The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Council of Governors 30.05.2019

MEETING
30 May 2019 14:00

PUBLISHED
24 May 2019

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	30/05/19		14:00
1. Committee Management			
1.1. Apologies		Chair	14:00
1.2. Minutes of the Previous Meeting held on 28 March 2019		Chair	14:05
1.3. Matters Arising		Chair	
1.4. Declarations of Interest		Chair	14:10
2. Board Reflection		All	14:15
3. Chief Executive Update		Chief Executive	14:25
4. Quality			
4.1. Quality Account External Audit		Interim Director of Nursing	14:35
5. COG Strategy			
5.1. Membership and Engagement Strategy Session Follow Up		Trust Secretary	14:40
6. Items to Note			
6.1. Senior Independent Director Appointment (verbal)		Chairman	14:45
6.2. Questions and Answers (Verbal)		Trust Secretary	14:50
6.3. Work Programme Review		Trust Secretary	14:55
7. Any Other Business			15:00
8. Date and Time of next meeting			
8.1. 25th July 2019 - Meeting room 1 - Public Board 11am / Council Of Governors 2.30pm			
9. Private Session with the Governors		Chairman	15:05

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Frank Collins, Chairman ☎ 4358
Chairman

COUNCIL OF GOVERNORS
28TH MARCH 2019

MINUTES OF THE MEETING

PRESENT:

Frank Collins	Chair	FC
Jan Greasley	Lead Governor/Public Governor, North Wales	JG
Colin Chapman	Public Governor, Shropshire	CC
Gill Pitcher	Public Governor, Shropshire	GP
Sue Nassar	Public Governor, Shropshire	SN
Russell Luckcock	Public Governor, West Midlands	RL
Karen Calder	Governor Stakeholder, Shropshire Council	KC

IN ATTENDANCE:

Mark Brandreth	Chief Executive	MB
Shelley Ramtuhul	Trust Secretary	SR
Craig Macbeth	Director of Finance	CM
Sarah Bloomfield	Interim Director of Nursing	SB
Harry Turner	Non-Executive Director	HT
Hilary Pepler	Non-Executive Director	HP
David Gilburt	Non-Executive Director	DG
Alastair Findlay	Non-Executive Director	AF
Paul Kingston	Non-Executive Director	PK

SECRETARY:

Gayle Murphy	PA to Trust Secretary	GM

MINUTE NO	TITLE	ACTION
	COMMITTEE MANAGEMENT	
1.1	**WELCOME & APOLOGIES** Apologies were received from: Katrina Morphet - Public Governor, Cheshire & Merseyside, Karina Wright - Stakeholder Governor, Keele University, Kate Chaffey - Staff Governor, Dr Julie Santy-Tomlinson – Public Governor, Rest of England and Wales, Peter David - Stakeholder Governor, League of Friends, Martin Coggon - Public Governor, North Wales, Allen Edwards - Staff Governor, Debbie Kadum - Interim Associate Director of Performance, Sarah Sheppard - Director of People, Kerry Robinson – Director Strategy and Planning, Steve White - Medical Director and Nia Jones - Director of Operations. FC welcomed Paul Kingston, a new Non-Executive Director at the Trust and Sarah Bloomfield, Interim Director of Nursing, in the absence of Bev Tabernacle, Director of Nursing.	
1.2 **1.3**	**MINUTES FROM THE PREVIOUS MEETING** The minutes from the previous meetings held on 29 November 2018 and 31 January 2019 were approved as a true record.	
1.4	**MATTERS ARISING** There were no matters arising from the meeting held on 29 November 2018. Following the meeting on 31 January 2019 KC advised that she had received complaints from members of the public regarding the cessation of the pain	

MINUTE NO	TITLE	ACTION
	management service whilst sitting on the Shropshire Council Health and Adult Care Scrutiny Committee. The advice given was to advise any concerned individuals to make a formal complaint to the Shropshire CCG. MB thanked KC for the update and commented that RJAH, if asked, would happily comment on chronic pain services in the county.	
1.5	**DECLARATIONS OF INTEREST** KC declared her involvement with the Shropshire Council Scrutiny Committees.	
2.0	**BOARD REFLECTION**	
	RL commented that due to the room layout it was sometimes difficult to hear what was being discussed and could this be noted for future meetings. However, GP added that room 1 is far better than the Boardroom for the meeting. FC acknowledged the comment and will ask the staff who layout the room to reflect on this for the future – although it was not easy to see how the room layout might be improved. **ACTION: SR and MB to look again at room configuration** GP commented on the new format of the Integrated Performance Report and how easier it is to listen to and take on board, compared to the previous versions. FC agreed and will feedback the comments from the Council. KC noted that during the presentation from Sir Neil McKay, she was pleased that the Board questioned him regarding housing in the county and how the STP was addressing the wider issues which can impact an individual and a population's health status. KC asked if when the Board reflects back to him on their thoughts, they could ask him to look at the whole system including local authorities not just the NHS system so they can be more integrated. FC commented that whilst the presentation was NHS centric, Sir Neil has embraced both the local authority and the third sector as important contributors into integrating care across the county. The comments from the Council will be included in the feedback. **ACTION: Council comments to be included in any feedback to Sir Neil McKay** JG acknowledged the staff CQC presentation was well delivered and appreciated by the Council and asked if this could be fed back to the members of staff who attended. FC agreed and commented he enjoyed hearing about the small examples that make such a big difference. KC added the prism glasses were a fantastic idea. PK commented on the point raised regarding a dedicated Physiotherapist in HDU and the fact that RJAH are delivering integrated care in this area. He asked whether, as the metric insists on a different type of intervention, whether there is a mechanism to go back to the CQC with a better model. MB said that the measure is for a critical care unit whereas RJAH has a high dependency unit. He will again point the potential for a non-critical care providing Trust being disadvantaged in a CQC inspection programme when he is in a suitable conversation with the CQC. CC questioned SB what her response will be to the staff refusing the Flu vaccine. SB advised that the Trust will be more proactive with gathering data and targeting the areas where there is genuinely-held concern about the evidence base and side effects of the vaccine. The Trust will share non biased information with staff prior to the vaccine campaign starting in 2019/20 to give staff the opportunity to ask questions in an open non-judgemental forum to enable them to make an informed	TRUST SECRETARY AND CHIEF EXECUTIVE CHIEF EXECUTIVE

MINUTE NO	TITLE	ACTION
	decision. The Trust will support staff that are needle phobic and find a solution to support this. CC added there are links in some cases where people have fallen extremely ill following the vaccine; he asked if this is this coincidental. DG commented there is a powerful message from an Anaesthetist on the staff Facebook page regarding the myths of the vaccine, which could be used more throughout the trust. SB agreed that it is a powerful message. External clinicians and GP's can be approached for an independent view so it doesn't look like the Trust is pushing ~~it's~~its own agenda. She added there will always be individuals who have a reaction to any vaccines but the Trust needs to share factual information not biased information. Staff side can support with the non biased messaging, whilst respecting staff rights to choose. In extreme circumstances risk assessments can be undertaken and if required staff could be re-deployed from high risk areas, if a clinical risk arises. MB stated that the Trust needs to continue talk about the evidence and not the myths of the vaccine. He commented there is more work to be done but he is pleased that the Trust has increased the take-up rate from 46% to 60%. However, this is still well behind neighbouring colleagues. SB commented that the vaccine strain from 3 – 4 years ago was not effective against the Flu strain at that time and so people lost confidence in the vaccine, the Trust is still dealing with this legacy. FC asked for any other questions. KC added that Maryse Mackenzie, Medicines Safety Officer, had expressed brilliant ideas during the CQC presentation. FC acknowledged that she was eloquently passionate. FC thanked the Council for their attendance at the Board of Directors meeting. The Council of Governors **noted** the updates in Trust Board.	
	QUALITY	

3.0	**QUALITY ACCOUNT UPDATE AND INDICATORS 2018/19**
	
	Sarah Bloomfield, Interim Director of Nursing, delivered a Quality Account update and Indicators presentation. The following points were made:
	
	• This is a statutory requirement for all NHS Trusts
	• The Governors have a role in agreeing the indicator for external audit to assess and also agreeing the indicators for the next year
	• The Quality Account is audited by external auditors each year
	• External auditors only audit data not quality of care or pathways
	• There are two mandated key performance indicators set by NHSi
	  ○ 62 day cancer waits
	  ○ 18 week RTT
	• The Governor's choose a third indicator and these have been discussed at the Quality and Safety Committee in order to provide some guidance with the choice.
	• Suggestions for locally selected indicators are:
	  ○ Readmission Rates - recommended by Quality and Safety	

MINUTE NO	TITLE	ACTION
	Committee ○ PROMS ○ VTE Assessment ○ C.Difficile A discussion took place regarding the choice of indicators; the Council ***agreed*** that the Readmission Rates should be chosen as the third indicator. DG questioned if the 18 week RTT data could be broken down to show the figures excluding the spinal total and then as a combined total for the trust, to make the point the target is being achieved. SB agreed that it could be reported in this way in the Quality Account. FC added that he has asked for the indicator to be treated this way in the Board papers and the Spinal activity should be ring-fenced in a separate indicator, as well as the Trust showing the combined performance. This should be actioned moving forward. **Action: SB to report the RTT figures minus the spinal total and as a Trust total, in the Quality Accounts moving forward** SB went on to discuss the Quality Account Priorities for 2019/20, and in particular the suggestions as discussed at the Quality and Safety Committee: • *Patient Safety* Ensuring the safe transfer both in and out of the hospital through the implementation of the Patient Passport • *Clinical Effectiveness* Improved management in the recognition of deteriorating patients (to include implementation of the deteriorating patient education package) • *Patient Experience* Implementation of the SWAN end of life framework Monitoring and learning from complaints A discussion took place regarding the choice of priorities; the Council supported the recommendations from the Quality and Safety Committee. FC thanked SB for her presentation.	INTERIM DIRECTOR OF NURSING
4.0	**ITEMS TO NOTE**	
4.1	**QUESTION AND ANSWERS** The Trust Secretary stated that no questions had been submitted prior to the meeting.	
	ANY OTHER BUSINESS	
5.0	GP commented she has had a discussion with SR regarding five Council members who are due for re-election in July 2019. If the election process is delayed there may be a period without these Governors which may cause a problem, not just for Council meetings but for the other tasks they carry out. SR responded that having looked at the timings, even allowing for Purdah as a consequence of the local elections in May, she was confident the election process could be completed in time so as not to cause an issue. FC thanked GP for raising the issue. CC pointed out that the Board headlines paper was very useful and questioned if the Board papers could be sent out any earlier. MB commented that if the Governors used electronic devices to access the papers it may be possible to them	

MINUTE NO	TITLE	ACTION
	access to the electronic portal to access the Board papers in advance of the meeting. **Action: SR to look at implementing adding the Governors onto the Board Portal for Board of Directors and Council of Governor's papers** CC asked if the board would have any objections to Governors attending the Clinical Audit Committee which is held twice a year at the Trust. MB stated that the Board would have to confirm this with the Chair of the Clinical Audit Committee and the Caldicott Guardian and would respond to the Governors as soon as possible. **Action: SR to confirm with the Chair of the Clinical Audit Committee and the Caldicott Guardian regarding Governors attendance** KC thanked the Board of Directors for hosting the Armed Forces Partnership Group meeting recently. MB noted they were very welcome. RL commented that over the last 6 months he had been involved in a number of conversations involving qualified nurses. The government has awarded a pay award of 1% but in his view this is inadequate –and may lead to difficulty in retaining staff. FC said that RL made a strong point but he was not sure how much leverage or influence the Trust would have in this issue but there are national forums that Chairs, CEO's and Governors attend where hne and the CEO may take the opportunity to raise the issue as appropriate. FC thanked RL for his comment and clear commitment to improving the well-being of all staff. CM added that public sector pay awards are increasing and will be increasing by 2% in the coming year. RL commented that he does not like to see trained staff leaving the profession in which they trained in, to gain more money elsewhere. FC added that pay can be an issue in some circumstances but an individual's decision to leave a place of work is usually multi factorial. SB agreed with FC and added that career pathways and opportunities are important retention initiatives and the Trust can work on these issues directly. KC commented that Shropshire Council are working on their key worker policy and it's link with the affordable housing strategy. It will offer key professionals the opportunity of jobs and housing in the same county. SN asked if the hospital houses were still available for staff. MB confirmed they are. JG thanked SR for the key headlines for the Board of Directors meeting and agreed that MB's suggestion of the portal may help the Governors in the future. FC thanked the Council for their input and brought the meeting to a close.	**TRUST SECRETARY** **TRUST SECRETARY**
6.0	**Next Meeting Thursday 30th May 2019 at 2.30pm**	

COUNCIL OF GOVERNORS - SUMMARY OF KEY ACTIONS

Ongoing Actions	Lead Responsibility	Progress
New Actions	**Lead Responsibility**	**Progress**
SR and MB to look again at room configuration	Trust Secretary And Chief Executive	
Council comments to be included in any feedback to Sir Neil McKay	Chief Executive	
SB to report the RTT figures minus the spinal total and as a Trust total, in the Quality Accounts moving forward	Interim Director of Nursing	
SR to look at implementing adding the Governors onto the Board Portal for Board of Directors and Council of Governor's papers	Trust Secretary	
SR to confirm with the Chair of the Clinical Audit Committee and the Caldicott Guardian regarding Governors attendance	Trust Secretary	

Deloitte.

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Findings and Recommendations from the 2018/19 NHS Quality Report External Assurance Review – Draft report

23 May 2019

Contents

Executive Summary

We have completed our review of the Trust's Quality Report and testing of performance indicators

Status of our work

- We have completed our review, including validation of the reported indicators.
- We are awaiting a final copy of the Quality Report and upon receipt we will issue our signed opinion letter for inclusion in the Quality Report.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance For Quality Reports for Foundation Trusts 2018/19".
- We anticipate signing an unmodified opinion to be included in your 2018/19 Annual Report.

The Care Quality Commission (CQC) inspected RJAH in 2018. The Trust was given an overall rating of 'Good'.

	2018/19	2017/18
Length of Quality Report	109 pages	106 pages
Quality Priorities	5	3
Future year Quality Priorities	4	3

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected 18 week referral-to-treatment waiting times and 62 day cancer waiting times as the publically reported indicators, based on NHS Improvement's specified order of preference. As the Trust does not provide A&E services, they were unable to select the A&E four hour waits indicator as one of their mandated indicators.
  - For 2018/19, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected 28 day emergency admissions.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the 18 week referral-to-treatment waiting times and 62 day cancer waits indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
- Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: 18 week referral-to-treatment waiting times, 62 day cancer waits and 28 day emergency readmissions.

Executive Summary (continued)

Summary of Quality Report and indicator review

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We are in the process of completing our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

	Overall conclusion
Content Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	G
Consistency Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?	G

Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.

From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019, the indicators in the Quality Report, subject to limited assurance, have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2018/19".

	Mandatory 18 Week RTT	Mandatory 62 Day Cancer	Local Indicator 28 day readmissions
Accuracy Is data recorded correctly and is it in line with the methodology?	B	G	G
Validity Has the data been produced in compliance with relevant requirements?	G	A	G
Reliability Has data been collected using a stable process in a consistent manner over a period of time?	G	G	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period?	B	G	G
Relevance Does all data used to generate the indicator meet eligibility requirements as defined by guidance?	G	G	G
Completeness Is all relevant information, as specified in the methodology, included in the calculation?	G	B	G
Recommendations identified?	Yes	Yes	No
Overall conclusion	B Unmodified Opinion	B Unmodified Opinion	G No opinion required

G No issues noted A Requires improvement B Satisfactory – minor issues only R Significant improvement required

Content and consistency findings

Content and consistency review findings

The Quality Report meets regulatory requirements

Content of the Quality Report

We are in the process of reviewing the content of the 2018/19 Quality Report against the content requirements set out in NHSI's Foundation Trust Annual Reporting Manual and supporting guidance ("ARM").

We are in the process of reviewing the Trust's Quality Report and nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019, the content of the Quality Report is not in accordance with the 2018/19 ARM.

Consistency of the Quality Report

NHSI require auditors to undertake a review of the content of the Quality report for consistency with the content of other sources of management information specified by NHSI in its "Detailed Guidance for External Assurance on the Quality Reports".

We are in the process of reviewing the consistency of the Quality Report against this supporting information required by NHSI and:-

- We do not anticipate identifying any significant matters specified in the supporting information which are not specified in the Quality Report.
- We do not anticipate identify any significant areas of the Quality Report that could not be confirmed back to supporting evidence.

Statement of Directors' Responsibilities

NHSI require NHS FTs to sign a Statement of Directors' Responsibilities in respect of the content of the Quality Report and the mandated indicators. The guidance requires these to be published in the Quality Report.

As part of our work we will review the Trust's Statement of Directors Responsibilities to confirm it is an un-amended version of the pro forma provided by NHSI.

Stakeholder Engagement

NHSI require auditors to consider the processes which NHS FTs have undergone to engage with stakeholders.

The Trust has circulated the Quality Report to stakeholders and has not yet received feedback from Shropshire and Telford & Wrekin Clinical Commissioning Groups as required by the ARM. The Council of Governors have provided feedback and this is included in the Quality Report.

Performance and indicator testing

18 week referral-to-treatment times

Our testing identified no significant issues

	Trust reported performance	Target	Overall evaluation
2018/19	90.26%	>92%	B
2017/18	89.49%	>92%	B
2016/17	88.5%	>92%	B

Indicator definition

Definition: "The percentage of patients on an incomplete pathway who have been waiting no more than 18 weeks, as a proportion of the total number of patients on incomplete pathways," reported as the average of each month end position through the year.

The national performance standard for the incomplete referral-to-treatment (RTT) metric (92%) was introduced in 2012. This metric is about improving patients' experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

Approach

- We met with the Senior Information Systems Analyst, the Information Manager and RTT Validation Team Leader from the Trust to understand the process from patient referral to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process.
- We discussed with management and identified whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on. No periods were identified by the Trust. Therefore, we selected a sample that contained a mixture of breaches and non-breaches.
- We selected a sample of 25 from 1 April 2018 to 31 March 2019, following patient records through until treatment. Due to the errors noted our sample size was increased to 28.
- Our approach to testing was split into two phases:
  - We undertook testing of the clock start and stop dates and the validity of these events to assess whether these were recorded in line with national RTT guidance. As part of this, we also considered any validations undertaken by the Trust and its impact upon the clock start and stop dates.
  - We have also reviewed the RTT incomplete tracking lists to assess whether, upon continuation or completion, patients appear on the appropriate lists.

18 week referral-to-treatment times

Findings

Interview

Findings:

- The Trust confirmed that each step along a patient's pathway is recorded in the patient administration system (PAS), iPatientManager. Clinic outcome forms are used to obtain clinical information about the patient's treatment status. The information is then documented on PAS. All referrals must be entered onto the system by the last working day of the month.
- On the 9th working day a file is downloaded from PAS by an Information Analyst which is used to produce the monthly RTT upload. The data extraction process is based upon activity date rather than transaction date, to ensure any activity for the reporting month that is processed at the beginning of the following month is included within the extract. The RTT upload is submitted to the Strategic Date Collection Service on the 13th working day of each month.
- The validation team undertakes rigorous daily checks of all RTT pathways with a key focus on pathways which are approaching internal milestone standards or those approaching 18 weeks. The validation team review all pathways with missing outcomes to identify pathways with potential missing clock stops. Further, the validation team review each pathway each time a patient is added to a waiting list and each time a pathway clock stop occurs.
- At month end there is an assurance check of all breaches which have been removed during the validation process. The Trust records all reasons for why breaches have been removed.
- The Trust has significantly reduced the number of exclusions. There is now only one exclusion which relates to automated exclusions for duplicate pathways to ensure only one RTT pathway is reported.
- All exclusions and removed breaches are signed off by the Information Manager and the Director of Operations.
- An Operational RTT Leads (senior management) meeting is held on a weekly basis. The meeting provides a forum to share concerns between admissions, outpatients and bookers. Issues are escalated to a weekly meeting between the Director of Nursing, Director of Finance, the Patient Access Manager and the Theatre Manager.
- The Trust actively chases those referrals from other trusts which are received without an accompanying Inter Provider Transfer (IPT) form.
- The Trust carries out monthly audits of 40 RTT pathways (20 under 18 weeks and 20 over 18 weeks). Any errors that are found during audits have a route cause analysis completed which is owned and led by the Operational team.
- As the Trust have improved their processes over the last few years, they have been able to spend more time on developing their business intelligence. For example, the RTT team now has a Key Performance Indicator dashboard which shows how well directorates are performing against targets.
- RTT e-learning training has been introduced in 2018/19 for the booking and access teams.
- The Trust provides individual targeted training for staff who continue to incorrectly apply the RTT rules.

Issues: None noted.

18 week referral-to-treatment times

Findings

Testing

Findings:

There was 1 error identified within the sample testing of 25 records as outlined below. Due to the error noted our sample size was increased to 28. No additional errors were identified in the extended sample.

- Clock start and validity testing: 0 (0%)
- Clock stop and validity testing: 0 (0%)
- 18 week breach testing: 1 (3.6%)
- 18 week incomplete RTT lists: 0 (0%)

Issues:

- During our year-end testing, 1 error was identified which led to the Trust under reporting a breach. This was due to an early clock stop being entered incorrectly. This was validated at a later date but meant the Trust under reported a breach for one month. This has resulted in a blue rating for 'accuracy' and 'timeliness'. **Recommendation 1 – Staff training – data entry**

Recalculation

Findings: The Trust has achieved performance of 90.26% against a nationally set target of 92%, which reconciles with the performance figure included in the Trust's final Quality Report.

Issues: None noted.

Deloitte view:

During our year-end testing, 1 error was identified which led to the Trust under reporting a breach. This was due to an early clock stop being entered incorrectly. This was validated at a later date but meant the Trust under reported a breach for one month. This has resulted in a blue rating for 'accuracy' and 'timeliness'.

The findings observed have resulted in concluding an unmodified opinion with respect to the 18 week RTT incomplete pathways indicator and a blue rating overall.

62 day cancer waiting times

Our testing has identified no significant issues

	Trust reported performance	Target	Overall evaluation
2018/19	58.3%	>85%	B
2017/18	75.8%	>85%	B
2016/17	92.6%	>85%	B

Indicator definition

Definition: "Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer."

The NHS Cancer Plan set the goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons.

Approach

- We met with the Trust's lead for 62 day cancer waits to understand the process from an urgent referral to the Trust to the result being included in the Quality Report.
- We evaluated the design and implementation of controls throughout the process.
- We selected a sample of 18 from 1 April 2018 to 31 March 2019 including in our sample a mixture of records in breach and not in breach of the target.
- 2 errors were identified during testing, however, as there were only 18 patient pathways to test, we were unable to extend the sample size.
- We agreed our sample of 18 to supporting documentation.

62 day cancer waiting times (continued)

Findings

Findings

Interview

Findings:

- The Trust has an EPR system in place and patient records can be accessed electronically.
- The Somerset Cancer Registry was introduced 1st April 2018.
- Somerset is a software application designed to collect relevant data throughout the patient's cancer journey. It allows information to be uploaded for national reporting purposes automatically.
- The Cancer team have employed a new 'Somerset administrator'. This individual also helps to cover the Cancer Patient Pathway Coordinator's (CPPC) role if they are ever absent.
- Following the introduction of Somerset, a Standard Operating Procedure has not yet been produced to formally document the processes involved in the capturing, recording and reporting of data, alongside escalation processes.
- The CPPC validates patient pathways to ensure data is accurate as new Cancer referrals are received.
- At month end data is downloaded from Somerset by the Information Team and any discrepancies are reconciled with the CPPC. Any adjustments are made before the deadline for the national submission.
- The Information Team prepare data for the Integrated Performance Report which is reported to Trust Board. Reports are also produced for the Finance, Planning and Digital Committee, Surgical Division, NHSI and CCGs.
- In previous years there have been issues in terms of capturing evidence for treatment dates for referred patients. To overcome this issue:
    - Emails from the receiving trusts are scanned on to the EPR to provide clear evidence that treatment has commenced.
    - The CPPC records the details of patient pathways which are shared within the commentary section of Somerset, including email and verbal updates via telephone.
    - The Trust has added wording to its referral letters reminding trusts to keep them informed of the patient pathway.
- All English cancer referrals must go through the e-referrals system as of 1st October 2018.

Issues: None noted.

Testing

Findings:

There were 2 errors identified within the sample testing undertaken as outlined below:

- Date of referral (start date): 0 (0.0%)
- Date of first treatment (stop date): 2 (11.0%). In addition there were 2 records where we were unable to conclude the stop date from the evidence available.
- 62 day breach testing: 0 (0.0%)

62 day cancer waiting times (continued)

Findings

Findings

Testing (continued)

Issues:

- During testing we identified 2 stop date errors. In both cases the Trust incorrectly reported the date the surgery took place rather than the admission date. This did not impact on the accurate reporting of a breach/non-breach. **Recommendation 2 - Staff training – stop dates**

In addition to the errors noted above 2 records were identified where we were unable to confirm the clock stop dates from the patient records. The Trust confirmed that the patients had been referred onto other organisations for treatment and were not able to provide documented evidence to confirm treatment had commenced. **Recommendation 3 – Standard Operating Procedure**

Recalculation

Findings: The Trust has achieved performance of 58.3% against a nationally set target of 85%. These figures reconcile with the performance included in the Trust's Quality Report.

Issues: None noted.

Deloitte view:

During testing 2 stop date errors were identified. The errors were not material to performance. Due to the errors identified an amber rating has been allocated to 'validity'.

In addition 2 records were identified where we were unable to confirm the clock stop dates from the patient records due to a lack evidence. In both cases the cancer pathway was shared with other providers. The Trust requests email evidence from the other organisations to provide a record of clock starts and stops that can be saved to the EPR, but other Trusts often fail to provide this. This has resulted in a blue rating for 'completeness'.

The findings observed have resulted in concluding an unmodified opinion with respect to this indicator and a blue rating overall.

28 day emergency readmissions

Our testing has identified no issues

	Trust reported performance	Target	Overall evaluation
2018/19	0.91%	1.00% (local target)	G

Indicator definition

Definition: The Trust is required to measure their performance using the following calculation:

- Numerator: The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0-27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon readmission coded under obstetric; and those where the readmitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.
- Denominator: The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to March 31st within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.

Approach

- We met with the Trust's leads for 28 day emergency readmissions to understand the process of identifying 28 day emergency readmissions to the overall performance being included in the Quality Report.
- There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 25 from 1 April 2018 to 31 March 2019 including reportable and non-reportable samples.
- The sample of 25 was tested back to the Patient Administration System (PAS) and Electronic Patient Record (EPR).

28 day emergency readmissions (continued)

Findings

Findings

Interview

Findings:

- The Trust maintains a spreadsheet which is updated via SQL queries to cross-reference new admissions against previous patient cases to configure the time since the last admission.
- The SQL query excludes maternity and chemotherapy patients. The Trust does not provide maternity or chemotherapy services.
- The spreadsheet includes information about the readmission source and whether it occurred within 28 days of the last discharge.
- Where patients have been readmitted within 28 days Information Analysts investigate the Electronic Patient Record (EPR). If clinical advice is required to validate the emergency readmission they will contact a matron.
- Emergency admissions are recorded in the Patient Administration System (PAS).
- The local spreadsheet is checked by the Data Quality Team weekly.
- There is also a monthly check by the Date Quality Team on the 5th or 6th working day whereby inpatient activity is checked to ensure the admissions picked up via the SQL query are non-elective admissions.
- The process is well documented and there are instructions to follow if the Information Lead is absent.
- The indicator is reported as part of the Integrated Performance Report to the Trust Board on a monthly basis. A version of this report is also reported to the Quality and Safety Committee.
- Divisional score cards are also produced for each surgical division.
- Performance is reported at the Quality Meeting with Commissioners on a monthly basis.
- The Trust has set itself a performance target for this indicator of 1.00%.
- No internal reviews have been carried out in year and this indicator is not a CQUIN for the Trust.

Issues: None noted.

Testing

Findings:

- Date of admission : 0 (0%)
- Date of discharge : 0 (0%)
- Date of emergency readmission: 0 (0%)
- Breach testing: 0 (0%)

Issues: None noted

28 day emergency readmissions (continued)
Findings

Findings

Recalculation

Findings: The Trust reported performance of 0.91% for 28 day emergency readmissions against a target of 1.00%. These figures reconcile with the performance included in the Trust's Quality Report.

Issues: None noted.

Deloitte view:

No errors were identified during testing, all data used to generate the indicator meets eligibility requirements and there are validation processes in place to ensure reporting of the indicator is accurate. The findings observed have resulted in concluding a green overall rating with respect to the indicator.

Appendices

Appendix 1: Recommendations for improvement

We have outlined a number of recommendations for the Trust as a result of issues identified from our audit

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
18 week referral-to-treatment	**Recommendation 1 – Staff training – data entry** The Trust should ensure there is a continued focus on staff training for data entry to support accurate reporting of clock stops.	Standard Operating Procedures and presentations provided to all staff on RTT, RTT e-learning available to all staff and weekly training session on RTT in place. RTT quiz to be launched. **Responsible Officer:** Alyson Jordan, Head of Patient Access **Timeline:** May – July 2019 **Process for updating Council of Governors:** Update at the council of Governor meetings.	Medium
62 day cancer waits	**Recommendation 2 – Staff training stop dates** The Trust should ensure the treatment date (stop date) is accurately recorded where patients are admitted for surgery. Staff should be trained to identify the correct date.	Standard Operating Procedure to be in place along with robust training. **Responsible Officer:** Alyson Jordan, Head of Patient Access **Timeline:** May – July 2019 **Process for updating Council of Governors:** Update at the council of Governor meetings.	Medium
62 day cancer waits	**Recommendation 3 – Standard Operating Procedure** It is recommended the Trust produces a Standard Operating Procedure which documents the processes for referred patients including the need to scan evidence from other trusts confirming treatment onto the EPR. As part of this the Trust should also consider creating a Single Cancer Tracker Mailbox so that the Cancer Patient Pathway Coordinator and Somerset Administrator have access to the same email trains, with evidence of treatment, when validating pathways.	Email box is in place now following recommendation. Standard Operating Procedure to be completed. **Responsible Officer:** Alyson Jordan, Head of Patient Access **Timeline:** May – July 2019 **Process for updating Council of Governors:** Update at the council of Governor meetings.	Medium

Appendix 2: Update on prior year recommendations

Our prior year recommendations have been addressed or are ongoing

Indicator	Deloitte Recommendation	Current year status
18 weeks referral-to-treatment	**Recommendation 1 - Staff training – Inter Provider Transfer forms** The Trust should consider reminding staff of the importance of ensuring completed IPT forms are provided where patients are referred on from other providers for treatment during their RTT pathway. **Responsible Officer:** Nia Jones **Timeline:** Ongoing process	**Management Update:** Training has been ongoing on IPT forms to existing and new staff and all staff to be signed off competent. **Current Status:** Welcome pack as part of staff training is in place and includes IPT 1 to 1 sessions and reminders are in place and sent to all staff on the importance of IPT. Inpatient staff have been trained and signed off competent on IPT forms. Outpatient staff had a training week 8 April and majority signed off competent. Focus is on getting 100% competent by end of June
18 weeks referral-to-treatment	**Recommendation 2 - Timeliness of validation** The Trust should review the focus and timing of validation to avoid incorrectly reporting breaches. **Responsible Officer:** Ian Roberts – Information Manager **Timeline:** 30th June 2018	**Management Update:** We have undertaken a review of our validation processes and following this steps have being taken to strengthened them with particularly emphasis on patients who move between different waiting lists. **Current Status:** Complete.
62 day cancer waits	**Recommendation 3 - Shared patients** The Trust should ensure processes are in place to follow up referred patients to capture evidence for treatment dates and referral dates. **Responsible Officer:** Nia Jones **Timeline:** Ongoing process	**Management Update:** Robust processes to be reviewed and put in place to ensure all dates captured. **Current Status:** All staff to be signed off competent in Standard Operating Procedures.

Appendix 2: Update on prior year recommendations

Our prior year recommendations have been addressed or are ongoing

Indicator	Deloitte Recommendation	Current year status
62 day cancer waits	**Recommendation 4 - Staff training – start dates** The Trust should ensure the referral date (start date) is accurately recorded from the GP referral form. Staff should be trained to identify the correct date. **Responsible Officer:** Nia Jones **Timeline:** Ongoing process	**Management Update:** As below. **Current Status:** Further training to be provided along with robust Standard Operating Procedures in place.
62 day cancer waits	**Recommendation 5 - Staff training – stop dates** The Trust should ensure the treatment date (stop date) is accurately recorded where patients have been referred onto other trusts for treatment. Staff should be trained to identify the correct date. **Responsible Officer:** Nia Jones **Timeline:** Ongoing process	**Management Update:** As below. **Current Status:** System issue on Somerset causes date issue, training to be documented and Standard Operating Procedures put in place.

Responsibility statement

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP

24 May 2019

Deloitte.

Membership Session Update

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	30 May 2019
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance and Quality
Paper Reviewed by:		Paper Ref:	N/A
Forum submitted to:	Council of Governors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the Council of Governors and what input is required?

The Council of Governors is asked to ***note*** the progress with actions agreed during the development session held in January 2019

2. Executive Summary

2.1. Context

In January 2019 the Trust invited NHS Providers to facilitate a development session with Council regarding its membership strategy and the ways in which membership could be improved. During this session a number of actions were suggested and taken away by the Trust Secretary

2.2 Summary

This paper presents an update with the progress of the actions suggested by the Council of Governors.

2.3. Conclusion

The Council of Governors is asked to **note** the progress with actions agreed during the development session held in January 2019

RJAH Council of Governors Governwell Training - Thursday 10 January 2019

Action Plan

Action	Date for Completion	Progress Update
Patient experience update at COG	May	On Agenda
Sports injury clinics for recruitment	June	SR meeting with Liz Reece
Publicise speakers for AGM	August	Gill Cribb confirmed as speaker
Membership leaflet to go in discharge packs	June	Additional leaflets ordered, SR to liaise with ward clerks/ward managers and matrons
Members open day	September	Will link with AGM
Explore membership information - screens in public areas	June	SR meeting with Phil Davies
Governors poster board – add leaflet holder	March	Completed
Pop up banner for recruitment	March	Completed
Surveys – via newsletter or separate means	July	Survey to be distributed via newsletter
Target medical centres/GP's to raise awareness of governors and seek feedback	June	Posters being produced
Target: Volunteers, League of Friends, staff families, patients and their families	June	SR meeting with Helen Knight and Victoria Sugden

Work Programme Review 19/20

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	30 May 2019
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:	N/A	Equality and Diversity Impact Status:	N/A
Forum submitted to:	Council of Governors	Paper FOIA Status:	Disclosable

1. Purpose of Paper

1.1. Why is this paper going to Council of Governors and what input is required?

This paper is presented to the Council of Governors to **note** the work plan.

2. Executive Summary

2.1. Context

It is best practice for committees to have a work plan in place to ensure that all of the areas required under the Governors Statutory duties will be covered.

2.2. Summary

This report sets out the work plan agreed by the Council of Governors the meeting dates for 2019/20 have been added and a proposed work plan outlined.

2.3 Conclusion

The Council of Governors are asked to ***note*** the work plan for 2019/20

Work Programme Review 19/20

	30th May 2019	25th July 2019	26th Sept 2019	28th Nov 2019	27th February 2020	April Meeting 2020 (TBC)
Statutory Reports						
Receive Annual Report and Accounts			X			
Receive Audit Reports			X			
Forward plan						
Consider strategic issues/priorities for Board to consider in the planning process					X	
Presentation of plan		X				
Quality						
2019 priorities					X	
Quality Indicators to be audited					X	
Quality accounts draft presented						X
Update on Quality Accounts Audit Actions	X	X		X	X	
Trust Developments						
As & When required	X	X		X	X	X
COG Strategy docs						
Membership & Engagement strategy						X
COG Governance						
COG Self-Assessment (inc review of outcomes from training)		X				
COG Annual report (for approval)		X				
COG Annual report presentation			X			
Standing items						
Membership report	X	X		X	X	X
Review of work programme	X	X		X	X	X
Question & Answer	X	X		X	X	X
Board Refection	X	X		X	X	X