The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 31.01.19

MEETING
31 January 2019 09:30

PUBLISHED
29 January 2019

Agenda

Location	*Date*	*Owner*	*Time*
Boardroom, Main Entrance	31/01/19	Frank Collins	09:30

1. Part One - Public Meeting		
1.1. Matters Arising	All	09:30
1.2. Minutes of the Previous Meeting (29th November 2018)	All	09:35
1.3. Declarations of Interest	All	09:40
1.4. Patient Story	Director of Nursing	09:45
1.5. Staff Story - Outreach Team	Director of Nursing	09:55
1.6. Chief Executive Update	Chief Executive	10:05
1.6.1. CQC Update	Chief Executive	
2. Strategy & Policy Updates		
2.1. Long Term Plan		
2.1.1. Planning Guidelines and Assumptions	Director of Strategy / Director of Finance	10:15
2.2. Standing Financial Instructions & Scheme of Delegation	Director of Finance	10:30
3. Quality & Safety		
3.1. Chair Report: Quality and Safety Committee	Non Executive Director	10:35
3.2. Chair Report: Risk Management Committee	Non Executive Director	10:40
3.3. Board Assurance Framework	Trust Secretary	10:45
3.4. Infection Control Quarterly Report	Director of Nursing	10:55
3.5. Freedom to Speak Up Update	Director of Nursing	11:00

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4. Performance & Governance		
4.1. Chair Report: Audit Committee	Non Executive Director	11:05
4.2. Chair Report: Finance Planning and Investment Committee (verbal)	Non Executive Director	11:10
4.3. Corporate Objectives Quarterly Review	Director of Strategy and Planning	11:15
4.4. Performance Report	Interim Associate Director of Performance	11:25
4.4.1. Financial Forecast	Director of Finance	
5. Items to note		11:55
5.1. M8 Performance Report	Interim Associate Director of Performance	
5.2. STP Update	Chief Executive	
5.3. Quality Surveillance Outcomes Notification Letter	Chief Executive	
5.4. Governors Update (verbal)	Trust Secretary	
6. Any Other Business	All	
6.1. Questions from the Public		12:15
6.2. Next meeting: 28th March in Meeting Room 1		

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC SESSION
29 NOVEMBER 2018
MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive	MB
Craig Macbeth	Director of Finance	CM
Nia Jones	Director of Operations	NJ
David Gilburt	Non-Executive Director	DG
Hilary Pepler	Non-Executive Director	HP
Bev Tabernacle	Director of Nursing	BT
Steve White	Medical Director	SW
Harry Turner	Non-Executive Director	HT

In Attendance:

Shelley Ramtuhul	Trust Secretary	SR
Sarah Sheppard	Director of People	SS
Debbie Kadum	Interim Associate Director of Performance	DK
Kerry Robinson	Director of Strategy and Planning	KR

FC opened the meeting with an announcement that this was HP's last Board Meeting as a Non-Executive Director. FC extended his thanks and appreciation for HP's efforts as a Non-Executive Director and was pleased to announce that HP had accepted an invitation to assume the role of Cultural Ambassador for the Trust and Advisor to the Board for a period of two years. In this role, HP will focus on equality and diversity, freedom to speak up and organisational culture.

FC also announced the re-appointment of David Gilburt as Non-Executive and Chair of Audit Committee following endorsement of his re-appointment from the Council of Governors.

MINUTE NO	TITLE
29/11/1.0	**APOLOGIES** Chris Beacock, Non-Executive Director
29/11/2.0	**MINUTES OF THE MEETING 27 SEPTEMBER 2018** The minutes of the meeting held on the 27th September 2018 were agreed as an accurate representation of the meeting.
29/11/3.0	**MATTERS ARISING** FC went through the actions which were noted to be completed or progress updates provided.
29/11/4.0	**DECLARATIONS OF INTEREST** None
29/11/5.0	**PATIENT STORY (PHIL BOUSFIELD)** FC advised that the patient has sent apologies unexpectedly due to family illness. BT provided an overview of the story that the patient had been due to share. She advised that Mr Bousfield has been associated with the hospital for some 30 years and has undergone many surgeries and ongoing care as an amputee. He wanted to share his story as he was very complimentary about his experiences. There was a press release in May this year which told his story about his disability.

	FC thanked BT for the summary and advised that the Board would try to get Mr Bousfield to a future meeting. The Board ***noted*** the summary of the patient story.
29/11/6.0	**END OF LIFE CARE** Julie Roberts, Assistant Director of Nursing and Clinical Governance attended to provide an overview of the Trust's work on end of life care. (The Board noted that Mr Ockendon, Consultant Spinal Surgeon had hoped to also attend but he was in Theatre). Julie introduced the Swan Model of End of Life and Bereavement Care and advised that this was first implemented in Salford Hospital in 2012 and has since been rolled out in over 50 hospitals. Julie explained that it is a patient and family focussed model aimed at empowering staff to care and to break the rules that do not exist. Julie provided an overview of the requirements of the model and the progress the Trust has made so far as follows: • End of life care champions in place • Clear terms of reference for end of life care group • Training has been rolled out • Free car parking for bereaved families • Hot drinks and cake vouchers in the new swan boxes • New Swan signs, so staff aware of what it means • Porters have asked to be included in debriefs • Funds identified for the replacement of the swan boxes and consumables HT asked about unexpected deaths and JR confirmed that this model applies to all deaths. HT also asked about cultural differences in dealing with unexpected deaths. JR advised that this has been recognised and by linking with Salford who have done a lot of work with ethnic communities, the Trust can learn from them DK asked whether there were plans to introduce Swan Rooms and JR advised that this is under consideration with early suggestions for Sheldon Ward to have a Swan Room BT commented that she was involved when this was first pioneered by Fiona Murphy at Salford and a lot of work went into the whole process and highlighted that this is not limited just to deaths in hospital. Patients can be treated within a hospital for a long time but may not die there and this has an impact on the teams. This model is cognisant of that. BT added that the Trust does not have that many deaths and that makes it even more important to have something to remind everyone of the competencies. FC acknowledged that the infrequency magnifies the importance of getting this right and commented that he was particularly pleased the porters have recognised their contribution in this. AF asked how the Trust supports or protects the boundaries for staff. JR advised that this model is individualised and will support staff who seek advice. MB added that around the basic concept of treating all patients as you would wish to see you're your family treated, there are very good systems and specialist staff to provide support.

	HT commented that the experts in palliative care are in hospices. He is aware that Hospice UK are doing a lot of work in this area. He advised he would be happy to facilitate connections. JR advised that the Trust have linked with the local hospices but she would always be willing to explore other opportunities. FC thanked Julie for attending and sharing the Trust's work on end of life care. The Board ***noted*** the presentation.
	STRATEGY AND POLICY UPDATES
29/11/7.0	**CHIEF EXECUTIVE UPDATE** MB provided an update on the following: • A thank you to staff for their openness and honesty with the CQC inspectors. The process is ongoing with well led interviews being held next week. • Prior to the CQC inspection, there was some CQC intervention around the Trust's IRMER processes in diagnostics. An improvement notice was issued but has since been lifted as a result of the hard work to get the processes and policies in order. • MB acknowledged the situation at SaTH and their CQC status. He confirmed that the Trust has reached out to the senior team to offer support. • MB welcomed Sir Neil McKay into the system as STP Chair. There is a meeting planned for the New Year to look at understanding what an integrated system looks like and the Trust's role in that. • MB is continuing to enjoy being the Digital Lead for the STP as there is a lot more that can be done to share health and social care information • SS has done some work around the European Settlement Scheme – the Trust's European staff have to pay £65 to go through the settlement scheme and the recommendation to the Board is that the Trust will pay this. SS added in addition to the financial support there will be support through the process. This decision was endorsed by the Board. • Thanks to SW his work to recruit to a new professorial role. The Trust is looking to make two appointments, firstly for a professor or senior lecturer in population orthopaedics and the second in a role of regenerative orthopaedics. • The Trust has received a Gold Award for supporting its Armed Forces staff. Maggie Durant attended to present the award to FC on behalf of the reservists. • The Veterans Orthopaedic Centre Appeal officially launched at Westminster. • The Trust held a STAR Conference with Steve Head as guest speaker. BT commented on his delivery and the tools he gave staff to work on their resilience. • Trust representatives attended the HSJ Awards as one of six finalists in 'Trust of the Year' category. • Celebration of Achievement Awards • Health Heroes – Louise Wakefield in Finance Team, Mike Bartholomew in Stores. MB went on to provide an overview of the Horatio's Garden Scheme. He confirmed that the ground break event has taken place and the plan of work is due to complete for an opening in April next year. **ACTION: Agenda item on integrated systems for next Strategy Board** The Board ***noted*** the Chief Executive's Update
29/11/8.0	**BACK TO THE FLOOR** KR provided a recap of the event held on 8 November. She explained this was the third event of its kind with more senior leaders involved than before (24 managers visiting 48

	areas). This was started as a result of feedback from the staff survey and Barometer Group and was aimed at improving communication between staff and managers. The Board noted the letters sent from the managers involved to the areas they visited. The following staff attended to share their experience of the day: *Connor Hodgetts – Interim Superintendent Radiographer* Connor explained he had hosted CM in Radiology. He had shown CM around the department and CM was able to experience the full diagnostic pathway from receipt of the request form to the reporting of the x-ray. Connor advised that the event was well received by the staff as it allowed them the opportunity to communicate directly with people they may not usually come into contact with. *Heidi Fuller, Lecturer in Medical Science* Heidi explained that FC had visited the research laboratories where he was able to see first-hand the breadth of research that was undertaken. She wanted FC to explore all the different areas and to demonstrate some of the basic experiments undertaken by the team. Heidi explained that most of the staff are employed by Keele University and hold honorary contracts with the Trust so it was good to be able to explain the relationship. The team were appreciative of the level of engagement. FC commented that it was a fantastic day for him to experience the work undertaken in the research laboratories. He commented on the strength of relationship between the Trust and the university and the long term patient benefit of the work they do. *Becky Warren – Ward Manager and Mark Salisbury – Deputy Director of Finance* Becky explained that the MCSI team had hosted MB and Mark Salisbury. She wanted them to understand the patient and staffing perspective of spinal injury care. MB had helped to wash a patient as she wanted him to understand the challenges of washing a paralysed patient. She also wanted them to experience what it is like to be a paralysed patient so with the use of weights, braces and gloves they were able to recreate scenarios spinal patients often experience. MB commented that the experience had demonstrated to him the importance of having the right staff. Mark Salisbury commented on the hard work physically and emotionally. He added that he had also visited Kenyon Ward which had recently been refurbished. As he had been involved in the financial sign off of the refurbishment work it was great to see the benefits of this for patients and staff. FC thanked colleagues on the speed with which the letters of endorsement had been issued following the event and added that they make for great reading. KR confirmed that another event is already being planned. The Board ***noted*** the update
29/11/9.0	**STRATEGY BOARD SUMMARY** KR presented a summary of the Strategy Board held in October. She advised that this is held in private due to commercial sensitivities but a summary was being presented for openness and transparency. KR outlined the following headlines from the meeting: • An overview of the process for development and implementation of the organisational strategy was provided for context • Delivery and achievement against the strategy since 2016 was considered • Prioritising focus on horizon two was agreed

	• External environment changes and their impact on Trust were considered • The role of RJAH for the future was debated HT said that the Trust needs to make sure it is sighted on the emerging landscape to ensure that it is ready to react. He queried the Trust's scenario planning particularly given that the Integrated Care Systems (ICS) are emerging at different paces. The Trust could look at different ICSs across the country. FC advised that some of this can revisited at the next Strategy Board. It has already been agreed that some time will be spent on developing an understanding of ICS and he was supportive of adding into this scenario planning. He was also conscious of including the Council of Governors in some of this work. **ACTION: Scenario planning to be included in the agenda for the next Strategy Board** **ACTION: Consideration to be given to holding a session for the Governors** The Board ***approved*** the summary as a position statement
	QUALITY AND SAFETY
29/11/10.0	**CHAIR'S REPORT - QUALITY AND SAFETY COMMITTEE** HP informed the Board that the committee had looked at outstanding issues in some detail such as the SOOS Service and Histopathology accreditation. There were some concerns with the progress of the action plan for the histopathology accreditation work but NJ has provided additional assurance regarding this since the meeting. The committee received a Divisional Quality Report from the Medicine Division and noted that this was the first report of this type from Medicine and that progress will be tracked with the second round of reporting. HP highlighted the culture and leadership work that was noted to have been undertaken in the Diagnostics Division and it was clear that had been good progress with a lot of work to make positive changes. SR added that the Board had previously received an update on the Trust's duty of candour work and she confirmed that the committee approved the new Duty of Candour Policy. The Board noted the Chair's Report.
29/11/11.0	**CHAIR'S REPORT - RISK MANAGEMENT COMMITTEE** SR presented the report in CB's absence and highlighted the following: The committee had received the Board Assurance Framework (BAF) and Corporate Risk Register. The committee was assured by the progress against the gaps in controls and assurances cited on the BAF but was only partially assured by the Corporate Risk Register and asked for additional review of the risks to be completed by the next meeting. The committee received reports on the Trust's risk management and patient safety alert management and was assured by both. The committee particularly noted the robust processes for the safety alert management. The committee received a deep dive into IT risks and was assured that these were being appropriately managed.

	The Board ***noted*** the Chair's Report.
29/11/12.0	**BOARD ASSURANCE FRAMEWORK** SR presented the Board Assurance Framework which had previously been presented to the Risk Management Committee. There had been no material changes to the risks but progress updates have been provided regarding the actions being taken to address the identified gaps in controls and assurances. MB highlighted the need to consider the acute services locally and the potential impact on the Trust. HT agreed that the risk to acute services may result in operational risks for the organisation. MB advised that this will be taken through operational Board and SR confirmed it would be considered for inclusion in the BAF. **ACTION: Operational Board and Executive Team to consider the impact of current issues impacting the local acute services on the Trust's operational risks.** CM commented that there are risks emerging around Brexit. SR advised that a risk has been added to the risk register and this will be considered in the context of the BAF. **ACTION: Brexit risk register entry to be considered in the context of the BAF** AF highlighted that risks 1.5 and 1.6 had been considered by the Finance Planning and Investment Committee earlier in the week with the following considered: Risk 1.5 relating to tariff stands at an amber rating. This was previously a red risk but was reduced due to an understanding that any agreed tariff would stand for 2 years. It has now been made clear that this will be a 1 year tariff but the downside on income remains capped at 2%. It was therefore agreed to leave this as an amber risk but important to recognise its potential as a significant risk. Risk 1.6 relating to operational processes was discussed and it was decided that additional controls and assurances were required in relation to the governance of these processes. It was noted that these would be picked up through the Performance Reviews. **ACTION: Review of additional controls and assurances regarding governance of surgical throughput and the achievement of activity plan** CM advised that in relation to Risk 1.5, the draft tariff has been published with the final tariff likely to be published before Christmas alongside the planning guidance. At this stage the Trust will be able to take a firm view on the risk. In the meantime, the NOA are supporting discussions regarding the specialist tariff. The Board ***noted*** the BAF
29/11/13.0	**INFECTION CONTROL QUARTERLY REPORT** BT presented the quarterly report on infection control and highlighted the collaboration this reflects between Estates and the Infection Control Team. BT highlighted the following: • The Trust currently has one acquired C.Diff following a successful appeal for the most recent case of C.Diff. This means the Trust remains on target for the year. • The HBV decontamination system was first used last year following MRSA on the Spinal Unit but it has been used more regularly since. BT confirmed that the Board will receive an update on its use going forward and whether an in-house system is required.

	• The Trust has continued to perform well in relation to MRSA • BT referred the Board to the training and audit results in the report for information • With regard surgical site infections, these were within parameters for hips and knees but spinal infections were an outlier. Individual consultant analysis has been undertaken with consistently low rates calculated per consultant with no themes or trends. The Trust is looking at whether there any data from Europe that can be used to undertake some benchmarking. BT advised that this will be reported on in the next quarter. DG asked for clarification about reportable MRSA cases and BT clarified that MRSA bacteraemia is blood borne which is reportable but MRSA present on the skin is not. The MRSA on the Spinal Unit was not reportable. FC asked about the graph on page 13 and queried the time period versus the incidents. BT agreed that this needed to be looked at again. HT asked about the hand hygiene and bare below elbow compliance. In particular he noted that Ludlow Ward had improved but appeared to be an outlier. BT commented on the challenges with carrying out the audits on Ludlow ward due to fact patients are cared in side rooms. BT confirmed that the ward manager has this as an area of focus. The Board ***noted*** the report.
29/11/14.0	**GUARDIAN OF SAFE WORKING** SW presented the report which outlines the safe working hours for doctors in training. He confirmed that there were no exceptions to report. SW expressed his gratitude to Chris Marquis for his work on this. DG commented that the report is as presented to Quality and Safety Committee, however, there were issues with the availability of data at the time. He asked if this had subsequently been made available and SW advised it had and that there was nothing to report. The Board ***noted*** the report.
29/11/15.0	**SAFE STAFFING INCLUDING DEVELOPING WORKFORCE SAFEGUARDS** BT presented the Board with an update on the Trust's safe staffing monitoring and outlined the escalation framework in place. BT advised how the Trust triangulates its staffing data with its incident data to ensure with no relationship identified between the Trust's incidents resulting in harm and staffing levels. BT also highlighted that an external consultant had been contracted to conduct a review of its nursing workforce.
29/11/16.0	**POLICY UPDATE AND POLICY FRAMEWORK** SR presented an update on the work the Trust has undertaken in relation to updating its Policy Database. Unfortunately, a significant number of policies had been identified as overdue for review and by way of response a risk based approach has been taken to prioritise those linked to the former NHSLA Risk Management Standards and following consideration of the Trust's incident data. The paper outlined the progress that has been made in reviewing and ratifying the higher risk polices with all either now ratified or under review with all anticipated to be ratified by the end of January 2019. In addition the remaining policies overdue for review are being tracked with all anticipated to be up to date by the end of the financial year.

	SR also presented the updated Policy Framework Strategy and highlighted the changes that had been made as follows: • Clearer roles and responsibilities in terms of updating the policies • Change in some of the ratifying bodies to ensure these were Trust committees • Extension of the review period from two years to three years • The ability to make minor but non-material changes without the need for further committee review • A clearer template for the policy format The Board ***noted*** the update and ***approved*** the Policy Framework Strategy
	PERFORMANCE AND GOVERNANCE
29/11/17.0	**CHAIR'S REPORT - AUDIT COMMITTEE** DG presented the Chair's Report. He highlighted that the committee was not quorate but there were no decisions required on this occasion. DG highlighted the following: • The committee received the Register of Interests and noted the reduction in compliance. However he was assured that this would be restored by the end of the financial year. • The committee noted the good progress with the Counter Fraud Action Plan. • The committee received a report from the Trust's Internal Auditors. An issue was raised regarding the recording of patient waiting times on Bluespier but following referral to the Finance Planning and Investment Committee assurance was gained. • The committee had previously had serious concerns about an information governance breach but was assured that this had been fully investigated by the Trust and the ICO case had been closed. The Board ***noted*** the Chair's Report.
29/11/18.0	**CHAIR'S REPORT – FINANCE PLANNING AND INVESTMENT COMMITTEE** AF provided a verbal report of the meeting which had taking place two days earlier. The meeting was fully quorate and the main agenda item was the performance of the activity in relation income and expenditure. It was noted that all service lines had made a contribution with variable margins. The committee also spent time going through the internal audit report The Board ***noted*** the Chair's Report
29/11/19.0	**CORPORATE OBJECTIVES UPDATE** KR presented an update of the Trust's current position against the corporate objectives. KR asked the Board to note the progress and confirmed that any indicated as amber had mitigating action plans in place. HT commented that it might be useful to have an assessment of where it is predicted performance against the objectives will be at the end of the financial year. KR confirmed that she would include this in the next report. **ACTION: Quarter 3 report to include a future look of where the performance is anticipated to be at year end against the objectives** The Board ***noted*** the Report
29/11/20.0	**PERFORMANCE REPORT M7**

DK introduced the Performance Report for M7. She advised that the Trust remains in segment 2 with an ambition for segment 1. There were three exceptions reports which were appended to the report.

DK also highlighted the layout changes and the fact that the detail has been moved to the back of the report because this had already been discussed at the committees..

Finally, DK advised that work had begun to link the report with the service improvement work and the impact this is having on the KPIs.

Caring for Patients

BT highlighted the following:

- The Trust reported one serious incident. This related to a patient triaged into SOOS to the wrong pathway. A full Root Cause Analysis is underway. Initially 17 patients were identified as at risk but of these only 2 required ongoing care which has since been received.
- The Trust reported a Never Event. A wrong sized prosthesis had being placed in the patient whilst in Theatre for a hip replacement procedure. This error was identified and rectified during the operation and given that the patient was not harmed there was no duty of candour obligations involved. The incident is being investigated and the staff members involved have been fully supported and helpful in looking at how this can be avoided in the future.
- There has been a slight increase in reported falls but with no or low harms and no serious incidents. It is recognised that the Trust has a large number of patients who do not comply with advice. An update on the Trust's falls prevention work went to Quality and Safety Committee this month and a new post campaign has been launched called 'Call or Fall'.
- There were 13 complaints in October. There is a new WICCMM (Weekly Incidents, Complaints and Claims Management Meeting) looking at those weekly complaints and incidents and deep diving into areas of recurrence or identified potential themes and trends. This will report back through Quality and Safety Committee. Overall complaints remain relatively low.
- Delayed discharges have increased. A paper went to Quality and Safety Committee which outlined the actions and improvements being undertaken. The plan is to take this back in January to update on progress. Delays in the system relating to equipment are currently coming out as a theme.
- There was one C. Diff case for September which has been successfully appealed.

HT asked about the delayed discharge and what mitigations are in place to address the increase that is likely to occur in line with the increase seen last year. BT advised of changes in process and getting an executive response to some of the delays. NJ felt that the Board was right to be concerned. The longest delays are with the Trust's complex patients and commissioner meetings are taking place to keep the momentum going on ensuring discharge arrangements are in place outside of RJAH.

SW confirmed that he had no exception to report.

NJ highlighted the following:

- Theatre cancellations on the day continue to be on target year to date with 14 reportable and 30 non reportable.
- One patient exceeded the 62 day cancer treatment target
- RTT stood at 90.66% with the trajectory met for the month.
- There were two patients waiting over 52 weeks. These were in relation to ACI treatments and discussions have taken place with NHSI regarding specialist nature

of this work and the extenuating circumstances. Due to a combination of patients having to restart their pathway following the death of Prof. Richardson, staff sickness and also the lack of alternative service providers has resulted in there being no easily accessible alternative. Assurance has been sought from NHS I around delivery of treatment by end of Mach 2019 and full harms assessments have been completed. There are three breaches anticipated for November, with a further increase in December and then reduction trajectories to the end of March.

FC asked about change in breach guidance and NJ advised this is due to come into effect at the beginning of the next financial year.

FC asked that for Board monitoring purposes the ACI specific patients are separated out and reviewed as "exceptional".

ACTION: ACI 52 week breaches to be separated out in the performance metrics.

DG asked about the list size and NJ advised on the reduction work that is ongoing, there were earlier issues with delays with RAS service which have since been resolved. DG asked if a contract query has been raised in relation to this. NJ confirmed the Trust has responded to a contract query highlighting this. NJ added that the referral triage rate is slightly higher than planned so being kept under close review. This does not mean the referral rate is inappropriate but rather that it does not meet the assumptions of the original proposal. Earlier in the year SOOS lost some capacity and the focus has been on recovering this.

NJ provided a presentation on Theatre Activity and highlighted that the Trust was currently 66 cases behind plan. There are improvement actions in place and the Trust is on target for November and December.

KR introduced Alyson Jordan and Denise Perrett to present the Breaking the Cycle information, based on the service improvement methodology.

FC commented on the dynamic process and that it was a credit to everyone involved. He asked about what has happened since 'Breaking the Cycle' - Alyson advised that the team are happier and currently there were +32 more cases than plan booked for surgery. Also, a training post is being introduced to assist with training new starters and a daily comms meeting is looking at the numbers and where the gaps are. Alyson explained the level of re-work involved in re-booking cancellations. KR added that this can be up to 75% rework.

MB advised that events like these with follow up progress do not happen without clear leadership.

Caring for Finances
CM highlighted the following:

- The Trust has achieved a surplus of £676k, this is a cumulative surplus position but short of plan by £200k
- Theatres income shortfall but over performance in all other areas.
- Increases in cost for pay and non-pay
- Action plan in place to address agency costs

Caring for Staff
SS highlighted the following:

- Sickness absence is being closely monitored by the Workforce Development Group. An action plan on mental health and emotional wellbeing is being finalised.

	The Board ***noted*** the update
29/11/21.0	**AGENCY REPORT** SS advised that there has been a focus on agency staff working at the Trust for more than 6 months. The team have been working through the list on an individual basis and already making progress. SS highlighted the importance and value of working with agency staff but that this needed to be balanced with looking at how regular attenders can be encouraged to come on board permanently. HT asked whether this was being challenged by NHS Improvement. CM commented that such a challenge is to be expected if the organisation is behind it's control total but over it's agency cap. HT commented on SaTH breaking the cap and MB commented that they were given permission to do this as they are in Special Measures but that it does have an impact on the wider market. SS commented on the importance of a collaborative bank across the system. **ACTION: Update back to the Board before the end of the financial year to review again** The Board ***noted*** the report.
29/11/22.0	**FINANCIAL MID-YEAR FORECAST** CM provided an overview of the financial mid-year forecast as follows: • YTD in a cumulative surplus position, • Earned the sustainability fund for the first two quarters of the year • For Quarter 3 there is £188k to recover by the end of the quarter in order to secure the sustainability fund for that quarter. • CM outlined the main drivers for the current position and the mitigations under review to recover the position FC asked what the value was of the sustainability fund currently at risk and CM advised that it is £200k for Quarter 3. FC asked where the LLP sits within the drivers and CM confirmed that it is within the Out of Job Plan (OJP) costs. An action plan has been taken to the Finance Planning and Investment Committee outlining the plan to reduce OJP. FC queried the cost of the drivers on CMs paper and CM clarified that the pressures are offset by certain mitigations which is how the gap has been calculated. FC commented that £400k to recover at M7, whilst challenging, is not overly material in the context of Trust-wide finances. CM advised the Executive Team have had a good discussion about what more can be done and provided some examples of the opportunities that have been identified. DG outlined that the cost pressures amount to £2m with a risk that these will not be fully mitigated. The Finance Planning and Investment Committee asked for a review of the capital management programme to take into account this risk. It was agreed that this would ensure the prioritisation of capital expenditure takes into account the potential for capital funds to decrease. FC asked about the realism of the mitigations, for example the theatre rental. CM advised that it is a significant opportunity but agreed that it was unlikely to deliver within

	the year. AF said that overall the clinical income was positive but the surgical income was down by £600k, this represents a big opportunity if this position can be recovered. HT added that the detail of the mitigations was missing and he questioned what would happen if it was a bad winter with ensuing pressure on the NHS system. FC agreed that sensitivity analysis is required. CM advised that he will bring an updated forecast to every Finance Planning and Investment Committee and Board meetings. The Board ***noted*** the forecast
29/11/22.0	**CONTROLLED DRUGS ACCOUNTABLE OFFICER ANNUAL REPORT** BT presented the Controlled Drugs Accountable Officer Annual Report. She advised that this had been considered by the Quality and Safety Committee. She added that Quality and Safety Committee had also had oversight of the Trust's review of the Gosport Report. The Board ***noted*** the update.
29/11/23.0	**M6 PERFORMANCE REPORT** The M6 Performance Report was noted to have been considered by the Board at the previous meeting but as this was held in private it was being presented to note this month in order to put it into the public domain. The Board ***noted*** the M6 Performance Report.
29/11/24.0	**RESEARCH UPDATE** The Board ***noted*** the research update provided.
29/11/25.0	**STP UPDATE** MB asked the Board to note the report presented. He advised that Sir Neil Mackay has commissioned work to look at the governance around the STP and the involvement of Chairs and Non-Executives which has been welcomed.
29/11/26.0	**CHAIR'S REPORT FINANCE PLANNING AND INVESTMENT COMMITTEE (SEPTEMBER)** The Board noted the written Chair's Report following the verbal update at the meeting in September.
29/11/27.0	**GOVERNORS UPDATE** SR presented an update of the activities the Governors had been involved in as follows: • Patient Safety Walkabouts • Sit and See • Russell Luckock had been presented with the Governor of the Year Award at the Celebration of Achievement Awards
ITEMS TO NOTE	
29/11/28.0	**ANY OTHER BUSINESS** MB highlighted the numerous Christmas events coming up over the next few weeks. FC offered the Board's appreciation to all involved in organising the Celebration of Achievement event.
	DATE OF NEXT MEETING: Thursday 31 Jan at 9.30 in the Meeting Room 1.
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

29 NOVEMBER 2018

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
Actions from Last Meeting	**Lead Responsibility**	**Progress**
29/11/9.0 STRATEGY BOARD SUMMARY		
Scenario planning to be included in the agenda for the next Strategy Board	Director of Strategy and Planning	Will be added to the agenda
Consideration to be given to holding a session for the Governors	Trust Secretary	Completed – potential facilitator and agenda sourced and included in the Board Development Programme
29/11/12.0 Board Assurance Framework		
Operational Board and Executive Team to consider the impact of local acute services on the Trust's operational risks.	Director of Operations	Completed – partner risks paper on the agenda and being fed into the Trust's risk registers where appropriate
Brexit risk register entry to be considered in the context of the BAF	Trust Secretary	Completed
Review of additional controls and assurances regarding governance of surgical throughput and the achievement of activity plan	Trust Secretary	Completed
29/11/19.0 CORPORATE OBJECTIVES UPDATE		
Quarter 3 report to include a future look of where the performance is anticipated to be at year end against the objectives	Director of Strategy	Completed

Planning Guidelines and Assumptions

0. Reference Information

Author:	Kerry Robinson, Director of Strategy and Planning	Paper date:	31st January 2019
Executive Sponsor:	Mark Brandreth, Cheif Executive	Paper Category:	Strategy
Paper Reviewed by:	Executive Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper is coming to Trust Board to provide an overview of the NHS Long Term Plan, together with the implications for this trust.

The Board are asked to discuss and note the contents of the NHS Long Term Plan.

2. Executive Summary

2.1. Context

In January 2019 the NHS Long Term Plan was published focusing on the next 10 years from the starting point of today, in the context of keeping all that's good about our national health service, but recognising the need to tackle the pressures our staff face whilst simultaneously making our funding go as far as possible. The plan recognises the need to accelerate the redesign of patient care to future proof the NHS for the next 10 years.

2.2. Summary

The NHS Long Term Plan is made up of seven chapters covering the following;

- A new service model for the 21st century
- More NHS action on prevention and health inequalities
- Further progress on care quality and outcomes
- NHS Staff will get the backing they need
- Digitally-enabled care will go mainstream across the NHS
- Taxpayers' investment will be used to maximum effect
- Next steps

This paper looks to summarise the 134 pages of the plan to actionable points for the Trust to consider in its future planning and strategic delivery.

2.3. Conclusion

The 2019/20 operational plan will be developed in consideration of the items within the NHS Long Term Plan, which furthers our already established organisational strategy which

remains suitably valid for the direction of travel and ambition set out in the NHS Long Term Plan.

3. The Main Report

3.1. Introduction

In January 2019 the NHS Long Term Plan was published focusing on the next 10 years from the starting point of today, in the context of keeping all that's good about our national health service, but recognising the need to tackle the pressures our staff face whilst simultaneously making our funding go as far as possible. The plan recognises the need to accelerate the redesign of patient care to future proof the NHS for the next 10 years.

3.2. The NHS Long Term Plan

The NHS Long Term Plan is made up of seven chapters covering the following;

- A new service model for the 21st century
- More NHS action on prevention and health inequalities
- Further progress on care quality and outcomes
- NHS Staff will get the backing they need
- Digitally-enabled care will go mainstream across the NHS
- Taxpayers' investment will be used to maximum effect
- Next steps

This paper summarises key content included in each chapter of items of most note in regards to impact for this Trust and our future planning and actions.

3.2.1. A new service model for the 21st century

The Plan sets outs that over the next five years investment in primary medical and community services will grow faster than the overall NHS budget, to deliver a series of improvements.

For this Trust and our focus upon MSK care elements that we are currently working upon are reinforced such as follows;

Improving out of hospital care

- Using predictive prevention to better support people to stay healthy and avoid illness complications.
    - Including use of a proactive population health approach focused on moderate frailty.
    - Targeted support for those identified with MSK conditions to maintain independence.
    - Falls prevention schemes, including exercise classes and strength and balance training.

Reduce pressure on emergency hospital services

- Expansion of community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices typically covering 30-50,000 people.
- Development of a standard model of delivery in smaller acute hospitals who serve rural populations.
- Placing therapy and social work teams at the beginning of the acute hospital pathway
    - Expectation that patients will have an agreed clinical care plan within 14 hours of admissions, including expected date of discharge.
- Patients will continue to have a choice at point of referral;
    - Anyone who has been waiting for six months will be specifically contacted and given the option of faster treatment at an alternative provider.

Planning Guidelines and Assumptions

Deliver person-centred care

- Improving care to people with dementia and delirium;
  - Research investment is set to double between 2015 and 2020 with £300m of government support.
- Social prescribing link workers will be in place by the end of 2020/21.
- Acceleration of Personal Health Budgets;
  - Including the provision of bespoke wheelchairs.
  - Expanded offer in mental health services for those receiving specialist end of life care.

Digitally enabled primary and outpatient care

- Digitising appointments and prescriptions; including telephone and video consultations;
  - Patients will be able to access virtual services alongside face-to-face services via a computer or smartphone.
- Outpatient services will be fundamentally redesigned
  - Looking to avoid up to a third of face-to-face outpatient visits.

A focus on population health and local partnerships through Integrated Care Systems (ICS).

- Local NHS organisations increasingly focusing upon population health and local partnerships with local authority-funded services, through ICSs.
- By April 2021 ICSs will cover the whole of the country. Every ICS will;
  - need to streamline commissioning arrangements.
  - Put in place a partnership board
  - Have a non-executive chair
  - Sufficient clinical and management capacity to implement system-wide changes.
  - Greater emphasis by CQC on partnership working
  - Clinical leadership aligned around ICS to create clear accountability to the ICS.
- Funding flows and contract reform will support move to ICS
  - System wide objectives will be agreed with a combination of national and local priorities.

3.2.2. More NHS action on prevention and health inequalities

To address the growing demand for healthcare created by a growing and ageing population the Plan sets out an aim to target the top causes of premature death in England. When focusing upon the impact for this Trust the following stand out;

Obesity

- The NHS will continue to take action on healthy NHS premises
  - The next version of hospital food standards will be published in 2019.
  - Strengthening these requirements and pushing further in securing health food for our staff and patients.
- Nutrition training
  - Together with the professional bodies and universities nutrition will have a greater place in professional education training.

Health Inequalities

- NHS England will continue to target a higher share of funding towards geographies with high health inequalities.
    - No area will be more than 5% below its new target funding share effective from April 2019, with additional funding growth going to areas between 5% and 2.5% below their target share.
- The NHS will set out specific, measurable goals for narrowing health inequalities.
- Continue to identify and support carers, particularly those from vulnerable communities.
    - National adoption of carer's passports.
    - Developments of electronic health records that allow people to share their caring status with healthcare professionals wherever they present.
- The NHS will continue to commission, partner with and champion local charities and community interest companies providing services and support to vulnerable and at-risk groups.
- Taking action to improve the mental health and wellbeing of our workforce and setting an example to other employers.

3.2.3. Further progress on care quality and outcomes

The Plan outlines a range of condition specific proposals, MSK care is not centrally identified in the plan, but is referenced in a number of sections.

Children and young people

- Over the next five years, paediatric critical care and surgical services will evolve to meet the changing needs of patients, ensuring that children and young people are able to access high quality services as close to home as possible.
    - Paediatric networks which will involve hospitals will ensure a co-ordinated approach to critical care and surgical services enabling children and young people to access specialised and non-specialised services.
- Selectively moving to a '0-25 years' service will improve children's experience of care, outcomes and continuity of care.
    - By 2028 aim is to move towards service models for young people that offer person-centred and age appropriate care, rather than an arbitrary transition to adult services based on age not need.

Cancer

- NHS England has asked Sir Mike Richards to lead a review of the current cancer screening programmes and diagnostic capacity.
- A new faster diagnosis standard from 2020 will be introduced to ensure most patients receive definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening.
    - Data collection for all patients will start in 2019, with full monitoring against the standard beginning in April 2020.
- The NHS will use its capital settlement to be negotiated in the 2019 Spending Review in part to invest in new equipment including CT and MRI scanners.
- Broader reforms of the way diagnostic services are organised, including pathology and imaging networks
- Extend use of molecular diagnostics and will routinely offer genomic testing.
    - From 2020/21 the NHS will begin to offer more extensive genomic testing.

- After treatment, patients will move to a follow-up pathway that suits their needs and ensures they can get rapid access to clinical support where they are worried that their cancer may have occurred.
    - Other cancers where clinically appropriate will come on line by 2023.

Short waits for planned care

- Work will be built upon work already undertaken to ensure patients have direct access to MSK First Contact Practitioners.
    - Expand the number of physiotherapists working in primary care networks.
    - Expand access to support such as the online version of ESCAPE-pain
- Sufficient funds will be allocated over the next five years to grow the amount of planned surgery year-on-year, to cut long waits and reduce the waiting list.
    - The phasing of this improvement will be partly shaped by the availability of staff to expand treatment capacity in hospitals and will be determined annually through the planning guidance process.
- The NHS will continue to provide patients with a wide choice of options for quick elective care
    - This includes making use of available independent sector capacity
    - Supported by a continued roll out of Capacity Alerts
    - Anyone who has been waiting for six months will be reviewed and given the option of faster treatment at an alternative provider.
- Recognition that looking to remove a third of outpatient appointments will distort how RTT waiting time performance is calculated.
    - The NHS National Medical Director's Clinical Standards Review will take this into account, in the spring.
    - Reintroduction of the incentive system under which hospitals and CCGs will both be fined for any patient who breaches 12 months.
- Backing of hospitals that wis to pursue the model of cold sites will continue.

Research and innovation

- Will increase the number of people registering to participate in health research to one million by 2023/24.
    - People will be able to view opportunities to participate and register their interest on the NHS App by 2020.
- Focus targeted investment in areas of innovation that will be transformative, particularly genomics.
    - During 2019, seriously ill children who are likely to have a rare genetic disorder, children with cancer, and adults suffering from certain rare conditions or specific cancers will begin to be offered whole genome sequencing.
- Expansion of the current NHS England 'Test Beds' through regional Test Bed Clusters from 2020/21.
    - Increasing share of total NHS R&D funding spent on real world testing.
- Invest in spreading innovation between organisations
    - Drive quality improvement through non-commercial models

3.2.4. NHS staff will get the backing they need

The Plan acknowledges that workforce growth has not kept up with need with staff not adequately supported to meet the changing requirements of patients over the past decade. The comprehensive workforce implementation plan is due to be published later in 2019

where the detail is anticipated, this section outlines some tangible goals and new programmes.

Nurses, AHPs and other staff

- Improving the nursing vacancy rate to 5% by 2028.
- An extra 5,000 nurse undergraduate places will be funded from 2019/20, a 25% increase.
- Plans to launch a new online nursing degree for the NHS, could be launched from 2020.
- Continue to invest in the growth of nursing apprenticeships.
    - 7,500 new nursing associates starting in 2019.
    - NHS Organisation should look to take on the lead employer model, setting up the infrastructure to deliver apprenticeships on behalf of several trusts.
- Grow wider apprenticeships in clinical and non-clinical jobs in the NHS
    - Expectation that employers will offer all entry-level jobs as apprenticeships before considering other recruitment options.
- Further development of the national AHP strategy, AHPs into Action
    - Specific recommendations to be put in place for podiatrists and radiographers.
- Development of annual campaigns for national recruitment in conjunction with Royal Colleges and trade unions is committed to.

Medical workforce

- Medical school places growing from 6,000 to 7,500 per year. This may grow further through the following options;
    - More part-time study options.
    - Expanding the number of accelerated degree programmes to train in four years rather than five years.
- Looking to accelerate the shift from a dominance of highly specialised roles to a better balance of more generalist ones.
- Also addressing;
    - Improve working lives of doctors in training – adequate time for supervision, accelerate implementation of 'step out and step in' training programmes, enabling the switch of specialities without re-starting training.
    - Accelerate the development of credentialing.
    - Reform and re-open the Associate Specialist grade ass an attractive career option.
    - Developing incentive to ensure speciality choices of trainees meet needs of patients by matching specialty and geographical needs.

International recruitment

- Looking for a step change in the recruitment of international nurses over the next five years.
- New national arrangements to support NHS organisations in recruiting overseas.
- NMC will update the English Language testing requirements for 2019.

Supporting current NHS staff

- Committed to improving staff retention by at least 2% by 2025.
- HEE has committed to increase the proportion of its total budget spent on workforce development in the short term.
- Employers support key to ensure staff are given the time out to develop their skills.
- Expansion of multi-professional credentialing.

- Promotion of flexibility, wellbeing and career development and redoubling efforts to address discrimination, violence, bullying and harassment.
    - Signal to The Social Partnership Forum programme on bullying and harassment.
- Respect, equality and diversity is recognised as the heart of the workforce implementation plan.
    - NHS England will invest an extra £1 million a year to extend the WRES work to 2025.
    - Each NHS organisation will set its own target for BAME representation across its leadership team and broader workforce by 2021/22.
    - A new Workforce Disability Equality Standard will be developed.
    - Gender Pay Gap for doctors and its contribution to gender equality in the NHS is recognised.
    - Experiences of LGBT+ staff is highlighted as an area of focus from staff survey results.
- Expansion of the practitioner Health Programme to help NHS doctors access specialist mental health support is highlighted.
- Expectation on induction and mandatory training will be clarified.

Productive working

- By 2021 electronic rosters and e-job plans will be expected to have been rolled out.

Leadership and talent management

- There will be a new compact with the most senior leaders
    - Commitments will be enshrined in a new 'NHS leadership code'
- Proposals to ensure that more senior clinicians take on executive leadership roles.
- Consideration of a professional registration scheme for senior NHS leaders.
- Establishment of a faculty of coaches and mentors.
- Developing the knowledge of improvement skills and how to apply them for all levels of leadership in the NHS.

Volunteers

- Encouragement of NHS organisations to give greater access for younger volunteers.
- Helpforce programme will get an investment of at least £2.3 million from NHS England to scale successful volunteering programmes, to double the number of NHS volunteers over the next three years.

3.2.5. Digitally-enabled care will go mainstream across the NHS

The Plan commits the NHS to be 'digital first' in ten years' time. Particular attention is given to both primary care and outpatient services.

- By 2020, every patient with a long-term condition will have access to their health record through the Summary Care Record accessed via the NHS App.
- There is an expectation of informatics leadership representation on the board of every NHS organisation.
- From 2020 no NHS organisation will use fax machines.
- A new wave of Global Digital Exemplars is anticipated, with continued roll-out of GDE blueprints to more fast followers.
    - Central funding will be made available to trusts to help them meet mandated standards and technical requirements.

- During 2019, population health management solutions will be deployed, by 2021/22 every ICS will have a system to support population health management.
- By 2021, pathology networks will mean quicker turnarounds, improved access to more complex tests.
- By 2023, diagnostic imaging networks will enable the rapid transfer of clinical images.
- Cyber security standards will be mandated and continually updated, by summer 2021 there will be a 100% compliance with this.
- By 2022/23 the Child Protection Information System will be extended to cover all health care settings.
- By 2024, secondary care providers will be fully digitised.

3.2.6. Taxpayers' investment will be used to maximum effect

The Plan outlines how the NHS will continue to become more efficient, restating the five tests set out by government in the 2018 budget.

Returning to financial balance

- By 2023/24 all NHS organisation are in balance.
- Reforms to the payment system moving funding away from activity-based payments and ensure a majority of funding is population-based.
    - Envisage retaining appropriate volume-related payments for elective care for now, alongside new incentives for improvements in quality.
- Expect all systems and trusts to implement proven initiatives including the Model Hospital, Rightcare and GIRFT.

Cash-releasing productivity growth of at least 1.1% per year

- Increased investment in Quality Improvement to accelerate work to end unjustified clinical practice variation.
- By 2021, all clinical staff to be deployed using an electronic roster of e-job plan.
- By 2023, all providers to use evidence-based approaches to determine how many staff they need on wards and in other care settings.
- Over the next five years, all providers will be expected to implement electronic prescribing systems.
- Reduce the prescribing of low clinical value medicines and items which are readily available over the counter.
- Generic medicines used where possible.
- All core transactional services will be automated over the next five years.
- Reduce the amount of non-clinical space by a further 5%.
- By 2020 reduce the NHS' carbon footprint by a third from 2007 levels.
- A new Patient Safety Incident Management System will replace the current NRLS by 2020.
    - Develop a shared and consistent Patient Safety Curriculum.
    - Develop Patient Advocates for Safety.
    - Develop a network of senior Patient Safety Specialists.
    - Design new Medication Safety and Mental Health Safety Improvement Programmes.
    - Work on falls and fracture prevention.

Reduce unjustified variation in performance

- Radically improve transparency.
- Reduce unwarranted variation.

    - Will be a core responsibility of ICSs
- Investing in QI, to ensure our staff have the skills and methodology to simultaneously improve care and reduce costs.

3.2.7. Next steps

2019/20 is positioned as a transition year, the next steps for implementing the Plan are;

- Local health systems receiving five year indicative financial allocations and being asked to produce plans for implementing the Plans commitments.
- The Clinical Standards Review and the national implementation framework being published in the spring, to be implemented in the October.
- The NHS Assembly being established in early 2019 which will advise the boards of NHSE and NHSI and oversee progress of the Plan.
- The Spending Review, expected in the Autumn, setting out allocations for NHS capital, education and training as well as public health and adult social care.

The Plan commits to automating and standardising the generation and storage of data to reduce the burden on frontline services and reduce duplication. It also undertakes to set out a single list of “essential interventions” (including effective e-rostering and e-job planning and processes for standardising and aggregating procurement demand for products and services) to maximise value. The national bodies will also work with the Health Foundation to increase the number of ICSs building their improvement capabilities.

3.3. Next Steps

The Trust Board is asked to discuss and note the contents of the NHS Long Term Plan.

3.4. Conclusion

The 2019/20 operational plan will be developed in consideration of the items within the NHS Long Term Plan, which further our already established organisational strategy which remains suitably valid for the direction of travel and ambition set out in the NHS Long Term Plan.

Appendix 1: Acronyms

NHS	National Health Service
RJAH	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT
MSK	Musculoskeletal
GP	General Practice
ICS	Integrated Care System
CQC	Care Quality Commission
CT	Computed Tomography
MRI	Magnetic Resonance Imaging
ESCAPE	Enabling Self-management and Coping with Arthritic Pain through Exercise
FCP	First Contact Practitioner
RTT	Referral to Treatment
R&D	Research and Development
AHP	Allied Health Practitioner
NMC	Nursing and Midwifery Council
HEE	Health Education England
WRES	Workforce Race Equality Standard
BAME	Black Asian Minority Ethnic
LGBT+	Lesbian Gay Bisexual Transgender plus other groups of sexual and gender minorities
GDE	Global Digital Exemplar
GIRFT	Getting It Right First Time
NRLS	National Reporting and Learning System
QI	Quality Improvement

Review of Standing Financial Instructions & Scheme of Delegation

0. Reference Information

Author:	Diana Owen, Head of Financial Accounting	Paper date:	31 January 2019
Executive Sponsor:	Craig Macbeth, Director of Finance	Paper Category:	Governance / Performance
Paper Reviewed by:	Audit Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors is asked to ***review*** the proposed amendments to the Trust's Standing Financial Instructions (SFIs) and Scheme of Delegation and ***approve*** the documents.

2. Executive Summary

2.1. Context

The SFIs and Scheme of Delegation set out the framework for how the Trust manages its financial affairs. They are required to be reviewed annually by the Board of Directors.

2.2. Summary

Following a review of both documents, a number of amendments are proposed. Key amendments relate to relate to approval limits (for charitable funds, special payments and petty cash) and a new section for sign-off of tender submissions. The rest are minor, relating to changes in terminology or titles, and adding clarification.

A full list of amendments is attached, together with revised versions of both documents, with additions and changes highlighted in yellow.

The proposed amendments and revised policies were reviewed by the Audit Committee at its meeting on 7th January 2019 and recommended for approval.

2.3. Conclusion

The Board of Directors is asked to consider and ***approve*** the proposed amended SFIs and Scheme of Delegation.

Review of Standing Financial Instructions & Scheme of Delegation

Proposed Amendments to SFIs and the Scheme of Delegation

SFIs

Para 8.5.1 : Authorisation of Competitive Tenders

Amended the individual authorisation limits to match those in the Scheme of Delegation i.e. 2 Executive Directors for tenders up to £249,999.

Para 21 : Risk Management & Insurance

Changed "*NHS Litigation Authority*" to "*NHS Resolution*" to reflect their changed name.

Scheme of Delegation

Amendments to terminology throughout

Changed "*Director of Human Resources*" to "*Director of People*".

Section 6.2 : Tender Submissions

Added a section covering sign-off by the Service Manager or Divisional Manager of tender submissions for services provided.

Section 9.2 : Expenditure on Charitable Funds

Increased limit for fund manager approval from £500 to £1,500 which is more practical.

Section 12.3 : Special Payments – Mileage Claims for Cancelled Clinics

Added a section for these claims, enabling authorisation at a more appropriate level. All special payments are currently approved by the Director of Finance. These claims are low value and would be better approved by clinic staff, avoiding delays for patients. For any higher value claims, approval by the Head of Financial Accounting is recommended.

Section 12.4 : Special Payments – Other

All special payments are currently approved by the Director of Finance. It is recommended that low value payments are approved by the Head of Financial Accounting.

Section 14 : Petty Cash Reimbursements

Increased limit for manager approval from £25 to £50 which is more practical.

Proposed petty cash purchases above the limit are currently approved by the Director of Finance. It is recommended that they are now approved by the Head of Financial Accounting.

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Standing Financial Instructions		
Unique Identifier:	POL028	**Document Type:**	Policy
Version Number:	6.0	**Status:**	Draft
Responsible Director:	Craig Macbeth, Director of Finance		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Trust wide		
Replaces:	Version 5.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Scheme of Delegation Matters Reserved to the Board		
Keywords:	SFI, SFIs, Standing Financial Instructions, Scheme of Delegation		

Considered By Executive Owner:	Craig Macbeth, Director of Finance	**Date Considered:**	18/12/2018
Endorsed By:	Audit Committee	**Date Endorsed**	??
Approved By:	Trust Board	**Date Approved:**	??
Issue Date:	??	**Review Date:**	??
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Standing Financial Instructions

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2. Introduction

2.1 General

2.1.1 The Trust's Standing Financial Instructions (SFIs) have been compiled in accordance with the requirements and provisions of The NHS Act 2006. They shall have effect as if incorporated in the Trust's Constitution.

2.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters Reserved to the Board and the Scheme of Delegation adopted by the Trust.

2.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

2.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Constitution.

2.1.5 The failure to comply with SFIs and Standing Orders as included in the Constitution can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

2.1.6 Overriding SFIs – if for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Director of Finance as soon as possible.

2.2 Terminology

2.2.1 Any expression to which a meaning is given in Health Service Acts, or in Directions made under the Acts, shall have the same meaning in these instructions; and

"Constitution" means the constitution, including the annexes, which was approved on authorisation as a Foundation Trust with any subsequent amendments approved in accordance with current legislation.

"Trust" means the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust;

"Accounting Officer" means the person who from time to time discharges the functions specified in paragraph 25 (5) in Schedule 7 to the 2006 Act;

"Board" means the Board of Directors of the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, as constituted in accordance with the Trust's Constitution;

"Budget" means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

"Chief Executive" means the chief executive (and accounting officer) of the Trust;

"Director" means a person appointed as a Director in accordance with the Constitution. The Directors of the Trust will be either:

- "Executive Director" which means a Member of the Board of Directors who holds an executive office of the Trust, and who was appointed in accordance with the Constitution;
  or
- "Non-Executive Director" which means a Member of the Board of Directors who does not hold an executive office of the Trust, and who was appointed by the Council of Governors in accordance with the Constitution.

"Director of Finance" means the chief financial officer of the Trust;

"Funds Held on Trust" means those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable;

"Independent regulator" means the independent corporate body established under the National Health Service 2006 Act, responsible for authorising, monitoring and regulating NHS Foundation Trusts;

"Legal adviser" means the properly qualified person appointed by the Trust to provide legal advice;

"Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust;

"SIRO" means Senior Information Risk Officer. This role is undertaken by the Director of Finance.

2.2.2 All references in these instructions to the masculine gender shall be read as equally applicable to the feminine gender.

2.2.3 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

2.2.4 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2.3 Responsibilities and Delegation

2.3.1 The Trust Board exercises financial supervision and control by:

(a) Formulating the financial strategy;

(b) Requiring the submission and approval of budgets within approved allocations/overall income;

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) Defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document;

(e) Receiving regular reports on financial performance

2.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "Matters Reserved to the Board" document. All other powers have been delegated to such other committees as the Trust has established, or to the Chief Executive or Finance Director.

2.3.3 The Chief Executive and Finance Director will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.3.4 The Chief Executive is ultimately accountable to the Board and, as Accounting Officer, to parliament, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The duties as Accounting Officer are set out in the "NHS Foundation Trust Accounting Officer Memorandum". The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met, and has overall responsibility for the Trust's system of internal control.

2.3.5 It is a duty of the Chief Executive to ensure that Members of the Board and employees and all new appointees are notified of, and put in a position to understand, their responsibilities under these Instructions.

2.3.6 The Finance Director is responsible for:

(a) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) Maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

In addition, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Finance Director include:

(d) The provision of financial advice to other members of the Board and employees;

(e) The design, implementation and supervision of systems of internal financial control;

(f) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.7 All members of the Board and employees, severally and collectively, are responsible for:

(a) The security of the property of the Trust;

(b) Avoiding loss;

(c) Achieving economy, effectiveness and efficiency in the use of resources;

(d) Conforming with the requirements of the Trust Constitution, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation;

(e) Maintaining effective risk management arrangements.

2.3.8 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2.3.9 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

3. Audit

3.1 Audit Committee

3.1.1 In accordance with the constitution and with reference to the Audit Code for NHS Foundation Trusts and the Code of Governance, issued by the Independent Regulator, the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference.

3.1.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

(a) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement or other appropriate independent assurances;

(b) The underlying assurance processes that indicates the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

(c) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification;

(d) The policies and procedures for all work related to fraud and corruptions as set out in the NHS Standard contract and as required by the NHS Counter Fraud Authority, and review and confirm the level of resources assigned for countering fraud;

(e) The Internal Audit Service ensuring that it meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board;

(f) The work of the External Auditor and consider the findings, implications and management's responses to their work;

3.1.3 Agree the Accounting Policies to be adopted for the preparation of the financial statements and receive the External Auditor's annual governance report prepared in accordance with the relevant International Accounting Standards. The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board.

3.1.4 The Audit Committee must assess the work and the fees of External Audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable. The Audit Committee shall make a recommendation to the Council of Governors with respect to the re-appointment of the External Auditors. The Trust will undertake market-testing for the appointment of external auditors at least once every five years.

3.1.5 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to the Independent Regulator via the Finance Director.

3.1.6 It is the responsibility of the Finance Director to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

3.1.7 Further detail on the role, responsibility and powers of the Audit Committee are contained in its Terms of Reference.

3.2 Director of Finance

3.2.1 The Director of Finance is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) Ensuring that the Internal Audit function is adequate and meets the NHS mandatory audit standards;

(c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(i) A clear opinion on the effectiveness of internal control;
(ii) Major internal financial control weaknesses discovered;
(iii) Progress on the implementation of internal audit recommendations;
(iv) Progress against plan over the previous year;
(v) Strategic audit plan covering the coming three years;
(vi) A detailed plan for the coming year.

3.2.2 The Director of Finance and designated internal and external auditors are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) The production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and

(d) Explanations concerning any matter under investigation.

3.3 Role of Internal Audit

3.3.1 Internal Audit will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) The adequacy and application of financial and other related management controls;

(c) The suitability and reliability of financial and other related management data;

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences;
(ii) Waste, extravagance, inefficient administration;
(iii) Poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Independent Regulator.

3.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

3.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

3.3.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for Internal Audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

3.3.5 The designated officers must carry out agreed audit recommendations within the timescale for action agreed with the Head of Internal Audit. Failure to do so shall be reported to the Audit Committee and to the Chief Executive who shall take necessary action to ensure compliance with such recommendations.

3.4 External Audit

3.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service.

3.4.2 The Trust must ensure that the External Auditor appointed by the Council of Governors meets the criteria set out in the Audit Code for NHS Foundation Trusts at the date of appointment and on an on-going basis throughout the term of their appointment.

3.4.3 External Audit must comply with the responsibilities and functions set out in the Audit Code for NHS Foundation Trusts and under Part 1 of the Health and Social Care Act 2003.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Trust's Chief Executive and Director of Finance shall monitor and ensure compliance with the requirements included in the NHS Standard Contract on fraud and corruption, and with the requirements of the Bribery Act 2010 and other relevant legislation that has been or may be enacted.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Counter Fraud Authority (NHSCFA).

3.5.3 The Local Counter Fraud Specialist shall report to the Trust's Director of Finance and shall work with staff in NHSCFA in accordance with the NHS Standard Contract.

3.5.4 The Local Counter Fraud Specialist will provide regular reports to the Audit Committee, including a written Annual Report.

3.6 Security Management

3.6.1 In line with their responsibilities, the Trust's Chief Executive will monitor and ensure compliance with the requirements included in the NHS Standard Contract on NHS security management. The Trust is now held to account by its NHS commissioners for performance against these standards.

3.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by guidance on NHS security management.

3.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

4. Business Planning, Budgets, Budgetary Control and Monitoring

4.1 Preparation and Approval of Plans and Budgets

4.1.1 The Chief Executive will compile and submit to the Board an Annual Plan which complies with the requirements of the Independent Regulator.

4.1.2 The plan will be approved by the Board of Directors and have regard to the views of the Council of Governors.

4.1.3 The plan will be submitted to the Independent Regulator in accordance with their timetable.

4.1.4 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

4.1.5 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

4.1.6 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.1.7 All budget holders will sign to agree their allocated budgets at the commencement of each financial year.

4.1.8 The Director of Finance is responsible for ensuring that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;

(b) The purpose(s) of each budget heading;

(c) Individual and group responsibilities;

(d) Achievement of planned levels of service;

(e) The provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

4.3 Budgetary Control and Reporting

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board in a form approved by the Board containing:

(i) Income and expenditure to date showing trends and forecast year-end position;

(ii) Movements in working capital;

(iii) Movements in cash and capital;

(iv) Capital project spend and projected outturn against plan;

(v) Explanations of any material variances from plan;

(vi) Details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) Investigation and reporting of variances from financial, workload and manpower budgets;

(d) Monitoring of management action to correct variances; and

(e) Arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) Any likely overspending or reduction of income is not incurred without the prior consent of the Board;

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised.

(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in SFI Section 13. The Capital Programme and any amendments will be approved in advance by the Board of Directors.

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

5. Annual Accounts and Reports

5.1 The Chief Executive, as the Accounting Officer, will sign the Annual Accounts.

5.2 The Chief Executive will direct the Director of Finance to:

(a) Prepare financial returns in accordance with the accounting policies and guidance given by the Independent Regulator, the Trust's accounting policies, and generally accepted accounting practice;

(b) Prepare and submit annual financial reports to the Independent Regulator and Parliament in accordance with current guidelines; and

(c) Submit financial returns to the Independent Regulator and Parliament for each financial year in accordance with the prescribed timetable.

5.3 The Trust's audited annual accounts must be presented to the Board of Directors for approval and received at a public meeting of the Council of Governors. A copy should be forwarded to the Independent Regulator and made available to the public.

5.4 The Trust will publish an Annual Report in accordance with the Constitution, and present it at the Council of Governors general meeting. The document will comply with the Independent Regulator's Financial Reporting Manual.

6. Bank and Government Banking Service Accounts

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the Independent Regulator.

6.1.2 Only the Director of Finance shall open or close bank accounts in the name of the Trust. The Board shall approve the banking arrangements.

6.2 Bank and Government Banking Service Accounts

6.2.1 The Director of Finance is responsible for all bank accounts and the Government Banking Service (GBS) accounts including:

(a) Establishing separate bank accounts for the Trust's non-exchequer funds;

(b) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

(c) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking Arrangements

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) The conditions under which each bank and GBS account is to be operated;

(b) The limit to be applied to any overdraft; and

(c) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.4 Tendering and Review

6.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals, and at least every five years, to ensure they reflect best practice and represent value for money. Following such reviews the Director of Finance shall determine whether or not re-tendering for services is necessary and seek the approval of the Finance, Planning & Investment Committee to pursue the proposed course of action.

7. Income, Fees and Charges & Security of Cash, Cheques and other Negotiable Instruments

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Trust shall follow the Department of Health guidance in the Operating Framework, or additional guidance issued by NHS England or the Independent Regulator, in setting prices for NHS service agreements.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

7.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received and deemed to be irrecoverable should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated promptly.

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) Ordering and securely controlling any such stationery;

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss, before the deposit is accepted.

7.4.5 To comply with money laundering legislation, the Director of Finance will issue instructions that the Trust will not accept cash payments of amounts greater than £10,000 in respect of any single transaction. Any attempts by an individual to effect payment above this amount should be notified immediately to the Director of Finance."

8. Tendering and Contracting Procedure

8.1 General

The tendering and contracting procedure below applies except where the requirement is covered by an existing NHS contract or framework. Dependant on the terms of the framework a direct award or mini-competition may be required to be completed. Shropshire Healthcare Procurment Service can advise on the most appropriate method.

8.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SFIs.

8.1.2 Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs.

8.1.3 The Trust shall comply as far as is practicable with the requirements of NHS Improvement guidance, the Treasury Financial Reporting Manual and "Estatecode" in respect of capital investment and estate and property transactions.

8.1.4 Orders must not be placed for goods or services which have been split or otherwise placed in a manner to avoid the financial thresholds for tendering.

8.2 Formal Competitive Tendering

8.2.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

(d) for disposals.

8.2.2 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £49,999;

(b) Where the supply is proposed under special arrangements negotiated by the DH or other NHS procurement agency in which event the said special arrangements must be complied with;

(c) Regarding disposals as asset out in SFI Section 15 "Disposals and Condemnations, Losses and Special Payments".

Formal tendering procedures may be waived in the following circumstances:

(d) In exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) Where the requirement is covered by an existing contract;

(f) Where NHS Supply Chain, Office of Government Commerce or other NHS agreements can be utilised;

(g) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) Where the timescale genuinely precludes competitive tendering (but failure to plan the work properly would not be regarded as a justification for a single tender);

(i) Where specialist expertise is required and is available from only one source;

(j) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the value of such work;

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record (a single source waiver form), authorised by the Director of Finance and/or Chief Executive, and reported to the next Audit Committee meeting.

8.2.3 Where the exceptions set out in paragraph 8.2.2 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.2.4 Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

8.3 Contracting/Tendering Procedure

Paper based or electronic tenders

The tendering process may be paper based or using an electronic tendering system. For tenders managed by the Procurement department, they use a fully audited electronic sealed bid process, where quotations and tenders cannot be opened until the set date and time. There is a complete electronic audit trail built into this process.

The following paragraphs indicate where the tendering process is different between paper and electronic.

8.3.1 Invitation to tender

(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(b) For paper tenders, all invitations to tender shall state that no tender will be accepted unless:

(i) Submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(ii) tender envelopes/packages do not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) For electronic tenders, the invitation shall state that only tenders submitted electronically will be considered.

(d) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable

(e) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects. Any other significant amendments must be notified to the Business Risk and Investment Committee.

8.3.2 Receipt and safe custody of tenders

(a) For paper tenders, the Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

(b) For electronic tenders, the tenders are locked automatically until the published date and time of opening. The date and time of receipt of each tender is stored electronically.

8.3.3 Opening tenders and register of tenders (paper tenders)

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Executive Directors or Board Directors, who will not be from the originating department.

(b) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(c) Every tender received shall be marked with the date of opening and initialled, alongside the tender total, by those present at the opening.

(d) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched;

(i) The name of all firms' individuals invited;

(ii) The names of firms individuals from which tenders have been received;

(iii) The date the tenders were opened;

(iv) The persons present at the opening;

(v) The price shown on each tender;

(vi) A note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(e) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (paragraph 8.3.5 below).

8.3.4 Opening tenders and register of tenders (electronic tenders)

(a) Because the Procurement department use a fully audited electronic sealed bid process, where quotations and tenders cannot be opened until the set date and time, there is a complete electronic audit trail of viewing, opening dates, times, responses and amendments, automatically built into the process.

(b) After the closing date the tender documents are available elelctronically to see. Only senior managers in the Procurement department have this access.

8.3.5 Admissibility

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.3.6 Late tenders

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer, or if the process of evaluation and adjudication has not started and the provisional results of the tender exercise have not been communicated to the originating department.

(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

8.3.7 Acceptance of formal tenders

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

(c) It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) Experience and qualifications of team members;

(ii) Understanding of client's needs;

(iii) Feasibility and credibility of proposed approach;

(iv) Ability to complete the project on time.

(d) Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file prior to requesting tenders, and the reason(s) for not accepting the lowest tender clearly stated.

(e) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(f) The use of these procedures must demonstrate that the award of the contract was:

(i) Not in excess of the going market rate / price current at the time the contract was awarded;

(ii) That best value for money was achieved.

(g) All tenders should be treated as confidential and should be retained for inspection.

8.3.8 Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8.3.9 Approved firms

(a) Firms invited to tender shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, they do not discriminate against any person because of colour, race, ethnic or national origins, religion, gender or sexual orientation and that they comply with the provisions of the Equal Pay Act 1970, Equality legislation, the Bribery Act 2010 or related legislation.

(b) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) The Director of Finance may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

8.4 Quotations: Competitive and Non-Competitive

8.4.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £15,000 but

not exceed £49,999. This is for expenditure where more than one supplier is generally available and excludes:

(a) Custom/bespoke made one-off items for patient care;

(b) High cost implants for complex surgical cases (e.g. scoliosis) where the total cost for the case is less than £20,000 and value for money can be evidenced.

8.4.2 Competitive Quotations

(a) Quotations should be obtained from at least 3 firms/individuals, unless the intended income or expenditure is less than £25,000 when 2 quotations will be acceptable. The quotations will be based on specifications or terms of reference prepared by, or on behalf of, the Trust;

(b) Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record;

(c) All quotations should be treated as confidential and should be retained for inspection;

(d) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why must be recorded in a permanent record.

8.4.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) Where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this paragraph apply.

8.4.4 Quotations to be within financial limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFIs except with the authorisation of either the Chief Executive or Director of Finance.

8.5 Authorisation of Tenders and Competitive Quotations

8.5.1 Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Quotations	
Designated budget holders	Up to £2,499
Divisional Managers	Up to £9,999
Deputy/Assistant/Associate Directors	Up to £19,999
Directors	Up to £49,999
Tenders	
2 Executive Directors	Up to £249,999
Trust Board	Over £250,000

8.5.2 These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust's Scheme of Delegation.

8.5.3 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.6 Where Formal Competitive Tendering/Competitive Quotation is not required

8.6.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) The Trust shall use the local procurement service for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the local procurement service - where tenders or quotations are not required, because expenditure is below £15,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

8.7 Significant and Material Transactions

8.7.1 All significant and material transactions must comply with the requirements of the Risk Assurance Framework and the Trust's Constitution.

8.7.2 All major transactions whether or not they comply with the definitions of "Significant or Material Transactions" will be risk assessed in line with best practice, and in line with the Trust's Investment Decision Making Policy and approved by the Trust Board

8.7.3 All significant transactions must be explicitly approved by the Board and the Trust's Governors.

8.8 Compliance Requirements for all Contracts

8.8.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Constitution and SFIs;

(b) EU Directives and other statutory provisions;

(c) Any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable;

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited. If a departure becomes necessary the reasons for the departure must be recorded in a permanent record and in the project file;

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.9 Agency or Temporary Staff Contracts

8.9.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding agency staff or temporary staff service contracts

8.10 Healthcare Services Agreements (see overlap with SFI No. 9)

8.10.1 Service agreements with NHS providers for the supply of clinical and non-clinical support services shall be drawn up in accordance with guidance issued by the independent regulator, or subsequent responsible NHS body.

8.11 Disposals (see overlap with SFI No. 15)

8.11.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) Items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;

(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) Land or buildings concerning which Secretary of State guidance has been issued but subject to compliance with such guidance.

8.12 In-House Services

8.12.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.12.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officers and specialist;

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support;

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative.

8.12.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.12.4 The evaluation team shall make recommendations to the Board.

8.12.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.13 Applicability of SFIs on Tendering/Contracting to Funds Held on Trust

8.13.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

9. Contracts for the Provision of Healthcare Services

9.1 The Chief Executive is responsible for signing the annual legally binding contract, with Commissioners, using the standard NHS contract terms and conditions where appropriate, detailing the basis on which the Trust will provide healthcare services. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation.

9.2 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the annual Business Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding costing and pricing of services, payment terms and conditions and amendments to service agreements.

9.3 Contracts should be so devised as to achieve activity and performance targets, minimise risk, and maximise the Trust's opportunity to generate income. The Trust will produce a local tariff in accordance with NHS guidelines, for services outside the scope of the national tariff.

9.4 The Director of Finance will report any negotiated contract which uses terms other than those laid down in the NHS Contract or the Operating Framework to the Trust Board.

9.5 The Director of Finance shall ensure that a summary of the Trust's agreed contracts is reported annually to the Board, prior to the start of the financial year. The Director of Finance shall also produce regular reports to the Board detailing actual and forecast contract income with a detailed assessment of the variable elements of income.

10. Terms of Service, Allowances and Payment of Members of the Trust Board and Executive Committee Employees

10.1 Remuneration and Terms of Service

10.1.1 In accordance with the Constitution the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Committee will advise the Board about appropriate remuneration and terms of service for the Chief Executive, and other senior employees not on Agenda for Change terms and conditions, including:

(a) All aspects of salary (including any performance-related elements/bonuses);

(b) Provisions for other benefits, including pensions and cars;

(c) Arrangements for termination of employment and other contractual terms.

There must be proper regard to the Trust's circumstances and performance, and to the provisions of any national arrangements for such members and staff where appropriate.

10.1.2 The Council of Governors will agree the remuneration for the Chairman and Non-Executive members of the Board.

10.2 Funded Establishment

10.2.1 The manpower plans incorporated within the annual plan will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Director of Finance.

10.2.3 The total funded establishment of the Trust may not be varied without the approval of the Chief Executive.

10.3 Staff Appointments

10.3.1 No officer or member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless the following conditions are met:

(a) They have delegated authority in accordance with the Scheme of Delegation.

(b) The appointment is within the limit of their approved budget and funded establishment.

(c) The appointment has been made in accordance with procedures agreed by the Chief Executive.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc. for employees.

10.4 Processing Payroll

10.4.1 The Director of Finance is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications;

(b) The final determination of pay and allowances;

(c) Making payment on agreed dates;

(d) Agreeing method of payment.

10.4.2 The Director of Finance will issue instructions regarding:

(a) Verification and documentation of data;

(b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) Maintenance of subsidiary records for pensions, income tax, social security and other authorised deductions from pay;

(d) Security and confidentiality of payroll information;

(e) Checks to be applied to completed payroll before and after payment;

(f) Authority to release payroll data under the provisions of the Data Protection Act;

(g) Methods of payment available to various categories of employee and officers;

(h) Procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) Procedures for the recall of cheques and bank credits;

(j) Pay advances and their recovery;

(k) Maintenance of regular and independent reconciliation of pay control accounts;

(l) Separation of duties of preparing records and handling cash;

(m) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

(a) Submitting time records and other notifications in accordance with agreed timetables;

(b) Completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an officer for:

(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation.

(b) Dealing with variations to, or termination of, contracts of employment.

11. Non-Pay Expenditure

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The levels to be delegated are set out in the Trust's Scheme of Delegation, which should be referred to for further detail.

11.1.3 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services;

(b) The maximum level of each requisition and the system for authorisation above that level.

11.1.4 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Ordering, Receipt and Payment for Goods and Services

11.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Finance Director (and/or the Chief Executive) shall be consulted.

11.2.2 System of Payment and Payment Verification

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Finance Director will:

(a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFIs and regularly reviewed;

(b) Prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of employees (including specimens of their signatures) authorised to approve payments;

(ii) Certification that:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- The account is arithmetically correct;

- The account is in order for payment.

(iii) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in paragraph 11.2.3 below.

11.2.3 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. where material, cash flows must be discounted to net present value at the prevailing discount rate);

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.2.4 Official orders

Official Orders must:

(a) Be uniquely identified by use of an internally approved process;

(b) Be in a form approved by the Finance Director;

(c) State the Trust's terms and conditions of trade, including the need for suppliers to quote a valid order number when submitting invoices for payment;

(d) Only be issued to, and used by, those duly authorised by the Chief Executive. Lists of authorised officers shall be maintained and a copy of each list supplied to the Director of Finance;

(e) May be transmitted by a system of Electronic Data Interchange (EDI) approved by the Director of Finance;

(f) Be authorised, prior to being issued, according to the Trust's Scheme of Delegation.

11.2.5 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice;

(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees. As laid out in the Standards of Business Conduct policy, this excludes:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) Conventional hospitality, such as reasonable lunches in the course of working visits.

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or using the corporate credit card;

(g) Verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) Changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(k) Purchases from petty cash or using the corporate credit card are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) Petty cash and corporate credit card records are maintained in a form as determined by the Director of Finance;

(m) Drugs shall only be ordered via the Pharmacy Department.

11.2.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property

transactions comply with the guidance contained within ESTATECODE or CONCODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.2.7 All staff have a responsibility for the maintenance of confidentiality of all information. No member of staff shall reveal information that could:

(a) Prejudice fair competition;
(b) Result in the Trust failing to achieve the most advantageous price in respect of purchases or income in respect of sales

Any breach of confidentiality, whether or not for personal gain, may render an individual open to to disciplinary action in accordance with the Trust's Disciplinary Procedures, and may ultimately result in dismissal.

11.2.8 Payments to local authorities and voluntary organisations made under the powers of section 256 of the NHS Act 2006 (previously known as Section 28a payments) shall comply with procedures laid down by the Director of Finance which shall be in accordance with this Act.

12. Financial Framework

12.1 External Borrowing

12.1.1 The Director of Finance will advise the Board concerning the ability of the Trust to pay interest and make repayments on any proposed new borrowing. The Director of Finance is also responsible for reporting periodically to the Board concerning any loans or overdrafts.

12.1.2 The Director of Finance will advise the Board if a working capital facility is required to safeguard short term cash flow. If required the Director of Finance will negotiate such a facility with a commercial bank.

12.1.3 Any application for working capital or overdraft facilities will only be made by the Director of Finance and the Chief Executive or by an employee so delegated.

12.1.4 The Director of Finance must prepare detailed procedural instructions concerning applications for working capital facilities or overdrafts.

12.1.5 All short term borrowing should be kept to the minimum period of time possible, consistent with the cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance and Chief Executive or an employee so delegated.

12.1.6 All long term borrowing must be consistent with the plans outlined in the Annual Plan and in accordance with the Treasury Management policy.

12.2 Investments

12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board of Directors and in line with the Treasury Management Policy and the Independent Regulator's guidance, "Managing Operating Cash in NHS Foundation Trusts" as outlined in the Trust's Treasury Management Policy.

12.2.2 The Director of Finance is responsible for advising the Board of Directors on investments and shall therefore report annually to the Board of Directors concerning the performance of investments held.

12.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.2.4 The Trust must comply with all relevant guidance published on investments from time to time.

13. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

13.1 Capital Investment

13.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to budget;

(c) Shall ensure that the capital investment is not undertaken without confirmation of commissioners' support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every new capital investment, the Chief Executive shall ensure:

(a) That a business case is completed in line with best practice as set out in the Trust's Business Case & Investment Policy. This should include:

(i) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) The involvement of appropriate Trust personnel and external agencies;

(iii) Appropriate project management and control arrangements.

(b) That the Director of Finance has reviewed and confirmed the costs and revenue consequences detailed in the business case.

13.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

13.1.4 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised budgets.

13.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure;

(b) Authority to proceed to tender (see overlap with SFI No. 8);

(c) Approval to accept a successful tender (see overlap with SFI No. 8).

13.1.6 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.2 Private Finance (including Leasing)

13.2.1 When the Trust proposes to use private finance or leasing (either a finance lease or an operating lease) the following procedures shall apply:

(a) The proposal must obtain approval commensurate with that which is required were the assets, goods or services to be obtained by outright purchase i.e. employees must follow annual planning guidance;

(b) The Director of Finance shall demonstrate that the financing represents value for money and genuinely transfers risk to the private sector in accordance with relevant guidance.

(c) Any finance or operating leases must be agreed and signed by the Director of Finance if less than £100,000 and the Director of Finance and Chief Executive above that.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.3.2 The Trust shall maintain an asset register recording fixed assets.

13.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) Stores, requisitions and payroll records for own materials and labour including appropriate overheads;

(c) Lease agreements in respect of assets held under a finance lease and capitalised.

13.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.3.6 The value of each asset shall be indexed to current values in accordance with the Trust's accounting policies.

13.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Trust's accounting policies.

13.3.8 The Director of Finance of the Trust shall calculate and pay capital charges as specified in the guidance issued by the independent regulator.

13.3.9 The Trust shall maintain a property register recording assets used in the delivery of Commissioner Requested Services, in accordance with guidance issued by the independent regulator.

13.4 Security of Assets

13.4.1 The overall control of capital assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including capital assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. These procedures shall make provision for:

(a) Recording managerial responsibility for each asset;

(b) Identification of additions and disposals;

(c) Identification of all repairs and maintenance expenses;

(d) Physical security of assets;

(e) Periodic verification of the existence of, condition of, and title to, assets recorded;

(f) Identification and reporting of all costs associated with the retention of an asset;

(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

13.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures. (see SFI No. 15)

13.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses. (see SFI No. 15)

13.4.6 Where practical, assets should be marked as Trust property.

14. Stores and Receipt of Goods

14.1 General

14.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum;

(b) Subjected to annual stock take;

(c) Valued in accordance with the Trust's accounting policies.

14.2 Control of Stores, Stocktaking, Condemnations and Disposals

14.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

14.2.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

14.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.2.4 Stocktaking arrangements shall be agreed with the Director of Finance, and there shall be a physical check covering all items in store at least once a year.

14.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.2.6 The designated manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.3 Receipt of Goods

14.3.1 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked by the appropriate department as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

14.3.2 All goods received, other than from NHS Supply Chain, shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

15. Disposals and Condemnations, Losses and Special Payments

15.1 Disposals and Condemnations

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers

15.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

15.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.1.5 Any disposal of IT equipment must also comply with the IT Security Policy.

15.2 Losses and Special Payments

15.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Finance Director must inform the relevant LCFS.

15.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify the Board and the External Auditor.

15.2.4 The Trust Board shall approve the delegation of the writing-off of losses, on an annual basis.

15.2.5 The Director of Finance shall take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

15.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15.2.8 All losses and special payments must be reported to the Audit Committee at every meeting.

16. Information Technology

16.1 Responsibilities and duties of the Senior Information Risk Officer (SIRO)

16.1.1 The Trust's nominated Senior Information Risk Officer (SIRO), who is responsible for the accuracy and security of the computerised data of the Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000);

(b) Ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient operation of the system;

(c) Ensure that adequate controls exist such that the routine computer operation is separated from system controls including development, maintenance and amendment;

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out;

(e) Ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

(f) Ensure that risks to the Trust arising from the use of I/T are effectively identified and considered and appropriate action taken to mitigate or control these risks. This shall include the preparation and testing of appropriate disaster recovery plans.

16.2 Responsibilities and Duties of Other Directors and Officers in Relation to Computer Systems of a General Application

16.2.1 The Foundation Trust Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner.

16.2.2 In the case of computer systems which are procured jointly with other NHS organisations, the responsible officer will send to the Director of Finance:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.3 Contracts for Computer Services with other Health Bodies or Outside Agencies

16.3.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.4 Requirements for Computer Systems which have an Impact on Corporate Financial System

16.4.1 Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as, but not limited to, an Information Technology Strategy;

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff and the Trust's auditors have access to such data;

(d) Such computer audit reviews as are considered necessary are being carried out.

17. Patient's Property

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- Notices and information booklets; (subject to sensitivity guidance)
- Hospital admission documentation and property records;
- The oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. Funds Held on Trust

18.1 Corporate Trustee

18.1.1 The Trust Board is responsible, as a corporate trustee, for the management of funds it holds on trust. The Trust Board is responsible for ensuring compliance with Charity Commission latest guidance and best practice.

18.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

18.1.3 The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

18.2 Accountability to Charity Commission and Secretary of State for Health

18.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

18.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

18.3 Applicability of Standing Financial Instructions to Funds Held on Trust

18.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

18.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

19. Acceptance of Gifts by Staff and Link to Standards of Business Conduct

19.1 The Foundation Trust Secretary shall ensure that all staff are made aware of the Trust Standards of Business Conduct policy, which gives guidance on the acceptance of gifts and other benefits in kind by staff.

20. Retention of Records

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

21. Risk Management and Insurance

21.1 Programme of Risk Management

21.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current guidance from the Independent Regulator, which must be approved and monitored by the Board.

21.1.2 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;

(b) Engendering among all levels of staff a positive attitude towards the control of risk;

(c) Management processes to ensure all significant risks and potential liabilities are identified and addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) Contingency plans to offset the impact of adverse events;

(e) Audit arrangements including Internal Audit, clinical audit, health and safety review;

(f) A clear indication of which risks shall be insured;

(g) Arrangements to review the Risk Management programme.

21.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current guidance from the Independent Regulator.

21.2 Insurance: Risk Pooling Schemes Administered by NHS Resolution

21.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.3 Insurance Arrangements with Commercial Insurers

21.3.1 Any decision to enter into insurance arrangements with commercial insurers must be taken by the Trust Board, the one exception being that the Trust may enter commercial arrangements for insuring motor vehicles owned/leased by the Trust, including insuring third party liability arising from their use, without Board approval.

21.4 Board Arrangements to be Followed in Agreeing Insurance Cover

21.4.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

21.4.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.4.3 The risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Policy Review

This policy requires consideration by the Audit Committee prior to approval by the Trust Board.

This policy will be reviewed every year.

Policy updated: January 2019
Next review due by: January 2020

Record of Amendments

Date	Section number	Amendments
Mar 2018	Various	Minor amendments & clarification to terminology, titles, etc.
	8.2	Clarified that the single source waiver form for waiver of competitive tendering is authorised by the Director of Finance and/or Chief Executive
	8.3	Added in requirements for electronic tenders as well as the existing paper ones
	13.1	Requirement for business cases for all new capital investments
Jan 2019	8.5.1	Amended individual authorisation limits for accepting tenders to match those in the Scheme of Delegation
	21	Changed “NHS Litigation Authority” to “NHS Resolution”

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Scheme of Delegation		
Unique Identifier:	POL030	**Document Type:**	Policy
Version Number:	7.0	**Status:**	Draft
Responsible Director:	Craig Macbeth, Director of Finance		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Trust wide		
Replaces:	Version 6.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Standing Financial Instructions (SFIs) Matters Reserved to the Board		
Keywords:	Scheme of Delegation, Delegation		

Considered By Executive Owner:	Craig Macbeth, Director of Finance	**Date Considered:**	18/12/2018
Endorsed By:	Audit Committee	**Date Endorsed**	??
Approved By:	Trust Board	**Date Approved:**	??
Issue Date:	??	**Review Date:**	??
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Detailed Scheme of Delegation

The delegation shown below is the lowest level to which authority is delegated. This delegation may be suspended in order to increase control response to special circumstances. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. In the absence of the officer with delegated authority, if arrangements are in place for a deputy to act up, which have been formally recorded, the deputy may exercise that delegated authority If no such arrangements are in place, the matter should be referred to the next highest senior officer. All items concerning Finance must be carried out in accordance with Standing Financial Instructions.

DELEGATED MATTER	AUTHORITY DELEGATED TO
1. Management of Budgets	
1.1 Responsibility of keeping revenue expenditure within budgets	
(a) Designation of Budget Holder for each area e.g. corporate, operations	Chief Executive
(b) Designation of divisional Budget Holders	Nominated Exective / Clinical Director
(c) At cost centre level	Divisional Manager or responsible manager
(d) Other areas (e.g. reserves)	Director of Finance
1.2 Responsibility of keeping capital expenditure within budgets	Capital Management Group oversight with accountability devolved to designated scheme officers.
1.3 Responsibility for activity income	Director of Finance
2. Investment & Banking	
2.1 Opening & closing of bank accounts	Director of Finance
2.2 Investment of surplus cash	
(a) National Loans Fund (up to £5m) • Up to 3 months • Over 3 months	 Deputy Director of Finance Director of Finance and Financial Planning & Investment Committee
(b) Other institutions (up to £2m) • Up to 1 month • Up to 3 months • Over 3 months	 Deputy Director of Finance Director of Finance Director of Finance and Financial Planning & Investment Committee
2.3 External borrowing	Trust Board

DELEGATED MATTER	AUTHORITY DELEGATED TO
3. Non Pay Revenue & Capital Expenditure	
Authorising non-pay requisitions & payments (excluding locums & agency staff) where there is sufficient budget available – this includes on-line requisitions & invoices using "Oracle" *Note – all limits quoted are including VAT*	
3.1 Routine goods & services	
(a) Approve requisitions/payments up to a level as agreed by the Divisional Manager but no greater than £499.	Budget Administrator
(b) Approve requisitions/payments up to a level as agreed by the Divisional Manager but no greater than £2,499	Budget Holder
(c) Approve requisitions/payments up to £9,999	Divisional Manager
(d) Approve requisitions/payments up to £19,999	Deputy/Assistant/Associate Directors
(e) Approve requisitions/payments up to £49,999	Director
(f) Approve requisitions/payments up to £74,999	Director of Finance
(g) Approve requisitions/payments up to £99,999	Chief Executive or Director of Finance **&** one other Executive Director
(h) Approve requisitions/payments over £99,999	Chief Executive & Director of Finance
Where operational necessity requires deviation from these approval levels an appropriate variation will be agreed within the budget holder limit of £2,499	Director of Finance
3.2 Specialist goods/services & exceptional items	
(a) Approve **pharmacy** orders/payments up to £74,999	Head of Pharmacy
(b) Approve **pharmacy** orders/payments over £74,999	Head of Pharmacy **&** Director of Finance or Chief Executive
(c) Approve theatre replenishment of agreed implant stock levels orders/payments up to £49,999	Theatre Divisional Manager or Theatre Procurement lead
(d) Approve **capital/works** requisitions/payments up to £9,999	Associate Director of Estates & Facilities
(e) Approve **capital/works** requisitions/payments, where scheme has been approved by the Board, up to the approved budget	Director of Finance
(f) Approve **theatre** requisitions/ payments up to £9,999	Theatre Manager
(g) All orders and contracts for goods/services over £9,999 & **exceeding a 12 month period** & subsequent variations to these contracts.	Director of Finance or Chief Executive

DELEGATED MATTER	AUTHORITY DELEGATED TO
4. Capital Schemes & Leases	
a) Selection of architects, quantity surveyors, consultant engineer & other professional advisors within EU regulations	Associate Director of Estates & Facilities
b) Financial monitoring & reporting on all capital scheme expenditure	Director of Finance or Nominated Deputy
c) Granting & termination of leases with annual cost up to £100,000	Director of Finance
d) Granting & termination of leases with annual cost over £100,000	Chief Executive & Director of Finance
5. Quotations, Tendering & Contracting	
Note – all limits quoted are including VAT, except for the limit where tenders are subject to EU tendering procedures (set at £181,302 from 1st January 2018 by the European Commission) which excludes VAT	
Where quotes need to be considered against the EU tendering threshold the quote values will be derived from the current GBP/EUR exchange rate and compared to the tendering threshold	
5.1 Quotation & tendering limits	
a) Obtaining 2 written quotations for goods/services expected to be from £15,000 to £24,999	Budget Holder in conjunction with SHPS
b) Obtaining 3 written quotations for goods/services expected to be from £25,000 to £49,999	Budget Holder in conjunction with SHPS
c) Obtaining 3 written competitive tenders for goods/services expected to be from £50,000 to £180,999	Executive Director/Divisional Manager in conjunction with SHPS
d) Obtaining competitive tenders in accordance with European legislation for goods/services expected to be over ***£181,000*** (excluding VAT)	Executive Director & Director of Finance in conjunction with SHPS
5.2 Waiving of quotations/tenders subject to SFIs	
a) Waiving of quotations from £15,000 to £49,999	Director of Finance
b) Waiving of tenders from £50,000 up to £180,999	Chief Executive & Director of Finance
c) Waiving of tenders over £181,000	N/A – no waiver or single tender action is allowed which would exceed the EU procurement limit
5.3 Tender opening /evaluation & acceptance	
a) Opening paper tenders *(electronic ones are automatic)*	2 Executive Directors or Board Directors
b) Evaluation of tenders	Panel including Divisional lead, Finance manager and appropriate specialist advisor(s)

DELEGATED MATTER	AUTHORITY DELEGATED TO
c) Acceptance of tenders up to £249,999 per year	2 Executive Board Directors
d) Acceptance of tenders over £250,000 per year	Trust Board
e) Approving expenditure over agreed tender/ quotation budget where tender/quotation price is greater than 10%, up to the value of £15,000	Director of Finance
f) Approving expenditure over agreed tender/ quotation budget where tender/quotation price is greater than 10% and over £15,000	Chief Executive
g) Maintenance of Tender Register	Foundation Trust Secretary
6. Contracts & Tenders for Services Provided	
6.1 Healthcare Contracts	
a) Signing of contracts up to the value of £5m	Director of Finance
b) Signing of contracts above the value of £5m	Chief Executive
c) Price of NHS contracts charges for all activity not covered by PBR tariff	Director of Finance
d) Private patients, overseas visitors, income generation and other patient related services	Director of Finance
e) Reporting to the Trust Board where a negotiated contract does not comply with the terms of the NHS Contract or the Operating Framework	Director of Finance
6.2 Tender Submissions	
Sign-off of tender submissions	Service Manager or Divisional Manager
7. Personnel & Pay	
7.1 Appointments	
a) Filling funded posts on the establishment with permanent staff	Director of People (in line with post approval procedures)
b) Appointing staff to posts not on the formal establishment with permanent staff	Director of People (in line with post approval procedures)
c) Appointing additional staff to the agreed establishment with specifically allocated finance	Director of People (in line with post approval procedures)
d) Granting of additional increments to staff within budget and in accordance with Trust policy	Director of People
e) Requests for upgrading/regrading to be dealt with in accordance with Trust Procedure	Director of People
7.2 Pay	

DELEGATED MATTER	AUTHORITY DELEGATED TO
a) Completing standing data forms affecting pay, new starters, variations and leavers	Budget Holder
b) Completing and authorising positive reporting forms.	
c) Authorising overtime	Appropriate Manager/Director
d) Authorising travel and subsistence claims	Appropriate Manager/Director
e) Approval of performance related pay	Chief Executive or Nomination & Remuneration Committee
7.3 Leave	
a) Annual leave	Line/Departmental Manager
b) Annual leave – carry forward up to a maximum of 5 days	Line/Departmental Manager
c) Annual leave – carry forward in excess of 5 days but less than 10 days.	Director of People
d) Special leave up to 5 days	Line/Departmental Manager in line with Trust policy
e) Special leave in addition to 5 days	Director of People in line with Trust policy
f) Unpaid leave up to 5 days	Line/Departmental Manager in line with Trust policy
g) Unpaid leave over 5 days	Director of People in line with Trust policy
h) Medical Staff leave of absence paid and unpaid (over and above normal annual leave entitlement)	Medical Director and Director of People
i) Time off in lieu	Automatic approval of line manager within the requirements of the organisation
j) Maternity leave – paid and unpaid	Automatic approval within guidance
7.3 Sick leave	
a) Any extension of sick leave over employee conditions of service	Divisional Manager/Director in conjunction with Director of People
b) Return to work part-time on full pay to assist recovery.	Director of People in conjunction with Divisional Manager/Director
7.4 Study leave	
a) All study leave outside of the UK	Chief Executive
b) Medical staff CME/professional leave excluding overseas	Medical Director
c) All other study leave	Divisional Manager/Director with support from line manager

DELEGATED MATTER	AUTHORITY DELEGATED TO
7.5 Relocation expenses Authorisation of payment of relocation/removal expenses incurred by officers taking up new appointments (in accordance with local policy)	
a) Up to £5,000	Director of People
b) Over £5,000	Chief Executive
7.6 Car & mobile phone users	
a) Requests for new and existing posts to be authorised as car users	Director of People/Director of Finance in liaison with Divisional Manager/Director
b) Requests for posts to be authorised as mobile phone users	Director of People/Director of Finance in liaison with Divisional Manager/Director
7.7 Other	
a) Grievance cases to be dealt with in accordance with the Grievance Procedure, and advice of a Human Resources Officer must be sought	Director of People in accordance with Trust policy
b) Staff retirement – extension of contract beyond agreed retirement age	Director of People in liaison with Divisional Manager/Director
c) Redundancy	Chief Executive and Director of People
d) Ill-health retirement – decision to pursue retirement on the grounds of ill-health	Director of People in liaison with Divisional Manager/Director
e) Dismissal	Director of People and authorised directors or Nomination & Remuneration Committee as appropriate
8. Engagement of Staff other than Employees	
a) Non-medical consultancy staff	Chief Executive or Director of Finance
b) Engagement of Trust's solicitors	Chief Executive or Director of Finance and 1 other Director
c) Booking of bank or agency staff: - Medical locums - Nursing - Clerical	Director of People (in line with Bank & Agency procedure)
9. Charitable Funds	
9.1 Approval for fundraising/appeal launching	
a) Projected fundraising up to £5,000	Executive Director
b) Projected fundraising between £5,001 and £250,000	Charitable Funds Committee.

DELEGATED MATTER	AUTHORITY DELEGATED TO
c) Projected fundraising over £250,000	Trust Board following Charitable Funds Committee approval & Divisional Manager/Director support
9.2 Expenditure (inclusive of VAT if not exempt)	
a) Up to £1,500	Fund Manager
b) From £501 to £10,000 per request	Chief Executive or Director of Finance
c) From £10,001 to £20,000 per request	Chief Executive & Director of Finance
d) From £20,001 to £50,000 per request	Charitable Funds Committee, or between meetings Director of Finance and Chief Executive in consultation with other Trustees
e) Over £50,001	Charitable Funds Committee
10. Agreement/Licences	
a) Preparation and signature of tenancy agreements/licences for staff, subject to Trust Policy on accommodation for staff	Director of Finance/Director of People/Associate Director of Estates
b) Extensions to existing leases	Director of Finance/ Director of People /Associate Director of Estates
c) Letting of premises to outside organisations	Director of Finance & Chief Executive
d) Approval of rent based on professional assessment	Director of Finance
11. Condemning & Disposal of Assets Items which are obsolete, redundant, irreparable or cannot be repaired cost effectively (including x-ray films, mechanical & engineering plant)	
a) With a current estimated value up to £2,500	Divisional Manager/Associate Director/ Director/Associate Director of Estates
b) With a current estimated value over £2,500	Director of Finance
12. Losses and Special Payments 12.1 Losses Loss of cash, fruitless payments, bad debts, damage to buildings/equipment and loss of equipment	All losses and special payments must be reported to the Audit Committee
a) Up to £10,000	Deputy Director of Finance
b) Between £10,001 and £50,000	Director of Finance
c) Between £50,001 and £100,000	Director of Finance and Chief Executive
d) Over £100,000	Director of Finance and Chief Executive and a member of the Audit Committee

DELEGATED MATTER	AUTHORITY DELEGATED TO
12.2 Special payments : severance payments	Nomination & Remuneration Committee following Treasury approval
12.3 Special payments : expenses claims for cancelled clinics/operations	
a) Up to £50	Clinic staff
b) Over £50	Head of Financial Accounting
12.4 Special payments : other	
Compensation under legal obligation, personal injury claims, loss of personal effects & maladministration	
a) Up to £1,500	Head of Financial Accounting
b) Up to £50,000	Director of Finance
c) Between £50,001 and £100,000	Director of Finance and Chief Executive
d) Over £100,000	Director of Finance and Chief Executive and a member of the Audit Committee
12.5 Notification of novel, contentious or repercussive special payments to the Department of Health	Director of Finance
13. Reporting of Incidents to the Police	
a) Where a criminal offence is suspected	Duty Manager in conjunction with Local Security Management Specialist
b) Where a fraud is involved	Director of Finance in conjunction with Local Counter Fraud Specialist.
14. Petty Cash Reimbursements	
a) Expenditure up to £50	Authorising manager for non-pay expenditure
b) Expenditure over £50 (exceptional circumstances only)	Head of Financial Accounting
c) Reimbursement of patients monies up to £100	Head of Financial Accounting
d) Reimbursement of patients monies in excess of £100	Director of Finance
15. Implementation of Internal & External Audit Recommendations	Appropriate Director
16. Maintenance & Update of Trust Finance Procedures	Director of Finance

DELEGATED MATTER	AUTHORITY DELEGATED TO
17. Receiving Hospitality Individual & collective hospitality (small items such as pens, diaries or chocolates need not be declared)	All staff required to make declaration in Trust's Hospitality Register & follow Trust's Standards of Business Conduct
18. Investment of Funds (including Charitable Funds)	Director of Finance in conjunction with Finance Planning & Investment Committee
19. Authorisation of New Drugs (inclusive of VAT) Estimated total yearly cost (inclusive of VAT) up to £25,000 Estimated total yearly cost (inclusive of VAT) above £25,000	 Medical Director & Director of Finance following advice from Drugs & Therapeutics Committee Medical Director & Chief Executive in conjunction with Executive Team, following advice from Drugs & Therapeutics Committee
20. Authorisation of Clinical Sponsorship Deals	Medical Director
21. Authorisation of Research Projects	Medical Director
22. Authorisation of Clinical Trials	Medical Director & Director of Nursing
23. Insurance Policies	Director of Finance
24. Risk Management	Chief Executive
25. Patients & Relatives Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico-legal complaints : co-ordination of their management	 Director of Nursing Director of Nursing Director of Nursing
26. Infectious Diseases & Notifiable Outbreaks	Director of Infection Prevention & Control
27. Relationships with Press a) Enquiries within hours b) Emergency enquiries outside hours	 Chief Executive or Head of Communications Duty Officer or Senior Manager on call

DELEGATED MATTER	AUTHORITY DELEGATED TO
28. Extended Role Activities Approval of nurses to undertake duties/ procedures which can properly be described as beyond the normal scope of nursing practice	Director of Nursing
29. Patient Services a) Variation of operating and clinic sessions within existing number for outpatients, theatres & others b) Proposed changes in bed allocation & use - Temporary Change - Permanent Change	Director of Operations Director of Nursing Chief Executive
30. Facilities for Staff not Employed by the Trust to Gain Practical Experience. a) Professional recognition, honorary contracts & insurance of medical staff b) Work experience students	Director of People in accordance with Trust Policy Director of People in accordance with Trust Policy
31. Review of Fire Precautions	Director of Operations
32. Review of all Statutory Compliance with Legislation and Health & Safety Requirements Including Control of Substances Hazardous to Health Regulations	Director of Operations
33. Review of Medicines Inspectorate Regulations	Director of Nursing in conjunction with Head of Pharmacy
34. Review of Compliance with Environmental Regulations (e.g. those relating to clean air and waste disposal)	Director of Finance in conjunction with Associate Director of Estates
35. Review of Trust's compliance with Data Protection Act	Director of Nursing
36. Monitor Proposals for Contractual Arrangements Between Trust and Outside Bodies	Director of Finance
37. Review of Trust's Compliance with Code of Practice for Handling Confidential Information in the Contracting Environment and Compliance with "Safe Haven" per EL 92/60	Director of Finance

DELEGATED MATTER	AUTHORITY DELEGATED TO
38. Keeping of a Declaration of Interests Register	Foundation Trust Secretary
39. Attestation of Sealings in Accordance with Standing Orders	Chairman/Chief Executive or nominated deputy
40. Keeping of a Register of Sealings	Foundation Trust Secretary
41. Keeping of the Hospitality Register	Foundation Trust Secretary
42. Retention of Records	Chief Executive
43. Clinical Audit	Medical Director

Key
SHPS : Shropshire Health Procurement Service

Policy Review

This policy requires consideration by the Audit Committee prior to approval by the Trust Board.

This policy will be reviewed every year.

Policy updated: January 2019
Next review due by: January 2020

Record of Amendments

Date	Section number	Amendments
Mar 2018	Various	Minor amendments & clarification to terminology, titles, etc.
	2	Amended investment and borrowing limits to reflect those quoted in the Treasury Management Policy
	5	Added note differentiating electronic tender opening from paper ones
Jan 2019	Various	Minor amendments & clarification to terminology, titles, etc.
	6.2	New section on sign-off of tender submissions
	9.2	Increased approval limit by fund managers for charitable funds expenditure
	12	Change of approval for low value special payments, including mileage claims for cancelled clinics
	14	Increased limit for petty cash expenditure & change of approval for requests over the limit

Chair's Assurance Report
Quality and Safety Committee – 17 January 2019

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	31 January 2019
Executive Sponsor:	Chris Beacock, Non Executive Director	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Quality and Safety Committee Meeting held on 17 January 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
- There were updates provided on some key areas of challenge. Namely, follow up backlog management and delayed transfers of care, histopathology accreditation
- The quarterly infection control report was received
- The Board Assurance Framework risks and Corporate Risk Register was received and reviewed, so far as the risks related to quality and safety
- An update was received on flu vaccination
- Various Chairs' Reports were received and considered

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 17 January 2019. A full list of attendees is outlined below:

Chair/ Attendance:			
Chris Beacock	Non-Executive Director	(Chair)	CB
David Gilbert	Non-Executive Director		DG
Bev Tabernacle	Director of Nursing/Deputy CEO		BT
Steve White	Medical Director		SW
Nia Jones	Director of Operations		NJ
Mark Brandreth	Chief Executive		MB
Nicki Bellinger	Deputy Director of Nursing		NB
Lindsey Leach	Governance Lead		LL
Julie Roberts	Assistant Director of Nursing and Governance		JR
Paula Jeffreson	Deputy Director of Operations		PJ
Simon Bird	Histopathology		SB
Eric Hughes	Divisional Manager for Diagnostics		EH
Gemma Brett	Divisional Manager for Surgery		GB
Amanda Peet	Divisional Manager for Theatres		AP
Sue Sayles	Infection Control Nurse		SS
Sian Langford	Deputy Facilities Manager		SL
Shelley Ramtuhul	Trust Secretary		SR
Apologies:			
Hilary Pepler, Board Advisor			
Leighann Sharp, Matron for Theatres			

3.2 Actions from the Previous Meeting

The Committee received the actions from the previous meeting and noted that these were completed save for the following for which updates were provided:

- Letter following unsuccessful appeal for infection control case will be drafted and forward to the Chief Executive.
- The committee was updated on the spinal infections and the work being undertaken to identify the requirements for the evidence-based work.

- The committee was advised that the meeting to discuss the diagnostics staff survey was scheduled for February.

3.3 Key Agenda

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
CQC Update		
The committee received a verbal update on the recent CQC inspection and well led review. The Trust continues to deal with incoming queries and was currently on track to receive the final report at the end of January. The committee was advised the report would be embargoed until the Trust undertakes a factual accuracy check; this will be completed via the Board portal as before. The committee was advised that a publication date would be announced as soon as it was known.		
Delayed Transfers of Care		
The committee received an overview of the current issues with delayed discharges across the organisation. It was understood that the largest being arranging packages of care. The actions that have been taken and the key steps going forward were outlined. The committee was assured that the problem was understood and actions were taken however the committee required further assurance to evidence the issue being resolved. The committee will receive a further update at the next meeting in February.	Y	Further updated to next meeting for assurance that actions being taken are resolving the issue.
Follow Up Back Log		
The committee received an update on the follow up backlog position for the Trust. The key headline of the report was that there has been a reduction in performance. The committee was advised of the long-term plan outlining a reduction in outpatient appointments and the additional resources needed to deliver this. The committee was advised the team continued to working on the validation of lists and on the capacity required to address the backlog and this would continue to be monitored. A further update will be provided to the committee at a later date.	Partial	Further assurance required regarding the harms review output
Policy Update		
The committee received an update on the progress with updating the policies which are aligned to the	Y	

quality and safety. The committee was assured by the progress made.		
Committee Effectiveness and Annual Report		
The committee effectiveness assessment was completed and reported within the annual report. The assessment outlined the following: • Delivery of the 2017 18 with plan • The work plan for 2018 19 • Review of the terms of reference • Review of the committee effectiveness • Statement of assurance from the committee chair The annual report will be presented to the audit committee for consideration regarding the performance against its responsibilities as defined in the current terms of reference. The overall conclusion was that the committee is effective and the annual report was approved for submission to the Audit Committee	Y	
Board Assurance Framework and Corporate Risk Register		
The committee received the reviewed Board Assurance Framework aligned to the Quality and Safety Committee. The framework was recently reviewed at the Risk Management Committee at the beginning of January and is due to be presented to the Board later this month. SR informed the committee the updated framework included updates to the actions in order to address identified gaps and controls. The committee received an update on the TSSU risk as the Trust had recently had an unannounced inspection visit which had gone well with no non-conformities highlighted. The committee queried the risk on the corporate risk register regarding MCSI staffing which despite mitigations had not reduced the risk. It was agreed that the Trust Secretary would review this ahead of the next meeting. The committee noted the Board Assurance Framework and Corporate Risk Register and was assured by the mitigating actions being taken.	Y	

Chair's Assurance Report
Quality and Safety Committee – 17 January 2019

Divisional Quality Report: Surgery		
The committee received the Divisional Quality Report for Surgery which highlighted incidents as red as a result of two serious incidents relating to falls occurring within the division within the reporting period. These had undergone full RCAs with appropriate mitigating actions identified. There was a separate report on the agenda for Serious Incidents. The committee discussed the breaking the cycle event and going forward how the division will concentrate on measuring the outcomes. Away days are being held to help develop and lead on the strategy for the division. The committee noted the divisional quality report and noted that overall assurance would be gained through the inclusion of actions and updates so this will be taken forward.	Partial	Divisional Quality Reports to include actions and updates for assurance around improvements being made.
Infection Control (Q3)		
The committee received an update on the infection-control data for quarter 3 with the following headlines: • One case of MRSA • One case of E. coli • Spinal infections have reduced when compared to the previous quarter • Hand hygiene compliance – it was noted that when only a small number of audits are undertaken at impact on the overall results recorded • The second the c.diff appeal has been upheld It was agreed that going forward Arthroplasty division needed to be separated out from knees for more transparent reporting. The committee noted the infection control report for quarter 3.	Y	
Serious Incidents		
The committee received an outline of the serious incidents that had occurred since the last meeting and also progress towards closure of those that were previously reported. It was noted there were currently six open Serious Incidents. Two reports had been completed and awaited final closure by the CCG, four are currently being investigated. The Never Event Report will be presented at the next meeting.	Y	

The committee was informed that the new WHO process was now in place and will be able to mitigate the risks that had resulted in the never event. The committee made some minor recommendations to the presentation of the report to include duty of candour and deadline dates but overall was assured by the management of the Serious Incidents.		
Histopathology Update		
The committee received an overview of the action progress and in particular the additional resource required within the team to ensure the outstanding actions are completed in order for the Trust to achieve full compliance. The committee discussed the option of gaining support from other organisations but noted this was limited due to the specialist nature of the service and the MSK service the Trust provides. The Trust is however investigating other networks with other specialist centres. The committee noted it would receive a further update in February.	Partial	The committee was assured that appropriate action was being taken but at this stage could not be fully assured. A further update to be received at the next meeting.
Flu Vaccination		
The committee received an the Flu Vaccination uptake. The committee was informed the Trust is currently at 55.7% compliance rate however a further 13% have opted out of receiving the vaccination. NHS Improvement has asked if the Trust is aware of the importance of the vaccine and the Trust has responded by sending an update. The committee noted the update and the actions being taken to optimise uptake.	Y	
NOA Update		
The Medical Director provided a brief update on the meeting held in November where discussions were held around the MSK national agenda and the national PROMS network, a further meeting is scheduled for March. The committee noted the update.	N/A	
Chairs Reports		
The committee received and noted the following chair's reports: • Patient Experience and Communication • Workforce Development Group	Y	

• Clinical Governance and Quality. • Safeguarding Committee • Research Committee		
Review of Work Plan		
The work plan was presented to allow the committee to reflect on changing priorities and external factors. The committee suggested the following: • Paediatrics divisional quality reports to be added • Follow Up Backlog Update to be added for the next meeting • Delayed Transfer of Care to be added for the next meeting. The committee approved the work plan in line with the above suggestions.	Y	
Attendance Matrix		
The committee attendance matrix was presented for information only with no attendance issues raised.	Y	
Any Other Business		
WHO Policy The committee was advised that the WHO Policy will be circulated for information outside of the meeting. *GIRFT* The committee was advised that the confirmed dates for the GIRFT session will be circulated shortly.		

3.5 Risks

During the course of its business on 17 January 2019, the Committee did not identify any risks for escalation but did identify that there needed to be closer monitoring of follow up backlogs and delayed transfers of care. It was agreed that updates will be presented to the next meeting.

3.6 Conclusion

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

Chair's Assurance Report
Risk Management Committee – 7 January 2019

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	31 January 2019
Executive Sponsor:	Harry Turner, Non Executive Director	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Risk Management Committee Meeting held on 7 January 2019 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the implementation of the Trust's risk management systems and controls to the Risk Management Committee. This Committee is responsible for seeking assurance on the Trust's risk management in order that it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended and met its quoracy requirements.
- There was good progress of actions from the previous meeting
- The Board Assurance Framework (BAF) and Corporate Risk Register were reviewed in full.
- Deep dives were received regarding Paediatrics and Estates and Facilities
- The work plan was reviewed and agreed

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 Risk Management Committee which met on 7 January 2019. The meeting was quorate with two Non-Executive Directors, there were three Executive Directors present. A full list of the attendance is outlined below and demonstrates good representation from the Divisions.

Chair/ Attendance:
Harry Turner, Non Executive Director (Chair)
Chris Beacock, Non Executive Director
Mark Brandreth, Chief Executive
Kerry Robinson, Director of Strategy
Craig Macbeth, Director of Finance
Shelley Ramtuhul, Trust Secretary
Eric Hughes, Divisional Manager for Diagnostics
Phil Davies, Head of Estates and Facilities
Amanda Peet, Divisional Manager for Theatres
Kirsty Evans, Surgery Matron
Judith Sansom, Clinical Governance Lead
Lindsey Leach, Clinical Governance Lead
Mary Bardsley, Assistant Trust Secretary
Gemma Brett, Divisional Manager for Surgery
Rob Freeman, Medical Representative
Julie Roberts, Assistant Director for Nursing and Governance
Nina White, SOOS Manager
Leighann Sharp, Matron for Theatres
Apologies:
Nia Jones, Director of Operations
Paula Jeffreson, Deputy Director of Operations
Sara Ellis Anderson, Matron
Mandy Bride, Matron
Bev Tabernacle, Director of Nursing
Sarah Sheppard, Director of People
Nikki Bellinger, Deputy Director of Nursing

Chair's Assurance Report
Risk Management Committee – 7 January 2019

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting had all been 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
1. Board Assurance Framework (BAF)		
The Committee received the Board Assurance Framework and noted the updates to the actions to address the gaps in control and assurance for each risk. The Committee noted that a new risk had been added in relation to EU Exit risk and the potential impact of this on services. The Committee discussed the need to extend this to not only identify the supply issues but also the potential impact on staff. The Committee discussed the process for updating the BAF for 2019/20 it was confirmed that this would be done once the new objectives had been set. The Committee was assured by the progress being made to address the gaps in controls and assurances.	Y	
2. Corporate Risk Register		
The Committee was presented with an updated register or all Trust risks with a current risk rating of 15+ and noted there had been no new risks identified. Two risks had been reduced and one had been closed as follows: **Reduced** ○ 1953 Charnley Labs – Business Continuity ○ 1955 Charnley Labs - Environment **Closed** ○ 1954 Charnley Labs – Patient Safety The Committee risks 1817 and 1876 which related to patient access and requested that these be amalgamated. The Committee noted that the Patient Access Manager was now in post and therefore the risk was being mitigated. The Committee asked for review of the committee oversight for each risk to ensure that it was a Board Assurance Committee and further to ensure that each risk lead was and Executive. The committee noted the Corporate Risk Register .	Y	

Chair's Assurance Report
Risk Management Committee – 7 January 2019

3. Risk Management Report		
The Committee was presented with an update of the Trust's position for November 2018 with the following highlights: • 291 reported incidents in November 2018 • 1 Serious Incident • 12 risks were closed in November • 55 risks have been closed in December The Committee considered the oldest recorded risks and noted 2 were recorded as treated and 8 were being tolerated. The Committee was advised that the Governance leads continue to reviews the risk register with the divisions and further risk management training is to be offered to all. The Committee discussed and agreed that going forward only risks that required treatment were required to be reported. In addition any tolerated risks overdue for review would be reported to ensure these are kept under annual review as required. The Committee noted the updated and was assured of the current position and the progress made.	Y	
4. Business Continuity Plan		
In the absences of the Director of Nursing and Deputy Director of Nursing the committee agreed to defer the approval of the Business Continuity Plan until the next meeting. The committee deferred the Business Continuity Plan to the next meeting.	N/A	
5. Never Event and Near Miss Annual Report		
The Committee heard how the Trust encourages staff to record near misses onto the DATIX system. This gives the Trust an opportunity to learn and shows a positive reporting culture within the Trust. The Committee noted there have been 219 near miss events recorded between Novembers 2017 - 2018. The Committee discussed how this information could be used and it was agreed that some analysis was required and would be represented to the committee.	Partial	Further assurance required following deeper analysis of the data
6. Paediatrics Deep Dive		
The Committee received a report outlining the risk register for Paediatrics. The following was highlighted: • A total of 21 finally approved risks is recorded • There had been 2 newly added risk since directorate		

started in Oct 18 neither of which were a high risk following appropriate mitigations: ○ Inability to automatically send two letters to two parent guardians ○ Reduced medical cover at weekends to support surgical patients • There are no high risks recorded • The majority of risks recorded are scored as very low The committee discussed the issue of separated parents both receiving a letter regarding the child's treatment and the fact that the current IT systems do not offer the choice to send more than one letter. It was agreed that this is to be a standard operating procedure and this would mitigate the risk. The committee discussed the risk relating to reduced medical cover at the weekends to support surgical patients, the committee was satisfied that given the mitigations in place and the historical evidence to support there had been no issues, this was a low-moderate risk. The committee was aware that the CQC inspection would have tested this and this would present an opportunity to review the mitigations in place. The committee noted the age of some of the risks and it was agreed that these should be reviewed, closed and reopened as new risks if the risk has evolved. The risk relating to children being seen in main outpatients was discussed and the committee was advised that the risk was relatively low given the mitigations in place. Such as ensuring children are seen at the first appointment on the clinic and the patients being flagged to the outpatient manager The committee congratulated the directorate on the first deep dive. The Committee was assured regarding the oversight and management of the risk register and noted that given this was the first deep dive this would evolve further.	Y	
7. Estates and Facilities Deep Dive		
The committee reviewed the Estates and Facilities Deep Dive which highlighted the following: • There are currently 143 finally approved risks recorded on the register • The department meets every 2 weeks to review the risks • The majority of the risks are recorded as tolerated • The department uses the risk register in conjunction with the capital planning programme The Committee was assured regarding the oversight and		

management of the risk register and noted that given this was the first deep dive this would evolve further.		
8. Review of Work Plan 2017/18		
The Committee received the work plan for 2017/18 and was satisfied that it had received all required items for the meeting albeit the business continuity plan was received but deferred to ensure appropriate discussion.	N/A	
9. Any Other Business		
The Committee was advised that Stress Risk Assessment Training was being carried out on 23 January to ensure there are adequately trained staff to conduct these assessments and ensure the Trust is proactive in its management of stress.	Y	

3.4 Risks to be Escalated

In the course of its business the Committee identified no risk that required escalation

3.5 Assurances Sought at the Last Meeting

There were no outstanding assurances from the previous meeting.

3.5 Conclusion

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

0. Reference Information

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

1. Purpose of Paper

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

The Board of Directors is asked to ***consider*** and ***approve*** the suggested amendments to the BAF (highlighted in blue).

2. Executive Summary

2.1. Context

The Board of Directors uses the BAF as tool to ensure effective management of any risks which have potential to impact on delivery of the Trust strategy.

2.2 Summary

This paper presents an update of the BAF which has been reviewed and update by the following committees:

- Risk Management Committee
- Audit Committee
- Finance Planning and Investment Committee
- Quality and Safety Committee
- Executive Team

These reviews have resulted in the increase of the following two risks:

- 1.3 – Failure to achieve activity and income target within planned cost base
- 4.2.- Potential inability to have the right workforce in the right place at the right time

In addition the paper outlines the actions taken to address the identified gaps in controls and assurances.

Conclusion

The Board is asked to:

- Note the content of the BAF
- Consider and agree the proposed changes
- Consider and agree any additional changes required
- Approve the BAF as a true reflection of the Trust's strategic risks

3. Main Report

3.1. Board Assurance Framework

The Board of Directors utilises the BAF to identify and track the management of risks to the delivery of the organisations corporate objectives and ultimately the strategy. It documents the controls and assurances in place for each risk and identifies any gaps which require action to be taken.

Attached at Appendix 1 is a copy of the BAF which has been reviewed and updated since its last presentation to the Board in November.

There have been two changes to the risks cited on the BAF as follows:

- Risk 1.3 relating to ability to meet the activity and income targets has been increased to reflect the current challenges
- Risk 4.2 relating to the workforce has been increased to reflect potential ongoing and increasing staffing pressures in key areas.

In addition, updates have been made to the actions to address identified gaps in controls and assurances.

3.2. Conclusion

The Board is asked to:

- Note the content of the BAF
- Consider and agree the proposed changes
- Consider and agree any additional changes required
- Approve the BAF as a true reflection of the Trust's strategic risks

Operational Excellence 1.1

Achieving Outstanding Patient Safety

Principal Risk: Inadequate or unsuccessful implementation of learning from incidents

Missed opportunities to prevent further incidents, risk of increased incidents. Reputational damage and poor patient experience. Lack of output from investigations reduces reporting

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	4	2
Likelihood	5	2	1
Total	25	8	2

Risk Details

Opened: May 2017
Reviewed Date: January 2019
Source of Risk: Incident data
Corporate Risk Register? (DX 1949)

Controls:

- ✓ Incident and Serious Incident Policy in place and updated
- ✓ Learning triangles introduced
- ✓ Robust Quality and Governance Structure
- ✓ Real time data and feedback via Datix with daily reporting of incidents to executive team
- ✓ Safety Summits (July 2017 and further summit planned on near misses)
- ✓ Reporting to Risk Management Committee of ongoing risks linked to incidents
- ✓ RCA training rolled out to wider organisation
- ✓ Automated feedback to staff who report incidents via Datix
- ✓ Quarterly safety bulletin
- ✓ WHO process revised following Never Event

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

- ✓ NRLS benchmarking
- ✓ CQC Monitoring
- ✓ Oversight and assurance by Quality and Safety Committee
- ✓ Monitoring by CCG with regular Quality Surveillance Meetings
- ✓ Internal audit report on incident management
- ✓ Internal audit on WHO process

Gaps in Controls:

- Manual patient feedback capture does not provide real time data
- Staff survey results low regarding feedback indicating a perception issue

Gaps in Assurance:

- Lack of specialty benchmarking

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Roll out of electronic solution for patient feedback capture	Director of Nursing	Sept 2018	The data impact assessment has been signed off by the Data Protection Officer. The hardware requirements are currently being addressed. The system is up and running, once the hardware requirements have been addressed live capture can commence	
Communication with staff regarding feedback	Trust Secretary	Oct 2018	Safety Rounds commencing w/c 7 January to share learning directly with staff in their areas. Safety Champion t-shirts on order to increase visibility	Completed
Benchmarking opportunities to be scoped	Medical Director	Nov 2018	Plan to raise benchmarking issue with the NOA. Trust Secretary to pick up with Medical Director following NOA meeting in November	

Risk Owner:

Director of Nursing

Lead Committee

Quality and Safety Committee

Operational Excellence 1.2

Delivering outstanding outcomes and experience

Principal Risk: Limitations as a result of IT capabilities

Inability to progress innovative ways of working due to limited IT infrastructure and resource, fragmented systems resulting in continuing inefficiencies, efficiency payback of new systems not full realised or optimised

Risk Rating:

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

Risk Details

Opened: March 2018
Reviewed Date: January 2019
Source of Risk: Risk Assessment
Corporate Risk Register? (DX 1537, DX 1706, DX852, DX1144)

Controls:

- IMT steering group oversight and action
- Actions in response to internal audit report on cyber security
- Actions in response to internal audit on IT general controls
- Annual penetration test with actions in response as required
- Incident policy in place
- Training in place
- KPI's monitored via IMT steering group
- Help desk review completed
- Chief Clinical Information Officer role in place
- Capital Management Group
- OLA's for service
- Shared governance arrangements for the STP
- Board have undergone Cyber Training
- IT Strategy approved the by the Board

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

- Oversight and assurance by Audit committee
- Oversight and assurance by FPI committee
- IG committee oversight and assurance
- NHS digital benchmarking
- NHS model hospital
- NHS Digital oversight
- STP Digital stream committee
- Internal audit report on cyber security
- Internal audit on IT general controls
- Specialty benchmarking in place via model hospital

Gaps in Controls:

- Financial viability to be tested
- Ability to implement digital strategy
- Clinical process standardisation
- Lack of clinical standards and innovation committee
- STP IM&T Development and Plans not going through the Trust's Governance framework
- Audit of SOPs to ensure adequate control

Gaps in Assurance:

- Training compliance on systems
- STP IM&T Development and Plans not going through the Trust's Governance framework
- Outcome of audit of SOPs

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
EPR procurement and development of EPR Business Case to include stakeholder engagement.	Associate Director of IM&T	Nov 18	Stakeholder engagement underway	

Stakeholder engagement.	Associate Director of IM&T	Sep 2018	Discussed at Clinical Cabinet and Clinical Management Board on 12 November. Plan for engagement in place and is ongoing.	
STP IM&T LDR to be circulated through FPI	Associate Director of IM&T	Feb 2019	To go on the agenda of the next meeting	
Audit of compliance with SOPs to be undertaken	Associate Director of IM&T	Mar 2019		

Risk Owner:

Director of Strategy and Planning

Lead Committee

Finance Planning and Investment Committee

Operational Excellence 1.3

Spending our money wisely

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

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

Risk Rating:

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

Risk Details

Opened: March 2018
Reviewed Date: January 2019
Source of Risk: Financial management
Corporate Risk Register? (DX 1604)

Controls:

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

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

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

Gaps in Controls:

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

Gaps in Assurance:

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

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Divisions to identify further mitigating schemes	Director of Finance	Ongoing	Ongoing discussions via Performance Meetings	
Demand and capacity modelling to be completed	Assoc. Director of Performance	March 2019	Surgical specialties on track to be deliver by the due date. Assessing the risk of not delivering on medical specialities by the due date.	
Bookings process to be reviewed	Director of Operations	~~Nov 2018~~ March 2019	Breaking the cycle event has been held which reviewed the booking process. There is a 3 month action plan for improvement in place.	
Audit of job plan compliance to be completed	Director of People / Director of Operations	January 2019	Incorporated into Internal Auditor Work Plan for 3 months time. BDO are undertaking the audit with their report due back end of January	

Risk Owner:

Director of Finance

Lead Committee

Finance Planning and Investment Committee

Operational Excellence 1.4

Meeting the requirements of our regulators

Principal Risk: Failure to improve performance in relation to the CQC core standards

Potential for reputational damage and impact on business growth. Inability to attract quality staff. Poor patient perception

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	5	5	1
Likelihood	5	2	2
Total	25	10	2

Risk Details

Opened: May 2017
Reviewed Date: January 2019
Source of Risk: CQC regulation
Corporate Risk Register? (DX 786, DX1744)

Controls:

- ✓ Implementation of 'Clutter Busters' on each ward
- ✓ CQC Action Plan and Mock CQC Action Plan
- ✓ Review and revision to Quality and Governance structure
- ✓ Removal of breach of licence
- ✓ Well Led Self-Assessment completed and action plan compiled
- ✓ Completed PIR to CQC
- ✓ Learning from recent CQC inspection with debriefs held with staff
- ✓ Gap analysis against the KLOEs completed
- ✓ Exec led reviews with Divisional leadership teams

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

- ✓ Regular meetings with CQC Officer
- ✓ Internal audit review of CQC action plan
- ✓ Board oversight and assurance
- ✓ CQC Mock Inspection held
- ✓ External reviews of both Theatres and Paediatrics
- ✓ Initial feedback from the CQC inspection team

Gaps in Controls:

- ~~Action plan to address gap analysis ongoing~~
- Up to date action plan required to address any gaps identified in recent inspection – draft report awaited

Gaps in Assurance:

- Published rating is from 2015

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Action plan to address gap analysis	Director of Nursing	~~Oct 2018~~ Feb 2019	Action plan completed. CQC draft report awaited following which the action plan will be updated and re-instated. In the meantime actions have been taken to address verbal feedback	Completed

Risk Owner:

Director of Nursing

Lead Committee

Quality and Safety Committee

Operational Excellence 1.5

Spending our money wisely

Principal Risk: Instability arising from fluctuations in the tariff from 2019/20 onwards

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

Risk Rating:

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

Risk Details

Opened: November 2016
Reviewed Date: January 2019
Source of Risk: Commissioning contract
Corporate Risk Register? (DX1490, DX1533, DX1602)

Controls:

- ✓ Feedback through NHS I consultation process
- ✓ Lobbying to support adverse losses via the NOA
- ✓ Trust actively participating in the development of future orthopaedic tariff as part of costing transformation programme (CTP) pilot scheme
- ✓ NOA and Expert Working Group
- ✓ Strong costing systems locally
- ✓ Framework set for a two year cycle

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

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

Gaps in Controls:

- 2019/20 national tariff will be based on national reference costs – historically this causes shortfalls in specialist activity prices

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Trust working with NHSI as part of pre-consultation early impact assessment	Finance Director	Ongoing	Ongoing discussions through the NOA with NHSi regarding a sustainable tariff for complex procedures	
Lobbying through NOA on tariff losses	Chief Executive / Finance Director	Ongoing	19/20 draft tariff received and discussions ongoing	

Risk Owner:

Director of Finance

Lead Committee

Finance, Planning and Investment Committee

Operational Excellence 1.6

Delivering outstanding outcomes and experience

Principal Risk: Inadequate operational processes

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

Risk Rating:

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

Risk Details

Opened: March 2018
Reviewed Date: January 2019
Source of Risk: National and local health landscape
Corporate Risk Register? (DX TBC)

Controls:

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

Assurance: Source of Assurance 2

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

Gaps in Controls:

- Booking pathway timeline compliance
- Financial viability of transparency model to be assessed
- Lack of real time oversight of bed capacity
- Follow up backlog project behind plan therefore management of backlog being impacted
- ~~Staffing issues in the Bookings Teams~~

Gaps in Assurance:

- Performance deep dives still embedding

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Operational Excellence Programme Board to develop programme plan	Director of Operations ~~/ Assoc. Dir of Performance~~	Ongoing	Programme Board held 11 June and proposed programme plan discussed. PIDs to go to monthly meetings going forward.	Complete
Options appraisal of existing technologies for control room model	Director of Operations ~~/ Assoc. Dir of Performance~~	Sept 2018	In house solution being implemented with project board established.	Complete
Phase 1 of co-ordination centre model to be implemented – using data in place and control room established	Director of Operations / Director of Strategy and Planning	Mar 2019		

Risk Owner:

Director of Operations / Assoc. Director of Performance

Lead Committee

Finance Planning and Investment Committee

Operational Excellence 1.7

Delivering timely access to patient care

Principal Risk: Inability to sustain the delivery of our access and waiting times

Lack of capacity in sub specialties together with a failure to follow polices and embed RTT management processes. Pressure on sub specialties where demand exceeds capacity. Potential to result in breach of contracts and key targets, potential for increased costs if OJP or external capacity used. Risk of patient safety issues due to long waits. Overall reputational damage.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	4	2
Likelihood	5	4	1
Total	20	16	2

Risk Details

Opened: November 2016
Review Date: January 2019
Source of Risk: National Targets
Corporate Risk Register? (DX885, DX1573, DX1601)

Controls:

- ✓ Fast track recruitment days for Theatre staff
- ✓ New Access Policy in place
- ✓ Close monitoring of shortfall in theatre sessions through daily Comm Cell
- ✓ Transformation work streams identified
- ✓ Additional consultants recruited in Spinal Disorders, Knee and Sports Injuries and Paediatric Orthopaedics
- ✓ Bed modelling completed with Kenyon opened as required to support activity
- ✓ CCG PLCV /VBC authorisation process placing controls on demand to RJAH
- ✓ Referrals being monitored as part of monthly planned care working group and monthly contract meeting with CCG (Service Performance Forum)
- ✓ Menzies M12 opened on 1 October
- ✓ Theatre recovery plan in place focussing on theatre efficiency – minutes utilised and cases per session with remodelling completed
- ✓ Consultant training on patient choice

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

- ✓ NHSi agreed recovery trajectories and monitoring and breach of licence removed
- ✓ Finance Planning and Investment Committee monitoring
- ✓ Planned Care Working Group monitoring
- ✓ Weekly exec comm cell
- ✓ Weekly activity and assurance meeting
- ✓ Mandated returns approved by Exec Team
- ✓ Data quality assessment of all KPIs
- ✓ Daily theatre activity comm cell
- ✓ Twice weekly theatre scheduling meeting
- ✓ Operational Board established with oversight of work to deliver access targets

Gaps in Controls:

- Transformation work ongoing
- Demand and capacity work ongoing but behind plan
- Case mix of RTT backlog continues. Reduction in backlog requires deliver of efficiency of theatres for inpatient activity
- Spinal Disorders capacity
- Control of the impact of CCG PLCV/VBC on SOOS demand and case mix imbalance
- SOOS model requires review
- Follow up backlog project behind plan

Gaps in Assurance:

- Lack of Consultant Referral Policy and compliance with the same

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Recruitment of required consultants	Medical Director	~~Oct 18~~ Mar 19	Upper limb consultant and professorial posts out to advert. Arthroplasty advert in draft	
Completion of capacity and demand work	Associate Director of Performance	~~Sept 18~~ Mar 19	Surgical specialties on track to be deliver by the due date. Assessing the risk of not delivering on medical specialities by the due date.	
Implementation of Administration Review recommendations to improve booking process	Director of Operations	~~December 18~~ ~~Mar 19~~	Head of Patient Access in post end of September, Improvement event undertaken in November 2018. Action plan in place for 3 month implementation.	
Progress follow up back log project	Director of Operations	Mar 19	Four key work streams have been established with project management resource identified. Plan takes to the end of March 2019 for full implementation. Aspects of the projects are at risk with the Deputy Director of Operations undertaking a risk assessment focussed on patient safety and a report to be submitted to Quality and Safety Committee.	
Development of Consultant Referral Policy	Medical Director	~~Nov 18~~ Mar 19	Work on the Consultant Referral Policy underway with discussion at Clinical Management Board. Policy in draft.	

Risk Owner:

Director of Operations

Lead Committee

Finance Planning and Investment Committee

Operational Excellence (NEW) 1.8

Delivering timely access to patient care

Principal Risk: Potential for EU Exit to impact on service delivery

Potential risk to continuity of supply which could compromise the Trusts ability to continue providing services. In particular services which rely on goods that are manufactured and transported from the EU would be affected. In addition a small number of the workforce will be affected by the resettlement arrangements

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (tolerance)
Consequence	4	3	2
Likelihood	4	3	1
Total	16	9	2

Risk Details

Opened: December 2018
Review Date: January 2019
Source of Risk: Legislation
Corporate Risk Register? (DX2000)

Controls:

- ✓ NHS Supply Chain managing border controls
- ✓ Risk assessment process for suppliers outside the supply chain
- ✓ National and Regional Teams issuing guidance
- ✓ Executive Lead in place
- ✓ Participation and completion of national procurement dashboards on Brexit risk.
- ✓ Frequent meetings with procurement officers to consider risk of supply.
- ✓ Risk assessments to be completed for all suppliers identified to be at risk
- ✓ Non Executive Lead to be identified

Assurance: Source of Assurance 3

- ✓ Audit Committee oversight with Risk Management Committee keeping under review on a monthly basis and escalating as required
- ✓ NHS Supply Chain management

Gaps in Controls:

N/A

Gaps in Assurance:

N/A

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Completion of risk assessments for goods and services at risk	Director of Finance	Mar 19	20% of remaining goods and services have been risk reviewed, amounting to 31 suppliers with alternative arrangements to be identified where possible. Remaining at risk suppliers to be flagged centrally to be included in overall strategy. Contingencies and alternative arrangements to be sought with UK based suppliers where possible.	

Risk Owner:

Director of Finance

Lead Committee

Audit Committee

Specialist Orthopaedic 2.1

Delivering outstanding outcomes and experience

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

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

Risk Rating:

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

Risk Details

Opened: March 2018

Review Date: January 2019

Source of Risk: National and local health landscape

Corporate Risk Register? (DX TBC)

Controls:

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

Assurance: Source of Assurance 3

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

Gaps in Controls:

- Further definition of specialist orthopaedic programme
- No process for addressing the impact of NHS E procurement for specialised service contracts
- No early warning systems for external providers

Gaps in Assurance:

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

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Strategy development	Director of Nursing	Report to Strategy Board in Feb 19	Definition for Specialist Services agreed at Trust Board in October	
Explore opportunities to input into the NHS Confederation and Federation of Specialist Hospitals collaboration	Director of Strategy and Planning	Mar 19	The Director of Strategy and Planning has made contact to explore this further	

Risk Owner:

Director of Nursing

Lead Committee

Finance Planning and Investment Committee

Specialist Orthopaedic 2.2

Delivering outstanding outcomes and experience

Principal Risk: Local health partners do not see the benefit of specialist orthopaedic services within the system

Ability to lead the MSK pathways compromised, difficulties integrating into the local system work with weak voice

Risk Rating:

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

Risk Details

Opened: March 2018

Review Date: January 2019

Source of Risk: National and local health landscape

Corporate Risk Register? (DX TBC)

Controls:

- ✓ Trust representation within the STP workstreams
- ✓ CEO and Chair Network for the STP
- ✓ Engagement with key partners in the local health system
- ✓ Kings Fund led workshops
- ✓ Trust strategy
- ✓ Horizon scanning
- ✓ Future fit response
- ✓ MSK Orthopaedic System Paper

Assurance: Source of Assurance 3

- ✓ STP updates to Board
- ✓ NHS I and NHS E input
- ✓ Board oversight of partner risks

Gaps in Controls:

- ~~Understanding of our partners risks~~

Gaps in Assurance:

- ~~Lack of sight of partner risks resulting in gaps in assurance relating to the impact and mitigations of those risks for the Trust~~

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Review the ways the Trust can ensure sight of partner risks	Director of Strategy and Planning	Dec 2018	Review of partner risks has been undertaken and report being taken to the Executive Team on 15 January for consideration and inclusion as required within the Trust's risk framework. Report will also go to Board in January.	Completed

Risk Owner:

Director of Nursing

Lead Committee

Executive Team

MSK 3.1

Delivering timely access to patient care

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

Potential reduction in activity at the Trust with loss of contracted work, impact on stability and availability of specialist work, potential for duplicate visits for patients, inability to respond to external factors. Host commissioner in financial recovery and requires material reduction in orthopaedic spend, impact for the Trust still to be determined.

Risk Rating:

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

Risk Details

Opened: May 2017
Review Date: January 2019
Source of Risk: External drivers
Corporate Risk Register? (DX1490, DX1533, DX1602)

Controls:

- ✓ Monitoring of GP referrals
- ✓ Horizon scanning in place
- ✓ Regular dialogue through contract meetings
- ✓ Monthly 1:1 between the Directors of Finance and Chief Executives
- ✓ Participation in MSK service developments and SOOS
- ✓ Delivery of QIPP prior approval requirements
- ✓ STP Directors Monthly Report
- ✓ Strategy deployment linked to objective setting
- ✓ Programme plan in place
- ✓ STP governance arrangements defined
- ✓ SOOS KPIs in place
- ✓ 1st phase complexity modelling completed
- ✓ Definition of MSK agreed by the Board

Assurance: Source of Assurance 3

- ✓ Strategy Oversight Group overseeing delivery
- ✓ Board reporting programme in place
- ✓ Clinical Cabinet established
- ✓ Local MSK Programme Board in place
- ✓ Finance, Planning and Investment Committee Oversight (Previously BRIC)
- ✓ Monthly performance report
- ✓ NHS I monitoring
- ✓ Shropshire CCG MSK Programme Board
- ✓ SOOS project board in place
- ✓ Contract in place with contractual review meetings
- ✓ Monthly MSK meeting with the CCG
- ✓ Updates to Q&S Committee
- ✓ Planned Care Working Group

Gaps in Controls:

- ○ Ability to implement strategy
- ○ Stakeholder relationships
- ○ System contract alignment with strategic MSK vision
- ○ Lack of triangulated system MSK reporting i.e. finance, outcomes, quality, experience, activity

Gaps in Assurance:

- ○ Lack of integration of MSK provider and commissioner programme boards, together with split commissioner reporting.
- ○ Lack of integration between local and specialised commissioning for MSK conditions
- ○ No national inclusion of MSK in NHS long 10 year plan

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Communications plan to be taken through the Executive Team Meeting	Director of Strategy and Planning	November 2018	Steer provided by the Board, to be followed up through the Executive Team	Completed

Risk Owner:

Director of Strategy and Planning

Lead Committee

Finance, Planning and Investment Committee

Culture and Leadership 4.1

Being an extraordinary place to work

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

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

Risk Rating:

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

Risk Details

Opened: Apr 17
Review Date: January 2019
Source of Risk: Staff survey results
Corporate Risk Register? (DX TBC)

Controls:

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

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

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

Gaps in Controls:

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

Gaps in Assurance:

- Service improvement expertise

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Review of how communications cascade works to be undertaken	~~Assoc. Dir of Performance~~ Director of People	Sept 2018	Survey of staff regarding communication has been issued with results now in the process of being reviewed and to feed into the Communications Strategy. First Fridays introduced for senior managers to improve visibility and link with staff	Completed
Business case to be developed for service improvement expertise	Director of Strategy and Planning	Oct 2018	Review of Service Improvement capability completed in September to now form part of drafted business case.	

Risk Owner:

Director of Strategy and Planning

Lead Committee

Quality and Safety Committee via Workforce Development Group

Culture and Leadership 4.2

Being an extraordinary place to work

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

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

Risk Rating:

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

Risk Details

Opened: March 2018
Review Date: January 2019
Source of Risk: Workforce
Corporate Risk Register? (DX 1745, DX1652)

Controls:

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

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

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

Gaps in Controls:

- Development of new roles
- Resource to support maintenance of number of bank staff
- Efficiency and timeliness of recruitment process
- Role specific recruitment plan
- Succession planning / workforce plans
- Lack of available coaching resources/capability
- Lack of triangulation of management information reporting
- Quantification of risk relating to pension tax changes - potential for clinical staff to drop PAs
- Unknown scale of STP changes

Gaps in Assurance:

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

Action Plan to Address Gaps

Action	Lead	Due By	Progress Update	Completed
Development of new roles and training routes for hard to fill roles	Deputy Director of HR	Mar 2019	New roles currently being considered are associate nurse roles and physician associates.	
Service improvement of recruitment and employment checks processes	Deputy Director of HR	Mar 2019	TRAC system to be discussed at the next Executive Team Meeting	
Development of a 5 year workforce plan which will include the identification of critical roles for succession planning purposes.	Deputy Director of HR	Mar 2019	Divisional level planning under way. Succession planning for senior team has commenced	
Role specific recruitment plans to be devised	Deputy Director of HR	Jan 2019	Workforce Development Group agreed recruitment plan for nursing.	

Level of risk relating to the pension tax changes to be assessed and documented on the risk register	Director of Operations	Jan 2019	Meetings with key staff have taken place to understand the scale of the risk and a preliminary risk assessment has been undertaken	

Risk Owner:

Director of People

Lead Committee

Quality and Safety Committee via Workforce Development Group

Appendix One: Assessment of Trust's Risk Appetite Against the 'Risk Appetite for NHS Organisations Matrix

Key Elements ↓	Risk Levels					
	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a key organisational objective	**Minimal** As little risk as possible. Preference for ultra-safe delivery options with low degree of risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and response systems are robust
Financial / Value for Money (VfM)	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of limited financial loss. VfM still the primary concern but will consider other benefits of constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits considered. Resources allocated to capitalise opportunities.	Investing in best possible return and accept the possibility of financial loss (with controls in place). Resources allocated without guarantee of return – 'investment capital' type approach	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself
Compliance / Regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances	Limited tolerance for sticking neck out. Want to be reasonably sure we would win any challenge	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup	Consistently pushing back on regulatory burden. Front foot approach informs better regulation
Innovation / Quality / Outcomes**	Defensive approach to objectives – aim to maintain/protect, rather than create or innovate. Tight management controls and oversight / limited devolved decision taking authority. General avoidance of systems / technology developments	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority is held by senior management. Only essential systems / technology developments to protect current operations	Tendency to stick to the status quo, innovations in practice avoided unless necessary. Decision making authority held by senior management. Systems / technology developments limited to protection of current operations.	Innovation supported, with demonstration of commensurate management control improvements. Systems / technology developments used to enable operational delivery. Responsibility for non-critical decisions may be devolved	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control	Innovation the priority – consistently 'breaking the mould' / challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust not tight control is standard.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation is viewed as a concern	Tolerance for risk taking limited to events where there is no chance of significant repercussions. Senior management distant from chance of exposure to attention	Tolerance for risk taking limited to events where there is no chance of significant repercussions. Should there be failure. Mitigations in place for undue interest	Appetite to take decisions with potential to expose the Trust to additional scrutiny/interest. Prospective management of organisations reputation	Willingness to take decisions likely to bring scrutiny but where potential benefits outweigh risks. New ideas seen as potentially enhancing reputation	Track record / investment in communications has built public, press and politician confidence that difficult decisions will be taken following benefits / risk analysis

** Where pursuit of the Trust's strategic objectives results in quality and outcome risks the Trust will adopt a cautious approach but will adopt a seeking approach for innovation risks.

Infection Prevention & Control & Cleanliness Quarter 3 Report 2018/19

0. Reference Information

Author:	Sue Sayles, Infection Control Nurse Phil Davies, Head of Estates and Facilities	Paper date:	17th January 2019
Executive Sponsor:	Bev Tabernacle, Director of Nursing	Paper Category:	Governance and Quality
Paper Reviewed by:	Infection Control Committee	Paper Ref:	N/A
Forum submitted to:	Quality& Safety/Infection Control Committee	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 are asked to **note** the progress report against the annual plan for:
Infection Prevention and Control and Cleanliness Report

2. Executive Summary

2.1. Context

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

2.2. Summary

	MRSA Bacteraemia RJAH Acquired	MSSA Bacteraemia RJAH Acquired	E *.coli* Bacteraemia RJAH Acquired	C. *difficile*
Month	**No. of Cases**	**No. of Cases**	**No. of Cases**	**No. of Cases**
October	0	0	0	**0**
November	0	0	1	**0**
December	0	1	0	**0**
Quarter	**0**	**1**	**1**	**0**

2.3. Conclusion

The Board of Directors will have seen through the Board performance papers that there have been no cases of reportable MRSA bacteraemia since 2006.

Summary in the main report shows current performance in cleanliness and infection control against the work plan.

3. The Main Report

3.1. Introduction

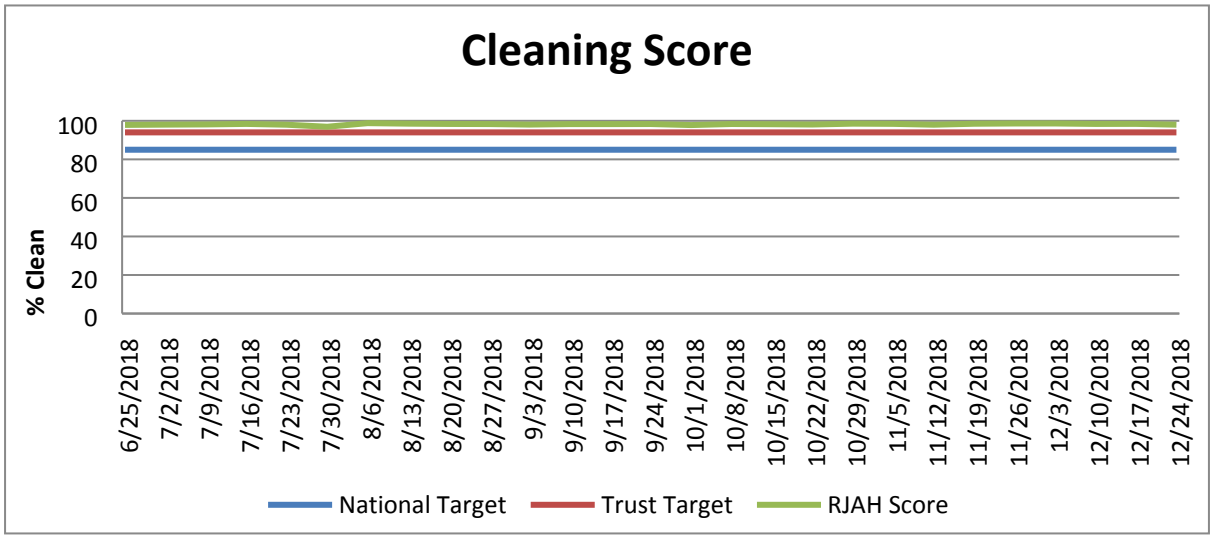
This report provides an update on progress made within quarter 3, 2018/19 to the Board of Directors, to ensure that the Board are briefed at a high level on any trends or issues that identify best practice or any gaps in assurance from which further work or actions are required.

3.1.2 Infection Control Committee

The IPC Programme of Work 2018 – 20, which has been developed in line with the Shropshire and Telford Health and Social Care Strategy, has been agreed at the Infection Control Committee in July 2018 and progress is reported quarterly.

3.2. Cleanliness

Measured cleanliness has been maintained above the National calculated target (85.0%) and Trust target (94.0%) over the most recent quarter, achieving an overall average for the quarter of 98.30% which is consistent with recent reporting periods. The below chart demonstrates the position for the last 2 quarters.

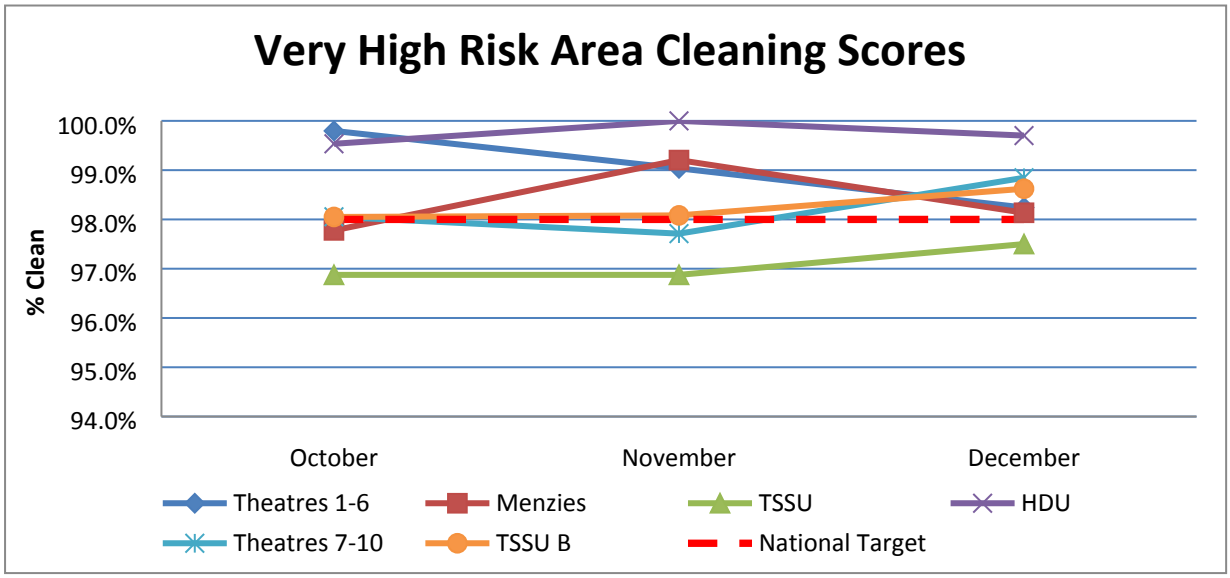


3.2.1. Cleanliness – High Risk Areas

Measured standards in the Very High Risk areas including Theatre areas, HDU and TSSU are displayed below:

- 99.0% Theatres 1-6
- 98.4% Menzies
- 97.1% TSSU - Main Theatre
- 99.7% HDU
- 98.2% Theatres 7-10
- 98.3% TSSU B

The graph below demonstrates scores in very high risk areas across the quarter. Failings are picked up through specific action plans, with supervisors performing regular spot checks to compliment a robust audit schedule.



Audit scores remain consistent in very high risk areas, with specific fails escalated on day of audit through the appropriate responsibility chain. Improvements on previous quarters have been seen in these high risk areas, which continue to be scrutinised weekly as part of a combined clinical/non clinical supervisor audit.

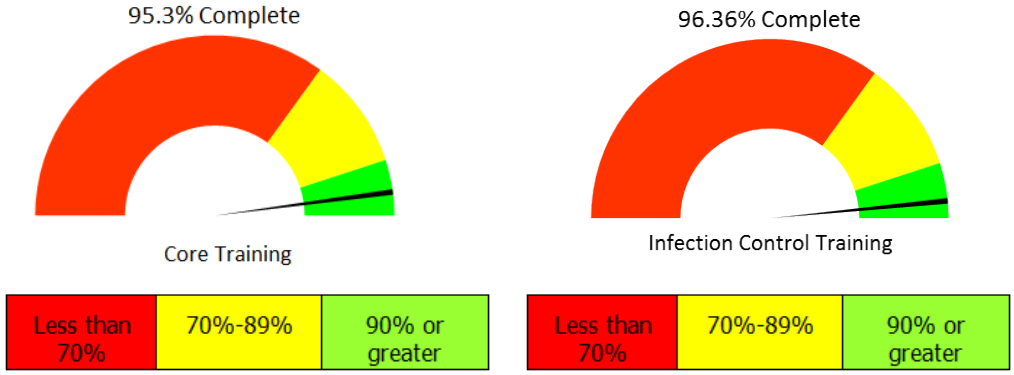
Domestic and facilities management continue to closely monitor standards; and work with the domestic and clinical teams to scrutinise areas for improvement – both in standards and methods of working.

Progress with action plans raised from infection control audits is reported though the infection control working group, where key stakeholders are able to discuss areas of best practice and any barriers to completion.

3.2.2. Cleanliness – Staff

Training has a very high compliance for the rolling 12 month period, demonstrating our commitment to the highest level of staff competency. The rolling year position at November 2018 (Latest data available) is demonstrated below:

Infection Prevention & Control & Cleanliness Quarter 3 Report 2018/19

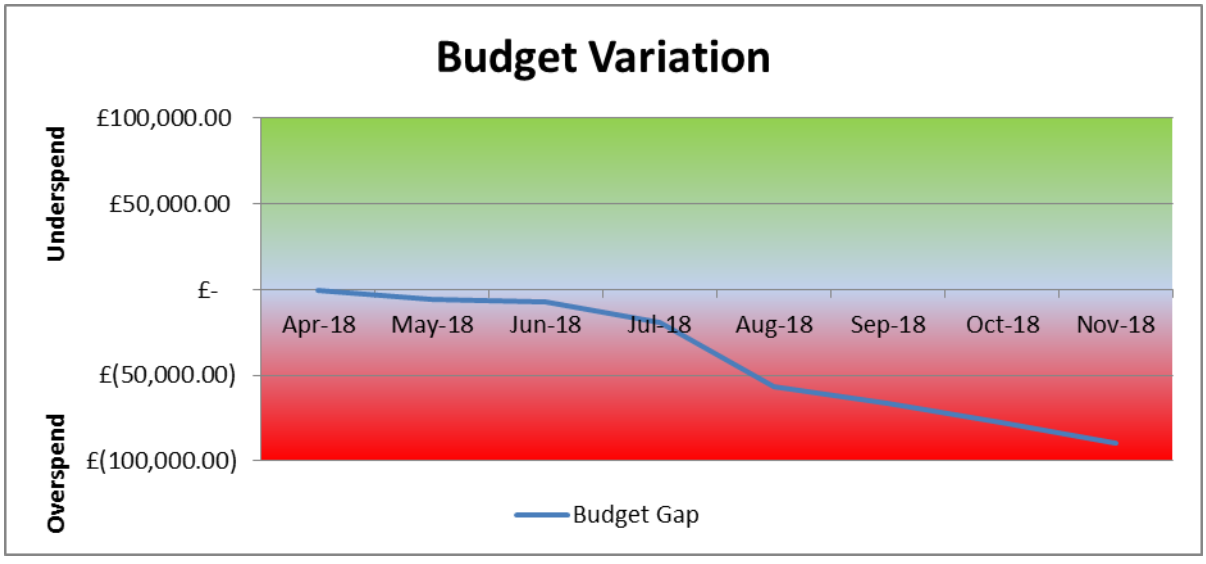


This quarter, the domestic team has benefitted from a Q&A session with the infection prevention and control nurse, giving the team chance to pick up individual queries and pin point areas for best practice improvements.

Estates have been providing the domestic team with enhanced water infection training to address issues including pseudomonas and legionella through good practice and flushing regimes

3.2.3. Cleanliness – Spend on Cleanliness

Cleaning is currently overspent, the majority of the over-spend is in staffing, where the impact of pay banding review has had a significant effect. The department continues to study best practice nationally to identify any possible efficiency potential whilst delivering a high standard service. Budget variation at November (Latest data available) is shown below.



3.2.4. Cleanliness – Patient Satisfaction

Patient compliments are regularly received and fed back to staff, reflecting the feedback from the CQC inpatient survey and the net promoter score. Latest quarter information is not available but will be reported via the next quarterly paper.

3.2.5. Cleaning Developments

HPV Decontamination

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

Date Requested	Date on site	Location	Requirement	Rationale
21/12/2018	22/12/2018	Powys Ward	1 Side Room	Terminal clean following far reaching contamination

CCG Quality and IPC Visit

Representatives from Shropshire and Telford & Wrekin CCG's visited the Trust on 11th December, undertaking a quality, patient safety and infection prevention & control review. The team visited Ludlow and Kenyon wards, and provided a summary of findings in a letter and associated recommendations.
The facilities team works with IPC to ensure swift resolve of any cleanliness actions.

- Dust & Residue inside soap/gel dispensers (both wards) – Actioned
- High dust on cupboards in treatment room (both wards) – Actioned
- Dust under bedside tables (both wards) – Actioned

These specific fails were communicated to all domestic staff via the team meeting to ensure they are not replicated in other areas. Over a 13 week period, audit scores in Kenyon & Ludlow have achieved 98.85% and 98.40% respectively.

3.2.6. PLACE

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

Nationally, NHS Improvement continues to work towards their review of the PLACE assessment, due for completion in March 2019. As a result of this review, the timetable for PLACE in 2019 has been deferred and is collections are not expected to begin until September 2019.

3.2.7. Compliance Update

Decontamination

Reverifications

A reverification is an annual audit to measure performance against design/current specification, all reverifications completed do date. Awaiting Authorising Engineer (AE) (Ventilation) sign off on one report.

Settle plate testing

Settle plate testing involves an agar plate to collect particles from the air, and then incubate in a lab to establish if there are any microbes that may pose a risk. Improved position from last quarter's results, decon group continue to monitor and escalate where appropriate.

Operational updates

TSSU Racking (for washer disinfectors) options considered to allow resilience during TSSU A Refurbishment works.

RO plant provides pure water to the washer disinfectors, for the disinfection stage of cleaning theatre equipment. RO Plant failed for several hours in the evening 19/11/18. Estates team reacted very well, traced fault (steam solenoid) and repaired around 00:30am that same evening. An SOP has been devised for the on-call engineers when required to implement contingency with the equipment if appropriate.

LEV testing scheduled for 28/01/19.

Water

AE(Water) has made several site visits to make recommendations to improve resilience in infrastructure from source to outlets.

Estates have devised an action plan which has been agreed as the best course by the AE (Water). A discussion following the AE (Water) recommendations has taken place around the replacement of the pipework across site. It was agreed that this would not be practical at this stage due to business continuity and capital investment required. These works may take several months to complete due to business continuity considerations. The action plan development is continually monitored by Water Safety Group.

The AE (Water) has also asked the Trust to consider the replacement of the water storage on site (located in the boiler house). A feasibility study has been completed with high level costs attributed. Subsequently, a capital bid has been lodged to replace three tanks (currently approx. 250,000 litres) with two tanks at 18,000 litres total.

Furthermore, the AE will be conducting a management audit of the control of water safety on site in February (date to be confirmed). Both the audit and the two safety documents will put the Trust in a much more informed position as to any shortfalls or gaps we have in the management of providing safe water to the site.

Two operatives in Estates have received training to become AP (Water). An AE (Water) assessment is to be arranged in due course to formally appoint.

All risks being managed through the risk register.

3.3. Infection Prevention & Control

3.3.1. Training

The Infection Control Training expires every 3 years .Ward/departmental managers are responsible for ensuring that staff are up to date with infection control training as part of the appraisal process. Interactive infection control training is delivered to all staff on induction including volunteers and work experience to the trust. Practical ward training is delivered on request. The latest quarter compliance data is not available but will be reported via the next quarterly paper.

Interactive infection control training was delivered to Powys and Clwyd ward teams during October, this included feedback from the appeals panel for the second case of C.*difficile* and the positive comments that had been highlighted.

3.3.2. Infection Control Link Meetings

October	• September C.difficle case • UV fogging standard operating procedure • Decontamination of sidewards following discharge of patients with alert organisms • Flu vaccine • SSI Nurse vacancy
November E update	• Norovirus season • Flu season
December	• CDI case appealls decision • Audit feedback • Flu vaccine update • MSSA bloodstream infection • FIT testing for FFP3 masks • Waste update from facilities

3.3.3. Audit

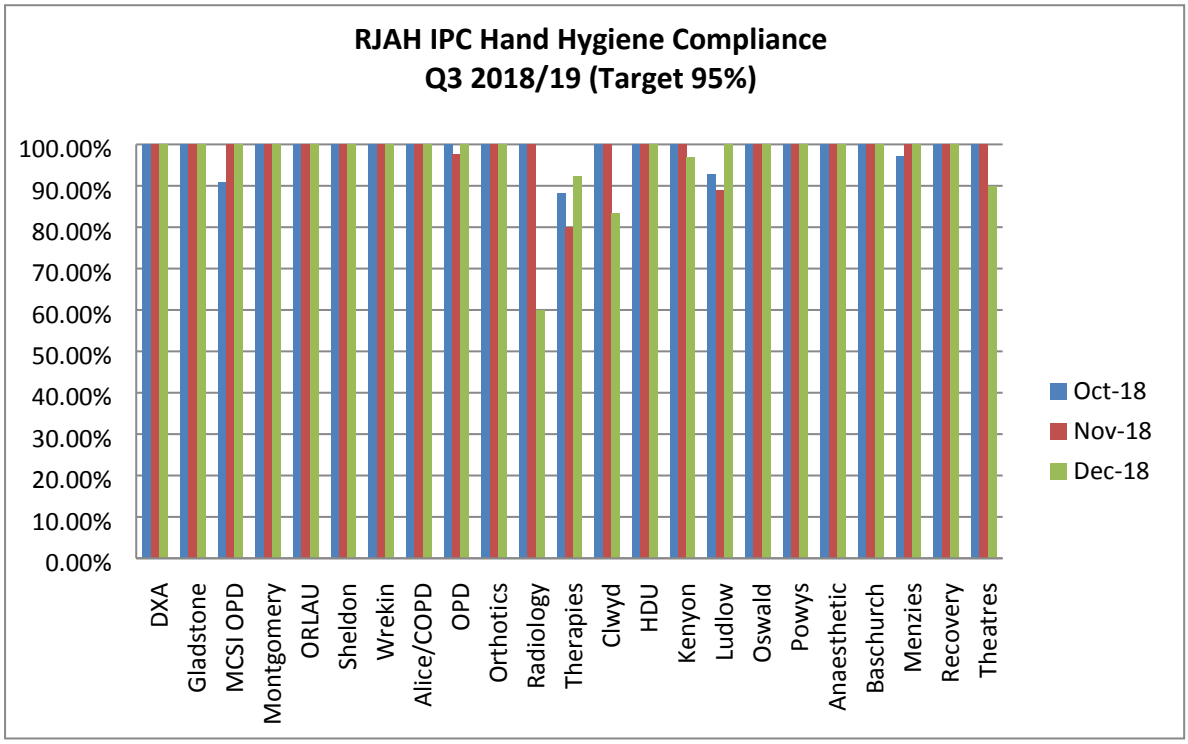
In Quarter 3, the identified planned clinical audits have been undertaken. These include audit tools from:

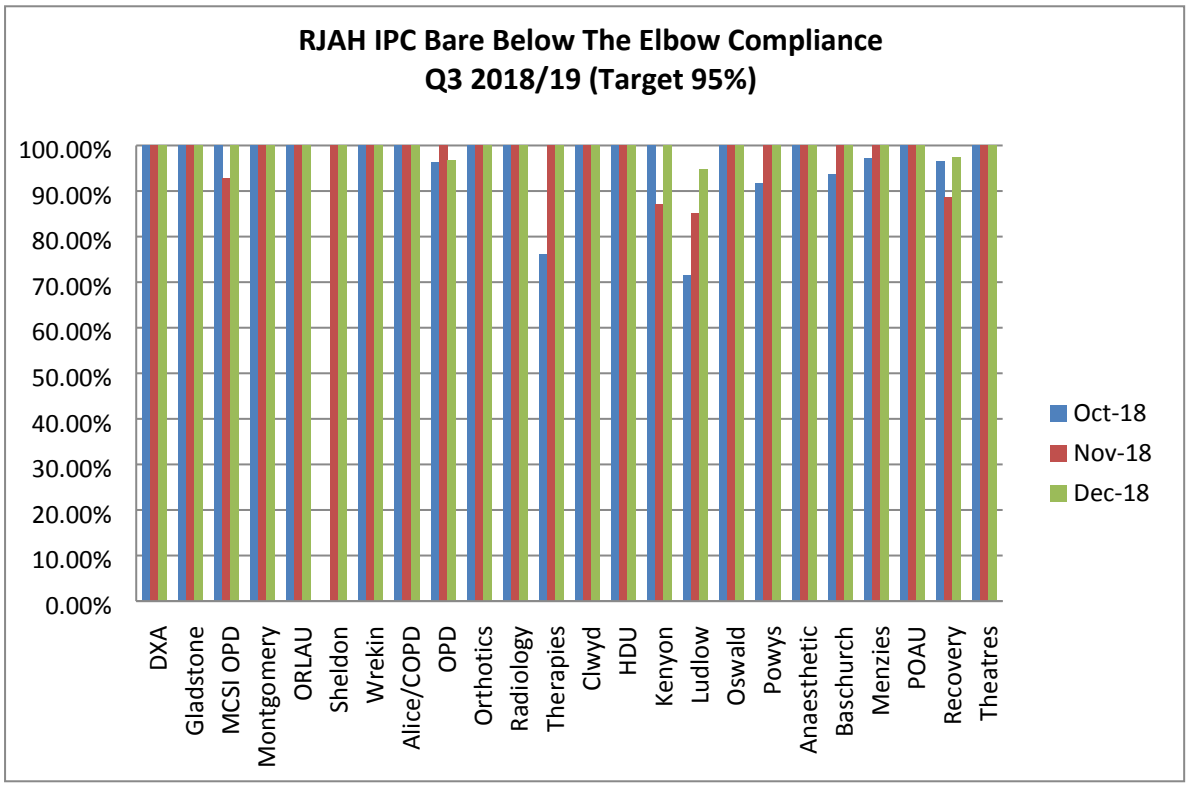
- A purpose designed environmental audit covering cleanliness, waste, linen, sharps, personal protective equipment, kitchens, hand hygiene facilities and isolation facilities.
- High Impact Interventions
- Hand hygiene/ Bare below the elbow audits

These audit results are displayed on ward STAR Boards.

3.3.3.1. Hand Hygiene

Infection Prevention & Control & Cleanliness Quarter 3 Report 2018/19



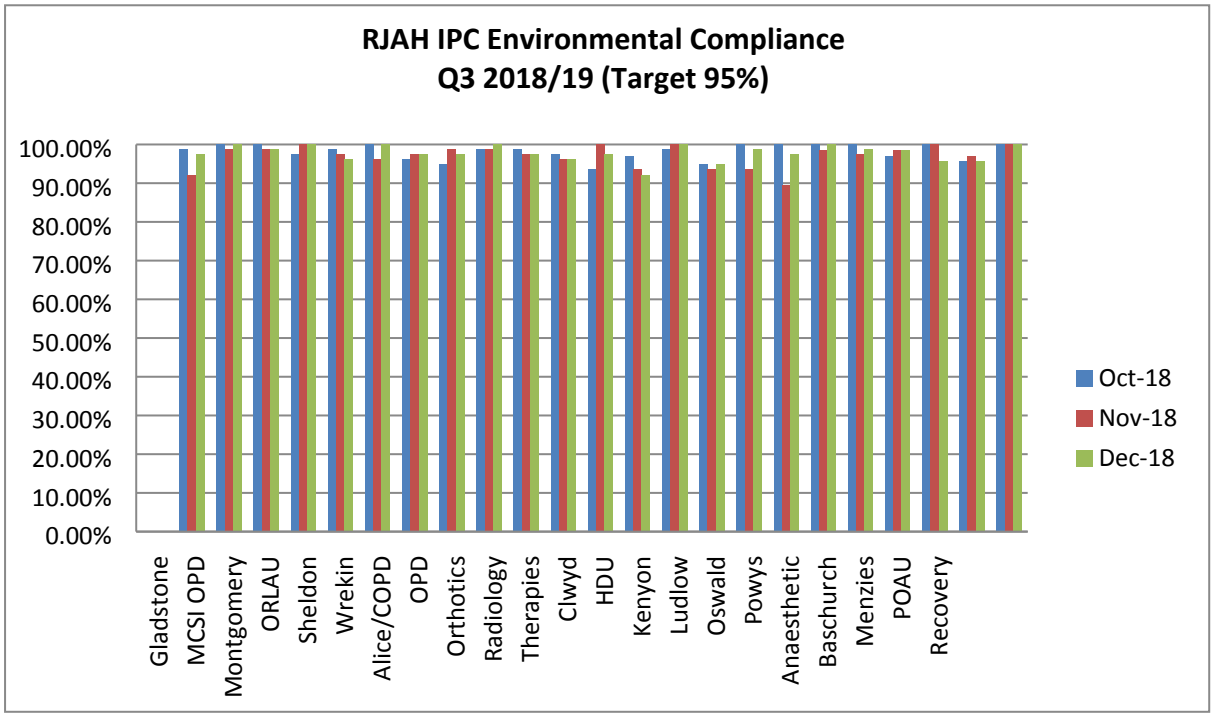


Infection Prevention & Control & Cleanliness Quarter 3 Report 2018/19

The overall hand hygiene and bare below the elbow audit compliance remains above 95%.

1436 hand hygiene audits were undertaken over quarter 3 with an overall Trust score of 98.82% compliance, and bare below the elbow element of the audit resulted in 97.86% compliance with 1450 audits completed. Staff are encouraged to challenge poor practice at the point of care and ward managers are encouraged to produce action plans for any areas achieving less than 95%.

3.3.3.2. Environment



The above graph demonstrates the monthly environmental audit results. The most common areas of non-compliance are:

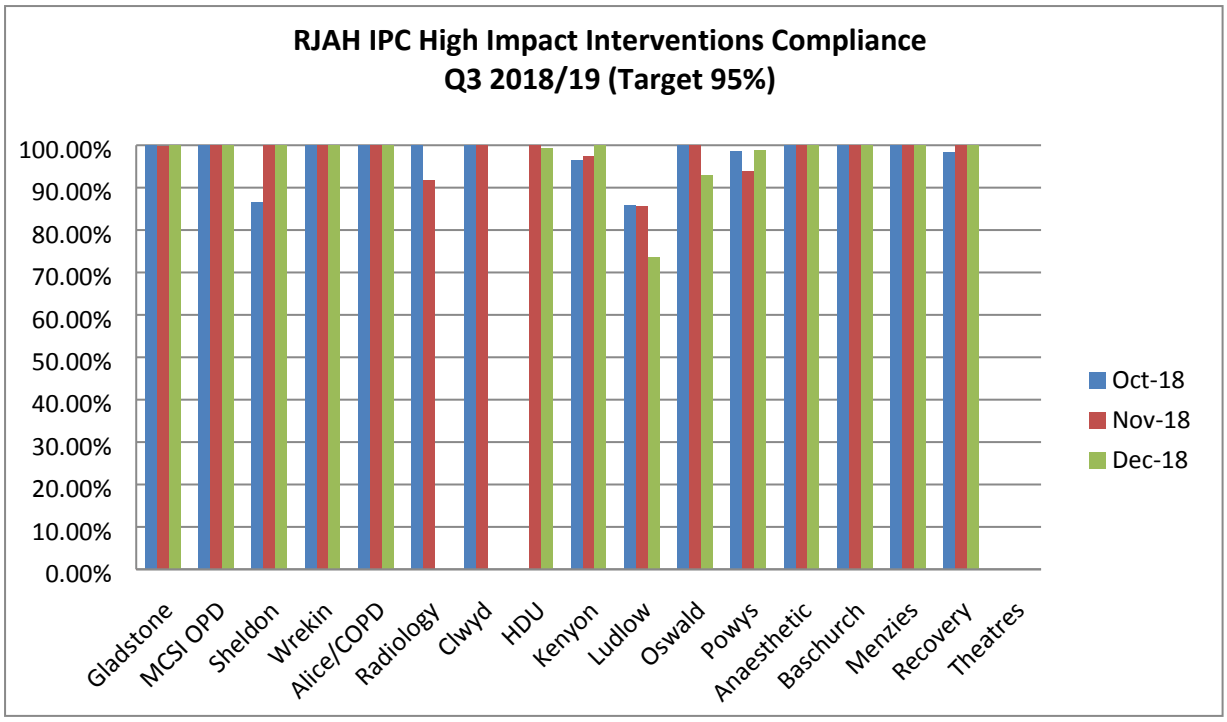
- Environment - Floors clean & in good state of repair
- Waste - Bags are not tied to trolleys
- Kitchen - No inappropriate items stored in kitchen
- Linen - Bags not over filled (2/3 full)
- Sharps - Bins are not overfilled

Any floors identified as being unclean are flagged to the domestics at the time of the audit; a floor replacement programme is in place, during December the Recovery ward and theatre stairs received new flooring.

Education around waste bags, kitchen items, linen and sharps bins will be disseminated at the infection control link nurse meeting.

3.3.3.3. Saving Lives: High Impact Interventions

Infection Prevention & Control & Cleanliness Quarter 3 Report 2018/19



6956 High Impact Intervention audits were undertaken over quarter 3 with a score of 98.39% compliance, which is consistently above the Trust target of 95%. These include insertion and care of peripheral, central and PICC lines; insertion and care of urinary catheters; prevention of surgical site infection.

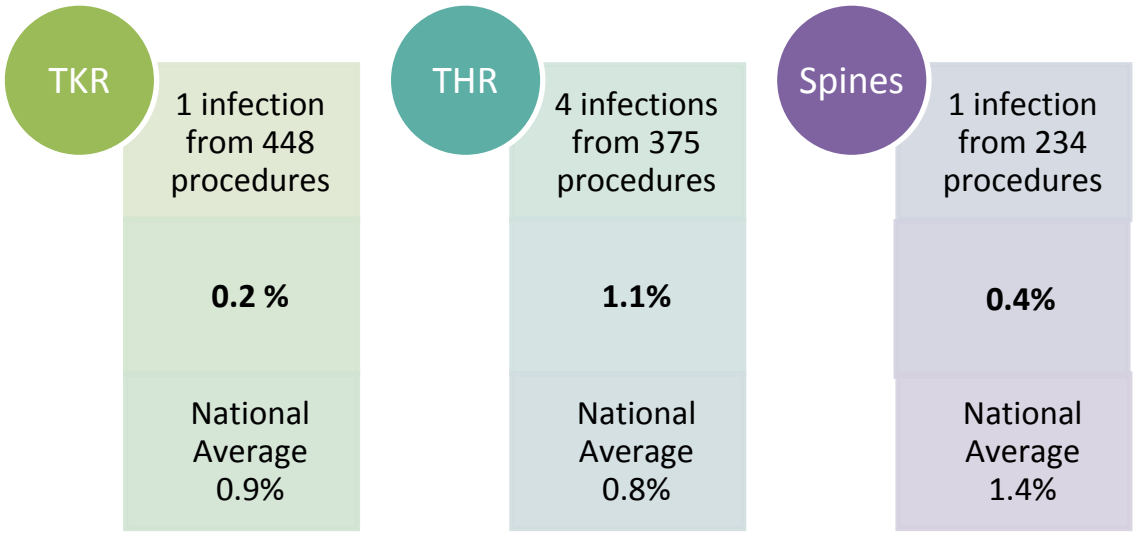
3.3.4. Surgical Site Surveillance

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

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

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

The data below shows the SSI rates for July-Sept 2018.



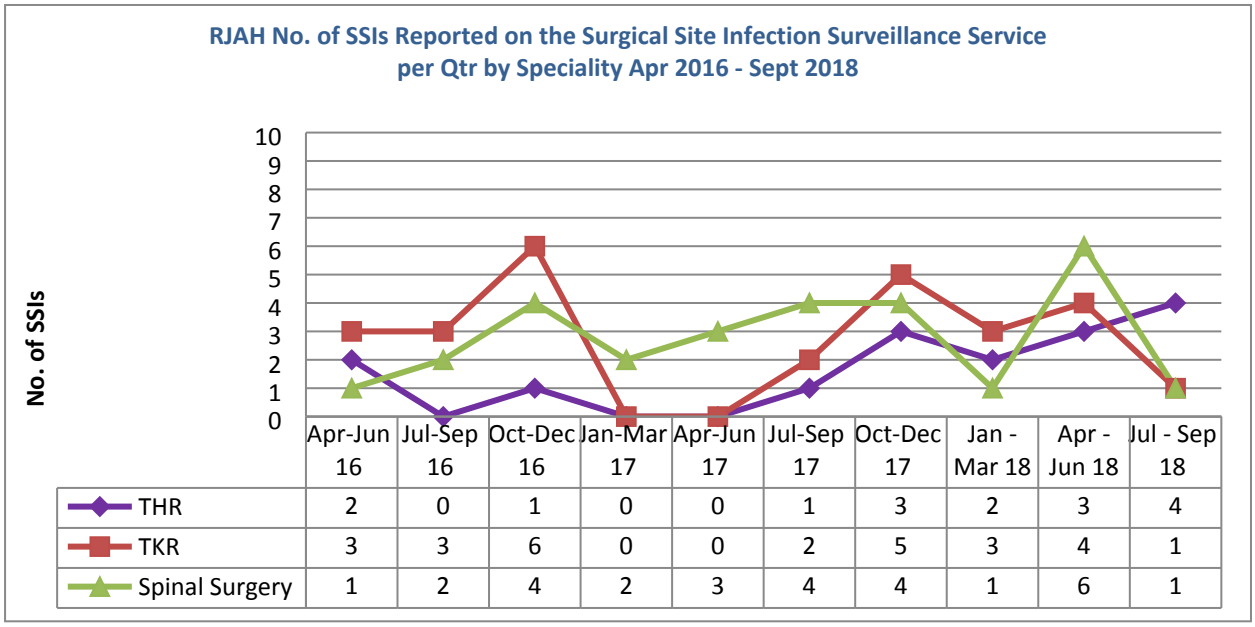
The Infection Control Nurse/ Surgical Site Surveillance Nurse liaise with Consultants concerning wound infections. The data for July-Sept 2018 has been verified and the results have been submitted to PHE and published on their web site. All of these infections were discussed and agreed at the infection Multi-Disciplinary Team meeting (MDT).

Infection rates for knee replacements and spines are well below the national average, however hip replacements are slightly above. All infections will continue to be monitored through the MDT.

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

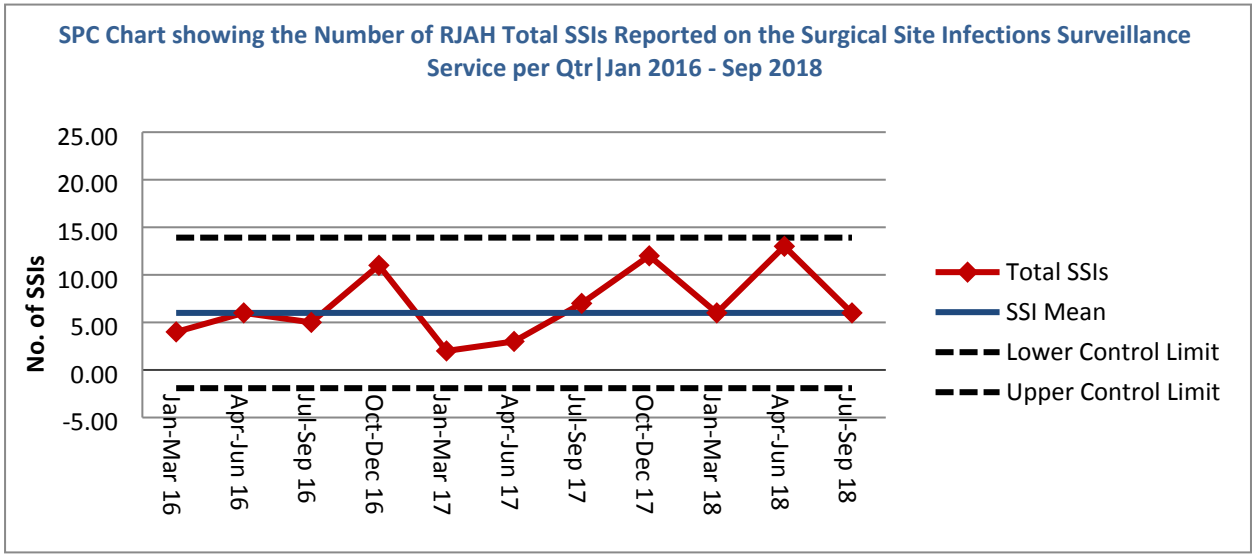
Infection Prevention & Control & Cleanliness Quarter 3 Report 2018/19

Graph showing trend in SSIs:



	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Apr-Jun 17	Jul-Sep 17	Oct-Dec 17	Jan - Mar 18	Apr - Jun 18	Jul - Sep 18
THR	2	0	1	0	0	1	3	2	3	4
TKR	3	3	6	0	0	2	5	3	4	1
Spinal Surgery	1	2	4	2	3	4	4	1	6	1

Statistical Process Control (SPC) Graph showing trend in SSIs:



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

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

3.3.5.
MRSA Swabbing & New Isolates

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

	Oct 18	Nov18	Dec 18
Eligible patients	1129	1145	895
Screened for MRSA	1126	1145	894
% achieved	99.73%	100%	99.89%
Target	95%	95%	95%

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

3.3.6. Alert Organisms

3.3.6.1. C.*difficle*

There have been no reported cases of C.*difficle* during quarter 3. The September case of C.*difficle* that was submitted to the appeals panel was upheld, with positive feedback of timeliness of isolation, obtaining a sample, appropriate antimicrobial prescribing and no indication to suspect transmission.

3.3.6.2 MSSA bacteraemia

During quarter 3 RJAH reported one case of MSSA bacteraemia to the HCAI surveillance database. The patient had undergone an acetabular ablation, a week later the patient developed sepsis, blood cultures obtained grew staphylococcus aureus. Tissue samples taken at wound washout also grew a staphylococcus aureus. A deep infection is the most likely source of the blood stream infection, this case will be discussed at a root cause analysis meeting and lessons learnt shared with the multi-disciplinary team.

3.3.6.3 E.*coli* bacteraemia.

During quarter 3 RJAH reported one case of E.*coli* blood stream infection to the HCAI surveillance database.

The patient had undergone knee surgery and post operatively became unwell with pyrexia and abdominal pain. Blood cultures obtained grew E.coli. A scan reported gall stones with biliary prominence which was the most likely source of the bacteraemia.

3.4 Outbreaks

There have been no reported outbreaks recorded during Quarter 3

3.5 Serious Incidents

There have been no serious incidents recorded during Quarter 3.

3.6 Infection Prevention & Control & Cleanliness Working Group

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

3.7 Conclusion

- The Trust reports positive outcomes against national set targets for HCAI:
  - The Trust continues to have no cases of MRSA bacteraemia.
  - The Trust has had two cases of C.*difficle* against a target set at one for 2018/19.
- All orthopaedic speciality surgery is being monitored closely and all cases of suspected/confirmed infections are discussed at the Consultant Led Weekly Infection MDT meetings.
- Improved communications and resolution of issues as a result of the re-established Working Group.

Sue Sayles: Infection prevention and Control Nurse
Bev Tabernacle: Director of Infection Prevention & Control

January 2019

Appendix 1: Acronyms

C.*difficle*	Clostridium difficile
E.coli	Escherichia. Coli
HCAI	Healthcare Associated Infection
KPI	Key Performance Indicators
MDT	Multi-Disciplinary Team
MSSA	Methicillin Sensitive Staphylococcus Aureus
MRSA	Methicillin Resistant Staphylococcus Aureus
PHE	Public Health England
SPC	Statistical Process Control
SSI	Surgical Site Infection
STAR	Sustaining Through Assessment and Review
TKR	Total Knee Replacement
THR	Total Hip Replacement
UTI	Urinary Tract Infection
HTM	Health Technical Memoranda
AE	Authorised Engineer
HPV	Hydrogen Peroxide Vapour
PLACE	Patient Led Assessments of The Care Environment
LEV	Local Extraction Ventilation

Infection Prevention & Control & Cleanliness Quarter 3 Report 2018/19

Glossary

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

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

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

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

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

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

1. Part One - Public Meeting	2. Strategy & Policy Updates	3. Quality & Safety	4. Performance & Governance	5. Items to note	6. Any Other Business

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Description	Comment
Number of English RTT patients currently waiting 52 weeks or more	At the end of December there were four English patients waiting over 52 weeks. Action See exception report
Target 0 at month end (External Measure, External Target)	
Executive Lead Director of Operations	

Description	Comment
Number of RJAH Welsh RTT patients currently waiting 52 weeks or more	There were seven patients waiting over 52 weeks at the end of December 2018. Action See exception report
Target 0 at month end (External Measure, External Target)	
Executive Lead Director of Operations	

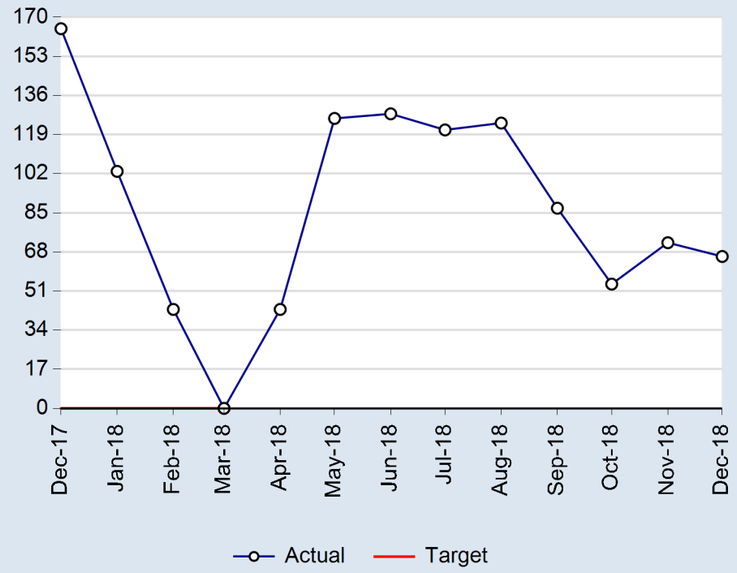
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers) -

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

Comment
At the end of December there were 66 Welsh patients waiting over 52 weeks who were all transfers of care from BCU. A trajectory is now in place running until the end of the financial year and no further transfers will be received.

Target
No target (External Measure, External Target)

Executive Lead
Director of Operations



English List Size - R

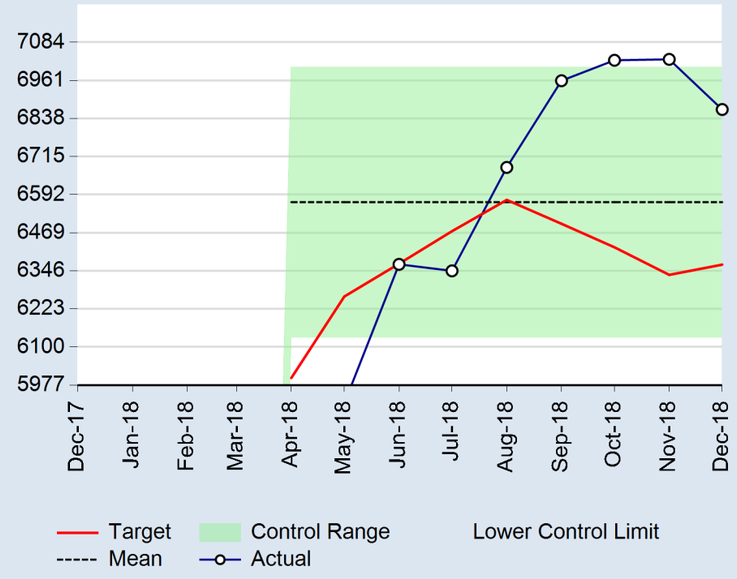
Description
Number of English patients currently waiting

Comment
The number of English patients waiting at the end of December is reported at 6867.

Target
6366 in December (Internal Monitoring)

Action
See exception report

Executive Lead
Director of Operations



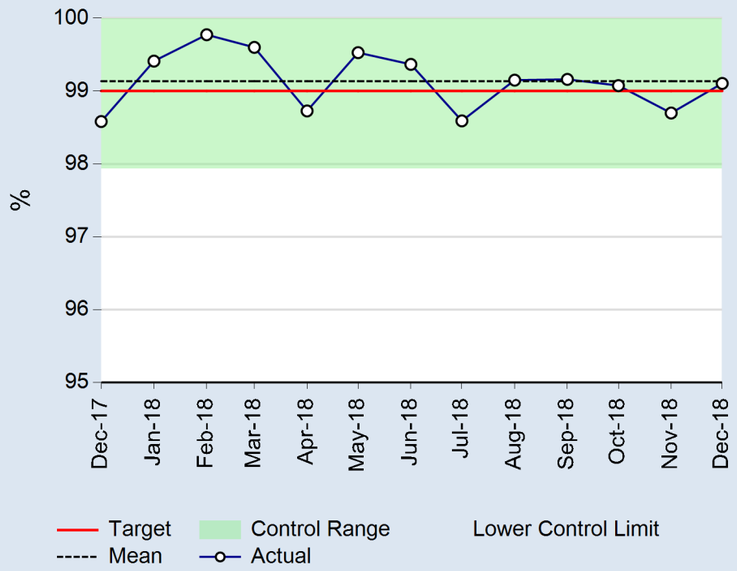
6 Week Wait for Diagnostics - English Patients - G

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

Comment
The 6 week standard for diagnostics was achieved this month and is reported at 99.10%. This equates to 5 patients who waited beyond six weeks.

Target
99% at month end (External Measure, External Target)

Executive Lead
Director of Operations



8 Week Wait for Diagnostics - Welsh Patients - A

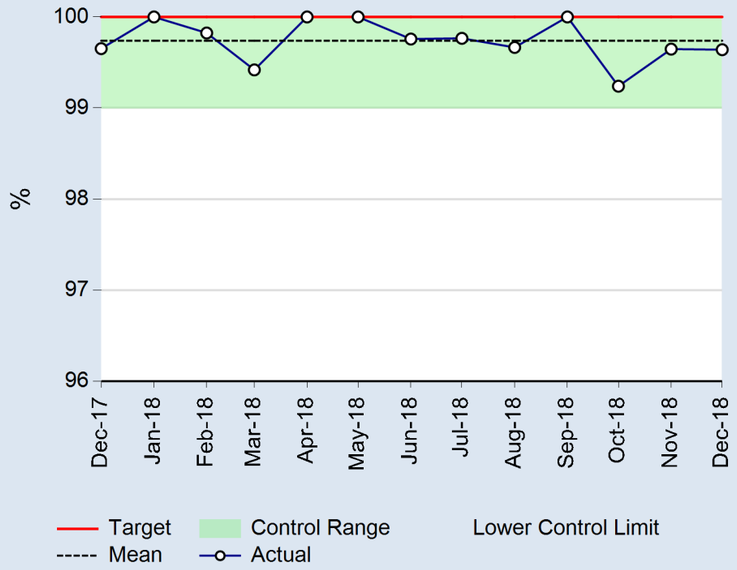
Description
% of Welsh patients currently waiting less than 8 weeks for diagnostics

Comment
The 8 week standard for diagnostics was not achieved this month and is reported at 99.64%. One patient waited longer than eight weeks.

Target
100% at month end (External Measure, External Target)

Action
Administrative delays led to the patient's referral not being received until week 9. Details have been shared with Commissioners to undertake the RCA assiated with delays from referral to receipt.

Executive Lead
Director of Operations



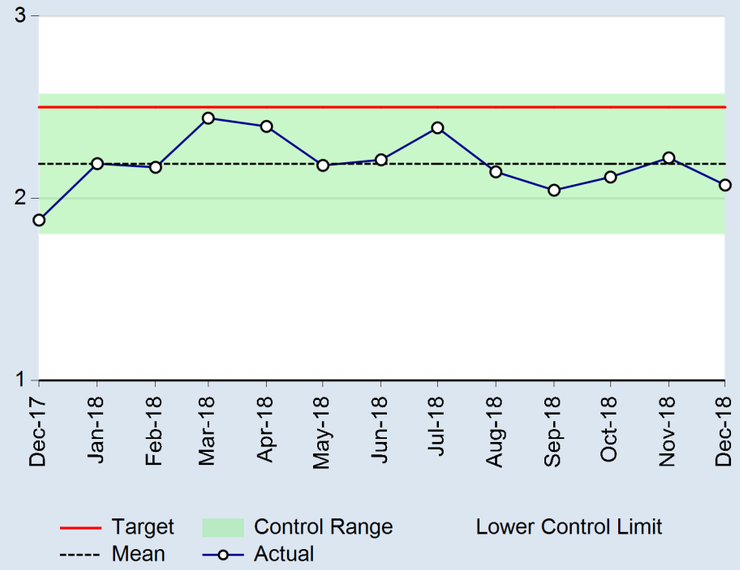
New to Follow Up Ratio (Consultant Led Activity) - G

Description
Outpatient new to follow up ratio (Consultant Led Activity)

Comment
The new to follow up ratio remains within anticipated levels and is green rated at 2.07 in December.

Target
2.5 follow up for each new in month

Executive Lead
Director of Operations



Referrals Received for Consultant Led Services* - A

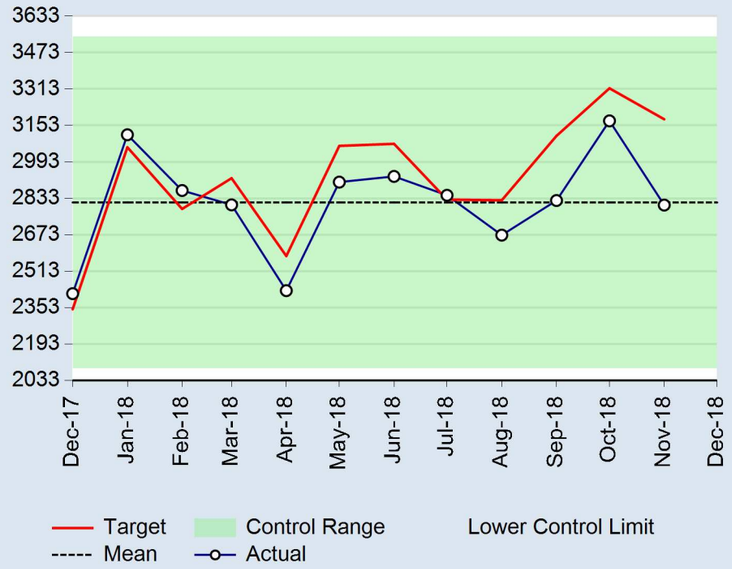
Description
Total number of referrals received in month (*Reported one month in arrears)

Target
3316 in October (Internal Monitoring)

Executive Lead
Director of Operations

Comment
The number of referrals received for consultant led services is amber rated this month with 2803 received against a plan of 3180.

Action
Referral levels are below plan year to date. Discussions are held monthly with commissioners to discuss variances against plan



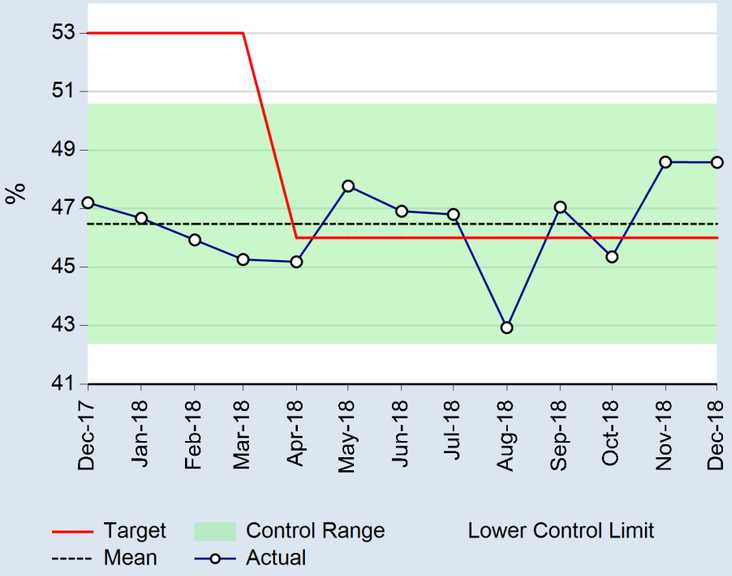
Overall Daycase Rate - G

Description
% of procedures performed as a daycase

Target
46% in March

Executive Lead
Director of Operations

Comment
The Daycase rate is green rated this month at 48.58% against the 46% target.



% Sessions Used Against Plan - A

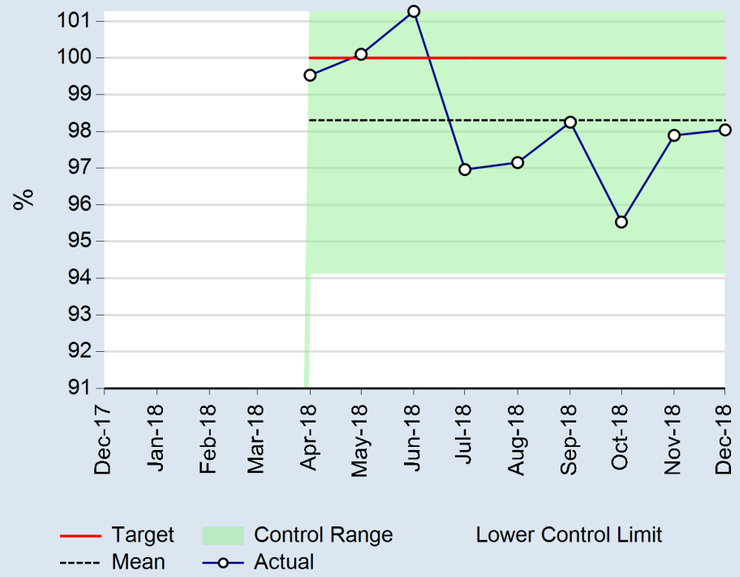
Description
% of sessions used against plan

Target
100% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
Performance against this measure remains amber rated this month at 98.04% sessions used against plan. This equates to 8 sessions behind plan.

Action
Improvements were seen in-month on the number of sessions lost in month with 12 sessions lost. There has been an increase in January of sessions lost associated with facilitating staff representation at the Memorial service in month and staff sickness. Further work is required to secure further sessions in quarter 4. Escalation meetings covering both session allocation and utilisation of lists continue to be led by a member of the executive team.



Touchtime Utilisation - A

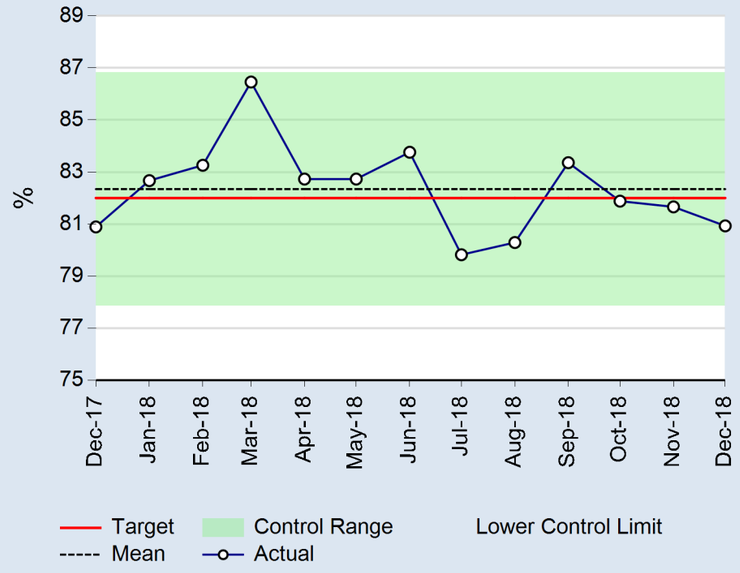
Description
% of Minutes Utilised replicating Touch Time methodology

Target
82% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
Performance in December was behind the 82% target at 80.93%.

Action
Performance improvement in this area is being progressed through the actions from the Breaking the Cycle event which highlighted root causes in relation to the issues of rescheduled episodes impacting on list utilisation.



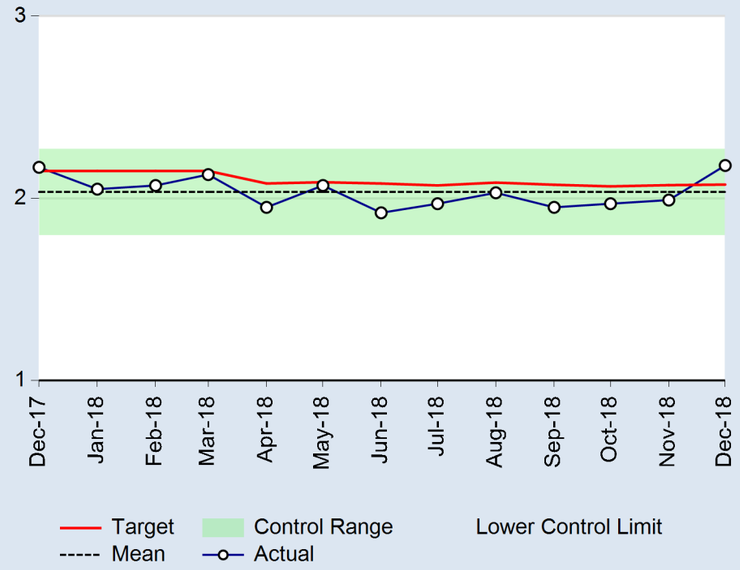
Theatre Cases Per Session - G

Description
Average number of cases per theatre session

Comment
Theatre cases per session is green rated in December at 2.18 against the 2.08 target.

Target
2.08 in December (Internal Monitoring)

Executive Lead
Director of Operations



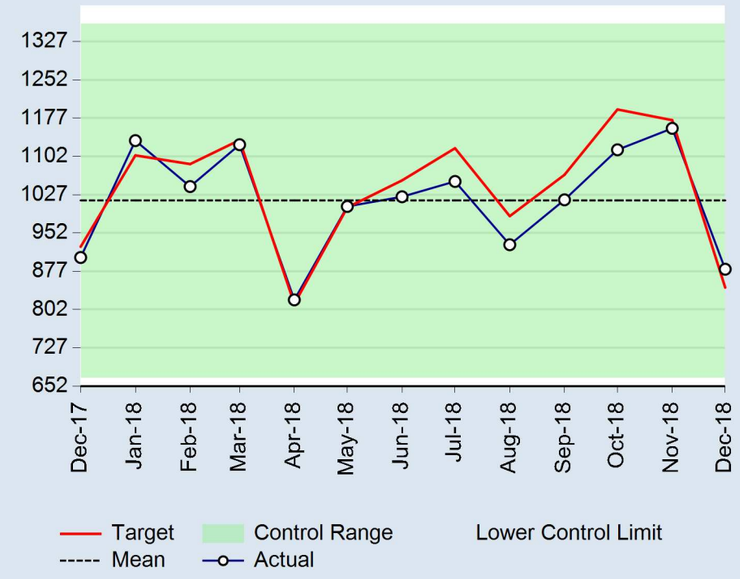
Total Theatre Activity - G

Description
Activity in theatres in month

Comment
A breakdown of Total Theatre Activity against plan is:
- T&O -797 against plan of 750 (+47 cases)
- MCSI - 33 against plan of 37 (-4 cases)
- Private Patients - 51 against plan of 58 (-7 cases)

Target
845 in December (Internal Monitoring)

Executive Lead
Director of Operations



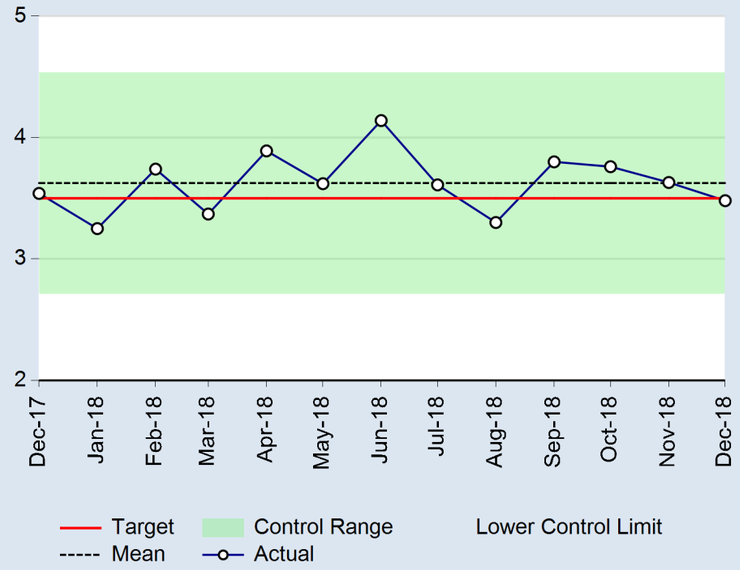
Average Length of Stay - G

Description
Elective patients length of stay (excluding daycase)

Comment
The average length of stay is green rated this month at 3.48 days against a target of 3.5 days.

Target
3.5 in month (Internal Monitoring)

Executive Lead
Director of Operations



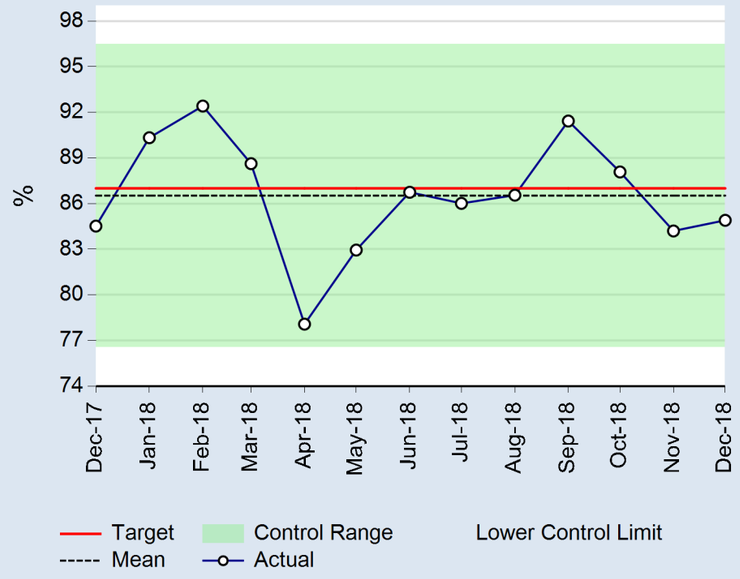
Bed Occupancy – Adult Orthopaedic Wards – 2pm - G

Description
% Bed occupancy at 2pm

Comment
The occupancy rate for adult orthopaedic beds is green rated this month at 84.90%.

Target
87% in month (Internal Monitoring)

Executive Lead
Director of Operations



Bed Occupancy – All Wards – 2pm - A

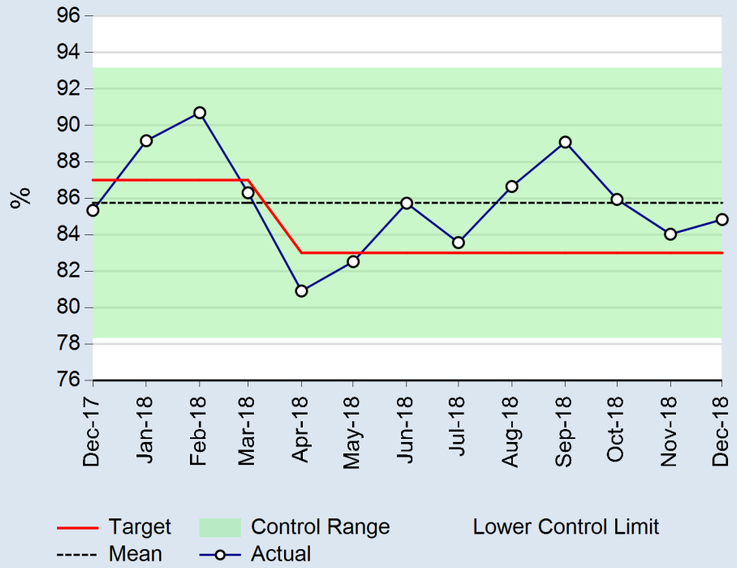
Description
% Bed occupancy at 2pm

Target
83% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
The occupancy rate for all wards is amber rated this month at 84.83%, above the 83% target. As anticipated, we continue to see high occupancy levels on our rehabilitation wards.

Action
High occupancy levels on our rehabilitation wards continue to impact this measure and remain an area of focus. We do not anticipate an improvement in year as the MCSI demand is higher than plan. Intermediate care beds business case if being submitted to NHSE to inform next year's plan.



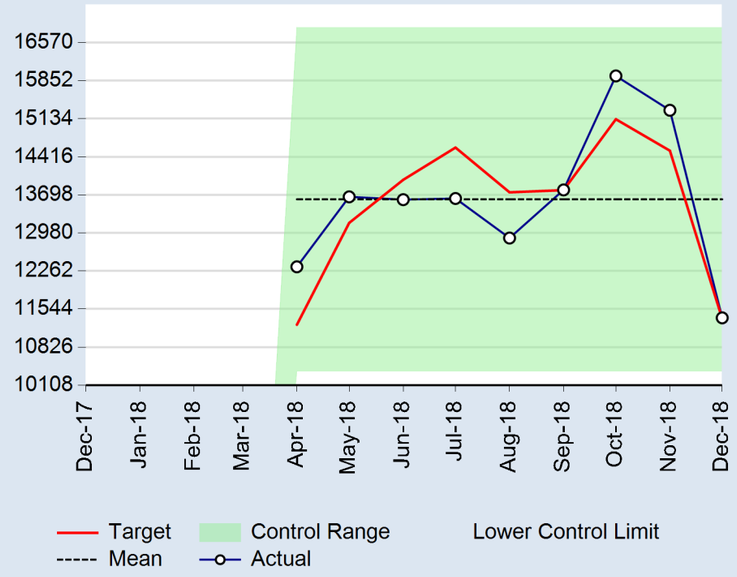
Outpatients Activity Attendances - G

Description
Number of attendances seen in Outpatient clinics

Target
11359 in December (Internal Monitoring)

Executive Lead
Director of Operations

Comment
The number of attendances was on plan in month 9 with 11377 against a plan of 11359.



Outpatient DNA Rate (Consultant Led Activity) - A

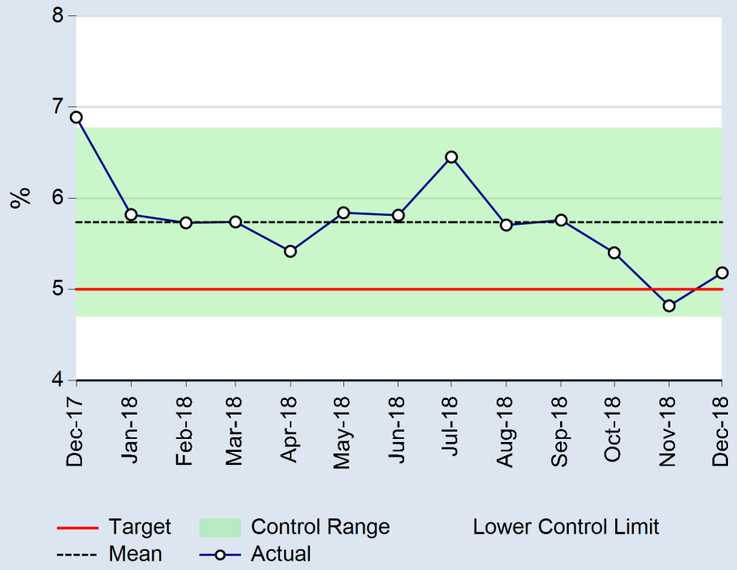
Description
% of outpatient appointments not attended

Target
5% in month

Executive Lead
Director of Operations

Comment
The DNA rate is amber rated in December at 5.18%. This equates to 399 missed appointments. The measure is impacted this month by reduced activity levels.

Action
There continues to be regular reviews of the data. Within the Surgery Division there has been focus on Paediatrics, Upper Limb and Knee & Sports Injuries sub-specialties. Where administrative capacity allows, calls are made to patients to confirm appointments and this has made a positive impact on this measure in previous months. Further assessment will be made to implement this as a process change where staffing levels allow. In some areas clinics are being overbooked to allow for DNAs where we can. This is something that may be implemented further to allow utilisation of clinics to be maximised.



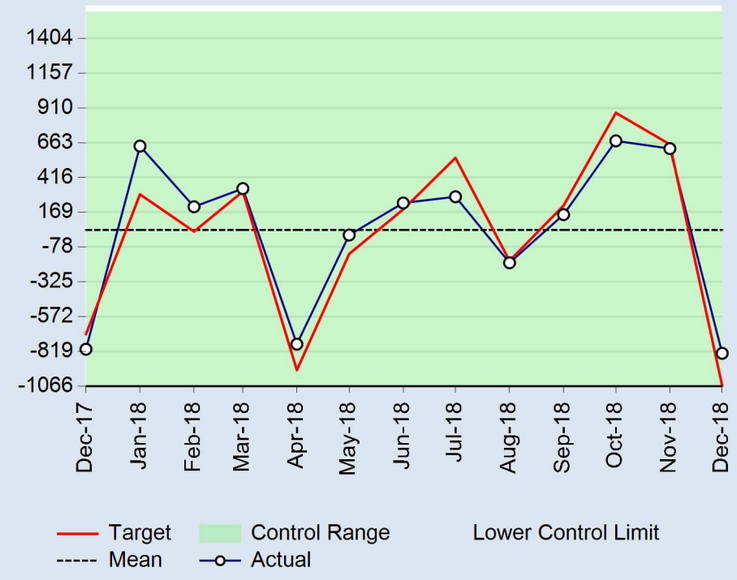
Financial Control Total - G

Description
Surplus/deficit adjusted for donations and excluding STF funding

Target
£1,104m

Executive Lead
Director of Finance

Comment
- £833k in month deficit, £232k favourable to plan
- £179k surplus year to date (£14k favourable to plan)



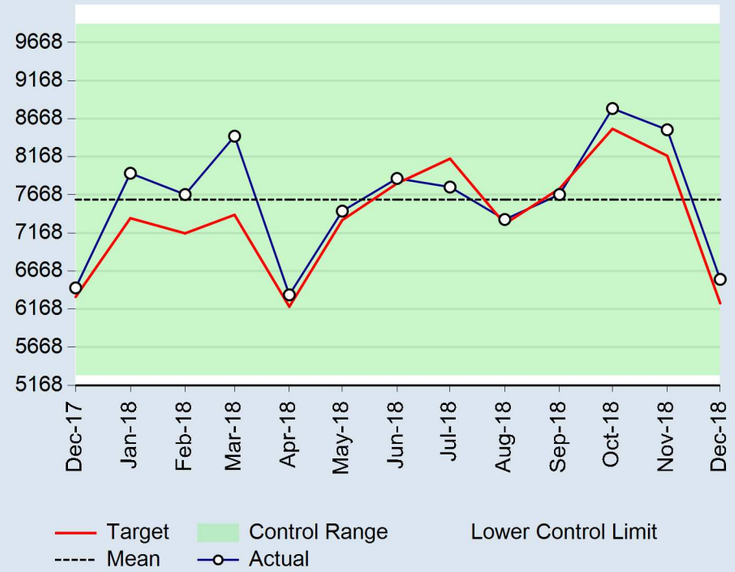
Clinical Income from Activity - G

Description
Income associated with clinical activities (excludes pass through drugs)

Target
£91.5m

Executive Lead
Director of Finance

Comment
- Overall £314k favourable:
- Theatres £158k ahead of plan plan
- Non theatres higher than plan driven by:
  - Surgical outpatients
  - Medicine inpatients



Private Patients Income - R

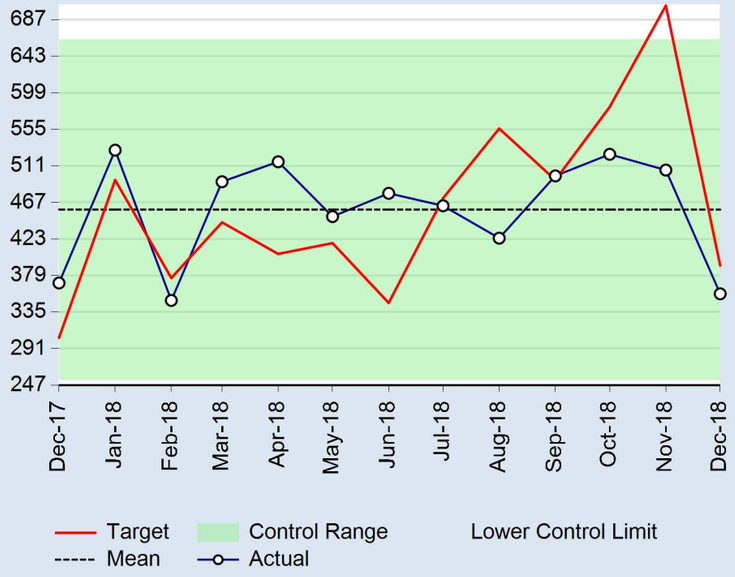
Description
Income generated by private patient activity

Target
£5.4m

Executive Lead
Director of Finance

Comment
- Overall £33k adverse to plan in month, ytd £150k behind plan

Action
Marketing campaign to be launched across multiple platforms to drive increase demand in Q4.
MCSI private bed utilisation



Other Income - A

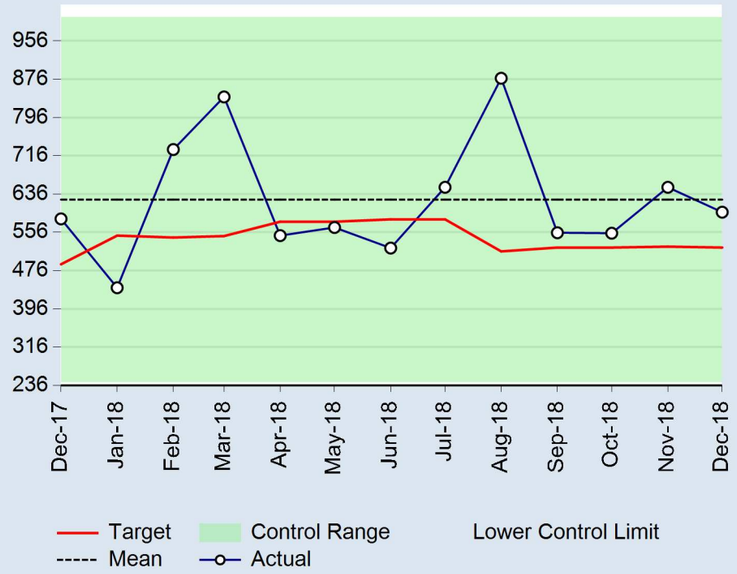
Description
Non-clinical income e.g. research, education and NHS Injury Cost Recovery (ICR)

Target
£6.5m

Executive Lead
Director of Finance

Comment

'- Underlying position excluding AfC pay award income £9k adverse to plan due to:
- Research - driven by reduced activity



Pay - A

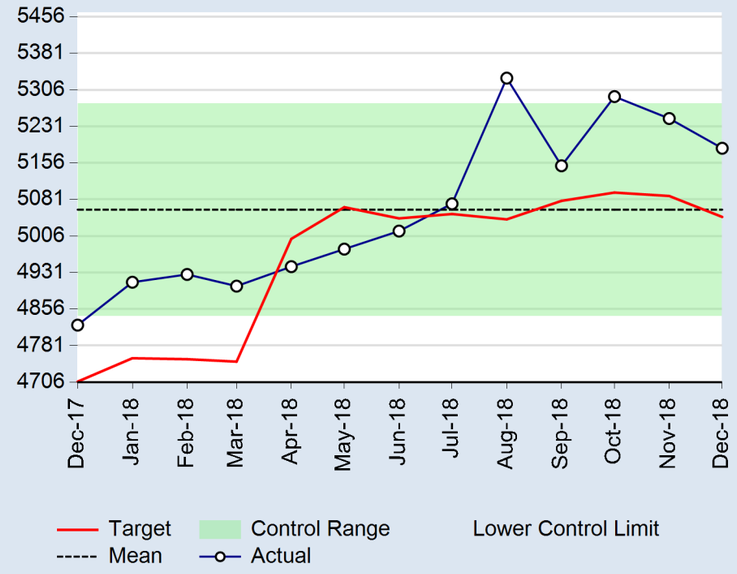
Description
Expenditure on workforce

Target
£60.7m

Executive Lead
Director of Finance

Comment

- Underlying position excluding AfC pay award income £58k adverse to plan due to:
- Nursing agency & bank pressures - theatres and medicine wards
- Medicine agency medical staff
- Non LLP OJP and vacancies partially offsetting



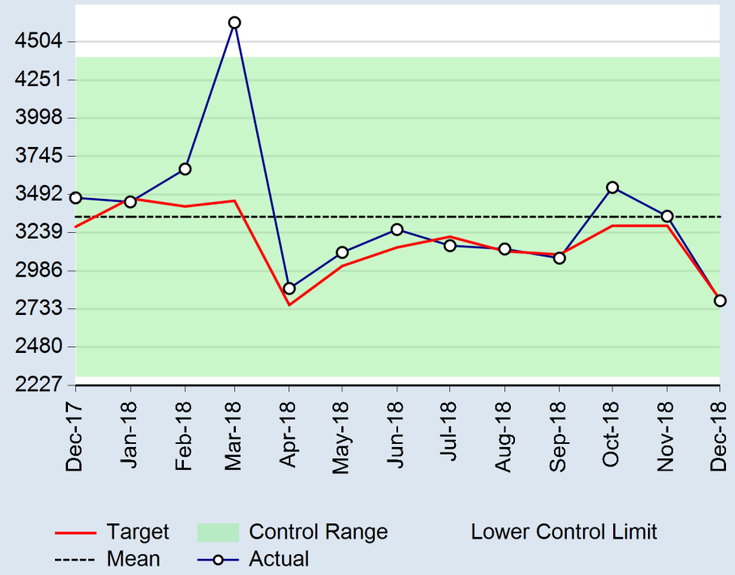
Non Pay - G

Description
Non-workforce expenditure e.g. consumables, implants and drugs (excludes pass through drugs)

Comment
- Non Pay £7k adverse to plan in month:
- Surgery LLP OJP
- Offset by Implants (Casemix and PP volumes)

Target
£37.5m

Executive Lead
Director of Finance



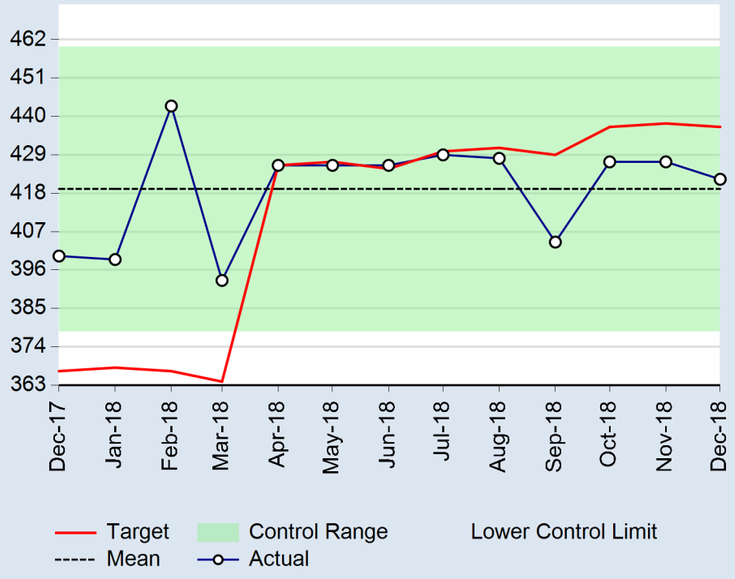
Financing - G

Description
Costs associated with financing the Trust i.e. depreciation, PDC and interest charges

Comment
- Finance costs are £15k favourable to plan in month driven by revised PDC and depreciation estimates

Target
£5.1m

Executive Lead
Director of Finance



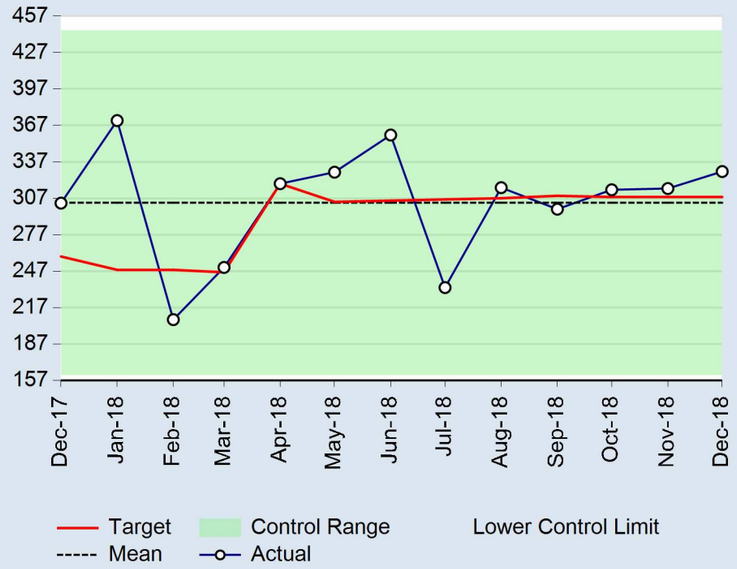
CIP Delivery - G

Description
Cost Improvement Programme requirement

Comment
- CIPs £21k ahead of plan in month - £37k ahead of plan YTD
- YTD we have achieved 78% of the annual target

Target
£3.6m

Executive Lead
Director of Finance



Agency Control Total - R

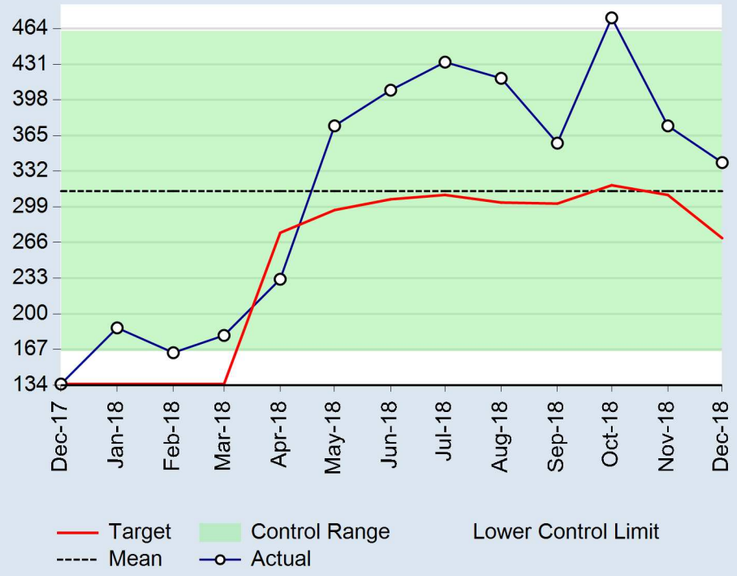
Description
Annual ceiling for total agency spend introduced by NHS Improvement

Comment
- Overall agency spend £70k above the ceiling in month (YTD £720k)
- LLP £98k adverse; (YTD £634k)
'Core' agency £28k favourable; (YTD £86k adverse)

Target
£4.0m

Action
Agency exception report details more information. Ongoing forecast and tracking against agreed actions to reduce agency spend.

Executive Lead
Director of Finance



Cash Balance - A

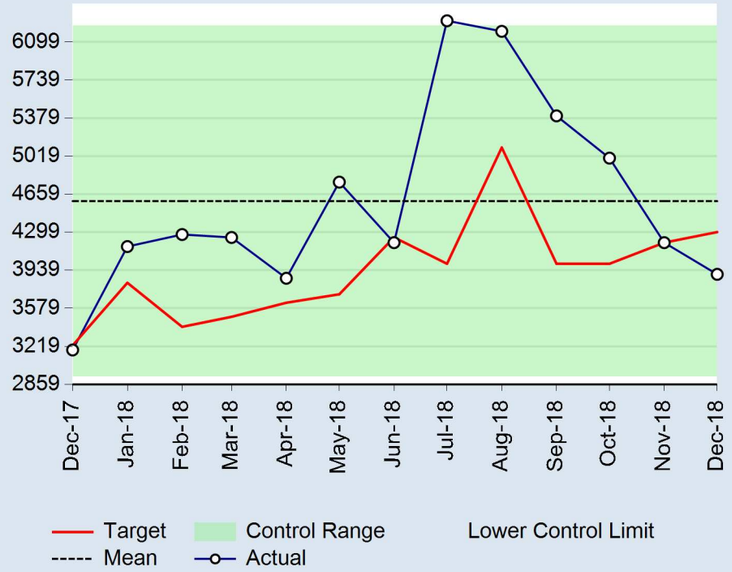
Description
Cash in bank

Target
£5m (at March 2019)

Executive Lead
Director of Finance

Comment
- Cash balances of £3.9m,
- £0.3m adverse to plan in month driven by contract over performance invoices not paid

Action
- £0.2m was received for Specialised Services overperformance to be secured in January.



Capital Expenditure - G

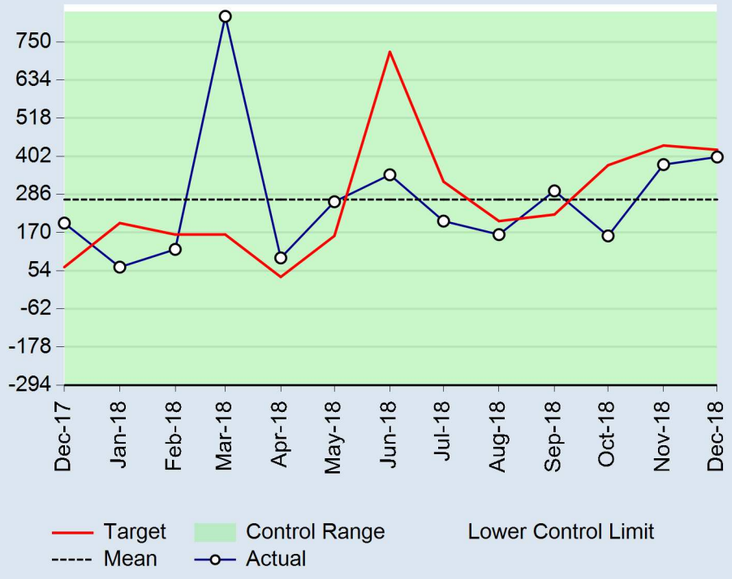
Description
Expenditure against Trust capital programme

Target
£4.3m

Executive Lead
Director of Finance

Comment
- Capital spend of £400k in month, £22k under plan in month
- £596k below plan YTD driven by phasing of plan

Action
Forecast underspend estimated at c£300k by year end.



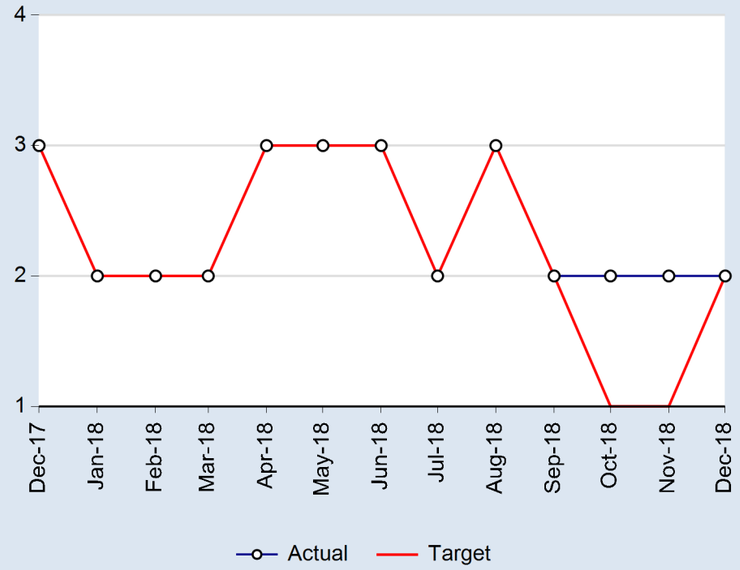
Use of Resources (UOR) - G

Description
Overall Use of Resources indicator

Comment
UOR on plan

Target
1 (at March 19)

Executive Lead
Director of Finance



Sickness Absence - R

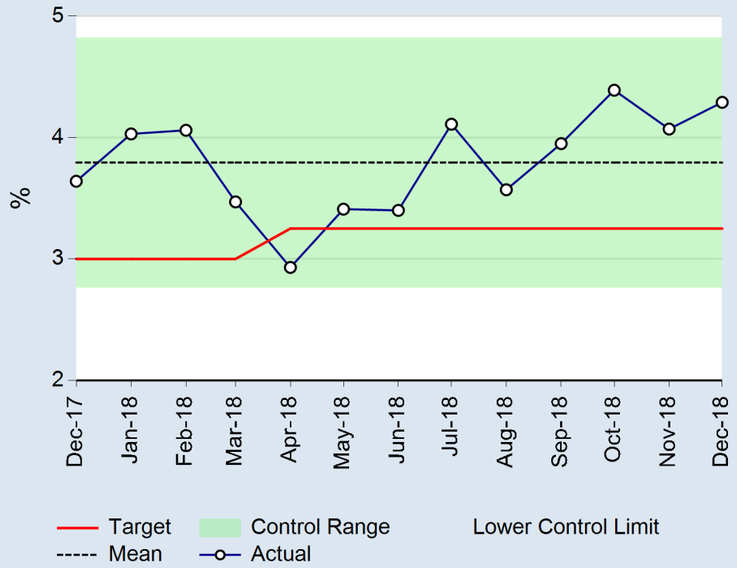
Description
FTE days lost as a percentage of FTE days available in month

Target
3.25% in month (Internal Monitoring)

Executive Lead
Director of People

Comment
December saw a further increase in absence largely due to an increase in short-term absences.

Action
Actions have been determined as part of both the People Excellence Work stream and our NHSI Improving Staff Health and Wellbeing Action Plan to support health promotion and improvement particularly in reducing the levels of absence due to stress/anxiety/depression and MSK which remain our highest two reasons for absence (for both long and short term absences). These actions are being monitored via the Workforce Development Group. There is also an increased focus of support to Medicine (5.25%) and Theatres (5.35%) which will be monitored through the Workforce Development Group.



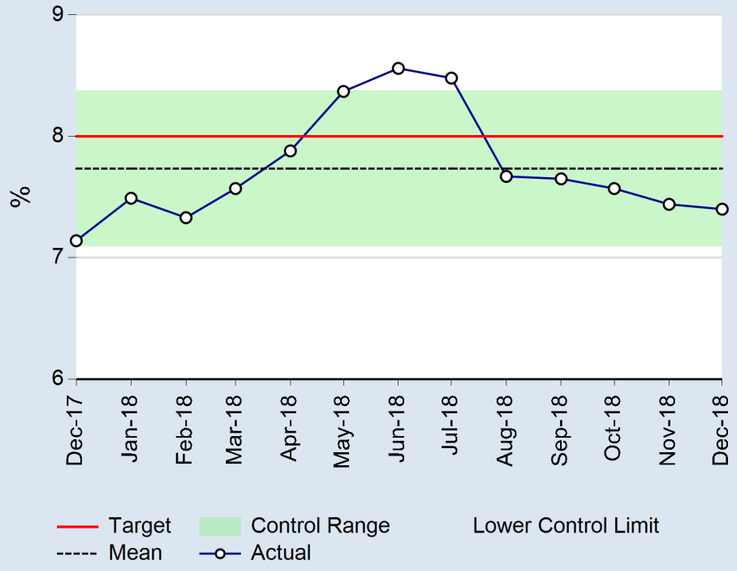
Voluntary Staff Turnover - G

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

Target
8% in month (Internal Monitoring)

Executive Lead
Director of People

Comment
There has been a further reduction in voluntary turnover and the measure is reported below (positive) the target.



Staff Appraisal - A

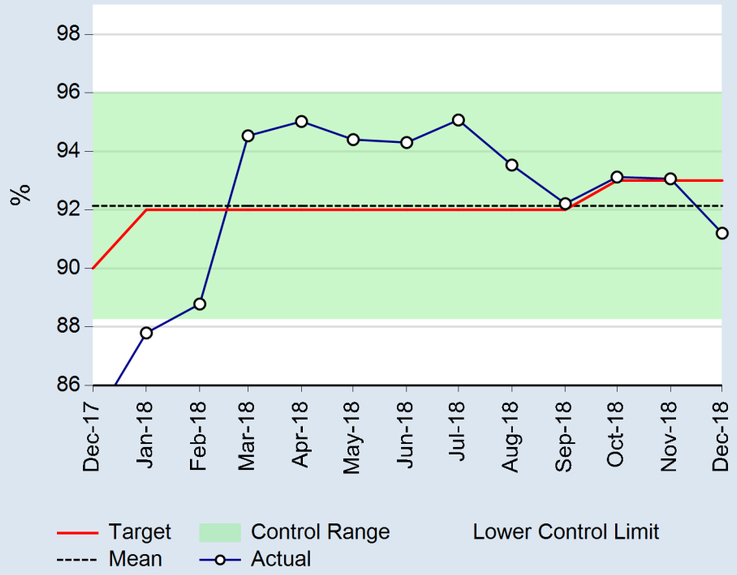
Description
% of staff who have had an appraisal within the last 13 months

Target
93% at month end (Internal Monitoring)

Executive Lead
Director of People

Comment
The appraisal rate has reduced and is now below (negative) the target.

Action
This will now be picked up by Workforce Development Group for agreed actions. Once these actions are agreed they will be monitored until performance returns to target.



Mandatory Training - A

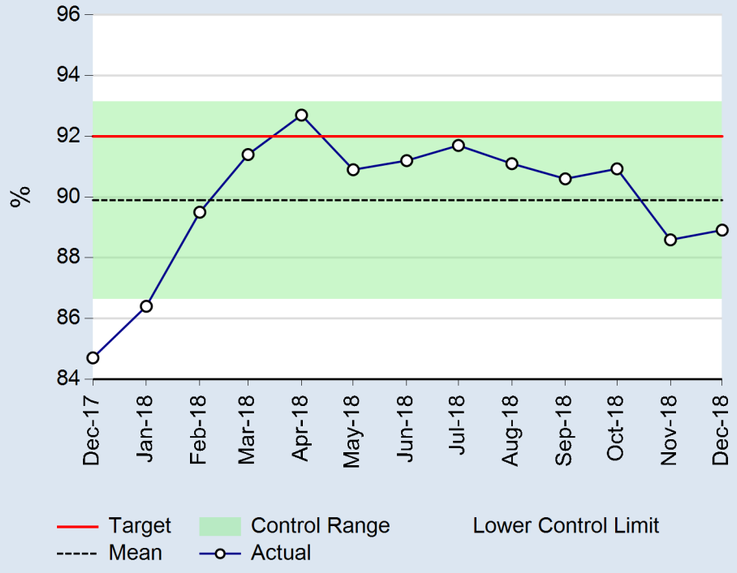
Description
The combined total of completed Fire, H&S or Moving and Handling training modules as a % of the total number of modules that require completion.

Target
92% in month (Internal Monitoring)

Executive Lead
Director of People

Comment
The completion rate for mandatory training has maintained its position in month, but remains below (negative) the target.

Action
The Workforce Development Group is continuing to monitor progress against the action plan to improve all statutory and mandatory training rates. There continues to be an immediate focus on increasing the completion rates for those Board reportable elements including Fire and Manual Handling).



Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st December 2018

Income and Expenditure £'000s

Category	Annual Plan	In Month Position			Year To Date Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	96,940	6,698	6,810	112	71,572	72,021	449
PSF	833	83	251	168	543	543	0
Private Patient income	5,831	391	357	(33)	4,368	4,218	(150)
Other income	6,529	524	598	74	4,937	5,523	586
Pay	(60,670)	(5,045)	(5,186)	(141)	(45,505)	(46,215)	(711)
Non-pay	(42,937)	(3,247)	(3,040)	207	(31,781)	(32,008)	(226)
EBITDA	6,527	(596)	(210)	386	4,134	4,082	(52)
Finance Costs	(5,197)	(437)	(422)	15	(3,880)	(3,814)	65
Capital Donations	200	20	32	12	180	183	3
Operational Surplus	1,530	(1,013)	(600)	413	435	450	16
Remove Capital Donations	(200)	(20)	(32)	(12)	(180)	(183)	(3)
Add Back Donated Dep'n	607	51	49	(2)	454	455	1
Remove PSF	(833)	(83)	(251)	(168)	(543)	(543)	0
Control Total exl PSF	1,104	(1,065)	(833)	232	165	179	14
PSF Earnt	833	83	251	168	543	543	0
Control Total	1,937	(982)	(582)	400	708	722	14
EBITDA margin	6.0%	-7.8%	-2.7%	5.1%	5.1%	5.0%	-0.1%

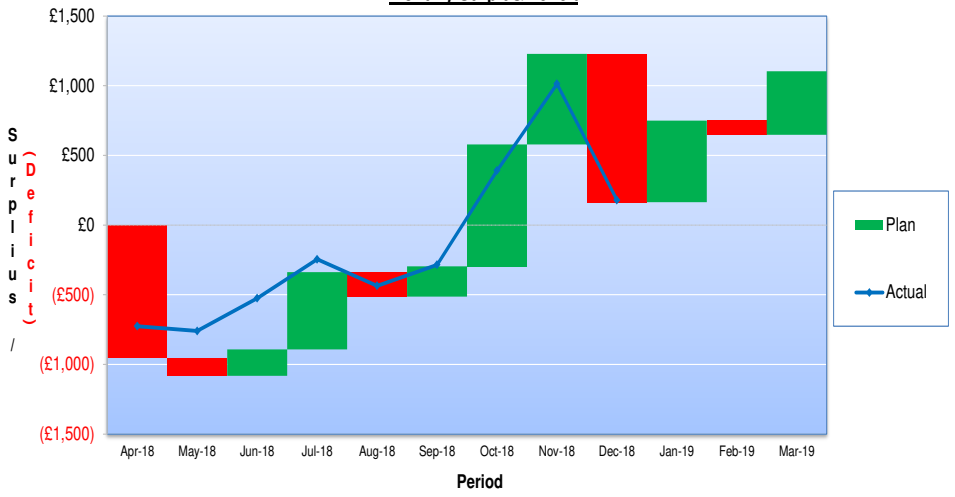
Capital service	1	I&E Margin	2
Liquidity (days)	1	Variance in I&E Margin	1
Agency	3		
Overall UOR	2		

	Dec-18	YTD
Debtor Days	25	19
Creditor Days	34	26

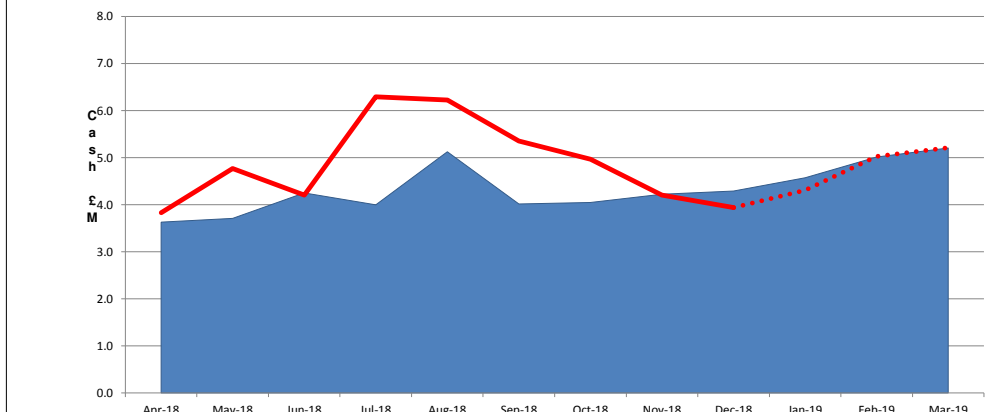
Statement of Financial Position £'000s

Category	Nov-18	Dec-18	Movement	Drivers
Fixed Assets	74,404	74,535	131	Additions less depreciation
Non current receivables	1,069	896	(173)	RTA/CRU withdrawals
Total Non Current Assets	75,473	75,431	(42)	
Inventories (Stocks)	1,039	1,159	120	
Receivables (Debtors)	9,083	8,372	(711)	Reduction in planned income during December versus contract payments (twelfths)
Cash at Bank and in hand	4,207	3,943	(264)	Reduction driven by clinical income over performance not yet realised in cash
Total Current Assets	14,329	13,474	(855)	
Payables (Creditors)	(10,818)	(10,391)	427	Reduction in planned expenditure during December
Borrowings	(1,176)	(1,176)	0	
Current Provisions	(84)	(84)	0	
Total Current Liabilities (< 1 year)	(12,078)	(11,651)	427	
Total Assets less Current Liabilities	77,724	77,254	(470)	
Non Current Borrowings	(6,472)	(6,472)	0	
Non Current Provisions	(186)	(186)	0	
Non Current Liabilities (> 1 year)	(6,658)	(6,658)	0	
Total Assets Employed	71,066	70,596	(470)	
Public Dividend Capital	(33,260)	(33,387)	(127)	
Revenue Position	(11,847)	(11,851)	(4)	
Retained Earnings	(1,050)	(450)	600	Current period Surplus, before control total adjustment
Revaluation Reserve	(24,909)	(24,909)	0	
Total Taxpayers Equity	(71,066)	(70,597)	469	

Monthly Surplus/Deficit



Cash Flow



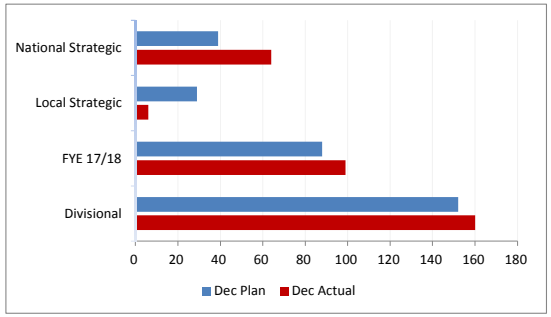
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Plan £M	3.6	3.7	4.3	4.0	5.1	4.0	4.0	4.2	4.3	4.6	5.0	5.2
Actual £M	3.8	4.8	4.2	6.3	6.2	5.4	5.0	4.2	3.9			
Forecast £M									3.9	4.3	5.0	5.2

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st December 2018

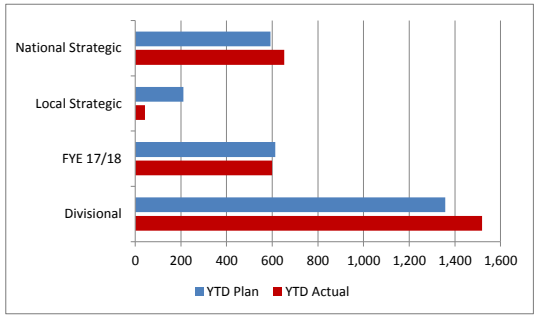
Cost Improvement Programme

CIP by Theme

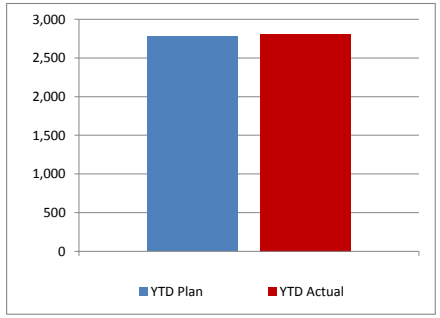
In Month CIP Achievement £000's



Year To Date CIP Achievement £000's

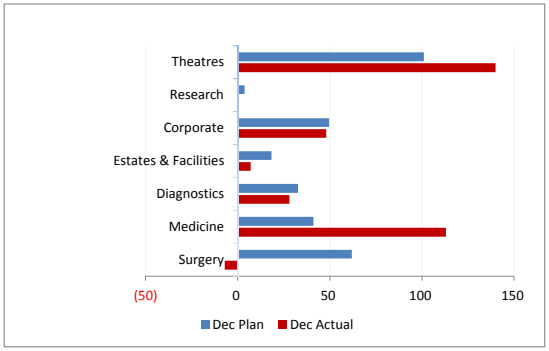


Trust YTD Achievement Against YTD Plan £000's

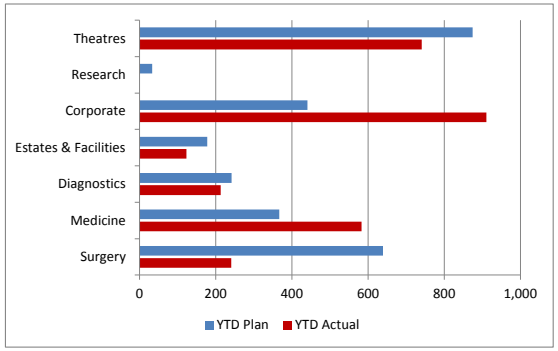


CIP by Division

In Month CIP Achievement £000's



Year To Date CIP Achievement £000's



RAG of Total Schemes Being Tracked

589	16%	b
1,924	53%	g
799	22%	a
300	8%	r
3,612	100.0%	

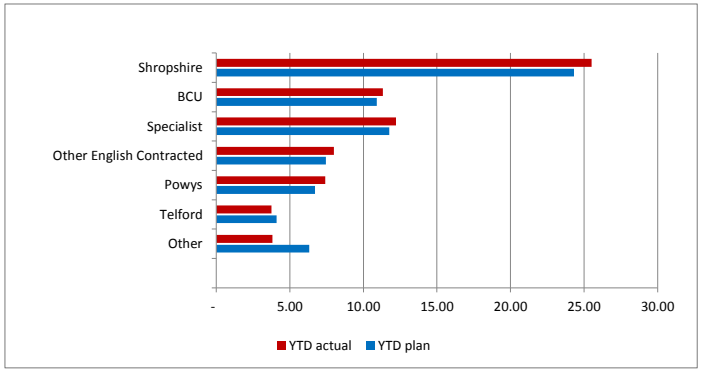
Capital

Year to date capital programme £000's

Position as at	1819-09	Capital Programme 2018-19			
Project	Annual Plan £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s
CT Scanner replacement infrastructure works	650	650	653	-3	653
TSSU solution	600	400	43	357	100
New IT network	200	0	0	0	200
Bed capacity solution	350	0	345	-345	350
Project management / implementation support	150	110	76	34	100
Estates backlog / CQC Site improvement	500	425	272	153	480
IT investment / replacement	300	210	57	153	319
Equipment and minor works investment / replacement	500	450	168	282	474
Fire safety work	200	150	155	-5	435
Kenyon toilet block	100	100	115	-15	115
Operational Control Centre	100	0	3	-3	100
EPR development	100	0	38	-38	100
Trust improvement bids	120	25	20	5	120
WiFi Project (PDC Funded)	127	127	121	6	127
Other (allocated from contingency)	82	75	57	18	82
Contingency	98	0	0	0	122
NHS Capital Funding	4,177	2,722	2,123	599	3,877
Donated Assets	200	180	183	-3	303
Total Capital Funding (NHS & Donated)	4,377	2,902	2,306	596	4,180

Commissioner Performance

Year To Date Commissioner Income against Plan £m



1. Part One - Public Meeting	2. Strategy & Policy Updates	3. Quality & Safety	4. Performance & Governance	5. Items to note	6. Any Other Business

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Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th November 2018

Income and Expenditure £'000s

Category	Annual Plan	In Month Position			Year To Date Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	96,940	8,634	8,829	195	64,874	65,211	337
STF	833	83	0	(83)	460	292	(168)
Private Patient income	5,831	704	506	(198)	3,977	3,860	(117)
Other income	6,529	526	650	124	4,413	4,925	512
Pay	(60,670)	(5,088)	(5,247)	(159)	(40,460)	(41,029)	(569)
Non-pay	(42,937)	(3,738)	(3,742)	(4)	(28,534)	(28,967)	(433)
EBITDA	6,527	1,121	995	(126)	4,730	4,292	(438)
Finance Costs	(5,197)	(438)	(427)	11	(3,443)	(3,393)	50
Capital Donations	200	0	19	19	160	151	(9)
Operational Surplus	1,530	683	588	(95)	1,448	1,050	(398)
Remove Capital Donations	(200)	0	(19)	(19)	(160)	(151)	9
Add Back Donated Dep'n	607	51	53	1	403	406	3
Remove STF Funding	(833)	(83)	0	83	(460)	(292)	168
Control Total exl STF	1,104	651	621	(30)	1,230	1,013	(218)
STF Earnt	833	83	0	(83)	460	292	(168)
Control Total	1,937	734	621	(113)	1,690	1,305	(386)
EBITDA margin	6.0%	11.4%	10.0%	-1.4%	6.5%	5.8%	-0.7%

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

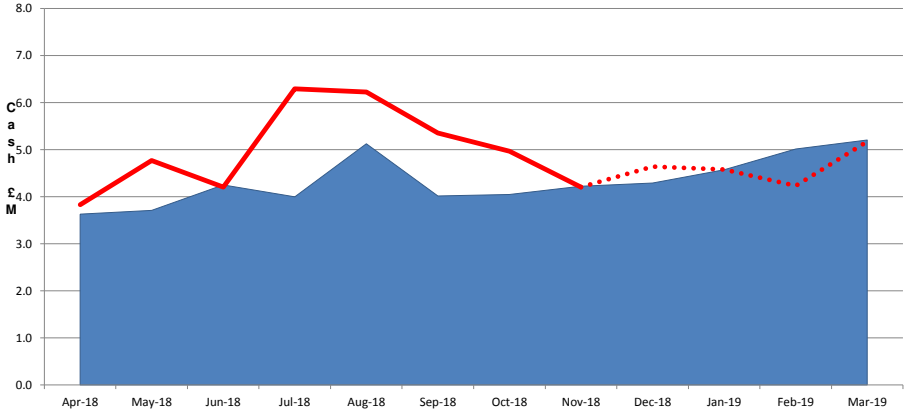
	Nov-18	YTD
Debtor Days	25	21
Creditor Days	34	30

Statement of Financial Position £'000s

Category	Oct-18	Nov-18	Movement	Drivers
Fixed Assets	74,299	74,404	105	Additions less depreciation
Non current receivables	947	1,069	122	RTA/CRU notifications
Total Non Current Assets	75,246	75,473	227	
Inventories (Stocks)	1,017	1,039	22	
Receivables (Debtors)	8,212	9,083	871	Clinical income over performance
Cash at Bank and in hand	4,971	4,207	(764)	Reduction driven by clinical income over performance not yet realised in cash
Total Current Assets	14,200	14,329	129	
Payables (Creditors)	(11,050)	(10,818)	232	
Borrowings	(1,176)	(1,176)	0	
Current Provisions	(84)	(84)	0	
Total Current Liabilities (< 1 year)	(12,310)	(12,078)	232	
Total Assets less Current Liabilities	77,136	77,724	588	
Non Current Borrowings	(6,472)	(6,472)	0	
Non Current Provisions	(186)	(186)	0	
Non Current Liabilities (> 1 year)	(6,658)	(6,658)	0	
Total Assets Employed	70,478	71,066	588	
Public Dividend Capital	(33,260)	(33,260)	0	
Revenue Position	(11,847)	(11,847)	0	
Retained Earnings	(462)	(1,050)	(588)	Current period Surplus, before control total adjustment
Revaluation Reserve	(24,909)	(24,909)	0	
Total Taxpayers Equity	(70,478)	(71,066)	(588)	

Monthly Surplus/Deficit

Cash Flow



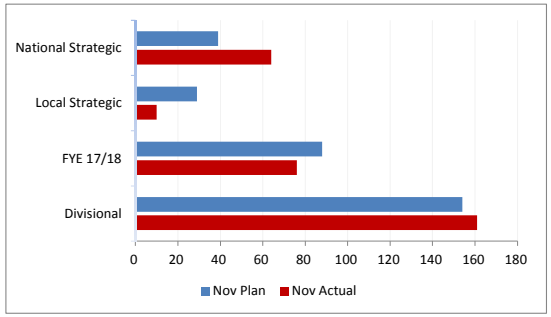
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Plan £M	3.6	3.7	4.3	4.0	5.1	4.0	4.0	4.2	4.3	4.6	5.0	5.2
Actual £M	3.8	4.8	4.2	6.3	6.2	5.4	5.0	4.2				
Forecast £M								4.2	4.6	4.6	4.2	5.2

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th November 2018

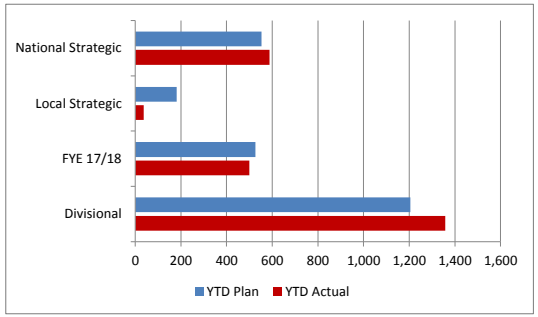
Cost Improvement Programme

CIP by Theme

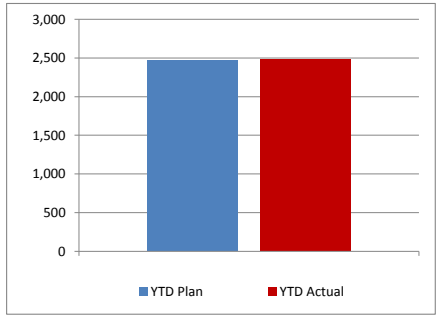
In Month CIP Achievement £000's



Year To Date CIP Achievement £000's

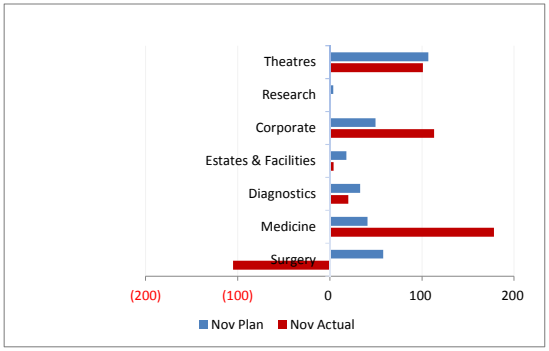


Trust YTD Achievement Against YTD Plan £000's

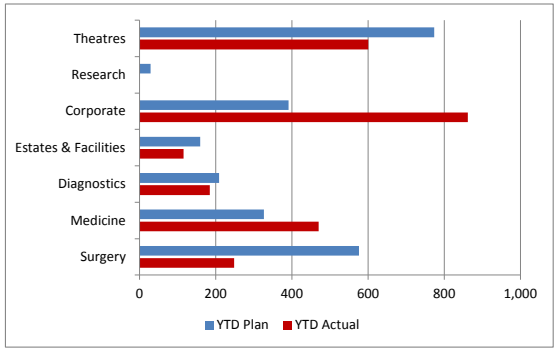


CIP by Division

In Month CIP Achievement £000's



Year To Date CIP Achievement £000's



RAG of Total Schemes Being Tracked

610	17%	b
941	26%	g
1,861	52%	a
200	6%	r
3,612	100.0%	

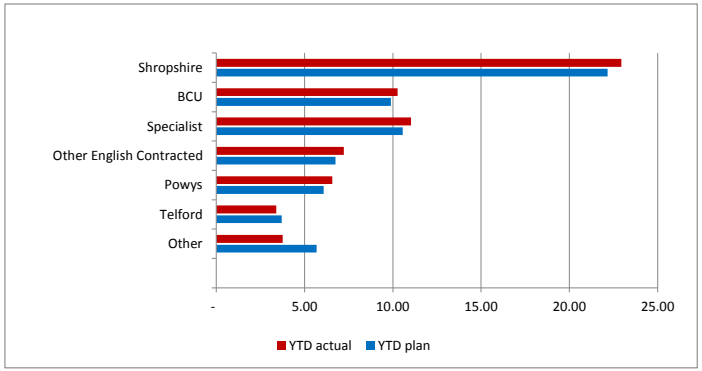
Capital

Year to date capital programme £000's

Position as at	1819-08	Capital Programme 2018-19			
Project	Annual Plan £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s
CT Scanner replacement infrastructure works	650	650	653	-3	653
TSSU solution	600	200	37	163	100
New IT network	200	0	0	0	200
Bed capacity solution	350	0	234	-234	350
Project management / implementation support	150	100	68	32	100
Estates backlog / CQC Site improvement	500	350	305	45	460
IT investment / replacement	300	180	57	123	300
Equipment and minor works investment / replacement	500	400	127	273	500
Fire safety work	200	150	54	96	440
Kenyon toilet block	100	100	110	-10	112
Operational Control Centre	100	0	0	0	100
EPR development	100	0	22	-22	100
Trust improvement bids	120	25	2	23	120
WiFi Project (PDC Funded)	127	90	76	14	127
Contingency	180	75	9	66	215
NHS Capital Funding	4,177	2,320	1,755	565	3,877
Donated Equipment	200	160	151	9	200
Total Capital Funding (NHS & Donated)	4,377	2,480	1,906	574	4,077

Commissioner Performance

Year To Date Commissioner Income against Plan £m



Exception Report – Agency Control Total

Performance Issue:

National Context

Reducing agency spend is one of the key priorities of NHS Improvement in returning the provider sector back to financial balance.

All NHS providers have been issued with an agency control limit by NHS Improvement to support this position and weekly returns are required from providers on agency shifts and costs. Overspends against the agency limit have an adverse impact on the Trust's UoR (Use of Resources rating) and could lead to Regulator intervention.

Local Context

RJAH has historically been one of the lowest users of agency in the region with a well-established internal bank. However, more recently national workforce shortages have continued to intensify with a consequence that agency requirements have been steadily increasing. This is in the context of increasing demand for our services.

RJAH has an agency control target comprising of two elements as follows:

- **'Core' agency** – Representing the traditional agency workforce of doctors and nurses. The limit of £1.56m is on par with prior year usage and whilst challenging is realistic to be achieved.
- **Oswestry Orthopaedics LLP** – Additional reporting of the costs of using flexible consultant capacity (out of job plan working). The target set for this year represents a £0.6m reduction from the previous year and whilst the Trust remains committed to reducing volumes of out of job plan working by recruiting additional consultants, the timelines required for this alongside a backdrop of increased overall planned activity mean that this element of our target is unachievable for this financial year. This position has been accepted by our Regulator and plans to reduce LLP spend going forward are tracked at our Performance Review meets.

'Core' Agency

Current Position

In terms of the 'core' agency spend an updated deep dive was presented to the November Finance Planning and Investment Committee detailing the key drivers for the year to date position and highlighting a number of short term actions and longer term workforce transformation plans that will support reduced agency usage.

Key headlines for November are as follows:

- October showed a benefit of £3k against the forecast driven by reduction in ward nursing
- £129k over the control target ytd, £9k deterioration against the cap in month.
- All agency spend is on clinical posts
- 55% of spend on Consultants and Doctors predominately covering vacancies in Medicine Division
- 19% of spend on Theatres staff covering vacancies and weekend working
- 19% of spend on nursing, shortfall against action plan due to increased usage on MCSI and surgical wards

Area	Month 8		
	Forecast	Actual	Variance
Ward Nursing - Surgery	£15,000	£9,627	£5,373
Ward Nursing - Medicine	£12,000	£7,797	£4,203
MCSI Doctors	£9,000	£11,076	-£2,076
Rheumatology Consultants	£70,000	£68,951	£1,049
T&O Doctors	£0	£0	£0
Theatre Scrub / ODP	£26,000	£29,892	-£3,892
Therapies	£0	£0	£0
Radiology	£0	£0	£0
Orthotics	£12,000	£13,728	-£1,728
Total	**£144,000**	**£141,071**	**£2,929**
Control Total	£131,780	£131,780	£0
Variance	**-£12,220**	**-£9,291**	**-£2,929**

Forecast Position

The updated forecast position, actions are in place within the divisions to reduce agency in Q4, this will forecast us to come under the core agency cap for year end.

Area	Actual Month 8				Dec	Jan	Feb	March	Total	Lead	Confidence	Assumptions / Comments
	M7 YTD	Forecast	Actual	Variance	1819-09	1819-10	1819-11	1819-12				
Ward Nursing - Surgery	£129,831	£15,000	£9,627	£5,373	£9,000	£9,000	£7,000	£7,000	**£37,373**	Kirsty Evans		Updated in Nov based on latest vacancy, recruitment and sickness information.
Ward Nursing - Medicine	£65,896	£12,000	£7,797	£4,203	£8,000	£8,000	£6,000	£6,000	**£32,203**	Mandy Bride		6 WTE appointed September 2018; 6 WTE vacancy remaining. 4 WTE Sickness. Recruitment day 24th November 2018.
MCSI Doctors	£84,019	£9,000	£11,076	-£2,076	£9,000	£0	£0	£0	**£6,924**	Lynne Morris		Appointment of International Spinal Fellow December 2018. Speciality Doctor & Clinical Fellow adverts close 21st November 2018. Second vacancy from 18th December and 3rd vacancy from 19th March 2019.
Rheumatology Consultants	£435,159	£70,000	£68,951	£1,049	£50,000	£47,000	£13,000	£13,000	**£124,049**	Karin Daelemans		1 x Dr E (50/50 TeMS)- assumed to continue all year. 1 x Dr R expected to be brought on to payroll January 2019 1 x Dr I to leave January 2019 upon start of specialty doctor & second international medical trainee
T&O Doctors	£41,227	£0	£0	£0	£0	£0	£0	£0	**£0**	Sue Pryce		No requirement assumed. New rotation will be in February 19.
Theatre Scrub / ODP	£194,040	£26,000	£29,892	-£3,892	£16,000	£25,000	£22,000	£24,000	**£83,108**	Amanda Peet		Reduced levels following reduction in double scrub and recruitment, adjusted for activity requirements.
Therapies	£2,036	£0	£0	£0	£0	£0	£0	£0	**£0**	N/A		No requirement
Radiology	£6,055	£0	£0	£0	£0	£0	£0	£0	**£0**	N/A		No requirement
Orthotics	£77,165	£12,000	£13,728	-£1,728	£9,000	£12,000	£14,000	£13,000	**£46,272**	Jane Dewsbury		2 x Orthotists - Authorised until 31/03/19. 3 weeks of agency sessions cancelled between Dec 2018 & Mar 2019.
Total	**£1,035,428**	**£144,000**	**£141,071**	**£2,929**	**£101,000**	**£101,000**	**£62,000**	**£63,000**	**£329,929**			
Control Total	£924,065	£131,780	£131,780	£132,358	£133,082	£124,265	£123,631	£123,577	£636,913			
Variance	**-£111,363**	**-£12,220**	**-£9,291**	**£129,429**	**£32,082**	**£23,265**	**£61,631**	**£60,577**	**£306,984**			

One off
High Confidence - minimal risk to forecast
Medium Confidence - some risk to forecast
Low Confidence - significant risk to forecast

LLP Agency

Current Position

Current LLP spend is £291k higher than planned, £536k over the agency cap, drivers for this overspend have been reported to the Finance, Performance & Investment committee, and actions will be tracked via this route. NHSI notified of £400k shortfall on agency plan for LLP due to activity growth, however cap not updated to reflect this.

Key drivers:

- New consultant slippage
- Contract penalties
- Job plan utilisation

	2018/19		
	Plan	Actual	Variance
Inpatients	997	1,197	-200
Outpatients	612	703	-91
Total	1,609	1,900	-291
Control Total	1,364	1,900	-536

Planned Remedial Actions:

The Trust is committed to keeping premium staffing costs to a minimum while delivering outstanding patient care. A number of remedial actions have been agreed to reduce agency spend for the remainder of the year.

'Core' agency:

- Agency procedure revamped with strong focus on controls with full Executive sign off of every appointment
- Further review of agency procedure to include requirement to review all long term agency and NHSI have set standard commission rates to be adopted by Trusts
- Detailed action plans in place with divisions and nominated leads – progress tracked through monthly performance meets
- 'Live' agency forecast maintained in line with action plans to track progress - if delivered will end year within agency limit for 'core' agency
- Confirmation of additional theatre and ward nursing staff commencing in September to alleviate pressures in theatres and the wards going forward
- Three nursing recruitment days planned for November, January and March to continue filling vacancies and attract staff to RJAH as an attractive place to work
- Transformation of the recruitment process to support fast track appointments and trouble shoot any delays
- New ways of working developed through service review methodology with overseas Doctors recruitment in the pipeline for Medicine division reducing reliance on traditional consultant models

Oswestry Orthopaedics LLP:

- The contractual performance actions for the LLP will be tracked through the Financial Planning and Investment Committee
- Monthly performance meetings held with provider to ensure delivery of contractual obligations
- Progression of consultant appointments in a number of sub specialties
- 'Live' forecast maintained in line with activity projections to ensure best use of resources
- Delivery tracked through monthly performance review meets
- Regular communication with NHS Improvement to ensure shared understanding of model and expectations

Ownership:

Executive Lead: Craig Macbeth, Director of Finance

Report Prepared By: Mark Salisbury, Deputy Director of Finance

Exception Report – Cancer 62 Days Standard (Tumour)

Performance Issue:

Performance against the Cancer 62 Days Standard (Tumour) has been below target and red rated for three consecutive months. Although breach reallocation is not yet functional in the National Cancer Waits Database we continue to follow the process of breach reallocation internally. The new national reporting approach was due to be used in official published performance reports from Q4 onwards (i.e. on pathways ending in Q3) but we have received notification from NHS Digital that this is now delayed until April 2019.

In the IPR narrative we also refer to the adjusted mitigated position each month, the table below summarises the National Reported and Adjusted Mitigated positions:

Reporting Period	National Reported Position			Adjusted Mitigated Position				
	Total Patients	Treated in Target	% Treated in Target	Total Patients	Treated in Target	% Treated in Target	No. of Patients Treated in Target	No. of Patients Not Treated in Target
April	0.5	0	0.00%	0.5	0	0.00%	0	1
May	1	1	100.00%	1	1	100.00%	1	0
June	1.5	1	66.67%	1.5	1.5	100.00%	2	0
July	1	0.5	50.00%	1	1	100.00%	2	0
August	0.5	0	0.00%	0.5	0	0.00%	0	1
September	0.5	0	0.00%	0.5	0.5	100.00%	1	0
October	2	1	50.00%	2	1	50.00%	1	2

The details surrounding the data above is summarised below:

April – In April there was one shared pathway with The Christie. Delays in the pathway meant we were unable to refer the patient to The Christie until Day 43. A full RCA was undertaken on this patient pathway with two areas identified for improvement associated with patient initiated delays and fast-tracking

of correspondence to alternative provider. Robust cross-cover has been addressed within the unit so that administrative procedures are always adhered to. The adjusted mitigated position is reported the same as national figures at 0.00%.

May – The standard was achieved in May with one patient whose entire pathway was seen at RJAH treated in target.

June – One patient, whose entire pathway was at RJAH, was treated in target but a second patient, who had a shared pathway with The Christie breached the standard. The patient was referred from RJAH on Day 32 and there were also administrative delays at The Christie. The adjusted mitigated position is reported at 100%.

July – Two patients were reported in July. The first was a shared pathway The Christie and this patient met the standard. A second patient, whose pathway was shared with SaTH breached the standard with a wait of 83 days. This was a result of many complex diagnostic tests that were required within the pathway however RJAH referred the patient in a timely manner on Day 16. The adjusted mitigated position is reported at 100%.

August – In August there was one shared pathway with The Christie and the patient breached the standard with a wait of 66 days. The patient required various diagnostic tests due to an unknown primary cancer so we were unable to refer the patient on to The Christie until day 45. The adjusted mitigated position is reported the same as national figures at 0.00%.

September - There was one shared pathway with The Christie and the patient breached the standard with a wait of 63 days due to patient choice. The adjusted position would actually be 100% as the patient was referred from RJAH to The Christie on Day 31.

October - There were three patients reportable under this measure. The first patient, whose entire pathway was at RJAH was treated in target. A second patient's pathway took 71 days where they patient was initially seen at RJAH and was then referred to The Queen Elizabeth Birmingham on Day 41. A third patient, also with a wait of 71 days, began their pathway at RJAH and was referred to Aintree University Hospitals on Day 44.

Planned Remedial Actions:

Year to date there have been 4 patients not transferred to alternative hospitals within the 38 day target as described in the breach allocation guidance.

- 1 in April, transferred on day 43 (5 days beyond target date)

- 1 in August, transferred on day 45 (7 days beyond target date)
- 2 in October
    - 1 transferred on day 44 (6 days beyond target date)
    - 1 transferred on day 41 (3 days beyond target date)

The breaches have been due to complex diagnostic pathways. Actions to improve processes by the 7 days over target described above have been identified by the Surgical Division:

- Cross-divisional working between Diagnostics Division and Surgical Division to increase one stop Diagnostics where appropriate
- Patient availability escalation process.
- Implementation of learning from RCAs

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Claire Jones, Principal Analyst & Data Quality Lead

Gemma Brett, Interim Divisional General Manager for Surgery

Exception Report – % Delayed Discharge Rate

Performance Issue:

Reporting Period	Trust		Surgery		Medicine	
	% Delayed Discharge Rate	Delayed Discharge Days	% Delayed Discharge Rate	Delayed Discharge Days	% Delayed Discharge Rate	Delayed Discharge Days
September	5.57%	253	0.72%	20	12.17%	233
October	6.10%	302	1.02%	30	13.53%	272
November	7.38%	359	1.17%	33	16.80%	326

Planned Remedial Actions:

1. **Patient Choice Policy:**

The Trust has adopted the Patient Choice Policy, formally known as the Reluctant Leavers Policy in line with all Shropshire and Telford NHS settings in 2017/18. This policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care. Those self-funding care will be offered the same level of advice and guidance regarding choice as those fully or partly funded by their local authority or NHS Continuing Healthcare (CHC).

An interim package of care or placement will be offered to a patient where a decision has not been made within three consecutive days of completion of step 3, available options have been declined, or where a decision has been made but the specific package, placement, or adaptation is not yet available. Patients do not have the right to remain in hospital to wait for their preferred option to become available. The interim package or placement is distinct from intermediate care. Consideration of interim arrangements must be accompanied by a risk assessment, including impact on any carers.

2. Anticipated Trajectory

The November 2018 position continues to show significant delays within the Medicine Division. The overall position is 16.80% of delays in Medicine with sub-categories of 27.89% for Gladstone Ward, 6.71% for Wrekin Ward and 8.74% for Sheldon Ward. Currently it is not envisaged that there will be any substantial improvement this financial year.

3. Escalation Arrangements

Escalation arrangements are contained within our Discharge Policy. We have developed further Standard Operating Procedures to support the escalation arrangements with key points of Escalation from wards, to matrons, to Director of Operations/Nursing and as a last resort to the Chief Executive. This has been implemented vigorously within the Trust since June 2018 in relation to MCSI delays with daily updates and Director to Director correspondence instigated between organisations.

A paper has been submitted to NHS Improvement by the Director of Operations in relation to commissioning of intermediate care beds and also for a review of increasing specialised commissioning beds for spinal injured patients. Assistance has been sought from the CCG to help facilitate the delays within MCSI.

4. Learning Events to improve working practices

Karen Smith, CHC lead for Cheshire attended the Trust in September 2018 to give a presentation to the Medicine Division on good practices associated with securing placements and packages of care. The MCSI service manager, resettlement office and deputy director of operations will be attending a meeting with representatives from BCU health board on 19th December to discuss ways to improve the delays in transferring patients resident in the north and east of Wales.

5. Patient information review

MCSI held an away day in August 2018 to identify areas for improvement in terms of patient information and support available for patients and relatives in preparedness for discharge. A further session was held on 5th November 2018 to develop the documentation.

6. Intermediate care model

The MSCI team are currently looking at opportunities for the development of intermediate care bed capacity being secured for their patients. This proposal will be developed to consider short term placement arrangements for the following patients:

- Post-operative pressure sores,
- Slow stream rehab,
- Patients awaiting CHC packages

The types of intermediate care placements that we require for our patients will require joint working with the intermediate care providers in order to ensure that the placement meets the complex needs of our patients.

Ownership:

Executive Lead: Bev Tabernacle, Director of Nursing

Report Prepared By: Nicki Bellinger & Paula Jefferson

Exception Report – Patients Waiting Over 52 Weeks (English)

Performance Issue:

Month	Total 52+ Weeks Reported	Of which, ACI Patients	Forecast - 52+ Weeks	Forecast – Of which ACI Patients	NHSI Trajectory No of ACI Patients
September	0	0			
October	2	2			
November	2	1			
December			4	3	3
January			4	3	3
February				4	4
March				1	0

*Unable to complete Feb/March forecast at this time due to the work taking place currently on this cohort of patients, figures at this stage would give false predictions.

Planned Remedial Actions:

One consistent area of non-delivery is spinal disorders. An action plan to deliver no breaches by the end of March 2019 is to be completed by the Surgical Division by 31st December 2018. This is to ensure that all work streams currently existing for spines are collated and measured effectively. Actions contained within the plan will be risk rated.

Examples of themes that will feature in terms of actions on the plan are as follows:

- At Clinical Cabinet in November 2018 a decision was made to implement a policy around pooling all spinal referrals (unless there is a specific reason that the patients need to stay with that named consultant). This policy is on a pilot basis for spinal disorders over the next 6 months so will be for review at the end of May. There are currently three consultants with longer waiting times within the subspecialty to focus transfer of referrals.
- Work is to be undertaken around obtaining additional theatre capacity for pressured consultants January-March so that they can concentrate on the inpatient backlog and allow new patients to move across to other consultants. This would allow the 52 week position to resolve and the wait times for new appointments to decrease.
- Understanding of what additional capacity can be gained from using the Fellow, Registrars and AHP differently (if any). Again, this will be assessed by the end of January.

The second area of non-delivery in recent months is ACI patients due to a) an increase in referrals of this type earlier in the year and b) Professor Richardson patients transferring over to other consultants and increasing the pressure on their existing ACI lists.

Capacity has been found for all but one English 52 week patient before March end, and we are in the process of confirming all surgery dates with each patient. For the outstanding patient, funding for an alternative method of treating ACI patients is being sought.

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Gemma Brett, Interim DGM Surgery

Exception Report – English List Size

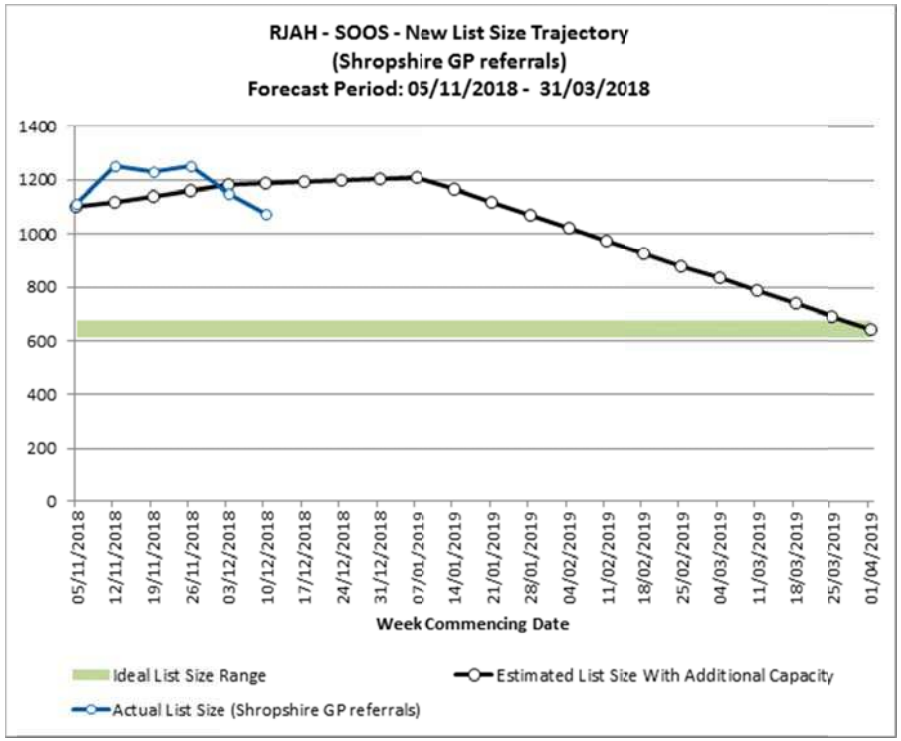
Performance Issue:

English List Size	
September 2018	6960
October 2018	7026
November 2018	7029

Planned Remedial Actions:

English waiting list size continues to grow with the main area of growth in the SOOS service. Actions being taken to bring the waiting list size down are as follows:

- Focus on delivering reduction in the waiting list and backlog between now and the end of March for surgery patients to ensure we meet targets required for trajectory, evaluation of what clinics and theatre sessions are required to deliver this to be undertaken w/c 17th December
- Remedial Action plan in place to increase capacity for new patient appointments in SOOS to reduce the backlog of patients waiting over 4 weeks and the overall list size. This includes increasing clinician hours in SOOS, reviewing clinic templates, over-recruitment to booking team and reviewing demand and capacity modelling.
- The waiting list size for SOOS is shown in the graph below (blue line). The green shading shows the ideal list size and the black line is the planned trajectory to reduce the SOOS waiting list size to the ideal position where patient can be seen within the target time of 4 weeks from referral.



Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Paula Jeffreson and Gemma Brett

Exception Report – % Reportable Cancellations

Performance Issue:

Reporting Period	% Reportable Cancellations
September	1.21%
October	1.13%
November	1.02%

Reporting Period	September	October	November
Emergency Case	5	2	3
Lack of HDU Bed	2	1	2
Lack of Kit	1	1	
Lack of Time	5	1	4
Patient Not Consented			1
Staffing Issues	1		
Surgeon / Anaesthetist ill/UTA		9	3
Total	**14**	**14**	**13**

Planned Remedial Actions:

The Reportable cancellation KPI of 0.7% of activity has been exceeded, as above, for the last 3 consecutive months. A full RCA is completed for every cancellation that occurs. The main themes and lines of review and work are outlined below:

Consultant Surgical or Anaesthetic Cases (12 cases, 5 occasions) - The key paretos for these cancellations demonstrate that the most significant driver of 12 cases is due to either Consultant Surgical or Anaesthetic sickness and, therefore, unavoidable.

Lack of Time (10 occasions) – This was predominately due to cases being more complex than anticipated/list overbooked, or secondary factors such as a list having HDU issues initially and being unable to commence the second case due to the patient drinking water, therefore, lack of time to do both cases. A deep dive/audit is being conducted on these cases to test the narrative against the theatre timings of the session. This will take into account the overall Touchtime of the session. There is also ongoing work reviewing lists at the daily comm cell meeting to gather additional information to assess trends in order to address/contest. Any trends identified will be shared with the Performance Managers to ensure this is factored into the bookings process following individual challenge.

Emergency Cases (also 10 occasions) – This was split between spinal, arthroplasty and upper limb cases. There is no separate emergency theatre facility at RJAH due to the elective nature of the facility and infrequent demand and resulting underutilisation that would result.

Lack of HDU Bed (5 occasions) - On the 5 occasions this was due to clinical factors delaying the discharge of patients already in HDU. Where appropriate, HDU beds are always booked a resource on Bluespier but in all these cases there were clinical indicators preventing the discharge of patients already utilising the beds.

Work continues to ensure all cancellations are challenged where possible on the day in order to mitigate by using both staff and other resources if this can be facilitated.

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Amanda Peet, Theatres Divisional Manager

Exception Report – Patients Waiting Over 52 Weeks (Welsh)

Performance Issue:

Patients Waiting Over 52 Weeks - Welsh	
September 2018	6
October 2018	3
November 2018	9

September – Spinal Disorders (6)

October – Spinal Disorders (3)

November – Spinal Disorders & Pain (9: 8 Spines, 1 Pain)

Planned Remedial Actions:

Consistent area of non-delivery is spinal disorders. An action plan to deliver no breaches by the end of March 2019 is to be completed by the Surgical Division by 31st December 2018. This is to ensure that all work streams currently existing for spines are collated and measured effectively. Actions contained within the plan will be risk rated.

Examples of themes that will feature in terms of actions on the plan are as follows:

- At Clinical Cabinet in November 2018 a decision was made to implement a policy around pooling all spinal referrals (unless there is a specific reason that the patients need to stay with that named consultant). This policy is on a pilot basis for spinal disorders over the next 6

months so will be for review at the end of May. There are currently three consultants with longer waiting times within the subspecialty to focus transfer of referrals.

- Work is to be undertaken around obtaining additional theatre capacity for pressured consultants January-March so that they can concentrate on the inpatient backlog and allow new patients to move across to other consultants. This would allow the 52 week position to resolve and the wait times for new appointments to decrease.
- Understanding of what additional capacity can be gained from using the Fellow, Registrars and AHP differently (if any). Again, this will be assessed by the end of January.

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Paula Jeffreson and Gemma Brett

Shropshire, Telford & Wrekin STP

Sustainability and Transformation Plan

Footprint Name and Number:
Shropshire and Telford & Wrekin (11)

Region:
Shropshire and Telford & Wrekin

STP Directors Update

January 2019

Our vision for health and care services in Shropshire, Telford & Wrekin

https://www.england.nhs.uk/systemchange/view-stps/shropshire-and-telford-and-wrekin/

Priorities

•Focusing on neighbourhoods to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.

•Multi-disciplinary neighbourhood care teams working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.

•Ensuring all community services are safe, accessible and provide the most appropriate care.

•Redesigning urgent and emergency care, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models.

•Making the best use of technology to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.

•Involving local people in shaping their health and care services for the future.

•Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.

STP Development Programme

NHS England are Providing a facilitated offer, delivered over a condensed time period:

- System Opportunity Diagnostic programme
  - Hypothesis testing, Validation and priority setting
  - Identification of transformation programmes and priorities
  - Qualitative self assessment
- System support (Facilitated learning events)
  - Wave 4 Commissioning Capability Programme
  - Leadership
  - Provider alliance
  - Structural architecture
- Development of ICS
  - ICS roadmap
  - Meeting the requirement of the ICS MOU

High Level Critical Path

Launch Event & Mobilisation

Detailed Diagnostic

Quantitative Analysis	**Qualitative Assessment**

Hypothesis testing workshops
- **Validation of opportunities**
- **Executive review , testing and validation**

Decision to proceed

Diagnosis and design phase

(weeks)

Transformation Programmes
- Planning for mobilisation
- Define support, structure & budgets
- Engagement and communication

Delivery and Support
- Programme management and expert PMO
- Access to subject matter expertise
- Best Practice
- Monthly gateway reviews

System Capacity Building
- Supporting development of leadership capacity and capability
- Facilitated workshops
- Action learning sets
- Development of appropriate financial strategies
- Governance and decision making

Transformation delivery and improvement phase (weeks)

- NHSE has coordinated the production of a quantitative deep dive of all key analytical data and matrix:
  - Right Care (2017/18)
  - Model Hospital Programme
  - Getting it Right First Time (GIRFT)
  - Benchmarking from Social Care
  - Benchmarking from CHC
- It is acknowledged that for Shropshire CCG some of this analysis is available in its Optimity Report.
- Co-produced with NHSI, the information will be collated into a Hypothesis pack for Shropshire

- Ambition is to support the identify any quick wins and to fully inform the production of an agreed set of transformation priorities.

Qualitative Self Assessment

- NHSE will co ordinate a qualitative self assessment exercise, the scope of which will be informed by the STP.
- Assessment will utilise the key concepts of the Integrated Care System (ICS) maturity index designed to provide a self assessment and anonymised baseline for the health system
- Approach:
  - Structured interviews around the core capabilities of: leadership and governance, readiness and commitment to operate as a single system, financial management, current performance, delivery and impact across the system.
  - Understanding the barriers to system development
- Output to shape the system **capacity support programme**

Diagnostic Review:

- Designed to support the system to identify opportunities available to the system
- Undertaken through both quantitate and qualitative analysis
- Quantitative data and information analysis output a report that seeks to quantify the identified opportunities.
- Qualitative diagnostic – self assessment to shape development programme

Facilitated Workshops – delivered over a number of sessions:

- To discuss data, information and evidence base
- Generate and test hypothesis
- Focused output on quantification of opportunities and next steps.
- Planning for delivery and system support
- Gateway signoff

Facilitated Programme Support / Action Learning Sets

- Support to executive leadership across the system
- Readiness and commitment to operate as a system across all partners
- Financial strategy and programme delivery
- Progressing the ICS – roadmap
- Meeting the requirements of the ICS MOU

Transformation priority programmes

- Intensive review and detailed shaping of selected priority programmes
- Gateway signoff

The offer:

- North Midland DCO have agreement with National Team to access:
  - External support and subject matter exercise
  - Length of high impact delivery 3-6 months
  - Expert facilitation of programme and workshops
- Transitional support to move to sustainable business as usual at approximately 3 months
- Delivery team shared across multiple high impact areas
- ICS programme facilitation (Jointly funded)

Project oversight

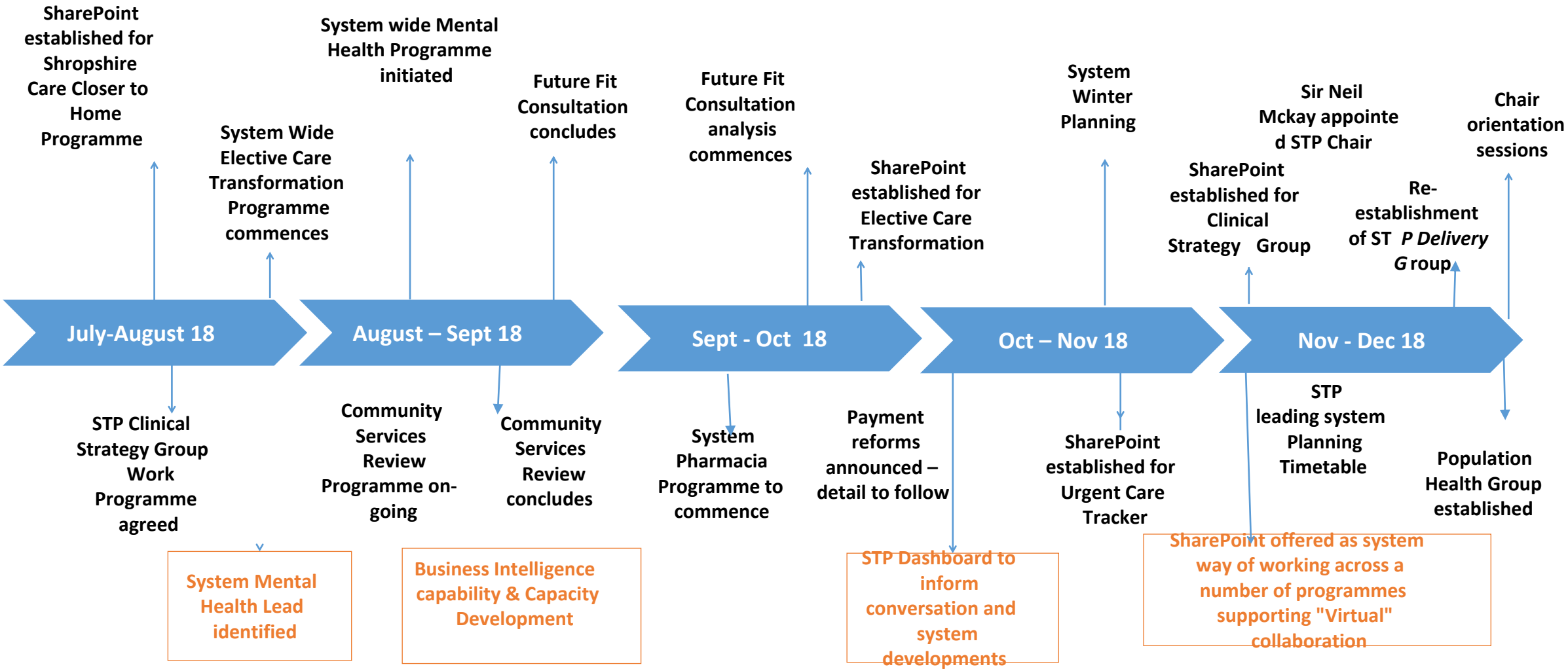
- NHSE/I project team to meet weekly
  - Facilitator/alliance
  - Project manager
  - Locality Director/leads

- Steering group to meet 2 weekly
  - STP leads
  - Alliance lead
  - Project manager
  - Expert advisors/regional support

Next Steps for Shropshire, Telford & Wrekin STP

- Work through the ICS 12 week Development Programme (start date to coincide with new STP Chair appointment)
- Develop Shropshire, Telford & Wrekin ICS Roadmap
  - Clear system Governance and programme management support
    - Aligned to system priorities
  - Further develop System Strategic Commissioning
  - Identify System Redesign Requirements
    - Clinically Led, building on the work of the STP Clinical Strategy Group
    - Understand **WHAT** enablement requirements are needed and **HOW** they will be delivered and by **WHEN**
    - Financial alignment
    - Estates
    - Digital
    - Workforce
    - Back Office functions
  - Be clear how as a system we will continually improve and sustain those improvements

Timeline of key STP activities Aug – Dec 18



System Wide Working

Strategic Development & Leadership

Recruitment of independent STP Chair

STP System Leaders Group

Local Workforce Action Board (LWAB)

STP Clinical Strategy Group

Health & Well-being Boards

Community Services review work programme

System Communication & Engagement

System wide consultation and feedback through existing mechanisms

Strategic Enablement

Strategic Estates Group

Strategic Back Office

Digital Enablement Group

Strategic Workforce Planning

Strategic System Finances

System population health & prevention (new)

System End of Life (new)

System Business Intelligence (Gap)

Strategic Delivery of change

Hospital reconfiguration (Future Fit)

Urgent & Emergency Care

- Winter Planning
- High Impact Changes
- Frailty
- IUC / 111

Out of Hospital Care Delivery

- Shropshire Care Closer to Home
- Telford & Wrekin Neighbourhoods

Primary Care Transformation

Mental Health Transformation

Cancer & End of Life

Elective Care Transformation – 8 workstreams identified

1.Procedures of Limited Clin Value 2. MSK

3. Ophthalmology 4. Diabetes 5. MRI

6. Out-Patients 7. Neurology 8. Dermatology

Pharmacia Programme

Local Maternity Services

- 132 Deliverables categorised as:

  - 47 Operational deliverables
    - Established indicators
    - Automated Data Collection through Statutory reporting (previously UNIFY)

  - 85 Transformation deliverables
    - Mix of quantitative and qualitative standards
    - Data sources not established for all quantitative standards
    - Non statutory/local reporting required for some
    - Being built into FYFV Dashboard as data sources are identified
    - **Monthly reporting on ALL 85**

Note:

These requests come through a variety of routes and land in different parts of the system, all with different deadlines and requirements using a mix of templates that are continually being revised

Updated Version 5.0
Oct 2018

Shropshire, Telford and Wrekin
Sustainability & Transformation Programme Governance Structure

Draft – tba - changes

STATUTORY ORGS
Requirement to adhere to own governance procedures

Provider Boards
Commissioner Boards
Local Authority Cabinets

- Telford & Wrekin CCG
- Telford & Wrekin LA
- SaTH
- RJAH
- ShropCom
- MPFT
- Shropshire CCG
- Shropshire LA

STP System Leadership Group

(System CEOs)

Health & Wellbeing Boards

Joint Health Overview Scrutiny Committee

STP Clinical Strategy Group

(System Clinical Leads)

Vulnerable Services Review
Clinical Strategy Improvement

STP Transformation Programme Delivery Group

System Enablement

- Communication & Engagement
- Strategic Workforce
- Strategic Estates
- Back Office
- Digital Enablement
- System Finance
- Population Health Management & Prevention
- Medicines Optimisation
- End of Life Programme

System Delivery

Telford & Wrekin

1. Community Resilience & prevention
2. Neighbourhood Teams
3. Systematic Speciality Review

- Urgent & Emergency Care
  High Impact Changes
  Frailty
- Acute Hospital Reconfiguration
  Future Fit
  Sustainable Services Programme
- Local Maternity Services
- Development of Primary Care
- System Mental Health Programme
- Elective Care Transformation Programme
- System Cancer

Shropshire

- Neighbourhoods & Prevention
- Care Closer to Home
  1. Frailty Front Door
  2. Primary Care Development
  3. Hospital at Home / Crisis intervention

Wider Stakeholder involvement across all work programmes

- Health Watch Telford & Wrekin
- Local Pharmacy Committee
- Shropshire Partners in Care
- Powys Teaching Health Board
- Severn Hospice
- ShropDoc
- West Midlands Ambulance Service
- Patient Groups
- Voluntary Sector
- Welsh Ambulance Service
- Wider independent organisations
- System Neighbours
- Health Watch Shropshire
- Subject Matter Experts

System Submissions to NHSE Governance

STP PMO currently support the following submissions to NHSE

1. Urgent & Emergency Care Tracker

- System Coordination of response by Prog Director Claire Old & Maggie Durrant
- Oversight and Exec sign off by Julie Davies on behalf of both CCGs

2. Elective Care Transformation Tracker

- System Coordination of response by CCGs & STP PMO Jill Barker
- Oversight & Exec sign off by Julie Davies on behalf of both CCGs

3. Mental Health Transformation – Tracker not yet available / required

- System Coordination of system Plan by STP Mental Health Strategy Group (co-chaired by Tony Elliot & Steve Trenchard (on behalf of both CCGs
- Oversight & Exec Sign off by Fran Beck on behalf of both CCGs

4. Clinical Vulnerable Services Stocktake

- Stocktake to establish vulnerable services across STP Footprint, support by Joanne Harding (STP PMO)
- Response coordinated through the Clinical Strategy Group on behalf of the system
- Sign off of final stocktake by STP Clinical Lead Julian Povey on behalf of the system

- All other submissions / reporting is unchanged and goes through existing Provider / Commissioner Governance processes
- Note STP has NO authority for sign off and existing governance arrangements MUST be met using Lead Execs as above

Appendixes

Following slides provide additional level of detail

These slides are “Live” and are continually updated as work programmes progressed, they are published bi-monthly

Commissioner Led Transformation Programmes

Shropshire – Care Closer to Home

Exec Lead – Julie Davies Clinical Lead Dr Jess Sokolov Programme Lead – Barrie Reis-Seymour

Phase 1

- Phase 1 is operationally functional as the Frailty Intervention Team (FIT) based within the A&E department of Royal Shrewsbury Hospital.
- The FIT works with frail patients to ensure that they experience as efficient an in-patient service as is possible; providing a bespoke assessment and evaluation in order to get the patient to the appropriate care setting rather than unnecessarily admitted into the acute bed base.
- The FIT helps us to understand the scale of the problem we need to address as a health economy, and the potential impact that can be achieved through getting things right in the community for our population.

Phase 2

- Phase 2 is about introducing proactive & preventative Case Management into the community and primary care.
- This will enable risk-stratification of our patients for earlier identification of needs.
- This will enable those most in need to be pro-actively managed with an integrated holistic health and social care plan, provided by a community based Case Management Team.
- This service is underpinned by the principles of keeping people as well as possible, for as long as possible, and in their own home or community.
- This will enable a clear understanding of what the requirements of the models in phase 3 are for the patients with a more acute/intense level of need.
- This will enable effective, fit for purpose strategic workforce and estate planning.
- This will improve patient & family experience, improve outcomes, and reduce admissions into the general hospitals.

Phase 3

- Phase 3 will introduce a range of higher intensity care settings & services into the community including:
- Hospital at Home,
- A Rapid Response Team
- Provision of Step-up beds capable of managing high levels of need acuity.
- Phase 3 will enable the full benefits of case management to emerge, providing other care settings into which patients can be transferred.
- Phase 3 will provide for significant market-place development.
- Phase 3 with Phase 2 provides layers of multiple care services that will keep people as well as possible and in the community or own home, reducing emergency hospital admissions to a critical minimum.
- Most importantly Phase 3 will enable us to serve our populations in a far more patient centred way than we can possibly achieve at this time.

NHS Shropshire Clinical Commissioning Group

Shropshire – Care Closer to Home - Progress

Phase 1 - update

- This remains operationally functional, it is the Frailty Intervention Team (FIT) based within Royal Shrewsbury Hospital A&E Department. Planning underway to implement at PRH A&E.
- FIT requirements in SaTH should taper off and reduce in time with the implementation of Phase 2 as a result of earlier intervention and proactive preventative care & support in the community.

Phase 2 - update

- Collaborative design of models and possibilities completed in July 2018.
- Final preferred model for risk stratification and case management approved by the Clinical Commissioning Committee on 15th August 2018.
- An Alliance Agreement being progressed that will enable the integrated working that will underpin the development of pilot demonstrator sites. This will involve finessing the model with the more detailed operational service delivery and workforce modelling.
- Monitoring and evaluation of pilots that will inform wider rollout across the county.
- Dedicated IT Task & Finish Group established to address need for shared data, and development of an electronic shared Care Plan.

Phase 3 - update

- Following 2 failed attempts at collaborative co-design (poor uptake from stakeholders, increasing system pressures and limited availability) the decision has been made for the in-house programme team to develop a range of Phase 3 model options by end of December 2018.
- In the new year, model options will be taken to GP, provider, and public & patient stakeholder workshops to provide critique, feedback and input that will further define a long list of possible model options.
- Phase 3 timeline being refreshed to reflect this necessary change in approach.
- It is likely that formal consultation will be required in elements of Phase 3, and this will be determine by the nature of the models that emerge in the design and option appraisal process.

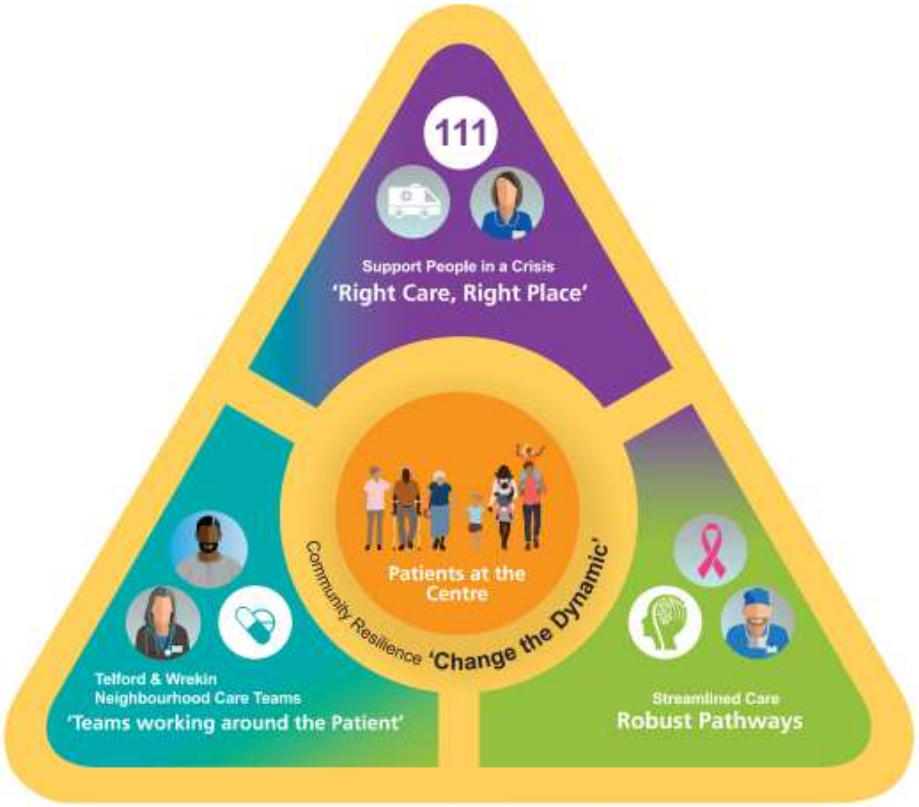
NHS
Shropshire
Clinical Commissioning Group

Telford & Wrekin Neighbourhood Programme

Exec Lead – Tracey Jones Project Lead – Ruth Emery

Programme needs to:

1. Improve availability and access to activities that will prevent the development of poor health
2. Improve early identification of illness to stop further deterioration
3. Promote self-care/self-management
4. Demonstrably increase effective community support available to support out of hospital care
5. Enable Primary Care Resilience (feeds into Primary Care local strategy)
6. Reduce dependency on statutory services
7. Develop a sustainable workforce
8. Reduce social isolation
9. Empowerment for people and professionals
10. Introduce new roles and ways of working
11. Ensure robust information accessible for communities and the professionals working with them
12. Ensure there are services and activities available closer to home
13. Develop well connected services and communities



System Partners / Enablers need to:

All stakeholders in the Telford and Wrekin area need to be open to change and new ways of working

Estates
- Support to ensure suitable estates to enable delivery, maximising to use of current resources available in addition to the development of new facilities

Communications
- Support with health literacy including mental health awareness

Digital
- Solution needed for shared patient records in particular those patients at risk
- Expertise/input regarding optimal use of assistive technology and how this can support the programme, and how IT can be utilised to work more effectively
- Develop data sharing agreement required across organisations

Workforce
- Supporting teams to develop a shared vision – neighbourhood working requires "virtual" teams and expertise on how this can work optimally is needed

Prevention
- Prevention is embedded throughout the programme, ensure awareness of programme and link where required

Out of Hospital
- Support with delivery of projects within programme – practical support needed

Mental Health

Development of STP wide strategy and governance .

Practical project support for AC OOA framework for 0-25 mental health (must do quickly) amd OOA adult mental health placements (longer term QIPP)

Crisis pathway for 16-18 year old children (including children who don't meet tier 4 threshold, those who have challenging behaviour and setting up PARA registers)

Encouraging Healthy Lifestyles
Targeting obesity, smoking and alcohol

Community Resilience
To support strong communities and improving access to community resources, including drop in service for mental health crisis, support for carers, the development of wellbeing hubs

Direct Care in the Community
To include the introduction of a dedicated care homes team, development of integrated neighbourhood teams, and review of intermediate care beds

Specialty Review
To include Diabetes and Respiratory

What the neighbourhood Programme Looks like for a single locality – an example

Using the data to drive the change

Description of Neighbourhood Working has fed into the Pre Consultation Business Case, including 5 year activity profiling for the acute

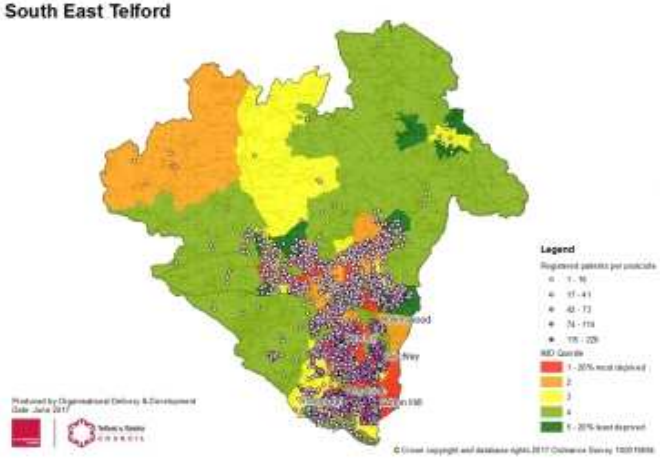
futurefit
Shaping healthcare together

Dementia diagnosis rate (add more context)
Rising hospital admissions (add more context)

NHS RightCare → *Diabetes outcomes need to be improved*

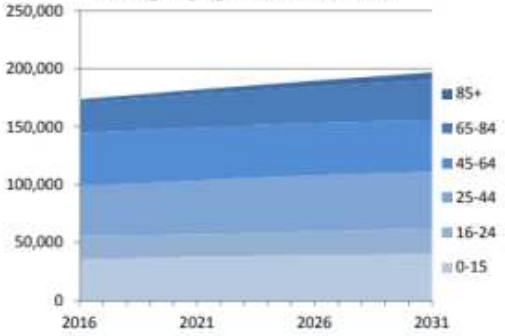
Between 2016 & 2031 the T&W population is expected to increase by 23,300 (13.4%). Over half of these are 65 and over, with the 85+ ages more than *doubling* (117.6%) and the 65-84 ages increasing by 33.1%. All England is expected to grow 10.2%, a slower growth than T&W(13.2%). The largest difference is seen in the T&W 25- 44 age group which expects 11.6% growth compared with just 3.2% for England.

South East Telford

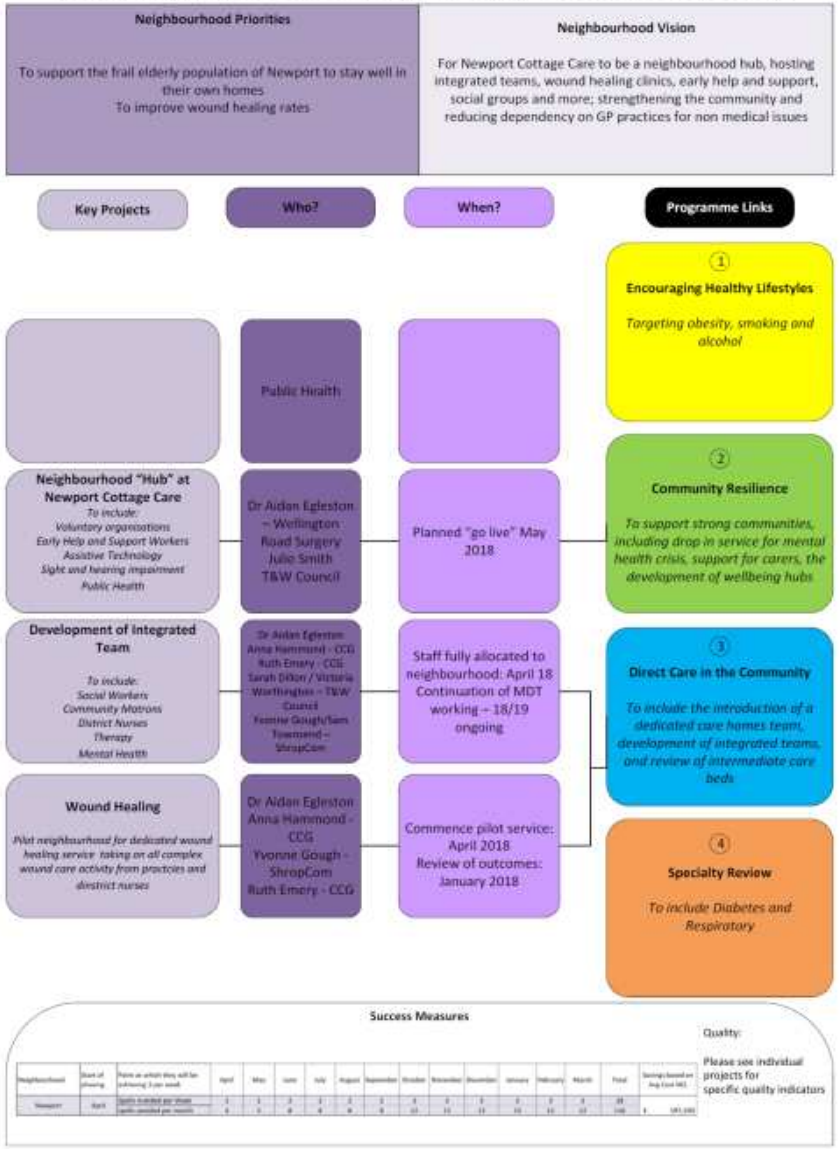


Practices and deprivation by neighbourhood – one of these for each n'hood has been produced

Figure 6: Telford and Wrekin projected population change by age band 2016 – 2031



NEWPORT LOCALITY: NEIGHBOURHOOD WORKING PROGRAMME PLAN ON A PAGE 2018/19 DRAFT



Telford Neighbourhoods – how it all fits together – delivering transformation

Case Study Examples to showcase progress

- Diabetes Management
- Hypertension Management
- Mental Health Hub – Branches
- Citizens Advice – Virtual Team
- Wound Healing project
- Community Information Portal
- Health Champions

Governance established

Engagement & Leadership in place

Co-Produced solutions to meet local need

Designed together

Delivered together

Telford Neighbourhood Programme

4 Neighbourhoods Formed

- Newport
- South East Telford
- Central Telford
- Telwell

Working with CSU Strategy Unit re: Logic Model and robust evaluation

Plan on a page for each Neighbourhood in place

Strong engagement with all sector partners, alliance agreement drafted to support new ways of working

Primary Care Programme – GPFV

Updated Aug 2018
Next update– Oct 18

Exec Lead – Nicky Wilde & Rebecca Thornley

Project Leads – Phil Morgan

Programme needs to:

The GPFV programme has five main elements:

New models of care
- Developing an approach to "working at scale" among practices using the guidance from NHS England to define and establish local "primary care networks"
- Linking practices working at scale to wider new models of care – i.e. Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG)

Extended Access
- Ensuring that 100% of the population has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at weekends/bank holidays (subject to local need) by Oct 1st 2018

Workforce
- Meeting national targets for increases in the number of GPs and other clinicians
- Retaining existing GP and other clinical staff in practices
- Developing at-scale approaches to workforce

Resilience/Workload
- Using the Resilience Fund to deliver practical, local solutions to increase resilience
- Implementing the 10 High Impact Actions

Estates and Technology Transformation Fund
- Delivering against key physical and digital projects, funded through the ETTF

In addition, CCGs are required to **invest** £3 per head, over two years, to enable Primary Care transformation.

System Partners / Enablers need to:

There are a number of enablers that would assist in the successful implementation of the GPFV programme:

Workforce
- The CCGs need to work with other health stakeholders to increase and improve the integration of workforce across different providers.
- The Care Closer to Home and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

Digital Information and Technology
- Key projects within the GPFV, particularly extended access and implementing the 10 High Impact Actions, are dependent on IT/digital solutions

Estates Investment
- Working across key STP stakeholders (local authority, public health, secondary and community providers) to utilise and develop the current and future estate

The progress:

New models of care
- Practices in both CCGs are increasingly working in groups/localities – further work is being planned with NHS England, including attending a conference on Primary Care Networks in September
- Primary Care is inputting into the development of both Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG)

Extended Access
- Current provision of evening and weekend appointments covers over 90% of the population
- Local pilots are being developed to ensure that the 100% target is met by October 1st

Workforce
- An STP Workforce Plan has been submitted with projects designed to address the recruitment and retention targets
- The CCGs are working with the STP workforce group to explore the possibility of developing banks for GPs and other clinicians.

Resilience/Workload
- Successful bids to the Resilience Fund have helped to increase resilience
- The CCGs are working with the national Time for Care team around the 10 High Impact Actions

Estates and Technology Transformation Fund
- A programme to install VOiP, VDI and WiFi across practices is being implemented
- Funding for 2018/19 projects (Skype and Telehealth) has been agreed
- Good progress has been made on a number of estates projects to address growing population GMS needs and to link with hospital service transformation

Interventions and process change milestones

- Increased levels of working at scale between practices
- 100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need
- Targets for workforce recruitment and retention across primary care met
- Successful implementation of the GPFV 10 High Impact Actions
- Successful implementation of ETTF funded IT and estates projects

Risks to delivery

Risks
1. Lack of alignment between the at-scale primary care plans and the Care Closer to Home /neighbourhood plans
2. Continued uncertainty around continuation of funding for extended access pilots and the post-October 1st scheme(s)
3. Inability of CCGs/GP practices to attract new GP and non-doctor clinicians to the local area
4. Pressure on revenue budgets from ETTF-funded capital estates projects
5. A change in historical culture is required to enable transformation and collaborative change in Primary Care which will take time to embed
6. Difficulty in accessing up to date and meaningful data to identify unsustainable practices who need support with resilience funding

Data

Extended Access
- Over 90% of the registered population currently has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at need – both CCGs are confident of achieving 100% access by 1st October 2018

Workforce
- NHS England targets for Shropshire STP are for 101 GPs and 47 non-Doctor clinicians to be recruited/retained by September 2020

Resilience/Workload
- Each of the practices across the STP need to implement at least two of the 10 High Impact Actions during 2018/19

Estates and Technology Transformation Fund
- VOiP Telephony Project – T&W - 16 sites now live for VOiP and Wi-Fi; SCCG – 16 sites now live for VOiP and Wi-Fi

DRAFT Local Maternity System

Exec Lead – Chris Morris

Programme lead- Fiona Ellis

Updated January 2019
Next update– Feb 2019

NHS England

NHS Improvement

Programme needs to:

Improve Safety
- Stillbirths and neonatal reduction
- Reduction in brain injury

Improve Choice and personalisation
- enabling all women to have a personalised care plan and choice in the care they receive

Increase midwife led births
- increase the number of women giving births in a Midwife led unit
-

Increasing investment in perinatal mental health

Develop continuity of carer

System Partners / Enablers need to:

Deliver actions in the workstream plans

Workforce
- Develop workforce plans to support LMS

Digital Information and Technology
- Digitally enable the workforce

Estates Investment
- Working across key STP stakeholders (local authority, public health, secondary and community providers) to utilise and develop the current and future estate

Maternity Voices
- Ensure co-production of all service transformation and new delivery models and specifications

The progress:

1. LMS Transformation Midwife is in post to support delivery of transformation projects, including continuity of carer.
2. Continuity of carer project launched.
3. Co-production workshop took place to agree approach to working in co-production.
4. Additional scanning resource in place
5. Commence Continuity of Carer Pilot.
6. Recruited transformation champions (front line staff with protected hours for LMS activities).
7. Completed implementation of projects funded through additional £150k non recurrent funding.
8. Implementation of AMU pilot (bringing it closer to consultant unit)
9. Deliver implementation plan for Specialist Per

Interventions and process change milestones

- Develop system governance and LMS programme
- Develop Maternity Voices and co-production of transformation planning
- Develop Digital enablement for Maternity Services
- Develop and implement workforce plans
-

Risks to delivery

The target of 20% women on a continuity of carer pathway by March 2019 is not met.

Effect of existing instability in maternity services on staff morale hinders continuity of carer pilot and roll out. (Publicity, change exhaustion and poor estate and working environments)

Capacity of front line staff to absorb additional activity generated by achieving safe CofC ratios.

Capacity of Senior management team to lead and deliver changes required to implement continuity of carer pathway.

Data

What performance metrics are used?

Local Maternity System

Exec Lead – Chris Morris Programme Lead – Fiona Ellis

NHS England NHS Improvement

Maternity Core Deliverables Overall RAG

X097	X098	X099	X100	X101	MTP1	MTP2	MTP3	MTP4	MTP5	MTP6
On Track	On Track	On Track	At Risk	On Track	On Track	On Track	On Track	On Track	On Track	On Track

Milestones

Ref	Critical Milestones (Rolling)	Due Date	Current Assessment
1	Safety - LMS Trust level representative engaged with and actively participating in safety collaborative	30/08/18	On Track
2	Continuity of Carer - Roll out plan (may include plan to pilot as req.) in place which factors in both workforce and financial implications	07/09/18	At Risk
3	Safety - Saving Babies Lives Care Bundle survey 9 results shared across LMSs	30/09/18	On Track
4	Continuity of Carer - Through MVP Engagement plan in place for ensuring local woman have voice in the development of the continuity of carer pathway	30/09/18	On Track
5	Continuity of Carer - Mechanism in place for being able to capture how women feel and think about their continuity of carer pathway	30/09/18	On Track

Key

Complete	**The Deliverable**	**or Milestone has been completed within specified timeframe**
On Track	**The Deliverable**	**or Milestone is currently on track to completed within specified timeframe**
At Risk	**The Deliverable**	**or Milestone is currently at risk of not being completed within specified timeframe**
Will not be met	**The Deliverable**	**or Milestone will currently not be completed within specified timeframe**

Local Maternity System

Exec Lead – Chris Morris Programme Lead – Fiona Ellis

NHS England NHS Improvement

Core Deliverables

No.	Ref	Type	Deliverable
1.	X097	Next Steps	Deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019.
2.	X098	Next Steps	Deliver full implementation of the Saving Babies Lives Care Bundle by 31 March 2019.
3.	X099	Next Steps	Deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan.
4.	X100	Next Steps	Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2019, 20% of women booking receive continuity.
5.	X101	Next Steps	Deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women are able to give birth in midwifery settings.
6.	MTP1	System Ask	All services are investigating and learning from incidents, and share this learning through their LMS and with others by March 2021
7.	MTP2	System ask	All services are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme by March 2021
8.	MTP3	System ask	All women are able to make choices about their maternity care, during pregnancy, birth and postnatally by March 2021
9.	MTP4	Oversight	The LMS is engaging with Operational Delivery Networks to deliver safe and sustainable models of neonatal care across England by March 2021
10.	MTP5	Oversight	The LMS has a credible plan for how its financial allocation (Transformation funding) will be spent, and is it on track to spend in year .
11.	MTP6	Oversight	The LMS has sufficient core staffing, and clear governance and reporting processes in place by March 2021

Mental Health

Executive Sponsor – Fran Beck | Programme Director – Steve Trenchard | Clinical Lead - Professor Tony Elliott | Programme Manager – Sara Edwards

Programme needs to:

1. Develop a five year integrated placed based all age **strategy for Mental Health** in line with the NHS long term plan.
2. Deliver the **implementation plan** for the Mental Health Forward View, ensure delivery of the mental health access and quality standards and ensure the baseline spend on mental health meets national requirements and realise targets for STW STP area.
3. Address STP MH Priorities, as outlined in the MH Priorities update report, to be progressed . Key priorities within this include:
   - **Mental & Physical Health**
   - Delivering a sustainable system-wide **IAPT service.**
   - Delivering against the **CYP LTP**
   - Delivering against the **Suicide Prevention Strategy**
4. Ensure there is wider stakeholder engagement in setting the priorities for transforming MH services across STW.
5. Provide system leadership to ensure mental health has parity of esteem with physical health services.

System Partners / Enablers need to:

1. Work across all systems to consider mental health needs of individuals.
2. Ensure services are trauma informed and trauma aware .
3. Focus on prevention and early intervention.
4. Demonstrate the application of a shared understanding of reasonable adjustments for individuals with mental health or learning disabilities issues.
5. Improve provision and support for out of area Looked After Children.
6. Support the delivery of the BeeU service action plan to enhance understanding amongst other agencies of role of BeeU service.
7. Have provision of both acute and PICU MH beds locally to avoid spot purchasing out of area based on competitive tariffs.
8. Work together to ensure mental health is integrated at place, in line with system wide transformation programmes.

The progress:

1. Extra Funding has been extended to current Provider to enable increase of Mental Health patients receiving employment support (IPS) under 5YFV (Wave 1).
2. Wave 2 bid submitted in Dec 2019 to support roll out of model in T&W.
3. Scoping underway to reduce PICU bed use out of area and improve quality.
4. Delivery issues in BeeU being addressed via a Remedial Action Plan with clear milestones and objectives. T&F Group in place to monitor progress.
5. Dementia diagnosis rate for T&W has for the last two months improved to meet the national benchmark of 66.7%.
6. CCGs meeting entry, recovery and waiting times targets for Access to Psychological services, but Shropshire will not meet full year 19% target.
7. **STP MH Strategic Group** has formulated it's ToR. Joint Chairing of the Group by STP MH Clinical Lead and STP MH Programme Director. Priorities agreed.
8. **A joint strategic needs assessment** undertaken to Identify service priority areas against 5YFV Plan. Presented to the STP Clinical Strategy Group. To form basis of the STP MH Strategy.
9. ***MH Workforce Plan*** *for STW is under development and is mostly complete for MPFT. STP wide workforce delivery plan response being worked up with next steps to align service delivery, workforce and financial plans and ensure it encompasses all MH workforce across all sectors.*

Key Interventions / Milestones

- Contractual talks pencilled for next two months with aim to increase IAPT access and introduce outcomes into contract.
- CYP LTP published and being refreshed quarterly which includes BeeU recovery action plan.
- *Programme plan to be produced for delivery of associated workforce transformation projects against* ***£100k STP/LWAB MH funding.***
- *Costings against workforce expansion being developed for completion of* ***Workforce Delivery Plan*** *with submission to HEE by end of 2018 .*
- Benchmark and scope likelihood of having local PICU beds to reduce OOA placements.

Risks to delivery

Risks

1. Issues related to the BeeU service being kept under close scrutiny through contractual and assurance routes. Progress being made but work to be done to understand numbers of children in primary care that might be on medication to assure shared care arrangements in place.
2. NHSE requirement that IAPT interventions be clustered and each treatment be tariff based will likely push contract prices up based on national reference costs which means there is a financial risk to the CCG to meet the required IAPT access targets mandated under the Five Year Forward View.
3. Drain on financial resources due to spot purchasing of beds for female PICU.
4. Gaps in provision, adult ASD (no LD), some patients might not receive required support.
5. Required workforce growth will not be achieved if there is no additional financial investment from CCGs/NHSE.

Data

- Mental health MDS (MHMDS) - difficult to manipulate .
- Data quality issues affect confidence in numbers and associated performance management functions.
- IaPTUS- IAPT service only.
- *STP Mental Health Workforce Plan - national figures translated into STP figures indicate that we need to grow the workforce by 160 WTE by 2020/21 to meet the agreed MH targets including IAPT, EI Psychosis, crisis intervention, hospital liaison and CYP workforce- from 2016 baseline. As at Nov 18 MPFT has seen an increase of 48 WTE- so a further 111.5 WTE required- new perinatal MH service will bring on board a further 7 WTE*

Updated Jan 2019

Elective Care Transformation Programme

This Programme of work consists of the following workstreams:

- Workstream 1 – PLCV Policies
- Workstream 2 – MSK
- Workstream 3 – Ophthalmology
- Workstream 4 – Diabetes
- Workstream 5 – Outpatients
- Workstream 6 – MRI
- Workstream 7 – Neurology
- Workstream 8 - Dermatology

All workstreams are currently in draft and are being worked up as part of the Elective Care Transformation Programme

1. Procedures of Limited Value

Exec Lead – Julie Davies Programme Lead Project Lead –

Programme needs to:

The programme is clearly setting out procedures determined to be of limited clinical value and each CCGs policy in relation to these interventions. The programme intends to manage unnecessary demand on acute hospitals and ensure unnecessary procedures are not carried out on patients.

System Partners / Enablers need to:

1. Ensure they adhere to the CCGs policies (Values Based Commissioning for SCCG / Excluded and Restricted Interventions Policy for TWCCG)
2. Implement any changes to the policies quickly and efficiently

The progress:

- VBC policy in place for SCCG and ERIP in place for TWCCG
- Prior approval process implemented for VBC and ERIP
- Quarterly review of VBC completed
- CSU completed review of ERIP for TWCCG
- Task and finish group completed review of recommendations for ERIP and identified that further clinical input is required

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- Clinical leads to discuss recommendations for ERIP in October
- VBC policy to CCC for approval in October
- Proposal for changes to ERIP in November
- Publish changes to VBC in xxx
- Publish changes to ERIP in January

Expected Benefits

- Improved control over procedures carried out on patients
- Patients not subjected to clinically inappropriate procedures
- Greater financial control for CCGs
- Improved utilisation of finite resources

Risks to delivery

Top 5 Risks

1. Providers do not follow the policies for the CCGs
2.
3.
4.
5.

Mitigating Actions:

1. Engage with providers to implement the policies

Data

- Number and cost of identified procedures carried out
- Number and cost of identified procedures rejected

2. MSK

Exec Lead – Julie Davies Clinical Lead - Programme Lead –

Programme needs to:

The programme is implementing the high impact interventions within MSK in the short term and exploring new models of care across the STP footprint in the long term.

(High impact interventions for MSK are triage for all routine referrals and implementation of a First Contact Practitioner pilot site)

System Partners / Enablers need to:

- Support implementation of VBC and ERIP in relation to MSK conditions across the pathways
- Ensure full utilisation of MSK triage for all routine MSK referrals
- Agree implementation of a pilot FCP service using existing resource
- Support development of new models of care for MSK
- Provide information to feed into the new models of care work
- Provide resource to deliver the project
- Potential pump prime funding may be required to gain the appropriate transformation of services required

The progress:

- Community MSK in place for TWCCG since 2015
- MSK triage in place for TWCCG since 2015
- MSK triage implemented in line with project plan for SCCG
- Prior approval for VBC and ERIP implemented
- MSK physiotherapy specification developed and implementation commenced for SCCG
- Self-management project commenced in SCCG
- FCP pilot site identified and agreed
- FCP pilot site planning undertaken
- Review of community MSK service in TWCCG in progress

Key Interventions / Milestones

- All SOOS staff in place by October
- Final community MSK report for TWCCG by November
- FCP pilot implementation to commence by first week in November
- FCP evaluation by March 2019
- Task and finish group established for new models of care during Q4

Expected Benefits

- Reduced demand on secondary care
- Reduced demand on primary care
- Alternative community based solutions
- Financial benefits for the CCG
- Improved access for patients

Risks to delivery

Risks

1. Availability of resource to complete required work
2. Differing models across the footprint
3. Lack of engagement from partners
4. High impact interventions do not deliver savings
5. Unmet need uses FCP slots resulting in no improvements and creating cost pressures

Data

- **TBC**

3. Ophthalmology

Exec Lead – Julie Davies Programme Lead Clinical Lead – Claire Roberts

Programme needs to:

The programme is implementing the High Impact Interventions for ophthalmology and improving pathways to eye care services.

The High impact interventions are:

1. Secondary care providers to develop failsafe prioritisation processes and policies
2. Secondary care providers to undertake a clinical risk audit of patients
3. Complete eye health capacity reviews to understand demand

System Partners / Enablers need to:

- Complete the High Impact Interventions assigned to them
- Share the output of the work in relation to High Impact Interventions with partners
- Work together to develop alternative pathways through the Local Eye Health Steering Group

The progress:

- Secondary care providers have developed failsafe prioritisation process and policies (are we sure?)
- Secondary care providers have undertaken a clinical risk audit of patients
- Procurement of optometry scheme provider commenced to deadline
- Tenders received and evaluation taking place

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- Award of new optometry scheme contract by January
- Review of corneal pathway
- Explore feasibility of virtual clinics
- Optometry provider service mobilisation by April 2019

Expected Benefits

- A sustainable model of care for our population
- Plans in place to provide required capacity
- Patient pathways that provide more out of hospital care
- Reduction in acute attendances
- Improved quality of care

Risks to delivery

Risks

1. Capacity to meet demand cannot be sourced
2. No bidders meet the required standard for the optometry scheme contract
3. Acute workforce continues to be fragile

Mitigating Actions:

Data

TBC

Diabetes

Updated October 2018 Next Update Dec 2018

Exec Lead – Julie Davies Clinical Lead –Dr Pepper Programme Lead Bethan Emerton

Programme needs to:

- Develop a system Diabetes Joint Strategic Needs Assessment
  - Highlight key areas for development including footcare, structured education, and treatment targets
- Develop a system diabetes prevention and management programme that aims to reduce the number of diabetics in Shropshire/ T&W and reduce the harm caused by the disease through improved disease management and coordinated service delivery. The programme should have at a minimum three areas of focus:
- 1) life course approach to prevention – including the wider determinants of health (education, work, environment)
- 2) Primary Care and community service offer
- 3) hospital pathway and service offer

System Partners / Enablers need to:

1. Prevention - Work with partners to deliver primary, secondary and tertiary prevention programmes including Social Prescribing, NDPP, and patient education
2. Communication – work with partners to deliver population health messages through a wide variety of media, including front line staff, MECC Plus & motivational interviewing
2. Workforce/ Training - upskilling the workforce to understand diabetes and improve clinical practice, medicines management as well as advice and guidance for patients
3. Connect to the Primary Care Framework to develop:
   - Primary Care programme to ensure patients are receiving NICE treatment targets (blood pressure, HBA1C, Cholesterol)
   - Developing individualised care to ensure that patients mental health and other co-morbidities are supported in a holistic way
4. Conduct demand and capacity review of Diabetes footcare services across the STP to identify gaps in commissioning and potential opportunities for improvements and innovations
5. Develop triage pathway to ensure that as many people as possible are supported in the community rather than secondary care
   - Connect to Neighbourhood, Care Closer to home transformation programmes
6. Ensuring quality in secondary care setting, and links back to community care and support

The progress:

- Development of a Shropshire/ T&W Diabetes Network
- Delivery NDPP across Shropshire and T&W
- Development of Social Prescribing and deliver of Healthy Lives/ Healthy Telford
- Development of MECC Plus Tier 1 and 2 training package, delivery started
- Development and implementation of Bradford Healthy Hearts model in T&W
- Prevention and Primary Care meeting – January 19 to determine key developments for the system

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- Implement NDPP
- Communication
- System Diabetes JSNA
- Connecting to and implementation of the Primary Care Framework
- Workforce Training

Expected Benefits

Patients / service users

- Reduced number of people progressing from pre-diabetes to diabetes
- Reduced prevalence of CVD, Obesity
- Increased number of patients achieving all three treatment targets across the STP. This will be measured using the national diabetes audit data.
- Increase number of patient attending a structured education course across the STP. This will be measured using the national diabetes audit data.
- A plan to improve footcare services across the STP in order to improve patient's care and reduce amputation rates.
- Reduce number of unnecessary referrals to secondary care.
- Improved knowledge and expertise of staff
- Coordinated delivery resulting in reduced cost to the system

Risks to delivery

Top 5 Risks 1. Capacity within the system to develop and deliver programme
2.Ability to connect the transformation programmes sufficiently to develop the system offer
3.
4.
5.

Mitigating Actions:

1. support from the STP
2. Connecting practice and supporting adoption of best practice from across the system
3. Following NICE Guidance

Data

Right Care Data
JSNA - will demonstrate key areas for improvement, delivery and monitoring

use data to describe progress
If no data available, describe what will be used to measure benefits

5. Outpatients Redesign

Exec Lead – Programme Lead Project Lead –

Programme needs to:

The programme is looking to reduce demand for outpatient appointments, both first and follow up, in secondary care and looking to develop alternatives to traditional outpatient appointments.

System Partners / Enablers need to:

- Engage in outpatients task and finish group
- Identify improved ways of working
- Implement changes agreed as part of the task and finish group

The progress:

- Analysis of outpatients activity completed
- Task and finish group set up
- Initial focus of group agreed to be Cardiology and Paediatric Ophthalmology due to opportunities identified in these areas
- Gastro workbook released by NHSE
- Gastro group set up to look at potential for improvements in this area

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- Deep dive into cardiology during October
- Deep dive into paediatric ophthalmology during November
- Implement identified quick wins during December and January
- Review new consultant to consultant policy (when received) and identify changes to local policy
- Explore use of apps and Telehealth by January

Expected Benefits

- Reduction in outpatient activity at SaTH
- Reduction in consultant led outpatient activity in SaTH
- More care delivered out of hospital
- Reduction in demand for outpatient appointments
- Reduction in avoidable attendance at outpatient appointments
- Improved use of finite resources
- Improved use of skill mix for delivering outpatient activity
- Opportunities for innovation and alternative delivery
- Financial benefits for partners

Risks to delivery

Risks

1.Partners don't engage in task and finish groups
2. Partners don't implement changes agreed
3. Released resource is filled with other patients so RTT improves for SaTH but savings are not made

Mitigating Actions:

Senior buy-in and support from partners

Data

TBC

6. MRI

Exec Lead – Programme Lead Project Lead –

NHS England NHS Improvement

Programme needs to:

- Describe what the programme is setting out to do

System Partners / Enablers need to:

1. What's needed from STP System partners to make this programme a success
2. What do system enablers need to consider,
   - Finance
   - Comms
   - Workforce
   - estates

The progress:

- Insert bullet points to describe what's been achieved so far

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

You add additional milestone boxes if useful or delete if not needed

Expected Benefits

Patients / service users

Staff

Oragnisational

Financial

Risks to delivery

Top 5 Risks

1.
2.
3.
4.
5.

Mitigating Actions:

Describe the risks and mitigating actions

Data

Use data to describe progress
If no data available, describe what will be used to measure benefits

7. Neurology Redesign

Exec Lead – Programme Lead Project Lead –

Programme needs to:

The programme is looking to develop a sustainable neurology service across the STP footprint.

System Partners / Enablers need to:

1. Support the CCGs in the development of a sustainable model
2. Engage in any required groups
3. Provide information as required
4. Work with any new providers moving onto the patch as part of the new models of care

The progress:

- Met with neighbouring CCGs to explore the option of joining forces
- Published Prior Information Notice (PIN) to test the market
- Held market engagement event
- Virtual meeting with neighbouring trust to begin discussions in relation to the support available

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- Virtual meeting with further neighbouring trust in October
- Virtual meetings with potential providers to gauge interest in November
- Procurement decision made (go out or work with individual provider or group of providers)
- Further actions to be determined
-

Expected Benefits

- Sustainable neurology service
- Neurology service delivered in county
- Improved use of skill mix for delivering outpatient activity

Risks to delivery

Risks

1. No provider is able to deliver a sustainable service
2. Providers are not able to deliver services in county
3. Increased cost as specialist service with no national tariff

Mitigating Actions:

Data

Use data to describe progress
If no data available, describe what will be used to measure benefits

8. Dermatology

Exec Lead – Programme Lead Project Lead –

Programme needs to:

The programme is to procure a community dermatology service across the STP footprint

System Partners / Enablers need to:

Partners to work with any new service provider

The progress:

- Task and finish group established
- Workshop held to map processes
- Service specification developed
- Finance and activity modelling completed

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- ITT published in October
- Evaluation completed in November and December
- Contract award by February 2019
- Service implemented by April 2019

Expected Benefits

- Support for the fragile acute service
- Sustainable dermatology services across the STP footprint
- Increased care closer to home
- Improved use of skill mix for delivering outpatient activity
- Improved likelihood of bidders due to increased activity levels

Risks to delivery

Risks

1. No bids are received for the service
2. Bidders set prices higher than current provision creating a cost pressure
3. Short implementation time impacts on ability of provider to mobilise

Mitigating Actions:

Data

Use data to describe progress
If no data available, describe what will be used to measure benefits

Acute Reconfiguration - Future Fit

Executive Lead – Debbie Vogler Programme Manager – Andrea Webster

NHS England NHS Improvement

Programme needs to:

- Ensure delivery of the required Decision Making Business Case
- Evidence conscientious consideration in relation to process
- Prepare and deliver a structured and agreed timeline and process of drafting, submission and approval of the DMBC
- Work with all key stakeholders to ensure DMBC accurately reflects all identified priorities, interdependencies, NHSE/NHSI approvals and engagement as well as taking into consideration the Participate Report to identify recommendations and any mitigations

System Partners / Enablers need to:

- Support the effective delivery of the Decision Making Business Case with relevant clinical and managerial support to key events
- Contribute to the development of the DMBC
- Provide required expertise to confirm and challenge assumptions and mitigations from Participate Report, consultation themes feedbacks, IIA Priorities and other relevant interdependencies
- Ensure alignment and engagement with NHSE/NHSI , Specialised Commissioning approvals process as required
- The OOH and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

The progress:

- The next phase of the Future Fit Programme is the development of the Decision Making Business Case. (DMBC)
- Joint Committee Terms of Reference has been prepared and submitted to the FF Programme Board on 24th October.
- An initial timeline has been developed in conjunction with SaTH and the FF Programme Team to outine development from SOC through to FBC and implementation
- Receipt of Participate Consultation Report will commence a high level implementation timeline for the drafting, approval and submission of the DMBC
- Support from tcI and NHSE continues to support the Programme

Key Interventions / Milestones

- Formal Public consultation ends 11th September 2018
- Analysis of surveys and feedback from the Consultation process collated into a Report by Participate Ltd by 9th November
- To Draft, develop and obtain fof the DMBC in line with agreed timescales and approval process
- Submit Final DMBC with recommendations submitted
- Joint Committee make recommendation

Risks to delivery

Risks

- FF Team capacity and resource needs to be maintained to support delivery of the DMBC
- High level timeline will require significant engagement and approvals process within a short timescale to meet proposed DMBC development and submission
- Telford and Wrekin local council elections could impact on timeline if PURDAH is actioned

Data

Urgent and Emergency Care

System Improvements

Plan on a Page

Mixed formats of plan on a page to reduce duplication

Urgent & Emergency Care – Transformation Programme

Implementation of UEC High Impact Changes

- Demand & Capacity Review
- Stranded Patients
- ED Systems & Processes
- Red2Green / SAFER
- Integrated Discharge Team
- IV Therapies in the Community
- Frailty
  - Frailty Team at ED front door
  - Reduce admissions / readmissions from care homes
  - Trusted Assessors

- Further details around the Urgent & Emergency Care work programme are available by contacting maggie.durrant@nhs.net

Urgent & Emergency Care – Transformation Programme

Key Messages – January 2019

- UEC (Draft) Governance Structure produced with ECIST support

- Improved Reporting with a new Winter Metrics Dashboard
    - Includes a wider set of metrics and includes daily and weekly monitoring of key outputs

- UEC Priority Action Plan (draft) produced with ECIST support; relates to SaTH led work-streams.
    - This collates action plans previously held separately
    - This will be utilised as the base from which a System-wide UEC Improvement Action Plan will be developed.

- Terms of Reference drafted, currently in consultation, for a new UEC Working Group

- Terms of Reference produced for a refreshed approach to conveyancing through an Ambulance Demand & Pathways Working Group, to be chaired by SCCG Head of In Hospital

- Refreshed Terms of Reference produced for SaTH High Impact Change Task and Finish Groups
    - Urgent Care Operational Group
    - Stranded Patients
    - Standard Work
    - Space Utilisation and Improved Flow
    - Site Management and Internal Escalation
    - ED Systems and Processes

A&E Delivery Board

DRAFT

Executive Team Meeting
Chair: Chief Executive (SW)

Urgent Care Operational Group
Chair: Chief Operating Officer (NL)

A&E Delivery Group
Chair: Urgent Care Director (CO)

- **Site management and internal escalation** Chair: Sara Biffen
  - **Escalation and Full Capacity T & F Group** Lead: Sara Biffen
- **Space utilisation and improved flow** Chair: Sara Biffen
  - Bed modelling / improved flow T & F Groups Lead: Sara Biffen
- **ED Systems and Processes HIC** Chair: Nigel Lee
  - **ED Value Stream** Lead: Sara Biffen
  - **ED systems and processes Incl. streaming, breaches, alternative pathways** Lead: Carol McInnes
  - **ED Workforce T & F Group** Lead: Victoria Rankin
- **Standard Work / SAFER/R2G HIC** Chair: Carol McInnes
  - **Standard work Value Stream** Lead: Gemma McIver
  - **Weekend / 7 day working acute T & F Group** Lead: Karen Barnett
- **Stranded Patients / Reducing LLOS** Chair: Edwin Borman
  - **Stranded patients project group** Lead: Gemma McIver
- **Whole system escalation** Chair: Claire Old
- **Frailty HIC** Chair: Fran Beck
- **Integrated Discharge HIC** Chair: Tanya Miles
  - **Complex Discharge RPIW T & F Group** Lead: Local Authorities
  - **Weekend / 7 day working whole system T & F Group** Lead: Claire Old
- **Demand and Capacity HIC** Chair: Julie Davies

Named Improvement and Informatics support to each stream

Finance, HR, Communications

Winter Plan Metrics – Dashboard V7 - EXAMPLE

A dashboard with the key metrics agreed by the LHSE to monitor winter performance is now produced and circulated weekly. The cells are populated with the latest available data provided to the CCG – some is daily, some weekly and some monthly. Previously reported historic performance data for each metric is available on the actual spreadsheet in the relevant subsequent tab.

NB: This is **UNVALIDATED** management information – and is for **illustration purposes of this reporting facility ONLY.**

ACUTE DEMAND METRICS	Plan	Latest actual	Var	Variance to Plan (%)
Ambulance Conveyance				
SaTH	88	137	49	55.68%
Walk-in Demand				
SaTH	265	282	17	6.42%
Direct GP Admission Referrals				
PRH	0	2	2	
RSH	0	3	3	
Admissions (exc Direct GP Admissions not through ED)				
SaTH	107	113	6	

COMMUNITY CAPACITY METRICS	Plan	Latest actual	Variance	% Bed Occupancy	Ave LOS
SATH2HOME capacity utilisation					
PRH					
RSH					
Community beds					
P2 - SCHT	97	99	2		13.0
P2 - RJAH	15	15	0		25.3
P2 - Independent Sector - SCCG	17	17	0		
P2 - Independent Sector - T&W CCG	12	12	0		
P3 - Independent Sector - Shrop LA	27	27	0		
P3 - Independent Sector - T&W LA	7	7	0		
Spot purchase - Shrop LA	35				
Spot purchase - T&W LA					
MIU Capacity					
Community Uptake	145.5	0	-145.5		
Community IV slots					
Community IV Slots	6	0	-6		

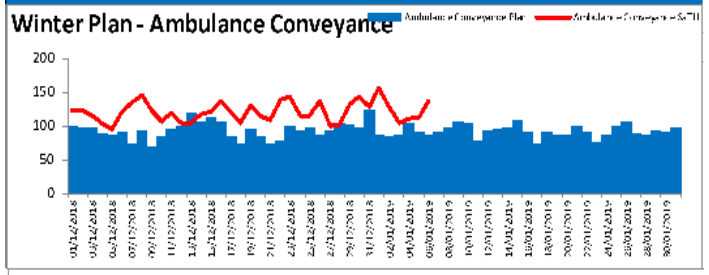
ACUTE INTERNAL FLOW METRICS	Plan	Latest actual	Var	Weekly Var
Number of Patients Streamed				
SaTH	69	99	30	176
% non admitted breaches				
PRH	90%	79.3%	-10.7%	
RSH	90%	80.8%	-9.2%	
% admitted breaches				
PRH	90%	38.9%	-51.1%	
RSH	90%	27.2%	-62.8%	
Minor Performance				
SaTH	95%	93.3%	-1.7%	
No. of stranded patients				
PRH	117	102	-15	
RSH	133	129	-4	
No. of super stranded patients				
PRH	23	36	13	
RSH	27	27	0	
Escalation beds open				
SaTH	30	39	9	

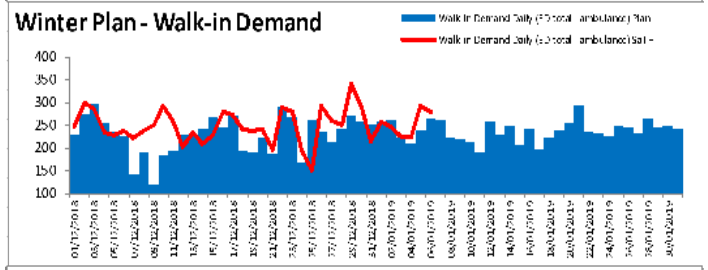
ACUTE DISCHARGE METRICS	Plan	Latest actual	Var	Weekly Var
No. of simple discharges				
PRH	19	28	9	19
RSH	29	34	5	4
No. of complex discharges				
PRH	1	0	-1	-5
RSH	2	2	0	-28
Shropshire CCG	1	1	0	-13
Telford CCG	1	1	0	-17
Powys	1	0	-1	-4
% discharges before midday		Absolute No.		Var to Plan
PRH	25%	8	28.6%	3.6%
RSH	25%	7	19.4%	-5.6%
No. of patients on the MFFD				
Shropshire	42	35	-7	
T&W	22	13	-9	
Powys	9	7	-2	
No. of FFAs received				
P1 & P3 Shropshire LA	64	20	-44	
P2 SPR Shropcom - Shropshire LA	19			
P1, P2 & P3 T&W LA	31	15	-16	
P1, P2 & P3 Powys LA	15			
% of P1 discharges within 48hrs of FFA receipt				
Shropshire LA	90%	45.5%	-44.5%	
T&W LA	90%	66.7%	-23.3%	
Powys	90%		-90.0%	

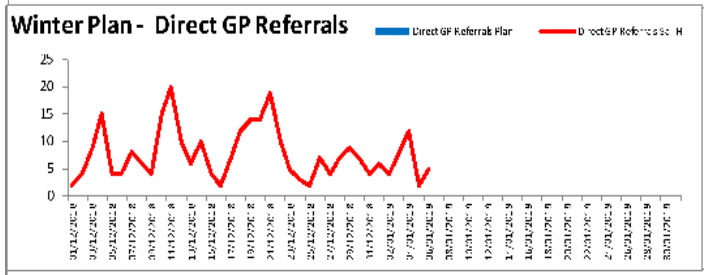
Winter Plan Metrics – Dashboard V7 EXAMPLE

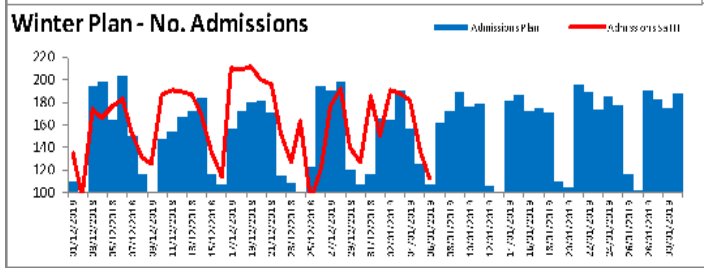
illustration purposes of this reporting facility ONLY.

ACUTE DEMAND METRICS

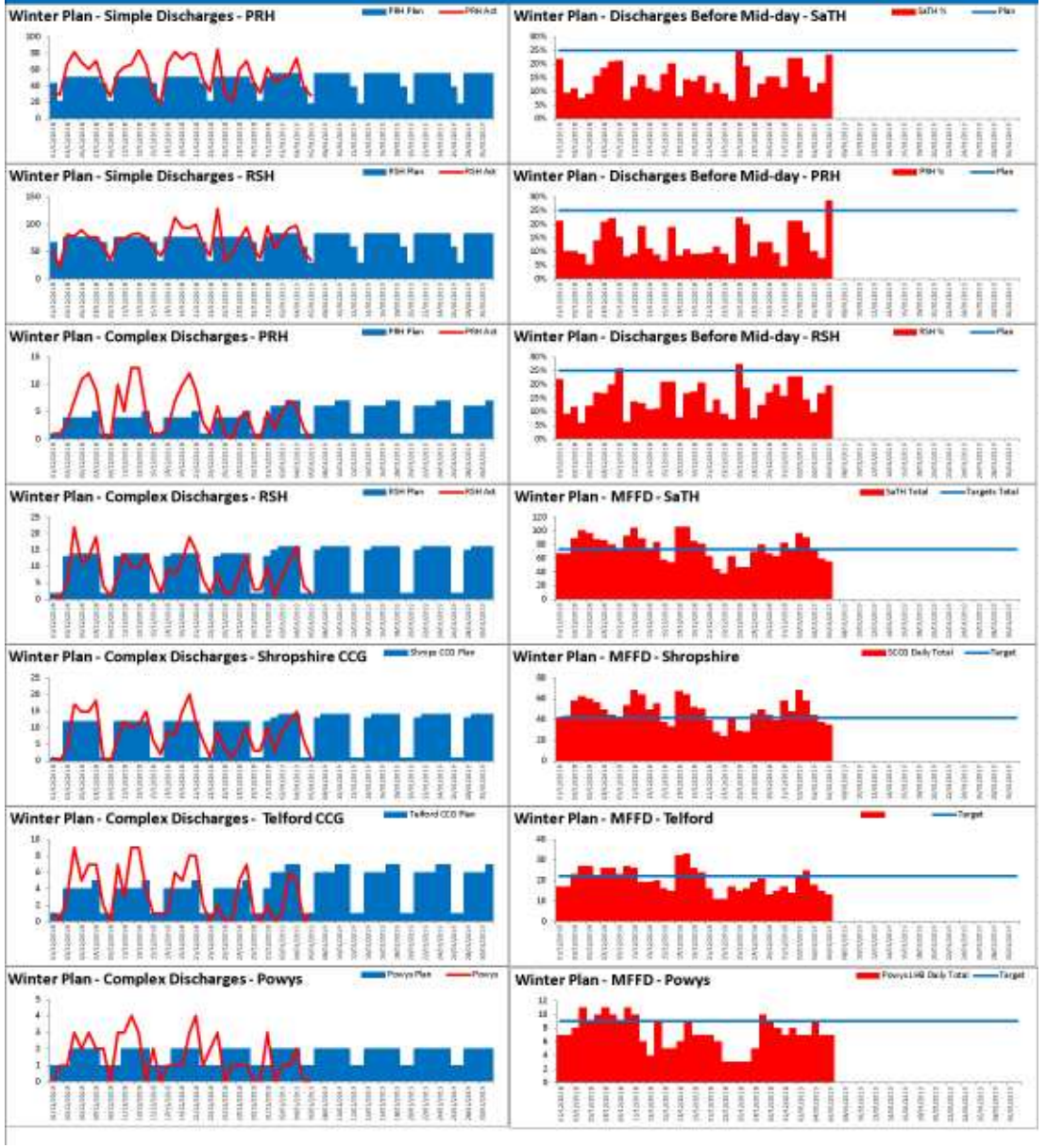




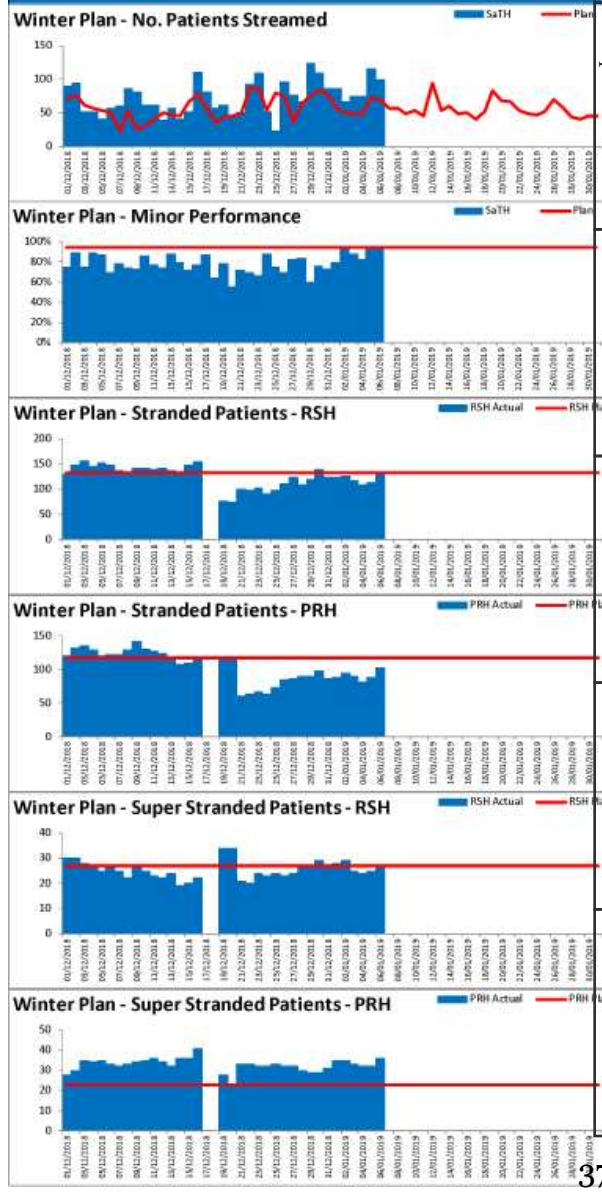




ACUTE DISCHARGE METRICS



ACUTE INTERNAL FLOW METRICS



Summary Report on Stranded Patients

Launched in December 2017 base line stranded number was 350 & Super Stranded Base line was 91
Reached 250 Stranded and 50 Super Stranded by July 2017 with further work continuing to sustain and build on the improvement further
The 3 main projects aligned to that have enabled the 'phase 1' step change have been:

1) Launch of Frailty Intervention Team (operating in A&E, CDU and AMU)
2) Daily Check Chase Challenge (both sites)
3) Case Management of all Super Stranded patients

Phase 2 launched in July 2018 and reaching 200 consistently and sustaining the improvement is the next key milestone within the Stranded Programme and the following schemes have been incorporated into the 'stranded project plan' to drive a further reduction

- Criteria Led Discharge
- Realignment of Discharge hubs and capacity to support Super Stranded and further culture shift
- 7 day services (therapies)
- PSAG work list to embed discharge planning into board rounds
- Value Stream – Standard Work (roll out of improvements)
- Pre 10 and pre 12 drive
- SaTH2Home (target those at 5-6 days)
- IV community Antibiotic pathways
- Flexing of community hospital criteria to support acute stranded reduction

Summary Report on Stranded Patients

Urgent Care Programme Board

The Shrewsbury and Telford Hospital NHS Trust

3A. Project Summary

Project Overview				Overall Project Status
Project Title:	Stranded Patient Reduction Project	Deadline:	On-going	Amber
Exec Lead:	Edwin Borman	Project Lead:	Gemma McIver	
Clinical Lead:	Gary Caton/ Kath Preece	Project Group:	Improving Patient Flow	
Date of Report:	16/01/2019	% improvement in admitted performance target 4%		

Progress, Issues/Risks, and Decisions Key Items completed this week/since the last report

Current Position

- Performance for Monday 14th January – 286 (58 Super Stranded), 36 above internal target however as demonstrated below, the significant step change in performance has been maintained so far
- Prior to Christmas resource was aligned from the care group to 'ramp' up the focus specifically at PRH and maintain the progress made to date at RSH to support the reduction of stranded patients which is starting to have an impact
- Super Stranded Patients performance (patients at 21 days and over) has improved significantly from this time last year. Currently delivering a reduction of 32% against a nationally agreed target of 21%
- NHSI have reported that SaTH are the third most improved Trust in the Country for stranded patient performance (baseline position taken 2017). SaTH have demonstrated consistent improvement for 8 consecutive months
- Overall average LOS at SaTH 2017 was 12 days. From August 2018, we are now consistently delivering an average LOS of 8-9 days

Key Issues/Risks

- Membership at the weekly stranded patient escalation meeting has declined both internally and externally – mitigation taken has been a 2019 re launch of the Stranded patient meeting. Non-attendance to be escalated to programme board as required
- Potential hidden delays in the system following the launch of SaTH2Home beds – mitigation taken has been to escalate these through the system conference calls
- Time taken to complete FFA's and ownership of task is an on going challenge particularly at PRH – as mitigation, actions to address this have been included in the new stranded patient project plan
- Therapy workforce fragility/ vacancies impacting on discharge planning and progression of patients across medicine wards – Discussed with Care Group Director and escalated to Executives December 2018

Summary Report on Stranded Patients

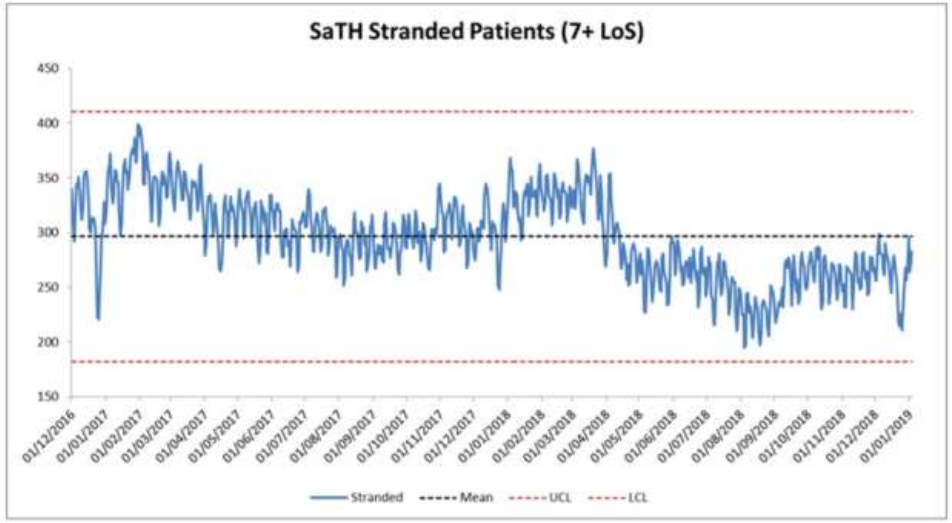
Urgent Care Programme Board

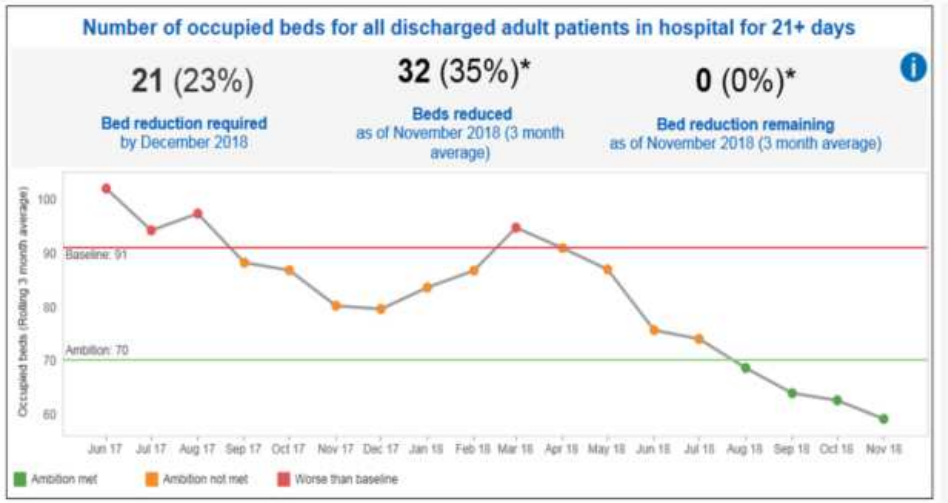
The Shrewsbury and Telford Hospital NHS Trust

Key Items for Next Week

- On-going support from SaTH2Home with additional bed based provision to prevent unnecessary delays
- Daily additional support to ward 15 and 16 to reduce super stranded numbers
- Social workers attendance at Check Chase Challenge
- Continue PDSA of Check Chase Challenge on the wards at PRH
- Ian Sturges visit planned 23rd January to support Criteria Led Discharge and Long Stay Wednesday (LSW) development and implementation
- Top performing Trust in the Country for improvement is The Wirral – SaTH have requested a contact to go and shadow see if we can adopt any of their practices
- Stranded patient project group to meet Fridays prior to the stranded patient escalation meeting – new project plan drafted to go through in the meeting
- Work with ECIST to explore correlation behind improved stranded patient numbers vs pre 12 discharge improvements

Performance





Unscheduled Care Standard Work Value Stream (SaTH)

3A. Project Summary

Project Overview				Overall Project Status
Project Title:	Unscheduled Care Standard Work Value Stream	**Deadline:**	Phase 2 - April 2019	Amber
Exec Lead:	Deirdre Fowler/ Cathy Smith	**Project Lead:**	Gemma McIver	
Clinical Lead:	Dr Perrot-Jones Gary Caton/ Kath Preece	**Project Group:**	Improving Patient Flow	
Date of Report:	16/01/2019	**% improvement in admitted performance target 4%**		

Progress, Issues/Risks, and Decisions Key Items completed this week/since the last report

Current Position

- At the start of the Standard Work Value Stream 42 Kaizen Bursts (areas of waste or improvement required) were identified - 22 Kaizen Burst's across USC wards have now been addressed with evidence of improvement and successful waste removal
- The key implementation target for the roll out of the respiratory value stream was to improve pre 12 discharges and reduce LOS by 2 days on every ward. Since the roll out (August) of the Standard work value stream in USC an overall 2.5 LOS reduction has now been achieved. Ward 15's increase in LOS is balanced against the reduction in ward 16 as the area are now starting to work as one unit. Ward 21's increase is aligned to currently limited therapy cover due to vacancies.

Decembers re-measures are as follows:

Metric (units of measurement)	Target	6	7	8	9	10	11	15	16	21	22r/27	24	27	28	32	Overall RSH	Overall PRH	Overall SATH USC
August (Base Line)	Reduction of 2 days	15	8		9	11	8	11	36	7	11	12		15	6	10	14	12
September		19	20		14	16	14	9	26	7	8	7		9	5	7	17	12
October		9	9	14	8	12	12	12	43	9	10	8	9	12	6	9	15	12
November		8	6	14	7	9	20	12	32	8	9	8	9	11	5	8	13	11
December		8	7	12	7	10	9	13	16	9	10	9	9	10	4	9	10	9.5

- Since the launch of the value stream, 9 USC wards have shown some improvement in pre 12 discharge (target is 30% transfer/ discharge by 12pm), PRH improvement is more than RSH and reasons for this may be the consistent use of discharge lounge and also that PRH have not made as much progress in the stranded patient metric - ECIST request has been made to support with understanding any correlation between Pre 12 and stranded metrics. Incentive for wards to reach 30% will be launched in February – Ward Managers and Matrons session held this month to reinforce the importance of this metric and Matrons to work with each area around improvement plans and trajectory this will be fed back through January re measures (Due January 28th).

Unscheduled Care Standard Work Value Stream (SaTH)

Metric (units of measurement)	Target	6	8	7	9	10	11	15	16	21	22r/27	24	28	32	27	Overall RSH	Overall PRH	Overall SATH USC
Quality % performance against number of discharges off the ward prior to 12pm																		
August (Base Line)	30%	24%		9%	12%	9%	14%	6%	19%	13%	8%	20%	18%	10%		13%	17%	15%
September		22%		27%	24%	31%	24%	13%	14.30%	19%	8%	21%	9.40%	6%		13%	22%	18%
October		22%	26%	18%	11%	20%	14%	8%	22%	21%	12%	13%	14%	12%	15%	15%	19%	17%
November		20%	22%	20%	13%	16%	16%	15%	0%	12%	10%	10%	10%	7%	10%	10%	15%	13%
December		14%	27%	18%	14%	14%	11%	15%	30%	8%	11%	10%	14%	10%	17%	12%	18%	15%

December re measures Standard work Improvement Area	Target	PRH	RSH	Overall USC	Improvement from Base Line (August)	Improvement from November	Detail
Site Safety AM huddle	100%	100%	100%	100%	↑	→	
Production boards	100% in all areas - Each area to score Level 1	100% 3 wards @ L1 5 wards @ L 2	100% 5 wards @ L 1 1wards @ L2	100% 8 wards @ L1 6 wards @ L2	↑	↑	• Work taking place with Matron of the day to use detail on production boards to feed into site safety and plan pre 12 discharges
People Link Board	100% each area L1	60% 6 wards L2	66% 4 wards L2	63% 8 wards L2 6 wards L3	↑	↑	• Pending TCI / Guiding group decision on reporting boards
Board Rounds Total amount of board rounds each week all MDT members are present	100%	64%	68.5%	66%	↓	↓	• Every board round does now have a medic present – decline in metric is due to therapy fragility • PSAG updated in flow has reduced following the nursing workforce challenges and having a designated coordinator daily
% time starts at 9am	100%	84%	84%	84%	↑	↑	
% PSAG updated in flow	100%	51%	68.5%	59.7%	↓	↓	
PM Huddles	100%	100%	100%	100%	↑	↑	Every huddle takes place following PDSA between 1- 3
Ward Rounds	Focus area for January -Wards 9, ward 21, ward 22re, ward 27 and ward 24 all have clinicians/ medics who are supporting the standard work ward rounds						
Kaizen	100% areas L4L and 5S roll out	100%	100%	100%	↑	↑	Every ward area now has a L4L and 5S project
Discharge Planning	Pending support to establish Criteria led discharge						
Patient discharge	Waiting complex discharge RPIW roll out						

Unscheduled Care Standard Work Value Stream (SaTH)

Key Issues/Risks

- In November pre 12 discharge lounge data was not accurately captured this was rectified for December however with the move and closure of the discharge lounge initially in January at RSH this problem re occurred this is being re addressed however again may impact on data quality for January
- Following observations on the discharge lounge at RSH when it is open batching is still occurring which means that patients are coded against the discharge lounge post 12 o clock even if they went earlier - giving an inaccurate picture of how much capacity has actually been created. Education with the staff nurses covering the area has been completed to support with data quality improvements and the matron is reiterating the importance of accurate data caption the use of bank and agency staff covering this area however is making the engagement and understanding of the importance around correct coding challenging
- Wards have fed back that PM huddles are driving pre 12 discharge however with the introduction of ward 27 and ward 8 those identified as definite discharges for the following day are often moved – Ward 27 are then unable to fulfil the plans for pre 12 due to limited pharmacy cover and a change in the coordinator/ turnover of the ward this impacts pre 12 performance
- A key metric for delivery in the standard work value stream is all MDT members present at board round this currently cannot be met due to the fragility/ vacancies in therapies pending a time table for when therapy can attend board rounds
- Commencement has taken place to roll out standard work ward rounds – this compliments/ reflects the SAFER model – variable engagement across both sites. Key clinical champions identified to support with promotion of the model and roll out

Items for Escalation

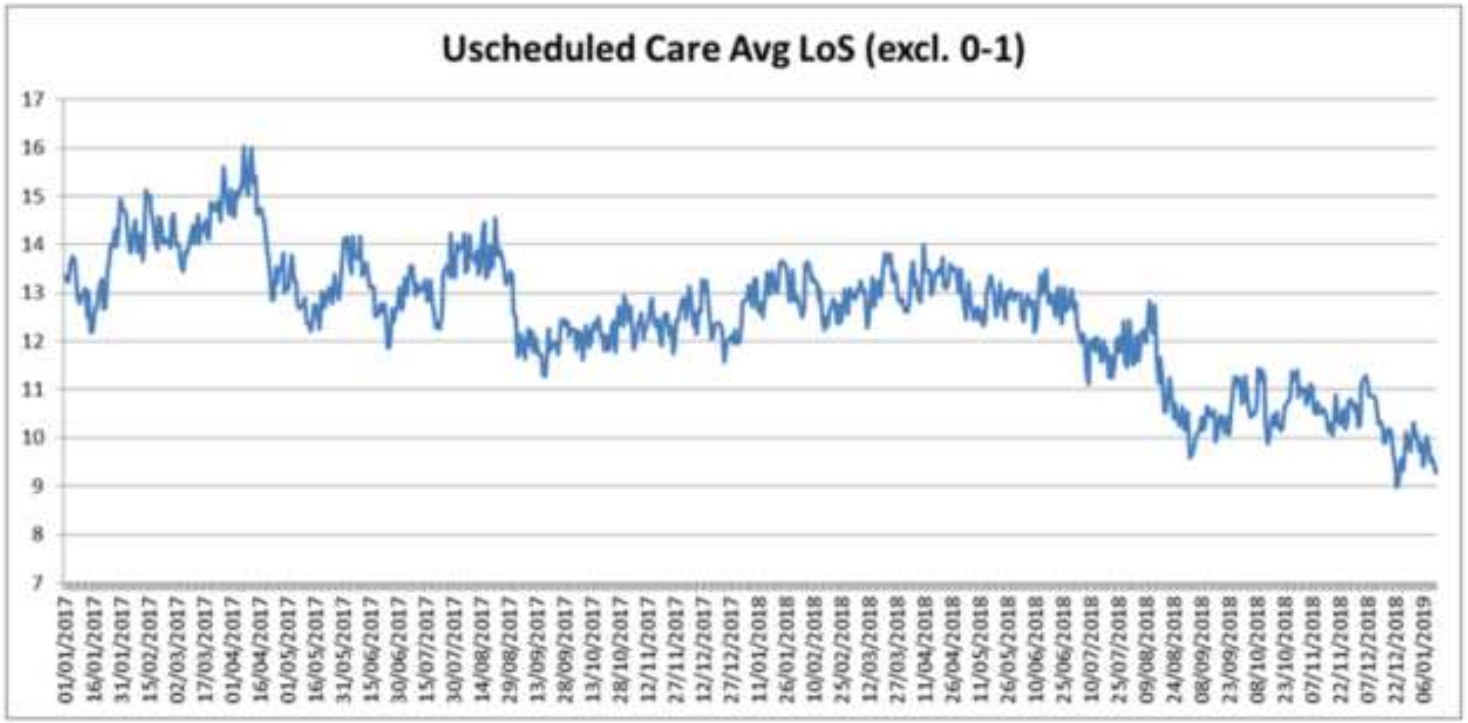
- MDT attendance at board rounds due to vacancies and workforce fragility – plan required to address

Key Items for Next Week

- Drive for people link boards – work commenced on a performance pack to help ward managers keep people link boards up to date
- Further work to standardise and improve the effectiveness of the PM huddle
- Launch an incentive/ competition to improve pre 12 discharge across all areas
- Measure the impact of standard work ward round roll out against the pre 12 metric
- Ward managers now taking re measures due 28th January
- Integration of Care Groups reports to be implemented now that we have agreement of value stream management going forward

Unscheduled Care Standard Work Value Stream (SaTH)

Performance – Length of Stay Metric



Red2Green/Safer

Improving Flow Steering Group

The Shrewsbury and Telford Hospital NHS Trust

3A. Project Summary

Project Overview				Overall Project Status
Project Title:	Objective 3 - Red 2 Green/SAFER	Deadline:		AMBER
Exec Lead:	Deidre Fowler	Project Lead:	Rachael Brown	
Clinical Lead:	To be agreed for each site	Project Group:	Improving patient flow	
Date of Report:	19th December 2018	% improvement in admitted performance target 4%		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Project / kaizen in place which incorporates SAFER principles under standard work. Task and finish group meeting fortnightly. First 2 sets of re-measures show improvements in some areas pm huddles, attendance at board rounds and nurse accompanying ward rounds. In the process of collecting next set of measures for October.
- Monthly data shows an increase in pre12pm discharges Trust wide, although still below trajectory. Current weekly performance shows a dip at 15% against a trajectory of 23%. This data set includes transfers to discharge lounge which are now open on both sites.
- Super - stranded patient reviews continue to take place on a weekly basis for both care groups across both sites. LOS threshold reduced to 18 days
- Red2Green function and clinical reasoning for changes to EDD live on psag. Developing tolerance reporting in line professional standards, to be in place by end of November
- Check, chase, challenge process in place across both sites for USC. Production board developed to provide visibility of daily metrics
- Long stay Wednesday format commenced w/c 19th November on both sites.

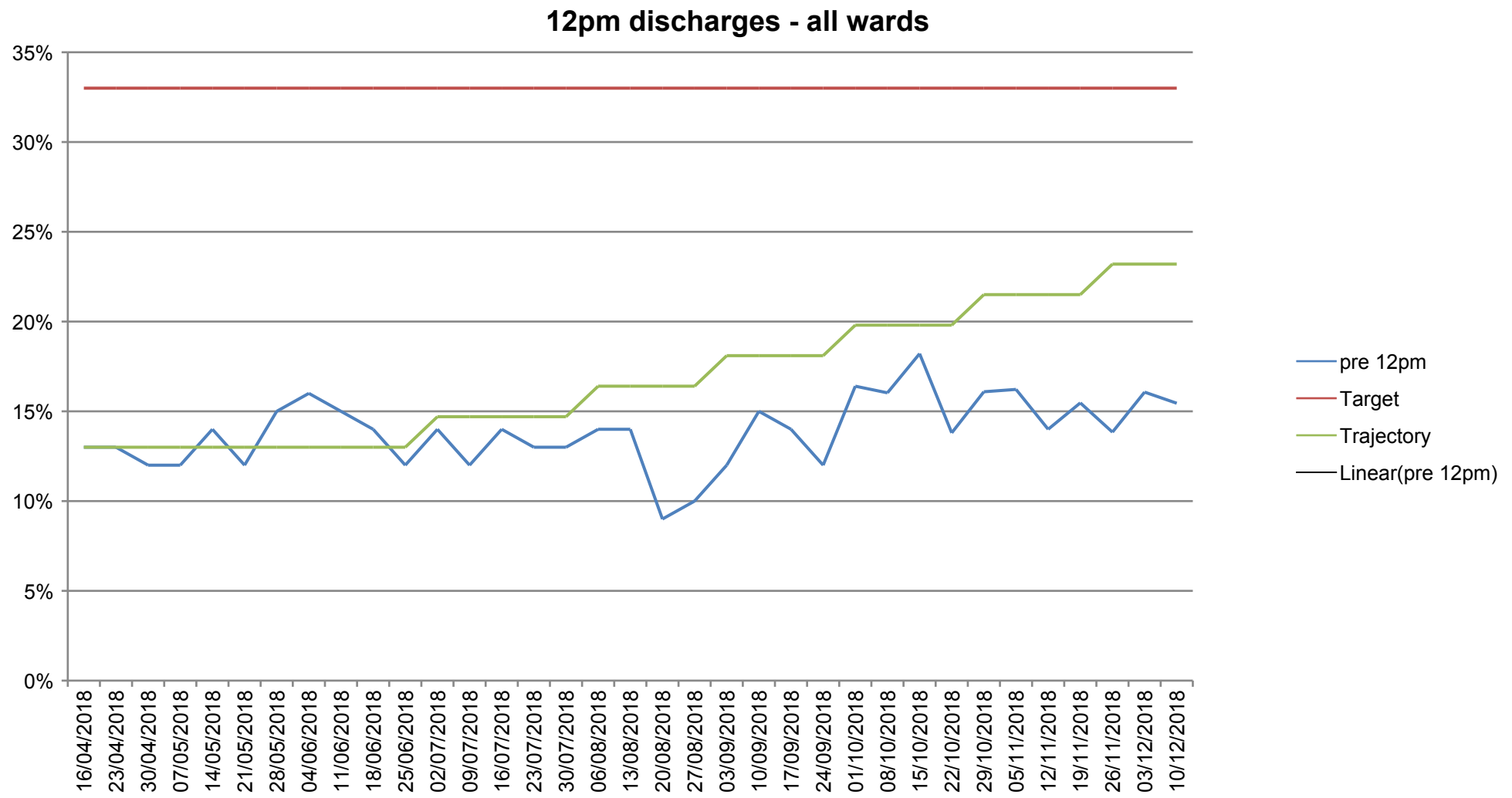
Key Issues/Risks

- Lack of Red2Green completion leading to insufficient and potentially misleading data on some wards. About half of all wards consistently submit data, although this does show an increase by changing from a paper format to psag.
- Pre-12 discharge performance still below trajectory
- Pace of change
- Medical engagement to work differently at ward rounds e.g. adopting the SORT model, and discharge summaries completed in a timely way to ensure morning flow

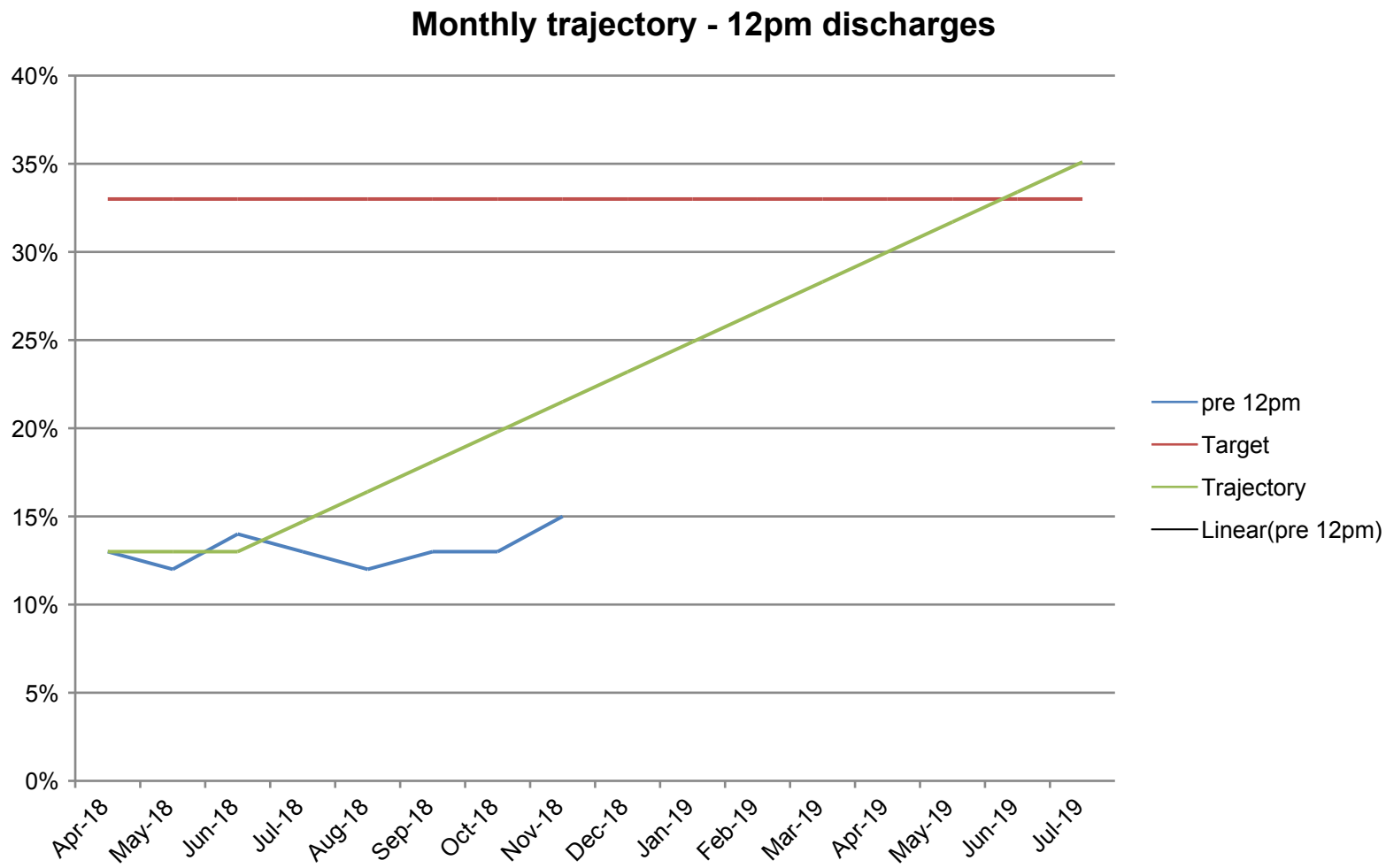
Key Items for next week

- Continue to work with the identified wards to understand processes, key issues and effectiveness with a view to making further improvements
- Stranded patient reviews both care groups, with weekly metrics, and escalation.
- Check, chase, challenge approach and process.
- Launch of long stay Wednesday

Red2Green/Safer – Improving Flow



Red2Green/Safer – Improving Flow



Integrated Discharge Team

Exec Lead – Claire Old Programme Leads – Sarah Dillon & Tanya Miles 18 Jan 2019

Top 3 Priorities in RED

SaTH needs to:

1. Increase the number of FFAs received by the discharging organisation before midday – target 80% before midday.
2. Increase the number of FFAs received per week to enable the LAs to meet their discharge trajectories (target: Shropshire 64 per week, Telford Wrekin 42) Through the demand and capacity work we will review the original figures for discharge to ensure that they are accurate as these have never been reached.
3. Nurse led discharge criteria embedded to improve earlier discharges
4. DLN's to be part of the discharge team- the case management approach to be embedded across both sites to ensure the correct approach toward discharges. Co-location of IDT staff where possible.
5. SaTH therapists to goal set for minimum 72 hours post discharge – this needs to be across all wards.
6. Transfer by relative/Red Cross should be default unless otherwise indicated
7. Anticipatory equipment planning and prescribed meds with person day before discharge
8. Need access to Senior Medical advice and diagnostics from SaTH for Admission Avoidance – to be considered at A and E group – Frailty at Front Door on both sites – decision needed re future running needed.

System needs to:

1. To consistently implement the system-wide Choice Policy in line with national guidance approved by all partners.
2. Further develop the system wide assistive technology offer.
3. Continue to support the admission avoidance pathway provided by Rapid Response nursing and social care teams.
4. Work together to ensure that weekend working plan includes ALL required agencies across all disciplines e.g. therapies with complex discharge patients/pharmacy/ DLN's/transport/SW/DR's to discharge patients
5. ASC continued market management to improve domiciliary care flow
6. System needs to implement RPIW action plan

The progress:

1. Continued work with the dom care market by both LA's to improve flow
2. IDT's working more efficiently with clear discharge numbers form the Hub.

Overall status

Red

Improvement in the A&E Quality Standard/Improvement discharge practice

Interventions and process changes

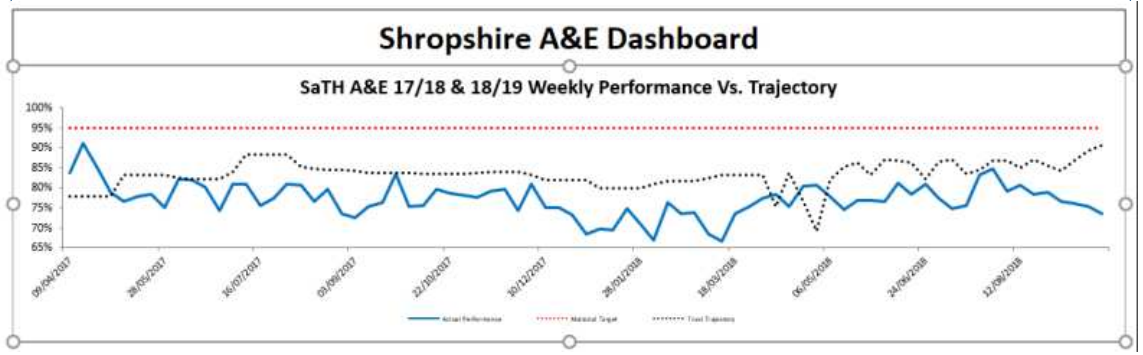
Consistent implementation of Check Chase Challenge across sites/wards

- Discharge Consultant nurse discharge especially at weekends
- Operational/Intermediate process and framework review and system wide agreement to new framework.
- Training across all partners regarding new intermediate care process.
- Red, amber, green process for all intermediate care pathways with twice weekly monitoring and MDT's.
- To progress to more weekend discharges need staff across the system focussing on simple and complex discharges
- SaTH therapists to goal set for minimum 72 hours post discharge
- Transfer by relative/Red Cross should be default unless otherwise indicated
- Anticipatory equipment planning and prescribed meds with person day before discharge

Risks to delivery

1. System wide commitment to follow through on actions ot consistent due to the diversion to deal with the acute day to day operational pressures. As aresult progress with this workstream is compromised.
2. Insufficient patients ready for discharge to achieve the required FFA numbers per week for the LA to hit their discharge trajectories
3. Provider failure dom/bed based care. Mitigation plan in place
4. BCF sufficiency to meet demand. New governance structure to support BCF board to monitor performance.
5. Medication protocols for discharge are stretched with both in house and external providers being challenged by CQC on their processes around discharges.

Data



IV Antibiotic Therapy – Community Based Delivery

Updated: 04/01/19
Next Update: February 2019

Exec Lead – Steve Gregory

Programme Lead – Yvonne Gough/Mandee Worrall

NHS England

NHS Improvement

Reasons for change

Why is the change indicated?

Give 4 reasons

- Admission avoidance
- Point prevalence data suggests 70 patients in acute beds suitable for community ambulatory delivery
- Reduce LOS
- Reduce number of stranded patients

Which Strategic Priority does this support?

- **Admission Avoidance** ☒
- **Length of Stay** ☒
- **Effective Discharge** ☒

Evidence to support change required

- National Priority
- ECIP – LOS projects and external support received suggests opportunity for delivery outside of acute bed base
- Admission avoidance; low admission avoidance attainment
- Volume of patient treatments within SATH for IV antibiotic therapy

Expected Benefits

Patients / service users

- Less stay in hospital, reduced dependency on acute hospital stay
- Understanding of alternative treatment options
- Encouragement for maintained independence

Staff

- Improve morale
- Improve MD Team working

Organisational

- Opportunity to challenge cultural working practices and to consider community options
- Improved communications between all the different organisations

Financial

- Reduced occupancy for IV antibiotic therapy

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- Development of pathways and governance for community 'chair based' antibiotic IV therapy
- Identify capacity within the MIU/DAART to deliver treatment
- Financial modelling for costs of drugs, consumables and pathway delivery and initial funding for equipment
- Agreement for pilot to commence October 2018 –April 2019, with funding stream approved
- Collection of data to validate efficacy of project

The progress:

Describe progress to date;

- Project live from 1st October 2018 delivering a chaired based service from Ludlow and Bridgnorth MIU plus DAART Shrewsbury (OD/BD IVs)
- Capacity to deliver within current staff resource for 12 additional appointments per day across the 3 sites using an inclusion and exclusion criteria
- Governance and medical responsibility agreed
- Staff matrix and competencies completed and relevant staff trained
- All medication stocked in the community
- Activity to be invoiced to SaTH direct
- Referrals through CCC – who will contact sites direct
- Rachel Brown (SaTH) engaging in-house to increase referrals
- SaTH to advertise in-house using posters and via in house communications forums
- Capacity uploaded to urgent care capacity hub and discussed during daily conference calls
- Fortnightly meetings continue – patient feedback form to be developed in Jan

Risks to delivery

Top Risks

1. Lack of engagement from referring partners
2. Reluctance to change prescribing behaviours
3. Insufficient patients identified for community delivery
4. Governance – maintaining medical responsibility within SATH
5. Finance – redirection of funding for pathway delivery
6. High re-admission rate
7. De-skilling of staff due to lack of referrals

Mitigating Actions:

- Full liaison and involvement of all partners including engagement workshops
- Robust capacity model; therefore financial redirection only required for those patients who attend this community provision
- Patient inclusion criteria with on-going virtual MDT until discharge
- Monitor all staff training and rotate through rapid response IV service if de-skilling

Data

Data set has been developed by Shropcom for community delivery. Manual calculation in place to ensure all activity recorded accurately during initial stages.

A system wide data will assess scale of opportunity and to validate efficacy of project (including but not limited to the following);

- Referral demand to be captured with referral speciality source and ward
- Number of patients suitable for OD /BD regimes
- LOS for patients receiving IV antibiotics
- Patient feedback and experience
- Number of avoidable admissions

Frailty Programme

Exec Lead – Fran Beck Programme Lead – Michael Bennett / Emma Pyrah

NHS England NHS Improvement

Programme needs to:

- Implement Frailty Front Door at RSH in line with the AFN model
- Develop and implement Frailty Front Door at PRH by October at the latest
- Develop Inter-Disciplinary Teams to have robust MDT approach to complex discharge and achieve target of 136 complex discharges a week
- Support home First and achieving 60:30:10 for pathways 1/2/3
- IDTs support and wider ICS/ICT support SATH Red2Green/ SAFER through in-reach support
- Reduce admissions from Care Homes through specific dedicated Teams or focus
- Provide overview and scrutiny of the DTOC High Impact Changes progress across the economy in achieving Mature RAG rating by end of Quarter 4 reporting.
- Reduce and maintain DTOC target levels and reduce length of time of patients on the work list

System Partners / Enablers need to:

- Clinical and managerial support from all organisations to ensure prioritising programme of work
- Collaborate to maximise the effective utilisation of learning from PDSAs, and audit in order to create behaviour and system change
- Clearly define objectives, activity, resource, milestones within each program work stream to enable accurate assessment of progress
- Accessibility of clinical expertise to support programme development including ECIST and AFN

The progress:

- Frailty Front Door at RSH Evaluation Action Plan in place; monitored through the Frailty Task and Finish Group
- 6 As Audit completed highlighting potential for reduced admissions, reduced length of stay, improvements in clinical and care pathways
- PDSA for Frailty at Front Door at PRH completed 25-27th July to develop model and improve existing pathways. Evaluation highlighted need for additional medical and therapy capacity – within Winter Plan
- Inter-Disciplinary Teams (Clinical Hub) in place on both sites seeking to achieve target of 136 complex discharges/ week. IDTs engaged in weekly Stranded Patient reviews
- Trusted Assessors in place facilitating early discharge to care homes
- Care Home MDT in place in T&W. Commenced piloting Emergency Passports in six care homes in conjunction with WMAS. Preparing to launch Red Bag Scheme
- Shropshire Deep Dive of Care Homes including review of CHAS and potential for piloting Miralife
- Relaunch of NHS 111*6 clinical advice line for care homes
- Developed DTOC High Impact Changes Action Plan to achieve Mature by end of Quarter 4 RAG rating

Key Interventions / Milestones

- Further develop Frailty at Front Door to maximise avoidable admissions and reduce length of stay on RSH site
- Develop and implement Frailty at Front Door at PRH to maximise avoidable admissions and reduce length of stay on PRH
- Implement DTOC High Impact Changes Action Plan to ensure achieving a Mature RAG rating by Q4
- Care Homes actively utilising the NHS111 * 6 line for telephone clinical advice from the NHS111
- Funding for Frailty team at Front Door at PRH to enable implementation and evaluation

Risks to delivery

- Current funding for Frailty at Front Door at RSH is based on local tariff Agreement. Risk that not agreed putting funding from April 2019 into question
- Current RSH infrastructure does not support working more upstream in ED to prevent admissions which limits to Service's impact on admission avoidance and potentially duplicates clinical input
- Additional capacity for Frailty at Front Door at PRH identified through PDSA. Needs approval through Winter Plan. Evaluation is needed to develop a Business Care for funding post April 2019
- Additional Domiciliary care capacity in both Boroughs to maximise complex discharges home for Pathway 1 and long term care at home supporting Home First and reduce length of time on the work list and recordable DTOCs

Data

- SATH reporting on Frailty at RSH highlighting impact on admissions and length of stay of Frail patient
- Need to develop methodology for monitoring impact at PRH
- Weekly reporting to A&E Delivery Group on performance related to complex discharge
- A Frailty dashboard is in place to monitor performance across both CCGs. This is being updated

Frailty Programme

Exec Lead – Fran Beck Programme Lead – Michael Bennett / Emma Pyrah

NHS England NHS Improvement

Project Summary

Project Overview				Overall Project Status
Project Title:	Frailty	Deadline:		AMBER
Exec Lead:	Fran Beck	Project Lead:	Michael Bennett/Emma Pyrah	
Clinical Lead:	Dr Finola Lynch/ Dr Jo Leahy	Project Group:		
Date of Report:	16th November 2018	% improvement in admitted performance target		TBC

Progress, Issues/Risks, and Decisions

Key Items completed since the last report

The Frailty Board meets on a monthly basis to oversee the programme

FI – Developing the Frailty MDT at RSH

- Frailty MDT embedded in RSH. Frailty screening at Front Door now routine
- Review of impact completed and Action Plan developed. Progress being monitored through the monthly Task & Finish Group for RSH.
- SATH using a ward area as FIT assessment area for patients predicted to have a 0-72 hour LoS.
- Reviewed role of HALO – monitoring potential conveyances and highlight potential diversions from ED
- Frailty dashboard illustrates differentiated performance seemingly attributable to Frailty at RSH

F2 – Developing the Frailty MDT at PRH

- Model or PRH developed through Task and Finished sub-group - 3 stage approach: admission avoidance through triage of potential conveyances so can utilise community services; assessment at Front for Front Door to potentially divert and / or diagnostics and turnaround; assess within ED/ AMU/ CDU for early discharge and care planning for deep bed base
- WMAS and SCT developed admission avoidance schemes:
- Rapid Response at Donnington with crews weeklong PDSA diverted 15 calls
- PDSA of Rapid Response and WMAS in a care as first responder PDSA for November. Average 3-4 visits daily. WMAS also uses CAD to highlight potential alternatives to crews.
- Seeking to trial accessing CAD reviews at peak times to propose alternatives to conveyance
- Rapid Response issuing all new patients with an emergency passport from 19.11.18. Passports will be placed with the patients medicine so accessible.
- SCT considering the promoting 1-3 days of immediate enhances domiciliary care
- Frailty at Front Door PDSA for 3 days with existing staff to measure potential impact. Review highlighted need for dedicated medical, ECP and therapy SATH senior managers are seeking clinical leadership options for the PRH FIT team.
- Continued planning meeting to develop improved pathways and processes between SATH and TICAT to have more integrated/ seamless functions

Frailty Programme

Exec Lead – Fran Beck Programme Lead – Michael Bennett / Emma Pyrah

F3 Reducing admissions from Care Homes T&W

- Care Home MDT in place. Targeting six highest admitting care homes (a home in each Neighbourhood) with training, clinical support and Rapid Response access for admission avoidance. The team are adopting best practice from around the country and establishing good working relationships with providers.
- Emergency passports have been implemented with WMAS across the six care homes
- Red Bag Schemes in the 6 care homes - bag which contains ACPs, DNARs, case notes, meds etc in case the person is seen by ambulance services and/or needs to go to A&E –now being implemented
- Month 6 showed reductions in admissions across the 6 care homes and reductions of £73k.
- End of life Care Group scoping Frailty EoL care of Frail patients

F4 Reducing admissions from Care Homes (Shrops)

- Deep dive of care home NEL activity nearing completion. Local data is still being cleansed and analysed however early indications are that performance looks favourable when compared to national rates, however, emergency admissions and A&E attendances are rising at a steeper rate than nationally.
- Improving Clinical care in Care Homes group (ICICH) in place

F5/6 Integrated Discharge Teams

- RPIW 4-9th November
- In medium term the IDT needs to be replicated in Telford with Discharge Liaison taking lead roles on complex discharges
- Complex Patients need to be identified earlier in their journey; this will be done immediately by IDTs Community Matron through Check Chase Challenge and ward sweep along with liaison with the DLNs

Delayed Transfers of Care High Impact Changes (HICs)

This is a nationally required self-assessment of each economy that reports on a quarterly basis through Better Care Fund reporting. Each economy is required to achieve MATURE by the Q4 report. This also includes a Red Bag Scheme or recognised alternative to be self-assessed as ESTABLISHED. Quarterly returns are meta-analysed by NHSE

- Seeking a consistent self-assessment approach to ensure consistent reporting across Shropshire and T&W
- Action Plan developed and reviewed within Frailty Board in October
- DToC High Impact Changes are system wide changes – including those already reported though A&E Delivery Group as part of ED Delivery Group
- Position at Q2 was
- Independent assessor role to be carried out by ShropCom ICICH team – 1xFTE post to be funded

Frailty Programme

Exec Lead – Fran Beck Programme Lead – Michael Bennett / Emma Pyrah

	Actions to achieve MATURE	Current RAG
Early discharge planning	EDD in place within 48 hours Embed flow processes eg SAFER, Criteria Led Discharge, End PJ Paralysis	
Systems to monitor patient flow	Demand and capacity modelling completed Capacity matches demand to support flow	
Multi-disciplinary/multi-agency discharge teams	Frailty Front Door in PRH in place ICT Operational Framework implemented	
Home First/Discharge to Assess	Consistent 60:30:10 discharge ratio	
Seven-day service	Weekend discharges at target levels Community MDT approach at weekends	
Trusted Assessors	Pathway decision 90%+ accurate first time Embed Trusted Assessor for care homes role	
Focus on choice	Fully implement agreed Choice policy Patient Information routinely provided	
Enhancing health in care homes	Care Home MDT in place Complete actions from ECHC self-assessment	
Red Bag scheme (Established by Quarter 4)	Utilised effectively in pilot areas	

RAG rating key: Not yet established Plans in place Established Mature Exemplary

Key Issues/Risks

1. Workforce retention is becoming increasingly fragile at RSH due to the lack of agreement of a recurrent funding process which includes a local tariff.
2. Securing sufficient clinical capacity and agreement on funding remains a risk for creating a MDT at PRH

Key items for next week

- Gaining clarity on funding RSH Frailty Team
- Gaining clarify on how to take forward the Frailty Team at PRH
- Further evaluation of the Care Home MDT impact
- Further evaluation of the admission avoidance Pilot (WMAS and Rapid Response in a car)
- Further meetings with SCT and WMAS to seeking potential for improved pathways for admission avoidance
- Actions and further action planning to ensure HICs achieve MATURE

Taskforce- Steering Group Report

Project Overview				Overall Project Status
Project Title:	ED Workforce	Deadline:	19/12/2018	AMBER
Exec Lead:	Victoria Rankin	Project Lead:	Karen Barnett	
Professional Lead:	Laura Kavanagh	Project Group:	ED Workforce Resourcing Steering Group	
Date of Report:	17th December 2018			

Project Summary

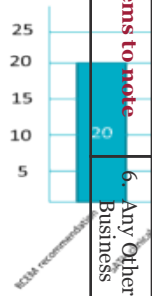
3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

ED Medical Workforce position

1. Consultant

We have four substantive consultants through December and four Locum consultants. We have 2 substantive consultants joining us through January and one in February. The diagram to the right shows the number (headcount and wte) of consultants through to the end of the financial year.



2. Middle Tier

There is an increase in locum middle tier doctors on both sites through December, with 3 more locum doctors joining in

	Commenced	Starting December
PRH	2	2
RSH	2	1

Taskforce- Steering Group Report

3. SHO

The SHO rota will be supported by substantive appointments that have been made recently as well as the full compliment of doctors joining through the training programme (Health Education England) from February.
Three senior clinical fellows are joining the organisation in January. These are middle tier level doctors that require a 3 month induction prior to them being able to work on the floor as middle tier doctors.
In addition 2 junior clinical fellows have been offered roles with us following the middle tier recruitment. These doctors have been offered, and accepted, SHO level roles.

ED Nursing Workforce position

Whilst the fill rate has improved, the % of substantive/agency is to note, particularly at PRH. This is a deteriorating picture as more substantive senior nurses leave the organisation. There has been organisational support for additional trained and untrained nurses on each shift through the Christmas and New Year period to support the departments due to the expected increase in demand.

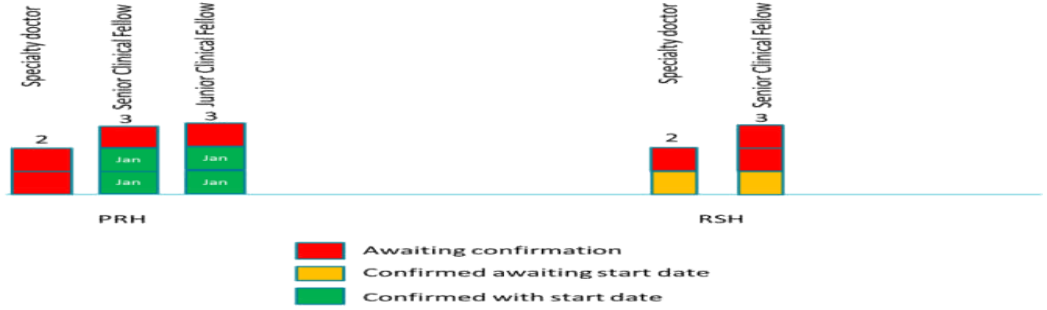
	RSH			PRH			Total		
	Substantive	Agency	Total	Substantive	Agency	Total	Substantive	Agency	Total
Day fill rate	58.8%	27.5%	86.3%	46.7%	49%	95.7%	52.5%	38.7%	91.2%
Night fill rate	81.3%	23.9%	105.2%	54%	44.3%	98.3%	67.6%	34.1%	101.8%

Recruitment activities:
Consultant advert closed but with no applicants. To go back out to advert straight away.

Middle Tier
There are 4 new Middle tier doctors confirmed to start with the Trust
2 senior clinical fellows arrived in the country at the weekend and will start with the Trust at the end of December. They will be on the MT rota during the day with consultant supervision and will be able to cover SHO level responsibilities at night. 1 further senior clinical fellow is still confirming start date. 1 specialty doctor, who can take the full MT rota responsibilities once assessed by our consultant body, is awaiting a confirmed start date.
10 doctors were interviewed on Wednesday 12/12/2018. 7 of these have been offered Specialty doctor roles and we are awaiting confirmation from them that they have accepted the offer.

SHO
2 doctors who had applied for middle tier roles have been offered, and accepted, Junior clinical fellow roles with the Trust – these will be included on the SHO rota.
4 further Trust doctors have been appointed. The February HEE fill currently has no gaps in our training place allocation.
From the interviews on Wednesday 17/12/2018, 2 doctors were offered Junior clinical fellow roles – we are awaiting confirmation of their acceptance.

OD activities:
Reviewed induction package for new starters.
Identified buddies for each new starter to support their induction into the area
Continue staff engagement activities through regular staff meetings



Taskforce- Steering Group Report

Longer Term solutions:

Escalation to execs:

1. CESR programme – confirmation is required from executives regarding the formal approval and support for this strategy and programme. Victoria Rankin to discuss with Executive colleagues to confirm leadership of this programme and expectations of the executive from the ED resource steering group.
2. Indian recruitment –Clarification is being sought with regard to the status of the actions in relation to the oversees recruitment from the twin organisation in India. This will then help to determine next steps in relation to the support we need to seek from recruitment companies

Key Issues/Risks

1. % nursing agency/substantive is significant through December, particularly at PRH
2. Still 8 Night shifts unfilled on Middle tier rota at PRH through December – out to agency at escalated rate
3. Financial risks highlighted due to increased workforce strategies in place against current recurrent budget and Trust financial strategy.

Key items for next week

Further work is progressing on workforce reporting – including linking budget to workforce graphs, trajectory for locum/substantive staffing

Key Escalation to Executives

1. The ED resource steering group recommends that the strategy continues to continue recruitment activity until the substantive number of consultants reaches at least 16wte consultants.
2. There are still 8 Night shifts currently unfilled at PRH between 17/12/2018 – 31/12/2018.
3. The steering group highlights the risks associates with a significant reliance on temporary workforce – particularly in relation to short notice for leave of absence.
4. There is a significant difference between the revised care group budget/financial strategy and the workforce that has been appointed to cover the middle tier in ED.
5. CESR programme – confirmation is required from executives regarding the formal approval and support for this strategy and programme. Victoria Rankin to discuss with Executive colleagues to confirm leadership of this programme and expectations of the executive from the ED resource steering group.
6. Indian recruitment –Clarification is being sought with regard to the status of the actions in relation to the oversees recruitment from the twin organisation in India. This will then help to determine next steps in relation to the support we need to seek from recruitment companies.

AHP Collaborative

Summary

Overview				Overall Project Status
Title:	AHP collaborative	Deadline:		Green
Lead:	Amanda Taylor	Key contacts:		
Date of Report:	September 2018			

Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

Project plan in place and reviewed as part of integration work stream in STP Driver diagram in place and reviewed as part of integration work stream   Storyboard_v01_SaTH_Shropcom.pptx Attended all AHP collaborative events and presented poster Currently in data capture continuing and being refined Networking between therapy teams in progress Continued development of good conversations and relationships with AHP lead in Shropcom (Liz Hagon)

AHP Collaborative

Key Issues/Risks

Timeline is tight to demonstrate significant changes though processes will be clear going forward. Community hospital (Whitchurch) about to lose its physio leaving one full time OT for the whole bed base Commitment from Orthopaedic surgeons to test the new system – discussions happening Data sharing across organisations to identify total time person away from home – Liz Hagon now has data and is merging from 2 systems

Key Items for next week / next period of work

Complete phase 2 Complete simple actions from project plan Continue changes in PDSA model

Measures of success

Overall time a person is away from home is reduced by a day Pathway decisions are correct for 60% of the time Patients and relatives expectations are aligned to service provision Patients are informed of their choices following orthopaedic surgery or admission to Whitchurch hospital Therapy staff across the system are clear on the services on offer in order to support patient decision making Transfer of care is more streamlined and effective

Transformation Enablers

System Improvements

Plan on a Page

Digital Enabling Programme

Exec Lead – Clinical Lead - Programme Lead – Rob Gray

NHS England Improvement

Programme needs to:

- developing the Local Digital Roadmap (LDR) - draft for NHS Digital Review October.
- Improve Connectivity : Provide seamless access networks and efficient procurement of new connections / wifi access for staff and citizens at all locations – close of financial year
- Populate Information sharing Gateway with agreements to allow sharing of information between organisations.
- Formulate an STP-wide plan for Cybersecurity: Ensure records and systems are secure.
- Improve Collaboration - Licensing future proof and cost efficient route for Microsoft and Office upgrades (towards O365 and CloudFirst)
- Identify & support digital requirements for all other programme groups
- Improve Digital Maturity Assessment scores to support programme success.
- Develop business cases as appropriate for possible future funding availability
- Analyse options for an Integrated care record across health and social care settings.
- Ensure and assist organisations within the STP to capture information electronically at point of care
- Implement a solution for Interoperability across the STP area.

System Partners / Enablers need to:

1. Ensure "Right Information available to the right person in the right time and location" enabling better outcomes for citizens.
2. Clarify the end vision and the level of commitment required from organisations.
3. Act as One! Agree the objectives of the enabling group in line with the strategic governance process at exec level.
4. Standardise on clinical coding (SNOMED-CT) for all organisations.
5. Provide resource (inc funding, project management etc) to define and plan programmes and projects
6. Involve digital solutions in all workstreams. Promote the modernisation and efficiency of paperless processes to increase efficiency through a digital programme
7. Conform to cyber-security requirements – and resource specialist support
8. Provide Strategic direction for an STP solution to enabling a system wide approach to an infrastructure that enables the use of all modern technologies to improve frontline patient care.

The Progress:

- Continue direct engagement with NHS England, and NHS Digital for strategic direction.
- New DEG chair, SRO and Exec Lead have met to agree LDR direction.
- LDR refresh to be reviewed and approved by partner organisation boards.
- HSLI bid for 8/19 funding accepted by NHSE. £885k to be awarded after BC approval.
  - Business cases now to be created and locally approved.
  - Benefits expectation and Value For Money form to be refined
- Project started - Enhance SCR for all active patients.
- Data Analytics forum to be defined as centre for data-driven decision making.
- Evaluating options for interim digital system in A&E to increase time-critical processes, reduce data-entry delays, and increase access to existing patient information.
- Funding bid in progress for EPMA at SCHT

Key Interventions / Milestones

- Oct-18. LDR refreshed and new Digital Programme defined. HSLI bid created and applied for.
- Nov-18. Summary Care Record enhancement initiative started, and visible in secondary care, starting with A&E. HSLI refinement and planning
- Dec-18. Network - Corporate Wifi access for all orgs planned for all sites. Business cases in progress for HSLI funding
- Jan-19.draw down funds for HSLI projects.
- Jan-19. Defined Procurement process started for Electronic Patient Record systems for SaTH and RJAH to support shared access to Integrated care records

Risks to delivery

Resources – (lack of revenue funding to progress strategic planning, and availability. commitment from senior management to release or increase resources)
Lack of Technology standardisation - Action :Identify interoperable platforms and recommending their use across the STP
Licencing costs are set to increase with a requirement to migrate to a supported set of office applications with revenue costs instead of capital.
Executive Strategic Direction is unclear.
Lack of clear co-ordinated approval processes for schemes with a cross-organisation impact.
Complex governance arrangement (STP is not an executive group with delegated authority.)

Actions:
DEG SRO, Exec Lead and co-chairs appointed

Data

Outline programme plan.

Strategic Estates Programme

Updated - January 2019
Next update – March 2019

Exec Lead – Clive Wright

Programme Lead – Becky Jones

Programme needs to:

- Use data in geographic layers at a very local level as evidence of emerging community need, & how or if they are being addressed
- Identify opportunities for developing community hubs, housing solutions or projects to support economic growth, where a local need is present.
- Inform the requirements for future service provision and ultimately guide the utilisation of the public estate
- Ensure estate is accessible, efficient and safe.
- Engage the expertise and knowledge of public sector delivery leads in developing community needs-based projects stemming from opportunities created by the One Public Estate work-stream.

System Partners / Enablers need to:

- Provide an integrated and co-ordinated healthcare estate relevant to redesigned patient /service user and staff pathways under the STP
- Deliver a reduction in estate
- Reduce / plan removal of backlog maintenance
- Support Estate aligning with and utilising the One Public Estate agenda
- Utilisation aligned with Carter review
- Deliver a Reduction in annual revenue costs
- Provide flexible estate that will enhanced a dynamic healthcare economy
- Develop local solutions drawing on all the assets and resources of an area
- Build resilience of communities.

The progress:

- Estates Workbook/Strategy completed and submitted on time and now a living document. Revisit and identify plan to get to a 'good' rating
- Project pipeline in early stages of development
- Joint OPE/STP Programme Delivery board established and functioning well
- Whitchurch Project Board up and running and Shropshire Council Cabinet report approved. Continuing on road to delivery
- Asset Mapping & data layering work with Shropshire Council going well, producing evidence base & assisting to inform opportunities with regular meetings taking place to ensure co-ordination between Council and health future planning needs
- Early stages of planning for OPE 7 projects
- Telford and Wrekin opportunities progressing, god working with Council and CCG.
- Planning workshop for estate strategy requirements for STP programmes to take place 19th March
- Providing support from national team to Future Fit programme to ensure whole system approach is reflected in business case

Key Interventions / Milestones

- Work to implement the recommendations of the Estates Strategy feedback
- Work with STP programme leads to identify the estate 'ask' and implement that into the revised STP plan
- Continue supporting system-wide work to deliver on system-wide projects, focusing initially on Future Fit with local, regional and national colleagues
- Improve disposal information and data and develop a disposals pipeline in conjunction with the project opportunities
- Focus on identifying future capital bids through developing a system-wide capital plan, to deliver system-wide clinical needs

Risks to delivery

Risks

- Timelines for funding bids vary across different organisations; aligning for cross-organisational estate projects difficult to achieve.
- Aligning existing projects and agreement on potential future opportunities
- Engagement not fully embraced
- Rejection of future capital bids through omission of estate projects/concepts from STP Estates Strategy
- Huge national focus on delivery of Wave 1 – 3 capital bids, need to ensure linkages are there and supported
- Lack of information around disposals and project opportunities

Actions:

- Transparency and awareness of funding timelines between organisations
- Agreed approach to partnership working
- Identify and Plan for interim arrangements
- Comprehensive links across all STP workstreams/enablers to include their known and anticipated estate implications

Data

- Validation and updates of SHAPE database (Health Service Estates) by all relevant organisations; ongoing requirement to maintain accuracy
- Property and Estates (Shropshire and Telford), Freehold land, Leasehold land, Leased land;
- Transport , Shropshire and Telford Bus routes 2016, Car and Van ownership *(2011 Census);*
- Demographic (covers Telford and Shropshire) *(2016 MYE ONS) ,*
- Deprivation (2015 IMD, DCLG)
- Community Facilities (e.g. libraries/schools)
- Older People,
- Health, including long-term illness & disability; health deprivation
- Planning Themes (Planning and Land Use Monitoring
- systems, Planning Policy Team
- Economy
- Housing Affordability

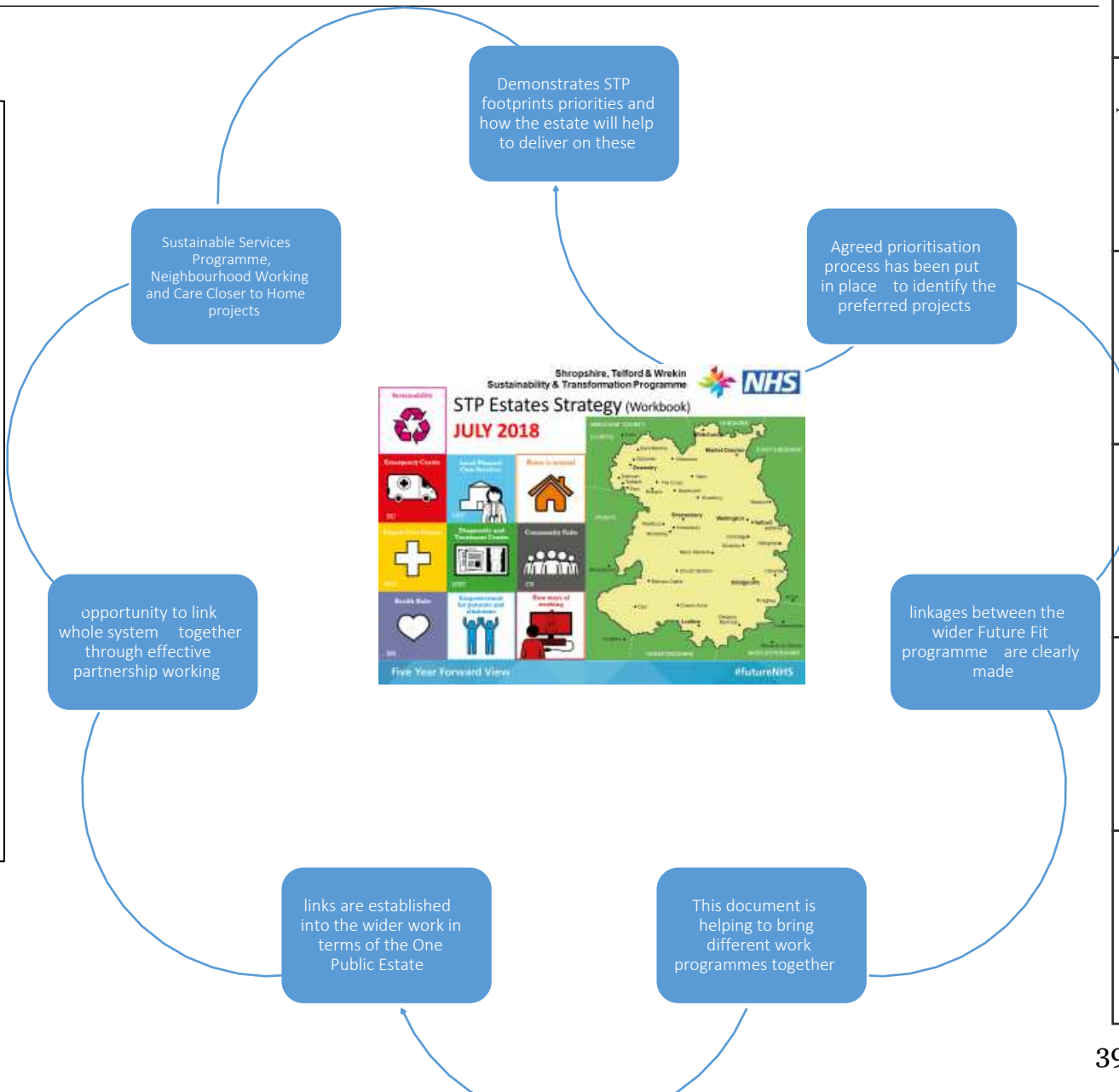
Strategic Estates Progress so far

The STP Estates Strategy has been a key piece of working with:

"ALL SYSTEM PARTNERS"

Through facilitated workshops, shared conversations recognising system interdependencies, increasing knowledge and understanding of Estates requirements across the system both now and in the future.

This strategy is facilitating system change through encouraging work to be done once by involving all partners in initial discussions, thus looking at the bigger picture and understanding the wider implications of organisational decisions….



Strategic Back Office

Updated Jan 19 Next update – Mar19

Exec Lead – Ros Preen Programme Lead – Maggie Durrant

Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;

Corporate services savings in the health economy, using recent benchmarking data,
Shared recruitment processes (by the Workforce Work stream)
Procurement savings through model hospital and PPIB data
Estate rationalisation (developed by the STP Estates Work stream)

- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value (e.g. target set to drive costs to the national median).

IT foundations to ensure the groundwork is most effectively procured to support the STP digital agenda.

System Partners / Enablers need to:

1. Support a level of ambition proposed by the programme – ie. drive costs to the national median (where there is one or other agreed benchmark where there isn't),
2. Sponsor and support the collaboration on key priorities, initially by sponsoring the CSU's diagnostic and option appraisal process.
3. Have an 'open book' approach to data and information to enable opportunity assessment,
4. Develop the relationship with other STP stakeholders to assess the opportunity for wider public sector benefits,
5. Agree a change programme in due course.

The progress:

- The group, on behalf of the STP health partners commissioned a piece of 'value added' work via Midlands and Lancs CSU to appraise the options for rationalising the 'back office' in health organisations.
- This work concluded just before Christmas with an initial review of the findings in December.
- A further review meeting is scheduled for February by the work stream, however in advance of this meeting, advice is being sought from the work stream SRO about the approach to gain top leader consensus on a 'programme' of work and it's content.
- Key findings of the review which covered £29m of healthcare expenditure were that there is potential opportunity for reducing costs in the back office ranging from £2.7 – 6.3m but scale is determined by ambition and scope, as well as embracing technology to support new ways of working.
- In the meantime, individual STP work streams are working on discrete aspects of rationalisation or collaboration (estates and workforce)
- All providers are using benchmarking data to support decision making, with the most recent national submission for corporate benchmarking now being included in the Model Hospital available to all STP health providers.

Key Interventions / Milestones

- Commence CSU diagnostic – Summer 18
- CSU diagnostic report received 10th December 18 for consideration
- Content and Key findings considered initially on 11th December 18
- Evaluate CSU diagnostic conclusions and agree programme of change – Spring 2019
- Implement change programme – Spring 19 onwards

Risks to delivery

Risks
The scale of opportunity will not be realised due to;

1. Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
2. Capacity and will to drive ideas forward across organisations at pace
3. A Shropshire centric preference not accessing the opportunity where it is at its greatest on a wider footprint (ie out of STP boundaries)

.....

Actions:
Using the CSU diagnostic and option appraisal process to increase pace, draw conclusions and propose a change programme which will require tangible agreement
Seek advice from the work stream SRO re gaining consensus to act and put a change programme in place
Consider how this might support any direction toward an Integrated Care System model
A review of the effectiveness of the existing county wide Procurement Group

Data

Model hospital (Carter)
Corporate services data (Model Hospital)
NHS Efficiency Map
Procurement data (PPIB)

Strategic Workforce Programme

Updated August 2018 Next update - October 2018

Exec Sponsor – Jan Ditheridge Exec Lead – Victoria Maher Programme Manager – Sara Edwards

Programme needs to:

1. Develop a system-wide **Strategic Transformation Workforce Plan** which supports Future Fit options linking acute and community models.
2. Develop and implement a system **Organisational Development Plan** to support new ways of working.
3. Develop **workforce sustainability** through the identification of learning and development, education and training needs and through supporting system programmes to implement change and support transformation.

System Partners / Enablers need to:

- **Work closely to share workforce intelligence**, undertake workforce modelling and strengthen system ownership of workforce strategies.
- **Work collaboratively** to attract, recruit and retain the current and future health and care workforce.
- **Agree system-wide requirements** in order to maximise the education, development and training opportunities for our workforce.
- Lead a **system programme** that delivers transformation and sustainability taking into account Future Fit options.
- Lead **cultural change** through health and care that supports **integrated working** which prioritises patients resulting in improved population health and wellbeing.
- Deliver **system-wide workforce solutions** and improvements in response to the system workforce challenges.

The progress:

- Agreement between STP partners on **priority areas** through the Strategic Workforce Group .
- **System-wide Workforce Strategy** – Baseline data being worked up via HEE.
- **Mental Health Workforce Plan –** Submitted with no requirement to resubmit. MH Delivery Plan now being addressed.
- **STP OD Group -** now set up with priorities being planned.
- **Local Maternity Services (LMS) Transformation Plan** developed. First draft of WFP taken to LMS Board and WF sub group meetings in progress. Leadership & Cultural Development Plan to follow in Autumn 2018.
- **GP Forward View Workforce Plan** has identified projects to address recruitment and retention targets and bids have been submitted to support GP recruitment, retention and resilience programmes.
- **2017/18 workforce investment programme** of £817,600 covering both primary care and acute services being delivered.
- **2018/19 workforce investment** scoping exercise in progress.
- **STP/LWAB** relaunched with priorities refreshed.
- **Education & Development Group** – Identification of priorities and development of Multidisciplinary Preceptorship Framework, Shared Learning Assets and Shared Statutory and Mandatory training projects.
- **Training Hub** – Re-establishment of the Shropshire and T&W Training Hub provision within the STP PMO.

Key Interventions / Milestones

- Complete the **workforce profile data** gathering and individual specialist workforce plans. Aligning with Future Fit Programme.
- **Leadership and OD Programme** with the King's Fund completed. NHSI (ACT Academy) **TCSL Programme** change management tools being used.
- Development of **Shared Recruitment** project and **Collaborative Bank –** Project Briefs developed with partner engagement.
- Implementation of a pilot **Rotational Apprenticeship Programme** with September 2018 start.
- Delivery of 2018/19 **STP/LWAB funded priority areas** and development of a **shared training/learning** offer to meet system needs and promote integrated working.

Risks to delivery

Risks:

- Planning without knowledge of future finances and service redesign/configuration. Future Fit Consultation ends in September 2018.
- Varying levels of stakeholder engagement driven by different approaches to Workforce and access to data.
- Ability to fund workforce development activities both in terms of finance and time.
- Risk to quality of STP submissions due to a lack of clarity around requirements .
- Timely decisions in respect of funding which affects education, development and recruitment.

Actions:

- Ensure strong workforce links with STP clinical /service priorities reporting into the Strategic Workforce Group.
- Continue to build relations through working together on identified projects/ task & finish groups.
- Identify priority development areas and align through STP PMO processes.
- Collaborating with HEE to access support and align programmes.
- Piloting areas of work to test outcomes.

Data

Shropshire Workforce Baseline:

STW system workforce baseline developed by HEE Workforce Intelligence Team utilising data from NHSI operational plans (workforce plan) for acute/community and mental health services, NHS Digital for primary care and NMDS for social care. Data presented at July meeting of Strategic Workforce Group and LWAB. The data provides demographic information, nurse to bed ratio and a comparison with the 17 LWABs across Midlands and East. A focused session with workforce planners to review the data and provide a response to HEE is currently being arranged.

Individual areas of workforce:

- **Mental Health Workforce** data included in the submission of the MH Workforce Plan in March.
- **Local Maternity Transformation Plan (LMS)** developed with workforce analysis being undertaken to inform WFP. Financial analysis underway with STP Finance Lead for LMS. WF risk register updated to include financial risks.
- **Primary Care workforce data** has been collated as part of the GPFV Workforce Plan.
- Cancer Alliance now linked into Collaborative Cancer Group to progress Cancer Workforce Plan.

Strategy

Caring, Responsive, Effective, Well-Led, Safe: A positive experience for patients, carers and families

The Shrewsbury and Telford Hospital NHS Trust

Severn Hospice

Shropshire Community Health NHS Trust

National Ambitions

- Individual care
- Fair access to care
- Comfort and Wellbeing
- Coordinated care
- All staff care
- Caring Community

Living Well HELPS ---> Dying Better

Facilitate effective personalised care planning and support of those important to the dying person

- Documentation provides clarity to all regarding patients' preferences/goals for living
- Important conversations
- Identify key worker
- Patient and carer access to documentation
- Shared electronic records

Ensure equal access to palliative and end of life care

- Develop systems with prognostication to identify patients in last year of life
- Co-ordinated processes for referral: clear Access criteria and Co-designed referral documents
- Establish a needs based model that identifies phase of illness and a system for prioritization
- Links with non-cancer specialists
- All supported by GSF and Frailty registers
- Support Transitional Care Initiatives

Establish 'Living Well' concept: support advanced & anticipatory care planning & timely access to services

- Culture of care is enablement
- Programs for palliative rehabilitation are established
- Expand homecare models to support a preference to die at home; further develop H@H service
- Provide necessary medication and associated documented administration authority

Work in partnership to ensure that care is coordinated between services

- Facilitated by Local Health Economy End of Life Group supported by CCGs
- Services compliment not replicate each other
- There is shared accessible documentation where possible (RESPECT, EOL care plan, PPC) and Flagging
- Integration of H@H with the Hospice Outreach Service

Ensure a competent workforce

- Identify education needs across services ; Establish education programmes
- Robust systems for appraisal and CPD across groups; System learning from Significant Adverse Events

Recognise compassionate communities voluntary support as an extension to services

- Severn Hospice continued roll out of coco
- Volunteering is seen as an arm to wider services
- Clinical services refer to established volunteer support
- Expand competencies in verification of death to facilitate this promptly and confidently

National Foundations

- Personalised care planning
- Shared records
- Evidence and information
- Those important to the dying person
- Education and training
- 24/7 access
- Co-design
- Leadership

DRAFT Population Health & Prevention

System Leads – Kevin Lewis / Helen Onions
Programme Lead – Penny Bason

Updated November 2018

Next update– December 2018

NHS England

NHS Improvement

The programme needs to:

1. Develop system architecture for population health, including a robust understanding of need through business intelligence and the JSNA
2. Support improved working for prevention across all organisations; in particular
- Develop our wider workforce to 'make every contact count' (MECC+) / proactive identification of people at risk of ill health and behaviour change conversations, brief interventions
- Prevent harm due to alcohol, obesity and CVD
- Support culture change and new working practices that help people at the earliest opportunity
- Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
- Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities by connecting with the national and regional population health management support mechanisms

System Partners / Enablers need to:

1. Embed population health management and prevention through all services and workstreams: this will involve:
- Systematically understanding need and capabilities
- Systematically raise awareness and deliver lifestyle advice, signposting and referral by healthcare and other professionals, e.g. through MECC +, PHE's One You, including for:
  - Stop Smoking Support
  - Weight management
  - Physical activity programmes
  - Immunisation opportunities, e.g. flu
- Improve the prevention, detection and diagnosis of CVD, specifically diabetes and hypertension
- Radically upgrade the role of the NHS in tackling harmful alcohol consumption, through screening, identification, brief advice and referral into treatment services
- Deliver prevention expectations of the national Cancer Strategy
- To ensure the systematic delivery of mental wellbeing services, including identification of mental ill health and prioritisation of emotional support
- **Work together to make best use of resource and expertise**

The progress:

Mobilisation of the National Diabetes Prevention Programme March-May
Neighbourhood working to build community capacity- focus on Healthy places, Active and Creative communities
Delivery of Social Prescribing initiatives and infrastructure
Supporting Carers through all age strategies and Dementia Companions
Delivery of Fire Safe and Well Visits (since July 17)
Develop and deliver a system prevention framework for all pathways
Developing very positive joint working across health and care
Individual Placement Support Service for those in secondary MH services

Telford & Wrekin – Healthy Telford
Development and Delivery of MECC Plus for NHS providers, VCS
Develop wellness Dyeveller, with strong use of social media to inspire behaviour change
Developing and nurturing our community health champions
Public Health Midwife, stop smoking support and maternal health advice
New Healthy Hearts Telford project, collaboration with BHF, CCG and Council

Shropshire – Healthy Lives
Development of an Integrated Care Navigation Programme, including Social prescribing – rolled out in 11 GP practices in partnership with Social Care, children's services, Job Centre, and the VCS
Delivery of the Public Health Nursing Service
Delivery of Healthy Lives Programme and prevention services

Opportunities

- Smoke free hospital and brief interventions in hospital
- Connecting to workforce (and funding) to support development of staff (link to MECC plus)
- Mental health hubs, MH support in Local Maternity hubs, Early help for children and young people, link to Estates
- Healthy hubs and social care support/ advice and guidance in hospital
- Risky behaviour CQUIN - link to MECC Plus

Key Interventions / Milestones

- Developing local Health & Wellbeing Intelligence Population health management
- Develop and Deliver System CVD, Diabetes and Obesity Strategy
- Deliver the prevention expectations of cancer strategy
- Develop system social prescribing infrastructure
- Development of a system plan to reduce harm related to alcohol
- Develop the system MECC Plus proactive approach, including training and delivery plan

Risks to delivery

1. Lack of buy in by partner organisations
   - Risk to strategy delivery
   - Risk to culture change needed
2. Investment in prevention programmes (national and local)
   - Local Authority Public Health Grant challenges
   - Lack of NHS investment in prevention
3. Medical and nursing capacity
   - NHS Trusts (SaTH, SSSFT, ShropCom, RJAH)
   - Primary Care

Outcomes – how do we know it's working? DRAFT

Public Health Outcomes Framework
- Healthy life expectancy
- Health Equity
  - Smoking rates
  - Obesity – children and adults
  - Physical activity
  - Wellbeing measures – Social Prescribing
  - Reduction in GP attendances
  - Reduction in unplanned hospital admissions
  - Cancer rates
  - Harm due to alcohol – alcohol admission rates

Connecting to other programmes

- Health and Wellbeing Boards Strategic Planning (both T&W and Shropshire)
- Better Care Fund (T&W and Shropshire)
- Rightcare
- STP Neighbourhoods and Out of Hospital Programmes – community development,
- GP 5 Year Forward View –
- Mental Health 5 Year Forward View – preventing
- Maternity Services Transformation
- Workforce – developing our
- Estates Partnership
- Musculoskeletal and Falls System Planning

National Office:
Quality Surveillance Team
NHS England
2c Skipton House
80 London Road
London
SE1 6LH

19th December 2018

Mark Brandreth
Chief Executive
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Dear Mark

Notification of Annual Assessment Outcomes for 2018/19 and Specialised Services Comprehensive Peer Reviews Visit Programme

Please find enclosed confirmation of the outcomes of the quality surveillance annual assessment process for 2018/19 for all specialised services. The outcomes will be used by regional commissioning teams to monitor quality of service delivery and compliance with NHS England's service specifications.

Options were derived following the completion of the annual assessment process which commenced with commissioner review of the provider self-declaration and other quality information including SSQD alerts, CQC reports, Healthcare Quality Improvement Partnership (HQIP) audits and other relevant national clinical audit flags.

The options for surveillance are summarised below:

1. Option One – **Routine Surveillance**:
Annual assessment has confirmed that the service is either 100% compliant with no risks identified or services that have not reached 100% compliance, but the regional teams have determined that this is not a material issue.

2. Option Two - **Enhanced Surveillance**:
a) **Provider Action** – Where it is agreed the non-compliance is amenable to a short-term action plan (6 months), the provider will be required to submit a Service Development Improvement Plan (SDIP). This will be specified within the contract and monitored via contractual processes.
b) **Commissioner Action** – Where it is identified that the non-compliance is not amenable to a short-term action plan, the commissioner will notify the provider, within six months of the discussion, of the action that they intend to take to ensure a sustainable compliant service in the future.
c) **Provider and Commissioner Action** – Where it is determined that the non-compliance in one service is amenable to both a short-term and longer-term action plan.

3. Option Three - **Peer review**:

a) National review plus either routine or enhanced surveillance
b) Regional review plus enhanced surveillance
c) Rapid review plus enhanced surveillance

The following services have been identified for comprehensive peer reviews for 2019/2020:

- Congenital Heart Disease
- Renal centres

In addition to the comprehensive review programme, regional risk based peer reviews will be agreed in the coming weeks, considering the outcomes of the 2018 annual assessment. Further communication will follow when those services are confirmed in preparation for the reviews. Furthermore, any peer reviews identified for CCG commissioned cancer services will be notified separately.

Regardless of the final option selected, all services are required to complete an annual self-declaration to be completed by the 30th June 2019 on the Quality Surveillance Information System (QSIS) this will include those services identified for a comprehensive or risk based peer review visit.

In response to provider feedback, the functionality and the service directory of QSIS is currently being revised. All specialised and cancer services with a standalone service specification will now be listed in the directory of services. The updated platform will be released early in the new year with regional training being made available, further details to follow.

In the meantime, if you require any further information regarding self-declaration or annual assessments please do not hesitate to contact your local SQM or AQM:
SQM Lorraine Winship, at l.winship@nhs.net or on 07917 767 293
AQM Vanessa Milner at vanessa.milner@nhs.net or on 07568431834

Yours Sincerely

Lorraine Winship
Senior Quality Manager
Midlands and East Region Quality Surveillance Team
Specialised Commissioning
NHS England

Pól Toner
Director of Nursing
Specialised Commissioning (region)
NHS England

CC:
Bev Tabanacle, QST lead
Angela Young, Quality Lead
Catherine Louis Supplier Manager

High quality care for all, now and for future generations

Annual Assessment Outcomes - 2018/19

Summary

Outcome	#
Routine surveillance	7
Grand Total	**7**

Service by Outcome

Row Labels	Sum of count
Routine surveillance	**7**
Complex Spinal Surgery (All Ages)	1
Paediatric Medicine Rheumatology	1
Paediatric Surgery: (Surgical Pathology, Anaesthesia & Pain)	1
Sarcoma Services (Bone and Soft Tissue)	1
Specialised Orthopaedic Services	1
Spinal Cord Injuries (All Ages)	2
Grand Total	**7**