The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 26.09.19

MEETING
26 September 2019 09:30

PUBLISHED
25 September 2019

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	26/09/19		09:30
1. Part One - Public Meeting			
1.1. Minutes of the Previous Meeting (July 2019)		All	09:30
1.2. Matters Arising		All	
1.3. Declarations of Interest		All	
1.4. Staff Story - Great Wall Marathon (Presentation)		Rob Fox	09:35
1.5. MSK Population Health (Presentation)		Geraint Thomas	09:50
2. Chief Executive Update		Chief Executive	10:05
3. Quality & Safety			
3.1. Chair Report: Quality and Safety		Non Executive Director	10:15
3.2. Chair Report: People Committee		Non Executive Director	10:20
3.3. Freedom to Speak Up Report		Director of Nursing and Hilary Pepler	10:25
3.4. Clinical Audit Annual Report		Medical Director	10:35
3.5. Guardian of Safe Working Hours		Medical Director	10:40
3.6. Consultant Appraisal Report		Medical Director	10:45
3.7. CQC Update		Trust Secretary	10:50
3.8. Workforce Race Equality Standard Annual Report		Director of People	11:00

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	26/09/19		09:30
4. Performance & Governance			
4.1. Chair Report: Finance Planning and Digital Committee (verbal)		Non Executive Director	11:10
4.2. Performance Report M5		Director of Performance, Improvement and OD	11:15
5. Items to note			11:35
5.1. Board Timetable		Trust Secretary	
5.2. STP Update		Chief Executive	
5.3. EU Exit Briefing		Director of Finance and Planning	
5.4. Performance Report M4		Director of Performance, OD and Improvement	
5.5. Governors Update (verbal)		Trust Secretary	
6. Any Other Business		All	11:50
6.1. NHS Capital Funding in 2019/20			
6.2. NHS Oversight Framework			
6.3. Questions from the Public			
6.4. Next meeting: 28th November 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
25 JULY 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 Bloomfield	Interim Director of Nursing	SB

In Attendance:

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

FC welcomed all Board members to the Public Board.

MINUTE NO	TITLE
25/07/1.0	**APOLOGIES** Sarah Sheppard and Alastair Findlay
25/07/2.0	**MINUTES OF THE MEETING 27 JUNE 2019** The minutes of the meeting held on the 27 June 2019 were agreed as an accurate representation of the meeting
25/07/3.0	**MATTERS ARISING** FC went through the actions which were noted to be completed or updates provided.
25/07/4.0	**DECLARATIONS OF INTEREST** PK confirmed he had been appointed as independent Safeguarding Chair for Dudley
25/07/5.0	**CHIEF EXECUTIVES THANK YOU** MB advised that before making his intended thank you he was sad to announce that a member of the catering team, Aisha Parish had died Aisha Parish and invited the Board to join a minutes reflection MB invited members of the Housekeeping and Catering Team to the Board in order that he may publicly extend his thanks and congratulations to them for delivering the best food. Further the Housekeeping Team were top in the country for cleanliness. The teams have consistently performed at the top year after year and a lunch was going to be held as a way of saying thank you for their hard work. FC commented that these teams are seen as a first point of contact for patients and their families so not only are they great ambassadors externally but internally for patients too.
25/07/6.0	**PATIENT STORY** SB welcomed the Bloor Family and advised that Eleanor had been a patient on Alice

	ward so was attending to share her story but that the Board would also hear her family's experience. Eleanor explained how she had been transferred by ambulance from University Hospitals North Midlands (UHNM) following a traumatic spinal cord injury. She was on bed rest for 6 weeks on Alice Ward where she received treatment, care and daily physiotherapy. She went in hydro pool, had school lessons with Helen and played with play co-ordinator. She found all the staff were friendly and wanted to do their best. Suzanne the Ward Manager had let her bring in her dog, Helen the Ward Teacher had helped her keep up with her school work And Holly the Play Coordinator was kind and patient. Eleanor explained she found it very quiet at the weekends and the play facilities outside were limited and the garden could be improved. The view was very grey and made her room feel dark and sad. Her family travelled from home and stayed overnight and the bathroom facilities were limited. The family room was good and appreciated. She admitted to being fussy with food and her family therefore brought her homemade meals. The family kitchen facilities were limited but her family were allowed to us the electric hob as she was a long term patient. Her only other comment was that a dishwasher would have been good. Mrs Bloor advised that the family had organised a walk to raise funds for Alice Ward as they would like to see the garden environment improved. Also, they are looking at reality goggles to make the experience of going to Theatre less frightening for children. FC commented that the Board hears patient stories every month and they are a real highlight and he always enjoys hearing the experiences of patients as they provide important feedback. DG asked about the Wi-Fi and Mrs Bloor advised this was ok. MB noted the comments about the family bathroom and advised that since Eleanor's inpatient stay the Trust has opened a new bathroom and shower facility. He also advised that there was a new garden being built for spinal cord patients and whilst children are not taken onto the spinal cord injury unit it would be good to think of a way patients with spinal cord injuries but who are not being cared for on the ward can access the garden. Mr Bloor thanked the hospital. PK asked if the hospital could change one thing what would it be and Eleanor responded the play facilities. She also advised that the green wall on the ward made her feel a bit funny after coming back from Theatre. Mrs Bloor explained that UHNM was very modern and given the good reputation of the Trust they had been expecting a modern environment however the room Eleanor stayed in was very dark. The nursing and medical care however was excellent. The weekends very quiet which was sometimes a challenge. MB advised that Eleanor was an unusual case as most paediatric patients are home for the weekend and it was for that reason it was important she was able to bring her home here. Mr Bloor advised that they had Eleanor's younger sister to think about as well. The Bloor family provided details of the sponsored walk they were organising and advised that they have raised £3000 so far.

	The Board thanked the Bloor family for sharing their story.
	STRATEGY AND POLICY UPDATES
25/07/7.0	**CHIEF EXECUTIVE UPDATE** MB provided an update on the following: • Welcome to Geraint Thomas, Lecturer in Population Orthopaedics, he will be attending a future Board to give a presentation. • It was the birthday of the NHS on 5 July. MB thanked the league of friends for organising popcorn and candyfloss And for the 'It's a Knockout Games' held in the main entrance • The Trust celebrated Armed Forces Day with the reservists • A new parents bathroom has been on Alice Ward paid for by the League of Friends and they have also supported the refurbishment of Cottage 3 • Hilary Garrett, Deputy Chief Nurse for NHS I and E visited the Trust and presented her vision of the long term plan for nursing. She also presented the Chief Nursing Officer silver medal to Ann Bishop, the first paediatric nurse in the country to receive such an award • Thanks extended to the Executive Team for diligence and hard work, working outside of portfolio to help and improve the Trust's performance position. • Fundraising continues to go well for the Veterans Appeal, with some fundraising opportunities being explored with national charities and Smith and Nephew. • Congratulations to Victoria Hall, Assistant Practitioner in Pre-Operative Assessment who was the Health Hero winner for the month The Board ***noted*** the update.
25/07/8.0	**QUALITY AND SAFETY COMMITTEE CHAIR'S REPORT** CB highlighted the following: • There had been good discussion at the Committee regarding the monitoring of deaths. It was noted that unexpected deaths are very unusual but that they get tracked and monitored. • The Committee reviewed the Histopathology action plan which was a complex and involved piece of work. He had the privilege of visiting the laboratory after the meeting. • The Committee received the Inpatient Survey Results and noted the good progress being made and the areas of focus for the year ahead. The Board ***noted*** the Chair's Report.
25/07/9.0	**Q&S ANNUAL REPORT** SR outlined the process for assessing the effectiveness of the Committee and confirmed that the results had been presented and agreed by the Committee. CB added that a survey had been undertaken of a small number of members with some areas for improvement identified but not anything significant. The main takeaway was the need to rotate the agenda to allow equal time for agenda items over the course of the year and this will be taken forward. The Board ***noted*** the report.
25/07/10.0	**SAFEGUARDING ANNUAL REPORT** SB presented the report and commented that the Trust as fortunate to have two experienced safeguarding leads. SB highlighted the following areas:

	• Good systems in place • There is an improving training compliance picture with a plan in place to ensure continued improvement • Board safeguarding training has been completed • A new clinical lead is in place for adult safeguarding, Mr Budithi • PK is the NED lead for safeguarding and is a national expert SB highlighted a particular future challenge regarding changes to the deprivation of liberty safeguards and advised the Board that there will be a lot of work to do to ensure compliance. PK commented that it was a thorough report. He felt that the Mental Capacity Act changes are going to challenge the entire system and will start at the age of 16 not 18. He was satisfied that the Trust was well prepared The Board ***noted*** the Safeguarding Annual Report.
	QUALITY AND SAFETY
25/07/11.0	**INFECTION CONTROL ANNUAL REPORT** SB presented the report and highlighted the following: • Additional support has been put into the team with an extra surveillance nurse to broaden screening activity • Another good year for infection prevention with no cases of MRSA. • There has been a reduction in E.coli but this needs to remain an area of focus There are growing issues around ESBL with chronic long term patients at a higher risk. There have been no instances of cross infection but the risk is well recognised. Thank you to CM and Capital Management Group for the estates work carried out on MCSI to further reduce risk of cross infection. • The Infection Prevention and Control Committee continue to meet for which SB is the chair. This has seen increased attendance. • There have been challenges with surgical site infections but the increased surgical site infection surveillance cover will support the work on this. • Consideration to now be given to how the tissue viability provision can be increased as the Trust is accepting more patients with complex wounds and infections. • Cleanliness audits show that patients rate the hospital highly so thanks extended again to the domestic and housekeeping teams. FC-commented on the significant contribution the housekeeping teams make to patient health and wellbeing in terms of infection prevention. DG commented on the increased flu vaccine uptake and asked when the flu campaign starts again. SB confirmed it would start in September. Karin Evans, the Practice Development Senior Nurse has developed a plan and SB is meeting with her soon to go through this. SB will be looking at what additional measures can be taken as a result of the feedback from staff as to why they did not have the vaccine. MB commented on the quality validation audit and in particular the results for TSSU and Orthotics. MB confirmed the TSSU refurbishment scheme is well underway and there have been issues with the Orthotics environment at Shrewsbury hospital however new accommodation has been found. It is anticipated that these actions will improve the results going forward. HT commented that the performance has been outstanding, particularly the year on year

	trends and national benchmarking. He was disappointed to see doctors bottom of the list for bare below the elbows. SB acknowledged this and advised that there have been discussions around what can be done to improve this going forward. CB asked about isolation facilities and whether it solves the problem. SB advised that it is a safe outcome as will enable the cohorting of patients. In the longer term more side rooms will be needed as this is a national issue relating to infection prevention and control. MB confirmed the doors were fitted yesterday. The Board ***noted*** the report.
25/07/12.0	**LEARNING FROM DEATHS REPORT** SW presented the report and explained that the Trust has very few deaths and most are expected in light of the medical ward which cares for patients who may be on an end of life pathway. So far this year, two expected deaths have been carefully reviewed by the Learning from Deaths Lead with no issues or concerns identified. The Learning from Deaths Lead has taken an interest in the system provision and is looking to meet with other organisations in the STP to look at how learning can be shared cross organisationally. HT commented that he was surprised that the swan palliative care work is not referenced and SW confirmed that he would look into that further. **ACTION: SW to look at the inclusion of the Swan palliative care work in the report** The Board ***noted*** the report.
25/07/13.0	**PROMS PERFORMANCE OVERVIEW** SW presented an overview of the Trust's PROMS performance and how the benchmarking comparisons have been undertaken • Comparator data presented for Knees and Hips. Adjusted post op scores show that the Trust ranks highest for both hips and knees • Evidence of gradual and continuous improvement PROMS Performance Presentations PK asked if whether given the small number reporting deterioration it is possible to dig into the data further. SW confirmed that this is already done. CB congratulated SW and his colleagues for the results. He commented that the hospital is about more than just hips or knees and therefore what assurance was there around other specialties e.g. spines. SW advised there is the British Spinal Registry and so data will start to come from there and there is also also independent data to be shared regarding foot and ankle. The Board ***noted*** the overview.
25/07/14.0	**CHAIRS REPORT FROM AUDIT COMMITTEE** DG highlighted the following: • There was review and discussion regarding the Board Assurance Framework. The Chair of Risk Committee and he felt that there would be a strengthened review if combined meeting was held at the beginning of the year so it has been agreed that SR will build this into future plans. • The Committee received an update on the fraud action plan. The fraud prevention did not previously meet the regulatory guidance and as such an action plan was pulled together to address the gaps. • Focus on the monitoring of preparation for Brexit.

	The Board ***noted*** the Chair's Report
25/07/15.0	**CHAIR'S REPORT FOR FINANCE PLANNING AND DIGITAL COMMITTEE** In the absence of AF, DG highlighted the following: • The Board will be aware from national reports the pressure on the NHS capital programme and the fact that NHSI and E are looking at how system wide capital programme savings can be identified. The Trust has identified a £150k contribution. • A large part of the meeting was spent discussing operational performance. Given the shortfall at the end of Q1, an additional meeting has been put in place in August to review the performance of July. The Executive Team are focussed on mitigations and will review these in due course for impact. The Board ***noted*** the Chair's Report.
25/07/16.0	**CHAIR'S REPORT FOR RISK MANAGEMENT COMMITTEE** HT highlighted the following: • The meeting was attended by Jan Greasley as Lead Governor. • The Committee noted the continued improvement in the process and management of risk within the Divisions. Appropriate citation of risks now in place. • The age of risks is being well managed • Actions and mitigations are appropriately up to date • Consistency across the Divisions has much improved and the cross divisional attendance has been reported back as useful. • This month the Committee received deep dives in to Theatres, Surgery, Diagnostics and Medicine. • The Risk Appetite was discussed and it was agreed this should be reviewed from an internal perspective and from a system perspective. It is recommended that the Board review this in due course • The Board Assurance Framework was reviewed and it was agreed there would be additional time allocated to this at the next meeting to allow for a deep dive. • Internal audit report was considered • Risk Management Report was received with significant improvements in risk management performance noted so the Committee felt that reporting could now be by exception The Board ***noted*** the Chair's Report
	PERFORMANCE AND GOVERNANCE
25/07/17.0	**PERFORMANCE REPORT – MONTH 3** KR presented the M3 performance report and highlighted the following: • Sickness absence had increased but was in line with trajectory • Staff turnover data has been updated retrospectively following a data quality review • Falls have increased in M3 but remain within the control range • Cancer waiting times have been met for 3 consecutive months • The list size has grown but by less than 1% • No English patients waiting over 52 weeks • Diagnostic waits remain a challenge • Theatre activity remains a challenge and is impacting on the financial position *Caring for Staff* PK asked about the 'other known causes' in relation to sickness absence and SS confirmed that there is a national system for the categorisation of sickness absence. The team are looking to increase understanding of why the Trust has so many recorded

	as 'other'. SS drew the Board's attention to performance in relation to turnover which is encouraging. FC commented on the triangulation of sickness and turnover and that it gives a mixed message and KR advised that the link is visible when you look at the hotspots that have been identified. MB commented that it in one of strategy sessions it would be worth looking at the triangulation of the performance data. **ACTION: Data triangulation to be included in a future agenda for the Strategy Board** *Caring for Patients* SB highlighted the following: • Review of the falls data has been undertaken despite it being within the control range. Having looked at falls in last month have had a few more non inpatient falls • Good month for infection prevention and pressure ulcers • Friend and Family Test results have improved back to usual levels. SW highlighted the following: • No unexpected deaths • VTE performance on target NJ presented the following: • Theatre activity was below plan in June with extensive discussion at the Finance Planning and Digital Committee. It is forecast that activity will also be below, below plan in July and the Finance Planning and Digital Committee has been taken through the key drivers. A weekly Theatre Delivery Board has been put in place to focus on immediate actions and working through the more medium term actions with full executive team and divisional management engagement. HT asked whether delayed discharges have any impact on theatre activity. NJ confirmed that the Trust does not have bed capacity issues in relation to surgical beds. *Caring for Finances* CM highlighted the following: • Lost trajectory against the control total by £0.5m • Income shortfall as a result of shortfall in theatre activity. • Anticipating July will deteriorate further but August is recoverable. • The focus is on stabilising the issues to remove blockages • A recovery plan is being formulated and will be taken to the Finance Planning and Digital Committee in August. MB confirmed that there will be an extraordinary meeting in August given the seriousness of the position The Board ***noted*** the Performance Report.
25/07/16.0	**GOVERNORS UPDATE** SR advised that the Governor elections were underway and that the outcome would be announced at the next Board.

	The Board ***noted*** the update
25/07/17.0	**AOB** SR raised the Pensions Proposal that had been discussed during a previously held Remuneration Committee. FC provided an update regarding the Trust's response to the treasury pension changes. FC outlined the potential impact this could have on the Consultants and Senior Staff and confirmed the Trust is considering options to assist with the impact of this through flexible working options. FC confirmed that no formal decisions had been made but asked the Board to note that it is on the agenda and a fully worked up proposal will be presented to a further Remuneration Committee in September for sign off. FC confirmed that he is participating in a sponsored walk on 21 September on behalf of the Orthopaedic Institute.
	DATE OF NEXT MEETING IN PUBLIC: Thursday 26 September at 9.30 in the Meeting Room 1.
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

25 JULY 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 In progress
30/05/5.0 VOLUNTEER STORY Memorial books and benches to be explored with the Interim Director of Nursing Option of a taxi phone at the main entrance to the hospital to be explored with the Director of Finance	Director of Nursing Director of Finance	Benches being selected in partnership with the Estates Department This is being progressed. The phone will have several contacts one of which will be a taxi firm
30/05/6.0 WOMEN IN SURGERY SS to look at interview panels and take recommendations to People Committee	Director of People	Balance of panels now considered by the Chief Executive as part of new appointments process
30/05/15.0 PERFORMANCE REPORT – MONTH 1 SS to include actions and impact on trajectory in next the narrative of the IPR next month.	Director of People	Completed
Actions from Last Meeting	**Lead Responsibility**	**Progress**
25/07/12.0 LEARNING FROM DEATHS REPORT SW to look in to including the Swan Palliative Pathway in the learning from deaths report	Medical Director	Current reporting is in line with National Quality Board guidance on Learning from Deaths. An update on the Swan Palliative Pathway will be presented to the Quality and Safety Committee.
25/07/17.0 M3 PERFORMANCE REPORT Data triangulation to be included in a future agenda for the Strategy Board	Director of Performance, Improvement and Organisational Development	On the agenda for the next Strategy Board

Chair's Assurance Report
Quality and Safety Committee (19th September 2019)

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	26th September
Executive Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance and Quality
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 the Board of Directors and what input is required?

This paper presents an overview of the Quality and Safety Committee Meeting held on 19 September 2019 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of patient safety and quality to the Quality and Safety Committee. This Committee is responsible for seeking assurance on the quality and safety of the services it delivers in order that it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended
- The quality report for the month was from the Surgery Division
- The committee discussed the NICE Guidance and Clinical Audit Annual Report
- The committee received an update on the STAR, TSSU, Histopathology and Patient Experience

2.3. Conclusion

The Board is asked to note the meeting that took place and the assurances obtained.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Quality and Safety Committee which met on 19 September 2019. A full list of attendees is outlined below:

Chair/ Attendance:
Membership:
Chris Beacock, Non-Executive Director (Chair)
David Gilburt, Non-Executive Director
Paul Kingston, Non-Executive Director
Hilary Pepler, Board Advisor
Mark Brandreth, Chief Executive
Sarah Bloomfield, Interim Director of Nursing
Shelley Ramtuhul, Trust Secretary
Nia Jones, Director of Operations
Attendees:
Mary Bardsley, Assistant Trust Secretary
Nicki Bellinger, Deputy Director of Nursing
Alyson Jordan, representing the Surgery Divisional Manager
Lindsay Leach, Governance Lead
Apologies:
Steve White, Medical Director

3.2 Actions from the Previous Meeting

The Committee received the actions from the previous meeting. An update was provided on those outstanding actions. The committee will receive an update on the Controlled Drug Accountable Officer Report, an audit has been scheduled which will be presented to the committee in November.

3.3 Key Agenda

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
NICE Guidance Annual Report		
The committee received the clinical audit annual report. The following was highlighted: • 219 guidance's issues with 4 being applicable	Partial	Further assurance is to be presented on the relevance and scrutiny of the NICE Guidance

to the Trust • 2 guidance's are currently being audited • Currently 43 guidance's need to be assess for relevance to the Trust. The committee discussed the process on reviewing the NICE Guidance's and the committee asked for further assurance on this. The committee noted the annual report.		which are applicable to the Trust. The committee requested the NICE Guidance compliance tracker is to be presented to the next meeting.
Clinical Audit Annual Report		
The committee received the clinical audit annual report. The following was highlighted: • Good attendance at the both MDCAM meetings and the Clinical Audit Committee • An audit of audits has been completed which has outlined some areas for improvement, an action plan is currently being developed • 2 NICE Guidance's have been audited • The clinical audit forward plan has been incorporated into the annual report for information The committee discussed the ongoing debate over cemented and non-cemented replacements. It was agreed that further information would be shared to the Board through GIRFT and not a local clinical audit. The committee noted the annual report.	Y	
Infection Control		
Overall the Trust has reported a positive Q1. The committee received the report and the following was highlighted: • 0 MRSA bacteraemia • 0 MSSA bacteraemia • 2 E-coli bacteraemia • 0 C.difficile The committee was informed the annual PLACE audit is scheduled and there is an expected change within the process. A report on the findings will be shared once available. Further discussions are to be held with the Ludlow ward manager to ensure bare below the elbows and hand hygiene tolerance remains acceptable. A risk assessment has been completed on safe sharps due to increase in incidents. The information will be shared with the risk management committee. The committee discussed the Trusts microbiology cover due to recent sickness. Concerns have been raised predominantly within in the Arthroplasty firm	Y	

due to the gap. The Trust is seeking support from other organisations as it is not essential for a microbiologist to be onsite.		
Patient Experience		
The committee received the patient experience report for Q1. The Trust reported a total of 20 complaints and 321 PALS contacts. There has been no cause of concern regarding these figures. The Trust identified the closure rate and response rate to complaints are to be improved. There were no incidents raised with the Ombudsman. Overall patient feedback remains positive and a 1 year review on the meridian system is to be completed. The committee were informed that the CQC are increasing asking for specific correspondence to complaints. The Trust explained there could be a potential increase in complaints recorded due to a change within the process. The organisation has agreed that a PALS concerns should be resolved within 1 week before escalating to a complaint. The committee noted the quarterly report.	Y	
Serious Incidents		
The committee was advised that there is currently 1 incident open on STEIS, which was reported in September. The committee discussed the complex never event. The committee were assured the Trust continue to support the patient and family member throughout the investigation. The Trust has discussed the incident with the CCG, to which they have agreed with the Trusts handling appropriately. The committee sought assurance that duty of candour had been exercised. Further details are expected to be shared with the Board in November. The committee noted the update.	Y	
Harms Assessment		
The committee received the quarterly update on the cancer and RTT breaches. It was noted there has been one breach of the Welsh 52 week standards – no harm was identified. The committee were reminded that the report excluded BCU patients. The committee were informed that were would not be a financial penalty for this.	Partial	The Trust is to be provided to the October Strategy Board to provide information and assurance on the follow up back log of patients including the

Chair's Assurance Report
Quality and Safety Committee (19th September 2019)

The committee was informed a process is to be put in place regarding the back log of follow up patients, further discussions with the surgical team is required. An update is to be provided to the October Strategy Board to provide information and assurance. The committee members raised concerns with regards to the back log figures increasing. The Trust explained an agreement is needed not only within the Trust but the CCG. The Arthroplasty firm have identified a total of 380 patients which will be discharged without harm. The Trust continues to provide a monthly update to the CCG.		Harms Assessment.
Histopathology Action Plan		
The committee received the monthly update on the Histopathology action plan. The committee were informed that there are currently 4 red actions due. It was discussed that the reviewing of documents is still ongoing but not completed due to staff annual leave and sickness. The Trust is dedicated to reduce the actions and it was noted the progress made. The committee were informed the Trust is expecting an inspection within Quarter 3.	Y	
TSSU Update		
The committee were informed the development remains on track for completion and it's currently progressing well. The committee praised the staff for their continued hard work and it was noted no out sourcing has been required. The progress will be shared weekly through social media and through the committee.	Y	
STAR Assessment		
The Trust has been receiving the STAR Assessment which is a ward and department accreditation system. A workshop was held in August with good attendance from senior nurses. The workshop included the review of the current STAR framework and discussions on improvements across the organisation including: • a continuous improvement system instead of an annual presentation • embed the performance indicators • make the system electronic. The committee noted the update.	Y	

Chair's Assurance Report
Quality and Safety Committee (19th September 2019)

Surgery Quality Report		
The committee received the Surgery Quality Report for discussion. The committee discussed the following: Safe staffing – there remains a 3.88 WTE gap within the nursing vacancies. The staffing associated risk is to be reviewed. STAR – there has been an update to the national guideline, with the focus being critical care. The committee asked for further information on the list of clinical audits for the division and queried the overdue action plans. The information will be shared at the next meeting under matters arising. Harms – there have been no harms within the division The committee note the quality report.	Y	Further information is to be provided on the clinical audit and the associated overdue action plans
CQC Action Plan		
The committee received an update on the CQC Action Plan and noted that all actions were on track for completion with no issues to raise. Further work is to be completed on the Accessible Standards and written information available to children in different languages. The committee noted the update.	Y	
Integrated KPI Report		
The committee received the integrated KPI for review, the following highlights were discussed: Pressure Ulcers - It was noted there has been a rise in pressure ulcers; however this remains within the Trusts tolerance rates. The Trust is encouraged to be more proactive, senior nurses are discussing the rise with ward managers to raise awareness. Safe Staffing - The figure remains good. Delayed Transfers of Care – Transfers from surgical areas remain a concern. The Trust has sourced external advice with regards to bed management. There was one expected death. The committee were informed a monthly learning newsletter is to be circulated across the organisation. The committee approved the Quality and Safety aspects of the Performance Report ahead of discussion at the Board.	Y	
Work plan 2019/20		
The committee received and approved the work plan for the future meetings. It was noted a NICE Guidance Compliance Tracker	N/A	

Chair's Assurance Report
Quality and Safety Committee (19th September 2019)

would be presented at the next meeting (October) in order to provide further assurance to the Board.		
Chairs Reports		
The committee received and consider the following Chair Reports: *Research Committee* The committee were informed the action plan regarding the ASCOT Trial has now been completed. The Clinical Trial Quality Policy will be presented to the Policy committee for formal approval. It was noted the local SOP are approved by the Research Committee. *Clinical Governance and Quality Committee* The committee were informed the committee will be revised. The meeting will be co-chaired by the Director of Nursing and Associate Medical Director.	Y	

3.5 Risks
During the course of its business on 19 September 2019, the Committee did not identify any risks for escalation.

3.6 Approval
During the course of the meeting, the committee approved the following:

- Work plan 2019/20
- Performance Report for Quality and Safety items for discussion at the Board of Directors meeting.

3.5 Any Other Business
The Trust was congratulated on the recent Improvement Champions Events which shared learning and improvement projects across the organisation. It was suggested some of the projects are to be presented to the Board.

3.7 Conclusion
The Board of Directors is asked to note the meeting that took place and the assurances obtained.

Chair's Assurance Report
People Committee 11th September 2019

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	26th September 2019
Executive Sponsor:	Paul Kingston, Non-Executive Director	Paper Category:	Governance and Quality
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 the Board of Directors and what input is required?

This paper presents an overview of the People Committee Meeting which was held on 11th September 2019 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's Caring for Staff performance to the People Committee. People Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate governance structures, processes and controls in place throughout the Trust to:

- Promote excellence in staff health and wellbeing
- Identify, prioritise and manage risks relating to staff
- Ensure efficient and effective use of resources

2.2 Summary

- The Trust held the second People Committee meeting
- The meeting was well attended
- The work plan was reviewed and further agenda items are to be incorporated into the plan
- Discussions were held regarding the Guardian of Safe Working Hours and the Freedom to Speak Up Guardian
- HR Metrics and Performance data was considered by the Committee

2.3. Conclusion

The Board is asked to note the meeting that took place and the assurances obtained.

Chair's Assurance Report
People Committee 11th September 2019

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 8th May 2019. The meeting was quorate with two Non-Executive Director and one Executive Director in attendance. A full list of the attendance is outlined below:

Chair/Attendance:
Members
Paul Kingston, Non-Executive Director (Chair)
Chris Beacock, Non-Executive Director
Harry Turner, Non-Executive Director
Kerry Robinson, Director of Performance, Improvement and OD
Sarah Sheppard, Director of People
In Attendance
Hilary Pepler, Board Advisor
Sue Pryce, Head of People Services
Shelley Ramtuhul, Trust Secretary
Liz Hammond, Freedom to Speak Up Guardian
Chris Marquis, Guardian of Safe Working Hours
Ruth Longfellow, Associate Medical Director

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting held in May and that all were completed.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declaration of Interest		
There were no announcements regarding declarations of interest.	N/A	
Guardian of Safe Working Hours		
The committee received the quarterly report outlining the Trust's performance in relation to safe working hours. The Guardian advised the committee that there had been no exceptions reported. The Guardian advised the committee that there is work underway to look at formalising the electronic reporting of exceptions through Allocate and also there were plans to link with the Freedom to Speak Up Guardian. The committee sought assurance regarding long term vacancy management and the Guardian confirmed that regular exceptions	Y	

Chair's Assurance Report
People Committee 11th September 2019

reports would prompt a job plan review aimed at addressing the gaps. The committee felt it would be useful going forward to have an indication of which vacancies are being tolerated and which are being mitigated.		
Freedom to Speak Up Annual Report		
The committee received the report and an update from the Freedom to Speak Up Guardian regarding the Trust's ongoing work. It was noted that there continues to be a focus on promoting the role and informing staff how they can raise their concerns. The committee was advised that it has low reporting with only 8 concerns raised since February although nationally reporting is increasing and therefore the Trust should expect to see an increase in reporting rates. The Freedom to Speak Up Guardian advised that the majority of reports have been anonymous and this can hinder the ability to investigate. Talks are being given to new staff regarding the importance of providing a name in confidence. The committee noted that October was 'Speak Up' month and there would be a campaign around this. The committee noted there had been a stepped change in the role of the Freedom to Speak Up Guardian and the Trust's Guardian was thanked for her hard work. The committee sought assurance regarding the Trust's reporting rates and felt that benchmark data would be useful. It was agreed this would be reviewed after one calendar year of the substantive Freedom to Speak Up Guardian put being put in place. The committee ***noted*** the report.	Y	Further benchmark data to be presented to the committee in the future
Divisional / Unit People Information		
The committee considered what information it would require from the Divisions (new Units) going forward and it was agreed that the operational information goes to the Performance Review Meetings and that a Chair's Report from the these meetings would provide the required assurance.	N/A	
Workforce Race Equality Standards Annual Report		
The committee received the Workforce Race Equality Standards Annual Report. It was noted that there were two areas that required additional focus: Bullying and harassment Appointment and shortlisting of BME staff The committee discussed the statistical analysis needed to understand these results further and it was agreed that these would be presented back to the next committee. It was noted that the WRES Team had predicted where Trusts should be and that this would be worth analysing in relation to the Trust. It was recommended to the committee that an Equality Diversity	Y	Equality Diversity and Inclusion Group to be established. Consideration to be given to a Non Executive Lead

Chair's Assurance Report
People Committee 11th September 2019

and Inclusion Group be established to take forward the required actions and enable the committee to provide assurance to the Board. The committee agreed this recommendation. Further the committee discussed consideration of a Non Executive Lead for the equality, diversity and inclusion agenda. The committee ***noted*** the report.		
Staff Experience		
The committee receive a paper outlining the work being undertaken to improve staff experience and there was an action plan outlining the implementation. The committee ***noted*** the work being undertaken and was supportive.	Y	
Employment Briefing		
The committee was advised that going forward it would receive updates on disciplinary actions being – given the sensitive nature this information would have to be limited and shared in confidence. The committee noted the current position with regard to staff disciplinary action and was assured that the Trust's policy was being complied with and that staff supported as required.	Y	
HR Metrics		
The committee considered the HR metrics and noted a request to change the calculation for turnover %. The data has been audited by the Information Team as part of the Data Quality Audits and it is recommended the data is calculated using WTE rather than head count. The committee approved the change in calculation. In addition the committee was advised there would be a change going forward with the topics included in the mandatory training figures as the reporting will be aligned to the core skills framework. The committee ***noted*** the updates.	Y	
Committee KPIs		
The committee reviewed the KPIs and particularly noted the sickness absence, vacancy rate, turnover, training and appraisal performance. The committee was advised that there had been a significant amount of work on sickness absence management and a new policy was going to the Joint Consultative Group in the following week. This will ensure staff are supported whilst sick, further the committee heard how the focus of the performance review meetings has shifted from implementation of the sickness policy to preventing staff sickness. The committee considered that a staff story regarding an experience sickness absence management would be helpful. The committee **noted** the KPI report.	Y	
CQC Action Plan		
The committee received an update on the CQC actions that sit within its remit and noted that these were either all completed or on track.	Y	

Chair's Assurance Report
People Committee 11th September 2019

The committee **noted** the report.		
CQC Action Plan		
The committee received the CQC actions which are aligned to the committee for information. The action plan will remain a standard agenda item and a tracker will be shared with the Board of Directors highlighting actions which are outstanding. The committee **noted** the CQC Action Plan.	Y	
Committee Work Plan		
The following amendments were required to the work plan: • Removal of divisional deep dives as this information will come from the Performance Review Meetings • Sub Group Chairs Reports to be added for the Equality Diversion and Inclusion Group and Staff Experience Group The committee **approved** the committee work plan in line with the above suggestions.	Y	
Committee Attendance Matrix		
The committee attendance matrix was shared for information only.	Y	

3.4 Approvals

The committee received no items for approval.

3.5 Risks to be Escalated

In the course of its business the Committee identified no risks for escalation.

3.6 Conclusion

The Board of Directors is asked to note the meeting that took place and the assurances obtained with regard to the format and remit of the Committee going forward.

Freedom to Speak Up Update

0. Reference Information

Author:	Elizabeth Hammond Freedom to Speak Up Lead	Paper date:	26th September 2019
Executive Sponsor:	Sarah Sheppard, Director of People	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	People Committee 11/09/2019 Board of Directors 26/09/2019	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to People Committee and what input is required?

The information is shared with the People Committee for information.

The committee is asked to **note** the Freedom to Speak Up report.

Freedom to Speak Up Update

2. The Main Report

2.1. Introduction

From the 1st February 2019 Liz Hammond has been employed for 7.5 hours a week as the Freedom to Speak Up Guardian for the Trust. Hilary Pepler and Jan Greasley are also Guardians at RJAH.

Since February the Guardians have been trying to promote the role by sending out information, via communicate, about the role and who the Guardians are.

The three main points which the Guardians are promoting are:-

1. Who the Guardians are
2. What concern can be raised
3. How to raise the concern.

Concerns can be raised about malpractice, risk or wrong doing that is harming the service we deliver.

This covers unsafe patient care, unsafe working conditions, inadequate training or induction of staff, lack of or poor response to a reported patient safety issue, suspicion of fraud or a bullying culture(across a team or organisation not individual cases)

Staff can raise their concerns either:-

- Directly with one of the Guardians
- Via the email;- Rjah.freedomtospeakup@nhs,net
- RJAH App. Either on apple stores or google play.

Since February I have been giving talks to all new staff about the role. During the next 12 months we will be arranging and visiting staff in their departments to explain the role and make staff aware of who the Guardians are.

Since February we have received and dealt with 8 concerns, unfortunately the majority of them have been received anonymously. This had made it difficult to give feed back or support those who raised the concerns.

Feedback is very important and the Guardians will be sending out, via communicate, an update to all staff about changes which have been made as a direct result of raising their concerns via FTSUG.

National, as the Guardian role is developing, concern reporting is raising. This year 6,274 concerns have been raised to NHS Guardians Nationally.

The National Guardian's Office asked Freedom to Speak Up Guardians in all trusts and foundation trusts for information on Freedom to Speak Up cases raised with them in the fourth quarter of 2018/19 (1 January to 31 March 2019). The latest results are set out in the attached table and reveal that 97 per cent of trusts have provided data this quarter.

Freedom to Speak Up Update

Q4 Data headlines

3,406 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions

928 of these cases included an element of patient safety / quality of care

1,312 included elements of bullying and harassment

122 related to incidents where the person speaking up may have suffered some form of detriment

506 anonymous cases were received

5 trusts did not receive any cases through their Freedom to Speak Up Guardian

220 out of 227 NHS trusts sent returns

Who is speaking up?

Based on the information provided, most cases were received from nurses:

Nurses

29%

Administrative / Clerical workers

15%

Allied health professionals (other than pharmacists)

13%

Other*

13%

Healthcare assistants

9%

Doctors

8%

Corporate service staff

Freedom to Speak Up Update

5%

Cleaning/catering/maintenance/ancillary staff
5%

Midwives
1%

Pharmacists
1%

Board members
<0.5%

Dentists
<0.5%

*includes health visitors, union reps and anonymous reports

0. Reference Information

Authors:	Claire McKechnie-Mason & Amanda Roberts	Paper date:	26th September 2019
Executive Sponsor:	Mr S White, Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	Mr C P Kelly, Consultant Clinical Audit Lead	Paper Ref:	N/A
Forum submitted to:	Quality and Safety Commiytee 19/09/2019 Board of Directors 26/09/2019	Paper FOIA Status:	Full

1. Purpose of Paper

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

For approval

2. Executive Summary

2.1. Context

This paper includes details on Clinical Audit Activity over the last financial year and a copy of the Clinical Audit Forward Plan as an appendix to this paper.

2.2. Summary

This paper states the National Audits we have been involved in, all NICE Guidance that has been audited, details of the Multi-Disciplinary Clinical Audit Meetings, and how many approved proposals and reports we have had in the last financial year. This paper also states what actions have or are being undertaken resulting from clinical audits and quality improvement projects.

2.3. Conclusion

We are asking the Trust Board members to read and approve the Clinical Audit Annual Report ahead of publication on the document centre.

3. The Main Report

3.1. Introduction

The report summarises the clinical audit activity for 2016/17. It provides an overview of the strategic, operational and developmental work that has been undertaken.
Main Title Clinical Audit Annual Report

3.1.1. Sub heading Overview of Clinical Audit Activity
3.1.2. Sub Heading Clinical Audit Committee
3.1.3. Sub Heading The Multi-Disciplinary Clinical Audit Meetings
3.1.4. Sub Heading National Institute for Health and Clinical Excellence (NICE) Guidance
3.1.5. Sub heading National Audits
3.1.6. Sub heading Action Planning
3.1.7. Sub heading Improvements through Clinical Audit and Quality Improvement
3.1.8. Sub heading The Year Ahead and Further Challenges

3.2. Associated Risks

None

3.3. Conclusion

The Trust Board are asked to read and approve the contents of this paper ahead of it being disseminated on the Document Centre-RJAH Intranet.

Appendix 1: Acronyms

NICE	National Institute for Health and Clinical Excellence
HQIP	Healthcare Quality Improvement Partnership
SCI	Spinal Cord Injury
DMD	Duchenne Muscular Dystrophy
CAC	Clinical Audit Committee

Clinical Audit Annual Report

2018/2019

Prepared by:

Claire McKechnie-Mason, Governance Lead for Medicine & Rehabilitation and Clinical Audit Lead

Amanda Roberts, Governance Assistant for Medicine & Rehabilitation & Diagnostics Divisions

On behalf of:

Mr S White, Medical Director

Mr C P Kelly, Consultant Clinical Audit Lead

3.1 Introduction

This report summarises the clinical audit activity for 2018/19. It provides an overview of the strategic, operational and developmental work that has been undertaken.

The last twelve months have presented challenges in terms of the organisation and administration of Clinical Audit due to the reorganisation of the Governance Department. There is no longer a dedicated audit facilitator role, though a Clinical Audit Lead – Claire McKechnie-Mason – has been appointed. Each Governance Lead and their Assistant is now responsible for the audits that are proposed and undertaken in their Division. The Governance Lead who is now responsible for Clinical Audit has promoted an increased focus on risk, incidents, and complaints in terms of our audit strategy and the restructure of the Governance Department should facilitate this further. She is updating the Clinical Audit Strategy for the Trust in line with the Clinical Audit Policy. Governance Leads and Clinical Audit Leads are committed to the improvement of our current strategy and endeavour to meet the new challenges with energy and creativity.

Last year clinical audit focused on using a technique called SNAP audits which are designed to capture a snap shot of patients quickly to determine if there are any concerns or risks that need immediate attention. This year we plan to continue with this piece of work.

Under the leadership of Lindsey Leach, Governance Lead for Corporate Services, we are in the process of undertaking an audit of audits to ensure our clinical audit process is working correctly using the full audit cycle. It will also identify any areas of weakness/concern within this area of governance. We will have a focus on involving Junior Doctors in Clinical Audit and Quality Improvement projects and training staff in Clinical Audit using our external training provider- Clinical Audit Support Centre. This year sees the Clinical Audit continue to focus on more realistic time frames for the completion of clinical audits and quality improvement projects. We also have increased interaction with Clinical Audit Leads ensuring that the unit meet with all leads on a regular basis or have regular interaction via email.

The department has a strong commitment to education and to providing all staff with the opportunity to access training. Last year we ran two Clinical Audit and Quality Improvement training days, facilitated by external trainers, which were well attended. There is a plan to increase the number of Clinical Audit and Quality Improvement training days we are able to offer staff across the Trust and details of this will be released in due course.

3.1.1 Overview of Clinical Audit Activity

Projects are categorised depending on their 'drivers' or rationale, which in turn inform the importance that can be given to each. The audit programme consists of national, strategic, Trust division driven projects and Service Evaluation projects which describe the allocated priority in line with HQIP guidance.

The Consultant Clinical Audit Lead and the Divisional Governance Leads are active in raising the profile of audit throughout the Trust and incorporating the Trust corporate objectives into projects.

Through the development and utilisation of the clinical audit programme, the department has provided substantial emphasis, support and expertise to clinicians and other staff in conducting high quality audit projects. All audits now have recommendations and a realistic and achievable action plan in place to ensure that any identified issues are resolved and improvement to the quality of patient care that the Trust provides implemented. Governance Leads follow-up and monitor these action plans to ensure their implementation. Re-audits are carried out when necessary to ensure we have improved our services and successfully addressed identified issues through Clinical Audit.

3.1.2 Clinical Audit Committee

The Clinical Audit Committee, chaired by Mr C P Kelly; Consultant Clinical Audit Lead or Mr A Bing; Consultant Orthopaedic Surgeon meet every 3 months and review all recently approved proposals, completed reports and action plans, as well as any other clinical audit-related activity.

Last year there was a change in the structure of the Clinical Audit Committee and we have now reduced the number of committee meetings from 6 per year to 4. This allows us to minimize any disruption to clinical services for the purposes of these meetings. Although we planned to have a non-executive director Chris Beacock involved in the last year, we have instead secured the involvement of Julie Roberts, Assistant Director of Nursing and Governance. Julie is keen to contribute to the process, helping us to choose appropriate and useful projects that will benefit patient care and the organisation. We also now have the Associate Director of Strategy and planning (Kerry Robinson) and Trust Secretary (Shelley Ramtuhul) that have joined the Clinical Audit Committee recently to whom are also strong links to Risk and Safety. Please see appendix 6 for the attendance of the meetings.

3.1.3 The Multi-Disciplinary Clinical Audit Meetings (MDCAM)

The Governance Department is committed to raising the profile of clinical audit and quality improvement projects within the Trust. With this in mind a bi-annual clinical audit presentation event is held to share best practice across the organisation. All staff members are invited to attend the event and staff who have completed audits are invited to present their findings and discuss their learning experience. This event is very well-attended by clinicians, non-clinicians

and the senior management team and generates a lot of discussion and learning. The Clinical Audit Committee has linked in with the Risk Management Committee and the Health and Safety Committee to ensure we focus on risk and incidents that occur at RJAH.

Staff who undertake Clinical Audit projects are encouraged and supported to present their findings to a multi-disciplinary audience. The Trust continues to encourage all staff to participate in the meetings and limit clinics and operations to facilitate this.

During 2018/19, 2 Multi-Disciplinary Clinical Audit Meetings were held. One chaired by Mr Kelly, Clinical Audit Lead, was held on 2nd May which was attended by 91 people and one chaired by Mr Bing on 6th November, which was attended by 80 people. A list of the presentations from the meetings can be found in appendix 3.

3.1.4 National Institute for Health and Clinical Excellence (NICE) Guidance

All published NICE guidance is reviewed monthly by Mr P Jermin, Consultant Anaesthetist/Consultant NICE Guidance Lead. All new NICE Guidance is also sent to monthly divisional meetings for discussion and to identify whether it is of relevance to the division. Any identified relevant guidance is sent to the specialist clinician in that area for a baseline review to be completed. A plan of action to improve the service is defined and implemented if it is found that we are not fully compliant with the national standard.

A baseline assessment/Statement of local practice was carried out for guidance's relevant to the Trust and where appropriate audits were undertaken to measure compliance are put in place. Audits that are being carried out or have been carried out in 2018/19 in relation to NICE guidance include:

- Patient Group Direction Policy Audit MPG 2
- Assessing and document the risk of venous thromboembolism CG 92
- National Rheumatology Audit CG 79, QS 33
- Reaudit Urological Service Provision CG 148
- Physical Activity in Children aged 5-18 PH 17
- Reaudit of Pneumonia in adults CG 191
- Medications prescription and dispensing for inpatients at MCSI NG 5
- Evaluation of incidence of DVT in patients undergoing lumbar fusion surgery QS 29
- Botox administration in Children with Cerebral Palsy CG 145
- Reaudit of Acute Kidney Injury among In-patients CG 169

3.1.5 National Audits

National clinical audit is designed to improve patient outcomes across a wide range of health conditions. Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

Although the majority of the national audits commissioned are not relevant, the Trust participated in the following national audits during 2018/19:

	Eligible to participate	% cases submitted
National Joint Registry	Yes	N/A
Elective Surgery (National PROMS Programme)	Yes	N/A
National Confidential enquiry-Chronic Neurodisability	Yes	100%
National Confidential enquiry-Perioperative Diabetes	Yes	100%

3.1.6 Action Planning

Good practice in Clinical Audit requires an action plan that is supported by the team with named individuals who take responsibility. Our 'action planning software' tracks the progress of actions to ensure we do what we say we do in order to complete the audit cycle and precipitate improvement in patient care. It is a Trust requirement to complete an action plan if corrective action is as a result of a clinical audit and, where appropriate, agree a date for reaudit. The Governance Team has implemented a system for tracking the progress of each action plan to ensure that the Clinical Audit cycle is completed in a timely manner. This year will see focus on the department ensuring actions are Specific, Measurable, Achievable, realistic and timely (SMART) to ensure excellent patient care is being adhered to.

3.1.7 Improvements through Clinical Audit and Quality Improvement

In the past year we have continued to encourage the teams to engage in Clinical Audit and Quality Improvement projects that are directly related to serious issues in the Trust, such as clinical incidents are other areas at risk highlighted to us by the clinical risk committee. We have continued to have difficulties engaging staff in the process of clinical audit at a time of staff shortages and continued increased demand on staff time. Although many of our staff are allocated time for clinical audit through Supporting Patient Activity (SPA) and others have no direct allocation of time for this process. Despite these difficulties we've had some excellent projects that have been presented to us with robust action plans and evidence of improvement of practice and patient care. The following three projects are examples of excellent practice.

A few examples of improvements made through clinical audit and quality improvement are below:

1. **Reaudit of National Joint Registry Data Capture at RJAH.**
    - The reaudit demonstrated that for total shoulder replacement (TSR) and total

elbow replacement our rates of compliance with NJR data entry have improved from the previous audit. All patients who underwent TSR had valid consent documented in NJR as opposed to 89% compliance in 2014. However 4 patients had incorrect entries (92% compliance) as opposed to 58% compliance in 2014

- Total Elbow replacement demonstrated 100% compliance to data entry as opposed to 70% in 2014 however 1 (12.5%) patient did not have a signed consent which was the same in 2014 audit.

2. **Reaudit of Date of surgery following referral of a patient with an ACL tear**
    - The aim of this audit was to asses if the Oswestry Sports Knee Department meets the required standards following implementation of the recommendations from the previous audit. The standard of care was for patients with an anterior cruciate ligament (ACL) tear is surgical reconstruction within 3 months from the time of injury.
    - Patients received ACL reconstruction within 3 months of decision to treat in 80% of cases. In 2013 53% of patients met this criterion
    - Patients had a definite diagnosis of an ACL tear at the time of surgical listing in all cases-this was not measured in 2013 audit.
    - Patients had an MRI scan of their knee prior to surgery in all cases. In 2013 66% of patients met this criterion.

3. **Reaudit of patient experience in the pre-operative assessment unit *Service Evaluation***
    - The majority of patients having planned surgery at RJAH are required to attend the pre-operative assessment (POA) clinic. The patient visit may take some time it is therefore in our interest to keep patient dissatisfaction with the process, facilities, and time taken for their attendance to a minimum. The initial Service Evaluation of this area was undertaken in 2015 – this is the re audit which focussed on obtaining further patient feedback of the process since implementation of the original recommendations.
    - The Overall experience was rated as higher in 2017 than 2015 (56% of patients' v 42%).
    - Most patient responses showed an increase in satisfaction, especially around communication, information sharing and interaction with staff.
    - There was an increase in satisfaction around waiting times and time of entire process.
    - There was an increase in satisfaction with the environment and facilities.
    - Average time spent in pre-op assessment clinic had decreased slightly between 2015 and 2017, with an increase in "face time" (where patients are actually seeing a staff member) and a reduction in "dead time" (where the patient is merely

waiting).

3.1.8 The Year Ahead and Further Challenges

Key objectives for forthcoming year:

1. Ensure that the Trust is fully compliant with the requirements of the National Clinical Audit and Patient Outcomes Programme, CQC Essential Standards of Quality and Safety, all relevant published NICE guidance, and GIRFT recommendations.
2. Locally agreed standard audits and service evaluations should be based on a strategic approach towards the types of audits that are undertaken so that they focus on the main Governance areas of risk, Datix incidents and complaints and contribute to the Trust Values.
3. Audits focused on quality, completion of the audit cycle and most importantly actions that result in improvement of patient safety, quality, and experience. For example, improving systems by ensuring that documents, policies, and procedures are updated based on the learning from clinical audit activities.
4. Ensure effective patient and public engagement in the whole audit process through active patient participation in an audit project.
5. Improve visibility of clinical audit learning by sharing across the Trust and improve visibility of Multi-Disciplinary Clinical Audit Meeting presentations by sharing across the Trust.

Appendix 1 - Clinical Audit Proposals approved in 2017/2018 & 2018/2019

Division	Priority 1		Priority 2		Priority 3		Priority 4		Priority 5	
	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19
Theatres	3	0	0	0	0	0	0	1	6	1
Surgery	2	0	2	0	0	1	10	7	2	8
Medicine& Rehabilitation	10	4	3	2	1	0	5	5	11	4
Corporate	2	0	0	0	0	0	2	3	2	0
Diagnostics	0	0	3	2	0	0	1	4	4	4
Paediatrics	N/A	3	N/A	0	N/A	0	N/A	4	N/A	3
Totals	**17**	**7**	**8**	**4**	**1**	**1**	**18**	**24**	**25**	**20**

Appendix 2 - Clinical Audit Reports approved in 2017/2018 & 2018/2019										
Division	**Priority 1**		**Priority 2**		**Priority 3**		**Priority 4**		**Priority 5**	
	2017/18	**2018/19**	**2017/18**	**2018/19**	**2017/18**	**2018/19**	**2017/18**	**2018/19**	**2017/18**	**2018/19**
Theatres	1	0	0	0	0	0	0	0	0	4
Surgery	1	2	0	0	0	3	4	3	6	2
Medicine& Rehabilitation	8	1	0	2	0	0	1	1	9	7
Corporate	0	0	0	0	0	0	0	0	0	1
Diagnostics	0	0	0	1	1	0	0	1	3	1
Paediatrics	N/A	1	N/A	0	N/A	0	N/A	0	N/A	0
Totals	**10**	**5**	**0**	**3**	**1**	**3**	**5**	**5**	**18**	**15**

Appendix 3

Presentations from the Multi-Disciplinary Clinical Audit Meeting 2nd May 2018

- Introduction
- Morbidity and Mortality Statistics
- Morbidity and Mortality Case Presentation
- Surgical Antibiotic Prophylaxis in Primary Joint Replacement
- Reaudit of Lead Gowns
- Human Factors
- Audit to review outpatient X-Ray requests
- Duty of Candour Survey
- Introduction of the Edmonton Frailty Score to improve patient outcomes
- Datix
- Acute Kidney Injury Audit

Appendix 4 – Attendance Figures for MDCAM meetings

Year	Attendance
2003	115
2004	52
2005	128
2006	110
2007	114
2008	No meetings
2009	148
2010	148
2011	212

2012	159
2013	159
2014	73 *
2015	89
2016	149
2017	139
2018	171

*Only one meeting was held in 2014/15 – Unfortunately the November meeting was cancelled

Appendix 5 – Clinical Audit Forward Programme 2019/20

What is Clinical Audit?

'Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria… Where indicated, changes are implemented…and further monitoring is used to confirm improvement in healthcare delivery.'

Principles for Best Practice in Clinical Audit (2002, NICE/CHI)

Clinical Audit is an integral part of the clinical governance framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic care against explicit criteria and the implementation of change.

All clinical staff will be expected to provide evidence of their clinical audit activity. For consultants evidence obtained from clinical audit will also form part of their individual portfolio for revalidation. However, it is important that all professional groups undertake audit of their practice in order to assure high standards of care for our patients.

In the light of clinical issues new audits will be added to this forward plan if required.

Clinical audit (CA) in 2018/2019 was very productive and 40 new audits and 7 re- audits were completed. Unfortunately as usual some audits never made it to completion and there was a cull of 8 audits which failed to progress according to Trust Guidelines. We continue to encourage valued multi-disciplinary audits which are of high priority to the Trust. Progress towards a timely report and useful Action plans is constantly monitored. We encourage staff to engage with us especially if they encounter problems.

Last year we had 2 successful Multi-Disciplinary Clinical Audit Meetings (MDCAM) in April and November. The format remains the same with Mortality and Morbidity discussion and presentation of some of the most useful audit projects during the previous year. During the year we had 18 presentations with discussion.

Progress with the "Audit of Audits" has been slow in 2018 due to staffing issues but we are on track to complete this valuable work before summer. It should guide us in defining any weaknesses of the process in order to make further improvements.

2019 brings changes in the staffing and management structure around Clinical Audit and is now in process of implementation. We now have Directorate management taking responsibility for CA. This should create closer links to Directorate Risk management and so promote more useful audit topics. Also we expect improved monitoring and facilitation of projects. We continue to use the CARMS (Clinical Audit Registration and Management System) and thank staff for their compliance with this paperless process of registration and monitoring. We hope that this re organisation will re invigorate CA in 2019.

We welcome back Amanda Roberts from maternity leave who now is Governance Assistant for the Medical and Diagnostics Division. During her absence CA was astutely managed by Carol Roberts and Lynda Reid and we thank them both for keeping us on track. In the restructure of the Governance Department, a new Clinical Audit Lead, Claire McKechnie-Mason, has been appointed. We welcome the other new staff in this new structure. It involves the following individuals working closely with the Clinical Audit Lead Mr Cormac Kelly, all of whom will sit on the Clinical Audit committee working together promoting Clinical audit as a vehicle for Quality improvement.

DIRECTORATE	Governance Lead	Governance Assistant
Medicine	Claire McKechnie-Mason	Amanda Roberts
Surgery	Sara Fox	Carol Roberts/Ashling Donohue-
Theatres	Judith Sansom	Julie Humber
Diagnostics	Alison Harper	Amanda Roberts
Corporate &	Lindsey Leach	Janet King

The Clinical Audit committee met 4 times last year (March, June, September and December). Current membership of the committee includes:

Clinical Audit Lead for RJAH	Mr Cormac Kelly
Clinical Audit Lead F&A	Mr Andy Bing
Governance Lead-Clinical Audit Lead	Claire McKechnie-Mason
Governance Assistant	Amanda Roberts/Janet King/Carol Roberts/Ashling Donohue-Harrison/Julie Humber
Assistant Director of Nursing and Governance	Julie Roberts
Patient Panel Member	Post Open
Statistics Analysist	Jan Herman Kuiper
CCG Representative	Post Open
NICE Guidance Lead for RJAH	Paul Jermin
Clinical Audit Leads	S.Gummaraju / S.Lewthwaite / R.Lalam / A.Bing / N.Kumar / P.Kandapalli / R.Freeman / S.Roberts / B.Balain / L.Sharp / S.Ho / R.Amarasena / I.Hanif
Risk Management Committee rep	Non-Executive C.Beacock/K.Robinson/S.Ramtuhu

Priority Table

All of our clinical audit and quality improvement projects are prioritised using guidance from the Healthcare Quality Improvement Partnership (HQIP); please see table below:

HQIP	
Priority 1	National requirements, including those identified for inclusion in the Quality Account
Priority 2	Internal must do audits
Priority 3	Directorate priority audits
Priority 4	Locally agreed standards
Priority 5	Service evaluations

As well as using the HQIP prioritising guidelines, we incorporate the Trust's strategic priorities to our projects; they are as follows:

Robert Jones and Agnes Hunt Orthopaedic Hospital	
Priority 1	*Operational Excellence*
Priority 2	*Local Musculoskeletal Services*
Priority 3	*Specialist Work*
Priority 4	*Culture and Leadership*

Monitoring

The Governance Leads/Assistants will be monitoring the forward plan as follows:

- Monthly clinical audit progress reports are sent to the clinical audit leads/divisions containing information regarding planned, accepted and overdue projects.
- All projects are discussed with the clinical audit committee (quarterly meetings) consenting with members who include healthcare professionals and patient panel representative on proposals, reports and action plans.

Trust Corporate Objectives

Within Clinical Audit and Quality Improvement we ensure that at least 1 Trust corporate objective are reflected in every project:

1. *Delivering timely access to patient care*

2. *Delivering outstanding outcomes and experiences*
3. *Achieving outstanding patient safety*

Main Key Risks

We have incorporated at least 1 main key risk into each project. The main key risks are:

1. Caring for patients
2. Caring for finance
3. Caring for staff

New activity to be undertaken in April 2019-March 2020

Corporate Services Division (including involvement from: Information, Wards, Patient Panel and Resuscitation)

Project Title	HQIP Priority (1-5)	Division	Audit Lead	Project Lead	Driver	Estimated Start Date	Trust Strategic	Main Key
Reaudit of Butterfly Scheme Service Evaluation 2019	5	1 & 2	1	Anne Worrall	Anne Worrall		Service	June
Reaudit of Outcome Data collection for Upper Limb Unit 2019	5	1 & 2	1	Samantha Davies	Mr C P Kelly		Evaluation	June
Audit of Serious Incidents Action Plans	4	Julie Roberts		Julie Roberts	Local Standards	April 2019	1, 2 & 3	1 & 3

Medicine and Rehabilitation Division (including involvement from: Rheumatology, Physiotherapy, MCSI, Paediatrics and Pharmacy)

Project Title	HQIP Priorit	Division Audit	Project Lead	Driver	Estimated Start	Trust Strategic	Main Key Risk
Reaudit of the communications of the decision to prescribe antimicrobials in orthopaedic infections	2	Sarah Norris	Imran Hanif	Clinical	May 2019	1, 2 & 3	1, 2 & 3
Reaudit of Sexual Disorder among men with SCI	5	Mr Kumar	Mr Kumar	Service Evaluation	October 2019	1	1
Assess the prescribing and interventions of intravenous vancomycin at RJAH Hospital	4	Craig Booth	Imran Hanif	Local Standards	September 2019	1, 2 & 3	1 & 2
National Rheumatology Audit	1	Dr R Amarasena	Dr R Amarasena	National Guidelines	April 2018	1, 2 & 3	1 & 2

Reaudit of Management of older persons with new spinal cord injury at MCSI	1	Mr K Kumar	Mr J Chowdhury	MASCIP		2 & 3	1
Reaudit of Heart Failure NICE Guidance 187	1	Dr S Ho	Dr Al-Washash	NICE Guidanc	April 2019	2 & 3	1
Reaudit of Delirium among in-patients	1	Dr S Ho	Dr K Hmon	NICE Guidance	**August**	2 & 3	1
Reaudit of Acute Kidney Injury among In-patients	1	Dr S Ho	Dr P Kandepalli	NICE	August 2019	2 & 3	1
Pharmacy Intervention Audit	1	Imran Hanif	Helen Downes	CQC		2 & 3	1
Outpatients Turnaround Times Audit	1	Imran Hanif	Wendy Mayne	CQC		1, 2 & 3	1
To Take Out (TTO) Turnaround Times Audit	1	Imran Hanif	Wendy	CQC		1, 2 & 3	1
VTE Policy and Anti Coagulation Audit	4	Imran Hanif	Supriya Kapas	Local Standards		2 & 3	1
Reaudit of Accuracy of discharge information to GPs	4	Imran Hanif	Kennita Myers	Local Standards		1, 2 & 3	1 & 2
Reaudit of compliance to NICE TA 383	1	Dr R	TBC	NICE		2 & 3	1 & 2
Physical Activity in Children aged 5-18	1	Sam Dawson	Claire George	NICE	June 2019	1, 2 & 3	1
Rheumatoid Arthritis in over 16's NICE Guidance NG 100 & Quality Standard 33	1	Dr R	TBC	NICE		1, 2 & 3	1 & 3
Upper GI bleed audit NICE Guidance	1	Dr S Ho	Dr Prasanth Kandepalli	NICE	May 2019	2 & 3	1

Surgery Division (including involvement from: upper limb, foot and ankle, arthroplasty, spines and sports knee)

Project Title	HQIP Priority (1-5)	Division Audit Lead	Project Lead	Driver	Estimated Start Date	Trust Strategic Objecti	Main Key Risk
Reaudit of day case anterior cruciate reconstruction	3	Mr A Barnett	TBC	Directorate Standards	TBC	2 & 3	1
NICE CG 92-Venous Thromboembolism: reducing the risk	1	Mr A Barnett	TBC	NICE Guidance	TBC	2 & 3	1
Reaudit of Plain Film Radiographs with GP referrals to elective lower limb orthopaedics	4	Mr A Barnett	TBC	Local Standards	TBC	2 & 3	1
Reaudit of Day Case ACL Reconstruction	3	Mr A Barnett	TBC	Directorate Standards	TBC	2 & 3	1
National Joint Registry Consent Rate Unknown	4	Mr A Barnett	Mr P Gallacher	Local Standards	TBC	2 & 3	1 & 2
Reaudit of Peri-Operative management of arthroplasty patients receiving warfarin therapy	4	Mr S Lewthwaite/Mr Karlakki	Junior Doctor	Local Standards	August 2019	2 & 3	1
Reaudit of Enhanced Recovery	4	Leighann Sharp	Junior Doctor	Local Standards	August 2019	2 & 3	1
Reaudit of Adequacy and accuracy of recording drug allergy status on EPR discharge summaries	4	Mr S Lewthwaite	Junior Doctor	Local Standards	August 2019	2 & 3	1
Reaudit of the standards of operation notes on scarf osteotomy	3	Mr A Bing	TBC	Local Standards	TBC	2 & 3	1
Reaudit of the evaluation of foot and ankle patient information leaflets	5	Mr A Bing	Jane Herbert	Service Evaluation	TBC	2 & 3	1
Are patient's co-morbidities being recorded correctly? Foot and Ankle with coding	5	Mr A Bing	Registrar	Service Evaluation	TBC	2	2
Adequacy of peripheral venous cannula (PVC) documentation	4	Mr M Ockendon	Mr G Manoharan	Local Standards	TBC	1, 2 & 3	1 & 3

Assessment of neurological deficit after surgery to relieve lumbar canal	5	Mr B Balain	Mr G Manohara	Service Evaluation	TBC	1, 2 & 3	1 & 3
Incidence of deep vein thrombosis in patients undergoing lumbar fusion surgery	5	Mr S Chitgopkar	Mr Chitgopkar	Service Evaluation	TBC	1, 2 & 3	1 & 3
Incidence of revision surgery for adjacent disease (ASD) after primary cervical surgery	5	Mr S Chitgopkar	Mr Chitgopkar	Service Evaluation	TBC	1, 2 & 3	1 & 3
Antibiotic prophylaxis in spinal surgery	5	Imran Hanif	Kieran Bentick	Service Evaluation	TBC	1, 2 & 3	1 & 3
Compliance of VTE assessment in foot and	4	Mr A Bing	Mr N Makwana	Local Standard	TBC	1, 2 & 3	1 & 3
Consent and Co-operation for National Registry for ACL Reconstruction Patients	4	Mr A Barnett	Gaynor Kanes	Local Standard	TBC	1, 2 & 3	1 & 3
Reverse Shoulder Arthroplasty patient	5	Mr C P Kelly	Mr M Ghandi	Service Evaluation	April 2019	1, 2 & 3	1 & 3
Reaudit of Outcome of Shoulder Decompression	4	Mr C P Kelly	Mr Amit Chaturvedi &	Local Standard	April 2019	1, 2 & 3	1 & 3
Short Stem Arthroplasty in Rheumatoid Arthritis, Radiological Review	5	Mr C P Kelly	Mr Robert Jordan & Mr Potter	Service Evaluation	April 2019	1, 2 & 3	1 & 3

Theatres Division (including involvement from: Anaesthetics, Recovery and Theatre)

Project Title	HQIP Priorit	Division Audit Lead	Project Lead	Driver	Estimated Start Date	Trust Strategi	Main Key Risks
Sepsis: recognition, diagnosis and early management	1	Dr S Gummaraj	Dr J Neil	NICE Guidance	TBC	2 & 3	1 & 2
Reaudit of Anaesthetic Record Keeping	4	Dr S Gummaraju	Dr Yaschik	Local Standards	April 2019	2 & 3	1
Reaudit of the Availability and use of colour coding	1	Dr S Gummaraju	Dr R Patil	RCoA	July 2019	2 & 3	1
Reaudit of Appropriateness and effectiveness of the care provided to diabetics for surgery	1	Dr S Gummaraju	Dr S Gummaraju & Dr P Kandepall	CQC Standards	June 2019	2 & 3	1

Reaudit of Paediatric recovery satisfaction evaluation	5	Leighann Sharp	TBC	Service Evaluation	TBC	2 & 3	1
Reaudit of Bedside transfusion practice	1	Leighann Sharp	Nicky Wilson	National Standards	TBC	2 & 3	1
Reaudit of Patient Satisfaction Survey	5	Dr S Gummaraju	Dr S Katti	Service Evaluation	February	1 & 2	1

Diagnostics Division (including involvement from: radiology, X-Ray, histopathology and Orthotics)

Project Title	HQIP Priorit	Division Audit Lead	Project Lead	Driver	Estimated Start Date	Trust Strategic	Main Key Risks
Reaudit of Pre-operative chest X-Ray Reports	3	Dr R Lalam	Dr P Tyrrell	Directorate Standards	April 2019	2 & 3	1
Reaudit of CTPA studies	4	Dr R Lalam	Naomi Winn	Local Standards	April 2019	1 & 3	1, 2 & 3
Reaudit of X-Ray Marker audit compliance	2	Dr R Lalam	Kate Herbert	Complaint	April 2019	1, 2 & 3	1 & 3
Reaudit of Gonad Shield in paediatric pelvic x- rays	4	Dr R Lalam	Kate Herbert	Local Standards	April 2019	1, 2 & 3	1 & 3
Reaudit of IRMER Auto Report	2	Dr R Lalam	Kate Herbert	Complaint	April 2019	1, 2 & 3	1 & 3

Paediatric Division (including paediatric surgery and medicine and ORLAU)

Project Title	HQIP Priorit	Division Audit Lead	Project Lead	Driver	Estimated Start Date	Trust Strategi	Main Key Risks
17/18_013 Paediatric Surgery, X-Ray request audit	4	Mr Derfel	Junior Doctor	4	April 2019	1, 2 & 3	1

Summary of Current Activity

The table below shows the clinical audit and quality improvement projects that are currently being undertaken in each division.

	Corporate Services	Paediatrics	Diagnostics	Medicine and Rehabilitation	Surgery	Theatres	Total
Priority 1	2	1	0	5	1	0	**9**
Priority 2	0	0	0	1	0	0	**1**
Priority 3	0	0	0	1	0	0	**1**
Priority 4	4	4	1	3	1	1	**14**
Priority 5	0	1	0	3	3	4	**11**
Total	**6**	**6**	**1**	**13**	**5**	**5**	

Current Audit Activity (projects being carried over to 2019/20)

DIVISION	Project Number	Project Title	HQIP Priority (1-5)	Division Audit Lead	Project Lead	Driver	Estimated End Date	Trust Strategic	Main Key
Corporate	17/18_017	Sepsis CQUIN Audit	1	Mr C P Kelly	Craig Lammas	CQUIN	April 2019	1, 2 & 3	1, 2 &
Corporate	17/18_057	An Audit of Audits: Are we completing the	4	Mr C P Kelly	Carol Robert	Local Standards	April 2019	1, 2 & 3	1, 2 &
Corporate	17/18_043	Digital Case note Audit	1	Mr C P Kelly	Ian Meredith	IG Tool Kit	August 2018	3	1, 2 & 3
Corporate	18/19_012	Audit of RJAH Subject Access Request	4	Julie Roberts	Sara Fox	Local Standards	Januar y	1, 2 & 3	1

Paediatrics	17/18_029	Reaudit of Orthopaedic registrar on-call handover	4	Mr D Williams	Mr B Mwaur	Local Standards	August 2018	1, 2 & 3	1
Paediatrics	18/19_010	Evaluation of the use of waterproof plaster for hip spica	5	Mr D Williams	Mr P Rao	Service Evaluation	July 2018	1, 2 & 3	1
Paediatrics	18/19_009	Paediatric Operative Notes to support	4	Mr D Williams	Mr D William	Local Standards	Septembe r 2018	1, 2 & 3	1
Paediatrics	18/19_016	Safety of prescribing	4	Mr D Williams	Dr R Kulshresth	Service Evaluation	August 2019	1, 2 & 3	1
Paediatrics	18/19_027	Paediatric Scoliosis SOP	1	Mr D Williams	Sara Ellis-	National Standards	March 2019	1, 2 & 3	1 & 3
Paediatrics	Governance Review	How are patients with CTEV managed in Ponseti clinic at	4	Mr D Williams	Mr N Kiely	Local Standards	TBC after approval of audit	1, 2 & 3	1
Theatres	16/17_004	Enhanced recovery after major spinal	5	Dr S Gummaraju	Dr J John	Service Evaluation	November 2018	1, 2 & 3	1
Theatres	17/18_038	Safety Attitudes: Frontline Perspectives from	5	Dr S Gummaraju	Dr S Shapter	Service Evaluation	August 2019	1, 2 & 3	1 & 3
Theatres	17/18_070	Evaluation of the Space Blanket for temperature	5	Dr S Gummaraju	Dr J John	Service Evaluation	March 2019	1, 2 & 3	1
Theatres	17/18_072	Analgesic efficacy of intrathecal morphine in posterior cervical	5	Dr S Gummaraju	Dr J John	Service Evaluation	Februar y 2020	1, 2 & 3	1
Theatres	18/19_024	Documentation of Spinal Anaesthesia at	5	Dr S Gummaraju	Dr N Hadden	Servic e	Decembe r	1, 2 & 3	1
Surger y	CARMS - 00328	The effectiveness of track and trigger systems in identifying deteriorating patients	1	Mr C P Kelly	Julie Newton	NIC E Guidanc	August 2018	1, 2 & 3	1
Surger	CARMS -	Outcomes of thumb CMC Joint replacement	5	Mr C P Kelly	Mr I Roushdi	Servic e	March 2019	1, 2 & 3	1
Surger	CARMS -	Outcomes of wrist replacement	5	Mr C P Kelly	Mr I Roushdi	Servic e	March 2019	1, 2 & 3	1
Surger	17/18_065	Audit of Revision Arthroplasty	5	Mr S Lewthwait	Davinder Singh	Servic e	July 2018	1, 2 & 3	1 & 3

					Bhachu				
Theatres	18/19_019	Validation of theatre times for the Model	4	Leighan n	Mr P Cool	Local Standards	May 2019	1, 2 & 3	1, 2 &
Surger y	18/19_023	Post-Operative instructions Arthroplasty	4	Mr S Lewthwaite	Mr R Banerjee	Local Standards	December 2018	1, 2 & 3	1 & 3
Medicine &	17/18_006	VTE risk assessment form completion in	3	Mr N Kumar	Becky Warren	Directorat e	Decembe r	1, 2 & 3	1 & 3
Medicine & Rehabilitation	17/18_011	MCSI Respiratory Audit: VC, peak flow and	5	Mr N Kumar/Sa m Dawson	Amy Wyatt	Service Evaluation	March 2019	1, 2 & 3	1 & 3
Medicine &	17/18_022	Preventing Pressure Ulcers NICE CG 179	1	Mr N Kumar	Alison Lamb	NIC E	April 2018	1, 2 & 3	1 & 3
Medicine &	17/18_047	Reaudit of Outreach service by MCSI	1	Mr N Kumar	Harriet Smith	CQC	January 201	1, 2 & 3	1 & 3
Medicine &	17/18_055	MCSI patient monthly	4	Mr N Kumar	Becky Warren	Loca l	July 2018	1, 2 & 3	1 & 3
Medicine &	17/18_067	MCSI Urology Admission Pack	4	Mr N Kumar	Becky Warren	Loca l	October 201	1, 2 & 3	1 & 3
Medicine &	18/19_001	National Rheumatology	1	Dr R Amarasena	Dr R Amarasena	National Audit	Decembe r	1, 2 & 3	1, 2 &
Medicine & Rehabilitation	18/19_003	Reaudit of Urological Service Provision at MCSI-NICE	1	Mr N Kumar	Thuya Win	NICE Guidance	November 2018	1, 2 & 3	1 & 3
Medicine & Rehabilitation	18/19_021	Medications prescription and dispensing	4	Mr N Kumar	Mr J Chowdhur	Local Standards	December 2018	1, 2 & 3	1 & 3
Medicine & Rehabilitation	Governance Review	Reaudit of BTA Therapy to manage focal spasticity in SCI	1	Mr N Kumar	Mr N Kumar	BTA Guideline	TBC	1, 2 & 3	1 & 3
Medicine & Rehabilitation	18/19_029	Review of physiotherapy provision at bone and soft tissue sarcoma centres across England	5	Sam Dawson	Gerain t Davie	Service Evaluation	April 2019	1, 2 & 3	1 & 3
Medicine & Rehabilitation	18/19_028	Appropriateness and total duration of antibiotic prescribing	2	Imran Hanif	Dona Ann Jacob	DoH Regulation	May 2019	1, 2 & 3	1 & 3
Medicine & Rehabilitation	18/19_034	Quality of pain relief and outcome of unused	5	Imran Hanif	Imran Hanif	Service Evaluation	May 2019	1, 2 & 3	1, 2 &

		case shoulder surgery				
Diagnostics/Oncology	18/19_026	Assess RJAH ability to meet the 28 day faster	4	Miss G Cribb	Miss G Cribb	Local standard

National Clinical Audit and Clinical Outcome Review Programmes

The table below lists the National Clinical Audits and Clinical Outcome Review programmes which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2019/20. The list includes those which may have relevance to our trust:

National Clinical Audit and Clinical Outcome	Host Organisation
Child Health Clinical Outcome Review Programme	The National Confidential Enquiry into Patient Outcomes and Death
Elective Surgery (National PROMS	NHS Digital
National Audit of Rheumatoid and Early Inflammatory Arthritis	British Society for Rheumatology
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership

Appendix 6-Attendance of clinical audit committee meetings:

Meeting dates 2017/18	2017/18 Attendees	Meeting dates 2018/19	2018/19 Attendees
Friday 9th June 2017	10	Friday 8th June 2018	11
Friday 8th September 2017	9	Friday 14th September	15
Friday 8th December 2017	9	Friday 14th December	9
Friday 9th March 2018	10	Friday 22nd March 2019	10

Safe Working Hours: Doctors in Training Q1 2018-19

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	26th September 2019
Executive Sponsor:	Steve white, Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety 19/09/2019	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 and what input is required?

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

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.

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 Apr-Jun 2019

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

April – 1 part time trainee

May – 1 part time trainee

June – 1 part time trainee

Vacant shifts

April - 6

May – 3

June – 0.25

Total spend has been £ 5625

Safe Working Hours: Doctors in Training Q1 2018-19

Medicine

Number of Vacancies

April – Info pending
May - Info pending
June - Info pending

Vacant shifts

April – Info pending
May – Info pending
June - Info pending

Total spend pending

MCSI

April – 2
May - 2
June - 2
July - 2
Aug - 2

Vacant shifts

April – 15
May – 10
June - 5
July - 6
Aug - 17

Total spend pending - £3510

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

As required, induction was attended in August. Awareness of the role, requirements etc. was reassuringly consistent. JDF continues with no concerns raised to report at this point. I am attending the national annual conference for GJDWH in October.

3.3.2 Software System

Expectation that the Trusts will move to the Allocate system. I am attending sessions at the GJDWH national conference targeted at electronic reporting systems and further information will be fed back in my next report

Associated Risks

As discussed in the previous report there needs to be reassurance to ensure our processes and engagement from all stake holders is embedded firmly to deal with any change from our current position of zero returns. With recent staffing changes this has not yet occurred but should be available for the next report.

Next Steps

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

3.4. Conclusion

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

Medical Appraisal and Revalidation Report

Author:	Jo Bayliss	Paper date:	28th August 2019
Executive Sponsor:	Mr Stephen White	Paper Category:	Governance and Quality / Performance
Paper Reviewed by:	Trust Board	Paper Ref:	
Forum submitted to:	Mr White	Paper FOIA Status:	Full

1. Executive Summary

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

It is mandated by NHS England for the Board to note these 4 papers and recommend any actions if concerned. It is also required that Annex D (section 4) is approved and signed by Mark Brandreth, Chief Executive Officer.

The Trust's performance on medical appraisal and revalidation is monitored quarterly by NHS England. To meet the requirements of NHS England, the Responsible Officer is also required to provide quarterly updates to the Trust board.

Purpose:
The purpose of appraisal and revalidation is to ensure that the doctors are up to date and fit to practice. Our achievement of being in the top 5% of Trusts in external benchmarking according to patients in the Friends and Family Test (Picker Study) includes highest levels of trust in the doctors. Similarly, we have the highest quality outcomes in England as reflected by the Patient Reported Outcomes Measures (PROMS) for hip and knee replacements. None of this is achievable without processes, and a culture, for doctors to develop. Central to this is our appraisal system, gathering information on individual performance, reflecting and learning with the support of expert appraisers on an annual cycle. The other area of consideration is the way we, as a Trust, respond to concerns about doctors and learn from incidents.

We note the following issues:
Doctors rated the management of the appraisal process and access to the necessary supporting information lower than previous years. Therefore we have improved communication with the Governance and Information departments to try and ensure that all information is available to doctors in a timely manner. We have also had issues with some doctors who have not demonstrated timely completion of statutory and mandatory training and so we have taken a more rigorous approach with them. This measure has not been universally popular! In addition there has been a much more rigorous approach to the inclusion of governance information from other hospitals were our doctors' work. This is improving but can still be difficult as some hospitals are not so organised in the way they provide Governance information.

In terms of **benefits** our Trust has an increased number of doctors compared to previous years and has a higher compliance of completion of appraisals (100%) within the year than the previous year and better than comparable designated bodies in the sector and total designated bodies. We continue this year to achieve 100% compliance rate for the number of completed appraisals within the first quarter of 2019-20. There were 4 doctors due to be revalidated in this quarter, 3 of whom were recommended for revalidation and approved by the GMC. One doctor was deferred due to insufficient supporting information for a recommendation to revalidate and this was approved by the GMC.

The local appraiser development and support group continues to meet 3 times a year with good attendance. As partners in the Integrated Care Service we are inviting medical appraisers form Shropshire Community NHS Trust to join us in the development sessions.

In May this year we created a Responsible Officer Advisory Group (ROAG) to meet and advise on the management of concerns about doctors. There were 41 concerns in 2018/19 of which all but two have been resolved by informal processes. No formal processes have been necessary.

Recommendation

The Board is asked to note the position with regard to medical appraisals and revalidation for quarter 1 of 2019-20 and also the findings from the annual appraisal audit and the Annual Organisational Audit comparator report from NHS England. The Board are also asked to formally approve the NHS England Annex D which follows in section 4.

2. The Main Report

The four sections;

Section 1: provides the details about the 105 doctors with a prescribed connection as at 30th June 2019 offering assurance against the trajectory for medical staff appraisals and revalidation in quarter 1 of 2019-20.

Section 2: provides the annual medical appraisal audit data for 2018-19 collated by Dr R Longfellow for the Board to note.

Section 3: provides the details from the RJAH personalised report from NHS England which enables the Board to compare its Annual Organisational Audit for revalidation responses against those from designated bodies of a similar type, and all designated bodies in England – no issues have been identified.

Section 4: this is the NHS England Annex D; Annual Board Report and Statement of Compliance which is a stipulated requirement for NHS England for Medical Appraisals and Revalidation.

Section 1- Quarter One's position for medical staff appraisals and Revalidation

2.1 Introduction

The Medical Director, Mr Stephen White is the Trust Responsible Officer (RO) and is now supported in this role by Dr Ruth Longfellow (sRO). The management and monitoring of medical appraisal and revalidation is now undertaken Mr Nilesh Makwana as the Appraisal Lead (AL), and the People Services Manager (PSM) Jo Bayliss.

A quarterly report has been provided to update the Board on the appraisal and revalidation of Doctors since October 2014 and includes the details of the quarterly submission to NHS England called the Annual Organisational Audit, (AOA) which is part of the Framework for Quality Assurance.

2.2 Actions undertaken during quarter 1, 2019/20

The Trust submitted the Annual Organisational Audit (AOA) return in June 2019 as required and the details of the AOA Comparator Report received in return are detailed in Section 4 of this report.

2.3 Appraisal and Revalidation Performance Data Quarter One

Table 1: 2019-20 appraisal compliance data as at 30th June 2019

Indicator	Q1 (1 Apr 19 - 30 Jun 19)	Q2 (1 July 19 - 30 Sep 19)	Q3 (1 Oct 19 - 31 Dec 19)	Q4 (1 Jan 19 to 31 Mar 20)
1. Number of doctors with whom the designated body has a **prescribed connection at end of quarter**	105			
2. Number of doctors **due to hold an appraisal meeting** in the reporting period	19			
3. The number of doctors who **held an appraisal meeting** in the reporting period	19			
4. The number of doctors **who did not hold an appraisal meeting** in the reporting period	0			
5. Number of doctors in #4 above for whom **the RO accepts the postponement is reasonable**	0			
6. Number of doctors in #4 above for whom **the RO does not accept the postponement is reasonable**	0			
Total number of completed appraisals for period 01/04/2019 to 30/06/2019	**19***			
Total % of completed appraisals for period 01/04/2019 to 30/06/2019	**100%***			

* *Figure excludes new employees who are exempt from an appraisal in the first 6 months of employment.*

Table 1 (above) shows the 2019-20 appraisal compliance data as at 30th June 2019.

The Trust achieved a 100% compliance rate for the number of completed appraisals within the first quarter of the year 2019-20.

The Medical Appraisal Policy ensures that all non-compliance and reasons for non-completion of a medical appraisal are followed up by the AL and PSM with the RO advised accordingly. The follow up algorithm includes a personal discussion between the AL and individual doctor and formal correspondence is issued regarding the matter if necessary.

2.4 Revalidation Recommendations

There were 4 doctors due to be revalidated in this quarter, 3 of whom were recommended for revalidation and approved by the GMC. 1 doctor was deferred due to insufficient evidence for a recommendation to revalidate and this was approved by the GMC. A date for revalidation has been set with time allowed to collect the required supporting information.

2.5 Training

The RO and Clinical Lead for Appraisals are booked to attend the Regional network meeting and training events in September 2019, plus will attend further meetings in 2020. Attendance enables them to maintain their designated accreditation.

The AL will continue to hold the local Appraiser Network meetings 3 times a year with the next session planned for October 2019. From this October these meetings will be held joint with medical appraisers from Shropshire Community Trust.

2.6 Associated Risks

There were no risks identified in quarter one; the process of revalidation deferment of the one doctor was clear and agreed.

2.7 Conclusion

The Board are asked to note the position for quarter 1 for Medical Appraisals and Revalidation.

Section 2- The annual medical appraisal audit data for 2018-19 collated by Dr R Longfellow.

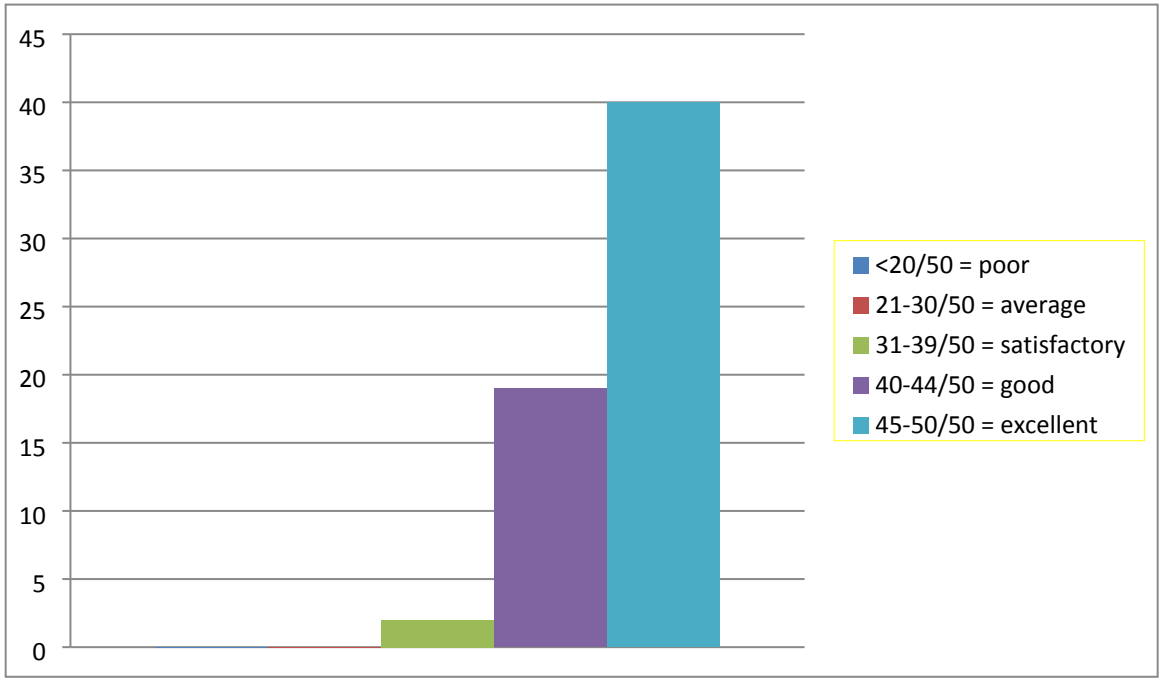
2.8 Audit of Appraisal Reports

During the past year at least one Appraisal Summary per appraiser has been audited using the ASPAT audit tool. This tool audits all aspects of what is and isn't included in the appraisal summary written by the appraiser following the appraisal discussion. It is an audit of the quality of the report produced by the appraiser and in no way reflects the calibre of the doctor being appraised. The audit was carried out by the Lead Appraiser. The ASPAT audit tool is a new tool developed by NHS England and looks at all aspects of the appraisal summary in more detail. ASPAT is scored out of 50 (Appraisal Summary and PDP Audit Tool).

Results

The ASPAT audit tool produces a score between 0 and 50. Scores between 45-50 represent high quality reports. Scores between 40-44 represent good reports. Scores between 31-39 represent satisfactory reports, scores between 21-30 average. Scores less than 20 are considered unacceptable.

Table 2: The table below shows the ASPAT scores out of 50, of audited appraisal reports, for appraisals undertaken over the last year (Y axis = Number of appraisals X axis = ASPAT scores)



Number of appraisal summaries attaining the ASPAT scores between 1 and 50 (1st April 2018 – 31st March 2019)

Interpretation of Results

The overall standard of reports was of a high quality, only 2 scored as 'satisfactory', the rest being 'good' and 'excellent'.

Action Plan

All Appraisers will receive individual feedback on their scores and comments made by the appraisees. Appraisers who produce low quality appraisal summaries are invited to a 1 to 1 session with the AL, with an aim of discussing how to improve the quality of their summaries. If they refuse to meet they are asked to stop undertaking appraisals (as happened with an appraiser who stopped appraising after March 2017). One appraiser agreed to attend a 1 to 1 meeting with the AL and the quality of the appraisal summaries has since improved significantly.

Attendance at Local Network / Support Group meetings

Three local network meetings were held in 2018/19 with good attendance. All appraisers agreed to attending at least one local network / development meeting a year.

Feedback audit

As part of the appraisal process feedback forms are provided for doctors who have been appraised to feedback using a 0 – 5 rating. The forms also indicate the length of the appraisal discussion and provide an opportunity for scoring and commenting on the following areas:

a) The management of the appraisal process.
b) Their appraiser's ability.
c) The usefulness of their appraisal.

54 feedback forms were returned for appraisals carried out between the 1st April 2018 and 31st March 2019. A summary of the results and comments is provided below.

	2015-2016	2016-2017	2018-2019	2018-19
Number of feedback forms returned	*19*	*19*	*45*	*54*
Management of appraisal process				
Mean duration of meeting in hours	1.9 hours	1.9 hours	2 hours	2 hours
Range of hours	1hr – 3.5hrs	1hr - 3hrs	1hr - 4hrs	1hr – 4hrs
Management of appraisal system	4.6	4.4	4.0	4.3
Access to the necessary supporting information	4.5	4.7	4.0	4.0
Rating of appraiser 1 - 5 (where 1 = poor and 5 = excellent)				
Appraiser preparation for my appraisal	4.9	4.9	5	4.8
Appraiser ability to conduct my appraisal	4.9	4.9	5	4.8
Appraiser ability to review progress against last year's PDP	4.9	4.9	5	4.8
Usefulness of appraisal				
Usefulness of appraisal for my professional development	4.8	4.6	5	4.4
Usefulness of appraisal in preparation for revalidation	4.8	4.5	5	4.5
Usefulness of my PDP	4.8	4.4	5	4.4

Results will be fed back to individual appraisers as part of their annual review. Doctors continue to rate their appraisers highly, but have still rated the management of the appraisal process and access to the necessary supporting information lower than previous years.
We have improved communication with the Governance and Information departments to try and ensure that all information is available to doctors in a timely manner. Despite this there were still issues with information being available on time. As a result a new system has been put in place.

A more rigorous approach to the inclusion and adequate completion of statutory and mandatory training at the time of appraisal has been introduced. This has not been universally popular by all doctors being appraised.

In addition there has been a much more rigorous approach to the inclusion of governance information from other hospitals were our doctors work. This is improving but can be difficult as some hospitals are not so organised in the way they provide Governance information. This is a work in progress, and is positively strengthening communication with our local hospitals.

Section 3: Annual Organisational Audit Report for revalidation responses against those from designated bodies of a similar type, and all designated bodies in England.

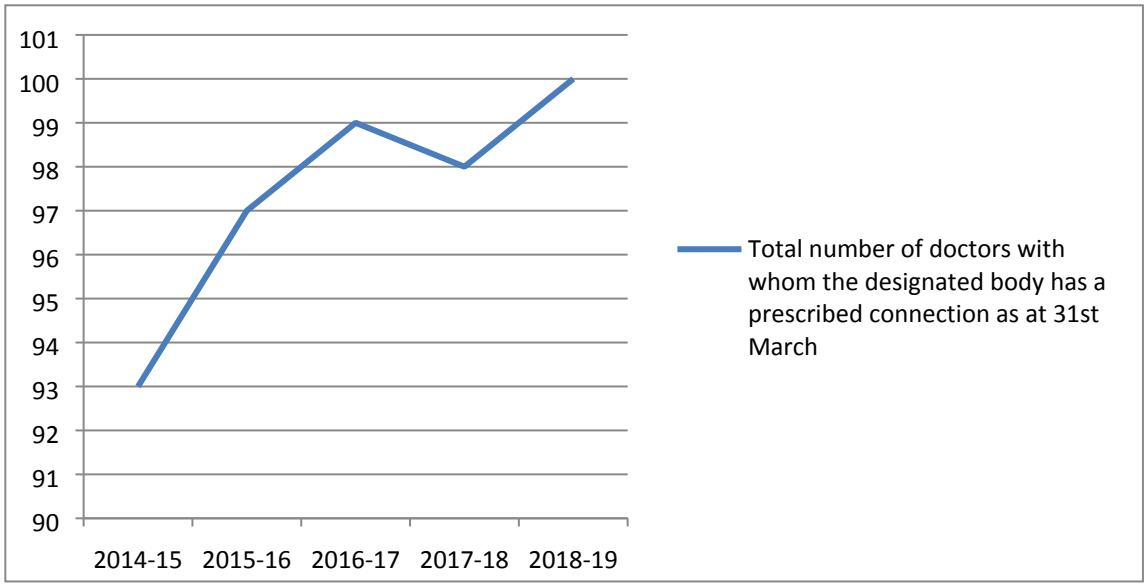
2.9 Report findings

At the end of quarter One, the Trust received its personalised report from NHS England, to enable the Trust to compare its Annual Organisational Audit for revalidation responses against those from designated bodies of a similar type, and all designated bodies in England.

The AOA exercise is designed to help designated bodies assure themselves and their boards (or equivalent management bodies) that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, and the arrangements for medical appraisal and responding to concerns, are in place and functioning effectively. Similarly, it provides a mechanism for assuring NHS England that the systems in place are functioning effectively and consistently.

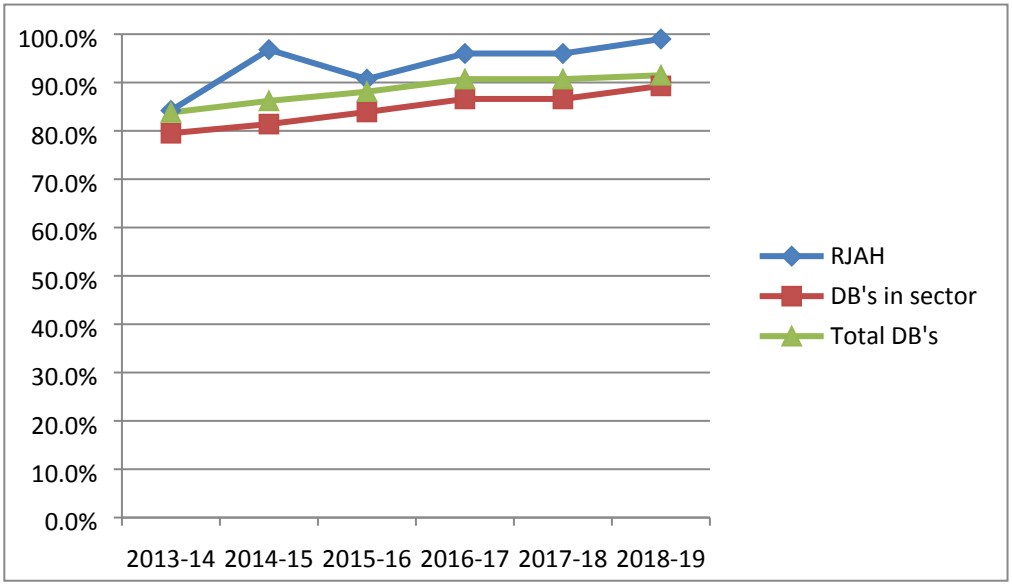
The key findings from the comparison reports from NHS England received since 2014 are summarised below for information:

***Graph 1:* Total number of doctors with whom the designated body (the Trust) has a prescribed connection as at 31st March each year**



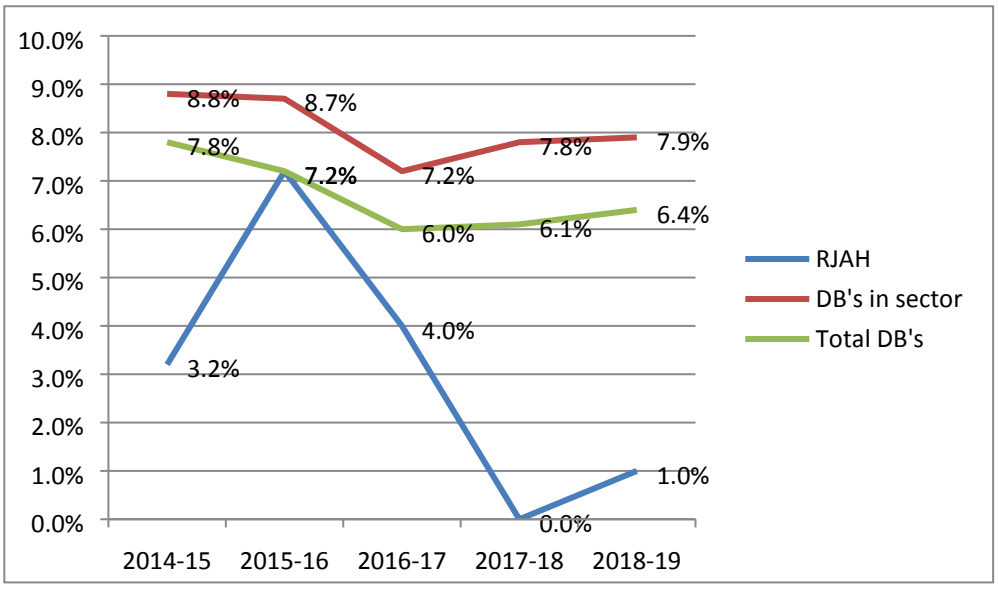
Graph 1 above shows that the number of doctors has increased again as at 31st March 2019 and there has been a steady increase in numbers since 2014.

Graph 2: ***Percentage of doctors with whom the designated body has a prescribed connection and who had a completed annual appraisal between 1 April – 31 March each year***



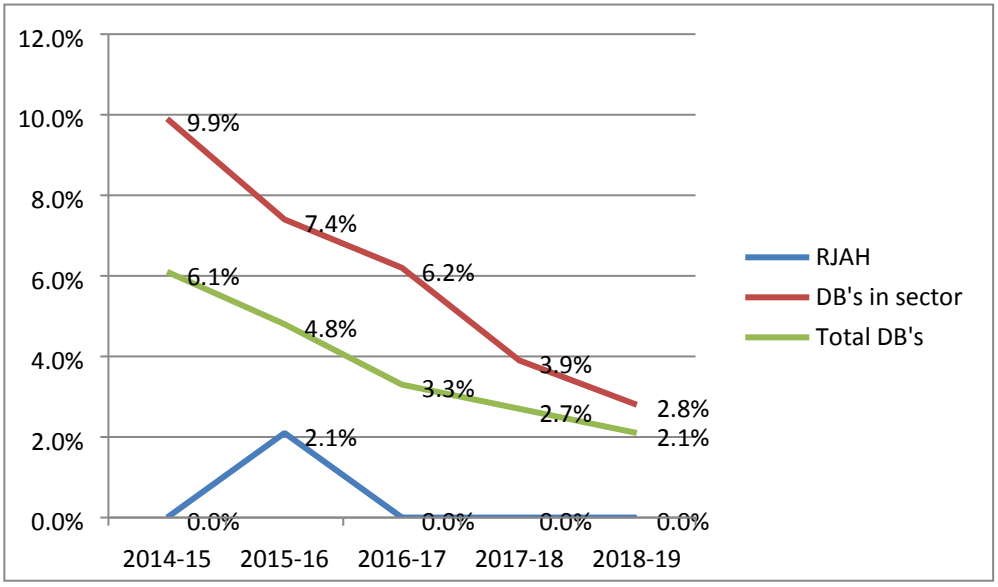
Graph 2 (above) shows that since 2014, the percentage of doctors who had completed an appraisal in year remained above the figures for both the designated bodies in the same sector and nationally.

Graph 3: ***Total percentage of doctors with whom the designated body has a prescribed connection and who had an approved incomplete or missed or delayed appraisal between 1 April - 31 March each year***



There was a spike in the number of doctors who had an approved incomplete or missed appraisal in 2015-16 due to factors relating to a lack of time by the appraisee due to clinical activity. This number reduced from 2016-17 due to more timely reminders and interventions regarding medical appraisals by the Appraisal Lead and Training Manager. In 2017-18 there were no appraisals that were incomplete or missed however, in 2018-19, one consultant had a delayed appraisal, due to incomplete supporting information. This has been addressed accordingly and resolved.

Graph 4: Total number of doctors with whom the designated body has a prescribed connection who had an unapproved incomplete or missed appraisal between 1 April – 31 March each year



Graph 4 shows the Trust has continued to ensure that no doctors are categorised as having an unapproved incomplete or missed appraisal.

The findings of the reports show that the Trust continues to compare very favourably with both the sector specific and national standards. Overall there continues to be an upward trend, not only in the appraisal rate, but also in the improvement of the system in general. Therefore no further action has been identified at this time to further improve the existing procedures.

3.0 Conclusion

The Board is asked to note the position with regard to medical appraisals and revalidation for quarter 1 of 2019-20 and also the findings from the annual appraisal audit and the Annual Organisational Audit comparator report from NHS England. The Board are also asked to formally approve the NHS England Annex D which follows in section 4.

Section 4: this is the NHS England Annex D - Annual Board Report and Statement of Compliance

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

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Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

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[1] *Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]*

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement of Compliance has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report
Section 1 – General:

The board of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 16/05/2019
Action from last year: None identified
Comments:
RJAH AOA Comparator report has been received. The report shows that the Trust continues to perform favourably and above the designated bodies across England, both in a similar sector and nationwide.
Action for next year:
To maintain performance and ensure that the number of doctors with whom the designated body has a prescribed connection have completed an annual appraisal in year is 100%

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:
To support the Medical Director in his role as RO, the Medical Appraisal Lead (RL) has been appointed as supporting RO and a new Medical Appraisal Lead (NM) has been appointed.
Due to a period of extended sickness, alternative arrangements were successfully put into place to cover the administration tasks of the medical appraisal and revalidation process.
Comments:
Both RL and NM have completed the necessary training, including Responsible Officer Training, and continue to attend the regional Medical Appraisal and Revalidation Network meetings.
Action for next year:
Nothing further at this time.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/~~No~~ [delete as applicable]
Action from last year:

Same response as for question 2

Comments:

Same response as for question 2.

Additionally, the administrative process has been reviewed and will be strengthened with a Standard Operating Procedure (SOP) being put into place.

Action for next year:

Production of SOP

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:

An accurate record of all licensed medical practitioners with a prescribed connection to the designated body was fully maintained throughout the year.

Comments:

The administrative process has been reviewed and will be strengthened with a Standard Operating Procedure (SOP) being put into place.

Action for next year:

Production of SOP

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:

The Medical Director / RO ensures that the revalidation process adheres to the Trust policy and GMC guidelines already in place.

Comments:

As above.

Action for next year:

Review and update process and policies in accordance to new Trust policy framework.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year:

The Medial Appraisal Lead undertakes an annual review of the medical appraisal process, data and feedback which is presented to the Board. No issues have been identified to date.

Comments:

Aspects of the administration process for appraisals and revalidation have been reviewed and streamlined to create some further efficiency in the process for consultant and medical staff.

Action for next year:

Consider undertaking / requesting external audit of appraisal and revalidation process to provide further assurance.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:

All locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development via the Study Leave for Consultant and Medical Staff policy and process, the appraisal and revalidation process which includes the provision of governance data and intelligence.

Comments:

Staff lists are run monthly to ensure all locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation are included in the processes.

Action for next year:

Nothing further identified at this time.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:

All doctors in the organisation are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation i.e. information about complaints, significant events and clinical outcomes so that this can be reviewed at their annual appraisal

Comments:

As a number of doctors also practice in other organisations they are required to provide data relating to this work at their appraisal so it can be reviewed and discussed. The Medical Appraisal Lead also checks this data has been supplied and discussed at the appraisal when quality assuring completed appraisals. This ensures that the appraisal is a comprehensive review of the doctor's fitness to practice and that all elements are completed and checked before the appraisal is signed off as satisfactory and meeting all the requirements by the Medical Director.

Action for next year:

To continue to work more closely with other organisations to ensure consultants and medical staff receive this data in a timely way.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

As per response for Q1.

Comments:

An issue was raised in year that the reports/data from the Clinical Governance and Information Departments was being sent "too early" for the data to be timely and relevant at the time of the appraisal meeting. Therefore following discussion between all relevant parties it was agreed that these reports are now generated and sent 6 weeks in advance of the appraisal anniversary date.

Action for next year:

To continue monitoring

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

No specific action was required as the Trust policy is compliant with national policy and has received the Board's approval

Comments:

None

Action for next year:

To review and update processes and policies in accordance to new Trust policy framework

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

The Trust has a total of 26 trained medical appraisers, with representatives from each of the different specialities, which ensures that the same appraiser cannot appraise the same person more than 3 times in a 5 year period.

Comments:
As above – no further comment

Action for next year:

Nothing further identified at this time.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year:

Medical appraisers are encouraged to participate in ongoing performance review and training/development sessions which are organised to take place three times a year. All appraisers agreed they would attend at least one network/development session per year (out of a potential 3) External speakers were invited to run appropriate developmental sessions which were well received by the medical appraisers. The sessions also enable peer discussion to take place.

Additionally, the results from the annual medical appraisal audit undertaken by the Medical Appraisal Lead are circulated to the appraisers collectively and as individualised feedback reports providing further feedback about performance in the medical appraiser role.

Comments:

No further comments

Action for next year:

Plan and arrange the programme content for the development sessions for the next year.

Include/invite colleagues who are medical appraisers from ShropCom to participate in the development sessions.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

Since October 2014, a quarterly report has been provided to update the Board on the appraisal and revalidation of Doctors. This report includes the details of the quarterly

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] *Doctors with a prescribed connection to the designated body on the date of reporting.*

submission to NHS England called the Annual Organisational Audit, (AOA) as part of the Framework for Quality Assurance.

The appraisal system is quality assured on a continuous basis by the Medical Appraisal Lead and the supporting RO role who audit all submitted appraisals using the widely used Appraisal Summary and PDP Audit Tool (ASPAT), produced by NHS England. An annual report of the audit findings is provided to the medical appraisers and submitted annually to the Board

Comments:

Audits of quality assurance have been completed and highlighted no major issues.

Action for next year:

To continue monitoring

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

In the period 01/04/2018 – 31/03/2019, the Trust had a total of 21 doctors to revalidate; 20 were recommended for revalidation and 1 doctor was deferred.

Comments:

The revalidation for 1 doctor was deferred due to insufficient evidence being provided by the doctor in a timely way for a recommendation to revalidate to be made.

Action for next year:

To continue monitoring and ensure all doctors have sufficient evidence in place in advance of revalidation date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

Revalidation recommendations made to the GMC are confirmed with the doctor. The reasons for the deferred recommendations are discussed with the doctor by the Medical Director and confirmed in writing prior to the revalidation due date.

Comments:

The Trust has a set of criteria which doctors are required to meet before a recommendation for revalidation is submitted. Failure to meet the set criteria will mean their revalidation recommendation will be deferred until it is met.

Action for next year:

To continue monitoring

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

The organisation aims to ensure that all doctors practise in accordance with the principles and values set out in Good Medical Practice and participate in the revalidation and appraisal process. The Trust also requires all doctors to participate in the systems and processes put in place to protect and improve patient care.

Comments:

The Trust received its CQC inspection report results in February 2019 and were rated good overall and outstanding for caring.

Action for next year:

To continue to build upon the results of the CQC inspection report and ensure all doctors continue to practice in accordance with the principles and values set out in Good Medical Practice and participate in the revalidation and appraisal process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

All doctors in the organisation are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation i.e. information about complaints, significant events and outlying clinical outcomes. This data is reviewed and discussed at their annual appraisal

Comments:

The Trust has a formal process to manage all complaints made to the Trust. All clinicians are provided with a copy of any complaints received regarding them or their practice or that of their Registrars.

Action for next year:

To continue monitoring

3. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

The Responsible Officer Advising Group (ROAG) was established in 2019 and meets on a monthly basis to discuss and agree appropriate actions regarding concerns about any licensed medical practitioner's fitness to practise (does not include trainees who are linked to the Training Programme).

Comments:

As above

Action for next year:

Update the Trust's Responding to Concerns Policy

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year:

Concerns raised are now discussed at the ROAG and follow up actions are undertaken as agreed. The ROAG aims to gives a balanced view, including that of a lay representative, and also looks at the concerns in the context of Human Factors, the environment, culture and systems. Clinical Leads have been invited to attend the ROAG if concerns have been raised to them and they wish to gain further advice and support.

Comments:

As above

Action for next year:

The ROAG intends to produce a yearly report on concerns discussed and outcomes. It will also carry out an analysis to ensure there is no bias.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your

[4]*This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.*

organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year:

We have good working relationships with the ROs at Shropshire Community Trust and Shropdoc. In addition we are strengthening relationships with local private hospitals, in particular Shrewsbury Nuffield Hospital and Spire Healthcare Wrexham

Comments:

We have no formal process for this

Action for next year:

To create and agree a formal process to follow with local hospitals and other hospitals where our doctors work.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

Any concerns are investigated locally by the Clinical Lead and Clinical Director supported by the Medical Director, Responsible Officer and People Services Department, in addition to the ROAG.

Comments:

Action for next year:

Ensure our Responding to Concerns policies are free from bias or discrimination

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

The Trust has a comprehensive recruitment process is in place with adheres with all legislation and NHS requirements for appropriate pre-employment background checks to ensure that all doctors including locum and short-term doctors, have the qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

[4] *The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents*

Comments:

Audits of the R&S procedures are undertaken periodically by the Trust's official Auditors i.e. BDO LLP

Action for next year:

To continue monitoring

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions**

  A summary of actions undertaken during the last year is as follows:

  1. To support the Medical Director in his role as RO, the Medical Appraisal Lead (RL) has been appointed as supporting RO and a new Medical Appraisal Lead (NM) has been appointed.

  2. The Medical Director, Support Responsible Officer and Medical Appraisal Lead have all completed the necessary training and continue to attend the regional Medical Appraisal and Revalidation Network meetings.

  3. The Medial Appraisal Lead continues to undertakes an annual review of the medical appraisal process, data and feedback which is presented to the Board.

  4. Aspects of the administration process for appraisals and revalidation have been streamlined to create some further efficiency in the administrative process for consultant and medical staff.

  5. All doctors in the organisation are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation i.e. information about complaints, significant events and outlying clinical outcomes. This data is reviewed and discussed at their annual appraisal. An issue raised in year related to the delivery date for these reports which was considered "too early" for the data to be timely and relevant at the time of the appraisal meeting. Therefore following discussion between all relevant parties it was agreed that these reports will now be generated and sent 6 weeks in advance of the appraisal anniversary date.

  6. Medical appraisers continue to participate in performance review and training/development sessions. External speakers attend these sessions

to run appropriate developmental sessions which have been well received by the medical appraisers.

7. The appraisal system is quality assured on a continuous basis by the Medical Appraisal Lead and the supporting RO role who audit all submitted appraisals using the widely used Appraisal Summary and PDP Audit Tool (ASPAT), produced by NHS England. An annual report of the audit findings is provided to the medical appraisers and submitted annually to the Board

8. In the period 01/04/2018 – 31/03/2019, the Trust had a total of 21 doctors to revalidate; 20 were recommended for revalidation and 1 doctor was deferred. The revalidation for 1 doctor was deferred due to insufficient evidence being provided by the doctor in a timely way for a recommendation to revalidate to be made.

9. The Trust has a set of criteria which doctors are required to meet before a recommendation for revalidation is submitted. Failure to meet the set criteria will mean their revalidation recommendation will be deferred until it is met.

10. The Responsible Officer Advising Group (ROAG) was established in May 2019 and meets on a regular basis to discuss and agree appropriate actions regarding concerns about any licensed medical practitioner's fitness to practise.

11. During 2018/19 there were 41 concerns

Type of concern	No. of concerns raised	Completed	Formal
Communication	1	1	0
Conduct	3	3	0
Grievance	0	0	0
Patient	6	6	0
Use of Equipment	2	1	0
Procedure	21	20	0
Health	1	1	0
Performance	7	7	0

Of these investigations 39 are now completed and closed. There is one investigation still in progress and one decision awaited.

The MD has held informal interviews with doctors. No written warnings have been given. The GMC has recently been informed about one concern, a Never Event (which will be included in next year's figures) as the MD is duty bound to report. The doctor concerned has been interviewed by the MD as procedure dictates. No doctor

has been removed from the medical register because of concerns although a few doctors have retired and relinquished their license to practice.

- **Actions still outstanding**

  There are currently only three actions still outstanding which are:

  1. Consideration to be given to undertaking external audit of the appraisal and revalidation process to provide further assurance.

  2. Anonymised data analysis from the ROAG meetings to be formally presented to the Trust Board periodically for information.

  3. Update our Responding to Concerns policies and ensure they are free from bias or discrimination

- **Current Issues**

  There are no current issues to report

- **New Actions:**

  The new actions to be undertaken in 2019-20 are as follows:

  1. Following the review of the administrative process an Standard Operating Procedure (SOP) is to be put into place

  2. The Trust medical appraisal policies and procedures are due to be reviewed in accordance to new Trust policy framework in 2019-20.

Overall conclusion:

The RJAH AOA Comparator report for 2018-19 shows that overall the Trust continues to perform favourably and above the designated bodies across England, both in a similar sector and nationwide for appraisal and revalidation. The data reviewed for completion of this document also supports that the Trust is meeting the requirements set out in the Framework of Quality Assurance for Responsible Officers and Revalidation and is compliant with the GMC standards/requirements for medical appraisals and revalidation.

Section 7 – Statement of Compliance:

The Board of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body:	Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Name: Mr M Brandreth	Signed: _ _ _ _ _ _ _ _ _ _
Role: Chief Executive Officer	Date: _ _ _ _ _ _ _ _ _ _

CQC Action Tracker

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	26 September 2019
Executive Sponsor:	Sarah Bloomfield, Interim Director of Nursing	Paper Category:	Governance and Quality
Paper Reviewed by:		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 the Board of Directors and what input is required?

The Board of Directors is asked to note the CQC action plan tracker and the oversight arrangements to ensure all actions are completed with appropriate assurance achieved.

2. Executive Summary

2.1. Context

The CQC Report of February 2019 made several recommendations which have been considered with appropriate actions identified.

The CQC Action Plan has previously been presented to the Board in its entirety with agreement that each assurance committee will receive an update at each meeting on the actions within its remit. This will assist in the triangulation of the action plan progress with the other reports they receive and the risks within their remit. The Board receives assurance of this via the Chair's reports but in addition it was agreed that a quarterly tracker would be presented.

2.2 Summary

This paper presents the second CQC Action Plan Tracker. The Board will note that in the main the actions are either completed or on track. The small number that are currently behind schedule are detailed in the main report along with a progress update.

2.3. Conclusion

The Board of Directors is asked to note the action plan tracker and the oversight arrangements in place.

3. Main Report

3.1. Introduction

The CQC Action Plan consists of 61 actions aimed at addressing 26 key observations of the CQC inspectors.

3.2. Current Status

As of 20 September 2019 the status of the actions was as follows:

Completed	C 40
On track	G 15
Behind scheduled but will be completed within a month	A 0
Behind schedule	R 2
Not applicable (i.e the work is not yet required to start)	N/A 4

Progress updates are provided below for those that are not currently on target:

Ref	Action	Due Date	Progress Update
15.1	A full review of the Critical Care Outreach service to be undertaken with regard to hospital cover	06/19	Business case to provide 24/7 critical care outreach cover has been written and is awaiting consideration from the Exec team as to progress – being considered in the context of the wider organisation restructure
22.2	Recommendations regarding system / process updates required for full implementation of the accessible information standard to be presented to Quality and Safety Committee	07/19	Review of the current systems has indicated that an electronic solution is not currently possible. Short term mitigating options are being considered and will be presented to the Quality and Safety Committee in October but the long term solution will need to come from the new EPR.

The full tracker is available at Appendix 1.

3.3. Conclusion

The Board of Directors is asked to note the action plan tracker and the oversight arrangements in place.

Ref	Activity	Action Lead	Target Date	Current RAG
Well Led				
CQC Observation: Divisional Quality and Safety Processes are not fully established within the divisional structure				
1.1	Implementation of new Governance Structure to ensure robust divisional governance support	Assoc. Dir. of Governance	08/19	G
1.2	Meetings to be held between the Governance Leads and Divisional Managers to ensure clarity of roles and responsibilities	Assoc. Dir. of Governance	04/19	C
1.3	Introduction of templated reports and agendas for oversight of divisional governance	Assoc. Dir. of Governance	04/19	C
1.4	Formal inclusion of the Trust's Divisional Governance Meetings into the Trust's Governance Framework	Assoc. Dir. of Governance	04/19	C
1.5	Clinical Governance Department to review divisional governance arrangements at 3 months and 6 months	Assoc. Dir. of Governance	10/19	G
1.6	Internal audit of divisional governance at 12 months	Assoc. Dir. of Governance	03/20	N/A
CQC Observation: An action plan to support the maintenance and sustainability of mandatory training rates needs to be developed				
2.1	Deep dive of departments highlighted in the staff survey as having potential cultural issues with associated action plans	Dir. of People / Dir. of OD, Improvement and Performance	06/19	C
2.2	Increased visibility and accessibility to the Freedom to Speak Up Guardian	Dir. of People	06/19	C
2.3	Review of Dignity at Work Policy with associated communications to relaunch the policy	Dir. of People	06/19	C
2.4	Improved education for managers	Dir. of People	03/20	G
2.5	Development of a People Committee to ensure adequate oversight of workforce	Dir. of People	04/19	C
CQC Observation: An action plan to support the maintenance and sustainability of mandatory training rates needs to be developed				
3.1	Review of the training needs analysis to ensure that staff training requirements are fit for purpose and in line with the core skills framework. This should include review of the compliance requirements	Dir. of People	05/19	C
3.2	Review and update of the Trust's Training Policy to align with output of training needs analysis review	Dir. of People	06/19	C
CQC Observation: The renewal process for the executive and non-executive vetting and barring process needs to be assured				
4.1	Process to be aligned to the production of the annual report to ensure annual renewal takes place	Trust Secretary	04/19	C
CQC Observation: The process for the review and ratification of policies needs to be assured				
5.1	Development of a tracker to monitor the updating of policies overdue for review	Trust Secretary	04/19	C
5.2	Introduction of proactive prompts to the authors / executive leads for policies due for review	Trust Secretary	04/19	C
5.3	Quarterly reporting to the ratifying body regarding any overdue policies / policies due for review within	Trust Secretary	09/19	G
CQC Observation: The Board Governance Framework was not reflective of changes to the committee structures				
6.1	Board Governance Framework to be updated	Trust Secretary	04/19	C
CQC Observation: The Trust needs to demonstrate its work to improve diversity and inclusion for patients and staff				
7.1	External review of current practice and policies to be commissioned in order to identify gaps	Director of People / Director of Improvement, OD and Performance	05/19	C

Ref	Activity	Action Lead	Target Date	Current RAG
7.2	Refresh of diversity and inclusion priorities in the People Plan	Director of People / Director of Improvement, OD and Performance	12/19	G
CQC Observation: Succession planning below Executive Level requires strengthening				
8.1	Development and implementation of a succession plan	Director of People	10/19	G
8.2	Maximise use of the Leadership Academy	Director of People	03/20	G
8.3	Participation in STP leadership activities	Director of People	03/20	G
Medicine				
CQC Observation: Sluices and areas containing COSHH found to be unlocked				
9.1	Inspection of sluices and COSHH to be included in the new H&S Inspection Checklist with follow up actions by the H&S Officer as required	Associate Director of Governance	05/19	C
CQC Observation: A small number of staff found to not be adhering to bare below elbows policy				
10.1	Staff not adhering to the policy to be identified and spoken to	Medical Director	N/A	C
CQC Observation: Issues identified with the Trust's prescription sheets				
11.1	EPMA business case to be developed with clear implementation timescales	Director of Nursing	09/19	G
CQC Observation: 7 day rehabilitation services not available				
12.1	Business case for 7 day services to be developed with clear implementation timeframes	Director of Operations	09/19	G
12.2	MCSI Review to incorporate a model of service which reflects 7 day availability of therapy services	Director of Operations	09/19	G
CQC Observation: The Trust needs to continue working on addressing delays in discharge processes				
13.1	Option for a step down bed provision to be considered with specialist commissioning	Director of Operations	09/19	G
13.2	ECIST to be asked to complete a review of the current processes to ensure all is being done to reduce delays	Director of Operations	05/19	C
Surgical				
CQC Observation: Cultural issues identified within Theatres in relation to respect and communication				
14.1	Meeting to be held with Divisional Manager and Matron to discuss the cultural issues in Theatres	Director of People	03/19	C
14.2	External support to be commissioned to examine the culture within the theatre department – to include review of the staff survey results	Director of People	06/19	C
14.3	Staff Cultural Ambassador role to be developed to support the culture work *(note: action superseded by theatre culture work)*	Chief Executive	04/19	C
14.4	Increased visibility and accessibility to the Freedom to Speak Up Guardian	Director of People	06/19	C
Critical Care				
15.1	A full review of the Critical Care Outreach service to be undertaken with regard to hospital cover	Director of Nursing	06/19	R
15.2	Review the processes in place to ensure that if multiple medical emergencies occur there is sufficient cover to maintain patient safety	Medical Director	06/19	C

Ref	Activity	Action Lead	Target Date	Current RAG
15.3	Sepsis training to be completed and documented	Director of Nursing	06/19	C
15.4	The unit can evidence adherence with the DOH Critical Care Guidelines and where compliance is limited this is adequately documented on the department risk register	Director of Nursing	06/19	C
15.5	The department completes MRSA screening prior to admission to the unit	Director of Nursing	06/19	C
15.6	Handovers are in place which are documented and regularly audited	Director of Nursing	06/19	C
15.7	The Pharmacist is visible in the unit and the medicines safety thermometer is completed	Director of Nursing	06/19	C
15.8	Audits of patient outcomes to be in place	Director of Nursing	06/19	C
15.9	There is a clear structure for the leadership of the unit and they have the required skills	Chief Executive	06/19	C
Children's and Young People				
CQC Observation: The out of hours cover available required strengthening				
16.1	Directorate to continue to update on progress with out of hours cover at the Performance Review Meetings	Director of Operations	09/19	C
16.2	Specialist Orthopaedic Programme Board to ensure that options for improving OOH cover are agreed	Director of Nursing	09/19	C
CQC Observations: Ligature risks for children to be addressed across the Trust				
17.1	Actions identified from the ligature risk assessment to be fully implemented and reflected across all Trust areas which children access in the Trust	Director of Nursing	04/19	C
CQC Observation: Written information for children to be made available in different languages				
18.1	Written information for children to be made available in different languages	Director of Operations	09/19	G
18.2	Paediatric Forum to monitor the development and implementation of information in different formats	Director of Operations	09/19	N/A
Outpatient Services				
CQC Observations: Poor noise proofing in some consultation rooms				
19.1	Noise level assessments to be undertaken by the Estates Department	Director of Operations / Assoc. Dir of Estates	05/19	C
19.2	Recommendations regarding mitigations to be presented to Capital Management Group and / or Risk Management Committee	Director of Operations / Assoc. Dir of Estates	06/19	C
CQC Observations: Process required for capture and analysis of incidents relating to the overbooking of clinics and cancellations				
20.1	Review of Datix to be undertaken to ensure that its configuration allows for the capture of overbooking and cancellation incidents	Associate Director of Governance	05/19	C
20.2	Divisional templates for governance to specifically include analysis of outpatient clinic incidents	Associate Director of Governance	06/19	C
CQC Observations: Mitigations to address overcrowding in the Outpatient Department to be identified				
21.1	Assessment of overcrowding to be undertaken and recommendations made to the Director of Operations	Director of Operations	10/19	G
CQC Observations: The availability of easy read information to be improved to ensure the consent process is completed appropriately				

Ref	Activity	Action Lead	Target Date	Current RAG
22.1	Review of systems and processes to facilitate full implementation of the accessible information standard to include the identification of patients with specific needs. *(note: decision taken to align with EPR work)*	Director of Nursing / Associate Director of IT	03/20	N/A
22.2	Recommendations regarding system / process updates required for full implementation of the accessible information standard to be presented to Quality and Safety Committee	Director of Nursing	07/19	R
CQC Observations: Clarity is required regarding the nursing leadership and representation for outpatients at assurance committees.				
23.1	Identification of the Senior Nurse Representative to be made clear in relation to attendance at the relevant committees.	Director of Nursing	04/19	C
23.2	Lone working risks for the HCAs within the department to be addressed	Director of Nursing	05/19	C
Diagnostics				
CQC Observations: Visibility of waiting times for investigations / procedures to be improved				
24.1	Method for displaying waiting times to be identified and implemented in Radiology	Director of Operations / Associate Director of IT	09/19	C
CQC Observations: Mitigations to address the risks which arise when the department is busy to be identified				
25.1	Activity planning for the surgery and medicine to be reviewed with a view to reducing activity in diagnostics on Mondays and Tuesdays if possible	Director of Operations	09/19	G
25.2	Risk assessment to be undertaken of any residual risk with citation on the Trust's risk register	Director of Operations	10/19	N/A
CQC Observations: Radiation warning signage to be improved				
26.1	Review of signage regarding radiation warnings to be undertake with improvements to be made where required	Director of Operations	04/19	C

Workforce Race Equality Standard (WRES) Annual Report

0. Reference Information

Author:	Sue Pryce, Head of People Services	Paper date:	26/09/2019
Executive Sponsor:	Sarah Sheppard, Director of People	Paper Category:	Governance and Quality / Performance
Paper Reviewed by:	People Committee 11/09/2019	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?

The Board are asked to note the WRES annual report.

2. Executive Summary

2.1. Context

The Trust is required to complete an annual submission of the Trust's data against the Workforce Race Equality Standard.

2.2. Summary

WRES is a set of 9 specific metrics (indicators) comparing experience and outcomes of NHS employees and job applicants.

The report outlines the Trust's performance against the mandatory metrics and any actions identified. The Trust remains encouraged with our overall measures and note the two areas of improvement.

2.3. Conclusion

The Trust will continue to ensure that Trust is a great place to focus on implementing the actions reported.

The committee is asked to note the annual update.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

DRAFT - NHS Workforce Race Equality Standard (WRES)

ANNUAL REPORT AND ACTION PLAN 2018/19

1. Introduction

This report has been compiled following the 2018/19 submission of the Trust's data against the Workforce Race Equality Standard.

The Trust is required to publish our report and action plan annually, therefore this report therefore sets out The Robert Jones and Agnes Hunt Orthopaedic Hospital NHSFT's performance information against the mandatory WRES metrics and our actions.

2. The Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) was mandated in 2015. It is a tool that aims to identify and reduce any disparities in experience and outcomes for NHS employees and job applicants of different ethnicities.

WRES should be utilised by NHS organisations to track progress to identify and help eliminate discrimination in the treatment of Black and Minority Ethnic (BME) employees.

WRES is a set of 9 specific metrics (indicators) comparing experience and outcomes of NHS employees and job applicants. Four of the indicators focus on the workforce data, four are based on data from the national NHS Staff survey questions and one indicator focuses on BME representation on Board.

- Metric 1: Percentage of staff in each of the AFC bands 1-9 and VSM compared with the percentage of staff in the overall workforce
- Metric 2: Relative likelihood of staffing being appointed from shortlisting across all posts
- Metric 3: relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
- Metric 4: Relative likelihood of staff accessing non-mandatory training and CPD
- Metric 5: Percentage of staff experience harassment, bullying or abuse from patients, relatives of the public in the last 12 months (national NHS staff survey indicators)
- Metric 6: Percentage of staff experiencing harassment, bulling or abuse from staff in the last 12 months (national NHS staff survey indicators)
- Metric 7: Percentage believing that the Trust provides equal opportunities for career progression or promotion (national NHS staff survey indicators)
- Metric 8: In the last 12 months having personally experienced discrimination a work from any of the following - manager, team leader or other colleagues (national NHS staff survey indicators)
- Metric 9: Percentage difference between organisations Board voting membership and its overall workforce.

3. **Actions taken in 2018/19**

The following actions commenced in 2018/19

- Implementation of case triage mechanism whereby potential employee relation cases are reviewed in partnership prior to commencing a disciplinary investigation, to ensure consistent and fair practice and reduce the risk of discrimination.
- Increased resource to Freedom to Speak Up roles
- Establishment of People Committee to raise the profile of equality on the people agenda

4. **WRES 2018/19 indicator findings**

		18/19 data	17/18 data	Progress
1.	% of staff in Agenda for Change bands and VSM compared with the % of staff in the overall workforce	See appendix 1	See appendix 1	No significant change
2.	Relative likelihood of white staff being appointed from shortlisting compared with BME	1.17 times more likely	0.72 times more likely	Deterioration
3.	Relative likelihood of staff entering the formal disciplinary process	0 – no more likely	0 – no more likely	No Change
4.	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	0.4 times more likely	0.36 times more likely	Deterioration
5.	KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White 18.6% BME 13.5%	White 17% BME 5.6%	Deterioration
6.	KS26 Percentage of staff experiencing bullying or abuse from staff in the last 12 months	White 25.6% BME 22.7%	White 25.4% BME 22.2%	Deterioration
7.	KF21 Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	White 88.6% BME 92.9%	White 90.9% BME 81.8%	Improvement
8.	Q17 in the last 12 months have you personally experienced discrimination at work from any of the following b) manager/team leader or other colleague	White 6.7% BME 18.2%	White 6.4% BME 22.2%	Improvement
9.	Percentage different between the organisation Board voting membership and its overall workforce	No BME Board members	No BME Board members	No change

6. **WRES Conclusions**

We remain encouraged with our overall WRES measures and note two areas of improvement, although there has been deterioration in some areas demonstrating that there more work that can be done to eliminate disparities in experience and outcomes for NHS employees and job applicants of different ethnicities.

Our cultural programme of work has assisted the improvement of our equality, diversity and inclusion, however we are particularly concerned with the following areas:

- percentages of staff experiencing bullying or abuse from staff in the last 12 months (regardless of ethnicity, metric 6)
- increase in percentage of BME staff experiencing bullying, harassment or abuse from patients, visitors or service users
- BME staff personally experiencing discrimination from a manager, team lead or other colleague

7. WRES Actions

Our ambition to ensure that RJAH is a great place to work will have specific actions in terms of civility and staff experience as part of the people agenda, alongside creating create “diversity of thought” whereby equality, diversity and inclusion is on everyone’s agenda and we becomes embedded within all our systems and processes to ensure impact for everyone.

Specific actions on each of the metrics are included within the action plan at Appendix 2.

Appendix 1 **Percentage of BME Staff compared with the percentage of staff in the overall workforce (Non Clinical, Clinical and Medical)**

	As on 31.3.18				As on 31.3.19			
		White	BME	Not Stated		White	BME	Not Stated
Non Clinical Staff	1	5.3%	0.2%	0.8%	1	5.1%	0.2%	0.5%
	2	11.7%	0.1%	0.5%	2	12.6%	0.0%	0.3%
	3	3.5%	0.1%	0.2%	3	3.5%	0.1%	0.1%
	4	5.9%	0.0%	0.1%	4	6.2%	0.1%	0.1%
	5	2.7%	0.0%	0.4%	5	2.9%	0.0%	0.4%
	6	1.7%	0.0%	0.1%	6	1.7%	0.0%	0.1%
	7	1.1%	0.1%	0.1%	7	1.3%	0.1%	0.0%
	8a	0.8%	0.0%	0.1%	8a	1.1%	0.0%	0.0%
	8b	0.4%	0.0%	0.0%	8b	0.4%	0.0%	0.0%
	8c	0.3%	0.0%	0.0%	8c	0.5%	0.0%	0.0%
	8d	0.1%	0.0%	0.0%	8d	0.0%	0.0%	0.0%
	9	0.1%	0.0%	0.0%	9	0.1%	0.0%	0.0%
	VSM	0.3%	0.0%	0.1%	VSM	1.0%	0.0%	0.0%
Clinical Staff	1	0.1%	0.0%	0.0%	1	0.1%	0.0%	0.0%
	2	10.1%	0.3%	0.8%	2	9.9%	0.6%	0.7%
	3	3.6%	0.0%	0.2%	3	3.7%	0.0%	0.3%
	4	1.0%	0.0%	0.1%	4	1.0%	0.0%	0.1%
	5	17.8%	0.2%	1.5%	5	17.4%	0.5%	0.8%
	6	9.0%	0.3%	0.7%	6	9.4%	0.3%	0.6%
	7	5.6%	0.0%	0.5%	7	5.3%	0.1%	0.5%
	8a	1.5%	0.3%	0.1%	8a	1.8%	0.2%	0.1%
	8b	0.2%	0.0%	0.1%	8b	0.3%	0.1%	0.0%
	8c	0.1%	0.0%	0.0%	8c	0.1%	0.0%	0.1%
	8d	0.1%	0.1%	0.0%	8d	0.1%	0.1%	0.0%
	9	0.0%	0.0%	0.0%	9	0.0%	0.0%	0.0%

	VSM	0.0%	0.0%	0.0%

	VSM	0.1%	0.0%	0.0%

Medical Staff		White	BME	Not Stated
	Consultants	3.6%	1.6%	0.5%
	non consultant career grades	0.2%	0.7%	0.2%
	Trainee grades	0.5%	0.8%	0.3%
	Other	0.3%	0.0%	0.1%

	White	BME	Not Stated
Consultants	3.5%	1.5%	0.6%
non consultant career grades	0.2%	0.8%	0.1%
Trainee grades	0.3%	0.5%	0.3%
Other	0.3%	0.0%	0.1%

Appendix 2 **WRES ACTION PLAN 2019/20**

	WRES Indicator/Metric	17/18 data	18/19 data	Analysis	Action
1.	Percentage of staff in each of the AFC Pay Bands compared with the percentage in the overall workforce	(Refer to Appendix 1)			Continue to monitor this data through the appropriate forum.
2.	Relative likelihood of white staff being appointed from shortlisting compared with BME staff	0.72 times more likely	1.17 times more likely	Deterioration	Instigate analysis of data to understand the reasons for non-shortlisting of BME applications.
3.	Relative likelihood of BME staff entering the formal disciplinary investigation compared with white staff	0 – no more likely	0 – no more likely	No Change	Review of triage/case conference arrangements.
4.	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	0.36 times more likely	0.4 times more likely	Deterioration, but remains a favourable position.	Ongoing encouragement to all employees to ensure they are able to access training to support their knowledge and skills promoting access to CPD opportunities. Analysis to understand if any staff group are affected.
5.	KF25 Percentage of staff experiencing harassment, bullying or abuse from patients relatives on the public in the last 12 months.	White 17% BME 5.6%	White 18.6% BME 13.6%	Deterioration. Staff survey data unable to pinpoint a particular staff group	Triangulation with datix information to establish if a particular staff group were affected in year. Any findings to be fed into an appropriate

				affected.	local group to agree actions.
6.	KS26 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White 25.45% BME 22.2%	White 25.6% BME 22.7%	BME and White staff experiencing similar levels which remains concerning.	Actions to fall within remit increasing “diversity of thought” on the people agenda to reduce the percentage of staff in any group being exposed to harassment, bullying or abuse. Actions falling under “excellent place to work” as a Trust wide objective. Actions falling under culture of civility and improved staff experience.
7.	KF21 Percentage believing that trust provides equal opportunities for career progression or promotion	White 90.91% BME 81.8%	White 88.6% BME 92.9%	Improvement on previously good position.	
8.	Q17 In the last 12 months have you personally experienced discrimination at work from any of the following? B) manager/team leader or other colleague	White 6.4% BME 22.2%	White 6.7% BME18.2%	Improvement	Actions to fall within remit increasing “diversity of thought” on the people agenda to reduce the

					percentage of staff in any group being exposed to harassment, bullying or abuse. Actions falling under “excellent place to work” as a Trust wide objective. Actions falling under culture of civility and improved staff experience.
9	Percentage difference between the organisations Board voting membership and its overall workforce	No BME Board members	No BME Board Members	No change.	

Chairs Assurance Report
Finance Planning and Digital Committee 24th September 2019

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	26th September 2019
Executive Sponsor:	Alastair Findlay, 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 24th September 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	24/09/19	Alastair Findlay	14:00

1. Introduction		
1.1. Apologies	Alastair Findlay	14:00
1.2. Minutes from the previous meeting	Alastair Findlay	14:05
1.3. Action Log	All	14:10
1.4. Declaration of Interests	All	14:15
2. Finance		
2.1. Performance Overview Report (Month 5)	Kerry Robinson	14:20
2.2. Finance Director Report	Craig Macbeth	14:25
2.3. Service Line Reporting	Victoria Brownrigg	14:30
2.4. QIPP Delivery Progress	Mark Salisbury	14:35
3. Policies		
3.1. Procurement Strategy and Update	Helen Lewis	14:40
4. Planning		
4.1. Internal Audit Theatre Activity Report	Gurpreet Dulay	14:50
4.2. Job Planning Action Plan	Nia Jones	14:55
4.3. Bookings Transformation and LLP penalty management	Alyson Jordan	15:00
4.4. Veterans Business Case (Paper to Follow)	Lee Osbourne	15:05
5. Digital		
5.1. Cyber Security Update	Simon Adams	15:10
5.2. Digital Strategy Update	Simon Adams	15:15

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 3, Main Entrance	24/09/19	Alastair Findlay	14:00

6. Committee Management		
6.1. BAF and corporate risk register (Paper to Follow)	Shelley Ramtuhul	15:20
6.2. CQC Action Plan (Paper to Follow)	Shelley Ramtuhul	15:25
7. To Note:		
7.1. Review of work plan	Mary Bardsley	15:30
7.2. Chair Report: Digital Steering Group	Simon Adams	15:35
7.3. PRM Divisional Letters	Kerry Robinson	15:40
7.3.1. Surgery		
7.3.2. Medicine		
7.3.3. Diagnostics		
7.3.4. Theatres		
7.3.5. Estates and Facilities		
7.3.6. Library Scanning Team		
7.3.7. E-Rostering		
8. Any Other Business		15:45
8.1. Next Meeting: 29th October 2019 at 2pm		

Month 5 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Principal Analyst and Data Quality Lead	Paper date:	26/09/2019
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 5 (August) 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 4% target at 4.86% being above target for four months out of five this financial year. However remains within normal variation.
- Turnover remains comfortably within 8% target at 6.12% another month at this level will conclude a step change in normal variation for this measurement.

Caring for Patients;

- No serious incidents for three consecutive months.
- Reduction delayed discharges from 6.82% to 4.75% outside target for over 12 months but within normal variation.
- All cancer waiting times standards met up to July (as reported a month in arrears), a fifth consecutive month.
- One unexpected death in August.
- Our English RTT open pathways performance is reported at 88.69%, 1.34% behind our trajectory, not meeting the regulatory standard for four months and below normal variation, linking to levels of theatre activity.
- No patients waiting over 52 weeks except BCU transfers with patients transferred to RJAH after waiting 52 weeks and over.
- Welsh diagnostics standard reported at 100% for third consecutive month. English diagnostics waits standard reported not meeting 99% target for eight consecutive months, however improvement plan showing impact with steady improvement for three consecutive months.

Caring for Finances;

- Theatre activity remains below plan and continues to impact on financial position.
- Outpatient activity remains behind plan for a third consecutive month.
- Agency non-core remains above the national target as it has for 13 consecutive months, but core within target.
- Use of resources score now sits at 3 which under the 19/20 oversight framework is a trigger point.

It is important to note that the following KPI's have action plans in place as requiring improvement to their data quality for reporting;

- Voluntary staff turnover
- Total patient falls
- Bed occupancy

2.3. Conclusion

It is anticipated that there will be small amendments to the latest IPR layout as we progress through the year, additionally with the recent publication of the NHSI 19/20 Single Oversight Framework further additional KPI's will be recommended to be added to committee reports together with changes to specific calculations.

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.

Integrated Performance Report
August 2019 – Month 5

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

Contents

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.

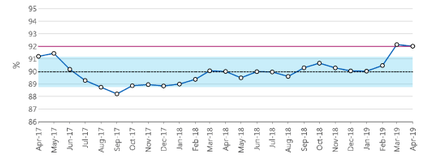
Data Quality Indicator

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**

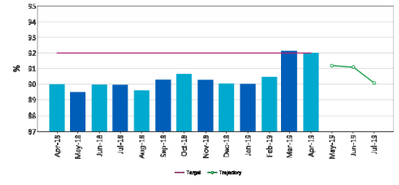
Trend graphs

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



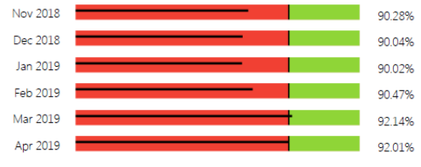
Trajectories

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

	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Sickness Absence	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%	3.75%	3.75%	4.52%	R	
Voluntary Staff Turnover	8.18%	8.14%	7.95%	7.65%	8.01%	7.88%	7.79%	7.34%	7%	6.86%	6.38%	6.65%	6.12%	8%	8%	6.12%	G	Sep-19

Integrated Performance Report
August – Month 5

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Patients

	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Serious Incidents	1	1	1	1	1	0	0	2	1	1	0	0	0	0	0	2	R	Apr-18
Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Total Patient Falls	10	15	20	13	16	11	10	8	5	11	16	10	8	10	50	50	G	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)	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%	95%			G	Apr-18
Number of Complaints	7	12	13	6	7	6	17	8	5	8	7	9	7	8	40	36	G	May-18
% Delayed Discharge Rate	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%	2.5%	2.5%	5.36%	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	0	0	2	0	1	0	0	0	3	R	Jun-19
RJAH Acquired C.Difficile	0	1	0	0	0	1	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	0	0	1	0	0	1	R	Apr-18
VTE Assessments Undertaken	100%	99.92%	99.71%	99.86%	99.91%	100%	99.84%	99.92%	99.91%	99.83%	99.73%	99.92%	100%	95%	95%	99.88%	G	Apr-18
Cancer Two Week Wait*	100%	100%	100%	100%	100%	100%	92.86%	100%	100%	100%	100%	96.77%			93%	99.06%	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)*	0%	0%	50%	100%	66.67%	50%	100%	100%	100%	100%	100%	100%			85%	100%	G	

Integrated Performance Report
August – Month 5

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	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 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	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%	92%	92%	90.5%	G	
Patients Waiting Over 52 Weeks – English	1	0	2	2	4	2	4	0	0	0	0	0	0	0			G	
Patients Waiting Over 52 Weeks – Welsh	8	6	3	6	7	3	6	1	0	0	1	0	0	0			G	
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)	124	87	54	72	66	52	26	0	1	6	18	86	128				G	
6 Week Wait for Diagnostics - English Patients	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%	99%	99%	98.1%	G	
8 Week Wait for Diagnostics - Welsh Patients	99.67%	100%	99.24%	99.65%	99.64%	99.66%	98.72%	100%	98.76%	99.72%	100%	100%	100%	100%	100%	99.72%	G	

Integrated Performance Report
August – Month 5

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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Caring for Finances

	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Total Theatre Activity	929	1,017	1,115	1,157	883	1,094	1,024	1,082	856	970	886	926	921	953	5,062	4,559	R	Sep-19
Bed Occupancy – All Wards – 2pm	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%	87%	83%	81.9%	G	Sep-19
Outpatients Activity Attendances	12,885	13,792	15,939	15,298	11,440	14,995	13,616	13,718	13,724	13,762	13,009	14,277	12,881	13,057	68,446	67,653	R	Sep-19
Financial Control Total	-190	152	676	621	-833	359	59	535	-775	31	-207	73	-288	-207	274	-1,166	R	
Income	9,080	9,194	10,357	10,004	8,048	9,583	9,049	10,278	8,677	9,508	8,842	9,486	8,837	9,068	47,159	45,350	R	
Expenditure	9,264	9,038	9,734	9,416	8,648	9,189	9,031	9,464	9,495	9,521	9,092	9,457	9,167	9,318	47,102	46,735	G	
CIP Delivery	310	298	327	311	329	284	307	358	165	192	260	231	300	265	1,205	1,142	G	
QIPP Delivery Risk Impact									106	86	-67	7	56	0	0	188	R	
Agency Core	122.05	112.7	171.62	141.07	105.5	90.56	45.75	68.59	51	68	44	69	77	132	660	309	G	
Agency Non-Core	296.21	243.2	302.08	233.41	234.72	243.13	243.43	317.48	229	239	221	232	254	175	818	1,175	R	
Cash Balance	6,200	5,400	5,000	4,200	3,900	4,700	4,300	5,700	5,100	4,900	5,000	9,100	5,500	4,700	4,700	5,500	G	
Capital Expenditure	164	297	160	377	400	304	165	1,327	260	336	162	3	3	433	1,866	1,804	G	
Use of Resources (UOR)	3	2	2	2	2	2	2	1	3	3	3	3	3	2	2	3	R	

Sickness Absence

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

4.86% against **3.75%** target

Breaching target red rated

Exec Lead:
Director of People

Integrated Performance Report

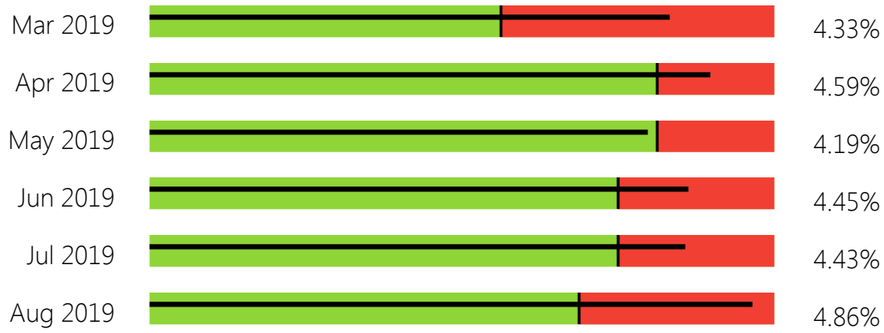
Narrative

There was an increase in sickness absence in August, and rates continue to be driven by long term absence which saw a further increase and continues to be above target. Stress/anxiety/depression was the single highest reason for long term absence in August (with therapy support workers, clinical support workers and nursing staff groups being the highest staff groups affected).

Action to Improve:Staff experience objectives being taken forward covering a number of wellbeing initiatives. People Services Business Partners continue to feed local wellbeing issues and action plans via PRM framework. Launch of revised sickness policy in September with improved focus on supportive conversations to minimise the risk of any issues of stress/anxiety/depression (work or home related) leading to absence if not dealt with in a supportive manner.

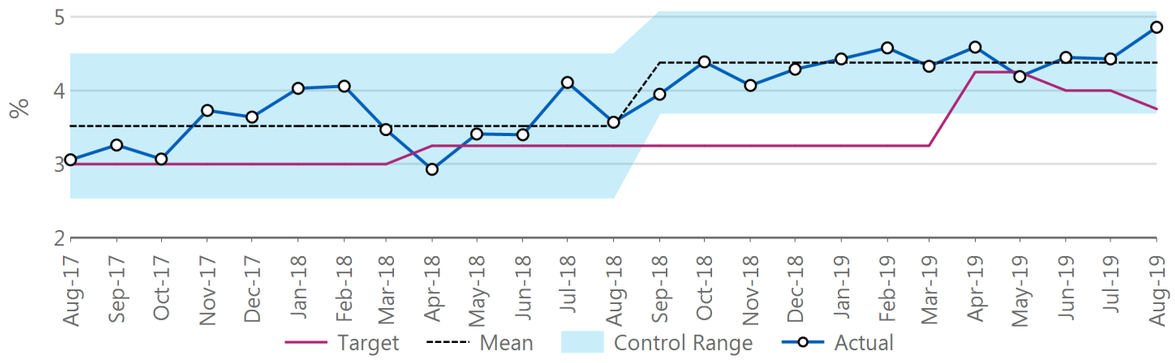
Further analysis of the data is going to be undertaken to review the trajectory provided.

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

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
3.06%	3.26%	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%

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Voluntary Staff Turnover

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

6.12% against 8% target

Within target green rated

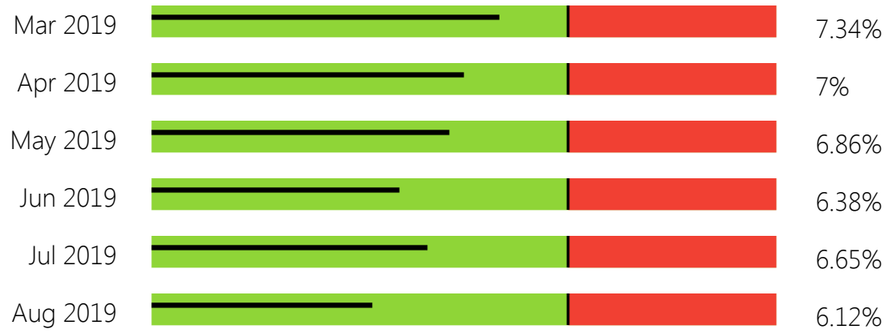
Exec Lead:
Director of People

Integrated Performance Report

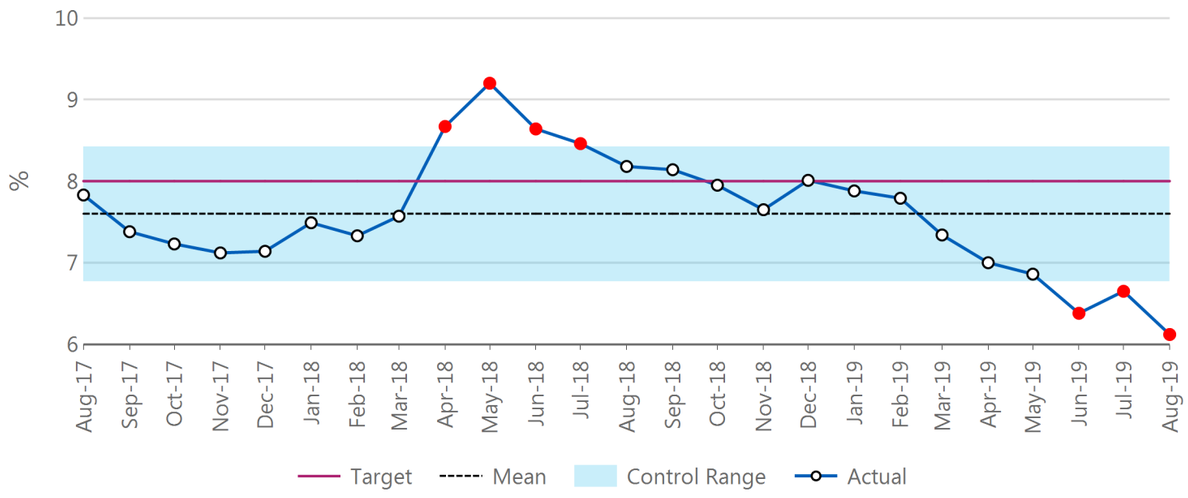
Narrative

Average leavers occurring in the last twelve month period was slightly lower returning in a slight reduction in our turnover rate for August, and therefore remains within target.

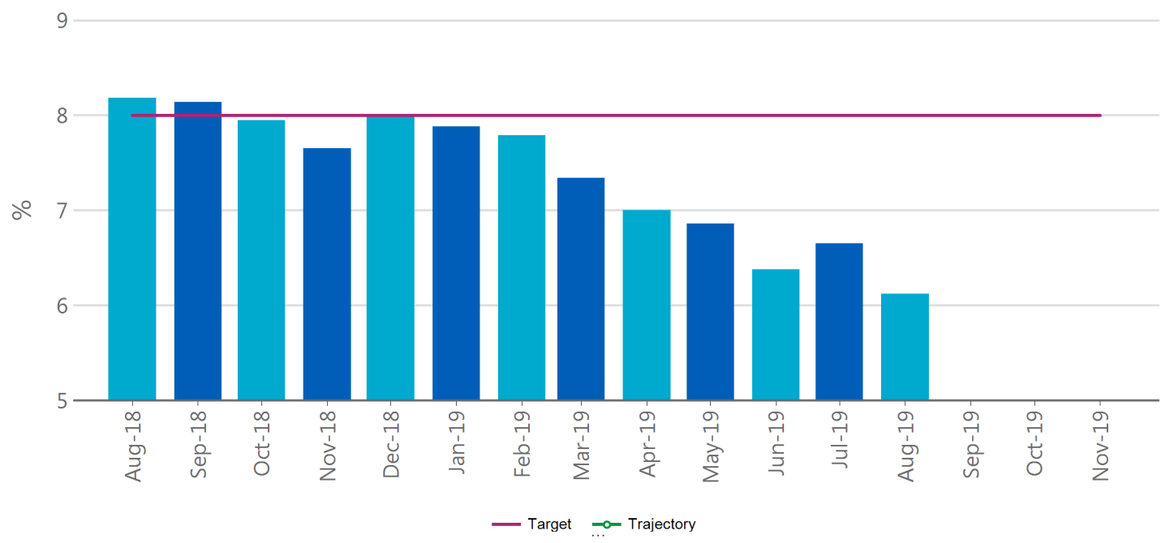
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
7.83%	7.38%	7.23%	7.12%	7.14%	7.49%	7.33%	7.57%	8.67%	9.2%	8.64%	8.46%	8.18%	8.14%	7.95%	7.65%	8.01%	7.88%	7.79%	7.34%	7%	6.86%	6.38%	6.65%	6.12%	6.12%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Serious Incidents

Number of Serious Incidents reported in month

0 against 0 target

On target green rated

Exec Lead:
Director of Nursing

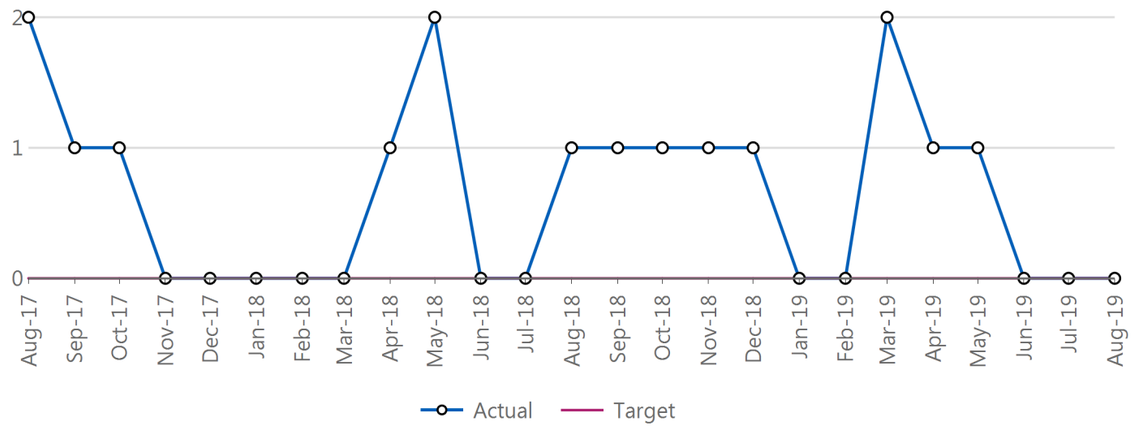
Integrated Performance Report

Narrative

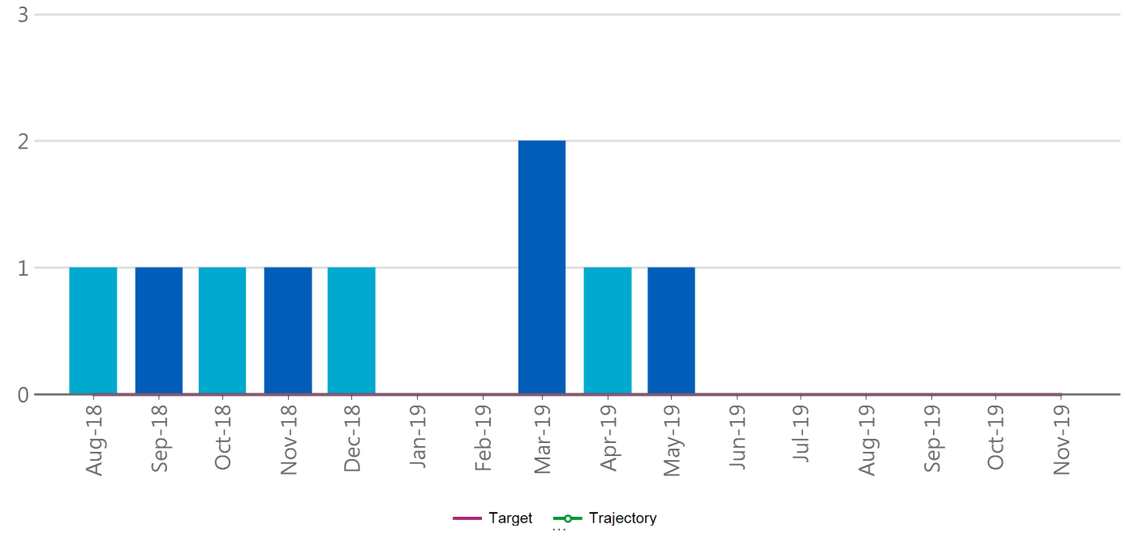
There were no serious incidents reported in August.

Performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

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

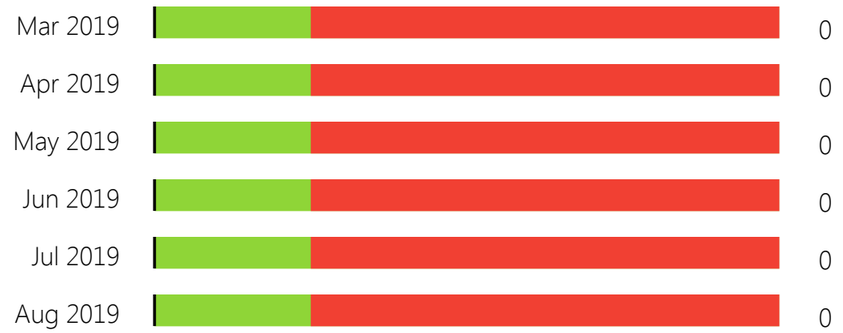
Exec Lead:
Director of Nursing

Integrated Performance Report

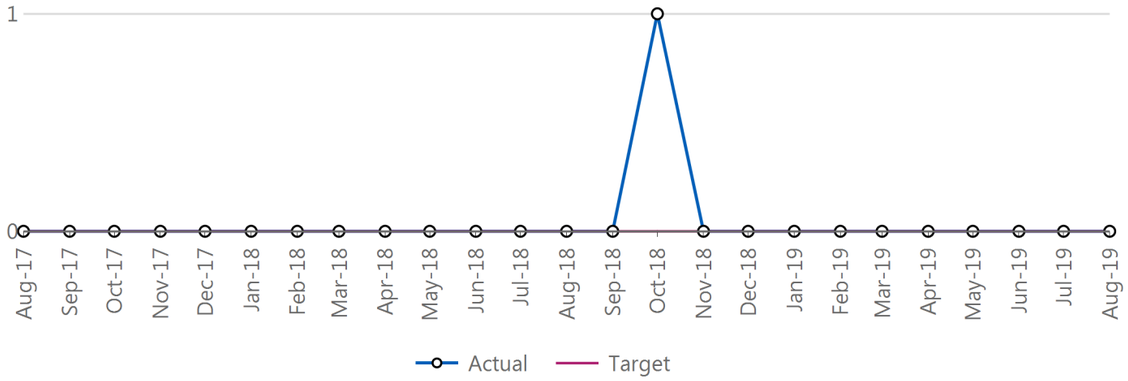
Narrative

There were no never events reported in August.

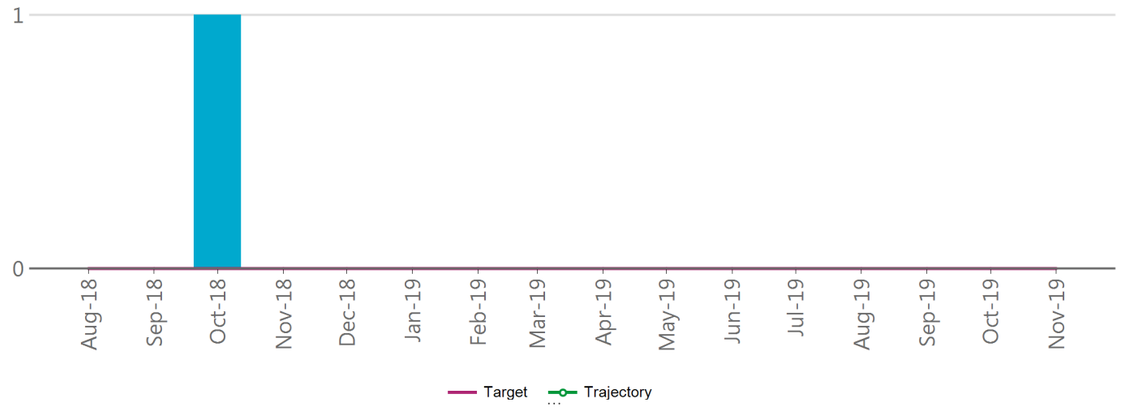
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Patient Falls

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

8 against 10 target

Within target green rated

Exec Lead:
Director of Nursing

Integrated Performance Report

Narrative

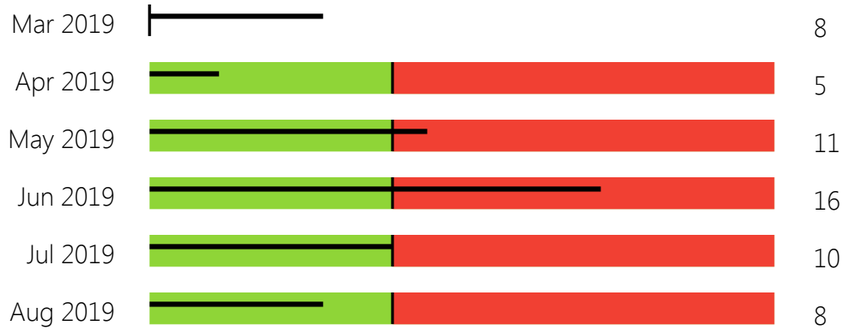
The Total Patient Falls KPI is green rated in August as there were 8 falls, 4 relating to inpatients and 4 relating to outpatients. The falls are broken down as follows:

- Low harm (7) 87.5%, made up of:
  - No obvious injury but unwitnessed (4)
  - Pain to shoulder and elbow, unwitnessed (1)
  - Skin abrasion, witnessed (1)
  - Swelling/lump to head, unwitnessed (1)
- Moderate harm (1) 12.5%, made up of:
  - Fracture to clavicle, unwitnessed (1)

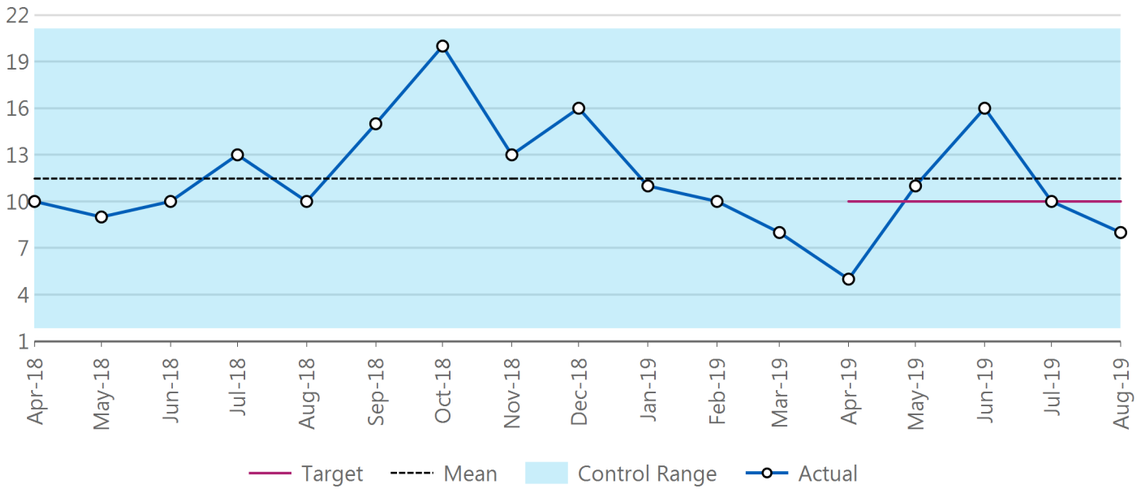
The falls occurred within the following wards/areas:

- Inpatient falls: Clwyd (1), Wrekin (1), Ludlow (1), Sheldon (1) Outpatient falls: Orthotics (1), Other - Diagnostic (1), Corporate/Estates (2)

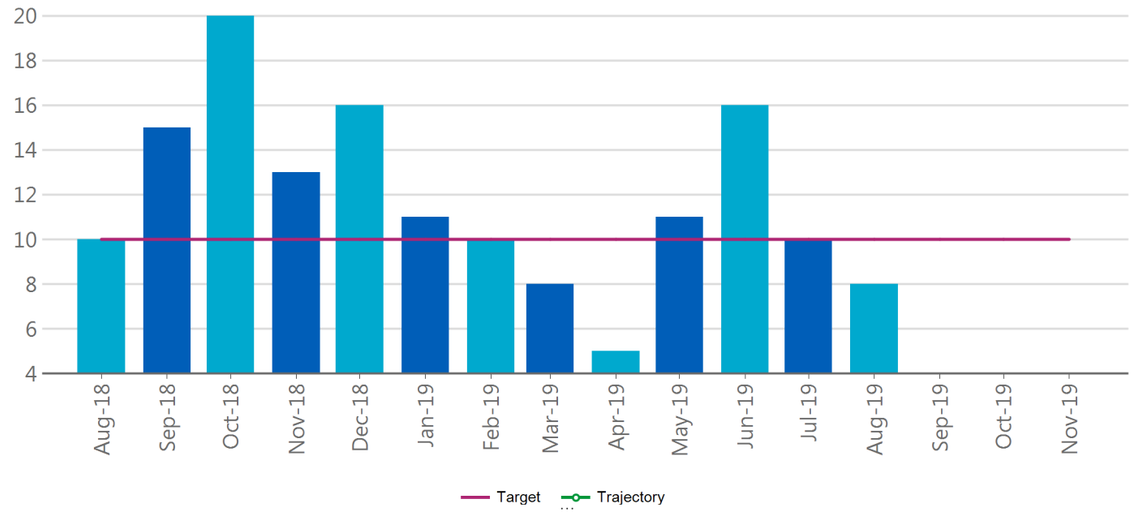
Performance against RAG ratings



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	YTD
10	9	10	13	10	15	20	13	16	11	10	8	5	11	16	10	8	50

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

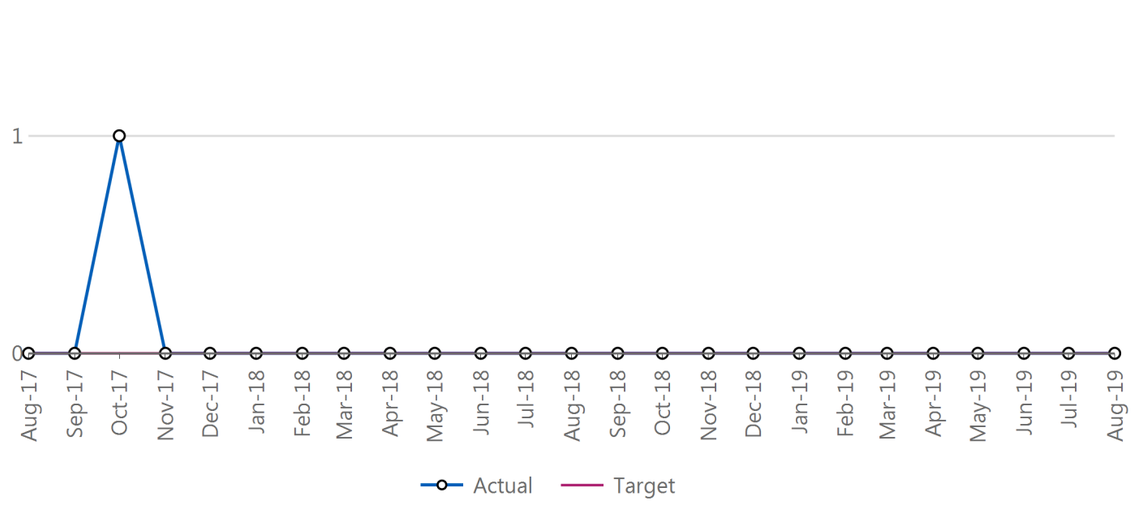
Integrated Performance Report

Narrative

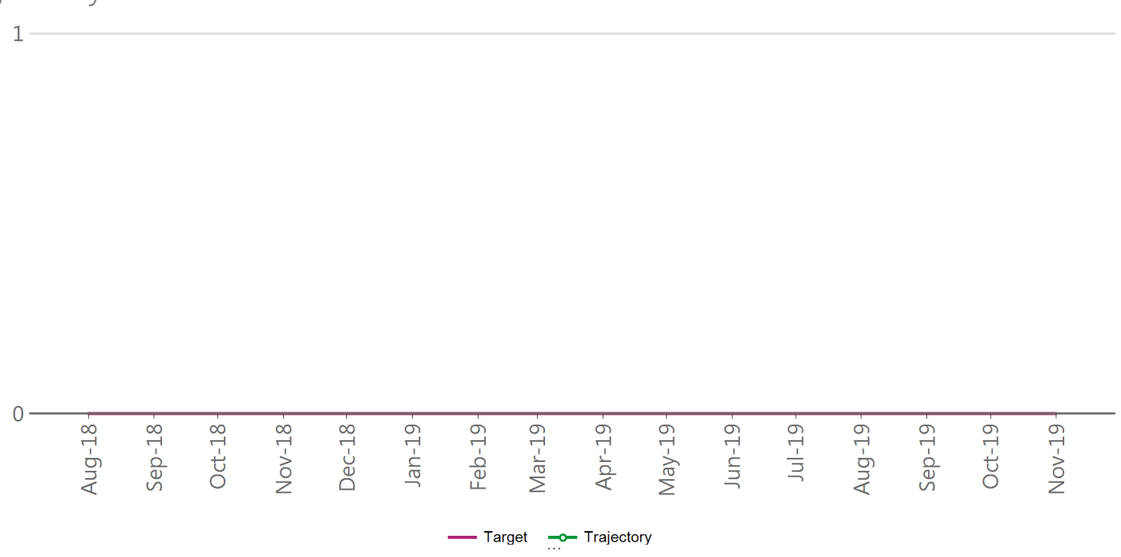
There were no category three or four pressure ulcers in August.

Performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

99.21% against 95% target

Above target green rated

Exec Lead:
Director of Nursing

Integrated Performance Report

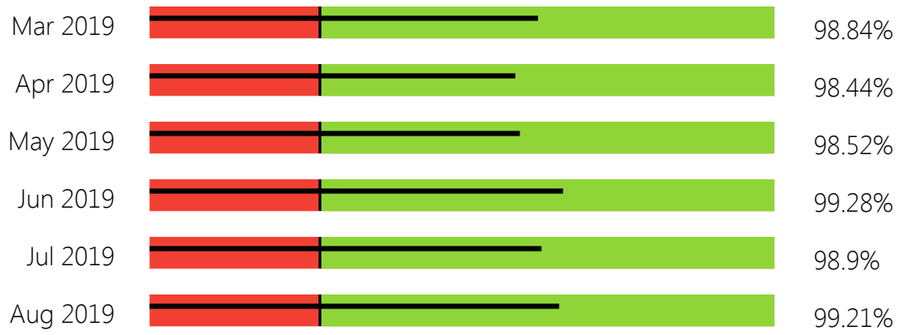
% of patients who would recommend the trust (inpatients and outpatients)

Narrative

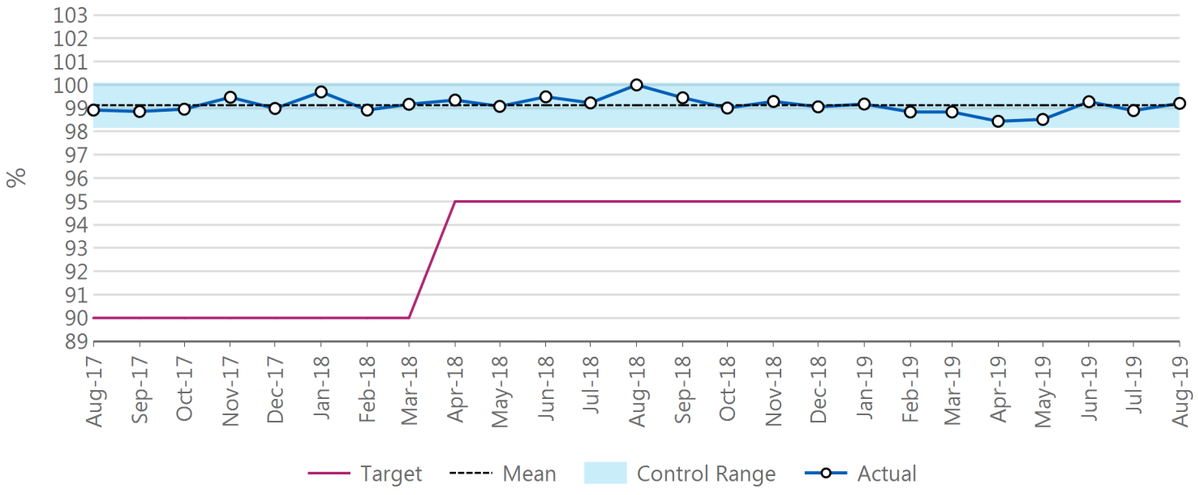
There were 757 responses collected with a breakdown as follows:
- 751 positive - giving a rate of 99.21% would recommend the Trust to friends and family
- 3 negative - giving a rate of 0.40% would not recommend the Trust to friends and family
- 3 responses as "neither likely or unlikely" or "don't know"

The number of compliments received in August was 328.

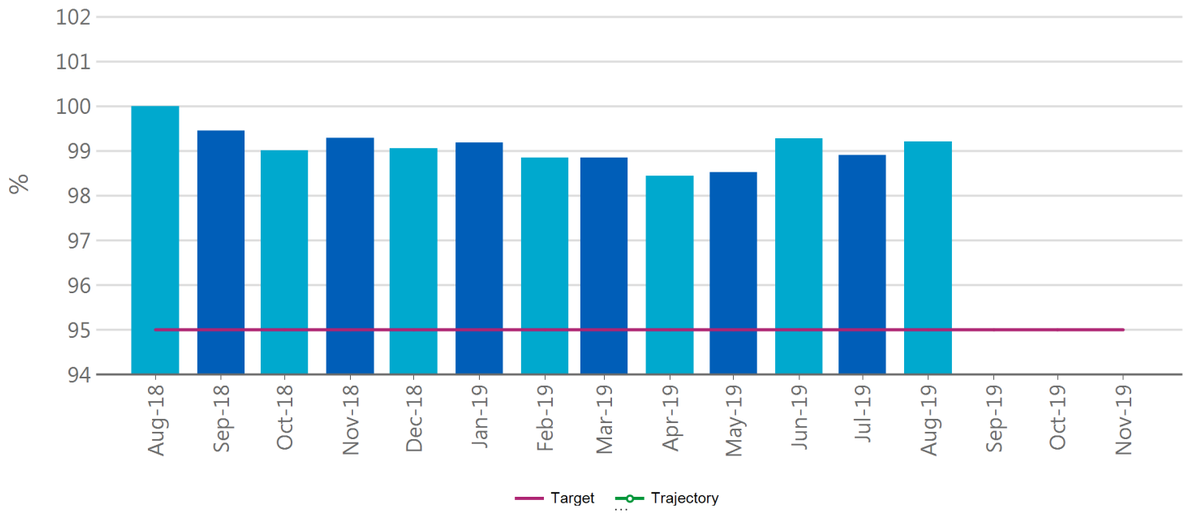
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
98.92%	98.86%	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%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Number of Complaints

Number of complaints received in month

7 against 8 target

Within target green rated

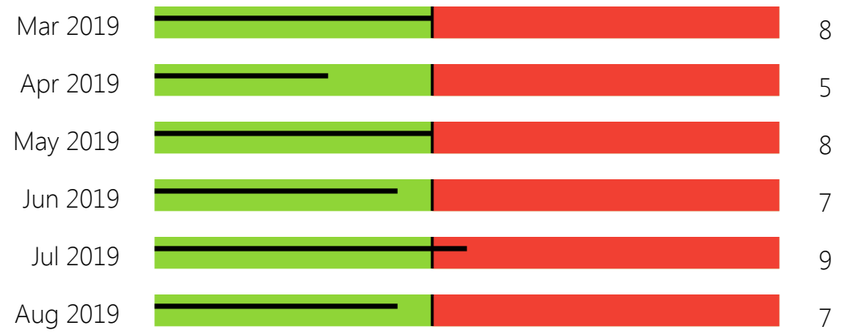
Exec Lead:
Director of Nursing

Integrated Performance Report

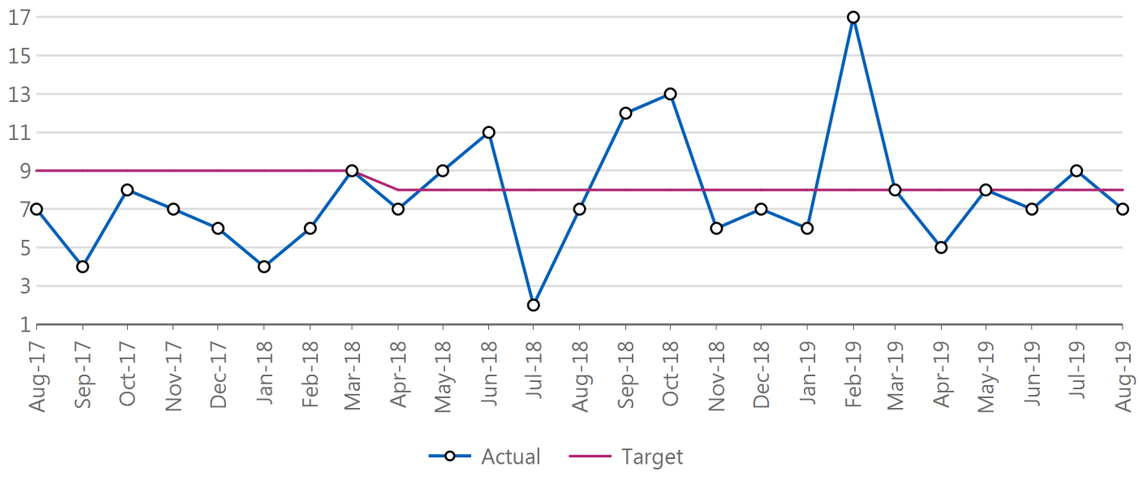
Narrative

There were seven complaints received in August. Three related to quality of care with reasons associated with attitude of staff (2) and a fall whilst an inpatient (1). Four complaints related to operational issues associated with information provided (1), waiting time to be provided an outpatient appointment (1), waiting time for surgery (1) and lack of physiotherapy (1).

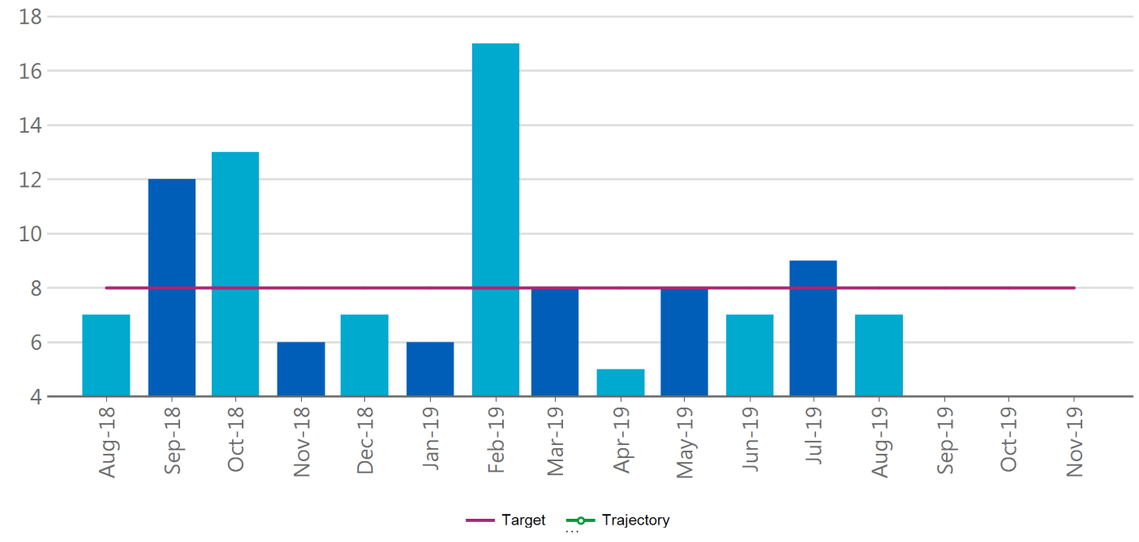
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
7	4	8	7	6	4	6	9	7	9	11	2	7	12	13	6	7	6	17	8	5	8	7	9	7	36

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 %

4.75% against 2.5% target

Breaching target red rated

Exec Lead:
Director of Nursing

Integrated Performance Report

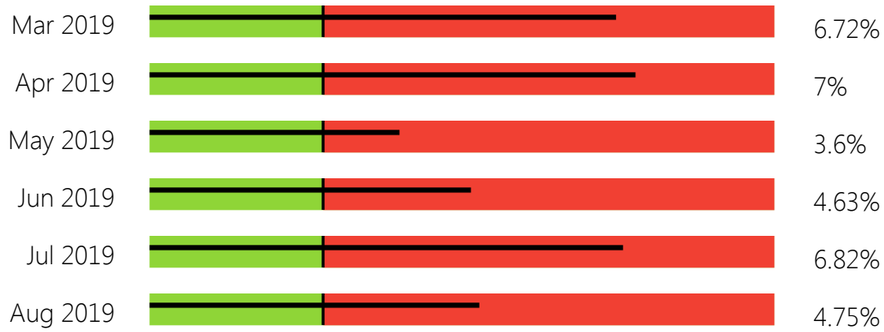
Narrative

The Delayed Discharge rate is red rated this month at 4.75%. The total delayed days for August is 203 days; 9 spinal injuries patients amounting to 151 days, 10 care of the elderly patients with 49 delayed days and 2 surgical patients with 3 delayed days. The patients fall under the responsibility of Shropshire (10), Resident in Wales (4), Dudley (2), Birmingham (2) and 3 other organisations with one patient each.

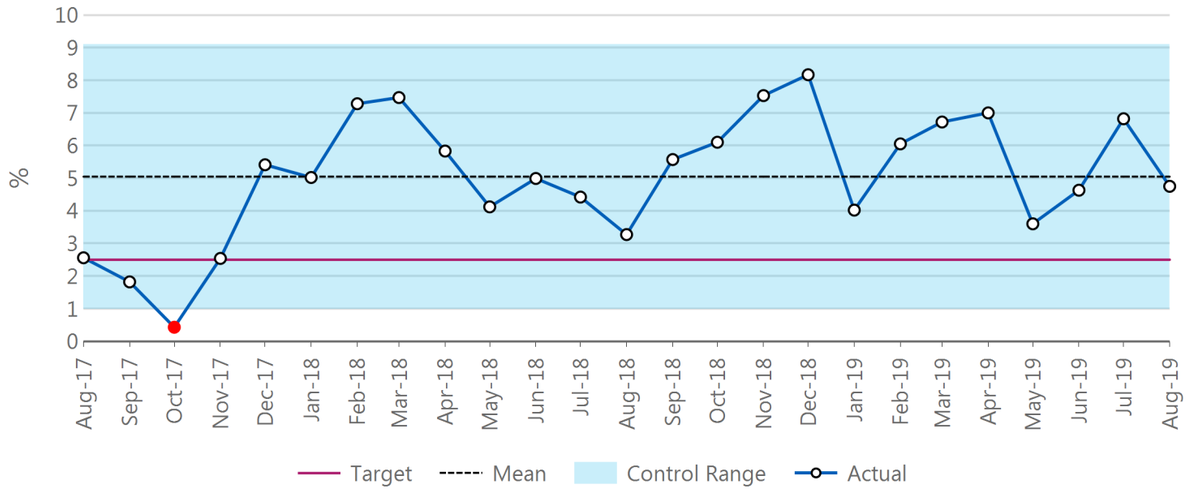
It has been identified that patients treated in the Tumour team are not being recorded as a delay when they have met the definition of a Delayed Transfer of Care as per the NHS England guidelines. This is being addressed by the Matron and Oswald Ward and it is possible that we will see an increase in the Delayed Discharge Rate in the coming months as a result.

Action to Improve:Work continues to implement the action plan that was agreed with ECIST.

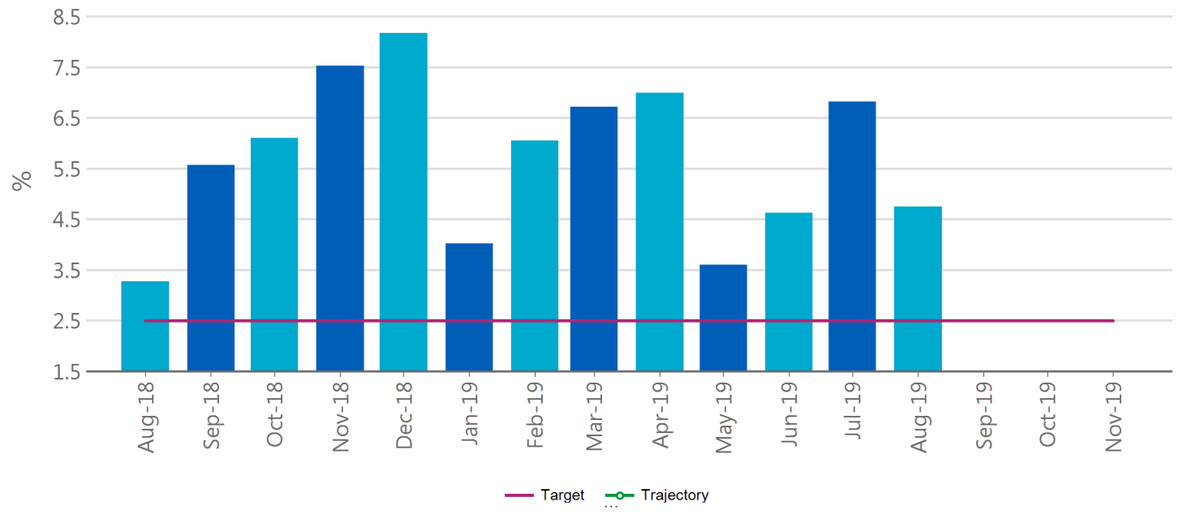
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
2.56%	1.82%	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%	5.36%

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

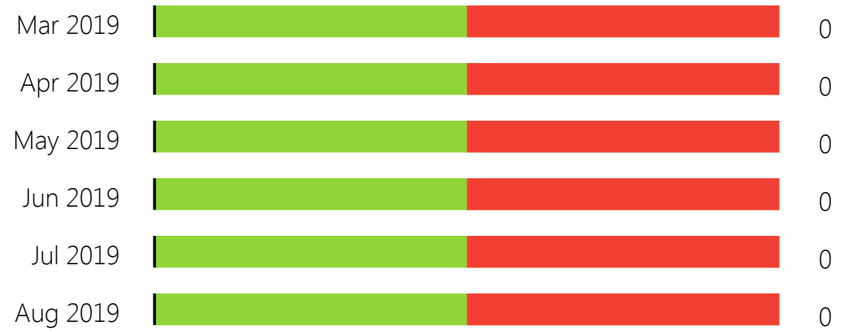
Exec Lead:
Director of Nursing

Integrated Performance Report

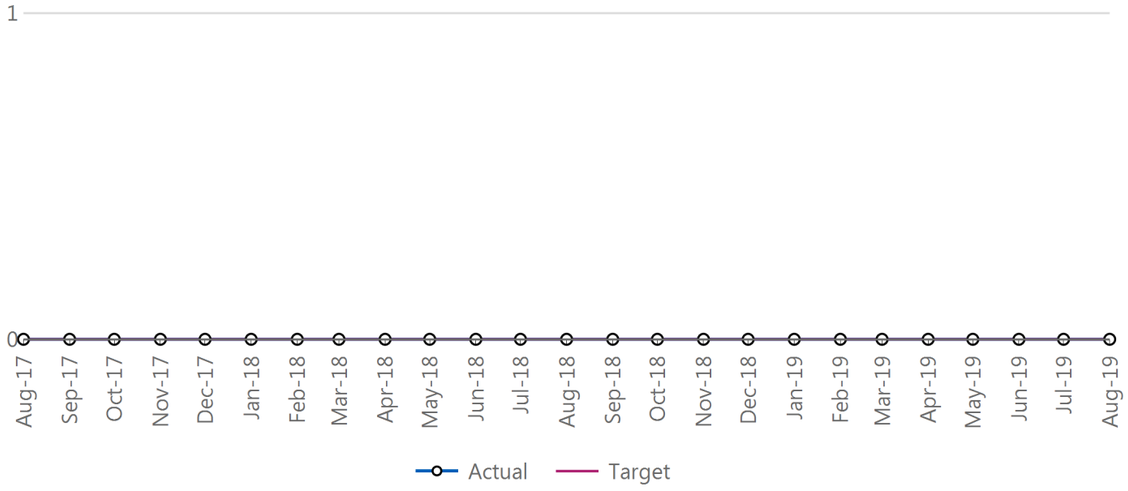
Narrative

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

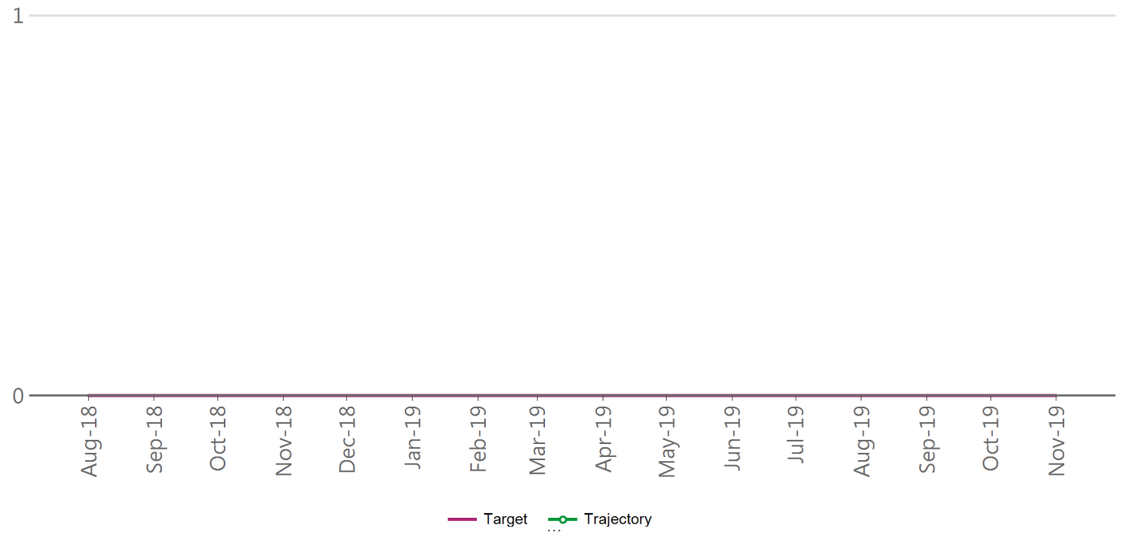
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

0 against 0 target

On target green rated

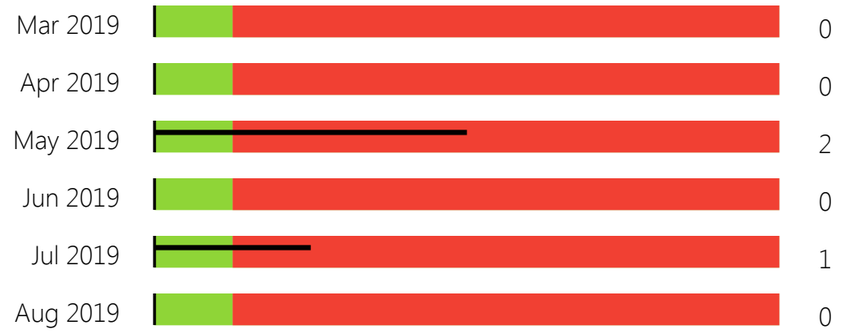
Exec Lead:
Director of Nursing

Integrated Performance Report

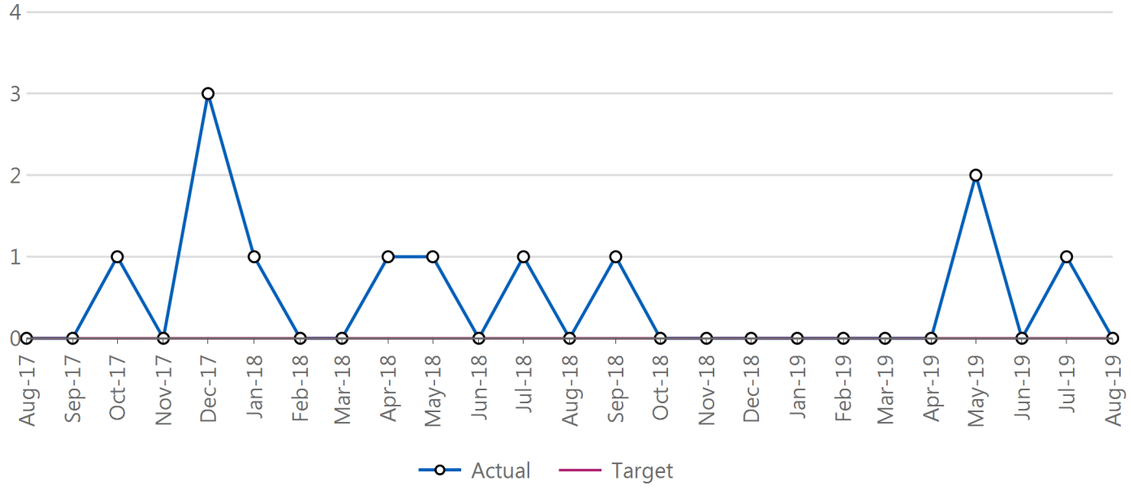
Narrative

There were no incidents reported in August.

Performance against RAG ratings



Performance over 24 months –



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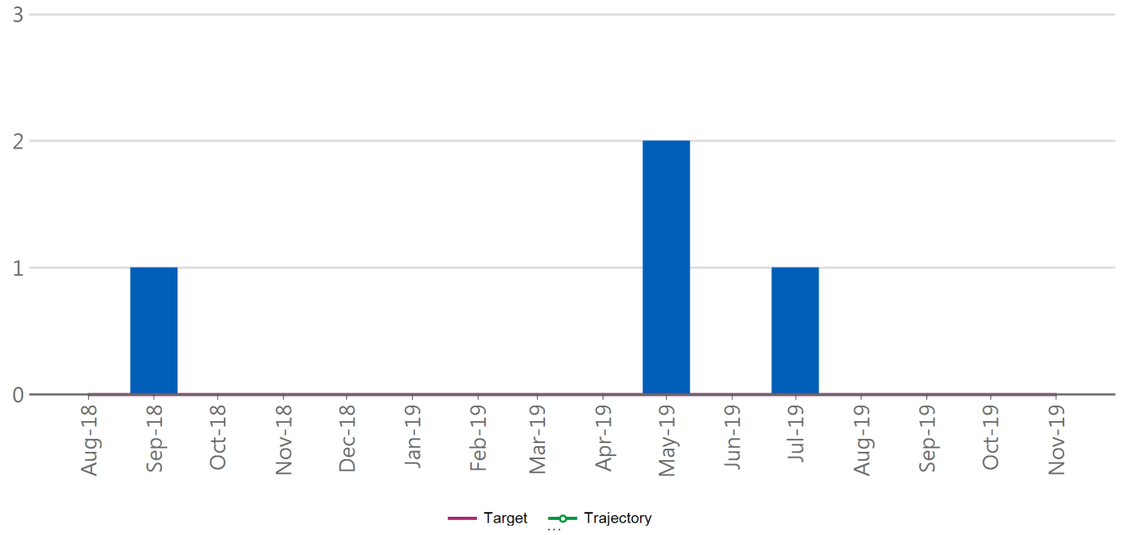


Heatmap performance over 24 months

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

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

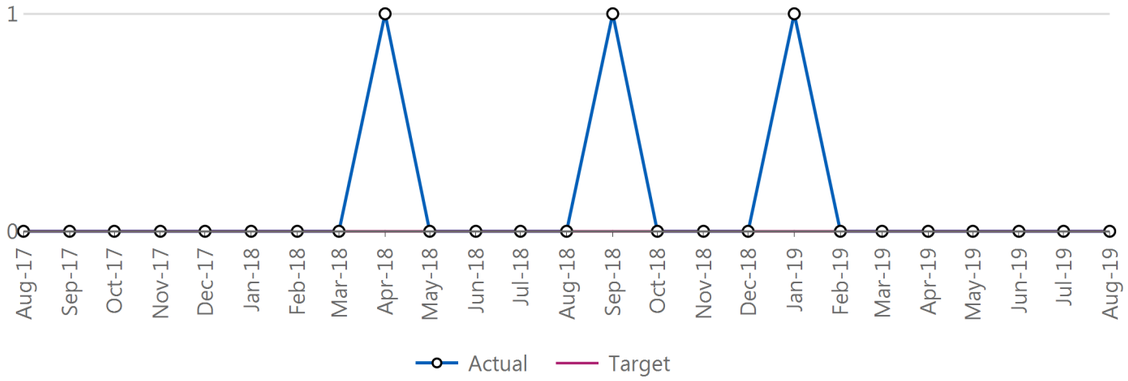
Integrated Performance Report

Narrative

There were no incidents reported in August.

Performance against RAG ratings

Performance over 24 months –



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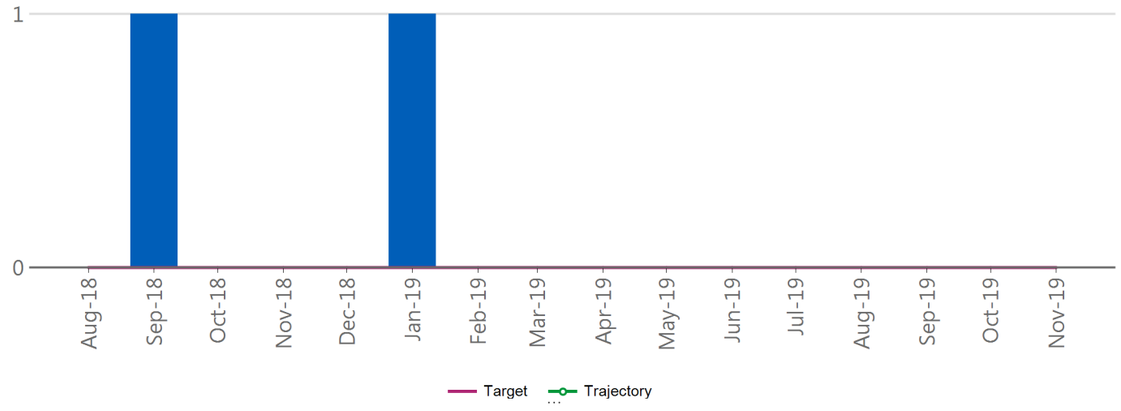


Heatmap performance over 24 months

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

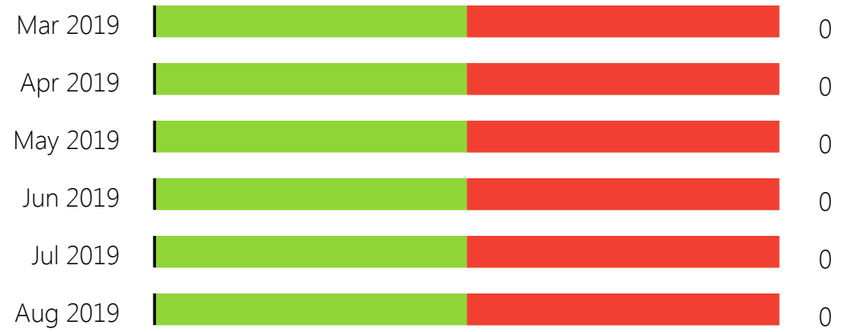
Exec Lead:
Director of Nursing

Integrated Performance Report

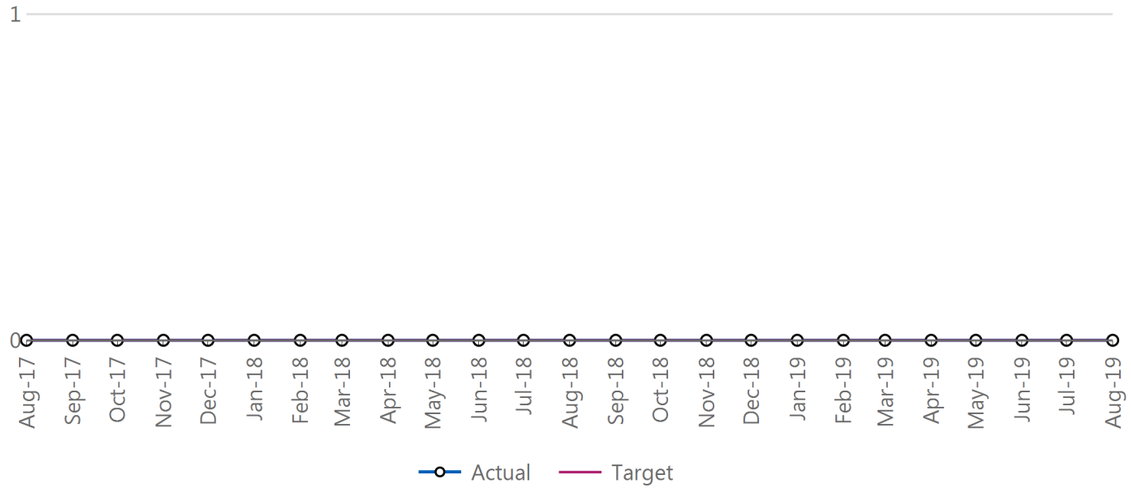
Narrative

There were no incidents reported in August.

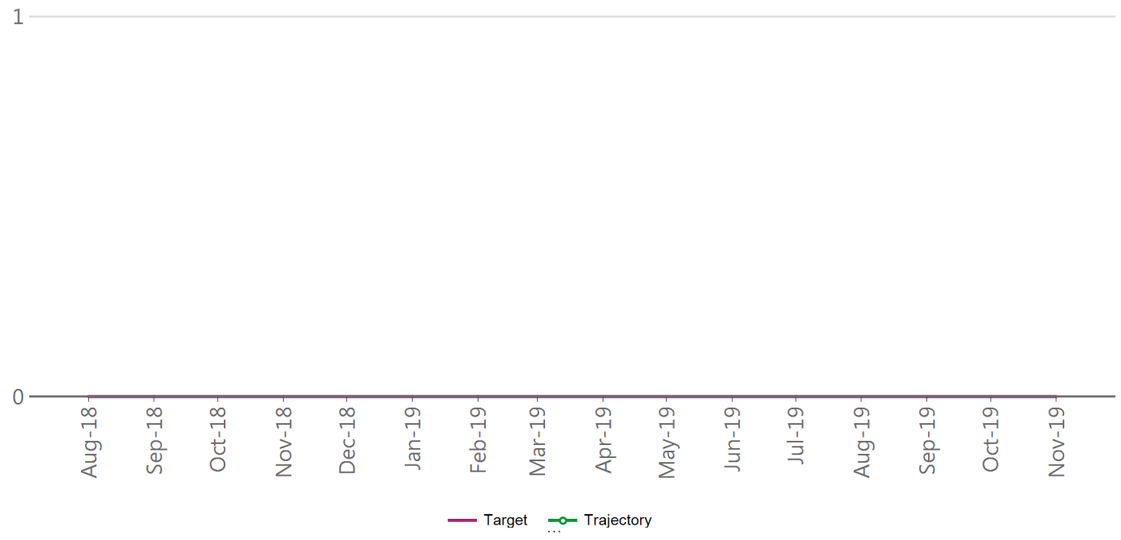
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

Unexpected Deaths

Number of Unexpected Deaths in Month

1 against 0 target

Breaching target red rated

Exec Lead:
Medical Director

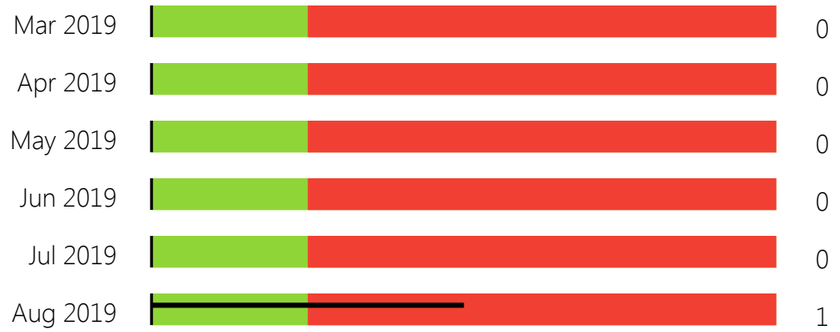
Integrated Performance Report

Narrative

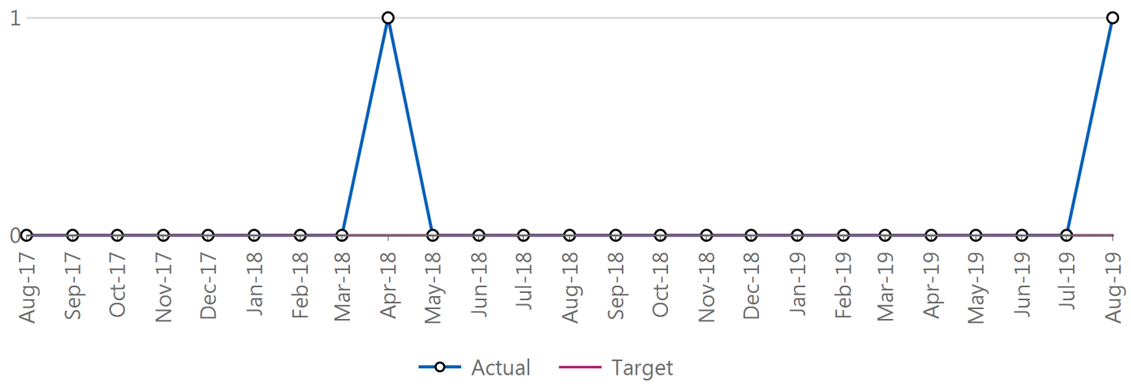
There was one death within the Trust in August which was unexpected. The surgical patient had undergone bilateral total knee replacements 11 days earlier.

Action to Improve:This incident is currently being investigated by root cause analysis. Upon completion, the findings will be presented at the Multidisciplinary Clinical Audit Meeting (MDCAM) by our Learning from Deaths Clinical Lead.

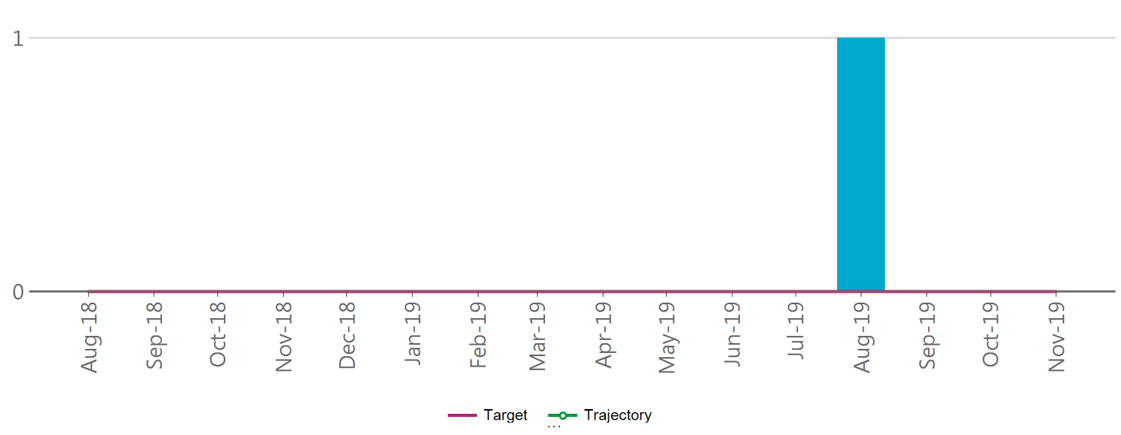
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

100% against **95%** target

Above target green rated

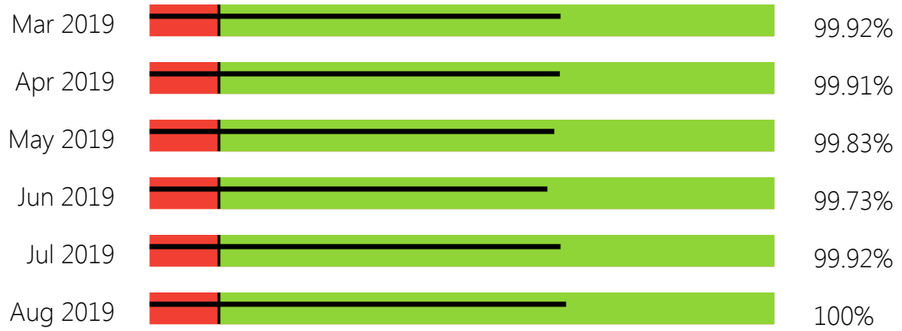
Exec Lead:
Medical Director

Integrated Performance Report

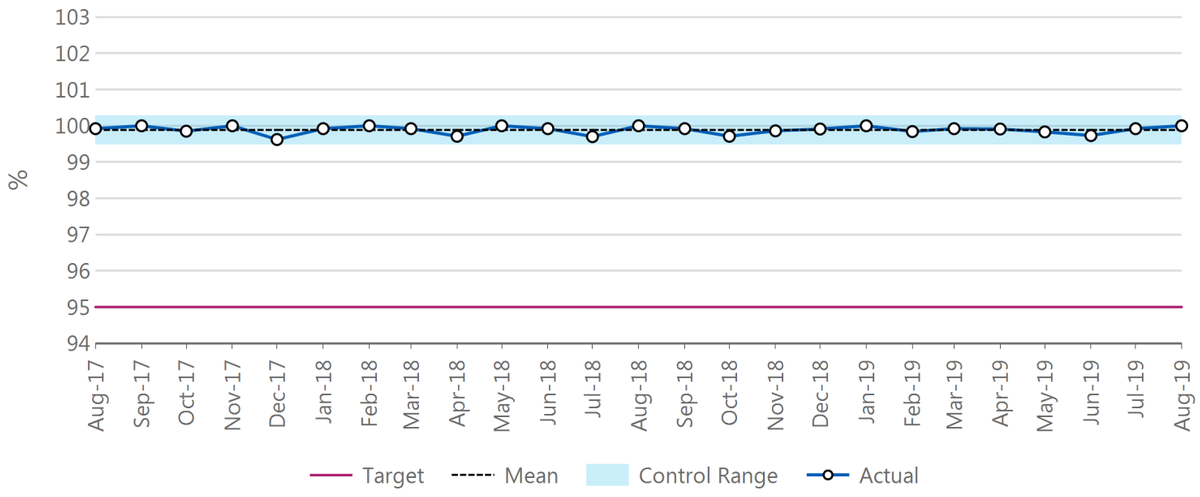
Narrative

The percentage of admissions risk assessed is reported at 100% in August and remains above the 95% target.

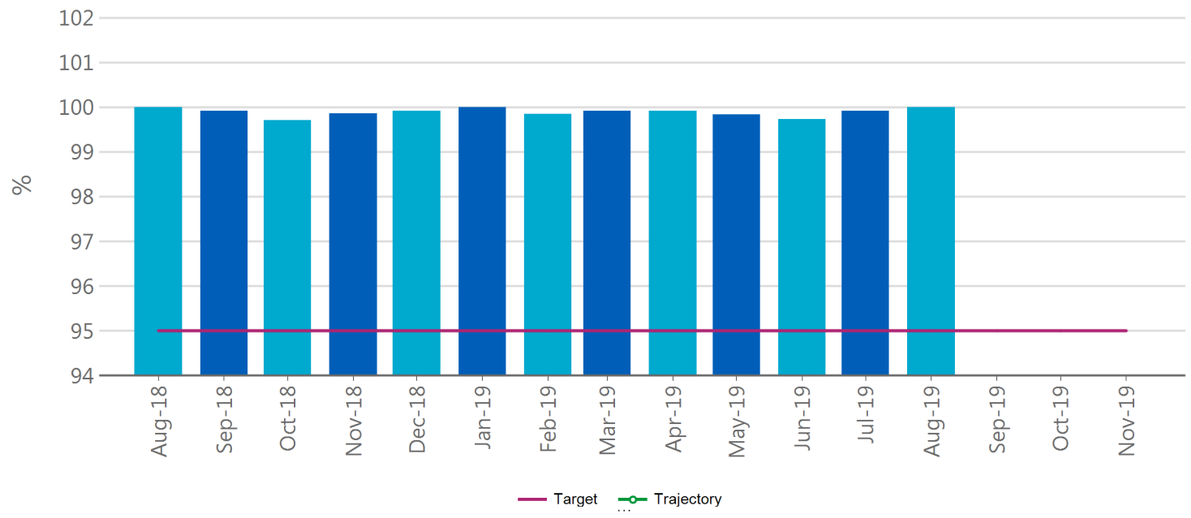
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
99.92%	100%	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%	99.88%

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)

96.77% against **93%** target

green rated

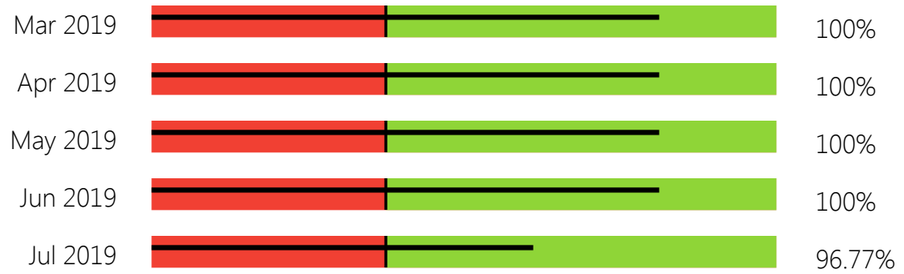
Exec Lead:
Director of Operations

Integrated Performance Report

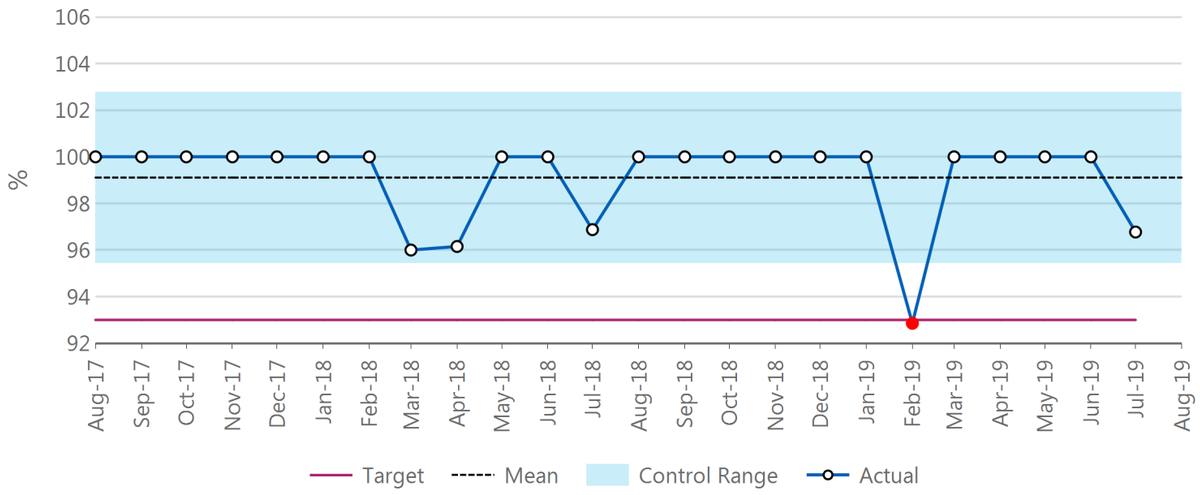
Narrative

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

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
100%	100%	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%		99.06%

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

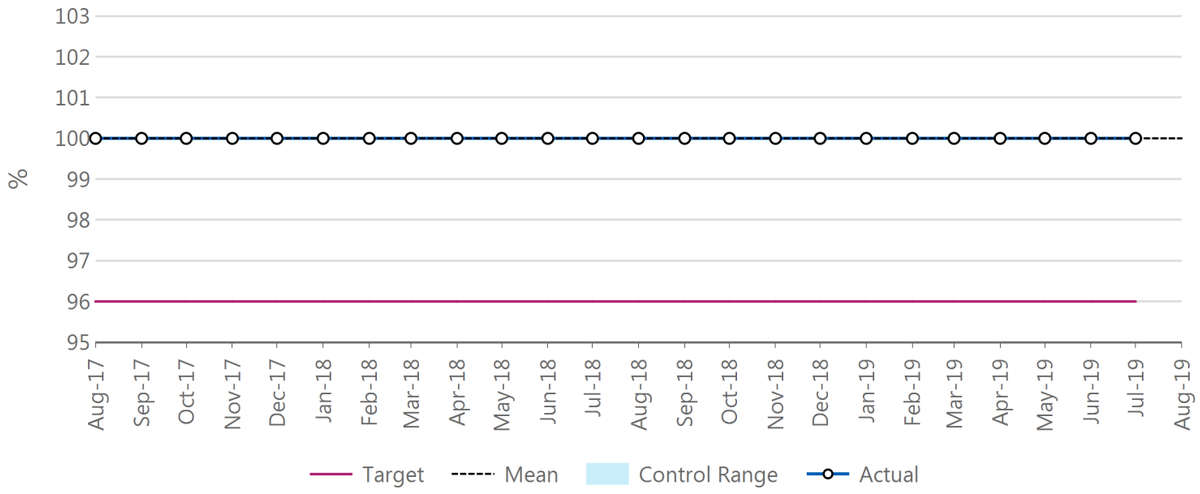
Integrated Performance Report

Narrative

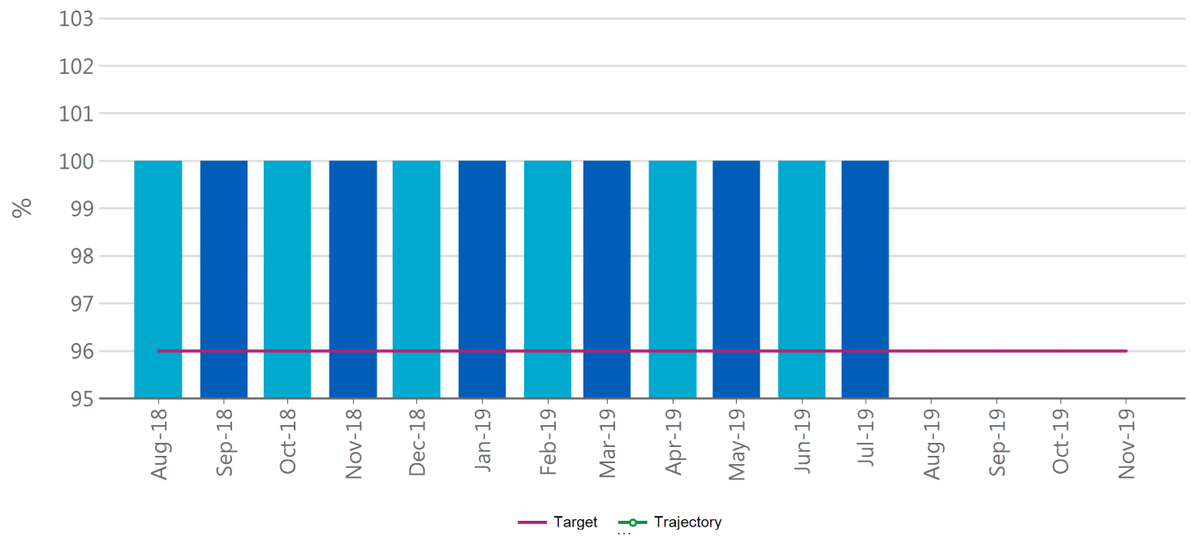
The Cancer 31 day first treatment standard was achieved in July and indicative data for August shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

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

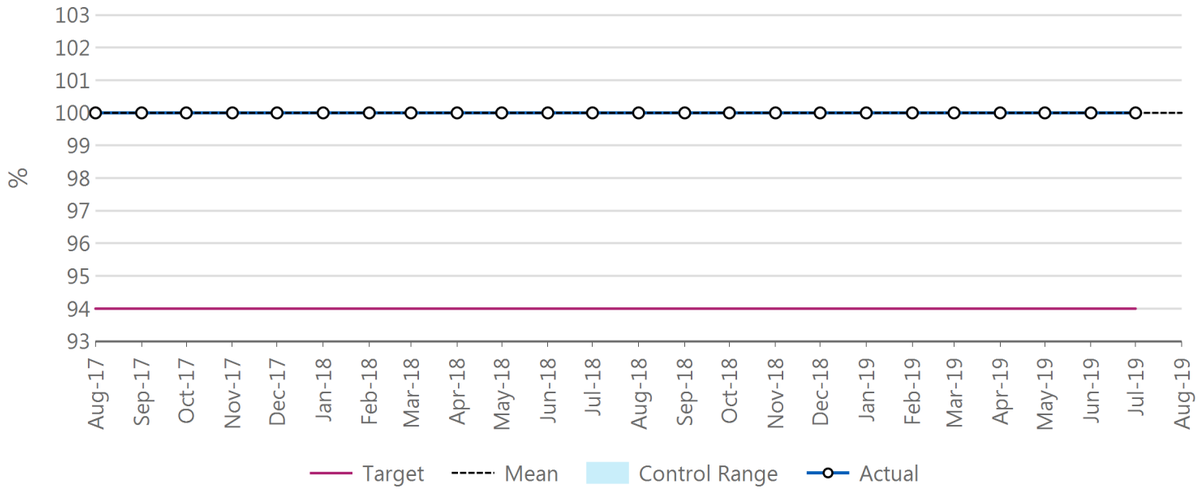
Integrated Performance Report

Narrative

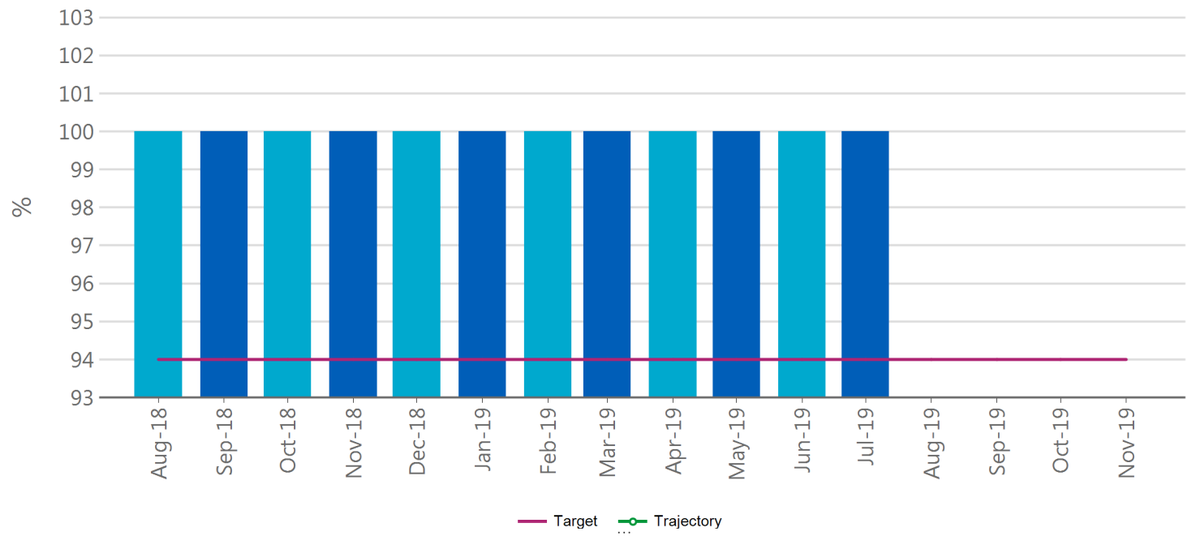
The Cancer 31 day subsequent treatment standard was achieved in July and indicative data for August shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

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

100% against 85% target

green rated

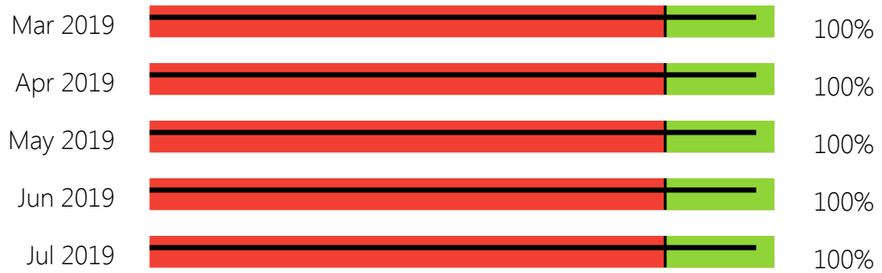
Exec Lead:
Director of Operations

Integrated Performance Report

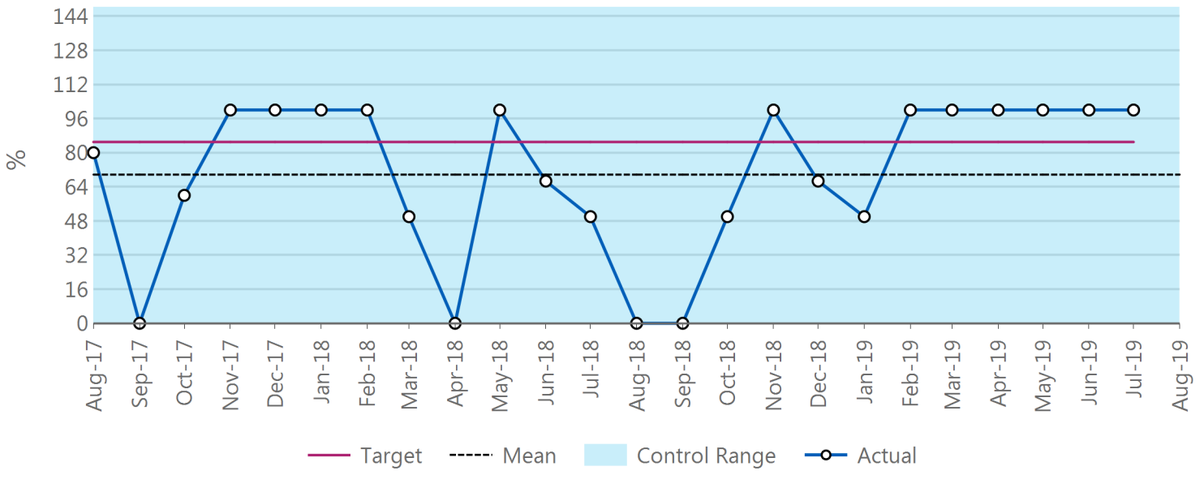
Narrative

The Cancer 62 day standard was achieved in July and indicative data for August shows achievement of the standard will continue.

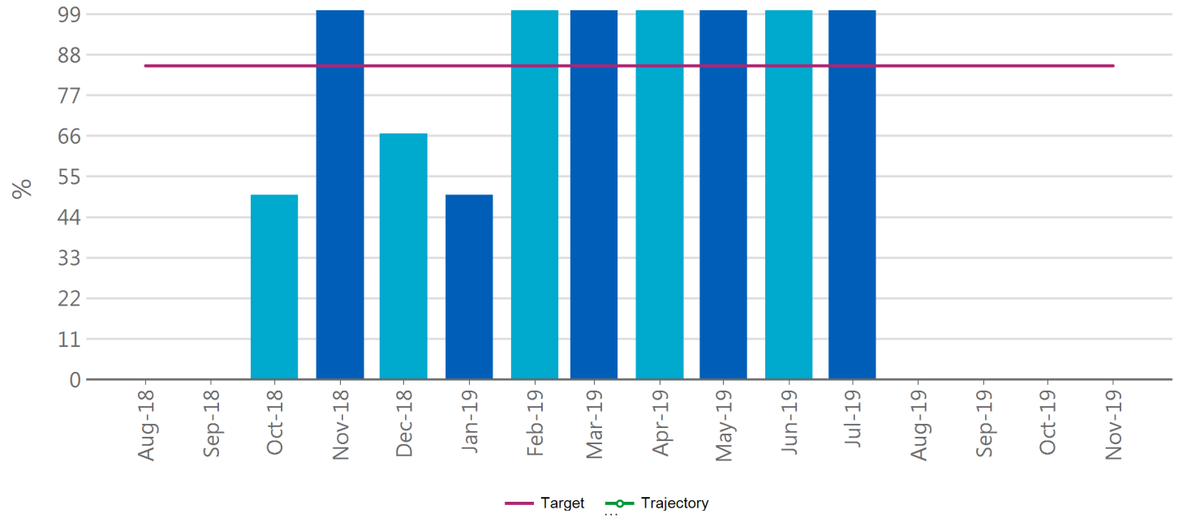
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
80%	0%	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%

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

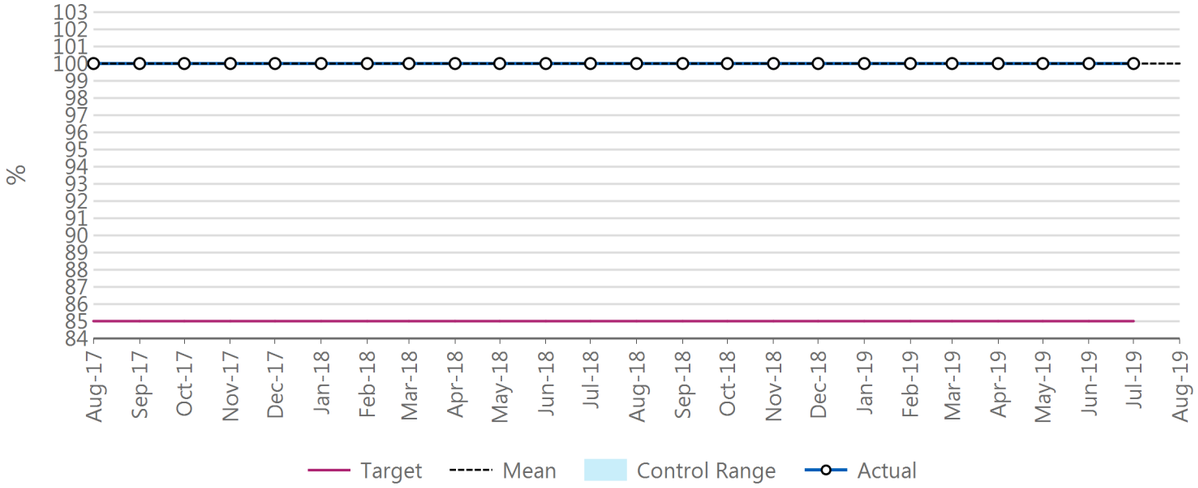
Integrated Performance Report

Narrative

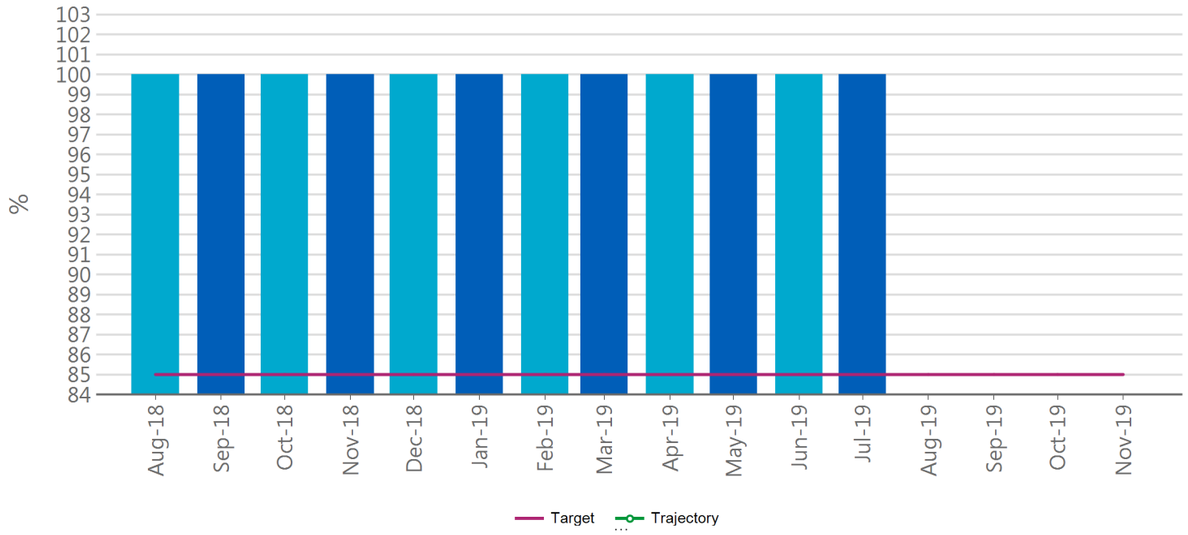
The Cancer 62 day consultant upgrade standard was achieved in July and indicative data for August shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

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

NHS
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

88.69% against **92%** target

Below target red rated

Exec Lead:
Director of Operations

Integrated Performance Report

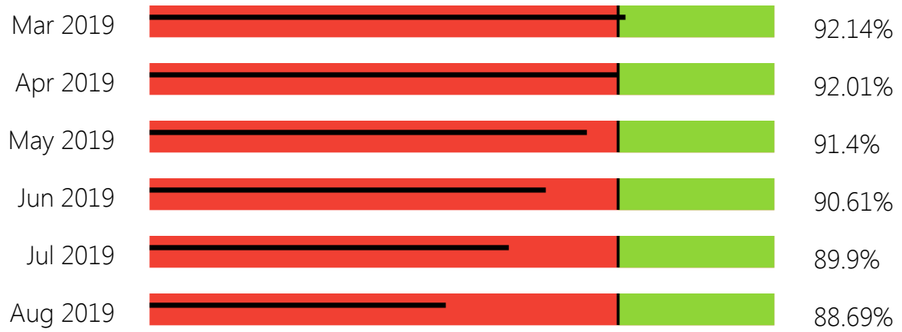
Narrative

Our August performance was 88.69% 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 764 in July to 850 in August. The reported position was behind our trajectory plan of 90.03%.

The performance breakdown by milestone is as follows: MS1 - 4825 patients waiting of which 110 are breaches, MS2 - 602 patients are waiting of which 203 are breaches, MS3 - 1248 patients are waiting of which 538 are breaches.

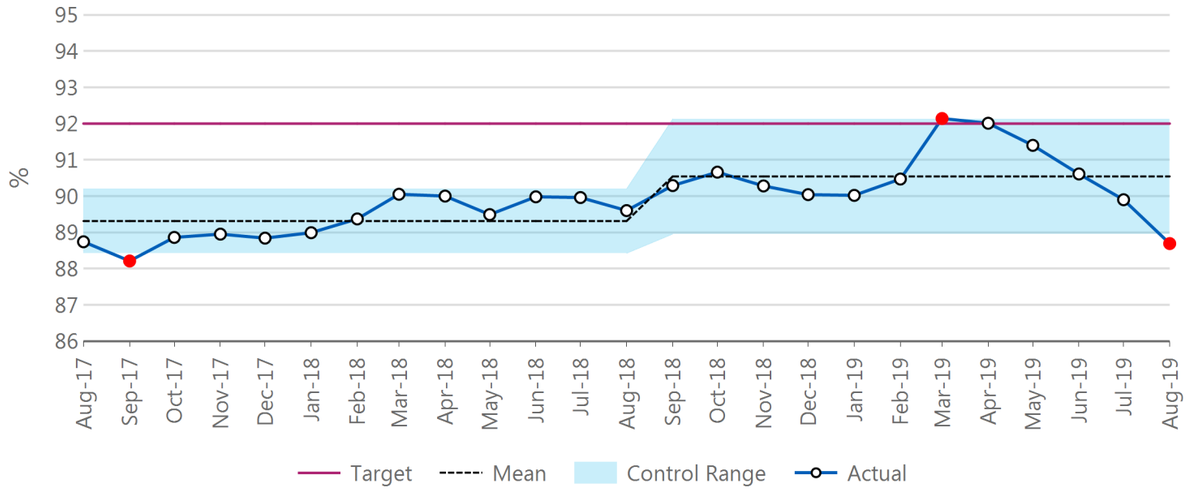
Performance in all Surgical sub specialties, with the exception of Tumour, remains below the 92% target. The lowest performance in August has occurred in the following areas: Spinal Disorders - 77.89%, Arthroplasty - 79.19% and Knee & Sports Injuries 82.46%. The Medicine division total is above target again this month at 97.11%, however there are sub-specialties that are failing to meet 92% with the lowest performance in these areas: Paediatric Orthopaedics (ORLAU) - 79.03%, Neurology - 89.39% and Spinal Injuries - 90.16%.

Performance against RAG ratings

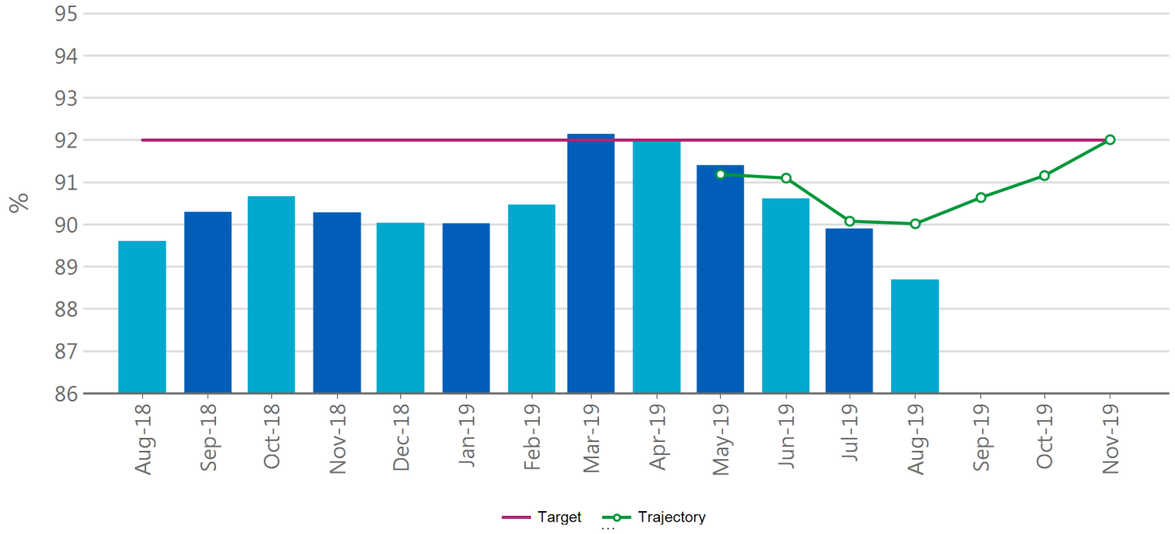


Performance over 24 months – SPC

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



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
88.74%	88.21%	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%	90.5%

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

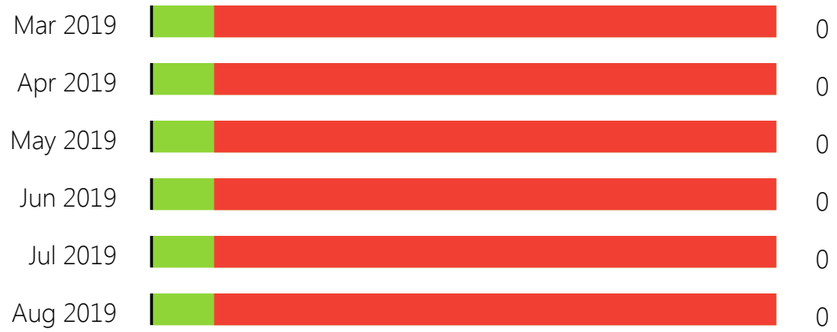
Integrated Performance Report

Narrative

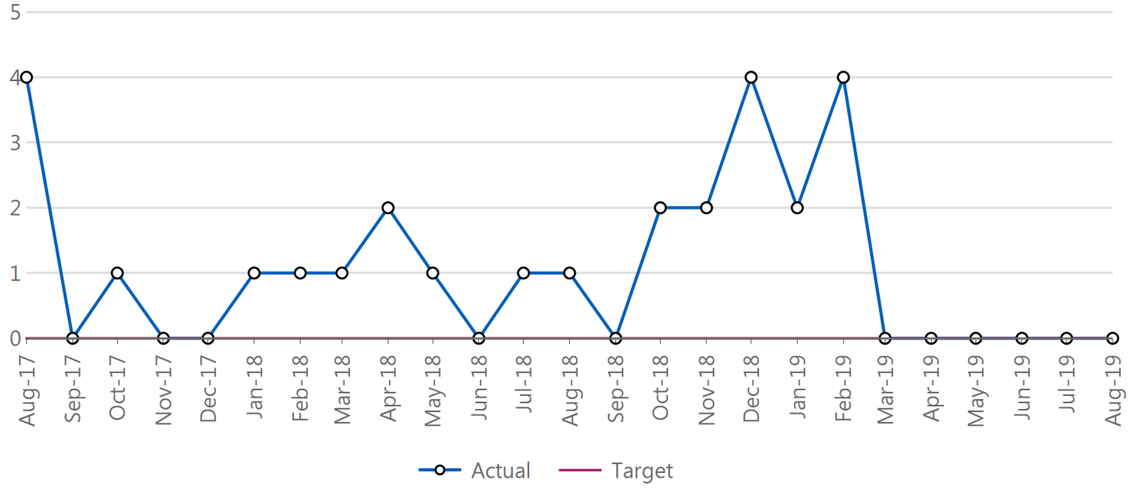
At the end of August there were no English patients waiting over 52 weeks.

The forecast figures show predicted 52+ weeks waits as follows:
- End of September - 0
- End of October - 0
-End of November - 0

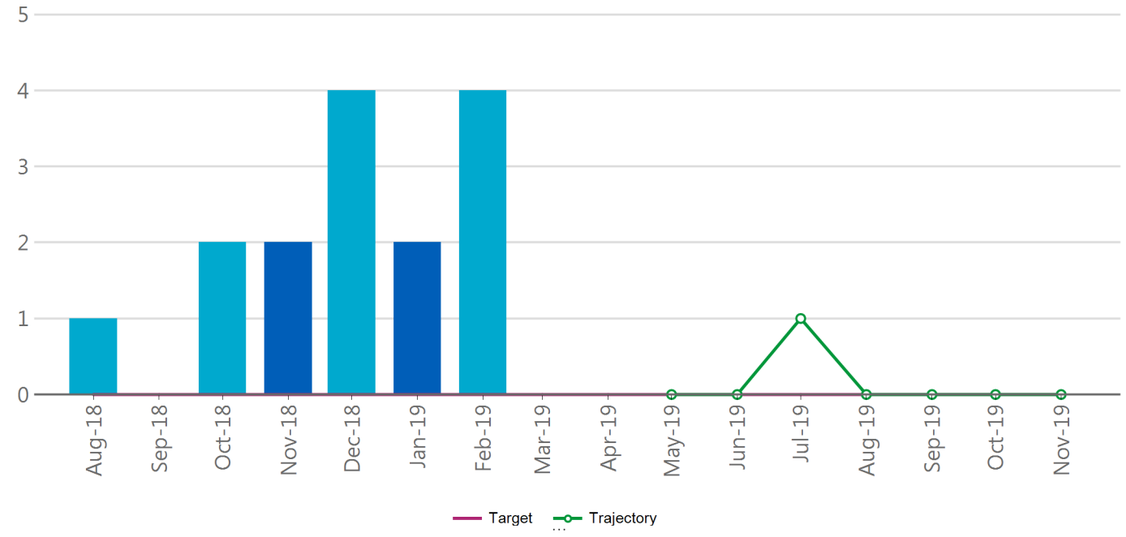
Performance against RAG ratings



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

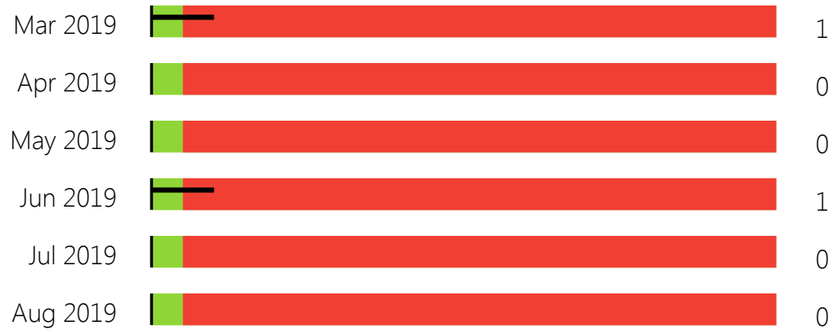
Narrative

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

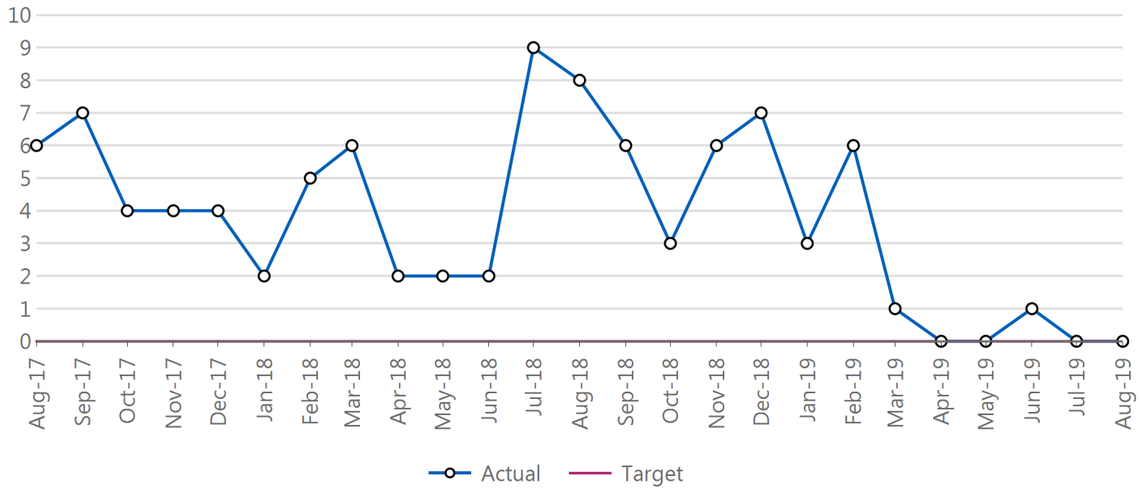
The forecast figures show predicted 52+ weeks waits as follows:
- End of September - 2 - Both Spinal Disorders
- End of October - 3 - Spinal Disorders (2), Arthroplasty (1)
- End of November - 4 - Spinal Disorders (3), Arthroplasty (1)

All of the forecast patients are BCU patients.

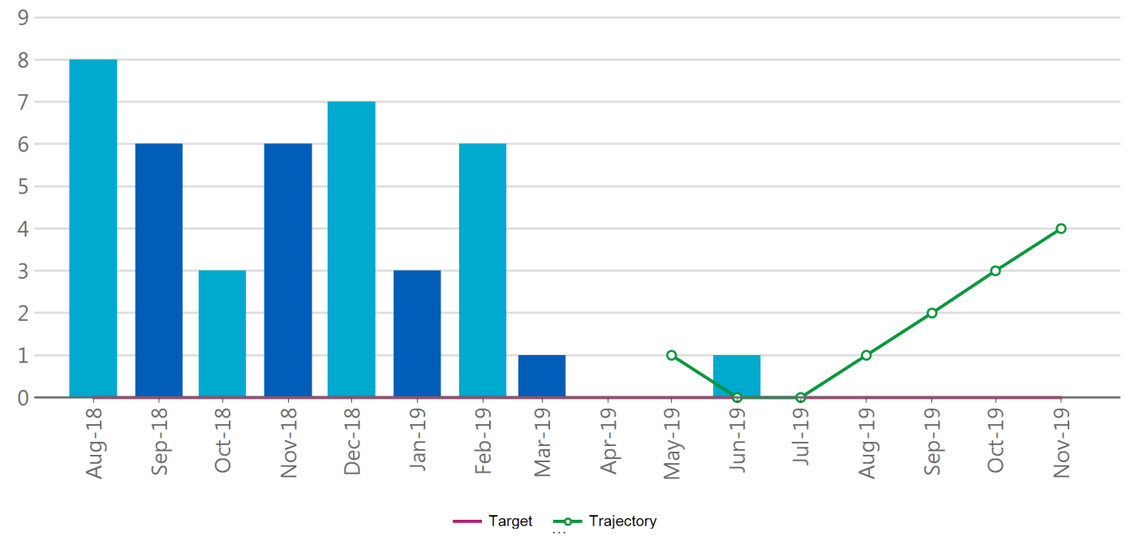
Performance against RAG ratings



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)

128 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.

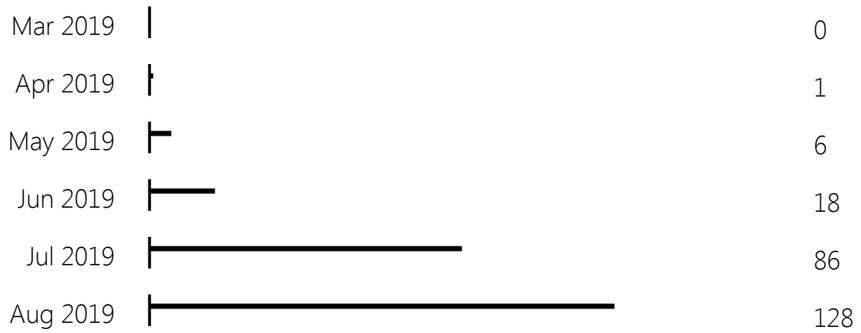
Narrative

At the end of August there were 128 Welsh patients waiting over 52 weeks who were transfers of care from BCU.

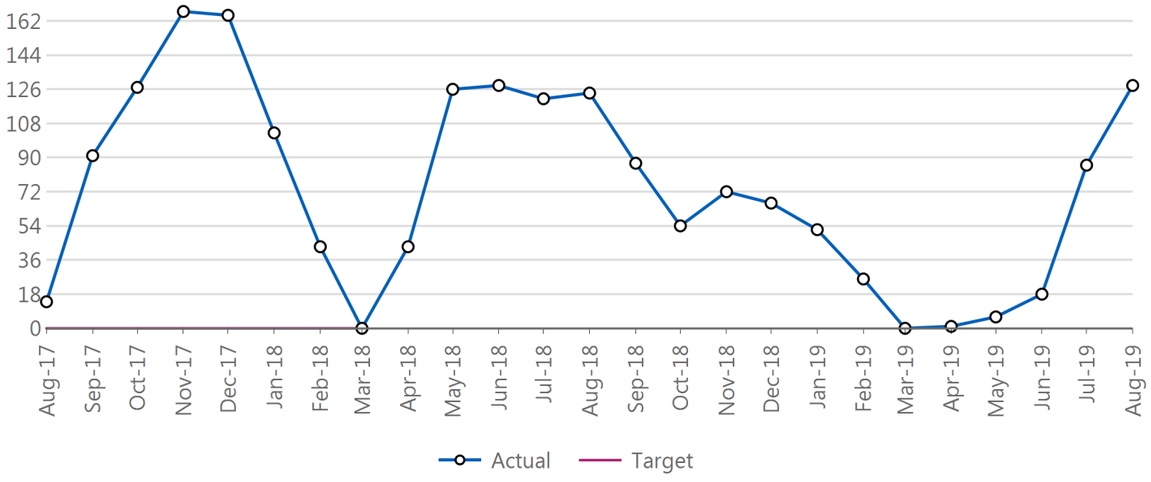
The forecast figures show predicted 52+ weeks waits as follows:
- End of September - 117
- End of October - 122
- End of November - 151

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

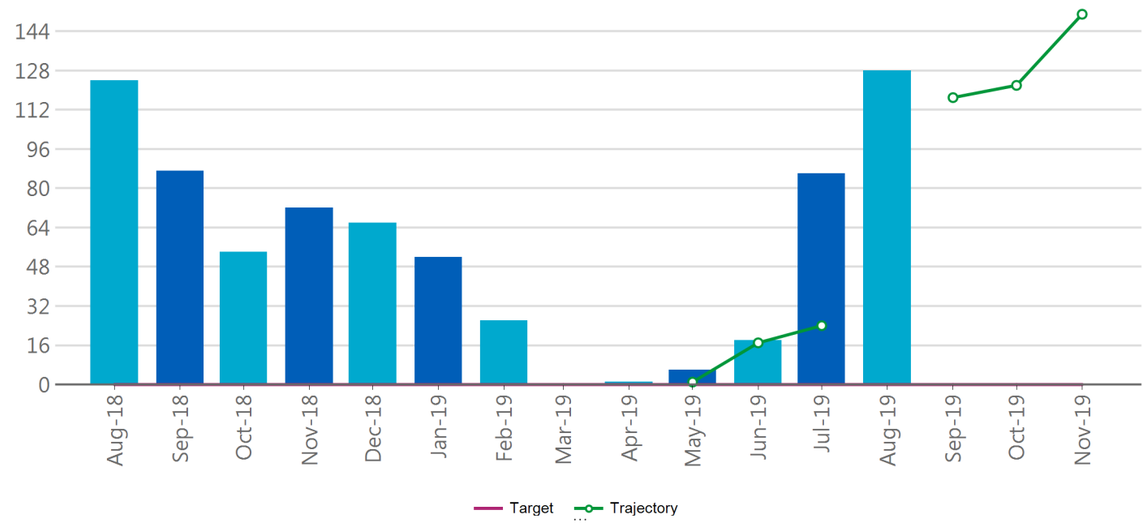
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
14	91	127	167	165	103	43	0	43	126	128	121	124	87	54	72	66	52	26	0	1	6	18	86	128

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

98.85% against **99%** target

Below target red rated

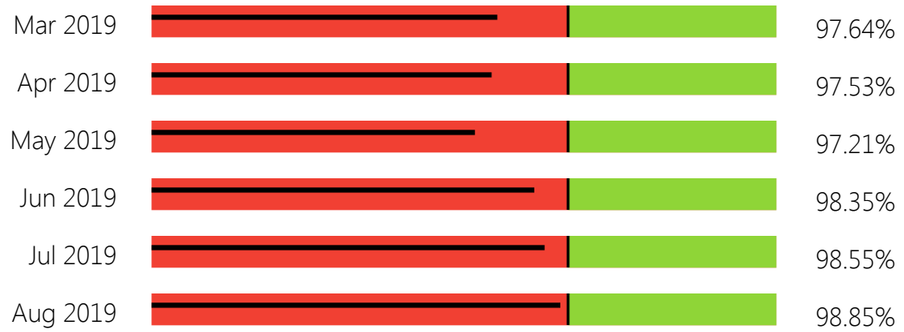
Exec Lead:
Director of Operations

Integrated Performance Report

Narrative

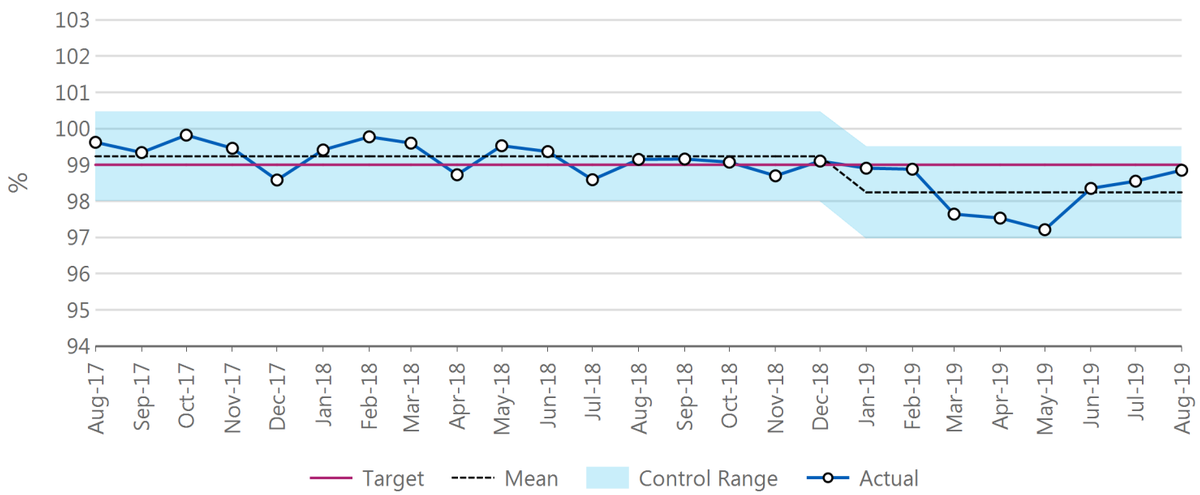
The 6 week standard for diagnostics was not achieved this month and is reported at 98.85%. This equates to 8 patients who waited beyond six weeks. The reasons associated with the delays were capacity (6), delay in receiving referral (1), mistakenly classified(1). Five of the six capacity breaches were in Ultrasound and these were due to consultant capacity because of study leave and annual leave however some breaches were mitigated by consultants working OJP in August.

Performance against RAG ratings

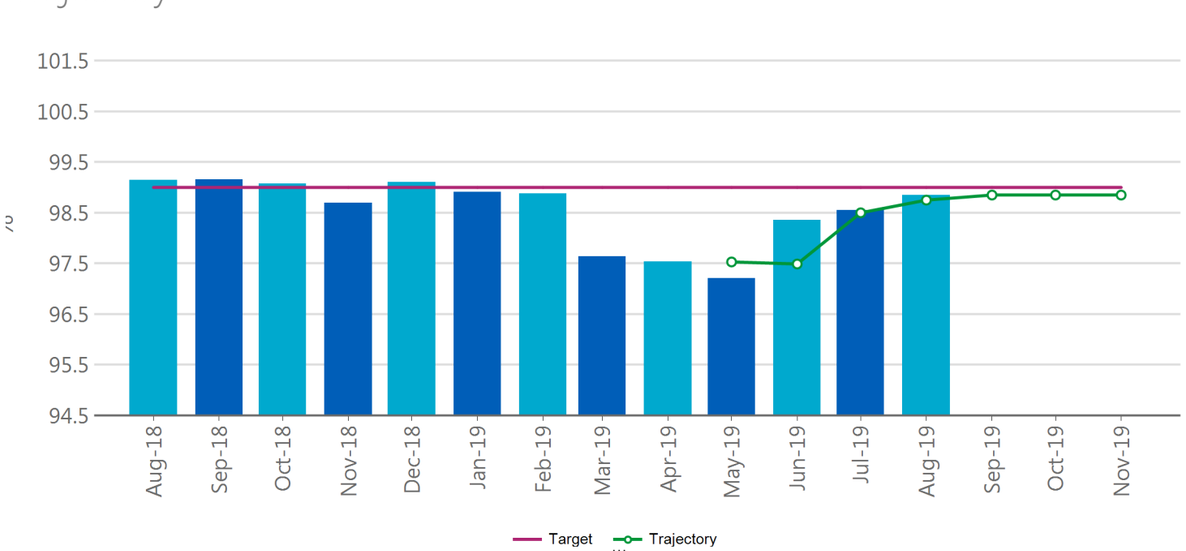


Performance over 24 months – SPC

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



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
99.62%	99.34%	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%	98.1%

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

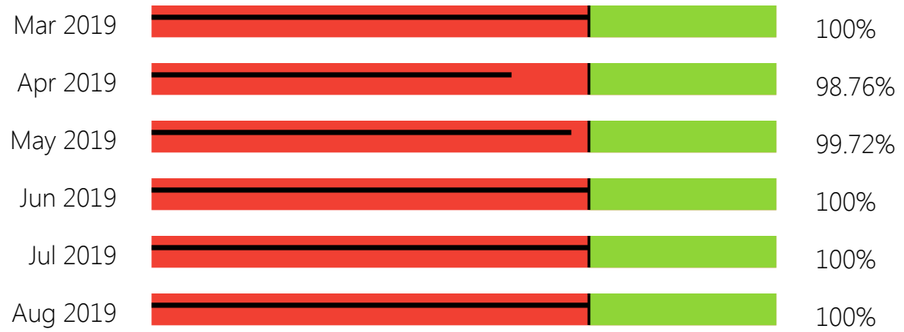
Exec Lead:
Director of Operations

Integrated Performance Report

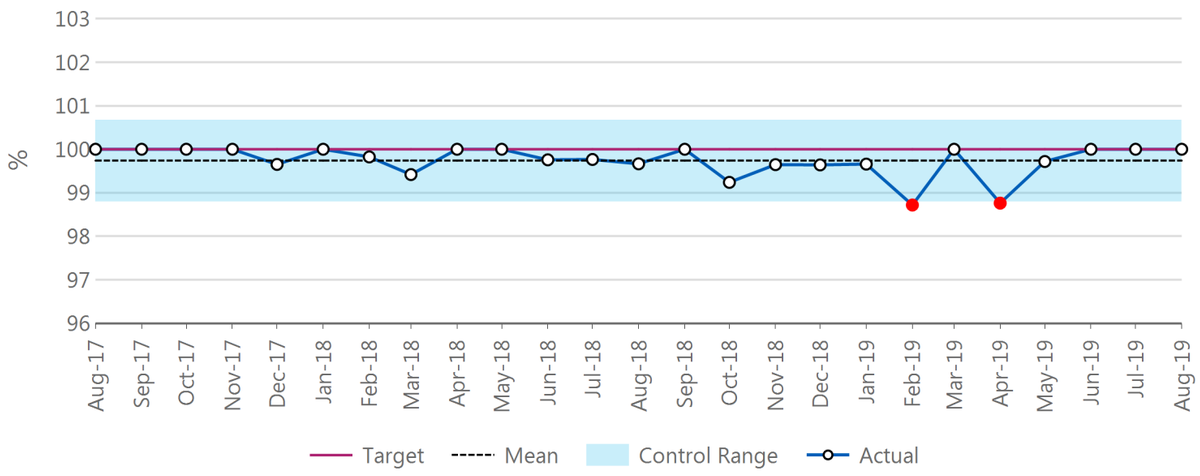
Narrative

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

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
100%	100%	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%	99.72%

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

Total Theatre Activity

Activity in theatres in month

921 against **953** target

Below target red rated

Exec Lead:
Director of Operations

Integrated Performance Report

Narrative

A breakdown of Total Theatre Activity against plan is:
- T&O - 829 against plan of 843 (-14 cases)
- MCSI - 50 against plan of 45 (+5 cases)
- Private Patients - 42 against plan of 65 (-23 cases)

The most likely forecast position for August for T&O was 756 with a best case of 782, as can be seen actual delivery of T&O was 829 surpassing our forecasts due to actions taken.

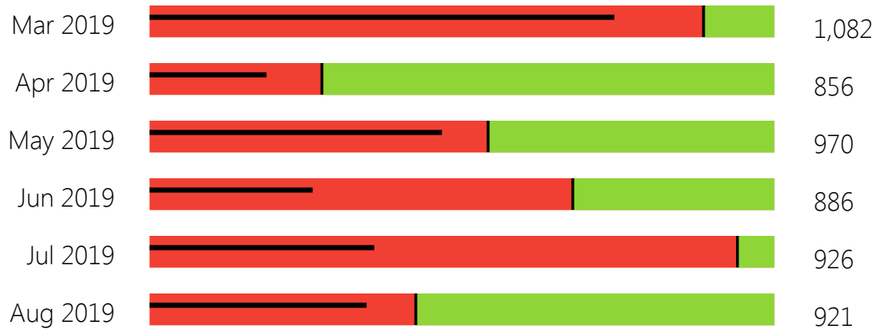
Further breakdown below by English and Welsh

	English	Welsh
- T&O	556	273
- MCSI	43	7
- PP	27	15

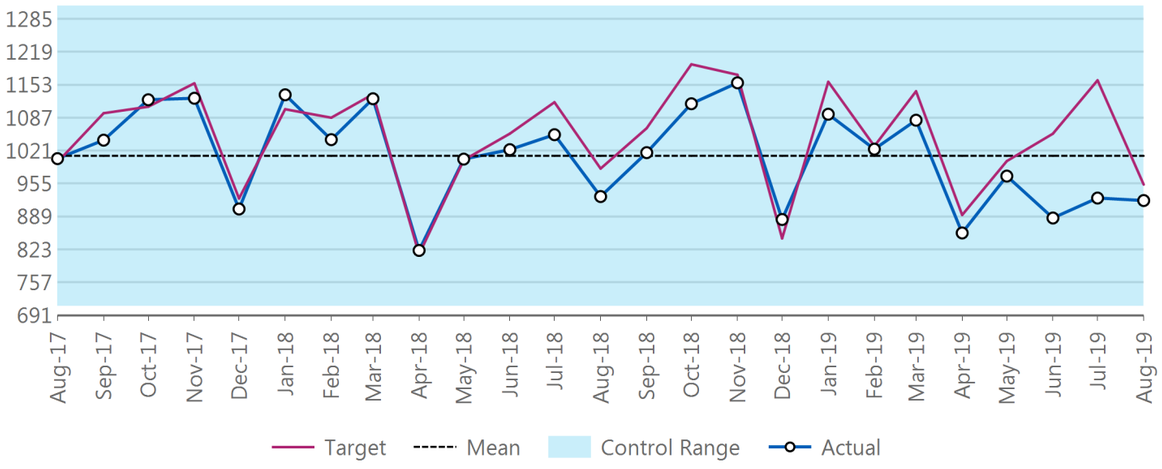
Please note, the target for this measure is that which was set at the start of the financial year. The trajectory reflects the revised plans agreed in August-19.

Action to Improve:Performance against the revised NHS and private patients activity profiles is being monitored through the weekly theatre delivery board.

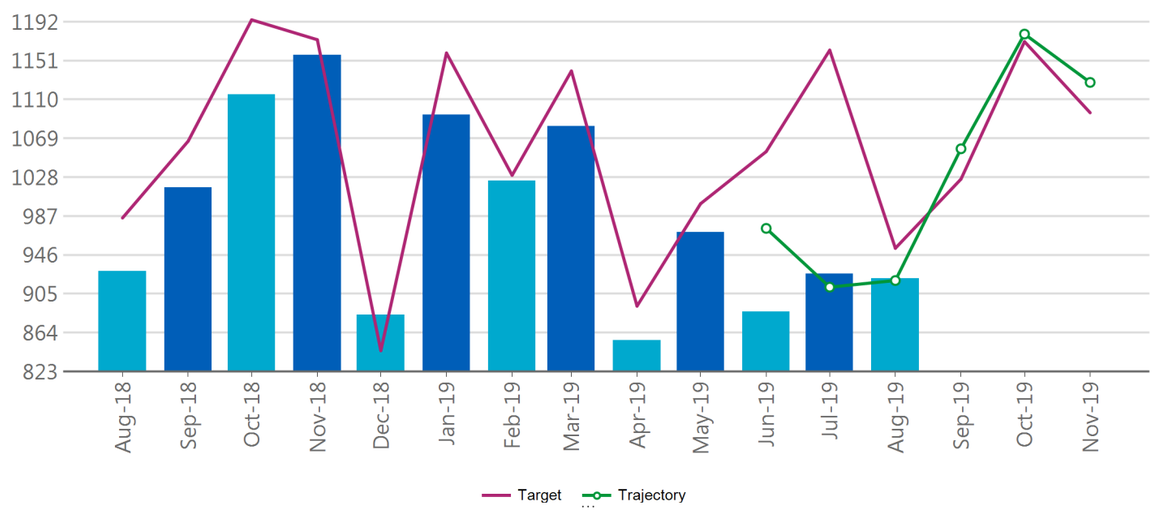
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
1,005	1,042	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	926	921	4,559

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

81.03% against **87%** target

Within target green rated

Exec Lead:
Director of Operations

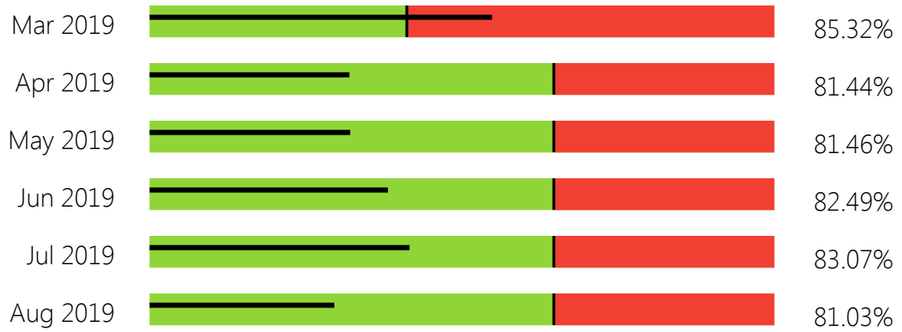
Integrated Performance Report

Narrative

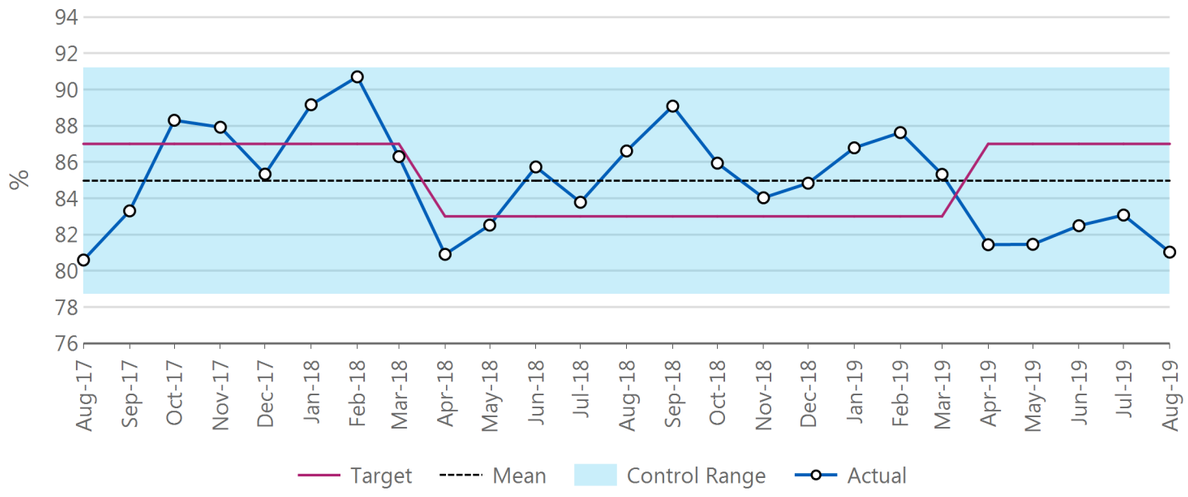
The occupancy rate for all wards is green rated this month at 81.03%. Occupancy across the Surgical Wards was:
- Alice 47.38%
- Clwyd 80.55%
- Kenyon 74.92%
- Ludlow 84.18%
- Oswald 85.06%

Occupancy within the Medicine Division was:
-Gladstone 94.70%
- Wrekin 93.02%
- Sheldon 83.51%
- Powys 38.57% (ward used for MCSI patients in August)

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
80.59%	83.3%	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%	81.9%

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

12,881 against 13,057 target

Below target red rated

Exec Lead:
Director of Operations

Integrated Performance Report

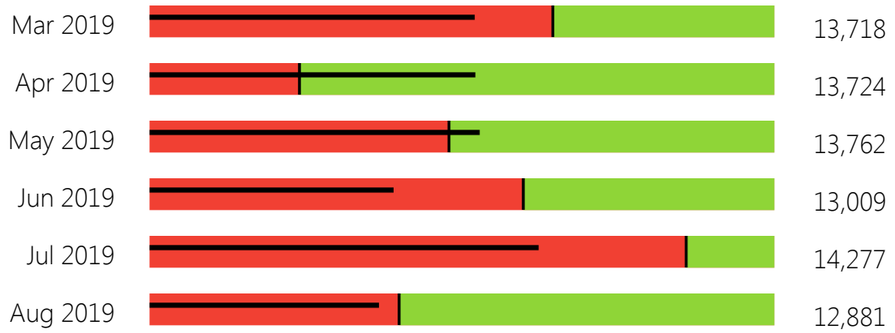
Narrative

The number of attendances was behind plan in month 5 with 12881 attendances seen against a plan of 13057. A divisional breakdown is:
- Surgery - 6307 against a plan of 6406 (-99)
- Medicine - 5433 against a plan of 5420 (+13)

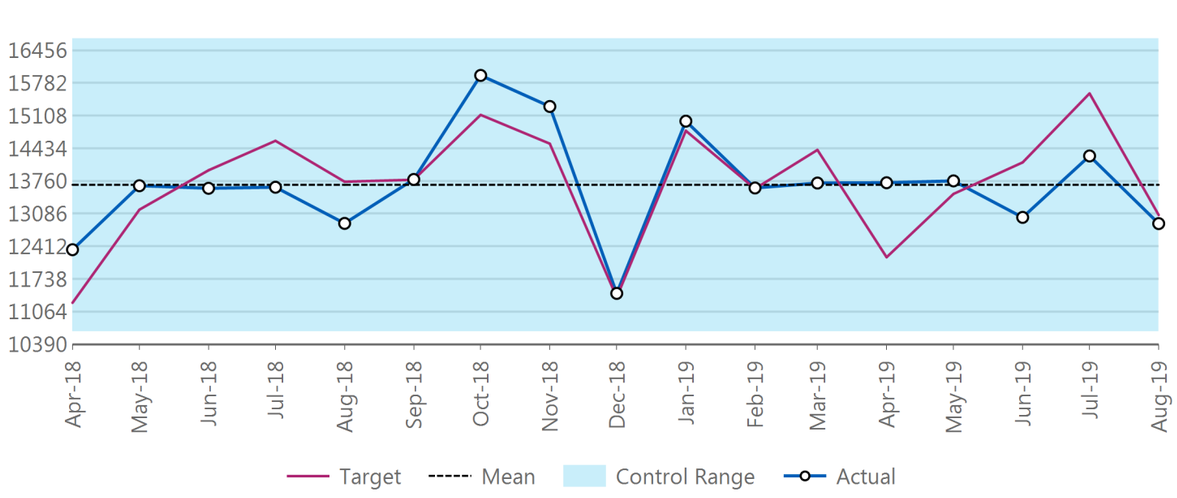
Areas behind plan to note were:
- Trauma & Orthopaedics
- Paediatric Trauma and Orthopaedics
- Medical Oncology

Action to Improve:Activity levels have been impacted by annual leave in the summer months. With reduced annual leave forecast in future months we anticipate delivery of planned activity. A trajectory is going to be compiled to monitor this and will be incorporated into next month's report.

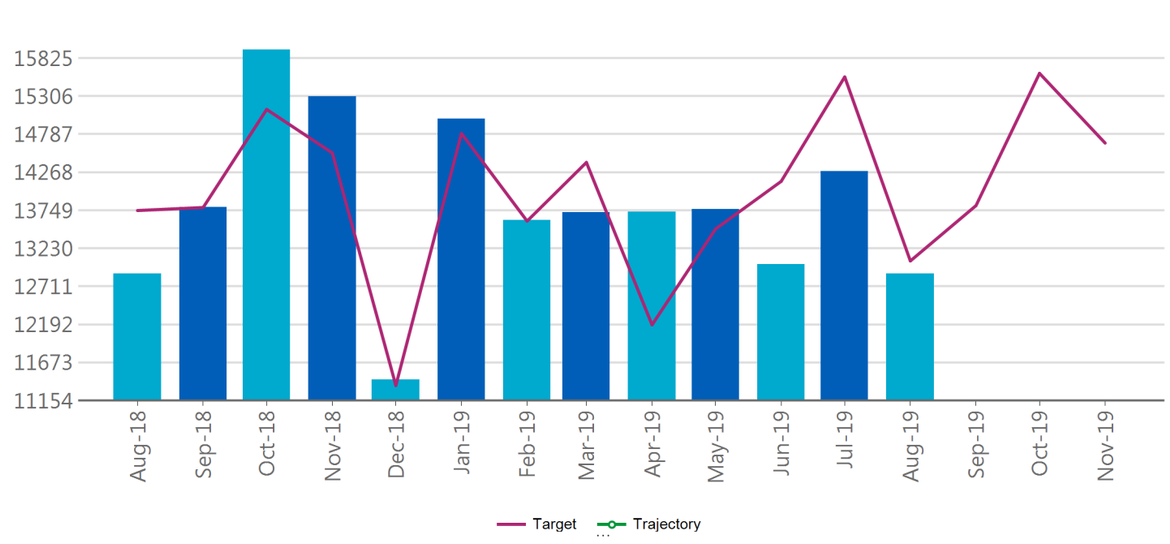
Performance against RAG ratings



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	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	13,762	13,009	14,277	12,881	67,653

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

Financial Control Total

Surplus/deficit adjusted for donations and excluding STF funding

-288 against -207 target

red rated

Exec Lead:
Director of Finance

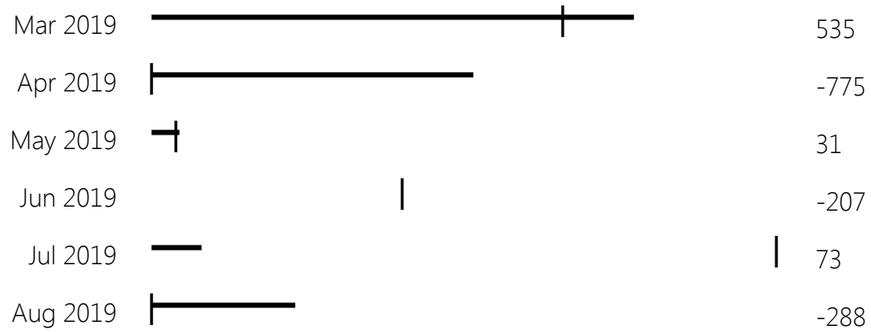
Integrated Performance Report

Narrative

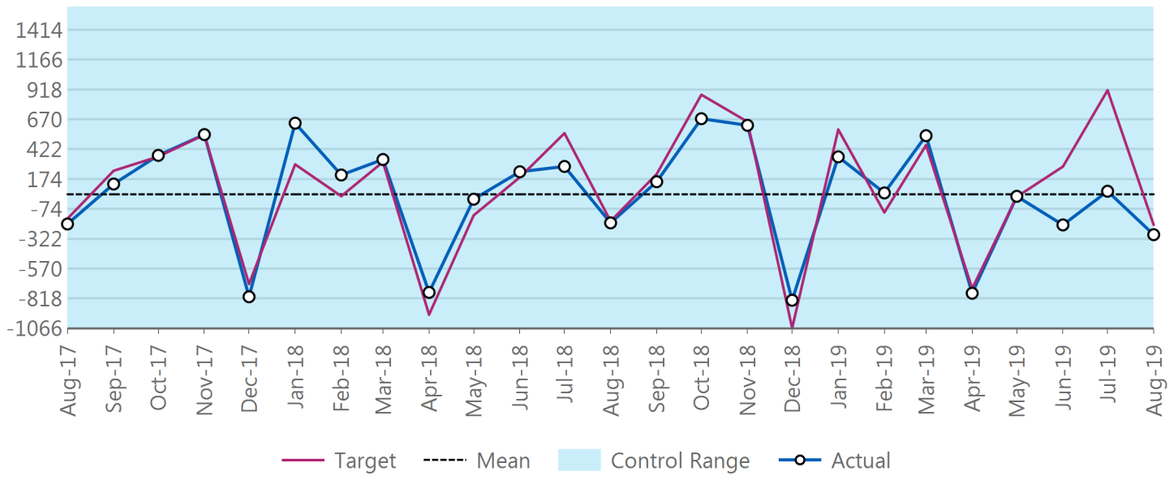
- £288k deficit in month, £81k adverse to plan
- £1,440k adverse variance to plan year to date

Action to Improve:Adverse variance in line with agreed recovery plan forecast assumptions driven by shortfall in theatre & private patient income - recovery plan details improvement actions and mitigations.

Performance against RAG ratings



Performance over 24 months – SPC



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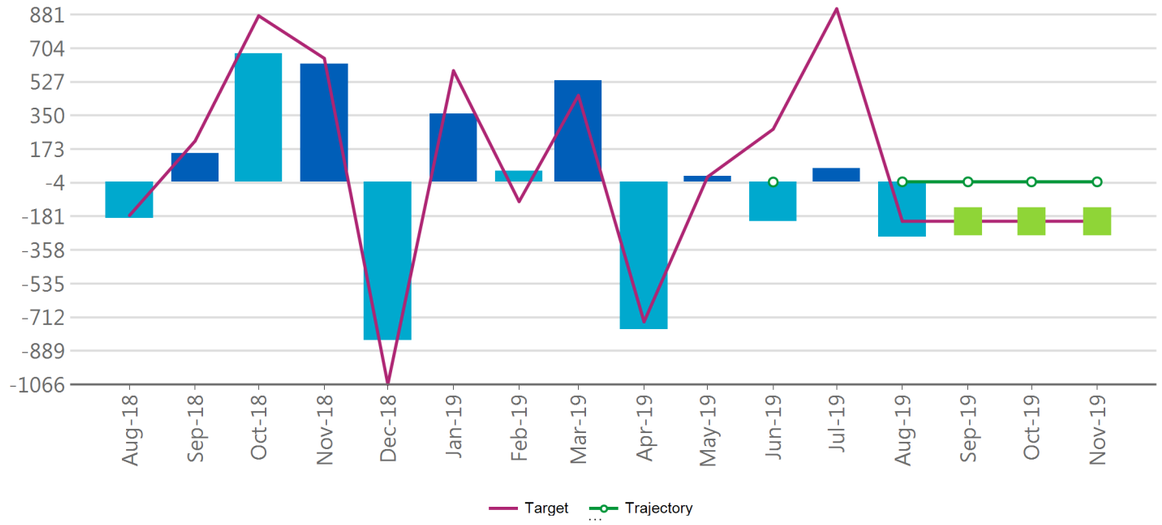


Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
-199	133	371	544	-804	639	208	337	-768	7	235	279	-190	152	676	621	-833	359	59	535	-775	31	-207	73	-288	-1,166

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

Income

All Trust Income, Clinical and non clinical

8,837 against **9,068** target

Below target red rated

Exec Lead:
Director of Finance

Integrated Performance Report

Narrative

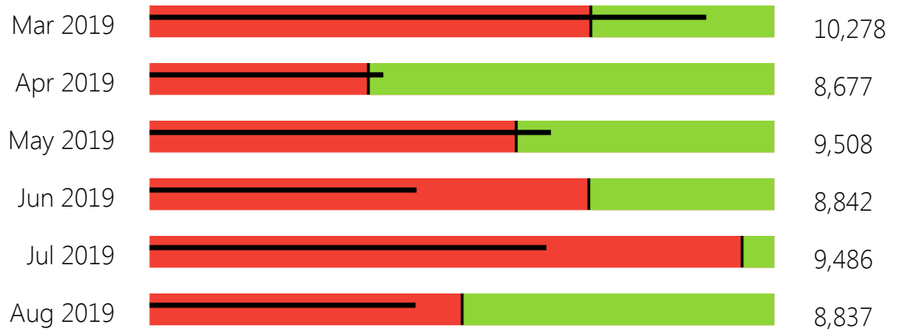
Overall £231k adverse in month:

- Theatre income adverse - case mix driven
- Medicine outpatients
- Private Patients (surgery)
- Partially offset by MCSI mitigation linked to urology additional sessions

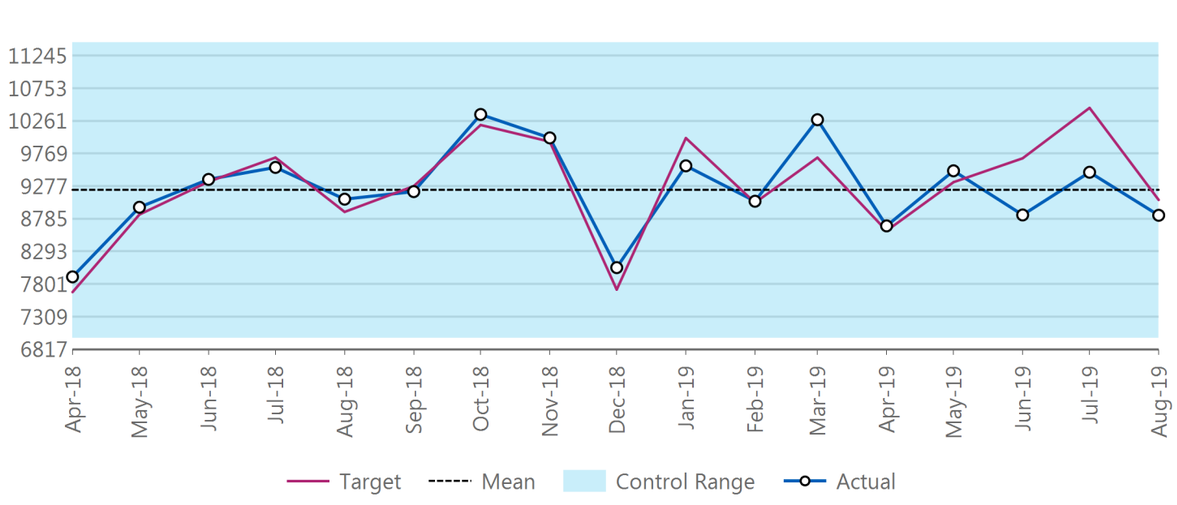
Action to Improve:Recovery actions developed for shortfall in theatre activity:

- Approved theatre recovery plan from September onwards
- Financial mitigations developed alongside recovery plan to further recover shortfall
- Performance review focus on delivery and action plans
- Weekly theatre delivery board in place

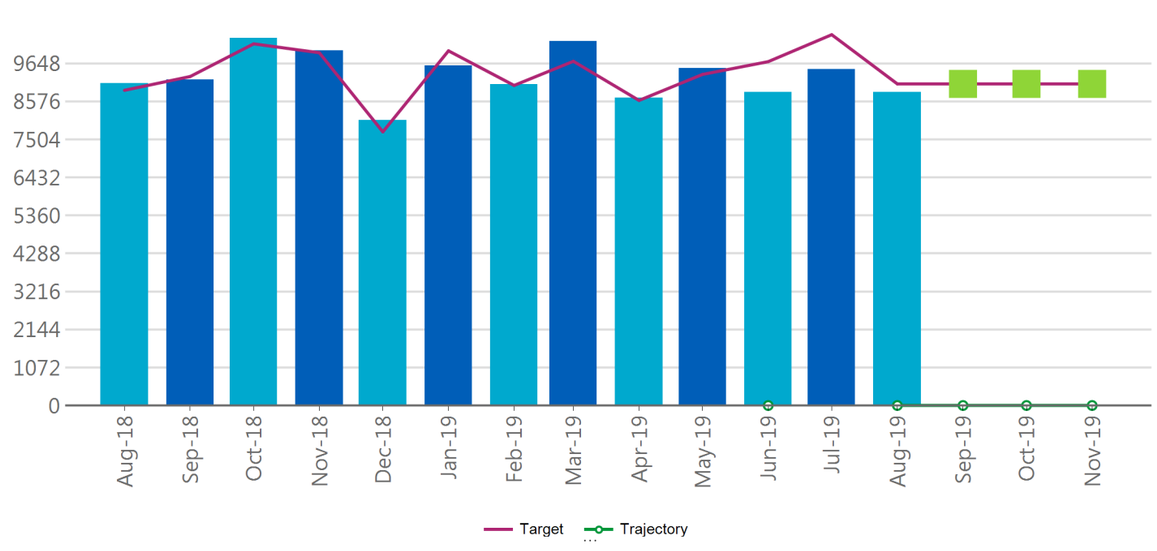
Performance against RAG ratings



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	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	9,486	8,837	45,350

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Expenditure

All Trust expenditure including Finance Costs

9,167 against **9,318** target

Within target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

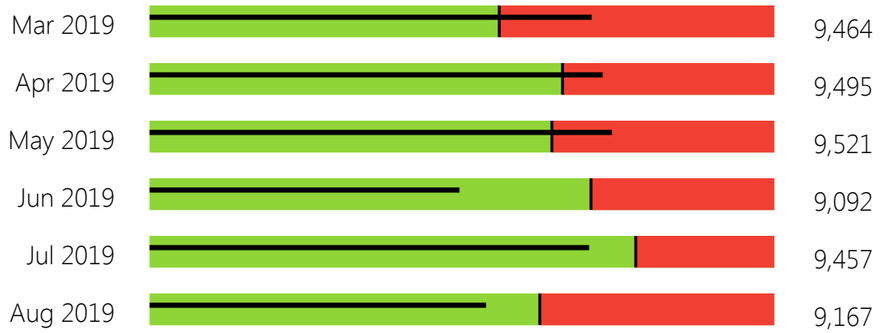
Narrative

- Overall £149k favourable in month:

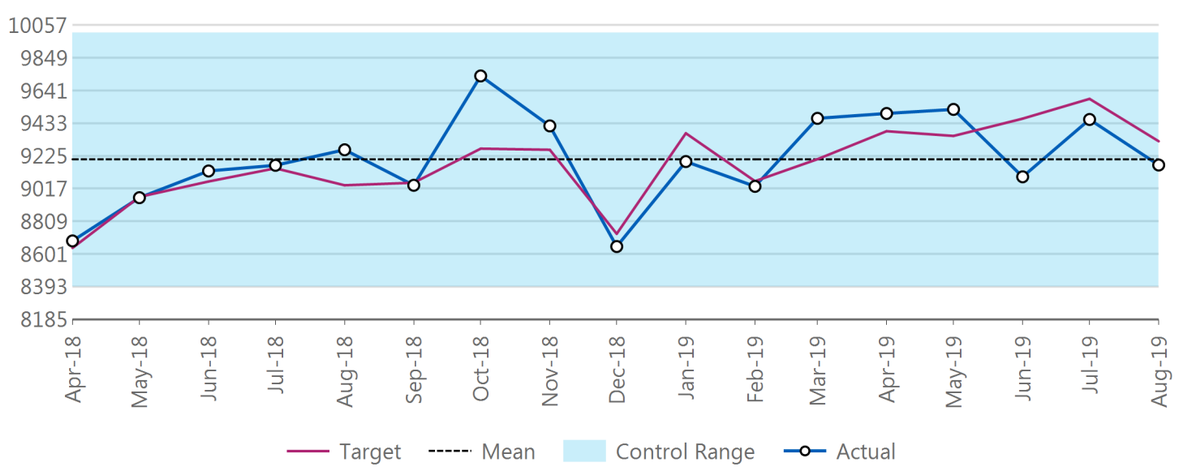
Pay favourable -
- Reduced Surgical OJP & vacancies

Non pay favourable:
- Expenditure controls & corporate reserves

Performance against RAG ratings



Performance over 24 months – SPC



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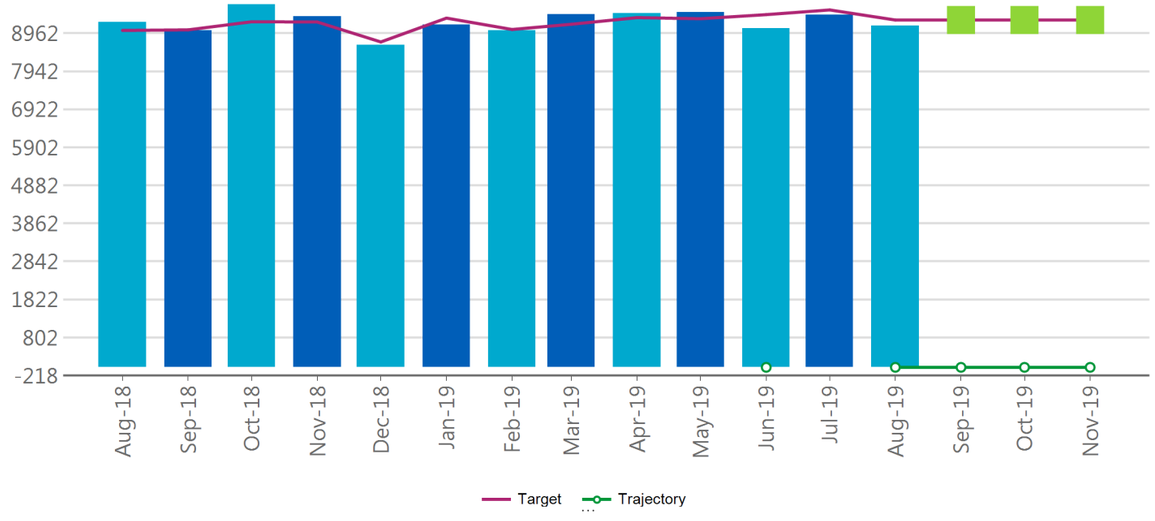


Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	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	9,167	46,735

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

CIP Delivery

Cost Improvement Programme requirement

300 against **265** target

Above target green rated

Exec Lead:
Director of Finance

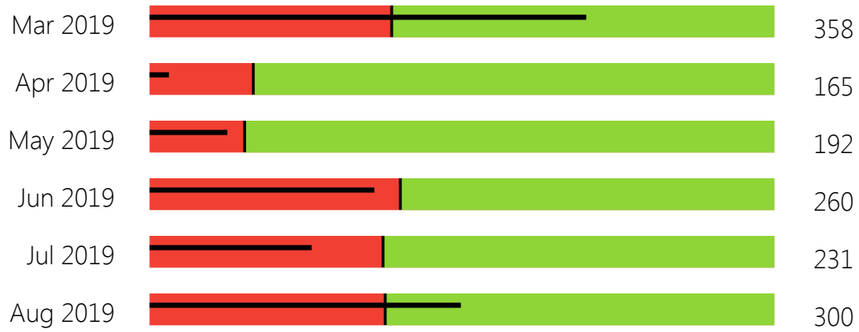
Integrated Performance Report

Narrative

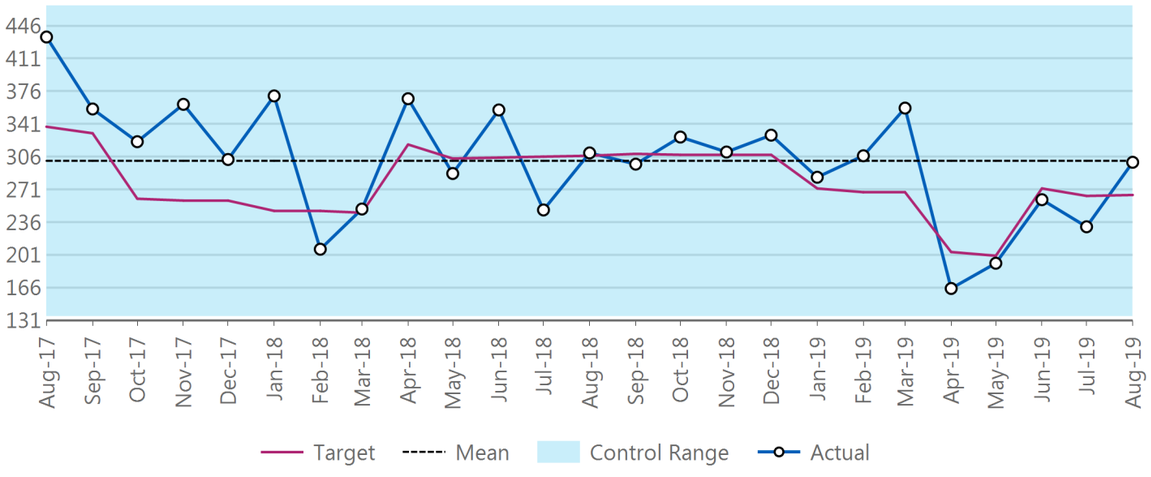
£35k favourable against plan in month
£63k adverse against plan YTD

Action to Improve:Forecast to deliver plan through identification of 20% mitigations ongoing
Action plan for divisions with unidentified schemes monitored through performance review meetings

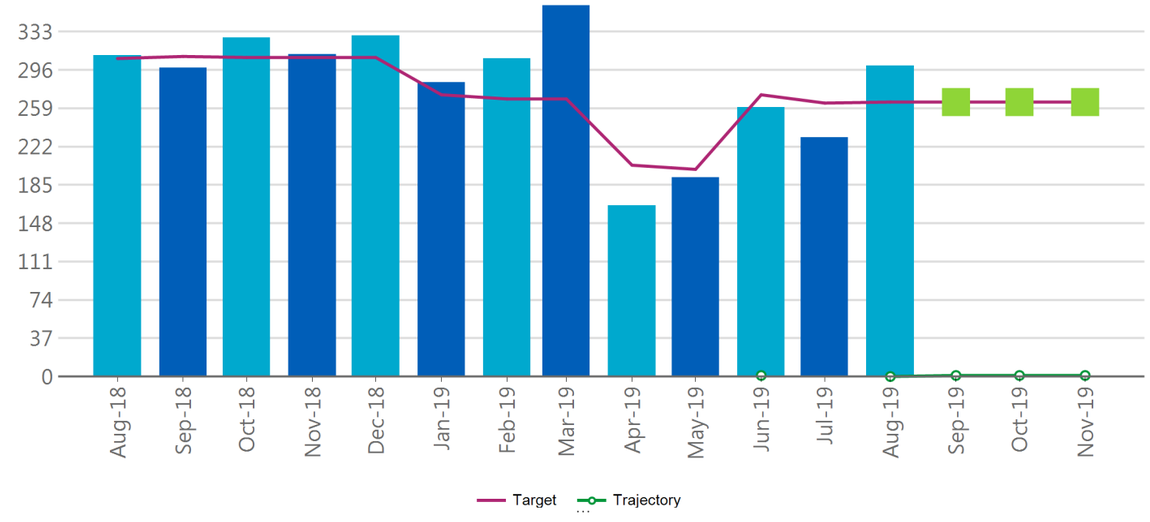
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
434	357	322	362	303	371	207	250	368	288	356	249	310	298	327	311	329	284	307	358	165	192	260	231	300	1,142

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

QIPP Delivery Risk Impact

MSK Transformation QIPP

56 against 0 target
red rated

Exec Lead:
Director of Finance

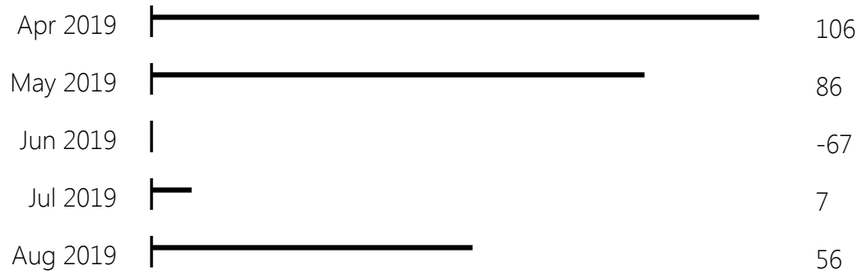
Integrated Performance Report

Narrative

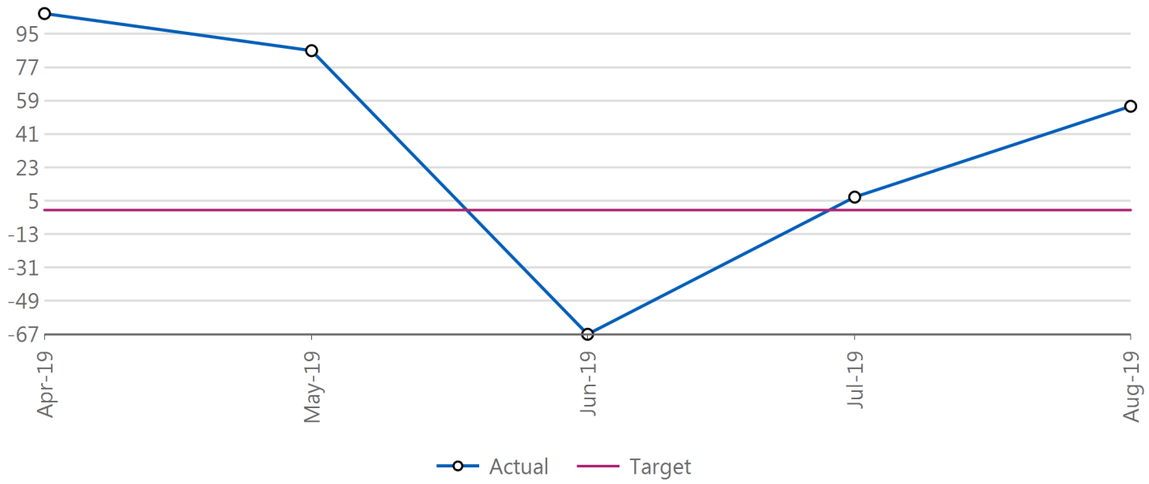
MSK risk share £56k in month, £188k risk provided for ytd

Action to Improve:Rebalancing of commissioner activity, more focused on Welsh work.

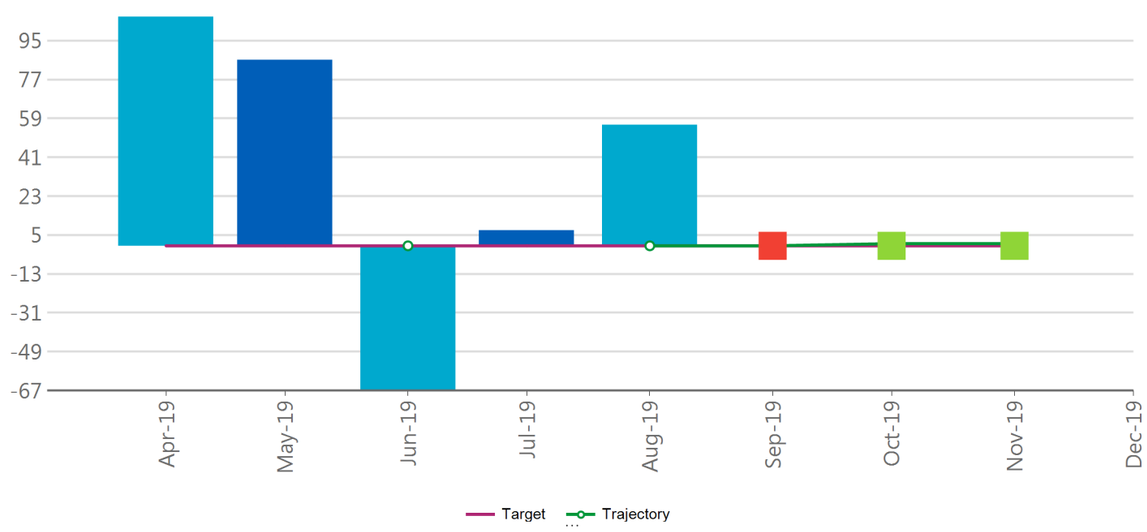
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	YTD
106	86	-67	7	56	188

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

77 against 132 target

Within target green rated

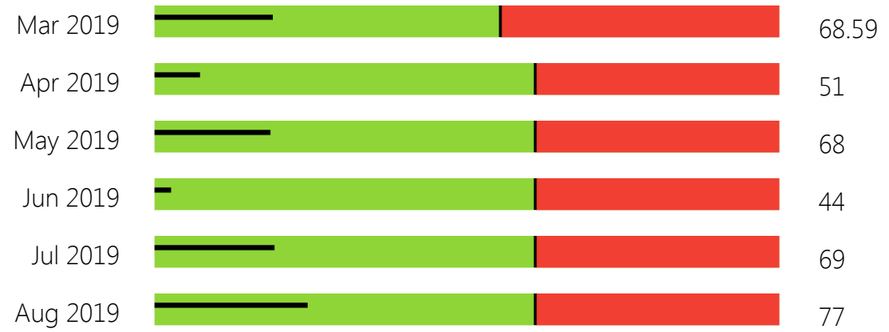
Exec Lead:
Director of Finance

Integrated Performance Report

Narrative

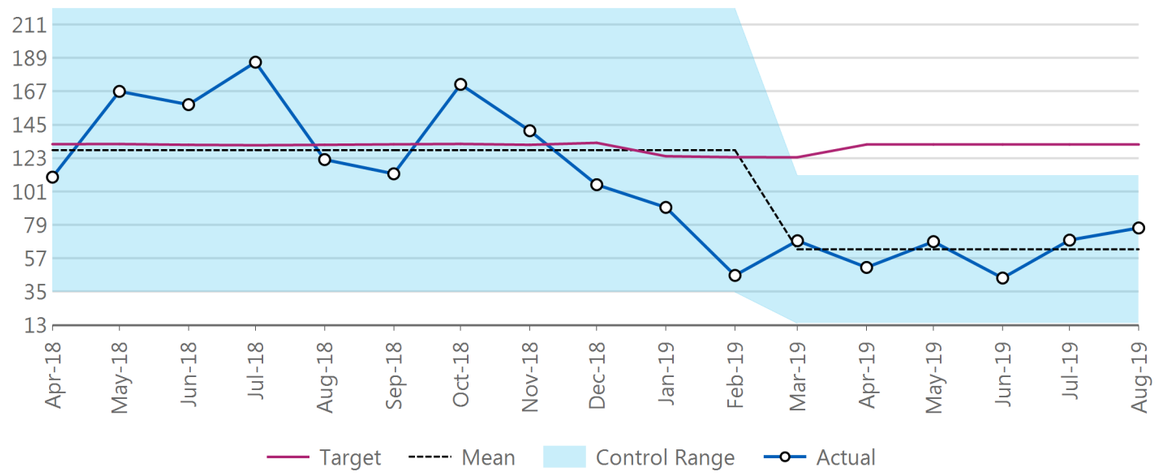
Core agency spend £56k favourable against cap in month

Performance against RAG ratings

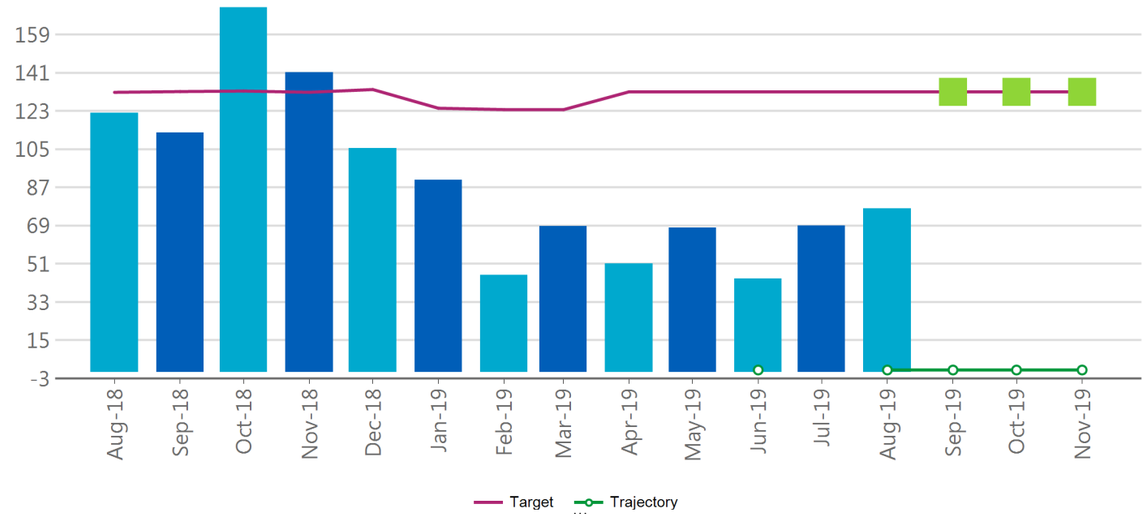


Performance over 24 months – SPC

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	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	69	77	309

NHS
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

254 against 175 target

Breaching target red rated

Exec Lead:
Director of Finance

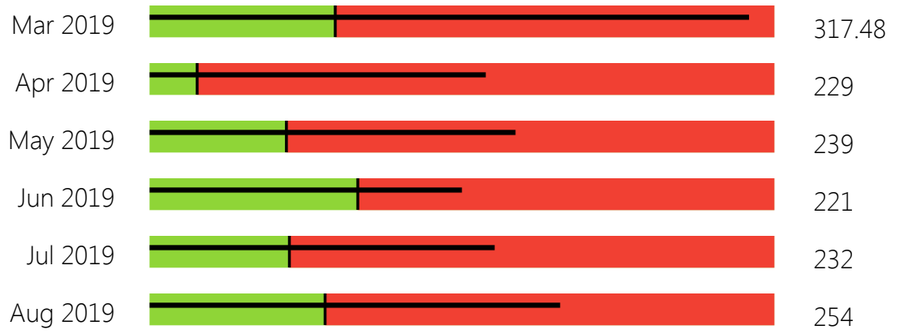
Integrated Performance Report

Narrative

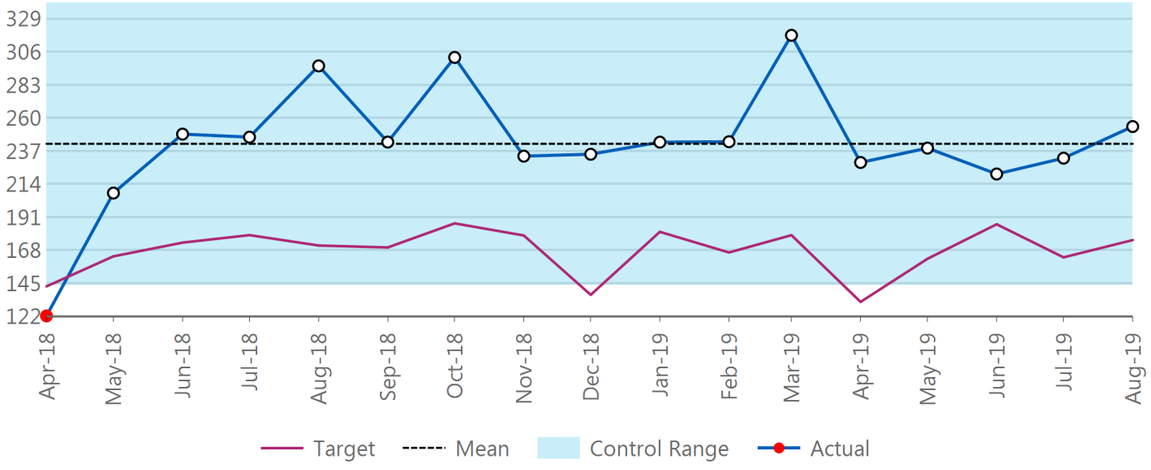
Non core agency spend £79k adverse against cap in month

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.

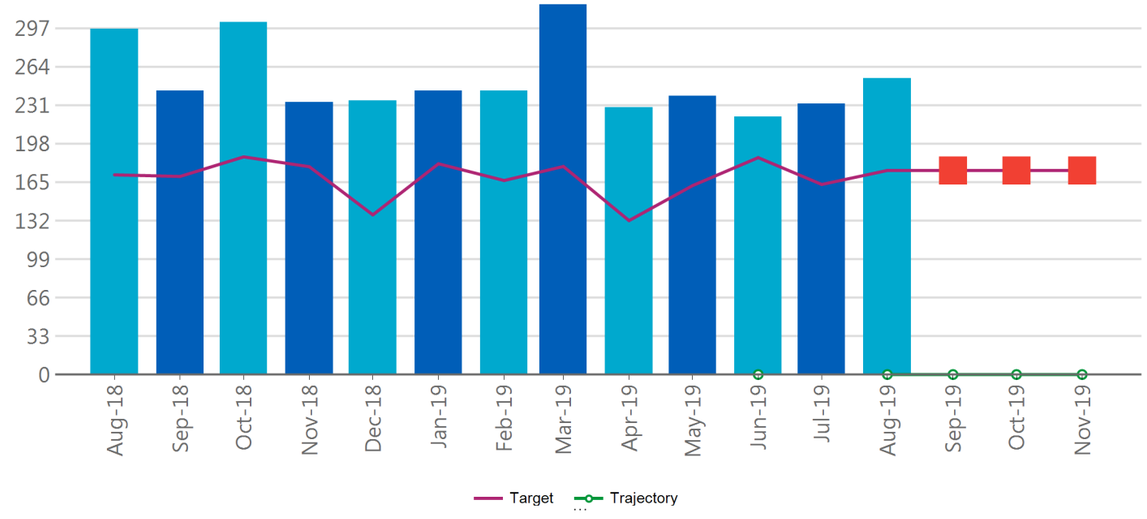
Performance against RAG ratings



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	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	232	254	1,175

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cash Balance

Cash in bank

5,500 against 4,700 target

Above target green rated

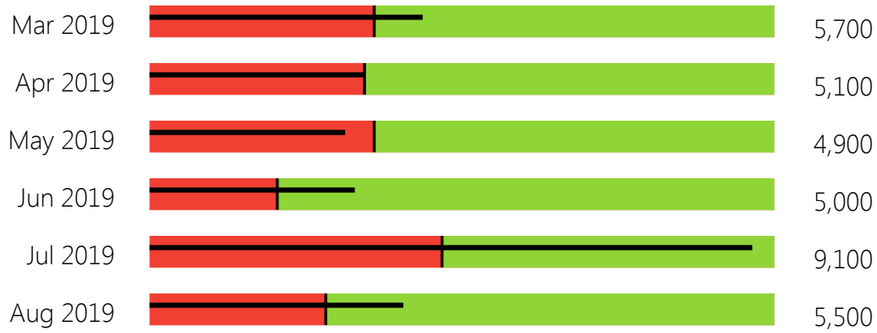
Exec Lead:
Director of Finance

Integrated Performance Report

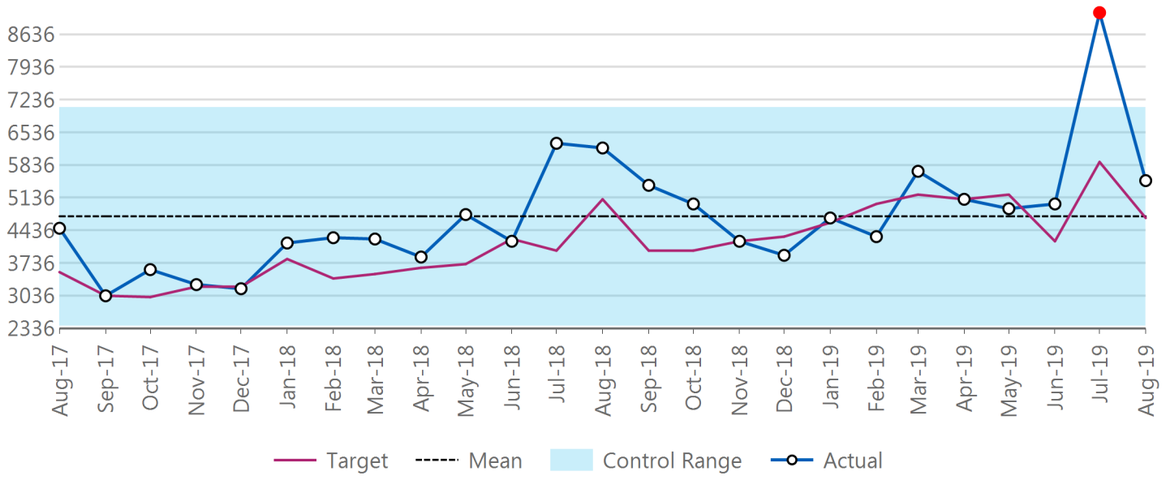
Narrative

Cash balances favourable against plan £0.8m as a result of profiling of Commissioner payments.

Performance against RAG ratings



Performance over 24 months – SPC



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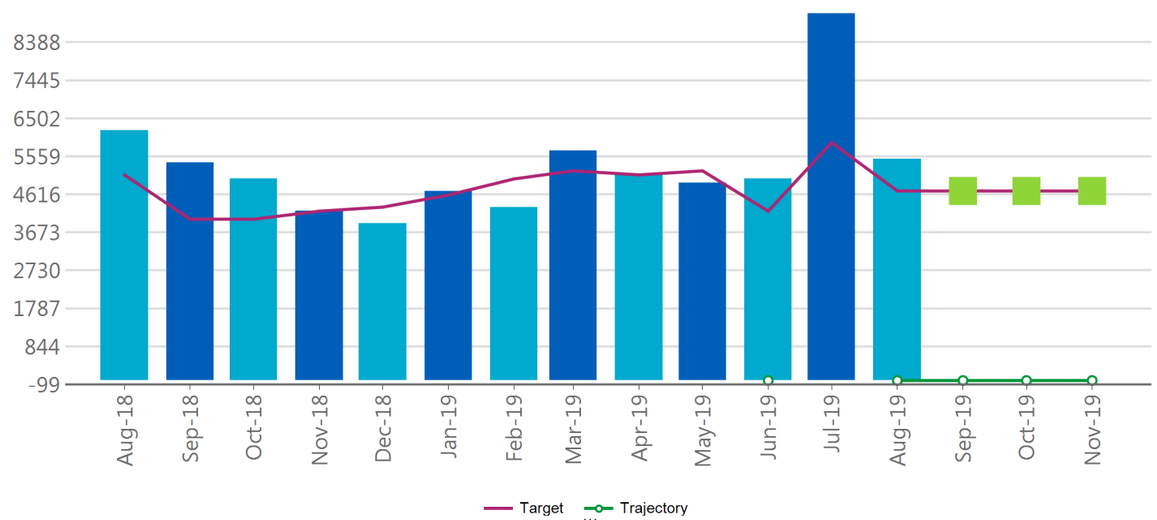


Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
4,480	3,032	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	5,100	4,900	5,000	9,100	5,500	5,500

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Capital Expenditure

Expenditure against Trust capital programme

3 against 433 target

green rated

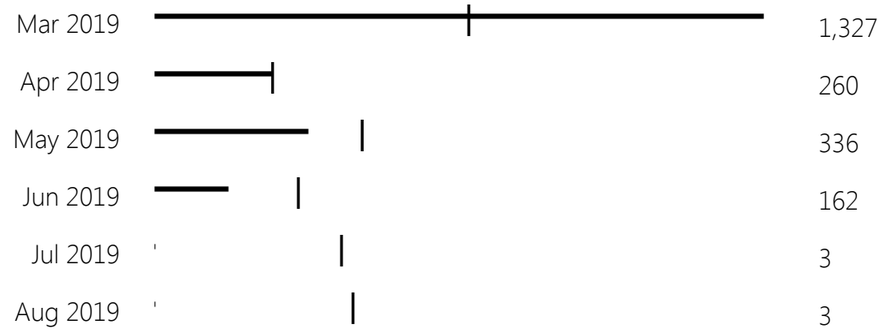
Exec Lead:
Director of Finance

Integrated Performance Report

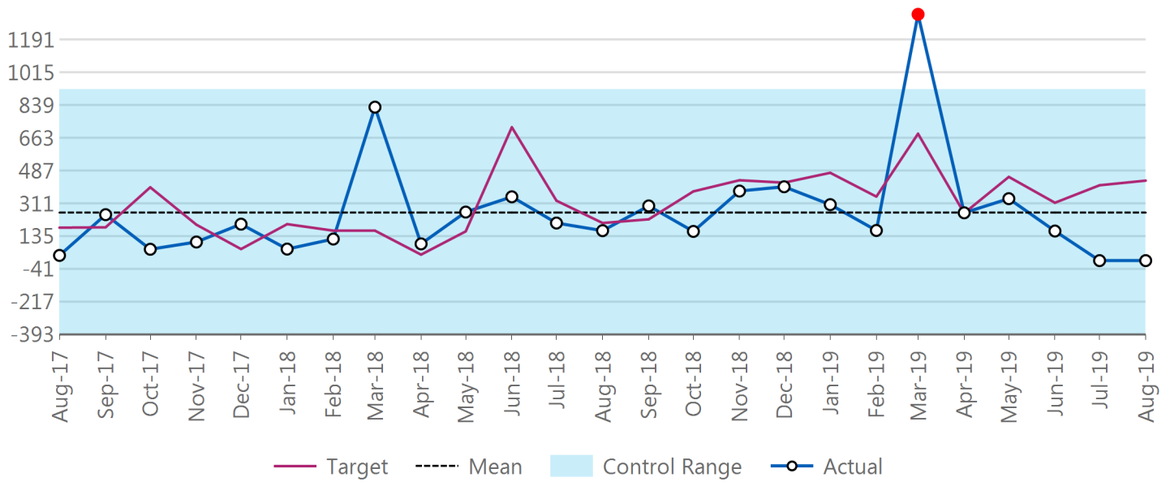
Narrative

Capital spend of £588k in month, £155k adverse in month, ytd £62k favourable.

Performance against RAG ratings



Performance over 24 months – SPC



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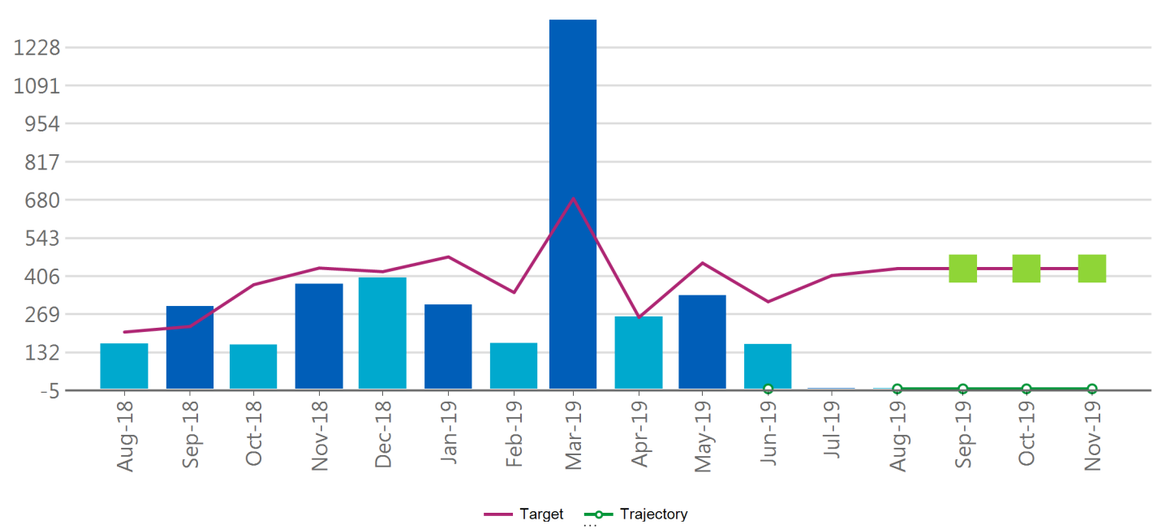


Heatmap performance over 24 months

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD
31	250	64	103	199	65	119	828	93	264	346	205	164	297	160	377	400	304	165	1,327	260	336	162	3	3	1,804

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Use of Resources (UOR)

Overall Use of Resources indicator

3 against 2 target

Above target red rated

Exec Lead:
Director of Finance

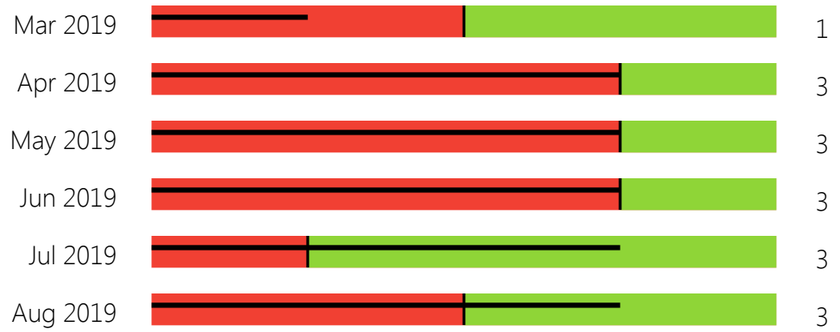
Integrated Performance Report

Narrative

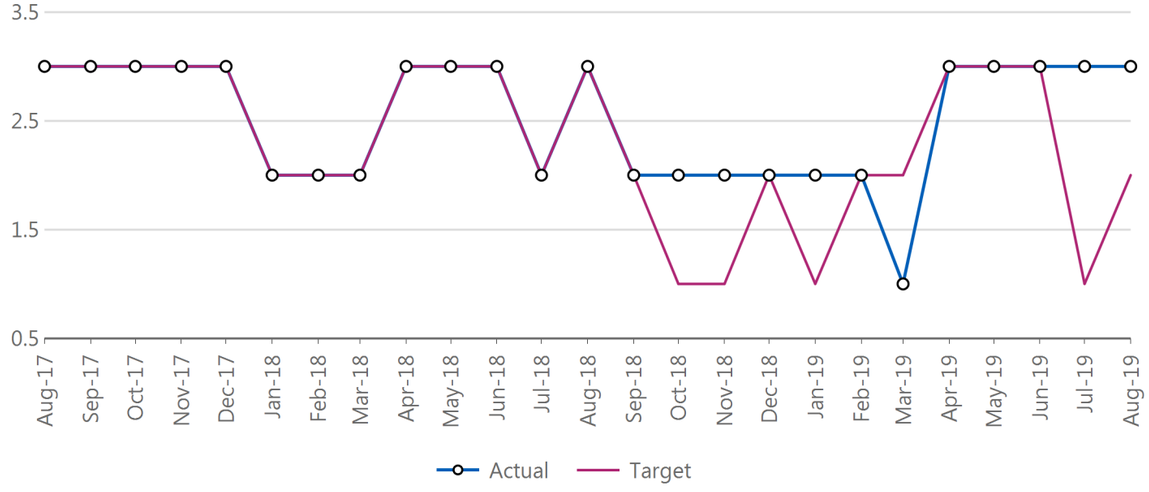
UOR is below plan in month driven from distance from plan.

Action to Improve:This is a trigger under the 19/20 oversight framework

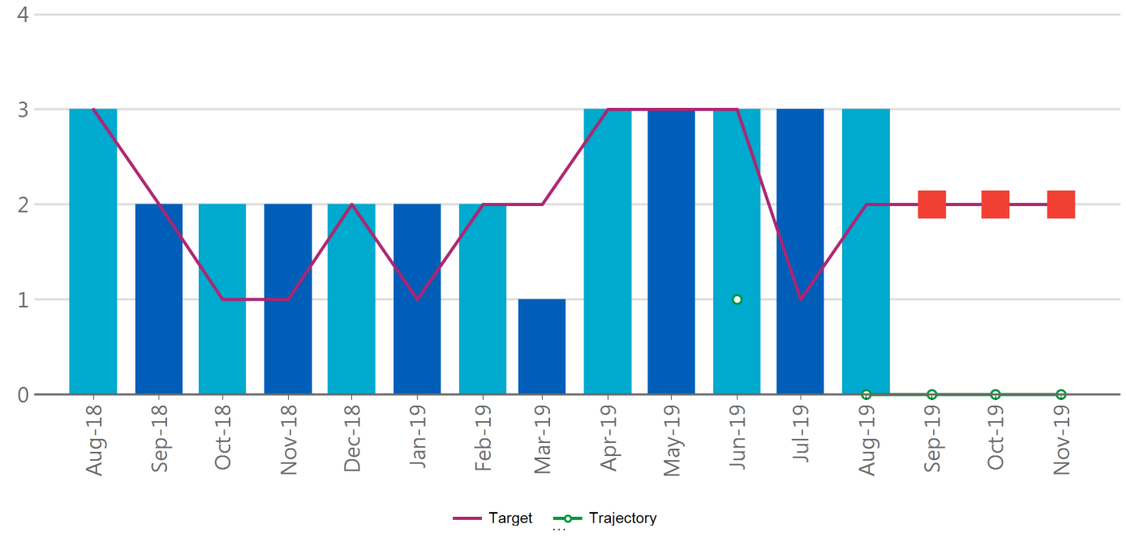
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

Board/Committee Dates 2020/21

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	26th September 2018
Executive Sponsor:	Shelley Ramtuhul, Trust Secretary	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors (Private)	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 of Directors is asked to consider and approve the suggested times and dates for the meetings scheduled for 2020/21.

2. Executive Summary

2.1. Context

The paper presents the suggested dates for the Board of Directors and the Trust's sub board committee meetings throughout 2019/20.

2.2. Summary

The papers outlines the:

- proposed times and dates for the meetings
- explanation behind the changes implemented

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

The paper presents the proposed meeting dates which will be scheduled between April 2020 and March 2021 to ensure timely and well organised diary management.

The meetings which will be scheduled are as follows:

- Board of Directors,
- Quality and Safety Committee,
- Risk Management Committee,
- People Committee,
- Audit Committee,
- Finance Planning and Digital Committee,
- Council of Governors,
- Annual General Meeting,
- Charitable Funds Committee,
- Joint Audit and Quality and Safety Committee,
- Joint Audit and Risk Management Committee

3.2. Proposed Dates

The suggested dates are tabled below:

Board of Directors (monthly including Strategy Board highlighted in blue)	
Thursday 30th April 2020	9.30am – 2.00pm
Thursday 28th May 2020	9.30am – 2.00pm
Thursday 25th June 2020	9.30am – 2.00pm
Thursday 30th July 2020	9.30am – 2.00pm
Thursday 24th September 2020	9.30am – 2.00pm
Thursday 29th October 2020	9.30am – 2.00pm
Thursday 26th November 2020	9.30am – 2.00pm
Thursday 28th January 2021	9.30am – 2.00pm
Thursday 25th February 2021	9.30am – 2.00pm
Thursday 25th March 2021	9.30am – 2.00pm

Quality and Safety Committee (monthly)	
Thursday 16th April 2020	2.00pm – 4.00pm
Thursday 18th June 2020	2.00pm – 4.00pm
Thursday 16th July 2020	2.00pm – 4.00pm
Thursday 17th September 2020	2.00pm – 4.00pm
Thursday 15th October 2020	2.00pm – 4.00pm

Board/Committee Dates 2020/21

Thursday 19th November 2020	2.00pm – 4.00pm
Thursday 21st January 2021	2.00pm – 4.00pm
Thursday 18th February 2021	2.00pm – 4.00pm
Thursday 18th March 2021	2.00pm – 4.00pm

Risk Management Committee (quarterly)	
Wednesday 8th April 2020	10.00am – 12.00md
Wednesday 8th July 2020	10.00am – 12.00md
Wednesday 7th October 2020	10.00am – 12.00md
Wednesday 13th January 2021	10.00am – 12.00md

People Committee (quarterly)	
Wednesday 10th June 2020	10.00am – 12.00md
Wednesday 9th September 2020	10.00am – 12.00md
Wednesday 9th December 2020	10.00am – 12.00md
Wednesday 10th March 2021	10.00am – 12.00md

Audit Committee (Quarterly)	
Monday 11th May 2020	10.00am – 12.00md
Monday 13th July 2020	10.00am – 12.00md
Monday 12th October 2020	10.00am – 12.00md
Monday 11th January 2021	10.00am – 12.00md

Finance Planning and Digital Committee (monthly)	
Tuesday 28th April 2020	2.00pm – 4.00pm
Tuesday 26th May 2020	2.00pm – 4.00pm
Tuesday 23rd June 2020	2.00pm – 4.00pm
Tuesday 28th July 2020	2.00pm – 4.00pm
Tuesday 22nd September 2020	2.00pm – 4.00pm
Tuesday 27th October 2020	2.00pm – 4.00pm
Tuesday 24th November 2020	2.00pm – 4.00pm
Tuesday 26th January 2021	2.00pm – 4.00pm
Tuesday 23rd February 2021	2.00pm – 4.00pm

Tuesday 23rd March 2021	2.00pm – 4.00pm

Council of Governors (Quarterly)	
Thursday 28th May 2020	2.30pm – 3.30pm
Thursday 30th July 2020	2.30pm – 3.30pm
Thursday 26th November 2020	2.30pm – 3.30pm
Thursday 25th February 2021	2.30pm – 3.30pm

Annual General Meeting (Annually)	
Thursday 24th September 2020	2.00pm – 4.00pm

Charitable Funds Committee (Quarterly)	
Thursday 25th June 2020	2.30pm – 3.30pm
Thursday 29st October 2020	2.30pm – 3.30pm
Thursday 28th January 2021	2.30pm – 3.30pm
Thursday 25th March 2021	3.00pm – 4.00pm

Joint Audit and Quality and Safety Committee (Annually)	
Thursday 21st May 2020	2.00pm – 4.00pm

Joint Audit and Risk Management Committee (Annually)	
Wednesday 8th April 2020	12.00md – 1.00pm

3.2 Identified Changes

The Board meeting in May has not been brought forward for the receipt of the Annual Report and Accounts. The rationale for this is that these documents are reviewed thoroughly by the Audit Committee, Risk Management Committee and Quality and Safety Committee as well as the external auditors. As per the process for sign off last year, the Annual Report will be approved by the Joint Audit and Quality and Safety Committee on behalf of the Board. The avoidance of bringing forward the May Board date is that it provides greater flexibility to finalise the reports and prevents the issues an earlier meeting creates with the preparing the M1 Performance Report.

Similar to the Joint Audit and Quality and Safety Committee the Trust will schedule a Joint Audit and Risk Management Committee for the discussion on the Board Assurance Framework and Corporate Objectives this is due for April 2020.

3.3. Next Steps

Once the Trust Board has approved the dates, the Board of Directors Programme will be created along with the sub board committee work plans.

The meeting invitations will be sent to those individuals who attend the meetings.

3.4. Conclusion

The Board is asked to ***consider*** and ***approve*** the proposed outline for 2020/21.

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

STW STP Long Term Plan: An Overview

September 2019

In Development

Developing ST&W STP's Long Term Plan

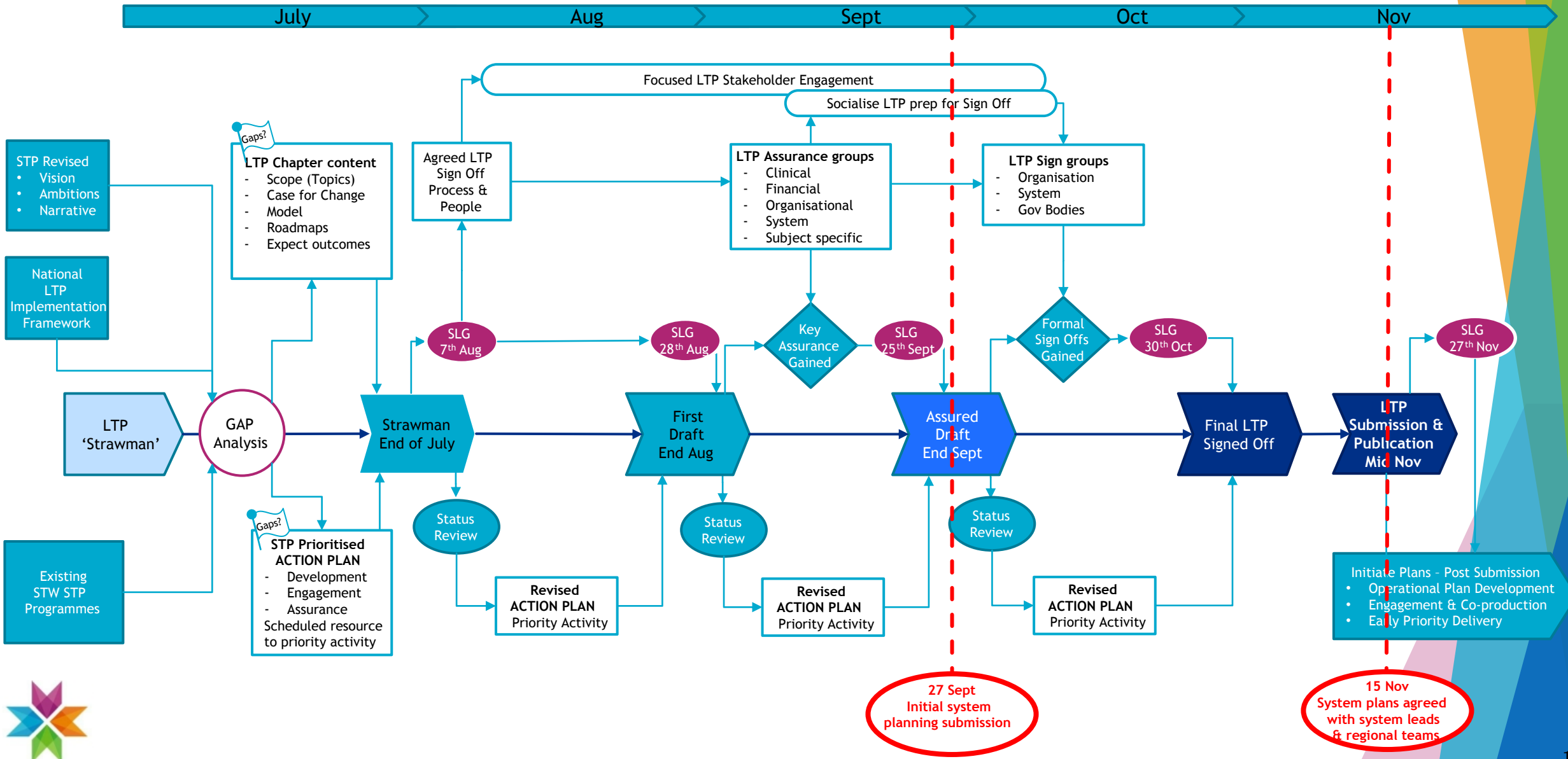
- Our one system plan will describe how all partners within the STP will work together locally to ensure current and future health and care needs are met. It will describe how the STP will deliver its agreed priorities and the requirements of NHS Long Term Plan Implementation Framework.

- The Long Term Implementation Framework expects ICSs and STPs to develop and publish their five year plans according to the following timetable:

By 27 September 2019	Initial submission of ST&W STP draft plan to NHSE/NHSI Midlands Team
By 15 November 2019	STP plan agreed with Senior Leadership Group and NHSE/NHSI Midlands team
November onwards	Local delivery plans to be developed

- Currently our ST&W STP Long Term Plan is DRAFT and will continue to evolve and change based on the feedback and views gathered across the system.

LTP Document Development & Sign-off Process



HWBB involvement in the development of STW LTP

- Audit of stakeholder engagement delivered to date and planned for future (including Shropshire, Telford & Wrekin Council's engagement)
- STP and Long Term Plan updates presented at the HWBB
- Council Councillors /Staff / VCS engagement on the NHS Long Term Plan via survey (August)
- HWB Board Member involvement in the development of the ST&W LTP:
  - Senior Leadership Group (SLG)
  - Healthwatch ST&W STP LTP Report
  - VCS ST&W STP LTP Engagement Event
  - Population Health Management and Business Intelligence (Chapter 2 of ST&W LTP)
  - Prevention & Place Based Care Cluster (Chapter 3 of ST&W LTP)
  - Telford & Wrekin Place (Chapter 3 of ST&W LTP)
  - Acute Care Development Cluster (Chapter 5 of ST&W LTP)

Long Term Plan – Draft Content

Chapter 1: Our System Structure and Governance to support delivery of change

Chapter 2: What underpins our ambitions

Chapter 3: Delivering a new service model for Prevention and Place based integrated care

Chapter 4: Delivery of world class Mental Health services

Chapter 5: Acute Care Development

Chapter 6: Support Services

Chapter 7: A comprehensive new Workforce plan

Chapter 8: Digital Enabled Care

Chapter 9: Estates

Chapter 10: Financial Sustainability & Productivity

Chapter 11: Next Steps – New Ways of Working

Our System Structure and Governance to support delivery of change

Our vision

We will work together with the people of Shropshire, Telford and Wrekin to develop innovative, safe and high quality services delivering world class care that meets our current, and future, rural and urban needs.

We will support people – in their own communities – to live healthy and independent lives, helping them to stay well for as long as possible.

As the world faces up to a climate emergency, we are committed to delivering an internationally recognised system known for its environmentally friendly services that make the best use of our resources.

In Development

Together as one, transforming health and care for Shropshire, Telford & Wrekin

- Shropshire, Telford & Wrekin's Sustainability and Transformation Partnership (STP) brings together health and social care organisations across the county
- Working more closely than ever before to transform health and care services to deliver world class care which meet current and future needs of our rural and urban populations
- We want all our residents in Shropshire, Telford and Wrekin – children, adults of working age, and older people, to live in good health for a long as possible throughout their life
- We will help them to live independent lives with a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it
- By joining up local services and working in collaboration with local people and our voluntary sector, we can achieve much greater benefits for our community
-

In Development

Together as one, transforming health and care for Shropshire, Telford & Wrekin

- Together we need to tackle the cause of the problems such as loneliness, poverty and obesity, and work differently so that services are joined up, making the most of new digital technology and using buildings that are fit for modern day health and care
- We need to do more to support people lead happier and healthier lifestyles by encouraging people to be more physically active, manage their weight or change habits such as stop smoking or alcohol abuse
- We need to reduce the growing demand on our services, staff and resources, making it easier for people to get an appointment, as some are waiting longer than we would like for treatment, and some are spending longer in hospital than they need to
- By working together, we can tackle some of the big problems we are facing, and can share skills, resources and money and give a better service to everyone, no matter where they live in Shropshire, Telford and Wrekin.

Together as one we will:

- Provide a greater emphasis on prevention and self-care
- Help people to stay at home with the right support with fewer people needing to go into hospital
- Give people better health information and making sure everyone gets the same high quality care
- Utilise developing technologies to fuel innovation, support people to stay independent and manage their conditions
- Attract, develop and retain world class staff
- Involve and engage our staff, local partners, carers, the voluntary sector and residents in the planning and shaping of future services
- Develop an environmentally friendly health and care system

In Development

ST&W LTP - Sign off approach
- Key groups to achieve sign off by 15th November

	Groups	Engage	Develop/ Input	Scrutiny	Sign Off	Approve
	Commissioning Governing Bodies	8&9 Oct				12&13 Nov
	Provider Governing Bodies	26 Sept				31 Oct
	STP Chairs Group	**25 Sept**				
	Telford & Wrekin H&WBB	26 Sept	TBC			
	Shrop H&WBB	12 Sept	22 Oct			
	Joint HOSC			2 Oct		
	Senior Leadership Group	Sept -	- Oct		30 Oct	
	Workstream SRO – LTP Chapter	Sept -	- Oct		24 Oct	

EU Exit Update

0. Reference Information

Author:	Craig Macbeth	Paper date:	26th September 2019
Executive Sponsor:	Craig Macbeth, Director of Finance	Paper Category:	Governance and Quality
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 the Board of Directors and what input is required?

This paper presents an update on the preparations for a no deal exit from the EU on 31 October 2019. This paper is presented for information purposes.

2. Executive Summary

2.1 Context

NHS preparations are being managed by a centrally co-ordinated task team who are disseminating information nationally on risks and required mitigating actions. As part of this the Trust is required to provide information and assurance to a regional team. One aspect of this is providing assurance that the Board is informed of any potential issues.

The Trust has put in place governance arrangements whereby the Audit Committee has oversight of the EU Exit preparation with support from the Risk Committee.

2.2 Summary

This paper outlines the current risks and mitigations for information purposes with any required ongoing assurances to be provided to the Board via the governance arrangements outlined above.

2.3. Conclusion

The Board is asked to note the Trust's preparations for a no deal EU exit.

EU Exit Update

Update on preparation for potential no deal 'Brexit'

1. Introduction

This paper provides an update to Board on arrangements for managing the potential consequences in the event of the UK leaving the European Union on the 31st October under a no deal Brexit scenario.

2. Management arrangements

In common with all other NHS organisations, oversight arrangements are being co-ordinated by a centrally co-ordinated task team who are keeping us advised on the potential risks and mitigating actions being put in place to manage.

Locally, we have in place a Brexit task team under our business continuity planning framework that manages information requests, communications and responds to events as and when they unfold. The team consists of:

Craig Macbeth, Director of Finance and Planning – Senior Responsible Officer
Nikki Bellinger, Deputy Director of Nursing – Business Continuity Planning Lead
Shelley Ramtuhul – Trust Secretary
Helen Lewis – Procurement Lead
Sue Pryce – Head of People Services
Simon Adams – Associate Director of I,M & T

3. Risks and mitigations in the event of a no deal Brexit

Supplies
The principle risk in the event of a no deal Brexit relates to the Supply chain of equipment and services. The majority of RJAH supplies (80%) are sourced under national NHS contracts and therefore covered by national contingency planning.

In a recent Regional briefing these contracts were reported as 'on track to secure continuity of critical supplies with a number of measures put in place including additional stock holding in warehousing facilities'. In the event of any future supply disruption, issues will be managed centrally under the direction of a national supply disruption response unit.

The remaining 20% of our contracts have been covered by local liaison with suppliers and completion of a centrally provided assurance template. This has highlighted minimal risk to supply disruption for our clinical supplies.

Assurance is therefore strong but all Trusts are advised to plan for potential short term delays to delivery patterns (items that can currently be ordered on next day delivery

may take 2-3 days) as a result of logistical changes. Stockpiling is not however an option, changes to ordering processes will be required to manage.

Workforce

RJAH employs approximately 40 EU citizens (less than 3% of workforce). It has been confirmed that all EU qualifications will still be recognised in the UK.

All will need to have completed a settled status application to remain working in the UK by 30th June 2021 and RJAH is supporting staff where required with such applications and ensuring they know they are valued and welcome to stay as employees of the Trust.

Reciprocal healthcare arrangements

From 1st November, EU nationals who are not eligible for UK health care will be charged for receiving elective care in NHS Hospitals (emergency care will still be free).

Systems will be introduced to identify this additional cohort of patients under overseas charging policy but volumes are expected to remain low.

Data Protection

There is a requirement for all NHS organisations to review in bound data flows from the EU that are relied upon and ensure appropriate safeguards are in place. A risk assessment for RJAH has identified minimal risk.

4. Recommendation

The Board is requested to note the arrangements in place to manage the potential disruption associated with a no deal EU exit.

Month 4 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Principal Analyst and Data Quality Lead	Paper date:	29/08/2019
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 4 (July) 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 sub-committees of the Board and included in this report.

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

Of note this month:

Caring for Staff;

- Absence remains above the 4% target at 4.43%
- Turnover remains comfortably within 8% target at 6.65%
- Q1 Staff Friends and Family Results reported this month, with low uptake of staff participating;

- 92.31% would recommend the Trust for care.
- 69.23% would recommend as a place of work.

Caring for Patients;

- No serious incidents reported in July.
- Reduction in falls overall and moderate or severe harm.
- No hospital acquired pressure ulcers in July.
- Nine complaints received, above the target of eight.
- Further increase in delayed discharges from 4.59% to 6.82%.
- All cancer waiting times standards met in June, a fourth consecutive month.
- Our English RTT open pathways performance is reported at 89.90%, 0.18% behind our trajectory.
- No patients waiting over 52 weeks except BCU transfers.
- Welsh diagnostics standard reported at 100% for second consecutive month. English diagnostics waits standard reported not meeting 99% target, but with improvement as per trajectory.

Caring for Finances;

- Theatre activity remains below plan and is impacting on financial position.
- Agency non-core remains above the national target, but core within target.
- Outpatient activity remains behind plan for a second month with year-to-date position now behind plan.

2.3. Conclusion

It is anticipated that there will be small amendments to the latest IPR layout as we progress through the year.

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.

Integrated Performance Report
July 2019 – Month 4

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

Contents

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.

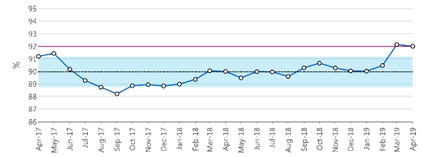
Data Quality Indicator

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**

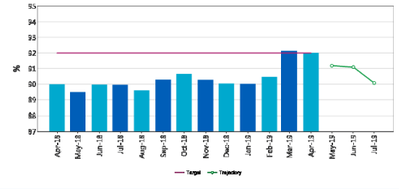
Trend graphs

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



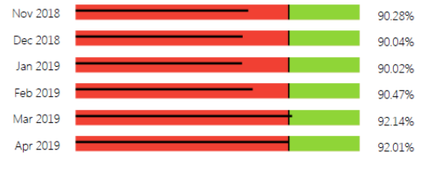
Trajectories

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

	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Sickness Absence	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%	4%	4.43%	R	
Voluntary Staff Turnover	8.46%	8.18%	8.14%	7.95%	7.65%	8.01%	7.88%	7.79%	7.34%	7%	6.86%	6.38%	6.65%	8%	8%	6.65%	G	
Staff Friends & Family – % of staff who would recommend Trust to friends & family if they needed care or treatment*			91.67%						99.14%			92.31%					NO FORE-CAST	Apr-18
Staff Friends & Family – % of staff who would recommend Trust to friends & family as a place to work*			78.27%						76.09%			69.23%					NO FORE-CAST	Apr-18
Staff Friends & Family – % of staff who responded*			2.84%						6.67%			2.22%					NO FORE-CAST	Apr-18

Integrated Performance Report
July – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Patients

	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Serious Incidents	0	1	1	1	1	1	0	0	2	1	1	0	0	0	0	2	R	Apr-18
Never Events	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Total Patient Falls	13	10	15	20	13	16	11	10	8	5	11	16	10	10	40	42	G	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)	99.23%	100%	99.45%	99.01%	99.29%	99.06%	99.18%	98.84%	98.84%	98.44%	98.52%	99.28%	98.9%	95%			G	Apr-18
Number of Complaints	2	7	12	13	6	7	6	17	8	5	8	7	9	8	32	29	G	May-18
% Delayed Discharge Rate	4.42%	3.27%	5.57%	6.1%	7.53%	8.17%	4.02%	6.05%	6.72%	7%	3.6%	4.59%	6.82%	2.5%	2.5%	5.05%	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	1	0	1	0	0	0	0	0	0	0	2	0	1	0	0	3	R	Jun-19
RJAH Acquired C.Difficile	0	0	1	0	0	0	1	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	0	0	0	0	0	0	G	Apr-18
VTE Assessments Undertaken	99.7%	100%	99.92%	99.71%	99.86%	99.91%	100%	99.84%	99.92%	99.91%	99.83%	99.73%	99.92%	95%	95%	99.85%	G	Apr-18
Cancer Two Week Wait*	96.88%	100%	100%	100%	100%	100%	100%	92.86%	100%	100%	100%	100%			93%	100%	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%	0%	0%	50%	100%	66.67%	50%	100%	100%	100%	100%	100%			85%	100%	G	

Integrated Performance Report
July – Month 4

	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 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	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%	92%	92%	90.96%	G	
Patients Waiting Over 52 Weeks – English	1	1	0	2	2	4	2	4	0	0	0	0	0	0			G	
Patients Waiting Over 52 Weeks – Welsh	9	8	6	3	6	7	3	6	1	0	0	1	0	0			G	
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)	121	124	87	54	72	66	52	26	0	1	6	18	86				G	
6 Week Wait for Diagnostics - English Patients	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%	99%	99%	97.93%	G	
8 Week Wait for Diagnostics - Welsh Patients	99.77%	99.67%	100%	99.24%	99.65%	99.64%	99.66%	98.72%	100%	98.76%	99.72%	100%	100%	100%	100%	99.64%	G	

Integrated Performance Report
July – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Finances

	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Total Theatre Activity	1,053	929	1,017	1,115	1,157	883	1,094	1,024	1,082	856	970	886	926	1,162	4,109	3,638	R	
Bed Occupancy – All Wards – 2pm	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%	87%	83%	82.12%	G	
Outpatients Activity Attendances	13,631	12,885	13,792	15,939	15,298	11,440	14,995	13,616	13,718	13,727	13,762	12,988	14,245	15,567	55,389	54,722	G	
Financial Control Total	279	-190	152	676	621	-833	359	59	535	-775	31	-207	73	912	-481	878	R	
Income	9,559	9,080	9,194	10,357	10,004	8,048	9,583	9,049	10,278	8,677	9,508	8,849	9,486	10,494	36,533	34,935	R	
Expenditure	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	9,588	37,784	37,565	G	
CIP Delivery	249	310	298	327	311	329	284	307	358	161	191	260	231	262	941	843	G	
QIPP Delivery Risk Impact										106	86	-67	7	0	0	132	R	
Agency Core	186.24	122.05	112.7	171.62	141.07	105.5	90.56	45.75	68.59	55	72	44	69	132	396	171	G	
Agency Non-Core	246.63	296.21	243.2	302.08	233.41	234.72	243.13	243.43	317.48	229	239	221	232	163	480	689	R	
Cash Balance	6,300	6,200	5,400	5,000	4,200	3,900	4,700	4,300	5,700	5,100	4,900	5,000	9,100	5,900	5,900	9,100	G	
Capital Expenditure	205	164	297	160	377	400	304	165	1,327	260	336	162	3	408	1,433	1,217	G	
Use of Resources (UOR)	2	3	2	2	2	2	2	2	1	3	3	3	3	1	3	3	G	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Sickness Absence

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

4.43% against **4%** target

Breaching target red rated

Exec Lead:
Director of People

People Committee

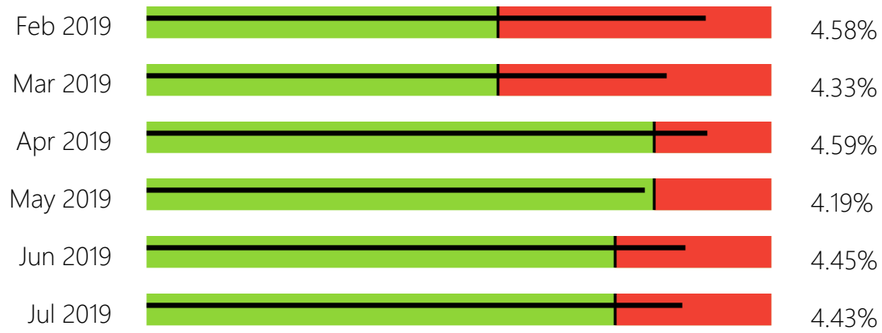
Narrative

There was a slight reduction in sickness absence in July and this continued to be driven by long term absences which saw a further increase and continues to be above target. A breakdown of areas is:
- Surgery – reduction in long term absence but short term absences increased. Both Kenyon and Ludlow Wards above target in both.
- Theatres - reduction in long term absences bringing overall position down. Long term absences continue in Operating Dept Practitioners, Recovery and Scrub. Theatre Escorts and TSSU have had short term absences above target for some months.
- Estates and Facilities – above target with long term episodes in catering, housekeeping and stores.

The highest individual reason for long term absences continues to be stress/anxiety and depression. 'Other known causes' was the second highest individual reason for long term absence; this is a known data issue with ESR.

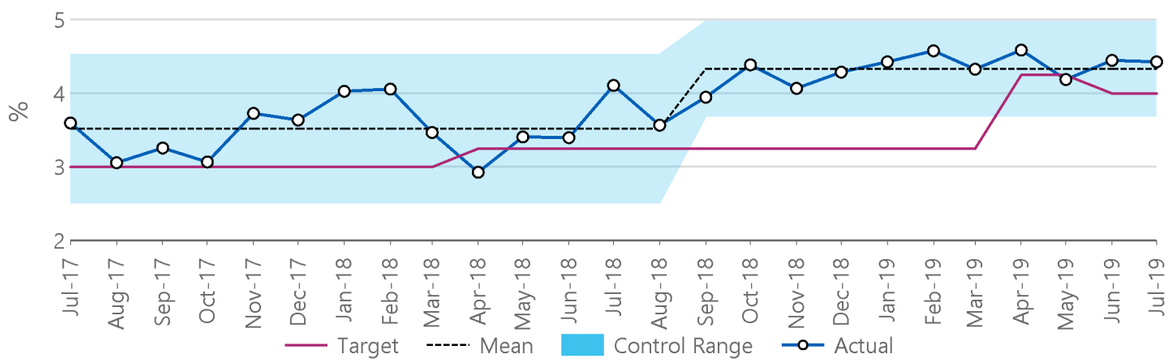
Action to Improve: HR Business Partners to deep-dive review those areas identified with either short term or long term absences continuing over a number of months to understand any trends and propose any action required via the PRM framework. Workshops with those involved with sickness absence support and departmental implementation of the new sickness absence policy will be undertaking during Q3. The Trust has secured a number of licenses for staff to access the Headspace meditation app and this has been operational during August

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

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
3.6%	3.06%	3.26%	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%	4.43%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Voluntary Staff Turnover

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

6.65% against 8% target

Within target green rated

Exec Lead:
Director of People

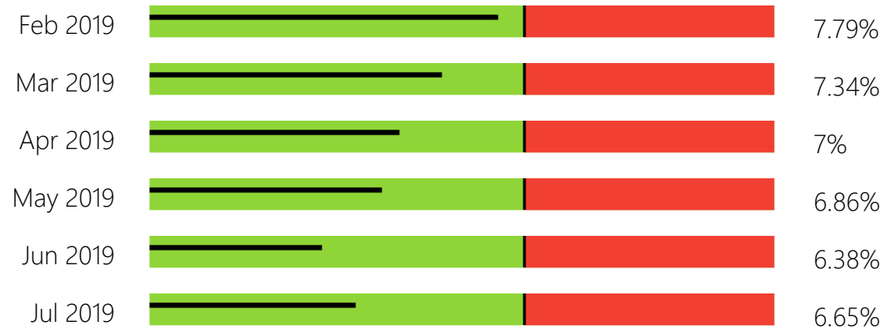
People Committee

Narrative

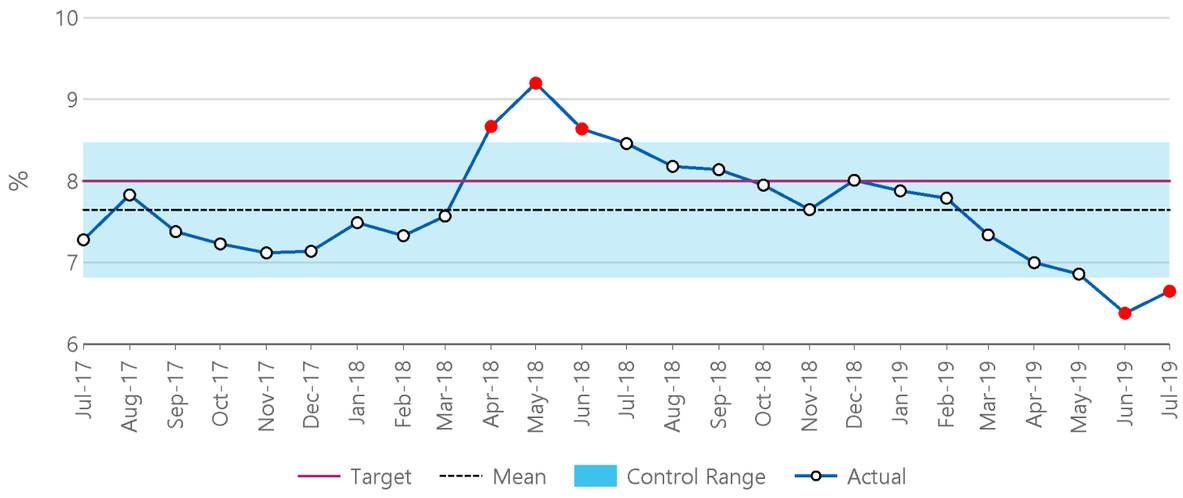
Average leavers occurring in the last 12 month period was slightly higher and therefore a shift in our turnover rate for July. No significant staff group or reasons for leaving identified in the shift reported.

As part of our internal data quality programme this measure is currently under review and initial findings indicate a proposal to the People Committee to consider an update to method of calculation so it relates to headcount rather than WTE.

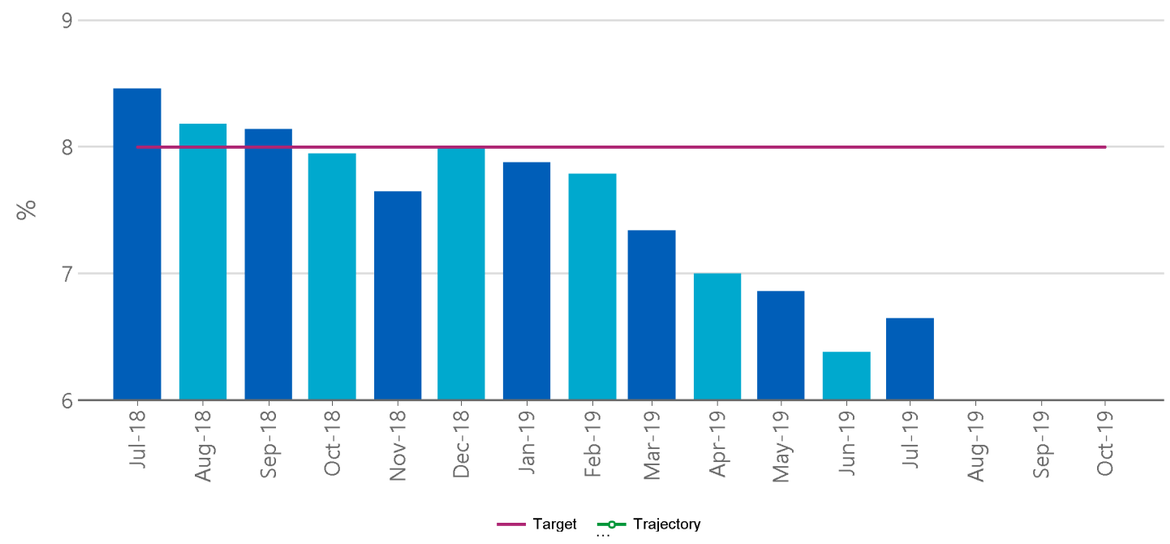
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
7.28%	7.83%	7.38%	7.23%	7.12%	7.14%	7.49%	7.33%	7.57%	8.67%	9.2%	8.64%	8.46%	8.18%	8.14%	7.95%	7.65%	8.01%	7.88%	7.79%	7.34%	7%	6.86%	6.38%	6.65%	6.65%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Staff Friends & Family – % of staff who would recommend Trust to friends & family if they needed care or treatment*

92.31% against N/A target

Exec Lead:
Director of People

People Committee

% of Staff who recommend RJAH to friends & family for care

Narrative

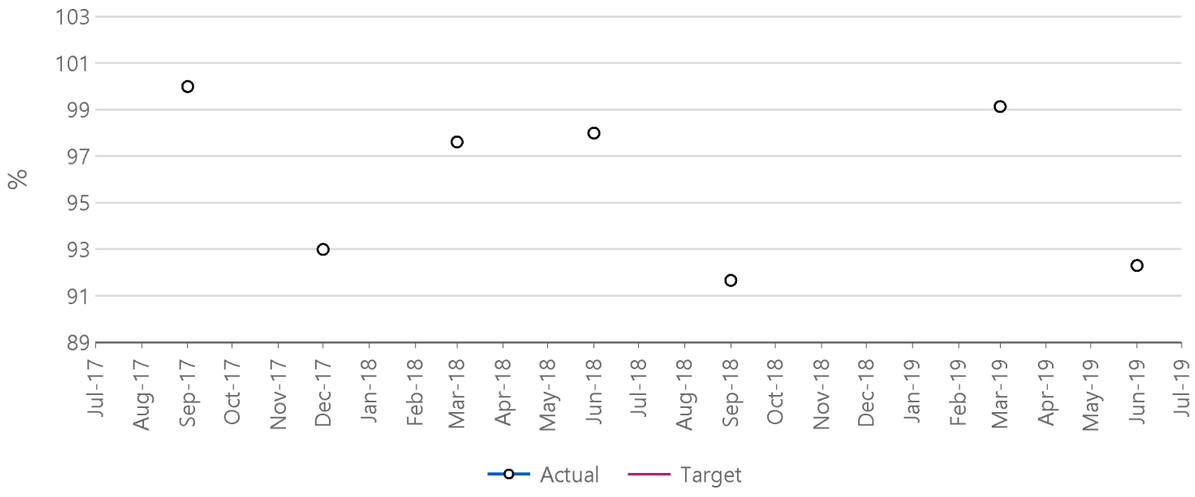
92.31% of staff who responded to the latest survey would recommend the Trust to friends and family if they needed care of treatment.

Some of the historic data has been updated as there was an error in the calculation whereby staff who had taken part in the survey but not answered the question were included in the calculation in error. This has now been rectified and reflected in the data presented in the graph.

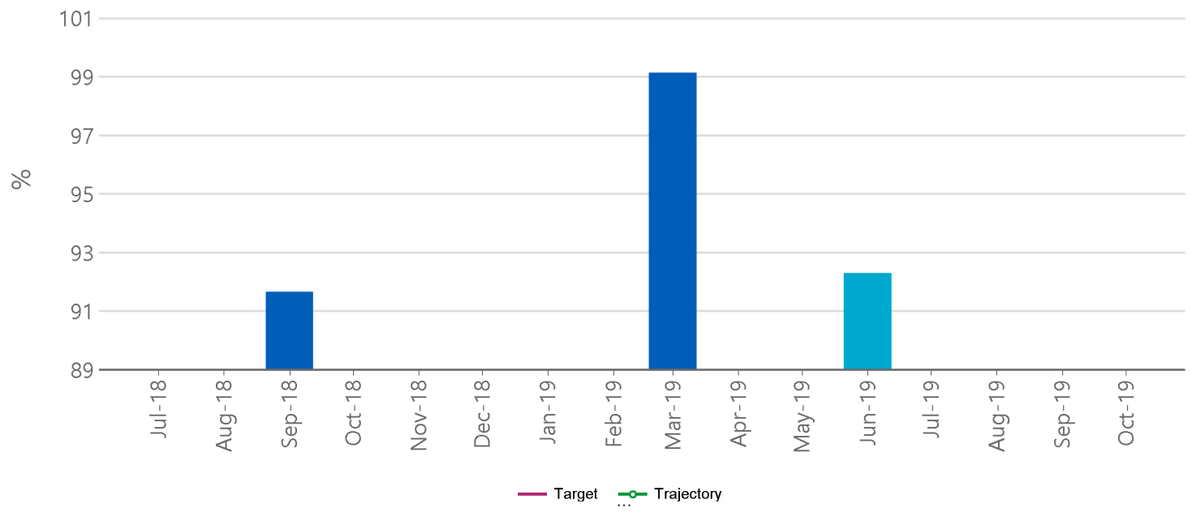
Performance against RAG ratings

Mar 2019	99.14%
Jun 2019	92.31%

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
		100%			93%			97.62%			98%			91.67%							99.14%			92.31%	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Staff Friends & Family – % of staff who would recommend Trust to friends & family as a place to work*

69.23% against N/A target

Exec Lead:
Director of People

People Committee

% of Staff who recommend RJAH to friends & family for work

Narrative

69.23% of staff who responded to the latest survey would recommend the Trust to friends and family as a place to work.

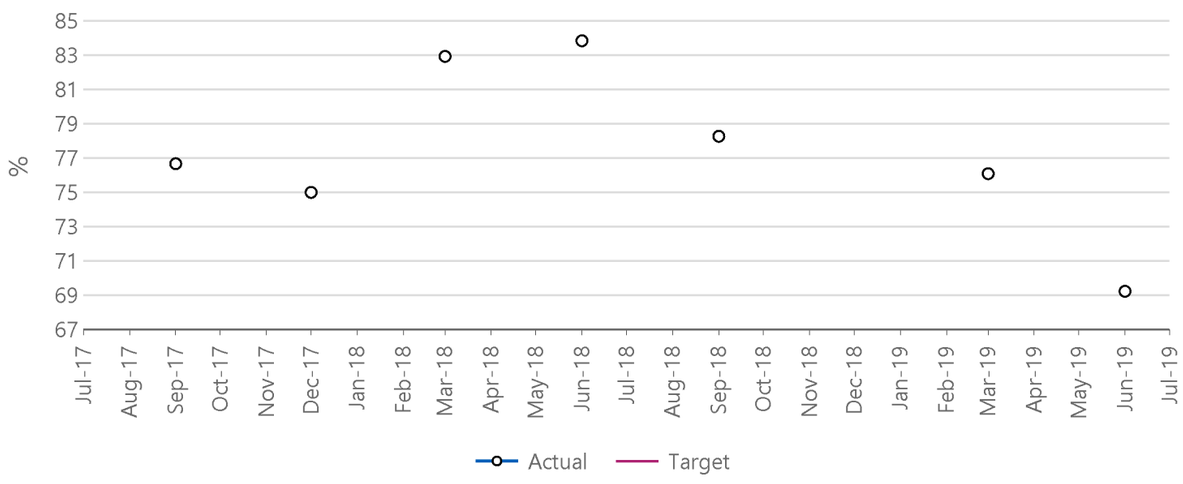
Some of the historic data has been updated as there was an error in the calculation whereby staff who had taken part in the survey but not answered the question were included in the calculation in error. This has now been rectified and reflected in the data presented in the graph.

Action to Improve:Encouragement for those completing the survey to include comments in the Q2 survey.

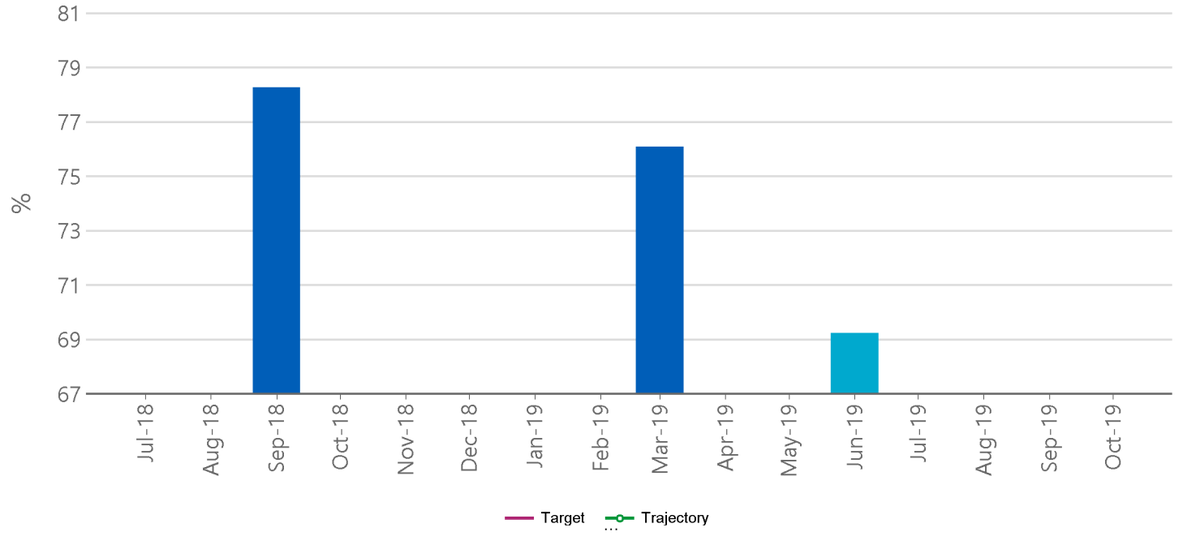
Performance against RAG ratings

Mar 2019	76.09%
Jun 2019	69.23%

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
		76.67%			75%			82.93%			83.84%			78.27%							76.09%			69.23%	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Staff Friends & Family – % of staff who responded*

2.22% against N/A target

Exec Lead:
Director of People

People Committee

% of Staff who Respond to the Friends & Family Test

Narrative

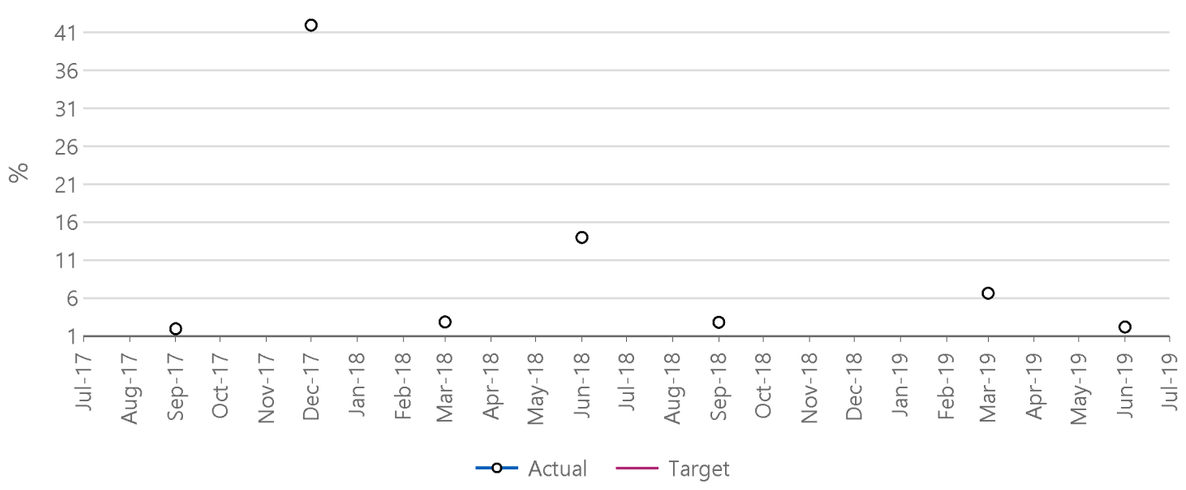
Just 2.22% of staff responses to the friends and family survey. This equates to 39 members of staff.

Action to Improve:Improved communication required to increase participation rates.

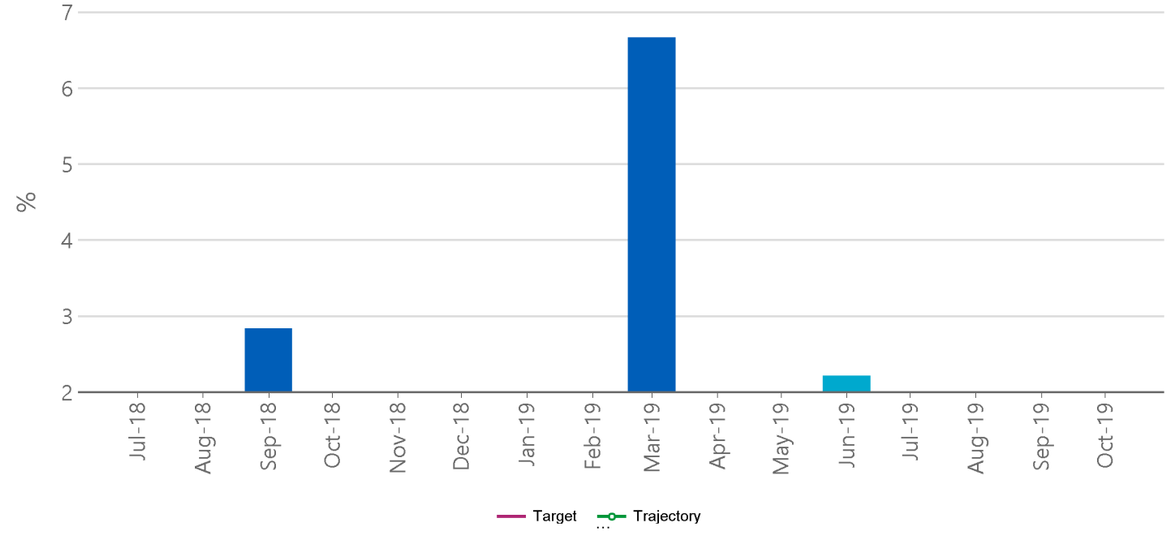
Performance against RAG ratings

Mar 2019	6.67%
Jun 2019	2.22%

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
		1.98%			42%			2.88%			14.02%			2.84%						6.67%			2.22%	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Serious Incidents

Number of Serious Incidents reported in month

0 against 0 target

On target green rated

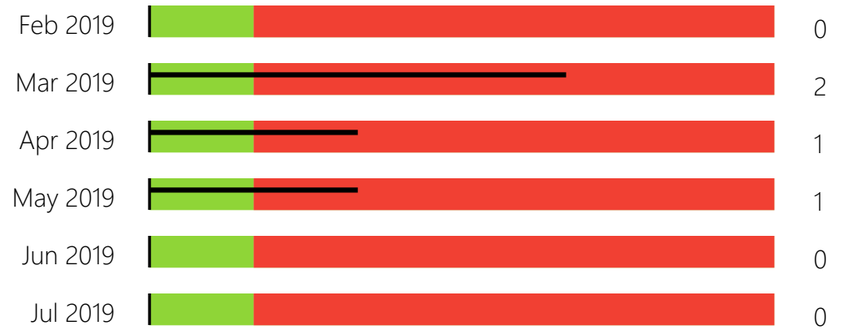
Exec Lead:
Director of Nursing

Quality and Safety Committee

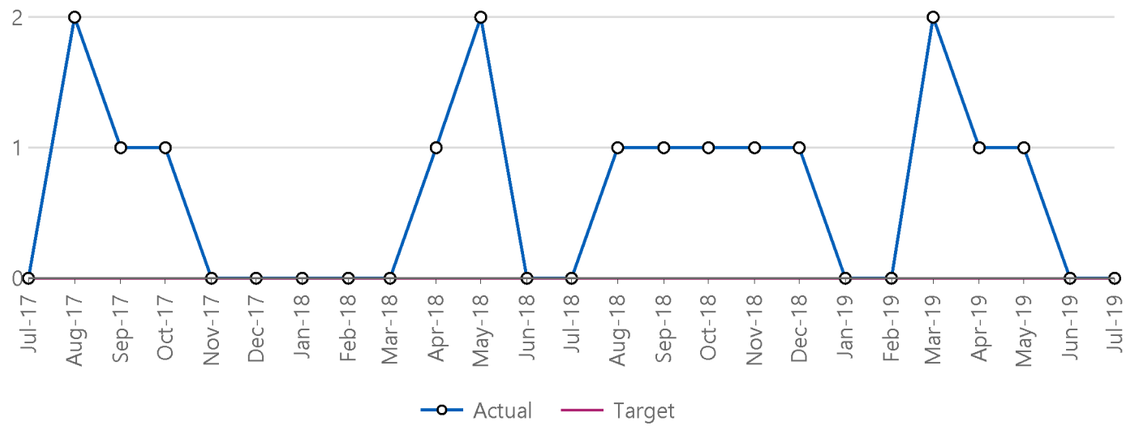
Narrative

There were no serious incidents reported in July.

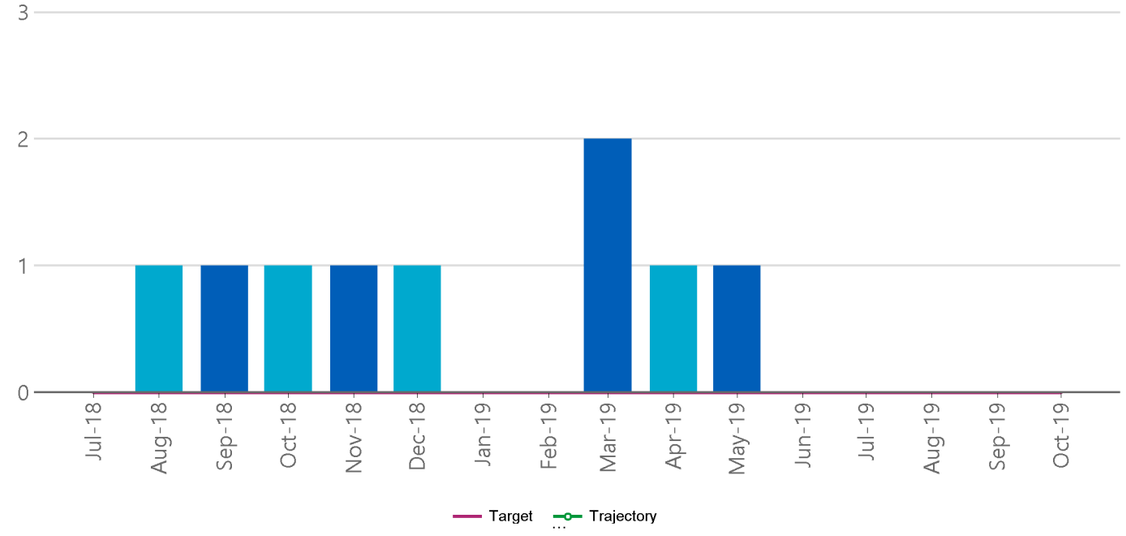
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

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

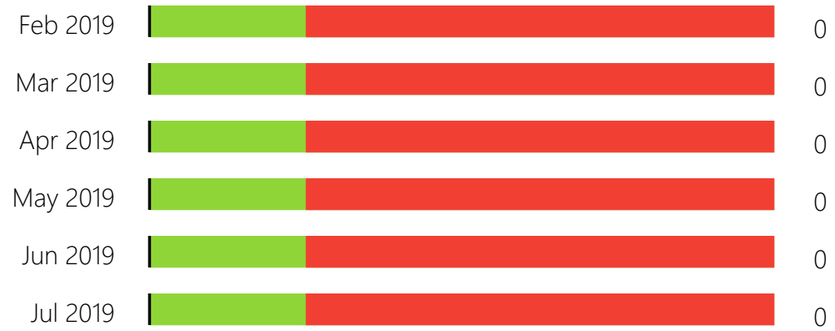
Exec Lead:
Director of Nursing

Quality and Safety Committee

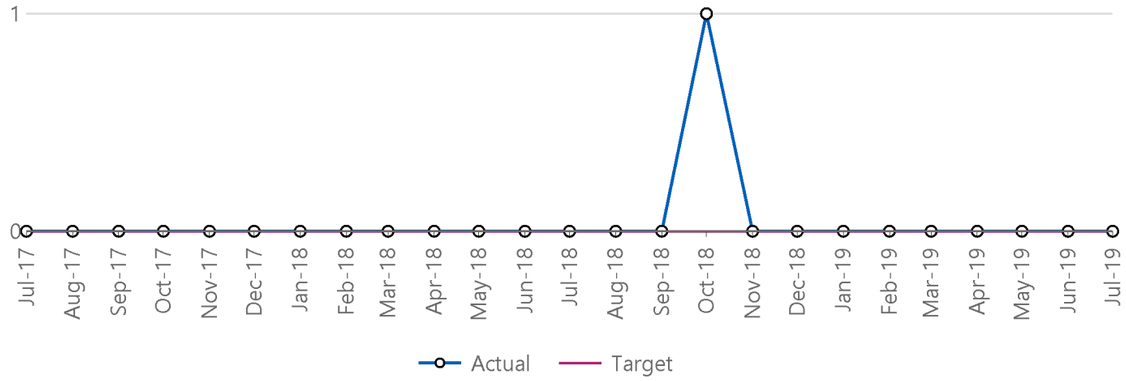
Narrative

There were no never events reported in July.

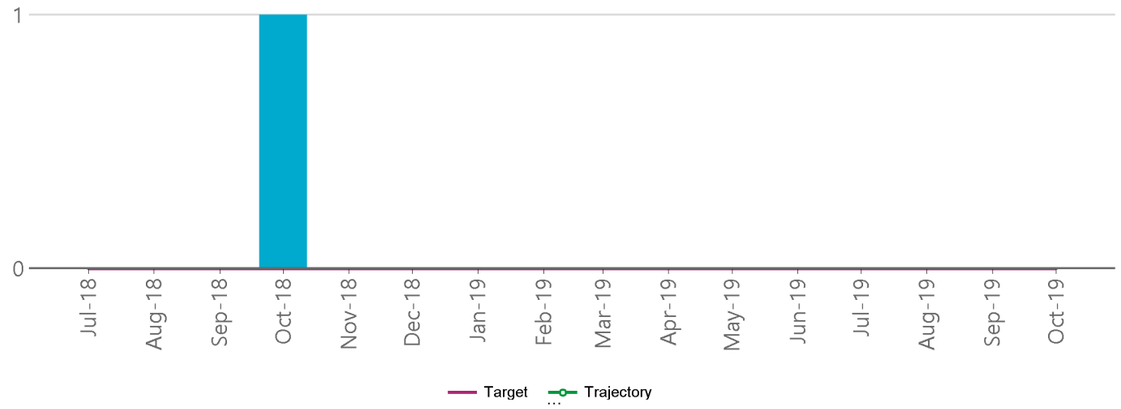
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

Total Patient Falls

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

10 against 10 target

On target green rated

Exec Lead:
Director of Nursing

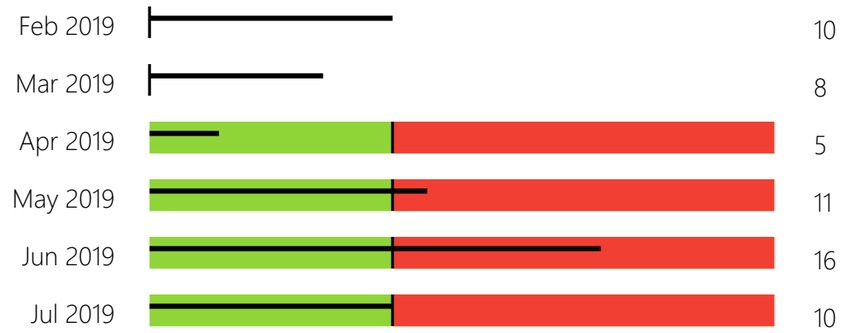
Quality and Safety Committee

Narrative

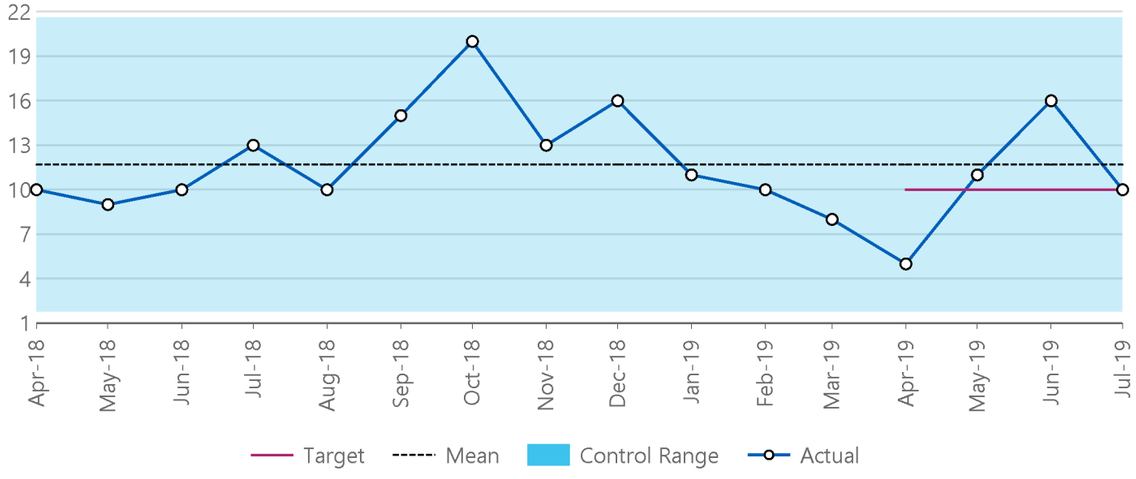
The Total Patient Falls KPI is green rated in July as there were 10 falls, 9 relating to inpatients and 1 relating to outpatients. The falls are broken down as follows:
- No Harm (2) 20%
- Low harm (8) 80%, made up of:
  - No obvious injury but unwitnessed (6)
  - Bump to head (2)

The falls occurred within the following wards/areas:
- Inpatient falls: Clwyd (3), Kenyon (2), Ludlow (2), Oswald (1), Sheldon (1), Therapies.

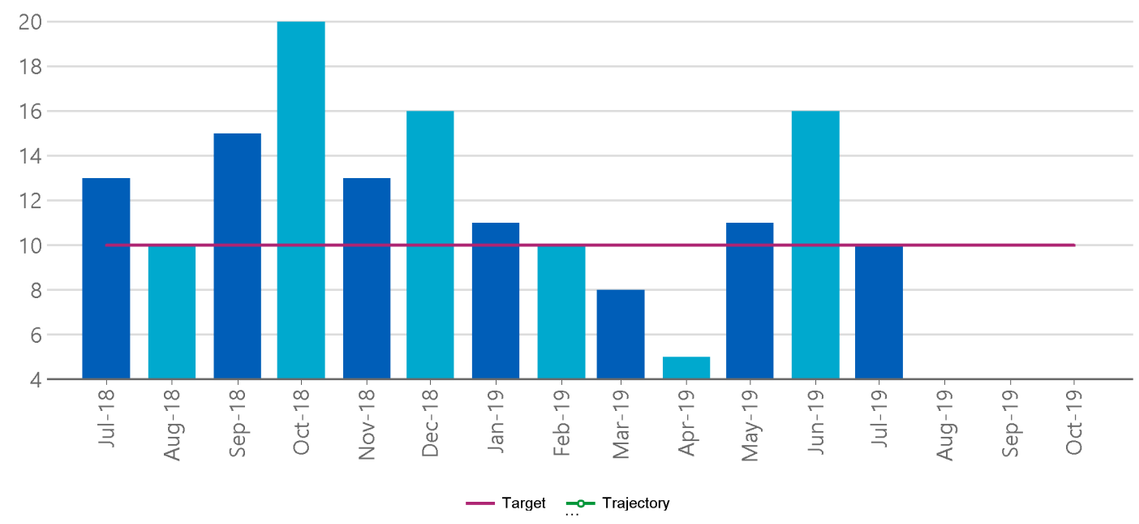
Performance against RAG ratings



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	YTD
10	9	10	13	10	15	20	13	16	11	10	8	5	11	16	10	42

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

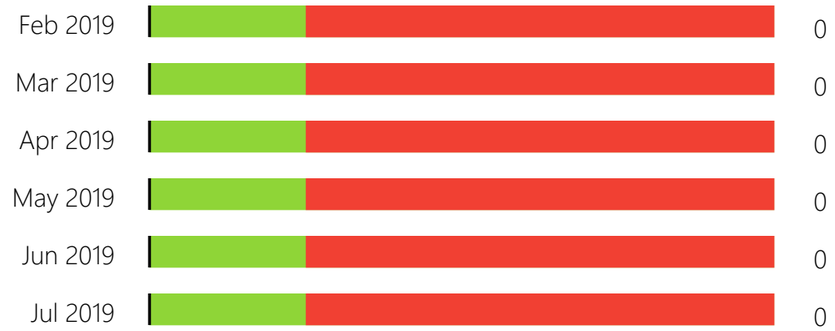
Exec Lead:
Director of Nursing

Quality and Safety Committee

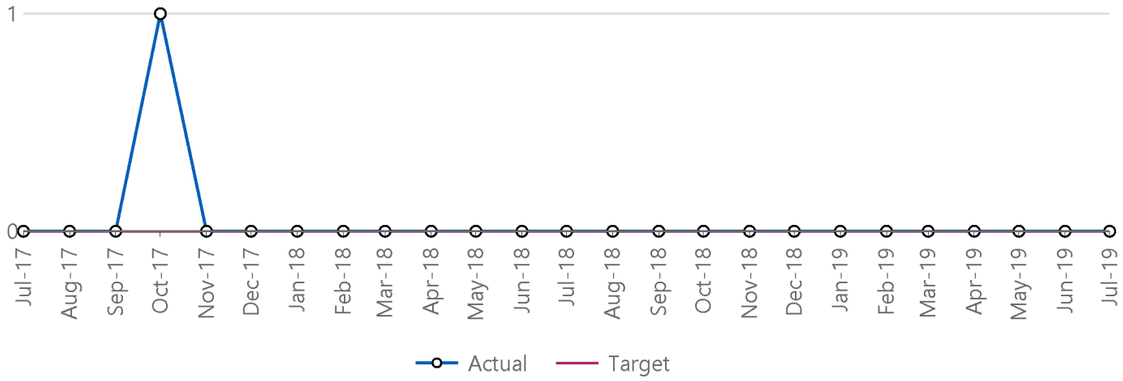
Narrative

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

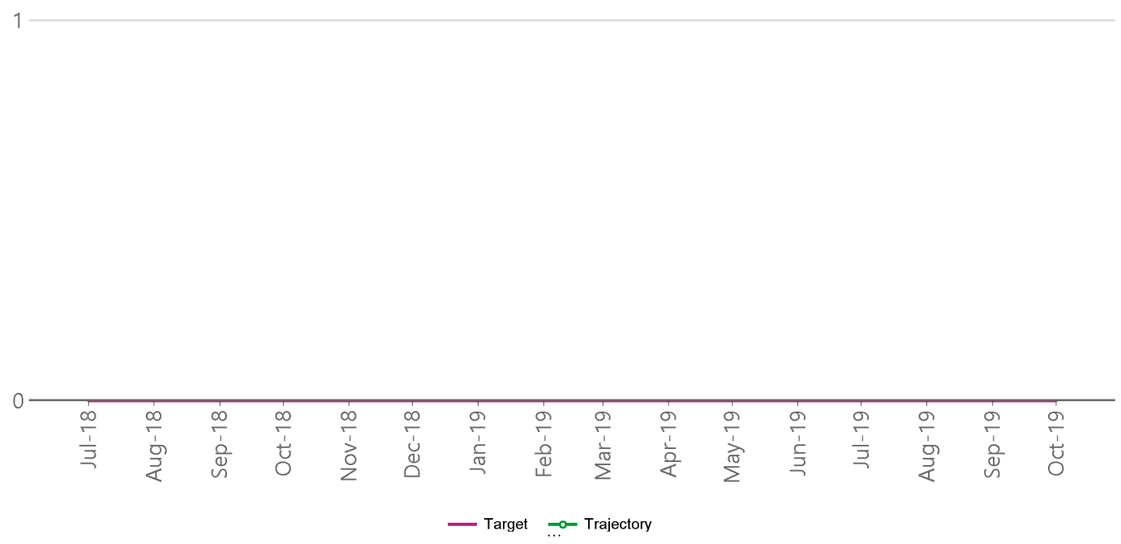
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

98.9% against 95% target

Above target green rated

Exec Lead:
Director of Nursing

Quality and Safety Committee

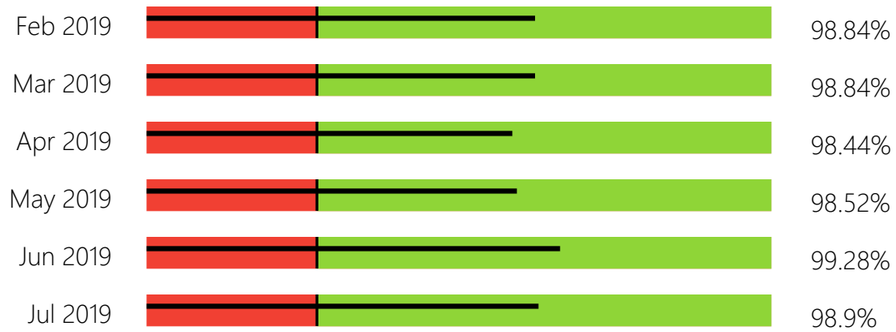
% of patients who would recommend the trust (inpatients and outpatients)

Narrative

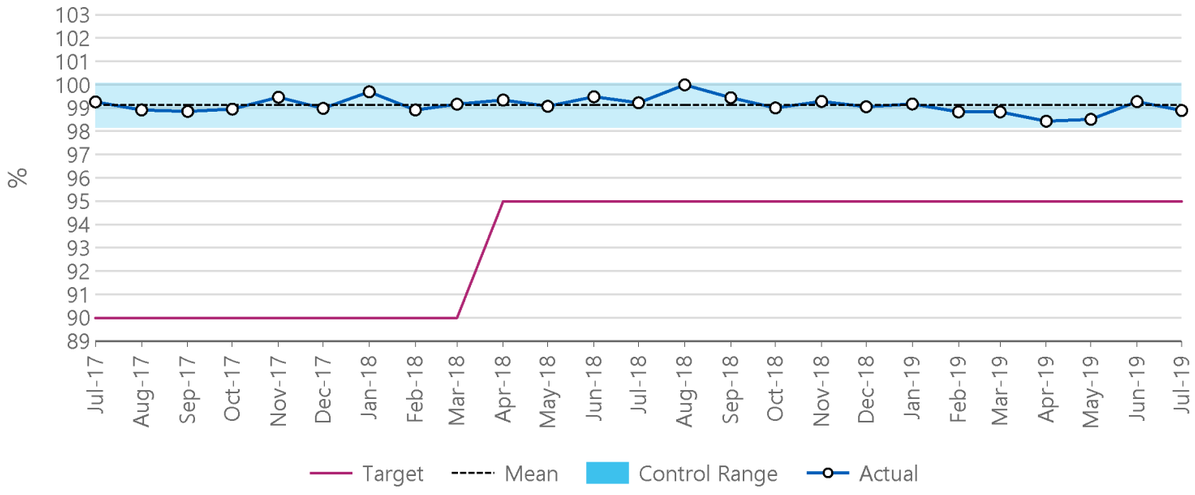
There were 819 responses collected with a breakdown as follows:
- 810 positive - giving a rate of 98.90% would recommend the Trust to friends and family
- 3 negative - giving a rate of 0.37% would not recommend the Trust to friends and family
- 6 responses as "neither likely or unlikely" or "don't know"

The number of compliments received in July was 450, the highest received in a month YTD.

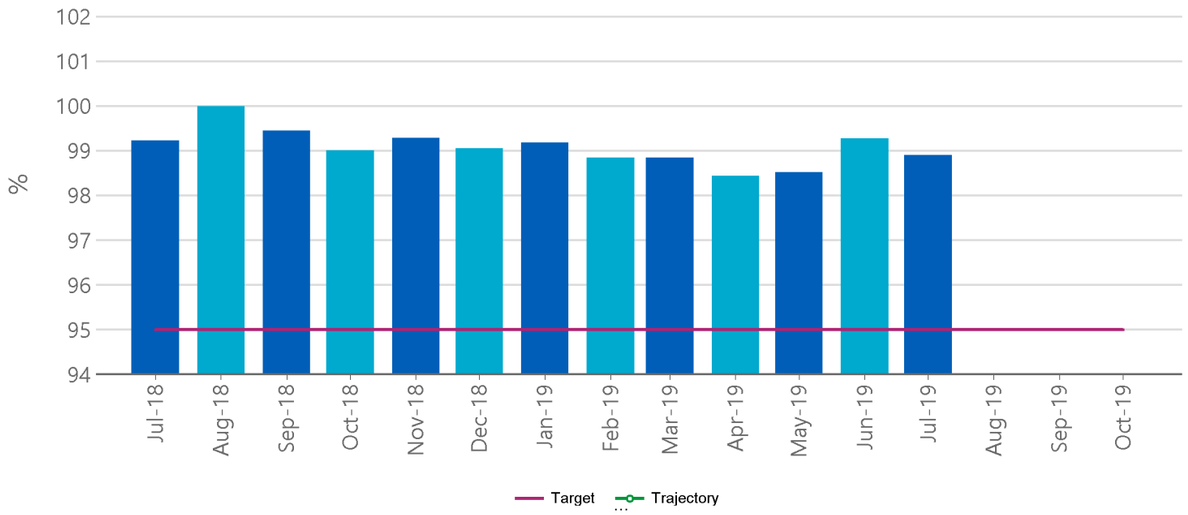
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
99.27%	98.92%	98.86%	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%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Number of Complaints

Number of complaints received in month

9 against 8 target

Breaching target red rated

Exec Lead:
Director of Nursing

Quality and Safety Committee

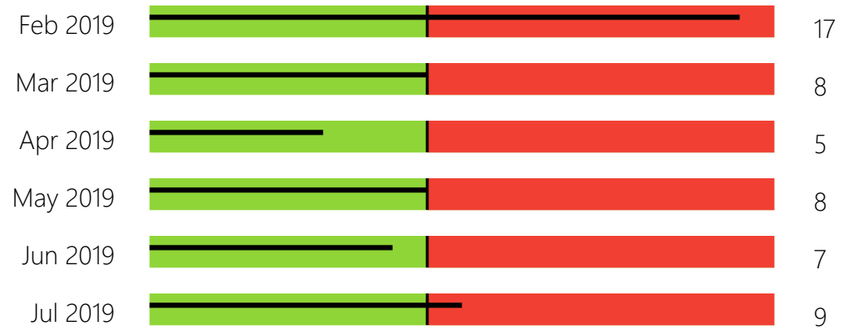
Narrative

There were nine complaints received in July. Five related to quality of care with reasons associated with outcome of surgery (2), advice given (1), acquired pressure sore (1) and care on ward (1). Four complaints related to operational issues associated with closure of pain service (2), waiting times (1) and patients discharged too soon (1).

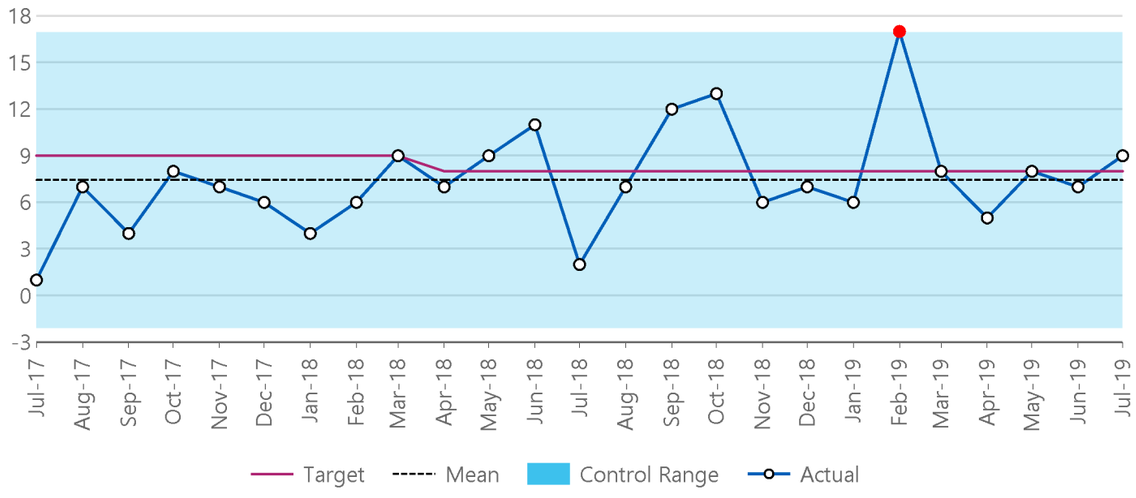
It should be noted that complaints received within the month do not necessarily relate to care delivered in this month. For example, this month two complaints relate to care delivered in 2018.

Action to Improve:As per Trust policy all complaints are fully investigated with any appropriate findings or actions assigned to relevant staff/areas.

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
1	7	4	8	7	6	4	6	9	7	9	11	2	7	12	13	6	7	6	17	8	5	8	7	9	29

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
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% Delayed Discharge Rate

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

6.82% against **2.5%** target

Breaching target red rated

Exec Lead:
Director of Nursing

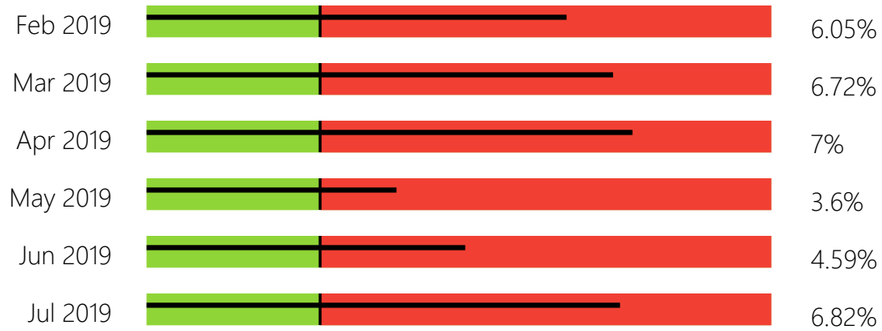
Quality and Safety Committee

Narrative

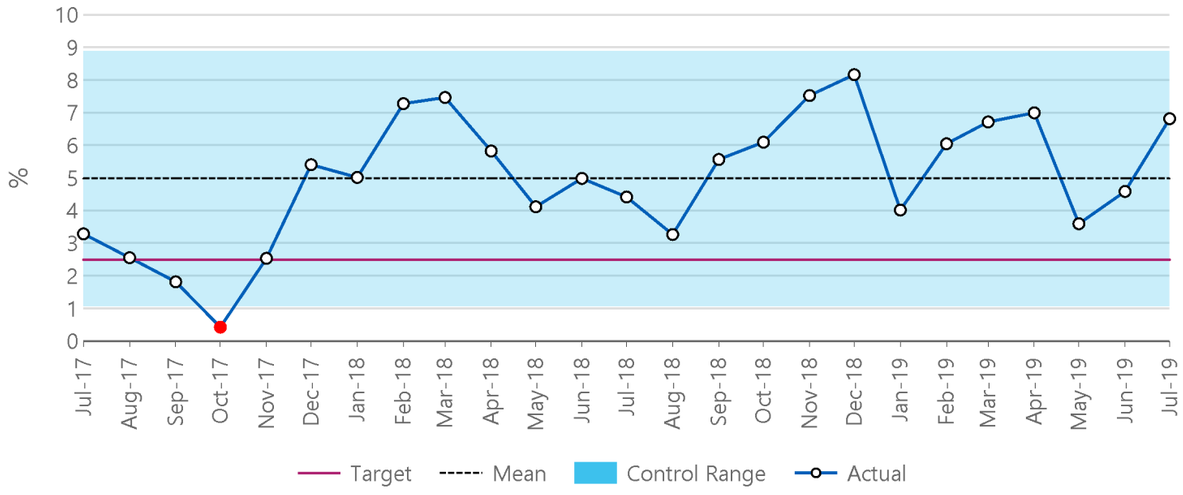
The Delayed Discharge rate is red rated this month at 6.82%. The total delayed days for July is 321 days; 11 spinal injuries patients amounting to 176 days, 14 care of the elderly patients with 60 delayed days and 10 surgical patients with 85 delayed days. The patients fall under the responsibility of Shropshire (16), Resident in Wales (6), Cheshire West and Chester UA (3), Birmingham (3) and seven other organisations with one patient each. A meeting has been held between Sarah Bloomfield and Shropshire CCG to discuss the Shropshire delays at the Trust. A pareto analysis has also been completed of all Trust delays in Q1 to identify the top reasons for delay - these are: awaiting care in home (37.1%), public funding (20.2%), further non acute NHS care (15.3%) and patient choice (12.8%).

Action to Improve:As anticipated, increased focus on delayed discharges through the control centre has improved our reporting of this data and so we have seen an increase on our surgical wards. We are going to scrutinise the supporting data to understand these delays as feedback from our Wards suggests we have seen an increase in the complexity of patients. We are also going to explore intelligence gathered through pre-op so there can be early identification of potential delays.

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
3.29%	2.56%	1.82%	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%	4.59%	6.82%	5.05%

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

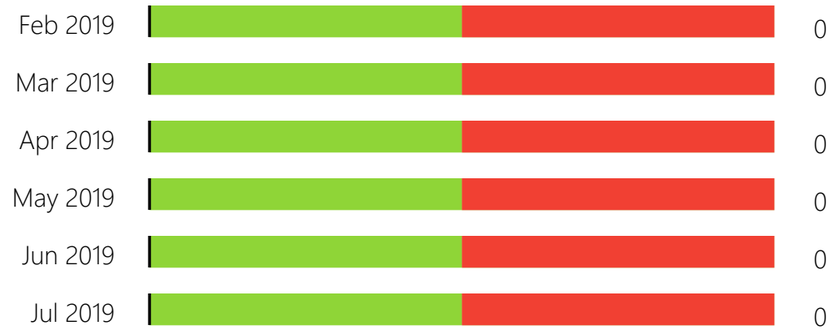
Exec Lead:
Director of Nursing

Quality and Safety Committee

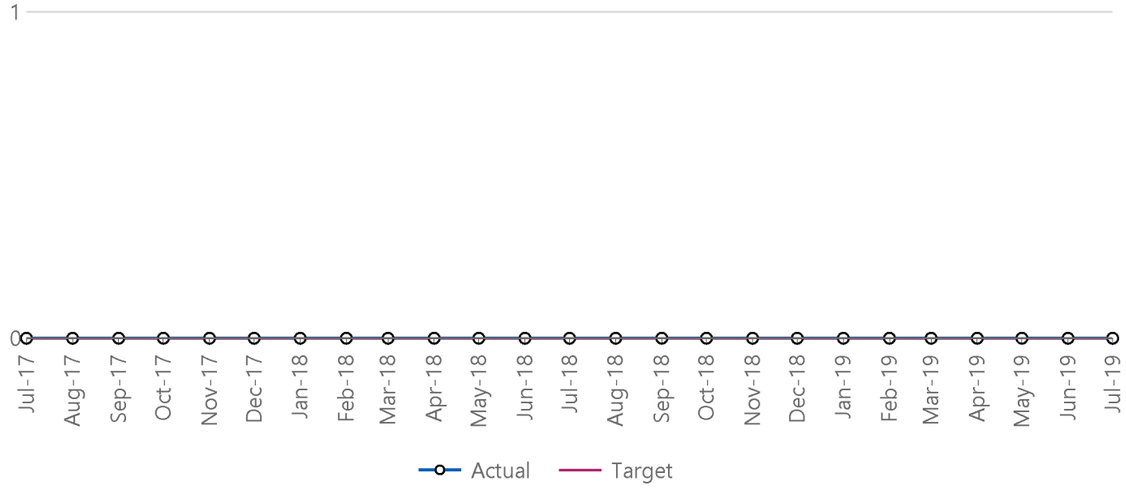
Narrative

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

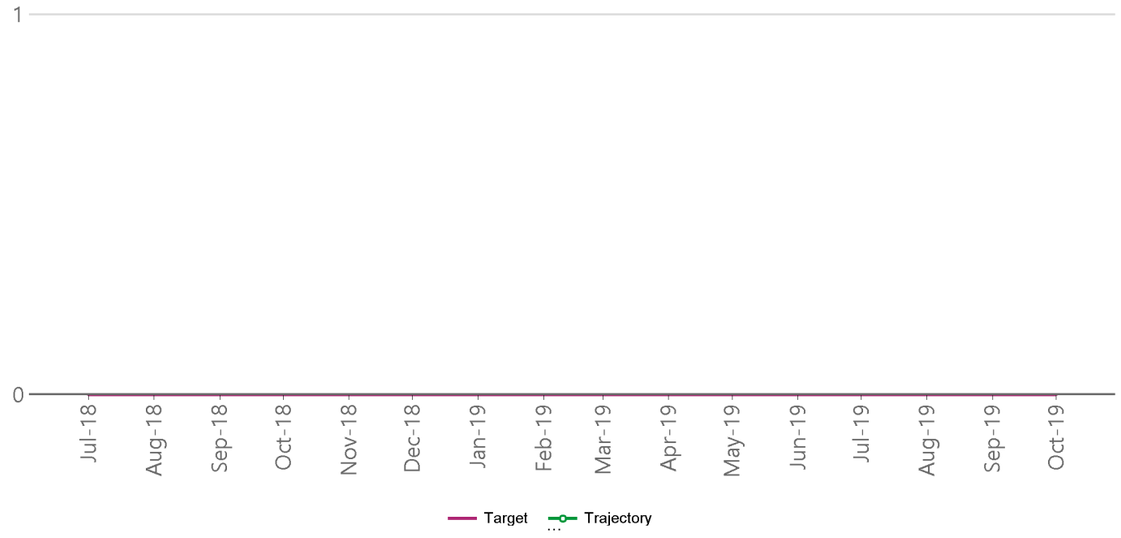
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

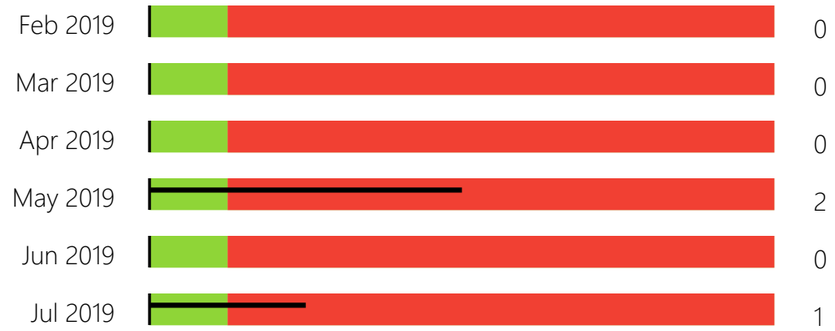
Quality and Safety Committee

Narrative

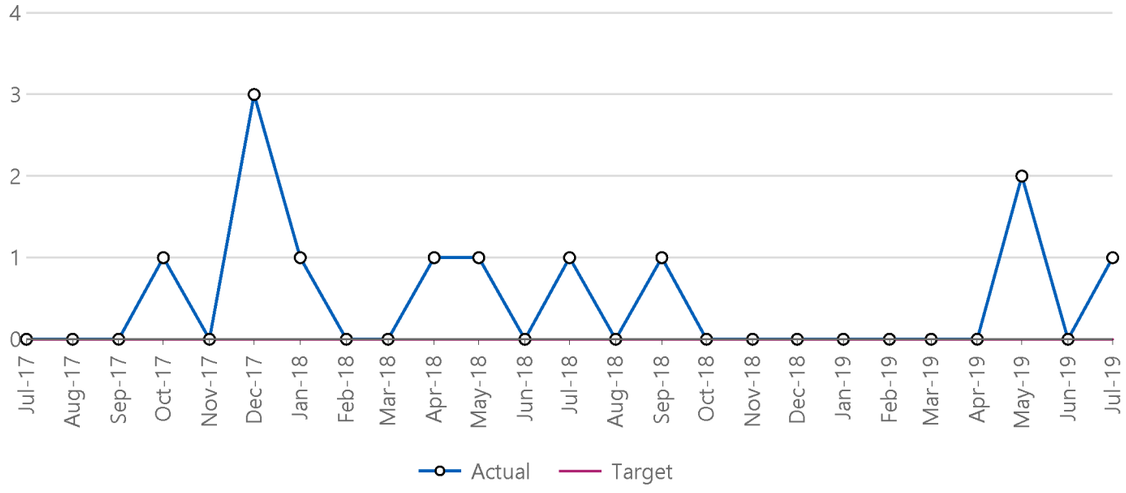
One patient acquired an E. Coli blood stream infection.

Action to Improve:The patient was reviewed on the microbiology ward round and treated with intravenous antibiotics. No further actions required.

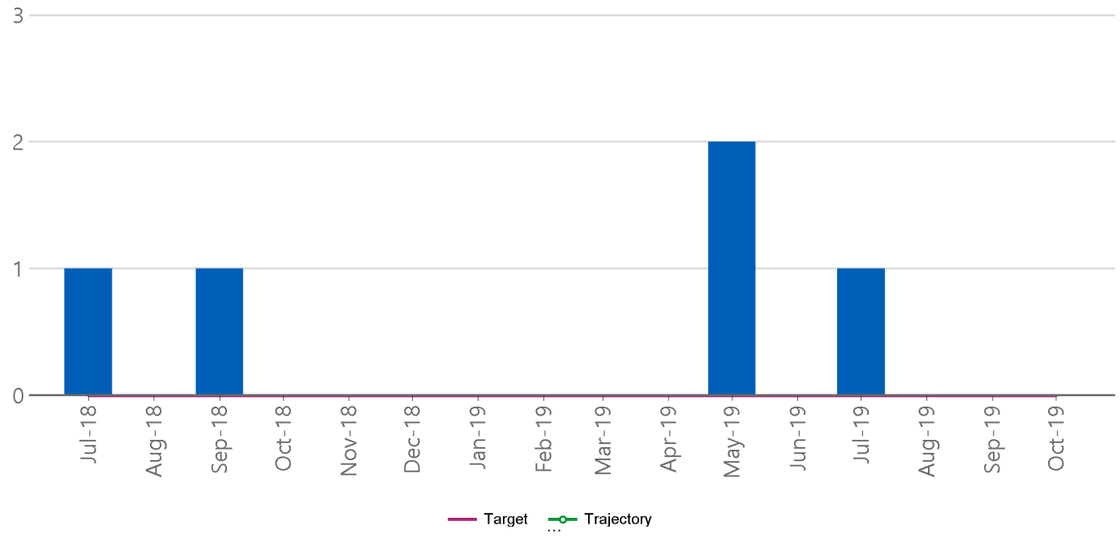
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

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

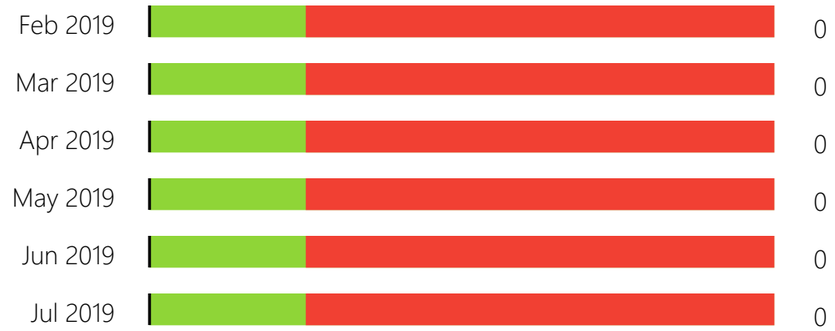
Exec Lead:
Director of Nursing

Quality and Safety Committee

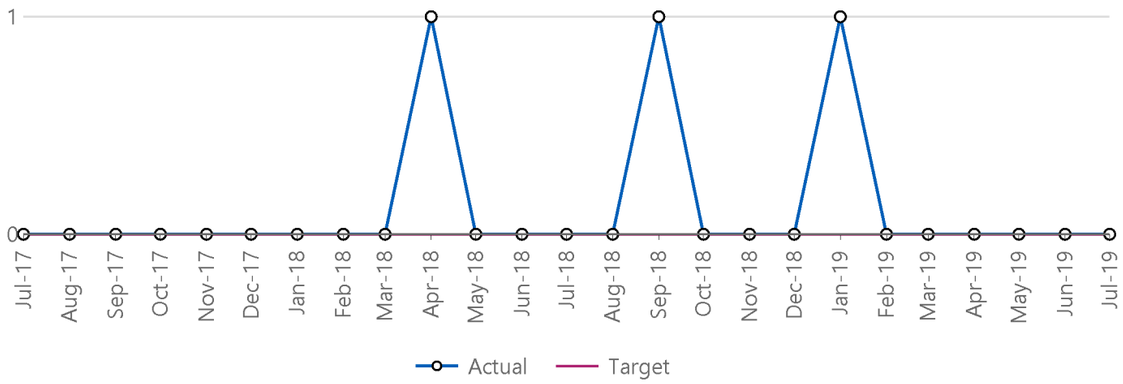
Narrative

There were no incidents reported in July.

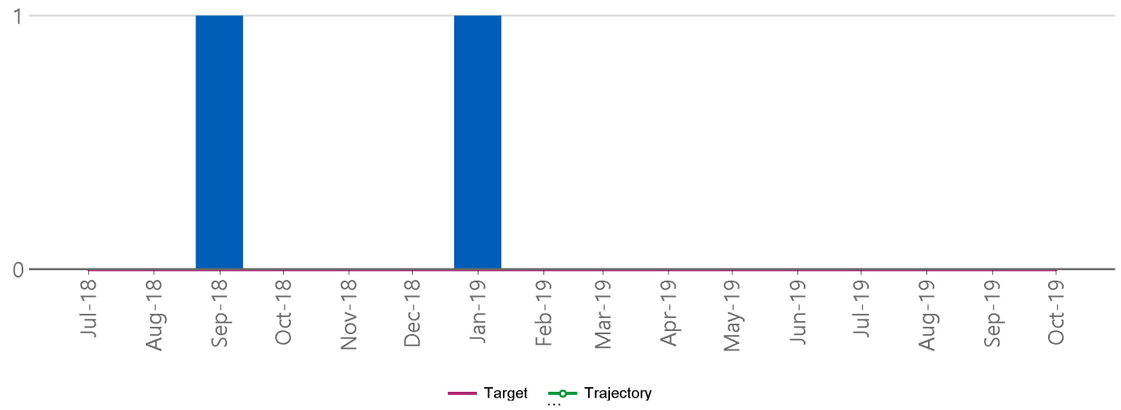
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

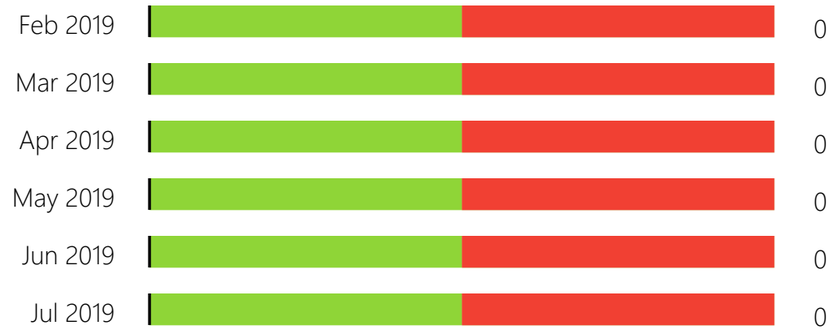
Exec Lead:
Director of Nursing

Quality and Safety Committee

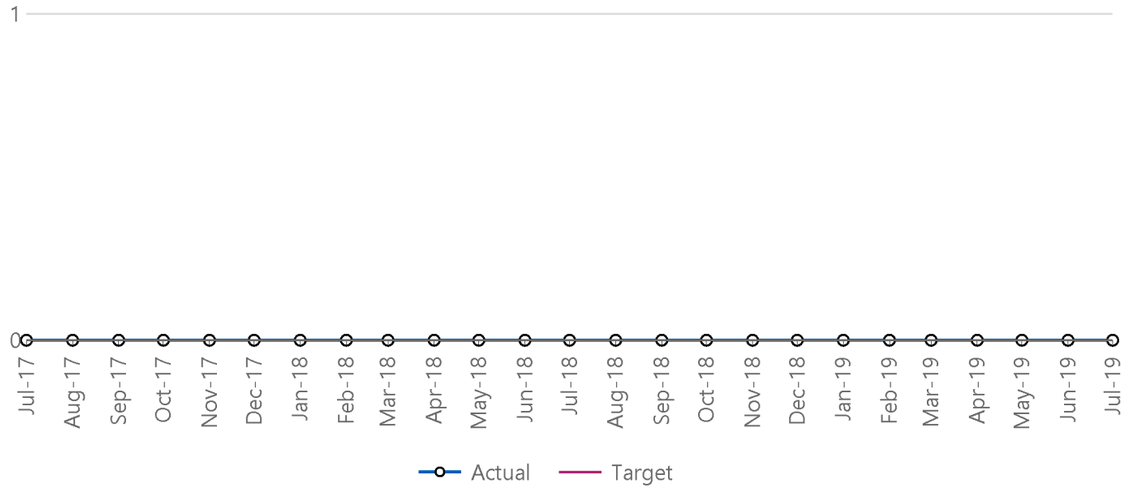
Narrative

There were no incidents reported in July.

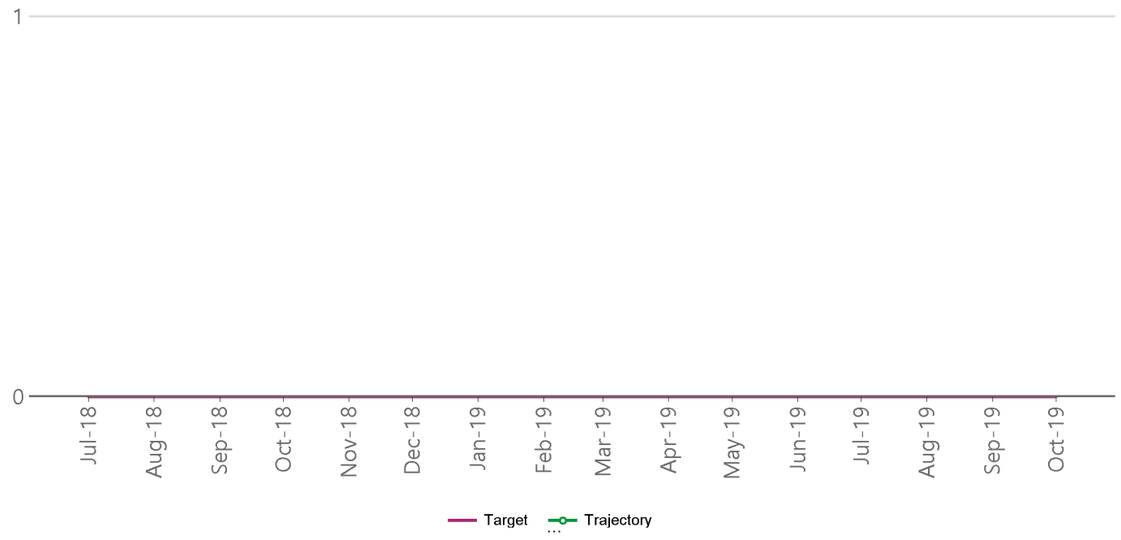
Performance against RAG ratings



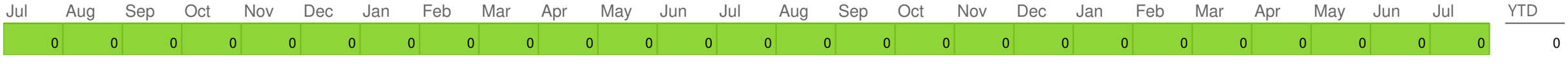
Performance over 24 months –



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

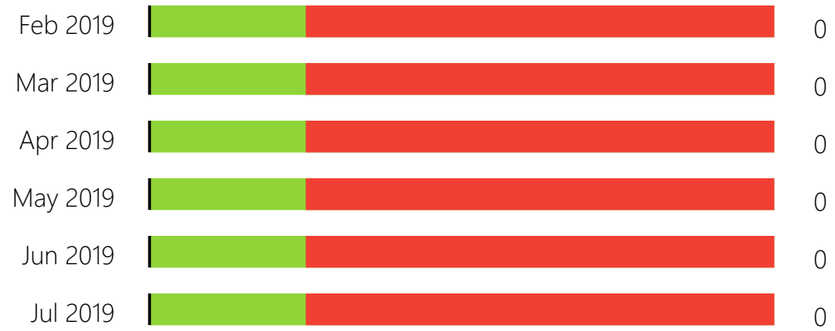
Exec Lead:
Medical Director

Quality and Safety Committee

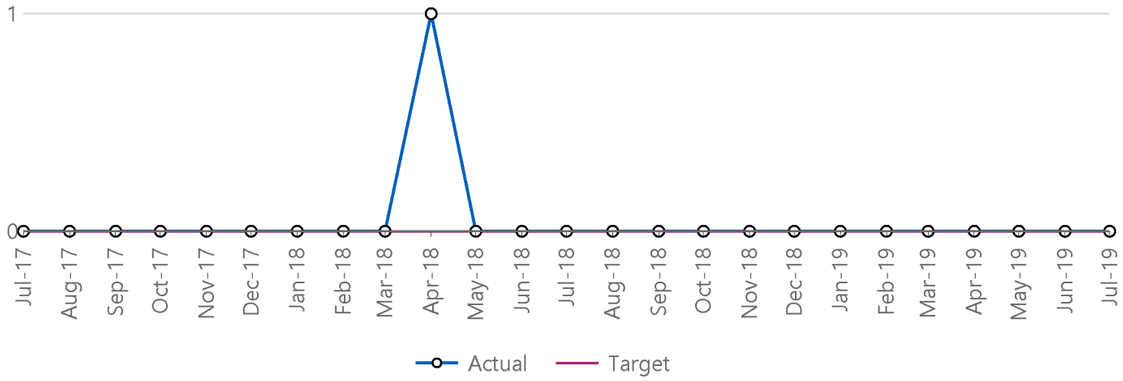
Narrative

There were no patient deaths within the Trust in July.

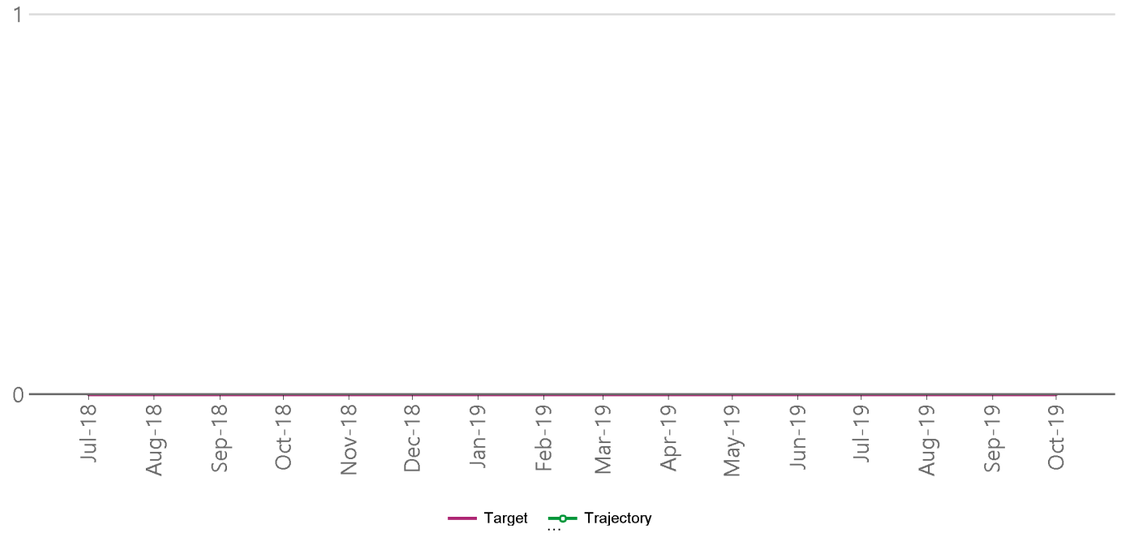
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

VTE Assessments Undertaken

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

99.92% against **95%** target

Above target green rated

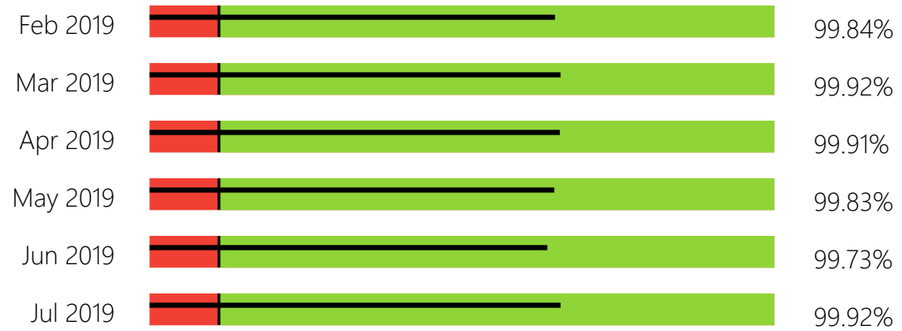
Exec Lead:
Medical Director

Quality and Safety Committee

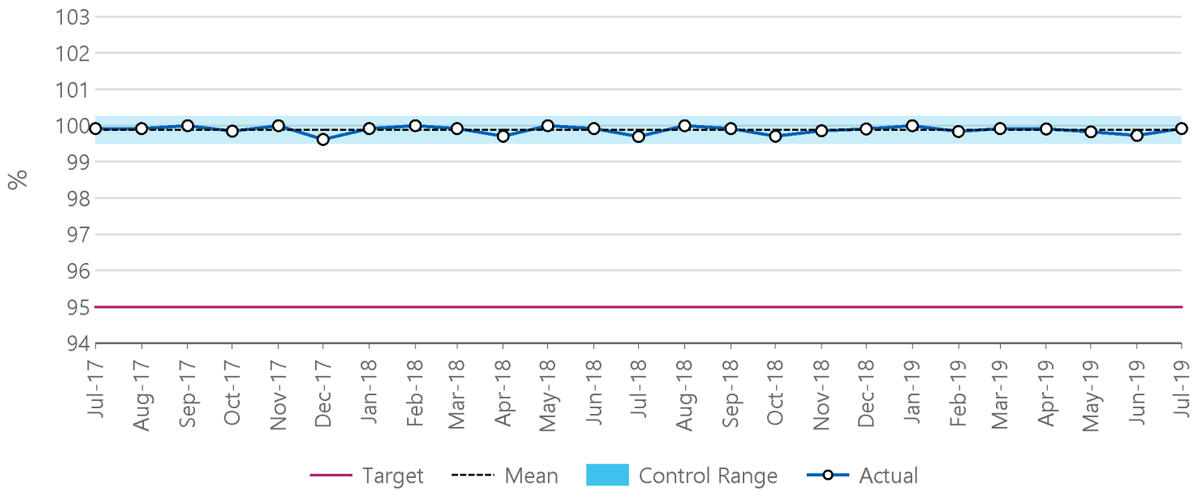
Narrative

The percentage of admissions risk assessed is reported at 99.92% in July and remains above the 95% target.

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
99.92%	99.92%	100%	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%	99.85%

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

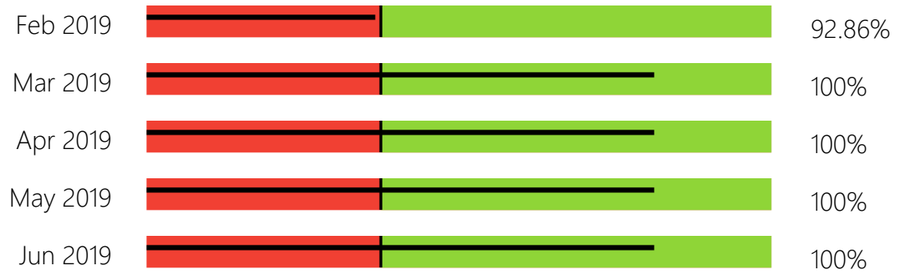
Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

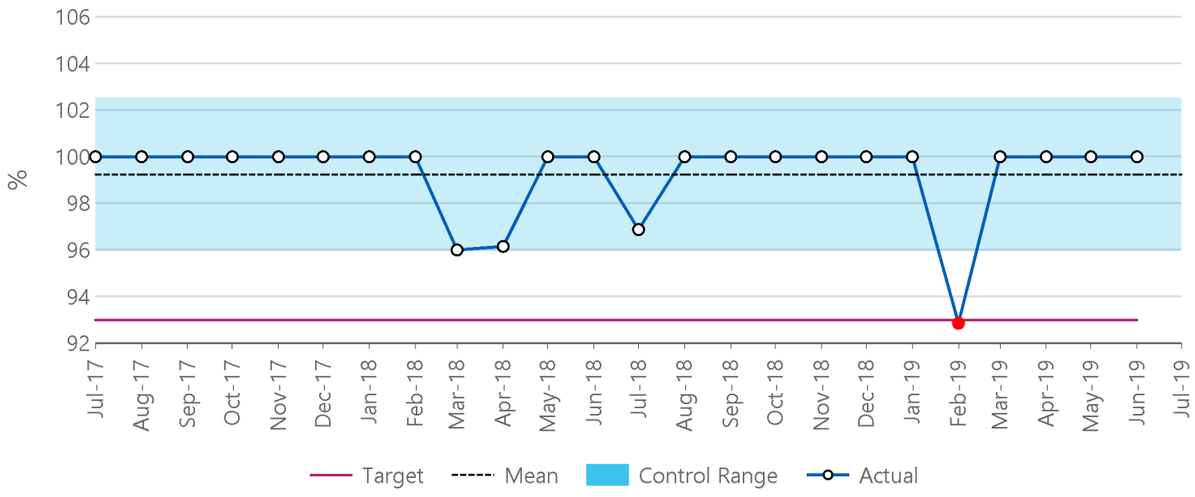
Narrative

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

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

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

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

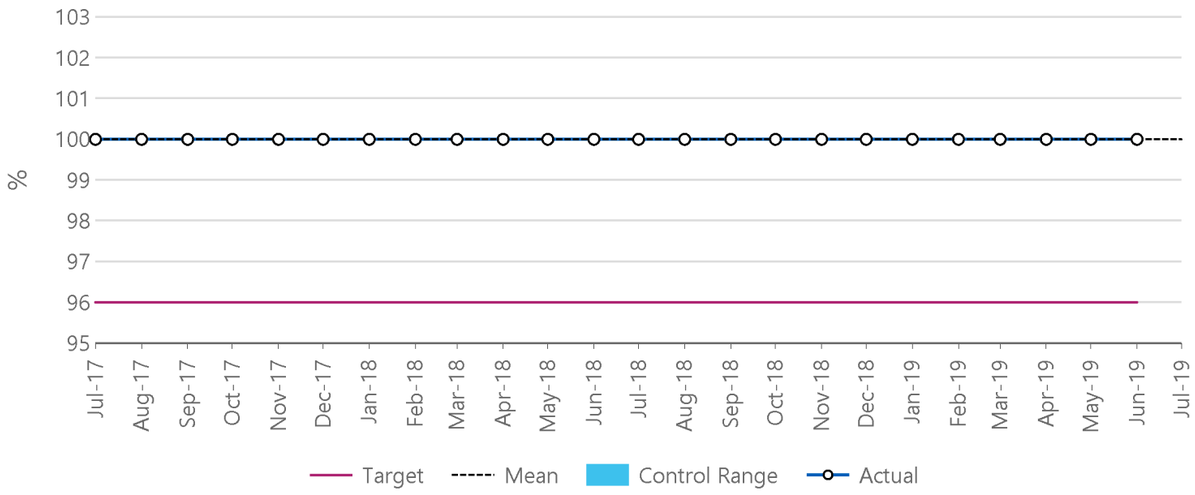
Finance, Planning and Digital Committee

Narrative

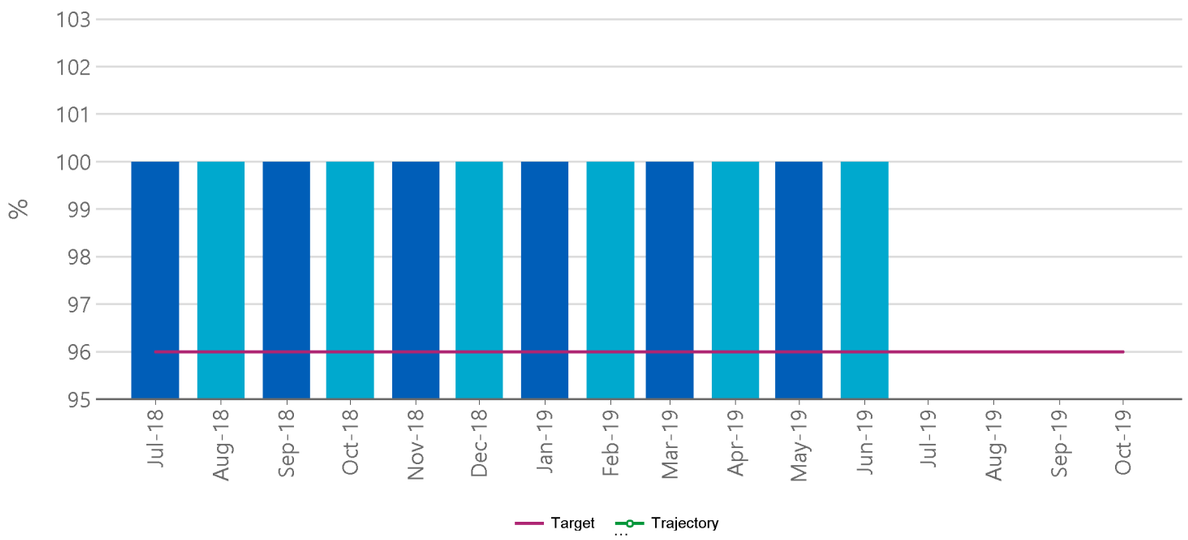
The Cancer 31 day first treatment standard was achieved in June and indicative data for July shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

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

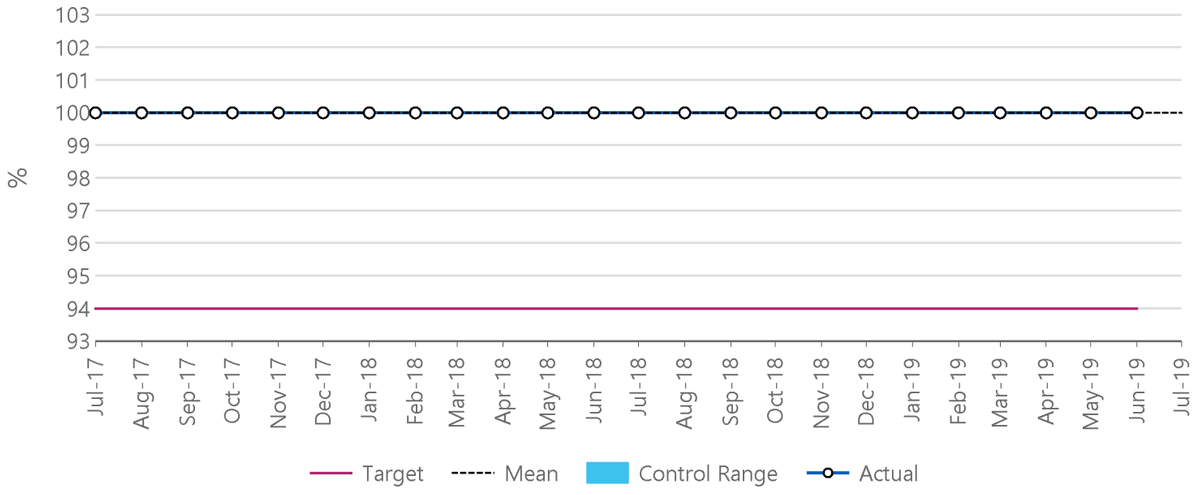
Finance, Planning and Digital Committee

Narrative

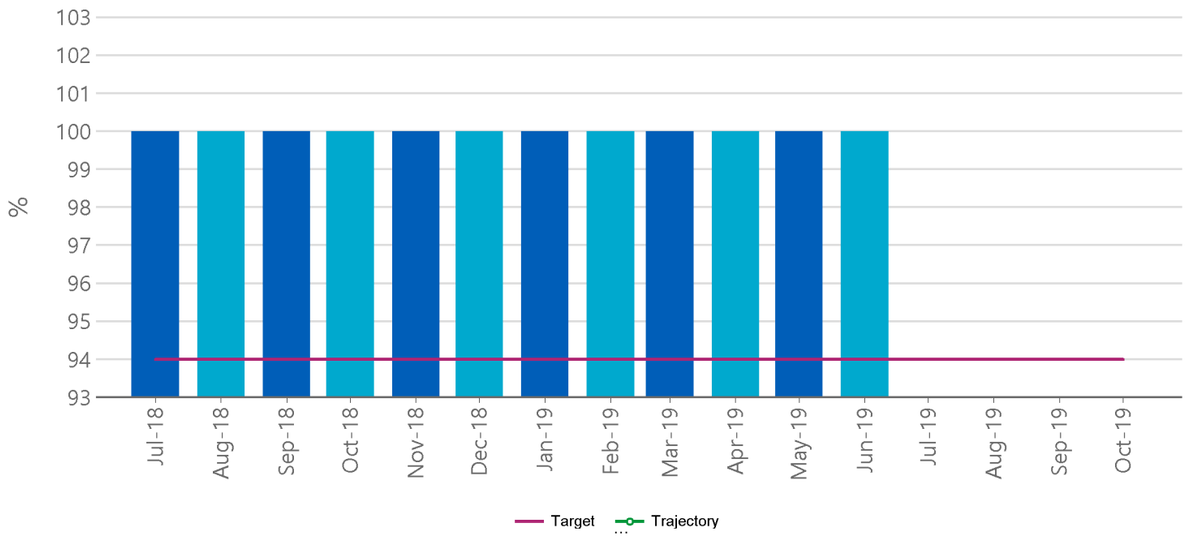
The Cancer 31 day subsequent treatment standard was achieved in June and indicative data for July shows achievement of the standard will continue.

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

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

100% against **85%** target

green rated

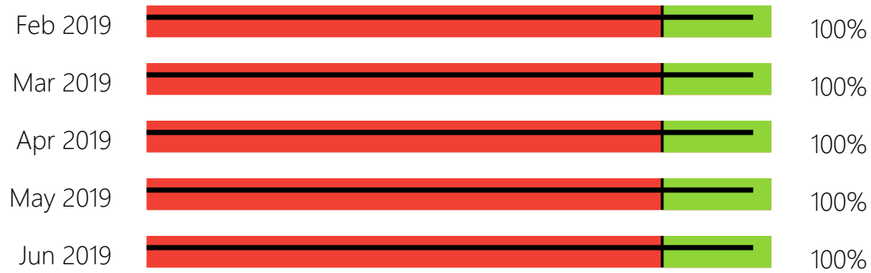
Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

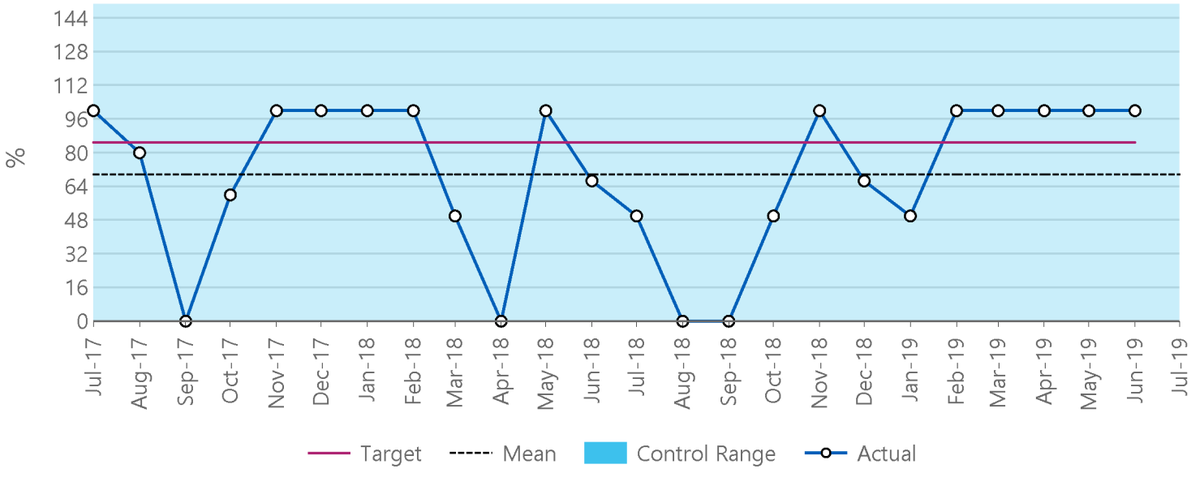
Narrative

The Cancer 62 day standard was achieved in June and indicative data for July shows achievement of the standard will continue.

Performance against RAG ratings



Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
100%	80%	0%	60%	100%	100%	100%	100%	50%	0%	100%	66.67%	50%	0%	0%	50%	100%	66.67%	50%	100%	100%	100%	100%	100%		100%

NHS
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

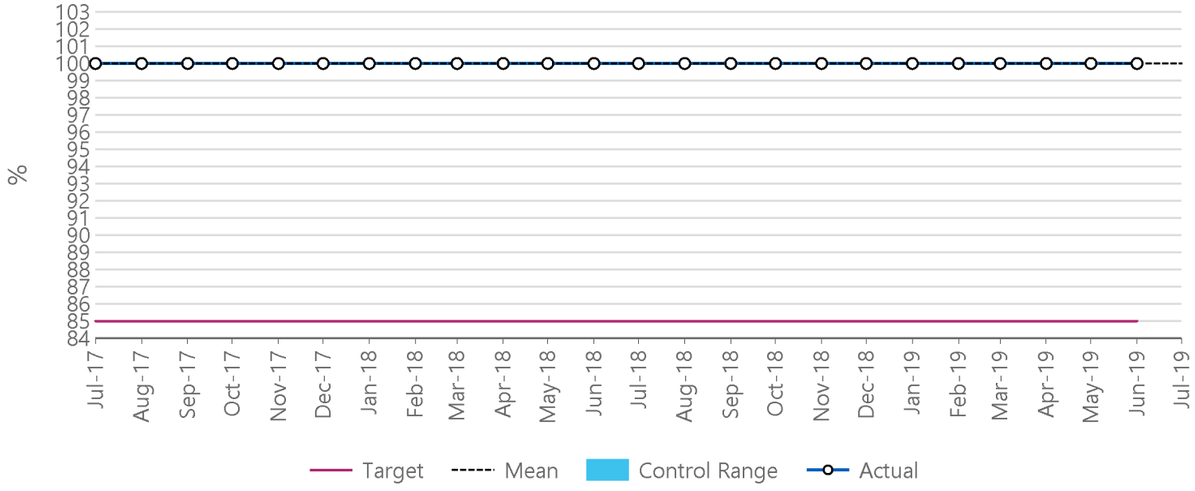
Finance, Planning and Digital Committee

Narrative

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

Performance against RAG ratings

Performance over 24 months – SPC



Trajectory

Heatmap performance over 24 months

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

89.9% against 92% target

Below target red rated

Exec Lead:
Director of Operations

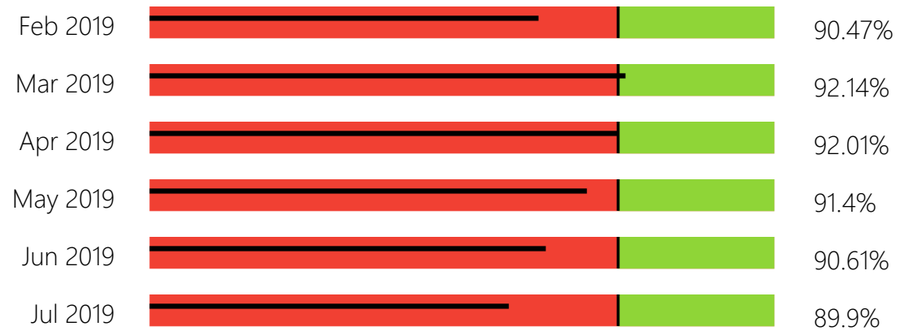
Finance, Planning and Digital Committee

Narrative

Our July performance was 89.90% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The number of breaches increased from 696 in June to 764 in July. The reported position was behind our trajectory plan of 90.08%. The performance breakdown by milestone is:
MS1 - 5004 patients, of which 102 are breaches, MS2 - 772 patients, of which 183 are breaches, MS3 - 1787 patients, of which 479 are breaches.
Performance in all Surgical sub specialties, with the exception of Tumour, has declined month on month since April 2019. The lowest performance in July has occurred in the following areas: Spinal Disorders - 78.16%, Arthroplasty - 82.87%, Foot & Ankle - 84.3%

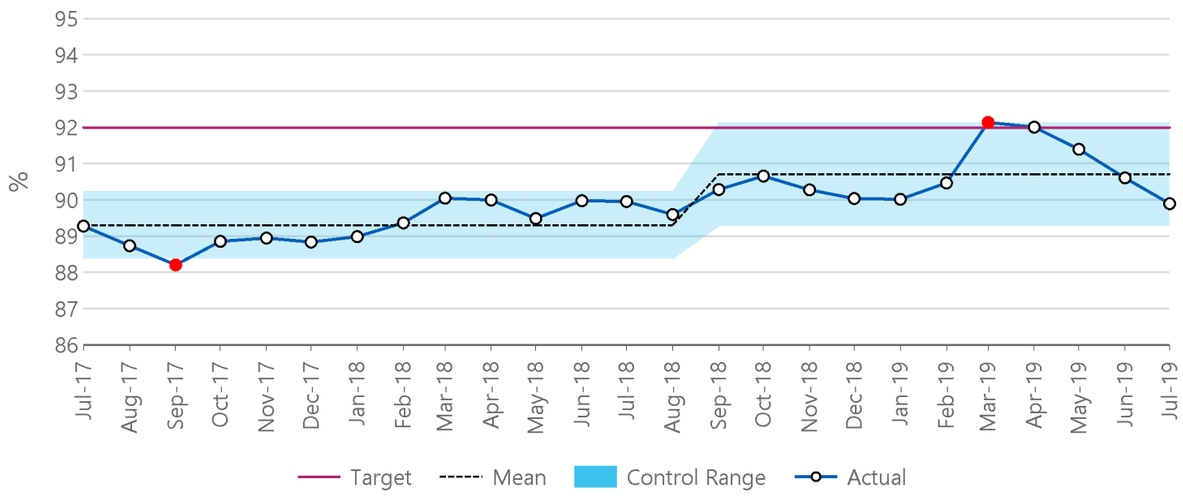
Action to Improve:Key areas of focus:
SOOS - stabilisation; Diagnostics - 6 Week Standard; Theatre Activity behind plan

Performance against RAG ratings

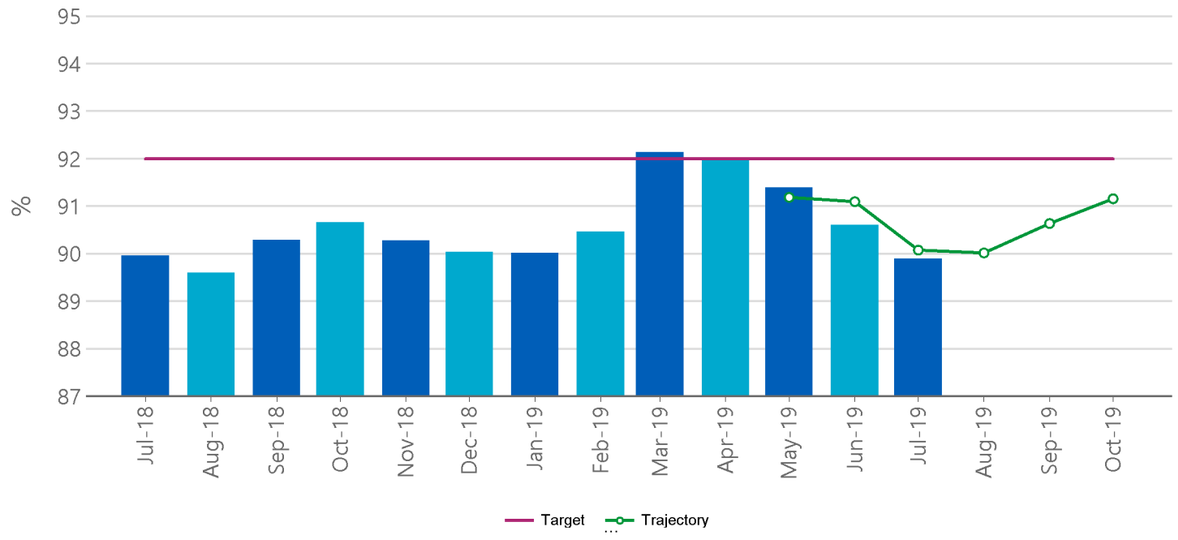


Performance over 24 months – SPC

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



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
89.28%	88.74%	88.21%	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%	90.96%

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

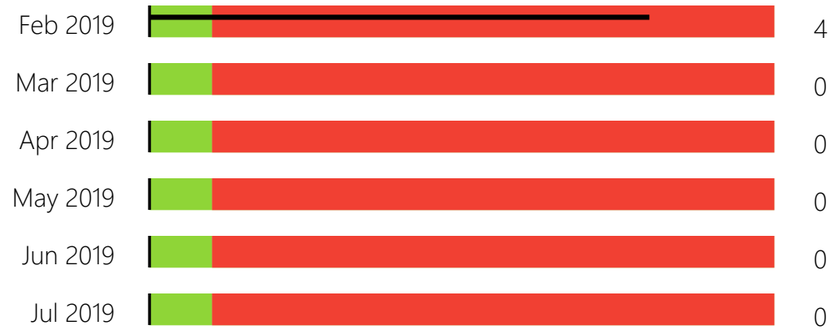
Finance, Planning and Digital Committee

Narrative

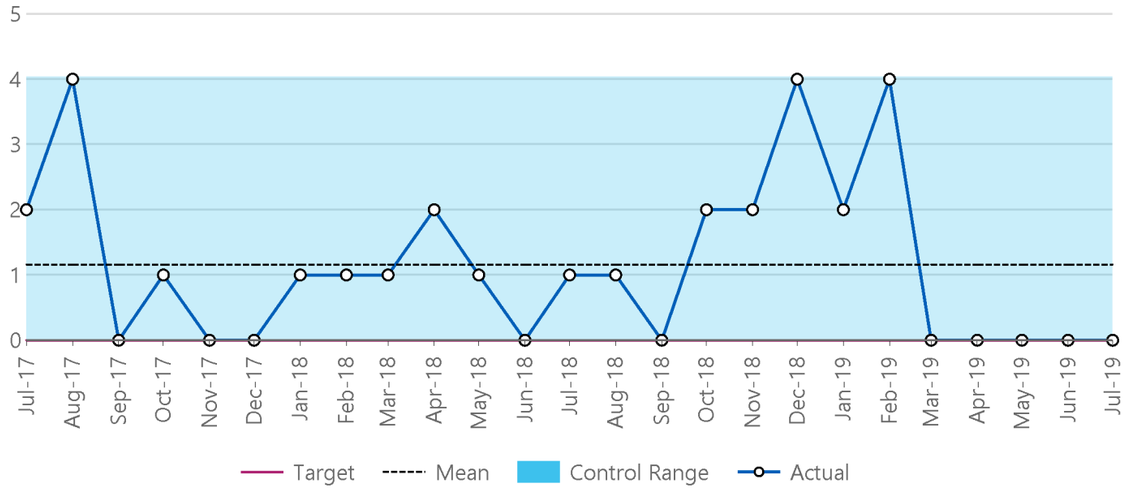
At the end of July there were no English patients waiting over 52 weeks. Additional capacity was sourced which enabled us to treat the patient who was forecasted in June as waiting 52 weeks in July.

The forecast figures show predicted 52+ weeks waits as follows:
- End of August - 0
- End of September -1 - Spinal Disorders
- End of October - 1 - Spinal Disorders

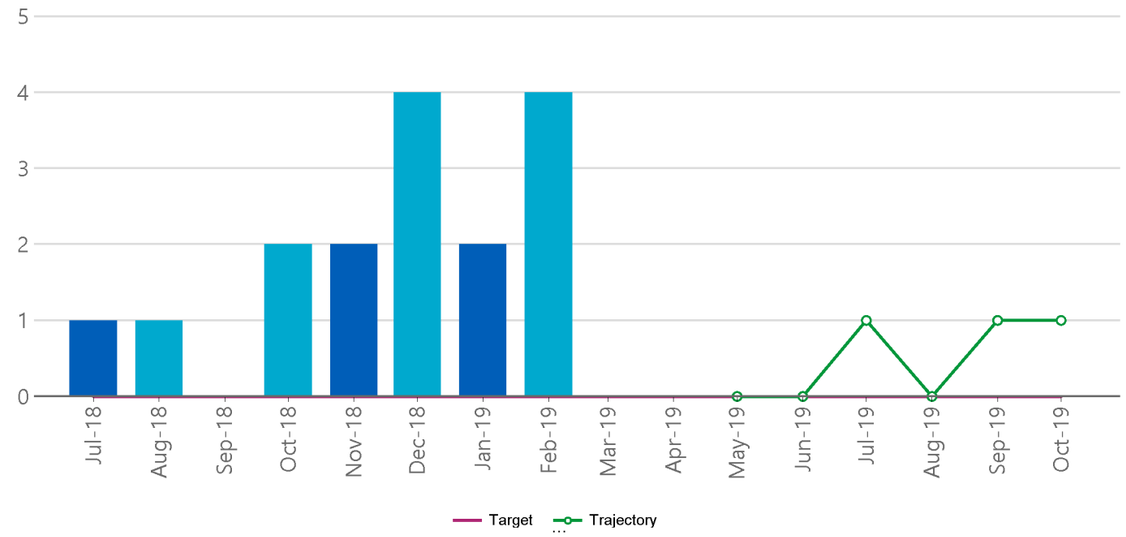
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
2	4	0	1	0	0	1	1	1	2	1	0	1	1	0	2	2	4	2	4	0	0	0	0	0

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

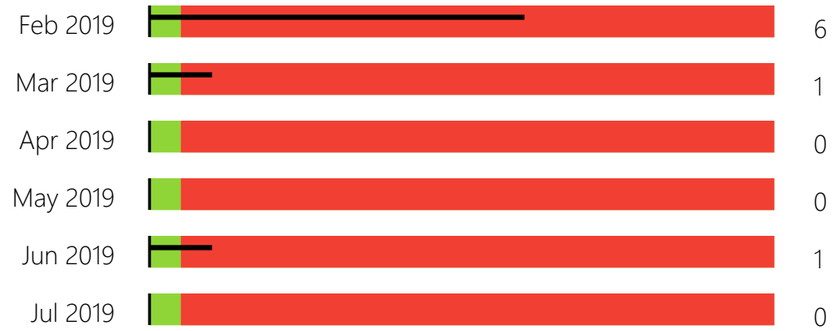
Finance, Planning and Digital Committee

Narrative

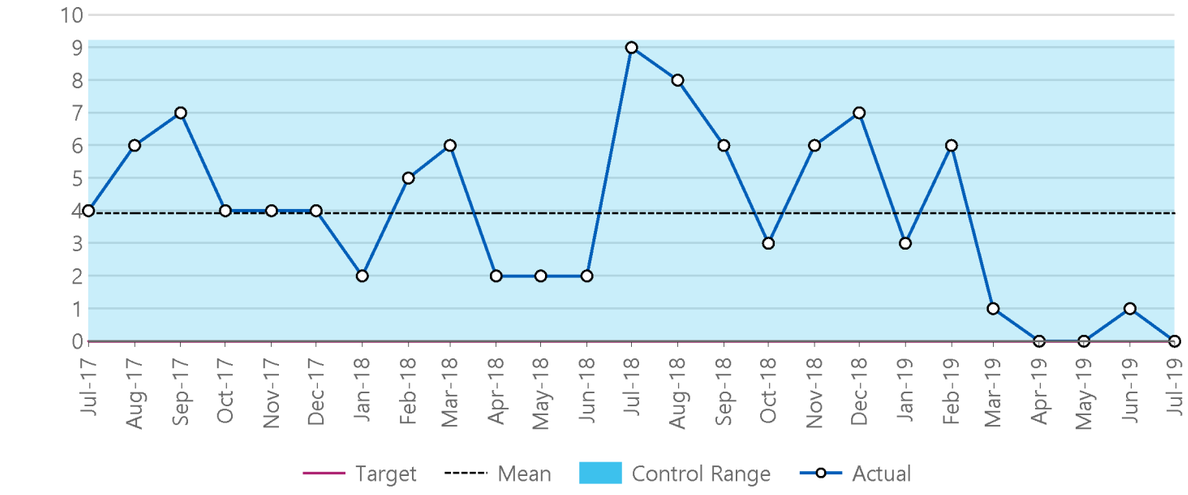
At the end of July there was no Welsh patients waiting over 52 weeks.

The forecast figures show predicted 52+ weeks waits as follows:
- End of August - 1 - Spinal Disorders
- End of September - 2 - Spinal Disorders
- End of October - 5 - Spinal Disorders (4), Paediatric Orthopaedics (1)

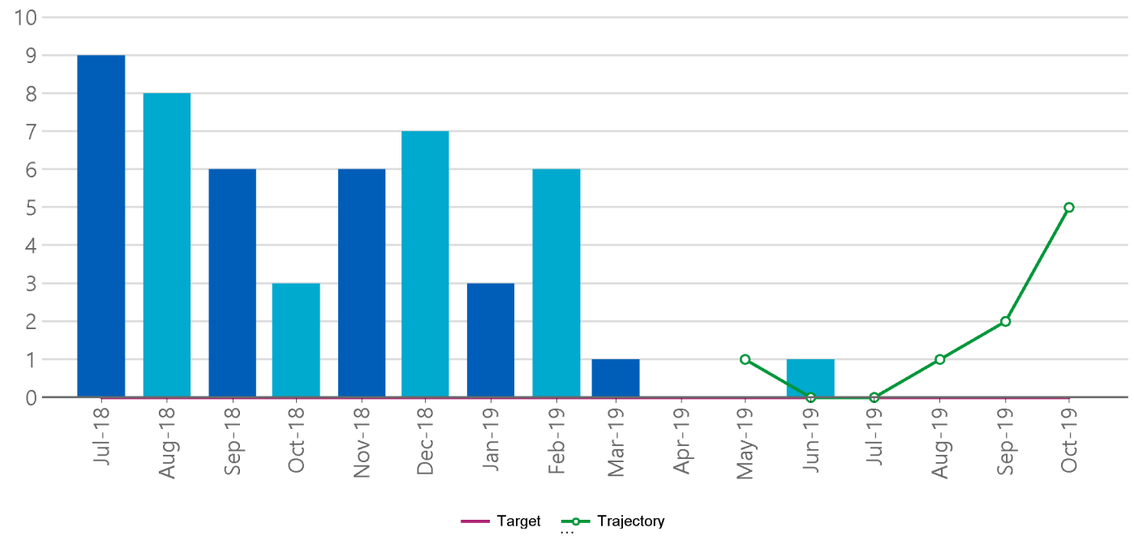
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)

86 against **N/A** target

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

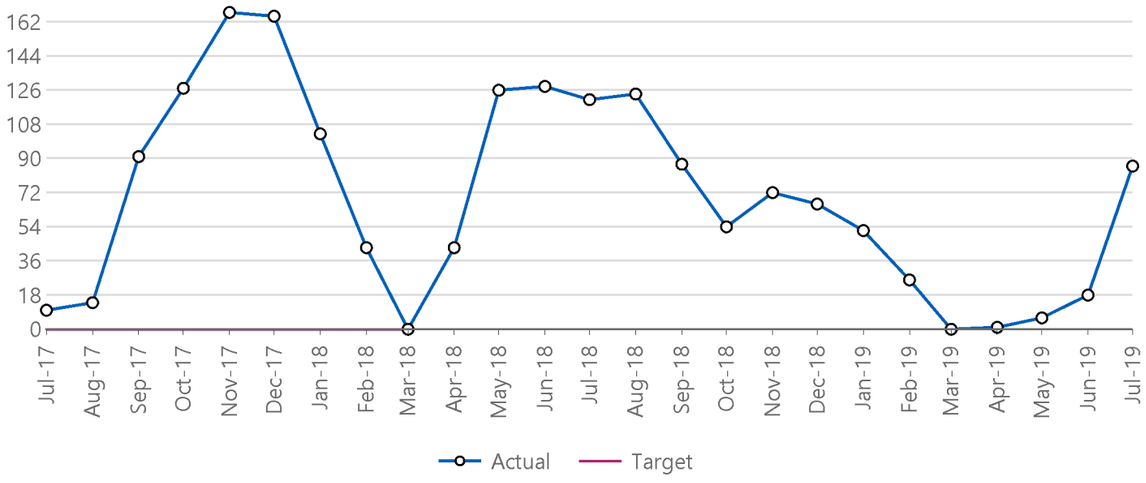
Narrative

At the end of July there were 86 Welsh patients waiting over 52 weeks who were transfers of care from BCU.

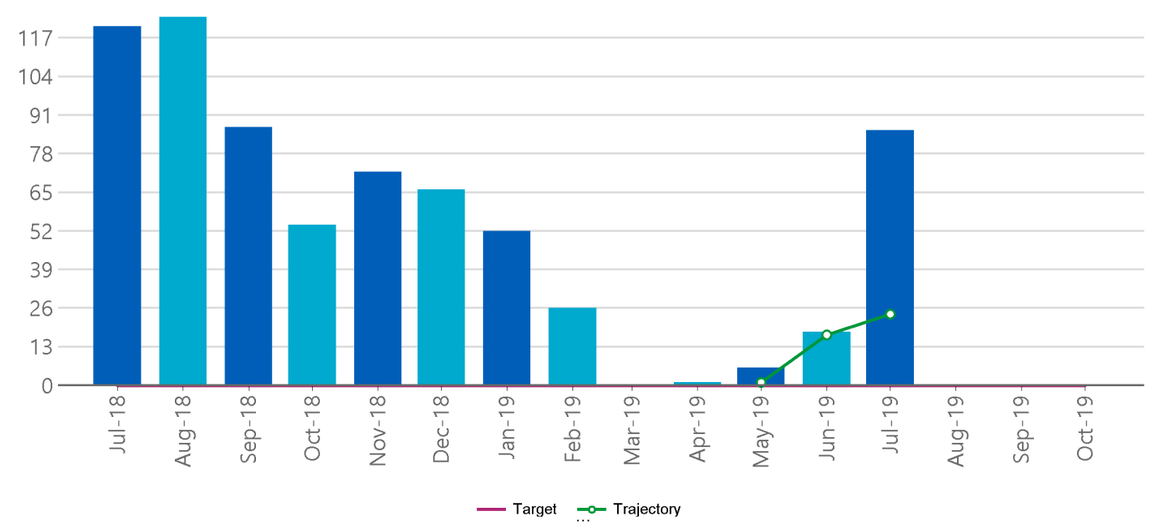
We have recommenced transfers of BCU patients to support waiting list reductions in North Wales for 2019/20. We are due to receive 500 transfers in total. These transfers have begun and we will receive all by the end of quarter three. The target for this measure is to treat all patients transferred by year-end.

Performance against RAG ratings

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
10	14	91	127	167	165	103	43	0	43	126	128	121	124	87	54	72	66	52	26	0	1	6	18	86

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

98.55% against **99%** target

Below target red rated

Exec Lead:
Director of Operations

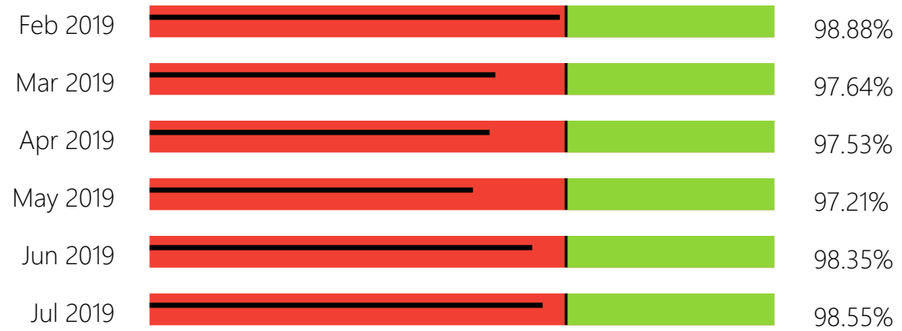
Finance, Planning and Digital Committee

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 98.55%. This equates to 11 patients who waited beyond six weeks. The reasons associated with the delays were capacity (9), cancellations (1) and delay in the request to Diagnostics (1).

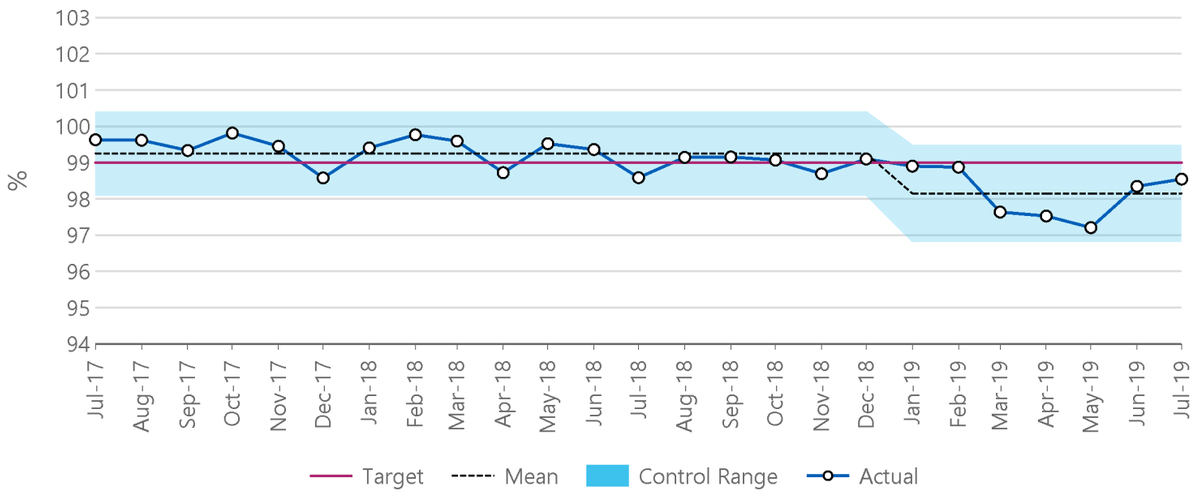
Action to Improve:Business cases are in progress to explore additional capacity.

Performance against RAG ratings

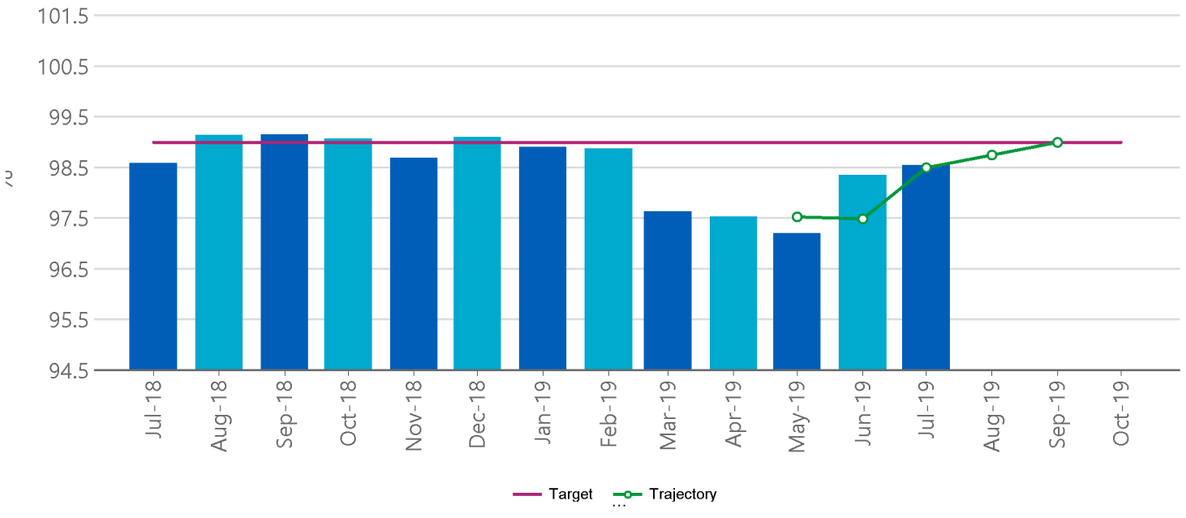


Performance over 24 months – SPC

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



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
99.63%	99.62%	99.34%	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%	97.93%

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

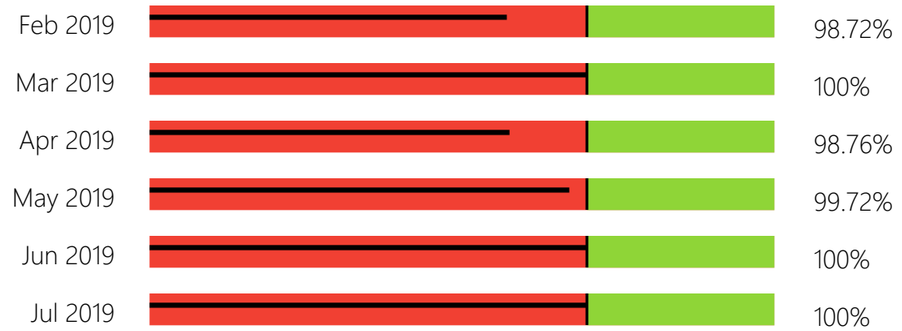
Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

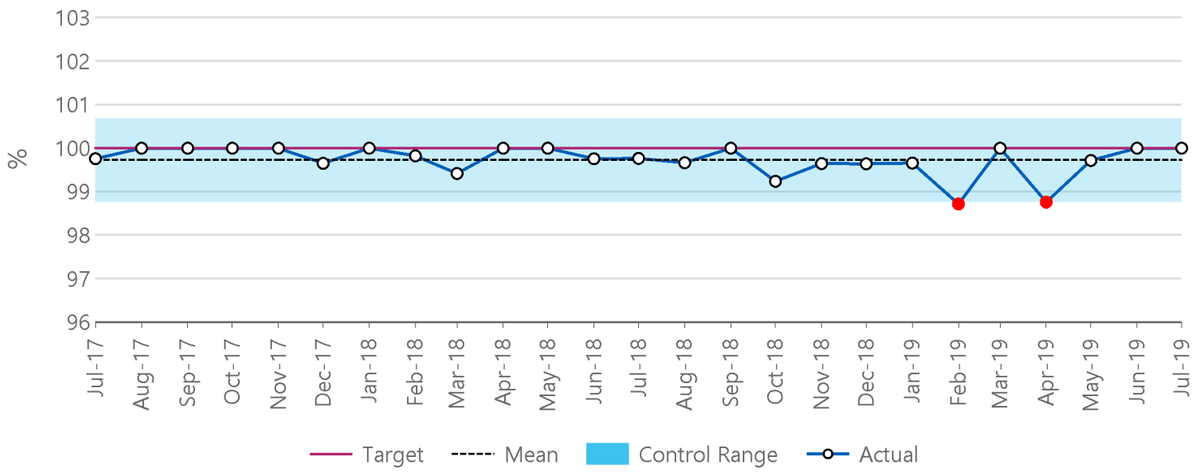
Narrative

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

Performance against RAG ratings



Performance over 24 months – SPC



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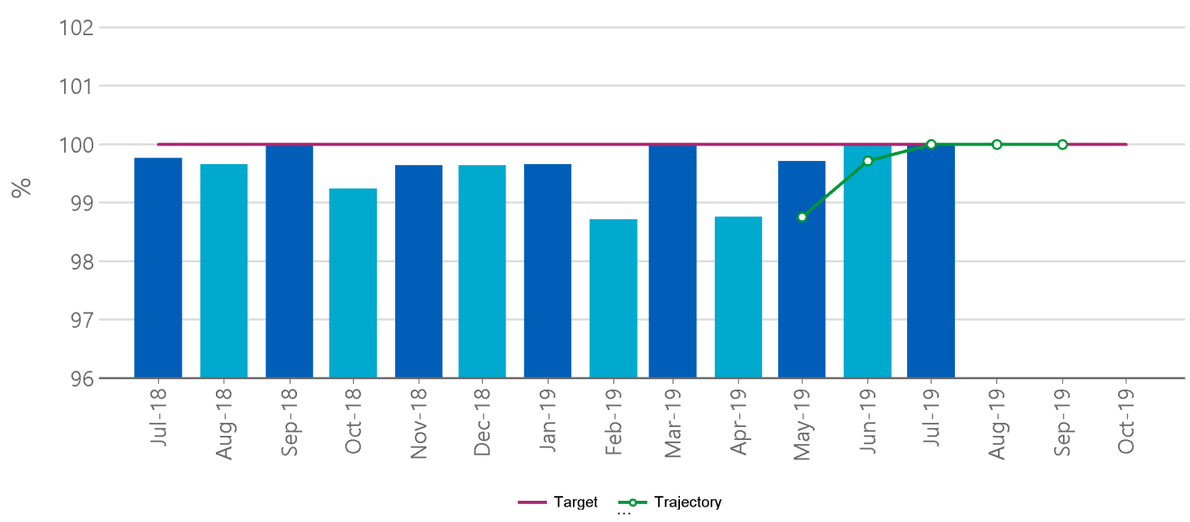


Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
99.76%	100%	100%	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%	99.64%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Theatre Activity

Activity in theatres in month

926 against 1,162 target

Below target red rated

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

Narrative

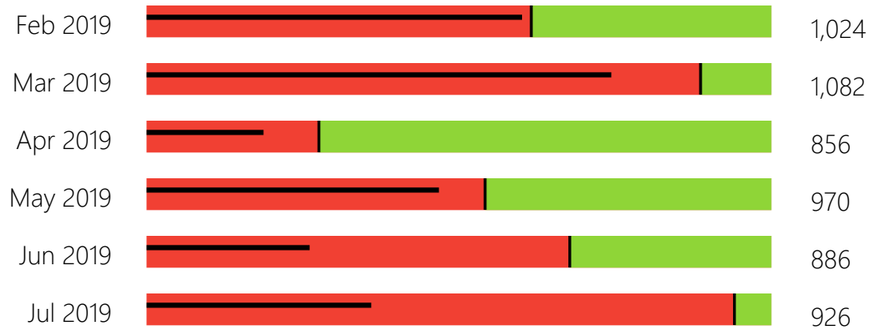
A breakdown of Total Theatre Activity against plan is:
- T&O - 812 against plan of 1039 (-227 cases)
- MCSI - 62 against plan of 44 (+18 cases)
- Private Patients - 52 against plan of 79 (-27 cases)

Drivers for T&O under-performance are consultant sickness (44 cases), annual leave processes (38 cases), Cancellations (42 cases), subspecialty waiting list sizes (28 cases).

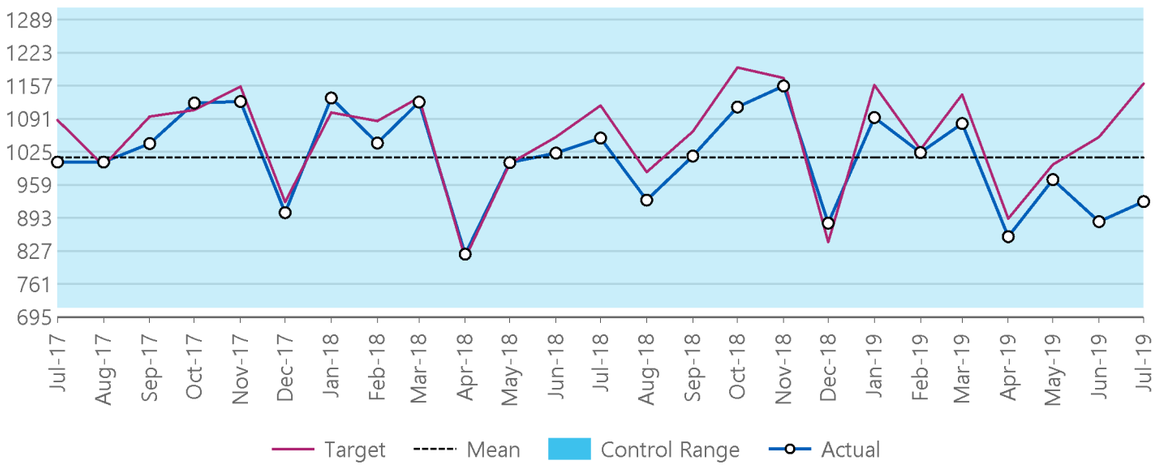
Action to Improve:We have an established Theatre Delivery Board for weekly oversight of the theatre activity position and have been making good progress to bring our August and September position back on plan. Our theatre activity plan for the remainder of the year has been updated taking into account the actions identified by the Theatre Delivery Board and a re-phasing based on activity per working day for the remainder of the year.
- We have detailed planned activity levels for the last 6 months of the year.
- We have included the activity for our new consultants that are now in post for the second half of the year.
- We have included activity to be achieved by improving our session allocation processes and internal controls on cancellations at less than 6 weeks.

This will continue to be monitored through the Theatre Delivery Board weekly.

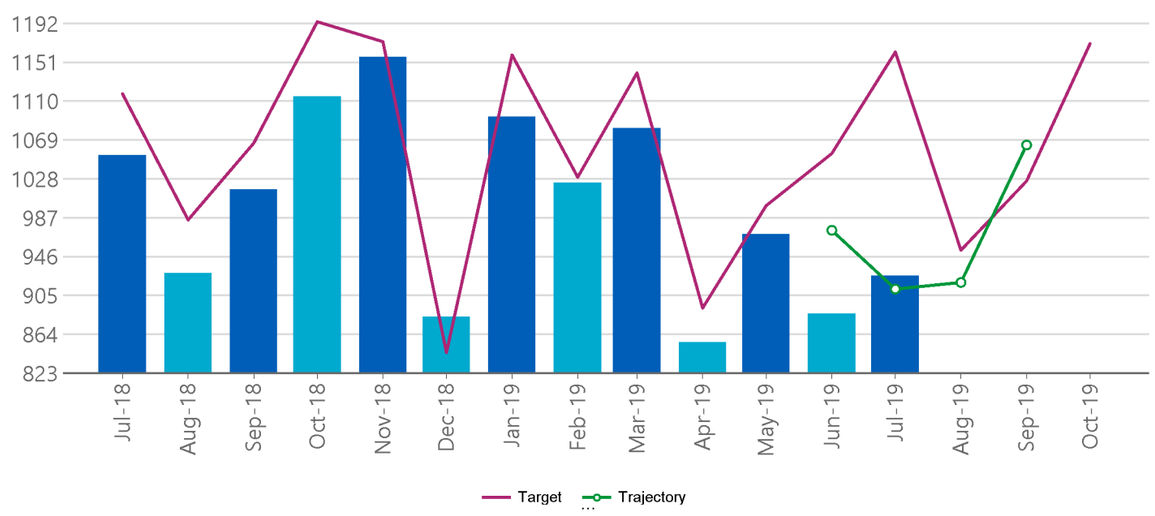
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
1,005	1,005	1,042	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	926	3,638

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

83.07% against **87%** target

Within target green rated

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

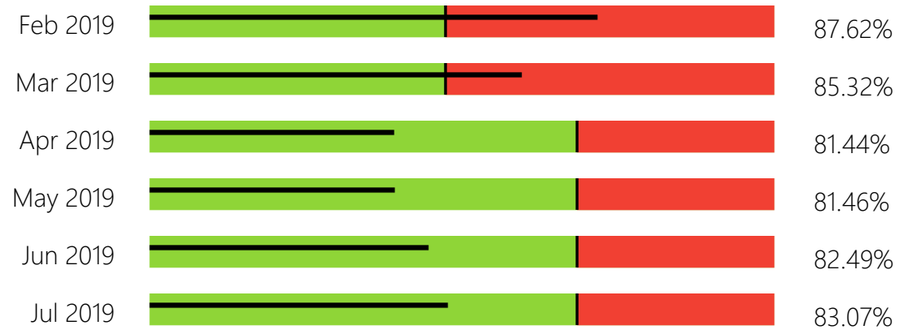
Narrative

The occupancy rate for all wards is green rated this month at 81.78%. Occupancy across the Surgical Wards was:
- Alice 47.36%
- Clwyd 83.94%
- Kenyon 80.61%
- Ludlow 80.57%
- Powys 78.56%
- Oswald 82.89%

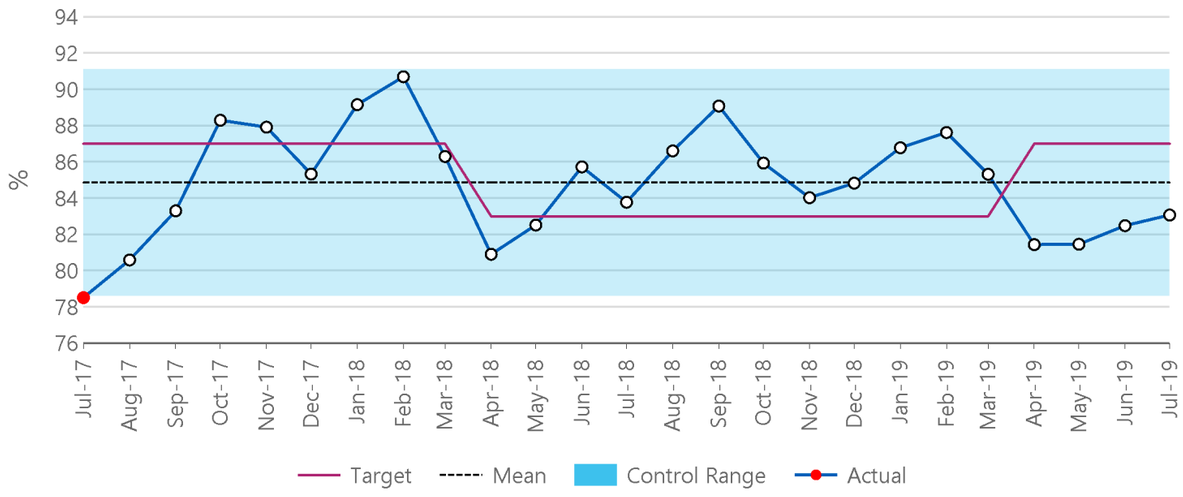
Occupancy within the Medicine Division was:
-Gladstone 95.65%
- Wrekin 98.49%
- Sheldon 82.45%

The Trust is continuing to explore and assess the beds required to meet demand. During July and August the beds on Powys Ward have been utilised to support MCSI activity.

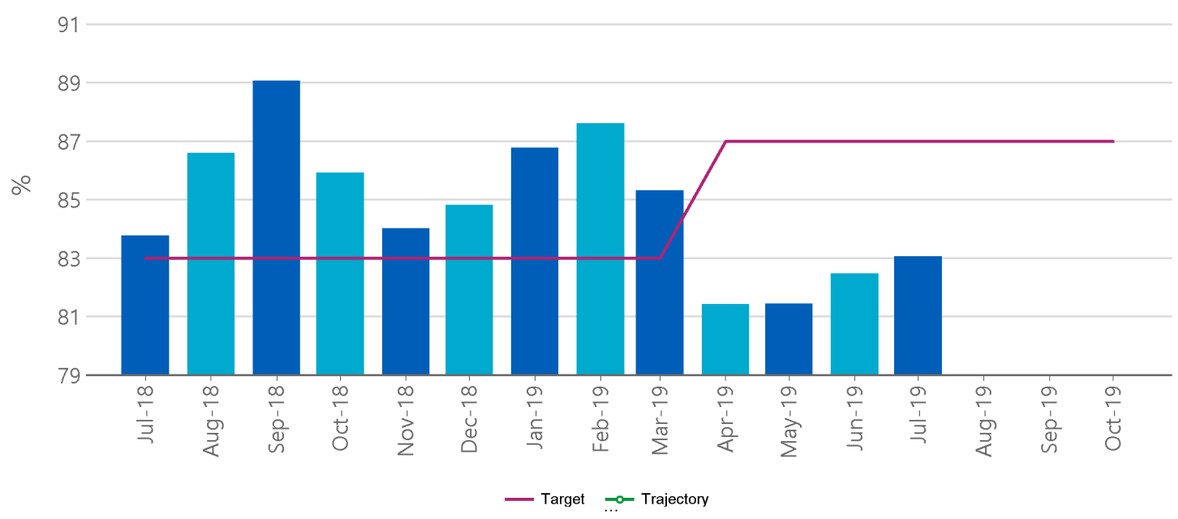
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
78.52%	80.59%	83.3%	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%	82.12%

Outpatients Activity Attendances

Number of attendances seen in Outpatient clinics - excludes SOOS and NCG as they are block contracts

14,245 against **15,567** target

Below target red rated

Exec Lead:
Director of Operations

Finance, Planning and Digital Committee

Narrative

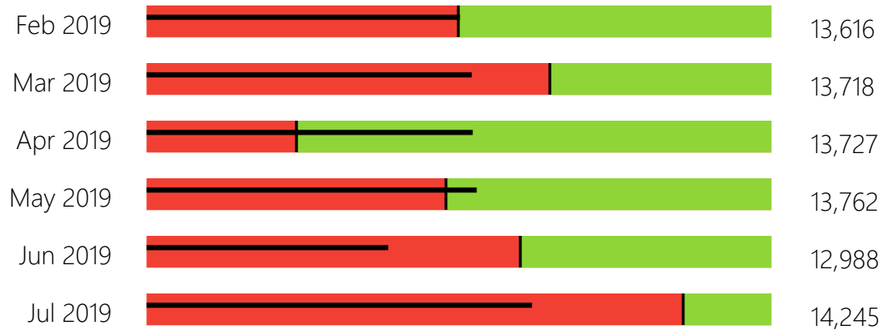
The number of attendances was behind plan in month 4 with 14245 attendances seen against a plan of 15567. A divisional breakdown is:
- Surgery - 7043 against a plan of 7896 (-853)
- Medicine - 5900 against a plan of 6190 (-290)

Areas behind plan to note were:
- Paediatric Orthopaedics & Upper Limb - impacted by Consultant sickness and leave
- Metabolic Medicine - impacted by Consultant leave and unfilled locum post

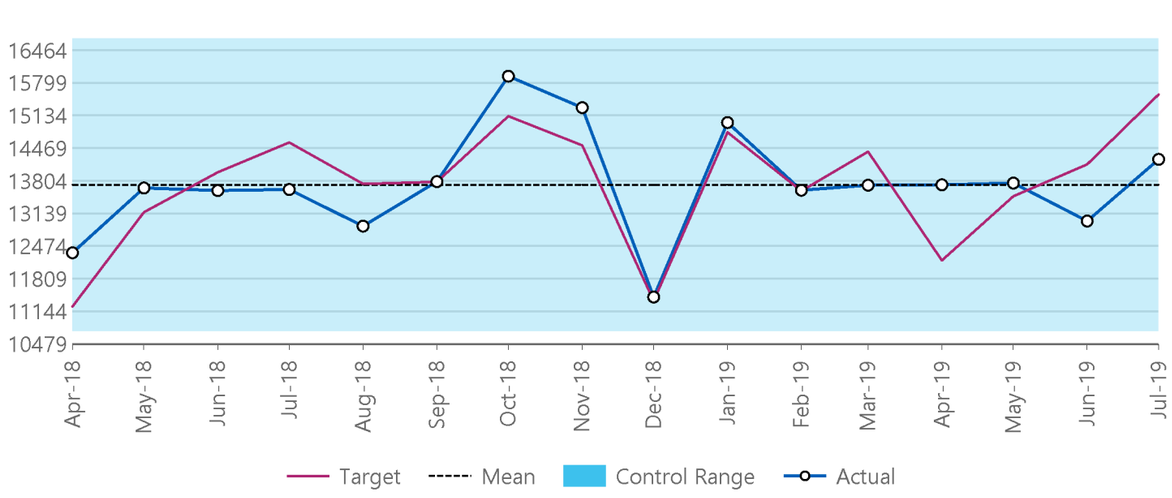
Action to Improve:Actions within Surgery are:
- Reduce DNAs in Outpatient clinics
- Improve utilisation in OJP clinics
- Book BCU transfers into clinics

Long-term actions within Medicine are:
- Recruitment of locum consultant
- Less annual leave is forecast

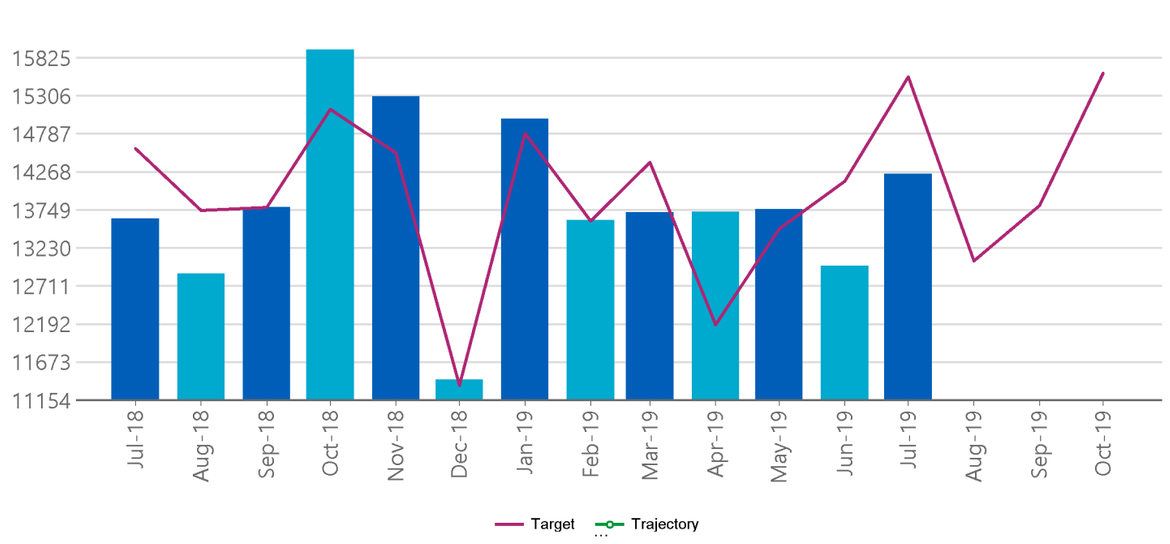
Performance against RAG ratings



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	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	13,727	13,762	12,988	14,245	54,722

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Financial Control Total

Surplus/deficit adjusted for donations and excluding STF funding

73 against 912 target

red rated

Exec Lead:
Director of Finance

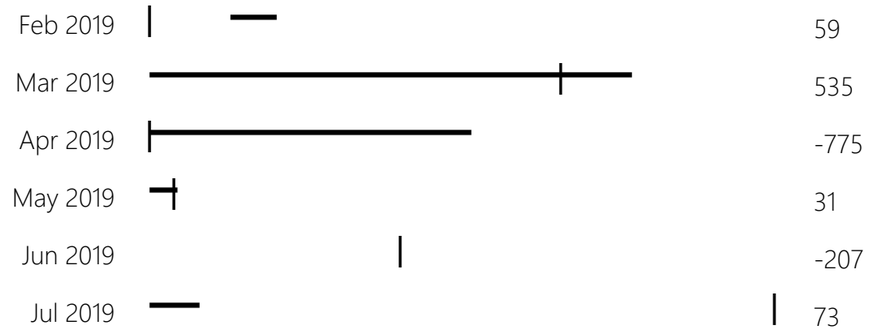
Finance, Planning and Digital Committee

Narrative

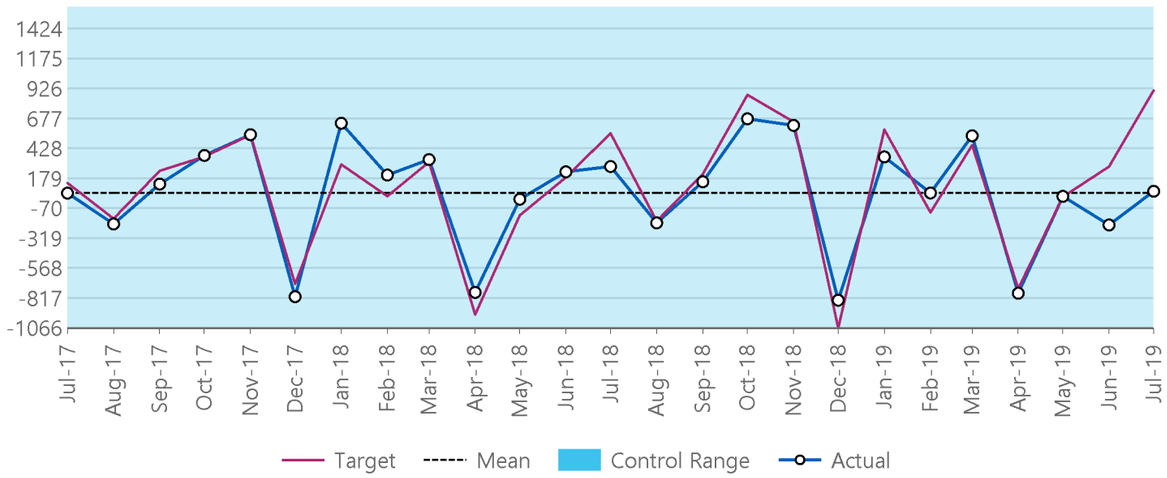
- £73k surplus in month, £839k adverse to plan
- £1359k adverse variance to plan year to date

Action to Improve:Adverse variance driven by shortfall in theatre activity - recovery plan details improvement actions and mitigations

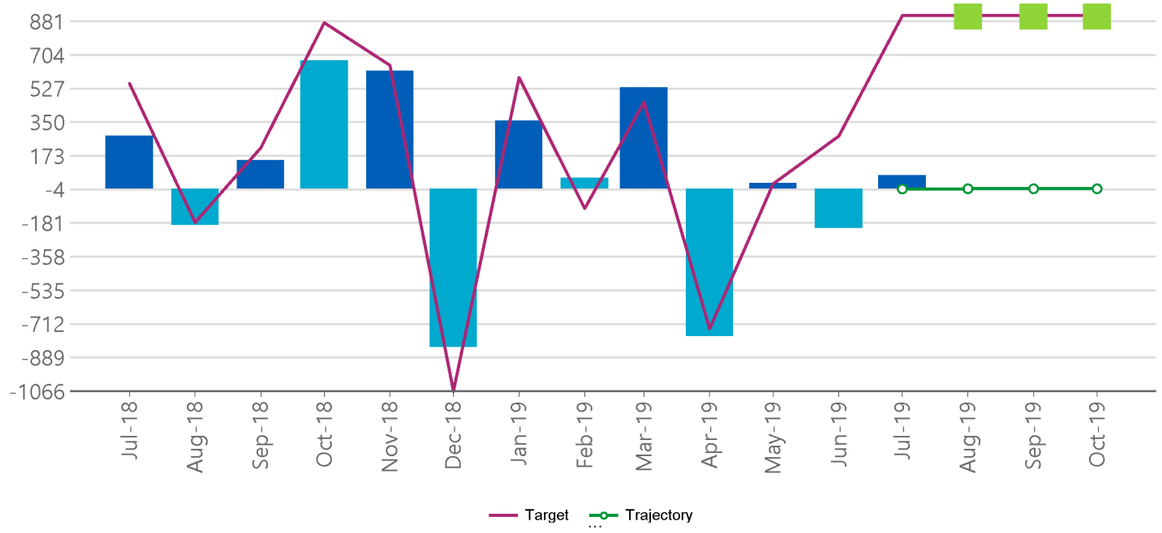
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
58	-199	133	371	544	-804	639	208	337	-768	7	235	279	-190	152	676	621	-833	359	59	535	-775	31	-207	73	878

Income

All Trust Income, Clinical and non clinical

9,486 against **10,494** target

Below target red rated

Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

Narrative

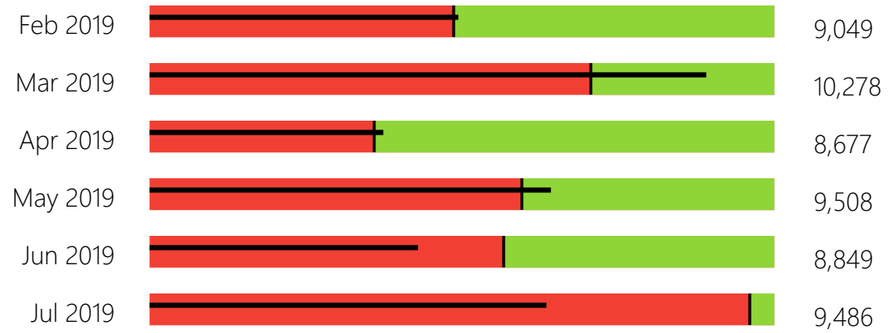
Overall £1,007k adverse in month:

- Theatre activity adverse to plan 227 cases
- Surgery and medicine outpatients s
- Private Patients (surgery)
- Partially offset by MCSI mitigation linked to urology additional sessions

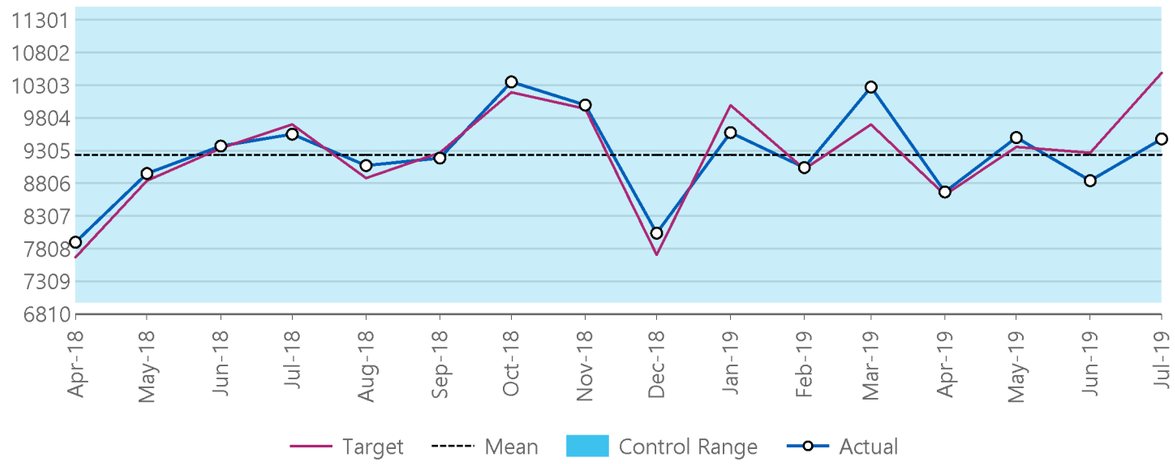
Action to Improve:Recovery actions developed for shortfall in theatre activity:

- Actions to recover August position (forecast to hit plan)
- Development and sign off of theatre recovery plan from September onwards
- Financial mitigations developed alongside recovery plan to further recover shortfall
- Performance review focus on delivery and action plans
- Weekly theatre delivery board in place

Performance against RAG ratings



Performance over 24 months – SPC



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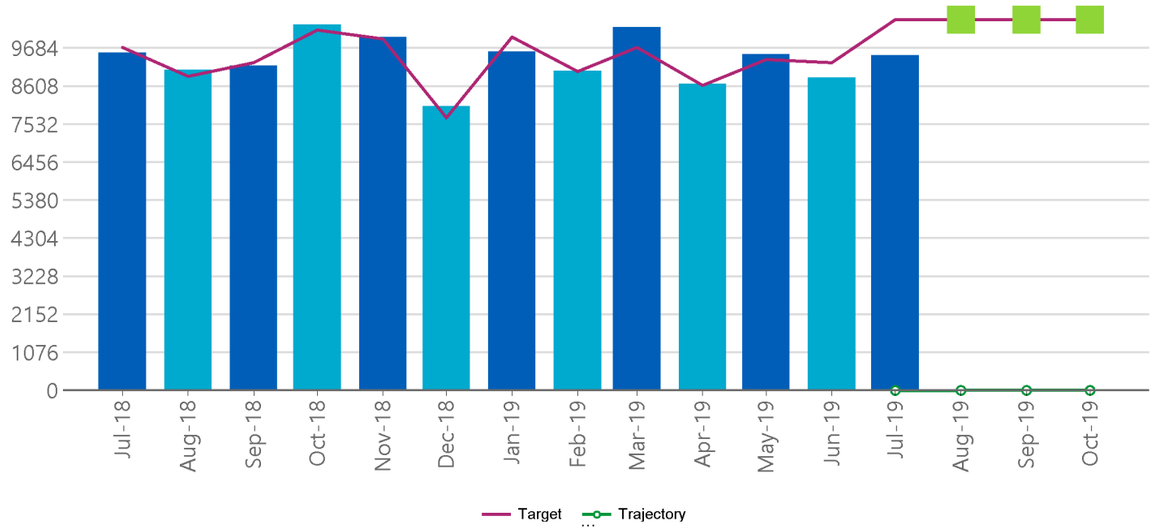


Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	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	8,849	9,486	34,935

Expenditure

All Trust expenditure including Finance Costs

9,457 against **9,588** target

Within target green rated

Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

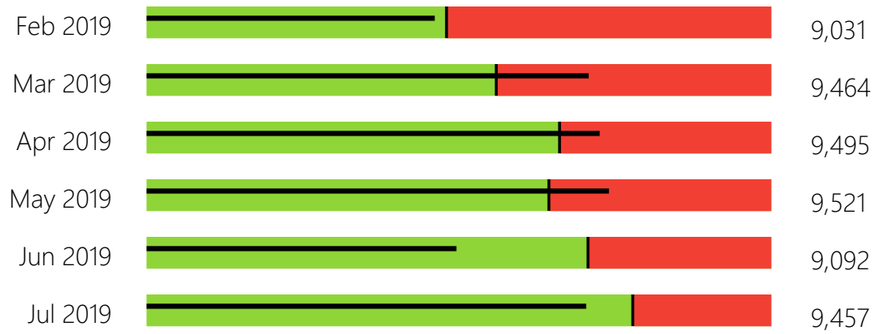
Narrative

- Overall £131k favourable in month:

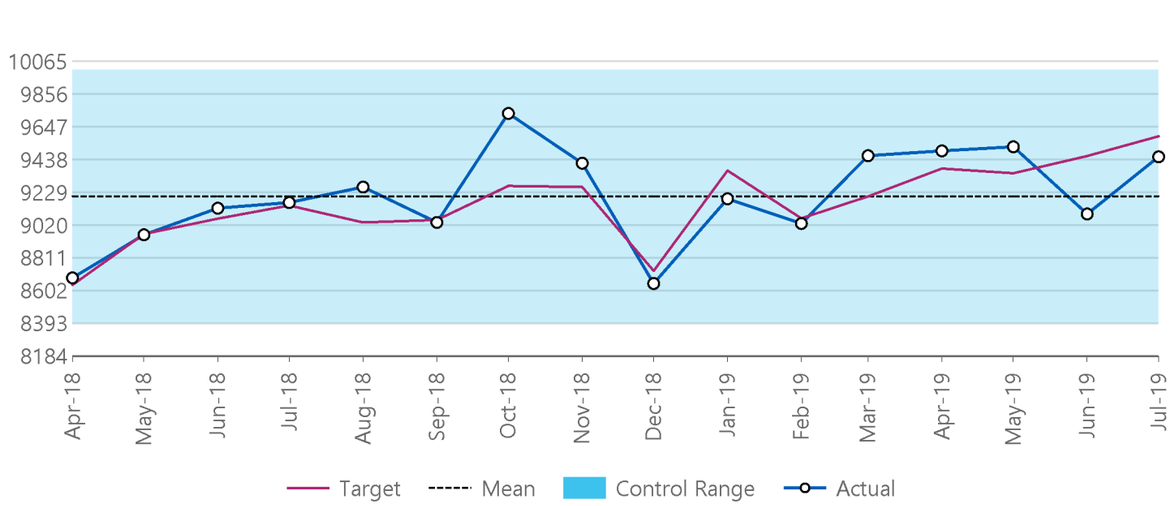
Pay favourable -
- Reduced OJP driven by activity shortfall
- Nursing pressures continued on medicine wards
- Bank and agency pressures on theatres

Non pay favourable:
- Implants and Theatre consumables favourable linked to activity
-Estates & facilities pressures

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	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	37,565

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

CIP Delivery

Cost Improvement Programme requirement

231 against **262** target

Below target red rated

Exec Lead:
Director of Finance

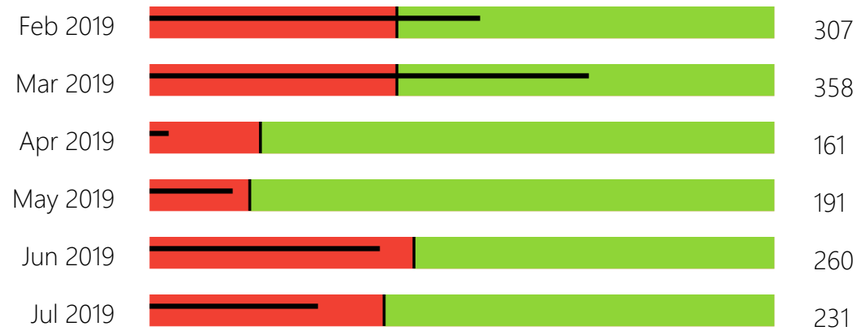
Finance, Planning and Digital Committee

Narrative

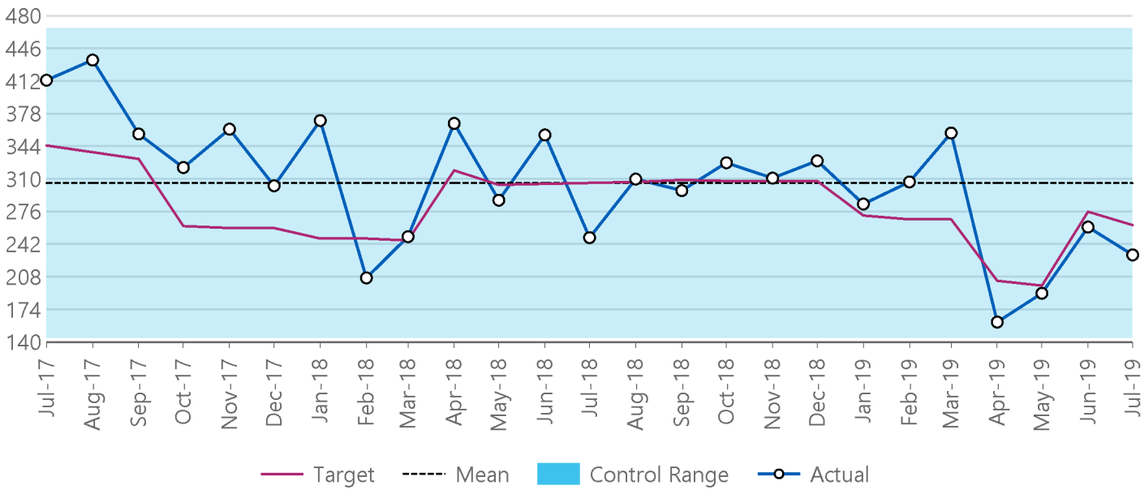
£31k adverse against plan in month
£98k adverse against plan YTD

Action to Improve:Forecast to deliver plan through identification of 20% mitigations ongoing
Action plan for divisions with unidentified schemes monitored through performance review meetings

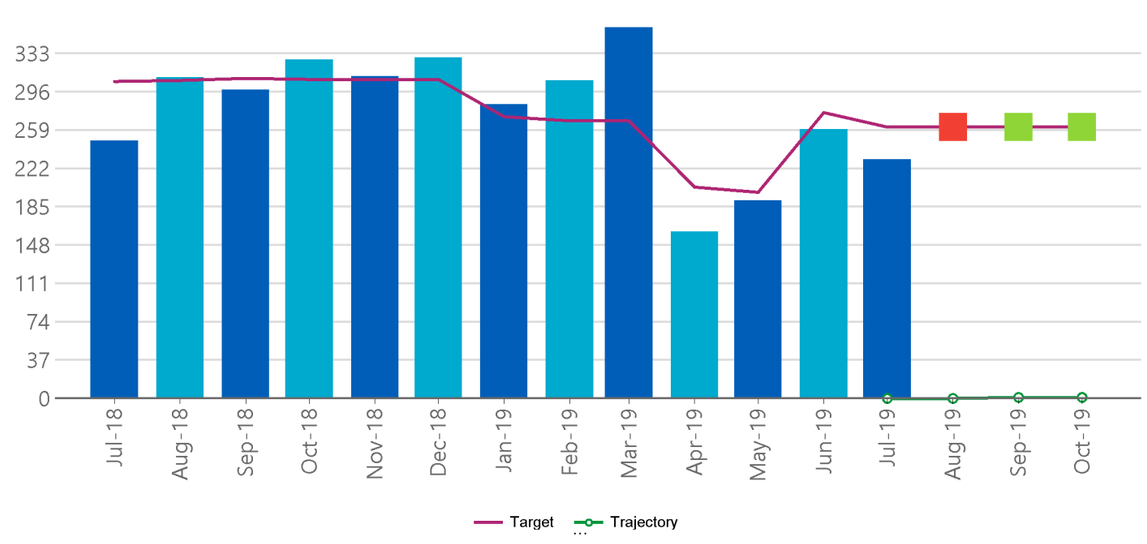
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
413	434	357	322	362	303	371	207	250	368	288	356	249	310	298	327	311	329	284	307	358	161	191	260	231	843

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

QIPP Delivery Risk Impact

MSK Transformation QIPP

7 against 0 target
red rated

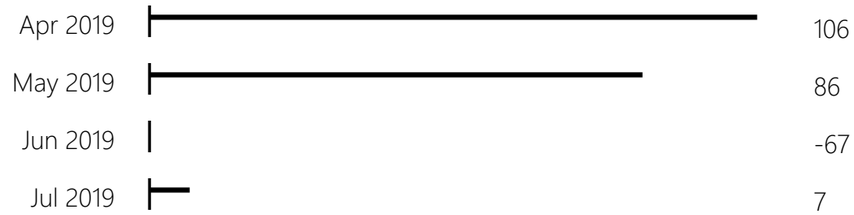
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

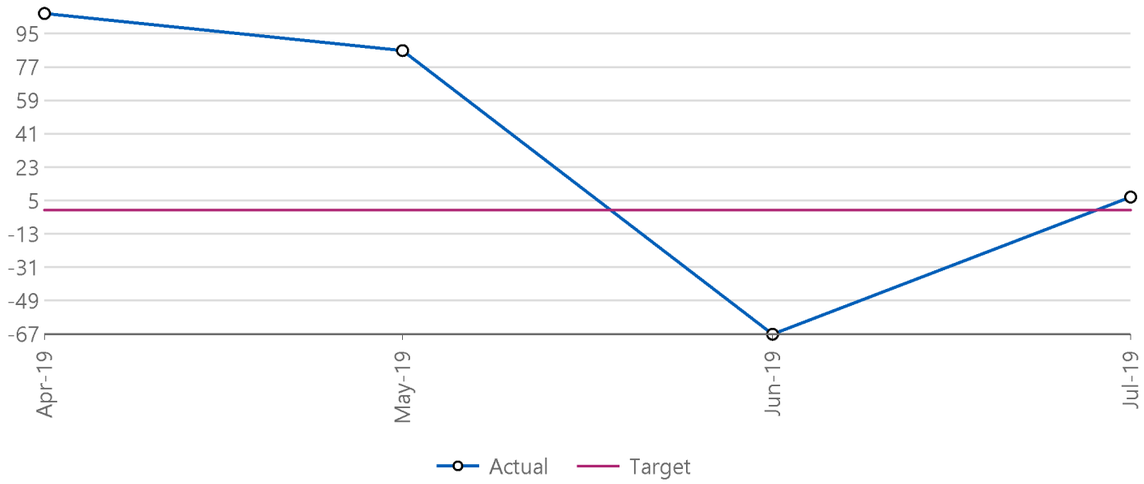
Narrative

MSK risk share £7k in month, £132k risk provided for ytd

Performance against RAG ratings



Performance over 24 months –



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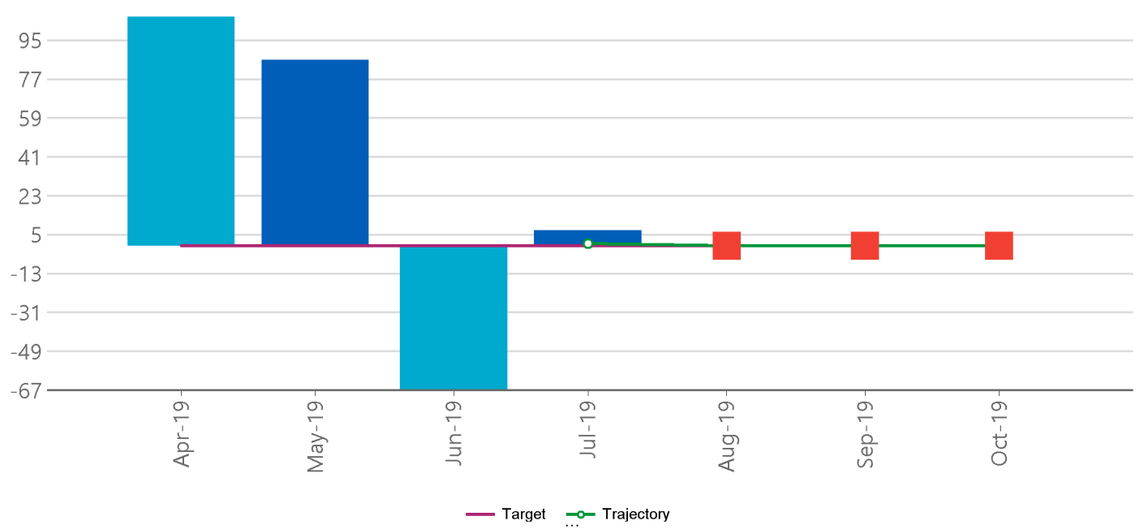


Heatmap performance over 24 months

Apr	May	Jun	Jul	YTD
106	86	-67	7	132

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

69 against 132 target

Within target green rated

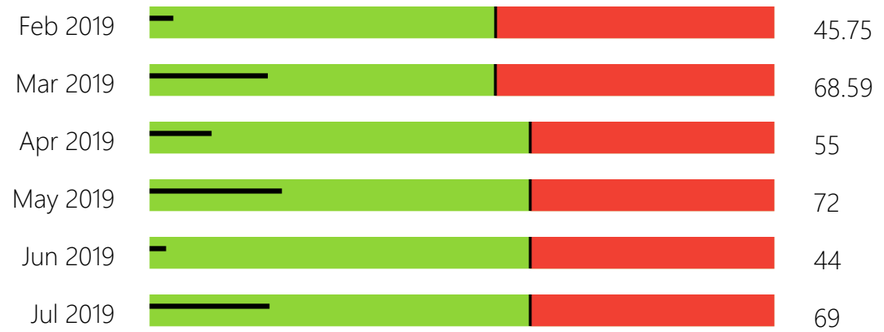
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

Narrative

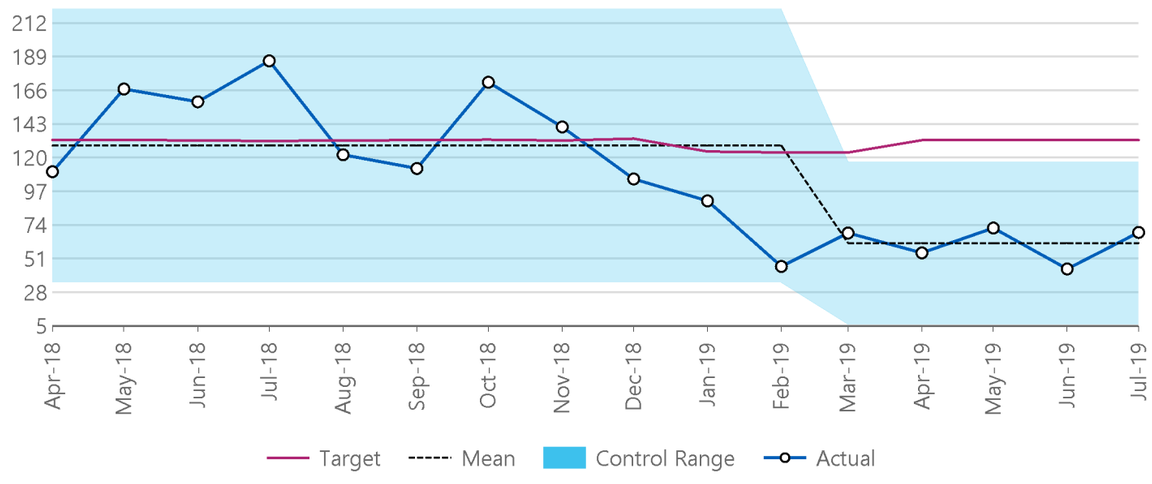
Core agency spend £63k favourable against cap in month

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	YTD
110.49	167	158.27	186.24	122.05	112.7	171.62	141.07	105.5	90.56	45.75	68.59	55	72	44	69	171

Agency Non-Core

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

232 against 163 target

Breaching target red rated

Exec Lead:
Director of Finance

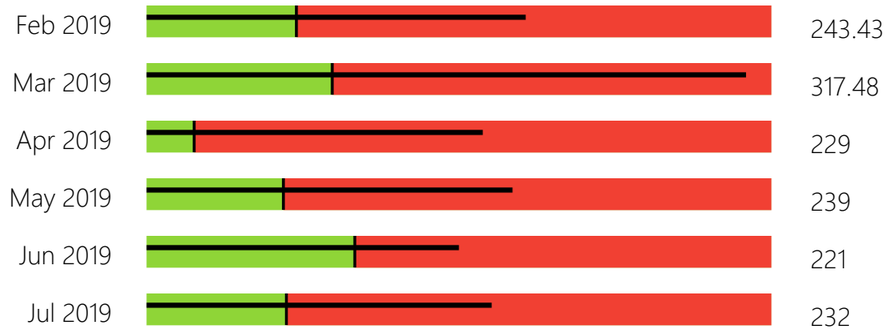
Finance, Planning and Digital Committee

Narrative

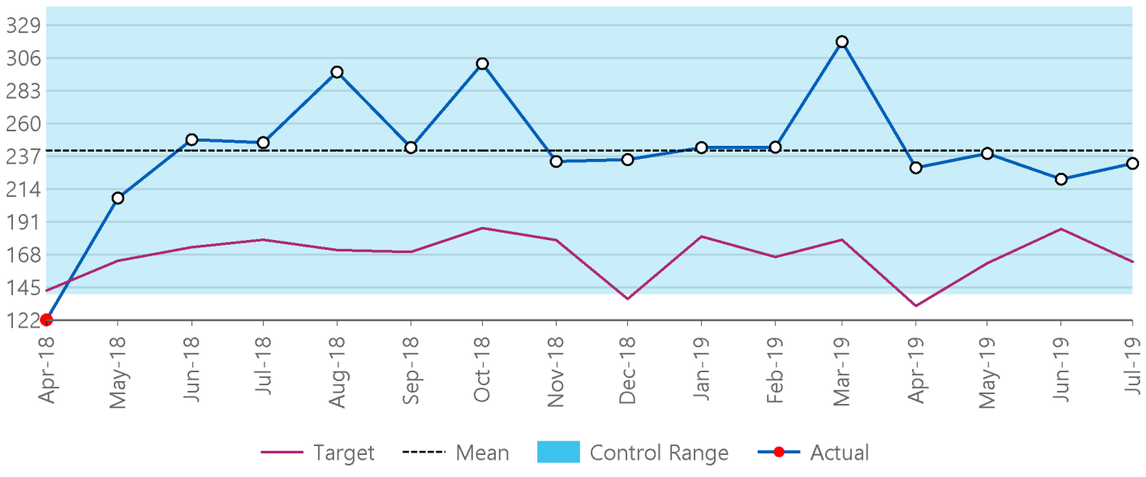
Non core agency spend £69k adverse against cap in month

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.

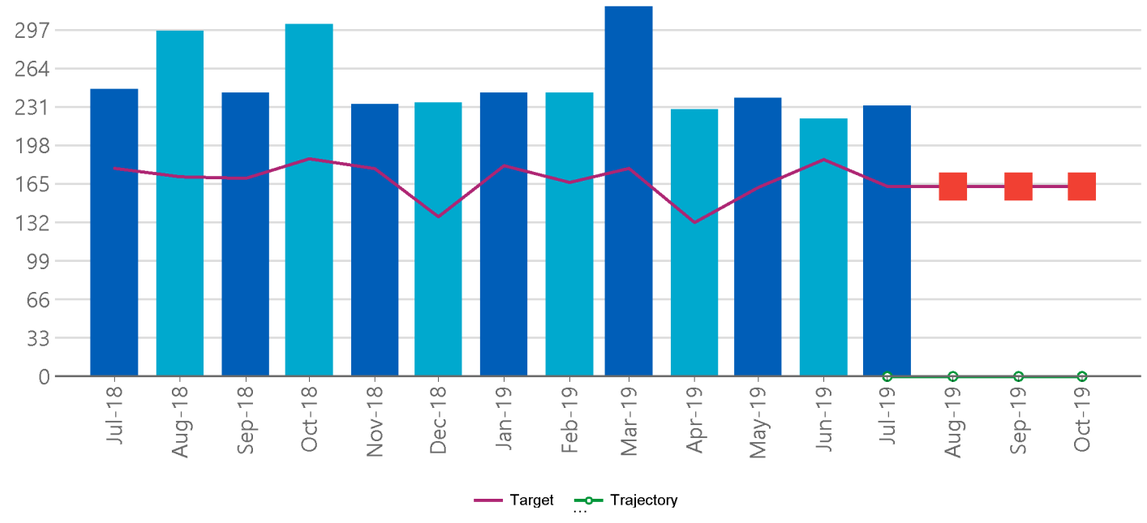
Performance against RAG ratings



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	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	232	689

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cash Balance

Cash in bank

9,100 against **5,900** target

Above target green rated

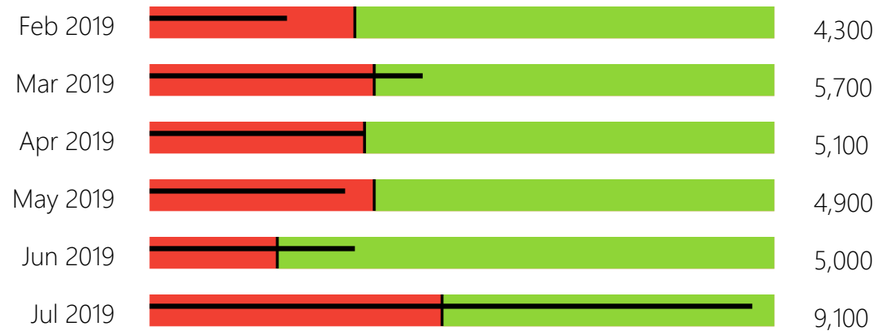
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

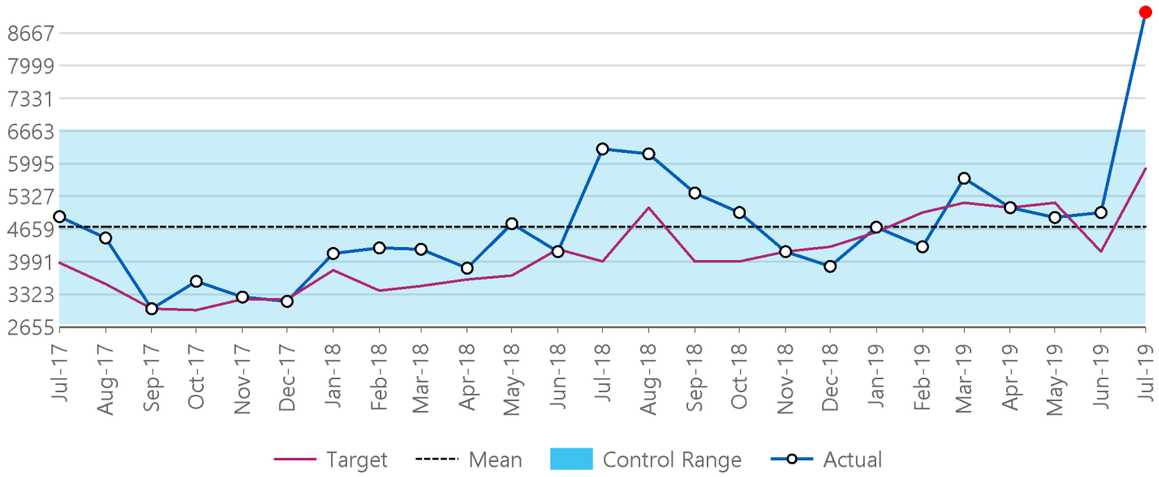
Narrative

Cash balances favourable against plan £3.2m driven by Shropshire CCG payment on account (August £2.6m) and 18/19 underperformance credits still outstanding.

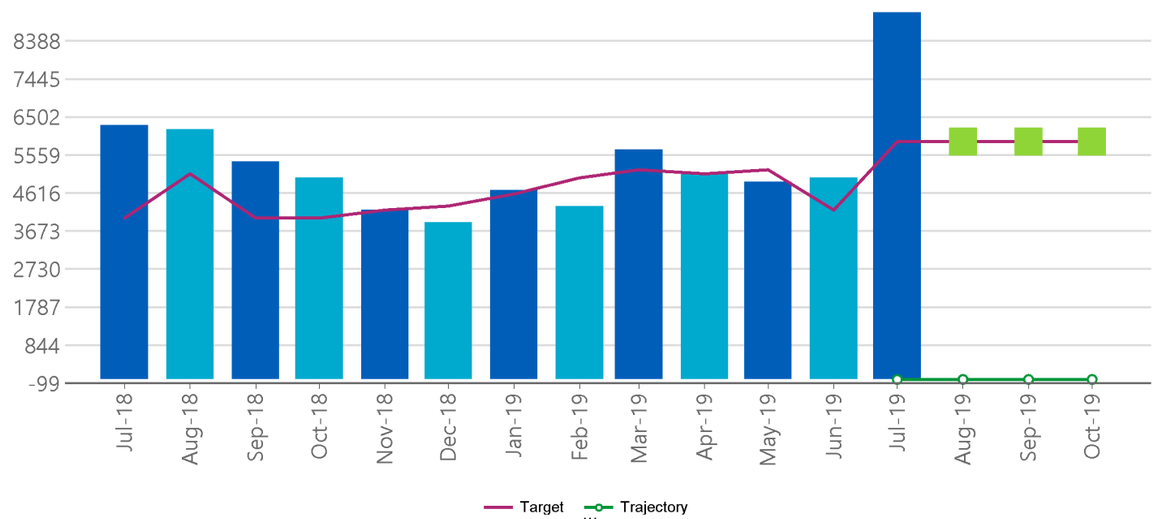
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
4,916	4,480	3,032	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	5,100	4,900	5,000	9,100	9,100

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Capital Expenditure

Expenditure against Trust capital programme

3 against 408 target

green rated

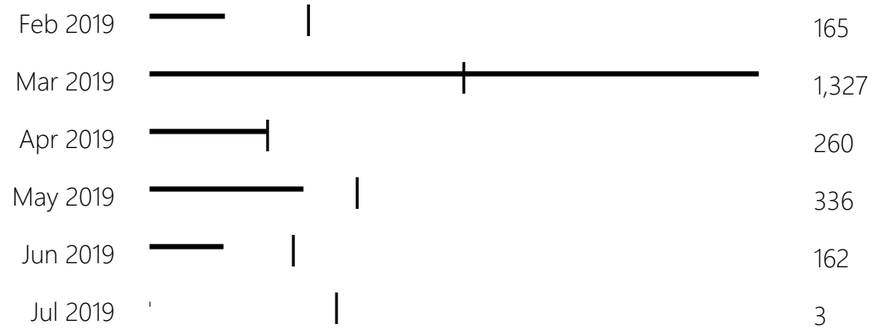
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

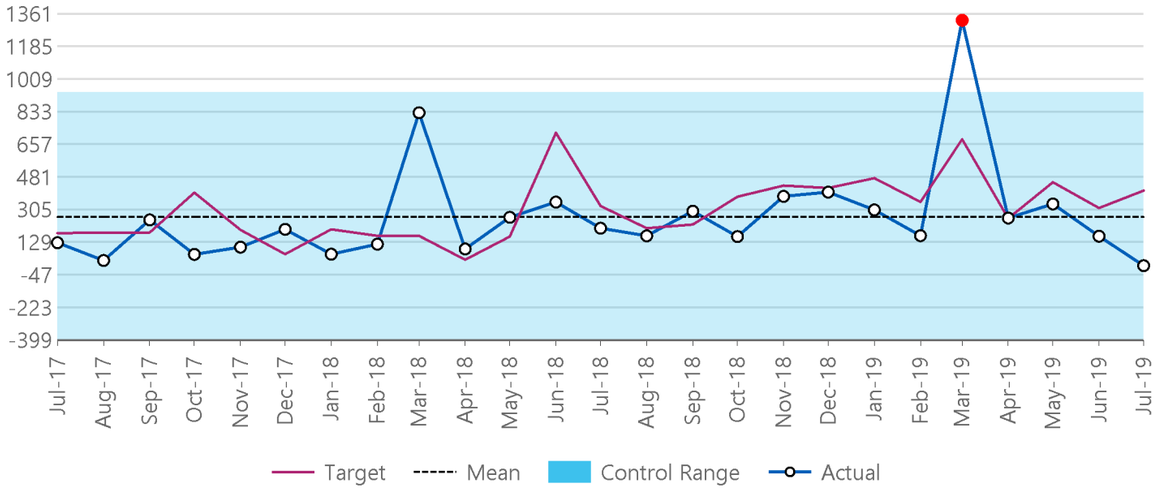
Narrative

Capital spend of £458k in month, £50k adverse in month

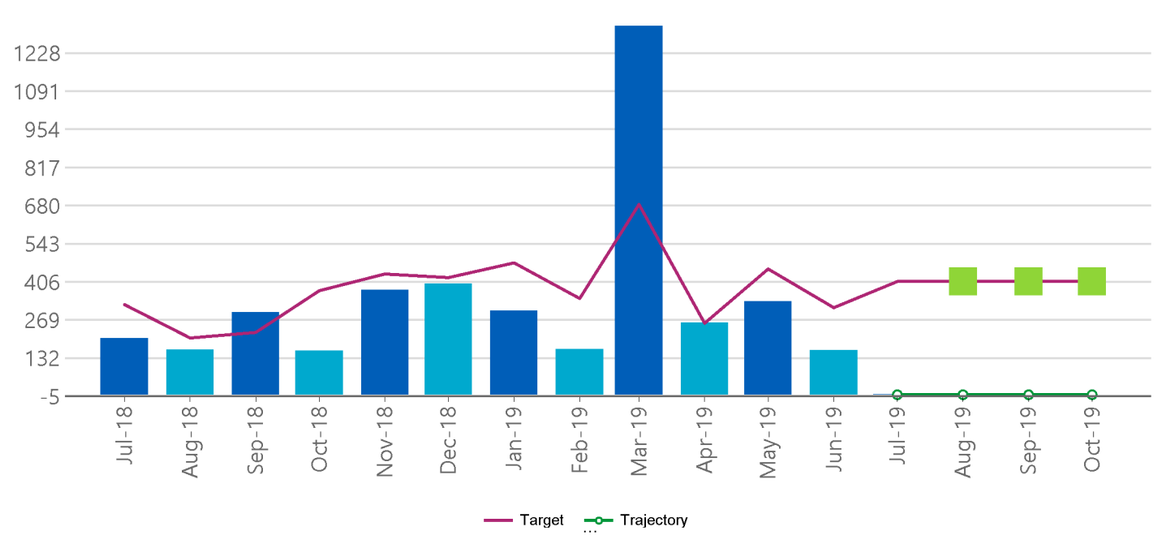
Performance against RAG ratings



Performance over 24 months – SPC



Trajectory



Heatmap performance over 24 months

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
127	31	250	64	103	199	65	119	828	93	264	346	205	164	297	160	377	400	304	165	1,327	260	336	162	3	1,217

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Use of Resources (UOR)

Overall Use of Resources indicator

3 against 1 target

Above target red rated

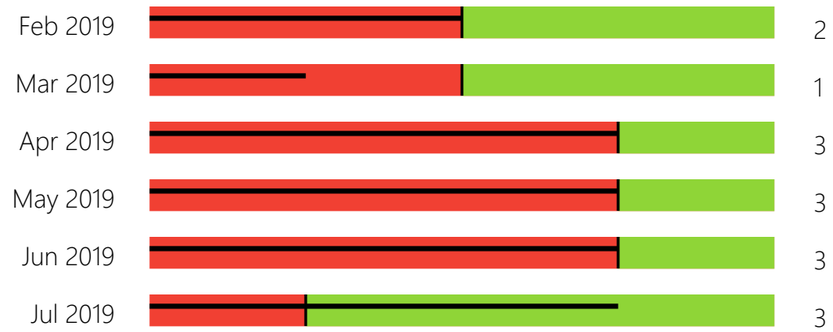
Exec Lead:
Director of Finance

Finance, Planning and Digital Committee

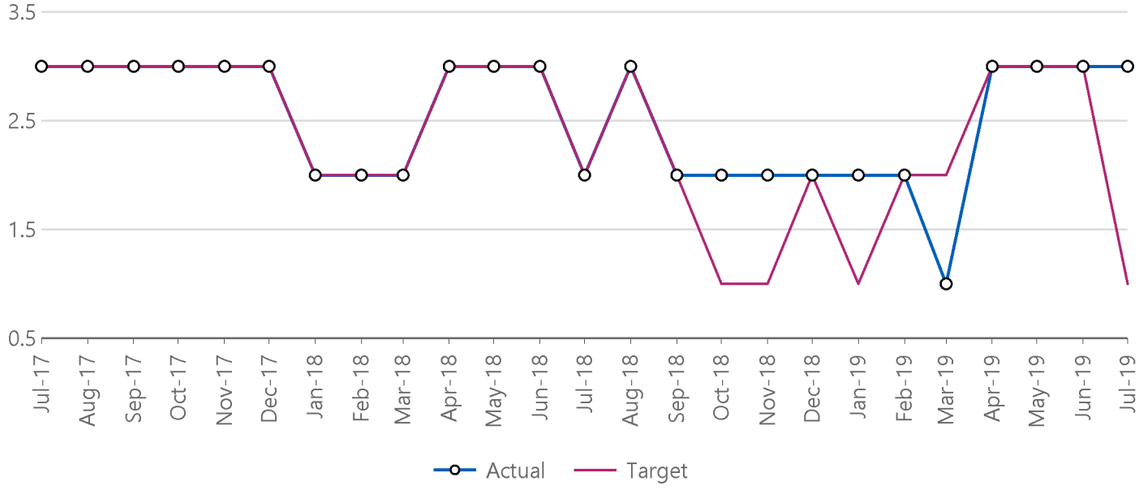
Narrative

UOR is below plan in month

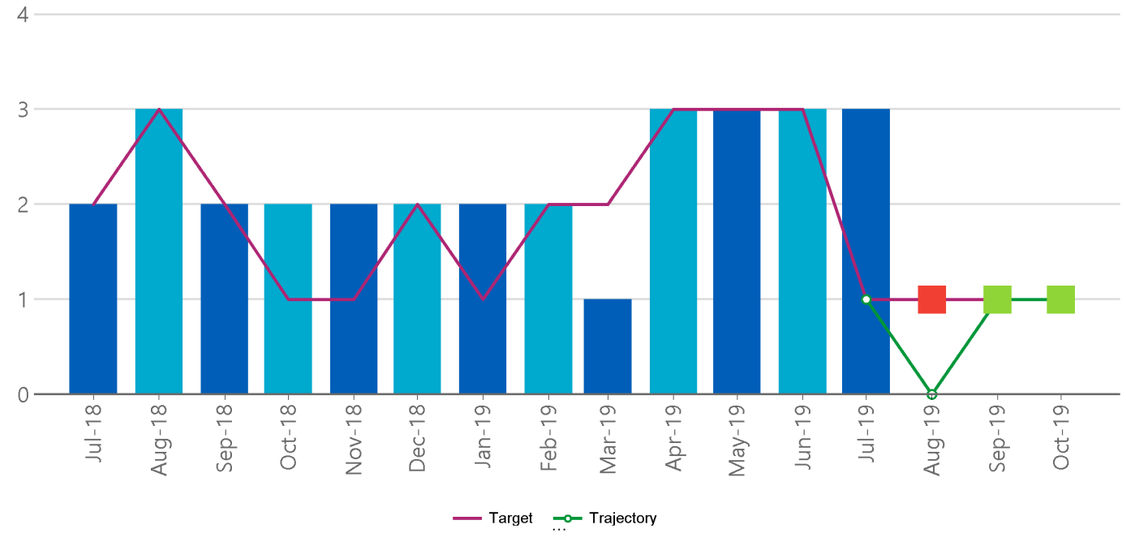
Performance against RAG ratings



Performance over 24 months –



Trajectory



Heatmap performance over 24 months

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

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st July 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	9,451	8,546	(905)	34,140	32,603	(1,537)
PSF	372	25	0	(25)	81	0	(81)
Private Patient income	5,854	505	420	(85)	1,931	1,882	(49)
Other income	6,004	500	520	21	2,020	2,027	8
Pay	(64,828)	(5,421)	(5,368)	53	(21,762)	(21,515)	247
Non-pay	(43,776)	(3,765)	(3,687)	78	(14,414)	(14,435)	(21)
EBITDA	6,772	1,295	432	(863)	1,995	562	(1,433)
Finance Costs	(4,890)	(402)	(403)	(1)	(1,608)	(1,615)	(7)
Capital Donations	150	13	0	(13)	43	7	(36)
Operational Surplus	2,032	906	29	(877)	431	(1,046)	(1,476)
Remove Capital Donations	(150)	(13)	0	13	(43)	(7)	36
Add Back Donated Dep'n	521	44	43	(1)	174	175	1
Remove PSF	(372)	(25)	0	25	(81)	0	81
Control Total exl PSF	2,031	912	73	(839)	481	(878)	(1,359)
PSF Earnt	372	25	0	(25)	81	0	(81)
Control Total	2,403	937	73	(864)	561	(878)	(1,440)
EBITDA margin	5.9%	12.4%	4.6%	-7.8%	5.2%	1.5%	-3.7%

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

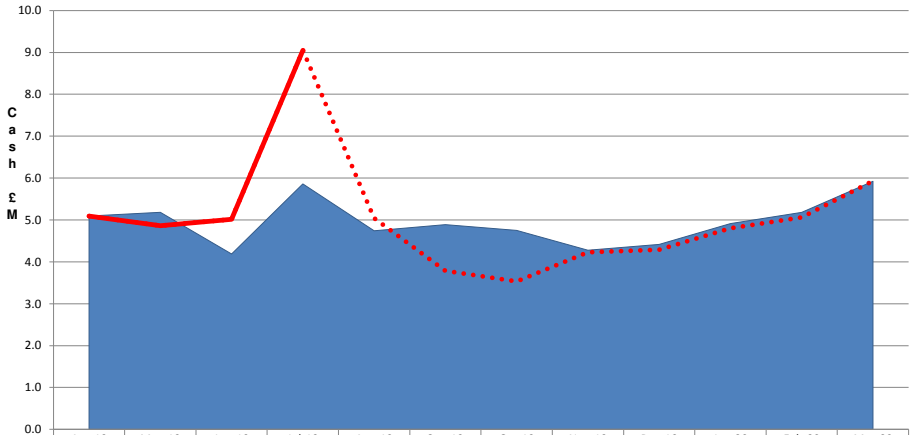
	Jul-19	YTD
Debtor Days	24	24
Creditor Days	33	33

Statement of Financial Position £'000s

Category	Jun-19	Jul-19	Movement	Drivers
Fixed Assets	71,508	71,715	207	
Non current receivables	887	873	(14)	
Total Non Current Assets	72,395	72,588	193	
Inventories (Stocks)	1,112	1,105	(7)	
Receivables (Debtors)	8,293	6,421	(1,872)	1819 PSF core and bonus cash received
Cash at Bank and in hand	5,023	9,051	4,028	Shropshire CCG payment on account (August £2.6m) & 1819 core and bonus PSF
Total Current Assets	14,428	16,577	2,149	
Payables (Creditors)	(10,885)	(13,195)	(2,310)	Shropshire CCG payment on account (August)
Borrowings	(1,225)	(1,237)	(12)	
Current Provisions	(88)	(85)	3	
Total Current Liabilities (< 1 year)	(12,198)	(14,517)	(2,319)	
Total Assets less Current Liabilities	74,625	74,648	23	
Non Current Borrowings	(5,884)	(5,884)	0	
Non Current Provisions	(146)	(140)	6	
Non Current Liabilities (> 1 year)	(6,030)	(6,024)	6	
Total Assets Employed	68,595	68,624	29	
Public Dividend Capital	(33,718)	(33,718)	0	
Revenue Position	(15,047)	(15,047)	0	
Retained Earnings	1,075	1,046	(29)	Current period surplus, before control total adjustment
Revaluation Reserve	(20,905)	(20,905)	0	
Total Taxpayers Equity	(68,595)	(68,624)	(29)	

Monthly Surplus/Deficit

Cash Flow



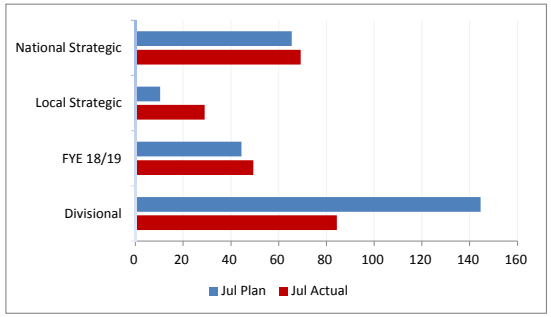
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Plan £M	5.1	5.2	4.2	5.9	4.7	4.9	4.8	4.3	4.4	4.9	5.2	5.9
Actual £M	5.1	4.9	5.0	9.1								
Forecast £M	5.1	4.9	5.0	9.1	5.0	3.8	3.5	4.2	4.3	4.8	5.1	5.9

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

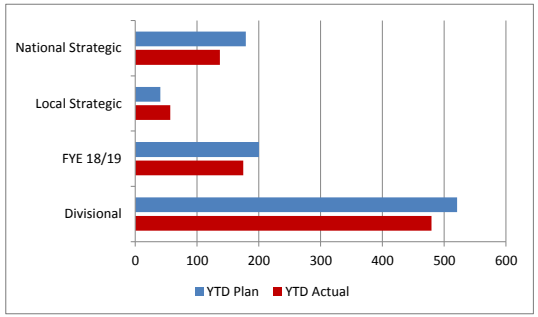
Cost Improvement Programme

CIP by Theme

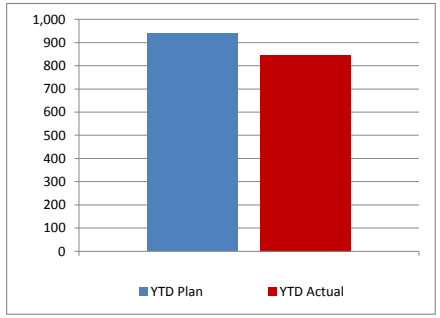
In Month CIP Achievement £000's



Year To Date CIP Achievement £000's

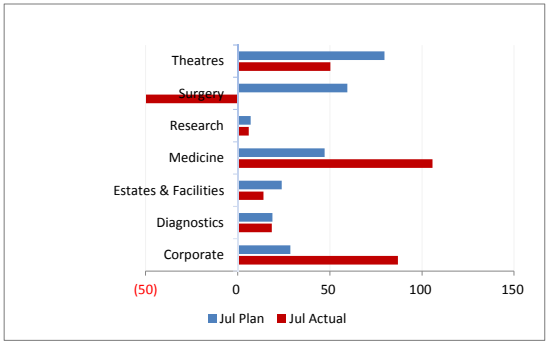


Trust YTD Achievement Against YTD Plan £000's

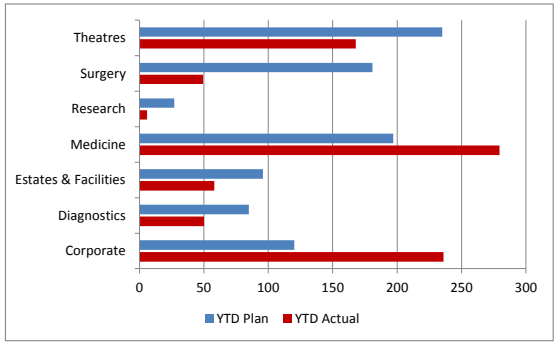


CIP by Division

In Month CIP Achievement £000's



Year To Date CIP Achievement £000's



RAG of Total Schemes Being Tracked

312	8%	b
1,336	32%	g
2,024	49%	a
478	12%	r
4,150	100%	

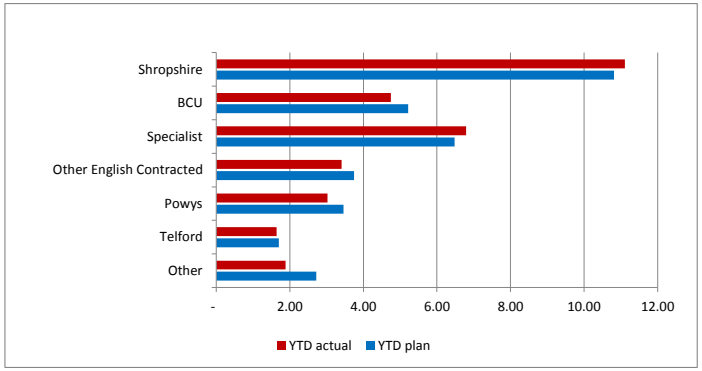
Capital

Year to date capital programme £000's

Position as at	1920-04	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	750	825	-75	1,350
Diagnostic equipment replacement	1,000	0	0	0	1,000
Replacement I/T network	400	225	186	39	400
EPR development	100	35	22	13	100
Digital Developments	100	0	0	0	100
Invest-to-save schemes	300	30	0	30	300
I/T investment & replacement	300	130	20	110	250
Backlog maintenance	400	150	74	76	300
Equipment & service continuity	500	50	50	-0	500
Project management	100	33	33	-0	100
Trust improvement bids	100	0	0	0	100
Contingency	300	0	0	0	300
NHS Capital Funding	4,950	1,403	1,210	193	4,800
Donated equipment / building works	150	30	7	23	150
Total Capital Funding (NHS & Donated)	5,100	1,433	1,217	216	4,950

Commissioner Performance

Year To Date Commissioner Income against Plan £m



FAO:

NHS Trust and Foundation Trust Chief Executives

STP and ICS Leaders

NHS Trust and Foundation Trust Financial Directors

Julian Kelly

Chief Financial Officer

Skipton House
80 London Road
London
SE1 6LH

England.cheiffinacialofficer@nhs.net

18 August 2019

Dear Colleagues,

Additional NHS capital funding in 2019/20

Earlier this month the Prime Minister announced a substantial increase in capital investment into the NHS. This is a significant start to addressing the critical infrastructure and maintenance issues across the NHS, and I am writing to set out the practical next steps. I should express at the outset my gratitude for the way in which you engaged with the request to set prioritised and constrained capital plans.

For 2019/20, the Government has agreed a £1.0 billion increase in the Department of Health and Social Care (DHSC) baseline capital expenditure limit.

This means that you can now revert to your original capital plans where these are funded by your trust's own income and reserves or where DHSC has already approved the business case or funding for programmes.

Trusts with existing emergency capital financing requirements that were included within the prioritised July plans should work with their regional team to progress an application for funding that can be submitted to DHSC. Subject to due process we do not anticipate additional delays in releasing these funds, so that we can proceed quickly to address critical maintenance issues. The ability of DHSC to approve any further emergency capital applications beyond this level will depend upon the national CDEL position, although we remain open to working with systems or regions who collectively wish to continue to agree prioritisation of capital spend at system level.

My request is that we collectively improve our capital forecasts and provide a taut and realistic view of the forecast outturn for your organisations in September. We will then be able to judge whether there is headroom to go further on tackling critical maintenance backlogs this year. In agreeing the level of funding that is available for emergency loans we have already assumed that there is around 10% slippage against original plans based on past behaviour.

The Government has also announced that it will provide £850 million to fund twenty new high value schemes through the Sustainability and Transformation Programme.

Trusts and systems that have had schemes approved as part of this have received confirmation from your NHS England & Improvement regional team and DHSC. Trusts will be able to access funding in the usual way through DHSC, with more details on the business case approval process to follow in due course. We will continue to develop this programme with the whole system through the Spending Review and Long Term Plan process.

This significant increase in investment and further steps that we are continuing to argue for through the Spending Review needs to be accompanied by a new capital regime. That regime needs to secure:

- clearer prioritisation at local and national level of investment;
- a stronger link to delivering increased productivity, financial efficiency;
- better use of our asset base, better patient care and delivery of the Long Term Plan goals; and
- greater strategic oversight over capital spending though the new health infrastructure plan, as set out by the Secretary of State.

Once more, I am grateful for all the work to set prioritised and constrained capital plans for 2019/20. It was an important step in demonstrating to Government the NHS ability to deliver financial control.

Yours sincerely

Julian Kelly

Chief Financial Officer

NHS England and NHS Improvement

CC

Dido Harding, Chair of NHS Improvement

David Prior Chair of NHS England

NHS England and NHS Improvement National Directors

NHS England and Improvement Regional Directors

NHS England and Improvement Financial Directors

NHS Oversight Framework 2019/20

August 2019

NHS England and NHS Improvement

NHS Oversight Framework 2019/20

Publication approval number: 000390

Version number: 1.0

First published: August 2019

Prepared by: Oversight and Assessment team

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the Oversight and Assessment team at nhs.oversightframework@nhs.net

Contents

Introduction

1. In recent years it has become increasingly clear that the best way to manage the NHS's resources to deliver high quality, sustainable care is to focus on organising health at both system and organisational level. NHS England and NHS Improvement are aligning their operating models to support system working. 2019/20 will be a transitional year, with our regional teams coming together to support local systems.

2. A new approach to oversight will set out how regional teams review performance and identify support needs across sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). This framework summarises how this new approach to oversight will work from 2019/20 and the work that will be done during 2019/20 for a new integrated approach from 2020/21.

3. Changes to oversight will be characterised by several key principles:

   - NHS England and NHS Improvement teams speaking with a **single voice**, setting consistent expectations of systems and their constituent organisations
   - a greater emphasis on **system performance**, alongside the contribution of individual healthcare providers and commissioners to system goals
   - working **with and through system leaders**, wherever possible, to tackle problems
   - matching **accountability for results** with improvement support, as appropriate
   - **greater autonomy** for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

Oversight in 2019/20

4. The existing statutory roles and responsibilities of NHS Improvement and NHS England in relation to providers and commissioners remain unchanged and are set out in the mandated support section of this document. The key change is the context in which they are applied, which will now reflect the principles set out above. This will serve to identify and address both:

- performance issues in organisations directly affecting system delivery
- development issues which may, if not addressed, threaten future performance.

5. In addition, leadership and culture at organisations and systems will form a core part of our oversight conversations as part of our commitment to making the NHS a better place to work.

6. Regional directors and their teams will lead on system oversight, working closely with organisations and systems and drawing on the expertise and advice of national colleagues. Existing tools – licence breach, powers of direction, special measures – will continue to be used where necessary to address organisational issues and support system delivery.

7. We are supporting ICSs to take on greater collaborative responsibility for use of NHS resources, quality of care and population health. In line with the move to greater autonomy for better performing local systems, oversight arrangements will reflect both the performance and relative maturity of ICSs. In 2019/20 it will be for regional teams to determine the level of oversight that best meets their assurance needs. Regions have been testing new ways of working and arrangements already in place will continue.

8. Oversight will incorporate:

   - System review meetings: discussions between the regional team and system leaders, drawing on corporate and national expertise as necessary, informed by a shared set of information and covering:
     - performance against a core set of national requirements at system and/or organisational level. These will include: quality of care, population health, financial performance and sustainability, and delivery of national standards
     - any emerging organisational health issues that may need addressing
     - implementation of transformation objectives in the NHS Long Term Plan.

     In the absence of material concerns, the default frequency for these meetings will be quarterly, but regional teams will engage more frequently where system or organisational issues make it necessary.

- Focused engagement with the system and the relevant organisations where specific issues emerge outside these meetings.

9. Organisational-level information flows will remain to ensure we can better understand drivers of system performance and identify situations where good system-level performance is masking underperformance at a local level. During 2019/20 we will make our reporting and dashboards, integrated performance data on activity and quality standards, available to organisations, systems, regional and national teams to enable performance discussions to use a 'single version of the truth'.

10. The specific dataset for 2019/20 broadly reflects existing provider and commissioner oversight and assessment priorities. These metrics are provided in Appendix 1 and split by their alignment to priority areas in the NHS Long Term Plan. Where appropriate these will be aggregated across system level and are likely to be complemented by purpose-built system metrics.

11. From 2020/21, the metrics for oversight and assessment purposes will include the headline measures described in the NHS Long Term Plan Implementation Framework against which the success of the NHS will be assessed. These Long Term Plan measures will be used as the cornerstone of the mandate and planning guidance for the NHS for the next five years.

Identifying support needs and organisation segmentation

12. Regional teams will use data from the metrics in Appendix 1 as well as local information and insight to identify where commissioners and providers may need support.

13. Where a clinical commissioning group (CCG) and/or provider is triggering a concern and a potential support need is identified, the regional team will consider why the trigger has arisen and whether a support need exists. The regional team will involve system leads in this process – both to identify the factors behind the issues and whether local support is available and appropriate.

14. Teams will use judgement to assess the seriousness, scale and complexity of the issues the CCG and/or provider is facing, based on information gathered, existing relationship knowledge, discussions with other organisations in the

system, information from partners and evidence from formal or informal investigations.

15. From 2019/20, ICSs and emerging ICSs will be increasingly involved in the oversight process and support of organisations in their system. NHS England and NHS Improvement are developing a maturity matrix for systems that will determine the relative responsibilities and freedoms at each stage of system maturity – and associated support available. When working with systems, regional teams will take into account the maturity of the system and this will determine the extent to which the system is expected to support or lead on the improvement activity.

16. Practically, regional teams – with system leaders where appropriate – will consider:

    - the extent to which the CCG and/or provider is triggering a concern under leadership capacity and capability, quality of care, financial management, and/or operational performance
    - any associated circumstances the CCG and/or provider is facing
    - the degree to which the CCG and/or provider understands what is driving the issue
    - views of system leadership and governance
    - the CCG's and/or provider's capability and the credibility of plans to address the issue
    - the extent to which the CCG and/or provider is delivering against a recovery trajectory.

17. Based on this assessment, teams will identify whether a CCG and/or provider has a support need and, if so, what level of support is required.

18. Having assessed a CCG and/or provider's support needs, it is up to regional teams to allocate them to a support 'segment' or category. For ICSs, support decisions should be taken having regard to the views of system leadership governance. The segment or category in which an organisation is placed is determined by the level of support teams have decided is appropriate (universal, targeted or mandated). It does not necessarily mirror the annual assessment for CCGs or the most recent Care Quality Commission (CQC) inspection rating for providers.

19. The relationship between a CCG and/or provider's identified support needs, and the type of support made available is summarised in Table 1. This support may come from system partners or other organisations.

20. Teams monitor and engage with CCGs and providers on an ongoing basis and where in-year, annual or exceptional monitoring flags a potential support need the organisation's situation may need to be reviewed. This will consider whether the level of interaction needs to change to monitor the issue and the organisation's response to it, and whether there is a need to change its allocated segment or category.

21. This integrated approach enables regional teams to look at the support requirements for CCGs and providers in parallel so that support and intervention are mutually reinforcing. Intervention should be proportionate and based on the organisation's performance and the capability of the system to deal with any issues in the first instance.

22. The regional team will determine how frequently they will review CCGs and providers' support needs and segmentation based on their performance against the metrics in the assessment framework.

Table 1: Provider and CCG support needs and level of support offered

	Providers		CCGs	
Segment/ category	**Description of support needs**	**Level of support offered**	**Description of support needs**	**Level of support offered**
1 (Maximum autonomy)	No actual support needs identified across the five themes described in the provider annex. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider supports providers in other segments.	**Universal (voluntary)**	No actual support needs identified across. Maximum autonomy and lowest level of oversight appropriate.	**Universal (voluntary)**
2 (Targeted support)	Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not considered needed.	**Universal + targeted** (not mandatory) support as agreed with the provider to address issues identified and help move the provider to segment 1.	Support needed but mandated action is not considered needed.	**Universal + targeted** support as agreed with the CCG to address issues identified and help move the provider to segment 1
3 (Mandated support)	The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts) but is not in special measures.	**Universal targeted + mandated** support as determined by the regional team to address specific issues and help move the provider to segment 2 or 1.	The CCG has significant support needs and is placed in the dedicated support regime.	**Universal targeted + mandated** support as determined by the regional team to address specific issues and help move the CCG to segment 2 or 1
4 (Special measures for providers; legal directions for CCGs)	The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.	**Universal targeted + mandated** support as determined to minimise the time the provider is in special measures.	The CCG is failing or at risk of failure with very serious/ complex issues that mean it is placed under legal directions.	**Universal targeted + mandated** support as determined to minimise the time the CCG is under legal direction.

Mandated support

24. Support for CCGs includes:

    - dedicated support regime for CCGs that need additional and tailored support
    - statutory powers of direction where NHS England is satisfied that either a CCG is failing or is at risk of failing to discharge its functions (as laid out in s.14Z21 of the NHS Act 2006 (as amended)).

25. Where mandated support is required for an NHS foundation trust the regional teams may call on the powers in the Health and Social Care Act 2012, using powers under the National Health Service Act 2006. In particular, teams may seek to agree enforcement undertakings with the provider. These include:

    - to direct a foundation trust to do, or stop doing, actions which render it in breach of its licence (s.105)
    - where a foundation trust in breach of its licence proposes actions (an undertaking) to address the breach, NHS Improvement can hold the foundation trust to account for the delivery of these actions (s.106) and take steps to penalise trusts if these are not delivered
    - where governance issues at a trust are causing a breach, or likely breach, of the licence, removing, suspending or disqualifying directors or governors and replacing them with interims. NHS Improvement can also add conditions to the foundation trust's licence to address the governance issue (s.111).

26. For NHS trusts, NHS Improvement has statutory powers of direction that include the appointment and removal of board directors and in any other area in regard to the exercise of the trust's functions that NHS Improvement deems appropriate (as described in the NHS Trust Development Authority Directions 2013).

Annual assessment of CCGs

31. As required by law, the annual assessment of CCGs by NHS England will continue in 2019/20. It is a judgement, reached by considering a CCG's performance in each of the indicator areas over the full year and balanced

against the financial management and qualitative assessment of the leadership of the CCG. Formally NHS England will continue to assess how CCGs work with others (including their local Health and Wellbeing Boards) to improve quality and outcomes for patients.

32. CCG assessment gives primacy to tasks in common over formal organisational boundaries and has not solely used metrics that only report on data within a CCG's control. Metrics have already been incorporated from NHS Improvement's provider oversight approach. Therefore, CCGs are expected to focus on the strength and effectiveness of their system relationships, using all the levers and incentives available to them, to make progress.

Developing a new oversight framework for 2020 onwards

33. The approach in this document combines current approaches to overseeing commissioners and providers. As teams come together and start working with systems and organisations, we will use 2019/20 to develop proposals for a new framework.

34. The specific metrics that will be used for oversight and assessment will include the measures identified in the NHS Long Term Plan Implementation Framework.

35. We will involve partners at key stages of the design work, which will consider:

- the purpose of the framework – what it is to be used for and the relative roles of performance management and sector development
- the scope of the framework and the approach to oversight at organisational and/or system level
- standard and transparent methodologies for monitoring, escalation and taking formal or informal action with organisations.

36. The framework will incorporate the commitments in the People Plan (see the Interim People Plan) to develop a leadership compact. This compact will be an important component of future oversight and will set out how the regional, national and local teams commit to behave towards each other.

37. The framework will also consider the balance between organisational and system oversight, and how system maturity will affect this.

Appendix 1: Oversight metrics

New metrics for 2019/20 are highlighted in bold. Metrics are aligned to priority areas in the NHS Long Term Plan. There are full definitions in the accompanying provider and CCG technical annexes.

Metrics introduced in 2020/21, including system metrics, will include the measures described in the NHS Long Term Plan Implementation Framework.

1. New service models		Oversight
	Integrated primary care and community health services	
1	Patient experience of GP services	CCGs
2	Patient experience of booking a GP appointment	CCGs
3	Emergency admissions for urgent care sensitive conditions	CCGs
	Acute emergency care and transfers of care	
4	Percentage of patients admitted, transferred or discharged from A&E within four hours	CCGs and providers
5	Achievement of clinical standards in the delivery of 7-day services	CCGs and providers
6	Delayed transfers of care per 100,000 population	CCGs
7	Population use of hospital beds following emergency admission	CCGs
8	Percentage of NHS continuing healthcare full assessments taking place in an acute hospital setting	CCGs
	Personalisation and patient choice	
9	Personal health budgets	CCGs
10	Use of the NHS e-referral service to enable choice at first routine elective referral	CCGs

2. Preventing ill health and reducing inequalities		
	Smoking	
11	Maternal smoking at delivery	CCGs
	Obesity	
12	Percentage of children aged 10-11 classified as overweight or obese	CCGs
	Falls	
13	Injuries from falls in people aged 65 and over	CCGs and providers
	Antimicrobial resistance	
14	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	CCGs
15	Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	CCGs
	Health inequalities	
16	Proportion of people on GP severe mental illness register receiving physical health checks in primary care	CCGs
17	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	CCGs
3. Quality of care and outcomes		
	General	
18	Provision of high-quality care: hospitals	CCGs and providers
19	Quality of Care metrics: a set of 30 quality proxies to identify any emerging quality concerns at acute, mental health, ambulance and community trusts – **see Provider annex for more details**	Providers
20	Provision of high-quality care: primary medical services	CCGs

21	Evidence that sepsis awareness raising among healthcare professionals has been prioritised by CCGs	CCGs
22	**Evidence-based interventions**	**CCGs**
	Maternity services	
23	Neonatal mortality and stillbirths	CCGs
24	Women's experience of maternity services	CCGs
25	Choices in maternity services	CCGs
	Cancer services	
26	Cancers diagnosed at an early stage	CCGs
27	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	CCGs and providers
28	One-year survival from all cancers	CCGs
29	Cancer patient experience	CCGs
	Mental health	
30	Improving Access to Psychological Therapies – recovery	CCGs and providers
31	Improving Access to Psychological Therapies – access	CCGs and providers
32	People with first episode of psychosis starting treatment with a National Institute for Health and Care Excellence (NICE)-recommended package of care treated within two weeks of referral	CCGs and providers
33	Mental health out-of-area placements	CCGs and providers
34	Quality of mental health data submitted to NHS Digital (DQMI)	CCGs and providers
	Learning disability and autism	

35	Reliance on specialist inpatient care for people with a learning disability and/or autism	CCGs
36	Proportion of people with a learning disability on the GP register receiving an annual health check	CCGs
37	Completeness of the GP learning disability register	CCGs
38	**Learning disabilities mortality review: the percentage of reviews completed within 6 months of notification**	**CCGs**
	Diabetes	
39	Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	CCGs
40	People with diabetes diagnosed less than a year who attend a structured education course	CCGs
	People with long term conditions and complex needs	
41	Estimated diagnosis rate for people with dementia	Providers
42	Dementia care planning and post-diagnostic support	CCGs
43	The proportion of carers with a long-term condition who feel supported to manage their condition	CCGs
44	Percentage of deaths with three or more emergency admissions in last three months of life	CCGs
	Planned care	
45	Patients waiting 18 weeks or less from referral to hospital treatment	CCGs and providers
46	**Overall size of the waiting list**	**CCGs**
47	**Patients waiting over 52 weeks for treatment**	**CCGs**
48	Patients waiting six weeks or more for a diagnostic test	CCGs and providers
4. Leadership and workforce		

49	Quality of leadership	CCGs and providers
50	Probity and corporate governance	CCGs and providers
51	Effectiveness of working relationships in the local system	CCGs and providers
52	Compliance with statutory guidance on patient and public participation in commissioning health and care	CCGs
53	Primary care workforce	CCGs
54	Staff engagement index	CCGs
55	Progress against the Workforce Race Equality Standard	CCGs and providers
56	Effectiveness of shared objective-setting and teamworking	Providers
57	Providing equal opportunities and eliminating discrimination	Providers
58	Black and minority ethnic (BME) leadership ambition for executive appointments	Providers
59	Reducing/eliminating bullying and harassment from managers and other staff	Providers
5. Finance and use of resources		
60	In-year financial performance	CCGs and providers
61	Delivery of the mental health investment standard	CCGs
62	**Children and Young People and Eating Disorders investment as a percentage of total mental health spend**	**CCGs**
63	Expenditure in areas with identified scope for improvement	CCGs
64	Children and young people's mental health services transformation	CCGs
65	**Reducing the rate of low priority prescribing**	**CCGs**

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