked to follow up backlog	Director of Improvement, Organisational Development and Performance	Completed
26/09/15.0 WORKFORCE RACE EQUALITY STANDARDS REPORT Discussion with MB and FC to take place to agree a Non-Executive lead for equality, diversity and inclusion.	Chief Executive / Chairman	
26/09/17 PERFORMANCE REPORT MONTH 5 Delayed discharge update to be brought to the next meeting	Director of Improvement, Organisational Development and Performance	On the agenda for November Board
26/09/18.0 BOARD COMMITTEE DATES Board date to be reserved for the last Thursday in August	Trust Secretary	Completed

Chairs Assurance Report
Quality and Safety Committee 21st November 2019

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	28th November 2019
Executive Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

This paper provides an outline of the Quality and Safety Committee Agenda for the meeting of 21st November 2019. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust to:

- Promote safety and excellence in patient care
- Identify, prioritise and manage risk arising from clinical care
- Ensure efficient and effective use of resources through evidence based clinical practice

2.2. Summary

Due to the timing of the committee it is not possible to provide a paper Chair's Report and this will be provided at the next meeting. The Non-Executive Director Chair of the committee will provide a verbal report covering the attached agenda from the committee.

2.3. Conclusion

The Board is asked to ***note*** the agenda and that a verbal report will be provided during the meeting.

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	21/11/19		14:00

1. Introduction		14:00
1.1. Apologies	All	
1.2. Minutes from the previous meeting	Chris Beacock	
1.3. Action Log / Matters Arising	Chris Beacock	
1.4. Declaration of Interests	All	
2. Caring for Patient		
2.1. Patient Experience Report (Q2)	Alison Harper	14:05
2.2. Infection Control Update (Q2)	Sue Sayles	14:15
2.3. Surgical Infection Presentation	Steve White	14:25
2.4. Histopathology Action Plan	Nicki Bellinger	14:30
2.5. Learning From Deaths	Steve White	14:40
2.6. Harms Updates	Nicki Bellinger	14:45
2.7. Accessible Information Standard	Nicki Bellinger	14:50
3. Committee Management		
3.1. CQC Action Plan	Shelley Ramtuhul	14:55
3.2. IPR Month 7	Nicki Bellinger	15:00
3.3. Divisional Quality Report - Diagnostics	Paula Jeffreson	15:10
3.4. Board Assurance Framework	Shelley Ramtuhul	15:20
3.5. Serious Incidents	Rob Freeman	15:25

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Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	21/11/19		14:00

4. Governance (for noting)		15:30
4.1. Review of Work Plan 2019/20	Mary Bardsley	
4.2. Attendance Matrix	Mary Bardsley	
4.3. IPR Month 6	Nicki Bellinger	
4.4. Chair Reports		15:35
4.4.1. Research Committee	Nicki Bellinger	
4.4.2. Safeguarding Committee	Nicki Bellinger	
4.4.3. Clinical Governance and Quality Committee	Nicki Bellinger	
4.5. EPRR Core Standards	Nicki Bellinger	
5. Any Other Business		
5.1. Next Meeting: 16th January at 2pm		

Safe Working Hours: Doctors in Training

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	28th November 2019
Executive Sponsor:	Steve White, Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	People Committee 13th November 2019	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Board of Directors and what input is required?

The Board of Director is asked to ***note*** the Trust's position in relation to safe working hours for doctors in training.

The paper has recently been presented for discussion at the People Committee on 13th November 2019.

2. Executive Summary

2.1. Context

As part of the 2016 Terms and Conditions for Junior Doctors it was agreed that additional safeguards would be put in place to protect the working hours of doctors in training. This included a Guarding of Safe Working to champion safe working hours and provide assurance to the Board in this regard.

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the July 2018 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

The Board is asked to ***consider*** and ***note*** this report from the Guardian of Safe Working which we believe gives substantial assurance.

3. The Main Report

3.1. Introduction

This paper sets outs the background and context around the introduction of the Guardian of Safe Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust.

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. 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. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours.

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. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

The Guardian will:

- Champion safe working hours.
- Oversee safety related exception reports and monitor compliance.
- Escalate issues for action where not addressed locally.
- Require work schedule reviews to be undertaken where necessary
- Intervene to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Distribute monies received as a result of fines for safety breaches.
- Give assurance to the board that doctors are rostered and working safe hours.
- Identify to the board any areas where there are current difficulties maintaining safe working hours.
- Outline to the board any plans already in place to address these
- Highlight to the board any areas of persistent concern which may require a wider, system solution.

The Board will receive a quarterly report from the Guardian, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade.
- Details of fines levied against departments with safety issues.
- Data on Rota gaps / staff vacancies/locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

Other new features of the 2016 contract include:

Work scheduling – junior doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments and the training opportunities available during the post or placement.

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, This is beneficial to employers as it will give real-time information and be able to identify key issues

as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

Requirement for junior .doctor forums to be set up - principally these forums will advise the Guardian of Safe Working who will oversee the processes in the new contract designed to protect junior doctors from being overworked. The Guardian and Director of Medical Education in each Trust and relevant organisation shall jointly enable a nomination/election process to establish a Junior Doctors Forum (or fora) to advise them and make appropriate arrangements to enable the elected representatives time off for their activities & duties in connection with their role. Election onto the forum will be for the period of rotation and replacements must be sought for any vacancies.

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period July – Sept. 2019 (Q2)

Orthopaedics	Training posts	11
	Of which Doctors in training on 2016 contract	5
Rehabilitation/ Spinal Injuries	Training posts	0
	Of which Doctors in training on 2016 contract	0

3.2.2 Exception reports (with regard to working hours)

The exception reporting system is designed to allow employers to address issues and concerns as they arise, in real time, and to keep doctors' working hours, both rostered and actual, within safe working limits. If the system of work scheduling and exception reporting is working correctly, in anything other than truly exceptional circumstances, the levying of a fine indicates that the system has failed or that someone – the supervisor, Guardian or the individual doctor concerned – has failed to discharge his or her responsibilities appropriately.

Any levying of a fine should therefore be followed by an investigation in to why it was necessary and remedial action to ensure that it does not happen again. The most important thing to remember is that fines should rarely, if ever be applied at all.

Currently there have been no exceptions reported to the Trust.

The trust continues to engage with the junior doctors regarding rotas and via the Junior Doctor Forum. At all stages care is taken to ensure hour's compliance is achieved without compromise to patient safety and our training responsibilities.

As it stands the Trust can be reassured we are compliant with the demands placed upon us.

3.2.3 Work schedule reviews

None – please see above. Work schedule reviews are triggered by repeat exception reporting highlighting an issue with a position or rota. With no exception reports, no work schedule reviews should be expected.

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of Vacancies

July – 1 part time trainee

Aug – None

Sept – None

Vacant shifts

July- 4

Aug – 5

Sept – 2

Total spend - £ 5325

Medicine

Number of Vacancies

July – 1

Aug - 1

Sept - 1

Vacant shifts

July – 0

Aug – 0

Sept - 0

Total spend - £2160

MCSI

July - 2

Aug - 2

Sept - 3

Vacant shifts

July - 6

Aug - 17

Sept - 19

Total spend pending - £6750

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

JDF continues with no concerns raised to report at this point. The Guardian for Safe Working Hours attended the national annual conference for GJDWH in October and subsequently met with the Guardian to Speak Out. The latter is now a recurring meeting. New starters at the Trust are met as part of their induction.

3.3.2 Software System

The expectation is that the Trusts will move to the Allocate system. Following the annual conference, Human Resources have been in contact with Allocate. We are awaiting dates for a formal meeting

Associated Risks

None identified at this time.

Next Steps

The Board is asked to ***consider*** and ***note*** this report from the Guardian of Safe Working.

3.4. Conclusion

Safe Working Hours: Doctors in Training

The Trust continues to see no exception reports or fines. This is strongly suggestive of a high level of satisfaction in the training and experience offered by the Trust to the Junior Doctors.

The Trust continues to work hard to fulfil its responsibilities under the terms of the new junior doctors' contract and based on available information and assessments appear to be compliant.

Christopher Marquis

Guardian of Safe Working

Infection Prevention & Control & Cleanliness Quarter 2 Report 2019/20

0. Reference Information

Author:	Sue Sayles, Infection Control Nurse Lead Phil Davies, Head of Estates and Facilities	Paper date:	28th November 2019
Executive Sponsor:	Nicki Bellinger, Interim Director of Nursing	Paper Category:	Governance and Quality
Paper Reviewed by:	Infection Control Committee October 2019 Quality& Safety Committee 21st November 2019	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1.Why is this paper going Board of Directors and what input is required?

The Board of Directors are asked to note the progress report against the annual plan for: Infection Prevention and Control and Cleanliness Report
The paper has previously been discussed at the Infection Control Meeting and the Quality and Safety Committee meeting in November 2019.

2. Executive Summary

2.1.Context

Through the monthly Board performance report, the Board are briefed on the mandatory bacteraemia and any key issues emerging from those results. Over and above the mandatory reporting, the Board receive a report at least four times per year from the Director of Infection Prevention and Control (Director of Nursing). This report includes a high level summary of the key issues in Infection Prevention and Control as well as cleanliness.

2.2. Summary

	MRSA Bacteraemia RJAH Acquired	MSSA Bacteraemia RJAH Acquired	E *.coli* Bacteraemia RJAH Acquired	C. *difficile*
Month	**No. of Cases**	**No. of Cases**	**No. of Cases**	**No. of Cases**
July	0	0	1	**0**
August	0	0	0	**0**
September	0	0	1	**0**
Quarter	**0**	**0**	**0**	**0**

2.3. Conclusion

The Board of Directors will have seen through the Board performance papers that there have been no cases of reportable MRSA bacteraemia since 2006.
Summary in the main report shows current performance in cleanliness and infection control against the work plan.

3. The Main Report

3.1.1 Introduction
This report provides an update on progress made within quarter 2, 2019/20 to the Board of Directors, to ensure that the Board are briefed at a high level on any trends or issues that identify best practice or any gaps in assurance from which further work or actions are required.

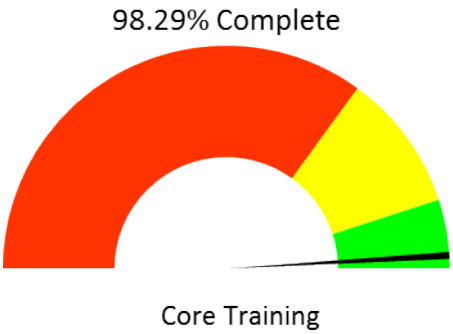
3.1.2 Infection Control Committee
The IPC Programme of Work 2018 – 21, which has been developed in line with the Shropshire and Telford Health and Social Care Strategy, has been agreed at the Infection Control Committee in July 2018 and progress is reported quarterly.

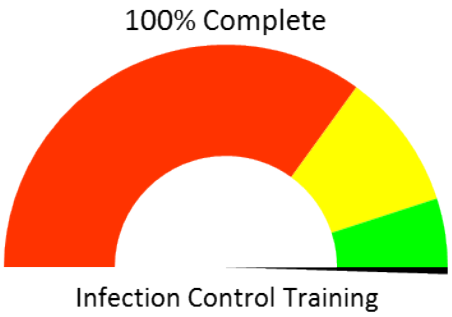
3.2.Cleanliness
Measured cleanliness has been maintained above the National calculated target (85.0%) and Trust target (94.0%) over the most recent quarter, achieving an overall average for the quarter of 98.84% which is consistent with recent reporting periods.

Over the quarter, only one area failed to meet the required national standard target for on audit – TSSU B. 13 elements required action against a maximum permissible number of 4 for this area.
Facilities management review actions in all non-compliant areas – damage to walls in TSSU B represent a significant proportion of the identified fails. Access to this area for the maintenance team is limited whilst TSSU A works are ongoing, staff are aware of the risk that comes with wall damage, cleaning is being provided to the surface to mitigate as best possible the risk of contamination. The estates team are ready to apply a white rock surface to the wall as soon as the department notify them that access is available.
Through the cleaning management process, we do not believe the wall damage presents an elevated risk.

3.2.2. Cleanliness – Staff

Training has a very high compliance for the rolling 12 month period, demonstrating our commitment to the highest level of staff competency. The rolling year position at end of September is shown below:

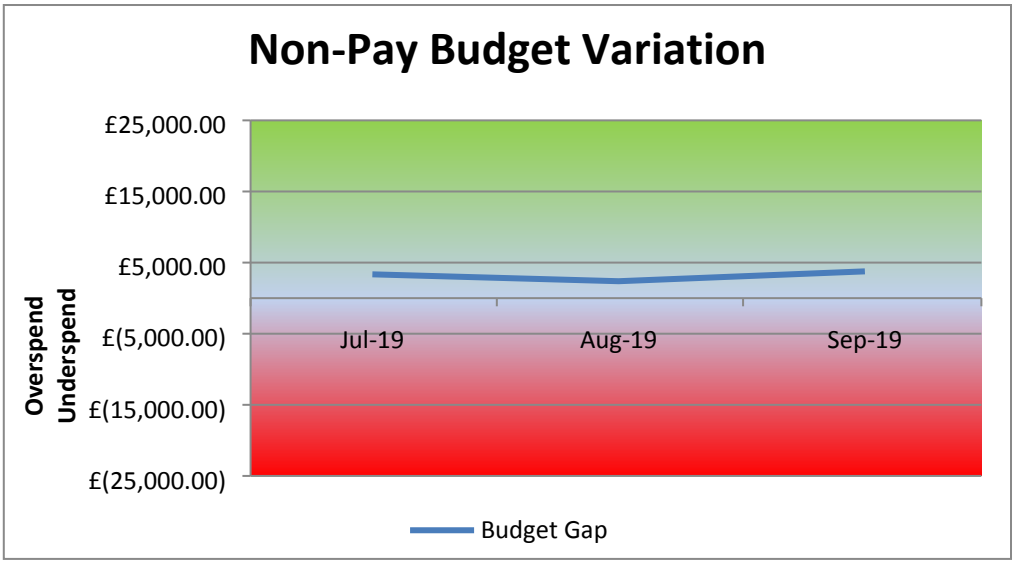




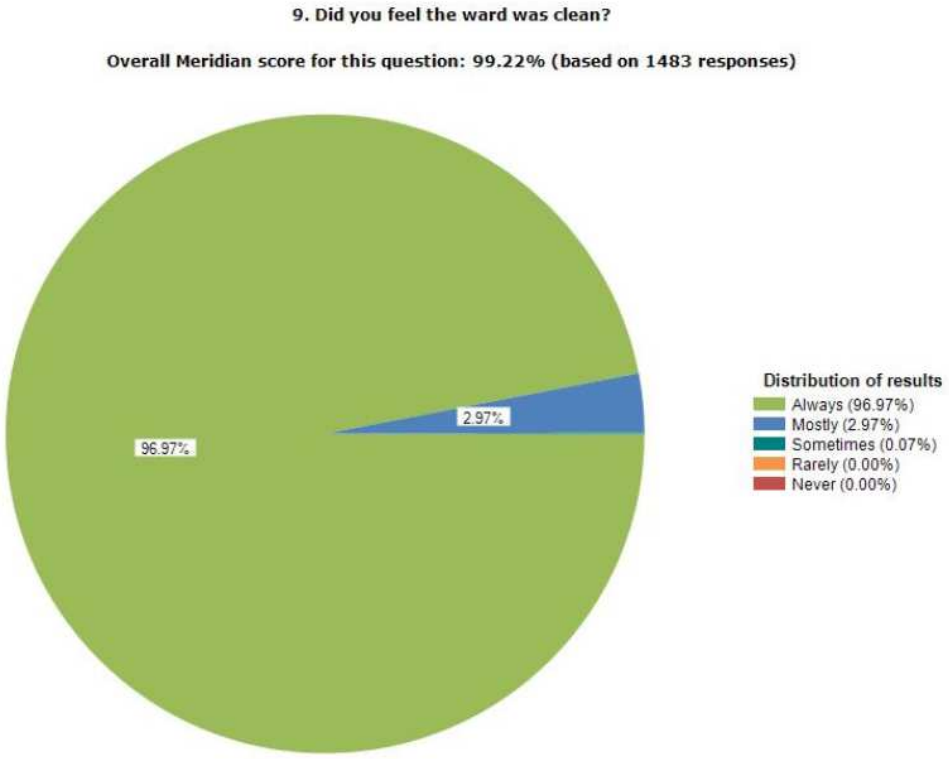
As part of the 2019/20 Facilities management strategy, a review of the PEAT's (Patient Environment Action Team) was completed. The team highlighted potential service improvements to be made by having staff on site trained in some basic pest control, to enable faster reaction times – alongside potential to deliver savings in contractor call outs. The PEAT team has completed this training in July 2019.

3.2.3. Cleanliness – Spend on Cleanliness (Excluding staffing)

The below chart demonstrates the position at September 2019:



3.2.4. Cleanliness – Patient Satisfaction



96.97% of patients surveyed felt their ward was ALWAYS clean. These survey results are reinforced by patient comments; within the quarter 19 compliments specifically relating to the cleanliness of the hospital were received. These are shared with staff & emphasised at team meetings.

3.2.5. Cleaning Developments

HPV Decontamination

The facilities team continues to provide HPV fogging decontamination in response to the Trusts needs via Dewpoint solutions. A summary of usage over the quarter is shown below.

Date	Ward	Area	Rationale
17/07/2019	Gladstone Ward	1 Bay	Long Term Cohorted Patients
23/08/2019	Clwyd Ward	1 Side Room	Patient - Infection
02/09/2019	Powys Ward	Entire ward	Utilised surgical ward for MCSI patients
03/09/2019	HDU	1 Side Room	Patient - Infection
27/09/2019	Wrekin Ward	1 side room	Long Term patient - Infection

The Trust requirements for HPV fogging form part of the Infection Control Working Group agenda; as usage of the equipment increases a case will have to be considered in relation to purchasing a unit as opposed to the current hire agreement that's in place.

Trial – Safer sharps bins

The department has instigated a trial of reusable sharps disposal system – SharpSmart. Initial areas of trial will include surgical & medical wards, an outpatient department and Theatres.

Benefits of such a system include:

- Reduction on sharps injuries at disposal
- Ease of use – no requirement to assemble containers; reducing incidents at disposal
- Compliance improvements – the system automatically locks when full
- Environmental impact – reducing single use plastic containers

Alongside operational improvements, this project aligns with the wider facilities management strategy for dilution of risk across the Trusts waste streams.

Feedback from the trial will be assessed via the infection control working group –expected start date for the trial is December 2019

3.2.6. PLACE

The Trusts PLACE assessment and action plan is shared publically via the Trust website.

Nationally, NHS Improvement has reviewed and released PLACE, including removing weighted scoring, assessing condition & appearance alongside cleanliness rather than as separate questions and up to date organisational questions. Overall, 400+ changes to the assessment questions & criteria have been made, meaning that this year's scores cannot be compared with previous ones; however improvements have been made in the ability to benchmark against other Trusts using the tool.

The Trusts 2019 assessment will be undertaken in quarter 3, with the associated action fed back to board through the infection control committee in quarter 4.

3.2.7. Compliance Update

Water Safety Update

82 Pseudomonas tests, 39 Legionella tests and 13 Hydro pool tests were carried out in Q2. Remedial actions to HTM04-01b and L8 ACoP were taken where any elevated results were found.

Estates Manager and Estates Mechanical Officer were interviewed by the AE (Water) 11th September 2019 to be appointed as AP(Water) for the Trust. The AE (Water) was satisfied so Estates are awaiting the certifications to complete appointment.

Decontamination Update

All Quarterly Periodic Testing successfully completed on the decontamination equipment used in TSSUB in Q2

LEV testing will be scheduled for January (14 monthly)

Quarterly settle plate testing conducted with no concerns in Q2 (note that TSSUA was not tested because the area was closed for refurbishment)

Weekly settle plate testing has continued in the barn theatres during the TSSUA works to monitor the effectiveness of the barrier seal between the two areas.

Electrical Estates Officer has now been appointed formally as AE(D)

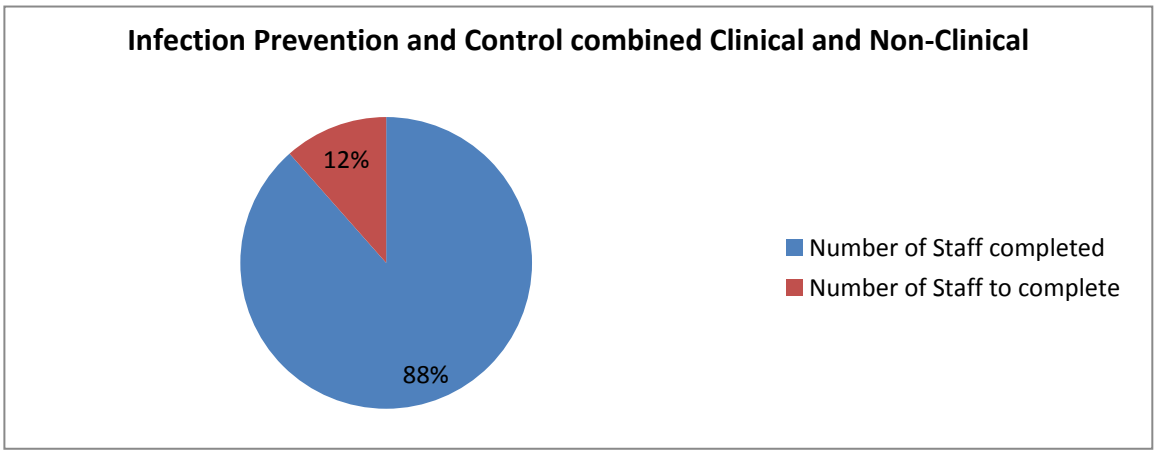
3.3. Infection Prevention & Control

3.3.1.Training
The Infection Control Training for clinical staff expires every year and non-clinical staff every 3 years. Ward/departmental managers are responsible for ensuring that staff are up to date with infection control training as part of the appraisal process. Interactive infection control training is delivered to all staff on induction including volunteers and work experience to the trust. Practical ward training is delivered on request.

The table below shows the compliance for annual clinical training, 3 yearly non-clinical training and a combination of the both at the end of Quarter 2 19/20:

Core Training Compliance Compliance - 30th September 2019		**Including Bank Staff**			
Validity Period	Course Name	Number of Staff required to Complete	Number of Staff completed	Number of Staff to complete	Compliance percentage
Annual	Infection Prevention & Control (Clinical Staff)	892	786	106	88.12%
3 Yearly	Infection Prevention & Control (Non-Clinical Staff)	557	496	61	89.05%
Annual/3 Yearly	Infection Prevention and Control combined Clinical and Non-Clinical	1449	1282	167	88.47%

The graph below shows the Annual/3 Yearly compliance up to Q2 19/20:



During September face to face Infection control training was delivered by the Infection Control Nurse over a four week period to capture all clinical staff on Powys and Clwyd ward.

Topics Included:-

- Sepsis presentation
- Trusts HCAI targets
- Alert organisms:- MRSA, C.difficile, ESBL, VRE, and CPE
- Antimicrobial stewardship
- Managing sharps and splash injuries
- Diarrhoea & Vomiting
- Isolation etiquette
- Use of personal protective equipment

3.3.2. Infection Control Link Meetings

Link meetings are held bi-monthly and attendance is monitored via the STAR evaluation process.

Agenda items include:-

August

- Infection Prevention and Control Quater 1 presentation detailing infection control activity for April- June
- Requirements to report CAUTI's
- Audit feedback
- I Auditor presentation
- Wound clinic /TVN support
- Safer Sharps

3.3.3. Audit

In Quarter 2, the identified planned clinical audits have been undertaken. These include audit tools from:

- A purpose designed environmental audit covering cleanliness, waste, linen, sharps, personal protective equipment, kitchens, hand hygiene facilities and isolation facilities.
- High Impact Interventions

- Hand hygiene/ Bare below the elbow audits

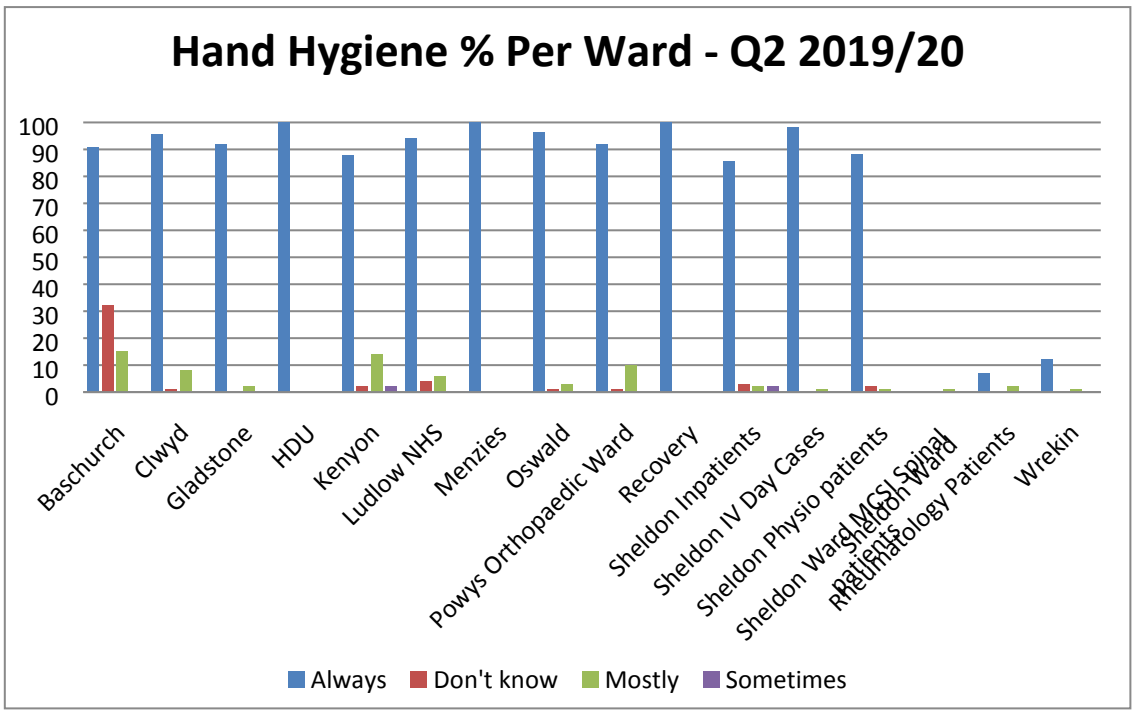
These audit results are displayed on ward STAR Boards.

3.3.3.1. Hand Hygiene

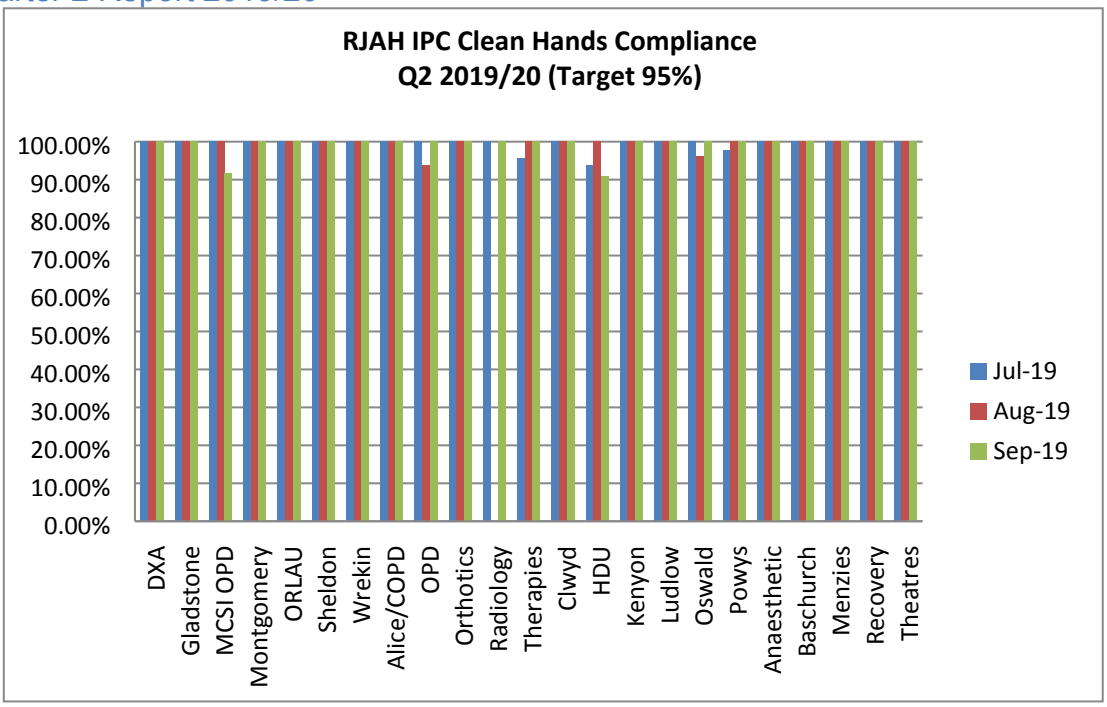
Hand Hygiene – Patient Feedback

The graphs below demonstrate the positive patient responses for the Patient Comment Card question 'Did the staff practice good hand hygiene?'

These results are consistent with the high compliance of the ward hand hygiene audits.



Hand Hygiene – Ward/Department Audits



The overall hand hygiene audit compliance remains above 95% at Trust level.

1490 hand hygiene audits were undertaken during quarter 2 with an overall Trust score of 99.46% compliance.

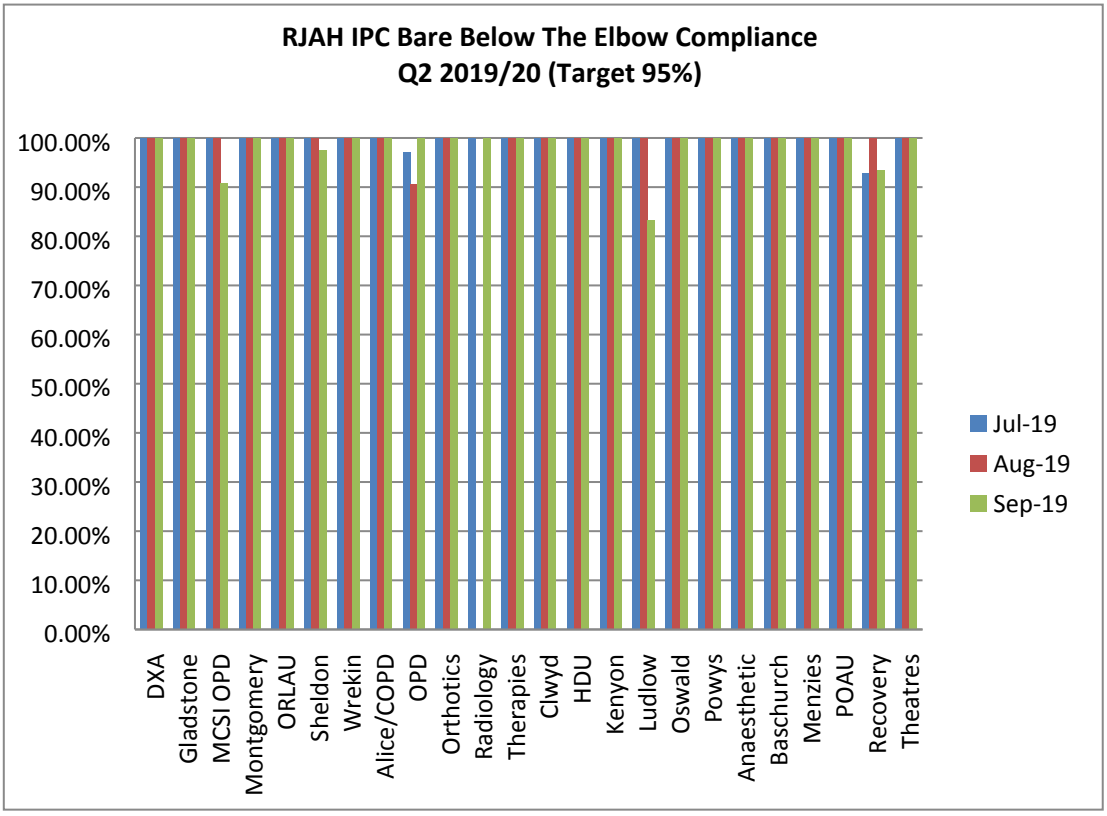
The above graph demonstrates the ward/departments compliance. The following ward fell below the 95% target for the following reasons:

- **Outpatients Department**
  - 93.75% achieved in Aug 2019
    - 30 out of 32 audits compliant, non-compliance: 2* Doctor
- **MCSI OPD**
  - 91.67% achieved in Sept 2019
    - 11 out of 12 audits compliant, non-compliance: 1* Doctor
- **HDU**
  - 93.75% achieved in Jul 2019
    - 15 out o16 audits compliant, non-compliance: 1* Doctor
  - 90.91% achieved in Sept 2019
    - 10 out of 11 audits compliant, non-compliance: 1* Doctor

Any audits not received by the deadline are not included in this report and departmental managers are informed.

Staff members are encouraged to challenge poor practice at the point of care and ward managers are encouraged to produce action plans for any areas achieving less than 95%.

3.3.3.2. Bare Below The Elbow



1561 Bare Below the Elbow audits were undertaken during quarter 2 with an overall Trust score of 99.24% compliance.

The following ward/departments fell below the 95% target for the following reasons:

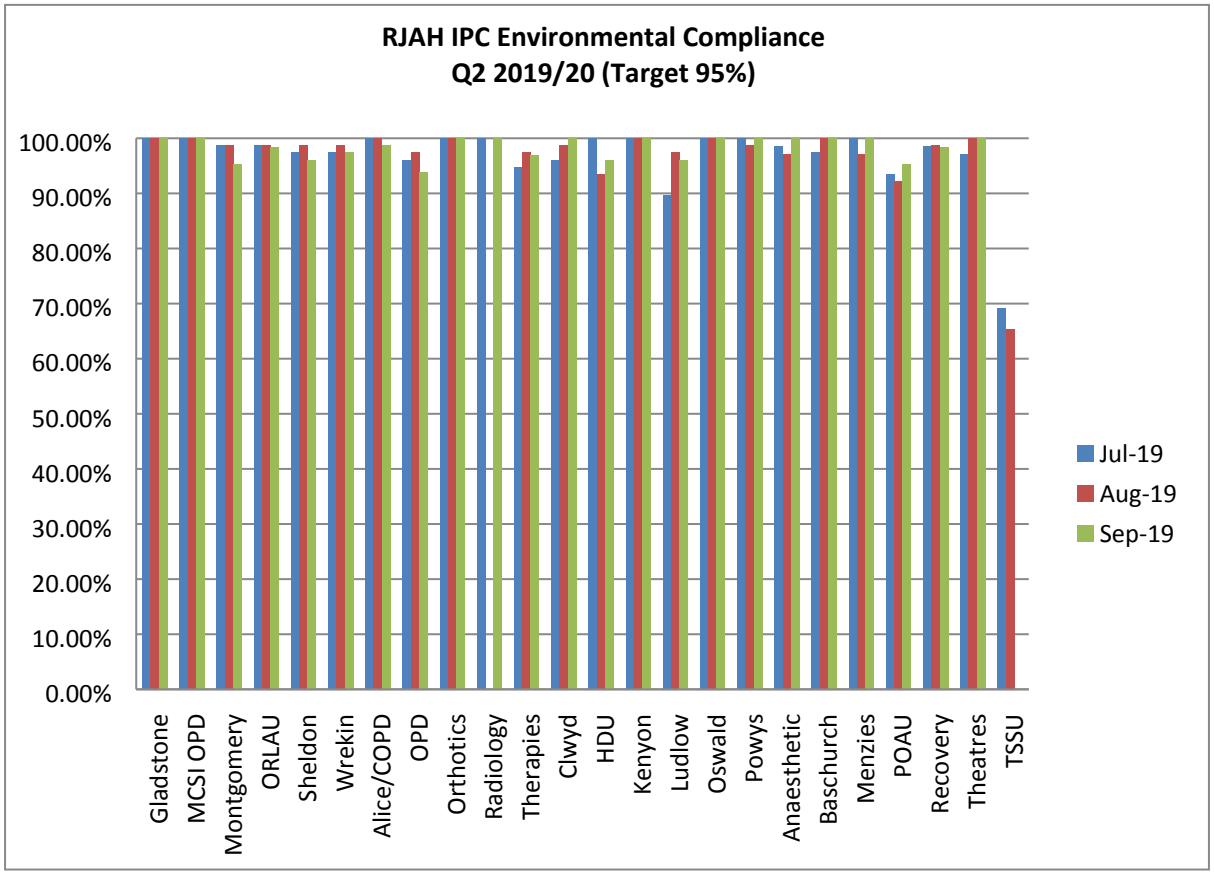
- **Recovery**

- 92.86% achieved in Jul 2019
  - 13 out of 14 audits compliant, non-compliance: 1* Doctor

- **Outpatients Department**
  - 90.63% achieved in Aug 2019
    - 29 out of 32 audits compliant, non-compliance: 3* Doctor
- **MCSI Outpatients**
  - 90.91% achieved in Sept 2019
    - 10 out of 11 audits compliant, non-compliance: 1* Doctor
- **Ludlow**
  - 93.33% achieved in Sept 2019
    - 15 out of 18 audits compliant, non-compliance: 3* Doctor

Staff members are encouraged to challenge poor practice at the point of care and ward managers are encouraged to produce action plans for any areas achieving less than 95%.

3.3.3.3. Environment



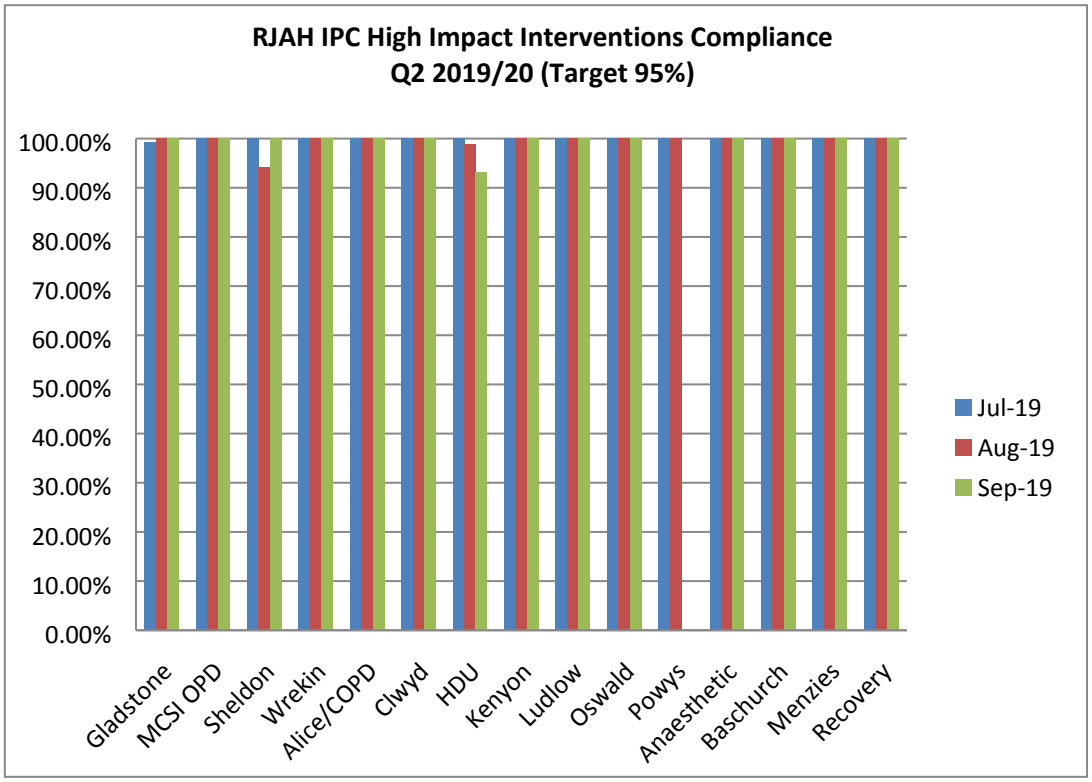
The above graph demonstrates the monthly environmental audit results.

nb: data unavailable for TSSU for Sept 2019 at the time of producing this report.

The most common areas of non-compliance for Q2 were:

Environmental Audit non-compliance areas	Jul-19	Aug-19	Sep-19	Grand Total
Floors clean & in good state of repair	1	4	3	8
Safer sharps devices are in use, or if not, a risk assessment has been completed	2	2	4	8
Staff training is up to date	1	3	2	6
High & low surfaces clean & free from dust	2	3	0	5
Bags are not over filled (2/3 full)	2	2	1	5
Furniture clean & in good state of repair (e.g. lockers, chairs, tables)	0	2	3	5
Bins are enclosed, foot operated & soft closing	2	1	1	4

3.3.3.4. Saving Lives: High Impact Interventions



6909 High Impact Intervention audits were undertaken during quarter 2 with a score of 99.77% compliance, which is consistently above the Trust target of 95%. These include insertion and care of peripheral, central and PICC lines; insertion and care of urinary catheters; prevention of surgical site infection.

The following wards fell below the 95% target for the following reasons:

- **Sheldon**

  - 94.12% achieved in Aug 2019
    - 11 out of 12 audits compliant. Peripheral Vascular Access Devices – Ongoing Care: non-compliance 1* Dressing

- **HDU**
  - 93.69% achieved in Sept 2019
    - 59 out of 60 audits compliant. Urinary Catheter Routine Maintenance: non-compliance 1* Hand Hygiene
    - 51 out of 60 audits compliant. Peripheral Vascular Access Devices – Ongoing Care: non-compliance 2* Hand Hygiene, 3* Vascular Access Device Access, 2* Administration Set Replacement, 3* Dressing

Audit findings are shared with the Ward Managers.

Infection Control Team Audits

Ultrasound department

Issues identified:-

- Restricted flow/ water temperature to the scrub sink
- Clinical supplies and dressing packs stored on open shelves
- Damage to walls and wallpaper
- Flooring stained and damaged

Results have been fed back to the Superintendent Radiographer

Hydrotherapy pool

Issues identified

- Arjo trolley on the poolside to be condemned and disposed of and hooks to be put on the wall estates requisition to be put Cube Planet
- Build-up of rust on the pool floor- to be cleaned/removed
- Main shower hand rail requires replacement
- Replacement plinths required

Areas of improvements from previous audit :-

- Grout in the changing room showers clean and in good state of repair
- New lockers in the changing rooms and pool side
- Poolside clean and tidy
- Benches in both ladies and gents changing rooms have been refurbished

Results have been shared with the pool manager and the water committee

Mid Cheshire laundry visit

A further unannounced Infection Prevention and Control visit was undertaken on 16/09/2019. Continued areas of improvement were noted including cleanliness, sharps safety, personal protective equipment, waste, and hand hygiene.

RJAH ,SATH & SCHT Infection Control teams are assured that the improved cleanliness standards are being maintained and monitored through the Mid Cheshire IPC teams . No further action will be taken by RJAH, SATH & SCHT Infection Control teams unless requested to do so by the facilities Consortium.

TSSU B Audit

Issues identified:-

- Kick plates to doors require replacement
- Doors propped open to allow access of trollies
- Areas of the flooring requires resealing

Areas of improvements:-

- Monthly descale of the washers and declutter of equipment
- Trolleys clean and in good state of repair

*All processing of theatre instruments are currently being undertaken in TSSU B which is a temporary measure until the 5 month rebuilding programme of TSSU A is completed.

3.3.4. Surgical Site Surveillance

Providing data to the national SSI process enables the Trust to benchmark on a national basis with other Trusts and promote the low infection rates within the Trust. The process uses nationally agreed criteria from which the definition of a Surgical Site Infection is formed. Understanding surgical site infection rates enables the Trust to estimate the size of SSI risk in patients undergoing specific operations.

The Trust submits the maximum of all data, which is above the national requirement for one quarter of surveillance in one category of surgery per year. Year round surveillance is performed in total hip, total knee and spinal surgeries.

The Trust submits surgical site infection data to the PHE database on a quarterly basis; these reports are always one quarter in arrears to allow a window of time for any infections to present.

The data below shows the SSI rates for Apr - Jun 2019.

TKR	THR	Spines
1 infection from 376 procedures	3 infections from 400 procedures	3 infections from 204 procedures
0.3%	0.8%	1.5%
National Average 0.8 %	National Average 0.8 %	National Average 1.3 %

Infection Prevention & Control & Cleanliness Quarter 2 Report 2019/20

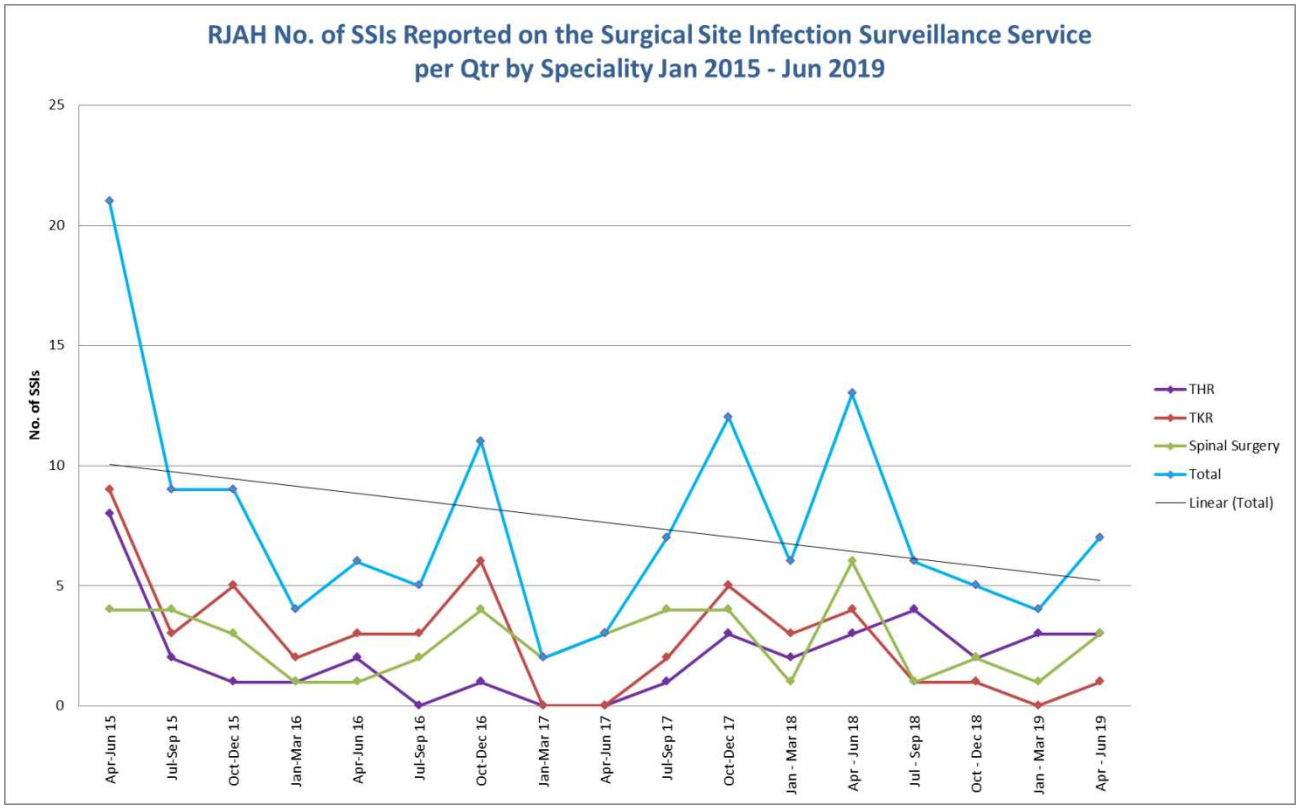
The infection Control Nurse/ Surgical Site Surveillance Nurse liaise with Consultants concerning wound infections. The data for Apr – June 19 has been verified and the results have been submitted to PHE and published on their web site. All of these infections were discussed and agreed at the infection Multi-Disciplinary Team meeting (MDT).

Infection rates for hips and knees are in line with the national average, for this period, spines has a rate that is just above the national average.

Additional information collection is currently under review by the Infection Prevention & Control Team, based on national standards aiming at minimising the risk of surgical site infection, which include skin preparation, prophylactic antibiotics, patient warming, maintaining asepsis, surgical environment, wound management and surveillance of surgical site infection.

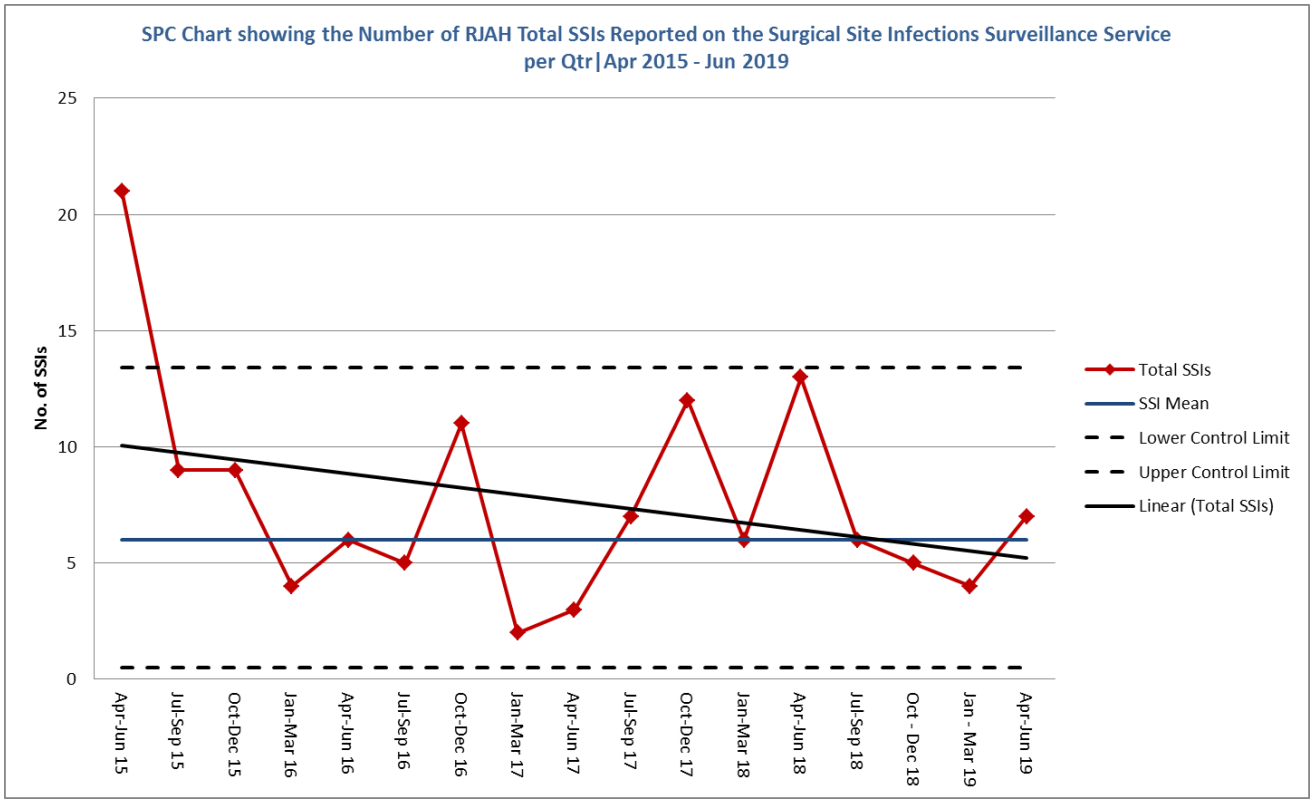
Graph showing trend in SSIs:

The graphs below show how we are monitoring the SSIs per quarter and tracking any trends.



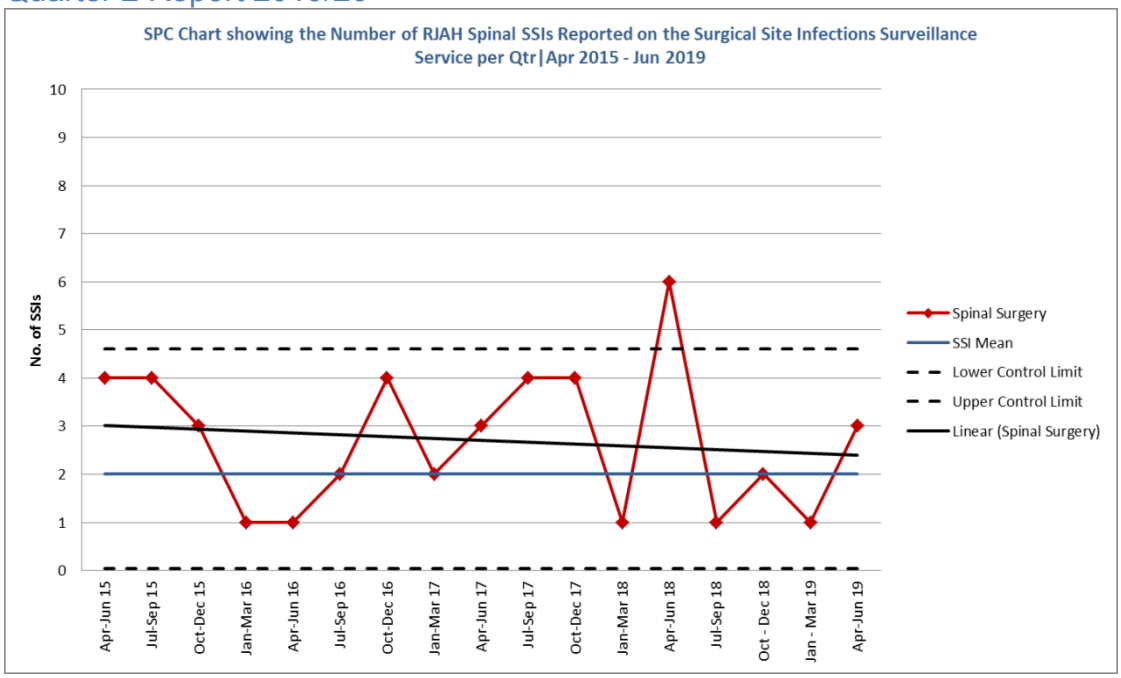
The above graph shows the downward trend of SSIs during the period Apr 2015 – Jun 2019.

Statistical Process Control (SPC) Graph showing a downward trend in total Hips, Knees & Spines SSIs and continues to perform within the normal limits for the Trust, following the peak in Apr – Jun 2015.

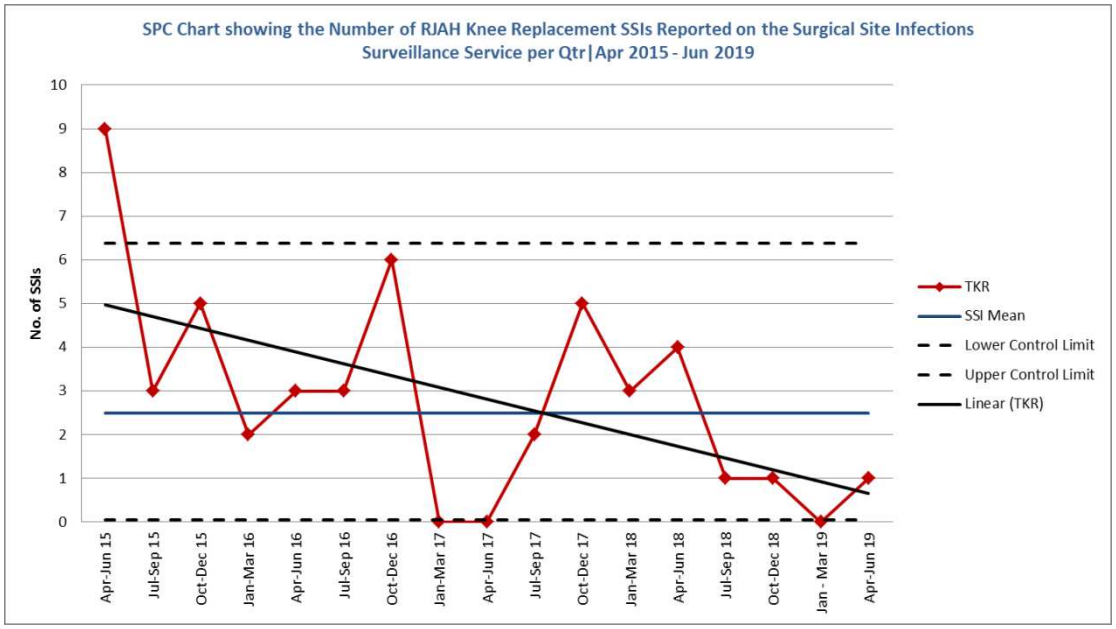


Potentially infected cases are reviewed at the weekly infection MDT including other orthopaedic specialities such as foot and ankle, hand/upper limb and paediatric; these are not submitted to PHE but are recorded on our local database.

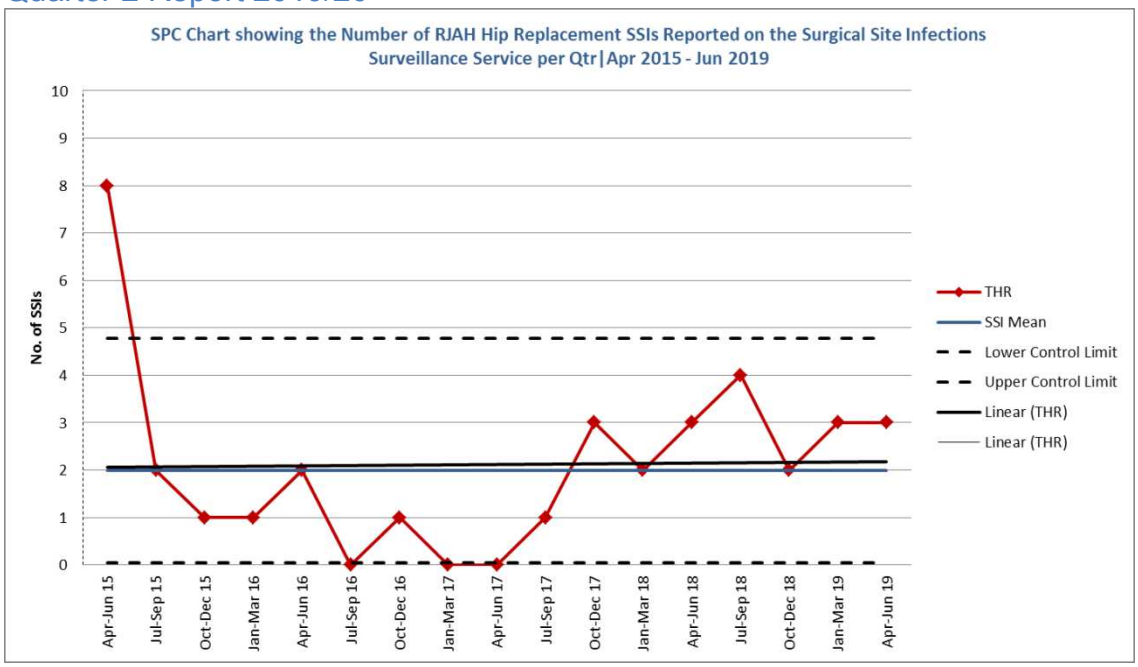
Statistical Process Control (SPC) Graph showing a downward trend in total Spinal SSIs and, with the exception of Apr – Jun 18, continues to perform within the normal limits for the Trust:



Statistical Process Control (SPC) Graph showing a downward trend in total Knees SSIs and, with the exception of Apr – Jun 2015, continues to perform within the normal limits for the Trust following the peak in Apr – Jun 2015:



Statistical Process Control (SPC) Graph showing a very slight upward trend in total Hips SSIs and, with the exception of Apr – Jun 2015, continues to perform within the normal limits for the Trust following the peak in Apr – Jun 2015:



The Trust continues to participate in the 2019 GIRFT (Getting It Right First Time) SSI audit for surgical site infections in hip, knee, shoulder, elbow, ankle replacements and spinal surgery until October 2019 with an aim to improve the quality of care within the NHS by reducing unwarranted variations.

By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

3.3.5. MRSA Swabbing & New Isolates

MRSA swabbing for all admissions continues and is monitored internally to ensure that the Trust remains compliant to the national requirement for reducing preventable Hospital Acquired Infections.

July 19		Aug 19	Sept 19
Eligible patients	936	939	1043
Screened for MRSA	929	939	1041
% achieved	99.25%	100%	99.81%
Target	95%	95%	95%

MRSA screening compliance remains well above the target of 95%.

3.3.6. Alert Organisms

3.3.6.1. C.*difficle*

There have been 0 cases of C.difficle to date against an annual target of no more than 3.

3.3.6.2. MSSA bacteraemia

There have been no cases of MSSA blood stream infections during Quarter 2.

3.3.6.3. E.*coli* /Gram negative bacteraemia.

There has been two cases of E.coli blood stream infection during Quarter 2. Both cases were due to E.coli urosepsis. The patients were treated with intravenous and oral antibiotics and reviewed on the Microbiology ward round.

3.4 Outbreaks

There have been no outbreaks recorded during Quarter 2.

3.5 Serious Incidents

There have been no serious incidents recorded during Quarter 2.

3.6 Infection Prevention & Control & Cleanliness Working Group

The monthly working group continues to improve communications between Infection Control, Operational Areas and Estates & Facilities by identifying and resolving issues in line with Trust priorities. The following issues have been discussed:

- Fogging Update
- Smartsharp Update
- Mid Cheshire linen services audit
- Estates workplan update including TSSU, Horatio's garden and improvements to décor on Powys
- Safer sharps
- Hydro pool

3.7 Conclusion

The Trust reports positive outcomes against national set targets for HCAI:

- No cases of MRSA bacteraemia.
- No cases of C.difficle against a target set at no more than 3 for 2019/20

All orthopaedic surgery is being monitored closely and cases of suspected/confirmed infections are discussed at the Consultant led weekly Infection MDT meetings.

Sue Sayles: Infection Prevention and Control Nurse
Nicki Bellinger: Director of Infection Prevention & Control
Date: Oct 2019

Appendix 1: Acronyms

MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
MDT	Multi-Disciplinary Team
E.coli	Escherichia. Coli
C.diff	Clostridium difficile
KPI	Key Performance Indicators
PHE	Public Health England
SPC	Statistical Process Control
SSI	Surgical Site Infection
STAR	Sustaining Through Assessment and Review
SCHT	Shropshire Community Health Trust
SATH	Shrewsbury and Telford Hospitals
TKR	Total Knee Replacement
THR	Total Hip Replacement
HCAI	Healthcare Associated Infection
UTI	Urinary Tract Infection
L8 ACoP	L8 Approved code of practice (HSE Legionella guidance)
HTM	Health Technical Memorandum
TSSU	Theatre Sterile Services Unit
CIP	Cost Improvement Program
HPV	Hydrogen Peroxide Vapour
GIRFT	Getting It Right First Time

Glossary

Bacteraemia: The presence of bacteria in the blood without clinical signs or symptoms of infection

Infection Prevention & Control & Cleanliness Quarter 2 Report 2019/20

C. difficile: or C. diff is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.

E coli: is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.

HCAI: Health Care Associated Infection. An infection acquired as a result of receiving treatment in a health care setting.

MRSA: or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria,Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.

MSSA: or Methicillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise as a consequence of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.

Learning From Deaths

0. Reference Information

Author:	Dr James Neil, Mortality Lead	Paper date:	28th November 2019
Executive Sponsor:	Mr Steve White, Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	Mortality Steering Group *November 2019* Clinical Governance and Quality Committee *November 2019* Quality and Safety Committee *November 2029*	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Board of Directors and what input is required?

Learning from Deaths summary report to Board for information.

Review of numbers.

2. Executive Summary

2.1. Context

To report the current numbers in last quarter for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No concerns identified.

All deaths expected and no issues with care.

We recommend substantial assurance is provided to the Trust Board.

3. The Main Report

3.1. Introduction

NHSI asks that we have an update for the board on the current state of LFD investigations/numbers/actions and themes identified.

3.2. Learning From Deaths Summary.

Date	Total Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes	Actions/Learning Identified
July 2019	0	0	0	0	None	None
August 2019	2	2	0	0	None	Good pre-op discussion. RESPECT policy would apply going forward.
September 2019	2	2	0	0	None	None
October 2019	2	2	0	0	None	RESPECT policy.

3.3. Associated Risks

None identified.

3.4. Next Steps.

The learning from deaths lead is liaising with local and national bodies concerning the implementation of the Medical Examiner process at RJAH.

3.5. Conclusion

National RESPECT process (https://www.respectprocess.org.uk/) is due to roll out later this year in Shropshire which formalises end of life care and treatment ceiling discussions.

31st October this went live at RJAH, and was presented to the staff in this Trust at the multidisciplinary clinical audit meeting (MDCAM) on 5th November 2019.

Appendix 1: Acronyms

LFD	Learning From Deaths
SJR	Structured Judgment Review
MSG	Mortality Steering Group

Flu Paper

0. Reference Information

Author:	Nicki Bellinger, Deputy Director of Nursing	Paper date:	28th November 2019
Executive Sponsor:	Nicki Bellinger, Deputy Director of Nursing	Paper Category:	Trust Board
Paper Reviewed by:	Executive Team Meeting October 2019	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

In September 2019 the Trust received a letter from Pauline Philips National Director of Emergency and Elective Care NHS England and NHS Improvement outlining the ambition to improve frontline healthcare workers up take of the flu vaccination with a recommendation that the Trust undertakes and produces a self-assessment for Trust boards to review.

2. Executive Summary

Summary

Frontline health and social care workers have a duty of care to protect their patients and service users from infection. Doctors are reminded of the General Medical Council's (GMC) guidance on Good Medical Practice (2013), which advises immunisation 'against common serious communicable diseases (unless otherwise contraindicated)' in order to protect both patients and colleagues.

The Trust has developed a multicomponent approach and to date have achieved a higher uptake than this time last year. 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. The Trust also uses incentives to encourage staff, and even small incentives, such as badge stickers, work to reinforce positive messages.

Staff are encouraged and reminded about the flu campaign and there are staff message which are distributed at least four times per week via the staff Facebook page, weekly roundup and communicate.

Conclusion

The Trust Board is asked to note the ongoing flu vaccination programme.

Flu Paper November 2019

Introduction

Influenza and the flu virus

Influenza (often referred to as flu) is an acute viral infection of the respiratory tract (nose, mouth, throat, bronchial tubes and lungs) characterised by a fever, chills, headache, muscle and joint pain, and fatigue. For otherwise healthy individuals, flu is an unpleasant but usually self-limiting disease with recovery within two to seven days.

Flu is easily transmitted and even people with mild or no symptoms can still infect others. The risk of serious illness from influenza is higher among children under six months of age, older people and those with underlying health conditions such as respiratory disease, cardiac disease or immunosuppression, as well as pregnant women. These groups are at greater risk of complications from flu such as bronchitis or pneumonia or in some rare cases, cardiac problems, meningitis and/or encephalitis.

Flu vaccination of frontline health and social care workers

Frontline health and social care workers have a duty of care to protect their patients and service users from infection. Doctors are reminded of the General Medical Council's (GMC) guidance on Good Medical Practice (2013), which advises immunisation 'against common serious communicable diseases (unless otherwise contraindicated)' in order to protect both patients and colleagues.

The Trust has developed a multicomponent approach and to date have achieved a higher uptake than this time last year. 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. The Trust also uses incentives to encourage staff, and even small incentives, such as badge stickers, work to reinforce positive messages.

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.

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.

Staff are encouraged and reminded about the flu campaign and there are staff message which are distributed at least four times per week via the staff Facebook page, weekly roundup and communicate.

Impact of flu each winter on the population

The impact of flu on the population varies from year to year and is influenced by changes in the virus that, in turn, influence the proportion of the population that may be susceptible to infection and the severity of the illness.

The influenza immunisation programme in the UK is based on recommendations by the Joint Committee on Vaccination and Immunisation (JCVI), an independent expert advisory committee that advises all UK health departments on vaccination and immunisation programmes.

Annual flu immunisation is recommended for:

• Those at particular risk of severe infection; the elderly, those who are immunosupressed and those with other underlying health conditions.

• Children aged 2 and 3 years.

• All primary school age children.

• Those at most risk of transmitting infection

• All health and social care workers with direct patient/client contact.

• Carers.

Guidance is available from the Specialist Pharmacy Services (SPS) on authorisation for administration of the influenza vaccine for health care staff.

This year, three types of flu vaccine will be used in the flu programme.

This will benefit patients by ensuring that they have the most suitable vaccine that gives them the best protection against flu. The three vaccines are:

• Adjuvanted trivalent flu vaccine (aTIV) – This is licensed for people aged 65 years and over and is the vaccine recommended by the Joint Committee on Vaccination and Immunisations (JCVI) for this age group.

• Quadrivalent vaccine (QIV) – This is recommended for children aged from 6 months to 2 years and in adults from 18 years to less than65 years of age who are at increased risk from flu because of a long term health condition.

• Live attenuated influenza vaccine (LAIV) – This is a nasal spray and is licensed for children and young people from 2 years old to less than 18 years of age. The age groups targeted in England for this vaccine in 2018/19 are two and three year olds (through their GP surgery) and school aged children in reception class through to Year 5 (through schools). If LAIV is clinically contraindicated QIV is used in this age group. Both are procured centrally by PHE and can be ordered via ImmForm

Flu vaccine effectiveness

There are two factors involved in determining the effectiveness of the flu vaccine. The first is the characteristics of the person being vaccinated and the second how good of a match there is between the circulating influenza strains and the vaccine itself. Professor Paul Cosford, PHE's Director for Health Protection and Medical Director, said:

"In recent years, we have typically seen an effectiveness of around 50% (ranging from 25 to 70%). Whilst it's not possible to fully predict the strains that will circulate in any given season, flu vaccination remains the best protection we have against an unpredictable virus."

Public Health England has run a pilot study of flu vaccination on school children and the results indicate primary school aged children have 94% lower GP influenza-like illness if vaccinated, compared to the unvaccinated group.

A study showed that flu vaccine reduced children's risk of flu-related paediatric intensive care unit (PICU) admissions by 74% during flu seasons from 2010-2012.

One study showed that flu vaccination was associated with a 71% reduction in flu-related hospitalisations among adults of all ages and a 77% reduction among adults 50 years of age and older during the 2011-2012 flu season.

Flu vaccination is an important preventive tool for people with chronic health conditions. Vaccination was associated with lower rates of some cardiac events among people with heart disease, especially among those who had had a cardiac event in the past year. Flu vaccination also has been shown to be associated with reduced hospitalisations among people with diabetes (79%).

Other studies have shown that vaccination can reduce the risk of flu-related hospitalisations in older adults. A study that looked at flu vaccine effectiveness over the course of three flu seasons estimated that flu vaccination lowered the risk of hospitalisations by 61% in people 50 years of age and older.

The flu vaccine has an excellent safety record

The risk of having a serious (anaphylactic) reaction to the seasonal flu vaccine is less than one in a million – much lower than the risk of getting seriously ill from having the flu itself. It's impossible to get flu from the having the flu jab because the vaccine doesn't contain live viruses. A very small number of people experience side effects such as aching muscles, but this is simply the immune system responding to the vaccine.

Robert Jones and Agnes Hunt Weekly Flu Percentages

Week ending 11/10/19 40.64 %

Week ending 18/10/19 48.95%

Appendix 1 – Healthcare worker flu vaccination best practice management checklist

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.	Yes
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Yes
	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	Yes
A4	Agree on a board champion for flu campaign	Yes
A5	All board members receive flu vaccination and publicise this	Yes
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Yes
A7	Flu team to meet regularly from September 2019	Yes
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Yes
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Yes
B3	Board and senior managers having their vaccinations to be publicised	Yes
B4	Flu vaccination programme and access to vaccination on induction programmes	Yes
B5	Programme to be publicised on screensavers, posters and social media	Yes
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Yes
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be	Yes
C2	Schedule for easy access drop in clinics agreed	Yes
C3	Schedule for 24 hour mobile vaccinations to be agreed	Yes
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Yes
D2	Success to be celebrated weekly	Yes

Controlled Drug Annual Report

0. Reference Information

Author:	Maryse Mackenzie, Medicines Management	Paper date:	28th November 2019
Executive Sponsor:	Nicki Bellinger, Interim Director of Nursing	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee 18th July 2019	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

This paper is for noting in relation to RJAH compliance around the safe management of controlled drugs (CDs).

The report was presented to the Quality and Safety Committee in July 2019.

2. Executive Summary

2.1. Context

This paper is for assurance around the management of CDs at RJAH

2.2. Summary

Assurance of compliance with

- Legislation
- Controlled Drug Local Intelligence Network (CD Lin) submissions
- CQC requirements
- Department of Health Legislation

2.3. Conclusion

For 2018-19 the Trust has been compliant with CQC requirements, CD Lin submissions and legislation changes.

3. The Main Report

3.1. Introduction

The CD Accountable Officers report sets out RJAH position for 2018-19 in relation to the safe management of CDs.

3.2. CD Accountable Officers Report for 2018-19

Trend analysis of supply patterns in clinical areas

Reporting of untoward incidents

CD Lin reporting compliance

3.3. Associated Risks

Authorised destruction of CDs witness list has been expanded to support more timely destruction of CDs.

3.4. Conclusion

The report provides assurance that RJAH manage CDs in line with CQC, CD Lin and latest Department of Health Legislation.

CD Accountable Officers Report for 2018-19

Robert Jones Agnes Hunt (RJAH) annual controlled drug (CD) report.

CQC compliance 100%

RJAH CD Lin representation is 100%

Submission of occurrence reports is 100%

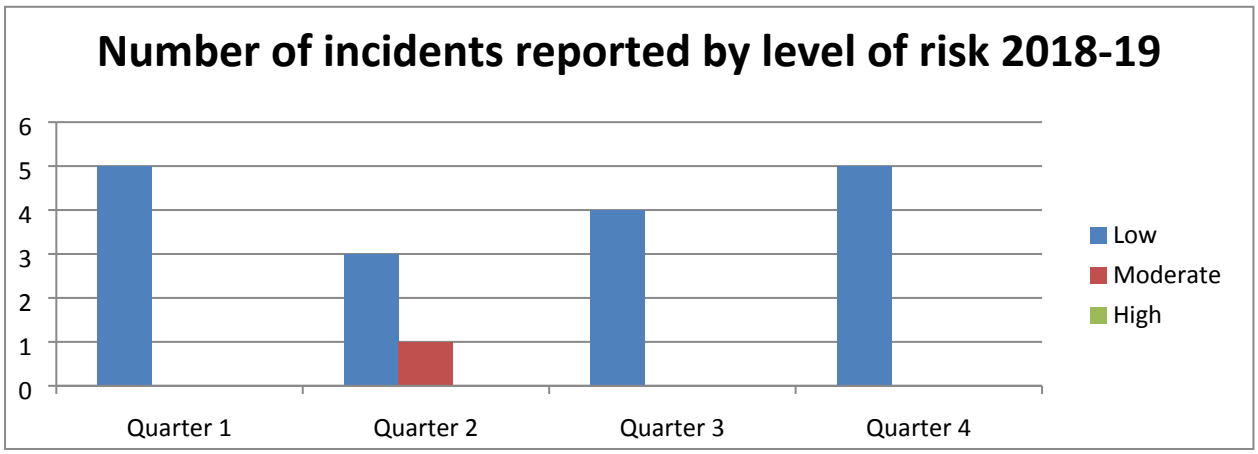
Update from 2017-18 annual report: All outstanding actions from the previous report have now been concluded**.**

Trend Analysis at RJAH
RJAH monitors and audits the management, prescribing and use of CDs. Discrepancies/incidents are reported via DATIX and then onto the CD Lin. The CDAO would be informed in person or by e-mail if concerns are noted/raised. Pharmacy completes monitoring of CDs and other abusable medicines monthly. Data is then reviewed and reported to the Trust Medicines Safety Officer (MSO). Any anomalies or changes in patterns noted are then reported via DATIX investigated and appropriate action taken.

For 2018-19 any noted anomalies or changes were found to have legitimate reasons for the identified change in pattern. The Trust has a defined audit process for CDs. The West Midlands Audit tool is used for all audits undertaken. The audits results go to Matrons, Ward Managers and MSO. Ward level action plans are produced to address any issues identified and followed up at the next re audit.

Reporting of Untoward Incidents
There have been no serious untoward incidents reported involving CDs for 2018-19. We have reported 18 incidents via DATIX that are reportable out to the CD Lin (appendix 1).
18 of the reported incidents were rated as low risk and 1 as moderate see Graph 1.

Graph 1



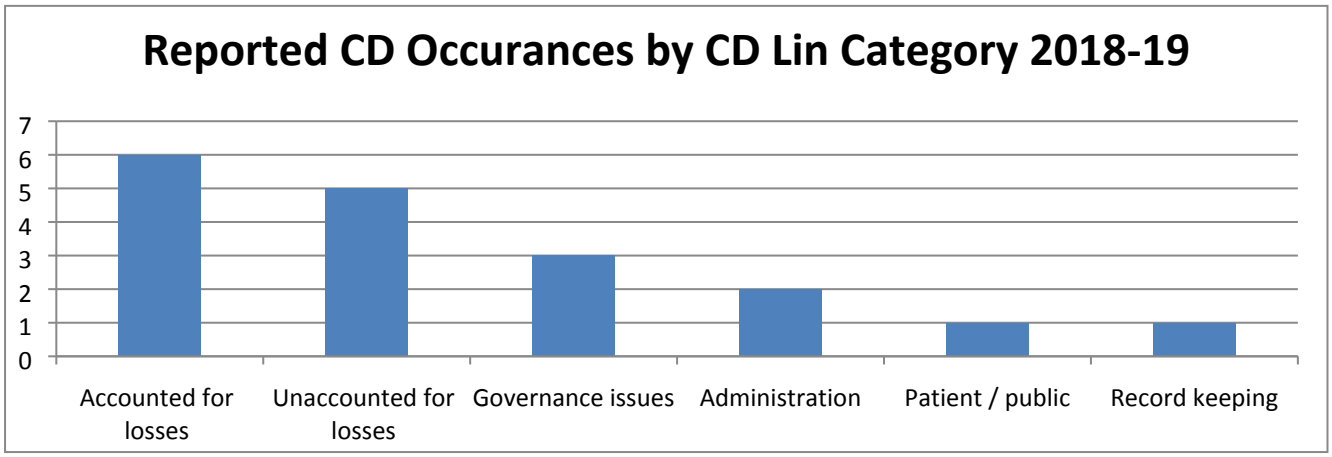
The 18 incidents for 2018-19 came under the following categories for reporting to the CD Lin.

CD Lin reporting categories:

- Accounted for losses
- Unaccounted for losses
- Governance issues
- Administration
- Patient / public
- Record keeping

See Graph 2 for number of incidents by reporting category.

Graph 2 RJAH reported CD incidents by CD Lin Category



To Note: though not required by the CD Lin we report locally on all CD incidents regardless of the schedule they may come under.

Moderate risk reported to the CD Lin

The moderate risk incident related to one individual in-patient who was found to be self-administering from their own illegal supply of subutex whilst being administered prescribed fentanyl patches and oxycodone liquid as an in-patient. We highlighted to the CD Lin our difficulty in access to specialist services when a patient is not actively in a substance misuse service.

Attendance of Controlled Drug Local Intelligence Network (CD Lin) meetings

It is a statutory requirement of the Trust's CDAO that a quarterly report is provided to the CDLIN. Regulation 29 requires CDAO to give an occurrence report to the accountable officer for the local area team that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report). RJAH have recorded 100% attendance at the CD Lin reginal meetings for 2018-19.

Submission of occurrence reports

There have been some changes to the regional platform for centralised reporting and during this time there has been a number of technical issues for users. RJAH have submitted an occurrence return for each quarter for 2018-19.

Destruction of Controlled Drugs

There are authorised witnesses for the destruction of controlled drugs. Appointments are made with the authorised staff to attend pharmacy to support the safe destruction of CDs. This list has been expanded to support more timely destruction of ward stock CDs. We plan to improve our timeliness of CD destruction for 2019-20.

Controlled Drugs Procedure

Over this twelve month period, there has been a change in procedure/policy at RJAH in line with the legislation changes for Gabapentin and Pregabalin.

Appendix 1: Local Incidents by Quarter for 2018-19

Quarter 1	Alice	Underage of midazolam
	Alice	Underage of midazolam
	Kenyon	Oxycodone 10mgMR administered instead of IR
	HDU	Accidental breakage Pethidine
	HDU	Lost Med after Pt dropped tablets while staff present
Quarter 2	Oswald	Error with entering Pt own CDs into register 53 documented when 52 in pack
	Pharmacy	Member of public handed oral morphine bottle over the dispensary counter
	Pharmacy	Substance misuse lack of external support for in-patients
	Gladstone	Incorrect entry into CD register and assumption of a full pack made
Quarter 3	Gladstone	Missing 25mcg fentanyl patch after administration and attachment to Pt
	Gladstone	Prepared dose of oxycodone not administered and left in the treatment room
	HDU	Accidental breakage midazolam vial
	Ana 7	Accidental breakage midazolam vial
Quarter 4	Wrekin	Oral Morphine Solution Calculation error
	Wrekin	Missing Tramadol tablet
	Clwyd	Missing Buprenorphine patch after administration and attachment to Pt
	Kenyon	Accidental breakage of full bottle of oral morphine solution
	Clwyd	Underage of oral morphine solution

Chairs Assurance Report
Finance Planning and Digital Committee 28th November 2019

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	28th November 2019
Executive Sponsor:	David Gilburt, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	Finance, Performance and Digital	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

This paper provides an outline of the Finance Planning and Investment Committee Agenda for the meeting of 26th November 2019. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance Planning and Digital Committee. This Committee is responsible for seeking assurance that the Trust is operating within its financial constraints and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2. Summary

Due to the timing of the committee it is not possible to provide a paper Chair's Report and this will be provided at the next meeting. The Non-Executive Director Chair of the committee will provide a verbal report covering the attached agenda from the committee.

2.3. Conclusion

The Board is asked to ***note*** the agenda and that a verbal report will be provided during the meeting.

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 3, Main Entrance	26/11/19		14:00
1. Introduction			14:00
1.1. Apologies		David Gilburt	
1.2. Minutes from the previous meeting (Oct)		David Gilburt	
1.3. Declaration of Interests		All	
2. Finance			
2.1. Performance Overview Report (Month 7)		Kerry Robinson	14:05
2.2. Outstanding Follow Up Lists		Kerry Robinson	
2.3. Finance Director Report		Craig Macbeth	14:20
2.4. In Year Re-Forecast Process		Mark Salisbury	14:35
3. Planning			
3.1. Planning Assumptions 2020/21		Mark Salisbury	14:45
3.2. Breaking the Cycle Update		Alyson Jordan	14:55
3.3. Service Line Reporting Update		Mark Salisbury	15:05
3.4. ACI Strategy		Jo Wales	15:15
4. Digital			
4.1. EPR Update (Presentation)		Simon Adams	15:25
5. Committee Management			
5.1. Board Assurance Framework (to follow)		Shelley Ramtuhul	15:30
5.2. Committee Annual Report (to follow)		Shelley Ramtuhul	15:35
5.3. CQC Action Plan (to follow)		Shelley Ramtuhul	15:40
5.4. Review of work plan		Shelley Ramtuhul	15:45

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 3, Main Entrance	26/11/19		14:00
6. To note:			15:50
6.1. Chair Report: IM&T Steering Group		Shelley Ramtuhul	
6.2. Performance Review Letters (M7)		Kerry Robinson	
7. Any Other Business			15:55
7.1. Next Meeting: 28th January at 2pm			

Month 7 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Principal Analyst and Data Quality Lead	Paper date:	28/11/2019
Executive Sponsor:	Kerry Robinson, Director of Performance, Improvement and OD	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

The Board is required to assure itself that the Trust is providing high quality, caring and safe health care services in accordance with national regulatory standards.

The purpose of the Integrated Performance Report (IPR) is to provide the Trust Board with the evidence of achievement against the national regulatory standards, identification of emerging risks and the assurance that an improvement plan is in place and is effective.

This paper is for information summarising the key performance indicators, highlighting areas of high or low performance for safety, quality, workforce, operational or financial metrics.

The Board is asked to note the overall performance as presented in the month 7 (October) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

The paper incorporates the monthly integrated performance report with associated narrative and descriptions of key actions.

2.2. Summary

In line with the Trust's Performance Management Strategy and Accountability Framework, Board-level Key Performance Indicators (KPIs) which are considered to drive the overall performance of the Trust have been agreed by the committees of the Board and are included in this report.

The Trust remains in segment 2 of the NHS Improvement Single Oversight Framework.

Areas of performance to highlight this month are as follows;

Caring for Staff;

- Increased sickness absence reported at 5.19%.

Caring for Patients;

- One serious incident reported in relation to treatment delays for pressure sore management, three reported year to date providing a red year end forecast.
- Increase in total patient falls throughout month although no falls resulting in moderate or severe harm, with four months out of seven now rated red and a forecast year end of red rating.
- Further increase in volume of complaints received.
- Increase in delayed discharges from 5.61% to 5.98% although remains within normal variation having been red rated for over 12 months.
- RJAH acquired E.Coli Bacteraemia reported in month, fifth occurrence so far this year giving a red rated year end forecast.
- Cancer 62 Day Standard not met in September with two shared breaches reported.
- Our English RTT open pathways performance is reported at 88.01%, 1% behind our FPD trajectory driven by a reduced waitlist size and increased breaches within milestone two and three impacting patients waiting 26 weeks.
- No patients waiting over 52 weeks except for Welsh transfer of care after 52 weeks.
- Both diagnostics standards reported above respective targets this month in line with agreed improvement trajectory.

Caring for Finances;

- Theatre activity behind plan for the month in line with September FPD update driven by anaesthetist sick/compassionate leave.
- Outpatient behind plan in-month and year to date, improvement plans in place with all areas of variance.
- Financial control total red rated, impacted by theatre activity and thus income.
- Expenditure remains green for five consecutive months with cost controls strongly in place.
- Agency non-core remains above the national target.
- Proportion of temporary staffing is consistently increasing and remains red rated.

2.3. Conclusion

The Trust Board is asked to ***note*** the report and where insufficient assurance is received via the responsible sub-committee of the Board, the Board will seek additional assurance.

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st October 2019

Income and Expenditure £'000s

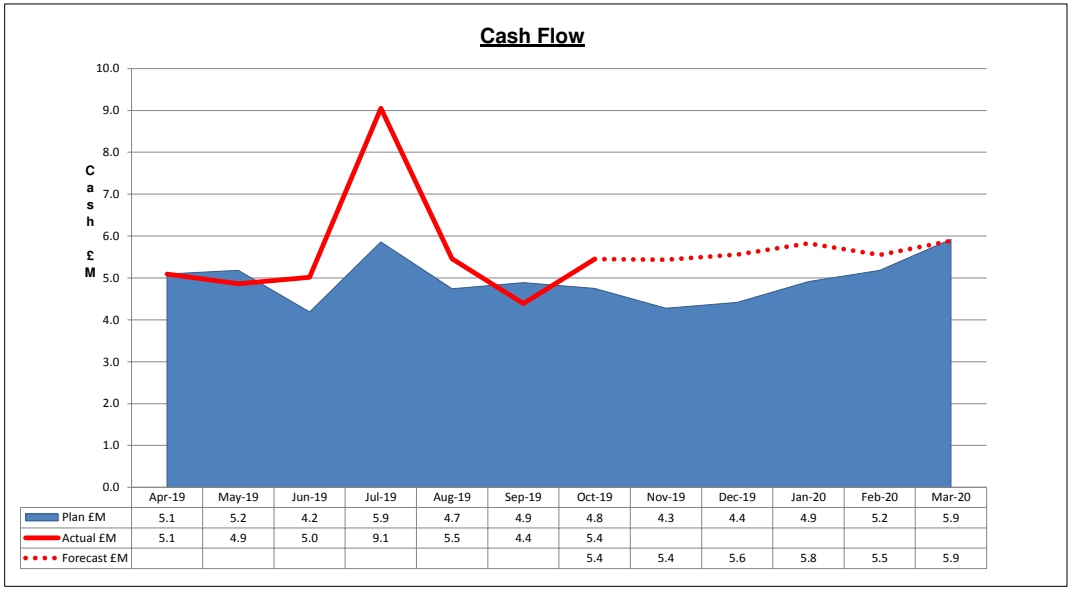
Category	Annual Plan	In Month Position			Year To Date Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	103,145	9,391	9,146	(245)	60,131	58,372	(1,759)
PSF	372	37	0	(37)	167	0	(167)
Private Patient income	5,854	552	577	25	3,462	3,242	(220)
Other income	6,004	500	532	32	3,513	3,575	62
Pay	(64,835)	(5,408)	(5,405)	3	(37,993)	(37,600)	393
Non-pay	(43,769)	(3,860)	(3,883)	(23)	(25,410)	(25,270)	140
EBITDA	6,772	1,213	968	(245)	3,871	2,319	(1,552)
Finance Costs	(4,890)	(411)	(400)	11	(2,821)	(2,822)	(1)
Capital Donations	150	13	0	(13)	83	35	(48)
Operational Surplus	2,032	815	568	(247)	1,133	(468)	(1,601)
Remove Capital Donations	(150)	(13)	0	13	(83)	(35)	48
Add Back Donated Dep'n	521	43	43	0	303	305	2
Remove PSF	(372)	(37)	0	37	(167)	0	167
Control Total exl PSF	2,031	808	611	(197)	1,186	(198)	(1,384)
PSF Earnt	372	37	0	(37)	167	0	(167)
Control Total	2,403	845	611	(234)	1,353	(198)	(1,551)
EBITDA margin	5.9%	11.6%	9.4%	-2.2%	5.8%	3.6%	-2.2%

Capital service	3	I&E Margin	3
Liquidity (days)	1	Variance in I&E Margin	4
Agency	2		
Overall UOR	3		

	Oct-19	YTD
Debtor Days	24	24
Creditor Days	33	33

Statement of Financial Position £'000s

Category	Sep-19	Oct-19	Movement	Drivers
Fixed Assets	71,919	71,840	(79)	Additions less depreciation
Non current receivables	737	772	35	
Total Non Current Assets	72,656	72,612	(44)	
Inventories (Stocks)	1,062	1,104	42	
Receivables (Debtors)	7,394	8,134	740	Clinical activity over performance (offset by payables below)
Cash at Bank and in hand	4,387	5,450	1,063	Welsh commissioner payments for transfer patients
Total Current Assets	12,843	14,688	1,845	
Payables (Creditors)	(10,153)	(11,385)	(1,232)	Clincal activity underperformance accruals (offset by recievables above).
Borrowings	(1,191)	(1,201)	(10)	
Current Provisions	(85)	(85)	0	
Total Current Liabilities (< 1 year)	(11,429)	(12,671)	(1,242)	
Total Assets less Current Liabilities	74,070	74,629	559	
Non Current Borrowings	(5,296)	(5,296)	0	
Non Current Provisions	(140)	(131)	9	
Non Current Liabilities (> 1 year)	(5,436)	(5,427)	9	
Total Assets Employed	68,634	69,202	568	
Public Dividend Capital	(33,718)	(33,718)	0	
Revenue Position	(15,047)	(15,047)	0	
Retained Earnings	1,036	468	(568)	Current period deficit, before control total adjustment
Revaluation Reserve	(20,905)	(20,905)	0	
Total Taxpayers Equity	(68,634)	(69,202)	(568)	



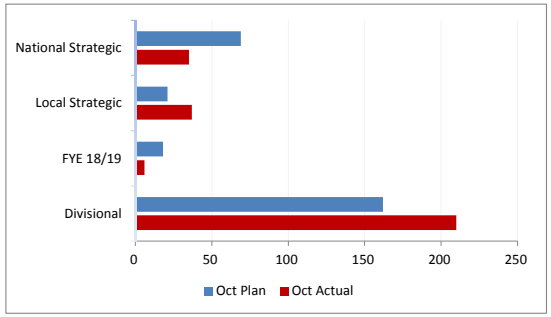
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Plan £M	5.1	5.2	4.2	5.9	4.7	4.9	4.8	4.3	4.4	4.9	5.2	5.9
Actual £M	5.1	4.9	5.0	9.1	5.5	4.4	5.4					
Forecast £M							5.4	5.4	5.6	5.8	5.5	5.9

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st October 2019

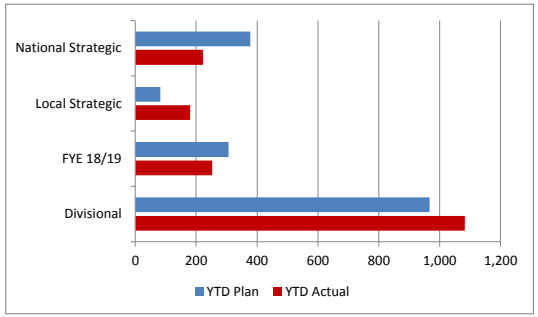
Cost Improvement Programme

CIP by Theme

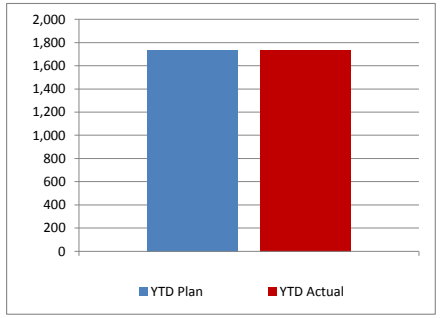
In Month CIP Achievement £000's



Year To Date CIP Achievement £000's

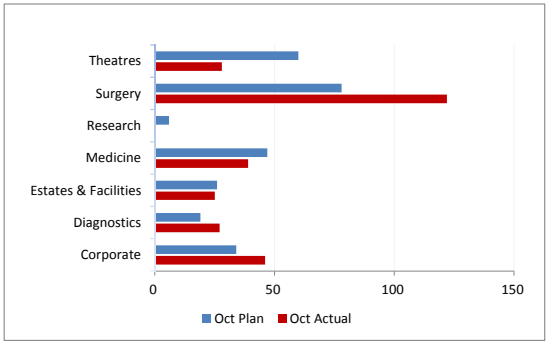


Trust YTD Achievement Against YTD Plan £000's

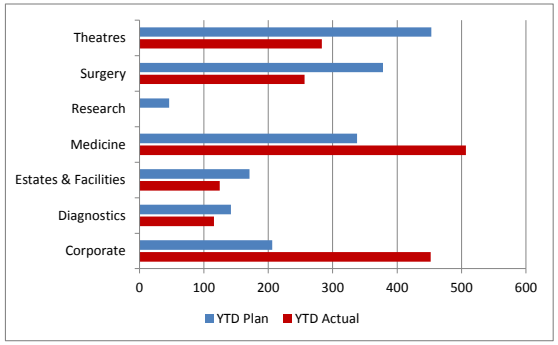


CIP by Division

In Month CIP Achievement £000's



Year To Date CIP Achievement £000's



RAG of Total Schemes Being Tracked

313	8%	b
1,116	27%	g
2,301	57%	a
420	8%	r
4,150	100%	

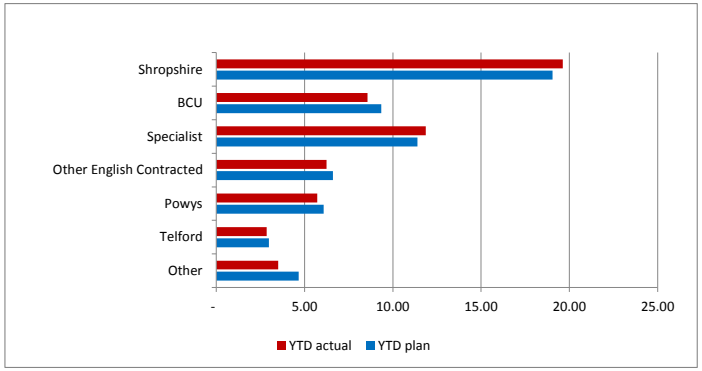
Capital

Year to date capital programme £000's

Position as at 1920-07 Capital Programme 2019-20					
Project	**Annual Plan £000s**	**YTD Plan £000s**	**YTD Completed £000s**	**YTD Variance £000s**	**Forecast Outturn £000s**
TSSU improvements & refurbishment	1,350	1,350	1,423	-73	1,465
Diagnostic equipment replacement	1,000	100	0	100	1,000
Replacement I/T network	400	400	196	204	400
EPR development	100	65	39	26	70
Digital developments	100	0	0	0	100
Invest-to-save schemes	300	90	9	81	264
I/T investment & replacement	250	210	20	190	250
Backlog maintenance	300	210	108	102	300
Equipment & service continuity	500	150	136	14	500
Project management	100	58	94	-36	126
Trust improvement bids	100	20	22	-2	109
Other - allocated from contingency	129	15	9	6	129
Contingency	171	65	0	65	87
NHS Capital Funding	4,800	2,733	2,056	677	4,800
Donated equipment / building works	150	70	37	33	150
Total Capital Funding (NHS & Donated)	4,950	2,803	2,093	710	4,950

Commissioner Performance

Year To Date Commissioner Income against Plan £m



Integrated Performance Report
October 2019 – Month 7

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Reading guide

The Integrated Performance Report (IPR) is designed to provide the Board with a monthly balanced summary of the Trust's performance across the three areas of the Trust's mission: caring for patients, caring for staff and caring for finances. To achieve this, the Trust has identified the Board-level Key Performance Indicators (KPIs), which are considered to drive the overall performance of the Trust. The report highlights key areas of improvement or concern enabling the Board to identify those areas that require the most consideration. As such, this report is not designed to replace the need for more detailed reporting on key areas of performance, and therefore detailed reporting will be provided to the Board and its committees to accompany the IPR where requested by the Board, its committees or the Executive Team. Contents of the report include:

Heatmaps
In month, year-to-date and forecast performance against target for each KPI and rolling 13-month performance information. A data quality indicator for each KPI is also included where available.

Narrative
Supporting narrative and trend graphs (with statistical process control where appropriate) are provided for each KPI including mitigating actions for red rated indicators.

Key

Key Performance Indicator RAG Ratings

Green	**YTD: Performance meets or exceeds target** **Forecast: Little risk of missing target at year end**
Red	**YTD: Performance behind target and outside tolerance** **Forecast: High risk of missing target at year end**

KPIs reported in arrears

KPIs reported in arrears, for which no current-month values are available, are marked with an asterisk (*) next to their name. The latest values for these KPIs are from the previous reporting month.

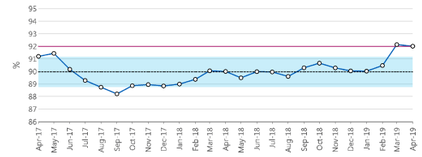
Data Quality Indicator

The data quality rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Blue	**No improvement required to comply with the dimensions of data quality**
Green	**Satisfactory – minor issues only**
Amber	**Requires improvement**
Red	**Significant improvement required**

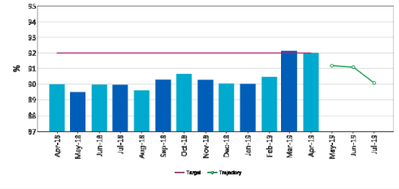
Trend graphs

Each KPI has a trend graph (or Statistical Process Control (SPC) where appropriate), which summarises performance over a rolling 24-month period.



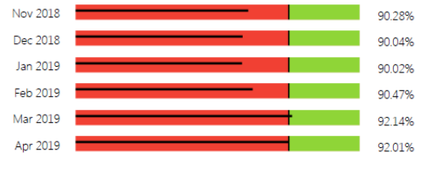
Trajectories

Where available, three-month trajectory data is included to indicate expected future performance. Historical trajectory data will be kept to compare actual performance with forecast performance.



Bullet graphs

Bullet graphs provide a clear visualisation to understand how well a KPI is performing against its target.



Thirteen-month heatmap view

Caring for Staff

	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Sickness Absence	4.39%	4.07%	4.29%	4.43%	4.58%	4.33%	4.59%	4.19%	4.45%	4.43%	4.86%	4.52%	5.19%	3.5%	3.5%	4.61%	R	
Voluntary Staff Turnover - Headcount	8.02%	8%	8.18%	7.94%	7.95%	7.37%	6.99%	6.86%	6.35%	6.59%	6.13%	6.77%	7.11%	8%	8%	7.11%	G	Sep-19

Integrated Performance Report
October – Month 7

Caring for Patients

	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Serious Incidents	1	1	1	0	0	2	1	1	0	0	0	0	1	0	0	3	R	Apr-18
Never Events	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	R	Apr-18
Total Patient Falls	20	13	16	11	10	8	5	11	16	10	8	12	17	10	70	79	R	Mar-19
RJAH Acquired Pressure Ulcers - Grades 3 or 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Patient Friends & Family - % Would Recommend (Inpatients & Outpatients)	99.01%	99.29%	99.06%	99.18%	98.84%	98.84%	98.44%	98.52%	99.28%	98.9%	99.21%	99%	99.07%	95%			G	Apr-18
Number of Complaints	13	6	7	6	17	8	5	8	7	9	7	15	19	8	56	70	R	May-18
% Delayed Discharge Rate	6.1%	7.53%	8.17%	4.02%	6.05%	6.72%	7%	3.6%	4.63%	6.82%	4.75%	5.61%	5.98%	2.5%	2.5%	5.48%	R	
Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Jun-19
RJAH Acquired E. Coli Bacteraemia	0	1	0	0	0	0	0	2	0	1	0	1	1	0	0	5	R	Jun-19
RJAH Acquired C.Difficile	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	G	Apr-18
RJAH Acquired MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Unexpected Deaths	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	R	Apr-18
VTE Assessments Undertaken	99.71%	99.86%	99.91%	100%	99.84%	99.92%	99.91%	99.83%	99.73%	99.92%	100%	99.76%	99.85%	95%	95%	99.86%	G	Apr-18
Cancer Two Week Wait*	100%	100%	100%	100%	92.86%	100%	100%	100%	100%	96.77%	100%	100%			93%	99.37%	G	
31 Days First Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			96%	100%	G	
31 Days Subsequent Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			94%	100%	G	
Cancer Plan 62 Days Standard (Tumour)*	50%	100%	66.67%	50%	100%	100%	100%	100%	100%	100%	100%	66.67%			85%	87.5%	G	

Integrated Performance Report
October – Month 7

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Cancer 62 Days Consultant Upgrade*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			85%	100%	G	
18 Weeks RTT Open Pathways	90.66%	90.28%	90.04%	90.02%	90.47%	92.14%	92.01%	91.4%	90.61%	89.9%	88.69%	88.54%	88.01%	92%	92%	90.17%	R	
Patients Waiting Over 52 Weeks – English	2	2	4	2	4	0	0	0	0	0	0	0	0	0			G	
Patients Waiting Over 52 Weeks – Welsh	3	6	7	3	6	1	0	0	1	0	0	0	0	0			G	
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)	54	72	66	52	26	0	1	6	18	86	128	164	172				G	
6 Week Wait for Diagnostics - English Patients	99.07%	98.7%	99.1%	98.91%	98.88%	97.64%	97.53%	97.21%	98.35%	98.55%	98.85%	98.99%	99.87%	99%	99%	98.46%	G	
8 Week Wait for Diagnostics - Welsh Patients	99.24%	99.65%	99.64%	99.66%	98.72%	100%	98.76%	99.72%	100%	100%	100%	98.87%	100%	100%	100%	99.63%	G	

Integrated Performance Report
October – Month 7

Caring for Finances

	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Total Theatre Activity	1,115	1,157	883	1,094	1,024	1,082	856	970	886	930	921	1,044	1,079	1,171	7,259	6,685	R	Sep-19
Bed Occupancy – All Wards – 2pm	85.94%	84.03%	84.83%	86.78%	87.62%	85.32%	81.44%	81.46%	82.49%	83.07%	81.03%	85.43%	85.06%	87%	83%	82.85%	G	Sep-19
Outpatients Activity Attendances	15,939	15,298	11,440	14,995	13,616	13,718	13,724	13,761	13,009	14,273	12,888	14,181	14,965	15,319	98,056	96,801	R	Sep-19
Financial Control Total	676	621	-833	359	59	535	-775	31	-207	73	-288	357	611	808	1,186	-198	R	
Income	10,357	10,004	8,048	9,583	9,049	10,278	8,677	9,508	8,842	9,484	8,837	9,585	10,256	10,443	67,106	65,189	R	
Expenditure	9,734	9,416	8,648	9,189	9,031	9,464	9,495	9,521	9,092	9,457	9,168	9,270	9,688	9,679	66,223	65,692	G	
CIP Delivery	327	311	329	284	307	358	166	192	260	231	301	301	287	270	1,734	1,738	G	
QIPP Delivery Risk Impact							106	86	-67	7	56	163	6	0	0	359	R	
Agency Core	171.62	141.07	105.5	90.56	45.75	68.59	51	68	44	65	77	93	125	132	926	522	G	
Agency Non-Core	302.08	233.41	234.72	243.13	243.43	317.48	229	239	221	231	254	252	314	187	1,176	1,740	R	
Cash Balance	5,000	4,200	3,900	4,700	4,300	5,700	5,094	4,861	5,013	9,051	5,457	4,387	5,450	4,751	4,751	5,450	G	
Capital Expenditure	160	377	400	304	165	1,327	260	336	162	458	588	119	170	428	2,803	2,093	G	
Use of Resources (UOR)	2	2	2	2	2	1	3	3	3	3	3	3	3	1	2	3	R	
Proportion of Temporary Staff							4.88%	5.48%	4.81%	5.3%	5.94%	6.14%	7.68%	5.61%	5.3%	5.75%	R	

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Sickness Absence

FTE days lost as a percentage of FTE days available in month

5.19% against **3.5%** target

Breaching target red rated

Exec Lead:
Director of People

Integrated Performance Report

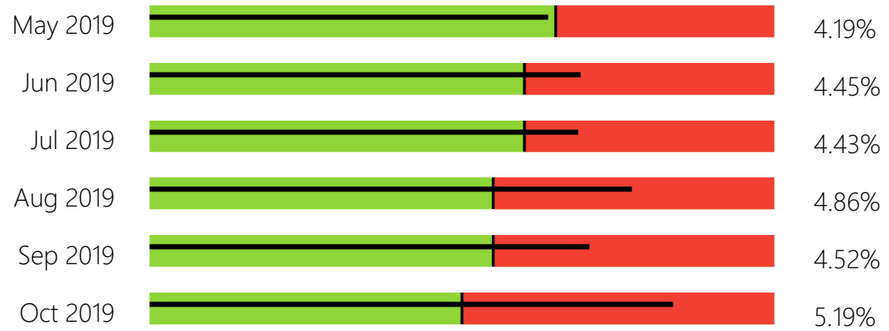
Narrative

There was an increase in sickness absence in October and despite a decrease in long term absences this was offset by the increase in short-term absence. Long term absence fell below the October Forecast. The highest individual reasons for both short and long term absence in October was stress/anxiety/depression.

Further analysis has taken place to refine the trajectory provided for November with assumptions made as follows; Short term absence forecast at 2.74% based on the known sickness levels for November known at 14th November and multiplied by two to give an estimate for the full month. Long term absence forecast at 2.13% by knowledge of individual cases of absence as at 11th November.

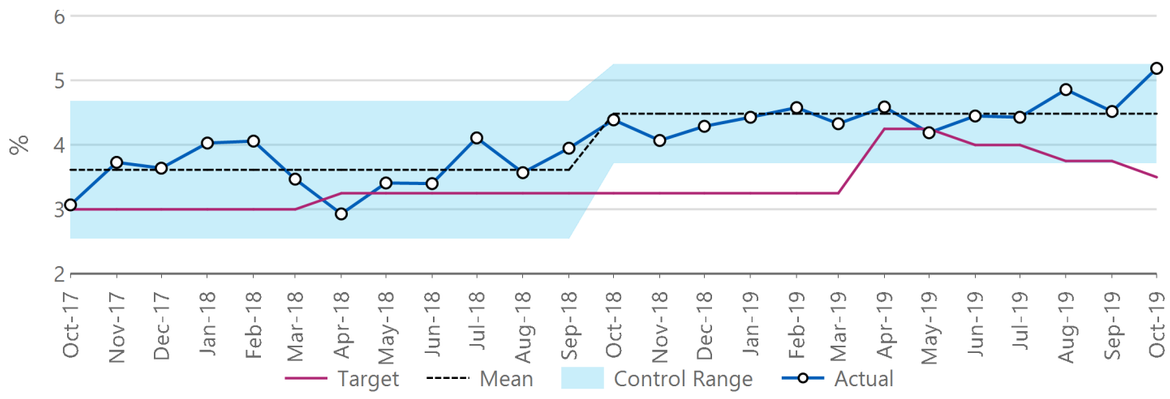
Action to Improve:As part of our staff experience project at a trust level we will be promoting sources of support for maintaining mental health wellbeing during October. At a divisional level understanding the themes and local actions will be fed into the PRM framework.

Actual performance against RAG ratings

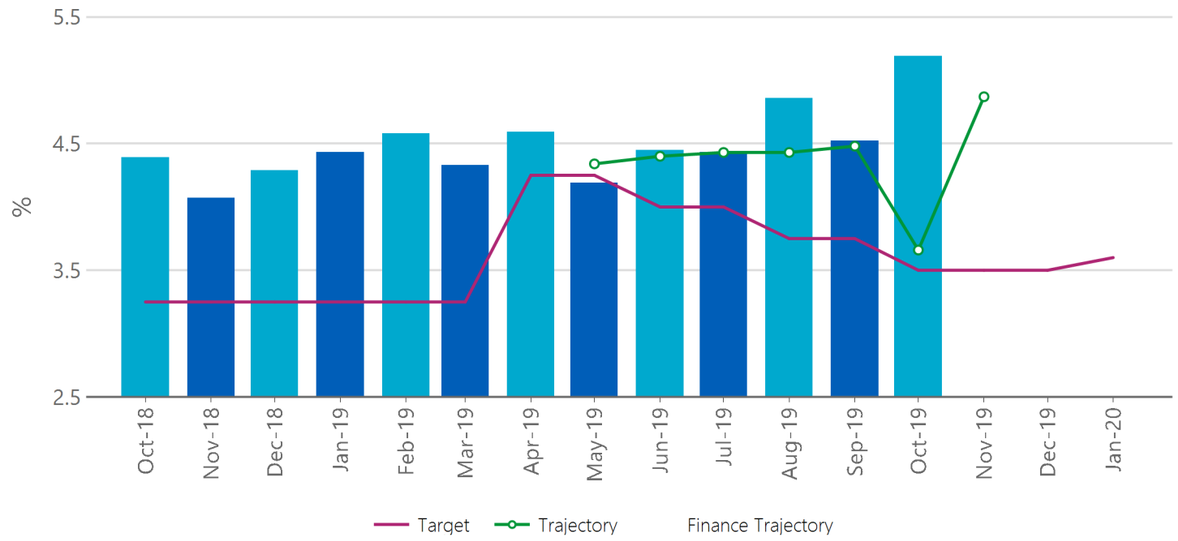


Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
3.07%	3.73%	3.64%	4.03%	4.06%	3.47%	2.93%	3.41%	3.4%	4.11%	3.57%	3.95%	4.39%	4.07%	4.29%	4.43%	4.58%	4.33%	4.59%	4.19%	4.45%	4.43%	4.86%	4.52%	5.19%	4.61%

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Voluntary Staff Turnover - Headcount

Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed

7.11% against 8% target

Within target green rated

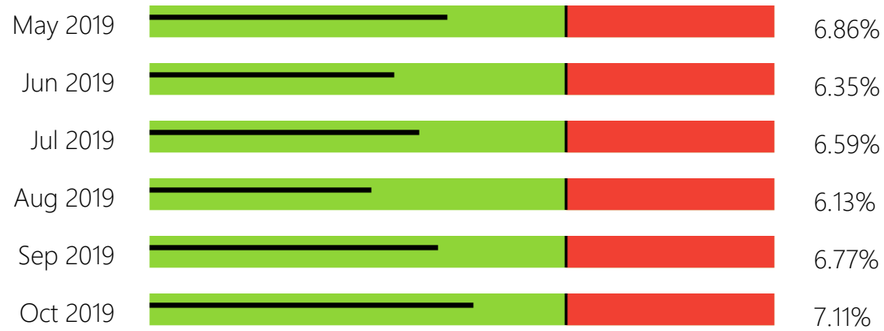
Exec Lead:
Director of People

Integrated Performance Report

Narrative

Headcount turnover is below (positive) the target, but the position has deteriorated further this month. Medicine Division were above (negative) the target.

Actual performance against RAG ratings



Performance over 24 months – SPC

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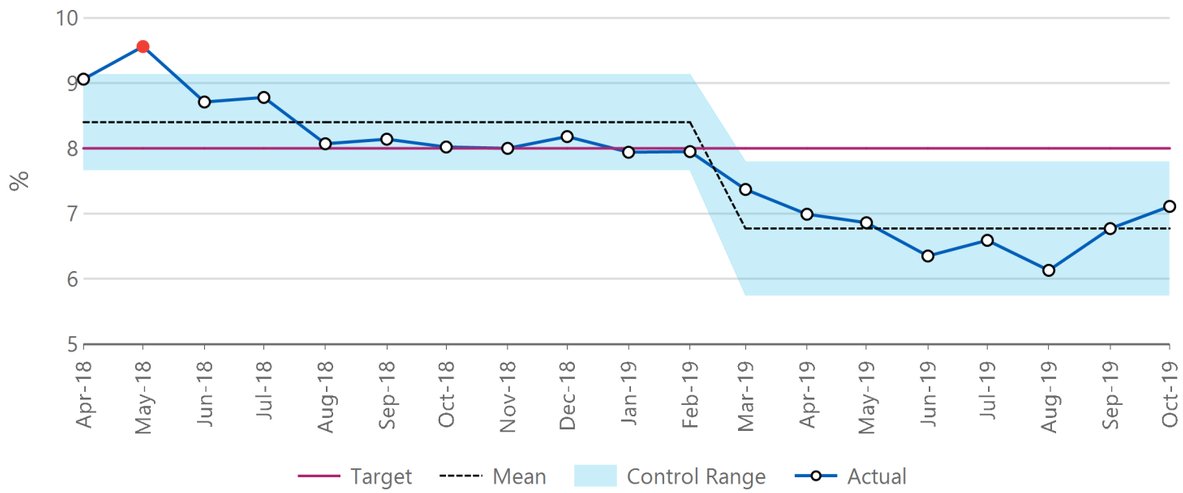
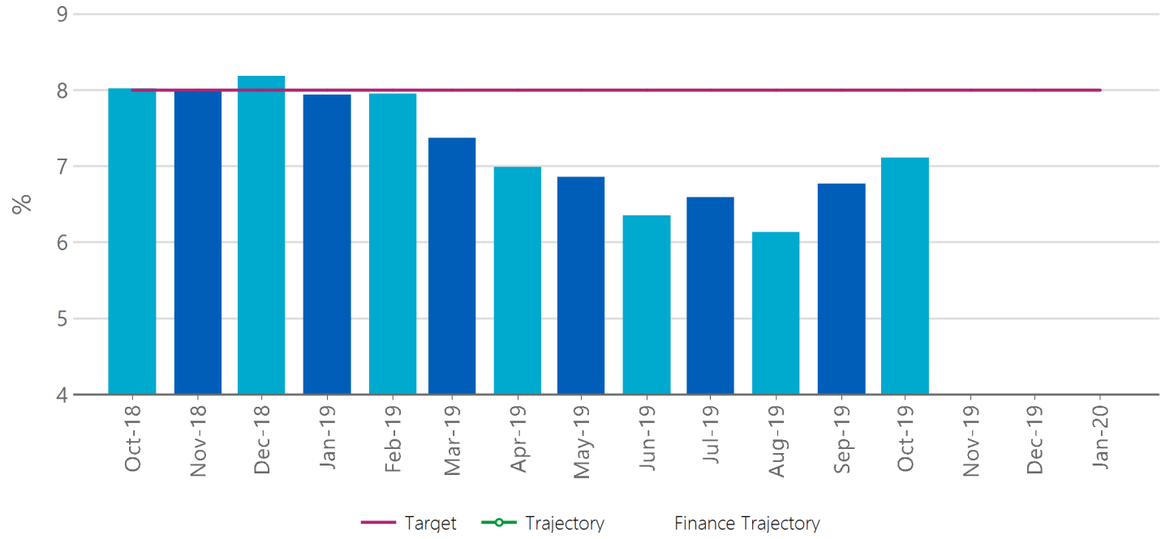


Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
9.06%	9.56%	8.71%	8.78%	8.07%	8.14%	8.02%	8%	8.18%	7.94%	7.95%	7.37%	6.99%	6.86%	6.35%	6.59%	6.13%	6.77%	7.11%	7.11%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Serious Incidents

Number of Serious Incidents reported in month

1 against 0 target

Breaching target red rated

Exec Lead:
Director of Nursing

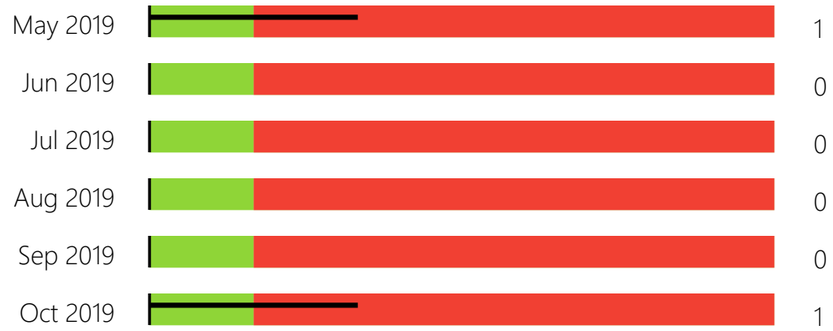
Integrated Performance Report

Narrative

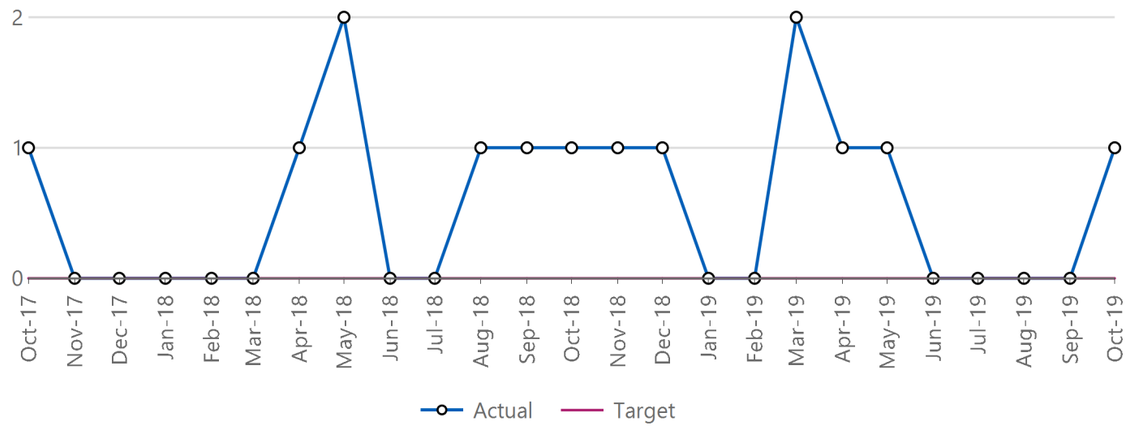
There was one serious incident reported in October relating to treatment delays in pressure sore management.

Action to Improve:A multi-disciplinary harms assessment is ongoing and actions will be fed back to the Quality and Safety Committee.

Actual performance against RAG ratings



Performance over 24 months –



Trajectory

Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
1	0	0	0	0	0	1	2	0	0	1	1	1	1	1	0	0	2	1	1	0	0	0	0	1	3

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Never Events

Number of Never Events Reported in Month

0 against 0 target

On target green rated

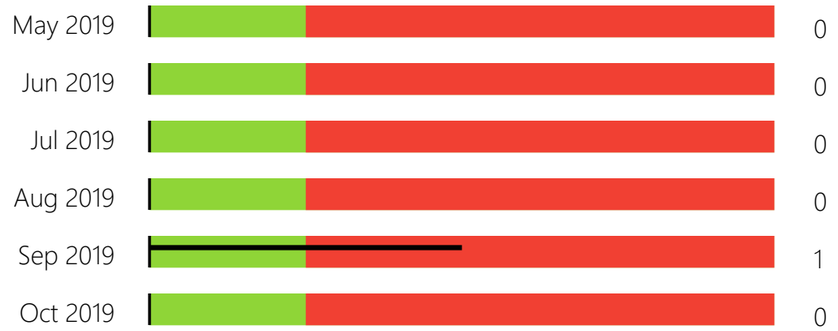
Exec Lead:
Director of Nursing

Integrated Performance Report

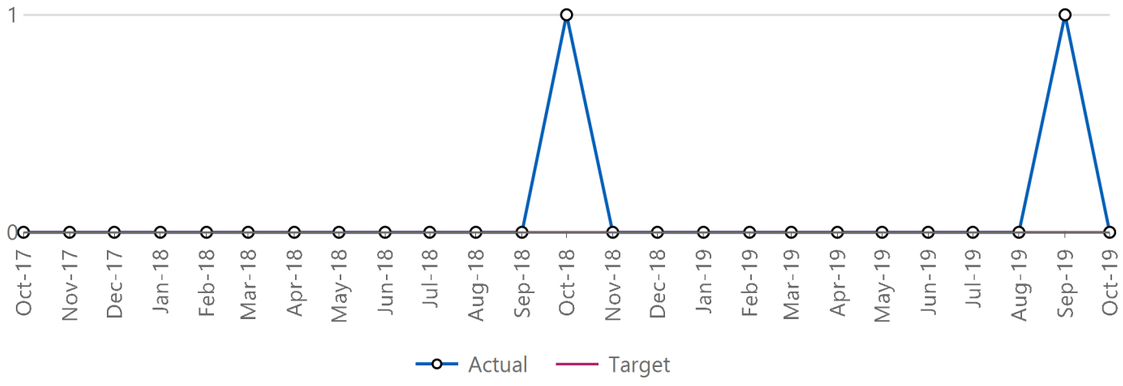
Narrative

There were no never events reported in October.

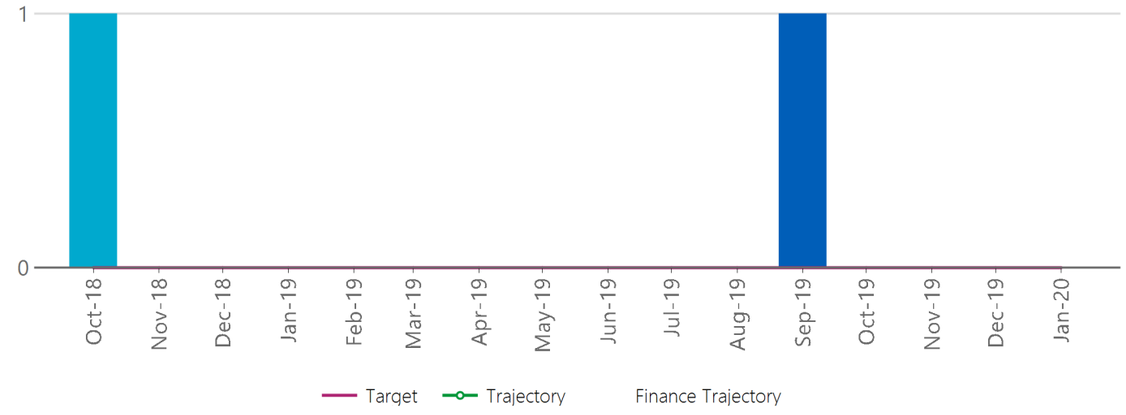
Actual performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Patient Falls

Total number of falls - excludes slips, trips and assisted slides

17 against 10 target

Breaching target red rated

Exec Lead:
Director of Nursing

Integrated Performance Report

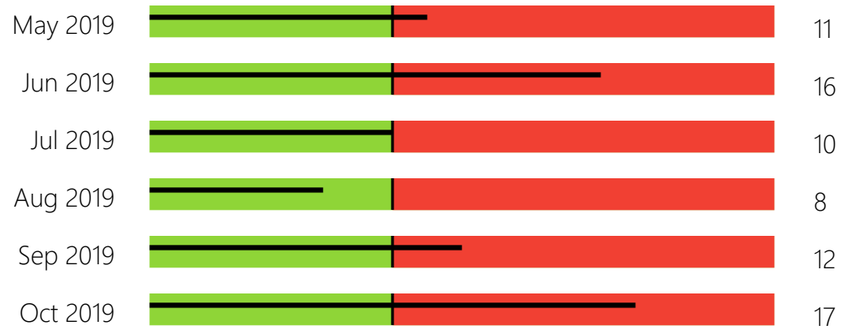
Narrative

The Total Patient Falls KPI is red rated in October as there were seventeen falls, fifteen relating to inpatients and two relating to outpatients. The falls are broken down as follows:
- No harm (3) 17.65%
- Low harm (14) 82.35%, made up of:
  - No obvious injury but unwitnessed (6)
  - Bruise/Graze (6)
  - Swelling (1)
  - Pain (1)

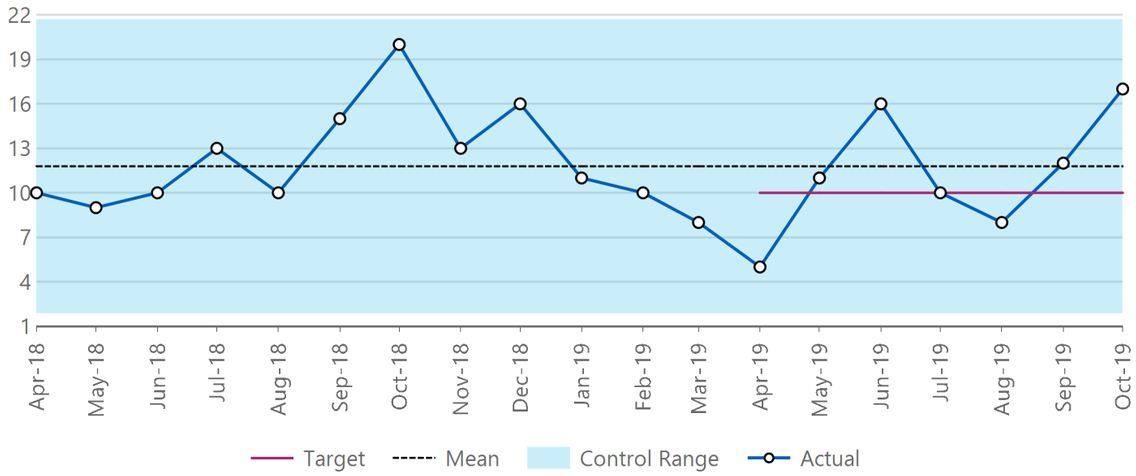
The falls occurred within the following wards/areas:
- Inpatient falls: Alice (2), Clwyd (1), Gladstone (4), Wrekin (2), Kenyon (1), Ludlow (2), Powys (2), other Medicine (1)
- Outpatient falls: Therapies (2)

Action to Improve:Each fall is reviewed on an individual basis to assistance the root cause of the fall. Unwitnessed bathroom falls continue to be a theme across the Trust so specific actions are implemented. A falls collaborative is scheduled to take place in January to look at prevention of falls.

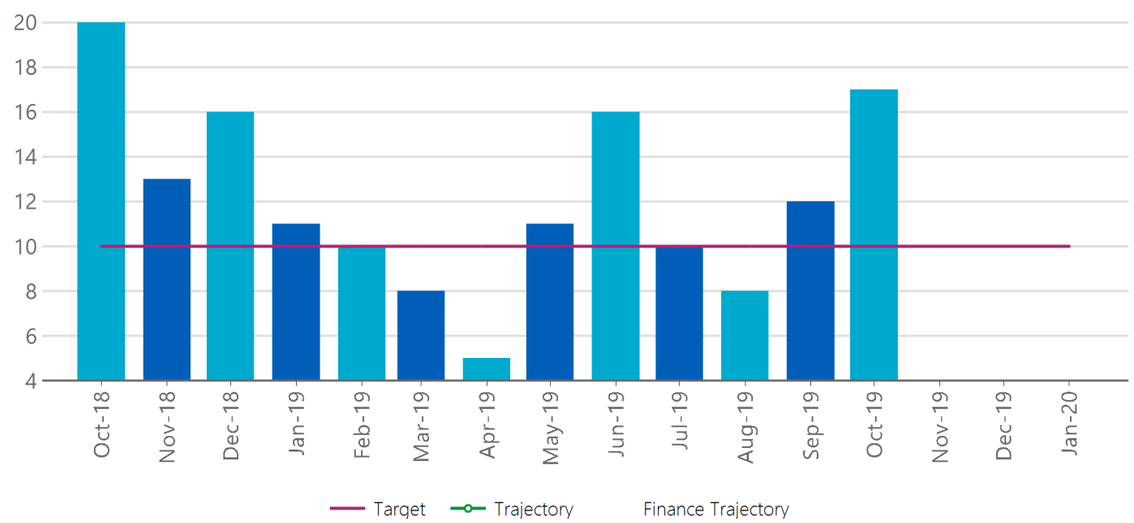
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
10	9	10	13	10	15	20	13	16	11	10	8	5	11	16	10	8	12	17	79

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired Pressure Ulcers - Grades 3 or 4

Total number of category 3 & 4 pressure ulcers acquired at RJAH

0 against 0 target

On target green rated

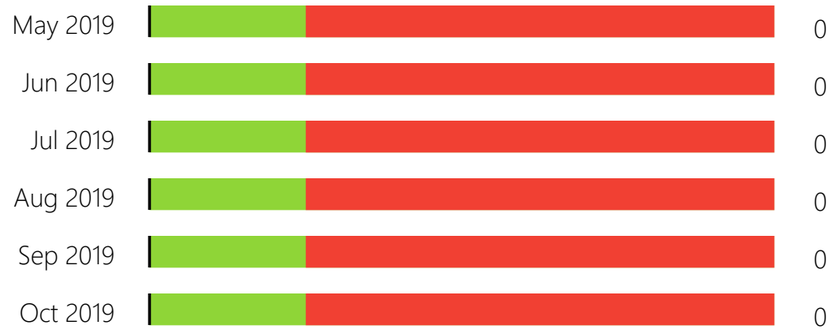
Exec Lead:
Director of Nursing

Integrated Performance Report

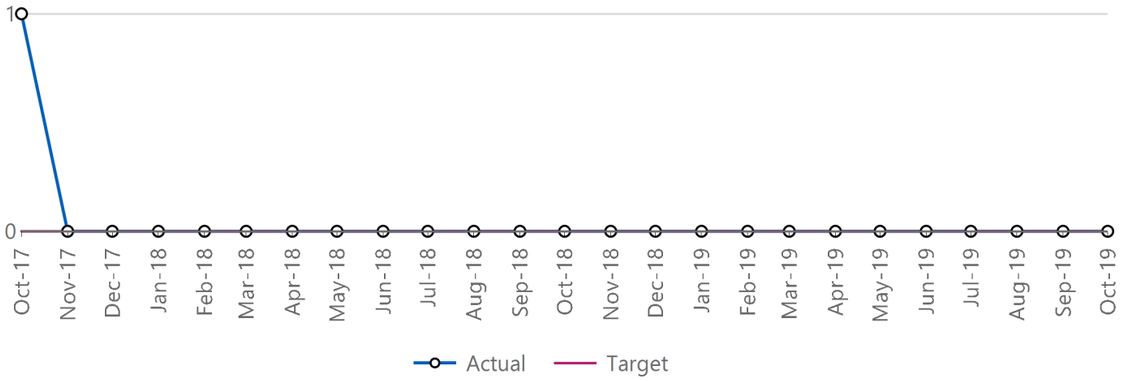
Narrative

There were no category three or four pressure ulcers in October.

Actual performance against RAG ratings



Performance over 24 months –



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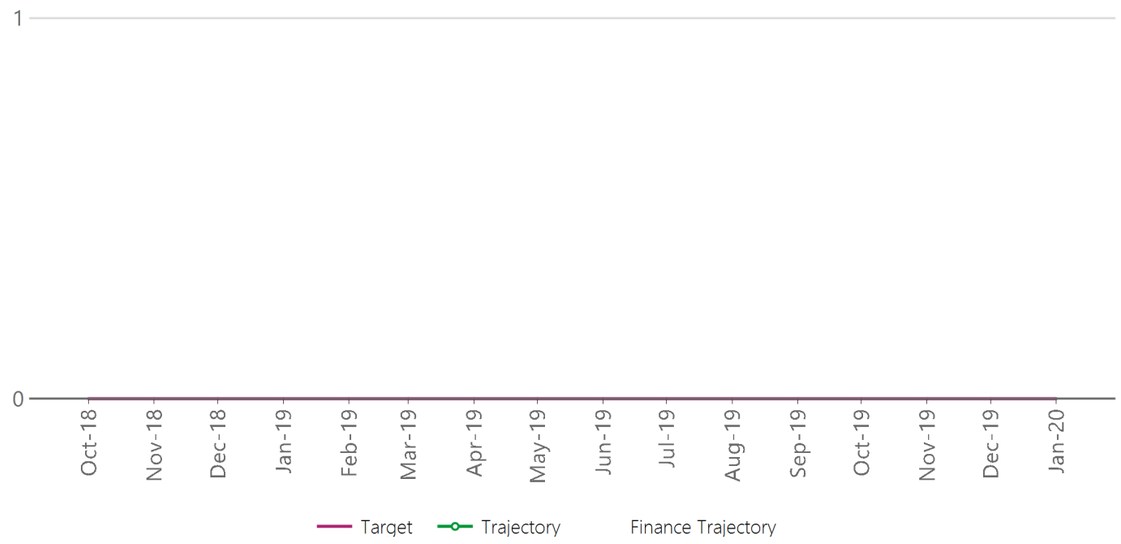


Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patient Friends & Family - % Would Recommend (Inpatients & Outpatients)

99.07% against 95% target

Above target green rated

Exec Lead:
Director of Nursing

Integrated Performance Report

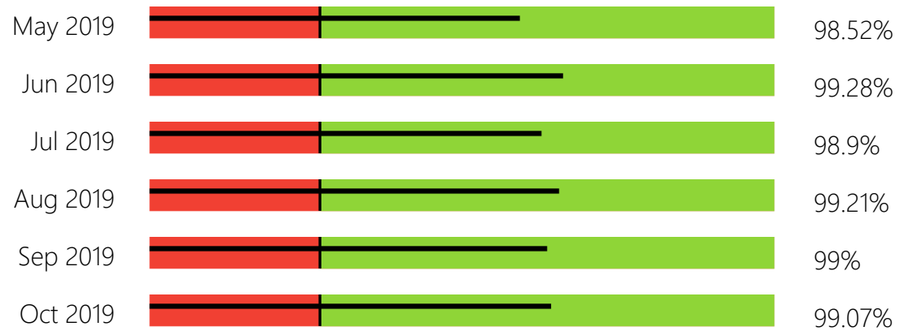
% of patients who would recommend the trust (inpatients and outpatients)

Narrative

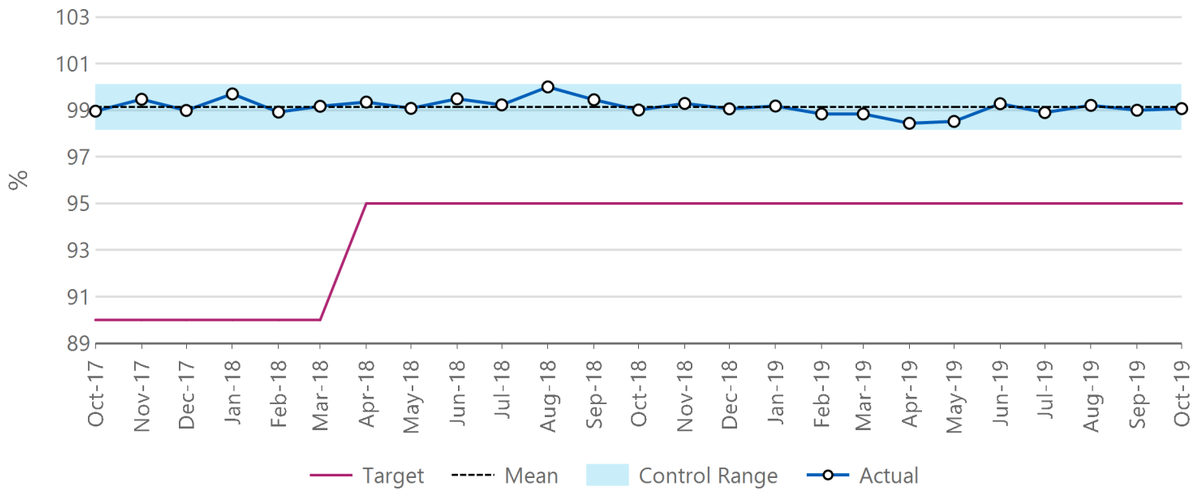
There were 756 responses collected with a breakdown as follows:
- 749 positive - giving a rate of 99.07% would recommend the Trust to friends and family
- 4 negative - giving a rate of 0.53% would not recommend the Trust to friends and family
- 3 responses as "neither likely or unlikely" or "don't know"

The number of compliments received in October was 298.

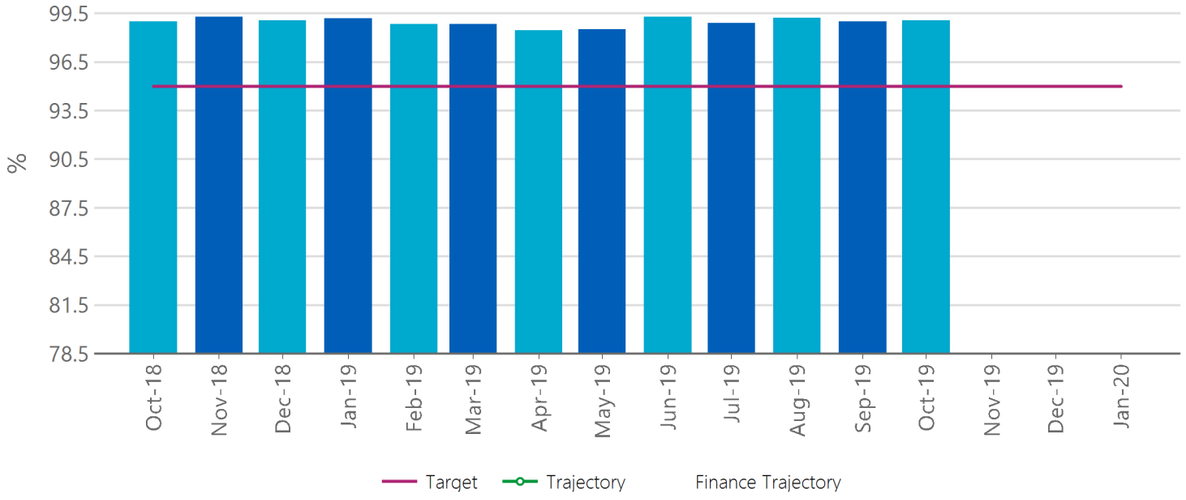
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
98.96%	99.47%	98.99%	99.7%	98.92%	99.17%	99.35%	99.08%	99.49%	99.23%	100%	99.45%	99.01%	99.29%	99.06%	99.18%	98.84%	98.84%	98.44%	98.52%	99.28%	98.9%	99.21%	99%	99.07%

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Number of Complaints

Number of complaints received in month

19 against 8 target

Breaching target red rated

Exec Lead:
Director of Nursing

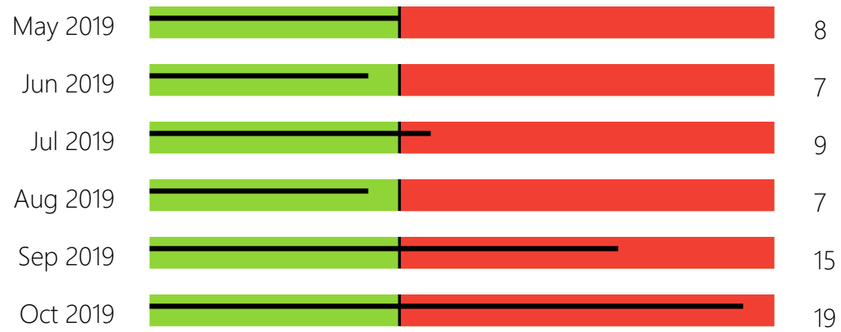
Integrated Performance Report

Narrative

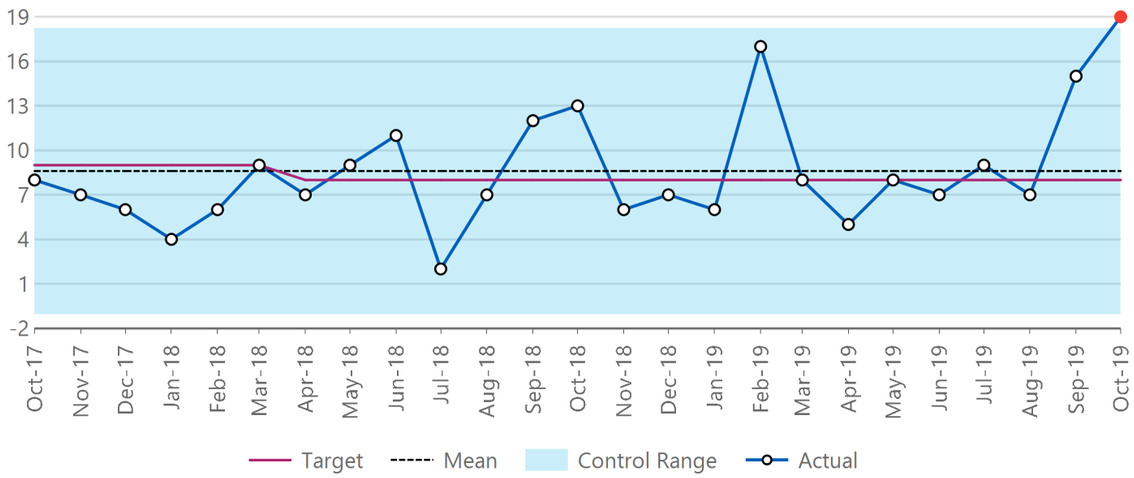
There were nineteen complaints received in October. Eleven related to quality of care with reasons associated with attitude of staff (3), care and advice given (1), mobility of knee following surgery (1), alterations to orthotic shoes (1), being referred to SOOS (1), concerns to why patient had a stroke following surgery (1), clinic notes following appointment with Registrar (1), unnecessary appointment to discharge patient (1) and treatment received (1). Eight complaints related to operational issues associated to timescale for treatment/surgery (3), attitude of staff (1), delays and lack of appointments (1), appointment letter sent to old address (1), patient confidentiality (1) and missed appointment due to wrong location on letter (1).

Action to Improve:As per Trust policy all complaints are fully investigated with any appropriate findings or actions assigned to the relevant staff/areas. With increased levels seen in October we will seek to establish any themes to the complaints received.

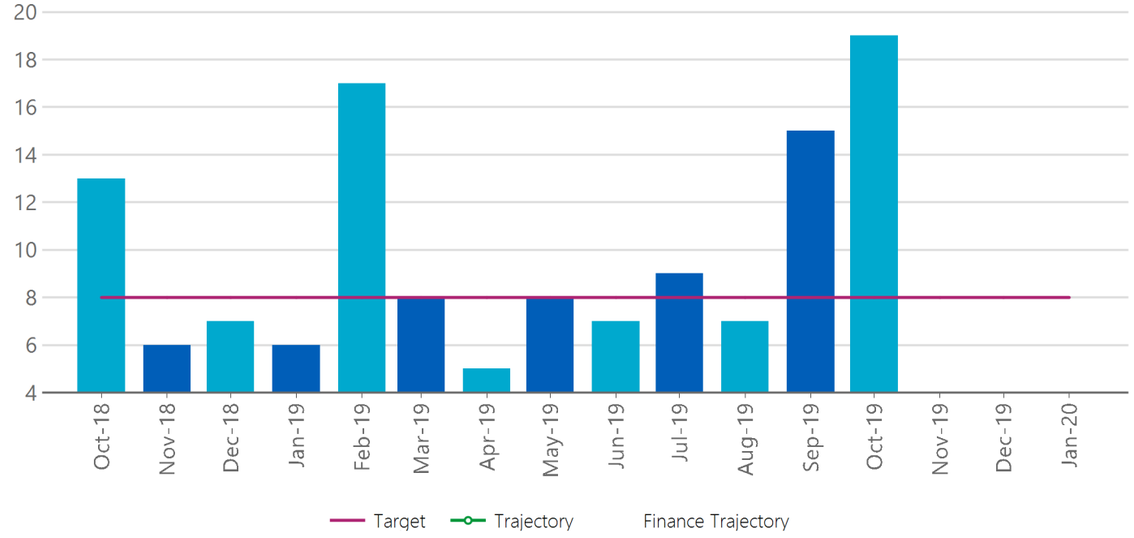
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
8	7	6	4	6	9	7	9	11	2	7	12	13	6	7	6	17	8	5	8	7	9	7	15	19	70

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

% Delayed Discharge Rate

The total number of delayed days against the total available bed days for the month in %

5.98% against **2.5%** target

Breaching target red rated

Exec Lead:
Director of Nursing

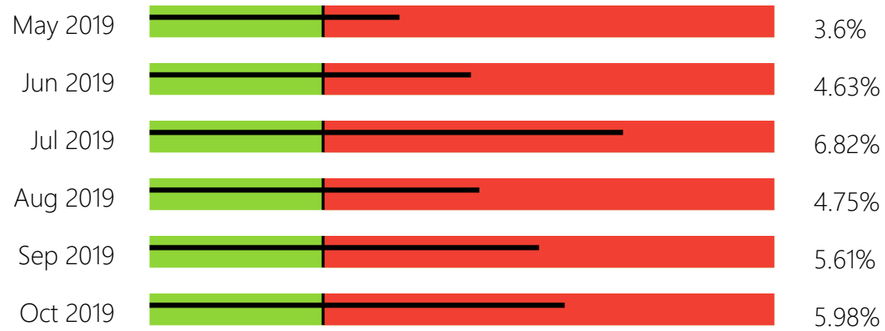
Integrated Performance Report

Narrative

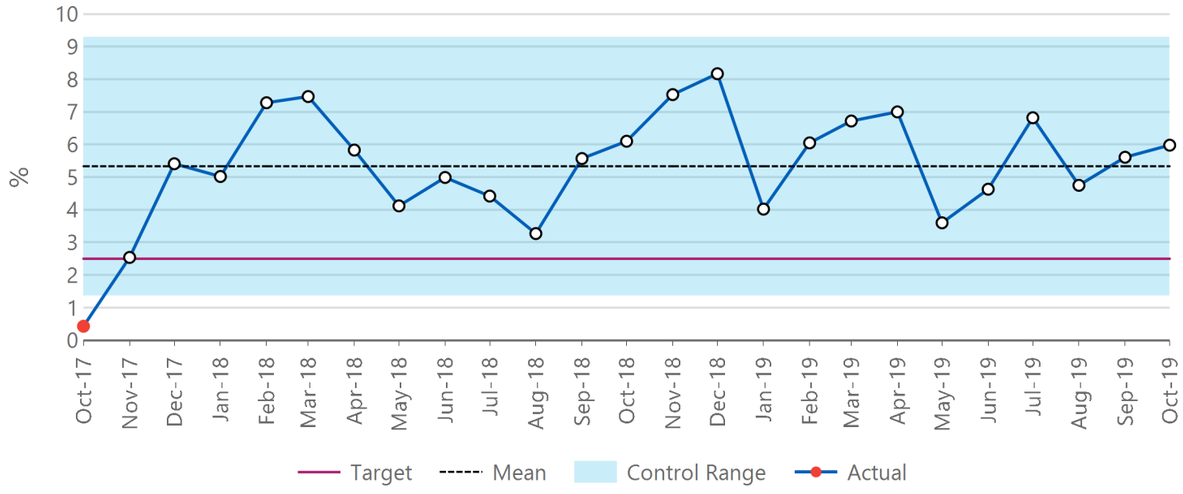
The Delayed Discharge rate is red rated this month at 5.98%. The total delayed days for October is 296 days; 11 spinal injuries patients amounting to 200 days, 12 care of the elderly patients with 73 delayed days and 6 surgical patients with 23 delayed days. The patients fall under the responsibility of Shropshire (13), Resident in Wales (5), Birmingham (2), Cheshire East (2) and 7 other organisations with one patient each.

Action to Improve:There has been an increase to the resource in the Resettlement team in MCSI which should have a positive impact on reducing the delayed transfers of care from November. Work continues to implement the action plan that was agreed with ECIST which will impact the delays attributable to Care of the Elderly patients.

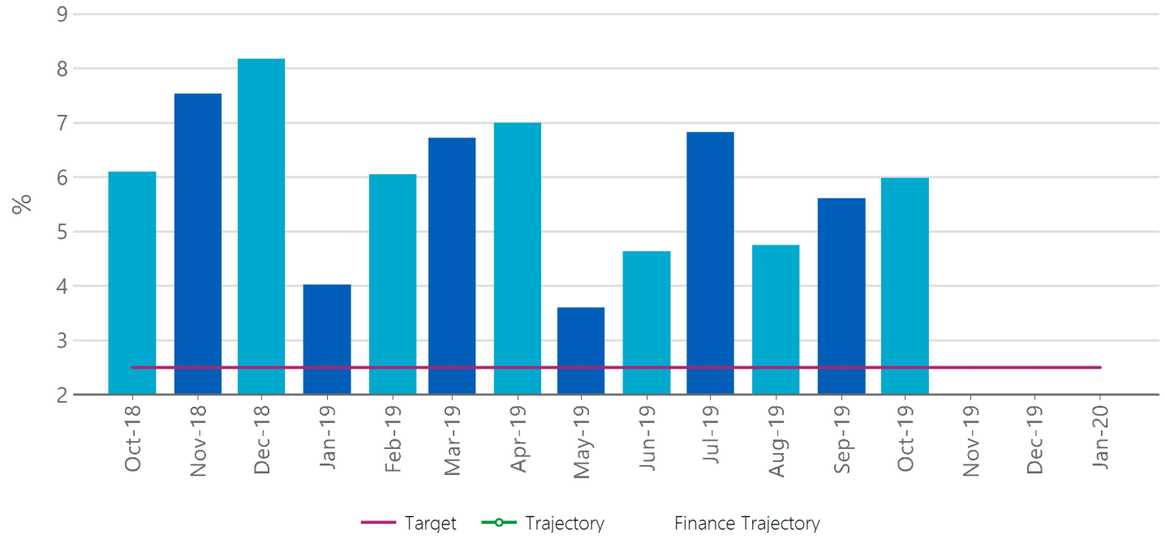
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
0.43%	2.54%	5.41%	5.02%	7.28%	7.47%	5.83%	4.12%	4.99%	4.42%	3.27%	5.57%	6.1%	7.53%	8.17%	4.02%	6.05%	6.72%	7%	3.6%	4.63%	6.82%	4.75%	5.61%	5.98%	5.48%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Mixed Sex Accommodation

Number of breaches to the mixed sex accommodation standard for non clinical reasons

0 against 0 target

On target green rated

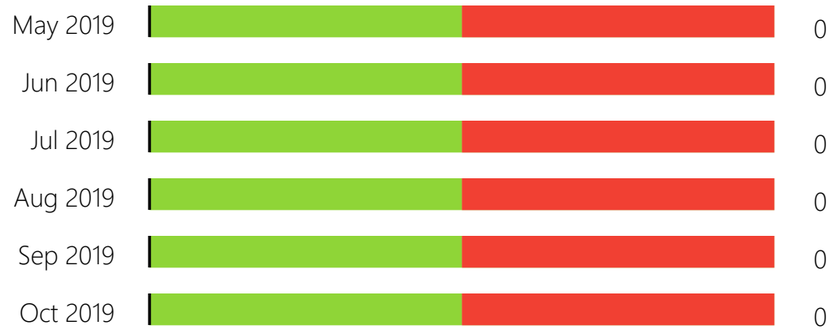
Exec Lead:
Director of Nursing

Integrated Performance Report

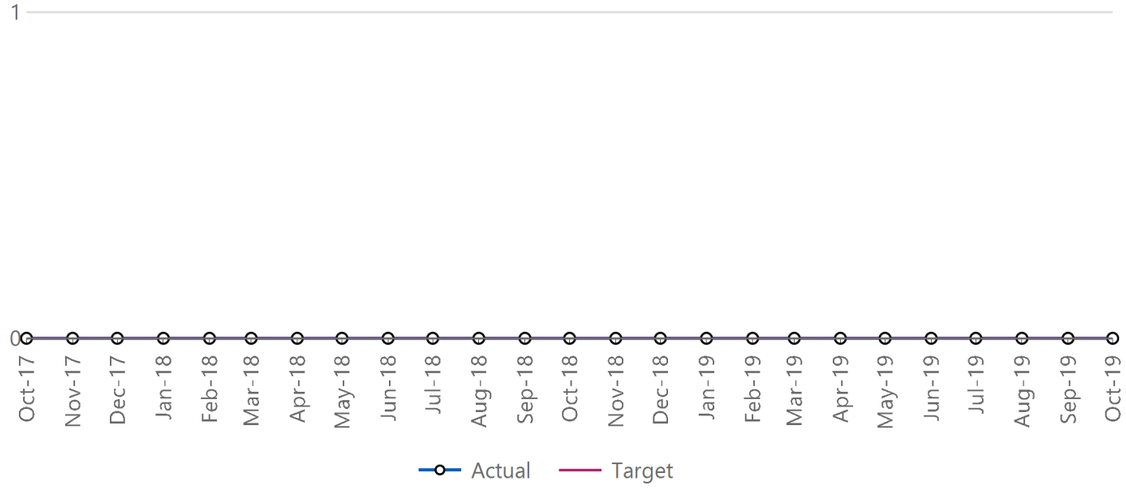
Narrative

There were no breaches of the mixed sex accommodation standard in October.

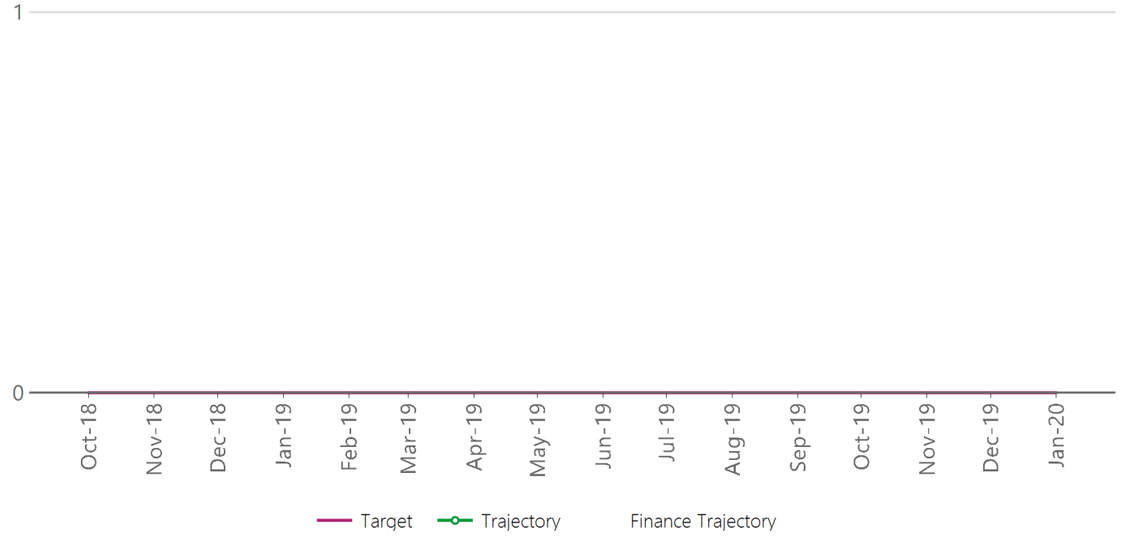
Actual performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired E. Coli Bacteraemia

Number of cases of E. Coli Bacteraemia in Month.

1 against 0 target

Breaching target red rated

Exec Lead:
Director of Nursing

Integrated Performance Report

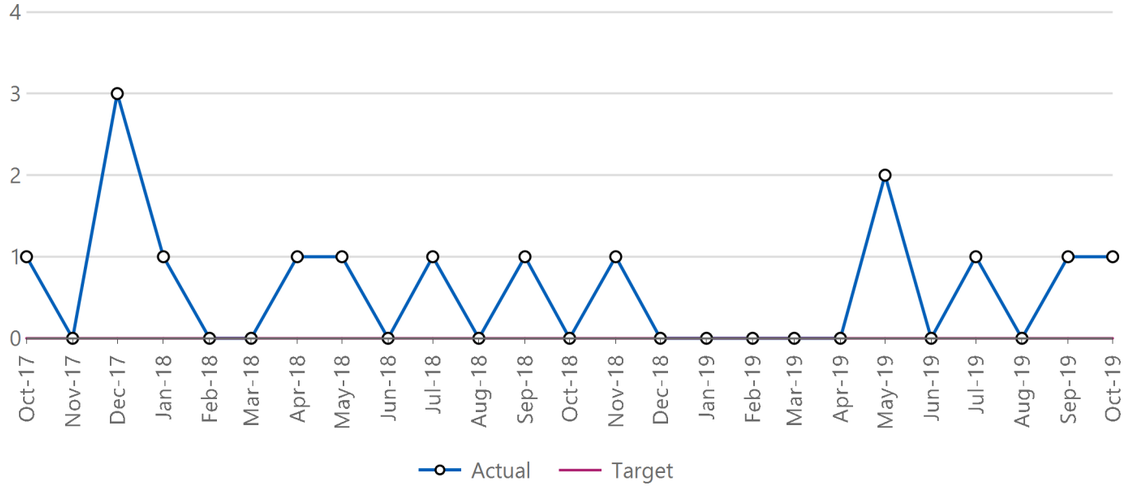
Narrative

One patient acquired an E. Coli blood stream infection in October.

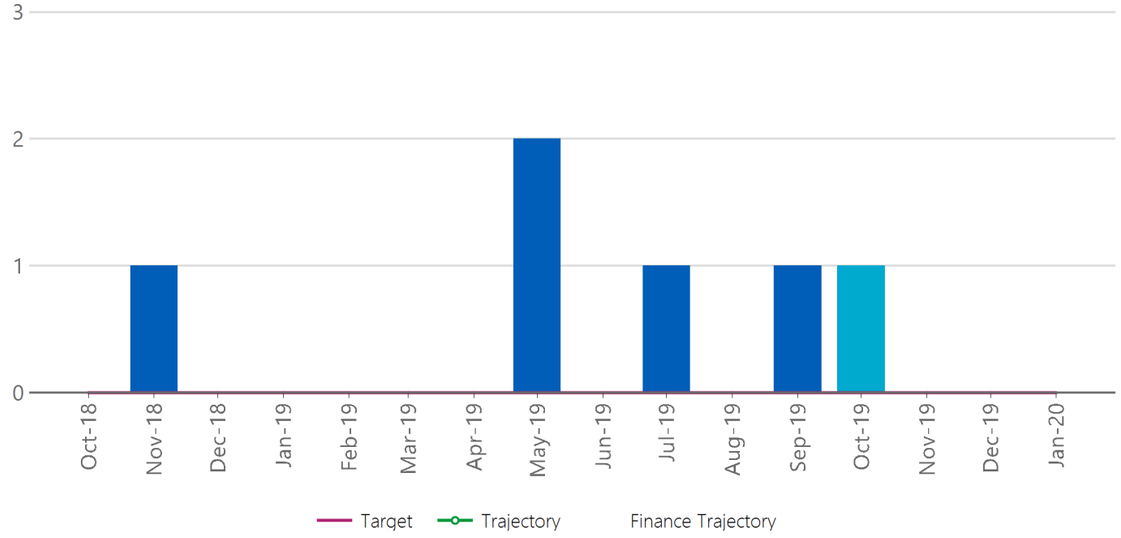
Action to Improve:The patient was suitably treated with antibiotics following microbiology advice.

Actual performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
1	0	3	1	0	0	1	1	0	1	0	1	0	1	0	0	0	0	0	2	0	1	0	1	1	5

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month

0 against 0 target

On target green rated

Exec Lead:
Director of Nursing

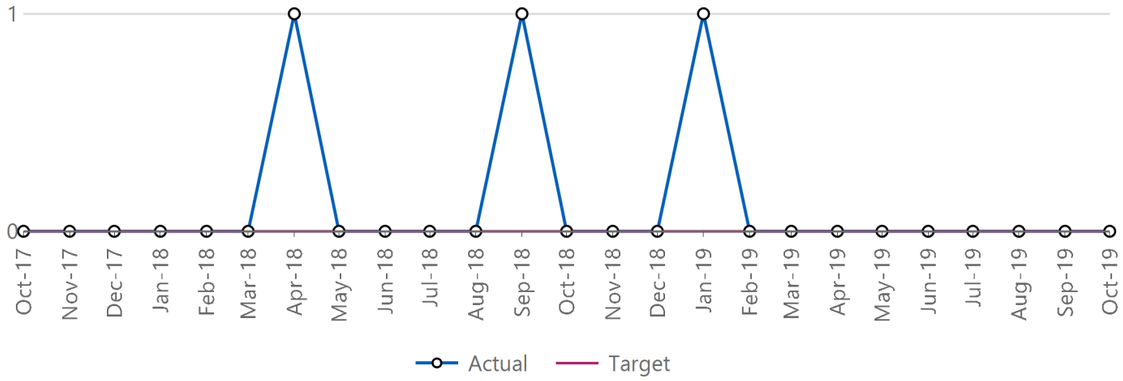
Integrated Performance Report

Narrative

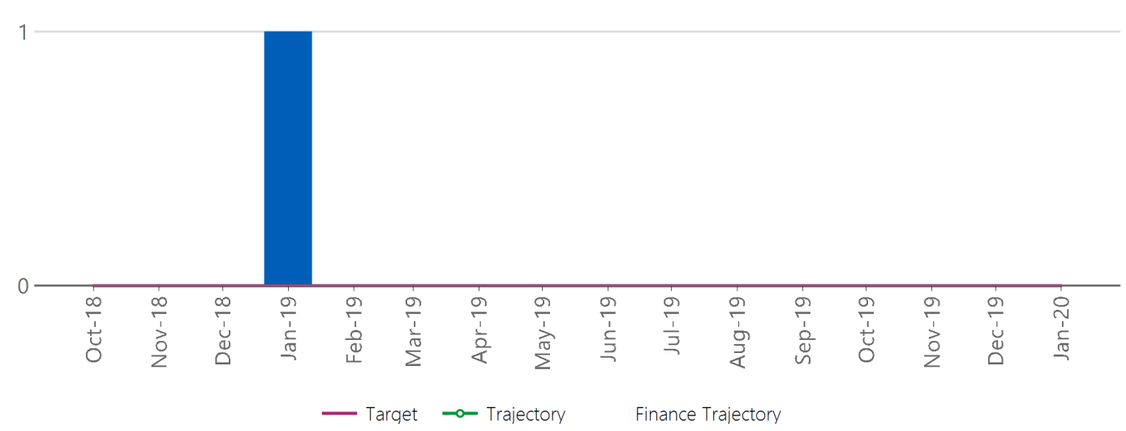
There were no incidents reported in October.

Actual performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired MRSA Bacteraemia

Number of cases of MRSA bacteraemia in month

0 against 0 target

On target green rated

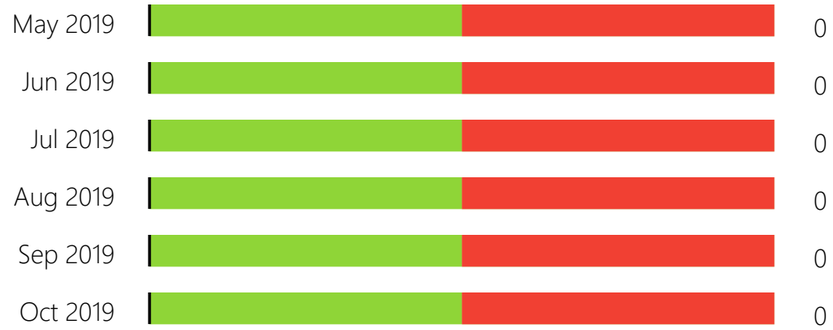
Exec Lead:
Director of Nursing

Integrated Performance Report

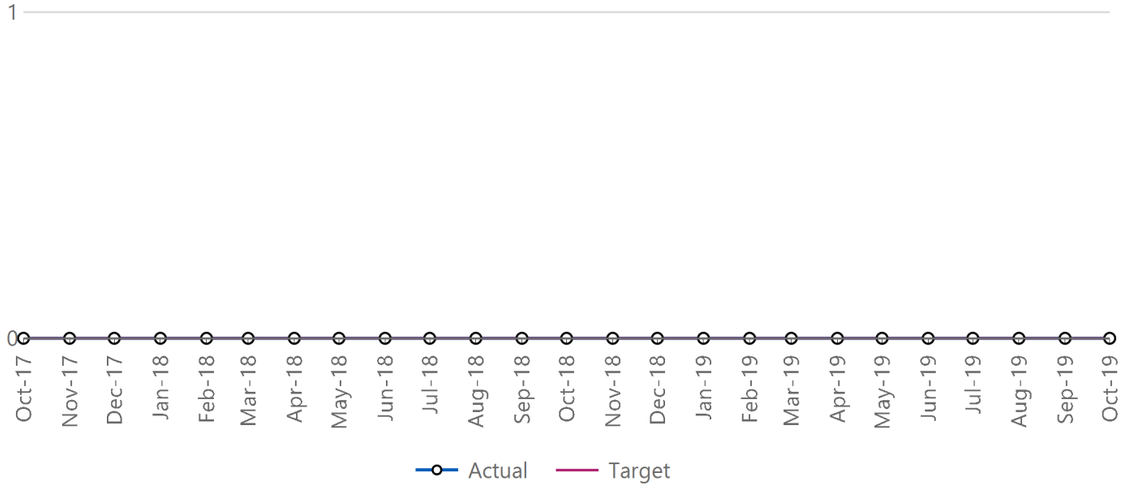
Narrative

There were no incidents reported in October.

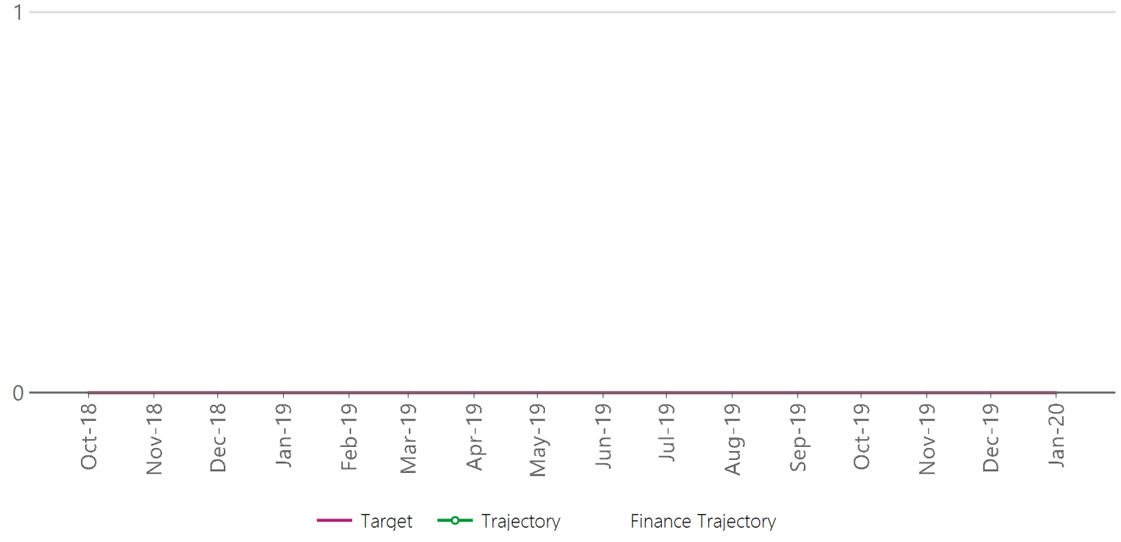
Actual performance against RAG ratings



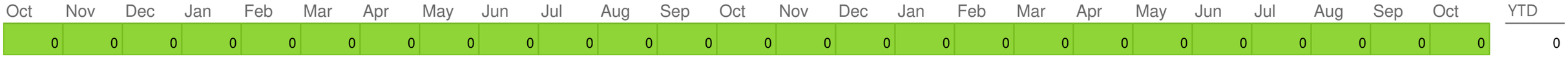
Performance over 24 months –



Trajectory



Heatmap performance over 24 months



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Unexpected Deaths

Number of Unexpected Deaths in Month

0 against 0 target

On target green rated

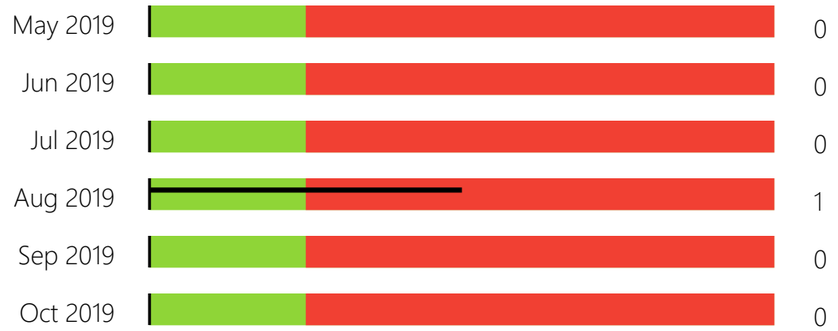
Exec Lead:
Medical Director

Integrated Performance Report

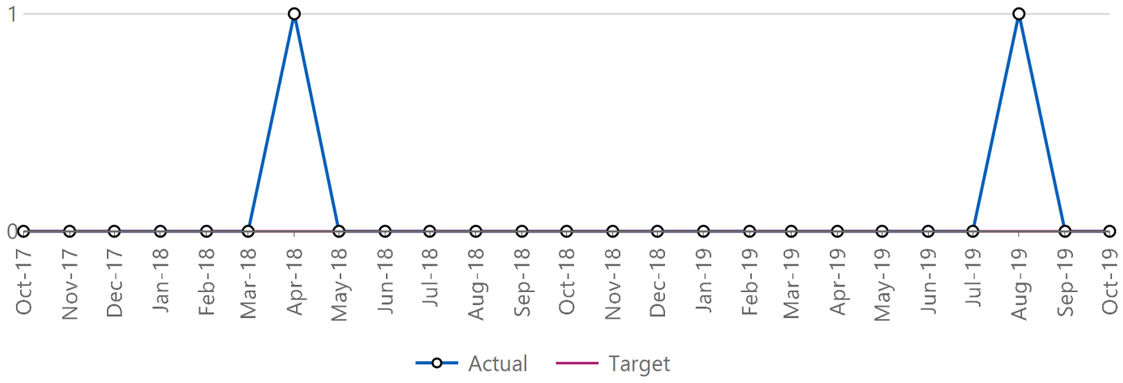
Narrative

There were three deaths in the Trust in October; one each on HDU, Clwyd ward and Sheldon ward. None of the deaths were unexpected.

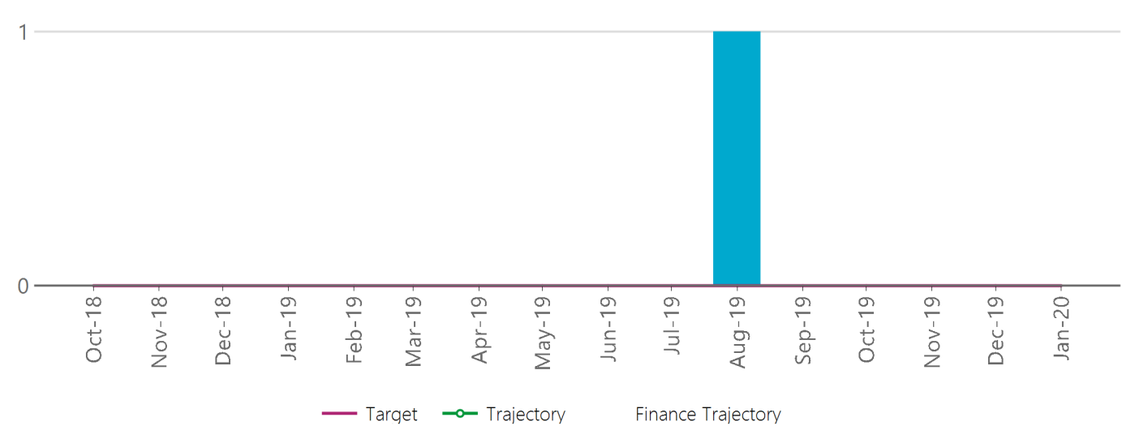
Actual performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

VTE Assessments Undertaken

% of adult admissions in the month who have been risk assessed for VTE

99.85% against **95%** target

Above target green rated

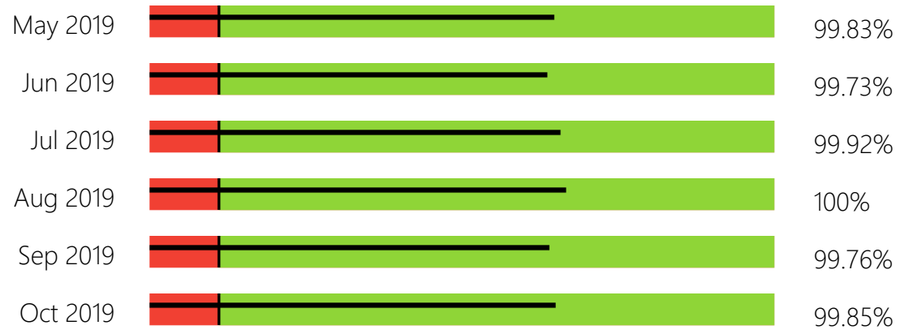
Exec Lead:
Medical Director

Integrated Performance Report

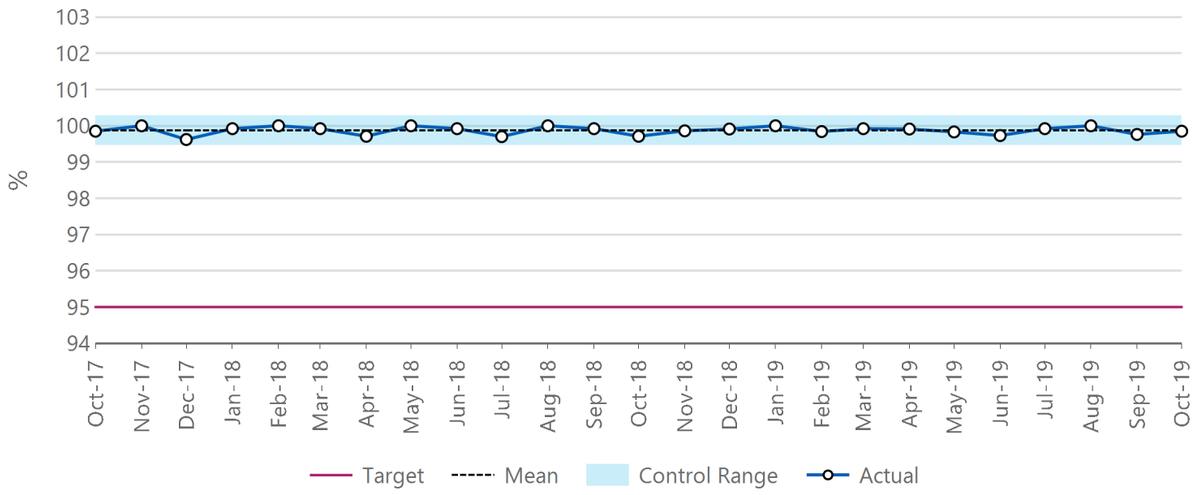
Narrative

The percentage of admissions risk assessed is reported at 99.85% in October and remains above the 95% target.

Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
99.85%	100%	99.62%	99.92%	100%	99.92%	99.71%	100%	99.92%	99.7%	100%	99.92%	99.71%	99.86%	99.91%	100%	99.84%	99.92%	99.91%	99.83%	99.73%	99.92%	100%	99.76%	99.85%	99.86%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cancer Two Week Wait*

% of urgent cancer referrals seen within 2 weeks (*Reported one month in arrears)

100% against **93%** target

green rated

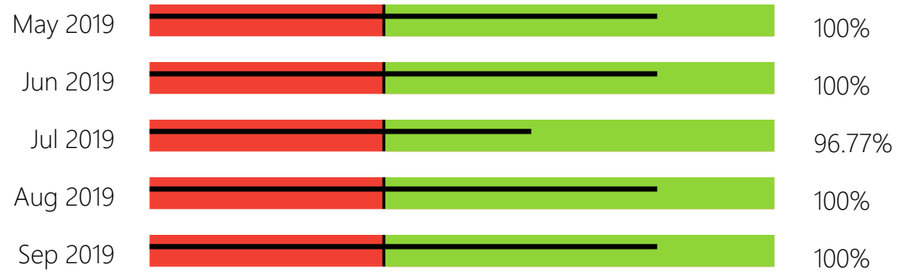
Exec Lead:
Director of Operations

Integrated Performance Report

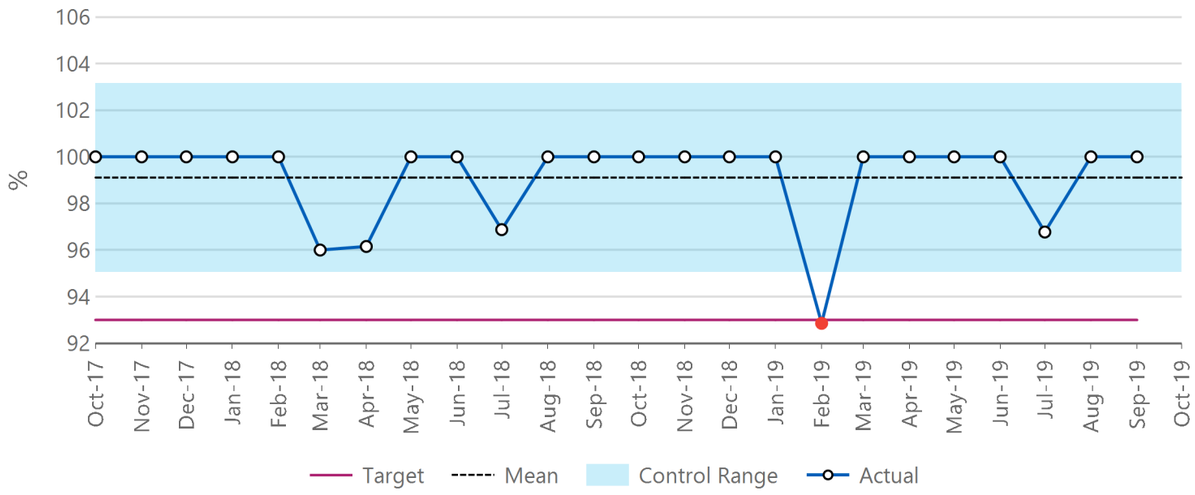
Narrative

The Cancer 2 week wait standard was achieved in September and indicative data for October shows the standard will be met.

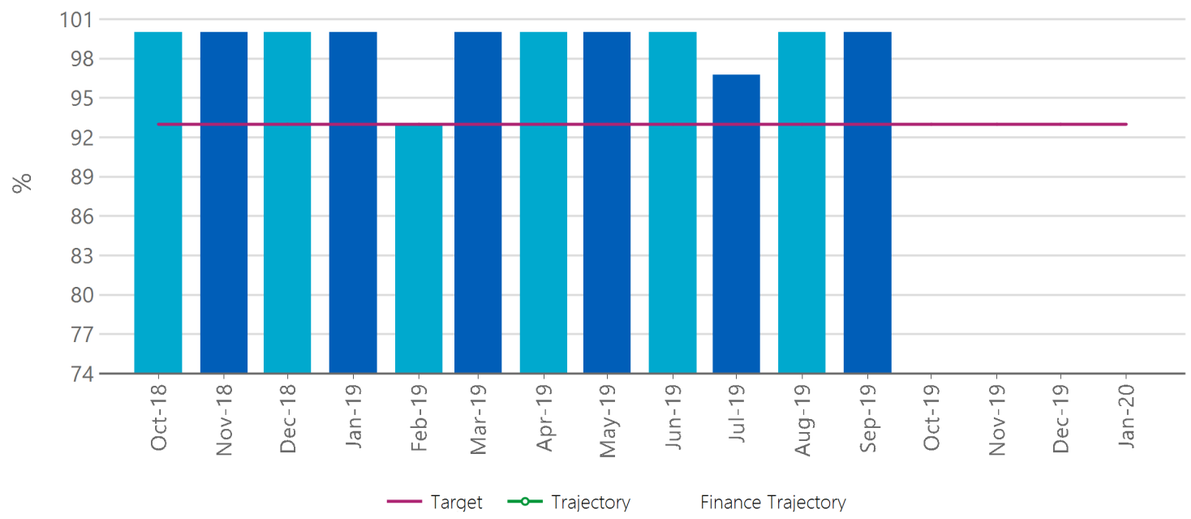
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
100%	100%	100%	100%	100%	96%	96.15%	100%	100%	96.88%	100%	100%	100%	100%	100%	100%	92.86%	100%	100%	100%	100%	96.77%	100%	100%		99.37%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

31 Days First Treatment (Tumour)*

% of cancer patients treated within 31 days of decision to treat (*Reported one month in arrears)

100% against 96% target

green rated

Exec Lead:
Director of Operations

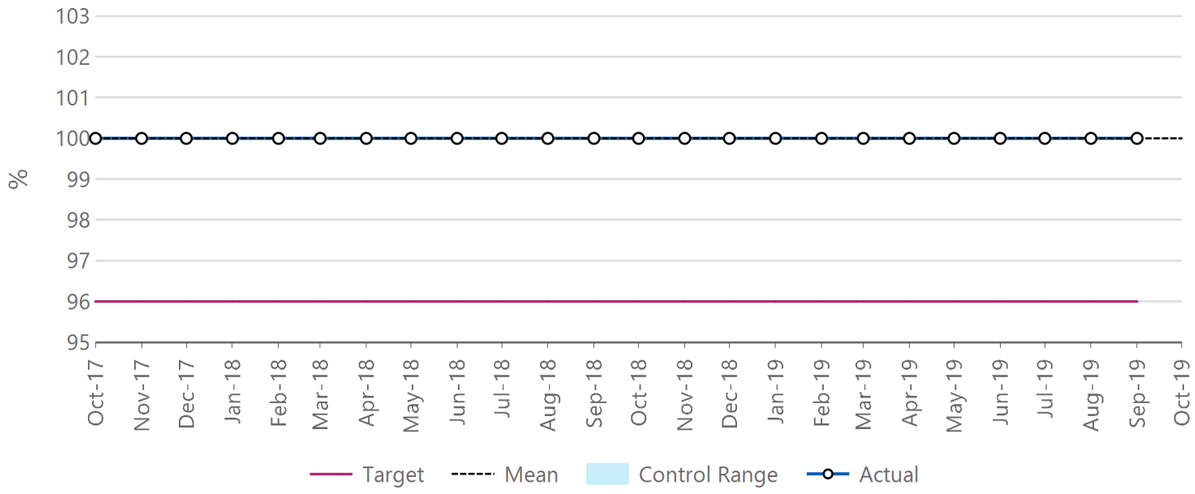
Integrated Performance Report

Narrative

The Cancer 31 day first treatment standard was achieved in September and indicative data for October shows achievement of the standard will continue.

Actual performance against RAG ratings

Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

31 Days Subsequent Treatment (Tumour)*

% of cancer patients subsequent treatment within 31 days of decision to treat (*Reported one month in arrears)

100% against 94% target

green rated

Exec Lead:
Director of Operations

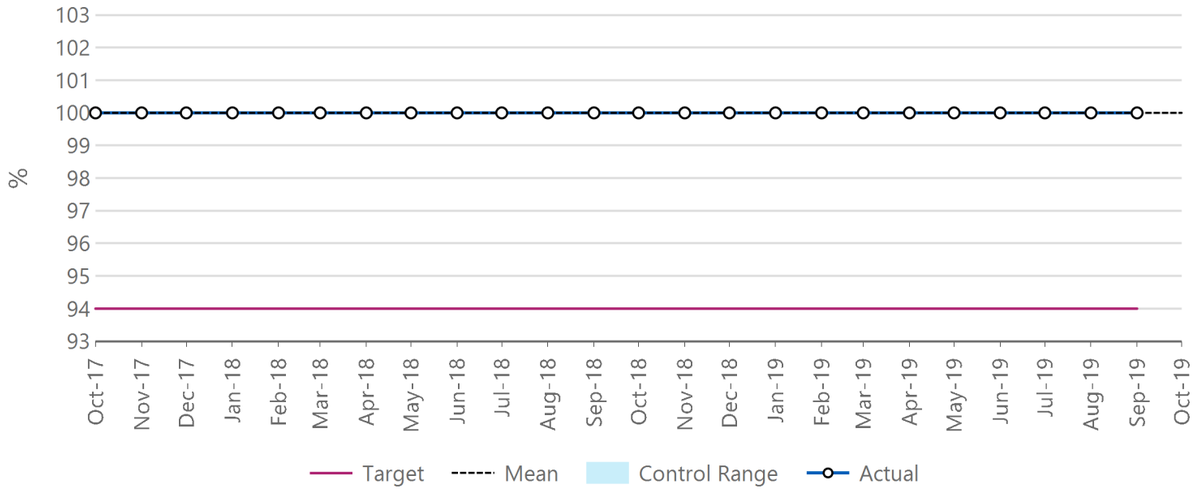
Integrated Performance Report

Narrative

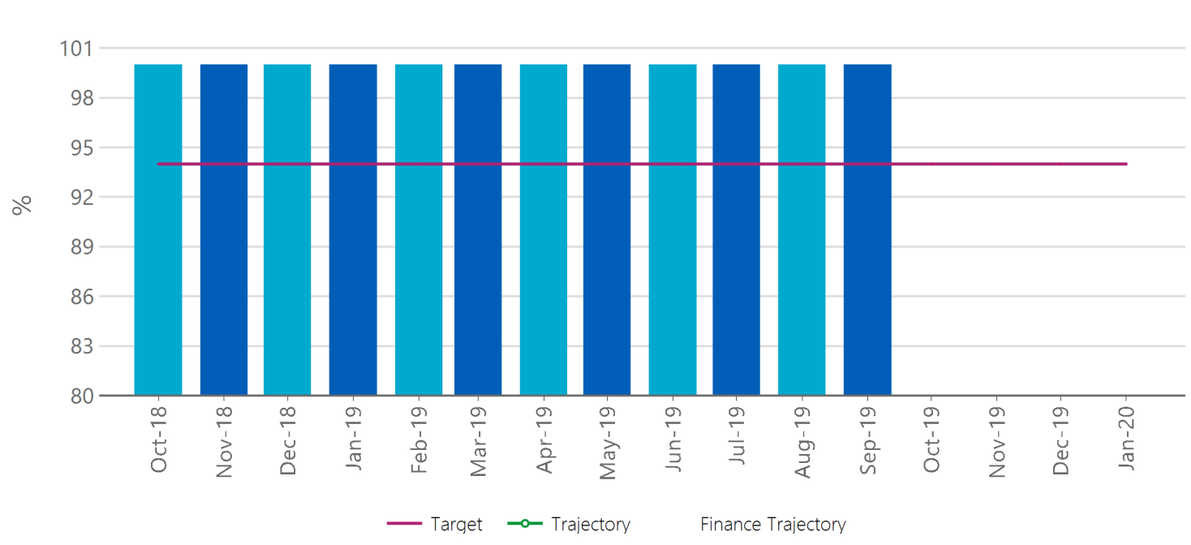
The Cancer 31 day subsequent treatment standard was achieved in September and indicative data for October shows achievement of the standard will continue.

Actual performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cancer Plan 62 Days Standard (Tumour)*

% of cancer patients treated within 62 days of referral (*Reported one month in arrears)

66.67% against 85% target

red rated

Exec Lead:
Director of Operations

Integrated Performance Report

Narrative

The Cancer 62 day standard was not achieved in September. There were six shared pathways reportable for September where four were treated within 62 days but two patients were breaches. One patient was a shared pathway was with SaTH and a second patient was shared with The Christie.

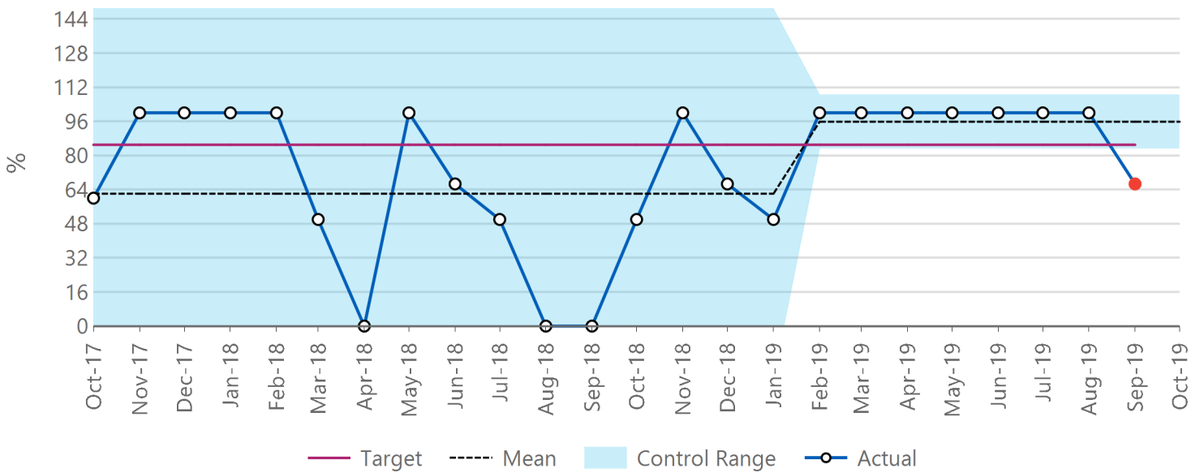
Indicative data for October shows achievement of the standard will be reported next month.

Action to Improve:The pathways of both patients who breached were complex so no particular actions are required from this, however, we believe the shared pathway with SaTH should be entirely their responsibility and are in discussions with NHS Digital to rectify this.

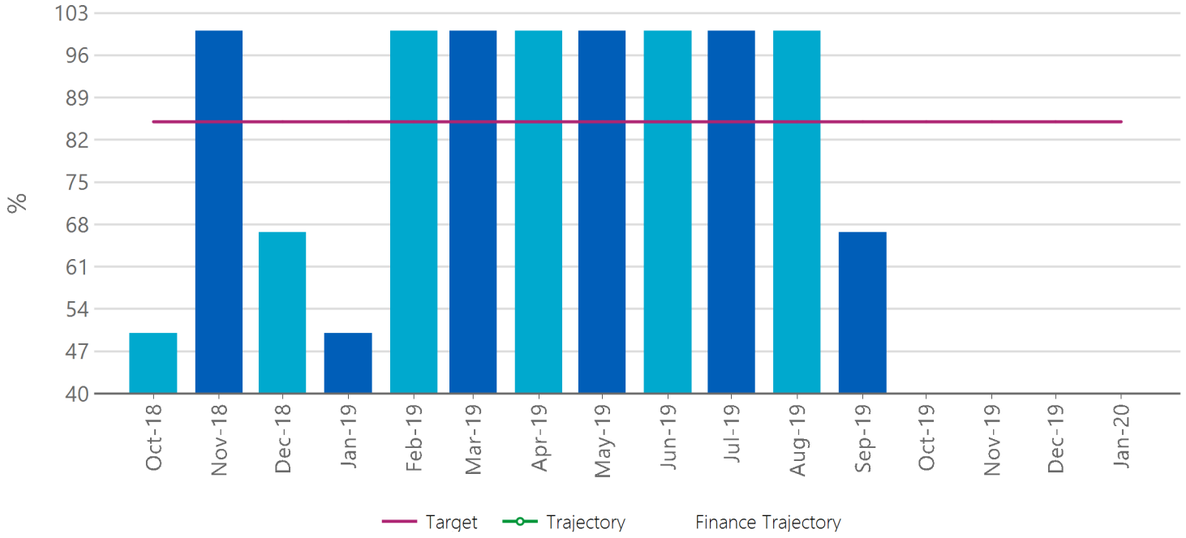
Actual performance against RAG ratings

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
60%	100%	100%	100%	100%	50%	0%	100%	66.67%	50%	0%	0%	50%	100%	66.67%	50%	100%	100%	100%	100%	100%	100%	100%	66.67%		87.5%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cancer 62 Days Consultant Upgrade*

% of cancer patients treated within 62 days of date of upgrade (*Reported one month in arrears)

100% against 85% target

green rated

Exec Lead:
Director of Operations

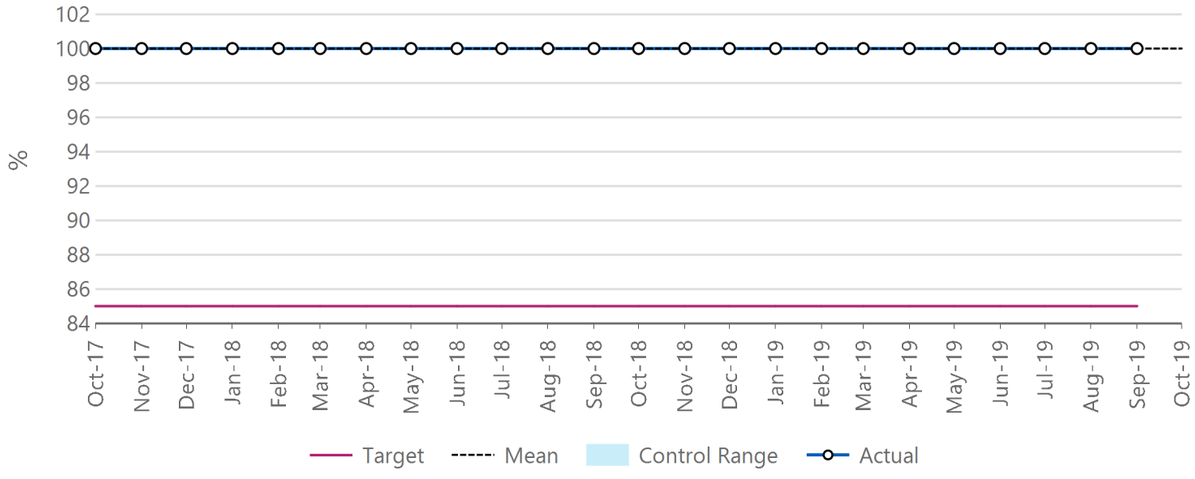
Integrated Performance Report

Narrative

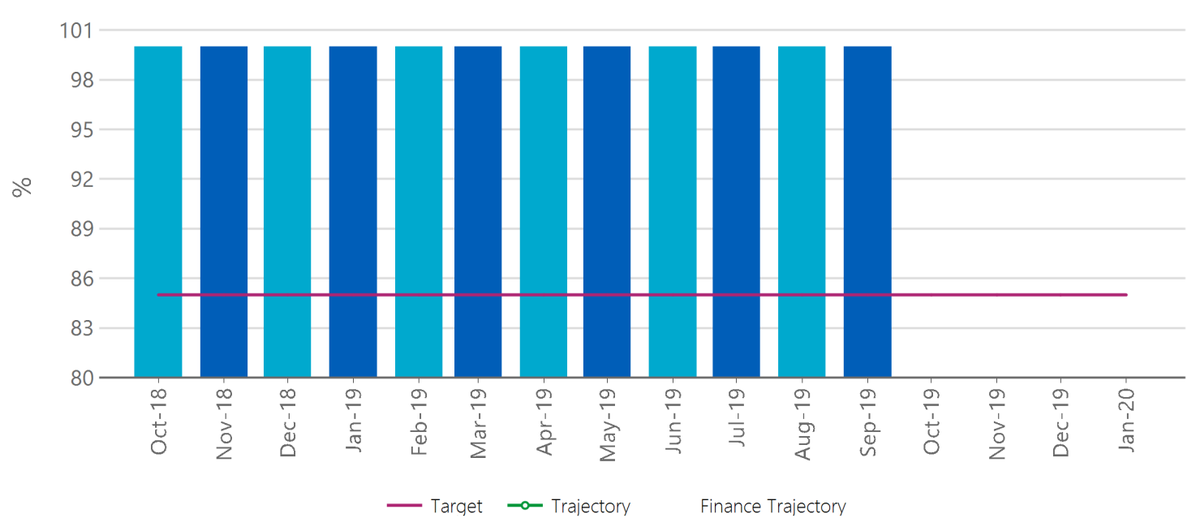
The Cancer 62 day consultant upgrade standard was achieved in September and indicative data for October shows achievement of the standard will continue.

Actual performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

18 Weeks RTT Open Pathways

% of English patients on waiting list waiting 18 weeks or less

88.01% against 92% target

Below target red rated

Exec Lead:
Director of Operations

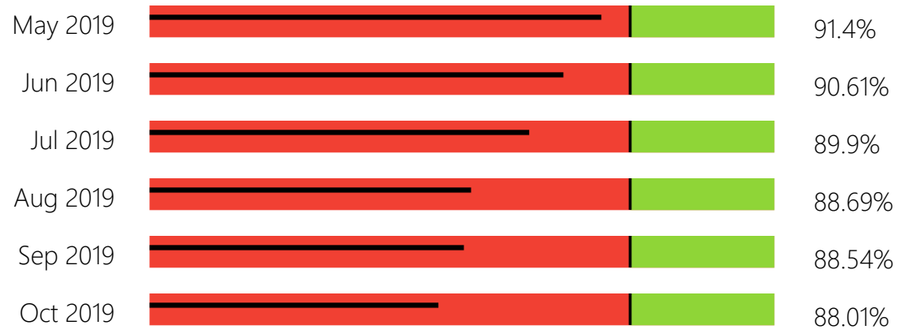
Integrated Performance Report

Narrative

Our October performance was 88.01% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The total number of breaches has increased from 849 at the end of September to 886 at the end of October. October's position is the lowest position reported since December 2016 which was 87.68%. The performance breakdown by milestone is as follows: MS1 - 4603 patients waiting of which 73 are breaches, MS2 - 874 patients are waiting of which 240 are breaches, MS3 - 1910 patients are waiting of which 573 are breaches.

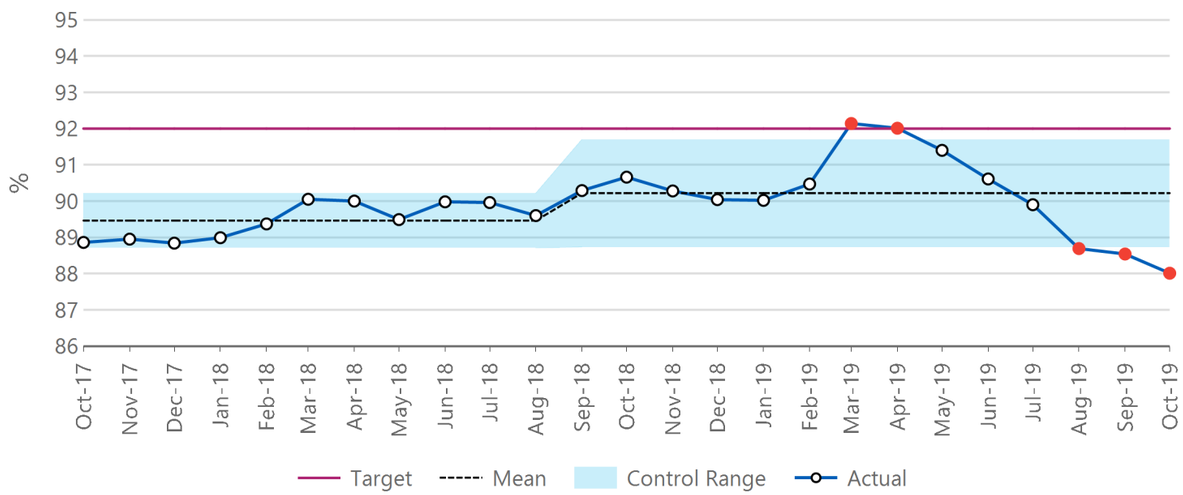
The reported position was behind our trajectory plan of 91.16%. The FPD agreed RTT trajectory looked to achieve 89.02% in Oct, the list size was 53 patients less than anticipated with 85 more breaches than expected, 37 in milestone 2 and the remainder in milestone 3. Further work is in place to ensure greater focus is placed upon ensuring patients that have been waiting longer are seen more timely.

Actual performance against RAG ratings

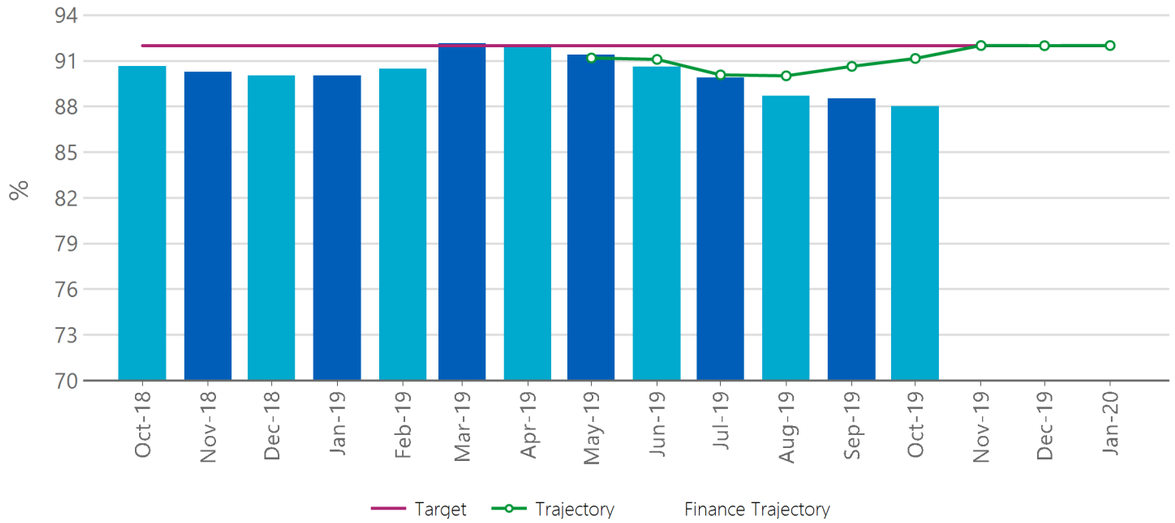


Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
88.86%	88.95%	88.84%	88.99%	89.37%	90.05%	90%	89.49%	89.98%	89.96%	89.6%	90.29%	90.66%	90.28%	90.04%	90.02%	90.47%	92.14%	92.01%	91.4%	90.61%	89.9%	88.69%	88.54%	88.01%	90.17%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patients Waiting Over 52 Weeks – English

Number of English RTT patients currently waiting 52 weeks or more

0 against 0 target

On target green rated

Exec Lead:
Director of Operations

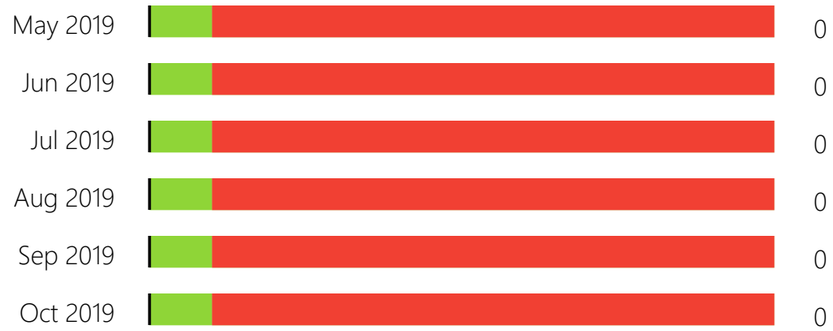
Integrated Performance Report

Narrative

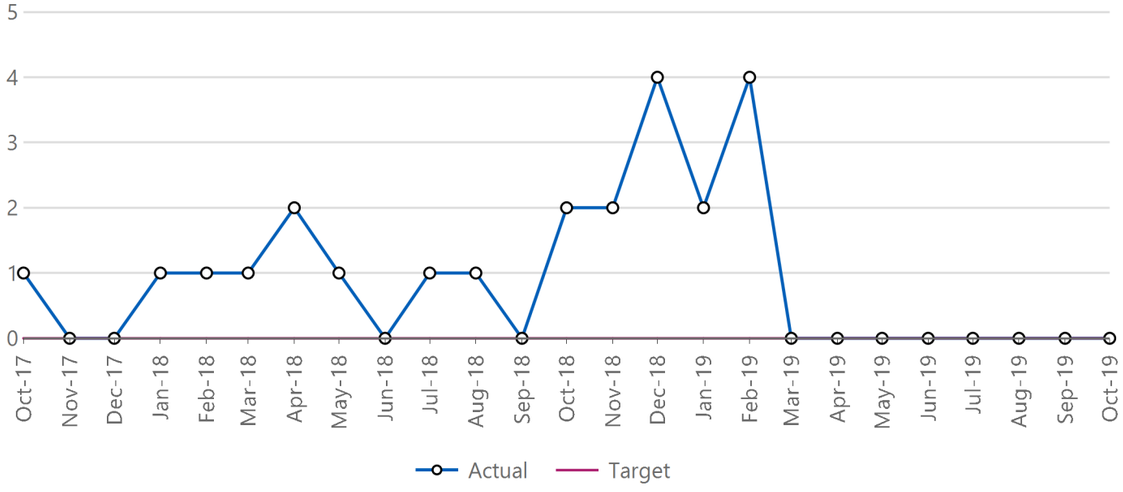
At the end of October there were no English patients waiting over 52 weeks.

The forecast figures show predicted 52+ weeks waits as follows:
- End of November - 1 (Arthroplasty)
- End of December - 1 (Foot & Ankle)
- End of January - 4 (Spinal Disorders)

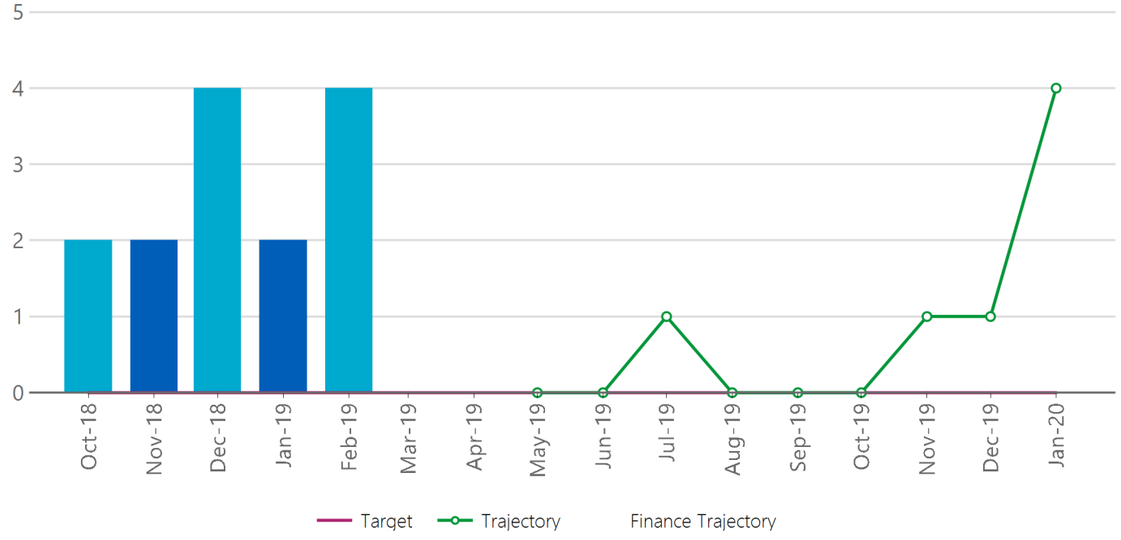
Actual performance against RAG ratings



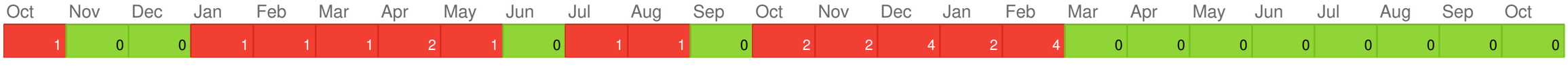
Performance over 24 months –



Trajectory



Heatmap performance over 24 months



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patients Waiting Over 52 Weeks – Welsh

Number of RJAH Welsh RTT patients currently waiting 52 weeks or more

0 against 0 target

On target green rated

Exec Lead:
Director of Operations

Integrated Performance Report

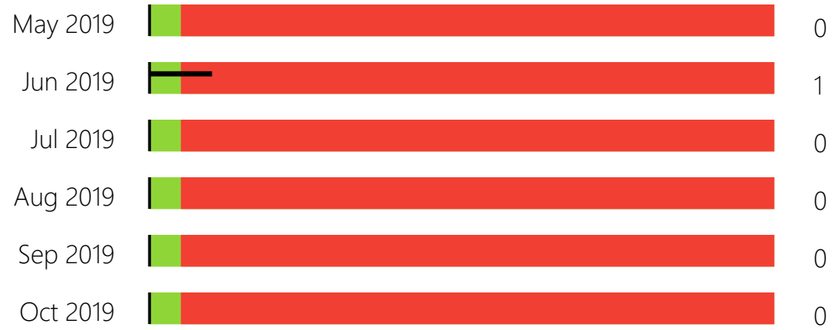
Narrative

At the end of October there were no Welsh patients waiting over 52 weeks.

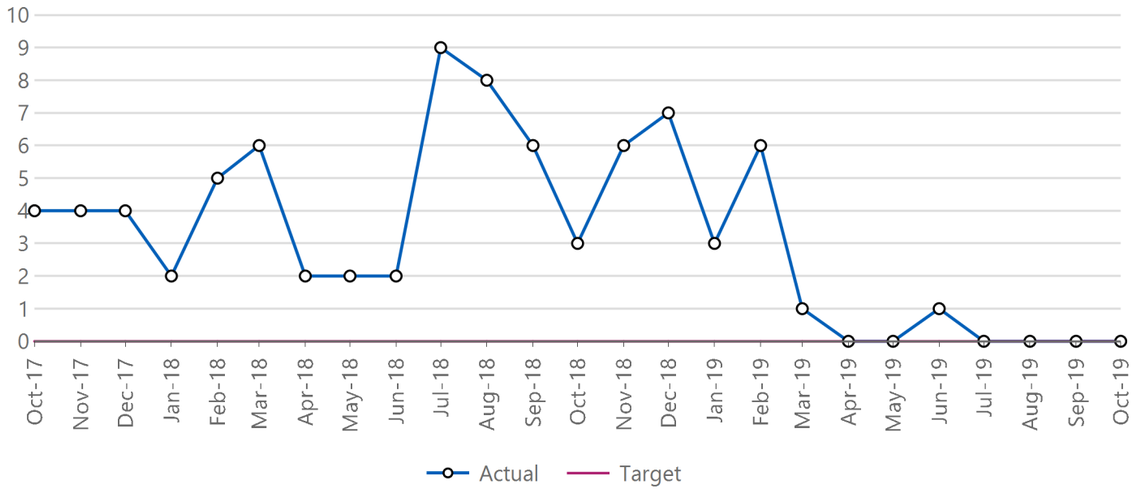
The forecast figures show predicted 52+ weeks waits as follows:
- End of November - 1 - All Spinal Disorders
- End of December - 2 - Both Spinal Disorders
- End of January - 6 - Spinal Disorders (4) and Arthroplasty (2)

The forecast patients are all BCU.

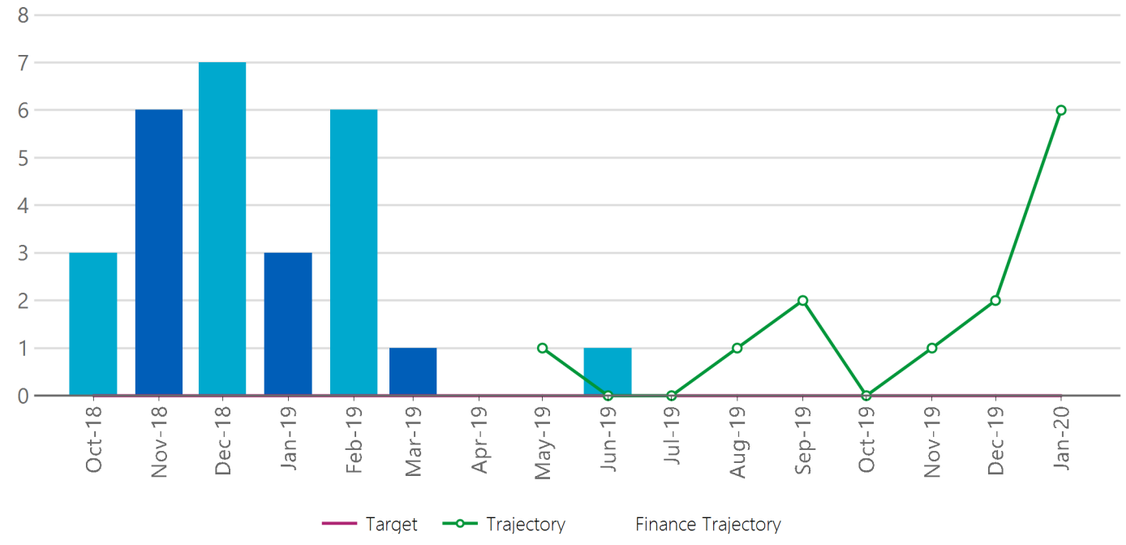
Actual performance against RAG ratings



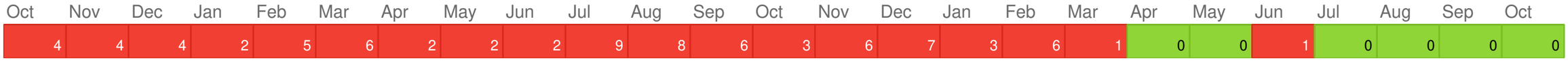
Performance over 24 months –



Trajectory



Heatmap performance over 24 months



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)

172 against N/A target

Exec Lead:
Director of Operations

Integrated Performance Report

Number of BCU transfer Welsh RTT patients currently waiting 52 weeks or more.

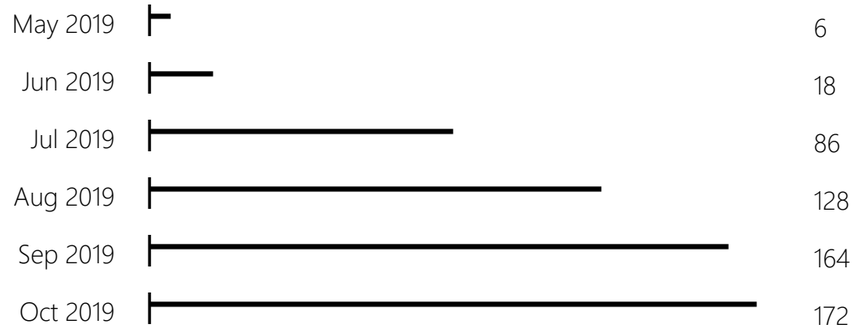
Narrative

At the end of October there were 172 Welsh patients waiting over 52 weeks who were transfers of care from BCU. Within the month of October 159 transfers were received.

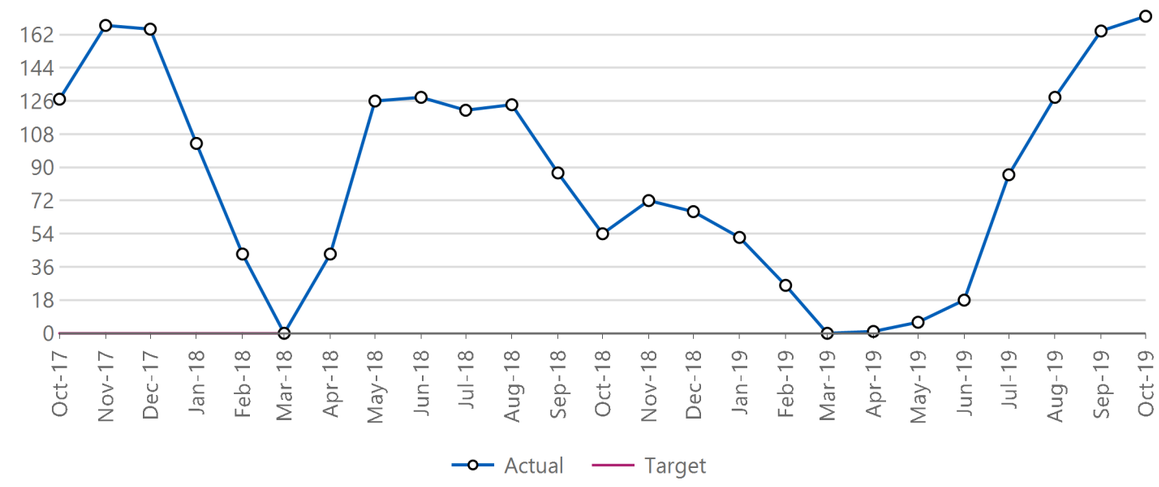
The forecast figures show predicted 52+ weeks waits as follows:
- End of November - 165
- End of December - 140
- End of January - 159

This forecast is based on the transfers received to date. The target for this measure is to treat all patients transferred by year-end.

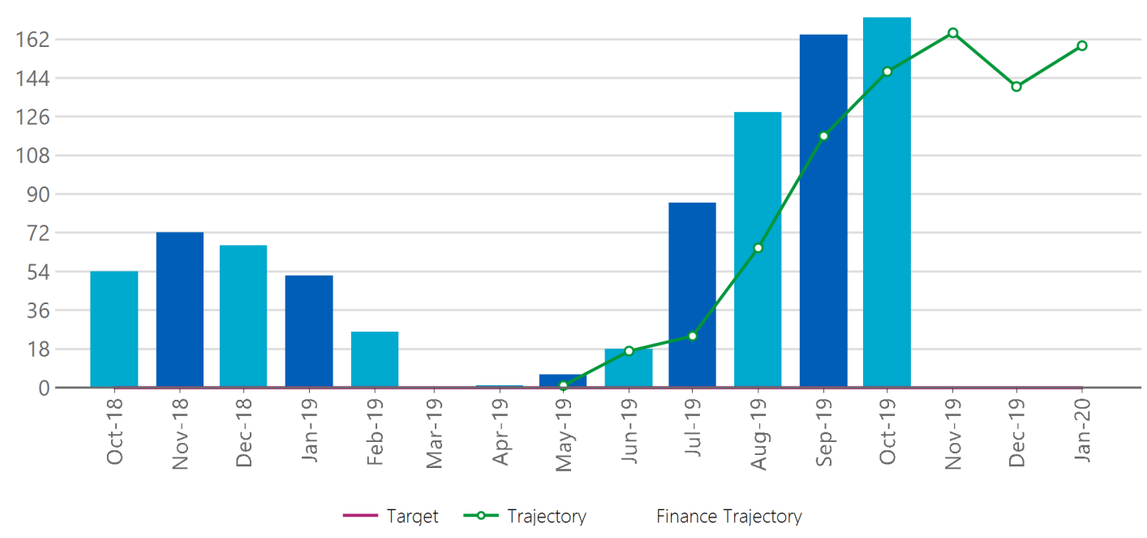
Actual performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
127	167	165	103	43	0	43	126	128	121	124	87	54	72	66	52	26	0	1	6	18	86	128	164	172

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

6 Week Wait for Diagnostics - English Patients

% of English patients currently waiting less than 6 weeks for diagnostics

99.87% against **99%** target

Above target green rated

Exec Lead:
Director of Operations

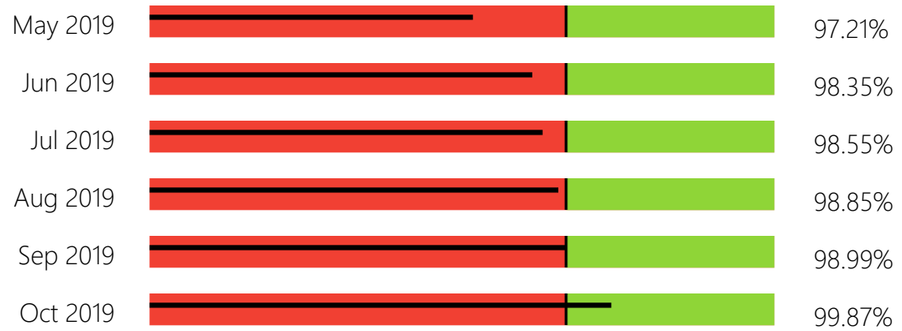
Integrated Performance Report

Narrative

The 6 week standard for diagnostics was achieved this month and is reported at 99.87%. This equates to three patients who waited beyond six weeks. This month's data point falls above our control range.

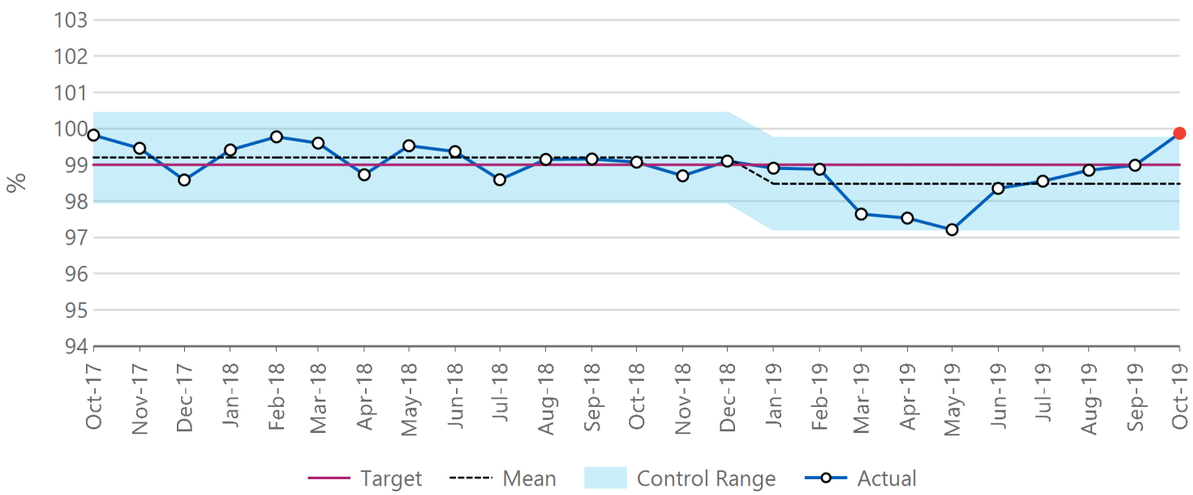
Action to Improve:Increased workload has been undertaken to achieve the 99% target this month. This has included additional telephone calls to patients and increased capacity now available in MRI due to extra 'out of job plan' slots. Going forward SOOS have also agreed to send more patients towards SaTH and to reduce their requests to one body part per scan. Additional permanent capacity should be available from January 2020.

Actual performance against RAG ratings

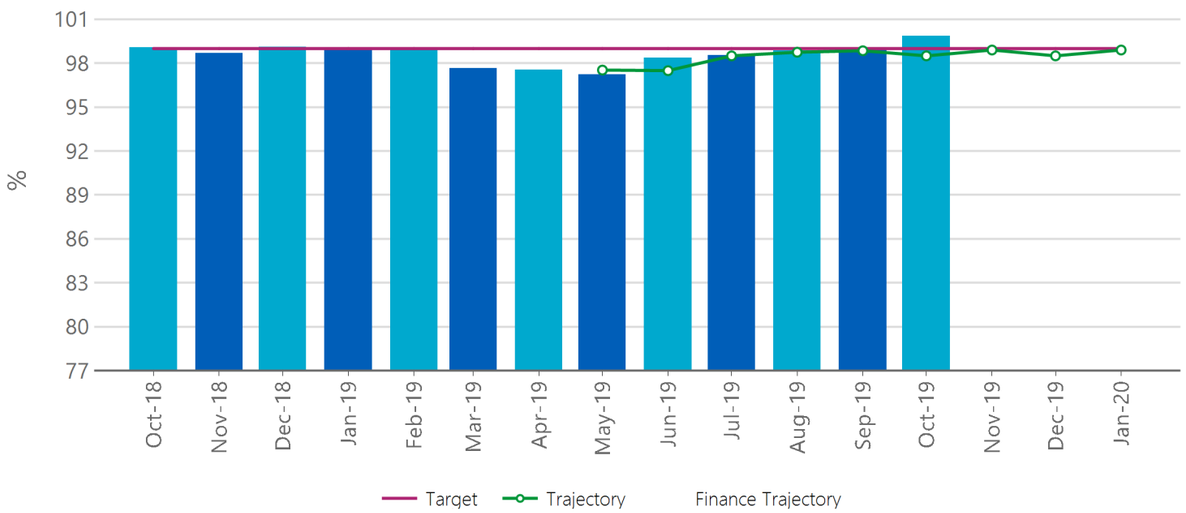


Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
99.82%	99.46%	98.58%	99.41%	99.77%	99.6%	98.73%	99.53%	99.37%	98.59%	99.15%	99.16%	99.07%	98.7%	99.1%	98.91%	98.88%	97.64%	97.53%	97.21%	98.35%	98.55%	98.85%	98.99%	99.87%	98.46%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

8 Week Wait for Diagnostics - Welsh Patients

% of Welsh patients currently waiting less than 8 weeks for diagnostics

100% against 100% target

On target green rated

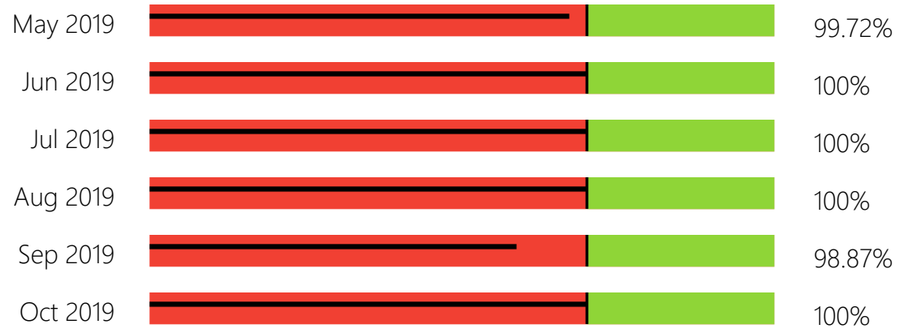
Exec Lead:
Director of Operations

Integrated Performance Report

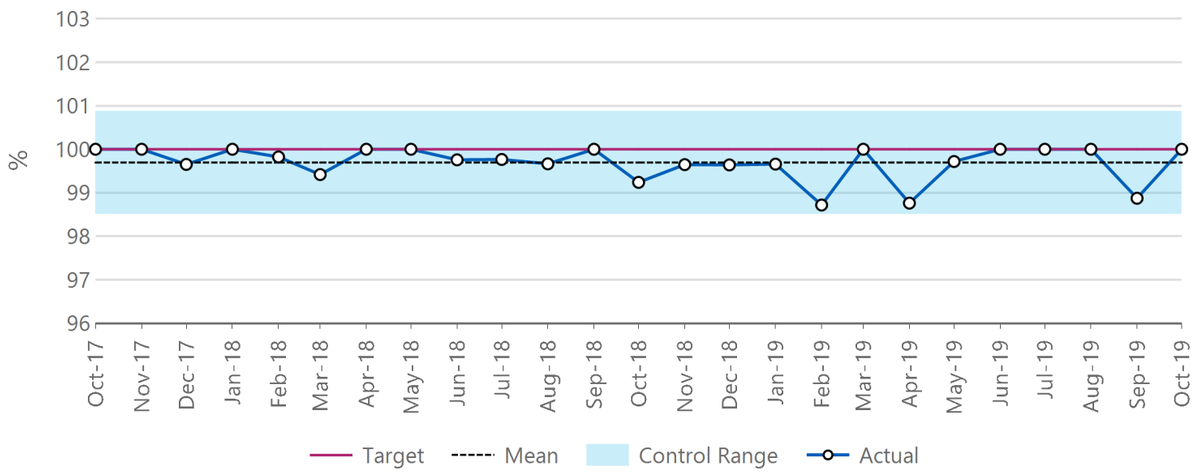
Narrative

The 8 week standard for diagnostics was achieved this month and is reported at 100%.

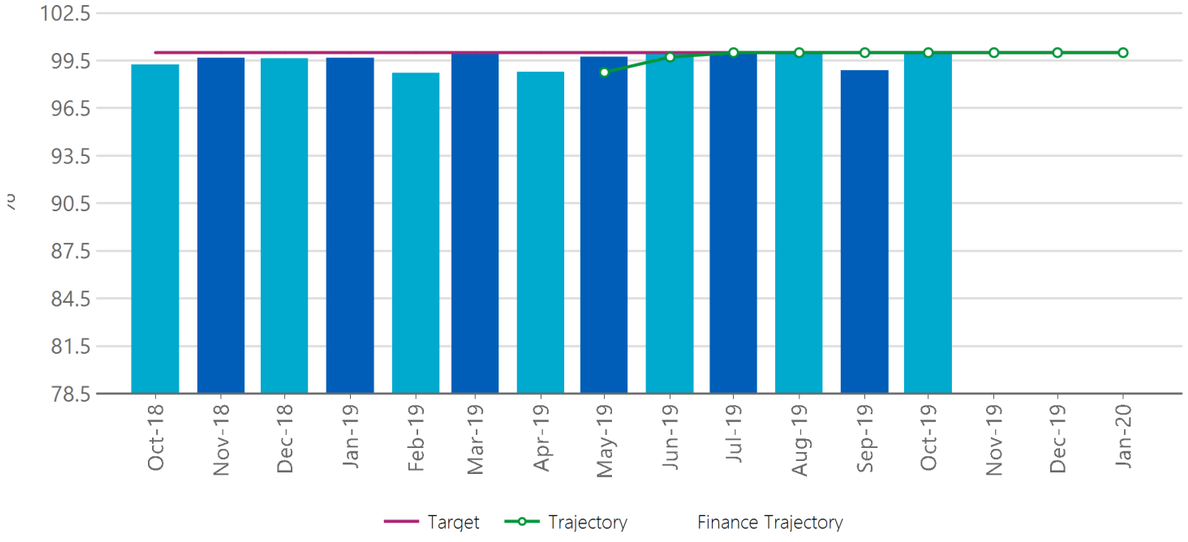
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
100%	100%	99.65%	100%	99.82%	99.42%	100%	100%	99.76%	99.77%	99.67%	100%	99.24%	99.65%	99.64%	99.66%	98.72%	100%	98.76%	99.72%	100%	100%	100%	98.87%	100%	99.63%

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Theatre Activity

Activity in theatres in month

1,079 against **1,171** target

Below target red rated

Exec Lead:
Director of Operations

Integrated Performance Report

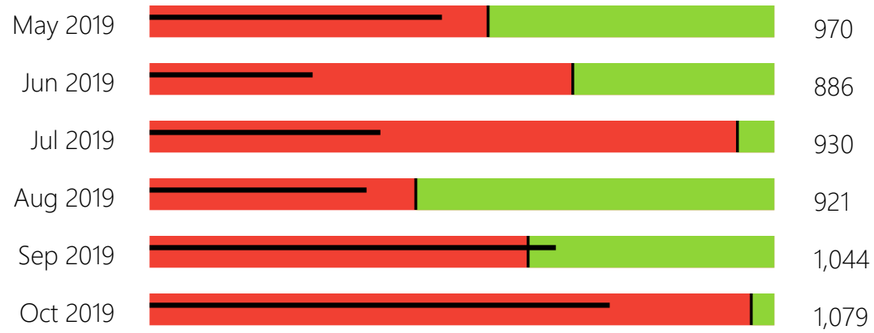
Narrative

Total Theatre Activity was behind plan in October. A breakdown of this is:
- T&O including Tumour & Hand Trauma - 961 cases. This was 82 cases behind the original plan and 92 cases behind the revised plan. This is broken down by:
  - T&O Only - 898 cases (-92 from revised plan)
  - Tumour - 32 cases (-8 from revised plan)
  - Hand Trauma -31 cases (+8 from revised plan)
- MCSI - 47 cases (+2 from plan)
- Private Patients - 12 cases (-12 from revised plan)

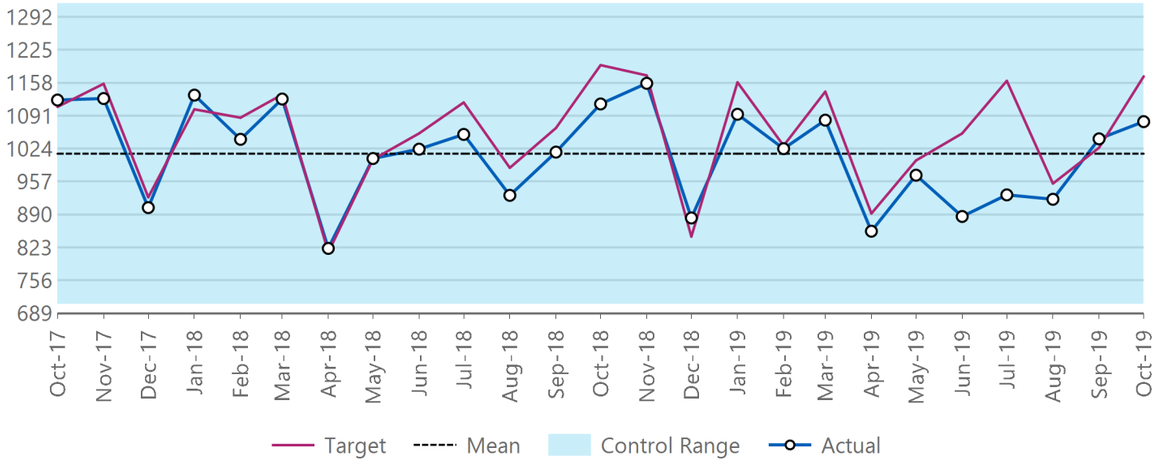
A shortfall of 47 sessions in the month gave a variance to plan of 92 cases, 66 sessions were affected by anaesthetist sickness/compassionate leave with a further 4 sessions with cancellations on the day driven from special variation issues. 12 sessions recovered through locum cover and a further 11 sessions recovered through goodwill of staff cancelling prearranged training/meetings/leave.

The trajectory reflects the revised plans agreed in October-19.

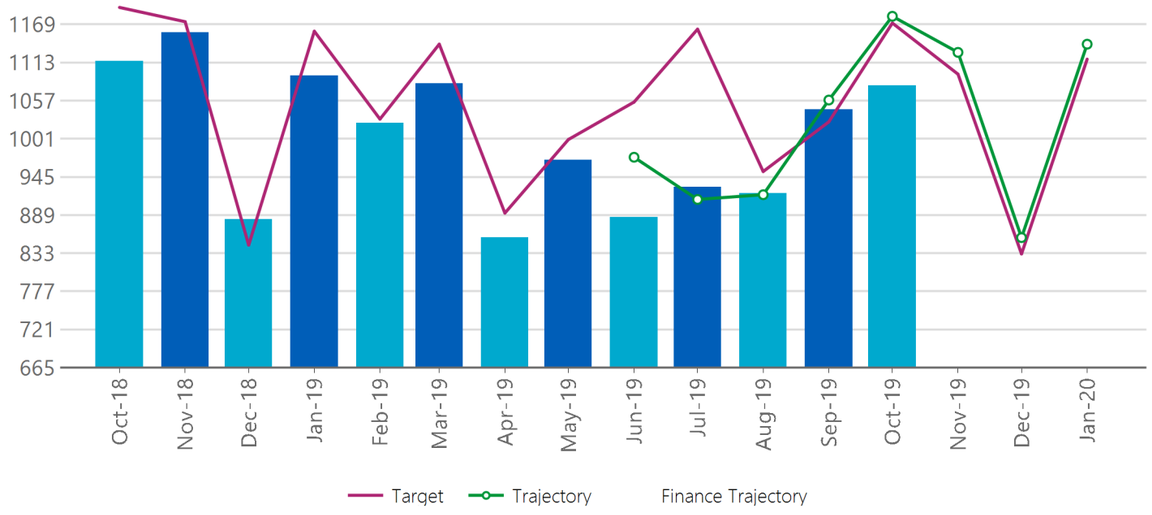
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
1,123	1,126	904	1,133	1,043	1,125	821	1,004	1,023	1,053	929	1,017	1,115	1,157	883	1,094	1,024	1,082	856	970	886	930	921	1,044	1,079	6,685

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

85.06% against **87%** target

Within target green rated

Exec Lead:
Director of Operations

Integrated Performance Report

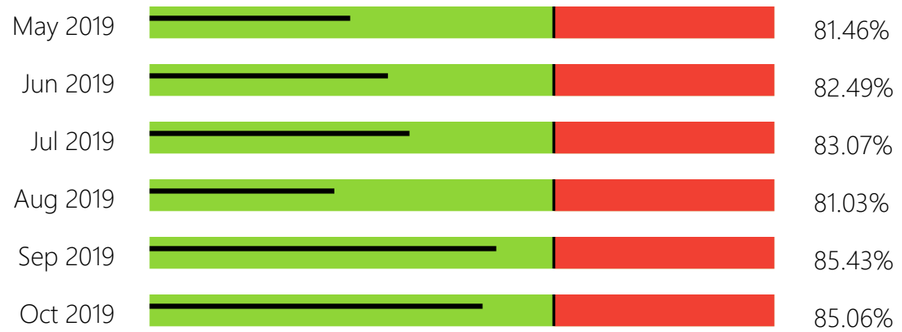
Narrative

The occupancy rate for all wards is green rated this month at 85.06%. Occupancy across the Surgical Wards was:
- Alice 45.9%
- Clwyd 89.77%
- Kenyon 84.10%
- Ludlow 92.32%
- Oswald 94.12%
- Powys 89.59%

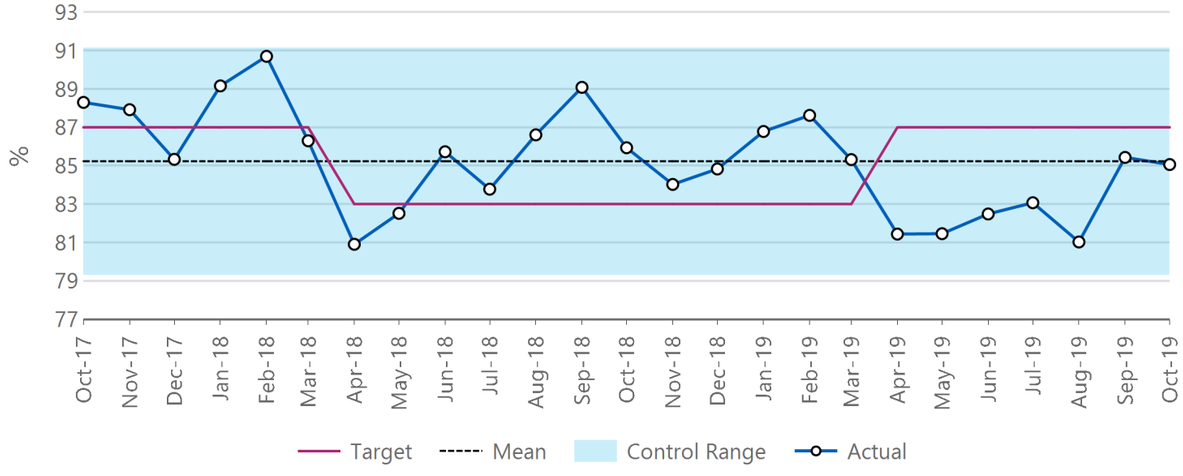
Occupancy within the Medicine Division was:
-Gladstone 85.84%
- Wrekin 92.24%
- Sheldon 81.50%

Following the recent data quality audit carried out on this KPI, several recommendations were identified and agreed. Work is ongoing to improve the accuracy of this data capture, which may have contributed to the sustained position reported this month.

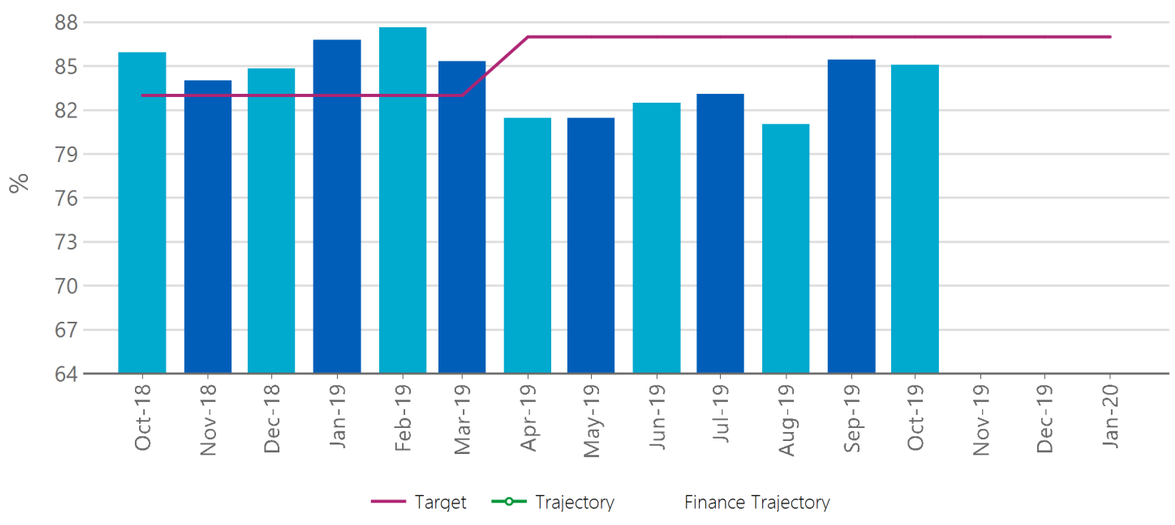
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
88.3%	87.92%	85.33%	89.16%	90.7%	86.3%	80.91%	82.52%	85.73%	83.78%	86.61%	89.08%	85.94%	84.03%	84.83%	86.78%	87.62%	85.32%	81.44%	81.46%	82.49%	83.07%	81.03%	85.43%	85.06%	82.85%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Outpatients Activity Attendances

Number of attendances seen in Outpatients clinic – excludes SOOS, MCSI and NCG as they are block contracts

14,965 against **15,319** target

Below target red rated

Exec Lead:
Director of Operations

Integrated Performance Report

Narrative

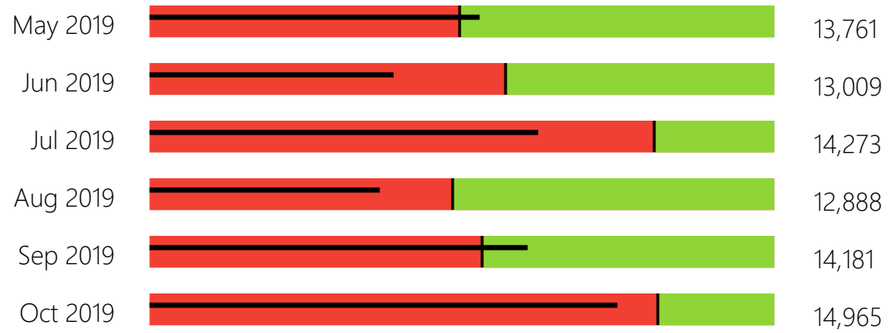
The number of attendances was 354 behind plan in month 7 with 14965 attendances seen against a plan of 15319. A divisional breakdown is:
- Surgery - 7781 against a plan of 7926 (-145) - YTD position +573
- Medicine - 5828 against a plan of 5986 (-158) - YTD position -973

In Surgery division, area behind plan to note were:
- Lower Limb (-255) - YTD position -208
- Upper Limb (-101) - YTD position -782

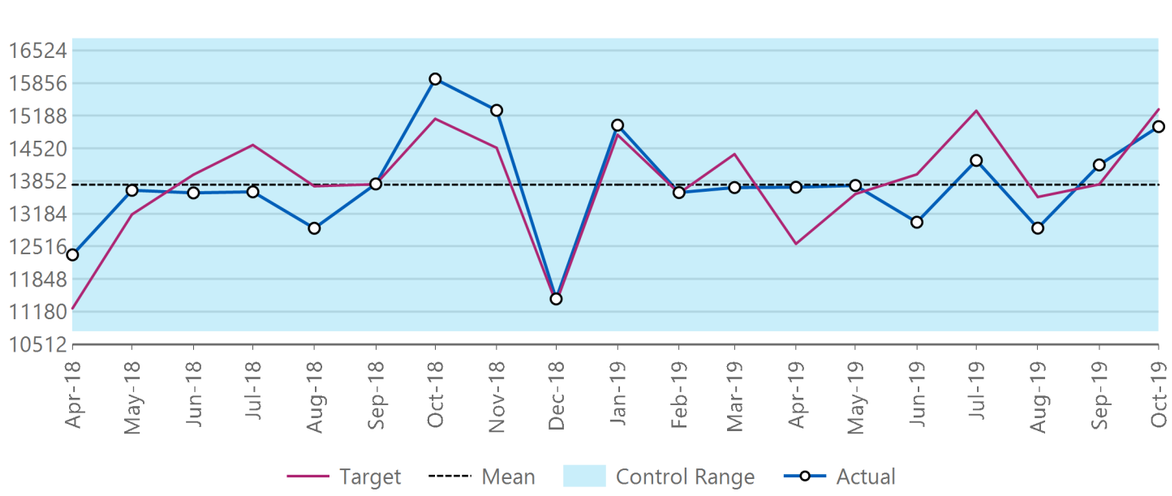
In Medicine division, areas behind plan to note were:
- Metabolic Medicine (-119) - YTD position -975
- Physiotherapy Clinics (-237) - YTD position -817

Action to Improve:Medicine division actions are increasing OJP activity and bringing forward follow up protocols for Metabolic Medicine, however it is noted that the Medicine plan is set at an increase of 2.78% on 18/19 delivered activity, yet activity delivered in 18/19 included over establishment in Metabolic Medicine and Physiotherapy therefore it is not expected for this current plan to be achieved in these areas

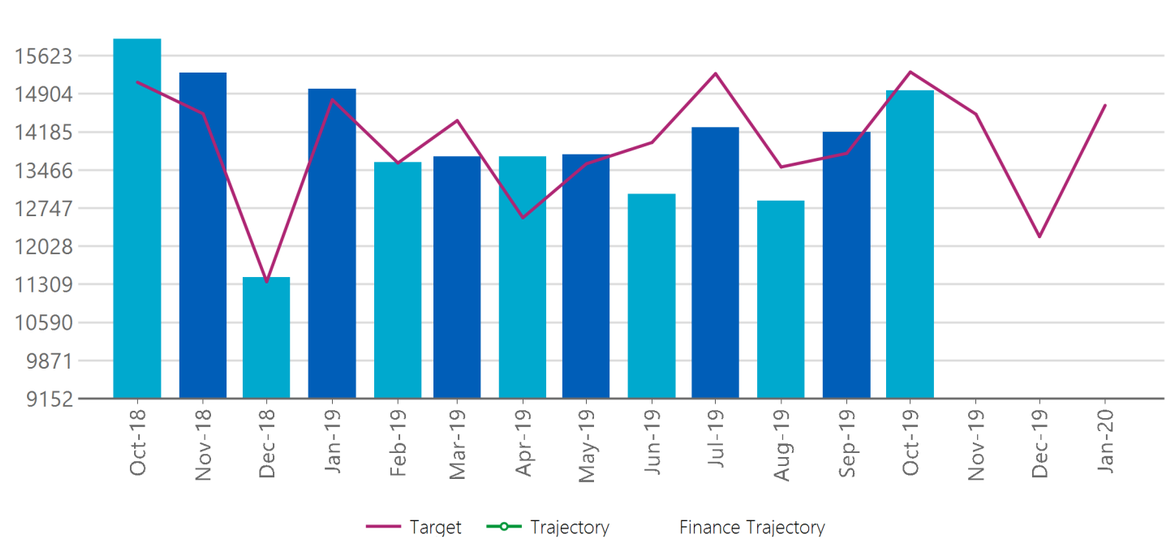
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
12,342	13,662	13,609	13,631	12,885	13,792	15,939	15,298	11,440	14,995	13,616	13,718	13,724	13,761	13,009	14,273	12,888	14,181	14,965	96,801

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Financial Control Total

Surplus/deficit adjusted for donations and excluding STF funding

611 against **808** target

Below target red rated

Exec Lead:
Director of Finance

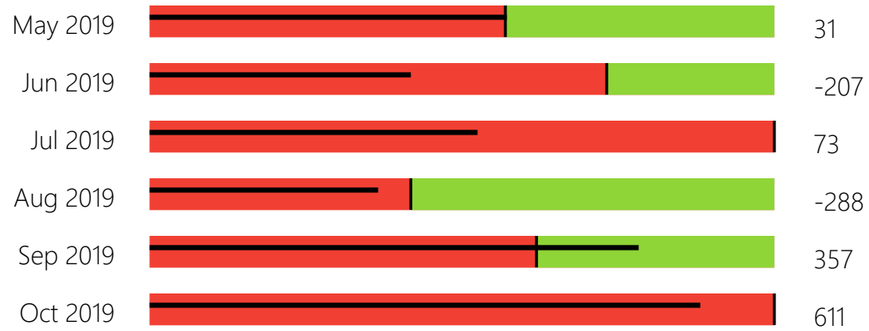
Integrated Performance Report

Narrative

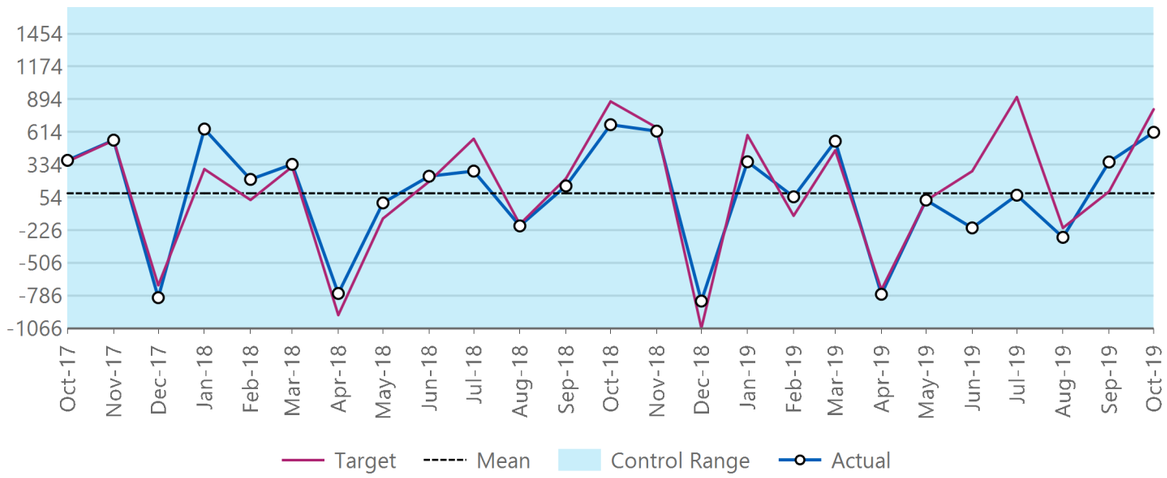
- £611k surplus in month, £197k adverse to plan
- YTD £1,384k adverse to plan

Action to Improve:Theatre recovery plan in place.
Further financial mitigations required to deliver control total - discussed in full at FPD.

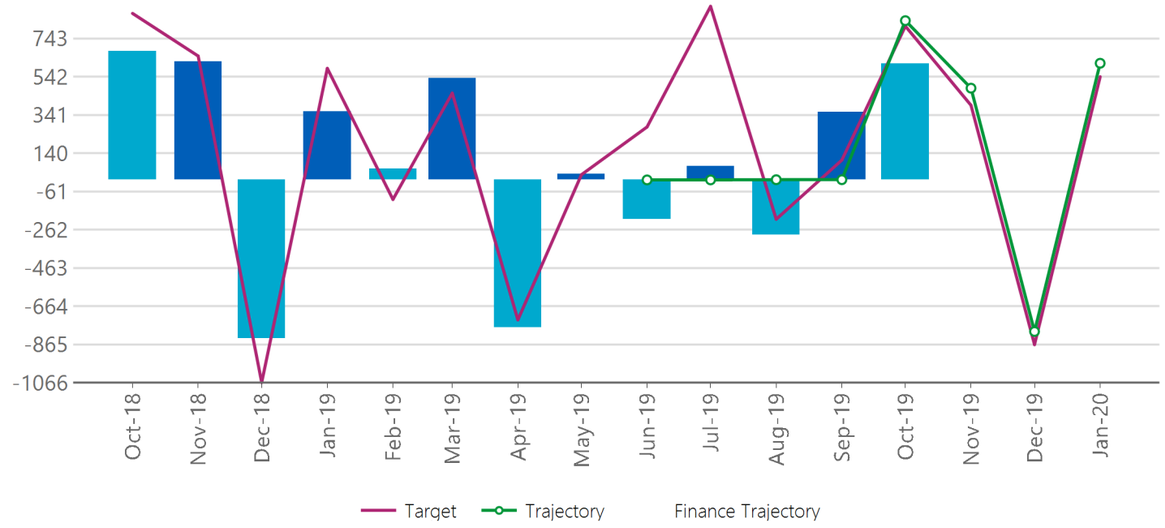
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
371	544	-804	639	208	337	-768	7	235	279	-190	152	676	621	-833	359	59	535	-775	31	-207	73	-288	357	611	-198

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Income

All Trust Income, Clinical and non clinical

10,256 against **10,443** target

Below target red rated

Exec Lead:
Director of Finance

Integrated Performance Report

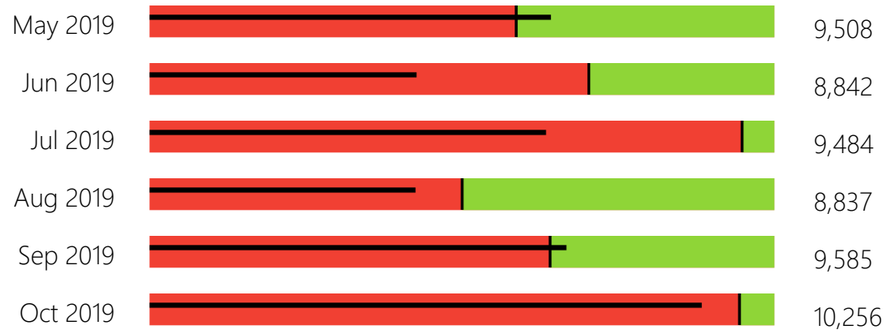
Narrative

Overall £188k adverse in month:

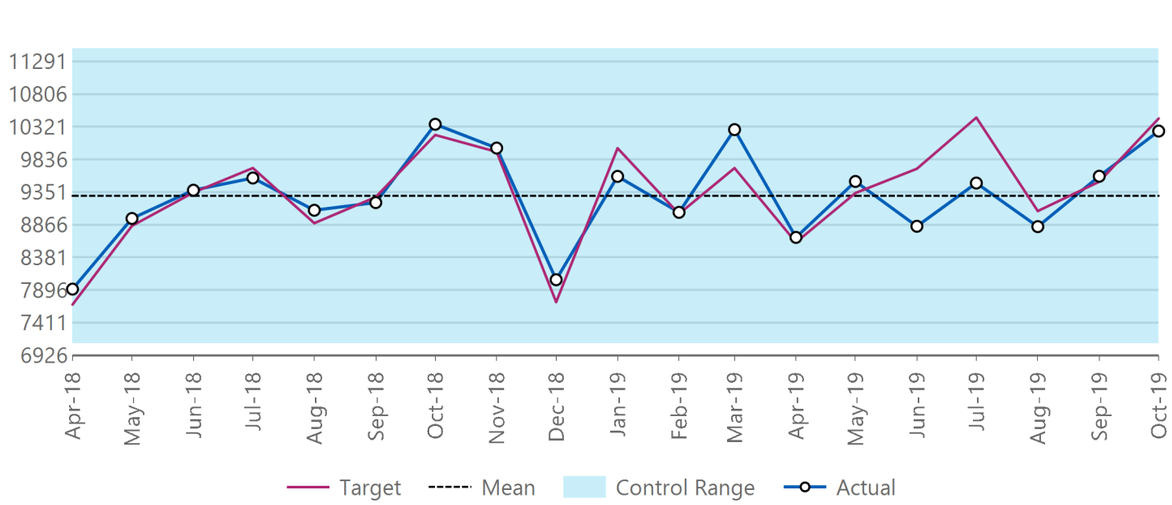
- Theatre activity adverse to recovery plan 92 cases
- MCSI activity adverse to plan
- QIPP performance improved in month
- Private patients favourable to plan

Action to Improve:Theatre recovery plan - assess and mitigate risk to future months and scope opportunities to deliver above plan to recover YTD shortfall.

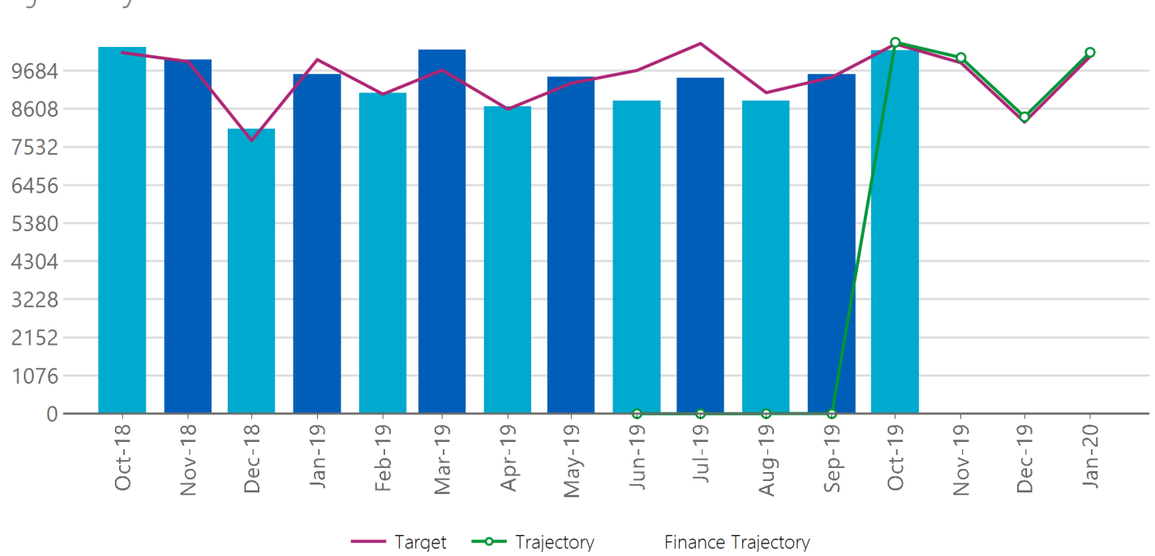
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
7,909	8,958	9,378	9,559	9,080	9,194	10,357	10,004	8,048	9,583	9,049	10,278	8,677	9,508	8,842	9,484	8,837	9,585	10,256	65,189

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Expenditure

All Trust expenditure including Finance Costs

9,688 against **9,679** target

Breaching target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

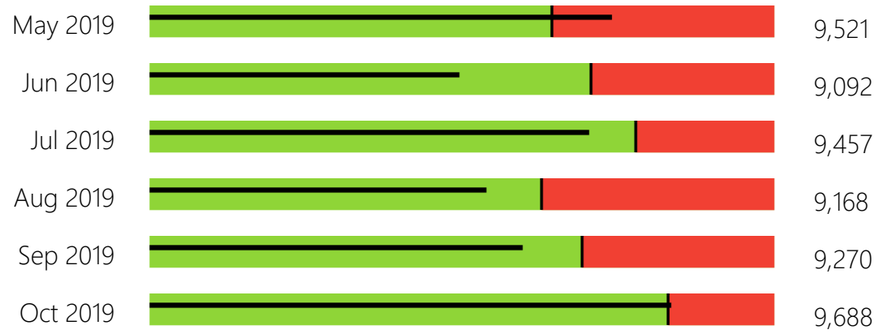
Narrative

- Overall £9k adverse in month:

Pay £3k favourable:
- Increased Nursing agency usage
- Anaesthetic OJP favourable (shows under LLP on non pay)

Non pay £12k adverse:
- LLP OJP adverse (now includes 4 anaesthetists offsetting pay above)
- Facilities adverse due to clinical waste & postage
- Finance costs favourable

Actual performance against RAG ratings



Performance over 24 months – SPC

Trajectory

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
8,684	8,959	9,129	9,165	9,264	9,038	9,734	9,416	8,648	9,189	9,031	9,464	9,495	9,521	9,092	9,457	9,168	9,270	9,688	65,692

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

CIP Delivery

Cost Improvement Programme requirement

287 against **270** target

Above target green rated

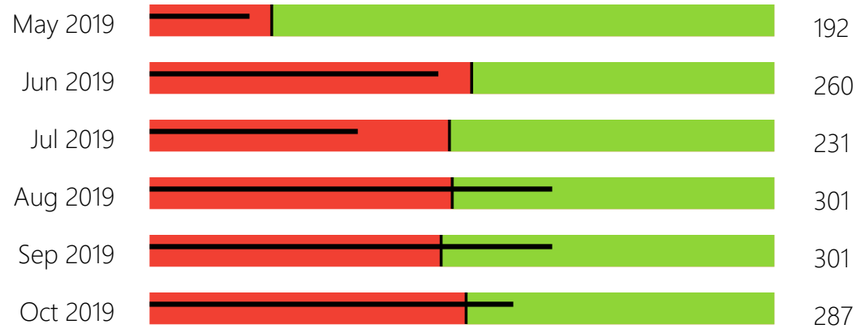
Exec Lead:
Director of Finance

Integrated Performance Report

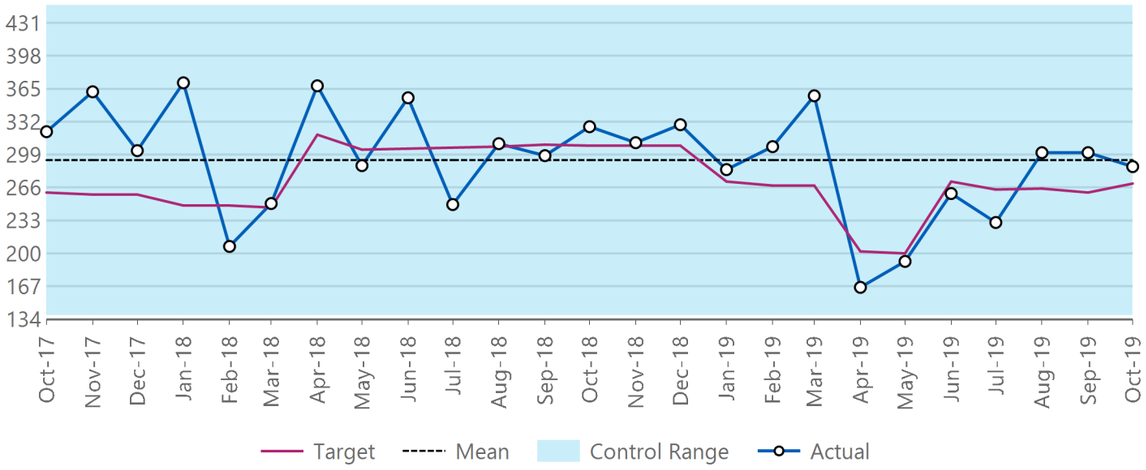
Narrative

£17k favourable against plan in month
£4k favourable against plan YTD

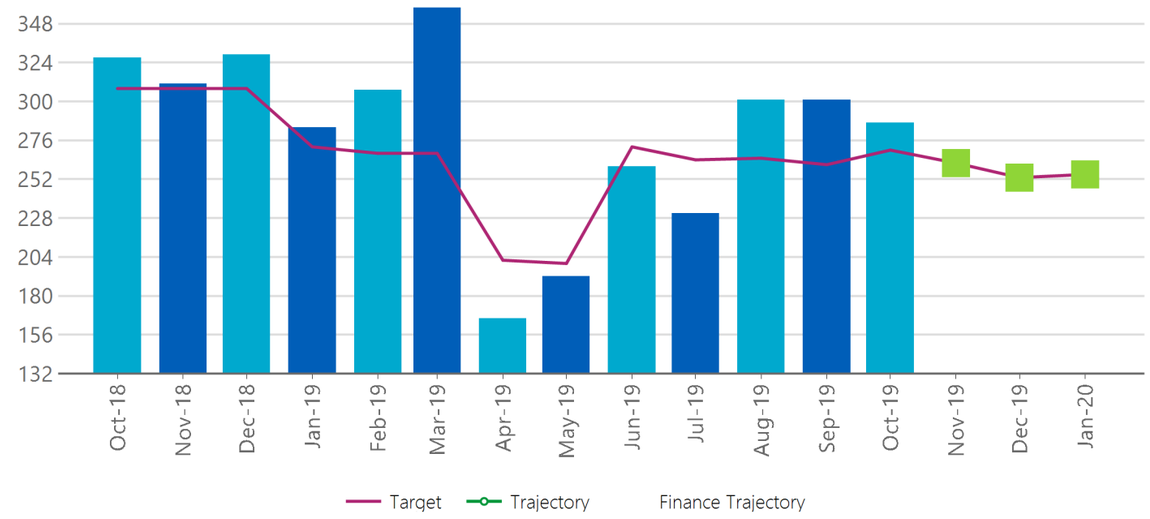
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
322	362	303	371	207	250	368	288	356	249	310	298	327	311	329	284	307	358	166	192	260	231	301	301	287	1,738

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

QIPP Delivery Risk Impact

MSK Transformation QIPP

6 against 0 target

Breaching target green rated

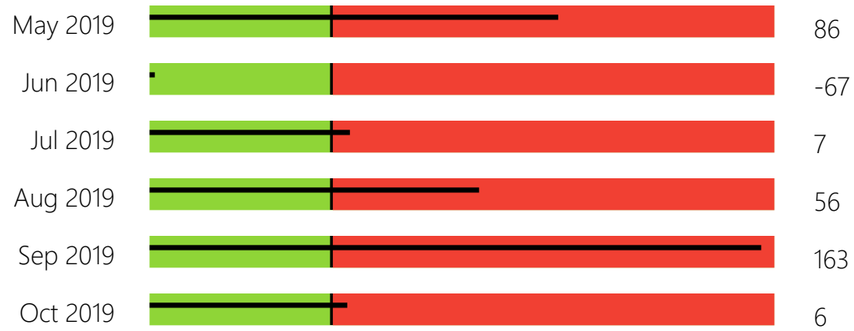
Exec Lead:
Director of Finance

Integrated Performance Report

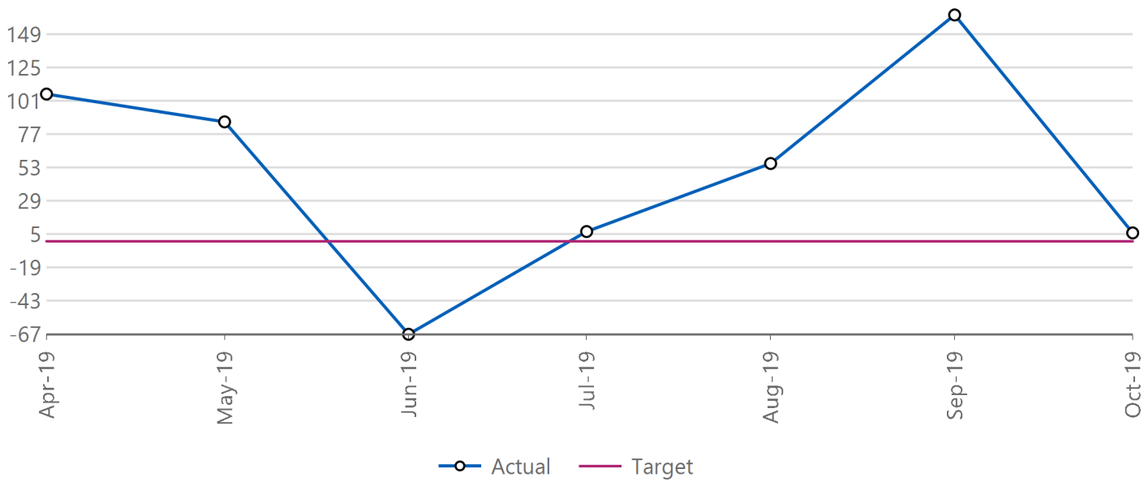
Narrative

MSK risk share £6k in month, £361k risk provided for ytd

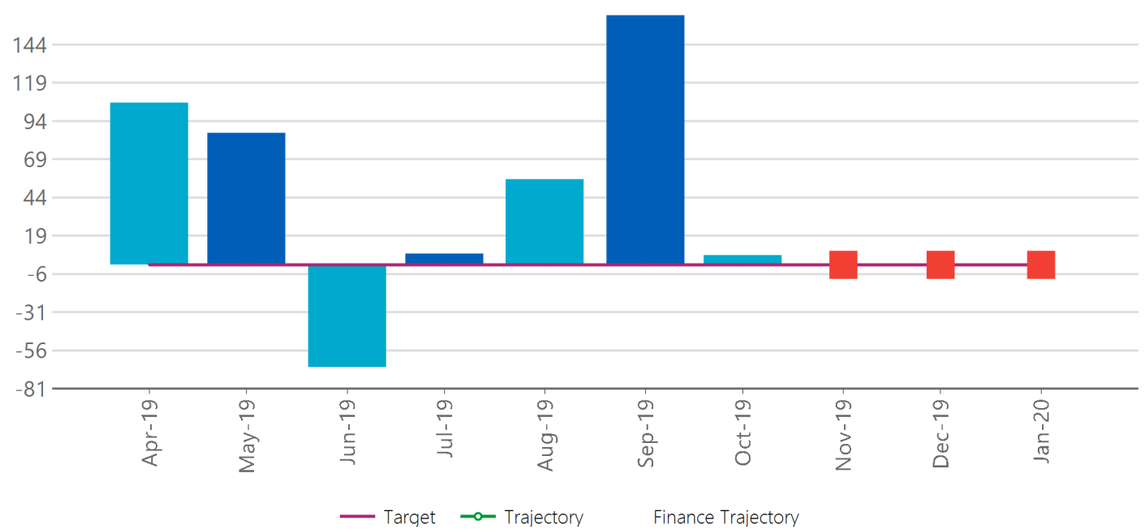
Actual performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
106	86	-67	7	56	163	6	359

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Agency Core

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency only

125 against 132 target

Within target green rated

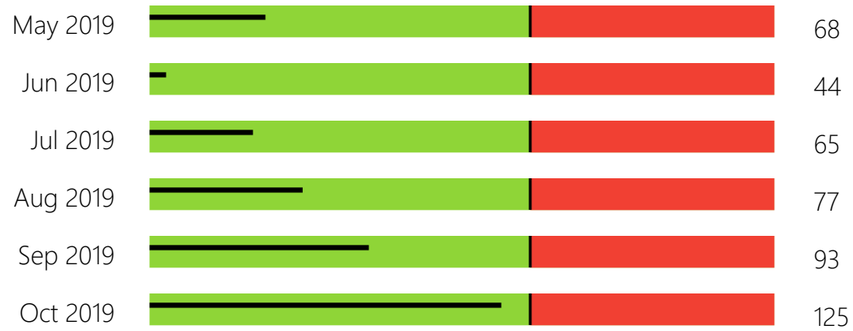
Exec Lead:
Director of Finance

Integrated Performance Report

Narrative

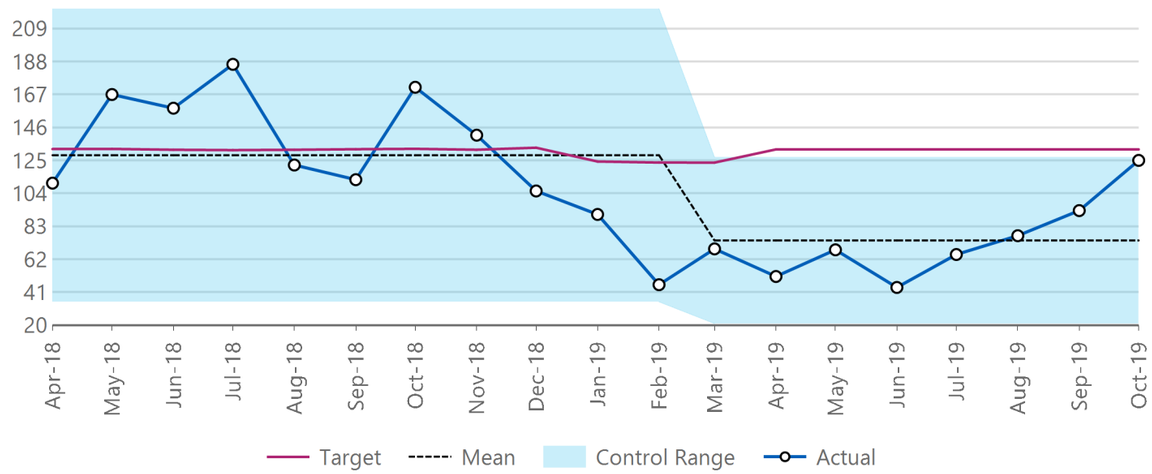
Core agency spend £7k favourable against cap in month

Actual performance against RAG ratings

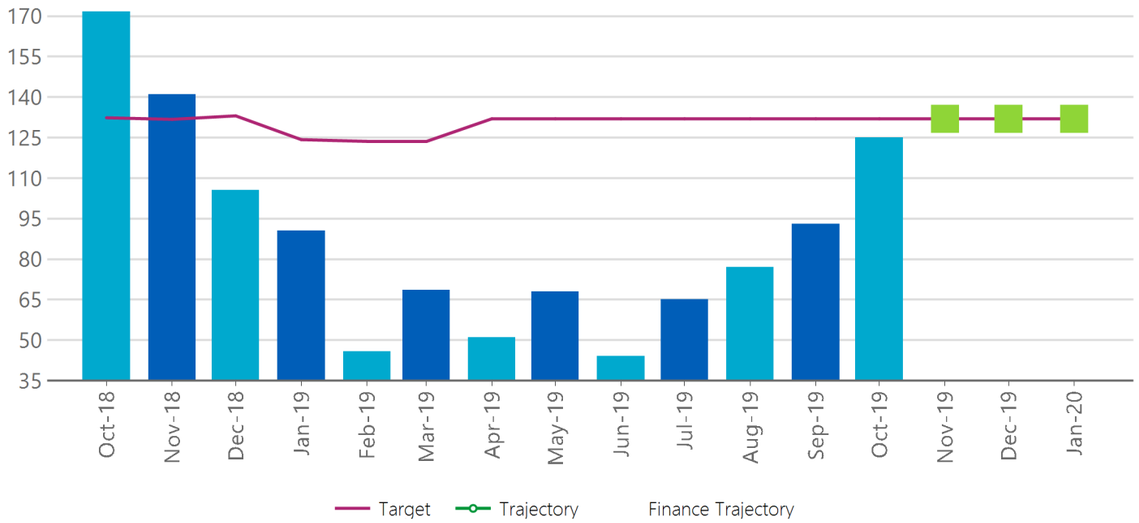


Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
110.49	167	158.27	186.24	122.05	112.7	171.62	141.07	105.5	90.56	45.75	68.59	51	68	44	65	77	93	125	522

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Agency Non-Core

Annual ceiling for total agency spend introduced by NHS Improvement - Non Core Agency

314 against **187** target

Breaching target red rated

Exec Lead:
Director of Finance

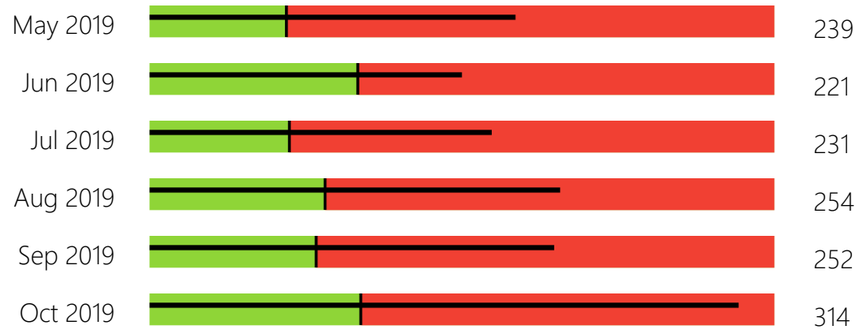
Integrated Performance Report

Narrative

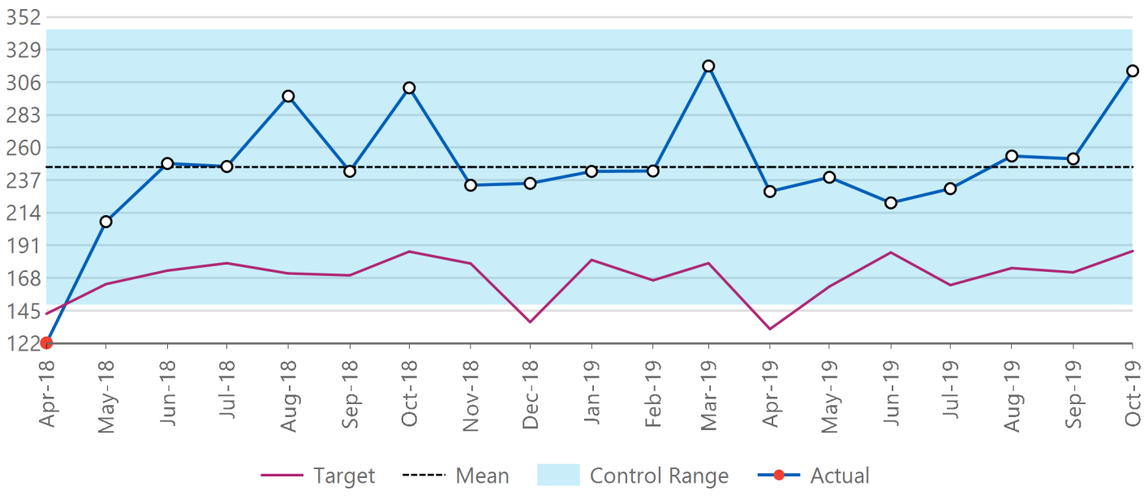
Non core agency spend £127k adverse against cap in month

Action to Improve:Agency limit for LLP does not align to operational plan - NHSI aware. Long term plan to reduce OJP to no more than 20% of total activity is dependent upon new consultant appointments and job plan productivity.

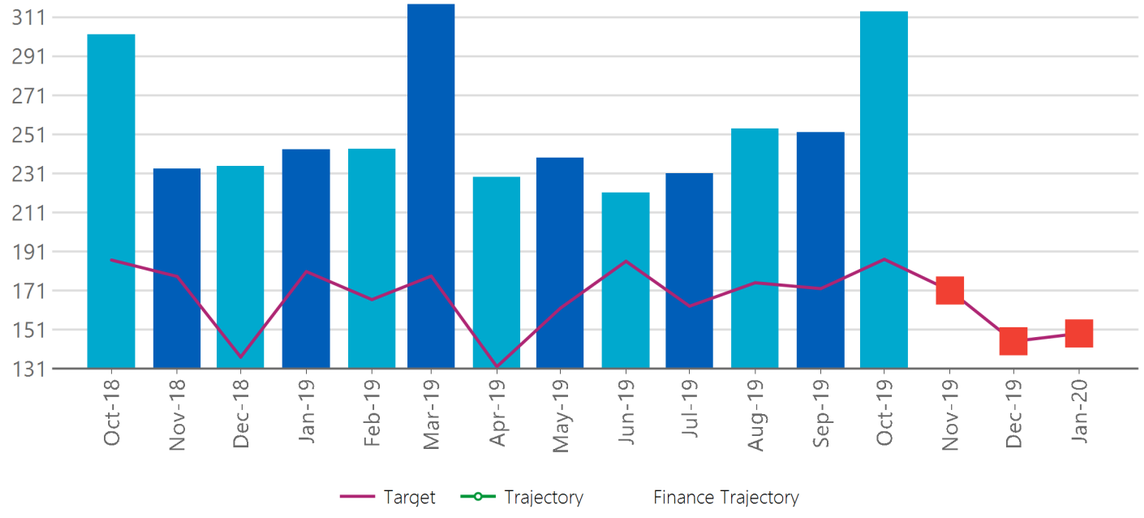
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
122.26	207.73	248.74	246.63	296.21	243.2	302.08	233.41	234.72	243.13	243.43	317.48	229	239	221	231	254	252	314	1,740

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cash Balance

Cash in bank

5,450 against 4,751 target

Above target green rated

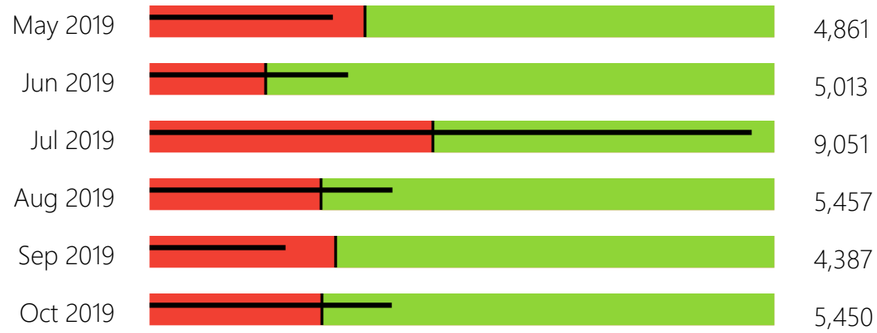
Exec Lead:
Director of Finance

Integrated Performance Report

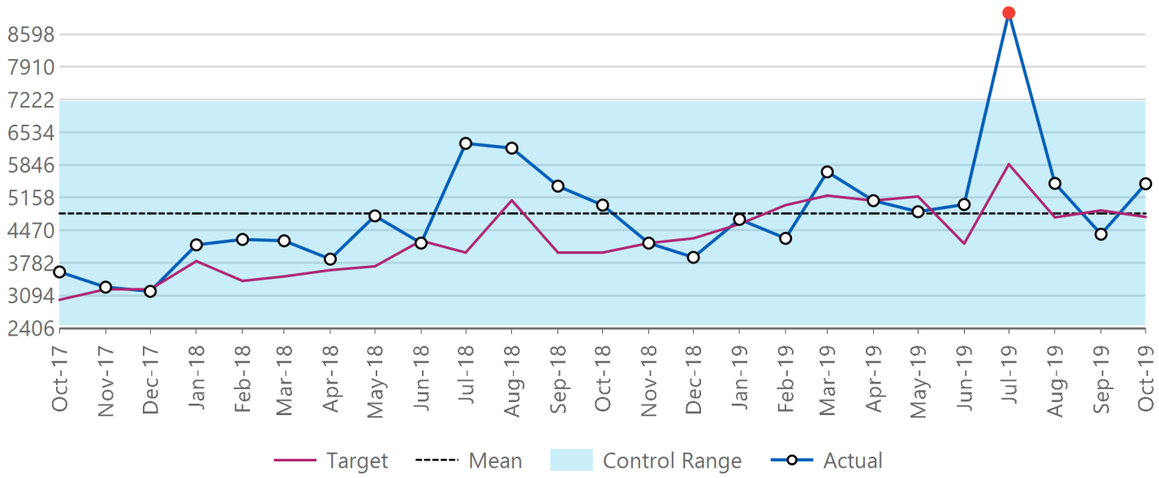
Narrative

Cash balances favourable against plan £0.699m due to receipt of funding for Welsh transfers

Actual performance against RAG ratings



Performance over 24 months – SPC



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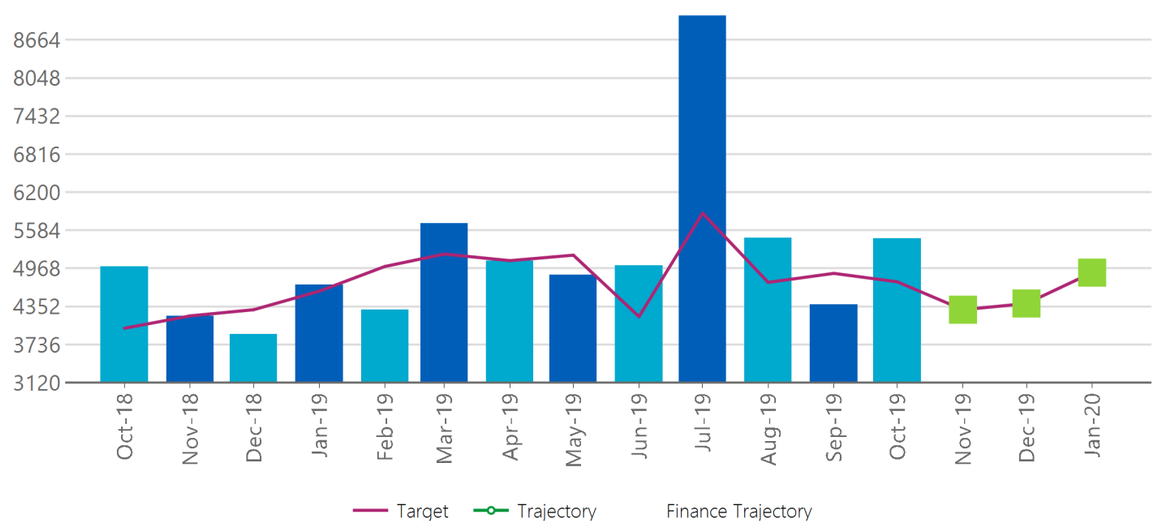


Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
3,593	3,272	3,184	4,163	4,277	4,249	3,863	4,773	4,200	6,300	6,200	5,400	5,000	4,200	3,900	4,700	4,300	5,700	5,094	4,861	5,013	9,051	5,457	4,387	5,450	5,450

Capital Expenditure

Expenditure against Trust capital programme

170 against **428** target

Within target green rated

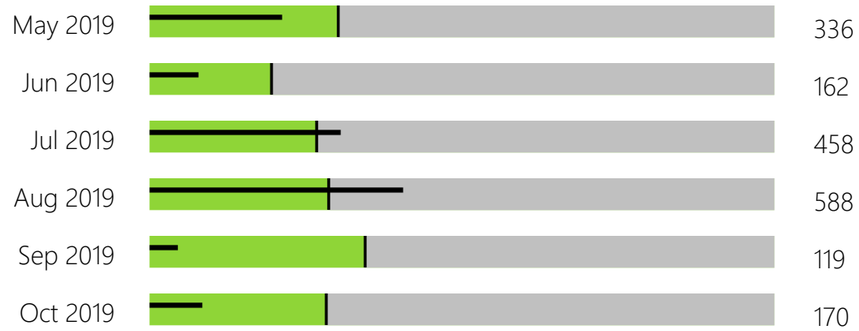
Exec Lead:
Director of Finance

Integrated Performance Report

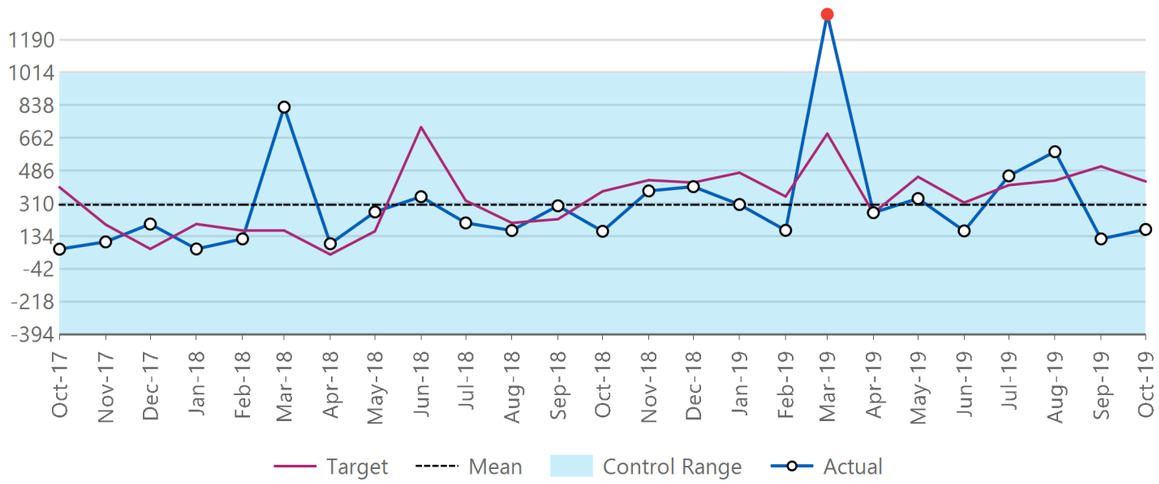
Narrative

Capital spend of £170k in month, YTD £710k under plan due to phasing investments (predominantly IT and diagnostics).

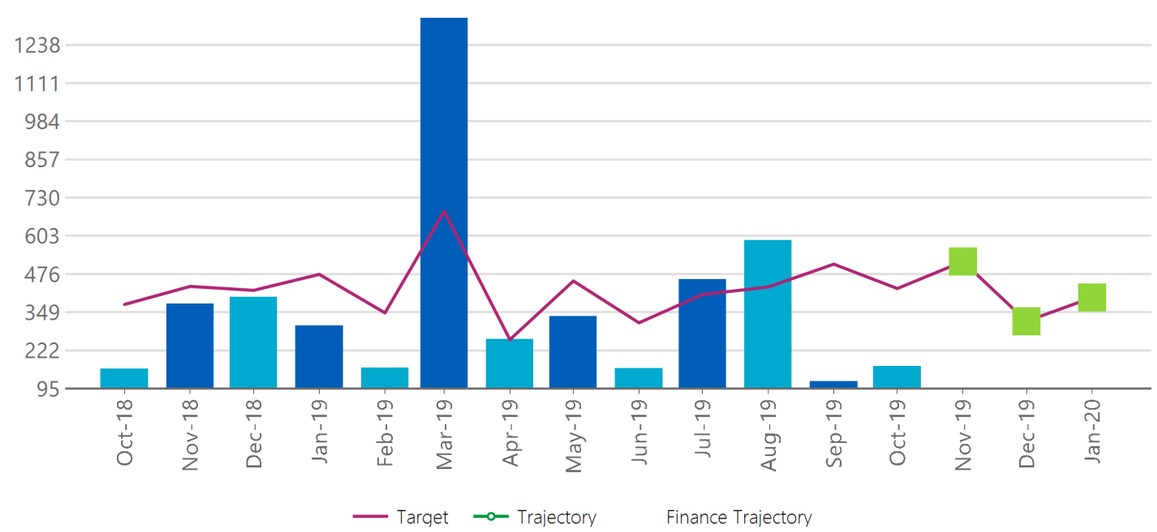
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
64	103	199	65	119	828	93	264	346	205	164	297	160	377	400	304	165	1,327	260	336	162	458	588	119	170	2,093

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Use of Resources (UOR)

Overall Use of Resources indicator

3 against 1 target

red rated

Exec Lead:
Director of Finance

Integrated Performance Report

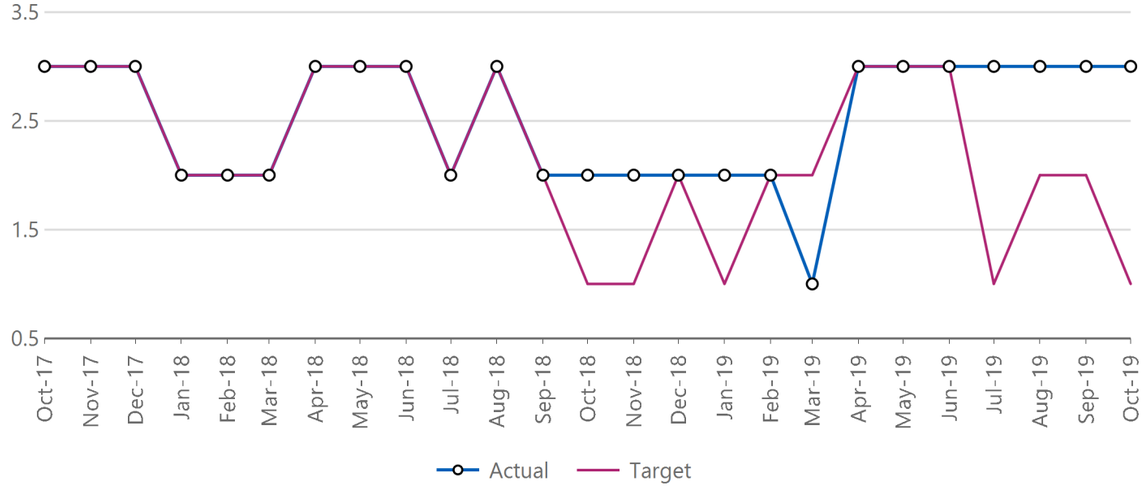
Narrative

UOR is below plan in month driven by cumulative I&E varinace against plan.

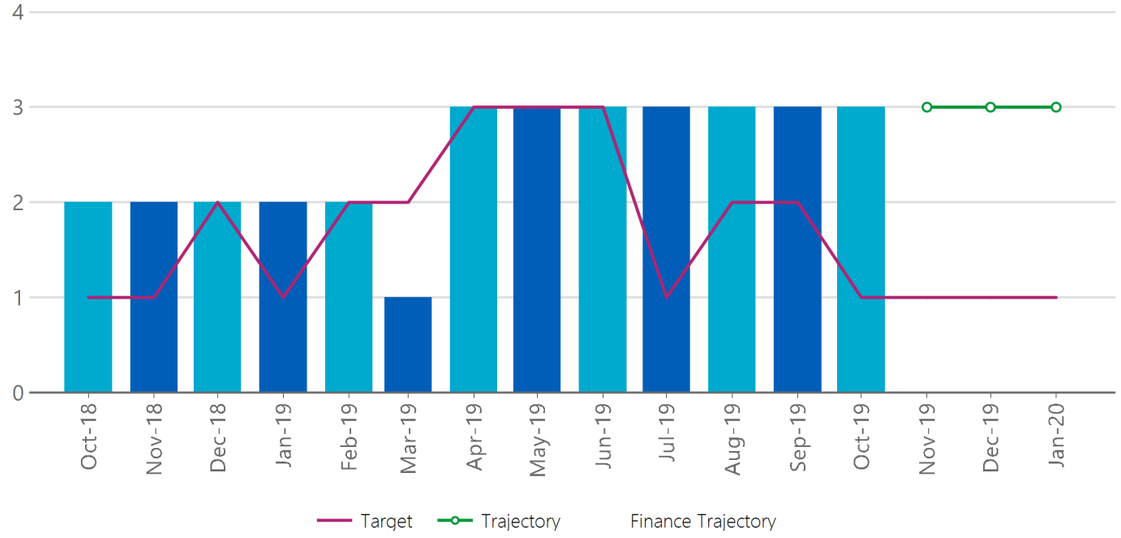
Action to Improve:This is a trigger under the 19/20 oversight framework and will improve with delivery against the financial recovery plan.

Actual performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
3	3	3	2	2	2	3	3	3	2	3	2	2	2	2	2	2	1	3	3	3	3	3	3	3	3

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Proportion of Temporary Staff

Agency staff costs as a proportion of total staff costs.

7.68% against **5.61%** target

Breaching target red rated

Exec Lead:
Director of Finance

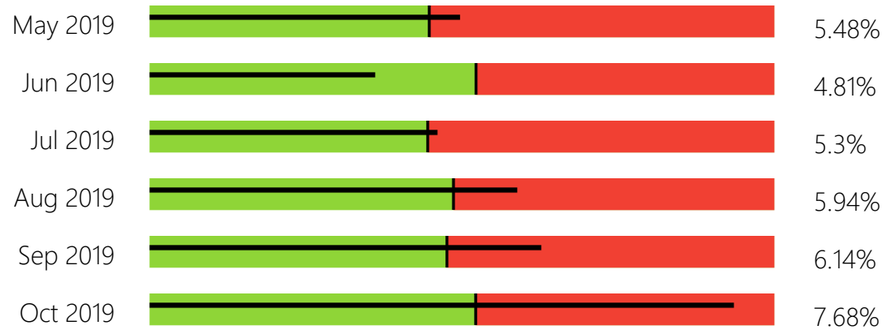
Integrated Performance Report

Narrative

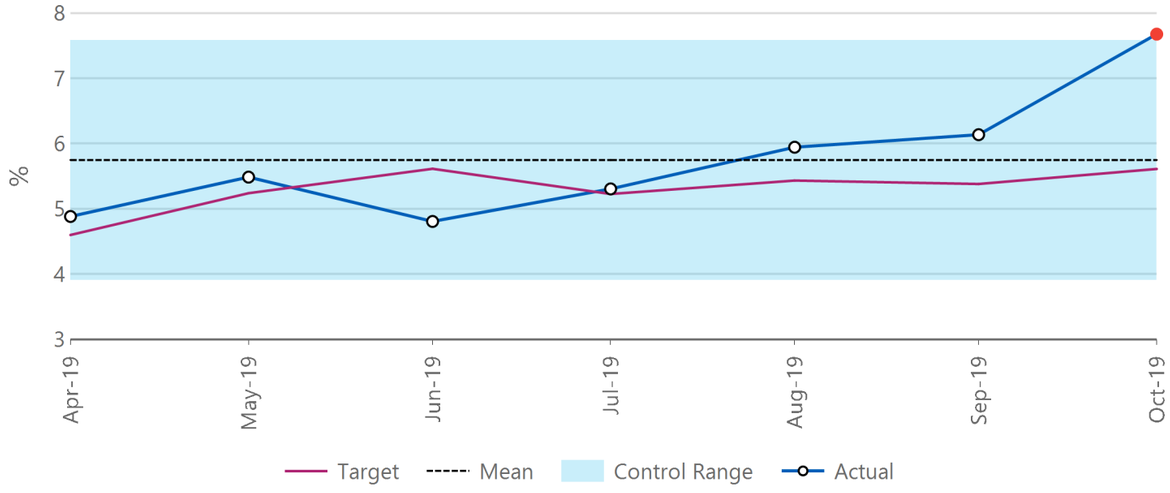
Agency % higher than cap due to Non core agency usage

Action to Improve:Executive sign off and challenge process in place to minimise agency usage.

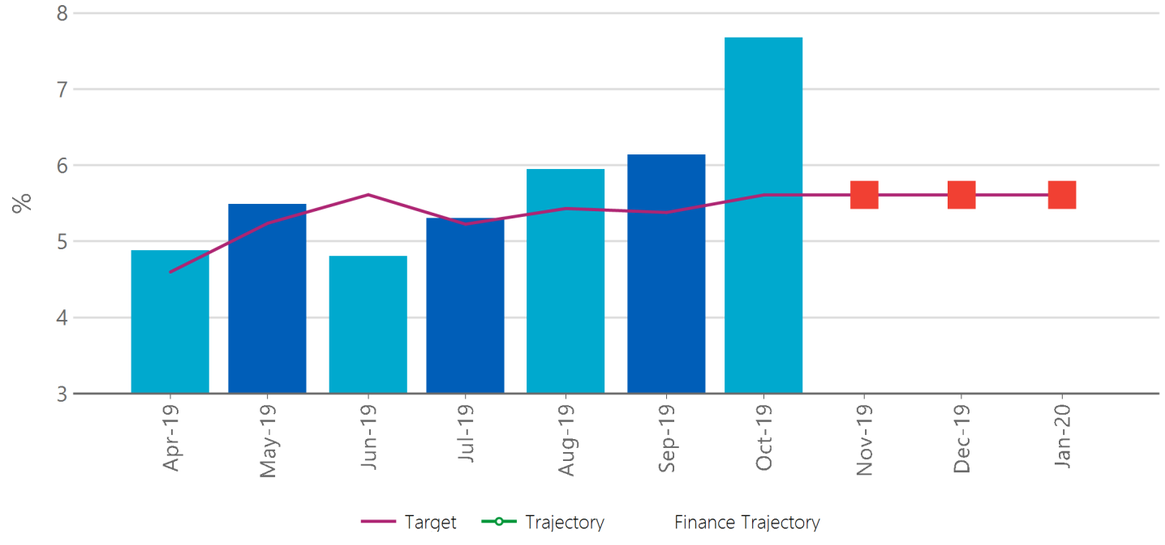
Actual performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
4.88%	5.48%	4.81%	5.3%	5.94%	6.14%	7.68%	5.75%

Treasury Management Policy

0. Reference Information

Author:	Diana Owen, Head of Financial Accounting	Paper date:	28th November 2019
Executive Sponsor:	Craig Macbeth, Director of Finance	Paper Category:	Performance / Governance
Paper Reviewed by:	Financial Planning & Investment Committee *29th October 2019*	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Board of Directors and what input is required?

The policy was reviewed at the Finance, Planning and Digital Committee on 29th October.

The Committee recommend the revised Treasury Management policy for approval by the Board of Directors.

2. Executive Summary

2.1. Context

The current version of this policy was approved in November 2017 with a required review date of November 2019.

2.2. Summary

The Treasury Management policy sets out the arrangements the Trust will make for managing its treasury activities including cashflow management, investments and borrowings.

Proposed amendments to the policy are listed at the end of the policy (section 7) and are only minor amendments to terminology throughout the policy, including changing “Financial Planning & Investment Committee” to “Financial Planning & Digital Committee”.

2.3. Conclusion

The Board of Directors is asked to ***consider*** and ***approve*** the policy.

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Treasury Management Policy		
Unique Identifier:	POL025	**Document Type:**	Policy
Version Number:	7.0	**Status:**	Draft
Responsible Director:	Craig Macbeth, Director of Finance		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Finance Department / Financial Planning & Digital Committee		
Replaces:	Version 6.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Standing Financial Instructions		
Keywords:	treasury, cashflow, investments, borrowing		

Considered By Executive Owner:	Craig Macbeth, Director of Finance	**Date Considered:**	10/10/2019
Endorsed By:	Financial Planning & Digital Committee	**Date Endorsed**	??/??/2019
Approved By:	Trust Board	**Date Approved:**	??/??/2019
Issue Date:	??/??/2019	**Review Date:**	??/??/2021
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Treasury Management Policy

1. Scope and Objectives

1.1. Scope

This policy sets out the arrangements the Trust will make for managing its treasury activities including cashflow management, investments and borrowings.

The investment of Charitable Funds is subject to a separate policy which is approved and monitored by the Charitable Funds Committee.

1.2. Objectives

The Trust's principal role is the provision of healthcare services. As such, the Board needs to ensure surplus operating cash is invested in accordance with its duty to safeguard and properly account for the use of public money.

The key objectives of the Treasury Management function are:

- To ensure sufficient cash is available to meet the day-to-day running costs of the Trust and maintain it as a going concern.
- To ensure any surplus cash balances are utilised in the most optimal way with regard to risk and return.
- To ensure competitively priced borrowings are available to be called upon if and when required.
- To maintain good working relations with the providers of the Trust's banking services.

2. Risks and Controls

2.1. Risks

The main risks relating to Treasury Management are set out below:

- Inaccurate cashflow forecasting leading to insufficient funds available to meet immediate operational requirements or lost investment return opportunity.
- Failure to optimise investment returns on surplus cash balances.
- Cash being tied up on long-term investment and not being available to meet unforeseen operational requirements.
- Cash placed on investment being lost due to the failure of the investing institution.
- Mis-appropriation of funds through undetected fraudulent activity.

2.2. Controls to Manage Risk

The following controls are in place to mitigate the risks identified:

- A cashbook is maintained daily, and a rolling 12 month cashflow maintained weekly and reviewed by senior management before being reported to the Trust Board monthly. Additionally, variances from forecasts are investigated and explained as part of Board reporting.

- Clearly defined roles and responsibilities for the Trust Board, the Financial Planning & Digital Committee, the Director of Finance, the Head of Financial Accounting, and the Financial & Systems Accountant.

- Adherence to the agreed investment policy (covered at section 4.1).

- Separation of duties between those who invoice and receipt for cash and those who make payments.

- Controlled access to bank accounts in terms of mandates, signatories and sign-off limits.

3. Organisation and Responsibilities

3.1. Trust Board

- Approves the Treasury Management Policy.

- Approves all external borrowing facilities and long term borrowing to support investments.

- Authorises sign off arrangements for drawing down external borrowing.

3.2. Financial Planning & Digital Committee

- Oversees the Investment Register (where active investment activity in commercial banking is taking place.

- Requests detailed reports on specific areas of performance/concern regarding the Trust's cashflow management

3.3. Director of Finance

- Approves cashflow profiling plans and ensures an appropriately resourced team and systems are in place to maintain and report.

- Regularly reviews the Treasury activities of the Trust and uses judgement to consider any points that should be brought to the attention of the Financial Planning and Digital Committee and/or Trust

3.4. Head of Financial Accounting

- Has operational responsibility for ensuring appropriate accounting systems are maintained and that regular cashflow projections are undertaken with any material variances investigated and explained.

- Reviews the Investment Register and is the first point of consideration for investment requests.

- Calculates the borrowing limit under the requirements of the Capital Service Cover metric (the degree to which the Trust's income covers it's financing obligations) to inform business case decisions on capital investment.

- Provides updates on Treasury Management issues for the Director of Finance, the Trust Board and the Financial Planning and Digital Committee as required.

- Assesses the impact on the Trust's Use of Resources Risk Rating regarding proposed investments.

3.5. Financial & Systems Accountant

- Manages treasury activities on a day to day basis within the agreed policies and procedures.
- Manages day to day relationships with providers of banking services.
- Maintains rolling cashflow forecasts based on operational plans.
- Identifies surplus cash for investment, and considers whether external investment is optimal by review of interest rates available.
- Undertakes a review of the credit ratings for commercial banks and compares these to the requirements under our Safe Harbour investment requirements.
- Maintains the Investment Register.
- Prepares weekly updates to Senior Finance Management and highlights any material variances from planned cash balances.
- Identifies any short term borrowing requirements.

4. Investments

4.1. Investment Policy

The Trust maintains a risk averse stance to investing its surplus cash balances and therefore forbids speculative trading/investment. All investments placed must meet the following criteria:

- Be with an institution that meets the permitted rating requirement issued by a recognised rating agency (defined in Appendix 2 – Safe Harbour Investments).
- Have a defined maximum maturity date.
- Be denominated in sterling, with any payments and repayments for the investment payable in sterling.
- Pay interest as a fixed, floating or discount rate. The interest rate secured from investments in non-government backed institutions must exceed the Public Dividend Capital interest rate given that daily cash balances are used to offset the annual calculation of dividend payable, but investments outside of the public sector are excluded.

In order to minimise risk, there is a capped limit of no more than £2m for investments placed with each approved institution, apart from the National Loans Fund which is a Government Treasury backed account, for which a limit of £5m will be applied.

4.2. Identification of Surplus Cash Balances for Investment

The Trust will seek to maintain cash balances equivalent to coverage for 15 days operating expenditure or no lower than £3m, whichever is the greater value. Surplus cash balances for potential investment will be identified from review of the following:

- Daily cash book.
- Rolling 12 month cashflow forecast.
- Longer term cashflows as reported in the Trust's most recent financial plan.

If a surplus of cash is identified, prior to recommending an investment, the Financial & Systems Accountant will check that:

- At least £500,000 will be remaining as a contingency in the cashbook over and above planned expenditure levels for the duration of the proposed investment.
- In addition to the £500,000 contingency prescribed above, at least a further £750,000 is available on 7 days notice without penalty.
- Sufficient cash will remain within the Trust's current accounts to meet all the Trust's projected financial commitments before the return of the investments (including payment of invoices in accordance with the Better Payments Practice Code).

4.3. Investment of Surplus Cash Balances

The Financial & Systems Accountant identifies the most appropriate way to invest the surplus funds with the permitted institutions.

The comparison quotes (including the do nothing option) and values are detailed onto an Investment Spreadsheet showing:

- Proposed amount of the investment.
- Proposed period of the investment.
- Rate of interest – if investing in a non-government backed institution (defined as all commercial banks) this must exceed the rate payable by the Trust in respect of its annual Public Dividend Capital (PDC) liability given that daily cash balances may be used to offset the asset value from which the dividend is calculated. The National Loans Fund is excluded from this requirement as it is included in the daily cash balance offset.
- The expected value of the return.

The required level of authorisation for investment is set out below:

Investment period	National Loans Fund (up to £5m	Non-Government Backed Institutions (up to £2m)
1 month	Deputy Finance Director	Deputy Finance Director
1 – 3 months	Deputy Finance Director	Finance Director
Longer than 3 months	Finance Director with approval from FPI	Finance Director with approval from FPI

The Financial & Systems Accountant maintains records of all investment transactions in an Investments Register.

As an additional control, the Trust's standing instruction to its investment counterparties is to send transaction confirmations directly to the Head of Financial Accounting, **not** to the Financial & Systems Accountant. This allows for them to be independently checked and matched to the daily movement records and the Investment Register.

4.4. Borrowing Policy

The Trust maintains a risk averse stance to funding and thus:

- Requires approval from the Board of Directors before obtaining any proposed funding facilities.
- Forbids entrance into trading positions or purely speculative training.
- Recognises the ongoing need for committed funds to be accessible to provide coverage for cash flow fluctuations or to support capital investments.

- Forbids pre-financing in anticipation of need.

4.5. Key Controls for Borrowing Facilities

Loan applications to support short-term working capital reqirements or to support long-term capital investment will be made by the Finance Director subject to the Trust's policies and procedures which comply with the instructions issued by NHS Improvement.

The Trust has in place a Business Case and Investment Policy which will ensure that any requirement for long term borrowing is subject to rigorous appraisal.

The Trust will adopt a risk averse attitude to funding, preferring where possible to use existing business cash-flow to provide the headroom required.

The Trust will not allow its authorised assets to be used to secure loans.

4.6. Borrowing Limits

There are no prescribed borrowing limits. Instead the Capital Service Cover metric (part of the Use of Resources Risk Rating) will be used to assess the affordability of the Trust's borrowing requirements.

Borrowings that trigger deterioration in the Capital Service Cover metric will require approval by the Board of Directors. This assessment should be made for a period of a minimum of five years aligned to the Trust's long term financial plans.

4.7. Borrowing Periods

All short term borrowings will be kept to the minimum period possible and advised to the Board as part of the monthly Finance Board report together with an explanation for the cause of the borrowing need.

All long term borrowings must be tested against the Capital Service Cover metric in defining a repayment period that does not impact the Trust's Use of Resources Risk Rating.

5. Reporting

5.1. Weekly Reporting

Each week the Financial & Systems Accountant prepares a cash forecast for the Head of Financial Accounting and the Deputy Director of Finance showing the current cash balances together with a month end projection which is compared against plan. This allows senior management to intervene in instances of non-receipt of significant contract payments or issues with excessive creditor payments.

5.2. Monthly Reporting

Each month the Financial & Systems Accountant updates the rolling cash-flow forecast for inclusion in the Finance Board paper. In addition the Trust's liquidity is tested as part of the Use of Resources Risk Rating calculation.

The Executive team receive an update on treasury matters from the Director of Finance as part of a monthly dashboard of financial performance issues.

5.3. Quarterly Reporting

A quarterly report will be provided to the Financial Planning and Digital Committee detailing investment activity (excluding the government backed National Loans Fund) and any short term borrowing requirements.

If no such activity has taken place then no report will be required.

5.4. Annual Reporting

The Trust's treasury management activities are reviewed and reported on annually by Internal Audit as part of their Main Financial Systems audit.

6. Policy Review

This policy requires consideration by the Financial Planning & Digital Committee prior to approval by the Trust Board.

This policy will be reviewed every two years.

Policy updated: November 2019
Next review due by: November 2021

7. Record of Amendments

Date	Section number	Amendments
Nov 2017	Various	Minor amendments to terminology, job titles, etc.
	4.2 & 4.3	Removed requirement to have no investments with commercial banks at the year end due to effect on PDC dividend – calculation has now changed
	4.3	Added in authorisation levels for National Loans Fund investments
	4.4	Removed references to commercial overdraft facility as no longer held
Nov 2019	Various	Minor amendments to terminology including changing "Financial Planning & Investment Committee" to "Financial Planning & Digital Committee"

Appendix 1

Investment Vehicles Used by the Trust

- The Government Banking Service
- The National Loans Fund, (NLF) – this is an approved investment under the NHS & Community Care Act 1990).
- Commercial banks supported by low risk credit ratings.

Appendix 2

Investment Criteria for "Safe Harbour Investments" as described by Monitor in Managing Operating Cash in NHS Foundation Trusts

Criteria	Detailed Explanation
Recognised rating agency	Only the following are recognised rating agencies: • Standard & Poor's; • Moody's Investors Service Ltd; and • Fitch Ratings.
Permitted rating requirement	The short-term rating should be at least: • A-1 Standard & Poor's rating; or • P-1 Moody's rating; or • F1 Fitch Ratings. The long-term rating should be at least: • A1 (Moody's); or • A+ (Standard & Poor's/Fitch Ratings).
Permitted institutions	Permitted institutions include: • Institutions that have been granted permission, or any European institution that has been granted a passport, by the Financial Services Authority to do business with UK institutions provided it has an investment grade[2] credit rating of A1/A+ issued by a recognised rating agency; and • The UK Government, or an executive agency of the UK Government, that is legally and constitutionally part of any department of the UK Government, including the UK Debt Management Agency Deposit Facility.
Permitted Investment Type	Only investments that offer a guaranteed fixed rate return are allowed. Investments in pools or speculative trading are not permitted.
Maximum Maturity Date	• The maximum maturity date for all investments should be 90 days. • The maturity date for any investment should be before or on the date when the invested funds will be needed.
Preferred concentration limit	• If an institution is either downgraded or put on credit watch by a recognised rating agency, the decision to invest with them should be reviewed. • Investments with permitted institutions should not exceed the set limit at any time.

2018 Clinical Excellence Awards Rounds

0. Reference Information

Author:	Sue Pryce, Head of People Services	Paper date:	28th November 2019
Executive Sponsor:	Sarah Sheppard Direcotr of People	Paper Category:	Performance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board what input is required?

In accordance with the Trust's Employed Based Clinical Excellence Awards Policy, the Trust Board are required to receive an annual report.

The Trust Board are asked to note the contents.

2. The Main Report

2.1. Introduction

In accordance with the Trust's Employed Based Clinical Excellence Awards Policy, the Trust Board are required to receive an annual report.

The Trust Board are asked to note the contents.

The EBAC met on 28 February 2019.

The number of consultants eligible for consideration	70
Of which the number of female consultants	9
Of the number of consultants from ethnic minorities	19
The age ranges of the consultants eligible for consideration	3 (36-40) 15 (41-45) 16 (46-50) 21 (51-55) 8 (56-60) 3 (61-65) 4 (66-70)
The number of award holders **including the 2018 allocation**	44
Of which the number of female consultants	6
Of which the number of consultants from ethnic minorities	38
Of which the age ranges of the consultants	1 (36-40) 7 (41-45) 10 (46-50) 15 (51-55) 5 (56-60)

	5 (61-65) 1 (66-70)
The number of applications received in the 2018 round	19
The names of consultants recommended for award in the 2018 round	R Amerasena – 1 point R Banerjee – 2 points B Burston – 1 point J Chowdhury – 1 point G Cribb – 3 points S Hay – 1 point * N Niely – 1 point N Kumar – 1 point J Maybin – 1 point R Potter – 2 points S Shapter – 2 points J Trivedi – 3 points T Willis – 2 points * Maximum number of points that could be awarded due to existing level of award
The investment level	21 £63,336
The amount invested	21 £63,336
The number of appeals that have been received	1
Compliance Statement The the Employer Based Clinical Excellence Awards round for 2018 was conducted in accordance with the requirements of the Trust Policy.	**EBAC Chair**

2.2 Conclusion

The Trust Board are asked to note the the EBAC annual report for 2018.

Appendix 1: Acronyms

EBAC	Employer Based Awards Committee

Corporate Objectives 2019/20 and Board Assurance Framework

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	31 October 2019
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:	Risk Management Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the Board of Directors and what input is required?

The Board of Directors is asked to ***note*** the current position in relation to the delivery of the Trust's Corporate Objectives and the associated risks.

2. Executive Summary

2.1. Context

The Board of Directors uses the BAF as tool to ensure effective management of any risks which have potential to impact on delivery of the Trust strategy. The Trust has defined its three key strategic aims as: Operational Excellence; Specialist Orthopaedic; MSK

All underpinned by a fourth aim relating to Culture and Leadership.

2.2 Summary

This paper presents the current position with regard to delivery of the corporate objectives for Q2 2019/20 and the management of the associated risks.

Each of the Board Committees have continued to receive a report at each meeting of the corporate objectives and risks that fall within their remit and the Risk Management Committee reviews the Board Assurance Framework on a quarterly basis.

The mitigating actions for the risks of delivery have been updated and highlighted in blue.

There is one risk which has been closed in relation to the lack of clear national strategy for the commissioning of our specialist services. This has been discussed at both the Finance Planning and Digital Committee and the Risk Management Committee.

2.3. Conclusion

The Board is asked to:

- Note the Q2 delivery against the Corporate Objectives
- Note the content of the Board Assurance Framework and consider any additional risks that should be articulated

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Patients — OBJ 1

Achieving Outstanding Patient Safety

Principal Objective: Reduce unwarranted variation with a focus in 19/20 upon reducing avoidable harm

This objective will focus on four key areas, GIRFT principles, falls, UTIs and managing deteriorating patients.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G	G			G

Objective Details

Opened: April 2019

Reviewed Date: September 2019

Key Measures:

- Lower UTIs in older people are diagnosed and treated in line with NICE guidance for 90% cases by year end
- All new devices across all disciplines are reviewed and approved through the New Devices and Procedures Committee
- Older people have recognised falls prevention measures in place. 80% compliance by year end.
- Implement quarterly audits of compliance with patient observations including NEWS.
- Ensure correct level of patient deterioration training available to reach trust wide compliance of 80% by year end.

Progress Update:

The work for diagnosing and treating lower UTIs in older people in line with NICE guidance is on track as is the process for the review and approval of new devices.

CQUIN meetings are being held regularly and performance is on track.

Quarterly audits of compliance with patient observations were carried out for Q1 and the results are to be presented to the next Patient Deterioration Committee.

The availability of training in the management of deteriorating patients has been reviewed with capacity increased for 2019/20.

Supporting programmes of work

- GIRFT action plan
- CQUIN
- Outpatients protocols
- Booking and scheduling review
- Model Hospital

Risks

BAF 1.1	Engagement with the clinical workforce fails to gain traction
BAF 1.2	Failure to apply nationally recognised evidence based practice

Lead Director:

Director of Nursing & Medical Director

Lead Committee

Quality and Safety Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 1.1 **OBJ 1**

Principal Risk: Engagement with the clinical workforce fails to gain traction

Inability to implement new processes aimed at reducing variation resulting in failure to reduce avoidable harm

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	3
Likelihood	3	3	1
Total	15	12	3

Risk Details

Opened: May 2019

Review Date: September 2019

Source of Risk: Risk Assessment

Corporate Risk Register? DX2178

Controls:

- ✓ Innovation Committee will ensure rationalisation of new procedures and equipment
- ✓ Forums for clinical engagement (Clinical Management Board, Clinical Cabinet, Multi-Disciplinary Clinical Audit Meeting, Medical Advisory Committee

Assurance: **Source of Assurance** **2**

- ✓ Oversight by Quality and Safety Committee
- ✓ Innovation Committee to oversee and rationalise the introduction of new techniques and equipment and to ensure evidence base.
- ✓ Operational Excellence Board
- ✓ Compliance with NICE guidance
- ✓ Participation in Clinical Audit

Gaps in Controls:

- C1: New clinical leadership structure will provide additional control but will not be in place until April 2020
- C2: Clarity required for roles and responsibilities

Gaps in Assurance:

- A1: Effectiveness of Clinical Quality Governance Committee

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
C1	Implementation of new clinical leadership structure	Chief Executive	Oct 2019	The new structure will come into place on 1 April 2020 with Clinical Chairs in place from 1 October 2019	Completed
C1	Clinical Chair job descriptions to provide clarity of roles and responsibilities	Chief Executive	Jul 2019	The job descriptions have been completed and circulated to the organisation, applications received and interviews scheduled.	Completed
A1	Review of Clinical Quality Governance Committee effectiveness to be prioritised	Director of Nursing / Trust	Jun 2019	Review undertaken and new terms of reference drafted. New meeting schedule put	Completed

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		Secretary		in place.	
A2	Further review of Clinical Quality Governance Committee effectiveness in 3 months time	Director of Nursing / Trust Secretary	Oct 2019	Review has been undertaken with changes made to the chairmanship and membership	Completed
C2	Mapping of roles in new structure to be undertaken with formal handover process for clarity	Chief Executive	Dec 2019	Statutory roles and key responsibilities have been identified with mapping to new roles being undertaken.	

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 1.2 **OBJ 1**

Failure to implement nationally recognised evidence based practice

Potential for avoidable harm or prevention of reducing avoidable harm. Inability to provide world class care if practice is not evidence based

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	3
Likelihood	3	3	1
Total	15	12	3

Opened: May 2019

Review Date: September 2019

Source of Risk: Risk Assessment

Corporate Risk Register? DX2177

Controls:

- ✓ Falls collaborative
- ✓ Falls management training needs analysis and records
- ✓ Falls policy
- ✓ CQUIN
- ✓ Quality account priorities
- ✓ Divisional Quality Reports

Assurance: Source of Assurance **2**

- ✓ Oversight by Quality and Safety Committee
- ✓ Integrated Performance Report metrics
- ✓ Innovation Committee
- ✓ Quarterly update on GIRFT
- ✓ CQRM oversight of CQUIN

Gaps in Controls:

- ~~C1: No clear work group for implementation of GIRFT principles~~
- ~~C2: Capacity and resource to provide the deteriorating patient training~~
- C3: Compliance with completion of falls documentation
- C4: Benchmarking for world class
- C5: Clear implementation plan required for GIRFT principles

Gaps in Assurance:

- A1: Monitoring of deteriorating patient training figures

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Complete d
C1	Working Group to be established to look at GIRFT principles	Medical Director	June 19	Initial meeting has taken place	Completed
C2	Review of capacity and resource required to deliver the required deteriorating patient training	Director of Nursing	June 19	Review of the capacity and resource required to deliver the training has been completed and meeting has taken place to agree the plan for increasing the training provision and other aspects of patient deterioration management.	Completed

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C3	Review of falls documentation to be undertaken to understand issues with completion	Director of Nursing	July 19	The assessments have been reviewed and communicated to the senior nursing team and ward managers.	Completed
C4	Consideration of benchmarking opportunities with recommendations to be presented to Quality and Safety Committee	Medical Director	~~Jul 19~~ Mar 20	Surgical Site Infections has been identified as the first benchmarking opportunity – the Medical Director is presenting this to the Board in October	
C1:	Alignment of agreed work programme for GIRFT principles to the Trust's committee structure and work plans	Medical Director / Trust Secretary	Nov 19	Medical Director, Trust Secretary and Business Insight Lead meeting to undertake gap analysis with a view to ensuring any gaps are picked up with through the Trust's governance framework.	

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Patients — OBJ 2

Delivering outstanding outcomes and experience

Principal Objective: Increased focus on MSK population health

This objective will focus on transition from volume based to value based, reactive to proactive and illness to health and wellness focus.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
A	A			G

Measurements of improvement:

- Alternative contract model in place for 2020/21 more focused upon value than volume.
- Roll out of Q Lab improvement programme
- Stabilisation of SOOS to be measured through improved KPI performance

Objective Details

Opened: April 2019

Reviewed Date: October 2019

Progress Update:

All providers have now responded to the STP on the clinical design, including RJAH in support with some further points of clarification.

The Shropshire JSNA is due to be presented at the next Health and Wellbeing Board, RJAH submitted comments to the last draft received by the 15th October for incorporation.

SOOS stabilisation has seen a 14% reduction in list size over the last 3 months equivalents to 211 patients, backlog by March 2019 in line with the published stabilisation plan. In this period sustainable capacity plans will be verified and actioned as required. Capacity and demand modelling has taken place for this work. Referrals into secondary care are currently sitting at 36.04% against a target of 39% and significantly reduced from the high point of 39.52% earlier in the year. Further work commences on conversation rates which have reduced by 1% but require a more significant movement to meet the target. A more granular review has taken place to target specific providers and areas.

All providers have now agreed to work together in looking to form a provider alliance, meeting scheduled for all system providers in November to move forwards.

Supporting programmes of work:

- Development of system healthcare pathways
- MSK joint strategic needs assessment
- SOOS continued development
- Q Lab improvement partnership – mental health, neck and back pain
- MSK PROMs

Risks

BAF 2.1	MSK service integration fails to deliver expected benefits due to lack of understanding of the self-management and non-surgical pathways

Corporate Objectives 2019/20 and Board Assurance Framework

- MSK self-management

Lead Director:	Lead Committee
Director of Performance, Improvement & OD	Finance, Planning & Digital Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 2.1 **OBJ 2**

Principal Risk: MSK service integration fails to deliver expected benefits due to lack of understanding of the self-management and non-surgical pathways

Potential reduction in activity at the Trust with loss of contracted work, impact on stability and availability of specialist work, potential for duplicate visits for patients, inability to respond to external factors. Host commissioner in financial recovery and requires material reduction in orthopaedic spend, impact for the Trust still to be determined. Potential for local health partners to not see the benefit of specialist orthopaedic services within the system

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	4	4
Likelihood	4	3	1
Total	16	12	4

Risk Details

Opened: May 2017

Review Date: September 2019

Source of Risk: External drivers

Corporate Risk Register? (DX1490, DX1533, DX1602)

Controls:

- ✓ Monitoring of GP referrals
- ✓ Horizon scanning in place
- ✓ Regular dialogue through contract meetings
- ✓ Monthly 1:1 between the Directors of Finance and Chief Executives
- ✓ Participation in MSK service developments and SOOS
- ✓ Delivery of QIPP prior approval requirements
- ✓ STP Directors Monthly Report
- ✓ Strategy deployment linked to objective setting
- ✓ Programme plan in place
- ✓ STP governance arrangements defined
- ✓ SOOS KPIs in place
- ✓ 1st phase complexity modelling completed
- ✓ Definition of MSK agreed by the Board
- ✓ Trust representation within the STP work streams
- ✓ CEO attends Senior Leadership Meetings for the STP
- ✓ Engagement with key partners in the local health system
- ✓ Future fit response
- ✓ MSK Orthopaedic System Paper

Assurance: **Source of Assurance** **3**

- ✓ Strategy Oversight Group overseeing delivery
- ✓ Board reporting programme in place
- ✓ Clinical Cabinet established
- ✓ Local MSK Programme Board in place
- ✓ Increased Finance, Planning and Digital Committee Oversight
- ✓ Monthly performance report
- ✓ NHS I monitoring
- ✓ Shropshire CCG MSK Programme Board with weekly oversight meetings introduced
- ✓ SOOS project board in place
- ✓ Contract in place with contractual review meetings
- ✓ Monthly MSK meeting with the CCG
- ✓ Updates to Q&S Committee on quality aspects
- ✓ Planned Care Working Group
- ✓ STP updates to Board
- ✓ Board oversight of partner risks

Gaps in Controls:

- C1: Ability to implement strategy
- C2: Stakeholder relationships
- C3: System contract alignment with strategic MSK vision

Gaps in Assurance:

- A1: Lack of integration of MSK provider and commissioner programme boards, together with split commissioner reporting.
- A2: Lack of integration between local and specialised commissioning

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- C4: Lack of triangulated system MSK reporting i.e. finance, outcomes, quality, experience, activity
- C5: Consultant body understanding of SOOS
- for MSK conditions
- A3: No national inclusion of MSK in NHS long 10 year plan
- A4: No inclusion of Specialised Services in the STP Operational Plan

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
C1, C2, C3, C4, A1, A2	MSK System Governance to be put in place	Director of Improvement, Organisational Development and Performance	Jun 19	STP MSK Transformation Board in place reporting to STP SLG, MSK design group reporting to STP MSK Transformation Board. Monthly update to exec committee from STP MSK Transformation Board	Complete
A1, A2	Ensure contractual CCG meeting put in place as per ToR for contract meeting and PCWG	Director of Performance, Improvement & OD	Nov 19	These meetings are now in place with the first meeting having taken place 14th August and subsequent meetings held quarterly	Complete

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Patients — OBJ 3

Delivering timely access to patient care

Principal Objective: Improving systems and processes for best care

This objective will focus on three key areas; job planning, booking and scheduling and outpatient protocols.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G	A			A

Objective Details

Opened: April 2019

Reviewed Date: September 2019

Key Measures:

- Implementation of the internal audit recommendations linked to job planning
- Implementation of 6-4-2
- Overarching protocol in place with roll out of sub specialty

Progress Update:

Dedicated resource for the implementation of 6-4-2 now in place, due to scale of work, unlikely to be fully delivered in 19/20, focus remains on creating sustainable steps of change through theatre recovery plan.

Clinical protocols have now been agreed in a number of subspecialties to use going forwards, there is ongoing debate regarding the retrospective application of the protocols to the existing backlog. The Ops Team are in the process of meeting with individual consultants to identify those who will consider discharge by letter following a virtual clinic review.

Supporting Programmes of Work:

- E-rostering work in partnership with Collinson Grant
- Co-ordination centre
- Demand and capacity implementation
- 6-4-2 theatre planning
- Pre-op transformation
- Outpatient model
- Job planning

Risks

BAF 3.1 Inadequate operational processes

Lead Director:

Director of Performance, Improvement & OD

Lead Committee

Finance Planning and Digital Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 3.1 **OBJ 3**

Principal Risk: Inadequate operational processes

Inability to reduce the number of rescheduled episodes, missed opportunities to prevent rescheduled appointments, reputational damage and poor patient experience, inability to backfill short notice cancellations, lack of an operational transparency model to support improvements in operations processes reducing efficiency opportunities.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	2
Likelihood	5	4	1
Total	25	16	2

Risk Details

Opened: March 2018

Reviewed Date: September 2019

Source of Risk: National and local health landscape

Corporate Risk Register? (DX 1572, DX1817, DX1980)

Controls:

- ✓ Access Policy in place
- ✓ Pre-operative Assessment Transformation work stream
- ✓ Daily scheduling / theatre comm cell
- ✓ Admin review completed, full implementation 2018/19
- ✓ Monitoring of efficiency KPIs
- ✓ Operational Excellence transformation programme working groups
- ✓ Patient Flow Co-ordinator in place
- ✓ Bed Management Policy in place
- ✓ Care co-ordination centre in place

Assurance: **Source of Assurance** **2**

- ✓ Daily Comms Cell
- ✓ Monthly Operational Board oversight
- ✓ Oversight and assurance via the Finance Planning and Investment Committee
- ✓ Inpatient Survey Performance
- ✓ Operational Excellence Programme Board
- ✓ Oversight from Strategy Board
- ✓ Weekly RTT Meeting / Surgical Division Meeting Deep dives for areas of red performance

Gaps in Controls:

- C1: Booking pathway timeline compliance
- C2: Financial viability of transparency model to be assessed
- C3: Follow up backlog project behind plan therefore management of backlog being impacted
- C4: Gaps in job planning governance and processes
- C5: 6-4-2 implementation

Gaps in Assurance:

- A1: Performance deep dives still embedding
- A2: Evidence of trained staff to meet protocols and policy

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
C4	Job Planning Policy to be reviewed and revised to ensure governance and process gaps addressed	Medical Director / Director of People	~~Jun 2019~~ Sept 2019	Policy reviewed and revised and ready to go to LNC	

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C1, C4	Development of Trust wide policy for delivery of outpatient based care	Director of Performance, Improvement & OD	~~Sept 2019~~ Jan 2020	Project plan in place for delivery of sub specialty protocols. Arthroplasty proposal shared with the CCG and agreement on approach to take forward. Further sub specialty proposals being submitted to the CCG as per project plan	
C1, C5	Implement booking and scheduling hub and embed processes aligned to 6-4-2	Director of Performance, Improvement & OD	~~Sept 2019~~ March 2020	Theatre PID developed and approved by Operational Excellence Committee. The project support and project plan will be presented to FPD in October.	
C3	Review of capacity requirements to be undertaken to address short term clearance of backlog	Director of Performance, Improvement & OD	Sept 2019	Demand and capacity review undertaken and being shared at sub speciality meetings in September and October	Completed

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Staff — OBJ 4

Being an extraordinary place to work

Principal Objective: Focus on providing an environment for our workforce to 'flourish at work'

This objective will focus on bullying and harassment, progress in the areas identified as cultural hotspots and inclusion.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G	G			G

Objective Details

Opened: April 2019

Reviewed Date: September 2019

Key measures

- Staff survey results on bullying and harassment
- Sickness absence and voluntary turnover in hotspots
- WRES / Staff survey

Progress Update:

Through more structured performance review meetings each Division is now focusing much more are the staffing kpi's, through this we have seen in Theatres a clear understanding of sickness levels by professional group, a clear action plan to address wellbeing and improvements in this kpi from the actions, reduction month on month for the last 3 months.

Surgery have completed a number of focus groups as part of their action plan through the PRM's and have six themes that they are now looking to improve, actions plans to address these themes are now being put in place.

Recent interviews for the re-organisation ensured that a values based interview took place that aligned to our Trust values and behaviours.

WRES report presented to the People Committee and Board of Directors

Freedom to speak up month taking place in October with freedom to speak up toolkit being completed.

Supporting programmes of work:

- Workforce wellbeing
- Excellent people management

Risks

BAF 4.1	Failure to improve staff engagement linked to communication between managers and the workforce

Corporate Objectives 2019/20 and Board Assurance Framework

- Strategic system workforce planning
- Staff development activities
- Role development/new role programme
- Statutory and mandatory training and delivery plan
- Signature behaviours and values
- How do we do business at RJAH
- How to be a great manager at RJAH
- Inclusion and dignity activity plan
- Streamlining of processes and procedures

BAF 4.2 Potential inability to have the right workforce in the right place at the right time

Lead Director:	**Lead Committee**
Director of People / Director of Improvement, OD and Performance	People Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 4.1 **OBJ 4**

Principal Risk: Failure to improve staff engagement linked to communication between managers and the workforce

Inability to improve the culture and behaviour of the workforce, difficulties attracting staff to the organisation leading to poor patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	4	2
Likelihood	5	3	2
Total	20	12	4

Risk Details

Opened: Apr 17

Review Date: September 2019

Source of Risk: Staff survey results

Corporate Risk Register? (DX 1264, DX 2175)

Controls:

- ✓ Ward / department buddying with escalation of issues to exec team
- ✓ Communications and engagement strategy
- ✓ Six monthly big conversations
- ✓ Leadership training and bite-sized modules for wider organisation
- ✓ Workforce Development Group in place
- ✓ Established Performance Review Programme
- ✓ Additional resource in place to assist with the delivery of the engagement programme
- ✓ Performance framework in place
- ✓ Patient Safety Walkabouts

Assurance: **Source of Assurance** **3**

- ✓ Regular updates to the Quality and Safety Committee and Board
- ✓ NHS I PRM
- ✓ Staff Survey
- ✓ Pulse Checks
- ✓ NHS I Oversight Framework
- ✓ Oversight from Workforce Development Group and People Commitee

Gaps in Controls:

- C1: Effectiveness of information cascade as a result of having no formal cascade process
- C2: Establishing / re-enforcing management visibility

Gaps in Assurance:

- A1: Service improvement expertise

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
A1	Business case to be developed for service improvement expertise	Director of Strategy and Planning	~~Jun 2019~~ Apr 2020	This has been put on hold in light of organisational restructure	

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 4.2 **OBJ 4**

Principal Risk: Potential inability to have the right workforce in the right place at the right time

Inadequate succession planning and talent management resulting in gaps in levels of expertise. Risk to staff morale resulting in increased turnover. Inability to increase activity safety to meet national targets resulting in further regulatory scrutiny. Poor patient experience and potential patient safety risks

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	3	2
Likelihood	4	4	2
Total	16	12	4

Risk Details

Opened: March 2018

Review Date: September 2019

Source of Risk: Workforce

Corporate Risk Register? (DX 1745, DX1652)

Controls:

- ✓ Recruitment plans to target vacancy hot-spots
- ✓ Sickness absence management
- ✓ Staff turnover monitoring
- ✓ Leadership training to support effective management and engagement of staff
- ✓ Line of sight of the detail of theatre usage
- ✓ 5 year people plan in place

Assurance: **Source of Assurance** **3**

- ✓ Performance report
- ✓ Safe staffing audits
- ✓ Turnover and sickness absence rates
- ✓ Quality and Safety Committee and Board and workforce development oversight
- ✓ Agency usage monitoring (within the cap)
- ✓ 50% of areas within target for vacancy percentages

Gaps in Controls:

- C1: Development of new roles
- C2: Resource to support maintenance of number of bank staff
- C3: Efficiency and timeliness of recruitment process
- C4: Role specific recruitment plan
- C5: Succession planning / workforce plans
- C6: Lack of available coaching resources/capability
- C7: Lack of triangulation of management information reporting
- C8: Quantification of risk relating to pension tax changes - potential for clinical staff to drop PAs
- C9: Unknown scale of STP changes
- C10: Recruitment limited by local workforce

Gaps in Assurance:

- A1: Lack of visibility to ward managers of staffing variances
- A2: Management capability review

Corporate Objectives 2019/20 and Board Assurance Framework

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
C1	Development of new roles and training routes for hard to fill roles	Deputy Director of HR	Jul 2019	Nurse Associate places with Chester University now in place and recruiting to a Senior Nurse post to lead the development and management of these roles. HEE funding received.	Completed
C6	Service improvement of recruitment and employment checks processes	Deputy Director of HR	Jul 2019	Recruitment process reviewed and time to hire timescales improved. National Streamlining Programme due to be circulated this month and the Trust will implement this.	Completed
C5	Development of a 5 year workforce plan which will include the identification of critical roles for succession planning purposes.	Deputy Director of HR	~~Jul 2019~~ Sept 2019	Workforce plan has been submitted for RJAH with the system wide workforce plan due to be resubmitted by the end of September	
C10	Recruitment and retention premiums to be explored	Director of People	Jul 2019	Recruitment and retention premiums have been reviewed but the business case does not evidence this is worthwhile due to the low number of vacancies.	Completed
C10	International recruitment to be explored	Director of People	Jul 2019	Participating with HEE on international recruitment, phased approach to be adopted, currently the priority is A&E nurses but Theatre and General Nurses to be progressed in the coming months	Completed
C9, C10	Implementation of the National Streamlining Programme	Director of Performance, Improvement & OD	Dec 2019		

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Finances — OBJ 5

Spending our money wisely

Principal Objective: Develop a more clinically led infrastructure and meeting architecture

The objective will focus on increasing clinical involvement in the leadership and management and review and rationalisation of organisational meetings to ensure they are effective and fit for purpose.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
G	G			G

Objective Details

Opened: April 2019

Reviewed Date: September 2019

Key measures:

- Demonstrable increase in clinically led decisions
- Reduction in non-value added meetings
- Committee effectiveness to be measured

Progress Update:

Clinical chairs appointed

Review of operational meeting structures has been undertaken and a review of sub-committees of the Board committees is underway.

Committee effectiveness assessments in place for Board committees and to be rolled out for sub-committees.

Supporting programmes of work

- How we do business at RJAH
- How to be a great manager at RJAH

Risks

N/A

Lead Director:

Director of People / Associate Director of Governance

Lead Committee

People Committee

Corporate Objectives 2019/20 and Board Assurance Framework

Caring for Finances — OBJ 6

Spending our money wisely

Principal Objective: Achieve and maintain the Single Oversight Framework (SOF) score of 2 and seek to improve underlying measures.

This objective will focus on the use of resources score.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast
3	3			2

Objective Details

Opened: April 2019

Reviewed Date: September 2019

Key Measure:

- Deliver control total trajectory for Income and Expenditure
- Deliver Agency Control total for core agency (Non LLP)
- Maintain cash balances at trajectory and enable repayment of financing commitments

Progress Update:

Currently materially off plan for control total but with recovery plan agreed with some risk of under shoot.

Month 6 data awaited.

Supporting programmes of work:

- Delivery of annual CIP programme supported by:
  - MSK Joint Transformation Board
  - Operational Excellence transformation programme
  - Workforce plan
  - Procurement strategy
  - Capacity alignment
- Delivery of activity and income plan within agreed cost base supported by:
  - Establishment of Co-ordination Centre
  - Capacity alignment

Risks

BAF 6.1	Failure to achieve activity and income target within planned cost base
BAF 6.2	Instability arising from fluctuations in tariff
BAF 6.3	Lack of clear national strategy for the commissioning of our specialist services

Lead Director: Craig Macbeth

Director of Finance

Lead Committee: Finance, Performance and Digital

Finance Performance and Digital Committee

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 6.1 **OBJ 6**

Principal Risk: Failure to achieve activity and income target within planned cost base

Potential impact on Trust's financial stability, inability to grow and invest as required, impact on cash balances, single oversight framework ratings adversely affected

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	2
Likelihood	5	4	2
Total	25	16	4

Risk Details

Opened: March 2018

Reviewed Date: September 2019

Source of Risk: Financial management

Corporate Risk Register? (DX 1604)

Controls:

- ✓ Cost improvement schemes identified to required level for 2018/19 with 20% contingency
- ✓ QIPP schemes identified to required level
- ✓ Carter recommendations embedded in savings scheme discussions
- ✓ Access to good quality benchmark information as per model hospital
- ✓ Daily tracking of theatre bookings
- ✓ Focus on theatre productivity
- ✓ Forward view of availability of LLP sessions and cost of this factored in to financial plan
- ✓ Risks reviewed on a monthly basis and addressed through performance reviews
- ✓ Lessons learned when setting the 2018/19 plan for theatre activity
- ✓ Detailed analysis of bookings process undertaken
- ✓ Mitigations CIPs identified and in place
- ✓ New post identified to track compliance with job planning
- ✓ SOOS KPIs in place

Assurance: **Source of Assurance** **3**

- Monitoring of CIP delivery via Divisional Performance Meetings
- Oversight by Operational Board and Finance, Planning and Investment Committee with mitigating actions identified and monitored
- QIPP monitored by RJAH and CCG at contract meetings
- NHS I oversight
- KPIs monitored via Board
- QIA process in place to ensure quality not impacted
- Planned Care Working Group oversight
- Theatre Recovery Board in place and tracking activity on a weekly basis

Gaps in Controls:

- ~~Further work required on future savings programmes~~
- C1: Demand and capacity modelling to be completed and behind plan
- ~~Uncertainty around compliance with consultant job plans~~
- C2: Reliance on OJP some of which is not based in contract
- C3: Implementation of action plan developed following bookings process review
- ~~SOOS KPIs to be defined~~

Gaps in Assurance:

- A1: Gaps in demand and capacity oversight
- A2: Audit of compliance with consultant job plans

Corporate Objectives 2019/20 and Board Assurance Framework

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
C2, A2	Deliver actions agreed to provide assurance on Consultant Job Plan fulfilment	Director of Performance, Improvement & OD	~~Jun 19~~ Sept 2019	Being tracked as part of response to internal audit with implementation in Q2. Business case for job planning software drafted and due for submission 24th September	
	Review post surgery follow up pathway protocol for delivery of QIPP to limit exposure to risk share	Director of Performance, Improvement & OD	~~Jun 19~~ Sept 2019	MSK Board Terms of Reference being reviewed to include reflection of commissioner requirements	

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 6.2 **OBJ 6**

Principal Risk: Instability arising from fluctuations in the tariff

Year on year fluctuations create a risk of instability, single oversight framework rating and segmentation adversely affected

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	3	3
Likelihood	5	4	2
Total	20	12	6

Risk Details

Opened: November 2016

Reviewed Date: September 2019

Source of Risk: Commissioning contract

Corporate Risk Register? (DX1490, DX1533, DX1602)

Controls:

- ✓ Lobbying to support adverse losses via the NOA
- ✓ Trust actively participating in the development of future orthopaedic tariff as part of costing transformation programme (CTP) pilot scheme
- ✓ NOA and Expert Working Group
- ✓ Strong costing systems locally
- ✓ Participation in tariff engagement
- ✓ Programme of work through NOA to direct appropriate resources for complex procedures
- ✓ Orthopaedic complexity uplift in place
- ✓ Welsh tariff confirmed

Assurance: **Source of Assurance** **3**

- ✓ Local pricing agreements to offset losses based on local PLICS
- ✓ NHS I engagement and recognition by pricing team
- ✓ NOA benchmarking
- ✓ CTP Report
- ✓ Confirmation that no organisation will lose more than 2%
- ✓ Finance Planning and Investment oversight

Gaps in Controls:

- ~~Confirmation regarding the tariff payable by Wales is still required~~
- C1: Transitional funding to be secured for 20/21

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
C1	Lobbying through NOA on tariff losses	Chief Executive / Finance Director	~~Ongoing~~ Jan 20	12 month programme to evidence NOA findings to lobby for inclusion in tariff from 2020/21	
C1	Liaison with National Tariff Team, Case Mix Office and Specialised Commissioning	Finance Director	Jan 20	Regular meetings taking place to clarify position	

Corporate Objectives 2019/20 and Board Assurance Framework

BAF 6.3 CLOSED **OBJ 6**

Principal Risk: Lack of clear national strategy for the commissioning of our specialist services

Risk of fragmentation and risk to sustainability of specialist services, centres of excellence diminished impacting on the quality of patient care for complex cases

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	4	3
Likelihood	4	3	2
Total	16	12	6

Risk Details

Opened: March 2018

Review Date: September 2019

Source of Risk: National and local health landscape

Corporate Risk Register? (DX N/A)

Controls

- ✓ NOA collaboration
- ✓ Engagement with specialist commissioners and NHS England
- ✓ Internal definition and understanding of specialist services with a wider view beyond specialist commissioning
- ✓ Complexity modelling completed
- ✓ NHS Confederation and Federation of Specialist Hospitals collaboration on the role and potential of specialist hospitals
- ✓ Input into Clinical Reference Group for Spinal Injuries

Assurance: **Source of Assurance** **3**

- ✓ Previous national strategy for specialised commissioning
- ✓ NHS I and NHS E oversight
- ✓ Trust strategy
- ✓ STP collaboration

Gaps in Controls:

- C1: Further definition of specialist orthopaedic programme
- C2: Process to address the impact of NHS E procurement for specialised services
- C3: No early warning systems for external providers

Gaps in Assurance:

- A1: No national inclusion of MSK in NHS long term plan 10 year
- A2: Lack of integration between local and specialised commissioning for MSK conditions

Action Plan to Address Gaps

Ref	Action	Lead	Due By	Progress Update	Completed
	Explore opportunities to input into the NHS Confederation and Federation of Specialist Hospitals collaboration	Director of Finance and Planning	Mar 19	Paper has been published on Specialist Hospitals	Completed

Risk Owner:

Director of Nursing

Lead Committee

Finance Planning and Investment Committee

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Month 6 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Principal Analyst and Data Quality Lead	Paper date:	31/10/2019
Executive Sponsor:	Kerry Robinson, Director of Performance, Improvement and OD	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

The Board is required to assure itself that the Trust is providing high quality, caring and safe health care services in accordance with national regulatory standards.

The purpose of the Integrated Performance Report (IPR) is to provide the Trust Board with the evidence of achievement against the national regulatory standards, identification of emerging risks and the assurance that an improvement plan is in place and is effective.

This paper is for information summarising the key performance indicators, highlighting areas of high or low performance for safety, quality, workforce, operational or financial metrics.

The Board is asked to note the overall performance as presented in the month 6 (September) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

The paper incorporates the monthly integrated performance report with associated narrative and descriptions of key actions.

2.2. Summary

In line with the Trust's Performance Management Strategy and Accountability Framework, Board-level Key Performance Indicators (KPIs) which are considered to drive the overall performance of the Trust have been agreed by the committees of the Board and are included in this report.

The Trust remains in segment 2 of the NHS Improvement Single Oversight Framework.

Areas of performance to highlight this month are as follows;

Caring for Staff;

- Absence remains above the 3.75% target at 4.52% being above target for four consecutive.

Caring for Patients;

- No serious incidents for four consecutive months, red rated for the year.
- One never event reported due to an allergy, red rated for the year.
- Patient falls (with moderate or severe harm) has maintained a green position this financial year and is forecast to remain as such for the year.
- A spike in complaints was seen in month six.
- Increase in delayed discharges from 4.75% to 5.26% remains within normal variation
- RJAH acquired E.Coli Bacteraemia has been red rated three month out of six and is rated red for a year end position.
- All cancer waiting times standards met up to August (as reported a month in arrears), a sixth consecutive month.
- Our English RTT open pathways performance is reported at 88.54%, 2.10% behind our trajectory – an updated trajectory is presented in FPD this month following theatre recovery plan impacts.
- No English patients waiting over 52 weeks.
- Both diagnostics standards reported below respective targets. The English diagnostic was 0.01% away from target.

Caring for Finances;

- Improvement in delivered activity through Theatres.
- Outpatient activity ahead of plan in-month but with YTD deficit of 368.
- Financial control total green rated following three months behind plan.
- Improved income position.
- Expenditure remains green for four consecutive months, previously driven by reduction in income, however position sustained for M6 with improved income position.
- Agency core has remained within target for 10 consecutive months. Agency non-core remains above the national target.
-

2.3. Conclusion

The Trust Board is asked to ***note*** the report and where insufficient assurance is received via the responsible sub-committee of the Board, the Board will seek additional assurance.

1. Part One - Public	2. Chief Executive	3. Quality & Safety	4. Performance &	5. Items to note	6. Any Other Business

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THE ORTHOPAEDIC INSTITUTE LIMITED

SUMMARY STATEMENT OF FINANCIAL ACTIVITIES INCLUDING INCOME AND EXPENDITURE ACCOUNT *FOR THE YEAR ENDED 31 MARCH 2019*

The financial reports have been extracted from the audited financial statements for the year ended 31st March 2019.

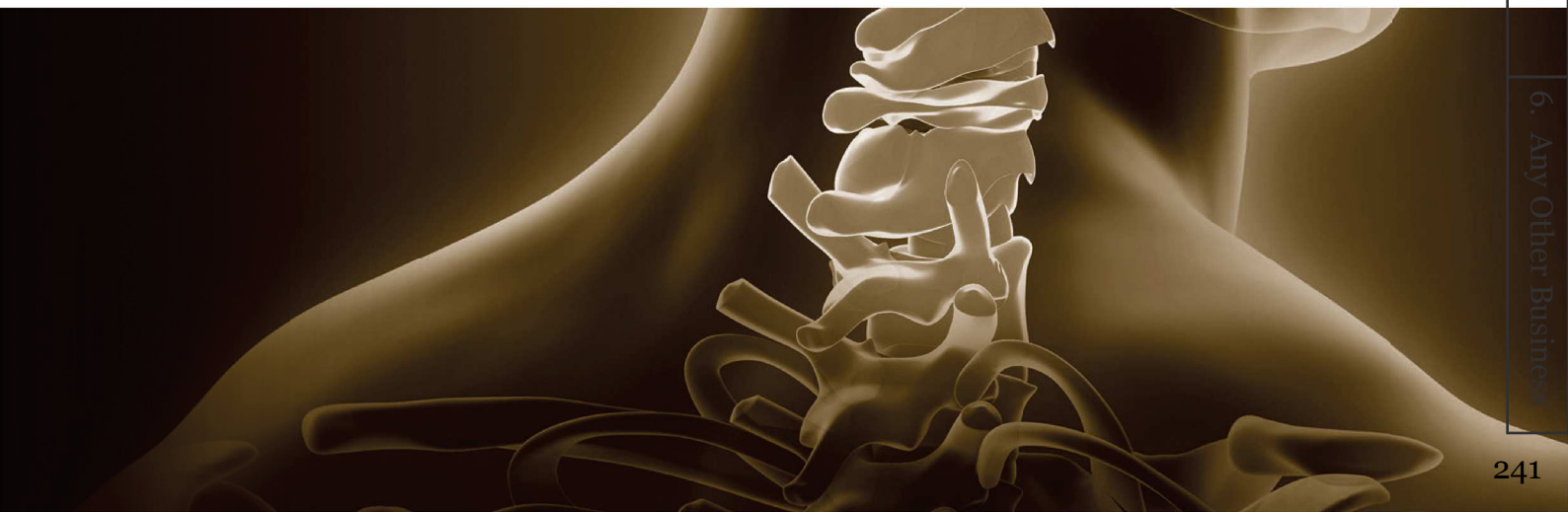
	Unrestricted funds	Designated funds	Restricted funds	Total	Total
	2019 £	2019 £	2019 £	2019 £	2018 £
Income from:					
Donations and legacies	22,987	-	145,265	168,252	96,682
Charitable activities	169,894	-	8,449	178,343	204,370
Investments	50,424	-	-	50,424	54,127
Total income	243,305	-	153,714	397,019	355,179
Expenditure on:					
Raising funds	93,727	-	15,984	109,711	104,724
Charitable activities	273,844	-	44,854	318,698	258,898
Total resources expended	367,571	-	60,838	428,409	363,622

*A full copy available upon request.

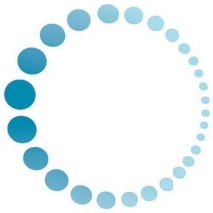
The financial statements were approved by the Trustees on 18 September 2019.
Dr B A Ashton – Chairman
Company Registration Number 02992437
Registered Charity Number 1044960

NATIONAL ORTHOPAEDIC ALLIANCE

ANNUAL REPORT 2018/19



1. Part One - Public	2. Chief Executive	3. Quality & Safety	4. Performance &	**5. Items to note**	6. Any Other Business



NATIONAL ORTHOPAEDIC ALLIANCE

ANNUAL REPORT 2018/19

1. Part One - Public	2. Chief Executive	3. Quality & Safety	4. Performance &	**5. Items to note**	6. Any Other Business

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***Please note – this is a non-statutory annual report and accounts**

Foreword

The National Orthopaedic Alliance (NOA) Board presents the NOA annual report and accounts.

Welcome to the 2018/19 annual report and accounts for the National Orthopaedic Alliance (NOA). 2018/19 was the NOA's first full year following the end of the NHS England vanguard programme, and what a busy year it was. We worked over the year to build ourselves up as a self-sustaining membership organisation and by the end of the year had a total of 18 member organisations.

2018/19 activity was focussed around finalising the NOA quality standards. These standards simplify the myriad of best practice guidance available, into a clear guide of 'what good looks like' in orthopaedic care. The standards cover 28 areas of orthopaedics and are available in the members' area of the NOA website. It is hoped that the introduction of these standards will have a major impact on patient care by giving NOA member organisations the tools they need to deliver quality work.

We also took steps during the year to increase our activity and share best practice initiatives based on member needs – holding our first Cost Improvement Programmes (CIP) workshop in March, 2019.

Early in 2018, the NHS England vanguard programme, which the NOA was funded by, came to an end. The NOA took this opportunity to revamp its brand. We created a new logo to help reinforce the alliance's renewed mission, establish its visual identity and support the spread of its work. Soon after, the NOA launched its new website - www.nationalorthopaedicalliance.co.uk. Work then began on a dedicated members' area which launched in early 2019.

We are pleased with the progress we have made during the year. Interest in being involved with the NOA is growing, and we look forward to continuing our work with members and supporters into 2019/20 and beyond.

Rachel Yates
NOA Director

Mark Brandreth
NOA Lead CEO

Website: www.nationalorthopaedicalliance.co.uk | **Email:** info.noa@nhs.net
Twitter: @NOAOrthopaedics | **Phone:** 0203 947 0849

History

The NOA was originally established as the Specialist Orthopaedic Alliance (SOA), a membership organisation of specialist orthopaedic providers offering benchmarking and buddying for members, and a more powerful voice for the specialty. In 2015, members of the SOA were successful in their bid to create the NOA vanguard through the NHS England New Care Models programme. This enabled the membership to grow and lay the foundation for the NOA as we know it today. Since 2018 when the vanguard programme ended, the NOA has existed as a standalone organisation funded by membership fees - as the SOA had done for ten years before it secured vanguard funding. The NOA is hosted by the Royal National Orthopaedic Hospital (RNOH) who manages the organisation's finances and the majority of its recruitment.

About us

The National Orthopaedic Alliance (NOA) is a membership organisation which brings together orthopaedic centres around the UK to reach a common high standard. We are based on a quality standards membership model founded on evidence-based descriptors of 'what good looks like' in orthopaedic care. The NOA champions to provide opportunities to collaborate across its membership, and offers a forum for members to share experiences and best practice with an aim of delivering consistent, high quality care for patients nationwide.

The NOA is led by the below founder member organisations and is supported by orthopaedic providers across the country:

- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Royal Orthopaedic Hospital NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust (Nuffield Orthopaedic Centre)

Aims & objectives

NOA's aims are to:

- Create a UK wide alliance of orthopaedic providers
- Develop a benchmarking framework showing what good looks like in orthopaedic care and outline the journey to quality improvement
- Act as a primary source of support to our members
- Promote high quality outcomes for patients
- Support our members by providing:
    - Benchmarking services
    - Early information on innovations within the sector and what's coming in terms of national policy that will impact on the delivery of elective orthopaedics
- Ensure our members views and perspectives reach the most appropriate audience and that their voices are heard at a national level

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Achievements

During 2018/19, or key achievements included:

Membership growth and quality

We continued to grow our membership to ensure we have maximum coverage across UK orthopaedic providers. We work with 50% of the top performing trusts according to the NJR top 10 list for procedures recorded during 2018.

NOA quality standards

The NOA quality standards were completed and uploaded to the NOA website members' area during 2018/19. There are 121 standards in total covering 28 areas of orthopaedics.

NOA stakeholders

During 2018/19 we grew our stakeholder database to over 850 members and it continues to grow.

Sharing best practice

At our quarterly meetings, our members have shared best practice in the following areas:

- Moving UKR to a day case pathway
- Orthopaedics in Belfast
- MSK
- Care Home Discharge Process
- ACI Cartilage Repair Surgery
- Tariff
- We have also had presentations on areas including:
- PROMs
- Theatre utilisation

NOA promotion and branding

- We have created a new logo and supporting corporate templates. These were launched in 2018/19 to help support the alliance's renewed mission, establish its visual identity and support the spread of the brand.
- A dedicated NOA website (www. nationalorthopaedicalliance.co.uk) was launched this year and is receiving positive feedback from members. The website's members' area launched thereafter and registration to the area grew steadily with over 50 registered users within a month of launching toward the end of 2018/19.
- When the vanguard project ended we relaunched our twitter profile as @NOAOrthopaedics (changed from @NOAVanguard). Continued social media engagement throughout 2018/19 saw our Twitter followers increase steadily.
- Attendance levels at our events, meetings and workshops continued to grow with some being over-subscribed.

Activities

Activities throughout 2018/19 have included:

- **Cost Improvement Programmes (CIP) workshop**
  One of our founder member organisations, the Royal National Orthopaedic Hospital (RNOH) asked the NOA for help setting up an exercise to share ideas and learning around the identification of CIP schemes for 2019/20. The proposal generated a lot of interest across the NOA membership, and on in March, 2019 the NOA held its first CIP sharing workshop which was a great success. Member organisations shared CIP information which enabled us to have meaningful conversations and produce detailed case studies which are now available to members on request. The CIP working group has already identified and voiced some gaps in available procurement intelligence to support with opportunity identification. The NOA team are supporting in devising ad hoc templates that allow further investigation and transparency of implant costs in addition to the national findings and work in this area. Another action falling from our CIP activity to date is to further investigate the orthopaedic findings within Model Hospital. The Model Hospital, a free digital tool from NHS improvement, supports the NHS to provide the best patient care in the most efficient way. It enables trusts to compare their productivity and identify opportunities to improve – something we want to support our members to do.

- Tariff
  Our work on tariff continued this year. We have led significant detailed research, which explains why we believe existing national tariffs are not fit for purpose for specialist orthopaedic care (carried out in both primary and tertiary centres). Based on the NOA's evidence and analysis, we engaged with NHSE and NHSI during 2018/19 to agree on the need for changes to be made.

- **Clinical Coding**
  The NOA Coding team are now working alongside the GIRFT Clinical Coding Project to deliver many common objectives. As part of this we are running a series of coding events in conjunction of the GIRFT Clinical Coding project team.

- **PROMS Network**
  The NOA and Northumbria Healthcare NHS Foundation Trust started work in 2018/19 to build a National PROMs Network - a space where member organisations can share experience and best practice. The aim of the network is to encourage members to work together to ensure that they, and their patients, are getting the most from PROMs through accurately and effectively capturing information. The network initially launched in orthopaedics in association with the NOA.

- **Bone Tumour Pathology**
  We are in the early stages of setting up a bone tumour pathology network, led by RNOH which aims to shore up bone tumour pathology services across the NHS and provide best practice guidance, recruitment support and capacity management.

- **Procurement**
  The procurement group is working to address issues some members have had working with Category Towers. The aim is to achieve best prices for our members and support data analysis to provide price transparency across our membership for key items e.g. primary THR prostheses. The group is also in contact with the GIRFT Procurement Lead to ensure we stay up to date and can leverage any identified opportunities.

Looking to the future

We believe that the future for the NOA is bright. In the coming year and beyond, we look forward to working on the below and much more.

2019/20 – strategic priorities

NOA's strategic priorities for 2019/20 and beyond are:

- Review and revise the NOA Quality Standards and add new standards pre-admission and post discharge
- Review the NOA literature review
- Develop and deliver workshops, meetings and information to support our members and promote sharing best practice
- NHS Long Term Plan integration - funding from membership fees will enable us to look to the NHS Long Term plan issues that will have an impact on orthopaedics and extract from that to inform our activity. Areas of focus will include:
    - Workforce
    - AI solutions to improve theatre efficiency
    - Continuous improvement
    - More work around CIP programmes
- Continue to:
    - Grow our membership
    - Work with and support NHSI to develop a fairer and more effective tariff for orthopaedic care
    - Support our members with Cost Improvement Programmes (CIPs) by sharing ideas and learning around the identification of CIP schemes for 2019/20 across membership by organising and facilitating a series of workshops
    - Engage with Category Towers and influence procurement for orthopaedics
    - Promote sharing best practice by our members through our meetings and workshops
    - Support bone pathology work across our membership
    - Develop our clinical coding work, building on the workshops and guidelines already produced. This includes:
        - Supporting the NOA tariff steering group and our partners Edge Health to make the case for improved specialised orthopaedic funding based on draft tariffs.
        - Work alongside Getting It Right First Time (GIRFT) to deliver common objectives.

Website: www.nationalorthopaedicalliance.co.uk | **Email:** info.noa@nhs.net
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Financial Update

Income

NOA income from membership fees are £200k

Expenditure

The total expenditure for the period to 31st March 2019 was £167k which included:

Staff costs	£66,000
Meetings and events	£18,000
Consultancy fees	£39,000
Other including: Lead Clinician Lead CEO Finance Director Data Analyst Communications Lead	£44,000
TOTAL	£167,000

There has been no material expense during 2018/19. Any unspent membership fees are always rolled over into the next year to fund bigger projects.

The NOA's expenditure plans for 2019/20 and beyond are:

- Evaluate our performance for 2018/19 – this will include responding to feedback from our members
- Continue to grow our membership – we aim to increase our membership by 10 percent year on year
- NHS Long Term Plan integration - funding from membership fees will enable us to look to the NHS Long Term plan issues that will have an impact on orthopaedics and extract from that to inform our activity. Areas of focus will include:
    - Workforce
    - AI solutions to improve Theatre Efficiency for our members
    - Continuous improvement
- More work around CIP programmes to enable investigation of ideas to prepare our members for business planning 20/21.
- Tariff - continue the work we have been doing on Tariff with an emphasis on Non-Specialist Tariff
- Sharing best practice - continue to promote sharing best practice by our members through our meetings, workshops and webinars
- NOA quality standards refresh - Refresh the existing Quality Standards and add new standards

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Structure, governance and management

Address

Registered Office
Royal National Orthopaedic Hospital
Brockley Hill
Stanmore
Middlesex
HA7 4LP

Email Address
info.noa@nhs.net

Website:
www.nationalorthopaedicalliance.co.uk

Principal officers and related parties

The members of The National Orthopaedic Alliance Board:

Name	Office
• Rachel Yates	*NOA Director*
• Ann Hoey	*NOA Deputy Director*
• Mark Brandreth	*NOA Lead CEO*
• Craig MacBeth	*Financial Lead*
• Peter Kay	*NOA Lead Clinician*

Accountability and reporting arrangements

- The NOA support team will record the proceedings and recommendations of all meetings of the NOA including recording the names of those present and in attendance.
- Minutes of the NOA meetings shall be circulated promptly to all members of the NOA
- The NOA Decision Making Board will be made up of:
    - Robert Armstrong – NOA Lead Chair (until end of 2018/19)
    - Mark Brandreth – NOA Lead CEO
    - Rachel Yates – NOA Director
    - Peter Kay – NOA Lead Clinician
    - Rob Hurd – GIRFT and NOA SRO
    - Ann Hoey – NOA Deputy Director
- The NOA Director will draw to the attention of the Board issues that require disclosure to the full membership or requires executive action.

The decision making Board has decision making powers with regard to the ratification of policies and approval of procedural documents. It will also provide recommendations on risk management and governance for the NOA.

Roles

NOA Support Lead/Team – responsible for administrative, communications and executive services for the alliance

Partnership Board attendee roles

Post	NOA role
Lead Chair	Provide strategic overview and political guidance and are closely involved with interface with parliamentarians (i.e. Ministers and other MPs and Peers) and chairs of other organisations.
Lead Chief Executive Officer	Guide the day to day policy decisions dictating the NOA's activity and provide support, expertise and information from the member trusts as required by the agreed work plan and/or events.
Other relevant directors and managers	In addition to taking participating in the work of any relevant sub-groups and to provide the relevant expertise as required.

Membership

Founding Members

- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Royal Orthopaedic Hospital NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust (Nuffield Orthopaedic Centre)

Fee Structure

The annual fee structure is as follows:

Single Trust	£10,000 per annum
Group/Collaboration of Trusts	£15,000 per annum

Fees will be invoiced 1st April

Each year the NOA will ask for all members' agreement on a forecast budget that lays out membership costs and likely expenditure. Founding members will also share the cost of additional, agreed, expenditure that arises

Sub-groups

Clinical *(led by Peter Kay)*

The Clinical Sub-group will own, oversee and report on the following work streams.

- A programme and process for outcomes evaluation.
- Develop proposals, and recommend sources of information, for the creation of briefing papers for a wide range of clinical and political audiences.

Finance *(led by Craig MacBeth)*

The Finance Sub-group will own, oversee and report on the following work streams.

- A series of benchmarking exercises, including reference costs and income.
- Regular procurement, clinical coding and cost-saving programme audits, reports and workshops.
- Tariff

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