The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 28.03.19

MEETING
28 March 2019 10:45

PUBLISHED
27 March 2019

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	28/03/19	Frank Collins	10:45

1. Part One - Public Meeting		
1.1. Minutes of the Previous Meeting (31 January 2019)	All	10:45
1.2. Matters Arising	All	10:50
1.3. Declarations of Interest	All	10:55
1.4. Staff Story - CQC Experience	Chief Executive	11:00
1.5. Sir Neil McKay - STP Presentation	Sir Neil McKay	11:20
1.6. Chief Executive Update	Chief Executive	11:50
2. Strategy & Policy Updates		
2.1. Strategy Board Session - Presentation	Director of Strategy and Planning	12:00
2.2. Corporate Objectives	Director of Strategy and Planning	12:05
2.3. Performance Management Strategy and Accountability Framework	Interim Assoicate Director of Performance	12:15
3. Quality & Safety		
3.1. Chair Report: Quality and Safety Committee (to follow)	Non Executive Director	12:20
3.2. Chair Report: Risk Management Committee	Non Executive Director	12:30
3.3. Learning from Deaths	Medical Director	12:40
3.4. Guardian of Safe Working Hours (Q3)	Medical Director	12:45

Continued on the next page...

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4. Performance & Governance		
4.1. Chair Report: Finance Planning and Investment Committee (verbal)	Non Executive Director	12:50
4.2. Performance Report M11	Associate Director of Performance	13:00
4.3. Board Governance Pack	Trust Secretary	13:10
4.4. Items to note		13:15
4.4.1. Communicating our Strategy	Director of Strategy and Planning	
4.4.2. CQC Action Plan	Director of Nursing	
4.4.3. NHSi Future Fit Letter	Chief Executive	
4.4.4. Charitable Funds Annual Report and Review of Effectiveness of Expenditure	Director of Finance	
4.4.5. Security Annual Report	Director of Finance	
4.4.6. Chair Report: Finance Planning and Investment Committee (January)	Non Executive Director	
4.4.7. STP Update	Chief Executive	
4.4.8. Governors Update (verbal)	Trust Secretary	
5. Any Other Business	All	13:25
5.1. Questions from the Public		
5.2. Next meeting: 25th April in Meeting Room 1		

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC SESSION
31 JANUARY 2019
MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive	MB
Craig Macbeth	Director of Finance	CM
Chris Beacock	Non-Executive Director	CB
Nia Jones	Director of Operations	NJ
David Gilburt	Non-Executive Director	DG
Bev Tabernacle	Director of Nursing / Deputy Chief Executive	BT
Harry Turner	Non-Executive Director	HT
Paul Kingston	Non-Executive Director	PK

In Attendance:

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

FC welcomed all Board members to the Public Board. FC welcomed Paul Kingston to his first meeting since being appointed as Non Executive Director and Hilary Pepler in her new role as Board Advisor.

FC asked for a moment of reflection regarding the loss of Theatre Nurse, Charlotte Harvey

MINUTE NO	TITLE
31/01/1.0	**APOLOGIES** Alastair Findlay, Non-Executive Director and Steve White, Medical Director
31/01/2.0	**MINUTES OF THE MEETING 29 NOVEMBER 2018** The minutes of the meeting held on the 29 November 2018 were agreed as an accurate representation of the meeting.
31/01/3.0	**MATTERS ARISING** FC went through the actions which were noted to be completed.
31/01/4.0	**DECLARATIONS OF INTEREST** DG advised that his role at Eastern Cheshire CCG has now come to an end.
31/01/5.0	**STAFF STORY** Staff from the Outreach Team attended to present to the Board an overview of the service they provide. The full presentation is available via the following link Critical Care Outreach Team Presentation. Highlights of the presentation were as follows: • A background to the service and the critical care provision it provides • The role of the Critical Care Outreach Team was outlined including averting admissions to HDU, facilitating timely admissions and discharges to and from HDU as required, keeping the hospital safe at night. • The importance of the role in managing deteriorating patients. • The benefit for patients

	• The benefits to staff • Hospital cover responsibilities and examples of a typical night and the type of workload. FC asked what the split was between clinical and non-clinical work and the data was presented with examples given of the non-clinical which the presenters stated sometimes includes "fetching and carrying". PK asked about the challenges of managing the mental health aspects of their work and the team advised that that they are experienced nurses and so this is part of their role. CB enquired about HDU admissions and whether there is any link between these and the pre-operative assessment process. The team advised that the pre-operative assessments screen the patient and assess any potential risks or issues for the patient with an HDU bed booked as required. However, not all issues can be screened in advance such as post-operative pain or acute issues such as deterioration a few days after surgery. It was noted that there is an increase in patient acuity and that patients can therefore be more unwell than they may have been previously. The team also highlighted the use of the early warning score system means increased referrals as there is a tendancy to escalate to the Outreach Team. CB asked about the medical support available. The staff had no concerns with this with the team confirming that they are able to obtain clinical advice over the phone or if attendance is required the medical on-call staff are on site within half an hour. BT asked about the team's role in training and building the competence of more junior staff across the organisation. The team advised that there are shadowing arrangements in place when dealing with complex or poorly patients so that there are learning opportunities. FC thanked the team for sharing their story. The Board ***noted*** the staff story.
31/01/6.0	**PATIENT STORY (DALE HARRISON)** BT introduced Dale who was currently an inpatient on Oswald Ward. Dale explained how he had been transferred to the Trust for care and treatment of a tumour in his pelvis. He had an initial operation which went well with a 12 week recovery but unfortunately further surgery was required in order to ensure all the tumour had been removed. Following his discharge he felt unwell so went to his local A&E. Fortunately, his consultant, Ms Shepherd arranged his transfer back to the Trust for treatment with antibiotics and further surgery to treat an infection. Again initially all was well but he then developed sepsis secondary to the bone infection. All in all he had been an inpatient for the last two months on antibiotics with plans to go home in the coming days on oral antibiotics. He advised that he will require a bone graft on his pelvis to repair the damage and ultimately he will require a hip replacement. Dale felt that he could not ask for a better place to receive care and he had nothing bad to say about Oswald Ward. FC commented that it is always interesting to hear from individuals about their experiences and Dale's resilience and spirit really came through. FC was pleased to hear of the quality of the care he had received but asked if there was anything that the Trust could improve. Dale advised that Christmas was a low point as he was transferred to Clwyd Ward because Oswald Ward was closed. There was nothing wrong with

	Clwyd Ward but it was a disruption to the routine he had developed with new nurses to get used to. Also, there was no wifi available on Clwyd Ward which he had found difficult as it was important to him to be able to communicate with his children. Dale also commented that the ward had only one tv remote control which was frustrating so he ordered some extra remotes from Amazon. FC recognised that the little things make a difference. MB thanked Dale for sharing his story and commented that the Trust would like to provide him with a refund for the remote controls. He also advised that the Trust will look at what improvements can be made to the wifi, recognising that this is important for patients. MB advised that Ms Karen Shepherd is one of the Trust's new consultants and he will drop a note to her to say thank you. **ACTION: Refund for remote controls to be arranged and also review of the wifi arrangements** Dale commented on the cottages and the fact that whilst they were a welcomed facility that had made a difference to him and his family, he felt they needed modernisation.. MB advised that this is currently being looked at. **ACTION: Update to be provided to the Board on the work on the cottages** The Board ***noted*** the Patient Story
STRATEGY AND POLICY UPDATES	
31/01/7.0	**CHIEF EXECUTIVE UPDATE** • MB provided an update on the CQC inspection. The first draft of the report has been received and the Trust now has two weeks to provide a response. This is embargoed so cannot be shared in public at the present time. MB wished to once again thank the staff for the way they conducted themselves during the inspection, their openness and honesty was commented on by the lead inspector. • MB advised that over the last month the Trust has been communicating with some patients about the future of the chronic pain service. It was decided at the end of 2018 that the requirements of NICE and the changes in the policy of the CCG resulted in a decision to move much of the service to a community provider because the Trust can no longer safely provide a service. The Trust has contacted the patients affected and are working with commissioners to support them to access different providers. The Trust has stopped taking new referrals and the service will close at the end of March 2019. The two staff affected have been redeployed within the Trust. • Lt Col. Carl Meyer has been nominated for a Soldiering On award. • Rev. Adrian Bailey's retirement after 17 years. MB extended his thanks to him not only for the service he provided as hospital chaplain but also in his role as a Governor. • The Trust received an award for commitment to PROMS • MB commented on the Staff Health and Wellbeing Day held recently and thanked the HR Team for organising this. • The long term plan has been published and thanks to KR, CM and the rest of the team for the work on the Trust's response to this. • CM has agreed to lead on the EU Exit planning and preparation and oversight will be in place through the Audit Committee via the Risk Management Committee as the Audit Committee will not meet again until April. • Thanks to Andy Barnett, Knee Surgeon. MB had the opportunity to shadow him on

	a trauma list at SaTH, it was very insightful and it has some given him some ideas on how the pathway can be improved for patients. • The appointment of Geraint Thomas, Senior Lecturer in Population Orthopaedics. • Sir Neil Mackay has asked to attend the Board regarding the STP and arrangements are currently being made. • Health Heroes were– for December, Sharon Long, ODP and for January, Sara Kaye Staff Nurse on Oswald Ward. The Board ***noted*** the Chief Executive's Update
31/01/8.0	**LONG TERM PLAN** KR introduced a briefing paper on the NHS's long term plan which was published in January 2019. She advised that the Trust is required to submit a draft of its Operational Plan by 12 February with the final version to be submitted by 4 April. She recommended submitting the draft with Executive Team approval but with the draft to be presented to the Board on 28 February to allow time to make changes before the final version is presented to the Board on 28 March before submission on 4 April. **ACTION: Agenda item for 28 February and 28 March** KR highlighted that it was worth noting there are still a number of items outstanding which will not be published until later in the year, namely: • Social care green paper • National workforce strategy – renamed national workforce implementation plan • Spending review • Clinical standards review KR commented on the following aspects of the plan: • There is a focus on outpatient reform and in particular an aim to reduce 1/3 of face to face outpatient visits. This would impact on current RTT measures but it is not entirely clear what this will mean until the clinical standards review is published. • It is anticipated that there will be an increase in surgical procedured to reduce waiting times • There is an introduction of hospital fines for patients waiting over 12 months, these will be split with the CCGs • There is an IT focus but no section in the operational planning guidance for IT. The delivery of this is dependent on funding which ends in 2021. • System working is not a thread but put in as a separate section. CM added the following on the financial elements: • Changes to the tariff for outpatients with a commitment to incentivise different models for outpatients and the same tariff irrespective of the appointment mode. • Control totals looking to be phased out so 19/20 may be the final year for these. DG asked about the opportunity to redesign outpatients and address the follow-up backlog issue, particularly if commissioners are going to implement the 52 week fine. NJ commented that there is a workshop planned for 11 February with the clinical team to focus on the appetite to redesign the Outpatient Service and look at alternative models. An update on this will be brought back to the Board. **ACTION: Update on the outpatient service redesign workshop to be presented to the Board.**

	PK felt that the workforce aspects of the long term plan appeared weak. SS advised that the Trust has had a People Plan in place for a while and the national workforce implementation plan is currently being worked on. The biggest challenge is how the Trust is going to undertake imaginative and innovative workforce planning as part of a wider system. SS was unable to give a date on an expected publication date for the national workforce implementation plan. The Board ***noted*** the update on the Long Term Plan.
31/01/9.0	**STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION** CM presented the Standing Financial Instructions and the Scheme of Delegation for the Board's ratification. He confirmed that the changes proposed were minimal and outlined in the paper. Further, CM advised that the Audit Committee have considered and agreed the changes in draft form. The Board ***considered*** both documents and ***approved*** the same.
	QUALITY AND SAFETY
31/01.10	**CHAIR'S REPORT - QUALITY AND SAFETY COMMITTEE** CB provided an update of the meeting which was held on 17 January and highlighted the following: • An update was received on the ongoing issues with the follow up backlog but with recognition of the importance of the harms reviews being undertaken. Further updates will be reported to the committee for assurance. • An update was received on the Histopathology accreditation work which is an ongoing challenge, the committee agreed on the importance of exploring collaboration with other providers. SS commented that she was present at the meeting but her attendance had been missed from the minutes. BT advised that assurance was obtained around delayed discharges. The Committee received an update on the escalation work and the further work being undertaken to explore this with a particular focus on the use of step down beds. The Board ***noted*** the Chair's Report.
31/01/11.0	**CHAIR'S REPORT – RISK MANAGEMENT COMMITTEE** HT provided an update of the meeting that had been held in January and highlighted the following: • The EU Exit risk has been added to the BAF • The current BAF is looking at 18/19 so this will be refreshed for 19/20 • The committee reviewed the corporate risk register. It was clear that the Governance Lead roles are embedding but these need to transition into managing the risk management process not the risks themselves. This requires some strengthening within the Divisions and work is underway on this. • The committee received a deep dive from the Paediatric Directorate. There were two key risks noted in relation to patient letters and children being seen in adult outpatients. The committee was satisfied that these were being mitigated. • The committee received a deep dive from the Estates Department and noted that many of the risks were under effective management. There was debate around some of the risks which were considered to be operational issues rather than potential risks. HT commented that the committee has been functioning for two years and therefore it was felt it is now time to revisit the purpose and remit of the committee. The following

	were discussed by the committee: • The need to separate corporate strategic and corporate operational risks • The production of an annual report to look at tracking the movement of risk • Templates to be put in place for the deep dives to ensure consistency and publish dates for attendance from the relevant division • Review of the approach to risk management from Board to Ward. It has been agreed that there will be some Board Development around this • Review of the risk registers to ensure Executive Leads and Assurance Committees are clear for all risks and ensuring workforce risks get adequate scrutiny. The Board ***noted*** the Chair's Report and welcomed his further thinking on future Committee structure and remit.
31/01/12.0	**BOARD ASSURANCE FRAMEWORK** SR presented the Board Assurance Framework and provided an overview of the process which had been reviewed by the Executive Team and each of the Assurance Committees. SR highlighted that two risks had been increased - the workforce risk and the achievement of activity and income targets and the Board agreed that these were reflective of the increasing challenges in these areas. The Board ***noted*** the report and the assurances contained within it with regard to the mitigating actions being taken to address the gaps in controls and assurance.
31/01/13.0	**INFECTION CONTROL QUARTERLY REPORT** BT presented the quarterly infection control report which had been presented to the Quality and Safety Committee. In terms of reportable infections for the reporting period there was one E.coli, one MSSA bacteraemia and the Trust was MRSA free. Further to previous discussions around infection rates this has been put into an SPC chart to breakdown the spinal injuries and arthroplasty infections. This indicated a drop in spinal infection rates but at the Quality and Safety Committee it was agreed that arthroplasty needed to be looked at in more detail. MB added that splitting the data has resulted in such small numbers being reviewed that there needs to be a further look at the most appropriate way to represent this. **ACTION: Further analysis to be undertaken and taken through the Quality and Safety Commitee** The Board ***noted*** the report.
31/01/14.0	**FREEDOM TO SPEAK UP (FTSU) UPDATE** BT presented the report and updated on where the Trust is with the Freedom to Speak Up arrangements. This has been an evolving process and the arrangements have been continually evaluated. The Board has previously been presented with the self-assessment and one of the outputs of this was the recommendation to recruit into a substantive role. Liz Hammond has been appointed into the post and BT is now looking to transfer some of the responsibilities with monitoring of the FTSU data to Liz from 1 February 2019. BT advised that following Hilary Pepler moving into her new role, the new Non Executive FTSU Lead would be David Gilburt to cover the gap until 31st March 2019 until a permanent arrangement is made but with continued support from Hilary Pepler in her role as Cultural Ambassador and also from Jan Greasley as an FTSU Champion.

	FC commented that a presentation to the Board would be good once Liz becomes established in her new role. **ACTION: FTSU Presentation to be added to the work plan for the future.** HT commented that there was no mention of local networks and BT confirmed that work is underway to look at this and Liz is keen to take this forward. DG asked for a meeting of the people who have FTSU as part of their role. He had not previously appreciated there was an app that could be used to raise issues. On looking at this it does not say where the message goes or who has access to it. HP advised that there has been a meeting to look at this and Liz is aware of the need to make improvements to the app and the staff's awareness of it. There is a plan for there to be some work with the departments and wards and Liz is going to a regional meeting to understand how other organisations have rolled this out. HP felt she could give assurance that the issues DG raised are being addressed The Board ***noted*** the update.
	PERFORMANCE AND GOVERNANCE
31/01/15.0	**CHAIR'S REPORT - AUDIT COMMITTEE** DG provided an update of the meeting held in January and highlighted the following: • There was good attendance • Both internal and external auditors demonstrated they were making good progress • There was one action outstanding on the counter fraud inspection action plan which is due to be completed by the end of March. The Board ***noted*** the Chair's Report.
31/01/16.0	**CHAIR'S REPORT – FINANCE PLANNING AND INVESTMENT COMMITTEE** CM provided an update on the meeting held in January in the absence of AF as the Chair of the committee. CM highlighted the following: • A significant part of the meeting was spent looking at the financial performance and the challenges • The committee looked at the emerging guidance and the plans for 2019/20 and how the Trust is working on the draft operational plan. DG added that the committee looked at the 18 week RTT performance and it was noteworthy that if the Trust's performance was monitored excluding spinal disorders the Trust would have achieved its target for each month of the year. FC agreed that the blended data can mask if there are certain specialities that may be slipping and need focus. The Board agreed that going forward the data should be reported to include and exclude spinal disorders. **ACTION: RTT data to be separated both including and excluding spinal disorders.** The Board ***noted*** the Chair's Report
31/01/17.0	**CORPORATE OBJECTIVES QUARTERLY REVIEW** KR asked the Board to note the progress against delivery of the corporate objectives for 2018/19. As requested KR had included a forecast RAG rating for the end of the year. It was noted that there were currently six objectives rated as amber with a risk to delivery but that there were mitigations in place. It was forecasted that the two following objectives would remain amber at year end: • Reducing rescheduled episodes

	• RTT FC commented on the forecast being a good addition. DG asked, with reference to the PROMS data collection and the creation of an electronic capture system, what assurance there was that the system is asking the right questions. KR advised the electronic system is taking the current paper process and making it electronic, it is being designed by the Outcomes Team, Paul Cool, Clinical Director for Surgery and a clinical scientist. The Board ***noted*** the report.
31/01/18.0	**PERFORMANCE REPORT** DK highlighted the change in the reports format to make the link between the report and Board committees stronger. Further she drew the Board's attention to the forward look to the end of year. *Caring for Patients* BT highlighted the following: • Performance against the quality indicators has been sustained • There was one serious incident for the month relating to an awareness under anaesthesia. There is an investigation team in place to carry out a full RCA. • Delayed discharges continue to perform poorly in relation to the targets, although there are some mitigating factors with regard to spinal injury patients and this has been deep dived by the operational team with different processes being looked at. • Medication errors were all low harm • There was one death which was not unexpected but will go through the learning from deaths process • There were four readmissions due to wound problems • 100% compliance with WHO process achieved HT asked about the serious incident data as throughout the year this has been reported as amber but the year-end rating is red. DK advised that this is linked to the agreed tolerance. MB added that DK is looking at this, whilst the Board has signed off the architecture there needs to be further debate on this. FC noted that with regard to the delayed discharges, the quantum of days had reduced but because it is a factor of available beds, it looks like it is worse than it is. He felt that this needed to be borne in mind. PK asked about safeguarding when a patient falls and subsequently dies. BT advised all issues such as falls, pressure ulcers etc are referred to the safeguarding team. NB highlighted the following: • Cancer performance targets met • There were four English patients waiting over 52 weeks – three ACI patients and one delay due to patient choice. There is a plan agreed with NHS I for the ACI patients. The laboratory production is back on track and patients have been dated to ensure delivery by the end of March. There are two breaches forecast for January 2019. There were seven breaches in relation to Welsh patients awaiting spinal disorder treatment. There are further breaches forecast in January and February but it is expected the target will be met at year end • RTT for December was 90% which was 1% below plan. With the exception of spinal disorders the Trust was delivering 92%. It is anticipated that the Trust will remain below plan in January but with improvements in the remainder of Q4 but

there is a risk to delivery by the end of Q4. The Finance Planning and Investment Committee have oversight on the service specific action plans aimed at delivering RTT with specific focus on spinal disorders and further strengthening of Patient Access Policy.

- Theatre activity performance exceeded the plan for December but is below plan for January by 70 cases. There is continued focus on theatre activity, particularly attached to the finance position. The team are currently looking at non activity financial mitigations

FC asked about the activity challenges. NJ advised that a number of sessions had been lost due to staff sickness and releasing staff on compassionate grounds but there is a focus on ensuring there are no further sessions lost going forward. FC asked if it is possible to get a view on February and NJ advised the Teams are working hard on filling the sessions. Currently there is a 30 case shortfall but steady progress is being made. DG asked if it was too early to think about March and NJ advised that the allocations are being refreshed to prioritisation in the right places and March is still being worked on.

CM advised that January is going to be a challenge and the daily oversight meetings have been reinstated to oversee the allocation of capacity. CM advised there will be a focus on looking at converting outpatient clinics to theatre activity where possible.

MB advised that there would a benefit to taking the Finance Planning and investment Committee through the waiting list sizes at a future date.

ACTION: Waiting list size agenda item to be added to the Finance Planning and Investment Committee for a future meeting.

CM advised that there is rebalancing to be undertaken of future job plans to ensure there is the right mix of outpatient and theatre allocation.

FC asked about support from the LLP and NJ advised there had been good engagement and DK reinforced that they are keen to help where they can.

Caring for Finances
CM highlighted the following:

- December was a good month and thanks were extended to the teams for their hard work. This supported a much stronger financial performance
- The Q3 trajectory was achieved for STF
- The year-end forecast is now the focus, January is anticipated to be a difficult month due to the shortfall in theatre activity.
- Mitigating schemes are in place albeit some are non-recurrent. These should help support financial performance to the end of the year to ensure hitting the year end control total. Each scheme has Executive support and they have been discussed at the Finance Planning and Investment Committee. The control total remains achievable but it will be a challenge.

MB commented that this year was the team's third year of trying to maintain performance over the Christmas period and the diligence of the operational planning, with the financial input, is clear to see. The same principles will now be applied to the other challenging times of the year such as Easter and the Summer Holidays.

FC asked about predicted loss in January and CM advised it is in the region of £400k pre-mitigations but there are opportunities to recover this.

DG asked about the support in place in Theatres given the recent bereavement. MB

	advised the Theatre Management Team have been providing support on an individual basis, there has been a lot of mutual support amongst the team. SS has ensured that there are counselling services available. SS advised there had been a low take up of the support offered as the staff are opting to support each other. PK asked about the research costs and CM advised there had been some issues getting the trials delivered, this has been managed through monthly recovery oversight with targets set and the performance against these targets has shown improvement. KR advised that there was an IG breach earlier in the year which had impacted but this was not the only impact. The processes have been streamlined and the governance improved and there is a recovery plan in place. The Board is due to receive a research update in March. PK offered his support with the Trust's research agenda given his background. *Caring for Staff* SS highlighted the following: • Sickness absence is being worked on by the Workforce Development Group. The focus is on transitioning from managing sickness absence to keeping staff well. In particular, looking at what it is like working at the Trust. There is still a focus on areas of high sickness and work is underway to look at other indicators to improve the work experience. • Staff turnover remains consistently low and significantly lower than other organisations • With regard to statutory and mandatory training, there have been issues with the national system which have not helped the Trust's training compliance. These have now been resolved. FC commented on the turnover data and asked if this could mask hotspots given that it is an overall statistic. SS confirmed that some areas have higher turnover than other but are still low relatively. HP stated that it is clear that workforce issues are moving up the agenda and she asked whether there could be a presentation to the Board on key workforce issues. SS suggested doing something in April when the staff survey is available. **ACTION: HR presentation for the Board to be added to the work plan for April** HT asked about the flu vaccine uptake and BT confirmed that it currently stands at 59%. The Trust has introduced opt out forms and completion of these was running at about 13%. This demonstrates that the Trust has engaged with staff. CB asked if it is known what staff sickness is related to flu and SS advised that it is a very small amount. MB added that the Trust has asked for support from NHSI to see if there is anything more that could be done that the Trust is not already doing. The Board ***noted*** the update
ITEMS TO NOTE	
31/01/19.0	**M8 PERFORMANCE REPORT** The Board ***noted*** the M8 performance report.
31/01/20.0	**STP UPDATE** MB presented the STP Update and highlighted the following: • MB is the lead CEO for the digital pathway • The commissioning improvement programme is underway but this is not an insignificant piece of work • The Board will have an opportunity to look at this in more detail at the next Strategy Board when integrated care will be explored in more detail.

	The Board was content that the update was self-explanatory and ***noted*** the update.
31/01/21.0	**QUALITY SURVEILLANCE OUTCOME LETTER** MB advised that this was presented for the Board to note that the Trust is currently on routine surveillance with bi monthly meetings. The Board noted the letter.
31/01/22.0	**GOVERNORS UPDATE** SR presented an update of the activities the Governors: • Governor workshop on Membership Engagement facilitated • Governor elections opened for Staff Governor and Powys Governor vacancy FC added that there are plans underway to hold a workshop for governors and NEDs on engagement and details of this will be circulated shortly. The Board ***noted*** the update.
31/01/23.0	**AOB** DG commented that the minutes of the last meeting mention a further back to the floor day. FC and MB confirmed that they are working on a date for this.
	DATE OF NEXT MEETING IN PUBLIC: Thursday 28 March at 11.00 in the Meeting Room 1.
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

31 JANUARY 2019

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
Actions from Last Meeting	**Lead Responsibility**	**Progress**
31/01/6.0 PATIENT STORY Refund for remote controls to be arranged and also review of the wifi arrangements	Trust Secretary/ Associate Director of IT	In progress, contact has been made with the patient regarding the refund and wifi arrangements under review
Update to be provided to the Board on the work on the cottages	Director of Finance	Verbal update to be provided
31/01/8.0 LONG TERM PLAN Agenda item for 28 February and 28 March	Trust Secretary / Director of Strategy and Planning	Completed
Update on the outpatient service redesign workshop to be presented to the Board in April.	Director of Operations	Added to the agenda
31/01/13.0 INFECTION CONTROL QUARTERLY REPORT Further analysis to be undertaken and taken through the Quality and Safety Committee	Director of Nursing	To be included in the next quarterly report due next month
31/01/14.0 FREEDOM TO SPEAK UP FTSU Presentation to be added to the work plan for the future.	Director of Nursing	Added to the work plan
31/01/16.0 CHAIR'S REPORT – FINANCE PLANNING AND INVESTMENT COMMITTEE RTT data to be separated both including and excluding spinal disorders	Director of Operations	Completed
31/01/18.0 PERFORMANCE REPORT Waiting list size agenda item to be added to the Finance Planning and Investment Committee for a future meeting.	Director of Operations / Trust Secretary	Added to the work plan
HR presentation for the Board to be added to the work plan for April	Director of People / Trust Secretary	Added to the agenda

NHS

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Aspiring to deliver world class patient care

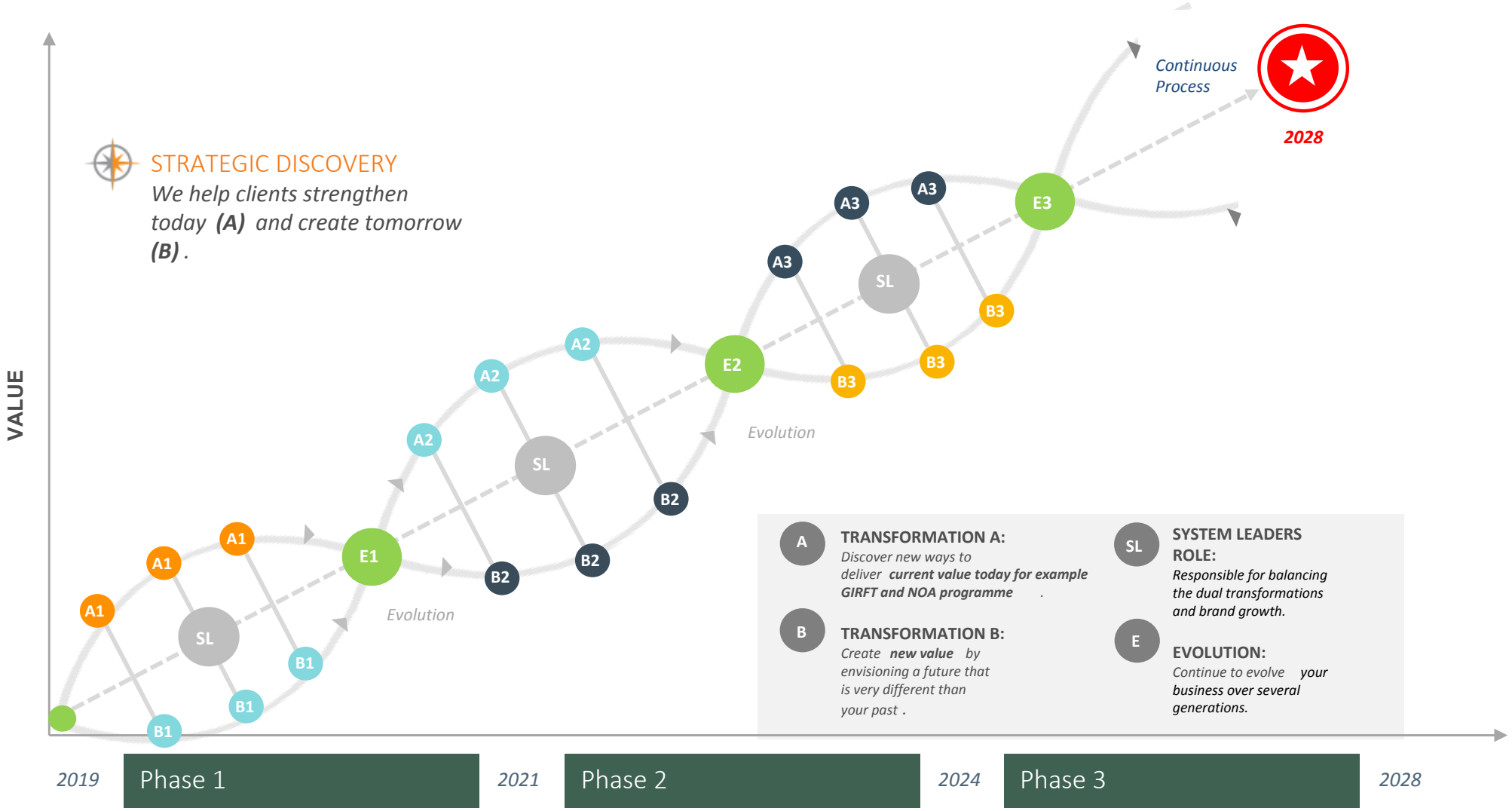
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Strategy session follow up;

Delivering on the promise of integrated care systems

Strategic Context

The ICS journey; dual transformation journey



Aspiring to deliver world class patient care

Themes emerging from our discussions;

- Population health
- Digital integration
- The role of RJAH in the emerging ICS

Health Check Domains

Suggested initial areas of focus for RJAH;

- Professional Practice
- Care coordination
- Health Information

Annual Objectives 2019/20

0. Reference Information

Author:	Kerry Robinson	Paper date:	28th March 2010
Executive Sponsor:	Mark Brandreth	Paper Category:	Strategy
Paper Reviewed by:	Q&S and FPI	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The board of directors is asked to approve in principle the 2019/20 annual objectives.

2. Executive Summary

2.1. Context

This paper outlines the proposed annual objectives for 2019/20.

2.2. Summary

The annual objectives are a fundamental element in the delivery of our organisational strategy and enabling the executives and divisions to align their proposed programme of activity for the coming financial year to the Trust's ambitions.

The six corporate objectives, whilst reviewed annually, will remain relatively consistent and represent a half-way house between strategic and annual planning.

The six corporate objectives are provided, with no amendments and the proposed cascade to the annual executive objectives which will then be fed into divisional and our workforces' objectives.

Monitoring of the objectives is through both a quarterly update to Board, together with the alignment of our key performance indicators within the integrated performance report, which is reported to board monthly. Assurance is managed through the board assurance framework.

2.3. Conclusion

The board of directors is asked to approve in principle our 2019/20 annual objectives. This will enable further work up of the definitions and measures before finalisation in April.

3. The Main Report

3.1. Introduction

The annual objectives are a fundamental element in the delivery of our organisational strategy and enabling the executives and divisions to align their proposed programme of activity for the coming financial year to the Trust's ambitions.

The six corporate objectives, whilst reviewed annually, will remain relatively consistent and represent a half-way house between strategic and annual planning.

Monitoring of the objectives is through both a quarterly update to Board, together with the alignment of our key performance indicators within the integrated performance report, which is reported to board monthly. Assurance is managed through the board assurance framework.

3.2. Corporate Objectives

Our agreed aim is; "Aspiring to deliver world class patient care"; on this basis our corporate objectives supported the delivery of this aim.

Our current corporate objectives are;

- Achieving outstanding patient safety
- Delivering outstanding outcomes and experience
- Delivering timely access to patient care
- Being an extraordinary place to work
- Spending our money wisely
- Meeting the requirements of our regulators

3.3. 2019/20 Annual Objectives

The circumstances of the Trust have changed within the last 12 months, with the Trust moving from 'requires improvement' to 'good' in its CQC rating, hence the 2019/20 annual objectives look to reflect this change in circumstance and move much more towards objectives that will fulfil our ambition of 'aspiring to deliver world class patient care' and therefore move to being much more strategic in focus, with the underlying supporting operational objectives being cascaded more clearly to Divisions and directorates.

Hence, a proposed format aligned with the Board Assurance Framework, enabling the Board to have visibility of the programmes of work and supporting actions to deliver the objective, together with the measurements from the Integrated Performance Report that should be utilised to review improvement and progress with delivery of those objectives. The proposed format encompasses the quarterly update to Board.

Annual Objectives 2019/20

Caring for Patients 1.1

Achieving Outstanding Patient Safety

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

This objective will see the bringing together of all the national data sources e.g GIRFT, Model Hospital, Right Care along with internally generated information to reduce unwarranted variation by benchmarking against national and peer best practice and clinical evidence

GIRFT has highlighted the unwarranted variation that exists within sub specialities including unnecessary procedures. GIRFT also makes us aware of where this affects clinical outcomes and patient experience and this will be a focus of improvement throughout 19/20. The Right Care Programme provides data on excessive interventions. For a population there is a ceiling to the benefits of procedures beyond which harms will accumulate without any further improvement in population health. The Model Hospital also provides useful data.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details

Opened: April 2019

Reviewed Date:

Measurements of improvement:

- Quality KPIs relating to harm (Integrated Performance Report)
- Standardised protocols and pathways in place
- Robust governance to address variation without impacting on innovative practice
- Management of deteriorating patients
- PROMS
- NJR
- Implementation of GIRFT recommendations

Supporting programmes of work:

- GIRFT action plan
- Pilot of referral acceptance in spinal disorders
- Outpatients protocols
- Booking and scheduling review
- Model Hospital

Action plan to reduce unwarranted variation

Action	Division / Dept Lead	Due By	Progress Update	Completed

Lead Director:

Director of Nursing & Medical Director

Lead Committee

Quality and Safety Committee

Annual Objectives 2019/20

Caring for Patients 1.2

Delivering outstanding outcomes and experience

Principal Objective: Increased focus on MSK population health

As a long term objective, 2019/20 is concentrated upon moving the organisation and local health system to transition from volume based to value based, reactive to proactive and illness to health and wellness focus. This will be through the lens of population health looking to use health data to drive our actions both clinically and functionally supporting integrated pathways, looking to introduce the concept of risk stratification and management of population by sharing and exchanging of data within and between our system to future proof integration patterns.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details

Opened: April 2019

Reviewed Date:

Measurements of improvement:

- Define what population health means for RJAH in the context of STP.
- Agreed STP vision for MSK services.
- MSK Joint Strategic Needs Assessment in place for STP.
- Reduced duplication of MSK services across STP.
- % PROMS across whole MSK pathway.
- Define what value v's volume basis is.
- Commencement of wellness initiative.
- Right Care variation reduction.
- GIRFT / NJR
- NOA deep dives
- Model Hospital Development of potential incentives for population health focus.
- Define specific MSK MDT and care pathway arrangements.
- Agreed patient engagement process established.

Supporting programmes of work:

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

Action plan to increase focus on MSK population health

Action	Division / Dept Lead	Due By	Progress Update	Completed

Lead Director:

Director of Performance, Improvement & OD

Lead Committee

Finance, Planning & Digital Committee

Annual Objectives 2019/20

Caring for Patients 1.3

Delivering timely access to patient care

Principal Objective: Improving systems and processes for best care

It is recognised that robust systems and processes are required in order to deliver the best care for our patients. This will ensure that patients are able to access the right care at the time it is needed . Delivery of this objective will see not only efficient use of resources but improved patient experience and care.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details

Opened: April 2019

Reviewed Date:

Measurements of improvement:

- 18 weeks RTT open pathways
- Patients waiting over 52 weeks
- Diagnostic wait times
- Bed occupancy
- DNA rates
- CQC Inpatient survey results
- Delayed transfers of care
- OJP working arrangement in measurements
- IJP measurements
- E-rostering measurements in place

Supporting programmes of work:

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

Action plan to improve systems and processes for best care

Action	Division / Dept Lead	Due By	Progress Update	Completed

Lead Director:

Director of Operations

Lead Committee

Finance Planning and Digital Committee

Annual Objectives 2019/20

Caring for Staff 1.4

Being an extraordinary place to work

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

The Trust recognises the importance of creating an organisation and culture where our staff can flourish in order to deliver the best possible patient care. We recognise that whilst our staff survey results compare extremely favourably with our comparators there remains much that can be done to improve our staff experience and environment. This objective will provide focus on the People Agenda and be developed and measured via the People Committee.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details

Opened: April 2019

Reviewed Date:

Measurements of improvement:

- Sickness absence
- Voluntary staff turnover
- Staff friends & family
- NHS staff survey
- Proportion of temporary staff
- Agency usage
- No. of staff entering formal disciplinary process
- No. of grievances raised
- No. of employment tribunals
- Reduction in People Processes and procedures

Supporting programmes of work:

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

Action plan to provide an environment for our workforce to 'flourish at work'

Action	Division / Dept Lead	Due By	Progress Update	Completed

Lead Director:

Director of People / Director of Improvement, OD and Performance

Lead Committee

People Committee

Annual Objectives 2019/20

Caring for Finances 1.5

Spending our money wisely

Principal Objective: Implement our clinically led infrastructure and meeting architecture

The organisation will be implementing a new structure during 2019/20 to increase the clinical involvement in the leadership and management of the Trust. This will include a review and rationalisation of organisational meetings to ensure they are effective and fit for purpose.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details

Opened: April 2019

Reviewed Date:

Measurements of improvement;

- No. of meetings
- No. of participants
- Length of time
- Appropriateness of each participant / clinical balance of meetings
- Performance assurance
- Cost of meetings
- Qualitative assessment of all regular meetings

Supporting programmes of work

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

Action Plan to implement our clinically led infrastructure and meeting architecture

Action	Division / Dept Lead	Due By	Progress Update	Completed

Lead Director:

Director of People / Associate Director of Governance

Lead Committee

People Committee

Annual Objectives 2019/20

Caring for Finances 1.6

Spending our money wisely

Principal Objective: Achieve a Finance and Use of Resources score as monitored by our Regulator under the Single Oversight Framework (SOF) of at least a 2 and seek to improve the underlying measures

The monthly finance score is calculated by scoring providers on a scale of 1 (best) to 4 against the following five metrics, and averaging these scores to derive an overall figure:

- capital service capacity
- liquidity
- income and expenditure margin
- distance from financial plan
- agency spend.

A provider's overall figure may be moderated down if it scores 4 on any individual finance metric, has not agreed a control total or is in special measures for financial reasons.

Objective Delivery / Forecast: To align to final plan submission

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details

Opened: April 2019

Reviewed Date:

Measurements of improvement:

- Control total trajectory
- Agency spend against control total
- Cash balances
- Delivery of agreed capital programme

Supporting programmes of work:

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

Action plan to maintain our UoR score and seek to improve the underlying measures

Action	Division / Dept Lead	Due By	Progress Update	Completed

Risk Owner:

Director of Finance and Planning

Lead Committee

Finance Planning and Digital Committee

3.3. Next Steps

The Board of Directors is asked to:

- Agree and approve the 2019/20 annual objectives.

Following approval of these objectives our Board Assurance Framework will be produced to align to these proposed objectives and our integrated performance report key performance indicators for 2019/20 will be realigned to our agreed objectives, for sub-committee cascade.

Appendix 1: Acronyms

NHSI	NHS Improvement
GIRFT	Get It Right First Time
CQC	Care Quality Commission
MSK	Musculoskeletal
SOF	Single Oversight Framework
HTA	Human Tissue Authority
PROMS	Patient Reported Outcome Measures
Q&S	Quality & Safety Committee
FPI	Finance, Planning and Investment Committee

0. Reference Information

Author:	Debbie Kadum Associate Director of Performance	Paper date:	26/03/2019
Executive Sponsor:	Mark Brandreth CEO	Paper Category:	Performance
Paper Reviewed by:	Finance, Performance and Investment	Paper Ref:	
Forum submitted to:		Paper FOIA Status:	Full

1. Purpose of Paper

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

There is a requirement to review the Performance Management Strategy and Framework annually.

2. Executive Summary

2.1. Context

The Trust Board is responsible for setting the strategic direction of the Trust. It has responsibility for monitoring performance against the agreed direction, and for ensuring that corrective action is taken where necessary when performance falls below expectations.

The fundamental purpose of this Strategy and Framework is to ensure delivery of the Trust's vision, strategic and corporate objectives whilst instilling a culture of continuous improvement to achieve its aspiration of delivering world class patient care.

2.2. Summary

- The core principles of the Strategy and Framework remain the same
- Roles and responsibilities have been more clearly defined to strengthen the accountability section.
- The link between a drive for continuous improvement and performance measurement has been articulated.
- A section on anticipated outcomes has been added.
- The role of the Board Committees in managing performance is highlighted.
- The need for robust data quality systems and processes is included.

2.3. Conclusion

The Board is asked to approve the refreshed Performance Management Strategy and Framework for 2019/20.

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Performance Management Strategy and Accountability Framework		
Unique Identifier:	SGY022	**Document Type:**	Strategy
Version Number:	5.0	**Status:**	For Approval
Responsible Director:	Director of Improvement, Organisational Development and Performance		
Author:	Interim Associate Director of Performance		
Scope:	Trust wide		
Replaces:	Version 4.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Trust Strategy, Board Assurance Framework, Risk Management Policy, Performance Review Terms of Reference		
Keywords:	performance, divisional management, clinical management, balanced scorecard, integrated performance report		

Considered By Executive Owner:	Chief Executive Officer	**Date Considered:**	14th March 2019
Endorsed By:	Finance, Performance and Investment Committee	**Date Endorsed:**	26th March 2019
Approved By:	Trust Board	**Date Approved:**	29th March 2019
Issue Date:	29th March 2019	**Review Date:**	1st April 2020
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

1. Introduction

A devolved accountability structure managed through a performance framework is in place at the Trust supported by a clinical leadership model and the Trust aspires to develop this model further over coming years. The underlying principles of this framework are to ensure that delivery of the Trust's strategy and corporate objectives are managed in a systematic way from 'Board to Ward'.

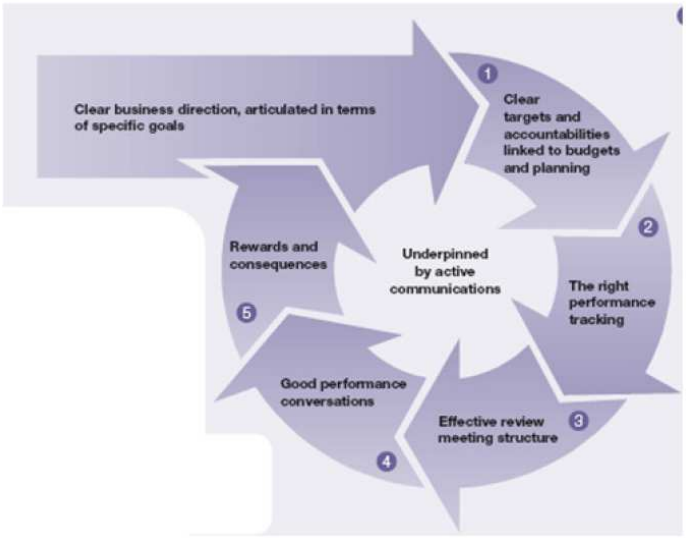
The framework supports the Trust's drive for continuous improvement towards our aspiration to deliver world class patient care.

The Board assesses the performance of the Trust on a monthly basis via the Integrated Performance Report (IPR) which includes balanced scorecards, narratives and heat maps for our three domains; Caring for Patients, Staff and Finances. A narrative is provided for all indicators with additional focus on actions required to improve performance on indicators that are either red or amber rated. Prior to the IPR being presented to Trust Board, performance indicators are reviewed by a committee of the Board to allow for more detailed scrutiny where required. A separate report on the delivery of corporate objectives is presented to the Board quarterly and measures within the IPR are also aligned to these objectives. The key performance indicators presented to Board are aligned with the NHSI Single Oversight Framework. The data included in the IPR is underpinned by a robust rolling data quality programme which is overseen by the Audit Committee.

This performance strategy supports and links with the strategy 'golden thread' and other key processes/strategies in the organisation such as the Board Assurance Framework, risk management processes, quality account production and the Board quarterly self-certification as a Foundation Trust.

2. Performance Management Principles

High performing performance management describes performance improvement in five steps:



The spectrum of performance stretches from underperforming or failing performance at one extreme, to excellent or world class performance at the other, and is illustrated below.

The Performance Spectrum

Breach of registration requirements and/or authorisation	Non-compliance with selected improvement standards or failure to meet improvement targets	Compliance with criteria, adoption of improvement standards and performance against national and local targets	Exceeding national targets, benchmarking and continued improvement
Failing	**Underperforming**	**Average to good**	**World-class**

(the spectrum of performance must be measured in terms of metrics, targets and standards)

3. Performance Accountability Framework

The framework consists of two stages:

- Planning phase – where objectives and performance measures are agreed via the Board and its committees annually and following review can be refreshed in year.
- Reporting and Review – the performance management process that supports the delivery of objectives through 'Board to Ward' reporting.

3.1 The Planning Phase

The planning process comprises two elements; strategic planning and annual planning.

Strategic Planning
The purpose of the strategic planning process is to:

- Develop and agree the Trust's mission, vision and strategic priorities
- Refresh the enabling strategies and set strategic objectives that will enable the Trust to achieve its vision

The Trust refreshed its strategy in 2018 and this covers the years 2018-2023. The overarching strategy 'golden thread' includes:

- **Our mission**: *'Caring for Patients, Caring for Staff, Caring for Finances'*
- **Our vision**: *'aspiring to deliver world class patient care'*
- **Our strategic priorities and enabling strategies**: *'Operational Excellence, Local Musculoskeletal Services, Specialist Work underpinned by Culture and Leadership'*
- **Corporate objectives** (delivered through annual objectives), **values** and **cultural characteristics**

Annual Planning

The purpose of the annual planning process is to:

- Develop an annual operating plan in line with the Trust's overall strategic direction and NHSI's detailed planning requirements. The latest plan formally submitted to NHSI covered the one year period 2019-2020.
- Agree the annual objectives to support delivery of corporate objectives including the responsible directors and key performance measures. The Trust's corporate objectives are:
    - Achieving outstanding patient safety

- Delivering outstanding outcomes and experience
- Delivering timely access to patient care
- Being an extraordinary place to work
- Spending our money wisely
- Meeting the requirements of our regulators

- Ensure the required outcomes key to delivery of the above can be measured by key performance indicators (KPIs).

- State the risks to the Trust should an outcome not be delivered (through the Board Assurance Framework).

- Link the KPI's to the annual Improvement Plan (currently Operational Excellence)

- The plan will be approved by the Trust Board as per the NHSI submission timetable.

3.2 Reporting and Review

3.2.1 Reporting

The Board assesses the performance of the Trust ten times a year at its Board meeting via the IPR which includes balanced scorecards, narratives and heat maps for the three domains of the vision as follows:

- Caring for patients
- Caring for staff
- Caring for finances

Performance information will be provided for the following periods:

- Monthly
- Year to date (from 2019/20)
- Year end forecast (from 2019/20)

The narrative provided for each indicator includes additional focus on actions required to improve performance on indicators that are either red or amber rated. Supporting graphical information to provide trend analysis, forecasts, benchmarking data, trajectories for improvement and statistical process control limits are in place where appropriate.

The balanced scorecard is also produced at the following levels in addition to Board level:

- Divisional level (reviewed at Divisional Performance Reviews)
- Department/Ward level (some specifics reviewed at Divisional Performance Reviews)

The annual corporate objectives, approved by the Board as part of the annual plan review, partly form the basis of the scorecard targets for the coming year. Additionally key regulatory targets aligned with the NHSI Single Oversight Framework and contractual requirements are also included.

The responsible Board committee for each indicator will approve targets and appropriate tolerances that will drive the exception reporting process for the year. Any exception reported will include an understanding of the cause of the variation and the action plan to rectify the performance. Indicators will be allocated to committees as follows:

- Caring for Patients – Quality and Safety Committee (with the exception of RTT targets as these are allocated to Finance Planning and Investment Committee)
- Caring for Staff – People Committee, Equality & Diversity Steering Group.
- Caring for Finances – Finance, Investment and Digital Committee

3.2.2 Performance Review

Performance is reviewed under the following framework (this is detailed further in Appendix 1):

- At each Trust Board ten times a year through the IPR aligned to the relevant Board Committee.

- All indicators included in the IPR are reviewed by a committee of the Board and action plans agreed for those indicators that have been red for three months or more.

- In addition to the above, the Board may request that an appropriate committee carries out 'deep dives' into certain performance indicators to ensure an appropriate level of granular review is carried out.

- Performance is also monitored through the Executive team meeting on a weekly basis focussing on key delivery metrics such as any serious incidents, infection control, activity, financial performance and waiting times.

- A monthly operational performance review is held with each clinical division monthly and corporate division annually. The review is chaired by the Director of Performance, Improvement and Organisational Development and includes Divisional Managers, Clinical Directors, Senior Nurses and Corporate Leads. The reviews will focus on divisional scorecard exception reporting, performance against corporate annual objectives and strategic work streams. Actions will be agreed to rectify areas performing below target and divisions will be held to account for delivery of these actions. Those clinical divisions demonstrating strong performance may be de-escalated to bi-monthly performance reviews as per the terms of reference for this meeting.

- NHSI mandate regular Executive performance review meetings to assess performance against the five domains of the Single Oversight Framework and determine the segmentation of the Trust as follows:

    - Quality of care (safe, effective, caring, responsive)
    - Finance and use of resources
    - Operational performance
    - Strategic change
    - Leadership and improvement capability (well-led)

- The Trust has an ambition to be rated in Segment 1 of this framework which is the highest possible rating.

- Delivery of the Trust's strategy is assessed through monthly Executive Strategy meetings and quarterly strategy board meetings and key project updates may also be requested through divisional performance reviews.

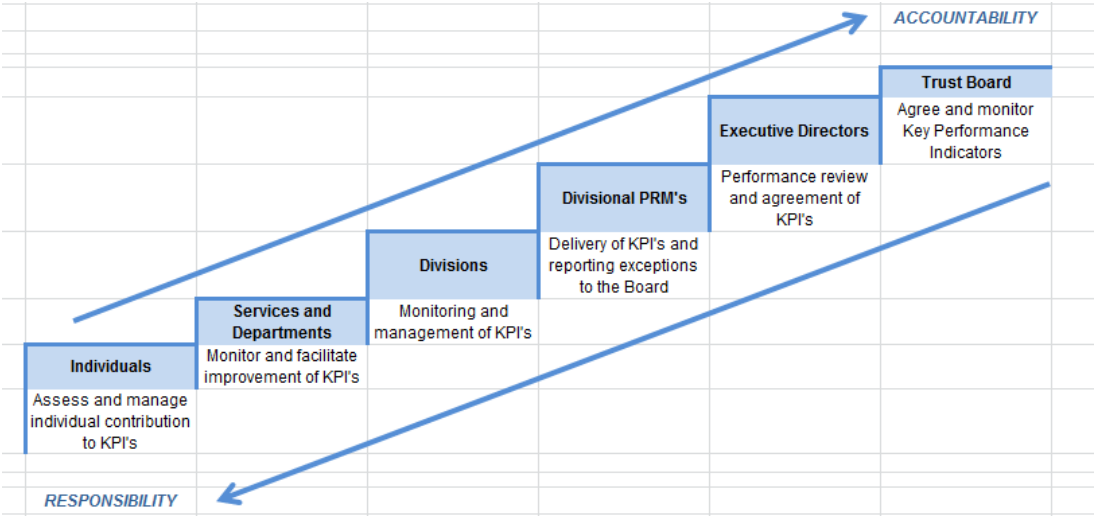
3.3 Data Quality

The performance and reporting framework supports the decision making processes of the Trust Board and the organisation. It is therefore critical that the Board can take assurance that the information reported is robust. Internally the Trust has developed a robust rolling programme of data quality audits for all of the metrics reported through this performance framework. This programme is overseen by the Audit Committee. Where appropriate the Board may require independent assurance on the data quality of key metrics. A data quality rating for each indicator is visible in the IPR for each indicator.

4. Responsibilities and Accountabilities for Performance Management

Whilst it is everyone's role to manage performance, the Board should drive a culture of performance by providing a clear strategic vision and annual objectives and by holding the Executive Team to account for delivery.

To deliver the performance framework a stepped approach to performance management is required which clearly specifies roles and responsibilities. It is essential that key targets, programmes, projects and actions are disaggregated throughout the Trust and hierarchy to ensure delivery of targets at every level and across the organisation as a whole; to understand what is expected of them and the part they play in the overall success of the Trust.



4.1 Chief Executive

The Chief Executive has overall statutory responsibility for performance management and has delegated responsibility for the leadership, development and delivery of the Performance Management Strategy and Framework to the Director of Performance, Improvement and Organisational Development.

4.2 Director of Performance, Improvement and Organisational Development

Has delegated responsibility for the leadership, development and delivery of the Performance Management Framework from 'Board to Ward including':

- A comprehensive integrated performance improvement regime with governance arrangements that ensure all national and local targets are monitored, reported, managed and resolved by the responsible Director.
- The provision of high quality business intelligence to inform and enhance the decision making availability of staff at all levels through the organisation.
- Setting comprehensive KPIs and targets to enable monitoring of the delivery of external and local requirements.
- Developing robust processes that enable the Trust to provide assurance on delivery of targets to regulators and other key stakeholders.
- Highlighting areas of both excellent and off-plan performance to the Board and its committees and ensuring plans are developed to improve performance where required by the responsible Director.

4.3 Directors

Responsible for ensuring services are delivered in line with commissioning requirements and meet the required safety and quality standards, financial targets and regulatory requirements.

Drive professional and managerial accountability in delivering key performance indicators and promoting leadership across the Trust to deliver the performance agenda.

Executive Director responsibilies include ensuring:

- That the Performance Management Strategy and Accountability Framework is implemented within their own sphere of responsibility;
- That managers and staff co-operate in applying the Strategy throughout their Division or Department;
- That steps are taken to secure resources for the implementation of associated controls following risk assessment;
- That targets for KPI's are agreed, communicated and delivered;
- That governance arragenments to underpin the Performance Management Strategy and Accountability Framework are in place.

4.4 Divisions

Each Division has a responsibility to act upon data quality reports produced by the Information Department.

Each Division will have its own Board and IPR, which reflects the content of the Trust's IPR Board report with the addition of the Division's own KPI's within it.

Divisional Managers, Clinical Directors and Performance Managers are responsible for:

- Ensuring services within their remit perform to the required standards/targets and maximise their potential;
- Acknowledging and rewarding excellent performance;
- Analysing service performance on a minimum weekly basis, establishing variances, trends, discrepancies or gaps;
- Scutinising the root cause of variances, trends, discrepancies or gaps and acting upon this to eliminate continued issues by developing action plans to recover;
- Escalating to the Executive Management Team via the Divisional Performance Review Meeting, areas of significant risk or opportunity.

4.5 Individual Staff Member

Individual staff members are responsible for:

- A commitment to deliver excellent service performance;
- Recording all information whether service user, finance, quality or workforce related in an accurate, complete and timely manner;
- Reviewing the data completed and highlighting to their manager any difference, gaps or trends with the information;
- Taking corrective action where necessary in order to achieve the required performance levels.

5.0 Improving Performance and Sharing Best Practice

Service Improvement whether Trust wide or operational within Divisions, individual services or departments will underpin all discussions and activity at RJAH.

If the organisation is to be successful in it's aspiration to deliver world class patient care it must continually strive to improve all aspects of performance across the domains of Caring for Patients, Staff and Finances.

The identification and sharing of best practice information, including benchmarking will support this drive for continuous improvement.

6.0 Key Outcomes expected from the delivery of the Performance Management Strategy and Accountability Framework

- All staff employed by the Trust will have a clear understanding of the value of managing performance supporting a culture and belief that achieving excellent performance is important;
- The Trust's Strategy and Corporate objectives are managed in a systematic way from "Board to Ward";
- All employees will have a demonstratable appreciation as to how their work contributes towards delivery of all of the Trust's priorities;
- Integrated performance management frameworks will be in place at all levels of the organisation;
- There will be integrated and timely reporting with high quality commentary for performance reviews;
- Data Quality will be taken seriously with good arrangements in place at all levels;
- Assurance rather than reassurance can be given.

7.0 Summary

The Performance Management Strategy and Framework (PMF) will support RJAH in achieving its vision and provide the Board with assurance against major work programmes, business objectives and key national and local targets. The PMF sets out a robust process for reviewing performance at Board level and Executive level and a process for early identification and escalation of performance issues in Divisions and Departments.

It is therefore incumbent upon all staff members to contribute to the measurement of performance, whether this is on an individual service user care pathway or at a strategic level in order to deliver the Trust's vision.

However, performance management is a dynamic process which needs to be actively managed to be effective. This framework will require proactive management and development if it is to grow in value to the Trust.

8.0 Review and Updating of the Strategy and Performance Management Framework

The Performance Management Strategy and Framework will be reviewed on an annual basis by the Director of Improvement, Organisational Development and Performance and any changes will be submitted to the relevant forum for endorsement, prior to the ratification by the Trust Board.

Appendix 1 – Meetings and governance

Meeting	Frequency	Who	Report
Board of Directors	Monthly	Chair - Chairman Trust Board	Trust level Integrated Performance Report Annual objective review (quarterly) Committees to review all KPIs prior to Board meeting and present a performance overview through the Chair's report
Executive Team	Monthly	Chair – CEO Executive Team	Trust level Integrated Performance Report
Executive Team	Weekly	Chair – CEO Executive Team	Key performance indicators e.g. serious incidents, infection control, waiting times targets, activity and financial performance
Divisional Performance Reviews	Monthly	Chair – Director of Improvement, Organisational Development and Performance Executive Team, Clinical Directors, Divisional Leads, Senior Nursing Team and Corporate Leads	Performance against corporate objectives, strategic updates, divisional scorecard exception reporting, financial performance, key risks, action plans and update of participation in organisational development programmes
Divisional Board Meetings	Monthly	Chair - Divisional Manager/Clinical Director Clinical Leads, Divisional Senior Team, Ward/Department Leads and Corporate Leads	Key Performance metrics for divisions/departments/wards
NHSI Performance Review Meetings	Monthly	Chair – NHSI Relationship Manager Executive Team and NHSI relationship team	Five domains of the Single Oversight Framework to determine the segmentation of the Trust

Appendix 2 – Record of Amendments

Record of Amendments to: Performance Management Strategy and Accountability Framework. V4.				
Amendments approved by: Chief Executive / Trust Board				**Date**
Section number	**Amendment**	**Deletion**	**Addition**	**Reason**

Chair's Assurance Report
Risk Management Committee – 6th March 2019

0. Reference Information

Author	Shelley Ramtuhul, Trust Secretary	Paper date	28th March 2019
Executive Sponsor	Harry Turner, Non-Executive Director	Paper Category	Governance and Quality
Paper Reviewed by	N/A	Paper Ref	N/A
Forum submitted to	Board of Directors	Paper FOIA Status	Full

1. Purpose of Paper

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

This paper presents an overview of the Risk Management Committee Meeting held on 6th March 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 was quorate.
- There was good progress of actions from the previous meeting
- The Board Assurance Framework (BAF) was presented with the progress against addressing the gaps in controls and assurances noted.
- The committee was assured regarding the management of the Research, Theatre, Surgery and Diagnostics divisions.
- The Risk Management Report provided assurance regarding the Trust's risk and incident management.
- An in-depth report was presented on the a recent RIDDOR incident
- 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.

Chair's Assurance Report
Risk Management Committee – 6th March 2019

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 6th March 2019. The meeting was quorate with two Non-Executive Directors and five Executive Directors in attendance. A full list of the attendance is outlined below.

Chair/ Attendance:	
Membership	
Harry Turner	Non-Executive Director
Chris Beacock	Non-Executive Director
Kerry Robinson	Director of Strategy and Planning
Bev Tabernacle	Director of Nursing
Mark Brandreth	Chief Executive Officer
Nia Jones	Director of Operations
Craig Macbeth	Director of Finance
In Attendance	
Shelley Ramtuhul	Trust Secretary
Paula Jeffreson	Deputy Director of Operations
Mark Lowe	Lead Performance Manager
Connor Hodgetts	Superintendent
Alison Harper	Governance Lead for Diagnostics
Sara Ellis Anderson	Matron for Diagnostics
Jo Wales	Deputy Research Manager
Julie Roberts	Assistant Director of Nursing and Governance
Rob Freeman	Medical Representation
Leighann Sharp	Matron for Theatre
Amanda Peet	Divisional Manager for Theatre
Judith Samson	Governance Lead for Theatre
Ian Gingall	Health and Safety Officer
Mary Bardsley	Assistant Trust Secretary
Apologies:	
Sarah Sheppard	Director of People
Kirsty Evans	Matron for Surgery

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting had all been completed.

Chair's Assurance Report
Risk Management Committee – 6th March 2019

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. Declaration of Interest		
There were no announcements regarding declarations of interest.	N/A	
2. Research Deep Dive		
The committee received the first deep dive from the Research department for review and challenge. The committee were informed that the department have recently been revising all policies and procedures and therefore identifying risks for the register. It was confirmed the Research Committee will report directly to the Quality and Safety Committee. The department have been allocated a Governance Lead who will be supporting the team with DATIX and recording of risks. The committee agreed partial assurance could be given on the process of the Research risk register.	Partial	It was recognised that the work was underway to capture the Research Department's risks and that this would be brought back to the committee
3. Surgery Deep Dive		
The committee received the Surgery Deep Dive for discussion. The following key points were highlighted: • 20 risks have been re-registered • 1 risk has increased • A total of 13 risks have decreased • A total 46 risks have been closed • There are currently two high risk recorded The committee discussed the two high risks which were 1455 safer staffing levels impacted due to nursing vacancies and 1876 spinal disorders consultant capacity. The committee were assured with the process in place to challenge the risk register. It was suggested the divisions incorporate the top risk into the performance review meetings presentation which will allow the Executive Team to challenge the risks from an operational perspective.	Y	
4. Theatre Deep Dive		
The committee received the Theatre Deep Dive for discussion. The following key points were highlighted: • 47 treated risks are recorded with 3 overdue for review • A total of 83 tolerated risks • 12 new risks have been recorded	Y	

• A total of 54 risks have been closed • There has been 1 increased risk. 792 - Damage to sterile wrap causes contamination of surgical instruments. • One risk has decreased. 1848 – O-Arm Trial From discussion regarding the risk tracker, it was noted there are a number of risk recorded which have remained static for 12months. The committee discussed the process of overarching risks which have been highlighted as overdue. The risks have been escalated within the division for further discussion and incorporated into the next Operational Board Meeting. Going forward overarching risks will be presenting into deep dives for all areas affected. Overall the committee were assured with the process in place to challenge and review the division's risks.		
5. Diagnostics Deep Dive		
The committee received the Diagnostics Deep Dive for discussion. The following key points were highlighted: • 35 treated risks of which 6 are overdue review • 11 new risks • 7 risks have been closed • 7 risk have been increased following a review • The highest risk score recorded is 15 – Risk 1658 Orthotics Department Environment Clinic room at The Royal Shrewsbury Hospital • A total of 8 old risks which have been re-registered • A total of 50 tolerated risks of which 5 are overdue review The committee discussed risk 1658 in detail. The Trust has not received a response from The Royal Shrewsbury Hospital regarding the risk. The committee were informed that the lack of space within the environment would require to be escalated. MB encouraged the team to look for alternative accommodation if the current is impacting on our patient service. A Health and Safety inspection is due to be completed on the accommodation including infection control. The process of which the risks are challenged and reviewed was discussed which provided assurance to the committee.	Y	
6. Board Assurance Framework and EU Exit Deep Dive		
The committee received and reviewed the Board Assurance Framework. It was noted there had been a change to the register; risk 1.4 relating to failure to improved performance in relation to the CQC core standards. The Trust has recently		

received its inspection report which demonstrated an improved rating. In addition, updates have been made to the actions to address identified gaps within controls and assurances. As the new financial year approaches the Trust will revise the Strategic Objectives in line with upcoming priorities and external factors. The updated Board Assurance Framework will be presented and discussed at the Board of Director Meeting. The committee **noted** the Board Assurance Framework. ***EU Exit Deep Dive*** The committee discussed the EU Exit deep dive. Following discussions the committee were assured with the process in place to monitor and highlight potential risks the Trust is currently facing with regards to the EU Exit. The members of the committee were informed that the Procurement team continue to monitor the suppliers on behalf of the Trust. The committee discussed the workforce application process including the EU national work force, reciprocal healthcare agreements and information systems. The committee can be assured the Trust are sighted on the risks and process in place to mitigate.	Y	
7. Corporate Risk Register		
The committee received the Corporate Risk Register as at 28th February which outlines the changes made since the previous meeting. There are a total of 16 risks recorded, with the majority being in Medicine and Rehabilitation department. A total of 5 risks have been increased: • 1455 – Safer Staffing Level impacted due to nursing vacancies • 1656 – RSH Orthotics Department – Environment • 650 – Patients planned read admissions date for urological procedure over • 1964 – Demand for Beds exceed capacity available • 1884 – Falsified medicines directive A total of 2 risks have been closed and removed: • 1746 and 1747 – Admissions and Appointments Staffing levels Following a review of the risk tracker, it was noted 5 of the 16 risks have remained static over the past 12 months. Overall the committee were assured with the process of challenging the corporate risk register and no risks were escalated.	Y	

Chair's Assurance Report
Risk Management Committee – 6th March 2019

The committee **noted** the corporate risk register.		
8. Risk Management Report		
The committee received the Risk Management Report which documents the Trusts current position in relation to reported incidents and risks and discussed the following: • Incident Backlog • Serious Incidents • Total of Risks • Benchmarking Date • NHS Staff Survey • Safety Champions • Top Categories • Live Risks The committee commented on the informative report and agreed the actions being highlighted were clearer. The committee **noted** the report.	Y	
9. RIDDOR Investigation Report		
The committee received two RIDDOR Investigation Reports. The first related to a member of staff who had a pre-existing condition which was not raised / considered and resulted in an injury. The committee discussed the issues regarding concerns with members of staff handover and how the Trust can rota staff safely. The committee was assured that training is available for staff and that the staffing levels were accurate at the time of the incident. The committee discussed the learning identified following the incident. It was noted the Safety Champions can share learning details through the organisation whilst completing a walkabout. The second RIDDOR report related to a staff member injured tripping over a trip hazard at the end of a bed. It was confirmed the beds within the Trust are still being inappropriately used to store foot pumps. The Health and Safety Advisor will continue to liaise with colleagues to mitigate the risk and raise awareness. The committee **noted** the RIDDOR Investigation Report	Y	
10. Workplan		
The committee received the work plan for 2019/20. The HR deep dive was deferred to the next meeting. The committee discussed the revised schedule for the meetings which will be quarterly, this commences from April 2019. The work plan will be revised prior to the next meeting. The committee **approved** the work plan for 2019/20	N/A	

Chair's Assurance Report
Risk Management Committee – 6th March 2019

11. Attendance Matrix		
The committee discussed the purpose of the attendance matrix, highlighting the importance of correct representation is in attendance at the meetings. The committee **noted** the attendance matrix.	N/A	

3.4 Risks to be Escalated

In the course of its business the Committee agreed there were no risks which required urgent 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.

Learning From Deaths

0. Reference Information

Author:	Dr James Neil, Trust Lead	Paper date:	26th March 2019
Executive Sponsor:	Mr Steve White, Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	Board of Directors	Paper Ref:	N/A
Forum submitted to:	Mortality Steering Group and Quality and Safety Committee	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report to the Board of Directors following the Quality and Safety Committee.

Review of numbers.

2. Executive Summary

2.1. Context

To report the current numbers in 2018 for Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No concerns identified.

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes	Actions/Learning Identified
September 2018	0	0	0	0	None	None
October 2018	2	2	0	0	None	None
November 2018	1	1	0	0	None	None
December 2018	1	1	0	0	None	None

3.3. Associated Risks

None identified.

3.4. Next Steps

Mr Burston has been identified as second reviewer for surgery.

3.5. Conclusion

No issues identified or specific learning from last four months.

Appendix 1: Acronyms

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

Safe Working Hours: Doctors in Training Q4

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	February 2019
Executive Sponsor:	Steve White, Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety	Paper Ref:	N/A
Forum submitted to:	N/A	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

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

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. During negotiations on the junior doctor contract, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, This is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational

opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period Oct - Dec 2018

Orthopaedics	Training posts	20
	Of which Doctors in training on 2016 contract	3
Rehabilitation/ Spinal Injuries	Training posts	1
	Of which Doctors in training on 2016 contract	1

3.2.2 Exception reports (with regard to working hours)

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

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

Currently there have been no exceptions reported to the Trust.

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

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

3.2.3 Work schedule reviews

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

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Safe Working Hours: Doctors in Training Q4

Please see Appendix 1

Trauma and Orthopaedics

Number of Vacancies

Oct – 2 part time trainees

Nov – 2 part time trainees

Dec – 2 part time trainees

Vacant shifts – Oct 2, Nov 5, Dec 0

Total spend has been £ 2465

Medicine

Number of Vacancies

Oct – 1 - but GP trainees in rotation

Nov – 1 - but GP trainees in rotation

Dec - 1 - but GP trainees in rotation

Vacant shifts – Oct 0, Nov 0, Dec 0

Total spend has been £ 0

MCSI

Number of Vacancies

Oct – 1

Nov – 1

Dec - 1

Vacant shifts – Oct6 6, Nov 7, Dec 9

Total spend has been £ 5336.4

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

Recent attendance at a regional level meeting highlighted good practice in a variety of Trusts. Close engagement between the Guardian to Speak Out and the GJDW was particularly evident and moving forward an area as a Trust we could actively develop.

3.3.1 Engagement

Engagement with the junior doctor workforce has continued to improve and the JDF provides an open forum for discussion. Attendance has fluctuated and I continue to try and achieve a broader representation and numbers at the meetings. Meetings have not highlighted any significant concerns from the junior workforce.

3.3.2 Software System

The position has not changed from previous reports.

Associated Risks

As it currently stands we are an outlier with respect to the lack of exception reports in the Trust. This was discussed at the JDF. Whilst there is no culture of bullying or intimidation behind this and juniors are encouraged to file reports as they feel appropriate, our position may draw scrutiny and inappropriate speculation as to the cause.

Next Steps

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

3.4. Conclusion

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

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

Christopher Marquis

Guardian of Safe Working

Finance Planning and Investment Committee Chair's Report

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	28th March 2019
Executive Sponsor:	Alastair Findlay, Non Executive Director	Paper Category:	Performance
Paper Reviewed by:	Finance, Performance and Investment	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2. Summary

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

2.3. Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 3, Main Entrance	26/03/19	Alastair Findlay	14:00

1. Introduction		14:00
1.1. Apologies	Alastair Findlay	
1.2. Minutes from the previous meeting	Alastair Findlay	
1.3. Action Log	All	
1.4. Declaration of Interests	All	
2. Matters Arising		
2.1. Orthopaedic Complexity Top Up Update	Craig Macbeth	14:10
3. Finance		14:20
3.1. Finance & Performance Report	Craig Macbeth/Nia Jones	
4. Planning		
4.1. LLP Governance and Actions	Debbie Kadum	15:00
4.2. BDO Job Plan Assurance Report (to follow)	Nia Jones	15:15
4.3. Operational Plan 2019/20	Craig Macbeth/Kerry Robinson	15:30
4.4. Capital Programme	Mark Salisbury	15:55
4.5. EPMA Business Case	Imran Hanif	16:05
4.6. Performance Management Strategy and Accountability Framework	Debbie Kadum	16:15

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 3, Main Entrance	26/03/19	Alastair Findlay	14:00
5. Committee Management			16:20
5.1. BAF and Corporate Risk Register		Shelley Ramtuhul	
5.2. Terms of Reference		Shelley Ramtuhul	
5.3. Review of the Workplan		Shelley Ramtuhul	
5.3.1. Attendance Matrix		Shelley Ramtuhul	
6. Any Other Business			
6.1. Next Meeting: 28th May 2019			

Month 11 Integrated Performance Report

0. Reference Information

Author:	Claire Jones Senior Information Analyst	Paper date:	29/03/2019
Executive Sponsor:	Debbie Kadum, Interim Associate Director of Performance	Paper Category:	Trust Board
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

This paper is for information and the Board is asked to note the Month 11 (February) Integrated Performance Report.

2. Executive Summary

2.1. Context

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

2.2. Summary

In line with the Trust's Performance Management Strategy and Accountability Framework, Board-level Key Performance Indicators (KPIs) which are considered to drive the overall performance of the Trust have been agreed by the sub-committees of the Board and included in this report.
The Trust remains in segment 2 of the NHS Improvement Single Oversight Framework.

There are 6 exception reports for KPI's which have not been met for 3 months running.

Exception Report	Trend	Responsible Sub-Committee
Sickness Absence	KPI not met for 3 months	Quality and Safety
% Delayed discharge rate	KPI not met for 6 months and position deteriorated from month 10	Quality and Safety
Patients waiting over 52 weeks - English	KPI not met for 5 months but forecast 0 by end of Q4	Finance, Performance and Investment
Patients waiting over 52 weeks - Welsh	KPI not met this financial year and forecast not to achieve year end	Finance, Performance and Investment
RTT	KPI not met for 4 months - forecast not to achieve 92% by end of Q4	Finance, Performance and Investment
OPD DNA rate	KPI not met for 3 months	Finance, Performance and Investment

Of note this month:

Caring for Staff

- Low vacancies and staff turnover trust wide;
- Performance on appraisals and mandatory training improving.

Caring for Patients

- No never events;
- No MRSA;
- No patient falls with moderate or severe harm;
- Number of complaints spiked in month leading to red end of year rating;
- Spike in RJAH acquired VTE (DVT or PE).

Caring for Finances

- Reportable cancellations now green after 5 months of failing the target;
- English list size reducing;
- 6 week diagnostic wait (English) red for last 2 months;
- Agency spend now amber;
- % of sessions used against plan and total theatre activity improved in month;
- Financial control total green in month but forecast amber for year end.

2.3. Conclusion

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

Integrated Performance Report
February 2019 – Month 11

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Contents

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Reading guide

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

Trust Performance Summary
This provides a balanced scorecard and summary of improving and deteriorating KPIs within each of the three areas of the Trust's mission. Year-to-date and forecast performance red, amber and green (RAG) ratings are also provided in this section.

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

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

Key

Key Performance Indicator RAG Ratings

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

KPIs reported in arrears

KPIs reported in arrears, for which no current-month values are available, are marked with an asterisk (*) next to their name.

The latest values for these KPIs are from the previous reporting month.

Data Quality Indicator

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

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

Trend graphs

Within the narrative section of this report, each KPI has a trend graph (Statistical Process Control (SPC) where appropriate), which summarises performance over a rolling thirteen-month period.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Trust performance summary

Caring for Staff

Improved

Staff Appraisal
Mandatory Training

Deteriorated

Sickness Absence

Caring for Patients

Improved

% Reportable Cancellations
% Non Reportable Cancellations
18 Weeks RTT Open Pathways

Deteriorated

Number of Complaints
% Delayed Discharge Rate
RJAH Acquired VTE (DVT or PE)

Caring for Finances

Improved

Theatre Cases per Session
Clinical Income from Activity
Agency Control Total

Deteriorated

Overall Daycase Rate
Average Length of Stay
Financing

Rolling 13 Months Trend Analysis / Year End Forecast

Caring for Staff

	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Sickness Absence	4.06%	3.47%	2.93%	3.41%	3.4%	4.11%	3.57%	3.95%	4.39%	4.07%	4.29%	4.43%	4.58%	3.25%	3.25	3.84%	R	
Vacancy Rate			7.94%	7.6%	7.56%	7.16%	7.08%	5.49%	4.66%	4.62%	3.95%	3.63%	3.16%	8%			G	
Voluntary Staff Turnover	7.33%	7.57%	7.88%	8.37%	8.56%	8.48%	7.67%	7.65%	7.57%	7.44%	7.4%	7.17%	6.99%	8%			G	
Staff Appraisal	88.78%	94.53%	95.02%	94.4%	94.3%	95.07%	93.53%	92.21%	93.12%	93.06%	91.2%	89.12%	90.07%	94%			R	
Mandatory Training	89.5%	91.4%	92.7%	90.9%	91.2%	91.7%	91.1%	90.6%	90.93%	88.59%	88.91%	90.1%	90.99%	92%			A	

Integrated Performance Report
February – Month 11

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Patients

	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Serious Incidents	0	0	1	2	0	0	1	1	1	1	1	0	0	0	0	8	R	Apr-18
Never Events	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	R	Apr-18
Patient Falls (With Moderate or Severe Harm)	0	0	0	2	0	0	0	1	0	0	1	0	0	1	0	4	R	
Total Patient Falls			10	9	10	13	10	15	20	13	16	9	10			135	G	
Inpatient Ward Falls Per 1,000 Bed Days	3.37	1.49	2	2.18	2.02	2.88	2.99	3.35	4.24	2.77	2.98	2.37	2.38	3	3	2.75	G	May-18
UTIs Associated with Catheters			2	0	2	2	3	1	0	0	0	0	0	5	55	10	G	
Pressure Ulcer Assessments	100%	100%	100%	99.9%	99.9%	99.91%	100%	100%	99.82%	99.83%	100%	99.91%	100%	99%	99	99.93%	G	Apr-18
RJAH Acquired Pressure Ulcers - Grade 2	2	3	3	2	1	2	0	1	1	2	1	6	1	1	11	20	R	Apr-18
RJAH Acquired Pressure Ulcers - Grades 3 or 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Patient Friends & Family - % Would Recommend (Inpatients & Outpatients)	98.92%	99.17%	99.35%	99.08%	99.49%	99.23%	100%	99.45%	99.01%	99.29%	99.06%	99.18%	98.84%	95%			G	
Number of Complaints	6	9	7	9	11	2	7	12	13	6	7	6	17	8	88	97	R	May-18
Safe Staffing	95.9%	95.5%	95.2%	96.2%	96.6%	96.4%	96.5%	97.8%	98.7%	98.4%	98.7%	98.2%	98.3%	90%			G	May-18
% Delayed Discharge Rate	7.28%	7.47%	5.83%	4.12%	4.99%	4.42%	3.27%	5.57%	6.1%	7.53%	8.17%	4.02%	6.05%	2.5%			R	
Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	
RJAH Acquired E. Coli Bacteraemia	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	4	R	
RJAH Acquired C.Difficile	0	0	1	0	0	0	0	1	0	0	0	1	0	0	1	3	R	Apr-18

	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
RJAH Acquired MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Medication Errors with Harm	0	1	1	2	2	3	1	0	2	1	2	0	1	2	22	15	G	
Unexpected Deaths	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	R	Apr-18
RJAH Acquired VTE (DVT or PE)	4	2	1	1	2	4	1	3	2	4	2	1	8	4	44	29	G	Apr-18
VTE Assessments Undertaken	100%	99.92%	99.71%	100%	99.92%	99.7%	100%	99.92%	99.71%	99.86%	99.91%	100%	99.84%	95%	95	99.87%	G	Apr-18
28 days Emergency Readmissions*	0.9%	1.38%	1.09%	1.39%	1.52%	0.99%	1.1%	0.9%	0.55%	0.71%	1.03%	0.47%			1	0.97%	A	
WHO Compliance			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100	100%	G	
% Reportable Cancellations	0.91%	0.88%	0.32%	0.18%	0.88%	0.17%	0.68%	1.21%	1.13%	1.02%	1.15%	1.88%	0.62%	0.7%	0.7	0.85%	R	
% Non-Reportable Cancellations	2.3%	2.29%	2.25%	2.56%	1.33%	1.84%	1.07%	1.99%	2.43%	1.49%	1.53%	2.13%	1.5%	2%	2	1.83%	G	
Cancellations Not Rebooked within 28 Days	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	R	
Cancer Two Week Wait*	100%	96%	96.15%	100%	100%	96.88%	100%	100%	100%	100%	100%	100%			93	99.29%	G	
31 Days First Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			96	100%	G	
31 Days Subsequent Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			94	100%	G	
Cancer Plan 62 Days Standard (Tumour)*	100%	50%	0%	100%	66.67%	50%	0%	0%	50%	100%	66.67%	50%			85	54.55%	R	
Cancer 62 Days Consultant Upgrade*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			85	100%	G	
18 Weeks RTT Open Pathways	89.37%	90.05%	90%	89.49%	89.98%	89.96%	89.6%	90.29%	90.66%	90.28%	90.04%	90.02%	90.47%	92%	92	90.05%	R	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Patients Waiting Over 52 Weeks – English	1	1	2	1	0	1	1	0	2	2	4	2	4	0	0		G	
Patients Waiting Over 52 Weeks – Welsh	5	6	2	2	2	9	8	6	3	6	7	3	6	0	0		R	
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)	43	0	43	126	128	121	124	87	54	72	66	52	26				A	
English List Size			5,918	5,918	6,367	6,346	6,680	6,960	7,026	7,029	6,867	6,595	6,357	6,650			A	
6 Week Wait for Diagnostics - English Patients	99.77%	99.6%	98.73%	99.53%	99.37%	98.59%	99.15%	99.16%	99.07%	98.7%	99.1%	98.91%	98.88%	99%	99	99.04%	A	
8 Week Wait for Diagnostics - Welsh Patients	99.82%	99.42%	100%	100%	99.76%	99.77%	99.67%	100%	99.24%	99.65%	99.64%	99.66%	98.72%	100%	100	99.75%	A	
New to Follow Up Ratio (Consultant Led Activity)	2.17	2.44	2.39	2.18	2.21	2.39	2.14	2.04	2.12	2.22	2.08	2.31	2.12	2.5	2.5	2.2	G	

Caring for Finances

	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Referrals Received for Consultant Led Services*	2,867	2,804	2,426	2,906	2,930	2,845	2,681	2,845	3,232	2,852	2,337	2,811			29187	27,865	G	
Overall Daycase Rate	45.93%	45.26%	45.18%	47.77%	46.91%	46.8%	42.93%	47.05%	45.35%	48.59%	48.58%	50.68%	45.66%	46%	46	46.93%	G	
% Sessions Used Against Plan			99.53%	100.1%	101.27 %	96.96%	97.15%	98.25%	95.53%	97.89%	98.04%	93.91%	95.01%	100%	100	97.5%	G	
Touchtime Utilisation	83.26%	86.46%	82.73%	82.73%	83.76%	79.82%	80.29%	83.36%	81.88%	81.66%	80.93%	82.66%	82.68%	82%	82	82.05%	G	
Theatre Cases Per Session	2.07	2.13	1.95	2.08	1.98	1.99	2.02	2.01	2.01	2.08	2.22	2.06	2.14	2.07			A	
Total Theatre Activity	1,043	1,125	821	1,004	1,023	1,053	929	1,017	1,115	1,157	883	1,094	1,024	1,030	11440	11,120	R	
Average Length of Stay	3.74	3.37	3.89	3.62	4.14	3.61	3.3	3.8	3.76	3.63	3.47	3.15	3.72	3.5	3.5	3.65	G	
Bed Occupancy – Adult Orthopaedic Wards – 2pm	92.41%	88.62%	78.07%	82.95%	86.75%	86.01%	86.55%	91.43%	88.08%	84.2%	84.9%	87.23%	90.07%	87%	87	86.08%	G	
Bed Occupancy – All Wards – 2pm	90.7%	86.3%	80.91%	82.52%	85.73%	83.78%	86.61%	89.08%	85.94%	84.03%	84.83%	86.78%	87.62%	83%	83	85.26%	A	
Outpatients Activity Attendances			12,342	13,662	13,609	13,631	12,885	13,792	15,939	15,298	11,440	14,891	13,455	13,601	149925	150,944	G	
Outpatient DNA Rate (Consultant Led Activity)	5.73%	5.74%	5.42%	5.84%	5.81%	6.45%	5.71%	5.76%	5.4%	4.84%	5.34%	5.98%	5.46%	5%	5	5.64%	R	
Financial Control Total	208	337	-768	7	235	279	-190	152	676	621	-833	358	59	-103	648	596	A	
Clinical Income from Activity	7,673	8,439	6,356	7,454	7,884	7,771	7,345	7,673	8,802	8,435	6,559	8,175	7,755	7,564	83400	84,209	G	
Private Patients Income	349	492	516	450	478	463	424	499	525	506	357	646	436	365	5312	5,300	G	
Other Income	729	839	549	566	524	568	551	474	474	569	515	297	484	508	5776	5,571	A	
Pay	4,927	4,903	4,943	4,979	5,016	4,991	5,006	5,069	5,211	5,166	5,104	5,138	5,146	5,037	55632	55,769	A	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Non Pay	3,661	4,632	2,869	3,108	3,260	3,153	3,131	3,070	3,539	3,348	2,788	3,238	3,226	3,114	34007	34,730	G	
Financing	443	393	426	426	426	429	428	404	427	427	422	435	435	439	4758	4,685	G	
CIP Delivery	207	250	368	288	356	249	310	298	327	311	329	284	307	268	3314	3,427	G	
Agency Control Total	164	180	232	374	407	433	418	358	474	373	340	334	299	290	3285	4,045	R	
Cash Balance	4,277	4,249	3,863	4,773	4,200	6,300	6,200	5,400	5,000	4,200	3,900	4,700	4,300	5,000	5000	5,200	G	
Capital Expenditure	119	828	93	264	346	205	164	297	160	377	400	304	165	347	3377	2,775	G	
Use of Resources (UOR)	2	2	3	3	3	2	3	2	2	2	2	2	2	2	1	2	A	

Integrated Performance Report
February – Month 11

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

In-month Summary

Caring for Staff

	Plan	Current month	Previous month	YTD actual	Year-end forecast
Sickness Absence	3.25%	4.58%	4.43%	3.84%	R
Vacancy Rate	8%	3.16%	3.63%		G
Voluntary Staff Turnover	8%	6.99%	7.17%		G
Staff Appraisal	94%	90.07%	89.12%		R
Mandatory Training	92%	90.99%	90.1%		A

Integrated Performance Report
February – Month 11

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Patients

	Plan	Current month	Previous month	YTD actual	Year-end forecast
Serious Incidents	0	0	0	8	R
Never Events	0	0	0	1	R
Patient Falls (With Moderate or Severe Harm)	1	0	0	4	R
Total Patient Falls		10	9	135	G
Inpatient Ward Falls Per 1,000 Bed Days	3	2.38	2.37	2.75	G
UTIs Associated with Catheters	5	0	0	10	G
Pressure Ulcer Assessments	99%	100%	99.91%	99.93%	G
RJAH Acquired Pressure Ulcers - Grade 2	1	1	6	20	R
RJAH Acquired Pressure Ulcers - Grades 3 or 4	0	0	0	0	G
Patient Friends & Family - % Would Recommend (Inpatients & Outpatients)	95%	98.84%	99.18%		G
Number of Complaints	8	17	6	97	R
Safe Staffing	90%	98.3%	98.2%		G
% Delayed Discharge Rate	2.5%	6.05%	4.02%		R
Mixed Sex Accommodation	0	0	0	0	G

	Plan	Current month	Previous month	YTD actual	Year-end forecast
RJAH Acquired E. Coli Bacteraemia	0	0	0	4	R
RJAH Acquired C.Difficile	0	0	1	3	R
RJAH Acquired MRSA Bacteraemia	0	0	0	0	G
Medication Errors with Harm	2	1	0	15	G
Unexpected Deaths	0	0	0	1	R
RJAH Acquired VTE (DVT or PE)	4	8	1	29	G
VTE Assessments Undertaken	95%	99.84%	100%	99.87%	G
28 days Emergency Readmissions*	1%	0.47%	1.03%	0.97%	A
WHO Compliance	100%	100%	100%	100%	G
% Reportable Cancellations	0.7%	0.62%	1.88%	0.85%	R
% Non-Reportable Cancellations	2%	1.5%	2.13%	1.83%	G
Cancellations Not Rebooked within 28 Days	0	0	1	1	R
Cancer Two Week Wait*	93%	100%	100%	99.29%	G
31 Days First Treatment (Tumour)*	96%	100%	100%	100%	G

	Plan	Current month	Previous month	YTD actual	Year-end forecast
31 Days Subsequent Treatment (Tumour)*	94%	100%	100%	100%	G
Cancer Plan 62 Days Standard (Tumour)*	85%	50%	66.67%	54.55%	R
Cancer 62 Days Consultant Upgrade*	85%	100%	100%	100%	G
18 Weeks RTT Open Pathways	92%	90.47%	90.02%	90.05%	R
Patients Waiting Over 52 Weeks – English	0	4	2		G
Patients Waiting Over 52 Weeks – Welsh	0	6	3		R
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers)		26	52		A
English List Size	6,650	6,357	6,595		A
6 Week Wait for Diagnostics - English Patients	99%	98.88%	98.91%	99.04%	A
8 Week Wait for Diagnostics - Welsh Patients	100%	98.72%	99.66%	99.75%	A
New to Follow Up Ratio (Consultant Led Activity)	2.5	2.12	2.31	2.2	G

Integrated Performance Report
February – Month 11

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Finances

	Plan	Current month	Previous month	YTD actual	Year-end forecast
Referrals Received for Consultant Led Services*	2,900	2,811	2,337	27,865	G
Overall Daycase Rate	46%	45.66%	50.68%	46.93%	G
% Sessions Used Against Plan	100%	95.01%	93.91%	97.5%	G
Touchtime Utilisation	82%	82.68%	82.66%	82.05%	G
Theatre Cases Per Session	2.07	2.14	2.06		A
Total Theatre Activity	1,030	1,024	1,094	11,120	R
Average Length of Stay	3.5	3.72	3.15	3.65	G
Bed Occupancy – Adult Orthopaedic Wards – 2pm	87%	90.07%	87.23%	86.08%	G
Bed Occupancy – All Wards – 2pm	83%	87.62%	86.78%	85.26%	A
Outpatients Activity Attendances	13,601	13,455	14,891	150,944	G
Outpatient DNA Rate (Consultant Led Activity)	5%	5.46%	5.98%	5.64%	R
Financial Control Total	-103	59	358	596	A
Clinical Income from Activity	7,564	7,755	8,175	84,209	G
Private Patients Income	365	436	646	5,300	G

	Plan	Current month	Previous month	YTD actual	Year-end forecast
Other Income	508	484	297	5,571	A
Pay	5,037	5,146	5,138	55,769	A
Non Pay	3,114	3,226	3,238	34,730	G
Financing	439	435	435	4,685	G
CIP Delivery	268	307	284	3,427	G
Agency Control Total	290	299	334	4,045	R
Cash Balance	5,000	4,300	4,700	5,200	G
Capital Expenditure	347	165	304	2,775	G
Use of Resources (UOR)	2	2	2	2	A

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

External Perception	Current Month Measurement
Single Oversight Framework Segment	2
CQC Rating	Good

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Sickness Absence - R

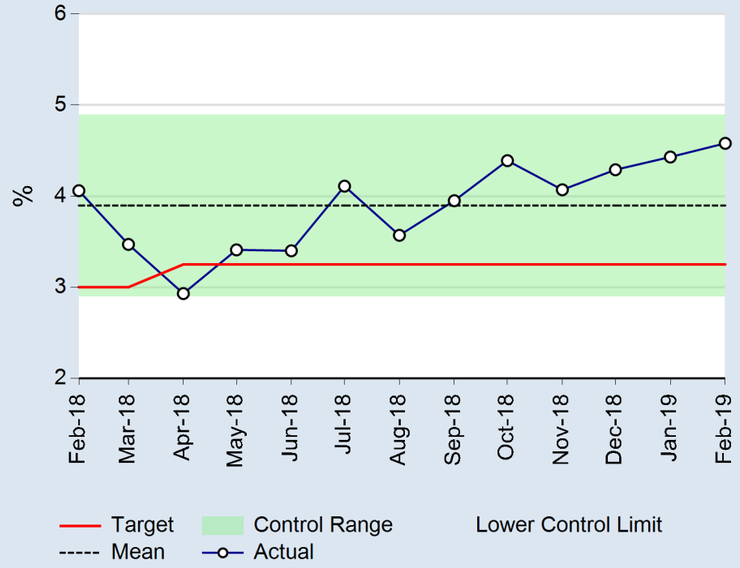
Description
FTE days lost as a percentage of FTE days available in month

Target
3.25% in month (Internal Monitoring)

Executive Lead
Director of People

Comment
February saw a further increase in absence. The Theatre Division absence rate has increased further and was 7.19% in February with a notable increase in long-term sickness absence.

Action
Actions continue as part of the People Excellence work stream, supporting a reduction in absence due to stress/anxiety/depression and MSK which remain our highest two reasons for absence. The HR team work with the Theatre Division to understand further the potential drivers for absence in this division.



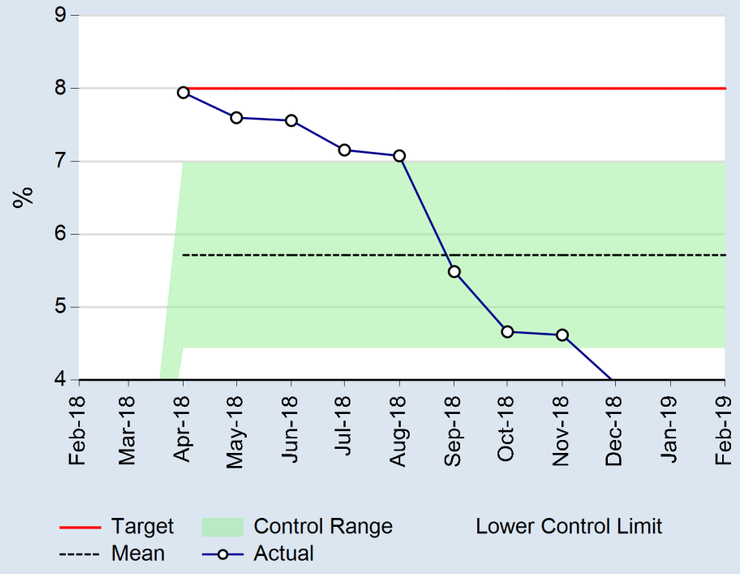
Vacancy Rate - G

Description
% of posts vacant at month end

Target
8% in month (Internal Monitoring)

Executive Lead
Director of People

Comment
There has been a further reduction in vacancies and the measure is reported below (positive) the Trust target.



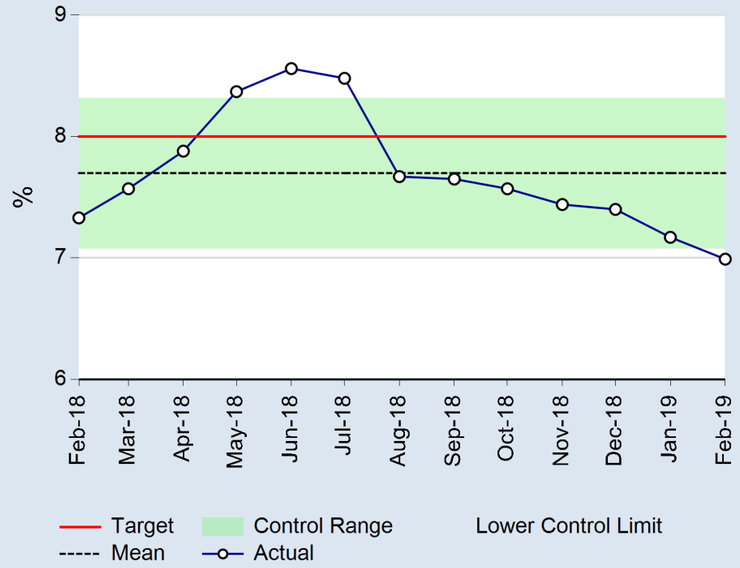
Voluntary Staff Turnover - G

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

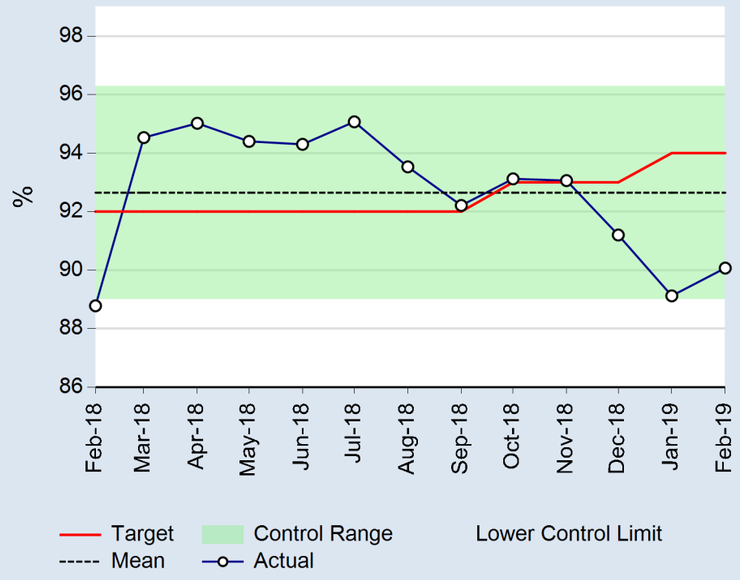
Description
% of staff who have had an appraisal within the last 13 months

Target
94% at month end (Internal Monitoring)

Executive Lead
Director of People

Comment
The appraisal rate has increased but remains below (negative) the target.

Action
The deteriorated position will be escalated to the relevant Divisions.



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Mandatory Training - A

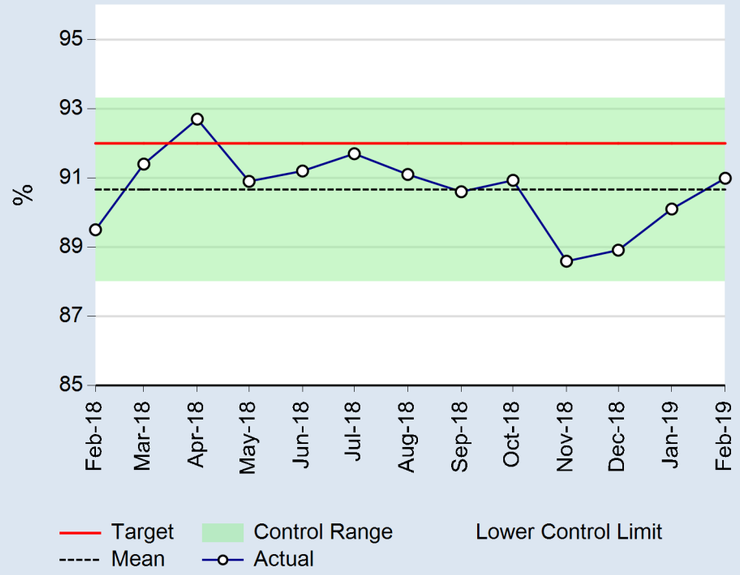
Description
The combined total of completed Fire, H&S or Moving and Handling training modules as a % of the total number of modules that require completion.

Target
92% in month (Internal Monitoring)

Executive Lead
Director of People

Comment
The completion rate for mandatory training has increased its position in month, but remains below (negative) the target.

Action
We will continue to monitor progress against improving our completion rates for those Board reportable elements including Fire and Manual Handling.



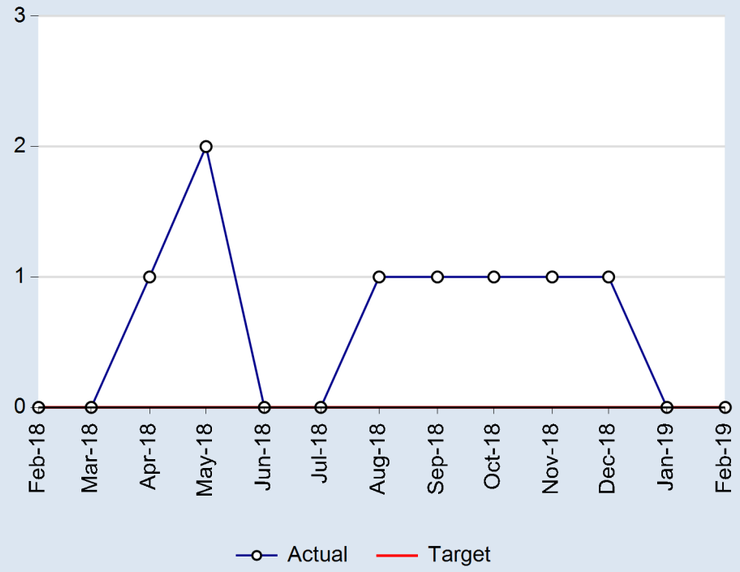
Serious Incidents - G

Description
Number of Serious Incidents reported in month

Target
0 serious incidents in month (Internal Monitoring)

Executive Lead
Director of Nursing

Comment
There were no serious incidents reported in February.



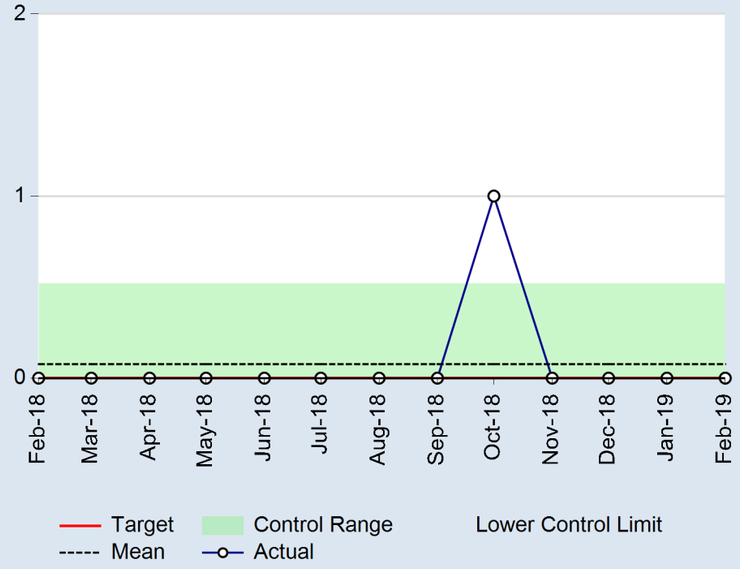
Never Events - G

Description
Number of Never Events Reported in Month

Target
0 never events in month (Internal Monitoring)

Executive Lead
Director of Nursing

Comment
There were no never events reported in February.



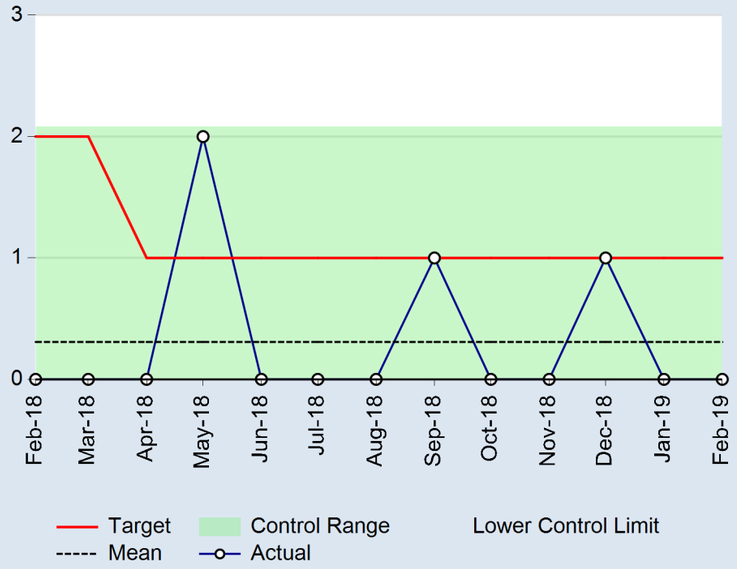
Patient Falls (With Moderate or Severe Harm) - G

Description
Number of patient falls with moderate or severe harm. The graph for this KPI also shows total patient falls split by level of harm.

Target
1 or fewer falls with moderate or severe harm (Internal Monitoring)

Executive Lead
Director of Nursing

Comment
There were no falls that resulted in moderate or severe harm.



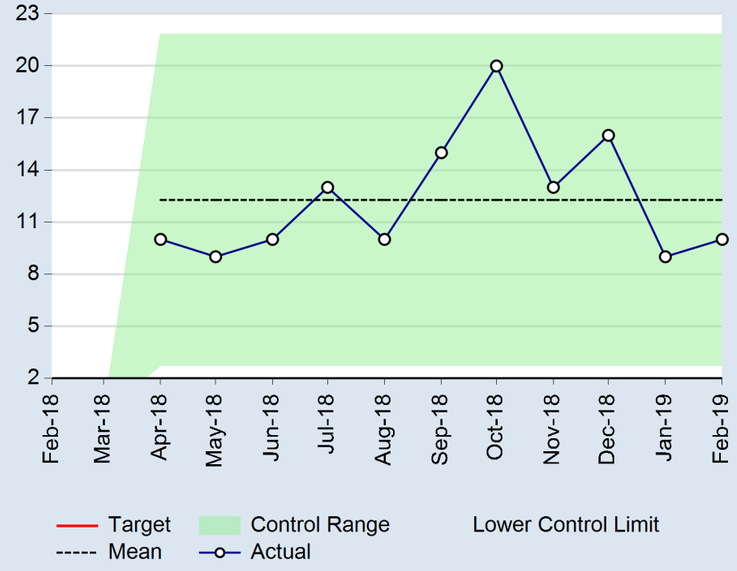
Total Patient Falls -

Description
Total number of patient falls

Target

Executive Lead
Director of Nursing

Comment
There were 10 falls in February all relating to Inpatients. A full breakdown is provided here:
- No harm (1) 10%
- Low harm (9) 90%, made up of:
  - No obvious injury but unwitnessed (5) 50%
  - Abrasion/graze (4) 40%



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NHS Foundation Trust

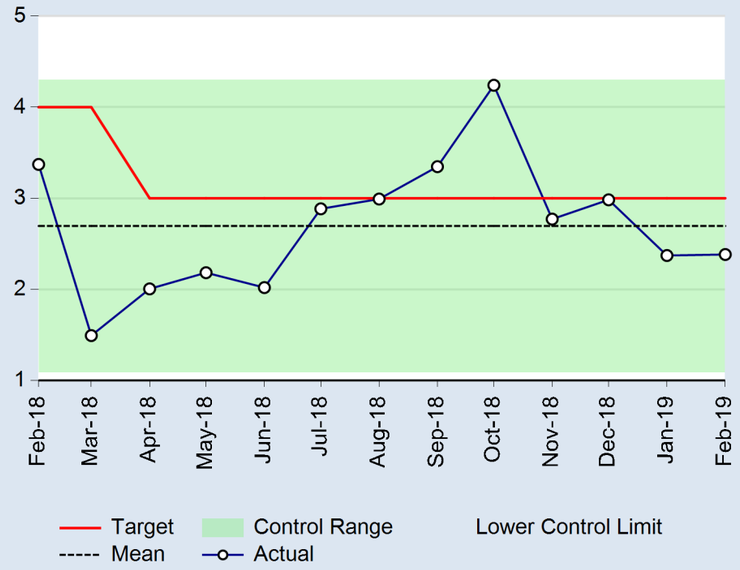
Inpatient Ward Falls Per 1,000 Bed Days - G

Description
Number of Inpatient Ward Falls per 1,000 Bed Days

Comment
There were 2.38 falls per 1000 bed days reported in February making this indicator green rated.

Target
3 or fewer falls per 1,000 bed days (Internal Monitoring)

Executive Lead
Director of Nursing



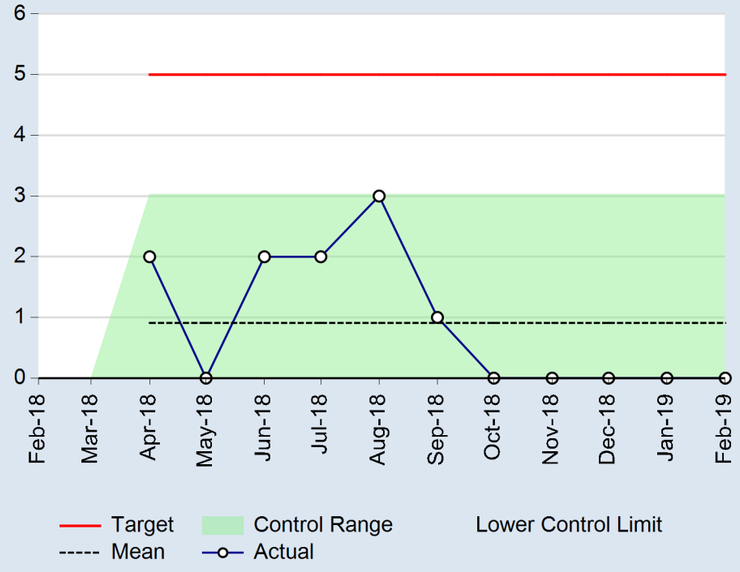
UTIs Associated with Catheters - G

Description
Total number of UTIs associated with catheters

Comment
There were no UTIs associated with catheters reported in February.

Target
5 in month (Internal Monitoring)

Executive Lead
Director of Nursing



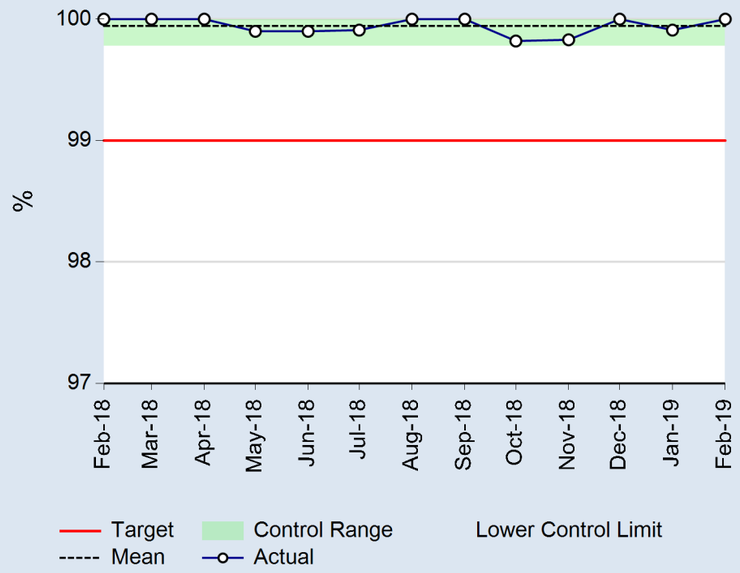
Pressure Ulcer Assessments - G

Description
% of adult admissions in the month who have been risk assessed for pressure ulcers

Target
99% in month (Internal Monitoring)

Executive Lead
Director of Nursing

Comment
The percentage of admissions risk assessed remains consistent and is reported at 100% in February.



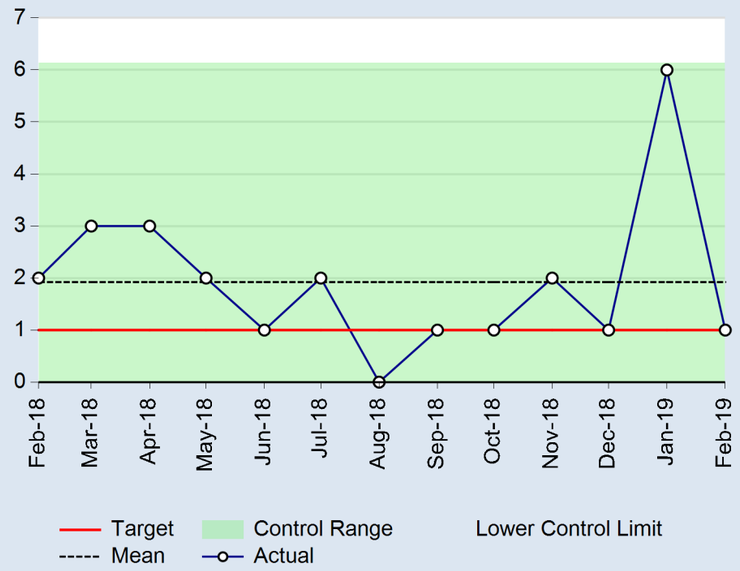
RJAH Acquired Pressure Ulcers - Grade 2 - G

Description
Total number of category 2 pressure ulcers acquired at RJAH

Target
1 in month (Internal Monitoring)

Executive Lead
Director of Nursing

Comment
One category two pressure ulcer was reported in February. The patient had been risk assessed on admission and their care package was updated appropriately.



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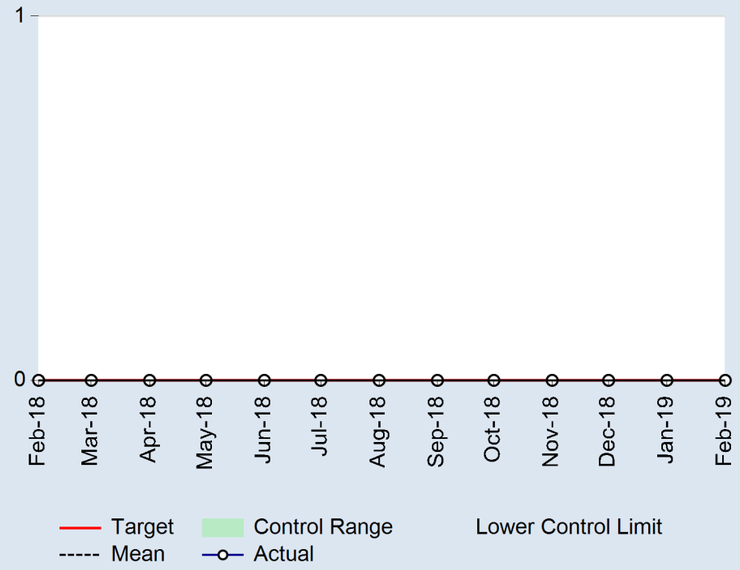
RJAH Acquired Pressure Ulcers - Grades 3 or 4 - G

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

Comment
There were no category three or four pressure ulcers in February.

Target
0 in month (Internal Monitoring)

Executive Lead
Director of Nursing



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

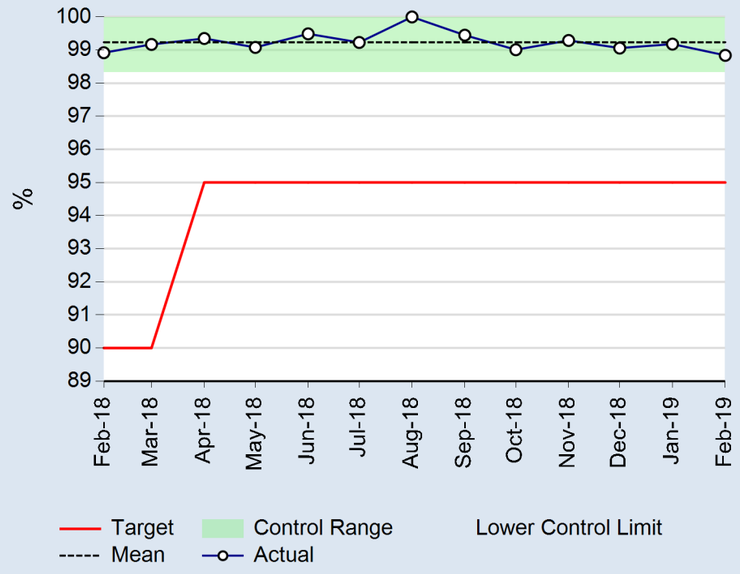
Description
% of patients who would recommend the trust (inpatients and outpatients)

Comment
There were 946 responses collected with a breakdown as follows:
- 935 positive - giving a rate of 98.84% would recommend the Trust to friends and family
- 3 negative - giving a rate of 0.32% would not recommend the Trust to friends and family
- 8 responses as "neither likely or unlikely" or "don't know"

The number of compliments received in February was 389.

Target
90% in month (External Measure, Internal Target)

Executive Lead
Director of Nursing



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Number of Complaints - R

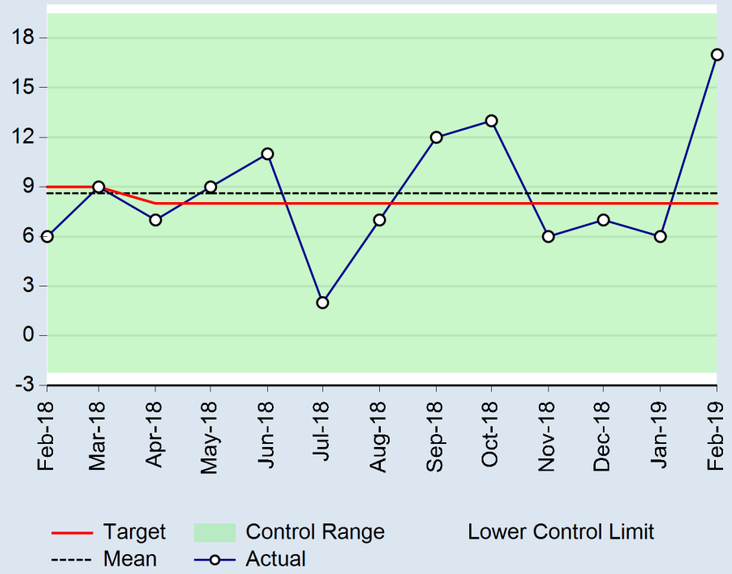
Description
Number of complaints received in month

Target
8 or fewer in month (Internal Monitoring)

Executive Lead
Director of Nursing

Comment
There were seventeen complaints received in February. Nine related to quality of care with reasons associated with waiting times (1), lack of physio following surgery (1), attitude of staff (2), advice from Consultant (3), appointment letter giving wrong location (1) and care from registrar (1). There were eight further operational complaints relating to the closure of the chronic pain service (6), issues relating to referral and outpatient appointment (1) and quality of food for a patient with coeliac disease (1).

Action
The increase in complaints particularly relates to the closure of the Chronic Pain Service.



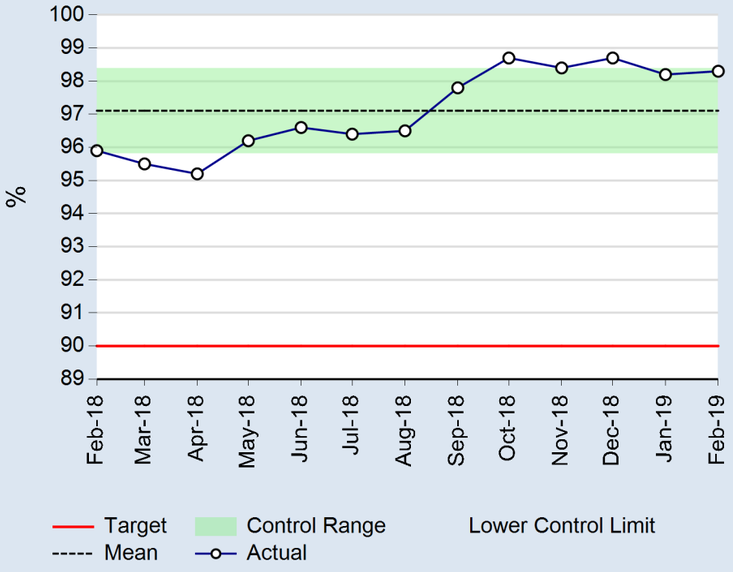
Safe Staffing - G

Description
% Shift Fill Rate.

Target
90% in month (External Measure, Internal Target)

Executive Lead
Director of Nursing

Comment
The overall shift rate for February was 98.30% against the 90% target. Supporting data is collected on a daily basis to monitor this metric. There were times throughout the month where average fill rates fell below target on some wards but they remained safely staffed at these times.



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% Delayed Discharge Rate - R

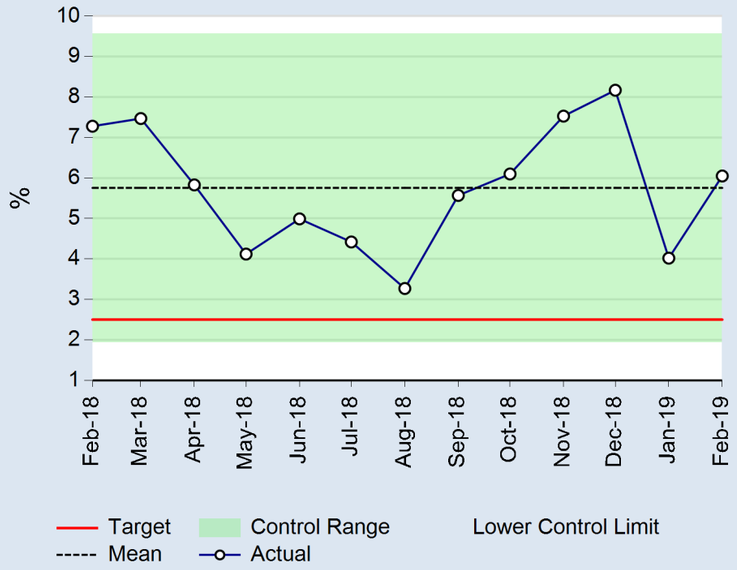
Description
The total number of delayed days against the total available bed days for the month in %

Target
2.5% in month (External Measure, External Target)

Executive Lead
Director of Nursing

Comment
The Delayed Discharge rate is red rated this month at 6.05%. The total delayed days for February is 268 days; 23 rehabilitation patients amounting to 233 days and 7 surgical patients amounting to 35 days. The patients fall under the responsibility of Shropshire (10), Wales (7), Staffordshire (2), Telford (2) and nine others with one patient each.

Action
See exception report.



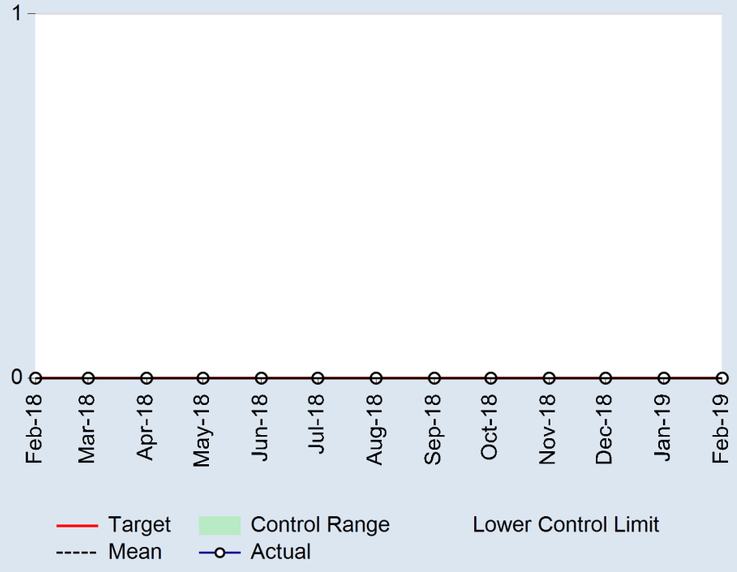
Mixed Sex Accommodation - G

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

Target
0 breaches in Month (External Monitoring)

Executive Lead
Director of Nursing

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



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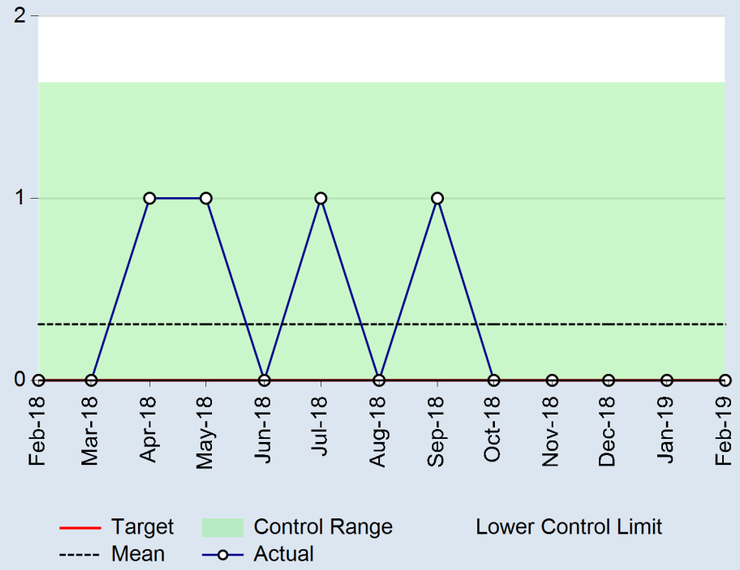
RJAH Acquired E. Coli Bacteraemia - G

Description
Number of cases of E. Coli Bacteraemia in Month.

Comment
There were no incidents reported in February.

Target
0 cases in Month (Internal Monitoring)

Executive Lead
Director of Nursing



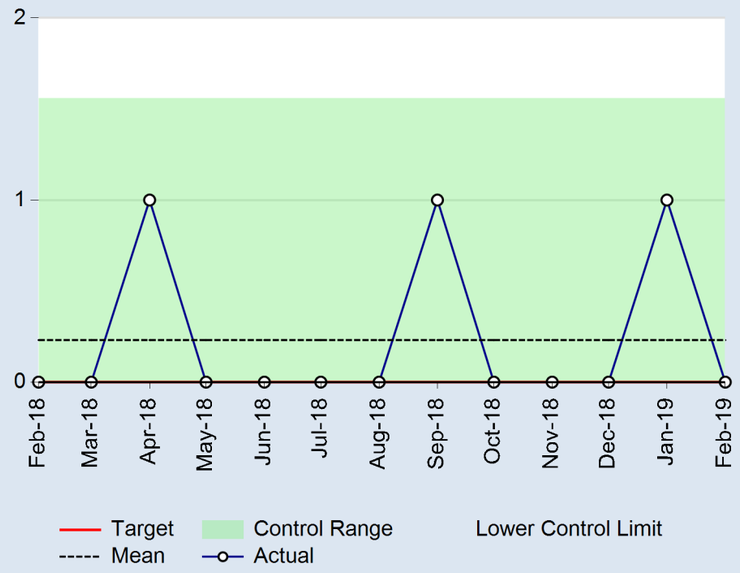
RJAH Acquired C.Difficile - G

Description
Number of cases of C.Difficile in Month

Comment
There were no incidents reported in February.

Target
0 cases in Month, Annual tolerance 1 per Year (External Measure, External Target)

Executive Lead
Director of Nursing



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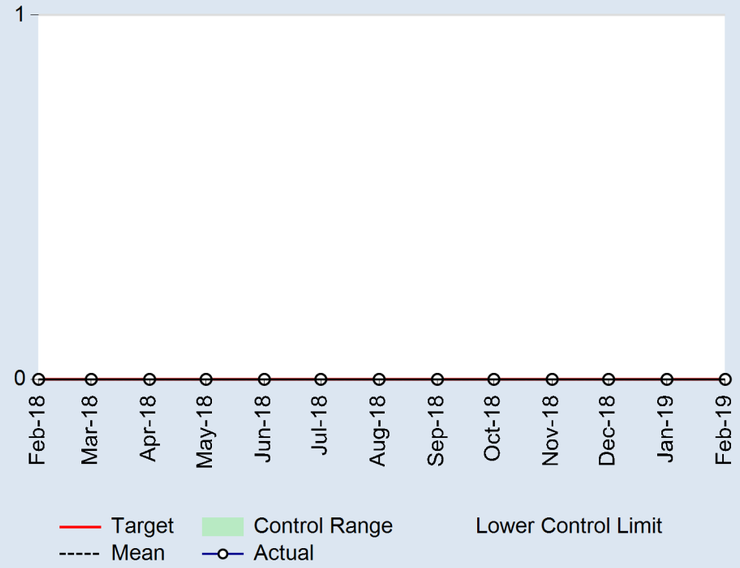
RJAH Acquired MRSA Bacteraemia - G

Description
Number of cases of MRSA bacteraemia in month

Target
0 cases in Month (Internal Monitoring)

Executive Lead
Director of Nursing

Comment
There were no incidents reported in February.



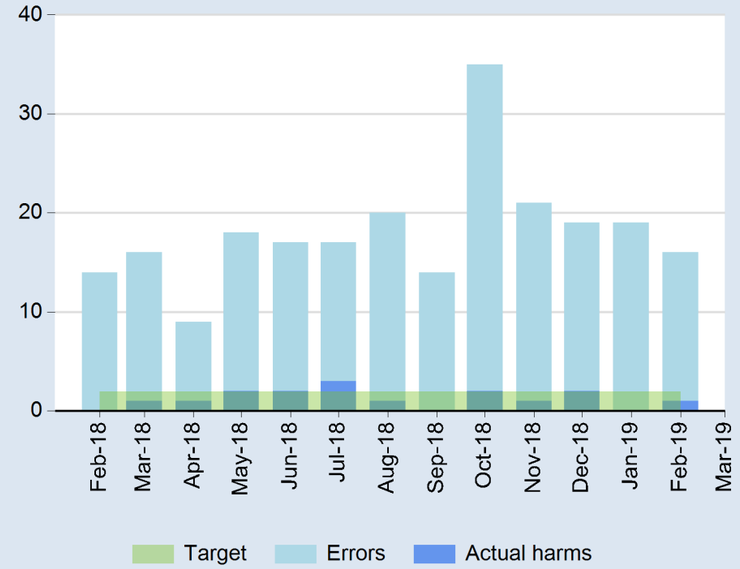
Medication Errors and those with Harm - G

Description
Total number of medication errors, and those with harm

Target
2 or fewer errors with harm (Internal Monitoring)

Executive Lead
Medical Director

Comment
There were fifteen medication errors reported in February. These are categorised as prescribing (4), administration (6), dispensing (4) and storage (1). One patient was deemed to sustain moderate level harm as they were not prescribed regular medication on admission and required admission to HDU post-surgery.



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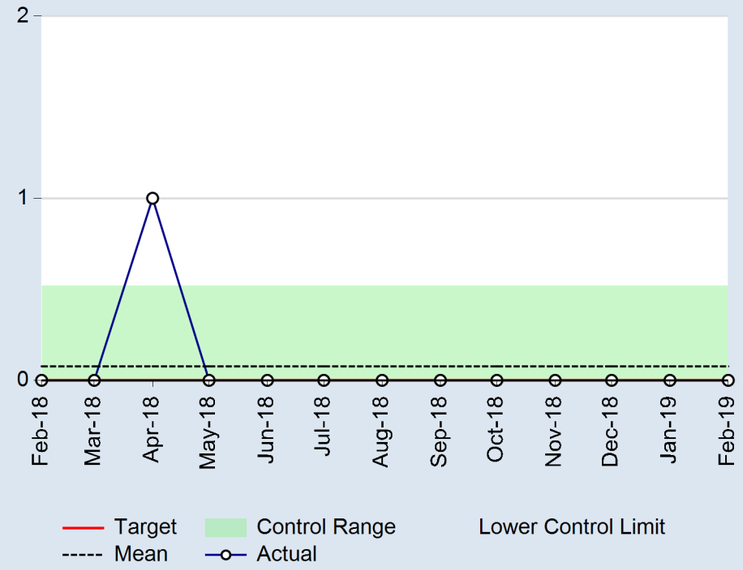
Unexpected Deaths - G

Description
Number of Unexpected Deaths in Month

Comment
There were one death on the Care of the Elderly Ward in February. The death was not unexpected.

Target
0 Unexpected deaths in month (Internal Monitoring)

Executive Lead
Medical Director



RJAH Acquired VTE (DVT or PE) - R

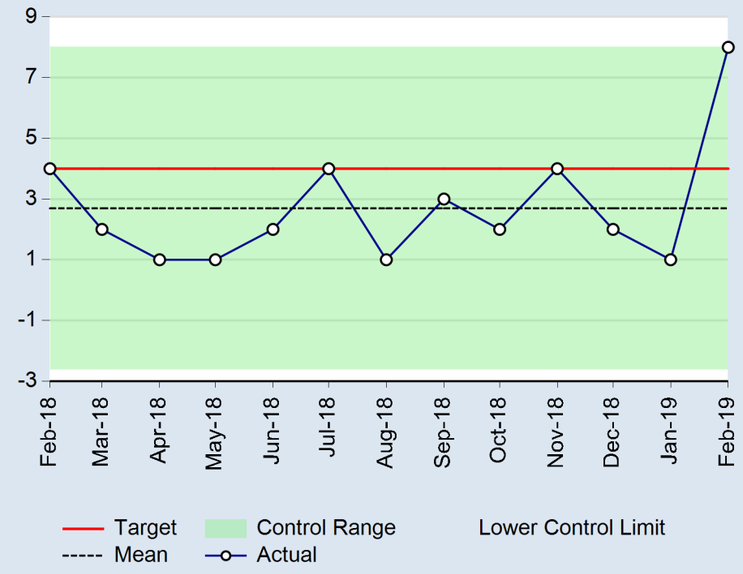
Description
Number of RJAH acquired DVT or PE within 90 days of surgery

Comment
Eight patients acquired a pulmonary embolism in February. The patients had received the following surgery; Spinal surgery (4), total knee replacement (2), shoulder decompression (1) and closure of pressure sore (1). All patients had been risk assessed in an outpatient clinic and correctly validated on admission.

Target
4 or fewer in month (Internal Monitoring)

Action
The incidents will be reviewed by the Venous Thromboembolism Clinical Lead and reported through the Quality and Safety Committee.

Executive Lead
Medical Director



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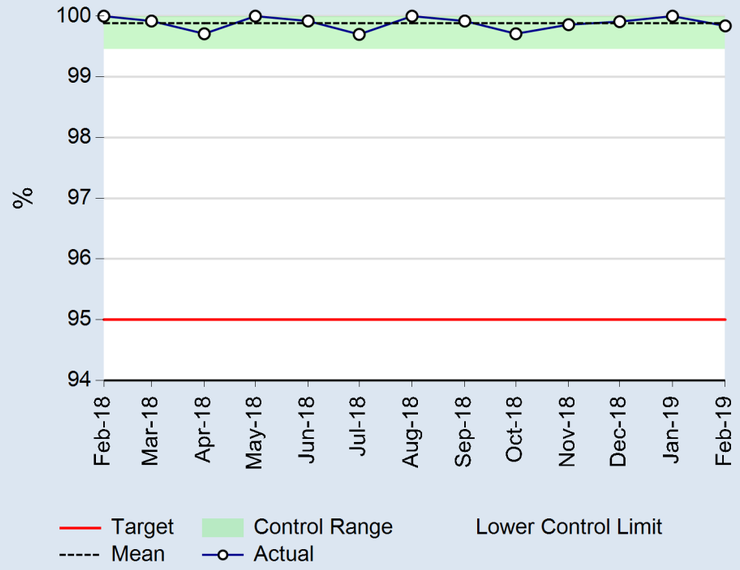
VTE Assessments Undertaken - G

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

Target
95% in month (External Measure, External Target)

Executive Lead
Medical Director

Comment
The percentage of admissions risk assessed is reported at 99.84% in February and remains above the 95% target.



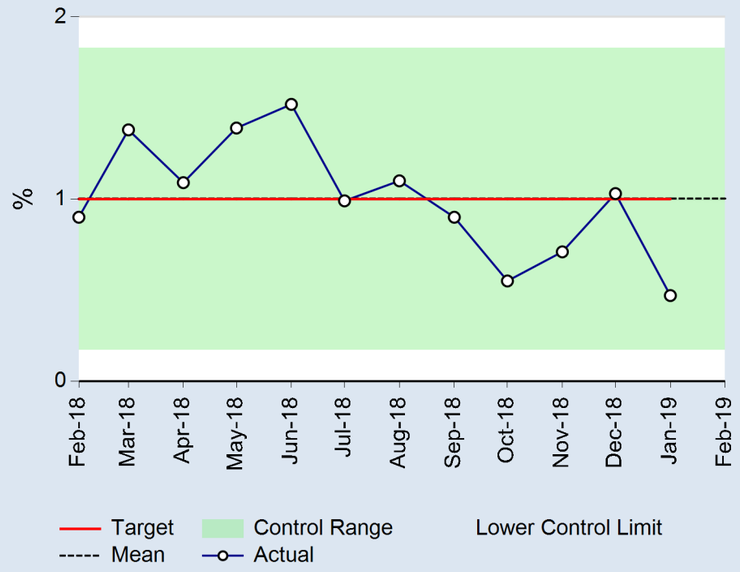
28 days Emergency Readmissions* - G

Description
% of patients readmitted to RJAH as an emergency following an overnight stay (*Reported one month in arrears)

Target
Less than 1% in month (Internal Monitoring)

Executive Lead
Medical Director

Comment
Three patients were readmitted as an emergency within 28 days of initial discharge in January 2019, giving a readmission rate of 0.47% against the 1% tolerance. The reasons for readmission were wound issues (2) and pain (1).



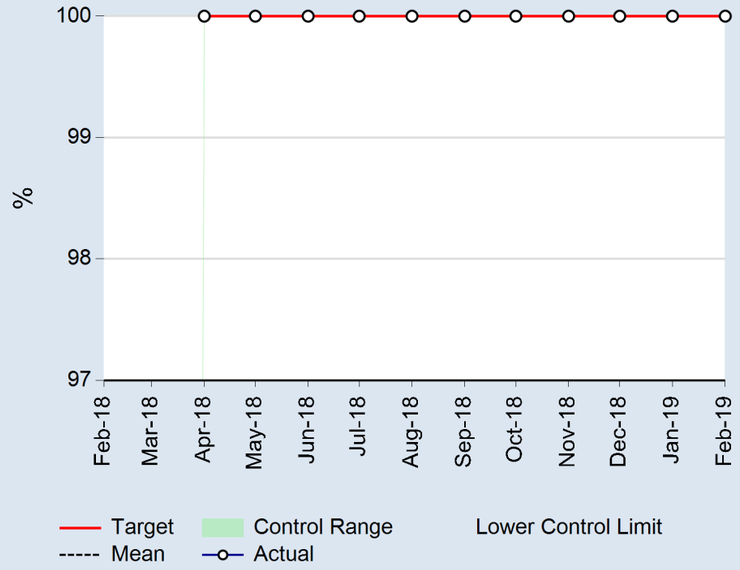
WHO Compliance - G

Description
% Compliance against completion of WHO Surgical Safety Checklist in Theatre Department

Target
100% in month (Internal Monitoring)

Executive Lead
Medical Director

Comment
We continue to monitor compliance by ensuring there have been no datix raised to report any failures in completing the WHO Surgical Safety Checklist. The compliance is reported at 100% in February.



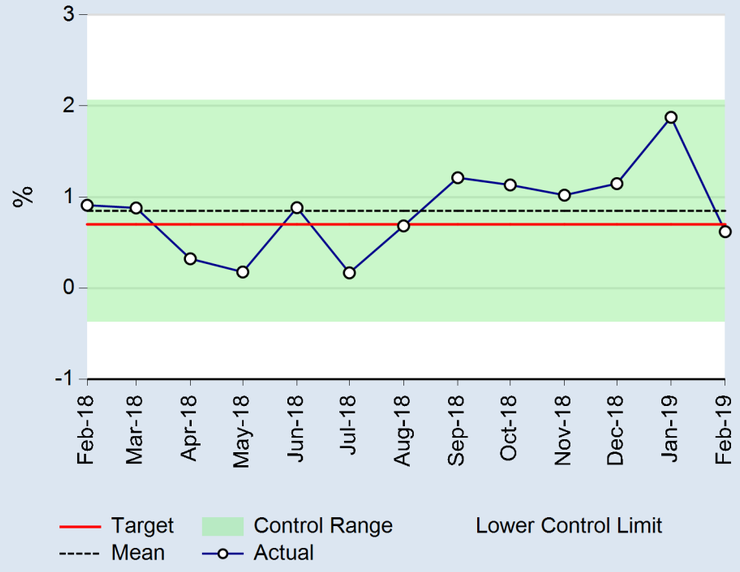
% Reportable Cancellations - G

Description
% of procedures which were reportable cancellations on the day i.e. within Trust's Control

Target
0.7% in month (External Measure, Internal Target)

Executive Lead
Director of Operations

Comment
There were seven reportable cancellations in February with reasons associated with lack of kit (3), lack of time (3) and an emergency case took priority (1). Based on activity levels carried out in February reportable cancellations are green rated at 0.62%.



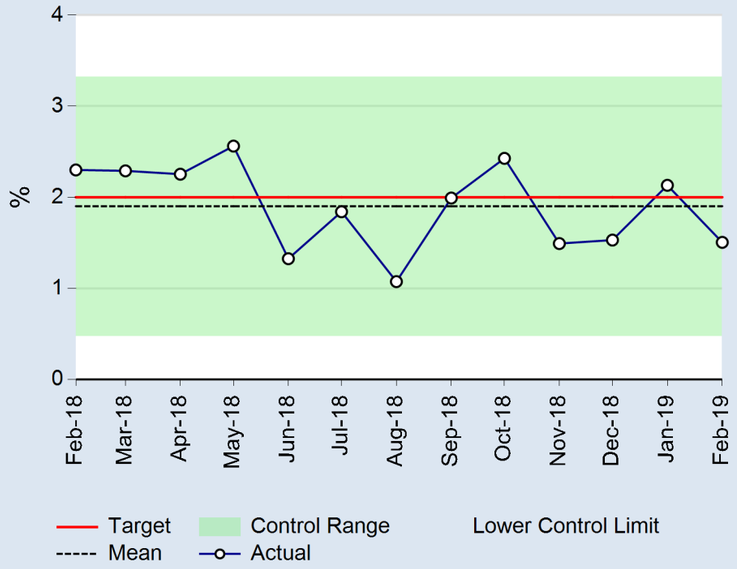
% Non-Reportable Cancellations - G

Description
% of procedures which were non-reportable cancellations on the day

Target
2% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
There were seventeen non-reportable cancellations in February with reasons associated with medically unfit (11), DNA (2), patient declined (2), operation abandoned (1) and surgery not required (1). Based on activity levels in February, non-reportable cancellations are green rated at 1.50%.



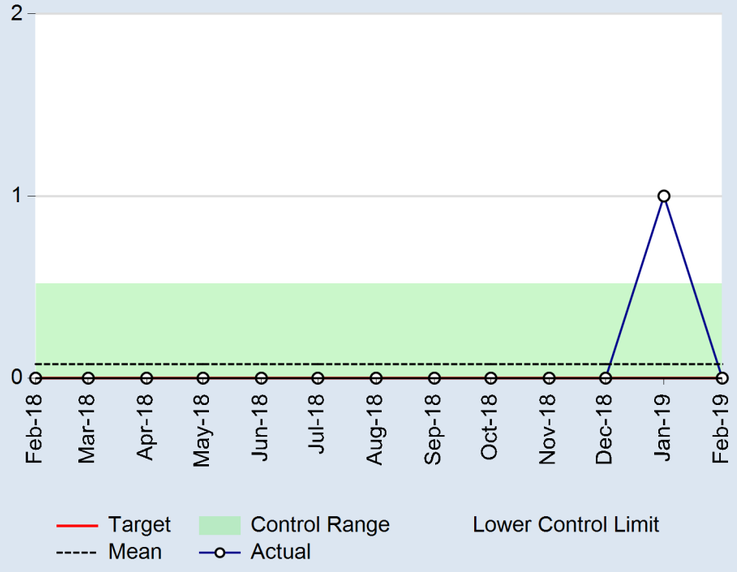
Cancellations Not Rebooked within 28 Days - G

Description
Number of theatre cancellations (reportable) not rebooked within 28 days

Target
0 in month (External Measure, External Target)

Executive Lead
Director of Operations

Comment
All reportable cancellations were rebooked within 28 days of cancellation.



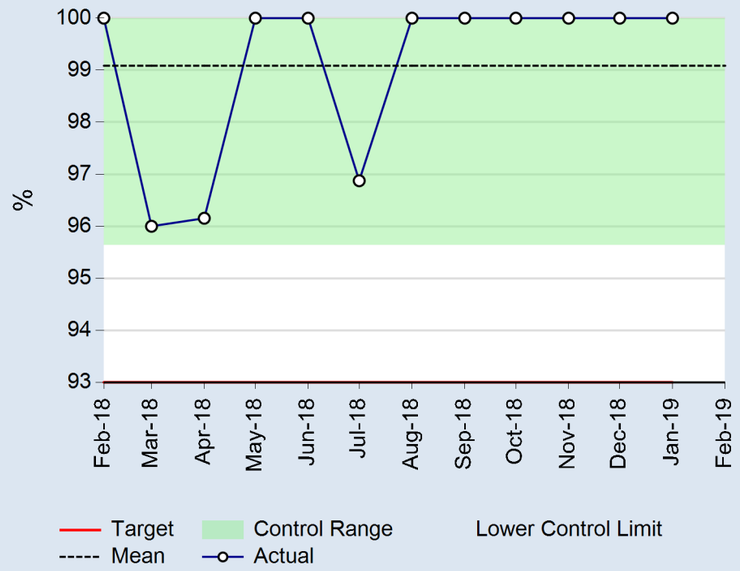
Cancer Two Week Wait* - G

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

Comment
The Cancer 2 week wait standard was achieved in January and but indicative data for February shows the standard will not be met.

Target
93% in month (External Measure, External Target)

Executive Lead
Director of Operations



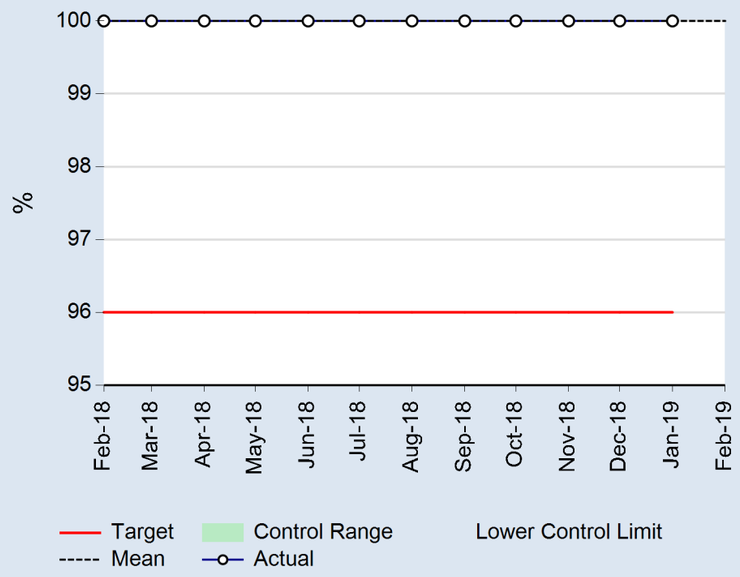
31 Days First Treatment (Tumour)* - G

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

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

Target
96% in month (External Measure, External Target)

Executive Lead
Director of Operations



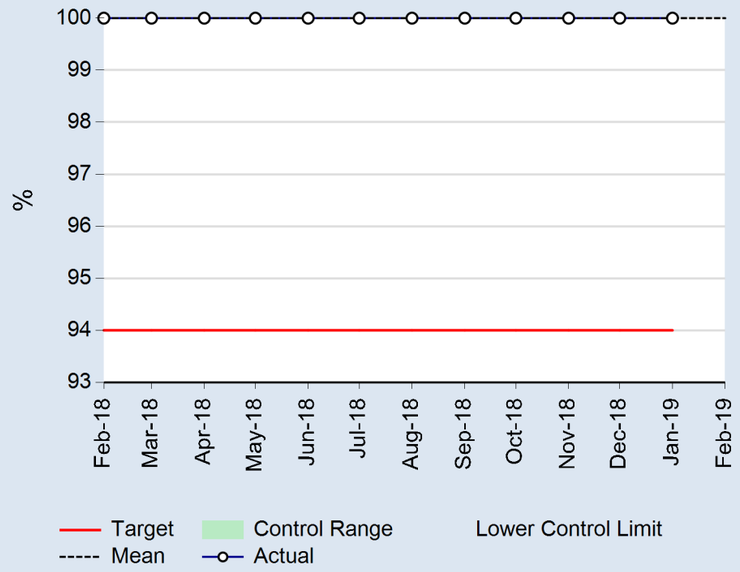
31 Days Subsequent Treatment (Tumour)* - G

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

Target
94% in month (External Measure, External Target)

Executive Lead
Director of Operations

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



Cancer Plan 62 Days Standard (Tumour)* - R

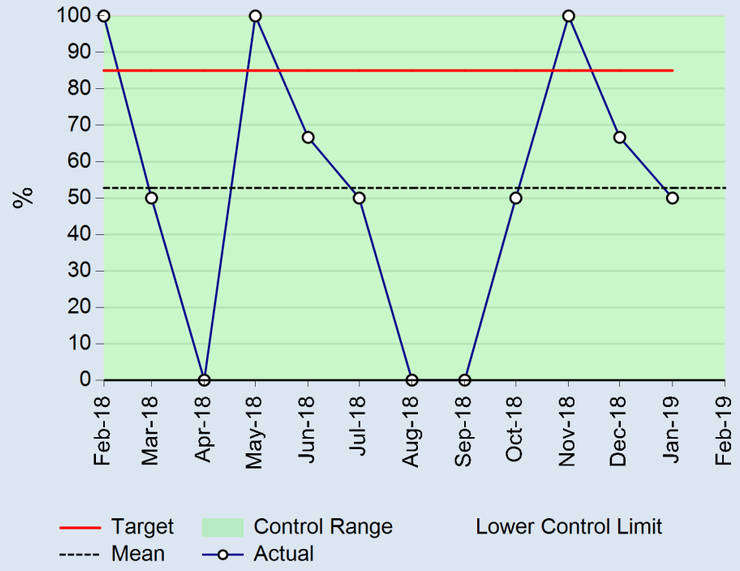
Description
% of cancer patients treated within 62 days of referral (*Reported one month in arrears)

Target
85% in month (External Measure, External Target)

Executive Lead
Director of Operations

Comment
The Cancer 62 day standard was not achieved in January. One patient, whose entire pathway was at RJAH was treated in target but two further patients who had shared pathways with other Trusts breached the standard.

Action
The first patient who breached the standard was a shared pathway with The Christie and due to various investigations required the patient could not be referred on until Day 46 so the breach reallocation would lie with RJAH. The second patient who breached the standard was a shared pathway with Royal Preston and this patient was referred to them on Day 31. Although breach reallocation is not yet functional in the National Cancer Waits Database we continue to follow the process of breach reallocation internally and the adjusted mitigated position would be 75% this month.



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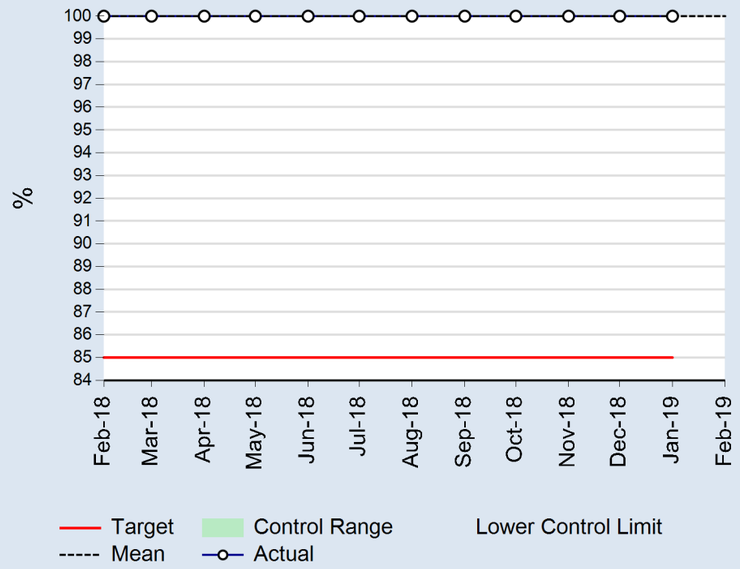
Cancer 62 Days Consultant Upgrade* - G

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

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

Target
85% in month (External Measure, External Target)

Executive Lead
Director of Operations



18 Weeks RTT Open Pathways - R

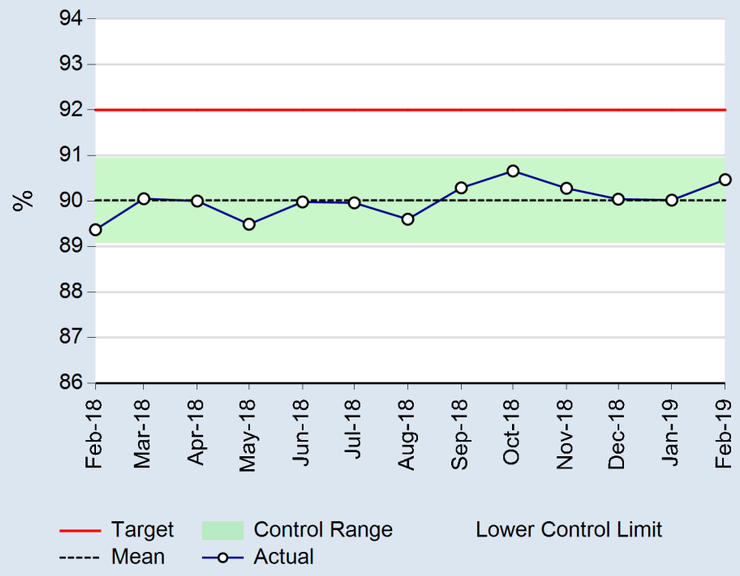
Description
% of English patients on waiting list waiting 18 weeks or less

Comment
Our February performance was 90.47% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The total number of breaches reduced from 658 in January to 610 in February.

Target
92% at month end (External Measure, External Target)

Action
See Exception Report.

Executive Lead
Director of Operations



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Patients Waiting Over 52 Weeks – English - R

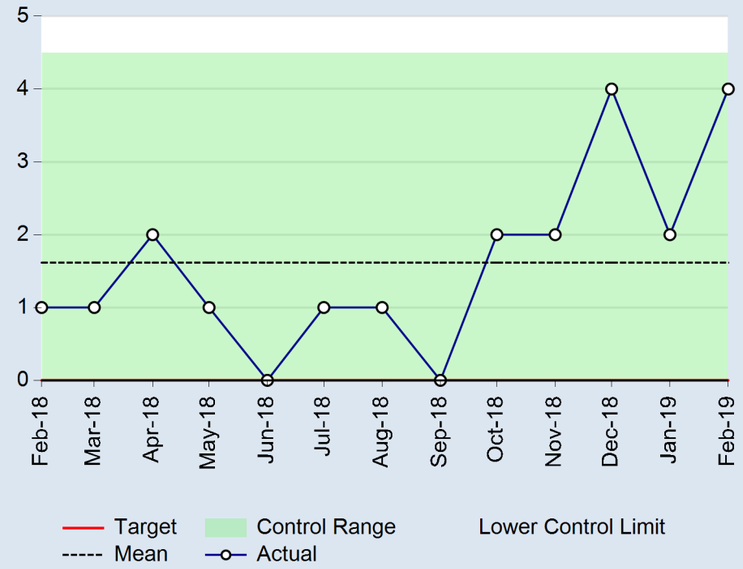
Description
Number of English RTT patients currently waiting 52 weeks or more

Target
0 at month end (External Measure, External Target)

Executive Lead
Director of Operations

Comment
At the end of February there were four English patients waiting over 52 weeks.

Action
See Exception Report.



Patients Waiting Over 52 Weeks – Welsh - R

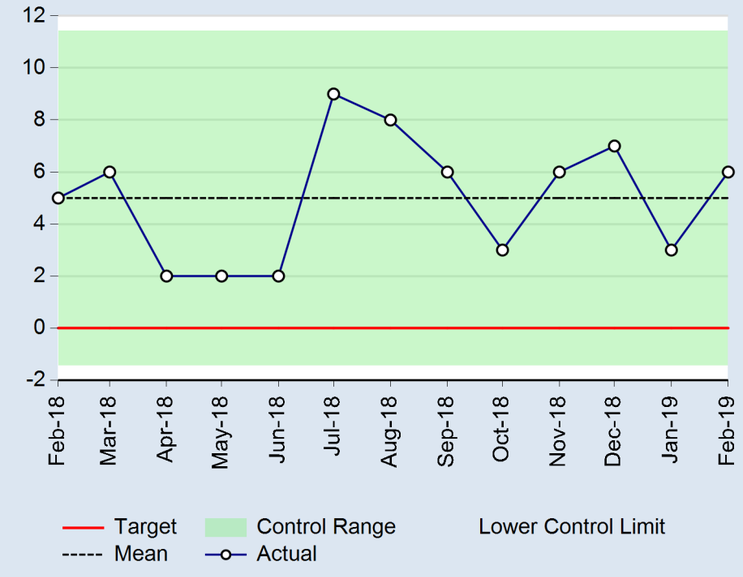
Description
Number of RJAH Welsh RTT patients currently waiting 52 weeks or more

Target
0 at month end (External Measure, External Target)

Executive Lead
Director of Operations

Comment
There were six patients waiting over 52 weeks at the end of February 2018.

Action
See Exception Report.



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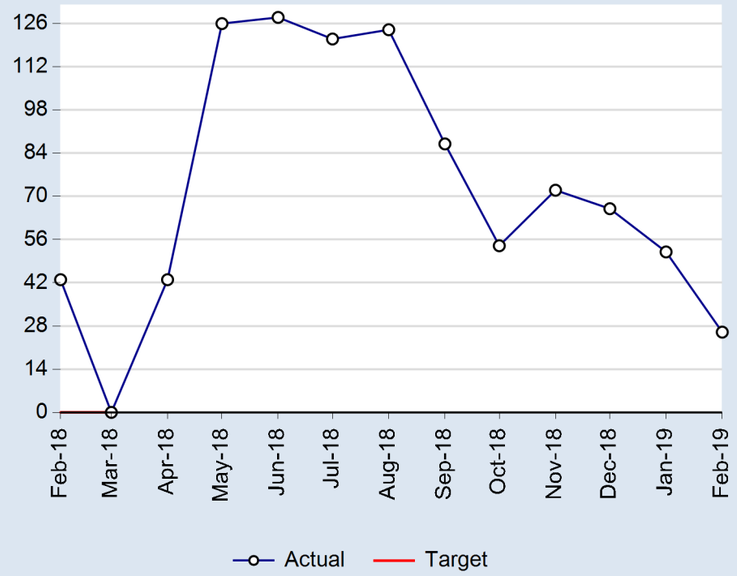
Patients Waiting Over 52 Weeks – Welsh (BCU Transfers) -

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

Target
No target (External Measure, External Target)

Executive Lead
Director of Operations

Comment
At the end of February there were 26 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.



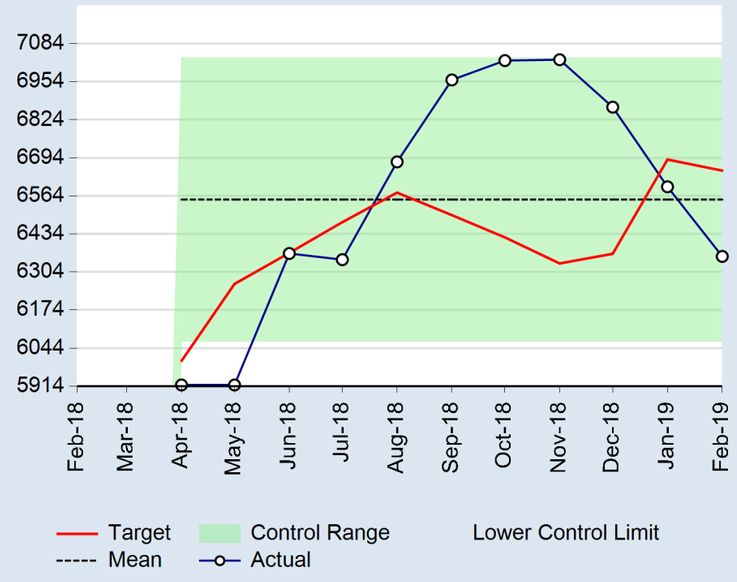
English List Size - G

Description
Number of English patients currently waiting

Target
6650 in February (Internal Monitoring)

Executive Lead
Director of Operations

Comment
The number of English patients waiting at the end of February is reported at 6357.



6 Week Wait for Diagnostics - English Patients - R

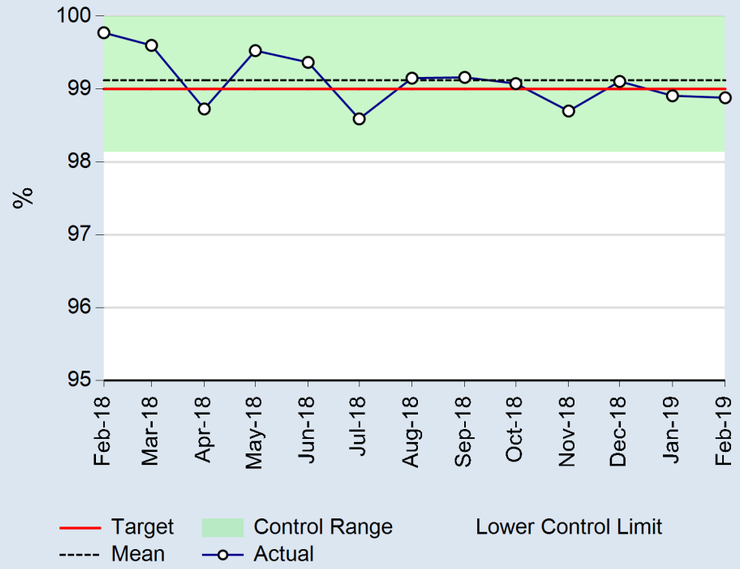
Description
% of English patients currently waiting less than 6 weeks for diagnostics

Target
99% at month end (External Measure, External Target)

Executive Lead
Director of Operations

Comment
The 6 week standard for diagnostics was not achieved this month and is reported at 98.88%. This equates to eight patients who waited beyond six weeks. The reasons associated with the delays were patient unable to attend (5), capacity issues (2) and delays in the request to Diagnostics (1).

Action
Actions are being taken to address the delays receiving requests to the Diagnostics Division. This will involve establishing a methodology for escalation of delays that can be consistently applied by the Division. It will involve feedback to referrers and escalation to both internal managers and CCGs.



8 Week Wait for Diagnostics - Welsh Patients - A

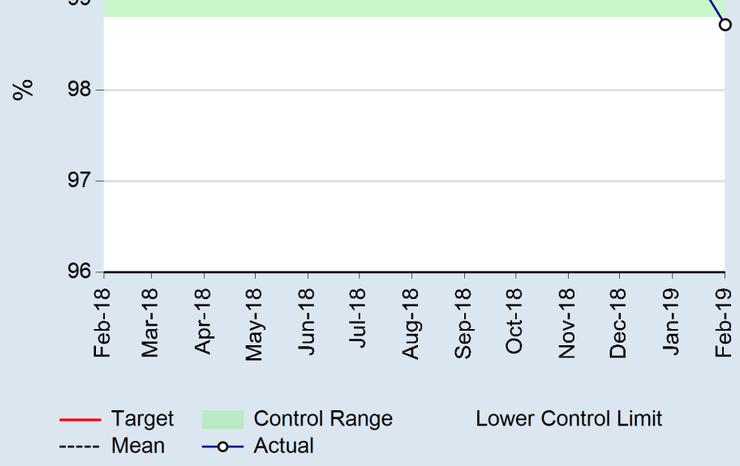
Description
% of Welsh patients currently waiting less than 8 weeks for diagnostics

Target
100% at month end (External Measure, External Target)

Executive Lead
Director of Operations

Comment
The 8 week standard for diagnostics was not achieved this month and is reported at 98.72%. This equates to four patients who waited longer than eight weeks. The reasons associated with the delays were patient unable to attend (1) and delays in the request to Diagnostics (3).

Action
Actions are being taken to address the delays receiving requests to the Diagnostics Division. This will involve establishing a methodology for escalation of delays that can be consistently applied by the Division. It will involve feedback to referrers and escalation to both internal managers and CCGs.



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

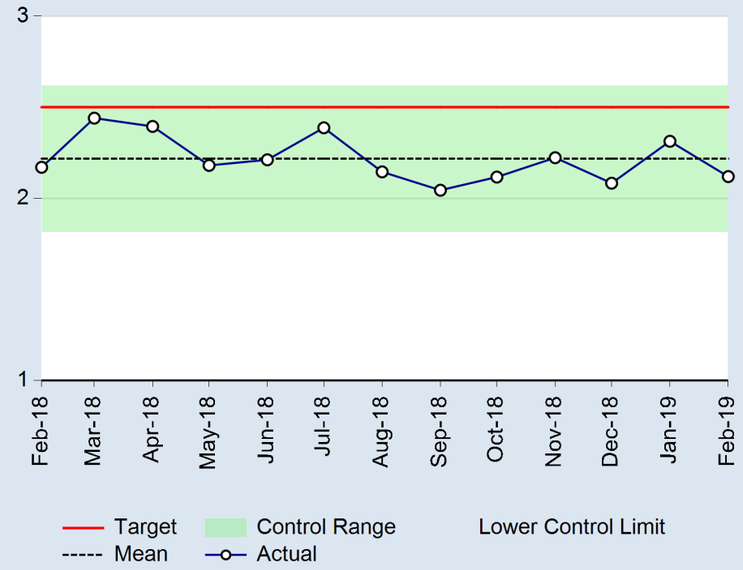
New to Follow Up Ratio (Consultant Led Activity) - G

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 2.12 in February.

Target
2.5 follow up for each new in month

Executive Lead
Director of Operations



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

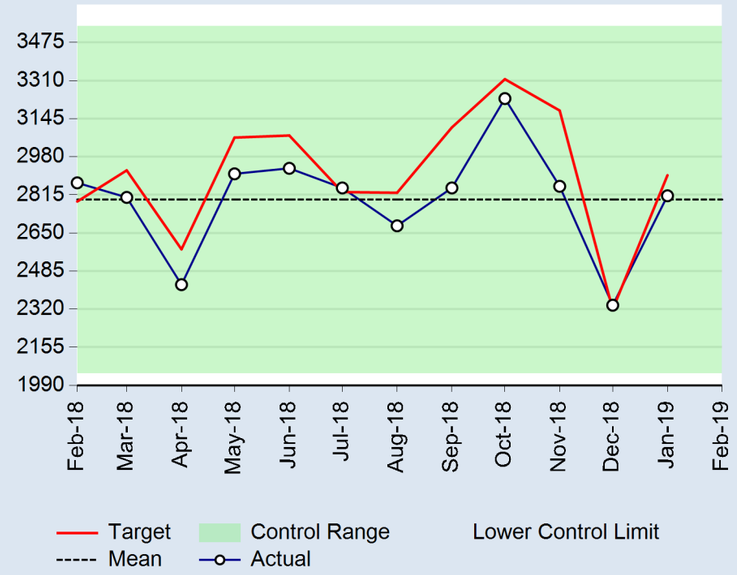
Referrals Received for Consultant Led Services* - G

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 within anticipated levels and green rated this month.



Overall Daycase Rate - A

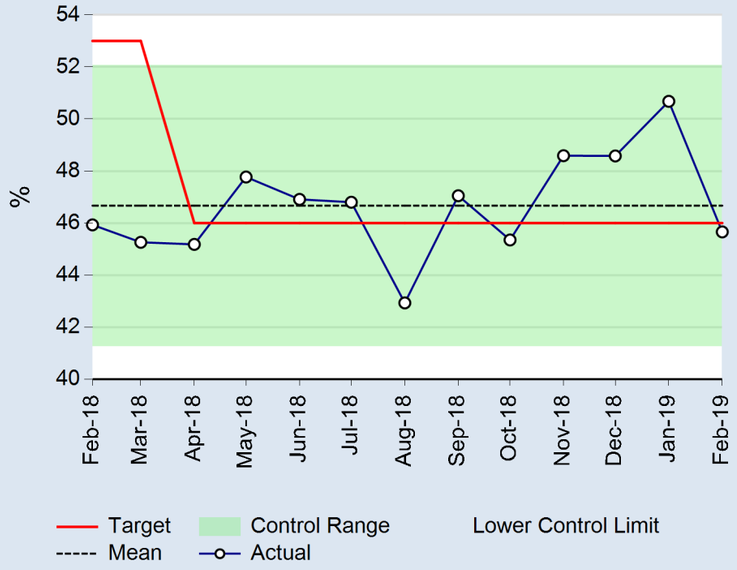
Description
% of procedures performed as a daycase

Target
46% in March

Executive Lead
Director of Operations

Comment
The Daycase rate is amber rated this month at 45.66% against the 46% target.

Action
Although the February position was below target the year to date position exceeds the 46%.



% Sessions Used Against Plan - A

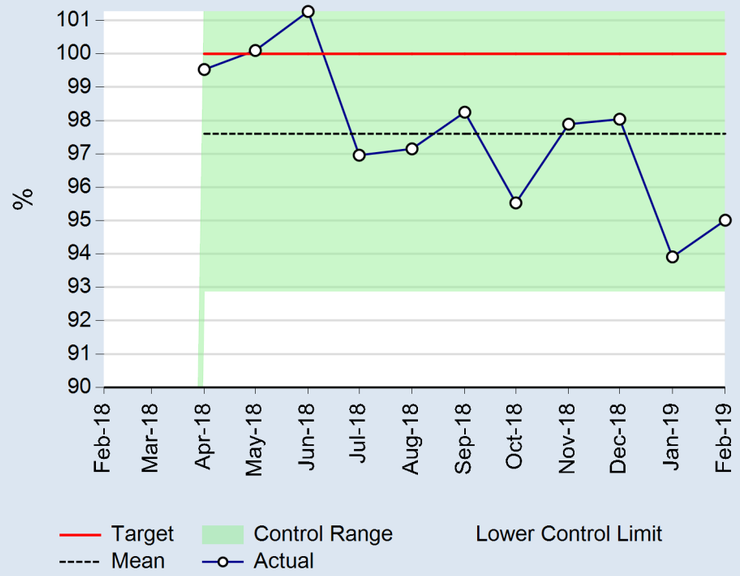
Description
% of sessions used against plan

Target
100% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
Performance against this measure is amber rated this month at 95.01% sessions used against plan. This equates to 25 sessions behind plan.

Action
Sessions are monitored on a daily basis. Discussions are taking place with consultants to use capacity for clinics and theatres where most appropriate. Bookings, gaps and sessions tracker is sent to Executive Team daily.



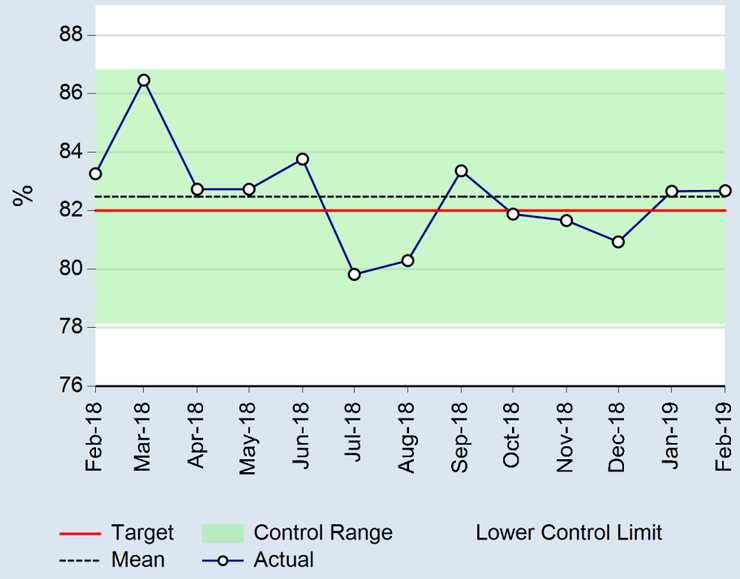
Touchtime Utilisation - G

Description
% of Minutes Utilised replicating Touch Time methodology

Target
82% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
Performance in February met the 82% target at 82.68%.



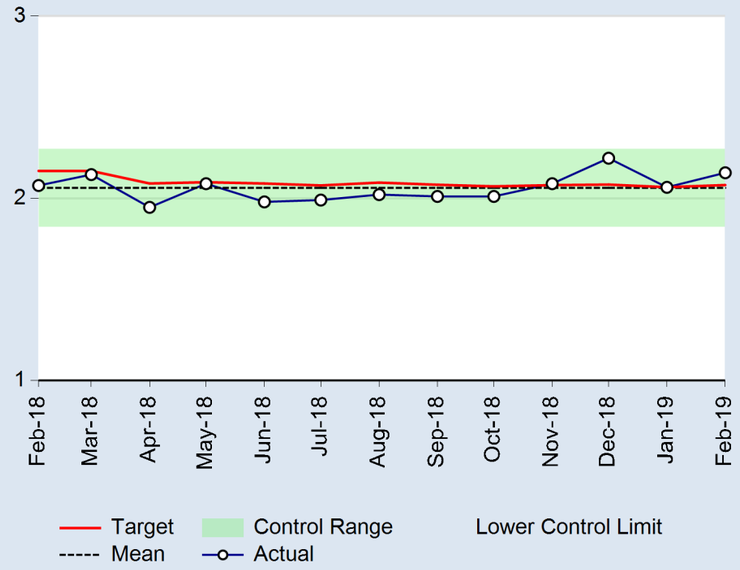
Theatre Cases Per Session - G

Description
Average number of cases per theatre session

Target
2.08 in December (Internal Monitoring)

Executive Lead
Director of Operations

Comment
Theatre cases per session is green rated in February at 2.14 against the 2.07 target.



Total Theatre Activity - A

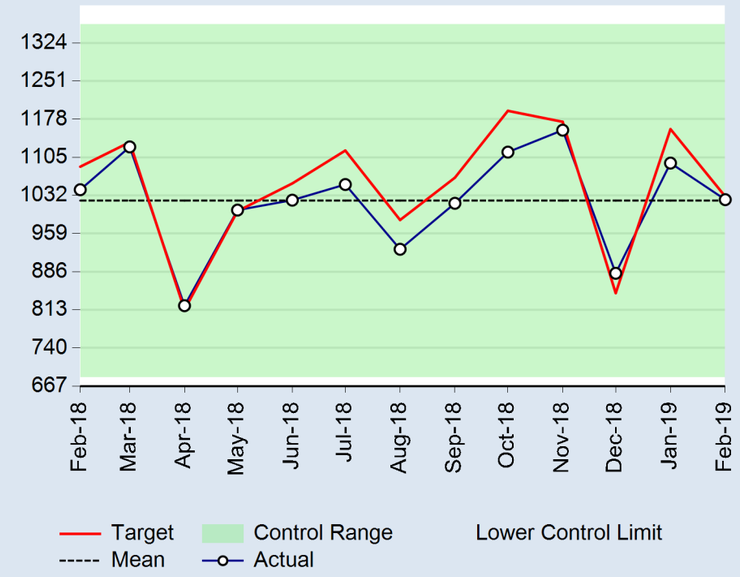
Description
Activity in theatres in month

Target
1030 in February (Internal Monitoring)

Executive Lead
Director of Operations

Comment
A breakdown of Total Theatre Activity against plan is:
- T&O -904 against plan of 948 (-44 cases)
- MCSI - 54 against plan of 30 (+24 cases)
- Private Patients - 66 against plan of 52 (+14 cases)

Action
Theatre activity is monitored daily and tracker is sent to Executive Team. Daily com cell meetings are held with theatres, implants and bed manager to check Theatre booking system two weeks in advance and fill gaps with available patients. Work is underway to with booking clerks and Consultants to deliver desired activity.



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Average Length of Stay - A

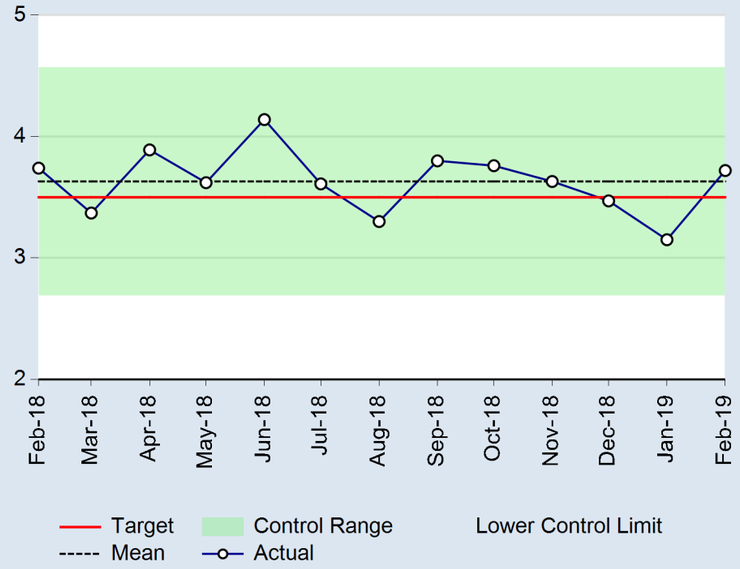
Description
Elective patients length of stay (excluding daycase)

Target
3.5 in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
The average length of stay is amber rated this month at 3.72 days against a target of 3.5 days.

Action
We continue to monitor the number of patients who require an extended stay as part of their treatment plan. In February six patients required a stay over 20 days as part of their treatment plan. Without these patients our average length of stay would be at 3.26 days. Senior nursing staff are also reviewing the patients who are admitted prior to the day of surgery to establish and themes.



Bed Occupancy – Adult Orthopaedic Wards – 2pm - A

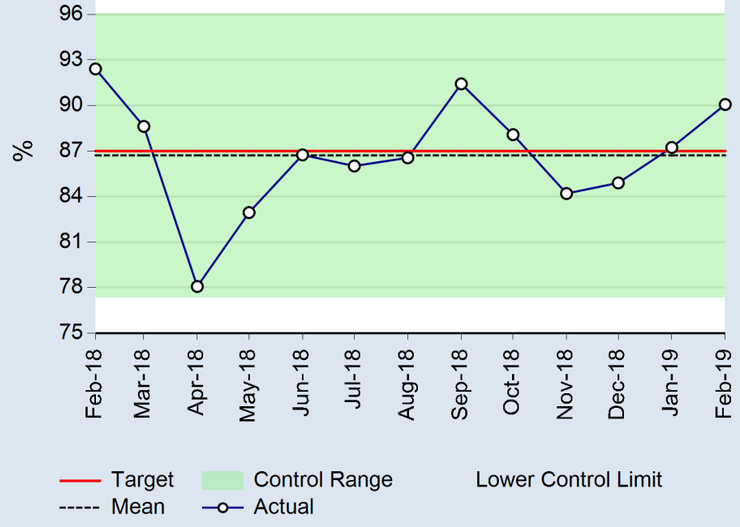
Description
% Bed occupancy at 2pm

Target
87% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
The occupancy rate for adult orthopaedic beds is amber rated this month at 90.07%.

Action
Activity levels in February have impacted on our occupancy rates on our surgical wards.



Bed Occupancy – All Wards – 2pm - A

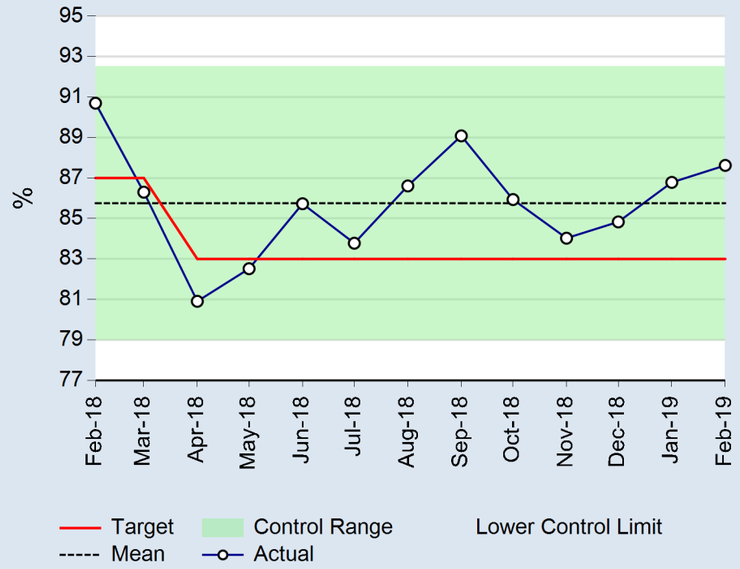
Description
% Bed occupancy at 2pm

Target
83% in month (Internal Monitoring)

Executive Lead
Director of Operations

Comment
The occupancy rate for all wards is amber rated this month at 87.62%, above the 83% target.

Action
As anticipated, we continue to see high occupancy levels on our rehabilitation wards.



Outpatients Activity Attendances - A

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 behind plan in month 11 driven by under performance in the Surgical Division.

Action
Although the February position was below plan, the year to date position exceeds it.

Outpatient DNA Rate (Consultant Led Activity) - R

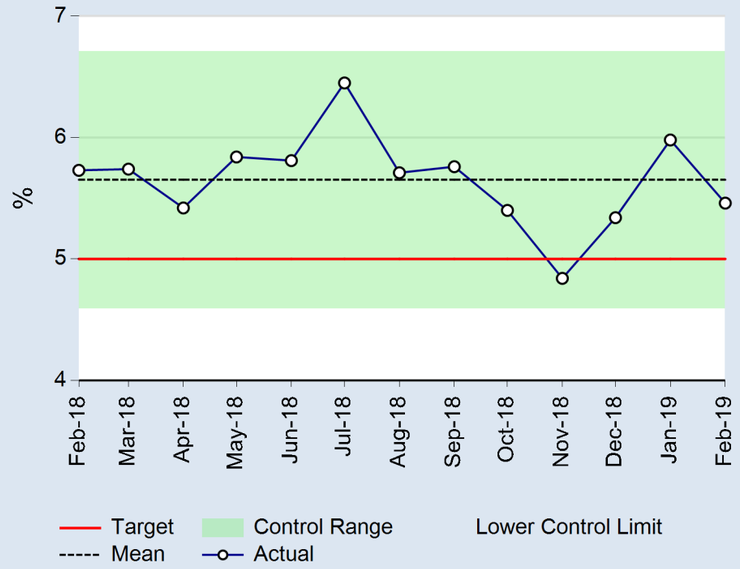
Description
% of outpatient appointments not attended

Target
5% in month

Executive Lead
Director of Operations

Comment
The DNA rate is red rated in February at 5.46%. This equates to 478 missed appointments.

Action
There continues to be regular review of the data where themes are established to adopt appropriate actions for specific sub-specialties.



Financial Control Total - G

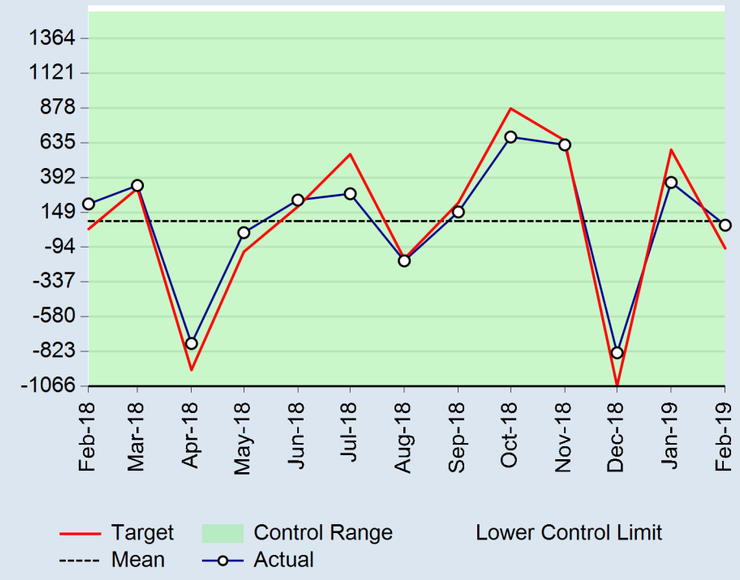
Description
Surplus/deficit adjusted for donations and excluding STF funding

Target
£1,104m

Executive Lead
Director of Finance

Comment
- £59k surplus in month, £162k favourable versus plan
- £596k Surplus ytd, £52k Adverse to plan

Action
Forecast has identified c£200k risk to achievement of control total based on activity shortfalls projected for March. Further mitigating action required to improve activity bookings and identify non activity related mitigations.



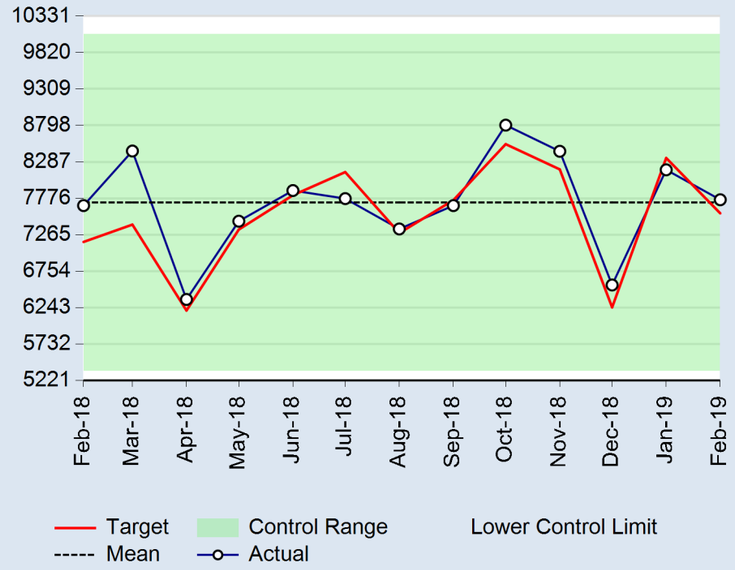
Clinical Income from Activity - G

Description
Income associated with clinical activities (excludes pass through drugs)

Target
£91.5m

Executive Lead
Director of Finance

Comment
- Overall £191k favourable despite major shortfall in theatre income:
- Risk provision released following contract settlement achieved
- Medicine division activity and MCSI over performed



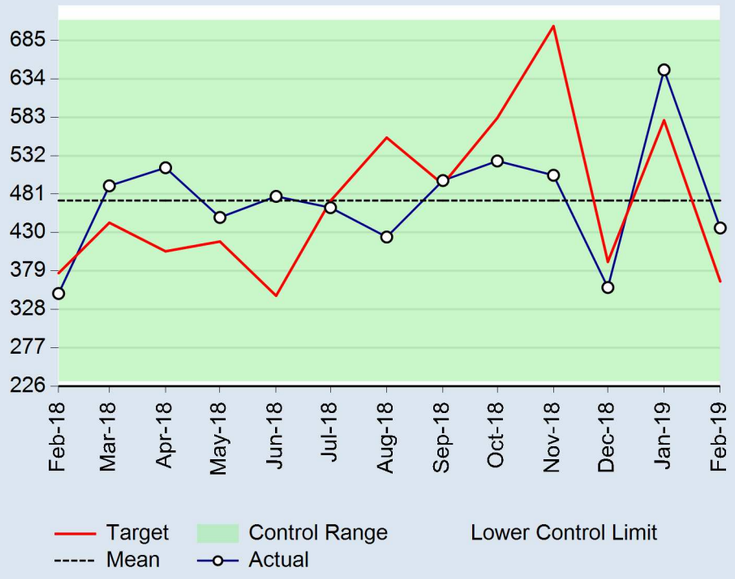
Private Patients Income - G

Description
Income generated by private patient activity

Target
£5.4m

Executive Lead
Director of Finance

Comment
- £71k favourable
- £12k adverse ytd



Other Income - A

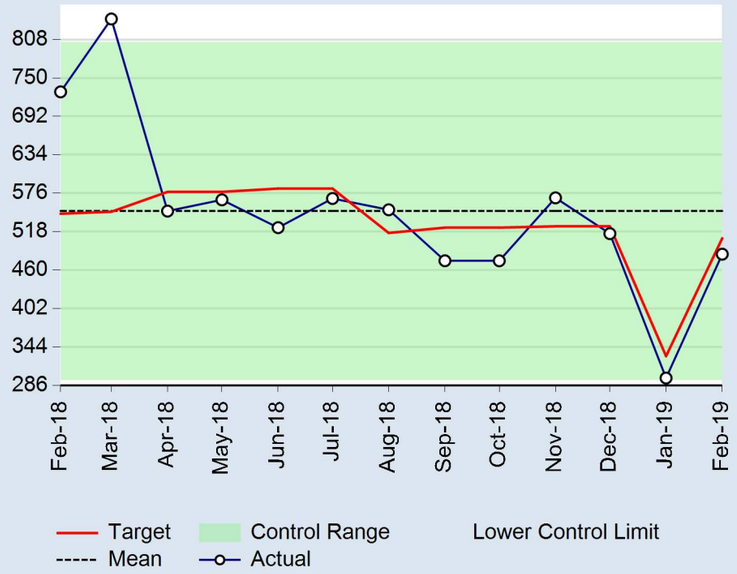
Description
Non-clinical income e.g. research, education and NHS Injury Cost Recovery (ICR)

Target
£6.5m

Executive Lead
Director of Finance

Comment
-Underlying position excluding AfC pay award income £26k adverse in month driven by research and education

Action
Education shortfall driven by placement activity, Research recovery plan on going, tracked through performance review meetings.



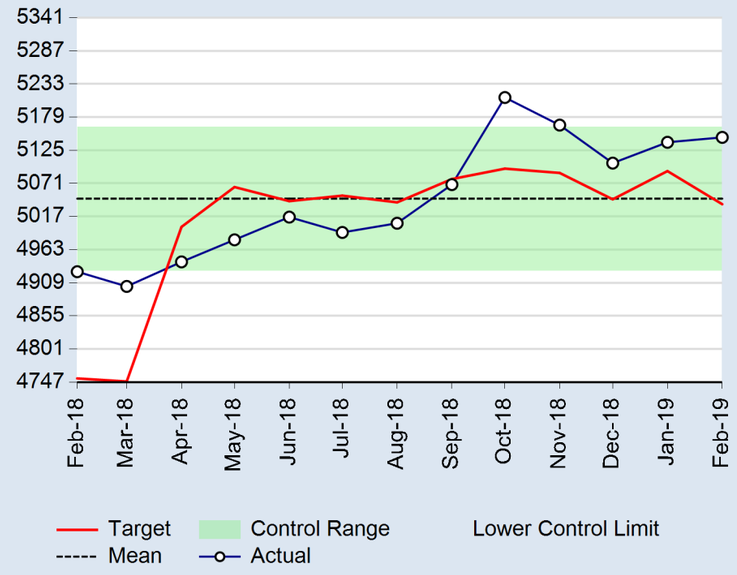
Pay - A

Description
Expenditure on workforce

Target
£60.7m

Executive Lead
Director of Finance

Comment
- £109k adverse (excluding AfC pressure) due to:
 - Increased nursing bank and agency usage linked to increased levels of sickness
  - Theatres £63k
  - Medicine Wards £24k
  - Surgery wards £20k



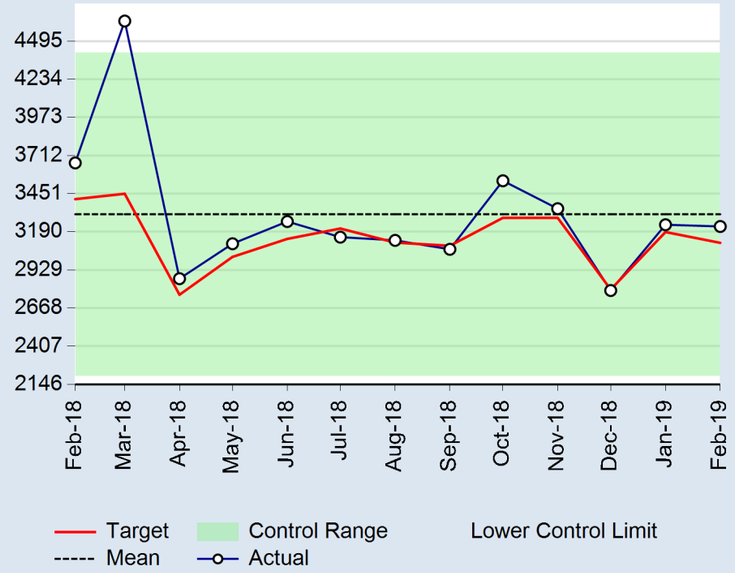
Non Pay - G

Description
Non-workforce expenditure e.g. consumables, implants and drugs (excludes pass through drugs)

Comment
- Non Pay £31k favourable excluding pass through costs driven by lower volumes of activity

Target
£37.5m

Executive Lead
Director of Finance



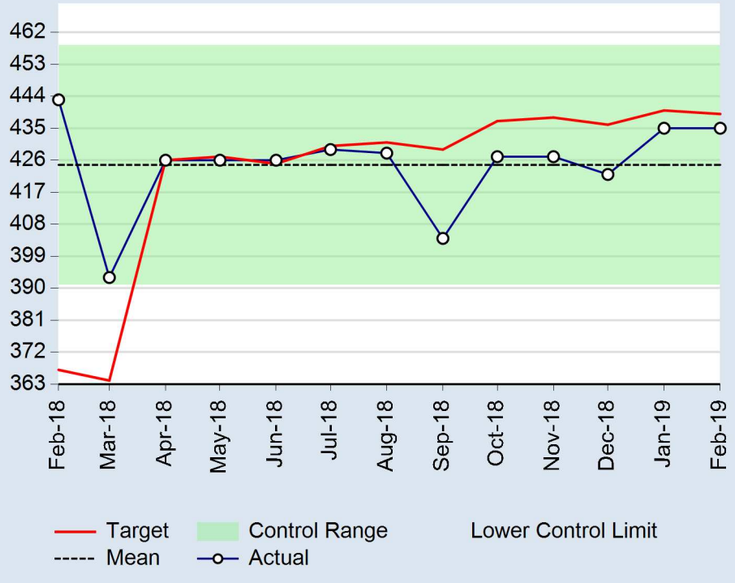
Financing - A

Description
Costs associated with financing the Trust i.e. depreciation, PDC and interest charges

Comment
- Finance costs are £4k favourable to plan in month

Target
£5.1m

Executive Lead
Director of Finance



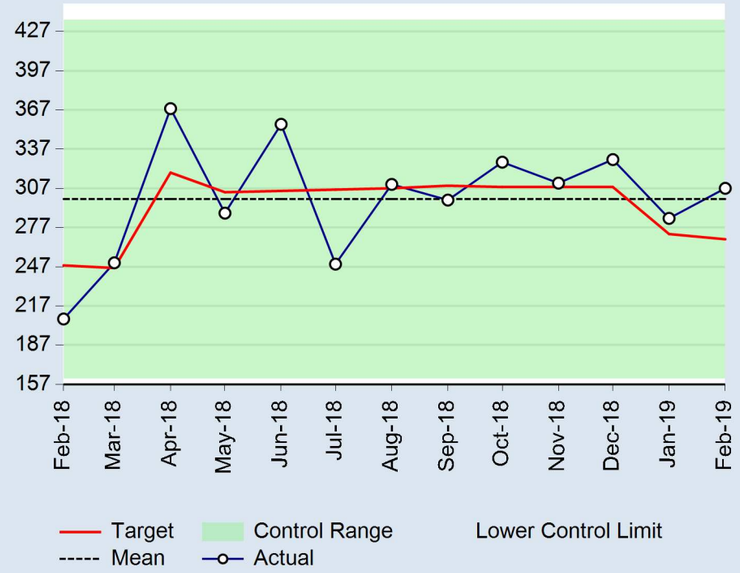
CIP Delivery - G

Description
Cost Improvement Programme requirement

Target
£3.6m

Executive Lead
Director of Finance

Comment
- CIPs £39k ahead of plan in month - £113k ahead of plan YTD



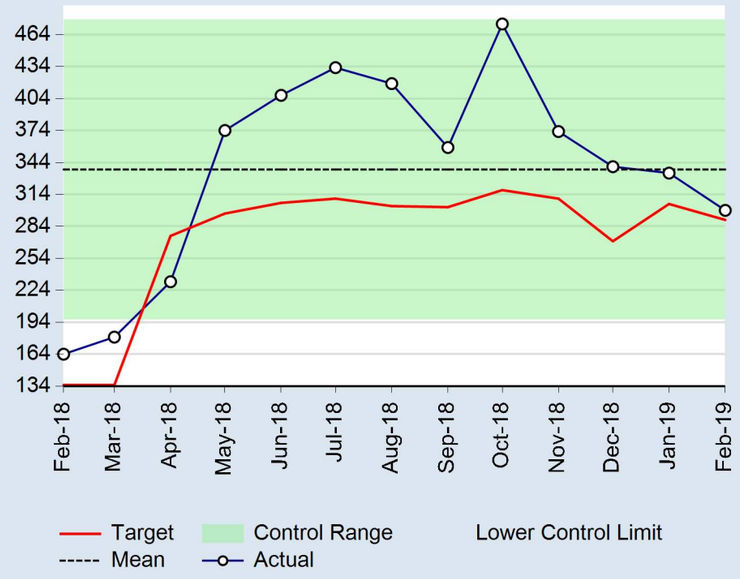
Agency Control Total - A

Description
Annual ceiling for total agency spend introduced by NHS Improvement

Target
£4.0m

Executive Lead
Director of Finance

Comment
-Agency spend £9k adverse against cap in month; YTD £757k adverse
- LLP £77k adverse; YTD £773k
- 'Core' agency £68k favourable; YTD £16k favourable and ahead of schedule with improvement plan



Cash Balance - A

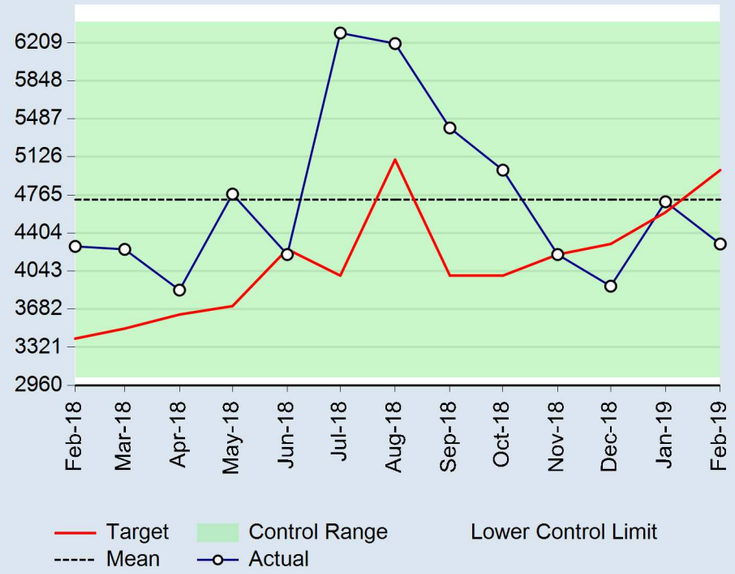
Description
Cash in bank

Target
£5m (at March 2019)

Executive Lead
Director of Finance

Comment
- Cash balances reduced by £0.4m in month to £4.3m and now £0.7m behind plan.
- In month reduction driven by loan repayment

Action
Secure cash from Commissioners for over perfromance as part of year end agreements.



Capital Expenditure - G

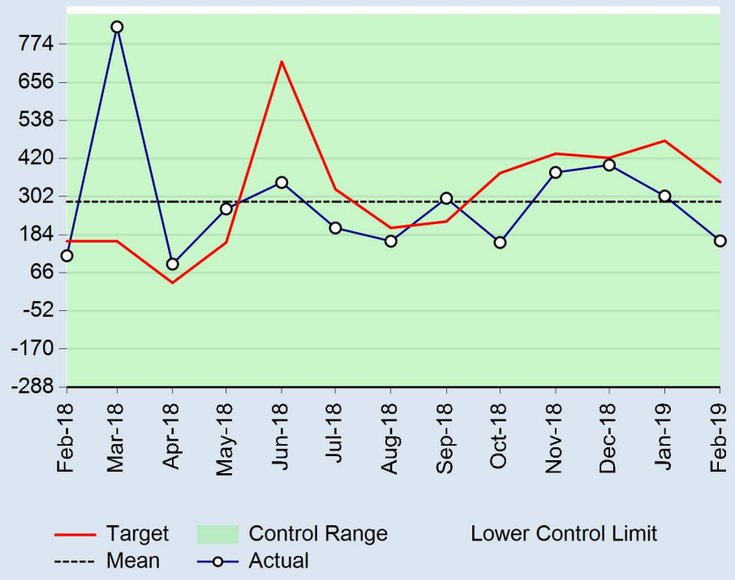
Description
Expenditure against Trust capital programme

Target
£4.3m

Executive Lead
Director of Finance

Comment
- Capital spend of £165k in month, £182k under plan in month
- £949k below plan YTD driven by phasing of plan

Action
Forecast underspend estimated at c£300k by year end driven by delays to TSSU scheme. Cash to be allocated to next years programme.



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

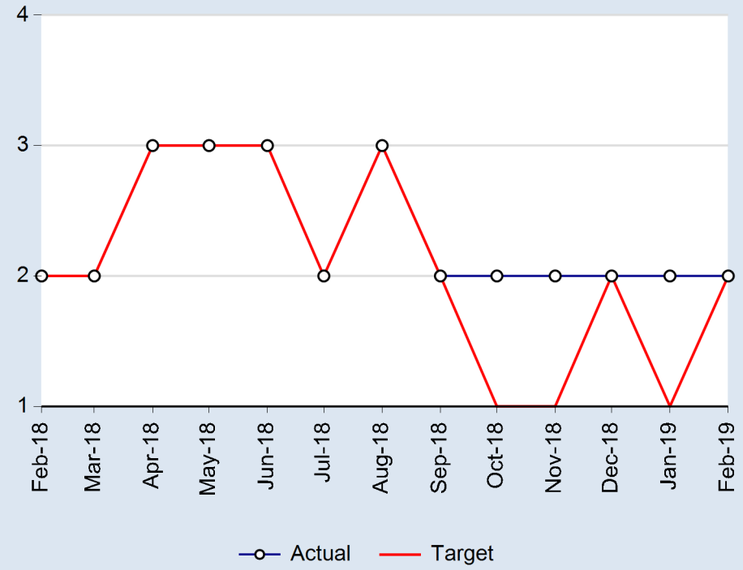
Use of Resources (UOR) - G

Description
Overall Use of Resources indicator

Target
1 (at March 19)

Executive Lead
Director of Finance

Comment
UOR maintained at level 2 and on plan in month.



Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 28th February 2019

Income and Expenditure £'000s

Category	Annual Plan	In Month Position			Year To Date Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	96,940	8,017	8,038	21	88,383	88,530	147
PSF	833	96	0	(96)	736	543	(193)
Private Patient income	5,831	365	436	71	5,312	5,300	(12)
Other income	6,329	528	564	35	5,996	6,464	468
Pay	(60,670)	(5,037)	(5,227)	(190)	(55,632)	(56,662)	(1,030)
Non-pay	(42,737)	(3,589)	(3,368)	220	(39,209)	(38,909)	300
EBITDA	6,527	381	442	62	5,586	5,266	(320)
Finance Costs	(5,197)	(439)	(435)	4	(4,758)	(4,685)	73
Capital Donations	200	20	11	(9)	200	282	82
Operational Surplus	1,530	(38)	19	57	1,028	863	(165)
Remove Capital Donations	(200)	(20)	(11)	9	(200)	(282)	(82)
Add Back Donated Dep'n	607	51	51	1	556	558	2
Remove PSF	(833)	(96)	0	96	(736)	(543)	193
Control Total exl PSF	1,104	(103)	59	162	648	596	(52)
PSF Earnt	833	96	0	(96)	736	543	(193)
Control Total	1,937	(7)	59	66	1,384	1,139	(245)
EBITDA margin	6.0%	4.3%	4.9%	0.6%	5.6%	5.3%	-0.4%

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

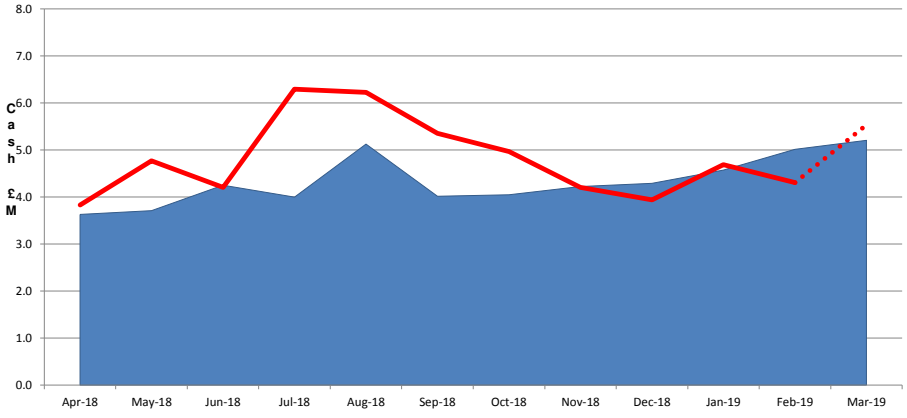
	Feb-19	YTD
Debtor Days	23	24
Creditor Days	31	34

Statement of Financial Position £'000s

Category	Jan-19	Feb-19	Movement	Drivers
Fixed Assets	74,558	74,442	(116)	
Non current receivables	848	829	(19)	
Total Non Current Assets	75,406	75,271	(135)	
Inventories (Stocks)	1,190	1,221	31	
Receivables (Debtors)	9,009	8,237	(772)	Settlement from specific commisioners as part of year end agreements.
Cash at Bank and in hand	4,690	4,308	(382)	Reduction driven by biannual loan repayment.
Total Current Assets	14,889	13,766	(1,123)	
Payables (Creditors)	(11,425)	(10,723)	702	Clearance of payables and reduction in clinical income risk reserve.
Borrowings	(1,176)	(1,176)	0	
Current Provisions	(86)	(86)	0	
Total Current Liabilities (< 1 year)	(12,687)	(11,985)	702	
Total Assets less Current Liabilities	77,608	77,052	(556)	
Non Current Borrowings	(6,472)	(5,884)	588	Biannual loan capital repayment
Non Current Provisions	(148)	(156)	(8)	
Non Current Liabilities (> 1 year)	(6,620)	(6,040)	580	
Total Assets Employed	70,988	71,012	24	
Public Dividend Capital	(33,387)	(33,387)	0	
Revenue Position	(11,848)	(11,853)	(5)	
Retained Earnings	(844)	(863)	(19)	Current period Surplus, before control total adjustment
Revaluation Reserve	(24,909)	(24,909)	0	
Total Taxpayers Equity	(70,988)	(71,012)	(24)	

Monthly Surplus/Deficit

Cash Flow



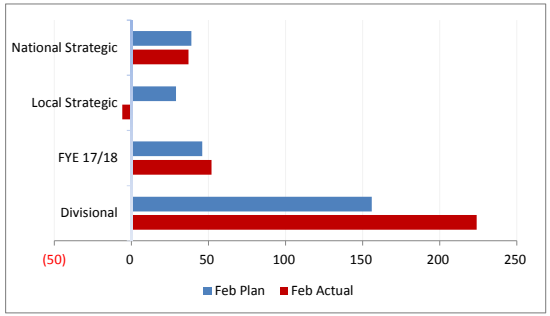
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Plan £M	3.6	3.7	4.3	4.0	5.1	4.0	4.0	4.2	4.3	4.6	5.0	5.2
Actual £M	3.8	4.8	4.2	6.3	6.2	5.4	5.0	4.2	3.9	4.7	4.3	
Forecast £M											4.3	5.5

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 28th February 2019

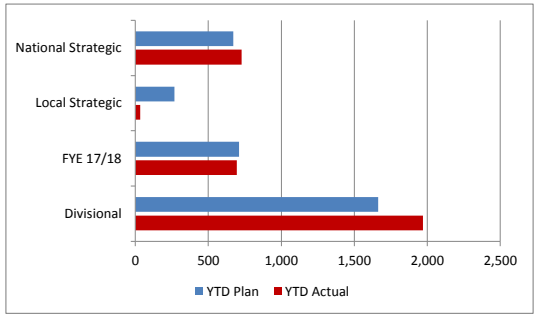
Cost Improvement Programme

CIP by Theme

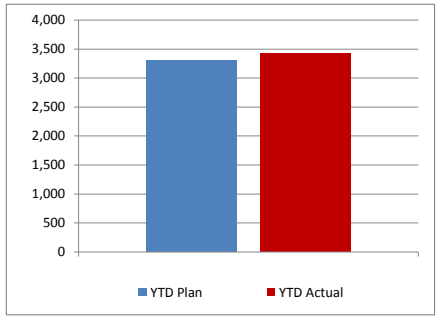
In Month CIP Achievement £000's



Year To Date CIP Achievement £000's

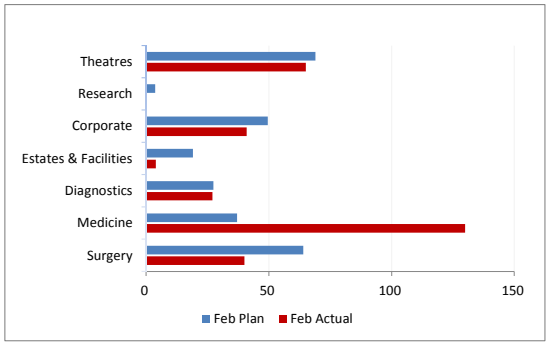


Trust YTD Achievement Against YTD Plan £000's

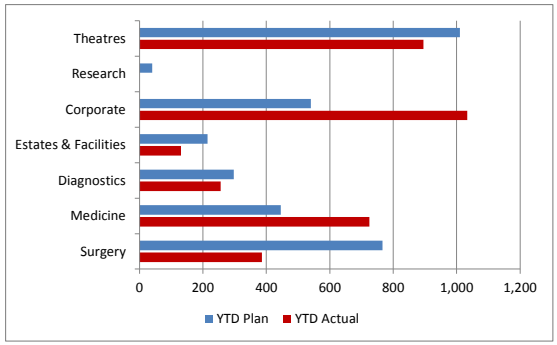


CIP by Division

In Month CIP Achievement £000's



Year To Date CIP Achievement £000's



RAG of Total Schemes Being Tracked

650	18%	b
2,817	78%	g
72	2%	a
72	2%	r
3,612	100%	

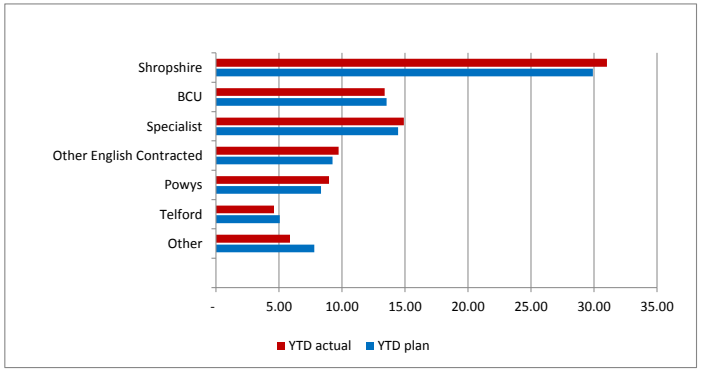
Capital

Year to date capital programme £000's

Position as at	1819-11	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	600	51	549	60
New IT network	200	100	0	100	200
Bed capacity solution	350	0	360	-360	360
Project management / implementation support	150	140	93	47	102
Estates backlog / CQC Site improvement	500	475	304	171	535
IT investment / replacement	300	270	199	71	319
Equipment and minor works investment / replacement	500	500	197	303	495
Fire safety work	200	150	243	-93	435
Kenyon toilet block	100	100	117	-17	117
Operational Control Centre	100	100	12	88	100
EPR development	100	50	29	21	65
Trust improvement bids	120	95	46	49	120
WiFi Project (PDC Funded)	127	127	121	6	129
Other (allocated from contingency)	82	75	57	18	82
Contingency	98	80	0	80	0
Pharmacy & Digital Pathology (PDC Funded	32	12	12	1	32
NHS Capital Funding	4,209	3,524	2,493	1,031	3,804
Donated Assets	200	200	282	-82	321
Total Capital Funding (NHS & Donated)	4,409	3,724	2,775	949	4,125

Commissioner Performance

Year To Date Commissioner Income against Plan £m



Exception Report – Patients Waiting Over 52 Weeks (Welsh)

Performance Issue:

Month	Total 52+ Weeks Reported	Of which, RJAH Patients	Forecast - 52+ Weeks	Of which BCU transfers	BCU transfers Trajectory
October		3			
November		6			
December		7			
January		3			
February		6			
March			13	22	0

October – Spinal Disorders (3)

November – Spinal Disorders (5) Foot and Ankle (1)

December – Spinal Disorders (5) Paediatrics (1) Knee & Sports Injuries (1)

January – Spinal Disorders (3)

February – Spinal Disorders (4), ACI (1), Pain (1)

March forecast - the majority have dates during March and will not breach the target. Three patients are at risk of breaching; Pain (1), Spinal disorders (2).

Planned Remedial Actions:

Spinal Disorders

Spinal disorders continues to be a service challenged for capacity, however the action plan detailed in last month's report and the new policy for pooling referrals where possible is having a positive effect. All but one of the 52 week breach patients will be mitigated by the end of March and this spinal patient also looks likely to be a clock stop.

Pain Service

The service will close at the end of March 2019 with patients waiting more than 36 weeks being seen by an outsourced provider before the end of March and the remaining repatriated back to their commissioning areas or discharged.

ACI

One patient is at risk of not getting their treatment within their breach month. Assessment of whether the patient can be part of a clinical trial is being undertaken, which would mean that the patient is not RTT applicable.

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Paula Jeffreson

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
December	8.17%	347	1.99%	46	15.53%	301
January	4.02%	191	1.13%	31	7.98%	160
February	5.96%	264	1.20%	31	12.57%	233

Planned Remedial Actions:

1. Anticipated Trajectory

Delayed transfers of care deteriorated in February 2019 with the rise seen in the Medicine Division in the Spinal Injuries unit. We continue to anticipate delayed discharges in this specialty as the key challenges of timely funding and care packages agreed are still present: the Trust is unable to request funding for packages of care until the patient is deemed fit for discharge which inevitably leads to a delay. In addition the high bed occupancy within the unit is placing increasing demands within the resettlement team to facilitate the complex discharge planning needs.

2. Escalation Arrangements

Escalation arrangements are continued as per the Discharge Policy and also the Standard Operating Procedures to support the escalation arrangements and facilitate patient discharge. The escalation process is via the 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. Assistance has been sought from the CCG to help facilitate the delays within MCSI.

3. Emergency Care Intensive Support Team (ECIST)

The national ECIST Team have agreed to undertake a review of the Trust delayed discharge process and to make recommendations with regards to improving this process. They visited the Trust on 15th March and an update will be provided to Board next month.

4. Co-Ordination Centre

Implementation of the Trust's future Co-Ordination centre from April will allow daily focus on delayed patients and the actions being taken to expedite their discharge.

Ownership:

Executive Lead: Bev Tabernacle, Director of Nursing

Report Prepared By: Paula Jeffreson, Deputy Director of Operations

Exception Report – Sickness Absence

Performance Issue:

Reporting Period	Sickness Absence
December	4.29%
January	4.43%
February	4.58%

Reporting Period	Sickness Absence				
	Trust	Surgery	Theatres	Medicine	Diagnostics
December	4.29%	3.86%	5.35%	5.25%	3.38%
January	4.43%	4.11%	6.50%	4.97%	3.10%
February	4.58%	3.69%	7.19%	5.52%	2.69%

Planned Remedial Actions:

1. Reasons for absence

The People Team continue to concentrate on ensuring that that the wellbeing of our people is a priority and as musculoskeletal and anxiety/stress/depression are 2 of our main reasons for sickness absence, there are currently two key actions being taken forward as part of the People Plan Work stream (People Excellence)

- Improving accelerated access to the Trust Physiotherapy Services
- Introduction of the recognised Mental Health First Aider role

A first cohort of Mental Health First Aider training is to be held in April. Alongside this we are looking at a corporate option to allow staff access to a mindfulness app.

The People team are working closely with the Physiotherapy Service during February and March to further promote the accelerated access to this service. We are also considering whether accelerated access for staff to the SOOS service is possible.

2. **Divisional Level action**

The People team are working closely with Medicine (particularly MCSI and SOOS) and Theatres (Scrub and ODP) to support understanding and ageing appropriate actions to support the reduction of incident of illness in these areas.

Ownership:

Executive Lead: Sarah Sheppard, Director of People

Report Prepared By: Sue Pryce, Head of People Services

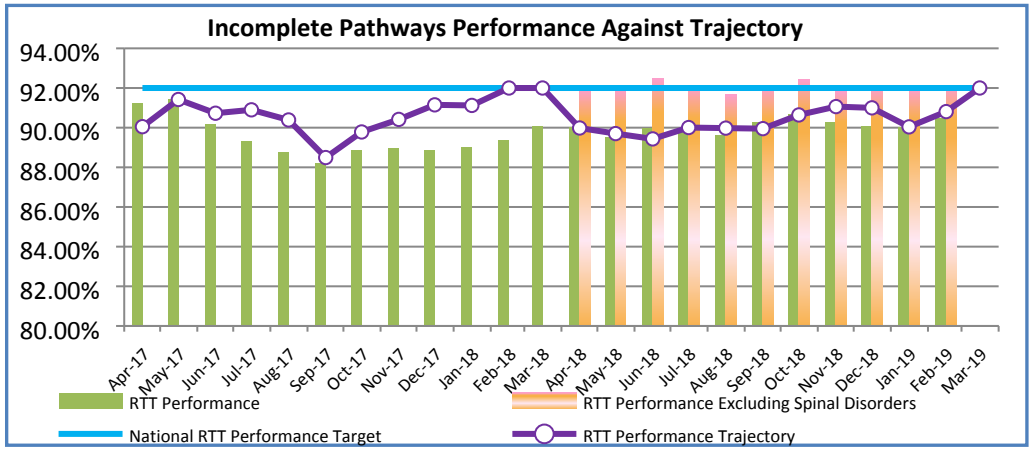
Exception Report – 18 Weeks RTT Open Pathways

Performance Issue:

Reporting Month	Reported Performance
December 2018	90.04%
January 2019	90.02%
February 2019	90.47%

The 18 weeks RTT performance has not achieved the target trajectory for the last 3 months. The main areas of challenge are in Pain, Spinal Disorders and in Spinal Injuries overdue planned readmissions. Overall performance is forecast to improve in the next month, but with risk to full delivery of 92% in Q4.

The graph below demonstrates the RTT performance with and without Spinal Disorders.



Planned Remedial Actions:

1. The Divisions have service specific action plans in place with particular focus on Spinal Disorders, Pain and Spinal Injuries. Each patient is being tracked daily through their 18 week pathway milestones.
2. In Spinal Injuries, pressure from acute admissions has led to insufficient beds for planned admissions. This is being mitigated through utilisation of beds on Sheldon ward as a temporary measure. A decision was made to cease these Sheldon ward admissions from 1st April as mixing surgical and care of elderly patients is being shown to have a detrimental effect on both patient and staff experience. Waiting list initiatives for day case urology patients are planned utilising Baschurch when available.
3. There are additional pain clinics planned in March delivered on site by an outsourced provider, IPMS which will clear the breaches prior to service closure.
4. Our strengthened patient access policy enables future improvements.
5. Focus on theatre activity for the remainder of Q4, reducing non-clinical commitments where appropriate.

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Paula Jeffreson, Deputy Director of Operations

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			
January	2	2			
February	4	4			
March			0	0	0

January – ACI's (2)

February – ACI's (4)

Planned Remedial Actions:

Capacity has been found for all English 52 week patients before March end, and all surgery dates have been confirmed with each patient. We are meeting the agreed NHSI trajectory and forecast that there will be no English patients breaching 52 weeks by 31st March 2019.

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Paula Jeffreson, Deputy Director of Operations

Exception Report – Outpatient DNA Rate

Performance Issue:

Reporting Period	Outpatient DNA Rate (Consultant Led Activity)
December	5.34%
January	5.98%
February	5.46%

The DNA rate for outpatients has been above the Trust target for 3 consecutive months, although this has reduced in February. The key subspecialties consistently over target are in the Surgery division: Paediatric Orthopaedics, Pain, Spinal Disorders, Sports Injuries, Tumour and Upper Limb.

Planned Remedial Actions:

- The Division is continuing to investigate the reasons for DNAs and refreshing the action plans for each of these subspecialties, excluding Pain which is closing at the end of the month.
- The admin and operational teams are applying the patient access policy rules to patients which DNA.
- There is a dedicated clerk for paediatric orthopaedics who contacts patients prior to their appointment to confirm and remind.

Ownership:

Executive Lead: Nia Jones, Director of Operations

Report Prepared By: Paula Jeffreson, Deputy Director of Operations

Board Governance Pack

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	28 March 2018
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:		Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors is asked to **consider** and **approve** the Board Governance Pack

2. Executive Summary

2.1. Context

On an annual basis the Board is required to review its governance arrangements. These are detailed in the Board Governance Pack.

2.2. Summary

The members of the Board of Directors have agreed to review and amend the Trust's Governance Framework for 2019-20 to ensure that there is adequate focus on workforce issues and the increasing digital agenda. Accordingly the committee structure has been reviewed and all committees have reviewed their terms of reference to reflect the changes.

The changes made to the Board Governance Pack are highlighted but to summarise:

- Personnel changes coming into effect from 1 April 2019 have been reflected
- The Finance Planning and Investment Committee is going to move from bi-monthly meetings to monthly to ensure more frequent scrutiny of the Trust's financial and operational performance. Further, the committees remit will include the Trust's digital agenda to become the Finance, Planning and Digital Committee.
- The Risk Management Committee is going to reduce from a monthly to quarterly meeting to allow for the People Committee meetings to take place quarterly.
- A People Committee will be established with a remit of workforce and organisational development.

2.3. Conclusion

The Board of Directors is asked to consider and approve the Board Governance Pack noting the changes to the committee structure that are being brought into effect from 1 April 2019.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD GOVERNANCE FOR THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Contents

Contents

1. THE BOARD OF DIRECTORS

1.1 The Collective Role of the Board

The collective role of the Board of Directors is to:

- ~~The general duty of the Board of Directors and of each Director individually, is to~~ Act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public (Health and Social Care Act 2012)
- Formulate Strategy
- Ensure accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust
- Provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed
- Ensure compliance by the Trust with its terms of authorisation, its Constitution, mandatory guidance issued by NHSi, relevant statutory requirements and contractual obligations
- Set the Trust's strategic aims, taking into consideration the views of the Council of Governors and ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives, and to review management performance
- Ensure the quality and safety of healthcare services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies
- Set the Trust's values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood and met
- Ensure that the Trust exercises its functions effectively, efficiently and economically

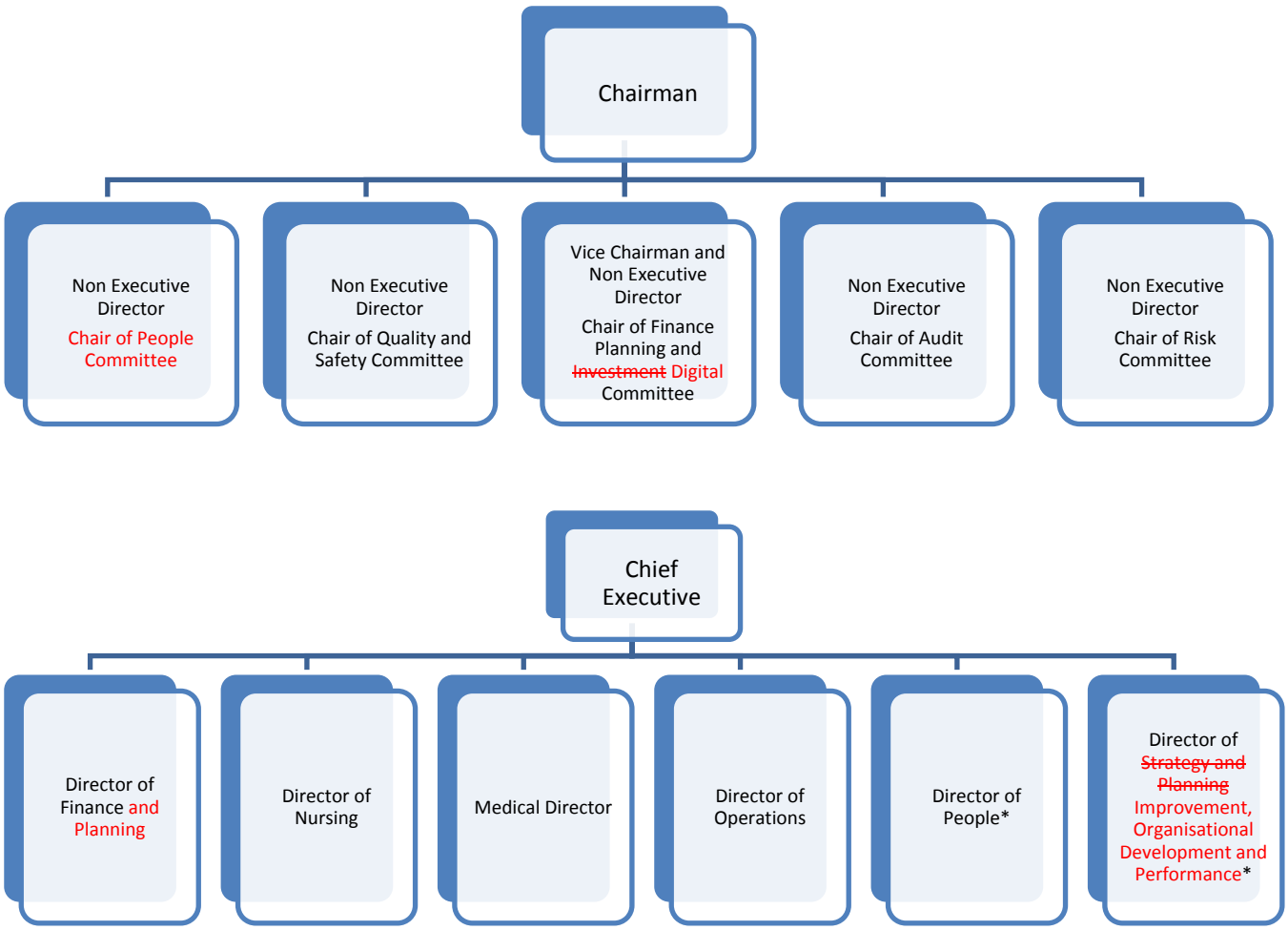
1.2 The Composition of the Board

The Board of Directors comprises:

- A Non-Executive Chairman
- No fewer than four and no more than six other Non-Executive Directors
- One of the Non-Executive Directors will act as the Deputy Chair and
- ~~One of the Non-Executive Directors will act as the~~ Senior Independent Director
- No fewer than four and no more than six Executive Directors, including a Chief Executive, a Finance Director, a Registered Medical Practitioner or Registered Dentist and a Registered Nurse or Registered Midwife

At any time, at least half the voting members of the Board (excluding the Chairman) will be made up of Non-Executive Directors.

RJAH Trust Board is constituted as follows:



** Non-voting members of the Board*

The Trust has a Foundation Trust Secretary to support the work of the Board. This role will also support the Council of Governors.

1.3 The Operation of the Board

The Board of Directors operates as a unitary body which is collectively responsible for the performance of the Trust and the exercise of its statutory powers. Accordingly all Directors, whether Executive or Non-Executive:

- Have joint responsibility for every decision of the Board and are required to take decisions objectively in the interests of the Trust
- Are responsible for leading and directing the Trust's activities and for helping to develop proposals on strategy
- Are responsible for monitoring the conduct and performance of management and for constructively challenging the decisions of the Board

1.4 Framework for the Performance Evaluation of the Board, its Committees and Directors including the Chairman

This framework sets out how the performance of the Board of Directors, its Committees, and its Directors, including the Chairman is regularly reviewed.

The collective performance of the board is reviewed on an annual basis and will be independently assessed every 3 years against the board leadership and governance framework set out by NHSi.

The Senior Independent Director leads the annual assessment of the performance of the Chairman in accordance with the process agreed with the Council of Governors (appendix A.1).

The performance of the Non-Executive Directors is assessed annually by the Chairman and includes 360° feedback from all members of the board of Directors (appendix A.2).

The performance of the Chief Executive is assessed annually by the Chairman and agreed with the Remuneration Committee based on agreed criteria (appendix A.3)

The performance of Executive and Associate Directors is assessed annually by the Chief Executive and agreed with the Remuneration Committee based on agreed criteria (appendix.A.3)

1.5 Appointments to the Board

The appointment of the Chief Executive is the responsibility of the Remuneration and Nomination committee made up of the Chairman and Non-Executive Directors. This appointment is subject to approval by the Council of Governors.

Executive Director Appointments (excluding the Chief Executive) to the Board are the responsibility of the Committee made up of the Chairman, Chief Executive and Non-Executive Directors. ~The Remuneration and Nomination.

Non-Executive Directors are appointed by a Committee of the Council of Governors

The Terms of Reference of these committees are included in the Appendices.
.

1.6 Standards for NHS Board members

The Board is responsible for ensuring that all of its members meet the “fit and proper person test” as required by the Health and Social Care Act.

The Board has adopted the “Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England”, which has been developed by the Professional Standards Authority (and was reissued in November 2013).

All members of the Board are expected to adhere to these standards.
(The Standards are attached at Appendix B).

In addition to this all managers in the Trust are required to comply with the “Code of Conduct for NHS Mangers” which can be found via Code of Conduct for NHS Managers. Further, all managers are required to comply with the Trusts Standards of Business Conduct Policy (Extract attached at Appendix C)

2. INDIVIDUAL ROLES WITHIN THE BOARD OF DIRECTORS

Non-Executive Roles

2.1 All Non-Executive Directors

The Board of Directors is a unitary body which is collectively responsible for the performance of the Trust and the exercise of its statutory powers.

Within the unitary Board, all Directors, whether Executive or Non-Executive, have joint responsibility for every decision of the Board and are required to take decisions objectively in the interests of the Trust. Non-Executive as well as Executive Directors are responsible for leading and directing the Trust's activities and for helping to develop proposals on strategy. Conversely, Executive as well as Non-Executive Directors are responsible for monitoring the conduct and performance of management and for constructively challenging the decisions of the Board

As part of their role as members of the unitary Board, non-executive directors have a particular duty to ensure that the decisions of the Board are subject to constructive challenge and to scrutinise management performance in meeting agreed goals and objectives.

In addition, non-executive directors who are determined by the Board to be independent in character and judgement and free from any business or other relationship which could materially interfere with the exercise of their judgement will be responsible, as the members of key committees of the Board, for:

- Monitoring the integrity of financial, clinical and other information
- Ensuring that financial and clinical quality controls and systems of risk management are robust
- Determining appropriate levels of remuneration of executive directors
- Playing a supporting role in appointing and, where necessary, removing Executive Directors, and in succession planning

2.2 Trust Chairman

The Trust Chairman provides leadership for the Board of Directors and the Council of Governors and ensures their effectiveness in all aspects of their role and agenda. Key responsibilities include:

- Ensuring the provision of accurate, timely and clear information to Directors and Governors
- Facilitating the effective contribution of Non-Executive Directors, Executive Directors and Governors and ensuring constructive relations between them
- Ensuring that the Board establishes clear objectives for the delivery of agreed plans and meeting the Trust's terms of authorisation and regularly reviews performance against these objectives

A statement on the division of responsibilities between the Trust Chairman and the Chief Executive, as agreed by the Board of Directors, is attached as Appendix D to this document.

2.3 Deputy Chairman

The Deputy Chairman is appointed from amongst the Trust's non-executive directors by the Council of Governors. Where the Trust Chairman has died or has ceased to hold office, or where he or she is unable to perform his or her duties as Chairman owing to illness, conflict of interest or any other cause, the Deputy Chairman will:

- Preside at meetings of the Board of Directors and the Council of Governors

- Exercise all the authorities vested in the Trust Chairman by the Standing Orders of those bodies, including the right to a casting vote where necessary.

2.4 Senior Independent Director

The Senior Independent Director is to be appointed from amongst the Trust's independent non-executive directors by the Board of Directors, in consultation with the Council of Governors. In addition to his or her responsibilities as a Non-Executive Director, the Senior Independent Director will:

- Lead the Non-Executive Directors in the evaluation of the Trust Chairman's performance as part of a process agreed with the Council of Governors
- Convene a meeting of the Non-Executive Directors, without the Trust Chairman, at least annually and on such other occasions as are deemed appropriate
- Be available to Members and Governors if they have concerns which contact through the normal channels of Trust Chairman, Chief Executive or Deputy Chief Executive/Chief Finance Officer has failed to resolve or for which such contact is inappropriate
- Maintain sufficient contact with, and attend sufficient meetings of, the Governors to listen to their views in order to help develop a balanced understanding of their issues and concerns.

Executive Roles

2.5 Chief Executive and Accounting Officer

The Chief Executive will manage the Trust in accordance with the values, objectives, policies and specific decisions of the Board of directors and ensure that all activities are directed towards their achievement. Key responsibilities include:

- Evaluating present and future opportunities, threats and risks in the external environment and current and future strengths, weaknesses and risks to the Trust
- Producing the annual business plan and ensuring that it is geared to achieving he Trust's vision and strategy
- Managing Executive Directors and Senior Managers and developing effective working relationships and communications with other staff
- Ensuring that the Board of Directors is given the advice and information it needs to perform its duties and that the business of the Board is properly conducted
- Establishing systems of control and limits of delegation and providing the Board of Directors with regular assurance on their effectiveness
- Establishing strong systems for performance management, focused on continuous improvement in the delivery of services, and maintaining close relationships with relevant regulatory bodies
- Promoting effective joint working with external stakeholders and other key partners
- Strategic leadership for the Trust's Information Management and Technology infrastructure and services
- Ensuring the Trust has a robust IM&T strategy in place to support the objectives of the organisation.

In his or her capacity as the Accounting Officer, the Chief Executive has personal responsibility for:

- The overall organisation, management and staff of the Trust and for its procedures in financial and other matters ensuring there is a high standard of financial management in the Trust as a whole,
- The Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation
- Financial considerations are fully taken into account in decisions by the Trust
- The propriety and regularity of public finances for which he or she is answerable, the keeping of proper accounts, prudent and economical administration in line with the principles set out in Managing public money, the avoidance of waste and extravagance and the efficient and effective use of the Trust's resources in their charge
- Ensuring that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity, prudent and economical administration, efficiency and effectiveness
- If necessary, informing NHSi of any proposed course of action which might infringe the requirements of financial propriety and regularity, prudent and economical administration, efficiency and effectiveness
- Appearing before the Public Accounts Committee as required to give evidence on any report by the Comptroller & Auditor General on the economy, efficiency and effectiveness with which the Trust has used its resources

A statement on the division of responsibilities between the Trust Chairman and the Chief Executive, as agreed by the Board of Directors, is attached as Appendix A to this document.

2.6 Director of Finance and Planning

The **Director of Finance and Planning** is accountable to the Chief Executive, the Board of Directors and the Council of Governors on all aspects of financial strategy and financial management. Key responsibilities include:

- Providing strategic leadership for finance across the organisation and helping to strengthen its contribution to the Trust's activities
- Providing comprehensive financial services to the Trust including the production of budget proposals, the development of effective budgetary control systems, the provision of accurate and timely information and advice and the compilation of monthly management returns and year-end accounts for statutory and regulatory purposes
- Managing financial agreements between the Trust and its stakeholders effectively in order to ensure appropriate recovery of costs
- Overseeing all financial systems and internal controls, including the development and modification of accounting systems when required
- Managing relationships with the Trust's internal and external auditors
- Providing strategic leadership for the development of the Trust's Estate, ensuring its contribution to the Trust's activities.
- Ensure that there are robust systems in place to provide the Board with high quality data to support performance management and decision making

- Overseeing the Trust's operational and financial planning

2.7 Medical Director

The Medical Director is accountable to the Chief Executive, the Board of Directors and the Council of Governors on medical and clinical matters, including compliance with national policy, and will provide professional leadership to all medical staff within the Trust. Key responsibilities, carried out in collaboration with other executive directors, include:

- Developing a culture within the Trust which promotes clinical governance and ensures its effectiveness
- In collaboration with the Director of Nursing, ensure that the quality of patient care is integral to all the Trust's activities
- Planning and implementing the clinical services strategy for the Trust
- Leading the Trust's relationships with bodies representing general practitioners and with the medical schools associated with the Trust
- Leading on medical workforce planning and developing plans for the Trust and the wider health economy
- Taking the lead on research on behalf of the Trust and developing relationships with universities and the wider research community

2.8. Director of Nursing and Deputy Chief Executive

The Director of Nursing is accountable to the Chief Executive, the Board of Directors and the Council of Governors on nursing matters, including compliance with national policy, and will provide professional leadership to all nursing staff and Allied Health Professionals within the Trust. Key responsibilities include:

- Developing and implementing nursing policies that achieve the Trust's strategic direction
- Fostering a culture that values continuing professional development and strives for excellence in the delivery of patient care
- In collaboration with the Medical Director, developing the clinical governance culture of the Trust and monitoring its effectiveness
- In collaboration with the Medical Director, ensure that the quality of patient care is integral to all the Trust's activities
- Leading patient and public involvement in the Trust and managing the Patient Advice and Liaison Service (PALS) and complaints service
- Board responsibility for Health and Safety
- Caldicott Guardian
- Director of Infection Prevention and Control (DIPC)
- Risk Management and Governance
- Safeguarding Executive Lead
- EPRR Executive Lead

- Deputising for the Chief Executive in his / her absence

2.9. Director of Operations

The Director of Operations is accountable to the Chief Executive, the Board of Directors and the Council of Governors regarding the delivery of operational performance within the Trust. Key responsibilities include:

- Ensuring the delivery of operational activity in accordance with agreements between the Trust and its stakeholders and national targets
- Provide executive leadership to the clinical divisions for service delivery.
- Board level accountability for the delivery for operational performance standards and targets and achievement against local and national standards.
- Corporate responsibility as a member of the Trust Board for overall formulation of policy and strategic direction of the Trust.
- Board level accountability for the delivery and management of partnerships and service/business development.
- Developing and implementing operational policies to achieve the Trust's strategic direction.
- Fostering a culture that values continuing professional development and strives for excellence in service delivery and patient experience.
- Meet agreed targets and objectives, and deliver within defined costs, timescales and resources.

2.10 Director of People ~~Human Resources~~

The Director of People ~~Human Resources~~ is accountable to the Chief Executive, the Board of Directors and the Council of Governors on human resource matters. Key responsibilities include:

- Ensuring effective matching of workforce to activity
- Facilitating continuous professional development and learning
- Developing the leadership capacity and capability

2.11 Director of ~~Strategy and Planning~~ Improvement, Organisational Development and Performance

The Director of Improvement, Organisational Development and Performance is accountable to the Chief Executive, the Board of Directors and the Council of Governors on ~~workforce~~organisational development matters and also the ongoing management of performance and the Trust's improvement agenda. Key responsibilities include:

- Ensuring the Trust ~~is positioned to achieve~~ has adequate oversight of its performance ~~strategic aims and objectives~~.
- Strategic leadership for the Trust's service improvement framework and agenda
- Ensuring the development and implementation of the Organisational Development Strategy

- As Senior Information Risk Owner (SIRO) ensuring that risks to data security are recognised and managed
- Design and ensure the effective operation of the Trust's process of continuous improvement
- ~~Strategic leadership for the Trust's Information Management and Technology infrastructure and services~~
- ~~Ensuring the Trust has a robust IM&T strategy in place to support the objectives of the organisation.~~

Board and Council Support

2.12 Foundation Trust Secretary

All Directors and Governors have access to the advice and services of the Trust Secretary, who has the following primary responsibilities:

- Ensuring good information flows within the Board of Directors, the Council of Governors and their Committees and between Senior Management, Non-Executive Directors and Governors
- Ensuring that the procedures and Standing Orders of the Board of Directors and the Council of Governors are complied with
- Advising the Board of Directors and the Council of Governors (through the Chairman) on all governance matters
- Supporting the induction of new Directors and Governors and assisting with their professional development

3. RESERVATION AND DELEGATION OF RESPONSIBILITIES

3.1 Matters Reserved to the Board

As recommended by the NHS Foundation Trust Code of Governance, the Board of Directors has expressly reserved certain key matters for its collective consideration and decision. The schedule of matters reserved to the Board of Directors is set out in Appendix E to this document.

3.2 Delegation to Officers

Matters which the Board of Directors considers suitable for delegation to individual directors and officers of the Trust are contained in the Scheme of Delegation and Standing Financial Instructions (SFIs), which are regularly reviewed and revised by the Board.

3.3 Delegation to Committees of the Board

The Board of Directors has established the following Committees, all of which are chaired by Non-Executive Directors, to exercise delegated responsibilities on behalf of the Board:

- Audit Committee
- Quality & Safety Committee
- Finance, Planning and Digital ~~Investment~~ Committee
- Risk Management Committee
- People Committee
- Nomination and Remuneration Committee
- Executive Directors Appointments Committee

The membership and key responsibilities of these Committees of the Board are summarised in Appendix F to this document.

4. THE COUNCIL OF GOVERNORS

4.1 The Role of the Council of Governors

The general duties of the Council of Governors are:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

- To represent the interests of the members of the trust as a whole and the interests of the public. (Health & Social Care Act 2012)

The specific statutory powers and duties of the Council of Governors are to:

- Appoint and, if appropriate, remove the Trust Chairman
- Appoint and, if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors
- Approve the appointment of the Chief Executive
- Appoint and, if appropriate, remove the External Auditor
- Receive the Trust's annual accounts, any report of the External Auditor on them and the annual report
- Approve "significant transactions", including plans to increase the proportion of income received from activities other than the health service in England by 5%

In addition, in preparing the Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

In exercising its powers and duties, governors are required by the NHS Foundation Trust Code of Governance to:

- Represent the interests of Trust members and Partnership Organisations in the governance of the Trust
- Act in the best interests of the Trust and adhere to its values and code of conduct
- Hold the Board of Directors collectively to account for the Trust's performance and ensure that the Board of Directors acts in such a way that the Trust does not breach the terms of its Authorisation
- Feedback information about the Trust, its vision and its performance to the constituencies and stakeholder organisations that elected or appointed them.

4.2 The Composition of the Council of Governors

In accordance with the Trust's Constitution, the Council of Governors will consist of 15 governors, to be composed as follows:

- Nine Governors elected by the Public Constituency
- Three Governors elected by the Staff Constituency
- Three Governors appointed by Partnership Organisations, including one Governor appointed by Shropshire Council.

4.3 The Operation of the Council of Governors

Meetings of the Council of Governors will be held at least four times a year, one of which will be an AGM.

The Council of Governors is not permitted to delegate any of its powers or responsibilities to any committee or individual Governor, but is able to appoint committees to assist it in the proper performance of its functions.

The Trust's Constitution provides for the appointment by the Council of Governors of an ad hoc Nomination Committee for the purpose of making recommendations to it on each exercise of its powers to appoint and re-appoint the Trust Chairman and other Non-Executive Directors and to remove another Non-Executive Director (including the Trust Chairman).

4.4 The Role of the Lead Governor

The Lead governor has a role to play in facilitating direct communication between NHSi and the Council of Governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chairperson or the Trust Secretary.

The Lead Governor may also facilitate communication between the Chairman and the Governors where the Governors consider this to be the most appropriate approach.

4.5 Interface between the Board of Directors and the Council of Governors

The Chairman is responsible for ensuring that there is effective communication between the Board of Directors and the Council of Governors.

The Board of Directors provides the Governors with their meeting agenda, prior to the meetings and copies of the minutes once approved.

The Board of Directors ensures that the Governors are given the opportunity to comment on the strategic and operational plans.

There is a process in place for the escalation of disputes between the Board of Directors and the Council of Governors. In the first instance the Senior Independent Director would seek to resolve the dispute. If he was unable to resolve this, an ad hoc Dispute Resolution Committee would be appointed, comprising an equal number of Governors and Non-Executive directors. If this committee were to be unsuccessful the Senior Independent Director would refer the dispute to an independent assessor who was agreeable to both parties.

APPENDIX A: Framework for the Performance Evaluation of the Board, its Committees and Directors including the Chairman

APPENDIX A.1: Process for the Annual Appraisal of the Chairman

Prior to the Non-Executive Directors meeting formally, the Senior Independent Director will consult individually with the Chief Executive, Executive and Non-Executive Directors. The Lead Governor will formally meet with the Senior Independent Director and any other Governor may choose to contribute.

All Board members will participate in a confidential *360°* questionnaire regarding the Chairman's performance.

Criteria

The criteria on which the appraisal will be based will include:

- RJAH annual performance
- Achievement of Board's key strategic objectives
- Leadership and effective working and development of the Board and Council of Governors
- Representational role on behalf of RJAH and stakeholder engagement

At the Non-Executive Directors' meeting the inputs from all sources will be considered and a collective assessment agreed.

The Senior Independent Director will then meet with the Chairman and subsequently confirm to the Board and Council that the appraisal has been conducted.

Timing

The appraisal should be conducted following the end of each financial year. This would normally be in May unless otherwise required.

APPENDIX A.2: Process for the Annual Appraisal of Non-Executive Directors

Process

Prior to the Non-Executive Directors (NED) meeting formally, the Chairman will consult individually with the Chief Executive and seek the views of the Council of Governors via the Lead Governor.

All Board members will participate in a confidential *360°* questionnaire regarding Non-Executive Directors performance which will address contribution and understanding of the following areas:

- The NED demonstrates sufficient understanding of the markets within which the RJAH operates
- The NED understands the strategic needs of the organisation and contributes to the development strategy.
- The NED understands and ensures compliance with regulatory, legal and governance requirements and makes relevant contributions to the management of risk
- The NED has effective relationships with other members of the Board
- The NED consistently behaves in a way congruent with the RJAH brand
- The NED dedicates sufficient time to undertake their role effectively
- The contributions of the NED at the Board meetings are consistent, providing a balance of support and challenge to the executive management team
- The NED is committed to the success of the RJAH and demonstrates passion and energy
- The NED's behaviour is helpful to forming and developing trusting relationships
- The NED's contribution to meetings is high quality and value added, demonstrating clear thinking and good judgement
- The NED effectively communicates any concerns they have, listens appropriately and follow's up proactively
- The NED is sufficiently independent and objective
- The NED challenges constructively and probes when appropriate

Overall, the performance of the NED adds value to the Board.

At the Non-Executive Directors' meeting with the Chairman the inputs from all sources will be considered and a collective assessment agreed.

The Chairman will confirm to the Council of Governors that the assessment has been conducted.

Criteria

The criteria on which the assessment will be based will include:

- RJAH annual performance
- Achievement of Board's key strategic objectives
- Contribution to effective working and development of the Board
- Representational role on behalf of RJAH and stakeholder engagement

Timing

The appraisals should be conducted following the end of each financial year. This would normally be in May unless otherwise required.

APPENDIX A.3: Criteria for the Annual Performance Assessment of the Chief Executive, Executive and Associate Directors

1.1 Directors will be set annual objectives which address the following six areas:

i. Annual Corporate Objectives
ii. Corporate Risks
iii. Supporting Strategies
iv. Other e.g. legislative
v. Standards of Business Conduct & Trust Values
vi. Personal Development

1.2 A mid-year review will be undertaken to discuss progress and address any barriers to progress which may have arisen.

1.3 An end of year review will be undertaken to determine the level of performance of the Director as follows:

i. Concerned
ii. Satisfactory performance
iii. Good
iv. Very good

1.4 The Chief Executive assesses the performance of the Executive & Associate Directors

1.5 The Chairman assesses the performance of the Chief Executive.

1.6 The remuneration committee will consider the recommendations of the Chairman and Chief Executive as part of the annual pay review process.

APPENDIX B: Standards for Board Members

1. Policy Statement

The Robert Jones & Agnes Hunt Orthopedic Hospital NHS Trust (the Trust) expects that all members of the Board of Directors understand and are committed to the practice of good governance and the legal and regulatory frameworks in which the Trust operates, and will apply the standards for members of NHS boards, as set out by the Professional Standards Authority (2012) and conform to the Fit and Proper Persons Requirements as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulation 5 and Schedule 4.

2. Application

The policy applies to Directors[1] by which is meant executive and non executive, permanent, interim and associate positons, irrespective of their voting rights at all times when directors are carrying out the business of the foundation trust or representing the foundation trust.

3. Responsibilities

All Board members

- Will abide by the Standards at all times when at the service of the NHS.
- Will understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.
- Will understand that they must act in the interests of patients, service users and the community they serve, and that they must uphold the law and be fair and honest in all their dealings.
- Will complete declarations upon appointment and annually thereafter providing their commitment to these standards.
- Will declare any failure to maintain the Standards, including the requirements of the Fit and Proper Persons

Head of Board Governance (Trust Secretary)

Will ensure appropriate declarations are provided on appointment, and annually thereafter as follows.

On Appointment
Standards for Board Members (Appendix 1)
Fit and Proper Persons Declaration (Appendix 2)
- Bankruptcy and Insolvency Register
- Disqualified Directors

Declaration of Confidence
Senior Managers Code of Conduct

Annual Declarations
Standards for Board Members (Appendix 1)
Fit and Proper Persons Declaration (Appendix 2)
Declarations of Interest

3. Monitoring

Directors will be monitored annually to confirm compliance and non compliance will be reported to the appropriate officer.

[1] As per Regulation 5~: Fit and proper persons: directors

APPENDIX C: Standards of Business Conduct Policy.

1. Policy Statement.

1.1. The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (the Trust) is committed to achieving the highest possible standards of corporate behaviour and responsibility. As such, the Trust requires all employees to abide by the standards and principles within this policy.

1.2. The Trust has adopted a set of values which should inform all activities within the Trust, including business conduct.

- Caring
- Excellence
- Friendly
- Professional
- Respect

2. Purpose

2.1 This policy sets out the overall intent and general principles the Trust will apply in relation to business conduct in order to comply with current legislation:

- Fraud Act 2006
- Bribery Act 2012
- Public interest Disclosure Act 1998
- the principles of public life defined by the Committee on Standards on Public Life (originally the Nolan Committee)
- Research Governance Framework 2005

1.3. Failure to comply with this policy may lead to disciplinary action, up to and including dismissal and staff may also be liable for personal prosecution.

2. Scope

2.1. This policy applies to all employees, students and trainees, agency staff and secondees.

3. Principles of Public Life –

3.1. In carrying out their functions, it is the responsibility of all staff to be guided by the Seven Principles of Public Life as follows:

Selflessness: Holders of public office should act solely in terms of the public interest: They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
Objectivity: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.
Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
Openness: Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and by example.

3.2. The means by which these principles should be applied in practice are set out within this policy.

4. Roles & Responsibilities

4.1. It is the responsibility of the Board of Directors to develop and sustain a culture of corporate responsibility and good governance

4.2. It is the responsibility of the Foundation Trust Secretary to maintain the Register of Interests and update it annually (appendix 1), and also to maintain a register of hospitality

4.3. The following staff categories will be required to complete the Register of Interests;

Medical Consultants
Senior Mangers (i.e. Band 7 or above)
"Oracle Approvers" (i.e. Staff authorised to approve requisitions on the electronic ordering system)
(The Directors duties to declare their interests are covered by the Trust's Constitution).

4.4. It is the responsibility of the Director of ~~Human Resources~~ People to communicate this policy to all new starters through the Trust induction process including providing a summary copy of the entire policy for staff categories identified in paragraph 3.4 above, (appendix 2), and provide guidance and support regarding its application as and when required, including summary information (appendix 3).

4.5. It is the responsibility of all staff to comply with this policy

5. Candour and Openness

5.1. The Trust is committed to supporting a culture of openness and candour, where errors are reported and learnt from.

5.2. All staff have a duty to comply with guidelines and duties of candour and openness as laid down by their professional bodies, external regulators or by statute, see Being Open policy

6. Prevention of Corruption (Bribery Act 2010)

6.1. The Trust has a responsibility to ensure that all Trust staff are made aware of their duties and responsibilities arising from the Bribery Act 2010. Under this Act there are four offences:

- bribing, or offering to bribe, another person (section 1);
- requesting, agreeing to receive, or accepting a bribe (section 2);
- bribing, or offering to bribe, a foreign public official (section 6);
- failing to prevent bribery (section 7).

6.2. All Trust staff are required to be aware of the Bribery Act 2010 and should also refer to paragraphs 16 and17 below for further guidance in relation to this.

7. Anti-Fraud measures

7.1. The Trust is committed to preventing fraud and staff are encouraged to report any concerns about potentially fraudulent activity.

7.2. For further information staff should consult the Anti-Fraud, Bribery & Corruption policy or contact the Local Counter Fraud Specialist.

8. Gifts and Hospitality

8.1. Where gifts or hospitality are given to individuals within the trust, subject to the guidance below regarding value, the overall principle is that they should firstly be refused, or secondly, if they cannot be refused, they should be made available to all staff within the department .

8.2. Gifts

8.2.1. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives can be accepted. Departments may place such gifts in a raffle so that they can be shared with other staff locally.

8.2.2. In cases of doubt staff should either consult their line manager or politely decline acceptance.

8.2.3. Cash gifts must not be accepted by an individual, but instead treated as a donation and deposited with charitable trust funds, where a record of the donation will be made.

8.2.4. Contractors should not offer gifts to Trust employees and this is specified within their contract.

8.2.5. If gifts are over £50 intrinsic value and it has been impossible to refuse them (e.g. left or sent anonymously) employees must make arrangements to share with their department (e.g. this could be done by a raffle) and include the gift on the Trust hospitality register.

8.2.6. In cases of doubt consult with your line manager and or the Trust Secretary and include on the hospitality register.

8.3. Hospitality

8.3.1. Lunches or dinners in the course of a working visit or attendance at a meeting or conference may be accepted by an individual.

8.3.2. Material work related hospitality, such as the sponsorship of courses, is covered in the Commercial sponsorship section 14.

8.3.3. Extravagant or non-work related hospitality e.g. an invitation to attend a major sporting event or free tickets to the theatre must not be accepted by an individual.

8.3.4. All hospitality offered, even if refused, should be recorded in the hospitality register which is held by the Trust Secretary.

8.3.5. When in receipt of hospitality, staff should comply with the Alcohol and Drugs policy, in particular the Trust expects that all employees will not consume / use alcohol during working hours.

9. Declaration of Interest

10.1. There are occasions when an employees' links to another business or organisation could place them in a position where this could cause a conflict of interests. This link could be by the employees' direct involvement or by having a partner or close relative having an involvement. This link could be in the form of employment, unpaid work or by being a director. The type of organisation which could cause conflict would be ones who supplied (or may wish to supply) goods or services or ones which operated in the field of healthcare. These links could cause conflict if the employee was in a position to influence decisions by the Trust concerning them.

9.1.1. Where any of these circumstances occur the employee should declare this in the "Register of Interests", this is held by the Trust Secretary (see section 11) Having declared an interest, employees must not enter into business with that individual or organisation unless however the Trust can take steps to mitigate any potential conflict.

9.1.2. For example, a Director may be required to leave a board meeting for any agenda item where there was a potential conflict; or employees would not normally be placed in a position where they were responsible for ordering goods or services from an organisation with which they have links, where this was unavoidable for operational reasons additional safeguards would be put in place.

9.1.3. A potential conflict could also arise if an employee held a position of authority in a health related charity or campaigning organisation.

10. Registers

The Trust maintains two registers which are held by the Foundation Trust Secretary as follows:

10.1. Register of Interests - This details interests held by managers or their close relatives (i.e. spouse or partner, parent, child or sibling and may include other relatives. Commons sense should be applied when deciding if a relative is a close relative).

10.1.1. Managers (see paragraph 5.3) are required to update, or confirm a nil declaration on an annual basis. If the circumstances of staff or their relatives were to change during the year, so as to pose a potential conflict of interests, they should inform the Trust Secretary straight away. New managers will be asked to declare their interest on appointment.

10.2. Hospitality Register - This holds ad hoc declarations of gifts or hospitality which should be made as and when they occur together with indicative values.

11. Secondary and Other Employment

11.1. Employees of the Trust must not engage in any secondary or other employment (including self-employment) which may conflict with their work or be potentially detrimental to the Trust. Before taking up any other employment, employees must put their request in writing to their Divisional Manager, or Director.

11.2. Secondary employment whilst absent from work due to sickness is not acceptable and failure to report secondary employment whilst absent due to sickness may be considered an offence under the Fraud Act.

11.3. Permission to engage in secondary or other employment will normally be granted if the following conditions are satisfied.

11.4. Working hours on other employment are conducted entirely outside of Trust contracted hours of work.

11.5. The employment is not in direct competition with the Trust's business and does not affect the business by, for example, loss of business or the passing on of confidential information.

11.6. The employee provides the Trust with the name and address of the other employer or organisation, an outline of the job role they wish to undertake and the hours they intend to work.

11.7. The work in not inherently hazardous or likely to put at risk the employee, other employees or patients. Staff are reminded that occupational sick pay is not normally payable for an absence caused by injuries whilst working for another employer and may affect their rights to the NHS benefits such as Superannuation Scheme,

11.8. The requirements of the working time regulations are met (including appropriate rest prior to commencement of work for the Trust).

11.9. Work excluded from this policy would generally include unpaid voluntary activities and private practice as specified in Consultant Contract (see below).

12. Medical Staff

12.1. Consultants and Staff and Associate Specialist who are employed under the terms of the new Contract may undertake private practice in accordance with the terms of that contract.

12.2. Staff and Associate Specialist who are employed under the terms of the old contract and associate specialists should refer to the guidance contained in “A guide to the management of Private practice in the NHS” (PM 979)11.

12.3. If a member of medical staff refers a patient to a nursing home in which he/she has an interest, they should declare that interest to the patient.

12.4. Medical staff cannot work for another organisation without the prior agreement of the Trust; following agreement, any such secondary employment should be declared in the register of interests.

13. Commercial Sponsorship

13.1. Research Funding - Employees undertaking research projects must declare any financial interests or potential conflict of interest that may arise from the research activity in accordance with the Research Governance Framework 2005.

13.2. Posts - The sponsorship of any post by an outside organisation must have the prior approval of the Chief Executive and be included in the declaration of interests.

13.3. Courses and Conferences - Sponsorship for Trust events such as; conferences, training, publications, team meetings and social events must be approved in advance by a Divisional Manager or Director.

13.4. Sponsorship for attendance by non-medical staff on a course must be approved in advance by a Divisional Manager or Director and attendance at courses abroad must have prior approval from the Director of People ~~Human Resources~~. The Trust study leave form allows for this approval process to be followed.

13.5. Sponsorship for attendance by medical staff on a course must be approved in advance by the medical Director and attendance at courses abroad must have prior approval from the Director of People ~~Human Resources~~. The Trust study leave form allows for this approval process to be followed.

13.6. Where the sponsorship includes the costs of travel/accommodation the recipient must declare that they are aware of their obligations under this policy and will act in such a manner as not to confer a commercial advantage onto the sponsoring company.

13.7. All sponsorship of courses and conferences must be declared on the hospitality register together with estimated value.

14. Supplies and Contractors

14.1. All Trust staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services are expected to adhere to professional standards in line with those set out in the Code of Ethics of the Chartered Institute of Purchasing and Supply (Appendix 3).

14.2. All Trust staff must treat prospective contractors or suppliers of services to the Trust equally and in a non-discriminatory way and act in a transparent manner.

14.3. Trust staff involved in the awarding of contracts and tender processes must take no part in a selection process if a personal interest or conflict of interest is known. Such an interest must be declared to the Trust Secretary as soon as it becomes apparent. Trust staff should not at

any time seek to give undue advantage to any private business or other interests in the course of their duties.

14.4. The Trust has duties under European and UK procurement law and staff must comply with standing financial instructions (SFIs) in relation to all contract opportunities with the Trust.

14.5. Trust staff must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to officers' and members' benefit schemes offered by the NHS or trade unions.

14.6. Trust staff invited to visit organisations to inspect equipment for the purpose of advising on its purchase will be reimbursed for their travelling expenses in accordance with the travel expenses policy laid down by the Trust. Such expenses should not be claimed from other organisations to avoid compromising the purchasing decisions of the Trust.

15. Use of Trust Property

15.1. Trust property or facilities should not be used for personal activity or benefit. This includes:-

15.1.1. Use of telephone (though limited use in extenuating circumstance is permissible).

15.1.2. Use of email. The "RJAH" email address should not appear in any literature or correspondence not directly related to Trust Business. This does not prevent employees from using e-mail to conduct related business in another capacity e.g. correspondence from staff side representatives acting in a trade union capacity or correspondence related to an appropriate professional organisation or membership.

15.1.3. Photocopying or printing.

15.1.4. Trust Postal System.

15.2. Trust premises, facilities or equipment should only be used for private business with prior approval, and arrangements must be made for the Trust to be reimbursed for the cost of providing these facilities.

15.3. Photographs and graphics on the Trust website are also Trust property and should not be reproduced without permission.

15.4. In the case of any doubt, an employee should speak to their line manager.

16. Use of Trust Identity

When employees are engaged in activities outside of their formal employment, they should not use the Trust name, logo, email address or any other reference to the Trust to promote those activities without the prior approval of the Chief Executive.

17. Political/ Campaigning activities

17.1. Any political or campaigning activity should not identify an individual as an employee of the Trust, beyond any statutory declarations required.

18. Links to Other Policies

18.1. Staff should familiarise themselves with the relevant Trust policies and procedures which are held on the Trust intranet. In particular it is important that staff are familiar with the Standing Financial Instructions, and Scheme of delegation.

18.2. If at any stage they have any queries concerning these policies they should refer the matter to their line manager.

- Openness (Whistle blowing)
- Email Policy
- IT Security Policy including Internet Usage
- Research Misconduct and Fraud Policy
- Alcohol and Drugs policy,
- Anti-Fraud, Bribery and Corruption Policy
- Standing Financial Instructions
- Social Networking and mobile devices policy.
- Being Open Policy (Duty of Candour)

19. Communication

19.1. A copy of the policy is available on the Trust intranet site, and copies are available in different formats on request, from the human resources department.

19.2. Newly appointed staff will be informed of the policy and procedure as part of the corporate induction process.

20. Monitoring

The declaration of Interests and the Hospitality registers are reviewed on a quarterly basis by the Audit Committee.

Managers are responsible for ensuring that their staff complies with good standards of Business Conduct.

APPENDIX D: DIVISION OF RESPONSIBILITIES BETWEEN THE TRUST CHAIRMAN AND THE CHIEF EXECUTIVE

The following division of responsibilities between the Chairman and the Chief Executive has been agreed by the Board of Directors.

Key Responsibilities

Chairman:

- Managing the business of the Board of Directors and the Council of Governors so as to ensure their effective performance
- Promoting the highest levels of integrity, probity and corporate governance and ensuring that these standards are embodied in the conduct of the Board of Directors and the Council of Governors
- Ensuring that the Board as a whole is able to play a full and constructive role in the development of the Trust's strategy and business aims
- Ensuring that the Board pays sufficient attention to the development of the Trust's business and the protection of its reputation

Chief Executive:

- Executive management of the Trust's business consistent with the strategic and business objectives agreed by the Board as a whole
- Ensuring that the affairs of the Trust are carried out in accordance with the highest standards of integrity, probity and corporate governance and that these standards are embedded at all levels
- Ensuring that the strategy and business aims set by the Board are aligned with statutory, regulatory and contractual requirements
- Formulating annual objectives, budgets and operational plans to deliver the strategy and business objectives set by the Board

Detailed Responsibilities

a) Board of Directors

Chairman:

- Setting the Board's agenda and managing the conduct of its business
- Ensuring that all Directors receive accurate, timely and clear information on performance, the issues, challenges and opportunities facing the Trust and matters which are reserved to the Board for decision
- Facilitating the effective contribution of all Directors and ensuring constructive relationships between Executive Directors and Non-Executive Directors
- Ensuring that Non-Executive Directors receive full, formal and tailored induction and participate in the Board development programme
- Ensuring that the Board undertakes and acts on formal and rigorous evaluation of its own performance

Chief Executive:

- Leading, motivating and directing the other Executive Directors and Senior Managers
- Ensuring that the Board is given the advice and information it needs to carry out its duties effectively and (in consultation with the Chairman) that the business of the Board is properly conducted
- Promoting the effective contribution of Executive Directors and Senior Managers to the proceedings of the Board and its Committees
- Contributing to induction programmes for new Directors and ensuring that management time is made available for this purpose
- Providing input to the evaluation of the performance of the Board and its Committees

and that of its Committees • Appraising the performance of Non-Executive Directors and acting on the outcomes of performance evaluation where necessary	• Appraising the performance of Executive Directors in their corporate and functional roles.

b) Council of Governors

Chairman:	Chief Executive:
• Leading the Council of Governors and setting its agendas	• Facilitating the work of the Council of Governors and its Committees, ensuring that they have sufficient resources and are able to meet sufficiently regularly to discharge their duties
• Ensuring that governors receive accurate, timely and clear information that is appropriate for their duties	• Ensuring that the Council of Governors is given the advice and information it needs to carry out its duties effectively and (in consultation with the Chairman) that the business of the Council of Governors is properly conducted
• Ensuring that Governors receive full, formal and tailored induction and are enabled to update their skills, knowledge and familiarity with the Trust • Leading the Council of Governors in periodically assessing its collective performance • Ensuring constructive relationships between the Board of Directors and the Council of Governors and that the views of governors and members are communicated to the Board	• Contributing to induction and development programmes for Governors and ensuring that management time is available for this purpose. • Providing input to the assessment of the performance of the Council of Governors • Ensuring that the views of governors and members are taken into account in the conduct of the Trust's business and the development of its strategic aims

c) Stakeholders

Chairman	Chief Executive
• Being a visible and accessible figurehead for the Trust's staff and the leading champion of its vision, values and objectives	• Performing the role of senior line manager and employer
• Taking the lead at ceremonial events and other corporate formalities	• Taking the lead on employee relations and internal communications on operational matters
• Promoting mutual understanding with external partners and stakeholder bodies through dialogue with their Non-Executive or elected leads	• Fostering good working relationships with external partners and stakeholders through the conduct of business with their Executive Officer Leads
• Supporting the Chief Executive in contacts with MPs and other political figures	• Taking the lead on contact with MPs and other political figures, with the participation of the Chairman as appropriate
• Taking the lead at public meetings	• Taking the lead on

and events and with voluntary groups, as the public face of the Trust, with the participation of the Chief Executive as appropriate • Acting as a confidential sounding board for the Chief Executive on key issues and decisions and providing advice, support or challenge as appropriate	communications with the media, with the participation of the Chairman as appropriate • Informing and consulting the Chairman on key issues and decisions and ensuring that the Chairman is aware of emerging opportunities and threats to the achievement of objectives

d) Accountability

Chairman	Chief Executive
• Accountable to the Board of Directors and the Council of Governors for the effective conduct of their activities	• Accountable to the Chairman (acting on behalf of the Board) and to the Board direct

e) Reporting Lines

Chairman	Chief Executive
• The Chairman is not responsible for the executive management of the Trust. Other than the Chief Executive and (in respect of matters relating directly to the Board of Directors or the Council of Governors) the Trust Secretary, no Executive Director, senior manager or other member of staff reports to the Chairman other than through the Board	• The Chief Executive is responsible for all executive management matters relating to the Trust. All members of executive management report, directly or indirectly, to the Chief Executive.

The appointment and removal of the Trust Secretary is a matter for the Chairman and the Chief Executive jointly

APPENDIX E: SCHEDULE OF MATTERS RESERVED TO THE BOARD OF DIRECTORS

The matters set out in the schedule below are specifically reserved for the collective decision of the Board of Directors.

1.	**STRATEGY AND MANAGEMENT**
1.1	Responsibility for the overall management of the Trust
1.2	Approval of the Trust's long-term objectives and business strategy
1.3	Approval of the annual operating and capital expenditure budgets and any material changes to them
1.4	Oversight of the Trust's operations ensuring: • competent and prudent management • sound planning • an adequate system of internal control • adequate accounting and other records • compliance with its licence, constitution, mandatory guidance issued by the independent regulator, relevant statutory requirements and contractual obligations • the quality and safety of healthcare services, education, training and research delivered by the Trust • the application of the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies
1.5	Review of performance in the light of the Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken
1.6	Extension of the Trust's activities into new business areas
1.7	Any decision to cease to operate all or a material part of the Trust's business
1.8	Any decision to undertake transactions which have been designated as “Significant transactions”,* subject to approval by the Council of Governors
1.9	Any decision to increase by 5% or more the proportion of its total income attributable to activities other than the provision of goods and services for the purposes of health service , subject to approval by the Council of Governors
1.10	Ratify decisions made under emergency powers
2.	**CORPORATE STRUCTURE AND STATUS**
2.1	Major changes to the Trust's corporate structure
2.2	Major changes to the Trust's management and control structure
2.3	Any changes to the Trust's status as an NHS Foundation Trust
2.4	Any proposal to establish a subsidiary company, joint venture or other corporate vehicle for the purpose of carrying out any current or proposed activity of the Trust
2.5	Any proposal involving a merger of the Trust with or takeover of the Trust by another organisation
2.6	Any acquisition or disposal of land

2.7	Any application to a planning authority for planning permission
2.7	Any proposal involving the Trust operating in another organisation (whether within the NHS or not) in the provision of services
2.9	Any use of the RJAH name or brand by another organisation for any purpose.
3.	**FINANCIAL REPORTING AND CONTROLS**
3.1	Approval of the quarterly financial report to the Independent Regulator.
3.2	Approval of the annual report and accounts, including the corporate governance statement and the remuneration report
3.3	Approval of any significant changes in accounting policies or practices
3.4	Approval of treasury policies, including foreign currency exposure and the use of financial derivatives
3.5	Receive Annual Audit Letter
4.	**INTERNAL CONTROLS**
4.1	Ensuring the maintenance of a sound system of internal control and risk management including: • receiving reports on, and reviewing the effectiveness of, the Trust's risk and control processes to support its strategy and objectives • undertaking an annual assessment of these processes • approving an appropriate statement for inclusion in the annual report • Approving Standing Financial Instructions.
5.	**CONTRACTS**
5.1	Major capital projects and Business Cases
5.2	Contracts which are material, strategically or by reason of size, or length of commitment entered into by the Trust in the ordinary course of business. Contracts, other than NHS, with a value per year in excess of £250k.
5.3	Contracts entered into by the Trust which are not in the ordinary course of its business.
6.	**COMMUNICATION**
6.4	Approval of formal submissions to the Department of Health, the Independent Regulator, the Care Quality Commission and other relevant NHS bodies concerning the Trust's compliance with applicable targets and standards
7.	**BOARD MEMBERSHIP AND OTHER APPOINTMENTS**
7.1	Nomination of a Deputy Chairman for formal appointment by the Council of Governors
7.2	Appointment of the Senior Independent Director in consultation with the Council of Governors
7.3	Establishment, Membership and chairmanship of Board committees
7.4	Nomination of Board representatives to any joint committee of the Board of Directors and the Council of Governors that may be established from time to time for any purpose
7.5	Appointments to the boards of any subsidiary company, joint venture or other corporate vehicle established by the Trust for the purpose of carrying out any

	current or proposed activity
8.	**DELEGATION OF AUTHORITY**
8.1	Approval of the statement on the division of responsibilities between the Chairman and the Chief Executive, which should be in writing
8.2	Approval and review of the terms of reference of Board committees
8.3	Receiving reports from Board committees on their activities
9.	**CORPORATE GOVERNANCE MATTERS**
9.1	Approval of the Trust Constitution, in conjunction with the Council of Governors
9.2	Undertaking at least annually a formal and rigorous review of the Board's own performance and that of its committees and individual directors
9.3	Determining the independence of non-executive directors
9.4	Review of the Trust's overall corporate governance arrangements
9.5	Receiving reports on the views of the Trust's members, patients, carers and members of the public
10.	**POLICIES**
10.1	Approval and revision of Trust-wide Policy Management guidance
10.2	Approval of key policies of general application throughout the Trust, including: • codes of conduct • health and safety policy • whistle blowing • business continuity • risk management
11.	**OTHER**
11.1	Approval of the appointment of the Trust's principal professional advisers, with the exception of the external auditor
11.2	Decisions relating to overall levels of insurance for the Trust, including proposals for the purchase of commercial directors' and officers' liability insurance and indemnification of directors.
11.3	Approve the arrangements relating to the discharge of the Trusts responsibilities as a corporate trustee for funds held on trust
11.4	This schedule of matters reserved for board decisions

Matters which the Board considers suitable for delegation are contained in the terms of reference of its committees and in the scheme of delegation.

In addition, the Board will receive reports and recommendations from time to time on any matter which it considers significant to the Trust.

*A Significant Transaction means a transaction which relates to;

- For UK Healthcare: investments, divestments or other transactions comprising > 25% of the assets, income or capital of the NHS Foundation Trust.

- For non-healthcare related and/or international; investments, divestments or other transactions comprising > 25% of the assets, income or capital of the NHS Trust or if a trust is in significant breach, any investment/divestment comprising >10% of the assets, income or capital of the trust.

APPENDIX F: MEMBERSHIP AND KEY RESPONSIBILITIES OF BOARD COMMITTEES

APPENDIX F1: Audit CommitteeTerms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum (See attached schedule)

The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. At least one of the members should have recent relevant financial experience. A quorum shall be two members. The Board will appoint a Committee Chair and Deputy Chair from the Committee members. The Chairman of the Trust Board shall not be a member of the committee.

3. Attendance

The Director of Finance and Planning, Trust Secretary and Head of Financial Management, as well as appropriate Internal and External audit representatives will be expected to attend each Audit Committee meeting. The Medical Director, Director of Nursing, Director of Operations and Director of Improvement, Organisational Development and Performance ~~Strategy and Planning~~ will attend as required. At least once a year the Committee will meet privately with the Internal and External Auditors.

The counter fraud specialist or representative will attend a minimum of two committee meetings a year.

The Chief Executive and other Executive Directors may be invited to attend, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that director.

The Chief Executive may be invited to attend the meeting at which the draft Annual Governance Statement is discussed with the Audit Committee and the process for assurance which supports it.

The Chair of the Board is not a member of the Audit Committee and will not attend unless invited by the Chair of the Audit Committee to attend certain meetings or for specific agenda items either to form a view and understanding of the Committees operations or to provide assurances and explanation to the Committee on certain issues.

The Director of Finance and Planning shall agree the agenda with the Chair of the Audit Committee and other attendees, organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Access

The Head of Internal Audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the committee.

5. Frequency

The Committee will meet at least four times per year, including at least one meeting a year with both the internal and external auditors but without Executive Board members. The external auditors or internal auditors may request a meeting if they consider that one is necessary.

6. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Reporting

The Chair of the Committee will report to the Board in as soon as practically possible following the Committee meeting, this will be no later than the Board meeting in the following month . A summary of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented. In addition to this the approved minutes of the meeting will also be submitted to the private session of the Board. This is in line with the committee reporting process agreed by the Board.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission (CQC) regulations.

The Committee will undertake an annual self-assessment, which will be presented to the Trust board, along with the Annual Report of the Committee's activities.

The Duties of the Committee can be categorised as:

1. Governance and Internal Control

The Audit Committee reviews the establishment and maintenance of an effective system of internal control across the Trust. The Audit Committee provides an oversight of the activities of internal audit, external audit, the local counter fraud service and the assurance on internal control, including compliance with the law and regulations governing the Trust's activities.

The Audit Committee oversee the annual audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal controls with respect to risk management in place. An annual Head of Internal Audit Report is presented to the Audit Committee.

In particular, the Committee will review the adequacy of:

- All control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission (CQC) regulations), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives and the appropriateness of the above disclosure statements.

- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.

- The policies and procedures for all work related to fraud and corruption as required by NHS Protect and best practice.

- The policies and procedures promoting an anti-bribery and corruption culture. This will include the "Whistle blowing" and Standards of Business Conduct policies and the Declaration of Interests and Hospitality registers

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Audit Committee will have oversight of the effectiveness of the Governance of Board Committees.

2. <u>Information Governance</u>

The Audit Committee are responsible for maintaining an oversight of Information Governance principally by monitoring the progress against the Information Governance toolkit.

The Audit Committee has a specific role with regard to data quality to review the process put into place by the Trust to ensure the accuracy of key data. This will be achieved through a regular report on data quality presented by the Information Manager at each meeting and additional reports by exception where required. Members of the committee may request further assurance where necessary.

The Quality & Safety Committee has a specific role to review data governance issues relating to patient information, in particular in investigating any Patient Identifiable Data SI's.

The Audit Committee has a duty to ensure that these specific matters have been referred to the appropriate committee and dealt with appropriately.

3. <u>Internal Audit</u>

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

- Reviewing and approving the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.

- Considering the major findings of internal audit investigations (and management's response), and ensure co-ordination between the Internal and External Auditors.

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust. Conducting an annual review of the effectiveness of Internal Audit and providing feedback to the Board and the Internal Auditors.

4. Counter Fraud Service

The committee will ensure that there is an effective Counter Fraud function that meets NHS Protects standards. It will approve the Counter Fraud Annual plan, receive the Annual report and receive regular progress reports into any special investigations.

5. External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment of the external audit service, the audit fee and any questions of resignation and dismissal, in accordance with the procedures governing NHS Foundation Trusts as appropriate
- Discuss and agree with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all External Audit reports, and any work carried outside the annual audit plan, together with appropriateness of management responses.
- Conduct an annual review of the effectiveness of External Audit and provide feedback to the Board and the External Auditors.

6. Other Assurances Functions

The Audit Committee shall be made aware of the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust.

These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. CQC, NHS Resolutions, NHSi etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

The Audit Committee shall receive details of Single Tender Waivers as approved by the Chief Executive or delegated Executive Director.

The Audit Committee shall receive a schedule of losses and compensations and approve appropriate write-offs.

The Audit Committee shall review the Registers of Declarations of Interest and Gifts and Hospitality.

7. Management

The Committee shall request and review, as appropriate, reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

8. Policies

The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Framework. These will include:

- Counter Fraud Policy
- Management of Conflicts of Interest Policy

9. Other Matters

Financial Reporting:

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies and practices;
- Unadjusted mis-statements in the financial statements;
- Letters of representation;
- Major judgmental areas; and
- Significant adjustments resulting from the audit

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

10. Reference Costs

The Committee shall review the process for producing the annual reference costs and confirm that the Trusts return is compliant with the given procedures prior to submission.

Approved by Board of Directors: ~~24 May 2018~~

Committees of the Board – Exec, Non-Exec and Others							
	Quality and Safety	**Audit**	**Finance Planning and Digital**	**Risk**	**People**	**Remuneration and Appointment (Exec)**	**Remuneration and Appointment (Non-Exec)**
Terms of Reference Requirement	3 NEDs and 4 Execs	3 NEDs	2 NEDs and 4 Execs	2 NEDs and 5 Execs [1]	2 NEDs and 3 Execs	Chairman, Chief Executive and 5 NEDs	Chairman / Senior NED + 4 Governors
Meetings Per Year	10 (plus extra-ordinary meeting with Audit)	4 (plus extra-ordinary meeting with Q&S)	10	4	4	As required	As required
Quorum	1 NED and 2 Exec	2 NEDs	1 NED and 2 Exec	1 NED and 2 Execs	1 NED and 2 Exec	(CEO Role) Chairman and 3 NEDs (Exec Role) Chairman, Chief Executive and 2 NEDs	(Chairman) Senior NED and 4 Governors (NED Role) Chairman and 4 Governors
NED Membership	(Attendance is required and makes up quorum,* denotes an open invitation)						
Frank Collins	*	*	*	*	*	✓	✓ (NED Role)
Alastair Findlay			✓			✓	✓ (Chairman)
Paul Kingston	✓	✓			✓	✓	
David Gilburt	✓	✓	✓	*		✓	
Chris Beacock	✓			✓	✓	✓	
Harry Turner		✓		✓	✓	✓	
Exec Membership	(Attendance is required and makes up quorum, * denotes an open invitation)						
CEO	✓	*	*	✓	*	✓ (Exec Role)	
Director of Nursing[2]	✓	*	*	✓	✓		
Medical Director*	✓	*	*	*	*		
Director of Finance and Planning	*	✓ (not a member)	✓	✓	*		
Director of Operations	✓	*	✓*	✓	*		
Director of People	✓*	*	*	✓	✓	✓	
Director of ~~Strategy and Planning~~ Improvement Organisational Development and Performance	*	*	✓	✓*	✓		
Associate Director of IT		*	✓	*	*		
Governor Membership	(Attendance is required and makes up quorum, ^denotes an and/or)						
Lead Governor							✓
Public Governor x 2							✓
Staff Governor					*		✓
Appointed Governor							✓
In Attendance	(Attendance is required but does not make up quorum)						
Trust Secretary	✓	✓	✓	✓	✓		✓
Hilary Pepler, Board Advisor	✓				✓		
Head of Financial Management		✓					

Deputy Director of Nursing	✓						
Assistant Director of Nursing and Governance	✓			✓			
Divisional Governance Leads				✓			
Internal Audit		✓					
External Audit		✓					
As Required	(Attendance is by invitation, * denotes an open invitation)						
Head of People	✓			*	✓		
Associate Director of Estates and Facilities	✓	✓		*	*		
Chief Pharmacist	✓	✓		*	*		
Clinical Leads	✓			✓	✓		
Q&S Matron	✓			*	*		
Theatres and Anaesthetics Representative[3]	✓			✓	✓		
Diagnostics Representative	✓			✓	✓		
Surgery Representative	✓			✓	✓		
Medicine and Rehab Representative	✓			✓	✓		
Medical Representative				✓	✓		
Nursing Representative				✓	✓		

[1] The Executive Directors have a buddy system and therefore one of the following should attend Director of Operations / Finance and Planning and Director of People / Director of ~~Strategy and Planning~~ Improvement, Organisational Development and Performance

[2] If the Director of Nursing is unable to attend an appropriate Nursing Representative will attend

[3] The divisional representatives can be one of the following:

Divisional Manager

Matron

Clinical Lead

APPENDIX F2: Quality and Safety Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Quality and Safety Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum (See attached schedule)

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Three Non Executive Directors
- The Board will appoint a Committee chairman and deputy chairman from the non-executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman or deputy Chairman
- Chief Executive Officer – invited to attend as required
- Medical Director
- Director of Nursing (Governance Lead)
- Director of Operations
- ~~Director of People~~

In exceptional circumstances a deputy may attend in place of an Executive Director.

The Board of Directors will appoint a Committee chairman from the Non-Executive members of the Committee and a Non-Executive Director will be nominated to chair meetings in the absence of the chairman.

A quorum will be one ~~two~~ Non-Executive members and two Executive members.

3. Attendance

The Trust Secretary, Deputy Director of Nursing and Assistant Director of Nursing for Governance will be expected to attend each meeting. The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Associate Director of IMT, Chief Pharmacist and Deputy Director of HR, Divisional Representative will only be expected to attend when a relevant paper is being presented. ~~together with their Clinical Lead.~~

~~A representative from each Division will be expected to attend each meeting.~~

The Director of Nursing shall agree the agenda with the Chair of the Committee and other attendees. A member of the Executive office secretariat will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Frequency of meetings

The Committee will meet at least 10 times a year for regular business. The Chairman of the Committee may call additional meetings.

5. Authority

The Committee is authorised by the Board to investigate any activity and is expected to make recommendations to the full board, within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

The Chair of the Committee will report to the Board in as soon as practically possible following the Committee meeting; this will be no later than the Board meeting in the following month. A summary of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented. In addition to this the approved minutes of the meeting will also be submitted. This is in line with the committee reporting process agreed by the Board.

The Committee will undertake an Annual self-assessment, which will be presented to the Trust board, along with an Annual Report.

7. Key responsibilities

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".
- The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust to:
    - Promote safety and excellence in patient care
    - Identify, prioritise and manage risk arising from clinical care
    - Ensure efficient and effective use of resources through evidence based clinical practice
- To ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.
- To consider NHSi Quality Governance Framework in the delivery of its key responsibilities
- To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.
- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.
- To receive reports from the following committees:
    - Patient ~~and Staff~~ Experience Committee
    - Safeguarding Committee
    - Clinical Governance & Quality Committee
- The Quality & Safety Committee shall review the Quality Accounts before submission to the Trust Board,
- The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy
- ~~To receive regular reports on workforce matters.~~
- ~~To receive regular reports on Health and Safety issues.~~

Clinical outcomes

- Monitoring the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
- Receiving and commenting on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.

Incident reporting and investigation

- Monitoring the effectiveness of the Trust's systems for reporting and investigating Serious Incidents (SIs), near misses and other incidents.
- Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.

Patient experience

- Monitoring the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
- Monitoring the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.

Approve and review of CQUIN requirements

Patient Information Governance

- Monitoring the arrangements to ensure the security of personally identifiable data.

~~Workforce~~

- ~~Review progress made in delivering key enabling strategies such as (but not limited to) Workforce raising any significant risks regarding their delivery to the Board.~~

Approved by Board of Directors ~~24 May 2018~~

Committees of the Board – Exec, Non-Exec and Others							
	Quality and Safety	**Audit**	**Finance Planning and Digital**	**Risk**	**People**	**Remuneration and Appointment (Exec)**	**Remuneration and Appointment (Non-Exec)**
Terms of Reference Requirement	3 NEDs and 4 Execs	3 NEDs	2 NEDs and 4 Execs	2 NEDs and 5 Execs [1]	2 NEDs and 3 Execs	Chairman, Chief Executive and 5 NEDs	Chairman / Senior NED + 4 Governors
Meetings Per Year	10 (plus extra-ordinary meeting with Audit)	4 (plus extra-ordinary meeting with Q&S)	10	4	4	As required	As required
Quorum	1 NED and 2 Exec	2 NEDs	1 NED and 2 Exec	1 NED and 2 Execs	1 NED and 2 Exec	(CEO Role) Chairman and 3 NEDs (Exec Role) Chairman, Chief Executive and 2 NEDs	(Chairman) Senior NED and 4 Governors (NED Role) Chairman and 4 Governors
NED Membership	(Attendance is required and makes up quorum,* denotes an open invitation)						
Frank Collins	*	*	*	*	*	✓	✓ (NED Role)
Alastair Findlay			✓			✓	✓ (Chairman)
Paul Kingston	✓	✓			✓	✓	
David Gilburt	✓	✓	✓	*		✓	
Chris Beacock	✓			✓	✓	✓	
Harry Turner		✓		✓	✓	✓	
Exec Membership	(Attendance is required and makes up quorum, * denotes an open invitation)						
CEO	✓	*	*	✓	*	✓ (Exec Role)	
Director of Nursing[2]	✓	*	*	✓	✓		
Medical Director*	✓	*	*	*	*		
Director of Finance and Planning	*	✓ (not a member)	✓	✓	*		
Director of Operations	✓	*	✓*	✓	*		
Director of People	~~✓~~*	*	*	✓	✓	✓	
Director of ~~Strategy and Planning~~ Improvement Organisational Development and Performance	*	*	✓	~~✓~~*	✓		
Associate Director of IT		*	✓	*	*		
Governor Membership	(Attendance is required and makes up quorum, ^denotes an and/or)						
Lead Governor							✓
Public Governor x 2							✓
Staff Governor					*		✓
Appointed Governor							✓
In Attendance	(Attendance is required but does not make up quorum)						
Trust Secretary	✓	✓	✓	✓	✓		✓

Hilary Pepler, Board Advisor	✓				✓		
Head of Financial Management		✓					
Deputy Director of Nursing	✓						
Assistant Director of Nursing and Governance	✓			✓			
Divisional Governance Leads				✓			
Internal Audit		✓					
External Audit		✓					
As Required	(Attendance is by invitation, * denotes an open invitation)						
Head of People	✓			*	✓		
Associate Director of Estates and Facilities	✓	✓		*	*		
Chief Pharmacist	✓	✓		*	*		
Clinical Leads	✓			✓	✓		
Q&S Matron	✓			*	*		
Theatres and Anaesthetics Representative[3]	✓			✓	✓		
Diagnostics Representative	✓			✓	✓		
Surgery Representative	✓			✓	✓		
Medicine and Rehab Representative	✓			✓	✓		
Medical Representative				✓	✓		
Nursing Representative				✓	✓		

[1] The Executive Directors have a buddy system and therefore one of the following should attend Director of Operations / Finance and Planning and Director of People / Director of ~~Strategy and Planning~~ Improvement, Organisational Development and Performance

[2] If the Director of Nursing is unable to attend an appropriate Nursing Representative will attend

[3] The divisional representatives can be one of the following:

Divisional Manager

Matron

Clinical Lead

APPENDIX F3: Finance, Planning and ~~Investment~~ Digital Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Planning and ~~Investment~~ Digital Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum (See attached schedule)

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- ~~Three~~ Two Non Executive Directors
- The Board will appoint a Committee chairman and deputy chairman from the non-executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman or deputy Chairman
- ~~Deputy Chief Executive/Chief Finance Officer~~
- Director of Finance and Planning
- Director of Improvement, Organisational Development and Performance ~~Planning & Strategy~~
- Director of Operations ~~– Invited to attend as required~~
- Associate Director of IM&T
- Director of People ~~HR~~ – Invited to attend as required
- Chief Executive Officer – Invited to attend as required

The Board of Directors will appoint a Committee chairman and deputy chairman from the Non-Executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman.

A quorum will be one ~~two~~ Non-Executive members and two Executive members.

3. Attendance

Other Executive Directors to attend as appropriate. The Trust Secretary ~~and Associate Director of Performance~~ will attend. The Chairman of the Trust may attend at the invitation of the Chairman of the Committee.

The Director of Finance shall agree the agenda with the Chair of the Committee. A member of the Executive office secretariat will, organise the collation and distribution of the papers, record the proceedings of the Committee and keep a record of matters arising and issues to be carried forward.

.

4. Frequency of Meetings

The Committee will meet at least ~~six~~ ten times a year for regular business. The Chairman of the Committee may call additional meetings.

5. Authority

The Committee is authorised by the Board to provide an objective view of the financial and performance position of the Trust and will act to oversee the delivery of achieving financial, activity and operational performance targets, making any decisions delegated to it and if appropriate, report and make recommendations to the Board, within its terms of reference.

The Committee is distinct and separate from the Audit Committee and will act to minimise any possible areas of overlap between these two Committees,

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

The Chairman of the Committee will report to the next Board meeting ~~by the month~~ following the Committee meeting ~~at the latest~~. A summary of the main issues of the discussion, drawing attention to any issues that require Board or Executive action, will be presented. In addition to this the approved minutes of the meeting will also be submitted. This is in line with the Committee reporting process agreed by the Board.

The Committee will undertake an Annual self-assessment, which will be presented to the Board, along with an Annual Report.

7. Key Responsibilities

The Finance, Planning and ~~Investment~~ Digital Committee supports and advises the Board on all aspects of the Trust's Annual and Long Term Financial Plans and recommends adoption of the plans to the Board of Directors.

Strategy

- To consider and approve the key planning and financial assumptions to be used in the five year strategy and annual operational plan.
- Oversight of strategic issues related to income e.g. changes to tariff, commissioning intentions, tendering for new services, risks from competition and market share.
- To consider and recommend Board approval of the Trust's Digital Strategy
- To consider recommendations of investment and disinvestment of Trust sub-specialty / service reviews ensuring strategic steer in keeping with the Trust strategy and objectives.
- Capital planning oversight, ensuring forward planning, regular review and recommendations including acquisitions and disposal of assets, in line with the Trust strategy and objectives.
- To consider, evaluate and if appropriate recommend for Board approval commercial developments and partnerships opportunities in keeping with the Trust strategy and objectives.
- To consider and recommend Board approval of material business cases as defined by the Trust SFI's (currently investments above c£250k)
- Consider post project evaluation reports on significant capital investments. This will include all schemes over £250k and other schemes which are considered to represent a significant risk to the Trust.

Oversight and Scrutiny

- Receive regular reports on financial performance including the overall financial performance against plan and associated risk rating, performance of Capital programme and the performance of activity against contract
- Oversight of the Trust's digital risks

- To oversee the delivery of the Trust's digital strategy and any associated risks to delivery

  - To evaluate progress and recommend further actions from the review of in year financial, CIP, activity, RTT and productivity performance information, including SLR review

  - Review the Trust's investment register of cash investment as required

  - To evaluate progress of service transformation and investment plans, ensuring establishment of models of best practice in line with the Trust strategy.

  - Promoting sustainability and receiving sustainability KPIs

  - To receive routine reports/minutes from designated working groups e.g. Capital Planning Group, I, M & T programme Board, Procurement Committee.

  - Receive relevant internal audit reports.

  - To provide oversight in respect of all aspects of business planning, partnerships and development.

  - To provide oversight to the Trust annual plan and its subsequent delivery.

  Policies/Strategies

  - The Committee shall approve such policies and strategies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy.

  - Review progress made in delivering key enabling strategies such as (but not limited to) Estates, Procurement, and IT raising any significant risks regarding their delivery to the Board.

Approved by Trust Board of Directors ~~24 May 2018~~

Committees of the Board – Exec, Non-Exec and Others							
	Quality and Safety	**Audit**	**Finance Planning and Digital**	**Risk**	**People**	**Remuneration and Appointment (Exec)**	**Remuneration and Appointment (Non-Exec)**
Terms of Reference Requirement	3 NEDs and 4 Execs	3 NEDs	2 NEDs and 4 Execs	2 NEDs and 5 Execs [1]	2 NEDs and 3 Execs	Chairman, Chief Executive and 5 NEDs	Chairman / Senior NED + 4 Governors
Meetings Per Year	10 (plus extra-ordinary meeting with Audit)	4 (plus extra-ordinary meeting with Q&S)	10	4	4	As required	As required
Quorum	1 NED and 2 Exec	2 NEDs	1 NED and 2 Exec	1 NED and 2 Execs	1 NED and 2 Exec	(CEO Role) Chairman and 3 NEDs (Exec Role) Chairman, Chief Executive and 2 NEDs	(Chairman) Senior NED and 4 Governors (NED Role) Chairman and 4 Governors
NED Membership	(Attendance is required and makes up quorum,* denotes an open invitation)						
Frank Collins	*	*	*	*	*	✓	✓ (NED Role)
Alastair Findlay			✓			✓	✓ (Chairman)
Paul Kingston	✓	✓			✓	✓	
David Gilburt	✓	✓	✓	*		✓	
Chris Beacock	✓			✓	✓	✓	
Harry Turner		✓		✓	✓	✓	
Exec Membership	(Attendance is required and makes up quorum, * denotes an open invitation)						
CEO	✓	*	*	✓	*	✓ (Exec Role)	
Director of Nursing[2]	✓	*	*	✓	✓		
Medical Director*	✓	*	*	*	*		
Director of Finance and Planning	*	✓ (not a member)	✓	✓	*		
Director of Operations	✓	*	✓*	✓	*		
Director of People	✓*	*	*	✓	✓	✓	
Director of ~~Strategy and Planning~~ Improvement Organisational Development and Performance	*	*	✓	✓*	✓		
Associate Director of IT		*	✓	*	*		
Governor Membership	(Attendance is required and makes up quorum, ^denotes an and/or)						
Lead Governor							✓
Public Governor x 2							✓
Staff Governor					*		✓
Appointed Governor							✓
In Attendance	(Attendance is required but does not make up quorum)						
Trust Secretary	✓	✓	✓	✓	✓		✓
Hilary Pepler, Board Advisor	✓				✓		

Head of Financial Management		✓					
Deputy Director of Nursing	✓						
Assistant Director of Nursing and Governance	✓			✓			
Divisional Governance Leads				✓			
Internal Audit		✓					
External Audit		✓					
As Required	(Attendance is by invitation, * denotes an open invitation)						
Head of People	✓			*	✓		
Associate Director of Estates and Facilities	✓	✓		*	*		
Chief Pharmacist	✓	✓		*	*		
Clinical Leads	✓			✓	✓		
Q&S Matron	✓			*	*		
Theatres and Anaesthetics Representative[3]	✓			✓	✓		
Diagnostics Representative	✓			✓	✓		
Surgery Representative	✓			✓	✓		
Medicine and Rehab Representative	✓			✓	✓		
Medical Representative				✓	✓		
Nursing Representative				✓	✓		

[1] The Executive Directors have a buddy system and therefore one of the following should attend Director of Operations / Finance and Planning and Director of People / Director of ~~Strategy and Planning~~ Improvement, Organisational Development and Performance

[2] If the Director of Nursing is unable to attend an appropriate Nursing Representative will attend

[3] The divisional representatives can be one of the following:

Divisional Manager

Matron

Clinical Lead

APPENDIX F4: Risk Management Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Risk Management Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum (See attached schedule)

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Two Non-Executive Directors
- The Board will appoint a Committee chairman and deputy chairman from the non-executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman or deputy Chairman
- Chief Executive Officer
- Director of Nursing
- Director of Operations or Director of Finance and Planning
- Director of People or Director of ~~Strategy and Planning~~ Improvement, Organisational Development and Performance

A quorum will be one Non-Executive members and two Executive members (or an appointed Deputy).

3. Attendance

A medical and nursing representative is required to attend each meeting.

The Deputy Director of Nursing, Assistant Director of Nursing and Governance and the Trust Secretary will be expected to attend each meeting. The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Divisional Managers will ensure divisional representation at each meeting for presentation of the divisional deep dives and will attend, where possible with their ~~Clinical Lead and Matron, for the divisional deep dives~~ Divisional Governance Lead.

~~The Patient Safety Manager and Divisional Governance Leads will be expected to attend each meeting .~~

The Associate Director of IMT, Chief Pharmacist, ~~Deputy Director~~ Head of People ~~HR~~, Associate Directors of Estates and Facilities and Finance Representative have open invitation to attend when there is an agenda item of interest and will be required to attend by invitation for discussions regarding their departments.

The Director of Nursing shall agree the agenda with the Chair of the Committee and other attendees. A member of the Executive office secretariat will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Frequency of Meetings

The Committee will meet ~~monthly ten~~ four times per year but this is to be reviewed in June 2018 following an assessment of the Committee with a view to the meetings moving to six per year if effectiveness is assured.

5. Purpose

The purpose of the Risk Management Committee is to have overall responsibility for establishing a strategic approach to risk management across the organisation, ensuring that the approach is pro-active. The Committee is also responsible for the overall co-ordination of risk

management activity. It ensures that the necessary processes are in place to achieve compliance with statutory requirements and to protect the Trust's patients, staff and assets. Risk management will be an integral part of the Trust's strategic and operational objectives.

6. Establishment of Risk Management Committee

The Risk Management Committee is established in accordance with guidance set out by the NHS Executive.

7. Authority and Accountability

The Committee is authorised by the Board of Directors to make executive decisions regarding the management of risk. . It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

The Chair of the Committee will report to the Board in as soon as practically possible following the Committee meeting; this will be no later than the Board meeting in the following month. A summary of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented. In addition to this the approved minutes of the meeting will also be submitted. This is in line with the committee reporting process agreed by the Board.

The Committee will undertake an Annual self-assessment, which will be presented to the Trust board, along with an Annual Report.

8. Duties

The committee is responsible for the following aspects of Risk Management:

The Committee is responsible for the following aspects of Risk Management:

- Promote systems which provide assurance and improve the quality of care, safety and experience of patients, carers, staff and visitors to the Trust
- Exercise oversight of the systems of governance and risk management and seek assurance that they are fit-for-purpose, adequately resourced and effectively deployed to concentrate on matters of concern
- Oversee the effective management of risks as appropriate to the purpose of the committee
- Seek assurances that the Trust complies with its own policies and all relevant external regulations and standards of governance and risk management (CQC framework)
- Review quality governance and require action to address any non-compliance with NHSi Quality Governance Framework
- Review of relevant external reports including CQC and ensure action plans are devised and performance managed to address any identified deficiencies in clinical governance
- Monitor investigations and sign off action plans of serious untoward incidents
- Satisfy itself and the Board that structures, processes and responsibilities for identifying and managing risks to patients, staff and the organisation are adequate

Ensure that standards and procedures relating to risk are embedded throughout the Trust, with mechanisms through the committee for detailed scrutiny of high and significant areas, including consultation with appropriate Trust staff

- Provide leadership to ensure risk is identified and managed proactively in accordance with the Board's risk appetite
- Champion and promote highly-effective risk management practices and ensure that the risk management process and culture are embedded throughout the organisation
- Maximise the delivery of objectives through an effective control system
- Keep risk under prudent control at all times and minimise over exposure to risk
- Improve the standard of decision making on risk management
- To receive and review the BAF bi-monthly and agree additions to the BAF
- Review and ensure compliance with nationally agreed regulated standards including: CQC and locally agreed standards STAR assessment
- Monitor outcomes in relation to patient experience projects identifying trends and ensuring action plans are reviewed and completed at a local or organisational level with identified risks monitored through the relevant risk management processes completed
- Review significant incidents as identified via incident reporting, claims or complaints.
- Review Divisional Risk Registers monitoring effectiveness of risk mitigation actions plans and escalate as appropriate.
- Recommend audits to be undertaken from identified incidents, complaint, claims and risks with high risk ratings reviewing outcomes and actions to completion
- Receive a report from the Clinical Audit Committee highlighting any risks with regard to progress against current clinical audits and any risks identified from completed clinical audits
- Receive a report from the Clinical Audit Committee highlighting any risks in relation to implementation of NIHCE guidance
- To raise awareness and understanding of Governance and risk management at all levels and among all staff within the Trust.
- Ensure Divisional responsibility for effective governance and risk management is in place and adhered to through local Divisional meetings
- To ensure all risks are scored appropriately via the Risk Matrix
- Develop an effective reporting mechanism to allow escalation of risk and governance issues from an operational level and to ensure the risk profile of the whole Trust can be consolidated and to ensure that this profile takes into account the level of risk identified through both a proactive process (i.e., risk assessment with assessment with forward planning) and also through reactive processes (i.e. incidents, complaints and claims).
- To provide the Executive Team with assurance that effective governance processes are in place across the organisation and that risks are being discussed and appropriate control measures are put in place to mitigate and reduce risks highlighted within the trust.

9. Clinical Risk/Quality Risk

Reviewing the Trust's strategy for management of clinical risk and monitoring the overall level of clinical risk within the Trust, taking account of CQC requirements and applicable regulatory guidance.

- Supporting the Audit Committee in assessing the overall scope and effectiveness of the Trust's risk management systems

- Reviewing the entries of the Trust's risk register which are relevant to the Committee and in line with the terms of reference.

10. Reporting Arrangements into the Committee

The Risk Management Committee receives summary reports detailing progress made against their divisional risk register and a review of the work of committees with delegated responsibilities for specific areas or risk. Reports are received from Facilities, Estates, Finance, Corporate, Diagnostics, IT, Medicine and Rehabilitation, Surgery, Surgery Services and Governance.

11. Required Frequency of Attendance by Members

It is highly important that members attend the Risk Management Committee on a regular basis and as a minimum 75% of all meetings (save for those with arrangements as outlined below). Where possible a delegated deputy should attend the meeting in the absence of a Risk Management Committee member.

- Chief Executive required to attend one meeting per quarter
- Either the Director of Finance and Planning or the Director of Operations should be in attendance at each meeting with a cumulative attendance rate of no less than 75%
- Either the Director of People / ~~Deputy Director of HR~~ Head of People ~~or the Director of Strategy and Planning~~ should be in attendance at each meeting with the Director of Improvement, Organisational Development and Performance representing in their absence to achieve a cumulative attendance rate of no less than 75%

12. Process for Monitoring the Effectiveness of all of the above

The effectiveness of the Risk Management Committee is monitored through the following:

- The Trust Board Minutes
- Internal Audit
- Annual Risk Management Report
- Associated action plans related to controls assurance framework

13. Review

The terms of reference will be reviewed annually ~~but with potential for a further review in June 2018 if the frequency of the meetings is to be reduced.~~

Approved by Board of Directors ~~24 May 2018~~

Committees of the Board – Exec, Non-Exec and Others							
	Quality and Safety	Audit	Finance Planning and Digital	Risk	People	Remuneration and Appointment (Exec)	Remuneration and Appointment (Non-Exec)
Terms of Reference Requirement	3 NEDs and 4 Execs	3 NEDs	2 NEDs and 4 Execs	2 NEDs and 5 Execs [1]	2 NEDs and 3 Execs	Chairman, Chief Executive and 5 NEDs	Chairman / Senior NED + 4 Governors
Meetings Per Year	10 (plus extra-ordinary meeting with Audit)	4 (plus extra-ordinary meeting with Q&S)	10	4	4	As required	As required
Quorum	1 NED and 2 Exec	2 NEDs	1 NED and 2 Exec	1 NED and 2 Execs	1 NED and 2 Exec	(CEO Role) Chairman and 3 NEDs (Exec Role) Chairman, Chief Executive and 2 NEDs	(Chairman) Senior NED and 4 Governors (NED Role) Chairman and 4 Governors
NED Membership	(Attendance is required and makes up quorum,* denotes an open invitation)						
Frank Collins	*	*	*	*	*	✓	✓ (NED Role)
Alastair Findlay			✓			✓	✓ (Chairman)
Paul Kingston	✓	✓			✓	✓	
David Gilburt	✓	✓	✓	*		✓	
Chris Beacock	✓			✓	✓	✓	
Harry Turner		✓		✓	✓	✓	
Exec Membership	(Attendance is required and makes up quorum, * denotes an open invitation)						
CEO	✓	*	*	✓	*	✓ (Exec Role)	
Director of Nursing[2]	✓	*	*	✓	✓		
Medical Director*	✓	*	*	*	*		
Director of Finance and Planning	*	✓ (not a member)	✓	✓	*		
Director of Operations	✓	*	✓*	✓	*		
Director of People	✓*	*	*	✓	✓	✓	
Director of ~~Strategy and Planning~~ Improvement Organisational Development and Performance	*	*	✓	✓*	✓		
Associate Director of IT		*	✓	*	*		
Governor Membership	(Attendance is required and makes up quorum, ^denotes an and/or)						
Lead Governor							✓
Public Governor x 2							✓
Staff Governor					*		✓
Appointed Governor							✓
In Attendance	(Attendance is required but does not make up quorum)						
Trust Secretary	✓	✓	✓	✓	✓		✓
Hilary Pepler, Board Advisor	✓				✓		
Head of Financial Management		✓					
Deputy Director of	✓						

Nursing							
Assistant Director of Nursing and Governance	✓			✓			
Divisional Governance Leads				✓			
Internal Audit		✓					
External Audit		✓					
As Required	(Attendance is by invitation, * denotes an open invitation)						
Head of People	✓			*	✓		
Associate Director of Estates and Facilities	✓	✓		*	*		
Chief Pharmacist	✓	✓		*	*		
Clinical Leads	✓			✓	✓		
Q&S Matron	✓			*	*		
Theatres and Anaesthetics Representative[3]	✓			✓	✓		
Diagnostics Representative	✓			✓	✓		
Surgery Representative	✓			✓	✓		
Medicine and Rehab Representative	✓			✓	✓		
Medical Representative				✓	✓		
Nursing Representative				✓	✓		

[1] The Executive Directors have a buddy system and therefore one of the following should attend Director of Operations / Finance and Planning and Director of People / Director of ~~Strategy and Planning~~ Improvement, Organisational Development and Performance

[2] If the Director of Nursing is unable to attend an appropriate Nursing Representative will attend

[3] The divisional representatives can be one of the following:

Divisional Manager

Matron

Clinical Lead

APPENDIX F5: People Committee Terms of Reference

To be confirmed following first meeting in May 2019

APPENDIX F6: Executive Directors Remuneration and Appointments Committee Terms of Reference

Constitution

The Board hereby resolves to establish Committee of the Board to be known as the Executive Directors Remuneration Committee and Appointments Committee
The Committee is a Non-Executive Committee of the Remuneration Committee and has no executive powers other than those specifically delegated in these Terms of Reference.

Purpose

To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the board.

When appointing the Chief Executive, the Committee shall be the Committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing other Executive Directors the committee described in Schedule 7, 17(4) of Act

The Committee shall ensure there is a formal, rigorous and transparent procedure for the appointment of new Directors and that Directors are 'fit and proper' to meet the requirements of the general conditions of the Trusts provider licence.

Membership

The membership of the Committee(s) shall vary according to the nature of the business to be discharged at a particular meeting as follows:

<u>For the appointment and remuneration of the Chief Executive</u>

Chairman of the Board
Non- Executive Directors

The quorum is the Chairman and three Non-Executive Directors.

<u>For the appointment of remuneration any other Executive Director</u>

Chairman of the Board
Chief Executive
Non-Executive Directors

The quorum is the Chairman, Chief Executive and two Non-Executive Directors.

Secretary to the Committee

The Director of People will act as the secretary to the committee(s), and will facilitate and attend all meetings of the committee. S/he will agree the agenda with the Chair of the Committee and other attendees organise the collation and distribution of the papers and keep a record of decisions and recommendations taken.

Attendance

The Committee may request an Independent advisor to attend.

Executive Directors may be requested to attend when the committee considers such issues as succession planning.

The Director of People will attend to facilitate the meeting and provide technical advice if required

Frequency of meetings

Ad hoc

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

Key Responsibilities

- As Requested by the Board, review the structure, size and composition of the board and make recommendations for changes as appropriate.
- As Requested by the Board, give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise requires within the board of directors to meet them.
- When considering the appointment of Executive Directors, the Appointment Committee must ensure that statutory roles are maintained and will take into account the views of the board of directors regarding the qualifications, skills and experience required.
- The Committee is responsible for ensuring that any Director nominated for a Board position, is "fit and proper" to undertake the role. The requirements, checks and declarations are shown at Appendix F6.1.
- Setting the remuneration of all Executive Directors, including salary and any performance related elements / bonuses or allowances and provision for other benefits including cars
- Ensuring the contractual terms of Executive Directors are in accordance with national policy and guidance, particularly in relation to the termination of employment, notice periods and pension benefits
- Determining whether a proportion of Executive Directors' remuneration should be linked to corporate and individual performance and, if so, approving an appropriate scheme of performance related remuneration.

Process for the Identification and Nomination of Chief Executive or Executive Directors

The process to be followed for the appointment of a new Chief Executive or Executive Director has been agreed by the Trust Board, and is included in appendix F6.2.

Suggestions for improvement to the process will be feedback to the Trust Board as appropriate, and the process will be periodically updated where agreed.

Reporting

The Chair of the Committee will report to the next meeting of the Board following the Committee, summarising the main issues of the discussion and drawing to the Board's attention any issues that require disclosure to the full Board or require Executive action.

Details of the Committee and the appointments made will be included in the Trust's Annual Report. When the Committee has met to appoint Chief Executive, the Chairman will prepare a report of the proceeding for the Governors, to assist them in approving the appointment.

Approved by Trust Board ~~24 May 2018~~

Appendix F6.1: Fit and Proper Person requirements, checks and declarations

- NHS Employers – Employment Checks Requirements
    - Identity
    - Right to Work
    - Professional Registration and Qualifications
    - Employment history and reference
    - Criminal record and barring
    - Work health assessment
- Current and previous directorships
- Conflicts of interest
- Declaration to abide by Standards for Members of NHS boards
- Declaration to abide by Trusts Standards of Business Conduct
- Declaration to maintain confidentiality

The following may not become a member of the Board of Directors

- A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- A person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it.
- A person who within the preceding five years has been convicted in the British islands of any offence if a sentence of imprisonment (whether suspected or not) for a period of not less than three months (without the option of a fine) was imposed on him or her).
- A person who has been barred from acting as a governor of an FT or disqualified as a director.
- A person with a history of any action against the principles of the NHS Constitution

Appendix F6.2: Process for the Identification and Nomination of Chief Executive or Executive Director

The standard approach to advertising and recruitment for executive appointments shall be as follows:

- Identify skills gap based on assessment of requirements of the post
- Liaise with the Remuneration Committee to confirm terms & conditions
- Update role description and person specification to reflect skills gap being addressed
- Consideration will be given to the use of agencies to assist with recruitment processes were appropriate
- Advertise through
  Local and or National newspapers (Shropshire; North Wales; Cheshire)
  NHS Careers Website/NHS Employers executive vacancies
  Trust Web Site through link to NHS Careers
  Email shot to FT Members
  Email shot to Trust Staff
- Pre-screening - Dependent on the number and standard of applications received the Committee will give consideration to the use of ability and psychometric testing in order to determine a short list for interview Committee (this may be via teleconference)
- Appoint Independent Adviser with appropriate professional background.

<u>For the Appointment of the Chief Executive</u>

Chairman of the Board
Minimum of three Non- Executive Directors
Independent Adviser (non-voting)

<u>For the appointment of any other Executive Director</u>

Chairman of the Board
Chief Executive
Minimum of two Non-Executive Directors
Independent Adviser (non-voting)

- Interview panel - Prior to the interview, panel members to be allocated areas of questioning, with sample questions to support them together with a scoring matrix to ensure decisions are based on a robust assessment of each applicant
- Interview panel recommendation for appointment of a Chief Executive will be made to the Executive Director Appointment Committee (sitting without the Chief Executive) and subject to the approval of the Council of Governors
- Interview panel recommendation for appointment of an Executive Director will be made to the Executive Director Appointment Committee
- Conditional offer made subject to completion of 'fit and proper' person checks

Suggestions for improvement to the process will be fedback to the Trust Board as appropriate, and the process will be periodically updated where agreed.

APPENDIX F7: Non-Executive Directors Remuneration and Appointment Committee Terms of Reference

Constitution

The Non-Executive Directors Remuneration and Appointment Committee (the Committee) is constituted as a standing committee of the Council of Governors. Its constitution and terms of reference shall be set out below, subject to amendment at future meetings of the Council of Governors.

Purpose

The Committee is responsible for appointing Non-Executive Directors, including the Chairman, to the Board of Directors.

The Committee shall ensure there is a formal, rigorous and transparent procedure for the appointment of new Directors and that Directors are 'fit and proper' to meet the requirements of the general conditions of the Trusts provider licence.

The Committee will also periodically be satisfied that plans are in place for orderly succession for appointments to Non-Executive positions, so as to maintain an appropriate balance of skills and experience on the board.

The Committee will recommend to the Council of Governors remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the chair (except in respect of his own remuneration and terms of service) and the chief executive and any external advisers.

The Committee will agree the process and receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

Membership

The membership of the Committee shall have a majority of governors, and will be chaired by the Chairman or by the Senior Independent Director in his absence, and will consist of the following

<u>For the appointment and remuneration of the Chairman</u>

Lead Governor
Senior Independent Director of the Board
2 public governors
1 staff governor and/or 1 appointed governor

<u>For the appointment and remuneration of any other Non-Executive Director</u>

Chairman of the Board
Lead Governor
2 Public Governors
1 Staff Governor and/or 1 Appointed Governor

Secretary to the Committee

The Trust Secretary will act as the Secretary to the Committee, and will facilitate and attend all meetings of the committee. She will agree the agenda with the Chair of the Committee and other attendees organise the collation and distribution of the papers and keep a record of decisions and recommendations taken.

Conflicts of Interest
The Chair of the Trust or any Non-Executive Directors present at Committee meetings will withdraw from discussions concerning their own remuneration of terms of service.

Attendance

The Committee may request on Independent advisor to attend. Director of People ~~Human Resources~~ will attend to facilitate the meetings and will be available to give technical advice if required.

Frequency of meetings

Ad Hoc

Authority
The Committee is authorised by the Council of Governors to act within its terms of reference and constitution as set out in this document. The Committee is authorised by the Council of Governors, subject to funding and Board approval, to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary. The Committee is also authorised to request such internal information as is necessary and expedient to the fulfilment of its function.

Key Responsibilities

- When considering the appointment of non-executive directors, the appointments committee, on behalf of the council of governors, will take into account the views of the board of directors regarding the qualifications, skills and experience required for each position.

  The skills and experience needed across the Non-Executive Directors of the Board, to ensure a broad range of appropriate knowledge and experience to ensure sufficient challenge to the executive team are determined as follows:

  - Legal
  - Financial
  - Business Strategy
  - Human Resources
  - Clinical/Research
  - Marketing/PR

- The Committee is responsible for ensuring that any Director nominated for a Board position, is "fit and proper" to undertake the role. The requirements, checks and declarations are shown at Appendix F7.1.

- In adhering to all relevant laws and regulations the Committee will establish levels of remuneration which:
  - Are sufficient to attract, retain and motivate Non-Executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;
  - Reflect the time commitment and responsibilities of the roles;
  - Take into account appropriate benchmarking and market-testing, which ensuring that increases are not made where trust or individual performance do not justify them; and
  - Are sensitive to pay and employment conditions elsewhere in the trust (not foregoing that non-executive directors are not employees)

Process for the Identification and Appointment of Non-Executive Directors

The process to be followed for the appointment of a new Chairperson or Non-Executive Director has been agreed by the Council of Governors, and is included in appendix F7.2.

Suggestions for improvement to the process will be fedback to the Council of Governors as appropriate, and the process will be periodically updated where agreed.

Reporting
Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to members of the Council of Governors, unless a conflict of interest, or matter of confidentiality exists.

The Committee will report to the Council of Governors after each meeting.

The Committee shall receive and agree a description of the work of the Committee, its policies and all Non-Executive Director emoluments in order that these are accurately reported in the required format in the trusts annual report.

Details of the Committee and the appointments made will be included in the Trust's Annual Report.

Approved by Trust Board ~~24 May 2018~~

Appendix F7.1: Fit and Proper Person Requirements, Checks and Declarations

- Criminal records checks
- Current and previous directorships
- Previous employment referencing
- Verification of relevant qualifications
- Conflicts of interest
- Reside within a constituency of the Trust
- Be a member of the Trust
- Declaration to abide by Standards for Members of NHS boards
- Declaration to abide by Trusts Standards of Business Conduct
- Declaration to maintain confidentiality

The following may not become a member of the Board of Directors

- A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- A person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it.
- A person who within the preceding five years has been convicted in the British islands of any offence if a sentence of imprisonment (whether suspected or not) for a period of not less than three months (without the option of a fine) was imposed on him or her).
- A person who has been barred from acting as a governor of an FT or disqualified as a Director.
- A person with a history of any action against the principles of the NHS Constitution

Appendix F7.2: Process for the Identification and Appointment of Non-Executive Directors

The standard approach to advertising and recruitment for NED appointments shall be as follows:

- Identify skills gap based on assessment of NEDs current skills and experience
- Amend generic role description and person specification to reflect skills gap being addressed
- Appoint Independent Adviser
- Liaise with Non-Executive remuneration Committee to confirm terms and conditions
- Advertise through :
    - Local and or National newspapers (Shropshire; North Wales; Cheshire)
    - Trust Web Site
    - Email shot to FT Members
    - NHS Careers Website
    - Email shot to Trust Staff
- Applications via on-line form together with covering letter to Director of People ~~Human Resources~~
- Long list (i.e. sift out inappropriate applications by Director of People ~~Human Resources~~ /Chairman)
- Short list agreed by Appointments Committee (this may be via teleconference)
- Nominations committee interview panel - Prior to the interview, panel members to be allocated areas of questioning, with sample questions to support them together with a scoring matrix to ensure decisions are based on a robust assessment of each applicant.
- Appointment Committee recommendation for appointment made to the Council of Governors for approval
- Conditional offer made subject to completion of 'fit and proper' person checks

Suggestions for improvement to the process will be fedback to the Council of Governors as appropriate, and the process will be periodically updated where agreed.

0. Reference Information

Author:	Chris Hudson, Communication Manager	Paper date:	Thursday 28th March 2019
Executive Sponsor:	Kerry Robinson, Director of Strategy and Planning	Paper Category:	Strategy
Paper Reviewed by:	Board of Directors	Paper Ref:	To be inserted by the person collating the agenda
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 going to Trust Board in response to a previous strategy board action that requested review of how we communicate our strategy to our various stakeholders.

2. Executive Summary

2.1. Context

This paper provides an overview of a series of focused actions that the Trust will be taking to assist in raising greater awareness of our organisational strategy both in and outside the organisation. Based on the key themes of;

- Building the strategy brand
- Awareness of the strategy
- Communicating the success of the strategy
- Reaching out to key stakeholders

2.3. Conclusion

There are a number of recommendations throughout the report which will now be put in place.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Communicating our Organisational Strategy

Sharing our long-term vision – inside and outside the organisation

1. Executive Summary

This paper sets out to present a series of actions that can be taken to help raise awareness of the RJAH Organisational Strategy, both inside the organisation and outside.

It is built around a series of key themes, which are:

- Building the strategy brand
- Awareness of the strategy
- Communicating the success of the strategy
- Reaching out to key stakeholders

Recommendations: There are a number of recommendations for action set out in the report. You can read more detail in the paper, but in summary these are:

- Building the brand by making **better use of the established colours for each of the strategic priorities**
- **Making good use of data** to show how the organisation is performing (including a year-end infographic as set out in Appendix 1.
- **More overtly linking existing Trust initiatives to the strategy** – so showing how the various work strands that staff see all fit together
- Organising a series of **Celebration Events** to showcase the work that have been done in each of the strategic priority areas
- Establishing a new **Stakeholder Bulletin** – so creating a channel by which the Trust can share key messages with key political stakeholders and other partners in the local health and social care system

2. Key Themes

2.1 Building the strategy brand

The refreshed Trust strategy was launched at the start of 2017-18, and introduced three key strategic priorities (Operational Excellence, Local Musculoskeletal Services and Specialist Services), with one underpinning priority (Culture and Leadership).

These were launched via staff briefings, video messages and a variety of written communications.

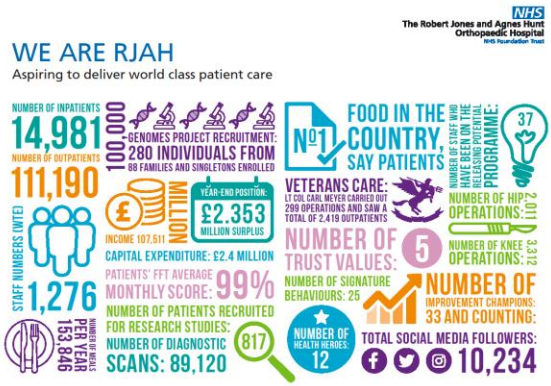
Now we need to think about how we build the brand to:

- maintain visibility
- recognise and share its impact

Use of colour – in the initial launch, each priority was assigned a colour as designated below. The colours came from graphics work done by our own Medical Illustration Department.

We can use these colours more effectively to signal the connection between different strands of work and the priorities. This will help to see how the work they do ties into our strategic priorities.

Use of data – as we approach year-end, we can bring our performance to life using data. We have previously prepared 'Our year in numbers' graphics in time for the AGM, but are planning to work to a faster turnaround this year, using a bright, new template.



See **Appendix 1** with this paper for a concept graphic. This includes 2017-18 data to showcase the approach, and will be updated at year-end.

It is an infographic that can be used in various arenas – from internal communications, to formal reports and presentations, and even social media – bringing our performance to life in a way that is likely to capture attention and allow conversations about strategy development to begin.

You can find this appendix at the end of the report or by clicking on the image to the left.

2.2 Awareness of the strategy

Existing programmes – a number of development and visibility initiatives have been launched in the last two or three years. When seen as a list, it does serve as a reminder of the amount of work that has been done – and many of these programmes feature in our recently-published CQC Report in one form or another.

Examples are:

<u>Development programmes</u>

- Releasing Potential
- Serving to Lead
- Improvement Champions
- Breaking the Cycle

<u>Visibility programmes</u>

- Executive Buddies
- Back To The Floor
- First Friday

Evidence from the Staff Survey 2018 shows that this work has had an impact. The survey showed, for example, that there has been a big increase over the last two years in staff saying they have the opportunity to suggest improvements in their area of work.

However, anecdotal evidence suggests staff are less clear on how this work fits

into the overarching Organisational Strategy. So they see value in initiatives such as the Ideas Scheme, but do not immediately grasp that this contributes to Operational Excellence.

It is proposed that the way the organisation communicates about such initiatives subtly changes, using some of the branding techniques outlined in the previous section, to more obviously illustrate the links to the overall strategy.

Celebration Events – another way to overtly recognise the progress we are making against our strategy is to celebrate it.

A quarterly programme of Celebration Events is proposed – with each one focussed on a different strand of the strategy so that all four get a moment in the spotlight over the course of the year.

These events would be a chance to stop and reflect on what has been achieved already, and to shine a light on what is planned next – helping staff to see and understand the direction of travel.

These events would need an organising group or team and resource would need to be found to do it well.

2.3 Communicating Success

It is important that the Trust can show evidence of where the Organisational Strategy is being delivered successfully.

That can be done qualitatively through means such as the Celebration Events proposed above. It can also be done more quantitatively through the use of hard data from independent NHS sources.

Good examples include the NHS Staff Survey and the Adult Inpatient Survey. These two surveys give a clear and verifiable snapshot of the organisation from the perspective of both our staff and our patients.

The Staff Survey published earlier this week, for example, gave some very positive indicators of where progress is being made – including, for example, in the area of improvement, where the numbers were very encouraging.

This was rightly celebrated – but there can and should be further more targeted communications to highlight that this fits in with our strategic priority of delivering Operational Excellence.

There are also less encouraging numbers in the Staff Survey concerning bullying and harassment – especially with regards bullying and harassment by colleagues, which has dipped 4% to show 23% of staff have experienced this. That has been highlighted as an area of focus already – but it also shows there is still work to do with regards to the strategic priority of culture and leadership.

2.4 Reaching Out

RJAH aims to be a key player within the Shropshire, Telford & Wrekin STP. The leadership team recognises the importance of being an outward looking organisation.

With that in mind, it is important that all stakeholders are engaged with the direction of travel and are able to easily grasp our Organisational Strategy

Key relationships are managed on a one-to-one basis by the Board and senior leadership team, but more can be done to support those senior leaders in shaping conversations regarding strategy.

Stakeholder Bulletin – a simple eBulletin is proposed, that would aim to give stakeholders headline news about developments within each of the four strategic priorities. This bulletin would be:

- produced quarterly
- high-level, with headline information and links to where more detailed information can be found, so making it accessible and easy to read

The audience for this bulletin would include:

- Governing Body members from our key commissioners
    - Shropshire CCG
    - Powys THB
    - Betsi Cadwaladr UHB
    - Telford & Wrekin CCG
- Board members in other local providers
- Shropshire, Montgomeryshire and North Wales MPs and AMs
- Council leaders and health leads
    - Shropshire
    - Telford & Wrekin
    - Powys
    - Denbighshire
- HOSC members

A draft of the proposed bulletin follows in **Appendix 2** of this report. Note this is in PDF form for your convenience – but the final bulletin would be issued in an email template that would be easier for users to access and read.

If approved by the Board, this bulletin is ready to be sent out next week at the start of the new financial year. Further drafts would then be scheduled for July 2019, October 2019 and January 2020. It is proposed that this would be managed by the Communications Team, with final sign-off sitting with Kerry Robinson, Director of Strategy and Planning and/or Mark Brandreth, Chief Executive.

The bulletin has been titled **RJAH Connected** – tying in with the existing 'Connect' brand which is used for the newsletter that is issued quarterly to our members.

3. Measuring Impact

Evaluation of a communications strategy of this nature can be challenging. It is proposed that both quantitative and qualitative evidence is used to assess, and revise as appropriate, the proposals in this paper.

Quantitative evidence can come from sources as set out earlier in the 'celebrating success' section. The Staff Survey is a useful tool for measuring many of these areas. Feedback also comes from patients in the form of the Friends and Family Test – where the free text comments can often be more revealing than the hard data.

Qualitative evidence can be obtained internally from conversations at formal events such as the monthly Staff Open Forum, or feedback on social media – including the Staff Facebook Group. Plans for a new intranet could also offer new opportunities to gather intelligence.

Externally, feedback from the quarterly Stakeholder Bulletin would be encouraged and monitored.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

APPENDIX 1

INFOGRAPHIC

‘WE ARE RJAH’

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

WE ARE RJAH

Aspiring to deliver world class patient care

NUMBER OF INPATIENTS
14,981

NUMBER OF OUTPATIENTS
111,190

STAFF NUMBERS (WTE)
1,276

NUMBER OF MEALS PER YEAR
153,846

100,000 GENOMES PROJECT RECRUITMENT:
280 INDIVIDUALS FROM 88 FAMILIES AND SINGLETONS ENROLLED

INCOME 107,511 MILLION

YEAR-END POSITION:
£2.353 MILLION SURPLUS

CAPITAL EXPENDITURE: £2.4 MILLION

PATIENTS' FFT AVERAGE MONTHLY SCORE: **99%**

NUMBER OF PATIENTS RECRUITED FOR RESEARCH STUDIES: **817**

NUMBER OF DIAGNOSTIC SCANS: **89,120**

№1 FOOD IN THE COUNTRY, SAY PATIENTS

VETERANS CARE:
LT COL CARL MEYER CARRIED OUT 299 OPERATIONS AND SAW A TOTAL OF 2,419 OUTPATIENTS

FACTA NON VERBA

NUMBER OF TRUST VALUES: **5**

NUMBER OF SIGNATURE BEHAVIOURS: 25

NUMBER OF HEALTH HEROES: **12**

NUMBER OF STAFF WHO HAVE BEEN ON THE RELEASING POTENTIAL PROGRAMME: **37**

NUMBER OF HIP OPERATIONS: **2,011**

NUMBER OF KNEE OPERATIONS: **3,312**

NUMBER OF IMPROVEMENT CHAMPIONS: **33 AND COUNTING:**

TOTAL SOCIAL MEDIA FOLLOWERS: **10,234**

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

APPENDIX 2

Stakeholder Bulletin

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

April 2019
Issue No 1

Welcome to the first edition of our new bulletin for partners and key stakeholders of The Robert Jones and Agnes Hunt Orthopaedic Hospital. We plan for this to be a quarterly bulletin, which will keep you informed about what is happening at the Trust and the progress we are making to deliver our organisational strategy.

Trust Highlights

CQC Report hails 'outstanding' staff

RJAH has been rated as 'Good' overall by the Care Quality Commission (CQC) and 'Outstanding' for caring – in an inspection report published recently.

Examples of outstanding practice were observed in medical care, children and young people services and diagnostic imaging. Mark Brandreth, Chief Executive at RJAH, said: "I am delighted for our fantastic staff, who really deserve to receive a CQC Report like this.

For more on this, see the news story on our website.

RJAH rated top place to work

RJAH is the best specialist NHS organisation to work for in the country – according to the results of the National NHS Staff Survey 2018 published recently.

More than 79% of staff at the specialist orthopaedic hospital said they would recommend working there in the annual survey, which covers every NHS employer in England. That is up 8% over the last two years.

For more on this, see the news story on our website.

Organisational Strategy

We have a vision of 'aspiring to deliver world class patient care'. We will deliver this through achieving our three key strategic priorities: integrated MSK services, orthopaedic specialist services and operational excellence. These three priorities are underpinned by a fourth: culture and leadership. Click here to read our full Strategic Plan.

Below is an update on some of the key work currently being done in each of these areas.

Organisational Strategy: Operational Excellence

Transforming our Pre-operative processes

A team is working on a project to improve patient experience of the pre-operative assessment process, which is currently impacted by too much variation between different clinicians. The first phase of this project saw the relaunch of a new Surgery Booking Office with additional admin support. This is aiming to improve communication and allow patients to have their pre-op assessment on the day they are listed for surgery wherever possible. In the four weeks after the Booking Office re-opened, 24 patients were able to do just that.

The next phase of the project is a focus on reducing cancellations on the day of surgery. Research has been done to understand why this happens, and an improvement plan drawn up.

For more information about this project, get in touch via the contact details at the end of this bulletin.

Co-ordination Centre launched

The Trust has this month launched a new Co-ordination Centre - a central location where information is held and analysed to ensure we are making the most of our staff and resources – limiting inactivity and delay for patients.

A multi-disciplinary team and they will be able to discuss in real time all the information we capture. It will discuss bed pressures and any resource issues or staffing issues we are aware of in the next 24 hours. By having representatives from across the hospital – Ward Co-ordinators, Physio, Pharmacy and Theatres – all together, we believe we will be able to react more effectively to any upcoming problems and find solutions.

For more information about this project, get in touch via the contact details at the end of this bulletin.

Organisational Strategy: Integrated Musculoketetal (MSK) Services

Partnership working

RJAH has been working closely with Shropshire Community Health, using non-recurrent funding from Shropshire CCG, to develop a new service model and clinical pathway for physiotherapy services in Shropshire.

When the project began last summer, there were areas of the county where patients were having to wait more than 12 weeks for an appointment – that has now been slashed with a target of 95% of patients being seen within four weeks having been met.

For more on this project, see the news story on our website.

Promotion of Self-Management

Clinicians know that by effective self-management, people can improve their MSK health and reduce the risk of significant future surgical interventions.

As such, a Self-Management Programme is being run in three phases. The first has seen the launch of a webpage signposting people to sources of useful information that they can use to manage their own health, and this has been launched – with plans to expand it further. Phases two and three will concentrate on a condition management education programme and the development of a combined system-wide programme involving the NHS, voluntary sector, local authority, Public Health England and the voluntary sector.

For more information about this project, get in touch via the contact details at the end of this bulletin.

Organisational Strategy: Orthopaedic Specialist Services

Pedal power for Veterans Appeal

Our appeal to raise £1.5 million to build the UK's first dedicated Orthopaedic Centre for veterans continues to gather pace.

As part of the fundraising effort, the charity team have secured a number of places for the 2019 edition of the Prudential RideLondon – and keen cyclists are invited to take part and support the appeal. For more information about this, visit our website.

For more information about the Veterans Orthopaedic Centre Appeal, go to www.rjah.nhs.uk/voca

RJAH in the TV spotlight

A special procedure – currently only offered in the UK at RJAH - used to treat patients with early arthritis is to be featured on the BBC's popular magazine programme, The One Show.

A type of cartilage cell transplantation procedure called Autologous Chondrocyte Implantation (ACI), it was approved for use on the NHS in 2017, following more than 20 years of trials.

The segment will be part of a series of features on osteoarthritis and is being arranged alongside national charity Versus Arthritis. The piece is due to be aired later in the spring, so keep an eye out for it.

Organisational Strategy: Culture and Leadership

Women's Network continues to grow

As part of our work on equality and diversity, the Trust has launched a Women's Network. This offers a safe space for discussion, and to look at what women need to support them in the obstacles they face on a professional basis.

The most recent event of our Women's Network took place on International Women's Day. It took the form of a workshop, led by Diane Danzebrink, a Personal Wellbeing Consultant, on Understanding Menopause.

For more information about this project, get in touch via the contact details at the end of this bulletin.

Service Improvement in the spotlight

The Trust has run two successful cohorts of Service Improvement Champions – and is now recruiting for a third.

The programme gives staff the opportunity to learn about and implement improvement methodology on their own projects. It's impact has already been seen in our latest Staff Survey results, which saw a big increase in staff saying they had the opportunity to suggest and implement new ideas that benefit patients.

For more information about this project, get in touch via the contact details at the end of this bulletin.

Stay in touch... We would welcome your feedback on this bulletin. Please contact us on 01691 404104 if you have any comments, or email rjah.communications@nhs.net.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

CQC Action Plan
March 2019

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	28 March 2019
Executive Sponsor:	Sarah Bloomfield, Interim Director of Nursing	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors is asked to note the action plan and the oversight arrangements to ensure completion and appropriate assurance is achieved.

2. Executive Summary

2.1. Context

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

The Trust was required to respond to the identified regulatory breach in relation to Critical Care by the 20th March 2019 and this section of the action plan has therefore been shared with the CQC.

The Quality and Safety Committee received the action plan and approved the oversight arrangements as outlined below.

2.2 Summary

The CQC Action plan outlines the identified actions and the executive lead for each. In addition the plan sets out what evidence or assurance will be sought with regard to completion of the actions. Finally, the plan outlines the risk of non-delivery and the Assurance committee assigned to oversee the management of this risk.

Each assurance committee will receive an update at each meeting on the actions within its remit in order to triangulate this with the other reports it receives and the risks that it reviews. The Board will receive assurance of this through the appropriate Chair's Reports but in addition a quarterly tracker for more detailed oversight and assurance.

2.3. Conclusion

The Board of Directors is asked to note the action plan and the oversight arrangements to ensure completion and appropriate assurance is achieved.

CQC Post Inspection Action Plan
March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
Well Led Corporate Actions									
1.	**Establishment of clear quality and safety processes within the divisions with clear line of sight within the Trust's Governance Framework.**								
1.1	Implementation of new Governance Structure to ensure robust divisional governance support is in place	Associate Director of Governance	Aug 19	New structure was implemented on 1 January 2019. Stakeholder feedback to be obtained at 6 months post implementation.	G	Governance Team Structure Stakeholder feedback Evidence of Governance Lead attendance at Divisional Governance Meetings	Inadequate resource for the governance agenda at divisional level with operational pressures impacting on resource available for governance issues	12	Risk Management Committee
1.2	Meetings to be held between the Governance Leads and Divisional Managers to ensure clarity of roles and responsibilities	Associate Director of Governance	Apr 19	Dates have been put in the diary.	G	Divisional Governance Lead and Divisional Manager JDs Output of meetings to be recorded in Risk Management Report	Lack of clarity of roles resulting in duplication of work and or reduced effectiveness of the governance processes	9	Risk Management Committee
1.3	Introduction of templated reports and agendas for oversight of divisional governance	Associate Director of Governance	Apr 19	Template Quality Report in place, work ongoing on template of Risk Deep Dive Report and work to commence shortly on the divisional agendas	G	Portfolio of divisional governance templates in place Committee effectiveness reviews – specifically on the issue of the quality of papers Review of Divisional Governance Meeting minutes at Executive Team Meeting	Inconsistencies in approach to governance from division to division results in reduced line of sight on emerging issues	9	Risk Management Committee
1.4	Formal inclusion of the Trust's Divisional Governance Meetings into the Trust's Governance Framework	Associate Director of Governance	Apr 19	Board Governance Pack is under review to be presented to the Board in March 2019.	G	Updated Board Governance Pack	Lack of oversight of the Divisional Governance Meetings results in reduced lines of sight on emerging issues	9	Risk Management Committee
1.5	Clinical Governance Department to review divisional governance arrangements at 3 months and 6 months	Associate Director of Governance	Sep 19	Work not yet required to commence. Reporting of the reviews has been added to the Risk Management	N/A	Reports to Risk Management Committee	Lack of post implementation review could result in late identification of gaps in governance processes	12	Risk Management Committee

CQC Post Inspection Action Plan March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
				Committee Workplan					
1.6	Internal audit of divisional governance at 12 months	Associate Director of Governance	Mar 20	Work not yet required to commence	N/A	Internal audit report	Lack of external scrutiny could reduce identification of gaps in governance	12	Risk Management Committee
2.	**Develop and implement a robust plan to support the reduction in bullying and harassment of staff**								
2.1	Deep dive of departments highlighted in the staff survey as having potential cultural issues with associated action plans	Director of People / Director of Improvement OD and Performance	Jun 19	Staff survey has been received and presented to the Board of Directors. Further analysis being undertaken to identify the areas for deep dives	G	Pulse check surveys in identified areas	Inability to undertake focussed work to reduce the incidence of bullying and harassment and to support staff who may have been affected. Inability to improve staff survey results	12	People Committee
2.2	Increased visibility and accessibility to the Freedom to Speak Up Guardian	Director of People	Jun 19	Substantive role of Freedom to Speak Up Guardian introduced. Work underway to improve the app and staff communications plan in place	G	Pulse check surveys in identified areas Reduction in grievances related to bullying and harassment	Potential for staff to feel unable to come forward and raise concerns	9	People Committee
2.3	Review of Dignity at Work Policy with associated communications to relaunch the policy	Director of People	Jun 19	Review of policy underway	G	Revised policy on Trust Net	Potential for staff to be unsure how to formally raise a concern and also for managers to be unsure of the process to respond	6	People Committee
2.4	Improved education for managers	Director of People	Mar 20	'Being a Good Manager' Programme being introduced and targeted induction for new managers	G	Pulse check surveys in identified areas Reduction in grievances related to bullying and harassment	Potential for capability issues within the management layers.	12	People Committee
2.5	Development of a People Committee to ensure adequate oversight of workforce	Chief Executive	Apr 19	The first meeting is scheduled for May	C	Minutes from the People Committee / Chair's Reports	Lack of oversight of workforce issues including bullying and harassment	12	Executive Team

CQC Post Inspection Action Plan
March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
3.	**Develop a robust plan to support the improvement and sustainability of mandatory training rates**								
3.1	Review of the training needs analysis to ensure that staff training requirements are fit for purpose and in line with the core skills framework. This should include review of the compliance requirements.	Director of People	May 19	Initial meeting has taken place to review the Trust's mandatory training requirements. Subject matter experts being engaged to assist with the rationalisation.	G	Statutory training framework which aligns to the Core Skills Framework Revised Training Needs Analysis for Staff	Staffing receiving unnecessary training or inconsistencies regarding which staff require certain training	6	People Committee
3.2	Review and update of the Trust's Training Policy to align with output of training needs analysis review	Director of People	Jun 19	Work not yet required to commence, policy will be updated once full review complete	G	Statutory training framework which aligns to the Core Skills Framework	Inconsistent application of compliance targets	4	People Committee
4.	**Develop a robust renewal process for the executive and non-executive vetting and barring checks**								
4.1	Process to be aligned to the production of the annual report to ensure annual renewal takes place	Trust Secretary	May 19	Work not yet required to commence	N/A	Completion of annual checks recorded in relevant personnel files Annual report to the Board of Directors	Potential for fit and proper person checks not to be kept up to date as per statutory requirements	6	Board of Directors
5.	**Develop and implement assurance processes to support the review and ratification of policies**								
5.1	Development of a tracker to monitor the updating of policies overdue for review	Trust Secretary	Apr 19	Tracker in place with monthly review and chasing of overdue policies taking place. Overdue polices have reduced from 230 to 170 as of Feb 2019	G	Reduction in number of overdue policies Tracker available for review Regular reports on progress to the Executive Team Meeting	Lack of focus to enable reduction of backlog of policies overdue for review. Staff unable to access up to date policies.	6	Executive Team

CQC Post Inspection Action Plan March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
5.2	Introduction of proactive prompts to the authors / executive leads for policies due for review	Trust Secretary	Apr 19	Automated prompts are already in place but in addition the Trust Office will contact the authors three months in advance of a policy review date	G	Reduction in the number of overdue policies Evidence of the proactive prompts	Inability to maintain timely review of policies once backlog reduced. Recurrence of policies being overdue for review	9	Executive Team
5.3	Quarterly reporting to the ratifying body regarding any overdue policies / policies due for review within the next 3 months	Trust Secretary	Jun 19	Initial reports have been submitted to the Board level committees. The next layer of committees needs review.	G	Reduction in overdue polices Committee workplans and reporting on policies	Lack of committee ownership and oversight of policies within their remit	9	Executive Team
6.	**The Board Governance Framework needs to be reflective of the current committee structures**								
6.1	Board Governance Framework to be updated	Trust Secretary	Apr 19	Revised pack due to be presented to the Board in March.	G	Updated Board Governance Pack	Lack of clearly articulated governance framework document	6	Board of Directors
7.	**Develop and implement a clear programme of work to improve Diversity and Inclusion for patients and staff**								
7.1	External review of current practice and policies to be commissioned in order to identify gaps	Director of People / Director of Improvement, OD and Performance	May 19	External review has been commissioned	G	Gap analysis	Failure to identify gaps in practice and policy that require control and assurance	12	People Committee / Quality and Safety Committee
7.2	Refresh of diversity and inclusion priorities in the People Plan	Director of People / Director of Improvement, OD and Performance	Jun 19	Work not yet required to commence	N/A	Robust diversity and inclusion priorities within the People Plan	Failure to address identified gaps in practice and policy	12	People Committee / Quality and Safety Committee

CQC Post Inspection Action Plan
March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
8.	**Opportunities for development and increased exposure for Deputy / Assistant Directors to be explored**								
8.1	Development and implementation of a succession plan	Director of People	Oct 19	NEDs appropriately sighted on executive level succession planning with work underway on the next level of management	G	Succession plan in place	Potential for gaps in senior management and specialist expertise. Risks arising from single points of failure	12	People Committee
8.2	Maximise use of the Leadership Academy	Director of People	Mar 20	Opportunities being explored and offered as appropriate	G	Evidence of uptake of Leadership Academy events /courses	Potential for gaps in leadership capability	12	People Committee
8.3	Participation in STP leadership activities	Director of People	Mar 20	Opportunities being explored and offered as appropriate	G	Evidence of attendance at STP events / meetings	Potential for gaps in leadership capability in relation to system working	12	People Committee
Medical Division Actions									
9.	**Sluices and areas containing COSHH to be locked at all times**								
9.1	Inspection of sluices and COSHH to be included in the new H&S Inspection Checklist with follow up actions by the H&S Officer as required	Associate Director of Governance	May 19	New checklist under development. Actions identified to be taken forward by the H&S Officer	G	New checklist ratified by H&S Committee	Inadequate oversight of H&S breaches relating to the security of hazardous and infectious substances	12	Risk Committee
10.	**All staff to adhere to the Trust's Bare Below Elbows Policy**								
10.1	Staff not adhering to the policy to be spoken to	Medical Director	N/A	The doctors identified as non-compliant during the inspection were identified and spoken to	C	Bare below elbows peer review results	N/A as delivery complete		Quality and Safety Committee
11.	**EPMA to be implemented to address current prescription sheet issues**								
11.1	EPMA business case to be developed with	Director of Nursing	Sep 19	Draft business case to be presented to the	G	EPMA implementation	Inability to reduce incidence of medication	12	Finance Planning and

CQC Post Inspection Action Plan March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
	clear implementation timeframes			Exec Team in May before presentation to the Finance Planning and Digital Committee for approval		Reduction in medication incidents	incidents		Digital Committee
12.	**7 day rehabilitation service to be rolled out**								
12.1	Business case for 7 day services to be developed with clear implementation timeframes	Director of Operations	Sep 19	Working group has been established to take this forward	G	7 day therapy service	Inability to scope and plan for 7 day working and potential for increased length of stay	6	Finance Planning and Digital Committee
12.2	MCSI Review to incorporate a model of service which reflects 7 day availability of therapy services	Director of Operations	May 19	MCSI Review is underway and due to be presented to the Executive Team in April	G	7 day therapy service	Inability to scope and plan for 7 day working and potential for increased length of stay	6	Executive Team
13.	**Continued focus on addressing delays in discharge processes across the service with a particular focus on MCSI**								
13.1	Options for a step down bed provision to be considered with specialist commissioning	Director of Operations	Sep 19	Proposal being drafted for presentation to Executive Team in April once the MCSI Review is completed.	G	Reduction in delayed discharges	Poor patient experience, lack of availability of beds for patients requiring admission	12	Finance Planning and Digital Committee
13.2	ECIST to be asked to complete a review of the current processes to ensure all is being done to reduce delays	Director of Operations	May 19	ECIST have commenced review with onsite visits scheduled	G	Reduction in delayed discharges	Lack of external assurance that all appropriate actions have been taken	12	Quality and Safety Committee

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March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
Surgical Division Actions									
14.	**Culture issues in Theatre to be addressed with a specific focus on respect and communication**								
14.1	Meeting to be held with Divisional Manager and Matron to discuss the cultural issues in Theatres	Director of People	Mar 19	Meeting has taken place with agreement to commission external support	C	Theatre management engagement	N/A as delivery complete		People Committee
14.2	External support to be commissioned to examine the culture within the theatre department – to include review of the staff survey results	Director of People	Jun 19	Analysis of the staff survey results has commenced and external support has been identified	G	Output of external review	Lack of independent view of the department, staff feeling unable to raise their concerns or be candid about the issues	12	People Committee
14.3	Staff Cultural Ambassador role to be developed to support the culture work	Chief Executive	Apr 19	Work is underway to set out the requirements of this role	G	Staff cultural ambassador role established and communicated to staff	Attempt to make further improvement with the organisational culture fail to gain traction	6	People Committee
14.4	Increased visibility and accessibility to the Freedom to Speak Up Guardian	Director of People	Jun 19	See 2.2	G	See 2.2	Potential for staff to feel unable to come forward and raise concerns	9	People Committee
Critical Care Actions									
15.	**In order to address the regulatory breach, the Trust should put in place processes to asses, monitor and review the performance of the critical care unit**								
15.1	A full review of the Critical Care Outreach service to be undertaken with regard to hospital cover	Director of Nursing	Jun 19	Paper going to Quality and Safety Committee this month regarding review of the hospital cover.	G	Output of the review to be presented to Quality and Safety Committee with recommendations to be implemented by the team and monitored via the Committee.	Failure to identify and mitigate gaps in the hospital cover that require control and assurance. Inability to address regulatory breach	12	Quality and Safety Committee

CQC Post Inspection Action Plan March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
15.2	Review the processes in place to ensure that if multiple medical emergencies occur there is sufficient cover to maintain patient safety	Medical Director	Jun 19	Clinical Director of Anaesthetics has been asked to oversee assessment of the processes	G	Output of the review to be presented to Quality and Safety Committee with recommendations to be implemented by the team and monitored via the Committee.	Failure to identify gaps in the service that require control and assurance Inability to address regulatory breach	12	Quality and Safety Committee
15.3	Sepsis training to be completed and documented	Director of Nursing	Jun 19	Deputy Director of Nursing is picking this up with the team	G	Training records Training compliance data	Potential capability gaps amongst staff. Inability to address regulatory breach	12	Quality and Safety Committee
15.4	The unit can evidence adherence with the DOH Critical care guidelines, and where compliance is limited this is adequately documented on the department risk register.	Director of Nursing	Jun 19	Deputy Director of Nursing is undertaking a review of the risk register to ensure it is reflective of the risks and mitigations	G	Documented gap analysis Risk register Output of Peer Review	Lack of compliance with DOH Critical Care Guidelines or lack of mitigation to non compliances	12	Quality and Safety Committee
15.5	The department completes MRSA screening prior to admission to the unit.	Director of Nursing	Jun 19	MRSA screening process now under review in relation to HDU admissions	G	Audit of MRSA screening completion	Potential for patient harm / increase in hospital acquired infection	15	Quality and Safety Committee
15.6	Handovers are in place which are documented and regularly audited.	Director of Nursing	Jun 19	Deputy Director of Nursing is meeting with the team to discuss this further. The Governance Team have been asked to audit the documentation in three months time.	G	Audit of documentation relating to handovers	Potential for suboptimal handover of patient care and inability to investigate incidents due to poor documentation	15	Quality and Safety Committee
15.7	The Pharmacist is visible in the unit and the medicines safety thermometer is completed.	Director of Nursing	Jun 19	The Pharmacist has been extended a invite to the safety huddle. The Medicine Safety Officer has been asked to take forward completion of	G	Safety huddle log sheets Completed medicines safety thermometer	Lack of MDT approach resulting in increased medication incidents	12	Quality and Safety Committee

CQC Post Inspection Action Plan
March 2019

Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
				the medicines safety thermometer					
15.8	Audits of patient outcomes to bein place.	Director of Nursing	Jun 19	ICNARC data is available but further review of audits that can be undertaken or available data underway	G	Output of review with identified reporting into Quality and Safety Committee and Clinical Quality and Governance Committee	Inability to see trends in patient outcomes	12	Quality and Safety Committee
15.9	There is a clear structure for the leadership of the unit and they have the required skills	Chief Executive	Jun 19	Director of Operations and Interim Director of Nursing to meet to review the structure in order to make recommendations	G	Clear structure in place and communicated to staff	Lack of clarity of roles and leadership structure reduces effectiveness and compromises line of sight	12	Quality and Safety Committee
Childrens and Young People Directorate Actions									
16.	**Continue to strengthen the cover available out of hours**								
16.1	Directorate to continue to update on progress with out of hours cover at the Performance Review Meetings	Director of Operations	Sep 19	Risk has been assessed and is on risk register. Current SLA with SaTH to continue in 2019-20 with telephone support from paediatricians out of hours. Paediatric surgeons have an on call rota for out of hours.	G	Performance Review Meeting notes Risk Register	Inadequate oversight and mitigation of any risks linked to out of hours cover. Lack of progress towards full compliance with national standards.	6	Executive Team
16.2	Specialist Orthopaedic Programme Board to ensure that options for improving OOH cover are agreed	Director of Nursing	Sep 19	Work not yet required to commence	N/A	Specialist Orthopaedic Programme Board meeting notes Updates to Executive Team and Strategy Board	Lack of progress towards full compliance with national standards	12	Executive Team
17.	**Ligature risks for children to be addressed across the Trust**								
17.1	Actions identified from the ligature assessment to be fully	Interim Director of Nursing	Apr 19	Risk assessment for Alice Ward has been completed with	G	H&S Committee oversight	Inadequate mitigation of ligature risks resulting in patient harm	15	Risk Management Committee

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Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
	implemented and reflected across all Trust areas which children access in the Trust			appropriate actions taken. Wider risk assessment of areas children access to be undertaken by the H&S Officer		Risk Register Completed action plan			
18.	**Written information for children to be made available in different languages**								
18.1	Written information for children to be made available in different languages	Director of Operations	Sep 19	Written information is currently available on request but additional measures to be looked at within the implementation of the accessible information standard	G	Availability of written information in different languages	Failure to meet diversity and inclusion standards for patients, poor communication with and experience for patients	6	Quality and Safety Committee
18.2	Paediatric Forum to monitor the development and implementation of information in different formats	Director of Operations	Sep 19	Work not yet required to commence	N/A	Availability of written information in different languages Paediatric Forum Minutes	Lack of oversight of implementation of information in different formats impacts on progress	12	Quality and Safety Committee
Outpatient Service Actions									
19.	**Mitigations to address the poor noise proofing in consultation rooms to be identified**								
19.1	Noise level assessments to be undertaken by the Estates Department	Director of Operations / Assoc. Dir of Estates	May 19	Assessments have been requested	G	Output of assessment Risk register with adequate mitigations in place	Lack of assessment would result in inability to identify and, if possible, make improvements	6	Risk Management Committee
19.2	Recommendations regarding mitigations to be presented to Capital Management Group and / or Risk	Director of Operations / Associate Director of Estates	Jun 19	Work not yet required to commence	N/A	Output of assessment Risk register with adequate mitigations in place	Failure to mitigate the noise level risk to a tolerable level	6	Risk Management Committee

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Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
	Management Committee								
20.	**Process for capture and analysis of incidents relating to the overbooking of clinics and cancellations to be developed**								
20.1	Review of Datix to be undertaken to ensure that its configuration allows for the capture of overbooking and cancellation incidents	Associate Director of Governance	May 19	Work not yet commenced	N/A	Output of gap analysis and revised configuration if required	Inability to capture the incidents and ensure adequate learning	6	Risk Management Committee
20.2	Divisional templates for governance to specifically include analysis of outpatient clinic incidents	Associate Director of Governance	Apr 19	Risk Management Report Template is in progress	G	Divisional governance templates	Lack of oversight of the OPD incidents results in reduced lines of sight on emerging issues	6	Risk Management Committee
21.	**Mitigations to address overcrowding in the Outpatient Department to be identified**								
21.1	Assessment of overcrowding to be undertaken and recommendations made to the Director of Operations	Director of Operations	Oct 19	H&S Officer has been asked to undertake a risk assessment relating to overcrowding	G	Risk assessment followed by risk register entry	Increased potential for a health and safety incident	6	Executive Team
22.	**The availability of easy read information to be improved to ensure the consent process is completed appropriately**								
22.1	Review of systems and processes to facilitate full implementation of the accessible information standard to include the identification of patients with specific needs.	Director of Nursing / Associate Director of IT	Jun 19	Work not yet commenced. To be included in the EPR procurement process in the longer term.	N/A	Gap analysis Recommendations for short term and long term solutions	Inability to fully implement the accessible information standards	12	Quality and Safety Committee
2.2	Recommendations regarding system / process updates required for full	Director of Nursing	Jul 19	Work not yet commenced	N/A	Recommendations for short term and long term solutions	Inability to fully implement the accessible information standards	12	Quality and Safety Committee

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Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
	implementation of the accessible information standard to be presented to Quality and Safety Committee								
23.	**Clarity is required regarding the nursing leadership and representation for outpatients at assurance committees.**								
23.1	Identification of the Senior Nurse Representative to be made clear in relation to attendance at the relevant committees.	Interim Director of Nursing	Apr 19	Meeting organised for the Director of Operations and Interim Director of Nursing to discuss the options	G	Senior Nurse Leadership Structure Evidence of representation at committees	Inadequate representation at committees resulting in reduced line of sight of issues in the department	12	Risk Management Committee
23.2	Lone working risks for the HCAs within the department to be addressed	Interim Director of Nursing	May 19	Lone working assessment due to be completed with ongoing monitoring of staff experience being put in place	G	Risk assessment in place with associated risk register entries Staff engagement	Potential for staff to be exposed to lone working risks without adequate mitigations in place	12	Risk Committee
Diagnostics Service Actions									
24.	**Visibility of waiting times for investigations / procedures to be improved**								
24.1	Method for displaying waiting times to be identified and implemented in Radiology	Director of Operations / Associate Director of IT	Sep 19	Imaging Services Managers has been asked to undertake a review	G	Patient feedback	Poor patient experience and lack of patient information	6	Quality and Safety Committee
25.	**Mitigations to address the risks which arise when the department is busy to be identified**								
25.1	Activity planning for the surgery and medicine to be reviewed with a view to reducing activity in diagnostics on Mondays and Tuesdays if possible	Director of Operations	Sep 19	Meeting arranged with CD for Surgery to take place in March to set priorities for job planning review	G	Revised activity plan Reduction in Monday and Tuesday activity in diagnostics	Inability to reduce Monday and Tuesday activity resulting in poor patient experience and pressures on staff	6	Risk Management Committee

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Ref	Action	Lead	Date	Progress Update	RAG	Assurance/ Evidence	Risk if not delivered	Risk	Assurance Committee
25.2	Risk assessment to be undertaken of any residual risk with citation on the Trust's risk register	Director of Operations	Oct 19	Work not yet commenced	N/A	Risk Register	Failure to adequately mitigate any residual risk	6	Risk Management Committee
26. Radiation warning signage to be improved									
26.1	Review of signage regarding radiation warnings to be undertake with improvements to be made where required	Director of Operations	Apr 19	Imaging Services Manager and Estates Department have been asked to undertake a review		Improved signage	Inadvertent exposure to radiation as a result of poor signage	8	Quality and Safety Committee

Mark Brandreth

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

mark.brandreth@rjah.nhs.uk

1 Feb 2019

Dear Mark,

Future Fit Joint Committee unanimously agrees the future of our two acute hospitals

We are writing to inform you that on Tuesday 29 January members of the Joint Committee of Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs) secured the future of our two local hospitals by voting unanimously to have Royal Shrewsbury Hospital become the Emergency Care site and Princess Royal Hospital focus in the future on Planned Care, with an Urgent Care Centre open 24 hours a day, seven days a week at both sites.

As you are aware, the decision follows many years of involvement by members of the public and over 300 clinicians, GPs and social care professionals and a robust public consultation, which brought about an unprecedented response rate from more than 3% of local people served by the hospitals.

We would like to take this opportunity to thank you for your input over the last few years. We are extremely grateful to for all the input, questions and feedback. All of this has helped us develop the proposals, have informed our decision making, and we hope will continue to play a pivotal part in helping us shape health services for local people.

We would like to reassure you that the decisions taken by the members of the Joint Committee were not taken lightly. They recognised that under either option, some people would have concerns and that there is much to be done now as we move towards implementation, but members were confident that it will lead to improved patient care and experience for our local population.

This is a landmark decision that by securing the £312m on offer from the HM Treasury will lead to the development of both hospital sites to deliver state of the art facilities in which staff will be proud to work patients will choose to be treated. It will also mean that the Trust can continue with its recent success in attracting and retaining the most highly skilled doctors and nurses to join the talented teams already working across both sites.

No services will change overnight. Robust plans are being developed that include a phased building programme over the next five years. We will continue to keep you involved and updated during this implementation process. Work will continue to identify and mitigate any impacts, particularly on some of our seldom heard groups, and in relation to specific concerns such as travel and transport.

We would like to conclude by summarising which services will be available at the two hospitals in the future and sharing the link to the website where more information will be shared in the next few weeks: www.nhsfuturefit.org

The following services will be provided at the Royal Shrewsbury Hospital:

- 24-hour Emergency Department
- Critical Care Unit
- Ambulatory Emergency Care Unit
- Emergency surgery and medicine
- Complex planned surgery
- Women and children's consultant-led inpatient services

The following services will be provided at the Princess Royal Hospital:

- Planned inpatient surgery
- Non-complex surgery
- Breast inpatient services
- Medical wards
- Women and children's services (excluding inpatient services)

Most people will still receive care and treatment in the same hospital as they do now, as the following services will be provided at both hospitals:

- 24-hour Urgent Care Centre (the majority of patients who attend our A&E departments will receive care and treatment here)
- Adult and children's outpatient services
- Day Case Renal Unit
- Tests (diagnostics)
- Midwife-led unit
- Antenatal Day Assessment Unit
- Early Pregnancy Assessment Service (EPAS)
- Maternity outpatients and scanning

We would like to thank you again for your ongoing support and look forward to continuing to involve you in shaping the future of our two vibrant local hospitals.

Kind regards

David Evans
Chief Officer
NHS Telford & Wrekin CCG

Dr Simon Freeman
Accountable Officer
NHS Shropshire CCG

Charitable Funds Annual Report & Accounts and Review of Effectiveness of Expenditure 2017/18

0. Reference Information

Author:	Diana Owen, Head of Financial Accounting	Paper date:	28 March 2019
Executive Sponsor:	Craig Macbeth, Director of Finance	Paper Category:	Governance / Performance
Paper Reviewed by:	Charitable Funds Committee	Paper Ref:	
Forum submitted to:	Board of Directors & Council of Governors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors and Council of Governors are asked to ***note*** the Charitable Funds Annual Report & Accounts and the Review of the Effectiveness of Expenditure for 2017/18.

2. Executive Summary

2.1. Context

At its January meeting the Charitable Funds Committee approved the Charitable Funds Annual Report & Accounts and the Review of the Effectiveness of Expenditure for 2017/18. The Committee asked that both documents were sent to the Board of Directors and the Governors for information.

2.2. Summary

Annual Report & Accounts

This document contains the report on the charity's performance during 2017/18 together with the associated financial statements, and the audit opinion from the Auditors.

Review of the Effectiveness of Expenditure

Charities are required by the Charity Commission to demonstrate their effectiveness. This summary reviews effectiveness for 2017/18 by demonstrating the results of spending the funds the charity receives.

2.3. Conclusion

The Board of Directors and Council of Governors are asked to ***note*** the Charitable Funds Annual Report & Accounts and the Review of the Effectiveness of Expenditure for 2017/18.

The Robert Jones and Agnes Hunt Orthopaedic Hospital Charity

Registered Charity Number: 1058878

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SUPPORTING RJAH HOSPITAL

2017-18

Trustee's Annual Report and Financial Statements
The Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund

Charity Registration No. 1058878

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TRUSTEE'S REPORT

Foreword by Chairman of the Corporate Trustee

Welcome to our annual report for the year ending 31 March 2018.

I am delighted to be reviewing another very successful year in which we raised nearly £360,000 and spent some £280,000 supporting the care and treatment of our patients and the wellbeing of our staff.

The reduction in funds raised during the year when compared to previous years is a result of 2017-18 being the first year for a while during which we weren't actively fundraising for a particular project or appeal.

We are delighted that our support contributed towards the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) being ranked amongst the best hospitals in the Country, according to a national survey of inpatients whilst our staff rated it in our annual staff survey as one of the best places to work and to be treated. RJAH has been shortlisted as Trust of the Year two years running in the prestigious Health Service Journal awards.

During the year we spent our funds on patients and staff facilities, providing improved patient areas, equipment, enhanced staff education and those small expenditures which can make such a difference to patient welfare and comfort.

Your donations and support made this work possible and your future donations are the key to our continued success. On behalf of the RJAH Charity, I thank everyone who raises or donates funds for us and I hope you will continue to be inspired to do so as every penny counts.

A large part of our funds come from legacies left by past patients and their family members. We would like to once again state our appreciation for the generosity of those who remember us in this way at what is always a difficult time for a family. Through these acts of kind generosity, we can enhance our patients' experiences at our hospital or carry out research to benefit current and future patients.

Looking to the future, we have taken the decision to be even more pro-active in promoting our charity and our hospital. To help in this goal we have recruited an experienced Fundraising Manager. Helen started with us in October 2018 and I'd like to take this opportunity to welcome her. I look forward to seeing the benefits she will bring both financially to the charity and to our supporters who will now have a clear contact at the hospital whose role will purely relate to the charity.

Lastly, I was honoured and delighted to attend the launch of our new Veterans' Orthopaedic Service Appeal at the House of Commons in October 2018. Helen and the project team are now taking this forward, looking to raise £1,500,000 in support of a dedicated centre for the treatment of military veterans.

Thank you all and I hope you enjoy reviewing this annual report

Frank Collins, Chairman
On Behalf of the Corporate Trustee
22 January 2019

Who we are

We are the Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund (RJAH Charity), an NHS Charity set up for the benefit of NHS patients and their families and carers, in particular those of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH NHS FT).

We were first registered as the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust Charitable Fund, Registered Charity No. 1058878, on 28 October 1996. We were renamed on 1 August 2011 as The Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund, following the change in status of the corporate trustee to an NHS Foundation Trust. The Charity is registered in England and Wales.

RJAH NHS FT is our Corporate Trustee with its Board acting on behalf of the Corporate Trustee. We are managed by a committee, known as the Charitable Funds Committee (CFC), which is made up of designated RJAH NHS FT Board members as detailed in the Principal Officer's section below.

Our annual report and financial statements relate to the funds administered for the public benefit by Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

What we aim to do: our objectives and activities

Our mission

By raising new money and careful management of our existing funds, we are able to make grants to RJAH NHS FT and the organisations it works with in order to fulfil its objective:

"Any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust."

Given this wide remit, the charity seeks in particular to add to or enhance the services provided by the NHS whilst ensuring the wishes of the donors are respected at all times.

RJAH NHS FT's stated ambition is to be recognised as the leading centre for orthopaedic care in the UK, with providing the highest quality care as their clear priority and the priority of all who work at the hospital.

We exist to raise funds and receive donations to provide resources and facilities to support the hospital in its work and meet the needs of patients and staff. By securing donations and legacies, we make a real difference to patients together with their families and friends as well as the staff who look after them both directly and indirectly.

We endeavour to ensure all donations are spent in accordance with the wishes of donors. Restricted funds are set up where necessary and, where a non-binding preference is expressed by a donor, unrestricted, designated funds have been created to benefit various wards, departments and activities each with a fund advisor from the relevant service or department appointed by the trustee to ensure this objective is met.

The income to achieve our objectives and strategy is mainly received from donations and legacies. The main areas of activity are patient and staff welfare, including new and refurbishment building expenditure and equipment provision.

Generating income and achieving our objectives involves all our partners including staff, patients and their families, carers and the local community.

Grants are made in accordance with charity law, our constitution and the wishes and directions of donors. In making grants, we endeavour to reflect the wishes of patients and staff by directing funds towards areas they tell us are in most need. During the year 2017-18, grants totalling £220,000 were made. Our future plans are to continue to raise our level of fundraising which will help us work with RJAH NHS FT to transform the care of our patients. We appointed a Fundraising Manager in October 2018 to facilitate this aim.

What we have achieved: highlights from the activities undertaken in the year

Our key aim is to serve NHS patients, in particular the patients of RJAH NHS FT for the public benefit. By working with the NHS we assist patients from every walk of life, irrespective of race, creed, ethnicity or personal or financial circumstances. We put this aim into practice by helping the patients, their families and carers, and visitors to the hospital by:

- Funding medical research to understand better the diseases affecting our patients today so that we can develop the cures and therapies of tomorrow.
- Enhancing the care our partner hospital can offer through making grants for new equipment and building improvements to deliver better facilities.
- Investing in NHS staff, in particular by supporting staff training.
- Supporting RJAH NHS FT in the creating of a caring environment for the patients receiving care, their families and visitors.
- Making a number of smaller grants for the provision of extra comforts for patients and to support social and other activities recommended as part of their rehabilitation.

We do this through a range of programmes funded by you, our generous donors. Highlights from the main programmes undertaken in the year are detailed below to give you a wider understanding of the difference we can make together to patients' lives both now and in the future.

Funding the treatments of tomorrow £32,000

We make available funds to sponsor non-commercial research in areas where our partner NHS Foundation Trust has considerable expertise, with a view to developing new therapies for treating and caring for patients. During 2017-18 we spent £32,000 on medical research excluding support costs.

RHAH NHS FT's research strategy is directed at "harnessing involvement in research to create a culture of enquiry and excellence amongst staff aimed at delivering world class care for our patients". Strong partnerships have been developed to support ongoing educational and research needs by RJAH NHS FT with the universities of Keele and North Staffordshire.

We are committed to supporting high quality, nationally competitive research. These projects reflect the nature of the designated funds they are funded from and are subject to the scrutiny of the Trust's Research Committee before approval. Grant applications are only entertained for projects already approved and supported in principle by RJAH NHS FT's Research Committee.

- Extracellular vesicles derived from mesenchymal stem cells and chondrocytes: characterisation and potential applications: In April 2016 the charity approved a bid for £98,000 to fund research into how different culture conditions may impact the effectiveness of treatments to modify inflammation and arthritic structural changes in the knee. The bid proposed building on previous research carried out at RJAH and progressing towards developing a stem cell based therapy for refractory rheumatoid arthritis (RA). Previous research at RJAH has shown the therapeutic potential of stem cells in treating refractory RA in pre-clinical model. This research expands on such work to investigate developing a novel treatment using the signals released by adult stem cells in the form of membrane-bound vesicles to modulate the immune response experienced in RA. Developing a cell free therapeutic will allow standardisation, characterisation and banking of vesicles as an off-the-shelf therapy. Funds were requested to evaluate the effectiveness of this treatment option in pre-clinical inflammatory arthritis model. The final £30,000 of this grant was handed over during 2017-18.

- £2,000 was handed over to the Institute of Orthopaedics towards funding a tennis elbow study.

Improving patient experience – attending to patient needs £14,000

- Some areas tend to have patients whose treatment involves longer stays and who may be relatively immobile and often require extra comforts to improve their morale. Birthday and Christmas presents and Easter treats are purchased for patients on the Children's and the Spinal Injuries Units as well as activity items such as craft materials, toys and DVD players and DVDs. We also pay the Sky subscriptions for these areas. During 2017-18 we spent £3,000 on these items.

- Our Spinal Injuries Unit held their annual dinner for patients and staff in April and we were pleased to support this by funding the table decorations on the evening.

- A picnic bench especially designed for disabled and wheelchair access was purchased to provide a facility allowing all users of the Trust's restaurant, Denbighs, to eat outside in a social environment. This was particularly appreciated during the warmer months and cost £3,400.

- A gas-fired barbeque has proved popular for patients, staff and mixed social events. Being on wheels, it is able to be deployed outside most ward and patient areas and cost £3,300.

- A Modern Apprentice was funded on the Spinal Injuries Unit, the Midlands Centre for Spinal Injuries, for part of the year at a cost of £1,300. The purpose of this post is to provide administrative resources to help staff improve networking and support activities for patients. An example of these activities is the annual patient dinner mentioned above.

- We were pleased to make a grant funding the accommodation and travel costs of some members of a delegation who travelled on a fact finding mission to America to research how Forces veterans are catered for in a separate and dedicated environment specifically designed for their care. It is planned to develop the Trust's current Veterans' Service by providing a centre with a more familiar, military feel. There our veteran patients may be comfortable in the knowledge that both staff and fellow patients will be aware of and understand issues specific to their past experiences in the military, should these arise. Raising funds to build this centre will be the charity's next appeal starting in 2018/19. For further details, see the future plans section on page 26.

- Lt Col. C E R Meyer, Consultant Orthopaedic Surgeon, leads the current service at RJAH and had the following to say regarding the trip to America:

  "In May this year representatives of the Veterans Service RJAH travelled to the Walter Reed Military Hospital in the United States. This is the largest military hospital in America; a large volume of its workload is for Veterans. We were able to see first-hand how Veterans care is provided both on a clinical and managerial level. It was particularly useful for me as a Surgeon to see how their theatre teams interact and how they manage their throughput both in outpatients and in theatres. It was also useful to see the extent to which charities support Veterans services in America. Hopefully this will be invaluable in helping us in our own fundraising efforts."

Providing better care using the latest technology £56,000

- A need was identified to ensure consistent measuring arrangements for the temperature monitoring of medicines within clinical areas of the hospital. We were pleased to fund this at a cost of £23,000. Mr Imran Hanif, Chief Pharmacist, explained the requirement for a number of medications to be stored within strict temperature limits. This system measures the temperature medicines are kept at in various clinical areas and sends an alert when a medicine had been stored out of temperature range and measures for how long, thus allowing us to supply this data to manufacturers and obtain their advice on whether the medicine could

still be used. Previously, if it was suspected medicine had been stored out of the temperature range then it would have to be disposed of at a cost to the Trust. Not only has installation of this system improved patient care but it could also help reduce future costs from wasted drugs by alerting staff of temperature excursions in a timely manner.

Maryse Mackenzie, Medicines Safety Officer (MSO) at RJAH updated us on the roll-out of the system:

"We have installed the temperature monitoring devices this year in all clinical areas. We continue to work with IT and the company to improve the consistency of the reporting before we go live. There are plans for a pilot of the system to take place in the new year."

- Funding of around £8,000 was given for an upright -86'C freezer to be sited elsewhere on site as a back-up for the two larger freezers based in the Bone Bank Office in Theatres. The Bone Bank supplies, procures, stores and provides donated femoral heads and other tissue allografts to be sued for patients who need surgery at the Trust. The femoral heads are used in revision hip surgery, spinal surgery and the tissue allografts are used in surgery on patients with a sports injury. Patients experience improvements in healing, pain relief, movement and, ultimately, quality of life.

- We purchased a BodiTrak Seat Mat at £5,000 for use with patients on our Spinal Injuries Unit, also known as the Midlands Centre for Spinal Injuries (MCSI). This is a mapping system which measures pressure on the skin of patients and is used to educate them about the care of their skin and the prevention of pressure sores.

- A table-mounted, mobile arm was purchased at a cost of £5,000 to assist Spinal Injuries patients who require some arm support and help with movement in the carrying out of daily functional tasks. This equipment increases the patients' independence by assisting them in carrying out actions for themselves such as cleaning their teeth or feeding which is not only useful but may give them back dignity and improve their morale and belief in what they might achieve.

- We spent over £3,000 on three patient observation monitors for the Tumour Unit, including Oswald Ward. These machines are essential to patient care. They have the facility to advocate safe practice when assessing oxygen saturation levels. They are gold-standard equipment used to ensure the safety and quality in assessing a patient's vital signs whilst they are being cared for.

- A new, mobile phlebotomy chair was purchased for use during Arthritis and Rheumatology clinics. This cost £3,000 and included leg supports and backrest which may be adjusted to ensure the most comfortable experience possible for patients, allowing of the fact they are having blood samples taken.

- The Children's Unit used funds to purchase a paediatric tilt-table system to enhance the treatment facilities they offer their patients. This system cost over £2,000 and is used to help patients mobilise during their rehabilitation see picture below.

- Other funds were granted for the purchase of a plastic skeleton for use during discussions with Pain Clinic patients and the maintenance of equipment previously purchased and supported by the charity. Sheldon Ward, which cares for our elderly patients, purchased a chair based falls system for just over £500. This is a sensor which monitors a patient's movement from a chair. A panel is placed beneath the chair cushion and connected to a control unit which triggers an audio and visual alarm when the chair is vacated. It is hoped this system will help alert staff to the risk of a patient falling and prevent injuries.

Improving the patient environment £17,000

- As part of RJAH NHS FT's continuing drive to ensure patients have the best experience possible whilst receiving treatment, the charity granted over £6,000 to fund new blinds for Kenyon Ward.

These were purchased as part of the modernisation of Kenyon Ward. This has not only improved the look and feel of the ward for patients but was driven by a Trust wide theme of taking measures to maintain or improve on infection control. Hayley Woodcock, Kenyon Ward Manager was very pleased with the result and said:

"The new modern look of Kenyon ward has been positive for both patients and staff. It has made the ward feel more modern compared to old, dated curtains which were in place."

- A few years ago, when the building works for the waiting area in Radiology were taking place, we funded the installation of a glass-sided fish tank to be installed in the wall dividing the waiting area from the hospital's main corridor. This large aquarium not only allows light through but the inhabitants and their antics are popular with patients, visitors and staff of all ages. The charity continues to fund the annual maintenance fee at a cost of £2,000 per year. Two year's maintenance was paid for in 2017-18 as a result of the timing of visits at the start and the end of the financial period, a total of £4,000 expenditure.

- The recently opened Tumour unit in the Bone Cancer Centre benefited from £1,000 spent on the purchase of an ice making machine and also some large, decorative pots for the centre's garden area.

- Similarly, Alice Ward on the Children's' Unit used £1,000 of their funds to purchase some high-backed chairs for patients to replace those which had become worn and even ripped in places and harder to clean as a consequence.

- The Children's' Unit also purchased a mobile privacy screen for use in their Outpatient Department to preserve patients' dignity in a clinical room where it was not possible to fit privacy curtains, at a cost of £400. They also spent £400 on five notice boards with lockable covers. These allow information to be displayed for patients whilst adhering to infection control standards as the covers are easily kept clean. Sheldon Ward spent £500 on replacement adjustable overchair/bed tables. The Ward Manager, Lorna Edwards, explained the previous tables had become shabby with use and required replacing, as much for the fresh and clean impression this would make on patients, increasing their confidence, as for actual infection control reasons.

- A bid for a future appeal to be held to raise funds to improve the gym and rehabilitation facilities for patients of the Spinal Injuries Unit, the Midlands Centre for Spinal Injuries (MCSI), was put forward during 2017-18. Funding of £30,000 to support further work involving external expertise was approved, of which £3,000 has been spent on design and project management as at 31 March 2018.

Recognising staff and improving morale £106,000

We recognise the impact staff morale has on staff motivation and how this, in turn, can affect the way patients experience their interactions with staff.

- Many donations are received from grateful patients in recognition of how the way staff have responded to them has made them feel as well as the treatment they have received. This is reflected in the use of funds to enable staff to attend courses which are not normally funded by the NHS but will benefit patients. These include counselling and listening skills courses, specialist interest conferences, morale boosting events, facilities and amenities. Grants for training totalling £60,000 were made during 2017-18.

- Drinking water was provided to all areas of the hospital at a cost of £8,000. Being properly hydrated means staff are less likely to suffer from mental and physical fatigue and are able to give their best to patients.

- The commitment and hard work of staff working at RJAH was recognised at its annual Celebration of Achievement Awards held in November 2017 at a cost of around £9,000.

The awards recognise the contribution made by both individuals and teams of staff, nominated by their peers for most award categories with everyone able to vote on the shortlisted nominees. They are a great chance for staff from all over the hospital to hear about and celebrate the work done by colleagues in other departments and to cheer on all those who had been shortlisted, both winners and runners up.

A total of 17 awards were presented to individuals and teams from the hospital during the ceremony held at the Lion Quays Hotel. The evening was compered by Mr Robin Banerjee, a Consultant Orthopaedic Surgeon at RJAH.

Mark Brandreth, Chief Executive of RJAH, said:

"*It was a brilliant evening and fantastic to have so many of our great members of staff come together to celebrate some of our achievements from the past year.*

Last night's ceremony rounded up a brilliant year for the hospital, as the night before a team of 10 of us attended the Health Service Journal (HSJ) Awards, where we were shortlisted in two categories, as well as being ranked No 1 in the country for overall patient experience in an inpatient survey carried out by the Care Quality Commission.

We have an incredible team at the RJAH working in clinical and non-clinical roles whom are making a massive difference to the lives of their patients and colleagues on a daily basis, so really last night was our chance to say thank you for everyone's efforts."

Frank Collins, RJAH Chairman, said:

"It was a pleasure and a privilege to spend the evening celebrating the achievements of the hard-working teams and individuals who work at RJAH.

Congratulations to all the winners, finalists and those who were nominated for awards, and I would also like to put on the record my appreciation for staff members who were unable to attend the event because they were on shift caring for our patients. That can't go without mention.

I am immensely proud to be chairman of this inspiring organisation and last night was no exception to that."

- Each year we make a grant to allow the hospital to provide a subsidised seasonal meal, available to all staff for a small charge in the staff and patients' restaurant Denbigh's. As

usual, the catering staff did a great job which was much appreciated by all who participated. The charity contributed over £4,000 towards the 2017 meal.

- £2,000 was spent during 2017-18 on staff health education with staff encouraged to visit our annual Healthy Horizons Day at which they have the opportunity to participate in various health checks and visit a number of stalls giving advice or advertising local activities.

- During the year, staff and the Trust were nominated for a number of prestigious, external awards and attended two award evenings where the Trust and staff members had been nominated and shortlisted for awards, at a cost of £17,000:
    - Nursing Times Awards
        - Managing Long Term Conditions Award – 'Hospital to Home' Surveillance Nurse Team who work with patients with spinal cord injury at the hospital's Midlands Centre for Spinal Injuries, visiting patients in the comfort of their own homes.
    - Health Services Journal Awards – nominated in two categories:
        - Provider Trust of the Year Award
        - Chief Executive of the Year Award

- In addition, we provide funds for the purchase of small gifts in recognition of long-term service for those who have worked for 30 years in the NHS. The cost for 2017-18 was £2,000. In addition, the Charity funded £1,500 for retirement gifts. Feedback shows, this small recognition of the loyalty and service given by these members of staff means a lot to them and acts a reminder to other staff how valued our staff are.

  Other, smaller areas of expenditure included support for the annual flu vaccination campaign and baskets of fruit to celebrate International Nurses Day.

Raising funds £9,000

- There was no official appeal being run by the Charity during 2017-18.

- Of the £9,000 spent on raising funds during 2017-18, £7,000 was the cost of places and T-shirts for our runners in the Virgin London Marathon who brought in £56,000; £1,600 was for final charges received relating to the Guttmann Conference organised by the Spinal Injuries Unit last year, bringing the total cost to £18,000 compared to the £36,000 received in 2016-17; Other expenditure included sweatshirts purchased to sell and raise funds to take patients from the MCSI on external outings or related to the cost of general fund raising expenditure such as collection buckets and tins.

- We do not have a fundraising team or employ anyone to arrange fundraising events. However, we do subscribe to a number of charity places in the Virgin London Marathon (VLM) in exchange for which we ask runners to try and raise at least £1,500. Each of these places costs us £360 on top of which we have the costs of advertising in the VLM magazine and providing T-shirts to all of our runners.

- We subscribe to the JustGiving website where pages linked to our charity may be set up for the receipt of online electronic donations. We also purchased a number of additional and replacement collection cans and buckets which we make available to those raising funds on our behalf.

How we funded our grants, our achievements and performance

The following figures are taken from the full financial statements, approved on 31 January 2019, which carry an unqualified audit report. The full financial statements and related accounting notes may be viewed from page 31 onwards of this report. This Trustee's Annual Report and Financial Statements publication has also been lodged with the Charity Commission.

Movement in Funds

At the start of the period, 1 April 2017, the total fund balance amounted to £826,000. This all related to unrestricted funds, the Charity held no restricted funds.

By the end of the period, 31 March 2018, the total fund balance amounted to £906,000 which was an increase of £80,000 during the year. This all related to unrestricted funds, the Charity held no restricted funds.

Money received during 2017-18 £358,000; Money spent during 2017-18 £278,000

We can only continue to support the work of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for as long as we receive the money needed. Almost all of our income comes from the voluntary efforts of the general public. Overall we spent £78,000 less than we received during 2017-18, before taking into account interest earned on cash deposit investments. With the interest of £2,000 earned on cash deposits taken into account, the funds increased by £80,000 overall during 2017-18. We would expect the funds to begin to increase again during 2018-19 with there being no large capital expenditure commitment by the Charity in year and the Veterans' Orthopaedic Centre Appeal being launched.

Money received – sources of funds

Total income for the year 2017-18 was £358,000, compared with £485,000 for 2016-17, a decrease of £127,000. This was mainly due to a decrease in legacy receipts.

Donations

We received £110,000 from donations during 2017-18 compared to £61,000 during 2016-17, an increase of £49,000 accounted for by one large donation, worth over £60,000, counteracting the reduction of donations expected in a year with no specific appeal area to attract additional donations.

As usual, the number of donations and grants received were so numerous that we cannot list them all but would like to take this opportunity to express our gratitude and heartfelt thanks to all who have and continue to support us which, in turn, allows us to support the patients of the RJAH NHS FT. The following list is just a sample of the generous support for us:

- One generous donor gave us £62,500 in memory of his brother who had been a patient on our Spinal Injuries Unit and whose estate he had recently inherited.
- A further £12,000 was received from families and friends in memory of loved ones; we are always so touched that they remember us at such a time.
- Over £3,000 was raised by one family for physiotherapy equipment on the Children's Unit, they raised the funds by organising a raffle with some great prizes.
- Over £2,000 was received from staff via the Staff Lottery salary deductions, 50% of which go towards the prize fund with the remaining 50% being a donation towards our charity.
- A grateful patient donated £2,500 to Mr Trevedi's Spinal Fund.
- £1,000 was raised for our Orthotics patients by the Café Stop Ride.
- One family gave us £1,000 to purchase wheelchairs.

- A £1,000 donation was received for bone tumour research.
- 109 other donations were received from a wide variety of donors including grateful patients and their families, local schools who had selected us as their charity to raise funds for and people kindly requesting donations to us instead of receiving gifts for birthdays, weddings and wedding anniversary celebrations. Staff and other supporters held fundraising events or took part in sponsored activities such as biking, cycling, walking, slimming, and running.

Legacies

Once again, we benefited from the generosity of our supporters who remembered us in their wills. The Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund are always very grateful to receive such legacies as they help us to provide state of the art equipment and facilities for our patients. We are aware that we receive these gifts at a sensitive time for the remaining family and we should like to take this opportunity to emphasise how grateful we are to be remembered in this way. We received legacy receipts totalling £189,000 during 2017-18 compared to legacy income for 2016-17 of £345,000, a reduction of £156,000.

- The 2017-18 income includes accruals of £155,000 for payments received during 2018-19 but known about and expected as at 31 March 2018.
- The reported income relates to eight legacies, including one where initial payments had been received in previous years; the amounts varied from £500 to £90,000 and were all gratefully received.
- All the legacies were allocated to unrestricted funds thus being available for us to use freely to further our objectives and benefit patients, their families and carers as well as staff.
- We recognise legacy income only once it is probable that the incoming resources will be received and the value of those incoming resources can be reliably measured.
- We have a subscription with an agency which reviews wills as they are released and alerts beneficiaries to the existence of potential legacies.
- Again, we are very touched to be remembered in this way and always try to take the wishes expressed in wills into account or discuss an acceptable alternative area of spend with families and/or executors where it is not possible to honour specific requests for whatever reason.

General Grants

No grants were applied for or received during either 2017-18 or 2016-17.

Other trading income - fundraising

A total of £57,000 was raised during 2017-18, a decrease of £19,000 on the £76,000 raised in 2016-17.

- £56,000 was raised by our Virgin London Marathon runners during 2017-18 compared to £37,000 raised in 2016-17. This reflected both an increase in the number of people signing up for our places year on year and a change in the timing of fundraising by runners with half the amount received from runners of the 2017 marathon after the event and half from runners of the 2018 marathon before it took place in April 2018.

We ask our runners to try and raise at least £1,500 and many of them exceed this by fundraising during the year holding pub quiz nights, cake sales, bag packing days, dances, coffee mornings and asking friends and relatives to sponsor them. Sometimes we are lucky and their employers offer to match the funds they manage to raise by themselves. Several staff members and relatives of patients were included in our teams and we are always grateful to those who are willing to put so much effort into supporting us.

- Nearly £1,000 was raised during 2017-18 by one supporter who committed to take part in seven "ultra-challenges", each being an endurance event of 100 km. These events span both 2017-18 and 2018-19 and he has raised over £4,000 in total in support of military veteran NHS patients. These funds have since been transferred to our Veterans' Orthopaedic Centre Appeal (VOCA) fund following its launch on 15 October 2018.

- In 2016-17 the Spinal Injuries Unit hosted the prestigious Guttmann Conference which brought in an income in year of £36,000. No such activity took place in 2017-18.

We know further events will take place in 2018-19 and have no doubt that yet again many entertaining and successful ways of raising funds will be found.

The varied activities carried out by us on behalf of our patients are all made possible by the generosity of so many different people.

So, thank you once again to everyone who contributed and to those who continue to support us.

Other income - interest on cash deposits £2,000

We earned £2,000 in interest on cash deposits during 2017-18 compared to £3,000 in 2016-17. Investment decisions are made in line with our Investment Policy which lays down strict criteria on the rating levels for organisations required before a cash deposit may be considered.

Money spent – what we spent the money on

Total expenditure on charitable activities during 2017-18 was £260,000 compared to £1,212,000 in 2016-17, a decrease of £952,000 reflecting the final contributions made to RJAH NHS FT in support of the new Theatres, Wards and Tumour Unit development at the end of 2016-17.

The focus of our charitable work is to advance patient care, firstly by funding equipment, facilities, therapies and training, secondly through supporting patients and their carers and families. During the year we continued to support a wide range of charitable and health related activities benefiting patients, their carers, their families and the hospital staff who care for them. Funds were used to purchase goods and services over and above those provided by the hospital from central NHS funds.

Details of actual expenditure are given under the "What we have achieved" section above, from page five onwards.

Our charitable work was made up of five programme areas plus the support costs we incur. The total values shown below include the allocation of support costs over the relevant headings.

Building and refurbishment

Total building and refurbishment expenditure for 2017-18 was £12,000 compared to £1,040,000 in 2016-17, a reduction of £1,028,000 mainly relating to the final grant payments totalling £1,000,000 in support of the new Theatres, Wards and Tumour Unit development being made in 2016-17.

Equipment

Total equipment and refurbishment expenditure for 2017-18 was £70,000 compared to £12,000 in 2016-17.

The NHS of course buys much of its own equipment for day to day use and has its own capital programme, but with advances in technology and technological obsolescence of existing equipment we can make a real difference to patients by purchasing various pieces of equipment, such as the medication temperature monitoring equipment, the freezer for the bone bank, the skin pressure measuring mats and the potential falls alert system mentioned above. Our aim is to help RJAH NHS FT to maintain the highest possible patient care.

Medical Research

We spent £38,000 on research in 2017-18, compared to £73,000 in 2016-17. This included the remaining part of the research grant approved last year and mentioned above. This was a decrease of £35,000 on 2016-17.

Patient education and welfare

Total spend on patient education and welfare in 2017-18 was £16,000 compared to £8,000 in 2016-17, an increase of £8,000. This movement was largely accounted for by two lots of aquarium, maintenance costs falling in 2017-18 and the purchase of a specialist built disabled-access picnic bench as detailed above.

The charity continued to fund other areas of expenditure books, CDs and DVDs for the Patients' Library, funding for spinal injuries patients to attend specialist courses and events, craft materials for patients and small Christmas or birthday gifts for long term and young patients.

Staff education and welfare

Total spend on staff education and welfare in 2017-18 was £124,000 compared to £79,000 in 2016-17 an increase of £45,000.

Expenditure mainly comprised non-statutory training at a cost of £60,000 in 2017-18 compared to £54,000 in 2016-17. This additional training benefits patients by expanding the care and treatment available to them and boosting staff morale to improve the environment in which patients receive treatment.

An increased area of expenditure was for staff to attend the prestigious Nursing Times and Health Service Journals awards evening to represent the Trust as we were nominated for awards.

Some funds were also used for other expenditure to improve staff morale such as the provision of drinking water, a health and wellbeing day, long service and retirement gifts and the Staff Awards Evening.

Other

There was no expenditure incurred in either 2017-18 or 2016-17 which did not relate to our charitable activities as detailed above.

Support costs

Support costs amounted to £43,000 in 2017-18 compared to £46,000 in 2016-17, a reduction of £3,000 due to a reduction in staff costs following a review of responsibilities and a change in personnel.

Support costs are made up of administration and governance costs.

The funds are administered by the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust staff and governed by the Director of Finance and a fixed proportion of their salary is charged to the Charitable Funds, this accounted for £36,000 of the costs in 2017-18, £38,000 in 2016-17 costs. The total hours of support given and recharged remained the same at 41.5 hours per week on average over the year.

External audit fees were £4,800 for both 2017-18 and 2016-17. Other operational costs include bank charges, our subscription to the Association of NHS Charities and the annual charitable funds accounting software licence fee and totalled £2,000 in 2017-18 compared to £3,000 in 2016-17.

Administration costs include the RJAH NHS FT salary costs relating to those carrying out our administration processes on a day to day basis together with our other operational costs including bank charges and the annual charitable funds accounting software licence fee. These were apportioned over the charitable activities grants payable on a pro-rata basis.

Governance costs are those associated with the governance arrangements and include the proportion of time devoted to the charitable funds by the Director of Finance, membership of the Association of NHS Charities and the External Auditor's fees. For the designated non-restricted funds, the cost of governance is charged straight to the undesignated General Fund. For the restricted funds, their share of governance costs are charged to each fund and then a transfer is made from the General Fund to the restricted fund for an amount equivalent to the restricted fund's governance costs.

The support costs are allocated across the charitable activities and fundraising expenditure areas on a pro-rata basis on fund balances and included in the totals mentioned in the paragraphs above.

Reference and administrative details

Officers and professional advisers report

Trustee details

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is the corporate trustee and the hospital Trust Board has devolved responsibility for the on-going management of the funds to the Charitable Funds Committee which administers the funds on behalf of the corporate trustee.

Principal Officers

The names of those people, who served on the Charitable Funds Committee (CFC), as permitted under regulation 16 of the NHS Trusts (Membership and Procedures) Regulations 1990, were as follows:

Name	RJAH NHS FT Board Role
F Collins	Chairman
A Findlay	Non-Executive Director
D Gilburt	Non-Executive Director
H Pepler	Non-Executive Director
H Turner	Non-Executive Director
M Brandreth	Chief Executive Officer
C Macbeth	Director of Finance

Members of both the Trust Board and the Charitable Funds Committee are not individual trustees under charity law but act as agents on behalf of the corporate trustee.

The Charitable Funds are registered with the Charity Commission (No. 1058878) in accordance with the Charities Act 2011.

Charitable Funds Committee (CFC) – terms of reference

1. Constitution

1.1. The corporate trustee of the Robert Jones and Agnes Hunt Orthopaedic Hospital Charity, has delegated operational management of the Fund to the Charitable Funds Committee. This is not a sub-committee of the Board but rather acts as agent for the corporate trustee. It has no executive powers other than those specifically delegated in these Terms of Reference.

1.2. The corporate trustee approved the establishment of the Charitable Funds Committee for the purpose of:

1.2.1. Ensuring stewardship and effective management of funds which have been donated, bequeathed and given to the Robert Jones and Agnes Hunt Orthopaedic Hospital Charity for charitable purposes.

1.2.2. Determining an investment strategy and arrangements for the investment of funds which are not immediately required for use.

1.2.3. Coordinating the provision of assurance to the corporate trustee that the funds are accounted for, deployed and invested in line with legal and statutory requirements.

1.2.4. Considering and approving the annual accounts for charitable funds for submission to the corporate trustee.

2. Role

2.1. The role of the Committee is to oversee the management of the affairs of the Robert Jones and Agnes Hunt Orthopaedic Hospital Charity. This is a delegated duty carried out on behalf of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust as sole corporate trustee of the charity.

2.2. The role is to ensure that the charity acts within the terms of its declaration of trust and appropriate legislation and to provide information to the trustee to enable it to gain assurance that the charity is properly governed and well managed across the full range of activities in line with the Charity's Governance Framework.

3. Membership

3.1. The membership of the Committee shall consist of:

3.1.1. Foundation Trust Chairman
3.1.2. Foundation Trust Chief Executive
3.1.3. Two Non-Executive Directors including the Audit Committee Chair who will serve as Deputy Chair of the Charitable Funds Committee
3.1.4. Director of Finance

3.2. A quorum will be two Non-Executive Directors (or the Chairman and one Non-Executive Director) and one Executive Director. The Trust Chairman will chair the Charitable Funds Committee.

4. Attendance

4.1. The following individuals shall normally be in attendance:

4.1.1. Finance Manager with responsibility for Charitable Funds
4.1.2. If appropriate, any external fund manager
4.1.3. All directors may attend should they wish to do so.

4.2. Finance shall agree the agenda with the Chair of the Committee and collate and distribute the papers and keep a record of matters arising and issues to be carried forward.

5. Frequency of meetings

5.1. The Committee will meet not less than four times a year, with one of those meetings attended by all of the directors. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

5.2. Members may participate in these meetings by telephone, video or computer link and participation in this manner shall be deemed to constitute presence in person at the meeting.

6. Authority

6.1. The Committee is authorised to oversee the management of the Charitable Funds, within its terms of reference and the charity's Governance Framework.

6.2. It will approve fundraising and expenditure within the limits delegated to it. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.3. The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Reporting

7.1. The Committee will circulate copies of the minutes of its meeting to all Board members.

7.2. The Charity's Annual Report will be presented to a meeting of the corporate trustee.

7.3. The Committee will also undertake a self-assessment and produce an annual report of its activities and effectiveness

8. Key responsibilities

8.1. To manage the affairs of the Robert Jones and Agnes Hunt Orthopaedic Hospital Charity within the terms of its declaration of trust and appropriate legislation.

8.2. To approve and review biannually the charity's Governance Framework which sets out the key principles of the charity and its day-to-day running including:

8.3. Investment and Banking Policy - to manage the investment of funds in accordance with the Charities' Act 2011 and, if necessary, appoint fund managers to act on its behalf;

8.4. Expenditure Policy – to ensure funding decisions are clinically and ethically appropriate, consistent with the charity's objectives and provide added value and benefits to the patients and staff of the Trust above those afforded by the Exchequer funds.

8.5. To receive regular reports on fundraising activities.

8.6. To implement as appropriate, procedures and policies to ensure that accounting systems are robust and donations received and recorded as instructed.

8.7. To approve the Trustee's Annual Accounts and Report and to ensure that all relevant information is disclosed.

8.8. Identify and consider the major risks to which the Charity is exposed and review the systems to mitigate those risks.

8.9. To evaluate its own membership and performance on an annual basis.

8.10 To keep abreast of Charity Commission guidance, charity law and other governance and legal requirements relating to charities.

8.11 To review annual these terms of reference, recommending any changes.

The Charitable Funds Committee reviews the training needs of the Trust Board. They are committed to keeping up to date with the legal and statutory requirements for charities by formal training and/or accessing publications, advice and updates from relevant bodies.

Principal Charitable Fund Adviser to the Trustee

The Director of Finance acts as the Principal Charitable Fund Adviser to the corporate trustee, under an approved scheme of delegated authority. He is responsible for ensuring that the funds are managed appropriately and with due regard to their purpose and requirements.

Delegated Authorities

The Trustee has delegated authorities for expenditure from charitable funds, both designated and restricted, which are shown below:

Up to £500 per request	Fund Advisor
Up to £10,000 per request	Chief Executive **or** Chief Financial Officer
Up to £20,000 per request	Chief Executive **and** Chief Financial Officer
Up to £50,000 per request	Charitable Funds Committee **or between committee meetings** Chief Executive **and** Chief Financial Officer in consultation with other Trust Board members including at least one Non-Executive Director
Over £50,000 per request	Charitable Funds Committee either at a regular meeting or a meeting especially called for that purpose

Principal Professional Advisers:

Auditor
Deloitte LLP
Statutory Auditor
1 City Square
Leeds
LS1 2AL

Solicitors
Hill Dickinson
Pearl Assurance House
2 Derby Square
Liverpool
L2 9XL

Bankers
Government Banking Service
Southern House (7th Floor)
Wellesley Grove
Croydon
CR9 1WW

Lloyds Banking Group
Faryners House
25 Monument Street
London
EC3R 8BQ

Principal Addresses

Registered Office
Charitable Funds, Finance Department
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Oswestry
Shropshire
SY10 7AG

Email addresses
RJAH.Charity@nhs.net
RJAH.Fundraising@nhs.net

Website
http://www.rjah.nhs.uk/Fundraising/Donations-and-Fundraising.aspx

Structure, Governance and Management

In its operation of the charitable funds, the corporate trustee has had regard to the Charity Commission's guidance on independence and established the Charitable Funds Committee to assist in maintaining independence. It does this by ensuring that the use of charitable funds is focused on the needs of the NHS patients, their carers and families.

All the funds held on trust as at the date of registration on 28 October 1996 were unrestricted. Our restricted funds were created after this date following the receipt of legacies with restrictive bequests and for the Appeals. Subsequent donations and gifts received that are attributable to the original funds are added to those fund balances within the existing charity. Apart from solicited donations to our appeal, all donations received are explicitly agreed with the donor to be unrestricted but with a preference, which is non-binding on the trustee, about where to spend the money. This is why they are treated as designated rather than restricted.

To assist the corporate trustee in the day to day management of the unrestricted charitable funds, the funds available for spending are allocated to designated funds within the General Fund related to the purpose of the donation or gift. For example, there are undesignated charitable funds for wards, for research and for specific areas such as the Midlands Centre for Spinal Injuries. Where no specific area is indicated then the gift is allocated to the non-designated General Fund.

Our funds are invested and accounted for separately from other income received by the hospital for the provision of healthcare. This is in accordance with the requirement of the 2011 Charities Act.

The corporate trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating the funds the trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, and the carers and staff who look after them.

New Trust Board members, as agents for the corporate trustee, are committed to familiarise themselves with their responsibilities. In broad terms, trustees have a duty to ensure compliance with

charity law and accounting regulations set out by the Charity Commission; a duty of prudence in ensuring that we remain solvent and income and property is applied solely for the purposes held within the governing document; and they also have a duty of care to donors and potential donors.

Our governing document is a Model Declaration of Trust dated January 1995 and is a legal document registering us with the Charity Commission and states our purposes, also known as our objectives.

Full use is made of Charity Commission guidance and support for trustees.

An induction pack is given to newly appointed members of the NHS Trust Board and Charitable Funds Committee as RJAH FT Board members are automatically required to act as agents of the corporate trustee as part of their employment terms. This includes our governing documents, the terms of reference of the Charitable Funds Committee, the most recent Trustee's Annual Report and Financial Statements and the Charity Commission guidance on being a trustee, public benefit, fundraising, risk management and the hallmarks of an effective charity together with internet links they might find useful. This pack is reviewed and refreshed on an on-going basis either when updated guidance is published or when guidance covering a topic or area is requested by a member.

The accounting records and the day to day administration of the funds are dealt with by the Finance Department located at Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, Gobowen, Oswestry, Shropshire, SY10 7AG.

Administration

Charitable funds received are accepted, held and administered as funds held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977, the National Health Service and Community Care Act 1990 and the National Health Service Act 2006. These funds are held on trust by the corporate body.

Our Annual Report and Financial Statements for the year ended 31 March 2018 have been prepared by the corporate trustee in accordance with Part 8 of the Charities Act 2011 and the regulations made thereunder; the Charities (Financial Statements and Reports) Regulations 2008 and the Regulatory Reform (National Health Service Charitable and Non-Charitable Trust Financial Statements and Audit) Order 2005.

The financial statements are presented under the Statement of Recommended Practice (SORP), Financial Reporting Standard 102 (FRS 102).

As at 31 March 2018, we are constituted of a total of 18 funds. These comprise an unrestricted General Fund split into one undesignated fund and 17 designated sub funds. No funds were either closed or opened during 2017-18.

The charity held no restricted funds as at 31 March 2018.

The Charitable Funds Committee (CFC) operates within the terms of reference and delegated powers set out by the Trustee. Members decide policy and make sure it is implemented. Day to day management is delegated to the Director of Finance.

Remuneration of Key Management Personnel

We are overseen by the CFC, made up of RJAH FT Board members who are seconded to this committee as part of their employment terms. There is no charge made by RJAH FT to us for their time and none of them receive any remuneration for their work on our behalf.

Grant Making Policy

The use of our funds is restricted by the governing document which established us for the purposes connected with the NHS. All grant requests have to be countersigned by the relevant Divisional Manager or Executive Director to confirm that expenditure would be in line with the strategic objectives of the division and the Foundation Trust. Authorisation is subject to the delegated authority levels

previously listed. Grants are normally made from our unrestricted funds. These funds consist of two elements, the General Fund and the designated sub-funds of the General Fund.

General Fund – constituted of gifts received where no particular preference as to its expenditure by donors. Any member of staff may apply for a grant from the General Fund. Typically this fund is used for areas with no or insufficient designated funds, or for hospital wide events or purchases.

Designated Funds – these contain gifts where a wish was expressed to benefit a particular part of the hospital or activity by the donor at the time the gift was made. Although their nomination is not binding on the trustee, the designated funds exist to enable us to honour the wishes of our donors without placing restrictions on us which might result in the monies not being spent in a timely manner. Each fund has a fund advisor, usually the clinical lead or the ward manager, who makes recommendations on proposed grants. Whilst these recommendations are not binding on the trustee, they are normally accepted.

Risk Management

The major risks to which we are exposed have been identified and considered. The Charitable Funds Committee has established a risk register which records these key risks, the steps taken to mitigate them, and actions required. This register is reviewed by the Committee as a standing agenda item and updated as required.

The most significant risks identified relate to the current economic climate including:

i) The impact on the level of donations received. We are seeking to mitigate this by:

- striving to increase awareness about us, including our objectives and our activities;
- ensuring shortcuts and links are available on our website to affiliated donation and fundraising websites;
- developing a link on our website to accept online donations directly;
- reporting on fundraising and donations at every CFC meeting;
- publicising fund raising activities and charitable expenditure;
- developing a fundraising strategy.

ii) The potential loss of funds on deposit should the financial organisation fail. We are seeking to mitigate this by taking the decision not to invest on the stock market and keeping funds in commercial banks which meet specific ratings aligned to NHS Improvement (NHSI) guidance as followed by RJAH NHS FT with a fund investment maximum per banking organisation as per FSA protection.

We have an Investment and Reserves Policy which was passed by the Committee and will be reviewed annually. This is discussed in greater detail in the Finance section.

Partnership Working and Networks

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is a related party by virtue of being our corporate trustee. By working in partnership with the Trust, the charitable funds are used to best effect. When deciding upon the most beneficial way to use charitable funds, the corporate trustee has regard to the main activities, objectives, strategies and plans of the NHS Foundation Trust. However, overriding this, the corporate trustee is required by the Charity Commission to ensure all decisions are made in our interest to further our charitable objects and that there is a clear and open process of decision making by the corporate trustee.

The trustee safeguards our independence by ensuring that sound governance arrangements are in place, in line with guidance issued by the Charity Commission.

We are a member of the Association of NHS Charities. A representative attends the Members' Interests Group, together with representatives of over 100 other NHS charities, where topics of mutual interest are disseminated and discussed with experience and advice shared.

Public Benefit Statement

The activities carried out for the public benefit by us, in partnership with Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, are broadly covered by the aims to:

- enhance the provision of high quality patient care for the public benefit;
- support research in areas relevant to the hospital's activity and patients, making such research publicly available; and
- support the provision of healthcare free at the point of need and care for the patients, families, carers and staff by focusing on areas not covered or fully supported by central NHS funds.

When setting these objectives and carrying out the activities described below the trustee has regard to both the Charity Commission's general guidance on public benefit and our objectives.

Reserves

Our reserves policy takes note of the Charity Commission publication CC19 Charities and Reserves and requires a minimum balance of reserves to meet 3 months of expected expenditure.

This publication defines reserves as being that part of a charity's unrestricted funds that is freely available to spend on any of a charity's purposes. This definition excludes restricted income funds, although holding such funds may influence a charity's reserve policy. Reserves will also normally exclude amounts designated for essential future spending.

Charity law requires any income received by a charity to be spent within a reasonable period of receipt and trustees should be able to justify the holding of this income as reserves.

The reserve is calculated as being that part of this charity's unrestricted funds that is freely available after taking account of designated funds which have been earmarked for specific purposes.

Calculation of reserves held as at 31 March 2018	
Total Funds	£906,000
Less restricted	(£0)
Less designated	(£761,000)
Reserves	**£145,000**

The reserve amount of £145,000 held as at 31 March 2018 is sufficient to meet the 3 months support cost target of £11,000 and a large part of the designated funds that have not been earmarked for specific expenditure so are available to the CFC for reallocation should the need arise. Our reserves are slightly higher than the £119,000 held as at 31 March 2017. The CFC is mindful of the Charity Commission's requirement that funds be spent in a timely manner and that reserve levels should not be high.

Going concern consideration

We have a duty to consider the future viability of the charity and whether we believe we will continue as a going concern.

The CFC has reviewed our status on behalf of the Corporate Trustee and has come to the conclusion there are no material uncertainties about our ability to continue as a going concern. Nor are we aware of any material uncertainties affecting the current year's accounts.

The CFC receives regular reports on our financial status, including current assets held and future expenditure committed to. They review the value of the actual reserves held compared to the

minimum reserve target, which has been set to cover four months of normalised spend. They consider estimated future revenue streams.

In future years, the key risk to us is a fall in income from donations or legacies. However, we do not commit to expenditure above the funds held at any time and thus are able to respond to a reduction in income by reductions in grant expenditure. Having taken these areas into consideration, the CFC has a reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future. See the risk management and reserves sections of the annual report for more information.

For this reason, we consider the going concern assumption is an appropriate basis on which to prepare these financial statements

Investment policy

The Trustees have adopted a prudent investment policy in the face of an uncertain financial climate. The policy is also informed by cash flow requirements, in particular the expectation of any significant expenditure or fundraising due to occur.

The Trustees have decided not to invest in equities and to place the funds on deposit, having due regard to the security rating of the investment bodies, with a view to maximising the return whilst maintaining security. This decision will be reviewed in the light of any improvement or positive change to the investment market.

The Trustees have decided that if, in the future, funds were to be invested in equities then no investment would be made in companies which derive a substantial amount of their profit from investment in tobacco, gambling or alcohol.

At the end of 2017-18 no funds were invested long term and all funds were either held with the Government Banking Service in our current account or in an instant access account with Lloyd's Bank plc which paid a higher rate of interest.

Present and Future Projects

- Veterans' Orthopaedic Centre Appeal (VOCA)

The Charity is proud to announce this appeal, launched in 2018/19 to help fund a new £1.5 million Veterans' Orthopaedic Centre at our specialist orthopaedic hospital, the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, to treat veteran patients in a bespoke care environment.

The current service, the first of its kind in the UK, delivers two outpatient clinics per month and is open to those who have served with the UK military, including National Service. It mostly treats arthritic lower limb problems, especially those requiring hip and knee replacements. The service is led by Lt Col. Carl Meyer, a consultant military orthopaedic surgeon at RJAH. This is an NHS service, provided exclusively for veterans.

We would like to develop the Veterans' Service by providing a dedicated environment specifically designed for their care and expanding the service to cover the whole range of orthopaedic treatment and rehabilitation and connecting to other healthcare services. The new, purpose designed Centre will be built to the highest standards and have a more familiar military feel to make our veteran patients more comfortable. It will provide a modern, state of the art facility in line with the Trust's vision to be the leading centre in orthopaedic care.

The aim is to complete the fundraising by September 2019. Any monies raised above the total will be used to further develop the patient experience with, for example, specialist equipment and furnishings.

We are extremely grateful to our Appeal Patrons:

Dame Vera Lynn CH OBE OStJ
The Second World War forces sweetheart, who remains a passionate supporter of the Armed Forces to this day. During the war she toured Egypt, India, and Burma as part of ENSA, giving outdoor concerts for the troops. Dame Vera released the album Vera Lynn 100 in 2017, to commemorate her centennial year. Dame Vera has devoted much time and energy to charity work connected with ex-servicemen, she is held in great affection by veterans of the Second World War to this day

Message from Dame Vera Lynn

"We owe veterans a great debt of gratitude, and I was encouraged to hear about the hospital's (RJAH) work treating more than 1000 patients with knee and hip problems as it means we are doing our duty to care for them after they have done so much

Dame Kelly Holmes
Dame Kelly began competing in middle distance events in her youth. She joined the British Army, but continued to compete at the organisation's athletics events. She took part in her final major championship in 2004, with a double gold medal-winning performance at the Athens Olympics, finishing as the 800m and 1500m Olympic Champion.

Message from Dame Kelly Holmes

I am delighted to be able to offer my patronage and support to the Veterans' Orthopaedic Service at The Robert Jones and Agnes Hunt Orthopaedic Hospital. As a proud veteran, I recognise the need for a first class medical support service for our veterans who have given so much for their country."

Brigadier Kevin Beaton OBE

One of the army's most senior medics. After a degree in history and politics he went to Sandhurst and then later left the military to study medicine. He is a GP who has served in the Balkans, Sierra Leone, Afghanistan and Iraq. He has been a doctor for military families and battle groups as well as having commanded a Medical Squadron, Medical Regiment, Field hospital and a Medical Brigade. Most recently he was the Military Medical lead for the UK Ebola response to West Africa.

Richard Kilty

Richard Kilty is a Lead Member of Team GB Sprint Team, a World and European 60 metre Indoor Champion and Gold Medal Winner at the 2018 Commonwealth Games. Richard started running competitively aged eight years old and has represented Great Britain at every age category

throughout his career. He is a passionate supporter of youth development and in recognition of this, in August 2018 was appointed an Honorary Colonel in The Army Cadet Force.

Garry Herbert MBE

The rowing cox who won gold at Barcelona in 1992 when he steered the British coxed pair to victory. Garry steered the British coxed pair (brothers Jonny and Greg Searle) to victory in the 1992 Barcelona Olympics and the 1993 World Rowing Championships. He is now a banker and a commentator for the BBC as well as a motivational speaker.

Lt. Colonel Ian Sawers

Lt Col Ian Sawers was appointed Deputy Chief Executive NW RFCA in 2002 after a career in the Army which included appointments as Protocol Staff Officer at HQ Berlin (British Sector); OC Regimental Signal Officers Wing at the School of Infantry; Principal Land Warfare Staff Officer at HQ Baltic Approaches in Denmark – a NATO appointment; CO 7th (Durham) Battalion the Light Infantry; and, Chief G2/G3 at HQ Wales and Western District. His voluntary duties include being the RIFLES City Colonel for Merseyside, the Shropshire County Coordinator for Help for Heroes.

More details may be found at https://www.rjah.nhs.uk/voca.

As always, the many changes in the NHS continue to shape the environment in which we operate. The reconfiguration of services and plans for redesigning patient care to meet the needs of the future will continue to influence the priorities for spending charitable funds.

The Trustees continue to review the expenditure plans for the designated funds.

Approved on behalf of the corporate trustee

Frank Collins
Chairman
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
22 January 2019

Trustee's statement of responsibilities

The trustee is responsible for preparing the Trustee's Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland".

The law applicable to charities in England and Wales requires the trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing these financial statements, the trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgments and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Signed on behalf of the trustee:

Frank Collins
Chairman
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
22 January 2019

Independent auditor's report to the Trustees of the Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund

Report on the audit of the financial statements

Opinion
In our opinion the financial statements of The Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund (the 'charity'):

- give a true and fair view of the state of the charity's affairs as at 31 March 2018 and of incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice, including Financial Reporting Standard 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland"; and
- have been prepared in accordance with the Charities Act 2011 and the trust deed.

We have audited the financial statements which comprise:

- the Statement of Financial Activities;
- the Balance Sheet;
- the Cash Flow Statement;
- the related notes 1 to 20.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland" (United Kingdom Generally Accepted Accounting Practice).

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the [group and of the parent] charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern
We are required by ISAs (UK) to report in respect of the following matters where:

- the trustees' use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the charity's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Other information
The trustees are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially

misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

Responsibilities of trustees
As explained more fully in the trustees' responsibilities statement, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the [group's and the parent] charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the [group or the parent] charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements
We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with the Act and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Matters on which we are required to report by exception
Under the Charities (Accounts and Reports) Regulations 2008 we are required to report in respect of the following matters if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the
- trustees' report; or
- sufficient accounting records have not been kept by the parent charity;
- we have not received all the information and explanations we require for our audit.
-

We have nothing to report in respect of these matters.

Use of our report
This report is made solely to the charity's trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Deloitte LLP

Deloitte LLP
Statutory Auditor
Leeds, United Kingdom

Deloitte LLP is eligible for appointment as auditor for the charity by virtue of its eligibility for appointment as audit of a company under section 1212 of the Companies Act 2006

Registered Charity No. 1058878

THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL CHARITY

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2018

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2018

	Note	2017-18 Unrestricted funds	2017-18 Restricted funds	2017-18 Total funds	2016-17 Unrestricted funds	2016-17 Restricted funds	2016-17 Total funds
		£000	£000	£000	£000	£000	£000
Income from:							
Donations and legacies	4	299	0	**299**	400	6	406
Other trading activities - fundraising	5	57	0	**57**	61	15	76
Investments - interest on cash deposits	6	2		**2**	3	0	3
Total incoming resources		358	0	**358**	464	21	485
Expenditure on:							
Raising funds	7	(18)		**(18)**	(34)	0	(34)
Charitable activities	8	(260)		**(260)**	(1,068)	(144)	(1,212)
Total expenditure		(278)	0	**(278)**	(1,102)	(144)	(1,246)
Net income/(expenditure) for the year		80	0	**80**	(638)	(123)	(761)
Transfers between funds	10	0	0	**0**	0	0	0
Net movement in funds		**80**	**0**	**80**	(638)	(123)	(761)
Reconciliation of funds:							
Total funds brought forward		826	0	**826**	1,464	123	1,587
Net movement in funds for the year		80	0	**80**	(638)	(123)	(761)
Fund balances carried forward at 31 March		**906**	**0**	**906**	826	0	826

There were no other recognised gains and losses for the year. All income and expenditure derives from continuing activities.

Notes from 1 to 20 form part of these Financial Statements

BALANCE SHEET AS AT 31 MARCH 2018

	Note	2017-18 Unrestricted funds	2017-18 Restricted funds	2017-18 Total funds	2016-17 Unrestricted funds	2016-17 Restricted funds	2016-17 Total funds
		£000	£000	£000	£000	£000	£000
Current assets							
Debtors	11	156	0	156	97	0	97
Cash at bank and in hand	12	834		834	761	0	761
		990	0	990	858	0	858
Creditors: amounts falling due within one year	13	(84)	0	(84)	(32)	0	(32)
Net current assets		906	0	906	826	0	826
Total assets less current liabilities		906	0	906	826	0	826
Net assets		**906**	**0**	**906**	826	0	826
Funds							
Unrestricted funds:							
General fund		145	0	145	119	0	119
Designated funds		761	0	761	707	0	707
Total funds	14	**906**	**0**	**906**	826	0	826

Notes from 1 to 20 form part of these Financial Statements

These Financial Statements of the Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund, registered number 1058878, were approved by the Charitable Funds Committee on behalf of the corporate trustee and authorised for issue on 22 January 2019.

They were signed on its behalf by:

Frank Collins
Chairman
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
22 January 2019

CASHFLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2018

	Note	2017-18 Unrestricted funds	2017-18 Restricted funds	2017-18 Total funds	2016-17 Unrestricted funds	2016-17 Restricted funds	2016-17 Total funds
		£000	£000	£000	£000	£000	£000
Net cash flows from operating activities	15	71	0	**71**	(923)	(408)	(1,331)
Cash flows from investing activities:							
Interest received		2	0	**2**	3	0	3
Net cash flows from investing activities		2	0	**2**	3	0	3
Net increase/(decrease) in cash and cash equivalents		73	0	**73**	(920)	(408)	(1,328)
Cash and cash equivalents at beginning of year		761	0	**761**	1,681	408	2,089
Cash and cash equivalents at end of year		**834**	**0**	**834**	761	0	761

Notes to the Financial Statements for the year ending 31 March 2018

Note 1: Accounting Policies

These accounting policies have been consistently applied throughout the Financial Statements and their associated notes.

Basis of accounting

The financial statements were prepared under the historical cost convention, in accordance with the Statement of Recommended Practice "Accounting and Reporting by Charities (SORP 2015)" applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102), effective 1 January 2015: and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2016.

We are a public benefit entity, a registered charity and its registered office is given on page 21.

Preparation of financial statements – going concern basis

On behalf of the Corporate Trustee, the Charitable Funds Committee considers there are no material uncertainties about our ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

The Charitable Funds Committee receives regular reports on our financial status, including current assets held and future expenditure committed to. They review the value of the actual reserves held compared to the minimum reserve target, which has been set to cover three months of normalised spend. They consider estimated future revenue streams.

In future years, the key risk to us is a fall in income from donations or legacies. We do not commit to expenditure above the funds held at any time and thus is able to respond to a reduction in income by reductions in grant expenditure. Having taken these areas into consideration, the Corporate Trustee has a reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future. See the risk management and reserves sections of the annual report for more information.

For this reason, they consider the going concern assumption is an appropriate basis on which to prepare these financial statements.

Note 1: Accounting Policies (continued)

Income

a) All income is included in full in the Statement of Financial Activities as soon as the following three factors can be met:

   i) Entitlement – arises when a particular resource is receivable or our right becomes legally enforceable.

   ii) Probability – when there is reasonable probability that the income will be received.

   iii) Measurement – when the monetary value of the income can be measured reliably.

b) Donations

   Donations are accounted for as income on receipt.

c) Legacies

   Legacies are accounted for as income either on receipt or once the receipt of the legacy becomes probable.

   Receipt is probable when:

   - Confirmation has been received from the representatives of the estate(s) that probate has been granted.
   - The executors have established there are sufficient assets in the estate to pay the legacy, and
   - All conditions attached to the legacy have been fulfilled or are within our control.

   If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy, where material, is shown as a contingent asset until all of the conditions for income recognition are met.

d) Grants receivable

   Grants receivable are accounted for as incomes either on receipt or once receipt becomes probable.

   Receipt is probable when all the conditions attached to the grant have been fulfilled or are within our control.

e) Interest receivable

   Interest receivable is accounted for on receipt and where a reasonable estimate may be made for interest relating to the period but not yet received which is accrued for.

f) Donated goods and services

   The charity received no donated goods or services.

Note 1: Accounting Policies (continued)

Expenditure

Expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

Grants payable are authorised in line with the delegated authority limits of the Charitable Funds Committee and all grants are made to the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in the furtherance of our objectives.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Expenditure is classified under the following activity headings:

a) Expenditure on raising funds

Expenditure on raising funds includes the costs incurred in generating fundraising income together with investment management fees, when applicable. Fundraising costs include expenses for fundraising activities and any fee paid for fundraising support.

No fundraising staff are employed.

b) Charitable activities

Expenditure on charitable activities is wholly in the form of grants made to linked, related party or third party NHS bodies and non NHS bodies in furtherance of the charitable objectives of the funds held on trust, primarily to benefit the National Health Service, wholly or mainly for the service provided by the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust. It includes all costs incurred in the pursuit of our charitable objects. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs is shown in note 9.

Grants payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment. A constructive obligation arises when:

i) We have communicated our intention to award a grant to a recipient who then has a reasonable expectation they will receive a grant.
ii) We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation they will receive a grant.
iii) There is an established pattern of practice which indicates to the recipient we will honour our commitment.

On behalf of the Corporate Trustee, the Charitable Funds Committee have control over the amount and timing of material grant payments and consequently where approval has been given by the trustees and any of the above criterial have been met then a liability is recognised. Where a grant is awarded with conditions attached, these conditions have to be met before the liability is recognised.

Where an intention has not been communicated then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether any conditions will be met then no liability is recognised but a contingent liability is disclosed.

Note 1: Accounting Policies (continued)

c) Support costs

Support Costs are those functions that assist but do not directly undertake charitable activities. Support costs are the costs of staff administering our income and expenditure, audit costs and other expenditure incurred in our day to day running. These costs have been allocated between the cost of raising funds and expenditure on charitable activities. The bases on which support costs have been allocated are set out in note 9.

d) Governance costs

Governance costs are classed as support costs and have, therefore, been apportioned between fundraising activities and charitable activities.

Fund structure

Where there is a legal restriction on the purpose to which a fund may be spent, the fund is classified in the Financial Statements either as a:

- Restricted fund or
- An endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. Our restricted funds tend to result from appeals for specified purposes.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are sub analysed between those where the trustee has the discretion to spend the capital (expendable endowment) and those where there is no discretion to expend the capital (permanent endowment). We currently hold no endowment funds.

Neither those funds which are endowment nor restricted funds are unrestricted funds which are sub analysed between designated (earmarked) funds where the trustee has set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and an unrestricted general fund which are at the trustee's discretion and represents our reserves.

The major funds held in each of these categories are disclosed at note 14.

Financial Instruments

Financial assets and financial liabilities are recognised when we become party to the contractual provisions of the instrument. All financial assets and liabilities are initially measured at transaction price (including transaction costs). We only have financial assets and financial liabilities of a kind that qualify as basic financial instruments which are initially recognised at transaction value and subsequently measured at their settlement value.

Debtors

Debtors are amounts owed to us. They are measured on the basis of their recoverable amount, see note 11.

Note 1: Accounting Policies (continued)

Cash and cash equivalents

Cash at bank and in hand is held to meet our day to day running costs as they fall due. Cash equivalents are short term, highly liquid investments and usually short notice interest bearing savings accounts.

Creditors

Creditors are amounts owed by us. They are measured at the amount that we expect to have to pay to settle the debt.

Pooling Scheme

We do not have an official pooling scheme.

Except where restricted funds are invested separately, all returns on any investments, including interest earned on short-term cash deposits, are apportioned on an average funds balance basis to the value of funds they relate to. The values of any separately invested funds are deducted from restricted funds values prior to apportionment. The Charitable Funds Committee believes this to be a fair and consistent approach. Any gains or losses made on the funds invested separately for restricted funds are solely allocated to the relevant restricted fund.

Note 2: Critical accounting judgements and key sources of estimation uncertainty

In the application of our accounting policies, which are described in note 1, the Charitable Funds Committee as agent of the Corporate Trustee are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The Charitable Funds Committee does not consider there are any critical judgements or sources of estimation uncertainty requiring disclosure.

Note 3: Related Parties

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH FT), the patients of which are our main beneficiaries, is our Corporate Trustee. We have made revenue and capital grant payments to RJAH FT for the benefit of NHS patients and these are detailed in note 8.

None of the members of the RJAH FT Board or parties related to them has undertaken any transactions with us or received any benefit from us in payment or kind.

The RJAH FT makes a number of clerical and transaction services available to us for administrative services at a cost of £36,000 (£38,000 2016/17) - see note 9. The amount recovered is set at a level to allow RJAH FT to recover its costs. The total number of hours recharged to the charity remained the same as for 2016/17 and the reduction in cost reflects the lower incremental bandings of staff in post during 2017/18.

3.1 Related party transactions

	Charitable Expenditure	**Fundraising**	**Total 2017-18**	Total 2016-17
	£000	**£000**	**£000**	£000
RJAH NHS FT reimbursement of pay costs	36	0	**36**	38
RJAH NHS FT reimbursement of non-pay costs	59	0	**59**	1,053
Total	95	0	**95**	1,091

3.2 Related party balances

	Debtors		**Creditors**	
	Total 2017-18	Total 2016-17	**Total 2017-18**	Total 2016-17
	£000	£000	**£000**	£000
RJAH NHS FT [1]	156	2	**10**	27
Total	156	2	**10**	27

[1]The 2017-18 debtor value includes £155k banked in March 2018 for three legacies.

Note 4: Analysis of income from donations, legacies and grants

	Unrestricted 2017-18 £000	Restricted 2017-18 £000	**Total 2016-17 £000**	Total 2016-17 £000
Legacies[1]	189	0	**189**	345
Donations[2]	110	0	**110**	61
General Grants	0	0	**0**	0
Total	299	0	**299**	406

[1] Payments from nine legacies were accounted for in 2017-18, ranging from £0.5k to £90k, of which three payments totalling £155k were received in early 2018-19 and accrued for in these accounts.

[2] Donations from individuals are gifts from members of the public, relatives of patients and staff. Other donations include corporate donations usually received in sponsorship of or matching funds raised by an individual, e.g. from their employer.

Note 5: Analysis of income from other trading activities

	Unrestricted 2017-18 £000	Restricted 2017-18 £000	**Total 2017-18 £000**	Total 2016-17 £000
Fundraising				
Virgin London Marathon	56	0	**56**	37
Guttmann conference (Spines)	0	0	**0**	36
Concert	0	0	**0**	2
Ultra Challenges	1	0	**1**	0
Other - aggregate	0	0	**0**	1
Total	57	0	**57**	76

The increase in funds from our Virgin London Marathon charity places reflects the increase in the number of places take up in 2017-18 compared to 2016-17.

The Guttmann conference is a prestigious annual conference hosted at a different site each year.

Note 6: Analysis of income from investments

	Unrestricted 2017-18 £000	Restricted 2017-18 £000	**Total 2017-18 £000**	Total 2016-17 £000
Interest received on cash deposits	2	0	**2**	3
Total	2	0	**2**	3

Note 7: Analysis of expenditure on raising funds

	Unrestricted 2017-18 £000	Restricted 2017-18 £000	**Total 2017-18 £000**	Total 2016-17 £000
Concert	0	0	**0**	1
London Marathon	7	0	**7**	6
Veterans' Clinic Appeal	2	0	**2**	0
Gutman conference - Spines	2	0	**2**	24
Other costs of raising funds	4	0	**4**	2
Support costs	3	0	**3**	1
Total	18	0	**18**	34

Expenditure is rounded to the nearest £1,000 and zero expenditure reflects spend of under £500.

Note 8: Analysis of expenditure on charitable activities

8.1 Analysis of expenditure by activity

Analysis of expenditure by activity	Grant Funded Activity 2017-18 £000	Support Costs* 2017-18 £000	**Total 2017-18 £000**	Total 2016-17 £000
Building and refurbishment	10	2	**12**	1,040
Equipment	59	11	**70**	12
Medical research	32	6	**38**	73
Patient education and welfare	14	2	**16**	8
Staff education and welfare	105	19	**124**	79
Total	220	40	**260**	1,212

* Support costs are allocated over grants payable on an expenditure value basis - see Note 9 for further analysis.

8.2 Analysis of expenditure by fund type

	Unrestricted 2017-18 £000	Restricted 2017-18 £000	**Total 2017-18 £000**	Total 2016-17 £000
Building and refurbishment	12	0	**12**	1,040
Equipment	70	0	**70**	12
Medical research	38	0	**38**	73
Patient education and welfare	16	0	**16**	8
Staff education and welfare	124	0	**124**	79
Total	260	0	**260**	1,212

We do not make grants to individuals. All grants are made to the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to provide for the care of NHS patients in furtherance of our charitable objectives. The cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity is disclosed in Note 8.1 above.

Note 9: Analysis of support costs - basis of allocation is percentage of expenditure

9.1 Support costs

	Unrestricted Funds 2017-18 £000	**Restricted Funds 2017-18 £000**	**Total 2017-18 £000**	Total 2016-17 £000
Salary recharges	36	0	**36**	38
External audit fee	5	0	**5**	5
Other non-pay costs	2	0	**2**	3
Total	43	0	**43**	46

Support costs are allocated over grants payable and cost of fundraising on an expenditure value basis as shown in notes 9.2 and 9.3. and included £11,500 for governance costs (2016-17 £13,700). Non-pay includes audit fees paid to Deloitte LLP and its associates of £4,800 (2016-17 £4,800). There were no non-audit fees paid to Deloitte LLP in either year.

No member of staff is directly employed by the charity. The funds are administered by the RJAH NHS FT staff with a proportion of their salary recharged to the charity.

9.2 Support Costs allocation by fund type

9.2.1 Support Costs allocation by fund type 2017-18

	Unrestricted funds expenditure 2017-18	**Unrestricted support costs allocated 2017-18**	**Unrestricted Total 2017-18**	**Restricted funds expenditure 2017-18**	**Restricted support costs allocated 2017-18**	**Restricted Total 2017-18**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Raising funds	15	3	**18**	0	0	**0**
Building and refurbishment	10	2	**12**	0	0	**0**
Equipment	59	11	**70**	0	0	**0**
Medical Research	32	6	**38**	0	0	**0**
Patient education and welfare	14	2	**16**	0	0	**0**
Staff education and welfare	105	19	**124**	0	0	**0**
Total	235	43	**278**	0	0	**0**

9.2.2 Support Costs allocation by fund type 2016-17

	Unrestricted funds expenditure 2016-17	Unrestricted support costs allocated 2016-17	Unrestricted Total 2016-17	Restricted funds expenditure 2016-17	Restricted support costs allocated 2016-17	Restricted Total 2016-17
	£000	£000	£000	£000	£000	£000
Raising funds	33	1	34	0	0	0
Building and refurbishment	859	37	896	143	1	144
Equipment	11	1	12	0	0	0
Medical Research	70	3	73	0	0	0
Patient education and welfare	8	0	8	0	0	0
Staff education and welfare	76	3	79	0	0	0
Total	1,057	45	1,102	143	1	144

9.3 Support Costs allocation by expenditure type

	Expenditure 2017-18	**Support costs allocated**	**Total 2017-18**	Expenditure 2016-17	Support costs allocated	Total 2016-17
	£000	**£000**	**£000**	£000	£000	£000
Raising funds	15	3	**18**	33	1	**34**
Building and refurbishment	10	2	**12**	1,002	38	**1,040**
Equipment	59	11	**70**	11	1	**12**
Medical research	32	6	**38**	70	3	**73**
Patient education and welfare	14	2	**16**	8	0	**8**
Staff education and welfare	105	19	**124**	76	3	**79**
Total	235	43	**278**	1,200	46	**1,246**

Note 10: Analysis of transfers

No transfers were made between restricted and unrestricted funds in 2017-18. In 2016-17 less than £500 was transferred between the unrestricted General Fund and the restricted Oswestry Bone Cancer Centre Appeal fund to reimburse the restricted fund for the cost of non-pay support costs in line with the unrestricted designated funds.

Note 11: Analysis of debtors

	31 March 2018	31 March 2017
	£000	£000
Amounts receivable within one year:		
Accrued income[1]	**0**	95
Amounts due from RJAH NHS Foundation Trust [2] for receipts on charity's behalf	**156**	2
Total debtors receivable within one year	**156**	97

[1]Outstanding legacy income, actual receipt was June 2017.

[2]Includes £155k for three legacy receipts.

Note 12: Analysis of cash and cash equivalents

	31 March 2018	31 March 2017
	£000	£000
Cash in current bank account	**330**	258
Notice deposit accounts (less than 3 months)	**504**	503
Total cash and cash equivalents	**834**	761

The notice deposits are sums held on interest bearing deposit with any bank and represent restricted appeals and funds held to facilitate cash flow and the fulfilment of obligations to make grant payments. The funds are held in instant access accounts and are, therefore, classified as cash and cash equivalents.

No cash or cash equivalents were held in non-cash investments or outside of the UK.

All the amounts held on interest bearing deposit are available to spend on charitable activities.

The relatively small movement in the cash balance held as at 31 March 2018 from 31 March 2017 reflects expenditure nearly matching income received by the charity.

Note 13: Analysis of Creditors

	31 March 2018	31 March 2017
	£000	£000
Amounts falling due within one year:		
Trade creditor accruals*	**10**	5
Accruals for grants owed to RJAH NHS FT	**74**	27
Total creditors falling due within one year	**84**	32

* The trade creditor accrual relates to an accrual for 2 years of external audit fees.

Amounts owed to related undertakings are non-interest bearing and repayable on demand.

Note 14: Details of material funds

14.1.1 Current year movement in material funds – restricted

There were no restricted funds held by the charity during the financial year.

14.1.2 Prior year movement in material funds – restricted

	Balance 31 March 2016	Income	Expenditure	Transfers	**Balance 31 March 2017**
	£000	£000	£000	£000	**£000**
A Oswestry Bone Cancer Centre Appeal	123	21	(144)	0	**0**
Total	312	116	(311)	6	**123**

14.2 Details of material funds – restricted

Name of fund	Description of the nature and purpose of each fund
A Oswestry Bone Cancer Centre Appeal	These were funds raised via the Oswestry Bone Cancer Centre Appeal set up to help fund a new Bone Cancer Centre to treat patients in a bespoke care environment. This was a short-term fund which ended with the completion of the new centre in 2016. All funds were committed for payment over to RJAH NHS FT, subject to completion of the project. The fund was closed by March 2017.

14.3.1 Current movement in material funds – unrestricted

	Balance 31 March 2017	Income	Expenditure	Transfers	Balance 31 March 2018
	£000	£000	£000	£000	£000
B Arthritis & Rheumatism	343	64	(48)	0	**359**
C MCSI unrestricted	247	18	(31)	0	**234**
D General	119	189	(163)	0	**145**
G Aggregate of remaining unrestricted funds	117	87	(36)	0	**168**
Total	826	358	(278)	0	**906**

14.3.2 Prior year movement in material funds – unrestricted

	Balance 31 March 2016	Income	Expenditure	Transfers	Balance 31 March 2017
	£000	£000	£000	£000	£000
B Arthritis & Rheumatism	427	1	(85)	0	**343**
C MCSI unrestricted	240	48	(41)	0	**247**
D General	14	196	(91)	0	**119**
E Site development	618	199	(817)	0	**0**
F Bone Cancer Centre	44	0	(44)	0	**0**
G Aggregate of remaining unrestricted funds	121	20	(24)	0	**117**
Total	1,464	464	(1,102)	0	**826**

14.4 Details of material funds – unrestricted

Name of fund	Description of the nature and purpose of each fund
B Arthritis & Rheumatism	A designated fund within the charity's general fund set up for arthritis and rheumatism related research and staff and patient welfare. Fund balance as at 31 March 2018 was £359,000 (31 March 2017 was £343,000).
C MCSI	A designated fund within the charity's general fund to benefit the patients and staff of the Spinal Injuries Unit known as the Midlands Centre for Spinal Injuries (MCSI). Fund balance as at 31 March 2018 was £234,000 (31 March 2017 £247,000).
D General Fund - undesignated	This fund is where all the unrestricted funds of the charity which have not been designated are shown. They are freely available to be used to further the objectives of the charity, within the specified authorisation limits. Thanks to a generous legacy replenishing funds spent on the new theatres, the fund balance as at 31 March 2018 was £145,000 (31 March 2017 £117,000).
E Site Development	This was set up during 2014-15 to separately designate funds which the charity planned to contribute towards the new Theatre Development. This development was completed in conjunction with the provision of a dedicated Tumour Unit, the Oswestry Bone Cancer Centre and was satisfactorily completed during 2016. Subsquently, the remaining funds were paid over leaving a nil balance as at 31 March 2017.
F Bone Cancer Centre	These were unrestricted funds which the charity allocated towards the new Bone Cancer Centre, being a share of a past legacy given for the benefit of patients of a ward where many cancer and tumour cases were treated. The ward has since closed as part of the site redevelopment works and the related funds re-allocated to follow the patients. The remaining funds were paid over during 2016 leaving a nil balance as at 31 March 2017.
G Aggregate of remaining unrestricted funds	15 designated funds (15 as at 13 March 2017). Each fund has a balance below 10% of the total value of the unrestricted funds. They mainly comprise funds held for wards and therapy areas. The total balance held in these funds as at 31 March 2018 was £168,000 (31 March 2017 £117,000).

Note 15: Reconciliation of cash flow net income/(expenditure) from operating activities

	Unrestricted funds	Restricted funds	Total funds 2017-18	Total funds 2016-17
	£000	£000	£000	£000
Net income for the year	80	0	**80**	(761)
Adjustment for interest receivable	(2)	0	(2)	(3)
Operating cash flow before movement in working capital	78	0	78	(764)
Decrease / (increase) in debtors	(59)	0	**(59)**	2
(Decrease) / increase in creditors	52	0	**52**	(569)
Cash generated by operating activities	71	0	**71**	(1,331)

Note 16: Financial Instruments

16.1 Financial risk management

Financial reporting standard FRS 102 requires disclosures on the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because we are a grant making charity only and do not rely on income from activities with their related contract performance risks, we are not exposed to a significant degree of financial risk. Our investment policy limits the investment of surplus funds to institutions with a low risk rating. Financial assets and liabilities are generated by day-to-day operation activities rather than being held to change the risks facing us in undertaking its activities.

Our treasury management operations are carried out by the finance department of the RJAH NHS FT within parameters defined formally within our governing document and Charitable Funds Committee Terms of Reference.

Currency risk

We are principally a domestic organisation with the great majority of our transactions, assets and liabilities being in the UK and sterling based. We have no overseas operations. We, therefore, have low exposure to currency rate fluctuations.

Interest rate risk

We hold no loans and do not rely to any significant degree on income from cash deposits and, therefore, have low exposure to interest rate fluctuations. We have no borrowings.

Credit risk

With the majority of our income coming from voluntary donations and legacies, we are considered to have a low exposure to credit risk.

Liquidity risk

We only commit to fund grant expenditure to the extent that funds are available. We hold no investments which could not be made available within 24 hours and, therefore, have a low exposure to liquidity risk. There would be an interest reduction penalty applied where early access is required of funds held in term deposits.

16.2 Financial assets

	31 March 2018 £000	31 March 2017 £000
Trade and other receivables excluding non-financial assets	**156**	97
Cash and cash equivalents	**834**	761
Total financial assets	**990**	858

The receivables held by us are reported at historical cost as they are all current and this is considered to be an appropriate measurement of their value to us.

16.3 Financial liabilities

	31 March 2018 £000	31 March 2017 £000
Trade and other payables excluding non-financial liabilities	**84**	32
Total financial assets	**84**	32

The payables held by us are reported at historical cost as they are all current and this is considered to be an appropriate measurement of our liabilities.

Note 17: Contingencies

There are no contingent gains or (losses) included in the accounts.

Note 18: Commitments, liabilities and provisions

We have no commitments or liabilities not recognised in these Financial Statements and have made no provisions.

Note 19: Trustee indemnity insurance

There was no expenditure on Trustee indemnity insurance in either 2017-18 or 2016-17 as the RJAH NHS FT is the Corporate Trustee with the Trust Board acting as its agents rather than Trustees in their own right.

Note 20: Trustee and key managers' remuneration

None of the RJAH FT Trust Board received any remuneration from the charity in 2017-18 (2016-17 nil).

There are no key management personnel costs incurred by us either directly or recharged by RJAH NHS FT. The charity is overseen by the Charitable Funds Committee on behalf of the RJAH NHS FT Board which, in turn, is acting on behalf of the RJAH NHS FT as our corporate trustee. Details of the RJAH NHS FT's key management personnel may be seen in their 2017-18 Annual Report and Financial Statements available on their website at the following link: www.rjah.nhs.uk.

Evaluation of Effectiveness of Expenditure 2017/18

Area of Expenditure	£	Narrative (figures quoted where > £10k)	Outcomes & Meeting Objective of the Charity
Patients			
Environment/Experience	**£19,660**	New blinds for Kenyon Ward, maintenance of the fish-tank on the main corridor, wheelchair user friendly picnic bench outside Denbighs, patient/family/staff party on Spinal Injuries, craft materials for patients on the Children's Unit and Easter, Christmas and birthday gifts. In addition, SKY television subscription for Spinal Injuries, portable DVD players and new books for the Patient Library, garden pots for the Tumour Unit garden, adjustable over-bed tables for Sheldon Ward and high-backed chairs for the Children's Unit, hairdressing for a patient and rehabilitation outings for Spinal Injuries' patients.	Benefits patients by providing an enhanced environment which will lead to a more pleasant experience
Research	**£32,275**	Second and final part of grant to Keele University for preliminary research into progressing a stem-cell based therapy for refractory rheumatoid arthritis (RA)	Benefits patients by increasing knowledge in these fields and potentially contributing to future treatments or equipment. All research projects are supported by the Trust's Research Committee
Equipment	**£56,976**	**Trust Wide** - £23k Pharmacy temperature monitoring system. **Hand Unit** - Portable diagnostic ultrasound machine. **Children's Unit -** mobile privacy screen, paediatric tilt table, tamper-proof notice boards and maintenance of Echo machine previously purchased by the charity. **Sheldon Ward** - Chair sensor system. **Bone Bank -** -86' C upright freezer. **MCSI** - pressure mapping equipment, arm support with table-mount, suppository gun. **Tumour Unit/Oswald Ward** - observation monitors. **Pain Clinic** - plastic skeleton. **Phlebotomy** - specialist chair.	Benefits patients by providing additional and specialised equipment beyond that funded by NHS funds
Other	**£4,696**	**MCSI -** provision of a Modern Apprentice to provide administrative resources around the improvement of networking and support activities for patients plus project management fees for the feasibility study regarding an SIU Gym.	Benefits patients by improving morale and standards of communication

Evaluation of Effectiveness of Expenditure 2017/18

Area of Expenditure	£	Narrative (figures quoted where > £10k)	Outcomes & Meeting Objective of the Charity
Staff			
Training and Education	**£60,977**	Training expenditure which is subject to the Foundation Trust's policies and includes a £50k fund administered by Human Resources, refreshment for on-site training courses, support for staff to attend conferences and subscriptions to professional publications e.g. Nursing Times and Core Orthopaedic Journal.	Benefits patients by improving staff with additional knowledge and skills which may be both directly beneficial to patients and also improve staff morale and interest in their jobs
Staff Rewards	**£34,722**	Staff Awards Evening at which staff and teams who had demonstrated an outstanding attitude or achiements are recognised, vouchers for long service awards along with the cost of leaving/retirement ceremony's and gifts, attending HSJ Patient Safety Awards (£10k), attending Nursing Times awards and subsidising staff towards the Christmas Meal sold in Denbighs.	Benefits patients by improving staff morale and encouraging involvement in the Trust and ownership of its reputation and outcomes
Environment	**£8,329**	Provision of drinking water dispensers	Benefits patients by improving staff morale and helping to prevent dehydration and tiredness
Wellbeing	**£2,012**	Staff Health and Wellbeing Day, fruit for Intenational Nurses Day.	Benefits patients by improving both staff healkth and morale
Area of Expenditure	**£**	**Narrative (figures quoted where > £10k)**	**Outcomes & Meeting Objective of the Charity**
Governance and Administration			
Governance	**£11,147**	Includes audit fee and membership of the Association of NHS Charities organisation.	Expenditure concerned with the running of the charity in a correct and proper way and with the correct skill and experience, checks and balances, policies and procedures required
Administration	**£31,700**	Administration support and database system, bank charges etc.	Expenditure incurred in the day to day running of the charity ensuring that funds are available and expenditure enabled in a timely manner
Area of Expenditure	**£**	**Narrative (figures quoted where > £10k)**	**Outcomes & Meeting Objective of the Charity**
Fund Raising			
Fund Raising	**£15,230**	**Sales and events** - Guttmann Conference for Spinal Injuries 2016-17 final fee £2k (total £26k raised £36k); London Marathon "Golden Bonds" £7k (raised £56k); Sweatshirts for sale by Spinal Activities; Gas-fired barbecue to be used at future fundraising events and be available for use by Denbighs. The Veterans' Appeal was successfully launched in 2018-19 but incurred expenditure in 2017-18 on a trip to see facilities in the USA.	Funds raised are reinvested in enhancing NHS patient treatment, environment and experience

0. Reference Information

Author:	Martine Williams, Facilities Managers	Paper date:	04/02/2019
Executive Sponsor:	Craig Macbeth, Director of Finance	Paper Category:	Governance and Quality
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 Trust Board and what input is required?

The paper provides the annual report on security management activities for the financial year ended 31 March 2018. The Board is asked to NOTE the contents of the report.

2. Executive Summary

2.1. Context

This annual report is a requirement of Service Condition 24 of the NHS Standard Contract and section 1.4 of the NHS Security Management Standards for Providers

2.2. Summary

Year	Total Security Incidents	Physical Assaults on Staff	Non-physical Assaults on Staff
14/15	61	9	13
15/16	54	5	7
16/17	70	3	15
17/18	66	3	14

2.3. Conclusion

This report has documented that the Trust has complied with the security management requirements of NHS Protect in 2017/2018 and also the requirements of Standard Condition 24 of the NHS Contract.

DATIX reporting of security incidents remains consistent. It should be noted that physical assaults against staff continue their downward trajectory against an increase in activity and reporting.

3. The Main Report

3.1. Introduction

Security affects everyone who uses, or works within, the NHS.

The security and safety of staff, patients, visitors and property must be a priority within the delivery and development of health services.

All of those working within the NHS have a responsibility to be aware of these issues and to assist in preventing security related incidents and losses.

Reductions over time in losses or incidents, through the consequences of violence, theft or damage will lead to more resources being freed up for the delivery of better patient care and contribute to creating and maintaining an environment where staff, patients and visitors feel, and are, more secure.

Under the provisions of the NHS Standard Contract, Providers are required to have in place and maintain security management arrangements in their organisations. Commissioners are required to review these arrangements to ensure the Provider implements any modifications required by the Commissioner. Aside from publishing this Annual Report, the Trust will also adopt three key principles designed to minimise the incidence of crime, and to deal effectively with those who commit crimes against the NHS.

The three key principles are:

'Inform and Involve' those who work for or use the NHS about crime and how to tackle it. NHS staff and the public should be informed and involved with a view to increasing understanding of the impact of crime against the NHS. This can take place through communications and promotion such as public awareness campaigns and media management. Working relationships with stakeholders will be strengthened and maintained through active engagement.

'Prevent and Deter' crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit crime. Successes will be publicised so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing crime by robust systems, which will be put in place in line with Trust policy.

'Hold to Account' those who have committed crime against the NHS. Crimes must be detected and investigated, suspects prosecuted where appropriate, and redress sought where possible. In relation to crimes against NHS staff, criminal damage or theft of NHS property, investigation and prosecution should be undertaken in liaison with the police and CPS.

3.2. NHS Standards for Providers

In April 2017, NHS Protect was dissolved, and as such, the standards enforced by NHS Protect are no longer imposed. This Trust has not received notice yet of further standards, or reporting mechanisms after this date.

In the absence of such standards, and in collaboration with regional and national best practice groups, the Trust has continued to use the most recent guidance in relation to healthcare security as a benchmark for internal compliance.

The standards were developed to support NHS providers in ensuring they have appropriate security management arrangements in place within their organisation, to protect staff and patients and to ensure that NHS assets are kept safe and secure, and the evidence gathered against these standards remains a valued point of reference for security management within the Trust.

3.2.1. Strategic Governance

Security Management Director (SMD)

The Director of Finance is the Board nominated Security Management Director (SMD) with responsibility for security management and ensuring that security issues are considered at the highest level and where necessary brought to the attention of the Board.

Local Security Management Specialist (LSMS)

The ongoing role of LSMS is embedded within the Trust and as a consequence advice and guidance are requested when there is an incident or issue that affects security.

The LSMS is responsible for reviewing and investigating all security-related incidents and ensuring post incident reviews are conducted. This includes police liaison, supporting and keeping witnesses informed, reporting to NHS Protect and giving crime prevention advice where appropriate.

Investigating security incidents or breaches in a fair, objective and professional manner to ensure those responsible for such incidents can be held to account for their actions is a vital aspect of the security management role.

Due to the relatively low level of incidents; the Trust combines the role of LSMS with the responsibilities of the Facilities Manager.

LSMSs are required to continue with professional development in order to keep up to date with developments in security management and to attend regional security specialist forums. The Trust Security Manager is a member of the Staffordshire & Shropshire NHS LSMS forum.

Following the drawdown of NHS Protect in 2016-17 as the national body for coordination of security management in the NHS, this voluntary forum is attended quarterly by LSMS from the area and all NHS sectors including Acute, Mental Health and Community services and provides opportunity for briefing, discussion and awareness raising on the latest security issues affecting Trust interests. In addition, the LSMS has attended numerous workshops at regional and local level in order to maintain and develop competence and to promote the Trust at national level.

3.2.2. Inform and Involve

The LSMS has ensured that RJAH staff and the public were informed and involved with a view to increasing understanding of the impact of crime against the NHS. This took place through communications, department visits and specific advice in relation to reported incidents.

Working relationships with stakeholders were strengthened and maintained through active engagement. Work was undertaken to change the culture and perceptions of crime so that it was not tolerated at any level.

Information and intelligence was provided via targeted alerts and also from colleagues in the police which allowed the LSMS to optimise the security management of the Trust.

Activities related to this standard include:

The Fire and Security Group met on a regular basis to discuss current fire and security matters and concerns. The group reported directly to the Health and Safety Committee which in turn reported to the Risk Management Committee.

The LSMS also worked closely with Governance and Estates personnel to ensure all security incidents were reported through the correct channels within the Trust and that all relevant personnel were notified

The LSMS and Local Counter Fraud Specialist have worked closely together throughout the year promoting a united approach to the management of both security and fraud within the Trust.

3.2.3. Prevent and Deter

Activities related to this standard include:

The LSMS has been proactively promoting a Trust-wide pro security culture, engaging with clinical staff to raise awareness of the options available to them to prevent and deter incidents of violence and aggression. This has led to improved incident investigation on a departmental level, promoting a learning ethos to security within the Trust.

The LSMS has proactively engaged with the Estates team to recommend security options for the capital projects. A close working relationship with the Estates department ensured that security recommendations, including the installation of CCTV where appropriate were also made for all refurbishment projects.

Close working relationships with West Mercia Police and Counter Terrorism Officers were maintained.

The Trust used the in-house newsletters & the daily email noticeboard to publicise security initiatives. All members of staff received a copy by e-mail with hard copy available for staff who did not have easy access to e-mail.

The Trust did not have a dedicated security presence on site, apart from the Christmas and New Year period when there is traditionally a reduced staff presence on site. The Trust had priority access to an on-call security company. Response times were monitored to ensure that an appropriate level of service was maintained.

The Trust continues to use these measures and encourage all departments to use risk assessment tools to help develop solutions to mitigate security risks and in particular those risks associated with violence and aggression within the workplace

3.2.4. Hold to Account

The use of Sanctions including Acknowledgement of Responsibilities Agreement (ARA) and warning letters was considered in all cases of violence and aggression to deter potential repeat offenders. There were no incidents that required ASBO's or the use of ARA's however a number of warning letters were sent to patients who had been who exhibited unacceptable behaviours.
A partnership working agreement continues to be used to reinforce acceptable behaviours where required.

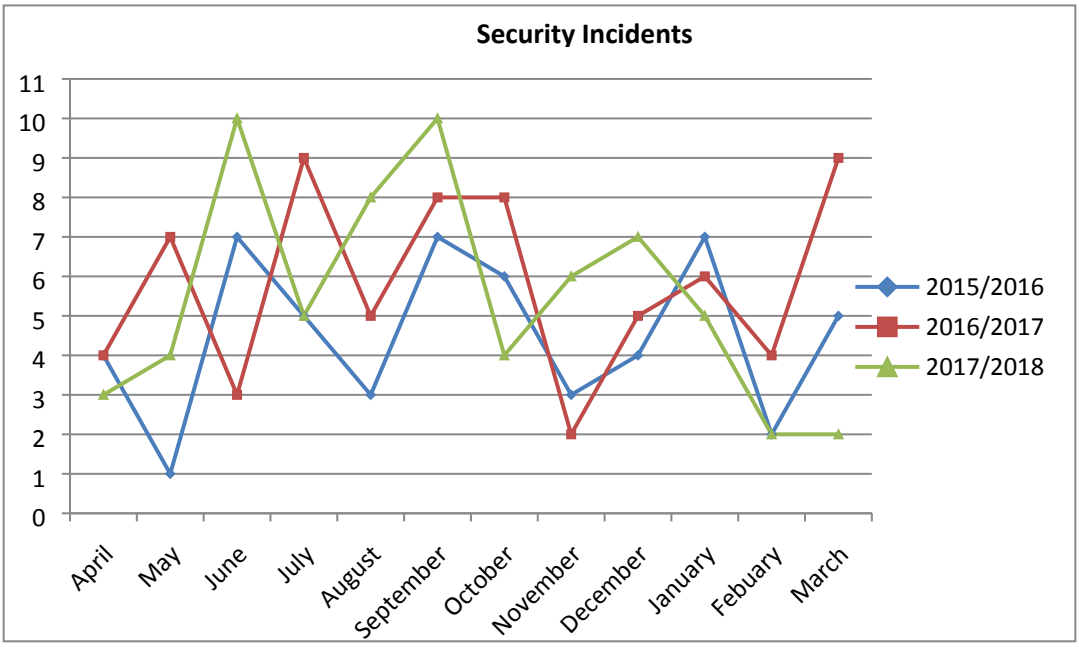
The LSMS had access to the DATIX incident management system and was automatically notified of all security incidents. A post-incident review was conducted where appropriate to ensure where possible new procedures, initiatives or physical security measures were introduced to reduce or prevent the incident from occurring again.

RJAH worked hard to reduce the risk of violence and aggression towards staff by a combination of preventative measures, training, investigation, learning from experience and actively pursuing the application of sanctions and redress.

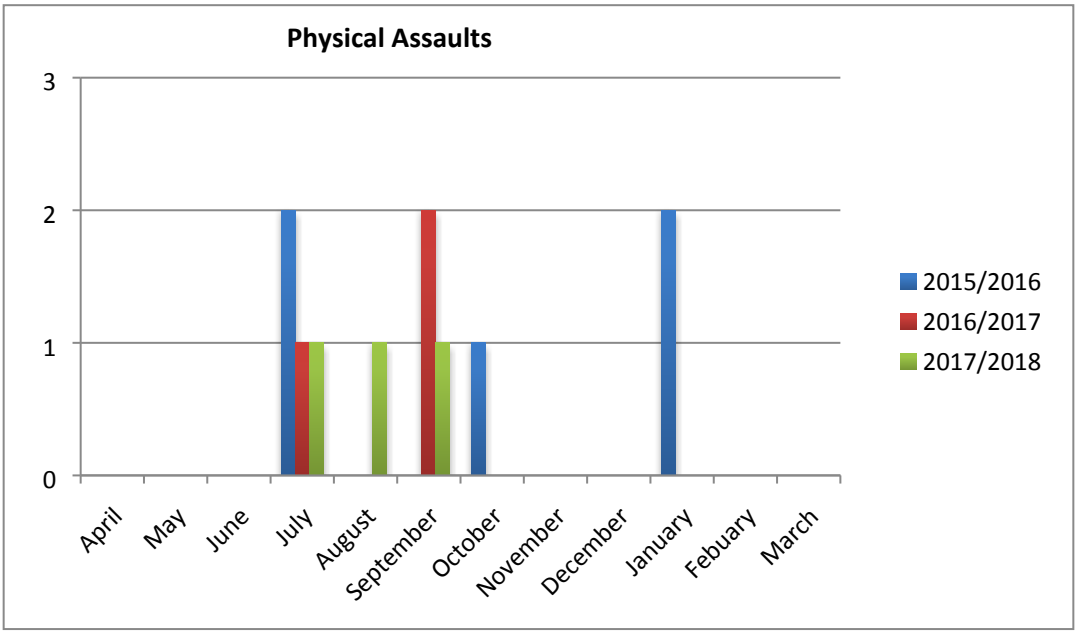
3.2.5. Security Incident Data

Security incident reporting remains key to the maintenance of a pro-security culture. Figures below demonstrate good awareness by staff on how to report and the need for doing so. Staff are also supported by the LSMS were required to complete accurate and appropriate reports.

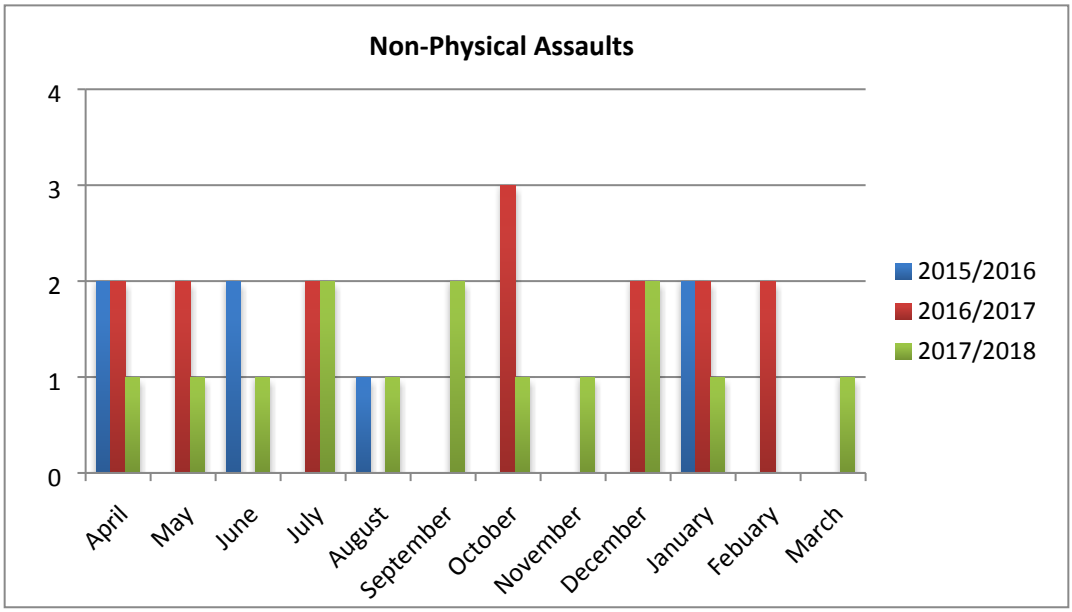
Detailed below are the categorised Security Incident Statistics Trust wide for period 1st April 2017 to 31st March 2018 compared with the previous two years.



The number of incidents reported via Datix has remained consistent. All incidents are summarised on a quarterly basis to the Fire & Security group and Trends analysed to promote dirented training/support where required.



There were no serious physical injuries, however the Trust considers any physical assault to be unacceptable. All staff victims were offered support by LSMS and Managers as well as having access to a confidential counselling service.



3.3. Associated Risks

From 1 April 2017 NHS Protect has ceased providing local support and development services, standards and guidance, with the primary responsibility for security management work remaining with the boards of local NHS organisations.

All security risks are managed in accordance with the Trust Risk Policy. All risks which have been scored and evaluated as requiring to be placed on the Trust Risk register, are entered on to the Datix system where they, and accompanying action plans, are regularly reviewed. The requirement to regularly review and record progress is initiated by a system generated electronic alert to the risk owner.

There are currently no recorded security risks scoring 12 or more (High).

3.3.1. Implications for RJAH

The role of the LSMS has remained at the forefront of security management over the course of this year, mitigating the lack of national compliance standards through regional best practice sharing, attendance at relevant National Association groups to ensure the Trust is proactively managing the lack of national standards.

3.4. Next Steps

The Health and Safety Committee is asked to NOTE the contents of the report

3.5. Conclusion

This report has documented that the without in date guidance, the Trust has worked to remain compliance with the most recent standards available with regards to Security Management.

RJAH has worked hard to reduce the risk of violence and aggression towards staff by a combination of preventative measures, improved training, investigation, learning from experience and actively pursuing the application of sanctions.

The organisation will continue to use these measures and encourage all departments to use risk assessment tools to help develop solutions to mitigate security risks and in particular those risks associated with violence and aggression within the workplace.

Similarly, the use of risk assessment for asset protection should encourage departments to reduce the risk to their premises and physical assets.

The LSMS has provided advice and assistance to departments on many security issues, and the organisation as a whole will continue to use the risk assessment model to reduce risk and focus on prevention.

Martine Williams

Facilities Manager / Local Security Management Specialist

Appendix 1: Acronyms

LSMS	Local Security Management Specialist
SMD	Security Management Director
DH	Department of Health

Chair's Assurance Report
Finance Planning and Investment Committee - 22nd January 2019

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	28th March 2019
Executive Sponsor:	Alastair Findlay, Non-Executive Director	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Finance Planning and Investment Committee Meeting which was held on 22nd 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 the Trust's financial performance to the Finance Planning and Investment Committee. This Committee is responsible for seeking assurance on that the Trust is operating within its financial constraints and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended,
- There was good progress of actions from the previous meeting with all actions completed and no issues raised.
- The work plan was reviewed and agreed.
- Consideration was given to the indicative Trust's financial position and performance including a forward look into February.
- The committee received an update on the STP Governance, EPR Business Case, Veterans and the Menzies post Evaluation.

2.3. Conclusion

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

Chair's Assurance Report
Finance Planning and Investment Committee - 22nd January 2019

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Finance Planning and Investment Committee which met on 22nd January. The meeting was quorate with two Non-Executive Director present. A full list of the attendance is outlined below:

Chair/Attendance:
Members
Alastair Findlay, Non-Executive Director (Chair)
David Gilbert, Non-Executive Director
Mark Brandreth, Chief Executive
Craig Macbeth, Director of Finance
Nia Jones, Director of Operations
In Attendance
Mark Salisbury, Deputy Director of Finance
Simon Adams, Associate Director of IM&T
Shelley Ramtuhul, Trust Secretary (Minute Secretary)
Apologies:
Bev Tabernacle, Director of Nursing
Debbie Kadum, Interim Associate Director of Performance
Kerry Robinson, Director of Strategy and Planning

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and receive an update on the progress of each. All actions were noted to be completed and no matters arising were raised.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declaration of Interest		
There were no announcements regarding declarations of interest.	N/A	

Chair's Assurance Report
Finance Planning and Investment Committee - 22nd January 2019

Finance and Performance Presentation		
The committee received an update on the Trusts Finances and Performance for Month 9. The committee discussed the following: • Cancer Target compliance. • Diagnostics targets were met for welsh patients if one English patients outstanding due to an administration error. • Theatre activity performance has improved • Behind plan for 52 weeks, RTT, forward look theatre activity and reportable cancellations. • A dedicated action plan has been put in place for spinal disorders with regards to 52 week waiter • SOOS waiting list An overview of the challenges being received from the CCG regarding RTT and it is clear that they are not taking the nature of the spinal disorders service into account. The challenges with the spinal injuries unit were highlighted, in particular the bed capacity for surveillance patients. The Trust was confident to achieve 92% by year end. The financial elements of the performance update and highlighted the following: • For the year to date the Trust is £14k above plan • Q3 trajectory has been achieved and therefore PSF of £230k will be received • The position is a significant improvement compared to M9 of the previous financial year but still challenges for Q4, the key is delivery through the theatre activity • Private patient income has been disappointing but partially offset by £26k in MCSI private patient fees • Agency performance has improved with regard to core agency at £28k under target although the LLP spend continues to be adverse. • Mitigations to address financial performance were outlined The committee **noted** the Finance and Performance Update.		
Finance Performance Report		
The Finance and Performance report for M7 was presented to the Committee and it was noted to cover the detail to support the information provided during	Y	

the previous presentation. The Committee **noted** the Finance and Performance Report		
LLP Contract Management		
The committee received an update on the actions to reduce the overspend on the LLP contract and the impact of these on the contract performance. The committee were advised there was now a greater awareness and management of the contract to prevent ongoing overspends and confirmed that the most significant benefit has been through the outpatient bookings with increased awareness amongst the bookings staff helping to reduce the penalties on outpatient bookings. The Trust continues to monitor the contract management. In addition, the Internal Auditors have been asked to conduct an audit of job plans. The Committee **noted** the update on the management of the LLP Contract.	Y	
STP – LDR Governance Update		
The Committee received an update on the governance arrangements for the sign off of the Local Digital Roadmap within the STP. Concerns were expressed that the Trust does not have a better sighting on the STP in general. MB advised that he has met with Sir Neil Mackay and it is clear that there is going to be a refresh on the governance – a further update will be provided to the Board. The Committee **noted** the STP and Governance Update.	Partial	In the meantime, it was agreed that the Executive Team have in place a structure to agree and take forwards the Local Digital Road Map governance and the Committee agreed that this should therefore rest with the Executive Team
EPR Business Case		
The Committee received an update regarding the progress towards the production of a full business case for EPR. The Committee noted that a full timeline was provided in the report. It was confirmed that the Trust remains undecided on the EPR partner. The Committee **noted** the update.	Y	
Veterans Update		
The Committee received an update on the Veteran's Service. It was noted that good progress was being made with the fundraising. A full update is due to be	Y	

Chair's Assurance Report
Finance Planning and Investment Committee - 22nd January 2019

provided to the Charitable Funds Committee. The Committee **noted** the Veteran's Update		
Menzies Post Project Evaluation		
The Committee received a post implementation evaluation of the recommissioning Phase 1 and 2 or the Menzies Unit. Phase 1 was successfully completed with flexible sessions fixed. Phase 2 was the plan for Menzies to be a stand-alone day surgery unit. This was deferred to use the use the theatre flexibly to increase physical capacity and in the latter part of 2017 the Theatre was leased out to BCU. This phase was therefore partially completed. The project will be closed with a new phase introduced with the re-establishment of the Task and Finish Group. The Committee **noted** the evaluation and **agreed** the recommendations.	Y	
Board Assurance Framework and Committee Risk Register		
The Committee received the risks on the Board Assurance Framework and Corporate Risk Register which related to its remit. SR questioned whether given the discussion regarding tariff there were any changes required to the score and the Committee agreed it was satisfied with the current score. The committee **noted** the BAF and Corporate Risk Register.	Y	
Review of the Terms of Reference		
The Committee received the Terms of Reference for considerations. Amendments were required committee membership only. The Committee **approved** the Terms of Reference subject to the requested changes.	Y	
Review of the work plan		
The work plan was reviewed by the Committee with some minor amendments agreed regarding future agenda items. The Committee **approved** the work plan.	Y	
Attendance Matrix		
The Committee **noted** the paper.	N/A	
Minutes: Capital Management Group		
The minutes from the recent Capital Management	Y	

Group was presented with no issues identified. The Committee **noted** the minutes from the Capital Management Group.		
Chair Report: IM&T Steering Group		
The Committee received the Chair's Report from the IM&T Steering Group. The Committee **noted** the Chair's Report.	Y	

3.4 Approvals

There were no approvals sought from the Committee.

3.6 Risks to be Escalated

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

3.5 Conclusion

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

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
28th March 2019

STP Director Update

Responsible Officer

Email: Phil.evans1@nhs.net

1. Summary

The attached report provides the Board with an update re: STP system response to developing a draft system narrative and the next steps

2. For Information

The Board is invited to:
Note – this pack will be updated by end of April 2019 (see slide 2)

a) Note System Challenges – Slide 6
b) Note system development towards and ICS – Slide 7
c) Future proposed use of system data to inform shared understanding and drive transformation – Slide 8
d) Delivery & Enablement Programme Updates – Slides 11-16
e) System understanding and approach to Activity, Finance & Workforce.

Upcoming changes to this pack are due on 11th April 2019
Notes:

- As part of this years planning process system partners are working closely together to further develop collaborative working as we work towards being an Integrated Care System (ICS)

- This involves alignment of activity, finance and workforce across commissioners and providers with an accompanying narrative that describes our priorities and plans for system improvement

- This draft was submitted on 19th April and is currently being further developed with additional detail for the 11th April submission

- The updated pack will be available following NHSE & I feedback in late April

STP Update for Shropshire Health & Well-Being Board 7th March 2019

This month the STP Directors update is taking a different format due to the collective system working on **19/20 Organisational Operational Plans** and aggregated data submissions for Activity, Finance and workforce.

System partners are continuing to work closely together as we establish refreshed working arrangements and system governance to improve outcomes for our population of Shropshire, Telford & Wrekin whilst making best use of every £ spent.

This update provides an extract from the recent Draft System Operational Plan Narrative submitted on 19th February. This work continues to evolve, all system partners continue to be involved at leadership, operational and delivery level in order to develop an achievable, credible system plan that we can all be part off. The next iteration is due for submission on the 11th April and following that, we have planned engagement and communication activities with all our system delivery and enablement programmes to refresh our system ambitions and deliverables.

This update focuses on what we know about our system thus far and will be combined with system data understanding of activity, finance and workforce in order that we collectively agree our priorities and shared resources to support delivery.

Going forward there will be a greater emphasis on:

- Development of a learning culture to support transformation
- Greater use of system data to establish shared understanding and identify priorities
- A focus on Workforce as a system enabler across all delivery programmes

It's important that we all recognise ourselves as contributing to STP / ICS development both as system partners and wider stakeholders and it's only through this collaborative working that system transformation can be achieved.

If you want to be more involved in the wider system understanding and development, Please don't hesitate to get in touch with the STP PMO who can assist your involvement in the relevant groups / organisations.

Future updates from April onwards will be via STP Quarterly Chair's Bulletin.

For further information contact stw.stp@nhs.net or jo.harding1@nhs.net

DRAFT System Operational Plan

Shropshire, Telford & Wrekin STP

19th February 2019

Our system plan has input from the following System Partners as well as wider stakeholders

Foreword by: Sir Neil McKay, Shropshire, Telford & Wrekin STP Independent Chair

- **This 19/20 system operating Plan forms the first year of our refreshed STP LTP due in the autumn 2019.**
- The Shropshire, Telford & Wrekin STP have worked collaboratively to bring single organisational operating plans from all system partners, including **Local Authority** plans in to an aligned narrative description that captures the following:
  - System Priorities& Deliverables
  - System understanding of activity assumptions
  - System understanding of capacity planning
  - System understanding of strategic workforce planning
  - System Financial understanding and agreed approach to risk management
  - Understanding of efficiencies and our collective responsibility to deliver those.
- In order to develop from an STP to an **Integrated Care System** , we are required to structure and manage ourselves differently going forward.
- Our system will make better use of our collective data to inform the initial **Bronze Data Packs** and later in the year the **Population Health & Prevention Dashboard** , both designed to improve our system business intelligence, understanding and planning for improved outcomes.
- As part of our LTP refresh, our system will be revisiting our ambitions and the expected outcomes for our population served. Details of these will be available in our LTP later this year.
- **System leadership capacity & capability** across all organisations is fundamental to our success and we will be completing two key programmes to support our strategic development in this area:
  - **System Commissioning Capability Programme**
  - **System ICS Development Programme**
- Transformation across all that we do to achieve ICS status by 2021/2022 is our goal. Our focus will be on system delivery and enablement to achieve high quality outcomes for our population whilst making best use of our collective system resources in order to get best value for every £ spent.
- The Long Term Plan refresh is our opportunity to work as a system, to meet our challenges of a growing elderly population with increasingly complex needs. Our system expertise (health, social care & wider stakeholders) will come together via our system **Clinical Strategy Group** that will in turn inform our **System Programme Delivery Group,** this will be the engine room of our system transformation.
- This plan has the support and sign-off through all our system partners via **System Leadership Group** and corresponding individual organisational governan

Sir Neil McKay, Independent Chair

Shropshire, Telford & Wrekin STP

Shropshire, Telford & Wrekin STP local context

- Shropshire, Telford and Wrekin STP can be characterised as a good place to live and work, with a good sense of community and volunteering, and the population we serve recognised as diverse, with challenges set by our geography and demography.
- Shropshire is a mostly rural county with 35% of the population living in villages, hamlets and dispersed dwellings; a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. Telford & Wrekin is predominantly urban with more than a quarter living in the 20% most deprived nationally and some living in the most deprived areas.

- The STP sits between some of the largest conurbations in the country (Birmingham to the South, Manchester and Merseyside to the North), as well as sharing its western border with Wales.
- The STP footprint is served by one acute provider (Shrewsbury & Telford Hospitals NHST), one specialist provider (Robert Jones & Agnes Hunt FT) , one community health provider (Shropshire Community Health NHST) and one mental health provider (Midlands Partnership FT) The ambulance provider is West Midlands Ambulance Service FT.
- There are two CCGs across the footprint; Telford & Wrekin CCG has a large, younger urban population (173k) with some rural areas and is ranked amongst the 30% most deprived populations in England. Shropshire CCG (308k) covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban aging populations.
- There are two corresponding local authorities in the footprint; Telford & Wrekin Council, and Shropshire Council
- There are two A&E sites within 28 minutes drive time of each other (Royal Shrewsbury Hospital and Princess Royal Hospital), both with growing volumes of attendances, regularly seeing 400-430 attendances across both sites each day.
- Residents of parts of the footprint will have reasonably long drive times to access acute services and the Shrewsbury site is isolated.
- The nearest major trauma centre is at Stoke on Trent (UHNM), in the neighbouring Staffordshire footprint.
- There are some high prevalence rates of mental health conditions identified in Shropshire/ T&W; there is one mental health provider with a full coverage of services available within the footprint. In addition to minimum Tier 3 and 4 inpatient wards, specialist beds and Tier 4 secure/forensic services are provided.

System Challenges

One of the significant challenges the system faces is that the single acute provider, Shrewsbury & Telford Hospitals NHS Trust (SaTH) has continued to be limited by insufficient access to a substantive workforce which has impacted on quality, performance and their financial position and has led to the Trust being placed in Special measures by NHSI.There are also reducing budgets in the care sector and complex political relationships across the system with challenges in Telford in particular where there is a Labour council and Conservative MP.

Demographics & geography:

- Ageing population; in the Shropshire Council area, 23% of the population is 65 years and over: compare to the England average of 17.6% . T&W Council area has a greater number than average of young people but a rapidly growing older population.
- A largely rural Shropshire in contrast with a relatively urban T&W provides challenges to developing consistent, sustainable services with equity of access.
- Shropshire STP area can be described as a low wage economy; consequently the wider determinants of health including education, access to employment and housing are significant issues to consider when developing services that support good physical and mental health.

Operational performance

- A&E: workforce constraints with consultant and middle tier medical and nursing staff vacancies at SaTH have affected performance, with year to date 4-hour performance at 75.87%
- Cancer: the system is failing to deliver consistently against key cancer standards in all specialties due to challenges with staffing combined with high numbers of referrals

Financial position – the system is facing in year financial pressures:

- There is an *underlying* deficit across both commissioners and providers of c.£56m, driven largely by financial challenges within Shropshire CCG and Shrewsbury and Telford Hospitals Trust.
- The two local authorities have been required to make significant savings over recent years, compounded by significant rising costs in delivering social care for both children and adults.

Workforce

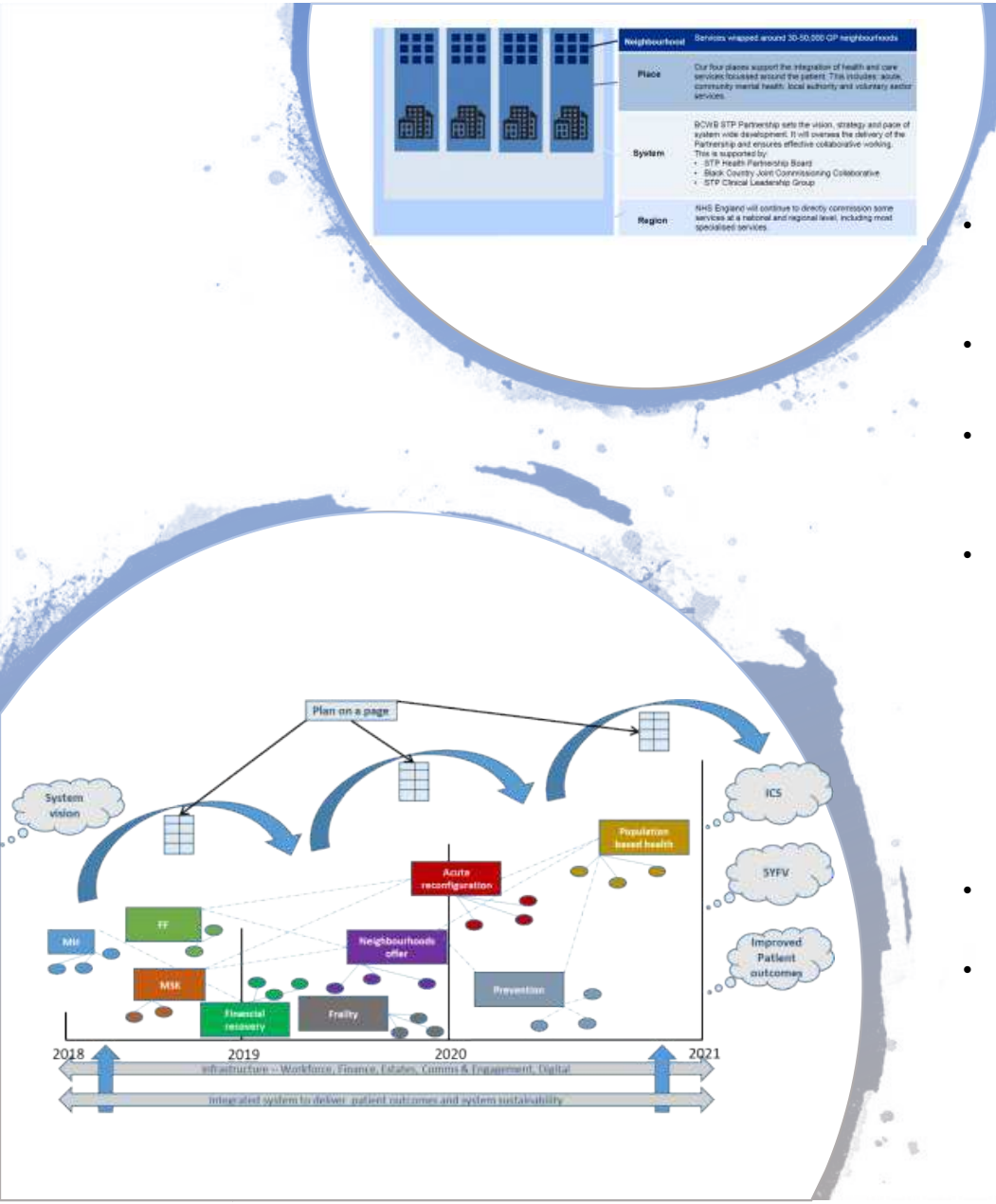
- **All providers (including the social care and domiciliary sector) report issues recruiting qualified staff due in large part to the geography and demography of the area.**

Quality

- Shrewsbury and Telford Hospitals Trust has recently been rated ‘inadequate’ by CQC and is in ‘special measures’. The Trust is involved in an ongoing independent review into neonatal and maternal deaths.
- Shropshire Community Health Trust and Robert Jones & Agnes Hunt FT are currently rated ‘requires improvement; both are undergoing current inspections.

Reconfiguration

- Public consultation on acute services reconfiguration (‘Future Fit’) completed; Final Decision Making Business Case approved by Joint Programme Board January 2019. Implementation over the next 5 years, subject to NHSI approval.
- Closer joint working between the two CCGs, exploring the options to move to a Single Strategic Commissioner. Interim Accountable Officer appointment for Shropshire County CCG to commence April 2019, following retirement of the incumbent.
- Midwifery-Led Units case for change just completed NHS England strategic sense check ahead of proposed reconfiguration consultation



Development towards an Integrated Care System

- STP System Leadership are progressing towards an Integrated Care System with aligned strategic thinking and delivery.
  - Shadow ICS board currently being developed
- Renewed Governance and leadership
  - STP governance refreshed (to be agreed)
- Commissioning Capability Programme
  - Development of strategic commissioning and wider partner engagement to shape together
- Integrated Care Development Programme
  - Integrated Care System Development (ICSD) - A programme to develop long term behaviors and capabilities to progress the development of local ICS architecture.
  - Commissioning in our 'ICS System' commissioning arrangements to support our wider objectives in order to transform the quality of care delivery and improve health and wellbeing for our population.
    - Functions of the CCGs
    - Services the CCG provide
    - Alignment of STP/CCG resources where possible
- Understanding the optimal level/scale at which to commission and where greater efficiencies can be sought.
- National Delivery Unit Data pack (Bronze Packs) - a standard data analytical pack produced from national data sources provided to system to identify system opportunities that will contribute towards financial sustainability and improved health and wellbeing outcomes.

Using system data to drive system change – System Bronze Pack – available 7th March 2019

Key Inputs: Multiple data sources across NHSE and NHSI.

Data	Source	Bronze Diagnostic
Right Care Data and Strategic Finance	RightCare	✓
ECIP	NHS Improvement	✓
GP Forward View	NHS England	✓
Model Hospital	Model Hospital	✓
CCG Activity and Benchmarking Tool	NHS England	✓
Local Authority Social Care Data	NHS Digital and LGA	✓
Mental Health Dashboard	NHS England	✓
Enhanced Care Home Data	NHS England	✓
NHS Operational Report	NHS Improvement	✓
BCF Plan (Data & Narrative)	System	Optional – for region to include. Training will be provided on how to access.
Health & Wellbeing/ Pop Health Data	Fingertips/LGA	
STP Plan	System provided	
External Consultancy Reports	System provided	

Triangulation of Data

Key Outputs: A summary 10-15 page output report is created based on the triangulation of the multiple data sources. The 3 key system drivers are documented.

STP/ICS Diagnostic: System Opportunity Overview

Key System Drivers / Summary Hypotheses

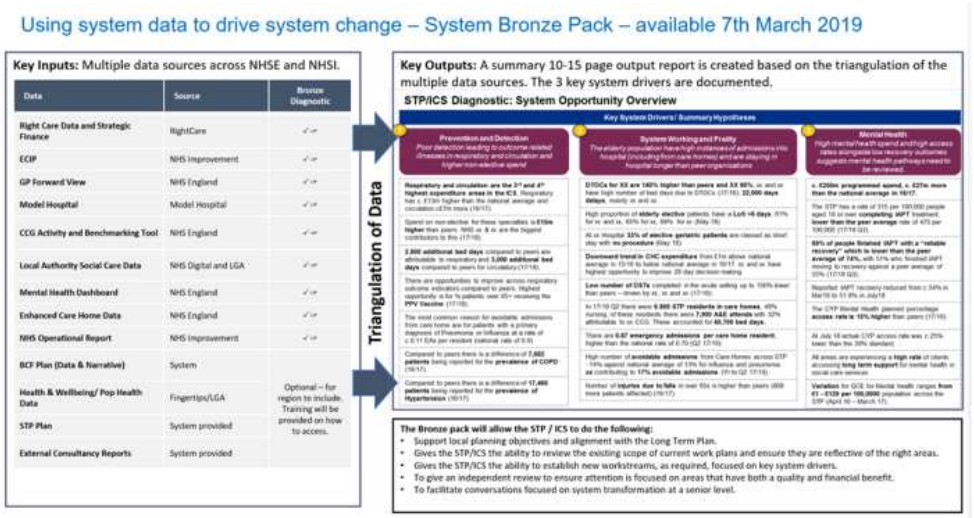
1 Prevention and Detection *Poor detection leading to outcome related illnesses in respiratory and circulation and higher non-elective spend*	2 System Working and Frailty *The elderly population have high instances of admissions into hospital (including from care homes) and are staying in hospital longer than peer organisations*	3 Mental Health *High mental health spend and high access rates alongside low recovery outcomes suggests mental health pathways need to be reviewed.*
Respiratory and circulation are the 3rd and 4th highest expenditure areas in the ICS. Respiratory has c.£13m higher than the national average and circulation c£7m more (16/17)	**DTOCs for XX are 140% higher than peers and XX 90%.** xx and xx have high number of bed days due to DTOCs (17/18). **22,000 days delays**, mainly xx and xx.	**c. £250m programmed spend, c. £27m more than the national average in 16/17.**
Spend on non-elective for these specialties is **£15m higher** than peers. NHS xx & xx are the biggest contributors to this (17/18).	High proportion of elderly elective patients have a **LoS >6 days**, 61% for xx and xx, 65% for xx, 68% for xx (May 18)	The STP has a rate of 315 per 100,000 people aged 18 or over **completing IAPT** treatment, **lower than the peer average** rate of 475 per 100,000 (17/18 Q3).
2,800 additional bed days compared to peers are attributable to respiratory and **3,000 additional bed days** compared to peers for circulatory (17/18).	At xx Hospitals **3..% of elective geriatric patients** are classed as short stay with **no procedure** (May 18)	**69% of people finished IAPT with a "reliable recovery" which is lower than the peer average of 74%,** with 51% who finished IAPT moving to recovery against a peer average of 55% (17/18 Q3).
There are opportunities to improve across respiratory outcome indicators compared to peers. Highest opportunity is for % patients over 65+ receiving the **PPV Vaccine** (17/18).	**Downward trend in CHC expenditure** from £1m above national average in 15/16 to below national average in 16/17. xx and xx have the opportunity to improve 28 day decision making.	Reported IAPT recovery reduced from c.54% in Mar18 to 51.8% in July18
The most common reason for avoidable admissions from care home are for patients with a primary diagnosis of Pneumonia or Influenza at a rate of c.0.11 EAs per resident (national rate of 0.9).	**Low number of DToCs** completed in the acute setting up to 100% lower than peers – driven by xx, xx and xx (17/18).	The CYP Mental Health planned percentage **access rate is 15% higher** than peers (17/18).
Compared to peers there is a difference of 1,[illegible] **patients** being reported for the **prevalence of COPD** (16/17).	17/18 Q2 there were **6.900 STP residents in care homes**, 48% [illegible] of these residents there were **7,900 A&E attends** with 32% attributable to xx CCG. These accounted for **40,700 bed days.**	At July 18 actual CYP access rate was c.25% lower than the 30% standard.
Compared to peers there is a difference of **17,469 patients** being reported for the **prevalence of Hypertension** (16/17).	There are **0.87 emergency admissions per care home resident**, higher than the national rate of 0.70 (Q2 17/18).	All areas are experiencing a **high rate** of clients accessing **long term support** for mental health social care services.
	High number of **avoidable admissions** from Care Homes across STP - 14% against national average of [illegible] for influenza and pneumonia. **xx** contributing to **17% avoidable admissions** (Q2 17/18).	**Variation** for GCE for Mental health ranges **from £1 - £129 per 100,0000** population across the STP (April 16 – March 17).
	Number of **injuries due to falls** in over 65s is higher than peers (809 more patients affected) (16/17).	

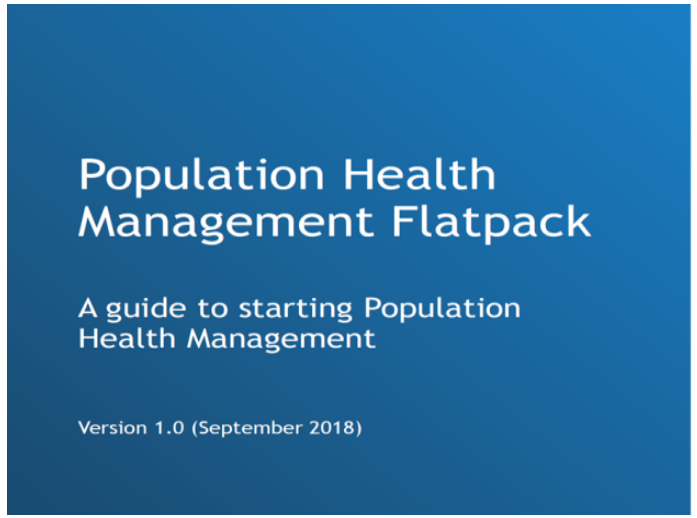
EXAMPLE

The Bronze pack will allow the STP / ICS to do the following:

- Support local planning objectives and alignment with the Long Term Plan.
- Gives the STP/ICS the ability to review the existing scope of current work plans and ensure they are reflective of the right areas.
- Gives the STP/ICS the ability to establish new workstreams, as required, focused on key system drivers.
- To give an independent review to ensure attention is focused on areas that have both a quality and financial benefit.
- To facilitate conversations focused on system transformation at a senior level.

Using system data to drive system change – Next Steps





NHS England

Public Health England

NHS Digital

Shropshire, Telford & Wrekin, plan on a page, STP Plan – to be refreshed through LTP refresh – Autumn 19

Vision – to be the healthiest population in England

Programmes and Priorities:

Population health and wellbeing

- Working across health and care to proactively support people to improve and maintain their health & wellbeing

Community Services

- Developing out of hospital services that support the diverse population we serve
- integrated working and primary care models
- Implement multi-disciplinary neighbourhood care teams
- Ensuring all community services are safe, accessible and provide the most appropriate care.

Acute & Specialist Hospital Services

- Redesigning urgent and emergency care, creating two vibrant 'centres of excellence'

Cancer	MSK
Maternity and Paediatrics	ENT
Stroke/ Cardiology	Respiratory
Ophthalmology	Elective Care

Enabled by:

Strong **partnership working** across health, care, public, private and voluntary and community sector

Making the best use of **technology** to avoid people having to travel large distances where possible

Communicating with and involving local people in shaping their health and care services for the future

Supporting those who deliver health and 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

Improving and making more efficient our **back office** functions

Making better use of our **public estate**

Outcomes:

- Improved healthy life expectancy
- Improved system efficiencies
- Increased partnership working across all delivery & enablement programmes

Measured by:
Quarterly Checkpoint review meetings

- Delivery Programmes
- Enablement Programmes

Governed by : ***(proposed)***
System ICS Shadow Partnership Board

- Shropshire CCG
- T&W CCG
- Shrewsbury & Telford Hospital
- Shropshire Community Health Trust
- Robert Jone s and Agnus Hunt
- Midlands Partnership Foundation Trust
- Shropshire Council
- Telford and Wrekin Council

Population health and prevention

Priorities :

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 in behaviour change and motivational interviewing
    - Proactively identify 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

Deliverables:

- Deliver system data repository, JSNA development and reporting processes
- Implement place based working with the local authorities (connected to primary care and community transformation);
- Deliver Stop smoking services for patients, expectant mothers, long term users of specialist mental health services and learning disabilities;
- Implement social prescribing, targeting CVD and weight loss services to people who need it most;
- Deliver greater uptake of the National Diabetes Prevention Programme;
- Ensuring children have the best start in life including access to mental health and early help support;
- Establish alcohol care teams in hospital and community

Primary care and community services

Priorities :

1. Developing out of hospital services that support the diverse population we serve
2. integrated working across Community Services, Acute Care, Primary Care, Social Care, Preventative services, and the VCS
3. Supporting the development of Primary Care
4. Ensuring all community services are safe, accessible and provide the most appropriate care.

Deliverables:

- Develop & deliver Primary Care Framework
- Develop & deliver Primary Care Networks
- Develop and deliver neighbourhood care models, including Care Closer to Home and Neighbourhood working
- Implement multi-disciplinary neighbourhood care teams across health, care and VCS that includes:
    1. Rapid Response
    2. Intermediate care/ hospital at home
    3. Care home support (including Care Home Advanced, Trusted Assessors, Care Home MDT)
    4. Social Prescribing and prevention services
- Implement frailty at the front door (acute service)

Referral to Treatment & Planned Care

Priorities :

- Streamlined care;
  - Outpatient activity
  - Cancer treatment
  - Musculoskeletal (MSK) services
  - Neurology
  - Local Maternity Services
- Robust pathways;
  - Achieving targets
    - 18 week referral targets – consultant lead treatment
    - 6 week diagnostic test target
    - 52 week treatment target
- Commission sufficient capacity;
- Improve patient experience of appointments and treatments;
  - Outpatient redesign

Deliverables:

- Monitor the acute trusts waiting list to ensure at the end of March 2020 does not exceed the waiting list at the end of March 2018
- Work with providers to develop a process for identifying patients exceeding 6 months on the waiting list and offering them an opportunity to move to an alternative provider
- Develop a process for identifying patients approaching 40 weeks on the waiting list to ensure no patient exceeds 52 weeks

Outpatient Redesign

- The CCGs plan to undertake a programme of work in relation to outpatients redesign. A task and finish group has been established with SaTH & RJAH to look at what changes can be made. The CCGs intend to use this task and finish group to undertake the following actions:
- Identify area where non face to face appointments can be implemented
- Explore areas where patient led follow ups can be implemented
- Develop process for identifying unnecessary frequent attenders and implement mitigating actions for these patients
- Align diagnostics with appointments
- Use national outpatient improvement dashboard to improve clinic utilisation
- Use the learning from the IBD app project to roll out to other areas
- Identify technology opportunities in relation to outpatient appointments

MSK

Priorities :

- Review MSK services within community and secondary care;
- Transforming operational processes and developing a single service model for the whole MSK pathway, using the results of the review and the First Contact Practitioner pilot evaluation;
- Delivering referral targets;
- Delivering quality and financially sustainable services.

Deliverables:

- Completed MSK review;
- New single service model for MSK that integrates with community and secondary care;
- Continue to monitor progress and quality

Maternity

Priorities:

- 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

Deliverables:

- Develop and progress the Midwife Led Unit Review
- Develop and implement pilot for continuity of carer programme
- Fully implement improvements in safety including Saving babies lives care bundle
- Deliver improvements in choice about maternity care, including by developing personalised care plans
- Implementing the neonatal quality improvement programme
- Develop workforce plan to improve core staffing with clear governance and reporting
- Developing a culture of learning and improvement

Urgent & Emergency Care

Priorities :

7 High Impact Change Model:

- Improvement in ED Systems and processes
- Reduction on Long Lengths of Stay
- Standard work of SAFER patient bed bundle and Red2Green across the system
- Frailty improvement
- Demand and Capacity modelling
- Integrated discharge function
- Ambulance demand and pathways improvement

Deliverables:

- Successful recruitment to the workforce
- Improving access to Same Day Emergency Care (SDEC)
- Improvement and development of frailty at the front door programme
- Sustaining and improving the reduction in long stays
- Ensure that data is available and used effectively to inform clinical decision making and future priority planning
- Discharge planning from moment of admission to prevent deconditioning and ensure a timely, home first approach for as many patients as possible
- Improve ED systems and processes to ensure efficient and effective care for patients
- Identify and manage constraints identified throughout the patient journey to ensure timely and effective care
- Effectively match capacity and demand through the use of data and intelligence
- Better use data to avoid conveyance and ensure patients are treated in the right place in the first instance

Cancer

Priorities :
Ambition – fewer people to be diagnosed with preventable cancers; improve mortality rates and improve patient experience

Priorities :

- Deliver the Living with and Beyond Cancer;
- Deliver cancer services that are accessible, timely and sustainable;
- Workforce and capacity – testing new ways of system working that will deliver more timely care;
- Improve against performance targets;
- Explore opportunities for improving urological cancer through joint working across the system

Deliverables:

- Implement a holistic needs assessment and care plan
- Develop treatment summaries to guide patients and GPs post treatment
- Develop and deliver the living well offer – providing advice, support and signposting
- Deliver the cancer care review – between the GP (or nurse) and patient
- Deliver person centred follow – up tailored to the patients
- Develop joint working processes for urological cancer

Mental Health, learning disabilities & autism

Priorities :

1. Children and Young People
    - Transformation plan
2. Mental Health Workforce Strategy
3. Suicide Prevention Strategy
4. Neighbourhood working
    - Developing an integrated model of delivery to support STP priorities
    - Realign and develop workforce
    - Developing relationships and integrating with community services including primary care, local authority, VCS
    - Perinatal mental health
5. Crisis response and admission avoidance
    - Development of dementia services (including community, rapid response, and
    - Use results of the winter pressures evaluation to

6.Address needs of vulnerable people

Deliverables:

- Develop and implement a system all age Mental Health Strategy
- Implement the suicide prevention strategy and action plan
- Embed mental health pathways into neighbourhood models of care
- Implement the children and young people local transformation plan
- Develop strategy for people with learning disabilities and autism, with clear actions for improvements
- Develop all age support team for individuals and families to reduce need for hospital care
- Development of local SEND partnership arrangements
- Review and joint work on complex care needs for children and adults
- Implement workforce strategy
- Strengthen out of hours crisis response
- Develop local dementia plans

Personalised health budgets and social prescribing

Priorities :

- Developing joint personal health budgets governance and delivery with the Local Authorities
- Develop joint processes and commissioning for CHC (health and care)
- Develop personal health budgets in line with the NHS model of Personalised Care
- Continue to progress the development of local models of Social Prescribing utilising funding to be allocated in 2019
- Connect social prescribing with out of hospital and primary care transformation programmes (Care Closer to Home and Neighbourhoods), and the Better Care Fund prevention strands and voluntary sector grants and contracts

Deliverables:

- Implement a robust system and governance for personal health budgets
- Implement new practices for jointly delivering CHC with local authority partners
- Progression of models of Social Prescribing by joining with out of hospital with additional funding, in connection with primary care
- Connect with data and infrastructure developments as part of Population Health Management programme

Long Term Priorities, linked to LTP

Priorities :
The LTP (Jan 2019) Describes 5 major changes

- Boosting 'out-of-hospital' care and finally dissolving the divide between primary and community health services
- Redesigning and reducing pressure on emergency hospital services
- Enabling more personalised care
- Making digitally-enabled primary and outpatient care mainstream
- Focusing on population health and partnerships with local authority-funded services, through new Integrated Care Systems everywhere

Deliverables:

- Closely working together as a system to deliver greater capacity in out of hospital care, through:
  - Population Risk Stratification
  - Establishing Primary Care Networks
  - Delivery of Integrated Care Teams
  - Case Management of complex / frail patients
- Delivery of a system wide Urgent & Emergency Care Strategy, working across all partner organisations, improving access for patients across the system for those that need it whilst reducing pressure on acute services
- Refresh our Local Digital Roadmap, focusing on:
  - People empowerment ("All people")
  - Processes – workflow and efficiency
  - Pace
- Using our STP Bronze Pack (Mar 2019) and later our Population Health "Flat Pack", using data to increase business intelligence capability and capacity to drive system transformation

System Enablers supporting delivery of priorities – building blocks for delivery

Workforce

Priorities :

System wide engagement
- Attract, recruit, retain
- Planning & modelling
- Education
- OD & leadership

Deliverables:

- Industrialise approach to scale opportunity
- Intensive support to redesign programmes;
- Workforce for the digital age (Topol)
- Improvement methodology systemwide
- Designing an employment framework for the ICS model

Estates

Priorities :
- An integrated & co-ordinated public estate, relevant to redesigned patient/service user and staff pathways.
- Ensure estate is accessible, efficient &

Deliverables:
- Estates Strategy review & future capital bids
- Improve disposal info /data & develop aligned

Back Office

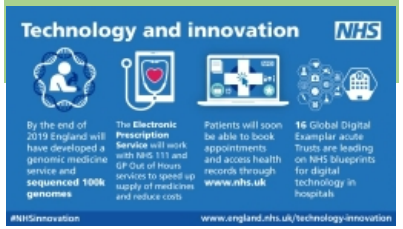
Priorities :
- Drive costs to the national median or other agreed benchmark, appraising options for rationalisation
- Sponsor & support collaboration & develop stakeholder relationships to assess opportunities for wider public sector

Deliverables:
- Once agreed, implement a change programme
- All providers to adopt an 'open-book' approach to data and information sharing
- Use benchmarking data to support decision making

Digital

Priorities :
- Finalising and agreeing the local digital roadmap to set strategic direction.
- Support partner organisations to achieve standard levels of digital maturity
- Progress towards a share d care record, to enable the best care from the use of all available

Deliverables:
- Digital shared care record available for appropriate use.
- A standard of infrastructure across all partner sites and devices to enable digital transformatio n
- Mobile enabled workforce.



Communication & Engagement

Priorities :
- Communicate our system wide plan re: LTP refresh
- Ensure wider stakeholder engagement and involvement in every delivery and enablement programme
- Develop STP/ICS website & Newsletter

Deliverables:
- Delivery of STP/ICS Comms & Engagement strategy
- Evidenced engagement within every programme of work
- Every organisation has increased awareness of system understanding of transformation programme

System Understanding of Activity Assumptions

The STP partner organisations have stated their system assumptions affecting activity to inform the demand and volume assessments. These high level assumptions are subject to further sense checks to ensure relevance, accuracy and consistency.
Forecast outturn activity as the basis for commencing 2019/20 contract negotiations. The current contract position, driven by activity and price is shown in the table below. No contracts have currently been agreed and negotiations are at various stages of development with activity and price variations chief amongst the reasons for current differences as at 19 February 2019.
Activity levels between commissioner and provider will be aligned having considered and agreed commissioner QIPP, other transformation initiatives including migration of services to community and activity avoidance schemes.

System Capacity Planning

- Significant amount of work was undertaken across the system to model the capacity requirements for winter 2018/19
- Real time activity data has been used to develop this model given the significant, unpredicted growth in demand
- Further work is now required to determine capacity requirements in acute and community settings
- Significant work is being done by the system to improve models of admissions avoidance, such as the ambulance conveyance reduction work. Improvement in ambulatory care models also being undertaken to minimise bed utilisation.
- SaTH is reviewing the bed utilisation over last year along with options for change that would reduce or increase bed utilisation
- Each assumption is then reviewed for impact on workforce and finance to then create the plan for 2019/20
- This is being shared, and further developed, with partners so that a joint plan is developed for the year
- Further work will be required to prepare appropriately for Winter 2019/20 with realistic demand profiling as a basis
- Significant changes predicted and improvement in patient management by direction to out of hospital services will need to be profiled, in order to accurately forecast demand, e.g. 111, urgent treatment centres and Future Fit
- Use valued care in mental health; and improving for excellence to improve the emergency care of people with mental health needs

Local System Winter Planning Approach

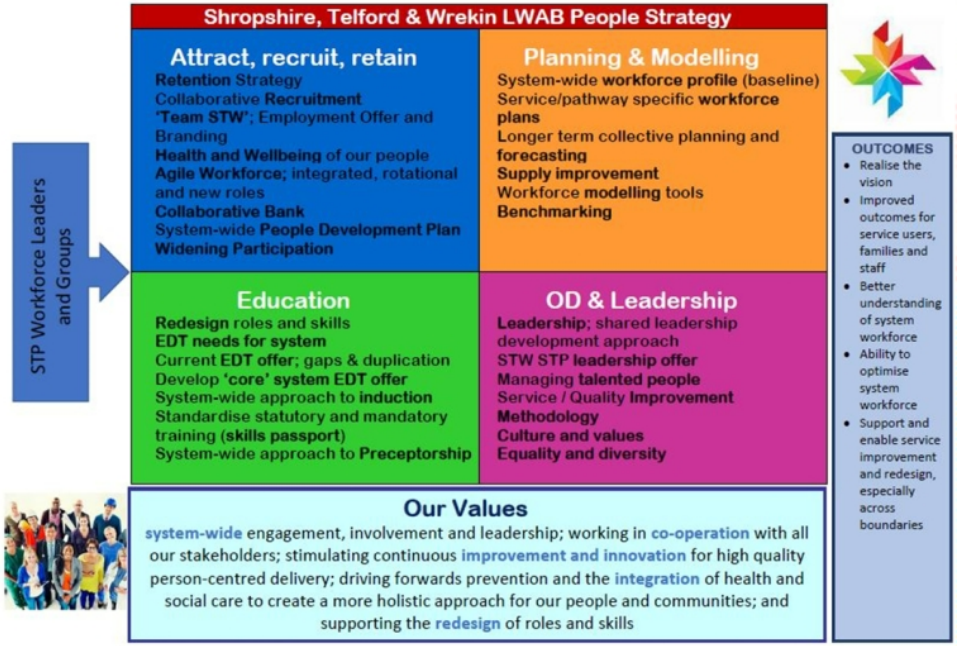
- The Plan has been developed through robust engagement of all key system partners overseen by the A&E Delivery Group. System stakeholders have also attended a NHSE workshop in April and 2 local planning workshops in July.
- In parallel, system demand and capacity modelling has been undertaken to determine predicted winter demand and required acute bed capacity to inform the bed bridge calculations.
- All Providers were asked to demonstrate an understanding of their demand and capacity over the winter months and provide an organisational winter plan which includes:
- Additionally, and phasing of escalation
- A workforce model to support 7-day working, senior decision making and escalation capacity
- 7-day working
- Christmas, New Year and Easter period
- Options for further surge capacity if required

System strategic approach to Workforce

The system workforce objectives are:

- To ensure the planning, recruitment and development of an engaged, talented and compassionate workforce for the future system
- To develop a sustainable future workforce who are equipped to meet the needs of our communities

Our **STP People Strategy** sets out how local organisations delivering health and social care services plan to work better together to ensure the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place to deliver quality and sustainable services to members of the public.



- The Strategy identifies four key areas for collective working; 1) Attract, Recruit and Retain; Agile Workforce, 2) Workforce Planning and Modelling, 3) Learning through Education, Development and Training Opportunities and 4) Organisational Development and Leadership including Equality and Diversity. The Strategy is underpinned by principles of system-wide, cooperation and collaboration, improvement and innovation, integration and redesign.

- As a result of achieving the ambition outlined in our People Strategy, we hope to succeed in:
  - Realising the vision of the People Strategy and new models of care
  - Improving outcomes for service users, families and staff
  - Building a better understanding of system workforce
  - Optimising our system workforce
  - Supporting and enabling service improvement and redesign, especially across boundaries

- Since the publication of the NHS Long Term Plan work continues to ensure the People Strategy reflects the ambitions and intentions outlined in the plan e.g. digital workforce and the volunteer workforce are new areas of focus that will be included within the next iteration of the People Strategy which remains a live document.

Our Local Workforce Challenges:

- Fragility of workforce for acute provider across medical, nursing and therapies
- Recruitment challenges and high vacancy rates, related to factors such as national workforce shortages, varying terms and conditions, geographical rurality, levels of morale
- Cultural challenges within organisations, with some staff groups or individuals resistant to change
- Morale and retention of staff as a result of major change or retendering within the system
- An ageing workforce and a reduced community of suitable people to seek to attract
- An uncertain future supply of staff, with difficulty attracting students to some courses, placements and recruitment to jobs upon qualifying
- Different expectations of the younger workforce, e.g. increased part-time and flexible working
- The image of health and social care in the general population

System-wide approach supporting strategy delivery

Primary Care
Significant improvement in the quality of workforce data and ability to set targets and trajectories,
The appointment of Primary Care workforce leads
Success in funding proposals for running retention programmes for GPs
Success in attracting funding for new Clinical Pharmacists
Introduction of the Physician Associate internship with four PAs to be placed in local practices
Significant increase in engagement with GP trainees with plans for fellowships and post-qualification support
Improved engagement with GP Nurses via established GP Nurse Educators/Facilitators and delivery of GP Nurse 10-point action plan
Upskilling of primary care workforce in independent prescribing, spirometry, management of long-term conditions, physical assessment and mentorship

Mental Health
Development of system-wide mental health workforce plan which led to the establishment of an STP Mental Health Delivery Group
Appointment of STP Mental Health Programme Director
HEE investment to support delivery of the mental health workforce development plan by upskilling the workforce to achieve Five Year Forward View for mental health
health awareness and first aid training made available across the system including health, social care, domiciliary care, fire service, police, ambulance
Focus on developing a new pathway for 0-25 (CYP) mental health including a workforce model

End of Life (Recommended Summary Plan for Emergency Care and Treatment - ReSPECT)
Implementation of the national ReSPECT model of care led by the STP End of Life Programme through partnership working
Workforce support through the development and implementation of an education programme to deliver ReSPECT training and resources for the system utilising a train the trainer model including all system partners
This will ensure a standardised and consistent process of transition and adoption of ReSPECT
EOLC and Swan Scheme education programmes developed and delivered across system partners supported by the End of Life Care Handbook
EOLC Volunteers trained at SaTH and Shropshire Community Health NHS Trust (looking to scale across the social care workforce)
System-wide access to Sage and Thyme training including communication tools and techniques for all partners acute, community, hospices, council and domiciliary care.

M&E - System Wide Opportunity Analysis

Shropshire, Telford & Wrekin : System Opportunity Overview

Regional Team Hypotheses

1 Day Case Surgery

RightCare shows that the overall rate of day cases in 17/18 is above that of peers, however some areas are still open for improvement.

Model Hospital suggests that the Shropshire and Telford Hospitals Trust could reduce their rate of bed days making better use of day case surgery.
Model Hospital presents the following opportunities

- General surgery – 127 bed days per quarter
- Gynaecology – 42 bed days per quarter
- Breast surgery – 35 bed days per quarter
- Orthopaedic surgery – 30 bed days per quarter

Procedures where day surgery could be optimised include incision and draining of perianal abscess and incision and draining of skin abscess.

Bed days could be reduced for these procedures by 27 days per quarter and 67 days per quarter respectively

2 Medicines Management

Respiratory prescribing has presented the largest prescribing opportunity in 16/17 and 17/18.

16/17 data shows that within respiratory prescribing the STP spend considerably more than peers on Corticosteroids (£869k opportunity) and Adrenoceptor stimulants (**£284k** opportunity)

RightCare data on pathways including prevalence, management and activity may help interpretation of these opportunities.

Biosimilars

Model Hospital has identified some areas where SATH could save money by increasing the uptake of biosimilar medications.

4 Musculoskeletal

RightCare MSK opportunity **£8.47m** in 17/18. The STP are spending more than their peers on a number of MSK indicators . Slightly more specialised commissioning activity occurs than similar peers.

CCGs spending above best 5 peers and the national average on elective admissions for osteoarthritis – Shropshire has one of the highest rates of spend in England in 17/18

In 17/18 NHS Shropshire CCG had one of the highest rates of spend on Primary Hip replacements in the country. 10% of Primary Hip Replacements were cemented compared to an average of 80% among the best 5 peers. However, the CCG are achieving positive health gains from primary hip replacements

Other procedures which stand out include Cervical Spinal surgery with the STP spending 144% more than lowest 5 peers and Sub-acromial decompression with the STP spending 96% more than lowest 5 peers

5 CHC

The CHC SIP programme estimates that based on 2016/17 expenditure levels, there are savings opportunities of **£1.73m** over the three years to 2020/21 in Shropshire

This is an interesting contrast to neighbouring Telford, who have no opportunities. Could the CCGs share approaches?

Workforce

Use of temporary staff within MPFT is the highest of all of its comparator hospitals .

RJAH and SATH also use a high proportion of temporary staff compared to their comparator sites.

Commissioning Capability

The system is currently considering the WSOA data pack through the **System Commissioning Capability Programme** that includes health & local authority colleagues.

Expected outcomes:

- All system efficiencies to be considered and actioned as agreed with system partners
- All efficiencies to be included in system financial position
- All risks to delivery to be identified and mitigated with system partners

- WSOA to be superseded in time by STP Bronze Pack (7th Mar 2019) & Population Health & Prevention Dashboard once delivered later this year (expected Autumn 2019)

System Financial Position & Risk Management

Managing Collective Financial Resources

- The Managing Collective Financial Resources (MCFR) framework has been developed to support systems to effectively manage their collective resources.
- The MCFR framework identifies six key activities that are critical to managing financial resources collectively. The framework is supported by a resource library of tools and case studies which will be updated regularly.

In addition to the six areas of system activity two additional factors have been identified as particularly important to whole system financial management.

These **factors** are:
- Implementation capacity and capability
- System leadership and culture

Current situation – reality check

The system recognises that at this draft stage, there is still system work to do in order to achieve the following:
- Agreed contract alignment and signing
- Agreed Final organisational Plans
- Final submission of system plans by 11th April

Alignment of Activity, Finance and Workforce data is happening through the triangulation work. Supporting that work is a commitment to reach shared understanding of current position but more importantly put processes in place to close the gaps identified through system collaborative working.

System leadership through chief officers and executives is key in identifying and delivering solutions, a system leadership away day is planned for 27th Feb with a focus on system mitigation of risks, particularly finance. Outputs from this will be included

System planning timeline